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Financing HIV and AIDS Interventions: Implications for Gender Equality

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Acronyms

AIDS	Acquired immunodeficiency syndrome
ART	Antiretroviral treatment
BCI	Behavioural change interventions
CBO	Community-based organisation
DFID	Department for International Development, UK
DHS	Demographic and Health Survey
FY	Financial year
GDP	Gross domestic product
GFATM	Global Fund to Fight AIDS, Tuberculosis and Malaria
HIV	Human immunodeficiency virus
ICTC	Integrated counselling and testing centres
IDA	International Development Association
M&E	Monitoring and evaluation
MAP	Multi-Country HIV/AIDS Program
MDG	Millennium Development Goal
MTCT	Mother-to-child transmission
NACO	National AIDS Control Organisation, India
NGO	Non-governmental organisation
OVC	Orphans and vulnerable children
PEAP	Poverty Eradication Action Plan, Uganda
PEPFAR	President's Emergency Plan for AIDS Relief
PLHIV	People living with HIV
PMTCT	Prevention of mother-to-child transmission
PRBS	Poverty reduction budget support
PRSP	Poverty reduction strategy paper
STI	Sexually transmitted infection
TB	Tuberculosis
TRIPS	Trade-related aspects of intellectual property rights
UNAIDS	Joint United Nations Programme on HIV/AIDS
UNDP	United Nations Development Programme
VCT	Voluntary counselling and testing
WAMM	Women's Affairs Ministers Meeting
WHO	World Health Organization

Executive Summary

Introduction

This paper was commissioned by the Commonwealth Secretariat for the Eighth Women's Affairs Ministers Meeting (8WAMM) to be convened in Kampala, Uganda in June 2007. Its purpose is to examine the implications for gender equality of financing conditionalities for HIV and AIDS interventions. It is also intended to provide Ministers with food for thought and concrete strategies for ensuring that development aid for HIV incorporates gender equality to meet the Millennium Development Goals (MDGs) and other international development commitments. It augments the Commonwealth Plan of Action for Gender Equality 2005-2015 with particular reference to aid conditionalities and financing for programmes designed to achieve gender equality as set out in Section 3.IV of that document on gender and HIV and AIDS (Commonwealth Secretariat, 2004).

The core of this paper's argument is that financing for development means financing to achieve equitable gender relations as central to the development process. Gender inequalities, it argues, make development impossible. The paper analyses policy documents and evaluations of four major donor agencies to assess support via funding conditionalities for gender equality programming as part of development aid targeting HIV and AIDS responses. The four agencies are (a) the Global Fund to Fight AIDS, Tuberculosis and Malaria (GFATM), (b) the President's Emergency Plan for AIDS Relief (PEPFAR), administered by the Global AIDS Coordinator Office in the US Government, (c) the UK Department for International Development (DFID) and (d) the World Bank. Conditionalities are also examined as regards access to treatment and care, including access to affordable antiretroviral treatment (ART).

Snapshots of the national response in five Commonwealth countries – Botswana, Guyana, India, South Africa and Uganda – are analysed to determine where gender equality appears in the national planning, and how that in turn is reflected in grant documents and in national budgetary allocations suggesting or establishing de facto national priorities.

The gender dimensions of HIV: development and policy implications

Apart from the fact that women constitute perhaps 50 per cent of those who are the targets of development programming, the nature of the work that women do makes them central to the survival and development strategies of any nation. A gender audit done by Moser (2005) shows, however, that the fundamental role women play in the economy and must play in development is largely left to its own devices. The critical question is whether there is a disjuncture between the language of the donor agencies in support of women's equality, and the way aid is structured in practice.

Historically, HIV was a problem that affected primarily men for a variety of reasons depending on the context. Today, however, whether it is transmission by intravenous drug use or by heterosexual sex, women are testing positive for HIV at a rate that is increasing faster than men's. Some agencies have begun to recognise the role that gender plays in uptake and effectiveness of prevention of mother-to-child transmission (PMTCT) programmes. This recognition is an important step, but

limited. All too often PMTCT and prevention for female sex workers are the only places where women's distinct vulnerability appears in national programming. There is also the consideration that PMTCT itself ought to be considered treatment, care and support for women living with HIV; its ubiquitous categorisation as a prevention technology repeats traditional development prejudices that see pregnant women as vehicles of their babies and render the women themselves invisible and secondary in concern.

As with women's inequality and marginalisation, gender work that gets at root causes of underdevelopment or maldevelopment is often seen as supplemental to the work of stimulating private sector growth, neo-liberal tax reform or deregulating markets. In fact, all of these have profoundly gendered effects. Gender programming cannot be something we come to after the 'core issues' have been addressed. It is so fundamental to how societies function, and to the solutions individuals, families and households find to cope with poverty, that it must be at the core of national and global solutions if we are not to miss the mark.

Financing of gender equality in HIV interventions: a donor policy and conditionality analysis

In carrying out this analysis there were two key concerns: the number and nature of conditionalities that are involved in accepting funds from donors, and the extent to which those conditionalities are flexible. We examine the public statements and results of evaluations as regards programming for gender equality in key international donor institutions and conditionalities surrounding the provision of treatment and support services to people living with HIV (PLHIV), particularly women living with HIV or AIDS, or women in households where a member is sick from AIDS-related illnesses.

Aid agencies and national plans analysed (where available) – summary of findings

Even though its programming supports a wide range of issues related to HIV/AIDS, the Global Fund is general rather than specific in addressing gender issues and is gender blind rather than gender specific. The Fund, in 'Partners in Impact' (2007) proposes to address the lack of a mainstream gender focus in its programmes.

The President's Emergency Plan for AIDS Relief (PEPFAR) is one of the largest bilateral HIV/AIDS donors in the world. However, as noted by Susanna Fried, 'PEPFAR provides a huge influx of new resources, changing not only the course of the pandemic, but the politics and priorities around prevention, treatment and care. In particular, PEPFAR's emphasis on abstinence only until marriage and on fidelity as core elements of HIV&AIDS programming have influenced not only those programmes and projects that seek PEPFAR funding, but national policy in PEPFAR recipient countries. Such policy changes particularly impact key groups whose marginalization increases their risk of infection and for whom the messages of "abstain and be faithful" may be meaningless or impossible to achieve' (2007, p 33).

PEPFAR is required by the legislation authorising it to support five priority strategies to address the gender dynamics of the pandemic: (1) increasing gender equality in HIV/AIDS activities and services; (2) reducing violence and coercion; (3) addressing male norms and behaviours; (4) increasing women's legal protection; and (5)

increasing women's access to income and productive resources (p 130). While at first glance these strategies sound familiar because they use the same terms as other agencies, the conditionalities attached make them mean quite different forms of programming on the ground. The community-based reports in *Missing the Target* (ITPC, 2005) show how initially disparate funding conditionalities merge in PEPFAR programming to 'undermine efforts to reach women at elevated risk, implement evidence-based prevention programmes, and utilize quality generic and fixed-dose combination drugs' (p 10). Combined, these conditionalities constrain, more severely than with other donors, programming possibilities with PEPFAR funds.

The UK Department for International Development (DFID) is explicit in its commitment to treatment programmes and to research on effective treatment and care for women and children, as stated in its *Global Health Partnership* (Crisp, 2007) strategy. The treatment and care principles are also emphatic about the strategic importance of women's role as partners and as beneficiaries, establishing that DFID programmes should be 'pro-poor, equitable and gender- and child-focused' (p 45). DFID also strongly supports the rights of 'countries [to] build capacity to make use of the TRIPS [trade-related aspects of intellectual property rights] flexibility provisions [and to] explore other ways to unlock the TRIPS flexibilities.' DFID would seem to be a key ally for strategic work on equality for women. In its own evaluation of its bilateral expenditure on MDGs over 2005/2006, however, promoting gender equality and empowering women has one of the three lowest levels of significant expenditure (DFID, 2006, p 124).

The World Bank is the oldest multilateral development financing mechanism in response to HIV/AIDS and has a strong background in development financing. It recognises that gender inequality is a serious obstacle to poverty reduction, in part through the impact of HIV/AIDS as stated in its excellent operational guide on *Integrating Gender Issues into HIV/AIDS Programs* (2004). It further states that 'the increasing numbers of women infected with HIV stresses the need for policies and interventions to focus on transforming gender roles and relations between males and females to support the deep-rooted behaviour change necessary to stem the spread of HIV/AIDS. Males can become part of the solution to the pandemic by focusing on their roles and responsibilities and actions they can take to reduce their own and their partners' and families' risk of HIV/AIDS' (p 2).

Given such a strong mandate and toolkit for addressing gender disparities, it is all the more disappointing that in the Bank's own evaluation document, gender is barely mentioned. As in the Global Fund documents, women are mentioned only as pregnant mothers who are the subjects of surveillance testing, or as candidates for PMTCT programmes, and not as women living with HIV themselves in need of care and support.

Snapshots from the frontline of the Commonwealth

The countries examined in this snapshot are Botswana, Guyana, India, South Africa and Uganda. The funding received from donor agencies in the fight against HIV/AIDS is examined along with national policies and strategies. The policies and conditionalities of the donor agencies discussed above are reflected in the programmes they funded in these countries. All five countries stress the needs and

rights of women in national health and development programmes. This emphasis was strongest in Botswana and Uganda, while research suggests the need for a more proactive approach to transform the high prevalence rate of HIV/AIDS in Guyana, India and South Africa.

Lessons learned and findings

The *Commonwealth Plan of Action for Gender Equality 2005-2015* states that ‘While many policies and commitments made by governments and international organisations make the connection between gender and HIV/AIDS explicit, these commitments are not always implemented. Some examples of best practice are emerging, but there is often a big gap between policy and practice because of insufficient resources, training and capacity, especially where public sectors and basic service provision have been cut back. There is a need for greater attention to be paid to the implementation of policies and commitments, and for increased monitoring of and accountability for service delivery on the part of multilateral institutions, governments and CSOs.’ (Commonwealth Secretariat, 2004)

The findings of this paper affirm the wisdom of these insights agreed to at 7WAMM. The assessment of what is happening at the country level should be the next step. While there has been some progress, in many respects opportunities for funding to address gender inequality in the context of HIV/AIDS have not been followed through. The openings are there but the core issues have not been addressed in strong gender equity programming. There should be the deliberate inclusion of key strategies at country level, based on gender analysis, to recognise and correct the central role of gender inequality as a driver of underdevelopment and of the HIV/AIDS pandemic and the stigma and discrimination against those affected and infected by the disease. In this regard, community involvement and the strategies for accountability for addressing gender inequalities in India’s Global Fund grant are an excellent beginning. Similarly Uganda’s approach of pursuing gender empowerment strategies that are embedded in an integrated poverty-reduction approach provides important lessons for other countries.

What this review has shown is that Commonwealth countries have been providing leadership in important breakthroughs in designing gender empowering strategies as an integral part of development programming, including HIV prevention, care and treatment programmes. The challenge of gender work is that it politicises the private, as second wave feminists asserted in the 1970s, and this is what makes the struggle for gender equality so difficult – it is so personal that many resist it on that ground alone.

I. Introduction: Blindness and Insight

“Gender equality is central to achieving the MDGs and other development goals, making it important to ensure that aid structures target and monitor progress towards gender equality goals” (UNIFEM, 2006).

“What would I say to her? I’d tell her to stand up for her rights; to be honest with their partner and themselves, first to be honest with them self. Try not to get tricked because of love. We blind our eyes because of it and in the end we are the ones to feel it. Feel the pressure when everything comes crashing down. I would say to them to be honest with themselves first. Love them self first take care of them self and then introduce condoms to their loved one and tell them the reason and if the other person don’t want to use condoms to protect his or herself, then the individual has to stand up and stick out that if there is no condom, there is no love.” (HIV-positive Jamaican woman in Haniff, 2006).

The two quotes above capture the dilemma at the heart of this paper. At the policy level, gender in development processes are seen as central by women’s machineries, although at times that has been a difficult argument to make clear. Simultaneously, on the ground, at the level of everyday life where underdevelopment is most acutely lived, gender determines both consciousness and behaviours in such a fundamental way that the effects of gender inequality are not noticed until they erupt into personal and household disaster. In this equation, even emotions and affective bonds considered outside the realm of politics – like a woman’s love for a man – becomes a central driver and a reflection of gender inequality at the level of fundamental consciousness and of behaviour.

These moments of blindness until a crisis brings insight are what make both quotes reflective of the significance of the challenge at this crossroads in development planning in the Commonwealth. How do we unmask the reality that our struggles with development are deeply gendered? How do we convince our societies that old modes of gender, even including our understanding of what ‘love’ means, are at the root of our challenges with achieving development? Or that a development crisis like the spread of HIV is a reflection of these gendered challenges, and not an external agent imposing itself on us and on our societies?

The epidemics of HIV and AIDS make these questions all the more urgent. In 2006 alone, an estimated 2.8 million people died of AIDS-related illnesses, 67 per cent of them in the Commonwealth. This is the epidemic of AIDS. In an age of early detection and comprehensive treatment, it can be eradicated.

Today some 38.6 million people are living with HIV globally, of whom 62 per cent, or 24 million, are people living in the Commonwealth. Of these 24 million, some 11.5 million are women and girls. This is the epidemic of HIV and it is much more difficult to stop.

It is important for us to speak to two different epidemics, perhaps three.

The *first epidemic* is that of HIV, marked by its invisibility. The human immunodeficiency virus (HIV) spreads mostly through unprotected sex in Western and developing countries, through sharing infected needles in Eastern Europe and, everywhere, through breast-feeding or transfusions of infected blood. HIV leaves no distinctive traces of infection, except perhaps flu-like symptoms for the first few days. It reproduces in the blood stream like other viruses, except it does so by destroying the white blood cells of the immune system.

Acquired immunodeficiency syndrome (AIDS), *the second epidemic*, is the dramatic, visible result of the work of HIV. Once the virus reproduces in the body by destroying the immune system, it leaves the infected person exposed to dangerous forms of both rare and common diseases. However, with access to the right medication combined with care and support, a person with AIDS can fight back against the virus and regain her or his health. It is therefore possible to move from a diagnosis of AIDS back to being HIV-positive, even to undetectable levels of the virus in the bloodstream.

Time has shown that HIV and AIDS thrive best in environments marked by poverty, social exclusion and political marginalisation. In country after country, as HIV has spread, it has taken hold first among the most disenfranchised. This contributes to the *third epidemic*, the epidemic of stigma, discrimination and exclusion, that drives the spread of HIV underground, and often makes HIV infection and the debilitating effect of AIDS a crisis for each person whose life HIV touches. AIDS can be treated with medication, but HIV, stigma and discrimination have proven intransigent to policy interventions.

Over the past few years, the rate of increase in new cases of HIV has escalated in women around the world. Studies show that this is because women are biologically more likely to be infected by sexual transmission than their male counterparts. It is also the result of deeply entrenched habits of thought and practice surrounding gender and gender roles that make women less able to take ownership of their lives, including their sexual behaviour. This disempowerment is all the more pernicious because it is normalised behaviour for 'good' women, or where sex is wrapped up in notions of romantic love that are fundamental to 'good' women's dreams of marriage and family.

For many women, sex takes place as a matter of trust and love, appropriate behaviour for a wife or a woman in love. Girls and boys are raised by both their mothers and fathers to believe that, for women, having and caring for a family, looking after a husband or male partner, being in love and becoming pregnant and having a child and are essential to a happy and fulfilling life for women.

The inequities in power relations between women and men become clear, however, when women in sexual relationships with men attempt to stop or change the way they have sex with those men. Suddenly (or not so suddenly) they are met with admonitions of inappropriate behaviour, or with violence designed to 'set them straight'. Both women and men, including the mothers and fathers of girls, are complicit in this, so deeply embedded is women's sexual submission to men in cultural notions of appropriate gender roles and expected sexual behaviour within a marital or sexually intimate relationship. As a result, in some Commonwealth countries it is legally impossible – depriving women of any recourse – for men to rape

their wives. A husband's sexual access to his wife's body is thus guaranteed by the state as much as by custom. Research from around the world has shown that, in the absence of structural support such as access to financial and political resources, women find themselves with few choices but to leave or to submit. In India, studies suggest that a majority of women infected with HIV were infected by unfaithful husbands (Bloom, Singh and Suchindran, 2005). In Uganda, many widows are subject to property grabbing and can find themselves evicted from their homes. 'Relatives always blame their widowed-in-law for having "killed" their son in case he dies of AIDS' reported one focus group of Ugandan men' (UNAIDS, 2001).

Reducing the spread of HIV, and mitigating its impact, is thus embedded in addressing cultural and other norms that cover up or support existing gender inequities and unequal and exploitative power relations, themselves drivers of underdevelopment. Addressing the spread of HIV and the impact of AIDS thus means addressing the same fundamental inequities that frustrate development programmes.

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The following section of this paper situates the conceptual linkages at the core of the paper's argument: that financing for development means financing to achieve equitable gender relations as central to development. Gender inequities, it argues, make development impossible.

In order for gender equality to be included in HIV financing, it must be supported at two levels: donor policy and national level programming. How gender equality arrives on the donor and national agenda is in itself a critical process, requiring partnerships in government and civil society as well as donor support. Both the process of this inclusion and the understanding of gender equality embraced in the response agendas are therefore critical to setting the stage for efficient and strategic action on the ground.

The subsequent two sections of this paper will address this. In Section III the paper analyses policy documents and evaluations of four major donor agencies to assess support via funding conditionalities for gender equality programming as part of development aid targeting HIV/AIDS responses. The four agencies are the Global Fund to Fight AIDS, Tuberculosis and Malaria (GFATM); the President's Emergency Plan for AIDS Relief (PEPFAR), administered by the Global AIDS Coordinator Office in the US Government; the UK Department for International Development (DFID); and the World Bank. Conditionalities are also examined as regards access to treatment and care, including access to affordable antiretroviral treatment (ART).

Section IV then looks at snapshots of the national response in five Commonwealth countries – Botswana, Uganda, South Africa, Guyana and India – to examine where gender equality appears in the national planning, and how that in turn is reflected in grant documents and in national budgetary allocations to see how that might reflect, or even establish, national priorities.

Finally, the paper closes by looking at some lessons learned for greater effectiveness of gender equitable programming in HIV/AIDS-related development aid packages for policy makers and programmers.

II. The Gender Dimensions of HIV: Development and Policy Implications

The new modalities of development aid, as well as the old ones, have been seen as providing a critical platform for work on women's equality. Coming from the Monterey, G8 and Paris meetings on aid modalities, the intention is for the focus on achieving the MDGs to be sharpened, the financing process to be more effective and reporting more efficient. In this context, it is important to note that the 2005 MDG target on gender – to eliminate gender disparity in primary and secondary education – has not been met (Birdsall, Ibrahim and Gupta, 2004).

In many Commonwealth countries, the purpose of development aid is greater equality in development processes. Development is defined, more or less, as 'an improvement in the living conditions of the people' (Nayyar, 2004, p 62). But development also goes deeper than that to look at what we mean by 'improvement'. Nayyar argues that improvement means ensuring 'the provision of basic human needs for all – not just food and clothing, but also shelter, health care and education' (ibid).

Within this, it is imperative to understand the extent to which the role of women is central to achieving these objectives. This is not only because women must be understood as among the people provided for in development aims, but also because of the central role women play in the formal and informal economy, and the extent to which gender inequality blinds policy makers, donor agencies, ministers of government and others to this reality. Across classes, ethnicities and national boundaries, women continue to provide critical care in providing the labour to manage the household and raise children. This is apart from the role they play in administering to men's needs. Macroeconomic policy analyses and indicators disguise this, not only reflecting the invisibility of women's work but also missing the strategic centrality of this work in effective policy-making and more broadly in national strategising. Apart from the fact that women constitute perhaps 50 per cent of those who are the targets of development programming, the nature of the work that women do makes them central to the survival and development strategies of any nation.

The challenge of incorporating these insights into development policy and financing is reflected in the many modalities for both addressing women's inequality and for achieving development – 'women in development,' 'gender and development' and so on – most of which have had limited successes and many missed opportunities.

One challenge is that while we often still speak of ‘integrating’ gender into development, the two are in fact fundamentally inseparable. This problem at the level of how we understand underdevelopment and development undermines the effectiveness of aid. Yet a gender audit by Moser (2005) of why strategies for transforming our understanding of the central role gender equality plays in development found three main problems:

- (a) evaporation (commitments not captured in implementation);
- (b) invisibilisation (lack of monitoring and reporting of progress, often due to lack of awareness on what to measure or how high the bar should be), and
- (c) resistance (from those who see it as ‘too time consuming’, not a priority in this situation, etc) (cited in Gaynor, 2006).

In all three instances, it means that the fundamental role women play in the economy and must play in development is largely left to its own devices. The critical question is whether there is a disjuncture between the language of the donor agencies in support of women’s equality, and the way aid is structured in practice.

This points again to the role that gender has been playing in the response to HIV for both historic and conceptual reasons. Historically, HIV was a problem that affected primarily men for a variety of reasons depending on the context. Today, however, whether it is transmission by intravenous drug use or by heterosexual sex, women are testing positive for HIV at a rate that is increasing faster than men’s. In fact, even in those instances where the main mode of transmission has been intravenous drug use, transmission for women has been largely through heterosexual sex with drug-using male partners (this, of course, is not to make invisible women who use drugs).

The emergence of a pandemic among women presents a challenge to the way the response to HIV has been conceptualised. Most of the models central to responses to HIV have centred around ideas of risk, and that to reduce risk each of us needs to know more about how HIV is contracted, understand our personal susceptibility and so change our behaviour – whether it be to abstain from sexual intercourse, be faithful to our partner or to use a condom. The problem with this is that it assumes we are all equal, that we make rational decisions about sex and that we are in a position to control when, where and how we have sex. This is often not the case. Gender inequality makes this particularly unlikely for women.

UNAIDS (1999) has identified core factors that place women at particular risk for HIV infection. Some of these can be addressed by the traditional responses of risk reduction, but others require more fundamental shifts that take us back to development processes that recognise the role gender plays. These factors show the challenges we stumble on when the impact of gender inequalities and gender roles is missed:

...as more women enter manufacturing sectors of the economy without the protective features of their families and home communities, young women are becoming sexually active at an earlier age and are often unaware of the risk of HIV and sexually transmitted diseases. Migration fostered by economic conditions has also contributed to an increase in the number of female-headed

households, while economic necessity is often linked to migration for the sex trade in south-east Asia. (p. 3)

UNAIDS comes closer to the issues when they examine the issue of vulnerability of women and girls:

Many women in monogamous relationships who are vulnerable to HIV through their partner perceive the negative economic consequences of leaving the high-risk relationship to be far more serious than the health risks of staying. Low-income girls may face an added risk of HIV because of vulnerability to the enticements of older men. (ibid)

Women's role and vulnerability also play a critical role in the response to AIDS. In most parts of the world, as we will see later in this paper, the focus for treatment, care and support is access to first and second line treatment, and treatment for opportunistic infections. In many instances, there is great pressure on hospitals for bed space. This means those ill from AIDS-related illnesses have to be looked after at home, and takes us back to women's unpaid work and the problems for policy and planning when it is invisible. For behind the concerns with economic costs and bed days as units is women's work and inventiveness in meeting basic needs for food, shelter and caring:

Women are likely to be disproportionately affected by HIV/AIDS when a male head of household falls ill. The burden of caring for children orphaned as a result of the pandemic is borne chiefly by women. Loss of income from a male income-earner may compel women and children to seek other sources of income, putting them at risk of sexual exploitation. (UNAIDS, 1999, p 3)

This assumes as well that the person who is sick is the male income earner, and not the woman herself. In that instance she is often left to her own devices, and it is the girl children who come to her aid. 'Girls carry a larger burden of domestic responsibility than do boys,' explain Barnett and Whiteside (2002, p 16), 'and are more likely to be kept out of school'. Further,

Children who care for adults may experience a world gone seriously awry. A young girl of eight or nine may be used to caring for younger siblings: she is unprepared to care for her mother, father or both of them. As well as the physical difficulties, there are inevitably difficulties of culture and sensibility. Coping with a parent who is weak and requires food cooked or water brought is one thing. Coping with a parent's severe diarrhoea, declining mental function and mood changes is quite another. Children also become uncommonly familiar with death. (p 17)

The same issues that leave women and girls to fend for themselves in the household have their counterparts in the wider structure of the economic and legal framework:

Gender-related discrimination is often supported by laws and policies that prevent women from owning land, property and other productive resources. This promotes women's economic vulnerability to HIV infection, limiting their ability to seek and receive care and support. (UNAIDS, 1999, p 4)

In India, one of many countries where gender discrimination is especially harsh, the

inability to own and access property is one of the biggest difficulties facing women in households affected by HIV/AIDS. HIV-positive women who have been abandoned by their husbands and ostracized from their communities and widows who have lost their husbands to AIDS-related illnesses are very often denied a rightful share of their husbands' property. The community or their in-laws throw them out, leaving them destitute and homeless. (Jain, 2006, p 1)

As in development work more broadly, and in addressing HIV as a developmental issue, we come back to the core challenge of whether we can see the role gender is playing in underdevelopment, and the fundamental role seeing and addressing gender needs to play in any effective response.

Some agencies have begun to recognise the role that gender plays in uptake and effectiveness of prevention of mother-to-child transmission (PMTCT) programmes. This is an important step, but limited. All too often PMTCT and prevention for female sex workers are the only places where women's distinct vulnerability appears in national programming. There is also the consideration that PMTCT itself ought to be considered treatment, care and support for women living with HIV; its ubiquitous categorisation as a prevention technology repeats traditional development prejudices that see pregnant women as vehicles of their babies and render the women themselves invisible and secondary in concern.

Yet the group that has been largely invisible in this analysis has been men. In fact, gender norms of masculinity have been shown to increase men's vulnerability as well. In some cultures, for example in the Caribbean, the submission to institutional authority required to do well in school settings, the perception of studying as inappropriate gender behaviour, as well as peer pressures towards types of behaviours seen as appropriate to men have led boys to drop out of the formal system and seek financial security through other means (see Plummer, 2006). In many parts of the world, notions of masculinity as dominating women and each other has led to high numbers of boys dropping out of school, increased involvement in gang activity including gang-related violence, multiple sexual partners, violence towards women and other men, and other counter-productive behaviours. Further, it is the persistent entrenchment (in parenting practices and other institutional social norms), by both women and men, of unequal social and male gender norms that reproduces and shores up gender inequality as the status quo in succeeding generations.

Recognising this, programmes have been developed and piloted in many countries in the Commonwealth to address and transform men's understanding of male gender norms (Chege, 2005; Levack, 2006; Verma et al, 2006). Often they have proven very effective, but their implementation remains small scale. As with women's inequality and marginalisation, gender work that gets at root causes of underdevelopment or maldevelopment is often seen as supplemental to the work of stimulating private sector growth, neo-liberal tax reform or deregulating markets. In fact, all of these have profoundly gendered effects (see, for example, Randriamaro, 2006).

A central challenge in the Commonwealth and elsewhere has been the model for understanding HIV. Initially HIV was the province of epidemiologists and other medical professionals, and the national responses were housed in the ministries of health. While the establishment of national AIDS committees and commissions, often at the urging of international donors, has reflected an attempt to shift the designation of HIV as centrally a health issue, the changes have often been either cosmetic or else conflict ridden, with the health ministers feeling undermined. More often, it has been both.

An administrative model that has proven successful is placing the response in the portfolio of the Head of State, but this is only effective when that Head of State is both informed and taking the lead on establishing a genuinely multi-structured approach and then monitoring its implementation. If the women's machinery does not play a central role in both the response development and monitoring and evaluation processes for administrative reasons, it means progress will be limited and the sudden explosion of the three epidemics among women becomes a logical consequence. While we may have made substantial progress in identifying gender inequality as one of the main drivers of the epidemics, it is an open question whether we do not lag behind in taking action based on that insight.

The central role of gender formation and gender equality in sustainable people-centred development makes evident why supporting such programmatic and strategic insights with financing is so critical. If we are to take account of the drivers of the problems we face and address underdevelopment at the root, gender programming cannot be something we come to after the 'core issues' have been addressed. It is so fundamental to how societies function – and to the solutions individuals, families and households find to ameliorating poverty – that it must be at the core of national and global solutions if we are not to miss the mark.

III. Financing for Gender Equality in HIV Interventions: A Donor Policy and Conditionality Analysis

Poverty and gender inequalities are driving factors in the spread and impact of HIV/AIDS. Women's unequal political and legal status perpetuates poverty, discrimination and lack of opportunity in social, economic and cultural spheres of activity, including access to and ownership of land and property, inheritance rights and decent work opportunities. (Commonwealth Secretariat, 2004)

...specific accountability indicators of the impact on gender equality of development spending at national and local levels are needed so that accountability institutions and civil society groups may scrutinize the quality and impact of spending decisions. (UNIFEM, 2006)

The donor agencies under review here can be grouped in several ways that relate to constraints on their ability to support gender equality in financing.

This is directly related to two key concerns: the number and nature of conditionalities involved in accepting funds from donors, and the extent to which those conditionalities are flexible. The Paris Declaration, although the implications are still

being thought through, lays down conditionalities about process rather than content of aid. While this may leave more room for manoeuvring as regards the politics of the content of aid, it means that processes will more tightly controlled, leaving a less varied range of partners for aid recipients. It remains to be seen to what extent the greater control over processes will come to exert pressure on the content of aid. In responding to the AIDS epidemic, for example, there has been much controversy over PEPFAR conditionalities preventing the purchase of generic versions of brand name antiretrovirals and medication to treat opportunistic infections (referred to as ‘single and limited-source medicines’). Other donors reviewed here rely on the pre-qualification programme from the World Health Organization (WHO) rather than restrict medicines to those approved by national institutions.

Conditionalities are directly related to the politics of those from whom a donor agency receives funds. As such, DFID and PEPFAR are directly funded by governments and are accountable to the politics of those governments. The political climate in the British Parliament and in the Bush Administration as regards gender equality is thus central to DFID and PEPFAR funding conditionalities. Governments, including the UK and the US, are also behind the policies and financing possibilities of the GFATM and the World Bank, but the fact that they are multilateral institutions means the political stance of any one government can be offset by the stance of the others.

The Paris Declaration, in shifting the way aid is delivered from programmes and projects to sectors, will make it harder to track financing commitments to gender equality as aid will be given in support of a broader government strategy. As Fried (2007) points out,

‘Country ownership’ has become the new mantra of both donors and the advocacy communities in donor countries, such as the United States and among international agencies. But where ‘country ownership’ becomes ‘government ownership’, there is an increased risk that already ‘vulnerable’ and marginalized groups in a society become further marginalized, and gender-equality priorities likewise. (p 3)

This has two sets of implications. First, it means oversight bodies such as women’s machineries will have to be even more vigilant in monitoring follow-through on commitments aimed at reducing women’s vulnerability and at empowering women. Second, it makes strategies and alliances to ensure financial allocations for addressing women’s empowerment even more central to the national development agenda. If such strategies are not included there, it will make progress much more difficult, and progress to scale impossible.

Further, Fried notes a trend that has mixed consequences for programming aimed at social inclusion for marginalised groups:

...donors are increasingly disavowing the practice of ‘aid conditionality’, in line with advocacy efforts by grantee countries and NGO allies for many years. The Global Fund, for example, states that ‘apart from a high standard of technical quality, the Global Fund attaches no conditions to any of its grants.’ And indeed, this is cause for celebration: far too often, conditionalities reflected the concerns and politics of donors, rather than the concerns and

needs of recipient countries. It is important, however, that country ownership and control not be confused with lack of transparency and accountability on the part of donors and grantee countries alike, or function as an excuse for a lack of gender analysis. (ibid, p 20)

In what follows, we examine the public statements and results of evaluations as regards programming for gender equality in key international funding institutions, and conditionalities surrounding the provision of treatment and support services to people living with HIV (PLHIV), particularly women, or women in households where a member is sick from AIDS-related illnesses.

The Global Fund to Fight AIDS, Tuberculosis and Malaria (GFATM)

The Global Fund to Fight AIDS, Tuberculosis and Malaria (GFATM – or Global Fund) is a relatively new mechanism, established in 2002 for financing national and regional responses to its three focus diseases. It seeks to have a structural impact through flexible, on-the-ground programming.

The GFATM is marked, as others have noted (for example, Fried 2007), by its absence of conditionalities and explicit support for a wide range of programming, including human rights reforms, prevention programmes and treatment, care and support for people living with HIV or AIDS (*Framework*, p. 4). Functioning through national or regionally driven programme proposals, it does not make gender a condition of support, although it does mention gender in a list of suggested concerns. It also recommends (though does not require) that gender be addressed in the composition of Country Coordinating Mechanisms. Gender is not an issue in evaluating principle recipients for grants – for example, gender inclusiveness in management positions. The Secretariat itself does have such targets, however (Fried, 2007, p 28).

Further, encouragement for gender equitable programming takes a back seat in its documents to gender-neutral health systems strengthening. The Global Fund's monitoring and evaluation (M&E) programme indicators have only one mention of gender, in asking for what is actually sex-disaggregated data on health-care workers trained. As this is the only indicator that is sex- or gender-specific, the Fund's M&E programme is effectively 'gender blind' rather than simply 'gender neutral'.

Global Fund statements that may seem at first glance to address gender equality are troubling on further analysis. For example, *Partners in Impact* (2007), an assessment of the Fund's impact, acknowledges that:

All grants are requested to include particular attention to vulnerable groups and gender issues. Where available, the results of routine service statistics for HIV treatment and testing, malaria ITNs [insecticide-treated mosquito nets] and TB suggest women are being reached. Data for vulnerable groups are often not routinely collected. There are clear gaps of critical importance: prevention of mother-to-child transmission (PMTCT) programs are underperforming and gender issues are at the core. The result is an epidemic of children with AIDS. (p 4)

While the report is correct that there are likely layers of gender issues at the core of the underperformance of PMTCT programmes, the concern here is the ‘epidemic of children with AIDS,’ rather than also the women living with HIV who are not accessing meaningful support, the same women who will likely have primary care responsibilities for children born with or without HIV. This is critical because it also speaks to gaps in access to ART for women living with HIV. The disappointing pattern of consistent, almost exclusive (even if unintentional), association of women with PMTCT programmes continues throughout the evaluation.

Access to free or subsidised treatment programmes are a cornerstone of Global Fund programming, and its grants can be used to purchase generic or brand name medications approved by the WHO, so long as it is at the lowest cost available via transparent bidding processes. As such, Global Fund grants have put 770,000 persons living with HIV on treatment (p 116), which, while the evaluation notes it is not enough, still achieves 120 per cent of the consolidated target established in grants (p 18). The Global Fund does not require gender-disaggregated data, although it suggests that more than half the persons on ART are women (p 20).

In *Partners in Impact*, the Global Fund proposes to address the invisibility of women in its programmes and the lack of a mainstreamed gender focus. As such, they advocate for better tools to include gender in proposals, grant design and annual reviews of grants to influence implementation. Diagnostics for grants are needed to identify gender issues beyond disaggregating service data. This needs to have a basis in national planning and disease strategies. There are critical gender challenges to better scale up Global Fund and country efforts. (2007, p 18).

This would require more stringent conditionalities on grants, introducing new variables into the grant writing and evaluation processes. It would also strengthen the hand of national machineries seeking to address gender equality in approved Global Fund grants.

The President’s Emergency Plan for AIDS Relief (PEPFAR)

With some US\$15 billion in available funds over five years, PEPFAR is probably the largest bilateral HIV and AIDS donor in the world. However, it is the most controversial of the donor agencies reviewed here, notably for its conditionalities.

In *Women Won’t Wait*, Susanna Fried (2007) notes:

PEPFAR provides a huge influx of new resources, changing not only the course of the pandemic, but the politics and priorities around prevention, treatment and care. In particular, PEPFAR’s emphasis on abstinence only until marriage and on fidelity as core elements of HIV&AIDS programming have influenced not only those programmes and projects that seek PEPFAR funding, but national policy in PEPFAR recipient countries. Such policy changes particularly impact key groups whose marginalization increases their risk of infection and for whom the messages of ‘abstain and be faithful’ may be meaningless or impossible to achieve. (p 33)

Openly influenced by conservative religious values, it advocates condoms ('C') as a last and least preferable resort for HIV prevention, promoting instead abstinence from sex before marriage ('A'), and fidelity within marriage ('B' – be faithful'). Together, this approach is known as the 'ABC' approach (PEPFAR, n.d.).

Within this context, PEPFAR is able to support programming that addresses a range of issues affecting women, including male responsibility (such as fidelity in marriage, delay of sexual debut), violence against women and other issues important for women. In analysing the drivers of the HIV epidemic, PEPFAR's *Third Annual Report to Congress* establishes that:

Among the harmful social norms and practices that increase the vulnerability of women and girls are those that: restrict women's access to HIV/AIDS information and services; severely limit women's control over their sexual lives, leaving them vulnerable to sexual violence and abuse and putting them at increased risk of HIV transmission; and deprive them of economic resources and legal rights necessary to protect themselves from HIV/AIDS and contribute productively to caring for others affected by the disease. (2007, p 129)

They also add it is important to note that:

...harmful social norms and practices can also increase vulnerability of boys and men, such as pressure from peers or others to have multiple sexual partners or to seek transactional sex. (ibid)

PEPFAR is required by the legislation authorising it to support five priority strategies to address the gender dynamics of the epidemics:

- 1 Increasing gender equality in HIV/AIDS activities and services;
- 2 Reducing violence and coercion;
- 3 Addressing male norms and behaviours;
- 4 Increasing women's legal protection; and
- 5 Increasing women's access to income and productive resources. (ibid, p 130)

While at first glance these strategies sound familiar because they use the same terms as agencies like the World Bank and DFID, the conditionalities attached make them mean quite different programming on the ground.

The gender priorities identified are in fact strongly conditioned by the principles of the 'ABC' approach, as is clearly laid out in PEPFAR's *ABC Guidance #1* (n.d.). PEPFAR is also clear that in its work with indigenous community groups, 'faith-based groups are priority local partners' (*Report on Community and Faith-Based Organizations*, 2005, p 2). While the *Guidance* speaks of 'gender inequities that foster the spread of HIV' (p 11), and of PEPFAR programmes 'coordinating with governments and NGOs to eliminate gender inequalities in the civil and criminal code and enforce existing sanctions against sexual abuse and sexual violence' (p 7), both strategies are to support PEPFAR's core strategy of ensuring that sex does not take place outside of marriage rather than to strengthen human rights.

Thus PEPFAR's conditionalities are straightforward when it comes to prevention:

...programs to reduce new infections in young women should focus on promotion of abstinence among young females, on reducing cross-generational sexual relationships, and on encouraging faithfulness and correct and consistent condom use among older males. (p 12)

A further and related conditionality is that at least 33 per cent of all PEPFAR funds must support programming advocating abstinence until marriage. In practice, this is best tracked by examining what percentage of the total budget for sexual transmission of HIV is spent on abstinence programming, so that this is separated out from blood safety and PMTCT programmes, for example. Healy Thompson (2007) of RHRealityCheck.org points out that abstinence and be faithful programming accounts for over half PEPFAR's spending, at 56 per cent. Condom promotion accounts for less than 44 per cent, and must include promotion of abstinence, testing for HIV, partner reduction and mutual faithfulness. Thompson notes that this is a potentially dangerous misalignment with the data we have showing 80 per cent of all new infections are through sexual contact.

PEPFAR has also spent a substantial amount of funds in providing treatment and support for PLHIV. In *Missing the Target: A report on HIV/AIDS treatment access from the frontlines* (2005), the International Treatment Preparedness Coalition, a global coalition of PLHIV and their advocates, state that the community members they spoke to from around the world had important praise for PEPFAR's treatment programmes:

PEPFAR has initiated HIV/AIDS assistance efforts in 15 countries over the past two years. Many report interviewees praised PEPFAR for quickly setting up treatment programmes with measurable goals and for operating in a determined and efficient manner.

At the same time, the Coalition had concerns about the integration of these programmes into sustainable systems that contributed to a country's long-term development interests:

This report corroborates that shortfall with examples of PEPFAR creating separate systems of care and failing to coordinate with others. PEPFAR is saving lives today; the question is whether it is building sustainable systems that will survive for the long term. (p 10)

Controversy surrounds PEPFAR's treatment programme as well because of conditionalities that state all medications purchased with PEPFAR funds, including generic medication, must be approved by the Food and Drug Administration (FDA) in the United States. Most other agencies, such as the Global Fund and the World Bank, rely on the WHO for this process.

Critics of PEPFAR policies argue that this limits the ability of agencies to maximise treatment funds (see Table 1). The Centre for Public Integrity reports that 'about half of the treatment money is going for antiretroviral drugs, which at the beginning were

required to be highly expensive name-brand drugs approved by the Food and Drug Administration and provided largely by major American pharmaceutical companies.’ Thompson states that in fact only 27 per cent of funds spent on antiretroviral drugs were spent on generic medication.

Table 1: Treatment: Total Antiretroviral Procurement and Delivery by Innovator and Generic, FY2006¹

Country	Innovator	Generic	Total	Generic (%)
Botswana	\$2,816,811	\$2,197,424	\$5,014,235	44%
Côte d’Ivoire	\$4,302,345	\$553,547	\$4,855,893	11%
Ethiopia	3,832,452	\$3,805,394	\$7,637,846	50%
Guyana	\$76,671	\$7,431	\$84,102	9%
Haiti	\$339,822	\$2,359,378	\$2,699,200	87%
Kenya	\$19,398,334	\$1,658,845	\$21,057,180	8%
Mozambique	\$1,382,476	\$230,900	\$1,613,377	14%
Namibia	\$888,031		\$888,031	0%
Nigeria	\$8,340,469	\$5,078,349	\$13,418,818	38%
Rwanda	\$338,535	\$605,618	\$944,153	64%
South Africa	\$5,968,289	\$253,879	\$6,222,167	4%
Tanzania	\$3,725,338		\$3,725,338	0%
Uganda	\$14,989,290	\$3,996,395	\$18,985,685	21%
Vietnam	\$1,818,359	\$1,222,267	\$3,040,626	40%
Zambia	\$11,831,514	\$7,825,313	\$19,656,827	40%
Total	\$80,048,737	\$29,794,741	\$109,843,477	27%

Footnote:
¹ December 2006 data from the SCMS survey of all 36 Emergency Plan partners who procure ARVs for focus countries. Survey requested information regarding the delivery of ARVs in FY2006; response rate was 100%.

Excerpted from PEPFAR’s *Third Annual Report to Congress* (2007) showing comparative expenditures between products made by global pharmaceutical companies (‘Innovators’) and those made by generic manufacturers.

Other critical conditionalities of US Government aid persist as well and place explicitly political restrictions on recipients of PEPFAR funding, particular a gag rule on a woman’s right to choose whether or not to have a child, or the recipient’s political stand on legalisation of sex work. Community-based reports in *Missing the Target* (ITPC, 2005) show how initially disparate funding conditionalities merge in PEPFAR programming to undermine the effectiveness of its programmes:

...there are grave concerns around PEPFAR-imposed policy prescriptions, including disallowing grantees from providing counseling on abortion; requiring grantees to adopt a policy specifically opposing sex work; promoting abstinence-only prevention approaches; and forbidding the use of PEPFAR funds to purchase medicines that are not approved by the U.S. Food and Drug Administration. These policies undermine efforts to reach women at elevated risk, implement evidence-based prevention programmes, and utilize quality generic and fixed-dose combination drugs. (p 10)

Combined, these conditionalities constrain, more severely than with other donors, programming possibilities with PEPFAR funds. Thus while PEPFAR documents promote US government partnerships with indigenous organisations and local government, in practice these partnerships are largely based on religious concurrence. The results are potentially quite disastrous for the 15 focus countries employing PEPFAR strategies. The Centre for Public Integrity notes that contrary to PEPFAR claims in its reports that its prevention strategy is working in Uganda, a country PEPFAR documentation holds up as the model on which the efficacy of its approaches is based, in fact

...success [gained before PEPFAR's interventions] seems to be reversing. In the two years since the new U.S. emphasis on youth abstinence began, the rate of new HIV infections has almost doubled, from 70,000 in 2003 to 130,000 in 2005, according to the director general of the Uganda AIDS Commission.

In the end, it will be up to the national partners to monitor whether PEPFAR designed and funded programmes are proving effective, and if so, to what extent.

The UK Department for International Development (DFID)

DFID is perhaps the most progressive agency under review, as regards its explicit statements on gender equality and the role of inequitable gender relations in stymieing development.

In *Eliminating World Poverty: A consultation document*, DFID asks a number of important macro level questions. An important one for us is that in asking how donors can help to build more effective states, it asks a related question, 'How can poor men and women be empowered to demand action from their governments and hold them to account' (2005, p 3). This speaks to two key issues: first, it opens the door to the reality that women and men may have different issues and require different strategies for empowerment, and that eliminating world poverty requires incorporating that reality. Second, it speaks to the need for national action from government and civil society and donor support to complement each other in relation to gender equality in development programming.

This is followed through in a key statement made in DFID's *Global Health Partnership*, which points out that 'there is now a great deal of evidence that education and empowerment – particularly of women – and helping people have more control over their lives and environment have profound and lasting effects' (Crisp, 2007, p 6). It is surprising, however, that in a document of almost 200 pages, there is no mention of the word gender, and that this is the only place that women occupy as women. Significantly, though, programmes dedicated to women do appear in case studies and the few statements in support of dedicated programming for women are strong. So, for example, DFID notes that

despite an often less powerful position in society, many studies have shown the impact that educating and empowering women can have on health. UK partnerships and programmes that engage with women in developing countries are likely to have a particular importance. (ibid, p 126)

Women appear again as ‘the bedrock of care’ especially for the poorest families who do not seek health care outside the home (ibid, p 136).

While these policy statements acknowledge women’s central role in the home in providing a safety net for care, the document takes an important step to acknowledge gender empowerment strategies as key to sustainable development. In particular, it describes micro-credit with education programmes that ‘deliver both microfinance and dialogue-based health education’ and have proven effective in ‘several rigorous impact studies’ (ibid, p 151). The combination of microfinance with education is also noted as effective in stimulating behaviour change in relation to HIV risk behaviour, suggesting again the link between addressing vulnerability and risk reduction.

This commitment to addressing structural inequality is made much more explicit in *Taking Action: The UK’s strategy for tackling HIV and AIDS in the developing world* (2004). Equality for women has a central place in DFID’s platform, and this is stated categorically, demonstrating an understanding of the cause and effect of gender inequality. The statements are clear as well on the link between stopping the epidemics of HIV and AIDS, women’s structural vulnerability and gender empowerment in designing rights-based prevention strategies:

Increasing rates of HIV among women of all ages highlight the importance of addressing the needs and rights of women and young people, particularly girls. Women’s vulnerability to HIV is made worse by unequal gender power relations and disrespect for women’s human rights. These gender inequalities are unlikely to be redressed through piecemeal action. Consequently programmes need to be wide ranging. For women they should cover sexual and reproductive health services and reducing violence; and improving education, employment, care, treatment and social protection. We will tackle the causes of women’s vulnerabilities to HIV, for example by promoting legislative reform and access to justice programmes that protect women and girls’ rights to freedom from sexual violence and abuse, and promote land and property inheritance. (2004, p 48)

DFID is equally explicit in its commitment to treatment programmes and to research on effective treatment and care for women and children (ibid, p 45). The treatment and care principles are also emphatic about the strategic importance of women’s roles as partners and as beneficiaries, establishing that DFID programmes should be ‘pro-poor, equitable and gender- and child-focused’ (ibid).

As regards procurement of medication, the DFID website includes a November 2006 public statement from Gareth Williams, the Parliamentary Undersecretary of State, that the UK Government, ‘strongly supports the rights of developing countries to make full use of the flexibilities allowed under TRIPS [trade-related intellectual property rights] so that medicines are affordable, accessible and meet public health needs’. They also assist ‘countries [to] build capacity to make use of the TRIPS flexibility provisions [and to] explore other ways to unlock the TRIPS flexibilities’.

At the national level, DIFD makes the commitment to:

- Support comprehensive programmes for women that address not only their access to sexual and reproductive health and rights but also access to education, employment and social protection.
- Support efforts to promote girls' education and work to support programmes tackling gender violence and stigma and discrimination.
- Make support for orphans and vulnerable children a cornerstone of our response, by dedicating at least £150 million over the next three years to address their needs.
- Support prevention and treatment programmes that meet the needs of marginalised groups.
- Promote the greater involvement of people with HIV and AIDS – including women, young people and marginalised groups – in planning and delivering programmes.
- Ensure that the human rights of marginalised and vulnerable groups, including women and children, are given proper attention. (2004, p 56)

DFID would seem to be a key ally for strategic work on equality for women. In its own evaluation of its bilateral expenditure on MDGs over 2005/2006, however, promoting gender equality and empowering women has one of the three lowest levels of significant expenditure (DFID, 2006, p 124).

The World Bank

The World Bank is the oldest multilateral development financing mechanism in the response to HIV/AIDS, having provided its first loan in 1988 (World Bank, 2005). As such, it has a strong background in development financing through both loans and grants, and brings experience in analysis, policy advice, financing and implementation support to bear in establishing its concerns and conditionalities.

The Bank has an excellent operational guide to mainstreaming gender in its HIV programming: *Integrating Gender Issues into HIV/AIDS Programs* (2004). As regards the interconnection between gender inequality and the spread of HIV, it is unequivocal:

Gender inequality is a serious obstacle to sustainable poverty reduction and socio-economic development, in part through its impact on HIV/AIDS. Research conducted by the World Bank shows that the more unequal the relations between men and women in a country, the higher its HIV prevalence rates. ...Because the epidemic is largely fuelled by gender-based cultural, social, economic and legal vulnerabilities and risks, addressing the interconnections between gender inequality and the risk factors for infection or the burden of care can yield significant payoffs. All development programs, and especially HIV/AIDS interventions, can contribute to a sustainable response to the epidemic if such programs and interventions recognize and address gender-based inequalities and risks. (p 2)

It further states that the increasing numbers of women infected with HIV stresses

the need for policies and interventions to focus on transforming gender roles and relations between males and females to support the deep-rooted behavior change necessary to stem the spread of HIV/AIDS. Males can become part of

the solution to the pandemic by focusing on their roles and responsibilities and actions they can take to reduce their own and their partners' and families' risk of HIV/AIDS. (ibid)

Checklists provided by the guide identify 'reducing poverty and economic dependency', 'addressing the negative effects of cultural norms', 'changing sexual norms', 'reducing violence against women', and 'improving laws, law enforcement, and legal access' as central to addressing women's risk for contracting HIV (p 8). The Bank is also clear that while the balance of power favours men on the surface, in fact gender norms, including homophobia, also place men at greater risk of infection (p 9).

Given such a strong mandate and toolkit for addressing gender disparities, it is all the more disappointing that in its own evaluation document, gender is barely mentioned. As in the Global Fund documents, women are also mentioned overwhelmingly as pregnant mothers, again in the context of prevention of HIV transmission to newborns, and not as women living with HIV themselves in need of care and support.

The stated purpose of *Committing to Results: Improving the Effectiveness of HIV/AIDS Assistance* is to assess 'the development effectiveness of the Bank's country-level HIV/AIDS assistance and [identify] lessons to improve the relevance, efficiency, and efficacy of ongoing and future activities' (2005, p 4) The evaluation reiterates the Bank's freedom to 'act to reduce HIV/AIDS at the country level directly, through helping governments to implement HIV/AIDS prevention, care, and mitigation, and indirectly, by supporting activities that reduce social vulnerability to infection. Examples of the latter are policies and programs to raise literacy, reduce poverty, and improve the status of women, all of which the World Bank also finances' (ibid, p 5).

Over the next 200 plus pages, gender is almost never mentioned, and women are mentioned only as pregnant mothers who are the subjects of surveillance testing, or as candidates for PMTCT programmes. It is left to the Chairman on behalf of the Committee on Development Effectiveness to regret that the evaluation did not take gender into consideration.

As regards access to treatment, in its *Generic Operations Manual* (Brown, Ayvalikli and Mohammad, 2004), the Bank is clear on the critical role donor agencies must play in financing ART in developing countries. They also note, however, that patents are covered by WTO rulings on trade-related intellectual property rights (TRIPS). Their procurement guide reminds recipients that those countries categorised as 'least developed' in fact 'are authorized to forgo the enforcement of patents on pharmaceutical products at least until January 1, 2016' (2004, p 124). They go on to remind grantees that governments of all countries, including those not considered least developed, also have the option of issuing a 'compulsory licence' under Article 31 of the TRIPS agreement to support procurement (ibid).

IV. Snapshots from the Frontlines of the Commonwealth

BOTSWANA

The Southern African country of Botswana is responding to an adult prevalence rate of HIV estimated at 37.4 per cent, one of the highest infection rates of HIV in the world. In 2001, urban antenatal surveillance reported a median infection rate of 45 per cent (Lush, Darkoh and Rmaotlhwa, 2006). UNDP has suggested that by 2010, in less than three years, more than 20 per cent of children in Botswana will be orphaned. UNAIDS estimates that 270,000 people are living with HIV, of whom 140,000 are women. Some 26,000 have died of AIDS and 69,000 children have already been orphaned by AIDS.

Botswana has also been active in raising funds to finance its response to its epidemics, securing a Round 2 grant from the Global Fund totalling US\$18.5 million and US\$22 million committed from PEPFAR in 2006 (according to PEPFAR), totalling over US\$40 million from those two sources alone.

In their own *National Strategic Framework for HIV/AIDS 2003-2009*, gender appears infrequently, but when it does appear it is in the context of inequality as a structural barrier to effective prevention and care. ‘Gender inequalities’, reads the *Strategic Framework*, ‘are a major factor in increasing women’s vulnerability to HIV/AIDS. Strategies to empower women need to be strengthened and require serious and immediate attention in terms of cultural, social and economic aspects of their lives’ (p 21). The *Framework* goes on to state that ‘Prevention is about changing societal behaviours in terms of sex, and also those contributory behaviours such as stigmatisation, gender inequality, and other social relations that underpin our actions’ (p 32).

These insights are buttressed by a resolve to embed gender relations and gender equality in behaviour change programming, with the mandate to ‘develop culturally appropriate Behavioural Change Interventions (BCI) at national and district levels to address vulnerable groups, particularly in terms of sex, gender relations, and alcohol abuse’ (p 24). The intention is for programming to not just include women as targets of information but also to address structural issues such as ‘income generation and economic empowerment’, ‘inheritance rights and legal status of women’, ‘power inequalities in gender relations’ and ‘education and promotion of gender equality and sensitivity’ (p 33).

‘It is increasingly clear,’ states the National Plan, ‘that the promotion of gender equality and advancement of women, from education to employment for example, has a direct effect of curbing the spread of the epidemic’ (p 62).

We would therefore anticipate strong attention to these issues in national allocations and grants to respond to HIV and AIDS, especially in grants from those agencies who speak openly about the need for gender equality. However, in order for these allocations to be meaningful in Botswana— as in the countries we will analyse in this paper – recognition of the central role played by gender equality must be matched or exceeded by insightful programmes that can bring meaningful change in providing women and girls with equitable access to the range of resources.

GFATM

Women appear in the HIV prevention component of Botswana's Round 2 proposal to the Global Fund as pregnant mothers and as sex workers. As women living with HIV, they are included as persons in need of treatment and support.

However, the proposal also attempts to address gender roles in provision of care, and especially to involve men in couples' testing for PMTCT and as peer recruiters for the PMTCT programme. Support group programming is also sex disaggregated, with men supporting men and women supporting women. Whether this is part of a strategy for empowering women is not clear.

There are important innovations, including the use of flexible conditionalities attached to grants to build hospices for persons living with HIV, to support day-care centres for children of persons living with HIV and to provide micro-credit through NGOs.

PEPFAR

On its website, PEPFAR states that 'Under the Emergency Plan, Botswana received more than \$24.3 million in Fiscal Year (FY) 2004, more than \$51.8 million in FY2005, and more than \$54.9 million in FY2006 to support comprehensive HIV/AIDS prevention, treatment and care programs'. The same site shows persons receiving abstinence and be-faithful programming (102,100) at almost double condom use promotion along with other methods (55,900). This is inevitably a product of PEPFAR priorities and conditionalities. In terms of other programmes, US\$933,000 was given to one organisation for palliative care, for example, and US\$50,000 for ethics and law reform.

DFID

DFID's direct support to Botswana stands at £2 million per year, with an additional £1 million provided through multilateral programmes according to its website. Of this, £46,000 is in financial aid other than poverty reduction, £1.5 million is for technical cooperation, £473,000 is in grants and other aid in kind and £12,000 is in debt relief. This aid covers a wide range of sectors, including education, HIV, poverty reduction, and other targets of the MDGs.

However, Botswana is not included in DFID's 2006 report on its Public Service Agreements, so a breakdown of the funds by specific area of focus is difficult to track.

World Bank

The Bank's primary programme for HIV development aid in Africa and the Caribbean is the Multi-Country HIV/AIDS Program (MAP). Because Botswana is considered a 'higher income' country, it is not eligible for the Bank's HIV grant programmes and has not had focused Bank support since fiscal year 1996. The Bank does note that more recently it 'has focused its involvement in Botswana on analytical and advisory work, including...an analysis of the development impact of HIV/AIDS on the economy in 2001'. Bank support to Botswana's response to HIV/AIDS has been limited to 'sharing of information at technical meetings of the Multi-country HIV/AIDS programs'. In its 2004 *Interim Review of the Multi-Country HIV/AIDS Program for Africa*, the Bank notes that although Botswana, like South Africa and Swaziland, has some of the highest rates of infection in the world, Bank restriction to International Development Association (IDA) countries means it cannot provide

Botswana with ‘the full range of its technical and financial services’ (p 11). It describes this as ‘a serious anomaly for which a remedy should be sought urgently’ (p 11).

GUYANA

Guyana has one of the highest prevalence rates of HIV in the Caribbean, with UNAIDS reporting a national average of 2.5 per cent. Further, Guyana is one of two PEPFAR Focus Countries in the Caribbean and, because of its low human development index (HDI), it also qualifies for substantial amounts of bilateral and multilateral aid. So harsh were Guyana’s economic conditions in the 1970s and 1980s that they saw poverty rates rising to 86 per cent between 1988 and 1991. By 1999, 36.3 per cent of the population still lived on US\$1.40 per day or less (*National HIV/AIDS Strategy*, p 14). UNAIDS estimates there are 11,000 people living with HIV in Guyana, of whom 6,600 are women aged 15 and up.

The *Guyana National HIV/AIDS Strategy 2007–2011*, like others in this review, does express an understanding that gender – and more importantly, gender inequality – plays an important role in the spread of HIV. In describing the ‘determinants’ affecting the spread of the epidemic, the document lists ‘stigma and discrimination, poverty, risky behaviour, gender roles and relations, cultural and social norms and differences among different generations’ (p 33).

Similarly, in identifying ‘guiding principles’ for the response:

The response must consider efforts at behaviour change, but must also address the vulnerability factors such as fear, denial, stigma and discrimination, gender equality and power differentials, poverty and livelihood insecurity, internal migration for employment purposes, social-cultural norms, values and practices, and the national legislative and policy environment. (p 37)

This places gender equality at the centre of the analysis. What is missing here, however, as in the other country strategies, is action to follow up the analysis. In the rest of the document, as well as in the M&E framework for the *Strategy*, gender is only mentioned for gender- (read sex-) disaggregated data. Women appear by far most often as the subject of MTCT programmes and as sex workers.

GFATM

In 2003, Guyana submitted a successful proposal to the Global Fund for US\$27 million. A search for programmes to address gender, however, yielded no mention of the term. The response to the section of the proposal form explicitly asking about gender provides somewhat of an explanation:

Unfortunately little is known about the gender dynamics of HIV/AIDS transmission here. Additional information on the cultural, behavioral and geographic variables that affect risk will provide information on how best to target interventions to males and females of different ages. Both sexes clearly need to be reached to stop the spread of the epidemic. (p 50)

There is conflation between sex and gender in this proposal that also appeared in the national *Strategy*. This suggests there will inevitably be a gap in how gender and gender equality are perceived:

Males and females have equal access to education and health care in Guyana. However, because of the way the health care system is structured, women make greater use of the health care system, e.g., for antenatal and pediatric care. It is expected that integrating HIV/AIDS efforts into existing reproductive health services will increase the likelihood that women receive services for HIV/AIDS prevention, treatment and care. (p 50)

Here women are seen as on an equal footing with men in two key social sectors. Further, the analysis suggests women make greater use of the public health-care system, although as pregnant women or new mothers. As a result, the suggestion is that incorporating HIV prevention and other services into the health-care system is one way to address gender. This actually does nothing to address the problems of vulnerability the *Strategy* identifies in its initial analysis. The proposal comes a bit closer to the issue when it speculates that: ‘The challenge for women may be implementing the acquired knowledge and skills in the context of their relationships’ (p 50).

The possibility that the grant will address gender inequality, however, is undone by the next sentences:

Additional effort will be necessary to ensure that men have the same level of access to information and services. Workplace and school interventions currently underway offer a strategic opportunity to reach men. However, existing programs and services will be evaluated to assure that barriers to men are overcome. In addition, males representing different sectors of society will be encouraged to participate in program planning and implementation to assure that effective strategies are in place for changing male attitudes and behaviors. (p 50)

The sex whose gender status makes them unequal and requiring strategic intervention turns out to be men.

PEPFAR

PEPFAR financial records released by the Centre for Public Integrity show some US\$6.4 million in aid to Guyana for 2004/2005. Approximately US\$606,000 was allocated for abstinence and be-faithful only programming (the only sexual prevention funding from PEPFAR) granted to the Red Cross. A further US\$460,000 was allocated for ART, US\$3.2 million for blood transfusion safety and US\$2.1 million for safe medical injections. Of this, US\$460,000 went to entities PEPFAR classified as faith-based organisations – that is, the entire allocation for provision of ART.

The PEPFAR website shows some US\$7 million allocated for fiscal year 2005, of which PMTCT was allocated US\$1.4 million, abstinence/ be faithful another US\$1.4 million, blood safety US\$2.1 million, and injection safety US\$1.1 million. The category ‘other prevention’ absorbs US\$1 million. Bearing in mind PEPFAR’s interpretation of that category, however, it inevitably includes voluntary counselling

and testing (VCT) (as well as condom promotion) in a context that advocates abstinence and being faithful.

DFID

DFID has an office in Guyana, an indication of its commitment to bilateral aid to that country. Its Caribbean strategy document also asserts that DFID has a long-term commitment to Guyana. Unfortunately, however, as often happens with the Caribbean, the country disappears from global analyses. Guyana is not mentioned in either the global health strategy or the annual report.

Guyana does hold a key place in the Caribbean bilateral strategy, however, which is based on the principle of focusing ‘bilateral assistance on supporting effective delivery of national poverty strategies in Guyana and Jamaica’ (p 2). The poverty focus encompasses three themes:

- economic and fiscal management and public service delivery within the framework of poverty strategies;
- trade, competitiveness and economic integration agenda; and
- HIV/AIDS and violent crime. (ibid)

HIV seems to come in behind fundamental poverty alleviation, however, for example when the document asserts that £14.5 million will be provided to Guyana for activities focused on poverty reduction. That support is to the implementation of the poverty reduction strategy paper (PRSP). The global report does state, however, that Guyana is expected to reach the MDG of poverty halved by 2015 (p 86).

World Bank

Guyana currently has an adaptable programme loan from the World Bank Caribbean MAP valued at approximately US\$11 million. As with the other project documents, however, the role gender inequality plays is understood only in descriptors of drivers, and not at the heart of the challenges or strategies. So, for example, gender is mentioned as important for message design for information, education and communication campaigns. Gender inequality is similarly mentioned as a factor in the social analysis that must be taken into account in developing the response. Gender inequality itself appears rarely. The term gender, for example, again becomes synonymous with sex in describing disaggregating of data. There is a moment of insight in the descriptive analysis of community consultations:

Gender issues were evident in the responses given by community members regarding risks and vulnerability to HIV/AIDS. The risks were slightly different for women and young girls especially. The lack of education or economic activities made girls fall prey to truckers and other men passing through the villages. Also, the presence of mining and other camps in the region induced young girls to begin consorting with miners and soldiers. There were also gender issues with regard to promotion of condoms and PMTCT. Some women mentioned the absence of men in all these efforts and wondered why the male role was hardly or never mentioned in the transmission of the virus when discussing PMTCT. Emanating from the discussion was a recommendation to utilize institutions that have all or majority male membership to integrate men into the HIV/AIDS campaigns such as using

Village Captains to introduce HIV/AIDS topic at sub-district meetings and raising the topic at RDC [Regional Democratic Council] and Chambers of Commerce. (p 94)

But again, the strategies described in the project appraisal document do not address the challenges hinted at in this description. The concept of the male role for example, does not appear again.

There is another important insight when the appraisal notes:

Currently, the target group [for condom distribution] has been primarily women who are provided with condoms by health workers (and expected to 'use' them). This, however, has not empowered women to protect themselves since they have not been provided with methods they can control such as spermicides and female condoms. (p 98)

However, the appraisal moves directly on to state 'NGOs working on social marketing of condoms as well as free distribution will be encouraged to work with indigenous communities' (p 98). This again does not follow through on the insight with a strategy to address it.

INDIA

In *Missing the Target* (2005), the International Treatment Preparedness Coalition makes the following stark report:

In India treatment remains unavailable for the vast majority of the millions of people living with HIV. Although the government has signaled increasing commitment to ART delivery, the national AIDS program has failed to act on several critical issues and national treatment guidelines are under-enforced and have several significant gaps. Many people seeking care are forced to travel long distances, and shortfalls in funding and human resources threaten efforts to expand the response. (p 3)

By all accounts, India has one of the highest numbers of people living with HIV in the world. UNAIDS estimates that 5.7 million people or more have contracted HIV, almost 6 per cent of the population of 1 billion people. The World Bank reports that India also has the highest number of cases of tuberculosis in the world.

Development indicators that are gender-disaggregated paint a grim picture. According to Ekstrand, Garbus and Marseille (2003),

There is an increasing gap between rich and poor states with regard to public resources available for health, with resultant disparities in health outcomes. A major concern is that as the central government reduces its role in health care delivery, with decentralization and privatization to fill the gap, safety nets for the poor (especially those in rural areas and women) are being threatened. This scenario is particularly worrisome as the ability of state governments to provide basic health care is imperiled, given their current and severe fiscal problems. (p 7)

The concern expressed here is borne out by the statistics and analyses of cultural patterns:

Prior to HIV/AIDS, there were already strong gender biases in access to health care. Recent studies have found when both a husband and wife are infected with HIV/AIDS, men routinely receive care and treatment ahead of their wives. Lack of money and distance to obtain treatment are also constraints to HIV-positive women's ability to access care. (p 10)

Conditions for women are also, in broad terms inequitable, although in some cases it is extreme:

Indian women's legal rights have generally not been implemented. India's sex imbalance is related to the comparative neglect of female health and nutrition, particularly during childhood. Other factors include increasing cases of sex-selective abortions (illegal but widespread); female infanticide; violence against women; suttee (wherein a widow is burned to death on her husband's cremation pyre, an illegal act); dowry murders (wherein a woman is killed due to insufficient gifts/money given by her parents at the time of her wedding); and discrimination in access to health care, nutrition, and employment opportunities. Despite socioeconomic changes, preference for sons continues in India....

There are acute gender disparities in literacy and education. Forty-eight percent of ever-married women are not involved in making decisions about their own health care. There are significant and persistent gaps between women's legal rights and their actual ownership and control of land. (p 9)

Gender-based violence, in such a context of inequality, is not surprising:

About 20 percent of ever-married women have experienced beatings or physical mistreatment since age 15 and at least one in nine have experienced such violence in the last year. Most of these women have been beaten or physically mistreated by their husbands. (ibid)

As such, India's National Strategic Plan identifies four core priorities:

- 1 Prevention of new infections in high risk groups and general population through:
 - a) Saturation of coverage of high risk groups with targeted interventions (TIs)
 - b) Scaled up interventions in the general population
- 2 Increasing the proportion of people living with HIV/AIDS who receive care, support and treatment.
- 3 Strengthening the infrastructure, systems and human resources in prevention, care, support and treatment programmes at the district, state and national levels.
- 4 Strengthening a nation-wide strategic information management system.

‘Initially, HIV spread among female sex workers and their male clients [including truck drivers], STI clinic patients, and professional blood donors’ (Ekstrand, Garbus and Marseille, 2003, p 18). The epidemic is also generalised, however, although unevenly across the country. Studies have also shown that a vast majority of the married women who have become infected have been infected by their unfaithful husbands (Newmann et al, 2000). Some 60 per cent of those living with HIV in India in 2005 were women.

GFATM

India’s Global Fund proposal asks for some US\$260 million for its HIV and AIDS component, out of US\$323 million requested in Round 6. India received Global Fund grant funds equalling almost US\$250 million in Rounds 2, 3 and 4.

The proposal to the Fund states a core concern of ‘mitigating the impact of HIV on the families especially women and children’ (p 43). This focus is incorporated into the capacity building and staffing activities as well as the programme areas themselves:

Capacity building and programme management interventions will mainstream gender in the programme cycle through: programme management training; gender balance in staffing; gender-sensitive organizational policies and gender training for staff and providers. Inputs of female PLHA [People Living with HIV/AIDS] will be incorporated while designing training programmes in order to deepen the team members’ understanding of gender issues and encouraging change in their attitudes and practices. (p 43)

The proposal also seeks a key role for women’s organisations that is critical in a context such as India’s, addressing psychosocial issues as well as issues of treatment and of economic empowerment:

Participation of women’s groups will be encouraged in community mobilization for demand generation and service utilization; in service delivery as counselors or laboratory technicians; as outreach workers for ensuring treatment adherence and compliance; and in home care teams. Women’s self-help groups will be involved in income generation activities and exploring livelihood options and self-financing schemes for PLHA. ...Demand generation will be conducted by NGOs and CBOs by increasing awareness of the public on importance, accessibility and confidentiality of testing and treatment and will specifically target women in the general population and also vulnerable women through strategies such as targeting sex workers and their children. (p 43)

As regards treatment, the proposal sets out a deliberate strategy to counter cultural prejudices and other barriers to women’s access to treatment:

The percentage of women accessing [PMTCT] services who follow up with ART services is at present a meager 15%. Linkages will be established between ICTC [integrated counselling and testing centres], ART centers and Community Care Centers to improve acceptability and accessibility of treatment, care and support services for HIV positive mothers and their children. The ICT component of the existing [PMTCT] programme will be

strengthened to emphasize where appropriate treatment for mothers, their partners and children will be available. (p 43)

The grant also addresses attrition from the antenatal programme, something few such programmes pursue:

Women who are found to be HIV positive during pregnancy, but do not qualify for ART treatment will be followed up. Inputs from PLHA will provide the requisite guidance to the community outreach workers to help them in encouraging the women to take up treatment and home based care for themselves and their children. ...In addition awareness about the availability of complete package of care services for children infected with HIV will have a snowballing effect and improve uptake of services by women. ...Interventions will improve female PLHA's access to care and support through women's fora in state PLHA networks and PLHA support groups at the district level. (p 43)

Finally, the programme builds accountability into the strategy:

Successful NGOs will be required to demonstrate that their workforce has a gender balance and that they have a clear policy to reduce gender discrimination, mainstream efforts to reduce gender bias etc. ART teams, NGOs, CBOs will be held accountable and their performance in reducing gender bias throughout the continuum of care and support will be monitored through the selection of disaggregated indicators such as the gender ratio of ART recipients and rates of non-adherence with ART. Regular gender audits of programme plan and implementation will monitor the effectiveness of mainstreaming efforts. Further, gender-sensitive M&E indicators will go beyond sex disaggregated data to capture programme-specific progress in access, utilization and quality of services. Technical assistance on gender will be provided through programme implementation, according to need. (ibid)

PEPFAR

The US Government provided over US\$29 million dollars in bilateral aid to India in fiscal year 2006, the Government's largest aid programme outside the PEPFAR focus countries (PEPFAR, 2006, 187). Based on what can be gleaned from its annual report, PEPFAR/ USAID's support in India goes in part to PMTCT, treatment and care and counselling outside of treatment centres. The US also funds prevention programming.

PEPFAR data on its India programme is sparse, likely because it is channelled through USAID India's country programme. So, for example, the target groups are much different from those we have seen earlier:

- high-risk groups (such as sex workers and their clients, including truckers and other men);
- sexually transmitted infection (STI) clients;
- women of reproductive age;
- youth in general;
- girls involved in trafficking;
- men who have sex with men;

- injectable drug users (perhaps); and
- urban and rural family members for HIV information and preventive services.

The PEPFAR report does sound traditional themes for its prevention work – for example, in the story of a migrant worker who was initially a day labourer but who ‘was sexually exploited by the contractor and managers at the construction site where she was working’ and turned to sex work (p 187). During an intervention by a PEPFAR/ USAID funded organisation, she became ‘empowered to share her experiences of sexual exploitation and take action to escape exploitation and prostitution’ and has become an outspoken advocate for women who are sexually exploited (p 187).

USAID India’s strategies are also embedded in the strengthening of the health system, and the indicators for the programme follow that logic.

DFID

India receives the most bilateral aid from DFID of any country in the world, some £253 million in 2005/06, down from £259 million in 2004/05 (*Departmental Report 2006*).

According to the National AIDS Control Organisation (NACO), DFID supports targeted interventions in a number of states in India

aimed at high risk groups, such as sex workers, injecting drug users, prison inmates, street children and migrant workers. DFID’s package of supported programmes also include: condom promotion; mass media programming through national television to raise awareness and address stigma and discrimination; a Resource Centre for Sexual Health to provide technical assistance to SACS; and programmes on gender and trafficking. The Project Management Organization, supported and funded by DFID, is also providing support through providing challenge funds for innovative projects and also a host of civil society interventions. (India Country Coordinating Mechanism, p 13)

Box 2: Getting More Children into School in India

India is making considerable progress towards universal primary education. Following the launch of the Government's national Sarva Shiksha Abhiyan (SSA) Elementary Education Programme in 2001, access to schooling has improved and the net enrolment rate has risen to 94 per cent in 2005 from 82.3 per cent in 2001.

Efforts are now concentrated in those states and districts with the highest numbers of children out of school. India can reach the universal primary education goal, but the number of children still out of school is large and innovative approaches are needed to reach those currently excluded.

An example of such an approach is the establishment of 'Education Camps for Girls'. These camps give girls a second chance to recover the missed early years of education. Girls are identified through community mobilisation programmes. Residential bridging courses provide the life skills and preparation for re-entry into formal schools at the level appropriate to their age. The programmes are provided in a protected, friendly and supportive environment to encourage both academic and personal development. In almost all cases the bridge courses are run by NGOs, usually in remote, rural areas of the country. Courses typically run for seven to nine months.

Since the girls are away from home they are free from the demands of domestic work and sibling care.

The results are impressive. Drop out rates are very low and achievement levels are high. The girls' health improves and they show remarkable increases in confidence and self esteem.

However, the camps are not a substitute for formal schooling. One potential problem is that the scheme might be seen to offer the attractive proposition of keeping a girl at home until she is eleven and then getting a primary school education in only one year.

Excerpted from DFID (2006). *Departmental Report 2006*, p 65.

World Bank

A review of the World Bank website shows India with some 33 approved grants from that institution, most of which are closed. Currently an agreement is being negotiated valued at US\$512 million to fund the current National HIV/AIDS Control Project III.

Project details are not publicly available as at writing.

SOUTH AFRICA

South Africa is home to some 5.5 million people living with HIV, and an estimated 320,000 people died from AIDS-related illnesses in 2005 alone (UNAIDS, 2006). UNAIDS further estimates that approximately 'two million South Africans living with HIV do not know that they are infected and believe they face no danger of becoming

infected - and therefore are unaware that they can transmit the virus to others' (ibid, p 13). South Africa has also been the subject of intense controversy both within the country and externally for its position on access to treatment.

Among the community of persons living with HIV in South Africa, UNAIDS reports that 'one in three women aged 30–34 years were living with HIV in 2005, as were one in four men aged 30–39 years' (ibid, p 11). This is in a context described as home to extremes of gender-based violence:

In most presentations of police rape statistics, South Africa is near or at the top. Household surveys represent another method of obtaining information on the extent of sexual violence. The last South African Demographic and Health Survey found a national rape prevalence of 7 percent, a range of 3 to 12 percent across provinces. Both police statistics and household studies reveal that young women – the demographic group most at risk for HIV/AIDS – are also at highest risk of being raped. (Garbus, 2003, p 7)

Garbus (2003) goes on to report that:

Rape, sexual violence, sexual harassment, aggression toward and physical and verbal degradation of female students by male schoolteachers and male classmates are widespread and largely normalized and tolerated. Girls who report sexual abuse are often further victimized and stigmatized by teachers and students. School authorities rarely ensure a sense of security at school nor counsel and discipline male perpetrators. (ibid, p 11)

As in other parts of the world, women living with HIV are also particularly vulnerable to stigma and discrimination:

Many women also face abuse and/or abandonment if they disclose their HIV-positive status. Lobola, a long-standing tradition whereby men purchase a wife by paying her family a dowry, also renders it difficult for women to leave their husbands, as this would require fathers to repay the dowry. (p 11)

South Africa's *Strategic Plan 2000–2005*, still in operation as a new *Plan* is developed, identifies the four focus areas:

- Prevention;
- Treatment, care and support;
- Human and legal rights; and
- Monitoring, research and surveillance. (p 16)

Among its key indicators, three pertain specifically to women: the percentage of sexually active women using condoms (under prevention), and two indicators specifically responding to the abuse of women:

- The number of reported rape cases;
- The number of cases of workplace legislation abuse related to employees contracting HIV. (p 17)

Data cited by the National Strategic Plan make evident the link between such extreme vulnerability of women and national statistics where it states that ‘young women aged 20-30 have the highest prevalence rates’ and that ‘young women under age 20 had the highest percentage increase compared to other age groups in 1998 compared to 1997’ (South African AIDS Council, 2000, p 8).

However, the human rights component of the *Plan* is weak at best, simply asserting that ‘appropriate’ social, legal and policy environments will be created or developed.

GFATM

The Provincial AIDS Council of the Western Cape Province Health Department submitted a Round 3 proposal of US\$66 million for HIV and AIDS.

South Africa’s Global Fund grant proposal makes no explicit reference to gender. However, it does note early the special vulnerability of women, especially poor women, and describes a context in which ‘a special effort is made in the current programme for women and single mothers who are HIV-positive’ (p 20). The proposal further describes three programmes targeting women:

- Prevention of mother to child transmission
- Priority for access to treatment in pilot treatment sites to pregnant women with children
- ARV prophylaxis for rape survivors. (p 11)

Given women’s role in providing home care for persons sick with AIDS-related illnesses, the home-based care support infrastructure proposed in the grant application would also benefit women. However, this is not explicitly stated. No structural level interventions to reduce women’s vulnerability are proposed.

South Africa has also had a Round 6 proposal, costed at US\$102.8 million, approved for funding although the grant has not been signed as of writing. It shows substantial progress in consideration of the particular vulnerability of women, reflecting recent research that captures women’s vulnerability across a range of variables:

Women are more vulnerable and at greater risk of HIV infection than their male counterparts. In South Africa a recent national population based survey indicates that in 2005 HIV prevalence among women in South Africa was 16.9% while that of men was 4.4% (HRSC, 2005). This difference is more pronounced in the age groups 20-29 years but particularly striking in the age group 25-29, where the HIV prevalence in the same survey was 33.3% for women compared to 12.2% men. A youth study by the Reproductive Health Research Unit (RHRU, 2002) found that among the 10% of youth who are HIV positive, 77% are women. (p 8).

Women’s wide-ranging vulnerability, including to sexual violence, as well as the feminisation of the epidemic, requiring targeted action and the central involvement of women in the response are positioned as central to the strategy laid out in the proposal:

In additional to biological, economic, social and other cultural vulnerabilities, women are more likely to experience sexual abuse, violence in particular

domestic violence including rape. The HIV and AIDS challenge is clearly feminised, pointing to gender vulnerability that demands urgent attention as part of the broader women empowerment and protection. In view of the high prevalence and incidence of HIV amongst women, it is critical that their strong involvement in and benefiting from the HIV and AIDS response becomes a priority. Teenage females have been underemphasized as a target group, even though pregnancy levels are high in this age group. (p 8)

Further, the proposal states that:

The focus of the prevention goal is to provide behaviour change communication services specifically targeted at the women, young people, and workplaces and under served communities in rural and urban informal settlements. (p 71)

In this regard, it is all the more disappointing that the structural issues making women so significantly more vulnerable to HIV are not addressed in the proposal. Rather, the focus is on traditional categories of activities such as mass media campaigns, community peer educators, caregivers and so on. These are important strategies, but experience has shown that even in the presence of high levels of knowledge, risk reduction for women in societies with such high levels of gender-based violence is extremely constrained in its effectiveness. While the proactive inclusion of women as part of the programmes is needed, this is insufficient to transform such deeply embedded inequities.

PEPFAR

PEPFAR financial records released by the Centre for Public Integrity show some US\$47 million had been allocated to South Africa's response in 2004/2005. Of this, approximately US\$2.3 million was allocated for abstinence and be-faithful only programming (the only sexual prevention funding from PEPFAR), US\$31.5 million for ART, US\$6.9 million for safe blood transfusions, US\$2.9 million for OVC and US\$4.2 million for safe medical injections. Of this, US\$17.3 million went to entities PEPFAR classified as faith-based organisations.

DFID

DFID's aid to South Africa covers a range of programmes, with a heavy focus on poverty alleviation. As regards HIV and AIDS, *Taking Action* reports that DFID works with the Nelson Mandela Foundation and the Anglican church, believing 'these organisations carry significant leadership and influence' (p 50). These progressive faith-based organisations are seen as lead partners in political advocacy and in providing services to advocate for greater attention to be paid to AIDS, lending their voices to social change processes and reducing stigma and discrimination (p 50). Approximately £3.4 million has been granted to Christian Aid, a progressive international faith-based organisation, to support the work of the Anglican church across Southern Africa. DFID's *Departmental Report 2006* further shows South Africa receiving £15.5 million in technical cooperation and £13.5 million in grants and other aid in kind.

In its 2005 *Performance Report* on the key indicator for the MGDs, South Africa is listed as having decreased its ratio of girls to boys enrolled in primary school between 1998 and 2002 (p 26).

World Bank

While several Bank documents refer to South Africa and the extremity of the epidemic there, as with Botswana the Interim Report on the MAP notes that:

...higher income countries in southern Africa such as South Africa...with some of the highest incidence rates in the world are not eligible for funding by the MAP, which is restricted to IDA countries. [As a result,] the Bank is unable to provide the full range of its technical and financial services to several of the most vulnerable populations in Africa. This is a serious anomaly for which a remedy should be sought urgently. (2004, p 11)

UGANDA

Among experts in HIV prevention programming, Uganda holds a unique place as one of the handful of countries that have successfully reversed the upward trend of the epidemic. 'In a decade, from 1989 to 1999,' write the World Bank on its website, 'reported HIV prevalence among STI clinic patients in Kampala decreased from a median of 52 percent to 23 percent.' This has made it a subject of intense scrutiny to discover what lessons learned can be transferred to other contexts. For its part, the Uganda Government has said in its *National Strategic Framework* that

Despite the acknowledged decline in sero-prevalence rates, the mechanisms that produced this reduction are not fully understood. Owing to weak monitoring, it is not possible to apportion the observed decline between the three factors of abstaining, being faithful to one's partner, and condom use. (p ii)

The *Framework* goes on to highlight that:

Although HIV sero-prevalence declined from 30 to about 10 per cent between 1992 and 1996, it appears to have stagnated since then. A sero prevalence rate of 10 per cent is still high given that HIV/AIDS results in certain death. (p iii)

The socio-political context in which Uganda is responding to the HIV and AIDS epidemics is complex. As in other parts of Africa, and indeed the Commonwealth, discrimination against women is entrenched and complex. A situation and response report on the epidemics in Uganda, produced by the AIDS Policy Research Center at the University of California San Francisco, describes the context for women:

Ugandan women are vulnerable to HIV given their low status, lower educational attainment, higher unemployment, and weaker negotiating skills within relationships. About 32 percent of married women in Uganda are in a polygamous union. The government has implemented a far-reaching affirmative action program to promote women's political participation. However, many customary and statutory laws discriminate against women in areas of marriage, divorce, and inheritance. (pp 8-9)

These customs include property grabbing (p 9). Further, a ‘landmark’ community-based study, the ‘Rakai’ project, states:

30 percent of women had experienced physical threats or physical abuse from their current partner. Ninety percent of women viewed beating of the wife or female partner as justifiable in some circumstances. The Rakai researchers underscored the strength of the association between alcohol consumption and domestic violence: women whose partner frequently or always consumed alcohol before sex faced risks of domestic violence almost five times higher than those whose partners never drank before sex. (ibid)

Further, Uganda’s *National Strategic Framework for HIV/AIDS Activities in Uganda: 2000/1–2005/6* (2000) points to the particular vulnerability of girls orphaned by AIDS:

When orphaned, gender disparities and cultural practices tend to render the girl child particularly exposed to exploitation and heavy responsibilities, especially in areas of housekeeping and agricultural production. Poverty and [being] orphaned also expose the girl child to a greater risk of HIV infection through early marriage, sexual abuse, and prostitution. (p ii)

Against this backdrop Uganda’s *National Strategic Framework* has identified three core goals:

- To reduce HIV prevalence by 25 per cent by the year 2005/6
- To mitigate the health and socio-economic effects of HIV/AIDS at the individual, household and community level
- To strengthen the national capacity to respond to the HIV/AIDS epidemic.

Within these core goals, there are several that directly relate to addressing gender inequality:

- Promoting behaviour change (abstinence, faithfulness and safer sex) among sexually active populations, particularly young people aged 15-24;
- Reducing the vulnerability of individuals and communities to HIV/AIDS, with a focus on children, youth and women;
- Reducing the current 15–25 per cent incidence of mother-to-child transmission (MTCT) by a third by the year 2005/6;
- Promoting therapeutic and preventive HIV vaccine development and trials in the different categories of the population;
- Providing care, support and protection of rights to at least 50 per cent of the families most affected by HIV/AIDS;
- Mobilising governments, civil societies, and the private sectors to reallocate and expand political action, financial commitment and programmes to address HIV/AIDS at various levels;
- Strengthening the information base on HIV/AIDS at national, district and lower levels;
- Strengthening the capacity to undertake research related to HIV/AIDS at various levels. (pp xxxvi–xxxvii)

Moreover, Uganda's Poverty Eradication Action Plan (PEAP) establishes gender as central to development:

The PEAP recognizes that economic incentives differ for men and for women, and that this has important implications for GDP growth and output. To this end, the PEAP identifies actions to enhance gender equality as one of the critical measures required to boost GDP growth to the 7 percent per year PEAP target.

The government incorporated key gender issues into the PRSCs [poverty reduction support credits] including: (a) supporting the mainstreaming of gender and equity objectives in *planning and budgeting* through implementation of the *gender and equity budget guidelines* issued in 2004; (b) deepening the work program on *gender and growth linkages* for policymaking in Uganda, with *increasing focus on trade and strengthening women's entrepreneurship*, as part of the wider growth supporting framework of the PEAP; (c) supporting further implementation of the Land Sector Strategic Plan to *strengthen women's land rights*; (d) continuing to support the *implementation of the gender-focused elements related to the justice, law and order sectors*, including strategies to support passage of the domestic relations bill, and to launch the preparation of the sexual offences bill; and (e) continuing support to the revision and subsequent implementation of the country's national gender policy. (p 7; emphasis mine).

In this regard, the PEAP is exemplary. The challenge will be in the implementation and, beyond that, to manage the social change process so that the impact envisioned by the strong package of interventions can be realised.

GFATM

Uganda's Global Fund grant requests US\$119 million in funds to strengthen its access to treatment programme, with a focus on PMTCT and on support for orphans and other children made vulnerable by HIV and AIDS. It further proposes to address treatment literacy, as well as capacity building for delivery of ART.

As the target is MTCT and orphans and vulnerable children (OVC), the proposal ties access to treatment for women to their entry into the health system via PMTCT programmes:

It is envisioned that introduction of ART in PMTCT centers will dramatically increase the number of women receiving voluntary counseling and testing and facilitate comprehensive clinical care for mothers and their families. (p 6)

The proposal also recognises the importance of substantive structural reform to address stigma and discrimination through legal sanctions and to find solutions to poverty exacerbated by HIV or AIDS:

One aspect of the program is enhanced legal support for orphans and widows. This gets directly to the issue of gender inequity. Enforcing the property rights of widows and prosecuting those who abuse girl orphans will directly protect

the rights of women. Assisting OVC families to generate more income, and keeping girls in school longer, should reduce sexual exploitation and the pressure for early marriage. (p 115)

The objective in support of this has important language:

Strategic Objective 6: To ensure the legal protection of the rights of OVC and OVC households as enshrined in the Ugandan Constitution, the United Nations Convention on the Rights of the Child, the Children's Statute, the goals of the United Nations General Assembly's Special Session (UNGASS) on HIV/AIDS. (p 100)

The activities in support of this important objective rely on a combination of community activism and legal advice that assumes legal protections are in place:

The main activities to be undertaken will include:

- (a) facilitation of information, education and communication campaigns to ensure that caregivers, teachers, community members, local and religious leaders are familiar with the fundamental principles of the rights of children, especially those who are orphaned and the widowed as well as [PLHIV]
- (b) mobilization of communities to provide resources from among their members to provide basic needs for the most needy OVC and OVC households among them
- (c) facilitation of legal consultation and aid to OVC and OVC households with regard to succession planning, property disputes, physical abuse, emotional abuse, sexual abuse and illegal child labour. (p 100)

PEPFAR

In their *Third Annual Report to Congress* (2007), as in all its documents, PEPFAR cites Uganda as a success story and the model for its emphasis on behaviour change, which it interprets as promotion of abstinence and monogamy as the best available options for risk reduction:

Long before PEPFAR was initiated, many nations had already developed their own national HIV prevention strategies that included the 'ABC' approach to behaviour change (Abstain, Be faithful, correct and consistent use of Condoms where appropriate). It was developed and successfully implemented in Uganda, and gained acceptance in a number of countries before PEPFAR's launch. In addition to earlier dramatic declines in HIV infection in Uganda, there is growing evidence of similar trends in other nations... (p 29)

PEPFAR's *Third Annual Report* makes clear the central role the agency plays in Uganda's response, covering a range of programming from laboratory strengthening to door-to-door testing and counselling, to provider-initiated testing and counselling, PMTCT programmes and programmes for children orphaned by AIDS.

PEPFAR financial records released by the Centre for Public Integrity show some US\$26.3 million in aid for Uganda for 2005. Of this, US\$3 million is allocated for

abstinence and being faithful programmes, US\$9 million for ART, US\$6.8 million for safe blood transfusion programmes, US\$3.5 million for OVC and US\$3.7 million for safe injection programmes. Some US\$11.6 million of this aid (almost half) was channelled to agencies categorised by PEPFAR as faith-based organisations.

DFID

In its 2005 *Performance Report*, DFID reports that Uganda – along with Lesotho, Rwanda and Zimbabwe – has reached gender parity of at least 98 per cent in schools, and is one of the countries with the strongest improvement since 1998 (p 8). The same *Report* also states that one DFID focus has been policy dialogue and it ‘has provided £550,000 in financial support to the Uganda AIDS Commission since 2003’ (p 40). In *Taking Action* (2004), DFID reports that it has committed £6.2m to an ‘HIV Umbrella Programme to assist Uganda’s AIDS response, including capacity building for government and civil society’ (p 19). Uganda is also a test case for improved donor harmonisation processes led in part by DIFD.

DFID’s *Departmental Report 2006* shows Uganda receives bilateral aid from DFID in the amount of £72 million, ranking 10th of the top 20 recipients of such aid. (India ranked number one.) The *Report* also shows that

DFID’s programme in Uganda is focused on support for the implementation of the Poverty Eradication Action Plan (PEAP). We are providing most of our support through PRBS [poverty reduction budget support] and in 2004 agreed a new arrangement to provide £145 million over three years. PRBS has helped increase public expenditure in key areas such as health and education. (p 47)

DFID argues that a combination of political will and coordinated donor support has yielded significant gains, including in areas key to gender equality such as poverty reduction and school enrolment:

The proportion of people living below the national poverty line has decreased from 56% in 1992 to 38% in 2002. Net primary school enrolment has increased from 62% in 1992 to 86% in 2003 after the introduction of free primary school education in the mid 1990s. Gender disparities in primary school enrolment have largely been addressed. Uganda improved its ranking in the UNDP’s *Human Development Report* from 154th out of 173 countries in 1994 to 144th out of 177 countries in 2005. (p 46)

While the consensus on Uganda, as elsewhere, is that the links between these structural development indicators that capture gender parity in development gains and reduction in HIV are not direct, there is the belief that they are inter-related if they reduce vulnerability. ‘Enormous progress has been made in reducing HIV/AIDS,’ DFID reports, ‘and prevalence in pregnant women has declined from 18% in the early 1990s to about 6% in 2005’ (ibid).

World Bank

In a grant to Uganda, the World Bank provided some US\$50 million for the period 2001–2006 (Uganda CCM, 2003).

In December 2005, Uganda came to a joint assistance agreement with a number of donor countries under the aegis of the World Bank, including the African Development Bank, DFID, Germany, the Netherlands, Norway and Sweden. The document is focused on three integrated strategies:

- supporting implementation of the country-owned and led revised PEAP to achieve the MDGs;
- collaborating more effectively, both among development partners and with the government;
- focusing on results and outcomes (including managing resources and improving decision-making for results, and strengthening systems for monitoring and evaluation).

The agreement is also an important step as it builds on donor harmonisation and the Paris Declaration. As such it identifies principles for action signed by all donors included in the joint assistance agreement (see Box 1).

Box 1: Poverty Eradication Action Plan Partnership Principles

Government

- Strengthens monitoring and accountability
- Continues focus on poverty eradication
- Assumes full leadership in the donor coordination process
- Discourages any stand-alone donor projects
- Develops comprehensive, costed, and prioritized sector-wide programs eventually covering the whole budget
- Further develops participation and coordination of all stakeholders
- Strengthens capacity to coordinate across government.

Donors

- Jointly undertake analytic work
- Jointly set output/ outcome targets
- Develop uniform disbursement rules
- Develop uniform and stronger fiduciary assurance and accountability rules
- Ensure integration of support in sector-wide programs
- Continue to increase untied budget support
- Increasingly delegate responsibilities to country offices
- Abolish topping up of individual project staff salaries
- End individual, parallel country programs and stand-alone projects
- Reduce the tying of procurement.

Excerpted from World Bank (2005). *Joint Assistance Strategy for the Republic of Uganda (2005-2009)*. Washington, DC: World Bank.

V. Lessons Learned for Gender Equitable Responses and Financing

“While many policies and commitments made by governments and international organisations make the connection between gender and HIV/AIDS explicit, these commitments are not always implemented. Some examples of best practice are emerging, but there is often a big gap between policy and practice because of insufficient resources, training and capacity, especially where public sectors and basic service provision have been cut back. There is a need for greater attention to be paid to the implementation of policies and commitments, and for increased monitoring of and accountability for service delivery on the part of multilateral institutions, governments and CSOs.” (Commonwealth Secretariat, 2004)

The findings of this paper affirm the wisdom of these insights agreed to at 7WAMM. An important point at 8WAMM will be to assess what is happening at the country level. While there has been some progress, in many respects opportunities for funding to address gender inequality in the context of HIV/AIDS have not been followed through. Most of the grants reviewed here were written before 7WAMM, but there remain some openings in the language of grant proposals, and in the public statements of most donors reviewed, to support stronger gender equity programming. The gap may be in concrete examples of effective programming. If we follow the trail of documents, the core issues have not been tackled, either because the central role gender inequality plays in undermining development programming is not frontally addressed, or perhaps because in the corridors of power, tackling gender equality is seen as a luxury that comes second or third to other ‘more pressing’ strategies and reforms for economic stability and growth. Or both, plus others.

Each of the national responses reviewed here has strengths and insights that can be productively adapted for other Commonwealth environments. A key lesson is the deliberate inclusion of strategies based on sound gender analyses, designed to confront gender inequality, requiring a two-stage process of honest situational analysis. First, we need to start with frameworks that can see and demonstrate the central role of gender inequality as a driver of underdevelopment and of the epidemics of HIV, AIDS and stigma and discrimination against those infected and affected by these diseases. Second, we need to follow through with a plan of action that is designed to address these factors head on, and to untie the potential of the people locked up by gender norms that imprison the human and economic potential of women and men in developing countries. The gap in Guyana’s Global Fund proposal, itself reflecting the gap in the national strategy document, is instructive.

In this regard, the community involvement and the strategies for accountability for addressing gender inequality in India’s Global Fund grant are a strong beginning, addressing the range of key services in the grant request, as well as addressing more difficult issues, such as community mobilisation and socioeconomic empowerment. These strategies are applicable to all the donors included here, although the most logical partners would be DFID, the World Bank and the Global Fund. For those countries where abstinence and monogamy may prove viable (rather than simply desirable) prevention strategies, PEPFAR is an active partner with a particular mandate to support faith-based organisations.

Similarly, Uganda's approach of pursuing gender empowerment strategies that are embedded in an integrated poverty-reduction approach are important to make the most of. In that regard, the recognition that stimulating private sector growth by supporting women's entrepreneurship is an important insight and underscores the critical lesson, that women and women's work are central to household and national economies.

This brings new insights to the challenges faced by Commonwealth countries, including Botswana. While the national strategy may provide some insights on the importance of addressing entrenched gender inequity, moving from those insights to concrete plans is more challenging. Donor conditionalities, as well as lack of harmonisation, may also constrain what is feasible to propose.

At the heart of the dilemma at the centre of this paper then is the notion of what it means to be empowered, to stand up for yourself as an individual, as a society, as governments; to be honest about what is happening to us and in our households; and to see with different eyes. Some women's affairs machineries may need to come to terms with the impact of the epidemics of HIV and AIDS on gender disparities in the Commonwealth, and indeed, the developing world more broadly.

At the heights of development aid policy-making, when the donor countries meet to make their own support to development more effective and accountable, there may further need to be attention to whether women as subjects of development, especially women living in poverty in the developing world, will disappear.

AWID (2007) has identified four key action points:

- 1 Advocacy for policy change is key but not enough.
- 2 Grassroots mobilisation and constituency building need to be backed as key strategies in our work, as part of collective power building.
- 3 Building alliances with other social movements is key to build up our political agency.
- 4 No organisation on its own will be able to foster the social transformations we are aiming at, therefore, we need to go beyond our organisations and prioritize building collective power.

These points have also been borne out in this analysis.

What this review has shown, however, is that Commonwealth countries have been providing leadership for important breakthroughs in designing gender empowering strategies as an integral part of development programming, including HIV prevention, care and treatment programmes that tackle poverty and disenfranchisement at the household and national levels. The strategies also reflect the power that coalitions of civil society, governments and donors partners who come prepared to listen can have when they work on an integrated strategy based on the equality of women and men and designed to unleash the creativity of a nation's people.

Since the Paris Declaration means the push is towards consolidated support for poverty reduction or other global strategies, it has two important implications for the work of women's machineries and development practitioners. First, gender equality will have to be embedded into national development policies and strategies. This

means more work for women's machineries in making strong arguments in terms that the country and fellow government officials and workers can understand. It means developing a political strategy, identifying and cultivating allies and advocates from across specialities and class lines, and gathering data strategically than can help make the case.

Second, it will become even harder to track funds dedicated to gender equality. This can ultimately mean at least several contrasting things, however. It can mean that gender targeted programming can disappear into general programming and budget lines. It can also mean that gender equity itself becomes a key element of the strategy, so much so that it is central to the budgeting process and so can be tracked and indicators measured. This would mean that programmes would include economic, cultural, psycho-social and political indicators, tracked not only by sex but also by impact on inequitable gender norms.

This paper began with some core questions:

- How do we convince policy makers that our struggles with development are gendered?
- How do we convince our societies that old modes of gender, even including our understanding of what 'love' means, are at the root of our challenges with achieving development?

A central issue with gender work is that it politicises the private, as the second wave feminists asserted in the 1970s. This is what makes gender so difficult – it is so personal that many resist it on that ground alone.

After reviewing the Commonwealth country strategies included here, it is clear that at the national level we need to work to make people see that the gender inequality blocking development is their everyday lived reality – in their families and at home with daughters, nieces, nephews and sons; on the street; in their workplace; and in national statistics. Where people have this insight, we can see the stark difference and the use of language that has become a common currency in principle. However, many are still stuck at the level of implementation; this is not a Commonwealth-specific problem.

Experience has shown that HIV and AIDS are symptoms of underlying inequities, inequities that can be embedded in the need for power among those who feel they need to control the minds and bodies of those around them according to their own needs rather than broader values of social justice and common humanity. HIV and AIDS, however, can also be about a common human need for love, fellowship and intimacy, particularly for women who have been raised with the idea that this is central to their social role and their personal happiness. Both cases can be deadly traps.

I want to close where we began, with the words of a Jamaican woman living with HIV in poverty. She cannot get a job, she says, because the applications for factory work she is trained for ask about HIV status, or else they want a health check that includes an HIV test because the insurance company requires it. Her husband is dead from AIDS-related illnesses so she alone is taking care of her children. It is a difficult

life. For her, reflecting on her own life and her vulnerability to HIV, how the virus entered her life through the front door intertwined with love is a key issue that is fundamentally not about morality:

“So it’s a dilemma that I look at sometimes and say when you get yourself in relationships sometimes it’s not that you want to run up and down, but because you want somebody for yourself, somebody you can come home to.... My worse fears though, I have friends who have relationships and their partner is still running up and down and I have a girlfriend who used to run up and down and has never been HIV positive. So when I look at it sometimes the more I am convinced that is not persons who have multiple sex partners who find themselves HIV positive. It’s probably where you are married or in a common-law relationship. Wanting to trust somebody and wanting to be there, wanting that person to know that you really love them or trust them, so you can build a life together.”

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