

How have global health initiatives impacted on health equity?

What strategies can be put in place to enhance their positive impact and mitigate against negative impacts?

A literature review commissioned by the Health Systems Knowledge Network

January, 2007

Johanna Hanefeld, Neil Spicer, Ruairi Brugha, Gill Walt

Please send comments to Johanna.Hanefeld@lshtm.ac.uk and Gill.Walt@lshtm.ac.uk .

Background to the Health Systems Knowledge Network

The Health Systems Knowledge Network was appointed by the WHO Commission on the Social Determinants of Health from September 2005 to March 2007. It was made up of 14 policy-makers, academics and members of civil society from all around the world, each with his or her own area of expertise. The network engaged with other components of the Commission (see http://www.who.int/social_determinants/map/en) and also commissioned a number of systematic reviews and case studies (see www.wits.ac.za/chp/).

The Centre for Health Policy led the consortium appointed as the organisational hub of the network. The other consortium partners were EQUINET, a Southern and Eastern African network devoted to promoting health equity (www.equinetfrica.org), and the Health Policy Unit of the London School of Hygiene in the United Kingdom (www.lshtm.ac.uk/hpu). The Commission itself is a global strategic mechanism to improve equity in health and health care through action on the social of determinants of health at global, regional and country level.

Acknowledgments

This paper was reviewed by at least one reviewer from within the Health Systems Knowledge Network and one external reviewer. Thanks are due to these reviewers for their advice on additional sources of information, different analytical perspectives and assistance in clarifying key messages.

This work was carried out on behalf of the Health Systems Knowledge Network established as part of the WHO Commission on the Social Determinants of Health. The work of this network was funded by a grant from the International Development Research Centre, Ottawa, Canada. The views presented in this paper are those of the authors and do not necessarily represent the decisions, policy or views of IRDC, WHO, Commissioners, the Health Systems Knowledge Network or the reviewers.

How have global health initiatives impacted on health equity?

Executive Summary

Global Health Initiatives (GHIs) have emerged as new models of development assistance in the fight against diseases in low and middle-income countries over the past decade. These structures are rapidly evolving and have succeeded in leveraging significant new amounts of funding – an estimated US\$ 8.9 billion was spent on responses to HIV/AIDS alone in 2006.¹ These expanded levels of funding have the potential for making a major impact on health systems at country level, by improving access to health services, prevention, treatment, care and support for specific diseases.

This paper explores the impact of GHIs on health equity, looking specifically at those involved in HIV/AIDS and focusing on gender equity. Three GHIs are examined in detail: the US President's Emergency Plan For AIDS Relief (PEPFAR); the World Bank's Multi-country AIDS Programme (MAP); and the Global Fund to Fight AIDS, Tuberculosis and Malaria (GF). Together these GHIs provide significant levels of funding for HIV/AIDS. All three GHIs focus primarily on alleviating the impact of HIV/AIDS, but operate in very different ways.

Each of the GHIs is examined for policy, programme and funding references to gender as a determinant of health equity and in relation to HIV/AIDS. We also explore the policy-making process for each GHI, and highlight key recommendations for further action. Since the three case study GHIs are relatively newly established, empirical evidence relating to their impacts is limited.

The analysis suggests that PEPFAR's overall approach to gender and women appears to be characterised by attempts to counter women's 'vulnerability', rather than to promote women's rights or entitlements, and that this may exacerbate inequities rather than alleviate them in some areas. However, evaluations suggest that the initiative has addressed some symptoms of inequity, by ensuring that access to services and treatment reflects a gender balance: For example, 61% of those receiving ARVs are women. While gender appears to have been neglected in past MAP strategies, a new HIV/AIDS Programme revised in 2006 will specifically address gender inequity. However, our report highlights continuing contradictions between World Bank-supported macro-economic policies and MAP HIV/AIDS policies in many countries – in relation to charges for education for example. The Global Fund guidelines encourage countries to consider social and gender inequalities in their funding applications, and the establishment of Country Coordinating Mechanisms has the potential for more open participation in decision-making. Experience in countries is however, highly context-specific. Analysis suggests all three GHIs may have had some negative effects on human resources, potentially exacerbating gender inequities, with, for example, the migration of health personnel from comprehensive to disease-specific services.

¹ This figure is the estimate for all funding for HIV/AIDS in 2006, not only funding leveraged from GHIs. UNAIDS (2006) 2006 Report on the Global AIDS Epidemic; ch. 10 'Financing the Response to AIDS', p.224. However, two-thirds of funding for HIV/AIDS comes from the 3 GHIs covered in this paper GFATM (2006) Investing in Impact: mid-year results report 2006. Geneva.

The analysis of the impact of these three GHIs on gender equity highlights the importance of local knowledge to ensure that programmes are aware of, and successfully address, gender inequities. The World Bank and Global Fund structures appear more successful in drawing on stakeholders' knowledge, or in highlighting existing inequities. PEPFAR is the only GHI to set numerical targets globally and nationally, and to monitor gender balances in reaching these targets.

The paper proposes nine key recommendations. GHIs should:

- Address explicitly the causes of gender inequities in access to health.
- Assess the impact of different interventions on social inequities.
- Include measures that are sensitive to gender and other equity priorities in setting targets and monitor progress towards these.
- Enhance the collection of gender-disaggregated data.
- Use national policy processes for empowerment in order to facilitate greater participation.
- Address GHIs' impact on health systems and human resources.
- Harmonise activities and programmes across GHIs to build on comparative advantage.
- Integrate social equity in access to health services within broader, macro-economic and development policies.
- Monitor and evaluate GHIs impact on social equity.

Introduction

This paper explores the impact of Global Health Initiatives (GHIs) on health equity, looking specifically at GHIs involved in HIV/AIDS and focusing on gender equity. Three GHIs are examined in detail, these are: the US President's Emergency Fund for AIDS Relief (PEPFAR), the World Bank's Multi-country AIDS Programme (MAP) and the Global Fund to Fight AIDS, TB and Malaria (GF). The paper concentrates on low and middle - income countries as they overwhelmingly form the focus of GHI expenditure on HIV/AIDS.

The paper further focuses on gender as HIV/AIDS disproportionately affects women and the poor, and an estimated 70 percent of the world's poor are women.² Women also carry the greatest burden of caring for others living with HIV/AIDS and orphans.

The volume of development assistance provided through GHIs means that their impact on health systems especially in resource poor settings is significant. The ways in which they engage or fail to engage with national health systems determine access to health services for large parts or whole populations. The interventions they fund, if they aim to address the causes of HIV/AIDS or any other focus disease, need to address the wider social determinants of health, such as poverty, gender inequality and discrimination. An assessment of Global Health Initiatives is imperative to understand health systems and their development in many countries. It is equally vital to develop appropriate and pragmatic strategies to successfully strengthen and build health systems' capacity to enable greater health equity.

Equity and health

Equity³ has emerged as a policy priority in global health assistance with the growing realisation that aid and health sector reforms only benefit the poor and marginalised sections of the population where issues of equity in access and outcomes of health care are explicitly addressed.⁴

Equity of access to health services is not the same as equity in health outcomes. Differences in outcomes arise through socio-economic circumstances external to the health sector, or indeed to variations in quality of health services provided. Access to health services is affected by many factors, including social and economic status (including 'race' or ethnicity), demography (gender or age) and geography. For example discrimination by staff against a particular section of the population might result in less effective services for that particular group.

² Sen, G., George, A., Oestlin, P. (2002) 'Engendering health equity: a review of research and policy', in Engendering International Health. The Challenge of Equity, MIT Press, Cambridge.

³ For the purpose of this discussion equity or inequity needs to be differentiated from equality or inequality in access to or attainment of health. Inequalities mean differences between different groups without making judgements as to their fairness. Inequities refer to a subset of inequalities that are deemed unfair. (Evans et. al. (2001) 'Introduction', p.4 in Challenging Inequities in Health, From Ethics to Action; OUP). Indeed some inequalities in access, such as exemptions from user charges for the poor or for high risk target groups, may be deemed equitable. Attaining optimal health should not to be compromised by the social, political, ethnic or occupational group into which one happens to fall. To the extent that disparities in health coincide with fault lines between such groups, these can be seen as unfair and thus as constituting inequities. (Evans: 2001).

⁴ Gwatkin, D., Bhuiya, A., Victoria, C. (2004), 'Making health systems more equitable'; The Lancet, Vol. 364.

Equity and HIV/AIDS

While social equity has emerged as an overarching concern in development and health, HIV/AIDS has particularly emphasised linkages between health and wider socio-economic factors of inequity and inequality.⁵ Socio-economic inequalities increase people's risk of HIV infection, and once infected they act as barriers to treatment, care and support for people living with and affected by HIV/AIDS. HIV/AIDS also reinforces inequities and perpetuates underdevelopment and poverty,⁶ including inequities linked to gender (see box 1).

Treatment and HIV/AIDS

Health systems play a key role in determining access to treatment and the care people receive, including for HIV/AIDS.⁷ Gender, geographic location, income and social status among others are factors determining equitable access to treatment, and all are mediated through the health system. Costs associated with transport can act as a barrier for people, particularly poor people in rural areas, and may act as a deterrent to accessing health care, getting tested or even seeking treatment.

The linkages between treatment, morbidity and socio-economic status became more starkly visible in the mid 1990s, when life-prolonging anti-retroviral drugs (ARVs) were developed. Initially deemed too expensive and complex for public health care systems in low and middle-income countries, by 2002 international political opinion was shifting and treatment was increasingly an option in the South. However, the availability of new and expensive treatments can exacerbate inequities, at least temporarily, where access to treatment remains limited. In June 2006 WHO estimated only twenty four percent of those requiring ARVs were receiving them worldwide⁸, and while systematic evidence is scarce, many are concerned about inequities in treatment access. In Zambia for example, one study on waiting lists for ARVs noted that '...many ... have the strong impression that people who are "better off" are the ones getting access...'.⁹

The HIV/AIDS epidemic has increased pressures on already weakened health systems. Problems are exacerbated by AIDS-related mortality among health care staff in high prevalence countries, high burdens of care in health facilities: these present major challenges for prescribing and treating people living with HIV/AIDS.¹⁰ An inherent feature of antiretroviral treatment (ART) scale-up in the poorest countries is that ART centres are initially established in urban settings, where there is a health infrastructure that can be augmented; and ART is rolled-out at a later point to rural areas. Two of UNAIDS' *Three Scenarios for AIDS in Africa by 2025* envisage a slow

⁵ Parker, R. (2000) 'Administering the Epidemic: HIV/AIDS Policy, Models of Development and International Health' in Whiteford, L., Manderson, L. Global Health Policy: The Fallacy of the Level Playing Field; Boulder: London.

⁶ Sabatier R (1989) AIDS in the Third World; Panos Institute: London.

⁷ Jones' study on Zambia cited below in the following also notes that 'Discussions of scaling up ARVs in Zambia must take place in the context of more general challenges of low coverage, poor quality and insufficiently funded health care.' Jones: 2005, p.85.

⁸ WHO (2006) Presentation by Kevin de Cock, HIV/AIDS WHO at the IAC Toronto August 2006. See <http://news.bbc.co.uk/2/hi/africa/4798343.stm>. Accessed September 2006.

⁹ Jones, P.S. (2005), 'On a Never-Ending Waiting List: Toward Equitable Access to Anti-Retroviral Treatment? Experiences from Zambia' p, 87. In Health and Human Rights; Vol.8, No. 2; Boston.

¹⁰ The G8 specifically recognised the debilitating impact of HIV/AIDS on the health care systems and the aim of providing universal access by 2010. See Gleneagles Communiqué http://www.fco.gov.uk/Files/kfile/PostG8_Gleneagles_Communique_0.pdf, accessed September 2006.

growth and stagnation around 20-25 % in the proportion of countries' populations on ART over the next 20 years.¹¹

BOX 1: Gender, equity and HIV/AIDS

Gender is particularly relevant and important to assess in this context, as HIV/AIDS disproportionately affects women. Women represent half of all people in the world living with HIV/AIDS, and in sub-Saharan Africa they constitute nearly 60% of all infections.¹² An estimated 70% of the world's poor are women.¹³ These gender inequities are reflected in women's greater vulnerability to HIV/AIDS.

While gender is a determining factor in equity, it does not operate in isolation, and must be considered alongside other socio-economic factors that might determine a person's access to health.^{14 15}

Women and girls are biologically more vulnerable to HIV infection than men. They carry the main reproductive burden, and are more likely to be affected by inadequate health services and treatment. They are also affected by gender-based violence, increasingly recognised as a deeply embedded and world-wide problem which has deleterious effects on women's health and wellbeing. The UN Political Declaration on HIV/AIDS acknowledged in 2006 that 'Gender inequalities and all forms of violence against women and girls increase their vulnerability to HIV/AIDS'.¹⁶

Gender also determines socio and economic status, which increases possible vulnerability to HIV infection. Women often have less access to economic resources and are financially dependent on a husband or partner. Where women find it difficult to gain formal or informal employment they may be more likely to resort to transactional or commercial sex, to ensure their survival and that of their children.¹⁷

Some cultural practices and norms may also make it harder for women to protect themselves against HIV infection. For example enforcing condom-use in a relationship may be difficult if the woman depends on her partner for survival or income. A recent study of injecting drug users in Ukraine found a higher incidence of HIV in female users than in male. Women interviewed said that as the stigma facing female injecting drug users was greater than that facing men, they were less likely to access prevention services, which would identify them as IDUs.¹⁸ In some countries it is

¹¹ UNAIDS. AIDS in Africa: Three scenarios to 2025. Geneva: UNAIDS.

¹² UNAIDS website: <http://www.unaids.org/en/GetStarted/Women.asp>. Accessed October 5th 2006.

¹³ Sen, G., George, A., Oestlin, P. (2002) 'Engendering health equity: a review of research and policy', in *Engendering International Health, The Challenge of Equity*, MIT Press, Cambridge.

¹⁴ Evans et al (2001), p.9.

¹⁵ Sen, G., George, A., Oestlin, P. (2002) 'Engendering health equity: a review of research and policy', in *Engendering International Health, The Challenge of Equity*, MIT Press, Cambridge.

¹⁶ United Nations General Assembly. 60/262 Political Declaration on HIV/AIDS. 87th Plenary Meeting, A/RES/60/262, June 2006. Sourced at <http://data.unaids.org/pub/Reprot/2006/20060615>

¹⁷ The Global Coalition on Women and AIDS (2006) *Economic Security For Women Fights AIDS*; Briefing Note No 3.

¹⁸ International HIV/AIDS Alliance (2006), *Recommendations from HIV/AIDS Alliance Study from Alliance Ukraine gender study help improve the effectiveness of HIV prevention services*; <http://www.aidsalliance.org/sw35159.asp>. Accessed September 2006.

considered inappropriate for a woman to travel on her own to access care. For example, in the Indian state of Uttar Pradesh, 80 percent of women require their husbands' permission to visit a health centre.¹⁹

Global Health Initiatives (GHIs) and gender equity – methods

Three global health initiatives are examined here: the US President's Emergency Plan For AIDS Relief (PEPFAR), the World Bank's Multi-country AIDS Programme (MAP) and the Global Fund to Fight AIDS, Tuberculosis and Malaria (GF). Together these GHIs provide almost two thirds of external funding going to HIV/AIDS: PEPFAR (21%), World Bank/UNAIDS (22%), Global Fund (21%).²⁰ In 2003 US President Bush pledged USD 15 billion over five years for addressing the epidemic.²¹ The World Bank MAP has provided USD 1.1 billion²² since 2000. The Global Fund has committed USD 6.8 billion (2002-2006).²³ All three GHIs focus primarily on alleviating the impact of HIV/AIDS, but operate in very different ways.

For each of the GHIs discussed here references or acknowledgements to gender as a determinant of health equity are examined, and where possible, the extent to which this is translated into policies and funding guidelines. We also explore the policy-making process for each GHI, and highlight key recommendations for further action. Since all these GHIs are relatively newly established, empirical evidence is limited. The report draws on a few studies which have been, or are being undertaken; some relatively independent 'grey' literature, which may or may not be in the public domain; and information provided by the GHIs themselves, UN bodies and aid agencies.

Materials used

A wide range of documents including academic and grey literature were analysed as part of this study. Extensive use was made of the evaluation reports, strategy papers and guidelines published by Global Fund to Fight AIDS, TB and Malaria, by the US Office of the Global AIDS Administrator and by the World Bank, including the consultation documents about the World Bank's new HIV/AIDS programme for sub-Saharan Africa, which was revised throughout 2006. All of these documents are available on the respective institute's web sites and where possible a web address has been provided.

Despite a lack of detailed information, especially about the longer-term impact of many GHIs at the country level, at the time of writing there was more information available about the Global Fund than about PEPFAR, and while there is a body of literature that has examined the

¹⁹ World Bank (2005) *World Development Report 2006. Equity and Development*; OUP: New York; p.52.

²⁰ Global Fund to Fight AIDS TB and Malaria. Investing in impact, mid-year results report 2006. Geneva: GFATM.

²¹ <http://www.pepfar.gov/> accessed January 11th 2007.

²² World Bank

<http://web.worldbank.org/WBSITE/EXTERNAL/COUNTRIES/AFRICAEXT/EXTAFRHEANUTPOP/EXTAFRREGTOPHIVAIDS/0..contentMDK:20415735~menuPK:1001234~pagePK:34004173~piPK:34003707~theSitePK:717148.00.html>. Accessed September 2006.

²³ Global Fund to Fight AIDS TB and Malaria (2006) <http://www.theglobalfund.org/EN/>. Accessed January 11th 2007.

impact of wider World Bank policies throughout the 1980s and 90s on health, very little independent analysis has focused on their Multi-country AIDS Programme. The paper also draws on independent evaluations of these global health initiatives, as well as the academic literature that analyses and studies their impact. Sources also include unpublished NGO reports, MSc and PhD theses. Most of this literature is very recent and varies in rigor, objectivity and generalisability.

For the introductory definitions of equity, gender and their interactions with HIV/AIDS writings on gender and health were consulted. Where evidence, especially on country-level impact has been scarce, the authors have drawn on their own on-going research and field work, including materials presented at the XV International AIDS Conference in Toronto in 2006.

The emergence of Global Health Initiatives

There have been two major, noteworthy changes in global health over the past decade. First, development assistance for health has increased hugely: it is estimated to have risen by 26% from USD 6.4billion in 1997 to USD 8.1billion in 2002.²⁴ A significant new funder in health is the Bill and Melinda Gates Foundation, providing some US\$ 6billion for health alone between 1999 and 2006.²⁵ The mechanisms through which aid is being delivered have also expanded, from grants and loans provided through bilaterals, multilaterals and the World Bank between the 1950s and 1990s, to include general budget support to governments and performance-based funding in the 2000s, the former provided by bilaterals, the latter initiated by the Global Alliance on Vaccines and Immunizations (GAVI) and the Global Fund. Increasing interest is being shown in such funding.²⁶

Second, the traditional donors in health (UN organisations such as WHO or bilateral agencies) no longer dominate international health policy as they did until the 1980s. The entry of the World Bank into health in 1984 heralded an opening of the health policy environment.²⁷ This was in part a response to disillusion with perceived stagnation and bureaucracy in the UN agencies, and the growth of civil society organisation activity, among other things.²⁸ Some of these new entrants, such as the Bill and Melinda Gates Foundation have had significant influence in global health policy, both as a Foundation in its own right, but more as a partner with others. Furthermore, the number of partnerships at the global level has proliferated enormously. These are extremely diverse in nature, scope and size²⁹ but they often

²⁴ WHO 2006. Engaging for Health. Eleventh General Programme of Work 2006 – 2015. WHO: Geneva. P5

²⁵ <http://www.gatesfoundation.org/GlobalHealth/Grants/default.htm?showYear=2006>. Accessed October 2006

²⁶ Barder and Birdsall (2006); 'Payments for Progress – A Hands-Off Approach to Foreign Aid' Center for Global Development Working Paper 102.

²⁷ Walt G Health care in the developing world, 1974 – 2001 in: Webster C (ed) *Caring for Health: History and Diversity*, Open University Press: Milton Keynes (2001)

²⁸ Buse K & Walt G Global public-private partnerships: Part 1 – a new development in health? *WHO Bulletin* 78; 4; 549 - 561 (2000)

²⁹ The Initiative on Public Private Partnership for Health, undertook a review of more than one hundred global health partnerships and classified these into seven different categories: product development, improvement in of access to health products, global coordination mechanisms, health service strengthening, public advocacy, education and research, regulation and quality assurances and other.

involve a partnership between the more traditional development actors, such as multilateral agencies, and new actors, such as private sector corporations, or philanthropic entities such as the Clinton or Rockefeller Foundations.³⁰ The International AIDS Vaccine Initiative (IAVI) for example, combines the Gates Foundation, private businesses, UN agencies and non-governmental organisations, with the purpose of developing a new product (in this case an AIDS vaccine).³¹ The Global Alliance on Vaccines and Immunization (GAVI) has some of the same partners, but a wider remit, which includes the introduction of new vaccines, strengthening existing childhood vaccinations as well as making inputs to the health system. Others, such as the Stop TB Partnership, Roll Back Malaria or Global Polio Eradication are more closely associated with WHO, and focus on fighting a particular disease.

Some of these partnerships are called Global Health Initiatives, but nomenclature is problematic. Initially called global public-private partnerships³², they have been variously referred to as global health programmes or global public policy networks among other names. Many organisations use the term to describe particular projects – often around specific diseases. For example, the World Economic Forum has a global health initiative which their website claims as the largest public-private sector network tackling HIV/AIDS, TB and malaria.³³ However, in general, most would agree that GHIs include state and non-state partners, involve new funding or leveraging of funds, and are shaped around a particular disease addressed through a strategy, or set of interventions.³⁴ While this definition covers most global health initiatives, it would preclude PEPFAR, which is a bilateral initiative, between the US government and recipient country partners. Brugha has summarised the various descriptions of different GHIs and defined them as ‘a blueprint for financing, resourcing, coordinating, and/or implementing disease control across at least several countries in more than one region of the world’³⁵. This definition includes PEPFAR.

The three GHIs examined in this paper differ from each other:

PEPFAR (the US President’s Emergency Plan for AIDS Relief), initiated in 2003, is referred to as a GHI largely because of its disease focus (on HIV/AIDS) and as it was initially designated to cover 15 countries addressing a global dimension to disease control. As a government initiative its budget is dependent on approval by the US Congress every year³⁶, and it has a global strategy for HIV/AIDS treatment, prevention and care, which follows a specific set of guidelines.³⁷ There is little policy

www.ippph.org 2006. While this categorisation is useful, GHI’s often fit more than one of these categories. Caines et. al in their study used four categories, research and development, technical assistance/service support, advocacy and financing. (Caines et.al.: 2004)

³⁰ Buse, K. et. al. (2000)

³¹ Some of the earliest examples of GHIs, such as the Mectizan Donation Program where partnerships with the private sector involving donations of medicines or product development. Brugha, R. (forthcoming), Buse, K. et. al. (2000).

³² Buse K & Walt G Global public-private partnerships: Part 1 – a new development in health? *WHO Bulletin* 78; 4; 549 - 561 (2000)

³³ See <http://www.weforum.org/en/initiatives/globalhealth/index.htm>. Accessed 5 October 2006

³⁴ Caines study found that most GHI’s or GHPs, focus on communicable diseases and that 60% focus on the ‘big diseases’ – HIV/AIDS, TB and Malaria. Caines, K. (2004) Addressing the impact of Global Health Partnerships; DFID Health Resource Centre: London.

<http://www.dfidhealthrc.org/shared/publications/GHP/GHP%20Synthesis%20Report.pdf>. Accessed September 2006.

³⁵ Brugha, R. (forthcoming), p.4.

³⁶ Brugha, R. (forthcoming), p.3.

³⁷ It has also been included as a GHI in recent reviews of these structures, such as the McKinsey study in 2005. McKinsey and Company (2005) Global Health Partnership: Assessing Country Consequences.

discussion on strategy at the country level, and the approach is largely top-down, from Washington D.C. to the country level.

PEPFAR is coordinated by the Office of the US Global AIDS Coordinator in Washington D.C., but most of its funding is channelled through existing US agencies in the 15 countries (largely in Africa) where it is active. 'Primary Partners' implement PEPFAR's strategy at a country level. These include national and international non-governmental organisations. They may include recipient countries' governments. In Guyana for example, the government's Prevention of Mother To Child Transmission (PMTCT) programme and the second-line anti-retroviral treatment is funded by PEPFAR.³⁸ Other 'primary partners' include private contractors or universities that win contracts to implement aspects of PEPFAR's country strategy.

Some primary partners provide grants to local 'sub-partners' who receive funding on a competitive basis. In Zambia for example, PEPFAR works through 43 primary partners who provide funding for 97 sub-partners. Thirty-four of the primary partners in Zambia are not local.³⁹

The World Bank, on the other hand, is a multilateral organisation, which introduced its Multi-country AIDS Programme (MAP) in 2000 in 29 countries in Africa. It is distinguished as a special initiative, and follows different structures and funding mechanisms within the Bank. The World Bank has been revising its HIV/AIDS strategy for Africa throughout 2006 and is expected to present an updated version in early 2007.⁴⁰ The aim of the World Bank MAP is to scale up the provision of HIV related treatment, care and prevention services. It does this through the provision of funds to government and civil society.⁴¹ The processes guiding MAP are relatively participatory, and include funding of civil society organisations.⁴² The World Bank's Global AIDS Programme coordinates the overall mainstreaming of HIV/AIDS activities across the Bank's programmes and is responsible for the coordination with other donors.⁴³ Country-level activities funded by the MAP have to be aligned to the respective country's government's strategy. A national HIV/AIDS coordinating authority (e.g. National AIDS Councils) and a strategic plan or framework are preconditions for countries to receive MAP funding. Since the nature of the interventions funded is decided by the recipient countries, and fits into the national

³⁸ Amnesty International (2006) '[I am not ashamed](#)' - HIV/AIDS and Human Rights in the Dominican Republic and Guyana;

³⁹ PEPFAR (2006) [Zambia – Partner and Sub-Partner Counts by Local Status, Organization Type and Program Area \(FY 2005\)](#) <http://www.state.gov/s/gac/progress/other/data/partners/60461.htm>. Accessed September 2006.

⁴⁰ Following an evaluation of the MAP in 2004, the World Bank presented a new Global HIV/AIDS Program of Action in December 2005, and throughout 2006 has undertaken a consultation of its Africa-wide HIV/AIDS programming, which will result in a new Agenda for Action on HIV/AIDS in Africa, preliminary concepts, methodology and outline of the Agenda were presented in August 2006. These different framework documents guide the World Bank's overall HIV/AIDS work, and draw heavily on MAP experiences. For part of the consultation documents, see <http://web.worldbank.org/WBSITE/EXTERNAL/COUNTRIES/AFRICAEXT/EXTAFRHEANUTPOP/EXTAFRREGTOPHIVAIDS/0,,contentMDK:20411613~menuPK:717155~pagePK:34004173~piPK:34003707~theSitePK:717148,00.html>. Accessed January 12th 2007.

⁴¹ World Bank brochure (2006) Multi-country AIDS Program for Africa.

⁴² 49,000 NGOs have directly received funds through the MAP; World Bank MAP website <http://web.worldbank.org/WBSITE/EXTERNAL/COUNTRIES/AFRICAEXT/EXTAFRHEANUTPOP/EXTAFRREGTOPHIVAIDS/0,,contentMDK:20415735~menuPK:1001234~pagePK:34004173~piPK:34003707~theSitePK:717148,00.html>. Accessed September 2006

⁴³ Nandini Oomman, (2006) [An Overview of the World Bank's Response to the HIV/AIDS Epidemic in Africa, with a Focus on the Multi-Country HIV/AIDS Program \(MAP\)](#); HIV/AIDS Monitor; Tracking AID Effectiveness; Centre for Global Development. <http://www.cgdev.org/section/initiatives/active/hivmonitor/worldbankaids>. Accessed September 2006.

HIV/AIDS plan, MAP funding effectiveness depends on strong national frameworks and adequate implementation.

The Global Fund to Fight AIDS, Tuberculosis and Malaria is a funding mechanism rather than an operational agency. It has no country presence, and operates through a small secretariat in Geneva. Countries apply for funds, through a Country Coordinating Mechanism (CCM), an independent, multi-partner body operating at the national level. The introduction of CCMs has opened the policy environment, allowing different stakeholders to take part in decision-making around strategies to combat HIV/AIDS, TB and malaria. Applications for funding are judged through a technical review process, by a set of Technical Review Panels, that make recommendations to the GF Board. Funds are awarded to one or more principal recipients (who may be government departments, national AIDS councils or civil society organisations) at the country level, and are overseen by a local fund agent, an independent auditor of expenditure and activities.⁴⁴ Funds are released on the basis of performance. One hundred and thirty six countries around the world receive funding from the GF.⁴⁵

Global Health Initiatives and equity

Given that most GHIs have only been in existence for a few years – the Global Fund was launched in 2002, the MAP in 2000 and PEPFAR in 2003 – it is too early to assess their longer-term impact on equity. Observers have noted both positive and negative potential influences. There is little doubt that the large amounts of funds flowing into HIV/AIDS programmes have increased considerably the numbers of people living with HIV/AIDS who have received treatment, and that expenditure on preventive activities and education has increased. How equal access is to these services is not clear, and many suggest there is likely to be an urban bias in relation to ARV treatment. Concerns have also been raised about diversion of attention and resources from core problems such as childhood diarrhoea or chronic alcohol related diseases, disadvantaging already marginalised groups. On the other hand, other usually stigmatized groups have gained from particular AIDS policies which have focused on vulnerable groups such as sex workers and injecting drug users.⁴⁶

There are a number of examples where GHIs have had some influence on national policies. One study suggests that the Global Fund was able to affect HIV/AIDS policies in China by making funding conditional on the revision of proposals regarding harm reduction methods. Through this insistence, groups working with injecting drug users, which had been excluded from policy fora, were invited to participate to revise China's HIV/AIDS policy.⁴⁷ Others have suggested that the Global Fund, by insisting on the formation of CCMs and the active participation of civil society organisations,

⁴⁴ Global Fund Framework Document (2003)

http://www.theglobalfund.org/en/files/publicdoc/Framework_uk.pdf. Accessed October 5th 2006.

⁴⁵ Global Fund website <http://www.theglobalfund.org/EN/>, Accessed January 12th 2007.

⁴⁶ International HIV/AIDS Alliance (2006), Recommendations from HIV/AIDS Alliance Study from Alliance Ukraine gender study help improve the effectiveness of HIV prevention services; <http://www.aidsalliance.org/sw35159.asp>. Accessed September 2006.

⁴⁷ Van Kerkhoff, L et al (2006) 'Linking global knowledge with local action: examining the Global Fund to fight AIDS, Tuberculosis and Malaria through a knowledge systems lens'. Bulletin of the World Health Organisation 84; 629 – 635.

has opened up policy processes to a wider community of people, information, resources and facilitated rapid programme implementation.⁴⁸

A systematic review of the effects of GHIs on health and equity has not yet been undertaken. Because of the diversity of players at the country level, continuing difficulties in harmonizing practices between donors, including GHIs, and problems in measuring impact, there are continuing problems of attribution, with all GHIs (and donors) wishing to claim impact around activities which are inherently co-funded achievements. This is particular true with GHI-specific evaluations.⁴⁹

The next section explores the extent to which GHIs have affected gender equity.

⁴⁸ Pawinski & Lalloo 2006 Multi-sectoral responses to HIV/AIDS: applying research to policy and practice. American Journal of Public Health; Vol 96, No 7; 1189 -91.

⁴⁹ Bennet S, Boerma J, Brugha R (2006) Scaling up HIV/AIDS evaluation. The Lancet, 367;

Global Health Initiatives and gender equity

PEPFAR's strategy on equity and gender

PEPFAR has acknowledged gender equity in its fight against HIV/AIDS and its publications state that it is working to ensure that activities it supports 'provide equitable access to services for both men and women'.⁵⁰ Monitoring data collected to evaluate and report on PEPFAR's implementation are gender disaggregated for all interventions; however it does not establish gender-sensitive implementation targets. Therefore, while PEPFAR can report that up to 2006, 61 % of all people receiving ART through its funding were women, it does not specify how or who should be reached to fulfil its target to provide treatment to two million people. Nevertheless, the gender data it collects, reporting numbers and percentages of men and women receiving services, provide a tangible way of measuring PEPFAR's gender equity effects.

As part of its focus on gender equity PEPFAR highlights its work to address imbalances and gender discrimination within legal codes. Examples are community level legal protection and female education in Zambia and Uganda, and support around inheritance rights in Kenya.⁵¹ However, the longer-term interventions aimed at addressing gender imbalances and changing causes for gender inequity are harder to evaluate than the distribution of ART to target populations. Evidence on the extent to which PEPFAR programmes have an impact on gender equity is mainly anecdotal in its own monitoring reports, and limited to certain successful case studies. PEPFAR's strategy focuses on treatment, prevention and care, as the three main areas of intervention. Within 'care' the specific burden of women as primary care givers in many country contexts is recognised.⁵² Strategies aimed at providing care for people living with HIV/AIDS and for orphans and vulnerable children (OVCs), including the training of new staff, are seen as implicitly addressing gender inequity.

Treatment programmes funded by PEPFAR focus on the provision of anti-retroviral medication, often building on existing government treatment programmes, but also introducing its own clinical guidelines and conditions for ART programmes it supports (see box 2). In 2005, 46 % of all PEPFAR funding was used for treatment. By March 2006, PEPFAR reported that of the 561,000 people that had received ART through its support, sixty-one percent were women, which PEPFAR has viewed as an indicator of its success in promoting gender equity.⁵³

⁵⁰ US Office of the Global AIDS Coordinator (2006), *Action Today, A Foundation For Tomorrow: Second Annual Report to Congress on PEPFAR*; Available on <http://www.state.gov/s/gac/rl/c16742.htm>. Accessed September 2006.

⁵¹ US Office of the Global AIDS Coordinator (2006), *Action Today, A Foundation For Tomorrow: Second Annual Report to Congress on PEPFAR*; Available on <http://www.state.gov/s/gac/rl/c16742.htm>, p. 67. Accessed September 2006.

⁵² Office of the Global AIDS Coordinator (2003), *The Presidents Emergency Plan for AIDS Relief, US Five Year Global Strategy*, p.43. See <http://www.state.gov/documents/organization/29831.pdf>. Accessed September 2006.

⁵³ US Department of State (2006), *Factsheet: Making a Difference: Supporting Antiretroviral Treatment*; US State Department website <http://www.state.gov/s/gac/rl/fs/2006/67451.htm>. Accessed September 2006.

BOX 2 - PEPFAR and anti-retroviral therapy

PEPFAR funding can only be used to purchase medication approved by the US Food and Drugs Administration (FDA). This excludes most generic, cheaper versions of ARVs, even if these are WHO approved. This means that the funding made available under PEPFAR regulations purchases medication at a higher cost than monies available through the World Bank MAP or the Global Fund. In other words, fewer medicines can be bought with PEPFAR funding.

This policy means that governments need to adopt flexible and sometimes complex strategies to ensure funds are used equitably and to greatest effect.⁵⁴ In Guyana for example, the government is using Global Fund money to buy all first-line ART generically for patients, while PEPFAR funding is only used in its PMTCT programme and for second-line treatment, where fewer generic medicines are available. Such pragmatic responses illustrate how countries are successfully adapting and incorporating the conditional support of GHIs into their national programmes. However, in other countries, like Zambia, where the combined funds from the Global Fund, PEPFAR and the government are insufficient to provide treatment for all people who require it, PEPFAR's policy may mean fewer people access medication.

Prevention

PEPFAR's approach to prevention is called the *ABC approach*: Abstinence until marriage, Be Faithful, and Condom-use⁵⁵. PEPFAR prevention strategies focus on abstinence approaches in young people, specifically on the delay in onset of sexual activity, and faithfulness in marriage. Condom distribution is recognised as a prevention strategy for people engaging in 'high risk' behaviour.⁵⁶ However women are not normally perceived by PEPFAR as high risk, unless they are sex workers, substance abusers or sexually active in discordant couples. This effectively means that the majority of women are not targeted by prevention campaigns or interventions that involve condoms.

UNAIDS estimates that 80 percent of new infections in sub-Saharan Africa occur through heterosexual intercourse, and that 60 percent of new infections are in women.⁵⁷ While precise proportions are not available, many HIV transmissions occur within marriage.⁵⁸ In this light the prevention approach championed by PEPFAR,

⁵⁴ PEPFAR's clinical guidelines recommend commencing ART when a patient's CD4 count is 300 or below; whereas WHO's guidelines, which have been adopted by most HIV/AIDS endemic and aid recipient countries, recommend ART be initiated at the lower CD4 count of 250. The consequence is that, under PEPFAR guidelines, more patients will be placed on ART using more expensive ARVs than those sourced with support from other donors.

⁵⁵ Office of the Global AIDS Coordinator (2003), *The President's Emergency Plan for AIDS Relief, US Five Year Global Strategy*, p.24. See <http://www.state.gov/documents/organization/29831.pdf>. Accessed September 2006.

⁵⁶ 'High risk populations or behaviour' are described as including, people engaging in casual sexual encounters, sex work, injecting drug use, migrant workers, men who have sex with men, or discordant couples.

⁵⁷ UNAIDS, UNFPA, UNIFEM. *Women and HIV/AIDS: Confronting the Crisis*. 2004; http://genderandaids.org/downloads/conference/308_filename_women_aids1.pdf. Accessed September 2006

⁵⁸ CHANGE has analysed data according to marriage onset of sexual activity and PEPFAR funding for many of the focus countries. Centre for Health and Gender (CHANGE) (2005) *Risk and Reality: US*

which appears to assume that 'be faithful' is an appropriate preventive measure within marriage is insufficient.⁵⁹ In some countries heavily affected by HIV/AIDS, including in Southern Africa, couples often live apart for long periods of time due to labour migration or for other economic reasons; this tends to increase the likelihood of multiple sexual partners even when married. In such a context, a policy stressing 'fidelity in marriage' over condom-use may lead to HIV infection of women, who are consistently 'faithful' to their partners. It may also reinforce social norms or perceptions that make it difficult for women to enforce condom use.

HIV testing

PEPFAR's prevention strategy includes a focus on prevention of mother to child transmission (PMTCT), through short course ART prophylaxis and a routine offer of HIV testing to pregnant mothers.⁶⁰ As a result, in 2006, 69 percent of all people tested by PEPFAR-supported counselling and testing were women.⁶¹ Routine provision of testing for HIV has been subject to intense debate during the past years, partly because of its potentially negative side-effects on women (see box 3). Routine provision of HIV testing in ante-natal clinics may also create inequities in access, by neglecting for example, non-pregnant or childless women, or men. The issue is not confined to PEPFAR, but of the three GHI's examined here, PEPFAR is the only one to have actively encouraged adoption of a routine test for all pregnant women receiving PMTCT services through its funding.

BOX 3 - To test or not to test

The fact that most people living with HIV are unaware of their status, has emerged as a key policy concern. In addition to the stigma and fear that might deter people from seeking an HIV test, many people do not have access to an HIV test. In 2004 WHO and UNAIDS estimated that only ten percent of people exposed to the virus and who needed a test had access to voluntary counselling and testing services.⁶²

Funding of HIV Prevention Programmes. See

<http://www.pepfarwatch.org/pubs/9CountryCollectionAtAGlance.pdf>. Accessed September 2006.

⁵⁹ PEPFAR does acknowledge in its prevention approach that even women faithful to one partner can be at risk either through sexual violence or the behaviour of their partner, but it is unclear how this is informing prevention work with women, as fidelity appears favoured prevention approach. So for example, PEPFAR's fact sheet on gender, acknowledges male behaviour as a risk factor for women but omits a mention of condoms use as a prevention strategy for women, and instead exclusively highlights the need to target male behaviour. <http://www.pepfar.gov/pepfar/press/76365.htm>. Accessed January 12th 2007.

⁶⁰ Office of the Global AIDS Coordinator (2003), *The Presidents Emergency Plan for AIDS Relief, US Five Year Global Strategy*, p.23 and 25. See <http://www.state.gov/documents/organization/29831.pdf>. Accessed September 2006.

⁶¹ US Office of the Global AIDS Coordinator (2006), *Action Today, A Foundation For Tomorrow*; this does not appear to inform their prevention policy.

⁶¹ Office of the Global AIDS Coordinator (2003), *The Presidents Emergency Plan for AIDS Relief, US Five Year Global Strategy*, p.23 and 25. See <http://www.state.gov/documents/organization/29831.pdf>. Accessed September 2006.

⁶¹ US Office of the Global AIDS Coordinator (2006), *Action Today, A Foundation For Tomorrow: Second Annual Report to Congress on PEPFAR*; Available on <http://www.state.gov/s/gac/rl/c16742.htm>. Accessed September 2006.

⁶² WHO/UNAIDS (2004), *Policy Statement on HIV Testing*; http://data.unaids.org/una-docs/hivtestingpolicy_en.pdf. Accessed January 15th 2006.

The issue of how to progressively scale up testing for HIV, while respecting and protecting the human rights of all patients has caused intense debate during the past years.⁶³ At the time of writing WHO and UNAIDS were consulting on a revised testing protocol that proposed a provider-initiated approach to testing, marking a change from previous approaches focusing more on patient-initiated testing.⁶⁴

Much of the debate on testing centres on the gender dimension. The policy of a routine offer of an HIV test to all pregnant women, instead of only to those who request a test, may have unintended consequences. As disproportionately more women than men are tested and aware of their HIV positive status, women are more likely to face the negative consequences of a positive test result. In contexts where stigma and discrimination prevail, this may result in loss of housing or shelter, violence from a husband or partner on disclosure, or loss of employment.⁶⁵ ⁶⁶ Clearly, population-wide coverage with PMTCT is beneficial, in terms of prevention of vertical HIV transmission and should be beneficial to the mother, if her current and future needs for ART are factored in. However, the risk inherent in a target-driven GHI, which has attribution needs, is that the longer term needs of women may fall by the wayside.

Sex work

PEPFAR recognises sex work (described in PEPFAR documents as 'prostitution'), as increasing people's - mainly women's - vulnerability to HIV/AIDS. The focus of its work with sex workers is to develop alternative income-generating activities, and create greater equality in the access to economic resources. However, a criterion for eligibility to PEPFAR (and all other US) funding includes a requirement that recipients pledge that they oppose sex work, including its legalisation. This part of PEPFAR's strategy has been criticised as working counter to best practice in engaging sex workers.⁶⁷

Organisations such as the Sangram Cooperative in western India have rejected US funding, as it would make it impossible for them to continue their fourteen years of working with sex workers.⁶⁸ The opposition to sex workers and the strict conditions that are imposed on work with them, might limit access to services for sex workers, as well as access to information and tools to prevent HIV/AIDS infections, or legal or

⁶³ For a summary of the debate, see 'Special Focus on Emerging Issues in HIV/AIDS', *Health and Human Rights*, Vol. 8.2.; Cambridge, MA, 2005.

⁶⁴ WHO (2006) *Invitation for public comment on draft WHO/UNAIDS guidance on provider-initiated HIV testing*; <http://www.who.int/hiv/topics/vct/publicreview/en/index.html>. Accessed January 15th 2006.

⁶⁵ Amnesty International, (2006), Report 'I am not ashamed' – HIV/AIDS and Human Rights in the Dominican Republic and Guyana

⁶⁶ The International Community of Women Living with HIV/AIDS (2005), 'The International Community of Women Living with HIV/AIDS: Point of View', *Health and Human Rights*, Vol.8, No. 2.

⁶⁷ Recognised best practice by UNAIDS includes the Sonagachi Project in Calcutta, which has centred its engagement of sex workers around the need legal protection of their rights to enable them to be safe, to fight stigma and discrimination and integrate sex workers into public life. Center for Health and Gender Equity CHANGE, (2005) Policy Brief: *Implications of US Policy Restrictions for Programs Aimed at Commercial Sex Workers and Victims of Trafficking Worldwide*. <http://www.genderhealth.org/pubs/ProstitutionOathImplications.pdf>. Accessed September 2006.

⁶⁸ Discussed in AlertNet; Kaplan, E. (2006) *Pledges and Punishment*, <http://www.alternet.org/audits/33284/?comments=view&clID=96620&pID=96270>. Accessed September 2006.

care services they require. The condemnation and opposition to sex work and prostitution adds to the stigma and discrimination.⁶⁹

The 'Gag Rule'

All US government funding, including PEPFAR, is subject to restrictions relating to abortion services and information about abortion and family planning services. These restrictions are referred to as the *Global Gag Rule* or the *Mexico City Policy*.⁷⁰ They stipulate that no US funding can go to health services that provide abortion, or organisations that provide information which includes the termination of a pregnancy as a choice, or to those which conduct advocacy around such services. This means that PEPFAR-funded programmes, including treatment and testing, cannot take place in the same facility or be delivered by a provider who offers comprehensive sexual and reproductive health services.

This also makes it difficult to use PEPFAR funding to strengthen overall health systems. Where they are so used, it is to the exclusion of comprehensive sexual and reproductive health services. One study in South Africa quoted a health department official saying 'PEPFAR won't fund anyone that does abortions. We have given women this right for twenty years. We have data to show our programs have prevented septic death. It would not be acceptable for our province to apply for PEPFAR funding because of the PEPFAR prescriptions, which are not in line with our government policies'.⁷¹

PEPFAR's overall approach to gender and women appears to stress women's 'vulnerability'. It is not framed in terms of women's rights or entitlements, a concept which underlies many gender and health equity discussions.⁷² The approach to sex workers (the majority of whom are women), and the restrictions on full information, tools of prevention and comprehensive sexual and reproductive health services reinforce gender inequities and are 'paternalistic' in approach. The routine offer of an HIV test to all pregnant women, as part of PEPFAR funding policies, may be seen as offering them a greater likelihood of giving birth to a HIV-negative baby. It also reinforces women's role and importance as carers and mothers, and may undermine them as individuals whose human rights need to be protected and guaranteed.

On the other hand, such a view needs to be tempered in the light of the dramatic scale-up in treatment access since the launch of PEPFAR, as well as the evolution and perhaps an increasing flexibility in PEPFAR's contribution to this scale-up. Its own evaluation suggests that PEPFAR has gone at least part of the way to

⁶⁹ Loff, B. et al (2003), 'Can health programmes lead to mistreatment of sex workers?', *The Lancet*, Vol. 361, Issue 9373, pp. 1982-1983.

⁷⁰ The White House (2001) *Restoration of the Mexico City Policy*, Memorandum for the Administrator of the United States Agency for International Development. <http://www.whitehouse.gov/news/releases/20010123-5.html>. Accessed September 2006.

⁷¹ Ghanotakis, E 2006. Are Global Health Initiatives Responding to Evidence of a Link between Gender Based Violence and HIV/AIDS? Unpublished MSc report, LSHTM, p22

⁷² Sen, A (2001), 'Health Equity: Perspectives, Measures' in Evans, T. et. al. *Challenging Inequities in health: from ethics to action*. OUP,

addressing some of the gender inequities, by ensuring that access to services and ARVs reflects a gender balance.⁷³

The World Bank MAP and gender equity

The World Bank MAP has received less attention than the Global Fund or PEPFAR, or even the impact of wider Bank policies and lending on health equity in developing countries. Given the unique position of the World Bank at the country level, especially its impact on health systems, an analysis of MAP's impact on equity, or that of other, future World Bank HIV/AIDS initiatives, needs to have an awareness of these broader linkages.

The World Bank as an organisation is committed to equity. 'Equity, defined primarily as equality of opportunities among people, should be an integral part of a successful poverty reduction strategy anywhere in the developing world.'⁷⁴ it states in its 2006 *World Development Report* – the World Bank's flagship publication – which focuses specifically on equity and development. However equity is not explicitly defined as an objective in the available MAP documentation. The World Bank's *Global HIV/AIDS Program for Action*, which was reviewed in 2006, does recognise some of the previous structural limitations of MAP programming, which have impacted on equity of access to services. It also explicitly acknowledges that with the increased provision of ART, equity is a concern.⁷⁵

The World Bank does not set specific targets for numbers of people to be reached by interventions; nor does it offer specific operational guidelines. A key feature of the MAP approach is that programmes should be needs-driven and locally designed. In addition to this reliance on country plans and systems for their implementation, MAP has limited incentives for performance, and does not remedy underperformance in specific ways.⁷⁶ Furthermore, as MAP evaluations have reported, a lack of adequate support and funding to Ministries of Health has meant that they have not been coping with the demands imposed by the escalating HIV/AIDS epidemic, including the demands imposed by MAP processes.⁷⁷ In part these problems arose from the 'learning -by -doing' way in which the MAP has rolled out; and the late realisation by the Bank of the importance of health systems in the response to HIV/AIDS. The MAP review noted that it is vitally important for the Bank to revisit its support for health systems.⁷⁸ In its revised *Global HIV/AIDS Program for Action* the World Bank has emphasised the need to ensure better national planning and frameworks, and better monitoring & evaluation (M&E) systems.⁷⁹

⁷³ Office of the Global AIDS Coordinator (2003), *The Presidents Emergency Plan for AIDS Relief, US Five Year Global Strategy* See <http://www.state.gov/documents/organization/29831.pdf>. Accessed September 2006.

US Office of the Global AIDS Coordinator (2006), *Action Today, A Foundation For Tomorrow: Second Annual Report to Congress on PEPFAR*; Available on <http://www.state.gov/s/gac/rl/c16742.htm>. Accessed September 2006.

⁷⁴ World Bank (2006) *Equity Enhances the Power of Growth to Reduce Poverty: The World Development Report 2006*.
<http://web.worldbank.org/WBSITE/EXTERNAL/NEWS/0,,contentMDK:20653001~pagePK:64257043~piPK:437376~theSitePK:4607,00.html>. Accessed January 15th 2006.

⁷⁵ World Bank (2005), *Global HIV/AIDS Program for Action: Briefing Note/Summary*;

⁷⁶ World Bank (2004)

⁷⁷ World Bank (2004)

⁷⁸ Nandini (2004), p.11

⁷⁹ World Bank (2005), *Global HIV/AIDS Program for Action: Briefing Note/Summary*;

Gender

The 2004 Interim MAP report specifically noted that, despite its importance, the need to ensure gender equity was completely absent from proposals and national frameworks in all but one of the six countries reviewed.⁸⁰ This meant that programmes funded through MAP had not considered either the impact of gender inequities in the design of services, nor the contribution MAP-supported programmes might have towards promoting gender equity. In response, the World Bank developed an *Operational Guide on Integrating Gender into HIV/AIDS Programming*, in November 2004, recognising that its funding and programmes were failing to address these issues.⁸¹

The Bank's *Global HIV/AIDS Program for Action* outlines how it will expand its gender related activities and operations, focusing mainly on legal frameworks, including women's inheritance and property rights, and gender-based violence.⁸² If implemented, these interventions will help address some of the underlying factors of gender inequity and could promote greater equity in HIV/AIDS prevention, treatment, care and support. However, the consultation documents for the *Agenda for Action in Sub-Saharan Africa* list gender concerns only under impact, rather than as one of the underlying determinants that needs addressing.

World Bank policy beyond the MAP

Given other World Bank and International Monetary Fund (IMF) lending and funding policies, and the Bank's unique position as a development agency, Bank evaluations have commented on the lack of integration of gender analyses into its wider development planning processes⁸³. The World Bank's own 1997 health strategy, outlining its support for health systems, did not include an HIV/AIDS component, which probably reflects its lack of engagement with the epidemic at that time.⁸⁴ World Bank macro-economic policies, during the 1980s and 90s, militated against attempts address inequities, and were seen as likely to increase gender inequities, in access to health services, as well as in the prevention of diseases⁸⁵ (see Box 4.). During the later 1990s the World Bank changed its policies to address some of these shortcomings and both the World Bank MAP, as well as its Poverty Reductions Strategy Papers are policy instruments aimed at addressing these.

Despite these changes the World Bank's own evaluations of MAP and its consultation documents acknowledge the lack of integrated planning as a

⁸⁰ World Bank (2004), *MAP Interim Review*, p.9,

<http://www.cgdev.org/section/initiatives/active/hivmonitor/worldbankaids>. Accessed September 2006.

⁸¹ The World Bank (2004), *Operational Guide: Integrating Gender Issues into HIV/AIDS Programs*,

<http://www->

wds.worldbank.org/external/default/WDSContentServer/IW3P/IB/2005/10/11/000090341_20051011143115/Rendered/PDF/337410Gender1and1HIV1AIDS1Guide1Nov104.pdf. Accessed September 2006.

⁸² World Bank (2005), *Global HIV/AIDS Program for Action*.

<http://siteresources.worldbank.org/INTHIVAIDS/Resources/375798-1127498796401/GHAPAFinal.pdf>.

Accessed September 2006.

⁸³ Shakow, A. (2006) *Global Fund – World Bank HIV/AIDS Programs: A Comparative Advantage Study*;

⁸⁴ *HIV/AIDS Agenda for Action in Sub-Saharan Africa: Concept Note for Consultation*;

<http://web.worldbank.org/WBSITE/EXTERNAL/COUNTRIES/AFRICAEXT/EXTAFRHEANUTPOP/EXTAFRREGTOPHIVAIDS/0,,contentMDK:20411613~menuPK:717155~pagePK:34004173~piPK:34003707~theSitePK:717148,00.html>.

⁸⁵ Wagstaff, A. (2002), 'Health sector inequalities and public policy', *Bulletin of the World Health*

Organisation, 80: 97-105. de Vogli, R., Birkbeck, G. (2005) 'Potential Impact of Adjustment Policies on Vulnerability of Women and Children to HIV/AIDS in Sub-Saharan Africa' in *Journal of Population and Nutrition*; Vol. 23., No. 2.

shortcoming and aim to ensure that future HIV/AIDS related programming is mainstreamed in other Bank development policies and instruments.⁸⁶ The consultation document for its 'HIV/AIDS Agenda for Action in Sub-Saharan Africa' specifically mentions the past failure to include HIV/AIDS concerns in Poverty Reduction Strategies.

BOX 4 Zambia – HIV/AIDS and education

Female education is recognised as a key factor in HIV prevention.⁸⁷ The World Bank describes education in its own publications as a 'social vaccine'.⁸⁸ Zambia is one of the poorest countries in the world⁸⁹, ranked 166th on the Human Development Index and has a generalised HIV epidemic.⁹⁰ Women and girls are particularly affected by HIV/AIDS - prevalence rates among 15-24 year olds are around 18 %, ⁹¹ significantly higher than in men (13%).⁹² While overall rates are only somewhat higher in women (54%) and partly reflect their greater biological vulnerability, the six times higher rate of HIV in 14-19 year old girls dramatically illustrates their much greater vulnerability and the lack of effective measures and social norms to protect them.

The Zambian government implemented many structural reforms during the 1980s and 1990s, including the liberalisation of its education and health sectors.⁹³ It has also implemented a budget reform programme, in repeated efforts to achieve debt relief.⁹⁴ Its reforms have often included adding an HIV/AIDS component to other policy areas. Zambia's Poverty Reduction Strategy Paper (PRSP) has an HIV/AIDS component and conditions for reaching Highly Indebted Poor Country (HIPC) completion point in 2005 included a national HIV/AIDS framework and the removal of fees in education for primary school children.

Despite these many programmes aimed at integrating HIV/AIDS prevention in all areas of policy, including the education sector, education from grade

⁸⁶World Bank (2004), MAP Interim Review; World Bank (2006), HIV/AIDS Agenda for Action in Sub-Saharan Africa; Concept Note for Consultation;

<http://web.worldbank.org/WBSITE/EXTERNAL/COUNTRIES/AFRICAEXT/EXTAFRHEANUTPOP/EXTAFRREGTOPHIVAIDS/0,,contentMDK:20411613~menuPK:717155~pagePK:34004173~piPK:34003707~theSitePK:717148.00.html> Accessed September 2006. The World Bank (2005) Global HIV/AIDS Program for Action; December 2005.

⁸⁷ Brent, R. J. (2006), 'Does Female Education Prevent the Spread of HIV/AIDS in Sub-Saharan Africa,' Applied Economics, Vol. 38, Issue. 5. UNAIDS, UNFPA, UNIFEM (2004) Women and AIDS: Confronting the Crisis, ch. 5. <http://www.unfpa.org/hiv/women/report/chapter5.html>. Accessed October 5th 2006.

⁸⁸ World Bank website. <http://web.worldbank.org/WBSITE/EXTERNAL/TOPICS/EXTEDUCATION/0,,contentMDK:20298959~menuPK:613702~pagePK:148956~piPK:216618~theSitePK:282386.00.html>. Accessed 5th October 2006.

⁸⁹ Zambia also has a PRSP, received MAP funding and undertook a series of social reforms to achieve HIPC completion point.

⁹⁰ UNDP (2006) Human Development Index: Zambia; http://hdr.undp.org/statistics/data/hdi_rank_map.cfm. Accessed September 2006.

⁹¹ 2002 prevalence rates quoted in <http://www.pepfarwatch.org/pubs/9CountryCollectionAtAGlance.pdf>

⁹² WHO (2005), Summary Country Profile for Treatment Scale-up: Zambia; http://www.who.int/3by5/support/june2005_zmb.pdf. Accessed September 2006.

⁹³ Gilson, L. et al. (2003), 'The SAZA study: implementing health financing reform in South Africa and Zambia', Health Policy and Planning, Vol. 18 (1); Zambia National Ministry of Education (2000), The Development of Education, National Report of Zambia; International Bureau of Education. <http://www.ibe.unesco.org/international/ICE/natrap/Zambia.pdf> . Accessed September 2006.

⁹⁴ Times of Zambia (2005) HIPC Completion: How Zambia Achieved it

seven onwards is not free.⁹⁵ Evidence also suggests that costs associated with education, such as books and school uniforms impose a burden on families that might prevent them being able to send their children to school.⁹⁶ The lack of free education for all appears paradoxical given evidence that female education helps prevent HIV/AIDS, the particular vulnerability of girls and young women in Zambia, and the Bank's attempts to address the impact of HIV/AIDS through MAP funding.

While the Bank has made attempts to integrate HIV/AIDS components into policy instruments, it stopped short of using development policies to address the inequities that drive the HIV/AIDS epidemic.

The Global Fund to Fight AIDS, TB and Malaria and equity

The Global Fund does not have a country presence. It enters into contracts and disburses funds through national *Principal Recipients* (both governmental and non-governmental) to address HIV/AIDS, tuberculosis and malaria. It does not set targets but relies on countries to develop these as part of their national proposals, developed by Country Coordination Mechanisms (CCMs). Its reliance on national recipients and Local Fund Agents (LFAs) for programme monitoring and reporting also means that the Fund has not collected data uniformly that are disaggregated by gender. The Fund's primary instrument to foster greater equity is through its founding policy and implemented through funding guidelines. Its *Framework* states that the Fund 'aims to eliminate stigmatisation and discrimination against those infected and affected by HIV/AIDS, especially women, children and vulnerable groups.'⁹⁷ and to provide funding for 'public health interventions that address social and gender inequalities...'.⁹⁸

In addition to the national monitoring and evaluation framework that forms part of country proposals, the Fund invites external evaluations and reviews, providing some qualitative information about the different structures, processes and their impact. The International Centre for Research on Women (ICRW) reviewed the Global Fund, including its impact and approach on gender. The findings criticised the lack of gender disaggregated data, and expressed a concern that its gender focus was restricted to women's representation on CCMs. This translated into a relative absence of programmes addressing underlying factors contributing to women's vulnerability to HIV/AIDS infection and gender inequity. For example the review found no specific reference to gender in relation to access to ARVs or to testing. ICRW highlighted that until 2004 the main emphasis in targeting women had been on PMTCT programmes. The authors also specifically noted the lack of programmes targeting gender violence.⁹⁹

⁹⁵ Jesuit Centre for Theological Reflection (2006), *How Free is Free Education: The Cost of Education in Lusaka*. July 2006. <http://www.jctr.org.zm/downloads/Cost%20of%20Education%202006.pdf>. Accessed September 2006.

⁹⁶ The Post Zambia 'How free is Education in Zambia', *The Post Newspaper*, Zambia: August 29th 2006.

⁹⁷ The Global Fund Framework, Section III, H10.

⁹⁸ Ibid. Section IV, H.

⁹⁹ ICRW (2004), *Civil Society Participation in Global Fund Governance: What difference does it make? Preliminary research findings June 2004*. http://www.theglobalfund.org/en/files/links_resources/library/studies/PP_PS2_full.pdf. Accessed September 2006.

By mid 2006, when the Global Fund was designing a five year evaluation, it was becoming increasingly apparent that the country level data available to it were inadequate for its evaluation needs. The Fund was able to demonstrate the allocation of its resources in relation to regional distributions of burden for the three diseases, including allocations to regions with the highest proportion of the burden (Africa) and to countries with the greatest numbers of infection. However, it did not have data on how resources were actually spent for the purpose of assessing the gender and other equity effects of scale-up in country programmes the Fund was supporting.¹⁰⁰ Lack of such data was an inherent feature of the Fund as a financing instrument where data collected by LFAs was mainly for the purpose of accounting for inputs to disease control. The availability of data on equity and gender effects in scale-up was dependent on the capacity of country monitoring and evaluation and reporting systems.

Country Coordination Mechanisms – an inclusive political space

The CCMs were a new body at the country level, opening a new political space for participation by civil society, including previously marginalised groups. Differences in the success of CCMs as participatory bodies that ensure country ownership have highlighted how these structures can potentially promote equitable participation.¹⁰¹ Criticism of CCMs during the first rounds of Global Fund proposals was partly attributed to a lack of clear guidelines from the Fund on CCM structure, function and processes, with some observers describing CCM processes as a rubber stamping exercises.¹⁰² Despite nominal involvement of NGOs on CCMs, in some countries their processes displayed low levels of meaningful participation.¹⁰³

The criticism of CCMs highlighted the need for clear communication and guidelines, capacity-building and empowerment,¹⁰⁴ which would help to promote equity and empowerment of groups previously marginalised in the political spectrum. The Global Fund responded by issuing a set of guidelines in 2003¹⁰⁵, which were revised in 2004 to include detailed criteria for composition of the CCMs. These guidelines specify sectors of representation and a minimum membership requirement of 40 percent from non-government, non-donor (multilateral and bilateral) agencies. However, the addition of a gender focus was somewhat vague and open to different interpretations: 'the Global Fund encourages CCMs to aim at a gender balanced composition'.¹⁰⁶ An evaluation by the Global Fund of female participation in the CCMs found a global average of 30 percent with regional variations from 45 percent in Latin America to

¹⁰⁰ Personal communication from Brugha in providing technical support to the Global Fund Secretariat, April to August 2006, in assessing the available evidence for answering the question: 'Is the report: Review of the Global Fund funding Portfolio. Funding the right things?'. Final draft, October 2006.

http://www.theglobalfund.org/en/files/terg/23_portfolio_rev.pdf

¹⁰¹ This section draws in particular on the evaluations of CCMs in Brugha, R. et al. (2005) *The Global Fund Tracking Study: a cross-country comparative analysis*

¹⁰² Brugha, R. et al (2005).

¹⁰³ Brugha, R. et al. (2005), p.11. Common recommendations included the need for capacity – building to enable participation, including funding, guidelines and communication.

¹⁰⁴ These concerns are reiterated in Brugha, R. et al (2005), McKinsey (2005) and Shakov, A. (2006)

Global Fund-World Bank HIV/AIDS Programmes: Comparative Advantage Study.

http://www.theglobalfund.org/en/links_resources/library/position_papers/gen2/. Accessed September 2006.

¹⁰⁵ Global Fund to Fight AIDS, TB and Malaria. Guidelines on the Purpose, Structure and Composition of Country Coordinating Mechanisms. June 4, 2003

¹⁰⁶ Global Fund to Fight AIDS, TB and Malaria (2004) *Revised Guidelines on the Purpose, Structure and Composition of Country Coordinating Mechanisms and Requirements for Grant Eligibility*; http://www.theglobalfund.org/pdf/5_pp_guidelines_ccm_4_en.pdf. Accessed September 2006.

only 18 percent in East Africa (see table 1 below for regional figures).¹⁰⁷ The data show that despite women's equal, or in the case of HIV/AIDS, larger disease burden, they have been under-represented on CCMs. In regions where women are particularly disproportionately affected by HIV, such as in Sub-Saharan Africa, 32% or fewer of the CCM's members are women.

Table 1:

Region	Percentage of women CCM members
East Asia and the Pacific	31 %
Eastern and Central Europe	37%
Latin America and the Caribbean	45%
North Africa and the Middle East	28%
Eastern Africa	18%
Southern Africa	32%
West and Central Africa	25%
South Asia	23%
Average and North	30%

A more recent study of CCM proposal development processes, which was commissioned by the Global Fund and involved data collection in seven countries in late 2005, sought information on how gender equity was being managed.¹⁰⁸ The perceptions among country stakeholders, most of whom were in the process of drafting Round 5 proposals, were that it was difficult to get CCMs to focus on gender mainstreaming and multi-sectoral responses, especially in Cambodia, Sri Lanka and Cameroon where the proposal was health and ART-focused. Where gender equity was given attention, e.g. Namibia and Nigeria, this was because countries had already prioritised the issue. Even in these countries, several respondents did not believe that this concern had been translated into equitable treatment of minorities more broadly. These country findings highlight the limited capacity of a top-down global initiative to drive what would be fundamental changes in country attitudes and practices.

National health services – the risk of a vertical approach

For the implementation of all activities funded, the Global Fund relies on national recipients, many of which are wholly or partly dominated by public sector bodies (Ministries of Health, National AIDS Councils). Its framework specifically highlights the need to link with sectorwide approaches (SWAPs) and Poverty Reduction

¹⁰⁷ The Global Fund to Fight AIDS, TB and Malaria; Technical Evaluation Reference Group, (2005), Assessments of Country Coordinating Mechanisms: Performance Baseline Result Tables; 'Table 1.2 Representation of women and non-governmental sectors on Country Coordinating Mechanisms'. http://www.theglobalfund.org/en/files/about/terg/announcements/161205_CCM_Assessment_Results.pdf, Accessed September 2006.

¹⁰⁸ Wilkinson D, Brugha R, Hewitt S, Trap B, Eriksen J, Nielsen L, Weber W. Assessment of the Proposal Development and Review Process of the Global Fund to Fight AIDS, Tuberculosis and Malaria. Assessment Report. Global Fund No.: HQ-GVA-05-010. Euro Health Group. http://www.theglobalfund.org/en/files/links_resources/library/studies/integrated_evaluations/GFTAM_Assessment_Report_7_March_2006_Final.pdf

Strategies.¹⁰⁹ Studies have suggested that the funding and programmes implemented by the Global Fund were seen as having exposed rather than having caused weaknesses in national health and HIV control systems.¹¹⁰ Initially the Global Fund did not place a particular emphasis on support to health systems in its call for proposals. However, by Round Five the Fund had invited specific proposals for strengthening health systems and human resources to promote greater access to the products and health services it was funding. Despite these efforts, some commentators still see the Fund as inherently vertical, because of its disease-focused funding. Verticalisation can create inequities in the health system and weaken more generic health service components and distract attention from non-focal diseases.¹¹¹ The examples of human resources (see box 5) highlight the potentially negative impact on health equity. However, it should be noted that the Global Fund is 'a learning organisation' and later round proposals that sought support for health workers were more likely to be successful than those submitted in Rounds One and Two.

BOX 5: The internal brain drain – GHI's and human resources

A study assessing the system-wide effect of the Global Fund in Ethiopia showed how because of the insecurity about funding, the government has been reluctant to increase salaries of staff in the health services.¹¹² Human resources are a major constraint in Ethiopia's health system. To address the human resource need created by the implementation of the Global Fund proposal, medical staff were hired on consultancy contracts at triple the salary available in the public sector. This has led to a verticalisation of the health sector with staff moving from one section of the sector to the next.¹¹³ It raises considerable concerns about the equitable access to overall health services. In Ethiopia the study found that a lack of integration of Global Fund projects with sexual and reproductive health services led to staff moving away from sexual and reproductive health services, and as a result a worsening human resources crisis in a part of the health sector that is disproportionately accessed by women and girls.

Studies suggest that PEPFAR-funded health service providers are also often paid higher salaries than those available in the public sector, potentially creating an internal brain drain. In some settings PEPFAR's ability to pay higher salaries has led to health managers and programme makers moving from government positions to local PEPFAR partners.¹¹⁴

In Guyana PEPFAR financed nine United Nations Volunteers doctors to help alleviate the impact of HIV/AIDS. These UNV doctors however were

¹⁰⁹ The Global Fund to Fight AIDS, TB and Malaria (2002) *The Framework Document of the Global Fund to Fight AIDS, Tuberculosis and Malaria*; <http://www.theglobalfund.org/en/about/how/>. Accessed September 2006.

¹¹⁰ Brugha, R. et al. (2005) *The Global Fund Tracking Study: a cross-country comparative analysis*

¹¹¹ SWEF. Common Research Protocol. Monitoring and Evaluating the Health System-Wide Effects of the Global Fund to Fight AIDS, Tuberculosis and Malaria. November 2003

¹¹² Partners for Health Reform plus (PHRplus) Banteyerga, H.; Kidano, A., Bennet, S., Stillman, K. (2005), *System- Wide Effects of the Global Fund in Ethiopia: Baseline Study Report*; p. 31 http://www.phrplus.org/swef.php?_number=5&PHPSESSID=e27d88460505fae66a22ef557cde7dfd. Accessed September 2006.

¹¹³ Ibid, p. 34.

¹¹⁴ Personal Communication February 2006.

from India, Kenya, Nicaragua, Nigeria, Pakistan, Sierra Leone, Sudan, Uganda, and Zambia - all low-income countries. Zambia, Uganda and Kenya are also PEPFAR focus-countries.¹¹⁵ While this intervention addresses the human resource crisis in Guyana, it is potentially worsening the crisis in the countries of the physicians' origins. The staff packages that UNV doctors receive, including housing and schooling for their dependents, are better than those a Guyanese doctor might receive, or what is available to physicians in their own public health care sectors.

In the case described in Box 5, women's access to quality sexual and reproductive health services has potentially been undermined by Global Fund funding. Again, these issues are not peculiar to the Global Fund and the problems related to the migration of health workers between public and private services, as well as the neglect of other, focal, diseases, are equity concerns for all GHI funding.

¹¹⁵ UNV (2005) News release, November 6th 2005 'UN Volunteer doctors mobilised to combat HIV/AIDS in Guyana', http://www.unvolunteers.org/infobase/news_releases/2005/05_10_05GUY_aids_doc.htm. Accessed September 2006.

Global Health Initiatives – conclusions

Global Health Initiatives have emerged as a new model of development assistance in the fight against diseases in low and middle- income countries during the past decade. These structures are rapidly evolving and have succeeded in leveraging significant new amounts of funding. At a country-level this funding has a potentially major positive impact on poor people's access to health services; and to prevention, treatment, care and support for specific diseases. This new level of funding – US\$ 8.9 billion for HIV/AIDS alone in 2006¹¹⁶ - has the potential for making an immense impact on health systems, and on wider issues of social equity that may affect access to health care, including gender equity and women's empowerment.

General characteristics

Despite the differences in the structures through which PEPFAR, the MAP and the Global Fund operate, and the policies and programmes they fund or implement, certain general characteristics about their effects can be observed.

By focusing on their strategies with regard to gender equity, this report suggests that GHIs have an impact through their policies and programmes, and through the processes that govern their policy design and implementation. PEPFAR's policy to ensure equitable access to ART for women serves as an example. It has directly resulted in gender equitable access to such treatment. The Global Fund's Country Coordination Mechanisms have shown the potential of this process to empower women, by providing new political spaces and by acknowledging their importance in the political process.

However, GHIs also have unintended impacts on gender inequities. PEPFAR's policy of making an HIV test a condition for women to receive PMTCT, may further exaggerate gender inequities, and a change in WHO guidance on the issue of testing means that this will affect all GHI funding. Through the absence of guidelines that require a gender focus, or specific targets relating to gender the World Bank MAP has neglected the opportunity to include gender equity concerns as part of MAP-funded national frameworks and programmes. All three GHIs are vertically shaped around one or more specific diseases. This has impacted on other parts of the health system, including human resources, and on the kinds of services available. The evidence from Ethiopia suggests that due to a neglect of sexual and reproductive health services, these may have worsened.

GHIs need to consider social inequities, including gender inequities, in designing context-specific programmes, to ensure that these are equally accessible to women and men. For example ensuring opening hours of a health facility that provides ART, that take into account their circumstances, will allow female farmers to access these services; and similarly the provision of health services that enable mobile male workers, such as truckers, to receive treatment. Ensuring equity of access to health services is, however, merely addressing the symptoms of underlying social inequities

¹¹⁶ This figure includes all funding for responses to HIV/AIDS, as estimated by UNAIDS, not just those leveraged by GHIs. UNAIDS (2006) 2006 Report on the Global AIDS Epidemic; ch. 10 'Financing the Response to AIDS', p.224. UNAIDS at the same time observes that funding levels are actually slowing down for HIV/AIDS. Over two-thirds of the funding for HIV/AIDS is provided by the three GHIs covered in this paper. GFATM (2006) Investing in Impact: mid-year results report 2006. Geneva.

that determine access to health. These include poor access by women to economic resources and their experiences of sexual violence. While all three GHIs examined here have acknowledged the need to address the underlying causes of inequity, their policies and funding so far fall short of fully addressing these.

GHI's also need to ensure that they do not directly impact negatively on gender equity. For example, despite a focus on the issue, PEPFAR funding requirements are potentially resulting in inequities. The focus on faithfulness in marriage, the policy on HIV testing, its condemnation of sex work and not approving the integration of services with comprehensive sexual and reproductive health services for all women, may increase inequities. PEPFAR may thus undermine the efforts of its own programmes to be more gender equitable, and to successfully fight HIV/AIDS.

The World Bank, while having HIV/AIDS components in its other policy instruments, has not integrated an analysis of its causes into broader development policy, as the impact of its economic reform programmes on education shows. While increasing efforts are being made to alleviate the impact of the epidemic, it is still not addressing the root causes of inequities of access to health in its planning. The Global Fund was designed as a purely financing mechanism for what would be a country-driven process. Consequently, it is limited to issuing guidelines and norms and does not collect or request data to determine if women or marginalised groups have equitable access to services that it supports.

Comparative advantages

Each of the three GHIs examined has a very distinct structure and set of policies or operational guidelines that impact on equity in a variety of different ways. These different structures interact at the country level and one of the main challenges is to ensure that this interaction is 'harmonised' and maximises the positive impact of resources. However, in practice, the 'harmonisation and alignment' agenda^{117, 118} has paid little attention to ensure gender and marginalised population equity is not sacrificed in pursuit of numbers-driven treatment targets.¹¹⁹ Competing claims to satisfy initiative-specific attribution characterised the relationship between the GHIs in 2005,¹²⁰ but by the 2006 International AIDS Conference, a consensus was being reached that country specific scale-up targets were needed, which could facilitate the future monitoring of gender -specific targets.

The most obvious difference between these three initiatives is that PEPFAR, as a bilateral initiative, is more top-down, directive and proscriptive; and opportunities for influencing and cooperating with it are limited. The World Bank and Global Fund rely on countries to define strategies that are then funded or supported. This has an impact on the ways in which they can foster or address inequities through their funding. The dilemma for them is that their more bottom-up approach, supporting countries to develop policy frameworks and strategic plans which they then fund, has been an impediment to ensuring funds are targeted to addressing gender and other equity concerns. Where PEPFAR might have an active strategy, designed and defined internationally to address gender inequity, the Global Fund and World Bank

¹¹⁷ Global Task Team, *Final Report 14 June 2005*. Geneva: UNAIDS.

¹¹⁸ *Paris Declaration on AIDS Effectiveness 2005*;

<http://www1.worldbank.org/harmonization/Paris/FINALPARISDECLARATION.pdf>. Accessed January 15th 2007.

¹¹⁹ Bennett, S., Boerma, J., Brugha, R. (2006) 'Scaling up HIV/AIDS evaluation', *The Lancet* Vol. 367.

¹²⁰ *ibid*

MAP have relied on fostering context-specific policies or structures. The World Bank MAP, at least in the past, has missed some opportunities to foster the development of programme proposals and national frameworks that address gender inequities.

PEPFAR and the World Bank have their own country-level oversight for implementing structures, whereas the Global Fund is a funding mechanism, working exclusively through local partners. This impacts on the kind of support and funding each agency is best able to provide. The World Bank for example is well placed to support and strengthen health systems, as well as to ensure that the impact on equity in access to health is considered in other areas of development planning, including poverty reduction strategies.

The World Bank and Global Fund structures appear more successful in drawing on stakeholders' knowledge in programme development, by requiring proposals and strategies to be developed at the national level according to their respective guidelines. Both the World Bank MAP and the Global Fund have introduced guidelines to foster the inclusion of gender specific programming in proposal development. The Global Fund, despite shortcomings, has been most successful in using its policy-making process as a potential tool for empowerment and enabling country-led programming.

PEPFAR is the only GHI examined here that sets numerical targets globally and nationally, and monitors gender balances in people reached. Its approach has been, in-effect, to set up parallel monitoring and evaluation (M&E) systems. The dilemma – again for the World Bank and Global Fund – is that, where they have monitored outputs, they have relied on national M&E systems. The weakness of these systems and countries' failure or inability to collect data that are disaggregated by gender and other important stratifying factors (socioeconomic status and access to services) has resulted in a failure to monitor the impact of the GHIs, and disease control scale-up more generally, by equity criteria.

Overcoming this obstacle and strengthening countries' systems capacity to monitor outcomes and impact will require more joined-up action by the WHO (as the normative UN agency) and the World Bank (as the agency with a particular remit for country systems strengthening). This needs to be supported by more effective conditionalities from the major funding agencies (including the Global Fund) to ensure that strategies target inequities and that systems monitor their effectiveness. It will also require a willingness among donors, especially PEPFAR, to sacrifice the rewards of attribution that parallel monitoring provides. However, ultimately, it is countries that need to take the initiative in establishing (and if necessary demanding support for) programmes that address the underlying determinants of marginalisation, including that of women; and then monitor their effectiveness. This has been the case in Haiti, which has conducted empowerment programmes with People Living with HIV/AIDS, Men who have Sex with Men (MSM) and Street Girls.¹²¹

The level of funding and profile of GHI's has meant that these have attracted considerable attention during the past two years and a number of in-depth

¹²¹ Kunin-Goldsmith J, Laurenceau B. Protection, empowerment, and meaningful involvement of PLWAs and vulnerable populations. Poster E7, XV1 International AIDS Conference, Toronto Canada, 13-18 August 2006.

evaluations, and comparative studies have been undertaken.¹²² These past evaluations acknowledge the need for a greater focus on health systems, and systemic impacts of GHIs, and the need for harmonisation. They do not fully address GHI's potential impact on social inequities, or on the strategies or structural changes that are required to address the inequities that determine access to health. In implementing the recommendations from these evaluations, GHI's impact on social equity needs to be addressed explicitly. At the same time, this discussion has concentrated on the impact GHI have on gender equity, and a number of recommendations are made here on how to address this issue more effectively. These do equally depend on the overall effectiveness of individual health partnerships or initiatives. They therefore need to be addressed together with other recommendation for greater overall effectiveness of GHI's.

Ultimately, none of the GHI's examined will achieve their aims of successfully responding to diseases like HIV/AIDS, TB and Malaria, unless wider issues of social inequity are addressed. It is therefore imperative that social equity concerns are reflected throughout all GHI policies, funding and processes.

Strategies for action – key recommendations

These recommendations refer in some instances to gender inequities specifically, but they can and should be applied to all other socio-economic factors that might determine access to health. They form an initial step for an advocacy strategy to ensure equity in access to health services and ultimately in health outcomes.

1. Address explicitly the causes of gender inequities in access to health. GHIs need to ensure that all interventions funded and implemented address the gender inequities that might determine access health services, and ensure that programmes and processes are equitably accessible to women and men. Programmes and funding also need to address the causes of social inequity, such as gender inequity. This includes gender violence, a lack of women's access to economic resources, and the full guarantee and protection of their rights.

2. Assess interventions' impacts on social inequities. All policies and programmes should be checked for their potential longer-term impact on social inequities before being implemented. This will help avoid long-term negative consequences, which might perpetuate existing social inequities or create new ones (for example the PEPFAR policies on sex work). Such assessments need to be country-driven and participatory, including all sections of a population.

3. Include measurements that are sensitive to gender and other inequities when deciding targets. This includes targets of numbers of people to be reached by Global Health Initiatives. Existing targets set such as the Millennium Development Goals and the national and global targets set for universal access need to be adjusted to reflect this. Where GHIs do not have a global target, an equitable global target, to be reached through cumulative programmes funded, can be a strategy to

¹²² These include the McKinsey study (2005), Shakov, A. (2006), Caines, K. et. al. (2004) [Assessing the Impact of Global Health Partnerships](http://www.dfidhealthrc.org/shared/publications/GHP/GHP%20Synthesis%20Report.pdf#search=%22DFID%20impact%20of%20Global%20health%20partnerships%22); DFID Health Resource Centre <http://www.dfidhealthrc.org/shared/publications/GHP/GHP%20Synthesis%20Report.pdf#search=%22DFID%20impact%20of%20Global%20health%20partnerships%22>. Accessed September 2006. And Brugha, R. et. al. (2004) the Global Fund Tracking studies, country and comparative studies. See <http://www.ghin.lshtm.ac.uk>

ensure greater health equity. Targets should measure health outcomes as well as services provided. This will monitor the quality of services, and safe-guard against discrimination.

4. Enhance the uniform collection of gender-disaggregated data. To enable monitoring of equity in access to services and participation in political processes, disaggregated data needs to be collected, and should be specifically gender disaggregated, including for the provision of health care services, prevention services and political process.

5. Use policy-making processes for empowerment. The policy design and implementation processes can address gender inequities by creating new political spaces for public debate, participation and empowerment. GHIs need to ensure their policy processes are open, and that they can capitalise on opportunities for redressing inequities. This includes equitable representation in policy processes and funding for capacity-building that will enable meaningful participation.

6. Address GHI impacts on health systems and human resources. Global Health Initiatives need to address the system-wide impact of their programmes and funding to avoid verticalisation and distortion of health systems and human resources. This is essential to ensure that access to health services does not become less equitable as a result of GHI's interventions. This includes ensuring that incentives between services are not subject to major imbalance. Particular attention needs to be paid to their impact on sexual and reproductive health services.

7. Harmonize to build on comparative advantage. To ensure equitable access to health services, programmes and interventions, to provide services to as many people as possible, and to ensure that programmes do not create inequities that hinder access to health for specific parts of the population, such as women and girls, GHI's need to coordinate their activities at the national level and draw on each other's comparative advantage. Clear communication flows to all groups and stakeholders is a vital first step in this.

8. Integrate social equity in access to health in other development policies. Strategies that address gender and other inequities that might determine people's access to health need to be cross-referenced throughout all development assistance and Poverty Reduction Strategies to ensure programmes funded and implemented by Global Health Initiatives are not undermined by the effects of other development assistance. This needs to go beyond having a disease specific component or focusing on the impact of a health crisis on development, and ensure that the causes of social inequities that determine access to health are considered and addressed.

9. Monitor and evaluate GHIs impact on social equity All M+E frameworks should have an indicator assessing intervention successes and failures in addressing social inequities. They should also have a set of indicators measuring wider socio-economic inequities e.g. income distribution, access to education etc, to assess how GHIs impact on these over time.