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**Background:** The Declaration of Commitment of the United Nations General Assembly Special Session on HIV/AIDS (UNGASS), in 2001, sets out several policy and programmatic commitments that pertain to women and the gender aspects of the HIV epidemic. Some of them are general, whereas others are more specific and include time-bounded targets. This article summarizes data on policies and strategies affecting women and men equity in access to antiretroviral treatment and other HIV services, as reported by countries but do not address other issues of gender, such as men having sex with men.

**Methods:** The analysis includes data from the National Composite Policy Index as reported by 130 countries in response to 14 questions relating to progress in creating an enabling policy environment for women. Additional data on gender equity in knowledge of HIV and access to HIV testing and antiretroviral treatment is obtained with other core UNGASS indicators. The review aggregates countries according to regions.

**Results:** A total of 147 countries provided national reports in which 78% of relevant UNGASS indicators were either completely or partially disaggregated by sex. However, 16% of countries did not report any HIV indicators by sex (with a range of 0%–29% across regions). A total of 82% (108 of 130) of countries report having policies in place to ensure that women have equal access to HIV-related services, but 14% of reporting countries also had laws and policies in place that hinder their ability to deliver effective HIV programs for women. About 80% of countries report having included women as a specific “sector” in their multisectoral AIDS strategies or action frameworks. However, only slightly more than half (53%) of those countries report having a budget attached to programs addressing women issues. As of the end of 2007, antiretroviral therapy reached 33% of people in need, and women represent a slight majority of those on treatment. The gender gap on HIV knowledge has narrowed, but overall levels of knowledge on how to prevent HIV remains at low levels, with only about 40% of young men (aged 15–24 years) and 36% of young women with correct comprehensive knowledge about HIV prevention.

**Conclusions:** Since 2001, a large majority of countries have integrated women-related issues into their national HIV policies and strategic plans. However, countries and regions with low-level or concentrated HIV epidemics lag behind countries with generalized epidemics in integrating women-focused policies into national frameworks. The lack of budget support for women-focused programs in half of the countries indicates that those policies have not been sufficiently translated into multisectoral activities. The engagement of development ministries in women’s social and economic empowerment is largely still lacking, which raises the concern that strategies to reduce gender inequality may also be lacking in broader development plans. The apparent attainment of gender equity in HIV testing and the delivery of antiretroviral treatment is an important achievement. There has also been a significant increase in countries’ abilities to collect and report data disaggregated by sex and age. The monitoring of women’s progress in HIV responses via the UNGASS reporting system provides important insights but should be complemented with data that strengthen understandings of the actual implementation of strategies, as well.

**Key Words:** gender, HIV, policies, UNGASS, women

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**INTRODUCTION**

Women and girls account for one-half of HIV cases worldwide, the majority of HIV infections in sub-Saharan Africa, and significant percentages of infections in other regions. More than 3 quarters of HIV-affected women live in sub-Saharan Africa.\textsuperscript{1,2} Throughout the world, women’s susceptibility to HIV infection is shaped by a complex interaction between socioeconomic and sociocultural relations, as well as biological factors that are associated with sexual transmission of HIV. Due to sociocultural norms, as well as gender and other inequalities, many women and girls lack the social and economic power to control key aspects of their lives, including sexual and reproductive decision making. As a result, women are at a disadvantage when it comes to accessing information about HIV prevention and negotiating safe sexual encounters. In addition to the personal burden of high rates of HIV infection, women and girls face higher rates of stigma, social ostracism and violence than men and generally have fewer...
legal protections—such as human rights protections, protections against violence, protections for their financial autonomy, and inheritance rights.

The 2001 Declaration of Commitment (DoC) of the United Nations General Assembly Special Session on HIV/AIDS (UNGASS) set out a number of policy and programmatic resolutions with key recommendations that pertain to women and the gendered aspects of the pandemic, some quite general, and others more specific, with time-bound targets.

Earlier, the International Conference on Population and Development (Cairo, 1994) and the Fourth World Conference on Women (Beijing, 1995) had focused attention on the impact of gender on sexual relations, reproductive health decision making and the transmission of HIV. Numerous commitments relating to the gendered aspects of HIV have accumulated subsequently. But progress in meeting those commitments is difficult to measure in the absence of reliable monitoring, clear time frames, strong advocacy and strengthened country ownership and responsibility.

The Joint United Nations Programme on HIV/AIDS (UNAIDS), in its first UNGASS DoC monitoring guidelines, developed indicators and methods to assist countries to specifically monitor their progress against the time-bound targets and key resolutions that Member States agreed to in 2001. The yardstick for measuring achievements was a set of 25 core national indicators, including 4 of the Millennium Development Goals. There was some initial concern whether governments would collect data and report on their progress against these indicators, unless (a) each indicator measured a specific commitment in the UNGASS DoC, (b) the number of indicators was limited, (c) indicators measured vital dimensions of multisectoral national AIDS programs to enhance ownership, (d) trends over time could be shown (which would require standardization across regions), and (e) the monitoring and evaluation process included civil society and vulnerable groups. In many countries, it took several years for government sector to open up the UNGASS reporting process to civil society.

The indicators were reviewed in 2005 and 2007 after each round of reporting, and additional indicators were incorporated.

One index, the National Composite Policy Index (NCPI), was designed specifically to assess progress in the development and implementation of legislation and policies related to national strategic plans, HIV prevention efforts, maintenance of human rights and provision of care and support. Specific questions on policies and programs related to women’s status and rights were integrated in various sections of the NCPI questionnaire.

The extent and quality of information contained in national reports submitted as part of the UNGASS monitoring process have improved vastly, making it increasingly possible to gauge whether countries’ HIV efforts are benefiting women and men equitably.

This article reviews the UNGASS monitoring and evaluation framework, with a specific focus on national program indicators:

1. Examine to what extent governments generally have adopted comprehensive policies on women and HIV;
2. Determine the main gaps for countries in achieving comprehensive policies and strategies on women and HIV;
3. Explore the extent to which improvements in women-based approaches in policy and strategic planning actually enhance equitable access for men and women to HIV prevention, treatment and care services.

METHODS

The NCPI is one of the 25 standardized UNGASS indicators. The NCPI questionnaire is compiled on the basis of a review of pertinent documents and information gathered from a variety of technical experts in monitoring and evaluation. Governments complete one section, which addresses strategic planning and political support. Representatives from local and international nongovernmental organizations complete the other section, which focuses on human rights and civil society involvement. In most of the reporting countries, civil society and UNAIDS were actively involved in the process of reconciling the interpretation of the data.

Gender equity in accessing services was also measured by using data from other UNGASS DoC indicators, including a composite indicator on knowledge about HIV and risk behaviors in young people and indicators on access to antiretroviral therapy (ART). In some cases, the information was supplemented with information from other sources, such as national household surveys (demographic and health surveys, multiple indicators cluster surveys and health data derived from health services’ surveys submitted to World Health Organization). National governments submitted country data to UNAIDS before the end of January 2008.

In the NCPI, 14 questions are relevant to women and HIV, 4 of which are open-ended questions that inform the overall analysis. All indicators relate to national policies and strategies. The review aggregates countries according to regions.

For the purpose of this analysis, the term gender refers to the social expectations, roles, status and power accorded to women and men because of their sex. Gender equality is the absence of discrimination on the basis of a person’s sex in opportunities, in the allocation of resources and benefits, or in
access to services. Gender equity refers to fairness and justice; it recognizes that women and men have different needs and power and that these differences should be identified and addressed in a manner that rectifies the imbalance between the sexes.

RESULTS

Response Rate

The number of countries reporting against the UNGASS indicators increased from 102 United Nations Member States in 2003 to 147 in 2008. The overall response rate was 77% (147 of 192 Member States). Importantly, almost all countries in sub-Saharan Africa and the Caribbean (the 2 regions with the highest HIV prevalence, together representing 67% of the global HIV burden) submitted reports in 2008. For the policy index section (NCPI), the response rate in January 2008 was 68% (130 of 192 countries), up from 46% in 2003.

Over time, UNGASS reporting of sex and age disaggregated data has been strengthened. The majority of countries now disaggregate HIV data by sex and report that information, making it possible to track shifts in the epidemic’s impact on women and girls over time against a number of indicators. In 2003, only 9 indicators requested data asking for a specific breakdown by sex and fewer than 1 in 5 reporting countries provided those disaggregated data. In 2008, of the 16 indicators for which sex disaggregation was requested, and for which any data was reported, 78% of indicators reported at least some sex disaggregation (partial or complete).

However, 16% (24 of 147) of countries do not yet monitor HIV programs by sex, with a range of 0%–29% across regions. One hundred percent of countries with generalized HIV epidemics do partially or completely disaggregate their indicator data by sex. In 2008, 29 of the 105 countries that indicated in the NCPI that data on ART coverage were disaggregated by sex failed to report disaggregated data for this UNGASS indicator.

Policy on Gender Equity to Access HIV Services

More countries than before reported that they have policies in place for ensuring that women and men have equal access to HIV-related services: 82% in 2007 compared with 75% in 2002. Progress is evident in all regions, although countries in East Asia and Latin America with “concentrated” HIV epidemics are least likely to have such policies.

However, 14% (18 of 129) of reporting countries also reported having laws and policies in place that present obstacles to their ability to deliver effective prevention, treatment, care and support for women, with a range of 29% in South Asia–Southeast Asia to 0% in Western Europe–Central Europe.

Women as a Target Population in National AIDS Plans, and Integration of Gender Issues in National Development Plans

More than 90% of countries report having included women and girls as explicit target populations in their national strategic AIDS plans, and slightly more than 80% list women as a “sector” in their multisectoral AIDS strategies. On the other hand, the national AIDS plans of about 20% of the countries do not yet include policies for empowering women.

In a separate (2008) survey conducted among UNAIDS country coordinators in 81 countries, more than half (53%) of the countries did not have programs for boosting women’s economic empowerment and more than two-thirds (69%) lacked programs for countering gender norms that increase women’s vulnerability to HIV. In that UNAIDS survey, fewer than 1 in 8 of the countries provided legal aid services or program interventions to enforce the property and inheritance rights of women and children in the context of HIV.

The UNGASS progress reports show that, globally, 71% and 65% of low- and middle-income countries have included reduction of gender inequalities and/or women’s economic empowerment, respectively, in at least 1 of the following plans: (a) National Development Plan, (b) Common Country Assessments, and (c) United Nations Development Assistance Framework. But fewer than 30% of countries have integrated those objectives in their (d) poverty reduction strategy articles, and fewer than 16% have incorporated them in (e) sector-wide approach instruments. Such integration is most widespread in the sub-Saharan Africa region, followed by South and South-East Asia, regions that account for 81% of the estimated total number of adult women (15 years and older) living with HIV globally. About 60% of countries in East Asia and Latin America have not yet incorporated women’s economic empowerment in at least 1 of their national development plans.

Half of the countries say that they have included efforts to reduce gender inequalities and boost women’s economic empowerment in their overall development plans. A little more than one-third of the countries have incorporated such efforts into their poverty reduction strategies, and almost as many have slotted them into sector-wide approach instruments. Countries in sub-Saharan Africa and South Asia were most likely to have taken these steps.

Of the countries reporting in the 2008 UNGASS round, 54% and 68% report that addressing violence against women and achieving greater involvement of men in reproductive health programs, respectively, are explicitly promoted as part of their HIV information, education and communication campaigns directed at the general population (Fig. 1).

Regions with concentrated HIV epidemics (including Eastern and Central Europe, Latin America and East Asia) have not taken violence against women and male involvement in reproductive health programs fully into account in their HIV responses.

Laws and Policies That Affirm and Protect the Rights of Women

Seventy percent of countries report the existence of laws and regulations that specify protections from discrimination for populations at higher risk for HIV infection, with those most commonly cited being women (87%) and young people (75%).

Nearly 90% of countries claim that they give sufficient attention to barriers that prevent women, children and most-at-risk populations from accessing HIV treatment, care and support services, except in East Asia and Latin America where the proportion is below 70%.
In the 2007 UNAIDS survey, UNAIDS asked its country coordinators in 71 countries whether laws blocking access to prevention, treatment, care and support services for sex workers were on the statute books. Such legislative barriers existed in more than 20% of those 71 countries and were most likely to be found in Asia, Oceania, Latin America and East and southern Africa. Countries in East and southern Africa accounted for 59% of the global total of women living with HIV in 2007. For example, only about half of the 71 countries said that they had trained law enforcement officials on the HIV-related legal, gender and other rights of most-at-risk populations.

Financing Women-Focused Programs

Policies can signal greater commitment. But to what extent are women-sensitive programs actually being implemented? A little more than half (53%) of the countries with women-focused policies say that they have provided specific, budgeted support for such programs—mostly in North America, Asia, the Caribbean and sub-Saharan Africa (Fig. 2). This suggests that women-focused HIV policies are not being implemented in nearly half of the countries with such policies. In addition, the indicator does not measure the amount of funding allocated to such programs and therefore, cannot assess extent and quality of programs in those countries that have provided budgeted support.

Young Men’s and Women’s Knowledge About HIV

Survey data from 64 countries indicate that 40% of men and 38% of women aged 15–24 years had accurate and comprehensive knowledge about HIV and about how to avoid transmission (UNGASS indicator 13). Although this represents an improvement, especially for women, over 2005 knowledge levels (when 37% of young men and 28% of young women were found to have a basic knowledge of HIV), knowledge levels in 2007 were still well below the DoC’s goal of ensuring comprehensive HIV knowledge in 95% of young people by 2010. This trend toward improvement in women’s knowledge about HIV prevention is shown in greater detail in Figure 3, which depicts the trend and the knowledge gap in the sub-Saharan region since 2003. Using Demographic and Health surveys data, results are shown for 14 countries in 2000–2003, for 9 countries in 2004–2005, and for 30 countries in 2006–2007. The gender gap is closing slightly.

Most countries (89%) report that they have integrated HIV education into their secondary school curricula, but only 65% address HIV education in primary schools, with countries in sub-Saharan Africa most likely to have done so. National governments in 67% of countries with generalized epidemics report that they have implemented school-based HIV education in most or all districts in need, and 42% say that they have put in place HIV prevention programs for out-of-school youth in most or all districts in need. However, responses from nongovernmental organizations indicate lower levels of implementation, at 51% and 28%, respectively. These lower estimates gain credence from the fact that only 34 of the 147 countries that submitted national progress reports in 2008 reported on the percentage of schools that taught life skills–based HIV prevention in the previous academic year. Among the reporting countries, this intervention was, on average, provided in less than 40% of schools. In addition, nongovernmental key informants in 36 countries (28%) state that they have laws, policies or regulations that actually impede young people’s access to HIV prevention and other services.
Gender Equity in AIDS Treatment

An estimated 3 million HIV-positive patients in low- and middle-income countries were receiving ART at the end of 2007. This represents a 42% increase in 1 year and a tenfold rise over the last 5 years, yet fewer than 40% of those in need were receiving ART.16 Equity in treatment access for women living with HIV has been a concern in light of the social and economic inequalities that exist between women and men, especially in many of the countries with the largest HIV burdens.17 Data show that across sub-Saharan Africa, women represent approximately 57% of people needing ART and comprise 61% of those receiving the treatment.16 In countries with low or concentrated HIV epidemics, they comprise even larger percentages of people on ART (Fig. 4). This suggests that women are not being discriminated against in terms of ART access. The finding seems in line with the general trend in which women tend to be more likely to seek health care services, compared with men.18

Preventing Mother-to-Child Transmission of HIV

Substantial reductions in mother-to-child transmission (MTCT) of HIV can be achieved through approaches such as short-course antiretroviral prophylaxis. In high-income countries, MTCT has been virtually eliminated by effective voluntary testing and counseling, access to ART, safe delivery practices and the widespread availability and safe use of breast-milk substitutes.18–20 In resource-poor settings, MTCT can be limited to well under 10% when the necessary services are available.21

In the 12 countries that reported sex-disaggregated data, 3 quarters or more of the adults and children who commenced ART were still receiving that treatment 12 months later. Treatment adherence was slightly stronger among women than men in 9 of those 12 countries.16

FIGURE 2. Percentage of countries in various regions reporting that women are addressed as a specific component of their multisectoral HIV strategies and with a specific HIV budget for their activities, 2008. Source: UNGASS Country progress reports, 2008. In parenthesis is the number of countries in the region.

Comparison With UNAIDS 2007 Review of Gender Assessments

The NCPI findings are consistent with the results of an assessment of gender and HIV issues conducted by UNAIDS in 2007.22 The assessment found increased recognition of the need to address gender inequality within national AIDS responses. It also noted that many recent efforts recognize the importance of addressing a broad range of gender-based vulnerabilities, including violence against women, women’s lack of inheritance and property rights, and the disproportionate burden of HIV care borne by women and girls. The assessment also noted important examples of leadership on gender issues, particularly in southern Africa.

The assessment identified several important challenges, including insufficient attention given to harmful male gender norms, and the tendency for gender planning efforts to occur separate from mainstream HIV processes, thereby limiting the extent to which such activities are budgeted and implemented, and limiting their impact across sectors. The assessment also found that few programs dedicate significant resources to empowering women and girls through law reform and legal support; social mobilization and economic empowerment schemes; campaigns against violence and inequality, harmful traditional practices and intergenerational sex; the provision of female condoms; the integration of HIV into sexual and reproductive health services; the prevention of early marriage; and efforts to keep girls in schools free of sexual violence.

DISCUSSION

Over the past 2 decades, research and strategies to combat HIV have increasingly recognized that HIV infection levels tend to be higher in women and girls than in men in sub-Saharan Africa and that the negative social and economic consequences of the HIV epidemic weigh most heavily on women and girls. They also have come to recognize that HIV prevention options are more limited for women (especially for those in marriages and other long-term relationships) and that gender-specific prevention, treatment and care programs, and services were needed.23 A series of commitments pertaining to such gendered patterns in HIV epidemic have emerged as a result.24

The Global Program on AIDS first efforts in monitoring and evaluation HIV prevention programs at country level started in 1992. The evaluation guide included 11 core indicators, each disaggregated by sex.25 However, since then, there is an ongoing debate about the need for specific gender-sensitive indicators that go beyond the disaggregation of data by sex.26,27 At the same time, the monitoring and evaluation of multisectoral national HIV programs has led to various development players (including United Nations agencies) calling for the inclusion of additional indicators. Harmonization efforts now emphasize country-led monitoring and evaluation systems, based especially on core national indicators that are needed for informing policy-making processes.27

In the recent past, countries in all regions have improved their capacities to monitor their HIV epidemics and track their responses. There is more and improved information available, which makes it possible to assess HIV responses in new ways, and to discern aspects of the responses that might have been obscured previously.15 The numbers of countries reporting against UNGASS indicators have increased impressively since 2003, as have the numbers of countries that are disaggregating those data by sex, thus providing new windows onto the gendered patterns of HIV epidemics and countries’ responses.

However, there is room for extending such progress. In several countries, data are being disaggregated by sex when collected at local level, but such potential richness of detail is not always reflected in national data and analysis.

In addition, clear improvements are needed in the extent and detail of information gathered for female sex workers and their clients, and for injecting drug users. Only 58 countries
reported information on whether female sex workers are being reached with HIV prevention services, whereas 87 countries reported on condom use among female sex workers. Several countries with significant injecting drug use–related epidemics did not provide sex-disaggregated data against some or all of those indicators.

The NCPI data collection exercise was based on the premise that national policies and strategies create the conditions and environment for national programs to develop and for HIV prevention, treatment and care services to be delivered equitably. However, the policy index cannot adequately measure whether women participate fully in the development of national AIDS plans and whether national AIDS planning and coordinating bodies, technical review panels and other structures are being strengthened with gender balance and expertise. Qualitative aspects are proving difficult to track.

An analysis to correlate the existence of women-friendly policies with progress or lack thereof on service delivery did not yield significant results. Indeed, it is very difficult to isolate the effect of progress in women-focused strategies from the many other factors (including other policies and strategies) that potentially affect service delivery outcomes. In addition, the NCPI can reflect whether certain policies and strategies exist, but beyond the data on key services presented above, the UNGASS DoC contains few indicators for assessing whether those policies and strategies are being implemented effectively and whether this has led to positive outcomes.

The NCPI was not designed to assess gender issues comprehensively. But it does offer insightful glimpses of the extent to which HIV responses now include women-focused elements. Additional improvements are needed to provide a more rigorous gendered analysis of HIV responses. Nonetheless, the available data show that many countries have made progress in including gender issues in their HIV strategies and policies. In every region, more countries than before have integrated women-related issues into their policies and national AIDS strategic plans. Progress has been strongest in countries experiencing serious "generalized" HIV epidemics. In countries where most people affected by HIV are men, however, "gender equity" (meaning that women affected by HIV, although a minority, receive the services they need) seems not to be a strong priority in HIV responses. It is possible that given the formal progress in a majority of countries, the policy index might soon become less relevant and that the focus should shift to examining financing, enforcement, and performance of these policies and strategies.

The fact that half of the countries with women-friendly policies have not provided budget support for women-focused programs is a major concern. So is the fact that women’s social and economic empowerment still does not feature prominently enough in many national development plans. This indicates that not only are gender equality issues frequently left out of national AIDS budgets but they also may be missing in a substantive way from the entire development picture, raising concerns about achieving the commitments to women in the DoCs and the MDGs.

The HIV knowledge gap between men and women has narrowed, but overall levels of prevention knowledge lag far behind the targets set in 2001. Women and girls are considerably less likely than men to know that condoms can prevent HIV infection, including in many of the countries with the highest HIV infection levels.

Coverage of programs for preventing MTCT has more than doubled in only 2 years (from 14% to 33%), but they still reach only a small minority of the women needing these services. That global average also hides huge diversity among countries, some of which have achieved 70% or higher coverage, whereas others struggle to reach even one-tenth of women in need, including in countries experiencing serious HIV epidemics. In addition, this indicator does not measure the prophylactic regimen, which is important to track countries moving away from single dose of nevirapine.

In the space of a few years, most countries have made some progress toward ensuring that women and girls benefit equitably from their AIDS responses, and a few have taken strong strides. Broad gender equity has been achieved with respect to current access to HIV testing and antiretroviral treatment. This in itself is a remarkable achievement. The support and gender equitable agendas of global HIV initiatives such as Multi country HIV/AIDS Program (MAP), the Global Fund, the U.S. President’s Emergency Plan for AIDS Relief (PEPFAR), UNAIDS and other development partners clearly have reinforced and strengthened national achievements in gender equity. But the proportions of women and men accessing those services remain much too low in all but a few countries.

More generally, the data collected in the UNGASS reporting process reveal little about the quality of those improvements and how they were achieved, and, they cast little if any light on socioeconomic and sociocultural factors that seem to have a significant bearing on women’s risks of HIV infection, including education levels and intimate partner violence. More efforts are needed to monitor factors that affect women’s vulnerability to HIV infection and countries’ efforts to address those factors.

The UNGASS monitoring reporting system does not, and cannot, exhaust the information that is needed to design and implement more effective HIV responses. But it represents one of the most comprehensive repositories of information the world has ever had describing countries’ HIV responses and the extent to which women and girls are benefiting from those efforts.

At a minimum, special attention needs to go toward ensuring that all countries collect and provide data that distinguish between the experiences of women and men in the global HIV pandemic, and use this data in shaping programs. The core indicators to follow up on the UNGASS DoC are meant to signal overall progress; they will always need to be supplemented with national-specific indicators on certain women’s issues and with special in-depth evaluation that can achieve deeper understanding of the country contexts, local experiences, and ways forward.

REFERENCES