

Kim Ashburn
Nandini Oomman
David Wendt
Steven Rosenzweig

Moving Beyond Gender as Usual

With contributions from

William Okedi, Caesar Cheelo,
Dirce Costa, Freddie Ssenooba,
Eleásara Antunes, Moses Arinaitwe,
Susan Choolwe-Mulenga,
Elizabeth Ekirapa Kiracho,
Suzanne Kiwanuka, Brian Munkombwe,
Aloysius Mutebi, Sarah Ssali,
and Minna Tuominen



How the U.S. President's Emergency Plan for AIDS Relief, the Global Fund to Fight AIDS, Tuberculosis and Malaria, and the World Bank's Africa Multi-Country AIDS Program are addressing women's vulnerabilities in the HIV/AIDS epidemic in Mozambique, Uganda, and Zambia

**Kim Ashburn
Nandini Oomman
David Wendt
Steven Rosenzweig**

Moving Beyond Gender as Usual

With contributions from

William Okedi, Caesar Cheelo,
Dirce Costa, Freddie Ssenooba,
Eleásara Antunes, Moses Arinaitwe,
Susan Choolwe-Mulenga,
Elizabeth Ekirapa Kiracho,
Suzanne Kiwanuka, Brian Munkombwe,
Aloysius Mutebi, Sarah Ssali,
and Minna Tuominen



How the U.S. President's Emergency Plan for AIDS Relief, the Global Fund to Fight AIDS, Tuberculosis and Malaria, and the World Bank's Africa Multi-Country AIDS Program are addressing women's vulnerabilities in the HIV/AIDS epidemic in Mozambique, Uganda, and Zambia

The authors' institutional affiliations are as follows:

- Kim Ashburn, International Center for Research on Women.
- Nandini Oomman, David Wendt, and Steven Rosenzweig, Center for Global Development.

In addition, this report would not have been possible without the collaborative efforts of the following people:

- Christina Droggitis, Center for Global Development.
- William Okedi, Consultant, Center for Global Development.
- Dirce Costa, Eleásara Antunes, and Minna Tuominen, Austral-COWI Consulting, Mozambique.
- Freddie Ssengooba, Moses Arinaitwe, Suzanne Kiwanuka, Elizabeth Ekirapa Kiracho, Sarah Ssali, and Aloysius Mutebi, Makerere University School of Public Health, Uganda.
- Caesar Cheelo, Susan Choolwe-Mulenga, and Brian Munkombwe, Health Economics Research and Training Programme, University of Zambia.

The authors gratefully acknowledge comments provided by Regina Benevides, Nancy Birdsall, David Gootnick, Geeta Rao Gupta, Karen Hardee, Jen Kates, Ruth Levine, Brenda Malinga, and Sharmila Mhatre. They also would like to thank staff at the World Bank, the Global Fund and the Office of the Global AIDS Coordinator for their assistance, including feedback on this report.

Any errors or omissions of fact remain the responsibility of the authors.

Copyright ©2009 by the Center for Global Development
ISBN 978-1-933286-40-2

Center for Global Development
1800 Massachusetts Avenue, NW
Washington, DC 20036
Tel: 202 416 4000
Web: www.cgdev.org

Support for the HIV/AIDS Monitor is generously provided by the Bill & Melinda Gates Foundation, the International Development Research Centre of Canada, the William and Flora Hewlett Foundation, the David and Lucile Packard Foundation, and the Swedish International Development Cooperation Agency.

Cover photo: ©2005 Arturo Sanabria, Courtesy of Photoshare.

This photograph is used for illustrative purposes only; it does not imply any particular health status, attitude, behavior, or action on the part of the people appearing in the photograph.

Editing and typesetting by Communications Development Incorporated, Washington, DC.

Table of contents

Summary	1
About this report	10
1. Setting the stage: national policies on gender and HIV/AIDS in Mozambique, Uganda, and Zambia	14
Mozambique: some analysis and strategic action to address gender, but lacking indicators or targets to measure progress	14
Uganda: fairly strong gender analysis, but with few corresponding actions or efforts to measure progress	16
Zambia: high-level commitments to addressing gender, but with few concrete actions to meet those commitments	19
2. The U.S. President’s Emergency Plan for AIDS Relief	23
Gender analysis in situational assessments and program design: increased attention to analysis, but with unclear effects on program planning	23
Programs addressing gender inequality: not systematically implemented across program areas, PEPFAR having no well defined process for developing country-level objectives	24
Accountability through gender-sensitive monitoring and evaluation: sex-disaggregated data, but with no way to track funding flows for gender-related programming or to measure long-term progress on gender issues	28
Gender capacity: PEPFAR and recipient organization staff have varying levels of gender capacity, but capacity building on gender has not been widespread	30
Recommendations for PEPFAR	32
3. The Global Fund to Fight AIDS, Tuberculosis and Malaria	34
Gender analysis in situational assessments and program design: proposals often include gender analysis, but analysis is not always used in program planning and proposal development	34
Programs addressing gender inequality: the Global Fund model is flexible, but limited, in funding and designing programs that address gender barriers	36
Accountability through gender-sensitive monitoring and evaluation: monitoring and evaluation lacks sex-disaggregated data and gender-related indicators	39
Gender capacity: building such capacity is not a key part of Global Fund grants	41
Recommendations for the Global Fund	44

4. The World Bank’s Africa Multi-Country AIDS Program	47
Gender analysis in situational assessments and program design: proposals include data on epidemiological and behavioral differences, but virtually no analysis of gender-related vulnerabilities and consequences	47
Programs addressing gender inequality: the MAP uses capacity building and support for community initiatives	50
Accountability through gender-sensitive monitoring and evaluation: performance assessment frameworks lack a gender focus, but include some sex-disaggregated data	51
Gender capacity: the MAP makes capacity building a focus of its gender work, but does not assess program performance or demonstrate results	53
Recommendations for the MAP	55
5. Moving beyond gender as usual	57
Annex A. Gender in development and in HIV/AIDS programming: key terms and resources	59
Annex B. Study methodology	61
Annex C. Case studies of program implementers and beneficiaries	66
Annex D. Sample terms of reference for a national gender analysis	78
Annex E. Sample gender-related indicators for program monitoring and evaluation	81
References	85

Summary

The analysis in this report focuses on how three large and influential donors—the U.S. President’s Emergency Plan for AIDS Relief (PEPFAR), the Global Fund to Fight AIDS, Tuberculosis and Malaria, and the World Bank’s Africa Multi-Country AIDS Program (the MAP)—address the risks, vulnerabilities, and consequences of the HIV/AIDS epidemic for women and girls

The global HIV/AIDS epidemic cannot be understood without considering male and female roles in society, a complex topic. To fight the epidemic successfully it is necessary to tackle the persistent challenges of gender-based violence, discrimination, and unequal access to resources. In short, serious attention to HIV/AIDS, and to the eventual success of global HIV/AIDS programs, requires a focus on gender inequality—defined in this report as differences in the rights, responsibilities, and opportunities provided for women and for men.

At the start of the global epidemic, in the 1980s, about a third of all people infected with HIV worldwide were women. Just one decade later more than half were women. Today in sub-Saharan Africa, 61% of all people infected with HIV are women. Women age 15–24 are the most vulnerable to HIV infection; in some sub-Saharan African countries HIV is twice as likely to be present in young girls as in boys the same age.¹

The analysis in this report focuses on how three large and influential donors—the U.S. President’s Emergency Plan for AIDS Relief (PEPFAR), the Global Fund to Fight AIDS, Tuberculosis and Malaria, and the World Bank’s Africa Multi-Country AIDS Program (the MAP)—address the risks, vulnerabilities, and consequences of the HIV/AIDS epidemic for women and girls.

Gender inequality increases the risk of contracting HIV for women and girls in a number of ways. The choices that women have—including choices about marriage, work, and where to live—are determined largely by society. Gender norms limit women’s ability to control the conditions of their sexual relationships, including risky sexual behavior. In addition, concepts of masculinity often create risk and vulnerability

for both men and women by encouraging risky behaviors such as having sex with multiple partners. Gender-based violence has been identified as a risk factor for HIV infection. And women’s limited access to education, employment, and other economic opportunities increases their economic vulnerability, which in turn makes them more likely to adopt risky sexual behavior.

Gender inequality further increases the harmful effects of HIV/AIDS for women and girls, creating barriers for them in accessing services. Gender-based violence and unequal power dynamics in the home can limit women’s access to counseling, testing, and treatment and can hinder them from disclosing their HIV-positive status. And women’s roles as mothers and caregivers mean that they often bear the greatest burden in caring for family and community members living with or affected by HIV/AIDS.

Recognizing that accounting for gender-specific vulnerabilities, capabilities, and constraints is crucial to the success of global HIV/AIDS programs, we analyze and compare the gender-related policies, strategies, and interventions used in Mozambique, Uganda, and Zambia by the three donors. In each case we look at how gender norms—and the resulting power imbalances between women and men

1. UNAIDS 2008.

PEPFAR, the Global Fund, and the MAP have made high-level commitments to address gender issues—but in the three study countries these high-level commitments have not yet produced concrete and systematic action on the ground

that lead women and girls to suffer disproportionately from HIV/AIDS—have been analyzed. We then describe how such analyses have been used to inform policies and programs.

Driving the study are four questions:

- In what ways do PEPFAR, the Global Fund, and the MAP analyze the relationship between gender inequality and HIV/AIDS in Mozambique, Uganda, and Zambia—examining women’s and men’s experiences, needs, and priorities—and how do the results inform the donors’ policies and programs for each country?
- What are the donors’ gender policies for the three study countries, and how are those policies put into practice through programming?
- What accountability mechanisms are there for addressing gender issues in donor-supported programming for the three study countries—either through monitoring and evaluation or through financial accountability?
- What capacity do donors and recipients have to address gender issues, and what efforts are being made to build capacity?

To answer these questions, country-based researchers reviewed donor and country policies, grey literature, and other documents. They interviewed key staff members at the donors’ country offices, in governments, and in recipient and subrecipient organizations. They also interviewed and held focus-group discussions with beneficiaries of HIV/AIDS programs that are designed to serve sex workers, to serve orphans and vulnerable children, and to prevent mother-to-child transmission.

Through these document reviews, interviews, and discussions we found that PEPFAR, the Global Fund, and the MAP have made high-level commitments to address gender issues and to make their programming more effective for women and girls. Yet we also found that, in the three study countries, these high-level donor commitments have not yet produced concrete and systematic action on the ground. (These findings are briefly presented in table 1 at the end of the summary. They confirm observations in a 2009 background report—also

produced by the Center for Global Development and the International Center for Research on Women—on the donors’ global-level policies for addressing gender inequality.²)

To better understand the effectiveness of the three donors’ efforts to provide a strong response to gender issues through HIV and AIDS policies and programs, we first review country contexts for the donors’ work.

National policies in Mozambique, Uganda, and Zambia: high-level rhetoric with few objectives or actions and little follow-through

In Mozambique, Uganda, and Zambia national policy documents assert a need to address the link between gender inequality and HIV/AIDS. The documents show a reasonable understanding of pertinent gender issues in each country. For example, Mozambique’s national AIDS strategy identifies local gender norms that increase women’s vulnerability and describes gender-related barriers to accessing services, such as those for preventing mother-to-child transmission.

However, little strategic action has been taken to follow through and address the gender issues identified by the three study countries’ national policy documents—and even less work has been done to design relevant indicators and targets for measuring progress. In Uganda for example, the national AIDS plan does not identify prevention strategies that address the gender-related vulnerabilities identified in its situational analysis, and it does not include any gender-related indicators to measure progress on addressing gender inequality. Because of such gaps, national efforts to address gender and HIV/AIDS in the three study countries remain largely rhetorical.

Mozambique’s national policy documents offer insight into the relationship between gender inequality and HIV/AIDS. They also provide for some actions to address that relationship—for example, promoting knowledge of, and access to, legal instruments for fighting

2. Ogden, Oomman, and Weeth 2008.

domestic and sexual violence. Nevertheless, the policy documents mandate no indicators or targets by which to measure progress made through these efforts.

Policy documents in Uganda include fairly strong gender analysis, identifying issues such as women's inability to negotiate safer sex and the greater burden that women face in caring for sick family members. Yet the policy documents do not have accompanying objectives, strategies, or indicators to address these issues.

Zambia has shown a high-level commitment to addressing gender and HIV/AIDS—for example, by establishing a cabinet-level Gender in Development Division. But in practice Zambia has not followed through. The reasons include inadequate funding and staffing, high staff turnover, limited access to gender analysis, and inadequate monitoring and evaluation systems for gender. Gender-related objectives in Zambia's national health plan for 2001–05 were not met.

PEPFAR: explicit commitments on gender, but with a global approach and a confusing set of policies that fail to address country-specific needs

PEPFAR provides the largest share of financing for HIV/AIDS programming in the three study countries. Its approach to gender is informed by a global gender strategy highlighting five strategic areas and four global goals for programs to promote gender equality. The five strategic areas are:

- Increasing gender equity in HIV/AIDS activities and services.
- Reducing violence and coercion.
- Addressing male norms and behaviors.
- Increasing women's legal protection.
- Increasing women's access to income and productive resources.

The four global goals are:

- To support the achievement of program goals for treatment (treat 3 million people), prevention (prevent 12 million infections), and care (care for and support 12 million

people) through mainstreaming gender across all programming areas.

- To make programs better and more sustainable by addressing gender dynamics through all intervention levels.
- To guarantee women's and men's equitable access to programs.
- To prevent or ameliorate program outcomes that may unintentionally and differentially harm women and men.

PEPFAR has added some gender analysis—analysis of the different needs, challenges, gaps, and opportunities related to HIV/AIDS for women and for men—to the situational assessments in its country operational plans. Yet the amount of such analysis varies in country operational plans, and whether it has been used for program planning is not clear.

PEPFAR has increased its gender programming, and it has supported some innovative operations research and combination programming (programming using a mix of gender-related strategies) in the study countries. Examples include a program in Mozambique to address sexual coercion and gender-based violence—by advocating for women's legal rights, by giving them legal support in dealing with violence, and by helping them to generate income—and a public health evaluation in Uganda on the relationship between intimate partner violence and HIV status disclosure.

Nevertheless, PEPFAR programs addressing gender inequality are not systematic. The reason is that PEPFAR has not established a process for translating its global gender goals and strategic areas into country-level program objectives. Its focus on short-term results, as opposed to long-term social change, neglects interventions that require longer-term implementation to shift gender norms. And some global-level PEPFAR policies, such as age restrictions on condom distribution and policies for working with sex workers, create confusion about what recipients may and may not do to address gender-related vulnerabilities—particularly in prevention programs.

To its credit, PEPFAR has been a leader in making sex-disaggregated data a priority. But it has no indicators to measure progress in its

PEPFAR has not established a process for translating its global gender goals and strategic areas into evidence-based country-level program objectives

Although gender has not been a main focus of the Global Fund in the past, a newly approved gender equality strategy reflects the Global Fund's commitment to improve its approach

five strategic areas—or for any other gender-related objectives. Instead, PEPFAR's monitoring is designed to count and report planned program activities according to the organization's five global strategies. PEPFAR is not able to track funds dedicated to addressing gender inequality.

Building gender capacity has not been a focus for PEPFAR, but technical assistance can be requested by country teams. Gender capacity varies in PEPFAR country offices, recipient organizations, and subrecipient organizations: only some have expertise in designing, carrying out, and evaluating gender-related programming. More of this expertise was found in primary recipient organizations than in subrecipient organizations.

The Global Fund: inadequate in its past gender approach, but now has a newly approved and promising strategy

Although gender has not been a main focus of the Global Fund in the past, a newly approved gender equality strategy reflects the Global Fund's commitment to improve its approach to gender.

The amount of gender analysis in situational assessments for Global Fund proposals has varied across countries and over time. When such analysis has been included, the proposed activities have not addressed the identified gender-related barriers or inequalities. And gender-related interventions paid for by the Global Fund have been few and far between—probably because, until the most recent funding round (round 8), the Global Fund did not clearly state its willingness to support these programs in its guidance to funding applicants. The Global Fund has now made that willingness explicit in its new gender equality strategy, which requires gender analysis and encourages programming to address gender inequality (particularly the vulnerability of women, girls, and sexual minorities).

The Global Fund has not required the reporting of sex-disaggregated data in the past. For that reason countries generally did not

report such data to the Global Fund—even when data were already sex-disaggregated in the countries' national information systems. The new gender equality strategy requires that countries report sex-disaggregated data.

Past Global Fund grants have not included gender-related indicators to measure changes in gender inequality. In addition, the Global Fund has no way to track the funds it gives to support gender-related programming.

The expertise of Global Fund recipient and subrecipient organizations to design gender-related objectives, strategies, activities, and indicators varies widely: the organizations differ in their ability to access gender-related tools and in their use of gender-related resources. Even so, Global Fund grants in the three study countries have not yet financed any capacity building on gender. The Global Fund's country coordinating mechanisms lack the capacity to design good gender-related objectives, programs, and performance measures. And other Global Fund actors, such as local fund agents and fund portfolio managers, often lack the capacity to evaluate and manage gender-related programming in grants. The new gender equality strategy tries to address some of these weaknesses.

The MAP: building gender capacity, but without measuring results

The World Bank has led globally in promoting gender equality and in developing tools and guidelines for gender mainstreaming at the national level. Its Africa Multi-Country AIDS Program, or the MAP, has tried to integrate gender issues into its programs and to align its gender-related goals and objectives with those developed by recipient countries.

The MAP is characterized by long funding cycles, typically five years, allowing more flexibility to support long-term interventions for sustained social change.

Situational assessments for MAP projects include some gender analysis, with gender experts provided. The gender analysis generally uses data on epidemiological and behavioral differences. Yet it does little to point to gender-related vulnerabilities, gender-related

consequences, or needed programmatic responses. The MAP's support for gender-related programming has consisted largely of three activities: funding gender ministries to support the AIDS response, ensuring that some capacity-building activities include gender training, and supporting some proposals for community initiatives with gender-related features.

Programmatic and financial accountability for gender-related programming is a particular weakness of the MAP. Impact and outcome indicators for MAP programs are mostly sex-disaggregated, but output indicators are not. None of the three countries have indicators to show whether MAP programs address gender inequality, and there is no way to know how much funding went toward gender-related programming.

The MAP has funded some gender training and gender-related technical assistance for national AIDS councils, ministries, district governments, and civil society groups—but neither the training nor the technical assistance has been evaluated in any way. Recipient and sub-recipient organizations carry out little gender-related programming, and their gender capacity remains low. Many projects supported through community initiatives do not use gender analysis in their design, have no programs to address gender issues in communities, and are not monitored or evaluated on gender issues.

Opportunities for donor collaboration

The three donors share goals with each other and with country stakeholders. In pursuing those goals the donors should collaborate in several ways, both to make the most of their comparative advantages and also to avoid duplicating each other's efforts. Each donor should rely on its special strengths; country contexts should be taken into account. We suggest three forms of donor collaboration: supporting national gender analysis, working together and with country stakeholders to improve national approaches to gender and HIV/AIDS, and learning from different approaches to addressing gender inequality.

Support national gender analysis. All donor programs would benefit from gender analysis that is robust and up to date. Since it would be inefficient for the three donors to undertake gender analysis separately, they should combine their resources to support a single, comprehensive national gender analysis to guide HIV/AIDS programming for each country. (For a sample terms of reference for a national gender analysis, see annex D of the full report.) Each donor should contribute technical expertise, funds, or other resources, depending on the donor's special strengths and on each country's context—including local capacity to conduct gender analysis and local resource constraints.

Work together and with country stakeholders to improve national approaches to gender and HIV/AIDS. Donor aid will become more effective when countries lead their national responses to gender and HIV/AIDS—and when those national responses are well coordinated. The donors should use their resources and expertise to help countries establish national gender-related objectives for the HIV/AIDS response, and to help them develop indicators for measuring performance against the gender-related objectives. (For sample gender-related indicators for program monitoring and evaluation, see annex E of the full report.) The donors also should work with countries to ensure that national policies on gender and HIV/AIDS are coherent with strategies on health, on gender, and on development.

Learn from different approaches to addressing gender inequality. All three donors have a stake in creating and sharing knowledge about effective gender-responsive programming to make HIV/AIDS programs respond more effectively to gender issues. Therefore, the donors should jointly support new comparative and operational research and the better dissemination of existing knowledge, both about overarching approaches to gender and about specific types of interventions. New knowledge could highlight the comparative advantages and disadvantages, in particular contexts, of targeted gender-related programming (which addresses gender

The MAP has tried to integrate gender into its programs through gender capacity-building activities and community initiatives, but does not systematically report results for these activities

PEPFAR should give clearer guidance on gender analysis, design gender programs around countries' needs, measure progress against country-level gender objectives, ensure that each country office has at least one gender focal point, and reexamine global-level policies and guidance

inequality as its primary focus) and of gender mainstreaming (a strategy to integrate gender-related concerns and experiences into the design, implementation, and monitoring and evaluation of all policies and programs so that women and men benefit equally and inequality is not perpetuated). For specific types of interventions, since some innovative and effective programs exist today but fairly little knowledge about them is generated and shared, better knowledge dissemination is needed. Such dissemination could help with scaling up successful programs and with transferring their principles to other settings.

Recommendations for moving beyond gender as usual

Based on our findings in the three countries, each donor can and should take several steps to better address gender inequality in its programs at the country level.

Recommendations for PEPFAR

Provide clearer, more detailed guidance on generating and using gender analysis in its country operational plans. Although PEPFAR's use of gender analysis in its country operational plans has increased, the amount of such analysis varies, and there is little evidence that it informs program development. Clearer, more detailed guidance from the Office of the U.S. Global AIDS Coordinator—on what analysis needs to be done, and on how such analysis should inform program planning—would help country teams better address the relationship between gender inequality and HIV/AIDS in country programs.

Design gender programs and objectives around countries' needs, not around global strategic areas or global gender goals. PEPFAR's five gender strategic areas and four gender goals, though a starting point, are global rather than country-specific. Designed merely as a roadmap for how countries should allocate gender funding, they do not consider local conditions or particular countries' needs. Objectives designed

by country teams should be country-specific, based on needs identified through comprehensive gender analysis at the country level.

Set clear, measurable gender-related indicators and targets to measure progress against country-level gender objectives. PEPFAR now has no gender-related indicators or targets to measure progress against its five gender strategic areas, its four gender goals, or other gender priorities. Indicators and targets set by country teams should ideally be based on country-level objectives derived from identified needs. They should include both output and outcome measures. And they should include both short- and long-term measures, to accommodate PEPFAR's annual reporting cycle while also measuring change over longer periods.

Ensure that each country office has at least one gender focal point—a person with expertise in designing and carrying out programs to address the relationship between gender inequality and HIV/AIDS. The gender focal point would ensure that needed evidence is available to inform the design of gender-responsive programs; would design gender-related objectives, indicators, and targets for country operational plans; and would review country operational plans to ensure that they address gender issues and provide needed technical assistance wherever gender capacity exists. In addition, the gender focal point would sensitize all PEPFAR country staff to gender issues and would join in discussions of gender-related policy among donor and government representatives at the country level.

Reexamine global-level policies and guidance—and gaps in such policies and guidance—that conflict with PEPFAR's stated gender goals, especially on prevention. Included in this category are age restrictions on condom distribution; requirements to use particular behavior-change messages for certain groups; the lack of a clear policy linking HIV/AIDS programs to reproductive health services; and policies on sex-worker programs that are confusing and conflict with stated PEPFAR gender goals, such as legal protection for women and increasing

women's access to services. These policy problems create confusion about what recipient countries may and may not do to address gender-related vulnerabilities, particularly in the countries' prevention programs.

Recommendations for the Global Fund

Ensure that country coordinating mechanisms and local fund agents—not just technical review panels—have the gender expertise they need. The Global Fund now encourages countries to include equal numbers of men and women in its country coordinating mechanisms—but this policy does little to ensure the inclusion of people who have technical knowledge and program experience on gender issues and gender-responsive policy, or who will support programs to increase gender equality. The Global Fund must explicitly require that country coordinating mechanisms include such people. Only their presence can ensure that project proposals identify relevant gender issues, that the proposals address those issues with programs and objectives, and that the proposals include indicators and targets to measure performance against the objectives. Also, if local fund agents are to assess the performance of grants on gender issues, they need people who can monitor and evaluate gender-responsive programming.

Ensure that the technical review panels and fund portfolio managers carefully assess the technical knowledge and implementation “know-how” of principal recipients who propose programs to address gender issues. No antiretroviral treatment program can perform well unless it includes people with certain key skills, such as managing a supply chain and testing blood for CD4 counts. In the same way, no program designed to address the relationship between gender inequality and HIV/AIDS can perform well unless it includes people skilled at designing, implementing, and monitoring and evaluating such programs. So it is essential that the Global Fund's technical review panels assess the capacity of principal recipients to address gender issues. Similarly, the fund portfolio managers who oversee grant implementation

should be able to identify both deficiencies in gender capacity and ways of addressing those deficiencies to make the programs described in the grant agreement successful.

Develop gender-related indicators for the Global Fund's monitoring and evaluation toolkit that fit the organization's performance-based funding framework. The Global Fund now has no gender-related indicators in its monitoring and evaluation toolkit. Including such indicators would make it known that they are acceptable within the performance-based funding framework; also, their inclusion might encourage otherwise reluctant recipients to request funds for gender-related programs (while countries would remain free to design their own indicators for proposals). Gender-related indicators for the toolkit should include output, outcome, and impact measures. In addition, they should measure both short-term and long-term change, allowing gender programs to fit the Global Fund's performance-based funding framework while measuring indicators over longer periods. For example, indicators could measure results from structural interventions that seek to address social, economic, political, and physical drivers of the HIV/AIDS epidemic.

Recommendations for the MAP

Ensure that comprehensive gender analysis—not just analysis of sex differentials in epidemiology and behavior—is used in project development, and ensure that such analysis informs the development of programs that explicitly respond to gender in all project components (community initiatives, the health sector, national AIDS councils). Project appraisal documents for the MAP now present statistical differences by sex, but only as background information—and the documents include no explicit programming to address the issues so identified. The documents contain very little analysis of how gender inequality shapes the spread and impact of HIV/AIDS, and they contain no analysis of its implications for programs now or in the future.

The World Bank's extensive project development process is meant to include situational

The Global Fund should ensure that country coordinating mechanisms and local fund agents have gender expertise, that recipients' capacity on gender is carefully assessed by its technical review panel, and that appropriate gender-related indicators are added to the donor's monitoring and evaluation toolkit

The MAP should ensure that project development includes comprehensive gender analysis, includes gender-related indicators, uses sex-disaggregated data consistently, and takes advantage of the World Bank's abilities to promote stronger national gender policies and long-term social change

assessments and project design and review. That process could be improved with built-in guidelines and support for:

- Doing more analysis of the relationship of gender inequality to HIV/AIDS.
- Using all available analysis in designing HIV/AIDS programming that explicitly addresses identified gender issues.

Develop and include gender-related indicators and use sex-disaggregated data across all parts of HIV/AIDS programs. The MAP has provided capacity building, technical assistance, and program support to national AIDS councils, sector ministries, and community initiatives. All those parts of the MAP can and should address critical gender issues—but to do so effectively, they need to be monitored and evaluated on those issues. The MAP project appraisal documents for Mozambique, Uganda, and Zambia include no gender-related indicators, and in many cases the data that they require are not sex-disaggregated. Although MAP documents emphasize gender in their rhetoric, the key indicators that they now use cannot show whether or how MAP programs respond to gender inequality or sex differences.

Examine what is working and what is not working in grantmaking facilities for MAP community initiatives, and develop guidance to help the facilities make grants that are more responsive to gender issues. The MAP's grantmaking facilities for community initiatives are often touted as a great success by the World Bank. Yet, as our evidence shows, many projects supported through the grantmaking facilities do not use gender analysis in their design, have no programs to address gender issues in communities, and are not monitored or evaluated on gender issues. As a result, a real opportunity for addressing gender at the grass roots is being lost.

Take advantage of the World Bank's abilities to address long-term issues of social structure and to encourage stronger national policies on gender and HIV/AIDS. The World Bank's mission and experience make it well positioned to encourage governments to foster social change and pursue long-term policy and institutional reforms. The Bank could do much to:

- Influence how national HIV/AIDS policies address gender issues.
- Strengthen the capacity and commitment of key ministries and other institutions to focus their countries' national HIV/AIDS responses on gender inequality.
- Use coordinated, comprehensive gender analysis to develop longer-term social change objectives for each national HIV/AIDS response—and help put the objectives in place.

Responsiveness to gender inequality will be an integral part of any successful effort to make the three donors' HIV/AIDS programs more effective. As PEPFAR, the Global Fund, and the MAP feel the squeeze of the global economic crisis, they will be pressed to do more with less. One important way to increase success across donor programs will be by addressing the kinds of gender inequality that hamper efforts to prevent the spread of HIV, to treat AIDS patients, and to care for people affected by the epidemic. Responding to gender inequality is especially crucial for effective prevention, which will be key to limiting future costs.

PEPFAR, the Global Fund, and the MAP have made a clear commitment to address gender issues. By taking the steps recommended in this report they can begin to move beyond their stated commitments—that is, gender as usual—to real actions that will advance the global fight against HIV/AIDS.

Table 1

Summary of gender-related approaches to HIV/AIDS in Mozambique, Uganda, and Zambia, by research area and question and donor

Research area and guiding question	The U.S. President's Emergency Plan for AIDS Relief (PEPFAR)	The Global Fund to Fight AIDS, Tuberculosis and Malaria	The World Bank's Africa Multi-Country AIDS Program (the MAP)
Gender analysis			
In what ways do the three donors analyze the relationship between gender inequality and HIV/AIDS, and how do the results inform the donors' policies and programs?	<ul style="list-style-type: none"> The extent of gender analysis in situational assessments varies. The use of gender analysis in program planning is not clear. 	<ul style="list-style-type: none"> The amount of gender analysis in proposals has varied—but generally such analysis has been lacking. When gender analysis has been included, the proposed activities have not addressed the identified gender-related needs. The Global Fund's new gender equality strategy requires that countries include gender analysis in their proposals. 	<ul style="list-style-type: none"> The MAP supports gender analysis to identify differences between women and men in epidemiological and behavioral data—but it supports little analysis of gender relations or gender-related vulnerabilities, effects, or needed program responses.
Gender-related programming			
How are the donors' gender policies put into practice through programming?	<ul style="list-style-type: none"> Some PEPFAR programs address gender inequality, but there is no systematic approach at the country level. The five strategic areas and four global gender goals are not translated into country level objectives and systematic programming that address identified needs. Gender-related programming is hindered by PEPFAR's focus on short-term results. 	<ul style="list-style-type: none"> Few Global Fund programs address gender inequality. The Global Fund's new gender equality strategy clearly states a willingness to support gender-related HIV/AIDS programming. 	<ul style="list-style-type: none"> The MAP's gender-related programs have consisted chiefly of three activities: <ul style="list-style-type: none"> Funding gender ministries to support the AIDS response. Including gender concepts in some capacity building. Supporting some community initiatives with gender-related features.
Gender-sensitive monitoring and evaluation			
What accountability mechanisms are there for addressing gender issues in donor-supported programming?	<ul style="list-style-type: none"> PEPFAR requires collecting and reporting sex-disaggregated data. No gender-related indicators measure progress in PEPFAR's five gender strategic areas—or for any other gender-related objectives. PEPFAR has no ability to track funds dedicated to addressing gender issues. 	<ul style="list-style-type: none"> The Global Fund's new gender equality strategy requires reporting sex-disaggregated data. Existing grants mostly have not reported sex-disaggregated data or data on gender-related indicators. The Global Fund has no ability to track funds dedicated to addressing gender issues. 	<ul style="list-style-type: none"> Impact and outcome indicators are mostly disaggregated by sex—but output indicators are not. No collection or reporting on gender-related indicators is required. The MAP has no ability to track funds dedicated to addressing gender issues.
Gender capacity			
What capacity do donors and recipients have to address gender issues, and what efforts are being made to build capacity?	<ul style="list-style-type: none"> Gender capacity in PEPFAR country offices, recipient organizations, and subrecipient organizations varies. Few efforts have been made to build gender capacity in recipient organizations, but technical assistance is available upon request from country teams. Gender capacity is greater in primary recipient organizations than in subrecipient organizations. 	<ul style="list-style-type: none"> Country coordinating mechanisms lack expertise in designing gender-related objectives, programs, and performance measures. Local fund agents and fund portfolio managers lack expertise in evaluating and managing gender-related programming. Gender capacity in primary recipient and subrecipient organizations varies widely. Grants have not financed gender capacity building. 	<ul style="list-style-type: none"> The MAP has funded some gender-related training and technical assistance for national AIDS councils, ministries, district governments, and civil society groups—but has not evaluated the training or the technical assistance in any way. In recipient and subrecipient organizations, capacity for monitoring and evaluation on gender issues remains low.

About this report

Gender inequality must be addressed if the spread of HIV/AIDS is to be reduced

Women and girls are now at the center of the HIV/AIDS epidemic in sub-Saharan Africa. More than 60% of those living with HIV in the region are female. For young people the difference is even starker—HIV prevalence is 3.2% in young women compared with 1.1% in young men.³

These statistics highlight what many scientists and public health specialists have recognized since at least the mid-1990s—that social and cultural factors, including gender inequality, must be addressed if the spread of HIV/AIDS is to be reduced.⁴ Yet public health efforts have traditionally focused on changing individual behavior. They have assumed that women, men, girls, and boys individually control their ability to behave in ways that prevent risk, reduce vulnerability, and limit the effects of infection and disease.

Interventions based on the assumption that people individually control their behavior have had limited success in the fight against HIV/AIDS. Such interventions ignore the structural factors—social, economic, physical, and political—that influence the spread and effects of the disease. Among the most important of those structural factors is gender inequality, which is linked in various ways to HIV/AIDS risk and vulnerability for women and girls. (*Gender* and *gender inequality*, in the senses adopted by this report, are defined in box 1. Other key terms are defined in annex A.)

Gender norms often limit women's ability to control the conditions of their sexual relationships, including risky sexual behavior.⁵ Concepts of masculinity often create risk for

men by encouraging such behavior (for example, having multiple sex partners).⁶ The most extreme expression of gender inequality—gender-based violence—has been identified as a risk factor for HIV infection⁷ and as a factor in limiting women's access to counseling and testing and hindering them from disclosing their HIV-positive status.⁸ Studies from Rwanda, Tanzania, and South Africa show a threefold increase in HIV infection among those who have experienced gender-based violence compared with those who have not.⁹

Women's limited access to education, employment, and other economic opportunities (such as credit) increases their economic vulnerability, which in turn makes them more likely to adopt risky sexual behavior.¹⁰ Although the mechanism through which girls' education affects HIV vulnerability still is not precisely clear, evidence is emerging that girls with more years of schooling are better able to negotiate conditions of sexual relationships. For example, results of a study in South Africa show that girls who complete primary school, compared with girls who do not, are twice as likely to use condoms. And girls who complete secondary school,

3. UNAIDS 2008.

4. Mann 1996.

5. Weiss and Rao Gupta 1998.

6. Barker 2005.

7. Dunkle and others 2004.

8. Maman and others 2000.

9. Global Coalition on Women and AIDS and World Health Organization 2004.

10. Hallman 2004.

Gender “is not a synonym for sex,” in the words of Thirteenth International AIDS Conference plenary speaker Geeta Rao Gupta.¹ Rather, as Rao Gupta goes on to explain:

[Gender] refers to the widely shared expectations and norms within a society about appropriate male and female behavior, characteristics, and roles. It is a social and cultural construct that differentiates women from men and defines the ways in which women and men interact with each other. Gender is a culture-specific construct—there are significant differences in what women and men can or cannot do in one culture as compared to another. But what is fairly consistent across cultures is that there is always a distinct difference between women’s and men’s roles, access to productive resources, and decisionmaking authority.

Gender inequality exists where women and men:

- Are not treated equally in laws and policies.
- Do not share equally in power and influence.
- Do not have an equal possibility to develop their full potential.
- Do not have equal access to services, financial resources, information, and technologies.
- Do not have equal opportunities, rights, and obligations in the public and private spheres—including those that are related to work and to other ways of generating income.

Gender equality does not mean that women and men are the same. Rather, it means that no one’s rights, responsibilities, and opportunities depend on his or her sex. Efforts to reduce gender inequality in national HIV/AIDS responses should be based on a commitment to realizing human rights, including nondiscrimination and freedom from violence.

Note

1. Rao Gupta 2000.

compared with girls who do not complete primary school, are almost four times more likely to use condoms.¹¹ Similar results are reported in various other studies in sub-Saharan Africa.¹²

Limited access to economic opportunities also makes women more dependent on men—and economic inequality in relationships has been associated with sexual coercion and an inability to negotiate condom use.¹³ Finally, women’s roles as mothers and caregivers mean that they often bear the greatest burden in caring for family and community members living with or affected by HIV/AIDS.¹⁴

Our study analyzes and compares the gender-related policies, strategies, and interventions

used in Mozambique, Uganda, and Zambia by three large and influential donors: the U.S. President’s Emergency Plan for AIDS Relief (PEPFAR), the Global Fund to Fight AIDS, Tuberculosis and Malaria, and the World Bank’s Africa Multi-Country AIDS Program (the MAP). Other donors, particularly some Northern European countries, have taken the lead in promoting gender equality to advance development. But PEPFAR, the Global Fund, and the MAP have great influence and responsibility in deciding whether and how HIV/AIDS policies and programs address gender inequality and gender-related issues at the country level. If these donors do not systematically address the various ways in which gender drives HIV/AIDS risk and vulnerability among women and men, the impact of the donors’ efforts to slow the epidemic will be limited.

To keep this analysis manageable we focus on how the three donors address the risks,

11. Hargreaves and Boler 2006.

12. Hargreaves and Boler 2006.

13. Luke 2003.

14. Ogden, Esim, and Grown 2006.

The report draws strong general lessons about what structures must be in place for the three donors to successfully address the relationship between gender inequality and HIV/AIDS

vulnerabilities, and consequences of the epidemic for women and girls—a focus that can include programs targeting men to improve HIV/AIDS outcomes for women and girls. We do not evaluate the donors’ efforts to address other important dimensions of the relationship between gender inequality and HIV/AIDS, such as the dimensions that affect individuals across all sexual diversities and not just heterosexual men and women. Also, we do not join the longstanding debate over the merits of gender mainstreaming compared with targeted gender-related programming and financing. Both approaches have their benefits and drawbacks—and, in practice, the line between them is often blurred. Rather than ask whether one approach is better, we ask whether each donor has structures in place to successfully address gender inequality in its programs.

Our retrospective view of how the donors’ gender-related policies and strategies have been put into practice from 2000 through 2007 uses evidence obtained from donor programs in the three study countries. Although the report contains much information, some types of evidence are uneven across donors or countries: a limitation due in some cases to the unavailability of data, to difficulties in accessing data, or to varying donor models and country contexts. Another study limitation is that, with a sample of just three countries, some of this report’s findings might not represent how donor programs work in other countries. Despite these limitations, the report draws strong general lessons about what structures must be in place if donors are successfully to address the relationship between gender inequality and HIV/AIDS.

The report recommends practical steps for each donor—steps that will make its programs better able to address gender inequality. The report also discusses how coordinated efforts can make the most of each donor’s special strengths and the special strengths of its country partners.

All three donors have global-level policies that recognize an urgent need to address gender inequality in their HIV/AIDS programming.¹⁵

But to what degree, and how, are such global-level policies and strategies on gender issues reflected in the donors’ country-level programs? To learn whether programming on the ground is gender-responsive, this study has asked four questions, each informed by certain premises about what is most likely to ensure gender-responsive programming (box 2). The answers to the four questions were sought using qualitative analysis of national-level donor and government policies, of recipient and subrecipient organizations, of program providers, and (to a lesser extent) of program beneficiaries.

Data were collected through document reviews and interviews in Mozambique, Uganda, and Zambia. Relevant policy and program documents were identified and reviewed. Key staff in the donors’ country-based offices, in host country governments, and at recipient and subrecipient organizations were interviewed for their specialized knowledge about setting policies and program priorities and about putting programs into practice. Interviews, focus group discussions, and participant observations were used to learn about the impact of the donors’ programs on particular beneficiaries—gathering data from beneficiaries of programs designed to serve sex workers, to serve orphans and vulnerable children, and to prevent mother-to-child transmission. (Details of the study methodology are in annex B. Beneficiary-level case studies are in annex C.) In addition, secondary resources were consulted to provide sample terms of reference for a national gender analysis (annex D) and sample gender-related indicators for program monitoring and evaluation (annex E).

Chapter 1 briefly reviews national efforts to address the relationship between gender inequality and HIV/AIDS in Mozambique, Uganda, and Zambia. Chapters 2, 3, and 4 present findings and make recommendations for the three donors: PEPFAR (chapter 2), the Global Fund (chapter 3), and the MAP (chapter 4). Chapter 5 appeals to each donor to act individually—and to all three donors to act collectively—to make gender-responsive programming a priority for action and so fight more effectively against the global HIV/AIDS epidemic.

15. Ogden, Oomman, and Weeth 2008.

Four research questions guided this study of gender-related HIV/AIDS policies, strategies and interventions used by three major donors in Mozambique, Uganda, and Zambia. Each question is informed by certain premises about gender and HIV/AIDS programming, outlined below.

- In what ways do the three donors analyze the relationship between gender inequality and HIV/AIDS in Mozambique, Uganda, and Zambia—examining women’s and men’s experiences, needs, and priorities—and how do the results inform the donors’ policies and programs for each country?** To ensure that HIV/AIDS policies and programs are appropriately designed, donors need a good analysis of how the epidemic affects women and men, girls and boys. The analysis should examine key epidemiological and behavioral surveillance data to determine whether there are differences by sex. It should then analyze such differences to learn why they exist and how they might be addressed. It should examine laws and regulations, security and freedom from violence, access to education and to economic opportunities, equitable access to services and technologies, and participation in political processes and program design. Finally, a good gender analysis should examine the experiences of implementers at the community level, highlighting barriers to operations. Comprehensive gender analysis is vital to understanding gender’s relationship to HIV/AIDS in a given country, and it is vital to ensuring that programs are based on identified needs—an essential feature of successful gender-responsive programming (see annex D for a sample terms of reference for a national gender analysis).
- How are the donors’ gender policies put into practice through programs that address gender issues?** Gender-responsive HIV/AIDS programming should address the needs identified by a comprehensive gender analysis. It should also reflect strategies and objectives that are informed by the analysis, as well as by evidence on the effectiveness of interventions designed to address links between gender and HIV/AIDS risk and vulnerability.
- What accountability mechanisms are there for addressing gender issues in donor-supported programming for the three study countries—either through monitoring and evaluation or through financial accountability?** Programs and financing should be monitored and evaluated so that donors are accountable for their commitments to fund gender-responsive programming. Donors should do programmatic and financial reporting on actions and outcomes. Programmatic reporting should have gender-specific indicators, and reported data on every indicator related to sex or gender issues should be sex-disaggregated (see annex E for sample gender-related indicators). Financial reporting—tracking funds spent to meet gender-related objectives—is also critical for effective planning.
- What capacity do donors and recipients have to address gender issues, and what efforts are being made to build capacity?** Donors must ensure that human capacity to address gender inequality is strengthened so that gender-responsive policies can be put into practice. To develop and manage gender-responsive programming, donor programs must develop an understanding of gender and must build gender-related specialized skills in their own staff, including hiring gender focal points or specialists where needed. The donors must also support capacity building on gender issues—in host country governments, in recipient and subrecipient organizations, and in implementing partners—through training, technical guidance, manuals, and tools for integrating gender into programs. Such technical support should complement and strengthen what staff learn on the job as they confront routine gender-related challenges in designing, carrying out, and evaluating effective programs.

In addition, throughout our analysis we examine an issue that cuts across the research questions: whether and, if so, how the donors are supporting existing national strategies to address the link between gender inequality and HIV/AIDS.

1

Setting the stage: national policies on gender and HIV/AIDS in Mozambique, Uganda, and Zambia

Do national responses adequately address the gender norms and the kinds of gender inequality that drive the spread of HIV/AIDS in the population, that make women and girls more vulnerable to HIV/AIDS, and that hinder access to HIV/AIDS services?

Mozambique, Uganda, and Zambia are affected differently by HIV/AIDS, and the structures of their national AIDS responses differ (table 1.1). Each country has national policy documents that assert a need to address the relationship between gender inequality and HIV/AIDS. The documents show a reasonable understanding of this relationship in each country. Yet there is little strategic action to follow up and address the issues identified, and even less work to design indicators and targets for measuring progress. As a result, the countries' national efforts to address gender and HIV/AIDS remain largely rhetorical.

To assess whether the national responses adequately address the gender norms and the kinds of gender inequality that drive the spread of HIV/AIDS in the population, that make women and girls more vulnerable to HIV/AIDS, and that hinder access to HIV/AIDS services, we ask whether each country's national policies for development, health, gender, and HIV/AIDS show a good understanding of gender inequality's link to the epidemic in the country. We ask whether the policies set forth specific strategies and objectives for a sector, or for the country as a whole, to address gender and HIV/AIDS. And we ask whether the policies include relevant gender-related indicators and targets to measure progress over specified periods.

In addition—while we recognize that no sector or agency alone can address all the forms of gender inequality that drive the spread of HIV/AIDS and worsen its effects—we ask whether national strategies are making the most of the special strengths of each sector and government agency for addressing various gender issues. Finally, we ask whether national policies mutually cohere: that is, whether the strategies and actions set forth in a country's national HIV/AIDS plan support those in its

national health and development plans, avoiding conflicts with those plans.

Mozambique: some analysis and strategic action to address gender, but lacking indicators or targets to measure progress

Three main policy documents guide Mozambique's national HIV/AIDS response in its approach to gender issues. Outlining strategies in national development, health, and HIV/AIDS policy, the documents include Mozambique's national poverty reduction strategy (guiding overall development policy);¹⁶ its national health sector HIV/AIDS strategy (guiding health sector policy); and its national AIDS strategy (guiding the multisectoral national AIDS response).

Mozambique's national poverty reduction strategy for 2006–09 recognizes the relationship between gender inequality and HIV/AIDS as a crosscutting development issue—yet its strategy on gender and HIV/AIDS is cursory. The strategy outlines priority actions to address gender-related HIV/AIDS issues, including:

16. Republic of Mozambique 2006.

- Adopting measures to reduce mother-to-child transmission.
- Approving and putting into practice a national gender policy and strategy.
- Revising legislation, especially legislation against domestic violence, to prevent discrimination against women.
- Identifying gaps in gathering and analyzing sex-disaggregated data.
- Carrying out other activities to reduce the prevalence of HIV/AIDS in women.

However, it is unclear how these somewhat abstract priorities will be realized. Because the strategy lacks specific goals and objectives to ensure follow-up, government agencies have only a very weak incentive to put the priorities into practice.

Mozambique's national poverty reduction strategy is important in setting its national priorities. Since the strategy offers only very weak incentives for addressing gender-related HIV/AIDS issues, national efforts on gender and HIV/AIDS could receive very low priority.

Gender analysis in the national poverty reduction strategy is not systematic. The strategy points generally to social issues that add to women's HIV/AIDS vulnerability, but it does not analyze specific issues that add to women's vulnerability or that hinder their access to services. Harmful gender norms are not fully examined.

The national poverty reduction strategy's monitoring framework—the performance assessment framework—is not gender-sensitive in tracking HIV/AIDS-related indicators. Most indicators in the performance assessment framework do not disaggregate data by sex. Just one HIV/AIDS indicator (the percentage and number of pregnant women receiving prophylaxis to reduce transmission) focuses on women. The poverty reduction strategy focuses on infants rather than on pregnant women and mothers, and it lacks gender-related indicators.

The HIV/AIDS strategy of Mozambique's national health ministry explicitly leaves it up to other institutions to address most gender-related HIV/AIDS issues—possibly creating a dangerous

Table 1.1 The HIV/AIDS epidemic and national responses in Mozambique, Uganda, and Zambia

Country	Number of people living with HIV/AIDS	HIV prevalence in adults ages 15–49	Key features of the national AIDS response
Mozambique	1.5 million	15.0%	<ul style="list-style-type: none"> • Most donor HIV/AIDS funding is provided through Mozambique's common funds for the health sector and for the national AIDS response—an important example of an attempt to coordinate donor programs. The Global Fund to Fight AIDS, Tuberculosis and Malaria and the World Bank's Africa Multi-Country AIDS Program (the MAP) provide funding through the common funds.
Uganda	940,000	5.4%	<ul style="list-style-type: none"> • The Uganda government is noted for its strong, comparatively early commitment to fighting HIV/AIDS. • The U.S. President's Emergency Program for AIDS Relief (PEPFAR) has provided a very high share of total HIV/AIDS funding, partly because corruption problems have created obstacles to support from the Global Fund.
Zambia	1.1 million	15.2%	<ul style="list-style-type: none"> • In Zambia's pioneering structure, four different recipients manage Global Fund grants for HIV/AIDS programs. • Zambia is noted for its high donor HIV/AIDS resources relative to its low population.

Source: UNAIDS 2008.

lack of accountability. The HIV/AIDS strategy for 2004–08¹⁷ argues that there is no significant difference in HIV prevalence between women and men—even though the reported HIV prevalence rates in Mozambique for 2006 were 18.1% for women and 13.9% for men.¹⁸

Discussing the health sector's specific role in the AIDS response, the national HIV/AIDS strategy notes:¹⁹

[The] health sector should not deal with the gender problem in its totality and complexity, given that many aspects should be addressed by other institutions and/or services, namely at the Ministry of Women and the Coordination of Social Action, Ministry of Education and Ministry of Youth and Sports.

Certainly the health sector cannot address all the social issues that contribute to gender

17. Mozambique Ministry of Health 2004.

18. UNAIDS 2006.

19. Mozambique Ministry of Health 2004, p. 61.

The lack of a gender focus in the Mozambique health ministry's national HIV/AIDS strategy conflicts with the strategy's declared desire to mainstream gender throughout HIV/AIDS activities

inequality. But the health policy's apparent lack of a gender focus creates a risk that the country's HIV/AIDS health services will not work to overcome gender-related access barriers. And if the health sector does not help address the epidemic's gender-related drivers, it will make more work for itself, as it will battle a higher number of future infections. Finally, the lack of a gender focus in the health ministry's national HIV/AIDS strategy conflicts with the strategy's declared desire to mainstream gender throughout HIV/AIDS activities (for a definition of gender mainstreaming see appendix A).

The Mozambique health sector's monitoring of its HIV/AIDS programs is not gender-sensitive. The health ministry's HIV/AIDS strategy has no gender-related indicators and few sex-disaggregated indicators.

The situational assessment in Mozambique's national HIV/AIDS strategy (2004–09)²⁰ discusses several aspects of gender inequality's relationship to HIV/AIDS, drawing on studies and government reports to address gender and HIV/AIDS. The situational assessment discusses gender-related drivers that increase infection rates, including crossgenerational sex, multiple concurrent partners, and men's need to prove their masculinity. And it discusses how women are made more vulnerable to HIV/AIDS by other social and cultural beliefs, practices, behaviors, and conditions related to gender norms—for example, purification practices, the subordination of women, sexual and domestic violence against women, and women's lack of economic power.

The national HIV/AIDS strategy includes some analysis of gender-related barriers to accessing services. It discusses gender differentials in access to counseling and testing, and it notes the different reasons why women and men access those services. The analysis shows a fairly good understanding of these gender-related drivers and vulnerabilities based on studies and government reports. Missing from the analysis, however, is the burden of care on women and girls.

20. CNCS 2004.

The national HIV/AIDS strategy includes objectives and strategies to address gender-related drivers and vulnerabilities identified in the situational analysis—but it sets forth no concrete targets for meeting the objectives. The gender-related objectives and strategies (table 1.2) respond to many of the issues raised in the situational assessment. Missing are strategies to overcome women's access to services. Also missing are concrete targets against which to measure progress on any strategy.

Most of the national HIV/AIDS strategy's indicators are sex-disaggregated, but the strategy has only one indicator to measure changes in harmful gender norms. All output, outcome, and impact indicators in the strategy are sex-disaggregated. In 2004 the list of indicators included none for harmful gender norms—those that increase vulnerability or pose barriers to access. A 2006 revision led to the inclusion of just one such indicator (the percentage of people who agree that the wife of a man with a sexually transmitted infection may either refuse to have sex with him or propose using a condom). The strategy's ability to measure progress against gender-related objectives remains limited.

Uganda: fairly strong gender analysis, but with few corresponding actions or efforts to measure progress

Several national policies guide Uganda's response to gender and HIV/AIDS. They include the national poverty eradication action plan (guiding overall development policy), the national gender policy (guiding the integration of a gender focus into national development programs), the health sector strategic plan (guiding health sector policy), the national HIV and AIDS strategic plan (guiding the multisectoral national AIDS response), and the HIV/AIDS strategic plan for the social development sector (guiding the AIDS response in social development ministries led by the Ministry of Gender, Labour and Social Development).

Uganda's poverty eradication action plan for 2004/05–2007/08 mentions gender as a cross-cutting development issue—but it barely discusses gender inequality's relationship to HIV/AIDS, includes no strategic actions to address that relationship, and lists no indicators that could measure progress on gender and HIV/AIDS. In a chapter on social development, the poverty eradication action plan discusses the needs for gender mainstreaming and for women's empowerment.²¹ Yet the plan includes very little specific analysis of gender inequality and its effects on health and development in Uganda. The document claims that a lack of responsiveness to gender has resulted from a lack of expertise among planners and implementers in applying gender analysis, from the limits on Ugandan communities' awareness of gender inequality, and from bureaucratic resistance to gender mainstreaming.

The action plan sets forth priority actions for gender mainstreaming, including putting the national gender policy into practice and producing and disseminating sex-disaggregated data. Yet none of the actions directly addresses issues related to gender and HIV/AIDS. In the plan's results and policy matrix, only one strategic objective—inclusive and empowered communities—proposes to address gender inequality, and the plan includes no indicators to measure progress against this objective. The plan generally seems to defer to Uganda's national gender strategy on all specific national efforts to address gender issues.

Uganda's national gender policy does not specifically address the link between gender inequality and health or HIV/AIDS. The policy, created in 1997, is supposed to be carried out largely by the Ministry of Gender, Labour and Social Development and the Ministry of Finance, Planning and Economic Development. Rather than include objectives, actions, or guidelines related to gender and health or to gender and HIV/AIDS, the policy lays out a somewhat general approach to focusing on gender in national

21. Uganda Ministry of Finance, Planning and Economic Development 2004.

Table 1.2 Gender-related objectives and strategies in Mozambique's national HIV/AIDS strategy

Priority areas	Specific objectives	Strategies
Preventing HIV infection	<ul style="list-style-type: none"> • Increase general knowledge about HIV/AIDS, and reduce the gender differential in such knowledge. • Reduce the extent to which social, cultural, and economic factors make women more vulnerable to HIV/AIDS. • Reduce mother-to-child transmission. 	<ul style="list-style-type: none"> • Inform, educate, and communicate—ensuring that messages on HIV/AIDS reach women. • Increase knowledge of women's special vulnerability to infection. • Discredit myths and preconceptions about women that lower their social status compared with men's. • Promote knowledge of, and access to, legal instruments for fighting against domestic and sexual violence. • Support development programs aimed at women. • Increase the proportion of births that occur in medical institutions. • Increase women's awareness of mother-to-child transmission.
Mitigating the consequences of HIV/AIDS	<ul style="list-style-type: none"> • Increase the capacity of people in households and communities affected by HIV/AIDS—especially women—to generate income. 	<ul style="list-style-type: none"> • Promote initiatives to make people in the communities better able to generate income. • Ensure that women are involved in such initiatives.

Source: Costa, Tuominen, and Antunes 2009.

development. That could be because the HIV/AIDS strategic plan for the social development sector is supposed to detail a national approach to gender and HIV/AIDS. But since the poverty eradication plan explicitly defers to the national gender policy on all national efforts to address gender issues, the lack of attention to health and HIV/AIDS in Uganda's national gender policy might reflect a problematic lack of high-level concern with gender inequality's relationship to HIV/AIDS in the national dialogue on health and development.

Uganda's health sector strategic plan for 2005/06–2009/10 includes little analysis of gender-related barriers to effective health programs and no analysis of gender inequality's relationship to HIV/AIDS. In a chapter on implementation, the health sector strategic plan discusses equitable access for vulnerable communities and individuals and includes a brief review of gender-related barriers to accessing health services.²² Examples include women's

22. Uganda Ministry of Health 2005.

The lack of attention to health and HIV/AIDS in Uganda's national gender policy might reflect a problematic lack of high-level concern with gender inequality's relationship to HIV/AIDS

low education levels, their lack of financial and decisionmaking power, and the household and childcare responsibilities that leave them little time to visit healthcare facilities. The plan's only mention of gender issues related to HIV/AIDS is a brief note that HIV prevalence in women exceeds that in men. However, the plan commits the health sector to conducting or participating in "surveys and other studies that can provide more information about client satisfaction and gender responsiveness."

The health sector strategic plan proposes to address some gender-related barriers to accessing health services, but generally it avoids addressing underlying gender norms that drive the spread of HIV/AIDS and increase vulnerability for certain groups. The plan mentions four strategies to address gender-related barriers to access: targeting men at the household level to teach them the importance of women getting healthcare, targeting women to teach them the importance of getting healthcare for themselves and their children, supporting reviews and field studies on gender inequality's relationship to health and health-seeking behavior, and building health workers' capacity to consider gender issues in their work.

A section in the health sector strategic plan on noncommunicable diseases includes a target to develop and disseminate a strategy against gender-based violence. But the plan does not note any link between gender-based violence and a communicable disease, HIV/AIDS. Nor does the plan discuss how other gender norms or gender-related barriers might contribute to the HIV/AIDS epidemic.

Sex-disaggregated data are collected under the health sector strategic plan, but the plan has no indicators to measure changes in gender norms. Indicators generally are disaggregated by sex where such disaggregation is relevant. But the plan's monitoring framework has no gender-related indicators to measure changes in gender inequality or in gender norms that drive the spread of HIV/AIDS (see annex E for sample gender-related indicators to be used in monitoring and evaluation).

In Uganda's national HIV/AIDS strategic plan for the social development sector for 2007/08–2011/12, a situational assessment identifies gender issues—but does not always explain what data, if any, support its analysis. In its situational assessment, the national HIV/AIDS strategic plan²³ cites the significantly higher HIV prevalence rate among women, especially young women and girls. Women's greater HIV/AIDS vulnerability is traced to their inability to negotiate safer sex, which is attributed in turn to their low social status, their economic dependency, and their fear of violence. The HIV/AIDS strategic plan also notes that women bear the greater burden of caring for sick family members, are more likely than men to be expelled from family homes, and are more likely than men to be denied treatment, care, and basic human rights. The plan thus identifies gender inequality as a key driver of the epidemic in Uganda. Still, the plan does not always explain what data—if any—underlie its account of gender issues and HIV/AIDS.

The situational assessment includes a review of Uganda's previous HIV/AIDS plan. The review points out that under the previous plan women and girls were among the most affected but the least served and that Uganda has not adequately addressed gender inequality's relationship to HIV/AIDS.

The national HIV/AIDS strategic plan does not include actions to address harmful gender norms identified in the situational analysis. The plan sets forth a few gender-responsive strategies, such as educating people about the risks of transactional and crossgenerational sex, targeting commercial sex workers for information and education campaigns, and including male partners in programs to prevent mother-to-child transmission. However, the plan includes no prevention strategies to address the gender-based vulnerabilities identified in its situational analysis as drivers of HIV/AIDS. Nor does the plan include any strategy to address the disproportionate burden of care on women compared with men.

23. Uganda Ministry of Gender, Labour and Social Development 2007.

The national HIV/AIDS strategic plan includes a monitoring and evaluation framework with sex-disaggregated indicators—but the framework has no gender-related indicators or targets. Although the plan requires reporting and using sex-disaggregated data where appropriate, it has no indicators or targets to measure changes in gender norms that drive the spread of HIV/AIDS or that increase the vulnerability of specific populations. However, the plan includes one indicator—still undefined when the document was published—that would measure men’s participation in providing social support (presumably yielding some information on the burden of care).

The national HIV/AIDS strategic plan focuses more on mainstreaming HIV/AIDS into the social development sector’s work than on integrating a gender focus into the national HIV/AIDS response. The plan lays out several ways in which the Ministry of Gender, Labour and Social Development will integrate HIV/AIDS concerns into its mandate to promote the rights and wellbeing of poorest and most vulnerable groups in the country, including women. But the plan contains little discussion of how the ministry should help to integrate gender concerns throughout the national HIV/AIDS response. The dearth of such discussion could cause gender programming to be sidelined within the Ministry of Gender, Labour and Social Development, which has a limited mandate. Instead, gender concerns should be integrated widely into programming led by other important actors in Uganda’s national HIV/AIDS response.

The national HIV/AIDS strategic plan has few objectives, strategies, and indicators that specifically address gender inequality’s relationship to HIV/AIDS. Objectives in the plan are fairly broad and target various vulnerable groups, with no special focus on women or girls. Some proposed activities could partly address gender-related HIV/AIDS issues: examples include involving men in preventing mother-to-child transmission, empowering vulnerable groups economically, integrating family planning and

HIV/AIDS services, promoting healthcare seeking among men, promoting protective legislation for vulnerable groups, and promoting protection methods that women and other vulnerable groups can control. However, the plan includes no indicators to measure progress for such programs.

Generally, the national HIV/AIDS strategic plan outlines ways to serve vulnerable groups as a whole, but without identifying and responding to the special gender-related vulnerabilities of women and girls. The reason might be that the plan’s situational assessment lacks a true, data-driven gender analysis—one that could support planning for an effective response to gender issues. Since the plan does not fully address gender anywhere, one can reasonably infer that a gender focus has not been fully integrated into Uganda’s national HIV/AIDS response.

Zambia: high-level commitments to addressing gender, but with few concrete actions to meet those commitments

Zambia has several policy documents that guide its approach to gender and HIV/AIDS. Among them are the national gender policy (guiding the integration of a gender focus into national development programs), the fifth national development plan (guiding overall development policy), the national health strategic plan (guiding health sector policy), and the HIV/AIDS strategic framework (guiding the multisectoral national AIDS response).

Zambia’s Gender in Development Division was created at the cabinet level to coordinate gender-related activities, including implementing and monitoring Zambia’s national gender policy and the gender-related part of its national development plan. To integrate a gender focus into its activities, Zambia’s government in 2000 adopted a national gender policy.²⁴ Policy objectives that address HIV/AIDS include:

- Increasing the provision of quality health-care for women and children.

24. Zambia Gender in Development Division 2000.

Uganda’s national HIV/AIDS strategic plan includes no indicators to measure progress for gender-responsive programs

Zambia's national development plan for 2006–10 commits the government to gender mainstreaming, including in policies and programs to control and prevent HIV/AIDS

- Encouraging men's involvement in caring for the chronically ill, especially those with HIV/AIDS.
- Developing health management information systems that disaggregate data by sex.
- Promoting awareness of the harm caused by some cultural practices.

In Zambia's national development plan for 2006–10,²⁵ a chapter on gender and development commits the government to gender mainstreaming throughout national development—including in policies and programs to control and prevent HIV/AIDS and other sexually transmitted diseases. Two strategies in the national development plan that affect HIV/AIDS programming are building capacity for gender mainstreaming in government institutions and establishing gender-sensitive information systems for planning and decisionmaking. Yet the plan explains little about how particular activities would meet Zambia's gender-related objectives, especially the objectives that address gender and HIV/AIDS.

In addition to the strategies mentioned in the national gender policy and the national development plan, Zambia's Gender in Development Division has tried to address gender-based violence through victim support units and through legislation to increase punishments for perpetrators.

The Gender in Development Division collaborates with Zambia's national AIDS council to mainstream a gender focus throughout line ministries' AIDS programs, and it runs a special program to reduce the impact of HIV/AIDS on women and girls. The Women, Girls and HIV/AIDS Program, launched in 2004 with support from the Joint United Nations Programme on HIV/AIDS, focuses on six themes:

- Preventing infection among women and girls.
- Improving girls' education.
- Preventing violence against women and girls.
- Promoting property and inheritance rights for women and girls.

- Raising awareness of women's and girls' roles in caring for people affected by HIV/AIDS.
- Increasing women's and girls' access to HIV/AIDS care and treatment.

The Gender in Development Division's policies and strategies mostly have not been put into practice. In the words of one key informant from the Gender in Development Division in Zambia:

... first and foremost, the recognition of the gender component being vital in these documents and policies is there. The gap is when it comes to the actual implementation . . . when it comes to the actual interventions, that is where gender has been missed out in most cases. Now if you miss out the gender perspective in the intervention, when it comes to implementations it is completely missed out. That is where the gap is.

This failure to put policies and strategies into practice has resulted from inadequate funding, limited access to gender analysis, inadequate monitoring and evaluation systems for gender, and inadequate staffing and high staff turnover. The Gender in Development Division is supposed to coordinate the entire government's gender programming, but it has just nine gender specialists: three for economic sectors, three for social sectors, and three for information management and analysis. In addition, the people responsible for putting gender-related policies into practice lack the technical capacity and tools to carry out programs, as a key informant explains:

When you look at the people mandated to implement, they also do not have the needed skills, so how do they implement gender related activities? And also, most of the guidelines are missing to guide those who have little skills, so this is where I see the gap. . . . The political will is there, it is just an issue of effective coordination capacity and all that.

25. Republic of Zambia 2006.

Zambia has not matched its gender mainstreaming rhetoric with concrete actions. Of several gender-related objectives in the national health strategic plan for 2001–05, not one was met.²⁶ The plan recognized a link between gender equality and its health goals, and it advocated gender mainstreaming in the health sector’s programs. Yet midterm reviews in 2004 and 2006 showed that the health sector was performing poorly against its gender-related goals.²⁷ A consultancy report in 2006 made programmatic and organizational recommendations to improve the national health ministry’s ability to address gender—for example, by making the ministry better able to cater to the needs of women in its HIV/AIDS programs.²⁸

Zambia has made some progress. It has run gender-responsive HIV/AIDS awareness and sensitivity campaigns targeted at women, men, and couples. It has integrated a gender focus into training for healthcare providers. And the recognition and reporting of domestic violence cases in Zambia has increased.²⁹

However, Zambia’s gender mainstreaming rhetoric is not accompanied by any ability to measure health-sector outcomes for evidence of such mainstreaming. So far the term has been used only in planning—it has not been applied in concrete actions.

Zambia’s national HIV/AIDS strategic framework for 2006–10 highlights gender’s relationship to HIV/AIDS in Zambia in several ways in its situational assessment—but it often does not explain what data support the analysis. In a situational assessment, the HIV/AIDS strategic framework notes the higher prevalence of HIV in women compared with men, especially in people under age 35.³⁰ The framework also lists several gender-related HIV/AIDS drivers and vulnerabilities, including:

- Men’s dominance and women’s lack of assertiveness in sexual relationships.

- Women’s acquiescence as their husbands engage in extramarital sex.
- Men’s unwillingness to use condoms, even when sexually transmitted diseases are a suspected risk.
- Cultural beliefs and practices, such as sexual cleansing, dry sex, and initiation ceremonies for female children.

In the situational assessment, high HIV prevalence rates in women and girls ages 15–24 are attributed to crossgenerational and transactional sex. High prevalence rates in women ages 30–34 are attributed to social and economic vulnerability, inadequate access to life skills and information, poor negotiation skills, and unequal protection under statutory and customary laws and traditions.

Except in these explanations for prevalence rates, the situational assessment in Zambia’s national HIV/AIDS strategic framework does not explain whether its claims come from national surveys, other studies, expert consultations, or mere speculation grounded in conventional wisdom. In addition, the assessment includes no analysis of gender differentials in the burden of care.

Gender is not well addressed in the national HIV/AIDS strategic framework’s objectives. Of 28 strategic objectives spread across six themes, only 1 addresses gender in any way: prevent sexual transmission of HIV with a special emphasis on youth, women, and high-risk behaviors (included under the theme of intensifying prevention).³¹ And only one gender-related strategy is set forth for achieving this objective: expand information campaigns to teach how gender norms drive HIV infection.

However, the strategic framework commendably encourages promoting men’s involvement in services to prevent mother-to-child transmission. Also, Zambia’s national AIDS council has developed a gender training manual to help people working on HIV/AIDS programs integrate a systematic gender focus into their programming.

Gender is not well addressed in Zambia’s national HIV/AIDS strategic framework

26. Zambia Ministry of Health 2004.

27. Zambia Ministry of Health 2004, 2006.

28. Zambia Ministry of Health 2006.

29. Zambia Ministry of Health 2004.

30. Zambia National HIV/AIDS Council 2006.

31. Zambia National HIV/AIDS Council 2006.

The national HIV/AIDS strategic framework's monitoring and evaluation policy requires that sex-disaggregated data be collected—but it has no indicators to measure changes in gender norms. Indicators to monitor Zambia's national AIDS response are drawn from 10 sources. All

the relevant output and outcome indicators for monitoring and evaluation are required to be disaggregated by sex. Yet no indicators are included to measure change in gender-based HIV/AIDS vulnerabilities.

2 The U.S. President's Emergency Plan for AIDS Relief

PEPFAR's gender strategy includes five strategic areas for addressing gender inequality and four global gender goals

The U.S. President's Emergency Plan for AIDS Relief (PEPFAR) is a bilateral U.S. government program. Over its first five years, from 2003 to 2008, it provided \$18.8 billion to support HIV/AIDS prevention, treatment, and care in poor countries. The majority of its funding goes to 15 focus countries with high HIV/AIDS burdens, 12 of them in sub-Saharan Africa.³²

PEPFAR derives country-level performance targets from its centrally created global targets for HIV/AIDS treatment, prevention, and care, originally the "2-7-10 goals":³²

- Treating 2 million AIDS patients.
- Preventing 7 million HIV infections.
- Supporting care for 10 million people infected with HIV and affected by HIV/AIDS, including orphans and vulnerable children.

In July 2008 the U.S. Congress reauthorized PEPFAR and increased the targets. Now the program aims to treat 3 million patients, prevent 12 million infections, and support care for 12 million people—the "3-12-12 goals."

PEPFAR's recipient country partners set country-specific numeric targets through negotiation with PEPFAR. Country teams—including staff from the U.S. Agency for International Development and the Centers for Disease Control and Prevention, among others—prepare an annual program planning document, the country operational plan. Feedback solicited from program beneficiaries includes an annual review of the past year's program performance.

PEPFAR's gender strategy includes five strategic areas for addressing gender inequality as well as four global gender goals (box 2.1).

This approach provides guidance at the global level—but program planning is conducted at the country level, in consultation with PEPFAR partners and country governments in each of the PEPFAR focus countries.

In 2005, requests from PEPFAR country teams for more guidance across program areas prompted PEPFAR to form its interagency technical working group on gender, with 30 members from various U.S. agencies that implement the PEPFAR program. The working group is mandated to review how country operational plans mainstream gender, to give technical assistance in the field, and to advocate for gender-related programming.

Gender analysis in situational assessments and program design: increased attention to analysis, but with unclear effects on program planning

*Recent situational assessments for Mozambique, Uganda, and Zambia—part of the development of their 2007 country operational plans—reflected increased attention to gender issues by making gender analysis more prominent, describing it in more detail, than earlier assessments had.*³³ Earlier

32. The 15 focus countries are Botswana, Ethiopia, Guyana, Haiti, Côte d'Ivoire, Kenya, Mozambique, Namibia, Nigeria, Rwanda, South Africa, Tanzania, Uganda, Viet Nam, and Zambia.

33. Country operating plans through fiscal year 2007 were reviewed for this report (fiscal year 2008 was publicly available only in December 2008, after data collection was completed).

PEPFAR's five strategic areas and four global goals for addressing gender inequality

The U.S. national authorizing legislation for PEPFAR, Public Law 108-25, referred to various factors in gender inequality's relationship to HIV/AIDS—for example, male behavior norms. In response, the Office of the U.S. Global Aids Coordinator defined five PEPFAR strategic areas for addressing gender inequality:

- Increasing gender equity in HIV/AIDS activities and services.
- Reducing violence and coercion.
- Addressing male norms and behaviors.
- Increasing women's legal protection.
- Increasing women's access to income and productive resources.

In addition, the Gender Technical Working Group work plan describes the following four global gender goals¹:

- Support the achievement of program goals for treatment (treat 3 million people), prevention (prevent 12 million infections), and care (care and support to 12 million infected and affected people) through mainstreaming gender across all areas of PEPFAR programming.
- Strengthen program quality and sustainability by addressing gender dynamics through all intervention levels.
- Guarantee women's and men's equitable access to programs.
- Prevent or ameliorate program outcomes that may unintentionally and differentially harm women and men.

Note

1. The four global gender goals are to be realized through the implementation of the high priority gender strategies (personal communication with Office of the U.S. Global AIDS Coordinator staff, March 12, 2009).

Source: Ogden, Oomman, and Weeth 2008.

country operational plans had mentioned the kinds of gender inequality and gender-related vulnerability that contribute to HIV risk and reduce access to treatment and care. But the 2007 plans clearly paid more attention to gender issues.

In Mozambique, for example, the 2004 country operational plan included only epidemiological data in describing the country's AIDS

Starting in fiscal 2009, PEPFAR country operational plans will be required to include a section specifically addressing gender. The guidance for this requirement, in appendix 21 of the 2009 country operational plan guidance document (PEPFAR 2008a, pp. 92–94), asks each country to describe any gender assessments that it has done or plans to do; to describe its gender strategy, if it has one; to state whether it has a gender focal point; and to explain how it will capture gender-related information through monitoring and evaluation.

epidemic. But by 2007 Mozambique's plan underlined the need for programs to address gender-based violence and sexual coercion, male norms and behaviors, and the effects of gender inequality on access to HIV/AIDS services.

Zambia's 2004 country operational plan mentioned several gender issues that increase women's risk of HIV infection, such as cross-generational sex, sexual violence and coercion, and higher seroconversion rates in discordant couples. The 2007 country operational plan goes further by noting several gender-related vulnerabilities that contribute to women's low access and low adherence to treatment regimens: limited decisionmaking power, the fear of stigma and discrimination related to HIV/AIDS, and limited resources for making trips to clinics and buying drugs.

Country operational plan guidance documents do not clarify what data should inform gender analysis, and do not clarify how the results of such analysis should be used to develop program objectives and to select appropriate interventions addressing identified gender issues. In PEPFAR's 2009 country operational plan guidance document, neither the gender section nor the strategic information section prescribes gender analysis methods for country teams to use in designing gender-responsive programming.³⁴ The extent to which gender analysis results are considered in the annual planning process is unclear.

Programs addressing gender inequality: not systematically implemented across program areas, PEPFAR having no well defined process for developing country-level objectives

Country operational plans show that PEPFAR has increased its gender-related programming

34. The fiscal 2008 country operational plan technical considerations document provides "discussion points" for program planning, a description of "gender approaches" for each of the key program areas, and illustrative examples of activities by program area that "demonstrate a focus on gender equity" (personal communication with staff at the Office of the U.S. Global AIDS Coordinator, March 30, 2009).

over time. PEPFAR's 2007 country operational plans included significantly more gender-related programming than did plans for previous years. For example, Mozambique's 2007 country operational plan had:

- A pilot program to provide post-exposure prophylaxis to women who have experienced sexual violence.
- A program to address sexual coercion and gender-based violence—advocating for women's legal rights and providing them with legal support in dealing with violence, as well as in activities to generate income.

Similarly, Uganda's 2007 country operational plan had:

- An HIV/AIDS education skills program to help girls and boys become more assertive, recognize high-risk relationships, and negotiate safe sex practices—including drama activities and school debates designed to encourage girls' involvement in school.
- A comprehensive prevention, treatment, and care program, carried out by a large local nongovernmental organization and including efforts to reduce gender-based violence and coercion, to address male norms and behaviors, to increase women's legal protection, and to increase women's access to income and productive resources.

And Zambia's 2007 country operational plan had:

- Training on women's and children's rights, especially inheritance and property rights, for caregivers and for families affected by HIV/AIDS.
- Developing a gender and health community facilitation guide to address links between health, gender norms, and traditional practices, with train-the-trainer workshops for field and program staff and three 5-day gender workshops in three districts.

PEPFAR also supports gender-related programming in some countries through centrally funded grants. Participating countries generally are chosen by the Office of the U.S. Global AIDS Coordinator, but country teams can request to be included in such programs and occasionally do. In addition to regular reporting, PEPFAR supports a range of public health

evaluations to evaluate particular programs, some of which have, or are currently evaluating, programs to address gender inequality.

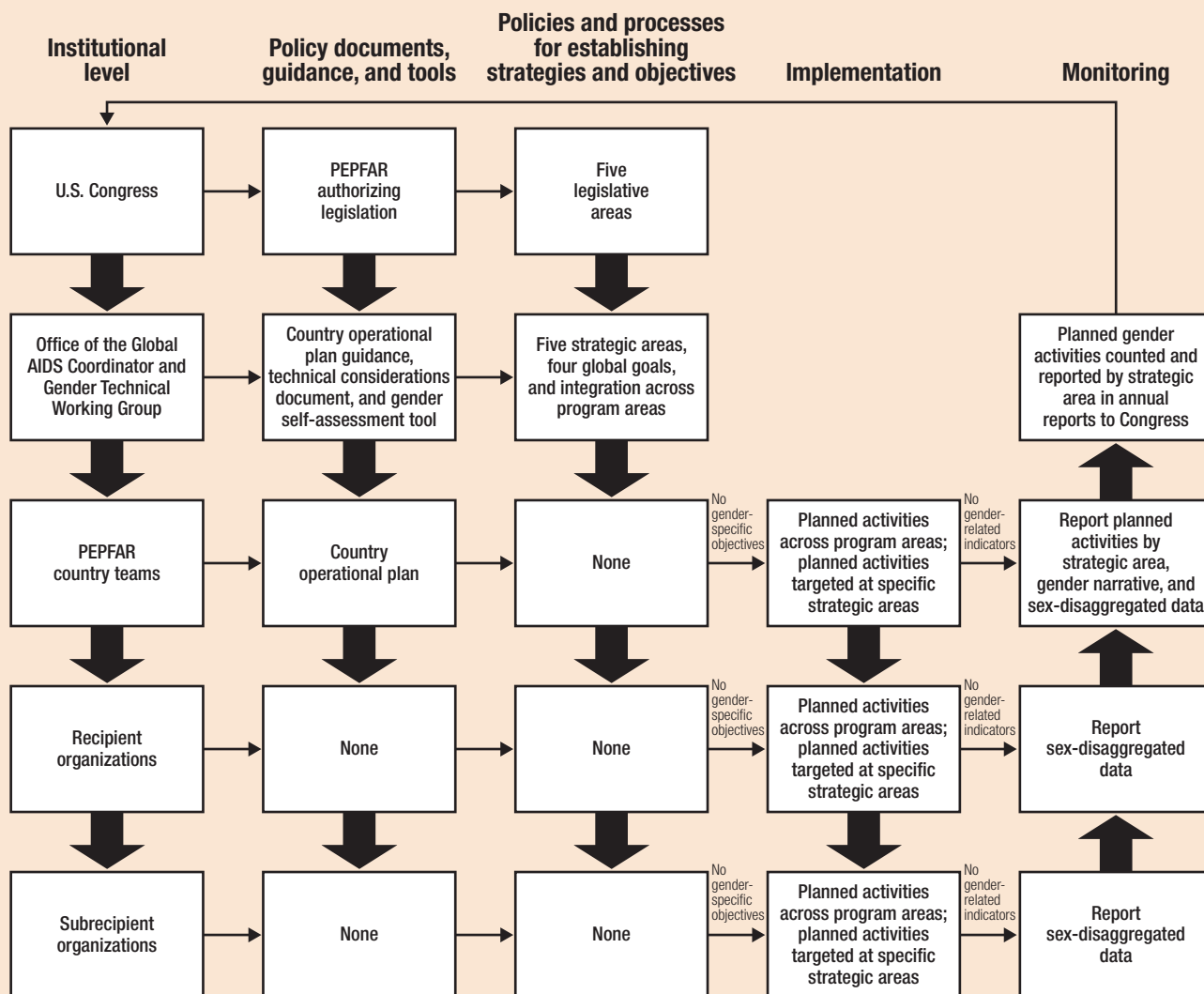
Gender-related programming at the country level is derived from PEPFAR's global strategy, but the global goals and strategies have not been translated into country-level objectives (figure 2.1). PEPFAR has made efforts to develop and provide guidance on gender-related programming to country-level PEPFAR teams through its technical considerations document.³⁵ And a PEPFAR interagency technical working group on gender has developed four global gender goals (see box 2.1). Yet it is unclear whether, or if so, how these gender strategies are implemented—or how these goals are achieved in any of the study countries (box 2.2). Interventions to address gender-related HIV/AIDS drivers are integrated in some of the 15 major prevention, treatment and care program areas funded by PEPFAR, but integration is not systematic or easily tracked because of the lack of measurable objectives.

PEPFAR's failure to translate guidance into specific objectives and programs is evident in its recipient and subrecipient organizations. One government official in Zambia noted: "We have programs with [the] Global Fund and [the] World Bank, but no well-defined [gender-related] programs with PEPFAR."

35. The technical considerations document, accompanied by a gender assessment tool, was introduced in 2006 and put into practice in all PEPFAR focus countries by 2007. Specific discussion points, including on gender, were developed by each of PEPFAR's technical working groups. These points include information about the types of gender-related activities that could be implemented across PEPFAR's program areas, as well as about those that specifically address one of the five strategic areas. The gender assessment tool is designed for use in assessments of gender mainstreaming by program implementers. The Gender Technical Working Group synthesizes information from PEPFAR's global five-year strategy, its authorizing legislation, and "global best practices" into profiles of gender mainstreaming approaches, with specific features identified as critical for each PEPFAR programmatic area. Programmers can rate each area separately from 1 (basic—no program activities include any of the features) to 5 (advanced—many program activities include the features). (Personal communication with staff at the Office of the U.S. Global AIDS Coordinator, March 12, 2009.)

PEPFAR has made efforts to develop and provide guidance on gender-related programming to country-level PEPFAR teams

Figure 2.1 PEPFAR's global gender strategies and goals are not translated into clear country-level program objectives or monitoring on indicators



Note: Vertical arrows show the translation of policies and processes from the highest to the lowest institutional level and the reporting of gender-based activities from the lowest to the highest institutional level. Horizontal arrows show the process at each institutional level for translating policies and guidance into strategies, objectives, programming, and program monitoring.

Source: Authors' construction.

PEPFAR's programmatic focus on shorter-term results—driven by targets reported to the U.S. Congress—hinders it from consistently integrating gender perspectives into programming over the longer term. PEPFAR staff are on country-level Gender Technical Working Groups in all three countries, yet they feel unable to fund interventions for longer-term social change. Instead, they feel they must fund activities to yield the short-term results required by their performance targets.

In Mozambique, for example, PEPFAR staff participate in an important gender working subgroup established in 2003. PEPFAR staff in Zambia also participated in technical working groups and collaborated with the Gender in Development Division—but reported that they felt unable to support programs for change in norms and attitudes over the longer term. The reason was PEPFAR's mandate to support programs for immediate, measurable HIV/AIDS relief.

PEPFAR's one-year planning and funding cycle, which is largely a result of the annual U.S. appropriations cycle, reflects the donor's short-term approach. According to staff at recipient organizations in all three countries studied, the one-year cycle has deterred PEPFAR implementers from supporting interventions that lead to long-term changes in gender relations, in harmful gender norms, and in risk behaviors.³⁶ Structural changes in society are not immediate—they require long-term planning and resource allocation.

Although PEPFAR has funded a few notable gender-related combination programs, few funds go toward addressing social drivers of HIV/AIDS. Combination programs that use a mix of gender strategies—such as the Survival Skills Training for Orphans Program in Mozambique, the HIV and AIDS Counseling and Services program run by The AIDS Support Organization in Uganda, and the Corridors of Hope II program in Zambia—have provided services to address certain gender-related HIV/AIDS drivers (individual, economic, social, and political). Yet very few programs include gender strategies that aim to increase women's legal rights, their productive assets, or their ability to earn income. Most of the interventions mainly focus on HIV/AIDS treatment, while very few address prevention (particularly reproductive health services) or the burden of care.

In the reauthorization of PEPFAR and the guidance documents to PEPFAR country teams, the comparative silence on the integration of reproductive health services with HIV/AIDS programs represents a missed opportunity to support this critical prevention strategy. A program implementer in Mozambique also mentioned age limitations on condom distribution as “inadequate” in a setting where young people below age 14 are sexually active.

36. Even though PEPFAR signs agreements with cooperating agencies for more than one year at a time, planning and results monitoring still occur on an annual basis. The annual planning process emphasizes short-term successes over longer-term structural changes.

Box 2.2

PEPFAR's lack of systematic gender guidelines and policies on the ground: a view from Uganda

At one Uganda subrecipient of PEPFAR funds—a district-level program for preventing mother-to-child transmission—gender integration has proved to be a challenge. A program manager reported holding frequent discussions with donors about gender issues, but noted that the donor has no specific guidelines or policies on gender:

[F]or every program there are discussions that are directed to gender issues, but for the policies we share with [donors], I have not seen that [gender integration guidelines or policies].

Managers also commented on efforts to change the broader social impact of HIV/AIDS. The managers have tried to link programs for preventing mother-to-child transmission to other, non-healthcare activities, but have not always received support from PEPFAR in doing so—even though some integrated programs do get PEPFAR funds. To the program managers it seemed that PEPFAR's preferred way to support programs is to have each partner focus on interventions that the partner knows and has experience in carrying out. As one manager noted:

[T]his [integrated support] is an area [in which] we have been struggling with them [donors,] because when you look at our program, it's integrated. We are not looking at only HIV and AIDS. We are also looking at social effects of HIV and AIDS, so we have asked [the donor] to allow us to use this money in education and [micro-]credit. I think this is not their interest and we would like them to come and support these activities.

All three 2007 PEPFAR country operational plans included funds for increasing access to health services, such as voluntary counseling and testing, preventing mother-to-child transmission, and antiretroviral treatment. In contrast, few of the interventions were designed to promote social change through activities outside health systems. PEPFAR's focus on health services does not account for the many kinds of gender inequality that can make it difficult or impossible for women to benefit from such services (box 2.3).

A study funded by the U.S. Agency for International Development and carried out by the International Center for Research on Women searched for promising program models in the PEPFAR's 12 sub-Saharan African focus countries. The study sought to highlight and document successful programs (not just PEPFAR-supported ones) that address at least two of four gender-related strategies: reducing violence and sexual coercion, addressing male

Varied forms of gender inequality can hinder girls and women from getting HIV/AIDS-related services, such as those provided by two PEPFAR subrecipients—a program in Zambia to prevent mother-to-child transmission and a program in Uganda to support orphans and vulnerable children.

Community-based health program to prevent mother-to-child transmission, Zambia. Beneficiaries of a PEPFAR-supported program to prevent mother-to-child transmission greatly feared that getting the program's services would prompt violent retaliation by their husbands. Disclosing HIV-positive status was a major obstacle for the women, who adhered to social norms of obeying their husbands and who expected violence as a part of marriage. As one beneficiary in Zambia reported:

Before my marriage I was counseled by elderly female relatives who emphasized that a woman should take a subordinate role within the household and should obey her husband. They even said that violence against women within the household was normal and acceptable, and a woman should remain in her marriage regardless of her husband's behavior.

Clinic staff confirmed that the women's fear of violence from husbands and partners often delayed the women in getting tested, prevented them from returning for test results, and prevented them from getting treatment or delayed them in doing so:

We have women reporting being abused by their husbands for being on antiretroviral treatment, and some have reported hiding antiretroviral treatment in meal bags just to protect their marriages and secure their safety and peace in their matrimonial homes. Some women stop medication altogether while others refuse to start medication. This mainly happens to women whose spouses refuse to accept their HIV status and blame it on their wives.

Men do not usually go for [voluntary counseling and testing] here; some men will wait for their wives to be preg-

nant, and when the women attend [an] antenatal clinic where [voluntary counseling and testing] is one of the services, they would want to know the HIV results of their wives as an indirect test for themselves. If they come out negative then they assure themselves that they are OK; but if they come out positive, the blame entirely falls on the women for bringing the disease in the home. One strategy our project has employed, however, is couple counseling and encouraging men to come with their wives for counseling and testing as a couple. Even when enrolling pregnant women on preventing mother-to-child transmission, we encourage—especially in the health centers we operate from—for men to be part of the clinics.

Faith-based orphans and vulnerable children program, Uganda. In a PEPFAR subrecipient program for orphans and vulnerable children in Uganda, girls had special needs and vulnerabilities. They were concerned about the threat of unwanted pregnancy and were generally at greater risk of transactional and crossgenerational sex than were boys. For example, girls who earned money in domestic work could be seduced by older men. Explains one primary school girl, “One of our colleagues was duped into a relationship. She conceived and gave birth. She is now staying with the guy.”

In addition, girls said that domestic responsibilities often prevented them from attending school and keeping up with their studies:

When I am at home, I am engaged in doing household work at the time when I am supposed to revise my books.

As the girls noted, boys had fewer household responsibilities:

When the boys reach home after school, they will tell them to go and fetch water while you, the girl, will stay home and wash plates, cook supper, and bathe the young ones. Imagine one task for the boy while the girl has many.

Boys had different fears and concerns, such as imprisonment for illegal activities.

norms and behavior, increasing women's legal protection, and increasing women's access to income and productive resources.³⁷

37. Detailed summary descriptions of these interventions are compiled in a gender and HIV compendium (ICRW 2009a) that was developed by USAID-funded AIDSTAR-One in collaboration with PEPFAR's Gender Technical Working Group. The compendium was implemented by the International Center for Research on Women, an AIDSTAR-One partner.

Accountability through gender-sensitive monitoring and evaluation: sex-disaggregated data, but with no way to track funding flows for gender-related programming or to measure long-term progress on gender issues

PEPFAR's recipient organizations report data for monitoring directly to PEPFAR quarterly, biannually, and annually. Subrecipient

organizations report data to recipient organizations on a similar schedule.³⁸ Accordingly, PEPFAR's performance targets aim to measure the numbers of people reached or activities carried out in the short term. The targets cannot measure changes that are likely to appear only in the long term, such as changes in attitudes to gender or in women's decisionmaking power. Even if the newly proposed requirements for gender-related indicators are adopted, they will not lengthen PEPFAR's attention span.

Program monitoring and evaluation

PEPFAR requires recipients to report sex-disaggregated data. All PEPFAR recipient and subrecipient organizations surveyed confirmed that they were required to report on activity coverage by sex. Generally they found such data useful for program planning.

PEPFAR has worked with governments to ensure that sex-disaggregated data are collected. In Mozambique, for example, PEPFAR recipient organizations have worked with the government to revise government reporting forms to include indicators specifically required by PEPFAR. And in Zambia PEPFAR has provided critical funds and technical assistance to establish an HIV/AIDS monitoring and evaluation system for disaggregating data by sex. Nevertheless, in the three countries studied, PEPFAR does not systematically share with national governments the data it collects.³⁹

By collecting and reporting data mainly on program inputs and outputs—not outcomes or impacts—PEPFAR has not been able to evaluate longer-term efforts to reduce gender inequality. Key informants in all three countries noted that PEPFAR, by mostly not requiring the collection of outcome or impact data, has severely limited its capacity to evaluate program quality and longer-term outcomes of gender inequality. PEPFAR supports some public health

evaluations of gender-related programming in its host countries: for example, in one Uganda district it has supported a study of intimate partner violence and HIV status disclosure. But such studies cannot replace regularly collected and reported data on long-term efforts to reduce gender inequality.⁴⁰

Because PEPFAR has no gender-related indicators, it cannot measure progress in its five strategic areas for addressing gender inequality. Gender-related indicators were absent from PEPFAR's country operational plans for 2004 through 2009. That absence means that few programs are designed to address the roots of gender inequality—doing so would not contribute directly to programmatic goals. Moreover, the absence of gender-related indicators prevents PEPFAR from measuring the impact of the programs that try to address gender inequality.

Several new PEPFAR program indicators proposed in 2009 had a gender focus. However, at the time of this report's writing the indicators (the "Next Generation indicators") had not been finalized.

The limited monitoring of gender-related programming at present is based on the requirement that PEPFAR report to the U.S. Congress on how it is addressing its five legislated gender strategic areas. In 2004–08 each country team was instructed to check boxes in the country operational plan to indicate how many program activities addressed gender issues. The technical considerations document for fiscal 2008 states: "In order to ensure that the legislative requirements are being addressed, country programs are asked to code their program activities according to these five strategies in development of their [country operational plans]. These legislative codes are essential to [Office of the U.S. Global AIDS Coordinator] reporting and legislative requirements."⁴¹ For fiscal 2009, country teams were also asked to

PEPFAR's short-term performance targets cannot measure changes, such as changes in gender norms, that are likely to appear only in the long term

38. For more detail on PEPFAR's monitoring and evaluation systems see Oomman, Rosenzweig, and Bernstein forthcoming.

39. Oomman, Rosenzweig, and Bernstein forthcoming.

40. For examples of qualitative and quantitative gender-related outcome indicators on which data can be measured routinely as part of a regular monitoring plan, see annex E.

41. PEPFAR 2007.

PEPFAR has not required that funds used for gender-related activities be tracked against measurable outcomes

write a separate gender narrative in the country operational plans describing PEPFAR's efforts to address in-country gender issues. Thus, monitoring of gender-related programming is designed to count the number of planned activities with a gender component and to yield an overall narrative of country-level efforts.

Financial monitoring

Funding for gender-related programming is dispersed across the budgets for PEPFAR's 15 program areas. PEPFAR has not required that funds used for gender-related activities be tracked. The most recent country operational plan guidance, for 2009, has no budget code for gender-related activities. Instead, such activities are incorporated into budgets for other program areas. As a result, recipient and subrecipient organizations need not track or report to PEPFAR the funds used for gender-related activities within their programs.

PEPFAR has no effective mechanism for tracking against measurable outcomes funds that are spent to address gender inequality. As indicated above, in 2004 through 2008 each country operational plan had tick boxes to indicate how many activities addressed gender issues and the total funds provided for each recipient. The tick boxes allowed the number of activities with gender-related features to be counted. But they did not indicate how much was spent on gender-responsive programming or what such programming achieved.

PEPFAR now requires a gender "program area narrative" in each country operational plan for fiscal 2009. The narrative is supposed to describe the country team's overall approach to addressing gender through programming, including program activities that will support PEPFAR's five gender strategic areas and the actions being taken to mainstream gender throughout all program areas. This new approach is promising—but it still does not allow PEPFAR to track funds spent on gender-responsive programming. Nor will it allow PEPFAR to report on the specific outcomes achieved with those investments.

Gender capacity: PEPFAR and recipient organization staff have varying levels of gender capacity, but capacity building on gender has not been widespread

In Mozambique, Uganda, and Zambia, PEPFAR country office staff had varying degrees of access to a staff gender specialist. PEPFAR's Uganda and Zambia country offices were found to have no staff members with specific expertise in designing, delivering, and managing programs to address gender inequality. Gender-related assistance from an interagency technical working group was available on request.

In Mozambique, when interviews for this study were held, the local offices of the Centers for Disease Control and Prevention and the U.S. Agency for International Development shared an interim gender focal point. But the person's responsibilities were not clear. Since then, according to the Office of the U.S. Global AIDS Coordinator, PEPFAR has hired a fulltime gender specialist in Mozambique. The 2009 country operational plan guidance recommended that country teams hire staff with gender expertise to increase country-level capacity.

Although the need to address gender issues is widespread, gender capacity at PEPFAR recipient organizations varies. In Mozambique, where recipient organizations noted the need to address gender issues, one recipient has a staff training program that includes gender training. The recipient trains all its subrecipients on gender concepts, using a facilitator's manual developed by the recipient with one of its partners. Gender-related barriers to accessing program services are a key topic for discussion in monitoring activities and in quarterly meetings with the subrecipients. Recipient and partner organization staff members are encouraged to consider male norms when addressing gender-related barriers to their work. An HIV prevention expert at the recipient organization in Mozambique noted, "when we speak of gender, we not only talk about women, but men as well," and described the organization's approach:

We have dealt with specific issues in an explicit manner. That is how we work with the various organizations. We identify the obstacles [that] prevent changes from taking place when it comes to gender; the factors playing in favor of the approach to gender; and the target public.

Other PEPFAR recipients in Mozambique do not have staff with specific skills in gender-responsive HIV/AIDS programming. These recipients lack gender tools, guidelines, and resources to guide program development and implementation. Some have taken the initiative by enlisting other recipients with expertise in designing and implementing gender-related programming to support them. Others have invested little in making their programs better able to address gender issues.

PEPFAR recipient organizations in Uganda recognized the need for gender expertise, but none of those contacted had staff with specific gender-related HIV/AIDS programming skills. Some staff members had received some form of gender training. Key informants mentioned accessing outside consultants when gender expertise was needed.

In Zambia some PEPFAR recipient organizations have put resources into accessing gender specialists, training, and materials. One recipient has two gender specialists who train and work with district- and community-level staff, helping the staff to plan and carry out gender-related programs. This recipient has produced a training manual about changing harmful gender norms:

We have a gender training manual that relates the traditional norms to gender and HIV/AIDS and addresses the inequalities in marriage. We therefore provide facilitation of gender equality. The manual covers marital rights, safe motherhood and men's involvement in these processes, [and] gender-based violence, amongst others.

Other recipient organizations in Zambia focus much less on gender expertise and

capacity building. Staff at those organizations feel a need to understand how gender issues affect their work.

Gender capacity appears generally to be lower at PEPFAR subrecipient organizations than at PEPFAR recipient organizations. PEPFAR subrecipients in all three countries acknowledged the need to address gender. Yet they typically have no gender specialists, no gender operational plan, and no comprehensive staff training on gender concepts. For technical assistance on gender PEPFAR subrecipients must rely on other organizations, such as larger nongovernmental organizations or district AIDS taskforces.

In Mozambique, for example, one PEPFAR subrecipient organization that trains and informs sex workers and their clients on reducing HIV vulnerability—while training the sex workers to find alternative income sources—confronts harmful gender norms every day. Interviewed staff members recognized the need to address gender, for example, by focusing the organization's efforts on men as well as women. Yet this subrecipient organization has no designated staff member with expertise in gender analysis and in designing and implementing gender-related programs who supervises program staff. No staff member has received formal training on gender, and none mentioned accessing any specific gender tools. Staff members lack a monitoring and evaluation framework with gender-related indicators, targets, and goals.

Perhaps it is not feasible to expect every organization to have formally trained or experienced gender specialists; however, access to certain types of technical support—including gender tools and monitoring and evaluation frameworks with indicators—should be available when needed.

The subrecipient organizations surveyed in Uganda have no staff gender specialists, though some gender issues have been included as part of training for certain staff members. Among the staff members who have received such training, technical staff tend to value gender expertise more highly than do nontechnical staff.

PEPFAR subrecipients in all three countries typically have no gender specialists, no gender operational plan, and no comprehensive staff training on gender concepts

PEPFAR's technical assistance to partner organizations has focused on program and budget management and monitoring, with gender-specific technical assistance provided on request

In Zambia a community support group for people living with HIV/AIDS noted the group's reliance on other organizations for gender expertise:

In areas [where] we do not have technical expertise we make use of other institutions, like [the] victim support unit of the police for gender based violence and the [District AIDS Taskforce] for other gender and HIV programming.

In PEPFAR recipient organizations, interest in recruiting staff with expertise in integrating gender issues into HIV/AIDS programs varies; so does commitment to such recruiting. Some organizations, valuing gender skills, seek to recruit staff members who can help integrate gender into HIV/AIDS programming. Information was not always available on whether gender knowledge is a specific recruitment criterion. However, it seems that this aspect of recruitment varies by organization.

In Mozambique, for example, one PEPFAR recipient organization does not require that staff have skills or knowledge of gender concepts or the relationship between gender norms, gender inequality and health. The organization has no staff gender specialist, and its staff has not received formal training on gender inequality's relationship to HIV/AIDS. In contrast, an HIV/AIDS specialist at another recipient organization in Mozambique noted that the recipient seeks gender expertise when recruiting staff members—adding that the organization's staff has a “fair idea” of gender concepts. And staff at recipient organizations in Uganda and Zambia reported considering gender expertise in recruitment. In those countries, organizations that lack staff members with gender expertise have relied on experts outside their organizations for technical assistance on gender issues.

PEPFAR's technical assistance to partner organizations has focused on program and budget management and monitoring—with gender-specific technical assistance provided on request from the country team or, more rarely, as a result of suggestions from country operational plan reviewers at

the Office of the U.S. Global AIDS Coordinator. Mozambique's PEPFAR country operational plans through 2007 do not mention any training on gender concepts or on gender-related barriers to accessing HIV/AIDS services, either for government staff or for implementing partners. However, as a result of a recommendation from the headquarters' programmatic review team in 2007, the Gender Technical Working Group provided gender training to PEPFAR partners carrying out prevention programs. That assistance resulted in the creation of a PEPFAR interagency working group in Mozambique.⁴²

The Zambia country team has not requested any technical assistance on gender, nor have Country Operational Plan programmatic reviewers recommended it. PEPFAR has no program for training focal points or implementing partners on gender issues. However, training on gender-related vulnerabilities and gender-related barriers to accessing HIV/AIDS services are sometimes integrated into capacity building for other program areas. For example, health workers are trained to provide voluntary counseling and testing, services to prevent mother-to-child transmission, and antiretroviral treatment services in accordance with national and international standards.

Recommendations for PEPFAR

Based on our findings in the three study countries, we recommend that PEPFAR take several actions to increase its ability to address gender inequality's relationship to HIV/AIDS.

Provide clearer, more detailed guidance on generating and using gender analysis in its country operational plans. Although PEPFAR's use of gender analysis in its country operational plans has increased, the amount of such analysis varies, and there is little evidence that it informs program development. Clearer, more detailed guidance from the Office of the U.S. Global AIDS Coordinator—on what analysis needs to be done, and on how such analysis should

42. Personal communication with staff at the Office of the U.S. Global AIDS Coordinator, March 30, 2009.

inform program planning—would help country teams better address gender inequality’s relationship to HIV/AIDS in country programs.

Design gender programs and objectives around countries’ needs, not around global strategic areas or global gender goals. PEPFAR’s five gender strategic areas and four gender goals, though a starting point, are global rather than country-specific. Designed merely as a roadmap for how countries should allocate gender funding, they do not take into account local conditions or particular countries’ needs. Objectives designed by country teams should be country-specific, based on needs identified through comprehensive gender analysis at the country level.

Set clear, measurable gender-related indicators and targets to measure progress against country-level gender objectives. PEPFAR now has no gender-related indicators or targets to measure progress against its five gender strategic areas, its four gender goals, or any other set of gender priorities. Indicators and targets set by country teams should ideally be based on country-level objectives derived from identified needs. They should include both output and outcome measures. And they should include both short- and long-term measures, to accommodate PEPFAR’s annual reporting cycle while also measuring change over longer periods.

Ensure that each country office has at least one gender focal point—a person with expertise in designing and carrying out programs to address gender inequality’s relationship to HIV/AIDS. The gender focal point would ensure that needed evidence is available to inform the design of gender-responsive programs; would

design gender-related objectives, indicators, and targets for country operational plans; and would review country operational plans to ensure that they address gender issues and provide needed technical assistance wherever gender capacity exists. In addition, the gender focal point would sensitize all PEPFAR country staff to gender issues and would join discussions of gender-related policy among donor and government representatives at the country level.

Reexamine global-level policies and guidance—and gaps in such policies and guidance—that conflict with PEPFAR’s stated gender goals, especially on prevention. Included in this category are age restrictions on condom distribution; requirements to use particular behavior change messages for certain groups; the lack of a clear policy linking HIV/AIDS programs to reproductive health services; and policies on sex-worker programs that are confusing and conflict with stated PEPFAR gender goals, such as legal protection for women and increasing women’s access to services. These policy problems create confusion about what recipient countries may and may not do to address gender-related vulnerabilities, particularly in the countries’ prevention programs.⁴³

43. Although no evaluation studies were identified for this report, available evidence suggests that some PEPFAR policies have negatively affected efforts to reduce the spread of HIV in target groups. In a 2007 Institute of Medicine evaluation report (IOM 2007), PEPFAR staff described how several PEPFAR policies led to the loss of opportunities to support innovative strategies—by varring HIV prevention information from being integrated into traditional youth education at the time of sexual initiation, and by hindering organizations from using peer education methods among sex workers.

PEPFAR should give clearer guidance on gender analysis, design gender programs around countries’ needs, measure progress against country-level gender objectives, ensure that each country office has at least one gender focal point, and reexamine global-level policies and guidance

3 The Global Fund to Fight AIDS, Tuberculosis and Malaria

The Global Fund's efforts to address gender are changing rapidly

The Global Fund is a mechanism for financing programs based on proposals and policies developed by recipient countries. Meant to be country-driven, the Global Fund model focuses on programming priorities that recipient countries set for themselves.

The Global Fund bases its decisions to fund the recipient countries' programs on performance against measurable programmatic targets. Country proposals are approved by the Global Fund board after being recommended by an independent technical review panel, which examines programs to ensure that they are relevant to the epidemiological context; that they are technically sound, with effective and proven intervention strategies; and that they are appropriately budgeted.

Even as the Global Fund retains its country-driven model in response to demand from recipient countries, it also has recently approved a new gender equality strategy to increase its support for addressing gender inequality's relationship to HIV/AIDS, tuberculosis, and malaria (box 3.1). Thus, the Global Fund's efforts to address gender are changing rapidly.

We hope that this retrospective analysis will be useful to the Global Fund as it develops its implementation plan for putting its new, innovative gender equality strategy into practice.

Gender analysis in situational assessments and program design: proposals often include gender analysis, but analysis is not always used in program planning and proposal development

Situational assessments in proposals submitted to the Global Fund have considered sex-disaggregated epidemiological data—mainly as

a reason for including programs addressing women's HIV/AIDS needs. Situational assessments for Mozambique, Uganda, and Zambia present epidemiological data showing that HIV/AIDS prevalence is higher in women than in men. Proposals developed in Mozambique and Zambia present sex-disaggregated data to show that HIV/AIDS prevalence rates in young women exceed those in young men of the same age. In Zambia the significantly higher rates for young girls ages 15–19, compared with rates for boys of the same age, were used in the country's round 1 proposal as evidence of crossgenerational sex. Similarly, the situational assessment in Uganda's round 3 proposal used epidemiological data to show that HIV/AIDS prevalence was higher in women generally than in men.

Attention to gender in the situational assessments has varied by country and over time. Global Fund proposal forms have become more explicit in asking countries to describe gender inequities that affect programs, but gender analysis continues to vary by country and by proposal. Zambia included gender analysis in both its successful proposals from rounds 1 and 4. Mozambique's successful round 6 proposal included more gender analysis than its successful round 2 proposal did—perhaps because one section of the round 6 proposal form asked countries to “describe gender and other social inequities regarding program implementation and access to the services to be delivered and how this proposal will contribute to minimizing these gender inequities.”

How the Global Fund's new gender equality strategy aims to address weaknesses in the donor's past approach to gender inequality

The Global Fund's new gender equality strategy (Global Fund 2008) indicates that the Global Fund will take the following direct actions through its board, its secretariat, its technical review panels, and its country coordinating mechanisms.

Board

- The Global Fund board and its committees will ensure that they have access to appropriate gender expertise and will strive for gender balance in leadership appointments.

Secretariat

- The Global Fund secretariat will recruit several senior-level staff to work specifically on gender issues, including a gender champion.
- Gender awareness training will be provided to all secretariat staff, and specialized training will be provided to key personnel, including fund portfolio managers.
- The secretariat will establish a gender section in its skills bank, with staff members able to give other secretariat staff specialist advice on topics such as sexual and reproductive health, violence against women, and issues affecting lesbian, gay, bisexual, and transgendered people.

Technical review panels

- One of the three key criteria that a technical review panel uses to evaluate proposals is soundness of approach. Technical review panels will treat this criterion as requiring evidence of a thorough gender analysis.

Country coordinating mechanisms

- The guidelines for proposals (issued for each round of funding) will require that applicants include, as part of their proposals, a gender analysis based on sex- and age-disaggregated data.
- Country coordinating mechanism guidelines will make it clear that a gender analysis should be the basis of program development.
- In addition to providing a gender analysis, applicants will be required to explain how vulnerable groups will be reached and how interventions will have a sustained impact on women and girls.
- The Global Fund will require that countries make sex- and age-disaggregated data available in their monitoring and evaluation systems. Countries that do not already collect such data will

be asked to request funding in their proposals to support data collection.

- In proposals to the Global Fund, country coordinating mechanisms "will be required to declare their capacity in gender." Country coordinating mechanisms that need to build capacity will be entitled to funding for this purpose.
- The Global Fund will provide tools to help country coordinating mechanisms achieve sex parity in their membership and leadership (for example, terms of reference for gender experts and for other country coordinating mechanism members).

The Global Fund and its partners will also promote gender equality in other ways, including the following:

- In-country partners will be encouraged to provide training, capacity building, and support, enabling country coordinating mechanisms to access high-quality gender expertise.
- The Global Fund and its in-country partners will promote a gender analysis in national strategy development and proposal preparation.
- As part of a national strategy applications process still under development, the Global Fund will promote including both a gender analysis and appropriate interventions in its criteria for validating national strategies.
- As part of the Global Fund's development of its partnership strategy, it will promote developing a network focused specifically on activities that address gender equality.
- The Global Fund will promote including government ministries responsible for gender and health ministry departments responsible for sexual and reproductive health in planning processes for national HIV/AIDS strategies.
- The Global Fund will promote involving global partners—multilateral and bilateral organizations, foundations, the private sector, and international, regional, and national civil society organizations—in all aspects of Global Fund grants (from proposal development to implementation) to help ensure that attention is given to gender equality.

The Global Fund secretariat is currently working on an implementation plan for the strategy.

Source: Aidspace 2008b.

Uganda's round 1 proposal did not mention gender analysis or gender-related drivers of the country's HIV/AIDS epidemic. But the

situational assessment in Uganda's round 3 proposal noted that women are considered more at risk for HIV infection and more vulnerable to

Increased interest in making the Global Fund's HIV/AIDS programming address gender issues has been fueled by pressure from outside donors and local interest groups

“the socio-economic burden due to AIDS.” The same proposal cited a “Rapid Assessment” of access to antiretroviral treatment, conducted by Uganda’s health ministry in 2002,⁴⁴ which showed that clinics providing free antiretroviral treatment were attended mostly by women while clinics that charged a fee for such treatment were attended mostly by men. In addition, Uganda’s round 3 proposal mentioned the need to strengthen women’s property rights, the high burden of care on single widowed mothers and grandmothers, and the need to provide economic opportunities for heads of households who support orphans and vulnerable children.

Although Uganda’s round 3 proposal thus gave attention to gender, the situational assessment in Uganda’s round 7 proposal lacked significant gender analysis.

Global Fund proposals often include no activities to address the effects of gender inequalities identified in situational assessments—casting doubt on whether program planning draws on the assessments’ gender analysis. The situational assessment in Mozambique’s round 6 proposal addressed several gender-related drivers: for example, it mentioned the need to involve men in preventing mother-to-child transmission programs to increase women’s access and use of such services. Yet the proposal defined no activities to address that need.

Zambia’s round 1 proposal mentioned several gender-related vulnerabilities, including sexual violence, women’s lower social status, cultural practices that hindered women from negotiating safer sex, and higher levels of stigma and discrimination against HIV-positive women. And Zambia’s round 4 proposal attributed women’s inability to access antiretroviral treatment to limits on their decision-making about health services, as well as to economic constraints that prevented them from going to clinics and buying drugs. Yet neither the round 1 nor the round 4 proposal suggested how data on gender and HIV/AIDS might be

used to make programs responsive to the gender issues identified in the analysis.

As a result, programs designed for Zambia did not adequately address gender-related barriers. The country’s round 4 proposal, for example, envisioned greater access to information and free antiretrovirals for women. That would address some of the economic constraints, but it would not address the more complex gender-related barriers mentioned in the proposal—women’s lack of agency and their limited decisionmaking power in the household.⁴⁵

Programs addressing gender inequality: the Global Fund model is flexible, but limited, in funding and designing programs that address gender barriers

As the Global Fund has clarified its willingness to support programs that respond to gender-related vulnerabilities, country-based advocacy groups have contributed to a greater focus on gender in some funding proposals. Although the Global Fund’s model is country-driven, its proposal development is influenced by the guidance it issues for each round of funding: such guidance lays out what the donor is willing and able to fund. An increased interest in addressing gender issues in HIV/AIDS programming has been fueled by pressure, not only from outside donors, but also from local interest groups such as Zambia’s Non-Governmental Organization Coordinating Council. The council pressured Zambia’s government and its Global Fund country coordinating mechanism to address gender inequality’s relationship to HIV/AIDS. Explains a Zambia National AIDS Network staff member:

45. A recent study of women and antiretroviral treatment in Zambia (Human Rights Watch 2007) found that the fear of violent retaliation from male partners after getting voluntary counseling and testing was a major cause of delays in women’s access to treatment and a major barrier to their staying on treatment regimens. When the study was released, Zambia’s round 4 Global Fund proposal had already been written. However, none of Zambia’s later Global Fund proposals has addressed gender-based violence as a barrier to antiretroviral treatment for women.

44. World Health Organization, Uganda Ministry of Health, and World Health Organization Uganda office (n.d.).

The first time we got the grant, it was for five years and ending this year June month end. Emphasis was on prevention [and] mitigation, and aspects of gender did not come out clearly; but [in] the one being proposed for 2008/09–2013, the aspect of gender has come out clearly. We normally have annual HIV/AIDS Conferences where we consult, and during the Conference, the aspect of gender came out clearly, such as gender based violence came out[,] so we sought to address it in the proposal and [it] has taken center stage in developing the proposal. We have one major player in this regard, the Non-Governmental Organization Coordinating Council (NGOCC), and we have involved them in our planning meetings.

Gender-related indicators were included in Mozambique’s round 2 proposal because nongovernmental organizations with experience in gender or women’s issues, such as the Mozambican Women’s Organization, the Mozambican Association for Family Development, and Pathfinder International—among others that gave important input on gender-related features of the epidemic—were involved in designing the proposal. In contrast, the round 6 proposal was prepared mainly by health sector staff (though it also included input from nongovernmental organizations), and its focus on gender was much more diffuse.

Mozambique’s Ministry of Health, in its strategy on HIV/AIDS and other sexually transmitted infections, states that gender issues will be dealt with by specialized organizations such as the Ministry of Women and Social Affairs, a possible reason why gender-related indicators were not integrated into the round 6 proposal for Mozambique.

The Global Fund’s flexibility enables it to support various gender-responsive programs—yet major gaps in several gender-related areas can be identified in all three countries. A count of approved Global Fund proposals with gender-responsive

programming (table 3.1) reveals major gaps in several areas, including:

- Developing and promoting gender-responsive policies.
- Providing family planning services for women.
- Distributing female condoms.
- Providing postexposure prophylaxis.
- Promoting women’s equitable access to care and treatment.
- Promoting women’s legal and human rights.
- Involving women in proposal development.

Table 3.1 Approved Global Fund proposals that include gender-responsive programming, by proposal information and country			
Proposal information	Mozambique	Uganda	Zambia
Total approved proposals from each country	6	8	6
<i>Approved proposals providing services specifically relevant to women</i>			
Providing sexual and reproductive health services	1		1
Providing more referral services for women	1		1
Providing family planning services for women			
Providing services to prevent mother-to-child transmission	2	3	1
Distributing female condoms			
Providing postexposure prophylaxis			
Providing insecticide-treated nets to pregnant women	2	2	3
Providing malaria prevention during pregnancy	1	1	1
Providing services for female sex workers	1		
<i>Approved proposals providing women with equitable access to services relevant to both men and women</i>			
Promoting women’s equitable access to care and treatment			
Developing and promoting gender-responsive policies			
<i>Approved proposals addressing women’s underlying vulnerabilities</i>			
Providing capacity-building services for community-based women’s groups	1	1	
Providing income-generating activities for women	1		
Seeking to keep girls in school			
Addressing violence against women	1		1
Promoting women’s legal and human rights			
Providing gender sensitization activities	1	1	
Providing sensitization and training related to HIV/AIDS programs targeting women	1	2	1
Providing sensitization and training related to tuberculosis programs targeting women	1		
Providing sensitization and training related to malaria programs targeting women			3
Seeking stigma reduction in all settings	1	2	3
<i>Approved proposals involving women in leadership</i>			
Involving women and women groups in proposal development			
Involving women and women groups as implementing agents	3		

Source: Kageni and Garmaise 2008; Aidsplan 2008a, pp. 46–49.

The integration of gender programming in Global Fund rounds 1–6 has been driven by implementers’ particular interests and missions

Gender-related programs supported by the Global Fund have been scattered—they lack a systematic, comprehensive approach to addressing gender-related HIV/AIDS drivers, vulnerabilities, barriers to access, and consequences (such as unequal burdens of care). The haphazardness of gender-responsive programs for HIV/AIDS supported by the Global Fund appears in table 3.1. Very little support has been provided to programs that would address gender inequality in access to services, for example—or that would respond to gender inequality by giving women leadership roles in designing Global Fund proposals and programs.

Two parts of Mozambique’s round 2 proposal included gender-responsive programming under the larger goal of reducing the spread of HIV/AIDS and mitigating its impact. The first, preventing and mitigating the social impact of HIV/AIDS, included interventions to expand youth friendly health services and programs, promote condom distribution and use, and run orphans and vulnerable children programs—none of which address the epidemic’s underlying gender-related drivers, such as gender norms. Still, some notable activities in the proposal addressed such drivers. One example was operations research among sex workers and their clients on the feasibility of female condom use. Another was promoting the “empowerment of women and male involvement” (though this activity was not described in detail).

The second part of Mozambique’s round 2 proposal that included gender-responsive programming focused on improving health services, including antiretroviral treatment, voluntary counseling and testing, and preventing mother-to-child transmission. No particular activities were listed that might increase male involvement in programs to prevent mother-to-child transmission.

Mozambique’s round 6 proposal included an objective to increase women’s access to services for preventing mother-to-child transmission, making such services better. Yet the round 6 proposal did not include activities to address the gender-related barriers that keep women away from the services.

Gender-related programming in Global Fund proposals for Zambia has focused on increased condom distribution, increased HIV/AIDS information targeting women, and access to free antiretroviral treatment for eligible women. Zambia’s round 1 proposal asserted that increased condom distribution would address women’s inability to negotiate condom use with partners. To be sure, ready access to condoms is a first step—but it does not necessarily enable women to gain their partners’ consent to use condoms.

Uganda’s round 3 proposal stated that increasing women’s property rights was critical to HIV/AIDS programming. Yet the proposal included no activities to address the issue.

More than half of the money from Global Fund HIV/AIDS grants across the three countries has been used to buy drugs—limiting the money available for other programs, such as those with a gender focus. Although the Global Fund putatively seeks to fill gaps in priority program areas, its funds have been used in all three countries largely to buy antiretroviral drugs.⁴⁶ Zambia in its round 4 proposal allocated \$129 million to drug procurement, out of a total \$253 million requested for HIV/AIDS activities. Mozambique in its round 6 proposal allocated close to \$124 million to drugs, out of the nearly \$199 million it requested from the Global Fund. Again, Uganda in its round 7 proposal allocated about \$132 million of \$269 million to drugs.

The Global Fund’s specific round guidance directs countries to carefully identify marginalized or “underrepresented groups in existing service delivery activities” and to develop programming that will serve those groups. In accordance with this principle, the integration of gender programming in rounds 1–6 has been driven by implementers’ particular interests and missions.

46. Oomman, Bernstein, and Rosenzweig (2007) found that PEPFAR and the Global Fund focused their funding on HIV/AIDS treatment and care, areas that are relatively well funded compared with HIV/AIDS prevention. Part of the Global Fund’s explicit mission is to fill such funding gaps.

The groups targeted in Global Fund proposals from Mozambique, Uganda, and Zambia include adolescents, people with HIV/AIDS, and orphans and vulnerable children.

The Global Fund should recognize that its current targeted approach might not address the role of underlying gender inequality in making women and girls more vulnerable to HIV/AIDS. Such inequality is present throughout the general population, not just in targeted groups.

Accountability through gender-sensitive monitoring and evaluation: monitoring and evaluation lacks sex-disaggregated data and gender-related indicators

The Global Fund encourages the use of national health information systems to monitor its programs, and it uses data from the national systems for monitoring. However, it also requires particular program indicators and has additional requirements for financial data. Its recipient organizations gather and verify data from its subrecipient organizations, with monitoring by local fund agents (who typically have no expertise in gender, but instead are accounting firms focused on financial rather than programmatic activities and measures).

Program monitoring and evaluation

Although sex-disaggregated data are collected in the three countries because their national health information systems require it, such data have not been used to systematically design Global Fund programs or for monitoring and evaluation; however, the Global Fund now requires sex-disaggregated data reporting as part of its new gender equality strategy. Mozambique nationally requires that sex-disaggregated data be reported on some indicators, such as the number of people on antiretroviral treatment. Yet data reported to the Global Fund have not been disaggregated by sex. Similarly, Uganda and Zambia require that sex-disaggregated data be reported on relevant impact and outcome indicators, as well as some program-level output

indicators—but reporting to the Global Fund has not been disaggregated by sex. However, reporting sex-disaggregated data to the Global Fund will now be required as part of the Global Fund’s new gender equality strategy.

*The Global Fund’s current monitoring and evaluation toolkit, developed in 2006, did not include specific gender-related indicators—possibly confusing countries over whether they could include indicators to track programs addressing gender issues.*⁴⁷ The monitoring and evaluation toolkit created in 2006 includes many internationally approved indicators that have been endorsed by several organizations, such as the World Health Organization, the World Bank, the Joint United Nations Programme on HIV/AIDS, PEPFAR, the Centers for Disease Control and Prevention, and the U.S. Agency for International Development. Yet the toolkit includes just one indicator (the percentage of most-at-risk populations reached with HIV/AIDS prevention programs) that can be applied to high-risk groups, such as sex workers, and that could be considered gender-related.

By virtually excluding gender-related indicators from its monitoring and evaluation toolkit, the Global Fund has missed an opportunity to systematically integrate gender into its HIV/AIDS programming over the past six years.⁴⁸

Monitoring and evaluation frameworks for programs supported by the Global Fund have not included indicators to measure progress on gender

47. The toolkit now includes a few gender-related indicators—for example, the number of sex workers using condoms—as well as others that can use sex-disaggregated data. However, some such indicators are targeted not at women, but rather at interventions and at specific populations. Since the toolkit is revised and approved in two stages, more or less in response to concerns of the moment, through two different groups—the monitoring and reference evaluation group and the service delivery areas—it is not easy to guess what other gender-related indicators might be planned for inclusion in the next round of revision. The current 2006 version is now under review.

48. Global Fund staff state that the next monitoring and evaluation toolkit, due in the third quarter of 2009, will include some gender indicators (personal communication, March 12, 2009).

By virtually excluding gender-related indicators from its monitoring and evaluation toolkit, the Global Fund has missed an opportunity to systematically integrate gender into its HIV/AIDS programming

The Global Fund's new gender equality strategy envisions a future system to track gender-related funding

inequality, gender-related drivers of HIV/AIDS, or gender-related barriers to accessing HIV/AIDS services. Few Global Fund grants have included activities that address gender and HIV/AIDS, but even proposals that did include such activities have rarely set forth indicators or targets for measuring progress.

Zambia's round 1 and 4 proposals, for example, aimed to change attitudes and cultural practices (such as dry sex, polygamy, and sexual cleansing) with multisectoral behavior-change communication campaigns and training for community leaders. But the proposals' monitoring and evaluation frameworks had no indicators to track changes in those attitudes and cultural practices. The round 1 proposal also called for promoting greater parity in men's and women's shares of the burden of care for individuals living with HIV/AIDS. But, again, the proposal included no indicators to measure the effects of such a promotion on women compared with men. Finally, the round 1 proposal sought to create gender-friendly voluntary counseling and testing services; once more, it lacked gender-related indicators to track progress on that activity.

Uganda's round 3 proposal aimed to shore up women's property rights and to increase income-generating opportunities for heads of households supporting orphans and vulnerable children. But no relevant indicators were provided. The proposal mentioned a need for activities to support income generation, yet it included no indicators to track how such programs empowered women, reduced their economic dependency on men, reduced their HIV/AIDS vulnerability, or helped them better manage the consequences of infection.

Mozambique's round 2 proposal was an exception, notable for including two gender-related outcome indicators:

- The percentage of women who believe that, if the woman's husband has a sexually transmitted infection, she can refuse to have sex with him or propose condom use.
- The percentage of adults ages 15–49 who believe that a woman should not refuse to have sex with her husband.

These indicators measure progress in:

- Promoting safe sexual behavior to prevent HIV infection and transmission.
- Reducing stigma and discrimination.
- Promoting positive living.
- Creating demand for services, such as voluntary counseling and testing and treatment for sexually transmitted infections.

However, Mozambique is not required to report on the two gender-related outcome indicators for its grant performance report—so it is not clear whether the data are being collected.

Financial monitoring

Most Global Fund grant expenditures on gender-related activities cannot be tracked against gender-specific outcomes. Such tracking is possible only when a country's proposal specifically outlines a discrete gender-related program. Otherwise, the Global Fund's local fund agent monitors grant performance at the country level but is unable to track funds disbursed or spent on gender-related activities—funds that are difficult to track because of the Global Fund's country-based system for proposal and budget planning and reporting.

Neither Mozambique, Uganda, or Zambia yielded evidence that funds spent on programming for gender and HIV/AIDS—or on specific interventions to empower women or reduce gender inequality—are being tracked. However, the Global Fund's new gender equality strategy envisions a future system to track gender-related funding for grants with significant gender-related features.⁴⁹

49. As part of the implementation plan for the new gender equality strategy, in grants that will have significant gender-sensitive or gender-transformative activities, the Global Fund has planned for those activities—and specific gender indicators—to be included in the performance framework as specific service delivery areas (which form the link between financial reporting and programmatic reporting). For future grants the Global Fund will be working on defining gender-related results and indicators and tracking the related expenditures in the form of specific service delivery areas where appropriate. Until those areas are in place, gender-related expenditures can be tracked only through a manual review of grant reports, through in-country reviews and analyses, or through specific country case studies (personal communication with Global Fund staff, March 20, 2009).

Gender capacity: building such capacity is not a key part of Global Fund grants

Not all of the Global Fund’s recipient organizations have gender experts on staff. Where gender focal points exist, they often have limited ability in analyzing gender dimensions of the epidemic and in designing and implementing gender-related programming. In addition, they are often in low-ranking positions. Furthermore, gender focal points by themselves cannot ensure that gender concepts are understood throughout institutions or that priority is given to gender-responsive programming—such persons need to be a part of broader efforts to build institutional capacity on gender.

The Global Fund has recently recruited to its Secretariat a senior-level “gender champion,” who will develop a detailed plan for putting the organization’s new gender equality strategy into practice. As a result, the Global Fund will likely begin to make clearer and more effective efforts to build gender capacity in the programs that it funds.

Because the Global Fund is a financing mechanism—not a traditional donor—it does not take explicit, direct steps to build a country’s capacity on gender unless a country requests such steps in its grant proposal. In one exception to this rule, the Global Fund has required that women be represented on country coordinating mechanisms. Yet such representation by itself cannot ensure that gender-related HIV/AIDS drivers will be addressed adequately in the proposals that a country coordinating mechanism develops and reviews. Having a certain quota of women members does not guarantee that gender principles will be integrated, gender analysis applied, or evidence used to support planning for more gender-responsive HIV/AIDS programming. Nor does it assure Global Fund recipient and subrecipient organizations of obtaining the gender expertise they need.

Mozambique’s national AIDS council, O Conselho Nacional de Combate Ao HIV/SIDA—one of two Global Fund primary recipients in the country—does not have a

gender focal point. Instead, it relies on “mentoring and coaching” by the Deputy Executive Secretary, who has had some training that was described as gender-related.

Uganda’s original Global Fund recipient organization, the Ministry of Finance, was on the gender team convened under Uganda’s poverty eradication action plan (the government’s overall national development strategy). Various sectors of Uganda’s government have gender focal points. But it is unclear whether those sectors include the Ministry of Health or the Uganda AIDS Commission—the other major Global Fund recipient organizations in Uganda—or whether gender experts in other ministries backstop their efforts.

Zambia’s round 1 proposal asserted a need to build capacity for gender analysis. It called for training in basic skills and techniques at every level of HIV/AIDS programming: planning, implementation, and monitoring and evaluation. Yet no program objectives were developed for gender analysis training, nor was capacity building mentioned in any accounts of planned activities. And the recipient organization, the Zambia National AIDS Network, does not have a gender focal point—though it is now recruiting for a gender specialist.

Global Fund recipient and subrecipient organizations have varying amounts of gender expertise, including familiarity with gender concepts and technical capacity for gender analysis. Only limited technical assistance related to gender has been requested or provided through country proposals (box 3.2).

Gender capacity at Global Fund recipient and subrecipient organizations in Mozambique varies greatly. Typically, however, it is less than adequate (box 3.3).

A key informant from Mozambique’s national AIDS council, O Conselho Nacional de Combate Ao HIV/SIDA, stated that program directors lack “gender sensibility and there is no gender consciousness in the country that would operationalize the gender perspective of the National Strategic Plan [for AIDS].” The national health ministry, O Ministério da Saúde, has a budgeted gender unit that is responsible

Only limited technical assistance related to gender has been requested or provided through country proposals

The Global Fund does not have staff in recipient countries. It does not provide direct technical assistance to country coordinating mechanisms or to recipient and sub-recipient organizations. Sometimes, at the request of a recipient country, technical assistance is funded through the Global Fund Secretariat. But to provide technical assistance to country coordinating mechanisms and to recipient and subrecipient organizations—including for gender-related activities—the Global Fund relies on other in-country donors and development partners, such as the Joint United Nations Programme on HIV/AIDS, the World Health Organization, the U.S. Agency for International Development, and the Australian Agency for International Development.

One of the objectives of the Global Fund's new gender equality strategy is to strengthen country-level partnerships among the development partners, to ensure that Global Fund recipient organizations request and receive needed technical assistance for gender-responsive programming.

for mainstreaming gender in the ministry and that provides training and technical support for ministry staff (but not for others outside the ministry). Since gender unit staff members do not have access to all ministry departments or to all levels of ministry decisionmaking, the unit's influence on programming is weak.

The lack of a gender focal point at Mozambique's national health ministry to work directly with the HIV/AIDS program shows the ministry's low commitment to gender-responsive HIV/AIDS programming. Within the ministry the National Directorate of Medical Assistance is responsible for ensuring that the ministry's response to HIV/AIDS is put into practice under its HIV/AIDS program. A gender focal point exists at the directorate but does not work directly with the program. The health ministry's gender unit collaborates with gender focal points who work directly in several departments in the ministry, but who have other responsibilities that often take precedence over their duties as gender focal points. That makes the focal points less effective, and it means that their effectiveness at integrating gender into HIV/AIDS programming often depends on their individual interest and capacity.

Mozambique's provincial- and national-level directorates also have gender focal points. The health ministry's gender unit uses a train-the-trainer model to train provincial-level

gender focal points who, in turn, train their provincial-level staff.

In Uganda a district health team that puts Global Fund programs into practice lacks a gender specialist, though it has access to the gender officer of another district department. District-level staff training in Uganda tends to address broader, more general health topics, with occasional attention to gender-related barriers or other concerns; no training specifically focuses on gender. The only training supported by the Global Fund in Uganda is on maternal and child health, and it does not have a gender focus (though it might contain gender-related themes).

In Zambia one Global Fund recipient organization, the Zambia National AIDS Network, relies primarily on existing staff members' skills and knowledge for technical guidance in addressing gender-related issues. Several of the staff members have some background on gender, but not all have received training.

The other Global Fund recipient in Zambia, the Churches Health Association of Zambia, makes human rights the basis for its approach to public health. The association has developed its own training program on human rights and gender issues, and it requires that all staff members receive training on gender inequality's relationship to HIV/AIDS. Subrecipient organizations, to receive the training, must request it during site visits by the association's program staff. A 2006 review report from the association⁵⁰ states that it has provided training on human rights and gender issues to hundreds of youth, opinion leaders, and individuals living with HIV/AIDS.

In Mozambique, Uganda, and Zambia, community-level providers of interventions and services supported by the Global Fund said that they confront gender issues routinely—though they have no training on gender and HIV/AIDS, no technical assistance for designing activities to address gender inequality, and no technical assistance for monitoring and evaluating such activities. The people who carry out programs in

50. CHAZ 2006.

In a community in Mozambique, health centers and hospitals refer HIV-positive women to a Global Fund–supported program for preventing mother-to-child transmission. The women are counseled on preventing mother-to-child transmission, and the program offers them related services. The Global Fund does not require that such programming include any strategies for addressing gender inequality.

Nevertheless, clinic and program staff at the organization identified gender inequality as an enormous obstacle for women wanting to access the services for preventing mother-to-child transmission. For example, women patients were often hindered from disclosing their HIV status—and thus from getting the services—by concerns about how the women’s male partners and families might react if the women’s HIV status was disclosed. One staff member for a program for preventing mother-to-child transmission in Mozambique reported:

Women do a thousand tests and they can undergo treatment over a long period of time, say two years. But they are unable to convince their partners to be tested. When women manage to convince their partners, they then repeat the tests as if it was the first time they were taking the test because they have not previously disclosed their status to their partners.

Another staff member recalled:

Today I attended a woman who has been undergoing treatment since 2006. I tried to find out what prompted her to have another child, considering that she had two already. She said her husband did not know that she had been having therapy since 2006.

According to clinic staff, women who had not disclosed their HIV status were also less inclined to stay on treatment after giving birth than were women who had disclosed their status:

They [HIV-positive women who have not disclosed their status] cannot go out before the baby is 40 days old. They should attend a ceremony to be able to take the baby out. The mother in law accompanies their daughters in law wherever they go. In situations of this nature women do not know how to react.

Similarly, nursing staff at the program noted that although most women agree to get the services for preventing mother-to-child transmission, not all will follow their treatment regimen—a combination of three drugs that must be taken with food. To support the women in staying on the regimen, the program gives monthly baskets of food supplies to them and their families.

Understanding gender-related cultural dynamics and the challenges to service provision that arise from difficulties with HIV status disclosure, the program carries out activities—based partly on suggestions from women program participants—to involve male partners in preventing mother-to-child transmission. The male partners of HIV-positive women who had been afraid to disclose their status to their partners received invitations to a meeting. The meeting was facilitated by HIV-positive men, who told the invitees that the invitees’ female partners had tested positive for HIV and urged the invitees to seek testing.

Staff at the organization’s program for preventing mother-to-child transmission must confront gender issues daily—and some have developed strategies to address those issues. Yet the organization has no mechanism to ensure that gender is integrated into these activities. As one staff member at a program for preventing mother-to-child transmission in Mozambique noted: “[Gender issues] are so present that it cannot be ignored, though we don’t have a designed strategy to address the gender issues.”

communities often understand gender inequality because of its direct, immediate effect on program success.

Subrecipient organizations in Zambia were found to have no formal staff training on gender—even though many programs that the organizations put into practice have a gender focus. For example, one subrecipient organization (described in annex C) raises awareness on women’s rights and sexual health. The project can access gender tools—including technical assistance, from Zambia’s Community Response to HIV/AIDS (CRAIDS)—and a manual and workshops—developed by the national

AIDS council—from the District AIDS Task Force. Yet project staff members appear to depend less on formal training than on informal, experiential learning when they must deal with gender-related obstacles to program success.

In Mozambique staff members at the recipient and subrecipient organizations that put programs into practice sometimes do and sometimes do not have gender training depending on the organization. Only organizations with a special interest, or with staff gender specialists, appear to use technical assistance from other organizations. This study identified no gender focal points or tools for gender-related

The Global Fund should ensure that country coordinating mechanisms and local fund agents have gender expertise, that recipients' capacity on gender is carefully assessed by its technical review panel, and that appropriate gender-related indicators are added to the donor's monitoring and evaluation toolkit

programming at any of the subrecipients that it examined in Mozambique.

The Global Fund does not directly provide gender tools or resources for addressing gender inequality in AIDS programming and policy—recipients rely on other tools and resources to develop the gender-related activities, if any, that they include in their proposals. Recipient organizations did not identify any gender tools or manuals that they can request from the Global Fund for program planning, for activity design, or for monitoring and evaluation. Several tools that were mentioned had been developed by national- and district-level HIV/AIDS programs.

In Uganda key informants reported using national-level policy documents on health topics, such as preventing mother-to-child transmission, to guide their development of program indicators. But those documents included no guidance for program planning that would address gender-related barriers to accessing services. So the indicators were developed on the basis of policy documents that were—presumably—developed for an entirely different purpose. That suggests the importance of the need for tools to develop gender-responsive programming and gender-related indicators for monitoring and evaluation.

Staff members at Global Fund recipient organizations in Zambia did not mention the Global Fund's monitoring and evaluation toolkit. However, they did refer to the national AIDS council's monitoring and evaluation toolkit. In addition, the Churches Health Association of Zambia has a human rights and gender toolkit to address the relationships among gender, sexuality, human rights, and HIV/AIDS. A manual for health workers, community based staff, and volunteers under the Local Community Competence Building and HIV and AIDS program, the Churches Health Association of Zambia's toolkit describes women's and children's rights; it discusses violations of those rights; and it suggests actions that communities can take in response. Staff members at Zambia's other Global Fund recipient organization, the Zambia National AIDS Network, did not report accessing any

gender-related tools or manuals for gender-related programming.

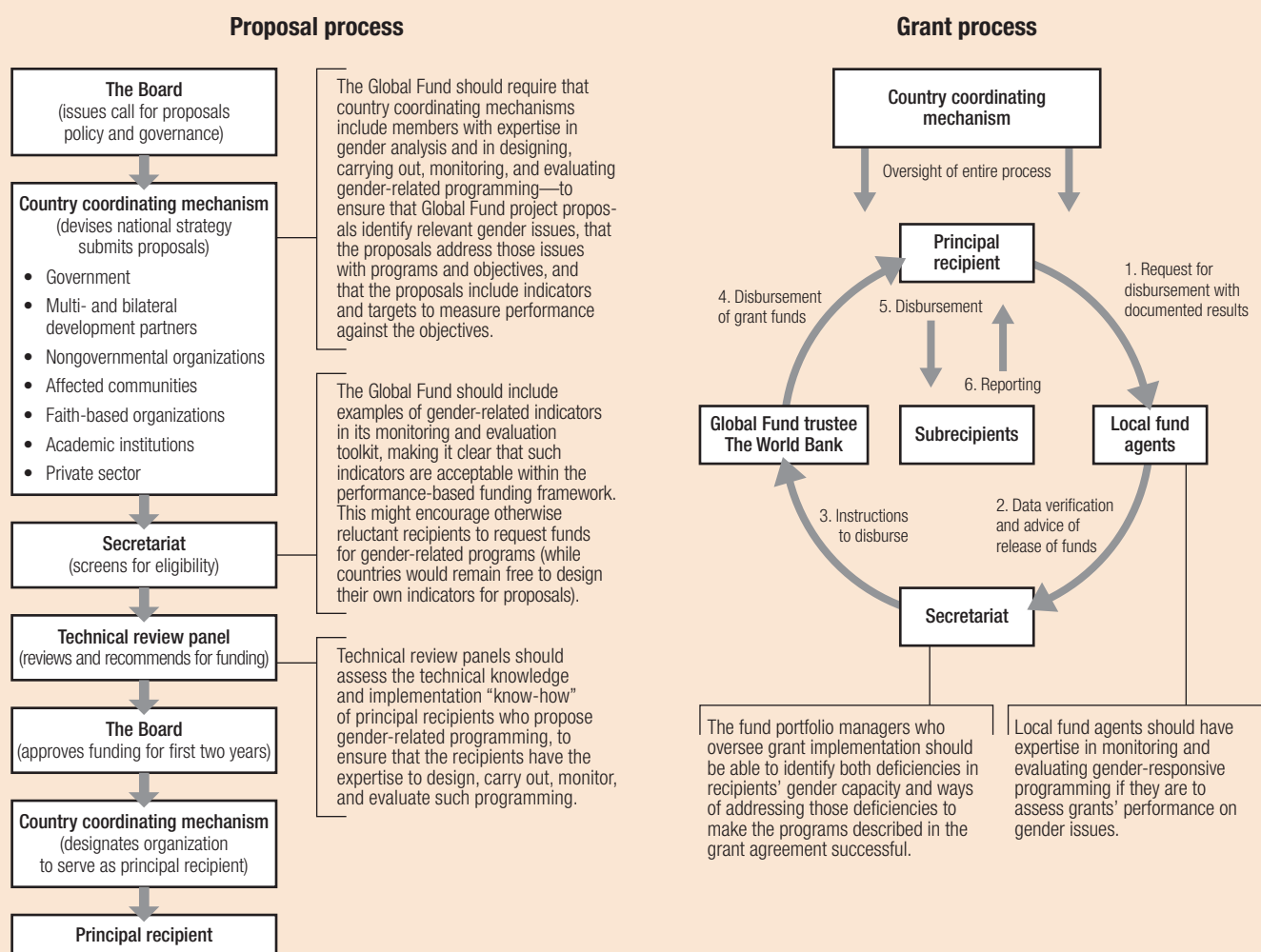
In Mozambique neither the health ministry, the national AIDS council, nor the subrecipient organizations examined for this report had any gender tools to guide programming. The health ministry's gender unit has trained focus people in the provinces to train staff at that level, and the ministry is now preparing a gender strategy for the health sector. But key health ministry informants state that the gender unit has little influence over programs and policies.

Recommendations for the Global Fund

Based on our findings in the three countries, we recommend that the Global Fund take several actions to increase its ability to address gender inequality's relationship to HIV/AIDS (figure 3.1). These recommendations can be incorporated into the drafting of the implementation plan for the new gender equality strategy.

Ensure that country coordinating mechanisms and local fund agents—not just technical review panels—have the gender expertise they need. The Global Fund now encourages countries to include equal numbers of men and women in its country coordinating mechanisms—but this policy does little to ensure the inclusion of people who have technical knowledge and program experience on gender issues and gender-responsive policy, or who will support programs to increase gender equality. The Global Fund must explicitly require that country coordinating mechanisms include such people. Only their presence can ensure that project proposals identify relevant gender issues, that the proposals address those issues with programs and objectives, and that the proposals include indicators and targets to measure performance against the objectives. Also, if local fund agents are to assess the performance of grants on gender issues, they need people who can monitor and evaluate gender-responsive programming.

Figure 3.1 Recommendations from the HIV/AIDS Monitor to the Global Fund to inform the implementation plan for its new gender equality strategy, organized by process and structure



Source: Authors' adaptation of figures retrieved from the Global Fund website at <http://www.theglobalfund.org/en/structures/?lang=en>.

Ensure that the technical review panels and fund portfolio managers carefully assess the technical knowledge and implementation “know-how” of principal recipients who propose programs to address gender issues. No antiretroviral treatment program can perform well unless it includes people with certain key skills, such as managing a supply chain and testing blood for CD4 counts. In the same way, no program designed to address the relationship between gender inequality and HIV/AIDS can perform well unless it includes people skilled at designing, implementing, and monitoring and evaluating such programs. So it is essential that the

Global Fund’s technical review panels assess the capacity of principal recipients to address gender issues. Similarly, the fund portfolio managers who oversee grant implementation should be able to identify both deficiencies in gender capacity and ways of addressing those deficiencies to make the programs described in the grant agreement successful.

Develop gender-related indicators for the Global Fund’s monitoring and evaluation toolkit that fit the organization’s performance-based funding framework. The Global Fund now has no gender-related indicators in its monitoring and

evaluation toolkit. Including such indicators would make it known that they are acceptable within the performance-based funding framework; also, their inclusion might encourage otherwise reluctant recipients to request funds for gender-related programs (while countries would remain free to design their own indicators for proposals). Gender-related indicators for the toolkit should include output, outcome,

and impact measures. In addition, they should measure both short-term and long-term change, allowing gender programs to fit the Global Fund's performance-based funding framework while measuring indicators over longer periods. For example, indicators could measure results from structural interventions that seek to address social, economic, political, and physical drivers of the HIV/AIDS epidemic.

4 The World Bank's Africa Multi-Country AIDS Program

The use of MAP funds to address gender inequality's relationship to HIV/AIDS through programming depends on the commitment and capacity of MAP recipient and subrecipient organizations

The World Bank's Africa Multi-Country AIDS Program (the MAP) has provided five-year funding to support the national HIV/AIDS policies of Mozambique (\$55 million over 2003–08), Uganda (\$50 million over 2001–06), and Zambia (\$42 million over 2003–08).

Perhaps uniquely, MAP funds are organized less by what they fund than by who they fund: generally they support the plans or capacity of certain institutions, or of certain types of institutions. Mozambique, Uganda, and Zambia receive their MAP funds to support:

- Funding the HIV/AIDS plans of National AIDS councils, sector ministries, and district governments.
- Building governments' and communities' capacity to plan and carry out the HIV/AIDS response.
- Funding the proposed community initiatives of civil society organizations, community groups, and members of the private sector.

Specific programmatic activities and objectives are not defined in World Bank MAP project documentation—they are defined only in the various work plans and strategies of the actors listed above. The use of MAP funds to address gender inequality's relationship to HIV/AIDS through programming thus depends on the commitment and capacity of MAP recipient and subrecipient organizations (figure 4.1). As one staff member of a MAP recipient organization in Mozambique explained:

The [World Bank] does not impose conditions on the implementation of the MAP. It makes proposals about issues that we should take into consideration and [O Conselho Nacional de Combate Ao HIV/SIDA, the national

AIDS council] decides on the relevance and priorities according to the national response.

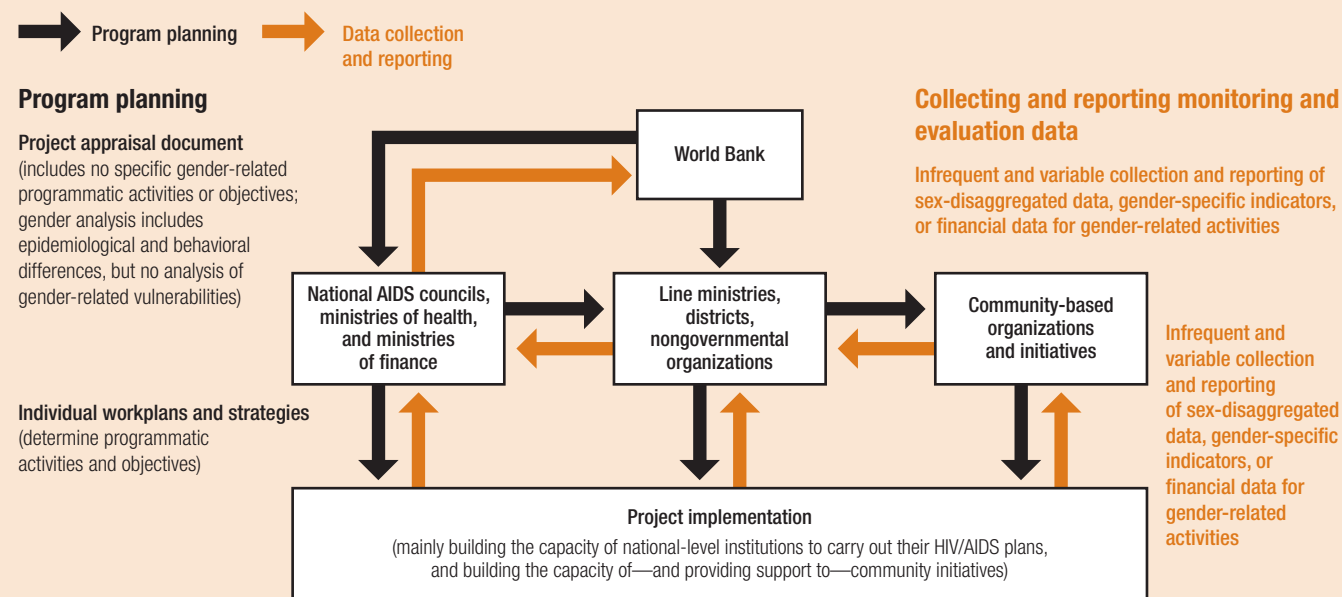
Gender analysis in situational assessments and program design: proposals include data on epidemiological and behavioral differences, but virtually no analysis of gender-related vulnerabilities and consequences

Situational assessments for MAP projects include some gender analysis, with gender experts provided—yet that gender analysis is limited. A MAP staff member in Mozambique remarked:

It is important to take into consideration the relation between gender and HIV/AIDS, but just this is not enough; we need to identify clearly the essential needs that we need to deal with. In different meetings that I have been participating in with the government institutions, I have the feeling that there is a lack of clear understanding of these needs and how to deal with gender in Mozambique. One of the gaps, also, is that we do not have examples of good practices that we could refer to.

Situational assessments for the MAP include gender analysis, but that analysis does little to

Figure 4.1 MAP-funded activities and objectives are defined in program planning by recipients and subrecipients, whose commitment and capacity thus determines how well MAP programming can address gender inequality (MAP processes for program planning and for collecting and reporting data)



Source: Authors' construction.

point to gender-related HIV/AIDS vulnerabilities and consequences—and the MAP does not identify needed programmatic responses. Situational assessments are done as part of a MAP project preparation process led by country government partners. They are then presented as background information in MAP project appraisal documents written by World Bank staff members.

The project appraisal documents for Mozambique, Uganda, and Zambia review national epidemiological and behavioral survey data—disaggregated by sex—to identify key differences in HIV prevalence and risk for women, men, boys, and girls. For example, the Mozambique project appraisal document uses data from a 1997 Demographic and Health Survey and a 2001 national survey of sexual and reproductive health among adolescents and youth (Inquérito de Saúde Reprodutiva e Sexualidade do Adolescente e Jovem) to show that HIV prevalence rates are higher for women ages 15–29 than for men in the same age group. In the Uganda project appraisal document, epidemiological data show higher infection rates among girls ages 15–19 and ages 20–24

compared with boys in the same age groups. In the Zambia project appraisal document, epidemiological data highlight the effects of transactional sex, the frequency of multiple partners among men, and the higher HIV infection risk for girls who have sex for the first time at a younger age compared with the risk for boys who do so.⁵¹

Most of the gender analysis in MAP project appraisal documents comprises general statistical analyses of sex-disaggregated data. But some of the documents suggest how particular kinds of gender inequality can increase a certain group's HIV/AIDS vulnerabilities or reduce its ability to manage the consequences of infection. For example, the Mozambique project appraisal document identifies (from the first national AIDS plan) features of women's social status that make them more vulnerable to HIV/AIDS, such as their low capacity to negotiate safer sex, their economic dependency

51. The data sources for the indicators include sentinel surveillance reports by the Joint United Nations Programme on HIV/AIDS, Zambia Demographic and Health Surveys, and Sexual and Behavior Surveys.

on men, and their low access to education. And the Uganda project appraisal document lists various social and economic consequences of HIV/AIDS: women, youths, and elders become household heads, and young people are forced to drop out of school to earn household incomes.

The Zambia project appraisal document discusses gender issues in somewhat greater depth. It explains how gender inequality makes women and girls more vulnerable to HIV/AIDS and more susceptible to its consequences, including:

- Property losses that women suffer when their husbands die.
- The burden of caring for sick family and household members.
- Increased HIV infection risk resulting from gender-based violence.
- Reduced access to voluntary counseling and testing and antiretroviral treatment services resulting from gender-based violence.

Although the project appraisal documents sometimes offer valuable bits of gender analysis, they cite no evidence to support that analysis. Through the documents the MAP has indicated its interest in addressing gender issues—but it does not go on to use past programmatic data to assess what has worked, nor does it use such data to identify needed programmatic responses for MAP in a given country context. The best that can be said of the gender analysis seen in project appraisal documents for the three countries studied is that, for Zambia at least, the MAP has linked several program areas to the gender issues it identifies. But the Mozambique and Uganda project appraisal documents scarcely mention program areas to address gender and HIV/AIDS.

The strategies, plans, and proposals for MAP country programs are created independently from the situational assessments in project appraisal documents. Recipient and subrecipient organizations must decide whether and how to conduct gender analysis and whether and how to apply such analysis to their programs. Those decisions will vary depending

on the organizations' awareness of gender and HIV/AIDS, their access to data and to existing analysis, and their previous experience with gender analysis. In Mozambique, Uganda, and Zambia, where the national HIV/AIDS response follows national AIDS strategies, any gender analysis that might have been done as part of preparing the national strategies does not appear to have influenced program design on the ground. A handful of subrecipient organizations have used gender analysis in developing their HIV/AIDS work. But most of the other actors that carry out MAP programs have not.

The World Bank has encouraged gender analysis, provided capacity through gender experts, and conducted occasional trainings on gender analysis—but the MAP model still does not incorporate systematic gender analysis at all levels of program design and planning. The World Bank has done extensive work on tools, methods, and guidelines for gender analysis, and has tried to bring some of that expertise to MAP programs in Mozambique, Uganda, and Zambia. Indeed, the Mozambique project appraisal document states the intention that “the preparatory process for community sub-projects includes comprehensive analysis of gender (and other social issues) that leads to selection of appropriate responses (such as income generating activities).”⁵² Yet interviewees at subrecipient organizations in Mozambique report that no such “comprehensive analysis” ever took place.

In Uganda the MAP provided training on district-level planning for HIV/AIDS programs. During the planning workshops MAP technical staff developed some situation analysis skills, including the skills to conduct gender-related situation analysis for HIV/AIDS plans. Thus, the MAP has made efforts to provide and build capacity on gender and HIV/AIDS (discussed in more detail below). But those efforts have never led to a systematic use of gender analysis to inform program planning at the level of recipient or subrecipient organizations.

52. World Bank 2003.

MAP recipient and subrecipient organizations must decide whether and how to conduct gender analysis and whether and how to apply such analysis to their programs

MAP funding to some community initiatives has supported services that address gender issues

Programs addressing gender inequality: the MAP uses capacity building and support for community initiatives

The MAP has planned activities to address gender issues through programs supporting HIV/AIDS plans for government ministries and, in addition, through small subgrants supporting community initiatives. Both types of programming are sporadic; both often lack resources and capacity. However, the result is that MAP funding to some community initiatives has supported services that address gender issues.

Of the many activities funded by the MAP that aim to build capacity, some have provided gender-related training and technical assistance for national AIDS councils, national government ministries, district governments, and civil society groups. In Mozambique more than a fifth of MAP funds were split between capacity-building efforts by community initiatives and by the national AIDS council. Similarly, in Uganda more than 15% of funds went to consultant services and training. In all three countries, such activities to build and provide capacity have included some attention to capacity on gender issues. Yet none of the three countries had MAP objectives for building gender capacity.

Some gender-responsive programming has been carried out with MAP funding by national government agencies, such as gender and education ministries—yet such programming is limited, and other national government agencies have no programs to address gender issues. Uganda's project appraisal document describes broad gender-related program areas for the Ministry of Education and Sports and the Ministry of Gender, Labour and Social Development. The document identifies the Ministry of Education and Sports to fund programs that provide material support and support in other forms (such as cash transfers) to households headed by women and children.⁵³ The document also assigns cer-

tain program areas to Uganda's Ministry of Gender, Labour and Social Development, the government agency with primary responsibility for gender across all sectors. Those program areas include:

- Counseling on condom use.
- Counseling on HIV risks from defilement, female genital mutilation, and early and forced marriages.
- Support for initiatives to empower women, led by women.
- Legislation to prevent the disinheritance of women.
- Legislation to prevent discrimination against women.
- Reforms to microfinance programs to address the specific needs of women and other vulnerable groups.

In Zambia the Ministry of Education took measures to ensure that girls affected by HIV/AIDS, and those in affected families, were supported to continue their education.

In all three countries various ministries have invoked the term *gender mainstreaming* in their HIV/AIDS plans (see definition in annex A). Uganda's Ministry of Gender, Labour and Social Development uses the term to signal that the ministry should integrate gender into the HIV/AIDS planning and programs of other ministries, and of district governments, while also providing community initiatives with support on gender issues. Zambia's Gender in Development Division uses the term to mean that it will train gender focal points in all other ministries and also that it will refer to gender in policies and plans.

However, none of the three countries has addressed gender in HIV/AIDS programming through joint efforts by all of its ministries. Most striking, none of the three countries' health ministries addresses gender systematically in its programs. Mozambique's health ministry, which receives more than 30% of the country's MAP funds, has even stated explicitly that gender is not its concern (discussed in chapter 1, above).

Most MAP-funded gender-responsive programming is carried out by community initiatives. The

53. We have no information about whether or, if so, how these programs were put into practice.

three countries studied all receive support for their community initiatives through the MAP; such support is designed with slight differences for each country. However, there is no evidence to indicate how many such initiatives have been supported; nor is there evidence to show that the MAP has processes in place to identify or support them. What is clear is that MAP structures have not systematically led community initiatives to use gender analysis or to consider gender issues, either in program planning, in operations, or in monitoring and evaluation.

The Mozambique project appraisal document, uniquely, calls for all MAP community initiatives in the country to do comprehensive gender analysis, to include women in decision-making, and to disaggregate all program data by sex. Although Mozambique's MAP community initiatives began to systematically disaggregate program data by sex in 2006, no other efforts have been made to realize the vision set forth in the project appraisal document.

Zambia's approach has been to integrate activities with a gender focus into the list of activities that the MAP seeks to support. For example, activities to reduce women's risk of HIV infection include:

- Encouraging voluntary testing.
- Harmonizing the age of consent, marriage, and maturity.
- Providing activities meant to delay sexual experience for young people.
- Providing basic education on HIV, sexually transmitted infections, and sexual and reproductive health.
- Empowering women for employment, information access, and social and economic recognition.

In addition, Zambia's Community Response to HIV/AIDS (CRAIDS), which approves proposals from community-based projects for MAP funds, has enforced strict priorities in approving funds for projects that target certain groups. According to a CRAIDS program manager in Zambia:

Special attention was given to the gender factors of HIV/AIDS in the context of the imbalance of power between men

and women . . . since women faced a greater risk of infection than men . . . and women were also the main caregivers.

Gender-related requirements are imposed on Zambia's MAP-funded projects during appraisal procedures. The requirements fall into three priority focus areas:⁵⁴

- Support to youth programs. Communities receiving MAP funds for this activity area must support at most two types of skills training, one to target male youths, another female youths.
- Support to vulnerable groups. Community groups receiving MAP funds for this activity area must identify what vulnerable groups they are targeting (for example, widows or single women). HIV/AIDS prevention activities that target women—including activities to promote voluntary counseling and testing and antiretroviral treatment—get special emphasis. Similarly, training activities for HIV/AIDS prevention that target vulnerable groups, particularly women, get special emphasis. Also emphasized are human rights and gender rights related to HIV/AIDS risks and vulnerabilities.
- Support to programs for the general population. Community groups receiving MAP funds for this activity area must focus on advocacy issues, including human rights and gender rights.

Accountability through gender-sensitive monitoring and evaluation: performance assessment frameworks lack a gender focus, but include some sex-disaggregated data

The MAP's systems for programmatic reporting and monitoring and evaluation are problematic in two ways. First, in their function: they depend on unreliable reporting between recipient and subrecipient organizations. Second, in their design: they lack objectives and

The MAP's systems for programmatic reporting and monitoring and evaluation are problematic

54. CRAIDS 2007.

The MAP's performance assessment frameworks do not require the data for input and output indicators reported by recipient and subrecipient organizations to be sex-disaggregated

indicators for measuring how well MAP programs address gender inequality's relationship to HIV/AIDS.

In Mozambique, Uganda, and Zambia, MAP monitoring is designed to yield almost no data that could be used to assess the MAP's approach to gender and HIV/AIDS—for example, sex-disaggregated data, data on gender-specific indicators, or financial data for gender-related activities. The lack of such data is especially striking at the program level. Such designs as are now in place for collecting gender-related data have managed, at best, to provide recipient organizations with some sex-disaggregated data on beneficiaries of community initiatives (and that with only limited success). According to a key informant in Mozambique:

The system is clear, and even has all the gender indicators such as data disaggregated by sex and age—but there is not enough technical capacity to collect the information to feed the system, especially in the provinces. But we as Partners Forum are working on technical capacity with [O Conselho Nacional de Combate Ao HIV/SIDA, the national AIDS council] in order to improve.

Program monitoring and evaluation

The MAP's impact and outcome indicators for all three countries are mostly—but not all—disaggregated by sex. The MAP's outcome and impact indicators in Mozambique, Uganda, and Zambia are drawn from each country's national AIDS strategy indicators, which are constructed from data in national epidemiological, behavioral, and other surveys. Mozambique's MAP project appraisal document does not require data on outcome and impact indicators to be sex-disaggregated; however, data for Mozambique are already disaggregated by sex in the country's national health system. And data on the indicators for Uganda and Zambia are generally sex-disaggregated.

The MAP's performance assessment frameworks do not require the data for input and output indicators reported by recipient and subrecipient organizations to be sex-disaggregated; in practice, some data reported by subrecipient organizations have been sex-disaggregated. In Uganda there has been one exception: an indicator on orphans and vulnerable children, initially requiring sex-disaggregated data, was changed after the mid-term review and no longer required disaggregation by sex.

The project appraisal document for Mozambique claimed that all community initiatives would collect sex-disaggregated data. A key informant from a Mozambique subrecipient organization, however, reported receiving little guidance, and no formal reporting forms, from the national AIDS council (O Conselho Nacional de Combate Ao HIV/SIDA) to use in reporting monitoring data. As a result the national AIDS council received reporting that was not uniform across subrecipient organizations, either in the type of data being collected or in the way data were formatted for reporting. Such forms and systems have since been formalized, and the narrative reports that subrecipient organizations now provide each month must use a specific format—with all data required to be disaggregated by sex. Although the forms are systematized on paper, regular reporting remains a challenge for organizations that carry out MAP programs.

For programs funded through the MAP in Zambia, sex-disaggregated data on major indicators are reported by Community Response to HIV/AIDS (CRAIDS), to which subrecipients report the data every three months. For example, the subrecipient Lusumpuko Community Initiative, which serves orphans and vulnerable children, uses monitoring and evaluation reporting tools to report data disaggregated by sex and by age.

The MAP has no gender-specific indicators in its project appraisal documents for Mozambique, Uganda, or Zambia. Neither the project appraisal document for Mozambique nor the project appraisal document for Uganda have any gender-specific indicators. The narrative

section in the document for Zambia includes two gender-related indicators: output level (the number of community initiatives funded that specifically address gender issues) and outcome level (the number of research activities focusing on gender). But neither indicator is included in the project summary (logical framework), which determines what is actually reported through the MAP's monitoring system for Zambia.

Financial monitoring

The MAP has no separate budget line for MAP funds spent to address gender issues, nor does it track such spending in any way. Although the MAP funds programs for gender-related activities—including capacity development on gender issues, certain ministry efforts, and community-based initiatives—it does not track the funds spent on those programs. Reports one informant from a MAP subrecipient in Mozambique: “When we submitted our proposal the donor didn't have any requirement related to gender programs; therefore, we are not able to tell how much money was used for gender-related programs.”

Gender capacity: the MAP makes capacity building a focus of its gender work, but does not assess program performance or demonstrate results

The MAP has funded some gender training and gender-related technical assistance for national AIDS councils, ministries, district governments, and civil society groups. But it has no specific objectives for those activities, and they are not monitored or evaluated. Gender capacity in MAP recipient and subrecipient organizations remains low—even in key institutions for addressing gender inequality's relationship to HIV/AIDS, such as the Ministry of Gender, Labour and Social Development in Uganda and the Gender in Development Division in Zambia. The World Bank country staff who work on the MAP have varying amounts of expertise in analyzing gender dimensions of the HIV/AIDS epidemic and in designing and

implementing gender-related programming; they draw on the expertise of consultants, of other Bank staff, and of specialists at other in-country agencies (such as gender ministries).

The training and technical assistance on gender issues funded by the MAP has not succeeded in building the capacity of either Mozambique, Uganda, or Zambia to integrate a gender focus into its national HIV/AIDS response. In Uganda the MAP's approach to gender and HIV/AIDS relied heavily on the Ministry of Gender, Labour and Social Development. The MAP supported the ministry's plan for gender mainstreaming across the national AIDS response—from the national AIDS council, through various other ministries, right down to the district governments and communities. As a key informant in Uganda notes:

The whole approach should be to impart skills in those who are charged with responsibility so that you don't always have to rely on the gender specialist. We had a community, a district, and national level components[,] and having a couple of gender specialists would not be adequate to address the gender concerns.

The broad gender mainstreaming mandate envisioned by Uganda's Ministry of Gender, Labour and Social Development was herculean—and it proved impossible to realize. Funds were too few, staff capacity too low. Most underfunded of all the relevant actors was the district-level gender office, which was meant to support all sectors for planning and carrying out programming. As another key informant in Uganda explains:

Even the [Ministry of Gender, Labour and Social Development] is not doing enough to be able to spearhead the issues of gender mainstreaming, and their respective departments at district level cannot provide the required guidance to the other departments in the districts. They are resource constrained and limited in terms of people on the ground.

Gender capacity in MAP recipient and subrecipient organizations remains low

Without specific objectives or indicators for the MAP's capacity building on gender, the effects of its support are far from clear

In Zambia the MAP has built capacity, focusing on existing gender focal points in government and on nongovernmental program staff; over 2003–05 such capacity building aimed to integrate a gender focus into Zambia's MAP programs and other national-level HIV/AIDS programming. The country's MAP recipient organization, the Zambia National Response to HIV/AIDS Project (ZANARA)—of which Community Response to HIV/AIDS (CRAIDS) is a part—was funded by the MAP to ensure that all Zambia government ministries consider gender issues when planning HIV/AIDS programs. Accordingly, ZANARA trained HIV/AIDS focal points in all government ministries to integrate gender into work plans. The training objectives included:

- Raising awareness of gender inequality and of its relationships with law, culture, poverty, and the spread of HIV/AIDS.
- Equipping field workers and AIDS activists with tools for integrating a gender focus into HIV/AIDS programming.

The program trained 40 staff members in selected districts before it was discontinued in 2008, when the MAP stopped funding it.

In Mozambique the MAP has organized at least one gender training for its country office staff. The training used gender manuals developed by the World Bank that addressed integrating a gender focus into HIV/AIDS programs, gender-responsive programming, and monitoring.

In 2008 a World Bank gender specialist focused on revising Mozambique's second national AIDS plan while helping government staff prepare for the Bank's annual meeting. The specialist addressed the development of gender-related objectives for the new plan.⁵⁵ One Bank staff member in Mozambique felt that the Bank's gender-related resources and technical expertise were not put to good use on this occasion:

[T]echnical knowledge is not sufficient if the specialists do not have the cultural and contextual knowledge of

gender dimensions in the country. On the other hand, the recipients of this technical guidance should clearly define their understanding of gender and what they want to achieve with the gender technical guidance.

The MAP's support for training and technical assistance on gender issues has likely built some in-country capacity on gender and HIV/AIDS programs. But, without specific objectives or indicators for such capacity building—without documentation, reporting, or evaluation—the effects of such support are far from clear. Only piecemeal evidence suggests that it has partly succeeded.

There are no gender focal points at MAP country offices in Mozambique, in Uganda, or in Zambia. In Mozambique the World Bank regional country office can dispatch a gender specialist—on request—to provide training or technical assistance, and at least one gender training course has been held for Bank country office staff. In Uganda the MAP has consulted with gender specialists at the Ministry of Gender, Labour and Social Development.

Capacity on gender issues in MAP recipient and subrecipient organizations varies across the three countries studied, but—with a few exceptions—it is fairly limited in all. In Uganda the MAP has relied on the Ministry of Gender, Labour and Social Development for gender expertise. The ministry conducts analyses, develops sector and district plans, vets and supports community initiative proposals, and helps build capacity. But the ministry's staff is overstretched, with just nine gender specialists to serve all sectors across Uganda. In each of the last three recent fiscal years the ministry received just 0.4%–0.5% of the national budget.⁵⁶

All Zambia government ministries are subrecipient organizations for MAP funds, and, in principle, each is supposed to have a gender focal point. Yet some ministries have no such person.

55. World Bank key informant interview.

56. Uganda Ministry of Gender, Labour and Social Development 2007.

Others have one who lacks needed expertise, or whose rank is low. For example, Community Response to HIV/AIDS (CRAIDS) has only a low-ranking gender focal point, and no gender specialist to support management and staff every day. When needs related to gender and HIV/AIDS arise, CRAIDS must turn to the Gender in Development Division for consulting services. Otherwise, the Zambia National Response to HIV/AIDS Project generally has low capacity on gender issues. Its staff have had no mandatory training on gender.

Zambia's government had some programming over 2003–05 to build capacity on gender issues and to integrate a gender focus into MAP programs and HIV/AIDS activities. But funds were few. The programming, coordinated by the national AIDS council and the Gender in Development Division, had specific objectives for building capacity on gender and HIV/AIDS. Trainees included gender focal points from government ministries, provinces, and districts.

Mozambique's MAP recipient organization, the national AIDS council (O Conselho Nacional de Combate Ao HIV/SIDA), has no gender focal point. In the council's institutional perspective, "gender is not an isolated issue but a crosscutting one. All our response is impregnated on gender and all council staff must use gender lenses when they receive a proposal."⁵⁷ Yet experience on the ground proves that national AIDS council staff do not consistently use such lenses.

One MAP subrecipient in Mozambique has three staff members—all teachers—who were trained on gender issues in 2004 and 2005 through the Ministry of Education and Culture. The focus was on equal access to education. In 2006 two other staff members were trained on gender issues by the Spanish Cooperation, and gender training for two activities was provided by the health ministry and Justa Paz, a nongovernmental organization. The trainings addressed gender concepts, cultural concepts that affect gender inequality, and women's negotiation skills.

Recommendations for the MAP

Based on our findings in the three countries, we recommend that the MAP take several actions to increase its ability to address gender inequality's relationship to HIV/AIDS.

Ensure that comprehensive gender analysis—not just analysis of sex differentials in epidemiology and behavior—is used in project development, and ensure that such analysis informs the development of programs that explicitly respond to gender in all project components (community initiatives, the health sector, national AIDS councils). Project appraisal documents for the MAP now present statistical differences by sex, but only as background information—and the documents include no explicit programming to address the issues so identified. The documents contain very little analysis of how gender inequality shapes the spread and impact of HIV/AIDS, and they contain no analysis of its implications for programs now or in the future.

The World Bank's extensive project development process is meant to include situational assessments and project design and review. That process could be improved with built-in guidelines and support for:

- Doing more analysis of the relationship of gender inequality to HIV/AIDS.
- Using all available analysis in designing HIV/AIDS programming that explicitly addresses identified gender issues.

Develop and include gender-related indicators and use sex-disaggregated data across all parts of HIV/AIDS programs. The MAP has provided capacity building, technical assistance, and program support to national AIDS councils, sector ministries, and community initiatives. All those parts of the MAP can and should address critical gender issues—but to do so effectively, they need to be monitored and evaluated on those issues. The MAP project appraisal documents for Mozambique, Uganda, and Zambia include no gender-related indicators, and in many cases the data that they require are not sex-disaggregated. Although MAP documents emphasize

The MAP should ensure that project development includes comprehensive gender analysis, includes gender-related indicators, uses sex-disaggregated data consistently, and takes advantage of the World Bank's abilities to promote stronger national gender policies and long-term social change

57. Mozambique national AIDS council (O Conselho Nacional de Combate Ao HIV/SIDA) key informant interview.

gender in their rhetoric, the key indicators that they now use cannot show whether or how MAP programs respond to gender inequality or sex differences.

Examine what is working and what is not working in grantmaking facilities for MAP community initiatives, and develop guidance to help the facilities make grants that are more responsive to gender issues. The MAP's grantmaking facilities for community initiatives are often touted as a great success by the World Bank. Yet, as our evidence shows, many projects supported through the grantmaking facilities do not use gender analysis in their design, have no programs to address gender issues in communities, and are not monitored or evaluated on gender issues. As a result, a real opportunity for addressing gender at the grass roots is being lost.

Take advantage of the World Bank's abilities to address long-term issues of social structure and to encourage stronger national policies on gender and HIV/AIDS. The World Bank's mission and experience make it well positioned to encourage governments to foster social change and pursue long-term policy and institutional reforms. The Bank could do much to:

- Influence how national HIV/AIDS policies address gender issues.
- Strengthen the capacity and commitment of key ministries and other institutions to focus their countries' national HIV/AIDS responses on gender inequality.
- Use coordinated, comprehensive gender analysis to develop longer-term social change objectives for each national HIV/AIDS response—and help put the objectives in place.

5

Moving beyond gender as usual

High-level commitments to addressing gender issues have not yet produced concrete and systematic actions and learning at the country level

Gender inequality poses a serious challenge to the three donors' HIV/AIDS programming. If the donors choose to ignore gender-related differences and gender-related structural causes associated with HIV/AIDS, the donors' programs will continue to have only a limited impact on the epidemic.

Although the U.S. President's Emergency Plan for AIDS relief (PEPFAR), the Global Fund to Fight AIDS, Tuberculosis and Malaria, and the World Bank's Africa Multi-Country AIDS Program (the MAP) have made high-level commitments to addressing gender issues and making their programs more effective, those commitments have not yet produced concrete and systematic actions at the country level. That is largely because the staff at donors' country offices, national governments, and recipient and subrecipient organizations lack technical expertise and experience in designing, carrying out, and evaluating gender-responsive programs. In addition, donors and national governments seem not to be learning from existing local efforts to address gender issues at the community level—partly because the donors and governments have no way to monitor and evaluate gender-responsive programming. Thus, approaches to gender-responsive programming continue as usual, with much rhetoric and little action.

This report has suggested several ways for each donor to move beyond gender as usual and make its HIV/AIDS programming more responsive to gender issues. PEPFAR has demonstrated its commitment to gender equality with its global strategy—five strategic areas for addressing gender inequality and four global goals. But its perspective needs to be less global and generic, with a sharper focus on country contexts. PEPFAR country teams should design country-level objectives, programs, and

indicators based on needs identified through country-level gender analysis. And it should drop constraints on prevention services—such as age-related restrictions and other restrictions on condom distribution—that conflict with its stated gender goals.

The Global Fund should be commended for its bold new gender equality strategy. Now it needs to ensure that the capacity exists for putting that strategy into practice—both in country actors, to design and implement gender-responsive programming, and in Global Fund structures (such as the technical review panels, country coordinating mechanisms, and fund portfolio managers), to evaluate and manage gender-related grant components.

The MAP has several strengths that enable it to act effectively on gender and HIV/AIDS. One is the World Bank's proven ability to get money to community-based initiatives; such initiatives could be an excellent channel for effective gender programming. Another is the Bank's expertise in policy and in building government capacity across sectors. Yet the MAP should use these and other strengths more effectively by systematically including clear, meaningful gender objectives and indicators to use in each area. For example, the Bank can use its experience working with governments on multisectoral policy to help countries make their national policies on gender and HIV/AIDS coherent—aligning national AIDS plans with national health plans and national development strategies.

The three donors and national stakeholders should collaborate in several ways to pursue their common goals

In addition to individual actions, the three donors and national stakeholders should collaborate in several ways to pursue their common goals:

Support national gender analysis. All donor programs would benefit from gender analysis that is robust and up-to-date. Since it would be inefficient for the three donors to undertake gender analysis separately, they should combine their resources to support a single, comprehensive national gender analysis to guide HIV/AIDS programming for each country. (For a sample terms of reference for a national gender analysis, see annex D.)

Each donor should contribute technical expertise, funds, or other resources, depending on the donor's special strengths and on each country's context—including local gender analysis capacity and local resource constraints.

Work together and with country stakeholders to improve national approaches to gender and HIV/AIDS. Donor aid will become more effective when countries lead their national responses to gender and HIV/AIDS—and when those national responses are well coordinated. The donors should use their resources and expertise to help countries establish national gender-related objectives for the HIV/AIDS response, and to help them develop indicators for measuring performance against the gender-related objectives. (For sample gender-related indicators for program monitoring and evaluation, see annex E.) The donors also should work with countries to ensure that national policies on gender and HIV/AIDS are coherent with strategies on health, on gender, and on development.

Learn from different approaches to addressing gender inequality. All three donors have a stake

in creating and sharing knowledge about effective gender-responsive programming to make HIV/AIDS programs respond more effectively to gender issues. Therefore, the donors should jointly support new comparative and operational research and the better dissemination of existing knowledge, both about overarching approaches to gender and about specific types of interventions. New knowledge could highlight the comparative advantages and disadvantages, in particular contexts, of targeted gender-related programming and of gender mainstreaming. For specific types of interventions, since some innovative and effective programs exist today but fairly little knowledge about them is generated and shared, better knowledge dissemination is needed. Such dissemination could help with scaling up successful programs and with transferring their principles to other settings.

Responsiveness to gender inequality will be an integral part of any successful effort to make the three donors' HIV/AIDS programs more effective. As PEPFAR, the Global Fund, and the MAP feel the squeeze of the global economic crisis, they will be pressed to do more with less. One important way to increase success across donor programs will be by addressing the kinds of gender inequality that hamper efforts to prevent the spread of HIV, to treat AIDS patients, and to care for people affected by the epidemic. Responding to gender inequality is especially crucial for effective prevention, which will be key to limiting future costs.

PEPFAR, the Global Fund, and the MAP have made a clear commitment to address gender issues. By taking the steps recommended in this report they can begin to move beyond their stated commitments—that is, gender as usual—to real actions that will advance the global fight against HIV/AIDS.

Gender in development and in HIV/AIDS programming: key terms and resources

This glossary of key gender-related terms is accompanied by a list of online resources for further learning about gender and HIV/AIDS in development (box A1).

Gender. “Gender is not a synonym for sex. It refers to the widely shared expectations and norms within a society about appropriate male and female behavior, characteristics, and roles. It is a social and cultural construct that differentiates women from men and defines the ways in which women and men interact with each other” (Rao Gupta 2000).

Gender analysis. “Gender analysis refers to the attempt to understand the culture, the patterns and norms of what men and women, boys and girls do and experience in relation to the issue

being examined and addressed. Where patterns of gender difference and inequality are revealed in sex-disaggregated data, gender analysis is the process of examining why the disparities are there, whether they are a matter for concern, and how they might be addressed” (Derbyshire 2002).

Gender equality. Gender equality exists where women and men:

- Are treated equally in laws and policies.
- Can share equally in power and influence.
- Have an equal possibility to develop their full potential.

Box A1

Online resources for gender in development and in HIV/AIDS programming

These resources on gender in development, gender’s relationship to HIV/AIDS, and gender issues in HIV/AIDS programming were online at the time of writing (for website addresses, see source entries in the references at the back of the report):

Resources on gender analysis and gender-responsive programming

- From the Department for International Development, a manual for policymakers and practitioners on gender issues in development (Derbyshire 2002).
- From the Institute for Development Studies, University of Sussex, a report on developing gender-sensitive indicators (Moser 2007).
- From the World Bank, a chapter from a sourcebook on poverty reduction strategy papers (PRSPs) that looks at gender issues in PRSP processes (Bamberger and others 2002).
- From the World Health Organization, a review paper on integrating gender into HIV/AIDS programming (Rao Gupta, Whelan, and Allendorf 2003).

Resources on gender and HIV/AIDS

- From the Institute of Development Studies, an overview report (Tallis 2002) and bibliography (Bell 2002).
- From the Women and International Development Program at Michigan State University, an annotated bibliography (Eibl and Foster n.d.).

- Have equal access to services, financial resources, information, and technologies.
- Have equal opportunities, rights, and obligations in the public and private spheres—including those that are related to work and to other ways of generating income.

Gender equality does not mean that women and men are the same. Rather, it means that no one's rights, responsibilities, and opportunities depend on his or her sex. Efforts to expand gender equality in national HIV/AIDS responses should be based on a commitment to the realization of human rights, including nondiscrimination and freedom from violence.

Gender focal point. Gender focal points are key to building organizations' capacity on gender issues. However, such focal points cannot ensure that programming is gender responsive for entire organizations unless a larger effort is made to systematically integrate gender across sectors, in high-level policies, and in national- and community-level programs.

Gender mainstreaming. Gender mainstreaming is a "commitment to ensure that women's as well as men's concerns and experiences are integral to the design, implementation, monitoring and evaluation of all legislation, policies, and programs so that women and men benefit equally and inequality is not perpetuated. The ultimate goal of gender mainstreaming is to achieve gender equality" (Derbyshire 2002).

Gender norm. Gender norms are learned—and evolving—behaviors, beliefs, and attitudes that a society considers appropriate for men and for women.

Gender specialist. For this report, a gender specialist is a person who understands gender differentials related to HIV/AIDS—that is, differences in how the epidemic affects women and men, and how those differences contribute to the spread of HIV and influence people's ability to manage its consequences. A gender specialist's knowledge should include:

- An understanding of basic gender concepts.
- The ability to think analytically about gender roles and relationships in relation to HIV/AIDS and social and economic development.
- The ability to identify specific gender-related issues that can be addressed programmatically.
- How to carry out, monitor, and evaluate gender-responsive programs.

Such specialized knowledge can be gained formally in an educational setting or informally through practical experience in designing, implementing, and evaluating gender-responsive HIV/AIDS programming. This report refers to various types of gender expertise that are needed to achieve objectives at the donor, national, subnational, and community levels.

Sexuality. Sexuality, though distinct from gender, is intimately linked to it. More than sexual behavior, sexuality is multidimensional and dynamic—the social construction of a biological drive. A person's sexuality is defined by whom the person has sex with, in what ways, why, under what circumstances, and with what outcomes. It is influenced by explicit and implicit social rules that are defined by the person's gender, age, economic status, ethnicity, and other factors (Zeidenstein and Moore 1996; Dixon Mueller 1993).

Study methodology

This annex explains why Mozambique, Uganda, and Zambia were selected for the study that produced this report. It then describes how research partners in the three countries collected information by reviewing policy and program documents and interviewing officials from the three donor agencies, the three governments, and recipient and subrecipient organizations, as well as other stakeholders. Finally, the annex points to the study's limitations.

Host country selection

Mozambique, Uganda, and Zambia were selected for this report because:

- They vary in their size, their HIV prevalence, their development indicators, the stage to which the epidemic has evolved in each country, the nature and strength of the government response, and the nature and strength of donor involvement.
- Despite these differences, the common location of all three countries in sub-Saharan Africa makes it possible to compare them in enlightening ways.

To study how three major global AIDS donors respond to gender inequality in these three countries is to see how their policies are put into practice on the ground, in countries with different epidemics and different social, political, and economic contexts.

Although our sample of three countries is too small to support broader inferences, looking at the donors' practices in several countries that differ from one another in important ways can point to underlying patterns of donor behavior.

Country-level research

In-country research for this report was conducted by local partners in each country, including

Austral-COWI Consulting in Mozambique, the Makerere University School of Public Health in Uganda, and the Economics Department of the University of Zambia. Field research was coordinated by a field director based in Nairobi, Kenya, and technical support was provided by a gender expert at the International Center for Research on Women in Washington, DC. The overall effort was managed and coordinated by the HIV/AIDS Monitor team at the Center for Global Development in Washington, DC.

Data collection methods included a desk review of donor and national government documents, grey literature, and other relevant documents (such as program reports). The desk review identified key policies and noted the extent to which they discussed results of gender analysis, pointed to key gender-related issues that the report should address, and yielded evidence of how those key issues had been addressed in national-level policies. Having a clear understanding of the policy context, prior to conducting key informant interviews, was critical.

Key informant interviews were conducted with donor officials, government officials, funding recipients, and other stakeholders in each country. Key informants were selected for their specific knowledge about efforts by the donors and the countries to address gender inequality's relationship to HIV/AIDS. Specific criteria were determined by country research teams.

At least one organization was sampled at each level of analysis for each donor. No more than three organizations were sampled at each level of analysis for any donor.

Key informant interviews are numbered and classified by donor, analytical level, and interviewee position in tables B1 (Mozambique), B2 (Uganda), and B3 (Zambia).

A verbal informed consent process was used before any data were gathered. Interviewers were trained in using the data collection instruments; all had interviewing experience. Senior-level researchers interviewed senior-level staff at donor organizations, recipient organizations, and national governments. Each interview was audiorecorded with the study participant's permission. Because of time constraints during data collection, not all interview transcripts were transcribed verbatim. Tapes were retained

during analysis so that researchers could refer to the recordings, to confirm interpretations and to crosscheck data. Ethics approvals were granted by relevant local and international ethical review boards before the research was undertaken.

Semistructured interview guides were developed and adapted to country contexts for each type of key informant. Thus, for each donor, different instruments were tailored to recipient-organization key informants, subrecipient-organization key informants, and government key informants. Some context-specific organizations were selected, such as civil society groups in Mozambique, with data collection instruments being tailored to those stakeholder groups.

Data collection instruments broadly covered the four research questions. Questions

Table B1 Mozambique key informants by organization, analytical level, position, and number of interviews or focus group discussions

Donor or other organization	Analytical level	Position	Number of interviews or focus group discussions
The U.S. President's Emergency Plan for AIDS Relief (PEPFAR)	Representatives of donor organization	Management	2 interviews
	Representative of recipient organization no. 1	Management	1 interview
	Representative of recipient organization no. 2	Management	1 interview
	Representatives of recipient organization no. 3	Management	1 interview
		Technical staff	1 interview
	Representatives of subrecipient organization no. 1	Management	1 interview
		Technical staff	1 interview
	Representatives of subrecipient organization no. 2	Management	1 interview
		Technical staff	1 interview
	Representative of subrecipient organization no. 3	Management	1 interview
The Global Fund to Fight AIDS, Tuberculosis and Malaria	Representatives of donor organization	Technical staff	2 interviews
	Representatives of recipient organization	Management	1 interview
		Technical staff	2 interviews
	Representatives of subrecipient organization	Management	1 interview
		Technical staff	2 interviews
	Beneficiaries of subrecipient organization	Clients of program to prevent mother-to-child transmission	2 focus group discussions
The World Bank's Africa Multi-Country AIDS Program (the MAP)	Representatives of donor organization	Technical staff	2 interviews
	Representatives of recipient organization	Management	1 interview
		Technical staff	1 interview
	Representatives of subrecipient organization	Management	1 interview
		Technical staff	1 interview
Civil society organizations, women's associations	Representative of civil society organization no. 1	Technical staff	1 interview
	Representative of civil society organization no. 2	Management	1 interview

Source: Authors' compilation.

Table B2 Uganda key informants by organization, analytical level, position, and number of interviews or focus group discussions

Donor or government	Analytical level	Position	Number of interviews or focus group discussions
The U.S. President's Emergency Plan for AIDS Relief (PEPFAR)	Representative of PEPFAR partner organization no. 1	Management	1 interview
	Representative of PEPFAR partner organization no. 2	Technical staff	1 interview
	Representatives of recipient organization	Management	1 interview
		Technical staff	1 interview
	Representatives of subrecipient organization no. 1	Clinical staff	1interviews
		Clinical-technical staff	2 interviews
	Representatives of subrecipient organization no. 2	Management	1 interview
		Management-technical staff	2 interviews
	Representatives of subrecipient organization no. 3	Management	2 interviews
	Beneficiaries of subrecipient organization no. 1	Clients of program to prevent mother-to-child transmission	
<i>Clients of services for orphans and vulnerable children</i>			
Beneficiaries of subrecipient organization no. 2		Primary school girls and boys	
	Secondary school girls and boys		2 focus group discussions
The Global Fund to Fight AIDS, Tuberculosis and Malaria	Representative of recipient organization no. 1	Management	1 interview
	Representatives of recipient organization no. 2 ^a	Management	1 interview
		Management–education staff	1 interview
	Representatives of subrecipient organization no. 1	Management–technical staff	3 interviews
	Representatives of subrecipient organization no. 2	Management-technical staff	3 interviews
	Beneficiary of subrecipient organization no. 1	Management	1 interview
Beneficiaries of subrecipient organization no. 2	Clients of program to prevent mother-to-child transmission		2 focus group discussions
The World Bank's Africa Multi-Country AIDS Program (the MAP)	MAP	Technical staff	2 interviews
Uganda government	Uganda AIDS Commission	Management-technical staff	2 interviews
	Ministry of Gender	Technical staff	1 interview

a. This program was funded initially through the MAP, later—after the MAP closed—through the Global Fund.
Source: Authors' compilation.

qualitatively assessed processes and procedures for accessing donor funds, donor support for national policies and programs, and interactions between donors and governments (recipient organizations and subrecipient organizations) related to technical support, monitoring and evaluation, evidence-based programming and policy development, and capacity strengthening. Information was validated by triangulating the data from several key informant interviews with evidence from documents.

At the beneficiary level, to manage the sampling process, three types of programs were selected for sampling. Data were collected from program staff and from selected beneficiaries of programs that received funding support

from one of the three donors to provide services to sex workers, to pregnant women (to prevent mother-to-child transmission), or to orphans and vulnerable children. Those beneficiary groups were selected because of the significance of gender in the power relationships that informed their access and use of prevention, treatment, care, and support services. The groups were also considered fairly easy to identify for data collection, in contrast with (for example) participants in mass media communication campaigns. Researchers initially planned to sample at least one program of each type that received funding support from each of the three donors, for a total of nine programs in each study country. But that proved impossible

Table B3 Zambia key informants by organization, analytical level, position, and number of interviews or focus group discussions

Donor or government	Analytical level	Position	Number of interviews or focus group discussions
The U.S. President's Emergency Plan for AIDS Relief (PEPFAR)	Representatives of recipient organization no. 1	Management-technical staff	1 interview
	Representative of recipient organization no. 2	Management	1 interview
	Representative of subrecipient organization	Management	1 interview
	Beneficiaries of subrecipient organization	Caregivers and clients of program to prevent mother-to-child transmission	1 focus group discussion
The Global Fund to Fight AIDS, Tuberculosis and Malaria	Member of country coordinating mechanism (National AIDS Council)	Technical staff	1 interview
	Representative of recipient organization no. 1	Management	1 interview
	Representative of recipient organization no. 2	Management	1 interview
	Representative of subrecipient organization	Management staff	1 interview
	Beneficiaries of subrecipient organization	Caregivers and clients of programs for orphans and vulnerable children and to prevent mother-to-child transmission	5 interviews
The World Bank's Africa Multi-Country AIDS Program (the MAP)	Donor institution (World Bank)	Technical staff	1 interview
	Representative of recipient organization	Technical staff	1 interview
	Representative of subrecipient organization	Management	1 interview
	Representative of subrecipient organization	Project staff, including caregivers	1 focus group discussion
	District government	Technical staff	1 interview
	District government	Technical staff	1 focus group discussion
	District government	Health staff	2 interviews
	Beneficiaries of subrecipient organization	Clients of services for orphans and vulnerable children (primary school girls and boys, secondary school girls and boys)	4 interviews
	Beneficiaries of subrecipient organization	Clients of services to prevent mother-to-child transmission	5 interviews
Zambia government	Ministry of Health	Technical staff	1 interview
	National AIDS Council	Technical staff	1 interview
	Cabinet office	Technical staff	1 interview

Source: Authors' compilation.

when some programs could not be identified, or could not be reached, by researchers working to collect data in a limited time and under logistical constraints.

Program beneficiaries were recruited for interviews with the help of the subrecipient organizations carrying out the programs. Staff from those programs were not present during data collection because their presence might compromise the data. Program staff and beneficiaries were interviewed. Focus group discussions and participant observation were also used to gather data from selected program beneficiaries—sex workers, pregnant women, and orphans and vulnerable children and their caretakers. Semistructured guides were developed

for each type of program beneficiary and implementer. Data collection instruments elicited information on beneficiaries' needs, their experiences in getting services, the adequacy of the services to their needs, and benefits or problems resulting from programs participation.

To ensure accuracy, a draft of this report was reviewed by technical experts and by representatives from each of the three donor organizations studied.

Study limitations

The authors selected Mozambique, Uganda, and Zambia for this study hoping to illuminate how donor practices vary with country

contexts. Both the small size of the sample (three countries) and the purposive sampling method mean that this report's findings cannot be fully generalized to countries other than those studied. Still, some findings could reflect similar circumstances in other African countries that partly resemble a study country. The report's recommendations suggest actions that would be useful in most contexts where they have not already been taken.

Information is sometimes uneven across countries or donors. That can reflect the unavailability of data, difficulties in accessing data, or varying donor models and country contexts, which cause heterogeneity in the data. For example, the MAP ended in Uganda in 2006 and had just ended in Zambia in 2008, so some

information on its activities was difficult to locate—particularly in Uganda. And time constraints limited the ability of country research teams, based in urban centers, to gather data in areas distant from those urban centers.

This report descriptively analyzes what the three donors studied have done and are doing to address gender inequality in their HIV/AIDS programs. The aim of such a descriptive analysis is to determine whether the building blocks for a successful effort are in place. The report cannot fully evaluate donor efforts on gender and HIV/AIDS against demonstrated needs in each study country. The relationship between donor efforts and demonstrated need is important, but reliable data on that relationship are lacking.

Case studies of program implementers and beneficiaries

These brief case studies from Mozambique, Uganda, and Zambia illustrate the experiences of several implementers and beneficiaries of programs supported by the U.S. President's Emergency Plan for AIDS Relief (PEPFAR), the Global Fund to Fight AIDS, Tuberculosis and Malaria, and the World Bank's Multi-Country AIDS Program (the MAP). The programs serve sex workers, pregnant women and mothers, and orphans and vulnerable children.

PEPFAR

Program for preventing mother-to-child transmission, district healthcare facility, Uganda. A district healthcare facility in Uganda is a subrecipient of PEPFAR funding through the Elizabeth Glaser Pediatric AIDS Foundation and the Uganda Program for Human and Holistic Development. Services to prevent mother-to-child transmission are provided through the healthcare facility. Interviews were conducted with healthcare facility staff, including a nurse manager and a laboratory technician and managers, and a focus group was held with women beneficiaries of the services to prevent mother-to-child transmission.

Managers interviewed at the district healthcare facility described a positive relationship with the donor and with recipient organizations. Managers also felt that having an indirect relationship with the donor through the recipient organization—not a direct relationship—made it easier for them to manage donor resources.

Gender integration is more challenging. A district healthcare facility manager for the program reported holding frequent discussions with donors about gender issues, but noted that the donor had not issued specific guidelines or policies:

[F]or every program there are discussions that are directed to gender issues,

but for the policies we share with them, I have not seen that [gender integration guidelines or policies].

Managers of programs for preventing mother-to-child transmission commented on efforts to affect the social impact of HIV/AIDS more broadly. The managers have tried to link other, non-health-related activities to their programs for preventing mother-to-child transmission, but have not always received support from PEPFAR in doing so—even though many integrated programs are funded through PEPFAR. PEPFAR's preferred way to support programs, it seems, is to have each partner focus on interventions that are known to the partner and that the partner has experience in implementing. According to the district healthcare facility manager:

[T]his [integrated support] is an area we have been struggling with them [donors,] because when you look at our program, it's integrated. We are not looking at only HIV and AIDS. We are also looking at social effects of HIV and AIDS, so we have asked [the donor] to allow us to use this money in education and [micro-]credit. I think this is not their interest and we would like them to come and support these activities.

Clinical staff reported receiving financial and inventory assistance from the primary recipient in supporting community outreach to provide pregnant women with voluntary counseling and testing, drugs, and malaria nets. Drug kits are supplied now, and a staff member stated that the primary recipient had helped to “put us [a district health facility] to some standard.” Clinic staff members also appreciated the laboratory testing that they can now provide for their clients (CD4 and PCR testing).

Women described three benefits from the program:

- Being less susceptible to severe infections.
- Being able to return to work.
- Being able to have healthy, HIV-negative babies.

Women also mentioned many obstacles, illustrating the complexity of the challenges to their use of services for preventing mother-to-child transmission. They emphasized the lack of male support. Male partners have power in making many health decisions, including HIV testing, and their permission is critical to accessing services for preventing mother-to-child transmission. They can withhold transportation funds from wives who get such services. And they can threaten to abandon their wives.

The stigma associated with HIV/AIDS makes women reluctant to be seen entering a clinic for preventing mother-to-child transmission. Male partners’ refusal to use condoms also emerged as a major concern in group discussions. Another major challenge was the time spent in travel to the facility, with the resulting loss to the women’s incomes. Taking a day off for a clinic appointment has costs—for transport and in lost income. Food insecurity is a concern for many women, especially widows and single heads of households.

In sum, the unmet needs of clients of services to prevent mother-to-child transmission included the lack of male support, the fear of disclosure, men’s refusal to use condoms, transportation costs, and economic challenges in providing food for families and formula for babies.

Program for preventing mother-to-child transmission, community-based organization,

Zambia. A community-based support group for people living with HIV/AIDS, based in a district in Zambia, was formed in 2002 as a subproject of a tuberculosis treatment program funded by PEPFAR through the Christian Children’s Fund. In 2003 the Christian Children’s Fund mandated the community-based group to carry out a program funding antiretroviral treatment for people in households infected with HIV and affected by HIV/AIDS. About 50 families benefited from the antiretroviral program, which also enabled them to buy sewing machines and gardening materials and to get training for four caregivers.

Since that first project with the Christian Children’s Fund, the community-based support group has continued to apply for and receive funds to carry out programs addressing local women’s HIV/AIDS vulnerabilities. The group has recognized how gender-related barriers hinder women from accessing antiretroviral treatment, voluntary counseling and testing, and services to prevent mother-to-child transmission—especially when women who have tested HIV-positive cannot negotiate access to antiretroviral treatment because of gender-based violence and victimization. Reports one project coordinator for the group:

We have women reporting being abused by their husbands for being on antiretroviral treatment, and some have reported hiding antiretroviral treatment in meal bags just to protect their marriages and secure their safety and peace in their matrimonial homes. Some women stop medication altogether while others refuse to start medication. This mainly happens to women whose spouses refuse to accept their HIV status and blame it on their wives.

Furthermore, the project coordinator observes:

Men do not usually go for [voluntary counseling and testing] here; some men will wait for their wives to be pregnant, and when the women attend

[an] antenatal clinic where [voluntary counseling and testing] is one of the services, they would want to know the HIV results of their wives as an indirect test for themselves. If they come out negative then they assure themselves that they are OK; but if they come out positive, the blame entirely falls on the women for bringing the disease in the home. One strategy our project has employed, however, is couple counseling and encouraging men to come with their wives for counseling and testing as a couple. Even when enrolling pregnant women on preventing mother-to-child transmission, we encourage—especially in the health centers we operate from—for men to be part of the clinics.

Beneficiaries of the organization's programs to prevent mother-to-child transmission were greatly afraid that getting the services would prompt violent retaliation by their husbands. Disclosing their HIV-positive status was a major obstacle for the women, who, according to one beneficiary, adhered to social norms of obeying their husbands and expecting violence as a part of marriage:

Before my marriage I was counseled by elderly female relatives who emphasized that a woman should take a subordinate role within the household and should obey her husband. They even said that violence against women within the household was normal and acceptable, and a woman should remain in her marriage regardless of her husband's behavior.

Staff at a clinic for preventing mother-to-child transmission confirmed that the women's fear of violence from husbands and partners often delayed the women in getting tested, prevented them from returning for test results, and prevented them from getting treatment or delayed them in doing so.

Orphans and vulnerable children program, subrecipient organization, Uganda. One subrecipient

organization is a faith- and community-based nongovernmental organization in Uganda, established in 1987 by the Small Basic Christian Communities with the support of the Franciscan Missionary Sisters for Africa. It receives funding from many different organizations, including from PEPFAR through Catholic Relief Services. It has 90 staff members (46 female, 44 male).

Programming priorities that include gender perspectives include:

- Providing prevention and treatment services.
- Providing care for orphans and vulnerable children.
- Promoting empowerment by providing education through adult literacy programs and regular youth education curricula.
- Economic empowerment through micro-credit projects.
- Promoting the rights of women, widows, and orphaned children.

The organization carries out integrated activities that promote PEPFAR's gender strategies. For example, the community offers free health services, peer-to-peer counseling, behavior change workshops, entrepreneurship skills training, and dance and drama facilities for people in its catchment area. Sports and recreation services have been used as an entry point for interaction between the youths and the peer educators, who teach the youths about HIV/AIDS and sexually transmitted infection prevention and treatment, and who give them positive peer support. Programs for orphans and vulnerable children at the organization have provided meals, shelter, clothing, school supplies, and medical care. Boys are trained in building and carpentry to assure them a livelihood. Funds are available to guardians by application. The funds are invested in income-generating activities, to help the guardians better support children in their care.

Four focus groups were held with orphans benefiting from the organization's PEPFAR-funded programs for orphans and vulnerable children. Two of the focus groups, one for boys and one for girls, included orphans in primary school (ages 12–14). The other two, one for

boys and one for girls, included orphans in secondary school (ages 13–17).

Both younger and older children appreciated the services they were provided through the organization, though they felt that the services were no substitute for what they had had before being orphaned. The children in the focus groups mentioned specific needs: food, shelter, consistent program funding, support in dealing with stigma and discrimination. Girls were at greater risk for transactional, cross-generational sex than boys were.

The quality and continuity of counseling depend on the capacity of the staff at the organization. That capacity is very limited compared with the children’s overwhelming counseling needs. Some needs remain unmet. Boys and girls are concerned about losing their guardians and feel insecure about their future education, as one beneficiary explained:

My biggest worry is “[W]hat if the company gets off . . . gets closed?” [W]ho will take care of me?”

Girls, in particular, were concerned about the threat of unwanted pregnancy. Some girls earn money in domestic work, where older men might seduce them into relationships—a fear among girls in the group, according to one primary school girl:

One of our colleagues was duped into a relationship. She conceived and gave birth. She is now staying with the guy.

Boys feared imprisonment for illegal activities. Girls often had to stay out of school to do household chores, or could not keep up with their studies because of their responsibilities at home. Said a primary school girl in the program:

When I am at home, I am engaged in doing household work at the time when I am supposed to revise my books.

And, as a secondary school girl in the program noted, boys did not have as many household responsibilities:

When the boys reach home after school, they will tell them to go and fetch water while you, the girl, will stay home and wash plates, cook supper, and bathe the young ones. Imagine one task for the boy while the girl has many.

Children in primary school get free meals, but children in secondary school and above do not. The older children said that Uganda’s universal secondary education policy, which prohibits the payment of money to guardians for meals, harms their education because if they are not able to eat at home, they are distracted by hunger when they go to school. Said a secondary school girl beneficiary:

The [universal secondary education] program which they have put at school is not good for me, because they have refused me to get food, yet we report to school early without eating anything. . . . I can’t concentrate on my books.

Sex worker program, PEPFAR subrecipient organization, Mozambique. A PEPFAR subrecipient organization in Mozambique works with female sex workers in two programs:

- Professional occupational training to give vulnerable women (chiefly women engaged in sex work) other ways of generating income.
- Providing condoms and HIV/AIDS information (group discussions, educational films, a newsletter on sexually transmitted infection) to female sex workers and male clients.

Female sex workers are involved in the project as peer educators. Staff members stated in interviews that the program—from design to evaluation—included women from the target population. However, it was not clear exactly what constituted such inclusion.

PEPFAR does not require the organization to provide any gender-related program goals, any objectives or activities for changing social norms associated with sex work, or any gender-related indicator data. The only gender-related data requirements from PEPFAR include the number and sex of participants in program activities.

The recipient organization that subgrants funds to the organization conducted an institutional diagnosis to identify strengths and weaknesses of the institution. Also, the Academy for Educational Development has developed a capacity building plan for the organization, to be implemented over 12 months and to include programmatic assistance in gender and HIV/AIDS. The organization hopes that the plan will broadly strengthen current programs. Finally, it would also like to develop a matrix to guide its programming, with gender-related program goals, objectives, activities, and indicators.

Interviews were conducted with program staff at the organization and with five women beneficiaries of the program (students in its cookery course). Beneficiaries were first interviewed in a group. Individual interviews were then held with two women from that group.

All the beneficiaries interviewed felt that the program had greatly influenced their relationships with their clients. Some women had found alternative ways to earn income. Others were still engaged in sex work, but now felt better informed on how to protect themselves and insist on condom use. One beneficiary reported:

I used to be a sex worker. I was invited by [the program] to attend a meeting, but did not know what it entailed. Nonetheless, I decided to go. During the debates I saw the opportunity to change my lifestyle. I felt that I was not doing the right thing. It was not because of a lack of money or food. . . . I felt my girlfriends had more freedom than me, they would go out and so I also became involved. Afterwards [coming to the program], I took part in a great many other projects[;] I liked it and felt committed to changing my life.

Another beneficiary said:

I work once in a while [as a sex worker] because I have children but nobody to help me. . . . The father of the children abandoned them. I am, however,

careful and take precautions. I reject clients who refuse to wear condoms, even though I might lose money.

The program's facilitated discussions on gender and HIV/AIDS, and the social support that the program offers, have helped the beneficiaries visualize themselves with other livelihoods and ways of life. One said:

We feel that we can work and earn money just like everybody else.

Again, one beneficiary explained:

If it had not been for [the program], I do not know what I would be doing today. . . . The biggest change in my life has been with my way of thinking, to be able to think that I can move forward. I am different because today I feel like doing things which enable me to reach my goals. I have learned how to dream.

Economic need is the greatest challenge for women targeted through the organization's programs. The women interviewed felt that the organization provided training in areas that are in demand in the job market, helping them find jobs after they finish the program. Reported one woman:

This cookery course has been highly beneficial. I would not have been able to attend a course of this nature had it not been for [the program], because I do not have the means to pay for enrolment fees. And to be able to work will be a great help in my life. Thanks to the course, I will be able to get a job and be better off.

However, the program lasts only 12 months for beneficiaries, which can make it difficult for them to sustain their positive outlook and to apply the skills they have gained. According to one beneficiary:

I thoroughly enjoy the field work. The only thing is that I would like it to last

longer so that one could gain more confidence. I would like it to be a permanent activity instead of a cyclical event. As it is, one loses momentum.

The Global Fund

Program for preventing mother-to-child transmission, Global Fund subrecipient organization, Mozambique. Through the Mozambique health ministry's Global Fund round 6 proposal one organization received financial support for a project to link HIV/AIDS prevention and treatment for pregnant women, which it began implementing in 2002.

One of the project's programs provides services to prevent mother-to-child transmission in hospitals in 4 of Mozambique's 11 provinces: Maputo Province, Maputo City, Sofala, and Zambézia. The services include counseling and testing, palliative care and antiretroviral treatment, treatment of opportunistic infections, mother-to-child prevention, nutrition support, and home-based care. The treatment targets pregnant women.

Researchers collected data at one site in Maputo, a referral unit for the project's services for preventing mother-to-child transmission. The services are offered there as part of a larger set of maternal and child health services, greatly facilitating access to pregnant women. Researchers interviewed staff members to discover their perspective on the program and the services. Data on beneficiaries were collected in two stages: first, a focus group comprised of women beneficiaries of the program to prevent mother-to-child transmission, and second, individual interviews with two women. We sought to relate information about the interviewees' current needs, about barriers they had encountered in trying to access services, and about their use of services for preventing mother-to-child transmission to other information about their lives.

Staff interviewees clearly see two benefits from locating the program to prevent mother-to-child transmission within hospital maternity wards. First, the location makes it easy for

women in antenatal care to get the services for preventing mother-to-child transmission. Second, it helps health staff to monitor women in antenatal care who may stop their HIV/AIDS treatment, providing an opportunity to reengage such women each time they return for antenatal care. According to a project staff member:

It is more practical to have a preventing mother-to-child transmission center within a maternity ward. It allows for a connection between the antenatal consultation and the program. This connection facilitates the monitoring of women who refuse to follow treatment, but who eventually return to the next antenatal consultation.

Clinic and program staff described gender inequality's enormous ability to hinder women from accessing services for preventing mother-to-child transmission:

Women do a thousand tests and they can undergo treatment over a long period of time, say two years. But they are unable to convince their partners to be tested. When women manage to convince their partners, they then repeat the tests as if it was the first time they were taking the test because they have not previously disclosed their status to their partners.

Again, one staff member stated:

They [gender issues] are so present that it cannot be ignored, though we don't have a designed strategy to address the gender issues.

Although project staff face gender issues daily, the project has no mechanism to integrate gender into the activities of the program to prevent mother-to-child transmission. The Global Fund does not require that such programming include any strategies to address gender inequality.

Health centers and hospitals refer HIV-positive women to the project, which provides them with pre- and post-test counseling. The women are counseled on preventing mother-to-child transmission and asked whether they want to get such services. Nursing staff at the project noted that although most women agree to get the services, not all will follow their treatment regimen—a combination of three drugs that must be taken with food. To support the women in staying on the regimen, the program gives monthly baskets of food supplies to them and their families.

Clinic staff noted that women patients were often hindered from disclosing their HIV status, and from getting the services for preventing mother-to-child transmission, by concerns about how the women's male partners and families might react if the women's HIV status was disclosed:

Today I attended a woman who has been undergoing treatment since 2006. I tried to find out what prompted her to have another child, considering that she had two already. She said her husband did not know that she had been having therapy since 2006.

According to the clinic staff, women who had not disclosed their HIV status were less inclined to stay on treatment after giving birth than women who had disclosed their HIV status:

They [HIV-positive women who have not disclosed their status] cannot go out before the baby is 40 days old. They should attend a ceremony to be able to take the baby out. The mother in law accompanies their daughters in law wherever they go. In situations of this nature women do not know how to react.

Understanding these cultural dynamics and the challenges to service provision that arise from difficulties with disclosure, the project carries out activities to involve male partners in the program to prevent mother-to-child

transmission. The activities were based partly on suggestions from women program participants. The male partners of HIV-positive women who had been afraid to disclose their status to their partners received invitations to a meeting. The meeting was facilitated by HIV-positive men, who told the invitees that the invitees' female partners had tested positive for HIV and urged the invitees to seek testing.

The meetings for male partners were suspended when the project had to stop purchasing additional antiretroviral drugs. Fearing that it would become unable to keep up with demand for the drugs—and not wanting to become responsible for endangering lives by putting patients on treatment that the patients might have to stop at some point—the project decided not to extend treatment coverage.

Women and their male partners continue to be tested as part of the program to prevent mother-to-child transmission. None of project's efforts to involve male partners of its women clients were well monitored or reported to the Global Fund.

Interviews with women participants in the organization's program to prevent mother-to-child transmission revealed both benefits from the program's services and concerns about the services. The women interviewed had the impression that the program was for women only. They described it as an opportunity to learn about their health status. They described the social and cultural limits on their power to make decisions related to their pregnancy and child care. They said that their family members—in particular their mothers-in-law—had great influence in such decisions. Mothers-in-law pressed the women to adhere to cultural norms that required breastfeeding. Participants feared that if they did not breastfeed they would be stigmatized as bad mothers. One program beneficiary reported:

At the time they told me that I could not breastfeed my baby. I was supposed to give formula to the child as of the sixth month. My mother cried. She said to my husband: "Please, let the baby be breastfed, because you are not

white.” My husband told her that the baby could only be fed with formula. My mother said the child would not survive.

Disclosing HIV-positive status was also a major source of concern for participants. Said one:

When I told my mother that I was HIV-positive she asked me whether I would tell my husband. She said I shouldn’t tell him, otherwise he would leave me. I told my mother that it was either my husband or my health. In this instance, my health comes first. My mother told me not to disclose my status.

Decisions to be tested for HIV typically required a husband’s permission. Women feared that their male partners would harm them violently or abandon them if the women disclosed their HIV-positive status. Women also faced the problem of male partners refusing to be tested. One woman beneficiary explained:

My husband refuses to be tested. I have asked him, but he refuses. He has fallen ill and I don’t know what to do now. I have asked the activists to come to my house to help me so that he could do the test. I counseled him over a long period. He refuses. I am not sure whether he is shy to do the test. I take the medication.

Another woman beneficiary said:

There are husbands who reject the test results. My husband refuses to be tested, regardless of how many times I ask him to do so. Since he is still very fat, he does not care. Even when he sees me taking medication he asks what am I doing. I only stare at him.

Program beneficiaries also feared being stigmatized as promiscuous or being blamed by their partners as a source of HIV infection.

Program to prevent mother-to-child transmission, district health clinics, Uganda. In Uganda, beneficiaries of two clinics’ services for preventing mother-to-child transmission were interviewed, as were program coordinators and staff members. A total of eight focus groups were held with beneficiaries of the services. Two key informant interviews were held with coordinators of the programs to prevent mother-to-child transmission, and two interviews were held with clinic staff at two health centers receiving funding for the programs through the Global Fund.

Services for preventing mother-to-child transmission in these two sites include counseling and testing, mother-to child prevention, family planning services, postnatal care, immunizations, outreach and follow-up care, antiretroviral treatment, and social support services. Transportation funds are provided to participants living far from the clinic sites. Outreach services are provided to women who cannot attend the clinic regularly, to help them continue with treatment. Clinic infrastructure has been extended to provide more privacy for counseling services. The clinics also provide women with condoms.

Benefits mentioned by program participants included:

- Access to antiretrovirals, which restored the women’s health and allowed them to return to normal activities, including work.
- The opportunity to have HIV-negative babies.

Access to treatment, and the dynamic shift in overall health, gave women a sense of hope and a renewed focus on planning for the future. According to women beneficiaries of the program:

When they gave us medicine we become strong and started working again, we got hope that we would be better again.

When I got medicine, I became better, I realized if I joined the program I would be able to plan for the future of my children.

When I came here, I was looking terrible[,] had lost a lot of weight[,] and

everybody outside there was looking at me[,] so I decided to join the program in hope of looking better and keeping the respect of my family.

The fear of positive HIV status disclosure caused great concern for the women interviewed in Uganda. Fear of disclosure often delayed testing and discouraged women from accessing treatment services and services to prevent mother-to-child transmission. Male partners often refused to be tested, or were tested secretly without disclosing their HIV-positive status to their wives. In the words of women program beneficiaries:

It is still a problem disclosing to a man[,] because sometimes others throw away tablets because they fear to be seen by their husbands, but if the men would know first and tell the wives it would be fine, because even if a woman quarrels after knowing she would eventually go and test.

Other women, once they disclose to their husbands, they are beaten and chased away from home; always the men claim that the women are the cause of the problem.

When I first came here for antenatal, I suspected I might be having AIDS; when I went back home I told my husband that the nurse wanted to treat both of us, and that if we don't go together they [the nurse] will not check me and they will not give me a letter to produce in the hospital [at the time of delivery]. He told me, if I have brought AIDS I should go for treatment alone and leave him out of it. But me I felt happy even if I was found sick because I knew I would save my baby.

Disclosing HIV-positive status to family and friends limits the support that women get for attending clinic visits to prevent mother-to-child transmission and in adhering to

treatment schedules. Women described fear of HIV-related stigma in the community, saying that they did not want to be seen going to the clinics.

Women complained about the lack of support from their husbands. The limited extent to which efforts were made to involve men in the services to prevent mother-to-child transmission made it more difficult for women to negotiate the use of condoms or other family planning methods after giving birth. Women said their husbands and partners lack information on family planning and safer sex. Focusing sex education and family planning counseling only on women was viewed as ineffective by one beneficiary, who said that men refuse to have sex with a condom and women become pregnant even while on antiretroviral treatment:

We are also taught about family planning[,] especially the use of condoms, injections[,] but our husband don't like condoms[,] but we are taught not to have unprotected sex because we risk increasing our viral load.

Economic strain meant that women could not buy cow's milk for their babies. Women also mentioned the shortages at the clinic, which required them to buy supplies for testing and other clinical care services. Women caring for orphaned children did not receive government support and were not financially equipped to care for their newborns and extended family members. Women suggested that more services be provided after delivery to support women facing these formidable economic constraints.

Clinic staff noted that some adjustments were made to serve clients better, particularly in following up women on treatment. Said one nursing officer in charge of the program:

What the unit did is . . . to get the details about the places where these people are staying. So in case someone fails to pick a certain drug[,] we have a group of health workers who go to the community with the diagnosis and look for those people. They move with the drugs;

if they find these people they give them the drugs.

Strategies that were used to encourage male involvement included inviting husbands and partners to informational seminars and offering free services to men who attended the clinic with their wives. Some interventions had potentially harmful effects: for example, denying services to pregnant women who were not accompanied to the clinic by their husbands or partners. Explained the nursing officer:

. . . we advised some of the men that if they are willing to come with their women[,] if the women are to be HIV positive, we assist those men too, by getting other samples, and they are tested free of charge through [Catholic Relief Services]. That was a specific service for men who were willing to come with their women. We also tell them that if you are positive and your wife is also positive, still the antiretroviral drugs are there free of charge.

The Global Fund does not require that program implementers integrate activities promoting male involvement into programs to prevent mother-to-child transmission. The steps taken by these district-level clinics were motivated by the knowledge that their programs would fail if they did not address some of the underlying gender-related barriers to women's access and use of services for preventing mother-to-child transmission.

Orphans and vulnerable children program, Global Fund subrecipient organization, Mozambique. The same project, described above, that provides prevention of mother-to-child transmission services also provides antiretroviral treatment to HIV-positive children and implements a nutrition support program for children in vulnerable situations, including orphans ages 2–15. This study's assessment included only the nutrition support program, which was initiated in 2005 and now provides services for 1,000 children (of whom 700 on average participate

regularly). Children are given one balanced meal each day. In addition to nutrition support, the program provides preschool for children ages 3–5; medical care and monitoring, including measuring and weighing children every six months; assistance with enrollment fees and birth registration; and basic health and hygiene education, along with fun outings.

Data collection at the beneficiary level included interviews with caretakers of orphans and vulnerable children who are beneficiaries of the program, interviews with project staff, and participant observation at project sites.

Interviews with the center director revealed the impact of the nutrition support. Beneficiaries come from poor households, with income unstable and below poverty levels. Meals received through the project are often the only meals children will eat in a given day. Children exhibit symptoms of nutrition deficiencies, such as stunted growth and malnutrition. They may begin the program in very poor health—but nutrition support causes rapid, dramatic improvement in a few weeks. Staff investigate cases in which improvement does not occur, inquiring with a child's caretakers to find out why.

The preschool education program was initiated in 2008 in response to injuries, and other dangers, that arose for families when adult household members had to leave small children at home alone while the adults were at work. The preschool program is now hoping to expand in 2009 to include more children.

The center has been successful in some cases, but not all, in persuading families to shelter and care for the children. Because the lack of professional training is a problem for adolescents, the center invites adolescents to volunteer with the project. That is only a stopgap solution; the center recognizes a need to train youth and young adults professionally to give them a livelihood.

Project staff emphasized shelter as one of the greatest needs for the children, especially for the orphans. That need is compounded for children living with HIV—particularly those who are symptomatic. At present the project does not shelter program participants.

Project staff noted that preschool-age children needed constant monitoring at home during the intervention, since many were left at home unattended.

Project staff key informants said in interviews that the needs of boys and of girls did not differ in degree but that gender roles affected their vulnerability to HIV in different ways. The informants discussed specific HIV risks including girls' use of transactional sex to access resources and boys' taking sexual risks to "prove their masculinity." The program does not implement any specific strategies to address gender-related risk factors for HIV. Project interventions assume the same needs for boys and girls, despite the staff members' clear understanding that HIV risks differ for boys and for girls.

Orphans and vulnerable children program, church-based community organization, Zambia. In Zambia a Global Fund primary recipient provides support to a church-based community organization project. Formed in 1999 as a music band in the Kafue District of Lusaka Province, the community organization project raises funds through performances and has also received funding through the Global Fund, the World Bank, and Community Response to HIV/AIDS (CRAIDS).

Kafue is plagued by economic distress and unemployment because of poor performance by the area's major employer, Nitrogen Chemicals of Zambia. The community has high HIV prevalence and a large population of orphans and vulnerable children. Pregnancy among teenage girls is a major concern in Kafue, creating HIV risk and increasing the burden on households that are already financially strained.

The community organization's primary activities are providing educational support—information on HIV/AIDS and "life lessons"—and paying school fees for some, but not all, children in each eligible household. Girls who leave secondary school are no longer eligible for program services. The project does not integrate gender-focused activities into its programming for orphans and vulnerable children.

For this study, five households that benefited from the project were visited: five headed

by children, one by a widow. Only one of the child-headed homes was headed by a boy. Each of the five households had one or more children who had benefited from the project's education program. Home visits and interviews with program staff revealed that the problem of orphans and vulnerable children was enormous in Kafue, and that the project was just one of several projects active in this programming area. (Kafue is near the capital of Lusaka, where many projects supporting orphans and vulnerable children are located).

All the households visited were financially distressed. All the household heads interviewed told how the project had helped them meet the children's education needs. Yet all noted that, although the project was helping, it did not have enough funding to support all the orphans and vulnerable children in Kafue.

All the household heads emphasized the problem of disciplining the children in their care. One guardian complained that the boys in her care were abusing alcohol and the girls had become pregnant. Several of the girls who headed households had their own children. Teen pregnancy seemed to be a central problem. Another interviewee complained that peer pressure harmed the children and that girls would easily enter sexual relationships, making them more vulnerable than boys to HIV/AIDS.

The MAP

Orphans and vulnerable children program, MAP subrecipient organization, Mozambique. An organization in Mozambique was requested by O Conselho Nacional de Combate Ao HIV/SIDA, the country's national AIDS council, to submit a proposal for providing services to orphans and vulnerable children. For the project's first year no gender-related goals, objectives, or indicators were included in the proposal, nor were they required by the national AIDS council or the World Bank. The only review recommendations that the organization received concerned the budget. For the project's second phase the MAP required community consultations—to identify needs, and to develop activities that would address those

needs. Yet no orphans and vulnerable children were consulted as part of the community consultations. No gender analysis was conducted, nor were there any donor mechanisms to ensure that one was conducted. Activities in the second phase have included giving nutrition supplements to people with HIV/AIDS, training community activists, mobilizing community leaders in the HIV/AIDS response, providing mobile services for people with HIV/AIDS, and furnishing the shelter for orphans and vulnerable children. Women are included in decisionmaking, not necessarily because of donor requirements, but because of the organization's principles.

The organization runs two day-and-evening centers for selected orphans and vulnerable children. They are not overnight shelters. During the days and evenings they provide the children with regular meals and activities. There are no programs on HIV/AIDS or sex education and no other educational activities. Each center has at least one live-in caretaker and two or three others who come during the days. The orphans and vulnerable children have needs related to the age and poor education of those who care for them at home. And the home responsibilities of girls—the demand that they spend more time than boys at home doing household chores—often delayed them or keeps them entirely away from center activities.

Orphans and vulnerable children in the program lack resources to procure food and clothing. Some also lack emotional support, having been rejected by their parents or other relatives. The girls' poverty makes them vulnerable to transactional sex. The children's greatest need is for secure, consistent funds to supply food and shelter, to keep them in school, and to enable them to earn income. Project staff members noted long delays in the arrival of funds from the World Bank, delays that hinder them from providing the services consistently.

Orphans and vulnerable children program, community-based program, Zambia. In Mumbwa district, Zambia, a community-based initiative established in 2004 provides education

materials and nutrition support to 106 orphans and vulnerable children. Eligibility depends on a child's vulnerability and on whether he or she is of school age.

Many children in the area are orphaned by their parents' AIDS-related deaths. Grandparents and other extended family members typically assume the burden of care for the children. High poverty in the community adds to the strain on such households, and a program staff member reported that the program was meeting a major need:

This community has so much poverty, but our children—especially the orphans, at least—stay in school because of this project; they provide our children with all the necessary materials needed in schools.

The organization does not carry out gender-related programming, but provides sex education through talks, home-based care groups, and sessions that include voluntary counseling and testing. The group emphasizes safe sex, antiretroviral treatment, and the need for girls to stay in school.

High teen pregnancy rates cause concern in program staff and in the community. Although the group recognizes differences between boys' and girls' needs, its focus in sex education is on the girls. Explains one caregiver:

Yes, problems experienced between boys and girls differ. Girl children are easily distracted, especially after puberty; hence they need extra care, and counsel, for them to remain focused on school. I have counseled children under my care to remain focused on school.

Program implementers recognized the need for reproductive health education for boys as well, because boys must "grow to be responsible men in society." The organization has no staff members with gender expertise. The program does not support girls who drop out of school because of pregnancy.

D Sample terms of reference for a national gender analysis

This annex presents a modified version of the terms of reference document for a national gender assessment commissioned by the International Center for Research on Women to analyze the gender responsiveness of national HIV/AIDS policies and programs.⁵⁸

Background

The International Center for Research on Women will provide technical and organizational support to make national HIV/AIDS policies and programs more responsive to gender issues. The center is currently looking for an implementing partner to do a national-level assessment of the gender responsiveness of national HIV/AIDS policies and programs.

Project objectives

There are four project objectives:

1. Assess strengths and gaps in national HIV/AIDS responses for addressing gender-based barriers and inequalities that undermine prevention, treatment, care, and support efforts.
2. Help create a local advisory group—to participate in planning the assessment, to review assessment findings, to make practical recommendations, and to design a strategic roadmap for putting the recommendations into practice.
3. Give technical and organizational support to advisory group members and other key stakeholders.
4. Develop, refine, and disseminate a universal set of tools with guidance on how to conduct a gender and HIV/AIDS assessment, how to constitute and nurture an advisory

group, and how to help with implementing a strategic roadmap.

The gender assessment will be conducted by a gender assessment team. The assessment will focus on six areas considered critical to developing gender-responsive policies and programs:

- Policies, laws, and enforcement mechanisms.
- Programs (for example: treatment, care, preventing mother-to-child transmission).
- Resources (for example: human, technical, financial).
- Data (for example: surveillance, monitoring and evaluation, sociobehavioral).
- Systems (for example: accountability, institutional coordination).
- Leadership.

Roles of the gender assessment team, project secretariat, and local advisory group

The gender assessment team will do a rigorous, rapid assessment of the gender responsiveness of national-level HIV/AIDS policies and programs. The team will receive organizational support from a project secretariat appointed by the International Center for Research on Women. The team also will receive close guidance from the local advisory group (see project objective 2, above). The advisory group will periodically review data from the assessment to ensure quality and coverage of the data addressing key questions in each of the six assessment focus areas.

58. ICROW 2009b.

Key functions of the gender assessment team

The gender assessment team will be responsible for 21 key functions in four categories: planning the gender assessment, conducting the assessment, developing recommendations and a strategic roadmap, and communicating and collaborating with the International Center for Research on Women.

Planning the gender assessment

1. Work with the International Center for Research on Women to finalize a plan for the gender assessment, including methods, sampling of key stakeholders and key informants, quality control and analysis, and a detailed budget.
2. Attend an assessment workshop with the International Center for Research on Women to develop a research plan, framework, sampling design, and tools.

Conducting the gender assessment

1. Provide a description of the HIV/AIDS epidemic with an analysis by sex and age.
2. Identify gender-related determinants of risk and vulnerability, including behavioral, socioeconomic, and cultural factors (for example: the differences between men and women in exerting autonomous control over one's body, the different risks of poverty for men and women, the division of labor between men and women, and the differences in household and community roles and responsibilities that affect men's and women's access to and use of HIV prevention, treatment, care, and support services).
3. Assess the governmental response to HIV/AIDS epidemic, including the government entities that are key to HIV/AIDS policy development and program planning and the mechanisms that promote participation in the national response by women and by people living with HIV and AIDS.
4. Identify current HIV/AIDS policies and describe any gender analysis that they mention.
5. Provide a descriptive and analytical review of the extent to which the current HIV/AIDS policies address specific gender-related issues—both those identified by the gender analysis in the policy documents and those identified by the gender analysis in the present assessment. Describe strengths and gaps in the current policies.
6. Describe programmatic goals and objectives outlined in current HIV/AIDS policies to address gender-related issues.
7. Identify achievements in addressing gender-related programmatic and policy concerns.
8. As much as possible, reflect on how gender is defined or considered by key stakeholders at national and subnational government levels, within civil society organizations, and among donors; on attitudes toward gender; and on the degree to which gender integration or gender mainstreaming is a priority at the national and subnational levels.
9. Identify any resource constraints—human, financial, or technical—in providing support for gender-responsive policy and program development and implementation in national and subnational government entities, in civil society entities, and in donor organizations.
10. Describe the collection and reporting of data and the dissemination of epidemiological, behavioral, and monitoring and evaluation data that are used to inform HIV/AIDS policy and program development. Identify strengths and gaps in data collection.
11. Identify strengths and gaps in institutional coordination and financial accountability (for example, in the tracking of investments in gender-related programming).
12. Identify strengths and gaps in stakeholder leadership for supporting gender-responsive policies and programs.
13. Prepare a descriptive and analytical assessment report draft and submit the draft to the International Center for Research on Women for review.
14. Revise the assessment report draft in response to review comments from the International Center for Research on Women.

15. Submit the final assessment report to the International Center for Research on Women.

Developing recommendations and a strategic roadmap

1. Present the results of the gender assessment to the local advisory group.
2. Work with the local advisory group in developing a strategic plan for addressing—as appropriate—the results of the gender assessment.

Communicating and collaborating

1. Communicate regularly with the International Center for Research on Women, to report on assessment activities and to troubleshoot methodological and implementation issues.
2. Collaborate with consultants from the International Center for Research on Women, including the project secretariat and policy consultants.

Recommended methods

To assess strengths and gaps in each country's current national HIV/AIDS policies and programming, the gender assessment team should use six methods:

- A review of existing serosurveillance, behavioral surveillance, epidemiological, and social science data—to explore the specific ways in which gender inequality drives the HIV epidemic in each country.
- A review of policy documents—to explore whether and how national HIV/AIDS policies address gender inequality as a driver of the epidemic.

- A review of HIV prevention, treatment, care, and support programming available nationally—to identify programs that do and do not address gender inequalities; to document their strategies for doing so; and to document what indicators the programs use to measure achievements toward gender-responsive program objectives.
- Semistructured in-depth interviews with key informants on policy formation, program design and implementation, and donor funding—to explore the interviewees' perceptions of gender responsiveness in current HIV/AIDS policy, programming, and funding.
- Participation with selected program implementing organizations.
- Direct observation—where possible—of existing HIV prevention, treatment, care, and support programs.

Deliverables

1. A research plan and timeline for gender assessment activities.
2. A local institutional review board application submitted for review and approval.
3. A final framework, with a sampling design and data collection tools.
4. A summary of how gender issues are integrated into selected current policies.
5. A summary of the present gender dimensions of the HIV/AIDS epidemic in Uganda, including a review of epidemiological, behavioral, and sociological data.
6. An assessment report draft.
7. The final assessment report.

E Sample gender-related indicators for program monitoring and evaluation

Integrating gender into HIV and AIDS programs requires using gender-related indicators—quantitative or qualitative indicators that measure changes in the relations between men and women over time—at various levels of program monitoring and evaluation. Such indicators help close the feedback loop from gender analysis to identifying specific gender issues that must be addressed, to strategic planning, to developing programmatic goals, objectives, and activities, back to gender analysis. Without data on indicators it is impossible to measure progress toward programmatic goals, to assess the effectiveness of interventions, or to learn how interventions can be improved.

Some indicators related to gender equality measure change at the population level. An example is the indicators that have been proposed for measuring achievement toward the third of the United Nations' eight millennium development goals for 2015 (promote gender equality and empower women).

International indices also measure gender equality. Examples include the Gender-related Development Index and the Gender Empowerment Measure.⁵⁹

A fairly extensive literature discusses how to measure women's empowerment at aggregate and household levels.⁶⁰ Indicators noted in the literature have been used to measure women's empowerment as an outcome (for example, women's education as a mechanism for empowering women) and as it is associated with other outcomes (for example, women's empowerment as it is associated with using modern contraceptives). The national demographic and health surveys and behavioral surveillance surveys include some measures related to gender and HIV/AIDS,

in areas such as the experience of violence and sexual behavior, attitudes, and beliefs.

Generally, however, few standardized indicators exist for measuring gender-related change at either the aggregate or household levels. To select indicators for a given intervention or vision of change, one must carefully review research to identify the most useful indicators and measures.

The crucial part of selecting gender-sensitive indicators is ensuring that they correspond to program goals, objectives, and activities that are specific and agreed to. An organization must decide clearly what change it envisions before it can select indicators to measure progress toward that change.

For cross-comparison and greater understanding of data, it is recommended that quantitative and qualitative gender-related indicators be used together. Also, participatory approaches—in which data are collected from program beneficiaries—provide rich information about the programs and services being designed, implemented, and evaluated.

Below are two sample sets of gender-related indicators that organizations might use to measure gender-related change in beneficiaries of interventions. Designed for a research project,

59. For an overview of these indicators and indices see Moser 2007.

60. Comprehensively reviewed in Malhotra, Schüler, and Boender 2002.

the indicators are based on a real combination intervention—using microfinance and HIV/AIDS education to reduce the spread of HIV—that has been scaled up to reach more than 100 villages. Accordingly, the sample women’s empowerment indicators are tailored to that intervention. Yet such empowerment measures can be adapted to HIV prevention, treatment, care, and support programs and can be used in monitoring or in evaluation.

First example: program promoting men’s support for female partners in getting services to prevent mother-to-child transmission (qualitative and quantitative process, outcome, and impact indicators). The following gender-related indicators (table E1) could measure progress toward the programmatic goal of increasing men’s support for their female partners in getting services to prevent mother-to-child transmission. These indicators illustrate just one way of mixing quantitative and qualitative measures at several levels of evaluation.

Second example: measuring economic empowerment for women (intervention-level gender-sensitive indicators). Gender-related indicators also could be used to evaluate a community-based trial of a structural intervention to decrease gender-based violence against women and increase women’s economic empowerment. (A sample survey measuring outcomes and impacts is in table E2.) Structural interventions are the interventions that can make lasting changes in gender inequality; quantitative indicators can be designed to evaluate them by measuring longer-term changes in outcomes and impact. The following example shows how such outcome and impact indicators create measures to ensure that projects are achieving long-term goals—not just short-term targets that are immediately achievable through service delivery.

A recent study was designed on the theory that improving women’s economic status in areas of high HIV prevalence and high poverty will reduce HIV/AIDS vulnerability and, over

Table E1 Sample gender-related indicators for measuring progress toward programmatic goals, by indicator type and level

Indicator type	Indicator level		
	Process	Outcome	Impact
Quantitative	<ul style="list-style-type: none"> The number of men participating in programs promoting men’s support of their wives and partners in accessing services to prevent mother-to-child transmission. 	<ul style="list-style-type: none"> The number of women reporting support from their partner in accessing services to prevent mother-to-child transmission. The number of women reporting having disclosed their HIV status to their partners. Among women who have disclosed their status, the number of women reporting negative reactions from their partners (violence, dispossession of property, loss of relationship) on disclosing their status. The number of mothers and fathers receiving antiretroviral treatment or other services (nutrition, referrals for health services) through this program. The number of women receiving treatment to prevent mother-to-child transmission. Increased consistent condom use among couples who want to avoid pregnancy. Increased use of family planning methods among couples who want to avoid pregnancy. 	<ul style="list-style-type: none"> HIV prevalence rate in newborns. Prevalence of violence among pregnant women accessing services to prevent mother-to-child transmission.
Qualitative	<ul style="list-style-type: none"> Acceptability of the program as a source of useful information and a service that helps one meet personal goals and needs. Changes in relationship with one’s partner. Changes in communication with one’s partner about preventing mother-to-child transmission, HIV prevention and treatment, or other sensitive topics. 	<ul style="list-style-type: none"> Attitudes about the acceptability of men in clinics providing services to prevent mother-to-child transmission. Attitudes about the woman’s role in making healthcare decisions. Attitudes about HIV and violence against women. Attitudes about disclosing one’s HIV-positive status. 	

Source: Kim and others 2007.

Table E2

Sample gender-related quantitative outcome and impact indicators and survey questions for measuring progress toward longer-term programmatic goals, by indicator

Indicator	Survey questions used to collect data on indicator
<i>Outcomes (primary and secondary)</i>	
Economic well-being	<ul style="list-style-type: none"> • Is your estimated household asset value greater than 2000 rand? • Are your expenditures on shoes and clothes greater than 200 rand per year?^a • Do you have a savings group membership?
<i>Women's empowerment^b</i>	
<i>Power within</i>	
Self-confidence	<ul style="list-style-type: none"> • If you were in a community meeting, how confident are you that you could raise your opinion in public?^a • Neighbors often share similar problems—how confident do you feel about offering advice to your neighbor?^a
Financial confidence	<ul style="list-style-type: none"> • In the event of a crisis, such as a house fire, how confident are you that you alone could raise enough money to feed your family for four weeks? • Is your ability to survive this kind of crisis better, the same, or worse than it was two years ago?
Challenges gender norms	[Series of six statements: for example, "A woman should do most of the household chores."]
<i>Power to</i>	
Decision-making	[Series of 10 questions about whether the partner's permission is or is not needed for making household decisions—small, medium, and large purchases; taking children to the clinic; visiting family or friends.]
Perceived contribution to household	Does your partner view the money that you bring into the household as the most important?
Communication	In the past year, have you communicated with anyone about sex or sexuality? ^a <ul style="list-style-type: none"> • Your partner?^a • Your children?^a • Any other household member?^a
Partner relationship (two questions asked about partner relationship over the past year)	<ul style="list-style-type: none"> • Has your partner encouraged you to participate in something outside the home that was only for your benefit? • Has your partner asked your advice about a difficult issue or decision?
<i>Power with</i>	
Social group participation	[Series of 18 questions about participation in a range of formal and informal social groups, such as a burial society and a village health committee.]
Collective action	In the past two years have you participated in a meeting, march, or rally on HIV/AIDS awareness? ^a
Experience of intimate partner violence—both physical (two questions) and sexual (two questions)	In the past 12 months has your partner ever: <ul style="list-style-type: none"> • Pushed you or shoved you? • Hit you with his fist or something else that could hurt you? • Physically forced you to have sex when you did not want to? • Have you had sex when you did not want to because you were afraid of what your partner might do if you refused?
Experience of controlling behavior during the past year	In the past 12 months has your partner ever: <ul style="list-style-type: none"> • Kept you from seeing your friends? • Insisted on knowing where you are at all times? • Wanted you to ask permission before seeking healthcare for yourself? • Insulted or humiliated you in front of other people?
Progressive attitudes about intimate partner violence	[Series of eight statements condoning intimate partner violence.] ^a
<i>Impact</i>	
HIV incidence in study communities	n.a.

n.a. is not applicable.

a. Data collected at followup only.

b. Women's empowerment is conceptualized here as comprising three types of power: "power within" (internalized qualities, such as confidence and critical thinking, that increase individual agency), "power to" (creating new opportunities without domination, for example, through independent decisionmaking), and "power with" (action with a communal dimension; group or collective action).

Source: Kim and others 2007.

time, will reduce HIV incidence in the population.⁶¹ The study combined the provision of microcredit—a poverty reduction strategy—with HIV/AIDS education for the poorest women in communities selected. First, a micro-

finance institution provided microcredit to the poorest women in each community. Loan centers were formed with borrower groups of up to eight women that received loans over 10–20 week cycles. The loan center met with each borrower group every two weeks and conducted ongoing business assessments. Second, the

61. Kim and others 2007.

study used the “Sisters for Life” curriculum to provide participatory gender and HIV/AIDS education. The study comprised two phases, I (trial) and II (scaling up). Phase I included structured training, with 10 sessions over 6 months. Phase II included community mobilization over 6–9 months.

A rigorous evaluation showed two results:

- Over a two-year period, levels of intimate partner violence decreased by 55% in women in the intervention group compared with women in a control group.
- Other intervention effects were seen, such as improved household economic well-being, increased social capital, and higher empowerment.

References

- Aidspan. 2008a. *Do Global Fund grants work for women?: an assessment of the gender responsiveness of Global Fund-financed programmes in sub-Saharan Africa*. Nairobi, Kenya: Aidspan.
- . 2008b. “Global Fund adopts new gender equality strategy.” *Global Fund Observer* 100. [<http://www.aidspan.org/index.php?issue=100&article=4>].
- Bamberger, M., M. Blackden, L. Fort, and V. Manoukian. 2002. “Gender.” In *A sourcebook for poverty reduction strategies*, ed. J. Klugman, 333–74. Washington, DC: World Bank. [<http://go.worldbank.org/J7LMR2D1V0>]
- Barker, G. 2005. *Dying to be men: youth, masculinity and social exclusion*. New York: Routledge.
- Bell, Emma. 2002. *Gender and HIV/AIDS: supporting resources collection*. Brighton, U.K.: Institute of Development Studies. [<http://www.bridge.ids.ac.uk/reports/CEP-HIV-SR.pdf>]
- CHAZ (Churches Health Association of Zambia). 2006. *Review report for CHAZ Work Plan 2006*. Lusaka, Zambia: Churches Health Association of Zambia.
- CNCS (Conselho Nacional de Combate Ao HIV/SIDA). 2004. *The National Strategic Plan for the Combat of HIV/AIDS 2004–2009*. Maputo, Mozambique: CNCS.
- Costa, D., M. Tuominen, and E. Antunes. 2009. *HIV/AIDS donor approaches to gender in Mozambique*. Maputo, Mozambique: Austral-COWI.
- CRAIDS (Zambia Community Response to HIV/AIDS). 2007. *Field and technical appraisal form*. Lusaka, Zambia: CRAIDS.
- Derbyshire, Helen. 2002. *Gender manual: a practical guide for development policy makers and practitioners*. London: Department for International Development (DFID), Social Development Division. [<http://www.dfid.gov.uk/Documents/publications/gendermanual.pdf>]
- Dixon Mueller, R. 1993. “The sexuality connection in reproductive health.” *Studies in Family Planning* 24 (5): 269–282.
- Dunkle, K. L., R. K. Jewkes, H. C. Brown, G. Gray, J. McIntyre, and S. Harlow. 2004. “Gender-based violence, relationship power, and risk of HIV infection in women attending antenatal clinics in South Africa.” *Lancet* 363 (9419): 1415–1421.
- Eibl, M., and V. Foster. N.d. *Annotated bibliography on gender and HIV/AIDS*. East Lansing, Michigan: Michigan State University Women and International Development Program. [<http://www.wid.msu.edu/resources/biblios/Gender%20and%20HIV-AIDS.htm>].
- The Global Coalition on Women and AIDS and the World Health Organization. 2004. *Violence against women and HIV/AIDS: critical intersections, intimate partner violence and HIV/AIDS*. Information bulletin series, no. 1. Geneva: World Health Organization.
- The Global Fund (the Global Fund to Fight AIDS, Tuberculosis and Malaria). 2008. Addendum to report of the Policy and Strategy Committee: the Global Fund’s strategy for ensuring gender equality in the response to HIV/AIDS, tuberculosis and malaria (“the gender equality strategy”). Eighteenth board meeting, New Delhi, India, GF/B18/4 addendum decision. Geneva: The Global Fund. [http://www.theglobalfund.org/documents/board/18/GF-B18-04_ReportPSC_Addendum.pdf].

- Hallman, K. 2004. *Socioeconomic disadvantage and unsafe sexual behaviors among young women and men in South Africa*. New York: Population Council.
- Hargreaves, J. and T. Boler. 2006. *Girl power: the impact of girls' education on HIV and sexual behaviour*. London: ActionAid International. [http://www.actionaid.org.uk/doc_lib/girl_power_2006.pdf].
- Human Rights Watch. 2007. *Hidden in the mealie meal: gender based abuses and women's HIV treatment in Zambia*. New York: Human Rights Watch. [<http://www.hrw.org/en/node/10530/section/1>].
- ICRW (International Center for Research on Women). 2009a. *Integrating multiple gender strategies to improve HIV and AIDS interventions: a compendium of programs in Africa*. Washington, DC: International Center for Research on Women. May 2009. [www.aidstar-one.com/sites/default/files/aidstarone_gender_compendium.pdf]
- . 2009b. Terms of reference for analysis of gender responsiveness in national HIV/AIDS policies. Draft. International Center for Research on Women, Washington, DC.
- IOM (Institute of Medicine). 2007. *PEPFAR implementation: progress and promise*. Washington, DC: The National Academies Press.
- Kageni, A. and D. Garmaise. 2008. Do Global Fund grants work for women?: an assessment of the gender responsiveness of Global Fund-financed programmes in sub-Saharan Africa. Nairobi: Aidspan. [<http://aidspan.org/documents/aidspan/aidspan-gender-paper-en.pdf>].
- Kim, J. C., C. H. Watts, J. R. Hargreaves, L. X. Ndhlovu, G. Phetla, L. A. Morison, J. Busza, J.D.H.Porter, and P. Pronyk. 2007. "Understanding the impact of microfinance-based intervention on women's empowerment and the reduction of intimate partner violence in South Africa." *American Journal of Public Health* 97 (10): 1794–1802.
- Luke, N. 2003. "Age and economic asymmetries in the sexual relationships of adolescent girls in sub-Saharan Africa." *Studies in Family Planning* 34 (2): 67–86.
- Malhotra, A., S. Schüler, and C. Boender. 2002. Measuring women's empowerment as a variable in international development. Background paper prepared for the World Bank Workshop on Poverty and Gender: New perspectives. Final draft. World Bank, Washington, DC.
- Maman, S., J. Campbell, M. D. Sweat, and A. C. Geilen. 2000. "The intersections of HIV and violence: directions for future research and interventions." *Social science and medicine*. 50 (4): 459–78.
- Mann, J. 1996. *AIDS in the World II*. London: Oxford University Press.
- Moser, A. 2007. *Gender and indicators: overview report*. Brighton: Institute of Development Studies. [<http://www.bridge.ids.ac.uk/reports/IndicatorsORfinal.pdf>]
- Mozambique, Republic of. 2006. *Action plan for the reduction of absolute poverty 2006–2009*. Maputo, Mozambique: Republic of Mozambique.
- Mozambique Ministry of Health (Ministério da Saúde). 2004. *National strategic plan to combat STI/HIV/AIDS, health sector 2004–2008*. Maputo, Mozambique: Ministério da Saúde.
- Ogden, J., S. Esim, and C. Grown. 2006. "Expanding the care continuum for HIV/AIDS. Bringing careers into focus." *Health Policy and Planning* 21(5):333-342.
- Ogden, J., N. Oomman, and L. Weeth. 2008. Assessing the gender responsiveness of the U. S. President's Emergency Plan for AIDS Relief, the Global Fund to Fight AIDS, Tuberculosis and Malaria, and the World Bank's Multi-Country AIDS Program for Africa. HIV/AIDS Monitor Background Paper. Washington, DC: Center for Global Development.
- Oomman, N., M. Bernstein, and S. Rosenzweig. 2007. *Following the funding for HIV/AIDS: a comparative analysis of the funding practices of PEPFAR, the Global Fund, and the World Bank MAP in Mozambique, Uganda, and Zambia*. Washington, DC: Center for Global Development.

- Oomman, N., S. Rosenzweig, and M. Bernstein. Forthcoming. *Are funding decisions based on performance?: a comparison of approaches as practiced by the Global Fund to Fight AIDS, Tuberculosis and Malaria, the U. S. President's Emergency Plan for AIDS Relief, and the World Bank's Multi-country AIDS Program for Africa*. Washington, DC: Center for Global Development.
- PEPFAR (U. S. President's Emergency Plan for AIDS Relief). 2008a. *FY 2009 country operational plan guidance*. Washington, DC: Office of the U. S. Global AIDS Coordinator.
- . 2007. *Technical considerations for the FY 2008 COP*. Washington, DC: Office of the U. S. Global AIDS Coordinator.
- . 2008b. *Technical considerations for the FY 2009 COP*. Washington, DC: Office of the U. S. Global AIDS Coordinator.
- PEPFAR Gender Technical Working Group. Forthcoming. *Integrating multiple gender strategies to improve HIV/AIDS interventions: a compendium of programs in Africa*. Washington, DC: PEPFAR and the International Center for Research on Women.
- Rao Gupta, G. 2000. "Gender, sexuality and HIV/AIDS: the what, the why and the how." Plenary address, Thirteenth International AIDS Conference, Durban, South Africa.
- Rao Gupta, G., D. Whelan, and K. Allendorf. 2003. *Integrating gender into HIV/AIDS programmes: a review paper*. Geneva: World Health Organization. [http://www.who.int/gender/hiv_aids/en/Integrating%5B258KB%5D.pdf]
- Tallis, Vicci. 2002. *Gender and HIV/AIDS: overview report*. Brighton, U.K.: Institute of Development Studies. [<http://www.bridge.ids.ac.uk/reports/CEP-HIV-report.pdf>]
- Uganda Ministry of Finance, Planning and Economic Development. 2004. *Poverty eradication action plan 2004/5–2007/8*. Kampala, Uganda: Ministry of Finance, Planning and Economic Development.
- Uganda Ministry of Gender, Labour and Social Development. 2007. *HIV/AIDS strategic plan 2007/8 to 2011/12 social development sector*. Kampala, Uganda: Ministry of Gender, Labour and Social Development.
- Uganda Ministry of Health. 2005. *Health sector strategic plan II*. Kampala, Uganda: Ministry of Health.
- UNAIDS (Joint United Nations Programme on HIV/AIDS). 2006. *AIDS epidemic update: a special report on HIV/AIDS*. Geneva: UNAIDS.
- . 2008. *Report on the global AIDS epidemic*. Geneva: UNAIDS.
- Weiss, E. and G. Rao Gupta. 1998. *Bridging the gap: addressing gender and sexuality in HIV prevention*. Washington, DC: International Center for Research on Women.
- World Bank. 2003. *Project appraisal document on a proposed grant in the amount of SDR 41.6 million (US\$55 million equivalent) to the Republic of Mozambique for the HIV/AIDS Response Project*. Washington, DC: World Bank.
- World Health Organization, Uganda Ministry of Health, and World Health Organization Uganda office. n.d. Report on a rapid assessment of access to antiretroviral therapy in Uganda. Draft, World Health Organization, Geneva.
- Zambia, Republic of. 2006. *Fifth national development plan 2006–2010*. Lusaka, Zambia: Republic of Zambia.
- Zambia Gender in Development Division. 2000. *National gender policy*. Lusaka, Zambia: Gender in Development Division.
- Zambia Ministry of Health. 2004. *Performance audit 2001–04*. Lusaka, Zambia: Ministry of Health.
- . 2006. *Consultancy report on gender mainstreaming in the health sector in Zambia*. Lusaka, Zambia: Ministry of Health.
- Zambia National HIV/AIDS Council. 2006. *National HIV and AIDS strategic framework 2006–10*. Lusaka, Zambia: Ministry of Health.
- Zeidenstein, S., and K. Moore, eds. 1996. *Learning about sexuality: a practical beginning*. New York: Population Council.

