Women WON'T wait

End HIV & Violence Against Women. NOW.

Equality and Equity in *Access*: TAKE ACTION to address Violence Against Women and Girls in the scale-up to U*niversal* Access

Violence is largely a cause of HIV infection among many women; violence in the homes and in the streets, violence everywhere –Ludfine Anyango, National HIV *Coordinator,*
ActionAID Kenya. (IPS, 24 January 2007)[1]

<u>No time to wait!</u>

Without addressing barriers to **universal access** ***presented by violence against women and girls, not only will the scaling up process not be equitable; it will not succeed.***

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A. No time to wait

In 2005, at the Gleneagles G8 Summit, G8 leaders vowed to dramatically scale up HIV&AIDS prevention, treatment, care, and support with the goal of coming “as close as possible” to universal access by 2010. Later that year, at the UN World Summit, governments worldwide signed on. But these lofty promises have yet to be translated into specific and concrete goals, time-bound targets and dedicated funding to address a major barrier to reversing the pandemic: violence against women and girls.

This policy brief, **Equality and equity in *access*[2]: take action to address violence against women and girls in the scale-up to universal access** joins other actors in mobilizing the participation of women’s health and rights groups in the universal access process. It provides:

- brief background information about the process;
- a series of core and recommended targets and indicators for national governments to integrate into their 2008 and 2010 targets that address the effort required to ensure sufficient attention is paid to violence against women and girls in the scale-up to universal access;
- a discussion about entry points for civil society participation (including an annex with information on weblinks); and
- an assessment of the challenges of addressing violence against women and girls in the current universal access process.

It concludes that stronger global guidelines are necessary to adequately and effectively address violence against women and girls at the country level. A set of core and recommended national targets, following the format used by UNAIDS, are provided.

B. Universal Access: A Brief Roadmap

Gender-based violence against women and girls,[*] and particularly intimate partner violence, is a leading factor in the increasing “feminization” of the global AIDS pandemic. Simultaneously, HIV&AIDS is both a cause and a consequence of the gender-based violence, stigma and discrimination women and girls face in their families and communities, in peace and in conflict, within and outside of intimate partnerships, and by state and non-state actors.

Governments, as well as the world’s premiere HIV agencies and donors, continue to treat HIV and violence against women and girls as separate issues. The result is that efforts to address violence as a cause and consequence of HIV infection are vastly underfunded. Equally importantly, the strategic imperative for integrating these efforts continues to suffer from a dangerous and dysfunctional split. Rather than comprehensively addressing this deadly intersection, national and global AIDS

[*] We understand violence against women and girls to be a form of gender-based violence. Gender-based violence is also targeted at men, boys and transgender persons. In this brief, we focus particularly on violence against women and girls because of the particularly lethal intersection of violence against women and girls and HIV&AIDS. We welcome and support work that addresses the broadest range of gender-based violence within and beyond the context of HIV&AIDS.

responses continually fail to grapple with its implications by treating each crisis separately, if at all. As UNAIDS notes,

> *Few programmes dedicate significant resources to empower women and girls through law reform and legal support; social mobilization and economic empowerment schemes; campaigns against violence and inequality, harmful traditional practices, and intergenerational sex; the provision of female condoms; the integration of HIV into sexual and reproductive health services; the prevention of early marriage; and efforts to keep girls in schools free of sexual violence.*[3]

As noted above, in 2005, the G8 countries, joined later that year by all member states of the United Nations, committed to dramatically scale up HIV prevention, treatment, care, and support with the goal of coming "as close as possible" to universal access by 2010. The *universal access* process, as agreed by governments, sets the strategic framework for the UN system response to HIV&AIDS and is crucial to reversing the spread of the pandemic.[4] Major pillars of the overall strategy include increased resources to fight AIDS; greater access to medications; and reduction of stigma, discrimination (including gender-based discrimination), vulnerability of persons affected by HIV and other health related issues.[5] However, *universal*, in this context, does not mean 100%. Rather, universal access to treatment is defined by UNAIDS as 80% coverage of those who would die within one year without such treatment. According to the UN Secretary General Ban Ki Moon, while "*universal access*" implies that all people should have access to HIV&AIDS services and information, true universal access has rarely been achieved – even in the industrialized world. The phrase, then, is ultimately used to rally countries to dramatically scale up all HIV related services.[6]

Governments of the world reiterated their commitment to the universal access process a year later, in June 2006 at the UN High-Level Meeting on AIDS. Extending their commitment, governments agreed to "set ambitious national targets, including interim targets for 2008…that reflect…the urgent need to scale up significantly toward the goal of universal access to comprehensive prevention programmes, treatment, care and support by 2010".[7]

The June 2007 G8 Summit added gender to its agenda as the leaders of the world's wealthiest nations committed to paying particular attention to women and girls in the context of fighting HIV. For the first time they emphasized "the importance of programmes to promote and protect human rights of women and girls as well as the prevention of sexual violence and coercion especially in the context of preventing HIV&AIDS infections"[8] as well as "improving the link between HIV activities and sexual and reproductive health and voluntary family planning programmes",[9] and promoting "knowledge about sexuality and reproductive health".[10]

Unfortunately, at the same time, they failed to reassert a time-bound commitment to achieving universal access, and many view this as a significant step backward. As the Johannesburg-based Inter Press Service put it "[t]his year's summit of the G8 heads of government will likely be remembered as a "how not to" organise such an event, for the contrast between the expectations it raised and its negligible accomplishments, and for its enormous security costs".[11]

Scaling up access to prevention, treatment, and care is clearly essential to reversing the pandemic. It is also fraught with complex challenges. As noted in the 2007 Secretary General's follow-up note to the implementation of the 2001 UN General Assembly Special Session on HIV/AIDS *Declaration of Commitment,* AIDS requires policymakers "to address deep social taboos", including those of sexual behaviours and power relations between women and men.[12] Violence against women and girls in particular is a major driver of the HIV pandemic as well as a consequence of it. Moreover, while the universal access process stresses country-led processes and targets, many civil society organisations worry that without global targets to hold governments accountable, the international community may not respond as fully as necessary.[13]

Efforts to achieve progress have been slow in their realisation. A report by NGO representatives to the June 2007 UNAIDS Programme Coordinating Board (PCB) put it starkly. According to current data:

- 90% of people with HIV do not know their status;
- 4.3 million new infections have occurred, with the vast majority in Africa;
- 89% of pregnant HIV positive women are not receiving PMTCT (treatment for the prevention of mother to child transmission);
- 530,000 children infected;
- 72% of those who need treatment do not have access to it;
- 2.9 million deaths due to AIDS have occurred, 72% of these in Africa;
- 81% of [injecting drug users] have no access to harm reduction; and,
- 42% of those who need them have access to condoms.[14]

Today, national and international commitment to universal access is crucial to reversing the HIV pandemic. But only in rare instances have states fully committed to grappling with women's human rights in relation to violence or HIV, and they have only rarely (and sporadically) engaged in a comprehensive process to effectively fight AIDS. Equally rarely have donors and other multilateral agencies created structures of accountability in service of respecting, protecting and fulfilling the human rights of women and girls. The "Women Won't Wait: End HIV and violence against women and girls. Now." campaign's March 2007 launch report, *Show Us the Money: is violence against women and girls on the HIV donor agenda?* looked at the policy, programming and funding patterns of the five largest public HIV donors and found that strong statements of policy concern "evaporate" at the level of implementation. The level of funding for efforts to address gender-based violence remains small and often marginalised, while the integration of violence against women programming in the much larger pot of funding for HIV is inadequate and hard to trace.

C. Entry points for Civil Society

Scaling up access to prevention, treatment, and care is clearly essential to reversing the pandemic. It is also fraught with complex challenges. As noted in the 2007 Secretary General's follow up note to the implementation of the 2001 UN General Assembly Special Session on HIV/AIDS *Declaration of Commitment*, AIDS requires policymakers "to address deep social taboos", including those of sexual behaviours and power relations between women and men.[15] Civil society--including women and girls living with HIV, organisations with expertise on gender-based violence, and organisations representing the needs and rights of other marginalised groups – such as sex workers,

men who have sex with men, transgender persons, indigenous communities and racial and ethnic minorities – is best placed to influence cultural norms of gender inequality driving the pandemic,

Moreover, civil society engagement will be strengthened by the participation of women's rights groups representing diverse and marginalised communities and with experience working on gender-based violence, particularly in the context of HIV. One of the most critical aspects of civil society participation is to ensure that the voices and experience of people living with HIV – especially women and girls whose voices are too often silenced – are given prominent position in designing and scaling up the global AIDS response.

Indeed, reaching the widest range of individuals and communities – with appropriate and accessible prevention tools and information as well as care, treatment and support – is essential to addressing the pandemic. Moreover, including them in the design and implementation of programming is the best way to ensure that interventions targeted toward them promote their rights as well as their health. For example, sex workers, same-sex practicing individuals (including men who have sex with men and women who have sex with women, whether or not they identify as lesbian, gay or bisexual)[16] and transgender people, are at risk of contracting HIV and of being the targets of violence. In some cases, they are at high risk, especially (but not solely) in those countries in which HIV is concentrated within these very groups and where their sexual practices are deemed criminal.[17]

UNAIDS has taken on the task of facilitating civil society participation in the universal access process. They have provided specific guidance to civil society organisations and have emphasised the importance of broad stakeholder participation to national governments in the target-setting process. In particular, UNAIDS country-level staff are the key liaisons between the national AIDS agency and civil society.

However, to date, national governments and UN agencies are falling short on their commitment to civil society. For example, the participation of women's rights organisations, HIV positive women's organisations, young people's organisations or community-based groups are not specified, measured nor actively pursued. As the International Council of AIDS Service Organizations found in their review of national processes to set universal access targets in over 30 countries,

> *UNAIDS has supported most of the processes where countries have set national targets for* universal access*. In their Operational Guidelines they advocated for governments to fully involve community organizations in the process in order to "help achieve effective outcomes and legitimate targets". In practice, however, it has not been clear how, or even if, women's rights and other community-based organizations were fully and actively involved – and, therefore, whether the targets are considered "legitimate".*[18]

Furthermore, UNAIDS has noted that while many governments included civil society organisation in the consultation process, far fewer civil society groups are consistently involved in key decision-making processes.[19] As they note in their 2007 *Presentation of policy guidelines to address gender issues*, it is imperative that civil society organisations with experience and commitment to addressing violence against women and girls, and especially those working at the intersection of violence against women and girls and HIV quickly and intensively engage in the process.[20]

D. National Level Targets

Since these processes are country-led, it is difficult to generalise about the overall progress of universal access, let alone assess the degree to which it addresses violence against women and girls. However, at this stage in the process there are some trends worth noting. As of June 2007, 92 countries had set universal access targets, employing different approaches to integrate these into their broader national AIDS strategies.[21]

However, a lack of baseline data on the scope of the problem and the size of vulnerable populations, limitations in health system capacity, and unpredictability of funding have impeded countries abilities to set targets, let alone achieve them.[22] Furthermore, many country plans fail to address gender inequalities. Targets rarely take gender into account, let alone violence against women and girls.[23]

E. Core and Recommended Targets and Indicators that address violence against women and girls in the context of HIV

In the following section, we provide two sets of targets and indicators. The first (Section F.1) contains core targets and indicators – these are essential initial steps required to address the intersection of violence against women and girls and HIV, and they represent the minimum effort that governments and the international community must take to grapple with this lethal linkage. Section F.2 provides a more detailed set of recommended targets and indicators in the areas of prevention, treatment, care and support that we propose for integration into countries' national AIDS and violence against women responses. We draw upon UNAIDS guidance in developing criteria for target-setting.[24]

E.1: Core targets and indicators

RATIONALE	TARGET	INDICATOR
Provision of PEP: PEP (Post Exposure Prophylaxis) is short-term antiretroviral treatment to reduce the likelihood of HIV infection after potential exposure.	Rapidly and massively scale up education about and provision of post-exposure prophylaxis (PEP) and emergency contraception to survivors of sexual violence at high risk of contracting HIV (with specific and measurable attention to providing PEP and educating health care providers about its use) in conflict, post-conflict and other emergency settings.	PEP and emergency contraception available on demand at 50% of each country's emergency care facilities, rising to 80% in 2010.
Training for Health Care Workers: Because health facilities are one of the few public institutions where most women interact at some point in their lives, health workers are in a unique position to identify gender-based violence and assist survivors. Properly trained, health workers can minimize the possibility that HIV positive women become victims of violence.	Swiftly expand training to 50% of all health care and service providers (with particular attention to those providing PMTCT, given potentially increased risk to pregnant women and girls of intimate partner violence[25] and with specific attention to conflict, post-conflict and other emergency settings) to recognise and	50% of health care workers trained to recognise and respond (appropriately, confidentially and with an eye toward advancing the human rights of violence survivors) to gender-based violence by 2008, rising to 80% by 2010.

	respond to the signs and symptom of gender-based violence as a routine part of HIV testing, treatment, care and support, rising to 80% by 2010.	
PMTCT-Plus: Traditional PMTCT strategies take a child-centered approach by preventing vertical HIV transmission through the use of antiretroviral drugs during pregnancy and labor, and by promoting safer feeding practices. Not only do these efforts focus mainly on the child, few incorporate anti-violence interventions, even though pregnancy is a risk factor for violence against women.[26] PMTCT+ offers a more holistic set of services for HIV positive pregnant women, providing preventative therapy, treatment, and care for women in their own right, as well as encouraging male participation in all stages of pregnancy, delivery, and care. In 2005, only an estimated 8-16% of pregnant women living with HIV received antiretroviral prophylaxis for prevention of mother-to-child transmission, or 11% globally.[27] However, it is rare that PMTCT efforts incorporate anti-violence interventions, even though pregnancy is a risk factor for violence.[28]	Achieve universal access to PMTCT+ services by 2010 by fully supporting and funding national PMTCT+ plans.	Access on demand to 80% of those in need of PMTCT+ by 2008, rising to universal access to PMTCT+ services by 2010.
Provision of Female Condoms: In many situations, women lack the power to insist on condom use by their male partners. Female condoms allow women to share greater responsibility for preventing HIV infection.	Rapidly expand the distribution of and public education about female controlled prevention methods, including the distribution of the female condom to women, men and transgender people, and with specific attention to providing condoms in a manner that also helps overcome the barriers to use, including information, education, accessibility and affordability.	Female condom available on demand to 50% of all requesting it by 2008, rising to 80% by 2010.

E.2: Recommended targets and indicators

Prevention: Gender-based violence and discrimination are critical factors hampering women's health and well-being and a central element in increasing women's risk of HIV infection. To the extent that prevention goals help to support comprehensive sexuality education for all women and young people, universal access will become a more realistic goal. Sexual violence, including mass rape in conflict and post-conflict settings requires programmatic responses specific to the conditions faced by women, girls, men and boys in complex emergencies and through humanitarian relief. Universal access, in this context, requires health care providers who are trained to recognise the signs and

symptoms of gender-based violence and able to respond appropriately, as well as adequate supplies of PEP, emergency contraception and more general sexual and reproductive health care.

RATIONALE	TARGET	INDICATOR
Discrimination: Stigma and discrimination continue to be a critical factor in hampering prevention efforts, as well as ensuring accessible, acceptable, affordable and quality treatment, care and support. As of 2005, only 61% of countries had adopted anti-discrimination laws.	Repeal laws that discriminate against people living with HIV&AIDS as well as laws that criminalize groups considered to be at risk.	80% of governments adopt anti-discrimination laws to protect people living with HIV&AIDS, as they agreed at the 2001 UN General Assembly Special Session on HIV/AIDS (UNGASS) by 2008, rising to 100% by 2010.
Provision of package of essential health care services: In peace or war, ***women and girls who survive violence need access to a package of emergency and medium term services that address health risk*** including special services – to address the impact of violence, to mitigate the potential of HIV infection, and to ensure their sexual and reproductive health. The package should include access to free, quality health care, including counselling, care and emergency contraception; appropriate compensation for harm; encouragement, support and protection as they report crimes, tell their stories and negotiate the justice system and chain from security and policing, through the health system and courts. These services must ensure the key elements of the right to health, i.e. services must be available, accessible, acceptable and of the highest possible quality, given resource constraints. A target that emphasizes increasing the availability of such a package would help facilitate the kind of health care and anti-violence intervention that will help reverse both epidemics.	An essential package of health care services (including sexual and reproductive health services, including both PEP and emergency contraception) available on demand, with particular attention to making this available in complex emergencies and refugee settings.	Universal access to reproductive health by 2015, as agreed by governments in the 2005 World Summit Outcome at the 60th session of the General Assembly held in Johannesburg, South Africa.
Harmful practices: Female genital cutting, early marriage, "date rape" and widow "inheritance" heighten women's risk of HIV infection and require intensive community-based interventions that seek gender equality, the empowerment of women and the promotion and protection of human rights – without which universal access will not be achieved. Such intensive efforts are already underway, but they	Anti-violence education programmes operating in all communities where violence against women and girls occurs. Integrated services for violence survivors and women living with HIV&AIDS should be developed, as an essential element of national and local AIDS response, addressing the full spectrum of their needs and rights.	Funding for women's rights (estimated at $400,000 by OECD countries in 2005 or 0.6% of ODA29) should be increased to 10% of AIDS funding (not including other investments in gender equality and anti-violence programming) by 2008, rising to 20% by 2010.

are massively underfunded and rarely integrated into HIV&AIDS responses. Such programming should be scaled up and integrated into national AIDS efforts.		

Testing: Women who test positive for HIV are often subjected to physical abuse from partners and families, and may also face isolation and homelessness.[30] Thus concern with the potential negative outcomes associated with relaxed informed consent and counselling requirements, particularly in terms of how this may foster violence against women, seems justified.[31]

RATIONALE	TARGET	INDICATOR
Ill-conceived policies and programmes: A focus on increased access, uptake and sustained use of services, without also tackling some of the drivers of both HIV and violence against women and girls, will leave open the potential for gender-based violence, for instance, to interfere with women's ability to access and use treatment and testing services. Targets should more appropriately emphasise gender equality (in testing, including gender-sensitivity and violence prevention training for providers.	Eliminate compulsory testing and ensure that new testing guidelines explicitly and actively combat discrimination and violence against all women and girls. The development of testing policies should vigorously seek equal and equitable participation of women and girls (especially those living with HIV&AIDS), including through mitigating the possibility of disclosure-related violence against women and girls, as well as other forms of violence that result from HIV positive serostatus.	50% of all governments adopting and applying gender-sensitive and human rights-based testing guidelines, with specific and measurable participation of women and other people living with HIV&AIDS, rising to 80% by 2010.

Treatment, care and support: Scaling up treatment without attending to stigma and discrimination by health care providers will result in a failure to fully achieve gender equitable universal access. Moreover, scaling-up the provision of anti-retroviral (ARV) treatment without also ensuring gender and human rights-sensitive "infrastructure, including trained practitioners, a safe and reliable drug delivery system, and simple but effective models for continuity of care, would be a disaster, leading to ineffective treatment and rapid development of resistance".[32]

RATIONALE	TARGET	INDICATOR
Gender-based violence training for PMTCT providers: As noted above, a focus on prevention of mother-to-child transmission is critical to achieving universal access. Pregnancy is also a risk factor for intimate partner violence. Thus, PMTCT providers are in a unique position to provide resources and referrals to violence survivors.	PMTCT providers trained to provide confidential, accessible and acceptable resources and referrals to violence survivors.	Training programmes conducted and information provided on resources and referrals for violence survivors to 80% of PMTCT providers, rising to 100% by 2010.

HIV/AIDS and anti-violence joint consultations: Joint treatment, care and support can more effectively address the intersecting impact of violence against women and girls and HIV&AIDS (and, therefore, come closer to universal access to treatment) when national AIDS planning and gender equality planning happen in consultation and coordination, rather than as separate and unconnected.	Gender equality and anti-violence planning and programming fully integrated into national AIDS plans. This includes through building the capacity of national AIDS staff to collect and analyse data that captures the intersection of violence against women and girls and HIV as a core elements of both crises.[33]	National AIDS plans and national anti-violence efforts built on joint programming and consultations in order to ensure that 80% of providers are trained by 2008, rising to 100% by 2010.

Finally, national anti-violence efforts and HIV endeavors will not succeed without the full participation of those most affected. This requires bringing women's rights, sexual health and rights, anti-violence and HIV-positive women's organisations fully into consultation at the planning phase, and continuing their active participation through costing, budgeting, implementation, and monitoring and evaluation.

F. Challenges to Universal Access

F.1: Interlocked crises

Women and girls encounter violence in their homes, communities, schools, workplaces, streets, markets, police stations and hospitals. And women who are HIV-positive face an additional danger: the stigma, violence and threat of violence against them. Violence, or the threat of it, not only causes physical and psychological harm to women and girls, it also limits their access to and participation in society because the fear of violence circumscribes their freedom of movement and expression as well as their rights to privacy, security and health.[34] Violence against women and girls limits their capacity to enjoy the full range of human rights. And, while stigma and discrimination are persistent and pernicious – especially in the context of HIV – women and girls face a host of other human rights violations: restrictions on their freedom of movement, freedom of expression, right to education, and right to the highest attainable standard of health, among others. Moreover, women are two to four times more likely to contract HIV during unprotected sex than are men, because their physiology places them at a higher risk of injuries, because they are less able to control the circumstances and conditions of sexual intercourse, and because they are more likely than men to be at the receiving end of violent or coercive (or unprotected) sex.

The impacts of both HIV and violence against women are exacerbated by inadequate services and non-rights-based approaches and failure to protect sexual and reproductive health and rights; laws that are weak or discriminatory toward women generally and those living with HIV&AIDS; social and community standards that validate the subordination of women and all others whose sexuality and gender identity do not conform to social standards of "appropriate" femininity and masculinity; and the intersecting forms of discrimination faced by women and girls because of their race, language, sexual orientation, ethnicity and class, etc.

Elements of AIDS testing, treatment and prevention interventions may also bring risk to women and girls, especially when policies and services are designed and implemented without attention to the realities of gender discrimination. Among the most critical risks facing women and girls as a result of poorly designed or implemented strategies and services are:

- the danger of violence connected to disclosure of HIV positive serostatus to male partners, family and community members and others,
- coercive testing in the guise of voluntary counselling and testing (VCT),
- the insidious treatment of women as vectors of disease,

One example that can link all of the points above is the case of PMTCT that fail to treat pregnant HIV positive women as clients with rights, or only as, and nothing more than, child-bearers. [35] HIV positive women are also subjected to violence at the hands of service providers when they are refused care, forcibly sterilised or forced to terminate a pregnancy.[36] **Without adequate attention to gender-sensitive and human rights-based services, universality will remain an unattainable goal.**

F.2: The opportunity of universal access, and the challenges

One of the major challenges in the universal access process can be found in the fact that the agencies responsible for promoting universal access, as well as those offering technical assistance on the country level, are often themselves still insufficiently addressing the intersection of violence against women and girls and HIV. UNAIDS and WHO have largely been tasked with moving the universal access agenda forward.[37] Yet analysis of UNAIDS and WHO – along with other major global HIV&AIDS actors such as the Global Fund to Fight AIDS, Tuberculosis and Malaria (Global Fund), the UK Department for International Development (DFID) and the US President's Emergency Plan for AIDS Relief (PEPFAR) – has found them to inadequately grasp the significance of violence against women and girls in the context of AIDS.[38] The latest UN progress report on universal access, for example, entitled *Toward universal access – scaling up priority* HIV *interventions in the health sector*, prepared by WHO, UNAIDS and UNICEF in April 2007, contains only two references to violence against women and girls.[39] **As the evidence base on women and girls' vulnerability to AIDS continues to grow, such gaps are particularly glaring.**

F.3: Realism versus equality?

Indeed, universal access overall- – and with regard to violence against women and girls in particular- – is fraught with tension between "realism" and "equality": While countries are encouraged to be realistic about the kinds of targets they set – that is to ensure that they are achievable – pragmatism may offer a convenient excuse for ignoring gender power dynamics which lead to violence against women and girls. And while the scaling up process is ultimately country owned, international bodies are responsible for setting global standards. Indeed, these intergovernmental bodies have issued several sets of guidelines to steer countries through the process. These include a small set of seven core and four recommended indicators to set global standards and suggestions for national target-setting.[40]

This drive to set targets and indicators may bring about real progress but only if commitments are made real – in terms of strengthening health systems; making medicine affordable, accessible, acceptable and of high quality; finding ways to sustain health care expertise in the most gravely affected countries that are seeing their doctors, nurses and other practitioners relocate to wealthier communities; allocating sufficient resources in the most efficient ways possible; and achieving progressive realisation of all human rights. Pressure to create specific and time-bound national targets has been hampered by weak national ownership and sporadic commitment by governments and donors alike. In response, the International HIV/AIDS Alliance proposes that "to turn this phenomenon around, greater accountability to people living with HIV&AIDS (PLWHA) and other citizens, greater involvement of all the sectors and stakeholders in national decision making, and greater financial transparency on AIDS spending will be the hallmarks of good national governance for universal access".[41] **And numbers matter: as WHO Director-General Margaret Chan puts it, "what gets measured gets done".[42]**

On the international level, however, such guidance is inadequate in addressing gender inequality in general and violence against women and girls in particular.[43] According to UNAIDS, these indicators "are designed to help countries assess the current state of their national response while simultaneously contributing to a better understanding of the global response to the AIDS pandemic, including progress towards meeting the targets in the *Declaration of Commitment on HIV&AIDS*". **However, neither core nor recommended indicators acknowledge the interrelationship between violence against women and girls and HIV.[44] The kinds of data they are set up to receive do not capture the complexities of gender with regards to HIV&AIDS nor do they consistently incorporate the experience and expertise of women and girls who are infected and affected by HIV&AIDS.**

For example, on the prevention side, one core indicator, "number of condoms distributed annually by public and private sector", does not specify *male* or *female* condoms or users, nor does it consider the numbers of couples who actually *use* those condoms or the gendered negotiations (and coercion) that may have taken place in order to influence their use. Another core indicator, "percentage of young men and women who have had sex before age 15", does not consider information on how many of those sexual encounters were coerced or forced.

F.4: Inadequate guidance

UNAIDS' recent *Practical guidelines for intensifying HIV prevention: toward universal access*[45] shows a more consistent effort to address violence against women and girls (and occasionally, other forms of gender-based violence) in the context of scaling up prevention. For instance, as an aspect of "planning for HIV prevention within the national comprehensive response", guidelines recommend (among other actions) ensuring implementation of human rights programmes including policies of zero tolerance for sexual violence, and legal reform that protects the rights of people living with HIV and vulnerable populations; sensitizing legislators, the judiciary and other key influencing bodies on HIV-related vulnerability and gender concerns; campaigns against stigma and discrimination, harmful gender norms, violence against women and intergenerational sex.[46] Working with men to change violent or risky behaviour is also emphasised as a critical aspect of reducing violence against women and girls.[47]

Other kinds of global operational and strategic guidance on national target-setting are so broad as to provide little sense of direction. For example, UNAIDS recommends the use of "process" and "impact" level targets to access progress towards universal access goals. Process targets represent identification of obstacles to scaling up by 2010, and include the category of "human rights, gender equity, stigma and discrimination" as a major factor that must be addressed in order to achieve universal access.[48] Violence against women and girls however is not specified as the particularly lethal obstacle we now know it to be. **Without prioritisation and specific technical guidance on the intersection of these pandemics, most countries have neither the knowledge nor the capacity to address them.**

And unfortunately, inadequate guidance sometimes results in ill-conceived policies. For example, a recent report on universal access by ActionAid International notes the critical need to ensure that prevention, treatment, care and support take the power imbalances between women and men fully into consideration. They note:

> *For example, VCT – voluntary counselling and testing – programmes often fail to understand that "voluntary" can become coercion in a context of gender inequality and a pervasive threat of violence. ABC – "abstain, be faithful, use condoms" – initiatives ignore the fact that many women and girls are not in a position to negotiate the conditions of a sexual encounter.*[49]

F.5: Unequal treatment

In the area of testing and treatment, there are similar gaps. The core indicator in this area, "percentage of women, men and children with advanced HIV infection . . . receiving antiretroviral combination therapy", does not capture *why* women might not have the same access to treatment. And without asking the question, it is unlikely that programmes will be designed to address these issues. For example, some women need permission from their husbands to leave the house or to access hospitals or clinics. Others cannot afford medication or may suffer violence from their partners or spouses if they try to seek treatment or adhere to a treatment regime (if they can afford it in the first place). In some cases, husbands and other relatives sabotage treatment for female family members, blaming them as vectors of disease, responsible for bringing HIV into their families.[50]

Women around the world testify to these poisonous linkages. For example, according to one woman in Guatemala:

> *Besides the physical damage, the multiple therapies, knowing that I am infected, my ex partner infected me, my husband at that time, as a way to put pressure on me, he grabs my medicines, the retrovirals, he throws the medicines at me and he says he has my life in his hands, this is also psychological violence.*[51]

And in the area of "care and support", the core indicator "percentage of OVC [orphans and vulnerable children] (boy/girl) aged under 18 whose household have received a basic external support package" doesn't acknowledge gender differences vis-à-vis HIV vulnerability, care and support. For example, female orphans may be more likely to be subjected to sexual exploitation and violence than their male counterparts. In such settings, dependent upon host families, girls may have little opportunity or information about counselling, medical or legal assistance in situations where they face violence or

coercion. If they are HIV positive, they may have no ability to access treatment, care and support.

Girls may also experience other forms of violence or practices that put them at risk of both violence and HIV, and other human rights violations, such as early marriage and denial of inheritance rights. Furthermore, this indicator does not acknowledge the role of women and girls in caretaking. It is believed that up to 90% of illness care is provided in the home, and that the principal givers of physical and psycho-social support are women and girls. It is often taken for granted that they will continue to provide unremunerated care and support to infected and affected family and community members, and in the process be forced to leave school or jobs and return home, even when they face violence by family members. **All in all, acts or threats of violence prove to be formidable barriers to accessing testing, treatment, care and support, even when these are available and affordable. In this context, special attention needs to be paid to the voices of women and girls living with HIV&AIDS, in order to build on their experience in refining and improving programming.**

G. Conclusion

Inattention to and neglect of these challenges will result in faulty or inadequate interventions. Indeed, in the worst case initiatives may even increase the threat of violence. They may also be inaccessible, unaffordable or unacceptable to diverse women and girls. To the extent that such interventions fail to address these barriers, they will also fail to confront and respond to the rapid and disproportionate increase in HIV infection among women and girls.

The universal access process represents an unprecedented opportunity to address the twin pandemics of HIV and violence against women and girls, and the deeply embedded gender inequality that fuels them. Strategies to ensure accountability regarding violence against women and girls – through the development and inclusion of country and global targets and indicators – can help ensure that aspects of gender-based discrimination and gender-based violence are an integral part of the global AIDS response.[52] In order to do so, they must fully incorporate the participation of women and girls, and, in particular women and other people living with HIV&AIDS.

Annex I: Sources for supporting civil society engagement in the universal access process:

Background information

- The UNAIDS website includes information on target setting by region at http://www.unaids.org/en/Coordination/Initiatives/Setting+national+targets.asp and by country at http://www.unaids.org/universalaccess/.
- UNAIDS, *Coordinating with Communities – Guidelines on the Involvement of the Community Sector in the Coordination of National AIDS Responses* at http://www.unaids.org/en/MediaCentre/PressMaterials/FeatureStory/20070611_coordinating_communities_guidelines.asp.
- UNAIDS, *The road to universal access* at http://www.unaids.org/en/Coordination/Initiatives/default.asp.
- UNAIDS, Uniting for HIV prevention at http://www.unaids.org/en/Coordination/Initiatives/default.asp.
- UNIFEM, Web portal on gender and HIV&AIDS at www.genderandaids.org
- Eldis on-line web resource and library, section on gender and HIV&AIDS at http://www.eldis.org/go/topics/resource-guides/hiv-and-aids/gender.
- International HIV/AIDS Alliance at www.aidsalliance.org.

To get started:

- International Community of Women Living with HIV/AIDS at http://www.icw.org/. See also Collaborative Fund for HIV/AIDS Women and Families in Sub-Saharan Africa at http://www.icw.org/node/299.
- International Council of AIDS Service Organizations (ICASO) at www.icaso.org.
- International Treatment Preparedness Coalition and the Tides Fund: The collaborative fund for HIV treatment preparedness at http://www.hivcollaborativefund.org/index.php?id=117.
- Universal Access AIDS Campaigning's *Universal access to AIDS Treatment Guide* at www.ua2010.org.

The "**Women Won't Wait: End HIV and violence against women and girls. Now.**" campaign website provides links to partners, including international and country-based campaign partners. Go to www.womenwontwait.org.

Many national and local organisations are actively engaged in the process, and we encourage you to be in touch with your country's major HIV&AIDS organisations and the international and intergovernmental agencies that support them, in order to get more information about the status of the universal access process in your country.

Annex II: UNAIDS Core and Recommended Indicators

A. Targets

(extracted from UNAIDS, *Scaling up toward* universal access*: consideration for countries to set their own national targets for HIV prevention, treatment and care.* April 2006, p. 11. Accessed at http://data.unaids.org/pub/Report/2006/Considerations_for_target_setting_April2006.pdf).

SELECTION OF TARGETS BASED ON EXISTING INDICATORS
The following tables are presented as guidance for the selection of national targets for moving towards universal accessuniversal access*. This information is already being collected in almost all countries and therefore can serve to inform the selection of key targets for 2008 and 2010. Not every indicator requires a target. Targets are more powerful for advocacy and resource mobilisation if they are limited in number and are used to capture the essential concepts of prevention, treatment and care.*
It is recommended that countries set no more than one or two targets for the primary programmatic areas. The total number for the complete, comprehensive programme should be between three and six targets.

TREATMENT [SF: this box won't let me insert comments normally so I'm putting them in brackets. Any reason why you can't put your "prevention, treatment and care" in that order, as in paragraph above and as in title of UNAIDS paper? (If you do, don't forget to change the Core Indicator #s!)]
Core Indicator 1:
Percentage of women, men and children with advanced HIV infection [SF: any reason this isn't "AIDS"?] (i.e. who meet eligibility criteria) who are receiving antiretroviral combination therapy
Recommended Indicator:
Percentage of adults and children on ART **[SF: do you want to define?]**who are still alive 12 months after initiation of antiretroviral therapy

PREVENTION
Core Indicator 2:
Percentage of HIV positive pregnant women receiving a complete course of antiretroviral prophylaxis to reduce the risk of mother-to-child HIV transmission
Core Indicator 3:
Percentage of general population or "most at risk" populations who received an HIV test in the past 12 months and were informed of the results*
Core Indicator 4:
Number of condoms distributed annually by public and private sector
Core Indicator 5:
Percentage of young men and women aged 15 to 24 who have had sex before age 15**[SF: delete this space for consistency.]Recommended Indicators:**
Coverage of targeted prevention programmes in low prevalence countries**
Percentage of young people (15-24) or "at risk" group who correctly identify ways of preventing sexual transmission of HIV and reject major misconceptions (male/female)** [SF: please double-check that your asterisks are correct--especially if you change the order of things on this page.]

CARE AND SUPPORT
Core Indicator 6:
Percentage of OVC (boy/girl) aged under 18 living in households whose household has received a basic external support package*** (in caring for the child) (The support package could include food, education, health care, and family/home and/or community support.)
[SF: ok that there's no Recommended Indicator here?]
NATIONAL COMMITMENT
Core Indicator 7:
Amount of national funds disbursed by governments in low- and middle-income countries [SF: a country can be low- or middle-income, as in, it's earning income??]
Recommended Indicator:
Implementation of the Three Ones[SF: what is this? Define?] (according to UNAIDS check list, including the involvement of civil society and other stakeholders)

* This target should cover testing in both health facilities and other locations.
** In concentrated epidemics, this indicator should be considered as "Core".
***Knowledge encompasses an understanding about the roles of delaying sex, reducing partners, and use of condoms in preventing sexual transmission of HIV

B. Principles for national target-setting

(Extracted from UNAIDS, *Setting national targets for moving toward* universal access*: operational guidance.* October 2006, p. 3. Accessed at http://www.e-alliance.ch/resources/actionalerts/hivaids/101006/Universal_access_guidance_6_oct.pdf.)

The basic principles for universal access are:

- services have to be *equitable*, *accessible, affordable*, *comprehensive* and *sustainable* over the long-term;
- national target-setting and tracking should be *standardised through global guidance* and based on a small set of core and recommended indicators, but determination of the levels of coverage achievable by the end of 2010, i.e. the *national targets*, must be a country-level process that takes into account the specific country context; and
- the *major requirement* for reaching targets is overcoming obstacles identified during the recent country and regional consultations.

The principles for setting national targets include:

- *country ownership and participation*
- *building on past efforts*
- *reviewing existing data and data collection systems*
- *reviewing existing indicators*
- *setting targets as part of national strategic plans*
- *identifying and overcoming obstacles to scaling up*
- *human rights, gender and the Greater Involvement of People living with HIV and AIDS (GIPA)*
- *quality of and equity in access to services*
- *setting priorities and overcoming obstacles to scaling-up prevention, treatment, care and support*

C. Existing Global Targets from UNGASS, UNICEF and the MDGs

(Extracted from UNAIDS, *Scaling up toward* universal access*: consideration for countries to set their own national targets for HIV prevention, treatment and care*, p. 14. Accessed at http://data.unaids.org/pub/Report/2006/Considerations_for_target_setting_April2006.pdf.)

SOURCE OF TARGET	TARGET BY 2005	TARGET BY 2010	TARGET BY 2015
Millennium Development Goal No. 6 Agreed Sept 2000 by 189 Countries			Halt and begin to reverse the spread of HIV
UNGASS Declaration of Commitment on HIV/AIDS Targets Agreed by all UN member states in June 2001 – 103 commitments which includes 30 time bound targets.	**COVERAGE AND INPUT TARGETS**: 90% of youth have information, education, services and life-skills that enable them to reduce their vulnerability to HIV infection. Annual spending on combating the epidemic in low and middle-income countries to reach between US$ 7 billion and US$ 10 billion. **IMPACT TARGETS** 25% reduction in HIV among young people 15 - 24 *in the most affected countries.* 20% reduction of the proportion of infants infected with HIV.	**COVERAGE AND INPUT TARGETS** 95% of youth have information, education, services and life-skills that enable them to reduce their vulnerability to HIV infection. (1) 80% of pregnant women accessing antenatal care have information, counselling and other HIV prevention services available to them. (2) Increase the availability of and providing access for HIV-infected women and babies to effective treatment to reduce mother-to-child transmission of HIV, as well as through effective interventions for HIV-infected women, including VCT, access to treatment, especially antiretroviral therapy, and where appropriate, breast milk substitutes and the provision of a continuum of care. **IMPACT TARGETS** 25% reduction in HIV among young people 15 - 24 *globally.* Reduce the proportion of infants infected with HIV by 50%.	

UNITE For Children UNITE Against AIDS		Provide either antiretroviral treatment or cotrimaxazole to 80% of children in need. Reach 80% of children most in need with basic services.	
"Three by Five" WHO/UNAIDS declared at UN GA Sept 2003	3 million receiving antiretroviral treatment		

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[1] Joyce Mulama, *End to HIV/AIDS a tall order in face of violence.* IPS at the World Social Forum, 24 January 2007, at http://www.ipsnews.net/news.asp?idnews=36294.

[2] We build on definitions recently provided by UNAIDS as follows: "Gender equality exists when both women and men are able to share equally in the distribution of power and influence; have equal opportunities, rights and obligations in the public and private spheres, including in terms of work or income generation; have equal access to quality education and capacity-building opportunities; have equal possibility to develop their full potential; have equal access to resources and services within families, communities and society at large; and are treated equally in laws and policies…". "Gender equity refers to the fact that, where needs of men and women are different, resources and programmatic attention should be in proportion to those needs; equal opportunities should be ensured; and if necessary, differential treatment and attention should be provided to guarantee equality of results and outcomes and redress historical and social disadvantages experienced by women". UNAIDS/PCB/(20)/07.11, p. 4, 20th Meeting of the UNAIDS Programme Coordinating Board, 2007, *Presentation of policy guidance to address gender issues.*

[3] UNAIDS/PCB(20)/07.11, 20th Meeting of the UNAIDS Programme Coordinating Board, *Presentation of policy guidance to address gender issues.* 27 April 2007. Accessed at http://data.unaids.org/pub/Presentation/2007/policy_guidance_address_gender_issues_item4_2_en.pdf.

[4] WHO, *WHO's contribution to universal access to HIV/AIDS prevention, care and treatment.* May 2006.

[5] The universal process is part of a series of government commitments including Millennium Development Goal 6 to halt and reverse the spread of the epidemic by 2015; the 2001 United Nations General Assembly Declaration of Commitment on HIV/AIDS, the African Union's 2006 Abuja Call for Accelerated Action and the 2006 United Nations Political Declaration on HIV/AIDS.

[6] Cite[SF: is this a note to yourself?] to recent report by UNSG.

[7] United Nations General Assembly Political Declaration on HIV/AIDS, resolution A/RES/60/262, UNGASS 2006.

[8] *Growth and Responsibility in Africa*, G8 Summit, Heiligendamm, paragraph 52.

[9] Ibid, paragraph 53.

[10] Ibid, paragraph 51.

[11] Julio Godoy, *Africa: G8 – Much Talk, Too Few Results.* Inter Press Service (Johannesburg), 9 June 2007. Accessed at http://allafrica.com/stories/200706090062.html.

[12] Note by the Secretary General, *Scaling up HIV prevention, treatment, care and support*, A/60/737 24 March 2006.

[13] *Tackling political barriers to end AIDS*, ActionAid International, 2007, p. 5.

[14] UNAIDS/PCB(20)/07.2, 2 May 2007, 20th Meeting of the UNAIDS Programme Coordinating Board, *Report by the NGO representatives.* Accessed at http://data.unaids.org/pub/Report/2007/report_by_%20ngo_representatives_%20item1.6_en.pdf.

[15] Note by the Secretary General, *Scaling up HIV prevention, treatment, care and support*, A/60/737 24 March 2006.

[16] We use the phrase "same-sex practising individuals" to encompass men who have sex with men, women who have sex with women and transgender persons, where appropriate. While the phrase is cumbersome, it accomplishes several important tasks: first, it emphasizes practises over identities – an important feature in working on sexually transmitted infections. Second, it is gender-neutral, encompassing the sexual practises of women, men and transgender persons. Finally, it escapes some of the accumulating connotations that might be associated with the terms "MSM" or "LGBT", as these are seen to impose identity assumptions on to whom it refers, whether or not they claim those identities. Our thanks to Cary Alan Johnson for this clarification.

[17] In some cases, lesbians are also at high risk, especially where they are specifically targeted for rape, as, for example, in South Africa. See Yakin Ertürk, *Integration of the human rights of women and the gender perspective: violence against women – intersections of violence against women and HIV/AIDS.* Report to the UN Commission on Human Rights, 2005. UN doc. E/CN.4/2005/72, paragraph 27, p. 9.

[18] ICASO, *Community sector report on the process for setting national targets for* universal accessuniversal access. Prepared for the 20th Meeting of the UNAIDS Programme Coordinating Board, June 2007. p. 4.

[19] UNAIDS/PCB(20)/07.8, op.cit., p. 11.

[20] See UNAIDS/PCB(20)/07.11, op.cit.
[21] UNAIDS, 20th Meeting of the UNAIDS Programme Coordinating Board, Geneva, Switzerland, June 2007. UNAIDS/PCB(20)/07.8.
[22] Ibid.
[23] Discussion with ICASO, 31 May 2007.
[24] "*Setting priorities and overcoming obstacles*: Targets should reflect priority activities for the national programme, particularly with regard to overcoming the obstacles that block people's access to prevention, treatment, and care and support. They should also seek to address the true drivers of the epidemic. The recent country and regional consultations identified major obstacles in the following areas: stigma, discrimination, the inequality of women and the marginalized status of key groups (such as sex workers, injecting drug users, men who have sex with men and prisoners); lack of predictable and sustainable financing; lack of affordable commodities; lack of human resources and strong systems; and insufficient accountability mechanisms. Setting targets must be linked to efforts to overcome these obstacles. Thus, it may be necessary to shift resources to areas not adequately addressed before. *Limiting the number of targets.* Targets are more powerful as a catalyst for increased and more effective action if they are limited in number, tied to key national needs, very carefully considered as far as feasibility, and then actively promoted. Countries should therefore set only one or two key targets for 2008 and 2010 in each of the four major programme areas (prevention, treatment, care and support). These could derive from existing targets or require the setting of new, additional targets, but should be broadly representative of the country's response to their HIV epidemic." UNAIDS, *Setting national targets for moving towards* universal accessuniversal access*: operational guidance.* October 2006.

[25] A survey article looking at pregnancy and intimate partner violence reported that "In studies of pregnant women, estimates of prevalence of abuse during pregnancy range from 0.9% to 20.1% (with most studies finding 4% to 8%). The study that reported the highest prevalence was one in which trained nurses asked patients in public health prenatal clinics about intimate partner violence at every prenatal visit.[[SF: Ditto.]In this study, pregnant teens were at even higher risk than adult women for interpersonal violence: 21.7% had been physically or sexually abused during the pregnancy, as compared with 15.9% of adult pregnant women attending the same clinic; 68% of the physical and/or sexual abuse of these pregnant teens was reported as being perpetrated by an intimate partner. Pregnant adolescents are also at risk of physical and sexual assault by other family members, acquaintances, and strangers." Leigh Kimberg, MD, *Addressing Intimate Partner Violence in Primary Care Practice.* Medscape General Medicine 3(1), 2001. Accessed at http://www.medscape.com/viewarticle/408937_print. See *Report of the UN Secretary General, In-depth study on all forms of violence against women*, UN doc. A/61/122/Add.1, paragraph 116. See also, Sandra L. Martin, April Harris-Britt, Yun Li, Kathryn E. Moracco, Lawrence L. Kupper, Jacquelyn C. Campbell, *Changes in Intimate Partner Violence During Pregnancy.* Journal of Family Violence, Volume 19, Number 4, August 2004, pp. 201-210(10); chapter 8.

[26] *WHO Multi-country study.*
[27] WHO, UNAIDS and UNICEF, Ibid., p. 7.
[28] UNAIDS/PCB(20)/07.
[29] See AWID and Just Associates, op.cit.
[30] J. Csete, R. Schliefer, J. Cohen. *"Opt-out" testing for HIV in Africa: a caution.* The Lancet, Vol. 363 • 7 February 2004, p. 494. In their research, they have found that "women frequently face spousal violence when they reveal that they are HIV positive or even show interest learning their status or obtaining care."
[31] See Ralf Jürgens and Glenn Betteridge, *HIV Prevention for Prisoners: A Public Health and Human Rights Imperative.* Interights Bulletin, V. 15, No. 2, 2004: 55-59.
[32] P. 7 20[SF: is this supposed to be p. 720? It should be at the end of the citation. But what is 267 then?] Merle A. Sande and Allan Donald, *Treatment of HIV/AIDS: Do the Dilemmas Only Increase?* Journal of the American Medical Association 292(2) 14 July 2004):267.
[33] Country assessments conducted for UNAIDS' *Presentation of policy guidance to address gender issues* found "insufficient capacity to create, collect and analyse indicators relating to the impact of programmes on the behaviour and needs of men/boys and women/girls" resulting in a lack of strategic information, inadequate data disaggregation and a lack of systematic assessment. See UNAIDS/PCB/(20)/07.11, op.cit, p. 8.
[34] According to the recent World Health Organization (WHO) multi-country study on violence against women, in 13 of their 15 study sites, one third to three quarters of women interviewed in their study sites had been physically or sexually assaulted by an intimate partner. See WHO Multi-country Study on Women's Health and Domestic Violence against Women accessible at http://www.who.int/gender/violence/who_multicountry_study/en/index.html.
[35] And, while national governments committed to adopting anti-discrimination laws to protect people living with HIV&AIDS at the 2001 UN General Assembly Special Session on HIV/AIDS (UNGASS), by 2005, only 61% of countries had done so. Ibid, p. 7.
[36] Amnesty International USA, *A fact sheet on HIV/AIDS, women, and human rights*, at http://www.amnestyusa.org/women/hivaids.html; Human Rights Watch, 2005, *Rhetoric and Risk:Human Rights Abuses Impeding Ukraine's Fight Against HIV/AIDS* at http://hrw.org/reports/2006/ukraine0306/7.htm.

[37] By way of background, in 2005, the Group of Eight (G8)[37], with the United Kingdom as president, convened its annual summit in Gleneagles, Scotland. At the "Gleneagles Summit" the eight countries (comprising 65% of the world's economy) pledged to double aid to Africa by 2010, including to come "As close to universal accessuniversal access to HIV/AIDS treatments as possible by 2010". [37] This pledge was expanded in May 2006 at the five year review of the UN General Assembly Session on HIV/AIDS. The Political Declaration to which governments present agreed, committed themselves to pursue "all necessary efforts to scale up nationally driven, sustainable and comprehensive responses to achieve broad multisectoral coverage for prevention, treatment, care and support, with full and active participation of people living with HIV, vulnerable groups, most affected communities, civil society and the private sector, towards achieving the goal of universal accessuniversal access to comprehensive prevention programmes, treatment, care and support by 2010" (paragraph 20) They also pledged their continuing commitment to the goal of achieving "universal access to reproductive health by 2015, as set out at the International Conference on Population and Development" (paragraph 18).

[38] Note by the Secretary General, *Scaling up HIV prevention, treatment, care and support,* A/60/737 24 March 2006.
[39] WHO, UNAIDS, UNICEF, *Toward universal access, scaling up priority HIV/AIDS interventions in the health sector,* p.49.
[40] UNAIDS, *Scaling up towards universal access, considerations for countries to set their own national targets for HIV prevention, treatment, and care*, April 2006.
[41] International HIV/AIDS Alliance. *Universal access to HIV treatment, care and prevention by 2010: What does it mean for civil society?* 2005. Accessible at http://www.aidsalliance.org/graphics/secretariat/documents/news/UNGASS/Universal%20access%20and%20civil%20society.pdf.
[42] Dr Margaret Chan, Director-General of the World Health Organization, *Address to WHO staff*, 4 January 2007. At http://www.who.int/dg/speeches/2007/address.to.staff/en/index.htm.
[43] Recent efforts within UNAIDS have attempted to bolster the agency's expertise in gender as it intersects with HIV&AIDS, both through the work of the Global Coalition on Women and AIDS and through the office of the UNAIDS advisor on gender and human rights. Part of this effort has resulted in the presentation of policy guidance on gender issues to the June 2007 Programme Coordinating Board. Accessible at http://data.unaids.org/pub/Presentation/2007/policy_guidance_address_gender_issues_item4_2_en.pdf.
[44] See Annex I for our recommend revisions to these core and recommended indicators.
[45] UNAIDS, *Practical guidelines for intensifying HIV prevention: toward universal access*, 2007. Accessed at http://data.unaids.org/pub/Manual/2007/20070306_Prevention_Guidelines_Towards_Universal_Access_en.pdf.
[46] Ibid, pp. 7-8.
[47] Ibid, p. 48.
[48] UNAIDS, *Setting national targets for moving towards universal access*, April 2006, p. 20.
[49] ActionAid International. *Tackling political barriers to end AIDS*, 2007.
[50] Conscious Media Forum and ActionAid International, Nepal, *Violence against women and girls and HIV – cause and consequence: case studies on intersection of twin pandemics,* 2007.
[51] Testimony collected by ActionAid International, Guatemala. [SF: Date?]
[52] For a discussion of innovative efforts to address the intersection of gender-based violence and HIV&AIDS, see Cynthia Rothschild, Mary Anne Reilly and Sara A. Nordstrom, *Strengthening Resistance: confronting violence against women and IV/AIDS, 2006,* at http://www.cwgl.rutgers.edu/globalcenter/publications/strengthening.htm. See also, Harvard School of Public Health, Program on International Health and Human Rights, *HIV/AIDS and Gender-Based Violence (GBV) Literature Review* at http://www.hsph.harvard.edu/pihhr/files/Final_Literature_Review.pdf.