UNAIDS/PCB(28)/11.5
6 June 2011

28th Meeting of the UNAIDS Programme Coordinating Board

Geneva, Switzerland
21-23 June 2011

Gender-sensitivity of AIDS responses

Additional documents for this item: *none*

Action required at this meeting - the Programme Coordinating Board is invited to: *take note* of the report recognizing that further monitoring of implementation of the UNAIDS Agenda for Accelerated Country Action on Women, Girls, Gender Equality and HIV will be done and reported to the Programme Coordinating Board through the Unified Budget, Results and Accountability Framework which includes outcomes and indicators specific to the gender dimensions of the response to AIDS.

Cost implications for decisions: *none*

EXECUTIVE SUMMARY

1. This report responds to the request of the 27th meeting of the UNAIDS Programming Coordinating Board to report to its 28th meeting on progress achieved, by country, in implementing the UNAIDS Agenda for Accelerated Country Action on Women, Girls, Gender Equality and HIV. This report picks up from the December 2010 progress report, which focused on UN accountability towards the UNAIDS Agenda for Women and Girls. It provides a snapshot of the status of country action to implement gender-responsive HIV programmes, rather than a comprehensive analysis. The data in the report were collected from 81 countries, in a collaborative and consultative process with partners at global, regional and country levels.

2. The report found that countries have made notable achievements in collecting and reporting disaggregated data. However, there remain significant gaps in the qualitative and quantitative data, critical for evidence-informed national strategic plans that fully address the HIV and sexual and reproductive health needs and rights of women and girls, in all their diversity.

3. The importance of the engagement and leadership of women living with HIV in planning, implementing and monitoring the national HIV response is recognized by countries. However, more needs to be done to address stigma and discrimination and to engage women living with HIV in the broader women's rights agenda. The limited participation of women living with and affected by HIV in country reporting to the Committee on the Elimination of Discrimination against Women suggests that significant opportunities remain to realize the potential synergies of the HIV and women's rights agendas.

4. An increasing number of countries are collecting population-based data on intimate-partner violence as a form of gender-based violence. However, many countries still do not use this data in their HIV response. Although countries are recognizing the need to prevent and manage the consequences of gender-based violence as part of the HIV response, this appears not to be accompanied by national programmes to change harmful gender norms and practices, including gender-based violence.

5. Countries recognize the need to link HIV and sexual and reproductive health at the policy, systems and services level. Increasingly, prevention of vertical transmission services are being integrated with the full range of sexual and reproductive health services, particularly for maternal and newborn health. However, services generally do not address the needs and rights of women living with HIV in their full diversity and throughout their life-cycle. The limited access to female condoms further illustrates the need for women-tailored HIV responses.

6. Access to resources remains a critical challenge for scaling up gender-responsive HIV programming. More than half the countries reported that no data were available on resources budgeted or allocated for interventions targeting women and girls within the national response, while ministries responsible for women, girls and gender equality generally did not have resources to address HIV. These findings suggest that the commitment and political will to address gender inequality as part of the HIV response are yet to be translated into adequate resource investment.

7. The UNAIDS Agenda for Accelerated Country Action on Women, Girls, Gender Equality and HIV has been instrumental in catalysing action at the country level and creating awareness on the importance of addressing the needs and rights of women and girls in order to achieve the Millennium Development Goals (MDGs), in

particular, MDG 3, 4, 5 and 6. UNAIDS and UN Women will carry this work forward, informed by this report, and guided by the Unified Budget, Results and Accountability Framework.

INTRODUCTION

8. Three decades into the HIV epidemic, women and girls comprise more than half of all people living with HIV, yet the global HIV response has failed to adequately address their needs. UNAIDS and UNIFEM (as part of UN Women), along with other partners, have therefore responded to a request from the UNAIDS Programme Coordinating Board to develop the UNAIDS Agenda for Accelerated Country Action on Women, Girls, Gender Equality and HIV (hereafter referred to as the UNAIDS Agenda for Women and Girls). This offers a framework built around three recommendations – generate and use evidence; support focused interventions; and mobilize political will – that is essential to high-impact programming for women and girls.

9. At its 27th meeting in December 2010, the Programme Coordinating Board *"requested UNAIDS to report on progress achieved in implementing the Agenda for Accelerated Action on Women and Girls by country at the 28th meeting of the Programme Coordinating Board*".

10. This report presents a snapshot of the status of key undertakings, and areas in need of additional support in countries, based on a scorecard. The scorecard was jointly developed by UNAIDS and partners, based on 14 strategic markers (see scorecard tool in Annex I) that serve as proxies for the strategic areas included in the UNAIDS Agenda for Women and Girls. Of the 90 countries where the UNAIDS Secretariat has a presence, 81 responded (see country responses in Annex II).

11. While many UNAIDS country offices consulted with partners to respond to the scorecard, this did not happen in all cases owing to time constraints in preparing the Programme Coordinating Board report. In addition, it should be noted that the scorecard is not an in-depth analysis of the underlying factors and contexts. For these reasons, the scorecard quantitative data was complemented with qualitative comments provided by countries and other sources of data, including UNGASS (United Nations General Assembly Special Session on HIV/AIDS) reports and civil society-generated information, such as the virtual global consultation[1] undertaken by Athena Network and the Global Coalition on Women and AIDS, in preparation for the 2011 United Nations High Level Meeting on HIV/AIDS.

12. The report presents and analyses the findings of the country reports and describes how UNAIDS and UN Women, delivering as one, have contributed, and how work will be carried forward, as articulated in the Unified Budget, Results and Accountability Framework.

SETTING THE SCENE

13. HIV is as much a challenge for social and human rights as it is for health: 30 years into the epidemic, sociocultural and structural factors (e.g. harmful cultural practices, violence, economic disparity, poverty, and lack of education) place women and girls at risk of HIV infection and continue to drive the HIV epidemic. As a result, more than a quarter of all new HIV infections take place among young

[1] http://www.womenandaids.net/CMSPages/GetFile.aspx?guid=40f78f66-b8cb-4a95-9cc0-7026b078fb9f

women aged 15–24, while in sub-Saharan Africa, women account for more than 60% of people living with HIV. These factors also contribute to the poor levels of sexual and reproductive health and rights, including maternal and child health, demonstrating the close interaction between MDG 3 (gender equality), MDG 4 (child health), MDG 5 (maternal health), and MDG 6 (HIV).

14. The UNAIDS Agenda for Women and Girls has served several purposes: as an advocacy tool; a catalyst for programmatic action; and a unifier of multiple stakeholders around a common platform for action. It has given prominence to issues previously downplayed or neglected in national HIV responses, including gender-based violence, sexual and reproductive health services, and the disproportionate burden of care that falls on women and girls. It has enabled women to raise a united voice on these issues. At the same time, there are increasing demands for resources and capacities, particularly for women's groups and networks of women living with HIV. These demands need to be addressed if country responses are to provide adequate solutions and accelerated actions for women and girls.

15. The commitment to gender equality in HIV is increasingly visible. For instance, countries with generalized epidemics, such as Benin, Lesotho, Namibia, Swaziland and the United Republic of Tanzania, have produced national action plans on women, girls, gender equality and HIV. Among countries with concentrated epidemics, Morocco and Viet Nam are taking steps to raise understanding of the gender-related drivers in a concentrated HIV epidemic, defining a tailored approach to gender and HIV, including addressing the risk of HIV transmission in long-term intimate partnerships. Results from the global virtual consultation, confirmed that the HIV response has created a momentum for advancing gender equality, generating opportunities for women on the margins to take the centre stage in the HIV response.

16. Countries are increasingly recognizing the need for an epidemic-tailored response that adequately addresses the needs of women and girls, and have embraced the UNAIDS Agenda for Women and Girls. In support of this, Joint UN Teams on AIDS are aligning their programming to national priorities. Further, the UNAIDS Agenda for Women and Girls has been initiated in about 80 countries in partnership with civil society.

17. Country-level dialogues, facilitated by the UNAIDS Agenda for Women and Girls, have made clear that stigma and discrimination are still major challenges for women and girls, particularly for those living with HIV and for young women. Action to comprehensively address these problems remains inadequate, as has been illustrated by the findings of the *People Living with HIV Stigma Index*[2]. A gender-sensitive response must confront the broader social barriers to health and rights, with the meaningful participation of women and girls, including those living with HIV and key populations at higher risk of HIV infection.

18. While women and girls living with and affected by HIV are involved in the HIV response and often play a leading role in community-based actions, their engagement is not always assured in the processes of setting polices and making related decisions. There remains a scarcity of financial support to substantively develop the leadership capacities of women, including networks of women living with HIV and women in key affected populations, such as sex workers and those who use drugs. Enabling women in all their diversity to take a leading role in efforts

[2] http://www.stigmaindex.org/

to change the HIV trajectory is crucial to achieving the MDG goals and needs to be made a key priority.

FINDINGS: SIGNIFICANT ACHIEVEMENTS BUT STRIKING GAPS

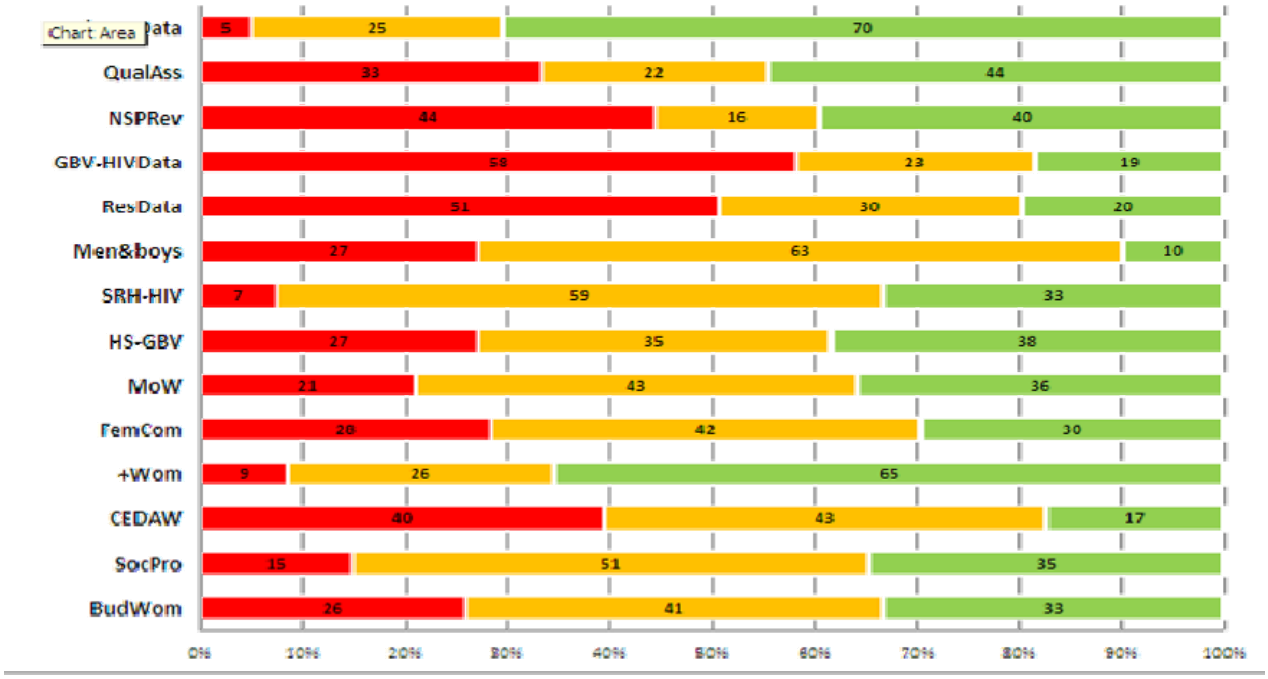
Overview

19. This section presents the findings according to the 14 strategic markers, starting with a global overview of performance. Findings are grouped into five themes: availability of data; engagement of women and girls, including those living with HIV; gender-based violence and gender norms; linking HIV and sexual and reproductive health services for women and girls; and resources.

20. National HIV responses are incorporating key elements of the UNAIDS Agenda for Women and Girls, adapting these to local epidemiological and social contexts; all 81 responding countries indicated they had initiated action on at least three of the 14 markers. Figure 1 presents a global overview of country responses for 14 strategic markers indicating the level of achievement for non-action (red), small-scale action (orange) and scaled-up action (green).

21. Figure one show some noteworthy findings; such as, the absence of gender-focused situation and response analyses that are critical for a robust planning process. On the positive side, there is a growing engagement of women living with HIV in national planning for HIV. Interestingly, this is in contrast to the limited engagement of women living with HIV in country reporting on national commitments to gender equality to the Committee on the Elimination of Discrimination against Women (CEDAW), and the low proportion of countries that have national programmatic action to engage men and boys in gender equality initiatives.

Fig. 1. Global aggregation of country responses (n = 81)



DisaggData = Age and sex disaggregated HIV data;

QualAss = Qualitative assessments of social, economic and legal risk factors;

NSPRev = National response gender review;

GBV-HIVData = Data on GBV-HIV linkages;

ResData = Data on national HIV resources for women's programmes;

Men&boys = Funding for men/boy's programmes;

SRH-HIV = SRH HIV integration;

HS-GBV = Health sector GBV policy;

MoW = HIV plans/budgets in women ministries;

FemCom = Female condoms;

+Wom = women living with HIV participate in response review;

CEDAW = HIV-affected women participation in CEDAW monitoring;

SocPro = Social protection available for women living with HIV;

BudWom = National response budgets for women organizations capacity development

Availability of data

22. The UNAIDS Agenda for Women and Girls emphasizes the importance of having quality data on the impact of HIV on women and girls as the basis for a relevant and effective response to the epidemic. The scorecard survey gathered information on the following key elements of "knowing your epidemic and response" called for by the UNAIDS Agenda for Women and Girls:

    - HIV-related epidemiological and behavioural data disaggregated by sex and age
    - Data on the prevalence of gender-based violence and its links to HIV
    - Qualitative data to better understand the vulnerabilities of women and girls
    - Assessing whether the national response is aligned to the needs of women and girls
    - Tracking the financial resources directed towards programmes for women and girls.

23. *HIV-related epidemiological and behavioural data disaggregated by sex and age.* Fifty-seven countries reported that they collect sex and age disaggregated epidemiological and behavioural data; 20 countries reported either epidemiological or behavioral disaggregated data; and only four countries indicated the absence of disaggregated data. This finding is in line with the UNGASS reporting requirements, though not necessarily by the five-year cohorts called for in the UNAIDS Agenda. Also, the country reports made no specific reference to disaggregated quantitative data for women by civil status, or data on the risk faced by adolescent girls and young women. Further data availability is not an end itself, and data is useful only when used. Some country reports highlighted poor national programme capacity to collect. analyse and interpret data, as well as limited use of data for strategic planning. Angola and Viet Nam, for example, indicated that age and sex disaggregated data was collected but not routinely analysed or made publicly available. Other country reports underlined the lack of data for persons under the age of 15 and above the age of 49, data that is particularly important given the scaling-up of antiretroviral treatment, the greater survival rates of children born with HIV, and the close-to-normal life expectancy of adults on treatment.

24. Gaps in data availability are even greater on sexual partners of key affected populations, such as sex workers of all genders, people who use drugs, men who have sex with men and transgender people. Countries with concentrated epidemics, including Bangladesh and Ukraine, indicated that the lack of data on the intimate partners of key affected populations was a major hindrance to understanding women and girls' exposure to HIV. In the Asia and Pacific region, considerable work is under way to link data on key affected populations to intimate partner transmission; China, for example, has recently completed such research in five provinces. Countries also pointed to the need for improved standardization and quality of behavioural data, reporting lack of consistency in data disaggregation for women in all their diversity.

25. *Data on the prevalence of gender-based violence and its links to HIV.* There also is a significant gap in country data analysis and use of information on gender-based violence and its link to HIV. Despite a growing body of empirical and qualitative data on the associations between the two, and the availability of some national data on the prevalence of gender-based violence in almost 100 countries, 58% (47 of 81) of countries reported that the HIV response was not informed by data on gender-based violence. Of the remaining countries, less than one fifth (15 of 31) have national data on the intersection between gender-based violence and HIV, allowing violence to be taken into account through their national response; and 23% of countries (19 of 81) collect data on an anecdotal or project basis. Lack of use of data will adversely affect the qualitative assessment of the vulnerabilities of women and girls, and equally hamper the response analysis. The reports indicate that governments increasingly recognize the need to address gender-based violence as a priority in the HIV response. The Dominican Republic has established a Committee on Gender-based Violence and HIV, comprising government and nongovernmental institutions, including HIV national authorities, dealing with gender, justice and health organizations. Morocco, on the other hand, has focused its efforts on key affected populations, including sex workers.

26. *Qualitative data to better understand the vulnerabilities of women and girls*. Several countries, particularly in sub-Saharan Africa, have conducted qualitative assessments of the social, economic and legal factors that put women and girls at risk of HIV. Without this data, it is likely that countries will treat the symptoms rather than the underlying causes of the HIV epidemic. In nearly 44% (36 of 81) of the countries that responded, the qualitative assessments were made by the national AIDS authority, while in a little less than one quarter of countries, they were carried out by partners, including civil society. Ethiopia established a national HIV prevention advisory group, consisting of government, United Nations and civil society representatives, which led an assessment of the factors fuelling the epidemics, including the specific vulnerabilities of women and girls. Interestingly, in the Caribbean, only Trinidad and Tobago reported that it had undertaken qualitative studies on the vulnerabilities of women and girls.

27. *Assessing whether the national response is aligned to the needs of women and girls.* A gender review of the national HIV response is essential to identify gender inequality and the needs and rights of women and girls. Overall, 39% (32 of 81) of countries conducted a gender review of the national response to HIV, with sub-Saharan Africa having the highest percentage of responding countries. Most of the reviews were undertaken as part of regular reviews of the national strategic plan, although not necessarily with the full participation of women’s groups or networks of women living with HIV. On the other hand, 44% (36 of 81) of countries did not conduct a gender review of the national response. Interestingly, the Gambia conducted a gender audit in preparation for the Beijing+15 meeting, linked to the review of the national policy on gender as part of the process leading to the enactment of the Women's Bill. In Viet Nam, the gender audit found significant gaps in the national HIV response, including how the rapid post-conflict development of the country affected men and women’s vulnerability to HIV. Viet Nam is now addressing these challenges in developing a new national strategic plan on HIV.

28. *Tracking the financial resources directed towards programmes for women and girls.* Closely related to the above is knowing the level of resources budgeted for and/or spent on programmes for women and girls. Only 16 countries have national data on resources available for women and girls, gender equality and HIV. Of these countries, six indicated they had also undertaken situation and response analyses, enabling a comprehensive understanding of how the national response addressed the epidemic. For those that have data, it is most often linked only to externally-funded projects, such as those financed by the Global Fund to Fight AIDS, Tuberculosis and Malaria.

Engagement of women and girls, including those living with HIV

29. The UNAIDS Agenda for Women and Girls called for women and girls, especially those living with HIV, young women and women from key affected populations, to be engaged in making decisions on developing, designing, implementing, monitoring and evaluating HIV policies and programmes. They bring to the planning and decision-making table the knowledge, capacity and experience of how the HIV response can best meet their HIV and sexual and reproductive health needs and rights.

30. The scorecard survey gathered information on the following key elements for engaging women and girls:

    - Participation of women living with HIV in the formal planning and review mechanisms of the national response to HIV
    - Availability of a budget to support the capacity of community-based organizations of women, especially women affected by HIV, under the national strategic plan
    - Participation of networks of women living with and affected by HIV in the national Committee on the Elimination of Discrimination against Women (CEDAW) monitoring and reporting processes

31. *Participation of women living with HIV in the formal planning and review mechanisms of the national response to HIV.* Two thirds (53 of 81) of the countries report that networks of women living with HIV are systematically represented in formal planning and review mechanisms of the national response. Uganda, for example, has vibrant networks of women living with HIV, including young women, from the district to the national level, that have a strong voice in influencing national policy. In Lesotho, the vice chair of the Country Coordinating Mechanism is a member of the national network of women living with HIV. A quarter (21 of 81) of the countries indicated that engaging women living with HIV in the national response was not systematic for several reasons. For example, Jamaica and China indicated that dedicated networks of women living with HIV had been formed only recently, so had not yet been fully integrated into policy dialogue. In Thailand and Ukraine, networks of women living with HIV are not formally recognized by the national AIDS programme because combined networks of men and women living with HIV have already been formally recognized. Further, 9% (7 of 81) of countries reported no participation of people living with HIV. This may be due to the absence of networks of people living with HIV, as is the case in Uzbekistan. UNAIDS' role in supporting countries to recognize the contributions of networks of women living with HIV is paramount to strengthening their leadership and access to funding.

32. West and Central Africa and Latin America report the highest number of countries that regularly engage women living with HIV. Despite Eastern and Southern Africa having the highest HIV prevalence among women and girls, not all countries in that region confirm that networks of women living with HIV are being engaged. Women's engagement is weaker in the Middle East and North Africa, where support for women's leadership needs strengthening. In the Caribbean, organized groups exist but they have not yet been given a seat at the table. These data indicate a limited culture of inclusion of women living with HIV in all their diversity in decision-making, planning and monitoring for the HIV response. Improving the situation will require capacity development and resource allocation.

33. *Availability of a budget to support the capacity of community-based organizations of women, especially women affected by HIV, under the national strategic plan.* Institutionalizing the leadership of women, including those living with HIV, in decision-making requires sustained and well-funded capacity development their networks. The scorecard findings suggest this has not yet happened. Only one third (27 of 81) of national

strategic plans have dedicated budgets for developing the capacity of women's organizations and networks of women living with HIV. Brazil, for example, issues national tenders to provide support to networks of women living with HIV. Where funding is available, many countries, including Nigeria and Ukraine, indicate such resources tend to come from external sources, such as United Nations joint programmes or from Global Fund grants. In other countries, including Venezuela and Mozambique, budget lines have been established but no or inadequate resources have been allocated. Similarly in Angola, despite women living with HIV being expected to support HIV testing, care and treatment services, few resources are available to develop their organizations and community outreach efforts. Further, one quarter of countries (21 of 81) indicate no resources are available to develop the capacity of women's organizations.

34. A greater percentage of countries in West and Central Africa have allocated resources to women's organizations through the HIV response. In Eastern and Southern Africa only six of 18 national strategic plans (33%) have a dedicated budget in this regard; this is likely to contribute to relatively lower levels of engagement. Similarly, only three of eight Caribbean countries indicate their national programmes extend funding support to women's organizations. This correlates with a low level of engagement of women living with HIV, further hampering effective action for women and girls in the context of HIV.

35. *Participation of networks of women living with and affected by HIV in national CEDAW monitoring and reporting processes.* The CEDAW accountability mechanism was highlighted by UNAIDS Agenda for Women and Girls as a strategic entry point for women's rights and HIV movements to collaborate for a rights-based approach to HIV. Some 41% (32 of 78) of countries who are signatories to CEDAW indicated that networks of women affected by HIV are not involved in national reporting to CEDAW. Papua New Guinea reported that this was due to a lack of capacity among the women's networks; the Dominican Republic cited the lack of a common platform with the women's rights movement. Only 17% of countries (14 of 78) reported that women living with HIV or other groups of affected women, such as sex workers and women who use drugs, participated in CEDAW country reporting processes. India and Botswana, however, indicated networks of women infected and affected by HIV were comprehensively engaged in CEDAW country reporting processes, and in the case of India, also in shadow reporting.

36. Paradoxically, compared with a strong engagement in HIV planning and review mechanisms, no countries in Latin America reported systematic participation of women affected by HIV in CEDAW reporting. Similarly, in Asia and Pacific, half of the responding countries indicated that affected women were not consistently engaged in the CEDAW country reporting mechanisms. The Caribbean, despite high rates of HIV among women, had low rates of participation by women affected by HIV in CEDAW reporting, possibly linked to the weak support for women living with HIV noted above. Countries from sub-Saharan Africa reported the highest rates of engagement with CEDAW by women affected by HIV; in 10 of 34 (30%) of countries. This correlates with the relatively high prevalence of HIV among women in the region, where HIV may be considered a top priority for women's rights. In Uganda, the Ministry of Gender, Labour and Social Development constituted a national gender and AIDS task force, involving networks of women living with HIV and key populations, among other partners. This approach was then expanded to the district and lower levels through the national women's councils to ensure wide coverage. Guinea noted that the implementation of the UNAIDS Agenda for Women and Girls created an opportunity to strengthen the engagement of women living with and affected by HIV in CEDAW reporting.

Gender-based violence and gender norms

37. Gender-based violence (including violence against women and girls and sexual violence), whether in concentrated or generalized HIV epidemics, is both a cause and a consequence

of HIV infection and a graphic illustration of gender inequality. Violence and fear of violence can prevent a woman from insisting on condom use or from refusing unwanted sex. Moreover, stigma, discrimination and the criminalization of key affected populations, including sex workers and women who use drugs, prevent women from reporting acts of violence against them and seeking assistance and redress. There is a growing concern that anti-trafficking laws and policies put in place to protect people from violence and exploitation are being used by law enforcers to arrest sex workers or demolish sex-work establishments, thereby increasing vulnerability.

38. The UNAIDS Agenda for Women and Girls therefore calls for appropriate systems to be established to investigate and document violence and the link between HIV and different forms of violence against all women and girls, including key affected populations such as sex workers, women living with HIV, women who use drugs, young women and transgender women, and support a comprehensive, multifaceted response within and beyond the health sector. The scorecard survey gathered information on the following key elements of engaging women and girls:

- Data on the prevalence of gender-based violence and its links to HIV
- National health-sector policy on gender-based violence
- Funding for programmes for men and boys that support gender equality under the national response

39. *Data on the prevalence of gender-based violence and its links to HIV.* As noted above in paragraph 25, the majority of countries reported that the HIV response was not informed by data on gender-based violence. This lack of appropriate data analysis hinders a better understanding within key responsible ministries of how violence contributes to HIV vulnerability and is a major obstacle to achieving an effective and robust response to gender-based violence through HIV programmes. Recognizing the crucial gaps in data, Botswana this year plans to incorporate variables on gender-based violence and HIV in antenatal clinic surveys. In addition, the country plans to undertake a national study on the prevalence of gender-based violence and its links with HIV. In Brazil, the Federal Government has developed a national pact to fight violence against women. This pact provides information on the links between violence and HIV and also specifically promotes sexual and reproductive rights and the prevention of HIV among women.

40. The countries that have utilized data on gender-based violence and HIV for the national strategic plan are mainly in sub-Saharan Africa and Asia and Pacific. Swaziland conducted a landmark study on violence against girls in 2008 that resulted in an innovative global public-private partnership, *Together for Girls*, which documents and addresses sexual violence against adolescent girls. The regions with the biggest gaps in data are Eastern Europe and Central Asia, and the Middle East and North Africa. Recognizing that gender-based violence reinforces gender inequality and increases the vulnerabilities of women and young girls to HIV infection, Jamaica has recently committed to address gender-based violence and HIV. The *Declaration of Commitment to Eliminate Stigma, Discrimination and Gender Inequality* committed the country to accelerate social change for gender equality and to eliminate gender-based abuse and violence, particularly against women and girls.

41. *National health-sector policy on gender-based violence.* Despite the limited application of gender-based violence data in HIV programming, the health-sector policy in 38% (31 of 81) of the countries does address gender-based violence. In Malawi, South Africa and the United Republic of Tanzania, ministries of health have developed guidelines for post-rape care and clinical management guidelines. One third of countries (28 of 81) have small-scale action implemented largely by civil society groups. In the Gambia, despite the absence of a national policy on gender-based violence and HIV, civil society groups have initiated their own policies and strategies. The remaining 27% (22 of 81) of countries still have no health-sector policy on gender-based violence.

42. Seven of eight countries in Latin America have health-sector policies to provide services for survivors of gender-based violence. Brazil, for example, has a women's unit in the Ministry of Health charged with strengthening health services for survivors of violence, with policy support from the Women's Ministry. In Venezuela, the Ministry of Women's Affairs works with other ministries and national agencies and programmes to address gender-based violence. Public health centres provide services to victims of violence, although not necessarily linked to HIV.

43. Two thirds of the responding countries in Eastern Europe and Central Asia do not yet have health-sector policies on gender-based violence. Some of the countries, Azerbaijan for instance, are in the process of developing such policies. In Kazakhstan, a law to prevent domestic violence has been adopted but not translated into comprehensive inter-sectoral national programming to prevent and respond to violence against women. In Asia and Pacific, Nepal indicates that there is no specific policy on gender-based violence, but that action is being taken in the health sector under the national campaign against gender-based violence led by the prime minister. This suggests that countries have taken different approaches, in accordance with the local context, to address gender-based violence.

44. *Funding for programmes for men and boys that support gender equality under the national response*. National funding for programmes for men and boys that challenge gender inequality, including education on gender equality in primary and secondary schools, remains insufficient. A total of 27% (22 of 81) of countries reported that no funds had been available through the national response for men and boys. Partnerships with men and boys are critical to change harmful norms and practices that undermine gender equality and human rights, and fuel gender-based violence. However, only 10% (8 of 81) of countries have secured national funding for scaled-up programmes involving men and boys that challenge gender inequalities. Ethiopia, for example, is using the community conversation approach to engage men and boys to challenge existing gender inequality. A majority of countries (51 of 81) indicate that they fund small-scale interventions. In Malawi, civil society projects target the vertical transmission programme encouraging men to accompany their wives to the health facility for HIV testing, as a means to address gender-based violence when women are found to be HIV-positive. Kenya established 'MenKen', a network of organizations working with men and boys for gender equality.

45. The countries that have secured national funding to engage men and boys are mostly in sub-Saharan Africa. Four regions – Asia and Pacific, the Caribbean, the Middle East and North Africa and Eastern Europe and Central Asia – indicate no national funding for national programmes engaging men and boys for gender inequality. In Asia and Pacific, there is a growing recognition of how important it is to address masculinity and male sexual behavior – for the health and well-being of males as well as their female intimate partners. In Viet Nam, for example, the recent gender analysis of the national response urged the government to focus more on men and masculinity.

Linking HIV and sexual and reproductive health services for women and girls

46. The UNAIDS Agenda calls for linking HIV and sexual and reproductive health programmes, fostering a comprehensive approach to addressing the needs and rights of women and girls. The importance of having integrated services and gender-sensitive health-service providers working from rights-based perspectives, and building bridges across the previously uncoordinated sectors of health and gender, are increasingly recognized at the national level. A fundamental principle of linking sexual and reproductive health and HIV is to address gender inequality and human rights. Integrated services that respect and protect the human rights of women and girls should include the entire range of sexual and reproductive health services, including comprehensive sexuality education. HIV is the biggest single cause of death for women of reproductive age, making the strengthening of links between sexual and reproductive health and HIV services a programmatic priority for

achieving the MDGs, particularly MDG3 (gender equality), MDG4 (reducing child mortality), MDG5 (improving maternal health) and MDG6 (HIV). The scorecard survey gathered information on the following key elements of engaging women and girls:

- Strengthening the bi-directional integration of sexual and reproductive health and HIV services addressed under the national strategic plan for HIV
- Female condoms are procured and distributed

47. *Strengthening* bi-directional *integration of sexual and reproductive health and HIV services addressed under the national strategic plan for HIV.* Seventy-five of the 81 responding countries have taken action to address the bidirectional linkages between HIV and sexual and reproductive health services. One third of countries (27 of 81) have addressed such linkages in their national strategic plans on HIV. Country feedback indicated small-scale or project initiatives are serving as models for scaling up. Only six of 81 countries have not taken action yet. Azerbaijan has a national sexual and reproductive health strategy that includes HIV and sexual and reproductive health. Nigeria's federal plan to scale up prevention of vertical transmission also includes attention to sexual and reproductive health. While similar state plans are being developed, integrated services are provided at selected sites across the country. Iran is undertaking a needs assessment and situation analysis on linking HIV and sexual and reproductive health within the primary health-care system in the areas required.

48. Sub-Saharan Africa and the Caribbean have the highest percentage of countries reporting linkages between sexual and reproductive health and HIV services in their national strategic plan. This reflects an emerging trend in the global HIV response towards more comprehensive approaches. However, the reality remains that comprehensive, quality HIV and sexual and reproductive health services are not yet accessible for all women and girls, particularly those living with HIV and key affected populations. Anecdotal reports indicate that women and girls living with HIV suffer stigma and discrimination as well as violation of their sexual and reproductive health rights at the service-delivery level. Almost two thirds of countries (23 of 32) in Asia and Pacific, Latin America, and Middle East and North Africa report project-scale models that can be expanded with additional resources. Viet Nam reported that experience gained through projects had enabled it to develop guidelines on linkages between reproductive health and HIV, and it would now expand this initiative to the national level.

49. *Female condoms are procured and distributed.* Female condoms are an essential component of a comprehensive HIV and sexual and reproductive health service package. Although it has been in the market for more than 18 years, the promotion of the only currently female-initiated HIV prevention method has been limited. In 2009, one female condom was available for 36 women worldwide or one female condom for every six women in Sub-Saharan Africa the promotion of the female condom has been largely limited to projects targeting key affected populations at higher risk, such as female sex workers. Only 30% (24 of 81) of the reporting countries make female condoms available through national prevention programmes, half of them in Eastern and Southern Africa. Uganda has scaled up the social marketing of female condoms through the new national HIV prevention strategy.

50. Most countries that address the bi-directional linkages of HIV and sexual and reproductive health services also procure and distribute female condoms. However, there remain serious challenges in accessing to female condoms, including total dependency of low and middle income countries on the international communities for female condom supply, lack of high political support, lack of competition among a variety of female condom products (as is evident with male condoms), donor being tied to the Female Health Company pricing (US$0,60 per piece as compared to US$0.03 for a male condom), constant supply shortages (e.g. in Kenya and South Africa), cultural barriers (e.g. in Djibouti) and affordability (e.g. in Guinea and Malawi). The limited marketing and subsequent limited

uptake of the female condom represent a missed opportunity for female-initiated HIV prevention commodity. Indeed lack of access to the female condoms reduces women's capacity to control their fertility and health, thus reinforcing gender inequality.

Resources

51. The allocation of resources is a key constraint to a more effective HIV response for women, girls and gender equality. Without sufficient resource allocation, the UNAIDS Agenda will not fully operate. The survey gathered information on the following key elements:

- Data on dedicated resources budgeted and/or spent for women and girls' programmes under the national strategic plan are available
- Government ministries in charge of gender and women's issues include HIV in their operational planning and budgeting
- Social protection mechanisms (e.g. cash transfers and microfinance) are inclusive of women living with HIV

52. *Data on dedicated resources budgeted and/or spent for women and girls' programmes under the national strategic plan are available.* While countries recognize the importance of integrating women and girls' programmes in the national HIV responses, this commitment is not yet reflected in budgeting. Most countries face challenges undertaking gender-responsive budgeting and measuring expenditure for women and girls through HIV responses. In India, the government is committed to gender-responsive budgeting, but with limited systematic application for programme planning and review. Countries have used different approaches to gauge the resources needed and available for women and girls in the context of HIV. Djibouti reported that such data are only available at the level of projects funded by the Global Fund and the United Nations. The Gambia has undertaken a National AIDS Spending Assessment, in the context of UNGASS reporting, to capture the resource flow and allocation to various groups, including women and girls.

53. *Government ministries in charge of gender and women's issues include HIV in their operational planning and budgeting.* Often, national HIV strategic plans have not adequately budgeted for women, girls and gender equality. Nearly one fifth (17 of 81) of the countries indicated that ministries responsible for women, girls and gender equality have no plans for HIV. In fact, about one third (29 of 81) of the countries indicated that the concerned ministry had included HIV in its plans and budgets. Further, even when a dedicated HIV budget is available, it is frequently inadequate, as reported in Nigeria and Sierra Leone. In the case of the Dominican Republic, the Ministry of Women does not access any government allocation and is thereby dependent on international funding. Nepal highlighted the need for capacity development to mainstream HIV in the Ministry of Women's Affairs policy and programming.

54. *Social protection mechanisms (e.g. cash transfers and microfinance) are inclusive of women living with HIV.* Social protection mechanisms are a key intervention to help women and girls protect themselves from HIV and mitigate the epidemic's impact. Just 35% (28 of 81) of the countries reported that social protection mechanisms, such as cash transfers and social assistance, were accessible for women living with HIV through national programmes. In Ecuador, for example, national social protection mechanisms provide universal coverage to women in poverty, single mothers, people with disabilities, inclusive of women living with HIV, without special provision for HIV status. Half of the countries (41 of 81) have some form of social protection for women, largely at local levels and supported by civil society groups. Mali has established, at a local level, income-generation and microfinance activities to reduce the vulnerability of women living with HIV. Some 15% (12 of 81) of the countries indicated that no social protection mechanisms were available to women living with HIV.

55. National social protection mechanisms are predominantly in place in Eastern Europe and Central Asia and Latin America. Most countries in these regions report that women living with HIV can access these mechanisms. In sub-Saharan Africa, a majority of countries extend some level of support, mainly through cash transfers and microfinance interventions, although scaling this up to a national scope is yet to be achieved. Angola, for example, indicated that less than 3% of all families were receiving food or other forms of social assistance other than a pension, with the support of government, civil society groups, churches, and the private sector. The Caribbean reported the highest percentage of countries where social protection inclusive of women living with HIV is not available. While the majority of countries reported that some level of social protection was available to women living with HIV, accessibility to women living with HIV on the ground remains unclear.

ROLES OF UNAIDS AND UN WOMEN

56. This section presents an overview of the strategic assistance provided to countries by UNAIDS and UN Women, delivering as one in support of implementing the UNAIDS Agenda for Women and Girls. It also describes how UNAIDS, under the Unified Budget, Results and Accountability Framework, and UN Women, will address the gaps and challenges identified in this report, and implement their commitments to address women and girls' rights and gender equality through expanded HIV responses.

Availability of data

57. UNAIDS has provided technical and financial support to countries to bolster their strategic information as the basis for developing appropriate interventions for women, girls and gender equality through HIV responses. For example, a dedicated catalytic funding window, Programme Acceleration Funds, has supported gender assessments of national strategic and action plans. Also, through the *Universal Access Now* initiative, 10 countries received assistance in conducting gender analyses of the national response to HIV. In addition to supporting country reporting systems and UNGASS indicators, which have included sex-disaggregated behavioural indicators, useful tools for countries to better "know your epidemic and response" from a gender perspective have been developed.

58. Recognizing the need for a standard approach to evidence-based strategic planning that countries can adapt to their local contexts, UNAIDS and UN Women are developing gender-sensitive normative guidance and tools. Through the AIDS Strategy and Action Plan (ASAP) service, UNAIDS and UN Women are supporting country capacity to develop evidence-informed strategic and action plans. For example, the Benin national AIDS commission has led a gender assessment of the national HIV response with the support of UNAIDS and UN Women to prepare for the development of a new national strategic plan for HIV. In follow-up, the country will start collecting gender-sensitive data on HIV. Similarly, South Africa is using the UNAIDS Agenda for Women and Girls to review its national strategic plan for HIV and inform the development of a new one. In West and Central Africa, UNAIDS and UN Women are revising the HIV strategic planning guidelines, an exercise that will help other regions deliver more robust responses aligned to the realities of women and girls.

59. Looking forward, UNAIDS and UN Women will support countries to ensure that the HIV-specific needs of women and girls are addressed in at least half of all national responses, including gender-based violence. UNAIDS and UN Women will specifically work with national partners, including women's groups, to strengthen the quantitative and qualitative evidence base, so that HIV responses appropriately and effectively address the needs and rights of women and girls and gender equality. UNAIDS and UN Women will facilitate the analysis and sharing of evidence on gender-based violence and HIV linkages, particularly

with countries reviewing or developing national HIV strategies or gender-based violence strategies to ensure scaled-up programmatic action through adequately resourced HIV responses. Technical support will therefore focus on expanding strategic information on gender-related vulnerabilities and inequities to improve programme implementation, including in crisis and post-crisis countries.

60. UNAIDS will equally support countries to ensure that strategic actions on HIV are incorporated into national gender plans, sexual and reproductive and maternal and child health plans, and women's human rights action frameworks, with appropriate budgets for implementation, monitoring and evaluation.

Engagement of women and girls, including those living with HIV

61. UNAIDS and UN Women, through the UNAIDS Agenda for Women and Girls, have called for the empowerment and engagement of women living with HIV, recognizing the barriers women living with HIV face in obtaining a "seat at the table". UNAIDS and UN Women have undertaken capacity development of civil society organizations to overcome these barriers and to ensure women's representation in decision-making forums. This was carried out in more than 20 countries in 2010, including in Liberia with the Liberia Women Empowerment Network and Light Association, assisting them to engage in the country's efforts to put the UNAIDS Agenda for Women and Girls into operation. UNAIDS and UN Women have been joined with the Global Network of People living with HIV, the International Community of Women living with HIV and the International Planned Parenthood Federation, in calling for an end to stigma and discrimination against women living with HIV and to document such episodes through the HIV Stigma Index. UNAIDS and UN Women have supported women living with HIV to be active participants in monitoring the national HIV response and national reporting on global commitments, most notably for UNGASS.

62. UNAIDS and UN Women have encouraged and supported the organization of women in key affected populations, including women who use drugs and sex workers, to increasingly participate in national responses. The 2010 Asian regional consultation on sex work and HIV, jointly convened by UNAIDS and civil society, broke new ground on these previously taboo issues. UNAIDS has also drawn attention to the importance of mainstreaming the rights of women living with HIV into the broader women's rights agenda through strengthening the engagement of women living with HIV in the work of the Committee on the Elimination of Discrimination against Women, albeit in a limited number of countries, such as Indonesia and Sri Lanka.

63. Building on the actions described above, UNAIDS and UN Women are committed to strengthening social movements that address HIV-specific needs and the rights of women and girls, and has included this in the Unified Budget, Results and Accountability Framework. To this end, UNAIDS and UN Women will urge governments to establish systems and policies to enable women living with HIV to participate in national planning and reviews. Furthermore, existing resources for institutionalized technical support can be tapped via closer collaboration with regional technical support facilities. UNAIDS will build on good practices, such as the 'Gender Exchange' established among networks of gender-equality advocates and clients and providers of technical assistance in Asia, to better coordinate technical support for women, girls, gender equality and HIV.

64. As part of its work to enable HIV to be addressed as a women's rights issue, UNAIDS and UN Women will provide dedicated support to women living with HIV, and facilitate collaboration around a common agenda. UNAIDS will also continue to advocate for and with marginalized groups of women to articulate their needs and rights through strengthened engagement in policy dialogue.

Gender-based violence and gender norms

65. UNAIDS and UN Women have worked with partners to generate better data on gender-based violence and HIV through several initiatives. UNAIDS and UN Women are part of a public-private partnership, *Together for Girls*, that aims to generate evidence on sexual violence against girls for accelerated multisectoral action. The UNiTE campaign led by the Secretary-General is the leading advocacy initiative of the United Nations on violence against women. It has worked to galvanize political will and resolve to prevent and eliminate violence against women, including through strengthening data systems. Additionally, studies by WHO and Demographic and Health Surveys in nearly 100 countries have yielded population-based data on violence against women. UNAIDS and UN Women have also supported 15 countries in their efforts to integrate a response to gender-based violence, including engaging men and boys, in their national HIV strategic plans.

66. Recognizing the gaps in national responses, UNAIDS and UN Women have initiated advocacy and technical support with selected countries to better incorporate gender-based violence into national HIV strategic planning in 15 countries. In Malawi, UNAIDS and UN Women have supported the establishment of model one-stop centres that provide integrated legal and medical services for the survivors of gender-based violence and which will be opened throughout the country. Considerable work is in progress to improve global guidance on protocols for clinical services in managing rape and other forms of physical abuse. UNAIDS and UN Women have also provided catalytic funding for initiatives that counteract violence. In Zambia, for example, UNAIDS and UN Women support the Ministry of Local Government and Housing to engage chiefs as agents of change on sexual and gender-based violence as part of broader work on HIV prevention through the availability of catalytic funds.

67. UNAIDS and UN Women have promoted gender equality by supporting the integration of comprehensive sexuality education and life skills education into school curricula. In South Africa, UNAIDS and UN Women have supported efforts to engage men and boys in efforts to transform social norms and power dynamics in the context of HIV. In conflict and post-emergency contexts, UNAIDS and UN Women have made efforts to incorporate actions against gender-based violence into early-recovery programmes.

68. Putting into operation its commitment to zero tolerance for gender-based violence through the HIV response, as reflected in the Unified Budget, Results and Accountability Framework, UNAIDS and UN Women will support country partners accelerate action around sexual violence and other forms of gender-based violence. UNAIDS and UN Women will facilitate the analysis of evidence on the links between gender-based violence and HIV.

69. This data will be used to support national strategic plans on HIV to integrate gender-based violence at the policy, programme and services level. This will include actions and resources that address and prevent epidemics through a multisectoral approach, including appropriate prevention and care protocols and linkages to non-health services. Dedicated attention will be paid to hyper-endemic and crisis and post-crisis countries to remove violence as a barrier to HIV prevention, treatment, care and support.

Linking HIV and sexual and reproductive health services for women and girls

70. UNAIDS and UN Women have strongly advocated for and supported countries in addressing the multifaceted links between HIV and sexual and reproductive health and in ensuring complementary service delivery. The thematic focus on *Sexual and Reproductive Health Services with HIV Interventions in Practice* at the June 2010 Programme Coordinating Board meeting was instrumental in further highlighting the importance of such an approach for universal access and to achieve MDGs 3–6. UNAIDS and UN Women have also advocated for appropriate action to address the violations of sexual and

reproductive health and the rights of women and girls living with HIV as a non-negotiable issue within the HIV response. UNAIDS supported the International Community of Women living with HIV to identify and summarize the main challenges faced by women and girls living with HIV. The outcomes were then discussed at the 2011 meeting of the Commission on the Status of Women, convened by UNAIDS and UN Women, resulting in key conclusions for the United Nations High Level Meeting on HIV/AIDS,

71. UNAIDS, UN Women and partners provided normative guidance and tools to support countries strengthen linkages between HIV and sexual and reproductive health. In particular, the Interagency Working Group on Sexual and Reproductive Health and HIV Linkages developed the *Sexual and Reproductive Health and HIV Linkages Resource Pack*, published in 2010. About 20 countries have used the rapid assessment tool for sexual and reproductive health and HIV linkages to assess and identify gaps in the policies, systems, and services related to sexual and reproductive health and HIV. As a result, the European Union, with the facilitation of UNAIDS, agreed to support countries through a four-year project entitled “Linking HIV and sexual and reproductive health and rights’ in selected countries in Southern Africa.

72. UNAIDS and UN Women convened a consultation of 16 countries that had implemented the tool, and eight countries about to do so. This enabled countries to share their experiences and results; review good practice; and identify actions to improve health, human rights and gender equality related to sexual and reproductive health and HIV. The outcomes will help countries plan national follow-up actions to strengthen linkages, including activities for inclusion in proposals to the Global Fund.

73. UNAIDS, UN Women and partners have committed to a bold new goal of eliminating new paediatric HIV infections and improving maternal health and survival by 2015, and have begun to develop strategic plans to achieve this goal, including related targets and indicators. UNAIDS will leverage this initiative to support scaled up comprehensive HIV and sexual and reproductive health services, including maternal and child health, for women and girls.

74. UNAIDS and UN Women will therefore specifically focus on strengthening the two-way linkage between HIV and sexual and reproductive health services, through advocacy, guidance and building the capacity of countries, engaging critical partners, particularly networks of women living with HIV and women’s groups. This will include work to prevent vertical transmission, scale up spouse and partner counseling and eliminate coerced abortion and sterilization of women living with HIV.

Resources

75. UNAIDS and UN Women have assisted governments and civil society groups to accelerate action on women, girls, gender equality and HIV, by providing catalytic funds, technical guidance and supporting capacity development. In addition, through advocacy at national, regional and global level, UNAIDS and UN Women have made a case for investing in women and girls through HIV responses.

76. UNAIDS and UN Women provided catalytic funding to networks of women living with HIV and women’s groups at different levels to strengthen their voice and advocacy to shape HIV-related public policy. For example, UNAIDS recently supported the Athena Network facilitate a global consultation of women to develop key messages for the High Level Meeting on AIDS. The virtual consultations brought together women from 95 countries and all walks of life to share their experiences and expectations of the response to HIV.

77. UNAIDS and UN Women worked in close partnership with the Global Fund and countries to translate the commitments made through its Gender Equality strategy into resources at the country level for the HIV-related needs and rights of women and girls. In 2010, for Global

Fund round 11, UNAIDS provided intensified technical assistance to countries to develop gender-responsive proposals to the Global Fund, as well as leveraging existing grants.

78. However, access to scarce resources remains a critical issue. Therefore, UNAIDS and UN Women commit, as articulated through the Unified Budget, Results and Accountability Framework, to ensure strategic actions for women and girls are incorporated into national AIDS strategic plans, with appropriate budgets. To this end, UNAIDS and UN Women will use their partnerships with global financing mechanisms, such as the Global Fund, Global Health Initiative, and Global Alliance for Vaccines and Immunization, to further invest in gender equality and women's rights within the HIV response. This will include prioritizing the capacity development of networks of women living with HIV and women's rights and gender equality groups.

79. In line with the UNAIDS Strategy 'Getting to Zero', the UNAIDS Unified Budget, Results and Accountability Framework allocates the programme's resources to its three strategic directions, including human rights and gender equality. In addition, gender equality, as a crosscutting issue, is also addressed through UNAIDS' work on prevention and treatment.

CONCLUSIONS

80. Increasing comprehensive quantitative and qualitative data on the gender dimensions of the HIV epidemic, including gender-based violence, should be a priority for countries because such a database is a foundation of a national response to HIV that truly addresses the needs and rights of women and girls, especially those living with HIV. Additional efforts are required to align HIV responses to the realities faced by women and girls.

81. Sustained and meaningful participation of women and girls in all their diversity, including women living with HIV, throughout the national HIV response as well as the broader development and human rights processes and forums, must be resourced to secure their human rights and counter stigma and discrimination. This requires access to capacity development assistance for rights literacy and community outreach.

82. HIV responses must address gender-based violence through a multisectoral approach. This should include national programmes to prevent and manage gender-based violence, and to reduce harmful gender norms and practices, such as the scaled-up engagement of men and boys for gender equality and expanded quality sexuality education.

83. Work addressing the bidirectional linkages of HIV and sexual and reproductive health services must focus on ensuring comprehensive stigma-free access to services for women and girls, particularly those living with HIV. This should include, among other interventions, capacity development of health-care personnel and increased access to female condoms. Global initiatives around the health of women and children should build on the efforts of HIV responses to address the full diversity of women's sexual and reproductive health needs and rights throughout their life-cycle, and ensure a bigger impact on the MDGs.

84. At the country level, there is a clear need to move beyond the catalytic funds made available by UNAIDS and UN Women, and to ensure robust resource mobilization and leveraging available funds for women, girls, gender equality and HIV. National ownership of HIV responses tailored to the needs of women and girls is critical for the allocation of adequate resources at the country level from domestic and global sources. This is required to support the leadership and empowerment of women and girls, including those living with HIV and those from key affected populations.

85. The Programme Coordinating Board is invited to take note of the report recognizing that further monitoring of implementation of the UNAIDS Agenda for Accelerated Country Action on Women, Girls, Gender Equality and HIV will be done and reported to the Programme Coordinating Board through the Unified Budget, Results and Accountability Framework

which includes outcomes and indicators specific to the gender dimensions of the response to AIDS.

ANNEX I SCORECARD QUESTIONNAIRE

Statement	Rating scale			
Please rate the progress of the national HIV response in relation to women, girls and gender equality.	**Red**	**Orange**	**Green**	**Comments**
Recommendation 1: Jointly generate better evidence and increased understanding of the specific needs of women and girls in the context of HIV and ensure prioritized and tailored national AIDS responses that protect and promote the rights of women and girls (knowing your epidemic and response)				
1. a. Generalized Epidemics: Age and sex disaggregated HIV epidemiological and behavioral data for the general population and key affected populations are available. b. Concentrated Epidemics: Age and sex disaggregated HIV epidemiological and behavioral data for key affected populations are available. *(According to UNGASS guidelines, this means for countries with generalized epidemics populations: female/male, and by ten-year cohorts, e.g., 10-14, 15-24, 25-34… etc., and for key populations: male/female below 25, and above 25)*	Not available	Only epidemiological or behavioral data are age and sex disaggregated	Both epidemiological and behavioral data age and sex disaggregated	If not available, please describe if missing for which population groups Countries with concentrated epidemics, please indicate here if data on sexual partners of key affected populations is available
Qualitative assessments of the social, economic and legal factors that put women and girls at risk of HIV have been conducted (situation analysis).	Not available	Assessments conducted with leadership of external partners or civil society	Assessments conducted with the leadership of the national authority (e.g. national AIDS commission/programme of ministry of women's affairs) and full engagement of civil society	
3. The country has undertaken a gender review/audit of the national response in the last three years (response analysis).	No review undertaken	Review undertaken with leadership of external partners or civil society	Review undertaken with the leadership of the national AIDS commission/progr	

			amme	
4. Country data available on the links between gender-based violence and HIV	Not available	Data available but not reflected in national AIDS strategic plan	Data available and reflected in national AIDS strategic plan	
5. a) In generalized epidemics, data on dedicated resources budgeted and/ or spent for women's and girls' programmes under the national strategic plan are available.	Not available	Only available for specific projects (e.g. GFATM, PEPFAR,)	Comprehensive national data from all sources available (e.g. NASA)	
Recommendation 2: Reinforce the translation of political commitments into scaled-up action and resources for policies and programmes that address the rights and needs of women and girls in the context of HIV, with the support of all relevant partners, at the global, national and community level				
6. The national response funds programmes with men and boys that challenge gender inequality.	None	Only small-scale projects funded	Scaled-up, national level programmes funded	
7. The national strategic plan addresses the strengthening the bi-directional (two-way) integration of sexual and reproductive health and HIV services.	No	implementing integration plan at select sites, or only covering select themes (e.g. four prongs of PMTCT)	implementing integration at national scale	
8. The health sector has a policy addressing gender-based violence.	No policy	Gender based violence only addressed by civil society groups	Ministry of Health has a policy on gender based violence	
9. Government ministries in charge of gender and women's issues include HIV in their operational planning and budgeting.	No	HIV plans included in plans, but not budgeted	HIV plans included in plans, and budgeted	
10. Female condoms are procured and distributed	No	For key populations only	Available to all women	

Recommendation 3: Champion leadership for an enabling environment that promotes and protects the human rights of women and girls and their empowerment, in the context of HIV, through increased advocacy and capacity and adequate resources				
11. Networks of women living with HIV participate in the formal planning and review mechanism of the national response to HIV.	No	Occasional engagement	Regular participants in formal planning and review mechanisms	
12. Networks of women affected by HIV, (e.g. women living with HIV, female sex workers, female drug user , trasnwomen) participate in national CEDAW monitoring and reporting processes –?	No participation	Occasionally participate	Regularly participate in CEDAW processes	
13. Social protection mechanisms (e.g. cash transfers and micro-finance) are inclusive of women living with HIV	No	Small-scale interventions at local levels	National social protection programmes,	
14. The national AIDS plan has a dedicated budget to support the capacity of community based organisations of women, especially women affected by HIV.	No	Small-scale initiatives, not included in national strategic plan	Funds allocated from national plan	

ANNEX II COUNTRY SCORECARD

	1. Disaggregated data	2. Qualitative assessments	3. National response gender review	4. GBV-HIV data	5. Data on national resources for women's programmes	6. Funding for men/boys programmes	7. SRH-HIV integration	8. Health sector GBV policy	9. HIV plans/budgets in women ministries	10. Female condoms	11. HIV+ women participation in response review	12. Affected women participation in CEDAW monitoring	13. Social protection for + women	14. Response budget for women organizations
East and Southern Africa														
Angola														
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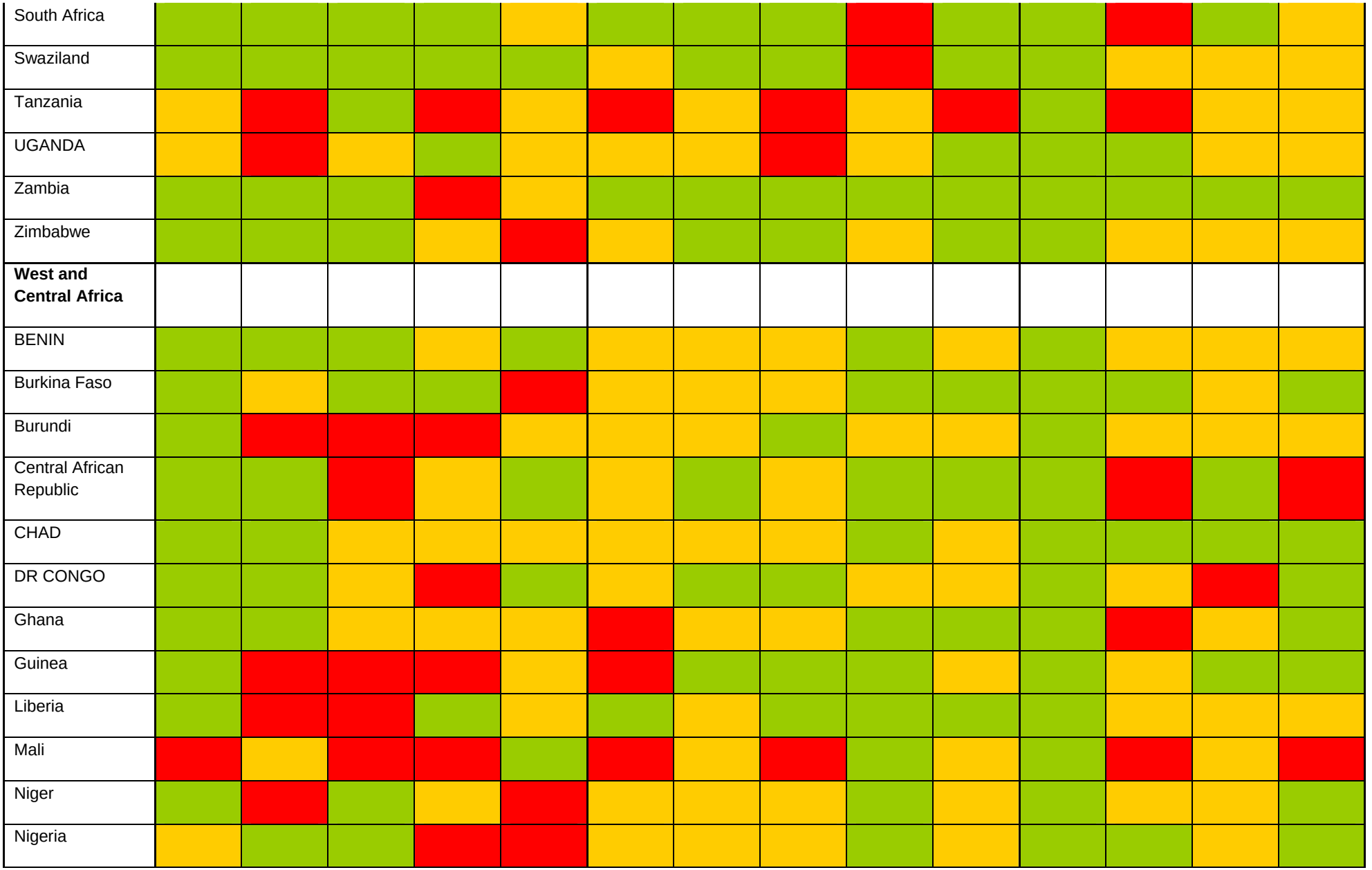
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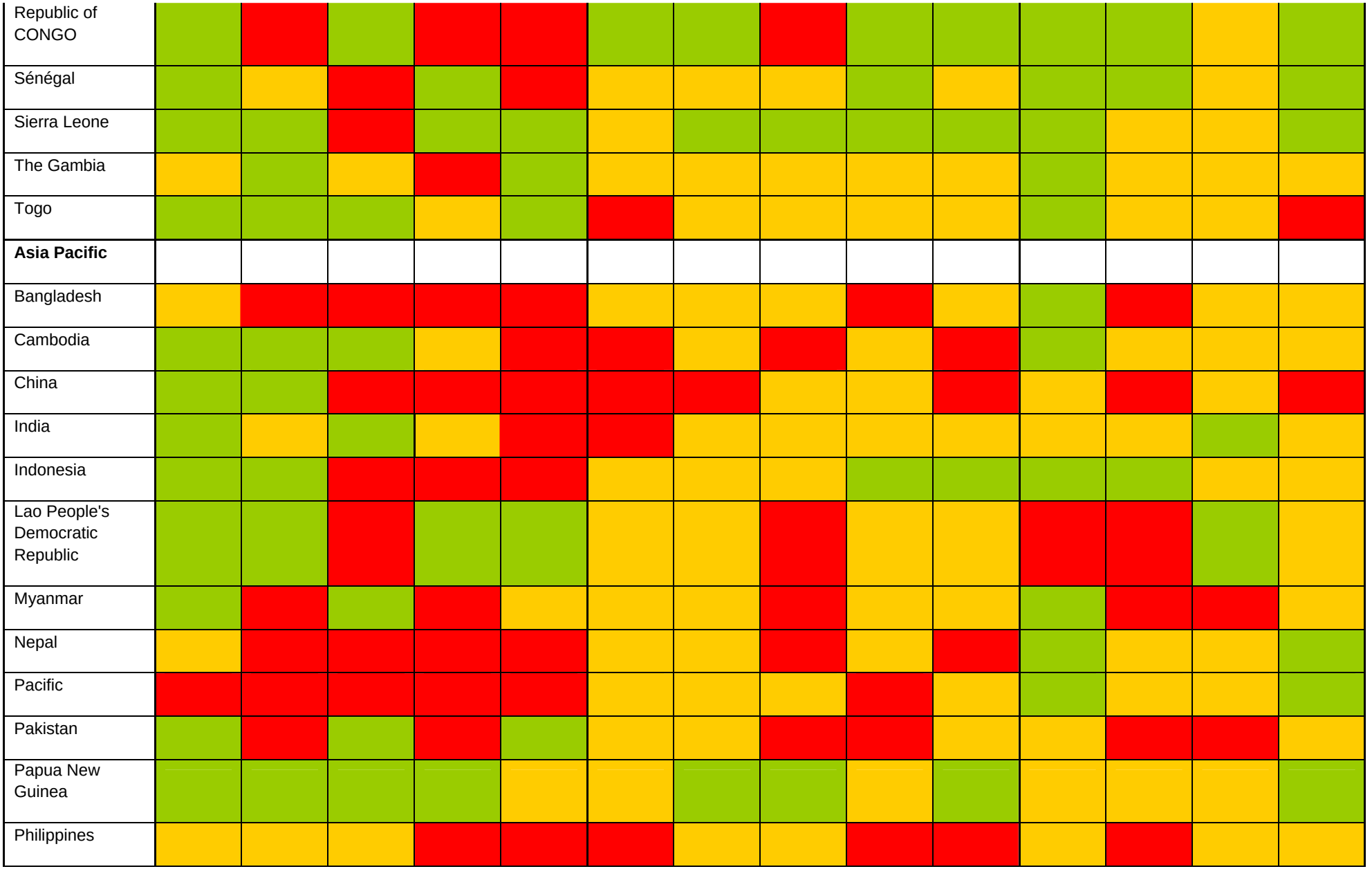

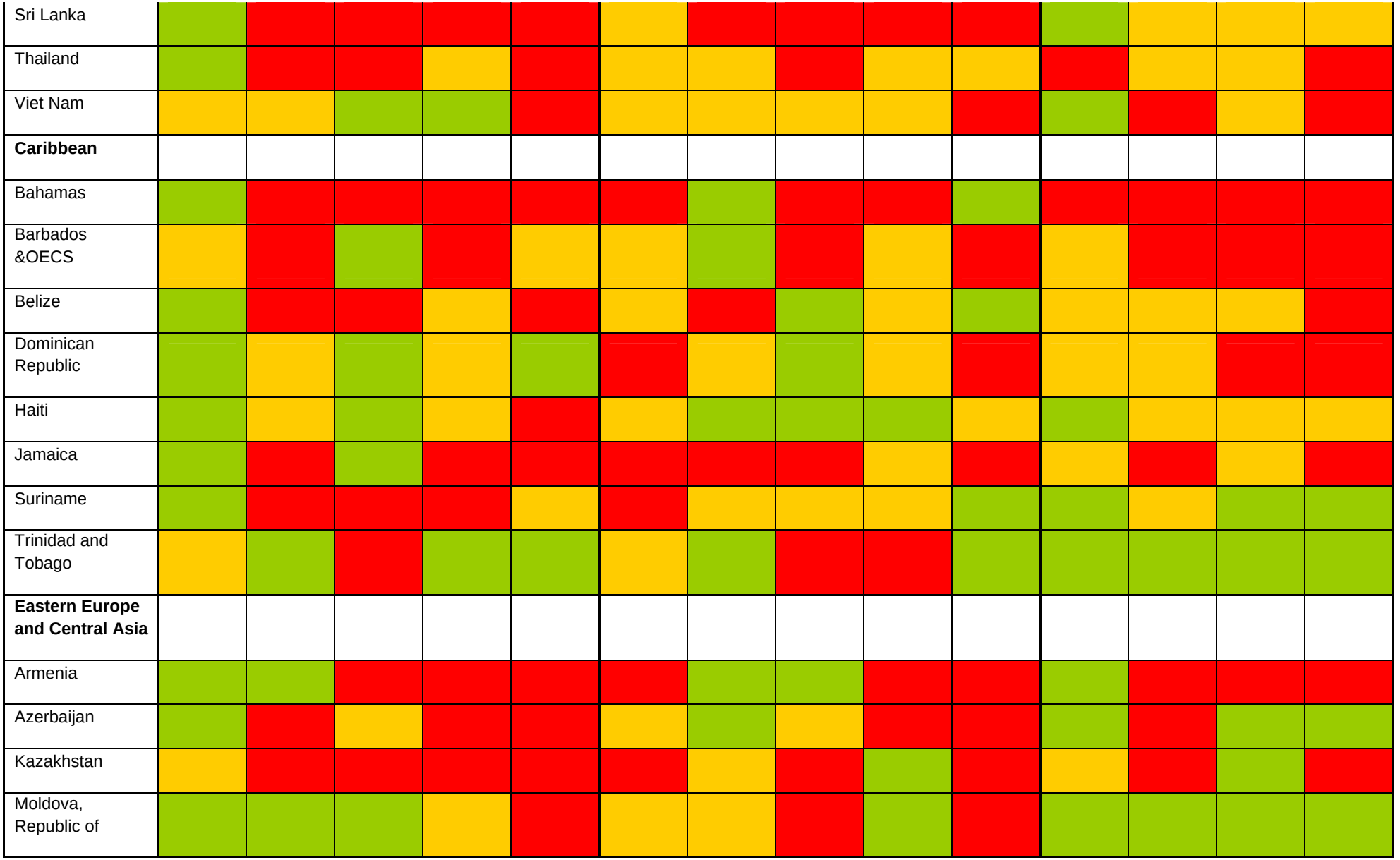
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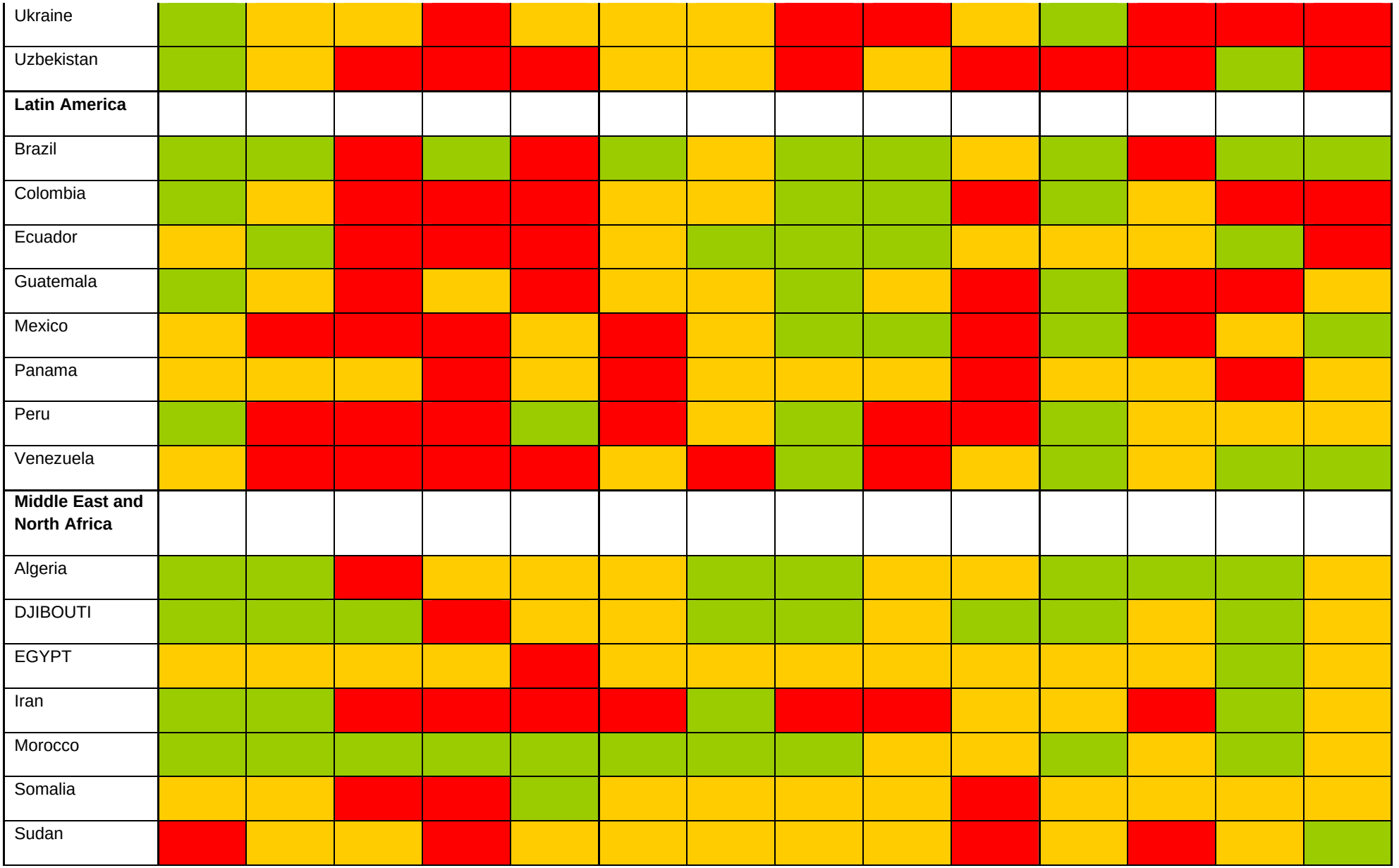
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