CHAPTER 11

Financing HIV and AIDS Interventions: Implications for Gender Equality

Robert Carr

Introduction: Blindness and Insight

> Gender equality is central to achieving the MDGs [Millennium Development Goals] and other development goals, making it important to ensure that aid structures target and monitor progress towards gender equality goals. (UNIFEM, 2006)

> Try not to get tricked because of love.... [Women] should love them self first, take care of them self and then introduce condoms to their loved one and tell them the reason and if the other person don't want to use condoms to protect his or herself, then the individual has to stand up and stick out that if there is no condom, there is no love. (HIV-positive Jamaican woman in Haniff, 2006)

The two quotes above capture the dilemma at the heart of this chapter. At the policy level, gender is seen as central to development processes by many stakeholders, although at times that has been a difficult argument to make clear. Simultaneously, on the ground, at the level of everyday life where under-development is most acutely lived, gender determines both consciousness and behaviours in a fundamental way. In this equation, even emotions and affective bonds considered outside the realm of politics – like a woman's love for a man – become a central driver and a reflection of gender inequality at the level of fundamental consciousness and of behaviour.

Both quotes together thus highlight the significant challenges faced at this crossroads in development planning. How do we unmask the reality that our struggles with development are deeply gendered? How do we convince our societies that old modes of gender, even including our understanding of what 'love' means, are at the root of our challenges with achieving development? Or that the spread of HIV is a reflection of these gendered challenges, and not an external agent imposing itself on us and on our societies?

The development crisis brought about by the epidemics of HIV and AIDS make these questions all the more urgent. And it is important to speak to two different epidemics, perhaps three. The *first epidemic,* that of HIV, is marked by its invisibility. HIV spreads mostly through unprotected sex in Western and developing countries, through sharing infected needles in Eastern Europe and, everywhere, through breast-feeding or

transfusions of infected blood. HIV leaves no distinctive traces of infection, except perhaps flu-like symptoms for the first few days. Today some 38.6 million people are living with HIV globally, of whom 62 per cent, or 24 million, are people living in the Commonwealth. Of these 24 million, some 11.5 million are women and girls.

AIDS, *the second epidemic*, is the dramatic, visible result of the work of HIV. Once the virus reproduces in the body by destroying the immune system, it leaves the infected person exposed to dangerous forms of both rare and common diseases. In 2006 alone, an estimated 2.8 million people died of AIDS-related illnesses, 67 per cent of them in the Commonwealth. However, with access to the right medication combined with care and support, a person with AIDS can fight back against the virus and regain her or his health. It is therefore possible to move from a diagnosis of AIDS back to being HIV-positive, even to undetectable levels of the virus in the bloodstream.

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

Over the past few years, the rate of increase in new cases of HIV has escalated in women around the world. Studies show that this is partly because women are biologically more likely to be infected by sexual transmission, but also because women are less able to take ownership of their lives, including their sexual behaviour. This disempowerment is all the more pernicious because it is normalised behaviour for 'good' women. Girls and boys are raised by both their mothers and fathers to believe that, for women, having and caring for a family, looking after a husband or male partner, being in love and becoming pregnant and having a child and are essential to a happy and fulfilling life.

The inequities in power relations between women and men become clear, however, when women in sexual relationships with men attempt to stop or change the way they have sex with those men. Suddenly (or not so suddenly) they are met with admonitions of inappropriate behaviour, or with violence designed to 'set them straight'. In some Commonwealth countries it is legally impossible – depriving women of any recourse – for men to rape their wives. A husband's sexual access to his wife's body is thus guaranteed by the state as much as by custom. Research from around the world has shown that, in the absence of structural support such as access to financial and political resources, women find themselves with few choices but to submit or face penury.

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

this chapter, then, is that financing for development means financing to achieve equitable gender relations as central to development.

The Gender Dimensions of HIV: Development and Policy Implications

The new modalities of development aid, as well as the old ones, have been seen as providing a critical platform for work on women's equality. The Monterey, G8 and Paris meetings on aid modalities call for the focus on achieving the MDGs to be sharpened, the financing process to be more effective and reporting more efficient.

Development can be defined, more or less, as 'an improvement in the living conditions of the people', where 'improvement' means ensuring 'the provision of basic human needs for all – not just food and clothing, but also shelter, health care and education' (Nayyar, 2004:62). Within this, it is imperative to understand the centrality of the role of women to achieving these objectives. This is not only because women are among the people provided for in development aims, but also because of the key role they play in the formal and informal economy, and the extent to which gender inequality blinds policy-makers, donor agencies, ministers of government and others to this reality. Moreover, across classes, ethnicities and national boundaries, women continue to provide the labour to manage the household and to bear and raise children. This is apart from the role they play in administering to men's needs. Macro-economic policy analyses and indicators disguise this, not only reflecting the invisibility of women's work but also missing the strategic centrality of this work in effective policy-making and more broadly in national strategising.

One challenge of incorporating these insights into development policy and financing is that while we often still speak of 'integrating' gender into development, the two are in fact fundamentally inseparable. This problem at the level of how we understand underdevelopment and development undermines the effectiveness of aid. Even when the central role gender equality plays in development is recognised in policy documents, a gender audit by Moser (2005 cited in Gaynor, 2006) found that when it came to taking action there were problems of evaporation (commitments not captured in implementation), invisibilisation (lack of monitoring and reporting of progress) or resistance (from those who see it as 'too time consuming', not a priority, etc.). This points again to the role that gender has been playing in the response to HIV for both historic and conceptual reasons. Historically, HIV was a problem that affected primarily men for a variety of reasons depending on the context. Today, however, whether it is transmission by intravenous drug use or by heterosexual sex, women are testing positive for HIV at a rate that is increasing faster than men's.

The emergence of a pandemic among women presents a challenge to the way the response to HIV has been conceptualised. Most of the models central to responses to HIV have centred around ideas of risk, and that to reduce risk each of us needs to know more about how HIV is contracted, understand our personal susceptibility and so change our behaviour – whether it be to abstain from sexual intercourse, be faithful to our partner

or use a condom. The problem with this is that it assumes we are all make rational decisions about sex and are in a position to control when, where and how we have sex. This is often not the case, and gender inequality makes it particularly unlikely for women.

UNAIDS (1999) has identified a number of core factors that place women at particular risk for HIV infection. Some of these can be addressed by the traditional responses of risk reduction, but others require more fundamental shifts that take us back to development processes that recognise the role gender plays. For example, women in monogamous relationships may view the negative economic consequences of leaving a high-risk partner as more serious than the health risks of staying, while low-income girls 'may face an added risk of HIV because of vulnerability to the enticements of older men' (p. 3). An additional factor is the link between economic necessity and the sex trade (ibid.).

Women's role and vulnerability also play a critical role in the response to AIDS. In most parts of the world, the focus for treatment, care and support is access to first and second line treatment, and treatment for opportunistic infections. In many instances, there is great pressure on hospitals for bed space. This means those ill from AIDS-related illnesses have to be looked after at home, usually by women. The loss of income from a male income-earner may also 'compel women and children to seek other sources of income, putting them at risk of sexual exploitation' (UNAIDS, 1999:3). If the woman was the main earner, she is often left to her own devices and it is the girl children who come to her aid. 'Girls carry a larger burden of domestic responsibility than do boys,' explain Barnett and Whiteside (2002:16), 'and are more likely to be kept out of school'.

The same issues that leave women and girls to fend for themselves in the household have their counterparts in the wider structure of the economic and legal framework. Laws and policies that prevent women from owning land, property and other productive resources increase 'women's economic vulnerability to HIV infection, limiting their ability to seek and receive care and support' (UNAIDS, 1999:4). In India, one of many countries where gender discrimination is especially harsh, lack of property rights is a major difficulty for women in households affected by HIV and/or AIDS. Women who are abandoned because they are HIV-positive or widowed due to HIV-related illnesses may be denied a share of their husband's property and left destitute and homeless (Jain, 2006).

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

Yet the group that has been largely invisible in this analysis has been men. In fact, gender norms of masculinity have been shown to increase men's vulnerability as well.

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

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

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

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

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

Four of the leading funding agencies are considered here: the Global Fund to Fight AIDS, Tuberculosis and Malaria (GFATM); the President's Emergency Plan for AIDS Relief (PEPFAR), administered by the Global AIDS Coordinator Office in the US

Government; the UK Department for International Development (DFID); and the World Bank. The ability of these agencies to support gender equality in financing is directly related to two key concerns: the number and nature of conditionalities involved in accepting funds from them, and the extent to which those conditionalities are flexible. For example, there has been much controversy over PEPFAR conditionalities preventing the purchase of generic versions of brand name antiretrovirals (ARTs) and medication to treat opportunistic infections.

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

The Paris Declaration, although the implications are still being thought through, lays down conditionalities about process rather than content of aid. While this may leave more room for manoeuvring as regards the politics of the content of aid, it means that processes will more tightly controlled, leaving a less varied range of partners for aid recipients. In shifting the way aid is delivered from programmes and projects to sectors, the Declaration will make it harder to track financing commitments to gender equality. As Fried points out, "where 'country ownership' becomes 'government ownership', there is an increased risk that already 'vulnerable' and marginalized groups in a society become further marginalized, and gender-equality priorities likewise" (2007, p. 3).

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

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

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

The GFATM is marked, as others have noted (for example, Fried, 2007), by its absence of conditionalities and explicit support for a wide range of programming, including human rights reforms, prevention programmes and treatment, care and support for people living with HIV and AIDS (PLWHA) (*Framework*, p. 4). Functioning through national or regionally driven programme proposals, it does not make gender a condition of support, although it does mention gender in a list of suggested concerns. It also

recommends (though does not require) that gender be addressed in the composition of Country Coordinating Mechanisms. Gender is not an issue in evaluating principle recipients for grants – for example, gender inclusiveness in management positions. The Secretariat itself does have such targets, however (Fried, 2007:28).

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

Global Fund statements that may seem at first glance to address gender equality are troubling on further analysis. For example, *Partners in Impact* (2007), an assessment of the Fund's impact, acknowledges that gender issues are at the core of the underperformance of PMTCT programmes. However, the main concern is the 'epidemic of children with AIDS' (p. 4), rather than also the women living with HIV who are not accessing meaningful support – the same women who will likely have primary care responsibilities for children born with or without HIV. This is critical because it also speaks to gaps in access to ART for women living with HIV. The disappointing pattern of consistent, almost exclusive (even if unintentional), association of women with PMTCT programmes continues throughout the evaluation.

In *Partners in Impact*, the Global Fund proposes to address the invisibility of women in its programmes and the lack of a mainstreamed gender focus. As such, it advocates for

> better tools to include gender in proposals, grant design and annual reviews of grants to influence implementation. Diagnostics for grants are needed to identify gender issues beyond disaggregating service data. This needs to have a basis in national planning and disease strategies. There are critical gender challenges to better scale up Global Fund and country efforts. (2007:18)

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

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

With some $15 billion in available funds over five years, PEPFAR is probably the largest bilateral HIV and AIDS donor in the world. However, it is the most controversial of the agencies reviewed here, notably for its conditionalities. Openly influenced by conservative religious values, PEPFAR advocates condoms ('C') as a last and least preferable resort for HIV prevention, promoting instead abstinence from sex before marriage ('A'), and fidelity within marriage ('B' – be faithful'). Together, this is known as the 'ABC' approach, clearly laid out in PEPFAR's *ABC Guidance #1* (n.d.) and has influenced 'not only those programmes and projects that seek PEPFAR funding, but national policy in PEPFAR recipient countries' (Fried, 2007:33).

In analysing the drivers of the HIV epidemic, PEPFAR's *Third Annual Report to Congress* establishes that harmful social norms and practices increase the vulnerability of women and girls by restricting their access to information, limiting their control over their sexual lives and depriving them of economic resources and legal rights (2007a:129). It also adds that it is important to note that 'harmful social norms and practices can also increase vulnerability of boys and men, such as pressure from peers or others to have multiple sexual partners or to seek transactional sex' (ibid.).

PEPFAR is required by the legislation authorising it to support five priority strategies to address the gender dynamics of the epidemics: increasing gender equality in HIV and AIDS activities and services; reducing violence and coercion; addressing male norms and behaviours; increasing women's legal protection; and increasing women's access to income and productive resources. While at first glance these strategies sound familiar because they use the same terms as agencies like the World Bank and DFID, the conditionalities attached make them mean quite different programming on the ground. While the *Guidance* speaks of 'gender inequities that foster the spread of HIV' (p. 11), and of PEPFAR programmes 'coordinating with governments and NGOs to eliminate gender inequalities in the civil and criminal code and enforce existing sanctions against sexual abuse and sexual violence' (p. 7), for example, both strategies are to support PEPFAR's core aim of ensuring that sex does not take place outside of marriage rather than to strengthen human rights.

Thus in terms of prevention, PEPFAR calls for programmes to reduce new infections in young women to 'focus on promotion of abstinence among young females, on reducing cross-generational sexual relationships, and on encouraging faithfulness and correct and consistent condom use among older males' (p. 12). At least 33 per cent of all PEPFAR funds must support programming advocating abstinence until marriage, but it has been pointed out that abstinence and be faithful programming in fact accounts for over half PEPFAR's spending, at 56 per cent (Thompson, 2007). Condom promotion accounts for less than 44 per cent, and must include promotion of abstinence, testing for HIV, partner reduction and mutual faithfulness. This is a potentially dangerous misalignment with data showing that 80 per cent of all new infections are through sexual contact (ibid.).

PEPFAR has also spent a substantial amount of funds in providing treatment and support for PLWHA. The International Treatment Preparedness Coalition (ITPC), a global coalition of PLWHA and their advocates, states that the community members they spoke to from around the world praised PEPFAR's treatment programmes, which had measurable goals and operated in a 'determined and efficient manner' (ITPC, 2005). However, the Coalition also had concerns about the integration of these programmes into sustainable systems that contributed to a country's long-term development interests.

Controversy also surrounds PEPFAR's treatment programme because of conditionalities that state all medications purchased with PEPFAR funds, including generic medication, must be approved by the US Food and Drug Administration (FDA). Critics argue that this limits the ability of agencies to maximise treatment funds, and most other agencies, such as the Global Fund and the World Bank, rely on the WHO for this process.

Thompson (2007) states that only 27 per cent of PEPFAR funds spent on ART drugs were spent on generic medication. In addition, there are explicit political restrictions on recipients of PEPFAR funding, particularly a gag rule on a woman's right to choose whether or not to have a child, or the recipient's stand on legalisation of sex work.

While PEPFAR documents promote US Government partnerships with indigenous organisations and local government, in practice these partnerships are largely based on religious concurrence. The results are potentially quite disastrous for the 15 focus countries employing PEPFAR strategies. The Center for Public Integrity notes that contrary to PEPFAR claims in its reports that its prevention strategy is working in Uganda, a country PEPFAR documentation holds up as the model on which the efficacy of its approaches is based, in fact, "In the two years since the new U.S. emphasis on youth abstinence began, the rate of new HIV infections has almost doubled, from 70,000 in 2003 to 130,000 in 2005, according to the director general of the Uganda AIDS Commission" (Rawls, 2006). In the end, it will be up to the national partners to monitor whether PEPFAR-designed and funded programmes are proving effective, and if so, to what extent.

The UK Department for International Development (DFID)

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

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

This is followed through in a key statement made in DFID's *Global Health Partnership*, which points out that 'there is now a great deal of evidence that education and empowerment – particularly of women – and helping people have more control over their lives and environment have profound and lasting effects' (Crisp, 2007:6). It is surprising, then, that in a document of almost 200 pages there is no mention of the word gender, and that this is the only place that women occupy as women. Programmes dedicated to women do, however, appear in case studies and the few statements in support of dedicated programming for women are strong. For example, DFID notes that the impact that educating and empowering women can have on health (ibid.). The document takes an important step to acknowledge gender empowerment strategies as key to sustainable development. In particular, it describes how programmes that 'deliver both microfinance and dialogue-based health education' have proven effective in stimulating behaviour change in relation to HIV risk behaviour.

This commitment to addressing structural inequality is made much more explicit in *Taking Action: The UK's Strategy for Tackling HIV and AIDS in the Developing World* (2004a). The central place of equality for women in DFID's platform is stated categorically, demonstrating an understanding of the cause and effect of gender inequality. The statements are clear as well on the link between stopping the epidemics of HIV and AIDS, women's structural vulnerability and gender empowerment in designing rights-based prevention strategies. DFID is equally explicit in its commitment to treatment programmes and to research on effective treatment and care for women and children. The treatment and care principles are also emphatic about the strategic importance of women's roles as partners and as beneficiaries, establishing that DFID programmes should be 'pro-poor, equitable and gender- and child-focused' (ibid.).

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

At the national level, DIFD makes the commitment to:

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

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

The World Bank

The World Bank is the oldest multilateral development financing mechanism in the response to HIV and AIDS, having provided its first loan in 1988 (World Bank, 2005a).

As such, it has a strong background in development financing through both loans and grants, and brings experience in analysis, policy advice, financing and implementation support to bear in establishing its concerns and conditionalities.

The Bank has an excellent operational guide to mainstreaming gender in its HIV programming: *Integrating Gender Issues into HIV/AIDS Programs* (2004a). As regards the interconnection between gender inequality and the spread of HIV, it cites its own research showing 'that the more unequal the relations between men and women in a country, the higher its HIV prevalence rates' and calls for all HIV/AIDS interventions to 'recognize and address gender-based inequalities and risks' (p. 2).

It further states that the increasing numbers of women infected with HIV highlights the need for policies and interventions 'to focus on transforming gender roles and relations between males and females to support the deep-rooted behavior change necessary to stem the spread of HIV/AIDS'. It goes on to underline that males can become part of the solution 'by focusing on their roles and responsibilities and actions they can take to reduce their own and their partners' and families' risk of HIV/AIDS' (ibid.).

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

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

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

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

As regards access to treatment, in its *Generic Operations Manual* (Brown, Ayvalikli and Mohammad, 2004), the Bank is clear on the critical role donor agencies must play in financing ART in developing countries. They also note, however, that patents are covered by WTO rulings on TRIPS.

Snapshots from the Frontlines of the Commonwealth

Botswana

Botswana is responding to an adult prevalence rate of HIV estimated at 37.4 per cent, one of the highest in the world. UNAIDS estimates that 270,000 people are living with HIV, of whom 140,000 are women. Some 26,000 have died of AIDS and 69,000 children have already been orphaned by the disease. Botswana has also been active in raising funds to finance its response to its epidemics.

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

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

GFATM

Women appear in the HIV prevention component of Botswana's Round 2 proposal to the Global Fund as pregnant mothers and as sex workers. As women living with HIV, they are also included as persons in need of treatment and support. The proposal attempts to address gender roles in provision of care, and especially to involve men in couples' testing for PMTCT and as peer recruiters for the PMTCT programme. Support group programming is also sex disaggregated, with men supporting men and women supporting women, though whether this is part of a strategy for empowering women is not clear. There are important innovations, including the use of flexible conditionalities attached to grants to build hospices for persons living with HIV, to support day-care centres for children of persons living with HIV and to provide micro-credit through NGOs.

PEPFAR

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

DFID

DFID's direct support to Botswana stands at £2 million per year according to its website, with an additional £1 million provided through multilateral programmes. Of this, £46,000 is in financial aid other than poverty reduction, £1.5 million is for technical cooperation, £473,000 is in grants and other aid in kind and £12,000 is in debt relief. This aid covers a wide range of sectors, including education, HIV, poverty reduction, and other targets of the MDGs. However, Botswana is not included in DFID's 2006 report on its Public Service Agreements, so a breakdown of the funds by specific area of focus is difficult to track.

World Bank

The Bank's primary programme for HIV development aid in Africa and the Caribbean is the Multi-Country HIV/AIDS Program (MAP). Because Botswana is considered a 'higher income' country, it is not eligible for the Bank's HIV grant programmes and has not had focused Bank support since fiscal year 1996. Bank support to Botswana's response to HIV and AIDS has been limited to 'sharing of information at technical meetings' of the MAP. In its *Interim Review of the Multi-Country HIV/AIDS Program for Africa*, the Bank notes that its lack of ability to provide Botswana with 'the full range of its technical and financial services' is 'a serious anomaly for which a remedy should be sought urgently' (2004b:11).

Guyana

Guyana has one of the highest prevalence rates of HIV in the Caribbean. UNAIDS reports a national average of 2.5 per cent and estimates there are 11,000 people living with HIV, of whom 6,600 are women aged 15 and up. Guyana is one of two PEPFAR Focus Countries in the Caribbean and, because of its low human development index (HDI), it also qualifies for substantial amounts of bilateral and multilateral aid.

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

Similarly, in identifying 'guiding principles' for the response it stresses that this '...must consider efforts at behaviour change, but must also address the vulnerability factors such as fear, denial, stigma and discrimination, gender equality and power differentials, poverty and livelihood insecurity, internal migration for employment purposes [and] social-cultural norms, values and practices...' (p. 37).

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

GFATM

In 2003, Guyana submitted a successful proposal to the Global Fund for $27 million. A search in this for programmes to address gender, however, yielded no mention of the term. The response to the section of the proposal form explicitly asking about gender provides somewhat of an explanation: 'Unfortunately little is known about the gender dynamics of HIV/AIDS transmission here' (p. 50).

There is conflation between sex and gender in this proposal that also appeared in the national *Strategy*. It states that males and females have equal access to education and health care, and the analysis suggests that women make greater use of the public health-care system, although as pregnant women or new mothers, and that incorporating HIV prevention and other services into the health-care system is one way to address gender. This actually does nothing to tackle the problems of vulnerability the *Strategy* identifies in its initial analysis. The proposal comes a bit closer to the issue when it speculates that: 'The challenge for women may be implementing the acquired knowledge and skills in the context of their relationships' (p. 50). The possibility that the grant will address this and other challenges, however, is undone by the next few sentences, which call for additional effort 'to ensure that men have the same level of access to information and services' (p. 50). In other words, the sex whose gender status makes them unequal and requiring strategic intervention is seen to be men.

PEPFAR

The PEPFAR website shows some $7 million allocated to Guyana for fiscal year 2005, of which PMTCT was allocated $1.4 million, abstinence/be faithful another $1.4 million, blood safety $2.1 million and injection safety $1.1 million. The category 'other prevention' absorbs $1 million. Bearing in mind PEPFAR's interpretation of that category, however, it inevitably includes voluntary counselling and testing (VCT) (as well as condom promotion) in a context that advocates abstinence and being faithful.

DFID

DIFD has an office in Guyana, and its Caribbean strategy document also asserts that it has a long-term commitment to the country. Unfortunately, however, as often happens

with the Caribbean, Guyana disappears from global analyses and is not mentioned in either the global health strategy or the annual report. Guyana does hold a key place in the *Regional Assistance Plan for the Caribbean*, however, which is based on the principle of focusing 'bilateral assistance on supporting effective delivery of national poverty strategies in Guyana and Jamaica' (2004b:2). The poverty focus encompasses three themes, one of which is HIV/AIDS and violent crime (ibid.). However, HIV seems to come in behind fundamental poverty alleviation.

World Bank

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

There is a moment of insight in the descriptive analysis of community consultations, which notes that there were 'gender issues' in regard to promotion of condoms and PMTCT: 'Some women mentioned the absence of men in all these efforts and wondered why the male role was hardly or never mentioned in the transmission of the virus when discussing PMTCT (2004c:94). But the concept of the male role does not appear in project strategies. Another important insight is when the appraisal notes that the target group for condom distribution has been primarily women, but this 'has not empowered women to protect themselves since they have not been provided with methods they can control such as spermicides and female condoms' (p. 98). However, the appraisal again does not follow through with a strategy to address this either.

India

By all accounts, India has one of the highest numbers of people living with HIV in the world. UNAIDS estimates that 5.7 million people or more have contracted HIV, almost 6 per cent of the population of 1 billion people. However, ITPC reports that although the government has signalled increasing commitment to ART delivery, treatment 'remains unavailable for the vast majority' (2005:3). HIV-positive women's ability to access care is constrained by lack of money and distance, and 'men routinely receive care and treatment ahead of their wives (Garbus and Marseille, 2003:10).

While 'initially, HIV spread among female sex workers and their male clients [including truck drivers], STI clinic patients, and professional blood donors' (ibid.:18), the epidemic is also generalised, although unevenly across the country. Studies have shown that the vast majority of infected married women were infected by their unfaithful husbands (Newmann et al., 2000). Some 60 per cent of those living with HIV in 2005 were women. Conditions for women are, in broad terms inequitable, although in some cases

it is extreme. There are increasing cases of sex-selective abortions, female infanticide, violence against women, dowry murders and discrimination in access to health care, nutrition and employment opportunities. In addition, there 'are significant and persistent gaps between women's legal rights and their actual ownership and control of land' (Garbus and Marseille, 2003:9).

India's National Strategic Plan identifies four core priorities: prevention of new infections in high-risk groups and the general population through saturation of coverage of high-risk groups with targeted interventions and scaled up interventions in the general population; increasing the proportion of people living with HIV or AIDS who receive care, support and treatment; strengthening the infrastructure, systems and human resources in prevention, care, support and treatment programmes; and strengthening a nation-wide strategic information management system.

GFATM

India's Global Fund proposal asks for some $260 million for its HIV and AIDS component, out of $323 million requested in Round 6. It received Global Fund grant funds equalling almost $250 million in Rounds 2, 3 and 4. The proposal states a core concern of 'mitigating the impact of HIV on the families especially women and children' (p. 43). Moreover, gender will be mainstreamed in the programme cycle through 'programme management training; gender balance in staffing; gender-sensitive organizational policies and gender training for staff and providers' and the inputs of female PLHA 'will be incorporated while designing training programmes in order to deepen the team members' understanding of gender issues and encouraging change in their attitudes and practices' (ibid.).

The proposal also seeks a key role for women's organisations that is critical in a context such as India's, addressing psychosocial issues as well as issues of treatment and economic empowerment. As regards treatment, the proposal sets out a deliberate strategy to counter cultural prejudices and other barriers to women's access, establishing links between integrated counselling and testing centres, ART centres and Community Care Centres.

The grant also addresses attrition from the antenatal programme, something few such programmes pursue, through following up those women found to be HIV-positive during pregnancy but not qualifying for ART treatment. It calls for inputs from PLWHA to guide community outreach workers in encouraging the women to take up treatment and home-based care for themselves and their children. Interventions 'will improve female PLHA's access to care and support through women's fora in state PLHA networks and PLHA support groups at the district level' (p. 43). Finally, the programme builds accountability into the strategy, requiring NGOs to demonstrate that their workforce has a gender balance and that they have a clear policy to reduce gender discrimination, mainstream efforts to reduce gender bias, etc.

PEPFAR

Under PEPFAR, India received approximately $29.3 million dollars in fiscal year 2006. Data on the India programme is sparse, likely because it is channelled through USAID India's country programme, and the target groups are different: high-risk groups (such as sex workers and their clients, including truckers and other men); sexually transmitted infection (STI) clients; women of reproductive age; youth in general; girls involved in trafficking; men who have sex with men; injecting drug users (perhaps); and urban and rural family members for HIV information and preventive services. Based on what can be gleaned from its annual report, PEPFAR/USAID's support in India goes in part to PMTCT, treatment and care and counselling outside of treatment centres (PEPFAR, 2007).

The US also funds prevention programming. The PEPFAR report sounds traditional themes for its prevention work – for example, in the story 'Sunita', a migrant worker who was sexually exploited by her employers and turned to sex work, but empowered by a PEPFAR/USAID funded organisation 'to share her experiences... and take action to escape exploitation and prostitution' (ibid., p. 187).

DFID

India receives the most bilateral aid from DFID of any country in the world, some £253 million in 2005/06, down from £259 million in 2004/05 (*Departmental Report 2006*). According to the National AIDS Control Organisation (NACO), DFID supports targeted interventions in a number of states in India aimed at high risk groups, such as sex workers, injecting drug users, prison inmates, street children and migrant workers. 'Its package of supported programmes also include: condom promotion; mass media programming through national television to raise awareness and address stigma and discrimination; a Resource Centre for Sexual Health to provide technical assistance to SACS; and programmes on gender and trafficking' (India Country Coordinating Mechanism, p. 13).

World Bank

A review of the World Bank website shows India with some 33 approved grants from that institution, most of which are closed. Currently an agreement is being negotiated, valued at $512 million, to fund the current National HIV/AIDS Control Project III. Project details are not publicly available at time of writing.

South Africa

South Africa is home to some 5.5 million people living with HIV, and an estimated 320,000 people died from AIDS-related illnesses in 2005 alone (UNAIDS, 2006). Among the community of persons living with HIV, UNAIDS reports that 'one in three women aged 30–34 years were living with HIV in 2005, as were one in four men aged 30–39 years' (ibid.:11). South Africa has also been the subject of intense controversy both within the country and externally for its position on access to treatment.

UNAIDS further estimates that approximately 'two million South Africans living with HIV do not know that they are infected and believe they face no danger of becoming infected – and therefore are unaware that they can transmit the virus to others' (ibid.:13). This is in a context described as home to extremes of gender-based violence. The South African Demographic and Health Survey found a national rape prevalence of 7 per cent, with a range of 3 to 12 per cent across provinces, and 'both police statistics and household studies reveal that young women – the demographic group most at risk for HIV/AIDS – are also at highest risk of being raped' (Garbus, 2003:7).

As in other parts of the world, women living with HIV are particularly vulnerable to stigma and discrimination and face abuse and/or abandonment if they disclose their status. Moreover, 'Lobola, a long-standing tradition whereby men purchase a wife by paying her family a dowry, also renders it difficult for women to leave their husbands, as this would require fathers to repay the dowry' (ibid.:11).

South Africa's *Strategic Plan 2000–2005*, still in operation as a new *Plan* is developed, identifies the four focus areas: prevention; treatment, care and support; human and legal rights; and monitoring, research and surveillance. Among its key indicators, three pertain specifically to women: the percentage of sexually active women using condoms (under prevention); the number of reported rape cases; and the number of cases of workplace legislation abuse related to employees contracting HIV. Data cited by the National Strategic Plan make evident the link between such extreme vulnerability of women and national statistics where it states that 'young women aged 20-30 have the highest prevalence rates' and that 'young women under age 20 had the highest percentage increase compared to other age groups in 1998 compared to 1997' (South African AIDS Council, 2000:8). However, the human rights component of the *Plan* is weak at best, simply asserting that 'appropriate' social, legal and policy environments will be created or developed.

GFATM

South Africa's Global Fund grant proposal makes no explicit reference to gender. However, it does note the special vulnerability of women, especially poor women, and describes a context in which 'a special effort is made in the current programme for women and single mothers who are HIV-positive' (p. 20). The proposal further describes three programmes targeting women: PMTCT, priority for access to treatment in pilot treatment sites to pregnant women with children and ARV prophylaxis for rape survivors. Given women's role in providing home care for persons sick with AIDS-related illnesses, the home-based care support infrastructure proposed in the grant application would also benefit women. However, this is not explicitly stated. No structural level interventions to reduce women's vulnerability are proposed.

South Africa has also had a Round 6 proposal, costed at $102.8 million, approved for funding although the grant has not been signed at time of writing. It reflects recent research that captures women's vulnerability across a range of variables, and targeted action and the central involvement of women in the response are positioned as central to the strategy it lays out. Further, it states that the focus of the prevention goal 'is to

provide behaviour change communication services specifically targeted at women, young people, and workplaces and under-served communities in rural and urban informal settlements' (p. 71).

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

PEPFAR

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

DFID

DFID's aid to South Africa covers a range of programmes, with a heavy focus on poverty alleviation. As regards HIV and AIDS, *Taking Action* reports that DFID works with the Nelson Mandela Foundation and the Anglican Church (DFID, 2004a). These organisations are seen as lead partners in political advocacy for greater attention to be paid to AIDS, lending their voices to social change processes and reducing stigma and discrimination. Approximately £3.4 million has been granted to Christian Aid, a progressive international faith-based organisation, to support the work of the Anglican Church across Southern Africa. DFID's *Departmental Report 2006* further shows South Africa receiving £15.5 million in technical cooperation and £13.5 million in grants and other aid in kind.

World Bank

While several Bank documents refer to South Africa and the extremity of the epidemic there, the Interim Report on the MAP notes that – as with Botswana – the Bank is unable to provide its full range of technical and financial services since the country is not eligible for MAP funding. Again, this is described as 'a serious anomaly for which a remedy should be sought urgently' (2004b:11).

Uganda

Among experts in HIV prevention programming, Uganda holds a unique place as one of the handful of countries that have successfully reversed the upward trend of the

epidemic. 'In a decade, from 1989 to 1999,' write the World Bank on its website, 'reported HIV prevalence among STI clinic patients in Kampala decreased from a median of 52 percent to 23 percent'. This has made it a subject of intense scrutiny to discover what lessons learned can be transferred to other contexts. For its part, the Uganda Government has said in its *National Strategic Framework* that the mechanisms that produced this reduction are not fully understood, as 'owing to weak monitoring, it is not possible to apportion the observed decline between the three factors of abstaining, being faithful to one's partner, and condom use' (p. ii).

The *Framework* goes on to highlight that although HIV prevalence declined from 30 to about 10 per cent between 1992 and 1996, it appears to have stagnated since then and that a 'prevalence rate of 10 per cent is still high given that HIV/AIDS results in certain death' (p. iii).

The socio-political context in which the country is responding to the HIV and AIDS epidemics is complex. As in other parts of Africa, and indeed the Commonwealth, discrimination against women is entrenched. Although the Government has put in place a far-reaching affirmative action programme to promote women's political participation, customary and statutory laws continue to discriminate against women in areas of marriage, divorce, and inheritance, and some 32 per cent of married women in Uganda are in a polygamous union (Garbus and Marseille, 2003).

Further, a 'landmark' community-based study, the Rakai project, found very high rates of domestic violence (experienced by 30 per cent of women), often linked to alcohol consumption. Uganda's *National Strategic Framework for HIV/AIDS Activities in Uganda: 2000/1–2005/6* (2000) also points to the effects of gender disparities and cultural practices on girls orphaned by AIDS, as they are particularly vulnerable to exploitation and heavy responsibilities, especially in areas of housekeeping and agricultural production. Poverty and being orphaned 'also expose the girl child to a greater risk of HIV infection through early marriage, sexual abuse, and prostitution' (p. ii).

Against this backdrop, the *National Strategic Framework* identified three core goals: to reduce HIV prevalence by 25 per cent by the year 2005/6; to mitigate the health and socio-economic effects of HIV and AIDS at the individual, household and community level; and to strengthen the national capacity to respond to the epidemic. Within these core goals, there are several actions that directly relate to addressing gender inequality, including promoting behaviour change among sexually active populations, particularly young people aged 15-24; reducing the vulnerability of individuals and communities to HIV and AIDS, with a focus on children, youth and women; reducing the current 15–25 per cent incidence of mother-to-child transmission by a third by 2005/06; and providing care, support and protection of rights to at least 50 per cent of the families most affected by HIV and AIDS (pp. xxxvi–xxxvii).

Moreover, Uganda's Poverty Eradication Action Plan (PEAP) identifies actions to enhance gender equality as one of the critical measures required to boost GDP growth and calls, for example, for mainstreaming gender in planning and budgeting, strengthening women's entrepreneurship and legal rights, and supporting a domestic violence bill, a

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

GFATM

Uganda's Global Fund grant requests $119 million in funds to strengthen its access to treatment programme, with a focus on PMTCT and on support for orphans and vulnerable children (OVC). It further proposes to address treatment literacy, as well as capacity building for delivery of ART. It envisions that the introduction of ART in PMTCT centres will 'dramatically increase the number of women receiving voluntary counseling and testing and facilitate comprehensive clinical care for mothers and their families' (p. 6).

The proposal also recognises the importance of substantive structural reform to address stigma and discrimination through legal sanctions and to find solutions to poverty exacerbated by HIV or AIDS. This includes enforcing the property rights of widows and prosecuting those who abuse girl orphans. It notes that 'assisting OVC families to generate more income, and keeping girls in school longer, should reduce sexual exploitation and the pressure for early marriage' (p. 115). Strategic Objective 6 calls for ensuring: 'the legal protection of the rights of OVC and OVC households as enshrined in the Ugandan Constitution, the United Nations Convention on the Rights of the Child, the Children's Statute, the goals of the United Nations General Assembly's Special Session (UNGASS) on HIV/AIDS' (p. 100).

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

(a) facilitation of information, education and communication campaigns to ensure that caregivers, teachers, community members, local and religious leaders are familiar with the fundamental principles of the rights of children, especially those who are orphaned and the widowed as well as PLWHA.

(b) mobilisation of communities to provide resources from among their members to provide basic needs for the most needy OVC and OVC households among them.

(c) facilitation of legal consultation and aid to OVC and OVC households with regard to succession planning, property disputes, physical abuse, emotional abuse, sexual abuse and illegal child labour. (p. 100)

PEPFAR

In its *Third Annual Report to Congress* (2007), as in all its documents, PEPFAR cites Uganda as a success story and the model for its emphasis on behaviour change, which it interprets as promotion of abstinence and monogamy as the best available options for risk reduction. The Report also suggests a central role for the agency in the country's response, covering a range of programming from laboratory strengthening to door-to-door

testing and counselling, to provider-initiated testing and counselling, PMTCT programmes and programmes for children orphaned by AIDS.

PEPFAR financial records released by the Centre for Public Integrity show some $26.3 million in aid for Uganda for 2005. Of this, $3 million is allocated for abstinence and being faithful programmes, $9 million for ART, $6.8 million for safe blood transfusion programmes, $3.5 million for OVC and $3.7 million for safe injection programmes. Some $11.6 million of this aid (almost half) was channelled to agencies categorised by PEPFAR as faith-based organisations.

DFID

DFID's *Departmental Report 2006* shows Uganda receives bilateral aid from DFID in the amount of £72 million, ranking 10th of the top 20 recipients of such aid. (India ranked number one.) The *Report* also shows that the focus is on implementation of the PEAP, mostly through poverty reduction budget support (PRBS), and a new arrangement was agreed in 2004 to provide £145 million over three years. PRBS is said to have 'helped increase public expenditure in key areas such as health and education' (p. 47).

DFID argues that a combination of political will and coordinated donor support has yielded significant gains, including in areas key to gender equality such as poverty reduction and school enrolment. While the consensus on Uganda, as elsewhere, is that the links between these structural development indicators that capture gender parity in development gains and reduction in HIV are not direct, there is the belief that they are inter-related if they reduce vulnerability.

World Bank

In a grant to Uganda, the World Bank provided some $50 million for the period 2001–2006 (Uganda CCM, 2003). In December 2005, Uganda came to a joint assistance agreement with a number of donor countries under the aegis of the World Bank, including the African Development Bank, DFID, Germany, the Netherlands, Norway and Sweden. The document is focused on three integrated strategies: supporting implementation of the country-owned and led revised PEAP to achieve the MDGs; collaborating more effectively, both among development partners and with the Government; and focusing on results and outcomes (including managing resources and improving decision-making for results, and strengthening systems for monitoring and evaluation). The agreement is also an important step as it builds on donor harmonisation and the Paris Declaration. As such it identifies principles for action signed by all donors included in the joint assistance agreement (World Bank, 2005b).

Lessons Learned for Gender Equitable Responses and Financing

While there has been some progress, in many respects opportunities for funding to address gender inequality in the context of HIV and AIDS have not been followed

through. There is language in grant proposals, and in the public statements of most donors reviewed, to support stronger gender equity programming. However, if we look at more closely at these documents, the core issues have not been tackled, either because the central role gender inequality plays in undermining development programmes is not frontally addressed, or perhaps because in the corridors of power tackling gender equality is seen as a luxury that comes second or third to other 'more pressing' strategies and reforms for economic stability and growth. Or both these reasons, plus others.

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

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

Similarly, Uganda's approach of pursuing gender empowerment strategies that are embedded in an integrated poverty-reduction approach is important. The recognition that supporting women's entrepreneurship stimulates private sector growth underscores the critical lesson that women and women's work are central to household and national economies. However, while a national strategy may provide some insights on the importance of addressing entrenched gender inequity, moving from those insights to concrete plans is more challenging. Donor conditionalities, as well as lack of harmonisation, may also constrain what it is feasible to propose.

At the heart of the dilemma at the centre of this chapter then is the notion of what it means to be empowered, to stand up for yourself as an individual, as a society, as governments; to be honest about what is happening to us and in our households; and to see with different eyes. Some women's affairs machineries may need to come to terms with the impact of gender disparities on the epidemics of HIV and AIDS. Donor countries may also need to pay greater attention to ensuring the visibility of women as subjects of development, especially women living in poverty in the developing world.

Since the Paris Declaration means the push is towards consolidated support for poverty reduction or other global strategies, it has two important implications for the work of women's machineries and development practitioners. First, gender equality will have to be embedded in national development policies and strategies. This means more work for women's machineries in making strong arguments in terms that the country and fellow government officials and workers can understand. It means developing a political strategy, identifying and cultivating allies and advocates from across specialities and class lines, and gathering data strategically than can help make the case.

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

This chapter began with some core questions: How do we convince policy-makers that our struggles with development are gendered? How do we convince our societies that old modes of gender, even including our understanding of what 'love' means, are at the root of our challenges with achieving development? A central issue with gender work is that it politicises the private, as the second wave feminists asserted in the 1970s. This is what makes gender so difficult – it is so personal that many resist it on that ground alone.

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

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

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

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

> So when I look at it sometimes the more I am convinced that is not persons who have multiple sex partners who find themselves HIV positive. It's probably where you are married or in a common-law relationship. Wanting to trust somebody and wanting to be there, wanting that person to know that you really love them or trust them, so you can build a life together.

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