



U.S. GLOBAL HEALTH POLICY

THE WOMEN, GIRLS, AND GENDER EQUALITY PRINCIPLE
OF THE U.S. GLOBAL HEALTH INITIATIVE (GHI):
HOW HAVE U.S. GOVERNMENT PROGRAMS RESPONDED?

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EXECUTIVE SUMMARY

The health and empowerment of women and girls around the world has been elevated as a priority on the U.S. diplomacy and development agendas. This has been evidenced by a number of actions taken by the Obama Administration, most notably the focus on women, girls, and gender equality (WGGE) as one of seven core principles of the Administration's Global Health Initiative (GHI). The GHI, announced in May 2009, was intended to promote a more comprehensive approach to U.S. government (USG) global health programs. As part of the GHI process, teams in countries receiving U.S. health assistance prepared GHI strategies, aligning their programs with the GHI's principles, including WGGE, and have begun to implement those strategies.

To begin to understand how the principle is being applied to programs on the ground, the Kaiser Family Foundation conducted key informant interviews with 15 GHI country teams as well as USG staff in Washington, DC. The findings from the interviews yielded nine central themes and trends related to the response to and implementation of WGGE (see Box 1). Overall, while the experiences of the country teams varied widely, the analysis found that the principle has provided a supportive platform to those country teams that already had established programming in the areas of women, girls, and gender equality, and prompted others to step up their efforts, especially on work related to gender equality, which is still evolving in most countries. The analysis also found that there were shared opportunities and challenges. For instance, the priority placed on WGGE by key USG leadership was critical to the promotion and implementation of the principle and there was consensus that the principle added value to the work of country teams. Yet, the lack of new money and limits on the flexibility of existing resources inhibited teams from fully funding gender-related efforts and developing new activities. Country team responses were more mixed on other topics, such as the scope of interagency coordination and integration, the role of PEPFAR in WGGE implementation, and the level of engagement between GHI teams and the host country governments. Additionally, other more technical aspects of WGGE implementation were also examined, including the role of gender staffing at the country level.

BOX 1. NINE CENTRAL THEMES & TRENDS IDENTIFIED IN THE ANALYSIS

1. Leadership contributed to the promotion and implementation of the WGGE principle.
2. WGGE principle reinforced existing efforts and added value to programming, but advancement of broader gender equality work limited.
3. Doing more without new resources challenging.
4. Scope of coordination and integration on WGGE varied widely.
5. PEPFAR provided both opportunities and challenges for WGGE implementation.
6. WGGE principle gained more traction when aligned with host country priorities.
7. Guidance needed on measurement and evaluation.
8. Gender staffing and training essential for WGGE programming, but inadequate in most countries.
9. Varying levels of technical assistance and other support provided by USG in Washington, DC.

The interviews demonstrated that the principle has had a clear influence on country strategies and programming, but it is still too early to assess whether or not the implementation of the principle is having its intended impact on health outcomes for women and girls, as well as their families and communities. At the same time, examining implementation of WGGE is particularly timely given recent changes being made to the GHI at the organizational and administrative levels. While the implications of these changes remain unclear, the emphasis on WGGE in the GHI and across USG development and foreign policy efforts remains and, therefore, the key themes identified during the course of this project can help inform policy discussions and future decisions about this work.

INTRODUCTION

The health and empowerment of women and girls around the world has been elevated as a priority on the U.S. diplomacy and development agendas. This has been evidenced by a number of policy actions by the Obama Administration, most notably the focus on women, girls, and gender equality (WGGE) as one principle of the U.S. Global Health Initiative (GHI).¹ Other important actions on women and girls have included: the establishment of the Office of Global Women's Issues within the State Department in 2009, headed by the first Ambassador-at-Large for Global Women's Issues;² the emphasis on women's roles in diplomacy and development in the State Department's Quadrennial Diplomacy and Development Review (QDDR) in 2010;³ the announcement by Secretary of State Hillary Clinton of the first Secretarial Policy Guidance on Promoting Gender Equality to Achieve Our National Security and Foreign Policy Objectives in 2012;⁴ and the launch of the U.S. Agency for International Development's (USAID) Policy on Gender Equality and Female Empowerment in 2012.⁵

The GHI, announced in May 2009 by President Obama, was intended to promote a more comprehensive U.S. government (USG) approach to global health programs, with the overarching goal of achieving greater impact. The GHI is guided by seven core principles, one of which, as noted above, is WGGE, which is designed "to redress gender imbalances related to health, promote the empowerment of women and girls, and improve health outcomes for individuals, families, and communities."⁶ As part of the GHI process, a subset of U.S. government teams in countries receiving U.S. health assistance prepared GHI strategies, aligning their programs with the GHI's core principles, including WGGE.⁷ A critical step, then, to understanding the impact of emphasizing such a principle in U.S. foreign assistance programs is assessing the extent to which it is being used on the ground to inform program planning and implementation.

To that end, this report presents the results of key informant interviews conducted by the Kaiser Family Foundation with representatives from 15 GHI countries. The report identifies nine central themes and trends that could help inform U.S. global health policy, as well as key opportunities and challenges for moving forward. It builds on prior work by the Foundation that more broadly looked at the WGGE principle, beginning with a roundtable discussion in November 2010 on the principle and the supplemental guidance on WGGE, which was developed by a USG Interagency Task Force on Women and Girls to help inform GHI implementation.^{8,9} This was followed in June 2011 with a Foundation publication analyzing the extent to which the WGGE principle was reflected in the first set of GHI country plans, which were developed by the "GHI Plus" countries—countries selected for accelerated implementation of the GHI.^{10,11}

This analysis comes at a particularly important moment in the GHI's trajectory. Soon after the research was completed, the USG announced changes to the organization and administration of the GHI, with the closing of the GHI Office and the establishment of an Office of Global Health Diplomacy at the State Department. While there remains some uncertainty about the GHI going forward, a joint message from the GHI principals (USAID, the Centers for Disease Control and Prevention (CDC), and the Office of the Global AIDS Coordinator (OGAC)) and the GHI leadership stated that the GHI will remain the government's "priority global health initiative" and carry forward "the enduring mandate of ensuring the GHI principles are implemented in the field."¹² Therefore, the findings from this report can help to inform policy discussions about the future of the GHI during this time of transition and to highlight the importance of the WGGE principle to fulfilling the GHI's goals.

OVERVIEW OF THE WOMEN, GIRLS, AND GENDER EQUALITY PRINCIPLE

The women, girls, and gender equality principle of the GHI aims to sharpen the focus on these areas across USG global health efforts. The principle is designed to address the “[g]ender-related inequalities and disparities [that] disproportionately compromise the health of women and girls and, in turn, affect families and communities.”¹³ The intent of the WGGE guidance, developed by a USG Interagency Task Force on Women and Girls, is to move away from an often exclusive focus on women and girls as beneficiaries of health services.⁹ As such, efforts to increase access should identify and address those gender-related factors and barriers that impede access. Importantly, the guidance seeks to go further by focusing more explicitly on issues of gender equality and by ensuring that women and girls will be key actors in the planning, implementation, and monitoring and evaluation of health and development programs. In fact, the emphasis on gender equality was intentional and significant—when initially launched, the principle was titled, “a women- and girls-centered approach” but was later re-titled to include “gender equality” to emphasize its importance to the principle’s goals.

The WGGE guidance was the first guidance to be developed and made publicly available for any of the seven core GHI principles. It was drafted in the fall of 2010, sent to a subset of GHI countries for input, and finalized in April 2011. The guidance contains two main components: three requirements to be included in each country strategy (a gender analysis, a narrative on how the team will implement the principle, and a description of measurement and evaluation of work related to the principle) and ten key implementation or programming elements in support of the WGGE principle (see Box 2). The ten elements are not requirements, nor are they prioritized in the guidance; rather, countries are requested to choose elements based on findings from their own gender analysis and in consultation with the host country, both government and civil society. The objective of the guidance is to have these elements

BOX 2. THE GHI SUPPLEMENTAL GUIDANCE ON THE WOMEN, GIRLS, AND GENDER EQUALITY PRINCIPLE—REQUIREMENTS AND IMPLEMENTATION ELEMENTS⁹

Requirements for Country Strategies

- Each country team must conduct a gender assessment and analysis.
- Each country team must provide a short narrative describing how they will implement the principle.
- Teams will collect sex- and age-disaggregated data and other relevant health statistics to enable the monitoring of progress and evaluation of effectiveness of programs related to the principle.

10 Key Elements of Implementation

- Ensure equitable access to essential health services at facility and community levels.
- Increase meaningful participation of women and girls in planning, design, implementation, monitoring, and evaluation of health programs.
- Monitor, prevent, and respond to gender-based violence.
- Empower adolescent and pre-adolescent girls by fostering and strengthening their social networks, educational opportunities, and economic assets.
- Engage men and boys as clients, supportive partners, and role models for gender equality.
- Promote policies and laws that will improve gender equality, health status, and/or increase access to health and social services.
- Address social, economic, legal, and cultural determinants of health through a multi-sectoral approach.
- Utilize multiple community-based programmatic approaches, such as behavior change communication, community mobilization, advocacy, and engagement of community leaders/role models to improve health for women and girls.
- Build the capacity of individuals, with a deliberate emphasis on women, as health care providers, caregivers, and decision-makers throughout health systems, from the community to national level.
- Strengthen the capacity of institutions, which set policies, guidelines, norms, and standards that impact access to, and equality of, health-related outreach and services, to improve health outcomes for women and girls and promote gender equality.

integrated into existing programs and platforms, not necessarily to launch new or stand-alone activities although that is also an option.⁹ An analysis by the Kaiser Family Foundation of seven of the eight GHI Plus country strategies found that all of these strategies addressed the health of women and girls as a top priority, and several went further, including efforts to include women and girls as decision-makers and planners in health care programs.

METHODOLOGY

To assess how USG country programs have responded to the WGGE principle, Kaiser selected 15 countries for analysis: Bangladesh, Cambodia, Democratic Republic of the Congo, Ethiopia, Georgia, Guatemala, Indonesia, Liberia, Malawi, Mozambique, Nepal, Nigeria, Rwanda, Senegal, and Tanzania. The set of countries included in this analysis was not a random sample of all GHI countries, but was instead chosen from the countries with publicly available GHI strategies. The selected countries were geographically diverse, had varying levels of U.S. investment and program portfolios, and represented both GHI Plus and “second round” countries. GHI planning leads were contacted in each country to request an interview with them and other relevant members of their GHI country team. The interview participants from GHI country teams varied, but included representatives from USAID, CDC, the Peace Corps, and the U.S. President’s Emergency Plan for AIDS Relief (PEPFAR), depending on the country. Input was also solicited from representatives of the USG’s Interagency Task Force on Women and Girls who had been working with the country teams to implement the principle. Interviews were conducted in late 2011 and early 2012.

Using a semi-structured interview guide, the following general topics were explored with each country team: the status of GHI implementation; whether the GHI had led to any changes in the way the USG “does business” on WGGE at the country level; issues around funding stream integration, coordination of services, and leveraging of resources specific to WGGE-focused programs; interactions with host country governments and civil society; metrics to evaluate the work under the WGGE principle; and other challenges and lessons learned.

It is important to note that this assessment is not meant to be an evaluation of the GHI or any country program, but, rather, is intended to identify themes, trends, opportunities, and challenges that may help inform discussions and decision-making pertaining to USG global health efforts broadly and the WGGE work specifically. In addition, the first GHI strategies, completed by the GHI Plus countries (six of the eight GHI Plus countries selected by the USG are included in this analysis), were approved in early 2011—the first one being approved in April 2011. Therefore, at the time of the interviews for this report, the GHI Plus countries were approximately one year into implementation of their strategies. The second round countries (the remaining nine included in this analysis) were at an even earlier stage of implementation, as their strategies were developed later and only approved in late 2011.

OVERVIEW OF COUNTRIES INCLUDED IN ANALYSIS

The 15 countries selected for analysis: Bangladesh, Cambodia, Democratic Republic of the Congo, Ethiopia, Georgia, Guatemala, Indonesia, Liberia, Malawi, Mozambique, Nepal, Nigeria, Rwanda, Senegal, and Tanzania – are diverse in terms of geography and composition of U.S. investment, as well as the health challenges faced by their populations and their socio-economic backdrops (see Appendices for USG program and funding information as well as for health and other data by country).

- They span four regions (Africa, Asia, Europe/Eurasia, and Latin America and the Caribbean). Most (nine) are in Africa, four are in Asia, one is in Europe/Eurasia, and one is in Latin America.
- Six are GHI Plus countries – the first wave of countries that prepared GHI strategies and were selected for accelerated implementation of the GHI and its principles – and the remaining nine are second round countries.
- The amount of health funding from the USG ranged from \$8.1 million in Georgia to \$573.2 million in Nigeria in FY 2011.¹⁴
- The composition of USG programs and funding varied significantly across the countries.¹⁴
 - All 15 received PEPFAR funding in FY 2011. PEPFAR accounted for the largest share of health funding in eight countries and ranged from 4% of USG global health funding in Bangladesh to 82% in Nigeria.
 - Countries also received a mix of maternal, newborn, and child health (MNCH); family planning/reproductive health (FP/RH); tuberculosis (TB); malaria; nutrition; and other USG funds in FY 2011, although not all received each funding stream and the amounts varied.
 - 15 received MNCH funds;
 - 14 received FP/RH funds;
 - 12 received TB funds;
 - 9 received malaria funds; and
 - 12 received nutrition funds.
- Women and girls in these countries face a variety of health and other challenges.¹⁵ For example:
 - Maternal mortality ranges from a low of 67 per 100,000 live births in Georgia to a high of 770 in Liberia (the 7th highest in the world).
 - Among countries with available data, all have an unmet need for family planning, with 11 having modern contraceptive prevalence rates of less than 50%.
 - Adolescent birth rates (births to mothers ages 15-19) range from 43 births per 1,000 adolescent women in Rwanda to 177 births per 1,000 adolescent women in Malawi.
 - Eight countries have HIV/AIDS epidemics where females make up more than half of all adults living with the disease; and young women are more likely to be infected than their male counterparts in most of the African countries included in the analysis.
 - Ten countries place legal restrictions on abortion in some cases; two countries prohibit abortion in all cases.
 - The ratio of girls to boys decreases as children move from primary to secondary schools and then from secondary and tertiary schools in nearly all countries with available data.

KEY FINDINGS FROM INTERVIEWS

Although most country teams were still in the early stages of implementing their GHI strategies at the time of the interviews, nine key themes and trends emerged from the discussions on WGGE, focused on such topics as leadership, the “added value” of the WGGE principle, funding, coordination and integration, the role of PEPFAR in the implementation of the principle, and monitoring and evaluation. These findings are outlined below.

Leadership Contributed to the Promotion and Implementation of the WGGE Principle

Leadership – in Washington, DC, and at the country level – was cited by several country teams, as well as by USG staff in Washington, DC, as critical to prioritizing the WGGE principle in country strategies and programming. First and foremost, the high-level recognition from the Obama Administration of the

importance of WGGE as a central element of the GHI gave the principle added resonance with many country teams. Two countries specifically noted the leadership of Secretary Clinton and, in the words of one GHI country team representative, “The fact that women, girls, and gender equality is the first principle, backed up by Secretary Clinton’s repeated emphasis and her personal championing of this principle...has made everybody put this on the radar screen.”

Additionally, the role of leadership from USG personnel at the country-level was noted by five countries. Several identified the importance of the role played by the U.S. Ambassador and/or the USAID mission director in reinforcing the principle in programming, as well as the role played by the GHI country team in ensuring strong gender-related programming.

However, instilling WGGE as a priority remained a challenge for some country teams and several emphasized the need for continued leadership on WGGE. According to one GHI representative, “We need to make sure WGGE is a priority that everybody buys into—not one person, not one team....”

WGGE Principle Reinforced Existing Efforts and Added Value to Programming, but Advancement of Broader Gender Equality Work Limited

While the prioritization of the WGGE principle and the scope of related programming varied quite significantly by country, there was consensus that the principle added value to the work of the GHI country teams. This included helping teams to articulate and prioritize activities, think about their work in new ways, and identify opportunities for efficiencies and synergies between programs. Overall, the principle provided a supportive platform and reinforced the work of those country teams that already had established programming in the areas of women, girls, and gender equality, and prompted others to step up their efforts.

Women as Beneficiaries

All 15 country teams had been engaging in work that directly addressed the health of women and girls prior to the advent of the GHI to some extent, such as providing maternal health services. The WGGE principle encouraged most country teams to more deliberately assess the extent to which they addressed women and girls specifically, including the barriers they face in accessing services. Four country teams in particular reported that the principle gave them “license” to think differently about population groups and how to better meet their needs with GHI programming (e.g., how to address the reproductive health needs of populations at high risk for HIV infection, such as sex workers and transgender populations, or how to use transportation networks for people living with HIV to help pregnant women to deliver at a health facility). Another GHI representative said the existence of the principle provided “momentum” to elevate the work even further—a sentiment shared by others as well. Additionally, one country noted a “renewed focus” on FP/RH activities due to the WGGE principle and the GHI’s overall emphasis on this issue, with a country representative describing a “quiet transformation” of the USG role on FP.

Gender Equality

While efforts to address women and girls as beneficiaries were more clearly defined components of country programs, work on gender equality was more nascent. The WGGE principle encouraged country teams to determine if their programs were taking the next step, going beyond viewing women and girls simply as beneficiaries of health services to a more comprehensive approach that promoted the active engagement of women and girls in the design, implementation, and monitoring of programs. Such work is inherently more complex and challenging and, overall, is still evolving in most countries. A couple of countries reported having broader gender equality efforts that “pre-dated” the GHI. One GHI

representative said, “The equality piece has changed the way we look at programs...In the past, gender meant equity and access, and now we’re thinking about opportunities for full participation of women.”

For those countries with more established programming in this area, the GHI was said to have given them an “endorsement” to approach the gender equality-related work in a more “deliberate” and “strategic way.” As another explained, “It’s not such an upward battle now—gender is front and center; the path will be a little easier and kinder.”

Examples of gender equality work cited – work both directly and indirectly related to health outcomes – included:

- Working with men and communities to understand the importance of antenatal care for pregnant women, and to involve men in FP programming;
- Focusing on gender-related social, legal, and cultural barriers, including addressing gender norms, healthcare decision-making, leadership, employment parity, and women’s rights;
- Promoting the enforcement or passage of laws related to gender-based violence;
- Working with men, boys, and community leaders to prevent and respond to gender-based violence;
- Increasing the numbers of women in health professions and in management structures of NGOs;
- Engaging religious leaders and gatekeepers to communities;
- Increasing political participation among women; and
- Promoting cross-sector programs focused on areas such as education for girls and school health programs, economic empowerment for women, nutrition and women’s access to agricultural resources, and democracy and governance.

Still, the encouragement of GHI country teams to examine their portfolio and its alignment with the WGGE principle did not necessarily translate into new programs, especially with regard to gender equality. According to one country team representative, “We still have a long way to go on gender dimensions.” While some countries said they bolstered or augmented programs in response to the GHI focus on WGGE, others said that their work had not shifted significantly, but they instead changed the way work was described or packaged.

Doing More Without New Resources Challenging

No “new” money was attached to the GHI, despite early expectations that the GHI Plus countries would receive some additional resources. Therefore, country teams were expected to plan for and implement the GHI with existing resources. This has proved challenging for a number of country teams interviewed. Six expressed that they lacked adequate resources to fully fund gender-related efforts and to develop new activities. One GHI country representative stated, “We are trying to get more out of what we are already doing, infusing what we’re doing with [WGGE].” A few country representatives specifically noted that they were “packaging” work differently, rather than developing new activities, given the lack of additional funding.

Although some said that it could be assumed that the GHI approach (which encourages coordination and integration) would ultimately produce efficiencies, a few interviewees pointed out that, in the short term, activities related to the GHI broadly and the principle specifically may not necessarily be more cost effective. As stated by one interviewee, “It takes resources to make changes.” Additionally, for two country teams, the lack of new money became a source of misunderstanding with their respective host governments, which expected that new resources would be attached to the GHI.

Scope of Coordination and Integration on WGGE Varied Widely

The GHI principles, including the WGGE principle, are intended to cut across USG health programs (e.g., HIV/AIDS, TB, malaria, FP/RH, MNCH, nutrition). Yet, as several respondents pointed out, the realities of integrating efforts across programs can be challenging. U.S. health funding comes from different funding streams, often controlled by different USG agencies or programming budget lines, which may be subject to different appropriations bills, reporting requirements, and restrictions. In addition, USAID missions also manage other USG development programs (e.g., education, democracy and governance, economic growth or “livelihoods”, and food security through Feed the Future).

Based on the interviews, some country teams managed to navigate the complexities of coordination and integration better than others. For many teams, the principle opened the door to greater communication among USG agencies in country, and for a few it opened the door to greater integration and cross-sector programming by encouraging teams to more proactively identify opportunities for efficiencies and synergies within and between programs to enhance the gender focus. The views on the ease or difficulty of integration, as well as the degree to which integration has occurred, varied quite strikingly—one country representative noted they had “no real problem” bringing funding streams together, while for others, integration has proven much more challenging.

There were a few key factors mentioned by interviewees that either facilitated or inhibited coordination and integration:

Underlying Interagency Relationships

Numerous interviewees said that the GHI provided a supportive environment for interagency coordination, encouraging a “whole of government” approach. Thus, the GHI often enhanced already strong interagency communications and coordination or allowed for, in the words of one interviewee, “more formalized discussions” on programming related to WGGE among the USG agencies and programs directly involved with health as well as other development efforts.

For some country teams, PEPFAR provided a platform for strong interagency communications that countries built upon as they began to implement the GHI. Specifically, one country representative said that prior to the GHI, coordination and integration happened mostly under PEPFAR (primarily between HIV/AIDS and FP programming) but that GHI has encouraged better coordination between nutrition and MNCH staff, among others.

A few countries shared concrete steps they have taken to encourage coordination under the GHI. One country mentioned that the Ambassador chairs an interagency meeting on health issues and in two others, staff have been co-located (e.g., USAID and CDC staff in one country, and PEPFAR and USAID health staff in another). In some cases, coordination was helped and encouraged by the mission director or others in leadership positions.

However, some countries noted the complexities of USG interagency dynamics and that tension between agencies over jurisdiction and funding persisted. These tensions were said to have inhibited communication and coordination among agencies, which prevented certain teams from applying a “whole of government” approach to programming.

Funding Flexibility

Regardless of the degree of integration among programs in their countries, nearly all country teams underscored the importance of and need for more flexibility in order to leverage existing funding to meet the goals of the GHI and the WGGE principle. Echoing the sentiment of numerous other

interviewees, one country representative said, “If we really want full integration, we need more flexible money. The money is all earmarked for specific things, which limits program flexibility.” According to another interviewee, “...we live in a world of appropriation and regulation; we are still figuring out how to leverage resources.” One country representative noted that it takes “creativity” to bring funding streams together.

Composition of USG Health Portfolio

Eleven country teams noted that integration of funding streams to provide comprehensive WGGE programming was easier and more effective when the USG funding portfolio in a country was more balanced—including relatively proportional shares of HIV/AIDS, FP/RH, MNCH, and other funding.

For some countries with large PEPFAR programs, integration has proven more difficult as the majority of the money provided to those countries is tied to HIV/AIDS programs with strict limitations on how the funds can be used for non-HIV/AIDS activities. At the same time, other countries in which PEPFAR accounts for a significant share of funding cited the program as serving as a platform for integration. These countries said that while earmarks are challenging and programs need to be accountable to congressional appropriations, integration is indeed possible.

One country noted an example of a new pediatric emergency ward and consolidated laboratory that were built with PEPFAR money, but which serve multiple purposes. In addition, PEPFAR funding helped renovate labor wards and train surgical officers in order to facilitate the prevention of mother-to-child transmission, which also contributed to maternal and child health services. According to the country team, the funding was still vertical, but the activities had a broader impact and the MNCH component probably would not have been pursued so aggressively without the GHI’s focus on that issue area. “The GHI opened areas PEPFAR could fund,” one team member noted. (*See further discussion on PEPFAR below.*)

Several country representatives noted that there were more opportunities for integration when most of the U.S. health funding came from USAID, which often has experience in integrating different program areas at the country level—both within the health portfolio as well as among other development programs. For instance, one USAID mission reported that they had integrated WGGE into all new Request for Applications (RFAs) for implementing partners.

Multiple Planning Cycles Across Programs

A challenge to integrating programs cited by interviewees is that they operate on different planning cycles, which are not streamlined. This applies particularly to the PEPFAR Country Operational Plans (COPs), the President’s Malaria Initiative (PMI) Malaria Operational Plans (MOPs), and other Operational Plans (OPs). GHI strategies, which are intended to cut across program-specific plans and identify new areas for greater impact and synergies, were largely developed separately. However, there has been movement toward coordinating these processes. For example, one country said that their COP process will be aligned with their OP and MOP processes during the next planning cycle.

PEPFAR Provided Both Opportunities and Challenges for WGGE Implementation

The role of PEPFAR was a topic of each interview—whether PEPFAR was a major presence in a country or not. In countries with a strong PEPFAR presence, PEPFAR played a significant role in shaping the approach countries took in developing their GHI strategies and how the WGGE principle was addressed. However, this played out in different ways for each country, depending on the country context and the magnitude of PEPFAR’s presence as a share of the USG global health portfolio. Clear differences

emerged from discussions with countries where PEPFAR accounted for the majority of USG programming and funding, and those that had a more balanced health portfolio.

For nine of the countries interviewed, PEPFAR provided a platform upon which GHI could build in terms of programming and infrastructure, as well as with communications and collaboration between and among USG agencies and implementing partners. A few countries have been able to capitalize on program integration already occurring under PEPFAR or identified opportunities for additional integration, such as between PEPFAR and FP/RH or malaria, or PEPFAR and MNCH (e.g., PEPFAR's focus on the prevention of mother-to-child HIV transmission had enabled the renovation of labor and delivery wards in one area, which in turn advanced maternal and newborn health goals). One GHI representative noted, "PEPFAR has been a platform for interagency cooperation, and GHI solidified that collaboration and provides us non-PEPFAR funds for wrap-around activities."

PEPFAR's focus on capacity building in some countries has helped support FP/RH services by increasing the training of health care workers and counselors. In one country, for example, PEPFAR funding provided technical assistance to the ministry of health to run a comprehensive care clinic for HIV in a hospital. This support helped strengthen the capacity of health care providers and counselors by training them to provide referrals to the FP/RH clinic, which was located on the same floor of the hospital.

While PEPFAR provided opportunities for country teams, the dominance of PEPFAR presented some complexities and challenges for the WGGE work. For instance, while the PEPFAR experience helped create an atmosphere for interagency collaboration in certain countries, it provoked interagency tensions over funding in other countries. In some countries, when funding was almost exclusively from PEPFAR, integration was often more complicated. Conversely, in countries that were not large PEPFAR recipients, more flexibility with integrating funding streams was noted by interviewees. On occasion, however, PEPFAR provided central funding for a program related to WGGE, such as PEPFAR's GBV Response Initiative in three countries.¹⁶

WGGE Principle Gained More Traction When Aligned with Host Country Priorities

All GHI country teams had cultivated working relationships with various entities in the host country government prior to the GHI, primarily the ministries of health, although the strength of those relationships varied as did the level of engagement of the host government in the GHI process. According to the interviews, the stronger relationships were prior to the GHI or the more the government itself was taking the lead in coordinating donors in health sector activities, the more involved the host governments were in the development of the GHI strategies and the more closely priorities aligned. In one country, the host country government's health plan and the GHI plan were cited "as nearly one in the same." In another, the government drafted the first iteration of the GHI plan and provided feedback on subsequent drafts. In yet another country, the host government made a joint statement with President Obama upon the release of the GHI strategy, acknowledging the collaborative relationship between the two governments on health.

Regarding the WGGE principle specifically, many of those interviewed indicated that the principle served as an entry point for discussions with the host government, enabling country teams to prioritize WGGE issues in these discussions, and, in some cases, helped "coalesce" the host country's thinking around WGGE. Seven of the country teams interviewed believed that the focus on the WGGE principle reflected the national government's plans to some extent.

In many of the selected countries, teams stated that government leaders and ministries of health were invested in the health of women, although usually less so with issues of gender equality. In countries

where the host government had not actively addressed gender issues, USG efforts to engage the government on these issues proved challenging (e.g., addressing cultural norms such as husbands needing to grant permission for their wives to seek medical care). Nevertheless, USG programs reported making some inroads in certain areas of women's health (e.g., access to family planning services).

GHI teams have found additional ways to engage and collaborate with country partners, many of which pre-dated the GHI, but are important to note given their potential role in WGGE efforts moving forward. For instance, one team is helping their host government engage with civil society groups (e.g., professional associations of obstetricians and gynecologists); one is discussing strengthening referral systems for women's health care services within the country; and another embedded consultants in the ministry of health to help manage logistics and commodity distribution related to FP.

Guidance Needed on Measurement and Evaluation

Measurement and evaluation was one of three requirements outlined in the guidance that were to be included in each country strategy. According to the guidance, measurement and evaluation should include collecting data to evaluate progress, notably sex- and age-disaggregated data as well as other relevant health statistics. Some countries have made progress, and have been collecting sex-disaggregated data where possible. A few also reported collecting age-disaggregated data or data that are primarily output-based (e.g., number of women receiving antiretrovirals for the prevention of mother-to-child transmission or number of deliveries in a health facility with a skilled birth attendant).

However, nearly all of those interviewed underscored the challenge of identifying and measuring outcomes to determine what is working with regard to WGGE programming, and many acknowledged that they have a long way to go on this front. Most countries noted the need for guidance on measurement and evaluation related to the WGGE principle, particularly help in identifying new metrics (including impact indicators) that can be tied to programming. One interviewee suggested that guidance on ways to analyze Demographic and Household Survey (DHS) survey data through a gender lens could also be helpful.

Although in the early stages of implementation, a number of countries reported that they have received pressure to show results related to the WGGE principle. GHI country teams understood the need for stakeholders, including the Obama Administration and Congress, to see results, but they emphasized that it is too early to assess impact of the principle and related programming.

Gender Staffing and Training Essential for WGGE Programming, but Inadequate in Most Countries

Staffing and improving capacity and training on gender within USG agencies and implementing partners were cited as important components to advancing programming on the WGGE principle. Gender-related programming was more firmly supported in countries that had designated a strong, full-time gender focal point, although most country teams still do not have such positions. Of the country teams interviewed, eleven referred to some form of gender-related staffing (e.g., gender "focal points", gender "advisors", gender-based violence focal points), although not all of these positions were focused exclusively on health. Furthermore, most of these positions had gender as an "add-on" to their regular responsibilities and/or these positions were housed in one USG agency without responsibility for looking at gender across all programs. One interviewee underscored the need for staff training on gender and suggested that guidelines on staffing and core competencies necessary for gender work be developed.

Varying Levels of Technical Assistance and Other Support Provided by USG in Washington, DC

As country teams developed their GHI strategies, there was variation in the level of support or technical assistance provided by the USG from Washington, DC. The supplemental guidance for the WGGE principle was finalized in April 2011, and, while cited as helpful by a number of countries, many of the GHI Plus countries had already submitted their GHI strategies and others were already far along in the process. Some country teams cited specific examples of helpful assistance from Washington, DC that included regional workshops on the GHI, although the WGGE principle was not usually a focus, and others have requested technical assistance to better review their programs through a gender lens. In addition, representatives from OGAC and GHI conducted a gender training session for USG staff in one country; two second round countries benefitted from GHI Plus country experiences; a few country teams found that the GHI strategy review process provided a helpful opportunity for the USG Interagency Task Force on Women and Girls to press country teams to elaborate on their gender programming; and at least one country had requested technical assistance to look at the country's portfolio through a gender lens.

On the other hand, some country teams reported little specific outreach or technical support from Washington, DC on the WGGE principle following the publication of the guidance in April 2011. In addition, a few interviewees felt that it would be helpful if the USG created a platform for teams to share "real world" examples of how they are addressing the principle from which others can learn.

LOOKING AHEAD

The interviews with GHI country representatives highlighted important themes and trends on the implementation of the WGGE principle, as well as USG global health efforts more broadly. While it is still too early to assess implementation success and whether or not the WGGE principle is having an impact on health outcomes for women and girls, as well as their families and communities, it is clear the principle has influenced country strategies and programming. Examining WGGE implementation is particularly timely given the recent changes being made to the GHI at the organizational and administrative levels. The implications of these changes remain unclear, but the emphasis on WGGE in the GHI and across USG diplomacy and development efforts remains and, therefore, the key themes identified during the course of this project can help inform policy discussions and future decisions about this work.

As the next steps for the GHI and efforts related to women, girls, and gender equality are considered, several questions and challenges will be critical to address:

- Will high-level leadership at the country-level and in Washington, DC continue to prioritize WGGE?
- How will the WGGE principle and related programming be sustained and embedded in each country's global health programming moving forward, as well as on the U.S. global health policy agenda more broadly?
- How will the work done under the GHI umbrella be linked to or leveraged by other USG efforts related to the health and empowerment of women and girls and the advancement of gender equality?
- How will global health programs continue to evolve from those focused on women and girls as beneficiaries to those addressing gender equality more broadly?

- How can USG funding streams be made more flexible to allow for integration across programming?
- How will the WGGE principle be reflected in program-specific plans and budgets (COPs, MOPs, OPs) in order to ensure it is a priority area across USG health efforts?
- How can PEPFAR platforms be further leveraged to implement the WGGE principle?
- What additional non-financial resources are needed to effectively implement WGGE programming (e.g., technical assistance, sharing of lessons learned from implementation, incentives)?
- Finally, how will the GHI transition impact the work on women, girls, and gender equality?

ENDNOTES

¹ U.S. Global Health Initiative, “About GHI” webpage, see: <http://www.ghi.gov/about/index.htm>.

² U.S. Department of State, “Office of Global Women’s Issues” webpage, see: <http://www.state.gov/s/gwi/>.

³ U.S. Department of State, *The First Quadrennial Diplomacy and Development Review (QDDR): Leading Through Civilian Power*, available at: <http://www.state.gov/s/dmr/qddr/index.htm>.

⁴ U.S. Department of State, *Promoting Gender Equality to Achieve Our National Security and Foreign Policy Objectives*, fact sheet, available at: <http://www.state.gov/s/gwi/rls/other/2012/187001.htm>.

⁵ U.S. Agency for International Development, *USAID Launches New Gender Policy to Ensure Gender Equality and Female Empowerment*, press release, available at: <http://transition.usaid.gov/press/releases/2012/pr120301.html>.

⁶ U.S. Global Health Initiative, “Principles” webpage, see: <http://www.ghi.gov/about/principles/index.htm>.

⁷ U.S. Global Health Initiative, “GHI in Country” webpage, see: <http://www.ghi.gov/country/index.htm>. According to the USG, GHI strategies were to be produced by approximately 40 of the more than 80 countries with USG health programs.

⁸ Kaiser Family Foundation, *The U.S. Global Health Initiative’s Women, Girls, and Gender Equality Principle: A Roundtable Discussion*, March 2011, available at: <http://www.kff.org/globalhealth/8128.cfm>.

⁹ U.S. Global Health Initiative, *Global Health Initiative Supplemental Guidance on Women, Girls, and Gender Equality*, available at: <http://www.ghi.gov/resources/guidance/161891.htm>.

¹⁰ Kaiser Family Foundation, *The Women, Girls, and Gender Equality Principle of the U.S. Global Health Initiative (GHI): Assessment of the GHI Plus Country Strategies*, June 2011, available at: <http://www.kff.org/globalhealth/8206.cfm>.

¹¹ The first eight “GHI Plus” countries identified by the USG were Bangladesh, Ethiopia, Guatemala, Kenya, Mali, Malawi, Nepal, and Rwanda.

¹² U.S. Global Health Initiative, *Global Health Initiative Next Steps - A Joint Message*, available at: <http://www.ghi.gov/newsroom/blogs/2012/194472.htm>.

¹³ U.S. Global Health Initiative, “Focusing on Women, Girls, and Gender Equality” webpage, see: <http://www.ghi.gov/about/principles/194857.htm>

¹⁴ Kaiser Family Foundation analysis of funding data from ForeignAssistance.gov, accessed October 1, 2012. See Appendix I for additional data.

¹⁵ See Appendix II for additional data and sources.

¹⁶ U.S. President’s Emergency Plan for AIDS Relief, *PEPFAR: Addressing Gender and HIV/AIDS*, available at: <http://www.pepfar.gov/press/2011/157860.htm>.

APPENDIX I. TABLE 1. GHI COUNTRIES INCLUDED IN ANALYSIS: OVERVIEW OF USG GLOBAL HEALTH PROGRAM PRESENCE

REGION	COUNTRY	GHI COUNTRY PLAN STATUS				USG GLOBAL HEALTH PROGRAM PRESENCE, FY 2011				
		GHI Plus	Second Round	FP/RH	MNCH	Nutrition	HIV/AIDS	Malaria	Tuberculosis	NTDs
Africa	Democratic Republic of the Congo		X	X	X	X	X	X	X	X
	Ethiopia	X		X	X	X	X	X	X	
	Liberia		X	X	X	X	X	X	X	
	Malawi	X		X	X	X	X	X	X	
	Mozambique		X	X	X	X	X	X	X	X
	Nigeria		X	X	X		X	X	X	
	Rwanda	X		X	X	X	X	X		
	Senegal		X	X	X	X	X	X	X	X
	Tanzania		X	X	X	X	X	X	X	X
Asia	Bangladesh	X		X	X	X	X		X	X
	Cambodia		X	X	X	X	X		X	X
	Indonesia		X		X		X		X	X
	Nepal	X		X	X	X	X			X
Europe and Eurasia	Georgia		X	X	X		X		X	
Latin America and the Caribbean	Guatemala	X		X	X	X	X			

Notes: For GHI Country Plan Status, “x” indicates whether the country was selected as one of the “GHI Plus” countries, which were the first set of GHI countries to submit strategies, or included in the “second round” of countries completing strategies. For USG Global Health Program Presence, “x” indicates program operated in country during FY 2011.

Sources: U.S. Global Health Initiative, “GHI in Country,” webpage, see: <http://www.ghi.gov/country/index.htm>, accessed May 7, 2012; Kaiser Family Foundation analysis of funding data from ForeignAssistance.gov, accessed October 1, 2012; Kaiser Familiv Foundation, “Major U.S. Global Health and Related Initiatives by Country,” as of May 2012, available at: <http://www.kff.org/globalhealth/7881.cfm>.

Notes: For GHI Country Plan Status, "X" indicates whether the country was selected as one of the "GHI Plus" countries, which were the first set of GHI countries to submit strategies, or included in the "second round" of countries completing strategies. For USG Global Health Program Presence, "X" indicates program operated in country during FY 2011.

Sources: U.S. Global Health Initiative, "GHI in Country," webpage, see: <http://www.ghi.gov/country/index.htm>, accessed May 7, 2012; Kaiser Family Foundation analysis of funding data from ForeignAssistance.gov, accessed October 1, 2012; Kaiser Family Foundation, "Major U.S. Global Health and Related Initiatives by Country," as of May 2012, available at: <http://www.kff.org/globalhealth/7881.cfm>.

APPENDIX I. TABLE 2. GHI COUNTRIES INCLUDED IN ANALYSIS: FY 2011 USG GLOBAL HEALTH FUNDING BY SECTOR

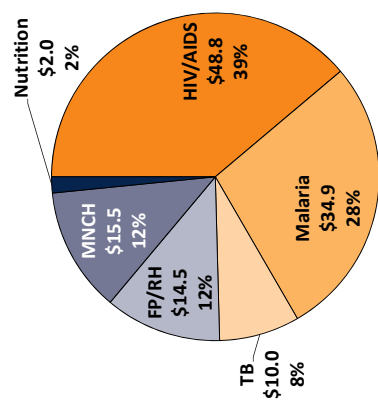
REGION	COUNTRY	FY 2011 USG FUNDING (US\$)							
		Overall	FP/RH	MNCH	Nutrition	HIV/AIDS	Malaria	Tuberculosis	Other
Africa	Democratic Republic of the Congo	125,681,000	14,471,000	15,469,000	1,996,000	48,835,000	34,930,000	9,980,000	0
	Ethiopia	395,571,000	27,943,000	20,956,000	6,685,000	289,089,000	40,918,000	9,980,000	0
	Liberia	35,140,000	6,986,000	7,984,000	998,000	5,500,000	13,273,000	399,000	0
	Malawi	114,443,000	11,677,000	8,982,000	3,992,000	61,948,000	26,447,000	1,397,000	0
	Mozambique	324,627,000	11,477,000	11,976,000	4,990,000	261,953,000	29,241,000	4,990,000	0
	Nigeria	573,198,000	25,449,000	22,954,000	0	471,227,000	43,588,000	9,980,000	0
	Rwanda	151,487,000	11,976,000	8,982,000	2,495,000	109,072,000	18,962,000	0	0
	Senegal	52,788,000	12,475,000	6,487,000	3,992,000	4,535,000	24,451,000	848,000	0
Asia	Tanzania	425,476,000	22,655,000	8,982,000	6,687,000	336,254,000	46,906,000	3,992,000	0
	Bangladesh	61,483,000	23,154,000	20,958,000	4,691,000	2,700,000	0	9,980,000	0
	Cambodia	35,460,000	4,990,000	8,982,000	998,000	15,500,000	0	4,990,000	0
	Indonesia	42,441,000	0	15,469,000	0	13,000,000	0	13,972,000	0
	Nepal	32,645,000	10,978,000	10,479,000	6,188,000	5,000,000	0	0	0
Europe and Eurasia	Georgia	8,085,000	1,520,000	3,495,000	0	850,000	0	920,000	1,300,000
Latin America and the Caribbean	Guatemala	18,068,000	6,587,000	5,988,000	3,493,000	2,000,000	0	0	0

Notes: This table reflects sources of USG funding for these programs that is specified at the country level at USAID and the Department of State and reported on ForeignAssistance.gov. This table does not include PEPFAR funding at other USG agencies, which is not reported on FA.gov, or USAID NTD Program funding data, which is not available at the country-level. Most, if not all, FY 2011 global health funding provided to these countries bilaterally was included under the GHI, with the exception of Georgia. Most of the FY 2011 global health funding for Georgia was through accounts that were not included under the GHI (e.g., Assistance for Europe, Eurasia and Central Asia Account, AEECA, and the Economic Support Fund, ESF). According to ForeignAssistance.gov, the "Other" category includes funding for addressing public health threats posed by infectious diseases not included in other categories as well as funding for non-communicable disease health threats.

Sources: KFF analysis of funding data from ForeignAssistance.gov, accessed October 1, 2012.

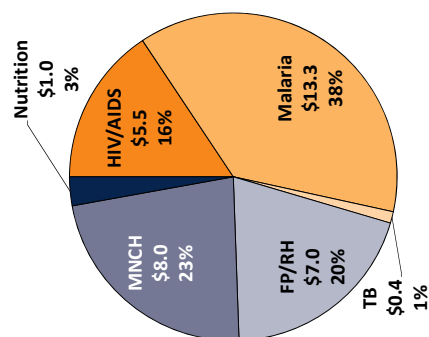
APPENDIX I. FIGURES. GHI COUNTRIES INCLUDED IN ANALYSIS: FY2011 USG GLOBAL HEALTH FUNDING BY SECTOR
(in US\$ millions)

FIGURE 1. DEMOCRATIC REPUBLIC OF THE CONGO



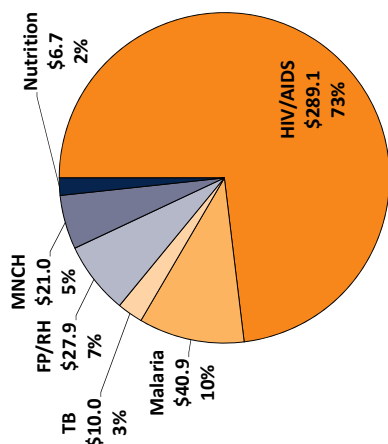
Total = \$125.7 million

FIGURE 3. LIBERIA



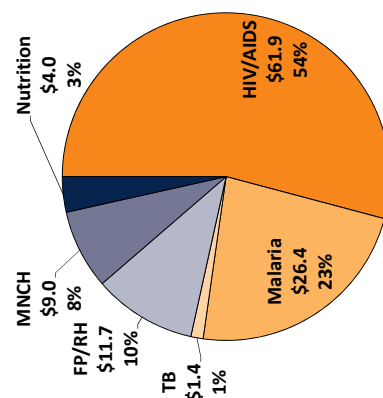
Total = \$35.1 million

FIGURE 2. ETHIOPIA



Total = \$395.6 million

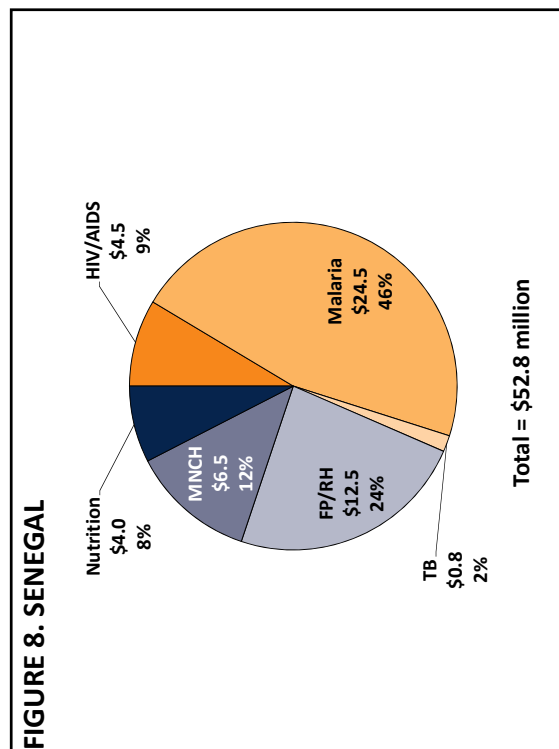
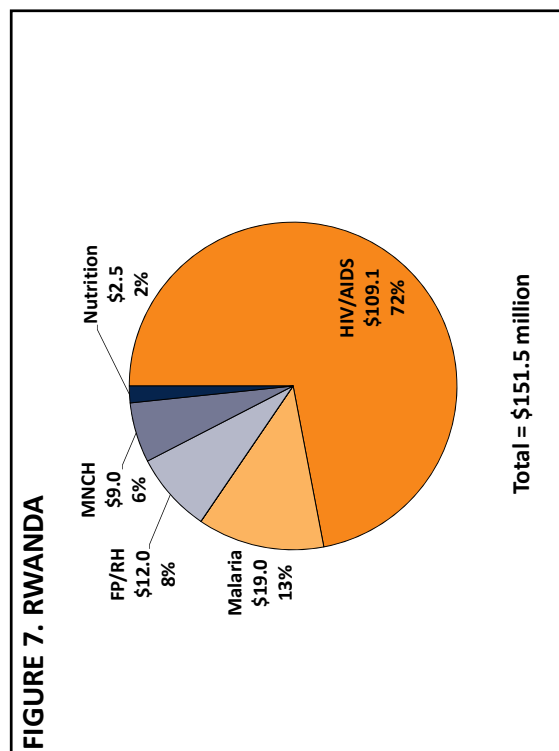
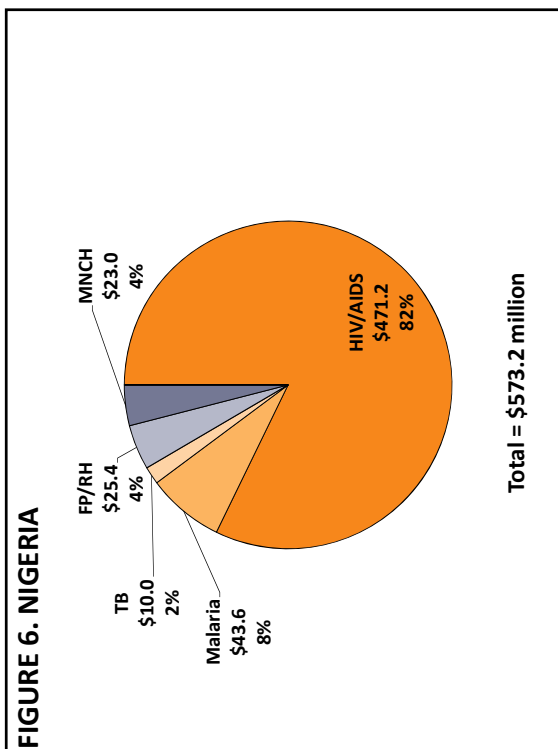
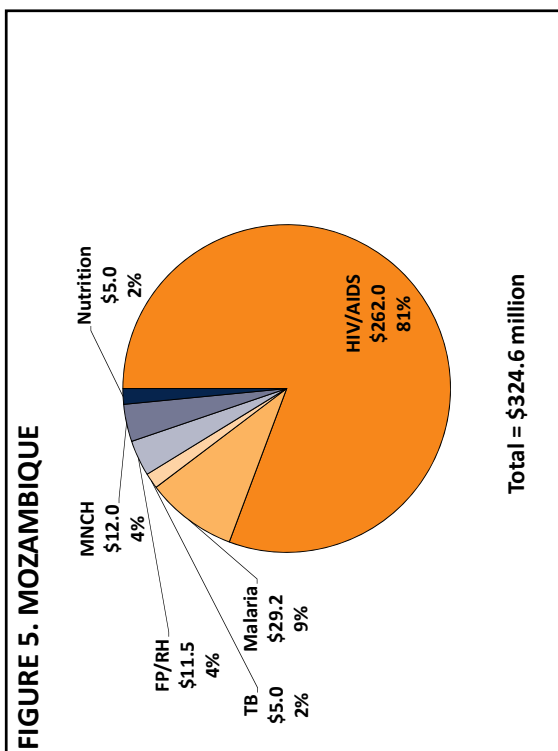
FIGURE 4. MALAWI



Total = \$114.4 million

Notes: While funding for neglected tropical diseases is included as part of the GHI, FY 2011 country-level funding is not available at this time and is not included in the total. According to ForeignAssistance.gov, the "Other" category (as seen in Georgia's funding) includes funding for addressing public health threats posed by infectious diseases not included in other categories as well as funding for non-communicable disease health threats. Data may not sum to 100% due to rounding.
Source: KFF analysis of funding data from ForeignAssistance.gov, accessed October 1, 2012.

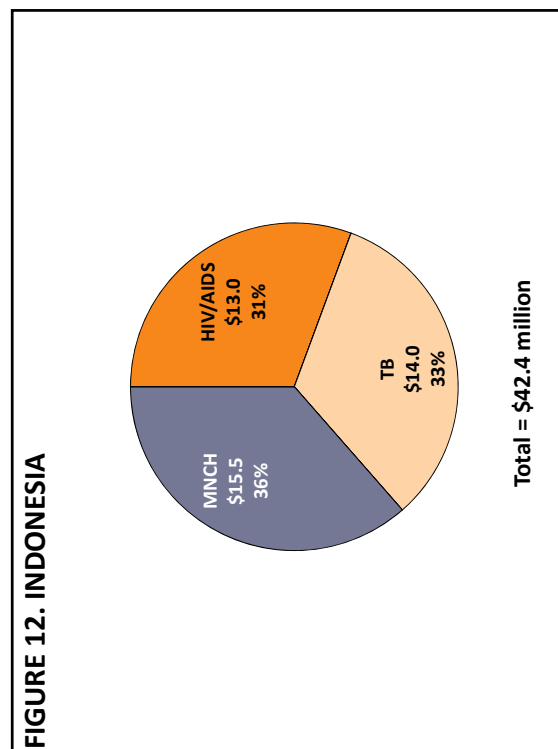
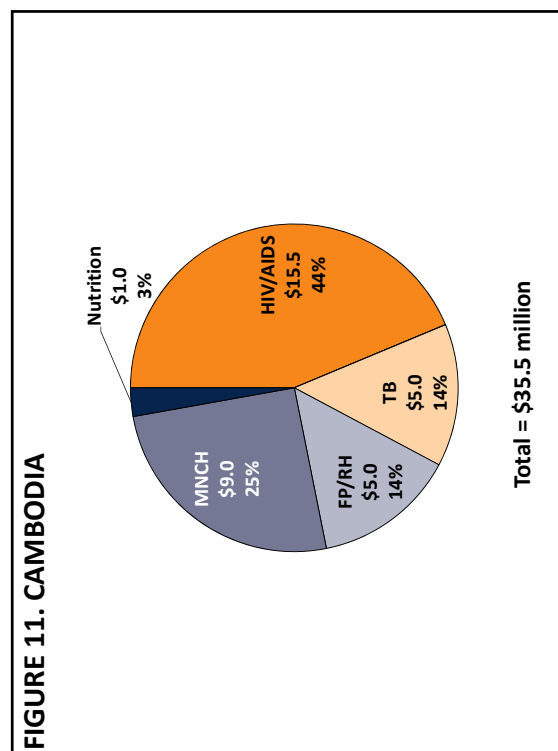
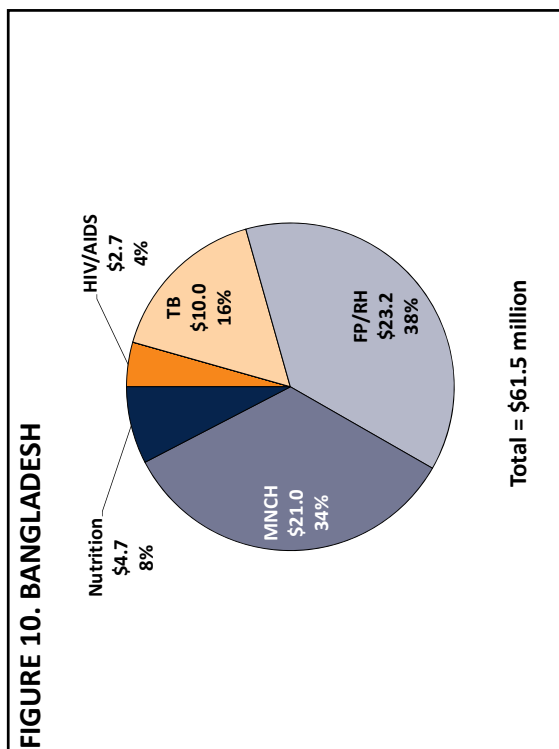
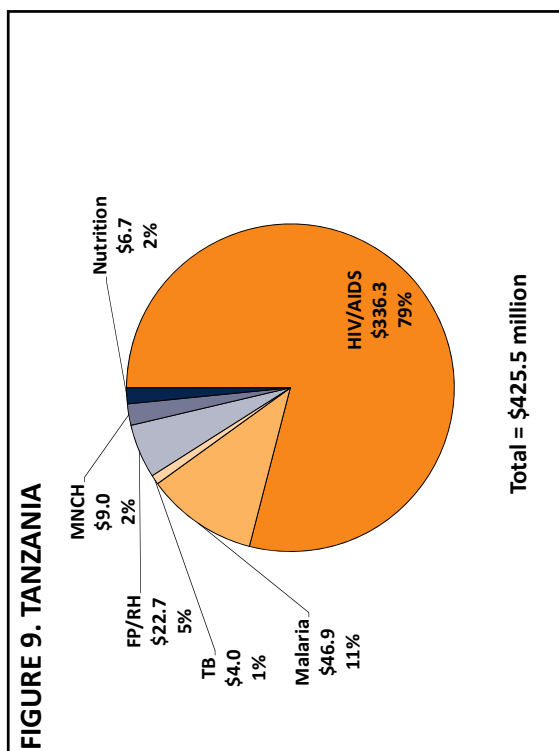
APPENDIX I. FIGURES. GHI COUNTRIES INCLUDED IN ANALYSIS: FY2011 USG GLOBAL HEALTH FUNDING BY SECTOR
(in US\$ millions)



Notes: While funding for neglected tropical diseases is included as part of the GHI, FY 2011 country-level funding is not available at this time and is not included in the total. According to ForeignAssistance.gov, the "Other" category (as seen in Georgia's funding) includes funding for addressing public health threats posed by infectious diseases not included in other categories as well as funding for non-communicable disease health threats. Data may not sum to 100% due to rounding.

Source: KFF analysis of funding data from ForeignAssistance.gov, accessed October 1, 2012.

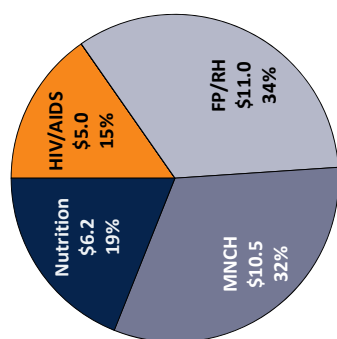
APPENDIX I. FIGURES. GHI COUNTRIES INCLUDED IN ANALYSIS: FY2011 USG GLOBAL HEALTH FUNDING BY SECTOR
(in US\$ millions)



Notes: While funding for neglected tropical diseases is included as part of the GHI, FY 2011 country-level funding is not available at this time and is not included in the total. According to ForeignAssistance.gov, the "Other" category (as seen in Georgia's funding) includes funding for addressing public health threats posed by infectious diseases not included in other categories as well as funding for non-communicable disease health threats. Data may not sum to 100% due to rounding.
Source: KFF analysis of funding data from ForeignAssistance.gov, accessed October 1, 2012.

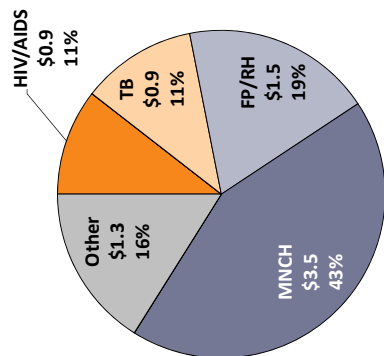
APPENDIX I. FIGURES. GHI COUNTRIES INCLUDED IN ANALYSIS: FY2011 USG GLOBAL HEALTH FUNDING BY SECTOR (in US\$ millions)

FIGURE 13. NEPAL



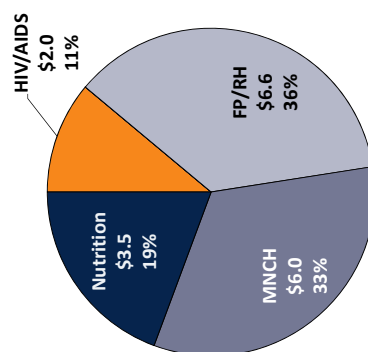
Total = \$32.6 million

FIGURE 14. GEORGIA



Total = \$8.1 million

FIGURE 15. GUATEMALA



Total = \$18.1 million

Notes: While funding for neglected tropical diseases is included as part of the GHI, FY 2011 country-level funding is not available at this time and is not included in the total. According to ForeignAssistance.gov, the "Other" category (as seen in Georgia's funding) includes funding for addressing public health threats posed by infectious diseases not included in other categories as well as funding for non-communicable disease health threats. Data may not sum to 100% due to rounding.
Source: KFF analysis of funding data from ForeignAssistance.gov, accessed October 1, 2012.

APPENDIX II. TABLE 1. GHI COUNTRIES INCLUDED IN ANALYSIS: KEY HEALTH INDICATORS

REGION	COUNTRY	MATERNAL MORTALITY RATIO 2010	ANTENATAL CARE COVERAGE (AT LEAST 4 VISITS) 2005-2011	SKILLED ATTENDANT AT BIRTH 2005-2011	UNMET NEED FOR FAMILY PLANNING 2005-2010	CONTRACEPTIVE PREVALENCE RATE 2005-2010	ADOLESCENT BIRTH RATE 2005-2010	WOMEN'S SHARE OF ADULTS LIVING WITH HIV/AIDS 2009	HIV PREVALENCE AMONG YOUNG PEOPLE AGES 15-24, BY GENDER 2009	ARV THERAPY COVERAGE AMONG HIV-INFECTED PREGNANT WOMEN AGES 15-49 ⁺ 2009-2010	
		deaths/100,000 live births	%	%	%	%	per 1,000 women, ages 15-19	%	% female	% male	estimate range %
Africa	Democratic Republic of the Congo	540	44	80	26	18	135	--	--	--	<1 - 1
	Ethiopia	350	12	10	34	15	--	--	--	--	--
	Liberia	770	66	46	36	11	--	61	0.7	0.3	29 - 53
	Malawi	460	46	71	--	41	177	59	6.8	3.1	23 - 31
	Mozambique	490	--	55	--	--	--	63	8.6	3.1	44 - 62
	Nigeria	630	45	34	20	15	123	59	2.9	1.2	7 - 10
	Rwanda	340	24	69	38	36	43	63	1.9	1.3	50 - 75
	Senegal	370	40	65	32	12	96	59	0.7	0.3	20 - 42
	Tanzania	460	43	49	22	34	116	61	3.9	1.7	52 - 68
Asia	Bangladesh	240	23	27	17	56	133	31	<0.1	<0.1	8 - 20
	Cambodia	250	59	71	25	40	--	63	0.1	0.1	17 - 40
	Indonesia	220	82	77	9	61	52	29	<0.1	0.1	5 - 15
	Nepal	170	29	36	25	48	--	33	0.1	0.2	4 - 14
Europe and Eurasia	Georgia	67	71	100	16	47	44	44	<0.1	<0.1	49 - >95
Latin America and the Caribbean	Guatemala	120	--	51	--	--	92	33	0.3	0.5	6 - 87
Global		210	55	69	11	63	50	49*	0.5*	0.3*	44 – 54 [^]

Notes: "--" indicates data is not available. * Indicates data is from 2011. [^] This indicator shows the range for the estimated percentage of pregnant women living with HIV who received antiretroviral medicine recommended by WHO for preventing mother-to-child transmission (PMTCT) of HIV. [^] Range is for all low- and middle-income countries.

Sources: WHO, et al., *Trends in Maternal Mortality: 1990 to 2010*, available at: <http://www.who.int/reproductivehealth/publications/monitoring/9789241503631/en/index.html>; WHO, *World Health Statistics 2012*, available at: http://www.who.int/gho/publications/world_health_statistics/en/index.html; UNAIDS, *Report on the Global AIDS Epidemic, 2010*, available at: http://www.unaids.org/GlobalReport/Global_report.htm;

UNAIDS, *Together We Will End AIDS, 2012*: <http://www.unaids.org/en/resources/campaigns/togetherwewillendaids/index.html>; UNAIDS, *AIDSinfo.org World Overview*, available at: <http://www.unaids.org/en/dataanalysis/datatools/aidsinfo/>; WHO/UNAIDS/UNICEF, *Global HIV/AIDS Response, November 2011*: http://www.who.int/hiv/pub/progress_report2011/en/index.html.

Notes: "--" indicates data is not available. * Indicates data is from 2011. ^ This indicator shows the range for the estimated percentage of pregnant women living with HIV who received antiretroviral medicine recommended by WHO for preventing mother-to-child transmission (PMTCT) of HIV. ^ Range is for all low- and middle-income countries.

Sources: WHO, et al., *Trends in Maternal Mortality: 1990 to 2010*, available at: <http://www.who.int/reproductivehealth/publications/monitoring/9789241503631/en/index.html>; WHO, *World Health Statistics 2012*, available at: http://www.who.int/gho/publications/world_health_statistics/en/index.html; UNAIDS, *Report on the Global AIDS Epidemic, 2010*, available at: http://www.unaids.org/GlobalReport/Global_report.htm; UNAIDS, *Together We Will End AIDS, 2012*: <http://www.unaids.org/en/resources/campaigns/togetherwewillendaids/index.html>; UNAIDS, *AIDSinfo.org World Overview*, available at: <http://www.unaids.org/en/dataanalysis/datatables/aidinfo/>; WHO/UNAIDS/UNICEF, *Global HIV/AIDS Response, November 2011*: http://www.who.int/hiv/pub/progress_report2011/en/index.html.

APPENDIX II. TABLE 2. GHI COUNTRIES INCLUDED IN ANALYSIS: OTHER KEY INDICATORS

REGION	COUNTRY	GENDER PARITY INDEX IN SCHOOL ENROLLMENT ⁺ 2010			WOMEN'S SHARE OF LEGISLATORS AND MANAGERS 1999-2008	SEATS HELD BY WOMEN IN NATIONAL PARLIAMENT 2011	PROPORTION OF YOUNG WOMEN AGED 20-24 MARRIED BY AGE 18 2000-2010	LEGAL AGE FOR MARRIAGE 1995-2007		EXISTENCE OF LEGAL PROTECTION AGAINST RAPE 2011	LEGISLATION REGARDING ABORTION 2012	EXISTENCE OF LAWS AGAINST FEMALE GENITAL MUTILATION 2008	GENDER INEQUALITY INDEX 2011	GLOBAL GENDER GAP INDEX 2011
		Primary	Secondary	Tertiary	%	%	%	Female	Male	Yes/No	Prohibited/ Restrictions/ No Restrictions^	Yes/No	Rank 1-146	Rank 1-135
Africa	Democratic Republic of the Congo	0.87	0.58	--	--	8	39	15	18	Yes	Prohibited	--	142	--
	Ethiopia	0.91	0.82	0.36	16	28	49	18	18	Yes	Restrictions in some cases	Yes	--	116
	Liberia	--	--	--	--	13	38	--	--	Yes	Restrictions in some cases	--	139	--
	Malawi	1.04	0.91	0.62	--	21	50	18	18	Yes	Restrictions in some cases	--	120	65
	Mozambique	0.90	0.82	--	--	39	52	14	16	Yes*	Restrictions in some cases	--	125	26
	Nigeria	0.91	0.88	--	--	7	39	--	--	Yes*	Restrictions in some cases	Yes	--	120
	Rwanda	1.02	1.02	0.77	--	56	13	21	21	Yes*	Restrictions in some cases	--	82	--
	Senegal	1.06	0.88	0.60	--	23	39	--	--	Yes	Prohibited	Yes	114	92
	Tanzania	1.02	--	0.82	16	36	37	18	18	Yes*	Restrictions in some cases	Yes	119	59
	Bangladesh	--	1.13	--	23	19	66	18	21	Yes	Restrictions in some cases	--	112	69
Asia	Cambodia	0.95	0.90	--	14	21	23	18	20	Yes	No Restrictions	--	99	102
	Indonesia	1.02	1.00	0.89	22	18	22	16	19	Yes	Restrictions in some cases	--	100	90
	Nepal	--	--	--	14	33	51	20	20	Yes*	No Restrictions	--	113	126
	Georgia	1.03	--	1.25	34	7	17	18	18	Yes	No Restrictions	--	73	86
Europe and Eurasia														
Latin America and the Caribbean	Guatemala	0.96	0.93	--	--	12	35	18	18	Yes*	Restrictions in some cases	--	109	112
Notes: "--" indicates data is not available. ⁺ The ratio of girls to boys (gross enrollment ratio). [*] Specifies protection against spousal rape. [^] Country prohibits abortion with no exception as to reason; permits abortion with restrictions as to reason; or permits abortion with no restrictions as to reason (however, many countries impose a limit on the period of time during which women can access the procedure). The Gender Inequality Index's highest ranking countries are where women fare equally to men in achievements along key dimensions. The Global Gender Gap Index's highest ranking countries have the smallest gaps in gender equality. Sources: Center for Reproductive Rights, <i>World's Abortion Laws 2012</i> , available at: http://worldabortionlaws.com/map/ ; U.S. Department of State, <i>2011 Country Reports on Human Rights Practices</i> , available at: http://www.state.gov/j/drl/rls/hrrpt/humanrightsreport/index.htm ; Center for Reproductive Rights, <i>Female Genital Mutilation (FGM): Legal Prohibitions Worldwide</i> , fact sheet, available at: http://reproductiverights.org/en/document/female-genital-mutilation-fgm-legal-prohibitions-worldwide ; UNICEF, <i>State of the World's Children 2012</i> , available at: http://www.unicef.org/sowc2012/statistics.php ; UN Statistics Division, available at: http://data.un.org/Default.aspx and http://unstats.un.org/unsd/demographic/products/indwm/ ; UNDP, <i>Human Development Report 2011</i> , available at: http://hdr.undp.org/en/reports/global/hdr2011/ ; World Economic Forum, <i>Global Gender Gap Report 2011</i> , available at: http://www.weforum.org/issues/global-gender-gap .														

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Sources: Center for Reproductive Rights, *World's Abortion Laws 2012*, available at: <http://worldabortionlaws.com/map/>; U.S. Department of State, *2011 Country Reports on Human Rights Practices*, available at: <http://www.state.gov/j/drl/rls/hrrpt/humanrightsreport/index.htm>; Center for Reproductive Rights, *Female Genital Mutilation (FGM): Legal Prohibitions Worldwide*, fact sheet, available at: <http://reproductiverights.org/en/document/female-genital-mutilation-fgm-legal-prohibitions-worldwide>; UNICEF, *State of the World's Children 2012*, available at: <http://www.unicef.org/sowc2012/statistics.php>; UN Statistics Division, available at: <http://data.un.org/Default.aspx> and <http://unstats.un.org/unsd/demographic/products/indwm/>; UNDP, *Human Development Report 2011*, available at: <http://hdr.undp.org/en/reports/global/hdr2011/>; World Economic Forum, *Global Gender Gap Report 2011*, available at: <http://www.weforum.org/issues/global-gender-gap>.



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