Promoting Gender Equality in HIV and AIDS Responses:
Making Aid More Effective Through Tracking Results
This publication has been produced by UNIFEM with the assistance of the European Union. The contents of the publication are the sole responsibility of the authors; they do not necessarily represent the views of UNIFEM and can in no way be taken to reflect the views of the European Union.

The European Commission promotes the general interest of the European Union, in particular by presenting proposals for European law, by overseeing the correct implementation of the Treaties and European law, and by carrying out common policies and managing funds.

UNIFEM is the women’s fund at the United Nations. It provides financial and technical assistance to innovative programmes and strategies to foster women’s empowerment and gender equality. Placing the advancement of women’s human rights at the centre of all of its efforts, UNIFEM focuses on reducing feminized poverty; ending violence against women; reversing the spread of HIV/AIDS among women and girls; and achieving gender equality in democratic governance in times of peace as well as war.

Promoting Gender Equality in HIV and AIDS Responses: Making Aid More Effective Through Tracking Results

Copyright © United Nations Development Fund for Women (UNIFEM) 2008


UNIFEM
304 East 45th Street
15th Floor
New York, New York 10017 USA
Tel: +1 212 906-6400

www.unifem.org
www.genderandaids.org

Design: CARIMAC.com
Promoting Gender Equality in HIV and AIDS Responses: Making Aid More Effective Through Tracking Results

Edited by

Robert Carr

Caribbean Centre of Communication for Development
Caribbean Institute of MEDIA and COMMUNICATION (CARIMAC)
As developing countries and donor partners re-focus development assistance around principles of national ownership and coordination, it is critical to ensure that gender equality and women’s empowerment are central to the aid effectiveness agenda.

Achieving the internationally agreed development goals hinges on advancing progress on gender equality. Today nearly all countries have policies on HIV and AIDS. However, as shown by the 2008 reports submitted to the United Nations Secretary-General assessing progress towards universal access to HIV prevention, treatment, care and support, and towards the targets set in the Declaration of Commitment on HIV/AIDS, countries continue to identify persistent challenges in responding to HIV and AIDS, specifically in eliminating factors that make women and girls vulnerable to the virus and its impact. While these challenges vary across countries, the need to invest in gender equality and the protection of women’s rights is a constant.

We know the importance of creating an environment that supports gender equality and protects women’s rights; however, we do not know the extent to which HIV/AIDS funding is contributing to such an environment. We also know how entrenched inequality and violations of women’s rights contribute to the feminization of the epidemic; however, we do not know if current aid flows are indeed ‘effective’ for women and girls and ultimately making a difference in their lives.

As part of a collaboration to prioritize gender equality in the aid effectiveness agenda, the European Commission (EC) and the United Nations Development Fund for Women (UNIFEM) have been working to get a clearer picture of the impact of HIV funding and policy on women’s lives, focusing on the impact of ending violence against women and improving women’s access to sexual and reproductive health and rights. In May 2008, UNIFEM and the EC organized an expert consultation on ‘Tracking and Monitoring Gender Equality and HIV/AIDS in Aid Effectiveness,’ to identify and promote approaches to ensure that the aid effectiveness agenda promotes greater investment and action on reducing HIV/AIDS among women and girls.

Participants developed recommendations for integrating the gender equality dimensions of HIV/AIDS into national development planning, implementation and budgeting; for strengthening current indicators for monitoring and tracking progress to eliminate violence against women and improve women’s access to sexual and reproductive health and rights in the context of HIV/AIDS; and for inspiring new areas of advocacy and new entry points for improving knowledge and awareness on gender equality and HIV and AIDS in the context of aid effectiveness.

This publication presents the key findings of the consultation; it highlights the gaps in tracking budgets and expenditures on gender equality, and the need to transform the structural conditions that heighten the vulnerability of women and girls to HIV. It underlines the need for comprehensive gender equality indicators for use in monitoring progress in meeting key targets and goals outlined within the United Nations Declaration of Commitment on HIV/AIDS.

It is our hope that the publication will provide inspiration and guidance for effective action.

Koos Richelle
Director-General
EuropeAid Cooperation Office

Ines Alberdi
Executive Director
UNIFEM
ACKNOWLEDGEMENTS

Edited by Robert Carr.

Coordinated by Nazneen Damji.

Copy edited by Tina Johnson.

With contributions and key research by Aida Olkkonen, Emily Krasnor, and Nazneen Damji.

A special thanks to the following colleagues that provided valuable information and support:

From UNIFEM: Angelika Kartusch, Joanne Sandler, Letty Chiwara, Maria Karadenizli, Marta Val, Nisreen Alami, Osnat Lubrani, Roberta Clarke, Sharon Fleming, Teresa Rodriguez and Vandana Mahajan.

From UNAIDS: Judy Polsky, Kristan Schoutz, and Nii-K Plange.

From the European Commission: Antoinette Gosses and Marianna Lipponen.

Finally, thanks to all the experts who participated in the consultation and presented papers.
**TABLE OF CONTENTS**

Introduction .............................................................................................................................................. vi

Walking the Walk: Closing the Programmatic and Financing Gap on Gender Equality, Violence against Women, and Access to Sexual and Reproductive Health Services in the Responses to HIV and AIDS – *Robert Carr* .......................................................... 1

Summary Report of the Expert Group Consultation on Tracking and Monitoring Gender Equality and HIV/AIDS in Aid Effectiveness ........................................................................................................ 16

International Community of Women Living with HIV/AIDS (ICW): Monitoring Access to Treatment and Care, Sexual and Reproductive Health and Rights and Violence against Women ‘by and for’ HIV positive women – *Luisa Orza* ................................................................. 25

Sexual and Reproductive Health and HIV/AIDS Indicators: Multi-level and Multi-faceted – *Carol Underwood* ................................................................................................................................ 31

Gender and Sexual and Reproductive Health Indicators in European Union Development Aid – *Mirjam van Reisen* and *Willemijn Nieuwenhuys* .............................................................................................................. 33

Annexes – developed by *Aida Olkkonen* ............................................................................................. 40

- Annex 1 – International Commitments: Indicators Related to Gender and HIV and AIDS, Sexual and Reproductive Health and Rights, and Violence against Women ................................. 40
- Annex 2 – Key Resources on Monitoring and Evaluation Indicators Related to Gender and HIV/AIDS, Sexual and Reproductive Health and Rights, and Violence against Women .............. 52

Endnotes ............................................................................................................................................... 56
INTRODUCTION

The 2006 review of progress on commitments made during the 2001 United Nations General Assembly Special Session (UNGASS) on HIV/AIDS was a turning point for the issue of women’s rights, and in particular violence against women, in the context of HIV and AIDS. While the 2001 Declaration of Commitment on HIV/AIDS included important language about the role of gender equality in addressing women’s needs, it took the coming together of the women’s movement and those who were active in the global response to HIV for the mismatch between standard programming tenets and women’s and girls’ vulnerabilities to come more clearly into focus.

Up until then, the women’s movement at the global level had achieved a number of commitments – the Convention on the Elimination of All Forms of Discrimination against Women (CEDAW) and the Beijing Declaration and Platform for Action among them – but these had not triggered the strong systemic change envisioned. As the figures for women’s increasing infection rates became more widely known, the need for a review of the approach to responding to the epidemic on the ground was clear.

Resources for HIV programming at the national level are always constrained by the frameworks established at the global level, including the 2001 Declaration of Commitment and the 2006 Political Declaration on HIV/AIDS, as well as the 2005 Paris Declaration on Aid Effectiveness, which looks to restructure the way development aid more broadly is understood and delivered. While some activist community groups and governments were trying – and at times succeeded – to forge new ways of addressing women’s needs in the responses to HIV and AIDS from a perspective founded in human rights for all women, the work was often piecemeal and not buttressed by a global policy response that supported that work, as well as its funding, its monitoring, and its evaluation. Shortcomings of a closed set of options – abstain, be faithful, or use a condom (the so-called ‘ABC’ approach) – needed to be forthrightly addressed, and solutions found for transforming the systemic response in light of the realities of women and girls, especially in developing countries where the epidemics of HIV and AIDS were spreading rapidly.

In this context, UNIFEM embarked on a programme of work to address this gap at the systemic level, especially in relation to aid effectiveness. The programme, ‘The aid effectiveness agenda: Promotion of the empowerment of women and girls in the context of sexual and reproductive health, violence against women and HIV/AIDS,’ supported by the European Commission, sought to provide concrete feedback and innovations in programming at the intersection of HIV, violence against women, and access to sexual and reproductive health services. It was thus intended to address the need for policy, programmatic and financing responses that build on an understanding of the role that gender-based violence and compromised access to sexual and reproductive health play in increasing women’s vulnerability. Because of the important role of monitoring and evaluation (M&E) frameworks in not only assessing the efficacy of interventions, but also, in practice, of driving interventions, the issue of indicators took centre stage. Also of primary concern was the recognition systems have a strong normative role.

An Expert Group Consultation, convened under the programme on 28-30 May 2008 in Santo Domingo, the Dominican Republic, provided an opportunity to share and analyse strategies to make aid more effective in addressing the vulnerabilities of women and girls through tracking financing for gender equality in the response to HIV and identifying, reviewing and refining key programme indicators. Experts examined how and where gender equality and HIV are being woven into the aid effectiveness agenda, drawing on country examples and existing efforts. The consultation also provided a forum for examining strategies to support nationally-led processes of tracking and monitoring progress to reduce HIV infections among women and girls by improving their access to sexual and reproductive health and rights and by reducing the violence they face.
A primary target for analysis is thus the normative framework in which responses are failing women, in particular the M&E frameworks of the major UN and financing institutions in the response to HIV, as well as the issues raised by the efforts to implement the Paris Declaration and promoting aid effectiveness. As such, the first chapter attempts to raise some questions about the gap between what we know and what we do in response to upholding women’s rights and responding to realities on the ground. Its focus is systemic and it is meant to raise questions for all those who have a role to play in addressing the epidemic about the lack of action on lived realities. Just as at the national level there is an understanding that knowledge about HIV is necessary but not sufficient to lead to 100 per cent condom use – the famous gap between knowledge and practice – so at the structural level the response has not followed through on analyses by local and international women’s groups, UNIFEM, the United Nations Development Programme (UNDP), the Joint United Nations Programme on HIV/AIDS (UNAIDS) and others of the gaps, failures and solutions to women’s access to rights. Those failures of inclusion at the systemic level play out at the local level in responses failing women and other marginalized groups in the midst of growing epidemics. A primary target for analysis is the normative framework, in particular the M&E frameworks of the major United Nations and financing institutions in the response to HIV, as well as the issues raised by the efforts to implement the Paris Declaration and promote aid effectiveness.

The second chapter is the summary report of the Expert Group Consultation, which looked closely at issues of tracking and monitoring gender equality and HIV/AIDS in the context of aid effectiveness. The meeting aimed to push the boundaries of current thinking at the local and global level to focus on how responses are failing women and to formulate concrete strategies for doing better. Experts from civil society, think-tanks, national AIDS programmes, women’s advocacy groups, multi-lateral institutions and the United Nations came together to share the tools for analysis they have been using, developing and advocating for at national and regional levels; this meant examining new frameworks for analysing the challenges and translating those frameworks into practice in concrete ways.

One of the presenters was Luisa Orza of the International Community of Women Living with HIV/AIDS (ICW), and in the third chapter she describes the work ICW has been doing to empower women to analyse the conditions under which local programming fails them, and to develop concrete advocacy entry points through a facilitated process. The outcome is a tool for ‘reality-checking’ women’s realities against government commitments, including to universal, discrimination-free access to prevention, care, treatment and support. The realities facing ICW members, the process of developing and applying the tool, as well as plans for future advocacy are all outlined here. Central to the problem described by Orza is the failure of the model that often determines how local responses are designed. Part of the failure involves rendering those shortcomings invisible, as Orza makes clear.

Carol Underwood, also based on her presentation, tackles the conceptual framework in which women’s realities become visible and can become more responsive to those realities. While Underwood does not invent new concepts – her paper is based on unpacking the social ecological model – it does propose a concrete alternative to prevailing models that remain the ultimate reference point for programming, funding and assessments of progress in the response. In particular, Underwood makes clear how the fundamental focus on the individual of existing responses that in turn set up M&E frameworks – for example condom or knowledge indicators – fails women because it does not take into account the extent to which women’s (and everyone else’s) choices are circumscribed by power differentials and complex intervening factors that deter individualistic solutions to risk reduction.

The contribution from the European External Policy Advisors, chapter 5, provides an analysis of indicators used and promoted by the European Union for evaluating access to key services for women and documented in toolkits and programming guides. These guides in turn have been used in a wide range of countries including Cameroon, the Democratic Republic of Congo, Ethiopia, Ghana, Honduras, Indonesia, Kyrgyz Republic, Nepal, Nicaragua, Papua New Guinea, Suriname and Ukraine. The paper recounts work already done on developing indicators for access to essential services and that address key drivers of women’s vulnerability. These include:

1. Infant mortality
2. HIV and AIDS (in relation to reproductive health)
3. Maternal mortality
4. Skilled attendance at birth
5. Family planning/contraception
6. Violence against women
7. Fertility
The Annexes provide important source material for those wishing to make substantive progress on bringing together the collective learning on making programming more responsive to women and girls. The first provides a brief review of indicators related to gender and HIV/AIDS, sexual and reproductive health and rights, and violence against women culled from international agreements. The agreements to which these monitoring tools correspond include the Millennium Development Goals, the Declaration of Commitment on HIV/AIDS, the Beijing Declaration Platform for Action, CEDAW and the Programme of Action from the International Conference on Population and Development (ICPD). The second is an annotated bibliography of institutions that have developed indicators to assess baselines and progress on women’s programming.

An important additional multi-media resource is provided with the first edition of this publication, as well as online (http://www.genderandaids.org). It provides insights and recommendations from the Expert Group Consultation, in the Dominican Republic, and voices and lessons from promising practices in the vanguard of women’s programming. It looks in particular at the intersection between violence against women and HIV; at aid effectiveness and the need for funders to address the intersections of violence against women, HIV, sexual reproductive health and gender; and at best practices in programmatic solutions to addressing these intersections.

There is no doubt that the process of transforming the policy framework in responding to women’s realities and rights is as urgent as it is overdue. We know this. It is embedded in the Political Declaration of 2006 and in the Declaration of Commitment made at UNGASS as well as in many situational analyses at the country and regional levels. The challenge ahead lies in holding the system accountable at the global level, even as we take responsibility for supporting – in designing and funding (and learning from) our M&E frameworks – work on the ground where our policy frameworks have their most important effect.
WALKING THE WALK
Closing the Programmatic and Financing Gap on Gender Equality, Violence against Women, and Access to Sexual and Reproductive Health Services in the Responses to HIV and AIDS

Robert Carr
Caribbean Centre of Communication for Development
Caribbean Institute of MEDIA and COMMUNICATION
University of the West Indies

Introduction

The chasm between what we know and what we do, between our ability to end poverty, despair, and destruction and our timid, often contradictory efforts to do so lies at the heart of the problem. The targets and indicators set by the Goals are framed in technical, results-oriented terms. But the response cannot be simply a technical one, for the challenge posed by the Goals is deeply and fundamentally political. It is about access to and the distribution of power and resources within and between countries; in the structures of global governance; and in the intimate spaces of families, households, and communities.¹

Millennium Development Task Force on Child Health and Maternal Health

“I tell you, the girls don’t got no say. When a fella wanna to do it he says ‘come, lets do it,’ and they just go along. The girls don’t say, ‘let us use a condom,’ they don’t say nothing. They are frightened that they will get beaten. A lot of them get beaten by their older men. In town you can see them getting beaten, cruel so, even in front of their friends. They go with big men and the man just beats then and don’t give them nothing, all the time, and then they go back and do it again, again, and again.”²

Adolescent Young Woman, Barbados

The epigraphs that open this paper lay bare the dilemma in addressing the cultural and political realities that have become clearer with the growing proportion of women and girls living with HIV in the developing world. At the macro level, progress towards globally agreed targets stymied by entrenched power interests that resist changes to the status quo. At the micro level, the vulnerability of women and girls is part of interpersonal struggles over power, access to resources, and the desire for intimacy at the heart of many sexual relationships.

This paper was commissioned by UNIFEM as the background document for the Expert Group Consultation on Tracking and Monitoring Gender Equality and HIV/AIDS in Aid Effectiveness, held 28-30 May, 2008 in Santo Domingo, the Dominican Republic. The meeting was held as part of a broader effort by UNIFEM and the European Commission to address the vulnerability of women and girls in the context of HIV and AIDS, and the need for policy, programmatic and financing responses that build on an understanding of the role that gender-based violence and compromised access to sexual and reproductive health play in increasing that vulnerability. With the redefining of the principles of international development assistance, agencies at the national, regional and international levels, including UNIFEM and UNAIDS, have been very concerned that issues affecting women and girls will slip off the international development agenda. Already progress on addressing entrenched and often culturally and institutionally sanctioned discrimination and inequalities has been uneven.
Particularly since the Political Declaration on HIV/AIDS, agreed to by Member States in 2006, there has been a great deal of emphasis on addressing the vulnerability of women and girls to HIV. As a critical factor in both vulnerability and resilience, gender has come to take a central place in concerns about the impact of HIV, including disproportionate burden of care that falls on women and girls because of existing gender roles. This work builds on key milestones in women’s rights agreed to by many States – the Beijing Declaration and Platform for Action and the Convention on the Elimination of All Forms of Discrimination against Women (CEDAW) in particular – that outline principles and actions to address gender inequality. Alongside more HIV-specific agreements and guidelines – the Declaration of Commitment on HIV/AIDS (2001), the Political Declaration (2006) and the International Guidelines for Human Rights and HIV (consolidated in 2006) – the global dialogue has reached important consensus on both the urgent need for action and the forms that action should take.

Gender analysis has become an important part of contextual analyses of drivers of HIV, with a particular emphasis on unequal gender relations and cultural norms of power and decision-making in regard to when and how sex takes place in heterosexual relationships. More recently those analyses have pointed to the pressure on men and boys to conform to machismo models of manhood that also narrow choices and exacerbate risk-taking. Reviews of action on gender in HIV programming show, however, that there is a gap between the analyses and the responses. Some country plans are notable for tackling structural issues directly, such as addressing inequalities embodied in legislation or policy, but most national responses to HIV and AIDS see women through a public health lens: either as mothers of unborn children or as sex workers at high risk for sexually transmitted infections.

Yet, recent developments have shown that progress is being made at least in some aspects of programming. For example, some country reports produced for the 2008 High-level Meeting on AIDS (the review of progress made towards the 2001 Declaration of Commitment on HIV/AIDS and the 2006 Political Declaration on HIV/AIDS) include an analysis of sex-disaggregated data. The recent decision by the UNAIDS Programme Coordinating Board to request the development of tools to support national-level action on women, girls and gender inequality, as well as the recent inclusion of technical guidance on gender in the Round 8 call for proposals of the Global Fund – a donor most often at the least directive end of the programmatic guidance spectrum – indicate progress in the struggle to make women’s inequalities visible and make national and global development planning accountable to women.

There is now growing interest in pushing into new areas of strategy and innovative programming that can address gaps in national and international responses, including an interest in identifying what works. Traditional entry points for programming, such as Prevention of Mother-To-Child Transmission plus (PMTCT+), sex worker HIV prevention, home-based care, and advocacy are being re-examined for new lessons and opportunities. The focus on overcoming structural vulnerability has become the frontier for new thinking of how to drastically curtail new infections and mitigate impact.

With the advent and scaling up of the Global Fund, the increased investment by the Gates Foundation, the scaling up of the President’s Emergency Plan for AIDS Relief (PEPFAR), the innovative work supported by the Open Society Institute, and other multilateral and bilateral funding opportunities, funding resources for HIV and AIDS responses are greater than ever, although still not sufficient and still unevenly distributed. The inadequacy of that funding has been the subject of heated and sometimes misguided debates that have pitted treatment programmes in the health sector against broader health systems strengthening. Although this debate has often been counterproductive, it highlights how the fiscal envelope is structured in official development assistance (ODA), and raises questions about what we mean by ‘sustainable health development’ and whether the Three Ones principles are observed in practice so that ODA for HIV responses strengthens primary health systems even as it allows for disease-specific responses.

Despite the increasing amount of funds, however, women’s realities are not being addressed at the national level (UNIFEM Caribbean, 2007). The ‘one life, two diseases’ approach now being advocated for addressing HIV and tuberculosis dominates. In the attempts to coordinate (and simplify) development assistance processes, through mechanisms such as the International Health Partnership Plus (IHP+), the impact of gender inequality as a driver of HIV has been largely hidden.
Programmes addressing the intersections between HIV, gender-based violence and access to sexual and reproductive health care and rights are rare. These intersections too often remain invisible or, where visible, unaddressed, pointing to the persistent gap between knowledge and behaviour in commitments made by governments and conditions of ODA on the one hand and the actual needs of women on the other. A comprehensive approach would allow for synergistic approaches to addressing gender-based violence, sexual and reproductive health services and rights, and HIV.

The issue of the content of ODA agreements is also important as we look to the commitments of the 2006 Political Declaration and the Millennium Development Goals (MDGs). Analyses conducted by women’s groups, governments and the United Nations have consistently shown that women’s labour, knowledge and struggles to sustain families and find creative solutions are central to poverty alleviation among the extreme poor. This emerges clearly in reviews of the survival strategies of the urban poor from across the South— for instance, in UN HABITAT’s global review of living conditions in major urban slums, *Tomorrow’s Crises Today.*

The Political Declaration on HIV/AIDS is clear on the connection between HIV and gender-based violence. The critical areas for concern in the Beijing Platform for Action and the scope of the articles of CEDAW lay out interconnected domains of women’s empowerment that underlie the higher or increasing infection rates among women and girls. As we shall see later, they are rarely referred to in HIV monitoring and evaluation (M&E) frameworks.

Initiatives to strengthen health systems broadly, under the umbrella of implementing the Paris Declaration, are designed to tackle these systemic failures to address the health needs of women and children. Having moved beyond a false antimony between vertical programming for AIDS and broader health systems strengthening, the debates now are about how sector-wide approaches (SWAp) can provide better access to improved health systems and programming for women after decades of promises that, on the whole, have not been realized. This will take sustained commitment from governments, donors, civil society, and United Nations partners to work in tandem on programme design, implementation and financing.

Three recent reviews of ODA financing for gender equality have shown a poor record of progress, with many programmes skirting the vulnerabilities facing women and the extent to which current dominant methodologies, such as the much-touted ‘ABC’ approach, do little to empower women who are most vulnerable to HIV or AIDS to protect themselves from contracting HIV (Carr, 2007; Fried, 2007; Oomman, Bernstein and Rosenzweig, 2007). Just as consistently, however, national strategies themselves fall short of programmes designed to address women’s vulnerabilities substantively.

It is critical that the new aid architecture, such as the initiatives stemming from the Paris Declaration, which is structured to avoid targeted funding in favour of sector-wide approaches and country compacts, pays particular attention to how women’s inequalities are addressed in the emerging programmatic and financing agreements. It is not a given that progress on women’s equality and recognition of rights will emerge from country compacts. Indeed, as the donor and United Nations communities step back from facilitating national dialogue, they should still find or create entry points for the voices of advocates for rights-based programming, including civil society and service providers, so they do not become marginalized programmatically or financially.

The first section of this paper explores what we know of the vulnerabilities of women and girls to HIV and AIDS in the context of restructuring aid modalities, based on research and analyses undertaken by women’s organizations, government agencies, women’s bureaus, the United Nations system, and donor agencies. In the second section, the paper examines established foundational issues and guiding principles for programming in the areas of gender equality, HIV/AIDS, violence against women, and sexual and reproductive health and rights. It then turns to look at some of the indicators that have been developed by key agencies and at two interventions, one programmatic and the other budgetary. Finally, the paper summarizes the opportunities ahead and next steps.
Knowing Our Epidemics Among Women and Girls

Women’s susceptibility to HIV is exacerbated by unequal power between women and men and the use of violence to sustain that imbalance, which limit women’s ability to negotiate safe sex.

UN Special Rapporteur on Violence Against Women

In its 2007 AIDS Epidemic Update, UNAIDS estimates that globally the proportion of women to men living with HIV remained stable between 2001 and 2007, although the number of those infected increased by about 1.7 million. Behind this statistic however, UNAIDS reported a complex mix of sexual realities, including HIV transmission to women from men who were infected through unprotected sex, including unprotected paid sex and/or sex with other men, and/or unprotected sex with people who use drugs.

The situation is not the same in all parts of the world. In sub-Saharan Africa, almost 61 per cent of adults living with HIV in 2007 were women, while in the Caribbean that percentage was 43 per cent (compared with 37 per cent in 2001). The proportions of women living with HIV in Latin America, Asia and Eastern Europe are slowly growing, as HIV is transmitted to the female partners of men who are likely to have been infected through injecting drug use or during unprotected paid sex or sex with other men. In Eastern Europe and Central Asia, it is estimated that women accounted for 26 per cent of adults with HIV in 2007 (compared with 23 per cent in 2001), while in Asia that proportion reached 29 per cent in 2007 (compared with 26 per cent in 2001).13

Figure 1: Percentage of adults (15+) living with HIV who are female 1990–2007

(Source: UNAIDS, 2007)

If we avoid the temptation to focus on percentages as a rationale for action and place greater focus on the dynamics of vulnerability or situations of high risk of infection within fast-growing epidemics, what emerges is the influence of women’s relationships to the men they love – or to the men who have, one way or another, sexual access to their bodies, on their vulnerability. Access to women’s bodies is directly related to a complex mix of love and the need for intimacy at one pole and coercion on the other.14 Women’s vulnerability takes place in a cultural context.15
Situations that put women at greater risk of infection are wrapped up in pervasive and accepted ideas of what it means to be a woman, and in particular, a ‘good’ woman. As Gupta, Whelan and Allendorf (2003) put it: “By defining the societal ideals of feminine and masculine behaviour and sexuality, gender norms greatly affect women’s and men’s access to information and services, their sexual behaviour and attitudes, and how they cope with illness once infected or affected” (p. 10). Bearing in mind the multiplicity of masculinities and femininities available, the authors identify areas of concern that gain particular importance because of the role they play as reference points in our responses to HIV and AIDS. They also critique the assumptions underlying these reference points and show how the suppositions underlying some traditional strategies do not apply to many women and in fact undergird the 1.4 million new infections among women reported by UNAIDS between 2001 and 2007.16

While many of these concerns are familiar, listing them here provides an important reminder of some of the key issues that must be addressed if we are to reduce the escalating infections among women and girls:

**Knowledge of Sex and HIV Risk** – women consistently report lower levels of knowledge about HIV prevention.

**Fidelity vs. Multiple Partnerships** – the ideal of the good woman promotes fidelity for women, whereas the ideal of the ‘real’ man promotes multiple partnerships.

**Motherhood as the Ideal** – there is pressure on women to see their role in society as reproduction, and the attendant battles with family and States to control women’s right to manage their reproduction.

**Dependence vs. Self-Reliance and Sex as a Marketable Commodity** – social norms are often embedded in law and cultural imperatives that establish the man as the head of the household, and give him control over resources within the household and access to resources outside the household, including access to sexual and reproductive health services.

**Sexual Domination, Homophobia and Violence Against Women** – the pressure to conform to cultural norms of appropriate masculinity as male sexual power over women, implicit in some contexts and explicit in others, and the fear of social outcasting often leads men to hide behind sexual relationships with women while secretly having sex with other men. That same notion of appropriate masculine behaviour supports and protects men who beat women as appropriate assertions of the masculine domain.

**Access to Services** – in many developing country contexts women’s access to services is wrapped up in power relations with the men who dominate the household and, for children, preference is sometimes given to boys over girls.

**Impact of Migration** – women and men who migrate often face restricted access to services and assets, as well as to information. Social and family support systems are often disrupted. For men and women moving in search of economic opportunities – both real and imagined – new sexual networks are often formed that increase vulnerabilities. Within these new networks, the factors listed above are also still very much in play.

**Impact of Ethnicity, Caste and Race** – women and men from socially marginalized or excluded groups face compounded limitations on access to resources, including health services, and other support services and resources.17

Women who confront gender norms and rebel against them face resistance. A woman’s sexual autonomy can become justification for her exclusion from social support systems, and in the case of sex workers, exclusion from protection by the law. For dissenting women – for example sex workers or women who have sex with women – sexual violence is sometimes seen as something they brought on themselves, a logical consequence of their choice of sexual autonomy.18

Women’s experience with HIV and AIDS is in the context of gender norms. Women living with HIV face greater stigma and discrimination than men. In some contexts it is commonplace for women to be accused by their partner’s family of
bringing HIV into the household. Perhaps not coincidentally, there are reports from sub-Saharan Africa of women being reluctant to get tested for HIV or to return for their results because of a fear of domestic violence. AIDS also disproportionately impacts women and girls because of the very dynamics articulated above: women and girls are expected to be the caregivers, regardless of whether they themselves are also ill. Widows in some cultures, are vulnerable to being cast out of their households by their dead husband’s family. These situations reflect the distribution of power and resources, and individuals and households negotiating their own socio-cultural and political contexts.

The connections between HIV and violence against women have been the subject of a great deal of research and advocacy. A literature review by the Harvard School of Public Health (2006) reports that:

HIV infection as relevant to GBV [gender-based violence] is primarily acquired through sexual relations, which themselves are greatly influenced by socio-cultural factors, underlying which are gender power imbalances. Gender based violence, or the fear of it, may interfere with the ability to negotiate safer sex or refuse unwanted sex. Furthermore, violence against a woman can interfere with her ability to access treatment and care, maintain adherence to ARV [anti-retroviral] treatment, or carry out her infant feeding choices. Evidence also exists that living with HIV can constitute a risk factor for GBV, with many people reporting experiences of violence following disclosure of HIV status, or even following admission that HIV testing has been sought. Thus a vicious cycle of increasing vulnerabilities to both GBV and HIV can be established. (p. 7)

Despite research showing the strong linkages between violence against women and HIV and AIDS, it rarely finds its way into the responses to HIV and AIDS. In Women Won’t Wait, Fried (2007) makes the case that:

Two pandemics threaten the health, lives and rights of women throughout the world: one is HIV&AIDS and the other is gender-based violence against women and girls. Violence against women and girls is a major contributor to death and illness among women, as well as to social isolation, loss of economic productivity, and loss of personal freedom. Research confirms that violence, and particularly intimate partner violence, also is a leading factor in the increasing “feminization” of the global AIDS pandemic, resulting in disproportionately higher rates of HIV infection among women and girls. Simultaneously, evidence confirms HIV&AIDS as both a cause and a consequence of the gender-based violence, stigma and discrimination that women and girls face in their families and communities, in peace and in conflict settings, by state and non-state actors, and within and outside of intimate partnerships. (p. 1)

This snapshot of the situation of women and girls is important for its identification of intertwined factors that are the focus of concern for our discussions. While there has been research on the intersections between violence against women and girls, including sexual violence, there is still a dearth of programmes addressing this, and too often those dealing with violence against women and those dealing with HIV operate in separate spheres to the detriment both of women and girls in need of services and of the programmes designed to support them. “Poverty, illiteracy, and gender power imbalances within families and communities limit women’s access to preventive care, drugs and treatment. Such treatment is critical not only to easing the burden of the disease, but to shielding women from further abuse.”

Understanding the barriers to women’s access is essential. The Millennium Development Task Force on Child Health and Maternal Health (MDG’s 4 and 5) described how despite the billions spent in development aid with the intention of improving the health and quality of life of women and girls in developing countries, the situation, according to major multilateral organizations, is at crisis levels.

The Task Force also made the point that “behind the failure of health systems lies a deeper, structural crisis, symbolized by a development system that permits its own glowing rhetoric to convert the pressure for real change into a managerial program of technical adjustments.”
Reviewing Calls for Change and Programmatic Transformation

HIV prevention strategies must be broadened so that they better respond to the challenging contexts of women’s lives. This means moving beyond only “ABC” to address the underlying vulnerabilities faced by women, including by expanding affordable access to prevention options that women can initiate and control.

Global Coalition on Women and AIDS

Given the analysis of the ways in which denying women and girls their rights undermines their ability to reduce their risk of contracting HIV, the critical next step is to examine key recommendations emerging from research and advocacy. These calls to action represent a consensus from women’s organizations, the United Nations and other partners, and provide important content for national programming aiming to increase the resilience of women and girls in relation to HIV, improve access to responsive sexual and reproductive programmes, and end gender-based violence. They are also intended to set the stage for action.

Calls for change in addressing women’s empowerment and gender equality in the context of HIV and AIDS propose a broad range of domains where action is vital. For example, the review paper on Integrating Gender into HIV/AIDS Programming distributed in the UN system’s Resource Pack on Gender and HIV/AIDS (2003) adopts a broad-based framework for action.

- **Do no harm** - the elimination of those assumptions, suppositions and stereotypes that are damaging to women’s and men’s ability to benefit from interventions and policy responses to HIV/AIDS.
- **Gender sensitive programmes** - prevention, care, treatment and support needs of men and women are often different, not only because of their distinct physiology, but more importantly, because the context of gender roles and relations substantially influences how women and men will respond to initiatives designed to reduce risk or vulnerability or to alleviate the impact of AIDS.
- **Transformative interventions** - transform gender roles and [HIV initiatives to] create more gender-equitable relationships [as] they seek to change the underlying conditions that cause gender inequities.
- **Interventions that empower** - seek to equalize the balance of power between women and men in order to reduce their vulnerability [and] tend to treat HIV/AIDS within a larger context of social and economic development.

The framework also makes the point, however, that technical programming cannot succeed without addressing structural elements for gender integration, which requires: political will and leadership; integrating gender into HIV and AIDS programmes; allocating appropriate financial resources; ensuring that technical knowledge and gender expertise exist at all levels and departments of institutions; ensuring effective data collection; implementing an institutional incentive system that rewards employees for addressing gender; and, finally, monitoring and evaluation.

Common to the many calls to action is the wide spectrum of factors that need to be addressed, as well as the focus on underlying issues. The United Nations Special Rapporteur on violence against women, its causes and consequences highlights the urgency of addressing violence and coercion as factors in HIV transmission.

Select recommendations from her Report are as follows:

- National policies and action plans would be vastly more effective if they acknowledged and acted on the interconnectedness between the two pandemics of HIV and violence against women;
- Complement legislative reforms and empowerment programmes with ‘cultural negotiation’ campaigns to raise awareness of the oppressive and discriminatory nature of certain practices pursued in the name of culture;
- Conduct gender-sensitivity campaigns to address violence against women as a product of larger power imbalances between the genders, and dispel male and female stereotypes that encourage violent behaviours;
• Enact or revise general anti-discrimination laws compatible with international human rights instruments, as well as the International Guidelines on HIV/AIDS and Human Rights (HR/PUB/98/1), in particular concerning all persons living with HIV/AIDS, protect against involuntary HIV testing, guarantee confidentiality of results in all sectors and ensure women’s rights to sexual and reproductive health, including their reproductive choice;

• Ensure comprehensive care for survivors of sexual violence, including the use of ARV drugs known as post-exposure prophylaxis (PEP). PEP can protect against HIV infection if administered immediately after intercourse or sexual assault. In situations of conflict and emergency, PEP should be provided as part of reproductive health kits available to IDPs [internally displaced persons] and refugees.

• Ratify international human rights treaties, in particular the Convention on the Elimination of All Forms of Discrimination against Women (CEDAW) and its Optional Protocol;

• Provide women and girls equal access to literacy, education, skills training and employment opportunities;

• Strengthen women’s economic independence, including through access to land, credit, agricultural extension, right to inheritance, and business and leadership skills training;

• Support women in their care-giving roles to alleviate the disproportionate burden of AIDS care that largely falls on them, through training, social protection mechanisms and financial support; and

• Adopt gender budgeting in all budgetary plans and allocations. (E/CN.4/2005/72; para 84)

These items address key structural issues that target the wider environment as well the technical components of programmes. For success, political commitment and action is central.

The Global Coalition on Women and AIDS (2007) advocates for similar action items, focusing on a rights-based framework and programmatic support backed up by commensurate financial commitments. It argues for States to:

• Secure women’s rights
  • Ensure that laws – whether statutory, de jure or customary – protect women against violence and uphold their right to own and inherit property.
  • Invest in strategies to educate the police, the judiciary, social service providers, civil servants and community leaders about laws and their legal responsibilities.
  • Develop and fund programmes to improve legal aid services and other forms of support so that women can claim their rights.

• Invest more money in AIDS programmes that work for women
  • Review and adapt existing AIDS strategies to ensure they work for women.
  • Expand access to the services women need – including education, sexual and reproductive health, antenatal care, prevention of mother-to-child transmission, and antiretroviral therapy.
  • Close the funding gap for microbicide development and the female condom.
  • Drastically scale up support to caregivers.

• Allocate more seats at the table to women
  • Review the membership of national AIDS coordinating bodies to ensure the meaningful representation of women and people with gender expertise.
  • Invest more in training women, especially those living with HIV, to be effective advocates and leaders in the AIDS response.
These action points echo, in some regard, the MDGs (for example, in leadership targets) and focus on structural challenges, programmatic components and the integration of women’s organizations into the national responses. They call for addressing social and political norms, creating a supportive environment for change, and a clear understanding of the interconnectedness of HIV and violence against women and girls, as well as the importance of women’s access to sexual and reproductive health and rights.

What is not addressed by either of these calls for action is the lack of health infrastructure through which women’s rights to health can be channelled. Although it is not often looked at in this light, health systems strengthening is the basis for realising this central, if sometimes forgotten, core right of women, children and men. In this regard, the recommendations of the Millennium Development Task Force on Child Health and Maternal Health are critical. They begin from the premise that “health systems must be understood not only as mechanisms for delivering technical interventions but also as core social institutions that are indispensable for reducing poverty, social exclusion, and inequity and advancing democratic development and human rights” (2005. p. 153). The Task Force suggests how health systems can play the central role accorded to them in achieving well-being and development.

The Task Force’s focus on health as a central point for women, and as a right that must be respected by national governments as well as by donor institutions, challenges traditional advice that freezes health care systems and rolls back health care protections in the name of fiscal responsibility. By positioning health care as a right and a central driver of development, and health care for women as an integral function of effective and efficient development policy, the Task Force challenges the marginalization of women’s health in the sphere of national and international macroeconomic policy as health care for women has earlier been challenged in the spheres of jurisprudence and the justice system.

Programmatic transformation is not successful when policy guidance relies on ideology rather than science and attempts to control women’s bodies. There have been many critiques of the fundamental inadequacy of the ‘ABC’ approach in protecting women and girls from infection. The same is true where access to sexual and reproductive health is severely compromised in the name of ideology; one of the most famous instances is the Mexico City Policy, more commonly referred to as the ‘Global Gag Rule.’ Indeed, policies that promote abstinence and being faithful and deprecate condoms, combined with a blind anti-trafficking agenda that requires recipients to adopt an anti-sex work position, have all converged on the frontlines of health care delivery to women and girls in poverty. Governments are dissuaded and NGOs constrained from working according to their conscience to support the rights of women and girls in favour of ideological positions imposed by some donors.

One impact assessment of this policy from the frontlines of Kenya finds that:

By crippling the country’s primary reproductive health care providers, the gag rule has undermined HIV/AIDS prevention efforts in Kenya. Given that HIV/AIDS is primarily transmitted via heterosexual sex, a crucial link exists between HIV/AIDS and basic sexual and reproductive health care. Family planning providers, then, play a key role in HIV prevention. Unfortunately, because of the gag rule and an increasing focus on HIV/AIDS, donors and policymakers have sidelined their support of reproductive health care providers.24

The gag rule thus sets up a false dichotomy between access to HIV prevention and care services and sexual and reproductive health services, when in fact the two are intimately connected. In the end, hardest hit are women and girls seeking health care.

Health care policies that ignore the realities of gender-based violence endanger women. For example, Voluntary Counselling and Testing (VCT) protocols for women that ignore violence against women can increase women’s real and perceived risk of violence and social exclusion.25 This blindness is itself based on side-stepping the extent to which violence against women pervades societies and intimate relationships.26 Such blindness prevents effective access to information, resources, and services for women and girls.
The recommendations by the Special Rapporteur, the Global Coalition and the Millennium Development Task Force indicate the breadth of work required to move from research and analysis to action. In many cases indicators drive programming, directing focus and signalling agreement on priorities for outcomes and for impact, as much as for process. To develop an M&E framework that matches the insights contained in calls to action, patterns emerging across donors and agencies must be examined to see what is being addressed and to locate the short-comings in monitoring progress to promote women's empowerment in the face of the epidemics. The power of the evaluation process and of agreed indicators can be used to challenge the response system and move from rhetoric to action.

The key issue, beyond the provision of services, is addressing the formal and informal political climate within which women's programming is designed, funded and executed. The report of the Millennium Task Force on MDG3 addresses the main barrier to effective responses: “Because gender inequality is deeply rooted in entrenched attitudes, societal institutions, and market forces, political commitment at the highest international and national levels is essential to institute the policies that can trigger social change and to allocate the resources necessary to achieve gender equality and women's empowerment.”(p. 1)

Civil society calls mirror precisely the same concerns, from the ‘Statements of ICW’ written in 1992, to the Nairobi 2007 Call to Action, to 2008’s ‘HIV/AIDS and Human Rights: Now More Than Ever.’ The UNAIDS paper on ‘Integrating the prevention of violence against women and PEP into the HIV Programmes’ is a breakthrough in this regard. The challenge is to unblock the move from knowledge to action. It is critical to confront policy evaporation in the move from analysis to action in design, funding, and monitoring and evaluation. An important step in addressing the effectiveness of aid must be the re-examination of how progress and impact on women and girls is evaluated, and how the measuring sticks reflect what is necessary for the realization of change. Having talked the talk, are we walking the walk?

**Brief Analysis of Issues Covered and Gaps in Established Indicators for Women and HIV and AIDS Programming**

Increasingly, women are dealing with the way violence puts them at greater risk of contracting HIV while women who are HIV-positive are more likely to be targets of violence because of additional layers of discrimination and stigma they face as a result of their health status. The impact of both HIV&AIDS and violence against women is exacerbated by inadequate services and protection of sexual and reproductive health and rights; laws that are weak or discriminatory toward women and people living with HIV&AIDS; social and community standards that validate gender inequality and the subordination of women; and the forms of multiple discrimination faced by women and girls because of their race, language, sexuality, ethnicity, and other, similar factors.

Women Won’t Wait Campaign

A review commissioned by UNIFEM of M&E indicators on gender and HIV, sexual and reproductive health and rights, and violence against women provides a revealing overview of the ways in which governments, United Nations agencies and private institutions have tried to measure progress on these issues. The analysis undertaken for this paper has made it clear, however, that on the whole HIV programming has failed on two main fronts: addressing the vulnerability of women and girls to HIV and AIDS, and addressing the intersections between that vulnerability, violence and meaningful access to sexual and reproductive health and rights.

Indicators have a powerful effect in directing programming focus and in establishing accountability across the system: for governments, civil society groups, donors and United Nations organizations. The challenge is to establish a manageable set of indicators that can guide programme outcome and impact to ensure that the needs and priorities of women and girls are effectively met in the responses to HIV and AIDS.
A UNIFEM mapping of the existing indicators for the Expert Group Consultation shows that most of them are focused on health, with scant attention paid to activities to increase women’s rights: their access to voice, resources, services and information. As other reviews have shown, most of the recommendations designed to remove barriers to effective prevention, care and treatment for women disappear in the shift from research and analysis to policy and programming. At the level of indicators – which measure core results expected – it is as if they had never existed.

Two examples of the evaporation of structural recommendations are the indicators for the Declaration of Commitment on HIV/AIDS (2001) and the MDG indicators themselves. Both fall far short of what the assessments, research and declarations have established as central for action. Of even greater concern, is the fact that the conceptual framework on which they are based is inimical to meaningful progress on reducing vulnerability and increasing resilience among women and girls, including recognizing the role of violence and coercion in women’s lives and sexual realities, and addressing access to sexual and reproductive health services. For example, the indicators contained in the Declaration of Commitment and the Political Declaration focus on knowledge (on the assumption that this will lead to changes in behaviour), forgetting the role of power in sexual relationships. The same is true for measures that ask about condom use at last sex. Other indicators measure who is getting tested and collecting their results. This may violate women’s rights and compromise their safety if violence is not taken into account in both testing protocols (for example, in decisions about couples testing) and in care and support systems and models. Another indicator, which encourages donors and national programmes to test pregnant women as an entry point to anti-retroviral therapy, exists in a cultural and political vacuum. Support models should include access to crisis intervention and domestic violence services where needed, and sensitization and intimate partner violence policies that bind security forces and reward compliance. These concerns are not reflected in the indicators for either the Declaration of Commitment or MDG6 on HIV.

Consequently such programmes will also be few and far between, as well as underfunded, at the national level. The focus on biomedical indicators is no doubt part of the legacy of HIV responses based on the biomedical model, and an approach tied to uptake of health services and interventions evaluated through knowledge, attitudes and practices (KAP) surveys.

Indicators for addressing gender-based violence similarly revolve around prevalence analyses of violence against women, and include a broader range of sectors and responses: legislation, the existence of support systems and their uptake, legislative frameworks and spending on violence against women. Female genital mutilation as an extreme form of such violence receives special focus. There are only a few indicators so far measuring the intersection of violence against women and HIV.

Indicators for gender-transformative HIV programmes could be informed by the diversity of violence against women indicators that ensure the key domains are addressed. Such a mix would challenge HIV and AIDS response systems to move from the status quo of acknowledging gender differences, which too often is interpreted as counting women and men tested or employing prevention models based more on ideology than evidence of constructive impact, towards interventions that empower women and men to make healthier choices about their sexual and reproductive health and about social and sexual relations that are more respectful of women’s rights.

Indicators for sexual and reproductive health show a similar trend in that they are based on tracking access to sexual and reproductive health services and KAPs regarding these services. In addition, the indicators address state processes for identifying and supporting such access, the range of services available to women and girls, and under what circumstances those are identified. The indicators also track financing, policies and legislation and have a special concern for maternal health and for a woman’s right to control her own fertility, including state attempts to control such rights and the consequences of such control efforts, including deaths. Unfortunately, there are few indicators addressing women’s rights and even fewer measuring the integration of HIV and sexual and reproductive health.

The challenge is for the indicators to support and even foster breakthroughs in comprehensive programming that have an impact on women’s needs. The range of expert recommendations described in the next chapter, provides a rough guide to the sectors in which progress needs to be measured. It is critical that indicators cross a range of sectors, the very domains established as central to an effective response and to the calls to action. While HIV programming can look to the
multisectoral nature of violence against women and sexual and reproductive health indicators as a model. Programmers in all three of these areas need to develop new indicators or adjust existing ones to capture the intersections between them. Advocacy efforts should also bring increased attention to the intersections of HIV and violence, and HIV and sexual and reproductive health in the lives of women and girls.

Examples of the spectrum of areas requiring urgent intervention and indicators, based on the national dynamics of epidemics, are:

- prevalence, incidence and death related to HIV, including TB;
- legislative and policy frameworks that prohibit stripping women of their rights by spouses, families or other forces, with a special focus on widows, and legislation against violence against women;
- access to a meaningful range of HIV, AIDS, violence and reproductive health services that recognize women's realities and so address power issues within couples and households, women's disproportionate responsibility for care, and women's realities in accessing treatment and support;
- utilization of those services, including uptake of integrated or networked services delivered by a range of providers, sexual and reproductive health rights and services, support systems for violence against women, PMTCT+, proactive and protective services for women's rights, and access to resources;
- cultural attitudes towards equality for women, recognizing that programmes addressing stigma and discrimination as a barrier in the response to HIV also need to address stigma and discrimination based on sex, as well as sex and HIV status together/ (for example, an HIV-positive woman's right to reproductive choices); care must be taken so stigma and discrimination programming does not become a substitute for respecting human rights;
- support for research and development, as well as promotion and distribution of HIV prevention and mitigation commodities and services that empower women and girls to make choices on their own behalf, such as microbicides, female condoms, water-based lubricants and other proven tools combined with developing capacities and skills in negotiating the use of such tools; and
- gender-responsive budgeting for all development programmes, recognizing that the range of domains in which action is needed must also be resourced.

This will require:

a. ensuring programmes take into account how the gender dynamics of national epidemics affect women and girls;

b. identifying, in consultation with a spectrum of actors including government, women’s bureaus, community organizations, researchers, gender equality and women’s rights advocates and United Nations partners, a package of evidence-based services and service providers;

c. designing and financing mechanisms that can link those services to provide a supportive system to empower women and girls and transform unequal gender relations;

b. implementing a system to ensure that such support systems are being effectively utilized by women who need them; and

e. identifying mechanisms to facilitate change of adverse cultural norms and practices.

A core task of the expert meeting was to identify outcome and impact indicators for measuring changes in the vulnerability of women and girls. This can trigger reflection on effective programming, on appropriate processes for identifying programming packages and providers, and on measures of success. These indicators can thus complement risk reduction indicators, such as those provided by KAPs surveys, as well as prevalence, incidence, service utilization and mortality indicators. This is the only means to the realization of MDG6 to “combat HIV” and MDG3 on women's equality, and in countries with growing epidemics, the first seven MDGs by means of the 8th, “a global partnership for development”, that holds development partners, especially national governments, accountable to their commitments to equality for women and girls.
Evaluation Lessons from Innovative Programmes: A Case Study of IMAGE, South Africa

Evaluation can help to understand areas of focus, help to identify expectations, and push our learning curve on bridging the gap between analysis and knowledge on one hand, and action on the other.

An important example of this is the IMAGE programme from South Africa which is an example of programme design that addressed multiple domains and had a strong evaluation component.

Intervention with Microfinance for AIDS and Gender Equity Study (IMAGE) was a three-year programme designed to address women’s access to resources and strengthen women’s resilience in HIV prevention and to intimate partner violence. It was a joint effort between the London School of Hygiene and Tropical Medicine, University of London, and the University of Witwatersrand and the Small Enterprise Foundation, a local microfinance initiative, in South Africa.

This programme is particularly well-known for crossing traditional boundaries between sexual and reproductive health programming and development/microfinance programmes, while taking into account key findings from both types of programming. First, it builds on the commitment women have demonstrated towards microfinance programmes. Second, it addresses women’s lack of access to resources, which is a significant barrier to the ability to make independent decisions about sexual and reproductive health, including sex with or without a condom with their primary and other partners. Third, it addresses another key finding from analyses that suggests increased risk of intimate partner violence against women who attempt to refuse sex or initiate condom use with their partners.

The design of the programme was based on two main threads: one of providing access to microcredit and the other of building a support system that provided participants with information, support for managing their small business programmes, and an opportunity to discuss HIV and gender and other issues in relation to sexual decision-making. The gender empowerment component had two phases: the first focused on small group discussions on key topics, and the second emphasized community activities designed and implemented by the participants. The latter included village workshops, marches, and community committees on crime and on rape, among others.

Microfinance and HIV prevention represent two distinct strategies for women’s empowerment that each have their own cultural rules and boundary management issues, both for those implementing the programmes and for the beneficiaries; their merger in the programme was not always straightforward. IMAGE was initially promoted as a joint programme, with microfinance and education coupled. Programme designers folded the gender empowerment/sexual and reproductive health programming into the microfinance components; so, for example, the facilitators of the Sisters for Life sessions were dressed in T-shirts that identified them as workers in the micro-finance programmes in order to address the perception of the appropriateness of discussing issues of gender and sexual and reproductive health in the programme.

A key element, was the complex, multi-layered M&E strategy developed by the university partners for the IMAGE programme, what it was able to demonstrate and the lessons learned. The strategy drew on experiences from both microfinance and HIV prevention programming, including using control groups. According to Hargreaves et al (2003), it was built on some key insights as an “integrated, prospective, randomized, controlled, community-matched intervention trial” (p. 32). By integration the researchers meant it was multi-modal, in recognition of the fact that change processes are layered and complex, with many intervening variables factoring in any given shift in individual or social norms. The M&E team also recognized that, particularly over the three-year span of the programme, change could easily be “sudden, discontinuous and unpredictable” (p. 32). Quantitative strategies were therefore used to provide baseline and post-intervention data for larger-scale pictures of processes and assessments of change. Qualitative strategies were used for monitoring and for interpreting the findings of the quantitative analysis. While this is often understood as the best model of M&E, it is rarely employed, and the study designers note it is often not followed. In a programme that is attempting to break new ground, however, a tight evaluation process is particularly important.
The evaluation looked at impact on three cohorts: the women who were loan recipients, the young people living in the household of the loan recipients, and the communities where those households were located.

The methodology included five components: participatory wealth ranking, profiling the control and experimental communities; monitoring of the educational Sisters for Life component; monitoring of key informants, the household, and loan groups; and a community-based participatory rural appraisal project.

The objectives of the evaluation also embody a focus on changing gender norms and women’s vulnerabilities that looked at both traditional indicators of success and shifts in resilience among the participants:

- To evaluate changes in individual agency among women who enrol in IMAGE, and compare this with women who do not have access to IMAGE.
- To evaluate changes in well-being, levels of communication and gendered power relations within households of women who enrol in IMAGE, and compare this with households that do not have access to IMAGE.
- To evaluate changes in social networking and the perceived strength of social cohesion among women who enrol in IMAGE, and compare this with women who do not have access to IMAGE.
- To evaluate changes in attitudes, responses to and experiences of gender-based violence among women who enrol in IMAGE, and compare this with women who do not have access to IMAGE. (p. 43)

The indicator domains are instructive. Outcome indicators for cohort one, direct programme participants, focused on the areas of household economic well-being, social capital gender equity (disaggregated as empowerment and vulnerability to violence). For cohort two, young people 14-35, outcome indicators focused on specific vulnerability to HIV infection, disaggregated as HIV awareness and sexual behaviour. For cohort three, those aged14–35 living in the community where the intervention took place, outcome measures were HIV awareness, sexual behaviour, and HIV incidence.

While the indicators in themselves are in many ways traditional, what is valuable is the ways in which they are combined to support and provide anchor points for programming that aims to produce widening circles of benefits by combining two traditionally separate but potent models of development intervention.

Stakes and Next Steps

“Women and children”—a tag line for vulnerability, an SOS for rescue, a trigger for pangs of guilt. Change must begin right there. The Millennium Development Goals are not a charity ball. The women and children who make up the statistics that drive the Goals are citizens of their countries and of the world. They are the present and future workers in their economies, caregivers of their families, stewards of the environment, innovators of technology. They are human beings. They have rights—entitlements to the conditions, including access to healthcare, that will enable them to protect and promote their health; to participate meaningfully in the decisions that affect their lives; and to demand accountability from the people and institutions that have the duty to take steps to fulfill those rights.36

Millennium Development Task Force on Child Health and Maternal Health, 2005

The processes outlined above require a dramatic change in approaches and mean, above all, letting go of the familiar boundaries of measuring outcome and impact for HIV programming. This is not going to be easy, although the process has begun in many quarters.

Who the individual is assumed to be, and the role she is assumed to have in controlling her sexual and related decision-making, is at the heart of the challenge. Too often, that subject is assumed to be an individual making rational choices premised on self interest, available to persuasion through information and education campaigns (IEC) and behaviour change communication campaigns (BCC), and freely choosing to act or not to act on that information. There is a tremendous gulf between this characterization and the realities of many women and girls, and it is in this gulf that we can locate women’s ability to access and assert their rights.
In many spheres, women’s realities are already recognized— for example, in programmes to promote women’s rights and empowerment, to address violence against women, to ensure access to sexual and reproductive health and rights, and others, often based in disciplines other than the biomedical sciences. These lessons learned have not, however, crossed into HIV and AIDS-related programming. As a result women are trapped in a dilemma. The services provided often do not reflect their realities, and the terms on which the debate is being waged, by and large, circumvent these realities at the operational level. As is made clear by the Millennium Task Force evaluation of two highly-related areas – child and maternal mortality – the dialogue has suffered because the rhetoric has not been matched by action, and because the fundamental issues of power over design of responses and of access to those responses are avoided. Too often both in policy debates and in the public mindset, ‘women and children’ become “a tag line for vulnerability, an SOS for rescue, a trigger for pangs of guilt” (pp. 3-4). This again circumscribes a fundamental issue of meaningful human development. Statisticians estimate that women and girls make up approximately 51 per cent of a given population, where sex-based discrimination does not manipulate that proportion. The review of MDG3 is clear on this as well: there can be no progress on any of the MDGs if the exclusion and abuse of women and girls is not addressed as a fundamental principle. Denial of the reality that abuse or denial of those rights undermines meaningful development amounts to gender apartheid. Equality for women is a matter of fundamental rights, as well as a logical step to achieving development goals and commitments. Beijing, CEDAW and other agreements are a means to that end, but programming to address women’s vulnerability to HIV and AIDS will not be realized without confronting power dynamics and holding ourselves accountable for change. Meaningful measures of success are an essential part of that package.

This requires a commitment on the part of all the players – particularly States and community organizations, as well as women’s bureaus, United Nations agencies, and donors – to achieving the MDGs and to addressing the vulnerability of women and girls. The Secretary General’s Report for the 2008 High Level Meeting on AIDS acknowledges the limitations of existing indicators when it reports that 80 per cent of countries have policies in place that are said to ensure equal access for women and girls to HIV prevention, care and support programming and goes on to state that only 53 per cent of countries provide budgeted support for women-focused programmes. The report’s recommendation is that “Countries should ensure a massive political and social mobilization to address gender inequities, sexual norms and their roles in increasing HIV risk and vulnerability” (p. 4). We need to hold Member States and the United Nations to this hard-earned acknowledgement of the breadth of the response that is needed to address the vulnerability of women, and the intersections between freedom from violence and coercion and universal access to meaningful sexual and reproductive health services.

There have been important meetings and strategic entry points that reflected this move from talk to action, including the High Level Meeting on HIV/AIDS in June 2008, the decisions of the UNAIDS Programme Coordinating Board urging the immediate development of specific tools and intensified action to assist countries in programming that addresses women, girls and gender inequality; and the Accra High Level Meeting on aid effectiveness in September 2008. Each of these was a milestone in the move towards aid effectiveness as well as directing it strategically to women and girls at the country level. The troubled history of the International Health Partnership and related initiatives (IHP+) is instructive: guidance for process must be accompanied by benchmarks for progress, and national ownership must denote the meaningful involvement of all national development partners. Without the move from talk to action, the opening provided by the Paris Declaration runs the risk of undoing development gains rather than allowing the process to rise to a new level of efficiency and effectiveness. The terms ‘efficiency’ and ‘effectiveness’ must come to mean, in the context of HIV, addressing the priorities of women and girls if those epidemics are to be stemmed.

In the end, the lessons learned here apply to all the MDGs. The role of the equality of women and girls in achieving them cannot be underestimated, and all the Goals are profoundly inter-dependent. For example, there can be no progress on HIV and tuberculosis without addressing women’s access to education, to maternal health and to health for their children. Without women’s equality, the eradication of extreme hunger and poverty will never be realized, as women are often the backbone of survival strategies for households and for families as well as in trade and the market. Sustaining the environment also means the education and empowering of women, both the poor women who rely most directly on nature to survive and, at the other extreme, those women in positions of authority in agencies and companies responsible for transforming the world’s natural resources into commodities to meet the world’s needs. Finally, this is impossible without the integration of equality of women into global partnerships – whether among developing country governments, civil society organizations, the private sector, donor agencies, or the technical support provided by the United Nations.
SUMMARY REPORT OF THE EXPERT GROUP CONSULTATION ON TRACKING AND MONITORING GENDER EQUALITY AND HIV/AIDS IN AID EFFECTIVENESS

Introduction

This chapter presents highlights from an Expert Group Consultation convened by UNIFEM in collaboration with the European Commission to identify approaches to ensure that the aid effectiveness agenda promotes greater action on, and investment in, reducing HIV and AIDS among women. The consultation provided an opportunity to discuss how to make aid more effective in addressing the gender dimensions of the epidemic through the tracking of financing for gender equality in the response to HIV and identifying, reviewing and refining key programme indicators. Experts examined how and where gender equality and HIV are being woven into the aid effectiveness agenda, drawing on country examples and existing efforts. They also made recommendations for advocacy to ensure that aid is ‘effective’ for women. More importantly, this convening of experts provided an opportunity to examine strategies and tools to support nationally driven processes of tracking and monitoring progress to reduce HIV infections among women by improving their access to sexual and reproductive health and rights and by reducing violence they face.

The right to sexual and reproductive health services and the right to live a life free from violence or the threat of violence are enshrined in many international agreements, declarations and conventions. These rights are intrinsically linked to the AIDS epidemic, and their denial specifically fuels increased risk of HIV infections among women. Almost half the HIV-positive people in the world are now women, but in Africa, where the epidemic has spread the furthest, young women are three times more likely to be HIV-positive than young men. Gender inequality leaves women with less control than men over their bodies and their lives. Women have less information about how to prevent HIV, and fewer resources to take preventative measures. When women and girls do have information, they often do not have the power to turn this information into knowledge to protect themselves. Risk of HIV infection is closely linked to women’s inability to negotiate safe sex or refuse unwanted sex and to sexual violence and rape.

The Expert Group Consultation built on outcomes of an earlier international consultation in Brussels organized by UNIFEM and the European Commission in 2005, which identified an initial set of considerations to ensure that gender equality is central to the aid effectiveness agenda. Outcomes of the earlier consultation provided the context for discussions during this meeting, particularly recommendations that suggest the introduction of gender-sensitive indicators in country policy matrices and poverty reduction strategy frameworks, and within budget frameworks in line with commitments to the Convention on the Elimination of All Forms of Discrimination against Women (CEDAW), the Millennium Development Goals (MDGs), the Beijing Platform for Action and other agreements that address social inequalities.
Information on investment to support gender equality and the elimination of discrimination against women in the HIV and AIDS response is limited. The first challenge is lack of information about budgets and expenditures on gender equality; such information could potentially provide insight into political commitment and priority-setting, inter-sectoral coordination, sustainability, flexibility of funding, and management issues such as balancing resource allocation with absorption capacity. The second challenge is the lack of appropriate and agreed-upon indicators. While many gender-related indicators have been identified in HIV and AIDS programming, few focus on women’s rights or empowerment, and even fewer link gender and HIV with sexual and reproductive health and rights or violence against women.

The Expert Group Consultation was convened with the overall aim of achieving the following key results:

- Recommendations for better integration of the gender equality dimensions of HIV and AIDS, specifically those that promote the elimination of violence against women and promote increased access to sexual and reproductive health and rights, into national development planning, implementation, and budgeting
- Consensus on suggested improvements to current indicators for monitoring and tracking progress to eliminate violence against women and to improve women’s access to sexual and reproductive health and rights in the context of HIV
- The development of advocacy recommendations and the identification of entry points for improving knowledge and awareness on gender equality and HIV in the context of aid effectiveness discussions.

**Recommendations for Integrating Gender Equality Dimensions of HIV and AIDS into National Development Planning, Implementation, and Budgeting**

Based on the presentations and discussions during the consultation, the experts agreed on a set of recommendations for better integration of the gender equality dimensions of HIV and AIDS, specifically those that promote the elimination of violence against women and promote increased access to sexual and reproductive health and rights, into national development planning, implementation, and budgeting.

1. **Adopt a conceptual framework for gender equality that takes into account multisectoral, structural and social factors that may constrain individual action.**

   A recurring theme during the consultation was the portrayal of women in discussions about HIV and AIDS. The focus on women’s risk behaviour often leads to a simplified view of how HIV among women can best be addressed. This is influenced by a reliance on data focused on the medical aspects of the epidemic. To more effectively address the HIV epidemic, more comprehensive data is necessary.

   Part of the reason for the limited approach is the dominance of epidemiological methodologies and medical indicators that assume individual agency and rational decision-making in a world free of power differentials. This approach does not adequately capture women’s and girls’ vulnerability to HIV in the context of their legal, economic and social status. For comprehensive programming, both epidemiology as well as contextual, social science studies are needed, particularly qualitative research that can provide greater insight into the gender equality dimensions of addressing HIV and AIDS, enabling a response that is culturally sensitive and takes into account social contexts and structural and environmental constraints.

   While ensuring the use of a more accurate set of indicators is a challenge, so is the proliferation of indicators in general. Experts highlighted the fact that countries face reporting fatigue as they struggle to collect data on indicators contained in international agreements and stipulated in donor requirements, and their own strategies and plans. Therefore, the call for harmonization across sectors within monitoring and evaluation (M&E) frameworks at the national level must be heeded.

2. **Ensure alignment of HIV programmes, national development priorities and international commitments on women’s rights, the MDGs, the Declaration of Commitment on HIV/AIDS, and human rights obligations.**
Many international agreements have brought attention to women’s rights (e.g., CEDAW, the Beijing Platform for Action and the Programme of Action from the International Conference on Population and Development), including agreements on the response to HIV and AIDS, such as the Declaration of Commitment on HIV/AIDS. Most governments have signed on to these conventions and international agreements, but are slow to implement their commitments at the country level. It is increasingly becoming apparent in the context of HIV that there is poor alignment between HIV-related commitments and plans on the one hand and national development strategies and efforts to implement international commitments on women’s rights, the MDGs and human rights obligations on the other.

Donors have a particular challenge in their mandates to monitor national strategies and international agreements and the consonance between them. They are, however, in a unique position to ensure that national plans adequately reflect the international agreements that countries have ratified, and that gender issues are included in national strategies, particularly on HIV and AIDS. In order to meet this mandate, donors may also have to be more vigilant about their own capacities and due diligence in the field and at headquarters in ensuring commitments to women’s rights are not forgotten.

The field of actors in development assistance has changed over time to now include the United Nations and other multi-lateral organizations, bi-lateral partners, private foundations, non-governmental organizations, and governments who have gone from funding recipients to being funders themselves. These actors often develop their own requirements, making it difficult to ensure alignment of gender equality priorities at the national level. Others, such as civil society and women’s organizations in particular, wish to be involved but are often not accorded a ‘space’ or lack technical capacity. The call for coordination and alignment is critical.

3. **Address gender equality in HIV programming at the High Level meeting on HIV, High Level Forum on Aid Effectiveness and the MDG review by including strategic programmatic actions and appropriate indicators.**

A series of opportunities for advocacy were identified during the consultation. For more detail, see the final part of this chapter.

4. **Build policy and programming based on the centrality of violence against women as a barrier to effective and comprehensive HIV prevention, care and treatment for women.**

Violence against women is a barrier to effective and comprehensive HIV prevention, care and treatment programming for women. Limited data on ways in which violence against women is both a consequence of HIV infection and a cause of increased risk to HIV can be a challenge in convincing donors and stakeholders of the need for increased investment and attention to these linkages.

5. **Advocate with leaders at all levels to support allocation of resources and programming to address intersections of gender-based violence and HIV in global, regional and national AIDS responses.**

There are clear linkages between women’s vulnerabilities and HIV and AIDS, between HIV and violence against women, and between HIV and women’s sexual and reproductive health and rights. Nonetheless, integrating HIV, responses to violence, and sexual and reproductive health into policies, programming and services is a challenge.

To prepare for advocacy, the purposes of research and evaluation must be clear: what the information will be used for, and how the results will be channelled into action or used to influence programme strategies and policy making. The use of data must be strategic in advocating for a specific issue: the challenge is to advocate for the transformative use of resources, so that the priorities and needs of all – women and men – are taken into account. The presentation of results must be able to convince decision-makers of the dynamics of the epidemic where issues such as gender equality, violence against women and constraints to access to sexual and reproductive health and rights are included as key areas of priority.
6. Integrate HIV, responses to violence, and sexual and reproductive health into policies, programming and services as needed.

In addition to donors harmonizing their actions, harmonization should take place among government machineries. The focus on HIV as a medical problem has limited the multi-sectoral approach that is needed to comprehensively address the epidemic among women. Ministries such as labour, education, gender, culture and others play critical roles in influencing the context of women’s lives. Promoting a holistic response, particularly one that factors in structural discrimination, will enable women to protect themselves and seek treatment and care when necessary.

7. Apply gender-responsive budgeting to HIV programming at all levels, including resource allocation and monitoring and evaluation.

A good understanding of programme costs is useful when advocating with decision-makers and promoting cost-effective interventions. Budget data, however, is often inaccessible or unavailable, is rarely disaggregated, and contains discrepancies between allocations and actual expenditures. Donor funding is not included, and expenditures are not tied to results. While, National AIDS Spending Assessments (NASA) in 2007 included an examination in the AIDS spending categories for national funding on AIDS-specific programmes involving women, few details are available of what exactly constitutes “AIDS-specific programmes involving women” in this analysis. Examining HIV programmes using gender-responsive budgeting tools would be beneficial at all levels. In addition, knowledge of expenditures by international partners helps a country to have a holistic idea of what resources are available and how they are spent.

8. Ensure substantive inclusion of gender equality machineries, civil society organizations, organizations of women and men living with HIV and gender equality advocates in national consultations and planning.

Civil society organizations have a key role to play in terms of monitoring and holding governments accountable for actions and priorities related to gender equality in the context of HIV and AIDS. Gender equality machineries, civil society organizations, organizations of women and men living with HIV and gender equality advocates often have limited involvement in national consultations and planning. Experts outlined and highlighted some useful tools currently being used to hold governments accountable, including shadow reports for the review processes of the Declaration of Commitment on HIV/AIDS and the Political Declaration on HIV/AIDS, and community-driven monitoring tools. These approaches are useful not only in reflecting on government reports, but also in bringing civil society together cross-sectorally.

9. Build and strengthen capacity in gender expertise and human rights of ministries and government bodies responsible for planning, budgeting, and resource allocations regarding HIV.

It is not enough to assume that mention of gender issues in a planning, implementation or monitoring document will lead to an effective response. ‘Gender’ is often used without a complete understanding of its meaning, and many times translates to limited and non-transformative programme activities targeting women. There may also be a reluctance to address the power relations that influence women’s access to rights, resources, and voice.

10. Strengthen women’s organizations where needed to fulfil their role as advocates and monitors in implementation of new aid effectiveness principles and modalities.

The “national ownership” called for in the Paris Declaration is a complex term: who exactly are the owners and whose perspectives are excluded? National governments, civil society and donors sometimes have different perceptions of gender equality and HIV and how to address these issues, and can play competing roles. Other groups may be entirely excluded from the process of defining priorities. The capacity of ministries and government bodies responsible for planning, budgeting, and resource allocations are often limited in regards to understanding the dynamics between gender equality, HIV, and human rights, and should be drawing on the expertise within women’s organizations. In turn, civil society organizations, including
women’s organizations, find it challenging to secure spaces to participate in planning processes whether it is on the Country Coordinating Mechanisms (CCMs) of the Global Fund or other national planning processes within the HIV response. Sometimes, these groups also find the processes challenging because of their limited knowledge and capacity. Across different sectors within government, there may not be sufficient gender expertise to integrate gender issues into HIV and AIDS strategies or programmes.

Recommendations for Strengthening Current Indicators for Monitoring and Tracking Progress to Eliminate Violence against Women and Improve Women’s Access to Sexual and Reproductive Health and Rights in the Context of HIV/AIDS

During the consultation, experts discussed in working groups the most relevant existing indicators on gender equality, violence against women and sexual and reproductive health to draw out and identify key indicators to monitor progress in addressing the interlinkages. Each group presented their conclusions and suggested improvements to current indicators for monitoring and tracking progress.

As with programming in general, the experts were concerned that the image of women being promoted through M&E frameworks and indicators was limited, portraying women only as partners of drug users, as pregnant women, as sex workers or as young women having unprotected sex. A more contextual understanding should be obtained through multi-faceted approaches. Experts identified once again the need for research, and particularly qualitative research, in order to obtain insights that may not be possible with quantitative research. It was also suggested that countries can broaden data collection by developing operational research agendas related to the Declaration of Commitment on HIV/AIDS, specifically the gender equality targets and commitments. In addition, countries need information on international AIDS spending priorities in order to better assess investment in women’s rights and needs.

Many indicators already developed and tested can be used or modified for use in gender and HIV programming. The UNAIDS indicator registry and digital library are two such tools. It was recommended that the group determine ways to support UNAIDS in their efforts to refine indicators within these tools.

Working group suggestions

Indicators on gender equality and HIV and AIDS

One of the working groups examined indicators on gender equality and HIV more broadly and concluded that current indicators on gender equality within the HIV context should be improved so that they capture the realities of women’s lives and the response more accurately.

The working group’s recommendations were to:

i. Review the National Composite Policy Index (NCPI) and the National AIDS Spending Assessments (NASA) to incorporate gender equality indicators that comprehensively capture women’s experience.
ii. Review country-level indicators and ensure gender equality indicators are incorporated at all levels – process, outcome and impact.
iii. At the country level, develop indicators to assess progress on and factors impeding universal access for sexual minorities.
iv. Donors should balance performance-based monitoring and a strict focus on quantitatively verifiable short-term results with long-term community concerns such as tolerance, rights violations, and demand for, quality of and access to services.
Indicators on violence against women and HIV and AIDS

The working group on indicators on violence against women and HIV extensively discussed existing indicators that would adequately capture the intersection between these two epidemics. As it stands, the indicators for monitoring implementation of the Declaration of Commitment on HIV/AIDS and the Political Declaration on HIV/AIDS do not specifically track violence against women. While there are many indicators and compendiums of indicators that have been developed to track violence against women, which are quite comprehensive, they do not address the intersection between violence and HIV. The group noted, however, that some indicators could stand as a proxy, such as the prevalence of sexual violence as an indicator of women’s vulnerability to HIV.

In the discussions, experts emphasized the need to disaggregate data by age, ethnicity, health status, socioeconomic status and place of residence in order to better understand the broader context within which women’s vulnerability to HIV and violence exist.

Three categories of indicators were identified:

i. Trend of the HIV epidemic and its relationship with violence, e.g., prevalence of coerced sex.
ii. Action and access – what access women have to information and services, e.g., number of women who report they do not have access to services because of violence.
iii. Government response and investments.

The working group suggested consideration of the following indicators:

• Prevalence of coerced sexual intercourse, disaggregated by age, ethnicity, place of residence, migration/displacement, socioeconomic status and health status.
• Prevalence of HIV and sexually transmitted infections in survivors of violence.
• Prevalence of women living with HIV who experience violence.
• Criminalization of all sexual assault regardless of relationship between perpetrator and victim.
• Existence of systems of reporting and tracking justice response.
• Existence of referral protocols between the justice sector and violence and HIV service providers.

Process

• Percentage of women presenting complaints of violence to police per 10,000 inhabitants, disaggregated by HIV status.
• Rate of condom use at last intercourse by women who have experienced violence.
• Rate of systems for reporting violence incorporating HIV screening.
  o Systems for reporting and tracking violence.
• Awareness and availability of post-exposure prophylaxis by the general public and health workers.
• Predictability and availability for multi-sectoral responses to the intersection of violence against women and HIV.
• Allocation of funding for multi-sectoral programming to address the intersection of violence against women and HIV.
• Availability, accessibility and uptake of services related to violence against women and HIV.
  o Conduct service availability mapping to assess level of coverage.
  o Number of shelters, level of utilization of services.

Outcomes

• Existence of policies and guidelines to address the intersection of violence against women and HIV.
• Attitudes, knowledge and behaviour of communities as it relates to prevention aspects of violence against women and HIV.
Working group discussions also centred around the challenges of the existence of data to support collection of the information required to monitor progress and suggested a range of solutions, from administrative reports from police and shelters to Demographic and Health Surveys – which provide an opportunity every four years for cross-checking. The group noted the constraints in terms of health services data as they can be difficult to obtain and interpret.

III. Indicators on gender, HIV, and sexual and reproductive health and rights

The working group on indicators on the intersection between gender, HIV and sexual and reproductive health and rights agreed on several principles:

- Gender-based indicators in sexual and reproductive health and rights should be context- and process-oriented as well as outcome-oriented, both qualitative and quantitative.
- The conceptual framework should be built on rights and responsibilities, which should underlie the development of indicators. A sample indicator:
  - Percentage of people who perceive control over sexual and reproductive decision-making by HIV status, sex, age and socioeconomic status.
- High prevalence countries disaggregate sexual and reproductive health and rights by HIV status. A sample indicator:
  - Percentage of women allowed by their husbands, partners and families to go alone to health centre, by HIV status.
- The United Nations should adopt a core set of indicators used across agencies, particularly those related to gender and women’s rights.

The working group on indicators on gender, HIV and sexual and reproductive health and rights suggested consideration of the following indicators:

**Context**

**Quantitative**

- Percentage of women and men from low, middle and high income groups who have accessed voluntary counselling and testing.
- Percentage of communities with primary education (followed up by: are schools safe ?)
- Percentage of schools with separate latrines for girls and boys.
- Percentage of communities with economic opportunities for women e.g. gainful employment, access to loans or microfinance.

**Qualitative**

- Barriers perceived or experienced by women in accessing voluntary counselling and testing are reduced over time.
- National reproductive health plans have a section on reproductive health services for HIV positive women and men.

**Process**

- Percentage of women who know about and feel able to demand all legal sexual and RH services.
- Percentage of HIV positive women who know about a full range of contraceptive methods.
- Percentage of HIV positive women who feel able to freely choose a contraceptive method.
- Among HIV positive women who choose to use a contraceptive method, percentage who were able to access the contraceptive method.
Outcome

- Among HIV positive women who chose to use a contraceptive method, percentage who used it consistently (about reproductive choice)

Sample set of indicators agreed to by the Expert Group

Through a discussion of the working group suggestions, the experts selected the most promising indicators to serve as examples of indicators that could be used to track progress in responding to the intersections between HIV/AIDS and violence against women; and HIV/AIDS and sexual and reproductive health and rights. These sample indicators would be helpful in advocating for more effective programming that takes into consideration key priorities for women.

Violence and HIV

Context

- Prevalence of HIV and sexually transmitted infections among women survivors of violence.
- Prevalence of women living with HIV who experience intimate partner violence (IPV), family and/or domestic violence and/or violence by non-partner perpetrators.

Process

- Rate of condom use at last intercourse by women who have experienced violence.
- Awareness and availability of post-exposure prophylaxis by the general public and health workers.

Outcomes

- Existence of policies and guidelines to address the intersection of violence against women and HIV in strategic sectors, including health and justice.
- Attitudes, knowledge and behaviour of communities as it relates to prevention aspects of violence against women and HIV.

Sexual and reproductive health and rights

Context

- National reproductive health plans have a section on reproductive health services for HIV-positive women and men.

Process

- Percentage of HIV-positive women who report being able to freely choose a contraceptive method.
- Among HIV-positive women who choose to use a contraceptive method, percentage who were able to access the contraceptive method.

Outcome

- Among HIV-positive women who chose to use a contraceptive method, percentage who used it consistently (about reproductive choice).

Entry Points for Advocacy Targeting Improved Knowledge and Awareness on Gender Equality and HIV/AIDS in the Context of Aid Effectiveness and Financing the Response to HIV and AIDS.

Based on the presentations and discussions during the consultation, the experts provided suggestions for advocacy to improve knowledge and awareness on gender equality and HIV and AIDS in the context of aid effectiveness.
They highlighted the need for a theoretical framework that links structural, social and individual determinants of gender inequality and the opportunities provided by the Paris Declaration to strengthen the focus on the intersections of HIV, violence against women and sexual and reproductive health and rights.

The recommendations outlined in the above sections were developed into a brochure (included in the multi-media toolkit) that could be used to raise awareness of the issues of monitoring and tracking of progress on addressing gender equality dimensions of HIV and AIDS, with a specific emphasis on violence against women and sexual and reproductive health and rights. This has been and will be used by the experts and others, including at events such as:

- High-level Meeting on AIDS, in New York, USA, 10-11 June 2008.
- International HIV/AIDS Conference, Mexico City, Mexico, 3-8 August 2008.
- Third High Level Forum on Aid Effectiveness, Accra, Ghana, 2-4 September 2008.

Other communication tools have also been created to support advocacy on the interlinkages between violence against women and HIV, as well as sexual and reproductive health and HIV, in order to support greater action on the gender equality dimensions of the HIV/AIDS epidemic.

The compact disc (CD) that accompanies the first printed edition of this book provides some tools for advocacy on these issues (the tools can also be downloaded from www.genderandaids.org). As the opening tutorial for the CD explains, these tools are meant to be flexible in their use, and are designed to support the work of national programmes, civil society, women’s machineries, donors and members of the UN family. Each one of these groupings will find different uses, internal and external, for these products. As the debates on aid effectiveness, strategies for empowering women and girls within HIV responses and addressing the intersections of HIV, violence and women’s access to sexual and reproductive health and rights evolves, it is hoped these tools will continue to play a role in informing the process and stimulating discussion about ways of improving the effectiveness of the HIV response.

The PowerPoint presentations from the Expert Group Meeting provide provocative questions from across the developing world and concrete ideas on addressing issues concerning women and girls in aid effectiveness. They can be used for planning, training and developing tools for measuring aid effectiveness, some at the macro level and some at the personal level.

The brochure that explains the recommendations from the Expert Meeting in brief is also included in the communication tools and can be reproduced for distribution or uploaded onto websites. It captures the thrust of new ideas in gender-sensitive indicators for tracking progress for women and girls in HIV programming from a social ecological perspective. The brochure comes with a flash presentation that contains key messages for all partners on the need for new ways of thinking in responding to issues of women and girls in response to HIV. It is designed to run as an independent presentation, can be uploaded onto a website, used as a primer advocacy piece to a panel or PowerPoint presentation on HIV, gender equality for women and girls, and aid effectiveness.

The set of three short videos also have multiple uses. Based on interviews conducted at the International AIDS Conference in Mexico City with key actors in the HIV response, they each address a core concern on the gender and aid effectiveness agenda: the intersection between violence against women and HIV; aid effectiveness and the need to address the intersections between violence against women, HIV and sexual and reproductive health and rights; and concrete examples of programming at these intersections. Each video can be used on its own to illustrate the issue it addresses, or as a trigger to group discussion. They can also be used together as part of a workshop or training programme.
INTRODUCTION

The International Community of Women Living with HIV and AIDS (ICW) is the only global network of HIV-positive women. It was established at the 1992 International AIDS Conference in Amsterdam, when the 50-or-so openly positive women attending the conference stormed the stage in protest at the desperate lack of space or voice allocated to HIV-positive women’s issues. ICW now has over 5,000 members in 130 countries. Our vision is for a world where all HIV-positive women:

• have a respected and meaningful involvement at all political levels—local, national, regional, and international—where decisions that affect our lives are being made;
• have full access to care and treatment (ACTS);
• enjoy full rights, particularly sexual, reproductive, legal, financial and general health rights, irrespective of our culture, age, religion, sexuality, social or economic status/class and race.

Positive Women Monitoring Change (PWMC)

In February 2005, in collaboration with the Action Aid-managed initiative Support for the International Partnership against AIDS in Africa (SIPAA), ICW carried out workshops in Lesotho and Swaziland. The workshops aimed to examine the national response of each country to the HIV and AIDS pandemic, with reference to international policy commitments to which the countries were signatories (in particular the Greater Involvement of People Living with HIV (GIPA) principle, the Abuja Agreement of 2001 and the UNGASS Declaration of Commitment of 2001). The workshop employed several stages of analysis to create a tool that could be used to assess the enactment of government commitment to these agreements. These included an analysis of the lived experiences of the participants; and analysis of the documents, first to see to what extent they addressed the rights, needs and concerns of HIV-positive women, and second to see whether HIV-positive women had experienced the effects of those political commitments on the ground. An analysis of the monitoring and reporting systems used to report on progress against international policy processes was also carried out. Finally, workshop participants developed their own monitoring and evaluation (M&E) tool to assess progress on issues both included and not included in the international policy documents.
The workshop examined three key areas in which HIV-positive women routinely come up against barriers in accessing their rights: access to care, treatment and support (ACTS); sexual and reproductive rights (SRHR); and violence against women (VAW). All three areas have resonance for all women regardless of their HIV status, but they hold particular concerns for HIV-positive women who face additional barriers in accessing their rights, and for whom contravention of their rights may have disastrous or fatal consequences. The resulting tool was intended for use by HIV-positive women and other actors working in the field of HIV and AIDS with a commitment to gender, human rights and in particular the rights of HIV-positive women.

Most available national and international level monitoring and reporting tools are gender blind, or at best gender neutral, and do not draw particular attention to the priorities of women or assess positive improvement in the lives of women in general, or HIV-positive women in particular. The Positive Women Monitoring Change (PWMC) tool intends to explore the realities of HIV-positive women's lives, including young HIV-positive women (aged 18-30), whose voices are consistently left unheard in decision making fora, and whose rights, concerns and needs both differ from those of older women and are usually overlooked. The tool intends to provide a platform for the voices of other marginalized women too, such as disabled women and sex workers. Thus the first part of the tool looks at positive women's knowledge and awareness of rights and issues that concern them in the three areas mentioned above (ACTS, sexual and reproductive health rights, and violence against women), but also their lived experiences of putting or attempting to put that knowledge into practice, and the challenges that they face in doing so.

The second part of the tool looks at the experiences and attitudes of service providers working in the three areas. This part explores the strengths and weaknesses of available services, and also considers the constraints and barriers service providers themselves face in providing quality care and support in resource poor, remote and under-prioritized settings. Women can use the first part of the tool to cross-check information they receive from service providers.

The third part of the tool takes the survey to government level, where it can be used to hold governments and ministries to account on their promises, to advocate for priority issues using evidence from both HIV-positive women and service providers, as well as to monitor the progress of government commitments.

More recently, and in view of experiences in using it in various situations, the PWMC tool has been further developed into a package including information sheets, position briefings and a training curriculum.

Why Gender and Access to Care and Treatment (ACTS)?

Women and men are accessing ARVs (anti-retrovirals) in equal number. Gender is not an issue.

– Anonymous, World Health Organization

ACTS is not only about numbers. It is also about quality support, advice and options obtainable for all. It is not only about getting medications. It is about changing the conditions of women's lives so we can use those essential treatments successfully. Both women and men face barriers at household, community, workplace, infrastructural and structural levels to accessing the life-saving treatment that can suppress viral loads and prevent HIV from developing into AIDS. Yet for women these barriers can come with greater costs than those that men face. Long distances, transport costs, waiting times, and household responsibilities can make it difficult to access ARVs and treatment for opportunistic infections, side effects and sexually transmitted infections. These barriers are exacerbated if women are economically dependent on male family members. Household violence or community stigma in response to disclosure can further inhibit ACTS, and even when the medications are available and accessible. Violence and stigma can make complicated adherence and demanding treatment regimens impossible to sustain. In the case of treatment for sexually transmitted infections, lack of partner support and/or taboos around discussing sexual health in combination with often hostile service providers can also acr as a barrier to women's ability to access and effect appropriate treatment and care.

Why Rights? Why Sexual and Reproductive Health and Rights

“Most of us live far from clinics. We travel by foot because we lack transport or money to pay for transport, including bicycle services to town.”

International Community of Women Living with HIV/AIDS (ICW): Monitoring ACTS, SRHR and VAW “by and for” HIV positive women
“A 44-year-old woman had to sell her ARVs in order to get some money to take care of 14 grandchildren, some living with her in her small home.”

“Our men refuse to let us go to hospitals because they will ask us to call our husbands to see if they have the infection too.”

“Our husbands or partners tend to force us to give them our ARV dose while they have not tested for HIV and don’t know their CD4 count.”

For women all over the world, actualization of sexual and reproductive rights can be challenging. Rights that are negotiated in the intimate realm often clash with each other, and often governments renege on their responsibility to act as duty bearer of these rights, regarding them as private matters for couples to sort out between themselves. Cultural practices, sexuality education (or lack of) and social mores also often contribute to women’s and men’s expectations of what may or may not be done or even spoken about when it comes to sexual intimacy. Yet the primary vector of HIV transmission is heterosexual sex. Furthermore, most women discover their HIV status in ante-natal settings at a time in their lives when support and safety (often lacking in the case of a positive diagnosis) are most necessary for the health and well-being of both mother and foetus. The impact of an HIV-positive diagnosis on immediate and/or future child-bearing and –rearing choices is immense; many positive women report being encouraged to abort pregnancies and/or be sterilized, and have family planning options restricted, sometimes with access to other services being dependent on these ‘choices’. There may be pressures from partners, parents and in-laws, and societal expectations on women to reproduce, while health services and policy makers often condemn positive women for that choice. Yet HIV prevention, treatment, care and support programmes cannot hope to be successful without the promotion and protection of women’s sexual and reproductive health rights.

**Why Violence against Women Living with HIV?**

“In Kenya in May, health workers told me at one clinic they had tested a pregnant woman and found her to be positive. One month later, she had been divorced and thrown out of her husband’s home.”

“What do you do about fulfilling your sexual needs and desires when you keep getting gynaecological infections as I do? With treatment you can have healthy, pleasurable, non-violent sexual activity.”

“I want very much to have a baby, but I want to be confident he or she will be okay in every sense.”

“I’d been to a hospital, and was told to have an IUD fitted. Then, when they checked my medical file and learned that I’ve got HIV they said, ‘Oh! This one’s infected! The HIV-infected should not use it’.”

It is increasingly recognized that intimate partner violence is a factor in HIV transmission. As well as being a direct cause of HIV infection in the case of rape and sexual violence, violence against women can also contribute to the increased likelihood HIV transmission when, for example, women are unable to negotiate safer forms of sex due to the threat of violence, or are afraid to leave risky relationships due to fears for their safety. However, it is increasingly being acknowledged that violence against women is not only a cause of HIV transmission but also a consequence, resulting in a self perpetuating cycle of violence and transmission. Moreover, violence against HIV-positive women goes well beyond the locus of the intimate or family relationships, and encompasses a range of structural and institutional violence as well. Violence against HIV-positive women can be situated at the household/family level, in the community, workplace, health services, judicial and legal services, and may be effectively endorsed by national and international policies and funding conditionalities, which encourage denial or perpetuation of situations, systems and policies that render HIV-positive women particularly vulnerable to violence.
INDICATORS

“When I was diagnosed I had a partner. The relationship became more violent – he said I brought a new problem into the family. The violence became more, he had other relationships. You get told off because you have HIV.”

“He says, ‘you have AIDS anyhow so you can’t compete with me. I have to have a life. You have HIV and won’t be around. So understand my other relationships’.”

“But they do not tell you if you keep it [the baby] A, B, C is there for you – they don’t give you the option. They sterilize you. You feel obliged to take the option they offer you or you feel you can’t take the immediate service you need.”

“Women were threatened that they will not receive ARVs if they don’t take the contraception.”

The PWMC tool suggests the following broad sets of indicators for each of the three groups that the tool seeks to speak to (HIV positive women, service providers and policy makers); the same indicators apply to each of the three thematic areas: ACTS, sexual and reproductive health and rights and violence against women.

HIV-positive women:

- Comprehensive knowledge of options and services for HIV treatment, care and support, sexual and reproductive health and violence against women.
- Access to appropriate and accurate information in local languages about ACTS, sexual and reproductive health and rights, and violence against women.
- Access to good quality, appropriate and comprehensive services for HIV-related care, treatment and support, sexual and reproductive health and violence against women including referral and follow-up services.
- Decision making power, without fear of violence or abuse, in relation to sexual, reproductive, lifestyle, and health choices.
- Respect and dignity shown by all staff within the relevant services.
- Ability to act upon and adhere to medical and psycho-social advice and treatment.
- Knowledge of relevant polices around ACTS, sexual and reproductive health and rights, and violence against women.
- Involvement at all levels of policy and programme consultation, design, development and implementation.

Services and service providers:

- Up-to-date knowledge, training and information regarding HIV-positive women’s health and rights in regard to care, treatment and support, sexual and reproductive health and violence against women.
- Provision of a full range of well-resourced services tailored to meet HIV-positive women’s needs.
- An understanding of the barriers and challenges that HIV-positive women face in accessing, adhering to and acting on the advice of health care and support services.
- Monitoring systems including complaints procedures for quality, effectiveness and improvement of services.
- Involvement of HIV-positive women in programmes, including design, development and monitoring of services.

Government and policy makers:

- Policies and programmes that specifically address HIV positive women’s ACTS, sexual and reproductive health and rights and experiences of violence.
- Clear responsibility and accountability mechanisms for policy implementation and monitoring.
• Adequate annual budget to address HIV-positive women’s ACTS, sexual and reproductive health and rights, and violence against women.
• Monitoring of international commitments, policies and programmes.
• Support campaigns that raise awareness about HIV-positive women’s rights to quality care, treatment and support, and sexual and reproductive health and to live free from violence and abuse.
• Endorse research that supports the rights and health of HIV-positive women.
• Actively involve HIV-positive women in policy-making, implementing, M&E reporting and improvement.

How Has Positive Women Monitoring Change (PWMC) Been Used?

To date, ICW has used the PWMC tool in Botswana, Kenya, Lesotho, Mozambique, Namibia, South Africa, Swaziland, Uganda and United Republic of Tanzania. In South Africa and Uganda, it has been used to carry out rapid assessments around HIV-positive women’s sexual and reproductive health rights through focus groups discussions. In Kenya, Namibia and United Republic of Tanzania, the ACTS section of the tool was adapted to conduct a treatment mapping exercise with HIV-positive women supported by the World Health Organization (WHO). Reports from the treatment mappings can be found on ICW’s website, and those relating to the rapid assessments are available from ICW.

In Lesotho and Swaziland, as well as developing the original model of the tool, ICW staff have worked with further groups of HIV-positive women in workshops to familiarize them with the issues covered in the tool and to add to them. It was originally envisaged that these workshops would enable the women to take the tool and run with it, but in the event it transpired that most women’s understanding of these issues was not sufficient to begin using the tool for monitoring. Instead the tool provided a framework for exploration, and additional issues arising from these workshops were fed into the existing framework. Similarly in Mozambique, the tool provided a thematic framework for ICW Southern Africa to conduct introductory workshops at which women mobilized around the issues encapsulated within the tool; the women used the questions to analyse and begin to politicize and prioritize their own experiences and concerns.

In Botswana and Namibia the tool has been used more recently in conjunction with the training curriculum. In Namibia this work took place with a group of HIV-positive young women (participants of ICW’s local Young Women’s Dialogue programme), with the intention that they would be able to go out to their communities and begin using the tool to monitor the situation of other young women living with HIV. Various challenges arose in the course of this programme, and a follow up workshop sought to address these, first by going through the process of developing a Young Women’s Dialogue Charter, and second by analysing and adapting the tool to fit the issues and demands raised in the Charter. This led to greater comprehension by participants of the framework of the tool and the relation between the tool and the issues identified in their own advocacy work. Logistical challenges and additional data-gathering methods were also addressed during this workshop. A report is available from ICW.

Finally the training that took place in Botswana aimed to equip a group of HIV-positive women from the national network of women living with HIV and AIDS (Bomme Isago) with skills to monitor sexual and reproductive health services. This work has been led by the Botswana Network on Ethics, Law and HIV/AIDS (BONELA), with support from ICW. We are waiting to hear how the work is progressing.

To date, then, the actual and potential outcomes and experiences of working with the tool can be summarized by the following:

• for two-way influence between ICW advocacy and the PWMC tool (findings are fed into ICW advocacy; emerging advocacy issues may be fed back into the tool);
• as a framework for gathering, analysing and presenting information (for example, in one on one interviews, or to guide a group discussion and as a structure for developing reports);
• for raising awareness of the issues with the three groups (positive women, service providers and policy makers). It also offers a structure to bring positive women together to discuss issues that are often overlooked in other fora;
• in workshopping to help positive women prioritize issues and set advocacy agendas;
• in evidence gathering for advocacy;
• to raise issues of concern among government representatives, service providers, civil society organizations and HIV-positive women;
• to use as a check list when asking questions at a meeting;
• to monitor government commitment to rights in policy and practice;
• to push for academics to use the tool (or some of the questions) in their research. (NB researchers can also use ICW’s ethical guidelines to ensure that they involve positive women in a way that is not solely extractive, or in policy analysis.);
• for civil society organizations (CSOs) in monitoring their own work or the work of others;
• in mobilizing positive women and other community groups around these issues through community assessments and needs assessments.

**Process Units/ Benefits**

• The process of developing or adapting the tool for local contexts provides an opportunity and framework for providing information to positive women, for positive women to analyze and begin to think politically about their experiences, and to engage with policy documents in relation to their own realities.
• The PWMC has been developed ‘by and for positive women’. This produces a different focus for research from most other data gathering or advocacy tools: one in which positive women are firmly at the centre of the process, in terms of both developing and asking research questions, and interpreting and presenting data. In the process of carrying out research, the fact that it will often be HIV-positive women speaking to other HIV-positive women to gather data has a significant impact on the depth and quality of the data collected, as the following quotation suggests:

  ‘I introduced myself but I did not state my HIV status at the beginning of the meeting and this caused no openness from the group of their status either. …The group participants were saying they wanted to get this information so they can help positive women in their community … they were not sure whether to state their HIV status but were comfortable to talk as if they wanted to help others rather than themselves. After realizing this, I informed them that I was HIV-positive and I felt the great relief from the group, they started to be open about their status and all participants started to participate openly without reservations.’

• With information and fact sheets accompanying the tool, working with PWMC also creates an opportunity to provide women with badly needed information, particularly around their sexual and reproductive rights, as well as basic information about HIV and AIDS, (treatment of) sexually transmitted diseases, prevention of mother-to-child transmission (PMTCT), and infant feeding. The tool also includes ICW position briefings about ACTS sexual and reproductive health rights, and violence against women, which can support advocacy efforts at various different levels.

The incorporation of a training curriculum to building skills and capacity around research, M&E and data collection and analysis supports the potential for positive women to use the tool for their own advocacy and for them to remain at the centre of any research processes using the tool. This curriculum also ensures that the process of developing and adapting the tool is not an extractive process but rather one from which participants are able to benefit in a variety of ways.
To protect girls and women from HIV, health advocates, practitioners, and policy makers must widen their aperture from a narrow focus on the individual-as-risk-taker to encompass the contextual and systemic factors that give rise to vulnerabilities. Most interventions to date have focused on individual behaviour change with little or no consideration of the social milieu and social structural conditions, or distal factors, that contribute to the proliferation and spread of the epidemic. To correct this imbalance, a more encompassing, systems perspective is required. The social ecological framework\(^1\) is a systems approach that views individuals as nested or embedded within a system of socio-cultural relationships – families, social networks, communities and nations. Each of these contexts potentially influences, directly or indirectly, an individual’s ability or propensity to act, in some instances thwarting change; in others, enabling change.

Traditional ‘risk factor’ epidemiology transmutes distal or systemic factors, such as access to social services, resource allocation and the distribution of power, into characteristics of individuals, thereby obscuring and minimizing the role of structural influences. The social ecological approach brings our attention to the fact that “the legal, economic, educational, and social status of women and girls”\(^2\) (emphasis added) renders them more vulnerable to HIV than their male counterparts and calls for multi-level and multi-faceted interventions.

The aforementioned distal or contextual factors do not influence HIV acquisition directly - that is, poverty does not cause HIV – but, rather, sociocultural and socioeconomic contexts work through intermediate variables, including HIV-related knowledge, attitudes, and social norms as well as social influence to place individuals at greater or lesser risk of engaging in those sexual practices – or proximate determinants – that potentially expose them to HIV. The proximate determinants of the sexual transmission of HIV are being sexually active, age at sexual debut, coital frequency, number of new partners, number of concurrent partners, type of sex, age differences between partners, circumcision of the male partner, and condom use.\(^3\) (The likelihood of HIV acquisition is further influenced by biological determinants, the discussion of which lies beyond the focus of this paper.)

Between the distal or systemic factors and proximate determinants lie intermediate factors, many of which have to do with individual girls. The underlying assumption of most HIV prevention programmes to date is that changes in the intermediate factors, such as improving HIV-related knowledge, encouraging social norms supportive of abstinence for adolescent girls and condom use for sexually active girls and women, will bring about a reduction in exposure to the proximate determinants of HIV, an assumption that fails to take into account the interdependence of distal, intermediate and proximate determinants. Yet, as attested by the literature,\(^4\) the girls most vulnerable to HIV are those who are orphans, early school leavers, socially marginalized, and/or who live in impoverished conditions – none of which is within the control of individual girls. These factors often overlap and crisscross, creating a vortex of vulnerability.
Clearly, changes at the intermediate levels are crucial, particularly when agency, or the capacity for purposive action, is strengthened in individual girls. But such changes will be limited and, in too many cases, impaired in the absence of programmatic interventions to alter community level and systemic barriers. The inherent weakness of the individual-level approach is tragically attested by the failure in most sub-Saharan African countries to arrest the epidemic. It is not enough to focus exclusively, or even primarily, on altering the intermediate factors as a way to reduce exposure to the proximate or behavioural determinants of HIV. A stridently bolder approach is urgently needed.

An appropriate response requires multi-faceted programmes accompanied by indicators to measure change and to hold donors and programme planners alike responsible for bringing about multi-level change. It is no longer sufficient to measure changes in knowledge, attitudes and behaviours. Rather, the international community must demand evidence that programmes are also effective in broadening access to services and resources.

The President’s Emergency Plan for AIDS Relief (PEPFAR) Gender Initiative to Reduce Girls’ Vulnerability to HIV, which will soon commence in three sub-Saharan African countries, is taking up this challenge by incorporating activities to affect distal, intermediate and proximate factors. Predicated on the assumptions of the social ecological framework, the Initiative will implement programmes at the individual level to enhance girls’ agency, or critical reflection and capacity to take action; work at the community level to create supportive communities; and seek to expand access to health care, school, and economic opportunities, thus addressing some of the distal factors that render girls vulnerable.

Although individual-level interventions alone are not the solution to protecting girls from HIV, the intermediate factors that render girls vulnerable are important. Strengthening girls’ HIV-related knowledge, attitudes, risk perceptions, self-efficacy, perceived social norms and agency to take protective actions or avoid risks are all necessary components of comprehensive HIV prevention interventions, but are rarely sufficient. Because adults’ views on these matters circumscribe to a greater or lesser degree girls’ behaviours and actions, programmes should address and indicators measure these same factors among adults in the community. Indicators will be developed to assess the degree to which the community provides an environment that protects and supports girls. These will include whether the community has taken action to enforce child defilement laws, to restrict minors’ access to alcohol, to create a safe environment for girls, and to prevent child marriage.

Given the importance of the school environment in determining whether girls will attend and remain in school, indicators will be incorporated into the evaluation to assess whether there is an active parent teacher association (PTA), safe passage to school, a safe school environment, sanctioning of teachers who sexually exploit students, and separate latrines for girls, among others.

One of the most successful strategies for increasing access to education – and, therefore, lowering HIV vulnerability – is the elimination of school fees and other related costs. Yet governments do not act alone in this arena. In fact, governments began to impose school fees when the International Monetary Fund and the World Bank forced them to do so as part of the agreement to obtain loans. This began in the mid-1980s as part of structural adjustment policies and continues to this day in many countries. A key indicator in any intervention to reduce girls’ susceptibility to HIV should be whether or not school fees and other material barriers to school attendance, such as uniform costs, have been eliminated.

Economic opportunities must also be extended to girls and their families as part of an equitable and enlightened approach to social and economic development as well as part of the effort to reduce HIV rates. Indicators in this area should include whether economic opportunities, such as savings, income-generating activities, microcredit and conditional cash transfers, are available to girls or, as appropriate, to their families.

Slowing the HIV epidemic in the Initiative countries will require complex, concerted and long-term interventions. We agree with the Institute of Medicine’s (IOM) statement that “factors that contribute to the increased vulnerability of women and girls to HIV/AIDS cannot readily be addressed in the short-term.” Yet, it is necessary to start now with as comprehensive an approach as is feasible.
Introduction

In the context of the UNIFEM programme ‘The aid effectiveness agenda: Promotion of the empowerment of women and girls in the context of sexual and reproductive health, violence against women and HIV/AIDS’, a survey was undertaken on gender and sexual and reproductive health indicators in European Union development aid.

According to an international consultation held in Brussels in 2005, organized by UNIFEM and the European Commission, in order to support gender equality, the new aid architecture should include:

- Adequate financing programmes that respond to women’s needs;
- Accountable systems for governments and donors to track and enhance their contributions to gender equality; and
- Gender-sensitive progress assessments, performance monitoring and indicators for aid effectiveness.

The survey was initiated as preparation to the conference on ‘Indicators for Sexual and Reproductive Health Rights’ to be organized by UNIFEM in 2008. The conference will elaborate how aid modalities can contribute positively, encourage country ownership and improve harmonization and aid effectiveness. The European Union and United Nations agree that the aid effectiveness agenda will bring greater ownership to national policy-making. This will increase the responsibility of national public policy making in all areas, including in gender equality, sexual and reproductive health and the fight against HIV. Agreement for budget support includes criteria and indicators that must include areas critical for gender equality.

Hence, the current policy environment needs indicators to track progress in the empowerment of women and violence against women, access to sexual and reproductive health and access to HIV prevention, treatment and care.

The Paris Declaration on Aid Effectiveness, adopted in March 2005, is a major initiative in the aid reform agenda. The Declaration contains 56 partnership commitments based on five overriding principles: ownership, alignment, harmonization, managing for results, and mutual accountability. The implementation of the Paris Declaration has led to fundamental changes in the mechanisms and processes for aid planning, coordination, implementation and evaluation.
The European Commission is spearheading new aid modalities. It has committed itself to an ambitious target of channelling 50 per cent of government-to-government assistance through country systems. This commitment means that it will choose general budget support and sector budget support as the preferred aid modality whenever the country situation permits and conditions are met. These imply direct financial transfer into the national budget on the basis of an agreed national strategy containing benchmarks on progress and a medium-term expenditure framework. It is therefore crucial that the national budget is responsive to the promotion of gender equality.

These new aid modalities are defined as follows:

**General budget support** (GBS) is a financing mechanism that involves the transfer of official development assistance (ODA) from donors to the national treasuries of their partner countries. Aid provided in the form of GBS is, therefore, managed in accordance with the partner countries’ own budgetary procedures.

GBS differs from **sector budget support** (SBS) in that GBS is focused on overall policy and budget priorities whereas the focus of SBS is on sector-specific concerns such as health or education.

Each country that receives GBS or SBS will sign a **Financing Agreement** with the European Commission. This contract specifies the goals, expected results and indicators, as well as the utilization of funds.

**Methodology**

We have focused on the 12 pilot countries that are identified for the European Commission/UNIFEM partnership. These are the Democratic Republic of Congo, Cameroon, Ethiopia, Ghana, Honduras, Indonesia, Kyrgyz Republic, Nepal, Nicaragua, Papua New Guinea, Suriname and Ukraine.

For this survey European Commission documents have been reviewed that provide guidelines for indicators to be used in country programming. In addition country-specific European Commission documents have been reviewed where indicators are included as part of the agreements between the European Union and the developing partners.

The above mentioned documents were assessed with regard to the presence of indicators related to gender equality, specifically on sexual and reproductive health-related indicators, including violence against women and HIV-related indicators selected their relevance to the country programming process.

The indicators found in the European Commission documents relate to the following areas:

1. Infant mortality
2. HIV and AIDS (in relation to reproductive health)
3. Maternal mortality
4. Skilled attendance at birth
5. Family planning/contraception
6. Violence against women
7. Fertility
The following **general European Commission documents** have been reviewed:

- Toolkit on mainstreaming gender equality in European Commission cooperation;
- Programming guide for Strategy Papers; Programming Fiche: Gender equality;
- Programming guide for Strategy Papers; Programming Fiche: HIV/AIDS;
- Programming guide for Strategy Papers; Programming Fiche: General Budget Support;
- Programming guide for Strategy Papers; Programming Fiche: Sector Budget Support;
- Programming Guidelines Strategy Papers; Thematic Guidelines;
- Framework Country Strategy Paper (CSP): a guideline for country analysis and the European Union response strategy. The CSP is a descriptive document that includes a country analysis;
- National Indicative Programme (NIP): Management tool to identify selected areas of cooperation for financing and measures and actions for attaining objectives;

The following **country-specific European Commission documents** have been reviewed:

- Country Strategy Papers (CSPs) for Indonesia, Cameroon, Democratic Republic of the Congo, Ethiopia, Ghana, Honduras, Indonesia, Kyrgyz Republic, Nepal, Nicaragua, Papua New Guinea, Suriname and Ukraine;
- National Indicative Programmes (NIPs) for Cameroon, Democratic Republic of the Congo, Ethiopia, Ghana, Honduras, Indonesia, Kyrgyz Republic, Nepal, Nicaragua, Papua New Guinea, Suriname and Ukraine;
- Financing Agreements for general budget support and/or sector budget support in Cameroon, Democratic Republic of the Congo, Ethiopia, Ghana, Honduras, Kyrgyz Republic and Nicaragua;

Table 1 provides an overview of the aims and nature of the documents reviewed.

**Table 1: Overview of documents for survey**

<table>
<thead>
<tr>
<th>Document</th>
<th>Aim and nature of document</th>
</tr>
</thead>
<tbody>
<tr>
<td>Toolkit on mainstreaming gender equality in European Commission cooperation</td>
<td>Assistance/non-binding</td>
</tr>
<tr>
<td>Programming guide for Strategy Papers</td>
<td>Guiding/non-binding</td>
</tr>
<tr>
<td>Framework Country Strategy Paper</td>
<td>Guidelines for descriptive analysis</td>
</tr>
<tr>
<td>National Indicative Programme</td>
<td>Guidelines for response strategy and fund allocation</td>
</tr>
<tr>
<td>Gender Equality and Women Empowerment in Development Cooperation, Communication from the European Commission to the European Parliament and the Council</td>
<td>Policy paper</td>
</tr>
<tr>
<td>Country Strategy Paper</td>
<td>Descriptive analysis</td>
</tr>
<tr>
<td>Financing Agreements</td>
<td>Binding document</td>
</tr>
</tbody>
</table>
Main Findings

1. **Toolkit on mainstreaming gender equality in European Commission cooperation**

   The Toolkit provides gender-sensitive indicators at different levels (macro, meso and micro) but does not mention sexual and reproductive health-related indicators.

2. **Programming guide for Strategy Papers; Programming Fiche: Gender equality**

   In this guide, there is broad reference made to gender-related indicators and a specific reference to sexual and reproductive health indicators, such as ‘antenatal care coverage’, ‘the rate of assisted skilled birth delivery’, ‘maternal mortality ratio’, ‘prevalence of HIV (disaggregated by sex)’, ‘adolescent fertility rate’ and ‘unmet need for contraception’. This guide refers to ‘indicators to be developed’. In this reference there is mention of an indicator related to prevalence of violence against women.

3. **Programming guide for Strategy Papers; Programming Fiche: HIV/AIDS**

   In this guide, there are several indicators that refer to sexual and reproductive health indicators, such as: ‘Number of Prevention of Mother-to-Child Transmission (PMCT) Gender and Sexual and Reproductive Health Indicators in the EU Development Aid centres’, ‘HIV prevalence among pregnant women aged 15-24 years (EC core MDG indicator)’, ‘Percentage of HIV-infected pregnant women receiving a complete course of antiretroviral prophylaxis to reduce the risk of mother-to-child transmission’.

4. **Programming guide for Strategy Papers; Programming Fiche: General Budget Support**

   In this guide, there is no reference to any gender-related indicators, including sexual and reproductive health indicators.

5. **Programming guide for Strategy Papers; Programming Fiche: Sector Budget Support**

   In this guide, there is no reference to any gender-related indicators, including sexual and reproductive health indicators.

6. **Programming Guidelines Strategy Papers; Thematic**

   In this guide, there is no reference to any gender-related indicators, including sexual and reproductive health indicators.

7. **Framework Country Strategy Paper: a guideline for country analysis and the EU response strategy**

   In this framework, there is no reference made to the use of gender-related indicators, including sexual and reproductive health indicators. The framework document does make a recommendation to include sex-disaggregated data in the CSP and to include analysis of gender-sensitive issues in the country description. Examples are: “special attention should be given to trafficking and violence against children and women” and “analysis of the state of progress in sexual and reproductive health rights and gender equality”.

8. **National Indicative Programme (NIP): Management tool to identify selected areas of cooperation for financing and measures and actions for attaining objectives**

   In this guide, there is no reference to any gender-related indicators, including sexual and reproductive health indicators.

In this document, there is an extensive list of gender equality indicators, which include indicators on education, health, governance and economic activity. The sexual and reproductive health-related indicators include three indicators on violence against women and five specifically on sexual and reproductive health. For violence against women, these are (1) Existence of legislation on domestic violence; (2) Extent of legal recourse for victims of violence; (3) Number of hours of teaching in schools per semester on the subject of violence and for military, police and judiciary personnel. For SRH, these are: (1) Rate of assisted deliveries; (2) Ante-natal/post-natal care coverage; (3) Existing AIDS strategy/ definition of targets in anti-AIDS and sexually transmitted viruses policy; (4) Prevention of HIV mother-to-child transmission; (5) Prevalence of HIV/ AIDS and malaria among pregnant women.

10. 21 Country Strategy Papers (CSPs) and National Indicative Programmes NIP

The CSP is a descriptive analysis of a developing partner. According to the ‘Framework Country Strategy Paper’, the CSP should include sex-disaggregated data in the country analysis.

A prerequisite for the establishment of gender-sensitive indicators is the availability of statistical data disaggregated by sex. Table 2 gives an overview of the reviewed CSPs where sex-disaggregated data related to sexual and reproductive health were available. Table 3 outlines indicators extracted from the NIP documents.

Table 2: Sex-disaggregated data and analysis in Country Strategy Programmes

<table>
<thead>
<tr>
<th>Sex-disaggregated data related to sexual and reproductive health</th>
<th>Incidence in 12 pilot countries</th>
<th>Countries</th>
</tr>
</thead>
<tbody>
<tr>
<td>Maternal mortality rate</td>
<td>8</td>
<td>Ghana, Honduras, Indonesia, Kyrgyz Republic, Nepal, Nicaragua, Suriname, Ukraine</td>
</tr>
<tr>
<td>Delivery by skilled health worker</td>
<td>8</td>
<td>Cameroon, Ethiopia, Ghana, Honduras, Indonesia, Nepal, Nicaragua, Ukraine</td>
</tr>
<tr>
<td>Under-5 mortality</td>
<td>4</td>
<td>Honduras, Kyrgyz Republic, Nepal, Nicaragua</td>
</tr>
<tr>
<td>Fertility rate</td>
<td>4</td>
<td>Honduras, Kyrgyz Republic, Nicaragua, Suriname</td>
</tr>
<tr>
<td>Contraceptive use</td>
<td>4</td>
<td>Honduras, Kyrgyz Republic, Nicaragua, Suriname</td>
</tr>
<tr>
<td>HIV/AIDS prevalence men/women</td>
<td>2</td>
<td>Honduras, Suriname</td>
</tr>
<tr>
<td>Coupled women who have suffered some physical or sexual abuse</td>
<td>1</td>
<td>Nicaragua</td>
</tr>
<tr>
<td>Girls who have been sexually abused before the age of 12</td>
<td>1</td>
<td>Nicaragua</td>
</tr>
<tr>
<td>% sexually abused girls that attempted suicide</td>
<td>1</td>
<td>Nicaragua</td>
</tr>
<tr>
<td>% of violence victims that report the situation to the police</td>
<td>1</td>
<td>Nicaragua</td>
</tr>
</tbody>
</table>
Table 3: Indicators extracted from the National Indicative Programme documents

<table>
<thead>
<tr>
<th>Gender-related indicators in CSPs - NIPs</th>
<th>Sexual and reproductive health indicator</th>
<th>Incidence among 12 pilot countries</th>
<th>Countries</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ratio of boys to girls in primary and secondary education</td>
<td></td>
<td>5</td>
<td>Cameroon, Ethiopia, Ghana, Honduras, Nicaragua</td>
</tr>
<tr>
<td>Number of jobs created through forestry investment, including number of women</td>
<td></td>
<td>1</td>
<td>Honduras</td>
</tr>
<tr>
<td>% of land tenure regularized, of which % benefiting and women</td>
<td></td>
<td>1</td>
<td>Honduras</td>
</tr>
<tr>
<td>Reduce maternal mortality</td>
<td></td>
<td>1</td>
<td>Ghana</td>
</tr>
<tr>
<td>Skilled attendance at delivery</td>
<td></td>
<td>3</td>
<td>Cameroon, Ethiopia, Ghana</td>
</tr>
<tr>
<td>HIV prevalence among 15-24 yr old women</td>
<td></td>
<td>2</td>
<td>Cameroon, Ethiopia, Ghana</td>
</tr>
</tbody>
</table>

11. Financing Agreements

In the reviewed Financing Agreements, we found the indicators shown in Table 4.

Table 4: Indicators extracted from the Financing Agreements

<table>
<thead>
<tr>
<th>Gender-related indicators in CSPs</th>
<th>Sexual and reproductive health indicator</th>
<th>Incidence among 12 pilot countries</th>
<th>Countries</th>
</tr>
</thead>
<tbody>
<tr>
<td>Gross enrolment rate primary education boys/girls</td>
<td></td>
<td>2</td>
<td>Ethiopia, Ghana</td>
</tr>
<tr>
<td>Gross enrolment rate secondary education boys/girls</td>
<td></td>
<td>2</td>
<td>Ethiopia, Ghana</td>
</tr>
<tr>
<td>Completion rate grade 1-5 boys/girls</td>
<td></td>
<td>1</td>
<td>Ethiopia</td>
</tr>
<tr>
<td>Gender-related indicators in CSPs</td>
<td>Sexual and reproductive health indicator</td>
<td>Incidence among 12 pilot countries</td>
<td>Countries</td>
</tr>
<tr>
<td>----------------------------------</td>
<td>------------------------------------------</td>
<td>----------------------------------</td>
<td>-----------</td>
</tr>
<tr>
<td>Delivery by skilled health worker</td>
<td></td>
<td>1</td>
<td>Ethiopia</td>
</tr>
<tr>
<td>HIV prevalence among 15-24 yr old women</td>
<td></td>
<td>1</td>
<td>Ethiopia</td>
</tr>
<tr>
<td>Reduction in infant mortality</td>
<td></td>
<td>1</td>
<td>Ethiopia</td>
</tr>
<tr>
<td>Contraceptive prevalence rate</td>
<td></td>
<td>1</td>
<td>Ethiopia</td>
</tr>
</tbody>
</table>

**Conclusion**

- In the ‘Toolkit on mainstreaming gender equality in EC cooperation,’ there is no mention of sexual and reproductive health indicators.

- In the ‘Programming guide for Strategy Papers; Programming Fiche: Gender equality’ there is mention of the need to develop indicators on prevalence of violence against women.

- In the ‘Programming guide for Strategy Papers; Programming Fiche: HIV/AIDS’ there are three interesting indicators related to HIV and gender.

- In the CSPs, only Nicaragua has sex-disaggregated data on violence against women.

- In the reviewed NIPs there are no indicators identified on violence against women and one indicator identified on HIV. This HIV-related indicator is only identified in the NIPs of the African countries.

- In the Financing Agreements there is no reference to indicators related to violence against women. Only in the Financing Agreement of Ethiopia was there an indicator on HIV and AIDS and gender.

In the so-called soft documents, the documents that function as guidelines and are not binding, there are frequent mentions of indicators related to gender equality and an occasional mention of indicators on sexual and reproductive health.

In the documents where funds are being allocated and documents that are binding, such as the NIP documents and the Financing Agreements, there are hardly any indicators related to gender equality or to sexual and reproductive health.

The indicators that are used for monitoring results within the aid effectiveness agenda are not gender-responsive, which reduces their effectiveness in reaching those who are most impacted by poverty in the developing world.

If gender equality and sexual and reproductive health rights are at the heart of European Commission development policy, then the European Commission should explicitly address the issue in its budget support programmes, which currently channel about 47 per cent of the Community’s aid to African, Caribbean and Pacific countries.
Annex 1
International Commitments: Indicators Related to Gender and HIV, Sexual and Reproductive Health and Rights, and Violence Against Women

Introduction

This document was prepared for the Expert Group Meeting on Tracking and Monitoring Gender Equality and HIV/AIDS in Aid Effectiveness, held 20-3-May 2008 in Santo Domingo, Dominican Republic. The meeting was sponsored by the European Commission in partnership with UNIFEM.

Countries have agreed to a number of commitments relevant to women and HIV, including the Millennium Development Goals (MDGs), the Declaration of Commitment on HIV/AIDS, the Beijing Declaration and Platform for Action, the Convention on the Elimination of All Forms of Discrimination against Women (CEDAW), and the Programme of Action from the International Conference on Population and Development (ICPD). While the MDGs and the Declaration of Commitment on HIV/AIDS identified specific indicators for monitoring progress, the other commitments only identified issues to be reported on or objectives. Indicators for monitoring the Beijing Declaration and Platform for Action have been suggested by the United Nations Social Commission for Asia and the Pacific (UNESCAP) and Economic Commission for Latin America and the Caribbean (ECLAC).

Millennium Development Goals

The eight MDGs – which range from halving extreme poverty to halting the spread of HIV/AIDS and providing universal primary education, all by the target date of 2015 – form a blueprint agreed to by all the world’s countries and all the world’s leading development institutions.

The goals, targets and indicators as developed in 2002 were used until 2007 to measure progress towards the MDGs. In 2007, the MDG monitoring framework was revised to include four new targets agreed by Member States at the 2005 World Summit.

Many countries collect data on the MDGs and prepare annual reports. Data can be viewed at the United Nations site for the MDG indicators (http://unstats.un.org/unsd/mdg/default.aspx).

The Goals and accompanying indicators most immediately relevant to monitoring progress on addressing intersections between HIV, gender-based violence and access to sexual and reproductive health are as follows:

Goal 3: Promote gender equality and empower women

Target 4: Eliminate gender disparity in primary and secondary education, preferably by 2005, and in all levels of education no later than 2015
9. Ratio of girls to boys in primary, secondary and tertiary education
10. (Dropped)*
11. Share of women in wage employment in the non-agricultural sector
12. Proportion of seats held by women in national parliament

Goal 5: Improve maternal health (new target)

Target 6: Reduce by three-quarters, between 1990 and 2015, the maternal mortality ratio

16. Maternal mortality ratio
17. Proportion of births attended by skilled health personnel
19c. Contraceptive prevalence rate*

Achieve, by 2015, universal access to reproductive health
• Adolescent birth rate*
• Antenatal care coverage (at least one visit and at least four visits)*
• Unmet need for family planning*

Goal 6: Combat HIV/AIDS, malaria and other diseases

Target 7: Have halted by 2015 and begun to reverse the spread of HIV/AIDS

18. HIV prevalence among pregnant women aged 15-24 years
19a. Condom use at last high-risk sex
19b. Percentage of population aged 15-24 years with comprehensive correct knowledge of HIV/AIDS
20. Ratio of school attendance of orphans to school attendance of nonorphans aged 10-14 years

Achieve, by 2010, universal access to treatment for HIV/AIDS for all those who need it (new target)
• Proportion of population with advanced HIV infection with access to antiretroviral drugs*

* Updates from “Revised MDG monitoring framework including new targets and indicators, as recommended by the Inter-agency and Expert Group on MDG Indicators” (2007)

In addition to several changes to the indicators, the framework confirms the adoption of four new targets, including:
• Under Target 6: Achieve, by 2015, universal access to reproductive health.
• Under Target 7: Achieve, by 2010, universal access to treatment for HIV/AIDS for all those who need it.

Declaration of Commitment on HIV/AIDS

The Declaration of Commitment on HIV/AIDS adopted by the United Nations General Assembly Special Session (UNGASS) is a critical international policy instrument in the fight against AIDS. By adopting the Declaration, countries agreed to time-bound commitments and regular reports on their progress. The United Nations Secretary-General entrusted the UNAIDS Secretariat with the responsibility for developing the reporting process, accepting reports from Member States on his behalf and preparing a report for the General Assembly. Member States are required to submit country progress reports to the UNAIDS Secretariat every two years. The 2008 reports can be viewed at http://www.unaids.org/en/KnowledgeCentre/HIVData/CountryProgress/2007CountryProgressAllCountries.asp.

Text from the Declaration that is relevant to addressing gender-based violence, access to sexual and reproductive health services and HIV and AIDS includes:

14. Stressing that gender equality and the empowerment of women are fundamental elements in the reduction of the vulnerability of women and girls to HIV/AIDS;

37. By 2003, ensure the development and implementation of multisectoral national strategies and financing plans for combating HIV/AIDS that address the epidemic in forthright terms; confront stigma, silence and denial; address gender and age-based dimensions of the epidemic; ... integrate a gender perspective; ...
47. By 2003, establish time-bound national targets to achieve the internationally agreed global prevention goal to reduce by 2005 HIV prevalence among young men and women aged 15 to 24 in the most affected countries by 25 per cent and by 25 per cent globally by 2010, and intensify efforts to achieve these targets as well as to challenge gender stereotypes and attitudes, and gender inequalities in relation to HIV/AIDS, encouraging the active involvement of men and boys;

60. By 2005, implement measures to increase capacities of women and adolescent girls to protect themselves from the risk of HIV infection, principally through the provision of health care and health services, including for sexual and reproductive health, and through prevention education that promotes gender equality within a culturally and gender-sensitive framework;

62. By 2003, in order to complement prevention programmes that address activities which place individuals at risk of HIV infection, such as risky and unsafe sexual behaviour and injecting drug use, have in place in all countries strategies, policies and programmes that identify and begin to address those factors that make individuals particularly vulnerable to HIV infection, including underdevelopment, economic insecurity, poverty, lack of empowerment of women, lack of education, social exclusion, illiteracy, discrimination, lack of information and/or commodities for self-protection, and all types of sexual exploitation of women, girls and boys, including for commercial reasons. Such strategies, policies and programmes should address the gender dimension of the epidemic, specify the action that will be taken to address vulnerability and set targets for achievement;

78. By 2003, ensure the inclusion of HIV/AIDS awareness and training, including a gender component, into guidelines designed for use by defence personnel and other personnel involved in international peacekeeping operations, while also continuing with ongoing education and prevention efforts, including pre-deployment orientation, for these personnel;


Note on indicators in the Declaration of Commitment:

“The recommended indicators used frequently by the countries reflect the international indicator standards set by a group of independent international technical experts who participate in the UNAIDS Monitoring and Evaluation Reference Group (MERG). These indicators have been tested, vetted and endorsed during a multi-year process involving countries participants and multiple bilateral and multilateral agencies.”


Suggested core indicators measure the effectiveness of the national response to HIV/AIDS and are used to prepare progress reports on implementation of the Declaration of Commitment on HIV/AIDS.
Below is a table summarizing the indicators, reporting schedule and methods of data collection for commitments made at the UNGASS on HIV/AIDS. The table is also divided into indicators for generalized and concentrated epidemics.

<table>
<thead>
<tr>
<th>Indicators</th>
<th>GENERALIZED EPIDEMIC</th>
<th>Reporting Schedule</th>
<th>Method of data collection</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Expenditures</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>National commitment and action</td>
<td></td>
<td></td>
</tr>
<tr>
<td>1. Amount of national funds disbursed by governments in low- and middle-income countries</td>
<td>Ad hoc based on country request and financing</td>
<td>HIV/AIDS National Spending Assessment Survey on financial resource flows</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Policy development and implementation status</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2. National Composite Policy Index</td>
<td>Areas covered: prevention, care and support, human rights, civil society involvement, and monitoring and evaluation Target groups: people living with HIV and AIDS, women, youth, orphans, and most-at-risk populations</td>
<td>Biennial</td>
<td>Desk review and key informant interviews</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>National programmes</strong></td>
<td>education, workplace policies, STI case management, blood safety, prevention of mother-to-child transmission coverage, antiretroviral combination therapy coverage, and services for orphans and vulnerable children</td>
<td></td>
<td></td>
</tr>
<tr>
<td>3. Percentage of schools with teachers who have been trained in life-skills based HIV education and who taught it during the last academic year</td>
<td>Biennial</td>
<td>School-based survey and education programme review</td>
<td></td>
</tr>
<tr>
<td>4. Percentage of large enterprises/companies that have HIV/AIDS workplace policies and programmes</td>
<td>Biennial</td>
<td>Workplace survey</td>
<td></td>
</tr>
<tr>
<td>5. Percentage of women and men with sexually transmitted infections at health care facilities who are appropriately diagnosed, treated and counselled</td>
<td>Biennial</td>
<td>Health-facility survey</td>
<td></td>
</tr>
<tr>
<td>6. Percentage of HIV-positive pregnant women receiving a complete course of antiretroviral prophylaxis to reduce the risk of mother-to-child transmission</td>
<td>Biennial</td>
<td>Programme monitoring and estimates</td>
<td></td>
</tr>
<tr>
<td>7. Percentage of women and men with advanced HIV infection receiving antiretroviral combination therapy</td>
<td>Biennial</td>
<td>Programme monitoring and estimates</td>
<td></td>
</tr>
<tr>
<td>8. Percentage of orphans and vulnerable children whose households received free basic external support in caring for the child</td>
<td>Every 4–5 years</td>
<td>Population-based survey</td>
<td></td>
</tr>
<tr>
<td>9. Percentage of transfused blood units screened for HIV</td>
<td>Biennial</td>
<td>Programme monitoring/special survey</td>
<td></td>
</tr>
</tbody>
</table>
### Knowledge and behaviour

<table>
<thead>
<tr>
<th>Knowledge and behaviour</th>
<th>Frequency</th>
<th>Methodology</th>
</tr>
</thead>
<tbody>
<tr>
<td>10. Percentage of young women and men aged 15–24 who both correctly identify ways of preventing the sexual transmission of HIV and who reject major misconceptions about HIV transmission target: 90% by 2005; 95% by 2010 - MDG indicator</td>
<td>Every 4–5 years</td>
<td>Population-based survey</td>
</tr>
<tr>
<td>11. Percentage of young women and men who have had sex before the age of 15</td>
<td></td>
<td></td>
</tr>
<tr>
<td>12. Percentage of young women and men aged 15–24 who have had sex with a non-marital, non-cohabiting sexual partner in the last 12 months</td>
<td></td>
<td></td>
</tr>
<tr>
<td>13. ** Percentage of young women and men aged 15–24 reporting the use of a condom the last time they had sex with a non-marital, non-cohabiting sexual partner - MDG indicator</td>
<td></td>
<td></td>
</tr>
<tr>
<td>14. ** Ratio of current school attendance among orphans to that among non-orphans, aged 10-14 - MDG indicator</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

### Impact

<table>
<thead>
<tr>
<th>Impact</th>
<th>Frequency</th>
<th>Methodology</th>
</tr>
</thead>
<tbody>
<tr>
<td>15. **Percentage of young women and men aged 15–24 who are HIV infected (target: 25% in most-affected countries by 2005; 25% reduction globally by 2010) - MDG indicator</td>
<td>Annual</td>
<td>HIV sentinel surveillance and population-based survey</td>
</tr>
<tr>
<td>16. Percentage of adults and children with HIV still alive 12 months after initiation of antiretroviral therapy</td>
<td>Biennial</td>
<td>Programme monitoring</td>
</tr>
<tr>
<td>17. Percentage of infants born to HIV infected mothers who are infected (Target: 20% reduction by 2005; 50% reduction by 2010)</td>
<td>Biennial</td>
<td>Estimate based on programme coverage</td>
</tr>
</tbody>
</table>

### CONCENTRALIZED/LOW-PREVELANCE EPIDEMICS

#### National commitment and action

<table>
<thead>
<tr>
<th>Expenditures</th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Amount of national funds disbursed by governments in low- and middle income countries</td>
<td>Ad hoc based on country request and financing</td>
<td>HIV/AIDS National Spending Assessment Survey on financial resource flows</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Policy development and implementation status</th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>2. National Composite Policy Index</td>
<td>Biennial</td>
<td>Desk review and key informant interviews</td>
</tr>
<tr>
<td>Areas covered: prevention, care and support, human rights, civil society involvement, and monitoring and evaluation</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Target groups: people living with HIV and AIDS, women, youth, orphans, and most-at-risk populations</td>
<td></td>
<td></td>
</tr>
<tr>
<td>National programmes: HIV testing and prevention programmes for most-at-risk populations</td>
<td></td>
<td></td>
</tr>
<tr>
<td>---</td>
<td>---</td>
<td>---</td>
</tr>
<tr>
<td>3. Percentage (most-at-risk populations) who received HIV testing in the last 12 months and who know the results</td>
<td>Biennial</td>
<td>Programme monitoring/special survey</td>
</tr>
<tr>
<td>4. Percentage (most-at-risk populations) reached by prevention programmes</td>
<td>Biennial</td>
<td>Programme monitoring/special</td>
</tr>
</tbody>
</table>

**Knowledge and behaviour**

| 5. Percentage of (most-at-risk population(s)) who both correctly identify ways of preventing the sexual transmission of HIV and who reject major misconceptions about HIV transmission | Biennial | Special survey |
| 6. Percentage of female and male sex workers reporting the use of a condom with their most recent client | |
| 7. Percentage of men reporting the use of a condom the last time they had anal sex with a male partner | |
| 8. Percentage of injecting drug users who have adopted behaviours that reduce transmission of HIV, i.e., who both avoid using non-sterile injecting equipment and use condoms, in the last month (for countries where injecting drug use is an established mode of HIV transmission) | |

**Impact**

| 9. Percentage of (most-at-risk population(s)) who are HIV infected | Annual | HIV sentinel surveillance |

**Global commitment and action**

| 1. Amount of bilateral and multilateral financial flows (commitments and disbursements) for the benefit of low- and middle-income countries | Annual | Survey on financial resource flows |
| 2. Amount of public funds for research and development of preventive HIV vaccines and microbicides | Annual | Survey on financial resource flows |
| 3. Percentage of transnational companies that are present in developing countries and that have HIV/AIDS workplace policies and programmes | Annual | Desk review |
| 4. Percentage of international organizations that have workplace policies and programmes | Annual | Desk review |

The National Composite Policy Index has several particularly relevant questions:

- Question A.I.2: Has your country integrated HIV/AIDS into its general development plans? Options include reporting on reduction of gender inequalities as relate to HIV/AIDS prevention/care.
• Question A.III.5: Which of the following prevention activities have been implemented in 2003 and 2005 in support of the HIV-prevention policy/strategy? Options include reporting on programmes to prevent mother-to-child transmission of HIV
• Question B.I.6: Does your country have a policy to ensure equal access, between men and women, to prevention and care?

Beijing Declaration and Platform for Action

The Beijing Declaration and Platform for Action is an agenda for the empowerment of women. It focuses on equality between women and men as a human right and a condition for sustainable development. The Platform for Action contains strategic objectives and actions to be taken but does not identify indicators. Implementation is discussed but does not include ongoing monitoring.

Relevant objectives include:

Strategic objective C.3: “Undertake gender-sensitive initiatives that address sexually transmitted diseases, HIV/AIDS, and sexual and reproductive health issues.”

Strategic objectives D.1, D.2 and D.3 related to violence against women.


Indicators suggested by regional organizations

Other organizations have suggested indicators for monitoring the Platform for Action. For example, UNESCAP put together a set for evaluating regional and international agreements on improving the situation of women and promoting gender equality. Relevant indicators include:

Women and health

• Deliveries with antenatal care
• Pregnant women with anaemia
• Deliveries attended by skilled health personnel
• Maternal mortality rate
• Induced abortion rate
• Contraception practice rate
• Prevalence rate of HIV/AIDS
• Prevalence of urban sex workers with HIV/AIDS
• Gender-sensitive programmes and policies to prevent HIV/AIDS

Violence against women

• Incidences of domestic violence
• Incidences of sexual violence against women
• Legislation against gender-based violence
• Support system for female victims of violence
• Production of statistics on gender-based violence
• Fund for research on violence against women

ECLAC has also developed a set of indicators, which were devised on the basis of the measures recommended to Governments in the Beijing Platform for Action, the Regional Programme of Action for the Women of Latin America and the Caribbean (1995-2001), and the Plan of Action of the Second Summit of the Americas. Given the scope of these recommendations, we have selected those aspects that are the easiest to measure with the statistics available in most of the countries, while remaining mindful of the variety of issues covered by the documents.

Indicators include:

Women and health
3.1.1 Existence of a national functional committee or norms and standards for reproductive health, including family planning and sexual health
3.1.2 Fertility among teenage women
3.2.1 Rate of change in the numbers registered as being infected with HIV/AIDS, by sex
3.3.3 Prevalence of cervical cancer among women
3.3.4 Prevalence of breast cancer among women

Violence against women
4.1.1 Sexual violence against individuals
4.1.2 Extent to which statistics exist on domestic violence
4.1.3 Deaths and non-fatal injuries due to domestic violence
4.2.1 Annual coverage of activities to provide training in human rights and humanitarian law to State officials
4.3.1 Legal sanctions for violence against women
4.4.1 Spending per woman on the prevention of violence


**Convention on the Elimination of All Forms of Discrimination against Women (CEDAW)**

The implementation of the Convention is monitored by the Committee on the Elimination of Discrimination against Women. At least every four years, States parties are expected to submit a national report to the Committee, indicating the measures they have adopted to give effect to the provisions of the Convention. “A report should include sufficient data and statistics disaggregated by sex relevant to each article and the general recommendations of the Committee.” Article 12 addresses Women and Health, specifically equal access to care, in particular to services around childbirth.

Some specific requests related to reporting are contained in the General Recommendations issued by the Committee. For example:

**General Recommendation 12 on violence against women**

Recommends to States parties that they should include in their periodic reports to the Committee information about:
1. The legislation in force to protect women against the incidence of all kinds of violence in everyday life (including sexual violence, abuses in the family, sexual harassment at the work place etc.);
2. Other measures adopted to eradicate this violence;
3. The existence of support services for women who are the victims of aggression or abuses;
4. Statistical data on the incidence of violence of all kinds against women and on women who are the victims of violence.

**General Recommendation 15 on women and AIDS**

(d) That all States parties include in their reports under article 12 of the Convention information on the effects of AIDS on the situation of women and on the action taken to cater to the needs of those women who are infected and to prevent specific discrimination against women in response to AIDS.
General Recommendation 19 on violence against women

(e) States parties in their reports should identify the nature and extent of attitudes, customs and practices that perpetuate violence against women and the kinds of violence that result. They should report on the measures that they have undertaken to overcome violence and the effect of those measures;

h) States parties in their reports should describe the extent of all these problems and the measures, including penal provisions, preventive and rehabilitation measures that have been taken to protect women engaged in prostitution or subject to trafficking and other forms of sexual exploitation. The effectiveness of these measures should also be described;

(j) States parties should include in their reports information on sexual harassment, and on measures to protect women from sexual harassment and other forms of violence or coercion in the workplace;

(n) States parties in their reports should state the extent of these problems [family violence, rape, sexual assault and other forms of gender-based violence, female circumcision, coercion in regard to fertility and reproduction] and should indicate the measures that have been taken and their effect;

(q) States parties should report on the risks to rural women, the extent and nature of violence and abuse to which they are subject, their need for and access to support and other services and the effectiveness of measures to overcome violence;

(s) States parties should report on the extent of domestic violence and sexual abuse, and on the preventive, punitive and remedial measures that have been taken;

(u) States parties should report on all forms of gender-based violence, and such reports should include all available data on the incidence of each form of violence and on the effects of such violence on the women who are victims;

(v) The reports of States parties should include information on the legal, preventive and protective measures that have been taken to overcome violence against women, and on the effectiveness of such measures.

General Recommendation 24 on women and health

9. ... States parties must report on their health legislation, plans and policies for women with reliable data disaggregated by sex on the incidence and severity of diseases and conditions hazardous to women's health and nutrition and on the availability and cost-effectiveness of preventive and curative measures. Reports to the Committee must demonstrate that health legislation, plans and policies are based on scientific and ethical research and assessment of the health status and needs of women in that country and take into account any ethnic, regional or community variations or practices based on religion, tradition or culture.

10. States parties are encouraged to include in their reports information on diseases, health conditions and conditions hazardous to health that affect women or certain groups of women differently from men, as well as information on possible intervention in this regard.

12. States parties should report on their understanding of how policies and measures on health care address the health rights of women from the perspective of women's needs and interests and how it addresses distinctive features and factors which differ for women in comparison to men, such as:....

14. ... States parties should report on how public and private health care providers meet their duties to respect women's rights to have access to health care.

17. ... States parties should therefore report on what they have done to organize governmental processes and all structures through which public power is exercised to promote and protect women's health.

19. ... Reports should therefore include comments on the impact that health policies, procedures, laws and protocols have on women when compared with men.

21. States parties should report on measures taken to eliminate barriers that women face in gaining access to health care services and what measures they have taken to ensure women timely and affordable access to such services.

23. In their reports, States parties should state what measures they have taken to ensure timely access to the range of services which are related to family planning, in particular, and to sexual and reproductive health in general.

26. Reports should also include what measures States parties have taken to ensure women appropriate services in connection with pregnancy, confinement and the post-natal period...

27. States parties should include in their reports how they supply free services where necessary to ensure safe pregnancies, childbirth and post-partum periods for women.

Source: http://www.un.org/womenwatch/daw/cedaw/
The 1994 International Conference on Population and Development (ICPD) articulated a bold new vision about the relationships between population, development and individual well-being. At the conference ICPD, held in Cairo, Egypt, 179 governments adopted a forward-looking, 20-year Programme of Action that built on the success of the population, maternal health and family planning programmes of the previous decades while addressing, with a new perspective, the needs of the early years of the twenty-first century.

The Programme of Action, sometimes referred to as the Cairo Consensus, was remarkable in its recognition that reproductive health and rights, as well as women's empowerment and gender equality, are cornerstones of population and development programmes. It is rooted in principles of human rights and respect for national sovereignty and various religious and cultural backgrounds.

The Programme of Action contains objectives and actions, but does not specify indicators.

Chapter IV - GENDER EQUALITY, EQUITY AND EMPOWERMENT OF WOMEN

A. Empowerment and status of women
4.3. The objectives are:
(a) To achieve equality and equity based on harmonious partnership between men and women and enable women to realize their full potential;
(b) To ensure the enhancement of women’s contributions to sustainable development through their full involvement in policy- and decision-making processes at all stages and participation in all aspects of production, employment, income-generating activities, education, health, science and technology, sports, culture and population-related activities and other areas, as active decision makers, participants and beneficiaries;
(c) To ensure that all women, as well as men, are provided with the education necessary for them to meet their basic human needs and to exercise their human rights.

B. The girl child
4.16. The objectives are:
(a) To eliminate all forms of discrimination against the girl child and the root causes of son preference, which results in harmful and unethical practices regarding female infanticide and prenatal sex selection;
(b) To increase public awareness of the value of the girl child, and concurrently, to strengthen the girl child’s self-image, self-esteem and status;
(c) To improve the welfare of the girl child, especially in regard to health, nutrition and education.

Chapter VI - POPULATION GROWTH AND STRUCTURE

B. Children and youth
6.7. The objectives are:
(a) To promote to the fullest extent the health, well-being and potential of all children, adolescents and youth as representing the world’s future human resources, in line with the commitments made in this respect at the World Summit for Children and in accordance with the Convention on the Rights of the Child;
(b) To meet the special needs of adolescents and youth, especially young women, with due regard for their own creative capabilities, for social, family and community support, employment opportunities, participation in the political process, and access to education, health, counselling and high-quality reproductive health services;
Chapter VII - REPRODUCTIVE RIGHTS AND REPRODUCTIVE HEALTH

A. Reproductive rights and reproductive health
7.5. The objectives are:
(a) To ensure that comprehensive and factual information and a full range of reproductive health care services, including family planning, are accessible, affordable, acceptable and convenient to all users;
(b) To enable and support responsible voluntary decisions about child-bearing and methods of family planning of their choice, as well as other methods of their choice for regulation of fertility which are not against the law and to have the information, education and means to do so;
(c) To meet changing reproductive health needs over the life cycle and to do so in ways sensitive to the diversity of circumstances of local communities.

B. Family planning
7.14. The objectives are:
(a) To help couples and individuals meet their reproductive goals in a framework that promotes optimum health, responsibility and family well-being, and respects the dignity of all persons and their right to choose the number, spacing and timing of birth of their children;
(b) To prevent unwanted pregnancies and reduce the incidence of high-risk pregnancies and morbidity and mortality;
(c) To make quality family-planning services affordable, acceptable and accessible to all who need and want them, while maintaining confidentiality;
(d) To improve the quality of family-planning advice, information, education, communication, counselling and services;
(e) To increase the participation and sharing of responsibility of men in the actual practice of family planning;
(f) To promote breast-feeding to enhance birth spacing.

C. Sexually transmitted diseases and HIV prevention
7.29. The objective is to prevent, reduce the incidence of, and provide treatment for, sexually transmitted diseases, including HIV/AIDS, and the complications of sexually transmitted diseases such as infertility, with special attention to girls and women.

D. Human sexuality and gender relations
7.36. The objectives are:
(a) To promote adequate development of responsible sexuality permitting relations of equity and mutual respect between the genders and contributing to improving the quality of life of individuals;
(b) To ensure that women and men have access to information, education and services needed to achieve good sexual health and exercise their reproductive rights and responsibilities.

D. Adolescents
7.44. The objectives are:
(a) To address adolescent sexual and reproductive health issues, including unwanted pregnancy, unsafe abortion, sexually transmitted diseases and HIV/AIDS, through the promotion of responsible and healthy reproductive and sexual behaviour, including voluntary abstinence, and the provision of appropriate services and counselling specifically suitable for that age group;
(b) To substantially reduce all adolescent pregnancies.

Chapter VIII - HEALTH, MORBIDITY AND MORTALITY

C. Women's health and safe motherhood
8.20. The objectives are:
(a) To promote women's health and safe motherhood; to achieve a rapid and substantial reduction in maternal morbidity and mortality and reduce the differences observed between developing and developed countries and within countries. On the basis of a commitment to women's health and well-being, to reduce greatly the number of deaths and morbidity from unsafe abortion;
(b) To improve the health and nutritional status of women, especially of pregnant and nursing women.
D. Human immunodeficiency virus (HIV) infection and acquired immunodeficiency syndrome (AIDS)

8.29. The objectives are:
(a) To prevent, reduce the spread of and minimize the impact of HIV infection; to increase awareness of the disastrous consequences of HIV infection and AIDS and associated fatal diseases, at the individual, community and national levels, and of the ways of preventing it; to address the social, economic, gender and racial inequities that increase vulnerability to the disease;
(b) To ensure that HIV-infected individuals have adequate medical care and are not discriminated against; to provide counselling and other support for people infected with HIV and to alleviate the suffering of people living with AIDS and that of their family members, especially orphans; to ensure that the individual rights and the confidentiality of persons infected with HIV are respected; to ensure that sexual and reproductive health programmes address HIV infection and AIDS;
(c) To intensify research on methods to control the HIV/AIDS pandemic and to find an effective treatment for the disease.

Source: http://www.unfpa.org/icpd/docs/index.htm
ANNEXES

Annex 2
Key Resources on Monitoring and Evaluation Indicators Related to Gender and HIV/AIDS, Sexual and Reproductive Health and Rights, and Violence Against Women

This document was prepared for the Expert Group Meeting on Tracking and Monitoring Gender Equality and HIV/AIDS in Aid Effectiveness, held 28-30 May 2008, in Santo Domingo, Dominical Republic. The meeting was sponsored by the European Commission in partnership with UNIFEM.

The purpose of the document is to provide guidance on existing indicators on gender and HIV; HIV and violence against women; and gender, HIV and sexual and reproductive health and rights. These key resources include publications and databases from United Nations agencies, government agencies and non-governmental organizations. The list is not comprehensive, but only contains resources with the most relevant indicators.

**Economic Commission for Africa**

Indicators are identified for physical abuse and mental health, reproductive health, and HIV and other STIs (sex-disaggregated).

**Economic Commission for Latin America and the Caribbean**
http://www.eclac.cl/publicaciones/xml/3/4713/lc1186i.pdf

A set of indicators based on the Beijing Platform for Action, the Regional Programme of Action for the Women of Latin America and the Caribbean, 1995-2001, and the Plan of Action of the Second Summit of the Americas. Several relevant indicators are proposed in Section 3 on Women and health (with one indicator on HIV) and Section 4 on Violence against women.
Economic and Social Commission for Asia and the Pacific


http://www.unescap.org/esid/GAD/Publication/Gender-Indicators.pdf

A set of indicators with which to evaluate regional and international agreements concerned with improving the situation of women and promoting gender equality. Relevant proposed indicators can be found in Section C on Women and health (with three indicators on HIV) and Section D on Violence against women.

Economic and Social Commission for Western Asia


The conclusions of the report identified the highest priority gender-related issues in the Arab region and related indicators. Relevant sections include reproductive health (with one indicator on HIV) and violence against women.

International Community of Women Living with HIV/AIDS


http://www.icw.org/files/monitoringchangetool-designed%2009%2008%20final_0.pdf

The tool was developed to help monitor government commitments to HIV positive women’s rights. The questionnaire has three sections: 1 - Access to Care, Treatment and Support; 2 - Sexual and Reproductive Rights; and 3 - Violence against Women.

Ipas


http://www.ipas.org/Publications/asset_upload_file245_2897.pdf

An NGO tool for monitoring progress toward three MDGs that provides an alternative for NGOs not able to measure the high-level indicators. The tool contains 10 benchmarks with questions.

MEASURE Evaluation


http://www.cpc.unc.edu/measure/publications/html/ms-02-06.html

Indicators can be found on women’s status and empowerment, sexually transmitted infections/HIV/AIDS, violence against women, female genital cutting, and composite indicators on gender equity in the organizational context and gender sensitivity in the service delivery environment.


This compendium contains a set of monitoring and evaluation indicators for program managers, organizations, and policy makers who are working to address violence against women and girls (VAW/G) at the individual, community, district/provincial and national levels in developing countries.

HIV/AIDS Survey Indicator watabase

http://www.measuredhs.com/hivdata/ind_summary.cfm
The HIV/AIDS Survey Indicators Database provides an easily accessible comprehensive source of information on HIV/AIDS indicators drawn from guides from UNAIDS, the United Nations General Assembly Special Session on HIV/AIDS (UNGASS), the MDGs, the President's. Several gender-related indicators are included in addition to sex-disaggregated indicators. Demographic and Health Surveys (DHS) http://www.measuredhs.com/aboutsurveys/dhs/modules_archive.cfm

Representative household surveys with large sample that provide data for a wide range of monitoring and impact evaluation indicators in the areas of population, health, and nutrition. In addition to the core questionnaire, modules on domestic violence, female genital cutting, maternal mortality and women's status can be attached.

**UNCHR**
(also available in French, Russian, Spanish, Arabic and Chinese from http://documents.un.org/mother.asp)

This report to the United Nations Economic and Social Council recommends a human rights-based approach to health indicators as a way of measuring and monitoring the progressive realization of the right to health. The annex table suggests structural, and outcome indicators based on a human rights-based approach in relation to the reproductive health strategy endorsed by the World Health Assembly in May 2004.

**UNAIDS**

Suggests core indicators to measure the effectiveness of the national response to HIV/AIDS and are used to prepare progress reports on implementation of UNGASS Declaration of Commitment on HIV/AIDS. The National Composite Policy Index includes items on gender and HIV/AIDS integration. Many indicators disaggregated by sex.


Tool 4 is a gender-sensitive monitoring and evaluation system and suggests examples of gender indicators to measure progress in reducing vulnerability to HIV infection, in guaranteeing a dignified and fulfilling life for women and men infected with HIV/AIDS, and in enhancing coping capabilities of women and men.

UNAIDS Inter-Agency Task Team on Gender and HIV/AIDS. Date unavailable. Gender-Sensitive HIV/AIDS Indicators for Monitoring and Evaluation. Geneva: UNAIDS.

This fact sheet contains a list of gender-sensitive indicators by type (inputs, outputs, impact and outcome), targets, and information sources.

**UNIFEM/UNAIDS/UNFPA**

Resource Pack on Gender and HIV/AIDS,
The Resource Pack, developed by the UNAIDS Inter-Agency Task Team on Gender and HIV/AIDS (co-chaired by UNIFEM and UNFPA), aims to strengthen the impact of national HIV/AIDS programmes by tackling a key underlying factor that fuels the epidemic: gender inequality. The Resource Pack analyses the impact of gender relations on the AIDS epidemic and provides guidance, including tools for effective advocacy and programming. The Resource Pack contains the following tools:

- Review paper, ‘Integrating Gender into HIV/AIDS Programmes’.
- 17 Fact Sheets with concise information on gender-related aspects of HIV/AIDS.

**World Bank**


Section 3.4 contains examples of indicators and potential sources by impact, outcome, input, and output.


Suggests gender-sensitive impact, outcome, input and outcome indicators for monitoring HIV.


Introduces five complementary indicators that provide a more complete and nuanced description of gender equality and women’s empowerment than just the MDGs alone.

**World Health Organization (WHO)**

http://whqlibdoc.who.int/publications/2006/924156315X_eng.pdf

Suggests a shortlist of indicators for global monitoring of reproductive health, including two on HIV.

**Databases containing data on gender and HIV/AIDS**

- DevInfo database – http://www.devinfo.org/
- ECLAC Gender Statistics in Latin America and the Caribbean – http://www.eclac.cl/mujer/proyectos/perfiles_en/default.htm
Endnotes

Walking the Walk - Robert Carr


7 “PMTCT+” refers to prevention of mother-to-child transmission programmes that address short courses of mother-to-child-prevention anti-retroviral treatment (ART), but extend that to include access to treatment after birth, testing for both mother and child, and enrolment where necessary of the father in ART, and psychosocial support for mother and caregivers in the household. It also extends into secondary prevention programming, and more broadly strengthening women’s health and family planning.

8 See, for example, Ooms, Gorik. 2006. ‘Health Development versus Medical Relief: The Illusion versus the Irrelevance of sustainability,’ PLOS Medicine 3: 1202-1205.

9 This gap between knowledge and action exists both in concrete implications of programmatic and financial agreements and accountability at the national and global levels, and the power dynamics of who is allowed into these conversations, and how the conversations are structured – the involvement of the affected communities, civil society, women’s bureaus and other partners alongside government and international partners.


11 See, for example, Randriamaro, Zo. 2005. ‘Making the Missing Link: MDGs, Gender and Macroeconomic Policy.’ New York: United Nations Division for the Advancement of Women.


17 Adapted from Gupta, Whelan and Allendorf, op. cit, pp.12-22.

18 Gupta, Whelan and Allendorf, op. cit.

19 Gupta, Whelan and Allendorf, op. cit.


21 Fried, op. cit.

23 ibid, para 82.


27 UN Millennium Project Task Force on Education and Gender Equality, 2005, op. cit.


30 See, for example, Fried, op. cit; UNIFEM Caribbean, op. cit.


**Sexual and Reproductive Health and HIV/AIDS Indicators: Multi-level and Multi-faceted - Carol Underwood**


6. IOM, op. cit.