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À PROPOS DES FEMMES ET DU VIH/SIDA AU SÉNÉGAL : UN NOUVEAU
REGARD. UNE ANALYSE FEMME/GENRE ET DÉVELOPPEMENT /
RETHINKING WOMEN AND HIV/AIDS IN SENEGAL :
A WOMAN/GENDER AND DEVELOPMENT ANALYSIS

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PREFACE

The impetus for this thesis project comes out of my experience as a consultant in Aboriginal community health conducting HIV/AIDS community-based research, developing education materials, training health professionals and evaluating HIV/AIDS projects. The dramatic growth of HIV among First Nations and Inuit women in the 1990's prompted the national research study I conducted on Aboriginal women and HIV/AIDS in 1998 that was part of a larger HIV/AIDS skills-building project that I coordinated for the National Indian and Inuit Community Health Representatives Organization. The research revealed how gender in its articulation with 'race' and class inequalities shaped their vulnerability to HIV, their experiences living with HIV and their access to treatment, care and supports as well as their preponderant role in caring for people living with HIV/AIDS (Ship and Norton 1998, 2000, 2001). But it also drew attention to the marginalization of Aboriginal women, if not their invisibility, in HIV/AIDS policy, programs and research as well as the noticeable lack of advocacy on their behalf by Aboriginal AIDS organizations and Aboriginal women's groups, illustrating how women and gender issues have been sidelined in the fight against AIDS close to home.

This action research project coincided with a trip to Senegal that I took in 1998 when the Society for Women Against AIDS in Africa (SWAA) was hosting an international conference on 'Women and AIDS in Africa' in Dakar. Many of the themes in this conference resonated with research I was conducting on Aboriginal women at the time and it brought home to me the need for a broader feminist analysis of HIV/AIDS and for political action to put gender and HIV/AIDS issues on policy agendas. This is no less important now, writing in the aftermath of the AIDS 2006 Toronto Conference in light of my involvement in the Blueprint Coalition for Action on Women, Girls and HIV/AIDS and Women's Networking

Zone, as it was then. AIDS is profoundly political. It is about power relations in the real world that shape how we conceptualize the pandemic and its impact, the policy responses and political choices that guide programs we develop to contain the spread of HIV and to treat the disease as well as the types of research we conduct. HIV/AIDS is as much about politics, power, social justice and social change as it is about health, medicine, science and technology.

The African proverb reminds us that ‘It takes a village to raise a child.’ This dissertation would not have been possible without the unique and special contribution of numerous people. In particular, I want to thank all of the individuals who took the time to participate in this research and share their knowledge and experience with me. My profound thanks to my thesis director, Professor Chantal Rondeau, Department of Political Science at the Université du Québec à Montréal, for her support and encouragement for this thesis project, her research expertise, timely and valuable insights. Many thanks to Professor Micheline de Sève, Department of Political Science at the Université du Québec à Montréal, for her incisive comments and wise counsel.

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This thesis is dedicated to all of the women and men living with HIV/AIDS in Senegal, a celebration of their strength and their courage and to all of the people who work tirelessly to stem the tide of AIDS.

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RÉSUMÉ

Cette thèse explore la féminisation du VIH/sida au Sénégal et l'approche sénégalaise étatique de lutte contre le sida. Elle remet en question l'idée reçue voulant que ce soit un modèle en matière de prévention du VIH, en matière de soins des personnes vivant avec le VIH/sida (PVVIH) et en tant que cadre institutionnel. En concevant 'les femmes et le VIH/sida' à partir d'une perspective féministe, elle présente une approche Femme/genre et développement qui pose les femmes et les relations de genre au centre d'une analyse de genre du contexte politique, économique, social et culturel qui sous-tend l'épidémie du VIH/sida au Sénégal et les politiques d'État en matière de VIH/sida. L'examen porte sur les multiples dimensions du phénomène de la féminisation du sida ; la vulnérabilité sociale des femmes, le statut social et économique des femmes séropositives et leur accès aux soins et à du soutien et le rôle des femmes en tant que prestataires des soins aux PVVIH. Ceci est relié à une analyse des politiques étatiques et du rôle des groupements de femmes dans *l'empowerment* et à leur plaidoyer en faveur des femmes dans le contexte du VIH/sida.

Il s'agit d'une recherche empirique avec un objectif pratique. Cette étude de cas se base principalement sur la recherche qualitative et une approche pluri-variée qui comprend l'observation, la recherche d'archives, l'analyse des politiques et des entrevues semi-structurées avec des représentant-e-s de divers groupes d'acteurs sociaux pertinents dans le domaine du VIH/sida. Sont mises en rapport l'analyse féministe sociologique basée sur l'intersectionnalité des oppressions du genre, et de la classe sociale et des relations nord-sud en ce qui a trait au VIH/sida et l'analyse politique féministe de l'État comme «hiérarchie genré» afin de révéler son rôle contradictoire dans la reproduction des inégalités de genre (hommes-femmes). L'analyse dégage le contexte des politiques étatiques sénégalaises en matière de VIH/sida et le cadre institutionnel d'élaboration de politiques qui limite son efficacité dans la lutte contre la féminisation du sida.

La thèse démontre comment les rapports inégaux de genre dans la sphère privée, touchant la sexualité, le mariage et la famille expliquent en partie le risque élevé des femmes face au VIH, en soulignant que la classe sociale, le statut matrimonial et l'âge dans un contexte d'inégalités nord-sud différencient en termes de vulnérabilité sociale les diverses catégories de femmes. Cette recherche révèle les insuffisances de l'approche genre en matière de prévention du VIH qui résident dans l'accès inégal des femmes à l'éducation, aux techniques de dépistage du VIH et au condom féminin, conséquence des rapports inégaux de genre dans leur interaction avec d'autres inégalités sociales ainsi que du peu de programmes axés sur le renforcement de la capacité des femmes de négocier des rapports sexuels sécuritaires et l'utilisation du condom. La 'protection de la femme' plutôt que '*l'empowerment* des femmes' est la conséquence de modèle de prévention 'ABC.'

Il est démontré également comment les inégalités de genre se reproduisent dans les situations économiques et sociales dans lesquelles les femmes séropositives vivent. Elles se retrouvent davantage en dessous du seuil de la pauvreté et elles sont responsables du bien-être et du soutien économique de leurs enfants. Elles font face à une double discrimination en tant que femmes et séropositives. Des inégalités de genre, de classe sociale et de provenance (selon la région et selon la division nord-sud) façonnent leur accès aux soins médicaux et au soutien psychosocial. Les femmes portent le fardeau de la maladie en tant que prestataires de soins non-rémunérés aux personnes et familles atteintes et affectées par la maladie et elles subventionnent les insuffisances dans les services communautaires et étatiques. Ceci démontre comment les rapports inégaux de genre sont reproduits dans le modèle sénégalais de soins et soutien qui est basé sur une conception neutre selon le genre (*gender-neutral*) des PVVIH.

L'État sénégalais n'as pas de politique efficace en matière de genre et de VIH/sida car des relations de genre inégales et une culture politique de la domination masculine se reproduisent à l'intérieur du programme national de lutte contre le sida et des structures d'élaboration de politiques qui marginalisent les questions de genre et limitent la capacité des groupements de femmes de plaider en faveur des femmes. L'absence d'engagement face à une perspective de genre se manifeste dans la sous-représentation des femmes et experts de genre dans les structures et processus d'élaboration de politiques, dans la marginalisation des questions femmes et de genre dans les discours de politique en matière de VIH/sida, dans l'intégration inégale (*mainstreaming*) du genre dans les orientations stratégiques, priorités politiques et les cibles en ce qui concerne la prévention, les soins et le soutien des PVVIH, la recherche, les questions d'éthique et de droits humains, la surveillance et évaluation des mesures appliquées. Cette étude de cas démontre les insuffisances du modèle sénégalais et souligne la nécessité de mettre les questions de genre de l'avant dans les politiques, la recherche et les programmes en matière de VIH/sida.

Femmes, VIH/sida, Genre et développement, Sénégal, État et politiques

RESUMÉ

This dissertation explores the feminization of HIV/AIDS in Senegal and the Senegalese state-centric approach in containing and addressing the epidemic. It challenges the widely held view that the Senegalese approach is a model in HIV prevention, in the treatment of people living with the disease and as an organizational template. It re-conceptualizes 'women and HIV/AIDS' from a feminist perspective. Utilizing a Woman/ Gender and Development approach, this study places women and gender relations at the centre of gender analysis of the political, social, economic and cultural context that underpins the HIV/AIDS epidemic among women in Senegal and state policy responses to it. It examines the multiple dimensions of the feminization of AIDS; women's social vulnerability to HIV, the social and economic status of seropositive women and their access to treatment, care and supports, and women's roles in the care of people living with the disease, linking them to an analysis of state policy responses and the role of women's organizations in empowering women in the context of HIV/AIDS and advocating on their behalf.

Empirical in focus and practical in objective, this single-case study is based primarily on qualitative research. It combines observation, archival research, policy research and semi-structured interviewing with representatives from the diverse groups of social actors in the HIV/AIDS domain. This study links an intersectional feminist sociological analysis of gender and HIV/AIDS with a feminist political analysis of the state as a 'gendered hierarchy' in order to capture its contradictory role in reproducing gender inequalities within the context of state HIV/AIDS policy responses and policy-making framework that limit its effectiveness in containing and addressing the feminization of AIDS.

It demonstrates how unequal gender relations in the private sphere of sexuality, marriage and the family shape women's elevated risk to HIV, although social class, marital status and age, within a context of north-south inequalities further differentiate the social vulnerability of different categories of women. It reveals the inadequacies of the Senegalese gender approach to HIV prevention that lie in women's unequal access to information, testing and the condom technologies, principally the female condom; a consequence of gender inequalities in its interaction with other social inequalities, as well as the lack of programs aimed at enhancing women's capacity to negotiate safe sex and condom use. 'Protecting women' rather than 'empowering women' is the consequence of the Senegalese ABC model of prevention.

It shows how gender inequalities are reproduced within the social and economic situations of women living with HIV/AIDS as they are more likely to be living in poverty, responsible for the financial welfare of their children and face double discrimination as women and as HIV positive. Gender, social class, regional

and north-south inequalities shape their access to treatment, care and supports. Women bear the disproportionate burden of illness as unpaid caregivers of people and families living with and affected by AIDS, subsidizing the gaps in state and community services and illustrating how unequal gender relations are reproduced in the Senegalese model of treatment care and supports that is premised on a gender-neutral definition of people living with HIV.

The state does not possess an effective gender and HIV/AIDS policy as unequal gender relations and a male-dominated political culture are reproduced within the state national AIDS control program and HIV/AIDS policy-making structures that serve to marginalize gender issues and limit the capacity of women's groups to advocate on behalf of women. Its lack of commitment to a gender perspective is manifested in the substantive under-representation of women and gender experts in the institutions and processes that make policy, in the marginalization of women and gender equality issues in AIDS policy discourse, in the uneven mainstreaming of gender and women's issues in strategic policy orientations, priorities and targets around HIV prevention, treatment, care and support of PHAs, research, ethics and human rights, monitoring and evaluation. This case study demonstrates the limits of the Senegalese model and highlights the need to foreground gender in matters of HIV/AIDS policy, research and programs.

Women, HIV/AIDS, Gender and Development, Senegal, State and Policy

INTRODUCTION

RETHINKING WOMEN AND HIV/AIDS IN SENEGAL

This thesis explores the multiple dimensions of the feminization of HIV/AIDS in Senegal. Grounded in Gender and Development feminist theories, it places women and gender relations at the centre of gender analysis of the social, political, economic and cultural context that underpins the spread of HIV/AIDS among women in Senegal and state policy responses to it. Utilizing a conceptual framework encompassing the multiple ways HIV/AIDS affects women, I examine state HIV/AIDS and related policies, women's vulnerability to HIV infection, the social and economic situations of women living with HIV/AIDS and their access to treatment, care and supports, women's roles in the care of people living with the disease and the role of women's organizations in empowering women in the context of HIV/AIDS and advocating on their behalf.

Women, HIV/AIDS and Development in Sub-Saharan Africa

HIV/AIDS was initially viewed as a white gay man's disease as a result of the focus on its emergence in San Francisco's gay community in the early 1980's.¹ Androcentrism, homophobia and a bio-medical approach in North America obscured focus on the global spread of HIV/AIDS, particularly in the Global South

¹. Putzel (2003: 7) defines HIV, the human immunodeficiency virus, "as a particular type of slow-acting retrovirus that is never fully eliminated from the body. HIV infects the CD4+ cells that devastate the immune system, making it vulnerable to opportunistic infections. It is the loss of CD4+ cells and the rapid rise of the amount of HIV circulating in the bloodstream (viral load) that indicates full-blown acquired immunodeficiency syndrome."

and among women (Patton 1994). The rapid spread of HIV, particularly in Sub-Saharan Africa, is inextricably linked to poverty, powerlessness, migration and population movements that are themselves linked to the broader deteriorating political-economies and social transformation (Barnett and Whiteside 2002; Panos Institute 1992). The socio-economic impact of AIDS is most severely felt in low-income countries and in households at or below the poverty line (World Bank 1999; UN 2001). In many of the most seriously affected states in Africa, the AIDS pandemic is reversing many of the development gains made since independence as life expectancy, child mortality, literacy and food production have deteriorated significantly (Poku and Whiteside 2005; Kleintjes et al. 2004). The June 2001 UN General Assembly Special Session on HIV/AIDS (UNGASS 2001) acknowledged that “HIV/AIDS is not only a health issue but also a development issue that has an impact on every aspect of life, requiring a response from all sectors: government, civil society and the private sector” (Commonwealth Secretariat and Maritime Centre of Excellence for Women’s Health 2002: 51).

HIV and AIDS have steadily risen, particularly among women, who accounted for half of the HIV/AIDS cases in 2007 (UNAIDS 2004b, 2006a, 2007), despite the implementation of national AIDS control programmes by most governments with the assistance of the World Health Organization (WHO). In North America and Western Europe, homosexual men remain the most affected by HIV/AIDS but HIV and AIDS rates have climbed not only among injection drug users but also among women largely as a result of transmission through heterosexual sex (UNAIDS 2004c). HIV transmission in Sub-Saharan Africa continues to be largely fuelled by heterosexual sexual relations (Baylies and Bujra 2000).² However, unlike gender patterns in North America and Western Europe

². HIV transmission occurs “when contaminated body fluids such as blood, semen and vaginal secretions pass from a carrier to another person. The main modes of transmission in Africa in order of importance are: unsafe heterosexual intercourse, mother-to-child transmission, use of infected blood products, intravenous blood use with contaminated needles and other blood related modes of transmission” (Putzel 2003: 8).

where women represent about 25% of the total estimated number of HIV/AIDS cases, women comprised 61% of the total HIV/AIDS cases in Sub-Saharan Africa in 2007 (up from 59% in 2005, 57% in 2003 and 55% in 2001) (UNAIDS 2007: 8; UNAIDS 2004c: 5, 2006a: 15). “Adult women in Sub-Saharan Africa are up to 1.3 times more likely to be infected with HIV than their male counterparts” (UNAIDS 2004c: 7). African women accounted for three quarters of all women living with HIV in 2005 (UNAIDS 2006a: 15). At greatest risk, are young women aged 15 to 24 years who are three times more likely to be infected than young men of the same age (UNAIDS 2004c: 7). In 2005, the HIV rate for young women in Sub-Saharan Africa was estimated at 4.3% but only 1.5% for young men (UNAIDS 2006a: 508).

In spite of a decline in new HIV infections in 2007, Sub-Saharan Africa remained the most seriously affected, with 68% of all people living with HIV/AIDS; an estimated 22.5 million people of the estimated 33.2 million HIV/AIDS cases worldwide at the end of 2007 (UNAIDS 2007: 3). However, AIDS epidemics vary throughout the region and within African states. Adult prevalence rates in West Africa remain lower than elsewhere in the Sub-Sahara, with adult HIV prevalence lowest in the Sahel countries, although Nigeria is said to have the largest epidemic in the region (UNAIDS 2007). HIV rates have declined in Côte d’Ivoire from 7.1% in 2005 to 4.7% in 2006 as well as in urban areas in Mali and Burkina Faso (UNAIDS 2007: 11, 19). The Central African Republic (6.2%) posted the highest rate in 2006 in Central Africa, although there is evidence that HIV rates are on the rise in urban areas in Chad (UNAIDS 2007: 20). In East Africa, some countries such as Uganda have witnessed a decline in new infections, largely as a result of its effective interventions among young people aged 15 to 24 years (UNAIDS 2001) and more recently, a decline in prevalence in Kenya and Tanzania was noted (UNAIDS 2007). The epicentre of the African AIDS pandemic has shifted from East Africa to Southern Africa (Iliffe 2006), where eight of the ten states had adult prevalence rates above 15.% in 2005, with Swaziland’s prevalence rate, the highest, estimated at 33.4% (UNAIDS 2007; UNAIDS 2006a: 506).

Senegal's Policy Response to HIV/AIDS – An African Success Story

Senegal, by contrast with other countries in Sub-Saharan Africa, has maintained a low and stable adult HIV infection (men and women aged 15 to 49 years) since the beginning of the pandemic, with estimates varying between 0.4% and 1.77% (Meda et al. 1999; UNAIDS 2006a).³ UNAIDS (2008: 5) set the adult prevalence rate for Senegal at 1.0%, with the low estimate at 0.7% and the high estimate at 1.4% for 2007, although there were regional variations with HIV prevalence rates highest in Kolda and Ziguinchor; a consequence of high levels of poverty, migration and instability as a result of the twenty year low level civil conflict in the Casamance (UNAIDS 2006e). Senegal's 2005 adult HIV prevalence rate (.9%) was still lower than that of neighbouring West African countries such as Mali (1.7%), Gambia (2.4%) and Guinée (1.5%) (UNAIDS 2006a: 506), where Islam, considered by some as a key element in maintaining low HIV infection rates, is also a predominant force in social and cultural organization. A low-prevalence country with a concentrated epidemic in high-risk groups, HIV/AIDS rates in Senegal are highest among female sex workers at 27.1% (UNAIDS 2006a: 510) and men having sex with men at 21.5% (Wade et al 2005: 2133).

Moreover, Senegal has been presented as a 'developing world' success story in HIV prevention largely as a result of early state intervention (Meda 1998; UNAIDS 1999a, 2001; Groupe thématique ONUSIDA/ Sénégal 2001; Crawford 2002; Hemmat 2003; Putzel 2003; Green 2003; Oppong and Mensah 2003; World Bank 2004b). This is all the more impressive, given its level of economic underdevelopment, widespread poverty and low ranking of 157 on the Human

³. There are two distinct HIV viruses, HIV-1 and HIV-2, with many subvariants. "HIV-2 is less pathogenic, has a longer latency period and appears to be most prominent in West Africa, while HIV-1 is firmly established worldwide" (Putzel 2003: 8). This also partly may explain the low stable prevalence rate in Senegal where, unlike other parts of Africa, "initially there was a higher proportion of HIV-2 cases although by the end of the 1980's and in the early 1990's, HIV-1 and HIV-2 were found in similar proportions" (Meda et al. 1999: 1406). For purposes of this research, HIV refers to both strains.

Development Index in 2005 (UNDP 2005; World Bank 2007). With the emergence of the first AIDS cases in 1986, the government of Senegal established the *Comité national pluridisciplinaire de prévention du VIH/SIDA* (CNPS) and immediately set up the *Programme national de lutte contre le SIDA et les MST* (PNLS), renamed the *Conseil national de lutte contre le SIDA et les MST* (CNLS) in 2002 (Putzel 2003; Groupe thématique ONUSIDA/ Sénégal 2001). As impressive, the Senegalese government initiated its national response before the WHO urged it to do so. From the outset, it implemented a wide-ranging comprehensive national response focusing on epidemiological, clinical and educational aspects. The general objectives of the PNLS were to monitor the scope of the epidemic, reduce HIV transmission, guarantee the safety of blood transfusions, promote education activities for the prevention of the sexual transmission of HIV, meet the psychological and medical needs of persons living with HIV/AIDS, strengthen prevention efforts for all sexually transmitted infections (STIs) and develop and coordinate research activities (Putzel 2003: 31). An Emergency Plan of Action was instituted in 1987, followed by two Medium Term Plans for the periods of 1988 to 1992 and 1994 to 1998, as well as plans for the period 1999 to 2003, 2002 to 2006 and 2007 to 2011 (République du Sénégal 2002a, CNLS 2007c).

The following elements of the Senegalese national policy response have been identified as contributing to its success in maintaining a low and stable HIV infection rate: early and strong action taken by the state, broad involvement of NGO's, community groups (women and youth), religious (Islamic) and community leaders, priority accorded to community-based interventions using local cultures and culturally-appropriate methods, screening of the blood supply, prevention efforts targetting commercial (registered) sex workers to improve HIV screening and prevention as well as treatment of sexually transmitted infections (STIs), the promotion of condom use and the institution of sex education in the school curriculum (Putzel 2003; RESER et al. 2000; UNAIDS 2001, 1999a; Niang 2001; Groupe thématique ONUSIDA/ Sénégal 2001; Meda et al. 1999).

It has been suggested that pre-existing social factors are also conducive to keeping the HIV infection rate low in Senegal, in addition to the initial predominance of the less pathogenic HIV-2 strain. This includes the role of Islam in Senegal, particularly adherence to Islamic family and sexual norms that encourage low-levels of pre-marital sex and extra-marital sex, later age of first sexual encounters among young women, the social control of women's sexuality, male circumcision and low levels of alcohol consumption (UNAIDS 1999a; Groupe thématique ONUSIDA /Sénégal 2001). Senegal also has a long tradition of emphasizing prevention and primary health care in health policy and Senegalese families spend more on health care than in neighbouring states (UNAIDS 1999a). Legalized prostitution in 1969 and the implementation of a STIs treatment program in the late 1970's allow for closer monitoring, testing and treatment of HIV and sexually transmitted infections, a co-factor in HIV transmission, among registered prostitutes (Putzel 2003; Ndoye 1991).

Senegal also has been cited as a model in the treatment of people living with HIV/AIDS as a result of the implementation of the national Senegalese Antiretroviral Drug Access Initiative (ISAARV) program that guarantees access to antiretroviral drugs, which up until recently was considered by medical experts as not feasible for countries in the Global South (Katzenstein et al. 2003; Desclaux et al. 2003). In 1998, the PNLS took the initiative on its own, partnering with France's *Agence nationale de recherche scientifique* (ANRS) to implement a pilot project to study the feasibility of providing anti-retroviral therapy (ART) for Senegalese AIDS patients (World Bank 2004b). Based on the success of the pilot project, the Senegalese state and the CNLS set up a national treatment program in 2002, with the goal of treating 7,000 AIDS patients by 2006 (Laurent et al. 2002; Desclaux et al. 2003; Lanièce et al. 2003). This initiative was made possible through World Bank MAP loans, funding from the Global Fund for AIDS, Tuberculosis and Malaria (GFATM) and negotiations with pharmaceutical companies for price

reductions for ART. Despite a series of price reductions in the cost of ART to enhance access, most AIDS patients could not afford a minimal financial contribution towards treatment and in 2004, Senegal became the first African country to provide anti-retroviral therapy to AIDS patients free of charge.

Finally, Senegal's National AIDS Program, along with that of Uganda, has been cited as a model organizational template upon for the World Bank's National AIDS Commissions and the Global Funds' Country Coordinating Mechanisms; both of which are mandatory for receiving funds from these agencies (Putzel 2003, 2005; World Bank 2004b). The *Programme national de lutte contre le Sida* (PNLS) was based on an intersectoral approach that involved representatives from all major government ministries and partnerships with civil society actors as well as foreign donors and experts and enjoyed political support at the highest levels of the presidency (Putzel 2003, 2005; World Bank 2004b). Unlike the majority of national AIDS programs in Africa and elsewhere, the *ministère de la Femme* has been a member of the Senegalese national AIDS control program from the beginning. The move to a multisectoral approach to addressing HIV/AIDS has served to enlarge civil society and private sector participation in the response. This also included the enhanced representation of women's groups in the revamped institutional structure.

The Feminization of HIV/AIDS in Senegal

Notwithstanding Senegal's low and stable HIV/AIDS prevalence rate, HIV/AIDS has been steadily rising among Senegalese women since 1988, particularly among female sex workers. In 1987, women with AIDS represented only 10% of all reported AIDS cases in Senegal but by 1992, they represented 30% of all cases (Niang 1997: 2). Data from the Senegal epidemiological surveillance program showed that the sex ratio for male and female HIV/AIDS cases narrowed to 1.15 by 2002 from 2.64 in 1988 (Wone 2002b: 6). Disease progression rates have

been rising much faster among women as compared to men and by 2002, the progression rate for men was 1.72 whereas for women was it was 3.95 (Wone 2002b: 5-6).

Senegalese women are now over-represented in the number of estimated HIV/AIDS cases in Senegal. UNAIDS estimated that Senegalese women, aged 15 to 49 years, comprised 59.4% or 38,000 of the 64,000 estimated adult HIV cases in 2007, up from 58.9% or 33,000 of the 56,000 estimated adult HIV cases in 2005 and 58.4% or 31,000 of the 53,000 estimated adult HIV/AIDS cases in 2003 (UNAIDS 2008: 5; UNAIDS 2006d: 2). HIV testing of selected households included in the *Senegal EDS-IV* revealed that women were over-represented in HIV statistics in both urban and rural areas in 2005. This data showed a female/male infection ratio of 2.25; or 225 infected women for every 100 infected men and a national prevalence rate of 0.7%, with women (0.9%) more infected than men (0.4%) (CRDH 2005a: 37), as Table 1 indicates.

Table 1: HIV Prevalence among Women and Men (15 to 49 years), EDS-IV 2005

Residence	Women %age	Men %age	Together %age
Urban	1.0	0.4	0.7
Rural	0.8	0.5	0.7
Total	0.9	0.4	0.7

Source: Centre de Recherche pour le Développement Humain (2005). *Sénégal enquête démographique et de santé 2005: Rapport préliminaire*. Dakar, p. 37.

As Table 2 indicates, HIV rates vary regionally. Infection rates are higher for women than for men in most of Senegal's regions.

Table 2: HIV Prevalence among Women and Men (15 to 49 years), EDS-IV 2005: A Regional Breakdown

Residence	Women %age	Men %age	Together%age
Region			
Dakar	0.7	0.5	0.6
Diourbel	0.1	0.0	0.1
Fatick	0.9	0.9	0.9
Kaolack	1.0	0.2	0.7
Kolda	2.7	1.1	2.0
Louga	0.7	0.0	0.5
Matam	0.5	0.8	0.6
Saint-Louis	0.9	0.0	0.5
Tambacounda	0.3	0.5	0.4
Thiès	0.4	0.3	0.4
Ziguinchor	3.4	0.8	2.2

Source: Centre de Recherche pour le Développement Humain (2005). *Sénégal enquête démographique et de santé 2005: Rapport préliminaire*. Dakar, p. 37.

The EDS-IV 2005 data also showed higher HIV prevalence rates among young women as compared to young men, although these rates are higher among women (CRDH 2005a: 37), as Table 3 indicates.

Table 3: HIV Prevalence among Women and Men (15 to 49 Years) by Age, EDS-IV 2005

Age	Women %age	Men %age	Together%age
15-19	0.2	0.0	0.1
20-24	0.8	0.2	0.5
25-29	1.5	0.0	0.9
30-34	0.9	1.2	1.0
35-39	0.6	0.8	0.7
40-44	1.7	1.6	1.7
45-49	1.9	0.6	1.3

Source: Centre de Recherche pour le Développement Humain (2005). *Sénégal enquête démographique et de santé 2005: Rapport préliminaire*. Dakar, p. 37.

UNAIDS (2008: 6) estimated the 2007 HIV prevalence rate at 0.8% among young women aged 15 to 24 years and 0.3% among young men aged 15 to 24 years in Senegal. As is the case in most African countries, young women are more likely

to be HIV positive than young men, although these rates are lower in Senegal than elsewhere in Africa.

HIV prevalence rates among registered female sex workers in Senegal have been on the rise, and increased from 13.0% in 2000 to 27.1% in 2005, despite HIV prevention programs targeting female sex workers and public health measures to control HIV and STIs among them (UNAIDS 2006a: 510). HIV prevalence rates among female sex workers in Dakar increased gradually from less than 1% in 1986, to 13% in 2000, to 14 % in 2002 and to 19% in 2004 and HIV-1 prevalence among sex workers outside of Dakar, in Kaolack and in Ziguinchor continued to increase from 0 % in 1986 to over 20% in 2002 (UNAIDS 2004d: 2, 2004b: 27). Sex workers testing positive for HIV in 2003 showed a 20.9% rate in Dakar, 10.9% in Thiès and 30.3% in Ziguinchor (CNLS 2004: 20). Estimated at 10.1%, the lower seroprevalence rate among clandestine female sex workers in Dakar as compared to registered sex workers is partly a result of their lower exposure due to a shorter time in commercial sex work (Laurent et al. 2003: 1813).

HIV/AIDS among pregnant women in Senegal has historically remained low, relatively stable and less than or equal to 3% (higher than 3% in this group constitutes a generalized epidemic) (CNLS 2004d: 29). Nevertheless, HIV/AIDS rates among women attending antenatal clinics have increased from 0.5% in 1998 to 0.8% in 2001 and to 1.1% in 2002 (UNAIDS 2004d: 2) to an average rate of 1.5% and a median rate of 1.9% in 2003 (CNLS 2004d: 20). HIV prevalence among young pregnant women aged 15 to 24 years is also on the increase, from 0.7% in 2003 to 1.2% in 2005 (UNAIDS 2006e: 2). Moreover, sentinel surveillance among pregnant women attending pre-natal clinics showed regional variations in HIV prevalence rates; some of which are higher than the national prevalence rate and dangerously close to the 3% benchmark, as Table 4 indicates, raising concerns about the efficacy of HIV prevention among married women.

Table 4: HIV Prevalence Rates among Pregnant Women

Sites	2003 HIV%age	2005 HIV%age
Dakar	1.7	3.6
Diourbel	1	1.1
Fatick	1.2	0.8
Kaolack	2	1.6
Kolda	2.8	3.0
Louga	0.8	0.6
Matam	2.2	---
Mbour	2	---
Saint-Louis	0.5	0.7
Tambacounda	2.6	3.6
Thiès	0.7	0.3
Ziguinchor	2.3	3.4

Source: CNLS (2004). *Bulletin Séro-épidémiologique No.11, 2004*. Dakar, p. 20. CNLS (2006). *Données épidémiologiques du VIH/sida au Sénégal 2004-2005*. Dakar, p. 22.

Women also represent a growing proportion of hospitalized AIDS patients in Senegal (CNLS 2004) and a growing proportion of the clients at the *Centre de traitement ambulatoire* at Fann Hospital (Gomes do Espirito Santo 2000). In 2007, it was estimated that 6,700 people received ART (56% coverage) up from 3,622 AIDS patients receiving ART (or 49% coverage) in 2005 (UNAIDS 2008: 13; CNLS 2006a: 28). UNAIDS (2006d:14) estimated that about 10,000 people required ART in 2005 but only about 35% were receiving treatment while in 2007 it was estimated that 12,000 people needed treatment (UNAIDS 2008: 13) No gender breakdown was given. In 2005, although 79% of medical regions offered the *Programme transmission mère-enfant* (PTME), only 16,114 pregnant women had been counseled around HIV testing and only 57 of the 4,000 (or 1%) estimated HIV pregnant positive women had received ART (UNAIDS 2006d: 18), up to 6% in 2007 (UNAIDS 2008: 16).

Despite the problems entailed in gathering accurate HIV/AIDS statistics (UNAIDS 2004c; Baden and Wach 1998), they nevertheless suggest that the Senegalese model is not an unqualified success with respect to women. The

increase in HIV/AIDS rates among women in general and among different categories of women in specific, as the statistics indicate, raises some pointed questions about the success of the Senegalese prevention model in containing the transmission of HIV among women. The data around HIV testing and access to ARVs in the context of the PTME suggests the need to examine more closely how women's experiences living with HIV/AIDS may differ from men's and the obstacles they may face in access to treatment as well as some of the deficiencies in the Senegalese model of treatment, care and support for PHAs. Moreover, it raises broader questions as to how women and HIV/AIDS issues are addressed within the Senegalese national AIDS program model and policy-making process.

Research Questions

This dissertation seeks to answer the following questions: What is the appropriate analytic framework for studying the feminization of AIDS in Senegal? What explains the feminization of HIV/AIDS and women's vulnerability to HIV in Senegal, despite Senegal's relative success in containing HIV? Does HIV/AIDS also affect seropositive women and men differently with respect to their social and economic circumstances as well as their access to treatment, care and supports? What are the limitations in the Senegalese prevention model and in the treatment, care and support model? Do state HIV/AIDS policy, programs and services take women and gender differences into account and how are women's interests and organizations represented in the national AIDS program?

Hypotheses

- a. Women's vulnerability to HIV is shaped not only by social class and north-south inequalities but also by unequal gender relations, age and marital status. The

gender approach in the Senegalese HIV prevention model is inadequate because it does not effectively address women's subordination and unequal gender relations.

- b. Unequal gender relations intersect with poverty and north-south inequalities to shape seropositive women's social and economic situations.
- c. Unequal gender relations intersect with poverty, regional and north-south inequalities to shape seropositive women's access to treatment, care and supports. Unequal gender relations are reproduced in the Senegalese model of treatment, care and support of people living with HIV/AIDS, as women bear the disproportionate burden of illness as caregivers of people with AIDS.
- d. The state does not possess an effective gender and HIV/AIDS policy as unequal gender relations and a male-dominated political culture are reproduced within the state national AIDS program (CNLS) and HIV/AIDS policy framework.

Methodology

I chose to conduct a single-case study of the feminization of HIV/AIDS in Senegal based primarily on qualitative research as it allows for the in-depth exploration of its multiple dimensions and state policy responses in addressing it. The case study method is widely used for evaluating the effectiveness of HIV prevention and intervention strategies (Mantell et al. 1997) and in other forms of women's health research (Reinharz 1992). The value of a case study is that it is concerned with completeness in the analysis of the social phenomena at hand (Reinharz 1992); all the more important given the lacunae in the existing literature and research on women and HIV/AIDS in Senegal. It allows us to bring into analytical focus those aspects of the feminization of AIDS that have received little attention, particularly women's preponderant role in the caregiving of PHAs, gender differences in the social and economic situations of women and men living with the disease and women and HIV/AIDS issues in state policy. It provides the

impetus to develop a more comprehensive research program designed to engender policy and improve prevention, care and support for women affected and infected. Though the results are not generalizable, the insights generated from this case study can be used to explore the multiple effects of HIV/AIDS on women elsewhere.

The single-case study is a useful tool for empirical feminist research (Reinharz 1992). It provides a holistic conceptualization that allows us to understand process and outcome as well the interplay of systems, structures, actions and the meanings of actors (Tellis 1997). It allows us to move beyond a narrow bio-medical approach with its focus on individual risk behaviours to situating the feminization of HIV/AIDS in Senegal in a broader social, cultural political and economic context, focusing on power inequalities that drive the epidemic and shapes responses to it. This is particularly important for understanding the multiple ways HIV/AIDS affects women. “The case study can be seen to satisfy three tenets of qualitative method: describing, understanding and explaining” (Tellis 1997: 3). It brings unequal gender relations in the private sphere into analytical focus and allows us to explore the links between gender inequalities and other forms of oppressive social relations that give rise to women’s subordination and to demonstrate how in the specific context of Senegal, these serve to exacerbate women’s HIV risk, their differential experiences living with the disease and their role as caregivers for people living with HIV/AIDS.

A qualitative case study approach also allows for the analysis of the role of ideas and discourses of actors in the construction of AIDS as an epidemic in Senegal, in the elaboration of state HIV/AIDS policy responses and in the development of program interventions. This allows us to better grasp how women and gender are constructed in HIV/AIDS discourses that shape policy, programs and research. A case study approach also allows for “multi-perspective analyses with consideration given to not just the voice and perspective of actors but also the relevant groups of actors and the interaction between them” (Tellis 1997: 5). The

focus on power relations help us to better grasp how certain conceptualizations of women and gender come to inform AIDS discourses, policies and programs. This also allows us to give voice to the experiences and concerns of women's organizations as well as to document and describe the power relations that affect their insertion into the HIV/AIDS response and policy-making process.

While women do not constitute my main or exclusive research subjects, I situate my research within an empirical feminist research tradition that Reinharz (1992:249) defined as "guided by feminist theory." The epistemological, methodological and ethical foundations of what constitutes feminist research have long been objects of feminist debates (Hesse-Biber et al. 2004; Imam et al. 1997; Gottfried 1996; Ristock and Pennel 1996; Dagenais 1994; Reinharz 1992). This literature points to the lack of consensus and uniform approach. At its most basic, a feminist methodology "aims at creating knowledge that is beneficial to women and other minorities" (DeVault 1999: 31 in Hesse-Biber: 2004: 22). My research shares this objective.

Drawing on feminist concerns with 'self-reflexive' research methodology and practices (Hesse-Biber et al. 2004; Arnfred 2004; Arnfred et al. 2004; MacIlwaine and Datta 2003; Gottfried 1996), I have tried to address the power inequalities in the research setting and how my social location as a white, western, university-educated professional affects the research process in an African country. As with all qualitative and feminist research, my findings are partial and shaped by my political commitments to gender analysis and gender equality. However, it is my objective to provide an alternative reading of HIV/AIDS in Senegal that places women and gender analysis at its centre. For some feminists, this research would be best conducted by Senegalese women, as a way of neutralizing the power inequalities in knowledge-production. However, given the limited possibilities for conducting this type of research in Senegal as it is dependent on external funding and not a priority for most external funders, although women and HIV/AIDS issues

are of concern to many practitioners in Senegal, I justified conducting this research. It is my hope that my thesis will serve as a springboard for future community-based research projects on women, gender and HIV/AIDS issues conducted with or by Senegalese women's groups and community-based organizations with a view to building their research capacities. Although overcoming the power inequalities in the research setting is no easy task, I will provide an in-depth résumé of my findings to all of the research participants that they can then use for advocacy purposes or any other purpose they deem useful as a way of ensuring that this research will be used to their benefit and to the benefit of Senegalese women.

Originality and Pertinence of this Thesis

The originality and pertinence of this thesis resides in its subject matter as it explores the feminization of HIV/AIDS in Senegal, a recently documented epidemiological trend, from a multidisciplinary social science perspective, drawing together political science, political economy of development and women's studies. In line with the growing emphasis on research into the social aspects of HIV/AIDS, this thesis contributes to the underdeveloped social science literature on women and HIV/AIDS in Senegal. It is a necessary but understudied component and complement to the bio-medical, epidemiological and behavioural research on HIV/AIDS and women in Senegal.

The originality of this thesis also lies in its conceptual framework that views the feminization of HIV/AIDS in Senegal not only as a health issue and a development issue but also as a gender issue. Despite the growing emphasis on gender analysis of HIV/AIDS, gender research on HIV/AIDS is still in its infancy in Senegal. The thesis offers a conceptual and analytic framework appropriate to subject matter that is grounded in and grasps the specificity of women's distinct social realities and captures the multiple ways in which the HIV/AIDS affects

women. Providing a comprehensive lens, it allows us to explore not only the situation of women living with HIV/AIDS in Senegal and women's vulnerability to HIV, but also, the burden of care shouldered by women as caregivers of people living with HIV/AIDS, usually overlooked in the dominant analyses of the Senegalese model of the care and support of people living with HIV/AIDS. As the thesis explores gender differences in the experience and impact of HIV/AIDS in Senegal, it contributes to a better understanding of how HIV/AIDS affects women and men differently and to the development of research, policy and programs that are more gender-sensitive and women-centered in Senegal. It provides a conceptual framework that is useful for exploring how HIV/AIDS affects women elsewhere.

In viewing the HIV/AIDS epidemic in Senegal as fundamentally gendered, I offer a gender analysis, grounded in Woman/Gender and Development feminist theories, concepts and research that place power, politics and policy at the forefront of analysis of the feminization of HIV/AIDS in Senegal. It conceptualizes gender as a social relation of power (male-female relations) in its interaction with other social relations of inequality based on social class, marital status, age, geographic location and north-south divisions that shape the diverse ways HIV/AIDS affects women in Senegal. The intersectional feminist framework better accommodates differences in women's experiences of HIV/AIDS while drawing attention to the role of unequal gender relations, often ignored in analyses of women and HIV/AIDS in Senegal.

I link an intersectional feminist sociological analysis of gender with a feminist analysis of the state and the HIV/AIDS policy-making process, in contrast to the mainstream literature on the political dimensions of HIV/AIDS in Senegal. This is essential to engendering state policy responses to HIV/AIDS if the feminization of AIDS is to be contained. Examining how unequal gender relations are reproduced within the state national AIDS program and shape policy, research agendas and program interventions can help to redress this inequity, foreground gender issues in the response, enhance the substantive participation of women's

groups in the policy process and further women's empowerment. This research came at a particularly opportune moment just prior to the elaboration of the 2007-2011 Strategic Plan for HIV/AIDS Senegal, with some research participants using insights from my research for input into the National Consultation.

While the objective of this research is primarily practical rather than theoretical, this case study also makes a contribution to the small and marginal but growing body of feminist theorizations of the Senegalese state and by extension, the African state and to Gender and Development theory. It integrates a feminist theory of the political within feminist Gender and Development perspectives that have as yet to theorize the state, even though the state is viewed as pivotal in this theoretical tradition as a site for women's struggles for gender equality and current campaigns for strengthening women's rights in Senegal as elsewhere in Sub-Saharan Africa. Drawing on more sophisticated feminist theorizing that moves beyond simplistic notions of the African state as a patriarchal state and conceptualizing it as a 'gendered hierarchy', which is autonomous from civil society and subject to it, shot through with gender, class and other power relations allows us to demonstrate how the piecemeal, ad hoc and fragmented approach, characteristic of the dominant approach to gender and development policies informed by a WID framework, is replicated by the Senegalese state in matters of gender and HIV/AIDS policy issues. This conceptualization also provides a more fruitful avenue for guiding feminist research and action around HIV/AIDS or other policy issues, as it is intimately bounded up with feminist theorizing.

Thesis Outline

Chapter 1, Rethinking Women and HIV/AIDS in Senegal, questions the widely held view that the Senegalese model is an unqualified success in addressing the feminization of AIDS. It provides a review of the literature and the problematic that centers on the diverse conceptualizations of HIV/AIDS and their limits, particularly

in coming to grips with gender inequality. It follows with a discussion of the research methods utilized for this study and the limitations of this research.

Chapter 2, Theoretical Framework: A Women/Gender and Development Approach, argues for the need to reframe HIV/AIDS and women in Senegal as a gender issue, centering on a feminist analysis of gender relations and women's subordination within the broader socio-cultural, economic and political context that drives the AIDS epidemic and shapes the state responses to it. In conceptualizing AIDS as a disease and responses to it as fuelled by multiple inequalities, it suggests that a revamped Women/Gender and Development approach to HIV/AIDS can best understand, explain and address the feminization of HIV/AIDS in Senegal. It links an intersectional feminist sociological analysis of gender and HIV/AIDS with a feminist political analysis of the state as a 'gendered hierarchy' in order to capture its contradictory role in reproducing gender inequalities within the context of state HIV/AIDS policy responses.

Chapter 3, The Gendered Context of HIV/AIDS in Senegal, provides an historical account of women's subordination within the context of the socio-political, cultural and economic transformation in Senegal. Beginning with an examination of women's traditional roles in diverse societies in pre-Islamic Senegal, it then explores the impact of Islamization and French colonial policies in shaping women's subordination in the private sphere of the family, sexuality, and marriage and in the public sphere of the polity, society and economy as well as the ideologies that reproduce women's subordination. It then turns to a discussion of the role of the modernizing Senegalese state in shaping women's subordination in these spheres in the post-independence period.

Chapter 4, Women's Vulnerability to HIV Revisited: Beyond Vectors and Vessels, examines the social determinants of women's vulnerability to HIV and state policy responses to containing HIV transmission. It shows how gender inequality in its

interaction with other social relations of inequality such as class, age and marital status, in a context of underdevelopment, shape the vulnerability of different categories of women such as married women, single women, young women and women engaged in sex work to HIV. It links the interplay between broad macro-level structures of inequality and micro-level individual high-risk behaviours that put women at risk for HIV. It examines current HIV prevention strategies showing how they address women's vulnerability to HIV and women's empowerment in a limited way in that they do not adequately attend to unequal gender relations in the private and public spheres or other broader structures of inequality.

Chapter 5, *Women Living with HIV/AIDS: Thinking Through Gender*, explores how gender inequalities in their interaction with other social relations of inequality are reproduced within the social and economic circumstances of people living with HIV/AIDS. It shows how seropositive women face greater challenges than seropositive as a result of unequal gender relations that make it more difficult for them to live positively. It explores the gendered nature of stigma and discrimination around AIDS showing how seropositive women face double discrimination and stigma; as HIV positive and gender discrimination as women that affect them in their social roles as mothers, wives, caregivers and workers. In examining current human rights and private sector initiatives, it shows how they do not adequately address the gendered dimensions of living with HIV/AIDS.

Chapter 6, *Gender in the Continuum of Care for Women Living with HIV/AIDS*, examines Senegal's state model of treatment, care and support to people living with HIV/AIDS, exploring state/civil society relations and roles in providing these services. It focuses on gender in the continuum of care for women living with HIV/AIDS provided by the state, the family and the community. It shows how gender, social class and regional inequalities in the context of underdevelopment limit seropositive women's access to medical and non-medical care and supports, despite the fact that women are over-represented in access to ART, testing and non-

medical services. It also explores the central role of Senegalese women as unpaid caregivers of people living with HIV/AIDS in the family and in the community, showing how this subsidizes the gaps in the Senegalese model of care.

Chapter 7, *Engendering State Policy*, examines Senegal's state HIV/AIDS policy, analyzing how women and gender issues are constructed in state policy discourses and policy priorities as well as examining women's formal and substantive representation in the political and institutional framework and policy-making process for addressing gender and HIV/AIDS issues. It argues that although the Senegalese state acknowledges the need to take gender into account, it does not possess an effective gender and HIV/AIDS policy, illustrating how gender inequalities and a male-dominated political culture are reproduced within the state institution and policy designed to address HIV/AIDS and limit the effectiveness of women's groups in gender and HIV/AIDS advocacy.

In the Conclusion, I retrace the main arguments of each chapter. I then discuss the larger practical and theoretical significance of this case study. I conclude with some preliminary recommendations as to the mainstreaming of a gender equality perspective in all aspects of Senegalese state HIV/AIDS policy, research and programs around prevention, care and support of PHAs, ethical and legal issues that more effectively addresses gender inequalities, women's subordination and women's empowerment, within broader strategies of social change. This also includes strengthening the role of seropositive women and women's groups in the policy process as well as in the development, delivery and evaluation of services.

CHAPTER 1

RETHINKING WOMEN AND HIV/AIDS IN SENEGAL

This chapter begins with review of the literature and the problematic that centers on the diverse conceptualizations of HIV/AIDS and their limits in explaining the feminization of HIV/AIDS in Senegal, particularly in coming to grips with gender. It examines the bio-medical and epidemiological/socio-behaviourial approaches, social science perspectives including culturalist, political economy and political science approaches, and various feminist approaches such as Women in Development (WID), Women and Development (WAD) and Gender in Development (GAD) referred to as gender approaches. Although the feminist literature on development conceptualizes these approaches as theoretically distinct, their institutionalization in development practices has rendered the important differences distinguishing them invisible (Rathgeber 1994; Kabeer 1994). I then discuss the multi-methods approach that I utilized for this case study, followed by a discussion of the limitations of the research.

1.1 Conceptualizing the Feminization of HIV/AIDS in Senegal: Review of the Literature and Problematic

Exploring the feminization of AIDS in Senegal necessarily raises the issue of the appropriate theoretical and conceptual framework that can best capture how HIV/AIDS affects women in Senegal. I situate the literature on Senegalese women and HIV/AIDS within the broader body of literature on women and HIV/AIDS, given the role of the international institutions in shaping international and national HIV/AIDS policy responses to the pandemic, particularly in Sub-Saharan Africa,

and the global management of AIDS. I examine the main conceptual approaches to understanding the forces that shape the epidemic and its impact, highlighting their strengths and weaknesses, focusing on how they conceptualize women and gender issues. I consider in turn bio-medical, epidemiological/socio-behavioural, social sciences, and various 'feminist' approaches.

Bio-medical Approach

The biomedical discourse and approach to HIV/AIDS advocated by scientists and medical professionals "has focused on the clinical and epidemiological characteristics of the disease, modes of transmission, strategies emphasizing individual risk behaviours and developing methods of prevention, treatment and care"(Lee and Zwi:2003:21). AIDS research and policy in the west, specifically in the USA rooted in a bio-medical model initially shaped the global institutional response and discourses around women and HIV/AIDS (Bastos 1999; O'Manique 2004). The early history of the epidemic in the USA and the role of the CDC served to sideline women within the epidemic (Hamblin and Reid 1991; Patton 1994; Treichler 1999) and marginalize African AIDS (Seidel and Vidal 1997; Bastos 1999). From the outset, American AIDS portrayed as 'homosexual' and African AIDS portrayed as 'heterosexual' constituted the basis for the epidemiological classificatory pattern of HIV transmission framed by the WHO. Pattern 1 characterized primarily by homosexual transmission of the infection and to a lesser extent, intravenous drug transmission, corresponded to the developed countries, the USA, the industrial west, Australasia and Latin America.¹ Pattern 2 characterized mainly by heterosexual transmission corresponded to the developing

¹ As Bastos (1999: 57) pointed out, "from a European-based international perspective, AIDS evoked Africa rather than male homosexuality as European institutes of tropical medicine regularly handled HIV/AIDS cases and most of the first AIDS patients were either African or had been to Africa."

world, particularly Africa and the Caribbean, was defined in relation to the northern norm (Bastos 1999).

In addition to establishing a dichotomy between ‘developed’, and ‘developing’ states and sidelining the African continent, the WHO classification also revealed gender biases, with disastrous implications for women. Throughout the 1980’s, women living with AIDS were virtually invisible in the dominant construction of the epidemic and women-specific conditions were side-lined (Preble and Seigel 1997). Men’s experiences served to define the range of presenting symptoms and the course of the illness (Baylies and Bujra 2000; Sherr et al. 1996). “Case definitions for women with AIDS, as well as children, supplied by the CDC were not forthcoming until the Second Decade: and even then were altogether inadequate, as acknowledged in a WHO meeting and subsequent report in 1990” (Seidel and Vidal 1997: 61). The inclusion of clinical manifestations of HIV unique to women by the CDC occurred only in 1993 (Rodriguez 1997), with the tracking of the natural history of HIV in women coming relatively late (Sherr et al. 1996). As a result, “many women went undiagnosed or wrongly diagnosed, resulting in delayed diagnosis and treatment and denying women access to disability and other benefits and services because they had not been diagnosed with AIDS” (Hamblin and Reid 1991: 4). It was also standard practice up until recently to exclude or limit women’s participation in drug trials, citing endangering women’s reproductive capacities or their failure to comply with research protocols as reasons (Murray 1997; McGovern 1997). “Biomedical research that might have enhanced women’s capacities for preventing HIV infection such as the development of female-controlled barrier methods and topical microbicides was also slow to develop” (O’Manique 2004: 24). Both of these methods are still not widely available (UNAIDS 2004e).

“AIDS in Africa has been constructed as a predominately medical matter. Although the virus is a bio-medical phenomenon, the conditions and reasons for its

spread are clearly social” (Seidel and Laurent 1997: 61). O’Manique (2004: 9) concurs,

Despite the attempt to ‘globalize’ the lens through which epidemics in Africa are understood, the pandemic is still overwhelmingly viewed first and foremost through a biomedical lens and secondly, through a narrow public health lens that focuses on individual sexual behaviour...the central focus of AIDS policy is based on the premise that individual sexual behaviour change brought about by information and education (IEC) is the main ‘weapon’ in the fight against AIDS until the development of a vaccine or cure.

The biomedical orientation has led to an almost exclusive focus on HIV and the mechanisms of its transmission rather than on the social determinants of its transmission. “As methodology, biomedical individualism has resulted in data being collected chiefly on individuals with or at risk for AIDS, and rarely on the social context of their lives” (Fee and Kreiger 1994: 265). The bio-medical model is problematic as it focusses on the behaviour of the individual within a framework of disease and fails to take into account how social, economic, cultural and political processes drive the epidemic, affecting the behaviour of individuals and groups and shape vulnerability to HIV/AIDS which is essential to the understanding and developing appropriate responses to containing HIV/AIDS and mitigating its impact (Stillwaggon 2006; Kleintjes et al. 2005; Hunter 2003, 2000; Kalipeni et al. 2003; Schoepf 2003; Barnett and Whiteside 2002; Boone and Batsell 2001; Hope 1999; Webb 1997; Seidel and Laurent 1997; Barnett and Blaikie 1992). Gender bias is embedded in the bio-medical model to women and HIV as it overlooks how the disease may affect women and men differently as a result of the complex interplay of gendered social, economic, political and cultural factors (Loppie and Gahagan 2001; Ship and Norton 1998; Seidel and Laurent 1997; Rodriguez 1997; Kreiger and Margo 1994; Patton 1994; McFadden 1992). As an approach, it also overemphasizes women’s agency and capacity to protect themselves from HIV in addition to displacing responsibility for disadvantage onto those who are its victims (Baylies and Bujra 1995; Farmer et al. 1996).

Clinical research rather than social science research has dominated the studies on people living with HIV/AIDS in Senegal (Becker 2000). The Senegalese ARV Access Initiative (ISAARV) study (Desclaux et al. 2002) remains the most comprehensive study to date on men and women living with HIV/AIDS in Senegal, with its main focus on the study of the feasibility of ART in Senegal. Despite the richness of the data, gender analysis was not a focus, although it was evident that gender inequality shaped seropositive women's economic situations and access to services. Diop's 1993 report focused on the socio-economic and psychological impact of HIV/AIDS on women. In a rare study, Diouf (1999) provides a descriptive account of the socio-economic and psychological difficulties HIV positive widows and orphans in Dakar face, arguing that HIV/AIDS policies need to better respond to the social, economic and health needs of seropositive widows and their children. Niang and Van Ufford's (2002) study focused on the impact of HIV/AIDS on children, and although gender analysis was not central, it noted that girls were more negatively affected than boys in families living with HIV/AIDS, a higher proportion of widowed and divorced seropositive women in families living with HIV/AIDS and the difficulties widows of migrants encountered in remarrying as they were thought to be HIV positive. Research on discrimination and stigma faced by PHAs has commanded little attention (with the exception of Mbodj and Taverne 2002; Cissé-Wone 1996), much less the gender-specific forms of discrimination faced by seropositive women, particularly HIV positive sex workers. Little if any research has focused on women-specific issues around breastfeeding, difficulties in imposing condom use in sexual relations, reproductive choice and childbearing (Sow 1998 touched on issues around sexuality), although some of this research is only now underway as part of the Sahara project.

Epidemiological/Socio-Behaviourial Approaches²

Gender biases also figured into HIV/AIDS discourses where women were taken into account; typically through discourses of blame (Patton 1994); a consequence of epidemiological discourses about ‘high risk groups’ (Seidel and Laurent 1997). “Epidemiology is concerned with the study of epidemic and certain communicable diseases and with finding a means of control and future prevention. It functions, mainly statistically, in terms of risk groups” (Seidel and Vidal 1997: 64). The emphasis of much of the epidemiological research is on studying sexual and other high-risk behaviours, with little attention given to the social or gendered context that might inform them. The preferred research tool is the WHO-designed KAPB (knowledge, attitude, practice and behaviour) survey and it is also used universally for purposes of international comparison as well as for developing HIV/AIDS prevention programming. As FHI (cited in Green 2003: 232), the organization that conducted the Behavioural Surveillance Studies (BSS) surveys in Senegal in 1997 and 1998 explained,

The BSS provides valuable data about HIV/AIDS related knowledge, attitudes and behaviours. The BSS methodology is a monitoring and evaluation tool designed to track trends in HIV/AIDS related knowledge, attitudes and behaviours in subpopulations at particular risk of HIV infection, such as female sex workers, injection drug users, migrant men and youth.

Most of the social research on HIV/AIDS and women in Senegal has focused on behavioural issues related to HIV prevention, consistent with the policy emphasis on prevention. Senegal has conducted a number of BSS surveys focusing on the military, female sex workers, male and female students, men and women in informal sector occupations and truck drivers (FHI 1997b, 1998; République du Sénégal, Ministère de la Santé Publique et Prévention 2001d, 2002/2003). While

² There is a substantial body of work on HIV education and behaviour change that concentrates on microsociological issues that speak directly to the interpersonal dynamics in of the spread and prevention of HIV (Boone and Batsell 2001; Collins and Rau 2000).

these studies are rich in data, there is little in the way of sustained gender analysis of responses to explain the gender differences in HIV knowledge, practices and behaviour that emerged from these studies. Moreover, the KAPB surveys reduce sexuality to a series of isolated and quantifiable items of behaviour (the number of condoms, sexual partners, sexual encounters, knowledge of HIV/AIDS and STIs, perception of risk, intention to reduce high risk behaviour etc) rather than viewing sexuality as “a complex of actions, emotions, and relationships whereby living bodies are incorporated into social relations” (Kippax and Crawford cited Barnett and Whiteside 2002: 74). These studies have been criticized for their narrow focus on the sexual culture of specific groups of women viewed as high-risk rather than on women in general (Barnett and Whiteside 2002).

Survey research has been the primary tool for studies conducted on sexual behaviour and HIV risk in Senegal; among men and women in Dakar (Ndiaye et al. 1998), and in rural Senegal (Lagarde et al 2000; Delaunay et al. 1999). Lagarde et al. (2000) noted differences in men’s and women’s perception of their personal risk associated with religion (Islam). Among men and women who considered religion important, men felt less at risk for HIV while women felt at higher risk and reported that they were less inclined to use condoms. The researchers suggested that, “religion may give men a protective feeling whereas for women it may be associated more with submission and the lack of control over their personal risk of HIV infection. These women may feel unable to intervene about their partner’s behaviour” (Lagarde et al. 2000: 2032). Despite pointing to the need to examine how gender differences and women’s subordination affect their perception of HIV risk in more depth, the research team did not view this as an area for further research.

Consistent with a focus on core transmitters and high risk groups, research on female prostitution, both legal and clandestine, in Senegal has commanded the most attention (Équipe Interpays ONUSIDA pour l’Afrique de l’Ouest et du

Centre. 2003; Gomes and Etheridge 2003; Laurent et al. 2003; Huygens 2001; Gomes 2000; UNAIDS 2000; Horri 1999; Tandia 1998; Camara 1998; Renaud 1997; Maturana and Diop 1996; Ndoye et al. 1996). However, with the exception of Gomes and Etheridge (2003) and Gomes (2000), research has not sufficiently focused on male clients of prostitutes and their role in the transmission of HIV, many of whom also have unprotected sex with female partners or wives. Although some of this literature sets female prostitution in a wider social and economic context and addresses some aspects of the discrimination faced by female sex workers, much of it is socio-behaviourial, concerned with developing a profile of the different types of prostitution, identifying the sites where it occurs, high risk behaviours and health-seeking behaviours around the use of medical services for HIV/STIs treatment for purposes of improving these interventions.

The purpose of much of the research on clandestine female prostitution is to improve HIV prevention, particularly HIV/STI testing and treatment to reduce the spread of HIV and STIs, a co-factor in HIV transmission, rather than address the root causes of prostitution and women's vulnerability to HIV or gender-based inequalities (see Laurent et al 2003; Huygens 2001). For example, the objectives of Laurent et al's (2003: 1811) study of clandestine prostitution in Dakar were to estimate seroprevalence of HIV/STIs, develop a socio-economic portrait, identify high-risk sexual behaviours and reasons for not registering as legal prostitutes in order to develop specific public health interventions for them (improving testing and treatment of STIs and the use of condoms in risky sexual transactions). In a similar vein, Huygens (2001) conducted a national study on clandestine prostitution in Senegal, rich in description on the multiple forms of clandestine female prostitution and transactional sex practices among different categories of women with the goal of improving HIV prevention and better treatment of sexually transmitted infections, a co-factor in HIV transmission.

Several research studies have focussed on migration (internal and international) and HIV/AIDS risk in Senegal, consistent with the emphasis on high-risk groups (Becker 1991; Kane 1993; Pison et al. 1995; UNAIDS 2000; Thiam et al. 2003; Thiam 2003; RARS et al. 2005). These studies have highlighted the tendency of male migrants to engage in riskier sexual behaviour than non-migrants that include multiple sex partners, frequenting prostitutes and inconsistent condom use. Thiam's study (2003: 84) of internal migrants in the Senegal River Valley showed that men who migrated as bachelors, divorcees or widowers were 20 times more likely to indulge in high risk sexual behaviours than married men and that migrants not living with a regular partner were 16 times more likely to see prostitutes or have sex with casual partners than those living with a regular partner. Thiam's study does not discuss the potential implications for women – future wives and partners who are at risk of becoming infected. Less is known about the high-risk behaviour of female migrants in this study, as few of the female research participants were open to discussing this.

Moreover, married returned male migrants pose an additional threat because of the risk of infecting their wives as Pison et al.'s 1995 study of seasonal migration in Mlomp in southern Senegal highlighted and to extended families in situations where the levirat and sororat are still practiced as the case among the Halpuular and the Tukolor in northern Senegal (Thiam 2003; Kane et al. 1993). Kane et al.'s 1993 study of 11 villages around Matam in northern Senegal showed that the HIV infection rate among returned male international labour migrants (27%) was considerably higher than that of non-migrant males (less than 1%) and as importantly, 20 of the 22 women with HIV in one of their samples were infected by their migrant husbands. It is not surprising then that the HIV infection rate among pregnant women in Matam is higher than the national average (CNLS 2004: 20). Sow et al.'s (1999: 138) study of 332 female patients with HIV/AIDS at CHU de Fann between 1993 and 1996 revealed that 75% of these women were infected by their seropositive husbands, most of whom were migrants. While migration is a risk

factor for HIV for men, gender inequality in marital relations with HIV infected husbands shapes women's vulnerability to HIV, given their lack of control over sexual relations.

Only a handful of studies have looked at or included female migration and HIV risk (RARS et al. 2005; UNAIDS 2000; Pison et al. 1995; Thiam 2003), in part because migration in Senegal has been largely a male phenomena (UNAIDS 2000). Female migration from rural areas to cities and towns has been steadily increasing, particularly among girls and young unmarried women, mostly in search of seasonal work as '*bonnes*' (Pison et al. 1995; RARS et al. 2005) and among female '*banabanas*' (petty traders)³ who wished to expand their business activities in Senegal, in neighbouring African countries or abroad (UNAIDS 2000). Commercial sex workers migrating within Senegal and to neighbouring African countries form a sizable portion of female migrants (UNAIDS 2000). Findings from the West African Research-Action and Migration and AIDS project (UNAIDS 2000: 32-33) indicated that gender biases and economic pressures weighed heavily on many commercial sex workers who often have little choice but to engage in unprotected sex with male clients who refuse to use condoms, despite their best efforts to impose them. It raises the issue of male control over sexuality in the context of commercial sex work and the need for more critical examination of unequal gender relations as a risk factor in the spread of HIV.

More recently, focus has turned to the high-risk behaviours of men having sex with men (MSM) in Senegal, many of whom are bisexual (Niang et al. 2002, 2003; Wone 2002; Kostermans and Diack 2004, Wade et al. 2005). Niang et al.'s (2002: 2) research with 250 MSMs revealed that many are at high risk of HIV

³ For Huygens (2001: 17), "Female '*banabanas*' are women with children who have been physically and financially abandoned by their husbands and are responsible for their families' survival. Many encounter difficulties in selling their goods and paying for all their families' needs, engaging in transactional sex to survive while other women engage in sexual relations with male whole sellers in order to procure their goods at a better price."

because of unprotected sex and a history of untreated STIs. This research also showed that “88% of the survey sample reported having vaginal sex and nearly a fifth had had anal sex with women” (2002b: 12). Moreover, “15% of this group is married, some are polygamous and about one-quarter of these men have children.” (Wone 2002b: 19). Wade et al.’s (2005: 2133) epidemiological study estimated the HIV prevalence rate among MSMs at 21.5% and revealed that 94.1% of respondents reported having sex with a woman in the five previous months preceding the interviews, 18% of the respondents had at least one unprotected sexual encounter with a female partner. In addition to putting themselves at risk for HIV, MSMs also put the women they have sexual relations with at risk for HIV.

Epidemiological discourses and practices have contributed to blaming women and constructing ‘women’ as social category in a narrow way (Rodriguez 1997). As Baylies and Bujra (2000: 4) point out.

Women have characteristically been viewed as responsible for transmitting the virus, whether as prostitutes infecting their (male) clients or mothers infecting their children; as ‘vaginas or uteruses’ Patton (1994), as ‘whores or mothers’ Caravano (1991) and, more gently by Sherr (1993) as ‘vectors or vessels.’

Alternately men have not been characterized as ‘vectors of transmission’, although the female to male rate of HIV transmission is significantly lower (Sherr et al. 1996; Bury 1992). In Senegal, as in Sub-Saharan Africa, much of the epidemiological research and consequent prevention efforts have targeted women in high-risk groups, principally prostitutes, constructed as the main vectors of HIV transmission rather than their male clients (O’Manique 2004; Seidel and Vidal 1997; Baylies and Bujra 1995, 2000). This has meant that “the risks to women as a whole, single or married, and rural or urban, because of their physiology, the social construction of gender and gender relations, women’s structural position, and poor general health, have largely not been addressed” (Seidel and Vidal 1997: 64). This is also the case with most targetted interventions aimed at women that are a

common feature in most national HIV/AIDS programs (Tallis 2002; Baylies and Bujra 2000; Diallo 1999; Seidel and Vidal 1997). For Seidel and Vidal (1997: 66),

The idea of 'risk groups' is also weak in terms of explaining the epidemic. In common with most other medical explanations, the epidemiological discourse of 'risk groups' is reductionist in that it proposes a single explanation for what is a complex social phenomenon.

Recognition of the limits of such research and of the ABC (Abstinence, Be Faithful, Use Condoms) approach to HIV prevention as well as the negative moralistic undertones embedded in the concept of 'risk groups', particularly by health professionals in African front-line states, has increasingly led to a focus on 'risk behaviours' and more significantly for developmental contexts, 'risk environments' (Seidel and Vidal 1997). This conceptualization better accommodates the social and economic factors that shape HIV risk. It "also takes into account many of the settings of women and child abuse, including rape, as part of a gendered rights discourse taken up by community groups...that is not conceptualized or legitimated within dominant medico-moral ways of thinking" (Seidel and Vidal 1997: 66).

A focus on risk environments and a gendered rights discourse is not widely used in HIV prevention research in Senegal, with the exception of Niang's research on women and HIV risk in Kolda and Tambacounda (1997, 1995) and Faye-Ndiaye and Fall-Diops' (1999) study on women, traditional practices, sexuality and HIV risk. Women's vulnerability to HIV 'as women' in Senegal has yet to command a comprehensive research study centering on gendered risk factors particularly women's lack of power to negotiate safe sex with husbands and or partners, and on risk environments that foster women's vulnerability to HIV. However, a few studies explored the feasibility of female-controlled barrier methods and the acceptability of female condom use among women (Faye et al. n.d.; Niang n.d.; Niang 1992).

Anthropology and Culturalist Approaches

By the 1990's, the limits of bio-medical and epidemiological approaches were apparent and recognition that AIDS raised broader macro-social, political economy and development issues in Africa as elsewhere emerged. Throughout the 1990's, and with greater intensity since 2000, a growing body of work in the social sciences has explored social, economic and cultural and political processes that underpin the spread of HIV in sub-Saharan Africa including several multidisciplinary social science anthologies on HIV/AIDS in Sub-Saharan Africa (See Kalipeni et al. 2003; Becker et al. 1999; Hope 1999; Dozon and Vidal 1997; Valins 1994). However, "the critical social sciences have been marginalized and under-funded" (Seidel and Laurent 1997: 61).

Early culturalist analyses of HIV transmission in Africa and explanations of the high prevalence rates of HIV in Africa and the unique pattern of equal male-to-female case ratio in Africa "centered on the so-called sexual permissiveness rooted in the absence of moral and institutional constraints, especially with regard to women, as typified in the 1989 work of Caldwell, Caldwell and Quiggan" (Mufune 1999: 23). This view has been roundly criticized as rooted in ahistorical, stereotypical, if not racist, and culturally reductionist overgeneralizations that fail to take into account the social and economic, much less gendered context that also shapes sexual behaviours, as Seidel and Laurent (1997: 73) point out,

The discourses in circulation about the refusal to use condoms, the absence of male circumcision in some regions or the practice of the levirate are examples of a culturalist approach to AIDS which sets up culture as the only explanatory factor in the current situation of the continent having to face up to AIDS.

Moreover, much of the culturalist discourse does not address the power relations between men and women and the central issue of negotiating sex (Seidel and Laurent 1997: 73). This is the case with Sow et al's 1998 research that describes how traditional marriage practices such as the levirat (a brother inherits his dead

brother's wife and children) and the sororat (replacement of a deceased wife with her sister) can foster the transmission of HIV in Senegal.

More recent approaches highlight how culture influences people's perceptions and practices pertaining to health, disease, sexuality, masculinity and femininity, intimacy, marriage as well as social relationships and their understanding of HIV/AIDS (Simms et al. 2006) and their importance in developing culturally-appropriate HIV prevention messages and programming (UNESCO 2002; UNESCO/UNAIDS 2002; Niang 2001). More recent trends in work on culture and HIV have begun to grapple with the interaction between gender and culture. Using a gender perspective, Faty-Ndiaye and Fall-Diop's (1999) research showed that Senegalese women were less empowered to negotiate safe sex as a result of traditional cultural practices and that there is still wide support among men and women for several traditional cultural practices that negatively affect women, despite knowing that they foster HIV transmission. Some of this work also has focused on discursive frameworks around African HIV/AIDS as sources of power, revealing sexist, racist or classist biases, pointing to the need view discourses around AIDS as sites of struggle and contested meanings that have a profound impact on public policy and interventions around HIV/AIDS (Setel 1999a, 1999b; Treichler 1999; Schoepf 2003, 1995; Seidel and Laurent 1997; Patton 1994, 1992). Delaunay et al. (1998) showed how Islamic religious norms have been central in constructing dominant medico-moral discourses around AIDS in Senegal, although they did not explore the gendered dimension.

Political Economy Approaches

“Poverty is most often cited by those who comment on the socio-economic context of the spread of HIV. Poverty is seen as a key factor leading to behaviours that expose people to risk of HIV infection” (Rau and Collins 2000: 5). Much of this research in the African context has focused on poverty-driven labour

migration and sex work, within the context of deepening inequality, globalization and underdevelopment, fuelled by neo-liberal economic policies, structural adjustment and external indebtedness as prime movers in driving the HIV/AIDS pandemic (Barnett and Whiteside 2006, 2002; Poku and Whiteside 2005; Poku 2004; Cheru 2004; Whiteside 2004; Équipe Interpays ONUSIDA pour l’Afrique de l’Ouest et du Centre. 2003; UNAIDS 2000; Hope et al. 1999; Farmer et al. 1996; Cross and Whiteside 1993; Barnett and Blaikie 1992). The main contribution of this literature has been to highlight the socio-economic determinants of HIV transmission and the intimate relationship between inequality, poverty, underdevelopment and vulnerability to disease.

While the link between poverty and gender inequality is inextricably intertwined in shaping women’s risk to HIV (O’Manique 2004; Baylies and Bujra 2000; Schoepf 2003b, 1997, 1988; Webb 1997; Farmer et al. 1996; Bennett 1990), this is not always adequately explored, particularly in the Senegalese literature. The research on legal and clandestine prostitution in Senegal shows that most of these women had little formal schooling, are divorced, widowed or single with no other sources of income, indicating how gender inequalities shape women’s insertion into sex work (see Laurent et al 2003; Gomes 2000, Gomes and Etheridge 2003; Huygens 2001; Horri 1999; Ndoye et al. 1996). Although some of this research acknowledges that prostitution can be considered as an extreme case of gender inequality, reflective of the situation of Senegalese women in general (Équipe Interpays ONUSIDA pour l’Afrique de l’Ouest et du Centre 2003; Huygens 2001; Tandia 1998; Renaud 1997), these links are not explored in any depth nor the gender-based inequalities that push women into prostitution such as their lack of access to education and limited work opportunities, much less the intersection of gender and class inequalities. Huygens (2001: 43), for example, concluded in his national study on clandestine prostitution in Senegal that it was necessary to “*voir la prostitution comme la conséquence d’une perte de statut sociale, d’une situation anormale.*” The Senegalese literature generally views poverty and economic

survival as the primary causes and growth of prostitution and transactional sex practices among women (see Équipe Interpays ONUSIDA pour l'Afrique de l'Ouest et du Centre. 2003; Gomes and Etheridge 2003; Laurent et al. 2003; Huygens 2001; Gomes 2000; UNAIDS 2000; Horri 1999; Tandia 1998; Maturana and Diop 1996; Ndoye et al. 1996). Notwithstanding the importance of class inequalities and poverty as prime movers of female prostitution, this does not explain why more women than men are involved in prostitution, why women are poorer than men or why single, divorced and widowed women are more likely to turn to prostitution. A fuller understanding of female prostitution necessitates a concept of women's vulnerability rooted in an analysis as to how gender and class inequalities shape the context for female prostitution.

Moreover, much of the work focusing on the impact of the devastating effects of HIV/AIDS on households and communities rarely includes an in-depth gender analysis or focuses on the role of women bearing the burden of disease as caregivers of people living with HIV/AIDS (see Poku 2004; Whiteside and Cross 2003; Barnett and Whiteside 2002). As a low prevalence country, socio-economic impact studies have not been an object of research in Senegal. Niang and Quarles Van Ufford (2002) addressed this issue in their study of the impact of AIDS on children, indicating gender differences negatively affecting women and girls were an issue as a result of the gender roles in the family. Coll-Seck (1996) pointed out that women bear the onus of care of PHAs in Senegal. However, little research has focused on the role of women, as caregivers of PHAs in Senegal (with passing mention made by Diouf 1999; Niang and Quarles Van Ufford 2002).

Political Science Approaches

The earliest work on the political dimensions of HIV/AIDS came from outside the discipline of political science. French anthropologists (Fassin and Dozon 1989; Dozon 1996) were among the first to call for viewing AIDS as a

political phenomenon, necessitating state action. Historians Becker and Collignon (1999) analyzed Senegal's HIV/AIDS policy within the context of colonial public policy approaches to sexually transmitted diseases while Kerouedan and Eboko (1999) focused on current public policy responses to HIV/AIDS in the African context. Gruenais' 1999-edited collection focused on state-civil society relations in structuring HIV/AIDS programs and policies. Other analyses have focused on the unequal power dynamics embedded in the relations between the international institutions (GPA, UNAIDS, the Global Fund) and state-sponsored national AIDS control programs (Poku 2004; Bastos 1999; Tarantola 1996; Viens 1996).

By contrast, "up until recently, political science as a discipline was slow to grapple with the AIDS crisis", as Boone and Batsell (2001: 4) pointed out, particularly in Africa (Patterson 2005).⁴ This literature on the political dimensions of AIDS has focused on the role of political culture in shaping state responses to HIV/AIDS, state and civil society dynamics, power relations in national and international policy-making in shaping the evolution of national AIDS control programs, the role of political leadership and commitment, the role of political instability/civil conflict in shaping the spread of HIV/AIDS and the implications of AIDS on governance and security. Despite the key roles that states, institutions, policy and programs play in reducing vulnerability to HIV and in addressing the impact of HIV/AIDS, these factors have generally been overlooked in analyses of the AIDS pandemic (Tallis 2002), particularly, with respect to women.

Much of the literature on HIV/AIDS in Senegal has focused on Senegal's (relatively) successful approach to HIV prevention (Simms et al. 2006; Hemmat

⁴ See Patterson's 2005 edited collection on the African state and HIV/AIDS crisis; Boone and Batsell (2001) on developing research agenda in international relations and HIV/AIDS; de Waal (2003) on HIV/AIDS and governance; and Eboko (1999) on the power wielded by northern experts and international institutions in structuring African state HIV/AIDS public policy responses and national AIDS control programs. Fourie (2006) examined the national AIDS policy-making process in the South African state.

2003; Opong and Agyei-Mensah 2003; Putzel 2003; Crawford 2002; UNAIDS 2001, 1999a; Groupe Thématique ONUSIDA/Sénégal 2001; Niang 2001; Lom 2001; Carolina Population Center 1998). This literature highlights the central role of political factors such as early state action, effective policy responses, political leadership and commitment, political stability and the active participation of groups from civil society in successfully keeping HIV at bay in Senegal. Eboko (2005) discussed the role of Senegalese political culture as an impetus to its rapid response while Delaunay et al. (1998) explored the nature of state-civil society relations (NGOs) and the role of international funders in the 'structuring of the *marché du sida*' around HIV prevention in Senegal and Côte d'Ivoire. Mbodj and Taverne (2002) analyzed the impact of antiretroviral treatment on the associative sector, focussing on the changing responses of the Senegalese Associations of People Living with HIV/AIDS in endorsing access to ARVs. Cissé-Wone (1996) examined the evolution of the Senegalese Associations of People Living with HIV/AIDS, focusing on how stigma limits their power to advocate on behalf of PHAs and participation in decision-making around HIV/AIDS issues.

However, much of this analysis is gender-neutral, in line with the broader political science literature on the African state (Mikell 1997; Mama 1996). Women as political actors and gender analysis have been sidelined in political analyses of HIV/AIDS in Senegal. There has been little sustained analysis as to how gender inequalities are reproduced within state HIV/AIDS programs that might reinforce women's subordination and limit their empowerment in mitigating the impact of HIV/AIDS. Gender analysis of state HIV/AIDS policies has commanded little, if any, attention, particularly as to how women and gender issues are constructed in Senegalese state HIV/AIDS policies or the potential gender biases and gender omissions that work to the detriment of women. Analyses of the success of Senegal's prevention model have generally ignored the gender differences in HIV/AIDS patterns, despite a growing body of literature highlighting the link between gender inequality and women's vulnerability to HIV in Senegal (Coll-Seck

1996; Niang 1997, 1995; Diallo 1999; Putzel 2003; Sidibe 2000; Wone 2002b). As Hemmat (2003: 8) observed,

Prevention programs in Senegal have been more successful in lowering the contraction rates among males than among females... while the number of infected males has not even doubled in the last fourteen years, the number of infected females has quadrupled” and that this is most likely a result of inequalities between the genders as well as a consequence of biological factors.

More recently, UNAIDS/WHO (2004b: 27) pointed to the need to intensify prevention work among (*female*) prostitutes and their clients in Senegal, noting the rise in HIV adult prevalence rates among them. Putzel (2003) recommended that more attention be accorded to the mother-to-child transmission of the virus as well as addressing the needs of women and children in the high-risk groups. This suggests the need to examine more closely how women and HIV/AIDS issues are addressed in state HIV/AIDS policies and operationalized in programmes and research.

Sidibe (2000) highlighted various forms of gender-based discrimination such as early marriage, double standards and some traditional practices (the levirate and female genital mutilation) that put Senegalese women and girls at higher risk for HIV/AIDS. Sidibe also suggested the need for effecting legislative changes to improve women’s status; also noted by Putzel (2003). Diallo (1999) rooted women’s vulnerability to HIV in unequal gender relations while Wone (2002b) provides a more thorough account of the legal, socio-cultural and economic factors that shape women’s subordination and heighten women’s vulnerability to HIV/AIDS and argues for the need to develop a new partnership between men and women, between the generations (women and girls) and to create a new future for Senegalese women. Their work suggests the need to examine more closely how state HIV/AIDS policies address broader strategies of social change to reduce gender and other forms of inequality and empower women.

Despite the importance accorded to the participation of civil society (NGOs) in the national HIV/AIDS response, little research has focussed on the role of women's organizations in the fight against AIDS, particularly how they are incorporated into the policy process, in decision-making and priority setting around HIV/AIDS. Only a handful of studies have examined the role played by women's organizations in HIV/AIDS prevention (Niang 2001, 1997, 1995; Groupe Thématique ONUSIDA/Sénégal 2001). Much of this literature is descriptive rather than analytical, highlighting organizational and technical difficulties rather than structural barriers that women's groups face in their prevention activities. Moreover, despite the growing importance of community care for PHAs and of orphans in Senegal, little research, with the exception of Niang (2001), has focussed on the roles of women's organizations in the care and support of women/people living with HIV/AIDS, in mitigating the impact of HIV/AIDS or in lobbying and advocacy around issues affecting positive women.

Gender Approaches to HIV/AIDS

A significant shift occurred in discourses around 'women and AIDS' in the second decade of the pandemic with the evolution of the Global Program on AIDS and UNAIDS which sought to counter discrimination and recast women and AIDS within a human rights framework (Tallis 2002; Baylies and Bujra 2000; Mann and Tarantola 1996; Hamblin and Reid 1991). At the same time, several social science anthologies on women and AIDS appeared in the 1990's examining HIV/AIDS from the standpoint of women's experiences (Roth and Hogan 1998; Goldstein and Marlowe 1997; Sherr et al. 1996; Long and Ankrah 1996; Schneider and Stoller 1995; Doyal et al. 1994; Berer 1993; Bury 1992; Manthorne 1990). Much of this work entailed collaboration between practitioners in the field, AIDS activists, researchers and scholars. Some of this work utilized gender analysis and also emphasized the need for women's empowerment in reducing their vulnerability but,

with few exceptions (Schneider and Stoller 1995; Doyal 1994), stopped short of calling for major structural changes.

Some of these anthologies drew on women's experiences in both developed and developing countries (see Long and Ankrah 1996; Berer 1993). However, gender relations was not a focus of analysis and policy prescriptions around improving women's status focused on legal reform rather than advocating for transforming gender relations; in part a reaction to the general antipathy, ambivalence, if not outright rejection of Western radical feminist discourses and ideologies (Long 1996; Akeroyd 2003). Consistent with Women and Development (WAD) analyses (Rathgeber 1994) which borrow on the insights of dependency theories, socio-economic inequality and poverty were seen to be the main determinants of women's vulnerability rather than unequal gender relations in these works.

At the same time, a growing body of feminist literature rooted in Gender and Development theory and themes explored different aspects of women and HIV/AIDS in Africa, making gender relations a central focus of analysis, often in its interaction with other forms of social inequality. Bennett (1990) explored the triple threat of HIV to women as individuals, as producers and as reproducers. Schoepf's pioneering work (1988, 1997, 2003b) analyzed gender and class inequalities in shaping women's HIV risk in the Congo-Zaire while McFadden (1992) explored issues of gender and sexuality in South Africa. O'Manique's (2004) analysis showed the links between neo-liberalism, socio-economic change and gender inequality in shaping women's experiences with HIV in Uganda. Bassett and Mhloyi (1994) analyzed the impact of HIV and AIDS on older women in Zimbabwe. Akeroyd (2003) explored gendered vulnerabilities and occupational factors around HIV transmission. Baylies and Bujra's (2000) edited collection focused on the role of women's groups in empowering women in Tanzania and Zambia. Baylies and Bujra (1999) examined how gender relations shaped HIV risk

among young women in Africa. Drawing on a feminist theorizing, Baylies and Bujra (1995) explored conceptual and methodological issues around women's empowerment in the context of HIV/AIDS and development in Sub-Saharan Africa. Siplon (2005) explored how patriarchy in the African context is an obstacle to effective policy-making around AIDS, focusing on state legislation. However, much of this work has been sidelined in dominant gender approaches to HIV/AIDS.

In the latter half of the second decade, there has been a gradual shift in 'women and HIV/AIDS' discourses in some development and UN agencies away "from the utilization of 'women' as a category of analysis and the implication that they are the problem" (Seidel and Laurent 1997: 66) towards the increasing use of gender as a category of analysis and presumably, a focus on social relations. The focus on gender was inspired by the shift from Women in Development (WID) perspective to a Gender and Development (GAD) discourse embodied in the mainstreaming gender agenda in the international organizations (Jain 2005; Snyder 2003; Bessis 2003; Rai 2002; Denis 2001; Jackson and Pearson 1998; Baden and Goetz 1997; Razavi and Miller 1995; Kabeer 1994).

A growing body of literature generated by UN development agencies, international AID agencies and research institutes highlighted the gender inequities in HIV transmission and spread, in access to health services, care and support and in its socio-economic impact and that women are generally the primary caregivers of PHAs (UNAIDS/UNPFA/UNIFEM 2004; UNAIDS 2004; Commonwealth Secretariat and Maritime Centre of Excellence for Women's Health 2002; Tallis 2002; Rao Gupta et al 2002; Matlin and Spence 2000; Smith and Cohen 2000; World Bank 2000; Baden and Wach 1998; Panos Institute 1992; Hamblin and Reid 1991; Bennett 1990). Despite the welcome recognition of the gender-differentiated impact of HIV/AIDS on women and of the need for developing prevention programs aimed at involving men as partners in prevention and in the care and support of PHAs (Jackson 2002; Rao Gupta 2000a; UNAIDS 2000; Baylies 2000;

SWAA 1999; Royal Tropical Institute 1998; UNAIDS 1998), much of the literature produced by international organizations in the UN system rests on a problematic conceptualization of gender and HIV/AIDS. The conceptual difficulties can be linked to the way in which Gender and Development approaches have been appropriated from feminist research and literature by international institutions and aid agencies and implemented in development practices, policies and discourses (Snyder 2003; Bessis 2003; Denis 2001; Baden and Goetz 1997; Razavi and Miller 1995a, 1995b; Rathgeber 1994; Kabeer 1994; Labrecque 1991).

Much of this literature on women and HIV/AIDS produced within the UN/UNAIDS system which has coordinated the international response to AIDS, is largely descriptive, rooted in broad non-contextualized generalizations about women, women's vulnerability, gender roles and gender differences in HIV/AIDS (Collins and Rau 2000). Gender often is still seen as synonymous with women, as in the use of the gender factor in the 2004 Global Report on AIDS. "The idea of gender as a relational concept is not usually well understood by AIDS practitioners, and is often understood to mean a special program for women" (Baylies and Bujra 2000b: 175). Rare is the use of gender as an analytic construct whereby it is conceptualized as a social relation based on power imbalances between men and women that shapes women's subordination to men in sexual relationships, in the family, in the economy, in politics and in society. Gender is conceptualized descriptively referring to gender norms, gender roles and/or gender differences rather than gender relations in shaping women's vulnerability to HIV and the impact of HIV/AIDS on women (see UNAIDS 1997a, 1998a, 1999b; Feinstein and Prentice 2001; WHO 2002). UNAIDS (1998a: 3; 1995: 11) defines gender as "what it means to be male or female, and how that defines a person's opportunities, roles, responsibilities and relationships...we learn it in our families and communities. These meanings will vary by culture, by community by family and by relationships." This view is taken up in the UNAIDS Gender and AIDS Almanac aimed at development practitioners and policy makers, which "adopts a gender-

based approach for the study of HIV/AIDS in order to examine how socially-defined gender roles influence HIV/AIDS prevention, transmission and care” explaining that “gender roles are a powerful feature of social organization, not only describing how men and women are expected to behave but influence power relations, decision-making authority and individual responsibility” (Feinstein and Prentice 2001: 4, 2000: 1). However, power relations shape gender roles and not the other way around. The focus on gender roles is derived from the gender roles training model for development practitioners in development economics (see Kabeer 1994). The emphasis on gender roles “testifies to the tendency within policy circles to treat gender in isolation from the structural perspectives that inform analysis of other forms of social inequality... leads to a focus on behaviour change at an individual level, rather than on policy change at the societal level” (Kabeer 1994 cited Sen et al. 2002: 6). This approach is consistent with the dominant emphasis in the global response to HIV/AIDS that privileges bio-medical individualism and neo-liberalism in policy responses to AIDS (O’Manique 2004; Lee and Zwi 2003; Parker 2000).

This conception of gender leads to “a static and reductionist definition of gender as (woman/man) – stripping away consideration of the relational aspects of gender, of power and ideology and of how patterns of subordination are reproduced” (Baden and Goetz 1998: 22). As Baylies and Bujra (2000) pointed out, the problem is not one of gender differences but of gender inequality. Moreover, to the extent that “gender relations are still not seen as a central analytical category or as constituting political interests” (Seidel and Vidal 1997: 63), women are taken to be a homogeneous social category. Little attention is paid to how unequal gender relations interact with other forms of oppressive social relations based on social class and north-south inequalities to differentially shape the women’s vulnerability to HIV and its impact. While this type of descriptive empirical research on gender roles and differences in HIV/AIDS “can provide invaluable insights and empirical evidence, it can under-specify the power relations maintaining gender inequalities

and in the process de-links investigation of gender issues from a feminist transformatory project” (Baden and Goetz 1997: 7) in which women’s empowerment and social change are central. This de-politicised conception of gender means that efforts to address HIV risk and impact do not challenge the underlying gender, social class and north-south inequalities and power relations.

Moreover, the UNGASS declaration (2001: 13), unanimously agreed upon by all member states including Senegal, emphasized that “gender inequalities and the empowerment of women are fundamental elements to reducing the vulnerability of women” and that “national policy responses need to address the gender dimensions of the epidemic and integrate a gender perspective into their strategies” (UN 2001: 20). However, the concept of empowerment is rarely defined. Addressing gender inequalities in the AIDS context are premised on a Women in Development (WID) approach, inspired by a liberal feminist framework that does not challenge structural inequalities and unequal power relations based on gender, social class, age and north-south divisions. The package of strategies usually entail improving women’s access to education and economic opportunities (income-generating activities), addressing discriminatory laws which work to women’s disadvantage around inheritance and land, and better access for women to HIV prevention services, care and support (see for example, UNAIDS/UNPFA/UNIFEM 2004; UNAIDS 2004e, 2004c; Feinstein and Prentice 2001; Smith and Cohen 2000; Reid 1991). A broad body of feminist research on development has shown the limits of WID approaches in fundamentally altering women’s subordination and unequal integration in the development process (Jain 2005; Snyder 2003; Bessis 2003; Rai 2002; Denis 2001; Jackson and Pearson 1998; Baden and Goetz 1997; Razavi and Miller 1995a; 1995b; Kabeer 1994). Their efficacy as strategies within the context of HIV/AIDS remains equally questionable.

Despite a recent broad consensus that gender inequality is one of the driving forces of the (HIV/AIDS) epidemic and the need to “engender the response to HIV/AIDS” in Africa as elsewhere, this broad recognition has not led to the systematic tackling of gender inequalities either in AIDS-related programs or within broader social, economic and political structures at local, state and international levels” (Irurzun-Lopez and Poku 2005: 227). Few of the insights generated by a small but growing body of feminist literature on women, gender inequalities (defined as gendered power relations) and HIV/AIDS in Africa have found their way into state HIV/AIDS policy, research, and interventions or spawned comprehensive research agendas designed to improve our knowledge of the diverse ways that HIV and AIDS affects women.

This is because policy makers, scholars, international donors and international institutions do not take gender seriously (Irurzun-Lopez and Poku 2005; Lewis 2005a, 2005b; Collins and Rau 2000; Seidel and Vidal 1997). As Collins and Rau (2000: 20) observed,

Gender bias permeates the HIV/AIDS arena. It lurks especially in aid agencies. Discussions of male sexual behaviour are felt to be threatening for aid agencies which are invariably internally biased (in differing degrees) and while they are so politically correct that gender is rhetorically acknowledged, it is not adequately examined.

Booth’s (1998) analysis of bureaucratic politics within the WHO demonstrated that it proved incapable of launching a global campaign for gender and sexual equality. Moreover, there is no single powerful agency within the UN system to represent women or women and HIV/AIDS issues other than UNIFEM, a small and marginalized department of the United Nations Development Fund for Women (UNDP) and its request to be a co-sponsor in UNAIDS was denied (Lewis 2005a). Gender mainstreaming in HIV/AIDS has yet to be implemented in most national AIDS control programs (Kleintjes et al. 2005). Major bilateral donors to HIV/AIDS programs in Africa do not necessarily prioritize either gender or women in funding

(Crawford 2002), despite the existence of WID and GAD units. To the extent that HIV/AIDS puts into stark relief the issues of gender inequality, poverty and distorted development in its most extreme form; the growing number of women dying from AIDS particularly in Sub-Saharan Africa, “the single greatest international failure in the response to HIV/AIDS, is the failure to dramatically intervene on behalf of women” (Lewis 2005a: 5).

This review of the literature shows how gender biases and power inequalities have served to marginalize women in HIV/AIDS research, policy and programs (Global Coalition on Women and AIDS 2006; ICW 2004; Commonwealth Secretariat et al. 2002; Tallis 2002; Loppie and Gahagan 2001; Ship and Norton 2000; Long and Ankrah 1996; Patton 1994; McFadden 1992). This has also noted by Diallo (1999) with respect to Senegal. It reveals the limits of current conceptualizations of women and HIV/AIDS in Senegal as well as the lacunae in existing research. There is no comprehensive research study to date on the feminization of AIDS in Senegal, despite the need for this type of contextual research if it is to be addressed in policy and interventions.

Although much of the Senegalese research points to the role of unequal gender relations in shaping women’s experiences with HIV/AIDS and policy responses there, it has of yet to be analyzed in a systematic and in-depth manner, particularly with respect to male-female relations in the context of sexuality, marriage and the family. To the extent that inequality is viewed as fuelling the AIDS epidemic in Senegal, the literature highlights social class inequality as a main driver of the epidemic in Senegal, pointing to the underlying context of Senegal’s economic underdevelopment but not explicitly bringing it into analysis. Moreover, HIV/AIDS does not appear to be viewed as fundamentally gendered. This suggests the need to re-conceptualize women and HIV/AIDS in Senegal from a gender perspective which would allow us to explore how gender inequalities are reproduced within HIV/AIDS, in addition to other forms of social inequality,

shaping the multiple ways it affects women differently from men as well as examine state policy responses and civil society initiatives to empower women to protect themselves from HIV and to mitigate its impact.

1.2 Research Methods

A multi-method approach sometimes referred to as “triangulation” was utilized for this single case study of the feminization of AIDS in Senegal involving secondary and primary research. While the primary research methods for data gathering are qualitative and interpretive, quantitative data was also utilized. Research methods included archival research, observation, policy research/analysis, and semi-structured interviewing with actors in the HIV/AIDS field. “A multi-method approach works to enhance understanding both by adding layers of information and by using one type of data to validate or refine another” (Reinharz 1992: 183). It allows us to validate the perceptions of the research participants, with the previous empirical research findings, existing documentation and/or existing quantitative data.

Archival research

Archival research in Senegal entailed gathering relevant documentation of a qualitative and quantitative nature on HIV/AIDS issues, particularly on women, not available on the internet or in Canada. Although much of the more recent documentation on HIV/AIDS in Senegal is accessible on the internet given the high level of international collaboration among a wide range of actors, earlier government policy documents, evaluation studies and research are not. Archival research included collecting previous HIV/AIDS Strategic Plans as well as more recent policy documents such as the national policy on Mother-to-Child Transmission, various protocols on the medical and psycho-social care and support of PHAs and registered sex workers, conference proceedings, theses,

epidemiological and seroprevalence/action research, social and behavioural research, as well as policy and program evaluation studies conducted by Senegalese nationals, donor partners and consultants. Related documents around poverty reduction strategies in Senegal and current proposed new legislation on the rights of PHAs and reproductive health were also collected. Where possible, I also collected documentation on the activities and programs of AIDS Service organizations involved in HIV/AIDS prevention and the care and support of PHAs, as these give some idea as to how gender issues are viewed by practitioners; some of whom are also involved in national HIV/AIDS policy-making process.

I also collected relevant gender-differentiated quantitative data from both written and oral sources. Documents included the most recent HIV/AIDS epidemiological surveillance statistics published by the Sentinel Surveillance Senegal and those from the 2005 Demographic and Health Survey, statistics on HIV voluntary testing, AIDS hospital admissions and AIDS patients frequenting the *Centre de Traitement Ambulatoire* (CTA). Socio-demographic data on membership in Associations of People Living with HIV/AIDS and data on the number of people accessing antiretroviral therapy (ART) came from oral sources from the respondents. Quantitative data provided empirical evidence to support or invalidate my hypotheses as well as the perceptions of research participants

Observation

I utilized the observation method to assist me in developing “an ethnographic sensibility in order to better understand acts and actors as much as possible from within their own frame of reference”(Yanow 2007: 409). I felt it essential as an outsider and as a white western university-trained professional and feminist that I needed to better understand how Senegalese women view and experience gender relations, women’s subordination and their place and role in

private and public spheres. I felt that this sensibility was essential to understanding and describing the context for policy-making around women and HIV/AIDS issues.

As a vital part of my research methodology, I chose to live with a large female-headed Senegalese family in a *'quartier populaire'* in Dakar as a way of better understanding and contextualizing the lives of the majority of Senegalese women, young women and girls. Living with a Senegalese family and participating as a 'family' member with reciprocal responsibilities helped me as an outsider to better grasp the cultural (and changing) constructions of femininity and masculinity, men's and women's social roles in the family and in the public sphere and the intersections of age and gender in family and social hierarchies. Living in a household whose income is just above the poverty line in a *'quartier populaire'* also gave me a better sense of the challenges and hardships that Senegalese families, particularly women, face as well as the survival strategies they employ to cope with poverty and economic precariousness that shapes their lives and their health. This helped me to better understand the broader social, economic and political context for HIV/AIDS policy-making priorities and program interventions.

Policy Research

Policy research focused on HIV/AIDS and related public policies enacted by government officials and government bodies. Although governments can refer to different levels of the state (Fourie 2006), my focus is exclusively on successive national governments' response to HIV/AIDS in Senegal, given its centralized top-down state structure, more precisely on the state-initiated national AIDS control program, the PNLN/CNLS, in formulating and implementing national HIV/AIDS policy which guides HIV/AIDS strategic priorities, research and program interventions in Senegal.

Policy research in the form of document analysis focused on two levels of HIV/AIDS policy: national HIV/AIDS and related policies, principally the Strategic Plans developed since the inception of the PNLs/CNLS which define the strategic orientations around prevention, treatment, care and support of PHAs, research and human rights legislation; and the Protocols produced by the health ministry and the CNLS around HIV testing and medical/ psycho-social care and support for PHAs that serve as national guidelines for the regional and district health units. A gender analysis of these documents was conducted to examine the conception of gender and 'women' in policy orientations and their implementation in research and program interventions in prevention, voluntary testing and the care and support of PHAs. This allows us to identify gender biases and gender gaps not only in policy but also in research, prevention and care and support strategies.

Policy research also included a gender analysis of state legislation that affects the status of women such as the Family Code, the Constitution, legislation on female genital mutilation, rape and violence against women, the legalization of prostitution, reproductive health and the Commission for the Elimination of Discrimination against Women (CEDAW) updates. A gender analysis of this legislation allows us to identify gender inequalities that work to the detriment of women, to assess the progress being made in reducing gender inequalities and as a consequence, to assess the effectiveness of promoting women's rights as a key strategy in reducing HIV vulnerability and mitigating the impact of HIV/AIDS.

Semi-Structured Interviewing

Policy research and archival research were supplemented with semi-structured interviews with participants drawn from five key groups of actors in the field of HIV/AIDS interventions: in national policy development, in national program development, in the delivery of HIV prevention services, in the delivery of medical care and community supports to women living with HIV/AIDS and in

research around HIV/AIDS. This included members of the *Conseil National de Lutte contre le Sida* (CNLS) and the *Mécanisme de coordination du pays* (CCM); representatives of AIDS service organizations working in HIV prevention and in the care and support of people living with HIV/AIDS; representatives of the Associations of People Living with HIV/AIDS; representatives of women's groups, NGOs and community-based organizations (CBOs) whose primary mandate is not HIV/AIDS but are working in the area; and members of the HIV/AIDS research community.

The purpose of these interviews was to gather information on actors' perceptions and views of women, gender and HIV/AIDS issues in Senegal in order to better understand how they are embedded in policy, research and programs. Interview questions centered on the role and importance of gender as a main driver of HIV/AIDS in Senegal, the conceptualization of gender and 'women' in state HIV/AIDS policy, research and programs, gender differences and the determinants of women's vulnerability to HIV risk, the strengths and weaknesses of current prevention strategies with women, gender differences in the social and economic situations of people living with HIV/AIDS and in access to medical care and supports, gender differences in caregiving, obstacles in delivery of community-based care for PHAs and the effectiveness of women's organizations in HIV/AIDS initiatives and in efforts to empower Senegalese women.

Respecting current norms of conducting research with human subjects and in the field of HIV/AIDS, my research protocol, interview guide and consent form were submitted to the *Comité d'éthique de la recherche avec des êtres humains de l'UQAM* for ethics approval, which it received. Charles Becker of the *Conseil National de Recherche sur la Santé* (CNRS), Professor Souleymane Mboup of the *Laboratoire Bactériologie et Virologie Centre Hospitalier Universitaire Aristide le Dantec*, Faculté de Médecine et de Pharmacie, Université Cheikh Anta Diop, Professor Salif Sow, *Chef du Service des Maladies Infectieuses*, Centre Hospitalier

Universitaire Fann and head of the national ISAARV program, Aziz Hane, program director of the *Réseau africain de recherche sur le Sida* (RARS) and Gary Engelberg, director of ACI-Baobab were contacted prior to leaving for Senegal regarding the protocols for conducting HIV/AIDS research in Senegal as well as making them aware of the research and soliciting their interest, if not their participation as respondents.

Upon arrival in Dakar and after meetings with the aforementioned people to discuss the HIV/AIDS research protocols in Senegal, in conforming to protocols for conducting HIV/AIDS research in Senegal, I submitted my research project, questionnaire and consent forms to the *Comité d'éthique de l'ANRS de Ministère de la Santé et de la Prévention Médicale* for ethics approval which it received provisionally, contingent upon my response to comments from committee members around the overall methodology of the thesis project. In line with their mandate, Professor Mboup and RARS, of which he is the current president, acted as my Senegalese advisors and partners, assisting with the submission to the Ethics Committee at the *Ministère de la Santé* as well as providing advice on conducting research. Gary Engelberg agreed to have me as a research associate of ACI and provided me with office space and access to ACI 's human and material resources, which facilitated my research and added further legitimacy to it.

An initial list of potential respondents, drawn from five different groups of actors in the HIV/AIDS field, was developed from the literature review and internet sources including USAID'S 2004 Directory of Associations of People. Living with HIV/AIDS, prior to leaving for Senegal. Upon arrival in Senegal, this list was reviewed by a staff member from the *Réseau africain de recherche sur le Sida* (RARS), the *Association sénégalaise pour le bien-être familial* (ASBEF), the Society of Women and AIDS in Africa (SWAA-Senegal) and Africa Consultants International (ACI-Baobab) to ensure that the interview list reflected the key players in HIV/AIDS policy, research, prevention and care and support of

people/women living with HIV/AIDS and to update the contact information. As a result, some revisions were made to the initial list of potential respondents. These individuals also reviewed the interview guide and consent form, providing feedback on potential bias and its appropriateness for Senegalese respondents. Some of these individuals assisted me in contacting a few potential respondents.

Although access to potential respondents was relatively easy, as a result of the support of ACI, Professor Mboup and RARS, coupled with my own white skin privilege as white western professional academic, the actual logistics of contacting people and arranging meetings proved to be incredibly time consuming. Contacting the research participants entailed several phone calls and changing these initial meeting dates as a result of their busy schedules. This was also the case with the in-depth interviews. The frequent power outages occurring for large parts of the day that have become all too commonplace in Senegal also affected my ability to reach certain prospective respondents by phone.

I chose to meet with potential respondents twice; for an initial meeting and for an in-depth interview. The initial meeting allowed us to get acquainted, discuss the research, in addition to providing respondents with a copy of the questionnaire, consent form, letter of introduction from my thesis director, letter from Professor Mboup and a copy of UQÀM's ethics certificate and then to arrange for another meeting to do the interview consequent upon the respondent's decision to participate in the research. Although a very time-consuming process, I felt that it was important to meet with each respondent initially as it helped to set up the interview process as a dialogue and an exchange of ideas and experience 'among equals.' It is my understanding from several of the respondents that this approach is not commonplace among the majority of western consultants and researchers and a few were pleasantly surprised with my approach. I met with twenty-six respondents twice. Seven respondents chose to be interviewed at the initial meeting. Consistent with ethical norms for conducting research with human subjects, all participants

were asked to sign a consent form specifying the objectives of the research, the purposes to which the research will be put as well as guaranteeing anonymity and confidentiality. All but eight respondents signed consent forms. Those who did not sign the consent forms did not deem it necessary. Each participant who signed a consent form was provided with a copy. While it is not standard practice to provide remuneration to research participants, this is not the case within AIDS research. While no respondent received an honorarium for participating in the research, I made small donations to 10 organizations with limited funding (smaller community-based organizations and the Associations of People Living with HIV/AIDS) as a way of compensating them for their time and energy.

I conducted thirty-three face-to face interviews, nineteen men and fourteen women, in Dakar during a four-month period from January 30 to May 28, 2006. Thirty interviews were conducted in French, one interview was conducted in English and two were conducted in both French and English, as these respondents wanted to use the opportunity to practice speaking in English. Twenty-four interviews were of two hours in duration and the remaining were one hour in duration as these respondents indicated that they could only spare an hour of their time. Although I had intended to record most of the interviews, it became apparent very early on that the severe power shortages occurring for large parts of the day that have become all too commonplace in Senegal was going to make this difficult. I chose instead to take extensive notes during the interviews, then transcribe them by hand and translate them into English shortly after it ended (mostly by candlelight), drawing upon my long experience in taking detailed field notes in diverse research settings. After the first four interviews were conducted, four questions were altered to better get at gender and policy issues, the vulnerability of young women to HIV/AIDS, difficulties around community care of people living with HIV/AIDS and the role of women's groups in the fight against HIV/AIDS.

Most of my research participants are involved in HIV/AIDS work in multiple capacities as members of the CNLS, as practitioners, in research or as members of associations or NGOs that work in related fields. Interviews were conducted with: nine members of the *CNLS* including one member of the Executive Secretariat; seven members of the CCM; two representatives from the *Ministère de la Santé et de la Prévention Médicale* and one representative from *Ministère de la Femme, Famille et développement Social*; five AIDS researchers specializing in epidemiology/behavioural (2), psycho-social (1), clinical (1) and social research (1); three researchers specialized in women's issues including HIV/AIDS; eleven representatives of AIDS service organizations that work in prevention and/or in the care and support PHAs and/or capacity-building; six medical professionals who are HIV/AIDS program directors in hospitals and outpatient clinics; six representatives of Associations of People/Women Living with HIV/AIDS including five PHAs (three men and two women); and seven representatives from women's groups, NGOs and CBOs who also conduct HIV AIDS activities. Fourteen of my research participants have participated in the national consultations to develop the HIV/AIDS strategic plans including the 2007-2011 Strategic Plan.

A content analysis of participants' responses was conducted utilizing both numerical and word-based thematic methods (Fischer 2003; Reinharz 1992). Content analysis involved counting the frequency of particular responses belonging to a set of predetermined themes in the interview questions. It also entailed a gender analysis of the content of responses to the themes in the interview guide. In order to respect the anonymity and confidentiality of my research participants, I have utilized only a number sign followed by a number to identify participants' in text quotations.

1.3 Statement of Limitations

Conducting archival research in Senegal on HIV/AIDS proved to be difficult. Many documents are not kept in archives, partly from lack of space to store them and the costs of maintaining archives or making reprints of materials are prohibitive for the under-funded National AIDS Control Programme and research/documentation centers in Senegal. There also is a cultural component; the emphasis on keeping documents is a Western norm, as a staff member of ACI pointed out. Not surprisingly, the most comprehensive, up-to-date and well-maintained documentation centre in Senegal was that of American NGO ACI-Baobab, where I found most but not all, of the documentation I was looking for. However, I was unable to obtain the first emergency HIV/AIDS plan and the 1999-2002 Strategic Plan as there were no copies in the documentation centre of the *Division IST/VIH, Ministère de la Santé et de la Prévention Médicale* or at the *Conseil National de Lutte contre le Sida*. The documentalist from the Ministère de la Santé, however, was most helpful in filling in the gaps regarding these plans and in providing a history of the evolution of the CNLS/PNLS.

While qualitative research is by its very nature not representative in the strict scientific sense, I endeavoured to conduct interviews with the range of pertinent actors. However, not all the organizations and individuals I contacted in Senegal were open to being interviewed or necessarily meeting with me to discuss the research, largely as a result of their busy schedules which did not allow for a two-hour interview; the case of representatives from two key organizations that work with female sex workers, and vulnerable groups. These groups however have been the focus of most of the social research. I had also hoped to interview more women's groups that have now added HIV/AIDS component to their well-established development activities. Time constraints and difficulties in obtaining their contact information acted as limit on the number of interviews I could conduct within the four-month time frame for the field research I had set. While their input

might have provided more insights on gender and HIV/AIDS issues in Senegal, women's groups are largely marginalized in the policy process and CNLS institutional structure.

As the emphasis of this research is on policy and programs and their impact, I chose not to interview those directly affected; HIV positive women or women from vulnerable groups on their views and experiences around HIV/AIDS, although this would have probably strengthened my analysis and provided additional insights useful for practitioners. During the course of the field research, two practitioners offered to assist me in conducting focus groups with HIV positive women and with clandestine sex workers. After consultation and reflection on their feasibility, I declined to do so as a result of constraints inherent in the process and protocols around the ethics of conducting research with human subjects. This would have required an addendum to the submission already made to Ethics Committee at the *ministère de la Santé et de la Prévention médicale* and require them to convene a special session to address my request, in addition to contacting the Ethics Committee at UQÀM. I decided instead that this might serve as a future community-based research project developed with Senegalese partners to enhance research capacity-building of women's groups within the tradition of research as empowerment (see Ristock and Pennell 1996).

CHAPTER II

THEORETICAL FRAMEWORK: A WOMAN / GENDER AND DEVELOPMENT APPROACH

This chapter elucidates the conceptual and theoretical framework that informs this analysis of the feminization of HIV/AIDS in Senegal. In taking HIV/AIDS as a disease fundamentally shaped by diverse forms of inequality (Barnett and Whiteside 2006; Petchesky 2003; Parker 2000; Hunter 2003; Farmer 1999), it argues for the need to reframe HIV/AIDS and women in Senegal as a gender issue in order to better grasp and address the feminization of AIDS, drawing on Gender and Development (GAD) feminist scholarship and theorizing. It offers a Woman/Gender and Development perspective centering on a feminist analysis of gender relations and women's subordination within a broader socio-cultural, economic and political context that drives the AIDS epidemic and shapes the state responses to it. Although Gender and Development theory is not a monolithic body of feminist scholarship, I draw on and discuss in turn several key themes that emerge from these writings that are relevant to a feminist analysis of HIV/AIDS in Senegal. These themes include conceptualizing gender, conceptualizing 'women' as a social category within an intersectional feminist framework, development, gender, state and policy, women's empowerment and the role of men and masculinities in social transformation.

2.1 A Woman/Gender and Development Approach

Taking women's empowerment and addressing gender inequalities in addition to eradicating poverty as essential to combatting HIV/AIDS (UNGASS

2001) in Senegal, I argue that this requires an appropriate theoretical and analytic framework that can grasp the complex interplay of multiple forms of inequality that drive the epidemic among women in Senegal, shape its impact and provide direction for social transformation. Such an approach is consistent with feminist analysis (See Dagenais 1994). Describing, understanding and explaining the feminization of HIV/AIDS in Senegal can best be accommodated by a feminist theoretical framework that I will call a Woman/Gender and Development approach (Snyder 2003). It is grounded in Gender and Development (GAD) feminist theorizations that conceptualize gender as a social relation of power (Rathgeber 1994; McIlwaine and Datta 2003) but maintains the focus on women and the problem of women's subordination at the centre of gender analysis (Snyder 2003).

I argue for the need to retain the focus on women for three principal reasons. First, GAD's emphasis is not on women per se but with the social construction of gender identities, gender roles, gender differences and gender relations (Rathgeber 1994). While the focus on gender relations illuminates the multiple social divisions and hierarchies between men and women as well as between women, an exclusive focus on gender relations can obscure the fundamental socially constructed differences and power inequalities between men and women (Richardson 1994). This is all the more important in light of the growing emphasis on gender and HIV/AIDS with initiatives aimed at promoting men's involvement and partnership in combating HIV/AIDS and in the care of PHAs, appealing to pragmatic necessity or men's self-interest (Baylies 2000). As Baylies (2000: 23) reminds us "a move toward men's involvement and partnership is in part a pragmatic realization that there are precisely limits, given gendered power relations, to what women can achieve." We need to ensure that gender approaches to HIV/AIDS do not serve to render women invisible or reinforce gender inequalities that work to their detriment.

Second, too much of the epidemiological and socio-behaviourial literature focuses on supposedly gender-neutral high-risk groups such as prisoners, migrants and injection drug users, obscuring gender differences within these categories. Despite the inordinate attention focused on female commercial sex workers, too much of it is focused on the profession rather than its gendered dimensions. In taking HIV/AIDS as fundamentally gendered phenomena, we can bring women in their socially defined gender roles as wives, mothers, sisters, daughters, workers and citizens into analytical focus. As is the case with the GAD perspective, a woman/gender and development perspective focuses attention on women's socially defined roles in reproduction and production (Rathgeber 1994) and by extension, also permits the analysis of women's socially defined roles in the community; 'triple jeopardy.' This allows us to explore how HIV/AIDS affects women in their multiple social roles. At the same, this perspective allows us to critically examine how the emphasis on women in these social roles obscures the focus on the health and needs of women as individuals in their own right and how these views are embedded in policy responses.

Third, a focus on women allows for the construction of 'women' as a political category around which broad-based coalitions and networks can advocate more effectively around women and HIV/AIDS issues at international, national or local levels while at the same time acknowledging the diversity of women's material circumstances, social identities, subjectivities and needs. This was the premise for participation of a wide range of local, national and international women's groups in the activities of the Women's Networking Zone at the AIDS 2006 Conference in Toronto.

Coupled with a focus on women, I argue for a focus on gender relations. This allows us to move beyond a focus on women in high-risk groups to a broader focus on "women as women" (#16), that is, on women as a social category, exploring how gender relations as social and power relations shape women's

subordination and the feminization of AIDS. This also allows to link analysis of gender norms and roles to an analysis of gendered power relations and inequalities between men and women that work to the detriment of women in the private and public spheres. In line with GAD's emphasis on gender relations, this allows us to examine how unequal gender relations shape women's vulnerability to HIV, their experiences in living with HIV and AIDS and in the care and support of people living with HIV/AIDS. We can situate the experiences of women in high-risk groups such as commercial sex workers, domestics or petty traders within a broader context of the multiple inequalities that women face as women and are reproduced, if not accentuated with HIV/AIDS. The focus on gender relations, hitherto ignored in Senegal, must become central to HIV/AIDS research as it informs policy, programs and the development of services.

As is the case with GAD perspectives (Rathgeber 1994), a Woman/Gender and Development approach also allows us to explore how gender relations intersect with other forms of social relations of domination such as age, marital status, social class and north-south relations (underdevelopment) to shape the impact of HIV/AIDS on different social categories of women in Senegal. As such, it opens up space for challenging various structural inequalities, rethinking current development discourses and practices and considering the role and responsibilities of men in the epidemic. It allows us to situate the feminization of AIDS within a broader gendered socio-cultural, economic and political context that drives the AIDS pandemic, drawing attention to how distorted development in the Senegalese context shapes the epidemic and responses to it.

The focus on power relations reminds us that policy responses are sites of political struggle and sites of gender politics that require a political analysis if we are to identify the key social actors and an enabling environment that can advance women's empowerment in the context of HIV/AIDS. It requires 'bringing the state back into' HIV/AIDS research and examining state-civil society power relations in

the development of HIV/AIDS policy, programs and interventions. A GAD perspective also takes the state as an object of analysis, viewing it as an important site in the provision of goods and services for women as well as constituting a key actor in the emancipation of women, with a focus on discriminatory laws (Rathgeber 1994: 84). In a similar vein, an expanded analysis of the state allows us to examine how the state organizes gender relations, may foster women's subordination and reproduce gender inequalities and biases in HIV/AIDS policies and programs. Finally, drawing on GAD's conceptualization of women as social actors and as agents of change (Rathgeber 1994), a Woman/Gender and Development approach allows us to explore the role of women's groups in empowering women and mitigating the impact of HIV/AIDS and the constraints that limit these initiatives.

2.2 Gender and Gender Relations in the Context of HIV/AIDS

Feminist analysis necessarily raises the issue of gender. While gender is often seen as synonymous with women, "gender connotes the social and historical constructions of masculine and feminine roles, behaviours, attributes and ideologies, which refer to some notion of biological sex" (Imam 1997: 2). Gender is neither given by nor founded on biological sex but rather "is the social organization of sexual difference...rather it establishes meanings for bodily differences" (Scott 1988: 3). Gender identities, as Imam (1997: 3) points out, are "situated within time and space, within the context of masculinities and femininities and more than one gender may be associated with biological sex, for example, as is the case of female husbands and male daughters among the Igbo in northern Nigeria." As I have argued elsewhere, gender refers to the social and historical construction of femininity and masculinity, identities and roles but they also are culturally contextualized, class specific and racialised, as is the case in multi-racial social formations such as the United States (Mujawamariya and Ship 2005).

Gender relations refer to social relations based on power imbalances between men and women that condition women's subordination to men in sexual relationships, in the family, in the economy, in politics and in society. Within Gender and Development theory, the concept of gender relations also refers to the social relations between women and between men, emphasizing how class, 'race' and north-south inequalities differentiate women as a social category and men as a social category (Rathgeber 1994). As Imam (1997: 5) points out, gender relations also include "the relations of categories of women to social phenomena such as the state and the political system and the different relations of groups of men to those same phenomena." For example, feminist studies on citizenship have shown that gender differentiates men and women's experiences (Siplon 2005; Wone 2002a).

Despite the widespread utilization of gender as a concept and analytical category in feminist scholarship and in most institutional policy-making contexts, it has come under critical scrutiny and remains a contested concept theoretically and politically. The self-reflexive turn in western scholarship with the emergence of post-modernism, post-structuralism and post-development trends along with African and other variants of post-colonialism scholarship have forced a re-thinking of the epistemological underpinnings of dominant concepts and categories (Zezele 2003). Current trends in African and feminist post-colonial and post-development scholarship have pointed to the Eurocentric foundations of gender as a concept rooted in a western radical feminist conceptualization of the nuclear family and its focus on women as individuals (Arnfred et al. 2004; Lazreg 2002; Marchand and Parpart 1995), raising the pointed question of its validity as universal concept, particularly with respect to Sub-Saharan Africa. For example, Oyewumi (2004) asserts that traditional feminist analyses of gender are not applicable to the study of Yoruba society. Some African feminists have rejected western feminism as a political form of struggle, preferring to draw on African-American 'womanist' perspective as articulated by Alice Walker on the grounds that it more closely in

tune with African women's experiences and subjectivities (Sow 1999; Imam 1997; Denis and Sappia 2004). The pre-occupation with difference, identity, culture, language and 'race' have also become central issues in the study of women's collective political action (Connelly et al. 1995). The growth of global feminism, no longer dominated by northern feminists, attests to the complexity of feminist concepts and political practices.

Notwithstanding these debates and points of contention often between northern and southern feminists and the move to develop gender studies indigenous to Sub-Saharan Africa (Imam et al. 1997; Arnfred et al. 2004), gender analysis rooted in feminist theorizations is relevant to the Senegal context (Sow 2001, 1999; Ly-Diop 1997; Mbodj 1997; Prinz and Tine 1990) and informs a growing body of Senegalese literature on women (Bop 2005, 2002; Sow 2002a, 2002b, 1997b, 1993; Wone 2002a, 2002b; Diaw 1999; Sarr 1998; AAWORD 1986; Savané 1982; Thiam 1978). Sarr (1998) reminds us of the need to apply a contextual analysis of gender that grasps the specificity and historicity of gender relations in Senegal rather than the wholesale application of any particular western feminist theory. Sow (1999) cautions that gender needs to be understood within an intersectional feminist framework that addresses other social relations of inequality and oppression that shape Senegalese and African development as a whole, as well as women's situations within this. In a similar vein, Imam (1997) cautions us not to re-invent the wheel, outlining how gender analysis can be appropriated to better address women's realities in the Sub-Saharan African context. Drawing on a Senegalese feminist tradition and bearing these insights in mind, I proceed on the assumption that gender analysis is both relevant and pertinent to the Senegalese context. It is all the more so in the exploration of HIV/AIDS as a multi-faceted, complex social phenomena, particularly as male-female relations in the private sphere are a crucial source of women's vulnerability to HIV and HIV is primarily transmitted to women through heterosexual sexual relations.

Gender and Women's Vulnerability to HIV

A focus on gender relations in the private sphere of sexuality, marriage and the family brings into analytical focus two key issues that have been under-explored with respect to HIV risk and women's vulnerability in Senegal: how women's lack of control over their bodies and sexuality as well as male domination and women's subordination within marriage heighten women's risk for HIV. Examining unequal gender relations and gender norms in sexual relationships, in marriage and in the family are all the more important, given that heterosexual intercourse is the main mode of HIV transmission among women, among Senegalese women and African women in general. "An estimated 60 to 80% of all infected women in Africa have had sex only with their husbands (UNAIDS 1999 cited in Hemmat 2003: 8). Yet, marriage as a major risk factor for HIV transmission for women in Senegal has generally been ignored in the Senegalese literature as dominant medico-moral discourses construct '*le libertinage sexuel*' in the form of pre-marital and extra-marital sex as the major sources of HIV risk.

A focus on gender relations as a force in shaping women's vulnerability to HIV is central to a conceptualization of AIDS as a disease fuelled by inequalities, with consideration given to "the contextual factors that foster vulnerability; the socio-cultural, economic and political factors that constitute the context of individual behaviour" (Whelan 1999: 6). Re-conceptualizing vulnerability as rooted in unequal power relations allows us to link individual risk to power dynamics and issues of social and economic inequality (Parker 2000). As such, individual risk and social vulnerability are inextricably intertwined. As a corollary, the fight against AIDS is re-conceptualized "as part of a broader process of social and economic change that must necessarily take place within the struggle to build a more just social order" (Parker 2000: 41). From this perspective, a focus on women's vulnerability to HIV necessarily raises the issue of gender inequality and women's empowerment in the context of HIV.

Rethinking women's vulnerability to HIV requires exploring the role of male-female relations, models of femininity and masculinity and gender norms in the social construction of risk and vulnerability. Gender norms, gender relations and women's subordination in Senegal have been profoundly shaped by pre-Islamic traditions, Islamization, French colonial politics and more recently, a modernizing state (Bop 2004; Mbow 2003; Sow 2003; Wone 2002b; Creevey 1996; Callaway and Creevey 1994). Gender norms serve to reinforce the subordination of women and unequal gender relations. In traditional societies in pre-Islamic Senegal, despite women's central roles as wives/mothers, as priestesses and healers, as guardians of tradition and rituals, in maintaining social, family and community networks and in agricultural production, gender relations were circumscribed by a dynamic of submission and obedience to the detriment of women (Wone 2002b: 12). Women's subordination to men in the private sphere of the family and in sexual relations originates in male control of female sexuality, fertility and reproductive and productive power. Although patrilineal and matrilineal systems characterized pre-Islamic societies in Senegal (Callaway and Creevey 1994), in both systems, the need for control over women's fertility and sexuality is linked to both biological and social reproduction of the family and the lineage, as Sow (2004: 14) pointed out,

Le control social de la fécondité des femmes par les règles culturelles (mariage, polygamie, mariage forcé et précoce, dot grossesse précoce, circoncision, deuil des femmes etc.), les taches domestiques dévolues aux femmes, l'intériorisation par les femmes et les hommes de ces règles comme la norme, sont révélateurs de l'ordre sexuel inégalitaire à la base du système social et politique et reproduit par les générations.

Islam accentuated masculine authority and dominance within the family and within the public sphere among the Tukolor, the Wolof and the Serer (Huskens et al. 2004; Wone 2002b; Callaway and Creevey 1994).

Marriage is a religious obligation, confirmed by Islamic prescription, and a social necessity for all men and women. Early marriages are the norm, although this is changing somewhat in urban areas, and is still encouraged among certain ethnic groups, particularly in rural areas. For the majority of women, getting married and having children are their absolute priorities; the source of their social status and social recognition (Adjamagbo et al. 2002; Dial 2001). As Huskens et al. (2004: 40) observed,

The symbol of femininity is a married, childbearing woman and infertility is therefore seen as a denial of femininity. Real women are married women and women's roles as mothers and wives are valued above all. By contrast, men are seen as the head of the household and the ideal (in urban areas) is to earn money to marry a woman and to maintain a family. The man should not show sensitivity or weakness, since he has the authority; he takes the decisions that have to be obeyed.

The dominant ideology of femininity casts women in the role of subordinate, submissive and obedient, economically dependent mother and wife, possessing such virtues as fidelity, piety, moral superiority, respect, courage, patience and the ability to persevere (Lecarme 1992). Girls are socialized to inequality from early on (Diaw 1999; Mbodj 1997). Self-denial is also required as women's success in her role as mother and wife is intimately to the success of her children as the Wolof proverb indicates (Adjamagbo et al. 2002). It is said, '*Ku soor sa jëkër yak say doom, jëkër du moroom sang la*' which translates as "all the bad that a woman does to her husband compromises the future of her children because the husband is not the equal of his wife, he is her master" (Adjamagbo et al. 2002: 5). The dominant socio-cultural norms of masculinity characterize men as independent, dominant, aggressive and the provider whose key virtues are strength, virility and courage (Gupta et al. 2002). For Adjamagbo et al. (2002: 5), "the socially valorized feminine model is that above all, of the married woman living in material prosperity and where her husband's generosity allows her to use her own economic resources for expenses other than those for basic necessities."

A gender analysis allows us to examine how prevailing socio-cultural and religious norms around masculinity and femininity put Senegalese women at risk for HIV. Although Islam dictates fidelity in marriage and pre-marital sexual abstinence for both Senegalese men and women, men are more likely to engage in transgressions of these dictates and be judged less severely than women (Adjamagbo et al. 2002). Good women, particularly young women, are supposed to be relatively ignorant about sex and passive in sexual interactions while men are expected to be experienced and more knowledgeable about sex. Senegalese men are more likely to engage in unprotected sex with multiple partners exposing themselves to HIV risk and putting women at risk (Meda et al. 1998). Socio-cultural norms of femininity make it difficult for Senegalese women to negotiate safe sex or refuse their husbands sex (ICW 2003). Women have little control over decision-making in matters of sexuality due to an acceptance of male dominance (Faty-Ndiaye and Fall-Diop 1999).

Moreover, exploring unequal gender relations allows us to make the links between male domination/women's subordination in the private sphere of the family, sexuality and marriage with practices and behaviours that put women at elevated risk for HIV. It allows us to link a range of individual risk factors to structural inequalities that shape women's subordinate situation and vulnerability to HIV. This includes the commonly cited HIV risk factors such as women's difficulty in negotiating safe sex and condom use, women's engagement in risky traditional practices to enhance sexuality to please husbands and partners, socio-cultural traditions such as early, forced marriages, levirate, polygamy, and harmful female initiation rites such as female genital mutilation (FGM) as well as domestic and other forms of violence against women (Wone 2002b). Female genital mutilation is a traditional practice that pre-dates Islam and is viewed as a rite of passage, an integral part of girls' socialization as women and as women from particular ethnic groups, symbolizing their purity and eligibility for marriage (Sow 2004; Dellenborg 2004). The prevalence of FGM is estimated at 20% and it is practiced by some

ethnic groups in southern Senegal but not the Wolof and the Serer (Huskens et al. 2004: 38). Violence against women is rooted in an ideology of male domination and superiority, control and power. While there is evidence to suggest that violence against women, in the form of wife battery, is a common occurrence in Senegal (U.S. Department of State 2003; Lecarme-Frassy 2000; Green 1999), this has gone unexplored in the literature on women's vulnerability to HIV.

Gender and Women Living with HIV/AIDS

The term people living with HIV/AIDS (PHAs) is a gender-neutral term that implies that both men and women share common experiences living with the disease and in their medical, social and emotional needs in order to live positively. A growing body of literature has documented how despite these commonalities, gender differentially shapes the social and economic experiences of men and women living with HIV/AIDS (Stephenson 2006; UNAIDS/UNPFA/2004; Jackson 2002; Desclaux et al. 2002; Ship and Norton 2000). A Woman/Gender and Development perspective brings gender differences into analytical focus, asking how gender inequality is reproduced, if not accentuated, within HIV/AIDS, in Senegalese women's experiences living with HIV/AIDS as women, as mothers, as wives, as producers and as caregivers of PHAs and orphans.

Social stigma and discrimination around HIV/AIDS continue to be pervasive obstacles that negatively affect the health and well-being of people living with HIV/AIDS and limit their access to medical services, care and supports. PHAs face social stigma in the family, in intimate relationships, in the community, in the work place and in health services that also constitute infringements on their human rights. However, most analyses of stigma and discrimination faced by PHAs in Senegal as elsewhere rarely take gender into account. Recent research has shown that gender stereotypes and gender inequality buttressed by cultural and religious norms play a role in differentially shaping seropositive men's and women's

experiences and fear of stigma and its impact (CRR 2005; UNAIDS/UNPFA/UNIFEM 2004; Commonwealth Secretariat and the Atlantic Centre of Excellence in Women's Health 2001; Degrées du Lou 2001; Ship and Norton 2000).

A Woman/Gender and Development perspective brings gender differences in seropositive women's and men's experiences of stigma, discrimination and their gender-differentiated consequences into analytical focus. Ship and Norton's (2000) research with First Nations women living with AIDS revealed that they face a double discrimination: as HIV positive and as women. Desgrées du Lou et al. (2001) suggested that women are more likely to be seen as the vector of HIV transmission, whether as wives or as women in the sex trade. Jackson (2002) observed that women are often the first to find out their status, usually as a result of HIV testing during the course of a clinic visit during pregnancy, and as such, are often accused of bringing HIV into the couple and the family. Partner notification of seropositive status puts some seropositive women at risk of domestic violence, abandonment and divorce that often results in a loss of social status, isolation and poverty (Niang and Van Ufford 2003).

This perspective also brings into analytic focus how specific gender-based challenges that seropositive women face around having children, breastfeeding and using condoms in sexual relations with spouses and partners relate to and constrain their ability to maintain their socially recognized social roles as a mothers and wives (Desgrées du Lou et al. 2001). Moreover, this allows us to explore how women's roles as mothers and primary caregivers in the family negatively affect the health and well-being of seropositive women, as they put the health and basic needs of their families before their own (Ship and Norton 2000).

A Woman/Gender and Development approach to HIV/AIDS also brings into analytical focus how gender inequalities are reproduced within seropositive

women's economic situations, if not accentuated, and shape their impact. Some research has shown that seropositive women are more likely to be economically and socially dependent on their husbands, have less access to economic resources, to education and to gainful employment and greater responsibilities for the health and welfare of their families (UNAIDS/UNPFA/UNIFEM 2004). In many cases, seropositive women have to assume greater financial responsibilities for family necessities and children's education in a context of families living with HIV/AIDS where a seropositive male breadwinner can no longer assume his financial responsibilities (ICW 2004). The social and economic situation is worse for HIV positive widows and their children who are victims of gender discrimination in inheritance laws, considered as social outcasts, with few options for economic survival for themselves and their children.

A Woman/Gender and Development approach also brings into analytic focus how unequal gender relations, in addition to other inequalities, may constrain seropositive women's access to a continuum of care for PHAs that includes medical treatment, care and supports throughout the progression of the disease that culminate in women having shorter life expectancies than men after an AIDS diagnosis (Commonwealth Secretariat and the Maritime Centre of Excellence for Women's Health 2002: 33). Treatment is defined as the range of medical services including testing, access to ARVs and other medicines for treating opportunistic infections, consultations and follow-ups necessary to treat and monitor HIV/AIDS and associated diseases. Access to treatment is, in fact, part of care for PHAs. Care refers to a "comprehensive integrated process which recognizes a range of needs for well-being that includes services and activities that provide counseling and psychosocial support, legal, financial and practical services, as well as nursing and medical care" (Whelan 1999: 5). Supports refer to "the resources men and women need to alleviate the economic and social consequences of the impact of interacting structures and social relations that promote or prevent women and men from accessing those resources" (Whelan 1999: 5). More attention needs to be paid to

how unequal gender relations; particularly women's lack of control over decisions around health, affect seropositive women's access to the range of AIDS services and supports in Senegal.

Gender and the Burden of Care of People Living with HIV/AIDS

A Woman/Gender and Development perspective draws attention to women's socially defined roles in reproduction, the care economy and the community, highlighting how unpaid activities associated with these social roles are essential to the social reproduction of families and communities and to subsidizing national development. It brings into analytical focus the links between gender and caregiving within the context of HIV/AIDS, highlighting how gender inequality is reproduced within the Senegalese model of treatment, care and support of PHAs, orphans and vulnerable children within the family and within the community. As a consequence of women's social roles as primary caregivers in the family and their traditional roles in the community, women are expected to play major roles in caring for PHAs, AIDS orphans and vulnerable children. Women and girls shoulder the burden of HIV/AIDS illness as caregivers of PHAs in the home, in non-medical care in the hospital and as volunteers in the community care initiatives (Global Coalition on Women and AIDS 2005; UNAIDS/UNPFA/UNIFEM 2004). Female family members are most likely to care for AIDS orphans and the disproportionate share of costs of caring for them is borne by women and girls. At the same time, women and girls suffer the mental, emotional social and financial costs of caring for PHAs disproportionately, in the absence of comprehensive state supports.

Women's unpaid labour as caregivers of PHAs, orphans and vulnerable children is taken for granted, if not invisible, in HIV/AIDS policies and programs. Their unpaid reproductive labour subsidizes the gaps in programs and the costs of providing comprehensive quality care and supports to PHAs, in the context of the

African state's limited capacity to provide these services and the unwillingness of external aid donors to fully fund various aspects of care and supports for PHAs, to which Senegal is no exception.

2.3 'Women' as a Social Category: An Intersectional Feminist Framework

A focus on gender necessarily raises the issue of the conceptualization of women as a social category. A broad body of feminist literature has argued that women can not be treated as a homogenous social category (Mohammed 2002; Denis 2001; Baylies 2000; Sow 1999; Bulbeck 1998; Imam et al. 1997; Dagenais 1994; Mohanty et al. 1991; Labrecque 1991). To the extent that gender shapes women's vulnerability to HIV, their experiences living with HIV/AIDS and their roles as caregivers of PHAs and AIDS orphans, women's experiences vary. The pioneering work of Schoepf (1988, 1996, 1997) illustrated how gender and class inequality in the context of economic crisis shaped the vulnerability of different categories of Congolese women to HIV. In addition to gender, social divisions based on social class, racism, geographic location, marital status and age differentially affect women's vulnerability to HIV, access to treatment, care, and supports and the burden of care they shoulder (Tallis 2002; Loppie and Gahagan 2001; Baylies and Bujra 2000; Ship and Norton 2000; Diallo 1999; Farmer et al. 1996; Long and Ankrah 1996).

A Woman/Gender and Development analysis of the feminization of AIDS and its impact conceptualizes Senegalese women as a heterogeneous social category. It acknowledges the intersection of multiple oppressions based on diverse social relations of power based on social class, age, matrimonial status, north-south and urban-rural divisions that interact with gender inequalities and differentially shape women's subordination in Senegal (Diallo 1999; Wone 2002b). It provides a more nuanced analysis of women's subordination within the context of HIV/AIDS.

While women as a social category are vulnerable to HIV risk because of their subordinate and secondary position in the public and private spheres, some groups of women are more vulnerable than others. Gender and poverty put some categories of women at greater risk of HIV. For example, widows and divorcees have little social status and few economic options for survival and may as well be forced into transactional sex to support their families. Women married to labour migrants who are involved in risky sexual behaviour may be unable to negotiate safe sex with their husbands while others may be forced into unprotected transactional sex to support their families while their husbands are absent. Transactional sex may be defined “as the exchange of sex for comfort, goods or money, not necessarily on a professional basis” (Whelan 1999: 15). Age and gender divisions put young girls and young women at the bottom of the social and economic hierarchy, making them more vulnerable to HIV risk. In poor families, girls are encouraged to help out economically and may be pressed into risky transactional sex or marriage with a man considerably older than who may be a carrier of HIV to support themselves and their families, illustrating how gender, age and social class inequalities shape the vulnerability of girls and young women.

Moreover, “it is precisely the link between control over potentially risky sexual relations and women’s position within the wider society that is crucial, however, for an understanding of vulnerability and the way in which HIV moves through populations” (Baylies 2000: 7), which a woman/gender and development perspective allows us to describe. Patterns of male domination and female subordination are replicated in the public sphere of the economy in Senegal and are in large measure at the origins of poverty among Senegalese women. Gender inequalities constrain women’s access to education, to employment opportunities and to economic resources such as land that underpin growing poverty among women.

Senegalese women have lower levels of formal education, are less likely to speak French, and are more likely to be illiterate (UNDP 2005). Women's official economic activity rate was 61.7% in 2001 and 72% of the male rate (UNDP 2003: 9) but these figures hide the true extent of women's labour, principally, their unpaid domestic and reproductive labour in the home and in the agricultural sector (CIDA 2001). Women are concentrated in the least lucrative and precarious sectors of Senegal's fragile economy, primarily in subsistence agriculture and remain largely excluded from the industrial labour force (World Bank 2001). Women predominate in the informal sector as self-employed workers in both cities and villages in Senegal; in small trade (nearly 75% of the labour force, grain processing (>90%) and other by products of agriculture and fishing (>80%) (CIDA 2001: 3). Despite some improvements, women remain under-represented in the public sector and where they are present in administration, health and education, holding mostly intermediary positions (CIDA 2001: 2). Women's incomes were estimated to be half that of men in 2001 (UNDP 2003). The 'feminization of poverty' often cited as a major source of women's subordination and vulnerability to HIV remains problematic as it obscures "the interconnected gender issues across social classes and socioeconomic strata" (Cecile Jackson cited in Jain 2005: 108).

A Woman/Gender and Development perspective brings into analytic focus the gender-differentiated impact of class inequality and growing poverty in Senegal. Structural adjustment programs, the 1994 devaluation of the FCFA and IMF/World Bank imposed liberalization policies have contributed to growing unemployment, higher prices of essential goods, increasing poverty and decline in government social services in Senegal (Simms et al. 2006; Fall 2003; Toure and Niang 2002). Women constitute a growing percentage of the poor in Senegal (Fall 2003). Female-headed households and women's participation in economic activities are on the rise in urban and rural areas (Bop 2003). Women in urban areas are increasingly burdened with a greater share of family responsibilities and costs around food, children's education and clothing as men are increasingly unable to

assume their responsibilities. Despite women's increasing share of financial responsibilities, men remain the head of the household (Adjamagbo et al. 2002). Poverty in rural areas is more acute (Toure and Niang 2002), contributing to the increasing outmigration of young girls and women in search of work. Gender inequalities limit women's economic options in the context of economic crisis, with women increasingly involved in informal sector work (Bop 2003). Gender subordination and poverty are at the heart of transactional sex and clandestine prostitution, which also are on the rise in Senegal, particularly among women who have had little formal schooling, are divorced or widowed with children or who can not survive on what they earn in informal sector work or agricultural work (Huygens 2001). Finally, the cutbacks in government spending in health, education and social services as a result of structural adjustment and privatization, coupled with the institution of user fees for many basic services, affects women more severely than men as they are more dependent on these services and are less able to pay (Fall 2003; Toure and Niang 2002; Seck 1997; Diop 1992). The burden of cutbacks to government spending and services more heavily affects women from disadvantaged social classes. At the same time, this also reveals the gender-differentiated impact of development policies.

2.3 Gender, AIDS and Development

Gender and Development theorists have been at the forefront of critiques of dominant international and state policies on integrating women into development, as I discussed in chapter 1. They have challenged the prevailing concepts of development as policy practices and discourses around development as well as a process of social and economic change (Pearson and Jackson 1998). In line with a social justice perspective on development, Young (1988: 7 cited in Dagenais 1994: 262) defined development as,

Un processus complexe impliquant l'amélioration sociale, économique, politique et culturelle des individus et de la société elle-même.

Amélioration dans ce sens signifie la capacité pour la société de satisfaire les besoins physiques, émotifs et de création de la population à un niveau historiquement acceptable, et de libérer le temps de travail humain de l'incessante nécessité des besoins essentiels. Ainsi, cela signifie l'augmentation des niveaux de vie mais pas de la consommation ostentatoire, et nécessite un type de société qui permet la distribution égale de la richesse.

A Woman/Gender and Development approach to HIV/AIDS in Senegal brings into analytical focus the broader context of development and current trends in the international political economy treating them as problematic forces that drive the pandemic and political responses and management of the HIV/AIDS pandemic at the global and local levels of the state and community. Although globalization refers to a wide range of economic, political, social and cultural processes, for this analysis, it refers to economic and financial processes as well as the growth of global system of governance by economic and supra-state interests (Gélinas 2000). However, it is a contradictory process whose impact is uneven. On the one hand, as Sow (2003) points out the globalization of human rights issues has served to promote women's rights and claims to equality, citing the international women's conferences, international campaigns and international human rights accords. In a similar vein, Petchesky (2003) explores these processes with respect to universal human rights to health and the struggles for access to life-enhancing ARV drugs. However, the international recognition of the broad panorama of human rights has been accompanied by processes of unbridled capitalist development, buttressed by neo-liberal economic policies (Lee and Zwi 2003), that have fuelled gender, class, racial and north-south inequalities (Hirata and Le Doaré 1998) that serve to undermine the realization of these rights.

Attention to the broader context of development and international political economy brings into analytical focus north-south inequalities driving the epidemic and shaping policy responses at both the global and local (national) levels. 'Globalization's pandemic' to quote O'Manique (2004), north-south inequalities are perhaps most evident in the distribution of HIV/AIDS cases globally, with the

overwhelming majority of cases in sub-Saharan Africa. The poor, the disenfranchised, the marginalized remain overwhelmingly infected and affected by the disease (Rau and Collins 2000). A focus on north-south inequalities brings into analytical focus the links between HIV/AIDS, development and overall health which is essential to understanding certain aspects of HIV transmission and the evolution of the disease among those infected; usually side-lined in bio-medical and public health responses that focus on individual behavioural responses and courses of action. This requires a better understanding of HIV/AIDS as a disease of 'development gone wrong' to quote Dr. Roy Msiska (cited in Müller 2005: 20). Stillwaggon (2006) draws attention to the links between nutritional, infectious and parasitic diseases in the context of poverty and distorted development in compromising the immune systems of Africans and in fostering disease susceptibility to HIV and AIDS. Tuberculosis, malaria and a variety of parasitic diseases are prevalent in Senegal as elsewhere in Sub-Saharan Africa and all play a role in enhancing viral load. A Woman/Gender and Development perspective raises the broader issues of health and development, showing how gender inequalities also come into play in this equation in fostering the rapid transmission of HIV and the progression of the disease among women.

This theoretical perspective brings into analytical focus not only the structural context for health and human development but also the context for developing health policy more generally and AIDS policy more specifically. It refocuses attention on human development and health, linking the overall disadvantaged health status of Senegalese men, women and children to the limited progress made in providing universal health care, access to vaccines and medical treatment, access to clean safe drinking water and sanitation, and as importantly to HIV and AIDS. Health policy and the public health response to AIDS has evolved in the context of Africa's increasing marginalization in the international political economy, massive debt burdens, structural adjustment, neo-liberal economics and health strategy informed by the Bamako initiative that limit the capacity to address

health issues in a comprehensive way. “In this regard, AIDS policy has evolved in a social and political context that has severely limited options” (O’Manique 2004: 9). The multiple weaknesses in health infrastructure in Senegal as elsewhere in Sub-Saharan Africa has meant that the state’s capacity to address the medical and psycho-social needs of PHAs is limited. It highlights north-south inequalities that undermine universal human rights to health and current development models and rationales premised on neo-liberal political economy and ideology.

A Woman /Gender and Development approach brings into analytical focus how processes of globalization, the influence of international institutions and the global management of HIV/AIDS affect and shape state policies and capacities to act. It takes the global management of HIV/AIDS, premised on bio-medical individualism and neo-liberal ideology, as problematic (Parker 2000; Lee and Zwi 2003; O’Manique 2004), showing how north-south inequalities are reproduced within global HIV/AIDS policy responses that are advocated for the ‘resource-constrained’ countries of the Global South. This includes the emphasis on prevention as opposed to treatment as cost-efficient, the increased role of the private sector as a source of AIDS funding, the channeling of funding through NGOs to implement policy responses, usually outside the orbit of the state, a community-based model of the AIDS impact mitigation rather than a state-subsidized model of universal programs and an individual rights and empowerment model rather than the promotion structural change and social justice (Poku 2005; O’Manique 2004; Cheru 2004; Barnett and Whiteside 2002). The re-definition of AIDS as a development problem is paralleled by the increased importance of the World Bank, a key member of the UNAIDS consortium of international institutions, as the major funder for AIDS programs in the form of loans based on conditionalities rather than grants (Stillwaggon 2006). This model further undermines the universal human right to health, most evident in the limited access of PHAs in the South to antiretroviral therapy.

It also brings into analytical focus how north-south inequalities shape the HIV/AIDS policy responses in African states. The post-colonial Senegalese state is characterized by a high-level of external dependence on foreign aid from a range of international and bilateral donors from western countries in the context of weak economic performance, indebtedness and World Bank/IMF structural adjustment policies (Seck 1997; Coulon 1995), limiting the autonomy of the state and its capacity to intervene in HIV/AIDS issues. The role of the state in responding to HIV/AIDS in Senegal and elsewhere has been undermined by structural adjustment policies that have demanded a contraction of state subsidies for health, education and social welfare, engendering growing poverty for the majority of Senegalese and constricting their access to these services (Baylies and Bujra 1995; Diop 2002). Senegal receives a substantial amount of funding for HIV/AIDS programs from the World Bank, UN agencies, Western aid agencies, voluntary organizations and corporations (Mobile Task Team 2005; Vinard et al. 2003). These institutions have a varying impact on the articulation of HIV/AIDS policy and programs in Senegal and on the role and place of gender within them.

2.5 Gender, State and Policy

Feminist and GAD analyses of the problematic policies around integrating women into development also raise the issue of the 'patriarchal' nature of the state and the way in which gender interests and gender relations have been organized (Pearson and Jackson 1998). This is of particular significance for understanding AIDS policy-making, particularly since the state is the key actor in elaborating national policies, programs and services, in providing funding for programs and research, and is expected to play a key role in addressing gender inequalities and women's empowerment in the HIV/AIDS pandemic (UNGASS 2001; UNAIDS 2006) Yet, there has been little analysis as to how women and gender issues and interests are constructed in Senegalese state policy in the key areas of prevention,

the treatment, care and support of PHAs, ethics and human rights, research and in monitoring and evaluation which are central to addressing the feminization of AIDS. Gender analysis of state HIV/AIDS policy is rare and Siplon (2005) is an exception.

A Woman/Gender and Development perspective brings the state and policy-making process into analytical focus, asking how gender relations and gender interests are organized and represented by the state in diverse policy contexts, drawing on feminist theorizing on the state. Policy made be defined as “a relatively stable, purposive course of action followed by an actor or set of actors in dealing with a problem or issue of concern” (Fourie 2006: 8). Policy encompasses “goals and means, policy environments and instruments, processes and styles of decision-making, implementation and assessment. It deals with institutions, political power and influence, people and professionals, at different levels from the local to the global” (Lee et al. 2002: 10). Feminist policy analysis “brings gender into analytical focus, asking how gender is constructed into state policies and how these policies are a force in ordering gender relations in diverse contexts. Gender enters into both the framing of policy and its differentiated impacts” (Gottfreid 2003: 4). It allows us to identify gender biases and omissions in discourses around HIV/AIDS embedded in state HIV/AIDS policy, that frame research and programs in prevention and the care and support of women living with HIV/AIDS.

Much of feminist theorizing on the state and gender relations has paid insufficient attention to how African states organize gender relations and gender interests (Mikell 1997) or to gender dynamics, statecraft and politics in Sub-Saharan Africa, particularly in the post-colonial period (Mama 1996), focussing primarily on western liberal democratic states rather than the ‘Third World’ post-colonial states (Waylen 1998). Feminist theorizing on the state in the industrialized countries has raised a number of key interrelated issues on which there is no consensus but which are of relevance to a gender analysis of state HIV/AIDS

policy. This includes how to conceptualize the state (as homogeneous or heterogeneous) and state policy (good or bad for women), the implications of mainstreaming gender into state structures, state feminism, the relations of women's groups and the state in furthering women's equality and the implications of women's increased participation in formal politics (Rai 2003; Waylen 1998; Staudt 1997, 1989; Kabeer 1994).

Feminist theorizing of the state, gender relations and women's subordination in Senegal is underdeveloped, although current analyses suggest that "gender inequalities are reflected in the state and reproduced by it" (Waylen 1998: 8). Laws formally passed by the state and government institutions represent one of the principal ways that the state constructs and perpetuates gender inequalities and women's subordination (Siplon 2005). Callaway and Creevey (1989) demonstrated how colonialism consolidated the political subordination of women and a public-private division in gender roles that had roots in traditional societies and had been reinforced by Islam in their exploration of the complex interrelations between Islam, the rule of law, colonial and post-colonial power relations in Senegal. Sow (1997: 141) suggested that the post-colonial Senegalese state reproduces gender inequalities through its legislation and programs, despite all of its national and international declarations on women's rights and equality. Certain provisions of the Senegalese Family Code and current reproductive health legislation substantiate this view. For example, abortion is illegal in Senegal except where the mother's health is in danger (GREFELS 2001). Although the Family Code was an attempt to modernize women's status, it nevertheless enshrined male domination, female subordination and gender inequalities that work to the detriment of women, consistent with Islamic and traditional cultural norms (Sow 2004; Creevey 1996). Despite changes to Senegal's Family Code since its institutionalization in 1972, it still recognizes the man or the husband as the head of the family; gives him the control over children, the right to four wives, the control over the dowry, and the

right to decide where the family will live (Wone 2002b). In accordance with Islamic law, males still receive a larger share of inheritance (Wone 2002b).

“Although the state is a gendered hierarchy, which has for the most part served to reinforce female subordination, there is space for the state to act to change gender relations” (Waylen 1998: 8). More recently, women’s groups have sought to get the notion of parental authority in the Family Code reversed to include women (Creevey 2006). The battles around Family Code, which have been the object of sustained conflict between Islamic clergy and Senegalese feminists (Sow 2004; 2003; Bop 2004; Creevey 1996) also lend weight to the notion that the Senegalese state is “not a homogeneous entity but a collection of institutions and contested power relations, a site of struggle, not lying outside of society and social processes, but having some autonomy from these which vary under particular circumstances” (Waylen 1998: 8).

As Lewis (2004: 34) points out,
Fragmentation and conservatism characterize much of post-colonial African state policy-making around gender issues and WID approaches tend to frame state policy responses and generate funding. As a consequence of pressures from donor agencies to democratize, state policy responses around gender are often piece-meal, ad hoc and uncoordinated initiatives whereby gender is arbitrarily woven into policy-making without a long-term vision or context for meaningful gender transformation.

Her insights are relevant to understanding how women and gender issues are constructed in Senegalese state policies in general but more specifically with respect to HIV/AIDS policies around prevention, the treatment, care and support of PHAs and human rights legislation.

If the state is a gendered structure, then the policies that emerge from states are also gendered (Waylen 1998). As Sow (2002a: 5) pointed out, “in their structuring, functioning and policy-making, contemporary African states create and reinforce gender inequalities.” Siplon (2005: 19) suggests that “patriarchy defined as a system of interrelated social structures which allows men to exploit women is present in government institutions where women are under-represented and constrained by sexism and stereotyping and where women’s groups are purposely subverted.” A growing body of research on women, politics and the state in Senegal points to the gendered nature of the state, a male-dominated political culture, the marginalization of women in the policy process and in decision-making and the limited power of women’s groups in addressing gender inequality issues, despite their incredible growth particularly in the 1990’s (Creevey 2006, 2003; Beck 2003; Sow 2002a; 2002b, 1997; Kassé 2003; De Diop 2002; Wone 2002a, 2002b; Diaw 1999; Toure 1999; Creevey 1996; Callaway and Creevey 1994, 1989). Culture and religion have also served to impede women’s advancement in formal politics in Senegal (Creevey 2006).

Despite the increasingly visible face of women in formal politics, men dominate in the inner circles of power (Geller 2005). Senegalese women remain under-represented in political office, ministerial posts and in policy-making positions despite some improvements in recent years (Creevey 2006; De Diop 2002; Kassé 2003).¹ Female legislators’ ability to wield effective political power around advancing women’s issues is constrained by their weak political base, their exclusion from male-dominated patronage networks, clientelism and an increasingly personalized power in the hands of the current president, whereby legislative institutions function to endorse government policy (Beck 2003; Geller 2005). How much input female legislators have, including female ministers and the

¹. Women’s political representation in the National Assembly of Senegal has steadily increased, from 1 seat in the period of 1963-1968 to 23 seats in the period of 2001-2006 (Kassé 2003: 2). In 2002, women accounted for 19.2% of those in the Senegalese legislature (De Diop 2002: 2) whereas in 2007, women held 22% of the seats in the lower house (Inter-Parliamentary Union 2007: 1).

ministère de la Femme, Famille et Développement social into policy processes and decision-making remains unclear. This is of particular importance in light of the fact that the *ministère de la Femme, Famille et Développement social*, whose function is to represent and advocate on behalf of women around HIV/AIDS issues, is a member of the *Conseil national de lutte contre le Sida* (CNLS), the national AIDS policy-making body and the Country Coordinating Mechanism CCM that administers the Global Fund grants.

Men have sought to control women's auxiliaries of the dominant political parties by picking their leaders (Beck 2003). Women's groups created by the state such as the *Fédérations des associations féminines du Sénégal* (FAFS) and the *Fédération nationale de groupements de promotion féminine* (FNGPF) have not been at the forefront of challenging government policies that discriminate against women or in advocating for gender equality. Given their close links with political parties in power, they have functioned as an effective conduit in carrying out government policy (Wone 2002a).

Addressing the feminization of AIDS in the Senegalese state policy response necessitates a better understanding of how political processes and institutions are gendered and how power inequalities between men and women as well as between groups of women shape policy, research agendas and program interventions around HIV/AIDS. Growing attention is now focusing on the formal representation of women's groups in the national AIDS programs, with calls to give women a greater voice in decision-making (UNAIDS 2006; Global Coalition on Women and AIDS 2006c; Duwury et al. 2005). A recent study of national AIDS control programs showed that women's groups were the least represented of all the key groups of social actors in these various national HIV/AIDS program structures (UNAIDS 2006c). In fact, 90% of the 79 country coordinating commissions surveyed in the aforementioned study indicated that there was little or no input from women's organizations (UNAIDS 2006a: 259). This raises pointed questions

as to why women's groups are marginalized in policy and decision-making, how representative these various HIV/AIDS bodies are, and how effectively the multisectoral approach accommodates gender equality and HIV issues in policy and programs. It suggests that that gender inequalities and a male-dominated culture are reproduced within the structures that make HIV/AIDS policy.

Moreover, enhancing women's formal representation in the CNLS does not necessarily translate into women's substantive representation in this state institution. In acknowledging women and women's groups as political actors, a focus on the state and the HIV/AIDS policy-making process also allows us to examine how women's interests and women's organizations are represented in the national AIDS control program in the HIV/AIDS policy process as a whole in Senegal. It allows us to examine the extent to which they are involved in decision-making and priority setting around HIV/AIDS, and assess the impact this has on developing priorities, programs and research around women as well as the identify obstacles women's groups and women as individuals in positions of power in the CNLS face in moving women, gender equality and HIV/AIDS agendas forward.

Women's groups in Senegal are heterogeneous in nature encompassing: traditional women's groups, government-sponsored women's associations and autonomous women's equality groups (Creevey 2004; Guérin 2002). Traditional women's groups have their origins in female cooperative work groups, village gender-based community groups such as the '*mbotay*' and gender-based community associations such as the '*tontines*' (Creevey 2004). Traditional '*tontines*' an outgrowth of the '*mbotay*' focused on holding traditional and religious ceremonies, by raising funds from their members while modern '*tontines*' are urban, more focused on providing mutual credit to their members, serving as a source of credit for economic activities (Guérin 2002, Creevey 2004). Other types of traditional women's associations include groups such as the Dimba (assist women with fertility and enhance their well-being) and the Laobé (organize

community ceremonies to enhance community unity as well as assist women to enhance their sexual prowess (Niang 2001, 1997). Government sponsored women's associations include the *Fédération des associations féminines* (FAFS) and the *Fédération nationale des groupements de promotion féminine* (FNGPF) (Wone 2002a; Cissé 2002) that encompass a wide range of traditional and more modern women's groups formed around development issues. These national associations were set up in the post-independent period and remain closely aligned to the political parties in power. Autonomous women's equality groups (Creevey 2006; Diaw 1999, Wone 2002a) have been in existence since the 1970's with the first feminist group Yeewu Yeewi (Raise Consciousness for Liberation) whose explicit goal was to transform gender relations which has been displaced by more recent groups such as Réseau Siggil Jiggen (Women Advance) and COSEF, which adhere to goals of equality but are more muted in their tone (Creevey 2006).

Women' groups can be distinguished by the way in which they address women's interests, following Molyneux's conception of practical gender interests and strategic gender interests for whom "practical interests are usually a response to immediate perceived need, and they do not generally entail a strategic goal such as women's emancipation or gender equality" (Molyneux 1985: 233 in Kabeer 1994: 90). Advancing practical gender interests defines the women's movement while advancing strategic gender interests defines the feminist movement, although women's equality groups in Senegal currently avoid this label, preferring to use the term women's equality movement (#33). Both the traditional women's groups and state-sponsored associations advance women's practical interests while the autonomous women's groups advance women's strategic interests. This distinction is important as it allows us to better understand how women and HIV/AIDS issues are articulated in policy, advocacy and lobbying by Senegalese women's groups in the context of HIV/AIDS.

2.6 Women's Empowerment in the Context of HIV/AIDS

Women's empowerment has often been advocated as a strategy and a solution to reducing women's vulnerability to HIV and to mitigating the negative aspects of the disease (Rao Gupta 2000; Rao Gupta et al. 2002; UNGASS 2001; Diallo 1999; Reid 1997a, 1997b; Baylies and Bujra 1995). Women's empowerment is central to GAD approaches, which view women as actors for social change and at the forefront of initiatives aimed at their empowerment (Rathgeber 1994). A Woman/Gender and Development approach to HIV/AIDS brings the concepts and practices of women's empowerment into analytical focus at the individual and collective levels, asking how, if at all, they are embedded in HIV/AIDS policy and intervention strategies and how effective they are.

The concept of women's empowerment was first articulated by DAWN and referred to the methods and strategies, particularly at the grassroots, used by and for women from the south in empowering the poorest of women (Sen and Grown 1987). For Richardson (1994: 245), women's empowerment includes women's control over their bodies, their person, their time and the products of their reproductive and productive labour; autonomy or the capacity to decide for themselves and to be free of other people's control and authority or the social recognition of their power and the capacity to act and make an impact. As Dagenais (1994: 263) reminds us, "*le processus d'empowerment comporte deux dimensions, une personnelle et une collective, qui se renforcent mutuellement et sans lesquelles il ne peut véritablement en être question.*" A key aspect of women's empowerment in the context of HIV/AIDS is the extent to which both women's individual and collective action address gender inequality and unequal gender relations and the obstacles they face.

A focus on women's groups and women's empowerment allows us to critically examine the meaning of women's empowerment, the content of HIV

prevention strategies and the extent to which prevention strategies facilitate the empowerment of individual women to better protect themselves from HIV/AIDS; that is provide life-skills training to negotiate safe sex, facilitate access to female condoms and voluntary testing, reproductive and sexual health programs. As importantly, this allows us to assess the extent to which these strategies may promote change in individual consciousness of Senegalese women, essential to empowerment, and identify some of the constraints in transforming women's consciousness. Senegalese women's organizations, both traditional and modern, play a key role in HIV/AIDS education and prevention with women, in the care and support of women and people living with HIV/AIDS as well as orphans and in advocacy and lobbying on women's behalf (Niang 2001; Groupe thématique ONUSIDA/Sénégal 2001). However, as Putzel (2003: 43) noted, "the representatives of women's organizations have complained that there has been little specific information and education directed at women." The CNLS (2006a: 31) acknowledged that prevention activities with women, particularly in rural areas, have been inadequate in part because the focus has been on youth. This suggests that gender inequalities reproduce themselves in state-supported HIV prevention programs and set limits on the scope and extent of the activities of women's groups.

More recent thinking on women's empowerment has drawn attention to the structural constraints posed by institutions and discursive practices that shape empowerment (Parpart et al. 2002). "Groups become empowered through collective action but that action is enabled or constrained by structures of power they encounter" (Parpart et al. 2002: 4). A Woman/Gender and Development perspective brings into analytical focus the micro-structural, organization and technical obstacles that women's groups face in empowering women in the context of HIV/AIDS as well as the macro-structural barriers which have received little critical examination. It also brings into analytical focus not only how the state may reproduce gender inequalities in policy around HIV/AIDS, but the extent to which it provides an enabling environment that facilitates women's individual and

collective empowerment to protect themselves from HIV and to mitigate the negative impact of HIV/AIDS.

There are a few examples of women's collective action around HIV/AIDS issues. Senegalese women came together in 1989 to form SWAA-Senegal, a woman-focussed HIV/AIDS NGO, to address the needs of women infected and affected by HIV (#16). It relies on a small number of paid staff and about 200 members who carry out activities on a volunteer basis (Diallo 1999: 252). In order to avoid reproducing gender inequality and women's subordination to men and provide an environment where women can address women's HIV/AIDS issues, SWAA's organization is headed up by a team of ten women and men are only permitted to become members (Diallo 1999). SWAA's activities that foster women's empowerment include a gender approach in HIV prevention, dispensing and advocating for the use of the female-condom, lobbying the Senegalese President as local and community leaders around specific women and HIV/AIDS issues and networking (sponsoring a pan-African conference on women and AIDS in Africa). Moreover, the Associations of People Living with HIV/AIDS also have served as a source of empowerment for some women both individually and collectively (Desclaux et al. 2002). Gender inequalities and the lack of responsiveness to women's concerns within these associations in Senegal led to the creation of the ABOYA, first and only association of women living with HIV/AIDS, in 2001 (Mbodj and Taverne 2002). A UNIFEM-sponsored leadership training program for ABOYA's members has helped it to begin to advocate on behalf of women living with AIDS and affected by it and lobby government Ministries to better address them (ANCS 2002).

With its focus on collective empowerment, a Woman/Gender and Development perspective brings into analytical focus the strategies used by women's groups to advocate on behalf of women in the AIDS epidemic in Senegal and to assess their efficacy and the constraints they face in so doing. This allows us

to critically examine the role that AIDS-focussed women's groups in Senegal such as SWAA and ABOYA play in empowering women, addressing women's practical (immediate needs for housing, income etc) and strategic needs (that address gender inequalities). Women's groups were at the forefront of demanding mandatory pre-nuptial HIV testing in order to prevent HIV transmission by infected HIV positive men to young women as a mechanism to protect them from infection (Faye 2003b), however this strategy did not receive wide social support in part because it raises ethical questions. A Woman/Gender and Development perspective also allows us to situate women and HIV/AIDS issues within the broader struggle for women's rights and women's equality within Senegal, examining links between AIDS-focussed women's groups and the broader women's movement in Senegal that has had some success in improving women's status. It allows us to examine the extent to which the broader women's movement has taken up and supported women and HIV/AIDS issues.

Recognition of the limits of HIV prevention strategies that focus on individual behaviour change to empower women to protect themselves has prompted calls to improve women's status in general, drawing attention to women's lack of power and control in matters of sexuality in the context of gender inequality (Rao Gupta 2000; Rao Gupta et al. 2002; UNGASS 2001; Matlin and Spence 2000; Whelan 1999; Long and Ankrah 1996). Improving women's status usually means improving women's access to education and economic opportunities (income-generating activities), addressing discriminatory laws which work to women's disadvantage, particularly around inheritance and better access for women to HIV prevention services, care and support. The rights-based approach also has included the traditional feminist concerns around women's sexual and reproductive health rights and ending gender-based violence. However, these strategies fall short of directly addressing women's lack of power and control in matters of sexuality in the context of unequal gender relations.

A Woman/Gender and Development perspective can help to specify the limits of current approaches, including rights-based approaches to countering gender inequality as well as identify additional, if not alternative, courses of collective action to further gender equality and social change. To the extent that a rights-based approach to chipping away at patriarchal systems and promote empowerment is increasingly used by southern feminists in general (McIlwaine and Datta 2003) and more specifically, by Senegalese feminists (Creevey 2006; Bop 2005; Sow 2003; Niang 2001; GREFELS 2001; Green 1999), a number of problems remain with this approach. There has been little analysis of the obstacles and limits of the rights-based approach to women and HIV/AIDS issues. “Establishing rights is not the same as exercising or realizing them and more attention needs to be paid to how rights are transformed into choices and concrete improvements for women” (McIlwaine and Dhatta 2003: 374). More attention also needs to be paid to the limits of legal reform in achieving gender equality, particularly the extent to which laws are enforced, whether they alter current religious and cultural norms that sanction the status quo and women’s subordination, and ultimately the extent to which this empowers women in the context of HIV/AIDS, that is; alters gendered power relations. Moreover, despite the emphasis on human rights and women’s rights agendas, the current context of processes of globalization, neo-liberalism and unequal capitalist development that serve to foster poverty and other forms of social inequality also undermine the realization of many of these rights.

2.7 Men and Masculinities in the Transformation of Gender Relations

The issue of women’s empowerment is intimately related to the issue of incorporating men and masculinities into HIV/AIDS strategies that has emerged with the reconceptualization of GAD approaches in the 1990’s and “the consensus that a genuine transformation of gender inequalities is impossible without the participation of men” (McIlwaine and Dhatta 2003: 374). In a similar vein, women-

only approaches to HIV prevention have come under criticism that they are limited as women alone cannot halt the HIV/AIDS pandemic (Baylies 2000: 20). Current gender and HIV approaches call for a greater focus on men's roles and responsibilities in preventing HIV transmission and in caring for people living with HIV/AIDS and for men's equal participation with women as agents of change (Faty-Ndiaye and Fall-Diop 1999; SWAA 1998; Cohen and Reid 1996).

A Woman/Gender and Development perspective to HIV/AIDS which views gender as a relational concept brings the social construction of masculinity and femininity and the inclusion of men into analytical focus. This approach opens up space to critically examine dominant conceptions of masculinity and 'maleness', men's roles as fathers, as husbands and as sexual partners, male sexuality and behaviour that puts not only themselves at risk but their female partners and their families at risk for HIV (SWAA 1998; Vonarx 2003). It also opens up space for examining how men are constructed as social categories in HIV/AIDS policies, identified as target groups in HIV prevention strategies and how their needs as people living with HIV/AIDS are met with respect to treatment, care and supports. These issues have only been raised recently in Senegal and have received scant attention in the literature.

A focus on gendered power relations can help to ensure that initiatives involving men in interventions do not serve to render women invisible or reinforce gender inequalities that work to the detriment of women (Niang in SWAA 1998). Despite the devastating impact of HIV/AIDS on individuals, families and communities, the epidemic presents an opportunity for addressing and transforming gender relations and other social relations of inequality towards greater social justice and equality not just for women, but also for the poor, for youth and the disenfranchised in Senegal.

CHAPTER III

THE GENDERED CONTEXT OF HIV/AIDS IN SENEGAL

To the extent that AIDS is a health crisis, it is fuelled by processes of globalization, uneven capitalist development and rapid social change and is inextricably linked to social and economic inequality (Parker 2000). Crucial to addressing the feminization of HIV/AIDS in Senegal is a better understanding of the social and economic processes and forms of inequality that underpin its spread. Although a growing chorus of voices point to the critical role that gender inequality plays in women's vulnerability to HIV (Niang 1997; Coll-Seck 1996; Diallo 1999; Wone 2002b, Sidibe 2001; Putzel 2005) and the disproportionate burden of the disease borne by women and girls in Senegal (Niang and Van Ufford 2002; Coll-Seck 1996; Diallo 1999), there has been little in-depth analysis as to how unequal gender relations shape the impact of HIV/AIDS on women and how they are socially, politically and economically structured and maintained, much less the role of the state in these processes. A fuller understanding of the gendered political, economic, cultural and social context that has fuelled HIV/AIDS among women and shaped policy responses to HIV/AIDS requires an examination of the gendered nature of the state, the key institution responsible for HIV/AIDS policy, and the way in which it organizes gender relations and gender interests.

This chapter explores the gendered political, economic, cultural and social context that has fuelled HIV/AIDS among women, linking a sociological analysis of gender inequalities with a feminist political analysis of the state's role in these processes. It centers on an exploration of gender relations and women's subordination within the broader context of socio-political and economic transformation in Senegal in order to show how the post-colonial state plays a

contradictory role in reproducing unequal gender relations. I begin with an historical overview of gender relations and women's status in traditional societies showing that although gender relations were unequal, women were not entirely powerless, playing central roles in religion, society, economy and politics. I then discuss the negative impact of Islamization and French colonialism in deepening women's inequality to men in the family and in marginalizing women in economy and politics. Patterns of unequal gender relations in the private and public spheres that emerged during the colonial period were reproduced by the post-colonial state through its changing policies on women in the development process, despite improvements made in women's status in the post-independent period and the activism of women's groups.

3.1 Gender Relations in Pre-Islamic Senegal

Providing an accurate account of gender relations in pre-Islamic Senegal is difficult, given the lack of information, biases in the existing historical literature and the fact that processes of Islamization and French colonialism that occurred at different rates in different regions (Creevey 1994). Analysts have suggested that in the traditional societies in pre-Islamic Senegal, women played central roles beyond those of wives and mothers, as priestesses and healers, as guardians of traditions and rituals, in maintaining social, family and community networks and in agricultural production (Wone 2002b; Mbow 2003, Callaway and Creevey 1994).¹ Female divinities were prevalent along the north coast of the country where fishing is an important economic activity. Women healers presided over fertility rites,

¹. Despite variation in the political and social structures of traditional societies, the Tukolor, Wolof and Serer were hierarchically ordered by castes. However, the Tukolor were patrilineal, more tightly organized and social distinctions were more rigid than other ethnic groups. Dual lineage systems appeared to have operated among the Wolof and the Serer, and the Serer are said to have been the most democratic, with less significant gaps between social groups, less authoritarian leadership and more collective work (Creevey 1996: 271). Diola social and political organization appeared to be more egalitarian.

possession rites (exorcism) and administered traditional medicines (Sow 2003). Women's roles in traditional religions were particularly strong among the Diola, the Serer and the Lebou (Mbow 2003; Creevey 1996).

Among the Wolof and the Serer, there was a political role for women from dominant castes, although this was not the case for the Tukolor (Creevey 1996). In the traditional Wolof states, the *lingueer*, usually the mother or maternal sister of the *brak* (king) was appointed by him and the *awo*, the first wife of the *brak* wielded considerable political power while among the Serer kingdoms of Sine and Saloum, the *lingueer* was either the mother or the eldest maternal aunt of the *bour* (Creevey 1996: 272). However, women's political roles in these socio-political systems were subordinate to those of men and they exercised power through them while men and women of lower castes were completely excluded from political power (Sarr 1998; Callaway and Creevey 1994; Sow 1993). Caste was determined by the male and his inherited profession (Diop 1985). Serer and Tukolor women had no property rights (Sow 1995; Callaway and Creevey 1994).

A division of labour based on sex and age marked the subsistence agricultural economies among sedentary ethnic groups who also conducted some trade primarily across the Sahara and North Africa (Callaway and Creevey 1989; Sarr 1998). Despite women's central roles in agricultural production that afforded them some power and their right to dispose of the surplus on the land that they worked, most women did not own land (Sow 1999; Creevey 1994). In Wolof kingdoms, men controlled the land and only they could inherit it, hire labour or buy slaves to work for them (Callaway and Creevey 1989: 96). Women had land use rights and were allowed to keep what they produced in their own plots, dispose of any surplus they produced as they chose and were compensated for the work they did in family fields controlled by their husbands as heads of family (Callaway and Creevey 1989). Among the Serer, women could inherit the rice fields from their mothers whereas among the Peul, land was owned communally and communally

granted to both men and women (Tine and Sy 2003). Among the Diola who were matrilineal, some women were able to control and own rice fields, although this was not the case among the Diola that were more patrilineal, although women in these groups could own their own granaries (Sow 1995; Callaway and Creevey 1994). Diola women in the Casamance region wielded greater political, economic and social influence as compared to women from other ethnic groups (Mbow 2003; Sarr 1998; Geller 1982).

In both patrilineal and matrilineal pre-Islamic systems, the need for control over women's fertility and sexuality was linked to both the biological and social reproduction of the family and the lineage (Sow 2004; Diop 1985). Women's central roles as mothers and wives and their functions in procreation and human reproduction constituted the main source of their subordination in traditional societies (Sow 2004). Marriage traditionally was a matter of consolidating alliances between groups (Sow et al. 1998; Wone 2002b; Sarr 1998). Unequal gender relations characterized marriage practices. Polygamy was common and viewed as a source of power and prestige for men as it assured self-sufficiency in agricultural economies (Mbow 2003). The practice of the *levirat* whereby a brother inherits his dead brother's wife and children, although it may be considered as a form of social protection for widows and children who were left with nothing in the event of a husband's death, was also strongly tied to the safety and continuity of the family's longevity and wealth, as well as to the maintenance of the alliances between families already put in place (Sow et al. 1998). Should a wife refuse to comply, her only option was to leave the household without her children (Sow et al. 1998). Similarly, the *sororat* entails the replacement of a deceased wife with her sister. Both practices give credence to the notion of women as property and signify the control over women's sexuality and reproductive capacities.

However, women were not entirely without power despite their subordinate roles as mothers and wives within the family. Women played key roles in the

circulation of goods in the form of gifts around the key family ceremonies, which formed part of women's roles as the guardians of traditional values and rituals (Sarr 1998). Despite women's centrality in traditional society, women were unequal to men; although social divisions based on age, gender, marital status and caste affected women's differential access to power and resources, in addition to differences in social and political organization of the principle ethnic groups.

3.2 Gender Relations and Islam

Islamization of Senegal's main ethnic groups occurred unevenly over a long period of time beginning in the 11th century and passing through two distinct phases of Islamic influences, although the main Islamic Brotherhoods were founded in the 18th and 19th centuries (Mbow 2003; Callaway and Creevey 1994; Geller 1982). Islamization progressed rapidly under French colonial rule, particularly among the Mourides and Layenne as a nationalist response to colonialism, westernization and Christianity, and deepened in the post-independence period (Sow 2003). As a religion, "Islam regulates all aspects of human life, prescribing a set of beliefs, a way of worship, a system of civil and criminal law, an economic and political system" (Creevey 1994: 278). It regulates the family, gender relations, social relationships and social norms of interaction. Notwithstanding a high degree of consistency, interpretations of Islamic precepts are open to a variety of influences and its practices vary as a result (Sow 2003; Mbow 2003; Bop 2005). Also, some earlier traditional practices associated with traditional aristocratic societies and traditional religions never entirely disappeared despite Islamization (Geller 2005). Moreover, Islamization did not entail the disappearance of traditional practices such as female genital mutilation or the levirat and sororat.

Muslims in Senegal are Sunni and organized into four Islamic brotherhoods based on Sufi traditions. "Sufism has its origins in the Middle East as

a mystical and ascetic movement but which in its popular form in the *tariqa* (the way) or brotherhood has often been based on the veneration of the divine personalities who possess the mystical gift of *Baraka*" (Cruise O'Brien 1971: 25), which in Senegal also includes devotion to the founders of the brotherhoods (Bop 2005). The Tidjani, Mouride, Layènne and Qadiriyya are distinguished by slight differences in ritual and codes of conduct (Copans 2000; Callaway and Creevey 1994; Geller 1982). They are highly organized structures with extensive reach into all regions of Senegal in both rural and urban areas, operating as vast networks of communication, social solidarity (social services) and social mobilization, each headed up by a *Khalife général* whose influence on religious, political and health issues is significant (Groupe Thématique ONUSIDA/Senegal 2001). By far not the largest brotherhood, but certainly the most powerful economically and politically, the Mourides have maintained a close relationship with the colonial and postcolonial state (Coulon 1981; Copans 2000; Geller 2005).

Studies on 'Islam and women' in Senegal are rare, reflecting gender biases in historiography (Mbow 2003). Despite the lacunae in the existing literature, Islam had a double impact on Senegalese women. Although it accorded them certain rights where none previously existed, Islam stripped women of much of the power and status they previously enjoyed, accentuating male dominance and female subordination (Sarr 1998; Creevey 1996; Wone 2002b). Islam's reconfiguring of the traditional family/social/political systems entailed the separation of the private sphere of the family from the public spheres of religion and politics, relegating women to the private sphere and accentuating male roles in the public spheres, although its impact varied somewhat by ethnic group (Mbow 2003; Sow 2003; Sarr 1998; Creevey 1996; Callaway and Creevey 1994).

Islam introduced the notion of individual rights, partially undermining community and family unitary systems, providing some rights and protection for women (Creevey 1994: 280-281). Women were accorded the right to inheritance

but not land from their fathers and only half of what their brothers were entitled to. Women were given the right to dispose of the income from the bride price as they chose. They were given the specific right to control what they earned which they had previously enjoyed by custom. Islam gave women family rights: regulating polygamy by limiting the number of wives a man could marry (4 wives), giving mothers rights to their children and mandating fathers to maintain the welfare of children even when in the mother's care.

Although women obtained certain rights, Islam deepened women's subordination and unequal gender relations in the private and public spheres, reinforcing patriarchal values of pre-Islamic traditional societies or inculcating patriarchal values where they did not previously exist. Islamic precepts and practices reinforced pre-existing gender and age cleavages and hierarchies within the family. The family is taken to be the centre of Islamic society and the paradigm for all social relations and is premised upon a hierarchical model of male domination and female subordination. Creevey (1996: 279) reminds us that

References to women in the sharia are that women are dependent on men and are fulfilled through their subordination to them. Although the roles of wives and husbands are viewed as complementary rather than unequal, it is quite clear that relationships within the family are hierarchical and patriarchal in nature.

Although the Qu'ran exhorts all Muslims to marry and establish a family and celibacy is frowned upon, women are subject to more intense social pressure to marry than men (Mbow 2003; Creevey 1996). Marriage and motherhood were trumpeted as women's primary social roles; the primary source of their social status and social recognition (Huskens 2004; Mbow 2003; Ajamagabo et al. 2002; 2004; Wone 2002b; Dial 2001). In valorizing women's social roles in the private sphere of the family, Islamization served to de-valorize women's critical roles as producers, placing them in a situation of economic dependence.

Along with the valorization of marriage and women's roles as wives is the valorization of maternity and their roles as mothers, and the two are inter-related. A wife's obedience to her husband is seen as having important consequences for her children as evidenced in the Wolof proverb '*ligeey u ndey anu dom*' or 'a child is but the reflection of a mother's behaviour vis-à-vis the father' (Mbow 2003: 6). Virtues of self-abnegation, stoicism, generosity and patience defined ideal motherhood values and behaviour. A wife's/mother's obedience to her husband is viewed as the basis of social equilibrium and the source of children's success in life (Mbow 2003). Despite the social value placed on women's roles as mothers and wives, they are subordinate and secondary to male roles in the family and in the public sphere. This view justified the domination and exploitation of women.

Unmarried girls were expected to be submissive to their parents and elders and as wives they were expected to obey their husbands (Bop 2003). Islam reinforced the social control of girls' sexuality through its religious and moral precepts (Groupe thématique ONUSIDA/Sénégal 2001). It emphasized the importance of marriage for girls and the interdiction of sexual relations outside marriage, particularly pre-marital sex. A high premium was also placed on girls' virginity, viewed as a symbol of family honour, and commanded a higher bride price (Mbow 2003). Islam contributed to the practice of early, forced marriages in some case before puberty, particularly among the Halpulaar (Mbow 2003).

Islam also reinforced male control of married women's sexuality. Unequal gender relations were reproduced within the sphere of sexuality and premised on male control over female sexuality and reproductive capacities. Although husbands were expected to satisfy their wives sexually, wives were expected to submit to their husband's sexual demands and women's bodies were essentially viewed as male property.

"As it is written in the Qu'ran Surate 11, Verse 223, 'your women are your field of labour; go to your field as you wish.' People use this to

justify men's sexuality and women's submission and the use of women's body to do with as they wish" (#18).

Islamic norms emphasize married women's faithfulness in marriage, with adultery viewed as a greater trespass of the marriage bond than was the case for men. In addition, women were expected to be circumspect in their social behaviour and not give the impression of sexual impropriety. This has given rise to a dense network of social surveillance of women's behaviour, emphasizing the social control over married women's sexuality (Groupe thématique ONUSIDA/Sénégal 2001: 14).

While divorce was allowed, it was men generally who made this decision and possessed the right to repudiate a marriage (Bop 2005) whereby a man pronounced 'I divorce thee, three times to end a marriage (Mernissi 1985). If a man only pronounced this twice, "the marriage bond would be suspended, after which the husband could resume the marriage" (Mernissi 1985: 52). Both polygamy and repudiation, rights granted exclusively to men, are also premised on the need to ensure men's sexual satisfaction, while severely regulating female sexuality (Mernissi 1985). Although women were given certain rights over children, Islamic law also guaranteed paternal authority of the husband over children in the event of divorce by regulating the conditions under which widowed and divorced women could remarry. Pregnant women are forbidden to remarry until they have given birth. Moreover, the institution of *idda* forbids widowed and divorced women to remarry until several menstrual cycles have passed.

Women's roles as leaders in religious rites as high priestesses and as healers were seriously curtailed, replaced by male healers and spiritual leaders, which Fatou Sow designated as a spiritual patriarchy (Sow 2003: 70). Notwithstanding women's influence and contributions to Islam in multiple ways, women cannot ascend to the position of Imam or Khalife of the brotherhoods (Mbow 2003). Within the Mouride brotherhood, women have been generally excluded from being *marabouts* or *talibes* (disciples) or involved in *dara*; the special *Mouride* camp

where young disciples stay for a period of time as devoted workers for their order, and only if a *marabout* has no sons could his daughter take over his leadership role (Rosander 2003; Creevey 1994). More recently, a feminine elite (*women/sokna* usually related to a founder or a *marabout* or daughter of a *marabout*) has emerged, although it is subordinate in status and dependent on the religious structures within the brotherhoods (Rosander 2003; Mbow 2003). A more contemporary practice, women have formed women-only, women-headed *dahiras* (religious associations to support marabouts and mobilize followers) (Creevey 1996). The cult of Mam Diarra Bouso in Porokhane is an example of how women's traditional religious power has been transformed by Islam (Rosander 2003; Creevey 1996).

As in the sphere of religion, with the re-creation of the old clan systems of pre-colonial kingdoms, women's political roles were transformed and their power significantly reduced. "The spread of Islam removed women from public office and promoted a more strictly patriarchal state system within traditional kingdoms" (Creevey 1996: 276). The *lingueer* and the *awo* did not disappear entirely but were informally accepted as the female relatives of the major *marabouts* and took on the authority that female relatives of the kings and nobles always had (Creevey 1996).

Unlike elsewhere in the Islamic world, veiling and women's seclusion were never adopted in Senegal and Senegalese women have more freedom (Creevey 1996). However, Islamization served to reinforce women's subordination in the public spheres and the private sphere of sexuality, marriage and the family.

3.3 Gender Relations under French Colonialism

French colonial rule in tandem with deepening processes of Islamization served to mutually reinforce women's subordination to men (Sarr 1998; Creevey 1996; Callaway and Creevey 1994; Sow 1993). French colonial control, complete

by 1885, was a “system of political, economic and cultural domination forcibly imposed by a technologically advanced foreign minority on an indigenous majority” (Geller 1982: 9). Through the imposition of the triple processes of racism, capitalism and sexism, colonial rule created new forms of inequalities based on gender, class, skin colour and regions in addition to shaping Senegal’s economic underdevelopment. To the extent that the ‘*mission civilisatrice*’ was proffered to justify French colonialism, it rested on the notion of racist ideology of the superiority of the colonizer and the inferiority of the colonized (Geller 1982: 9). The imposition of patriarchal norms regarding women’s place was an essential element of the ‘*mission civilisatrice*’ and the domestication of women was furthered by the incursion of Christianity. The colonial vision of women explicitly valorized their roles in reproduction as mothers and wives in the private sphere of the family and the domestic economy and limited their participation in the public spheres of the commercial economy, politics and the state (Sow 1993). The colonial state reproduced and reinforced unequal gender relations through its policies on assimilation, economic development, education and health.

French colonialists introduced the French model of a centralized top-down state structure with secular administrative and political institutions as well as a legal system based on the Napoleonic Code (Callaway and Creevey 1994). “Colonial Senegal was divided into two distinct political and administrative entities that reflected the differences in status between the citizens of the communes and the subjects of rural Senegal” (Geller 1982: 10). The French policy of assimilation allowed for the setting up of a territorial assembly in Senegal (*Conseil Général*), municipal councils patterned on those found in metropolitan France and a representative to the French Chamber of Deputies in Paris (Geller 1982). Africans born in the four communes of Dakar, Gorée, Saint-Louis and Rufisque, about 5% of the population, enjoyed the benefits of French citizenship including the right to participate in politics (Geller 1982).

Outside the four communes, the rest of the colony was divided into fifteen administrative districts or '*cercles*' each governed by a French commandant who ruled in an authoritarian manner, denying subjects political and civil rights. Each '*cercle*' was divided into several cantons headed by African canton chiefs who were chosen by colonial authorities, and were responsible for executing the unpopular tasks of collecting taxes and recruiting men for labour *corvées* (Geller 1982). In rural areas, French colonial political power emanated from the top down through the intermediaries of the brotherhoods and marabouts became local political leaders. From the 1950's on when the French permitted the Senegalese to vote for delegates to the French National Assembly, Senegalese western-educated politicians in political parties continued the tradition established in the French colonial era of seeking the support of leaders of the brotherhoods to get the vote out (Callaway and Creevey 1994).

The French policy of assimilation in Senegal entrenched gender discrimination in the political sphere as western-educated male intellectuals were primed to become political leaders. Only male African citizens from the four communes could participate in electoral politics and hold political office, provided that they met certain educational qualifications (Geller 1982). Similarly in the rural areas, women were not chosen to be canton chiefs. Women only received the right to vote in 1956 with the *Loi Cadre* that instituted adult suffrage (Callaway and Creevey 1994: 167). Traditional practices such as the *levirat* and *sororat* were banned by the French colonial administration in 1939 because they were perceived as 'un-Christian' and not because it was a question of women's rights, although it proved ineffective in eradicating them completely (Wone 2002b). "The question of women's political rights was only addressed much later on and with great ambivalence on the part of colonial authorities, despite women's active participation in political events and the struggle for independence" (Sow 1993: 5).

Senegal's colonial economy was shaped by the political and economic imperatives of its colonial master. Colonial economic policies fostered the development of monocultural economy based on groundnut production and limited light industrialization entailing the transformation of primary products for export or light industries producing for local consumption (Amin 1973; Boone 1992). The *Pacte colonial* assigned the colonies a subordinate position in the division of labour whereby the colonies were to provide France with raw materials, agricultural commodities and protected markets for French industry (Boone 1992). Although Senegal was already incorporated into the changing world capitalist economy as an exporter of groundnuts following the demise of the Atlantic slave trade in 1840, colonial economic policies further enhanced Senegal's unequal integration into the world capitalist economy as an exporter of primary commodities based on unequal terms of trade (Amin 1973; Geller 1982). Moreover, as Boone (1992: 10) cogently observed, French colonial policies left

three legacies that would prove to be critical in shaping the postcolonial political economy: peasant production of an export crop, the primacy of trading networks rather than production itself as a locus of capital accumulation and the weakness of the indigenous business class.

French policies also left lasting legacies that were to prove critical in shaping women's roles in the post-colonial political economy. Processes of capitalist development, the privileging of cash crops over food production and the imposition of western norms regarding women's place served to marginalize women's roles in agricultural production, relegating them to subsistence production for home consumption or at best for the less lucrative domestic market, mostly in petty commerce and crafts (Sow 1993). The incursion of European products and the declining demand for local cloth that was spun by Tukolor women in the north, served to dramatically reduce their incomes (Callaway and Creevey 1994). Colonial authorities targeted men in the introduction and expansion of commercial cash crops, as they were oblivious to women's key roles in agricultural production (Coquery-Vidrovitch 1997; Sow 1993). By the end of the 18th century, the French

were offering incentives to male farmers to grow peanuts and they benefited from inputs (credit, selected seeds and fertilizers) and new technologies whereas women were initially excluded from this process except as dependent labour with little access to these new tools of production (Creevey 1996). Similar patterns of gender discrimination occurred in the promotion of irrigated rice cultivation in the Senegal River Valley in the 1930's (Drevet-Dabbous 2001). The introduction of cash crop farming also served to further reduce women's access to land as the more fertile land was designated for more lucrative commercial agriculture (Sow 1995). It increased women's work as they were required to work in their husband's/family fields as well as cultivate their own fields in addition to the wide variety of other domestic and household tasks they were required to perform (Sow 1993). Finally, in matters of land tenure, colonial land policies, as was the case in most traditional societies, prohibited women from owning or managing land (Sow 1993), although they could inherit it (Tine and Sy 2003).

French colonial rule also provided the impetus for emergence of a modern urban sector concentrated in Dakar (and to a lesser extent, Saint-Louis, Rufisque and some larger towns in the interior); where the major import-export houses and colonial banks were headquartered (Geller 1982). Gender discrimination was a fundamental feature of the development of new economic activities in urban areas as men were recruited, trained and employed in the new industries and commercial businesses, and women would only be drawn into the wage labour market in urban areas much later on (Creevey 1996), creating patterns of gender inequality in access to salaried employment in the modern urban economy that have persisted into the post-colonial era. Moreover, male rural out-migration during this period in search of wage labour opportunities in urban areas also increased the workload and responsibilities of rural women but not their power or authority (Creevey 1996).

Access to western education formed part of the colonial '*mission civilisatrice*' and policy of assimilation, intended to transmit colonial cultural and

social values as well as create a western-educated African elite in addition to constituting the principal conduit into the colonial urban economy and polity. French schooling initially was limited to the children of European and Christianized Creole families of the four communes (Coquery-Vidrovitch 1997). Girls' access to formal education was more limited than was the case for boys as girls were directed toward gender-stereotyped occupations such as mid-wives, teachers and nurses, consistent with their roles as mothers and caregivers (Sow 1993). The few girls who received formal schooling were from educated Christian families, as Muslim families initially refused to send their children to Christian schools, although this changed slowly later on (Diokhané et al 2000). The first French school was opened in 1817 in Saint-Louis and a girls' school was opened in 1819 by nuns of Saint Joseph de Cluny (Diokané et al. 2000: 3). Education for girls primarily consisted of transmitting Christian values and norms around women's roles and women's place; teaching them to be perfect housewives, to sew, keep house, do laundry and speak French, while boys were being prepared for work in offices and commerce (Diokané et al. 2000). "The French civilizing mission reinforced women's subordination even as it was offering them new skills through the few new schools opening" (Creevey 1996: 277). French colonial policies created gender, class, regional and rural-urban inequalities with respect to access to education.

The promotion of western medicine in French colonial West Africa, designed to improve the health of Africans, also formed part of the '*mission civilisatrice*' that required the creation of a new social strata of educated Africans deemed (*les évolués*) (Turriffin 2002; Echenberg 2001; Becker and Collignon 1999). Colonial authorities recognized that training African women could further their project of social domination and the promotion of western health education and birthing techniques by facilitating access to African families (Turriffin 2002). While men were recruited to be doctors, women were recruited to be midwives. *L'École des sages-femmes* was set up as part of but separate from the medical centre established in Dakar in 1922 to train African medical personnel. (Turriffin

2002: 71). Drawing on women's traditional roles as midwives, this occupation became the exclusive avenue of entry for educated women into the health professions and into the professions in general until 1938 when a teachers' training school for women was opened in Rufisque (Turriffin 2002: 72). The introduction of western medicine challenged the legitimacy of traditional medicine and women's roles as healers, further eroding their social status and power (Echenberg 2001).

3.4 Women, Gender Relations and the Post-Colonial State

Gender relations in the post-colonial period continue to be influenced by traditional, Islamic and western influences, as mediated by the post-colonial state. The Senegalese post-colonial state is the key actor in national development and the principal architect of 'women's promotion', although subject to the influence and activism of women's groups demanding greater autonomy and women's equality (Wone 2002a). Gender inequalities and unequal gender relations are both reflected in the post-colonial state and constructed by it. State policies to promote women's roles in development have not substantially altered patterns of women's subordination and gender inequalities inherited from the colonial era in the public spheres of the economy and polity and in the private sphere of the family, despite some improvements made in women's status (Ba 2002; Sow 1993; Wone 2002a). Women remain in a subordinate position to men within the family, the economy and the polity, although age, marital status, class and rural-urban divisions further shape differences in women's material circumstances.

From 'Integrating Women' to 'Integrating Gender' into Development?

Inheriting the hierarchical political structure of the colonial state, the post-colonial state did not alter the French model of a centralized top-down state structure with secular administrative and political institutions as well as a legal

system. Senegal is divided into 10 administrative regions under the authority of a regional governor that are in turn divided into three departments with the exception of the Dakar region with four departments. Each department is further divided up into communes and ‘*arrondissements*’ (Simms et al. 2006). A quasi-democracy since independence in 1960, political power is concentrated in the hands of the president and there are signs of a creeping ‘democratic authoritarianism’ particularly under the aegis of the current president (Creevey 2006; Geller 2005; Coulon 1995). Senegal has enjoyed relative political stability, despite a twenty-year low-level civil conflict in the Casamance arising from its political marginalization. The 1990’s witnessed the dramatic growth of associational activity among all sectors of civil society, particularly among women, building on a long tradition of citizen involvement in public life (Diop 2002; Geller 2005).

Léopold Senghor, Senegal’s first president, viewed the participation of women as essential to the state-led development and modernization process rooted in ‘African socialism.’ Premised on an essentially conservative and traditional view of women, Senghor’s policy of ‘women’s promotion’ consisted largely of expanding and promoting women’s social roles in national development and construction through ‘*animation féminine*’ through women’s animation centres and the *École Nationale d’Enseignement Technique Féminin de Dakar* (Wone 2002a). To this end, women’s groups, particularly young women, were mobilized to carry out a programme of activities, designed by the party in power, that entailed organizing literacy courses, sewing, health education and market gardening in rural and urban areas. Providing women with civic, family and health education was deemed necessary to assist them in enhancing their capacities as mothers, as wives as producers and as citizens. However, ‘*Animation féminine*’ aimed at modernizing women’s roles in the domestic economy while ‘*animation masculine*’ centered on improving men’s participation in national economic development (Sow 1993). Women were exhorted to “*équilibrer les budgets familiaux pour contribuer à l’équilibre du budget national*” (Wone 2002a: 10). Despite lip-service paid to

women as producers and citizens, Senghor's policies on women in national development served ultimately to further entrench patterns of gender inequality inherited from the colonial era, particularly their economic and political marginalization as well as reinforce women's primary roles as mothers and wives.

Senegalese women made some gains during Senghor's rule. Key achievements included the implementation of the Family Code that accorded some protection and rights to women, the appointment of two female ministers and the creation of a women's bureau within the state (Ba 2002). Despite limited inclusion in the structures of government, women's participation in development consisted essentially in promoting state policies in the name of national development rather than promoting women's development and women were absent from planning and decision-making around national development policies (Sow 1993; Cissé 2002; Wone 2002a). The UDS/PS women's wing of the main political party and the *Fédération des associations féminines* (FAFS) created in 1977 were too closely aligned with the state and ruling party to challenge the WID approach or to develop an autonomous women's agenda based on women's liberation or gender equality, revealing the limits of state feminism under Senghor.

Abdou Diouf's accession to power in 1983 marked a partial rupture with Senghor's policies evoked by "*sursaut national en opposition à la négritude*" (Wone 2002a: 9). Named '*Gooru Mbotay*' (man at the service of women or for some the power exercised by him), his policies on 'women's promotion' evolved during a more favourable international context for promoting women's equality (Wone 2002a). He created the *Fédération nationale de groupements de promotion féminine* (FNGPF) whose main goals were in line with a WID approach: integrating women into productive circuits, increasing their access to technology and implementing labour-saving projects, and developing revenue-generating projects and cooperatives for women (Wone 2002a). Under Diouf, the first Plan of National Action for Women was implemented in 1982 with the objective of improving

women's position in the economy through programs in education, training, health, nutrition, employment and income-generating activities (Creevey 2002).

Apart from revising the Family Code, Diouf increased women's representation within the state by appointing a few female ministers in some in non-traditional posts and creating a national ministry with a women's secretariat, in addition to putting into place measures to promote women within the Parti Socialiste (Wone 2002a). However, his policies did little to alter women's subordination in the economy (Sow 1993), illustrating the limits of the Diouf's WID approach. The imposition of structural adjustment policies during his tenure did little to enhance women's access to education, social and health services and contributed to the feminization of poverty.

Abdoulaye Wade and the *Parti démocratique sénégalais* (PDS) came to power in 2000 through a coalition of opposition parties identified as *l'Alternance* based on a platform of *SOPI* (change), marking a partial rupture with the previous policies of the PS. Wade has been associated with a move toward modernizing Senegalese society, particularly women's status (Creevey 2006). As one respondent (#7) pointed out, "Wade appears to be committed to women's rights." This in part reflected in the high profile campaign to halt violence against women, spear-headed by the First Lady (Creevey 2006). The *Direction nationale de l'Équité et de l'Égalité de Genre* located within the women's Ministry was created as part of his commitment to women's rights, although the *Stratégie nationale pour l'Égalité et l'Équité de Genre 2005-2015* was much later in coming (République du Sénégal 2006b). He has also taken up the practice of consulting with advisory groups on women's rights such as *l'Observatoire des Droits de la Femme et de l'Enfant* created by the Association of Female Jurists (Creevey 2006; République du Sénégal 2006b). *Centres d'Assistance et de Formation pour la Femme* have been put in place since 2003 to address women's rights issues (République du Sénégal 2006b). During his first term, key constitutional and legal changes to enhance women's

equality with men through a new Constitution and a revised Family Code were instituted (Sidibe 2001; Creevey 2006). Wade increased the number of female ministers in the government and appointed the first female prime minister, although short-lived, in Senegal, Mame Madior Boye (Creevey 2006).

However, despite these impressive achievements aimed at equalizing gender relations, this largely has occurred at the legal and juridical level. Processes of equalizing gender relations are in their infancy. It remains to be seen how these legislative changes will be enforced and to what extent they can profoundly alter structurally based gender inequalities. Also, uneven economic development and deteriorating social conditions during Wade's tenure are undermining women's economic and social position, particularly in rural areas and among urban poor women. Moreover, it remains to be seen how successful policies emphasizing access to micro-credit for women and labour-saving technology aimed at improving women's position in the economy as part of the poverty-reduction strategy will be in altering unequal gender relations and reducing poverty among women.

Courting and containing the power of Muslim brotherhoods, the legacy of colonial politics, has been crucial element of clientelist politics of the post-colonial state, although it has varied under each of these regimes; to which Wade is no exception (Creevey 2006; Geller 2005; Copans 2000; Villalon 1999; Coulon 1995, 1981). As a consequence of the continuation of old patterns of collaboration between religious and political elites, culture and religion continue to limit rapid advances in gender equality in general, and not simply in the sphere of formal politics as Creevey (2006) suggested.

3.4.1 Regulating Gender Relations in the Private Sphere: Legitimizing Women's Subordination

Regulating marriage and the family has been a key aspect of state policy as both the 1992 Constitution and the current 2001 Constitution, article 16 stipulate that “marriage and the family constitute the natural and moral basis of the human community. They are placed under the protection of the state” (CRLP 2001: 12). The Family Code, implemented in 1972 is the primary piece of legislation that regulates gender relations within marriage and within family, although some provisions of the Constitution and the Penal Code also legislate on matters pertaining to the private sphere of the family, marriage and women's rights (République du Sénégal 2006b).

If gender inequalities are both reflected in the post-colonial state and constructed by it, nowhere is this more evident than with respect to the Family Code, which upholds a patriarchal model of marriage and the family with profound repercussions for women's subordination in the public and private spheres. Although the Family Code was an attempt to ‘modernize’ women's status, it incorporated aspects of Islamic and customary law (Sow 2004; Creevey 1996). In essence, it legitimates male dominance and female subordination in matters of family and marriage, viewing women as minors whose decisions need to be made by the male head of household, whether a husband or a father. Despite changes to the Family Code over time that discarded some gender discriminatory provisions such as the husband's approval for his wife to work outside the house and to choose her type of employment, gender discrimination in the Code persists. In 2002, the Family Code still recognized the male or the husband as the head of the family, with the right to control over children, the right to four wives although women have the right to choose matrimonial regime they want, the control over the dowry, the final say in disposing of the household goods as he sees fit, a larger share of inheritance and the right to decide where the family will live (Wone 2002b). As

Bop (2005: 8) observed, “although the Family Code gives options to both Muslims and Catholics the freedom to practice these principles according to their respective religions, these options are exercised by men only because women are subordinate to men in both religions.”

The new Constitution adopted in 2001 included provisions to protect the family and strengthen some of women’s rights. Article 7, in particular, enshrines gender equity and gender equality in access and ownership of land, in education, in employment, in the determination of salary and taxation (République du Sénégal 2006b: 2). Moreover, several government initiatives are currently in the works to eliminate gender inequalities in matters of taxation and family benefits for salaried women workers as a result of the patriarchal definition of head of family (République du Sénégal 2006b). A ministerial working group has also been put into place to develop practical ways to integrate gender equality and the care economy into macroeconomic policy as well as ensuring that government budgets are gender-sensitive (République du Sénégal 2006b).

However, key provisions of the Family Code are in clear violation of the 2001 Constitution that guarantees male-female equality (Bop 2005). The Family Code continues to be the battleground between conservative Muslim leaders and more progressive women’s groups, pressing for additional changes to the Code (Brossier 2004). Women’s equality groups have been at the forefront to get the provision around parental authority reversed.

“There is currently a battle around the Family Code to get changes around parental authority, giving women equality with men. There is legislation but it has not been passed yet but I think it will be passed soon. The Association of Female Jurists, of which I am a member, created an *Observatoire* to monitor some of these issues and act as a consultative body to the President.” (#7)

Even if feminists are successful in getting women recognized as the head of the family, an extensive education campaign will be needed to change deeply ingrained

social attitudes, shaped by traditional cultural influences and religion, around the acceptability of gender equality in male-female relations in the family and in the couple. As is the case with other rights issues, many women, particularly uneducated, poor rural and urban women, do not know their rights and as a result of social and family pressure may be unwilling to exercise these rights (Wone 2002b).

3.4.2 Women's Subordination in the Economy

Patterns of unequal gender relations; of male dominance and female subordination have been reproduced within the post-colonial economy, in part, the legacy of gender inequalities instituted during the colonial era and partly the result of structural adjustment policies in a context of economic crisis. Official data on labour force participation showed that in 2004 women made up 42% of the official labour force (World Bank 2007c: 1). UNDP's data (2003:9) showed women's official economic activity rate at 67.1% in 2001; 72% of the male rate. This data however, hides the true extent of women's labour, principally their unpaid domestic and reproductive labour in the home and in the agricultural sector (CIDA 2001). Moreover, women are increasingly engaged in a variety of income-generating activities in the informal sector to supplement declining household incomes and this does not always figure into official statistics because of gender biases based on the assumption of the male head of household breadwinner and female dependent housewife model (Bop 2003, 1996; Adjamagbo et al. 2002).² Structural adjustment policies and the intensification of poverty have had a gender-differentiated impact contributing to the increasing impoverishment of women and are affecting gender relations and roles in the family (Bop 2003; Abdoul et al. 2002).

² In 2005, the population was estimated at 11.7 million, with a growth rate of 2.7% (World Bank 2007a: 1). Women made up 52% of the population, while 55.6% of the population is under 20 years of age and almost 64% under 25 years of age (CNLS 2006a: 4).

Concentrated in the agricultural sector, women comprise 70% of the agricultural labour in rural areas (Ngagne and Becker 2006). Women make up a fraction of the industrial labour force, employed primarily in food, cosmetics and pharmaceutical industries as a result of lower levels of literacy, access to technical training, lack of information about job opportunities and gender biases associated with the status of women (CIDA 2001: 3). Women are under-represented in the public sector and concentrated in gender-stereotyped domains such as health, education and administration, accounting for only 3,016 of the 37,000 technicians, supervisors and managers in 1999 and 4% in managerial positions (CIDA 2001: 3).

Senegal's current economic crisis is rooted in the continuation of colonial economic policies by the post-colonial state, the key actor in post-colonial economic development, in its vulnerability to changes in the international political economy and the nature of the social basis of the state (the particular alliance of foreign, urban and rural ruling class fractions) in whose interests economic policies were implemented (Boone 1992). The key elements of Senegal's post-colonial political economy entail the privileging of a monocrop economy based on groundnut production in the central basin region for export (Boone 1992; Youm 1991). Peasant production of groundnuts for export and international loan capital invested by the state constituted the principal motor of economic development of the post-colonial economy (Thioub et al. 1998). The state presence was extended into rural areas to control land and labour and its monopoly over the peanut export business allowed it to appropriate directly a large share of the rural surplus, which was used for developing public sector employment and the expansion of social services rather than re-investment in rural areas (Boone 1992; Thioub et al. 1998). State policies to promote import-substitution industry did not challenge the dominance of French capital in this sector, which remained foreign-owned, managed and staffed (Boone 1992). Commerce rather than production is the main source of capital accumulation, with local capital concentrated in the competitive, less lucrative segments of the commercial sector, in transport and in urban real

estate while French capital and state enterprises dominated in the heavily regulated formal-sector industry, commerce and banking (Thiouba et al. 1998).

Senegal was re-classified as a highly indebted poor country by the World Bank in 2000, with its debt accounting for 51% of the GDP in 2004 down from a high of 87% of the GDP in 1995 (World Bank 2007b:1). By 2007, most of Senegal's debt had been cancelled and current projections indicate that in 2008 it stands at 13% of goods and exports (AWEX consulted 21 /11 /2007). Groundnuts remain a principal export crop (although its importance is declining as foreign currency earner), along with cotton, rice, sugar cane, fish products and market garden crops destined for Europe while millet and sorghum are cultivated for domestic consumption, along with cattle raising and fisheries (Juteau 2004; World Bank 2007b). Phosphates and light manufactures also make up key exports (World Bank 2007a), while tourism is a growing foreign currency earner (Juteau 2004). Industry made up 19.7% of the GDP in 2004 while manufacturing accounted for 11.5% and services 63.5% (World Bank 2007b: 1). Transportation, real estate, communications and commerce are the most dynamic sectors of the economy (World Bank 2006).

World Bank and IMF structural adjustment programs in place from 1981 to 2006 (ADB/OECD 2007: 10), neo-liberal economic policies and the 1994 devaluation of the economy entailed the weakening of state institutions and reduction in its services, growing unemployment and poverty, increasing prices for consumer goods and a decline in living standards (Fall 2003; Touré and Niang 2002; Creevey 2002; Diop 2001). The 1994 devaluation of the currency served to spark economic growth with economic growth rates of around 4% to 5% yearly since that time (Seck 1997; Diagne 2002; World Bank 2006). However, despite the growth in the GNP per capita, poverty and social class inequalities have been steadily increasing (Diagne 2002; Diop 2001). Food security continues to be an issue, as Senegal remains highly dependent on imports of rice from Thailand and

wheat (Seck 1997; Diop 1992). Moreover, the country has been slipping on the Human Development Index, ranked 156 in 2003, it was ranked 157 in 2005; an indication of deteriorating economic and social conditions (UNDP 2003, 2005). The GNI per capita (Atlas Method) in 2004 was \$710 US (World Bank 2007b: 1). UNDP (2005: 2) statistics indicated that in 2003, 33.4% of the Senegalese population was living below the national poverty line, 28.3% of the population was living on less than \$1US a day and 67.8% of the population was living on less than \$2US a day. Marginal improvements in poverty reduction were noted by the ESSAM 11 (2001) study that indicated 57.1% of the population was living in poverty and 48.5% of households were poor with urban poverty touching one in three families in Dakar (IMF 2005: 10).

Although people in Dakar are comparatively better off as opposed to the rest of the country, 60% of the urban population has no permanent jobs or regular incomes, 60% of urban households are living below the poverty threshold (\$1US a day), 60% of households spend less than 15,500 FCFA per person per month on basic necessities such as rent, food, clothing and health and 83% of the population has no welfare protection for even partial reimbursement of medical expenses (Desclaux et al. 2003: S98; Canestri et al. 2002: 65). Housing subsidies and programs also have tended to benefit privileged social classes rather than the poor and households with no running water that must use the public fountains pay three to four times more than those with running water (Juteau 2004: 66).

A 1999 study on household access to essential services in urban areas revealed that while 72.8% of households were connected to the electrical network and 65.7% of households had running water, possession of consumer goods was much lower as only 50.8% of homes had television, 22.9% had a fixed telephone and only 11.1% had a vehicle (Lanièce et al. 2002a: 35). By contrast, rural electrification is considerably less developed, somewhere around 15% (IMF 2005). In absence of available data, one may assume that the possession of consumer

goods is considerably lower in rural areas as well. Data around access to improved water and improved sanitation showed pronounced rural-urban inequalities despite improvements in the last decade (UNDP 2005). Within rural areas, access to improved water and sanitation are also marked by regional inequalities (IFAD 2006). These inequalities unnecessarily add to rural women's workloads and negatively affect their health.

The increase in poverty has been most severe in rural areas, where the majority of the population is located, in part because the poor are concentrated in the least productive sectors of the economy such as agriculture, particularly women in subsistence farming (Diagne 2002; Diop 2001). Although agriculture only accounted for 17% of the GDP in 2004 (World Bank 2007b: 1), half of the Senegalese population is involved in agricultural production (*Document de stratégie de réduction de la pauvreté 2001*). In 1998, it was estimated that 75% of the poor were in rural areas and 58% of rural households were poor, with poverty highest in certain regions of the country, notably Kolda, Fatick, Louga, Kaolack and Tambacounda (Adjamagbo and Antoine 2002: 527). Rural poverty is concentrated in the centre, northeast and southern parts of the country, where rural out-migrations is also highest (IFAD 2006). Urban areas also have benefitted more than rural areas from Senegal's poverty reduction strategy (IMF 2005).

Women's position in rural areas is particularly bleak. Unequal gender relations continue to shape women's lack of access to land; a key factor of production (Bop 2003; Drevet-Dabbous 2001; Diop 1997; Sow 1993; Mackintosh 1989). The 1964 '*Loi sur le domaine national*' whose goal was to provide equal access to land for rural agricultural producers and the 1972 '*Réforme de l'administration territoriale et locale*' designed to give rural agricultural producers more autonomy and power in managing their productive activities did little to enhance women's access to land or increase their power in rural decision-making bodies, much less challenge customary laws around land tenure (Sow 1997b: 259).

Lack of access to land has affected the success of income-generating projects such as market-gardening projects initiated by the state in the 1980's as women rural producer groups still face enormous difficulties in obtaining sufficient good quality land to make production profitable (Sow 1997b). In addition, as is the case elsewhere in Africa, female farmers have less access to formal credit, bank loans, equipment, agricultural inputs, new technologies, labour and agricultural extension services (Ba 2002). Gender inequalities in access to land and other inputs combine to render female agricultural production less profitable than is the case for men. In addition, female farmers' productivity is also constrained by the sexual division of labour that assigns them a variety of household and child-rearing tasks.

Small-scale agricultural production units are increasingly unable to provide households with a sufficient income to meet basic needs (Mackintosh 1989; Ba 2002, Huygens 2001). Both rural men and women are engaged in various forms of temporary and seasonal wage labour to supplement incomes as well as non-agricultural income-generating activities, although women fare less well. "Industrial sites such as Richard Toll sugar refining complex in northern Senegal attract seasonal labour migration. Many women hoping to get work end up in sex work because the demand outstrips the number of available positions" (Hygens 2001: 23). Gender inequalities are reproduced within patterns of wage labour and income-generating activities as rural women are increasingly shouldering the financial burdens for rural households. Ba's (2002) study of agricultural producers in the Casamance revealed that women's incomes from non-agricultural economic activities were less than men's and were used to supplement family expenses such as clothing and school fees for children while men's earnings in part were directed toward paying for food expenses but also for marrying a second or third wife. Similar gender patterns have been documented for the peanut-producing areas around Kaolack and in agricultural areas Diourbel (Diop 1997; Mackintosh 1989). Moreover, in many cases, rural women require their husbands' permission to engage in income-generating activities (Diop 1997).

Married Halpulaar and Soninké men from the Senegal River Valley looking for work as labourers in France and educated Senegalese seeking professional work opportunities in neighbouring and Central African countries made up the majority of migrants in the 1960's and 1970's (Tall 2002). Married men usually left their wives and families at home for long periods of time, increasing women's and girls' workloads and often placing them in a precarious economic situation, giving rise to a growing proportion of female-headed families. In 2002, female-headed families accounted for 13.1% of families in rural areas but 25.7% in urban areas (Badji and Boccanfuso 2006: 3). Civil conflict, which has heightened poverty and the deterioration of services in the Casamance, has amplified migration with almost equal numbers of males and females leaving the region. Rural out-migration has fuelled increased and uncontrolled urbanization, with Dakar the main locus of internal migration (Diop 2001). Senegal is among the most urbanized of African states, with 46% of the population residing in urban areas, primarily concentrated in Dakar, with 22.4% of the total population (CNLS 2006a: 4). Touba, Kaolack, Thiès, Diourbel and Ziguinchor all have populations in excess of 50,000 inhabitants (Juteau 2004: 65).

Liberalization of the economy entailed the gradual restructuring of the labour market, heightening gender, age and class inequalities in access to employment and paid work. The downsizing of the civil service and the 1993 reduction in salaries resulted in a declining standard of living and purchasing power of civil service employees who make up a sizable part of the middle class, forcing many to develop additional sources of income in order to survive (Diop 2001). A 2001 Dakar labour market study indicated that while official unemployment among the active population was only 11.7%, it was higher among women at (14.1%) than among men (9.9%) but these figures masked the real problem of underemployment that affected roughly 72.5% of the working population (OECD 2005: 16). The average salary in 2001 in Dakar was 58,200 FCFA (\$110US) but varied by sector

(OECD 2005: 16). About 7.5% of workers were employed in the public sector where the average monthly salary with fourteen years of employment was 149,700 FCFA (\$283US) while for those in administration with eight years of employment, the average salary was 134,700 FCFA (\$254US) (OECD 2005: 16). About 16.1% of workers were employed in the private sector where with about eight years of employment, the average salary was 113,100 FCFA (\$214US) while 76.4% of workers were employed in the informal sector, earning on an average 39,000 FCFA (\$74 US) while working an average of 47 hours a week (OECD 2005: 16).

The reduction of jobs in the formal economy, particularly, the civil service, the main employer in the modern economic sector and a key avenue of mobility for educated women, has negatively affected women's employment. (Diop 2001; Ajamagbo and Antoine 2004). In 1989, 46% of women with secondary education or higher between the ages of 30 and 49 were employed as '*cadres*' in the tertiary sector whereas in 2001, only 18% of these women held similar posts whereas during the same time period, the proportion of male '*cadres*' declined from 63% to 42% (Adjamagbo et al. 2002: 11). The process of de-skilling has forced educated women into secretarial, commercial and traditional craft activities as they are less likely than men to be hired as '*cadres*' (Adjamagbo et al. 2002).

De-skilling among women who have completed some high school has also occurred in the tertiary sector. In 1989, 72% of these women were employed in the tertiary sector of the economy and only 21% were employed in petty commerce or small-scale craft activities (Adjamagbo et al. 2002: 11). By 2001, only 59% of women having completed some high school were employed in the tertiary sector and 36% of women were involved in informal sector activities (Adjamagbo et al. 2002: 11). Women with little if any formal education are overwhelmingly concentrated in informal sector activities, with most investing in micro-commerce and retail activities; and their numbers are growing, accounting for 68% of informal sector workers in 1989 and 76% in 2001 (Adjamagbo et al. 2002: 11).

Economic liberalization has engendered dramatic growth in informal sector economic activities, drawing on and heightening gender, age and class inequalities in access to employment and paid work. In 1995, it was estimated that the informal sector accounted for 90% of all paid employment in Senegal (Creevey 2002: 95). A sexual and age division of labour operates within the informal sector of the economy. Notwithstanding the emergence of Senegalese female entrepreneurs who now dominate retail and wholesale textile trade in Dakar (Sarr 1998; Creevey 2002), women are concentrated in the least lucrative and most precarious sectors of the informal economy as itinerant vendors, petty traders in foodstuffs and other food service activities, particularly in Dakar (CIDA 2001; Lecarme-Frassy 2000). Men are more likely to be involved more lucrative informal commerce in imported beauty care products, pharmaceutical products, articles of clothing, watches and jewellery and knock-off designer handbags, although some women have made inroads in these areas (Lecarme-Frassy 2000; Creevey 2002). Within the fishing industry, a key economic activity, men control the production and wholesale commercial activities as well the control over the lucrative commercial market in large-size fish and seafood while women are involved in retail sales in local food and fish markets (Lecarme-Frassy 2000: 22).

Unemployment rates have grown, particularly among the young, who are concentrated in informal sector activities in urban areas; as one of the few economic options (Biaya 2001; Huygens 2001). A gender division of labour operates in the informal sector of the economy, favouring young men over young women. Young men are more likely to work as apprentices and vendors whereas girls and young women (ages 15 to 29 years) are less involved in informal sector commercial activities, except as assistants to parents, a mother or an aunt (Adjamagbo et al. 2002). Girls and young women, many of whom are illiterate, and rural emigrants particularly among the Sereer and the Diola, are more likely to work as domestics in increasingly precarious and deteriorating conditions, despite

its regulation by legislation (Adjamagabo et al. 2002). The occupation pays anywhere from \$45US to \$100US monthly for a twelve-hour work day in most homes, depending on the income of the household where domestics are employed. Many domestics cannot survive on their salaries, often sending part of this income to their families. In order to supplement their income, many are engaged in a variety of transactional sex practices as a survival strategy.

International migration is on the rise taking on new forms from older patterns, with new destinations in Europe (although a more diversified number of countries), the USA and to a lesser extent Canada, in part a response to declining economic conditions in Senegal and to globalization. Transfer payments from émigrés constitute a growing and significant source of income not only for families trying to survive in urban and rural areas but also as a source of investment in a variety of commercial activities, real estate and local development initiatives in the country (Tall 2002). The growing role of migrants, particularly those involved in transnational networks based on family, ethnic and/or religious affiliations as actors in national development has led to the creation of a specific Ministry to better regulate these processes (Tall 2002; Copans 2000). Unequal gender relations also shape women's economic opportunities with respect to international migration, which is still largely male-dominated. Although young educated female migrants make up an increasing proportion of the new international migration, particularly to the USA (10%), they are largely excluded from the transnational but more lucrative Mouride commercial networks (Tall 2002). Primarily settling in New York, they are concentrated in female-specific occupations such as food services and hairdressing that generate less revenue for re-investment in Senegal (Tall 2002).

The poor and women are more negatively affected by the withdrawal of the state which entailed a reduction in health services, in social services and education. Women in both urban and rural areas are increasingly paying for the costs of children's schooling are off-loaded onto families (Bop 2003). In disadvantaged

suburban neighbourhoods in Dakar such as Diamaguene, local women's groups organized to improve access to water, garbage removal and sanitation systems through utilizing women's traditional solidarity networks such as '*tontines*' as a source of financing these improvements (Bop 2003). '*Tontines*' and '*mutuelles de santé*' organized by women play an important role in making funds available to poor families to meet some of their health care needs (Bop 2003).

3.4.3 Women's Access to Education: Persistent Inequalities

Women's subordinate position in the economy is also intimately linked to their low levels of educational attainment. Economic crisis, the declining incomes of families in tandem with government cutbacks to education and the imposition of user fees and the growing costs of school fees; a function of structural adjustment policies, limit access to education in Senegal (Diop 2001; Seck 1997; Diokané et al. 2000). Moreover, access to education continues to be marked by gender and social class inequalities as well as regional disparities, favouring certain regions (Dakar) and urban areas (Adjamagbo and Antoine 2002; Diokané et al. 2000); the legacy of colonial education policies. Finally, some analysts have suggested that religion, Islam, may also be a factor in the resistance to formal education, particularly for girls, as the most heavily Islamised zones in Senegal and among the heavily Islamised ethnic groups such as the Pulaar and the Wolof, showed the lowest education rates (Diourbel, Kaolack, Tambacounda) (Diokhané et al. 2002: 28, 39). However, as Callaway and Creevey (1994) suggest that the relationship between religion and education is complex in the Senegalese context and other social and economic factors need to be taken into account.

Recognizing the disparities in education access and attainment, the Senegalese state implemented a 10-year sectoral program in education funded by the bilateral and multilateral aid donors, with ambitious goals that also included

achieving gender parity by 2005 and gender equality by 2015 (Jacobsen et al. 2007).³ Thus far, the gains have been less than impressive. The overall adult literacy rate in 2004 was low at 39.3%; much lower among adult women (29.2%) as compared to men (51.1%) (World Bank 2007c: 1). The gender gap in primary school enrolment has been narrowing since 1990. By 2004, the female net primary school enrolment was 64% as opposed to 68% for males, and progression to grade 5 rates were 79% for boys and 77% for girls, with overall primary school completion rates at 49% for boys and 42% for girls (World Bank :2007c: 1). Despite gains made by young girls, the youth literacy rate among 15 to 24 year-olds shows persistent gender disparities, with the male literacy rate at 58.5% and the female literacy rate at 41% (World Bank 2007c: 1). Although girls' enrolment in secondary school has increased, it is still lower than that of boys as they comprise only 39.6% of enrolment at this level (UNDP 2006), with girls concentrated in the technical sector, particularly commerce, while boys are concentrated in the literary and scientific sectors leading to university (Diokané et al 2000). Notwithstanding the rapid increase in university enrolments, female students represented only 24% of those enrolled at Université Cheikh Anta Diop in 1997 (Diokané et al. 2000: 12).

Unequal gender relations, the persistence of gender bias, traditional practices and the sexual division of labour in the family continue to shape girls' unequal access to formal western education, despite government policies and projects designed to counter this (Diokané et al. 2000). In some cases, families are reluctant to send girls to schools as they fear this will lead to the loss of social control over girls' sexuality culminating in pregnancy outside marriage and in other cases girls are not sent to school as they are married off at an early age (Diokané et al. 2000). In many families, where economic choices need to be made about whom

³. Reform of the curriculum and increasing the number of female teachers are also objectives of this policy initiative, designed to address gender bias and inequality in the education system. Enhancing the quality of education, increasing retention rates of students and reducing the gap between rural and urban inequalities in access to education are among the many objectives of this 'education for all initiative' (Jacobsen et al. 2007).

to send to school, boys are generally selected over girls, justified by the argument that girls don't need to be educated as they will eventually get married "as this Wolof proverb affirms '*Tarou diguène seye*' (marriage is the moral beauty of a woman)" (Diokané et al. 2000: 27). Girls are more likely to be withdrawn from school to help with domestic chores and subsistence agriculture in rural areas as a result of the sexual division of labour in the family (Juteau 2004). Young girls are increasingly leaving school to seek paid employment in urban areas to help out families; a consequence of declining rural incomes and standards of living (Vandermeersch 2001; Bop 1996).

Gender biases persist in schooling as the education system is a principal agent of gender socialization, based on the premise that girls' principal life goal is marriage while boys need to be prepared for gainful employment. Girls are oriented toward gender-stereotyped occupations in the less lucrative areas of the economy, limiting their career and educational aspirations. This also is internalized by many young girls who see education as a passport to enhanced marriage prospects rather than as a gateway to a profession or career (Diokané et al. 2000).

Closely linked to the issue of access to formal education is the issue of competency in the French language that is essential to better employment opportunities, access to information and services and participation in politics. Gender inequalities persist regarding fluency in the French language. Although French is the official European language of governments, academic institutions and the media, the legacy of French colonial policy, "more than half of the adult population is still not literate in French" (Geller 2005: 138), particularly women.⁴

⁴. Six major ethnic groups that make up close to 95% of Senegal's population; Wolof (42%), Halpulaar & Tukulor (24%), Serer (14%), Diola (4%) Mandinka (3%), Soninke (1%), with Lebou, Bassiri and Manjak composing the balance and Europeans and the Lebanese making up 1% of the population (Geller 2005: 15). Despite its multi-ethnic character, a progressive Wolofization of popular culture, of national identity and national language is in evidence (Geller 2005; Diouf 1994).

3.4.4 Women's Health is Not a Priority

Unequal gender relations intersect with social divisions and inequalities based on age, social class, geographic location (urban/rural and north/south divides) that shape women's health status, their access to health services and policies around women's health. Basic health data for Senegal shows a disadvantaged health profile. Life expectancy at birth in 2005 was still low at 56.1 years; 55 years for men and 57 years for women in 2004 (World Bank 2007a: 1). Gender differences in life expectancy are less pronounced in Senegal than is the case with industrialized countries. About 24% of the population experienced malnutrition during the period 2000 to 2002, although malnutrition and anaemia are more pronounced among women and children (UNDP 2005: 13). This is an all too common consequence of poverty and underdevelopment (lack of access to safe drinking water, inadequate sanitation, unhygienic practices, inadequate health services), exacerbated by neo-liberal policies of health reform, privatization and cost-effectiveness (reduction in services, increased costs for consultations and medicines). Women's disadvantaged health status is also linked to gender inequalities that include: low levels of education and competency in French that make access to health information difficult, the persistence of certain cultural practices that endanger women's health (female genital mutilation, repeated pregnancies, nutritional taboos and practices favouring men), the health risks women face in carrying out their reproductive and domestic tasks and their lack of decision-making over their own health, reflective of unequal gender relations (CRDH 2005b; Sow and Bop 2004; Sow 1997b).

Women's access to health services is constrained by inequities in the public health system. The public health system is pyramidal in structure (Brunet-Jailly 2000). At the top, the national or central level, are the agencies of the central government such as the Ministry of Health and other government departments and services where priorities in health are defined (République du Sénégal 2005b). A

second strategic level is made up of 10 medical regions covering the 10 administrative units that correspond to Senegal's administrative regions. Each medical region is headed up by a chief medical doctor or '*médecin-chef de région*' (MCR), who is a representative of the Ministry of Health and who is in charge of coordination and of the regional team of supervisors responsible for the different health programs in the region (République du Sénégal 2005b). The third is the operational level made up of 52 health districts (*districts sanitaires*) in both rural and urban areas (Simms et al. 2006: 231). Each health district has a Health Centre located in every major town of the '*département*' as well as a certain number of health posts and health stations (Cornu 2003: 10). A district chief medical doctor who supervises a team of trained medical personnel oversees the health district, where programmes are executed. As a result of decentralization in the early 1990's, the local community manages health centres, posts and stations (Cornu 2003).

Senegal has a three-tiered system of public health facilities. According to Simms et al. (2006: 231), the first level comprises 750 health posts that provide basic curative care, care for the chronically ill, antenatal care and family planning and 55 district health centres that receive first-level referrals from health posts and provide limited hospitalization services. The second level is composed of seven regional hospitals with a capacity of 100 to 150 beds that are located mainly in provincial cities and provide some specialized care (Simms et al. 2006: 231). The third level includes one teaching hospital and six general hospitals located in the capital city of Dakar. In addition, several Christian church-based facilities provide health care, primarily to low-income families (Simms et al. 2000).

Formal user fees for health services have been in place since 1972, along with a private health system and based on the Bamako Initiative since 1991 that prioritizes efficiency and cost-recovery over 'health for all', although this has made only a modest contribution to increasing revenues for the health sector (Simms et al. 2006: 233; World Bank 2005). Most poor and low-income Senegalese cannot

afford to pay for health care in the public health system, despite the fact that costs for services are much lower than is the case with the private clinics and private doctors (Brunet-Jailly 2000). The private health system comprises 1 hospital, 24 clinics, 414 private practices and business sponsored medical services, 700 pharmacies and 20 laboratories that provide analysis of medical tests (CNLS 2007c: 10). Many poor people and women consult traditional healers rather than western medical services as their first course of action in health matters; occasionally with fatal consequences, as I witnessed during the course of my research.

Senegal's health system remains under-financed with the bulk of financing coming from state and household budgets (Simms et al. 2006). The state health budget currently represents 6.5 % of the national budget and the share of external donor funding is increasing (Bop 2005: 24; Vinard et al 2003). Although Senegal has one of the best health systems in Africa, a legacy of colonial policy, structural adjustment policies have negatively affected the development of the health sector. Although the number of hospitals increased from 7 to 18 between 1960 and 1988, the number of beds per population also decreased from 1 bed per 1,209 people to 1 bed per 2,109 people in a context of rapid population growth (Diop 1992: 31). Lack of financing, insufficient health personnel, inadequate equipment and medicines and a limited number health institutions concentrated in urban areas are indicative of Senegal's underdeveloped health sector. In 1999 there was only 1 doctor per 17,000 inhabitants (WHO norms of 5 thousand to 10 thousand), 1 nurse per 8,700 inhabitants (WHO norms of 300) and 1 mid-wife per 4,600 women of reproductive age (WHO norms of 300) (CNLS:2002a:10). Currently, there is 1 health post per 11,470 inhabitants (WHO norms of 5 thousand to 10 thousand), 1 health centre for 176,072 inhabitants (WHO norms of 50,000) and 1 hospital for 480,186 inhabitants (WHO norms of 150,000) (CNLS 2007c:11).

Rural-urban inequalities also affect access to health services as hospitals are concentrated in Dakar and the patient-doctor ratio is lower than say, Louga (Thioub

et al. 1998). About 50% of rural households are within a one-kilometre distance from a health centre and only 35% of rural households have access to a maternity centre (Juteau 2001 :67). Moreover, the Demographic and Health Surveys have repeatedly shown that women, particularly in rural areas, encountered a number of obstacles in accessing health care. Female informants cited the inadequate provision of medical services (lack of services, availability to services, distance and availability of certain drugs) and the high cost of consultations and medications as major barriers to access (CRDH 2005b; République du Sénégal 1999).

Women's access to medical services is further constrained by their lack of power to make decisions about their own health, despite their social roles as caregivers in the family and in the community. The 2005 DHS (CRDH 2005b :48) revealed that within the family, decisions around health care are primarily made by husbands alone (67%) and to a much lesser extent wives (13.7%) and only 6% of couples make these decisions jointly while in 13% of cases, someone else, usually a male relative, decides. Women who are older, divorced, working, better educated and in urban areas are more likely to have the final word about health care (CRDH 2005b: 48). Moreover, many health providers reinforce unequal gender relations by insisting that married women present written authorization from their husbands before providing them with requested birth control methods (Bop 2005; Juteau 2004). Health services and health policies in Senegal are constructed upon an ideology of familism (Wuest 1993) rooted in the prevailing unequal gender relations typical of the Senegalese extended family and reproduce them.

Health policies around population, family planning and sexual and reproductive health, continue to construct women's health in terms of their roles in biological and social reproduction, women as mothers and caregivers, expressed in the dyad of 'maternal and child health' (CRLP/GREFELS 2001; Lo 1991). Women's health in general is not a priority, despite the intimate relationship between women's health and child's health. Moreover, despite the policy emphasis

on maternal and child health, the maternal mortality rate in Senegal continues to be high, showing signs of fluctuation, at 690 deaths per 100,000 live births in 2000, up from 560 in 1992 (World Bank 2004; UNDP 2005: 3), although more recent statistics show a decline to 401 deaths per 100,000 live births for the period 1998 to 2005 (CRDH 2005b: 234). As one respondent (#29) pointed out, the decrease in the maternal mortality rate in Senegal is partly due to women's groups like APROFES in Kaolack region that have successfully intervened in this area. The main causes of death are haemorrhage following delivery or induced abortion, accidents as a result of medical malpractice performing caesarean sections, hysterectomies, infections caused by lack of hygiene and pre-existing illnesses such as high blood pressure, diabetes and anaemia aggravated by pregnancy (Bop 2005; Diadiou et al. 1991). Moreover, maternal mortality rates are higher in rural areas, linked to inadequate health services and skilled birth attendants, particularly emergency obstetrics (Adjamagbo and Antoine 2002). There can be no 'safe motherhood' until there is 'safe womanhood'; that is until poverty, underdevelopment and gender inequality that shape women's health are addressed as determinants of maternal health (CRLP/GREFELS 2001).

Population policies focus on reducing the birthrate rather than addressing broader population health issues. Population policies, designed by external aid donors and the state, are predicated on state control over women's fertility and reproductive capacities and women have little, if any, input to policy choices (Sow and Bop 2004). Declining fertility rate amongst Senegalese women (from 7 children in 1980 to 5 children in 2003); a trend also evident but not as pronounced in rural areas, is linked to increasing urbanization and social change within the context of economic crisis rather than the effectiveness of state policies of population control (UNDP 2003: 2; Adjamagbo and Antoine 2002). Despite policies promoting family planning and their integration into maternal and child health services, the use of modern contraceptive practices remains low among women aged 15 to 49 years of age; 7% in 1990 and 11% in 2000, although it is

highest amongst urban, educated women (World Bank 2007c: 1; Adjamagbo and Antoine 2002). Low condom use among married women has been attributed to women's lack of control over sexuality and reproduction as well as to gendered religious and cultural norms that valorize women's role in biological reproduction.

Current reproductive health policy is made up of three pillars: population and development, a national program for reproductive health and advocacy/IEC (Hardee et al. 1998), going beyond previous narrow concerns with population growth and control. New sexual reproductive health legislation, the *Projet de loi no. 04/2005 relatif à la santé de reproduction*, was passed in 2005 (République du Sénégal 2005f). It rests on the right of all couples and individuals to freely decide how many children they wish to have, to the treatment of STIs and HIV/AIDS and the improvement in the quality of life and interpersonal relations (République du Sénégal 2005f: 1). The reproductive health services offered by the government include: IEC around family planning, safer motherhood, post-abortion care, child health and the promotion of breastfeeding, prevention and treatment of STIs and HIV/AIDS, prevention and treatment of the range of genital infections including all cancers, assistance with infertility, the fight against FGM, sexual violence and other practices that negatively affect reproductive health, the promotion of adolescent reproductive health and addressing all other health conditions that affect sexuality and reproduction (République du Sénégal 2005f: 4). This legislation also includes some aspects of HIV/AIDS prevention and treatment services provided by the Ministry of Health, a key player in the CNLS. Despite integration of these services, the national AIDS control program, the CNLS, remains a distinct state supported program which sets overall national HIV/AIDS policy, under the authority of the Prime Minister's office.

Reproductive health is still a new concept in Senegal and is only acceptable when expressed in terms of the family, consistent with the ideology of familism, and as such, women's rights and the rights of adolescents around reproductive and

sexual health are not that well accepted (Hardee et al. 1998; Bop 2005). As a result of the activism of women's groups, a law was passed in 1999 defining and punishing violence against women, banning domestic violence, pedophilia, sexual harassment, rape, incest female genital mutilation and trafficking in women although its enforcement is difficult (République du Sénégal 2006b; Bop 2005). However, rape within marriage is not legally recognized (Bop 2005). Only therapeutic abortions where the health of the mother is in danger are allowed and abortions for any other reason are subject to criminal prostitution (Bop 2005). Despite new legislation that is also designed to improve women's sexual and reproductive health rights, women still lack control over their bodies and the power to make decisions around their health, sexuality, fertility and reproduction.

The issue is even more pronounced with respect to young women. Young women who wish to terminate an unwanted pregnancy have no other recourse but to clandestine abortions, as access to safe abortions is not universal. While there are few statistics on abortions outside of the hospital setting, one study conducted in Pikine, a sprawling low-income suburb of Dakar that attracts migrants, revealed that 30% of women having had at least one pregnancy had undergone an abortion (Adjamagbo and Antoine 2002: 539). Young people have limited access to family planning and reproductive health information and methods as many health care providers feel that they should not engage in pre-marital sex (Bop 2005). Health care providers reproduce dominant gender norms and gender inequalities with respect to adolescent health and sexual and reproductive health rights. Diop and Ba's 1998 study of decentralization of reproductive health policy and services showed that local leaders, primarily conservative males in polygamous marriages who are not western-educated but who dominate the local health council, share these views and almost half are opposed to birth control as well.

3.4.5 Women's Under-Representation in Formal Politics

Women's equal participation and representation in formal political sphere is essential to women's equality with men and to policy-making fostering gender equality. Notwithstanding recent improvements in women's political representation, gender inequalities in the formal political system have not disappeared. Women remain under-represented in positions of power, decision-making and policy, particularly at the regional, district and village levels, as Table 1 shows.

Table 3.1: Women's Representation in Government, 2006

Position	Percentage
Government ministers	22.5%
Advisors to the President	20%
Advisors to the Prime Minister	26%
Deputies in the National Assembly	19%
Members of the Council for Economic & Social Affairs	28%
Magistrates	15%
Ambassadors	12%
Regional Government	.03%
Regional Councils	14.5%
Regional Council Presidents	9%
Rural Councils	11.3%
Village Chiefs	almost non-existent

Source: République du Sénégal MFFDS (2006) *Rapport national du Sénégal sur la mise en oeuvre de la déclaration solennelle des chefs d'État et de Gouvernement sur l'égalité entre les hommes et les femmes en Afrique*. Dakar, p. 9.

Many of the gains made by women, particularly among educated and professional women, at the national level of government are the result of the current

president's own commitment to improving women's political representation and the activism of the autonomous women's group, the *Conseil Sénégalais des Femmes* (COSEF), rather than as a result of profound changes in civil society or politics as usual. Rural women, poor women and uneducated women continue to remain outside the halls of power and decision-making at all levels.

Moreover, despite their increasing visibility in formal political structures, female parliamentarians and ministers have little power in government decision-making and in policy-making, partly as result of their weak power base and marginalization in clientelist networks but also because the National Assembly itself tends to rubber stamp policy decisions made by the president rather than initiate policy (Creevey 2006: Beck 2003). Many of the improvements in women's status and progressive legislation promoting women's rights have come as a result of the activism of autonomous women's groups rather than as an initiative of the state, female parliamentarians or state-initiated women's federations, revealing the limits of Senegalese state feminism, as this respondent (#18) remarked, "women now are fighting for their rights and if things have changed, it is because women have fought for this."

As Creevey (2006: 168) observed, at the moment, there appears to be favourable context for the activism of women's equality groups provided they do not take on the persona of militant western radical feminism, which has been the case since the 1990's, as the *Réseau Siggil Jigeeen* has eclipsed *Yewwu Yewwi*.

"It is difficult to be a feminist in Senegal. Addressing male-female relations is still very delicate issue, even in many women's organizations. Many of the women's organizations are comfortable addressing equality issues in the public sphere but not questions like abortion rights, lesbian rights, young girls who are raped and become pregnant but can't have a legal abortion. The only legal options for abortion is if the mother's health is in jeopardy and then it takes three to five doctors to agree to permit the abortion to take place and this takes time. – a woman can die waiting for a legal abortion. The feminist agenda is in retreat. Okay, we got the legislation passed, for example, to

prosecute violence against women but this is not enough. We need to do more concretely in addressing these issues. Doing talks on the radio and the television is just not enough to change attitudes and stop violence...Feminism is still seen as a western importation and I am often accused of this.” (#12)

3.5 Conclusion

This chapter explored the broader gendered political, economic, cultural and social context that has fuelled HIV/AIDS among women. In exploring gender relations and women’s subordination within the broader context of socio-political and economic transformation in Senegal, it has shown how they have been reconstructed over time. As importantly, it has shown how the post-colonial state plays a contradictory role in reproducing unequal gender relations through policies and legislation in matters of the family and marriage, women’s insertion into the urban and rural economies, education, health and women’s substantive representation in the formal political system. Patterns of unequal gender relations in the private and public spheres that emerged during the colonial period were reproduced by the post-colonial state through its changing policies on women in the development process, despite improvements made in women’s status in the post-independent period and the activism of women’s groups. To the extent that women play key social roles in the family and the community, women are the social lions, to quote one respondent (#13), they remain in a subordinate and secondary position to men who make the decisions and hold the power. As these respondents point out,

“Our society demands this of us as women. We have a privileged place in society but at the same time we are neglected. Women are at the centre of the family. The family unit converges around women, joy, happiness, misery, bad times and good times. She is the mother, the wife, the sister, the confident and the counsellor. It is she who directs society because she is at the heart of the family. However, women are economically marginalized. Economically men are the first to benefit. Despite this, women must and do fulfill their social obligations.” (#16)

“The role of women in society. Women have a lot of responsibility but little power and it is men who keep them in that place as part of the decor. Men need to understand that women’s lack of power is a loss for society as a whole and that they need to support women.” (#5)

Although the 2001 Constitution recognizes equality between men and women, the persistence of gender discrimination in the Family Code and the state’s failure to enforce national legislation outlawing various forms of discrimination against women provide further evidence of the contradictory role played by the post-colonial state in altering inequities between men and women. As such, as a “gendered hierarchy”, this raises pointed questions as to the state’s capacity to formulate effective gender-based HIV/AIDS policy that addresses gender inequalities that shape women’s vulnerability to HIV, seropositive women’s social and material circumstances and their access to care and supports as well as foster women’s empowerment.

CHAPTER IV

RETHINKING WOMEN'S VULNERABILITY TO HIV: BEYOND VECTORS AND VESSELS

Crucial to addressing the feminization of HIV/AIDS in Senegal is an exploration of the specific social determinants of women's vulnerability to HIV and analysis of the efficacy of current prevention strategies in reducing their vulnerability to HIV. Although policy documents acknowledge women as a vulnerable group, this has not been a focus of in-depth research. This is partly a consequence of the dominant public health response to containing the spread of HIV in Senegal as elsewhere. It is premised on a narrow bio-medical and epidemiological focus regarding the prevention of HIV transmission via high-risk groups such as prostitutes and migrants and intervention strategies promoting individual behaviour change and risk reduction.

The development of more strategic approaches in the 1990's integrating treatment and care also entailed increased attention to "contextual factors that foster vulnerability; the socio-cultural, economic and political factors that constitute the context of individual behaviour" (Whelan 1999: 6). This view links individual risk to power dynamics and issues of social and economic inequality, re-conceptualizing vulnerability as rooted in unequal power relations (Parker 2000). As such, individual risk and vulnerability are inextricably intertwined and the fight against "AIDS is re-conceptualized as part of a broader process of social and economic change that must necessarily take place within the struggle to build a more just social order" (Parker 2000: 41). From this perspective, a focus on women's

vulnerability to HIV necessarily raises issues around gender inequality and women's empowerment to protect themselves from HIV.

To the extent that social and economic inequality are viewed as key determinants of vulnerability shaping individual risk behaviours, poverty and the liberalization of sexual norms in Senegal have been cited in policy documents as key factors driving the epidemic and putting people at risk for HIV (CNLS 2002a; République du Sénégal 1994). Despite the growing recognition that gender inequality plays a critical role in women's vulnerability to HIV in Senegal (Niang 1997; SWAA 1998; Diallo 1999; Coll-Seck 1996; UNIFEM 2001b; Wone 2002b, Sidibe 2001; Putzel 2005), in-depth analysis of how unequal gender relations shape women's and girls' vulnerability to HIV, much less their interaction with other social relations of inequality, is lacking. As some respondents observed, the dominant discourses around AIDS in Senegal do not frame it as a gender issue and the feminization of AIDS is not viewed as a fundamental problem.

“Despite lip-service given to the feminization of AIDS, the feminization of AIDS is not really considered to be a problem or a fundamental AIDS issue...We need a national gender and HIV research program. The research is still too bio-medical, too behavioural and too epidemiological. There is too little social science research on women and AIDS. Some of the work that has been done is too programmatic. It was conducted in function of technical needs in response to policy issues and priorities. It didn't really get at the heart of the problem; the problem of the social relations of gender and social class. It doesn't clearly identify the problem of inequality. We need to say, for example, that polygamy is a problem and clandestine prostitution among young women is a problem, linked to poverty but we also need to discuss their links with gender relations.”
(#11)

This chapter explores the social determinants of women's vulnerability to HIV and state responses to containing HIV transmission among women. I argue that unequal gender relations and women's subordination within the context of the private sphere of sexuality, marriage and the family, buttressed by Islamic ideology and traditional cultural practices, are central determinants of women's vulnerability

to HIV. However, gender intersects with other social relations of inequality such as social class, age and marital status, in a context of underdevelopment that shapes the vulnerability of different social categories of women such as married women, single women, young women and women engaged in commercial sex work. I argue that the Senegalese HIV prevention model addresses women's social vulnerability and women's empowerment in a limited way because it does not adequately tackle unequal gender relations in the private and public spheres or broader structures of social inequality.

I begin by briefly discussing the HIV prevention model in Senegal, focussing on its gender approach, showing how women and gender issues are addressed in current HIV prevention strategies. I then turn to an analysis of the social determinants of women's vulnerability to HIV showing how gender inequality (defined as unequal gender relations), in its interaction with other forms of social inequality in the context of heterosexual relations within and outside marriage shapes women's and girls' vulnerability to HIV, placing them at greater risk than men and boys. I go on to examine the main HIV prevention strategies, showing how unequal gender relations in their interaction with other social relations of inequality shape women's unequal access to HIV information and education, to condom technologies and to voluntary testing, limiting their effectiveness in addressing and reducing women's social vulnerability to HIV.

4.1 The Senegalese HIV Prevention Model: An African Success Story Revisited

Considered an African success story and a 'developing world' HIV prevention model, the Senegalese state played a key role in initiating and developing a national policy response to HIV/AIDS with the emergence of the first AIDS cases, in contrast to many other countries in Sub-Saharan Africa (Eboko 2005; Putzel 2003, 2005; UNAIDS 1999a). In 1987, the Senegalese government set

up the *Comité national pluridisciplinaire de prévention du VIH/sida* (CNPS) and the *Programme national de lutte contre le SIDA et les MST* (PNLS), housed in the Ministry of Health (Putzel 2003: 31). In addition to its many responsibilities, the CNPS was responsible for developing the national strategy for preventing HIV/AIDS and in conjunction with three main working groups (clinical, epidemiological and education), implementing the strategy (République du Sénégal 1987: 30). Premised on an intersectoral approach from the outset, the CNPS comprised senior bureaucrats from eleven Ministries including the *Ministère du Développement social* that housed the women's bureau (the women's ministry has changed names several times since), while the working groups were largely composed of medical experts, with the exception of the IEC working group that included some Senegalese educators (République du Sénégal 1987:30). The *Comité restreint* (the executive committee) held decision-making power in all areas except the over all coordination of studies, research and actions related to AIDS in each of the sectors (République du Sénégal 1987). The PNLS moved to ensure the safety of the national blood supply to reduce the risk of HIV transmission through blood transfusions in 1987 and in 1989 set up epidemiological surveillance, with the assistance of Harvard University School of Public Health, to monitor HIV infection trends and patterns in different sectors of the Senegalese population (Groupe thématique ONUSIDA/Sénégal 2001:21). The national program to combat sexually transmitted infections was integrated into the HIV prevention strategy at the outset, making it easier to conduct HIV prevention with official sex workers (the first group to be targeted) by drawing on health structures already in place to monitor legalized prostitution (Meda et al.1998).

HIV prevention of new infections has been the priority of the state policy response since the inception of the national AIDS control program; in the absence of a vaccine and the state's limited capacity to provide treatment options (ART) to PHAs up until recently. This approach also was endorsed by international policymakers and experts as the optimal policy choice for resource-constrained

'third world' countries up until recently (O'Manique 2004; Lee and Anthony 2003; Parker 2000). Since 2000, new forms of funding from the World Bank and the Global AIDS, Malaria and Tuberculosis have made an integrated approach to prevention and treatment possible. As a beneficiary of funding from these two sources, the Senegalese state has been able to scale up some key HIV prevention activities around voluntary testing, HIV testing for pregnant women and control of sexually transmitted infections (STIs) (co-factor in HIV transmission) as well as increasing funding to community organizations and NGOs to enhance their role in HIV/AIDS prevention (Simms et al. 2006). Although increased funding has allowed for a more integrated approach to prevention and treatment, the state PNLS budget for prevention activities in 2004 accounted for 34% of the total and was larger than the budget for treatment and care of PHAs emphasizing the priority accorded to prevention (CNLS 2006a: 18). The budget breakdown in 2004 also provides some idea as to HIV prevention priorities: community mobilization activities (43%), control of STIs (22.35%), condom distribution (10.30%) counselling and testing (7.41%), social marketing of condoms (5.2%) and programs directed at female sex workers and their clients (3.54%) (CNLS 2006a: 20).

The Senegalese approach to HIV prevention combines: IEC strategies, (information, education and communication), CCC (communication for behaviour change) ICC (intervention for behaviour change and APP (participatory prevention approach) (CNLS 2006a: 22). It blends both a mass education campaign and interventions targeting high-risk groups, female sex workers and more recently their clients, migrants, young people in the informal sector and men having sex with men, as this respondent (#8) explained,

"Senegal's good fortune was to address HIV very early on in the epidemic through wide-ranging mass awareness campaigns via the engagement of the state and the community sector (NGOs, associations and women's groups). The early response from 1986 to 1992 and the basic role of these actors was to make the general population aware of the existence of the virus, a role of early warning and wake-up that served to make the general population aware of the

modes of transmission and modes of prevention through IEC activities in training, education and communication. By 1992, the most prominent NGOs, Sida-Service, Jamra, ENDA and MIDA became quite critical of the limits of this approach. The population appeared to be informed but there was no real significant behaviour change. They also argued that the work of NGOs was too dispersed and there needed to be better coordination and harmony to avoid duplication of services and ensure a certain degree of uniformity in basic prevention messages. As a result of a process of evaluation in 1992, this led to the creation of ICASO Senegal, which provided a common framework for concerted action to promote and implement innovative strategies to promote behaviour change. ICASO's structure and mandate allowed for frontline workers to agree upon coordinated and harmonious intervention strategies and for each frontline actor to target a specific group for intervention, young people, women, prostitutes, people in the informal sector, the workplace, PHAs, vulnerable children and the religious community. The different vulnerable populations were identified, divided and specifically targeted. This process also allowed frontline actors to think critically about the best approaches to reach their specific target groups, to become more aware and better understand the preoccupations and concerns of their target groups by discovering and using local knowledge and methods in order to encourage actors to take responsibility for their actions and initiate behaviour change."

Community mobilization with NGOs, diverse social networks, local community groups and associations working closely with key constituencies such as women and youth in conducting HIV education is a key component of the Senegalese prevention model as is the involvement of religious authorities to avoid a 'war around condom use'; cited as a best practice (Patterson 2006; Groupe thématique ONUSIDA/Sénégal 2001; Niang 2001).¹ An ABC message; 'Abstinence, Be Faithful, Use Condoms' constitutes the main HIV prevention message that emphasizes individual responsibility for protecting oneself from HIV. It entails complementary discourses with religious leaders advocating abstinence

¹. As early as 1987, political dialogue to involve political and opinion leaders in large-scale mobilization was implemented using numerous links and intermediate structures of the state and civil society, "in addition to health workers who provide basic and reliable scientific information and religious leaders who enhance the credibility of messages and promote their acceptance by the general population" (Niang 2001: 13).

and fidelity (*le préservatif moral*) and the secular NGOs community advocating for and distributing condoms (*le préservatif latex*), as the last recourse for those who cannot control their sexual impulses (Delaunay et al. 1998). As Delaunay et al. (1998: 129) observe, the Senegalese approach to HIV prevention adopted by the state-initiated PNLs emphasized,

The preservation of tradition/custom and the established order (whether it be with respect to prostitution or more broadly with respect to the Islamic way of life) rather than the more emancipatory approach to HIV prevention coming from the key NGOs that were pioneers in HIV prevention in Senegal.

As we shall see, the ABC approach to HIV prevention is problematic as it does not address the gendered implications of HIV vulnerability. In fact, the gender approach to HIV prevention in Senegal has not been well documented or explored in depth. Only a few key documents refer to a gender approach to HIV prevention (see Niang 2001; Groupe thématique ONUSIDA/Sénégal 2001; CNLS 2006a). They point to the involvement of a broad range of women's groups, local, regional and national, traditional and modern, in IEC and CCC activities with women and girls as well as the development of some women-specific materials around HIV prevention as the key elements of the Senegalese gender approach to HIV prevention. Official documents highlight the work of the *ministère de la Femme, Famille et Développement social*, AIDS-focussed women's groups such as SWAA and more recently, ABOYA (a women's PHA association) as well as the networks of women's groups such as the FNGPF and FAFS (CNLS 2002), although a myriad of other women's group conduct HIV prevention on a regular or sporadic basis.² Most but not all women's groups focus on women-only activities.

“In our experience when women get together among themselves, it is easier for them to talk, discuss and express themselves when men are

². The *Fédération nationale des groupements de promotion féminine* (FNGPF) is made up of 6,816 women's groups operating at the national, regional, departmental and local levels that work in the areas of IEC, training, micro-credit income-generating activities and reducing women's workloads (Cissé 2002: 12). The *Fédération des associations féminines du Sénégal* (FAFS) comprises about 400 associations and women's groups that are also involved in various forms of development work (Fall 2001: 1)

not present. When men are present, we found that women tended to be more reticent and shy about speaking frankly about sexuality and intimacy. This is our approach. I would imagine that other NGOs use the same approach.” (#7)

However, HIV prevention with women and girls is not the exclusive purview of women’s groups. In some cases, HIV prevention workshops for women and girls are run by male animators, partly because “men are viewed as the purveyors of information deemed important” (Hansen 2006: 20).

HIV education and prevention combines mass awareness campaigns aimed at women in general and targeted interventions aimed at specific groups of ‘vulnerable’ women particularly official and clandestine prostitutes, and to a lesser extent, women the informal sector, female vendors and market women, beauticians and hairdressers, young women and women workers in factories (Niang 2001; Groupe thématique ONUSIDA/Sénégal 2001; Fall 2001; Seck 1999; Diallo 1999). Based on the review of the literature and my interviews, HIV prevention activities conducted by women’s groups include developing some specific materials around women’s reproductive health issues, discussion groups, promoting HIV testing and the *Programme transmission mère-enfant* (PTME) among women, negotiating condom use and safe sex, promoting condom use, particularly the female condom, the development of income-generating projects, addressing harmful traditional practices and advocacy. Groups vary in the extent to which they employ some or all of these activities and the extent to which a gender approach is utilized; that is exploring gender differences in a relational way, explaining how unequal gender relations are central to difficulties women and girls face in protecting themselves from HIV infection and employing empowerment strategies (CEDPA 2003; Seck 1999; Niang 1995; SWAA 1998). In part, this is because of the relative newness of the concept of gender itself.

“Gender as a concept has only been recently imported into the French language and milieu. So you need to speak French or English but gender issues can be understood by women because they are living

them. We need to make the language more accessible and give women the opportunity to express themselves and appropriate these concepts.” (#29)

“There is also a problem at the level of organizational capacity. AIDS women’s groups and NGOs; most do not use a gender approach in their work. They need training and they need gender training. Working with women doesn’t mean a gender approach. Some people reject the gender approach and gender mainstreaming because they do not know what it means.” (#11)

A majority of respondents (17/27) expressed their dissatisfaction with current HIV prevention initiatives targeting women and girls, citing several limitations that I will discuss in more depth in the final section of this chapter. Half of the respondents (13/25) expressed the view that more attention needs to be paid to issues around women’s and girls’ vulnerability in research, policy and programs, with a few arguing for the need to think more deeply about the determinants of their vulnerability. Given that reducing vulnerability among women is one of the priorities of state HIV/AIDS policy according to the 2007-2011 strategic plan (CNLS 2007c), a closer examination of the social determinants of women’s and girls’ vulnerability is critical, if HIV prevalence rates are to be kept under 2% and if the feminization of AIDS is to be contained.

4.2 Gender and Women’s Vulnerability to HIV

How HIV/AIDS is framed is essential to the development of policies, programs and strategies preventing and containing the disease. Broad explanations of the determinants fuelling the AIDS epidemic in Senegal provided by respondents highlighted economic, cultural and social factors such as the economic context of high poverty within the context of economic crisis (18/27), the persistence of traditional cultural practices (14/27), and social factors such as family breakdown (3/27). As the primary mode of transmission in Senegal is heterosexual relations

and more recently men having sex with men, it is not surprising that the majority of respondents also cited high risk sexual behaviour (*'le libertinage sexuel'*) primarily among female sex workers and to a lesser extent, men having sex with men (18/27). A few respondents also cited issues such as taboos around sexuality (3/27), the lack of awareness of one's serostatus and/or the existence of the disease (10/27) and women's biology (4/27). While most of my respondents cited a variety of gender inequalities such as gender norms (8/27), male dominance (14/27), women's lack of control over sexuality (7/27) and/or women's economic dependence (10/27), some did so as an afterthought, suggesting that AIDS is not viewed as fundamentally gendered by these respondents.

Women Are More Vulnerable than Men

However, the overwhelming majority of respondents (25/27) perceived women as more vulnerable to HIV than men and young women (18/19) as more vulnerable to HIV than young men. At the same time, several respondents (9/27) also suggested that men and young men are also vulnerable and that any adequate understanding of women's vulnerability to HIV also requires examining men's and young men's vulnerability to HIV as they are inter-connected.

Respondents pointed to biological, social, cultural, economic and political determinants that shaped women's greater vulnerability to HIV: women's biological vulnerability (10/27), the persistence of harmful socio-cultural practices/traditions (18/27), economic crisis and poverty coupled with women's economic dependence (16/27), gender norms/ideologies and gender inequalities in the private sphere of sexuality, marriage and the family (23/27), religious precepts which maintain male dominance (6/27), women's lack of education/access to information (6/27) and women's marginalization in politics (4/27). Respondents viewed women's greater vulnerability to HIV as a result of a complex interplay of these multiple dynamics, illustrating the gendered context of HIV/AIDS.

In contrast to major policy documents, the majority of respondents acknowledged the role of men and of gender inequalities in shaping women's greater vulnerability to HIV, raising the sensitive issues of unequal gender relations and male dominance in the private sphere of sexuality and marriage; themes that have not been adequately explored in the HIV/AIDS research in Senegal. Key issues they raised centered on women's lack of power in decision-making in sexual relations (10/27), women's lack of power in decision-making in the couple and the family (5/27) and gender norms based on double standards in dominant conceptions of masculinity and femininity (10/27). While these insights are not new as a broad body of international literature has addressed some of these issues, women's lack of control in negotiating safe sex in fostering their social vulnerability was only first acknowledged in Senegalese policy discourse in the 2007-2011 HIV/AIDS Strategic Plan (CNLS 2007c: 16).

Up until that time, the argument that the social control of women's sexuality has been essential in explaining the low and stable HIV prevalence rate was common currency and part of policy discourse (Groupe thématique ONUSIDA/Sénégal 2001: 14; CNLS 2002a: 11), although as Meda et al. (1998) pointed out that this assumption has of yet to be tested with rigorous research. This contention is problematic as it renders invisible the major source of women's social vulnerability to HIV; unequal gender relations in the private sphere. "Women are less empowered to negotiate condom use than men due to a prevalence and general acceptance of male dominance in the household" (Faty-Ndiaye and Fall-Diop 1999: 1), which is reinforced through gender socialization. A majority of respondents (17/27) rooted women's greater vulnerability to HIV in women's status: women's secondary and subordinate status in the couple, the family and/or the economy.

"One of the major obstacles is women's lack of autonomy in the current socio-cultural context, lack of financial autonomy and decision-making power." (#7)

“Yes women generally speaking and young women. It is a societal phenomenon. Despite the many advances made, women are still relegated to a secondary position, in a state of submission and dependency. Stigmatized. To be a woman is to be under someone’s control. You are seen only as a woman.” (#21)

“For SWAA, women as women are a vulnerable group. The first AIDS cases in 1986 were almost exclusively men who were migrants and one woman who was actually from Burkina Faso. In 1989, the first AIDS cases appeared among people who had never left Senegal. They were the wives of male AIDS patients. They were faithful to their husbands, at home taking care of their children and their families while their husbands were migrating for work. They returned and infected their wives. Women have only the right to be in a state of submission, to be subordinate to men. They don’t have the right to ask their husbands to have safe sex or use condoms. They submit and then they get HIV.” (#16)

“Yes, because they are women, their status as women, women’s biology, their weak economic power and their economic dependency. Women are in a secondary and subordinate position in relation to their husbands. There is no equality between the sexes. Young women are financially dependent on men. Even in the labour market, men are the priority.” (#26)

Several respondents (8/27) suggested that some groups of women and girls are more vulnerable than others. They cited young sexually active women, married young girls, young female domestics, women married to migrants, poor, uneducated rural women and young women/women involved in clandestine prostitution and transactional sex, pointing to how gender intersects with other social relations of inequality in shaping women’s vulnerability to HIV.

Women’s Biology

Several respondents cited the well-known arguments around women’s biology as a factor in their enhanced vulnerability to HIV. Women’s increased risk to HIV can be partly explained by women’s physiology as there is a higher concentration of HIV in semen than in vaginal fluids and the area exposed to the

virus is larger in women than in men. Women are two to four times more likely to contract HIV from an infected male partner than is the case for non-infected men from infected women. Girls are even more vulnerable as their bodies have not yet matured and vaginal tearing is more common in girls than in women. HIV passes more easily to girls (Booth 1998). To the extent that biological factors shape women's and girls vulnerability, it is the social context of sexuality (Rao Gupta 2000a; Whelan 1999; WHO 2003; ICAD 2003), more specifically, the unequal power relations based on gender, social class, age and marital status that facilitate HIV transmission in women and girls to which I now turn.

Socio-Cultural Practices

A majority of respondents identified a variety of socio-cultural practices that enhance HIV transmission and contribute to women's greater vulnerability to HIV (18/27). These included the levirat/sororat, early and forced marriages among girls, polygamy, female genital mutilation and tattooing. Wone (2002b) provides a comprehensive account of the range of traditional practices that put women at higher risk for HIV. There is a gendered component as most of these practices are rooted in male control over women's sexuality, their bodies and reproductive capacities that serve to reinforce patterns of male domination.

“Socio-cultural representations and practices such as the levirat, female genital mutilation, the sororat, and early marriages, often forced, aimed at controlling women's sexuality, contribute to the spread of HIV/AIDS and to women's vulnerability.” (#19)

Female genital mutilation is a traditional practice among certain ethnic groups in Senegal that reinforces male control over women's sexuality, fertility and reproductive capacities, as it is a means to decrease female sexual desire in order to limit women's sexual activity and increase sexual repression (Niang 1995). This practice can transmit HIV when an unsterilized blade is used for an entire group of girls. One study found a higher rate of HIV infection among women from the

southern region of Senegal where FGM is practised extensively as compared to women from other parts of Senegal where it is rarely practised (Niang 1995).

Despite the awareness of the risks associated with practices such as the levirat/sororat, FGM, polygamy and early marriages, many men and women still approve of them, as Faty-Ndiaye and Fall-Diop's (1999) research revealed. Moreover, although current legislation bans some of these traditional practices, their persistence suggests the need to address men's and women's attitudes and behaviours more fully (Bop 2005).

Gender Socialization to Unequal Gender Relations: Thinking through Masculinities and Femininities

Several respondents suggested that gender norms around masculinity and femininity contribute to the vulnerability of girls and young men as well as men and women but in different ways. To the extent that pre-marital sex is frowned upon by culture and religion for both young men and young women, gender norms reveal a double standard and serve to reinforce patterns of female subordination and male dominance. Girls are expected to be virgins before marriage and ignorant in matters of sexuality. Pre-marital sex among young single women is judged more harshly than is the case for young men who are expected to be sexually active. Similarly, married men's extra-marital affairs are tolerated but not adultery by married women (Meda et al. 1998).

“In Senegalese society, young men are encouraged to have sexual experience. They are more exposed to risk by society and by the way society defines masculinity. Boys want to be seen as men, unprotected sex and multiple partners. Girls are expected to be virgins before they get married. There is greater control over their sexuality.” (#18)

“The acceptability for men to have multiple partners. Mothers tend to be proud of their sons if they have a lot of girlfriends but would be shocked if this were the case with their daughters.” (#1)

“Girls are more inhibited than boys. They are not really allowed to ask questions about sexuality. If they do ask, they are often accused of being sexually active. Even their girlfriends will accuse them or judge them negatively. In this respect boys have more freedom and can discuss some of these issues with their friends. This is compounded by a lack of communication between parents and their children about matters of sexuality. Parents don’t broach these issues with their children. This leaves girls isolated and turned inward on the self. Then there is the economic aspect, poverty. Most young women have fewer resources than boys but they have greater needs and it is difficult to pay for them.” (#7)

From birth to adult age, traditional gender socialization prepares women and men for their respective roles in the family and in marriage and by extension in the public sphere of work, economy and politics. ‘*Boroom neek*’ (*responsable de la chambre*) signifies women’s subordinate status as mothers and wives while ‘*boroom ker*’ (*responsable de la maison*) signifies men’s dominant status as head of the family, the provider and protector (Mbodj 1997: 209).

“As we say in Wolof, ‘*Jiggen Dey Munt F*’, a woman must stay and endure. This is inculcated in women, as part of their socialization to inculcate submissiveness. A woman must be submissive. In Wolof, ‘*Takk Meyé N*’ it means marriage but it has two significations. We have given the women in marriage but it also means I have married her and attached her like a ewe. The vocabulary of marriage expresses women’s submission. Culturally when you marry and before you go to your husband, a girl or a woman is surrounded by the family and provided with advice during specific ceremonies. ‘*MUN*’, you must endure. You must listen to what your husband says. You must obey. The family also says ‘*Jiggen Metoul*’; a woman is not complete unless she is married. The family advice inculcates submission.” (#13)

“Young girls are highly influenced by media images and materialism. They all have to look a certain way and wear a certain type of clothing, very taken with the whole aspect of being women, very feminine and they are very attentive to what is happening in terms of fashion and to ‘*Mokkpocc*’ the art of pleasing your man. Every Senegalese woman aspires to be married and to be a good wife to her husband. Women are willing to steal to uphold this ideal. As a result, women are willing to ‘*MUN*’; to be patient in the face of very painful and unacceptable behaviour that mothers encourage daughters to stay in these relationships. Young independent women are willing house slaves.

Marriage gives them status and prestige and it is significant. Modern polygamy and the modern wife and mother; this is an important rite of passage. Women who don't go through it are not seen as complete. There is also the conception of alliance and marriage is strategic increasing social capital, who you know and what strengths those people possess to get things done.” (#1)

Marriage and children remain the main priorities for the majority of Senegalese women; the source of their social status and social recognition (Huskens 2004; Adjamagbo and Antoine 2004). The model of male-female relations within marriage is premised on a patriarchal model of male dominance and authority and female subordination and dependence (Lecarme 1992; Adjamagbo et al. 2002). As Dial (2001: 4) points out, “*Il est certain que le cadre familial du mariage, lieu de discrimination légale et, de fait, en ce qui concerne la définition des statuts et des rôles, permet de maintenir les rapports de dépendance (des femmes).*” The ‘ideal model’ of gender relations in the family reinforces women’s economic dependence on her husband, limits her economic options and her decision-making power. The context of polygamous marriage further reinforces male dominance and female dependence (Vonarx 2003). The situation of dependence is most acute for poor, uneducated, traditional women with several children, particularly in rural areas, who have fewer options for economic survival and autonomy.

“Poor less educated women can’t say no to sex, can’t leave their marriages, are trapped in relationships, sexuality is out of their control. Even where they have the perception of danger, there is not much they can do about it.” (#1)

Economic crisis and westernization in the context of globalization and underdevelopment are transforming patterns of sexuality and dominant conceptions of masculinity and femininity in Senegal, particularly among young men and women, around “the trilogy of sexuality, marriage and conjugal life” (Biaya 2001: 81). Many young men are delaying marriage or are unable to have a relationship with young women their own age because they cannot afford to give them gifts or provide financial assistance to the girls’ family, making it difficult for young men to find sexual partners, creating a crisis of masculinity (Biaya 2001). This has

limited the pool of potential eligible marriage partners for young women and intensified their rivalry with other women, in the context of modern polygamy, for access to older men to provide for their economic needs, if not those of their families, and cement their social status as married women. “This rivalry touches not only aspects of dress, appearance, but also bodily gestures, culinary prowess, dance techniques and the ability to keep lovers through erotic and sexual prowess” (Biaya 2001: 78).

Pressures to marry and keep a husband in the context of economic crisis and the impoverishment of women lead many to engage in risky erotic practices. Women are socialized to make the conjugal home their priority, to satisfy their husbands’ needs and to ensure the successful education of their children (Wone 2002b). The use of erotic practices to heighten male sexual pleasure is a widespread practice in Senegal that includes dry sex and inserting various herbal and chemical products into the vagina; practices identified as putting women at greater risk for HIV. The main consumers of these products are married women in polygamous marriages and divorced women who are willing to engage in risky behaviour in order to keep a husband or to get a male partner to marry her (Wone 2002b).

Women’s Economic Dependency in the Context of Poverty and Underdevelopment

A majority of respondents (16/27) pointed to the economic context as a prime mover in increasing women’s vulnerability to HIV, citing poverty, women’s economic dependency on men and their lack of economic power. Economic crisis and poverty are driving forces pushing women into ‘clandestine prostitution’ and high-risk behaviours, as several respondents (11/27) affirmed. Notwithstanding the impact of class inequality in limiting women’s economic options, women’s economic dependency and lack of economic power are intimately bound up with gender inequalities in access to education and employment opportunities. They are

also the consequence of the dominant model of patriarchal male-female relations within the private sphere, premised on women's subordination and domestication, whereby married women who were previously economically active prior to marriage withdraw from these activities in order to become housewives and mothers. In the current context of frequent divorce and male withdrawal of support for children (Adjamagbo et al. 2002), divorced women with children find themselves in particularly difficult circumstances.

A growing number of young women and girls are engaging in various forms of transactional sex, referred to in the literature as clandestine prostitution (Huygens 2001), and high-risk behaviours partly to live up to changing gender norms around femininity and the 'modern woman', particularly in Dakar, and partly as a survival strategy in a context of economic crisis and family pressures. As it is a common practice in Senegal for men to give gifts to women (#13), a result of the commodification of gender relations, women whatever their age engaged in transactional sex practices do not see themselves as prostitutes.

"There is enormous social pressure on young women, the gazelle effect, to be beautiful. You are forced to. Even mothers put pressure on their daughters. What do young women do when they can't buy nice clothing, gold jewellery and style their hair? My daughter has to be beautiful. 'M'baraan' a young woman can have several companions, a handsome young man, a married man with money and a young man who gives her money who is the fiancé. They don't necessarily have sexual relations with the younger men but they do with the married man. It is prostitution but if you say this to a woman who is doing this, she will say I am not a prostitute. Sugar daddy. Young girls are poorer than young men, have less money and less resources than women so some are involved in prostitution." (#13)

Although transactional and survival sex practices touch the most vulnerable groups of young women; domestics (*les petit bonnes*), 'banabanas', itinerant petty traders, waitresses, refugees, minors and young single mothers (Huygens 2001), not all the young women who engage in transactional sex practices are poor or living on the hem of life. Female university students, usually drawn from more privileged

social classes, are increasingly resorting to transactional sex practices, in part, because they have fewer economic resources than their male counterparts (Niang et al. 2003). This illustrates how gender inequalities differentiate the circumstances of young men and women drawn from the same social class.

“Some of the male students frequent prostitutes from Medina and Fass, poor neighbourhoods not too far from UCAD. Some of these women also come to the campus. Some of the female students have sugar daddies, rich men, staff from international organizations, others have boyfriends and some women are prostitutes. Young women have less financial resources than men. There is a lot of competition between young women for men. This is campus life. Part of the problem is, I will call it modernization. The modern young woman is at the top – she is well-dressed, well-coiffed, has chic clothing and a chic hairdo, using artificial hair pieces.” (#17)

Although prostitution is legal and tolerated in Senegal, it is a gender-stereotyped stigmatized occupation. The pervasive tendency to refer to a wide variety of practices involving the exchange of money, goods or services as prostitution within public discourse and policy circles serves to reinforce persistent social stigma around female sex workers and prostitution as a female-identified occupation. It also serves to camouflage the fact that many women who engage in a variety of transactional sex practices do so out of sheer necessity, for their economic survival and the economic survival of their families. Utilizing a less morally loaded term such as ‘survival sex’ would help to refocus attention on the gender inequalities, more often than not in their interaction with class and age inequalities that shape these practices amongst women.

Vulnerability of Female Sex Workers Revisited: Beyond ‘Reservoirs of Infection’

Commercial female sex work is legal in Senegal and regulated since 1969 by law that sets the conditions for its practice (Niang 1995: 30). To be a registered sex worker, one needs to be a female 21 years of age, register with the Health

Service, obtain a special booklet and undergo periodic examination to control STIs and HIV (Ndoye et al. 1996).³ It is estimated that there are about 20,000 registered sex workers but this figure is not accurate as some sex workers register in several locations (Wone 2002b: 15). Moreover, official prostitutes make up about 20% of all female sex workers while clandestine prostitutes (sex workers over the age of 21 who engage in the occupation on a regular basis) are not registered and do not benefit from access to information, health care and medical treatment (CCISD 2004: 44). Unofficial sex workers also include under-age sex workers, some as young as twelve and thirteen, call girls who are women of higher income practising the trade from their homes and informal sex workers over the age of 21 years who practice the trade occasionally, often to supplement their incomes (CCISD 2004). Although brothels are illegal (pimps are also), they are commonly found in the poorer neighbourhoods in Dakar (Gomes do Espirito Santo and Etheridge 2003).

Recent research identified a growth in clandestine prostitution particularly among younger women and divorced Senegalese women (Huygens 2001; Wone 2002b), illustrating how gender, age and class inequalities shape the insertion of women, young women and girls into prostitution in the current context of economic crisis. The demographic portrait of official and clandestine sex workers that emerged from the Behavioural Surveillance Survey (République du Sénégal 2001d: 12) showed that a high proportion of women in each group were divorced, (53% of official sex workers versus 39% of unregistered sex workers in Dakar), had children living with them (47% of registered sex workers versus 37% of unregistered sex workers in Dakar) and over a third lived with their parents while a small proportion lived with their husbands. Somewhat surprising, the data also showed higher levels of formal educational attainment as 57% of registered prostitutes in Dakar had some primary and secondary schooling while 66% of unregistered prostitutes had the same levels of education (République du Sénégal

³. The law does not actually provide for male prostitution. Male homosexual prostitution has been observed in Dakar, Mbour and Ziguinchor in tourist areas. As well, there are male prostitutes who service female tourists (CCISD 2004).

2001d: 12). The PROCLAN study of 390 female clandestine prostitutes in Dakar in 2000 showed that 42% had no schooling at all, 41% had only a primary level of schooling, 16.9% had secondary schooling while only .3% had university level schooling (Wone 2002b: 16). Renaud's (1997: 13) study of female prostitutes in Kaolack revealed that 58% of female commercial sex workers had no formal education at all and 30% of them also earned money through a second source usually commercial activities (goods, perfume, clothing or jewellery) or doing laundry, hairstyling or working in restaurants or bars. Despite some variations around education attainment, all of the research on female prostitution has shown similar disadvantaged demographic profiles (Renaud 1994; Ndoye et al. 1995; Maturana and Diop 1996; Horri 1999; Huygens 2001; Laurent et al. 2003; Gomes do Espirito Santo and Etheridge 2003).

Notwithstanding the relative success of HIV prevention efforts with registered sex workers in Senegal who post lower HIV infection rates as compared to sex workers than elsewhere in Africa, the rates of HIV among them has steadily risen (UNAIDS 2006a, 2004d). This is all the more disconcerting as condom use among Senegalese women is the highest among registered female sex workers who have been the main targets of HIV prevention campaigns (Meda et al. 1998). A few studies have shown that condom use with male clients is higher among registered prostitutes (97% use with last regular client and 99% with last client) than is the case among clandestine prostitutes (Huygens 2001: 21; République du Sénégal 2001d; Laurent et al. 2003). Moreover, condom use with regular sex partners is much lower among registered female sex workers at 60% and even lower with non-client partners at 50% (Huygens 2001: 21). Laurent et al's research (2003: 1814) showed that only 30% of clandestine female prostitutes utilized condoms with regular clients and 17.3% stated that they used condoms systematically with regular boyfriends. Some of these 'clients cum boyfriends' may be HIV positive and the instability of these relationships and rapid succession of partners put sex workers at increased risk for HIV.

“Girls use condoms with clients but sometimes when clients become regular partners, then they stop using condoms with the client cum boyfriend. They go out for a while, then they break up and she gets another partner. The cycle repeats itself.” (#25)

Although Senegalese sex workers deploy a variety of strategies to impose safe sex (UNAIDS 2000c; Renaud 1994), many still encounter difficulties imposing condom use with male clients who want unprotected sex. “It is a problem consistently seen throughout Africa” (AMREF 2006: 58). Gender inequalities in negotiating safe sex and economic pressures force sex workers to engage in risky sexual encounters in order to feed their families and pay for their needs (UNAIDS 2000c). UNAIDS (2007: 20) affirms that “unprotected sex work is critical in HIV transmission in Senegal and to the high rates of HIV among sex workers.” Yet, scant attention has been paid to how sex workers contracted HIV in the first place, to the role of men’s behaviour and to how unsafe sex in their non-client sexual relationships contributed to their vulnerability to HIV in Senegal, as elsewhere (Booth 2004). The difficulties that sex workers face in negotiating safe sex with clients is an expression of the more fundamental inequalities based on gender, class and age inequalities that shape their entry into prostitution; their subordinate position as women in society and in the economy, complicated by limited rights for women. Prostitution and survival sex remain among the few options for a growing number of women, living on the hem of life, in the context of economic crisis.

The Vulnerability of Married Women

The focus on female prostitution as ‘vectors of transmission’ and ‘reservoirs of infection’ has led to a lack of attention to women’s vulnerability to HIV within marriage. Sow et al’s study (1999: 138) of 332 female patients with HIV/AIDS revealed that 75% of the seropositive female clients seen at Fann Hospital, the national centre for HIV/AIDS treatment, between 1993 and 1996 were monogamous and had contracted HIV in marriage from husbands who were migrants. An earlier study of female patients in an infectious diseases ward

indicated that 30 % of women had acquired HIV through sex work but 50% had contracted it through marriage (Hamblin and Reid 1999: 15). These studies suggest that marriage is a risk factor for women and call for an examination of unequal gender relations within marriage.

Several respondents pointed to women's lack of power in decision-making in matters of sexuality among married couples as a key determinant of women's vulnerability. Women's lack of power over decision-making in sexual relations is a function of their lack of control over their own bodies and complicated by their economic dependence. Unequal gender relations and the acceptance of male dominance within matters of sexuality are buttressed by religious and socio-cultural norms, which are internalized by women and men through their socialization. Islamic precepts reinforce the notion that "it is the duty of a wife to satisfy her husband, her husband's sexual needs" (#4) and many married women feel that they cannot refuse their husband sex. Some fear that their husbands will leave them for another woman (Faty-Ndiaye and Fall- Diop 1999; Niang 1995). This attitude remains widespread among women and is borne out by the findings in the DHS IV (CDRH 2005b). The study found that although the majority of women approved of a woman refusing her husband sex if he had a STI (82%), if she had just given birth (84%) and if her husband had sexual relations with other women (63%), only a minority of women (27%) actually felt that it was justified for a woman to refuse her husband/partner sex or make this decision (CRDH 2005b: 51). Moreover, 45% of women surveyed supported the idea that men were justified in hitting their wives if they refused to have sexual relations with their husbands (CRDH 2005b: 51) Women who are divorced or widowed (*en rupture d'union*) (34%) were more likely to see refusing sex as justifiable and to have the last word on this decision (34%) (CDRH 2005b: 52). This data indicates that there is a disjuncture between what women may say in public and what they may actually do in their relationships with men, also noted by Faty-Ndiaye and Fall- Diop (1999).

For some respondents, women's limited decision-making power in matters of sexuality is related to the broader context of their limited decision-making power within the couple and marriage union. The Wolof expression '*Ci ker gi, goor yo mo boat bi*' (roughly translated as 'in the home, men wear the pants') expresses the idea that men are the head of the household and head of the family, legitimated in the Family Code and buttressed by religion and culture.

"The situation of women, yes it is a factor in women's vulnerability. Women must submit to men. Women do not have decision-making power in the couple and in the family. It is men who decide especially where Muslim women are concerned. They must obey their husbands'...Women need to have a greater share in decision-making in the couple and in the family. There needs to be more pressure for change and this is a process." (#9)

"With respect to women, power relations in the couple and in the family. The husband views his wife's body as belonging to him and therefore he can have sex with her whenever he wants even if he is HIV positive. Parents see their daughters as belonging to them and they can marry them off to whomever they want without considering or knowing all that much about the prospective husband and what he has done; someone with money, a husband who was a migrant and who also might be HIV positive. Economic considerations also play into this for women who accept this type of marriage." (#18)

Male dominance in decision-making in the household is borne out by data from the 2005 DHS IV showing that even in matters that relate to women's social roles in the family around caregiving, domestic labour and maintaining social networks, women do not make the key decisions. It showed that 13.7% of women made the decisions about health, 7.5% made decisions about important household purchases, 15.8% made decisions about daily household purchases and 14.6% made decisions around visiting family and friends, although 55.6% of women made decisions about meal preparation (CRDH 2005b: 48). Moreover, although the Family Code gives women the right to choose the marriage option (polygamy, monogamy), this is often ignored in practice (Wone 2002b). Many women in rural areas are still unaware of these provisions (Juteau 2004). For women who are married according to Islamic law, there is no option other than polygamy.

“Women’s social situation is perhaps a factor contributing to HIV in terms of decision-making. Women are relegated to a secondary position in matters of sexuality. Men initiate it; it is not even a question of negotiation...It is men who decide at the moment the marriage is taking place whether they will adopt a monogamous or polygamous union. At the *Mairie*, the question is directed to the man and not the woman, even when she is present.” (#3)

“The Constitution says men and women are equal. But when you go before the *Mairie*, the civil court, men are still viewed as the head of the family.” (#12)

Married women’s difficulties in negotiating safe sex and condom use is a consequence of women’s lack of power over deciding when and where they will have sex, reinforced by unequal gender relations. In 2000, only 11% of women aged 15 to 49 years were using them in the context of family planning (Adjamagbo and Antoine 2002; World Bank 2007c: 1). This is largely related to the fact that having several children is a key to women’s social status and social recognition (Wone 2002b). In the context of HIV, this becomes more problematic.

“Women have little power to decide within the couple. She cannot say to her husband ‘I want you to use a condom even when she knows that he is sleeping with other women. She faces the real possibility of being divorced and repudiated by her husband, if not repudiated by the family. The husband will use this as proof that his wife is showing him a lack of respect, which is what her will tell the family even though he has multiple sex partners. Her asking him to use a condom is constructed as an insult to the man.” (#7)

“Condom use is not really an option for most married women. It is not part of their reality. They cannot impose condom use to protect themselves and they cannot refuse sexual relations with their husbands even when they know he has two or three mistresses. They can’t protect themselves and they don’t have decision-making power.” (#12)

“Condom use has increased enormously, particularly among sex workers and their clients and probably around younger educated people. For married couples, the main message is fidelity and abstinence. Condom promotion is primarily aimed at target groups such as young people and mobile groups who are vulnerable. Getting married couples to use condoms is quite difficult because of the weight

of religion, which prohibits the use of condoms as it interferes with procreation. We promote messages of fidelity and abstinence.” (#8)

Extra-marital sex is more common among them than women, although less pronounced than elsewhere in Africa (Meda et al 1998). In the context of polygamous marriages, an HIV infected man who has been engaged in extra-marital high risk sex is likely to infect all his wives and children. Similarly, married bi-sexual and homosexual men engaged in risky unprotected sex, are also highly likely to infect their wives. For women whose husbands are engaged in unprotected extramarital sex, the inability to negotiate safe sex can be fatal.

“Yes, women are more vulnerable than men within the framework of marriage. There is the matter of their social vulnerability and women bear the consequences of their husband’s sexual behaviour. They often can’t impose the use of condoms or refuse to have sex with their husbands. I had a patient, a woman, a teacher. She had herpes on her body, under her arms, which is usually a sign of HIV infection. I suggested that she take the HIV test which she did. She tested positive. She told me that she was not surprised as her husband had several sexual partners. She is now getting treatment. We called in the husband to get tested and he tested positive for HIV. But it was her attitude, she wasn’t surprised and she accepted the diagnosis. Women like her bear the consequences of their husband’s behaviour.” (#2)

At the same time, the institution of marriage is undergoing transformation. The period of celibacy is becoming longer for both women and men, the choice of spouse is increasingly a matter of individual choice, divorce is relatively frequent and women’s economic contribution to the family finances is more taking on greater significance (Adjamagabo et al. 2002). In the context of lengthy periods of male migration, deteriorating social conditions and declining incomes are forcing a growing number of married women into high-risk behaviours and transactional sex to provide for their own needs and/or the needs of their families. As importantly, one study found that married women whose husbands could not support their families made up a small but growing proportion of sex workers (Wone 2002b).

“We see married women engage in extra-marital sexual relations, adultery. Their husbands can’t support them and they get involved in transactional sex, disguised prostitution.” (#25)

To the extent that married women are vulnerable to HIV, young married women are extremely vulnerable. Approximately, 36.1% of Senegalese women were married before the age of eighteen (Bruce and Clark 2004: 8). Early marriages are also more common among certain ethnic groups where men have higher rates of migration for work (among the Toucouleur and the Peul) and in rural areas (#7).

“Early marriages are often imposed on young girls but less so than on young men. A cousin who was a migrant made some money and came home. Families want to give him the young female cousin. He on the other hand might or might not want to do this or might not necessarily want to get married. Pressure to get married is much heavier for young women, for women in general.” (#16)

Often ignored in HIV prevention strategies (#13), adolescent female brides are at greater risk for HIV. The EDIV data revealed that the HIV infection, although low among teens (15 to 19 years of age), was higher among females than males (CRDH:2005a:37). Faye et al’s (1999: 136) study conducted at the Fann Infectious Diseases Unit among young girls fifteen to twenty years of age showed that although HIV rates increase with age among women, young married women whose only sexual partner was their husband, contracted HIV through marriage. Conversely, this was not the case for young men. The authors suggested that their vulnerability was due to socio-economic factors. However, gender, age and class inequalities shape the vulnerability of teen brides. Often married to men considerably older and most likely migrants, adolescent brides have less power in decision-making than women around matters of sexuality and in the household and are at a greater disadvantage in imposing safe sex particularly with older male partners (CRDH 2005; CEDPA 2003). Teen brides are more often than not less educated, isolated from their family and friends as many go to live with their husband’s family and have less access to reproductive health information (Bruce

and Clark 2004). The vulnerability of teen brides to HIV is reinforced by the lack of enforcement of girl's legal rights (De Konnick 2003; CRLP 2001).

“Young girls, many are forced into early marriage, some as young as age fifteen, younger than the legal age of sixteen years prescribed in the Family Code for women. In rural areas, many more girls get married before age sixteen. Their bodies are not fully developed and they are biologically vulnerable. They marry men who are at least twenty years older, if not more, who are sexually experienced and might have had multiple partners.” (#18)

The Vulnerability of Single Women

The number of single women whether unmarried, divorced or separated has been on the rise. In 1998, they constituted 44% of the female population aged 20 to 29 years of age whereas fifteen years earlier they made up only 13% of this population (Diallo 1999: 249). Social change and economic crisis have contributed to this growing trend as well as single women's increased responsibility for covering all the costs of their economic survival and that of their families. Gender and class inequalities in the labour market have made it increasingly difficult for poor divorced and single women to eke a living and many are obligated to engage in transactional sex to survive whereas many educated, professional, middle class divorced women in Saint-Louis and Dakar are choosing to enter polygamous marriages as a strategy for upward social mobility, combining the social requirement of respectability as married women with a certain measure of financial autonomy (Dial 2001).

“Some women who are not married here, they are taken care of by men, supported by men who really want nothing more than sex. They're considered as fiancées and men give them money or pay their rent, pay for food or for clothing. These women usually stay with one man. They don't know whether or not he is healthy. They don't really want to know. They are not really looking to find out whether he has HIV or not. As long as it is about survival, they don't want to hear about AIDS. They believe or want to believe that it is not going to touch them personally.” (#25)

Gender, age and class inequalities shape the social and economic situations of divorced women, particularly acute for young divorced women with children. Most have given up their economic activities, professions or careers in order to assume their roles as mothers and wives and upon divorce find themselves with few economic options and a lack of support from divorced husbands who by law are required to provide food for the family. It is not surprising that divorced women with children figure prominently in sex work, making up 66.5% of the clandestine prostitutes according to the PROCLAN study and 79% of registered prostitutes (Wone 2002b: 17). The lower social status of divorced women combined with gender inequalities in the conditions of divorce as well as the lack of protection and rights of divorced women also illustrate how gender inequalities shape women's economic dependency and social class position.

Gender inequalities and patterns of male dominance are reproduced in heterosexual relations outside of marriage. A key aspect of Senegal's successful prevention strategy is the increase in condom use in high-risk sexual encounters (Niang 2001; Meda et al. 1998). However, there are gender-differentiated patterns around condom use that point to gender inequalities in negotiating safe sex in non-marital sexual relations. Studies have shown consistent patterns around condom use among groups considered high-risk: condom use is much higher among men and young men than is the case for women and young women in both occasional encounters and with regular partners; and both men and women are more likely to use condoms in occasional sexual encounters than with regular partners (Meda et al. 1998; République du Sénégal 2001d, 2003a). For example, a 1997 Dakar study found that condom use in occasional sexual encounters among youth (15 to 24 years) was higher for young men (68.4%) than for young girls (41.4%) and higher for adult men (66.5%) than for adult women (47.3%) (Meda et al. 1998: 26).

Although condom use for single women and divorced women is higher than among married women, many of these women experience difficulties in imposing

condom use in occasional sexual encounters (Niang 1997). Results from the BSS 2001 provide some evidence that women rather than men don't use condoms because of a partner's refusal (République du Sénégal 2001d). Male respondents cited lack of money, limited sexual pleasure and trust in a partner as reasons for not using condoms with partners whereas a partners' refusal to use a condom, the desire to get pregnant and trust in a partners were cited by female respondents (République du Sénégal 2001d). Niang's (1997: 32) research revealed that itinerant female merchants in Kolda who engage in occasional extra-marital sexual encounters often don't ask partners to use condoms for fear of being accused of being prostitutes.

The Vulnerability of Young Women

To the extent that gender norms shape the vulnerability of both young men and young women to HIV and the available data shows that although young men are more sexually active than young women (Meda et al. 1998; République du Sénégal 2001d; CEDPA 2003), the rates of HIV infection are higher among young women as opposed to young men in both age categories of 15 to 19 years of age and 20 to 24 years of age (CRDH 2005b). This suggests that young women are more vulnerable to HIV than young men, notwithstanding the fact that young men are considerably more sexually active than young women and in this respect they are more exposed to risk. Young men are more likely to have their first sexual encounters with older married women or prostitutes but they are more likely to use condoms. Young women are more likely to have their first sexual encounters with men much older than themselves and less likely to use condoms.

For some young women and girls, it is sexual curiosity that motivates them to engage in unprotected pre-marital sex (#25). However, for others like female vendors in the informal sector who can barely eke out a living, pregnancy is seen as a strategy to get married, a way out of poverty, and they engage in unprotected sex

to do so (Dial 2001: République du Sénégal 2001d). Early pregnancies outside of marriage is also a growing phenomenon, with 26% of first births taking place prior to marriage, although half are legitimated shortly thereafter (CEDPA 2003: 8).

“What I have seen in the field, many young girls, some are pubescent. They are interested in sex. A lot of these girls end up getting pregnant their first time, an undesired pregnancy and some contract HIV. This happens a lot in poor neighbourhoods. There is also the corruption of minors by older men who use them. Most of the young girls, their first sexual encounter is with an older man – a much older man, some of the age of their fathers, some the age of their grandfathers.” (#25)

Age, gender and social class inequalities affect young women’s ability to impose condom use. Expected to be submissive, “young women are not well equipped to negotiate condom use with an older partner or one who is wealthier” (CEDPA 2003: 20). They are less likely to purchase condoms and depend on their partners to provide and use them because of the stigma associated with condom use and prostitution. Dominant gender norms around young women’s femininity reinforce gender inequalities and their vulnerability to HIV.

“For young women who are sexually active and involved with someone who they suspect might be seropositive, what do they do? How much power do they have to impose, let alone raise the issue of condom use? In some milieus, a young woman cannot even raise the issues of condom use and safe sex. People look at you and it makes collaboration and young people’s involvement more difficult.” (#17)

“Many young people don’t want to use condoms. Young women don’t carry condoms they ask young men to get them. Many young people don’t use them partly because they are too expensive for most young people, three condoms for 150 FCFA for the PROTEC brand. It is still too expensive. We give them out when we play and young people take them and use them.” (#15)

The increase in transactional sex practices among young women is a function of gender, age and social class inequalities that shape the material circumstances of the majority of young women and girls. Girls are less educated, have fewer economic options than boys and are more likely to be in situations of economic dependence as a result of prevailing gender norms and unequal gender

relations. The feminization of poverty is the most acute in rural areas (Bop 2003; Touré and Niang 2002). Girls and young women constitute a growing proportion of rural out-migration to cities like Dakar and elsewhere in search of work and a better life. As they are less educated and less likely to speak French, they are concentrated in gender-stereotyped informal sector jobs as domestics and itinerant petty traders in food products that are precarious and pay less well than the informal sector jobs held by young men. However, most of these young women cannot survive on what they earn from these jobs and many engage in transactional sex to pay for their own necessities and those of their families. Several respondents suggested that these two groups of young women are particularly at risk.

“The rural exodus, young women who work as domestics and maids, migrants, are under a lot of pressure. They are faced with a loss of identity and are in search of a new identity. They end up doing what city people do, especially in the suburbs like Pikine where promiscuity is rampant. There is a concentration of migrants from inside and outside of Senegal. Many people are poor and illiterate, and sanitary conditions are lacking. All this puts young women at risk.” (#17)

“The diminishing authority of heads of families, poverty and the inability of families to respond to the economic needs of their children. There are girls out there paying not only for their own needs but also for the needs of their families. The families know but they don’t ask where the money is coming from. These young girls are more vulnerable to infection, less plugged into sources of information and partially illiterate.” (#1)

“For many girls who are minors, it is their mothers who initiated them to take clients. They get involved in clandestine prostitution to get food to eat and to feed the family. They ignore the risks and the spread of AIDS because they are not well-informed.” (#25)

As the previous discussion has shown, unequal gender relations in the private sphere of male-female relations within and outside marriage as well as in the context of sex work are critical in shaping women’s enhanced vulnerability to HIV, although this intersects with age, class and other social inequalities. The acceptance of male dominance and female subordination among both women and

men remains a societal phenomenon. Senegalese women who contribute money to the household of their own accord still accept male dominance in household decision-making as the DHS IV revealed. Although working women with an income are more likely to have the last word on key decisions in the household, that proportion was relatively low at 15%, although higher than for women not working (5%) and working women who received no income (6%) (CRDH 2005b: 48). While women's financial contribution to family survival and maintenance is on the rise, creating tensions within the couple, it has not substantially altered unequal gender relations in the family or the pervasiveness of male dominance (Bop 1996, 2003; Adjamagbo et al. 2002; Adjamagbo and Antoine 2004). Moreover, many educated, professional and financially independent women in Senegal still accept male domination within their marriage, as these respondents pointed out.

“Women's economic situation their economic dependence is real enough but that does not explain everything. I know women who are financially independent but when we discuss the issue of condoms, many of these women say ‘I can't use condoms, he will divorce me.’ These women can't discuss the issue or ensure that they will be protected from unsafe sex. I have discussed this with many women. The problem is one of power relations. When we as women raise this issue around condom use and safe sex, it is perceived by men that we want to dominate but this is not the case but rather that everyone can protect him or herself (*trouver leur compte*).” (#29)

“For urban women, some of the barriers have come down. More women are working. More women are in politics – just look at the number of cabinet ministers. They feel that they have achieved equality. But when I point out, yes you are working, yes you are earning an income and yes you are autonomous. But what happens when you go home at five or six o'clock, to cook for your husband because you have to. Marriage, it is slavery.” (#12)

This challenges the generally accepted contention in international HIV/AIDS policy circles that increasing women's economic power and financial independence and their access to formal education will reduce women's dependency on men and ultimately, their vulnerability to HIV (UNAIDS/UNFPA/UNIFEM 2004: UNAIDS 2004e, 2004c; ICW 2004; Feinstein

and Prentice 2001; Smith and Cohen 2000; Reid 1991). This suggests that enhancing women's financial autonomy, economic options and access to education are necessary but insufficient conditions for reducing women's vulnerability to HIV infection. It points to the need to acknowledge and address unequal male-female relations in the context of sexuality, health and other key issues in the private sphere as essential to the overall package of strategies designed to reduce women's vulnerability to HIV. This also means calling into question dominant gender norms around masculinity and femininity that serve to sustain gender inequalities and enhance risk to HIV for both males and females.

4.3 Addressing Women's Vulnerability to HIV in Prevention Strategies?

“Women and AIDS should not be separated from women's issues as long as we have not regulated women's social situation. HIV is both individual and collective.” (#29)

Analysis of the efficacy of HIV prevention strategies with women turns on the extent to which they foster women's empowerment; that is their enhanced capacity to protect themselves from HIV at both an individual level and at a collective level (Baylies and Bujra 1995) and tackle the social determinants of women's vulnerability to HIV. The main Senegalese HIV prevention strategies targeting women include providing basic information (IEC), HIV testing and counselling, access to condoms, training in negotiating safe sex and the development of income-generating projects.

Women's groups play a key role in women's individual and collective empowerment, in particular the promotion of the female condom. Women's groups were at the forefront of an initiative to implement compulsory pre-marital testing for couples as a way of protecting young women from HIV positive men who refused to divulge their status, although this initiative was rejected on ethical

grounds (Faye 2003b). Registered female sex workers in Kaolack banded together to refuse male clients who insisted on unprotected sex (Renaud 1994). Women's collective empowerment also includes actions by women's groups that advocate for women's rights and gender equality (Baylies and Bujra 1995). However, women's groups are hampered by a lack of funding for their work (12/23), the lack of human, technical and financial capacity (7/23) and the socio-cultural context (2/23) but more importantly by their exclusion from HIV/AIDS decision-making structures (9/27), issues which I will address in more depth in chapter 7.

I argue that the dominant HIV prevention strategies are limited in their efficacy in reducing women's individual risk and enhancing women's individual empowerment, their control over their bodies and over sexuality, as a result of gender and other forms of inequality that constrain access to information, testing, condom technologies and empowerment training around safe sex negotiation.. Concerned with individual risk reduction and empowerment, these strategies do little to tackle gender and other social inequalities that underpin women's enhanced social vulnerability to HIV. As Baylies and Bujra (1995) caution, women's empowerment cannot substitute for broad structural changes to transform intersecting social relations of inequality that underpin women's vulnerability.

Access to HIV/AIDS Information

Knowledge about HIV and STIs is essential in protecting oneself from these diseases and constitutes one of the fundamental ways in which Senegalese prevention strategies address women's vulnerability for several respondents (6/27). To the extent that access to information is crucial to HIV risk reduction and behaviour change, studies have shown persistent gender differentials regarding knowledge around HIV/AIDS and STIs, with women somewhat less knowledgeable than men, although these differentials vary by age, level of education, income and region (CRDH 2005a; République du Sénégal 2001d). The 2001 Behavioural

Surveillance Survey revealed that although male apprentices and female vendors in the informal sector were less knowledgeable than male and female students about HIV and STIs, female vendors were the least knowledgeable about HIV prevention methods and were the least likely to have used condoms in their last sexual encounter (République du Sénégal 2001d: 16-17). Women who are better educated, living in urban areas and somewhat older are the most knowledgeable.

Respondents identified several problems with current strategies. HIV IEC strategies favour urban and semi-urban areas over rural areas, with rural women having less access to HIV information than women in urban areas. Given that HIV rates in urban and rural areas are about the same, there is an urgent need to redress this imbalance, as several respondents observed (10/27), also noted by the CNLS (2006a). Youth in general are less knowledgeable about HIV/AIDS, particularly around preventing its transmission, with young girls aged 15 to 19 years the least knowledgeable (CRDH 2005a; CNLS 2002a). The CNLS (2006a: 31) has acknowledged that HIV prevention activities, while prioritizing young people, have inadequately targeted women, particularly in rural areas, and even with respect to female sex workers. One may add to this young girls and young women.

The association of AIDS with female prostitution has led to the perception that not all women are at risk for HIV; a perception that is internalized by many married women, as several respondents pointed out, although Lagarde et al's 2000 research suggested otherwise. Respondents also mentioned that certain groups of women, who are particularly vulnerable, have been less well targeted. They cited as married women (housewives, young wives and wives of Muslim religious leaders), rural women, clandestine prostitutes, young female domestics and women in the informal sector of the economy as well as post-menopausal women, female professionals and intellectuals whom they considered less vulnerable.

Gender inequalities also shape access to information. Several respondents (7/25) identified women's lower levels of education and literacy in the French language as an impediment to their access to information, often provided in French and using medical terminology women are not familiar with. Although an increasing number of education materials are available in national languages (3/25), more needs to be done. Unequal gender relations also constrain women's ability to participate in information workshops and discussions.

“Village women, many have simply not been exposed to HIV education and much less to contact with people living with HIV/AIDS. Religion also poses a problem. It hinders women from speaking out and demands that women obey their husbands and the family reinforces this. It is hard to get women to come to HIV education meetings. They are supposed to be at home cooking and taking care of children. Many just don't have the time or else they need their husband's permission to come to the session.” (#26)

“To be able to reach certain women, you have to go through the husband. This is a difficulty around HIV testing, even in the case of women attending HIV information workshops. Often, she cannot tell her husband what the workshop is about because the husband may accuse her of having HIV or extramarital affairs.” (#4)

Access to HIV Testing and Counselling

State policy increasingly emphasizes improving HIV testing rates among the general population through voluntary and anonymous testing (CDVA) and pregnant women through the *Programme transmission mère-enfant* (PTME) as key prevention strategies for reducing HIV transmission (CNLS 2007c). The available data on HIV testing shows that more women were tested than was the case for men (APAPS 2005; CRDH 2005a, 2005b; CNLS 2002a), although there are regional variations. The DHS IV second generation surveillance testing revealed that 81.9% of urban women and 86.6% of rural women were tested while the rates for rural men and urban men were lower at 77.6% and 73.7% respectively (CRDH 2005a: 36). Moreover, refusal rates were higher among men at 15.9% for urban men and 15.5% for rural men as compared to women at 10.9% for urban women and 8.9%

for rural women (CRDH 2005a: 36). These differentials raise some interesting gender issues around male resistance to testing, male responsibility for risk reduction and gender biases in HIV testing strategies.

“Women are more aware of the need for testing and the PTME than men, in part because there has been a great effort to promote anonymous voluntary testing for women. This would partly explain the statistics that show more women visiting the centres for testing.” (#6)

Although data around HIV testing patterns as early as 2002 showed that women were over-represented in HIV testing (CNLS 2002a), no targets were set in the 2007-2011 strategic plan to increase men’s rates of HIV testing (see CNLS 2007c: 49). As such, this puts the onus on women for HIV testing. The failure to tackle this issue more thoroughly limits the effectiveness of testing in reducing women’s risk to HIV as male resistance to HIV testing also serves to increase women’s vulnerability as they are more likely to be infected by their partners.

A similar problem is evident with the PTME as a prevention strategy. It focuses on reducing mother-to-child transmission of the virus rather than preventing HIV infection in women. “*Se faire dépister pour la survie de l’enfant et la famille*” was the key slogan launching the 2006 *Semaine nationale Femme – Sida*, sponsored by the *ministère de la Femme*. Drawing on women’s roles and responsibilities for family and child health and well-being, the PTME intervention strategies target pregnant women rather than couples or families, placing the burden of responsibility on women for preventing HIV transmission “*pour assurer le moyen plus efficace et le plus sûr pour assurer la survie de l’enfant et de la famille*” (Sonko 2006). The term ‘mother-to-child transmission’ also reflects gender biases. It reinforces the idea that women are somehow to blame for infecting their children, reflecting and reinforcing broader cultural notions that women are somehow responsible for children’s abnormalities, disabilities or ill-health or other family deaths (Niang 1997; Jackson 2002). Using the gender-neutral term of parent-to-child transmission would avoid blaming women, draw attention to men’s

roles in infecting HIV positive children and encourage male and joint responsibility for protecting children and the family (Jackson 2002; Matlin and Spence 2000).

Unequal gender relations and women's lack of control over decision-making around health are barriers to women's access to testing. As several respondents pointed out, many women don't get tested because their husbands refuse to give permission for the HIV test and if they do allow their wives to get tested, they refuse to take the test.

"The socio-cultural situation that puts women in a state of dependency. If I have to go consult a doctor or other health practitioner, I have to have my husband's permission. Socially, women are supposed to get someone else's advice and they know that it is someone else, a husband, a brother and usually a male that makes the decisions about issues that concern them but which they do not necessarily understand." (#29)

"We need to talk about the PTME, testing and family planning. Women don't necessarily have all the information. We also involve men and community leaders because men have the decision-making power. Women can't get tested without their husband's permission. If she does so without his permission, problems ensue. We need to get men on board." (#7)

"Women have no voice in the couple and in the family. Women who come for pre-natal consultations, the HIV test is offered to them. Women ask for time to ask their husband's permission and even then only 50% of them return. If they were as well informed as their wives, they would accept. Many refuse because they don't believe AIDS exists. We need to do some real sensitization work with men around HIV testing for everyone. Men have the authority in the family and they are the head of the family. When it comes to the PTME and HIV testing, only women come in for pre-natal consultations. Men are the problem when it comes to issues around getting tested for HIV." (#16)

To the extent that couples are being urged to take the HIV test (Sonko 2006), intervention strategies around HIV testing to target husbands and increase their involvement and responsibility in protecting their wives and their children

remain under-developed and limited to a few regions in Senegal. More emphasis needs to be placed on targeting men, as some respondents (5/25) pointed out.

Access to Female Condoms and Negotiating Safe Sex

Women's empowerment within the context of risky sexual relations turns on women's access to female controlled barrier methods such as the female condom and women's capacity to negotiate safe sex and/or impose condom use. They are particularly important in the Senegalese context where most women encounter difficulties in imposing or negotiating safe sex. SWAA, a woman-focused AIDS organization, has long been at the forefront of promoting the female condom among women and in advocating for a reduction in their cost (UNIFEM 2001b). More recently, a one-day forum on women's vulnerability organized in 2003 by the ANCS and UNIFEM recommended developing advanced strategies to promote the female condom. However, access to female condoms remains limited for most Senegalese women, despite the fact that studies show a favourable attitude towards their usage among both men and women (Niang 1997; SWAA 1998).

In spite of the success in the social marketing of male condoms, female condoms have not been integral to these initiatives. Many women and young women are not even aware of the existence of female condoms partly because the social marketing of this prevention method has not targeted all groups of women in all regions of the country on down to the village level (ANCS and UNIFEM 2003). Despite the activism of women's groups in promoting their use among all women, AIDS policy targets focus on their use by female sex workers.⁴ As marriage is seen to protect women and married women are not viewed as vulnerable, married couples are not the primary targets in the social marketing of condoms. Female condoms are not widely available either in health centres or in the commercial

⁴ The 2002-2006 strategic plan set a target of 30% female condom use by this group and that 30% of women aged 20 to 49 years know about this prevention method (CNLS 2002a: 42) while the 2007-2011 Plan only sets a target for their increased distribution at an affordable price (CNLS 2007c: 49).

establishments that sell male condoms. They are more expensive than male condoms and most women cannot afford to purchase them.

“In my study, their first problem is not getting pregnant, not AIDS. They need to become aware of AIDS. The boys think they are responsible for STIs and pregnancy and they have to protect themselves but many don’t think they will get AIDS. How many young women even know about female condoms? When we do workshops showing how to use condoms, how many times do we show how to use the female condom? Female condoms cost 600 FCFA and male condoms cost 25CFA. Female condoms are simply not affordable for most women.” (#18)

“Femidon, the female condom, is not widely available. The social marketing has largely been a failure. SWAA doesn’t give us female condoms, despite the fact that we work with clandestine prostitutes. We approached UNIFEM for a project on Femidon and there was no follow-up. Femidon can be found in the offices and not on the streets.” (#25)

“We are involved in promoting the female condom as a way for women to have control over their bodies and protect themselves. In the context of the PTME and Family Planning, the female condom is distributed to women by SWAA. It costs 600 FCFA and it is too expensive for the average Senegalese woman.” (#7)

As such, the limited availability of an effective female-controlled HIV prevention method serves to dis-empower women and reinforce their limited capacity to negotiate safe sex or impose condom use, thereby contributing to women’s social vulnerability to HIV. A few respondents were critical of the current IEC/CCC approach to HIV prevention, pointing out that it does not adequately address women’s lack of power to protect themselves in matters of sexuality. They noted that HIV prevention strategies focussing on women’s empowerment or life skills training to enhance safe sex negotiating skills and address broader issues around this are not that well-developed, particularly for married women or widely used beyond a limited number of NGOs and women’s groups working in the area.

“Getting into women’s groups and milieus is easy enough. Women are conscious of the fact that AIDS is an issue for them and they have the information. The ability to discuss and take control of the

decision-making process to protect themselves is the problem. Women don't have the power – men do.” (#7)

For the majority of respondents, the challenge is developing culturally appropriate models of female empowerment in the context of HIV/AIDS.

“How do you do more than simply provide a basic prevention message? How do you provide more life skills for married women to better protect themselves? Poverty reduction strategies are just beginning to consider the relationship between poverty, HIV and vulnerability. We need to develop strategies that are appropriate for this society, for women to protect themselves without putting into danger the institution of marriage, the source of their social status. We don't want to empower women to get divorced. We need to involve men. We can't do it the way we do it in the West; the demonization of men and a confrontational strategy. Then you get imbalanced training and all the responsibility goes to the male. There is no working together towards a solution.” (#1)

“In reality do the programs targeting women really respond to women's needs? Do these programs actually give women the tools but not the capacity to negotiate safe sex with husbands or partners, without breaking up the couple? This is not that useful. The reason we have this situation is because the programs target women primarily giving them knowledge but not the power to act on that knowledge. Some programs target men but don't necessarily make men aware of women's problems or women's needs. We need to involve men to protect women in order to protect the family.” (#29)

“Respect for tradition. We try to encourage women to discuss sensitive issues with their husbands in a respectful fashion, *'la sensibilité de proximité.'* This is compatible with our traditions.” (#2)

However, for a few respondents, prevention strategies do not adequately address the structural determinants of women's vulnerability such as the imbalance in male-female relations and poverty.

“For me, power relations are the cause. I don't think that prevention programs see this in this way or address this. They talk about socio-cultural factors. For example, we will cite lack of access to education. Many women are literate in national languages and they have knowledge. This does not define power relations. The problem of

women's vulnerability to HIV is socially constructed power relations.” (#18)

“In terms of strategy, the trend is toward sensitization and prevention communication for behaviour change with the individual as the target. If we want to better understand high-risk behaviour we need to look at risk environments. What are the situations that contribute to women's vulnerability and what needs to be changed? Improving the environment and the milieu needs to be prioritized.” (#13)

Addressing Women's Economic Dependency: Income-Generating Projects

Initiatives designed to address women's economic dependency and lack of economic power have taken the form of developing income-generating projects for women, primarily although not exclusively, targeting commercial sex workers. This strategy has been used by NGOs working in this area as assisting female commercial sex workers to leave the profession permanently is one of their central goals (Enda Tiers-Monde 2004; Soumare 2003; Groupe thématique ONUSIDA/Sénégal 2001). The strategy has yielded disappointing results and is fraught with difficulties including inadequate skills-building and training for participants around project management and the demands of funders for complex evaluations beyond the scope of the participants' capacity (Groupe thématique ONUSIDA/Sénégal 2001). Projects also did not generate sufficient income to serve as an inducement to leave the profession as many sex workers can make more money from sex work, although incomes from this vary (Groupe thématique ONUSIDA/Sénégal 2001: 62). The limited success of income-generating activities in this area is indicative of the general limitations inherent in many of the micro-enterprise and micro-credit schemes designed to boost the incomes of poor women as a response to economic crisis (Rai 2002).

“The whole question of women's vulnerability to HIV. Poverty that has increased with economic deterioration, the changes in family structure in both urban and rural areas, the increase in divorce, the growing number of women with children that find themselves without financial means of survival and the failure of income-generating

projects to restore the dignity of women. Many women are sinking deeper and deeper into poverty resulting in the growth of official and unofficial prostitution and transactional sex. Many widows also find themselves without the financial means of survival.” (#4)

To the extent that HIV issues are now being integrated into poverty reduction strategies in Senegal (CNLS 2007c), gender and HIV strategies need to be better integrated into them. Inducing women to leave prostitution necessitates addressing gender, age and class inequalities around access to education, training and employment, land and agricultural inputs as well as strengthening women's rights around inheritance and supports in the event of divorce or widowhood that shape women's entry into prostitution. Greater consideration needs to be given to how state policies around rural and urban development contribute to poverty, migration and the increase in commercial sex work that underpin women's and girls' vulnerability to HIV.

The Limits of Women's Empowerment: Men and Masculinities

Women's empowerment within the context of HIV prevention in Senegal raises two separate but inter-related issues: the structural context of unequal gender relations and male dominance within the private and public spheres and the limits of current approaches that do not address men's responsibilities and roles in the epidemic. Growing attention in the international arena is focussing on how men's behaviour determines the spread of HIV, putting not only themselves at risk but also their female partners and their families at risk, and the limits of women-focussed HIV prevention strategies in the context of male-dominated societies. Involving men more deeply in HIV prevention and in the care and support of PHAs are increasingly viewed as necessary to equalizing the unequal gender-based impact of the pandemic borne by women and girls (Commonwealth Secretariat and the Atlantic Centre of Excellence in Women's Health 2002; UNAIDS 2000; Royal Tropical Institute 1998; SWAA 1999; Cohen and Reid 1996). This view was shared by several respondents (9/27).

As we have seen, most of the HIV prevention efforts in Senegal tend to focus on ‘responsibilizing’ women for preventing HIV, given their social roles in the family and in the community. ‘Women are the gateway to the family’, as more than one respondent remarked. Moreover, as this respondent (#29) explained,

“Unlike women, getting men involved as peer educators is more difficult to do because they want to be paid. They do not want to work as volunteers. It is also easier to reach women, as they are more accessible to health service providers particularly as users of child and maternal health programmes.”

To the extent that HIV prevention strategies target men, it is men in specific high risk groups such as migrants, truck drivers, the military, young men in the informal sector rather than men in general (Groupe thématique ONUSIDA/Sénégal 2001; CEDPA 2003). However, men as a social category are also vulnerable and their vulnerability to HIV puts women at risk. Almost half of the respondents pointed to the need to involve men more deeply in prevention initiatives in order to reduce women’s vulnerability to HIV (10/27), arguing that as heads of families, men have the decision-making power around health decisions and around sexuality.

“Men are vulnerable, if not more vulnerable because they believe that they know everything, that they have enough knowledge and that they are educated. They think that they don’t really need prevention programs. Men see health in general as a woman’s issue, especially reproductive health, and by extension HIV. There was a film on HIV and STIs. And it scandalized my husband, who like many men didn’t think they existed. These diseases are seen as shameful and an issue of modesty (*sutura*). It means that men don’t want to go to the doctor or talk to the wife.” (#29)

“HIV affects everyone. Decisions around HIV should not simply be left to the head of the family. Everyone needs to be able to make decisions around their health. We need to do more sensitization with religious authorities and male heads of households to make them understand that women need to be able to make their decisions around health. It is not that women want to take men’s places but everyone needs to be able to make decisions around life, If we give life, we need to be able to protect it...One of the major difficulties with respect to behaviour change is that men feel threatened.” (#16)

Previous research in Senegal on HIV prevention education conducted by traditional women's groups, the Dimba and the Loabe, in Kolda with men and women showed that their efforts had no impact on raising men's awareness or changing their behaviour around condom use, although it proved more effective with women (Niang 1995, 1997). Some respondents suggested that gender-specific strategies need to be developed to target men in general, using men's groups.

“We need to develop education programs targeting married men. Perhaps a conference organized by SWAA with the involvement of men. First of all, men's groups and associations need to open up dialogue among men. The ANCS, the RNP and mixed groups should play a role in opening dialogue, perhaps even develop a consortium with SWAA in synergy with JAMRA, RESER SIDA MIDDA and the Imams. This is not just a women's problem. We need to develop a strategy to involve men in order to protect women.” (#3)

“Religious groups and settings might also provide a good place for targeting men. In fact faith-based organizations are not all that different from non-faith-based organizations in their basic message. The basic message is the same. ‘Abstinence, Be faithful, Use Condoms.’ These issues relate to men protecting women and protecting children.” (#29)

However, as this respondent (#5) pointed out, the issue is not men's lack of involvement as they have participated too much. The real issue is that HIV prevention is insufficiently focussed on gender inequality and women's lack of power to protect themselves and gender norms that sustain this. This requires developing strategies to make men more aware of these issues and women's needs in order to more effectively address them and change their behaviour.

“Reducing vulnerability, is the focus on the right target group? When we look at the response aimed at combating HIV, everything we do to reduce vulnerability is aimed at women. We do sensitization with women. We focus on informing women. We try to set up income-generating activities for women to reduce the economic gap that women face vis-à-vis men but the decisions with respect to sexuality and reproduction are the prerogative of men. We need to focus on men who decide not to wear condoms, not to get tested for HIV and who

make children. It is men who make the decisions and women follow. We need to focus on men and to work on men's mentality and issues of masculinity." (#19)

4.4 Conclusion

In exploring the social determinants of women's vulnerability to HIV, I have shown how unequal gender relations and women's subordination within the context of the private sphere of heterosexuality, marriage and the family, buttressed by Islamic ideology and traditional cultural practices, place women and girls at higher risk for HIV than men and boys and limit their capacity to protect themselves. A key aspect of women's and girls' vulnerability to HIV is that they are less empowered to negotiate and impose safe sex. In emphasizing how unequal gender relations affect women's vulnerability to HIV, I have shown how gender intersects with other social relations of inequality such as social class, age and marital status to shape the vulnerability of different social categories of women such as married women, young women, single women and women engaged in commercial sex work.

Moreover, an analysis of the principal HIV prevention strategies in the Senegalese state response reveals how unequal gender relations in their interaction with other social relations of inequality also shape women's unequal access to HIV information and education, to condom technologies and to voluntary testing. It highlights the limits of its gender approach to addressing women's social vulnerability and fostering women's empowerment. The state-religious partnership and the ABC approach to prevention are problematic for women and girls. This inadvertently may heighten women's vulnerability to HIV in that it promotes the belief that if women are faithful to their husbands or sexual partners, they are not at risk for HIV (Bridge 2002). It overemphasizes women's agency and does not adequately address the structural inequalities that shape women's individual and collective capacity to protect themselves from HIV. There is little room for

advocating for women except within the confines of their traditional roles as mothers, wives, educators and caregivers, much less challenging women's subordination and unequal gender relations in the couple, the family or the broader society that contributes to the feminization of AIDS. 'Protecting women' rather than 'empowering women' best characterizes the Senegalese gender approach to prevention, which Sidibe (2001) identified as a gender-neutral approach.

"We need to be able to offer women the possibility to see themselves and be considered as people in their own right so that women can take control of their lives and make decisions. Consciousness-raising needs to be done." (#16)

If women's vulnerability to HIV is to be more effectively addressed, there is need to view HIV/AIDS vulnerability as fundamentally gendered.

"The issue is: How does a specific social and medical problem such as HIV/AIDS reproduce itself within gender relations? How do gender relations contribute to the reproduction of these problems? We need to act on and address issues of gender relations if we want to find durable solutions to HIV/AIDS." (#5)

A more effective gender approach needs to be developed to counter the feminization of HIV/AIDS and address women's and girls' vulnerability. This calls for a comprehensive national HIV prevention strategy targetting men as a social category that includes addressing unequal male-female relations in the private sphere, in addition to initiatives tackling poverty and women's economic dependency. This also requires more strategies to foster women's individual and collective capacities to protect themselves from HIV and address broader structures of social inequality that fuel the epidemic among women and girls.

CHAPTER V

WOMEN LIVING WITH HIV/AIDS: THINKING THROUGH GENDER

HIV positive men and women have similar needs in order to live positively. This includes full acceptance as valued members of the family and the community, affordable, accessible quality medical care, social supports, the satisfaction of basic needs and living free of fear, stigma and discrimination.

“The situation of people living with HIV/AIDS (PHAs) in general is this, the social situation is this and we all face the same difficulties: how to live positively, how to accept one’s HIV status, first of all; how to participate in the family and get help from the family; how to get help from one’s entourage; to live in a non-stigmatized situation; to get married and have children; and to have our families respect us as sero-concordant or sero-discordant couples.... Having easy access to medical care helps seropositive people live better. Living positively means living in the community.” (#14)

Living positively is a challenge for the majority of PHAs in Senegal as HIV/AIDS reproduces social class and north-south inequalities in their living conditions, undermining their human rights to health. While poverty and underdevelopment are recognized as major obstacles to the health and welfare of PHAs in low-income contexts in Sub-Saharan Africa as well as in the industrialized world (Aboriginal peoples), less attention has been paid to how gender inequality differentiates the social and economic situations of seropositive men and women within these contexts. Although most of my research respondents (23/25) pointed to gender differences in seropositive men and women’s economic and social situations, few of them linked this specifically to gender inequality. In the context of the feminization of AIDS in Senegal, addressing gender inequality is all the more important if seropositive women are to be empowered to live positively.

This chapter explores how gender shapes the economic and social circumstances of women living with HIV/AIDS in Senegal differently from men. It argues that seropositive women face greater challenges in living positively than men as HIV/AIDS reproduces and exacerbates gender inequality, unequal gender relations and the subordinate status of women. It accentuates seropositive women's responsibilities associated with their social roles as mothers, wives and caregivers and undermines their roles as workers. HIV positive women are more likely to be in situations of economic and social dependence, with greater responsibilities for the health and welfare of their families as caregivers, with fewer economic resources, supports and greater needs, which negatively affect their health. Seropositive women also face double discrimination: as HIV positive and gender discrimination as women. They are judged more harshly than seropositive men, more likely to be blamed, repudiated, ostracized or abandoned. Moreover, positive women face specific gender-based challenges that relate to and affect their social roles as mothers and wives that make it more difficult to maintain confidentiality around their HIV status. To the extent that gender inequality interacts with social class and north-south inequalities to differentiate the material and social circumstances of seropositive Senegalese women, social divisions based on marital status, age and occupation also come into play. State-supported human rights initiatives to protect PHAs and empower them to live positively do not adequately address gender inequalities, undermining the rights of seropositive women.

I begin by providing a brief socio-economic and demographic portrait of PHAs in Senegal; the majority of whom are poor, situating this within the broader context of economic underdevelopment in Senegal. I then examine how gender differentiates seropositive women's economic situations and social responsibilities from those of seropositive men, showing how unequal gender relations are reproduced and accentuated within HIV/AIDS. I then turn to a gender analysis of social stigma and discrimination around HIV/AIDS showing how seropositive

women are victims of double discrimination as HIV positive and as women. I then explore the gender-based challenges that seropositive men and women face around the disclosure of HIV status showing how gender inequality works to the detriment of seropositive women. I then address the gendered dimensions of the rights of seropositive men and women.

5.1 Gender, Poverty, Underdevelopment and HIV: ‘Most PHAs are Poor’ But ‘Most Female PHAs are Poorer’

There is ample evidence that shows the links between poverty, underdevelopment and HIV/AIDS (Stillwaggon 2006; Poku 2005). HIV positive people generally live longer and better in western industrialized countries, although this varies by ‘race’, social class and gender, illustrating how diverse forms of social inequalities shape the impact of HIV/AIDS on racialized minorities and disadvantaged groups (Baylies 2000). In Canada, disease progression to full-blown AIDS occurs more rapidly among seropositive Aboriginal people who do not live as long as white Canadians (Ship and Norton 2000). These trends also have been observed in Sub-Saharan Africa, partly a result of more virulent strain of HIV but also as a result of poverty and underdevelopment (Stillwaggon 2006).

Poverty in the context of underdevelopment undermines Senegalese PHAs’ capacity to live positively. Tuberculosis, malaria and a variety of parasitic diseases play a role in enhancing viral load among PHAs in Senegal as well as serve to compromise people’s immune systems (Stillwaggon 2006). HIV positive people in Senegal as elsewhere in Africa are more likely to contract tuberculosis; a trend far less common in industrialized countries (Barnett and Whiteside 2006). Inadequate nutrition and lack of access to clean drinking water and adequate sanitation serve to further foster HIV susceptibility by compromising people’s immune systems.

“Underdevelopment is definitely an issue. The involvement of the European Union in setting up the Global Fund for AIDS, TB and

Malaria was really significant. These are all diseases linked to poverty and to underdevelopment. We need to address these issues in the fight against AIDS...the link between social and economic factors and health is really clear with cholera. We recently had, last year, an outbreak of cholera at Touba. It was linked to the unsanitary conditions there. Because it was the Magal, it was hushed up. With respect to AIDS, the links between the medical and socio-anthropological aspects are both direct and indirect. Nutrition is a good example and is essential to building antibodies. A seropositive person needs to eat well and to have a balanced healthy diet. If the person is malnourished, ARVs will not be as effective in immunosuppression of the disease. ” (#28)

Senegalese PHAs from privileged socio-economic classes maintain a better quality of life. Their living conditions are better: they enjoy more comfortable housing arrangements, essential services such as electricity, running water, indoor plumbing, adequate sanitation and greater access to consumer goods such as refrigerators and cars, in addition to domestics to take care of labour-intensive and physically draining household tasks. They are more likely to maintain a healthy and balanced nutrition, including using bottled water, which is essential to boosting their immune systems and maximum effect of antiretroviral therapy. Wealthier PHAs have better access to the range of medical services, including private medical facilities, are less visible as PHAs and can better keep their HIV status a secret. Their health is less likely to deteriorate from the stresses of material deprivations and precariousness and they are more likely to be in a position to mitigate the impact of HIV arising from distorted development.

However, as most of my respondents pointed out, the majority of PHAs in Senegal are poor, although developing an accurate socio-economic and demographic portrait is difficult as the majority of PHAs live in secrecy. The few studies that addressed the economic situations of people living with HIV/AIDS in Senegal have shown that the majority of PHAs share a similar socio-economic and demographic profile to that of the general population in urban areas (see chapter 3 for an in-depth socio-economic and demographic portrait of the urban and rural

populations in Senegal). Most are poor, living at or below the poverty line, with few options for work or income generating activities. Many PHAs are married with large families, with some in polygamous households (CNLS 2006a; Desclaux et al. 2002, 2003; Gomes do Espirito Santo 2000). Gomes do Espirito Santo's (2000: 19) socio-economic and demographic profile of HIV/AIDS patients at the *Centre de Traitement Ambulatoire* (CTA) and of those admitted to Fann Hospital showed that the majority of the men were hawkers, traders or skilled workers while the majority of women were unemployed housewives, with a high proportion of widows (23.9%) who contracted HIV from their husbands. This profile is similar to that of the participants in the ARV clinical trials, most of whom were unable to pay even a small amount of money towards their medical treatment (Desclaux et al. 2002). As this respondent (#2) observed¹,

“The pattern of HIV infection among men in Senegal is different from patterns in Central Africa. Here, it is petty traders, some middle class men and migrant males who are infected with HIV; they make up about 90% of the cases. They are highly mobile, unmarried and they migrate to outlying regions to sell their merchandise. They are out of the reach of social and sexual controls, lack support and contact which pushes them into risky sexual relations with women, that doesn't cost that much, with sex workers. The young men that are in Central Africa and the Ivory Coast send money home. There is a strong link between HIV and migration; 90% of migrants infected are men.”

In Senegal, the poor are the most visible in medical and community services as well as in the Associations of People Living with HIV/AIDS.

“The majority of PHAs, certainly the members of our Associations of People Living with HIV/AIDS, have few resources, are unemployed and deal with all the problems related to a lack of money, nutrition, housing etc.” (#9)

“From our HIV testing unit, I know that not all of the men who have tested positive are poor. Generally, the people who are most visible are poor but not all seropositive people, mostly men, are poor. Even at Fann, they have a night-time schedule for high profile people, army

¹. Bipolar distribution of HIV/AIDS has been noted in Central Africa and in Southern Africa, where HIV/AIDS has decimated the ranks of male urban elites, as well as heavily affecting the poor in urban and rural areas (Poku 2005; Schoepf 1997, 1988).

officers, government people and professionals to come in and take their medications.” (#6)

Many PHAs cannot afford the costs of rent, food and other basic necessities that are essential to survival and living positively. Many PHAs depend on family or friends for housing and to pay the costs of basic necessities and medical care (Lanièce et al. 2002a). Transfer payments from family members working outside of the country constituted an important source of revenue for 40% of the patients who were interviewed in the ISAARV pilot project (Lanièce et al. 2002b: 47). Living with HIV/AIDS in Senegal tends to impoverish individuals and families, whose costs for treatment and nutrition increase over time, as their incomes diminish (CNLS 2006a; Diouf 1999; Niang and Van Ufford 2002; Sow and Desclaux 2002).

“Many seropositive people have already lost their jobs partly because they waited too long to get tested and they were too sick to work. Some were afraid their employer would find out and if they did, they would be let go from their jobs. Some of these people did not know that their company might assist them with care and support... Most seropositive people are poor and getting poorer. The family and the community need to do more to support and help them.” (#14)

“In the beginning with ARV therapies, even at a reduced cost, few PHAs could afford them – only those who had insurance or good jobs could. The strategy was to get a third person who could pay for the PHA in question but even that proved difficult. The impact of HIV and the cost of treatment on the family serve to deplete their economic resources and impoverish it.” (#4)

However, there are gender differences in the economic situations of men and women living with HIV/AIDS, as the majority of respondents (20/25) pointed out. Gender inequality interacts with poverty in the context of underdevelopment to differentially shape the social and material circumstances of seropositive women and men. Women living with HIV/AIDS are more likely to be poor, financially dependent on their spouses or families and have fewer economic resources and fewer options for income-generating activities than male PHAs. As a consequence, the majority of seropositive women are less likely to be able to pay for treatment, medicines, medical consultations, rent, food, clothing and other basic

necessities, as almost all the respondents (22/25) asserted. Their observations are borne out by the Senegalese ISAARV study which showed that HIV positive women were generally poorer than HIV positive men, in part because they were generally less educated and three times more likely to be unemployed or underemployed (Lanièce et al. 2002a: 33-36).

“The situation of women with HIV is completely different from men. Women are financially dependent on men and don’t have the financial means to purchase their medications...For women, there is not enough support, particularly financial support and income-generating activities.” (#2)

“Women’s economic situation. Women have less access to money and other kinds of resources. Seropositive women have certain needs for care and nutrition. If she has little money, she can’t meet these needs...Women-headed households, wives, widows with children. They are particularly vulnerable. They are alone with no supports whether they are heads of household or where there is a male head of household who doesn’t really participate in supporting the family or his contribution is limited.” (#18)

“What we have seen is that the majority of HIV positive women are financially dependent on their husbands or their parents. Their medical ‘*prise en charge*’ is more difficult because most of these women have no sources of income.” (#3)

The economic situation of the majority of female PHAs in urban areas reflects the economic situation of women in Senegal in general. Women are less educated, more likely to be illiterate, less economically active, concentrated in less lucrative gender-specific economic activities and have much lower revenues as compared to men (UNDP 2005), reflecting the patterns of male dominance and gender inequalities in the economy. Women’s limited access to credit and loans to develop their own income-generating activities and businesses is accentuated in the context of HIV as some financial institutions will not loan money to HIV positive women (#7). Some seropositive women are reluctant to borrow money as they fear they may not be able to it back and what few valuables they have will be seized as loan re-payment (#26). Although little is known about seropositive women in rural

areas of Senegal, as this has not been a focus of research, one can only assume that the situation is even more difficult for them, as poverty is higher in rural areas (Diagne 2002). Living with HIV/AIDS reproduces and accentuates gender inequality and the financial difficulties that seropositive women face.

“Problems of gender inequality. Women have fewer resources, less access to information, to education and less money than men. Women have less money than men to pay for the costs of the disease. They have more difficulties.” (#19)

Seropositive women’s financial dependence on men or their families is a consequence of unequal gender relations in the family and in marriage, bolstered by gendered cultural and religious norms, premised on patterns of male dominance and female subordination that severely limit women’s economic opportunities and options. It is a common practice in urban areas that once many economically active women marry, they withdraw from the work world for lengthy periods of time to become full-time housewives and mothers, often becoming economically active later on in life (Adjamagbo and Antoine 2004; Adjamagbo et al. 2002). Their withdrawal from economic activity during the prime of their lives puts them at a severe disadvantage, having to settle for less lucrative economic activities. This situation is accentuated in the case of seropositive women and its consequences are more devastating, particularly when they have no choice but to assume the role of principal bread-winner in families living with HIV/AIDS.

However, not all seropositive women are stay-at-home wives and mothers. The DHS IV data showed that women who were working at the time of the study had a higher HIV prevalence rate at 1.4% as compared to the HIV prevalence rate of 0.6% for women who were not working during this period (CRDH 2005b: 313-314). The HIV prevalence rate among working women was also double the national HIV prevalence rate of 0.7% (CRDH 2005a: 37). The higher rate of HIV among working women may be a consequence of gender discrimination in labour force participation and women’s incomes. HIV/AIDS negatively affects the career aspirations and employment opportunities of working women living with the

disease. Some seropositive women have been forced to leave their jobs because they were too ill to work or because of fear of stigma, leaving them more dependent on husbands and families (ICW 2005; UNIFEM 2001b). Some seropositive women enrolled in various types of professional training courses or other studies have been forced to drop out for lack of money, health reasons or fear of discrimination. In rural areas, seropositive women, particularly those engaged in agricultural labour, have no choice but to keep on working, given their essential roles in subsistence food production and for export, (Mbaye and Becker 2006; Tine and Sy 2003), even though it may compromise their health and well-being.

Although seropositive women as a whole are economically disadvantaged as compared to HIV positive men, social divisions among women based on marital status differentiate the material circumstances of seropositive women. Seropositive widows and divorcees as well as single women appear to be particularly disadvantaged, as several respondents pointed out. As is the case of single-parent female-headed families in Senegal (Adjamagbo et al. 2002; Bop 2003, 1996), seropositive female-headed, single-parent families living with HIV experience severe economic difficulties and have more needs, made worse by living with the illness. Many have HIV positive children for whom they are the sole support and as their needs grow, their economic situation deteriorates (#18).

“Widows and single women who are seropositive find themselves rejected, cast out of their families. They have real problems paying rent, paying for food and paying for clothing.” (#23)

“Women have more needs. Many are widows with children. They are the head of the household and responsible for supporting their children and paying for their children’s education...Nutritional support, we have more women coming here to feed themselves and their families for food baskets. They think first and foremost about their children and put them before themselves. Men seem to find a way to fulfil their needs...the number of women, widows, single-parent heads of households with children is increasing. We have more women coming here than men.” (#19)

“More women than men have a lot of problems. More women have problems paying for the costs of transportation, paying for prescriptions for herself and for her HIV infected children. Paying rent. Women who have lost their husbands are often alone with their children, isolated because and they have no money because they don’t share their status.”(#22)

Single parent female-headed families composed of widows or divorcees with children make up a growing segment of the women living with HIV/AIDS but they are not necessarily the head of the household (Desclaux et al. 2002; Gomes do Espirito Santo 2000; Sow 1999; Niang and Van Ufford 2002). Niang and Van Ufford’s (2002: 12) national study of the socio-economic impact of HIV/AIDS on children in Senegal revealed a higher proportion of seropositive widows (22.4%) as compared to seropositive widowers (0%) and a higher proportion of married seropositive men (75.8%) as opposed to married seropositive women (28.6%). Lanièce et al.’s (2002a: 33) analysis of the socio-demographic profile of the participants in the ISAARV pilot study also showed that 62% of HIV positive men were married as compared to 33% of HIV positive women, while 51% of HIV positive women were heads of monoparental families with children as compared to 15% of men. Seropositive widows are more likely to have HIV-infected children. As one research study showed, most HIV positive children live with a parent who has HIV/AIDS; 74% of HIV positive children have at least one parent who has died of AIDS; 59% have lost their father, 29% lost their mother and 12% both parents (CNLS 2005: 7). Moreover, a growing number of seropositive women are refusing to stay in marriages where their husbands had infected them and are initiating divorces, although there has been little research on this social phenomenon. As this respondent (#23) explained,

“When I found out in 1992 I was HIV positive, actually when I realized that it was my husband who infected me with HIV, I divorced him and I came home to my mother with my two children who were four and six years old. I even experienced discrimination from her. She didn’t want to see me when I had sores all over my body. She forbade my children to come near me and to touch me.”

The economic situation of seropositive widows with children is extremely precarious, as numerous respondents pointed out. Diouf's (1999: 12) study showed that the majority of seropositive widows had been economically dependent on their husbands (85.4%) and most had little education, no profession and no visible means of economic support. Although half of these women had started small-scale income generating activities, they did not generate sufficient revenue to provide economic independence for these women and their dependents. Many women were forced to sell household goods to pay for their families' needs nor were they assured an inheritance in the event of a husband's death.

“HIV positive women run the risk of having their inheritance expropriated or they just don't give it to you.” (#13)

Diouf's study showed that while the majority of husbands had left something to inherit, 32.9% of seropositive widows had not received their inheritance because in 20% of the cases, the issue had never been discussed and in 6.1% of cases, conflicts delayed the division of property (Diouf 1999: 14). In polygamous marriages 17.1% of women were dissatisfied with their share of the property division while in 8.5% of cases, the decision was overturned (Diouf 1999: 14). Desperation and destitution force some seropositive Senegalese widows to engage in high risk sexual relation for their own and their families' survival, putting themselves at risk for re-infection and putting their partners at risk for HIV (UNIFEM 2001).

Many seropositive sex workers who are single mothers with children are also forced to keep working in the sex trade to support themselves and their families (Renaud 1997). Income-generating activities aimed at assisting female sex workers to find alternate forms of income have proved inadequate as a substitute to sex work (Groupe thématique ONUSIDA/Sénégal 2001). As is the case with other seropositive women, “many seropositive sex workers also can't afford to pay the costs of eating well necessary for boosting their immune systems to ensure maximum effectiveness of antiretroviral drugs” (Soumare 2003: 57). Those who

cannot refuse their clients unprotected sex put themselves at risk for re-infection while putting their partners at risk for HIV.

5.2 HIV Positive Women and the Double Burden of Care

“Women have power in society. They are the social lions. They create links within the family and between families. It is women who create and maintain social relationships and solidarity that is central to HIV prevention and the care and support of PHAs” (#13)

The gender division of labour and social responsibilities in the Senegalese family assigns men and women distinct social roles. Men are the head of the family and the principal bread-winner and decision-maker. Women’s main social roles are as wives and mothers, responsible for reproductive labour that includes the physical reproduction of the family, domestic household tasks, the emotional support and nurturing of children and all family members, and maintaining family and social networks. A few respondents suggested that men and women living with HIV/AIDS have different preoccupations as a result of their distinct social roles.

“With respect to everyday life, seropositive men and women have different concern and pre-occupations. Seropositive men are more concerned with finding work. Women are concerned with family survival and children are a major pre-occupation. Most seropositive women have anywhere from one to five children and they don’t have an income.” (#10)

Although ideally men are responsible for paying for all the family’s needs such as housing, clothing, food, essential services and school fees, the reality is somewhat different. As a consequence of economic crisis, growing poverty, structural adjustment and liberalisation of the economy, men are increasingly less able to fulfill these obligations and Senegalese women are increasingly burdened with a greater share of family costs for food, clothing and children’s education (Sow and Bop 2004; Adjamagbo and Antoine 2004; Fall 2003; Bop 2003, 1996; Dial 2001; Locoh 1995). This situation is reproduced and accentuated with

HIV/AIDS, as many HIV positive women have to assume an increasing number of economic responsibilities in families living with HIV/AIDS as male heads of household may be too sick to work, in addition to their social and reproductive roles. This usually leads to a drop in disposable household income (UNAIDS 1998) and to increasing tensions in the couple, as some men view this as a threat to their paternal authority (#20). Despite having fewer economic options than seropositive men, Senegalese seropositive women are more often than not responsible for the economic support of children, many of whom are quite young, as half of the respondents (13/25) pointed out.

“Women are more pre-occupied with the family unit, even if both husband and wife are seropositive and poor. The woman is more concerned about ensuring adequate food and nutrition for the family and they fight hard to do this. They are also pre-occupied with taking care of their children, particularly if they are HIV positive. They are much more pre-occupied with this than men, to see that their children get schooling among other things.” (#6)

“Many seropositive women do not work and are dependent financially on their husbands. They have little autonomy. They often can’t afford medicines or transportation to and from the CTA. They are responsible for their children and often can’t afford school fees, even food. They are more likely to care for the financial needs of their children than is the case with men. Often when women find out they are seropositive, their first thought is who will care for my children or are my children infected with HIV. Men don’t usually ask these questions.” (#24)

In addition to taking on a greater share of the financial burdens in families living with HIV/AIDS, seropositive women are expected to fulfill their primary social roles as wives and mothers. As primary caregivers and nurturers in the family, this means that HIV positive women are responsible not only for caring for themselves, but also for their children, their husbands and their families (Jackson 2002; Ship and Norton 2000; Diallo 1999). As women are the foundation of the family, HIV positive women are responsible for the management of family crisis, in addition to her normal social obligations in the family.

“Caregiving is one of women’s roles in society. Women are expected to be caring and compassionate. The work of the mother - *Liggeye u*

ndeye le' - the success of the children is seen as a direct result of how their mother raised them. AIDS doesn't change this...Assuring the care and support of children in the case of death. This is a bigger problem for women - what is going to happen to their children, to their babies...

Seropositive women are also responsible for protecting the reputation of the family and keeping HIV status secret, in addition to fulfilling her other social responsibilities such as meeting social needs, taking part in ceremonies and visiting her mother.” (#1)

“HIV positive women are the primary caregivers in the family and provide the main support. She will take care of her husband who is HIV positive, even if he is the one who infected her and make sure he takes his meds. She will do what she has to, go wherever it is necessary to feed her family and to take care of the children. Women play a more active role in family survival.” (#33)

Seropositive women face difficulties in fulfilling their social roles. Increased responsibilities associated with the disease such as caring for infected family members leave less time for seropositive women to meet their social obligations. Depleting financial resources and/or failing health also contribute to this.

“HIV positive women have fewer resources. They are less able to play their social roles as women in society. They have more difficulty participating in tontines. They cannot go or afford to give money at baptisms. They may not be able to or can't afford to cook for her husband and in-laws. If the in-laws know that the wife is HIV positive, they won't let her cook. At the CTA, the HIV positive women prepare meals there. It makes them feel useful. Many seropositive women question their ability to fulfill or arrive at fulfilling the roles expected of them in the family and in the community.” (#13)

5.3 Seropositive Women's Health is not a Priority

“Most women caring for sick husbands or sick babies will have HIV themselves and their own health may be deteriorating as they are expected to look after everyone else” (Jackson 2002: 212). Niang and Van Ufford (2002) also noted that seropositive Senegalese women continue to assume all their domestic responsibilities in families living with HIV. As a consequence of women's social

roles in the family and in the couple, it is more difficult for HIV positive women to attend to their own health needs as they put their health needs last. Many HIV positive women must make difficult choices between paying for their own health needs and paying for basics for their families (Ship and Norton 2001). As Diouf's (1999: 14) study showed, seropositive widows who sold household belongings did so primarily to feed their children (24.4%) and only secondarily for their own health care needs (8.5%). As this respondent (#7) pointed out, seropositive women's social responsibilities as family caregivers have a "negative impact on their health and well-being"; a view also endorsed by this respondent (#13),

"HIV positive women take care of the children and the household. If her husband does not have enough money, then she cannot have a maid. This has a negative impact on her health because she has to do all the work...all the weight of the response to the management of the crisis is on her..." "Many women can't afford to pay for transportation to and from the hospital. If they have some money, they think first about using it to feed their children."

Married seropositive women are less likely to get support and care from their husbands and more likely to give care to HIV positive husbands and children. How much support they receive from other family members depends on whether they have disclosed their status or not. The lack of emotional, social and physical support increases stress and has a negative impact on the health of seropositive women. As these respondents observed,

"Women get less support, particularly in the couple and in the family. This is more emotionally difficult for women than it is for men. Men deal with the loss of family support better, partly because they are raised to be less emotionally connected." (#6)

"Women need support from other women, more so than men need support. The way women are and their need to communicate. Showing warmth and talking, this is more important for their well-being. Their HIV status is something they can't really share. They want to talk about it but they can't, particularly with other women. How do you deal with this in intimate relationships?" (#1)

Seropositive women are also more likely to be exposed to re-infection because of unequal gender relations. Despite the promotion of condom use and safe sex practices to reduce HIV transmission and re-infection in counselling and secondary prevention programs with HIV positive people (#9; #10), seropositive women face the same gender constraints as seronegative women around imposing or negotiating safe sex. They also lack the power to negotiate safe sex with their seropositive husbands or refuse them sexual relations. As one study revealed, men who participated in a HIV prevention workshop “told the facilitators that condoms are okay for using with other women but not for using with their wives” (Niang 1997: 18). As a consequence of men’s reluctance to use condoms with their wives, many married HIV positive women experience difficulty protecting themselves from re-infection.

“Sexuality is another problem. Many seropositive women who want to avoid re-infection have a difficult time imposing the use of condoms with their husbands. Seropositive husbands in many cases still don’t want to use a condom.” (#33)

“Sexuality, it is a shameful to talk about sexuality. In the context of HIV to avoid re-infection or new infection in a seropositive couple, many men still do not want to use condoms and it is men who make the decisions.” (#7)

“The issue of sexual practices and the idea that sexual relations should be natural. Using condoms is not part of our tradition. As the Ivorian proverb goes, ‘One never eats a banana with the skin on’ the passive role of women within the framework of marriage. According to religious rules, it is the duty of a wife to satisfy her husband. In this sense, rape in the context of marriage is not recognized as an issue.” (#4)

Sow’s (1998: 7) study of fifty-four HIV positive women who had been infected by their migrant husbands resorted to one of two strategies with respect to their sexual behaviour: either leaving the conjugal union or submitting to non-protected sexual relations. As this respondent (#13) observed,

“We need more research around HIV and decision-making in the couple, women’s status and negotiating condom use in couples living

with HIV/AIDS. When the husband refuses to use a condom, he is putting his wife at risk for infection and re-infection.”

The ideology of familialism embedded in Senegalese health services and in the broader society means that HIV positive women's health is rarely viewed as a priority in its own right (ICW 2005), but rather is considered in the context of their social roles as mothers, primarily around mother-to-child transmission of HIV. For example, recent Protocols developed in Senegal to address the nutritional needs of PHAs do not consider the specific nutritional needs of individual women, for whom anaemia is a bigger problem than for men and a problem for African women in general (#2). The DHS IV data suggested that 60% of Senegalese woman suffer from anaemia (CRDH 2005a: 26); a consequence of repeated pregnancies, prolonged breastfeeding, parasitic infections and cultural practices that assign the larger and most nutritious portions of meals to men (Sow and Bop 2004). Living with AIDS and lack of money compound this health problem. Where the nutritional needs of HIV positive women are considered, it is with respect to the needs of nursing mothers; as is the case in the *Guide de prise en charge ambulatoire des personnes vivant avec le VIH* (2004) and *Guide de prise en charge nutritionnelle des personnes vivant avec le VIH* (2005). Some respondents also suggested that some doctors need to be more attuned to the woman-specific gynaecological problems that affect HIV positive such as cervical cancer and the slow progression of sexually transmitted diseases that manifest themselves later in women (#2; #6). As Sow and Bop (2004) remind us, safe motherhood is only meaningful within the context of safe womanhood. Greater attention needs to be given to the overall health and well-being of seropositive women and women in general.

Moreover, “data from Africa indicate that men are more likely to be admitted to hospital than women and that family resources are more likely to be used and potentially depleted for medication and care for males rather than for female members of the household” (UNAIDS 1998: 6). This is a consequence of

women's gender subordination in the family and the social devaluation of women's social roles as caregivers and nurturers, as this respondent (#18) pointed out,

“Women's gender position in the family. Their health is often devalued. There is no equality. If in a family both the man and the woman are seropositive, we look to support and assist the man to get medical treatment first. Women's health is not taken seriously. Maternal mortality is a good example.”

5.4 Stigma and Discrimination: ‘It's not the Disease that Kills us but the Stigma’

Most people living with HIV/AIDS experience stigma and discrimination on the basis of their HIV status, as well as live in fear of being stigmatized and its discriminatory consequences (actual or potential) (Jackson 2002). A social construction of deviation from some socio-cultural ideal or norm, “stigma is a powerfully discrediting and tainting social label that radically changes the way individuals view themselves and how they are viewed by others, with profound social consequences” (WHO 2003c: 9). Discrimination is a consequence of stigma, transforming gender, class, racial, sexual orientation and other social divisions into concrete social inequalities (Marlink and Kotin 2004). Studies from Sub-Saharan Africa have suggested that “AIDS stigma is linked to people's sense of sexual morality and their fear of breaking taboos (WHO 2003c: 9). HIV/AIDS stigma is also “linked to broader, existing inequalities evident in society and in societies' often negative view of expressions of sexuality” (Tallis 2002: 13). This is also the case in Senegal, as these respondents explained.

“The stigma, it is a shame for all PHAs. What is clear is that once you announce your seropositive status publicly, you lose your status in the eye of everyone. This viewed as a malediction from God – punishment for sexual promiscuity and people don't want to be seen as promiscuous” (#9)

“The image people have of AIDS is that AIDS equals Death. Even today, people still think if you look healthy and you look well, then,

you can't have AIDS. This goes back to the AIDS messages and part of it is the weight of religion. The negative perception of AIDS, it is seen as a consequence of deviant practices, promiscuity, homosexuality.” (#10).

“I think that in Senegal seropositive status is linked to prostitution. Female PHAs are more often than not perceived as prostitutes. Many of these women have a hard time getting acknowledged in society, much less participating fully. AIDS is linked to prostitution. Seropositive men – it is viewed as normal if men seek out prostitutes. This is a paradox of Muslim society.” (#16)

PHAs in Senegal face pervasive social stigma and discrimination in the family, the society, the community, the work place and in health services that complicate their ability to live positively and constitute infringements on their human rights (Atchadé and Spencer 2003; Synergie 2003: 10-13), although this remains an under-studied aspect of AIDS research in Senegal. Stigma and discrimination around HIV/AIDS continue to be obstacles that negatively affect the health, well-being, social and material situations of the majority of PHAs in Senegal (CNLS 2006). Stigma around HIV/AIDS takes many forms in Senegal.

“It can be physical. In the street people point at you or threaten you. In the family people have been attacked and thrown out of the house. Verbally, people are hurtful. They use proverbs to judge you negatively. People won't touch your things. They isolate you and they won't allow you to eat with the family.” (#14)

“When I informed the owner of the house where I was living that I am seropositive. The owner had me leave the house for fear that I would infect it with HIV...At Hôpital Principale, a pregnant seropositive woman was ready to give birth but when the mid-wife found out she was seropositive, she just left the patient. It was the doctor (gynaecologist) who intervened and provided care to the patient.” (#9)

“After I did a testimonial on the radio, I had to leave my village and take refuge outside of Dakar. People recognized my voice. I have also been the object of ‘cinema’ – people come and stare at me because they want to see what a seropositive person looks like...The stigma comes from people close to us, some of whom we work with, some people who do awareness work, sometimes they are the first people to stigmatize us.” (#10)

Living with HIV/AIDS carries a negative image of PHAs and most try to remain anonymous and invisible, which also has a negative impact on their health. Many PHAs, if not most, live in secrecy and hide their serostatus from family, friends, neighbours and colleagues. Many HIV positive people do not inform their families of their serostatus for fear of stigma and discrimination or for bringing shame on the family's good name. Renaud's (1997) indicated that many seropositive female prostitutes in Kaolack did not disclose their HIV status to their families for fear of bringing shame on them. As this respondent (#10) re-iterated,

“There is still a lot of misperception and lack of accurate information about HIV/AIDS. People see it as dishonouring the family and a danger.”

PHAs are not always well treated in their families as a result of fear and stigma and a lack of knowledge as to how HIV is transmitted, as these respondents pointed out,

“Basically, we all live the same realities. PHAs living with the family, they isolate you. You don't eat with the rest of the family. Sometimes they put up a barrier in front of your room to keep you closed off to not contaminate the rest of the family. Everyone actually tries to keep their status a secret, especially those who live in villages, for fear of being stigmatized. Stigmatization and discrimination towards people living with HIV/AIDS...When the family finds out, they will make you leave the house. Even if you are there with your things, you will still feel ill at ease. At work, you will be fired without any compensation. People are afraid that they will be infected with HIV from a seropositive person. It is because they are ignorant and they don't have all the information. They think it is like TB or meningitis” (#23)

“A seropositive colleague who was sharing a house with his brother was told that there were certain parts of the house he was not allowed to enter. The brother was afraid he would infect the whole house.” (#9)

Living with HIV/AIDS and the stigma associated with it exacerbates social isolation and negatively affects mental health of PHAs.

“Stigma begins with the fears of the seropositive person. How does the other see us? How does the other judge me? Treat me? We are in a

world where we live in society. Individualism does not have a place in Senegalese society. We live through our social relationships. There is just not enough research on the perceptions of PHAs.” (#3)

“Fear that the family knows that one is seropositive, fear of rejection and stigma. This makes it more difficult for seropositive people to accept their own serostatus. Many people when they test positive for HIV in Senegal, their first thought is what will my family think, and if they know what will be the consequences. Sharing this information, divulging their serostatus is important for living positively - the fear of being rejected.” (#14)

“AIDS, the level of stigma is still very pronounced. It is still taboo among the general population. People don’t want to be identified openly as seropositive. Only Ismaila Goudiaby, he is the only HIV positive person who does testimonials without covering his face.” (#8)

The DHS IV study provided some evidence of the pervasive and deeply ingrained negative social perceptions and social attitudes towards PHAs within Senegalese society, using four different criteria: readiness to take care of a PHA, willingness to buy vegetables from an HIV positive vendor, allowing an HIV positive teacher to continue teaching and the necessity of keeping a positive serostatus secret (CRDH 2005b). On all four indicators, men expressed more tolerant attitudes as compared to women, although women who were better-educated, wealthier and living in urban areas were generally more tolerant (CRDH 2005b: 276). The study concluded that tolerance of PHAs in Senegal is very weak overall, with only 4% of women and 9% of men expressing an overall attitude of tolerance towards PHAs (CRDH 2005b: 275). The idea of buying vegetables from an HIV positive vendor received the least support from both men (36.1%) and women (26.4%), suggesting that many people are still not that knowledgeable about how HIV is transmitted, despite well-developed HIV education programs.

The gender differences emerging from this study are also an indicator of the gender inequalities in access to accurate HIV education and information that work to the detriment of women, particularly in rural areas. Moreover, this resulted indicate that the stigma around AIDS is probably more severe for PHAs in rural

areas; also a function of the rural-urban inequalities in access to HIV/AIDS information, education and services. These results also highlight weaknesses in the community-based strategy in addressing stigma and discrimination around HIV/AIDS. As these respondents observed,

“We still have much to do to de-stigmatize HIV/AIDS and to get people to accept that it is not a death sentence or ‘*une maladie condamnable*’.” (#2)

“There is still a lot of stigma and discrimination and the work in this area has been weak because to combat them, it requires that government policy involve PHAs to a much greater extent in articulating these messages. How can seropositive people speak to the community to make it more aware and better informed about HIV/AIDS so that seropositive people can live positively and the community can live with seropositive people? All of the organizations and NGOs in synergy need to get involved and contribute more effectively to combat stigmatization and discrimination. The more we stigmatize PHAs, the more people refuse to get tested. The more PHAs refuse to come out into the open, the more it can cause significant harm and pose a threat to the community. It is important to better inform the community so that it can change its attitudes, its behaviour and its vision of PHAs.” (#9)

5.4.1 Double Discrimination as HIV Positive Women

Although all PHAs live in fear of stigma and discrimination around living with the disease, HIV positive women generally are more afraid of the potential consequences of stigma, rejection and discrimination and more likely to suffer their consequences (WHO/UNPFA 2006; WHO 2003c; Leroy 2004; Degrées du Loû 2001; Ship and Norton 2000; Schoepf 1997). At the heart of these issues are unequal gender relations that shape women’s subordinate economic and social circumstances and gender biases in dominant discourses around HIV/AIDS that lead to the blaming of women for the transmission of the disease.

Where HIV is viewed as a sign of sexual promiscuity and/or prostitution, women face more stigma and rejection than men (Commonwealth Secretariat and the Maritime Centre for Excellence in Women's Health 2001; UNAIDS 1998). This appears to be the case in Senegal. HIV positive women appear to be judged more harshly than men in Senegal, as the majority of the respondents (15/25) suggested HIV positive women tend to be seen as morally and sexually loose women, as prostitutes or as adulterers. Gender bias and a double standard inform the gender-specific stigma that HIV positive women experience in Senegal, buttressed by cultural and religious norms.

“Globally, generally all PHAs are victims of stigma and discriminated against but women more so because of the link with prostitution. With respect to their social situations, tolerance shown to male PHAs and female PHAs is different. An infected man is not well seen but with respect to seropositive women, we immediately think about prostitution. This image is extremely pejorative in a country where HIV prevalence is low and people are religious. Stigma is a real problem in Africa but it is lessening. Women are more likely to feel the impact of HIV and stigma.” (#20)

“Stigma around sexuality gets reproduced in the case of seropositive women. Your perception of seropositive women, the first thing you look at is sexuality, her sexuality. She must have been a prostitute or promiscuous. This is shameful for women who are judged more harshly in this respect than seropositive men – multiple sex partners, promiscuity... The discrimination that seropositive women face has to do with religion and beliefs about the place accorded to women and the control of women. A certain subordination of women and their lack of power with respect to decision-making and their roles and place in the family and the society. Inequalities reproduce themselves within the AIDS disease and are reproduced by them such as the stigmatization of women.” (#17)

“Generally both male and female PHAs have to deal with discrimination and stigma. Women are more stigmatized as a result of getting HIV. It is often seen as a punishment from God because she wasn't faithful to her husband. Men can pretty much do anything and it is tolerated more so than in the case of women, even though we also stigmatize men. (#19)

“Seropositive women are more harshly judged than seropositive men. As Senegalese men we are a paradox. We want women who are virgins but who also have sexual experience.” (#4)

Although HIV positive women are generally judged more severely than seropositive men, seropositive female sex workers are judged the harshest. Social distinctions are made on the basis of women’s marital status and how they got infected. Married women who contracted HIV from their husbands are more likely to be viewed as ‘innocent victims’ (Diallo 1999: 248), implying that seropositive female sex workers and/or sexually active single women are neither innocent nor victims but somehow deserve their fate for transgressing cultural and religious norms around sexuality. Female prostitutes face triple discrimination: as women, as sex workers and as HIV positive. As this respondent (#4) pointed out,

“Seropositive women. If it is a widow, despite her socially devalored status, what she has to say is taken more seriously. It resonates because she is seen as a victim in accomplishing her duty as a wife and a widow. But young single girls, they are not taken seriously because they are more often than not seen as having contracted the disease from promiscuous sexual behaviour.”

Some respondents (5/25) suggested that women are more likely to be blamed as the source of HIV infection in a sero-concordant couple/family, even where it has been established that men were the source of infection. Niang’s (1997: 18) research in Kolda and Tambacounda gives some credence to this observation as he reported that men participating in a discussion group around HIV transmission blamed women for HIV/AIDS transmission arguing that women can’t resist sex, conjuring up images of women’s sexual promiscuity. Blaming women for HIV transmission is also in part the consequence of gender inequality and women’s secondary social status in Senegal, as these respondents pointed out,

“Seropositive women also face more stigma and discrimination... Women’s status makes their lives more difficult, added to this, their seropositive status.” (#19)

“The reason for the increase of HIV among pregnant women in certain regions of the country and their vulnerability is the status of women

and gender relations – married women infected by their husbands. They are afraid to disclose because they will be blamed as the source of infection, as responsible. This raises the broader issue of why married women are vulnerable.” (#5)

5.4.2 Disclosure of HIV Status: Gendered Consequences

Stigma and discrimination around HIV/AIDS have profound consequences around disclosure of serostatus for both HIV positive men and women. However, the gender-differentiated impact around the disclosure of one’s HIV status is more keenly felt by women and is related to women’s subordination and gender bias.

Abandonment and Rejection

The consequences of divulging one’s status are more severe for seropositive women. A woman disclosing her HIV status may be put at risk of abandonment and violence, as some studies in the US, Kenya and Tanzania have shown (WHO 2003). Just as women are more vulnerable to various kinds of violence, domestic and conjugal, it is likely that they are more vulnerable to violence following disclosure of serostatus. Although there is little research around this in the context of Senegal, this respondent (#1) suggested,

“Violence against women is also a problem in the context of partner notification of serostatus. Women are victims of many kinds of violence – physical, psychological and verbal. This is a problem in Senegal.”

HIV positive women are more likely to be abandoned with their children and with no financial resources, as some respondents pointed out. This is perhaps less pronounced in Senegal as opposed to other African countries, as one study in Senegal found (Niang and Van Ufford 2002).

“Women are more vulnerable to being blamed as the source – women are viewed as the vessel and the carrier of the disease. Although it doesn’t happen as much in Senegal as in other African countries but

women can be blamed and thrown out by their husbands and not taken in by the family...Widows, divorcees and women who have been abandoned, they need financial and material support to survive. This goes back to pre-infection and the situation of divorced and widowed women. We need to examine how we protect them.” (#1)

“Women are more vulnerable to being abandoned, rejected or repudiated and thrown out into the street. They are chased out of the family. They are divorced – even when they have the courage to announce their seropositive status. Divorce in the Muslim way only requires a man to say, ‘I divorce you’ in front of a witness three times.” (#13)

Men and women also internalize prevailing ideologies of appropriate gender-defined sexual behaviour that shapes how they view stigma. It is linked to prevailing forms of gender bias and their subordinate social and economic situations. As this respondent (#9) observed,

“Women tend to self-stigmatize more than men. They are more likely to hide, to escape and to avoid situations where they might face rejection. They are more likely to be rejected and this is more difficult because they are more likely to be in a situation of economic dependence.”

This appears to be particularly true for young single girls rather than married women who often view themselves as victims of injustice and some use this as a way of increasing their power in the couple. (Sow 2003). Sow’s (2003: 74) research showed that that young unmarried girls living with HIV were more likely to blame themselves and view their HIV status as a punishment for transgressing sexual norms whose ultimate end is ‘social death’ with no possibility of fulfilling their reproductive function while young single men were more likely to view their serostatus as a matter of chance or a sign of their virility.

“What AIDS does to one’s self-image. It is an important issue for men but it is even more important for women in such as coquettish society. ‘*Bien dans ma tête, bien dans ma peau.*’ HIV positive women feel dirty, ugly and unattractive. It destroys their persona as women. It is a discriminatory thing. If you are an HIV positive woman, you are a whore. If you are an HIV positive man, you are a ‘*guerrier.*’ ” (#1)

Loss of Social Status and Power

Stigma and discrimination around HIV/AIDS also results in a loss of power and social status for PHAs, as living with the disease socially devalues them in the eyes of the family, the community and the society. This is accentuated in situations where PHAs are unable to care for themselves and are dependent upon the family to provide for all their social, financial and health needs (Sow and Desclaux 2002).

HIV positive women are more likely than men to be dependent on their families for economic support that serves to increase their dependency and their submission. The loss of social status and power may be more devastating for women, as women's social status and decision-making power is weaker than that of men in the family, the society, the economy and the polity. Seropositive women may lose social status and power within the family and within the society, as a result of disclosing her HIV status.

“When a woman's seropositive status is divulged, she faces difficulties in certain social situations: she can be excluded from decision-making or even in being present in ceremonies or events in the family. It is stigmatization. The perception is and often this is not the case that she became HIV positive because of ‘*vagabondage sexual*’.” (#6)

The Limits of Family Support

Moral and social judgements around how one contracted HIV/AIDS affects the support one can expect from the family, as Sow and Desclaux (2002: 86) suggest,

Patients who are considered by their families to have been contaminated as a result of behaviour which transgressed moral rules find support less easily than those who are seen as innocent, as victims. Married women, whose husbands were suspected of being the source of their infection, generally have the status of victim which allows them to benefit from family solidarity.

However, not all married HIV positive women, particularly seropositive widows, benefit from family solidarity, particularly the husband's family. Diouf's

study of 82 widows (70 of whom were HIV positive, over half of whom had between two and four children) (1999: 11) revealed that 70.7% of them were forced to leave their in-laws house upon the death of their husbands, as a result of conflict, although she did not elaborate on the nature of the conflicts (1999: 13). Although it may be that, as this respondent (#33) observed,

“Many seropositive women live with their in-laws. These women risk being *répudiée*. They are often accused of being the source of HIV infection... that it was the woman who infected the husband.”

Many seropositive widows are forced to live with their deceased husbands' family and are often victims of discrimination, ignorance of the disease and mistreatment. The impact on them and their children can be quite negative.

“Acceptance is a problem - stigma. The community does not accept HIV-positive women. These women are more often than not rejected by the community; more so than men. 80% of our members are widows, living with their husband's family who tend to accuse them of being *le porte-malheur*. The women who have the financial means are usually obligated to leave the house of the husband's family to rent a room somewhere, leaving them isolated and lacking family support. Those women who cannot afford to leave and have no choice but to remain with the husband's family this usually impacts negatively on them. They don't eat well. They are given small portions of food and have to eat by themselves. People don't want to touch their belongings and are often verbally nasty to them.” (#23)

HIV Positive Women's Need for Secrecy: Protecting Themselves, Their Children and Their Families

Keeping serostatus secret is in part cultural and a function of the Wolof concept of *'sutura'*, as this respondent (#3) explained,

“Even if an action is condemned, judged as negative, we look to hide and to protect the person. It is the Wolof concept of *'sutura'*. It is linked to avoiding or preventing stigma.”

Both men and women endorse the idea of the need to keep one's HIV status secret, as the DHS IV data showed. Women (68%) were more likely than men

(59.7%) to endorse the view that HIV positive people should keep their status secret (CRDH 2005b: 273-276). Gender differences indicate that women are more sensitive to the idea of '*sutura*.' They are responsible for protecting their families and more likely to suffer the consequences of discrimination.

Although all seropositive people in Senegal have needs for secrecy, HIV positive women appear to have greater needs for secrecy and confidentiality than seropositive men because they are more harshly stigmatized and face more discrimination, as several respondents indicated. No seropositive woman to date has publicly disclosed her serostatus unveiled.

“Women are more stigmatized. They are afraid to publicly announce that they are seropositive. A seropositive woman will not do a testimonial with her face uncovered people judge her more severely they start asking questions about how she got the disease. Did she not get the disease because she was a prostitute or an adulterer? When, in fact, most of these women were infected by their husbands. It is the opposite for men. No one asks them how they got the disease. They can go on radio or television and publicly say that they are HIV positive like Ismaila Goudiaby does. No one asks him how he got the disease. Seropositive status is more stigmatizing for women.” (#7)

“You are seen as a carrier of the virus. Everyone avoids you – friends, girlfriends, male friends and neighbours. I wear a small veil to cover my face when I appear on television.” (#23)

In addition to shielding themselves from public scrutiny and moral condemnation, seropositive women in their social roles as mothers and as wives are responsible for protecting their children and their families from discrimination and stigma from the extended family, the school and from the community (Ship and Norton 2000). If a seropositive woman's status is disclosed, it is more likely to have negative consequences for her children, as this respondent (#4) pointed out

“The testimonials of PHAs who make personal appearances, who show their face, including seropositive women, although it is harder for them. It is harder for seropositive women – there is greater stigma attached to them. Generally discussing sexuality openly disturbs people. But also, looking at Senegalese men and their sexual identity.

Children suffer more if you say that their mother is a whore than if you say their father is a hot rabbit. The child has to react to an insult about his mother. The stigma of HIV is worse for women. At the root is the basic education of men, of Senegalese men. The economic roles of Senegalese women are very limited but her social responsibilities are very heavy in the couple, in the family and in the society. As we say, the Wolof proverb, the future of the child is in close relationship with the qualities of the mother. Women are condemned more quickly.”

“Seropositive women expend more energy to keep their seropositive status hidden. They are well dressed and well groomed so that no one will know. She has to fight for this, to keep confidentiality and keep up appearances.” (#33)

Regarding HIV positive children, seropositive women will be doubly stigmatized, as the child’s abnormalities are attributed to her behaviour (Ninag 1997: 22). The need to protect seropositive children from stigma and discrimination in the school and in the community is even more pressing for seropositive mothers. Despite the limited research on HIV stigma and discrimination around this issue, there is some evidence to suggest that that is a problem. Van Ufford and Niang’s (2002: 22) study showed that at least one-third of the children in their study had been rejected by friends because of their HIV status. They found no evidence of discrimination in schools, mostly because parents had not disclosed either the child’s or the family’s serostatus. Keeping secrecy adds to the stress that seropositive women experience and reinforces their social and emotional isolation.

Less Able to Keep Secrecy

Seropositive women face specific gender-based challenges that relate to and complicate their ability to fulfill their social roles as mothers and as wives. Despite women’s needs for secrecy and confidentiality, they are less able to keep their positive serostatus a secret because of their subordinate status, lack of financial resources, greater economic dependence and issues related to reproductive choice, marriage and sexuality. Men are less likely to reveal their HIV status to their female partners because of their social and economic dominance in Senegalese society, in

gender relations in the couple and the family, putting their seronegative wives and partners at risk for contracting HIV.

“Men are less likely to divulge their HIV status than women. We have to get them to tell their partners. Women generally divulge their status faster, that they are seropositive because they are *soumises* and they don't have a choice. Men have the means to keep their status a secret longer.” (#24)

“It is more difficult to get men to divulge their seropositive status to their female partner. They don't want to accept the blame. It can take three to four months to get men to tell their wives that they are HIV positive. What seems to work is if we tell HIV positive men that if their wife is pregnant, she can contaminate the child with HIV. Men don't want to infect their children. They want to protect their children more than their wives.” (#2)

Marriage

Marriage is essential to women's social recognition as women in Senegal (Sow and Bop 2004; Diouf 1999). Widowhood for women represents a loss of social status and economic resources. The social and family pressure to re-marry can be intense, as this respondent (#23) pointed out,

“Remaining a widow without remarrying. What this means is people will say you are an adulterer, particularly if you are a young woman and you will not be accorded the social recognition from people. You will not be able to speak in community meetings and people will not take you seriously...

The family wanted me to remarry with my late husband's older brother but I refused. I did not want to. His family abandoned me with six children. They did it to put pressure on me, hoping I would give in. I never did. I did what I had to. I sold peanuts by the side of the road, sold ice, used to go to the Casamance to get fish and palm oil to resell in Dakar, sold crafts to feed my children and pay for their studies.”

As all women, HIV positive widows and single women are under social pressure to marry and marriage is often a way out of their financial difficulties (Diouf 1999). However, only five of the widows in Diouf's (1999: 15) study remarried for purposes of resolving their financial difficulties and finding a father for

their children. Although the widows who did not remarry desired to do so, fear of infecting a partner (36.6%) and desire to hide their HIV status (26.8%) prevented them from so doing (Diouf 1999: 15).

Gender subordination of women and the stigma around HIV/AIDS makes marriage more challenging for seropositive women, limiting their opportunities. Many have kept their seropositive status a secret from their families and as a result, when seropositive women have prospective suitors, the family often does not understand the seropositive woman's refusal to consider the marriage proposal. They are caught in the dilemma: of responsibility to divulge their HIV status to a prospective husband and at the same time, the desire to keep their status a secret. The problem is particularly acute for young widows.

“The problem of young female seropositive women who wish to remarry, their despair. They are afraid to share the information about their seropositive status to their potential husband for fear that the man will refuse to marry them. Young, beautiful, healthy-looking women – the stigma of HIV, it is heartbreaking. It is a social issue not a medical issue.” (#2)

Widows are under greater pressure to remarry than is the case of HIV positive men. Seropositive widows have fewer choices and are less likely to remarry than is the case for seropositive men. Although all seropositive people face the same dilemmas around disclosure of serostatus to a prospective marriage partner, men are more likely to keep their serostatus a secret because their position of economic and social dominance affords them a greater margin for manoeuvre.

“Men, if they have the means (money), they can find non-seropositive women and remarry. Seropositive women are in a more difficult position. It is more difficult for them to remarry and their marriage choices are more limited. She must act responsibly and inform her potential husband. If her status is known, the likelihood of marriage is, he won't want her. Actually, more and more seropositive people are remarrying among themselves.” (#7)

“There is a need for nuance and caution with respect to generalizing but there is less pressure on men to remarry than is the case for women. It may not be the case across the board but we are more

tolerant and patient with men with respect to remarriage. In the case of a widower with children, he will be told you need to find a mother for your children. In the case of a widow with children, she will be told you need to find a father for your children and a husband to not be exposed to temptation outside of marriage.” (#4)

Reproductive Choice: Pregnancy and Breast-Feeding

Pregnancy is, above and beyond the simple desire to have children, a moral, religious and social obligation and women are expected to fulfill their reproductive function within the context of marriage in Senegal (Sow and Bop 2004: 20). Bearing children socially largely defines women’s ‘femininity’ and is the primary source of women’s power in the private sphere of the family, which is controlled by men, whether as fathers or uncles of paternal or maternal lineages (Sow and Bop 2004: 21). Women who are sterile or have difficulties conceiving are marginalized and usually blamed in situations where couples cannot conceive. Not having children for married seropositive women signifies a loss of social status and power.

“The desire for children among women is very strong. This is normal and a goal of marriage. If she is not pregnant, then she is stigmatized. For men, they don’t want to live a useless life without children – the deep desire to live through another who resembles you. Nobody would dare renounce the continuation of his family. Rural women who can’t have or don’t have children are seen as useless. Children are especially important as a source of labour, particularly girls, although the preference is for boys. This is beginning to change in urban areas but there are still male intellectuals who think this way. When women have difficulty getting pregnant, they will do whatever they have to in order to have children including going to traditional healers. For some people, its God’s will that these women are sick” (#22)

“Pregnancy is a real problem for seropositive women who want to have children and this is specific to women whose main social role is being a mother. Do I want to get pregnant and run the risk of infecting my child? Most doctors counsel HIV positive women not to have children and it is a real problem for women.” (#7)

Prior to the availability of ARVs in Senegal, HIV positive women were counselled to not have children in order to avoid the risk of transmitting the virus to their babies, as a few respondents pointed out. Now, however, the problem of having children in sero-discordant couples is the most acute.

“Before the accessibility to ARVs, HIV positive women and parents were encouraged not to have children and not to get pregnant because there was no PTME program. With sero-concordant couples, we can now allow them to have children because the ARVs are available. There is a whole process and protocols which are in place now.” (#22)

“When the couple is sero-discordant, the man is HIV positive and the woman is not. This is a real problem for the woman that is difficult to resolve, given the importance of marriage and children.” (#24)

The seronegative wife runs the risk of becoming infected with HIV in order to get pregnant or she runs the risk of being socially marginalized if she does not have children. This situation is particularly difficult for newly married young wives who have no children. Moreover, pregnancy brings with it increased costs that weigh heavily on the financial resources of families living with AIDS.

“The care and support pregnant seropositive women, particularly around the issues of breast-feeding, the cost and accessibility of powdered milk, providing nutritious foods for their children and paediatric medications for infected children.” (#20)

Transmission of HIV through breast milk can occur at any time during lactation, although the risk appears to be greatest during the first months of infant life and persists as long as breastfeeding continues, complicated by a number of clinical factors (WHO 2003). In developed countries, replacement feeding has been integrated with few problems into interventions to reduce mother-to-child transmission of HIV. However in developing countries, the issues are more complex, illustrating how north-south inequalities put HIV positive women and their children at higher risk of HIV. Exclusive breastfeeding is advocated as best “for infants during the first six months of life and helps to protect the mother against pregnancy and replacement feeding carries an increased risk of infant

morbidity and mortality associated with malnutrition and infections other than HIV” (WHO 2003: 14). Most seropositive women cannot afford to purchase infant formula and do not have access to safe water. Also, cultural norms demand that women breast-feed. Not breastfeeding presents a very public display of women’s HIV status in societies where breastfeeding is the norm. Seropositive Senegalese mothers are faced with these dilemmas, as these respondents pointed out.

“Breastfeeding is another real problem for seropositive women. Doctors tend to counsel seropositive pregnant women not to breastfeed – you don’t want to transmit the virus to your unborn child. But women who don’t breast-feed, people stigmatize them. This is seen as not acceptable. This also relates to confidentiality and keeping serostatus secret. It is a difficult decision and it becomes harder for seropositive women to maintain the secrecy of their status.” (#7)

“Stigma around not breastfeeding. Some women breast-feed because they are afraid someone will find out they are HIV positive...Artificial milk is not readily available and accessible for most nursing women. We cannot provide enough milk for them. We can only give them two containers of milk, twenty-five packages of powdered milk and women have to procure the rest by themselves.” (#26)

“We recommend artificial breast-feeding – the bottle. The problem is money. Many women can’t afford to buy milk. It is expensive. Then there is the problem of explaining this, of using the bottle, to family and friends. We counsel women to say that the doctor said not to breast-feed. That’s what we tell seropositive mothers. It usually works and people stop asking questions.” (#24)

While some women are open to and do use bottle feeding as Niang et al.’s (2003) research shows, as one respondent pointed out, “some seropositive women continue to breastfeed in order to hide their seropositivity.” (#26) Difficulties around replacement feeding; notably the lack of access to affordable formula and clean water, highlight how north-south and other structural inequalities undermine universal standards of care for seropositive women in Senegal and women’s rights to health, to safe motherhood and to safe womanhood.

5.5 Human Rights or Women's Rights: Supporting HIV Positive Women?

The preceding discussion has shown the links between HIV/AIDS related stigma, discrimination and the violation of PHAs' human rights. As Tallis (2002: 8) notes,

People living with HIV/AIDS and those affected by these epidemics are often unable to live a life of equality, dignity and freedom as their rights are often violated on the basis of their HIV status. This includes the right to privacy, confidentiality, access to acceptable healthcare, reproductive and sexual health services, employment, education, freedom of movement and the right to travel.

The links between stigma around HIV/AIDS, discrimination and the human rights of PHAs were first formulated by the international community in the London Declaration on AIDS Prevention and ratified in 1988 at the World Summit of Ministers of Health on Programmes for HIV Prevention (Marlink and Kotin 2004: 56), although Jonathan Mann, the first director of the WHO GPA, originally conceptualized this (Csete 2007; Siplon 2005). Since then, declarations from the WHO and the UN reiterated this position, re-framing HIV/AIDS within a human rights framework away from discourses of blame, fear, and victimization (Tallis 2002; Mann and Tarantola 1996; Hamblin and Reid 1991). Despite the longstanding view of AIDS as a human rights issue, "progress towards ensuring the rights of PHAs has remained slow at the national level: In 2001, only 17% of the WHO's 191 member states reported specific legislation against HIV and AIDS-related discrimination" (Marlink and Kotin 2004: 56).

Ensuring the rights of PHAs comes under the domain of the state, as it is the central institution responsible for the welfare of its citizens, for developing and enforcing rights legislation as well as the signatory in ratification of international human rights legislation (Bop 2005). It is also the key institution guaranteeing the

rights of women. Despite the existence of a variety of initiatives and legislation to protect the rights of PHAs, as I will show, they do not adequately address the rights of seropositive women, illustrating the contradictory role of Senegalese state as a gendered hierarchy in reproducing gender inequality.

Senegal participated in the 2004 regional workshop for west and central African states hosted by Family Health International to assist them in developing legislation to protect the rights of PHAs, as this respondent (#9) told me,

“There is still no legal and ethical legislation around HIV/AIDS, protecting the rights of seropositive people. There was a conference in Chad in 2004; it was a regional conference for parliamentarians and legislators. Each representative was looking at how to introduce this legislation; a draft document was developed, into his or her home country.”

Although the Senegalese state has yet to implement comprehensive legislation to protect the rights and liberties of PHAs in Senegal (CNLS 2007c), there are indications that this legislation will not adequately address the gender-specific discrimination that seropositive women face or address their needs. The *Loi type relative à la prévention, la prise en charge et le contrôle du VIH/SIDA*, which serves as the model legislation, integrates rights around prevention and treatment, and is based on several international human rights charters and declarations including CEDAW, the Convention for the Elimination of all Forms of Discrimination against Women. Interestingly enough, it does not mention the 2002 Barcelona Bill of Rights on Women and HIV/AIDS that was spearheaded by the International Community of Women Living with HIV/AIDS, along with other women's groups, that outlines a broad set of fundamental rights that address gender inequalities. The *Loi Type* outlines the multiple rights of PHAs around confidentiality, notification of HIV status, voluntary testing, access to the range of medical and non-medical services and supports, access to insurance and credit, employment, housing and education as well as the right to live with respect and with dignity, free of stigma and discrimination.

It asserts in its introduction that women in Sub-Saharan Africa are more heavily infected than men and acknowledges that women in particular experience multiple forms of marginalization based on cultural norms, poverty, in access to formal education and in paid employment (AWARE-HIV/AIDS 2004: 1). Although it mentions women's marginalized status and the need for governments to recognize women's vulnerability and take action to address their specific needs (AWARE-HIV/AIDS 2003: 2), it does not, in fact, identify gender inequalities that seropositive women face in access to information and services or in women's capacity to negotiate safe sex. There are no measures to address seropositive women's preponderant role in the care and support of families living with HIV. In the section on HIV/AIDS education and information, it does not insist that prevention education also address gender inequality in the spread of HIV or call for women's groups and women's national machineries to be a part of developing HIV education materials for the school system. There are no special provisions to protect women around issues of partner notification, although the *Loi type* addresses the issue of partner notification.

“The legal gaps or loopholes are a problem. There is no law around the issue of partner notification. As a doctor, I cannot divulge a patient's seropositive status to his female partner. There are limits to medical confidentiality around partner notification. It is an ethical dilemma when a doctor can not inform a partner of the serostatus, placing women at risk.” (#2)

Striking a balance between doctor-patient confidentiality and partners' right to know and protect themselves from infection, the legislation proposes that after a period of six weeks if the PHA has not notified his or her spouse or partner of his or her serostatus, the medical professional may do so without compromising his ethical responsibility to confidentiality. However, the legislation does not address the issue of partner notification in the context of male-female relations outside of the scrutiny of the hospital/medical services setting nor the gender-specific

consequences of violence, abandonment or repudiation that seropositive women are more likely to face in disclosing their serostatus.

“At the level of the judicial system, there are no laws to protect women. There is a legal gap. There are too many cases of HIV positive men marrying women and not informing them of their seropositive status. These men infect their wives and there is no legal recourse at the moment, although we are working on it.” (#7)

Although the proposed legislation exhorts states to address the conditions that contribute to the spread of AIDS such as poverty, gender inequality, high-risk cultural practices and marginalization (AWARE-HIV/AIDS 2004: 2), it does not concretely address gender-based inequalities in inheritance rights, access to land, education and other forms of legal discrimination that women experience or identify the cultural practices that put women at risk for HIV. It does not in fact address the broader health, economic, social and political rights of PHAs in general such as access to safe drinking water, sanitation, food security and shelter that are essential to living positively. This model legislation illustrates two major deficiencies: a narrow conception of the human rights of PHAs and the occlusion of gender inequality that undermines the rights of female PHAs.

Although I was unable to obtain a copy of the Senegalese draft legislation, which was in the process of being drafted while I was conducting my research and scheduled to be implemented in December 2006, this respondent (#11) told me that there was little in the initial draft to address gender-specific rights violations that affect women.

“We had a meeting for a law that will be adopted in December of 2006, a meeting with parliamentarians about protecting vulnerable groups for the legislation around the rights of PHAs around issues of stigma and discrimination in the workplace, housing, etc. There is currently no legislation. We had to fight to get a gender component, to get special treatment for women but it was refused. It is not seen as integral to HIV/AIDS.”

To date, a two-day conference was held in June of 2006 attended by parliamentarians, the CNLS and civil society groups who drafted the proposed Senegalese legislation. It is still under study in the Ministry of Health, and it has as yet to be passed as law by the *Assemblée nationale*, although other participants of the regional workshop such as Benin, Guinea, Mali, Niger and Togo have already put legislation in place (Sow 2007).

Despite the absence of all-encompassing legislation to protect the rights of PHAs, other legislation and initiatives implemented by the state address some of these issues. I will address issues around women's access to medical and non-medical services in the following chapter. Issues such as partner notification, violence, sexual exploitation and access to treatment for sexually transmitted infections are addressed in the new reproductive health legislation passed in 2005. However, even here, the legislation does not adequately address gender inequalities that work to the detriment of women. The articles 10 through 13 that identify violence, sexual exploitation and rape as criminal offences (République du Sénégal 2005f: 5) fail to mention that rape or gender-based violence against women and girls is more common, much less acknowledge the links between violence, rape and male domination. Under the definition of rape in the Penal Code, which prohibits rape and makes it punishable by imprisonment (law no. 06-99), the victim of a rape can be either male or female, although the same law makes domestic violence (against women and girls) punishable by imprisonment and fines and outlaws female genital mutilation (Centre for Reproductive Law and Policy 2001: 17). However, rape in the context of marriage is not recognized.

Chapter 6 Articles 16 through 18 of the new reproductive health legislation attempts to address the issue of partner notification and the voluntary transmission of HIV through unprotected sex; that is a seropositive person knowingly engaging in unprotected sex with a seronegative partner. If sexual relations of this nature result in HIV infection, the guilty party can be imprisoned for up to two years and fined anywhere from 100,000 FCFA to 1 million FCFA whereas if it occurred in

the context of rape, the punishment is doubled (République du Sénégal 2005f: 6). A person who knowingly infects a child younger than thirteen, a pregnant woman, an elderly or disabled person will be liable to the maximum punishment (République du Sénégal 2005f: 6). While this legislation makes the voluntary transmission of HIV an offence, the protocol for taking these cases before the courts is not spelled out or how this will be enforced.

Although these provisions ostensibly protect both men and women, they do not adequately address gender inequalities that work to women's detriment. Women or girls who become pregnant within this context, potentially with an HIV positive child, have no recourse to abortion as it is illegal and are forced to bear the lifelong consequences. It offers little to married women who are expected to submit to their husband's demands for sex, who may be unable to negotiate safe sex and condom use and for whom rape in the context of marriage is not recognized. Whether seropositive women will use this legislation to bring their partners to justice remains to be seen, as many of these women stand to lose more than they will gain. As Jackson (2002: 366) points out, "Culture itself tends to follow far behind the legal and human rights framework." Some of these provisions serve to reinforce male dominance and enshrine male rights at the expense of women's rights and women's empowerment.

Initiatives to address discrimination of HIV positive workers have been implemented in the workplace in Senegal in some companies in the private sector of the formal economy, as these respondents pointed out,

"There has been some movement in the private sector. Some businesses have done AIDS awareness and provide some services to employees who are HIV positive but it is not wide spread. An employee won't lose his or her job because there is legal recourse for this type of discrimination" (#9)

"We do mediation in the workplace. We provide legal and juridical accompaniment in cases where HIV positive employees have lost their jobs because of their serostatus or where confidentiality was breached.

The view of AIDS in the workplace and in the business sector has changed somewhat with the Charter that was signed. Two key issues were around respecting confidentiality and getting involved in supports for employed PHAs. The *Conseil national du Patronat* is now also involved in the fight against HIV/AIDS. One of the things they do is a two-day workshop for businesses on basic AIDS awareness and advocacy.” (#14)

However, the private sector involvement in HIV/AIDS prevention and care and support of PHAs suffers from a number of limitations, despite efforts to increase its involvement. According to the CNLS (2006: 31), in 2004, some 48 businesses in the private sector had HIV programs in place, increasing to 65 by mid-2005 and to 72 businesses by the end of 2005. The low prevalence rate and the minimal impact of AIDS on productivity in Senegal, in contrast with high prevalence countries such as South Africa, have meant that private sector companies have been slow to mobilize around this issue (Sida-Entreprises 2007). Existing initiatives are mostly undertaken by very large companies such as the Chemical Industries of Senegal (ICS), the Autonomous Port of Dakar, SONOTEL and SOFIDEX or of the subsidiaries of multinational companies such as SDV, TOTAL, BICS, NOVOTEL, MTOA and SOBOA, who meet on a regular basis to discuss their experiences (Sida-Entreprises 2007). The efforts of the private sector appear to be disjointed and uncoordinated (Corporate Council on Africa 2006).

Efforts to expand the role of the private sector in HIV/AIDS prevention and the care and support of PHA are underway, as one of the priorities of the 2002-2006 HIV/AIDS Strategic Plan, with these efforts intensified in the 2007-2011 Plan (Corporate Council on Africa 2006). The enhanced participation of the private sector in HIV prevention and in the care and support to PHAs is a key aspect of the multisectoral approach advocated by the World Bank (World Bank 2001c) who promotes this strategy in Senegal to offload public sector costs for AIDS programs onto the private sector. A partnership has been developed between the CNLS, some companies and the *Caisse nationale de Sécurité Sociale*, which has the capacity to mobilize 12,000 businesses in both the formal and informal sector, to integrate

HIV/AIDS program into their policy on the social protection of workers (CNLS 2006: 31). The *Conseil national du Patronat* (CNP), now a member of the CNLS, was set up with World Bank and ILO funding (Sida-Entreprises 2007). Funds are currently ear-marked for HIV/AIDS projects for business to develop HIV programs, although only one grant was awarded in 2006 (Corporate Council on Africa 2006). Unless there are substantial financial inducements, it is unclear how willing small and medium-size businesses will be to get involved.

Gender blindness is apparent in the private sector initiatives and strategies as those who make policy appear to hold the traditional notion of women as mothers and housewives as opposed to women as workers. The vast majority of Senegalese workers are not employed in the private sector of the formal economy, and women even less so. These initiatives do more to benefit men, particularly professionals and skilled labour. Important as these initiatives are, they do little to improve social protection and extend work benefits for the vast majority of Senegalese women, particularly seropositive women who are unemployed or self-employed in the informal sector. As importantly, there appear to be no specific strategies for business to develop employee training programs for seropositive women to assist them in developing marketable skills or provide job opportunities, in part because of a pervasive gender bias that conceives women as mothers and wives rather than as workers. No strategies appear to be in place to encourage successful female entrepreneurs (see Sarr 1998) to get involved in these initiatives, particularly in mentoring and assisting seropositive women to develop more lucrative commercial activities in areas such as textiles and consumer goods.

5.6 Conclusion

HIV/AIDS reproduces and exacerbates gender inequalities as well as social class and north-south inequalities that limit the ability of Senegalese PHAs to live

positively and undermine their human rights and dignity. Gender shapes the social and economic situations of seropositive men and women differently. Seropositive women face greater challenges than seropositive men in living positively as a consequence of unequal power relations between men and women. HIV/AIDS accentuates seropositive women's responsibilities associated with their social roles as mothers, wives, caregivers and workers. HIV positive women are more likely to be in situations of economic and social dependence, with fewer economic resources and greater responsibilities for the health and welfare of their families as caregivers, which adversely affects their health. Age, marital status and occupation further differentiate the social and economic circumstances of seropositive women.

The persistence of multiple forms of stigma and discrimination further constrain the ability of PHAs to live positively. Seropositive women face double discrimination: as HIV positive and gender discrimination as women. They are judged more harshly than seropositive men, more likely to be blamed, repudiated, ostracized or abandoned. Although their needs for secrecy are greater than for men because of their subordinate position as women, they are less able to keep secrecy. Human rights efforts fail to adequately address the gendered dimensions of living with HIV/AIDS, particularly the underlying gender and other social inequalities that fuel stigma and discrimination and undermine the realization of these rights.

If seropositive women are to be empowered to live positively, acknowledging and tackling the multiple ways gender inequality shapes their economic and social circumstances and limits their rights are central. This requires moving beyond a gender-neutral conception of PHAs that renders the specificities of seropositive women's experiences invisible.

Supporting seropositive women to live positively requires moving beyond the dominant conception of seropositive women as simply mothers and wives and recognizing their roles as producers and workers. This requires addressing gender

inequality and sexism in access to education and within the labour market as central to the economic and professional re-insertion of seropositive women in the labour market that will permit them to live autonomously, with respect and with dignity.

“We need capacity-building for seropositive women in managing projects and in specialized training for them to develop occupational skills and competencies to get paid work...Access to mutual credit, seropositive women don't benefit from this. The rules need to be adjusted to accommodate the situation of seropositive women and for the Associations of Women Living with HIV/AIDS.” (#26)

Supporting seropositive women to live positively also requires rethinking the limits of the current human rights initiatives that do not address the multiple social inequalities that inform stigma and discrimination and undermine the realization of the human rights of PHAs. It requires linking human rights and women's rights more closely, addressing gender inequality and discrimination within the law, particularly those provisions of the Family Code around inheritance rights of widows and girls, paternal authority in the family, the rights to disposal and division of property within marriage, women's access to land and women's rights as workers, as these serve to deepen the economic precariousness of the material circumstances of infected and affected women and girls. Gender inequalities embedded in traditional practices such as the sororat and levirat, polygamy and early marriages that in the context of HIV/AIDS play a role in transmitting the disease (ICW 2005), undermine women's equality and autonomy and put women and girls at higher risk for HIV need to be addressed both legally and socially.

Supporting seropositive women also necessitates the development of a more comprehensive community-based strategy to address stigma and discrimination around HIV/AIDS that severely curtails the rights of PHAs. As importantly, community-based human rights education around HIV/AIDS will require addressing gender bias, discrimination and inequality that work to the detriment of seropositive women and girls.

CHAPTER VI

GENDER IN THE CONTINUUM OF CARE FOR WOMEN LIVING WITH HIV/AIDS

Living positively with HIV/AIDS requires a complex continuum of care and supports that involves the health system, the family and the community. Ideally, care for seropositive people encompasses “a comprehensive integrated process which recognizes a range of needs for well-being that includes services and activities that provide counselling and psychosocial support, legal, financial and practical services as well as nursing and medical care” (Whelan 1999: 5) that includes access to antiretroviral treatment and drugs for opportunistic infections. Supports refer to “the resources men and women need to alleviate the economic and social consequences of the impact of interacting structures and social relations that promote or prevent them from accessing resources” (Whelan 1999: 5). Human rights to health in the context of living with HIV/AIDS includes access to quality care and supports for PHAs, in addition to access to prevention services, education, housing, clean water, balanced nutrition and freedom from stigma and discrimination (Petchesky 2003).

North-south inequalities and poverty in the African context serve to limit seropositive people’s access to the continuum of care services needed to live positively and to mitigate impact, undermining their rights to health (Poku 2005; O’Manique 2004; Lee and Zwi 2003; Barnett and Whiteside 2006, 2002; Petchesky 2003; Parker 2000). More recently, a growing body of literature has highlighted gender inequalities in access to care, medical treatment and home and community

based psychosocial supports, that work to the detriment of positive women in Africa as elsewhere and contribute to women's preponderant role as caregivers of PHAs (Stephenson 2006; ICW 2005, 2004; UNAIDS 2004f, 1998; UNAIDS/UNPFA/UNIFEM 2004; WHO 2003c; Ankrah et al. 1996; Doyal 1994).

This chapter examines Senegal's model of care (medical treatment and psychosocial supports) for PHAs, focussing on gender in the continuum of care as it shapes women's access to services and contributes to women's preponderant role as caregivers of PHAs in the home and in the community. It explores two dimensions of access to care: the availability of services provided by the state public health system, the community and the family and the social inequalities based on gender, class and geographic location that may impede access even where services are available. I argue that notwithstanding seropositive women's over-representation in access to ART, in HIV testing and as recipients of community-based AIDS services in Senegal, access to care for the majority of female PHAs remains constrained by gender, class, rural-urban and north-south inequalities. In addition, as a result of a gender-neutral conception of PHAs in state HIV/AIDS policy, gender-specific AIDS services for seropositive women remain under-developed. The multiple limitations in the Senegalese model of care and supports for PHAs place greater burdens on Senegalese women as caregivers and as users of services, as women subsidize the gaps in existing services through their unpaid reproductive care. Although considered an exemplar in the medical treatment of PHAs, the Senegalese model of care and supports is limited in its capacity to address all the needs of seropositive women.

I begin by briefly discussing the Senegalese model of care and support for PHAs in order to show how treatment, defined largely as access to ART, is privileged over other forms of medical care and non-medical supports that are essential to the health and well-being of PHAs. Following that I examine medical

services available to PHAs, including HIV testing, the ISSARV and the PTME, and the barriers that affect women's access to these services. I then turn to an examination of the community care strategy, focussing on home care and community care in order to show how the Senegalese state strategy places greater burdens on infected and affected women.

6.1 The Senegalese Model of Care and Support for PHAs

Access to antiretroviral treatment (ART) constitutes the cornerstone of medical treatment of AIDS in industrialized countries (Petcheskey 2002) whereas in the Global South, particularly in Sub-Saharan Africa, access to ART was not, until recently, a treatment option for PHAs who make up the majority of PHAs world-wide (O'Manique 2004). In 2006, only 1.3 million people in the 'developing world' of the roughly 40 million people living with HIV/AIDS had access to ARV treatment, accounting for 20% of people with advanced AIDS receiving ART, despite the WHO 3 by 5 initiative launched in 2003 to ensure treatment for 3 million PHAs in low and middle-income countries by 2005 (UNAIDS 2006a: 151; UN 2006: 5). In 2006, only 9% of pregnant HIV positive women in the Global South were receiving ART, falling way short of the UNGASS target of 80% coverage (UN 2006: 5). Every day 15,000 people in the 'developing world' die from untreated HIV, tuberculosis and malaria (Russell 2007: 227). By 2004, twenty-five million people had died of AIDS, although deaths from AIDS continue to climb in the 'developing world', while they decline in the industrialized world (UNAIDS 2006a: 2). In 2006, 2.1 million Africans died of AIDS, comprising 72% of all AIDS deaths globally and up from the 1.9 million AIDS deaths in 2004 (UNAIDS 2006a: 2-4). The number of new HIV infections each year shows no sign of abating, as 4.3 million adults and children were infected with the disease in 2006 (UNAIDS 2006a: 2). As a consequence of access to ARVs, along with access to a

range of medical and non-medical services and a higher standard of living, AIDS is now viewed as a chronic disease in industrialized countries. However, in the Global South, it continues to be viewed as a death sentence.

International policymakers, giant pharmaceutical companies and international public health experts advanced highly contentious arguments justifying limited access to ARVs for African AIDS patients and elsewhere in the 'developing world'. This included the high cost of ARV treatment and its impact on the overall health budgets, the limits of African health systems, the assumption that Africans were incapable of complying with complex HIV treatment regimens and the lack of access to clean water, food and basic medicines necessary for the prevention and treatment of opportunistic infections associated with full-blown AIDS that would undermine the effectiveness of ART (Russell 2007; Patterson and Ciemminis 2005; Desclaux et al 2003). "As recently as 2003, the WHO Essential Drug List, the gold standard guiding rational drug use in poor countries, excluded ARVs because of the cost" (Russell 2007: 231). As a consequence, treatment options for Senegalese PHAs were quite limited up until recently (World Bank 2004b). By 2006, 5,200 people had died of AIDS in Senegal (UNAIDS 2006d: 2).

"In 1989, in the early years, support for seropositive women was very limited because we did not have access to ARVs. Women were seen here at Fann Hospital Psychiatric Services. We really had nothing to offer. All we could do was talk. There was no money really to assist women with all their other needs either." (#16)

The limited access to ART in conjunction with underdeveloped health services and substandard living conditions in the 'developing world' illustrates how north-south inequalities entrench double standards and undermine universal rights to health. It raises the haunting spectre of a not so subtle global racism that has condemned the majority of non-white, poor PHAs to a certain and rapid death sentence, couched in supposedly neutral arguments of economic efficiency in matters of health and HIV/AIDS service delivery.

However, in the 1990's, a confluence of trends including AIDS activism and dramatic price reductions brought about through generic competition particularly from Brazil and India served "to shame policy-makers into abandoning trade policy that put drug companies' profit motives before public health to pressure them to endorse ARV treatment as feasible and necessary in poor countries" (Russell 2007: 231).¹ Since 2000, the World Bank MAP program and the newly established Global Fund to Fight AIDS, Tuberculosis and Malaria (GFATM) also made funding available to 'developing countries' to enhance ART access, in addition to other care, support and prevention activities.² Funding from the GFATM and the World Bank³ allowed for a more integrated prevention, treatment and care approach entailing the scaling up of medical services for PHAs, including voluntary and anonymous testing, mother-to-child transmission services and enhancing access to previously unaffordable life-prolonging drugs for HIV positive adults and children in Senegal as elsewhere in the 'developing world.' Speaking of the Senegalese case, this respondent observed (#6),

"For a long time, partners and donors refused to fund activities linked to '*prise en charge*'. In some cases, people themselves refused. What advantages could I have? Better not to know my status. Now we have more funding for ARVs from the Global Fund. MAP funding means that '*prise en charge*' is taken more seriously."

¹. See Petchesky (2003) for a fuller account of the evolution of the Global Campaign for Access to Medicines within the context of the World Trade Organization (WTO) Trade-Related Intellectual Property Rights (TRIPS) agreements favouring the patents and practices of the giant pharmaceutical companies.

². There are significant differences between the two forms of funding. The World Bank MAP (Multi-Country HIV/AIDS Program) came out of its 1999 strategy to intensify action to contain AIDS in Africa and provides loans to states for HIV/AIDS Control and Prevention Projects. The Global Fund disburses grants to both states and NGOs. It was set up in 2001 as a private and voluntary initiative dependent on the generosity of largely Northern donors (states, individuals and foundations) for its funding (Patterson and Cieminis 2005).

³. The Senegalese state contracted a 30 million dollar reimbursable loan from the World Bank MAP program for an HIV/AIDS Prevention and Control Project (ID P074059) covering the period of February 7, 2002 to September 30, 2008 (World Bank 2001c). Grant disbursements in Round 1 and Round 6 were made to the CNLS (state) and to the *Alliance nationale contre le sida* (ANCS), covering the periods 2003 to 2008, although the funding for the CNLS was twice that for the ANCS (GFATM website for Senegal grants portfolio consulted 31/10/2007).

Senegal's model of care and support for PHAs comprises those activities that address the medical needs of PHAs (*prise en charge médicale*) and those that address the psychosocial, legal and financial needs of PHAs (*l'appui psychosocial*). Enhancing the quality of care and reducing the socio-economic impact are two key objectives of state policy initiatives around the care and support of PHAs (CNLS 2006a: 13). For the first time, the 2007-2011 HIV/AIDS Strategic Plan identified the need to take gender into account in decision-making, planning, targeting and execution of interventions (République du Sénégal 2007c: 28). However, at the same time, the state continues to utilize the gender-neutral concept of PHA that renders gender-specific differences and inequalities between seropositive men and women invisible. To date, these issues have been unevenly addressed in the various Protocols created by the Ministry of Health that serve as national guidelines around testing, counselling and the care and support of PHAs to be used at sites all across the country⁴; all the more important in the context of decentralization of services to areas with less medical and technical expertise than is the case in Dakar. The ideology of familism is also reproduced within these Protocols that emphasize women's roles as mothers with less attention paid to the broader array of individual needs of seropositive women. Furthermore, much of the data around access to care (medical treatment and psychosocial supports) produced for monitoring and evaluation purposes is not gender-disaggregated, making it difficult to assess if programs are meeting the needs of seropositive women, suggesting that the feminization of AIDS is not a priority.

⁴. The *Guide de counselling VIH/sida* (2003) does not clearly address many of the gender-specific issues that affect seropositive women face around male-female relations in the couple discussed in the previous chapter but rather alludes to them in a gender neutral way. Predictably, mother-to-child transmission is mentioned only with respect to women. The *Politique, normes et protocoles de conseil et dépistage volontaire du VIH* (2005) is a gender-neutral guide. The *Guide de prise en charge médicale des patients vivant avec le VIH/sida au Sénégal* (2005) addresses some women specific issues such as cervical cancer but not gender issues around nutrition needs of seropositive women or the care needs of female caregivers. The *Paquet intégré des services essentiels de nutrition pour la prise en charge nutritionnelle des PVVIH (PISEN)* (2006) makes passing reference to the problem of anaemia among women of childbearing age while the *Guide de prise en charge nutritionnelle des PVVIH* (2004) does not address women's specific nutritional needs.

The state public health sector is charged with diagnosis and the medical '*prise en charge*' of PHAs around sexually transmitted diseases (STIs), tuberculosis, opportunistic infections and ARV therapy (CNLS 2006a: 3). State-run medical services also provide counselling for newly-infected PHAs through certified social workers who provide basic information on AIDS and available services and supports as well as on-going counselling for PHAs on ART (#22). Civil society organizations and the community provide a growing battery of non-medical aspects of support and assistance for PHAs and their families, orphans and vulnerable children that includes various kinds of psycho-social, financial and nutritional support, and developing income-generating activities (CNLS 2006a: 3). Invisible in policy, homecare for PHAs is provided by families and constitutes a key component of the community care strategy. Scaling up treatment and the World Bank emphasis on decentralization of services and greater civil society and private sector participation in the response means that the community and the family will be expected to take on more significant roles in the non-medical care and support of PHAs, families affected by HIV/AIDS and orphans and vulnerable children. This is premised on the American model of addressing HIV/AIDS and the assumed African state's ineffective if not neglectful, role in addressing the epidemic (Webb 2004; Putzel 2003, 2006; Kerouedan and Eboko 1999), although the Senegalese and Ugandan cases suggest otherwise (Putzel 2003; Eboko 2005).

Data from the 2006 Senegalese five-year UNGASS review sheds some light on state expenditures for treatment and care which made up 21.55% of the budget as 16.17% went to ART, 4.25% to treatment of opportunistic infections, .73% to laboratory follow-up, .12% for palliative care and .29% for nutritional support while expenditures for the '*prise en charge*' of orphans and vulnerable children (1.34%) and reducing the socio-economic impact of HIV/AIDS (1.54%) were minimal (CNLS 2006a: 18). In 2004, the state spent 144,000 FCFA (just under

\$300 US) per person living with HIV/AIDS, with 23,240 FCFA (just under \$50 US) for antiretroviral therapy (CNLS 2006a: 16).

For the first time, more funding is to be earmarked for care and support of PHAs as opposed to prevention, as budget projections for the *Plan stratégique de lutte contre le Sida 2007-2011* shows that 21 927 454 700 FCFA will be allocated to the care and support of PHAs, most of which will be set aside for the medical care of PHAs (15 928 161 600 FCFA) while 19 336 227 703 FCFA will be allocated to prevention (CNLS 2007c: 47). However, funding for the care and support of orphans and vulnerable children as well as for psychosocial support and community care of PHAs, activities mitigating the socio-economic impact of AIDS, remain heavily under-funded, with 2 999 646 550 FCFA earmarked for each of these strategies (CNLS 2007c: 47). As this respondent (#13) remarked with respect to the 2002-2006 HIV/AIDS strategic plan, “The strategic plan prioritizes treatment. Community care is not a priority.” This appears to be the case with the latest HIV/AIDS plan for 2007-2011, illustrating the limits of Senegalese care and support strategy.

The bulk of the financing for the PNLs comes from external sources made up of various multilateral and bilateral aid agencies, international NGOs and the World Bank. Sources of financing for the PNLs in 2004 were as follows: 56.93% comes from public funds of which 7.2% is from the state budget and 49.78% from World Bank MAP funding (ie; a reimbursable loan contracted by the state); 10.72% from private funds (households) and 32.36% from external funding – 18.95% from multilateral agencies, 7.49% from bilateral agencies and 5.91% from non-profit international organizations (CNLS 2006a: 16). Donor funding in 2004 was channelled to program administration (22.33%) and a variety of HIV prevention activities (CNLS 2006a: 18), with minimal contributions to community care of PHAs, orphans and mitigating impact, and no funds disbursed by multilateral and

bilateral agencies for this. Moreover, donor funding is also subject to donor priorities rather than accorded to meet regional needs (Mbengue and Gamble 2001). Despite the increased importance and funding accorded to community care and mitigating socio-economic impact, they do not appear to be priorities for funders or for the CNLS. As this respondent (#10) put it,

“We have had discussions with the CNLS around policy issues about developing policies that accommodate all our needs as seropositive people for improving our quality of life. But this is a developing country and we cannot get everything in one shot. The money is just not there.”

6.2 Scaling up Treatment for PHAs in Senegal

Senegal has been cited as an exemplary case in the treatment of people living with HIV/AIDS in the African and southern context (Gruénais et al. 2006). The Senegalese state provides anonymous and voluntary testing, antiretroviral therapy and mother-to-child transmission services free-of-charge. Strengthening each of these services with the goal of universal access by 2010 are key state HIV/AIDS policy priorities (République du Sénégal 2007c: 28).

Voluntary Testing: People’s Right to Know their Status

HIV testing is the first step in access to treatment and care, in addition to its function as an essential component in the prevention and containment of HIV transmission. It is estimated that 90% of seropositive people in Africa do not know their serostatus (UNAIDS 2004f). Scaling up treatment and care of PHAs in Senegal has been accompanied by the expansion of voluntary HIV testing services, premised on people’s right to know their HIV status. The first *Centre de conseil et dépistage volontaire et anonyme* (CDVA) in Senegal was opened in 2000 (APAPS 2005: 4). CNLS (2006a: 26-27) reported that in 2004, there were 9 operational

CDVA and 56 functioning voluntary testing sites (SDV). By 2005, this had grown to 12 CDVA operational in 8 regions: Dakar (5), Ziguinchor (1), Kaolack (1), Saint-Louis (1), Fatick (1) and Thiès (6) and 76 SDV sites: Dakar (19), Saint-Louis (9), Thiès (8), Kaolack (6), Louga (6), Fatick (6), Tambacounda (6), Ziguinchor (5), Diourbel (5), Kolda (4) and Matam (2) functioning in 10 regions. At least, four Senegalese NGOs are involved in the implementation and functioning of the CDVA sites (CNLS 2007c: 22).

The APAPS' (2005: 36) technical evaluation of the CDVA centres showed that young people (the median age was 26 years) and women (64.5%), with 48.2% married and 48% single, made up the bulk of the clients at the CDVA sites. Women were over-represented in two age categories: those under 25 years and in the 25 to 49 age bracket while men were slightly over-represented in the 50 plus age category. Use of the CDVA HIV testing services was highest in Dakar, whereby 2 centres accounted for 67% of clients, including a sizable number of clients from outside the region of Dakar wishing to ensure a higher degree of confidentiality and avoid stigma (APAPS 2005: 35). HIV prevalence during this 4-year period of 2000 to 2004 for all the CDVAS was 5.3%, with a total of 13,239 people tested. (8,541 women and 4,698 men) (APAPS 2005: 35), although no gender breakdown was provided. Despite the expansion of these HIV testing services, they are under-utilized by both women and men, particularly men (CNLS 2006a: 3).

In addition to testing, all sites offer pre and post-test counselling that serves as an entry point for access to medical care and psychosocial supports and services for HIV positive people. According to the CNLS UNGASS follow-up evaluation (2006a: 29), all 6,075 PHAs (active files) in health structures had received some counselling. However, no gender breakdown was given for this data. The failure to provide gender disaggregated data on HIV prevalence rates in the case of a major technical evaluation of HIV testing sites or to provide a fuller discussion of gender

differences in testing and counselling are indicative of the absence of a gender perspective with respect to HIV/AIDS service delivery and more pointedly, within the CNLS itself. It is indicative of the lip service paid to the feminization of AIDS within the national AIDS control program itself and to the limited recognition of the gendered nature of HIV/AIDS and its impact.

Senegalese Antiretroviral Drug Access Initiative (ISAARV): Enhancing Access

Prior to ISAARV program, antiretroviral therapy was available only to a few wealthy Senegalese (mostly men) who could afford to obtain medical treatment in industrialized countries. In Senegal, “about twenty to thirty people were purchasing drugs at a cost of 80,000 FCFA to 300,000 FCFA available at three locations in Dakar, usually private clinics and under the care of a handful of doctors with expertise in the area” (Ndoye et al. 2002: 17).

In 1998, the Senegalese Antiretroviral Drug Access Initiative (ISAARV) was implemented as a result of the confluence of several factors. This included the state’s commitment to allocate an annual budget for the purchase of antiretrovirals and reagents, CD4 and plasma viral load kits, price reductions for antiretroviral drugs and effective collaboration between Senegalese technical experts executing the program and partners from the North (Simms et al. 2006). This was the first ARV pilot project initiated by a government in Africa as UNAIDS was unwilling to fund such a project in Senegal at the time (World Bank 2004b). “After reaching agreements for antiretroviral drug price reductions with pharmaceutical drug companies and generic drug makers, the Senegalese government arranged to subsidize over 95% of the costs of patient care.” (Marlink and Kotin 2004: 85). The ISAARV program started with five drugs; zidovudine, lamivudine, stavudine, didanosine and indinavir (Desclaux et al. 2003: S99). Under the direction of the Clinic for Infectious Diseases at CHU de Fann, it involved providing access to

antiretroviral medication to PHAs, follow-up and monitoring patient adherence to treatment regimens and drug resistance to ARVs and the promoting clinical trials (CNLS 2006a: 27). From 1998 to 2002, all patients identified for treatment were referred to the National Hospital (CHU de Fann) in Dakar on a pilot basis. Initially, a cost-sharing strategy for ARV tritherapy on a sliding scale basis was implemented. Eligible patients were asked to pay part of the cost: 190,000 FCFA for well-off people and 40,000 FCFAs for people with salaries, although the amount was reduced to 5,000 FCFAs in 2003 (CNLS 2006a: 28). However, despite reduction in the costs of drugs, many patients were unable to pay even a minimal amount of money towards the cost of the drugs.

“Based on the results of the ISAARV pilot project, even charging patients 20,000 FCFA or 15,000 FCFA (about \$40 or \$35 US) a month, they couldn’t afford it.” (#2)

Despite some problems, the 18-month pilot project with a cohort of 180 patients and a 1 to 1 ratio of men and women, “showed good clinical, immunological and virological effectiveness and good adherence to the drug regimen comparable with that of developed countries” (Simms et al. 2006: 235), thus demonstrating the feasibility of ART in a developing country.

The *Centre de Traitement Ambulatoire* (CTA), an outpatient AIDS treatment centre, was also set up in 1998 at CHU de Fann.

“The CTA was created in 1998. The activities began at the same time as the ISAARV program, administered by Infectious Diseases CHU de Fann. The ISAARV is a government initiative that financed part of the costs of medical services to PHAs. The CTA was set up after it became clear from an evaluation conducted by Fann Infectious Diseases Unit that PHAs were most of the hospitalized clients and taking up most of the hospital beds. The idea of the CTA was developed to reduce hospital admissions of PHAs and to offer a place, a pavilion to them with outpatient medical and psychosocial services, reduce hospital stays and provide secondary prevention and treatment to help PHAs maintain their health. The project is actually a project of OPALS, *Organisation panafricaine de lutte contre le sida*. The

president is Professor Omar Sylla. There is an international office and offices in participating African countries. The purpose of OPALS is to promote NGO participation in HIV prevention activities. An agreement was signed between OPALS, and the *ministère de la Santé* to set up this service and to commit funding.” (#24)

In 2002, Senegal adopted a holistic, decentralized approach to treatment and care, enlarging access to testing in hospitals, health centres and larger health posts. Programmes to prevent mother-to-child transmission (MTCT or the PTME in French) were also set up, along with alternate strategies for the determination of CD4 counts and protocols for the treatment and care of PHAs were developed for use throughout the country, in both public and private health sectors (Simms et al. 2006: 236). Participation in the WHO/UNAIDS ‘3 by 5’ initiative also helped Senegal scale up access to treatment (WHO 2006). By early 2003, eight drugs were available, with nine different preparations and a total of 23 different combinations including 20 three-drug regimens (Desclaux et al. 2003: S99).

In December of 2003, the government announced that testing, access to ART and follow-up monitoring of CD4 counts and viral load were to be free of charge (CNLS 2007c), largely as a result of effective lobbying of the president by key Senegalese medical experts in HIV/AIDS management, treatment and research (#2). In January 2004, Senegal became the first African country to provide free access to ART, demonstrating high level political commitment to improving treatment and care to PHAs and extending access to the poor and the marginalized on the basis of need rather than financial means (Simms et al. 2006). Moreover, ART is available to residents of Senegal, not just Senegalese nationals, meaning that PHAs from neighbouring African states can access therapy (World Bank 2004b). Senegal is currently in the process of decentralizing its ISAARV program, making ART and the treatment of opportunistic infections available to PHAs in all of its medical districts (WHO 2006). Scaling up ART has also coincided with a growing number of HIV positive women accessing services.

“Since 1998, we have had a steady increase in clients from 50 to 2000 clients. In 1998, the gender breakdown of the 50 clients was 70% men and 30% women...the latest statistics in 2006 show a gender breakdown of 65% women and 35% men, as patients of the CTA... We started to notice around 2004 that men were less numerous than women patients. This change in tendencies probably began since the year 2000.” (#24)

As a result of the state’s initiative and support from international donors, access to ART has steadily expanded in the recent past. The number of patients under treatment increased from 20 to 30 HIV positive people in the period 1998 to 2000, to 80 in the period 2000 to 2002, to 150 in the period 2003 to 2004 and from 1,350 to 3,622 in the period from 2003 to 2005 (CNLS 2006a: 28; Desclaux et al. 2003: S98), a figure also cited by four different respondents participating in my research. In 2007, 5,900 PHAs were receiving ART up from 4,764 PHAs as of May 31, 2006 (Diouf 2007: 31; CNLS 2007c: 23), although neither report provided a gender breakdown. However, as this respondent (#2) told me, by 2006 “women constituted about 58% of the PHAs receiving ART”, although this was not the case early on, according to this (#16) respondent,

“In the early stages of the ISAARV program, treatment access favoured men because they were working or could find work, forgetting that it is women who stay home and look after children and the household. They deserve the same opportunity for treatment.”

However, despite these impressive achievements, the ISAARV did not meet its objective of providing 7,000 PHAs with ART by 2006 (Simms et al. 2006: 236). Although 3,622 people received ART in 2005, it represented only 47% coverage (CNLS 2006a: 28). More disturbing, only 1.4% of seropositive pregnant women received treatment to reduce perinatal transmission of HIV (UNAIDS 2006a: 446).⁵ It also has been suggested that HIV positive female sex workers may be under-accessing effective treatment (ART) (Diouf 2007). Despite decentralization, the

⁵ . There is some discrepancy in these figures as the CNLS (2007c: 49) fixed the coverage rate of pregnant seropositive women receiving ART at 48% in 2005. Nevertheless, it remains inadequate.

majority of PHAs in 2006 were still treated through CHU de Fann through the *Centre de Traitement Ambulatoire* (CTA) in Dakar with 2,520 case files (2000 active case files) (#2 & #24). The CNLS (2006a: 28) reported that 1,254 people living outside of Dakar were receiving treatment in 2005 and most resided in urban areas; with 241 patients in Kaolack, 194 patients in Ziguinchor, 166 patients in Louga, 147 patients in Saint-Louis, 88 patients in Kolda, 8 patients in Fatick, 15 patients in Thiès, 91 patients in Matam and 57 patients in Tambacounda. This suggests that access to ARVs and psychosocial supports for PHAs in rural areas is more limited, particularly for poor rural HIV positive men and women, despite the fact that rural and urban HIV rates are similar.

Although access to ART is free, both men and women encounter obstacles in observing treatment regimens, as five respondents pointed out. Stigma around AIDS is a key issue as many PHAs wish to keep their serostatus secret, which interferes with treatment. However, gender differences and inequalities also play a role in compliance with treatment regimens. It appears the need for secrecy related to stigma is stronger for women, as these respondents suggested,

“Stigma, once we have developed the treatment regimens for a patient. He or she has to want this and be ready to disclose his or her serostatus in the household. If he or she doesn’t, taking the medication at home is a problem. Let me give you an example, a woman who lives in Saint-Louis was given tritherapy in 3 big boxes to take home. She complained ‘I can’t take these home.’ I can’t explain why I need these drugs. The drugs were there but she refused to take them. We had to explain why she needed to take the drugs. After we did so, we suggested that she take the bottles of pills out of the boxes so they would be easier to conceal. Then she took them. Stigma is a real issue and a problem.” (#22)

“The need for secrecy related to stigma and the ability to maintain secrecy is perhaps more difficult for women to observe their treatment regimen.” (#7)

“Many women hide to take their ARVs. Some of our members leave their meds at our locale and come here to take them so no one will find

out. Some women actually come in every day to take their meds.” (#26)

“Women are particularly sensitive to this issue. They don’t want others to know because they are going to ask. If women have to explain what they are for, there are going to be even more questions. They risk being rejected by the family or by friends. Among our clients who have said that they don’t want to take the drugs at home for fear of someone finding out, women are more numerous, probably 2 women for every 1 man, who don’t want to take the drugs at home.” (#24)

HIV positive women also encounter more obstacles than men that relate to gender inequality, their subordinate status and their social responsibilities as caregivers. They include women’s limited availability due to household responsibilities, stigma, the cost of medical exams and analyses of tests, economic dependence, keeping appointments, adequate nutrition and the accessibility of health centres (Alliance International contre le VIH/sida and ANCS 2005 :70). For men, these obstacles were identified: their professional activities, not divulging the information with their family and entourage and the schedule for taking their medication (Alliance International Contre le VIH/sida and ANCS 2005: 70).

Nutrition is also a key issue affecting the observance of treatment regimens and the effectiveness of the drugs. Healthy and balanced eating is essential to boost the immune system and for maximum efficiency of ART. Many PHAs don’t eat well, as one respondent (#14) pointed out. While nutrition and anaemia are common problems for all PHAs, gender inequalities serve to heighten these issues for seropositive women as a result of repeated pregnancies, breastfeeding and cultural traditions which assign women the smallest and least nutritious portions of food (#2), which have been inadequately addressed in the Protocols on care for HIV positive people (see footnote 4). A Taskforce on Nutrition and HIV was set up in 2005 to address the problem of nutrition and whose mandate is to develop more collaborative strategies involving medical services, the community sector and

international donors to improve the nutritional status of PHAs (CNLS 2007c: 24). It remains to be seen whether it will address gender inequalities around this issue.

The Programme Transmission Mère-Enfant (PTME)

Perinatal transmission services constitute an essential component of HIV prevention and the care and support of pregnant seropositive women and their children. Mother-to-child transmission of HIV, also known as vertical transmission, is responsible for about 1,500 new infections infants daily, with the majority of cases in sub-Saharan Africa (WHO 2003: 12; WHO 2005). HIV infection can occur during the pregnancy (5-10% risk), during labour and delivery (10%-15% risk), during breastfeeding (5-20%) risk, with breastfeeding up to 6 months (20-35% risk, and with breastfeeding from 18 to 24 months (30-45%) (WHO 2005: 13). Without treatment, the risk of an HIV positive pregnant woman infecting her newborn is 20% to 40% and with treatment, the risk of HIV transmission is considerably reduced to 2% to 5% (République du Sénégal 2005b: 13). The UN agencies recommend a four-pronged strategy to prevent mother-to-child transmission of HIV that includes: primary prevention of HIV infection among parents, the prevention of unwanted pregnancies (including safe abortion for HIV positive women where permitted by law), prevention of HIV transmission from seropositive pregnant women to their babies, and the treatment, care and support of infected and affected women, their infants and young children, partners and families (WHO 2003: 12).

The mother-to-child transmission prevention pilot program (PTME) in Senegal was implemented as part of the ISAARV pilot program in 2000 at three sites in Dakar – CHU Le Dantec, L'Hôpital Principal et Centre de santé Roi Baudoin in Guédiawaye, with the assistance of several external donors (République du Sénégal 2005b: 22). The purpose of the pilot project was three-fold: to provide free voluntary testing for pregnant women, to offer ARV drug therapy to HIV

positive pregnant women and to assist seropositive women in choosing alternatives to breastfeeding (*substitution de lait maternel*) in order to reduce the transmission of HIV from mother to child as well as provide medical care for HIV positive women and children.

The results from pre-natal consultations between the years July 2000 to November 2002 showed that of 23,949 women, the HIV test was offered to 21,548 women (90%), of which 16,807 women (78%) agreed to be tested but only 11,500 (53%) women actually got tested for HIV (République du Sénégal 2005b :23). The HIV prevalence rate among this group of women was 1.4% and after 18 months of operation of the program, with a 4% rate of mother-to-child transmission (République du Sénégal 2005b: 23). Despite the relative success of this pilot program, evaluation of the program identified several logistical and administrative constraints in its operations including limited public awareness of its existence and but more pointedly, the low rate of testing among pregnant women (République du Sénégal 2005b). In Guédiawaye, a sprawling densely populated low-income suburb of Dakar, specific difficulties were encountered in providing adequate support to fulfill the multiple needs of low-income pregnant and HIV positive women in precarious social and economic situations. Gender constraints around the stigma of not breastfeeding, the desire for secrecy and an absence of communication with husbands also negatively affected interventions (République du Sénégal 2005b).

In 2004, PTME programs were extended to three pilot regions; Dakar, Saint-Louis and Ziguinchor and by the end of 2005, they had been expanded to 40 operational sites in ten of eleven regions (CNLS 2006a: 26; WHO 2006). Despite a sizable investment to expand the program and efforts to target pregnant women, the performance of the PTME testing services has been disappointing, given the estimated 370,000 births annually in Senegal (CNLS 2006a: 26, 36). During the period of June 2000 to September 2002, only 10,338 pregnant women of the 15,500

who accepted actually got tested. From 2002 to November 2004, 10,733 women of the 13,417 women who agreed to be tested actually took the HIV test. During the period of 2003 to 2005, 20,371 of 58,044 women actually got tested (CNLS 2006a: 36). The acceptance rate for voluntary HIV testing among pregnant women targeted was very low at 32% in 2005 (CNLS 2006a: 2).

An evaluation of the PTME identified psychological, socio-cultural and structural barriers factors affecting the under-utilisation of this service (République du Sénégal 2005c). These included: women's lack of information about HIV/AIDS, particularly around mother-to-child transmission, a lack of information about existing services at the local level, inadequate pre-test counselling, confidentiality and a lack of trained counsellors, the need for husband's consent to get tested for HIV, the perception of low individual risk and fear of divulging serostatus in the medical milieu (République du Sénégal 2005c: 56). Apart from acknowledging the need for husbands' consent for testing, other aspects of gender inequality that might constrain women's use of these services such as the potential negative consequences of HIV diagnosis in reinforcing women's social and economic vulnerability were not considered.

“Women are blamed. It is the woman who is seen as bringing misfortune. It often comes out when women get tested during the course of pregnancy. She may be diagnosed first, even though the husband brought the infection into the couple...MTCT. Women are ultimately seen as responsible, men are not. We need to start using the term parent-to-child transmission.” (#13)

Despite awareness of the need to provide information, involve men and open up dialogue in the context of the family in order to improve the use of PTME services (République du Sénégal 2005c), a national strategy to target husbands and increase their involvement and responsibility has yet to be developed, much less address the more sensitive issue of women's right to control over her body and to make decisions about her health and the health of her children. One respondent

suggested that the gender component of the PTME is weak, although this may be more a function of how policy and program guidelines are translated into practice.⁶

“The social aspects of the PTME are much less well-developed and the gender component is missing. They provide some psychosocial counselling and people talk to you. After that you are forgotten. The psychosocial dimensions of the disease are addressed but the gender component is missing.” (#13)

Although most of my respondents identified the PTME as a defining feature of the Senegalese gender approach to addressing HIV/AIDS in that this program is designed for women, the actual objectives of the PTME indicate otherwise. It reproduces the ideology of familism and women serve as the *'porte d'entrée'* for the reduction of HIV transmission broadly speaking and for the care and support of infected children and families. The key objectives of this program are: to promote less risky sexual behaviour, to improve the treatment of sexually transmitted infections and to reinforce the *'contrôle sanitaire des prostituées'* (CNLS 2006f: 7). Moreover, the official CNLS document asserts that *“en réalité autant elle vise à protéger l'enfant dont la mère est infectée autant elle se préoccupe de la pris-en-charge médicale de cette dernière”* (CNLS 2006f: 7). The PTME offers five free services that include voluntary testing, ARV prophylactic treatment for children, ARV treatment and monitoring for HIV positive mothers, the provision of food supplements with the options for newborns and the pre-and post accompaniment and support of a social and legal nature for the mothers (CNLS:2006f: 7). Although the program provides access to medical treatment, psychosocial support and legal assistance to seropositive pregnant women, seropositive women's health appears to be a secondary priority.

⁶ . The *Document de référence de la prévention de la transmission mère-enfant du VIH* (2005) devotes chapter 5 to addressing the psychosocial, financial, legal, and nutritional needs of HIV positive pregnant mothers. It takes up some but not all of the gender-specific issues facing seropositive women.

6.3 Persistent Inequalities in Access to Medical Care for HIV Positive Women

For the majority of respondents, access to treatment for PHAs means access to ARVs and most suggested that this was not a problem as they are now available free-of-charge. However, despite Senegal's impressive achievements in enhancing access and state commitment in expanding treatment, providing free access to ART and subsidizing the costs of other drugs related to opportunistic infections (#20), access to treatment is still limited, largely a function of north-south inequalities and economic underdevelopment. A major constraint is the Senegalese state's limited capacity to provide sufficient funding to cover the costs of comprehensive medical care for PHAs. Availability and access to ART in Senegal are heavily dependent on the vagaries of external funding and the priorities of donors. In fact, the *Plan stratégique de lutte contre le Sida 2007-2011* has as a stated objective ensuring ARV access to PHAs for the duration of this plan (CNLS 2007c: 40).

“The state is playing a more important role, providing about 1 billion FCFA for treatment access and increased it to 1.75 billion FCFA for ART. But there is still only limited access despite the fact that ART is free. Currently there are about 4,000 people on ART treatment out of about 80,000 HIV positive people in Senegal. Their CD4 count has to be less than 350; these are WHO and CDC criteria, which we follow. ART costs a lot of money. The financial envelope is a constraint on enlarging access.” (#22)

Access to treatment is also constrained by frequent problems with the national system of acquiring, supplying and administering ART, other drugs and laboratory supplies which put HIV positive people's health at risk. The problem is particularly acute in rural areas (CNLS 2006a: 37). Scaling up treatment has highlighted the inadequacies in human, technical and financial resources of the Senegalese public health system, despite international assistance to address these gaps (Simms et al 2006; WHO 2006; CNLS 2007c; World Bank 2004). Regional disparities in available health services in Senegal also limit access to medical

treatment, particularly for PHAs in rural areas (République du Sénégal 1999), as this respondent (#24) reiterated,

“Access is difficult for clients who live in villages in rural areas because they can’t afford the cost of treatment and access to a qualified doctor is also difficult.”

Decentralization of the ISAARV program has been underway since 2003, with the eventual goal of full service delivery in the ‘*districts sanitaires*.’ The package of services includes HIV testing, psychosocial support, diagnosis and treatment of opportunistic infections and ARV therapy for chronic infection among adults and children, mother-to-child transmission services and care for people accidentally exposed to contaminated blood (CNLS 2006a: 28-29). The ISSARV program but not the entire range of services was available in all 11 regions of Senegal in 2005, with 17 of 20 hospitals (85%) and 26 of 54 health centres (48%) offering medical care and psychosocial support for PHAs (CNLS 2006a: 29).

“We pay for the costs of certain services. The problem may be in the regions where they may not have all the services. Like in the district of Mbao. This is also a ‘*pays du sud*’ and funding is a problem. Fann Hospital in Dakar is better equipped than hospitals in the regions.”
(#20)

Regional disparities also affect seropositive women’s access to the PTME. Despite the expansion and decentralization of this program, some regions where rates of pregnant women testing positive are higher than the national average such as in Tambacounda, Kolda and Matam, have fewer sites. Strategies to promote testing and the use of PTME services among pregnant women in some regions are also less well developed. SWAA’s PTME activities, at the time of this research, targeted only five regions: Kaolack, Ziguinchor, Louga, Fatick and Dakar (#7).

“Even the HIV-specific health services for PHAs, they are not readily accessible to all seropositive women. Regional disparities are a problem. A woman might have to leave Ziguinchor to give birth to a child in the PTME in Dakar. She may not have the money to take a taxi to Dakar and return home. The PTME programs are all in Dakar and some regional capitals like Kaolack. So if you live in Kaffrine and

you need to use the PTME in Kaolack, you have to go to Kaolack. Time and money constraints.”(#13)

“What we need to do is scale up the PTME, to offer testing to every pregnant woman This needs to be boosted, scaled up, particularly in the regions but more importantly in the districts when women come in for pre-natal visits. We need to strengthen women’s negotiating skills with respect to convincing their husbands to come in and get tested. It’s been learning by doing. We now understand that we need to explain why it is important for them to know their serostatus – to not infect their babies. That even if they are HIV positive, there are medications they can take which can prevent HIV infection in their unborn babies. The percentage of women who say I need to ask my husband if I can get tested is declining because they are more willing to take the initiative in getting tested once they understand why it is important.” (#2)

Although medical specialists in Dakar, particularly at Fann and the CTA, have been more effective in addressing gender-based barriers women experience in using the PTME, this is not necessarily the case in regions, where there is less expertise in HIV/AIDS care and fewer qualified medical professionals, highlighting weaknesses in the decentralization strategy that works to the detriment of women.

“In Ziguinchor, there are more women getting tested than men. In anonymous voluntary testing, women are more open to accepting the results. All too often, it is the husband who poses the problem. At one site, the statistics for the period from December to March 2006, in the PTME pre-natal consultations, 230 women were approached to be tested but only 13 accepted. Most gave the reason that their husbands refused. They were ready to take the test but their husbands refused. They said we have to ask our husbands. When they came back, they said our husbands refused so we refuse. (#30)

The goal of universal access to care for PHAs will remain elusive so long as the entire package of services for PHAs is not free of charge and the public health system charges for medical services. Health services user fees further constrain access for HIV positive people and penalize the poor. ARVs and some of the associated costs around CD4 testing and the costs of drugs for opportunistic

infections (TB), drugs to treat thrush and access to enriched flour to boost the immune systems of PHAs are free for PHAs on the ISAARV program as of 2004 (World Bank 2004d; CNLS 2006a). However, the majority of PHAs are not on the ISAARV program and may not be so for some time as they are in the early stages of the disease. HIV positive people not participating in clinical trials or the ISAARV program are obligated to pay for all their own medical services (#22) and most do not have any form of medical insurance.⁷ Several respondents (7/25) pointed out that social class inequalities mean that many PHAs who are poor simply cannot afford all the associated medical costs for their care, also noted by the CNLS (2006a: 28). Many cannot afford to purchase vitamins, eat a balanced diet, transportation to and from medical services or the costs of palliative care.

“Medical treatment for secondary effects and many of the opportunistic infections are not free. The costs are expensive. We have to pay a fee for the consultation. There are fees for complementary medical exams (ultra sound etc.) and prescriptions that cost a lot of money. People just don’t have the money to pay for transportation when they need medical treatment.” (#14)

Gender inequality interacts with poverty to limit access to the range of medical services that many HIV positive women require as they have fewer economic resources and greater health needs. Paying for essential drugs for opportunistic infections, consultations, testing and adequate nutrition is more difficult, particularly for women not in the ISAARV program or in clinical trials. Seropositive women require more exams and consultations for treatment of sexually transmitted infections and monitoring of cervical cancer, a key woman-specific indicator of AIDS (#26, #16).

“The majority of women with HIV are economically dependent on their husbands or their parents. Their medical *prise en charge* is more difficult and most don’t have income-generating activities...Medical care – the problem of diet, a healthy diet. Women have a more difficult

⁷. Community-based initiatives, spear-headed by Senegalese AIDS service organizations, are underway to promote the development of ‘*mutuelles de santé*’ specifically for PHAs with the objectives of assisting them in covering their medical costs.

time assuring healthy eating than men do and lack of money is an issue. Lack of money is also a problem in treatment of opportunistic infections that seropositive women develop and her status as a person with little decision-making power. (#3)

Unequal gender relations in the couple and the family also serve to constrain seropositive women's access to health care. Almost half the respondents (12/25) pointed out that many women lack the power to make their own decisions around health issues and cannot access treatment without their husband's permission; also noted by the ISAARV pilot project (Lanièce et al. 2002).

“The first difficulty is around diagnosis. Men can find out faster if they are HIV positive. They make the decision to go and get tested. Married women need their husband's permission. If he is not there, then she may need her mother-in-law's permission. Access to diagnosis is more difficult. It usually happens later on in the disease. Women get treated later in on the disease.” (#18)

“Within the ARV access program, there are more women than men on the program. Within medical services, women are over-represented in terms of HIV testing and care and support. The difficulty is that women often have to ask men (their husbands etc.) for their permission for treatment.” (#20)

Stigma and discrimination also impede access to medical care for HIV positive people and violate their human rights. A national consultation in 2003 on human rights issues that affect people living with HIV/AIDS in Senegal identified four principal forms of human rights violations in medical services that include: HIV testing without clear and informed consent, violation of patient confidentiality, refusal to treat HIV positive people and complicity in not treating HIV positive people (Atchadé and Spencer 2003: 29).

In some cases, fear of being identified and stigmatized prevents some PHAs from getting needed treatment, as this respondent (#14) told me,

“Seropositive people are afraid to be hospitalized. There is stigma around going into the Infectious Diseases Unit. People are going to say

there goes an AIDS patient. People hide and they don't always go to get medical help for fear of becoming known as an AIDS patient.”

Fear of stigma is also justified. One respondent (#10) told me of a case where a PHA was hospitalized for a lengthy period of time at a hospital, one of the doctors used to say to him, “*bonjour le siddéen*”, as though he was not a person and it made the PHA feel really ill-at-ease but added that other doctors were just great. This incident constitutes a breach of patient’s privacy, confidentiality in addition to compromising full recovery.

Despite HIV/AIDS training for health personnel, some PHAs do not always receive the care they are entitled to as a consequence of stigma or discrimination around HIV/AIDS. A few respondents suggested that, the problem was usually not with doctors who cared for HIV positive people but with other medical staff who are afraid to touch HIV positive patients because of their blood (#1).

“With respect to some health professionals and hospital settings, there are still hospitals and medical services which refuse to treat PHAs, instances where PHAs were turned away and there have been a few cases of seropositive pregnant women being turned away from hospitals or else PHAs are just not given the care they deserve. This is discrimination.” (#14)

“With the exception of the doctors who treat seropositive people, you risk having problems with some of the other medical staff...when my husband, who is HIV positive, had an accident and was brought into the ER at the hospital, as soon as he told the staff he was HIV positive and not to touch his blood, the staff left the room, and left him unattended. I had to get a doctor from the Ministère to intervene so he could get treatment.” (#23)

A few respondents reported cases of mistreatment or a refusal to treat seropositive pregnant women by nurses in pre-natal and post-natal care and midwives in some health care units for fear of coming into contact with

contaminated blood (#1) or who advise women to go to the PTME to have their babies (#13). As this respondent (#26) conveyed,

“When I think about priorities for women – medical treatment, the organizations involved in care and support, the health centres in specific, services are not accessible. One has to pay...It is difficult to be accepted in maternity units, even in hospitals in Dakar. There is a lot of discrimination. In 2002, with my own childbirth, the mid-wife, when she saw PTME on my health booklet, this means seropositive, she said out loud, we should be careful. She didn’t help with the birth. She left me completely alone a whole day on the floor. I didn’t even have the right to a bed. The whole night I suffered. The gynaecologist finally came in the morning to see if the baby was okay and didn’t have any infections. They did not even call the doctor to let him know that they were not going to treat me or my baby. I didn’t even explain this to the doctor when he came in the morning. He wasn’t going to do anything. We have had workshop after workshop. We have raised these issues time and time again. There is little change around this. It happens often enough. It has been worse for other women. One woman lost her baby. She was completely alone. They didn’t take the baby or wash the baby. They left them alone and the baby died.”

Seropositive women may also be victims of HIV testing without their consent or their confidentiality may be breached within the medical milieu and in some cases, after HIV testing, they may not be informed of their HIV status but this may be conveyed to the woman’s husband, violating her human rights and putting her at risk of abandonment, divorce or repudiation (Atchadé and Spencer 2003).

6.4 Community Care and Support

Home-based and community-based care for PHAs are integral components in the Senegalese response to HIV/AIDS as elsewhere in Sub-Saharan Africa as both the family and the community are expected to play major roles.. Most of the non-medical care and support for PHAs, their families, orphans and vulnerable children in Senegal is provided through families and community-based care from

the Associations of People Living with HIV/AIDS, the *'cellules'* organized around hospitals and a small number of NGOs. Decentralization of services will heighten the role of the family and the community in AIDS care in Senegal.

6.4.1 The Burden of Home-Based Care: Women Affected by HIV/AIDS

The extent to which PHAs benefit from family support and care depends on whether the individual or family has disclosed its status. Many PHAs do not disclose their status or have access to family support because of fear of stigma and rejection for themselves and for their families.. As several respondents (6/25) pointed out, the care and support of PHAs in the family is contingent first and foremost on which member or to whom the seropositive person discloses his or her HIV status. Some PHAs may decide to disclose to a close friend or not at all while others may disclose only to a spouse or to one or two family members.

“It depends on the case. Case by case, it is different. Some PHAs are responsible for themselves almost entirely. Those who share their serostatus usually don’t have the means to take care of themselves and they delegate this responsibility. Associations for People Living with HIV/AIDS and other groups play a role as well.” (#4)

“The whole family is stigmatized when one or more members are HIV positive. Care and support is relatively new for many families. They often don’t really know how to best care for and support PHAs beyond accompaniment of the PHA. Training is actually needed around managing HIV in the family around nutrition issues, psychosocial issues and social re-insertion (into society) to improve and assist the family in caring for and supporting PHAs.” (#20)

Even with disclosure, family solidarity and support for PHAs in a context of economic crisis may be limited (Niang and Van Ufford 2002; Sow and Desclaux 2002). Caring for PHAs and orphans drains the family’s resources over time and many poor families simply cannot provide the sustained economic support to PHAs. Niang and Van Ufford’s (2002: 15) research showed that “just after the

revelation of HIV infection, or the re-occurrence of infection of disease symptoms, families substantially benefited from assistance provided by relatives, friends or neighbours but that resource mobilization declined over time.”

“When AIDS enters the household, women and girls provide the care. Globally up to 90% of the care due to illness is provided in the home by women and girls” (UNAIDS/UNPFA/UNIFEM 2004: 31). The UN’s Secretary-General’s Task Force 2004 Report on Women and AIDS in Southern Africa revealed that two-thirds of caregivers in the households surveyed were female and close to 25% were over the age of 60 (Global Coalition on Women and AIDS 2005: 2). With the privatization of health care and the reduction of state services in Sub-Saharan Africa, governments rely on home care to fill the gap in state services, primarily provided by the unpaid labour of women and girls, many of whom are poor. Moreover, “most poverty reduction plans and state AIDS policies seldom take women and girls caregiving into account; it remains unpaid and undervalued in economic terms” (UNAIDS/UNPFA/UNIFEM 2004: 31).

Women’s unpaid caregiving is not taken into account in Senegalese poverty reduction plans and strategies (Touré and Niang 2002). In a similar vein, there has been little recognition of the role of women’s unpaid labour in the care and support of PHAs in research (Diallo 1999) or in HIV/AIDS policy, as this respondent (#26) pointed out, and who also suggested that it should be paid. Although ABOYA is working with researcher Yassine Fall on a project to cost account women’s unpaid labour as caregivers of PHAs with a view to developing financial remuneration for them (#13), women’s roles in caregiving remain invisible, devalorized and taken for granted, as this respondent (#27) remarked,

“Caregiving. Women do the caregiving. It is not paid work. It is not valorized. It is simply taken for granted. Women play a huge role in psycho-social support of PHAs both at home and in the hospitals.”

A few respondents (4/25) pointed to the sexual division of labour in the family whereby male heads of the household, fathers or husbands are generally responsible for taking care of the financial needs of the people living with the disease while women, as wives, mothers, sisters or grandmothers, are responsible for the emotional, medical and family support. Two-thirds of the respondents (17/23) suggested that women perform the bulk of the caregiving for PHAs in the home, in the family and in the hospital because these are women's social roles.

“Generally, I would say women. Women are in charge of caring for sick people. Women know who is sick in the family. The father will buy drugs but when one is sick enough to be hospitalised and one has to go to the hospital, it is women who take them. If the person requires special food, women will make it and bring it to the hospital. They will wash their clothing, provide comfort and wash the person. Who does the caregiving? The mother, the wife, the sister. First off, it would be the wife and mother who take care of the sick person. If she can't do it, the sister who is closest to her will cook and do the washing. This is a result of cultural socialization. We are raised to do it.” (#18)

“It is women. Women take care of sick people and they prepare food. It is a part of women's traditional roles as caregivers and it is reproduced within HIV/AIDS in the home and in the hospital. Men come to visit in the evening while women stay the whole day. Mothers, sisters, aunties and grandmothers. Some women will even stop their economic activities to take care of the sick person. Few men stay the night unless they are really close relatives.” (#17)

“It is men. They purchase the prescriptions and the drugs. Women take care of the sick in the hospital. They do the accompanying of PHAs. Men don't usually stay, as they have to work. Women are the caregivers in the hospital generally and also in the AIDS world.” (#2)

In addition to domestic tasks such as cooking, cleaning and washing clothing as well as assisting PHAs with observing their treatment regimens, women also may accompany their seropositive husbands when they travel for medical treatment or they may travel to consult *marabouts* with the hope of improving their husband's health (Niang and Van Ufford 2002: 15). In these cases, wives may also

be accompanied by other women (a sister, a cousin or a close friend). Daughters, irrespective of their age, are involved in tasks such as bringing meals to the diseased and carrying out domestic activities which would typically be attributed to the mother such as shopping for food, cooking meals, taking care of children, cleaning house and hauling water.

The care and support of PHAs in the home disproportionately affects young girls as they usually take on domestic tasks and take care of sick parents and younger children in HIV infected families, when their mothers are sick (Mbaye and Becker 2006; Niang and Van Ufford 2002). Young girls are more likely to drop out of school, if choices have to be made about whom to send to school, when a father is sick and can no longer work. Diouf's (1999: 12) study of seropositive widows and women affected by HIV showed that when women were too sick to perform their domestic activities, these activities were carried out by their children, usually daughters (6.1%) and/ or by a sister (12.2%). With the death of parents, girls' inheritance rights may be compromised as she receives less than her brothers.

In addition to caring for PHAs, female family members are often called upon to care for AIDS orphans, defined as children who have lost one or both parents, and other vulnerable children. In the past, complex cultural and social practices such as the levirat and the sororat traditionally assured the care and support of orphans and children in the event of divorce but their importance is waning (Niang and Van Ufford 2002). As this respondent (#3) pointed out,

“We have also seen or observed that when the mother dies or is divorced there is a negative impact on the children. The father, if he has another wife, he does not take care of the children. The pre-occupation with children and their future weighs more heavily with women. Traditionally, children were taken care of by the in-laws. Now with AIDS and the stigma it carries, linked also to a deteriorating economic situation, taking care of orphans is a problem for the extended family. They may not have the space or cannot afford to

clothe, feed and send a child to school. If it is known that it is AIDS, it is even more difficult.”

Nevertheless, women continue to play an important role in the care and support of orphans. Niang and Van Ufford's (2002: 16) study revealed that “AIDS orphans who lost both parents are adopted in most cases by their grandmothers, the latter being the child's closest relatives, while children of a deceased wife may be brought up by their mother's sisters, grandmothers or maternal aunts.”

While some patients dying of AIDS are admitted to hospitals for palliative care, others choose to die at home, with some returning to their natal villages (Renaud 1997). The situation of female caregivers of terminally ill PHAs is even more stressful as their responsibilities for the care needs of PHAs in the terminal phase are greater. They are faced with the physically, mentally and emotionally draining tasks of caring for all the needs of PHAs in the absence of AIDS hospices in Senegal (#22), as there are few financial supports and palliative care services for terminally ill PHAs who choose to die at home or respite care for caregivers (#18). This is all the more challenging for rural female caregivers, who lack basic amenities and have fewer supports and services than their urban counterparts.

Female caregivers of PHAs in Senegal face numerous financial difficulties as well as lack supports, information and training that would assist them in better addressing the needs of those they care for as well as their own health needs. Although a training manual on family and community care and support of PHAs has been developed, it has not been widely circulated (Diouf 2007). It remains to be seen how well it addresses the plight of female caregivers.

“Female caregivers experience all kinds of problems: lack of money and lack of resources, stigma and keeping serostatus secret, illiteracy. They don't really know what is being written about them and some may not understand written instructions for providing support to the PHA. Stress from work overload. No help, men don't usually help. There are no programs for burn-out for caregivers...In the continuum

of care from hospitals to family care, there has been no real reflection on this—except perhaps from ESTER which is trying to work with hospitals and the community sector. There are maybe 20 organizations that work in some aspect of community care and most of this is concentrated in Dakar and Saint-Louis.” (#13)

“Female caregivers experience economic difficulties for food and vitamins. 51% of Senegalese families live below the poverty line. The labour that they lose also has negative consequences on their children and an increased workload such as having to do more laundry with no running water. PHAs need a specialized diet, which requires more attention to preparing meals and increases the domestic workload. You need at least 15 litres of water to wash the sheets of someone with AIDS. Plus you need to boil their drinking water. Water has to be paid for. Many don’t even have money to take the *‘car rapide’* to accompany PHAs to and from medical appointments. Liberalization of the health and social services sector has been on the backs of women.” (#18)

The lack of attention to the situation of caregivers in conjunction with the absence of state and community programs such as a family allowance to assist with expenses accentuate their difficulties, compromise their own health, increasing their levels of stress, fatigue, despair, discouragement and economic burdens and ultimately, negatively affect the care and support of PHAs (#26).

6.4.2 Community Care: NGOs and Associations of PHAs

The lion’s share of community care for PHAs in Senegal is provided by a small number of NGOs that are national in scope, concentrated in Dakar and the Associations of People Living with HIV/AIDS. Although a growing number of community-based organizations (CBOs) are now starting to become more involved in this aspect of care (CNLS 2006a), much of it is on a voluntary basis and varies from region to region. In regions outside of Dakar, the regional hospitals provide

many of these services, with varying support and involvement of NGOs and community-based organizations (Groupe thématique ONUSIDA/Sénégal 2001).

Based in Dakar, the principal NGOs involved in the care and support of PHAs and their families, orphans and vulnerable children are Society for Women and AIDS (SWAA) (HIV positive women and children), *Sida Service* and the *Centre de la promotion de la santé Cite Keur Damel* (PHAs and orphans), ASSED (orphans and vulnerable children), CEGID (orphans and vulnerable children) and *Synergie de l'Enfance* (orphans and vulnerable children) as well as AWA and *Enda Santé* who target female sex workers. In addition, the ANCS, ACI-Baobab and COSSEN are involved in capacity building for the Associations of People Living with HIV/AIDS and CBOs around prevention and the care and support of PHAs in Dakar and in the regions (Mbaye et al. 2005). Almost all of these organizations are heavily dependent on external funding and donor priorities for the programs and services they offer, limiting the range and type of services they can offer, with most providing services in a few but not all of the regions (Mbengue and Gamble 2001).

If the community-based care for PHAs remains the '*parent pauvre*' of the Senegalese HIV/AIDS strategy, women-focused HIV/AIDS services are even less well developed. The SWAA is the only woman-focused HIV/AIDS specific NGO involved in care and support of infected and affected women and ABOYA is the only female PHA association for HIV infected and affected women. Both groups suffer from a serious lack of funding for their activities, despite the fact that SWAA was the first NGO to get involved in the care and support of HIV infected women and their children and orphans. As half the respondents (14/25) pointed out, women's groups in Senegal appear to be less involved in care and support of PHAs as opposed to prevention activities; in part because their mandates are around development issues. However, many women provide care and support to PHAs on a voluntary basis; for example as part of relay teams trained by NGOs such as

ASBEF, as is the case in Saint-Louis (Niang 2001) or as part of the objectives of Catholic women's groups. As these activities are part of women's traditional social and community roles, they are taken for granted and hence invisible in the documentation and discourses on AIDS. Moreover, women's groups also lack the funding and capacity to get more involved and have been marginalized in the community care strategy, although SWAA was a pioneer in the field.

“In 1992, when we started to see AIDS orphans, SWAA was the first NGO to get more involved and initiated assistance to infected and affected women with orphans. We began by providing clothing for children and community feasts for the two big Muslim holidays – the end of Ramadan and the Tabaski. We also began to assist with schooling of orphans, buying clothing, school supplies and paying fees. This started the first initiatives in community *'prise en charge'* and involvement of civil society.” (#16)

“Women's groups play a much greater role in education and awareness activities as opposed to the support and care of PHAs, partly due to the lack of funding. This is a real constraint. Many of the women's groups were involved in development work and were created and trained for this. With the advent of AIDS, they added this issue area to their regular activities.” (#3)

“The CNLS has not worked very closely with women's groups. This is a shame because women are the most heavily affected by AIDS.” (#20)

Increasing policy and donor emphasis is only now being placed on the care and support of AIDS orphans and vulnerable children, as part of AIDS community care and essential to impact mitigation. Although primarily concerned with improving care for children affected by HIV/AIDS, programs also offer some needed supports to parents, particularly divorced, single and widowed female PHAs with children. Orphans and vulnerable children are “under 18, who may or may not be infected with HIV, have one parent who is HIV positive or deceased, living in a milieu affected by HIV or at risk and whose health, education and socialization is compromised or inadequately safeguarded” (CNLS 2005:8). Niang and Van Ufford's (2002) study showed that the responsibility for orphans came down to a

limited number of family members and the most substantial support appeared to come from projects, associations, AIDS focussed NGOs.

The CNLS reported that 6,029 orphans and vulnerable children benefited from some type of nutritional, psychosocial and school assistance in 2004, although no gender breakdown was provided (2006a: 29). With an estimated 20,000 orphans and vulnerable children in Senegal (CNLS 2005), it would appear that the needs of the vast majority are not being met. The absence of gender-disaggregated data also makes it difficult to assess the extent to which girls' needs are addressed. Niang and Van Ufford's (2002: 15) study showed that about 13% of children with HIV/AIDS benefited from some assistance, with the majority of those children living in Tambacounda, Dakar and Saint-Louis and that 20% of these children had at least one parent who benefited from an income-generating project for PHAs. Moreover, the number of orphans and vulnerable children continues to increase, particularly in the regions such as Matam, Tambacounda, Saint-Louis, Kaolack and Ziguinchor (CNLS 2006a: 29). Regional inequalities also affect access. The limited supports for these children and the lack of income-generating projects for parents are most acutely felt by HIV positive mothers and women affected by HIV/AIDS.

Assistance to PHAs in the period 2003 to 2005 consisted of psychosocial support in Dakar and in the regions and included home visits, hospital visits and the '*groupes de parole*' as well as nutritional support entailing nutrition education and community meals and accompaniment (CNLS 2006a: 29). In 2004, more than 2,400 PHAs benefited from some form of psychosocial support, increasing to 10,000 PHAs by 2005 (CNLS 2006a: 29). Some 3,900 PHAs benefited from one or more of the range of psychosocial, financial or other services offered by NGOs and community-based organizations (CNLS 2006a: 29). However, given that the estimates of the number of PHAs in Senegal vary from 49,000 to 80,000 people (UNAIDS 2006a), it is clear that only a small proportion of PHAs are benefiting

from these services. The absence of gender-disaggregated data from the CNLS on the number of PHAs accessing services complicates the task of developing an accurate assessment as to how many women benefit from these services. The lack of attention to gender suggests yet again that lip service is paid to the feminization of AIDS.

Associations of People Living with HIV/AIDS

Seropositive women and those affected by the disease also use the services and supports provided by the Associations of People Living with HIV/AIDS, although they pay minimal membership dues so that the Associations can cover some of their operating costs. Currently, there are 15 Associations of People Living with HIV/AIDS including 1 national association, the *Réseau national des personnes séropositives* (RNP+) and one women's association for infected and affected women (ABOYA). Six associations are based in Dakar, 2 associations are in St. Louis while Kaolack, Tambacounda, Ziguinchor, Kolda, Matam and Richard Toll each have one (#9 and #10). Only 3 associations were in existence in the 90's and most are relatively new, created since 1998 (Mbodj and Taverne 2002).

Male dominance and the subordination of women also are reproduced within the Associations of People Living with HIV/AIDS. Up until a short time ago, men headed up the associations and were the liaison in hospitals and other health structures including the PNLs, arguing that female PHAs generally were uneducated, lacking the skills for these positions and activities (Mbodj and Taverne 2002). Currently, there are six female presidents of PHA Associations in Senegal (#9 & #10). Increasingly, as a few of my respondents pointed out, seropositive women's involvement in the Associations is serving to foster their empowerment, also noted by (Mbodj and Taverne 2002).

ABOYA (AND BOK YAKAAR or '*Unis dans l'espoir*' in French) was set up in 2001 to better respond to women's needs and to differentiate themselves from the RNP+ and the other associations headed by men (Mbodj and Taverne 2002). In 2006, ABOYA had one association in Dakar and one in Saint-Louis, providing services to 200 infected and affected women between 25 and 66 years of age, with most between the ages of 25 and 35, and 300 orphans and vulnerable children, including some whose parents have now passed away. Only one of their members had paid employment. ABOYA's financial resources are limited (#26).

"Despite the network of Associations for People Living with HIV/AIDS, there was no association for women until recently. Men didn't listen to women or take their concerns seriously, particularly around stigma in the community, like coming in the front door of the locale. Women were afraid they would be identified. Men were also the heads of all the Associations. That is why an association of PHAs for women was created to address the specific needs of infected and affected women...

The organization was created because women have more problems than men. HIV positive women, they are the ones who take care of HIV infected husbands when they are sick, but when HIV positive women are sick, their husbands do not necessarily do the same. They take care of and look after the needs of their children. They manage and resolve family problems. For example, if the husband doesn't have work or money, they go out looking for the means to feed the family."

The Associations of People Living with HIV/AIDS are expected to provide the bulk of the supports for PHAs which is their mandate as civil society actors as laid out by the CNLS (2007b: 9) in its document on the roles of diverse actors in the fight against AIDS. The Associations of People Living with HIV/AIDS in Dakar all offer similar services to PHAs, depending on their resources, as six respondents from different Associations of PHAs pointed out. These services generally include: 1) '*groupes de paroles*'; 2) home visits; 3) hospital visits; 4) community suppers and/or community meals; 5) distribution of food baskets and nutrition education; 6) information about medical care, treatment and drug therapies; 7) social reinsertion and mediation with family, health professionals

and/or the workplace; 8) prevention education and awareness-raising activities for both seropositive and seronegative people particularly around HIV testing; 9) assistance to orphans and vulnerable children including covering some of the financial costs of their schooling, clothing etc.; 10) covering some or all of the medical costs of PHAs and; 11) depending on whether they have a certified social worker, individual counselling. As this respondent (#14) explained,

“Our vision is to improve the quality of life of PHAs, members of the Associations and those coming to the CTA; to enhance access and to reinforce the supports offered around medical care and services, psychosocial supports, material and financial assistance so that PHAs can better take care of themselves.”

More than half of the respondents (14/25) suggested that seropositive women and women affected by HIV/AIDS are the major users of community supports and services. Despite their need for greater secrecy and confidentiality, seropositive women are also more likely than men to be involved in the Associations of People Living with HIV/AIDS. This also reflects how gender and social class inequalities shape PHAs involvement in the Associations. As these respondents observed,

“Intellectual men, cadres and professionals, army officers, they tend not to frequent the associations of PHAs. If men can take care of their needs, we don’t see them. In the west, PHAs have invested in the PHAs associations. In Senegal, it is the exact opposite. Many people are ashamed and quite a few get treatment outside of Senegal.” (#9)

“Women tend to frequent the Associations more than men. Men don’t have the time. They are either out looking for work or trying to make some money. Men also hide more. They are less likely to divulge their status to their families than women. They put on sunglasses, hats and hide.” (#14)

“There are a number of reasons why men, certain groups of men, don’t frequent the PHA associations. For some, they are not credible or they don’t like the profile or personalities of individual members. Some men want to keep their seropositive status a secret, only their partner or intimate companions may know. To be involved in an Association

means to publicly accept one's status and that it will be known by all the members. Some women don't want this either. For women, though, getting involved in an Association, they get emotional support from other seropositive women that they don't get in the family. Women are no longer alone and they can 's'épanouir', even develop as women.” (#6)

Seropositive women now make up the majority of members of the Associations of People Living with HIV/AIDS where membership is open to both seropositive men and women. AND DEGGO (*Ensemble pour mieux s'entendre*) at the Infectious Diseases unit at Fann Hospital provides services to about 80 members; 50 women and 30 men (#22). BOK JEFF (*Agir ensemble*) was created in 1999 by the medical staff and social workers at the CTA to deliver support activities for PHAs frequenting this outpatient clinic. It provides services to 200 members between the ages of 18 to 50 years; 65% are women and 35% are men (#14). ASASSFA (*Association sénégalaise d'aide aux séropositives et leurs familles*), based in Dakar, was created in 1992 providing services to about 103 HIV positive people; 96 women and 7 men, between the ages of 25 and 49 (#23). HIV positive women are more likely to need emotional support, to break out of isolation and to access the services they provide (financial and nutritional) for PHAs and their children, as they are more in need of supports and services. In addition, “a lot of women are illiterate and have fewer qualifications for finding work” (#10).

“Women's visibility in the Associations is growing because there are more infected women now but they also need these services more, particularly widows with children.” (#23)

“There are more women than men in the associations because women accept their serostatus faster. They are more keen to come in and to share their experiences to get emotional support contrary to men who are afraid to share their emotions. Women are more available. Most are not working. Women need the services offered for themselves and their children. Women are more sensitive. Many say at ABOYA, you listen to us. This is the best.” (#26)

“More women than men are using our services for moral support because they may not get this at home or in the family, for material support and nutritional support such as the food kits (10 kilos of rice, 5 litres of oil, 3 kilos of sugar, 1 sack of milk and 4 bars of soap) and for financial support for children’s education for fees and for school supplies. They also need financial support to pay for CD4 and viral load testing as well as medications for opportunistic infections.” (#22)

However, not all seropositive women frequent the Associations. HIV positive sex workers tend not to use the services of the Associations of People Living with HIV/AIDS in Dakar, in Kaolack or in Zinguichor, as a few respondents observed, in part a function of the double stigma of being HIV positive and a sex worker. Enda Santé and AWA provide supports to HIV positive female sex workers similar to those provided by the Associations of PHAs (ANCS 2007).

“In the beginning, sex workers who were seropositive didn’t really join the PHA associations. It is a double stigma, sex work and seropositive. Many of these women were afraid and they didn’t want people to know about their private lives. Now there is an association for seropositive sex workers. They are not excluded from becoming members of the associations and they are free to belong or not. Generally they do not belong to ABOYA. I’m sure that they don’t want them. It is perhaps more a question of the part of the work we do around prevention of HIV re-infection among seropositive people, which requires a behaviour change. Not all sex workers want to change their behaviour. It is more of an indirect kind of pressure and people self-select out.” (#9)

“In Ziguinchor, HIV prostitutes do not frequent the association of PHAs partly because the association tries to get sex workers to leave prostitution. In Dakar also, many HIV positive prostitutes don’t use the PHA associations either. ABOYA’s membership is made up of HIV positive married women and HIV positive single women. HIV positive prostitutes don’t want to be visible, to be identified as HIV positive and they want to keep working as prostitutes.” (#30)

6.5 The Limits of the Senegalese Community Care Model

West African states were much slower in organizing support for home care for PHAs, unlike those in East and Southern Africa (Ilfie 2005). In Senegal, there are relatively few civil society organizations involved in the care and support of PHAs (CNLS 2006a). As this respondent (#2) mused,

“The weak points of the Senegalese strategy are the *‘prise en charge communautaire’* and advocacy. I often wonder why we are not as developed as Uganda (TASO) in this respect or Zambia with respect to home care. I wonder if the low prevalence in Senegal is a factor. In high prevalence countries in Africa, everybody talks about AIDS. Every one has someone living with or has died of AIDS.”

However, as a majority of respondents (16/25) pointed out, state HIV/AIDS policy does not prioritize community or home care, citing as evidence to support this contention, the lack of funding and resources for these activities, which I discussed at the outset of this chapter.

“The state and the CNLS don’t budget for community care and support. The money comes from external funders; the World Bank and the Global Fund. The money is channelled through the CNLS to HACI, ANCS, Sida-Service, Enda and *Synergie pour l’Enfance* that provide some support or from PHAs themselves through their membership dues in the Associations of People Living with HIV/AIDS but most of these people are poor. There is still no hospice for PHAs as there are in western countries, although ESTER is interested in this but we need 338,226 Euros for this facility. The RNP+ has asked for a hospice and to improve the programs combatting stigmatization and discrimination.” (#22)

“The social situation of the PHAs is pretty generalized. Senegal is an underdeveloped country. Poverty is widespread and 80% of the PHAs are poor. There is just not a lot of funding for assistance for PHAs. There needs to be solidarity among PHAs to make improvements in our situation.” (#14)

Also, the early strategies around care and support of PHAs in Senegal focussed almost exclusively on treatment and the medical aspects of the disease,

with little attention given to the range of non-medical needs (Synergy 2003). As a result, community participation; the participation of community groups, particularly women's groups, was marginalized at the outset. The weak involvement of community-based organizations also is a result of the limited initiatives around developing their capacity. As this respondent (#8) explained,

“Our mandate is to promote awareness, provide information to the regions and promote capacity-building, networking and community mobilization. We have regional cells and work with close to 2,000 groups in each of the regions. Our problem is that our funding only covers part of the work we do. At the level of the departments and rural communities, there has been a lot of decentralization but it is at these levels that they need capacity-building in leadership, in advocacy and in counselling. We don't really have the funds to do this work.”

Although they are expected to provide the bulk of community care for PHAs, the Associations of People Living with HIV/AIDS face enormous constraints that limit their effectiveness and their ability to provide services. These include the stigma around HIV/AIDS, the low visibility of the Associations and their members, the limited advocacy and the sheer poverty of most of their members (CNLS 2007c, 2006a; Mbodj and Taverne 2002). The Associations also face financial, organizational and human resource constraints, particularly the newer associations in the regions outside Dakar, as six respondents representing the Associations of PHAs pointed out. They receive inadequate funding for their many programs and services, due in part to their status as associations rather than as NGOs (Delaunay et al. 1998) and in part to the low priority accorded to community care in state policy.

“Care and support. The funds allocated for this is insufficient. The demands for our services have increased. Money comes from the CNLS, HACI Senegal and the ANCS. A lot of money is spent on prevention and not enough on the care and support of PHAs. We need to invest more in the care and support of PHAs because a seropositive person who lives well lives with a chronic disease is better able to give testimonials and become visible. With access to better medical care, we see the difference with seropositive women. They put on weight, they dress well. Some get married and live positively. This helps

people to come out of hiding, to break the stigma and to show that AIDS doesn't have to be a death sentence.” (#14)

Moreover, the Associations of People Living with HIV/AIDS operate with few paid staff as services and activities are provided on a voluntary basis, including the work of presidents who function as directors of these associations, as two respondents remarked. Many Associations, particularly in the regions, do not even have a locale for their activities, much less computers and vehicles that would assist them in expanding their networks and activities, as three respondents told me. Most associations would benefit from capacity building around leadership, advocacy, fund-raising and more medical information around HIV/AIDS, treatment and other issues, as one president of an Association of PHAs observed. Although the CNLS (2007c: 42) acknowledged the need to enhance capacity building and leadership training for local and national actors in the 2007-2011 HIV/AIDS Strategic Plan, minimal funding is earmarked for these activities.

The devaluation of community actors, specifically PHAs, particularly in the medical milieu, means that treatment and care initiatives do not benefit fully from the experience and skills of PHAs. GIPA, the greater involvement of PHAs, is a relatively new concept in Senegal.

“We encountered resistance in the beginning in the hospital setting to our involvement in support, accompaniment and counselling around voluntary testing and with pregnant women partly because we are not medical personnel. Initially some doctors, social workers and midwives were resistant to having us present but that has changed somewhat. They are more open to us now and accept the need for the involvement of the RNP+. We need to do more advocacy around increasing the involvement of PHAs in voluntary testing centres so that they can make better use of our knowledge, skills and competencies.” (#10)

The limited development of the community care sector undermines impact mitigation. This also places greater burdens on women and girls to subsidize the

gaps in state and community services through their unpaid labour in the home and community care for PHAs and makes it more difficult for seropositive women and their families to live positively.

6.6 Conclusion

This chapter explored gender in the continuum of care for PHAs from medical services, to home and community care, highlighting the strengths and weaknesses of the Senegalese model of care and supports for PHAs. Seropositive women in Senegal are now over-represented in access to antiretroviral therapy, in HIV testing (although this varies by region) and as recipients of community-based HIV services. However, access to quality medical care and psychosocial supports for the majority of female PHAs remains constrained not only by class, rural-urban and north-south inequalities but also by unequal gender relations. The persistence of user fees, regional disparities in medical and non-medical services and supports and inadequate state and donor funding for medical, home and community care illustrate the limits of the Senegalese model of care and support for PHAs in general and for seropositive women in particular.

As a model endorsed by the World Bank, UNAIDS and international donors such as USAID, it illustrates all too vividly how the burden of non-medical care and supports is displaced onto the family, community groups and the Associations of People living with HIV/AIDS; those who have the fewest resources to grapple effectively with the complexity of the needs of PHAs, their families, AIDS orphans and vulnerable children. As this respondent (#3) observed,

“It is time that the state stops delegating responsibilities and powers to communities that simply don’t have the resources to carry out these activities. It is also time that we stop talking about HIV as a factor in development and that we explore how development can contribute to the fight against AIDS; for example raising the purchasing power of

families in general so that HIV-affected families can afford treatment for opportunistic infections, adequate food and need not be supported by programs that simply don't have the resources to meet the demand.”

The limits of the Senegalese care model for PHAs place a greater burden on women, both affected and infected, illustrating how gender inequalities are reproduced within state services and policy in this area. Women's unpaid and unrecognized labour in reproductive care in the home, in the community and in hospitals subsidize the gaps in state and community care services to PHAs and orphans that are essential to mitigating the impact of HIV/AIDS. Female caregivers play a vital role in the care and support of PHAs are virtually invisible in the continuum of care services and within policy, as a consequence of the absence of a gender perspective on care and supports for PHAs.

As a consequence of a gender-neutral conception of PHA in state HIV/AIDS policy, gender-specific AIDS services for seropositive women remain underdeveloped within medical services and non-medical supports for infected and affected women. The reproduction of the ideology of familism within the range of AIDS services and supports means that the emphasis is on women's needs as mothers or as heads of families rather than on the totality of their needs as women and as individuals and women's limited control over decision-making around health remains intact.

“There needs to be more work around issues of ‘seropositivity’. AIDS care services are not as developed as they should be and not sufficiently focused on women-specific needs.” (#1)

If universal access to care is one of the principal goals of state HIV/AIDS policy, addressing gender inequality in its interaction with other forms of social inequality that impede access to the broad spectrum of service is essential. This also requires addressing the gender-specific needs of women affected and infected

through comprehensive state-supported national programs, as this respondent (#26) explained,

“We need to improve the conditions for the care and support of seropositive women. We need to review the implementation of nutritional support programs. What exists is not at all adequate. It is not a national program. It is available largely through the Associations of PHAs and only in a few regions like Dakar and Saint-Louis. We need to make consultations, testing, analysis and medications for opportunistic infections free of charge. Seropositive women simply don’t have the money to pay for this. We need subsidies for housing for widows and seropositive women who want to escape the control and critical eye of their in-laws – this bad woman, she killed our son. There is no national program for the care of children. We need help with paying fees, professional training, school supplies, clothing, nutritional support and assistance with purchasing medications. There also needs to be care and support for caregivers, especially seropositive caregivers, psychological and emotional support and family allowance to help with family expenses.”

Central to this is the collection of gender-disaggregated data to ensure gender equality in access to services and supports as well as the greater involvement of seropositive women in designing, delivering and evaluating them.

CHAPTER VII

ENGENDERING STATE HIV/AIDS POLICY

State HIV/AIDS policy is central to addressing the feminization of AIDS in Senegal. Despite the important role played by the Senegalese state in organizing the national HIV/AIDS policy response (Eboko 2005; Putzel 2005, 2003), gender has not been a focal point of policy, programs and interventions, as elsewhere (Siplon 2005; Irurzun-Lopez and Poku 2005). More recently, attention has turned to addressing gender in HIV/AIDS policies, programmes and institutions (Global Coalition on Women and AIDS 2006; Kleintjes et al. 2005; Bridge 2004; WHO 2003a; Commonwealth Secretariat and the Atlantic Centre of Excellence in Women's Health 2002; Rao Gupta et al. 2002; UNAIDS 2001b, 1999b; Matlin and Spence 2000; Whelan 1999; Royal Tropical Institute 1998). Calls have been made to 'give women more seats at the decision-making table' in order to better address the gendered dimensions of HIV/AIDS and the impact on women (UNAIDS 2006; Global Coalition on Women and AIDS 2006; Duwury et al. 2005). Despite the increased attention to gender in policy responses, much of this literature has stopped short of analyzing the nature of the state and its institutions that develop and execute policy, how they organize gender interests and gender relations or the role of women's groups/national machineries in the policy process.

This chapter examines Senegal's HIV/AIDS policy framework and its efficacy in addressing the feminization of AIDS and fostering women's empowerment, situating it within the broader context of state-civil society relations and the way the Senegalese state organizes gender relations and gender interests. Drawing on Prügel and Lustgarten's (2006) analysis of women and development

policies, I conduct a gender analysis of HIV/AIDS policy that combines both a policy analysis focussing on the extent to which 'women' and gender issues are mainstreamed into HIV/AIDS policy whose successes and failures need to be measured and a political analysis of HIV/AIDS policy as a site around which gender politics operate.

Although considered as a model organizational template for national AIDS commissions (Putzel 2005), I argue that despite Senegal's effective state-centric approach to HIV/AIDS, it does not possess an effective gender and HIV/AIDS policy because a male-dominated political culture and unequal gender relations are reproduced within the CNLS and policy-making structures, paralleling trends of women's marginalization in formal politics in Senegal (Creevey 2006; Beck 2003; Callaway and Creevey 1994). The lack of commitment to a gender perspective is evident in the formal and substantive under-representation of women and gender experts in the institutions and processes that make policy, in the marginalization of women and gender equality issues in AIDS policy discourses, in the uneven mainstreaming of gender in strategic policy priorities and targets around prevention, treatment care and support, research, ethics, monitoring and evaluation and in a weak institutional framework for gender and AIDS advocacy. Despite reference to a gender approach to HIV/AIDS, it is not coherently articulated, systematically applied in all policy areas or necessarily universally endorsed by policy-makers and external donors. As a consequence, gender issues in HIV/AIDS policy are marginalized and the capacity of women's groups to advocate on behalf of women is limited. The Senegalese state policy response to HIV/AIDS may be best characterized by a gender-neutral state-led, bio-medical and top-down multisectoral approach, dominated by medical/scientific expertise and international donors. As such, the policy response is inadequate to address the feminization of AIDS and promote women's empowerment, illustrating the limits of the state as a gendered hierarchy in matters of HIV/AIDS.

I begin by briefly examining the Senegalese state-initiated HIV/AIDS policy response embodied in the *Programme national de lutte contre le SIDA* (PNLS) (1987-2001) in order to demonstrate how a male-dominated political culture was reproduced within it early on that entailed sidelining women and gender issues from the outset and marginalizing women's groups in the policy-making process. I then turn to a gender analysis of current HIV/AIDS policy framework as embodied by the *Conseil nationale de lutte contre le Sida* (CNLS) and the expanded multisectoral approach showing their limitations; principally a failure to take gender seriously in policy discourses, strategic priorities and in the institutional framework which limits the participation of women's groups in policy and decision-making around HIV/AIDS and their advocacy efforts.

7.1 The *Programme National de Lutte contre le SIDA*

Considered an example of an effective state-centric approach to HIV/AIDS Senegal's national policy response to HIV/AIDS has been shaped by different aspects of its political culture (Eboko 2005). This includes a centralized state structure, clientelist politics with various institutional networks into diverse constituencies and a long tradition of associational activity. Senegal also possesses a relatively well-developed health infrastructure, a highly-trained cadre of medical professionals and institutes of scientific research with international links; a legacy of French colonial policy creating Dakar as a centre for tropical medicine in French West Africa (Eboko 2005; Putzel 2005).

Acting on the advice of Senegalese medical and scientific expertise¹, president Diouf was quick to launch state action in response to the emergence of the first AIDS cases and prior to the WHO-sponsored Global programme on AIDS

¹. Professor Souleymane Mboup was a key player in the international team that discovered the HIV-2 virus in Senegal. Along with Dr. Ndoeye and Dr. Awa Coll-Seck head of Infectious Diseases at Fann Hospital at the time, they met with president Diouf to discuss developing a national response.

advised them to do, building on Senegal's continued involvement in HIV/AIDS research (Putzel 2005), in contrast to most other African states (Eboko 2005; UNAIDS 1991a). In 1986, The Senegalese government established the *Comité national pluridisciplinaire de prévention du SIDA* (CNPS) and immediately set up the *Programme national de lutte contre le Sida et les MST* (PNLS), housed in the Ministry of Health in the Division of Sexually Transmitted Diseases (Putzel 2003). Among its many responsibilities, the CNPS was responsible for developing and implementing national HIV prevention strategy, in conjunction with three main working groups (clinical, epidemiological and education) (République du Sénégal 1987). An intersectoral approach to HIV/AIDS in Senegal was instituted at the outset, as the CNPS was composed of senior bureaucrats from eleven different Ministries, including the *ministère du Développement social* that housed a women's bureau, *secrétariat d'État à la Condition Féminine*.² The working groups were largely composed of medical experts except for the IEC working group that included some Senegalese educators. The *Comité restreint* possessed decision-making power in all areas but the over-all coordination of studies, research and actions related to AIDS in each of the sectors (République du Sénégal 1987).

The initial HIV/AIDS policy-making structure and process was largely the sphere of Senegalese medical and scientific experts, government bureaucrats and external funders (USAID, the WHO, UNDP), gradually evolving to include civil society actors in a limited way. In 1990, a fourth working group was added; a commission for legal and ethical issues made up of representatives from the education sector and NGOs. (#32) The working groups developed the strategies for each of the priority areas, which were then incorporated into the national

². In 1991, the Women's Bureau became the *ministère de la Femme, de l'Enfant et de la Famille* until 1988 when it was renamed the *ministère de l'Action sociale et de la Solidarité nationale*; a process it has undergone several times since. Moreover, its structure has alternated between constituting a separate ministry and a secretariat as part of the *ministère du Développement social* (MFFDS website 09/15/ 2006; Wone 2002b; Sow 1995). In 2004, it became the *ministère du la Femme, Famille et Développement social*. In 2008, it became the *ministère de la Famille, de l'Entreprenariat féminin et de la Micro finance*. I will refer to the women's ministry as *ministère de la femme*, its official designation at the time of my research.

HIV/AIDS plan prepared by Dr. Ndoye, the head of the PNLs. The executive committee retained the overall authority for the program. (#4, #32) The CNPS became the *Comité national de lutte contre le Sida* and was responsible for the coordination and monitoring of the national HIV/AIDS strategy, the *Programme national de lutte contre le Sida* (République du Sénégal 1994). The CNPS worked closely with the WHO as well as other international institutions and a variety of bilateral AID agencies, all of whom exerted varying degrees of influence in developing Senegal's policy response.

“The Executive was responsible for the coordination. They developed the proposals that were validated by the four groups and their partners; state partners (ministries) and external funders who could make suggestions that were then incorporated into policy initiatives.” (#4)

“Years ago, the PNLs worked closely with international agencies to develop their short and middle term plans. Senegal actually developed its first plan before the GPA contacted us. For years, these plans – a medium term planning process in concert with international AID agencies defined the response. High-level local experts like Dr. Awa Coll-Seck and Professor Mboup, who had a lot to say, also drafted the response. Multilateral and bilateral donors, USAID, the European Union, the French Cooperation and to a certain extent CIDA played significant roles in crafting policy in one way or another.” (#1)

Cognizant early on of the need to mobilize civil society actors in the fight against HIV/AIDS and drawing on a long tradition inherited from the colonial era of courting the Islamic brotherhoods as clients of the state (Geller 2005; 1982; Copans 2000; Villalón 1999; Coulon 1995, 1981), president Diouf and the heads of the state national AIDS program played a key role, through the mediation of JAMRA, a religious NGO, in involving Muslim leaders, as allies in the fight against AIDS, given their enormous power within the country (Putzel 2005). The purpose was to develop a consensus around the promotion of condoms, as religious leaders were generally opposed to the use of condoms and many tended to see it as a punishment for moral transgression (Putzel 2003; Niang 2001; Groupe Thématique ONUSIDA/Sénégal 2001). As Delaunay et al. (1998: 124) point out,

The state-religious partnership developed during a post-Senghorian political conjuncture marked by the re-composition of clientelist relationships linked to the state and the renewed power of Islam served in part to legitimize the PNLS as a state institution capable of addressing the social and collective dimension of HIV/AIDS.

Although viewed as complementary, the state also sought to ensure that religious messages around HIV/AIDS supplemented bio-medical ones by working with more moderate religious authorities (Delaunay et al. 1998). This is consistent with the long established political practice of negotiating/containing the power of Islamic authorities (Geller 2005). Catholic religious leaders were involved later on.

“The central state played a pivotal role in creating the space for the associational sector to act but also in initially mobilizing it around HIV/AIDS” (Putzel 2006: 179). The Parti Socialiste drew on its deep reach into a network of different constituencies. Although little attention was given to the role of women’s groups in the first medium term plan of 1988 (Wone 2002b), a few years later the government and the PNLS met with state-created national women’s federations such as the *Fédération des associations féminines* (FAFS) and the *Fédération nationale des groupements de promotion féminine* (FNGPF) to develop HIV prevention activities targeting women, which they did along with SWAA. “International NGOs such as ENDA worked closely with the government from the top-down to establish associational activity with other key constituencies, using pre-existing organizations or creating new ones” (Putzel 2005: 179). Medical doctors and social workers working with PHAs were instrumental in setting up the first Associations of People Living with HIV/AIDS in Senegal at Fann Hospital in the early 1990’s and later on at the CTA (Mbodj and Taverne 2002; Delaunay et al. 1998), although the first women’s PHA association came into being much later. After assisting at an annual conference hosted by the Society for Women and AIDS in Africa (SWAA), SWAA-Senegal, the first and most important AIDS-focussed women’s NGO in Senegal, was set up in 1989 by female medical professionals Dr. Awa Coll-Seck and Professor Assiatou Gaye Diallo and maintains a close

relationship with the senior HIV/AIDS medical establishment, although it is an independent NGO (#16). The state, at the urging of the senior Senegalese medical establishment, set up the ISAARV initiative to make ART available to Senegalese PHAs and later on to provide them free-of-charge (Simms et al. 2006; Mbodj and Taverne 2002), unlike other countries in Africa where civil society organizations and Associations for People Living with HIV/AIDS play a key role in demanding access to treatment (Siplon 2005; Webb 2004; Parker 2000; Bastos 1999). Western NGOs and scientists, in fact, initiated the arguments for the dual prevention and treatment strategy rather than African states (Patterson and Cieminis 2005).

Despite the important emphasis on community mobilization and a participatory approach, the partnership between the state and civil society actors was an unequal one. Civil society actors (NGOs, CBOs, Associations of PHAs, religious groups) generally were not involved as decision-makers in the HIV/AIDS policy process and no guiding principles or framework for policy dialogue between the state (PNLS) and these actors were in place (Jurgens and Dia 2006). Their inclusion in the policy process was limited to the role of intermediaries (*relais*), supporting state HIV/AIDS policies and spreading the prevention messages to their specific constituencies (Delaunay et al. 1998). Communities as a whole were not mobilized at a grass roots level around identity politics as was the case with gay men in the USA (Kerouedan and Eboko 1999) but rather specific actors were mobilized by the state whose proximity and capacity to mobilize different constituencies targeted for HIV prevention (IEC) activities such as women or youth (Synergie 2003; Putzel 2003; Delaunay et al. 1998). As these respondents explained,

“There was relatively little input by the community into the policy process. Only the NGOs that cultivated a role with the PNLS like ICASO Senegal, which is now called COSSEN who have been close to the powers that be in the last ten years have had a voice but not a strong voice.” (#1)

“Very early on there was collaboration between the PNLS and the IST program which was integrated into the PNLS in part because the team included representatives from the Laboratoire at CHU du Dantec and

representatives from the sexually transmitted diseases unit at Fann Hospital. Later on, a few NGOs such as RESER/SIDA and RARS in 1988 and JAMRA in 1989 got involved in the awareness campaigns as it was understood fairly early on that AIDS was not simply a medical issue. Now institutions and groups that intervene in the fight against AIDS are more involved in developing and executing awareness campaigns and in defining their target groups but at the same time, they respect the priorities set out in the strategic plans.” (#3)

The limited role for civil society actors in the policy-making process during this period also meant that women’s groups had little input into the policy agenda around women, gender and HIV/AIDS issues.

7.2 The *Conseil Nationale de Lutte contre le Sida* : The Multisectoral Approach

Significant changes occurred in the structure of the PNLIS in 2002, partly a result of Senegal’s participation in initiatives such as the 2001 Economic Commission of Africa Forum, the 2001 OAU summit and the 2001 UNGASS Special Assembly that called for a broader national response to HIV/AIDS played a role (Synergie 2003) but primarily in order to satisfy World Bank MAP and The Global Fund to Fight AIDS, Tuberculosis and Malaria (GFATM) funding criteria (World Bank 2001c; The Global Fund 2002); the two main funders of Senegal’s HIV/AIDS program. As Putzel (2003: 28) explains,

Both the World Bank’s MAP and the Global Fund require countries to establish a supra-ministerial and multisectoral national committee or commission to oversee a national programme. The Bank demands that ‘a high-level HIV/AIDS coordinating body such as a national HIV/AIDS council or equivalent has been established to oversee the implementation of the strategy and action plan. This body should include broad representation of key stakeholders from all sectors including PHAs. The Global Fund requires the establishment of ‘country coordination mechanisms’ which it describes as ‘national consensus groups’ made up of representatives from government, NGOs, the private sector, people living with HIV/AIDS, TB and Malaria, religious and faith groups, academic sector and UN agencies active in the country.

This new structure, the *Conseil national de lutte contre le Sida* (CNLS) was created in 2001 by presidential decree, under the auspices of the Prime Minister's Office rather than the Ministry of Health (CNLS 2002a). This move was to satisfy the World Bank's criteria of demonstrating high-level political leadership for HIV/AIDS policy and programs. The PNLs became the *Division de lutte contre le VIH/sida et IST*, housed in the Ministry of Health (Putzel 2003). The re-vamped institutional framework also coincided with the implementation of an expanded multisectoral approach to HIV/AIDS that entailed enhanced community and private sector participation as well as regionalization and decentralization of the response with respect to funding and programming, endorsed by the World Bank (2001c).

Developed as a more effective alternative to the bio-medical response under the aegis of Ministries of Health, the Multisectoral approach is conceived of as better able to grapple with the complex nature of HIV/AIDS and the social determinants of the disease. The multisectoral approach to HIV/AIDS entails an integrated and broadened approach involving a partnership between the state, civil society and the private sector in the fight against AIDS. It was endorsed by all the signatories of the UNGASS Declaration at the 2001 UN Special General Assembly on HIV/AIDS (Commonwealth Secretariat and the Atlantic Centre of Excellence in Women's Health 2002). At the same time, national AIDS commissions and the scaling up of policy responses are premised on UNAIDS' 'Three Ones' principles with a view to more effective coordination of the multisectoral policy response: one national AIDS coordinating authority, one agreed upon HIV/AIDS action framework and one agreed upon country level monitoring and evaluation framework (Diouf 2007).

In 2007, the Senegalese HIV/AIDS institutional framework included national, regional, departmental and local structures. The CNLS, the *Secrétariat exécutif de lutte contre le Sida* (SEN) and a fiduciary agency responsible for

financial administration make up the key institutions at the national level (CNLS 2007c). The CNLS is mandated to set national policy orientations and is the key decision-making structure (CNLS 2007c). As a decentralized structure, the CNLS is represented at the regional level by the *Comités régionaux de lutte contre le Sida* (CRLS), at the departmental level by the *Comités départementaux de lutte contre le Sida* (CDLS) and at the local level by the *Comités locaux de lutte contre le Sida* (CLLS) (CNLS 2007c, 2007b). These councils operate under the highest administrative authority at each level (CNLS 2007b). They are responsible for the planning, coordination, monitoring and supervision of the regional integrated multisectoral plan, based on national policy priorities (CNLS 2007b).

In 2007, the CNLS was made up of 48 members drawn from all sectors of society including the prime minister (president), the Minister for Health and Medical Prevention (first vice-president), the Minister of Economy and Finances (the second vice president), ministers from the key ministries involved (9), political officials including a representative from the office of the President of the Republic, the first vice-president of the National Assembly, the first vice-president of the *Conseil de la République pour les Affaires économiques et sociales* (CRAES) and the governors of each region (11) and the presidents of the CRLS, the president of the CCM (Global Fund), civil society actors including three local NGOs, two representatives from PHA associations and three representatives from national networks (women and youth), two members of religious denominations, one representative of the *Patronat* and one representative of the *Centrales syndicales* (CNLS 2007c: 66). The CNLS also included several associated members such as the coordinator of the UN system, the president of the *Groupe thématique de système des Nations Unies pour le lutte contre le sida*, two representatives of multilateral and bilateral aid donors and any experts with particular competencies who may also be invited to participate (CNLS 2007c: 66). Required to meet four times a year, the CNLS does not hold these meetings regularly (Diouf 2007).

Although the CNLS is the principal actor responsible for assisting the government with the definition, orientation and operationalization of national HIV/AIDS policy, it is the SEN that oversees policy and programs and actually develops the strategic priorities (CNLS 2007c; 2002a Synergie 2003; Putzel 2003), taking into account key donor priorities, which guide the development of strategies, programmes, research and project funding. The SEN is composed of the executive secretary, the program heads and the representatives of the focal points within strategic ministries and civil society as well as representatives from the agencies involved in technical and financial administration. Should the SEN deem it necessary, it can include experts in the field of HIV/AIDS (CNLS 2002a). The SEN holds periodic meetings to ensure the functioning of the CNLS. Its permanent bureau is made up of the directors of the PMO's Cabinet, the Minister of Economy and Finance and of Health and Medical Prevention, the health advisor to the President of the Republic, the executive secretary of the CNLS, the president of the Thematic Group on AIDS, the president of the CCM, one representative for the PHA associations, civil society and the private sector (CNLS 2007c: 67).

The Senegalese government also set up a country coordinating mechanism, the *Instance de coordination générale*, in February 2002 in compliance with Global Fund grant requirements at the time of the Round 1 call for proposals, initially composed of 24 members (CNLS 2002c). The CCM is responsible for preparing coordinating and monitoring Global Fund grants. Renamed the *Instance de coordination nationale* but referred to as the CCM, in 2005, it comprised 46 members; 50% of whom were from civil society representing local NGOs, women's groups, faith-based organizations, associations of people living with HIV/AIDS and malaria, academics, research institutions, youth groups and the private sector (Patterson 2006: 74-75).

The re-vamped institutional structures for HIV/AIDS policy-making are not without their problems, principal among them, the unequal power relations upon

which they are constituted and which they reproduce; gender, north-south and state-civil society inequalities. The CNLS and the national AIDS program are heavily dependent on external funding, particularly on the World Bank MAP loan at this moment. The CNLS executive secretariat was wholly funded by the Bank and has been criticized for a narrow focus on donor activities rather than on the national policy response as a whole (Diouf 2007). Now that MAP funding is coming to an end, the executive secretariat is in negotiations with the Senegalese state to secure its funding (Diouf 2007). The withdrawal of the Bank has meant that the Regional Councils are now without financial assistance and the entire decentralization process is in jeopardy (Diouf 2007).

The composition of the CNLS continues to reflect and reproduce unequal power relations between the state and civil society, as non-state actors remain under-represented in it (Jurgens and Dia 2006). The process for choosing civil society actors as members of the CNLS and their lack of communication with the larger constituencies that they represent have been criticized (Diouf 2007). The *Observatoire*, a coalition of five key NGOs including ACI-Baobab, *Synergie pour l'Enfance*, ANCS, *Enda Santé* and *Sida- Service*, was created to strengthen civil society participation in the policy-making process and in the policy response as a whole to more effectively meet the specific needs of individual regions, communities, localities and marginalized groups (Jurgens and Dia 2006).

7.3 The Limits of Gender in the Multisectoral Approach

7.3.1 The Under-Representation of Women's Groups in the CNLS/CCM

Despite criticisms of these new institutional frameworks (Diouf 2007; Jurgens and Dia 2006; Putzel 2003, 2004, 2005), they have served to increase the

presence of civil society actors in general and of women's groups in specific in the HIV/AIDS policy-making process. This mirrors broader trends around women's increased participation in formal politics in Senegal in recent years (République du Sénégal 2006b; Creevey 2006; Geller 2005; Sow 2002a) and trends towards greater democratization in Sub-Saharan Africa (Patterson 2006). Although women's groups are better represented in the Senegalese institutional and policy-making structures than is the case elsewhere, they still are under-represented in this process; a pattern noted for the vast majority of national AIDS programs (UNAIDS 2006).

In 2007, women were represented by SWAA, ABOYA and the *Fédération nationale des groupements féminins* along with a representative of the *ministère de la Femme, Famille et Développement social* within the CNLS (CNLS 2007b). Moreover, at that time of this research, all seven program managers of the Executive Secretariat (SEN) were women, one of whom was a gender expert, with Dr. Ndoye the head of the SEN (CNLS website 01/01/2007).³ Despite the increased presence of women and women's groups within the CNLS, they remain under-represented within it. They are excluded from the '*bureau permanent*' of the SEN where the real power resides. Moreover, while the World Bank organizational template for the national AIDS commissions has a requirement that women's interests be represented, it has not developed any specific guidelines as to what groups or organizations should be involved or set a gender quota for their representation, that might rectify the power imbalance that shapes the inclusion and capacity of women's groups to act. Unequal gender relations characteristic of the formal political system in Senegal have reproduced themselves within this key HIV/AIDS policy-making body, as this respondent (#5) observed,

“In the conception of policy, women's groups are not heavily represented in the places and structures where policy is developed or in the institutions such as the CNLS itself. Men are much more

³. As of January 2008, there were changes in the composition of the SEN and the female gender expert appears to have been replaced by a male, although women continued to occupy most of positions of program managers. (CNLS website 03/18/2008)

numerous and at least three-quarters of the CNLS members are men. Gender relations are an issue here too...

The impact of HIV is social and economic. This increases poverty and social disequilibrium. In HIV policies there is a lack of vision with respect to social transformation. Policy is elaborated within the constraints of maintaining the status quo. We need radical change. To get to this we need to listen to people at the base, to young women, to older women. We need to hear what they have to say and provide them with the space and freedom to express their views. There is little space for women to express their views. Women are used as a '*masse de main d'oeuvre mais elles ne décident pas.*' "

Women appear to be less well represented as heads of the regional and departmental HIV/AIDS committees which are primarily made up of regional, departmental and local government officials and medical doctors (CNLS website 30/06/2007), as is the case with civil society actors in general (Jurgens and Dia 2006). Moreover, while civil society actors are to be represented at these levels, there is no requirement for a gender balance or for the inclusion of women's groups (see CNLS 2007b). Women are virtually excluded from decision-making positions at the regional and departmental levels, reproducing women's limited representation in the political structures at these levels. Given the current trends towards greater regionalization and decentralization of the national response, promoted by the key funders to health and HIV/AIDS programs such as the World Bank, the Global Fund and USAID, this means that women's capacity to make decisions around funding and programs targeting women and gender and HIV/AIDS issues at these levels remains limited.

Within the CCM, in addition to the *ministère de la Femme*, women's groups were represented by ABOYA and the *Fédération nationale des groupements féminins* and 14 of 46 (30%) members are women (GFATM 2005). Perhaps, most striking is the fact that SWAA, with its woman-focussed mandate, gender perspective in organization and programs and long history of expertise in prevention and care and support of HIV infected and affected women, orphans and vulnerable children, is not a member of the CCM but only a recipient of Global

Fund grants through the community based portion administered by the ANCS, a Senegalese NGO with international links. The majority of female members of the CCM were chosen to represent specific constituencies other than women. This raises two broader questions: how women's interests are represented in the CCM and who should represent them.

A recent evaluation of the Global Fund documents showed that it lacked a clear agenda for addressing gender issues (Duwury et al. 2005: 7). In light of this review, the Global Fund now insists that there be a gender balance in the CCMS with at least one person with gender expertise and that project proposals possess a gender perspective (GFATM 2005). However, none of these criteria are elaborated in any detailed way and questions remain as to how they are implemented. Although women made up 30% of the members in the Senegalese CCM, hardly a gender balance, Senegal's 2006 submission to the Global Fund was accepted (CNLS 2006d). Moreover, beyond the ritual acknowledgement of women as a vulnerable group, the strategic orientations around HIV/AIDS in the CNLS 2006 funding application revealed little in the way of gender mainstreaming. The idea that the national AIDS commissions and CCMs should be broadly representative of all sectors in society calls into question the unequal power relations between societal groups that shape their inclusion and voice within these structures.

7.3.2 A Gender Perspective within the CNLS/CCM?

The presence of women in the CNLS does not in and of itself guarantee the implementation of a gender perspective. The presence of a gender expert in the CNLS in and of itself is insufficient to move a gender and HIV/AIDS program forward if there is not an overall a commitment to mainstreaming gender into institutions and programs, as one respondent (#11) pointed out.

“I do not have enough power to change the CNLS. The study I did for UNIFEM was not taken up by the CNLS. The CNLS is a gender-blind structure. The big boss is a man who runs it. He will argue that look,

all my program managers are women but I will say yes, this is true but they do not have a gender perspective.”

As several respondents (9/26) pointed out, the gender approach to HIV/AIDS in Senegal is not that well articulated, not well understood or systematically applied. A few respondents (3/26) suggested that lip service is paid to gender issues and it isn't a fundamental policy or program pre-occupation.

“It isn't elaborated in a specific way. The approach is multisectoral, involving the state or public sector, civil society and the private sector. The women and HIV dimension is taken into account. The PTME program is about women. Women are at the centre of the strategy around mother-to-child transmission in order to reduce the risk.” (#6)

“I admit that the gender approach in the area of HIV/AIDS has just started to be on the right track. The gender dimension has not always been a preoccupation in our policies and it has not been a focus of our activities. Now however, we can not but take gender issues into account, given the feminization of AIDS.” (#20)

Concretely, is there really a gender approach? We have talked about it but really apart from the PTME, there are no specific programs for women in general that I know of, prostitution or the PTME but women as women, women with HIV/AIDS they have no specificity.” (#16)

There appears to be a lack of consensus as to what gender means as an approach to HIV/AIDS in policy and in practice. When asked about the gender approach to HIV in Senegal, a few participants said they did not know what it meant; all the more significant as some of these respondents participated in the National Consultation workshop to develop 2007-2011 HIV/AIDS Strategic Plan and are also CNLS members at large and in the expert working groups. Despite their unfamiliarity with the concept of gender, these respondents were quite aware of multiple gender differences in men's and women's experiences of HIV/AIDS.

For the majority of my respondents, gender equated with women (18/26), to mean programs for women such as the PTME or prevention efforts to address

women's vulnerability (11/26), the involvement of women's groups in HIV prevention (4), women in positions of authority as program managers or presidents of the Association of People Living with HIV/AIDS (3) and/or gender equity in services (2). A smaller number of respondents (8/26) suggested that gender referred to gender differences between men and women, citing gendered vulnerabilities to HIV and the need to involve men in HIV prevention activities as essential to reducing women's vulnerability to HIV. Of this group, five respondents viewed gender as unequal power relations between men and women, with equality or equity a goal of a gender approach to HIV/AIDS. For these respondents, there is no gender approach to HIV/AIDS in Senegal. Many members of the CNLS do not necessarily possess a gender perspective premised on a conception of gender as a social relation or a power relation or are resistant to this view.

"Many men get upset when we talk about gender. They feel that it is a challenge to paternal authority." (#20)

"For the most part, those who manage the programs don't have a sensitivity to gender issues, even in government organizations and institutions don't have sufficient awareness around the issues and developing appropriate strategies. The Education Ministry reproduces social norms around gender." (#13)

"Because the CNLS is a national program of the state, it is obliged to take women into account. How they take women into account – women as wives, women as mothers (the PTME) and, women as workers (sex-workers). This is how they target women. Women are not viewed as human beings in their own right. We don't have a vision of women as individuals. To say that women are vulnerable, it is maddening. It is a social construction and women do not have economic and political power...when we speak about women and HIV/AIDS, it comes down to women as vectors of transmission or breastfeeding." (#18)

Moreover, there appears to be a lack of political commitment within the state to including gender in a substantive way in the multisectoral approach to HIV/AIDS, as evidenced in funding.

“The government doesn’t really give a whole lot of importance to the issue and position of women in the fight against HIV/AIDS or to women and AIDS issues. The whole question of women’s vulnerability and the fact that women are more vulnerable is evident in the financing of programs. Programs targeting women are not seen as a priority by the CNLS. For example in the CNLS stream *Société civile et communautaire*, women’s projects received less funding and women’s groups and associations received less funding. For 2004 to 2005, 50 women’s projects were funded but 150 projects for youth were funded, particularly aimed at young men or boys.”

External donors participate as members of the CNLS and CCM, as participants in the national consultation to develop the HIV/AIDS strategic plans and sectoral plans of line ministries and as funders to NGOs. However, their support for a gender perspective in policy orientations and program interventions varies. This was noted in a study on gender criteria in bilateral and multilateral aid agencies funding in francophone West Africa (ICW 2005). HIV prevention targetting women’s and mother-to-child transmission rather than the rights of HIV positive women and tackling the socio-economic determinants of women’s vulnerability tended to dominate (ICW 2005). A few respondents observed that gender mainstreaming in HIV/AIDS is not an objective of most external funders in Senegal, despite the fact that they have Gender and HIV/AIDS units

“Gender isn’t systematically applied in action. Everyone talks about the feminization of AIDS and that we need to focus on women. This is the current discourse but there is not enough in the way of strategies and actions that take gender into account. Very few of our partners with the exception of CCISD (Sida 3 project) insist on a gender component. USAID and the World Bank don’t insist on it. The CNLS manages and administers the MAP funding. The international AID agencies don’t push for a gender component. This needs to be a requirement of funders – how we take gender into account” (#13)

The World Bank, the major external donor to the Senegalese HIV/AIDS program, has only just begun to examine how gender can be better mainstreamed into its MAP funding projects in West Africa. Its recommendations for Senegal focussed on integrating gender-differentiated targets to measure the success of a

limited range of prevention activities, with no mention made of the gender issues affecting women's burden of care, issues affecting HIV-positive women or addressing unequal gender relations (Ligiéro and Kostermans 2004). It reflects the World Bank's technocratic, depoliticised approach to gender and development issues (Bessis 2003; Prügel and Lustgarten 2006; Razavi and Miller 1995b).

7.3.3 'Women' in the National Consultation Policy Process: 'One Voice among Many'

As with its predecessors (the medium term plans of the 1990's), the 2002-2006 and 2007-2011 HIV/AIDS strategic plans were developed through a national consultation process. Both of these consultations involved an expanded number of actors drawn from the senior medical establishment, the public sector (government ministries), civil society (NGOs and associations of people living with HIV/AIDS), external funders and the private sector. The general process for developing and defining the national strategies entailed a two-day planning session whereby actors invited to participate are organized into specific thematic working groups that make recommendations that are then incorporated into the strategic plan. Once the strategic plan is developed, it is then validated by key participants. This process is used at both national and regional levels. Women's groups remain under-represented in this policy-making process and the lack of a gender perspective on HIV/AIDS affected the policy outcome.

The national consultation for the 2002-2006 Strategic Plan included the representative of the *ministère de la Femme* as well as several representatives from a few key women's groups. Equally important, a working group on 'women' was set up as a theme group. However, this did not appear to substantially alter current policy conceptions of women and HIV/AIDS issues. The focus appeared to be heavily skewed towards prevention as opposed to treatment, care and support of

seropositive women and rights issues. A few respondents who participated in the working group on women expressed their dissatisfaction with it.

“The response to HIV, in the last strategic plan (2002-2006), they put in place a working group on ‘women.’ There were a few of us who worked on this issue but it was very superficial. There was no real reflection on the determinants of women’s vulnerability – what makes women vulnerable. There was no real reflection as to who is the most vulnerable and what needs to be done.” (#13)

“In terms of the national consultation for 2002-2006 strategic plan, the participation of the *ministère de la Femme* and women’s groups was quite weak despite the fact that there was a working group on women. But the working group on women was largely made up of bureaucrats and representatives of the *Fédération des associations féminines du Sénégal* and SWAA. There wasn’t really a broad enough participation of women’s groups.” (#27)

Women’s groups were also under-represented in the national consultation process to develop 2007-2011 HIV/AIDS Strategic Plan organized by the SEN. ‘Women’s interests’ were limited to representation by SWAA, FNGPF, FAFS, ABOYA and the *ministère de la Femme*, well as AWA that works with female sex workers. Chosen by the SEN on the basis of their expertise, 115 key actors were invited to take part in this workshop to develop the strategic orientations. This included political officials (5), the SEN (8), representatives from the key Ministries (8 although Education and Labour both have more than 1 representative), unions (3), private sector (2), the health sector (22), the Finance ministry (1), PHA associations (2), national NGOs (16), religious organizations (4), the CRLS (11 members plus 3 doctors from three regional hospitals) and technical and financial partners/funders (30) (CNLS/SEN *Lettre circulaire de 10 mai 2006*). Despite broad representation from civil society and a certain democratization of the HIV/AIDS policy-making process, civil society actors were under-represented in this process, particularly Senegalese NGO, CBOs and PHA associations while medical professionals and external funders were over-represented. In spite of official acknowledgement of the feminization of AIDS, no working group on women was

put in place for this consultation, giving credence to the idea that lip service is paid to this issue.

“No working group specifically focussed on ‘women’ was put in place for this consultation, with no groups using an explicit gender approach in the development of strategies. The argument goes that if you have a working group on women, then you should have one for youth, for the military etc.” (#11)

As part of the state’s commitment to health for all (#3) and World Bank emphasis on decentralization and regionalization of projects and funding, they are becoming much more important elements of HIV/AIDS policy-making (#29); ‘*planification intégré*’ as part of ‘*gestion intégré*’. This was also a consequence of intense lobbying from the *Observatoire* advocating for regionalized and decentralized program planning to better meet the needs of the regions and of marginalized groups (#1, #13). Regional committees are taking a more important role in developing regional plans that also feed into the national strategic plan (see the regional plans in the CNLS 2002b). A few respondents felt that this is already showing positive signs explaining that,

“For the 2007-2011 national consultation, there is better representation of women’s groups in the strategic planning in Tambacounda and in Thiès, partly as a result of decentralization. There is better participation of groups like APROFES who want more focus on women’s vulnerability. The *ministère de la Femme* is also focussing on taking gender into account which is also UNDP’s emphasis this time, in planning and implementing HIV/AIDS policies.” (#27)

“The process is now different – regionalization and decentralization. Regions are now developing plans based on their needs. This is the process for the 2007-2011 Strategic Plan. I assisted at two planning workshops one in Dakar and the other in Thiès. Thiès region identified its needs and strategic priorities. The issue of women was on the table; not gender, but women – How to reduce the feminization of the epidemic, develop sensitization strategies, increasing the information given to women and develop income-generating activities to reduce the socio-economic need among women. The focus was also on the PTME and voluntary testing is an emergent theme. There were about 70 people in the workshop but I’m not really sure how many women’s groups took part and the Plan hasn’t been finalized.” (#19)

Other respondents, however, were less enthusiastic about the impact of women's increased participation in the decentralization and regionalization planning process, pointing to structural barriers and gender biases that impede women's substantive participation in developing strategic orientations and decision-making around priorities.

“Just because women are present doesn't mean that they are actively participating. So you can have twenty women present but that doesn't mean that they are participating because they may not know how or they don't have the knowledge. The women's groups, their representatives in the CNLS and right on down to the village level, there may be two or three women like myself but more not like me. Will they be heard?” (#29)

“The HIV/AIDS programme is largely inspired by a technocratic vision in terms of intervention, programs and policies. It is the experts, the doctors and consultants, both national and international who provide what is considered to be the criteria in these areas and who are chosen for input. Women who don't share this profile but who have a lot of useful things to say about HIV/AIDS issues are not part of this process. Women are less educated have less access to formal education and who are less likely to speak French are hardly present in this institution, in policy structures and in political structures. At the base, these women have their own experts, using local languages and expertise in their local rural communities. We need to bring these women into policy and political structures.” (#5)

While a majority of the respondents (15/26) felt that decentralization and regionalization represented positive steps in making HIV/AIDS policies more responsive to regional and community needs, it is unclear whether these trends will enhance the formal and substantive participation of women's groups in the process and make 'women and HIV/AIDS' issues more central to strategies. Previous research on decentralization and women's participation at local levels of decision-making in Senegal has shown mixed results with respect to enhancing women's formal and substantive representation in these political structures (Abdoul et al. 2002; Beck 2003; Patterson 1999; Sow 1997).

7.3.4 'Women' and Gender in HIV/AIDS Policy Discourses

The increased presence of women in the CNLS and in the national consultation process has not been accompanied by a significant change in HIV/AIDS policy discourses around 'women', gender and women's empowerment, as an examination of successive HIV/AIDS plans, the key policy documents, shows.⁴ These plans articulate the main strategic priorities for the national HIV/AIDS policy response and are essential to obtaining funding from external donors (see the World Bank 2001c; CNLS 2006d) in addition to serving as the basis for CNLS funding of projects.⁵

'AIDS – Disease of Poverty and Development': What about Gender?

How HIV/AIDS is framed, whether as a health issue, a human rights issue, a reflection of gender inequalities, an emergency situation or a development issue, leads to certain policy and program outcomes as opposed to others (Patterson 2006: 138). The discourse articulated in successive national HIV/AIDS plans as to the main driving forces of the HIV/AIDS epidemic in Senegal has remained fairly consistent over time: HIV is transmitted through heterosexual sex primarily through prostitution and migration, both of which are exacerbated by poverty and the weakening of social control and sexual norms based on religious precepts (defined as development). This view is articulated in *The Plan à Moyen Terme 2 1994-1998* (République du Sénégal 1994: 1) which states that "the actual spread of the disease

⁴. "By 1998, the huge '*plan à moyen terme*' was *dépassé* and the PNLs was integrated into the *Programme de Développement Intégré de la Santé* (PDIS), as line items according to activity, contribution and funder. The actual plan for 1999 to 2002 was never made public and hastily put together by Dr. Ndoye to obtain funding from the World Bank.", as this respondent told me (#32).

⁵. See the CNLS document, *Appel à proposition de projets* le 12 juin 2006 soliciting HIV/AIDS project proposals from civil society groups that respond to the strategic priorities outlined in the 2002-2006 Strategic Plan. Such is also the case for ANCS funding from The Global Fund to civil society groups (see the ANCS website; consulted December 6, 2006).

through prostitution and migration...Poverty and the importance of sexual transmission constitute the determining factors of the spread of HIV in Senegal.” It elaborates further (ibid 1994: 9).

La voie de transmission du VIH la plus incriminée au Sénégal est la voie hétérosexuelle. La multiplicité des partenaires, les relations sexuelles précoces et les résistances à l'utilisation des préservatifs, la libéralisation des mœurs sexuels, surtout dans les zones urbaines et semi urbaines, en sont les facteurs déterminants. Cependant, au cours des travaux de séminaire de consensus national, la majorité des participants est tombée d'accord pour affirmer que la pauvreté, aggravé par la crise économique, pousse les hommes et les femmes à émigrer vers les capitales régionales et à l'étranger. Le recensement de 1991 a ainsi révélé que dans les zones urbaines, la prostitution est développée et on note une prévalence assez élevée de VIH et des MST chez les prostituées. Les nouvelles infections sont à craindre chez les adolescents des zones urbains, arrivant à l'âge sexuellement actif, et chez les nouveaux immigrants des zones rurales.

Despite the inclusion of a socio-economic analysis of the spread of HIV/AIDS in Senegal and emphasis on the “need to combat poverty and prostitution in order to reduce HIV transmission” (République du Sénégal 1994: 12-13), they are not linked to a broader analysis of Senegal’s political economy, processes of globalization and the gender-differentiated impact of structural adjustment policies. Gender inequality and the subordination of women, particularly young women, do not appear to be considered as drivers of the epidemic, much less as a factor in driving women into prostitution and migration. Moreover, women as a social category were not viewed as a vulnerable group. Rather gender bias is implicit in the allusion to the increasing percentage of non-married women ages 15 to 29 who presumably are involved in unprotected pre-marital sex and as such their sexual behaviour constitutes a driver of the epidemic. Alternately, no analysis was undertaken around changing norms for marriage and pre-marital sex among young men and how this might affect male sexuality and the spread of HIV. Finally, where women were considered, it was with respect to how HIV infection in women will affect Senegalese society and economy, similar to WID approaches that focus on what women will do for development. “Given the

social status of women, their role in society as mothers, educators, wives and caregivers, contracting HIV would have a dramatic impact on the socio-economic situation of the country” (République du Sénégal 1994: 11).

The 2002-2006 Strategic Plan (CNLS 2002a: 11) expanded on this view of AIDS articulated in the *Plan à Moyen Terme 2 1994-1998* as a problem of poverty and development (westernization and liberalization of sexuality).

...Les facteurs de vulnérabilité favorisant la propagation de l'épidémie notamment ceux liés à la pauvreté, à la prostitution, à l'analphabétisme, aux conflits et à la mobilité des personnes. Il existe toujours des faits socio-économiques qui affaiblissent le contrôle social de la sexualité. Ainsi la pauvreté et l'urbanisation ont favorisé le recul de l'âge du mariage chez les jeunes filles et une plus grande sexualité pré-nuptiale. En effet, il était établi selon l'enquête démographique et de Santé en 1997 que l'âge du premier rapport sexuel est de plus en plus précoce. À l'âge de 15 ans, 16% des femmes ont déjà eu des rapports sexuels et à 18 ans, cette proportion passe à 55%. La situation que connaissent les adolescents et les jeunes dans le domaine de chômage, de la pauvreté, de manque d'information peut les exposer à des comportements sexuels qui les rendent particulièrement vulnérables à VIH. De même, l'émigration des hommes peut les soustraire au contrôle social de leur milieu d'origine et les rendre vulnérables à l'infection. Cette vulnérabilité serait liée à la promiscuité, à l'adoption des comportements sexuels à risque (fréquentation de prostituées, prostitution masculine, homosexualité).

Although this plan is the first to acknowledge gender as a determinant of sexual behaviour and male-female relations in that it asserts that “sexual norms are fixed in terms of gender” and describes the gender-specific prescriptions and mechanisms of the social control of women’s and men’s sexuality, buttressed by religion and culture (CNLS 2002a: 11), it offers contradictory views of gender as a driver in the epidemic and by extension, on women’s empowerment. On the one hand, it takes up the argument verbatim explicitly articulated elsewhere in reference to Senegal (see UNAIDS 1999; Groupe Thématique ONUSIDA/Sénégal 2001; Niang 2001; Meda et al. 1999) and endorsed by some international experts as Delaunay et al. (1998: 128) have pointed out, that social control over sexuality,

particularly female sexuality, in Senegal is a factor inhibiting HIV spread. As such, rather than viewing young women as a vulnerable group and the need to empower young women, it suggests the need to reinforce the social control of their sexuality. It precludes examination as to how age and gender inequalities interact with class inequality to shape the vulnerability of young women and girls. At the same time, this document (CNLS 2002a: 11), again borrowing almost verbatim from texts by Niang (2001) and Groupe thématique ONUSIDA/Sénégal (2001) also pointed to unequal gender relations that favour men, asserting that,

De manière générale, au Sénégal, les rapports de genre restent très déséquilibrés en faveur des hommes: mais on remarque, surtout cette dernière décennie, l'émergence d'un mouvement de fond très significatif animé par un grand nombre d'associations et d'organisations féminines. Ce mouvement revendique de meilleures conditions et une amélioration du statut de la femme. C'est dans ce sens, que des lois ont été adoptées contre l'excision, la violence conjugale et le harcèlement sexuel. On peut supposer que ce mouvement en faveur des femmes au Sénégal peut être versé parmi les facteurs favorables à la lutte contre l'épidémie.

Despite acknowledging gender inequality and the potential of women's groups to advocate for change and improvement in the status of women, there was no analysis in this document of women's vulnerability to HIV, much less how gender inequality in its interaction with class and other forms of inequality might put young women at greater risk for HIV. It also assumes that the broader women's movement will address issues of women's inequality to men and this does not need to be addressed within the HIV/AIDS policy response.

The 2007-2011 Strategic Plan marks somewhat of a watershed in that for the first time, policy discourse acknowledges women's vulnerability to HIV as "rooted in their biology, their disadvantaged economic status and in a discriminatory socio-cultural context whereby they dispose of limited decision-making power in matters of sexuality, particularly in negotiating condom use" (CNLS 2007c: 16). However, female sex workers are treated as a separate category

from women in general. There is no gender analysis of the determinants of the vulnerability of other categories of vulnerable groups identified in this plan such as youth, orphans and vulnerable groups, mobile groups, informal sector workers and those involved in *'petits métiers'*, prisoners and PHAs.

In fact, the Plan defines vulnerability in terms of “the level of risk for an individual or group linked to behaviour or events and consequences of their exposure” (CNLS 2007c: 14) rather than in terms of social determinants and broad structural inequalities. Vulnerability is considered “in relation to economic activities exercised by vulnerable groups in certain locations” (CNLS 2007c: 14). Despite the fact that female sex workers and men having sex with men have the highest rates of HIV and are the most exposed to HIV (CNLS 2007c: 28), gender is not considered as a fundamental determinant of their vulnerability. Despite the fact that HIV rate is higher among women, with a female/male ratio of 2.25 to 1 (CDRH 2005a: 37), women as a social category are not viewed as a key population exposed to high risk. In fact, only women ages 25 to 49 years are viewed as a key population exposed to HIV risk but not the most exposed to HIV risk. While youth aged 15 to 24 years are included in the category of key populations exposed to HIV risk, young women whose HIV rates are higher than those of young men are not identified as a key population (CNLS 2007c: 28). The inconsistent gender analysis of vulnerability to HIV is indicative of the lip-service paid to the feminization of AIDS in state policy.

7.3.5 'Women' and Gender in HIV/AIDS Strategic Policy Priorities

For the first time, the 2007-2011 Plan identified “equity in access to interventions as well as taking gender into account in decisions, implementation and the targeting of interventions” as *'principes directeurs'* of HIV/AIDS policy (CNLS 2007c: 28). It also identified the implementation of a policy “to strengthen

taking gender and vulnerable groups (PHAs and orphans /vulnerable children) into account at all levels of execution of interventions” as a policy priority (CNLS 2007c: 28). However, as I will show, gender is inconsistently mainstreamed into strategic policy orientations around prevention, the care and support of people living with HIV/AIDS, ethical and legal issues, research, monitoring and evaluation into the 2007-2011 Strategic Plan, as is the use of a gender equality perspective outlined by UNIFEM (2006). It reflects a haphazard, piecemeal approach, consistent with the state’s approach to gender issues in general.

HIV Prevention Targeting Women: Addressing Risk or Vulnerability?

A key objective of the 2007-2011 Plan is to reduce the transmission of the disease and its impact, as was the case with previous plans, although scaling up access to prevention services takes on greater importance in this plan. Policy priorities and HIV prevention strategies targeting women have been consistent over time emphasizing HIV prevention with groups viewed as high risk (used interchangeably with vulnerable) – prostitutes and pregnant women - rather than with prevention efforts aimed at women per se to reduce their social vulnerability. Although the PMT 1987-1992 identified a number of high-risk target groups such as homosexuals, prostitutes, people with untreated STIs, soldiers, students and migrants, only the control of prostitution and the prevention of perinatal transmission of HIV (preventing pregnancies in seropositive women) were identified as key strategies (République du Sénégal 1987: 16). In a similar vein, the PMT2 1994-1998 identified adolescents (gender-neutral), migrants (male) from rural areas and their spouses as well as male and female adults in urban areas, particularly in economic centres and long-distance traffic routes, as targets for HIV prevention (République du Sénégal 1994: 11). However, of the three key prevention strategies outlined in this plan (reduction of HIV transmission through sex, reduction of HIV transmission through blood transfusion and preventing mother-to-child transmission), the only female target groups actually mentioned

were prostitutes and seropositive pregnant mothers. Although one of the activities for reducing HIV transmission through the blood supply entailed preventing anaemia among women of reproductive age (République du Sénégal 1994: 12), no concrete strategies were put in place to reduce this health problem.

As is the case with its predecessor (CNLS 2002a; 36), the main HIV prevention strategies targeting female sex workers center on the use of male and female condoms, negotiating safe sex including convincing male clients to use condoms, improved treatment for STIs and better medical '*prise en charge*' (CNLS 2002a: 36). No mention is made in the 2007-2011 Strategic Plan of strategies to promote condom use with their regular partners, which is significantly lower than with clients. The only two targets set are increasing the knowledge base of female sex workers (90%) and their use of condoms with male clients (with more than 95% of sex workers using them) (CNLS 2007c: 53). No social indicators were built into the 2007-2011 Plan to evaluate how vulnerability/risk factors will be addressed such as the number of women leaving prostitution. This is consistent with a bio-medical approach to reducing HIV transmission focussing on individual responsibility. There is little in the way of concrete strategies to address risk environments or reduce the social vulnerability of female sex workers.

Like their predecessors, the main prevention strategies in the 2002-2006 Strategic Plan entailed the promotion of less risky sexual behaviour, improving treatment of STIs and strengthening the public health measures to control HIV transmission via female prostitution (CNLS 2002a: 35-36). The strategies also prioritized the reduction of the percentage of sexually active young men and increased condom use in occasional sexual encounters by young men and young women aged 15 to 19 years (CNLS 2002a: 42-43). The targets, however, reveal gender biases with respect to expected outcomes as 65% of men but only 60% of women are expected to use condoms in occasional sexual encounters (CNLS 2002a: 43). Somewhat surprisingly, the 2007-2011 Strategic Plan retains similar

biases with respect to targets with 75% of young men and 70% of young women (aged 15 to 19 years) abstaining from sexual relations and only 70% of young men and 60% of young women using condoms in occasional sexual encounters (CNLS 2007c: 53).

Empowerment or life skills training strategies around negotiating safe sex or imposing condom use to enhance women's capacity to protect themselves from HIV infection barely figure in the HIV/AIDS plans. The only target set in the 2002-2006 Plan was that 30% of women aged 20 to 49 years know about the female condom (CNLS 2002a: 42), with 30% of prostitutes eventually using them (CNLS 2002a: 46). However, no such target was set in the 2007-2011 Plan. Similarly, the social marketing of condoms targets sex workers with the goal of 100% use by them (CNLS 2002a: 34). No mention is made of strategies to reduce price or improve women's access to female condoms. Although the 2007-2011 Strategic Plan identified "greater availability and an increased sales of affordable male and female condoms" as strategies (CNLS 2007c: 53), no targets were set for each type of condom use or for an increase in the number of women using them. Strategies do not address the structural factors such as the power imbalance in male-female relations that shape the vulnerability of women and girls. The Plan also was silent on involving men more deeply in prevention efforts, as only the involvement of women's groups in HIV prevention was cited, with a target of 80% of them able to identify at least two methods of prevention against HIV (CNLS 2002a: 42).

As was the case with its predecessor, the 2007-2011 Plan also emphasized increasing the use of the PTME from 48% to 80% and increasing the number of people tested and counselled in the CDVA sites from 143,000 to 712,720 people (CNLS 2007c: 53). No strategies were articulated in this plan to address gender issues around husband's refusal to get tested for HIV, as was the case of its predecessor. Similarly, although general targets were set for the number of people to be tested, there were no gender-differentiated targets established in this Plan.

For the first time, a sectoral plan emphasizing HIV prevention with women and girls developed by Women's Ministry was included in the 2002-2006 Strategic Plan (CNLS 2002a: 32). It identified the following strategies: promotion of a gender approach in implementing HIV/AIDS programs, coordination of interventions with women, women's capacity-building with respect to HIV/AIDS; integrating IEC/CCC activities around HIV/AIDS in all program activities targeting women; promotion of male and female condom use, advocacy to protect young girls and the development of a advocacy and awareness-raising around the PTME and voluntary testing (CNLS 2002a: 32). Despite mentioning a gender approach to prevention, this was not spelled out in any detail. No strategies were identified to address women's vulnerability to HIV resulting from multiple forms of intersecting social inequalities. Despite acknowledging the need to protect young girls, no concrete objectives and activities were specified in this Plan as to what this might entail. No strategies or explicit targets were set to improve prevention education to rural women, except in some of the regional plans (see CNLS 2002b).

Despite the emphasis on gender, the Ministry of Women's sectoral plan was not included in the 2007-2011 Strategic Plan. As was the case with previous HIV/AIDS strategic plans, the need to develop enhanced HIV prevention strategies for women, young women or girls was not identified. No explicit targets were set to improve rural women's access to prevention services or that of other groups of women whose access to HIV prevention education is restricted, despite identifying this limitation in the Five-Year UNGASS review (CNLS 2006a). No mention was made of the need for gender training for civil society, government and private sector actors in the 2007-2011 Strategic Plan to ensure that gender is taken into account in decisions, targeting and the implementation of interventions, although it identifies the key "role of women's groups in addressing social and cultural practices that are conducive to HIV transmission" (CNLS 2007c: 37). To this end, FAFS conducted gender and HIV training in Dakar in October 2007 and ENDA

sponsored a workshop on gender and masculinities (ANCS website 26/11/07), although this work is in its infancy

Care and Support of PHAs: A Gender-Neutral Definition

Unlike the PMT 1994-1998 which identified the need to promote women's rights in the context of HIV/AIDS and conduct research on the situation of AIDS widows and orphans (République du Sénégal 1994: 13-14), the 2002-2006 Strategic Plan's priorities for the care and support of PHAs was silent on the specific social, economic, medical and psychological needs of seropositive women or of gender differences around HIV/AIDS in general. As I discussed in the previous chapter, the various Protocols developed by the Ministry of Health, with hardly any input from PHAs and women's groups, around the care and support of PHAs also are premised on this view of gender-neutrality, with little attention paid to the individual needs of HIV positive women.

Two strategies were identified in the 2002-2006 Plan regarding the psycho-social '*prise en charge*' of PHAs; providing nutritional support for PHAs and children affected by HIV/AIDS and developing income-generating activities to enhance PHA incomes (CNLS 2002a: 38). Although it is generally recognized that seropositive women are more economically disadvantaged than men (Desclaux et al. 2002; Diouf 1999), no gender-specific targets were set with respect to ensuring that seropositive women will benefit from such projects, only that 50% of PHA Associations have such projects (CNLS 2002a: 51). Moreover, no mention was made of the burden of care that women affected and infected shoulder in the care and support of PHAs and no strategies were identified to alleviate this situation.

The 2007-2011 Strategic Plan does little to address gender biases and the lack of attention to gender differences in the care and support of PHAs or access to programs, despite greater emphasis on strengthening medical and psycho-social

services, supports and access to income-generating activities and employment (see CNLS 2007c: 41). One key difference in this Plan is the priority accorded to better meeting the needs of orphans and vulnerable children under the age of eighteen. While this will go some way to reducing the negative impact on vulnerable children and by extension, on their families, particularly female-headed single parent families living with HIV/AIDS, no gender-differentiated strategies to reducing impact on women and girls were identified in this Plan. Countering discrimination and stigma faced by PHAs was identified as a key strategy in the 2007-2011 Plan (see CNLS 2007c: 42), although no mention was made of strategies to combat the gender-differentiated impact of AIDS discrimination.

Research: Non-existent Gender and HIV/AIDS Research Programme

Bio-medical research dominated the HIV/AIDS research agenda outlined in the 2002-2006 Strategic Plan and to a lesser extent, socio-behavioural research, contingent upon funding being available (largely from external donors) (see CNLS 2002a: 39). No mention was made of the need for social science research. Moreover, despite the close links between research and effective interventions, the 2002-2006 Strategic Plan did not identify the need to develop a gender and HIV research program, much less address issues of women's vulnerability to combat the feminization of AIDS (see CNLS 2002a: 53), although several respondents (13/25) identified this as a serious shortcoming in the HIV/AIDS research agenda and its links with policy. For a few respondents (3/26), the inattention to gender in social research around HIV/AIDS is also shared by external donors who fund research.

The *ministère de la Femme* was not cited as a (potential) partner in research activities in the 2002-2006 Strategic Plan. As a few respondents (4/26) pointed out, people infected and affected have little input into HIV/AIDS research agendas, as is the case of women's groups and community-based organizations in general. Where research is conducted, it is the prerogative of medical, international and university

experts, “fuelling the perception that research is an intellectual and academic enterprise.”(#21) Moreover, as a few respondents pointed out, research itself is not always incorporated into policy initiatives. Wone’s (2002b) research on women’s vulnerability is a case in point. (#11) Research is not that effectively disseminated, particularly to women’s groups, in part because there is no clear structure for research activities within the CNLS. (#28)

More attention was accorded to research, specifically operational research, in the 2007-2011 Strategic Plan. It identified the need to organize a national consultation on research needs and capacities, conduct research on the baseline indicators measuring the impact of interventions, evaluate the quality of services and finance operational research (clinical, public health, socio-behavioural and social science) on the determinants of vulnerability (see CNLS 2007c: 45). However, it did not identify the need for research on women’s social vulnerability to HIV or the feminization of AIDS. This Plan was silent on the need to ensure gender criteria in research and that research be effectively disseminated to women’s groups and community groups. The women’s ministry, women’s groups and community groups were not identified as central partners in developing research priorities or agendas in research strategies outlined in this Plan.

Legal and Ethical Priorities: Human Rights or Women’s Rights?

Tackling the pervasive and negative impact of discrimination and stigma faced by PHAs in Senegal remains one of the weakest aspects of Senegalese HIV/AIDS policy. The *PMT 1987-1992* first mentioned the need to protect the rights of PHAs viewing it as a responsibility of the Justice Ministry (République du Sénégal 1987: 17) but it did not distinguish between any gender-specific differences. The *PMT2 1994-1998* also identified the need to promote and protect the individual rights of PHAs particularly around discrimination, the rights of HIV positive people, the right to information and confidentiality, and specifically

mentions the need to protect the rights of women (République du Sénégal 1994: 14). However, it did not identify these rights. No clear objectives or mechanisms were laid out as to what should be done, how and by whom.

Although the 2002-2006 Strategic Plan asserted that respecting and strengthening the rights of PHAs constituted a guiding principle (CNLS 2002a :29), no strategies were set out to address the multiple forms of discrimination PHAs face or to develop comprehensive legislation to promote and protect their rights, much less attend to gender-specific differences around stigma and discrimination. This Plan also made no mention of the need to address legislative measures that discriminate against women such as property laws, land rights and inheritance rights or advocate for the right of widows to family allowance. Nor did it identify any non-legislative measures to improve the status of women that are an essential component of mitigating the impact of HIV/AIDS on women and reducing their social vulnerability (Putzel 2003; Sidibe 2000). It did, however, acknowledge the need to review the current legislation on prostitution to address some of its outdated aspects (CNLS 2002a: 39). Finally, the *ministère de la Femme* was not identified as a partner in developing legislative measures around HIV/AIDS, despite the fact that it is the key government ministry responsible for promoting women's status and for promoting social development. In a similar vein, the 2007-2011 Strategic Plan did not address any of these gender issues around rights and ethics.

Monitoring and Evaluation

Monitoring and evaluation of HIV/AIDS programs, strategies and targets are important components in the 2007-2011 Strategic Plan and essential to improving the policy response. Despite acknowledging the need to take gender into account, gender does not appear to be a central variable in the monitoring and evaluation of interventions. Many key targets set out in the 2007-2011 Strategic Plan for measuring improvements or impact in strategies around HIV testing, in

access to condoms, in access to services, counselling and supports for PHAs as well as in keeping HIV infection rates at or below current figures are not gender disaggregated. As such, data gathering will continue to reflect this omission, as was the case with Senegal's Five-Year UNGASS review (CNLS 2006a). The failure to make gender central to monitoring and evaluation illustrates the lack of CNLS commitment to a gender perspective in addressing HIV/AIDS and to mainstreaming gender into the overall state policy response.

Thus, the inconsistent mainstreaming of gender in strategic policy priorities brings into sharp relief the lip-service paid to gender and to addressing the feminization of AIDS in Senegal. It would seem that women's enhanced representation in these processes is a necessary but insufficient condition to mainstream gender into strategic policy priorities and policy discourses.

7.3.6 Weak Political/ Institutional Support for Gender Advocacy around HIV/AIDS

The majority of respondents (22/25) indicated that women and HIV/AIDS issues should be more visible in policy, research and programs, although two respondents felt that this should be conceptualized within the context of the '*couple mère-enfant*' (#20) or as the '*porte d'entrée par excellence*' in working with the family (#28). The need for greater visibility centered on the inadequate attention to women's vulnerability to HIV (8/25) including better targeting of female sex workers and girls, the needs of female PHAs (3/25), women's roles in caregiving (3/25), empowerment and life skills training for women to reduce their HIV risk (6/25), women's legal rights and protection (5/25) and improving women's status (economic power, education levels) (8/25). Half of the respondents felt that more research was needed on issues of women's vulnerability to HIV to guide policy and program interventions (13/25), with three respondents suggesting that the CNLS

needs to develop a gender and HIV research program. Almost half the respondents (12/25) suggested that women's groups should be more involved in community care and support of PHAs while a few respondents (4/25) pointed to the need to involve women's groups in program development.

Several respondents (9/25) pointed to the limited input of women's groups into state HIV/AIDS policy as a constraint shaping the inadequate attention to women and gender issues in the national HIV/AIDS policy response. Twenty-one respondents pointed to the need for stronger advocacy for women and HIV/AIDS issues, although they were divided as to what actors were best placed to do this. Several respondents (7/21) suggested that women's groups alone would be best placed to advocate for women and HIV/AIDS issues. Nine respondents suggested that women's groups needed to work with various partners drawn from NGOs, community-based organizations, the CNLS, pressure groups and /or the *ministère de la Femme*. I argue that unequal gender relations and the marginalization of women's groups and the *ministère de la Femme* in the current state HIV/AIDS policy framework limits their capacity to advocate for women and HIV/AIDS issues.

Ministère de la Femme, Famille et Développement Social

The *ministère de la Femme* has been involved in the national AIDS program from the outset, charged with the responsibility of representing women's interests and advocating for women around HIV/AIDS issues, as well as developing strategies and programs for its clientele; targetting women around HIV issues through its networks with women's groups. In official discourse, it is considered to be one of the key government ministries in the CNLS. However, as several respondents observed, there is a gap between official discourse and actual reality. The *ministère de la Femme* is a minor player in the Senegalese government and it lacks the resources to significantly shape policy (Callaway and Creevey 1994; Beck

2003); a consequence of its weak structural position within the government, its lack of financial resources and political clout and the limited broad social support for addressing women's issues. "Major policy decisions continue to be made by the president, the prime minister and the men heading major ministries" (Callaway and Creevey 1994: 167). The weak structural position of *ministère de la Femme* in the Senegalese government is a problem common to most women's national machineries in Africa that undermines these institutions' capacity to implement policy changes to promote women's rights and challenge gender inequities (Van der Westhuizen 2005; Rai 2002; Bell 2002). This is reproduced within the CNLS, the CCM and the HIV/AIDS policy-making process and serves to undermine the *ministère de la Femme*'s capacity to advocate for women. This makes it difficult to develop an effective women/gender and HIV/AIDS program, much less challenge current state HIV/AIDS policy orientations. As these respondents pointed out,

"The *ministère de la Femme* itself, despite the lip-service paid to it, is not really seen as strategic. It has no real power as a focal point and no real influence to move gender issues forward or to move women and AIDS issues forward." (#27)

"For an issue to be a priority, you need to provide the financial, human, material and technical resources. The *ministère de la Femme* has the least amount of money and basically functions with funds from international organizations like UNDP. Many of the activities depend on funding from international organizations such as UNDP, UNIFEM, even the Canadian embassy. This is the framework for intervening. On the one hand there is a lot of talk about the importance of women but in practice, the Ministry has to work with limited resources to improve women's situation. If you take the case of AIDS, the women's ministry doesn't really have a program on women and AIDS." (#18)

Moreover, the weak structural position of the *ministère de la Femme* within the CNLS and CCM has further been undermined by major changes in funding to its activities and the limited support for women and gender issues in HIV/AIDS accorded by major funders. It now receives a smaller amount of money for its HIV/AIDS activities as a result of the World Bank MAP funding criteria.

“One of the major problems that we face is financing our activities. The envelope for the HIV/AIDS programme is small; it is 7 million FCFA and it comes from the CNLS, AID agencies and matching funds from the government. The *ministère de la Santé et Prévention* gets the lion’s share of the funding from the state and external funders. AIDS is still seen as a medical issue. For the *ministère de la Femme*, the issues are social and it focuses is on the social dimensions and impact of HIV/AIDS. This is as important as access to ARVs, if not more important. As far as the social issues go, the *ministère de la Femme* has an important role to play but this is not seen as a priority.” (#27)

“The role of the Ministries in the fight against HIV/AIDS is changing as a result of MAP funding. Monies are now accorded to NGOs and community groups rather than Ministries that received funding cuts. The focus is on civil society. The *ministère de la Femme* is now involved in coordination, support, supervision and policy orientation rather than the execution of programs which is what they did before. A clarification of their role was needed and they are supposed to be involved in capacity-building, advocacy and lobbying.” (#13)

Despite its new role in advocacy, lobbying, capacity building and policy around women and HIV/AIDS issues away from the delivery of front-line services, this has not corresponded to *ministère de la Femme*’s increased power in policy and decision-making within the CNLS. As this respondent explained (#27),

“We are not part of the selection committee of the CNLS. The *ministère de la Femme* is not part of the committee that selects or chooses the projects that will be funded. We don’t really know what is going on or what criteria are used in the selection of projects or what the priorities are. We are not even consulted regarding women’s projects to be funded. For example, when the ANCS got the Gender and HIV project, we were not consulted and we really couldn’t coordinate with them. The process for selecting projects needs to be more open, more democratic and more transparent.”

Some community groups also share the view that the process for the selection of projects to be funded by the CNLS and the Global Fund grant needs to be more transparent and democratic (Jurgens and Dia 2006).

“In the second round of MAP funding, the gaps in capacity were identified and we have project funding to address these gaps, project funding chosen by and approved by the National Commission. Its members are chosen by

the CNLS. It is not a democratic process. The CNLS is skewed toward medical experts and ministries who make up the bulk of the members. Community representatives, of whom we are one, are not that numerous in the CNLS, particularly the PHA associations which are not that well-developed or vocal around this issue.” (#8)

Even with the creation of an ‘AIDS focal point’ within *ministère de la Femme* as part of the multisectoral response, it does not appear to be a priority within the Ministry itself. Apart from setting up a fund of 10 million FCFA earmarked for the development of income-generating activities for seropositive women’s associations as part of the *Projet crédit des femmes* (République du Sénégal 2006b: 4), women and AIDS issues do not appear to be that well integrated into the *ministère de la Femme*’s other main programmes around poverty reduction and gender equality. Although funds also are earmarked for seropositive people within the poverty reduction program, there appear to be no gender-specific targets (République du Sénégal 2006b: 5). There is no mention of a women and HIV/AIDS program on the website of the *ministère de la Femme* and the ‘*responsable*’ herself still does not have a phone number listed on its website directory.

“The HIV focal point is not really a priority and the political commitment to this issue within the Ministry is weak. There is not enough money for projects. Also Ministers come and go. They change too often. It is too political. The current minister is not involved enough in promoting women’s advancement in general. Previous Ministers were better at this.” (#27)

Women’s Groups

As is the case with *ministère de la Femme*, women’s groups in the CNLS face a number of obstacles that limit their power to influence HIV/AIDS policy orientations or to challenge unequal gender relations within the policy-making process. Although a large number of diverse women’s groups including traditional and modern women’s groups, women’s associations and federations have been mobilized in the fight against AIDS (Niang 2001; CNLS 2002a), only a limited number of women’s groups are involved in the CNLS and the policy-making

process or work closely with the CNLS (#20). Moreover, although the 2007-2011 Strategic Plan has ear-marked money for leadership training and capacity-building for community groups (see CNLS 2007c: 42), it made no mention of the need to strengthen the role of women's groups in these areas. Similarly, it made no mention of the need to organize activities for or around gender advocacy issues, although it identifies strengthening of advocacy activities.

Both FAFS and the FNGPF are state-initiated women's federations composed of a variety of women's associations. Both have alternately been members of the PNLs and the CNLS. FAFS' original mandate was premised on an essentially conservative view of women while the FNGPF's mandate is to address women's practical interests (women's immediate needs for housing, employment, reducing work loads) rather than women's strategic interests (addressing gender inequality) (Cisse 2002). Neither is likely to challenge government policy or existing unequal gender relations, revealing the limits of state feminism in Senegal in general (Cisse 2002) and more specifically, around gender and HIV/AIDS issues.

Moreover, despite FAFS and FNGPF's long if not sporadic involvement in AIDS activism, HIV/AIDS is not their main mandate. It is not listed on the FNGPF website as a key program (www.cncr.org consulted 02/01/2007), although FAFS lists it as a program. Even though FAFS has done extensive HIV prevention work with women, consistent funding for HIV/AIDS prevention has been a problem for its activities (Fall 2001). As some respondents also pointed out, HIV/AIDS programming and advocacy represent an additional burden for many women's groups that were formed around development issues and women's groups are often expected to do HIV/AIDS work on a voluntary basis.

“When we talk about women's groups, we need to distinguish between the women's (political) movement made up of equality groups, local women's associations and traditional women's groups. They are not as involved in HIV prevention or the care and support of PHAs as they could be. They often don't have the resources such as money, people, training and information or HIV is just not their focus.” (#33)

“Only a few women’s groups are specifically focussed on HIV/AIDS. The other women’s groups are focussed on development issues and they only do sporadic HIV interventions in HIV prevention. Some women’s groups do development work but don’t see AIDS as a development issue. There is no synergy and not a lot of discussion. Some of these groups see AIDS as a development issue.” (#17)

The AIDS-focussed women’s groups in the CNLS such as SWAA and ABOYA lack the financial and human resources to be major players in the policy process. Despite its long involvement and expertise in working with women and its gender approach (Diallo 1999; SWAA 1998), SWAA itself worked on a voluntary basis through the first decade of its activities (Putzel 2006). It is hampered by a lack of funding for its projects (#19), leaving little time for advocacy and lobbying activities. As a few respondents observed, woman’s groups such as SWAA and ABOYA as well as the *ministère de la Femme* function more like AIDS service organizations as opposed to lobby groups forcefully advocating on behalf of women and HIV/AIDS issues. This partly is a consequence of their dependence on funding from the CNLS and other external donors which is earmarked for service delivery rather than advocacy, lobbying or even policy research. Although SWAA is a member of COSSEN, the key civil society actor in the CNLS, COSSEN does not appear to advocate on behalf of gender and HIV/AIDS issues and its leadership has been challenged by the Observatoire.

ABOYA’s own capacity to advocate is severely circumscribed by the Senegalese socio-political and cultural context, despite the growing acceptance of GIPA, the greater involvement of People Living with HIV/AIDS, in policy and activist circles. It has shown some promise in raising the profile of women and AIDS issues in some parts of Africa, particularly in those countries with high HIV/AIDS rates and has successfully been used by gay men in the USA and Brazil to influence policy (Siplon 2005). However, the context in Senegal is quite different. The low infection rate, the level of stigma around AIDS and the over

dependence of Associations of PHAs on CNLS funding and state institutions has limited the influence of the RNP+ to influence policy. ABOYA is a relatively new organization and it lacks leadership experience, funding and trained personnel to be a major player in HIV/AIDS policy. The UNIFEM supported Gender and HIV project (ANCS 2002), which provided leadership training for ABOYA to help it strengthen its lobbying and advocacy skills and capacities is not an on-going project because funding is no longer available. As this respondent (#33) explained,

“This project ended in 2004 because UNIFEM did not have any more funds for it. It had its own funding cut partly because the UNDP judged that gender was integrated into the HIV/AIDS program.”

ABOYA’s demands for a comprehensive state-supported national program for seropositive women around nutrition, reduction of medical bills, professional training and re-insertion into the labour force as well as supports for their children have as yet to be incorporated into the government’s commitments to women and HIV/AIDS issues (ANCS 2002; République du Sénégal 2006b). Its current demands appear to address women’s practical needs, although with time and gender training, this may develop into a set of demands that address women’s strategic needs. Moreover, support within the CNLS for advocacy and lobbying by the *ministère de la Femme* around women and HIV/AIDS issues is weak.

“We requested funding from the CNLS to develop a network of women’s groups involved in the fight against HIV/AIDS to strengthen advocacy initiatives and lobbying around HIV and reproductive health issues but the funding request was turned down by the CNLS.” (#27)

Alternately, several respondents also emphasized that HIV/AIDS focussed women’s groups seem to have weak links with the political women’s movement in Senegal (working on equality issues). As a result, AIDS as a women’s issue and a political issue hasn’t been taken up by the political women’s movement.

“There is no bridge between women and AIDS groups and the women’s rights groups and women’s equality groups. There is no political vision of women and HIV/AIDS. Given this, it is not surprising that we have not adopted a gender-mainstreaming approach in the CNLS...There is a lot of talk about gender. It is politically

correct to talk about gender but the reality is that there is a lack of advocacy and lobbying on gender and HIV issues for the following reasons. The AIDS women's organizations like SWAA are not really connected to the more political women's groups that lobby for women. SWAA doesn't really advocate at this level. They function more as an AIDS service organization and execute programs in line with program priorities. They don't advocate at a political level. There is also a problem at the level of organizational capacity – AIDS women's groups and NGOs - most do not use a gender approach in their work. They need training and they need gender training. Working with women doesn't mean a gender approach. Some people reject the gender approach and gender mainstreaming because they don't know what it means." (#11)

"We don't really get the sense that in the area of AIDS, women's groups are really involved, unlike when they mobilize around more political issues. Women's groups should be playing a very important role and women are the most threatened by HIV/AIDS. Despite the fact that many women are militants in women's groups, they don't really mobilize around HIV/AIDS and women's issues." (#20)

"The commitment of women's groups to HIV/AIDS issues varies. Some groups are more involved than others such as APROFES and ASBEF now in the PTME and voluntary testing but the Réseau Siggil Jiggen hasn't really taken up HIV/AIDS as a women's issue, although many of its member groups do or have done HIV prevention." (#27)

"Despite the feminization of AIDS, the women's movement is just not involved enough. For example, the Réseau Siggil Jiggen addresses all the issues that prevent women from achieving equality with men or from improving their status but they don't really have a gender and HIV program." (#33)

However, the lack of support for women and HIV/AIDS issues is also partly related to the limited financial and human resources of the *Réseau Siggil Jiggen* (RSJ), an umbrella women's lobby and advocacy group for women's rights and gender equality in sustainable development created in 1993, with formal NGO status accorded in 1995 (*Réseau Siggil Jiggen* pamphlet 2006). It is made up of sixteen women's groups working on diverse issues such reproductive health, education, political participation, economic empowerment and the law. Its request

for HIV/AIDS project funding from the ANCS, which administers a portion of the Global Fund grant ear-marked for community groups and NGOs was turned down in 2006 at the same time as its funding from a specific donor-based program to promote women's rights was terminating. The *Réseau* itself is heavily dependent on external funding and its activities are subject to the changing priorities of international and bilateral aid organizations. It suffers from funding shortfalls for its main mandate and insufficient personnel, as is the case with the majority of women's groups, whether community-based groups, national networks or local associations. The lack of human, technical and financial resources also constrains its capacity of to enlarge its sphere of action around advocacy and lobbying.

AIDS-focussed women's groups also do not appear to have well-developed links with COSEF (The Senegalese Council for Women), a national non-partisan women's NGO created in 1995, whose mandate is to develop female leadership in all areas, fight discrimination against women and bring more women into decision-making positions (COSEF website <http://www.h-net.org/~diop/cosefsite>, consulted 21/12/2007). It was successful in getting more women elected in the 2000 and 2006 parliamentary elections (Creevey 2006) and partnered with the RSJ in the struggle for formal recognition of women as head of the family in the Family Code. A partnership with COSEF might help to strengthen gender and HIV/AIDS advocacy efforts in political and government policy circles, given its links to female ministers and parliamentarians.

Although high-level political commitment (the endorsement by successive Senegalese presidents) has been a long-standing feature of the Senegalese HIV/AIDS policy response, AIDS as a political issue has not really been taken up by parliamentarians in the National Assembly in general or by female parliamentarians in specific, as several respondents (7/23) pointed out.

“For female parliamentarians, AIDS is not a priority. Getting re-elected is more important than raising development issues and AIDS issues. We need female parliamentarians who are interested in women

and AIDS issues and ready to take this up with other elected members in the national assembly. There also needs to be better links between the political women's movement and groups working on HIV/AIDS issues to develop a gender and HIV component to the AIDS program, using gender mainstreaming rather than a separate section or strategy that integrates a women and development perspective." (#17)

"AIDS as an issue hasn't really been taken up by parliamentarians or by political parties as far as I know. They need to get more involved in this issue. The PHA associations need to be better positioned politically and more involved in the political process." (#9)

As a consequence of weak political and institutional support for gender and HIV/AIDS advocacy, lobbying and advocacy around women and HIV/AIDS issues are weak both within the CNLS and in the broader society.

7.4 Conclusion

Changes to the structure of the national AIDS control program, an expanded multisectoral approach and the increased presence of women and women's groups in the CNLS and CCM have not yet led to a greater emphasis on policy priorities around women and HIV/AIDS or to more transformative interventions and research programs that address gender inequalities and alternately empower women. Unequal gender relations and a male-dominated political culture are reproduced within the national AIDS control program, the CNLS and CCM, that serve to marginalize women and gender issues in HIV/AIDS policy and limit the capacity of women's groups to advocate on behalf of women. Women's groups remain under-represented in the HIV/AIDS policy-making and decision-making process. They constitute one voice among many, with weak policy input, execute rather than initiate policy and do not necessarily possess a gender perspective around HIV/AIDS. Moreover, despite formal acknowledgement of a gender approach to HIV/AIDS in Senegal, it is not systematically articulated or

systematically applied in all policy areas or necessarily endorsed by policy-makers and external donors. It is a gender-neutral policy response that does not challenge unequal gender relations and other social inequalities that shape the multiple ways HIV/AIDS affects women and ultimately serves to dis-empower women. As such, it can not effectively address the feminization of AIDS.

If 'women and HIV/AIDS' issues are to have a higher profile in policy, in interventions and/or in research to more effectively address the feminization of AIDS and women's groups are to play a key role in advocating and lobbying for these issues, as most respondents affirmed, a more supportive political and institutional policy environment needs to be developed. This requires a political commitment to a gender equality perspective within the CNLS and all levels of government, particularly at the highest levels of the Presidency and the Prime Minister, given their power in setting policy, along with gender equality training for all the diverse partners working on HIV/AIDS including women's groups. This also requires changes to the institutional structure of the state national AIDS program (CNLS and the CCM) to ensure more equitable representation of women's groups within the policy process to strengthen the commitment to mainstreaming gender equality in HIV/AIDS policy as well as support women's groups with capacity-building and leadership training around Gender and AIDS advocacy.

Given the relative success of the Observatoire, the coalition of five civil society actors, in enhancing the civil society role in policy, AIDS-focussed women's groups might want to utilize a similar strategy. Strengthening links with the political women's movement and female parliamentarians advocating for women's equality might help to develop a political vision of women and HIV/AIDS within a social justice framework linked to sustainable development. The creation of a Gender Observatoire, not unlike that proposed by Wone (2002b), would help to ensure that this vision will be mainstreamed into the multisectoral approach to HIV/AIDS in Senegal.

CONCLUSION

This dissertation explored the feminization of HIV/AIDS in Senegal, a relatively recent and disturbing trend that has received insufficient attention in research, programs and state policy. It questioned the widely held view that the Senegalese state-centric model of addressing HIV/AIDS is an unqualified success, given its failure to contain the spread of HIV among women. It further questioned its efficacy in addressing other key aspects of the feminization of AIDS such as its model of care and support as well as its institutional and policy framework for addressing the epidemic.

It answered the following questions: What is the appropriate analytic framework for studying the feminization of AIDS in Senegal? What explains the feminization of HIV/AIDS and women's vulnerability to HIV, despite Senegal's relative success in containing HIV? Does HIV/AIDS also affect seropositive men and women differently with respect to their economic and social circumstances as well as access to treatment, care and supports? What are the limitations in the Senegalese prevention model and in the treatment, care and support model? How do Senegalese state HIV/AIDS policy, programs and services take women and gender differences into account? How are women's interests and organizations represented in the national AIDS program?

Premised on the need to re-think how 'women and HIV/AIDS' in Senegal is conceptualized and addressed in Senegalese state policy, this dissertation offers an alternative feminist reading of 'women and HIV/AIDS' in Senegal rooted in Gender and Development theorizations. It reframes 'women and HIV/AIDS' as a fundamentally complex gendered social, political, economic and cultural phenomenon. It argues that a revamped Woman / Gender and Development approach can best understand, explain and address the feminization of AIDS in

Senegal. This perspective places women and gender relations at the centre of gender analysis of the political, social, economic and cultural context that underpins the HIV/AIDS epidemic among women in Senegal and state policy responses to it. It also rejects mainstream atomistic analyses that focus on a single dimension of women's experience with HIV/AIDS, opting for a comprehensive conceptual framework that encompasses the multiple ways the epidemic affects women. This dissertation examined women's social vulnerability to HIV, the multiple issues faced by women living with HIV/AIDS that included their economic circumstances, social situations and access to treatment, care and supports, and women's roles in the care of people living with the disease, linking them to an analysis of state policy responses and the role of women's organizations in empowering women in the context of HIV/AIDS and advocating on their behalf.

Drawing on conceptions of HIV/AIDS as a disease fuelled by multiple social inequalities as well as the policy responses to it, it situates analysis within a broader social justice framework that links HIV/AIDS policy responses to broader strategies for social transformation aimed at the eradication of gender, social class and north-south inequalities. A Woman / Gender and Development approach can best grasp the multiple inequalities that drive the epidemic among women in Senegal and shape its impact as well as identify avenues for social transformation of underlying structural determinants. Conceptualizing gender as a social relation of power that maintains a focus on women and the problem of women's subordination at the centre of gender analysis brings into analytical focus the central role of unequal relations between men and women in the private sphere of sexuality, the family and marriage in shaping various aspects of the feminization of AIDS largely ignored in dominant analyses of AIDS in Senegal. Utilizing an intersectional feminist analysis that takes women as a heterogeneous social category, I explored how gender in its interaction with other social relations of power based on social class, north-south inequalities, geographic location, age and marital status shape the impact of HIV/AIDS on different categories of women. Central to this perspective

is a critical analysis of the role of the state and its policy response to HIV/AIDS, which I take as problematic. I conceptualized the Senegalese state, not as a neutral entity, but as a 'gendered hierarchy' which is both autonomous from civil society and subject to it, shot through with gendered, class and other power relations. Linking an intersectional feminist sociological analysis of gender and HIV/AIDS with a feminist political analysis of the state as a 'gendered hierarchy' allows us to capture the contradictory role of the state in reproducing gender inequalities within the context of state HIV/AIDS policy responses that limit its effectiveness in containing and addressing the feminization of AIDS in Senegal.

Re-thinking HIV/AIDS and women begins with elucidating the gendered political, economic, cultural and social context that fuels HIV/AIDS among women, emphasizing how gender relations have been reconstructed over time to women's detriment within the broader context of socio-political and economic transformation in Senegal relating to Islamization, French colonialism and in the post-independence period. I showed how the post-colonial state has played a contradictory role in reproducing unequal gender relations through policies and legislation in matters of family and marriage, rural and urban economic development, education, health and women's substantive representation in the formal political system. I argued that patterns of unequal gender relations in the private and public sphere were reproduced by the post-colonial state through its changing policies on women in the development process, despite the improvements made in women's status in the post-independent period and the activism of women's groups. To the extent that women play key roles in the family and in the community, they remain in a subordinate and secondary position to men within these spheres as well as within the economy and the polity. Although formal equality between men and women was enshrined in the 2001 Constitution, the state's failure to enforce national legislation and international agreements outlawing various forms of gender discrimination against women coupled with the persistence of gender discrimination in the Family Code provides further evidence of the

contradictory role of the state in fundamentally altering the power imbalance in gender relations that work to the benefit of men. It points to the limits of the state as a “gendered hierarchy” in formulating effective gender-based policy on HIV/AIDS that addresses gender inequalities and fosters women’s empowerment.

Re-thinking women’s vulnerability to HIV requires moving beyond a narrow formulation of women in high-risk groups, common to the epidemiological and socio-behavioural models of addressing individual HIV risk, to an analysis of women’s social vulnerability to HIV. I examined women’s social vulnerability to HIV in order to link this to individual risk behaviours and state responses in containing HIV transmission. I showed how unequal gender relations and women’s subordination within the context of the private sphere of sexuality, marriage and the family, buttressed by Islamic ideology and traditional cultural practices play a crucial role in constructing women’s vulnerability to HIV; particularly with respect to women’s limited capacity to impose or negotiate safe sex. In examining the social vulnerability of different categories of women including women engaged in commercial sex work, married women, single women and young women, I also showed how gender interacts with other social divisions and relations of inequality based on age, marital status and social class, within a context of underdevelopment, to differentially shape HIV risk.

I explored the gender approach in the Senegalese model of HIV prevention in order to assess its effectiveness in addressing women’s social vulnerability to HIV. An analysis of the model showed that the principal prevention strategies in the Senegalese state policy response based on an ABC approach fail to adequately address unequal gender relations in their interaction with other social inequalities that shape women’s unequal access to HIV information and education, to condom technologies, particularly the female condom which is key to women’s control over their bodies, to voluntary testing and the mother-to-child transmission program. I argued that ‘protecting women’ rather than ‘empowering women’ best characterizes

the Senegalese gender approach to HIV prevention as it does little to alter unequal gender relations or address the broader gendered social and economic determinants of women's vulnerability. As such, the Senegalese model of prevention is limited in its effectiveness in containing HIV transmission among women, addressing women's social vulnerability to HIV and fostering women's empowerment.

Rethinking 'women and HIV/AIDS' in Senegal also requires thinking through gender in the experiences of living with the disease and moving beyond a gender-neutral conceptualization of PHA. I showed how HIV/AIDS reproduces and exacerbates gender, social class and north-south inequalities that limit the ability of Senegalese PHAs to live positively as well as undermine their human rights and dignity. Poverty in a context of underdevelopment serves to compromise seropositive people's health and welfare as PHAs encounter multiple obstacles in meeting their basic needs for housing, nutrition, access to basic consumer goods, clean water and sanitation as well to the broad range of health and other services.

However, gender shapes the social and economic situations of seropositive men and women differently. Seropositive women face greater challenges than seropositive men in living positively as a consequence of gendered inequalities and unequal power relations between men and women. HIV/AIDS accentuates seropositive women's responsibilities associated with their social roles as mothers, wives, caregivers and workers. HIV positive women are more likely to be in a situation of economic and social dependence, have fewer economic resources and greater responsibilities for the health and welfare of their families as caregivers, with fewer supports and greater needs which have a negative impact on their health. Age and marital status further differentiate the social and economic situations of seropositive women.

The persistence of multiple forms of stigma and discrimination continue to weigh heavily in limiting the ability of PHAs to live positively. I showed how

gender also shapes the experiences and impact of stigma and discrimination around HIV/AIDS. Seropositive women face double discrimination: as HIV positive and gender discrimination as women, if not triple discrimination in the case of HIV positive sex workers. They are judged more harshly than seropositive men, more likely to be blamed, repudiated, ostracized or abandoned. Although their needs for secrecy are greater than for men, because of their subordinate position as women, they are less able to keep secrecy. I also showed how current human rights initiatives fail to address the gendered dimension of living with HIV/AIDS, much less underlying gender and other social inequalities that fuel stigma and discrimination and undermine the realization of the rights of PHAs.

In a similar vein, I considered gender in the analysis of the continuum of care for women living with HIV/AIDS from health services, to home and community care. A model in the treatment of PHAs, the Senegalese state provides free access to ART; one of the first African countries to do so. Seropositive Senegalese women are over-represented in access to antiretroviral therapy, in HIV testing, although this varies by region, and as recipients of community-based care. However, access to quality medical care and psychosocial supports for the majority of female PHAs remains constrained not only by social class, rural-urban and north-south inequalities but also by gender relations. The persistence of user fees for health services, regional disparities in access to medical and non-medical services and supports, and the limits of state and external donor funding for medical, home and community services illustrate the limits of the Senegalese model of care and support for PHAs. Unequal gender relations further complicate women's access to care and supports as they have limited control over decisions relating to their own health and welfare.

The Senegalese model of care and supports illustrates all too vividly how the burden of non-medical care and supports is displaced on to the family, community groups and the Association of People Living with HIV/AIDS; those

who have the fewest resources to grapple effectively with the complexity of the needs of PHAs, their families, AIDS orphans and vulnerable children. The limitations of the Senegalese care model for PHAs place a greater burden on women living with AIDS and women affected by it, illustrating how gender inequalities are reproduced within state services and state policy in this area. Women's unpaid and unrecognized reproductive labour in home care, community care and in hospitals as well as other medical services subsidize the gaps in state and community care services for PHAs and AIDS orphans that are essential to mitigating the impact of AIDS. Female caregivers, who play a vital role in the care and support of PHAs, families living with HIV, AIDS orphans and other vulnerable children, are virtually invisible in the continuum of care services and within state policy. This is a consequence of the absence of an effective gender perspective in state HIV/AIDS policy in matters of care and supports for PHAs.

Re-thinking 'women and HIV/AIDS' also requires critically examining the nature of the state and policy-making structures. Although considered a model or organizational template for national AIDS commissions, I show that despite Senegal's relatively effective state-centric approach in addressing HIV/AIDS, it does not possess an effective gender and HIV/AIDS policy because unequal gender relations and a male-dominated political culture are reproduced within the CNLS, the CCM and policy-making process. Changes to the structure of the national AIDS program, an expanded multisectoral approach and the increased presence of women and women's groups in the CNLS and CCM have not as yet led to a greater emphasis on policy priorities around women, to a Gender and HIV research programme or to more transformative interventions that address gender inequalities and empower women.

The lack of commitment to a gender perspective is evident in the formal and substantive under-representation of women and gender experts in the institutions and processes that make policy, in the marginalization of women and gender

equality issues in AIDS policy discourse, and in the uneven mainstreaming of gender and women's issues in strategic policy orientations policy priorities and targets around HIV prevention, care and support of PHAs, research, ethics and human rights, monitoring and evaluation. Despite reference to a gender approach to HIV/AIDS, this is not coherently articulated, systematically applied in all policy areas or necessarily universally endorsed by policy-makers and external donors. The concept of gender itself is subject to multiple meanings among key social actors who make policy, develop and implement programs and conduct monitoring and evaluation. As a consequence, gender issues in HIV/AIDS policy are marginalized and the capacity of women's groups to advocate on behalf of women is limited. The policy response does not adequately address the feminization of AIDS in Senegal, illustrating the limits of the state as a 'gendered hierarchy' in matters of HIV/AIDS policy.

While the objective of this research is primarily practical rather than theoretical, this case study also contributes to the small and marginal but growing body of feminist theorizations of the Senegalese state and by extension, the African state. It integrates a feminist theory of the political within feminist gender and development perspectives that have as yet to theorize the state, even though the state is pivotal in this theoretical tradition as a site for women's struggles for gender equality and current campaigns for strengthening women's rights in Senegal as elsewhere in Sub-Saharan Africa. Drawing on more sophisticated feminist theorizing that moves beyond simplistic notions of the African state as a patriarchal state and conceptualizing it as a 'gendered hierarchy' allows us to demonstrate how the piecemeal, ad hoc and fragmented approach, characteristic of the dominant approach to gender and development policies informed by a WID framework, is replicated by the Senegalese state in matters of gender and HIV/AIDS policy issues. This conceptualization also provides a more fruitful avenue for guiding feminist research and action, as it is intimately bounded up with feminist theorizing.

Problematizing the state and other institutions that make policy and analyzing the gendered socio-political context within which HIV/AIDS policy is made allows us to lay bare the role of gender politics in shaping institutions, policies and conceptualizations of HIV/AIDS that work to the detriment of women in Senegal. This helps us better understand how women and gender issues are constructed in HIV/AIDS policy and why we have been so slow to grapple with and effectively address the feminization of AIDS as well as empower women within the context of the epidemic not only in Senegal but elsewhere.

While important in its own right, the broader significance of this case study for practitioners and policy-makers resides in Senegal's status as a model for containing and addressing HIV/AIDS and the limits of its state-centric approach with respect to women. It argues that no model of containing and addressing HIV/AIDS can be considered a 'success' if it continues to sideline women and gender equality issues in policy, in programs and in research.

Countering the feminization of HIV/AIDS in Senegal calls for the recognition of the fundamentally gendered nature of the epidemic and the mainstreaming of a gender equality perspective along the lines advocated by UNIFEM (2006). Such an endeavour entails the greater participation of women, particularly seropositive women, as equal partners in all aspects of development, implementation and evaluation of policy, research and programs as well as women's enhanced participation in decision-making to ensure that women's perspectives and lived experiences are taken into account. Developing a comprehensive Gender and HIV research programme, rooted in a social justice and participatory framework, is essential to informing state policy and state action in matters of HIV prevention, the treatment, care and support of women living with HIV/AIDS and human rights initiatives.

Key to a Gender and HIV research programme is a fuller understanding of women's social vulnerability to HIV among different categories of women. More research is needed that better grasps how gender inequality in the context of the private sphere of sexuality, marriage and the family interacts, particularly women's limited capacity to negotiate safe sex, with other forms of social inequality that shape women's elevated risk to HIV. Other relevant research issues include women, migration and HIV risk, sexuality and the social vulnerability of young women and young men, drug use and HIV risk, the effectiveness of current HIV prevention messages and the role of masculinities and femininities in constructing social vulnerability to HIV. An action research perspective would link this research to developing comprehensive national HIV prevention strategy targeting men as a social category that includes a focus on addressing unequal male-female relations in the private sphere as well as the public sphere.

A fuller understanding of gender differences in experiences living with HIV/AIDS is also central to a Gender and HIV research programme. If HIV positive women are to be empowered to live positively, acknowledging and tackling the multiple ways gender inequality shapes their economic and social circumstances and limits their human rights are essential. This requires moving beyond a gender-neutral conception of PHA that renders the specificities of seropositive women's experiences invisible to acknowledging PHAs as gendered subjects. It also calls for re-conceptualizing seropositive women as workers and as producers as well as addressing their needs as individuals and not simply in their social roles as mothers and wives. More participatory and action research is needed around stigma and discrimination that PHAs encounter in diverse settings such as the family, the community and the workplace as well as around barriers they face in access to health care and supports. This would help to link research to the development of community-based human rights education around HIV/AIDS that would also address gender bias, discrimination and inequality that work to the detriment of seropositive women and girls.

If women and HIV/AIDS issues are to have a higher profile in state policy, in interventions and in research to more effectively address the feminization of AIDS and if women's groups are to play a key role in advocating on behalf of women, a more supportive political and institutional policy environment needs to be developed to enhance women's collective empowerment. This requires changes to the institutional structure of the state national AIDS commission to ensure more equitable representation of women's groups and civil society actors within the policy-making process and to provide them with capacity-building and leadership training around Gender and AIDS advocacy. This requires a political commitment to a gender equality perspective within the CNLS and all levels of government, particularly at the highest levels of the Presidency and the Prime Minister. This calls for gender equality training for all the diverse partners working in the area of HIV/AIDS including women's groups.

Empowering women in the context of HIV and supporting seropositive women to live positively also entails not only strengthening and engendering current human rights initiatives for PHAs as well as implementing strategies to realize these rights but also bolstering women's rights. Strengthening the links with the political women's movement and female parliamentarians advocating for women's equality in matters of family law, sexual and reproductive health, in the economy and in the polity is essential to developing a political vision of women and HIV/AIDS within a social justice framework linked to sustainable development. The creation of an independent Gender Observatoire, made up of diverse civil society actors, both women and men, committed to gender equality and social justice, will help to ensure that this vision will be mainstreamed into the multisectoral approach to HIV/AIDS in Senegal. Developing closer links with global campaigns and social movements that share these goals will also help to strengthen these initiatives at the level of the state.

However, as a strategy for containing and addressing the feminization of AIDS in Senegal, fostering women's individual and collective empowerment through gender equality mainstreaming and the promotion of human/women's rights at the level of the state alone have their limits, as this case study also illustrates. The fragility of the Senegalese state in the face of powerful external economic and political forces and the relative autonomy of the state from internal social forces limit its capacity as a political and economic actor, particularly in matters of women's rights and gender equality.

As HIV/AIDS in the third decade is rapidly drawing to a close, it is perhaps time to integrate the human rights and empowerment models of political action in combating the disease with broader strategies of social and economic transformation premised on social justice as the goal of development. Re-thinking current conceptions of gender, AIDS and development premised on a liberal rights agenda is essential in the current context of global crisis and global economic recession that exacerbate gender, social class, regional and north-south inequalities with potentially devastating consequences for the poor and the marginalized. Current global economic and political processes do not augur well for containing the AIDS pandemic and providing effective treatment and supports for those who need it most in Senegal as elsewhere in the Global South. Despite its devastating impact on individuals, on families and on communities, the HIV/AIDS epidemic offers the possibility for social transformation and social justice not just for women but for the poor, the young and the disenfranchised in Senegal. The time for action is now. If not now, when?

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APPENDIX 1

INTERVIEW GUIDE

Interview Guide

Number: _____

1.0 State HIV/AIDS Policy

- 1a. What do you think are the underlying causes of the HIV/AIDS epidemic in Senegal? Is the situation of women a factor?
- 1b. Please describe how HIV/AIDS policy and priorities around women and HIV/AIDS are established and what actors are involved.
- 1c. What is Senegal's gender approach to HIV/AIDS (policy, interventions, research)?
- 1d. Do HIV/AIDS issues affecting women need to be better represented in policy, programs and research? If so, please explain why. How and by whom, would this be best accomplished? What are the main obstacles to implementing these changes?

2.0 Prevention

- 2a. Are women more vulnerable to HIV than men? Please explain. Are young women more vulnerable to HIV than young men?
- 2b. How do HIV prevention activities address the sources of women's vulnerability?
- 2c. What groups of women are not being reached by HIV prevention activities? Is it important to reach all women? Please explain.
- 2d. What difficulties have been encountered in HIV/AIDS prevention with women?

3.0 Gender Discrimination & Women with HIV/AIDS

- 3a. Is the social and economic situation of women living with HIV/AIDS different from that of men living with HIV/AIDS?
- 3b. Do seropositive women face specific forms of gender discrimination as women living with HIV and AIDS that are different from men? If so, please explain.
- 3c. What types of obstacles do seropositive women face in obtaining treatment, care and support? Are they different from those faced by seropositive men?
- 3d. Do seropositive women have specific needs for treatment, care & support that are different from men? If so, please explain what they are and why.

4.0 Women as Caregivers of People Living with AIDS

- 4a. Who are the primary caregivers of people living with HIV/AIDS in the family? Explain why. What difficulties do female caregivers encounter? Are they different from those experienced by male caregivers?
- 4b. What organizations and/or groups individuals are the primary caregivers of people with AIDS and AIDS orphans in the community? What challenges are encountered in community care of PHAs?

5.0 Women's Organizations

- 5a. What roles do women's organizations play in the fight of HIV/AIDS in Senegal? Should the roles of women's groups be strengthened?
- 5b. What obstacles do women's groups face in carrying out their activities?

- 6.0 Any additional comments?

Participant Consent Form

(for AIDS Organizations, NGO's, women's groups, PNLs/CNLS, AIDS researchers and researchers specializing in women's issues)

Title of the Doctoral Research:

L'impact de VIH/sida sur les femmes au Sénégal: une analyse de genre / The Impact of HIV/AIDS on Women in Senegal: A Gender Analysis

Doctoral candidate:

Susan Judith Ship, Political Science Department, Université du Québec à Montréal

The proposed study is entitled: *L'impact de VIH/sida sur les femmes au Sénégal: Une analyse de genre / The Impact of HIV/AIDS on Women in Senegal: A Gender Analysis*. The objectives of the proposed doctoral research are the following:

- 1). To examine the gendered political, social, economic and cultural context of HIV and AIDS in Senegal.
- 2). To explore how HIV and AIDS affects women in Senegal with respect to: state HIV/AIDS policies (PNLS) and related policies; women's vulnerability to HIV, the social and economic situation of women living with HIV/AIDS and their care and support, the role of female caregivers of people living with HIV/AIDS; and the role of women's organizations in the fight against HIV and AIDS.

The information gathered from your participation in this research will be used to contribute to current social research on women and HIV/AIDS in Senegal, to develop gender analysis of HIV and AIDS, to understand how HIV and AIDS affects women and men differently and to suggest ways to strengthen research, policies and programs affecting women.

The data gathered will be used to complete the doctoral dissertation and be used in future academic publications. A résumé in French of the principle research findings will be sent to you.

If I agree to participate, my participation will consist essentially of attending one interview that will take approximately an hour and a half to two hours on the premises of your organization. The interview will be conducted in French unless I indicate that I prefer to be interviewed in Wolof. In which case, the interview will be conducted with the assistance of an interpreter with the requisite professional skills, chosen by the milieu of whom I approve. The interview will be tape-recorded, unless I indicate that I would prefer not to have my interview taped. I understand that my confidentiality and anonymity will be respected.

I understand that my participation is entirely voluntary. I am free to withdraw from this project at any time, before or during an interview, refuse to participate, and refuse to answer questions without any consequences. I have received assurance that the information I will share with the researcher will remain strictly confidential and that my anonymity will be maintained in all written materials or oral presentations based on the data gathered from this Ph.D research project.

I understand that my participation is voluntary and that I will receive no monetary compensation.

For more information, you can contact Susan Judith Ship by telephone at 001-416-633-1452 or by email at sj.ship@sympatico.ca or ship.susan@uqam.ca or in writing at the Département de Science Politique, Université du Québec à Montréal, Case Postale 8000, Succ. Centre-ville, Montréal, Québec, Canada, H3C 3P8.

This project has received the approval of the *Comité institutionnel d'éthique de la recherche avec des êtres humains de l'UQAM (CIÉR)*. Any information requests or complaints about the ethical conduct of this research may be addressed to my thesis director in writing to Professor Chantal Rondeau, Département de Science Politique, Université du Québec à Montréal, Case Postale 8000, Succ. Centre-ville, Montréal, Québec, Canada H3C 3P8, by telephone at 001-514-987-3000, local 4540 or by email: rondeau.chantal@uqam.ca . For any problem that can not be resolved with the thesis director, you can contact the President of the CIÉR, Dr. Joseph Josh Levy by email at levy.joseph_josh@uqam.ca or by telephone at 001-514-987-3000, local4483. He may also be reached at the office of the Committee by telephone at 001-514-987-3000, local 7753 or by email at cier@uqam.ca

There are two copies of the consent form, of which I may keep one.

I _____ am interested in collaborating in this Ph.D research entitled: *L'impact de VIH/sida sur les femmes au Sénégal: Une analyse de genre / The Impact of HIV/AIDS on Women in Senegal: A Gender Analysis*.

Participant's Signature

Date

Researcher's Signature

Date