evaluation

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EVALUATION OF DFID POLICIES AND PRACTICES ON GENDER EQUALITY AND WOMEN'S EMPOWERMENT

PHASE II - THEMATIC EVALUATION MODULES HIV & AIDS

Rachel Grellier
Options Consultancy Services Ltd
CAP House, 9-12 Long Lane, London EC1A 9HA, UK

DEPARTMENT FOR INTERNATIONAL DEVELOPMENT

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LONDON
1 Palace Street
London
SW1E 5HE
UK

GLASGOW
Abercrombie House
Eaglesham Road
East Kilbride
Glasgow
G75 8EA
UK

Tel: +44 (0) 20 7023 0000 Fax: +44 (0) 20 7023 0016
Website: www.dfid.gov.uk
E-mail: enquiry@dfid.gov.uk
Public Enquiry Point: 0845 300 4100
If calling from abroad: +44 1355 84 3132
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DEPARTMENT FOR INTERNATIONAL DEVELOPMENT

EVALUATION REPORT

Evaluation of DFID Policies and Practices on Gender Equality and Women's Empowerment

Phase II - Thematic Evaluation Modules
HIV & AIDS

Rachel Grellier
Options Consultancy Services Ltd
CAP House, 9-12 Long Lane, London EC1A 9HA, UK

Disclaimer
The British Government's Department for International Development financed this work as part of the United Kingdom's aid programme. However, the views and recommendations contained in this report are those of the consultant, and DFID is not responsible for, or bound by the recommendations made.

Evaluation Department
Abercrombie House, Eaglesham Road, East Kilbride, Glasgow G75 8EA, UK

FOREWARD

BY MARK LOWCOCK,
DIRECTOR GENERAL FOR CORPORATE
PERFORMANCE AND KNOWLEDGE SHARING

DFID recognises gender equality and the empowerment of women as essential both for the elimination of world poverty and the upholding of human rights. Since 1985, we have worked to support this area, as laid out in our Strategy Paper[1].

In 2005, the international community will consider progress towards the Millennium Development Goals (MDGs). Many of the hardest-to-reach MDGs are related to gender. Two examples are the goals to reduce deaths in pregnancy and childbirth, which are still unacceptably high, and the goal to increase girls' education, which has been shown to have many positive knock-on effects including on child health and on economic growth.

2005 also marks the 10th anniversary of the Beijing Declaration and Platform for Action. World leaders will be meeting in March to consider progress towards the goals identified in Beijing.

As a contribution to this renewed effort, DFID is currently conducting an evaluation of it's policies and practice on gender equality and women's empowerment. The evaluation will provide independent and systematic evidence of the effectiveness of DFID's contribution to international gender equality goals. It will draw lessons from experience to inform our future strategy.

This is one of a series of working papers produced in preparation for the main evaluation. These are rapid reviews and provide indicative evidence on eight thematic areas of DFID's work:

- Voice and Accountability
- Maternal Mortality
- Gender Violence
- The Enabling Environment for Growth
- Education
- Conflict and Post Conflict Reconstruction
- HIV and AIDS
- Migration

Any feedback on this paper should be addressed to Jo Bosworth in Evaluation Department

[1] Poverty Elimination and the Empowerment of Women. This is currently being reviewed and updated.

ACKNOWLEDGEMENTS

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CONTENTS

GLOSSARY

Gender Equality
Women having the same rights and opportunities in life as men, including the ability to participate in the public sphere.

Women's Empowerment
A process of transforming gender relations through groups or individuals developing awareness of women's subordination and building their capacity to challenge it.

Gender Mainstreaming
A strategy to ensure that women's and men's concerns and experiences are integral to the design, implementation, monitoring and evaluation of all legislation, policies and programmes in any area and at all levels.

Twin Track Approach
DFID's strategy combining focused actions aimed at women's empowerment and gender-aware actions in the mainstream of development work.

Evaporation
When good policy intentions fail to be followed through in practice.

Invisibilization
When monitoring and evaluation procedures fail to document what is occurring 'on the ground'.

Resistance
When mechanisms are used to block gender mainstreaming based on 'political' opposition (itself embedded in unequal gender power relations) rather than on 'technocratic' procedural constraints.

Sources : Adapted from Reeves & Baden (2000); Moser et. al, (2004); DFID (2000); and Darbyshire (2002)

EXECUTIVE SUMMARY

Focus of the Evaluation

S1 This evaluation report provides a short description of key issues in relation to gender and HIV and AIDS, a brief historical summary of key International, UK and DFID policies towards gender and AIDS (including the Millennium Development Goals and reviews the extent to which DFID's gender policy commitments are incorporated in the identification, design, implementation and monitoring of DFID's HIV & AIDS investments in three country programmes.

Meeting the HIV/AIDS Challenge

S2 '…the AIDS epidemic cannot be understood, nor can effective responses be developed, without taking into account the fundamental ways that **gender** influences the spread of the disease, its impact, and the success of prevention efforts.'[2]

S3 Over the past two decades the number of people living with HIV and AIDS has risen to 39.4 million, of whom 17.6 million are women. In sub-Saharan Africa, almost 57% of adults living with HIV are women and girls, and young women aged 15-24 years are approximately three times more likely to be living with HIV than men of the same age.

Approach and Methodology

S4 The evaluation is based on the Canadian International Development Agency (CIDA) Framework for Assessing Gender Equality Results, and aims to capture key elements of DFID's gender mainstreaming activities in decision-making, rights, and access to resources. The framework also allowed for tracking of interventions across the development of a programme of work from design to monitoring and evaluation. Three case studies were assessed against this framework, on the basis of intervention documentation backed up by email, telephone or face-to-face interviews with key informants.

Key Findings

S5 There were a number of key findings, summarised below:

- Of the approximately 2 billion pounds of DFID commitments marked as HIV/AIDS spending from 1995-2005, around 46% also had a marker for gender. For expenditure data the pattern is similar.

- This overall picture masks key differences between countries. There is considerable disparity between international ranking by HIV prevalence and the percentage of investments with a Policy Information Marker System (PIMS) marker for HIV and AIDS. Further, none of the three countries ranked highest for HIV and AIDS prevalence (all of which have women accounting for more than 50% of adults living with HIV) have any PIMS markers for gender. In Uganda, where 60% of adults living with HIV are women, none of the HIV and AIDS investments have a gender marker. In Zimbabwe and Zambia however,

[2] UN Millennium Project, 2005, p.54.

over two thirds of DFID investments have HIV/AIDS markers, and over half of these investments also have Principal (P) or Significant (S)[3] gender markers. These figures suggest that the extent to which gender issues are mainstreamed in HIV/AIDS interventions varies considerably between countries.

- The difficulties inherent in gender mainstreaming are recognised by some of DFID's country offices. An example from this evaluation is the initiative taken by DFID's China office to develop a country specific gender mainstreaming strategy (China 2003 – Jolly and Ying). China is now making real progress in the direction of gender mainstreaming.

- DFID's policy on gender mainstreaming is well articulated and policy documents distributed. However, there is evidence from the field that country office staff have not been sufficiently well trained on how to actually implement the policy. So far DFID has provided few explicit guidelines to staff setting out what processes are required to effectively mainstream gender into HIV and AIDS programmes.

- Moreover, when project documentation is examined closely it becomes apparent that it is difficult, if not impossible, to accurately judge the extent to which DFID attempts and/or succeeds in mainstreaming gender in its HIV and AIDS programmes. The PIMS system, which was designed to track gender mainstreaming, is not used consistently and is therefore not altogether reliable. Gender is not always clearly identified in monitoring and evaluation reports. DFID monitoring systems do not provide consistent information about gender in HIV and AIDS spending.

- One may surmise from the evidence provided by the country offices that gender mainstreaming may be more widely implemented than the official documentation suggests. On the other hand it may be that Moser's suggestion that gender issues become evaporated or at best invisible may indeed be occurring in DFID's projects. But evidence on that is inconclusive. The lack of documentation is cause for concern and needs further investigation in the systematic evaluation.

- There was insufficient evidence with which to demonstrate with any certainty whether Moser's concepts of 'evaporation', 'invisibilization' and 'resistance' are occurring in the DFID's programmes selected for this evaluation.

- Despite DFID's commitment to gender mainstreaming there is evidence from the programmes selected for this evaluation (China, Uganda and Peru) that gender mainstreaming is not as high on the list of priorities as may be expected from the DFID policy documents. However, it is also clear that increasing gender mainstreaming is not always feasible for a bilateral donor most especially when the country has other urgent priorities (e.g. China's Health VIII Support programme). Field reports also make it clear that DFID has limited leverage to influence national policies and practice.

[3] A Principal marker means the main aim of the intervention, without which it would not take place; while a Significant marker means an important, but not the principal, reason for undertaking the project.

- Reviewing the situation in all the three countries selected for this evaluation suggests that, even where there was a gender PIMS marker, the impact of the intervention could not be adequately determined.

- The evaluation methodology framework selected for this evaluation (the Canadian International Development Agency - CIDA) provided a useful, flexible and adequate framework with which to examine gender mainstreaming in the three selected country offices and was well received by respondents. However, the utility of the framework in investigating the three major project dimensions: decision-making; rights and access to resources and benefits of development, was limited. It is also noteworthy that the key dimensions recommended by CIDA were not altogether appropriate to DFID's work.

Key Recommendations

S6 The following recommendations for DFID's work on gender and HIV and AIDS, and for the systematic evaluation, are made:

- DFID should continue to engage in ongoing and sustained dialogue with governments, civil society and stakeholders on the importance of gender mainstreaming in all its HIV/AIDS programmes and in continually repeating the 'gender' message. It is important to ensure that whatever progress has been made in mainstreaming gender is not lost. It is essential that examples of best practice and evidence-based information be made available.

- The current development of an HIV and AIDS Web Portal, in conjunction with the UK AIDS Consortium, provides the opportunity to significantly improve access to best evidence on priority issues. It is recommended that 'gender' is added to the priority topics.

- Where DFID investments are through Direct Budgetary Support (DBS), or 'Partnership funds', DFID must ensure that donor harmonization on the importance of gender mainstreaming should remain high on the HIV and AIDS agenda.

- The complexity and breadth of many DFID programmes has meant that gender mainstreaming is not routinely reported unless it is explicitly included in DFID technical and Monitoring & Evaluation documents. It is essential therefore that gender mainstreaming indicators are included in Terms of Reference, and programme log frames. DFID investments in HIV and AIDS and Gender must be clearly recorded by type of intervention and outcome.

- The correct use of PIMS marker will facilitate future evaluation of gender mainstreaming and ensure that DFID's policies are implemented in the field.

- DFID should provide field staff with better guidelines and training on how to implement gender mainstreaming activities in its HIV and AIDS programmes. The recent UK Government strategy highlights goals but does not give practical guidance on how they can be achieved. An operational guide similar to that produced by the World Bank Gender and Development Group (2004) would be a way of addressing these problems.

- Accountability to quantified targets will be increased if the recommendations of the 2005 Millennium Task Force on HIV and AIDS are adopted. This will help ensure that DFID implements rigorous, systematic, quantifiable and appropriate evaluative indicators and processes, and that project documentation consistently includes explicit reference to activities and outcomes relating to PIMS markers and provides evidence of programme progress towards DFID/UK government strategy goals and MDGs.

- DFID should develop better methods for monitoring and evaluation of gender mainstreaming, and use and develop emerging methods to assess impact. These will help determine the links (if any) between interventions, outcomes and impacts. (Francis Watkins Dec. 2004 – Gender Mainstreaming). In order to assess gender mainstreaming it is important that all data collected by DFID is disaggregated by gender (Watkins 2003).

- Value would be added to the forthcoming Systematic Evaluation by consulting international and in-country civil society organisations such as members of the UK HIV and AIDS Consortium, the International Community of Women Living with HIV and AIDS (ICW), WOMANKIND Worldwide and others, to assess their perception of DFID's gender mainstreaming. Contact with other international donors would also provide information on their views of DFID's role in donor harmonization around HIV and AIDS and gender mainstreaming.

- It is recommended that future evaluations reconsider the evaluation framework. It would be pertinent to review available evaluation frameworks against current DFID conceptual thinking and strategy documents, in particular the new RBA 'how to' note for maternal mortality reduction. More obviously, the quality of the data in DFID programming has to be systematised and improved.

1 INTRODUCTION

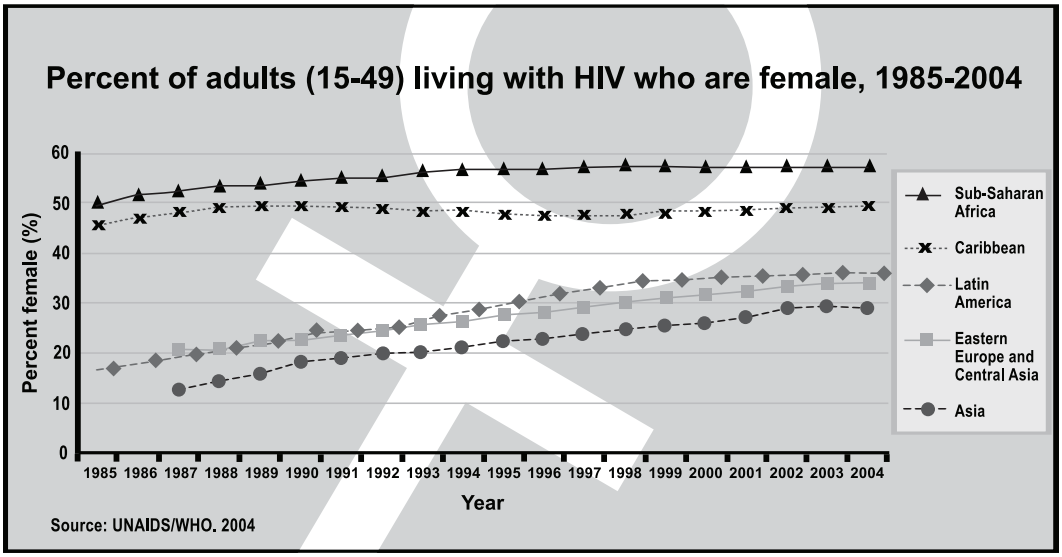
1.1 This report presents the outcome of a thematic review of gender mainstreaming in DFID investments in HIV and AIDS interventions. A key purpose was to test methodologies and propose hypotheses for a larger DFID evaluation of gender (2005).

1.2 The most recent UNAIDS annual update (2004) on the pandemic[4] shows that:

- the number of adults and children living with HIV is at its highest level ever (39.4 million)
- since 2002 new infections have increased by nearly 50% in East Asia and by 40% in Eastern Europe
- in regions of sub-Saharan Africa, numbers of people dying of AIDS are being matched by numbers of people newly infected with HIV

1.3 Nearly half of all people living with HIV are women (17.6 million). Recent data indicate a steady increase in the number of infections among women. In sub-Saharan Africa, where the epidemic has been established for the greatest length of time, young women aged 15-24 years are approximately 2.5 times more likely to be living with HIV than young men[1]. In other regions, where numbers of people living with HIV and AIDS are increasing, the proportion of women and girls affected is rising and currently represents 36% of those living with HIV and AIDS in Latin America and 34% in Central Asia (Fig. 1).

Fig. 1



1.4 Tackling prevention, treatment and care, and impact mitigation (reducing the direct and indirect effects of HIV and AIDS) is now a high priority for donors such as DFID. The perception of HIV and AIDS as a clearly defined medical problem has changed, as the wider, multi-

[4] UNAIDS 2004: www.unaids.org

dimensional implications of the epidemic and the 'complex and diverse realities of women, men and children's lives' (Tallis 2002:1) are recognised. To be successful and sustainable, interventions need to address both the practical needs (for example assisting with caring for the ill, earning an income and having sufficient food) and strategic interests (such as inheritance rights) of men, women and children[5].

1.5 Inequalities between men and women increase poverty and dependency[6], which in turn increases both women's susceptibility and vulnerability to infection, and also limits their access to prevention, treatment and care interventions (Box 1) There are clear advantages to mainstreaming gender in HIV and AIDS investments, as without reducing HIV infection and curbing the social and economic impact of AIDS the achievement of the Millennium Development Goals (MDGs) and national social and economic development which DFID supports, will be seriously compromised.

Box. 1 Key issues increasing women's susceptibility and vulnerability to HIV and AIDS

Biology: Women are almost twice as likely to become infected with HIV during heterosexual intercourse than men because they are more likely to develop micro-lesions during sexual intercourse and male semen contains higher concentration of virus than female secretions per unit volume.

Violence: Domestic violence is reported by 10-50% of women worldwide – often accompanied by sexual violence. This is exacerbated by armed conflict (where rape may take place). Other aspects include trafficking of women, female genital mutilation, and beliefs about having sex with young girls overcoming HIV infection

Coercion*:* Women are often economically and socially dependent on men. This can reduce women's control over sexual relations, for example they cannot refuse unprotected sex with their husband or commercial sex partner.

Sharing the Care Burden: Household work, raising children and caring for the sick reduce opportunities for education and earning money.

Economic and legal barriers Legislative and regulatory frameworks frequently discriminate against women in property and inheritance rights, reproductive and sexual rights, and employment rights.[7]

[5] One example of this is the programme of the AIDS Support Organization, funded by DFID Uganda.
[6] Detailed information on the main issues regarding HIV and AIDS can be found in Barnett and Whiteside (2002). Moser et al (2004) give information on important aspects of gender. Discussion of gender in relation to HIV and AIDS is provided by Tallis (2002) and The Gender and Development Group (2004).
[7] Women and HIV/AIDS: Advocacy, Prevention and Empowerment: International Women's Day 2004, United Nations, Backgrounder.

2 METHODOLOGY

2.1 Methods used in recent gender evaluations[8] were reviewed at the outset of the evaluation. Drawing on these, particularly the evaluation frameworks developed by CIDA (2003) and Tallis (2002) and bearing in mind the time and resource constraints to this work, an evaluation framework was developed (Table 1). The framework divides gender mainstreaming activities into the categories of 'decision taking', 'rights', and 'access to resources and benefits of development' (vertical axis) and key stages of the project cycle (horizontal axis).

2.2 Gender mainstreaming and evidence of results were tracked through intervention documentation and email correspondence, and/or telephone or face-to-face interviews with key informants. These explored strategies taken in gender mainstreaming in three DFID country offices (China, Uganda and Peru). These countries were chosen on the basis of type and level of funding and the stage of the AIDS epidemic. The evaluation covers programming from 2000-2005; insufficient information was available on the earlier period. The DFID HIV and AIDS Policy Team was also consulted. Attempts were made to identify activities, interventions, constraints and results that might not have been articulated in the written documentation. However, the bulk of the analysis is based on written documents.

2.3. Data was examined in the light of Moser *et al*'s (2004) concepts of :

- 'evaporation' (i.e. policy fails to be followed through in practice)
- 'invisibilization' (i.e. monitoring and evaluation procedures fail to document what is happening in the field) and
- 'resistance' (i.e. mechanisms to block gender mainstreaming are based on 'political opposition rather than on technocratic procedural constraints')

[8] CIDA (2003); Ellis (2004); Braithwaite M et. al (2003), Tallis (2002). Framework for Assessing Gender Equality Results, Work in Progress, Gender Equality Division June 2003; Ellis, Evaluating the Australian overseas aid programme – a third generation of evaluation? Draft submitted to Canberra Bulleting of Public Administration April 2004; Braithwaite M et al, Thematic Evaluation of the integration of gender in EC development Co-Operation with Third Countries Volume 1, Final Report March 2003.

Table 1: Evaluation Framework

		Mainstreaming gender			
		Identification	**Design**	**Implementation**	**Monitoring & Evaluation (M&E)**
		• *Concept note* • *Terms Of Reference*	• *Project Memorandum*	• *Terms Of Reference* • *Proposal* • *Project Reports*	• *Activity to Output Review* • *Output to Purpose Review* • *Project Completion Report*
Equality and Empowerment	**Decision taking:** • Capacity for public participation • Representation among decision makers • Household & individual decision making	• *Need identified?* • Is reference made to international/DFID policy/goals/targets? Are key gendered problems highlighted at this stage both in relation to the dimensions (decision taking/rights/access to resources) and to different levels, e.g.: • At household level in relation to susceptibility/vulnerability, prevention, care/treatment and impact mitigation (decision making, access to resources) • At community/facility level in relation to susceptibility/ vulnerability, prevention, care/treatment and impact mitigation • Within the health system and policy making arenas Are problems approached strategically or practically (national programmes supported?)	• *Need identified and reflected in the design?* • Has an analysis of gender dimensions necessary to inform investment design been made? • Does the analysis and design reflect priority given to international/DFID policy/goals? • How is the interface between gender and other aspects of social exclusion, stigma/discrimination, and vulnerability addressed? • Are specific budget lines allocated to address gender issues? • Are other resources allocated re. gender? Does the situation and risk analysis take account of key gendered problems in relation to: • Each of the dimensions (decision making, rights, access to resources) and • At different levels of programming i.e. household/community; health system; sector; policy.	• *Deeper understanding of need pursued and responded to?* • In what ways has gender mainstreaming reflected in investment/programme policy, strategy and activities? • Are some dimensions (decision making, rights, access to resources) given more priority? Why? • Are gender issues given more priority at some levels (e.g. household vs. sector)? Why? • Is the manner of implementation explicitly linked to international/DFID policy/goals? • How have any resources allocated specifically for gender (financial/other) been used? • Have the approaches taken influenced other donors/strategies in country/ regional and/or international levels? • What have been the enabling and constraining factors to addressing gender dimensions of HIV and AIDS programmes?	• *Need reflected in the M&E framework and reviews?* • Is gender 'transparent'? • Do reported results tie in with international/DFID policy/goals? • Evidence of change/ progress/ results within the dimensions of decision-making, rights and access to resources? • Evidence of change at different levels (community/household; facility, health system, sector)? • Evidence of impact in susceptibility/ vulnerability, prevention, care/treatment and impact mitigation? Can progress be attributed to interventions related to gender issues? • Evidence of influence on the way in which others perceive and address gender issues e.g. government, civil society, and private sector? • Evidence of linking between gender and other aspects of social exclusion/ vulnerability? • Evidence of linked impact on poverty reduction? • Evidence of increased political/high level commitment/scaling-up?
	Rights: • Legal system • Public awareness • Response to gender-specific rights violations				
	Access to resources & benefit of development • Livelihoods & productive assets • Institutional capacity • Policy & programme change				

(Adapted from CIDA, 2003)

3 INTERNATIONAL POLICY

3.1 Table 2 summarises key international policies and commitments in the areas of gender and HIV and AIDS.

3.2 The need to address inequalities between men and women has been highlighted since the development of the Convention on the Elimination of all forms of Discrimination Against Women (CEDAW) in the late 1970s. It was made more explicit during the early 1990s, when development strategies, policies and commitments were criticised for focusing on women's role as mothers and carers, and increasing their access to services rather than addressing fundamental sources of inequality between men and women (Elson and Evers, 1998). With the adoption of the Beijing Platform for Action in 1995, the term 'gender mainstreaming' came into widespread use. Table 2 illustrates the gradual move over time to inclusion and empowerment approaches.

3.3 The Millennium Development Goals and targets on gender and AIDS (Table 2) are major drivers of international policy and interventions. However, they have been criticised for not sufficiently mainstreaming gender and AIDS and keeping the focus on particular indicators such as girls in school and '3 by 5'. It has been pointed out that addressing gender is of critical importance to every MDG (WHO Department of Gender and Women's Health, 2003:1 and UNIFEM (http://www.mdgender.net/). It is important to remember that in addition to meeting quantified targets it is essential that consideration is given to whether the poor and very poor, and both women and men are among those who benefit from interventions.

Table 2: Summary of International Policies and Commitments

International Commitments	HIV and AIDS Objectives	Gender Objectives
2005 Millennium Project – review of progress toward the Millennium Development Goals (MDG's) commissioned by the UN Secretary General and supported by UNDP. Ongoing.	The interim reports of the HIV and AIDS Task Force is proposing quantitative benchmarks to make the MDG for AIDS a verifiable commitment. Suggested targets for 2015 are: 1) Reduce prevalence among young people to 5% in the most affected countries and by 50% elsewhere by 2015 2) Ensure equitable and sustainable access to antiretroviral therapy to at least 75% of those in need by 2015.	A root cause of the epidemic is identified as gendered social vulnerability. This is to be addressed through HIV and AIDS interventions but also through broader social and structural development. Seven strategic priorities identified by the Millennium Task Force on Education and Gender Equality: Strengthening opportunities for post primary education for girls, while simultaneously meeting commitments to universal primary education Guaranteeing sexual and reproductive health rights Investing in infrastructure to reduce women's and girls time burdens Guaranteeing women's and girls property and inheritance rights Eliminating gender inequality in employment by decreasing women's reliance on informal employment, closing gender gaps in earnings and reducing occupational segregation Increasing women's share of seats in national parliaments and local government bodies Significantly reducing violence against girls and women.
2001 UN General Assembly Special Session (UNGASS) on HIV and AIDS, Declaration of Commitment	Roadmap for a comprehensive multifaceted response to HIV and AIDS. Focus on 4 core aspects: 1. Prevention and social mobilization 2. Access to treatment and supporting people living with HIV and AIDS. 3. Reducing vulnerability. 4. Managing and mitigating the impact of HIV and AIDS.	Article 14 of the Declaration stresses 'that gender equality and the empowerment of women are fundamental elements in the reduction of the vulnerability of women and girls to HIV and AIDS'. Objectives: Article 37: By 2003 address gender-based dimensions of the epidemic. Article 53: By 2005 ensure that at least 90% of men and women aged 15-24 have access to IEC. Article 61: By 2005 ensure development and accelerated implementation of national strategies for women's empowerment.
2000 Millennium Declaration signed by all 191 UN member states. Millenium Development Goals (MDGs), targets and indicators agreed	MDG 6: Combat HIV and AIDS, malaria and other diseases Target 7: Have halted by 2015 and begun to reverse the spread of HIV and AIDS Indicators: HIV prevalence among pregnant women ages 15- to 24 Condom use rate of the contraceptive prevalence rate Condom use at last high-risk sex Percentage of 15-24-year-olds with comprehensive correct knowledge of HIV and AIDS Ratio of school attendance of orphans to school attendance on non-orphans ages 10-14	MDG 3: Promote gender equality and empower women Target 4: Eliminate gender disparity in primary and secondary education preferably by 2005 and to all levels of education no later than 2015. Indicators: Ratio of girls to boys in primary, secondary and tertiary education. Ratio of literate females to males of 15-24 year olds. Share of women in wage employment in the non-agricultural sector Proportion of seats held by women in national parliament.

International Commitments	HIV and AIDS Objectives	Gender Objectives
2000 World Bank Multi Country HIV and AIDS Programme (MAP)	Aim to broaden focus away from health, increase access to prevention, care and treatment programmes.	Emphasis placed on 'vulnerable groups' (including 'women of childbearing age').
1999 ICPD + 5, (I79 countries approved a new plan to accelerate implementation of the ICPD Plan of Action)	Key future action no. IV: 'Reproductive rights and reproductive health' includes: 'Prevention and treatment of sexually transmitted diseases including HIV and AIDS': 'Governments, from the highest political levels, should take action … to develop and implement national HIV and AIDS policies and action plans …. Gender, age-based and other differences in vulnerability should be addressed …..'	Key future action no III: 'Gender equality, equity and empowerment of women' comprising: Promotion and protection of women's human rights The empowerment of women Gender perspective in programmes and policies Advocacy for gender equality and equity
1997 International Development Targets	Achieve a 25% reduction in HIV infection rates among 15-24 year olds in worst affected countries by 2005 and globally by 2015	By 2015 Reduce by three –quarters the rate of maternal mortality. Attain universal access to reproductive health services.
1995 4th Conference on Women in Beijing	Strategic objective C.3 is to 'undertake gender-sensitive initiatives that address sexually transmitted diseases, HIV and AIDS and sexual and reproductive health issues.	International agreement to a comprehensive Platform of Action for gender equality and empowerment
1994 International Conference on Population and Development (ICPD) Cairo	Chapter VIII: Health, morbidity and mortality. Focuses on: Preventing and reducing the spread of, and minimizing the impact of HIV infection, and ensuring that individuals living with HIV have adequate medical care and are not discriminated against.	Chapter IV: 'Gender equity, equality and the empowerment of women'. Focuses on: The empowerment of women and improvement of their status as important ends in themselves and essential for the achievement of sustainable development. Eliminating all forms of discrimination against the girl child, eliminating the root causes of son preference, increasing public awareness of the value of the girl child and strengthening her self-esteem. Encouraging and enabling men to take responsibility for their sexual and reproductive behavior and their social and family roles.
1979 Convention on the Elimination of all Forms of Discrimination Against Women (CEDAW). (2004 Ratified by 175 countries)	-	Article 10 provides that States must take measures to ensure women's equal rights with men to education. Among the provisions of Article 12 is the requirement to take all appropriate measures to eliminate discrimination against women in the field of health care in order to ensure, on a basis of equality of men and women, access to health-care services, including those related to family planning. Article 16 requires States Parties to eliminate discrimination against women in the context of marriage and family relations.

3.4 The UNAIDS/UNGASS (UN General Assembly Special Session on HIV & AIDS (2001) indicators (www.unaids.org) form a basis for international commitment and action against HIV and AIDS. Although HIV and AIDS is a complex, multi-dimensional issue cutting across all sectors and in both the public and the private environment; there remains a tendency for quantifiable objectives and targets to focus more on health issues e.g. the number of people accessing voluntary counselling and testing (VCT), or the percentage of women receiving prevention of mother to child transmission) services (PMTCT).

3.5 In 2004 the Global Coalition on Women and AIDS (2004) identified 7 key priority areas for addressing the 'feminization' of the pandemic i.e. the increasing vulnerability of women to HIV, and the increasing proportion of women amongst the total number of people living with HIV. These were:

- prevent HIV infection among girls and young women
- promote access to new prevention options, including microbicides for women/girls
- reduce violence against women
- ensure equal access by women and girls to care and treatment
- support improved community based care, with a special focus on women and girls
- protect inheritance and property rights of women and girls
- support on-going progress towards universal education for girls

3.6 Recent work by UNIFEM (partly funded by DFID) has increased a focus on indicators of women's empowerment and gender equality in the context of HIV and AIDS (Tallis 2002). UNIFEM are also engaging in a three-year multi-level programme, building national capacity to review laws and policies relating to HIV and AIDS (www.unifem.undp.org/hiv_aids/). UNFPA are also currently influencing inclusion of gender issues in policy development. Another good source of social indicators is the International Centre for Research on Women web site, www.icrw.org.

3.7 There is a tendency for both international and national policy documents to use the term 'gender' almost as a synonym for 'women'. Major policy documents reviewed make little or no reference to men and masculinities. There is also a tendency to use 'women and the poor' as examples of vulnerable groups. This implies, even if unintentionally, that these are homogeneous groups and thus the complexity of susceptibility and vulnerability to HIV and AIDS may be poorly represented at international policy level.

4 UK AND DFID POLICY

4.1 Table 3 summarises key UK government policies and commitments related to gender and HIV and AIDS.

4.2 The UK's recent strategy on HIV and AIDS (*Taking Action: The UK's strategy for tackling HIV and AIDS in the developing world, July 2004*) describes UK commitments to tackling the pandemic, and relates these to broader international goals, in particular the MDGs. The strategy sets out what the UK Government will do to achieve 'stronger political direction, better funding, better donor coordination and better HIV and AIDS programmes' (p1). The strategy states an explicit intention to take a rights-based approach and ensure 'that the needs and rights of women, young people – including orphans – and marginalized groups are adequately addressed' (p8). It reasserts DFID's commitment to addressing gender issues, and focuses specifically on the impact of gender inequalities on vulnerability to HIV and AIDS. The strategy identifies ten clear objectives relating to gender and HIV. Moreover, the strategy document points out that 'these gender inequalities are unlikely to be redressed through piecemeal actions', so that programmes should be wide ranging, and it asserts that the UK government will support comprehensive programmes for women that tackle gender violence, stigma and discrimination.

4.3 More generally, DFID is committed to promoting gender equality and facilitating the empowerment of women throughout all its policies and programmes. The key concepts are articulated in DFID's *Target Strategy Paper: Poverty Elimination and the Empowerment of Women* (September 2000). The purpose of this strategy is to 'ensure that women's empowerment and gender equality are actively pursued in the mainstream of all development activities', through ten specific objectives. The report states that 'future work will concentrate on supporting fundamental changes in policy, laws and attitudes while maintaining strategic links with work at the grass roots'. This is to be achieved through three channels: support to government, civil society and the private sector: collaboration and coordination with other development partners; and through strengthening DFID internal capacity.

4.4 DFID's 'twin-track' approach to gender mainstreaming aims to integrate the concerns of women and men throughout DFID's work, while at the same time working to empower women within specific interventions (Moser et al 2004). This approach mirrors a wider emphasis among international donors on mainstreaming gender into the development process. Overall, the commitments in Table 3 reflect a shift in gender theory over the period studied, and a clear and concise explanation of this shift can be found in the DFID Gender Manual (Derbyshire 2002).

4.5 Successful implementation of gender sensitive policies requires a re-consideration of institutional practices ('internal gender mainstreaming') and programmes ('external gender-mainstreaming') (Tallis 2002:43). Despite DFID's policy to mainstream gender into all its investments, concerns have been raised that this is failing to have sufficient impact at country level (UNDP 2003, Moser et al 2004, Watkins 2004). In a recent gender audit of DFID Malawi, Moser et al (2004) viewed this as due to 'evaporation, invisibilisation and resistance' to addressing gender issues (see paragraph 2.3). This may reflect the comments of Whelan (1999) and Tallis (2002) that lack of training and understanding can reduce the impact of gender mainstreaming even where commitment exists.

4.6 During this review the UK Government's 2004 strategy on HIV and AIDS was described by some members of DFID as still having an undue emphasis on health despite recognizing the broader perspectives of HIV and AIDS. DFID staff praised the strategy for setting clear goals, but noted the lack of explicit guidelines on the processes needed to effectively mainstream gender into HIV and AIDS investments, and how to strategize non-health related aspects of the pandemic.

Table 3: Summary of UK and DFID policies and commitments related to gender and HIV and AIDS

National Commitments	HIV and AIDS Objectives	Gender Objectives
2004 Taking Action: The UK's Strategy for Tackling HIV and AIDS in the Developing World	Supporting MDG, UNGASS and ICPD[9] targets. 25% reduction in young people living with HIV	Increasing women and girls' access to SRH services by 2005
	3,000,000 people receiving treatment by end of 2005 (50% of these women and children) – link to WHO 3 x 5 goal. National plans in place to meet the needs of orphans and children made vulnerable by HIV and AIDS by 2005. Rapid implementation of the Three Ones, linking donor help to national priorities.	Increased access to sexual and reproductive health services for women and girls by 2005. At least 50% of people receiving ARV by 2005 to be women and children Increased investment in research addressing issues of poor, women and children
	On track to slow the progress of HIV and AIDS by 2015.	
2004 Working Partnership with the Joint United Nations Programme on HIV and AIDS (UNAIDS). DFID Institutional Strategy Paper	Partnership objectives include DFID inputs on: A rights-based approach to HIV work. Support for the Global Coalition on Women and AIDS (partnership objective 1). Prioritize PCB[10] effective advancement of discussions on gender and HIV and AIDS through UNIFEM and UNFPA (Partnership objective 4)	See opposite
2004 Sexual and Reproductive Health and Rights: A Position Paper	Proposed outcomes include: Reduced incidence of HIV and sexually transmitted infections.	Main focus on women and equality but some mention of empowerment and of men's needs. Explicit rights-based approach based on principles of inclusion, participation and obligation. Aiming to accelerate progress towards ICPD goals. Proposed outcomes: Improved maternal and newborn health Accessible, high quality family planning choices. Elimination of unsafe abortion Greater awareness of sexual health and reduced risky behaviour Gender equality, rights, accountability and equity realized everywhere.
2004 HIV and AIDS Treatment and Care Policy	Equitable provision for women and children required. Countries encouraged to set a target of 50 per cent of treatments direct to women and children	Supporting women's involvement in legislative decision making Pro-poor, gender and equity focused. Commitment to promoting gender equality and empowering women (linked to MDGs).
2003 UK's Call for Action on HIV and AIDS	Link between HIV and poverty, culture and vulnerability acknowledged. Aiming to meet WHO 3 x 5 goal (the aim of getting 3 million people on ARVs by the end of 2005) (http://www.wpro.who.int/media_centre/fact_sheets/fs_200312_3X5AIDS.htm) Supporting the UN 'Three Ones' Recognition of women's vulnerability	Commitment to promoting gender equality and empowering women (linked to MDGs).

[9] International Conference on Population and Development (1994).

[10] Programme Coordination Board, UNAIDS governance body.

National Commitments	HIV and AIDS Objectives	Gender Objectives
2001 HIV and AIDS Strategy	Increasing multi-sectoral support with focus on: Building political leadership and national capacity Tackling the underlying causes of vulnerability Maximising the contribution of all sectors Prevention to care continuum Supporting development of knowledge generation	Focus on gender inequalities and women's rights.
2000 Better Health for Poor People: Strategies for Achieving the International Development Targets	Impact of HIV and AIDS linked to women's reproductive health and role as mothers	See opposite
2000 White Paper: Making Globalization Work	HIV and AIDS viewed as a health issue.	No linking of gender and HIV and AIDS
2000 Gender Target Strategy Paper: Poverty Elimination and the Empowerment of Women	Brief reference to women's increased susceptibility to transmission of HIV. Reference to 1999 Cairo target regarding information, education and access to services.	Ten objectives: • To promote equality in rights for women and men through international and national policy reform • To secure greater livelihood security access to productive assets, and economic opportunities for women as well as men • To further close gender gaps in human development, particularly education and health • To promote the more equal participation of women in decision making and leadership roles at all levels • To increase women's personal security and reduce gender-based violence • To strengthen institutional mechanisms and national machineries for the advancement of women in governments and civil society • To promote equality for women under the law and non-discrimination in access to justice • To reduce gender stereotyping, and bring about changes in social attitudes in favour of women • To help develop gender aware approaches to the management of the environment and the safeguarding of natural resources • To ensure that progress is made in upholding the rights of both girls and boys, within the framework of the Convention on the Rights of the Child Objectives linked to CEDAW, DAC and UN. Brief reference to men and masculinities.
1997 White Paper: Eliminating World Poverty: A challenge for the 21st Century	HIV and AIDS viewed as a health issue.	Focus on poverty reduction. Beginning to set out a twin track approach to achieving gender equality. No clear linking of gender and HIV and AIDS

5 INTERNATIONAL 'BEST PRACTICE'

5.1 In order to contextualise the analysis of DFID's efforts at mainstreaming gender issues into its HIV and AIDS programmes a number of international examples of best practice interventions were identified. As used here, the term 'best practice' means the application of knowledge about what is working and not working in different situations and contexts. UNAIDS uses specific criteria for 'best practice', including evidence of effectiveness, efficiency, relevance, ethical soundness and sustainability. (Best Practice and HIV/AIDS: www.unesco.org/education/educprog/pead/GB/AIDSGB/AIDSGBtx/BestPrac/CadBesPr.html - undated). The examples quoted below include some in which the focus is on an exchange of experience, pilot testing, operational research, and other projects and programmes, documentation.

5.2 An analysis of a selection of international 'best practice' programmes (some funded by DFID) show that, whether the focus is on prevention, treatment and care, or impact mitigation, there are certain features that need to be included if the impact of interventions is to be effective and sustainable. A sample of projects which demonstrate each of these features is shown in Table 4. The features are:

- *Empowering women* – in order to reduce women's susceptibility to HIV and to minimise the impact of AIDS-related illness women need to have improved access to knowledge, risk perception, skills/self efficacy, have access to condoms and clear sexual identity as well as services. Participation in decision making also needs to be increased both at household level, between wives and husbands, wives and mothers-in-law, women and their sexual partners; and at a wider level between women and health workers, traditional leaders and programme staff. In addition, creating greater equality in access to education, women's access to income earning opportunities, political participation and protection from violence are also essential. Empowering women represents a significant social change. Which of the above issues individual programmes should prioritise is dependent on the programmatic objectives and setting.

- *Male involvement* – involving men in prevention, testing, care and support programmes is essential for HIV and AIDS programmes. Without this, women are less able to negotiate condom use, refuse unsafe sex, access health services and will continue to take on the major burden of caring for the sick in addition to their existing domestic and income-earning work. In many societies men are less likely to seek health services or information because of the way 'masculinity' is perceived. This increases the likelihood of sexually transmitted infections remaining untreated and has implications for increasing transmission of HIV.

- *Reducing stigma* – this is essential to improve willingness to take up VCT, to improve community support and to reduce barriers to accessing services. Disclosure of HIV-positive status is unlikely to occur unless people feel safe to do so. For example this applies to women who can be perceived as being to blame for transmission of HIV to their babies or their husbands. Stigma and discrimination can cause men to lose their jobs, and prevent them from accessing VCT or using condoms.

- *Community-based participation, education and mobilization* – without the support and understanding of communities it is difficult for individuals to fully engage in prevention, treatment and care, and impact mitigation activities. Improving understanding of the wider community can reduce stigma and discrimination, improve the likelihood of meeting the needs of people living with HIV, and increase community and social support networks. These are essential if emotional and practical, as well as medical, support is to be increased for men, women and vulnerable children.

5.3 Brief summaries of a selection of best practice case studies are provided in Table 4. Please note that although the table is divided into major mainstreaming features that most of the programmes/projects in fact incorporate more than one feature.

Table 4 Some examples of best practice[11]

Key Gender Mainstreaming Features	Programme /Project examples	Interventions
Empowerment of women	The Female Condom and AIDS. UN Best Practice Collection. www.unaids.org --- Access to Credit for Women Living with HIV/AIDS: Society for Women and AIDS in Kenya and Family Health International www.fhi.org --- Addressing Broader Gender Inequalities for STI/HIV Prevention: Sonagachi STD/HIV Intervention Project (SHIP), India. (Sex worker project) www.unaids.org --- Promoting HIV Positive women's Health and Rights; Voices and Choices. International Community of women Living with HIV/ AIDS, Thailand and Zimbabwe www.icw.org	Promoting and improving access to the female condom through including it as part of the range of Contraceptive options made available to women --- Developing programmes that go beyond health care Services e.g. improving food security, income Generating activities, orphan support and improving Women's inheritance rights --- Addressing social and economic gender inequalities such as gender based violence, women's lack of income, limited access to education and denial of legal rights. Project exemplifies the importance of women initiating change. Sex workers learn to negotiate safe sex as well as better treatment by society. Focus is on structural issues of gender. --- Ensuring that reproductive health care for women and men living with HIV are accorded their rights and are provided appropriate sexual and reproductive health needs.
Men's involvement	Men and AIDS- A gendered approach. 2000 World AIDS Campaign, UNAIDS, Geneva --- Men as Partners: Transforming norms of masculinity to reduce gender-based violence and prevent HIV (Engender Health and the Planned Parenthood Association, South Africa). www.engenderhealth.org ---	An analysis of the major issues and providing examples of needed intervention and points for action focusing on men thus ensuring success in HIV/AIDS programmes. --- Encouraging critical examination of stereotypical views of men's sexual domination/ multiple partners and women's passive role in sexual relationships. Working with men to reduce this.

[11] Source: Interagency Gender working Group (IGWG), 2004; Women and Health Programme, WHO, 2003; Integrating Gender into HIV/AIDS Programmes, WHO, 2003; www.eldis.org; www.unaids.org (best practice collection).

	'Promoting Gender Equitable Approaches to Young Men's Involvement: Men's Partnership in Women's Reproductive Health'. Society for Integrated Development of Himalayas (SIDH), India. www.sidh.org --- Promoting male involvement in PMTCT: Findings from Horizon Operations Research" Horizons, UNICEF, Network of AIDS Researchers in Eastern And Southern Africa (Kenya), and PMTCT Working Group (Zambia) www.popcouncil.org	--- Encouraging communication between men and women to enable women and men to talk about relationships and methods of protection and/or contraception. ---
Reducing stigma	The Healthy Highways Project, India. DFID and the Government of India, National AIDS Control Programme. www.unaids.org --- 'Addressing Gender in anti-stigma and Discrimination Efforts: Modules from understanding And Challenging HIV stigma: A toolkit for Action (Change Project) www.changeproject.org PMTCT, community Dialogue and Stigma: Community involvement in the Prevention of Mother to Child Transmission of HIV: Insights and Recommendations" (ICRW and Horizons/Population Council) www.icrw.org	De-stigmatising condom use and reducing gendered assumptions about the use of condoms. Encourage men to have VCT to help reduce perception of women being to blame for HIV infection. Promoting community and men's understanding of PMTCT as the equal responsibility of men and Women.
Community based participation	Our Families, Our Friends: An Action Guide: Mobilize your community for HIV/AIDS Prevention and Care. UNDP 2000 --- Community empowerment in HIV/AIDS prevention: A case study of the integrated Community Care and Support Project in Kenya. Daudi N. Nturibi – Family Programme Promotion Services (2004)	Inclusive community action to combat HIV and AIDS consisting of prevention, counselling and support to both men and women. Gender sensitivity implicit in guide.

	A Community Based Approach to Providing Reproductive Health Services to Internally displaced People: American Refugee Committee, Sudan www.rho.org	Ensuring women have access to health care services Including working with members of their households such as husbands and mothers in law who often control decisions making over accessing care. Integrating HIV/AIDS awareness throughout Community health workers.
	Community Involvement to Shift the Burden of Care' Peace Corps, Malawi Malawi @peacecorps.gov	Developing home-based care programmes that attempt to take into account the increased burden of care that falls on women and girls. This can include encouraging men and boys to share responsibilities for caring for people living with HIV/AIDS.
Providing education and information to men and Women about gender issues, sexuality and the risks of HIV/AIDS Infection Advocacy Training manuals	'Stepping Stones: A Training Package on HIV/AIDS, Gender Issues, Communication and Relationship'. Action Aid & DFID. www.actionaid.org/stratshope/ssinfo.html	Stepping Stones: Participatory method that works at community level to improve open communication, increase gender equity and empower women and men, young and old, to protect their sexual health. Developed by ActionAid in 1995 and now used in over 100 countries, most recently in Latin America and the Caribbean.
	Building Provider Capacity to address Gender and Sexuality: Integration of HIV/ST Prevention, sexuality and Dual Protection in Family Planning: A training Manual www.engenderhealth.org	Developing methods to assess gender and sexuality HIV and STI risk and provide appropriate information and services to all clients.
	Primary School Action for Better Health Kenya'. DFID, CfBT, University of Windsor, Ontario, Canada www.cfbt.com/whatwedo/international or www.psabh.info	Working with girls and boys in formal and informal educational settings to identify gendered sexual, social and economic factors that influence vulnerability to HIV infection.
	'Tailoring HIV/AIDS advocacy programmes to Specific Needs' International Planned Parenthood Federation www.eldis.org/static/DOC12588.htm	Identifying and using information channels and networks which men, women, girls and boys can access and with which they are most comfortable.
	Building Provider Capacity to Address Gender and Sexuality: Integration of HIV/STI Prevention, Sexuality and Dual Protection in Family Planning: A Training Manual www.engenderhealth.org	Working with health care workers to prevent assumptions that some women do not need to worry about HIV prevention e.g. married women. Highlighting that the correct and consistent use of condoms implies responsible behaviour and not unfaithfulness.

	--- Senegal Youth Assessment Report: The Informal Sector and HIV/AIDS: Prevention Practices and Strategies'. CEDPA 2003 www.cedpa.org --- Handbook to Access on HIV/AIDS Related Treatment: A collection of Information, tools and resources for NGOs, CBOs and PLWHA groups. www.unaids.org	Training teachers/facilitators and peer educators to work with male and female in- and out-of school youth. --- Providing women with information, emotional support and information on referral services. Other interventions needing to be provided include information on nutrition and quality care to opportunistic infections and access to ARVs

6 DFID INVESTMENTS RELATED TO GENDER AND HIV AND AIDS (1995-2005)

6.1 DFID uses the Policy Information Marker System (PIMS) to track its bilateral investments (commitments and expenditure) on priority policy objectives. This is intended to inform policy debate, monitoring and aid management and to assist project design. PIMS markers must be applied to any investment of £100,000 or more (although there are a few exceptions). There is a PIMS marker for projects to 'combat HIV and AIDS', and a PIMS marker for 'combatting gender discrimination'. Investments can be marked as not targeted ('0'), significant ('S') or principal ('P').

6.2 Using spread-sheets provided by DFID Statistics Department relating to financial commitments and expenditure from financial years 1995/96 to 2004/05, all investments with a 'P' or 'S' marker for HIV and AIDS were identified. The results are shown in Table 5. The first column illustrates the level of commitment made to HIV and AIDS, which totaled £2.7 billion for the whole period. Actual expenditure on commitments was £185 million for 1995/96 – 1999/2000, and £1.5 billion for 2000/01 – 2004/05.

6.3 The second row in Table 5 shows all DFID investments where there is both an HIV and AIDS PIMS marker (P or S) *and* a Gender PIMS marker (P or S). 47% (£1.25 billion) of HIV (P or S)-marked commitments also had a gender marker (P or S). A similar pattern is shown if we look only at investments which had a P HIV/AIDS marker, with 45% of total funds committed having either a P or S marker for gender. However, less than 1% of the c. £1.1 billion that was marked with a P for HIV/AIDS 1% also had a P marker for gender. More detailed analysis would be needed to understand this result.

Table 5 DFID's commitments and expenditure in HIV and AIDS 1995 – 2005

	Commitment 1995/96 – 2004/05 (£)		**Expenditure 1995/96 – 1999/2000 (£)**		**Expenditure 2000/01 – 2004/05 (£)**	
Level of DFID investment in HIV and AIDS globally by HIV PIMS marker P or S and total T	**P**	1,101,517,575	**P**	82,885,458	**P**	516,064,819
	S	1,584,264,325	**S**	101,935,105	**S**	953,739,278
	T	2,685,781,900	**T**	184,820,563	**T**	1,469,804,097
Level of DFID investment globally where there is both an HIV and gender PIMS marker (HIV, Gender) e.g. P,P = HIV P & Gender P, S,S = HIV S & Gender S	**P,P**	510,000	**P,P**	61,410	**P,P**	404,467
	S,P	36,871,037	**S,P**	7,801,194	**S,P**	18,069,544
	S,S	725,858,849	**S,S**	54,942,481	**S,S**	374,901,195
	P,S	496,007,402	**P,S**	31,533,189	**P,S**	166,730,364
	T	1,259,247,288 (47% of total HIV-marked P or S projects)	**T**	94,338,274 (51%)	**T**	560,105,570 (38%)

6.4 A summary of DFID bilateral investment in countries with the highest HIV and AIDS prevalence rates, and those selected as country case studies, is provided in Table 6. There is considerable disparity between international ranking (in terms of HIV/AIDS prevalence) and the percentage of bilateral funding given a Principal or Significant marker for HIV and AIDS. There is also a major disparity in the proportion of these HIV and AIDS investments that also have a PIMS marker for gender. For example, in the countries ranked highest for HIV and AIDS prevalence (Swaziland, Botswana and Lesotho), all of which have women accounting for more than 50% of adults living with HIV, the percentage of the DFID commitment with an HIV marker is very low (1 – 10%) and there are no HIV/AIDS investments with PIMS markers for gender. Another clear disparity is seen in Uganda, where 60% of adults living with HIV are women, yet no HIV and AIDS investments have a gender marker. This is cause for concern and needs further investigation in the systematic evaluation.

6.5 There are however countries which show a different pattern. In Zimbabwe and Zambia for example, both also countries with high HIV/AIDS prevalence, the percentage of the DFID commitment which has HIV/AIDS PIMS markers is high (79% and 65% respectively) and of this, over half of the investments also have P or S gender markers. Namibia is also interesting, as whilst the investment in HIV/AIDS is relatively low (11% of total DFID commitments are marked for HIV/AIDS), two thirds of the HIV/AIDS investments also have a gender marker.

6.6 Caution should be taken in drawing firm conclusions from this data, since there is some evidence that PIMS markers are not used consistently. Discussions with DFID advisers highlighted lack of clarity both in the UK and in country offices about the identification and use of PIMS. Moreover, programmes are often complex, so that even a P (principal) marking for HIV/AIDS does not necessarily mean that the entire financial commitment or expenditure relates to HIV/AIDS. A further limitation of the PIMS system is that although the system has input sector codes that identify key areas of activity for each investment, the definitions provided for the two codes related to HIV and AIDS (Table 7) are extremely general and also have areas of overlap. It is not possible to use DFID codes to identify specific activities such as prevention, treatment and care, and impact mitigation. In recognition of these issues, and in particular the programming links between HIV and AIDS, reproductive, maternal and child health, the Policy Division recently proposed and disseminated new guidance on marking and drawing the links between investments in these areas. However, there remains a need for quality control mechanisms around the use of PIMS.

Table 6 Summary of DFID investments in countries with highest HIV/AIDS prevalence

Country	National HIV/AIDS prevalence rates adults (15-49)		Women as % of adult population living with HIV[2]	Gender Development Index[3]		Overall DFID commitment in country since 1995 & % this with a 'P' or 'S' HIV marker	% of HIV/AIDS commitments with a 'P' or 'S' gender marker
	%	Rank	%	Value	Rank		
Swaziland	38.8	1	55	0.505	137	4,083,022 (10%)	0%
Botswana	37.3	2	57	0.581	128	7,831,813 (0%)	0%
Lesotho	28.9	3	57	0.483	145	17,197,489 (5%)	0%
Zimbabwe	24.6	4	58	0.482	147	117,939,656 (79%)	52%
South Africa	21.5	5	57	0.661	119	255,757,620 (41%)	41%
Namibia	21.3	6	55	0.602	126	21,767,705 (11%)	67%
Zambia	16.5	7	57	0.375	164	147,690,529 (65%)	54%
Malawi	14.2	8	57	0.374	165	368,732,215 (57%)	57%
Mozambique	12.2	9	56	0.339	171	189,070,053 (31%)	41%
Uganda	4.1	29	60	0.487	146	309,174,395 (52%)	0%
Peru	0.5	72	34	0.736	85	28,941,471 (0%)	0%
China	0.1	124	3	0.741	94	210,111,930 (43%)	24%
TOTAL						**1,678,297,898**	

1 Source: United Nations Millennium Development Indicators, 2003 (http://unstats.un.org/unsd/mi/mi_series_results.asp?rowID=729&fID=r5&cgID=)
2 Source: UNAIDS Country Profiles 2004 (http://www.unaids.org/en/geographical+area/by+country.asp)
3 Source: UNDP Human Development Reports 2002 (http://hdr.undp.org/statistics/data/indic/indic_282_1_1.html)
4 Source: DFID 2004 Commitments

Table 7 DFID Input Sector Codes for HIV and AIDS related activities

Input code	Activities
74011	Health cross-cutting code: education; advocacy; information; impact assessments; mitigation
74012	All activities related to HIV/AIDS control including information, education and communication; voluntary counselling and testing; prevention; treatment, care and support; research; sexually transmitted disease control and prevention.

Source: DFID Pink Book 'Project Header Sheet Guidance'

6.7 An alternative source of information on the overall level of DFID expenditure is provided by a report by the National Audit Office of DFID's response to HIV and AIDS (2004). This provides a general breakdown of expenditure, and shows the overall country-level HIV and AIDS expenditure by type of intervention for the period 1997 – 2003 (table 8). However, the original data from which this information was drawn were not accessible for this study, which prevented any detailed breakdown by country for this evaluation.

Table 8 Country level HIV and AIDS expenditure by type of intervention (1997-2003)

Type of intervention	DFID expenditure on HIV and AIDS
Unclassified	34%
Prevention and advocacy	20%
National strategies	15%
Care and support	11%
Capacity Building	6%
Global strategy	5%
Treatment	5%
Research	3%
Impact mitigation	1%

(Source: National Audit Office analysis of DFID data, 2004)

6.8 A key issue highlighted by the above table is the high percentage of 'unclassified' expenditure. This implies that the purpose of over one third of DFID expenditure on HIV and AIDS during this period cannot be categorized.

6.9 The historical focus on prevention and advocacy activities means that 20% of expenditure has been on these activities. The small (1%) proportion that has been spent on impact mitigation is, however, out of proportion to the actual populations currently living with or affected by HIV and AIDS including the increasing number of women who are affected both as sufferers and as care givers. In countries where the epidemic is generalized and mature, such as Uganda, there may be a need for a considerably higher proportion of expenditure to be spent on impact mitigation.

7 COUNTRY CASE STUDIES

7.1 China

Investments reviewed:

MIS	Project title	Project dates	PIMS Markers		Expenditure
145555003	China HIV/AIDS Project	1999-2005 (extended to 2006)	Combat HIV/AIDS	P	£4,836,332
			Removing gender discrimination	S	
145001001	Health VIII	1999-2005	Combat HIV/AIDS	S	£9,057,098
145555011	HIV/AIDS Education	N/A	N/A		-

Background and challenge

China is a lower middle-income country with 31 provinces, Autonomous Regions and municipalities reporting cases of HIV and AIDS. The number of HIV and AIDS cases is increasing particularly rapidly in the central provinces. However the epidemic is still regarded as a concentrated epidemic. The initial risk of transmission was largely through injecting drug use followed by unsafe blood plasma and heterosexual transmission. Throughout the country there are substantial income disparities, large-scale labour migration and gender imbalances, all of which are known to increase susceptibility and vulnerability to HIV and AIDS. A national Medium and Long Term Plan (MLTP) for the Prevention and Control of HIV and AIDS was agreed in 1998, and a coordinating body reports directly to the State Council. The Government of China (GoC) has been mobilizing a multi-sectoral response to HIV and AIDS since 2002.
At this stage of the epidemic the main challenge is to prevent further transmission while also putting in place appropriate treatment and care interventions. From the perspective of gender mainstreaming, the challenge is to improve equality between men and women in accessing prevention and treatment, but more fundamentally to work towards changing power relationships between men and women, and between women and the State.

DFID interventions

7.1.1 Gender disparities in China are evident in many areas despite a formal commitment by the Chinese Government to gender equality. DFID's programmes in China are designed to address three cross-cutting themes (China Country Strategy paper 2002-2005):

- effective pro-poor government policies and initiatives
- participation of poor people in decision-making
- tackling social exclusion and promoting gender equity

7.1.2 DFID is committed to: 'increase our efforts, within our projects, to support the Chinese Government's commitment to gender equity. We will ensure that future activities are assessed for their capacity to address rising trends in gender inequality…' (China Country Strategy paper

2002-2005) DFID's Asia Division Director's Delivery Plan (DDP) and the China Country Strategy Paper (CSP) have been noted as examples of 'best practice' in gender mainstreaming (Watkins 2003). DFID programmes have engaged in substantial capacity building on gender with national counterparts at all levels, from programme staff through to Government departments. Slides prepared by DFID UK have been useful in assisting with this, but DFID China view their strategic priority as identifying individuals within the GoC who can champion gender mainstreaming at a high level. Strategic advantages are also seen as occurring through increasing links with key academics, 'Government' NGOs such as the China Women's Federation, other international donors and international civil society organisations which receive DFID funding such as UNIFEM, and the UN Theme Group on Gender.

7.1.3 As shown earlier in Table 6, 43% of DFID's total commitment in China since 1995 (approx £210 million) has had a PIMS marker for HIV. Table 9 shows how this investment is spread across economic sectors, using DFID's input sector codes. The majority of DFID funds committed for HIV and AIDS have been coded as 'communicable disease control'. This ties in with the clear need to focus on preventing transmission of HIV in order to prevent a generalised epidemic. From the data it can be seen that the amount committed to health education appears disproportionately small in comparison, and that none of the DFID investments in China that are categorised P or S for HIV and AIDS have the health cross-cutting code 74011 (see Table 7 for definition). However, it is possible that this reflects difficulties in input code marking and that these figures do not accurately represent activities undertaken within each initiative.

7.1.4 Overall, only about one quarter (24%) of HIV-marked funding has also been given a marker (P or S) for gender. Of the seven investments coded as multi-sectoral responses to HIV and AIDS (code 74012), none have a 'P' PIMS marker for gender, and only two an 'S' marker for gender. However, these two latter projects make up almost 90% of the funding in this category.

Table 9 Percentage of DFID investment in China by economic sector for activities categorised 'P' or 'S' for HIV and AIDS

Economic Sector	Percentage of total Commitment	Number of investments
Communicable disease control	31.6%	2
Health Policy	24.4%	6
Multisectoral Responses to		
HIV and AIDS	15.4%	7
Private sector development	1.9%	1
Statistics	0.8%	1
Strengthening civil society	0.8%	2
Pro-poor health	0.5%	2
Health education	0.2%	1
Reproductive health	0.1%	1

(Source: DFID Statistics Department spreadsheet)

7.1.5 It was the intention to examine three DFID-funded programmes in China in further detail (see table at beginning of chapter). However, during the study it became apparent that the HIV and AIDS Education project had not in fact progressed beyond concept note stage, and that the Health VIII programme, despite being given a 'significant' PIMS marker for HIV and AIDS and an Input Sector Code of 20% for HIV and AIDS, was not perceived by the country office to have any HIV and AIDS component. (The latter project did, however, provide useful information on gender mainstreaming.) The following discussion therefore relates primarily to the China HIV/AIDS Project (1995-2005).

7.1.6 It is evident that at the design stage of the China HIV/AIDS project the social appraisal highlighted the need for greater understanding of gender dynamics and inequalities. At the implementation and monitoring and evaluation stages DFID documentation suggests that gender mainstreaming may have largely 'evaporated'. Reasons for this include:

- a general lack of understanding of 'gender' concepts, e.g. the Medium and Long Term Plan (MLTP) relates to broad international HIV and AIDS goals but is 'gender blind'
- lack of capacity of in-country programme staff
- focus on rapidly improving service delivery for 'hard to reach' groups masking the need to understand causes and dynamics of inequality and lack of access to information and treatment and care

7.1.7 Annex E of the 1999 China Project Memorandum shows that approximately 50% of expenditure is to be targeted at prevention and treatment of HIV and sexually transmitted infection. Social marketing of condoms represents the greatest single expenditure, followed by development of Information, Education and Communication (IEC) messages and the development of community-based care pilot models. However, it is equally crucial to ensure that women are able to negotiate condom use with their sexual partners. Neither sex workers nor the majority of Chinese women are at present in a sufficiently strong social or economic position to be able to insist on their clients/ or husbands using condoms.

7.1.8 The HIV/AIDS Project has supported a wide spectrum of activities including:

- strengthening strategic planning and management capacity
- increasing access of at-risk and vulnerable groups to information and services for prevention and treatment of STIs and HIV and AIDS
- developing affordable care models for people with HIV
- developing and operationalising a project evaluation system

These appear to be appropriate activities for the current stage of the epidemic in China.

7.1.9 Where gender and other weaknesses have been recognised during annual project evaluations, the country office has taken steps to address them. For example, the need to address underlying issues of power dynamics and rights, and the weaknesses in systematising appropriate gender mainstreaming and analysis, was explicitly recognised in the 2002 Output to Purpose Review (OPR). The project review of January 2003 noted that the project needed to increase the capacity of the Project Management Office (PMO) staff and partners to undertake gender analysis, and recommended that increased awareness of the relationship between gender discrimination and HIV should be addressed through on-going training and capacity building for project staff and the adoption of the gender mainstreaming strategy recommendations. In response to this concern DFID China invested in technical assistance to produce a Gender Mainstreaming Strategy for the project in 2003 (Jolly and Ying 2003a). This highlighted areas of strength and weakness in the implementation of gender issues within the project. These are summarised in relation to evaluation frameworks in Box 2.

Box 2 Summary Areas of strength and weakness in implementation of gender issues in the China HIV/AIDS Project

Process:
Approaches tend to be either gender blind, gender neutral or enforce gender stereotypes.
Gender inequalities are described but infrequently addressed, as is empowerment of women.
Causes and explanations of unequal power dynamics and social relations are seldom addressed.
Although opportunities for working with civil society gender-focussed partners are limited this could be expanded both nationally and internationally.

Outcomes:
Data are seldom disaggregated by gender
Indicators measuring changes in gender inequalities and power dynamics have not been used.

Impact:
Primary stakeholder groups are increasing in activity
Political commitment is increasing
Limited quantifiable outcomes and qualitative analysis to explain outcomes and impact.

Scaling up:
This has not yet been implemented, although guidelines have been produced which provide a good potential strategy once greater government support for reducing gender inequalities and discrimination has been achieved (Jolly and Ying, 2003b)
'Good practice' and operational and policy documents have been produced which have enriched and strengthened both sub-project activities and understanding of gendered issues. The Gender Mainstreaming Strategy recommends developing these further and increasing their utilisation throughout the programme.
Some of the problems faced clearly stem from national and provincial Government, others reflect DFID's institutional limitations, and some reflect an overlap between the two, for example lack of sex disaggregated data. Strengthening, institutionalising and consistently mainstreaming gender training and tools within DFID China and its programmes, will be an important step in increasing the potential to successfully encourage and support the Government of China (GoC) to embark on new but essential approaches to addressing gendered inequalities and women's empowerment if HIV and AIDS prevention, care and impact mitigation strategies are to be successful. As has been described in OPRs and Annual Reviews since 2003, this will involve a shift from focusing on behaviour change to social change through an understanding of the multi-dimensional complexities that cause, reinforce and exacerbate gendered aspects of poverty and discrimination.
(Drawn from: Jolly and Ying 2003a.)

7.1.10 The Gender Strategy identified areas of good practice that provided a strong basis for improving gender mainstreaming within the HIV and AIDS Project. However, the application of the strategy was 'lost in a sea of changes' as a DFID member of staff put it. Gender training is

now planned for April 2005 at which activities will be planned that can realistically be implemented during the remaining life of the project. It is important that work continues to strengthen understanding of gender concepts, investing in and acting on the 2003 gender strategy, while continuing to work with high risk groups such as intravenous drug users, and developing links with the education system to meet the needs of children affected by HIV and AIDS.

7.1.11 According to country staff, another area where the DFID project is having some effect is on collecting and utilising sex-disaggregated data. DFID China report that health experts are becoming increasingly aware through epidemiological data that existing interventions are not effectively reaching both men and women, or are reaching different groups of women and men.

Discussion

7.1.12 Overall, gender mainstreaming activities in China have had to develop from a relatively low 'gender awareness' perspective. Despite this, and the limited capacity for civil society engagement in gender issues, significant progress has been made. At present progress is reportedly clearest in terms of collection of sex-disaggregated data, which is important if the gendered impact of interventions is to be understood[12]. The single HIV and AIDS project examined had included gender issues in the design, but faced challenges in implementing these. However project and DFID staff were well aware of this and were taking steps to address the situation, including gender training.

[12] The utilisation of this data, however, and other quantifiable outcomes by gender could not be identified from documentation received for this evaluation.

Table 10 Summary of gender mainstreaming in the China HIV/AIDS Project

	China HIV and AIDS Project 145003001	Identification	Design	Implementation	M&E
EQUALITY AND EMPOWERMENT	**Decision taking:** • **Capacity for public participation** • **Representation among decision makers** • **Household & individual decision making**	Need identified for multisectoral approach avoiding a solely medical response to meet the needs of those most at risk. Focus on improving delivery of services to marginalised groups (intravenous drug users (IDUs) and commercial sex workers (CSWs). Notes changing gender roles in country. Linkages made to: Infant and maternal mortality targets and to GoC Medium and Long Term Plan for AID Prevention and Control (1998). Approach consistent with 'the policies and plans of other donors'. Need for rights-based and non-discriminatory approaches identified. Key gender problems explicitly identified in the Social Appraisal: 'This project will increase understanding of the differential impact of project interventions on men and women in China and will contribute to the development of gender equitable protocols and interventions in prevention and care'. *Greatest focus is on 'rights' and 'access to resources' rather than on 'decision taking'. The social appraisal in particular focuses on gender issues, prevention, access to care and reduction in discrimination.*	Design based on 'Strategic Framework for DFID's Response to HIV and AIDS' not on DFID Gender TSP. Analysis of gender dimensions to inform investment design made through cost benefit analysis of interventions for women and averting STIs among CSWs. No analysis of social costs of HIV and AIDS. Reflects international/DFID policy goals including human rights, GoC targets in 'Medium and Long Term Plan', Reproductive Health Target (Cairo). Gender issues are not explicitly included in the project design. Situation and risk analyses take account of poverty but not of gender. The focus is on improving equality of access to care between rich and poor, and urban and rural populations rather than between men and women. Activities focus on high-risk groups (IDUs and CSWs) rather than high risk activities. There is little explicit discussion of gender issues or examination of power dimensions. *Greatest focus is on 'rights' and 'access to resources' rather than on 'decision taking'.*	Gender mainstreaming not occurring. 'Gender' is a new concept to majority of in-country project staff e.g. assumption that IDUs = men and CSWs = women. However, considerable progress is being made in improving basic understanding of 'gender' on which to then build future activities. Work uneven in terms of gender. Dependent on key individuals. Traditional health focus means people need persuading of compelling reason for looking at gender. BUT epidemiological data now revealing achievements and weaknesses and increasing realisation that these are linked to more than just being marginalised by engaging in activities 'beyond the law' i.e. that gender has an important part to play. Gender strategy developed in 2003. But major management review, DFID and project staffing changes meant the 'gender strategy was lost in a sea of changes'. Gender training booked for project staff in April 2005. Emphasis to be placed on its meaning and relevance to the project, realistic activities that can be done at a practical level within remaining life of project. *Focus largely on individual decision taking and access to resources'.*	General 'need' reflected in M&E framework and reviews. Gender NOT transparent in outputs/OVIs until 2004 OPR. Data increasingly being disaggregated by gender. Evidence of change/ progress/results at country office (gender strategy and forthcoming gender training); among in-country staff (growing awareness of concept of gender), some improvement in services; and advocacy e.g. All China Women's Federation. Focus on groups engaged in high risk activities. 2004 Annual Review highlighted dimension of 'the family': men, women and children re accessing resources & services. All affected, different approaches needed. Research commissioned and reported. Allies made - important culturally but difficult to measure. Linking to Beijing Gender Development Network. *M&E indicates gradual improvements in capacity and representation in decision-taking, and access to resources.*
	Rights : • **Legal system** • **Public awareness** • **Response to gender-specific rights violations**				
	Access to resources & benefits of development: • **Livelihoods & productive assets** • **Institutional capacity** • **Policy & programme change**				

7.2 Uganda

Investments reviewed:

MIS	Project title	Project dates	PIMS Markers (*)		Expenditure
067555059	HIV/AIDS Umbrella Fund	2002-2005	HIV/AIDS	P	£2,705,692
067555024	TASO	1998-2002	HIV/AIDS	P	£1,782,896
067680090	Family Planning	1999-2003	HIV/AIDS	S	£473,409
067683006	Building HIV/AIDS Advocacy, Care & Prevention	2001-2005	HIV/AIDS not identified		-

(*) Note that none of these projects have PIMS markers for gender

Background and challenge

Although HIV and AIDS prevalence in Uganda is falling, the country still has a generalized epidemic. UNAIDS estimated (end 2003) that there are 450,000 people living with HIV/AIDS of whom an estimated 270,000 (range 170,000-410,000) are women and overall antenatal HIV prevalence in 2002 was reported to be 6.5% AIDS is the leading cause of death for those aged 15–49 years (UNAIDS). The impact of this stage of the epidemic means that single, widowed surviving mothers and elderly widowed grandmothers now head a significant number of households. As a result, there is a substantial need for both treatment and care, and impact mitigation interventions to explicitly address gendered inequalities that limit women's access to care.

Both gender and HIV and AIDS have been mainstreamed into Uganda's national plans, including the National Poverty Eradication Action Plan (PEAP), and across the majority of, if not all, sectors. The Uganda AIDS Commission (UAC) is the coordinating body for the Government of Uganda's HIV and AIDS effort and oversees implementation of the National Strategic Framework for HIV and AIDS and the World Bank funded Uganda AIDS Control Project (MAP). DFID provides Direct Budgetary Support (DBS), Health Sector Wide approaches (SWAp) and programmatic funding. It has a well-established relationship with the UAC and Government.

The main challenge at present is to improve linkages between donors, and to ensure that changing modalities of funding and new treatment and care regimes (particularly antiretroviral treatment) continue to address issues of gender within HIV and AIDS projects.

DFID Interventions

7.2.1 DFID currently provides Direct Budgetary Support (DBS), SWAp and project-based assistance to Uganda. Referring back to Table 6, we can see that 52% of DFID's overall commitment in Uganda between 1995 and 2005 has a PIMS marke for HIV/AIDS (£309.2 million). Of this, Table 11 reflects the emphasis on mainstreaming HIV and AIDS into the SWAp and on multi-sectoral responses. No DFID investments in Uganda categorised by 'P' or 'S' for HIV and AIDS have the health cross-cutting code 74011 (covering education, advocacy, information, impact assessments and mitigation). It is also noteworthy that there is an apparent lack of investment to provide support for strengthening civil society and integrating HIV and AIDS interventions into reproductive health (at 0.4% and 0.1% respectively); key areas in which HIV must be mainstreamed if DFID's objectives are to be achieved.

Table 11 Percentage of DFID investment by economic sector for activities categorised 'P' or 'S' for HIV and AIDS (1995-2005)

Economic Sector	Percentage of total Commitment	Number of investments
Health SWAp	85.4%	1
Multi sectoral Responses to HIV and AIDS	8.4%	10
Sanitation/Waste Control	3.1%	1
Health Policy	1.2%	3
Balance of Payments	0.6%	1
Disaster relief mitigation	0.6%	1
Reproductive health	0.4%	2
Communicable disease control	0.2%	1
Strengthening civil society	0.1%	1

(Source: DFID Statistics Department spreadsheet)

7.2.2 None of DFID's commitments in Uganda with a PIMS marker for HIV/AIDS have a PIMS marker for gender. Indeed, Uganda has recently been noted as having only a small level of financial commitments prioritised for 'gender equality' within the PIMS system (Watkins 2004). Despite these figures, gender mainstreaming has been given considerable attention by DFID Uganda, the Government of Uganda and other DBS and SWAp basket donors[13]. Detailed analysis of the inclusion of gender mainstreaming within the PEAP was also commissioned in 2004 by DFID (Moncrieffe 2004). Reasons for gender mainstreaming being a key focus in DFID and Government of Uganda (GoU) activities include the existence of a strong women's movement; strong gender advocates in key Ministries; and a substantial and growing body of analytical work on gender inequality and poverty.

7.2.3 Since June 2001 all DFID HIV and AIDS specific projects in Uganda have technically been incorporated under the HIV and AIDS Umbrella Project. Four programmes/projects were originally selected for the purpose of this evaluation. However, the HIV and AIDS Advocacy project had minimal documentation and this could not be provided in time for this evaluation by the country office. Secondly, the Family Planning Project does not fall under the HIV and AIDS Umbrella Programme although it is marked S for HIV and AIDS.

7.2.4 The Umbrella Programme Project Memorandum shows that approximately 75% of DFID's investments were channelled into support for three national NGOs and three separate HIV and AIDS initiatives. Detailed budgetary information by programme was not available for analysis, and the information that was provided was broken down into tasks or categories such as 'transport' or 'personnel costs' rather than specific activities.

7.2.5 OPRs do show that the HIV and AIDS Umbrella Programme is making a significant contribution to both government and civil society's efforts to reduce the transmission and impact

[13] See: van Diesen and Yates 2005, Blackden 2004, Nordic Consulting Group 2004, Ministry of Finance, Planning and Economic Development 2003.

of HIV and AIDS. However, project documentation provided for this evaluation did not allow for a full assessment of the strengths and weaknesses of the Umbrella Fund, nor of each of the individual projects funded by it. Relating to gender specifically, the available documentation particularly for the monitoring and evaluation stages does not clearly identify gender as a key component, although information obtained from the country office shows that it is a major consideration.

7.2.6 Information was however, available for the activities of The AIDS Support Organisation (TASO) and these highlight the situation in Uganda where the HIV epidemic is mature and generalised, and affects the majority of households in one way or another. As a result TASO activities range across prevention, treatment and care, through to impact mitigation. They provide palliative care, including psychosocial support to people living with HIV and AIDS, and the main focus is on facilitating other NGOs, CBOs and other civil society organisations to undertake similar activities. Women are actively involved in post HIV test clubs, in identifying priorities and in planning what action they and their communities can take. In TASO projects there is a strong emphasis on community decision-making and leading interventions.

7.2.7 In addition the Umbrella Programme has as its purpose 'improved co-ordination and implementation of the multi-sectoral HIV/AIDS activities in support of the PEAP and the National Strategic Framework for HIV/AIDS' (DFID OPR 2004). In part, due to the success of the Umbrella Programme and the increasing awareness in Uganda about the epidemic, the demand for services provided by both the Government and civil society partners is now outstripping supply. The Programme responded to this by expanding VCT services both as a prevention measure and also to identify potential recipients for antiretroviral treatment (ART). As this is likely to be a key area of activity in the future, it is recommended that expansion of VCT services should be accompanied by effective monitoring and evaluation that includes disaggregation of data on uptake of services by gender.

7.2.8 Areas of opportunity and constraints in the implementation of gender issues within Uganda generally, and the HIV and AIDS Umbrella fund in particular are summarised in Box 3 in relation to the evaluation framework.

Box 3 Areas of strength and weakness in implementation of gender issues in DFID's Uganda Programme

Process

A rights-based approach is taken in conjunction with poverty alleviation.

The Civil Society Umbrella Programme has gender mainstreaming as a key focus, the HIV and AIDS Umbrella Programme does not. However, The AIDS Support Organisation (TASO) which is funded by the HIV and AIDS Umbrella Programme analyses gender elements as part of its strategic plan. Accountable grants are held by a number of HIV and AIDS civil society organisations which address gender although there are no discrete budget lines or specific criteria for this to be included as part of the funding selection process.

Approaches are gender sensitive e.g. increasing uptake of VCT among men to match that of women and encouraging male support of positive partners.

Understanding of underlying causes and explanations of unequal power dynamics and social relations is good as they have been addressed in numerous academic and technical papers.

DBS only indirectly supports HIV and AIDS activities. Donor Coordination Group on Gender is attended by a cross-section of donors so awareness of gender issues is high.

Outcomes

The concept of 'gender' is well accepted, mainstreamed and given budget lines within many GoU sectors.

DFID HIV and AIDS programmes do not have a specific budget line but gender mainstreaming still appears to be occurring within the majority of activities.

The outcome of gender mainstreaming is making significant progress at national and organisation levels but there is still progress to be made, particularly for highly vulnerable and marginalised groups of men and women.

Lack of mention of 'gender' in Terms of Reference (TORs) and Output to Purpose Reviews (OPRs) hides outcomes of 'gendered' interventions.

Impact

The Donor Coordination Group on Gender has improved consensus building for inclusion of key benchmarks on gender in the policy matrix of the World Bank's Poverty Reduction Support Credit (PRSC). Conversely the SWAp/DBS environment can also discourage discussion on more controversial issues. This impact of changing funding modalities needs further exploration.

Unequal gender relations still exist. Policy changes need to continue to be supported in practice and vice versa.

Scaling-up

Scaling-up is occurring but the impact of HIV and AIDS at all levels is severely affecting capacity to do so.

Scaling up of treatment interventions will be difficult in 'hard to reach' communities that are currently badly affected by the epidemic because of structural marginalisation e.g. access to health services

Gender empowerment can be difficult to scale up from grass-roots level as women's 'time poverty' often prevents participation and is not explicitly recognised in programme/project design.

7.2.9 The continuing disparities in men and women's access to VCT, care and impact mitigation interventions are well documented and offer the potential for important lessons to be learnt for other countries at a similar stage of the epidemic. It has become evident that currently more women than men are accessing VCT and care mainly through Prevention of Mother To Child Transmission (PMTCT) programmes. It is thus important that emphasis be placed on facilitating **both** men and women's access to VCT and scaling up provision of appropriate care, support and impact mitigation activities through key civil society organisations such as TASO. As access to ARVs becomes more widespread it will also be important to ensure that both men and women benefit equally from this medication. It is essential that gender disaggregated quantitative and qualitative data is collected and analysed to monitor and track the impact of new forms of treatment**.**

7.2.10 Given the status of the epidemic in Uganda, it is surprising that no investments are categorised explicitly as covering gender advocacy or impact mitigation. A problem of umbrella

funds, however, is that the breadth of their remit means that individual components become invisibilized during routine monitoring and evaluation of the programme (as opposed to monitoring and evaluation of individual projects funded under the Umbrella) unless explicit reference is made to them, for example in TORs for OPRs. Although there is evidence that overall the majority of approaches and interventions are gender sensitive there is a need for a clearer method of categorising gender mainstreaming.

7.2.11 Given the problems of loss of capacity at all levels due to the impact of AIDS it is important that the Umbrella Programme continues to provide technical assistance to the Government of Uganda to ensure that progress that has been made in mainstreaming gender is not lost. It is equally important that emphasis continues to be placed on facilitating men and women's access to VCT and scaling up provision of appropriate care, support and impact mitigation activities through key civil society organisations such as TASO who are best able to work with communities to identify appropriate, achievable and sustainable initiatives.

Table 12 Mainstreaming Gender in HIV/AIDS projects in Uganda

	Uganda HIV and AIDS Umbrella Fund 067555059	Identification	Design	Implementation	Monitoring & Evaluation
EQUALITY AND EMPOWERMENT	**Decision taking:** • **Capacity for public participation** • **Representation among decision makers** • **Household & individual decision making** **Rights:** • **Legal system** • **Public awareness** • **Response to gender-specific rights violations** **Access to resources & benefits of development:** • **Livelihoods & productive assets** • **Institutional capacity** • **Policy & programme change**	Need identified for multi sectoral strengthening of institutional capacity and for policy strengthening. Continuing need for incorporation of civil society policy advice recognised by GoU. 'Gender' not highlighted in initial log frame. Interventions are based on the DFID Health Target Strategy Paper (TSP), the DFID HIV/AIDS document 'Fighting back' and draft 'progressive illness' policy document. No discussion of rights based approaches, although implicitly embedded in activities to increase influence of civil society organisations in national and international advocacy. Key gender problems not identified other than higher prevalence levels among women than men. *Emphasis is placed on 'decision taking' particularly in capacity for public participation and representation among decision makers; 'rights' and 'access to resources and benefits of development, particularly policy and programme change.*	*No design documentation available on the HIV and AIDS Umbrella Programme.*	Since 2003 organisational capacity has strengthened and HIV and AIDS activities have been mainstreamed into all sectors. This includes a focus on gender within individual activities funded by the Umbrella Fund although documentation for this evaluation does not provide detail on these activities. 2003 OPR recognised that as part of Output 1 there is a commitment to '**empower** Civil Society with a robust interface to influence and monitor policy making' but lack of capacity limits its contribution. In 2003 the main focus of activities was on poverty reduction (i.e. equality) rather than on rights based (i.e. empowerment) issues. In 2005 emphasis was understandably still placed on the 'poverty-illness spiral'. Despite lack of discussion of dynamics and causes of poverty, gendered relationships causing, reinforcing different economic and non-economic aspects of poverty are being addressed by Umbrella Fund individual projects. *'Decision taking', 'rights' and 'access' incorporated into DFID Uganda HIV and AIDS activities*	Evidence of increasing influence of civil society organisations and clear attribution of the Programme to success in some areas. Focus on need for further institutional capacity building. 2004 OPR: 'Women' recognised as a key group to be targeted for interventions but no other discussion of specific gendered implementation. Insufficient information provided on M & E as part of this evaluation to be able to assess clearly areas of strength and weakness of gender mainstreaming activities.

7.3 Peru

Investments reviewed:

MIS	Project title	Project date	PIMS Markers (*)		Expenditure
122555015	Health Rights Project	2003-2008	HIV/AIDS	S	£736,762
			Promote gender equality and empower women	S	
122555005	Multi-sectoral population project	1999-2001	HIV/AIDS	S	£2,028,144
			Removal of gender discrimination	S	

Background and challenge
Peru is a middle-income country with unequal wealth distribution. The number of people living in poverty is increasing. Half of Peruvians live in income poverty and a fifth in extreme income poverty, mostly poor indigenous rural people. Despite improvements in some health indicators, old problems have become more entrenched and new diseases have appeared, widening the gap between different geographical areas and groups.

Peru's HIV epidemic is concentrated in vulnerable groups and most transmission occurs through sexual contact. Men account for the majority of reported cases but the gap between men and women has been narrowing. (USAID Health Profile Peru HIV/AIDS, March 2005); UNAIDS (2004) estimates that Peru had 82,000 cases of HIV/AIDS at the end of 2003

DFID Interventions

7.3.1 The Government of Peru explicitly supports a 'Rights-Based' approach to development and DFID's work has been based on enhancing democracy, rights and poverty reduction. The Regional Assistance Plan (RAP) set out DFID's plans for future activities. However, the closure of bilateral country programmes in Peru in March 2005 has meant challenges for DFID and reduced potential for direct input into gender mainstreaming in HIV and AIDS interventions. In the future the focus will largely be on working with other partners and multilateral donors.

7.3.2 Peru was selected as a case study for this evaluation because it reflects a smaller development programme than many others, but is one which has had an explicit focus on adding value to the work of other International institutions. In light of the current shift towards Direct Budgetary Support it was felt that important lessons could be learnt from the Peru country office's work with the World Bank, Inter-American Development Bank and European Commission. The closure of the Peru country office was thought to provide a good opportunity to review lessons learned.

7.3.3 The two projects reviewed have both gender and HIV and AIDS marked as 'significant' in the PIMS markers. However despite a strong emphasis on a Rights Based Approach (RBA) in health and an acknowledged HIV and AIDS problem, particularly in certain areas and among groups engaging in high risk activities, such as men who have sex with men (MSM) and CSWs there is no mention of HIV and AIDS in the 2003-2006 Country Assistance Plan (CAP).

7.3.4 The DFID Peru country office was unable to fully participate in this evaluation due to work pressure. As a result the evaluation was based on documentation received from the DFID Evaluation Department in the UK.

Table 13 Percentage of DFID investment by economic sector for activities categorised 'P' or 'S' for HIV and AIDS In Peru

Economic Sector	Number of investments	Percentage of total commitment
Health Policy	1	74.7%
Reproductive Health	1	25.3%

7.3.5 The Peru Programme's Concept notes demonstrate a coherent range of strategies including strengthening stakeholder participation in health policy decision making, strengthening inclusive working with health care providers and providing citizens with rights to health and health care. Each of these was relatively equally budgeted within the planned financial commitments.

7.3.6 The only evidence of programme impact was that the reproductive health project, Multi-Sectoral Population Project made good progress in increasing women and men's access to reproductive health, and increasing provision of care within communities. No detail was available, however, for specific HIV and AIDS interventions.

7.3.7 A summary of documentation reviewed are summarised in Box 3 below and highlights the lack of clear information on gender and HIV/AIDS in the Peru programmes.

Box 3 Areas of strength and weakness in implementation of gender issues

Process
A rights-based approach has been taken in conjunction with poverty alleviation.
Although issues of gender and HIV and AIDS are problems encountered by the very poor in Peru and are intrinsically linked to rights, 'gender' was not mentioned in the Health Rights Project Memorandum, and HIV and AIDS was not mentioned in the Project Concept Note. However, reference is made to the DFID Gender TSP in documentation on the design and relevance of the project.
The need to develop a free package of basic health care targeted on pregnant women and children is highlighted.
The log frame at Purpose level describes the need for incorporation of gender issues into public policy. Indicators are given for reducing maternal mortality, HIV and AIDS infection rates and sexual violence against women
The focus appears to be on 'women' rather than on women and men from a gender perspective.
The Multi–Sectoral Project describes increasing sustainable use of reproductive health services among both men and women, but the log frame does not differentiate by gender in the OVIs.
Young and adult men and women in both rural and peri-urban areas are identified as primary stakeholders but, again, Indicators and Means of verification (MOVs) are not disaggregated by sex
Outcomes
Initial measures of Multi-Sectoral Project achievement are not disaggregated by gender.
Lack of mention of 'gender' in TORs and OPRs hides outcomes.
Impact
No Information
Scaling-up
No Information

7.3.8 Gender mainstreaming in the prevention and care of HIV and AIDS is demonstrably a key component of successful interventions. It therefore remains relevant to ongoing work by both DFID and its partner international donors especially as traditional gender roles in Peru are still rigidly defined in many communities. There are reports that gender awareness work by NGOs has enabled women to have a greater voice in the home and this raises interesting issues for analysis of whether gender work is having an 'empowering' effect. However, the data on HIV and AIDS in Peru indicates that there is still much to be achieved in raising awareness on gender issues.

7.3.9 Working with the Government of Peru via other development donors offers the opportunity for DFID to provide information and guidelines on how key cross-cutting issues such as gender and HIV and AIDS can be incorporated into Government led activities. Identification of constraints, approaches and achievements could lead to important lessons being flagged which will be of relevance to other country offices who are increasing their links with other donors and providing DBS to Governments.

Table 14: Gender mainstreaming in HIV/AIDS Programmes in Peru

		Identification	Design	Implementation	M&E
Equality and Empowerment	**Health Rights Project 122-555-015**	• *Concept note* • *TORS*	• *Project Memorandum* • *Log frame*	• *TORS* • *Proposal* • *Project Reports*	• *Activity to Output* • *Output to Purpose* • *PCRs*
	Decision taking: • Capacity for public participation • Representation among decision makers • Household & individual decision making	Need to strengthen relationships between state and civil society within the health sector to facilitate pro-poor change. Explicit facilitation of rights-based citizen relationships to influence public policy, expenditure and management decisions. Reference made to: DFID Health & Human Rights TSP DFID Gender TSP 'Understanding Pro-poor Change' (Unsworth 2001) UK Gov White Papers on International Development (1997,2000) Government of Peru (GoP) and civil society's agenda: Peruvian Social Letter (2001) Need to develop free package of basic health care to target pregnant women and children. Reduction of inequality and empowerment (not disaggregated by gender) by participation, inclusion and obligation.	Design incorporates understanding and negotiating the mainstreaming of gender and indigenous issues in health sector vision and policy framework. Emphasis on changing power relations leading to discrimination and inequality. Log frame at Purpose level describes need for incorporation of gender issues into public policy. OVIs given for reducing maternal mortality, HIV and AIDS infection rates and sexual violence against women. Adult women one of key beneficiary groups. Explicit rights based approach including mention of World Bank aim to facilitate empowerment of the poor so that they have 'social control'. DFID Gender TSP used to guide design although it tends to be gender blind apart from mention of 'women' benefiting.	N/A	N/A
	Rights : • Legal system • Public awareness • Response to gender-specific rights violations				
	Access to resources & benefit of development • Livelihoods & productive assets • Institutional capacity • Policy & programme change				

8 DISCUSSION

8.1 Outcomes, Impact and Contribution of DFID Investments

*'Much has been written about the impact of HIV and AIDS but there has not been much success in **measuring** the human impact of HIV, especially in relation to gender (Whelan 1999). Despite this, there is ample evidence that women are affected disproportionately.'* (Tallis 2004: 25) (Author's emphasis).

8.1.1 The multi-faceted impact of HIV and AIDS on women and men is difficult to 'measure', as is measuring the impact and sustainability of long–term non-medical interventions. It is important therefore that DFID investments in HIV and AIDS and gender need to be clearly recorded even though it might be difficult to subsequently attribute impact to cross cutting issues such as gender mainstreaming.

8.1.2 There are significant inconsistencies in the use of PIMS markers as has already been mentioned earlier, and programme documentation often does not include gender issues in Terms of Reference or in OVIs or MOVs in log frames. It was noted however that although the absence of a 'gender' PIMS marker in the documentation does not necessarily reflect the reality of what happens in practice, the complexity and breadth of many programmes means that gender mainstreaming is unlikely to be routinely reported unless it is explicitly included in DFID technical and M&E documents.

8.1.3 DFID staff that were interviewed as part of this evaluation reported a lack of familiarity and access to either DFID or externally produced toolkits and manuals, and little or no training by DFID in gender mainstreaming. This indicates a lack of institutionalisation of gender mainstreaming and perpetuates existing perceptions that gender is the remit of Social Development Advisors and that its 'language' (along with that of rights-based approaches) is problematic and excludes those from other disciplines. This is compounded by the perception among DFID staff participating in the evaluation that the recent UK Government strategy on HIV and AIDS highlights goals but does not give practical guidance on how they can be achieved.

8.1.4 In fact, the DFID Gender Mainstreaming Manual (2002) is an excellent resource document. It was originally distributed as a 'pilot exercise' but is now freely available at www.dfid.gov.uk. However, during interviews for this evaluation a need was expressed for a 'roadmap of options' with which to address gender issues. This indicates that awareness of the Gender Manual is limited among DFID staff. The operational guide produced by the Gender and Development Group (2004) for the World Bank would also assist DFID staff.

8.1.5 The current development of an HIV and AIDS Web Portal, in conjunction with the UK AIDS Consortium, has the potential to significantly improve access to evidence on priority issues, briefing packs and Ministerial speeches. To date 'gender' has not been selected as one of the ten priority topics, although it will be included to an extent in the 'violence against women' section. However, if the web portal is expanded to cover 'gender mainstreaming' it could provide information on activities, resources, recommended reading, best practice case studies, tool kits etc. These are the resources which were requested on several occasions by DFID staff during this evaluation.

8.1.6 Where DFID investments are through Direct Budgetary Support (DBS), donor harmonisation on the importance of gender mainstreaming is important if it is to remain high on the HIV and AIDS agenda. Keeping broad gender-related issues on the agenda appears relatively unproblematic. However, addressing politically and culturally controversial aspects of gender mainstreaming and women's empowerment are much more difficult**.** Additionally, monitoring and evaluation of HIV and AIDS interventions generally appears to be a weakness not only of DFID but of other bi- and multi-lateral donors. A recent DFID Institutional Strategy Paper highlights the need for DFID and UNAIDS to work together to improve monitoring and evidence of improved performance: '(information exists), but is difficult to access. A set of shared baseline indicators across co-sponsors and from country to headquarters level need developing and then more effective monitoring systems established.' (DFID 2004b: 6).

8.2 Availability and Quality of Information

8.2. Programme documentation was obtained from DFID's Evaluation Department and from DFID country offices in Uganda and China. Interviews and substantive email correspondence were held with members of the DFID HIV and AIDS Policy Team and with DFID staff in Uganda and China.

8.2.2 The evaluation has highlighted difficulties in accessing documentation. When the original choice of programmes and projects had been amended to reflect the availability of information, pressure of time and commitments on DFID staff meant that it took longer to receive documentation than was originally assumed. This also applied to contacting and arranging interviews with country staff. This suggests that a longer lead-in time will be required for the systematic evaluation.

8.2.3 The quality of documentation is variable. The majority of the documents, particularly at the implementation and M&E stages give little explicit evidence of gender mainstreaming. This is not to say that it does not occur, but that the pressure of incorporating and reporting on a wide range of activities and priorities means that choices, assumptions and trade-offs are made when deciding what to include. This makes it difficult to tell whether gender mainstreaming is evaporating or becoming invisible in the projects (other than when specific reviews or strategy documents on the matter are commissioned). On balance the written documentation provided was insufficient to provide evidence of success or failure in mainstreaming of gender in HIV and AIDS interventions. For this to be possible the documents would need to provide detailed information, for example on

- *Programme purpose:* improving equitable gender access to treatment for sexually transmitted infections, or ARV
- *Programme activity:* what specific activities undertaken, how many men and women involved
- *Programme impact:* % increase over time disaggregated by age, marital status, livelihood etc

8.2.4 The forthcoming evaluation will need to place greater emphasis on interviews or correspondence with country-office staff and consider including other stakeholders in the evaluation so that the perception of other donors, community and non-government organisations such as members of the UK HIV and AIDS Consortium, International Community of Women Living with HIV and AIDS (ICW), and WOMANKIND Worldwide and others are also taken into account. With the increasing move towards DBS analysis of issues associated with this should form a particularly important component of the systematic review. This, too will require a more substantial period of time than was available for this evaluation.

8.2.5 DFID staff is cognisant of the fact that explicit strategic goals create an obligation towards accountability to both taxpayers and the international community, yet at present the information generated from DFID's investments is not sufficient to do this with confidence. Accountability will be increased if the recommendations of the 2005 Millennium Task Force on HIV and AIDS are adopted. This will make it all the more important for DFID to implement rigorous, systematic, quantifiable and appropriate OVIs, or other evaluative indicators and processes. DFID will also need to ensure that project documentation consistently includes explicit reference to activities and outcomes relating to PIMS markers and provides evidence of programme progress towards DFID/UK government strategy goals and MDGs.

8.3 Appropriateness of the Evaluation Framework used

8.3.1 In some ways, the framework developed for this evaluation was a satisfactory, flexible and practical tool. It appeared to be well received by interview respondents, was useful as a tool for tracking gender across the life of an investment from identification to M&E, and in enabling identification of points where policy evaporation or invisibilisation were occurring.

8.3.2 However, the utility of the framework in investigating, in any depth, the three major dimensions: decision making; rights and access to resources and benefits of development was limited. This was in part due to the rapid nature of this evaluation pre-study. However it was also because DFID documentation (e.g. project concept notes, project memorandum) does not have this level of information on any one issue. In addition, this was not the framework used by DFID advisors to guide their thinking (it was drawn from a CIDA model), so it was difficult to relate the dimensions used in the framework to work on the ground.

8.3.3 For this reason and also given the plethora of 'frameworks' available, it would be pertinent to review the framework against current DFID conceptual frameworks and strategy documents, in particular the new RBA 'how to' note for maternal mortality reduction.

8.3.4. The issues listed in each column, which CIDA used to represent the key dimensions (decision-making, rights and access to resources and benefits of development) are not entirely appropriate for reviewing gender mainstreaming in HIV and AIDS interventions. It is suggested that prior to the systematic review it would be useful for DFID to decide which key issues it wishes to be incorporated into each dimension. This would increase the framework's appropriateness for reviewing programmes.

8.3.5 It is suggested that the seven strategic priorities identified by the Millennium Task Force on Education and Gender Equality (2005), which encompass aspects of equality and empowerment and link each one clearly to HIV and AIDS, might create a more practical framework and bring DFID up to date with the most recent thinking on ways of achieving the MDGs. Alternatively the left hand column of the CIDA framework could be split into 'prevention', 'treatment and care' and 'impact mitigation'. But this would only be possible if clearer information can be obtained on each of these activities than was possible for this evaluation.

8.3.6 This review has illustrated that country offices work predominantly within specific national contexts. The impact that this has on gender mainstreaming can be seen clearly in this evaluation by comparing China and Uganda. In China gender mainstreaming is virtually a new concept that does not obviously fit well with the broader political environment. In Uganda elements of gender mainstreaming have been incorporated into Government and donor documents and activities for a substantial period of time, and have been the subject of considerable attention both nationally and internationally. These different starting points and contexts underpin the necessity for flexible yet systematic approaches, and the need to optimise lesson learning and sharing.

8.3.7 In addition to evaluating programme documentation it would also be useful to look at the spend on technical assistance used explicitly for gender mainstreaming. This could then be disaggregated by, for example, aid modality. This would be useful as DFID staff have limited influence on national policy where DBS is in place.

8.3.8 It would also be useful to examine more closely, through in depth interviews, the ways in which gender power dynamics are addressed in HIV and AIDS interventions. Investments in social marketing or microbicide development were viewed by respondents as sometimes being preferable at institutional level to, for example engaging in impact mitigation activities, because they do not require complex and difficult to quantify indicators of impact. It is important to know whether this is correct and, if it is, whether this is due to political imperatives, lack of understanding, a sense of being overwhelmed by what needs to be done to change gender power relations, or whether it is because transformatory and empowering interventions are difficult and politically sensitive.

8.4 Issues for Consideration in the Systematic Evaluation

8.4.1 The following are issues that this evaluation has highlighted as needing further investigation and that were beyond its scope but which would add value to the systematic evaluation:

- Incentives to mainstream gender in HIV and AIDS investments, such as achievement of MDGs, IDTs, national social and economic development, and reductions in transmission of HIV and the impact of AIDS, are not highlighted. To what extent are these understood at all levels of DFID, and can reporting measures indicate the progress and impact of these investments without adding administrative burdens to already heavy workloads of DFID country and programme staff?

- To what extent do current processes and procedures hide or reveal areas of evaporation, invisibilisation or resistance?
- Is there systematic monitoring and evaluation of gender mainstreaming within HIV and AIDS interventions at planning, process, and outcome stages?

- What variations in approach and/or impact of gender mainstreaming occur within different aid modalities e.g. programmatic, DBS and SWAps. In what ways does each inhibit or enhance gender mainstreaming from both equality and empowerment perspectives?

- What variations in approach and/or impact of gender mainstreaming occur within different HIV and AIDS foci e.g. prevention, treatment and care, and impact mitigation?

- How are resources (including financial, technical and training) operationalised?

- Do agreed harmonisation principles (The Three Ones[14]) between donors and partners enhance or constrain gender mainstreaming?

- How relevant, effective and efficient are gender-mainstreaming approaches in HIV and AIDS interventions?

[13] The Three Ones are: One agreed HIV and AIDS action framework, one national AIDS coordinating authority, one agreed country-level monitoring and evaluation system. Agreed by all major international donors in 2004.

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ANNEX 1

Documents received for China from DFID Evaluation Department

145001001 Health VIII
Numerous

14555501 HIV/AIDS Education
DFID Project Header Sheet
Programme concept note
Incomplete logframe (No OVIs or MOV) Feb.2001

145003001 China HIV/AIDS Project
DFID Project Header Sheet
1999 Project Memorandum Various letters
2001 OPR (Prism)
2001 OPR Aide Memoire
TORS for 2002 OPR
2002 OPR (Mission Report and Aide Memoire, NOT Prism)
2003 Jolly S, Ying W 'Gender Mainstreaming Strategy for the China-UK HIV/AIDS Prevention and Care Project'.
2003 Jolly S, Ying W 'Key Issues on Gender and HIV/AIDS in China: Report for DFID'.
2003 OPR (Prism)
2003 Annual Review Mission of China-UK HIV/AIDS Prevention and Care Project: Social Annexe
2004 OPR TORS
2004 OPR (Prism, annexes and Aide Memoire)

145555003 HIV/AIDS TC Support
2001 OPR (Prism) – Identical to 145003001 OPR other than cumulative spend.

Documents received for Uganda from DFID Evaluation Department

067555024 NGO: The AIDS Support Organisation (TASO)
1998 Project Header Sheet
1998 Correspondence
1998 Application for Bridging Funds
1998 Project Submission for Bridging Funds
1998(?) Project Rationale 2000 Project Header Sheet
2001 OPR (Prism)
2002 OPR (Prism)

067555059 HIV/AIDS Umbrella Programme
Project Header Sheet
2001 Correspondence
2002 Correspondence
2002 Project Memorandum
2003 OPR (Narrative Report)
2004 OPR (Prism)
2005 Project Concept Note

067680090 Expansion of Family Planning Reproductive Health Care
1999 Project Header Sheet

067683006 Building HIV/AIDS Advocacy, Care and Prevention
2001 Project Header Sheet
2002 Progress Report

General
First Draft Revised National Gender Policy (September 2004)
Blackden M (2004) *Out of Control: Gender and Poverty in Uganda, A Strategic Country Gender Assessment,* World Bank
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PRSC Policy Result Matrix: Uganda PRSC4-6 (2004/5 – 2006/07) Government of Uganda
PEAP Revision Guide
Moncrieffe J *Gender Analysis of Sector PEAP Revision Papers*
Moncrieffe J *Gender Analysis of First PEAP Draft*
Klasen S *Gender and Economic Growth in Uganda*
Lawson D *Gender Analysis of Existing Household Data Sets*
Ministry of Finance *Budget Call Circular and Guidelines on Gender and Equity*

Documents received for Peru from DFID Evaluation Department

122555005 Multi-Sectoral Population Project
Project header sheet
1999 Extension to the Multi-Sectoral Population Project
2003 OPR (prism)

122555015 Health Rights Project
Project Header Sheet
2001 Project Concept Note
Undated (2001?) Log frame
2002 Project Memorandum