

What's the Budget? Where's the Staff?

Moving from Policy to Practice

*An update on institutional responses to the intersection
between violence against women and girls and HIV*

Women **WON'T wait**
End HIV & Violence Against Women. **NOW.**

About the Women Won't Wait Campaign

"Women Won't Wait" is an international coalition of organisations and networks committed to and working to promote women's health and human rights in the struggle to comprehensively address HIV and end all forms of violence against women and girls. The campaign focus is on tracking and where necessary call for changes in the policies, programming and funding streams of national governments and international agencies. Women Won't Wait was officially launched on March 2007.

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1. Executive Summary

Violence against women and girls and HIV are global, intersecting health and human rights crises. Research demonstrates how women's risk of, and exposure to, threats or actual violence, particularly intimate partner violence, is a leading factor in women's heightened vulnerability to HIV.¹ Meanwhile, women are subjected to different forms of violence on a daily basis due to their real or perceived HIV status, whether in their homes, in the workplace, in schools, in health facilities or elsewhere. Both epidemics limit women's power and participation in society and their agency over their own lives and bodies, sustaining women's economic, political, social and sexual subordination as well as denial of women's human rights. Even though it is established that a human rights based approach is critical to achieving gender equality, or ensuring a gender transformative response to violence against women and HIV, it is often inadequate or absent in institutional policies and programmatic responses to the twin epidemics. Political will is likewise too often lacking to ensure a sustained, resourced and transparent response to the intersection of HIV and violence against women.

According to estimates released by UNAIDS in 2008, women account for half of all people living with HIV worldwide, and over 60% of HIV infections in sub-Saharan Africa. Over the last 10 years, the proportion of women among people living with HIV has remained stable globally, but has increased in Eastern Europe and Central Asia.² UNAIDS also estimates that three-quarters of young people living with HIV in sub-Saharan Africa are young women aged 15-24.³ Even as we remain deeply concerned about the proportion of HIV infection among women and girls, we must also remember that HIV, in both generalised and concentrated epidemics, has gender-specific, disproportionate and devastating impacts on women and their rights, exacerbated by pervasive discrimination suffered by women and girls around the globe.

In 2001, the Declaration of Commitment on HIV/AIDS (DoC) was adopted at the United Nations General Assembly Special Session on HIV/AIDS (UNGASS-AIDS).⁴ This DoC called for stronger leadership by governments, the prioritization of prevention, as well as care, support and treatment, the realization of human rights, both to reduce vulnerability to infection and to ensure respect for people living with HIV/AIDS and the prioritization of women's empowerment.⁵ The 2008 review of progress made towards the DoC by the UN General Assembly revealed that "the gap between available resources and actual need was hampering efforts to achieve universal access goals".⁶ Furthermore, the rate of progress in expanding access to essential services was failing to keep pace with the expansion of the epidemic itself. With 2010 marking the ten-year milestone for UNGASS DoC monitoring, it is disheartening that the funding gap continues to hinder the achievement of many commitments.

In 2007, the Women Won't Wait Campaign started to monitor policies, programming and funding priorities of key multilateral and bilateral agencies to assess their response to the twin, intersecting crises of HIV and violence against women and girls. We also asked whether these efforts were gender transformative and advanced women's human rights or whether they adopted an instrumentalist approach to gender equality. *What's the budget? Where's the staff?: Moving from policy to practice* is the third report produced by the Women Won't Wait Campaign, aimed at holding institutions accountable for turning policy rhetoric into practice. As in our earlier reports, *What's the budget? Where's the staff?* analyses the policies, programmes and funding patterns of five agencies: the UN's global agenda setting agency on HIV, **UNAIDS**, the two largest multilateral donors, the **Global Fund to Fight AIDS, Tuberculosis and Malaria** and the **World Bank**, and two of the largest bilateral donors working to combat the HIV epidemic, the US Government's President's Emergency Plan for AIDS Relief (PEPFAR) and UK Government's **Department for International Development (DFID)**.

We take note of some of the distinct progress made by several of these institutions, particularly UNAIDS and the Global Fund and the US Office of the Global AIDS Coordinator (OGAC). These agencies are showing increased attention to this intersection in their policies, funding priorities and guidelines. Indeed, this renewed and more substantial attention paid to violence against women and HIV is evidence of the success of women's movements and women's rights advocates to date, including the Women Won't Wait Campaign. **What remains to be seen, however, is how these policies will be transformed into practice.**

We are now at a juncture where the institutions lagging behind need to step up and devote the necessary resources (human and financial) to the development of policies that place violence against women and gender inequality at the centre of any HIV response. Moreover, policy-level recognition will be meaningless if it remains only on paper and is not transformed into concrete, measurable and resourced programming that advances women's human rights through an integrated, multi-sector approach to violence against women and HIV.

SUMMARY OF FINDINGS

The five institutions

Progress has been made, to varying degrees, by most of the five institutions analysed in our three-report series. However, even where progress has been made, it is clear that we are only part of the way towards achieving truly integrated and sustainable responses to the two epidemics.

Both UNAIDS and the Global Fund have made significant policy advances. This includes the UNAIDS' Agenda for Accelerated Country Action for Women, Girls, Gender Equality and HIV (2010-2014) along with Priority 8 of the UNAIDS Outcome Framework 2009-11 on meeting the HIV needs of women and girls and stopping sexual and gender-based violence and the Global Fund's Strategy for Ensuring Gender Equality in the Response to HIV/AIDS, Tuberculosis and Malaria. However, these documents suffer from a range of shortcomings, including an erroneous distinction between sexual and gender-based violence, failure to adopt a holistic response to *all forms* of violence against women, the lack of detailed information to demonstrate how these policies will be resourced and implemented in countries and the absence of gender indicators for the Global Fund's Country Coordinating Mechanisms (CCMs) to measure gender-related outcomes.

The US Government's Global Health Initiative (GHI) claims to advance women-centred health care, and its most recent investment to scale-up interventions to prevent and respond to gender-based violence in three PEPFAR countries is commendable. In addition, many of the policies which were criticized for being unsound, ideologically driven, and detrimental to the health and rights of women and people living with and affected by HIV&AIDS have been removed, with restoration of US funding for UNFPA, repeal of the Global Gag Rule⁷ and an end to the discriminatory 20-year AIDS Travel Ban.⁸ However, the flat-lining of US funding for the global AIDS response, the Anti-Prostitution Loyalty Oath and the continuing emphasis on "abstinence" and "be faithful" programming only serve to hinder progress that has been made and signify the absence of a whole-hearted commitment to a human rights and evidenced-based, gender-sensitive response to the HIV epidemic.

It is equally commendable that DFID has committed a sizeable investment in health system strengthening. However, without clear gender equality objectives and outcomes, gender transformative programme guidelines and budget allocations, we are unable to discern exactly how this investment will improve the ability of health systems to respond to violence against women, HIV and multiple forms of gender-based discrimination. In particular, it is unclear what proportion of the budget will be dedicated to respond to women's sexual and

reproductive needs, the needs of survivors of violence or women living with HIV.

The World Bank undeniably remains of most concern. Bank funding continues to be allocated, including to the HIV epidemic, without attention to women's heightened risks of violence, even where violence against women specifically impacts women's economic productivity, an area of particular concern for the World Bank. The Bank's narrow and instrumentalist approach to women's empowerment continues to be at odds with the fundamental goal of achieving gender equality and women's rights as a matter of justice and human rights.

Where's the money?

The current global funding environment presents a significant challenge to women's organizations and movements. AWID notes how, "In times of systemic crisis like the one faced today (economic, environmental, food, energy, social, work and care crises), progress made on gender equality and women's rights is among the first to be eroded".⁹ According to the OECD - DAC Statistics Department, between 2004 and 2008, there was a significant increase in overseas development aid from USD 104 million to USD 373.32 million for "women's equality organisations and institutions";¹⁰ although this could partly reflect increased use of the gender equality marker.¹¹ The period 2007 and 2008 saw a drop in the contributions of Norway and Denmark, although they remain important contributors to women's organisations, while the US has consistently diminished its support to gender equality organizations and institutions since 2004.¹²

Furthermore, with donor resources increasingly channelled through governments in accordance with the aid effectiveness agenda, civil society organizations are left to rely on government plans that are often gender blind.¹³ Women's organisations have raised their concerns with the Aid Effectiveness Agenda and the need to align with developing country priorities and strategies, even when they overlook gender. Following strong mobilisation and advocacy from women's groups, the Accra Agenda for Action, which emerged from the Third High Level Forum on Aid Effectiveness in September 2008, recognised the vital importance of addressing gender in a more systematic and coherent way. Women's groups will continue their advocacy towards the 4th High Level Forum on Aid Effectiveness in Seoul, Korea in late 2011, pushing for targets and measurable commitments on gender equality. Gender responsive budgeting must be part and parcel of the aid effectiveness agenda.

Progress towards key international commitments, including the Programme of Action of the United Nations International Conference on Population and Development in 1994, the Beijing Declaration and Platform for Action in 1995, and the Millennium Development Goals (MDGs) remains plagued because governments and donors have failed to invest the necessary human and financial resources to make sustainable progress on gender equality. Despite the fact that the MDGs do not include a specific indicator on violence against women, the Millennium Declaration specifically resolved to "combat all forms of violence against women and to implement the Convention on the Elimination of All Forms of Discrimination against Women".¹⁴ All strategies should therefore recognise and act on the link between violence against women, gender equality and HIV, integrating MDG 3 on gender equality, MDG 5 which includes indicators on reproductive health and MDG 6 on HIV, malaria and other diseases.

Where are the women?

Women's organizations, networks of women living with HIV, sex workers' rights organizations, and other organisations committing to advancing women's human rights, are frequently excluded from national planning processes, including the design of the national AIDS response. This exclusion is particularly potent for

groups representing marginalised women. In order to fulfil national, regional and international commitments to gender equality, all national governments and donors, including the five institutions assessed here, must take real steps to ensure that the needs and views of diverse groups of women are adequately represented, respected and incorporated into policies, program and budget design. The new UN gender entity has great potential to serve as a key multilateral champion of women's rights with a specific mandate to promote and support women's participation in decision-making processes at all levels. It is critical that the new entity is constituted to make this a reality.

Transparency and accountability

Transparency is the key to civil society monitoring and in turn, the ability of citizens to hold all governments, multilateral donors and UN agencies accountable for turning their policy commitments into resourced actions at the country level. A troubling finding in *What's the budget? Where's the staff?* and our 2007 and 2008 reports, is the failure of several of the agencies to make their policies, programming and funding documents, including information on sub-recipients contracted to undertake gender equality programmes, easily available to civil society organisations. Furthermore, the failure of agencies and national governments to develop and use monitoring tools inhibits concrete assessments of gender equality outcomes of programmes. We call on all five institutions to design, disseminate and apply gender equality indicators more broadly and specific indicators to monitor violence-related interventions in all HIV programming. Governments, bilateral donors and multilateral agencies must be made to answer for their international commitments.

A comprehensive approach

For many in charge of the global response to the HIV epidemic, the relationship between HIV prevention and intimate partner and sexual violence seems to be the most obvious and immediate. However, we know women are subjected to different forms of violence on a daily basis, in an expansive range of settings and by a range of actors, including in their homes, by partners or families, in the workplace, in schools, in health facilities and elsewhere. We also know that all forms of violence have a direct impact on women's ability to protect themselves from HIV. In addition, violence or the threat of violence has a severe impact on HIV positive women's ability to access HIV treatment, care and support services. A comprehensive response to the twin epidemics must encompass the wide range of risks of violence that women, including women living with HIV, face in all settings. Further, a response to violence against women must not be restricted to prevention interventions, but integrated across treatment, care and support. Moreover, combating violence against women must be made a central priority on its own, as a grave and unacceptable violation of the fundamental rights of women.

OUR CALL

That these five institutions play a critical role in stemming the HIV epidemic hardly bears repeating. At this juncture, a decade into the new millennium, there are no excuses for institutional agendas that do not take into account evidence from the field on the root causes of this epidemic, especially amongst women and girls and the particular harms facing women and girls who are living with HIV. Long-term, sustainable change requires a serious commitment by governments, donors and agenda setting institutions to challenge gender inequality; integrate a gender, rights-based analysis into programme design, development and evaluation; allocate the necessary human and financial resources; and place violence against women and girls at the centre of the HIV agenda.

Our call

1. **What's the budget? Where's the staff?** UNAIDS, the Global Fund, OGAC through PEPFAR, the World Bank and DFID must guarantee the allocation of substantial resources, human and financial, to deliver on their promises. All policies designed to address gender inequality in the context of HIV and specifically the intersections between violence against women and girls and HIV, must be backed by substantial, predictable, and sustained funding, with established budget lines for gender equality and specifically violence against women. All five institutions must also ensure that staff with the required gender expertise is involved in policy development and programming, including monitoring and evaluation, from the international level through to country offices.
2. **Transparency.** All five institutions must foster civil society monitoring through greater transparency in their allocation of funds. Stronger efforts must be made to track expenditure of country-level resources assigned to programmes for women, girls, gender equality and HIV, with specific monitoring and evaluation indicators for gender equality and violence-related interventions in all HIV portfolios. The Global Fund must make information on all fund recipients and sub-recipients publicly available. The World Bank in particular must prioritise disaggregating project spending data in the context of its funding for HIV epidemic.
3. **Ensure that the Global Fund's Country Coordinating Mechanisms (CCMs) shape national development proposals that prioritise violence against women and girls and HIV.** CCMs must be given targeted technical assistance, training and ongoing support from the Global Fund's partners, such as UNAIDS, WHO and others, to enable them to submit proposals that give substantial attention to gender in their country-level HIV response. Formal mechanisms must be established to ensure that all organisations working on women's rights, sexual and reproductive health and anti-violence programming are given access to CCMs to preparation the preparation of Global Fund grant proposals and the implementation, monitoring and evaluation of grant agreements. Responses to HIV will be of limited impact if those most affected are not included and respected at the decision-making table.
4. **UNIFEM must be made a co-sponsor of UNAIDS. We expect that the new gender entity, once established, will be a co-sponsor of UNAIDS.** In the meantime, UNIFEM should be made a co-sponsor and given the space and voice to influence the agenda. This will reflect recognition of the specific experiences of women and girls in the context of HIV.
5. **Work towards integrated health systems that better support women and girls.** Health systems must be responsive to the needs and experiences of all men and women. They must incorporate interventions aimed at the prevention and treatment of diseases affecting women, including HIV, alongside services that are responsive to the needs of survivors of violence. Simultaneously they must integrate programming to provide access to a full range of other high quality and affordable sexual and reproductive health care services.

2. Introduction

Violence against women and girls and HIV are global, intersecting health and human rights crises. Research demonstrates how women's risk of, and exposure to, threats or actual violence, particularly intimate partner violence, is a leading factor in women's heightened vulnerability to HIV.¹⁵ Meanwhile, women are subjected to different forms of violence on a daily basis due to their real or perceived HIV status, whether in their homes, in the workplace, in schools, in health facilities or elsewhere. Both epidemics limit women's power and participation in society and their agency over their own lives and bodies, sustaining women's economic, political, social and sexual subordination as well as denial of women's human rights. Even though it is established that a human rights based approach is critical to achieving gender equality, or indeed ensuring a gender transformative response to violence against women and HIV, it is often inadequate or absent in institutional policies and programmatic responses to the twin epidemics. Political will is likewise too often lacking to ensure a sustained, resourced and transparent response to the intersection of HIV and violence against women.

According to estimates released by UNAIDS in 2008, women account for half of all people living with HIV worldwide, and over 60% of HIV infections in sub-Saharan Africa. Over the last 10 years, the proportion of women among people living with HIV has remained stable globally, but has increased in Eastern Europe and Central Asia.¹⁶ UNAIDS also estimates that three-quarters of young people living with HIV in sub-Saharan Africa are young women aged 15-24.¹⁷ Even as we remain deeply concerned about the proportion of HIV infection among women and girls, we must also remember that HIV, in both generalised and concentrated epidemics, has gender-specific, disproportionate and devastating impacts on women and their rights, exacerbated by pervasive discrimination suffered by women and girls around the globe.

Since its launch in 2007, the Women Won't Wait Campaign has been at the forefront of advocacy calling for globally acknowledgement that violence against women and girls is both a driver and consequence of the HIV epidemic. Today, a number of governments, UN agencies and other international institutions are showing increased attention to the intersections between the twin epidemics in their policies, funding priorities and guidelines. Indeed, this renewed and more substantial attention paid to violence and HIV is evidence of the success of women's movements and women's rights advocates to date, including the Women Won't Wait Campaign. **What remains to be seen, however, is how these policies will be transformed into practice.**

The Women Won't Wait Campaign is therefore calling for *concrete* and *resourced* action by multilateral and bilateral agencies and national governments to prevent and respond to the intersection of violence and HIV, advance women's human rights and to mitigate the impact of persistent human rights violations on women's and girl's lives and health. To make real progress in confronting the HIV epidemic, prevention, treatment, care and support, efforts must be made to address the violence endured by many women around the world that puts them at greater risk of HIV. Simultaneously, all HIV interventions must respond to the violence women face in light of their real or perceived HIV status and associated stigma, discrimination and other rights violations. Furthermore, a holistic response to the twin epidemics requires that sexual and reproductive health services are provided in conjunction with HIV and violence-related interventions.

In 2001, the Declaration of Commitment on HIV/AIDS (DoC) was adopted at the United Nations General Assembly Special Session on HIV/AIDS (UNGASS-AIDS).¹⁸ This DoC called for stronger leadership by governments, the prioritization of prevention, as well as care, support and treatment, the realization of human rights, both to reduce vulnerability to infection and to ensure respect for people living with HIV/AIDS and the prioritization

of women's empowerment.¹⁹ The 2008 review of progress made towards the DoC by the UN General Assembly revealed that "the gap between available resources and actual need was hampering efforts to achieve universal access goals."²⁰ Furthermore, the rate of progress in expanding access to essential services was failing to keep pace with the expansion of the epidemic itself.

With 2010 marking the ten-year milestone for UNGASS DoC monitoring, it is disheartening that the global response continues to fall behind – for every two people put on ARVs, another five are getting infected.²¹ The funding gap continues to hinder the achievement of many commitments. Programmes to prevent the vertical transmission of HIV from mother to child currently reach only 33% of those in need, while the UNGASS target is 80% by 2010.²² Among youth aged 15-24 years, only 38% of females and 40% of males can demonstrate accurate and sufficient knowledge about ways to protect themselves from acquiring HIV, far short of the UNGASS target of 90% by 2010.²³ UNAIDS and its partners are currently working to revise the process for country monitoring of the response to the HIV epidemic. We call on UNAIDS and its partners to ensure that future UNGASS/AIDS review processes and country reporting are transparent and include formal mechanisms at the national level for the participation of CSOs, with particular attention to women's organizations and organisations of women living with HIV.

Furthermore, while the intersection between violence and HIV is increasingly being recognised and addressed in policy rhetoric, frequently only sexual and intimate partner violence are addressed in policies and guidelines. In this regard, it is essential that all stakeholders recognize the relationship between HIV&AIDS and *all forms of violence against women*. Analysis and programming focussed on intimate partner and sexual violence tackles only part of a bigger picture, ignores the risks facing women in all public and private spaces, and as a result will have a limited, even skewed, impact on both the HIV and violence against women epidemics.

Defending human rights

Women living with HIV face a range of real and potential human rights violations, including non-consensual testing and disclosure of results, partner notification, forced abortion and sterilisation, stigmatisation and shunning by families and communities, as well as threats or actual acts of violence. Specifically in the context of HIV treatment, Human Rights Watch have reported how violence can grossly interfere with the ability of a woman to access treatment and care and adhere to ART.²⁴

It is imperative that all individuals, groups and institutions working to combat HIV and violence against women adopt and maintain a human rights approach. A human rights lens is essential to better understand the multiple and overlapping forms of discrimination women and girls face and address the interlocking matrix of oppression that women who are poor, women of colour, women who are positive, women who are sex workers, women who use drugs, women who are lesbians, bisexual, transgender or intersex, experience. Such an approach is needed to address the specific experiences of those women who are most vulnerable in the intersection of these epidemics.

Around the globe, there is an escalation in the violations suffered by marginalised men and women, particularly if they are living with HIV. The growing trend to criminalize exposure to and transmission of HIV is severely undercutting gains made in the fight against the epidemic.²⁵ Moreover, criminalisation endangers and oppresses women further, by heightening the risk women face of violence and abuse; by strengthening prevailing gender inequalities in healthcare and family settings; by further promoting fear and stigma and by increasing women's risks and vulnerabilities to HIV and to HIV-related rights violations.²⁶ A further alarming trend is the criminalization of same-sex sexual relations, which not only violates a range of fundamental

international human rights but is also counterproductive to the prevention of HIV transmission,²⁷ driving already marginalized groups further underground and hindering HIV awareness-raising programs. Furthermore, decisions to criminalise individuals for consensual, same sex relations between adults in private foster a climate of homophobia, stigma, discrimination and violence, a deeply concerning trend. Such homophobia also fosters abuse, abduction, rape and murder of lesbian women,²⁸ who continue to experience abuses by state authorities in prisons, by the police, as well as private actors such as their families and communities.²⁹

The Special Rapporteur on the right of everyone to the enjoyment of the highest attainable standard of physical and mental health, Anand Grover, in his 2010 report has interrogated the relationship between the right to health and the criminalisation of three forms of private, adult, consensual sexual behaviour: same-sex conduct, sex work and HIV transmission.³⁰ He calls for decriminalization and repeal of laws, alongside monitoring and accountability to ensure protection against violations and human rights education for all health professionals. The Special Rapporteur specifically notes that “that decriminalization is only one necessary response to each of these issues, alongside other measures necessary as part of a comprehensive right to health approach. Where decriminalization has been adopted, it is noted to have positive health outcomes. These include human rights education, participation and inclusion of vulnerable groups, efforts to reduce stigma and discrimination, and appropriate health regulations in respect of these groups.”³¹

Accountability for women’s human rights

Where’s the money?

The current global funding environment presents a significant challenge to women’s organizations and movements. A number of civil society organisations (CSOs) have been fervently monitoring the levels of funding for gender equality, violence and women’s rights by donor governments, multilateral agencies, private foundations, women’s funds and other institutions. This includes the Association for Women’s Rights in Development (AWID), whose strategic initiative, Where is the Money for Women’s Rights (WITM), has made great strides in highlighting the levels of funding and support by donors and other institutions for gender equality programmes, women’s rights organizations and movements.³²

AWID notes how, “In times of systemic crisis like the one faced today (economic, environmental, food, energy, social, work and care crises), progress made on gender equality and women’s rights is among the first to be eroded”.³³ Furthermore, with donor resources increasingly channelled through governments in accordance with the aid effectiveness agenda, civil society organizations are left to rely on government plans that are often gender blind.³⁴ Ultimately, the resources available to respect, protect and fulfil women’s rights appear scarce.³⁵ Official Development Assistance (ODA) therefore remains inadequate to reach the commitments made in Cairo and Beijing over fifteen years ago and at the Millennium Summit ten years ago, driven in part by the lack of political will required to invest much needed resources in gender equality and women’s rights.³⁶

What gets measured matters

Monitoring of funding by CSOs has been hindered by the lack of effective tools specifically designed to assess the level of support for women’s rights initiatives. One of the few existing monitoring tools, the Gender Equality Policy Marker, developed by the Development Assistance Committee of the OECD in 1999, applies only to OECD member states and reporting has been uneven. Recent analysis of this reporting suggests that while more donor countries are screening their aid with the Gender Equality Policy Marker, there is not enough information provided by donors for CSOs to use this tool as a reliable base for assessments.³⁷ Without concrete

monitoring mechanisms and systematic transparency in budgetary allocations, women's organizations face persistent challenges in holding bilateral and multilateral donors accountable for the fulfilment of women's fundamental human rights.

Will the UN deliver on women's rights?

In the context of multilateral funding, there is no single mechanism for monitoring and accountability. The UN has great potential to serve as a key multilateral champion of women's rights through the new UN gender equality and women's empowerment entity. Until now, UNIFEM, the only agency with a mandate to work solely on gender equality, has been under-resourced and has lacked the institutional power required to influence others in the UN system. The new "gender entity" can be positioned to call for increased global support for gender equality and to mobilize significant resources. The capacity of the new UN "gender entity" to advance this agenda will depend on the entity's institutional framework, guaranteed predictable and substantial funding, strong operational capacity at the country-level, strong leadership and clear mechanisms to ensure the meaningful participation of CSOs, particularly women's groups.³⁸ There are, however, significant and justifiable concerns from CSOs that the new structure will scale-up the existing one, along with its shortcomings. This includes the current lack of authority within the UN system of agencies like UNIFEM to hold others accountable for gender-related goals.³⁹

It is particularly important that the new UN "gender entity" has a clear mandate to advocate for all of the world's women, including in the context of HIV. While the gender implications of the HIV epidemic have been clear for decades, UNIFEM has not been made a co-sponsor of UNAIDS. Despite this marginalization, UNIFEM has been programming on gender equality and HIV/AIDS for over 10 years, building capacity and knowledge on the intersection between gender inequality, violence against women and girls and HIV. The UN Trust Fund to Eliminate Violence against Women, an inter-agency mechanism managed by UNIFEM, has also been making grants to programmes that specifically address the linkages between violence against women and girls and HIV and promote an integrated approach to health systems and healthcare. The Women Won't Wait campaign and other CSOs expect that the new gender entity will be a co-sponsor of UNAIDS. In the meantime, it is imperative that UNIFEM be made a co-sponsor of UNAIDS and be given a place at the decision-making table within the UN system where the global AIDS response is designed and resourced. To be a co-sponsor of UNAIDS would not only give UNIFEM, in the interim, and the new "gender entity", in the future, space and voice to influence the agenda but would also be a recognition of the specific experiences of women and girls in the context of HIV.

What's the Budget? Where's the Staff?

The Women Won't Wait Campaign has produced two reports since 2007, *Show Us the Money* and *What Gets Measured Matters*. Both these reports examine the policies, programmes and funding patterns of five agencies: the UN's global agenda setting agency on HIV&AIDS, **UNAIDS**, the two largest multilateral donors, the **Global Fund** and the **World Bank**, and the two largest bilateral donors, the US' **PEPFAR** and UK's **DFID**. We started this monitoring process at a time when none of the institutions explicitly tracked their investments in programmes and projects addressing violence against women as a component of their HIV&AIDS efforts. This 2010 report, *What's the Budget? Where's the Staff?: Moving from policy to practice* is an update on the progress made by these five agencies in increasing attention to and funding programmes that address violence against women and girls in the context of HIV prevention, treatment, care and support. Our report highlights where we have come since our initial assessment of the five agencies and what needs to be done to ensure that policies are translated into resourced actions.

While noting the significant progress some agencies have made in tackling violence against women as part of their HIV portfolios, it remains unclear how policy documents and operational plans will be implemented in countries. UNAIDS, the Global Fund and the US Office of the Global AIDS Coordinator, which is responsible for the implementation of PEPFAR, have released policy documents which have the potential to outline an architecture for gender-responsive HIV programmes. However, the steps that will be taken to operationalise and resource (both financial and human) these policies at the international and national levels, with a clear human rights analysis and attention to violence against women and girls, remain unclear. This update *What's the Budget, Where's the Staff?: Moving from policy to practice* poses critical questions about how such recent policy developments will be translated into action.

Integrating policies on gender inequality and HIV is an essential first step; it also requires political will, strong leadership and commitment of resources. Operationalising these policies raises more complex issues at the country level including questions about monetary resources, the capacity of staff, particularly in relation to gender expertise, civil society participation, and leadership. Implementation requires budget allocations and mechanisms that allow for comprehensive rights-based programming and robust and transparent systems for monitoring allocations and spending.

Methodology

We recognize that the five agencies examined in this and earlier reports are different institutions, whose internal structures, goals and priorities vary. As such, this study has focused largely on the institutions' individual policies that address the intersection between violence against women and girls and HIV. Where such policies were not available or are non-existent, policies on HIV and gender equality more broadly were examined.

When collecting data for this report, we faced various challenges with regards to institutional transparency. UNAIDS and the Global Fund and to a large extent, the OGAC which is responsible for the implementation of PEPFAR, make their policy documents available online with fairly comprehensive search engines. This enabled a thorough policy review as well as an examination of the types of programmes that receive funding. The World Bank and DFID, however, do not have specific policies that address the intersection between violence against women and girls and HIV. Furthermore, the lack of publicly available, detailed, sex-disaggregated information on programmes that receive funding from these institutions prevented a thorough analysis and monitoring of the priorities of these agencies.

In addition to document review, individuals who are responsible for work on gender inequality and HIV within each agency were invited to share details on the progress that had been made within their institution on addressing the links between violence and HIV. We were able to communicate with representatives from UNAIDS and the Global Fund. Despite repeated attempts, we received no response from DFID and OGAC. Individuals contacted at the World Bank indicated that there was no one on staff that could speak to the issue in question. This further limited the amount of data and information that we were available to analyze for this report. The response from the World Bank, in particular, sheds light on the degree of importance placed by the institution on violence against women, HIV and their intersection.

This report is organized by institution; each has been analyzed in turn for the progress they have made in addressing the intersection between HIV and violence against women in their policies, priorities and the guidance offered to country-level staff. At the end of each agency analysis, we make a set of recommendations to augment the efforts that have been made or to address gaps that persist. In addition to reporting on the progress of these agencies, the final section of this report includes a discussion on health systems strengthening

(HSS) and what is required to ensure that health systems offer an integrated, rights-based approach to health for survivors of violence and/or women living with HIV. We recommend the use of the Essential Services Package (ESP), a tool-kit designed by the Women Won't Wait Campaign and its partners. The ESP provides a check-list of essential services and reforms required in a number of key settings typically at the interface of violence against women and HIV. These include health systems, humanitarian and emergency relief and recovery situations, schools, police and law enforcement. The ESP is a tool that can assist donors, national governments and multilateral agencies to implement their policies at the country level and should be employed to ensure that HSS initiatives respond to the specific experiences, rights violations and needs of all women, for whom health systems are often inaccessible or unresponsive. Our report concludes with some overall recommendations and our call for action.

Finally, a note on what was and was *not* analyzed for this report. Our report focuses primarily on the global policy advances made between August 2008 and May 2010 by the five institutions. We have not analyzed the specific practices of individual country offices or country level policies, where such policies differ from global policies. Such a detailed exploration, although critical, requires additional resources and was beyond the scope of this study.

3. Overall findings

The United Nations Joint Programme on AIDS (UNAIDS)

The United Nations Joint Programme on AIDS (UNAIDS) was established in 1994 by a resolution of the UN Economic and Social Council. Launched in January 1996, UNAIDS and its Secretariat bring together the efforts of ten UN organisations– or co-sponsors⁴⁰ – to respond to the HIV pandemic. UNAIDS work is guided by these 10 co-sponsors, together with a Programme Coordinating Board (PCB) representing 22 governments from all geographic regions and five NGO delegates, also with cross-regional representation.

UNAIDS engages in five core functions:⁴¹

1. Mobilizing leadership and advocacy for effective action on the epidemic;
2. Providing strategic information and policies to guide efforts in the AIDS response worldwide;
3. Tracking, monitoring and evaluation of the epidemic;
4. Engaging civil society and developing partnerships; and
5. Mobilizing financial, human and technical resources to support an effective response.

UNAIDS aims to “capitalize on the comparative advantages” of the co-sponsoring agencies, while maintaining its focus on coordination, coherence and accountability. In this role, UNAIDS is uniquely placed to highlight the gender-specific causes and consequences of the pandemic on women and girls, particularly in relation to violence, and the centrality of gender to understanding the disease as a health and human rights crises.

Summary of findings on UNAIDS from *Show Us the Money (2007)* and *What Gets Measured Matters (2008)*

Despite being an agency that controls far fewer funds than the donors discussed in our analysis, *Show Us the Money* highlighted the critical role of UNAIDS in placing key issues on the global AIDS agenda. Our 2007 analysis revealed minimal attention to violence against women in key UNAIDS publications, including its biennial flagship publication, *Report on the global AIDS epidemic*, in which UNAIDS publishes country-specific data on the epidemic and international responses. *Show Us the Money* also noted the lack of practical tools to track and report on the incidence of violence against women, as well as a failure to monitor and evaluate programmes to address the causes and consequences of violence in the context of the epidemic. The 2007 report called for UNAIDS to move from recognizing gender issues, including violence against women, in theory to a practical response.

At the time of publishing *What Gets Measured Matters*, UNAIDS was in the process of developing a new guidance aimed at expanding gender equality objectives in national-level responses to HIV. Despite this being the right step forward, our review revealed a number of shortcomings in UNAIDS’ guidance. This included the lack of specific references to rights promotion and rights protection. Furthermore, the UNAIDS guidance lacked specific examples of how to address each of the “gender-specific” impacts of HIV on women, girls, men and boys. Finally, while the UNAIDS guidance allocated a separate category under prevention as well as resources to violence against women, violence-related interventions were limited to the realm of prevention rather than being incorporated as an integral part of all aspects of the global AIDS response. The final version of the guidance was not endorsed by the UNAIDS Programme Coordinating Board (PCB).

One other development noted in our last assessment of UNAIDS was the explicit budgeting for interventions addressing gender inequality and violence against women in the Global Resource Needs Estimates (GRNE), although the estimated budget for interventions addressing violence against women was negligible. *What Gets Measured Matters* noted a strong commitment by UNAIDS to improve integration of gender equality and women’s rights in the HIV response. We expected to see more efforts in 2009, as requested by the PCB, to establish targets and indicators in all program planning, to review tools, to strengthen the gender capacity in the UNAIDS Secretariat and co-sponsors, and to develop more coordinated and strategic technical support for national AIDS responses.

Since our last assessment in 2008, UNAIDS has taken substantial steps in the global policy arena to begin addressing gender inequality and violence against women in the fight against HIV. In the past year, three important documents have been approved by the Programme Coordinating board (PCB) which set the stage for donors and national stakeholders to take proactive steps toward prioritizing gender equality:

1. The Joint Action for Results: UNAIDS **Outcomes Framework** 2009-11 approved in May 2009;
2. The UNAIDS **Action Framework: Addressing Women, Girls, Gender Equality and HIV**, approved in August 2009; and
3. **Agenda for Accelerated Country Action** for Women, Girls, Gender Equality and HIV: Operational Plan on Women, Girls, Gender Equality and HIV (2010-2014).

Despite these policy advancements, progress on gender-related policies had been slow until early 2009. As noted in *What Gets Measured Matters* and reiterated in the UNAIDS Second Independent Evaluation 2002-2008, released in September 2009, the process of developing a guidance on women, girls, gender equality and HIV has been particularly lengthy, the initial draft guidance compiled by UNDP not being accepted at the PCB meeting in April 2008 due to the draft's shortcomings.⁴² The Second Independent Evaluation further revealed how UNAIDS' capacity to address gender and HIV is limited at the global level, with the UNAIDS Secretariat having only three staff working on gender including with the Global Coalition on Women and AIDS (GCWA).⁴³ Moreover, gender-specialists from co-sponsors have noted the struggles they face within their own agencies to overcome resistance to a genuinely transformative approach to gender and sexuality.⁴⁴

Furthermore, some concerning trends have emerged in our analysis of the three policy documents listed above. These include:

1. An emphasis on intimate partner and sexual violence as opposed to *all* forms of violence against women and girls;
2. A focus on interventions to address violence against women and girls at the *prevention* stage, as opposed to all stages of HIV interventions;
3. A lack of sufficient acknowledgement of the inverse relationship between HIV and violence, namely violence as a *consequence* of actual or perceived HIV status; and
4. Inadequate attention given to the rights, lives and experiences of HIV positive women.

Joint Action for Results: UNAIDS Outcomes Framework 2009-11 ("Outcomes Framework")

The Outcomes Framework is a broad set of priorities for UNAIDS that aim to achieve universal access to HIV prevention, treatment, care and support, particularly in the context of the MDGs.⁴⁵ Some of the key priorities identified include reducing sexual transmission; strengthening the linkages between sexual and reproductive health and HIV policies and guaranteeing equal access to treatment, care and support for women and girls. The priorities also attempt to address head-on some of the concerning trends regarding the criminalisation of homosexuality and HIV transmission, calling for the removal of punitive laws, policies, practices, stigma and discrimination that undermine the AIDS response and foster further rights violations.⁴⁶

Initially a set of 9 priorities, a revised set of 10 priorities was released in March 2010, with substantial amendments to the former priority on violence against women and girls and with an additional priority focusing on the empowerment of men who have sex with men, sex workers and transgender people to protect themselves from HIV infection and to ensure full access antiretroviral therapy. Unfortunately, the amended Outcomes

Framework was drafted with no consultation with civil society organisations and were released with limited publicity, raising the question of whether further amendments will be made in the future with such limited notification.

Prior to the amendment, Priority 7 read:

We can stop violence against women and girls: By making the response to AIDS an opportunity to reduce intimate partner and sexual violence and developing comprehensive responses to gender-based violence and HIV prevention within and beyond the health sector.

This language was considered problematic in a number of ways, particularly for limiting the response to intimate partner and sexual violence, thereby ignoring the realities of stigma, discrimination, family and community violence and other rights violations that many women, especially HIV positive women, face. There is no doubt that the links between HIV prevention and intimate partner and sexual violence seem to be the most obvious and immediate. However, research demonstrates that different forms of violence perpetrated by different actors inhibit women's and girls' ability to prevent HIV as well as access and adhere to treatment.⁴⁷

A further concern was the call for a "reduction" in violence against women. To address violence against women is not simply a question of quantitatively reducing incidence but rather a holistic response that facilitates increased visibility of the problem, prevention of violence, transparency in data collection and accessible and responsive services for survivors. When there is concerted action against violence against women and girls, it often leads to a spike in reporting, which might appear as a failure to "reduce" violence. Therefore, setting up a priority that simply called for a reduction failed to capture the broad range of work required in anti-violence interventions, and had the potential to make conditions for reporting even more difficult for women.

Despite these shortcomings, the language of the former priority 7 was undoubtedly very specific, demonstrating a clear push for agencies and national governments to take responsibility for reducing gender-based violence as part of the HIV response. It precisely and valuably called for interventions within and beyond the health sector.

The new priority, now priority 8, reads:

We can meet the HIV needs of women and girls and can stop sexual and gender-based violence: by building on the synergies between the gender and AIDS response for positive change to the lives of women and girls and by utilizing opportunities to comprehensively respond to sexual and gender-based violence.⁴⁸

The new priority 8 gives greater attention to gender equality and women's empowerment than the previous language. This is a welcomed change that reflects the many structural inequalities that exacerbate the risks facing women of both HIV and violence. However, the amended language adopts an outdated needs-based approach and fails to reflect a human rights-based approach to empowering women to take control of their own lives and claim their own rights and entitlements.

Furthermore, while we value the attention given to gender equality more broadly, the amended priority deflects the focus away from violence-related interventions as central to the HIV response. Moreover, what is inexplicable and of particular concern is the separation of sexual and gender-based violence. The terms

gender based violence and violence against women in international treaties and consensus documents⁴⁹ refer to all forms of (actual or threats) violence, including physical, sexual and psychological coercion and arbitrary deprivation of liberty, in both public and private life. *The Convention on the Elimination of All Forms of Discrimination Against Women* defines gender-based violence against women in its General Recommendation 19 as “violence directed against a woman because she is a woman or that affects women disproportionately”.⁵⁰ This indicates that gender-based violence or violence against women, including sexual violence, results from gender and power inequalities.

Finally, the language lacks specificity. No reference is given to any of the key settings in which interventions must be located, including health settings, schools, among law enforcement and police. The language of “synergies” is imprecise and fails to name those who are responsible for collaborating and ensuring strong and sustained integration of gender, violence and HIV-related interventions.

That addressing gender-based violence has been established as one of the ten most important in the highest-level document guiding the UNAIDS family is in large part a credit to the sustained lobbying and collective action over many years by women’s organizations, human rights and HIV groups, and other civil society actors. However, the shortcomings in the language of priority 8 leaves the Outcomes Framework wanting.

Operationalising these priorities is a further challenge. As it stands, countries are urged to select a few of the priorities and build programmes around them. It is imperative, therefore, that countries are convinced, supported and guided to take on Priorities 8, along with the other priorities to end punitive laws and protect the rights of MSM, transgender people and sex workers. The Second Independent Evaluation reveals how national capacity on gender and HIV remains weak. Gender issues in national HIV strategies are often not linked to other national plans and there is little engagement by CCMs with national ministries responsible for women and gender. Calling for “synergies” therefore will be insufficient to ensure strong country-level implementation. As women’s rights activists will testify, there is political resistance to confronting violence against women and girls as a self-standing issue, let alone as a factor for HIV vulnerability or consequence of perceived or actual HIV status. The fact that these frameworks set global agendas and priorities does lend credibility and clout to gender equality-related priorities. However, there may be challenges in effectively reaching and convincing more than 160 countries to adhere to such a policy. Setting priorities such as Priority 8 carries the responsibility of bringing all the players along for the process, including supporting and facilitating the participation of women’s organisations and networks of women living with HIV&AIDS. Substantial investment, both human and financial and strong harmonisation among all country-level actors is essential.

UNAIDS Action Framework: Addressing Women, Girls, Gender Equality and HIV (“UNAIDS Action Framework”)

The Action Framework is an important, although overdue step in global agenda setting on gender equality in HIV policies and programmes.

The Action Framework is organized around three “Action Areas,” namely:

1. Strengthening strategic guidance and support to national partners to ‘know their epidemic and response’ in order to effectively meet the needs of women and girls;
2. Assisting countries to ensure that national HIV and development strategies, operational plans, monitoring and evaluation frameworks and associated budgets address the needs of women and girls in the context of HIV; and
3. Advocacy, capacity strengthening and mobilization of resources to deliver a comprehensive set of measures to address the needs and rights of women and girls in the context of HIV.

The Action Framework recognises how the current HIV epidemic is emblematic of the gap between rhetoric about global commitments to promoting and protecting women’s human rights and the reality facing many women and girls around the world.⁵² Human rights based programming is recognised as core to any response, with a critical first step being meaningful participation in the development, execution and evaluation of AIDS strategies.⁵³ The document also notes the range of rights violations experienced by women living with HIV&AIDS, including forced sterilisation and forced termination of pregnancies.

Some of the Action Framework’s greatest strengths include recognition of:

- the lack of a strong evidence base, be it epidemiological, sociological or concerning questions of sexuality, gender identity and the impact of cultural norms on women and girls;⁵⁴
- the need to address the structural inequalities that women and girls face, be they legal, social or economic;⁵⁵
- the impact of the economic crisis on the risks facing women and girls, including the deterioration of social services due to government and donor budget cuts, diminishing household incomes, which may result in increased unsafe or transactional sex and the financial pressures facing families and their impact on girls schooling,⁵⁶ and
- the essential role of HIV-positive women and groups that work on women’s human rights – including sexual and reproductive health and human rights, gender-based violence, rights of sex workers, rights of women who have sex with women, and transgender persons – in national AIDS responses.⁵⁷

It should be noted also that while the entire Action Framework makes clear references to all forms of violence against women and girls, we are concerned about a bias towards almost exclusively addressing sexual and intimate partner violence. It is essential that any response to the two epidemics address the risk of all forms of violence more broadly, whether the cause or consequence of HIV transmission. Such services must be included in a minimum services package, as outlined in the Essential Services Package (ESP) discussed in Section 4 below, for a comprehensive AIDS response at the country level and should not be limited to sexual and intimate partner violence.

The Action Framework, like this report, calls for a move from policies to fully-funded programmes.⁵⁸ It emphasizes effective monitoring and evaluation of national AIDS plans, calls for gender-sensitive indicators and recommends that relevant sex and age-disaggregated qualitative and quantitative data are collected.⁵⁹ We call on UNAIDS and other stakeholders identified in this report to ensure that the call to move from policy to programmatic change is heeded and that both the Action Framework and the Agenda for Accelerated Action, discussed in the following section, are backed by political will, UN leadership at the international, regional and national levels, and the necessary financial and human resources.

Agenda for Accelerated Country Action for Women, Girls, Gender Equality and HIV: Operational Plan on Women, Girls, Gender Equality and HIV (2010-2014) (“Agenda for Accelerated Country Action”)

The Agenda for Accelerated Country Action was developed to support the implementation of the UNAIDS Action Framework, in light of the “pressing need to address the persistent gender inequalities and human rights violations that put women and girls at a greater risk of, and more vulnerable to, HIV and that threaten the gains that have been made in preventing HIV transmission and in increasing access to antiretroviral therapy”.⁶⁰ It forms the operational plan for implementation of the Action Framework. With a time-frame of five years, the Agenda for Accelerated Country Action will be implemented by UNAIDS and UNIFEM from January 2010 to December 2014, with all stakeholders to be held accountable for delivering results—including those in the UNAIDS family, individual cosponsors, the Secretariat, the UN joint teams on AIDS, UNIFEM and other partners. It is important to point out at the outset that the process of drafting this document, facilitated by the UNAIDS secretariat, was consultative. Representatives of governments, CSOs and UN agencies were members of the three Working Groups and the Global Task Force on Women, Girls, Gender Equality and HIV, with multiple opportunities for civil society organisations to make substantive contributions to the draft documents. The quality of the final document reflects this consultative process.

The Agenda for Accelerated Country Action is a comprehensive document which attempts to mobilize constituencies, resources and political commitment to move this agenda forward. It addresses the following three key issues:

1. Knowing, understanding and responding to the particular and various effects of the HIV epidemic on women and girls;
2. Translating political commitments into scaled-up action to address the rights and needs of women and girls in the context of HIV; and
3. Ensuring an enabling environment for the fulfilment of the women’s and girls’ human rights and their empowerment, in the context of HIV.

The Agenda for Accelerated Country Action presents a strong set of recommendations and goals essential for the realisation of a gender sensitive AIDS response at the country level. First, it aims at achieving an improvement in the quantitative and qualitative evidence-base in order to better demonstrate the specific needs, risks and impacts of HIV on women and girls and to better inform policies and programmes. Secondly, it aims to achieve harmonized gender equality indicators, both of which have been noted as persistent gaps by the Women Won’t Wait Campaign.

On the political front, the Agenda for Accelerated Country Action calls for a translation of political commitments

into scaled-up and resourced policies and programmes. Specifically, one key result area is that “all forms of violence against women and girls are recognized as violations of human rights and are addressed in the context of HIV”.⁶¹ Finally, adopting a human rights approach, the Agenda for Accelerated Country Action recognizes the centrality of the empowerment of women and girls to drive the transformation of social norms and power dynamics. In this respect, it calls for “increased financial resources for women, girls and gender equality in the context of HIV”.⁶²

That a human rights approach is intended to guide the implementation of the Agenda for Accelerated Country Action is undeniable. Recommendations include supporting countries to report to CEDAW with age and sex-disaggregated data on how the HIV epidemics affect women and girls. The response to HIV is actually seen as a possible “catalyst” to “bring about socio-cultural, political and legal transformations to promote, protect and fulfil the rights of women and girls”.⁶³

An important feature of the Agenda for Accelerated Country Action is the consistent call for comprehensive multi-sector services for HIV, tuberculosis and sexual and reproductive health. Violence against women and girls is included in the requirements of a minimum package of integrated services but reflecting the emphasis of earlier documents, the focus is placed on sexual violence. In order for integrated services to be truly comprehensive, programmes and services that address all forms of violence against women and girls must be made an additional component of integrated multi-sector services. Limiting the focus to sexual violence disregards the evidence and will weaken the AIDS response in the long run.

The Agenda for Accelerated Country Action recognizes how, beyond financial resources, much can be achieved by “utilizing political will and commitment, such as ensuring the engagement of women in decision-making at all levels”.⁶⁴ It rightly states that “much can be done by allocating and more effectively using existing resources for the AIDs responses”.⁶⁵ However, the question of what new resources, financial and human, will be dedicated by all actors to implement the Action Framework remains unanswered and of significant concern to civil society. Sporadic references are made to funding transparency, including the need to “support governments to track expenditure of country-level resources allocated to programmes for women, girls, gender equality and HIV”.⁶⁶ These recommendations must be translated into practice. Primarily, we wait to see what staff and budgets will be set aside by all implementing parties, including UNAIDS, UNAIDS co-sponsors and governments, to ensure the success of the Action Framework. The scale, breadth and potential of the Agenda for Accelerated Country Action cannot be understated and requires financial commitment, gender expertise, transparent budget allocation and spending as well as an open and effective system of monitoring and evaluation.

UNAIDS has created the Gender and AIDS team which will be primarily responsible for implementing the Agenda for Accelerated Action and Priority 8. What remains of primary concern, however, is whether adequate budgets and staff with gender expertise exist both at the secretariat and the country level to drive implementation. Without guaranteed commitment of resources, the Action Framework, Agenda for Accelerated Action and Priority 8 will have limited impact in countries, especially where there is sporadic interest or resistance.

Resource Needs and Allocation

In February, 2009, UNAIDS released the Global Resource Needs Estimates (GRNE) for 2009-2011 which estimates what is needed to achieve universal access to HIV prevention, treatment, care and support by 2010 and to ultimately achieve MDG 6, to halt and reverse the spread of HIV by 2015.⁶⁷ When the previous estimates were released in 2007, UNAIDS included for the first time, budget lines for the prevention of violence against women in its calculation of resource needs. The 2007 GRNE focused on “using the infrastructure of HIV programmes

to explicitly engage individuals and communities in discussions and dialogue regarding power, gender, masculinity and violence.”⁶⁸ This move was hailed with appreciation but was also met with criticisms, in part due to the limited focus on anti-violence programmes in the context of HIV prevention only.

The 2009 GRNE reinforces the limited scope of UNAIDS’ approach to the intersection between violence and HIV. Anti-violence programming in the budgeting process has been placed in the context of HIV prevention.⁶⁹ While the addition of capacity building for VCT providers and those stakeholders involved in responses to sexual assault are welcome, the failure to budget for anti-violence measures across the treatment, care and support interventions reveals the limitations of these estimates. Tackling stigma and promotion of human rights are, however, recognized as cross-cutting issues.⁷⁰ Unfortunately there is no indication that community consultation on the new estimates took place before the release of this report, which may have led to more thorough estimates. We wait to see whether and when UNAIDS will cost anti-violence programmes across the prevention, treatment, care and support spectrum.

Based on the estimates and the priorities laid out in the Outcomes Framework, the Uniform Budget and Workplan 2010-11 (UBW) has allocated over \$44 million to “stopping violence against women and girls.” In fact, the overall allocation to Principal Outcome 7, which addresses the “vulnerability of, and impact on women and girls, young people, children, populations affected by humanitarian crisis and mobile populations,” has increased from \$32 million in the UBW 2008-09⁷¹ to around \$79 million in UBW 2010-11.⁷² These increases are promising. However, it remains to be seen how UNAIDS co-sponsors will actually utilize these resources. One immediate setback is the merging of women and girls with children and with “populations of humanitarian concern”. Collapsing the categories of women and girls with children is problematic for a number of reasons. Firstly, this approach is symptomatic of the limited understanding and labelling of women largely in the context of their roles as mothers. This is an approach that has historically rarely addressed women’s rights or challenged gender inequality. Secondly, collapsing half the world’s population with a group that is surviving emergency situations and living under extreme duress for extended periods renders invisible the specific experience of women in humanitarian crises and diverts much needed attention from long-term sustainable anti-violence programmes that are integrated into health systems.

The Global Coalition on Women and AIDS

The Global Coalition on Women and AIDS, a UNAIDS-led initiative launched in 2004, is a worldwide alliance of civil society groups, networks of women living with HIV, women’s organizations, AIDS service organizations, and the UN system, committed to strengthening AIDS programming for women and girls.⁷³ The main priorities of the GCWA for 2009-10 have been information sharing and the provision of tools, research and capacity building support as well as providing country-level support, to strengthen roadmaps and operational plans.⁷⁴ Through its advocacy and networking, the GCWA has drawn increased attention to the effects of HIV on women and played a role in stimulating action in response.

In our 2007 report, we had noted that the GCWA seemed to suffer from an “uncertain status and relative marginalization” and we were concerned that there was a “lack of clear commitment on the part of UNAIDS to assure that the GCWA can have a significant impact at overall policy and programming.”⁷⁵ While UNAIDS has announced the creation of a Gender and AIDS unit within the secretariat with the responsibility to implement the Agenda for Accelerated Country Action and Priority 8, what is unclear is the continued role and mandate of GCWA. The Women Won’t Wait Campaign believes that the GCWA must be mandated to facilitate and support its CSO members to monitor the implementation of UNAIDS policy documents, including the Agenda for Accelerated Action and the priority outcome on meeting the HIV needs of women and girls discussed extensively in this report.

Recommendations

- **Comprehensively respond to all forms of violence against women and at all stages of the HIV response.** Despite a broader understanding of violence against women in UNAIDS policies, in practice, there is a tendency to confine attention to only sexual violence and intimate partner violence. It is important that UNAIDS broadens the scope of its attention to violence and its intersection with HIV. Furthermore, UNAIDS should explicitly recognise and address violence as an integral part of all aspects of the global HIV&AIDS response at all stages, including prevention, treatment, care and support.
- **Mobilise resources at the country-level for implementation of Priority 8 and the Action Framework through the Agenda for Accelerated Action.** UNAIDS must dedicate significant, predictable and sustained funds, with clear and transparent budget lines, for implementation of these policies. UNAIDS must also ensure that sufficient staff with gender expertise are engaged in implementation at the secretariat and country-level.
- **Provide specific support (including financial support) for CSOs, including women's organisations, to implement the Agenda for Accelerated Action and subsequent monitoring of the same.**
- **Utilise the bodies established to develop the Agenda for Accelerated Action,** namely the Global Task Force on Women, Girls, Gender Equality and HIV and three working groups, to act as an ongoing advisory group on gender equality, violence against women and HIV.
- **Ensure substantial funds are allocated for anti-violence measures across the prevention, treatment, care and support spectrum in future Global Resource Needs Estimates.** UNAIDS must use its leadership position to ensure that new and expanded resources are allocated for anti-violence interventions. Strategies must be developed to prevent gender-based violence, including in schools, in families and other settings.
- **Support the work of the Global Fund and CCMs as they implement their Gender Equality Strategy and Strategy in Relation to Sexual orientation and gender identity.**
- **Influence the health systems strengthening discourse towards greater integration of violence against women and HIV interventions.**
- **Support research and help develop a stronger evidence base.** UNAIDS is uniquely placed to foster research and disseminate information on HIV and its intersection with violence against women and girls. Emphasis must be placed on strengthening the data collection systems at the country level. UNAIDS must also provide additional resources for the profiling and scaling-up of existing programmes that work.

Global Fund for AIDS, Tuberculosis and Malaria

Established in 2002, the Global Fund to fight AIDS, tuberculosis and malaria is an international financing institution that has, to date, committed USD 19.3 billion in 144 countries to support large-scale prevention, treatment and care programmes in response to the three diseases.⁷⁶ It provides a quarter of all international financing for AIDS globally, two-thirds for tuberculosis and three quarters for malaria.

Effective functioning of the Global Fund at the country level depends on strong Country Coordinating Mechanisms (CCMs), a multi-stakeholder, public-private partnership, composed of a broad spectrum of representatives, including from government, donors, NGOs and the private sector. CCMs develop and submit grant proposals to the Global Fund based on what they see as priority needs at the national level. These proposals are reviewed by the Technical Review Panel (TRP), a body of experts who determine the technical merit of proposals, considering the soundness of approach, feasibility and potential for sustainability.⁷⁷ Each year, one round of proposals is considered by the TRP for funding. The Global Fund's Board also includes representatives from civil society.

In the words of the Global Fund, "It does not provide normative guidance or technical assistance, and is not an implementing agency. The strength of the Global Fund is its ability to be a catalyst, supporting countries' efforts to take the gender dimensions of the three epidemic(s) into account in their proposals and subsequent programme implementation, while recognizing the need for a broad network of partners to support countries to do this."⁷⁸

Summary of Global Fund findings from *Show Us the Money (2007)* and *What Gets Measured Matters (2008)*

Show us the money revealed the lack of accountability of Country Coordinating Mechanisms (CCMs) for not only incorporating a gender analysis into plans but actually translating this into measurable outcomes. This was driven, in part, by the Global Fund's emphasis on a country-driven process and priority setting. While we lauded the principle of country ownership, we were concerned that this principle in practice meant government ownership to the exclusion of meaningful participation of CSOs, especially women's organisations, in the planning and proposal development process. We were further concerned that without women's groups at the table, funding was allocated based on political priorities rather than substantive evidence about the most effective and gender-sensitive response to HIV.

While a lack of gender balance among CCMs was among our findings in *Show Us the Money, 2007* brought surprisingly public and high level policy change at the Global Fund, as well as greater attention to gender and HIV than had previously existed. *What Gets Measured Matters* highlighted a new mandate for the Global Fund to institute a "gender-sensitive response" to the three diseases. This was a multi-pronged process that included hiring new staff (so called "Gender Champions"), increasing gender expertise at the Secretariat, as well as in the CCMs and Technical Review Panel (TRP). The process also aimed to ensure that country proposals that were submitted addressed the particular needs of women and girls. The focus was expanded to include family planning, sexual and reproductive rights and the needs of sexual minorities.

What Gets Measured Matters considered the results of the Round 7 call for proposals. "Human rights and gender equality" was one of six criteria that were included in the proposal guidelines as a factor considered by the TRP in determining whether the proposal exhibited a sound approach to tackling the diseases. While violence against women was not specifically referenced in Round 7 guidelines, applicants were requested to describe how proposed interventions would decrease social inequalities (related to class, gender, etc.) by targeting particular groups most in need of interventions. It is increasingly evident that favourable attention is given by the TRP to proposals that address the "vulnerabilities facing women". The 2008 report demonstrated, however, that many groups working on gender and HIV felt it was difficult to develop proposals that were both gender-sensitive and evidence-based, due to the lack of currently available data linking gender-based initiatives to disease outcomes. In addition, our 2008 report revealed that the Global Fund has not moved beyond the most basic collection of sex-disaggregated data.

The Global Fund's Strategy for Ensuring Gender Equality in the Response to HIV/AIDS, Tuberculosis and Malaria ("The Gender Equality Strategy") and the Global Fund Strategy in relation to Sexual Orientation and Gender Identities ("SOGI Strategy")

The most significant development at the Global Fund since our last analyses was the adoption of The Global Fund's Strategy for Ensuring Gender Equality in the Response to HIV/AIDS, Tuberculosis and Malaria ("The Gender Equality Strategy"). This strategy was developed to increase the amount of resources directed at gender sensitive and gender transformative programming. Importantly, the Gender Equality Strategy makes explicit the Global Fund's support for programmes that address gender-based-violence as a driver of the HIV epidemic.

The Gender Equality Strategy states that the Global Fund will champion and fund proposals that:⁷⁹

- Scale up services and interventions that reduce gender-related risks and vulnerabilities to infection;
- Decrease the burden of disease for those most at-risk;
- Mitigate the impact of the three diseases; and
- Address structural inequalities and discrimination.

It further states that the Global Fund will achieve this by focusing on four key goals:⁸⁰

1. **Ensure Global Fund's policies, procedures and structures** (including the CCM, and TRP) effectively support programmes that address gender inequalities;
2. **Establish and strengthen partnerships** that effectively support the development and implementation of programmes that address gender inequalities and reduce women's and girls' vulnerabilities, provide quality technical assistance, and build capacity of groups who are not currently participating in Global Fund processes but should be;
3. **Develop a robust communications and advocacy strategy** that promotes the Gender Equality Strategy and encourages programming for women and girls and men and boys; and
4. **Provide leadership**, internally and externally, by supporting, advancing and giving voice to the Gender Equality Strategy.

The Gender Equality Strategy calls for stronger CCM guidelines that specify how gender should be taken into account, along with ensuring that CCMs have access to high quality gender expertise.⁸¹ Although the Gender Equality Strategy is an important development, implementation has been slow and the Global Fund has not been proactive in disseminating information about it. There needs to be grassroots level information sharing and technical assistance to ensure that women's groups know the priorities articulated in the Gender Equality Strategy and are supported to participate in the CCMs to influence proposal development.

The Global Fund Strategy in relation to Sexual Orientation and Gender Identity (SOGI Strategy) notes that men who have sex with men (MSM), transgender people, and female, male, and transgender sex workers face challenges in being able to access or benefit from Global Fund grants. They have limited access to decision-making bodies of the Global Fund and face social and structural barriers to the realisation of their health and rights.⁸² The SOGI Strategy outlines concrete actions that the Global Fund, as a major international funding entity working to addressing challenges of health from frameworks of evidence, human rights, and measurable

outcomes, can take to address the vulnerabilities and needs of MSM, transgender people, and sex workers in the fight against the three diseases.⁸³ This commendable strategy will complement the Gender Equality Strategy.

To date, the Global Fund has not yet done enough to guarantee the right to health of MSM, transgender persons, sex workers and others, who often experience discrimination or violence in health-settings. The SOGI Strategy, therefore, is a good first step to address these shortcomings. Once again, resources and staff will be necessary to operationalise the SOGI Strategy and ensure that its full potential is realised. Furthermore, despite attempts by the other institutions in this report to offer to involve civil society, marginalised groups have limited opportunities to influence funding priorities and the design of programs. The Global Fund's SOGI Strategy therefore offers an example for inclusive and participatory decision-making for the other agencies analysed in this report.

The role of Country Coordinating Mechanisms (CCMs) and the Technical Review Panel (TRP)

A significant opportunity to ensure that violence against women and girls as well as gender equality goals are prioritized in proposals lies with the Country Coordinating Mechanisms (CCMs). While a noble aim, the "country-driven" approach for proposal development does not ensure that women's rights are adequately addressed. This is primarily because women are generally unable to access and participate in national-level planning processes. In addition, comments by staff from the Open Society Institute (OSI) revealed that while CCMs often undertake an adequate gender analysis of the problem, they face difficulties translating this analysis to programmes and budgets.⁸⁴ The guidelines and criteria for funding help CCMs to prioritize certain goals. However, CCMs require targeted technical assistance, training and ongoing support from the Global Fund's partners, such as UNAIDS, WHO, GTZ and OSI, to be able to submit proposals that meet all these criteria.⁸⁵ There must also be a concerted effort by the Global Fund and its partners to ensure women's organizations, including networks of women living with HIV, transgender and sex worker's rights organizations, are engaged in CCMs and the process of proposal development. The UNAIDS Action Framework calls for advocacy by governments and CCMs to set a 40% quota for women with the necessary expertise to participate in the CCMs to ensure the needs and views of women and girls are adequately represented, a recommendation that if implemented would no doubt be reflected in increased attention paid to violence against women and gender equality in future funding proposals.⁸⁶

Notably, the Global Fund has undertaken important analyses of past rounds of funding to assess the integration of gender into its grants. This systematic approach to revising the grant-making protocol is a valuable process and can be duplicated by other donors. The survey of Round 8 proposals, the results of which were announced in November 2008 revealed that countries across the board fell short of systematically addressing gender dimensions. Fact sheets and guidance offered to CCMs for the Round 9 call for proposals called for the development of proposals "incorporating a gender-sensitive approach to programming."⁸⁷ For Round 9 proposals, which were approved in November 2009, the Technical Review Panel (TRP) included people with expertise in gender equality. There is also a period between Phase 1 and 2 after 2 years of implementation of a particular proposal when the TRP has another opportunity to assess whether or not gender equality has been addressed adequately in the action plan and the work plan. These windows must be capitalized upon in order to ensure the integration of violence against women and girls into national AIDS responses.

In addition, the materials made available to civil society actors by the Global Fund must advocate for addressing violence against women and girls and provide information about the availability of funds to address this issue

when included in a country-level proposal. There is hope that future rounds of proposals, particularly in light of the Gender Equality Strategy, will demonstrate a deeper understanding of the need and new requirement to address gender equality in order to retain Global Fund support.

Monitoring and Evaluation Toolkit

One of the more disappointing developments since our last review of the Global Fund involved the release of the third edition of its Monitoring and Evaluation Toolkit in February 2009. The Toolkit outlines the “minimum necessary” indicators for national level monitoring of the HIV epidemic and response.⁸⁸ This new edition of the Toolkit only calls for sex disaggregated data to capture gender equality. The Global Fund notes, “At this stage, this edition of the toolkit proposes no additional standard indicators that directly measure equity in access or provision of health care for the three diseases or health systems strengthening.”⁸⁹ In the companion document, which lists indicators for each disease, “countries are encouraged to use nationally recommended indicators to measure progress in a specific programme area not covered in this toolkit (such as gender-based violence).”⁹⁰ Despite the Gender Equality Strategy and the Global Fund’s apparent interest in ensuring a gender analysis to create effective HIV programmes, it is a major shortcoming that there is not one single indicator recommended to the CCMs that is designed to measure a gender-related outcome.

Other opportunities for increased attention to violence against women

The relationship between UNAIDS and the Global Fund offers an important avenue for technical support and guidance. The UNAIDS Action Framework and Agenda for Accelerated Country Action is designed to guide national AIDS responses, which are in essence what the CCM proposes to the Global Fund. Therefore, both the Action Framework and Agenda for Accelerated Country Action provide an insight into what the Global Fund can expect from CCMs, particularly given UNAIDS representatives participate in CCMs in many countries. The Global Fund should use both documents as guidance during the TRP process and for developing fact sheets for CCMs.

One final opportunity lies with the Global Fund protocol itself. During the process by which a proposal becomes a grant agreement, there are a number of openings to conduct targeted advocacy to influence the shape of the final grant agreement. Even when there is no mention of violence against women and girls in the proposal there is room for CSOs to urge the principal recipient to promote research on the intersections between violence against women and girls and HIV. It is research like this that will bolster efforts to increase resources needed for violence against women and girls programming.

As noted in *Show Us the Money* and *What Gets Measured Matters*, the Global Fund does not make detailed information about sub-recipients publically available. While proposals often list potential sub-recipients, specific information about all stakeholders involved in the implementation of accepted proposals is critical for CSOs to know which groups are implementing gender-related programming. Without transparency concerning recipients and sub-recipients, the ability of CSOs to urge all implementing parties to accord adequate attention to violence and gender in their programming, is severely hindered. Transparency on sub-recipients also facilitates monitoring by CSOs so as to ensure that those implementing gender equality and violence against programmes have the necessary expertise and experience.

Recommendations

- **Ensure representation of women living with and affected by HIV at every level of planning, decision-making, implementation, and evaluation.** The Global Fund, CCMs and TRPs must also include participation of women's human rights groups, especially groups with expertise in sexual and reproductive rights, gender-based violence and its intersection with HIV and groups of women living with HIV.
- **Provide clear guidance and support the development of country proposals addressing gender issues, particularly violence against women.** The Global Fund must continue to provide a clear definition of what is meant by gender in the context of the three diseases, as well as guidance and examples of what is meant by "gender-responsive programming" in the form of fact sheets and other guidance, to ensure adequate attention is paid to gender equality at the proposal development, consideration, implementation and evaluation stages. More attention should also be paid to HIV/tuberculosis co-infection among women and girls.
- **Ensure country-level training on gender equality.** The Global Fund should invest in across-the-board gender and human rights training, especially training on women's and girl's sexual and reproductive rights, gender-based violence, and women's rights and its intersection with HIV&AIDS.
- **Re-assess the extent to which gender-related targets have been implemented throughout the project lifecycle.** The TRP has an opportunity to reiterate the importance of gender equality in HIV&AIDS responses between Phase 1 and 2, when the TRP considers whether or not gender equality has been addressed adequately in the action plan and the work plan, as well as at the final stage of evaluation.
- **Foster the development of baseline knowledge on the HIV epidemic and its causes and consequences.** Urge grantees to collect baseline data on the extent, nature, and drivers of violence against women in specific settings, develop and disseminate guidance to facilitate the collection and analysis of this information, and provide flexible funding to address these factors.

US President's Emergency Plan for AIDS Relief (PEPFAR)

PEPFAR was originally launched in 2003 by President George W. Bush through the Global AIDS Act and represented a USD 15 billion bilateral commitment to support HIV&AIDS prevention, care and treatment programmes in 15 focus countries. In the first five years, the programme claims to have provided HIV&AIDS treatment to over 2 million people, and care to more than 10 million people.⁹¹

The 2008 reauthorization of PEPFAR, often referred to as PEPFAR II, authorized funding of up to \$48 billion until 2013. The United States' policy in the area of HIV is in a state of transition as the administration under President Obama moves away from singularly addressing HIV, to adopting a more expansive integrated approach to global health, where HIV remains a key focus but within a broader ambit of issues. To this end, PEPFAR is transitioning away from an "emergency response to global HIV and AIDS to a more sustainable, country-led response".⁹² However, the evident reduction in the amount of funds committed by the US Government for HIV interventions is of serious concern. It is clear that the Administration is not adequately funding PEPFAR and is failing to contribute its fair share contribution to the Global Fund to Fight AIDS, Tuberculosis and Malaria.

While there are undoubtedly positive changes between PEPFAR II and the original law that will facilitate a heightened level of attention to violence against women and girls in the context of HIV programmes, a number of challenges remain. In sub-Saharan Africa in particular, where all but three of the 15 focus countries are located,⁹³ PEPFAR's emphasis on abstinence only until marriage and fidelity has increased the risk of infection for groups who are most marginalized and for whom the messages of "abstain and be faithful" are often meaningless in light of the risks they face in the context of HIV infection and its causes and consequences.

Summary of findings on PEPFAR from *Show Us the Money (2007)* and *What Gets Measured Matters (2008)*

Our 2007 report showed that although at the time PEPFAR was the largest bilateral donor, it was, and remains, the most controversial. While the most explicit of all the institutions studied in its commitment to address violence against women and girls in the context of HIV&AIDS, rules and regulations on the use of funds have elicited criticism from internal and external actors, particularly with regard to PEPFAR's ABC approach (abstinence, be faithful, use a condom). In *Show Us the Money*, we highlighted the concerns of women's rights and HIV&AIDS activists about the use of PEPFAR funding to promote traditional gender roles and women's subservience, weak linkages with reproductive and sexual health and rights programming and the tendency to partner with HIV-service or faith based organizations, who, at best, may have less programming experience in field of violence against women and girls and at worst, may not be committed to advancing women's human rights.

PEPFAR took strides in 2007 to integrate gender into its programming and overall strategies, but the reach, content and success of many of its programmes was unclear. Along with a funding directive that 33% of prevention dollars be spent on abstinence-until-marriage programmes, the authorising legislation for PEPFAR specified a five-pronged approach to support strategies to integrate gender into programming in the areas of prevention, care, and treatment. The five components of the approach are: increasing gender equity in HIV/AIDS activities and services; reducing violence and coercion; addressing male norms and behaviours; increasing women's legal protection; and increasing women's access to income and productive resources. What was missing from the US Office of the Global AIDS Coordinator (OGAC) and demanded by *What gets measured matters* was concrete data about the types of programmes being implemented, whether or not these programs were serving those that needed them the most, and the indicators used by OGAC to monitor and evaluate the gender-sensitivity of those programmes.

US Global Health policies under the Obama Administration

PEPFAR II exists under a very different political environment than the original law that was passed in 2003. In addition to the up-scaled investment in global health through the Global Health Initiative discussed below, many of the policies which were criticized for being unsound, ideologically driven, and detrimental to the health and rights of women and people living with and affected by HIV&AIDS under former administrations have been removed. While other equally serious barriers remain including the “ABC- *abstinence, be faithful, use a condom*” programming and Anti-prostitution Loyalty Oath discussed below, in general, these reversals will improve the US government’s ability to provide and promote evidence- and rights-based care, treatment and prevention services for those affected by HIV&AIDS.

Key policy changes include:

- Restoration of US funding of the United Nations Population Fund (UNFPA);⁹⁴
- Repeal of the “Global Gag Rule.” Officially known as the Mexico City Policy, the Global Gag Rule barred any foreign organisation receiving US foreign aid from using *its own funds or funds from other donors* to perform abortions; advocate for reform to abortion laws and related policies; or provide information, make referrals, or counsel women on the procedure—even in countries where abortion is legal. Although the Gag Rule did not apply to PEPFAR funding, it inhibited comprehensive approaches to sexual and reproductive health and led to uncertainty among recipients about how their US aid could be used;
- Reversal of a 20-year ban on federal funding of domestic needle exchange programmes. This has opened the door for US-funded programmes overseas to better address the risks facing women who inject drugs or in relationships with people who inject drugs;⁹⁵
- End of the discriminatory 20-year AIDS Travel Ban. As of January 4, 2010, the US government can no longer deny non-US citizens entry into the US based on their HIV status.⁹⁶

Another welcomed development was President Obama’s creation of the Office of Global Women’s Issues in June 2009 and appointment of Melanne Verveer as the Ambassador-at-Large for Global Women’s Issues. Unquestionably, the new Office will increase attention to the political, economic and social barriers to women’s empowerment around the globe, as well as facilitate better informed US foreign policy decisions, particularly in terms of the intersection between violence against women and girls and HIV. After vociferous advocacy by women’s rights activists in the country, the UK Government followed suit shortly after with the appointment of Baroness Kinnock to lead the Government’s work to tackle violence against women overseas. The success of both roles in advancing the rights of women now depends on sufficient human and financial resources, as well as political will at the highest levels, dedicated to supporting their mandates.

PEPFAR II

A number of changes have been introduced to PEPFAR II, along with welcome developments at the Office of the Global AIDS Coordinator (OGAC). Of all the institutions assessed in this report, these changes position the US Government as most advanced in terms of programme-level attention to violence in the context of HIV. CSOs, however, remain deeply concerned that the levelling-out of US funds will severely hinder programming.

In December 2009, OGAC released a high-level policy document outlining PEPFAR’s Five-Year Strategy,

according to which PEPFAR will move away from an emergency response and emphasise instead a more comprehensive, country-driven, sustainable approach. This means working to combat the drivers of the epidemic by strengthening health systems, encouraging the involvement of civil society, focusing on the person not the virus, and addressing violence against women. Key to improving the health and rights of women, particularly those living with HIV&AIDS, the framework calls for participatory approaches, evidenced-based responses and particular attention to marginalized groups. This administration's focus on integrating health services, with a particular focus on integrated HIV and SRH services, is a radical departure from the Bush administration's requirements that country teams not use PEPFAR money for family planning.

PEPFAR II removes the "AB earmark" – a requirement that one-third of PEPFAR's prevention funds support "abstinence-only-until-marriage" and "be faithful" programmes. This rule was replaced by the condition that countries with generalized epidemics spend at least 50 percent of their funds for prevention of sexual transmission of HIV on "activities promoting abstinence, delay of sexual debut, monogamy, fidelity, and partner reduction."⁹⁷ This funding preference is not mandatory, although justification needs to be given if not heeded. While the amendments are an improvement, it is essential that the US Government withdraws its current "ABC policy" altogether and replaces it with a comprehensive HIV prevention policy.

A further development which should facilitate better monitoring by CSOs of how US aid is used in the context of HIV and violence against women is OGAC's new procedures for monitoring programme-level performance on gender and violence. Formerly, PEPFAR instituted budget allocation rules, which established rigid funding silos and provided strict percentage-levels for spending depending on whether the activity was considered a preventative, treatment or care service. In practice, these were inappropriate, counterproductive and needed to be replaced.

The most recent Country Operational Plan (COP) Guidance (2010-11) outlines the new PEPFAR process for monitoring programme performance on gender and violence against women. Countries are now required to write technical narratives about how they address gender across programmes. This requires cross-referencing activities that are occurring within different programmes within each narrative and articulating the intersections between violence and HIV. Violence against women has been assigned a cross cutting budget code to track progress. Other gender strategies will be captured with "key issue tick boxes."⁹⁸

OGAC's detailed guidance recognizes that programmes addressing violence against women and girls and HIV can be complex and multi-faceted, which may include clinical services, behavioural change interventions, and local and systems-level work with law enforcement, legislative, and judicial bodies. It is not yet clear if this "cross-cutting" budget attribution will actually help illuminate the intersections between violence and HIV. However, there is potential for this cross-cutting method to help better track gender-related spending, particularly on anti-violence initiatives, across a range of programmes.

OGAC's guidance also provides a number of valuable suggestions for activities that could be implemented to address violence against women and coercion in the context of HIV,⁹⁹ many of which are also discussed in the Women Won't Wait Campaign's Essential Services Package (ESP) discussed in Section 4 below. OGAC's recommendations include:¹⁰⁰

- Screening and counselling for gender-based violence within HIV/AIDS prevention, care, and treatment programmes;
- Strengthening referrals from HIV/AIDS services to GBV services and vice versa;
- Strengthening rape care services, including the provision of HIV PEP (*Post-exposure prophylaxis*);

- Strengthening linkages between health, legal, law enforcement, and judicial services and programmes to prevent and mitigate GBV; and
- Research and programme evaluation regarding the associations and interplay between GBV and HIV/AIDS, and HIV/AIDS services.

The most recent development in the context of US funding for violence interventions was the US Government's pledge in May 2010 of an additional \$30 million to support three partner countries – Tanzania, Mozambique, and the Democratic Republic of Congo – in scaling up gender-based violence prevention and response efforts. To pursue this intensified approach, PEPFAR will support comprehensive response packages for survivors of violence at selected health facilities, increase gender-based violence prevention programmes to address the underlying causes of violence, improve linkages with other sectors and addressing policy and structural barriers. PEPFAR will also look for synergies with US Government agencies and other partners that already focus on violence-related development issues, such as education, reproductive health, democracy and governance, and economic growth. Unquestionably, this new pledge reflects years of advocacy by women's rights organisations and other groups and strong advancements in the US Government's policy with respect to HIV and women's rights. CSOs will no doubt be closely monitoring the implementation of these efforts in the three countries and continue to advocate for wide-spread scale-up across all PEPFAR countries.

Challenges for PEPFAR II

PEPFAR II retains a major flaw that will continue to make it difficult to address the realities of women's lives within HIV programmes, the Anti-Prostitution Pledge. Also known as the Anti-prostitution Loyalty Oath (APLO), it mandates that international NGOs and service providers who receive aid through PEPFAR sign an oath explicitly stating opposition to prostitution and sex trafficking and that no PEPFAR funds may be used to promote or advocate for the legalisation of prostitution.

In November, the Obama Administration proposed new regulations to govern the anti-prostitution pledge. Among other things, the proposed regulation adds language that the recipient organisation opposes prostitution and sex trafficking "because of the psychological and physical risks they pose for women, men, and children." These new regulations do not cure the free speech problems caused by the oath and will continue to threaten the effectiveness of HIV programming. At the time of writing, the final regulation had not been published.

A further challenge relates to ongoing political and monetary support for PEPFAR. There is a legitimate fear among the HIV movements that in moving PEPFAR from an emergency plan to one that is more sustainable, the US Government will not invest the needed resources for PEPFAR and the AIDS epidemic.

Global Health Initiative (GHI)

In May 2009, President Obama announced a new \$63 billion investment over six years - the Global Health Initiative (GHI) - as a critical component of US foreign policy. According to the US Government, the GHI aims to build on the "health gains" that have been achieved in relation to HIV/AIDS, malaria, tuberculosis, family planning, nutrition, maternal, newborn, and child health, and neglected tropical diseases by devoting resources to the "implementation and expansion of proven interventions through a strengthened delivery platform, with a particular focus on a woman- and girl- centered approach".¹⁰² The focus on a women and girl centered approach to health care reflects recognition of the fact that women are often marginalized from healthcare and mainstream healthcare systems.¹⁰³ The GHI's focus on integrated and coordinated health-

care and multi-sector approaches present an excellent opportunity to expand the concept of health strategies beyond disease treatment and to confront broader social and structural barriers to women's health and rights.

Requirements of a New Approach: Women-Centered Programming

Women-Centered Programming

Strategic Integration and Coordination

Country Ownership

Sustainability and Health Systems Strengthening

Improved Metrics Monitoring and Evaluation

Women must be at the center of any global health strategy. Research shows that where women are valued, protected, educated, and healthy, there are long-term benefits for their families and communities, including increased child survival, decreased health care costs, expanded access to health care for their families, and improved productivity and household incomes.

Integrate women-focused interventions among our health programs, linking maternal health services with family planning, prevention of mother-to-child transmission of HIV, and other services.

Include specific program requirements that will improve outcomes for women, including:

- Provision of community-based care
- Sex-disaggregated data collection and analysis ~ Multi-sectoral approaches/linkages
- Country-level policy reform and government capacity strengthening ~ Promotion of women as health providers and training providers in women-centered care

Establish review mechanisms to ensure that women's issues are incorporated into every stage of the GHI, including:

- Policy considerations: Identify how each health program will integrate women's issues at the policy development stage
- Procurement: Include gender considerations in procurement documents and evaluation criteria for program awards
- Metrics and evaluation: Develop indicators to track progress of a gender-integrated approach and institute a reporting requirement on gender for each health program

At present, however, the components of a "women- and girl-centred approach" remain largely undefined and a key question for the Obama Administration is what the GHI understands to be a holistic women-centred, health care system. We also question whether a "women-centred approach" necessarily translates to an approach that places women's rights at the center of health systems strengthening. The GHI aims, among other things, to improve maternal health and reduced maternal mortality as well as prevent 54 million unintended pregnancies. In this regard, a number of key questions need to be answered in respect to the type of integrated healthcare system the GHI will promote, particularly in the context of issues considered controversial in US domestic politics such as abortion, emergency contraception and access to health care for sex workers, gay, lesbian, bisexual transgender and intersex persons and other groups of individuals often marginalized from healthcare systems.

Recommendations

- **Scale-up the size of the US Government's investment in global health.** The levelling-out of US funding of PEPFAR and the meagre increases in US funds over the last two years represent a huge setback in the global response to both the HIV and violence against women and girls epidemics.
- **Ensure permanent changes to policies that have hindered and continue to hinder global responses to HIV&AIDS.** To build on the success made to date, OGAC and the US Congress must ensure that resources are directed towards evidenced-based prevention of HIV transmission among women and girls. PEPFAR's current ABC guidance should be withdrawn and replaced with guidance for comprehensive prevention including female condom programming. Legislation should be introduced to prevent the re-introduction of the anti-reproductive rights Mexico City Policy under a future administration
- **Remove the Anti-Prostitution Loyalty Oath.** Restrictions like the Anti-Prostitution Loyalty Oath hamper the ability of countries to serve those most in need to sexual and reproductive health services, often by pushing those most marginalised and discriminated, such as sex workers, underground and furthering the risk of discrimination, violence and other rights violations.
- **Ensure the Office of Global Women's Issues is resourced.** It is essential that the US Government allocates a substantial budget and staff to the Office of Global Women's Issues, with transparent reporting on allocations and spending, to support the success of the Office and the work of the Ambassador-at-Large for Global Women's Issues.

World Bank

As one of the largest long-term financers of HIV prevention, treatment, care and mitigation in developing countries, the World Bank plays a significant role in determining the degree to which national HIV strategies and plans are gender-responsive. The Bank began providing HIV funding in 1986, and thus predates PEPFAR and the Global Fund. Bank assistance to HIV initiatives comes predominantly through its International Development Authority (IDA) in the form of grants and interest-free loans. Its oldest and largest initiative is the Multi-Country AIDS Programme (MAP) in Africa and the Caribbean. The AIDS Strategy & Action Plan (ASAP) program, an effort led by the World Bank on behalf of UNAIDS, provides country-level technical support for national HIV strategy planning.

Summary of World Bank findings from *What Gets Measured Matters* (2008)

Show Us the Money revealed that the World Bank's efforts to translate progressive, gender specific policies on violence against women in the context of HIV into programming, had only been partially successful and often lacked specificity at the regional and country levels. The shortcomings in the Bank's work were seen as part of a broader problem of the Bank's systematic failure to address issues of gender inequality. Attempts to simplify key gender-related concerns in user-friendly documents and support programs that are easily replicable from one country to the next led to an overly simplistic or linear approach to gender equality.

In 2008, *What Gets Measured Matters* revealed very concerning evidence, not of progress, but rather regression. While gender equality featured prominently in the Bank's policies and strategies, its approach lacked a nuanced analysis of the multiplicity of factors influencing the feminisation of poverty, including violence against women and HIV.

The World Bank's documents and tools used both for internal planning and external analysis of global trends suffered from extreme compartmentalisation of complex issues, many of which women's rights advocates and activists, including the Women Won't Wait Campaign, regard as deeply intertwined. Since the World Bank did not track efforts to eradicate violence against women within its HIV portfolio, it was difficult for researchers of our 2008 report to ascertain exactly what proportion of programming efforts and funding streams addressed linkages between the two. Projects and programmes that did address "gender" as a thematic area, as categorized by the Bank, focused more on women as sex workers or maternal health, i.e. prevention of mother to child transmission, than on issues of violence and power relations. While it is essential that services are directed towards women who are sex workers and mothers this limited focus revealed a problematic and instrumentalist reduction of women to "carriers" of HIV.

Overall challenges

The World Bank's approach to addressing gender inequality is decidedly instrumentalist. The World Bank Group's Gender Action Plan (GAP), *Gender Equality as Smart Economics*,¹⁰⁵ which was introduced in 2006 and also endorsed by the G8, resulted from a high-level consultative meeting in February 2006 to explore the implementation challenges facing MDG 3 and to identify concrete ways to accelerate progress toward gender equality. In essence, the Bank's action plan is designed to "make markets work for women and empower women to compete in markets" which places the market at the centre of the analysis as opposed to women.¹⁰⁶ The GAP focuses largely on the concept of gender mainstreaming primarily in economic sectors, where the Bank argues it has a comparative advantage and which fits the Bank's core competencies. This focus on gender mainstreaming has persisted despite extensive critiques of gender mainstreaming in the wider women's rights movement.

Notably, the GAP recognises some of the shortcomings in the Bank's work to date in relation to gender, including weaknesses in measuring the sex-disaggregated impact of the Bank's assistance.¹⁰⁷ The focus on enhancing "women's contribution to economic growth", however, greatly diminishes the ability of Bank-funded programmes to practically address endemic and entrenched gender inequality, as well as the intersections

between HIV and violence against women and girls. Most glaringly, the Bank's framework lacks a human rights approach, an essential lens through which to analyse gender inequality, the denial and violations of women's rights and the intersection between the two pandemics.

World Bank spending on HIV and sexual and reproductive health has declined in recent years, ostensibly because of the increase in spending by other multilateral and bilateral donors such as the Global Fund and OGAC.¹⁰⁸ World Bank funding specifically for HIV dropped from a peak of USD1.3 billion and 23 projects in 2004 to USD790 million and 10 projects in 2006, representing a 40 percent decline in funding and a 57 percent decline in the number of projects.¹⁰⁹ Spending on population and reproductive health projects declined by 30 per cent, from USD1.8 billion in 2003 to 1.3 billion in 2006.¹¹⁰

Furthermore, while it may be true that new actors are "filling the void" to fund HIV and SRRH programs, there are concerns about the impact of Bank policies on public health spending. The Bank traditionally adopted Structural Adjustment Programs (SAPs) for developing countries, which tended to promote privatization and deregulation, including in health and education sectors, without appropriate guarantees for universal access to affordable health care. While the Bank has moved away from imposing direct cuts on public spending, the International Monetary Fund ("IMF"), a partner of the World Bank, continues to engage in forms of conditionality, which often lead to public spending caps in an effort to reduce budget deficits. While the Bank is attempting to focus more on financing individual projects as opposed to advising on broader macro-economic reforms, it continues to favour countries with IMF programs in place. Furthermore, while the Bank claims to have moved away from promoting cuts in public spending in the 1990s, it has not done so consistently. One study reveals that the World Bank funded Multisector HIV/AIDS Project in Ghana was promoting user fees for ARTs.¹¹¹

In light of the cross-conditionalities that result from the Bank's partnership with the IMF and inconsistencies in the Bank's decisions to move away from promoting a reduction in public spending and increased burdens for financing health care on individuals, the Bank's approach continues to constitute a major threat to women's rights. What begin as legitimate calls by the Bank and other major financiers for governments to engage in more efficient financing and service delivery, often translate into reduced public health expenditure, cuts in service delivery and/or quality. In turn, this increases women's burden of unpaid care, reduces women's ability to participate in paid work and undermines public health programming to address HIV and reproductive health, let alone violence against women and girls.¹¹²

ASAP, the AIDS Strategy and Action Plan, which began operating in 2006, provides external reviews of actual or draft national HIV strategies. Interestingly, the review of 34 national strategic plans in 2009 indicated that most plans could benefit from greater attention to gender and to marginalised groups.¹¹³ Yet, the Bank does not provide guidance to countries and regional initiatives on how to address these shortcomings.

A further and glaring issue that has emerged not only in this review but also persistently in *Show Us the Money* and *What Gets Measured Matters* is the lack of publicly-available, detailed data on project spending. Even where Bank-funded projects address HIV or gender, these components are embedded so deeply within health or social spending that it is virtually impossible to track specific spending on such components as HIV prevention, treatment, care and support or reproductive health more broadly. Similar concerns about Bank transparency, in the context of HIV funding, have been raised by other organisations, including the HIV/AIDS Monitor at the Center for Global Development.¹¹⁴ The Bank needs to prioritise disaggregating project spending data to enhance transparency and civil society monitoring.

In this section we discuss what is publicly available from the World Bank in relation to HIV and gender, including

the Two-Year Progress Report to the World Bank Group's Gender Action Plan and the Agenda for Action – World Bank's Commitment to HIV/AIDS in Africa (2007-2011).

Gender Action Plan – Two-Year Progress Report

As of January 2009, the World Bank's Gender Action Plan (GAP) had allocated USD 29.3 million to initiatives in its four main action areas: operations; results-based initiatives; research, impact evaluation and statistics; and communications including the Adolescent Girls Initiative and the Doing Business Gender Project.¹¹⁵ The GAP is an embodiment of the market driven analysis that the World Bank employs, reflecting a concern with women's empowerment only insofar as it supports women's engagement with markets. Consequently, the GAP lacks a human rights approach despite the centrality of human rights to poverty reduction and development. As a result, the Bank ignores in its entirety the central element of empowering women to enhance women's abilities to claim their human rights.

Interestingly, the importance of a human rights approach for achieving good governance and political stability has not surfaced in the World Bank approach to date despite the fact that thirteen of the 72 countries that receive funding for women's empowerment work are considered "fragile states."¹¹⁶ Despite the grave need for specific attention to both violence against women and girls and the heightened risks of HIV infection in conflict and post-conflict settings, these issues are left unaddressed. The GAP also maintains a focus on the private sector and women's participation in and benefits from private sector development projects, thereby failing to challenge the previously criticized privatisation framework.¹¹⁷

The Adolescent Girls' Initiative (AGI) is a new programme launched in 2008 as part of the GAP, designed to "smooth the transition from school to productive employment for girls and young women aged 16-24 by helping them complete their education, build skills that match market demand, find mentors and job placements, and by offering incentives to potential employers to hire, retain and train young women."¹¹⁸ Five countries that are slated to receive funding for the AGI are post-conflict settings, namely, Afghanistan, Liberia, Nepal, Sudan and Rwanda. However, there is no mention of addressing violence in young women's lives or the impact that violence has on the ability of girls to access and perform in education or achieve economic security, empowerment and autonomy. Similarly, while recognizing that a major challenge to the GAP's implementation is the fact that a significant number of GAP initiatives are in post-conflict countries, the GAP Two-Year Progress Report does not directly discuss violence against women.

Furthermore, although the GAP Two-Year Progress Report refers to the financial and food crises, both of which have direct impacts on the risks facing women and girls of both violence and HIV, the World Bank once again solely restricts its focus to the market, focusing on women as "economic agents".¹¹⁹ Despite recognising how women's participation is compromised by socio-economic factors, including those resulting from the food and financial crises, the Bank nonetheless maintains a narrow focus on women as producers in the market.

Perhaps the greatest weakness in the Gender Action Plan is that it is structurally undermined by the Bank's own Operational Policy (OP). OP 4.20 renders the Gender Action Plan virtually ineffectual by excluding development policy loans from the mandate for gender integration.¹²⁰ These policy-based loans account for 25-50% of World Bank loans.¹²¹ While the Bank states it is moving away from harmful economic policy conditions, due to engagement in cross-conditionality, these loans continue to impact public sector expenditure on healthcare and increase the demand on women as unpaid carers that result from reductions in government-provided social services.¹²² As a consequence of OP 4.20, a significant portion of Bank loans are outside of the purview of the Bank's only mandatory gender and development policy, leaving some of the most harmful impacts on the rights of men and women unchecked.

World Bank's Commitment to HIV/AIDS in Africa: Agenda for Action, 2007-2011

The Agenda for Action (AFA) is a five-year action plan for the World Bank's support to sub-Saharan Africa in response to the HIV/AIDS epidemic.¹²³

The AFA has four principal objectives:¹²⁴

- **Reaffirm** the World Bank's commitment to long-term support for curbing the spread of HIV/AIDS in Africa;
- **Articulate** the comparative advantages of the Bank in a harmonized international programme of support and, consequently, the potential role for the Bank;
- **Identify** priority interventions for the next generation of activity, whether funded by the Bank or others, based on evidence of success and lessons of experience; and
- **Specify** actions the Bank will need to take to ensure it can respond to the demands of member countries and other partners for financial, technical, analytical, and collaborative support.

The AFA is the second stage of the World Bank's Multi-Country AIDS Programme (MAP), which was approved in 2000 as a 15-year strategy. Devised in three stages, the first phase of MAP focused on an emergency response; the second phase, through the AFA, is focused on scale-up and mainstreaming prevention, treatment, and care; while in the final phase, MAP will move to targeting groups or areas where HIV persists.

A recent analysis by the Center for Global Development reveals that MAP programmes vary considerably by country and depend on the commitment of the recipient and sub-recipient organisations to ensure the integration of a gender analysis.¹²⁶ MAP project appraisal documents contain little analysis of how gender inequality shapes the spread and impact of HIV. Even when there appears to be a gendered approach, this analysis does not inform strategic plans or programmes but remains at the level of assessments and programme design. In the limited instances where there is integration at the operational level, the lack of follow-up hinders the extent to which gender-related risks are analysed. The MAP also has no means of tracking spending on gender as there is no dedicated budget line for MAP funded gender-related activities.¹²⁷

A further glaring omission in the AFA is the lack of attention paid to the socio-economic impact of HIV on women's productivity. There is abundant evidence that women carry the greatest burden of care when a family member becomes ill as a result of HIV. In many situations, women are not able to continue to engage in work force participation and, when they do remain in the workforce, they suffer the double burden of work in the market economy and at home. Often, it is girls and elderly women who end up as caregivers and may face risks of violence in this capacity. The AFA acknowledges an "impact on households and welfare" of the HIV epidemic, referring to women's "limited empowerment and restricted access to and control over resources, assets, and opportunity".¹²⁸ Nonetheless, the World Bank's analysis of the implications remains limited to the economic realm, including the interrelationship between the epidemic, a drop in economic productivity, depleted household savings, decreased consumption and a reduction in investment opportunities.¹²⁹ The socio-economic impacts, including violence against women, are omitted from the Bank's analysis.

Recommendations

- **Prioritise women's empowerment as an end in and of itself.** The Bank's policies, programs and funding priorities must move away from the current focus on women as instrumental to reducing poverty and inducing economic growth. The Bank must pay attention to securing the rights of women and gender equality. Economic growth alone is not sufficient to overcome poverty and simultaneously may exacerbate gender inequalities, when women's rights and social justice has not been taken into account.
- **Increase expertise about gender issues and the underlying determinants of gender inequality within the Bank.** Bank publications, policies and tools should demonstrate a stronger gender analysis with greater attention to the gender-specific causes and consequences of HIV and specifically violence against women.
- **Prioritise funding for HIV strategies that include programming on violence against women.** Bank loans and grants can be made contingent on addressing violence against women and girls in the context of HIV strategies. World Bank's Commitment to HIV/AIDS in Africa: Agenda for Action, 2007-2011 and the Adolescent Girls' Initiative must be expanded to address violence against women in conflict-ridden and post-conflict countries.
- **Ensure the inclusion of gender equality indicators and sex-disaggregated data.** Although MAP documents emphasise gender on paper, the key indicators used in MAP programmes do not show how these programmes are gender-sensitive and respond to gender inequality.
- **Remove the exemption for development policy loans for having to meet Operational Policy 4.20.** Requiring all development policy loans to meet Operational Policy 4.20 is essential to ensure that all World Bank development loans are implemented with a gender perspective and to enhance the effectiveness of the Gender Action Plan.¹³⁸

The UK Department for International Development (DFID)

DFID is the development aid agency of the United Kingdom, leading the government's global anti-poverty strategy. In 2008/09, DFID provided £5.5 billion in aid to poorer countries.¹³¹ DFID's overseas development aid budget will increase to £7.8 billion by 2010/11. By 2013, the equivalent of 0.7% of the UK's gross national income will be dedicated to development assistance, an increase from 0.36% in 2007/08. DFID supports multilateral funds such as the Global Fund, with up to £1 billion dedicated to the Global Fund until 2015.¹³² The Department also supports the drug purchasing facility UNITAID, which has helped to provide more than 75.6 million people on treatments for HIV&AIDS, Tuberculosis and malaria.¹³³

Summary of DFID findings from *Show us the money* (2007)

Show Us the Money noted DFID's strong commitment to fighting HIV&AIDS, as the second largest bilateral donor for HIV&AIDS programming (after the US) and as a major advocate on the issue at the 2008 Gleneagles G8 Summit. However, DFID's lack of an incisive and detailed gendered analysis of the links between HIV and violence against women and girls was clear. DFID was found to be operating within a policy framework that at the broadest level viewed HIV&AIDS and violence against women as linked. However, when our analysis moved beyond what was said in public speeches to what directives were actually written into policy and what was being done at the country and project-level, it became obvious that HIV and violence against women were often presented as parallel rather than intersecting. *Show Us the Money* noted a lack of a marker for work on violence against women in DFID's database of grantees, an absence of clear HIV&AIDS budget lines and in line with the *Paris Declaration on Aid Effectiveness*, a tendency to adopt a sector-wide approach to funding, rather than the more easily tracked program spending. The absence of clear budget lines, combined with mainstreaming of HIV&AIDS into wider programme areas, such as health, education and poverty eradication, made it difficult for our researchers to compile accurate financial information. We also found that DFID's policy recognition of the importance of integrating sexual and reproductive health and rights, HIV&AIDS and gender more broadly had not yet manifested as intersectional programming. At the time, we anticipated the emergence of new challenges for CSOs around monitoring and evaluating DFID's efforts in light of the continuing trend to move from direct financing of projects to sector-wide approaches. At the time of writing *What Gets Measured Matters*, DFID had not released its new HIV and AIDS strategy. As a result, DFID was not reviewed in the 2008 report.

UK Global Health strategies

In June 2008, the UK Government released its second strategy for halting and reversing the spread of HIV in the developing world, along with a pledge of £6 billion until 2015 to strengthen health systems and services.¹³⁴ This investment in the international effort to achieve stronger health systems around the globe is unprecedented. However, it reveals a significant shift in DFID's approach which will have implications for the global AIDS response and work that addresses the intersection between HIV and violence against women.

As with the US Government's focus on promoting "women- and girl-centred health care", DFID's commitment to fund health systems strengthening begs the question of what the department understands to be a "strong" health system. In particular, what remains as yet undefined is how and to what extent, in DFID's view, a strong health system would advance women's rights to the highest attainable standard of health and incorporate violence-related interventions and ensure integrated programming in relation to violence against women, HIV and sexual and reproductive health.

Finally, transparency remains a persistent problem with regard to civil society monitoring of DFID's funding, particularly in the realm of HIV and violence against women. Part of the challenge in tracking DFID's spending stems from the department's ongoing multilateral efforts and the inability of even DFID to identify the particular impact of its attribution of funds to multilateral initiatives, such as the Global Fund.¹³⁵ However, despite the monitoring challenges facing DFID as a bilateral donor and major contributor to global multilateral

efforts, DFID must unquestionably improve its monitoring of HIV and violence interventions. In light of DFID's decentralised and country-level funding model, it is particularly important that all country programmes are provided the necessary tools to aid country-level tracking of budget allocations and spending.

Achieving Universal Access: The UK's Strategy for Halting and Reversing the Spread of HIV in the Developing World (Achieving Universal Access Strategy), 2008-2015

This second strategy document lays out DFID's priorities for 2008-2015 and builds on the work of *Taking Action*, the UK's first strategy for tackling HIV (2004-2008). In the Achieving Universal Access Strategy, DFID continues to assert itself as a champion of a human rights approach to HIV programming and of integrating HIV and SRH services to achieve universal access. DFID sees this as a cornerstone of its response to the epidemic and maintains a gender analysis, in particular with regards to understanding gender inequality as a driver of the HIV epidemic and the need for a comprehensive and multi-sector approach for longer term change.¹³⁶

The Achieving Universal Access Strategy identifies four main priorities in the effort to halt and reverse the spread of HIV:¹³⁷

1. Increase effort on HIV prevention; sustain momentum for treatment; increase effort on care and support;
2. Respond to the needs and protect the rights of those most affected;
3. Support more effective and integrated service delivery; and
4. Making money work harder through an effective and co-ordinated response.

Priorities 2 and 3 focus on addressing the human rights and gender-related consequences of the HIV epidemic. The scope of issues articulated in DFID's Achieving Universal Access strategy includes stigma and discrimination, integration of gender analyses into national AIDS plans, participation of HIV positive people, and politically sensitive issues such as adolescent SRRH, men who have sex with men, and harm reduction. The language is direct and informed by current thinking on HIV and human rights. DFID promotes integrated service delivery, taking into account a range of essential services that are geared toward women and girls, in particular health services and education. Unfortunately, the final priority 5, "How we will turn our strategy into action," negligibly addresses only some of our key questions around staffing numbers and capacity.

Violence against women and girls is partially addressed within DFID's Achieving Universal Access Strategy. In the call for longer term change, there is an acknowledgement of the need to transform gender norms and address the structural inequalities that women and girls face:

Effective action on AIDS also requires long-term changes in deep-rooted human attitudes and behaviours. It is important to work more with men and boys, and with the justice and education sectors, to change attitudes towards violence against women, harmful traditional practices (such as child marriage and female genital mutilation) and other structural inequalities.¹³⁸

DFID's Achieving Universal Access Strategy reflects recognition that violence against women and girls significantly increases their risk of HIV infection as well as the increased risk of violence for women who test positive for HIV. DFID notes that, "women and girls report increased violence for refusing sex, requesting

condom use, accessing HIV counselling and testing, and for testing HIV-positive.”¹³⁹ It appears, however, that DFID’s response to the intersectional relationship between the twin epidemics is through health systems strengthening and multi-sector approaches. More specific details are absent from the strategy. Education programmes are also put forward as a key way to challenge attitudes around masculinity and violence.¹⁴⁰ Aside from these and scattered references to the importance of programmes that work with men and boys to challenge gender norms, there are no other specific recommendations in DFID’s Achieving Universal Access Strategy to concretely address the links between HIV and violence against women and girls.

Intersectional programming and monitoring

To date, DFID has unquestionably prioritised funding strategies aimed to broadly achieve gender equality and women’s empowerment. DFID does not altogether fail to acknowledge violence against women as an obstacle to battling HIV&AIDS in its programming. However, lack of publicly available data makes it difficult to discern the extent to which the intersection is being address at a programmatic level.

The Achieving Universal Access Strategy discussed above includes a companion document, a Monitoring and Evaluation Framework.¹⁴¹ It contains one violence related question in the reporting template for DFID country offices that recognizes the relationship between HIV and violence: “What is DFID doing to reduce women’s susceptibility to HIV infection, e.g. gender-based violence?” There are several other monitoring provisions that could assist in undertaking a gender analysis. However, country staff and aid recipients would require specific guidance and support to be able to fully maximize these monitoring opportunities.

In other programming documents, it is clear that DFID lacks an intersectional approach. For example, the Africa Gender Equality Action Plan 2009-12,¹⁴² for example, outlines how DFID-funded programmes will work to increase economic opportunities for women; facilitate their social and political empowerment; ensure progress is made towards eliminating gender-based violence; and strengthen DFID’s and its partners’ capacity to deliver on gender equality. However, neither the components addressing HIV prevention, treatment and care, including for pregnant women living with HIV, nor those commitments outlined for combating violence against women, recognise the complex intersection between the causes and consequences of both. Instead, both are outlined vertically in silos.

At a policy level, DFID has long acknowledged the close links between promoting sexual and reproductive health and tackling HIV&AIDS. Regrettably, DFID has indefinitely postponed the publication of its Maternal Health and Sexual and Reproductive Health and Rights Strategy, initially planned for mid- 2009.¹⁴³

International Health Partnership

Former Prime Minister Gordon Brown launched the International Health Partnership (IHP+) in September 2007, as part of a renewed global push to meet the MDGs on health. The IHP+ has three main goals in the context of donor aid for health reforms:

- focusing on improving health systems as a whole and not just on individual diseases or issues;
- providing better coordination among donors; and
- developing and supporting countries’ own health plans.

Initially, eight “first wave” countries in Africa and Asia signed IHP+ compacts, involving a negotiated agreement between governments, donors and national stakeholders on identifying, mobilizing and using resources more effectively and with greater accountability.¹⁴⁴

However, the £6 billion commitment has been earmarked for health systems strengthening with little to no guidance on how to shape proposals addressing gender and human rights within that framework. The UK Parliament itself has noted with concern that “DFID has no mechanisms in place to track the impact which its £6 billion funding for health systems will have specifically on HIV/AIDS care, despite this being one of the key elements of its Strategy” and rejected DFID’s assertion that it is not “feasible, practical or desirable” to specify how its £6 billion in health systems funding will be allocated.¹⁴⁵ They in turn recommended that DFID provide a meaningful breakdown of its spending plans for this funding package, at least over the next two to three years, including an indication of how HIV/AIDS programmes are likely to benefit.¹⁴⁶ The Women Won’t Wait Campaign supports this recommendation and recommends also that DFID outlines its health system spending plans in the context of violence against women, as well as integrated programming for violence, HIV and sexual and reproductive health services.

In its assessment of DFID’s health system strategy, the UK Parliament has also noted that not all HIV prevention and long-term care takes place within the health system and that DFID must ensure that the HIV&AIDS Strategy, within and outside of health system strengthening, continues to reach marginalised groups.¹⁴⁷

As noted elsewhere in this report, recent changes in the aid environment have had and continue to have a persistent impact on the level and scope of funding for projects and programmes addressing the two epidemics. In light of the change of government in the UK in May 2010, it is difficult to predict how the IHP+ will develop or what issues will form the core of DFID’s investment in health systems strengthening in the years to come.

Recommendations

- **Increase transparency in how DFID funds are allocated and utilised.** DFID must take greater steps to create an enabling environment for civil society monitoring. While DFID has a fairly thorough gender analysis of the HIV epidemic with a clear articulation of the intersectional relationship between HIV and violence against women and girls at the policy level, this must be translated into priorities, budgets and staffing at a programmatic level.
- **Provide a more detailed outline of DFID’s priorities within health system strengthening.** The dedication of funds to health systems strengthening, while relevant and long-term in approach, has the potential to limit the extent to which DFID address the complex intersection between HIV and violence. It is essential that DFID provides concrete and transparent information on how its funding of health system strengthening will enhance fulfilment of the right to health of all women.
- **Create gender equality indicators for programme staff, including indicators for violence-related intervention specifically, as well as in the context of HIV&AIDS.** DFID must also create monitoring and evaluation mechanisms to monitor how its funds for health systems strengthening will specifically promote an integrated approach to violence, HIV&AIDS, SRRH and gender equality interventions.
- **Ensure ongoing investment towards achieving the goal of universal access.** The USD 3 billion funding shortfall announced by the Global Fund to fight AIDS, Tuberculosis and Malaria will affect its ability to deliver vital HIV programmes. DFID is a long-term contributor to the Global Fund and must use its role as a leading bilateral and multilateral donor to encourage other governments and international donors to make substantial and predictable financial commitments to the Global Fund.

4. Health systems strengthening: Promoting investment in women's and girls' right to health

Since the adoption of the Millennium Declaration in 2000 and the endorsement by the UN General Assembly of the time-bound Millennium Development Goals (MDGs) in 2001, the World Health Organization (WHO) and other agenda-setting bodies have encouraged donors and policy makers to focus on health systems strengthening (HSS) as a way to promote development in the health sector. Both multilateral and bilateral donors, such as the Global Fund, OGAC and DFID, have responded to this call. In the case of DFID, the UK government has pledged to invest £6 billion over seven years to strengthen health systems and services.¹⁴⁸ This pledge has come at a time where US funding for PEPFAR has been levelling out, the meagre increases in US funds over the last two years undermining progress in responding to the HIV epidemic.

As WHO has identified, the renewed commitments and energy of a number of governments around the world to HSS presents an opportunity to create sustainable change and enhance global efforts to meet the MDGs. It is, however, critical that we determine what is meant by a strong health system, particularly in the context of women's rights to health and health care, and how health systems can adopt an integrated approach to providing health care in the context of HIV, violence against women and other sexual and reproductive rights and health issues. It is also an opportunity to give attention to the "development dimensions" of HIV and address the structural drivers that fall outside of the health sector which are nonetheless central to achieving positive changes to health and human rights more broadly.

There are persistent voices especially in civil society that support the exceptionality of HIV and believe in separate and specialized services to reach most at-risk groups. These voices have challenged the argument that AIDS exceptionality has distorted health systems as well as the notion that HSS in and of itself will address the HIV crisis and prevent its spread and mitigate its impact. It is essential that the HSS initiatives not be used as vehicles to abdicate donor and national governments' responsibilities to achieve Universal Access to prevention, treatment, care and support as enshrined in the 2001 Declaration of Commitment. The 'choice' between HSS and HIV is a false and dangerous one. Rather, multilateral and bilateral donors and national governments must continue to invest in HIV and violence against women interventions specifically, and as part of promoting stronger health systems. In fact, the response to both these epidemics must be seen as a unique opportunity to strengthen the wider health sector and achieve broader gender equality and human rights goals. Integration is essential if we are to achieve this goal. Any effort directed towards HSS must promote enhanced health-related HIV services, including voluntary counselling and testing, male and female condom programming, PMTCT and treatment within health systems while promoting greater synergies with other sexual and reproductive health services. This is essential to building a strong and sustainable health system. Simultaneously, we must continue to reach at-risk groups who are marginalized, excluded from or discriminated against in health systems or for other reasons, seek treatment, support and care outside of mainstream health systems.

Defining a strong health system

According to WHO, "HSS means addressing key constraints related to health worker staffing, infrastructure, health commodities (such as equipment and medicines), logistics, tracking progress and effective financing".¹⁴⁹ WHO further notes that a health system "needs to provide services that are responsive and financially fair, while treating people decently".¹⁵⁰ This final element is central and it is pivotal that all health care systems adopt

a rights-based approach to health. The Beijing Declaration and Platform for Action also notes that health “is a state of complete physical, mental and social well-being and not merely the absence of diseases or infirmity”.¹⁵¹ It further states that health systems and programmes often fail to consider the socio-economic inequalities facing women or the lack of autonomy that a woman may have regarding her health.¹⁵²

The right to the highest attainable standard of health has been articulated in several of the international human rights treaties to which governments around the world have committed. This includes the International Covenant on Economic, Social and Cultural Rights which has been ratified by 160 countries and sets out basic global standards on the fundamental nature of the right to health.¹⁵³ The right to health contains both freedoms and entitlements. The freedoms include the right to control one's health and body, including sexual and reproductive freedom, and the right to be free from interference, such as the right to be free from non-consensual medical treatment and experimentation. By contrast, the entitlements include the right to a system of health protection which provides equality of opportunity for people to enjoy the highest attainable level of health.¹⁵⁴

According to WHO, a rights-based approach to health means integrating these human rights norms and principles in the design, implementation, monitoring, and evaluation of all health-related policies and programmes.¹⁵⁵ Human dignity is at the core of a strong health system and attention must be paid to the needs and rights of marginalised and excluded groups. A health system must be made accessible to all, with non-discrimination on the basis of sex, sexual orientation and gender identity. Furthermore, mechanisms must be in place to prevent violations perpetrated by health personnel, including forced sterilisations and forced abortions suffered by women living with HIV&AIDS. Integrating human rights into development also means empowering poor people, ensuring their participation in decision-making processes which concern them and incorporating accountability mechanisms which they can access.

HSS must be designed to benefit all women and men. However, it is a particular paradox that health services are so often inaccessible to women or unresponsive to their needs given that health systems are so highly dependent on women, who form the backbone of the formal healthcare workforce and informal provision of health care within the family.¹⁵⁶ This fact must form the basis of any donor funding and programmes designed to strengthen health systems. According to international standards, comprehensive national development strategies should promote women's rights to health throughout their life span¹⁵⁷ and it is essential that donor money be directed towards such strategies. HSS, therefore, must incorporate interventions aimed at the prevention and treatment of diseases affecting women, while integrating policies to provide access to a full range of high quality and free health care, including SRH services.¹⁵⁸ The realization of women's right to health requires the removal of all barriers interfering with access to health services, education and information, particularly in the area of SRH while simultaneously addressing the specific needs of survivors of violence and/or those living with HIV.

Integration of HIV, SRRH and VAWG

The 54th Session of the Commission on the Status of Women in 2010 emphasised the need to “strengthen policy and programme linkages and coordination between HIV and AIDS and SRH, and their inclusion in national development plans, including poverty reduction strategies and sector-wide approaches”.¹⁵⁹ All policies guiding the funding priorities and work of donors and other institutions must incorporate such an approach.

There may, however, be significant challenges faced in re-designing health systems to better address the

intersection. This is particularly the case where health systems have been designed and normalized to operate a multi-pronged and yet parallel approach to HIV, SRRH and violence against women and girls. Furthermore, the stigma often associated with perceived or real HIV status or being a survivor of violence, has made integration of all services and outreach to all women, in mainstream health systems, a challenge. Whether we are to integrate HIV interventions into SRH infrastructure or vice versa, incorporating violence prevention, detection and management is critical. Moreover, when working to improve health care systems, it is essential that we promote an integrated approach to HIV, violence against women and SRRH more broadly from the outset.

Integration on the ground: Turning policy into practice with the Essential Services Package

The global community is at a juncture where there is substantial evidence defending the need for meaningful and cost-effective integration of interventions for HIV, SRRH and violence against women and girls at the country level. In an effort to guide how donors and other institutions operationalise their policies, the Women Won't Wait Campaign has developed the Essential Services Package (ESP) which offers concrete strategies for integrated programming based on experiences from around the world. The ESP offers guidance on a set of services that must be provided in key settings, including health systems, humanitarian and disaster zones and by schools, law and policing personnel, to comprehensively address HIV, violence against women and girls and SRH, with a coordinated, cost-effective, efficient and human rights based approach.

Our call: What do we expect from donor and institutional policy and practice?

Donors and other institutions are increasingly seeking to promote stronger health systems, including the US Government through its Global Health Initiative (GHI) and the UK Government, through its substantial investment in HSS and its International Health Partnership (IHP). Creating an environment for women to reach the highest attainable standards of physical and mental health will require such initiatives as the GHI and IHP to not only promote basic health services, but to recognize and address the economic, cultural, social, and legal barriers facing women and girls seeking to access those services.¹⁶⁰ To successfully foster strengthened health systems, both initiatives must address the many experiences of discrimination that a woman may have throughout the course of her life and create a legal and social environment in which women can make autonomous decisions about their bodies, health and health care. Moreover, a truly stronger health system is only one that offers integrated, gender-sensitive and rights-based services for all women and men.

Further, in strengthening health systems, donors and international institutions must ensure they respond to women's needs and advance women's rights more broadly. This includes recognizing that women and girls are disproportionately burdened with unpaid care work and expanding and investing in public health services in order to shift the burden of care from women to states. This would thereby strengthen women's workforce participation and increase women's economic security, empowerment and autonomy. Shrinking public expenditure and the "commercialisation" of existing public services has had devastating impacts on women and girls, both in terms of their ability to access their rights to education, health, etc., as well as on their increased burden of care. There is a case to be made for an end to women's unpaid labour subsidising states and reinvestment in existing public services such as health and education, so as to increase women's economic security, empowerment and autonomy.

This review of the current policies and funding priorities of key donors and agenda-setting agencies reveals

how increasing attention is being paid to health systems as a pivotal element of national and international development strategies. HSS offers an entry point to continue to promote integration of services designed to address HIV, violence against women and girls and SRRH more broadly. The ESP provides a tool for operationalising integration on the ground. Integration of this kind stands at the forefront of ensuring sustainable and strong health systems.

5. Conclusions

While recognising the distinct differences in the goals and missions of the institutions analysed in this report, our three assessments since 2007 have highlighted significant and important disparities in the progress made by each of these institutions. This includes the extent to which each institution recognises violence against women and girls as a cause and consequence of HIV, and whether a transparent process exists to facilitate civil society oversight. Indeed, even where progress has been made, it is clear that we are only part of the way towards achieving truly integrated responses to the two epidemics.

UNAIDS' Action Framework on Women, Girls, Gender Equality and HIV, along with the Outcome Framework, and particularly Priority 8 on meeting the HIV needs of women and girls and stopping sexual and gender-based violence, are important steps in UNAIDS' role in setting the global agenda on gender equality in HIV policies and programs. We hope UNAIDS' achievements will have far reaching effects on the approaches of the other institutions analysed in this report. What is as yet unclear, however, is the link between UNAIDS' global policies and its programmatic work on the ground. It remains to be seen whether sufficient resources will be allocated to make the Agenda for Accelerated Country Action for Women, Girls, Gender Equality and HIV for 2010-2014 or indeed the Outcome Framework priority area real and effective in achieving multi-sector services for HIV, violence and SRRH more broadly. The Global Fund, too, has made significant strides in addressing gender equality through its Gender Equality Strategy, yet remains limited by the lack of indicators for Country Coordinating Mechanisms (CCMs) to measure gender-related outcomes. It is hoped that UNAIDS's Agenda for Accelerated Country Action, can in part, address this shortcoming and offer some guidance to CCM's to design and monitor interventions on HIV and violence against women.

The US Government's Global Health Initiative (GHI) marks a positive step towards holistic health sector reform. The US Government, through its Office of the Global AIDS Coordination and PEPFAR, arguably more than the other four institutions, recognises how SRRH, violence against women and HIV intersect. While the impact of the Country Operational Plan Guidance for 2010-2011, designed to facilitate improved monitoring of performance in relation to HIV and violence, remains to be seen, it is a commendable step towards increased transparency of monitoring and evaluation. However, PEPFAR remains plagued by its continuing emphasis on "abstinence" and "be faithful" programming and the Anti-prostitution Loyalty Oath (APLO), which acts as a severe threat to the effectiveness of HIV programming in reaching at-risk groups. Along with the flat-lining of US funding, we appear to be at a juncture where the progress achieved through US Government support could see concerning reversals in the coming years.

Compared with PEPFAR, the Global Fund and UNAIDS, funding for HIV by DFID and the World Bank is widely dispersed, cutting across other themes. When it comes to the World Bank, gender equality is contextualised within the primary goal of economic and market growth. Bank funding continues to be allocated, including to the HIV epidemic, without attention to women's heightened risks of violence, even where violence against women specifically impacts women's economic productivity, an area of particular concern for the World Bank. Not only does a lack of disaggregated data on project spending make monitoring and evaluation of the Bank's work impossible, but furthermore, the lack of strategic policies to address the relationship between women's empowerment and rights, as an end in themselves, as well as a driver for economic development, undermine the efficacy of Bank loans.

DFID, while clearly recognising the bi-directional relationship between HIV and violence in its 2008-2015

strategy document, *Achieving Universal Access*, continues to primarily channel money into health system strengthening (HSS). While the size of DFID's contribution is commendable, this approach makes it difficult to discern how this investment will improve the ability of health systems to respond to violence against women, HIV and multiple forms of gender-based discrimination.

As with the World Bank, the lack of publicly available information makes it difficult for civil society to accurately assess how DFID's £6billion will be used to transform health systems in countries where a two-track approach to violence against women and HIV has been normalised. Indeed, it seems that DFID itself has yet to define how its broad investment in HSS will be allocated to individual issues.

An overarching conclusion when analysing the five institutions is the importance of accountability mechanisms for CSOs that are working to monitor these institutions and advocate for changes to policies at the global level and practices at the country level. In this regard, CSOs welcomed the opportunity to engage with UNAIDS on the development of the *Agenda for Accelerated Country Action*. Such civil society participation must be sustained. It is essential that external observers can track and monitor funding for HIV, violence against women and SRRH more broadly in order to continue to advocate for an integrated, multi-sector approach to health systems to address the needs of women and girls.

6. Annexes

Annex I: Acknowledgements

We chose *What's the budget? Where's the staff?* Moving from policy to practice as the title of this report because it poses questions that are critical to the success of any initiative on women's rights, violence against women in and of itself and when it intersects with HIV. We offer thanks to the many activists who have ensured that these questions are consistently posed, and we acknowledge Peggy Antrobus for most recently articulating the core of these resource questions in such a precise way.

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The research conducted for this report was carried out by Surabhi Kukke, who contributed to drafting substantial components of this report. The section on PEPFAR was predominantly authored by Maeve McKean. The final report was drafted by Ramona Vijeyarasa, and Neelanjana Mukhia.

The analysis and our findings should only be attributed to the authors.

Personnel attempted to be contacted for this study

As noted above, we made persistent attempts to contact all of the five institutions analysed in this report. Unsuccessful attempts were made to contact individuals at the following organisations:

- Global Health Council (contacted October 2009);
- the Global Fund for AIDS, Tuberculosis and Malaria (contacted August 2009);
- the US Office of the Global AIDS Coordinator OGAC (contacted September 2009);
- The Global Fund (contacted August 2009);
- The World Bank (contacted July and November 2009); and
- DFID (contacted July and September 2009).

Annex II: Abbreviations

ABC	abstain, be faithful, use condoms
ART	anti-retroviral treatment
CCM	country coordinating mechanism (within GFATM)
COP	Country Operational Plan (within PEPFAR)
CSO	civil society organisation
DFID	(UK) Department for International Development
GFATM	Global Fund to Fight AIDS, Tuberculosis and Malaria
HSS	health systems strengthening
IDA	International Development Authority (within the World Bank)
MAP	Multi-Country AIDS Programme (of the World Bank)
OECD/DAC	Organization of Economic Cooperation and Development/Development Cooperation Directorate
OGAC	US Office of the Global AIDS Coordinator
PCB	(UNAIDS) Programme Coordinating Board
PEP	post-exposure prophylaxis
PEPFAR	(US) President's Emergency Plan for AIDS Relief
PMTCT	prevention of mother-to-child transmission
SRRH	sexual and reproductive rights and health
UBW	Unified Budget and Workplan (within UNAIDS)
UNAIDS	Joint UN Programme on HIV/AIDS
UNDP	United Nations Development Programme
UNFPA	United Nations Population Fund
UNIFEM	United Nations Development Fund for Women
USG	US government
WHO	World Health Organization

Annex III: Endnotes

- ¹ Cynthia Rothschild, Mary Anne Reilly and Sara A. Nordstrom, *Strengthening Resistance: Confronting Violence Against Women and HIV/AIDS*. Center for Women's Global Leadership, 2006; Suzanne Maman et al., The intersections of HIV and violence: Directions for future research and interventions, *Social Science Medicine* (2000) 50(4): 459-78. See also Naeemah Abrahams et al., Sexual violence against intimate partners in Cape Town, South Africa: Prevalence and risk factors reported by men, *Bulletin of the World Health Organization* (2004) 82: 330-337; Claudia Garcia-Moreno et al., *WHO Multi-country Study on Women's Health and Domestic Violence against Women*. World Health Organization and PATH, 2005; Vivian F. Go et al., When HIV prevention messages and gender norms clash: The impact of domestic violence on women's HIV risk in slums of Chennai, India, *AIDS and Behavior* (2003) 7(3): 263-272; Ariane van der Straten et al., Sexual coercion, physical violence and HIV infection among women in steady relationships in Kigali, Rwanda, *AIDS and Behavior* (1998) 2(1): 61-73 among others.
- ² UNAIDS, *Status of the Global HIV Epidemic: 2008 Report on the Global AIDS Epidemic*, 36, Geneva, Switzerland. See <http://data.unaids.org/pub/GlobalReport/2008/jc1510_2008_global_report_pp29_62_en.pdf> (accessed 14/06/10).
- ³ UNAIDS, *Women, Girls, Gender, Global Coalition of on Women and AIDS*. See <http://search.unaids.org/Results.aspx?q=women&x=0&y=0&o=html&d=en&l=en&s=false> (accessed 17/05/10).
- ⁴ UN General, *Global Crisis – Global Action" Declaration of Commitment on HIV/AIDS*, June 27, 2001. See <<http://www.un.org/ga/aids/docs/aress262.pdf>> (accessed 17/05/10).
- ⁵ Ibid.
- ⁶ 2008 High level meeting on AIDS, *Progress in AIDS response but still a long way from meeting global targets: Governments review international response to AIDS at United Nations General Assembly High-Level Meeting 10-11 June*. See < http://data.unaids.org/pub/PressRelease/2008/20080609_hlm_pr_en.pdf> (accessed 25/05/10).
- ⁷ Officially known as the Mexico City Policy, the Global Gag Rule barred any foreign organisation receiving US foreign aid from using *its own funds or funds from other donors* to perform abortions; advocate for reform to abortion laws and related policies; or provide information, make referrals, or counsel women on the procedure – *even in countries where abortion is legal*. Although the Gag Rule did not apply to PEPFAR funding, it inhibited comprehensive approaches to sexual and reproductive health and led to uncertainty among recipients about how their US aid could be used. See section on PEPFAR.
- ⁸ Introduced early in the HIV pandemic, the US travel ban prevented visits to the US by people with HIV except in exceptional circumstances. Currently, some 67 countries around the world have some sort of HIV-specific laws that restrict the entry, stay or residence of people living with HIV. See IAS Applauds White House Announcement of Repeal of the United States' Discriminatory and Ineffective HIV Entry and Immigration Ban, 30 October 2009. See <<http://aids2008.org/Default.aspx?pagelid=379>> (accessed 14/06/10).
- ⁹ Lydia Alpizar et al. 2009-2010 *FundHer Research Update Brief 1: Context and trends influencing the funding landscape for gender equality and women's organizations and movements*. Association for Women's Rights in Development, Mexico City, 2010, 8.
- ¹⁰ Ibid, 20.
- ¹¹ Ibid, 18.
- ¹² Ibid, 20.
- ¹³ Ibid, 12.
- ¹⁴ United Nations Millennium Declaration, Resolution adopted by the General Assembly A/Res/55/2, 8 September 2000. See < <http://www.un.org/millennium/declaration/ares552e.htm>> (accessed 07/06/10).
- ¹⁵ See above note 1.
- ¹⁶ UNAIDS, *Status of the Global HIV Epidemic: 2008 Report on the Global AIDS Epidemic*, 36, Geneva, Switzerland. See < http://data.unaids.org/pub/GlobalReport/2008/jc1510_2008_global_report_pp29_62_en.pdf> (accessed 14/06/10).
- ¹⁷ UNAIDS, *Women, Girls, Gender, Global Coalition of on Women and AIDS*, above note 4.
- ¹⁸ UN General, *Global Crisis – Global Action" Declaration of Commitment on HIV/AIDS*, June 27, 2001. See <http://www.un.org/ga/aids/docs/aress262.pdf> (accessed 17/05/10).
- ¹⁹ Ibid.
- ²⁰ 2008 High level meeting on AIDS, *Progress in AIDS response but still a long way from meeting global targets: Governments review international response to AIDS at United Nations General Assembly High-Level Meeting 10-11 June*. See < http://data.unaids.org/pub/PressRelease/2008/20080609_hlm_pr_en.pdf> (accessed 25/05/10).
- ²¹ International AIDS Society, Optimizing HIV treatment. See < <http://www.iasociety.org/Default.aspx?pagelid=389>> (accessed 04/06/10).
- ²² UNAIDS, Monitoring country progress. See <<http://www.unaids.org/en/KnowledgeCentre/HIVData/CountryProgress/Default.asp>> (accessed 25/05/10).
- ²³ Ibid. See also Wilza Vieira Villela and Alessandra Nilo, Monitoring UNGASS-AIDS goals on sexual and reproductive health: Comparative report, 2008 and Wilza Vieira Villela and Alessandra Nilo, UNGASS-AIDS and the Sexual and Reproductive Health of Women: Civil Society Report 2010 (forthcoming).
- ²⁴ Human Rights Watch, *Hidden in the mealie meal: Gender-based abuses and women's HIV treatment in Zambia*, Vol. 19, No. 18(a), December 2007. See <<http://allafrica.com/download/resource/main/main/idadtcs/00011453:4a6d7180c50dfa826e5f3158f5dd3a07.pdf>> (accessed 24/05/10).

- 25 UNAIDS, Policy brief: Criminalization of HIV transmission. See <http://data.unaids.org/pub/basedocument/2008/20080731_jc1513_policy_criminalization_en.pdf> (accessed 25/05/10).
- 26 Athena Network, *10 reasons why criminalisation of HIV exposure and transmission harms women*. See <http://www.womenwontwait.org/index.php?option=com_content&task=view&id=183&Itemid=1> (accessed 25/05/10).
- 27 AIDS Lex, Director of the Lawyers Collective (India) and UN Special Rapporteur on the right of everyone to the enjoyment of the highest attainable standard of physical and mental health, 15 December 2009. See <<http://www.aidslex.org/English/Ask-The-Experts/Experts-Details/?&rid=23>> (accessed 24/05/10).
- 28 The Women Won't Wait Campaign, for which ActionAid has been the secretariat since 2007, has reported persistent violence against lesbian women. See Vicci Tallis, *Violence against lesbians, gays, bi-and transsexuals*. See <http://www.womenwontwait.org/index.php?option=com_content&task=view&id=191&Itemid=107> (accessed 21/05/10).
- 29 Amnesty International USA, *Women's human rights*. See <<http://www.amnestyusa.org/violence-against-women/violence-against-women---a-fact-sheet/page.do?id=1108440>> (accessed 21/05/10).
- 30 Report of the Special Rapporteur on the right of everyone to the enjoyment of the highest attainable standard of physical and mental health, Anand Grover, Human Rights Council, 14th Session, U.N. Doc. A/HRC/14/20, 27 April 2010.
- 31 Statement by Mr Anand Grover, Special Rapporteur on the right of everyone to the enjoyment of the highest attainable standard of physical and mental health, 14th session of the Human Rights Council, Agenda Item 3: Promotion and protection of all human rights, civil, political, economic, social and cultural rights, including the right to development, 3 June 2010, Geneva, Switzerland. See <<http://www.un.org.au/files/files/HRC%2014%20-%20Anand%20Grover%20Statement%20FINAL%2003June10.pdf>> (accessed 14/06/10).
- 32 See generally Fernanda Hopenhaym et al., *Fundher 2008: Money watch for women's rights movements and organizations*, Association for Women's Rights in Development, Toronto, Canada and Mexico City, Mexico, 2008.
- 33 Lydia Alpizar, *2009-2010 FundHer Research Update Brief 1*, above note 9.
- 34 Ibid, 12.
- 35 Natalie Raaber, *UNIFEM Discussion: counting the costs! Financing for gender equality in economic crisis and recovery*. Association for Women's Rights in Development. See <<http://awid.org/eng/Issues-and-Analysis/Library/Unifem-Discussion-Counting-the-costs!-Financing-for-gender-equality-in-economic-crisis-and-recovery>> (accessed 17/05/10).
- 36 Lydia Alpizar, *2009-2010 FundHer Research Update Brief 1*, above note 9.
- 37 Lydia Alpizar et al. *Context and Trends Influencing the Funding Landscape for Gender Equality and Women's Organizations and Movements*. 2010, 38.
- 38 Ibid; See also GEAR, *Gender Equality Architecture Reform Campaign*; GEAR, 2010. See GEAR <<http://gear.groupsite.com/main/summary>> (accessed 17/05/10).
- 39 Aids-Free World, *Building a UN Women's Agency That Will Work for the World's Women*. See <<http://www.aids-freeworld.org/content/view/365/208/>> (accessed 17/05/10).
- 40 The 10 co-sponsors are: the office of the United Nations High Commissioner for Refugees (UNHCR), United Nations Children's Fund (UNICEF), World Food Programme (WFP), United Nations Development Programme (UNDP), United Nations Population Fund (UNFPA), United Nations Office on Drugs and Crime (UNODC), International Labour Organization (ILO), United Nations Educational, Scientific and Cultural Organization (UNESCO), World Health Organization (WHO) and the World Bank. UNIFEM, while not an official cosponsor of UNAIDS, also plays an instrumental role in developing policy and implementing programs on gender and HIV/AIDS.
- 41 UNAIDS, *UNAIDS Secretariat*. See <<http://www.unaids.org/en/AboutUNAIDS/Secretariat/default.asp>> (accessed 18/05/10).
- 42 Derek Poate, Paul Balogun and Kathy Attawell, *UNAIDS Second Independent Evaluation 2002-2009*, September 2008, 8.48-8.49. See <http://data.unaids.org/pub/BaseDocument/2009/20091002_sie_final_report_en.pdf> (accessed 04/06/10).
- 43 Ibid, 8.53.
- 44 Ibid, 8.52.
- 45 UNAIDS, *Joint Action for Results: UNAIDS Outcome Framework 2009-2011*. 2009, 9. See <http://data.unaids.org/pub/Report/2010/jc1713_joint_action_en.pdf> accessed 07/06/10
- 46 Ibid, 8.
- 47 See for example Suzanne Maman et al., The intersections of HIV and violence: Directions for future research and interventions, *Social Science Medicine* (2000) 50(4):459-78; Vivian F. Go et al., When HIV prevention messages and gender norms clash: The impact of domestic violence on women's HIV risk in slums of Chennai, India, *AIDS and Behavior* (2003) 7(3): 263-272; Ariane van der Straten et al., Sexual coercion, physical violence and HIV infection among women in steady relationships in Kigali, Rwanda, *AIDS and Behavior* (1998) 2(1): pp. 61-73
- 48 UNAIDS, *Joint Action for Results*, above note 52, 8.
- 49 For example, *Convention on the Elimination of All Forms of Discrimination against Women*, adopted Dec. 18, 1979, G.A. Res. 34/180, UN GAOR, 34th Sess., Supp. No. 46, at 193, U.N. Doc. A/34/46, 1249 U.N.T.S. 13 (entered into force Sept. 3, 1981); *Beijing Declaration and the Platform for Action*, Fourth World Conference on Women, Beijing, China, September 4-15 1995, U.N. Doc. A/CONF.177/20 (1996); *Programme of Action of the International Conference on Population and Development*, Cairo, Egypt, Sept. 5-13, 1994, U.N. Doc. A/CONF.171/13/Rev.1 (1995)

- ⁵⁰ CEDAW Committee, General Recommendation 19, 11th Session, 1992, ¶ 6.
- ⁵¹ UNAIDS, *Action Framework: Addressing Women, Girls, Gender Equality and HIV*. 2009, 1. See <http://content.unpd.org/go/cms-service/stream/asset/?asset_id=2200458> (accessed 14/05/10).
- ⁵² Ibid, 2.
- ⁵³ Ibid, 3.
- ⁵⁴ Ibid, 5.
- ⁵⁵ Ibid, 5.
- ⁵⁶ Ibid, 6.
- ⁵⁷ Ibid, 6.
- ⁵⁸ Ibid, 12.
- ⁵⁹ Ibid, 14.
- ⁶⁰ UNAIDS, *Agenda for Accelerated Country Action for Women, Girls, Gender Equality and HIV*. UNAIDS, Geneva, 2010, iii. See <http://data.unaids.org/pub/Agenda/2010/20100226_jc1794_agenda_for_accelerated_country_action_en.pdf> (accessed 10/05/10).
- ⁶¹ Ibid, v.
- ⁶² Ibid, v.
- ⁶³ Ibid, 2.
- ⁶⁴ Ibid 2.
- ⁶⁵ Ibid 6.
- ⁶⁶ Ibid, 7.
- ⁶⁷ UNAIDS, *What countries need: Investments needed for 2010 targets*. 2009. See <http://data.unaids.org/pub/Report/2009/JC1681_what_countries_need_en.pdf> (accessed 05/05/10).
- ⁶⁸ UNAIDS. *Financial Resources Required to Achieve Universal Access to HIV Prevention, Treatment, Care and Support*. UNAIDS, Geneva, 2007, 20. See <http://data.unaids.org/pub/Report/2007/jc1678_fin_res_req_en.pdf> (accessed 29/04/10).
- ⁶⁹ UNAIDS. 2009. *What countries need*, above note 74, 15.
- ⁷⁰ Ibid, 8.
- ⁷¹ UNIADS, *Unified Budget and Workplan, 2008-2009*. See <http://data.unaids.org/pub/BaseDocument/2007/2008_2009_ubw_en.pdf> (accessed 07/06/10).
- ⁷² UNAIDS, *24th Meeting of the UNAIDS Programme Coordinating Board: UNAIDS 2010-2011-Unified Budget and Workplan*, Geneva, Switzerland, 22-24 June 2009. See <http://data.unaids.org/pub/InformationNote/2009/20090515_20102011_ubw_final_en.pdf> (accessed 07/06/10).
- ⁷³ The Global Coalition on Women and AIDS (GCWA), *About GCWA*. See <<http://www.womenandaids.net/about-gcwa.aspx>> (accessed 04/06/10).
- ⁷⁴ The Global Coalition on Women and AIDS (GCWA), *Priorities for 2009-2010*. See <<http://www.womenandaids.net/about-gcwa/priorities-for-2009-2010.aspx>> (accessed 09/06/10).
- ⁷⁵ Susana T. Fried, *Women Won't Wait Campaign: Show Us the Money: Is violence against women on the HIV&AIDS donor agenda?* Washington, DC: ActionAid, 2007, 47.
- ⁷⁶ See <<http://www.theglobalfund.org/en/>> (accessed 17/05/10)
- ⁷⁷ The Technical Review Panel is a body of technical experts that reviews all proposals. According to the Global Fund, the (TRP) "reviews eligible grant proposals for technical merit (soundness of approach, feasibility and potential for sustainability) ...Based on this review the TRP recommends proposals for funding to the Board. The TRP consists of a maximum of 35 experts. Each expert is appointed by the Board for a period of up to four Rounds."
- ⁷⁸ The Global Fund to Fight AIDS, Tuberculosis and Malaria, *The Global Fund's Strategy for Ensuring Gender Equality in the Response to HIV/AIDS, Tuberculosis and Malaria ("The Gender Equality Strategy") as set out in the Addendum to the Report of the Policy and Strategy Committee*. The Global Fund Fight AIDS, Tuberculosis and Malaria, New Delhi, 2008, 1. See <http://www.theglobalfund.org/documents/board/18/GF-B18-04_ReportPSC_Addendum.pdf> (accessed 17/05/10)
- ⁷⁹ Ibid, 4.
- ⁸⁰ Ibid, 4.
- ⁸¹ Ibid, 5.
- ⁸² The Global Fund to Fights AIDS, Tuberculosis and Malaria, *The Global Fund strategy in relation to sexual orientation and gender identities (SOGI)*, Geneva, 5-6 May 2009, 1. See <http://www.theglobalfund.org/documents/publications/other/SOGI/SOGI_Strategy.pdf> (accessed 04/06/10).

- ⁸³ The Global Fund to Fights AIDS, Tuberculosis and Malaria, *The Global Fund strategy in relation to sexual orientation and gender identities (SOGI)*, Geneva, 5-6 May 2009, 1. See <http://www.theglobalfund.org/documents/publications/other/SOGI/SOGI_Strategy.pdf> (accessed 04/06/10).
- ⁸⁴ Personal Communication, Shannon Kowalski, OSI, August 20, 2009.
- ⁸⁵ Ibid.
- ⁸⁶ UNAIDS, Agenda for Accelerated Country Action, above note 53, 18, 19.
- ⁸⁷ The Global Fund to Fight AIDS, Tuberculosis and Malaria, *Fact Sheet: Ensuring a Gender Sensitive Approach – Global Fund Fact Sheet Series 1 of 6*. 2008. See <http://www.theglobalfund.org/documents/rounds/9/CP_Pol_R9_FactSheet_1_Gender_en.pdf> (accessed 13/05/10).
- ⁸⁸ The Global Fund, *Monitoring and Evaluation Toolkit: HIV, TB, Malaria and Health Systems Strengthening, Part 2: Tools for monitoring programs for HIV, tuberculosis, malaria and health systems strengthening*, 2009, 67.
- ⁸⁹ Ibid, 36.
- ⁹⁰ Ibid.
- ⁹¹ See <<http://www.pepfar.gov/about/index.htm>> (accessed 17/05/10).
- ⁹² The 2008 reauthorization often referred to as PEPFAR II funds the program for \$48 billion through 2013. Tom Lantos and Henry J. Hyde U.S. Global Leadership Against HIV/AIDS, Tuberculosis, and Malaria Reauthorization Act of 2008 (P.L. 110-293).
- ⁹³ The 15 PEPFAR focus countries are Botswana, Cote d'Ivoire, Ethiopia, Guyana, Haiti, Kenya, Mozambique, Namibia, Nigeria, Rwanda, South Africa, Tanzania, Uganda, Vietnam and Zambia
- ⁹⁴ For more information, see White House Press Release, *Statement of President Barack Obama on Rescinding the Mexico City Policy*, 23 January, 2009. See <http://www.whitehouse.gov/the_press_office/StatementofPresidentBarackObamaonRescindingtheMexicoCityPolicy> (accessed 17/05/10).
- ⁹⁵ Housing Works blog, *What the end of the syringe exchange ban means*, Diana Scholl, December 17, 2009. <<http://www.housingworks.org/blogs/detail/what-the-end-of-the-syringe-exchange-ban-means/>> (accessed 17/05/10).
- ⁹⁶ See <<http://www.iasociety.org/Default.aspx?pagelid=386>> (accessed 17/05/10).
- ⁹⁷ Tom Lantos and Henry J. Hyde United States Global Leadership Against HIV/ AIDS, Tuberculosis, and Malaria Reauthorization Act of 2008, Section 403. See <<http://www.pepfar.gov/documents/organization/108294.pdf>> (accessed 17/05/10).
- ⁹⁸ President's Emergency Plan for AIDS Relief, *FY 2010 Country Operational Plan (COP) Guidance: Programmatic Considerations*, 2009, 48. See <<http://www.pepfar.gov/documents/organization/127185.pdf>> accessed 17/05/10).
- ⁹⁹ Ibid, 74
- ¹⁰⁰ Ibid.
- ¹⁰¹ US Government Office of the Spokesman, *PEPFAR Launches Increased Commitment to Scale Up Gender-Based Violence Approaches*, Washington, D.C., 2010. See <<http://www.state.gov/r/pa/prs/ps/2010/05/141531.htm>> (accessed 17/05/10).
- ¹⁰² US Government, *Implementation of the Global Health Initiative: Consultation document*. See <<http://www.pepfar.gov/documents/organization/136504.pdf>> (accessed 24/05/10).
- ¹⁰³ See generally CHANGE, *A woman-centered approach to the US Global Health Initiative*, Washington, D.C. 2010. See <<http://www.genderhealth.org/files/uploads/change/publications/womancenteredapproach.pdf>> (accessed 17/05/10).
- ¹⁰⁴ Saving Lives, Strengthening systems" US Government presentation, 5 August, 2009, (On file with authors).
- ¹⁰⁵ World Bank Group, *Gender Equality as Smart Economics: A World Bank Group Gender Action Plan (Fiscal years 2007-10)*. Washington, D.C. 2006. See <<http://www.fafia-afai.org/files/gap.pdf>> (accessed 12/05/10).
- ¹⁰⁶ Ibid, 4.
- ¹⁰⁷ Ibid, 3.
- ¹⁰⁸ Elaine Zuckerman, *Problems in the World Bank's Gender Action Plan and Gender Policy: World Bank Independent Evaluation Group*, 19 March 2009, 3. See <http://www.genderaction.org/images/Event09.03.19_WB%20Independent%20Evaluation%20Group_EZ.pdf> (accessed 11/05/10).
- ¹⁰⁹ Suzanna Dennis & Elaine Zuckerman, *Mapping Multilateral Development Banks' Reproductive Health and HIV/AIDS Spending, Gender Action*, Washington D.C., September 2007. 10. See <<http://www.genderaction.org/images/Gender%20Action%20MDBs%20RH-AIDS%202007.pdf>> (accessed 07/06/10).
- ¹¹⁰ Ibid.
- ¹¹¹ Ibid, 24.
- ¹¹² See Suzanna Dennis and Elaine Zuckerman. *Gender guide to World Bank and IMF: Policy-Based Lending*, 2006.
- ¹¹³ UNAIDS, *ASAP: Progress report December 2009*. See <<http://siteresources.worldbank.org/INTHIVAIDS/Resources/375798-1151090631807/ASAPPRDecember2009.pdf>> (accessed 07/06/10).

- ¹¹⁴ Nandini Oomman et al. *Are funding decisions based on performance?* HIV/AIDS Monitor, Center for Global Development, Washington D.C. 2010. See <<http://www.cgdev.org/content/calendar/detail/1424101>> (accessed 10/05/10).
- ¹¹⁵ World Bank Group, *Gender Action Plan Two-Year Progress Report*, Washington D.C., 2009. See <<http://web.worldbank.org/WBSITE/EXTERNAL/TOPICS/EXTGENDER/0,,contentMDK:22148542~pagePK:210058~piPK:210062~theSitePK:336868,00.html>> (accessed 17/05/10).
- ¹¹⁶ Ibid.
- ¹¹⁷ Elaine Zuckerman, *Gender Equality as Smart Economics: A World Bank Group Gender Action Plan (GAP) (Fiscal years 2007-10)*, Gender Action, Washington D.C., January 2007. See <http://www.genderaction.org/images/04.22.08_EZ-GAPlan%20Critique.pdf> accessed 07/06/10).
- ¹¹⁸ World Bank Group, *The Adolescent Girls Initiative: An alliance for economic empowerment*. See <<http://web.worldbank.org/WBSITE/EXTERNAL/NEWS/0,,contentMDK:21914520~menuPK:34482~pagePK:2524753~piPK:51421526~theSitePK:4607,00.html>> (accessed 01/06/10).
- ¹¹⁹ World Bank Group, *Gender Action Plan Two-Year Progress Report*, above note 122, 2.
- ¹²⁰ World Bank Group, *Operational Policy 4.20: Gender and Development*. Washington, D.C. 2003, footnote 1. See <<http://web.worldbank.org/WBSITE/EXTERNAL/PROJECTS/EXTPOLICIES/EXTOPMANUAL/0,,contentMDK:20064559~pagePK:64141683~piPK:64141620~theSitePK:502184,00.html>> (accessed 17/05/10); See also Elaine Zuckerman, *Gender Equality as Smart Economics*, above note 124.
- ¹²¹ Elaine Zuckerman, *Gender Equality as Smart Economics*, above note 124; See also Suzanna Dennis and Elaine Zuckerman. *Gender guide to World Bank and IMF*, above note 119.
- ¹²² Suzanna Dennis and Elaine Zuckerman, *Gender guide to World Bank and IMF*, above note 119, 3.
- ¹²³ World Bank Group. *The World Bank's commitment to HIV/AIDS in Africa: Our Agenda for Action, 2007-2011*, Washington D.C. 2008. See <http://data.unaids.org/pub/Report/2008/20080514_agenda_for_action_en.pdf> (accessed 17/05/10).
- ¹²⁴ Ibid, 2.
- ¹²⁵ Ibid, 3.
- ¹²⁶ Christina Droggitis et al. *Going beyond gender as usual: Why and how global HIV/AIDS donors can do more for women and girls*. Center for Global Development, Washington D.C. 2009, 47-48. See <<http://www.cgdev.org/content/publications/detail/1422652/>> (accessed 17/05/10).
- ¹²⁷ Ibid, 47-48.
- ¹²⁸ World Bank Group. *The World Bank's commitment to HIV/AIDS in Africa*, above note 130, 14.
- ¹²⁹ Ibid, 15.
- ¹³⁰ Elaine Zuckerman, *Gender Equality as Smart Economics*, above note 124.
- ¹³¹ DFID, About DFID. See <<http://www.dfid.gov.uk/About-DFID/Quick-guide-to-DFID/Who-we-are-and-what-we-do/>> (accessed 14/05/10).
- ¹³² DFID, Key achievements. See <<http://webarchive.nationalarchives.gov.uk/+http://www.dfid.gov.uk/about-dfid/quick-guide-to-dfid/key-achievements/>> (accessed 14/05/10).
- ¹³³ DFID, Key achievements.
- ¹³⁴ DFID, *HIV and AIDS*. See <<http://webarchive.nationalarchives.gov.uk/+http://www.dfid.gov.uk/Global-Issues/How-we-fight-Poverty/HIV-and-AIDS/HIV-and-AIDS-in-depth/>> (accessed 14/05/10). See also DFID. *Achieving Universal Access: The UK's strategy for halting and reversing the spread of HIV in the developing world*. 2008, 9. See <<http://www.dfid.gov.uk/Documents/publications/achving-uni-access-mon-eval.pdf>> (accessed 14/05/10).
- ¹³⁵ House of Commons: International Development Committee, *Progress on the Implementation of DFID's HIV/AIDS Strategy: Government Response, Third Special Report of Session 2009-10*. 2010, 3. See <<http://www.publications.parliament.uk/pa/cm200910/cmselect/cmintdev/342/342.pdf>> (accessed 14/05/10).
- ¹³⁶ DFID, *Achieving Universal Access*, above note 141.
- ¹³⁷ Ibid, 62-65.
- ¹³⁸ Ibid, 25.
- ¹³⁹ Ibid, 24.
- ¹⁴⁰ Ibid, 25.
- ¹⁴¹ Ibid, 12-14.
- ¹⁴² DFID. *Gender Equality Action Plan, Africa Division*, 2009-2012. See <<http://www.dfid.gov.uk/Documents/publications/africa-gender-equality-action-plan.pdf>> (accessed 15/05/10).
- ¹⁴³ House of Commons, *Progress on the Implementation of DFID's HIV/AIDS Strategy*, above note 142, 4.
- ¹⁴⁴ This included Burundi, Cambodia, Ethiopia, Kenya, Mali, Mozambique, Nepal and Zambia. See WHO, *Scaling-up for better health (IHP+) update*. Issue 1, 2007. See <http://www.who.int/healthsystems/strategy/IHP_update1_Nov07.pdf> (accessed 14/05/10).

- ¹⁴⁵ House of Commons, Progress on the Implementation of DFID's HIV/AIDS Strategy, above note 142, 2.
- ¹⁴⁶ Ibid, 2.
- ¹⁴⁷ Ibid, 3.
- ¹⁴⁸ Douglas Alexander, *Achieving Universal Access: The UK's strategy to tackle AIDS in developing countries*. 2008. See <<http://www.dfid.gov.uk/Media-Room/Speeches-and-articles/2008/Achieving-Universal-Access/>> (accessed 19/11/09).
- ¹⁴⁹ World Health Organisation (WHO), *What is a health system?* See <<http://www.who.int/healthsystems/about/en/>> (accessed 20/04/10); See also Savigny, D et al. *Systems thinking for health systems strengthening*. Geneva: WHO Press, 2009.
- ¹⁵⁰ WHO, *What is a health system?*, above note 156.
- ¹⁵¹ Beijing Declaration and Platform for Action, Fourth World Conference on Women, Beijing, 4-15 September, U.N. Doc. A/CONF. 177/20 (1995) 1995, para 89.
- ¹⁵² Ibid, para 90.
- ¹⁵³ International Covenant on Economic, Social and Cultural Rights, General Assembly resolution 2200A (XXI) (entered into force 3 January 1976), Article 12.
- ¹⁵⁴ Committee on Economic, Social and Cultural Rights, *The right to the highest attainable standard of health: Substantive issues arising in the implementation of the International Covenant on Economic, Social and Cultural Rights*, General Comment No. 14, E/C.12/2000/4, 11 August 2000, 8.
- ¹⁵⁵ WHO, *Human Rights Based Approach to Health*. See <<http://www.who.int/trade/glossary/story054/en/index.html>> (accessed 20/04/10).
- ¹⁵⁶ WHO, *Women and health: today's evidence tomorrow's agenda*. Geneva, WHO Press, 2009, 12.
- ¹⁵⁷ Committee on Economic, Social and Cultural Rights, *The right to the highest attainable standard of health*, above note 161, 21.
- ¹⁵⁸ Ibid, 21.
- ¹⁵⁹ Commission on the Status of Women, "Women, the girl child and HIV and AIDS," 54th Session, 12 March 2010, E/CN.6/2010/L.2/Rev.1, para 8.
- ¹⁶⁰ See generally CHANGE, *A woman-centered approach to the US Global Health Initiative*, above note 110.

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