What about Women?

The Failure of HIV/AIDS Initiatives to Address the Needs of African Women

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HIV/AIDS continues to claim the lives of more African men, women and children than any other disease or conflict. As populations across the continent experience the destructive effects of this pandemic, the most marginalized communities feel the brunt.

Africa Action calls for a new and intense international focus on the situation of African women, as the only effective means to combat this pandemic.

Year after year, Africa continues to be the world region hit hardest by the pandemic. In 2006, roughly two out of three individuals living with AIDS were African and three out of four AIDS-related deaths occurred in Africa.[1] **African women in particular have become the face of the AIDS pandemic. Of the almost 25 million Africans living with HIV or AIDS, 59 percent of those are women.** The entrenched social and economic inequalities that disenfranchise women also put them at highest risk for infection. As a result, African women 15 to 24 years of age are three times more likely to be living with HIV or AIDS than their male counterparts.[2]

In the 1948 Universal Declaration of Human Rights, the international community affirmed health to be a fundamental human right. However, the harsh reality is that health is treated as privilege, determinant upon access to information, vital social services and resources. That the substantial bulk of HIV/AIDS infections and deaths occur in Africa is not a coincidence. It is a feature of the global system of inequality tied to geographic place, race, class and gender, known as *global apartheid.* Global apartheid captures a fundamental and pernicious inequality in the relations between the Global South and the northern or developed countries. The South contains the majority of the globe's population and is saddled with poverty and most persons living with HIV/AIDS. In contrast, the minority developed economies maintain their privileged perch atop the pyramid by ruling and controlling financial and political international organizations.[3]

The World Bank's economic policies have played a decisive role in the African nations' accumulated debt. In the 1980s, the World Bank and International Monetary Fund (IMF) employed harmful structural adjustment and stabilization policies. Today, these institutions continue to hold countries responsible for odious and illegitimate debts and enforce loan conditions, which consistently undermine African nations' economic development. Overall, African nations' increased debts have translated into declines in annual incomes and greater overall impoverishment. Structural adjustment policies, prescribed for African nations with the goals of promoting economic development, cut marginalized communities off from basic

services necessary for survival. Such policies have been particularly harmful for the most vulnerable populations in these African nations, negatively impacting the health status of women and children.

Through conditions attached to African countries' loans, the international financial institutions have forced African governments to institute specific economic policies that prioritize loan repayment over health care. African governments are forced to reduce spending on health, privatize health services and introduce "user fees" for vital health services. The cumulative result is that across the continent, health infrastructures are debilitated and basic services are inaccessible to Africa's poor. Clearly, such policies have contributed to African nations' vulnerability and to the pandemic's spread.

Poverty, gender, race and class are also major factors exacerbating the spread of the pandemic. As a result of global apartheid, Africa not only bears the brunt of the pandemic, but also possesses inadequate resources to combat it. External debts and the economic drain of debt servicing have substantially constrained African nations' capacity to finance development and respond to urgent health crises. As poverty limits health resources, individuals' right to healthcare access becomes dependent on geographic location in the world, class, race and gender. As a result, poor African women lack access, rendering them especially vulnerable.

This international crisis merits an international, comprehensive response. Three programs – the World Bank's Multi-Country AIDS Program (MAP), The President's Emergency Plan for AIDS Relief (PEPFAR) and the Global Fund to Fight AIDS, Tuberculosis and Malaria – have emerged as the predominant initiatives to address the pandemic. These programs represent the largest financial commitments addressing HIV/AIDS in the hardest hit region in the world. Their size and goals are commendable, but fighting this pandemic means confronting the fundamental elements that facilitate its spread, namely, the increased threat of infection African women experience on a daily basis because of social and economic inequalities.

African Women: The Face of the Pandemic

Violence against women is not solely an African phenomenon. But when this violence is combined with economic and social inequalities and inadequate access to health resources and information, African women are most vulnerable to HIV infection.

Unequal power relationships in society, within families and in intimate relationships compound women's risk of infection. Poverty, illiteracy, gender-based violence such as physical abuse and harassment, economic factors such as women's lack of autonomy, cultural stereotypes, and intergenerational marriage preclude women from choosing whether they would like to engage in sexual encounters, and when they do engage in them, these factors limit women's ability to negotiate safe-sex measures to protect against infection.

Physical and sexual abuse including rape, sexual harassment and assault, trafficking and forced prostitution all stem from women's unequal status and increase their risk of becoming HIV positive. Gender-based violence in the home and community pose a persistent threat to African

women's autonomy.[4] Women are also vulnerable in conflict situations, especially where rape is used as a tool of violence.[5]

Even marriage does not protect women and young girls, as married African women report high rates of infection. In the marital context, the factors that undermine women's power are reproduced. The threat of physical violence undermines women's ability to control the circumstances in which sex takes place, and they are unable to negotiate condom use with their husbands who may have extramarital sex partners. When their husbands engage in migrant work, women are at additional risk of infection. In a research study conducted in Cameroon, husbands who were away from home for one month had a higher HIV prevalence (7.6 percent) than husbands who remained at home for that same time period (1.4 percent).[6] In addition, married women are likely to frequently engage in intercourse with their partners, and this increases their infection risk.[7]

Despite a global trend in the increasing age at which individuals marry, early marriage in Africa is still common. When young girls are married to older men in intergenerational marriages, these young girls and women are less able to negotiate the terms for safe sex practices. In many African countries, the majority of married, sexually active girls who are 15 to 19 years of age experience higher rates of infection than their sexually active, unmarried peers. All girls at this early stage of physical development are biologically more susceptible to infection, but for those who are married, their partners are more likely to be older men who have had previous sexual partners and are less predisposed to condom use. As a result, these young girls' risk of infection is increased.[8]

A combination of poverty, marginalization and the resulting power dynamics between men and women force women and young girls into risky behavior such as transactional sex. Transactional sex could include commercial sex work for money, but it also extends to sex provided in exchange for necessities that women cannot otherwise access – these could include food, household goods, or school fees.[9]

As a result of global apartheid, harmful economic policies and unequal opportunities, African women experience a higher likelihood of becoming infected with HIV. Fighting HIV and AIDS means fighting the factors driving its spread. This includes addressing the inequalities and behaviors that promote African women's disenfranchisement. An effective effort to combat HIV and AIDS requires the full recognition of this situation and a sustained response that is tailored to women's needs. The international community must develop a response that supports women's empowerment.

The International Commitment to Address HIV/AIDS

In recent years, African governments and other members of the international community have reiterated a commitment to combat women's disenfranchisement and HIV/AIDS. Declarations, resolutions and pledges recognized the need for women's empowerment in general and linked this necessity to women's particular susceptibility within the scope of the pandemic.

In 2000, the United Nations Millennium Summit set eight Millennium Development Goals (MDGs) for combating poverty, hunger, disease, illiteracy and discrimination against women by 2015. Among these goals was the objective to empower women and promote gender equality and reverse the spread of diseases such as HIV/AIDS. The MDGs embody international commitments and provide countries with development targets.[10]

In 2001, African governments created the Abuja Declaration and Framework for Action, establishing a formal commitment to intensify African efforts to tackle HIV/AIDS. The declaration appealed to donor countries and organizations to complement African HIV/AIDS resources and support in financing and mobilization efforts oriented under the direction of local initiatives.[11] African civil society in particular pushed for this declaration and its future implementation.

Later that same year, the UN General Assembly Special Session (UNGASS) adopted the Declaration of Commitment on HIV/AIDS, which acknowledged gender equality and women's empowerment as "fundamental elements" in reducing the pandemic's spread. It called for global action in the form of cooperative partnerships between the public and private sectors and civil society. It set several targets, including the establishment of initiatives involving the private sector, civil society, vulnerable groups and those living with HIV/AIDS, increased access in local communities to a wider range of culturally conducive preventative programs, and a reduction in HIV prevalence in young men and women around the world.[12]

In June 2006, UNGASS reconvened to review past progress of its then five-year-old commitments. **In that time, despite the creation of international initiatives to address the pandemic, the expansion and feminization of the pandemic had continued.** In the formal declaration that followed, the assembly acknowledged their inadequate response and reaffirmed the need for universal, comprehensive prevention, treatment and support programs. However, it failed to provide the bold leadership commitments and targets that would demand the global action envisioned in the original declaration. Governments' consistently weakened the final declaration's demands, acknowledging the immense gap in HIV funding without committing to close it, watering down language on prevention, and falling short of identifying the vulnerable groups within the pandemic.

HIV/AIDS has spread at an astonishing pace throughout Africa as a consequence of the global disparity in economic, health and human rights resources. As the death toll of AIDS-related deaths continues to rise, it presents a significant obstacle to future development. These international commitments must serve as a major impetus for cooperation, collaboration and international initiatives on HIV/AIDS. They must lend necessary attention to the pandemic in general, particularly to African nations' struggle, and set the stage for future work.

Major International HIV/AIDS Initiatives at Work in Sub-Saharan Africa

Three initiatives have emerged in response to international calls for action on HIV and AIDS: the World Bank's Multi-Country HIV/AIDS Program (MAP), a $1.12 billion project focused on 29 African and Caribbean countries; the President's Emergency Plan for AIDS Relief (PEPFAR), a

five-year, $15 billion U.S. initiative operating in 123 countries with 60 percent of funds devoted to 15 focus countries; and the Global Fund to Fight AIDS, Tuberculosis and Malaria, a $7.6 billion project supporting programs in 136 countries. This report is based on the available information of the listed initiatives' policies and program work. It examines their approaches and key challenges in combating this pandemic in Sub-Saharan Africa.

Despite international declarations and intentions to address women's vulnerabilities within the scope of the pandemic, this issue continues to receive insufficient attention in policy and program work. A substantive commitment to women and HIV/AIDS is needed to curb the pandemic's spread and establish long-term change. This report will examine each of these initiatives, with a particular emphasis on their work in addressing women's vulnerabilities and the steps that must be taken.

World Bank Multi-Country HIV/AIDS Program for Africa (MAP)

In September 2000 the World Bank launched its Multi-country HIV/AIDS Program (MAP) in Africa and the Caribbean to allocate financial and technical support to nations' HIV/AIDS efforts in the form of grants, loans and zero-interest credits and advising. MAPs are currently active in 29 African countries, and their role is to assist local countries' HIV/AIDS initiatives. As one of the large international financial institutions, with the purported goal of facilitating economic development, this $1.12 billion program represents an insufficient monetary contribution toward a commitment to HIV/AIDS. The World Bank must significantly bolster its program funding, as well as ensure that current funding is used in the best way possible.

The stated goal of MAP is to increase local communities' access to prevention, care and treatment programs, with an emphasis on reaching out to youths, young women and other at-risk populations through country-driven projects.[13] The MAP describes its approach as strengthening existing programs on the ground by empowering community stakeholders with the funding and decision-making authority within projects. Government agencies, usually charged with project leadership with the requirement to collaborate with other societal sectors, are said to possess wide latitude in designing country plans and disseminating World Bank funds.[14]

The World Bank's operational guide for integrating gender into its HIV/AIDS programs outlines a number of concrete ways that projects could include gender into intervention approaches. At the project level, the guide recommends that projects identify female vulnerabilities according to the local community and the necessary interventions. It also suggests that workers collaborate with community leaders who could influence policies in support of vulnerable and at-risk populations. For monitoring and evaluation, the guide advises that programs separating statistical data by gender and employ gender-oriented indicators for measuring project success in addressing female vulnerabilities.

Unfortunately, within many of the MAPs, none of the indicators outlined within projects specifically address violence against women. In addition, many of the project indicators focus on outreach, and therefore projects are measured by their success in disseminating a message

without measuring the impacts on changing behavior.[15] Ensuring that gender and behavioral changes are a priority will achieve more long-lasting results.

In actual program implementation, the World Bank has yet to follow its own advice in adopting progressive, gender-sensitive strategies for tackling women's vulnerabilities. MAPs do incorporate gender and women' issues into project plans and programming, and gender issues do appear with regularity. But unfortunately, the issue is often introduced in on a superficial level and in a token manner, without laying out a specific plan for developing methods to empower women. Often, women's vulnerability is referenced in a country project's introductory local assessment of the pandemic, but the issue is not thoughtfully incorporated into the HIV/AIDS strategy. In instances when it is incorporated, it is either insufficiently addressed or there is a lack of specificity in how it would be addressed within the project's scope. [16] The World Bank has already outlined strategies for implementing gender in HIV/AIDS programs, but has yet to include these strategies in its schemes in a universal manner.

Although gender is stated as a focus of many MAPs, an interim review of the program showed that some governments were not incorporating it into their country plans.[17] In Uganda's country project assessment, young women 15-49 years are identified as a group with a particularly high infection rate. However, in the project's planning and measurements, instead of using young women's infection rates as an indicator to measure the success of the project, women are mentioned only in the context of reducing mother-to-child transmission and monitoring for prenatal care.[18]

Angola's country project, headed by its Ministry of Health, made a much more substantial effort to address violence against women and their vulnerabilities. It identified the large number of young women living with HIV/AIDS and made plans to address this by developing interventions that support less risky behavior for women, increasing women's capacity for negotiation in sex encounters and decreasing the stigma against women who are living with HIV or AIDS. It also targets widows in its projects, recognizing that these women's poverty, gender disparity and lack of access to information marginalize them.[19] However, although this project does focus on women, it does not include men as a group to be targeted, whose behavioral attitudes toward women would impact the status of women.[20]

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

In his January 2003 State of the Union address, President George W. Bush announced the President's Emergency Plan for AIDS Relief (PEPFAR), a U.S. approach to addressing the pandemic. Later that year, the U.S. Congress passed the U.S. Leadership Against HIV/AIDS, Tuberculosis and Malaria Act. The President signed the Act, establishing PEPFAR, the highest-funded health care initiative of a single nation to a single disease. PEPFAR is administered by the Office of the Global AIDS Coordinator (OGAC).

PEPFAR provides $10 billion of its assistance to 15 focus countries determined to be the most significantly affected by HIV/AIDS. Twelve of those 15 focus countries are in Sub-Saharan Africa: Botswana, Cote d'Ivoire, Ethiopia, Kenya, Mozambique, Namibia, Nigeria, Rwanda,

South Africa, Tanzania, Uganda and Zambia. PEPFAR's goals are to prevent 7 million new HIV/AIDS infections, treat 2 million individuals with AIDS-related illnesses and provide additional care and support to 10 million individuals living with AIDS or otherwise affected by it, including orphans and vulnerable children. Through PEPFAR, the U.S. had pledged $1 billion to the Global Fund.

Instead of supporting existent international or local initiatives addressing the pandemic, the U.S. sought to effectively "reinvent the wheel" and employ its own ideological approach. In addition, the emphasis on focus countries is too constricted, and invests in some countries while ignoring others with equally or even greater HIV prevalence. In the creation of this U.S.-led initiative and in its geographic focus, the U.S. framework for fighting the pandemic has been far too narrow, limiting its potential for success.

The most recent UN report on global AIDS categorized Lesotho, Swaziland and Zimbabwe as some of the most severely affected, with HIV prevalence levels ranging between 20% and 33%. None of these countries have been selected as PEPFAR focus countries, however. PEPFAR represents an enormous contribution to the fight against HIV and AIDS, but the narrowness of the program's conception, in terms of geographic scale, is a missed opportunity for an effective, broad response in some of Africa's hardest hit areas.

In its policy approach, OGAC emphasized the vulnerability of women as a fundamental aspect of the pandemic's spread and outlined gender components for PEPFAR projects. One of the most fundamental ways PEPFAR has provided gender-sensitive information is by requiring gender-specific statistical data, a first and basic step to allow for gender analysis in an international HIV/AIDS program.[21]

PEPFAR projects demonstrate a rhetorical commitment to countering gender inequalities, but because of lack of transparency, it is difficult to determine how effectively these components address women's needs.[22] PEPFAR must be more transparent concerning its operations and gender-sensitive measures by providing thorough statistics on projects' outcomes. At the same time, PEPFAR may be counting its own focus-country projects and those in Global Fund (to which the U.S. provides about a third of contributions) as PEPFAR successes. In counting both individuals provided treatment through PEPFAR and some individuals provided treatment in the Global Fund thanks to U.S. contributions, its total figures provide a distorted view of projects' actual effectiveness.[23]

In its first three years, by and large, project success was measured by calculating the program's reach within communities, with little regard for its success in effecting change in behavior on the individual or community level. Project success was measured by the estimated number of individuals reached with PEPFAR's prevention messages, including through community outreach, training to provide HIV/AIDS-related services or provided treatment, but there is no consideration for the impact of such programs, especially in changing long-term public behavior.[24] Instead of measuring the number of individuals reached through community outreach efforts such as media campaigns and radio broadcasts, projects must track the number of individuals actually employing the prevention practices that PEPFAR emphasizes.

Recognizing the need to curb new HIV/AIDS infections, PEPFAR has devoted a substantial amount of its efforts and assistance to prevention. The mainstay of PEPFAR's prevention strategy has been the "ABC" approach (Abstinence, Being faithful, and Correct and Consistent use of Condoms), which is coordinated into all of the program's intervention efforts. Prevention activities include abstinence and faithfulness projects, community outreach programs, mass media programs and other media campaigns where abstinence was the primary behavioral objective.[25] The emphasis on prevention is on A and B programs, targeted at delaying youths' participation in first sexual encounters, promoting secondary abstinence for those already sexually active and promoting mutual faithfulness and reducing partners in long-term sexual relationships and marriage.[26]

PEPFAR's moral ideology in its ABC framework interferes with proven scientific techniques on how to combat HIV/AIDS infections. Research has shown that clear and consistent condom use prevents HIV transmission, and condom must be a critical element to comprehensive HIV prevention to cut the spread of infections.[27] Still, PEPFAR only provides condoms to limited groups. Within PEPFAR's ABC framework, condom education and promotion efforts are limited to those who, according to PEPFAR, practice risky sexual behavior, such as commercial sex workers, those who engage in sexual activity with someone of unknown HIV status, injection drug users and men who have sex with men.[28] PEPFAR's stance is not nearly comprehensive enough and leaves many women at risk.

PEPFAR-funded programs are significantly limited by U.S. regulations in the information and services they are able to provide. For example, condom education and promotion must be accompanied by promotion of abstinence and faithfulness. Funds cannot be used to physically distribute or provide condoms in school settings or to individuals under the age of 15 under any circumstances; funds cannot be used to market condom use among youths; funds cannot be used for marketing campaigns that targets youths and organizations may not encourage condom use as a primary intervention for HIV protection.[29] The effect of this is that local communities are debilitated by the lack of condom access, and also possibly vital information on protection measures.

In some limited scenarios, condom education and promotion would be a possible for youths over the age of 15 when identified as at-risk.[30] But for those 14 years or younger, it would not be a possibility, despite the risk that young girls face. Because the average African girl and woman is not likely to fit into these groups, they lack access to the condoms that could protect them from infection. On the ground, given PEPFAR's partnerships with certain fairly conservative faith-based organizations working in communities, the actual provision of condoms to high-risk groups has been more of a "best-case scenario" than a routine one.[31]

The U.S. Leadership Against HIV/AIDS, Tuberculosis, and Malaria Act of 2003 establishing PEPFAR recommended that 20 percent of funds allocated to the program be spent on prevention. Furthermore, it required that, beginning in the 2006 fiscal year, 33 percent of that prevention funding be spent on abstinence-until-marriage activities. When OGAC in turn established policies for PEPFAR spending it surpassed the recommendation by requiring that one-third of PEPFAR funds go toward prevention, and within the prevention scope of activities, two thirds go toward AB activities. For the prevention budget, for every $1 that country teams can spend on

condom education and promotion activities, they must spend two dollars on abstinence and faithfulness ones.[32]

A report by the U.S. Government Accountability Office (GAO) rightly criticized the AB spending requirement because it drew spending away from other, equally necessary prevention activities, thereby reducing their overall effectiveness. In the report, 17 out of the 20 country teams stated that the abstinence-until-marriage spending requirement necessitated that the teams isolate funding for AB from C activities. They also complained that it limited their ability to respond to the cultural and social needs of locally identified risk populations to prevent HIV infection. Ten of the 17 teams requested exemptions, citing that the spending requirement meant reduced spending on other prevention efforts -- prevention of mother-to-child transmission (PMTCT), disseminating messages to high-risk populations, providing medical and blood safety activities and care programs – so that the AB spending requirement could be met. For example, one country team reported that meeting the AB funding requirement meant drastically reducing the PMTCT budget from $1.4 million to $350,000.[33]

PEPFAR's emphasis on AB prevention methods flies in the face of scientific evidence and dangerously downplays the effectiveness of condom use and more comprehensive preventative methods that would better concentrate on women's socioeconomic and cultural environments. In the GAO report, country teams noted the majority of infections were being transmitted in married or stable, cohabiting relationships, but because these individuals were not categorized in a high-risk group under PEPFAR guidance, they were unable to access more comprehensive ABC information.[34]

This ABC approach, with its heavy emphasis on abstinence and faithfulness, fails to truly address the factors that make women susceptible to infection. It provides options to women in situations in which they actually exercise very little, if any, control. The fact that the program promotes abstinence and faithfulness as the central themes in HIV prevention when married women constitute a striking number of HIV infections is evidence enough that this particular approach is insufficient.

This year, PEPFAR plans to add on to its gender strategies by addressing male norms and behaviors, responding to gender violence and identifying interventions for young girls' vulnerabilities. However, such changes have not yet been implemented, so it remains to be seen the extent to which they are implemented and their possible effects in changing behaviors.

On March 27, 2007, representatives Barbara Lee (D-CA) and Chris Shays (R-CT) introduced the Protection Against Transmission of HIV for Women and Youth (PATHWAY) Act. The PATHWAY Act was introduced for the first time in 2006. If adopted, it would remove the stipulation for half of prevention funding to be spent on abstinence-until-marriage programs. It would also call for the development of a more comprehensive HIV prevention strategy that addresses women and girls' vulnerabilities, including comprehensive health education beyond the ABC approach, increased access to male and female condoms and the integration of HIV prevention with reproductive health services.[35] The passage of the PATHWAY Act would be a significant step toward supporting African women threatened by HIV infection.

As a short-term program, PEPFAR has a vested interest in ensuring that its country projects have a vital and lasting impact. PEPFAR must better incorporate violence against women and into its intervention projects in order to address the inequality issues at the heart of the pandemic. PEPFAR therefore must adopt a more comprehensive approach that focuses specifically on women's vulnerabilities.

The Global Fund to Fight AIDS, Tuberculosis and Malaria

Founded in 2002, the Global Fund operates as a financing instrument to attract and manage international donations in the fight against the AIDS pandemic. Instead of implementing its own programs in recipient countries, the Global Fund leverages international financial resources to support existing local programs. In this manner, the Global Fund encourages local ownership by focusing on the technical quality of countries' grant proposals and leaving program design and implementation to local representatives in the public and private sectors and civil society. In this spirit of cooperation, internationally funded programs reflect the needs identified by local governments and agencies. Envisioned in 2000, the Global Fund was still in the works but received broad international support at the United Nations General Assembly Special Session on HIV/AIDS in 2001.

Since fundraising began in 2001, the Global Fund has attracted a total of $4.7 billion in pledged financing. The U.S., the largest contributor to the Global Fund, has generally contributed about 33 percent of the Fund's operating budget, or one dollar for every two dollars provides by other donors. The U.S. therefore serves as strategic leadership for leveraging funds for the Global Fund, and unfortunately, continually fails to contribute its fair share based on its global economic power.

The Global Fund recognizes the disproportionate impact of HIV/AIDS in Sub-Saharan Africa, and it has funneled the majority of funds toward Africa and HIV/AIDS projects. The Global Fund's greatest strength is in its integration of civil society in the country coordinating mechanisms (CCM). In CCMs, civil society, including individuals from NGOs as well as individuals living with HIV, sit on the board in equal partnership with government agencies and private institutions, and all collaborate to implement projects. The creation of these country-level partnerships fully mobilizes a country's AIDS response. CCMs develop national priorities and submit grant proposals to the Global Fund for funding approval. When approved, principal recipients identified by the CCM implement the projects on the ground using Global Fund grants.

Within its guidelines, the Global Fund has stated its recognition of gender inequalities within the pandemic, but given its stated commitment toward country ownership or projects, it has only encouraged gender representation within the CCM and other bodies and the desirability of a gender perspective in project work. CCM guidelines list the representation of a gender perspective in the CCM as desirable, but not requisite to grant approval.[36] Instead of proactively ensuring that projects include this necessary approach in their HIV prevention work, the Global Fund has left it to the prerogative of individual countries to include the issue at their discretion.

Fortunately, in its most recent round, it has begun calling for proposals that address the issue and discuss how projects will mainstream gender equality throughout their programs.[37]

An independent evaluation of country projects in Rounds 3 and 4 (in 2003 and 2004) found that across the board, CCMs had failed to achieve a gender balance in their composition or use a gender perspective in their work. In addition, many projects lacked statistical data that differentiated by gender. The Global Fund should require statistical data separated by sex to differentiate between male and female recipients of HIV prevention, treatment or care services.[38] Without data differentiated for sex, it becomes nearly impossible to monitor and evaluate projects' true effectiveness in addressing women's issues in the pandemic.

In its case study of Cameroon, the Global Fund consultant highlighted the absence of representation of women within the CCM. Many of the established women's and community associations that would focus specifically on women's health issues had not been informed of the CCMs activities and were not included in its CCM constituency.[39] In the case study of Benin, although women were included in a list of vulnerable groups to be targeted for HIV/AIDS prevention efforts, their mention was only in the capacity of sex workers and pregnant females (with the aim of preventing infections to their infants).[40]

Some countries with Global Fund financing did proactively address women's vulnerabilities to HIV. In Ivory Coast, the CCM sought to change behavioral attitudes through training sessions with peer educators, discussions and psychological groups to female victims of violence, and in Equatorial Guinea, the CCM focuses on the economic factors that put women at a disadvantage in relationships and in society, and it focused on the socioeconomic factors at the root causes for violence against women, sexual harassment and prostitution.[41]

Providing few conditions for proposals and allowing countries such leeway in directing their programs permits countries to more specifically address the pandemic as it relates to their constituency. However, it also leaves the possibility that CCMs will leave women's vulnerabilities and gender out of their country plans. In addition, many CCMs lack representation from women's NGOs and Women's Ministry government agencies, which would provide crucial gender perspective to project work.[42] The Global Fund must strongly encourage the participation of women's associations within CCMs. Few country proposals included the input of such organizations, and as a result, commitment to women was often overlooked in case studies of African countries. Civil society represents a key resource on this issue, and the CCMs must be inclusive in order to best reflect the needs of their communities.

At a minimum, the Global Fund requires the membership and participation of persons affected with the disease in the CCM, which upon actual implementation, may or may not involve women who are living with or vulnerable to HIV/AIDS that could and would speak to the role of their economic and social conditions in their status. A handbook on guidelines for improving CCMs recommends the representation of gender and vulnerable groups in CCM, although this has yet to be implemented.[43] The Global Fund must ensure that its participants, both male and female, and from all society's sectors, possess the skills, strategies and gender expertise to address the issues of gender inequity central to the pandemic. Such understanding is central to a systemic process for addressing gender issues.

The Global Fund's main opportunity for influence is in its application guidelines, review of grant applications and application recommendations. The technical review panel, a committee comprised of international health and development experts, review countries' project proposals and recommend projects for grants. At this level, there is not yet consideration given to whether these technical experts possess the gender expertise to look for gender-sensitive approaches in project proposals. Within its 34-member technical review panel for Round 7 grants, only two individuals expressed an expertise in reproductive or women's health issues. The Global Fund must actively seek technical advisors in its review panels who can use their gender expertise to recommend positive policies for country projects to address the social and economic environments that influence women's increased infection rates.

The Global Fund has had laudable success in galvanizing the international community in funding local initiatives, particularly in the area of AIDS. The structure of Global Fund country projects, relying on CCMs to plan and oversee the implementation of HIV/AIDS work, means that country have input in the planning and implementation of project initiatives. With this more democratic input, projects are more culturally conducive and more likely to reflect and address communities' needs. However, to create sustainable and long-lasting changes that can curb the spread of the epidemic among at-risk groups such as women, the Global Fund must see to it that projects incorporate a gender perspective in their work.

Conclusion

These international initiatives represent a strong commitment toward fighting the African HIV/AIDS pandemic. However, there remains much to be done. Each of these programs must scale up its efforts, specifically in addressing the factors within women's environment that make them vulnerable to infection. They must also continue to strengthen partnerships with civil society and gender experts to establish a calculated plan for successfully curbing HIV infections.

The urgency of the HIV and AIDS pandemic, and its disproportionate affect on African women, will not diminish without the presence of comprehensive, effective international action. The international community must fulfill its responsibility to focus its efforts on women's particular vulnerabilities in this devastating pandemic.

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