Transforming the National AIDS Response

FINANCING FOR GENDER EQUALITY IN THE HIV RESPONSE

UN WOMEN

UN Women is the United Nations organization dedicated to gender equality and the empowerment of women. A global champion for women and girls, UN Women was established to accelerate progress on meeting their needs worldwide.

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BACKGROUND AND DISCUSSION PAPERS

FINANCING FOR GENDER EQUALITY IN THE HIV RESPONSE

EXPERT GROUP MEETING
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UN WOMEN

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ACRONYMS

AGYW	Adolescent girls and young women
AIDS	Acquired Immune Deficiency Syndrome
ART	Antiretroviral therapy
ARV	Antiretroviral drugs
ASC	AIDS spending category
AWID	Association for Women's Rights in Development
CBO	Community-based organization
CEDAW	Convention on Elimination of All Forms of Discrimination Against Women
CCM	Country Coordinating Mechanisms of the Global Fund
CRS	Common reporting standard
CSAG	Civil Society Advisory Group
CSO	Civil society organization
DAC	Development Assistance Committee
DREAMS	Determined, Resilient, Empowered, AIDS-free, Mentored, and Safe
FBO	Faith-based organization
FLOW	Funding Leadership and Opportunities for Women
FSW	Female sex workers
GAM	UNAIDS Global AIDS Monitoring
GBS	Gender Budget Statement
GBV	Gender-based violence
GEM	Gender equality marker
GRB	Gender responsive budgeting
HIV	Human Immunodeficiency Virus
ICW	International Community of Women Living with HIV
ILO	International Labour Organization
IPV	Intimate partner violence
KI	Key informant
KP	Key populations
KPI	Key performance indicator
MPT	Multipurpose prevention technologies
MSM	Men who have sex with men
NACA	National AIDS Coordinating Authority
NASA	National AIDS Spending Assessment
NGO	Non-governmental organization
NSP	National HIV Strategic Plans

OECD	Organisation for Economic Co-operation and Development
OVC	Orphans and vulnerable children
PAPWC	Pan African Positive Women's Coalition
PEP	Post-exposure prophylaxis
PEPFAR	United States President's Emergency Plan for AIDS Relief
PLHIV	People living with HIV
PMTCT	Prevention of mother-to-child transmission of HIV
PrEP	Pre-exposure prophylaxis
RCNF	Robert Carr Civil Society Networks Fund
RCT	Randomized control trial
SACA	State agency for the control of AIDS
SDG	Sustainable Development Goal
SRHR	Sexual and reproductive health and rights
STD	Sexually transmitted disease
STI	Sexually transmitted infection
TA	Technical assistance
UHC	Universal health coverage
UN	United Nations
UNAIDS	Joint United Nations Programme on HIV and AIDS
UNDP	United Nations Development Programme
UNFPA	United Nations Population Fund
UNICEF	United Nations Children's Fund
UNU-IIGH	United Nations University International Institute for Global Health
UN Women	United Nations Entity for Gender Equality and the Empowerment of Women
VAW	Violence against women
VCT	Voluntary counselling and testing
VMMC	Voluntary medical male circumcision
WHO	World Health Organization
WLHIV	Women living with HIV

EXECUTIVE SUMMARY

The Expert Group Meeting on Financing for Gender Equality in the HIV Response was convened by UN Women in collaboration with the United Nations University International Institute for Global Health (UNU-IIGH) on February 5-6, 2019.

The meeting brought together key experts who have worked on: i) financing for gender equality within HIV and/or health sectors; ii) financing for gender equality more broadly; and iii) gender-responsive HIV strategies, plans, and programmes, to discuss action, research and policy priorities. Participants reviewed current experiences and existing approaches to track financing for gender equality in the HIV response; explored tools and strategies available for estimating resource needs, costing, allocating budgets, tracking expenditures, and monitoring investments towards gender dimensions of the epidemic; and reflected on the current situation of funding for the leadership and engagement of women's organizations and civil society in mobilizing on gender equality in the HIV response.

Participants agreed that little information is currently available on financing of gender-responsive HIV strategies, plans, and programmes. Specifically, it is difficult to know presently, how much funding is directed toward interventions and approaches that account for the influence of unequal gender norms on HIV risk; and/or the influence of unequal gender norms on access to HIV prevention, treatment, care and support services; as well as, working towards transforming gender norms. The lack of information points to a gap between political commitments and implementation. The inclusion of gender equality priorities in national HIV strategic plans does not automatically translate into budgetary allocations. This may be due to confusion about the influence of gender inequality on HIV outcomes; lack of gender analysis and assessments; insufficient knowledge of gender-responsive interventions; the lack of large-scale evidence on the effectiveness of gender-responsive HIV interventions in terms of HIV outcomes; lack of efforts to cost gender-responsive HIV strategies; and limited inclusion of interventions and approaches that are designed to factor in unequal gender norms and transform them.

Encouraging governments to allocate budgets for gender-responsive HIV strategies, plans and programmes, and to fund interventions and approaches that transform unequal norms while effectively achieving HIV outcomes requires time, energy, and capacity building in gender analysis and gender responsive budgeting (GRB). A potential financing strategy that warrants further consideration is cross-sectoral co-financing for gender equality, which would contribute not only to eliminating HIV but also other development priorities. To encourage sufficient HIV budget allocations for gender equality, setting financial targets for gender equality in the HIV response can be considered. Increasing the use of gender markers and expanding gender content in tools such as Global AIDS Monitoring and national AIDS spending assessments could facilitate tracking financing for gender equality interventions.

The leadership and engagement of women's organizations and civil society is critical to mobilizing and accountability for gender equality in the HIV response. However, most civil society organizations, particularly women's organizations and networks of women living with HIV, have limited access to funding, particularly long-term core funding. Such funding would enable them to shift their focus from short-term service delivery and constant fundraising to strategic planning on how to effectively respond to their constituent's needs. In addition to traditional HIV donors, women's organizations need to consider an array of funding sources, including the private sector, social investment, and crowd funding. To effectively advocate for financing for gender responsive HIV strategies, plans, and programmes, women's organizations also need strengthened capacities in programming, costing and budgeting, advocacy and negotiation skills, and monitoring investments in gender equality.

Priorities for action, research and policy

The purpose of the Expert Group Meeting was to identify action, research and policy priorities for further consideration and implementation by the partners in the HIV response, including UN agencies, governments, civil society organizations, academia, and others. Below are priorities identified by the experts as necessary to strengthening financing for gender equality in the HIV response and funding for the leadership and engagement of women's organizations and civil society in mobilizing on gender equality in the HIV response.

Four priorities that were considered fundamental to moving the agenda forward and were discussed in depth to identify specific action steps for implementation were:

- Define gender equality interventions and approaches to facilitate costing, resource estimation, budgeting, and tracking efforts. This would improve the reliability of financial tracking efforts and help focus research.
- Call attention to the gap between commitments to address the impact of gender inequality in the HIV response and funding towards their implementation, by writing an Op-ed piece or one-page summary journal article that highlights the key issues in financing for gender equality in the HIV response.
- Broaden the evidence base on effective HIV interventions for adolescent girls and young women (AGYW), including options for HIV prevention, and develop global implementation guidance to assist formulation of country strategies for addressing AGYW in the HIV response and advocate for increased funding.
- Map the funding landscape for gender equality and for women's organizations to identify new and emerging sources of funding for women's organizations and networks to support their advocacy women's needs in the HIV response.

Here below are additional areas for action and prioritization that emerged from the discussions over the two-day meeting.

Short-term priorities

- Engage in and influence in the 2020–2030 UNAIDS resource needs estimation process to increase the visibility of gender equality interventions in the estimates.
- Advocate for a Women's Rights subgroup in the UNAIDS Reference Group on Human Rights to facilitate a specific focus of the Reference group on issues of women's rights and gender equality in the HIV response.
- Advocate for the use of the revised UNAIDS Gender Assessment Tool to better understand and address gender equality dimensions in the national HIV response.
- Design a new funding mechanism to support women's organizations engage in the HIV response and consider including into the new UNAIDS investment book.
- Encourage women's organizations to take advantage of the new 70% local funding requirement of the United States President's Emergency Plan for AIDS Relief, which directs an increased proportion of program funding to local organizations, including local women's organizations.

Medium to Longer-term priorities

- Undertake research and increase the evidence base on how gender equality interventions and approaches that integrate gender dimensions can improve HIV testing, treatment, and adherence

rates and contribute to the achievement of 90-90-90 targets.
- Bring together HIV program managers and financial planners, civil society organizations (CSOs) and women's organizations, government partners, and donors at the national level to analyse and strengthen the country's financing of gender equality priorities in the HIV response
- Advocate for cross-sectoral co-financing for gender equality in the HIV response towards improving gender equality outcomes, whilst addressing structural drivers of HIV and envisioning positive outcomes across sectors (i.e. HIV, women's reproductive and sexual health, education, economic security). Co-financing provides the opportunity to achieve HIV objectives in a cost-effective manner.
- Promote efforts by implementers to undertake costing exercises for gender-responsive HIV strategies, plans and programmes.
- Advocate to national and local governments for the use of GRB in the HIV responses at national and local levels.
- Develop financial targets for gender equality interventions and approaches within the HIV response, particularly at the national and local levels.
- Develop guidance on the use of the gender equality marker specifically for the HIV response.
- Strengthen institutional capacity of CSOs in advocating for gender-responsive HIV programming, the use of GRB for HIV strategies, programmes, and plans, data collection, budget and costing skills, and monitoring and auditing financial investments in the HIV response.
- Develop standards for meaningful CSO participation to ensure that decision-making processes are inclusive and support CSOs in representing the priorities and needs of their constituents.
- Advocate with existing HIV donors to prioritize gender equality in their financing of HIV strategies and programmes.
- Explore new funding streams in the changing funding landscape, ranging from private sector corporate social responsibility to social investment.

Contributors

This document is a compilation of background and discussion papers commissioned for the UN Women Expert Group Meeting:

1. Financing Gender Equality in the Context of HIV: A Mapping of Interventions by UN Women and Other Actors, Background paper, by United Nations Entity for Gender Equality and the Empowerment of Women (UN Women)

2. Financing for Gender Equality in the HIV and Health Responses, Discussion Paper, by United Nations University – International Institute for Global Health

3. Lessons to Increase the Gender-Responsiveness of HIV/AIDS National Strategic Plans: A Qualitative Inquiry in Eswatini, South Africa, and Zambia, Background Paper, by Bergen Cooper, Center for Health and Gender Equity (CHANGE) & Jennifer Sherwood, amfAR, The Foundation for AIDS Research

4. Financing the Engagement and Participation of Women Living with HIV in the HIV and Health Response, Background Paper, by Lillian Mworeko, International Community of Women Living with HIV – Eastern Africa

5. Financing Women's Organizations & Mobilization for Gender Equality: One of the Keys to Ending AIDS, Background Paper, by Alessandra Nilo, Gestos, with Claudio Fernandes and Juliana Cesar Tavares

6. Financing the Role of Care Work Sector in the HIV and Health Response, Background Paper, by Violet Shivutse, Huairou Commission

7. Financing the Engagement and Organization of Young Women, including those Living with and Affected by HIV, in the HIV Response, Background Paper, by Unami Jeremiah

1. Financing Gender Equality in the Context of HIV: A Mapping of Interventions by UN Women and Other Actors

Background paper

United Nations Entity for Gender Equality and the Empowerment of Women (UN Women)

1.1.

INTRODUCTION

Addressing gender inequality and the structural barriers that underpin women and girls' vulnerability to HIV infection is increasingly being recognised as an essential component in efforts to eradicate HIV. In support of the *2016 United Nations General Assembly Political Declaration on HIV and AIDS*[1], commitments, policies and plans at global and national levels have integrated gender responsive measures in the continuum of HIV prevention, treatment and care.

While commitments to gender equality in the HIV response are clear, less is known about financial investments in strengthening gender equality. Are effective, gender-transformative HIV interventions being identified and costed, are they allocated a budget in the HIV program, is the funding disbursed, and are the expenditures being tracked? How is the decline in HIV funding impacting the level of funding for gender equality and the prioritization of interventions?

Participants at a 2016 *Strategy Discussion on Gender Equality and HIV/AIDS: Putting Gender Justice at the Centre of the Fast Track to End AIDS* convened by the United Nations Entity for Gender Equality and the Empowerment of Women (UN Women) identified three key challenges to gender justice in the HIV response: a) lack of resources and de-prioritization of commitments to gender equality and women's empowerment; b) an emphasis on health-systems, services, and commodities at the cost of structural and social approaches to improving gender equality; and c) a lack of sustainable funding, particularly for women's groups and caregivers.

The purpose of this paper is to contribute to the discussion on financing for gender equality in the HIV response by presenting the findings of a mapping of current efforts by UN Women and other partners, including civil society, academia, and donors. The mapping was commissioned by UN Women and prepared by Nazneen Damji, Elena Kudravtseva, Apala Guhathakurta, Niamh O'Grady and Aida Olkkonen for the Expert Group Meeting on financing for gender equality in the context of HIV. Although it is by no means a comprehensive account, it is a useful starting point for understanding what strategies are currently being used and identifying areas where work could be strengthened.

Following a brief overview of the relationship between gender equality and HIV, the findings are presented in three sections:

1. UN Women's support to gender responsive budgeting of HIV programmes and financing of interventions that strengthen gender equality interventions in the HIV context;

2. Efforts by national governments, academia, and civil society to cost, allocate, and track funding for gender equality in HIV programming; and

3. Financial support to women's organizations and networks of women living with HIV to increase gender equality and women's empowerment.

1 2016 United Nations General Assembly Political Declaration on HIV and AIDS: On the Fast Track to Accelerating the Fight against HIV and to Ending the AIDS Epidemic by 2030. Available at: https://www.unaids.org/en/resources/documents/2016/2016-political-declaration-HIV-AIDS

BOX 1

2016 United Nations General Assembly Political Declaration on HIV and AIDS: On the Fast Track to Accelerating the Fight against HIV and to Ending the AIDS Epidemic by 2030

[We] Remain deeply concerned that, globally, women and girls are still the most affected by the epidemic and that they bear a disproportionate share of the caregiving burden, note that progress towards gender equality and the empowerment of all women and girls has been unacceptably slow and that the ability of women and girls to protect themselves from HIV continues to be compromised by physiological factors, gender inequalities, including unequal power relations in society between women and men and boys and girls, and unequal legal, economic and social status, insufficient access to health-care services, including sexual and reproductive health, and all forms of discrimination and violence in the public and private spheres, including trafficking in persons, sexual violence, exploitation and harmful practices. *(A/RES/70/266, Para. 41)*

1.2.

OVERVIEW OF GENDER EQUALITY IN THE HIV RESPONSE

Vulnerability to HIV infection, access to quality treatment and care, and the consequences of HIV on a person's life are influenced by gender. **Gender** refers to the socially constructed characteristics of women and men, the normative expectations of how women and men should behave, their roles, and the distribution of power in relationships. **Gender norms** – unwritten and socially-shared rules – guide expectations about how women and men should behave, including the degree of tolerance for diversity. This includes behaviour related to sexual encounters, for example whether women and men should have access to condoms and contraceptives and be comfortable using them, and whether women and men should benefit from health services, education, and income generating opportunities. **Gender equality** in the HIV context means that society expects that women and men have equal conditions to realize their full rights and potential to be free of HIV. In most societies, however, power is unequally distributed, putting women at a disadvantage. Gender *inequality* means that women and men have unique challenges in terms of HIV prevention, treatment, and care because of gender norms.

Gender norms hinder HIV prevention by women and men. In many societies, men are expected to take risks and be in control of women, resulting in limited communication, negative attitudes towards condoms, more partners, and more alcohol abuse. Conversely, women are often expected to be obedient and passive,[2] hampering condom negotiation and safe sexual behaviour. Combined with women's biological

2 See discussion in Greig et al. (2008). Gender and AIDS: time to Act. *AIDS*, 22(Suppl 2) (August), pp. S35–S43.

and physiological vulnerability to HIV,[3] women, particularly young women, account for a high proportion of new infections. In sub-Saharan Africa, women represented 59% of new infections among adults (aged 15 and older), while adolescent girls and young women (aged 15-24 years) accounted for one in four HIV infections in 2017 despite being just 10% of the population.[4] Globally, young women aged 15-24 are twice as likely to acquire HIV as their male counterparts.[5]

Gender norms influence women's and men's HIV testing and treatment. Norms related to masculinity may discourage men from HIV testing and treatment, resulting in delayed treatment initiation and more severely compromised immune systems.[6] At the same time, women often lack authority over resources, which limits their access to services and choices for survival. Women also often face greater stigma and discrimination that push them further away from necessary and lifesaving services and increase their vulnerability to violence. AIDS-related illnesses are the leading cause of death among 15-49 years-old females globally.[7]

3 Studies of sero-discordant couples have found that women have upward of twice the probability of infection if exposed to HIV e.g. Nicolosi A, Corrêa Leite ML, Musicco M, Arici C, Gavazzeni G, Lazzarin A. (1994). The efficiency of male-to-female and female-to-male sexual transmission of the Human Immunodeficiency Virus: a study of 730 stable couples. *Epidemiology*, Vol. 5, No. 6, pp. 570-5.

4 UNAIDS. (2018). Global AIDS Update: Miles to Go, Closing Gaps, Breaking Barriers, Righting Injustices. UNAIDS/JC2924.

5 UNAIDS. (2018). *Women and Girls and HIV*. Geneva: UNAIDS.

6 Braitstein P et al. (2008). Gender and the use of antiretroviral treatment in resource-constrained settings: Findings from a multicenter collaboration. *J Women's Health*, Vol. 17, No. 1 (Jan-Feb), pp. 47-55.

7 UNAIDS. (2018). *Women and Girls and HIV*. Geneva: UNAIDS.

Strategies to address gender inequality within the HIV context are not the same as strategies to address HIV among women (or men, for that matter). For example, although prevention of mother to child transmission (PMTCT) targets women, it does not shift gender norms merely by being available. Health services that are offered to women, such as voluntary counselling and testing (VCT), antiretroviral therapy (ART), and PMTCT, however, can be used to strengthen gender equality if they are designed to be gender-responsive. Similarly, services can support men in redefining expectations for masculine behaviour. For example, the Vezimfihlo! Project in South Africa equipped counsellors who worked in VCT settings to address gender issues and particularly gender-based violence (GBV).[8]

Shifting gender norms requires work on several inter-locking levels: individual, social, and structural. Programmes that engage a range of people at multiple levels are more effective than programmes that only work on one level.[9] For example, individual knowledge of condom use also requires negotiation about their use and the availability of condoms. Examples of proven HIV interventions that strengthen gender equality are described below.[10]

8 Jewkes R, Christofides N, Mooideen V, Ngobeni R. (2007). *Vezimfihlo! A training manual for addressing gender-based violence in VCT*. Pretoria: Medical Research Council.

9 Yaker R. (2017). *Background Paper: Identifying and Describing Approaches and Attributes of Normative Change Interventions*. Washington DC: Institute for Reproductive Health, Georgetown University.

10 The list draws on the summary table provided by Remme et al. (2014). Cost and cost-effectiveness of gender-responsive interventions for HIV: a systematic review. *Journal of the International AIDS Society*, Vol. 17, No. 19228.

1.2.1
Individual knowledge, skills, and self-agency

On the individual level, factors such as age, sex, race and ethnicity, knowledge, attitudes, values, beliefs, self-efficacy, and skills influence a person's beliefs and expectations about women and men in relation to sexual behaviour, health-seeking behaviour etc. Interventions that increase awareness of the role of gender in sexual and reproductive health behaviours and support women and men to develop relationships based on gender equality can increase safer sex and reduced sexually transmitted infections (STIs) and HIV. Education in a group setting targets both individuals and their social networks.

- **Health education on gender and HIV:** Learning about the implications of gender norms through individual and group education can help women and men take action to remain healthy. For example, individual and small-group education for married women on sexual communication and empowerment reduced the rate of reported unprotected sex in India by 17%.[11] Group education sessions for young men in India doubled partner communication about condoms, sex, STIs, and/or HIV and condom use.[12] Two-hour education sessions to female sex workers in Armenia on gender empowerment and self-efficacy doubled consistent condom use.[13]
- **Curriculum-based sexuality and HIV education addressing gender and power:** Young people are often effectively reached with education on the links between gender and health through school-based educational interventions. A review of 22 studies found that that 80% of interventions that addressed gender or power were associated with a significantly lower rate of STIs or unintended pregnancy (compared to 17% of those that did not).[14] A curriculum-based intervention on gender norms and HIV in Tanzania increased young men's seeking of HIV testing by 30% and young women's condom use by 10% and HIV testing by 20%.[15]

11 Raj A, Saggurti N, Battala M, Nair S, Dasgupta A, Naik DD, et al. (2013). Randomized controlled trial to test the RHANI Wives HIV intervention for women in India at risk for HIV from husbands. *AIDS Behav*, Vol. 17, No. 9, pp. 3066-80.

12 Verma R, Pulerwitz J, Mahendra VS, Khandekar S, Singh A, Das S, et al. (2008). *Promoting Gender Equity as a Strategy to Reduce HIV Risk and Gender-Based Violence Among Young Men in India. Horizon Final Report*. Washington, DC: Population Council.

13 Markosyan K, Lang DL, Salazar LF, DiClemente RJ, Hardin JW, Darbinyan N, et al. (2010). A randomized controlled trial of an HIV prevention intervention for street-based female sex workers in Yerevan, Armenia: preliminary evidence of efficacy. *AIDS Behav*, Vol. 14, No. 3, pp. 530-7.

14 Haberland N (2015). The case for addressing gender and power in sexuality and HIV education: a comprehensive review of evaluation studies. *International Perspectives on Sexual and Reproductive Health*, Vol. 41, No. 1, pp. 311-51.

15 Magige H, Manaku N, Schueller J, Ricardo C. (2008). Transforming Gender Relations to Promote Youth HIV Prevention in Tanzania. Abstract TUPE0701. XVII International AIDS Conference. Mexico City, Mexico. Aug. 3–8.

1.2.2
Social networks and communities

On the social level, interpersonal relationships and community dialogue on the desired characteristics of women and men and how women and men should behave can either promote health and well-being or be a source of stigma. Support from peers and others people look up to (also defined as the reference group[16]) encourages women and men to prevent HIV and to seek treatment and care.

- **Couples counselling:** When men are involved in learning about HIV at the same time as their female partners, they are able to support their partners in protecting their health. For example, as a result of male involvement through couple counselling, HIV-1-seropositive women were 3 times more likely to return for Nevirapine and to report administering Nevirapine at delivery in Kenya.[17] In Tanzania, HIV-seropositive women whose partners attended counselling were three times more likely to use Nevirapine prophylaxis, four times more likely to avoid breastfeeding and six times more likely to adhere to the infant feeding

16 For further reading on tackling the structural drivers of HIV through social norms, see Cislaghi B and Heise L (2018) STRIVE Technical Brief: Social Norms. London: London School of Hygiene & Tropical Medicine.

17 Farquhar C, Kiarie JN, Richardson BA, Kabura MN, John FN, Nduati RW, et al. (2004). Antenatal couple counseling increases uptake of interventions to prevent HIV-1 transmission. *J Acquir Immune Defic Syndr*, Vol. 37, No. 5, pp. 1620-6.

method selected than those whose partners did not attend.[18]

- **Peer education and support:** Social support from peers and friends helps reinforce the practice of healthy behaviours by women and men. Self-help groups in Vietnam for HIV positive mothers increased the number of women receiving ART from 1 in 9 to 15 in 15.[19] The use of peer educators increased the proportion of female sex workers in India reporting 100% condom use by 39% in 15 months (compared to 11% in the control group).[20]
- **Community mobilization:** Interventions that support community dialogue around gender and HIV can shift social and gender norms to be more supportive of the health of women and girls. In Uganda, the SASA! Project engaged communities in dialogue around gender norms, reducing the odds of sexual concurrency reported by men by 43% and women experiencing intimate partner violence by 52%.[21] In India, dialogue between policy makers, police officers, human rights lawyers and journalists with female sex workers improved understanding between these groups and decreased experiences of violence by the sex workers by 30%.[22]
- **Mass media:** Radio and television shows, print materials, and social media can stimulate discussion about the impact of gender norms on health, challenging people to change harmful behaviours. For example, in South Africa 38% of people exposed to Soul City's integrated health messages including GBV and HIV through three media channels reported 100% condom use, compared to 6% in the control group.[23] Exposure to the Straight Talk campaign in Uganda was associated with greater girls' self-assuredness, sense of gender equity, and the likelihood of having a boyfriend but not having a sexual relationship; and lower likelihood of boys' sexual activity, greater likelihood of resuming abstinence and of taking relationships with girls seriously.[24]

18 Msuya SE, Mbizvo EM, Hussain A, Uriyo J, Sam NE, Stray-Pedersen B. (2008). Low male partner participation in antenatal HIV counselling and testing in northern Tanzania: implications for preventive programs. AIDS Care, Vol. 20, No. 6, pp. 700-9.

19 Nguyen TA, Oosterhoff P, Ngoc YP,Wright P, Hardon A. (2009). Self-help groups can improve utilization of postnatal care by HIV-infected mothers. *J Assoc Nurses AIDS Care*, Vol. 20, No. 2, pp. 141-52.

20 Basu I, Jana S, Rotheram-Borus MJ, Swendeman D, Lee SJ, Newman P, et al. (2004). HIV prevention among sex workers in India. *J Acquir Immune Defic Syndr*, Vol. 36, No. 3, pp. 845-52.

21 Abramsky T, Devries K, Kiss L, Nakuti J, Kyegombe N, Starmann E, et al. (2014). Findings from the SASA! Study: a cluster randomized controlled trial to assess the impact of a community mobilization intervention to prevent violence against women and reduce HIV risk in Kampala, Uganda. *BMC Med*, Vol. 12, No. 122.

22 Beattie TS, Bhattacharjee P, Ramesh BM, Gurnani V, Anthony J, Isac S, et al. (2010). Violence against female sex workers in Karnataka state, south India: impact on health, and reductions in violence following an intervention program. *BMC Public Health*, Vol. 10, No. 476.

23 Goldstein S, Usdin S, Scheepers E, Japhet G. (2005). Communicating HIV and AIDS, what works? A report on the impact evaluation of Soul City's fourth series. *J Health Commun*, Vol. 10, No. 5, pp. 465-83.

24 Adamchak S, Kiragu K, Watson C, Muhwezi M, Nelson T, Akia-Fiedler A, Kibombo R, Juma M. (2007). *The Straight Talk Campaign in Uganda: Impact of Mass Media Initiatives, Summary Report. Horizons Final Report*. Washington, DC: Population Council.

1.2.3
Structures: services, infrastructure, livelihoods

On the structural level, services, infrastructure, livelihoods, policies and laws, etc. shape the HIV context in different ways for women and men. Access to education and livelihoods, for example, expands the choices that women and men have to improve their lives and empowers them to care for their health, including by preventing HIV or seeking treatment and care.

- **Female condoms:** An analysis of five randomized controlled trials on the effectiveness of the female condom found that the availability of female

condoms increased the number of protected sex acts.[25] For example, adding female condoms to a male condom promotion and distribution peer education programme in Kenya increased consistent condom use among female sex workers by 70%.[26]

- **Formal education/literacy:** An educated woman has the skills, information, and self-confidence to protect her health. Women with some schooling are nearly five times as likely as uneducated women to have used a condom the last time they had sexual intercourse. Literate women are three times more likely than illiterate women to know preventive behaviours.[27]
- **Cash transfers:** Direct transfer of money to targeted groups aim to reduce poverty and vulnerability; conditional cash transfers set certain requirements to participation, such as school enrolment. Most studies on cash transfers have found positive effects on sexual behaviours, with programmes more effective among young women.[28] Cash transfers or material support to schoolgirls reduced HIV prevalence by 64% in Malawi.[29]
- **Microfinance:** Small loans to the poor allows people to pursue entrepreneurial projects that generate income. For some women who are struggling to survive, the loans provide an alternative to sex work. Young women participating in a microfinance scheme in rural South Africa were 64% more likely to have accessed VCT and 24% less likely to have had unprotected sex at last intercourse with a non-spousal partner.[30] Women with longer microfinance experience in Haiti were 72% less likely to report partner infidelity and 3.95 times more likely to use condoms with an unfaithful partner.[31]

Evidence of the effectiveness of HIV interventions in strengthening gender equality is clear, and has been recognized in international and national policies, commitments, and plans. Despite these commitments, funding for interventions to advance gender equality within HIV programming is limited. The following sections examine what the UN Women and other partners are doing to improve financing for gender equality in the context of HIV. Efforts include building capacity in gender responsive budgeting (GRB); advocacy for increased budgets for gender-responsive HIV interventions; financing civil society, including women's organizations and networks of women living with HIV; creating spaces for policy dialogue; calling for improved costing of gender-responsive HIV interventions; and assessing and tracking HIV budget allocations for gender equality interventions.

25 Vijayakumar G, Mabude Z, Smit J, Beksinska M, Lurie M. (2006). A review of female-condom effectiveness: patterns of use and impact on protected sex acts and STI incidence. *Int J STD AIDS*, Vol. 17, No. 10, pp. 652-9.

26 Thomsen SC, Ombidi W, Toroitich-Ruto C, Wong EL, Tucker HO, Homan R, et al. (2006). A prospective study assessing the effects of introducing the female condom in a sex worker population in Mombasa, Kenya. *Sex Transm Infect*, Vol. 82, No. 5, pp. 397-402.

27 Global Campaign for Education. (2004). *Learning to Survive: How Education for All Would Save Millions of Young People from HIV/AIDS*. Johannesburg: Global Campaign for Education.

28 Pettifor A, MacPhail C, Nguyen N, Rosenberg M. (2012). Can money prevent the spread of HIV? A review of cash payments for HIV prevention. *AIDS Behav*, Vol. 16, No. 7, pp. 1729-38.

29 Baird SJ, Garfein RS, McIntosh CT, Ozler B. (2012). Effect of a cash transfer programme for schooling on prevalence of HIV and herpes simplex type 2 in Malawi: a cluster randomised trial. *Lancet.*, Vol. 379, No. 9823, pp. 1320-9.

30 Pronyk PM, Kim JC, Abramsky T, Phetla G, Hargreaves JR, Morison LA, et al. (2008). A combined microfinance and training intervention can reduce HIV risk behaviour in young female participants. *AIDS*, Vol. 22, No. 13, pp. 1659-65.

31 Rosenberg MS, Seavey BK, Jules R, Kershaw TS. (2011). The role of a microfinance program on HIV risk behavior among Haitian women. *AIDS Behav*, Vol. 15, No. 5, pp. 911-8.

1.3.

UN WOMEN'S EFFORTS TO SUPPORT FINANCING FOR GENDER EQUALITY IN THE CONTEXT OF HIV

1.3.1 Introduction

This section maps the work that UN Women has been doing in the area of financing for gender equality in the context of HIV, in order to better understand the substance and scope of UN Women's work. The mapping employed a mixed method methodology, combining qualitative (interviews) and quantitative (document review) methods through primary and secondary data collection methods. Secondary data entailed a literature review of relevant background documents on UN Women's work on financing gender equality in the HIV response. Primary data included interviews with key informants involved in UN Women interventions in Rwanda and Nigeria. The purpose of these interviews was to triangulate data from the secondary source analysis, and to gather updates on any work not captured in the documentation.

The desk review and the subsequent interviews were informed by overarching questions designed to elicit specific details about examples of relevant activity in the area of financing gender equality in the context of HIV. The underlying research questions covered the range of UN Women interventions that feature financing for gender equality in the context of HIV, the results achieved, and the strategies employed in these interventions.

1.3.2 UN Women interventions on financing for gender equality in the HIV context

This mapping will outline what the UN Women is doing at a substantive level to improve financing for gender equality in the context of HIV. However, it is important to note from the outset, that the vast majority of field-based examples collected are contributing to multiple areas of gender equality in the context of HIV and are not specifically limited to financing for gender equality and HIV in isolation. For example, the capacity strengthening of government officials on budgeting for gender equality and HIV will have wider effects beyond increased knowledge and understanding of GRB. This suggests that interventions were designed with a view to providing holistic responses to the array of obstacles to gender equality and the empowerment of women and girls in the context of HIV.

Working across such a broad spectrum requires UN Women at country level to respond to both the needs of the women living with HIV and the need for programming that supports increased resources

for gender equality and HIV. It should also be noted that all of the work that will be detailed here builds on earlier UN Women interventions. The foundations of this work were already in place, created by a long history of awareness-raising, advocacy, technical support and capacity-building at a basic level and capacity-strengthening at a more advanced level to both duty-bearers and rights-holders. For example, in Rwanda, UN Women has had a long-term focus on GRB.

UN Women has taken varied approaches to financing for gender equality in the context of HIV. The interventions reviewed can be seen as falling into three categories, which can form the basis for a typology of interventions – see Table 1 below. The bibliography describes the documents reviewed for each country. Section 1.3 gives a broad outline of the range of approaches undertaken by UN Women.

TABLE 1

Typology of interventions undertaken by UN Women

Typology of interventions	Countries
Support to government to include resourcing for gender equality in national plans on HIV	Rwanda Nigeria
Evidence generation and research to inform policy-influencing and advocacy	**Asia and the Pacific:** Cambodia, Indonesia and Thailand **Latin America and the Caribbean:** Argentina, Bolivia, Brazil, Colombia, Costa Rica, Haiti, Honduras, Mexico, Nicaragua, Peru, and Uruguay Vietnam
Support to women living with HIV (WLHIV) organisations to access financing for gender equality	Uganda Zimbabwe

1.3.2.1 Rwanda

The programme **Supporting Gender Equality in the Context of HIV/AIDS 2009 and 2013** was jointly funded by the European Commission and UN Women and was implemented in five countries (Cambodia, Jamaica, Kenya, Papua New Guinea, and Rwanda).

The objectives of the programme were:

1. Ensuring that organisations of WLHIV and women affected by HIV/AIDS provide leadership for and influence the shaping of policies, programmes, and resources allocation that address the HIV/AIDS epidemic in the five selected countries; and

2. Enhancing national commitment to and action for addressing gender equality in the national AIDS response in the five selected countries. The programme worked with national AIDS coordinating agencies (NACA) and civil society organisations, including organisations and networks of women living with HIV.

It is important to note that while the programme had broader objectives, this paper will only focus on the aspects of the programme that relate to financing for gender equality in the context HIV, particularly in Rwanda, where there were significant results with regard to GRB and HIV.

The programme supported GRB initiatives in Cambodia, Jamaica, and Rwanda, (e.g. training on GRB for NACA, gender analysis of the NACA budget, development of a GRB tool). Additionally, UN Women also produced a Policy Guide, '*Budgeting for Gender Equality Outcomes in the HIV Response*,' with

BOX 2

What is a gender-responsive budgeting initiative?

A gender responsive budgeting initiative does not aim to produce a separate budget for women. Instead it aims to analyse any form of public expenditure, or method of raising public money, from a gender perspective, identifying the implications and impacts for women and girls as compared to men and boys. The key questions are: What impact does this fiscal measure have on gender equality? Does it reduce gender inequality, increase it, or leave it unchanged?

The focus on gender inequality can be structured so as to take account of other forms of inequality, such as class, race and religion. The key question might be reformulated as: Does this fiscal measure improve, worsen, or leave unchanged the position of the most disadvantaged women?

A gender budget initiative always involves a gender analysis of some dimension of raising and use of public money. But there is no single way of doing this, and a number of analytical tools can be used.* The implementation of the initiative can take several forms, depending on its political location, the extent of coverage and the stage of the budget cycle at which it is undertaken. Similarly, the findings and results can be presented in different ways, depending on the objective they are meant to achieve.

Source: UNIFEM (now part of UN Women) 2002. Gender Budget Initiatives: Strategies, Concepts and Experiences.

* Elson, Diane. (1998). 'Integrating Gender Issues into National Budgetary Policies and Procedures: Some Policy Options,' Journal of International Development 10, pp.929-41; Budlender, Debbie and Rhonda Sharp. 1998. How to Do a Gender-Sensitive Budget Analysis: Contemporary Research and Practice. Sydney: Commonwealth Secretariat/Australian Agency for International Development.

the objective of sensitizing stakeholders – including donors and NACAs – to the merits of GRB, as well as to propose a set of simple yet comprehensive guidelines that can help design and steer sustainable gender responsive initiatives in HIV policies and budgets. The programme in Rwanda built on a previous UN Women programme on integrating GRB in Rwanda, which was piloted with five ministries.

Rwanda's *National Accelerated Plan for Women, girls and gender equality and HIV 2010-2014* contained recommendations that specific interventions for promoting gender equality in the HIV response be matched with corresponding budgets. However, as a standalone plan, monitoring, evaluation and expenditure tracking for gender equality was not incorporated into existing HIV monitoring and evaluation structures and required additional, ad hoc efforts. The mid-term review of the *National Strategic Plan on HIV and AIDS 2009-2012* noted that very little data existed on resource allocation from a gender perspective and recommended that national and international partners conduct gender responsive budgeting of HIV interventions in order to determine and remediate issues with budget inequality relative to need.

UN Women worked with high level officials in the Ministry of Finance and Economic Planning to train Rwanda Biomedical Centre (RBC) staff on GRB. Additionally, UN Women Rwanda, RBC and the Institute of HIV/AIDS, Disease Prevention and Control (IHDPC) commissioned a study to analyse the HIV and AIDS resource allocations for 2006-2009 to use as a baseline and a lesson to improve the gender-equitable resource distribution during the *National Strategic Plan 2009-2012 on HIV and AIDS*. Based on the findings of the research, context specific GRB tools and strategies were developed. This also included a capacity development strategy for NACA representatives with the objective to equip them with the knowledge and skills in identifying, implementing and allocating resources to effectively address gender priorities within the national HIV response. The GRB

BOX 3

Results in Rwanda

As a result of this programme, HIV was one of the components covered in the health budget statements submitted along with the budget to parliament in 2011, 2012, and 2013.

for HIV exercise analysed expenditures in all HIV and AIDS programmatic areas (i.e. prevention, care, treatment and support, impact mitigation, monitoring and evaluation, coordination and capacity building) using a gender lens. The time period under which these parameters were investigated and analysed was 2006-2009. The methodology also included a mapping of organisations that were part of the HIV subsector. The GRB approaches and tools were used as the instruments against which these parameters were examined.

A GRB action plan was subsequently developed and this included the methodology and tools to help integrate GRB in the national HIV response. The uniqueness of this initiative was that it proposed a 'six step GRB tool'[32] that covered the entire HIV planning continuum. This tool is a synthesis of popular international tools[33] on GRB and is contextualized to the Rwandan HIV context. According to the researchers, this tool is inclusive as it enables tracking the achievements of GRB in HIV programmes and funds.

The final evaluation of the programme found that it had influenced government resource allocations that supported gender equality and human rights in several of the NACAs in the programme countries. For example, in Papua New Guinea and Cambodia, the NACAs continued to fund training activities started by the programme. In Rwanda, resources were allocated by RBC/IHDPC to keep the gender advisor position. The evaluators noted that the context allowed for implementation of gender-responsive budgeting in Rwanda,[34] because the country had a wealth of experience in this area from which it could draw.

UN Women, in collaboration with humanitarian actors especially, UNCHR, Ministry in charge of refugees, Ministry of Gender and Family Promotion, Gender Monitoring Office, local and international NGOs, has spearheaded gender needs assessment in six refugee camps in Rwanda[35]. The aim of the assessment was to provide a sound gender baseline that would inform gender equality programming and policy and operational decisions of humanitarian actors. The assessment focused on eight dimensions that encompass HIV/AIDS, including health. The findings showed differences between women and men in reception of HIV and care support at the health facilities in the six camps. For example, there were 2.5 to 3 times more women than men receiving HIV care and support, and 2 to 7 times more women than men identified with sexually transmitted infections. The availability and use of services for antenatal care and prevention of mother-to to-child transmission of HIV offered at these facilities enabled detection of HIV and other sexually transmitted infections among refugee women. In addition, sensitisation and awareness activities were conducted by community workers and peer educators, and World AIDS day was commemorated in all camps and urban areas (2016). Direct support was also provided by the World Food Programme through general distribution including food and cash-based transfers to refugees, especially supplementary feeding to 1,414 people living with HIV and AIDS.

In the context of GBV prevention and response, UN Women has supported the scale up and establishment

32 Step 1: Gender analysis of the situation of men and boys, women and girls; Step 2: Gender aware policy appraisal; Step 3: Gender disaggregated beneficiary analysis; Step 4: Gender Responsive Budget Statement; Step 5: Gender disaggregated budgetary expenditure analysis; Step 6: Gender disaggregated expenditure incidence analysis.

33 GRB initiative developed by experts in GRB from South Africa, Australia and the UK, especially under the Commonwealth Secretariat (CommSec) pilot project.

34 End of Programme Evaluation of the European Commission-UN Women programme 'Supporting Gender Equality in the Context of HIV/AIDS'. Available at: https://gate.unwomen.org/Evaluation/Details?evaluationId=4743

35 Ayoo Osen Odicoh. (2016). Consolidated Report: Inter-Agency Gender Assessment of Refugee Camps in Rwanda. UNHCR, MIDIMAR, UN Women. Available at: https://www.unhcr.org/rw/wp-content/uploads/sites/4/2017/06/Final-Report-IAGA.pdf

of 23 Isange One Stop Centres (IOSCs)[36] countrywide providing comprehensive support to GBV victims including medical, psychological, forensic/investigative, judicial and legal assistance under one roof to avoid re-victimization. From June 2014 to the end of 2016, 12,289 victims of GBV and child abuse received comprehensive assistance through the 23 IOSCs. The medical assistance available included provision of post-exposure prophylaxis kits and HIV post-exposure prophylaxis within 48 hours, screening for and treatment of sexually transmitted infections, provision of emergency contraception, treatment of injuries and other conditions as required.

36 UN Women. (2016). Isange One Stop Center: Comprehensive and Multi-Sectoral Approach to Gender Based Violence and Child Abuse.

2018 Update

The promotion of gender equality remained a priority in the subsequent Rwanda *HIV and AIDS National Strategic Plan 2013–2018*. The principles outlined in the gender and HIV strategy adopted in 2010 and operationalized in the *National Accelerated Plan for Women, Girls, Gender Equality and HIV 2010–2014* were integrated in this national strategic plan.

In a context characterised by limited funding, UN Women has continued to support the leadership and participation of women living with HIV through initiatives ensuring their meaningful participation in decision-making that affects their lives. Recently, this has included restructuring the Rwanda Network of People living with HIV (RRP+) to include women throughout the organisation, at Board level, and in the creation of a gender unit. UN Women has also supported capacity building for Board members and primary cooperatives and the functioning of the gender unit. UN Women has also supported the Rwandan chapter of the Pan African Positive Women's Coalition (PAPWC), an advocacy platform for African women and girls living with HIV, to develop their strategic plan 2017-2021 which includes actions on organizational resource mobilisation that will target both local, government and external sources of funds and other resources. Finally, UN Women has shared tools for mainstreaming gender equality and HIV into plans and budgets with key stakeholders.

1.3.2.2 Nigeria

In 2015, NACA with the support of UN Women, the Joint United Nations Programme on HIV/AIDS (UNAIDS) and the United Nations Development Programme (UNDP) implemented a project titled **Institutional Strengthening for Enhanced Gender Responsive HIV Response in Nigeria.** The goal of this initiative was to strengthen institutional mechanisms for strategic integration of gender mainstreaming in the national, state level (5 states) and institutional responses to HIV and AIDS in Nigeria. The project also empowered social movements of women living with or affected by HIV and men's groups to effectively advocate for inclusion of their priorities in HIV plans, strategies and budgets. The second phase of the project expanded on gains of the 2015 project, but with a focus on women and girls, especially vulnerable ones, and their access

BOX 4

Results in Nigeria

- Analysis of gender responsiveness of HIV budgets and plans
- Communication tools for GRB in the HIV response
- Two gender and human rights responsive trainings reaching NACA staff, staff of the Federal Ministry of Health, Women Affairs, Budget and Planning, Ministry of Justice, Ministry of Finance, Human Rights commission, Nigerian Police Service, Prisons Services, SACAs of the Federal Capital Territory, Benue and Kogi States, networks of women and young people living with HIV and civil society organisations like FIDA and NINERELLA.

to HIV prevention, treatment, care and support programmes. The aim was to ensure that NACA and state agencies for the control of AIDS (SACA) have the institutional capacity to develop gender responsive HIV plans and budgets by undertaking a gender analysis of national plans and budgets on HIV, develop road maps for gender budgeting and capacity building of various stakeholders on the implementation of the road map, among other activities.

The budgets of NACA and Benue SACA for 2016 were reviewed along with some of the policies that guided the national response. A situation analysis was also conducted to set a proper context for advocating for the adoption of GRB as a viable strategy. The gender equality-related interventions in the budgets were identified and the percentage value of the allocated funds for such interventions as well as the actual released funds were determined.

The gender analysis found that the budget allocated to gender equality related interventions in the national HIV response was less than 1% of NACA budget. Furthermore, the allocated resources were not actually released.[37] This limited the ability to conduct activities that would address gender inequality pertaining to the HIV response. Furthermore, the analysis concluded that there were significant gaps in tracking mechanism for GRB amongst other gender equality and women empowerment tools in the national HIV/AIDS response.[38]

The NACA assessments in this project found that key government officials, with the power to prioritise resources into activities that would impact women and facilitate increased access to services for women, had limited knowledge of GRB.

Following the involvement and engagement of stakeholders[39] throughout the entire process, and as part of the technical oversight and coordination for gender mainstreaming in the national HIV/AIDS response, the national technical team is providing ongoing mentoring support and supervision to planning and budgeting unit within NACA and other relevant institutions to promote provision of gender responsive HIV services. This supportive process will include ongoing mentoring of focal persons in the MDAs, capacity building for various levels of relevant decision-making actors, and periodic visits and hands-on training where necessary. Strategic communication methods would also be used to compile, document and disseminate information on best practices.

The engagement with the Strategic Knowledge Management Department of NACA will also be strengthened through continuous technical support for review meeting, data collection and validation to ensure gender and human rights are not left out of the national HIV information management system and the national AIDS spending assessment (NASA).

37 National Agency for the Control of AIDS. (2016). Promoting Gender Responsive Budgeting in the National Response on HIV and AIDS in Nigeria: Analysis of Gender Equality-Related Components of Budgets of NACA & Benue SACA. Abuja: NACA.

38 Ibid.

39 Stakeholders included: NACA (implementing partner), the Benue State AIDS Control Agency (BENSACA), the FCT and Kogi State AIDS Control Agencies (KOSACA), the Association of Women Living with HIV/AIDS in Nigeria (ASWHAN) and Society for Women and Children Living with HIV/AIDS in Nigeria (SOWCHAN), The Federal Ministry of Women Affairs and Social Development.

NACA ensured the consultation of national and state actors; these include relevant focal and desks officers in the Ministries of Finance, Budget & Planning, Justice, the responsible committees on Health, HIV and gender issues in the National Assembly. Civil society and community-based groups were among all other relevant stakeholders that contributed and participated in the entire process. Male Champions for gender equality were also contributors and beneficiaries from the entire process.

2018 Update

Rights and gender responsiveness are a fundamental principle of *Nigeria's National HIV and AIDS Strategic Framework 2017-2021*, specifically the respect for gender equality and fundamental human rights through adoption of rights-based and gender-responsive approaches in HIV programming by all

stakeholders and at all levels. The most recent NASA, which is currently underway, will include tracking resources spent on gender equality initiatives.

UN Women continues to support the economic empowerment of women living with HIV. In 2018, NACA with the support of the UN Women collaborated with the Association of Women Living with HIV in Nigeria and the Women Interfaith Council, Kaduna, to implement a project for the economic empowerment of women and girls vulnerable to HIV and GBV. The goal of this initiative was to economically empower one hundred women and girls living in conflict areas in Nigeria who are living with, affected by and/or vulnerable to HIV and AIDS through the transfer of economic empowerment, livelihood and conflict resolution skills. The project was implemented in selected locations in Kaduna State and Abuja environs between April to June 2018.

1.3.2.3 Cambodia, Indonesia and Thailand

In 2016, the UN Women Regional Office contracted a consultant to produce a paper that analysed GRB in the HIV responses of Cambodia, Indonesia and Thailand, along with guidance on GRB for the region. The GRB tool selected for this analysis was the 'Five Step Approach' (also referred to as "gender aware policy appraisal").[40]

The paper found the following:

- Cambodia has a generally gender responsive HIV response in terms of policy (i.e. on paper). The government agencies and NGOs are committed to gender equality, and willing to apply GRB to the HIV response.
- Indonesia has a notably transparent environment that is enabling general planning and budgeting. It also has specific regulations on GRB, which provide a favourable context for applying GRB to the HIV response.
- Thailand has significant domestic funds allocated to the HIV response, demonstrating government commitment to reversing the HIV epidemic, and an enabling environment for applying GRB to their HIV response.

Furthermore, the paper found that two areas crucial for applying GRB to HIV responses, home-based care and the participation of women living with HIV and female key populations in the HIV response, are largely absent from programming and budgeting processes. Women's participation and leadership in the planning and monitoring and evaluation of each country's response and budget has been a persistent challenge, especially for Cambodia and Thailand.

The paper also highlighted the crucial issues that are common for the three countries:

- A predominant focus on women as child-bearers (pregnant women) or sex workers and entertainment workers as vectors of HIV within policies, plans, and/or programmes. There is no regard for the preferences and empowerment of the women themselves.
- Condom programmes, and post-exposure prophylaxis programmes, are gender blind and

40 Five Step Approach to GRB:

Step 1 refers to reviewing the situation of women, men and transgender people in the HIV policies, plans and programs for each country.

Step 2 assesses if there is a gender perspective, and if so, if it then results in promoting gender equality or women's empowerment. A checklist of questions was developed that focused on the gender responsiveness of HIV policies, plans, and programming. It is essential that there is coherence between political commitments and budget allocations and expenditures.

Step 3 reviews the HIV budget allocations in relation to national HIV policies and plans and includes analysis of budgets for the most recent Global Fund Concept Note under the New Funding Model.

Step 4, budget expenditure, is combined with Step 3 as a consequence of data limitation. Information on the NASA is not always available, and in some cases, it does not reflect changes in HIV policies and plans. A second checklist of questions was developed to assess if an enabling environment for a GRB process is present.

Step 5 entails comparisons between the years to assess improvement. Step 5 was not included in the UN Women Report as it was not possible to make comparisons.

do not make any reference to unequal gendered power dynamics in sexual relationships. This lack of analysis affects violence against women and gender-based violence programmes.
- There is no understanding of the need to align HIV responses with laws and policies related to gender-based violence and violence against women with other gender equality laws, such as inheritance and property laws, fundamental for a gender responsive HIV response.
- The situational analyses in the areas of sexual and reproductive health and rights, policies, plans, and programmes highlight the needs of women and transgender women. Yet, the corresponding budgets that are developed do not always include these priorities.
- There is an absence of disaggregated information in terms of community led anti-stigma campaigns. For example, what is the focus of such campaign, who they are led by, and whether they involve key populations and transgender women, and especially women living with HIV. This makes it impossible to assess whether these campaigns are gender responsive.

The guidance on GRB for the HIV response in Asia and the Pacific region offers programme managers, national planners, and civil society organisations a resource on how to integrate gender equality into HIV policy and planning.

1.3.2.4 Latin America and the Caribbean

The UN Women regional office undertook a rapid assessment of the allocation of public funds for the programmes related to the needs of women in the context of the HIV epidemic. The rapid assessment began by reviewing documents, along with the data obtained from a questionnaire directed at women and their organisations involved in advocating for measures related to the prevention and treatment of HIV, health in general, violence, equality and empowerment.

Although 15 countries were initially consulted, the information discussed corresponds to the 11 that responded: Argentina, Bolivia, Brazil, Colombia, Costa Rica, Haiti, Honduras, Mexico, Nicaragua, Peru and Uruguay. The Assessment found that in 8 of the 11 countries the funds for HIV come from the public sector through centralized or decentralized health mechanisms, with the exception of Haiti, Honduras and Bolivia where international sources represent 99%, 43%, and 36.8% respectively. Nevertheless, all the countries face difficulties in identifying the allocations for specific programmes for women, especially in terms of the access to ARV, prevention, and subsidies or transfers.

In relation to the lack of information and data, the responses to the questionnaire indicate that, in the participating countries, the information on assigned funds does not take into account the variables of sex and age that highlight the issue of HIV and AIDS for women in all their diversity. The only information disaggregated by sex and age is used to determine the basic profile of the epidemic in a specific geographic area.

1.3.2.5 Viet Nam

This gender assessment was a rapid exercise to analyse the extent to which Viet Nam's response to HIV acknowledges, and then acts on, the recognition of gender inequality as a key determinant of HIV. A key outcome of the assessment was to provide suggestions and recommendations for strengthening and increasing efforts to address gender in the response, including practical recommendations for the *National Work Plan on HIV/AIDS Prevention and Control 2016-2020* and other relevant sectoral policies and plans, as well as Viet Nam's Law on HIV/AIDS.

The assessment found that there is no way to track money that is currently spent on gender and HIV in the near-absence of gender-specific and gender-related goals in the national strategy, and with no specific gender-related activities or allocated staff. This also makes it impossible to measure gender-specific activities (with the exception of PMTCT or harm-reduction among female sex workers), or activities that potentially contribute to gender equality (mainstreaming). The assessment made the following recommendations relating to funding:

- Once a clear framework to address gender and HIV is in place, increase national capacity in gender analysis to ensure the integration of gender in planning and writing HIV funding proposals, and reporting on results.
- Increase the funding pool by identifying new donors specifically to fund gender and HIV strategies and seek specific funding for programmes aimed to improve the empowerment of women.
- Work with existing donors (such as the Global Fund to Fight AIDS, Tuberculosis and Malaria, or the Global Fund, which has recently adopted a new gender strategy) to increase dedicated funding for gender and HIV.
- Ensure gender responsive budgeting for HIV. This will be dependent on the elaboration of a national strategy with clear indicators to monitor and ensure systematic attention to all elements that address women and girls in all their diversity and across programmes.
- Strengthen synergies/interlinkages to achieve programme efficiencies, and scale-up services for women from multiple entry points, including by integrating HIV services with those related to gender-based violence and family planning/sexual and reproductive health services. This would mean such services could reach a wider group of women, including women from key populations and others with specific vulnerabilities.

1.3.2.6 Uganda

UN Women provided leadership and technical guidance for prioritization of gender equality and addressing the needs of women and girls during the Global Fund Concept Note development for Uganda covering the period 2018-2020. As a result, a total sum of US$10 million was allocated to Uganda as catalytic funding for addressing the specific needs of women and girls over the 3-year period. Priority areas of investment include pilot programmes for second chance education for >4,000 adolescent girls and young women (15-19 years) and economic empowerment for >3,000 young women (20-24 years) through livelihoods skilling and cash transfers per year in ten priority districts of Uganda.

Additionally, UN Women worked with local governments in the Karamoja sub-region to strengthen capacities for GRB as is required by the Uganda Public Finance and Management Act 2014. Some of the local governments in the region are in a position to prioritise and make budget allocations for addressing the needs of women and girls living with HIV in their local government annual workplans and budgets for the financial year 2017-2018.

UN Women continues to collaborate with the Equal Opportunities Commission and the Civil Society Budget Advocacy Group to ensure that government ministries departments and agencies at all levels respect the provisions of the Public Finance and Management Act 2014 in terms of gender equity budgeting and expenditures.

1.3.2.7 Zimbabwe

In Zimbabwe, UN Women provided technical support to women's groups under the umbrella organisation, the Women's Coalition of Zimbabwe (WCOZ), and coordinated their participation in the national process to develop a *Concept Note for the Global Fund to Fight AIDS, Tuberculosis and Malaria*. This culminated

in Zimbabwe securing an US$8 million grant for three years from the Global Fund for national HIV and AIDS programming for adolescent girls and young women. Additionally, with UN Women's support, the women's sector also developed a document detailing the key HIV and AIDS and sexual and reproductive health issues affecting adolescent girls in Zimbabwe and the priorities for women. The detailed priority document made it as an Annex to the documents submitted with the Global Fund concept note.

As a result, for the first time in the country, the US$8 million grant for programming on adolescent girls and young women is supporting the establishment of One Stop Centres which are key to responding to GBV as well as piloting the SASA! model that interrogates power dynamics between women and men in an effort to address GBV which increases vulnerability of women and girls to HIV infection. This was the first-time women were mobilized through the WCOZ, which groups more than 80 women's organisations across the country, and contributed to the various stages of the conceptualization, design and writing of a Concept Note and budget for the Global Fund application grant. After confirmation of the Global Fund grant, UN Women Zimbabwe also provided a regional expert to technically support the women's organisations to apply to be sub-recipient to manage the adolescent girls and young women grant.

1.3.3
Strategies

UN Women has pioneered many routes to ensure adequate funding for gender equality in the context of HIV. Interventions that have resulted in resource allocations that support gender equality and human rights in HIV budgets have often taken a holistic approach combining analysis of policies and budgets with capacity strengthening of key decision-makers and rights-holders, along with the development of tools and guidance. This section unpacks the approaches that were employed by UN Women.

1.3.3.1 Capacity Strengthening on GRB in the context of HIV

In both Rwanda and Nigeria, UN Women's interventions strengthened the institutional capacities of the NACAs to integrate gender equality and human rights considerations into their budgets as well as the capacity of other line ministries involved in the multi-sectoral HIV response. In both countries, UN Women worked closely with the ministries of gender or women's affairs to strengthen the integration of HIV in their respective policies and programmes. Gender audits, on-going institution- wide trainings, development of training materials and tools, and the placement of gender advisors in NACAs formed part of a comprehensive package of capacity development support provided by the programme.

UN Women's emphasis on capacity-building has proved central to achieving results. According to informants, capacity-building has proved a key route to creating commitment to GRB, increasing interest amongst decision-makers and changes in political will in planning and finance functions and NACAs, as well as commitment to advocacy for GRB amongst civil society actors who had participated in workshops.

In Nigeria, key staff from relevant authorities participated in capacity strengthening on gender responsive HIV and AIDS plans and budgets using the *National Gender Mainstreaming and HIV and AIDS Guidelines and Training Manual*. The project was designed to avoid a 'parachute-drop' approach to training. Crucially, key stakeholders were involved and engaged throughout the entire project, as part of the technical oversight and coordination for gender mainstreaming in the national HIV and AIDS response. This national technical team now provide on- going mentoring support and supervision to the planning and budgeting unit within NACA and other relevant institutions that promote provision of gender responsive HIV services.

In Rwanda, the programme trained staff in NACAs and key ministries and coordinators of the District AIDS Control Committees on gender-sensitive programming, monitoring and evaluation in the context of HIV. A previous UN Women programme had built capacity on GRB, and so there was a cohort of staff in the Ministry of Finance and Economic Planning that could support UN Women to train Rwanda Biomedical Centre staff on GRB. This prior GRB capacity strengthening of key high-level officials was crucial to achieving results in Rwanda.

Capacity strengthening is hugely valuable in creating a cadre of decision-makers with skills and knowledge of the links between gender equality and HIV and the importance of resourcing initiatives that address these intersections. Along with becoming familiar with the analysis and use of gender concepts, tools and strategies for GRB in the context of HIV, these training events are also conducive to participants strengthening linkages with other key stakeholders and/or decision-makers and sparking ideas on how to integrate GRB into HIV budgets going forward. However, capacity strengthening is not an outcome in itself; the litmus test for this is the extent to which GRB has been integrated into HIV budgets and whether that funding is disbursed.

1.3.3.2 Institutionalizing gender expertise through the placement of Gender Advisors in NACAs

Another supporting strategy that has proved successful is the institutionalisation of gender expertise in the NACA. Gender Advisors were supported in each of the NACAs in Cambodia, Jamaica, Kenya, Rwanda and Papua New Guinea, through the European Commission – UN Women programme, Supporting Gender Equality in the Context of HIV and AIDS (2009-2013). These Gender Advisors ensured the participation of networks of women living with HIV in national, regional and global HIV policy forums. Furthermore, through the coordination of the Gender Advisors, the programme trained more than 800 NACA staff, including at subnational levels, on integrating gender equality and human rights in HIV policies. In Rwanda, the Gender Advisor served as a gender focal point and a gender mainstreaming champion within the NACA. The programme evaluation found that having a dedicated, long-term gender advisor within NACAs was fundamental to integrating gender equality into plans and policies. The Gender Advisor position has since been institutionalized in Rwanda.

UN Women has a history of supporting gender expertise in NACAs. The UN Women publication, "Transforming the National AIDS Response: Mainstreaming gender equality and women's human rights into the 'Three Ones'" (2012)[41] cites as a case study a project in Nigeria where UN Women and its partners worked with national and international development partners to fund five gender and HIV and AIDS specialists. These specialists served on a team of some 20 consultants who assisted the development of the country's National Strategic AIDS Action Framework. As a result of this project, a full-time government post for a gender focal person was created in NACA's Monitoring and Evaluation Unit. A Gender Technical Committee, which included donors and development partners, became a standing committee of the NACA, and supports the gender focal person and development partners implementing HIV and AIDS programmes.

41 UN Women. (2012). Transforming the National AIDS Response: Mainstreaming gender equality and women's human rights into the 'Three Ones'.

1.3.3.3 Supporting organisations of women living with HIV

Another strategy is supporting women's organisations to access financing directly from other donors. A 2014 situation analysis of access to funding by organisations of women living with HIV, gender

and women human rights organisations in Uganda found that most of the available funding focuses on direct provision of services and that organisations of women living with HIV, whose focus is on advocacy and human rights, cannot easily access funding.[42] Empowering women to advocate for their rights is a cornerstone of UN Women's work.

42 International Community of Women Living with HIV & AIDS Eastern Africa. (2014). Are women's organizations accessing funding for HIV & AIDS: Rapid Situation Analysis of access to funding by organisations of women living with HIV, gender and women human rights organisations in Uganda.

UN Women has taken on a catalytic role in supporting women's organisations to access funding through different forms of technical support. In 2017, UN Women's technical assistance helped women's organisations in Uganda and Zimbabwe to articulate their needs and priorities in Concept Notes for the Global Fund. Technical support and coordination by UN Women of women's groups and other gender advocates ensured that the proposals met the standards required to attain funding.

1.3.3.4 Creating an evidence-base for future advocacy

Budget and gender assessments of the HIV response remain useful tools to gauge appetite for further work, to track commitments made on gender equality and to use in advocacy efforts. They clarify the extent to which gender equality is a priority in a particular HIV response and confront the reality that only when there are adequate allocations can commitments be converted into results. However, these assessments are only one step on the continuum of interventions.

Rather than use these strategies in isolation, UN Women has frequently taken a more holistic, long-term strategic approach, like for example in Rwanda and Nigeria, specifically combining capacity-strengthening of government and civil society, lobbying government to institutionalise gender responsive budgeting in the HIV response, and producing budget-related analysis. Policy level advocacy and strategic engagement with key policy makers must be sustained for effective GRB in the national HIV response. Furthermore, GRB, a potentially key strategy for sustaining integration of gender equality in the national response to HIV, is more likely to succeed if there is already a whole-of-government commitment to addressing gender inequalities in the context of HIV.

1.3.4 Discussion

Adequate resourcing is fundamental to transformative HIV responses that address the gender equality dimensions of the epidemic as well as the empowerment of all women and girls, particularly those living with or vulnerable to HIV. UN Women has made explicit and substantive efforts to address the gaps between gender responsive policies and plans with corresponding resourcing in multiple settings. UN Women has employed multiple strategies including capacity strengthening, such as the training and sensitisation of key government personal, along with generating analyses and assessments of GRB in the context of HIV. The projects in Rwanda and Nigeria combined knowledge-generation and capacity-building approaches.

UN Women has generated multiple assessments on the financing of gender equality in the context of HIV and research-based policy guidance, which contain strategies for engaging with key decision-makers and ensuring that the priorities and needs of women vulnerable to and living with HIV are reflected in resource allocation. Furthermore, UN Women has generated guidance on GRB in the context of HIV that is useful for further actions and other actors.

UN Women has also supported the leadership of women living with HIV to advocate for increased resources on gender equality and women's empowerment within the Global Fund Concept Notes and meaningfully participate in the Country Coordinating Mechanisms, overseeing the implementation of the Global Fund at country level.

1.4.

UN WOMEN APPROACHES IN FINANCING CIVIL SOCIETY ON GENDER EQUALITY AND HIV/AIDS

1.4.1
Background

Civil society is a key constituency for UN Women. It plays a vital role in promoting gender equality and women's rights at all levels. UN Women partners with international, regional and national networks of women living with HIV, women's organizations, alliances and coalitions of women caregivers, legal and human rights organizations, and community-based, grass-roots and media organizations to increase the influence of women living with HIV, to promote their leadership and meaningful participation in all decisions and actions in the response to the epidemic. There are different approaches and mechanism UN Women employs in doing so. This section provides a summary of approaches and examples of UN Women's support and funding of civil society in the area of gender dimension of HIV.

1.4.2
UN Women's support to the civil society: Key approaches

Investing in leadership capacity

UN Women considers participation and engagement of the networks of women living with HIV as central to transforming the national HIV responses. For example, since 2016, UN Women collaborated with the International Community of Women Living with HIV in delivering the Feminist Leadership School.

The training resulted in strengthened leadership and advocacy skills of women living with HIV from China, Indonesia, Thailand and Viet Nam to engage in the national HIV strategies, Convention on Elimination of All Forms of Discrimination Against Women (CEDAW) reporting and Global Fund concept notes development.

In Uganda, in 2017, UN Women worked with the International Community of Women living with HIV-East Africa to mobilize, build leadership capacity and mentor representatives of 32 national and district-level networks and organizations of women living with HIV, particularly young women. As follow-up to the training and mentorship programme, women successfully advocated for integration of gender equality issues into design of the *United States President's Emergency Plan for AIDS Relief (PEPFAR) 2017 Country Operational Plan* and review of the *2018-2025 HIV Prevention Roadmap for Uganda*.

BOX 5

Delivering the 2030 Agenda for Sustainable Development:

The 2030 Agenda for Sustainable Development places a strong emphasis on gender equality and women's empowerment as a stand-alone goal and throughout the agenda and reinvigorates efforts to eliminate gender inequalities that hamper women and girls' ability to confront HIV and mitigate its impact.

The fundamental principle of the 2030 Agenda of *leaving no one behind* paves a way for UN Women to reach those *furthest behind first* by ensuring national HIV strategies are informed by sex- and age-disaggregated data and gender analysis; up-scaling what works in tackling the root causes of inequalities; and supporting women and girls in all their diversity to meaningfully engage in decision-making in HIV responses at all levels.

Supporting mobilization and advocacy

UN Women places an emphasis on the importance of supporting and facilitating women's organizing and mobilizing to advocate for gender-transformative HIV response at all levels. For instance, in Zimbabwe, since 2015, UN Women has assisted women's organizations to mobilize and advocate collectively for the gender-responsive Global Fund grant. The joint advocacy resulted in the approved Concept Note prioritizing programming on adolescent girls and young women and HIV, with a total of US$8 million allocation for 2018-2020.

In 2016, UN Women's *'Engagement+ Empowerment=Equality'* effort resulted in mobilizing over 1,000 young women and adolescent girls, including 250 living with HIV, in Kenya, Malawi and Uganda. Through mentoring, capacity building and peer support, young champions engaged in the design and validation of the *All-In* assessments and advocate for inclusion of issues young women and girls face in the context of HIV. In nine months, the young champions were able to reach and mobilize thousands of other young women through outreach activities, including through social and print media.

Creating spaces for policy dialogue

UN Women continues to create spaces to ensure women living with HIV have a seat at the table in the discussions around the design, implementation, monitoring and evaluation of the national and local HIV strategies and monitoring frameworks. For example, in 2016-2017, UN Women facilitated dialogues between the national AIDS coordinating authorities and the networks of women living with HIV to meaningfully contribute to the design and review of the national HIV strategies in 11 countries (Cameroon, China, Kazakhstan, Morocco, Sierra Leone, South Africa, Tajikistan, Tunisia, Uganda, Ukraine, and Zimbabwe).

In 2014-2015, with advocacy from UN Women, women living with HIV were elected as voting members of

the Global Fund Country Coordinating Mechanisms in Indonesia, Kazakhstan, Tajikistan and Zimbabwe.

UN Women has been a founding member and supporter of the Women's Networking Zone (WNZ) for the International AIDS Conferences since its first convening in 2006. These efforts increased the visibility of women's organizations at the conferences and provided a space for them to advocate for greater accountability, funding and implementation of actions to advance women's priorities. Designed by and for women living with HIV, the majority of the WNZ events are usually led by women.

Strengthening programmatic capacity

The inclusion of civil society organizations in international, regional and national decision and policy making fora is important; however, UN Women also places a great emphasis on ensuring the networks of women living with HIV have substantive policy and programmatic capacity to meaningfully contribute to and influence these strategic decision-making processes. For instance, to support national and local planning to implement the 2030 Agenda, in 2016, UN Women partnered with the International Community of Women Living with HIV to ensure over 200 women living with HIV from 10 countries – Belarus, Democratic Republic of Congo, Kazakhstan, Kenya, Mozambique, Namibia, Russia, Thailand, Ukraine and Zimbabwe – voiced their priorities and engaged with policy-makers to influence localizing the Sustainable Development Goals (SDGs). A Guide to the SDGs for the networks of women living with HIV was developed and disseminated; it outlines key strategies to ensure SDGs implementation works for women living with HIV.[43]

43 International Community of Women Living with HIV. (2016). *A Guide to the SDGs for the Network of Women Living with HIV*. Nairobi: ICW.

Granting mechanisms

Launched in 2009, the Fund for Gender Equality is a grant-making mechanism within UN Women exclusively dedicated to advancing gender equality and women's economic and political empowerment.[44] The Fund for Gender Equality has successfully awarded US$ 64 million to 120 grantee programmes in 80 countries, reaching over 10 million women, girls and boys as direct beneficiaries. As of 2017, women living with and affected by HIV constituted about 7% of all beneficiaries of the Fund for Gender Equality globally.[45] For example, with support from the Fund for Gender Equality, the All Ukrainian Network of People living with HIV influenced gender policies in the Ukraine to become sensitive to issues faced by women who live with HIV and to the engendering of national HIV policies by including gender aspects of service provision, sections on other vulnerable groups, women's reproductive rights and sex-disaggregated data. As a result of the project, the Positive Women Network was established and is now the main driver of gender equality and HIV issues in the country.

Established by UN General Assembly Resolution 50/166 in 1996[46] and administered by UN Women on behalf of the UN System, the UN Trust Fund to End Violence Against Women awards grants to civil society organizations, governments and UN country teams to prevent and respond to violence against women and girls, including addressing the intersections of violence and HIV.[47] Since its creation, the UN

44 See http://www.unwomen.org/en/trust-funds/fund-for-gender-equality

45 UN Women. (2017). FGE Thematic Factsheet: *'Leaving no one behind'* in action. New York: UN Women. Available at: https://www.unwomen.org/en/digital-library/publications/2017/3/leaving-no-one-behind-in-action

46 A/RES/50/166

47 See http://www.unwomen.org/en/trust-funds/un-trust-fund-to-end-violence-against-women

Trust Fund has awarded US$ 128 million to 462 initiatives in 139 countries and territories.

For instance, in 2016-2017, it awarded over US$ 2 million in grants to civil society in 11 countries – Cameroon, China, Cote D'Ivoire, Egypt, Haiti, Jamaica, Kenya, Myanmar, South Africa, Tanzania and Thailand – for programming to prevent violence and HIV and strengthen response to violence against women living with HIV. Grassroot Soccer, a grantee in South Africa, used the power of football to educate and empower over 8,000 girls aged 13-16, including those living with HIV, with the final evaluation attesting to increased HIV knowledge and access to violence and HIV services. Another grantee, Trócaire, implemented SASA! Faith[48] in 4 rural communities of Kenya. Twenty-eight community activists engaged with faith leaders to prevent violence and HIV among young rural women, particularly those with disabilities.

In 2010-2014, with support from Foreign Affairs, Trade and Development Canada, UN Women increased women's access to property and inheritance rights as means to reduce vulnerabilities to, and mitigate the impact of, HIV and AIDS. UN Women awarded US$2.2 million in small grants of up to $75,000 to twenty grantees including legal service organizations, community-based and grassroots networks, and organizations of women living with HIV in Cameroon, Ghana, Kenya, Malawi, Nigeria, Rwanda, Tanzania, Uganda, and Zimbabwe. Grantees have enhanced the awareness of legislators, policymakers, local and traditional leaders, and communities on the specific vulnerabilities of women living with or affected by HIV. Furthermore, grantees empowered women living with HIV to report violations and pursue redress through rights-awareness and legal literacy interventions. Two short videos have been produced on the key outcomes of the programme and achievements of one of the grantees in Zimbabwe.[49]

48 SASA! Faith is a guide to preventing violence against women and HIV in faith-based communities and was co-created by Trócaire and Raising Voices. SASA! Faith takes the structure, process and content of the original SASA! and adapts it for use in Christian and Muslim communities. It is an initiative in which leaders, members and believers of a religion come together to prevent violence against women and HIV.

49 See https://www.youtube.com/watch?v=GlVGooFdEAU&feature=youtu.be and https://www.youtube.com/watch?v=wi86ZlrpWoY&feature=youtu.be

Supporting service delivery efforts

UN Women has been supporting the networks of women living with HIV to provide specific and tailor-made services to women and girls living with or affected by HIV. For instance, in 2014-2016, UN Women worked with the National Network of Women's Organizations Living with HIV/AIDS and Tuberculosis (MUKIKUTE) in Tanzania to improve access of women who use drugs and living with or affected by HIV to harm reduction and HIV services. In Temeke and Kinondoni Districts, there was an increase of 30% in the number of women who use drugs visiting the MUKIKUTE drop-in centre to access harm reduction services, HIV information and legal advice.

In Uganda, UN Women fostered collaboration between 60 cultural and community leaders and 78 women living with HIV in rural areas to identify women's rights violations and gender-based discrimination in the context of HIV. This work has resulted in increased trust in informal justice mechanisms at the local level, faster review of complaints, particularly from women living with HIV, and stronger coordination with the formal justice system.

In Malawi, in 2017, UN Women provided technical and financial support to the Coalition of Women Living with HIV and AIDS, which rendered services to over 5,000 women and girls' survivors of violence, including those with low income and those living with or affected by HIV.

Prioritizing community-driven work

UN Women continuously invests in community-driven approaches that have yielded evidence to demonstrate what works most effectively in addressing gender inequalities and violence against women in the context of HIV. In 2018, a HeForShe community-based initiative engaged over 34,000 men and women across three districts of South Africa, resulting in improved attitudes and behaviours to prevent gender-based violence and HIV. Preliminary data shows that within just 8 months of implementation, over 22,000 participants (46% women and 54% men) reported accessing HIV testing.

Ensuring the voices of women living with HIV in the inter-governmental processes

UN Women supports civil society participation, including women living with HIV, in a number of intergovernmental processes such as the Commission on the Status of Women and the High-Level Meetings on HIV/AIDS. For example, UN Women supported consistent engagement and up-dates for the civil society, including the global networks of women living with HIV, in preparation for the 60th session of the Commission on the Status of Women and the 2016 High-Level Meeting on HIV/AIDS. The Commission on the Status of Women Resolution 60/2 on Women, the Girl Child and HIV and AIDS was adopted with strong language that acknowledges women and girls' vulnerabilities in the context of HIV, the importance of securing their sexual and reproductive health and reproductive rights, ending all forms of violence, and reducing the burden of care work.[50]

UN Women contributed to the civil society participation in the public hearings and other engagements around the draft *2016 United Nations Political Declaration on HIV and AIDS*.[51] The Declaration has been adopted with stronger gender equality commitments, including implementing gender-responsive national HIV strategic plans, promoting women's leadership in the HIV response, addressing HIV and GBV intersections, and protecting women's sexual and reproductive health and reproductive rights. The Declaration also includes a target to reduce new HIV infections in adolescent girls and young women.

UN Women facilitated inputs from and participation of the networks and organizations of women living with HIV in countries reporting on the implementation of the CEDAW. For example, in Ukraine, with UN Women's support, women living with HIV co-authored the shadow report, which they presented to the CEDAW Committee members at the CEDAW session in 2017.[52] A survey of 1,000 women living with HIV was conducted in Ukraine by the national network to assess how CEDAW implementation addresses the rights of women living with HIV and to inform the shadow report to the CEDAW Committee.[53] This work resulted in the CEDAW Concluding Comments to Ukraine calling for accelerated HIV prevention among women and girls and improved access to gender-based violence services for women to prevent HIV.[54]

50 E/2016/27-E/CN.6/2016/22

51 A/RES/70/266

52 Legalife-Ukraine, Insight, Positive Women, Svitanok (2017) *Shadow report on the situation of women who use drugs, women living with HIV, sex workers, and lesbian, bisexual women and transgender people in Ukraine*. Available at https://tbinternet.ohchr.org/Treaties/CEDAW/Shared%20Documents/UKR/INT_CEDAW_NGO_UKR_26367_E.pdf

53 Moroz S. (2017). *Human Rights of Women Living with HIV in Ukraine*. Kyiv: UN Women.

54 CEDAW/C/UKR/CO/8

Supporting research and knowledge generation

UN Women supports the networks of women living with HIV to design, inform, lead and undertake research and generate knowledge on the priority issues pertaining to the gender dimension of HIV in

order to inform national HIV responses. For example, in 2017 UN Women released the 'Key Barriers to Women's Access to HIV Treatment: A Global Review', which was carried out by ATHENA Network, AIDS Vaccine Advocacy Coalition, and Salamander Trust and led and governed by a Global Reference Group of 14 women living with HIV from 11 countries.[55] The report surfaces key issues women face in accessing treatment, including: the scarcity of existing data on women's experiences with HIV treatment; violence against women, and fear of violence, as a major barrier to women seeking care and treatment; poverty, limited economic and educational opportunities; unpaid care work responsibilities, including for family members affected by HIV; and stigma and discrimination from health care workers. The report findings have also been published in the Health and Human Rights Journal in December 2017.[56]

55 AVAC, Athena Network, Salamander Trust. (2017). *Key barriers to women's access to HIV treatment: A global review*. New York: UN Women. Available at: https://www.unwomen.org/en/digital-library/publications/2017/12/key-barriers-to-womens-access-to-hiv-treatment

56 Orza L et al. (2017). In Women's Eyes: Key Barriers to Women's Access to HIV Treatment and a Rights-Based Approach to their Sustained Well-Being. *Health and Human Rights Journal*. Vol. 19, No. 2, pp. 155-68. Available at: https://cdn2.sph.harvard.edu/wp-content/uploads/sites/125/2017/12/Orza.pdf

Strengthening institutional capacity

Investing in institutional strengthening of the networks of women living with HIV is an essential prerequisite for stronger and vibrant women's movement that has capacity to advocate for an impactful change in the HIV response. For instance, in Mozambique, in 2017, UN Women helped to engage community-based groups of women living with HIV across several HIV-affected districts in the self-assessment of their internal capacity to expand their opportunities to access decision-making and resources. Based on the outcomes of the self-assessment, 24 members were able to further increase their capacity on association-building, organizational effectiveness and leadership, and developed specific action plans to improve the community groups' organisational skills and sustainability. In Rwanda, for the past 3 years, UN Women has been supporting the establishment and strategic planning process for the Network of Women Living with HIV (FRSL+), currently the leading organization of PAPWC Chapter Rwanda.

Creating mechanisms for consistent engagement with UN Women

Since its establishment, UN Women set up advisory groups at the global, regional, and national levels known as Civil Society Advisory Groups (CSAGs).[57] The CSAGs serve as forums for dialogue and sustained engagement at all these levels. They keep UN Women grounded in the issues and constituencies that UN Women serves. Presently, there are 42 CSAGs set up, or in the process of being set up, with more than 500 members in total. Many CSAGs include women living with HIV as members.

57 See http://www.unwomen.org/en/partnerships/civil-society/civil-society-advisory-groups

1.5.

OTHER ACTORS' EFFORTS IN FINANCING GENDER EQUALITY IN THE CONTEXT OF HIV

1.5.1 Introduction

National and donor governments, civil society, and academic partners are also involved in efforts to strengthen financing for gender equality in the HIV response. This section provides examples of the work done by these partners. In particular, the mapping sought to determine what partners are doing in terms of:

- costing effective interventions that strengthen gender equality in the HIV context and estimating resource needs; and
- assessing, tracking, and advocating for budgets for gender-responsive HIV interventions.

The mapping was conducted through a desk review of secondary data available online during September – December 2018. In addition, the mapping reviewed specific tools such as NASA and the Global AIDS Monitoring process to describe content related to financing gender equality interventions. Review of donor efforts focused on the five largest donors identified in the Kaiser Foundation/UNAIDS study *Donor Government Funding for HIV in Low- and Middle-Income countries in 2017*: United States, United Kingdom, France, Netherlands, and Germany. Because of the wealth of information available online and the specificity of the research topic, the mapping should not be considered an exhaustive description of the work being done in financing gender equality in the HIV response.

1.5.2 Efforts to estimate resource needs

Costing gender responsive HIV interventions

The first step in financing interventions to strengthen gender equality in the HIV context is to understand how much they cost. This work is driven by program managers and academics through costing and cost-effectiveness studies.

Remme and colleagues conducted a systematic review of costing and cost-effectiveness studies on

gender-responsive HIV interventions.[58] Of 22 gender-responsive interventions found to be effective for HIV, only half had costing and economic evaluations. The review was not able to locate any (cost-)effectiveness studies of gender-responsive components linked to ART, male circumcision or programmes for men who have sex with men and their female partners, even though 50% of HIV spending across low- and middle-income countries goes to treatment and care.

The study found that some interventions, such as female condom promotion and cash transfers, are cost-effective but often are not included in investment frameworks. The authors recommend that programmes consider reallocating spending to better accommodate activities that address gender equality and GBV, and increasing co-financing for interventions that tackle the structural drivers of HIV, such as inequalities in access to education, poor livelihoods and harmful gender norms.

58 Remme M, Siapka M, Vassall A, Heise L, Jacobi J, Ahumada C, Gay J, and Watts C. (2014). The cost and cost-effectiveness of gender-responsive interventions for HIV: a systematic review. *Journal of the International AIDS Society*, Vol. 17, No. 19228.

Resource modelling

Costing data on gender-responsive HIV interventions is incorporated into resource models used in government HIV budgeting exercises. Some of the better-known models include the Goals, AIDS Impact Model, and Resource Needs Model in the Spectrum/OneHealth Tool by Avenir Health, widely used and supported by UN agencies; Optima HIV by the Burnet Institute and the World Bank; the AIDS Epidemic Model by the East-West Center; Epidemiological Modeling by the Institute for Disease Modeling; and Global Health Decisions by the University of California, San Francisco. While these models disaggregate data by sex,[59] this mapping did not examine if and how the models incorporate gender-responsive interventions.

One illustrative example of an HIV resource modelling exercise that includes interventions for gender equality is the 2016 analysis of the resources needed by the Fast-Track Approach by Stover and colleagues.[60] The analysis included coverage goals and effects for:

- key populations: sex workers, men who have sex with men, transgender, people who inject drugs, and prisoners;
- behaviour change interventions: condom promotion and cash transfers for girls;
- medical interventions: PMTCT, voluntary medical male circumcision (VMMC), post-exposure prophylaxis (PEP), pre-exposure prophylaxis (PrEP), testing, pre-ART care, and adult ART; and
- social enablers: community mobilization, media communications, and other general population approaches that support behaviour change.

In addition to cash transfers for girls (in countries with low rates of secondary enrolment for girls), gender is specifically mentioned under media communication as a way to target social, cultural and gender norms that may hinder behaviour change, and under development synergies which includes prevention of violence against women. Figure 1 summarizes the resources needed by low- and middle-income countries by intervention. Two-thirds of the resources go to ART (39%), program enablers[61] (10%), services for key populations (9%), and condoms (7%).

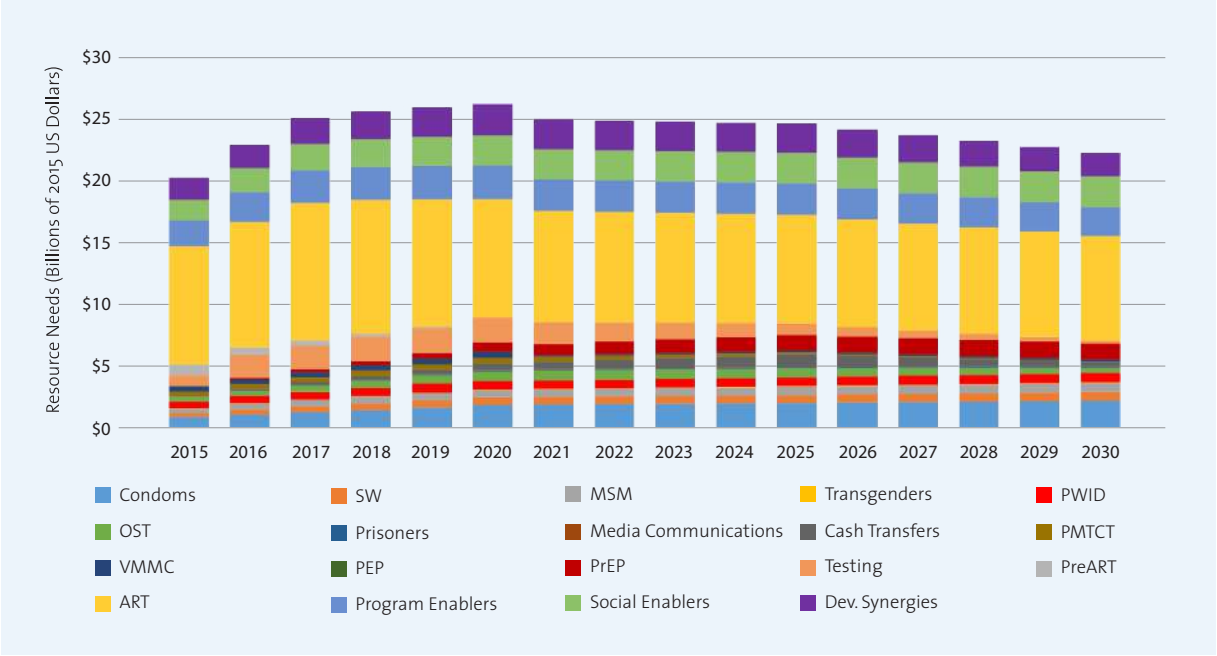
59 Kahn J, Bollinger L, Stover J, Marseille E. (2017). Improving the Efficiency of the HIV/AIDS Policy Response: A Guide to Resource Allocation Modeling. In: *Disease Control Priorities (third edition): Volume 6, Major Infectious Diseases*. Holmes K, Bertozzi S, Bloom B, Jha P, eds. Washington, DC: World Bank.

60 Stover J, Bollinger L, Izazola JA, Loures L, DeLay P, Ghys PD, et al. (2016). What is required to end the AIDS epidemic as a public health threat by 2030? The cost and impact of the Fast-Track Approach. *PLoS ONE*, Vol. 11, No. 5: e0154893. doi:10.1371/journal.pone.0154893

61 Program enablers include planning and coordination, administration, supplies and logistics, staff training, monitoring and evaluation including surveillance and information systems.

FIGURE 1

Annual resource needs by intervention, 2013-2020



Stover et al. (2016).

Key: SW = sex workers, MSM = men who have sex with men, PWID = people who inject drugs, OST = opioid substitution therapy, PMTCT = prevention of mother-to-child transmission, VMMC = voluntary medical male circumcision, PEP = post-exposure prophylaxis, PrEP = pre-exposure prophylaxis, Dev. Synergies = Development Synergies

Discussion

Efforts to cost gender-responsive HIV interventions have been limited. Even when costing data on evidence-based interventions is available, the interventions are not always included in resource models. The omission of budget lines specifically for gender equality interventions may undermine country efforts to comprehensively fund their HIV response, particularly interventions that also strengthen gender equality.

1.5.3
National government efforts to assess and track financing for gender equality in the HIV response

Countries can assess and track their HIV expenditures through budget analysis, public expenditure reviews, systems of health accounts, and NASA. This section provides a cursory review of selected NASA reports in terms of their reporting of expenditures on gender-responsive interventions, and briefly describes reporting on Global AIDS Monitoring indicators for HIV expenditures.

National AIDS Spending Assessments (NASAs)

NASA indicators assess the current levels of spending and resource allocation across various programmes and interventions. By October 2018, 70 countries had conducted NASAs.[62] The NASA includes eight classes of spending categories (see Box 6). Gender-responsive interventions are found in three AIDS spending categories:

- ASC 01: Prevention includes female condoms and microbicides, both female-controlled methods.
- ASC 06: Social protections and social services include cash transfers.
- ASC 07: Enabling environment includes support to women's groups and people living with HIV to strengthen their capacity to advocate for effective HIV prevention, care, and social support, AIDS-specific programmes focused on women, and programmes to reduce GBV.

In addition, NASA guidelines recommend cross-classification with targeted/intended beneficiary populations where possible, for example whether prevention or treatment is targeting the general male or female adult population, boys, girls, young men, young women, adult and young men living with HIV, adult and young women living with HIV, boys living with HIV, and girls living with HIV.[63]

BOX 6

NASA classes of AIDS spending categories (ASCs)

01 Prevention

02 Care and treatment

03 Orphans and vulnerable children

04 Programme management and administration

05 Human resources

06 Social protections and social services

07 Enabling environment

08 Research

62 UNAIDS National AIDS Spending Assessment (NASA) Country Reports. Available at http://www.unaids.org/en/dataanalysis/knowyourresponse/nasacountryreports. Accessed on 10 October 2018.

63 UNAIDS. (2009). National AIDS Spending Assessment (NASA): Classification and Definitions. UNAIDS / 09.23E.

Methodology

The mapping reviewed the extent to which NASA reports for six selected countries addressed gender equality. The six countries included:

- Three of the five countries reporting the largest HIV budgets according to the 2018 Global AIDS Monitoring: Kenya, China, and Mexico. The other two countries – South Africa and Brazil – have not submitted NASA reports.
- Three countries with HIV prevalence over 10% in 2017 (AIDSinfo accessed 15 October 2018) and a NASA during the past five years: Swaziland, Mozambique, and Namibia. Other high prevalence countries either did not have reports (South Africa and Zimbabwe) or had reports that were relatively old (Lesotho 2005-2006, Botswana 2009-2012, and Zambia 2012).

The assumption was that countries with large budgets or with severe epidemics would have financial reporting systems better equipped to capture expenditures on gender-responsive interventions.

The mapping examined two questions in each of the NASA reports:

- Discussion of gender equality concerns in the background or introduction which would demonstrate an understanding of the linkages between gender and HIV, and
- Expenditures on gender-responsive HIV interventions included in the NASA guidelines, specifically cash transfers for girls, support to women's organizations, programmes focused on women, programmes to prevent GBV, female condoms, and microbicides.

Findings

Table 2 summarizes the findings of the mapping conducted for this report, including expenditures for the gender-responsive interventions for the six countries, and notes the extent to which gender equality was discussed in the respective context.

Discussion

The cursory review of six NASA reports is by no means intended to provide a comprehensive picture of spending on gender-responsive HIV interventions. However, it does raise interesting questions for further discussion and exploration. In particular:

- Only two of the six countries discussed the links between gender and HIV in their introduction or context. While this may be due to space limitations, it may also illustrate low prioritization of gender equality in HIV financing.
- Only half of countries reported expenditures on female condoms and none included microbicides, two female-controlled prevention methods. This may be because the methods have not been approved by the government or because the resources are not specifically tracked.
- None of the reports reported expenditures for cash transfers. This may be because they are not considered appropriate for the epidemiological context (i.e. concentrated epidemic) or because the value of cash transfers for girls is not yet recognized.
- None of the reports reported expenditures to support women's organizations.
- Three of the countries reported expenditures on programmes to focused on women, ranging from US$ 55,795 to US$ 835,800. In all three countries, this category of expenditure was less than 1% of the total AIDS budget and less than 7% of the ASC 07 enabling environment classification.
- Three countries reported expenditures on programmes to prevent violence against women, ranging from US$ 50,000 to US$ 130,000. In all three countries, the budget was less than 1% of the ASC 07 classification.
- Three countries did not break down spending by sex-disaggregated beneficiary categories. Increased cross-classification of spending categories with beneficiary populations may help determine how expenditures are being directed to women and men.

The findings suggest that some countries either do not have HIV financial reporting systems that are able to capture spending on the specific gender-responsive HIV interventions examined here, or that the interventions are not being implemented. There may also be room for improvement in the design and/or use of the NASA tool itself.

Reporting on Global AIDS Monitoring indicators

Countries also submit data on their HIV expenditures through the UNAIDS Global AIDS Monitoring (GAM) process. GAM tracks progress on international commitments, including Commitment 8: Ensure that HIV investments increase to US$ 26 billion by 2020, including a quarter for HIV prevention and 6% for social enablers[64].[65] Commitment 8 indicators are:

64 Social enablers: Activities to support the implementation of basic programs as defined in the UNAIDS Investment Framework, including political commitment and advocacy; mass media; laws, legal policies and practices; community mobilization; stigma reduction and human rights programmes.

65 UNAIDS. (2018.) Global AIDS Monitoring 2019 - Indicators for monitoring the 2016 United Nations Political Declaration on Ending AIDS. UNAIDS/JC2941.

TABLE 2

Summary of mapping results: expenditures on gender-responsive HIV interventions and discussion on gender equality from NASA reports of six selected countries (year in parentheses; expenditures in US$)

	China (2012) *(Dehong Prefecture only)*	Kenya (2011)	Mexico (2010-2011)	Mozambique (2014)	Namibia (2012-2014)	Swaziland (2010-2013)
Discussion of the links between gender and HIV in the introduction, background, or context	Describes HIV prevalence among pregnant women, but not gender equality	Describes inequitable gender norms as a key driver of the epidemic	Describes HIV prevalence among women, but not gender equality	None	Describes HIV prevalence among women, but not gender equality	States that risk factors include gender inequality and GBV
Total HIV budget	6.8 million	2,466 million	535 million	322 million	213 million	857 million
ASC 01 - % expenditures on prevention	1.3 million (20%)	496 million (20%)	167.8 million (31%)	88.8 million (27%)	34.1 million (16%)	162.6 million (19%)
Expenditure on female condoms	Not included	Not included	Not included	90,473	170,500	154,143
Expenditure on microbicides	Not included	Not included	Not included	Not included	Not included	Not included
ASC 06 - % expenditures on social protection and services	3,693 (<1%)	31.0 million (1%)	Not included	914,176 (0.3%)	3.3 million (1.6%)	2.1 million (<1%))
Expenditure on cash transfers to girls	Not included	Not stated	Not included	Not included	Not included	Not included
ASC 07 - % expenditures on enabling environment	591 (<1%)	70 million (3%)	1.3 million (<1%)	8.5 million (3%)	12.1 million (6%)	11.2 million (1.3%)
Expenditure on support to women's groups	Not included	Not included	Not included	Not included	Not included	Not included
Expenditure on support to programmes focused on women	Not included	Not included	Not included	490,943	55,795	835,800
Expenditure on prevention of GBV	Not included	0.13 m	Not included	50,000	Not included	78,968
Spending on beneficiary populations disaggregated by gender*	No	Yes	No	No	Yes	Yes

* Marked "yes" if report provides data on: Adult and young women (15 years and over) living with HIV and Female adult population. Marked "no" if description of beneficiary populations does not disaggregate by sex.

8.1 Total HIV expenditure

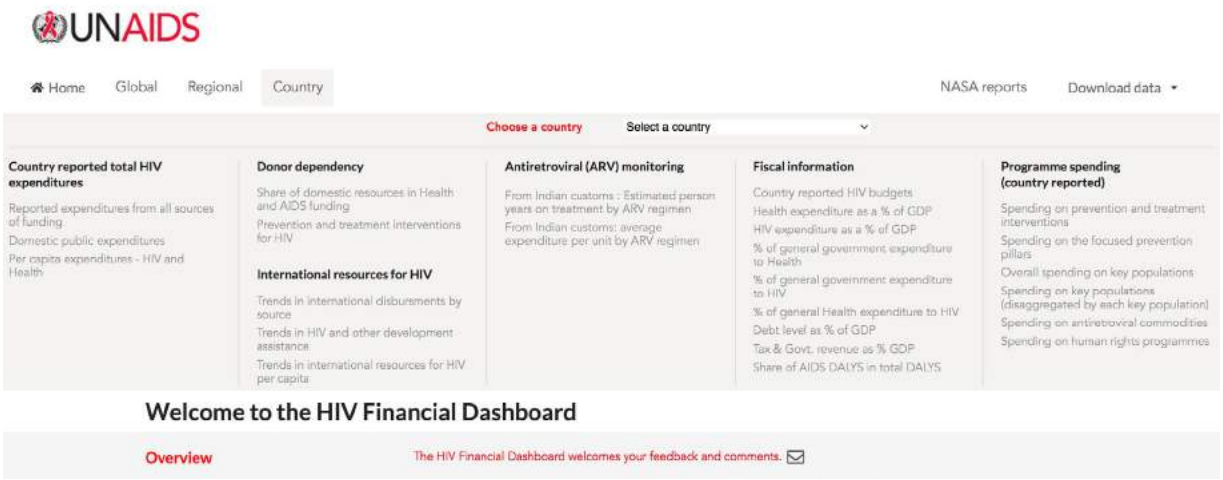
Domestic and international HIV expenditure by categories and funding sources:

- 8.1A Expenditure on HIV testing and counselling
- 8.1B Expenditure on antiretroviral therapy
- 8.1C Expenditure on HIV-specific laboratory monitoring
- 8.1D Expenditure on tuberculosis (TB) and HIV
- 8.1E Expenditure on the five pillars of combination prevention
- 8.1F Expenditure on preventing the mother-to-child transmission of HIV
- 8.1G Expenditure on social enablers
- 8.1H Expenditure on cash transfers for young

Expenditure data can be accessed from the **UNAIDS HIV Financial Dashboard,** currently in beta version.[66] It aims to provide strategic information on HIV resources for policy-makers, program directors, and researchers, by bringing together more than 85 different indicators on HIV financial resources into a single platform. The data sheet includes expenditure data on the programmes above. In addition, the country-level dashboard summarizes data as seen in Figure 2 below.

66 UNAIDS HIV Financial Dashboard. Available at http://hivfinancial.unaids.org/hivfinancialdashboards.html. Accessed 10 October 2018.

FIGURE 2
HIV Financial Dashboard country-level dashboard*



* UNAIDS HIV Financial Dashboard. Available at http://hivfinancial.unaids.org/hivfinancialdashboards.html. Accessed 10 October 2018. Accessed January 3, 2019.

1.5.4
Donor efforts to track financing of gender equality in the HIV response

Donor governments play a key role in influencing HIV program priorities through their budget allocations. This section describes the findings of a limited review of donor documents on their efforts to finance gender equality in the HIV response.

Methodology

The mapping sought to determine how funding for gender equality is tracked in the HIV budgets of the top five donors to HIV programming. According to the Kaiser Foundation/UNAIDS study *Donor Government Funding for HIV in Low- and Middle-Income countries in 2017*, the top donors to HIV programming are the United States, followed by the United Kingdom, France, the Netherlands, and Germany.[67] The mapping reviewed the HIV policies, strategies, and plans for these governments to explore four key questions:

- How is gender equality prioritized in the HIV program?
- How much funding is directed toward gender-responsive HIV interventions according to data from the Organisation for Economic Co-operation and Development (OECD)'s Common Reporting Standard (CRS)?
- How does the country track HIV funding directed toward gender equality interventions?
- How is support to women's organizations prioritized in the HIV program?

67 See http://files.kff.org/attachment/Report-Donor-Government-Funding-for-HIV-in-Low-and-Middle-Income-Countries-in-2017

Findings

Table 3 summarizes the findings of the mapping conducted for this report. Longer descriptions for each country, also compiled during the mapping, are included in Annex 1.

TABLE 3

Summary of approaches to budgeting and tracking spending on gender-responsive HIV interventions by five largest donors to international HIV efforts, 2009-2016

	United States	United Kingdom	France	The Netherlands	Germany
Gender prioritized in HIV program documents	Yes. PEPFAR Gender Equality Strategy	No stand-alone HIV program. Committed to gender equality.	No stand-alone HIV program. Committed to gender equality.	No stand-alone HIV program. Committed to gender equality.	No stand-alone HIV program. Committed to gender equality.
Proportion of STD/HIV funding directed to gender equality interventions (OECD CRS)	20-23% during 2011-2016	59-69% during 2009-2016	Varies from 2% to 42%	Increased from low of 31% in 2009 to high of 98% in 2018	Over 95%
Funding for projects where gender equality is a principal objective (CRS)	~5% during 2011-2016	0% 2009-2015; 24% in 2016	0% 2009-2016; 22% in 2016	Increased from 10% in 2009 to 84% in 2016	Varies from 5% to 24%
Method to track funding	Unclear	Unclear	Modified OECD-DAC framework	OECD-DAC framework	OECD-DAC framework
Funding for women's organizations and networks working with HIV	Unclear	Emphasis on third-party funding e.g. Robert Carr Foundation	Commitment expressed	Emphasis on third-party funding e.g. FLOW	Unclear

Discussion

Tracking donor HIV budget commitments to gender equality is challenging for two reasons:

- HIV is increasingly integrated with sexual and reproductive health and rights (SRHR): With the exception of the United States, which has a stand-alone HIV program (U.S. Government's PEPFAR) with its own gender strategy, countries have integrated HIV with SRHR. As a result, these countries no longer have a stand-alone policy or program for HIV. This has resulted in difficulties in tracking financing not only for gender equality in the HIV response, but for HIV programming in itself (e.g. see United Kingdom).
- Tracking funding for gender equality in integrated projects is a challenge: Budget allocations for gender-responsive HIV interventions were more likely to be found for HIV projects that have gender equality as a main objective e.g. projects focusing on GBV, or the U.S. Government's Determined, Resilient, Empowered, AIDS-free, Mentored, and Safe (DREAMS) public private partnership which has a specific focus on HIV among adolescent girls and young women. It appears to be much more difficult to track funding when gender equality is mainstreamed into an HIV project that does not primarily focus on gender equality.

Reporting under the Organisation for Economic Co-operation and Development

A tool familiar to most donors is OECD's CRS. OECD member countries have committed to report whether the activities they fund target gender equality as a policy objective (Box 7). Reporting is also categorized by sector, including funding for control of STDs, including HIV.

The data can be used to monitor funding for gender equality for STD control including HIV. For example, in 2016, 19% of funding disbursements for STD/HIV had gender equality as a principal or significant objective

BOX 7

OECD Gender equality policy marker

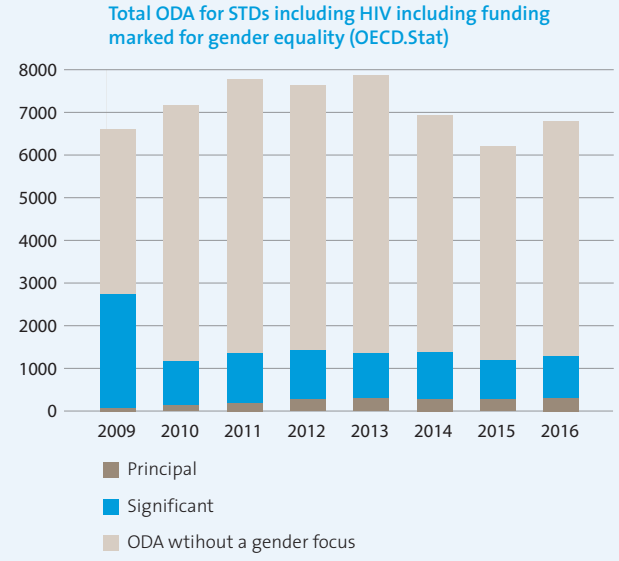
Principal (G2): Gender equality is the main objective of the activity (the activity would not have been undertaken without this objective).

Significant (G1): Gender equality is an important objective but not the principal reason for undertaking the activity.

Not targeted (G0): The activity has been screened against the maker but has not been found to target gender equality.

FIGURE 3

Total ODA for STDs including HIV funding marked for gender equality



(Figure 3). However, only 4% of funding in 2016 had gender equality as a principal objective.[68]

68 OECD OECD.Stat Dataset: Aid projects targeting gender equality and women's empowerment (CRS). Available at https://stats.oecd.org/. Accessed 12 October 2018. Selected for code 13040: STD Control including HIV/AIDS, for developing countries, gross disbursements, current prices, bilateral allocable, USD in millions. CRS dataset: Total funding for code 13040 STDs control including HIV; selection for ODA, all channels, gross disbursements, all types, current prices, USD in millions.

The OECD Network on Gender Equality (GENDERNET) tracks DAC members' support to gender equality and women's rights, including in the HIV response. The annual report summarises data on aid focused on gender equality and women's empowerment for each DAC member.

1.5.5
Civil society efforts to build capacity in gender responsive budgeting, in budget advocacy, and tracking funding

Civil society plays an important role in advocating for quality HIV services, supporting community-led HIV services, and advocating for new resources. Some organizations have also taken on the role of budget monitoring and advocacy. This may become increasingly important during the shift to domestic funding, which may exacerbate inequalities in the HIV response.[69]

69 International Treatment Preparedness Coalition. (2017). Civil society must participate in domestic funding dialogues – here's how. 6 October. Available at http://itpcglobal.org/civil-society-must-participate-domestic-funding-dialogues-heres/

Methodology

The mapping conducted an internet search to identify the work of organizations involved in tracking funding for gender equality in the HIV response. Search phrases combined: gender or gender equality with HIV, financing, funding, investing, budget, cost, spend, allocation, disbursement, and advocacy.

Findings

The mapping identified several organizations working on financing for gender equality in the HIV response. Their roles include capacity building in gender responsive HIV budgeting, budget advocacy, and/or tracking gender-responsive HIV budgets. These examples should be considered illustrative, given the immense amount of information online and the limited nature of the mapping.

The **Budget Advocacy School in Ukraine** builds the capacity of civil society institutions working in public health and budget advocacy in the countries of the region of Eastern Europe and Central Asia. This has included training to networks of women living with HIV in budget advocacy campaigns.[70]

The **Coalition for Gender and HIV & AIDS Advocacy** (COGHAA) worked to increase technical and financial support for gender-sensitive and transformative HIV and AIDS programming in Malawi. The work involved capacity strengthening for NACA; gender analysis of NACA budget; and development of a GRB

70 Budget Advocacy School. (2018). Budget advocacy school was held in Poltava for CO "Positive Women", 27 April. Available at http://budgetadvocacy.ua/en/analiz-efektivnosti-der-zhzakupivel-ustanovami-zahistu-zdorov-ja-2/

tool and policy guidance. The project was supported by the German BACKUP Initiative from 2009 to 2012. Additional, current information on COGHAA has not been found online.

The **Forum for Women in Democracy** (FOWODE) was at the forefront of introducing GRB to Uganda and currently has a Gender and Economic Policy Programme which engages in economic policy issues.[71] FOWODE coordinates the Eastern Africa Gender Budget Network which in 2006 organized a training workshop in gender budgeting for HIV/AIDS.[72] More recent information on their activities related to financing gender equality in the HIV response has not been found online.

The **Health Action Rights Group** in Uganda evolved from the Women's Treatment Action Group which was formed by a number of women living with HIV/AIDS to advocate for access to healthcare and treatment. Its mandate includes research and health budget advocacy.[73] The group does not have its own website and further information is unavailable.

The **Positive Womenís Network** in Tamil Nadu, India, advocated for a gender-sensitive approach to HIV budgeting, and successfully advocated for income support for widows who were HIV-positive.[74] The organization's website describes a range of activities to tackle issues affecting women and children with HIV and AIDS, but does not provide details on their work with budget advocacy.[75]

The **Resource Tracking for HIV Prevention Research & Development Working Group** tracks investment trends for biomedical HIV prevention options, including AIDS vaccines, microbicides, PrEP, treatment as prevention, VMMC, female condoms, PMTCT, and multipurpose prevention technologies.[76] The Working Group includes AIDS Vaccine Advocacy Coalition, the International AIDS Vaccine Initiative, and UNAIDS.

The **Tanzania Gender Networking Programme** (TGNP) advocates for gender-responsive policies, budgets, structures, plans and programmes.[77] Under the Feminism Activism Coalition, TGNP pioneered Tanzania's Gender Budget Initiative in 1997,[78] focusing on Gender Policy and HIV/AIDS.[79] More recent information on the Initiative has not been found online.

The **Institute for Democracy in South Africa** (IDASA) was a political think-tank which monitored the performance and accountability of the government.[80] It also tracked government prioritization of HIV in the budget.[81] IDASA also founded the South Africa's Women's Budget Initiative in 1995,[82] although whether it also assessed HIV budgets is unclear. After the government withdrew in 2001, the Initiative's future was

71 Forum for Women in Democracy. (2016). Gender and Economic Policy Programme. Available at http://fowode.org/wordpress/our-programmes/#1481119703105-d4f48363-a4f9

72 Pambazuka News. (2006). East Africa: Training workshop in gender budgeting for HIV/AIDS, 24 May. Available at https://www.pambazuka.org/gender-minorities/east-africa-training-workshop-gender-budgeting-hivaids

73 I-network. (2019). Profiles: Health Action Rights Group (HAG). Available at http://www.i-network.or.ug/rep/index.php?option=com_content&view=article&id=86:health-rights-action-group-hag&catid=40:profiles&Itemid=59

74 Nakray K. (ND). Gender Budgeting in India: Is it a silent revolution? Available at https://editorialexpress.com/cgi-bin/conference/download.cgi?db_name=IAFFE2009&paper_id=172&file_type=slides

75 Positive Women Network. (2015). Available at http://www.pwnplus.in/

76 Resource Tracking for HIV Prevention Research and Development Working Group. (2018). *HIV Prevention Research and Development Investments 2017: Investing to End the Epidemic*. New York: Resource Tracking for HIV Prevention R&D Working Group.

77 TGNP Mtandao. (2019). What we do. Available at http://tgnp.org/what-we-do/

78 Module II – Introduction to gender mainstreaming and gender analysis, case study 2: Gender budget initiative: the case of Tanzania. Available at https://www.ndi.org/sites/default/files/Handout%202%20-%20Gender%20Budget%20Initiative%20Case%20of%20Tanzania.pdf

79 Women for Water Partnership. (2016). Tanzania Gender Networking Programme Factsheet. Available at https://www.womenforwater.org/tgnp-factsheet.html

80 Wikipedia. (2018). Institute for Democratic Alternatives in South Africa. Available at https://en.wikipedia.org/wiki/Institute_for_Democratic_Alternatives_in_South_Africa

81 Roberts RA, Hickey A, Rosner Z. (2006). The role of community involvement in HIV programmes in South Africa. In *The HIV Pandemic: Local and Global Implications*, Beck EJ, Mays N, Whiteside AW, Zuniga JM, eds. Oxford: Oxford University Press.

82 Budlender D. (ND). Introduction: The Fifth Women's Budget. Available at https://www.internationalbudget.org/wp-content/uploads/Introduction-to-the-Fifth-Womens-Budget-Initiative.pdf

in question.[83] IDASA folded in 2013 due to financial difficulties.[84]

83 Hassim S. (2006). *Women's organizations and democracy in South Africa*. Madison: The University of Wisconsin Press.

84 IOL. (2013). Idasa to close after 27 years, 26 March. Available at https://www.iol.co.za/news/politics/idasa-to-close-after-27-years-1492013

Discussion

With the exception of the Resource Tracking for HIV Prevention R&D Working Group, information on non-profit and civil society groups tracking and advocating for funding for gender equality in the HIV response was difficult to find. This suggests that either:

- Little work is being done by civil society on gender-responsive HIV budgeting or tracking expenditures for gender-responsive HIV interventions. This may be due to lack of organisational interest or lack of budget. Research in Nigeria found that CSOs are often dependent on international donors for funding, and that grants to CSOs are almost always for service delivery. This results in weakened advocacy efforts, particularly at the national level. Civil society advocacy is shaped and limited by donor funding choices and capacity development efforts.[85]
- The work that is being done at the intersection of HIV and gender financing is not published online. This may particularly be the case with smaller organizations that have limited budgets.
- Organizations that work on advocating for and tracking funding for gender equality in the HIV response have been forced to downsize or shut down due to internal or external constraints. One of the constraints may be the lack of HIV funding for CSOs. According to UNAIDS, 40% of CSOs working with HIV have experienced funding declines since 2013.[86]

85 Williamson RT, Rodd J. (2016). Civil society advocacy in Nigeria: promoting democratic norms or donor demands? *BMC Int Health Hum Rights*, Vol. 16, No. 19, doi: 10.1186/s12914-016-0093-z

86 UNAIDS. (2016). *Investing in community advocacy and services to end the AIDS epidemic*, 4 April. Available at http://www.unaids.org/en/resources/presscentre/featurestories/2016/april/20160404_community_advocacy

1.6.

FINANCIAL SUPPORT TO WOMEN'S ORGANIZATIONS AND NETWORKS OF WOMEN LIVING WITH HIV TO INCREASE GENDER EQUALITY AND WOMEN'S EMPOWERMENT

Women's organizations and networks of women living with HIV play a key role in designing and implementing programmes to increase gender equality and women's empowerment. UN This section describes other funding for women's organizations, particularly for HIV programming.

1.6.1
Overall funding for women's organizations

Women's organizations, particularly in developing countries, are not well-funded. The median income for women's organizations was only US$ 20,000, as found by a study by the Association of Women in Development in 2013. Half (52%) of the women's organizations in the study had never received multi-year funding and 48% had never received core funding support.[87] Similarly, a GENDERNET study found that 80% of gender-focused aid by OECD member states to CSOs in 2014 was for specific projects related to gender equality; only 20% was for core support.[88] Core support enables CSOs to strengthen their organizational capacity, adapt and innovate, and respond to their constituents' needs.

87 Arutyunova A, Clark C. (2013). *Watering the Leaves, Starving the Roots: The Status of Financing for Women's Rights Organizing and Gender Equality*. Toronto: Association for Women in Development.

88 OECD DAC Network on Gender Equality. (2016). *Donor support to southern women's rights organisations: OECD findings*. Paris: OECD.

1.6.2
Funding for women's organizations and networks working in HIV programming

Little research exists on HIV funding for women's organizations and networks. In 2014, the International Community of Women Living with HIV Eastern Africa studied whether organizations of women living with HIV and women human rights organizations in Uganda were benefiting from the increased funding for HIV. The study found that, to a large extent, the organizations did not experience resource growth despite an overall increase in HIV funding for the country.[89]

89 International Community of Women Living with HIV& AIDS Eastern Africa. (2014). Are women's organizations accessing funding for HIV & AIDS: Rapid Situation Analysis of access to funding by organisations of women living with HIV, gender and women human rights organisations in Uganda.

1.6.3
Discussion

Women's organizations and networks of women living with HIV are often hampered by their small size and limited growth opportunities, which limits their ability to compete with larger CSOs. In addition, the integration of HIV with SRHR and of women and girls with key and vulnerable populations has broadened competition for women's organizations wishing to work specifically with HIV. For example, the majority of UK investment in key populations and women and girls is now channelled through multilateral organizations and the Robert Carr Civil Society Networks Fund (RCNF).[90] RCNF supports international and regional civil society networks that work with people living with HIV, gay men and other men who have sex with men, people who use drugs, sex workers, transgender people, migrants, and youth. The All-Party Parliamentary Group report on *No One Left Behind* suggested that RCNF's work be expanded to include women's organizations. Women's civil society groups are concerned that "the push towards a key populations approach, where women and girls are not defined as a key population despite being disproportionately affected and facing similar barriers to accessing services, makes it harder for women's CSOs to access funding."[91]

90 The All-Party Parliamentary Group on HIV & AIDS. (ND). *No One Left Behind: Towards a Sustainable HIV Response for Key Populations and Women and Girls*. London: APPG.

91 The All-Party Parliamentary Group on HIV & AIDS. (ND). *No One Left Behind: Towards a Sustainable HIV Response for Key Populations and Women and Girls*. London: APPG.

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UN Women (2018) *Internal report for UBRAF.* Headquarters, New York.

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UN. (2014) *Report of the Secretary General on Women, the girl child and HIV and AIDS* (E/CN.6/2014/12, 2014). Available at www.un.org/ga/search/view_doc.asp?symbol=E/2016/27

UN Women (2012) *Transforming the National AIDS Response: mainstreaming gender into the three ones*. New York. Available at http://www.unwomen.org/en/digital-library/publications/2012/1/transforming-the-national-aids-response

UN Women (2015) *Championing Gender Equality in the HIV Response: the Experiences of five programme countries*. Available at http://www.unwomen.org/en/digital-library/publications/2015/4/championing-gender-equality-in-the-hiv-response-the-experiences-of-five-programme-countries

UNAIDS (2016) *Political Declaration on HIV and AIDS*. Available at www.unaids.org/en/resources/documents/2016/2016-political-declaration-HIV-AIDS

UNAIDS (2016) *Prevention Gap Report*. Geneva: UNAIDS.

UNAIDS (2017) *Unified Budget, Results and Accountability Framework (UBRAF) Performance Monitoring Report*. Geneva: UNAIDS.

UNAIDS (2018) *2018 Global AIDS Update: Miles to Go, Closing Gaps, Breaking Barriers, Righting Injustices*. Geneva: UNAIDS.

1.8.

APPENDIX: FINANCING FOR GENDER EQUALITY IN SELECTED DONOR HIV PROGRAMMES

United States

Development aid for HIV flows primarily through the PEPFAR implemented by the USAID. One of the five PEPFAR priorities is adolescent girls and women.[92] In 2013, PEPFAR updated its Gender Equality Strategy to help PEPFAR country teams and implementing partners (a) develop country and regional operational plans, (b) design programmes that integrate gender issues, and (c) work to advance gender equality throughout the HIV continuum of prevention, care, treatment and support. Along with the requirement that all HIV programmes should identify gender-related issues and take concrete steps to address them throughout the program cycle, there was a new PEPFAR requirement added, which was to undertake a gender analysis related to HIV at the country-level by March 2016.[93]

92 The United States President's Emergency Plan for AIDS Relief. (ND). Adolescent Girls and Women. Available at https://www.pepfar.gov/priorities/girlswomen/index.htm

93 The United States President's Emergency Plan for AIDS Relief. (2013). *Updated Gender Strategy*. Washington DC: PEPFAR, Washington D.C.

Funding for gender equality in the HIV response*

Data from OECD shows that while United States Government bilateral aid disbursements for STD control including HIV have declined, the amount for projects with a gender objective has remained at approximately US$ 1,000 million (20-23% of the total disbursement) during the past five years. Most of the funding is for projects where gender equality is a significant objective.

* Funding figures for all five countries extracted from OECD OECD.Stat Dataset: Aid projects targeting gender equality and women's empowerment (CRS). Available at https://stats.oecd.org/. Accessed 12 October 2018. Selected for code 13040: STD Control including HIV/AIDS, for developing countries, gross disbursements, current prices, bilateral allocable, USD in millions. Total funding for code 13040 STDs control including HIV; selection for ODA, all channels, gross disbursements, all types, current prices, USD in millions.

How is funding tracked?

The Fiscal Year 2018 Congressional Budget Justification Supplement for PEPFAR provides a breakdown of the PEPFAR budget by country/region, core funding, implementing agency, and other funding categories.[94] Budget line items for each country are provided for antiretroviral drugs (ARV) and adult and paediatric treatment, but does not include any gender markers. Country Operational Plan Strategic Discussion Summaries highlight gender-transformative activities and efforts to shift gender norms and address GBV, and the Budget and Target Reports provide targets for GBV (GEND-GBV),[95] but not the budget amounts.[96] The PEPFAR Dashboard does not provide expenditures over time for addressing GBV (not a program area).[97]

94 The United States President's Emergency Plan for AIDS Relief. (2018). *Fiscal Year 2018 Congressional Budget Justification (CBJ) Supplement*. Available at https://www.pepfar.gov/reports/progress/277818.htm

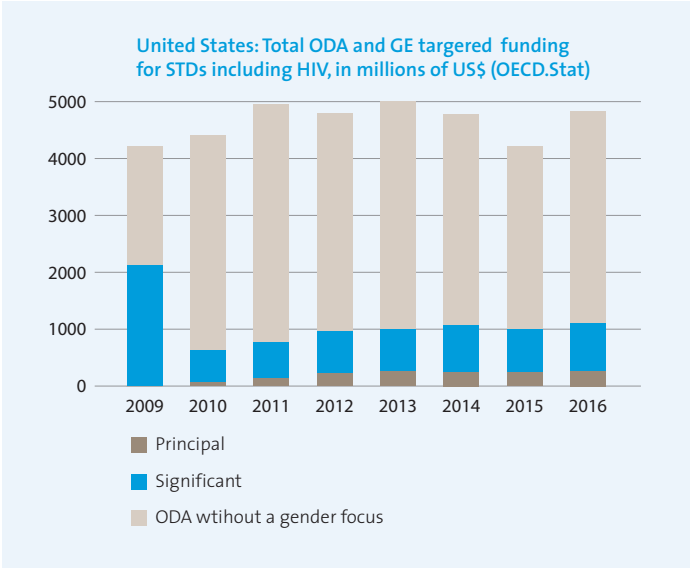
95 Number of people receiving post-gender-based violence (GBV) clinical care based on the minimum package. PEPFAR (2017) *Monitoring, Evaluation, and Reporting (MER 2.0) Indicator Reference Guide*. Available at https://www.pepfar.gov/documents/organization/274919.pdf

96 The United States President's Emergency Plan for AIDS Relief (2017) *FY 2017 PEPFAR Operational Plan Budget and Target Reports*. Available at https://www.pepfar.gov/countries/cop/fy2017/c77383.htm

97 PEPFAR Panorama Spotlight. Available at https://data.pepfar.net/country/expenditure?country=Global&year=2012&yearTo=2016

FIGURE 4

United States: Total ODA and GE targeted funding for STDs including HIV, in millions of US$



The Foreign Aid Explorer is a data repository for tracking all foreign assistance activities funded by the U.S. Government. This collection of datasets contains the U. S. Government's Annual Assistance Report to the OECD DAC. While it contains an OECD DAC Sector Summary, data on gender marked expenditures could not be found.[98]

98 USAID (2019) Collection of U.S. CRS++ Annual Submissions to the OECD. Available at https://www.usaid.gov/data/dataset/9729eab5-b9d5-475d-84e8-08bd8a6cc7fe

Funding for women's organizations working on HIV

The PEPFAR webpage for partnerships describes work with community and civil society, faith-based organizations, and the private sector.99 Many of these partnerships work on gender equality, such as the public-private partnership Together for Girls, which focuses on preventing sexual violence against girls.[100] While in all likelihood specific PEPFAR country programmes may work with women's organizations, an explicit organizational prioritization of support specifically to women's organizations could not be found.

99 PEPFAR. Sustainability and partnerships. Available at https://www.pepfar.gov/priorities/sustainabilitypartnerships/index.htm

100 Together for Girls: Strength in Numbers. Available at https://www.togetherforgirls.org/

United Kingdom

The Department for International Development's (DFID) last published document on HIV was the 2011-2015 HIV Position Paper, which identified support for key populations and women and girls as a priority. However, the 2016 Bilateral Development Review states that "UK remains firmly committed to ending the AIDS epidemic as a public health threat by 2030. AIDS remains the leading killer of girls aged 10-14 across the globe today. The UK will continue to play our part and champion the rights and needs of the most vulnerable; adolescents, girls and young women, key populations and all those still left behind by the huge progress we are proud to have made."[101]

101 Department for International Development. (2016). *Rising to the challenge of ending poverty: The Bilateral Development Review 2016*. London: DFID.

Funding for gender equality in the HIV response

UK's funding for STD control including HIV has dropped significantly from almost US$ 350 million in 2009 to US$ 23 million in 2016. However, as reported by the UK to the OECD, the proportion of STD/HIV projects with a gender equality objective has mostly remained in the 59%-69% range, and in 2016, 24% of project disbursements had gender equality as a principal objective.

The majority of UK investment in key populations and women and girls is now channelled through multilateral organizations including the Global Fund, RCNF, UNITAID, and UNAIDS.[102]

102 The All-Party Parliamentary Group on HIV & AIDS. (ND). *No One Left Behind: Towards a Sustainable HIV Response for Key Populations and Women and Girls*. London: APPG.

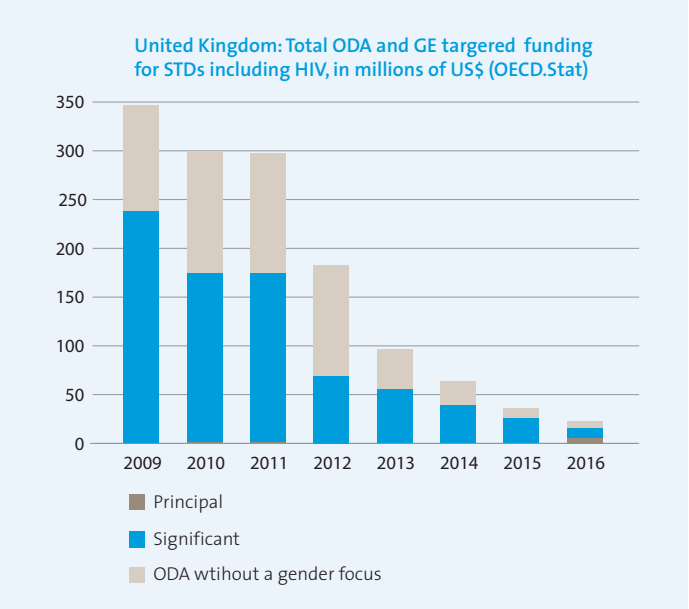
How is funding tracked?

DFID's support to gender equality and women's empowerment in the HIV response has largely been integrated into sexual and reproductive health programmes. Because of this integration and the challenges in using the HIV Policy Marker, tracking funds for HIV is challenging, not to mention funds for gender equality in the HIV response. "DFID has lost its ability to measure its impact within the HIV response. DFID's policy marker cannot track whether HIV has been successfully integrated into wider SRHR, health and development programmes or if it has completely disappeared. DFID cannot track the results it is achieving within the majority of its bilateral spending on HIV." [103]

103 StopAIDS. (2017). *A Stocktake Review of DFID's Work on HIV and AIDS*. London: StopAIDS.

FIGURE 5

United Kingdom: Total ODA and GE targeted funding for STDs including HIV, in million US$



Funding for women's organizations working on HIV

A significant recipient of civil society funding is the RCNF. RCNF supports international and regional civil society networks that work with people living with HIV, gay men and other men who have sex with men, people who use drugs, sex workers, transgender people, migrant, and youth.[104] DFID's investment in the RCNF was £5 million between 2015-2018. In July 2018, DFID announced an increase of 20%, bringing its total contribution to £6 million (2019-2021). However, the All-Party Parliamentary Group report on *No One Left Behind* suggested that RCNF's work be expanded to include women's civil society groups. Women and girls are generally not defined as a key population, which makes it harder for women's CSOs to access funding, for example from the Global Fund.[105] DFID also currently has new mechanisms for funding civil society, UK Aid Connect, UK Aid Direct, and the Small Charities Fund.

104 Robert Carr Fund for Civil Society Networks. Available at http://www.robertcarrfund.org/

105 The All-Party Parliamentary Group on HIV & AIDS. (ND). *No One Left Behind: Towards a Sustainable HIV Response for Key Populations and Women and Girls*. London: APPG.

France

France does not have a specific HIV policy or strategy. France's Strategy for Global Health 2017 prioritizes integrated approach to fight communicable diseases including HIV, including giving greater prominence to gender in policies and programmes (Priority 1, Objective 2).[106]

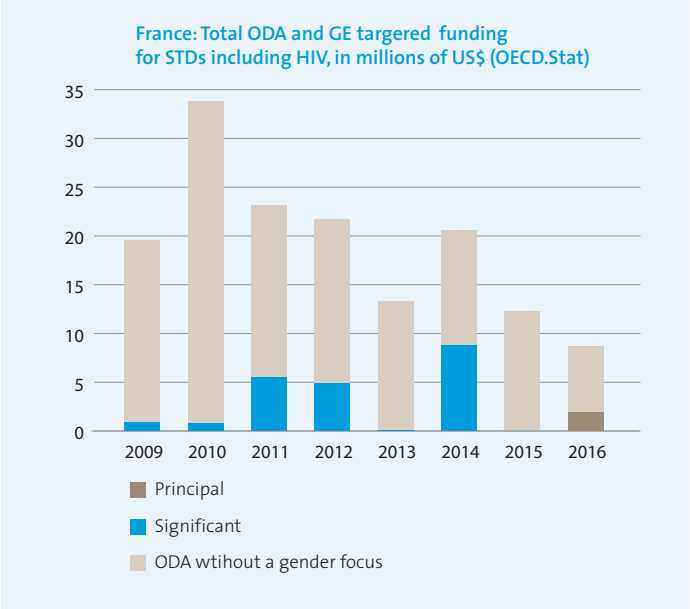
106 France Diplomatie. (2019). France, a key player in global health. Available at https://www.diplomatie.gouv.fr/en/french-foreign-policy/health-food-security-nutrition-sustainable-agriculture/health/article/france-s-strategy-for-global-health-2017

Funding for gender equality in the HIV response

According to OECD.Stat, the amount of funding provided by the French Government to STD programmes including HIV has declined. Contributions to gender equality priorities within STD and HIV programmes have varied from year to year, from 2% of all funding for STD control including HIV in 2009 to 42% in 2014. No STD/HIV projects had gender equality as a principal objective until 2016.

FIGURE 6

France: Total ODA and GE targeted funding for STDs, including HIV, in million US$



How is the funding tracked?

France has developed its own rating scale to improve tracking of funding for gender equality, including in the HIV response, and account for Agence Française de Développement (AFD) financing provided in the framework of the OECD-DAC.[107] A project focus on gender equality is determined through five questions:

- Does the project take into account the needs and interests of men and women (through diagnosis, participation, communication)? Alternatively, has a **dialogue** been engaged with counterparts on gender equality in the sector/organization concerned? *Mark 1*
- Is one of the project's explicit objectives to ensure that **women have effective access to the services**/ amenities/goods provided under the project? Alternatively, is one of the project's objectives to encourage **women to control the resources in the sector concerned** and to foster their participation in the project's governance processes? *Mark 2*
- Is one of the project's main objectives **to empower women and to reduce the structural inequality** between men and women (control of resources, participation in governance bodies, effective implementation of institutional/legal changes)? *Mark 3*
- Will the project maintain gender inequality (although it may provide an opportunity to reduce inequality, it does not include any specific measure to do so)? *Mark -1*
- Is there a risk that the project will aggravate gender inequality? *Mark -2*

Projects marked 3 in the AFD are given a 2 in the OECD-DAC framework; 2 receives a score of 1; and 1, 0, -1, and -2 receive a score of 0, respectively.

107 Agence Française de Développement. (2014). *Methodology Guide to the "sustainable development opinion" mechanism*. Paris: AFD.

Funding for women's organizations working on HIV

The *AFD Strategy: Partnerships with Civil Society Organizations 2018-2023* highlights the French Government's desire to strengthen partnerships with CSOs and increase the share of official development assistance channelled through them. The sectors where CSOs received the most funding during 2012-2016 were: health and the fight against AIDS (18% of total financing), governance and human rights (18%), and agriculture (18%). The amount of funding for HIV is not specified. Going forward, AFD aims that "the women's associations supported in the context of projects have greater visibility. They are key actors in the implementation of activities that contribute to reducing gender inequalities and consequently need to be better known."[108]

108 Agence Française de Développement. *Strategy: Partnerships with Civil Society Organizations 2018-2023*. Paris: AFD.

The Netherlands

The Netherlands Ministry of Foreign Affairs (MFA) does not have a specific HIV policy. HIV/AIDS prevention is integrated with SRHR, with gender equality a cross-cutting goal in all areas.[109]

109 Ministry of Foreign Affairs of the Netherlands. (2018). *Investing in Global Prospects: For the World, For the Netherlands*. The Hague: Ministry of Foreign Affairs of the Netherlands.

Funding for gender equality in the HIV response

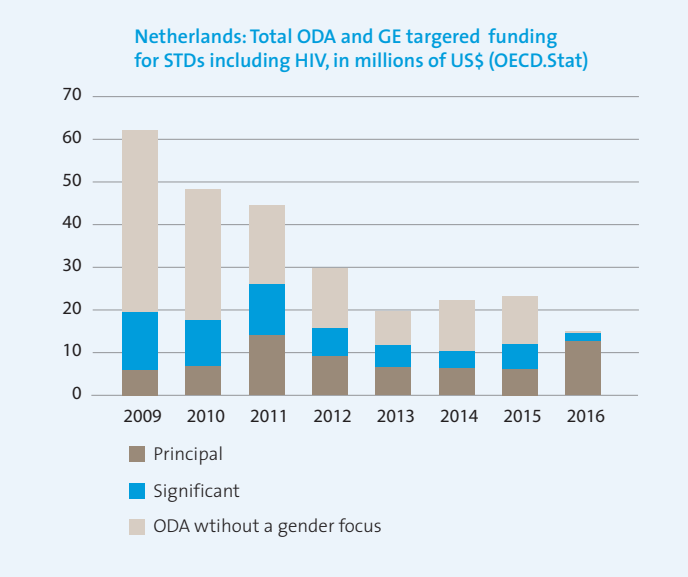
While funding from the Government of the Netherlands for STD control including HIV has declined, the proportion earmarked for gender equality has increased from 31% in 2009 to 98% in 2016. Almost all (98%) STD/HIV funding disbursed in 2016 had a gender equality objective, of which the majority was for projects with gender equality as the principal objective.

How is the funding tracked?

Funding for gender equality, including in STD and HIV programmes, is tracked using the OECD-DAC framework. However, a 2015 evaluation of the Dutch international gender policy for the period 2007-2014 found that tracking funding for integrated gender equality budgets was not possible because of the inconsistent use of the gender marker. Funding could only be tracked for budgets for the stand-alone track focusing on women's political participation and leadership, economic independence, combating violence against women and support for the UN Security Council Resolution 1325 on women and peace and security.[110]

FIGURE 7

The Netherlands: Total ODA and GE targeted funding for STDs including HIV, in million US$



110 Ministry of Foreign Affairs of the Netherlands. (2015). *IOB Evaluation: Gender sense and sensitivity - Policy evaluation on women's rights and gender equality (2007-2014)*. The Hague: Ministry of Foreign Affairs of the Netherlands.

Funding for women's organizations working on HIV

To achieve gender equality and empowerment of women and girls, the MFA has a strong focus on strengthening women's participation in political and other decision-making and women in leadership.[111] A key tool is the Funding Leadership and Opportunities for Women (FLOW) fund, which supports women's leadership and strengthens political participation, economic empowerment and resilience against violence with an allocation of 93 million EUR for the period of 2016-2020. HIV is not a thematic priority.[112] As with the MDG3 Fund and the first FLOW fund, no preference was given to women-led or feminist organizations.[113] The nine recipients included Women for Women International, SNV, International Women's

111 Ministry of Foreign Affairs of the Netherlands. (2018). *Investing in Global Prospects: For the World, For the Netherlands*. The Hague: Ministry of Foreign Affairs of the Netherlands.

112 Government of the Netherlands. Funding Leadership and Opportunities for Women (FLOW 2016-2020). Available at https://www.government.nl/topics/grant-programmes/documents/decrees/2015/06/12/funding-leadership-and-opportunities-for-women-flow-2016-2020

113 Government of the Netherlands. (2016). Letter on the selection of projects for FLOW 2016-2020. Available at https://www.government.nl/documents/letters/2016/02/25/letter-dated-on-the-selection-of-projects-for-flow-2016-2020

Development Agency, Action Aid, Consortium Rutgers, Promundo, and Sonke Gender Justice, Consortium Simavi, Solidaridad, and Healthy Entrepreneurs Foundation, Hivos, and the Panos Institute West Africa.[114]

The previous MDG3 Fund similarly invested in projects that promoted equal rights and opportunities for women and girls. An evaluation of the fund in 2015 found that 55% of fund recipients were women's rights organizations and 13% were women's funds. HIV was not a thematic priority.[115]

114 Government of the Netherlands. Funding Leadership and Opportunities for Women (FLOW 2016-2020).

115 Government of the Netherlands. (2015). IOB – Evaluation of the MDG3 Fund o 'Investing in Equality (2008-2011). Available at https://www.government.nl/documents/reports/2015/04/01/iob-evaluation-of-the-mdg3-fund-investing-in-equality-2008-2011

Germany

Germany integrates HIV interventions into broader health systems and interventions on sexual and reproductive health and rights (SRHR).[116]

116 Federal Ministry for Economic Cooperation and Development. (ND). HIV and infectious diseases. Available at http://health.bmz.de/what_we_do/HIV_and_infectious_diseases/index.html

Funding for gender equality in the HIV response

While German funding for STD control including HIV has declined, the proportion of funding categorized as contributing to gender equality has consistently remained above 95% of disbursements. Funding allocated to STD/HIV programmes that have gender equality as a principal objective has ranged from 24% in 2012 to 5% in 2016.

FIGURE 8

Germany: Total ODA and GE targeted funding for STDs including HIV, in million US$

How is the funding tracked?

The Federal Ministry for Economic Cooperation and Development (BMZ) began using the OECD DAC gender markers in 2001. However, because the practical application of gender markers in German development cooperation indicated that there are divergent interpretations of the OECD DAC criteria for allocating the markers, the BMZ identified new criteria for awarding the gender markers in 2006. Changes included the improved use of verifiable indicators and data on gender, a requirement for gender analysis and concrete action plans, provision of detailed rationale for the marker selected, and assessment across the entire cooperative project or program.[117] The Deutsche

117 GTZ. (2006). *Impacts on Gender Equality in Development Cooperation Interventions: Gender Markers in Technical and Financial Cooperation.*

Case Studies and Standard Materials. Available at http://www.oecd.org/dac/gender-development/40068894.pdf

Gesellschaft für Zusammenarbeit (GIZ)[118] guidance on the policy marker system in 2014 also discussed the DAC gender equality marker and provided examples of development cooperation measures for which gender equality is a principal (GG 2) or significant (GG 1) objective.[119]

118 GIZ is the technical arm of the BMZ in the German aid program structure. In was created in 2011 through a merger of German Technical Cooperation (GTZ), German Development Service (DED), and InWEnt.

119 GIZ. (2014). *The Policy Marker System: DAC Markers, BMZ Markers - Guidelines*. Available at http://www.oecd.org/dac/gender-development/BMZ%202014%20The%20Policy%20Marker%20System.%20DACBMZ%20Markers.%20Guidelines.%20EN.pdf

Funding for women's organizations working on HIV

Working with civil society is a component of many GIZ projects. However, information could not be found on the extent of funding specifically for women's organizations working with HIV.

2. Financing for Gender Equality in the HIV and Health Responses

Discussion Paper

United Nations University –
International Institute for Global Health

"We, Heads of State and Government and representatives of States and Governments (...) [c]ommit to achieving gender equality and the empowerment of all women and girls, to respecting, promoting and protecting their human rights, education and health, including their sexual and reproductive health, by investing in gender-responsive approaches and ensuring gender mainstreaming at all levels, supporting womenís leadership in the AIDS response and engaging men and boys, recognizing that gender equality and positive gender norms promote effective responses to HIV."

Political Declaration on HIV and AIDS, United Nations General Assembly

8 June 2016

2.1.

EXECUTIVE SUMMARY

The 2016 Political Declaration on HIV and AIDS includes bold high-level commitments from global and national actors to achieving gender equality and empowering women and girls, as well as a recognition that addressing gender-inequitable norms will contribute to a more effective HIV response. In this paper, we set out to examine the extent to which gender equality is being prioritised and financed in HIV responses and discuss relevant innovative approaches and lessons on financing structural interventions in HIV and health.

Limited accountability frameworks

We find that despite strong political will and remarkable progress in raising the profile of gender equality in the HIV agenda, it is still not possible to determine whether commitments have been matched with adequate resources. There are insufficient efforts and no harmonised system to track financing and expenditures in this programme area. This is compounded by a lack of clarity on what is considered a gender equality investment in the context of the HIV response. Within current policy, guidance and accountability frameworks, there is a lack of specificity and consensus on which gender-transformative interventions to prioritise in HIV responses, and limited impact targets for gender equality and related tracking mechanisms to hold stakeholders accountable. This is likely to further constrain the levels of financing available for, or counted as, investments in gender equality.

Current levels of gender equality prioritisation and spending

These policy and implementation challenges limit the visibility of gender equality spending at global and national levels. Gender-related expenditures appear to be subsumed under the category of 'social enablers', which are on average 3-12% of total HIV spending. Based on an analysis of the last AIDS spending assessments in selected countries, we found that between 0.7% and 15.2 % was spent on women-specific programmes, and 0-1% on gender-transformative programmes. More recently, there have been important initiatives by global funders and in some national responses to prioritise comprehensive gender-responsive programmatic packages, specifically for adolescent girls and young women in sub-Saharan Africa. However, the levels of investments in the structural intervention components within those packages to transform gender norms and promote gender equality are still relatively low and are likely to require further investments to scale-up delivery and reach.

Recommendations

To increase the volume and efficiency of gender equality investments within the HIV response, we recommend the development of a clear and common conceptualisation of gender equality programming as the basis for better standardised tracking and financing. We also propose that, given the multi-sectoral benefits of investing in gender equality, the HIV response should consider outcome-based and cross-sectoral financing mechanisms to leverage non-HIV platforms and investments.

RECOMMENDATIONS FOR INNOVATIVE FINANCING OF GENDER EQUALITY IN HIV RESPONSE

1. Set a financing target for gender equality expenditures within HIV responses for greater prioritisation of gender equality investments within the HIV resource envelope.
2. Prioritise the right gender-transformative interventions within HIV platforms and combination packages of services.
3. Leverage non-HIV platforms and resources through cross-sectoral co-financing for large scale programmes with gender equality objectives.
4. Ensure greater accountability through gender-responsive expenditure tracking.
5. Consider channelling resources through ring-fenced financing or outcome-based financing.

2.2.

INTRODUCTION

The end of AIDS is nowhere in sight. An estimated 36.9 million people were living with HIV in 2017, of which 1.9-2.5 million were newly infected.[1] [120] While AIDS has claimed the lives of over 35 million people, an estimated 940,000 people died of AIDS-related causes in 2017 alone.[1] The international community has set itself the ambitious target of ending AIDS as a public health threat by 2030. To achieve this goal, UNAIDS launched the Fast-track initiative and the 90-90-90 targets to frontload investments before 2020 to optimise treatment and control the epidemic.[2,3] Despite great optimism and substantial progress towards these treatment targets, there is an important recognition that they will not be met without addressing the structural drivers of risk, service uptake and adherence.[2,4,5]

Women and girls continue to be disproportionately affected by the epidemic. HIV is the leading cause of death for women aged 15-44 worldwide, with girls accounting for more than 75% of all new adolescent HIV infections in the hardest-hit countries.[6,7] Gender inequality within intimate relationships, families, communities and at higher structural levels consistently undermines the HIV response. Gender-inequitable norms, power imbalances and violence against women and girls lead to constrained personal agency, inequitable access and control over resources, and normalised experiences of discrimination and violence, that impede protective HIV-related behaviours, service uptake and ultimate prevention and treatment outcomes. [6,9–13]

The global AIDS response has acknowledged the role of gender inequality in the HIV epidemic, and made repeated commitments to promoting gender equality and gender mainstreaming, starting with the Declaration of Commitment in 2001, and then the Political Declaration on HIV in 2006.[2] The 2016 Political Declaration on HIV and AIDS marked the strongest commitment to gender equality to date, with a bold pledge to pursue "transformative AIDS responses to contribute to gender equality and the empowerment of all women and girls," including an explicit target to reduce the number of adolescent girls and young women newly infected with HIV to below 100,000 by 2020.

120 Superscript numbers in this paper refer to the respective numbers in section 2.8 Endnotes.

Despite these lofty global commitments and increasingly ambitious targets, international HIV financing is dwindling, as evidenced by a 20% drop between 2013 and 2016.[4,6,14] In this context of diminishing resources, there is a greater prioritisation of biomedical approaches to prevent and treat our way out of the epidemic, and a retrenchment of resources to address the structural drivers of HIV that continue to fuel transmission and constrain effective treatment coverage. At present, about 56% of HIV financing is spent on ART treatment; a proportion that has been increasing with time.[14]

The gap between gender equality policy commitments and the programming reality on the ground has been flagged as an area of concern.[4,15,16] Interventions that address inequitable gender dynamics are perceived as luxuries that could be considered in a previous time of plenty, but do not make the cut anymore, as national responses need to prioritise the most cost-effective interventions with demonstrated HIV endpoints.[17–19]

An underlying argument for this lack of prioritisation has been that there is not enough evidence and consensus on which interventions effectively address gender inequality within the HIV response, and how these interventions enhance the effectiveness of basic HIV programmes. Moreover, assessments of their value for money suggest that they may not be cost-effective from an HIV perspective. This reflects a more general concern around structural approaches, which tend to be undervalued in investment analyses because their non-HIV benefits are ignored.[20,21] Current policy documents provide limited or inconsistent guidance on the difference between interventions that are focussed on women and girls, and interventions that aim to promote gender equality. Programmes that target women and girls, such as prevention of mother-to-child transmission (PMTCT) programmes, are often synonymized with gender equality, although most do not include transformative elements that address power imbalances or seek to change the position and roles of women in society.

Other policy challenges that have been raised in the literature include the absence of accountability frameworks for global and national actors to track and report on gender equality investments and achievements (see Box 1). For one, political commitments have fallen short of setting specific outcome targets for gender equality (with the exception the 2016 prevention target for adolescent girls and young women (AGYW), in comparison to the specificity articulated in other HIV targets. Even where gender equality targets are in place, the focus is usually on gender-based violence (GBV) and excludes other domains, such as caregiving, education, human rights, social protection and other intermediate structural outcomes (sociocultural, policy and regulatory) that contribute to gender inequality in HIV.

Indeed, at a process level, only 57% of the 96 countries reporting to UNAIDS had integrated aims of gender equality in their national HIV policies and strategies in 2017.[22] An analysis of national strategic plans for HIV in 18 sub-Saharan African countries found that only 31% of targets were sex-disaggregated, with most of those related to GBV.[15] Moreover, the limited set of gender-responsive interventions included have generally not been costed or budgeted for, and thus not adequately resourced and implemented.[16]

BOX 1

Challenges in Gender Equality Policy & Financing in the HIV Response

- Lag in national implementation of gender strategies and specific targets[14,15]
- Weak accountability frameworks with lack of defined gender equality categories and definitions for resource tracking[16]
- Top-down agenda-setting and programmatic development without consultations with grassroots women's groups[16]
- Data reporting gaps within current global reporting requirements[17]
- Lack of consensus on the strength of existing evidence on the impact and value of gender equality interventions[17–19]

In this paper, we seek to:

- summarise the evidence on which gender-responsive interventions HIV responses should invest in to achieve gender equality;
- examine the extent to which gender equality is being prioritised and financed in HIV responses; and
- present innovative approaches and lessons learned on financing structural interventions in HIV and health.

In the next section, we clarify our conceptual framing of the rationale for financing gender equality within HIV responses, as well as how this influences the type of interventions and actions we consider for investment. We use this framing and proposed categorisation of gender-responsive investments to guide the rest of the paper. We then provide an overview of what gender equality investments are known to work and represent good value for money. Next, we present the financing landscape and the extent to which gender equality is being resourced at the global and national level, before discussing potential strategies to increase financing for this area and tap innovative financing approaches. Finally, we summarise our findings and present a set of recommendations for consideration.

2.3.

FRAMING GENDER EQUALITY INVESTMENTS IN HIV RESPONSES

2.3.1
Rationale for investing in gender equality

There are two conceptual approaches to prioritising and financing gender equality in health programmes (and indeed in other sectors).[23] The first considers that the health sector has a distinct mandate to contribute towards the achievement of gender equality. Conceptually, this means that in addition to its health objectives, it has an equally important gender equality objective. In principle, this is the basis for promoting gender mainstreaming, and the idea that the achievement of gender equality and women's empowerment is 'everyone's business'. This is also how the HIV response tried to galvanise multi-sectoral action and HIV mainstreaming in other sectors, by handing them an HIV mandate. Evidence suggests that the results of this gender (and HIV) mainstreaming approach, even within the wider health sector, have been mixed and overall, rather limited.[24–26]

The second approach and rationale for investing HIV resources in gender equality interventions is the instrumental or efficiency approach, which takes the standpoint that HIV responses need to address gender inequality to enhance the efficiency of HIV interventions and achieve HIV outcomes. This instrumental approach now dominates in the HIV field, with the ubiquitous treatment and prevention cascades. The cascade is a programmatic interventionist

approach that takes effective intervention coverage as its endpoint and breaks this down into distinct steps along the client/patient pathway from needing a service or an intervention, to making full use of it and reaping its benefits. Gender inequality and GBV are viewed as barriers and factors that cause attrition along the cascades. Most of the current evidence relates to how these factors undermine the treatment cascade. Indeed, a global review of the literature and experiences found that while there have been improvements from the supply-side for better access, women still face barriers to treatment, due to violence at the family, community and healthcare institutional levels, along with pervasive cultural, economic and human rights-related factors.[27]

At the individual level, internalized stigma, fear and past experience of violence influence health-seeking, induce mental health challenges, and contribute to lower rates of treatment initiation, follow-up and adherence. In economic terms, many women in need of treatment struggle to meet basic needs, such as food and nutrition, housing, school fees, and transport. They tend to prioritise and allocate resources to their children first, before themselves. Additionally, women and girls often face an amplified economic and work burden of HIV, due to disparate income and leadership levels, HIV-related discrimination (termination or refused employment), gender norms that encourage participation in the informal sector (without legal protection of their work, and without employer-contributed health insurance), and higher representation in caregiving roles within homes and communities. Therefore, even in cases where treatment or interventions are highly subsidised at the point of use, the associated economic costs, such as transport and opportunity costs restrict the uptake.

Within healthcare institutions, many women and girls encounter violations of their rights, privacy and confidentiality, such as when health care professionals disclose their status to family, other staff or clients without prior consent, coerce or force sterilization, refuse care, and do not link them with appropriate levels of information or counselling. Within families, communities and national settings, women and girls encounter physical, sexual, psychological and emotional violence, or have constrained personal agency to make decisions, including the need to seek spousal or parental permission in health-seeking, as a result of prevailing gender norms and/or national legal frameworks.

GBV and intimate partner violence (IPV) is the most severe manifestation of gender inequality, and its impact on HIV risk and treatment has been better researched and documented than other domains. Evidence on how GBV is a barrier to HIV treatment has been reported in systematic reviews of quantitative and qualitative studies (as summarised in Table 1).[28]

TABLE 1

Evidence on GBV as a structural barrier along the treatment cascade

AGYW access to HIV testing and linkage to care	AGYW access to ART initiation	AGYW adherence and retention in care
Gender inequality undermines women's decision making autonomy about HIV testing.[29] Fear of IPV prevented some women from accessing testing, but other studies showed no difference in uptake or access by IPV status. One study suggested that IPV motivates HIV testing.[30] Fear of violence prevented disclosure.[30]	IPV was associated with inability to access care and treatment, although one outlier did not show an association.[30] IPV was associated with lower 'current ART use' among women in a meta-analysis.[31] Women were reluctant to, or did not include at all, their male partners in PMTCT services due to fear of violence.[32]	IPV reduced odds of women adhering to ART by half.[31]* Partner abuse associated with poor medication adherence leading to poor treatment outcomes (VL, CD4+).[33] IPV associated with treatment discontinuation in two studies.[18] Some evidence for IPV increased loss to follow up.[31]

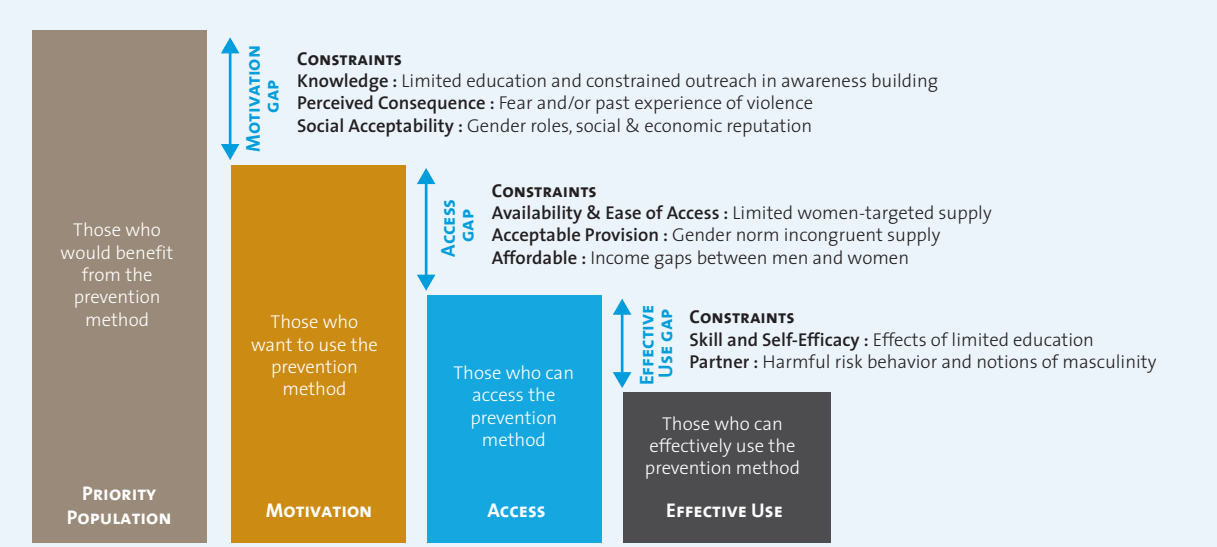
Source: Review of systematic reviews from STRIVE[5]

Beyond this, there are gaps in the literature on the impact of gender equality in the HIV response. Research has placed less emphasis on how and the extent to which gender disparities affect effective coverage for prevention interventions (excluding pregnant women and PMTCT), and among specific groups of vulnerable women, such as women who inject drugs or those whose partners have sex with men, where there is often limited sex-disaggregated data and quantitative studies on human rights violations, gender inequality and discrimination in care.[27]

Although there is less evidence on the role of other sources and manifestations of gender inequality in HIV prevention, qualitative data and grey literature provide compelling illustrations of how gender inequality similarly undermines HIV outcomes for key population groups, and in generalised epidemic settings.[27] Figure 1 is an adapted reproduction of the prevention cascade that draws attention to how gender inequality is likely to impede HIV prevention outcomes and how gender-equality interventions could target and address barriers to effective service use and coverage.

FIGURE 1

Gender Inequality along the Prevention Cascade



	Motivation	Access	Effective Use
Interventions	Sex-Education, Education and Peer-based Programmes	Mass distribution, Integrated Health Service, Outreach, Legislative Change	Incentives, Behavioural Counselling
Platforms	School, media, community including NGOs	Legal and regulatory system, health sector, private actors including NGOs and employers	Legal and regulatory system, health sector, private actors including NGOs and employers

Source: Adapted from STRIVE[5]

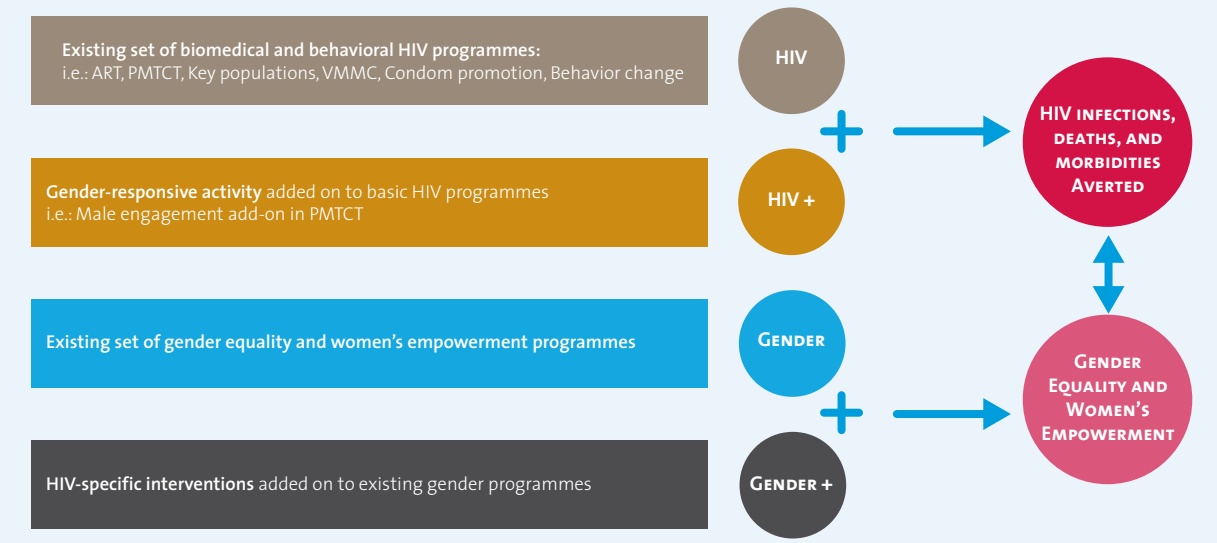
2.3.2
Proposed categorisation of gender equality interventions for HIV

The objectives of gender equality investment and the envisioned pathways to impact will determine the delivery platforms used and thus the types of interventions considered – indeed the 'why' influences the 'what'. Building on this logic and available evidence, HIV responses more likely prioritise gender-responsive interventions that can be added to HIV programmes to enhance their effectiveness. They are therefore more likely to limit themselves to HIV delivery platforms. However, HIV programmes may also invest in HIV-specific interventions that can be added to women's empowerment or gender equality programmes, again to maximise their HIV benefits.

Remme and colleagues (2014) present a conceptual categorisation and investment approach for gender-responsive activities within HIV responses (see Figure 2).[34] Interventions with both HIV and non-HIV impacts can be grouped into these categories, based on what their primary objectives are, and how they relate to basic HIV programme activities:

- **HIV category** includes basic programme activities within HIV responses that have direct HIV impacts and are primarily aimed at reducing HIV transmission, morbidity and mortality.
- **HIV+ category** includes gender-responsive intervention components that are added on to existing HIV programmatic platforms to address gender-related barriers, and thereby enhance the effectiveness of the basic HIV programme. An example would be transformative community mobilisation and empowerment activities for female sex workers (FSW), which would be included in the HIV programme for this population group, to prevent their exposure to violence and criminalisation, and enable them to adopt protective behaviours.
- **GENDER category** includes gender equality or women's empowerment programmes with no HIV-specific component or objective, but with demonstrated downstream HIV impacts. For example, GENDER activities include expanded secondary schooling for girls, or cash transfers for adolescent girls and young women.
- **GENDER+ category** includes HIV-specific intervention components that are added on to gender equality or women's empowerment programmatic platforms (GENDER+), such as an HIV training component for microfinance beneficiaries and post-exposure prophylaxis (PEP) in post-rape care.

FIGURE 2
Conceptual categories and investment approach for financing gender equality in HIV



While the HIV category includes biomedical and behavioural interventions that directly impact on HIV outcomes, other categories could indirectly contribute to positive HIV impact, either as part of HIV service packages or in combination with non-HIV services. Interventions that are delivered within HIV service platforms are likely to be assessed and financed differently than interventions delivered through non-HIV implementers in broader gender or development programmes. We discuss this and provide several suggestions of innovative co-financing and resource mobilisation arrangements in Section 2.6.

In addition, when conceptualising gender-responsive interventions, an important distinction needs to be made between interventions that consider gender factors and intentionally target specific groups of women to achieve certain policy or programme goals (gender-specific) on the one hand; and interventions that actively seek to address the causes of gender disparities and transform harmful gender norms, roles and power dynamics (gender-transformative) (refer to WHO definitions in the Appendix).[35] In this paper, we focus on the gender-transformative interventions with the ability influence gender dynamics and balance of power at institutional, cultural and relational levels.[10,18] These interventions are distinct from the gender-specific interventions and programmes that target women and girls (such as standard PMTCT and FSW programmes), which may not intrinsically change the social position of women, or address the negotiation of gender-based power, choice and ability within intimate relationships, familial, community or national settings.

2.4.

GENDER EQUALITY INVESTMENTS - WHAT WORKS AND BEST BUYS

The 2016 Political Declaration on HIV and AIDS committed to 'pursuing transformative AIDS responses to contribute to gender equality and the empowerment of all women and girls.'[2] Yet, there is limited clarity and consensus around which interventions are considered transformative, and have been found to be effective and cost-effective. Overall, many HIV stakeholders think there is insufficient evidence on their effectiveness and that they are less cost-effective than other HIV interventions options.[5,17,19]

Moreover, investments in such structural approaches have been further limited by perceptions that they are difficult to measure, too complex to address and too engrained to influence within programmatic timeframes, given the perceived long-term nature of social change.[28]

For over a decade, a relatively consistent menu of options has emerged in HIV strategic plans and programmes for intervening at the structural, health systems, community and interpersonal level to address gender inequality. The 2016 Political Declaration on HIV and AIDS commitments in this area include the following domains of interventions and actions:[2]

- Healthcare and social interventions for HIV prevention and treatment
- Economic empowerment and education

- Community mobilization – social capital, peer support and collective empowerment
- Advocacy and fulfilment of human rights
- Legislative reform that provides access to justice and non-discriminative legal frameworks
- Stigma and discrimination reduction programmes that targets general and key populations, and health care professionals
- HIV risk reduction communication and demand creation for prevention and treatment
- Shifting norms around gender-disproportionate unpaid care and domestic work, and delayed health-seeking behaviour
- Gender-based harassment, exploitation and violence prevention and response
- Support for women's leadership in the AIDS response.

2.4.1
Gender equality interventions with demonstrated HIV impact

There is a growing body of evidence on the impact of gender-transformative interventions within these domains, particularly for generalised epidemic settings.[18,34,36–38] Since 2010, the What Works consortium has been compiling and assessing the evidence base on women-specific and gender-transformative interventions. It currently includes over 2,000 research articles and studies published before 2011, including academic and grey literature, across multiple intervention areas from 94 countries. Grading of retrieved and included studies was based on a modified Grey scale, where an intervention was considered to 'work', based on the number of studies and countries in which it was found to be effective, and the strength of the study designs. Table 2 summarises the state of the evidence and includes interventions that have the most reliable and consistent evidence of impact (as presented by the authors).

Programmes and policies that focus on contextual, structural and sociocultural factors underlying gender inequality have consistently been found to create an enabling environment for effective HIV responses.[38,39] A focus on these elements has been found to increase protective behaviours and decisions especially among young women, more gender-equitable relationships, decreased gender-based violence, improved services for women, empowerment and an increased ability to cope with HIV. In addition, successful implementation of programmes has produced important HIV-related outcomes, such as reduced numbers of sexual partners, increased consistent condom use, reduced transactional sex, and reduced reported events of violence and substance use.

It is worth noting that the current body of evidence has several limitations. It mainly comprises country-level, observational or modelling studies, with limited meta-analysis, systematic reviews, randomised controlled trials or comparative trials. Although the impact of economic interventions, such as conditional cash transfers and micro-credit schemes have been explored, there are very few trials, and even fewer with a comparative or RCT design, or with HIV endpoints.[42] Many such interventions do not objectively or directly change the societal position of women in a way that enhances their choice or agency to engage in protective behaviours.[42] For many interventions that aim to address gender-based economic inequalities, such as supported employment and income-generating activities, there is still insufficient rigorous study and assessment of effectiveness in reduced risk.[40] For instance, nuanced and contextual understanding of how micro-financing initiatives reduce HIV risk or vulnerabilities in women is required. Women with higher levels of education or training, or established business or finance experience may benefit more from microfinance or loan schemes. Yet, without proper mentorship and training on the financial burden of loan repayments, this intervention can have unintended negative consequences.[40] Similarly, in sexual and reproductive health interventions, the evidence base for specific intervention types is weak, such as for supporting disclosure and providing youth-friendly services on HIV specific outcomes.[39]

At the same time, there should also be recognition that randomised controlled trials may not be suitable for the evaluation of certain structural

interventions and policies. Instead, interdisciplinary implementation science may be more fit-for-purpose to strengthen the evidence base to inform decision-making.[38] Several available reviews adopt a narrative approach to discuss contextual and programmatic heterogeneity, but this approach is often perceived to be a weaker level of evidence based on traditional biomedical frameworks of evidence appraisal. In practice, these may provide rich and more holistic insights on programme implementation. Programmes that do not integrate local cultural and contextual considerations can increase the risk of violence rather than reduce it; or increase mobility and engagement in risky behaviours.[38] In general, the adaptation of interventions to local contexts and scaling up based on people-centred, participatory, and gender equality principles is often not well achieved.[38,41]

Based on the available evidence published in peer-reviewed journals from the What Works for Women and Girls compendium, there is a moderate strength of evidence (based on conventional biomedical assessment of evidence levels) in some intervention types such as interventions to keep girls in school, stigma/discrimination reduction, use of contraception and family planning services, and education on SRH on HIV outcomes. There are still important gaps and weak levels of evidence in other intervention areas, namely on gender and care work, legislative and policy reform, and on women's leadership in AIDS responses. As these analyses were based on studies published up until 2011,[38,39] an updated review of evidence would be required. Given the breadth and nature of the interventions under consideration, there is need for a clear classification and mapping of outcomes, with consensus on evidence appraisal frameworks that perhaps draw more heavily on social policy evaluations and implementation science.

TABLE 2:

State of the evidence on gender-transformative interventions that work for women

Enabling Environment focussed Interventions that Work[38]			
Gender Equality Target Area	Interventions that Work	HIV-related Outcomes	Number of studies, Country and Context
Transforming gender norms	Training, Peer and partner discussions, Community-based education	Improved HIV prevention (condom use, reduced infection rates) testing, treatment and care (including voluntary counselling) *noted increase in transactional sex in Stepping Stones programme	Six studies in: South Africa (2) - Stepping Stones programme (RCT) involving male engagement in rural community, and One Man campaign through population communication), Brazil - Program H quasi-experimental study on male participation in group reflection and education on masculinity, and social marketing for condom use India - community male engagement Tanzania - community based male engagement Botswana - Workplace peer group programme
Addressing violence against women	Community-based participatory-learning approaches involving women and men	Creates more gender-equitable relationships, decreases violence, higher condom use	Four evaluation studies in: South Africa (3) - Stepping Stones programme involving male engagement in rural community, and One-Man campaign through population communication) Ethiopia - PEPFAR Male Norms Initiative

Promoting women's employment, income and livelihood opportunities	Increased employment opportunities, microfinance or small-scale income generating activities	Reduced behaviour that increases HIV risk *Microfinance noted to also increase risk of violence, and counterproductive behaviours when ineffectively designed	Four studies in: South Africa (2) - IMAGE study (two-year follow-up) Haiti - Microfinance for women Congo - Income generating and HIV prevention for women
Advancing education for girls; increasing duration and attainment	Policy reform (increasing primary and secondary years of education), abolishing school fees	Reduced HIV risk with increased school attendance *conditional cash transfers considered 'promising' intervention by authors- single country/ study available at time of analysis by authors	Twelve studies on impact of educational impact, and two on abolishing school fees in sub-Saharan Africa and Asia (South Africa, Zambia, Malawi, Lao PDR, Ethiopia, Zimbabwe, and one country analysis on Ethiopia, Ghana, Kenya, Malawi, Mozambique)
Reducing stigma and discrimination	Community-based interventions that provide accurate information about HIV transmission; Training for providers along with access to the means of universal precautions	Reduced HIV stigma and discrimination against people with HIV	Twelve studies: Seven studies on providing accurate information on HIV from Viet Nam, Thailand (2), China, Nigeria, Ghana and Malawi Five studies on training from Viet Nam, India, China, Turkey, and multi-country analysis from Africa (case study design - Lesotho, Malawi, South Africa, Swaziland, and Tanzania)

Sexual and Reproductive Health Interventions[39]

Gender Equality Target Area	Interventions that Work	HIV-related Outcomes	Number of studies, Country and Context
Access to sexual and reproductive health	Contraception/ family planning in HIV services	Increased condom and contraceptive and dual method use, avert unintended pregnancies, VCT	Eleven studies from Uganda (3), South Africa (2), Kenya (2), Haiti, Malawi, Nigeria, Zambia, with evidence spanning Gray scale levels II to V
	Early post-partum visits that include family planning, HIV information and services	Increased condom use, contraceptive use, HIV testing and treatment, reduced unintended pregnancies	Three level III studies from Cote d'Ivoire, Kenya and Swaziland
Behavioural	Youth-friendly clinic services	Increased use of reproductive health service, including counselling and testing	Three level III studies from Mozambique, Madagascar and a multi-country systematic review by WHO in developing country settings
	Supporting disclosure	Increased condom use among sero-discordant couples	Three studies including one level IV study from South Africa and two abstracts from Uganda and the Caribbean region

Education	Providing information and skill-building support for HIV positive people	Reduced unprotected sex	Four studies comprising of two level I studies (meta-analysis; one from USA and one multi-country), one level III multi-country review, and one level V study using focus groups from Zambia
Access to medicines	Providing anti-retroviral therapy	Increased preventive behaviours, including condom use	Eight studies that include five level III studies (3 from Uganda, one from Kenya and one multi-country), and three level IV studies (one longitudinal study from Rwanda and Zambia, one survey analysis from Brazil, South Africa and Uganda and one survey analysis from Mozambique)

Note: Evidence from systematic review of randomised controlled trials (Gray I) , randomised controlled trials of appropriate size (Gray II) or non-randomised comparative studies (Gray IIIa) from two or more countries; or five or more studies based on non-comparative (Gray IIIb), non-experimental from more than one centre or research group (Gray IV) or qualitative, descriptive or expert opinion data from more than one country (Gray V).[38,39]

2.4.2
Costs and cost-effectiveness

There is limited data and analysis of the cost-effectiveness and economic value of gender-responsive interventions in HIV responses. Many of the available impact assessments and effectiveness studies do not include a costing component or any economic analysis, and are scarcely available across intervention types, making it difficult to assess the cost-effectiveness of these interventions.[34] Further research is required to bridge this gap and enable informed investment cases and investment decisions.[34]

From the available body of evidence, the following interventions can be considered cost-effective:[34]

- Male involvement and couple counselling for the prevention of vertical transmission;
- Community mobilization and female condom promotion for female sex workers;
- Expanded female condom distribution for the general population;
- Post-exposure HIV prophylaxis for rape survivors; and
- Cash transfers for schoolgirls and school support for orphan girls may also be cost-effective in generalised epidemic settings.

The cost-effectiveness of gender-transformative interventions from the HIV perspective will be influenced by the target populations, the inclusion of demand creation components to optimise uptake, and whether costs are shared with other non-HIV budgets. Not surprisingly, concentrating on women at greatest HIV risk (key and vulnerable populations) appears to be particularly cost-effective.[34] Accompanying components to programmes and contributing dynamics, such as demand creation for programme uptake, inclusion of anti-retroviral use in programme assessments, and overall high population prevalence also contribute to overall returns on investment.[34] For example, programmes that emphasise female condom use would need to integrate supplementary demand creation components, such as subsidised access, since unit costs are often higher than for male condoms, as well as awareness building through training for use and negotiation skills in intimate relationships. The incremental cost of these add-on demand creation activities and their effectiveness at creating new demand in target populations will influence the value of the intervention.

2.4.3
Interventions with gender equality impact included in policy

It is encouraging that some of the evidence on what works for gender equality, and is good value for money, is partially echoed in current policy and operational guidance, including the Five Prevention Pillars in the UNAIDS Prevention Road Map 2020[43] (Box 2). Moreover, within the Fast Track approach, cash transfers for women and girls is also included among priority programmes (given evidence of impact in areas with low school enrolment)[44] and is one of the expenditure sub-indicators identified for reporting in the Global AIDS Monitoring framework that tracks country progress and action on the 2016 Political Declaration on HIV and AIDS.[2,44]

BOX 2

UNAIDS Five Prevention Pillars

- **Combination prevention**, including comprehensive sexuality education, economic empowerment and access to sexual and reproductive health services for young women and adolescent girls and their male partners;
- **Evidence-informed and human rights-based prevention programmes for key populations**, including dedicated services and community mobilization and empowerment;
- **Strengthened national condom programmes**, including procurement, distribution, social marketing, private-sector sales and demand creation;
- **Voluntary medical male circumcision** in priority countries that have high levels of HIV prevalence and low levels of male circumcision, as part of wider sexual and reproductive health service provision for boys and men;
- **Pre-exposure prophylaxis** for population groups at higher risk of HIV infection.

2.5.
FINANCING LANDSCAPE FOR GENDER EQUALITY IN HIV

2.5.1
Trends in global HIV financing

In 2016, approximately 25% of total global health spending was spent on HIV/AIDS, with US$ 19.1 billion invested in preventing and treating HIV. This was nearly double the available resources in 2006 (US$ 10 billion).[4,14] However, at the current scale of investment, the epidemic will continue to outpace the response, and the future global cost of inaction will continue to increase.

A global price tag of US$ 26 billion a year was included in the 2016 Political Declaration on HIV and AIDS, but there is still a global funding gap of about US$ 7 billion. While the Fast-Track approach calls for an increase in HIV financing, there are substantial funding gaps

that are disproportional across countries and regions. For instance, countries in the Southern and Eastern African region only have 4% gaps to reach levels set by the FastTrack approach, compared to an 88% gap in Western and Central Africa.[4]

There is a marked rise in domestic resourcing of national responses, but a flatlining or dwindling of international funding. The global share of domestic spending has increased from 50 to 57% in the 2006-2016 period, and is the dominant source of financing in Asia, Latin America, and Europe.[4,7] International funding has been either flatlining or decreasing in several region, even though it remains the dominant source of financing in the Caribbean, Western and Central Africa.[4]

A large share of HIV financing is spent on treatment, and resource allocation for prevention and structural interventions to address the social drivers of the epidemic is limited. In the 2016 Political Declaration on HIV and AIDS, signatories committed to spend at least 25% of HIV finance on prevention, and at least 6% on social enabling activities. These include activities like advocacy, community mobilization, human rights programmes, and interventions to reduce stigma and discrimination.

From our review of available financing and expenditure data sources, it was not possible to ascertain how much is being spent on gender equality in the global AIDS response. Although gender equality interventions are embedded in key investment frameworks that have guided HIV resource allocation in recent years,[44,45] there are no accountability mechanisms to separate and track these investments and their impact.

Country reporting on 'social enabler' spending may provide some indication of an upper limit on what is being spent on gender-transformative interventions, as this would typically be subsumed under this category. In 2017, countries spent between 1-10% of total HIV expenditure on social enabler interventions. Some countries reported higher levels of spending on social enablers than this range, namely Kiribati (32%), Samoa (27%), Senegal (27%) and Madagascar (22%) (see Table 7 in Appendix).[4] All the Middle Eastern, Latin American and Caribbean countries that reported social enabler spending spent 6% or less. Low and lower-middle income countries tended to spend a higher proportion of total AIDS expenditure on social enablers, suggesting greater prioritisation of systemic and structural interventions.

Gender equality programming is included in principle within the Fast-Track approach, where relevant programming often falls under the category of social enablers (similar to the Investment Framework's critical enablers and development synergies, see Figure 3 and Appendix).[44,45] The notable exception is cash transfers for AGYW, which is reported separately. In GAM 2018, 35 countries reported the implementation of cash transfer programmes for young women.[46] Although women-specific programmes like PMTCT and FSW are to be reported separately in the Fast-Track country monitoring, our assumption is that they do not include gender-transformative approaches. Although they do not necessarily focus on transforming the relational, social and structural position of women and girls within a country context, they may cumulatively or secondarily reduce gender disparities and produce positive gender equality impacts.

There is limited guidance on translating gender equality commitments into actions and targets. Indeed, specific targets or outcomes from HIV programmes are lacking and not clearly articulated for country-level implementers. For instance, the zero-discrimination target in the Fast-track approach specifically identifies "increasing commitment to achieving gender equality and eliminating gender-based violence". However, programmatic guidance for the pursuit of gender equality is not well communicated, even though there are some relevant intervention components that address gendered power dynamics and the structural causes of gender inequality, such cash transfers to keep girls in school and social protection measures.

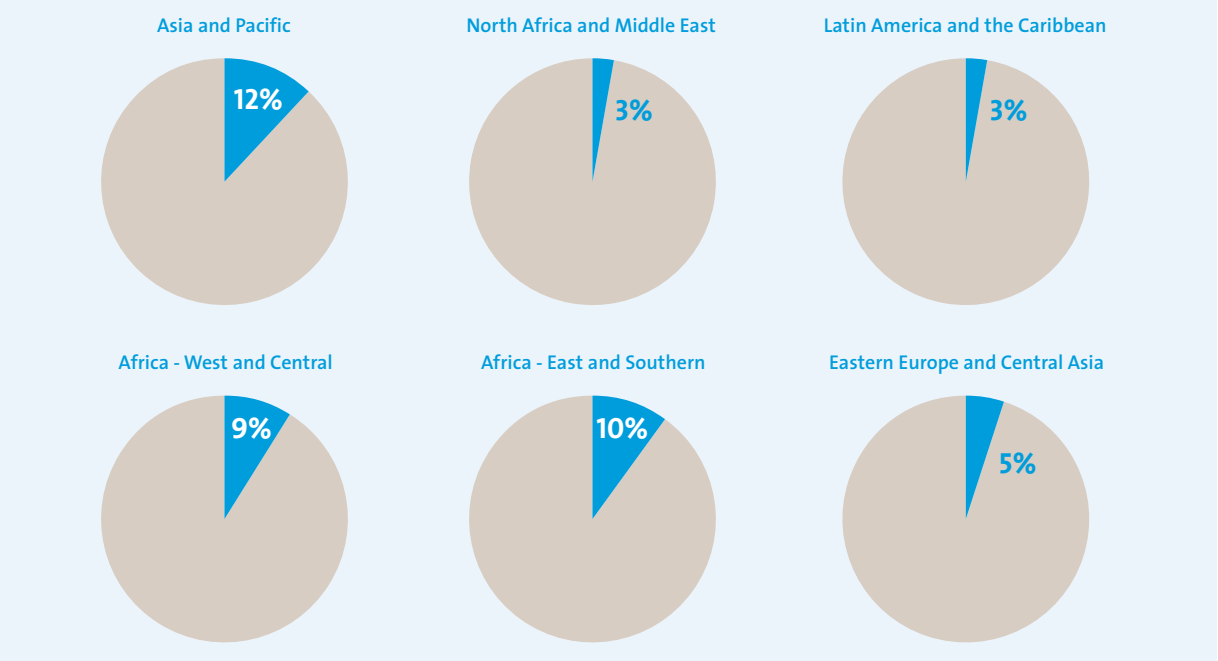
Similarly, comprehensive gender equality targets are not clearly defined in other HIV policy and tracking mechanisms, beyond gender-based discrimination within key populations and GBV markers. In Commitment 4 of the Global AIDS Monitoring (GAM) framework – 'Eliminate gender inequalities and end all forms of violence and discrimination against women

and girls, people living with HIV and key populations by 2020', the focus is on reducing stigma and discrimination in key populations, and the incidence of intimate partner violence. The lack of specific gender equality targets prevents countries from prioritising it in their HIV responses and being held accountable to the lack of action and investments.

As a result, there are no gender-responsive budgeting (GRB) or expenditure tracking mechanisms embedded within existing impact or expenditure tracking systems, which is a barrier to assessing the levels of prioritization and existing spending. Even where programme-level, category-based or gender-disaggregated reporting of spending may be required (i.e. through expenditure tracking methodologies and initiatives such as Global AIDS Monitoring requirements from the 2016 Political Declaration on HIV and AIDS, UNAIDS country reporting, NASA, Systems of Health Accounts), many countries do not report spending beyond overall national totals of HIV spending, or the total spending by source (domestic or international).[4]

FIGURE 3

Regional spending on social enablers (average % of total HIV spending)



2.5.2
International financing for gender-responsive programming

Despite the flat-lining of international funding, major HIV donors and countries that provide development assistance have made noteworthy commitments to promoting gender-responsive and gender-transformative programming. Specifically, PEPFAR and the Global Fund have established financing strategies at an organizational or institutional level to address the specific needs of AGYW, particularly in sub-Saharan Africa. In the absence of formal gender equality accountability mechanisms, these donor-driven commitments are variably conceptualised by internal stakeholders and decision-makers. Nonetheless, the scale of investment in gender equality, as opposed to gender-specific programming (PMTCT or male circumcision) is still either extremely low or not visible in current reporting.

U.S. President's Emergency Plan for AIDS Relief (PEPFAR)

PEPFAR has spent over US$ 70 billion through bilateral HIV programmes since 2003, with US$ 6.6 billion invested in 2016 alone.[47] The 2014 PEPFAR Gender Strategy states that HIV programmes should identify gender-related issues and take concrete steps to address them throughout the programme cycle. In 2011, there was an attempt to integrate PEPFAR Gender Strategies into HIV Programmes for Most-At-Risk Populations with the following targets: increasing gender equity and access to HIV programmes and services; reducing violence and coercion; addressing harmful gender norms and behaviours; increasing legal rights and protection; and increasing access to income and productive resources. Despite this, PEPFAR expenditure tracking since 2012 does not capture gender equality programme components.

The most notable gender-specific initiative within PEPFAR is the DREAMS initiative that aims to contribute to the global target of reducing new HIV infections among AGYW (see Box 3). DREAMS developed a comprehensive combination prevention package of services that includes biomedical, behavioural and structural interventions, namely adolescent-friendly HIV testing and counselling, expanded contraceptive method mix, condom promotion and provision, PrEP, and safe spaces (for AGYW); education subsidies, cash transfers, financial literacy and parenting programmes (for their households); school-based HIV and violence prevention,community mobilisation and norms change (for their communities). Yet, based on PEPFAR's expenditure data, only approximately 3.8% of total PEPFAR resources were allocated to these interventions for AGYW, suggesting that the scale of investment and priority is still relatively low.

BOX 3

Determined Resilient Empowered AIDS-free Mentored and Safe Partnership (DREAMS)

PEPFAR, in partnership with the Bill & Melinda Gates Foundation, Girl Effect, Johnson & Johnson, Gilead Sciences and Viiv Healthcare, launched the Determined Resilient Empowered AIDS-free Mentored and Safe (DREAMS) Partnership in 2014 to reduce new HIV infections by 40% among the highest risk AGYW in high-burden countries by 2017. The initial commitment of US$ 385 million, supplemented with US$ 85 million for a DREAMS Innovation Fund (60% of which was allocated to small community-based organizations), was to deliver a core multi-sectoral intervention package to address the structural drivers that increase girls' HIV risk, such as poverty, gender inequality, sexual violence and lack of education. During the implementation years (2016-2017), a total of US$ 249 million were allocated across 10 high-burden sub-Saharan African countries (see Appendix) to prevent HIV transmission through the core package of interventions for young women, as well as their male partners, families and communities.

The Bill & Melinda Gates Foundation is funding an impact evaluation study in Kenya, South Africa and Zimbabwe. Early results note high awareness and participation in DREAMS, with HIV testing services and school-based prevention education being the most accessed interventions. DREAMS has successfully mobilised communities and governments to deliver a complex programme across sectors, with individual-level interventions often integrated within community/family level interventions. DREAMS introduced innovative services (e.g. social asset building, PrEP) and collaborations, offering a model that could be adapted to diverse contexts, with sufficient commitment and resources. The 10 countries have integrated DREAMS into their operational plans, and South Africa, Swaziland and Malawi are planning to scale it up. DREAMS-like activities were also added in national responses in Botswana, Cote D'Ivoire, Haiti, Namibia, and Rwanda.

The Global Fund to Fight AIDS, Tuberculosis and Malaria

Gender equality and the promotion of women's rights continues to be a strategic objective for the Global Fund in 2017-2022. At programme and spending levels, the Global Fund pursues gender-specific targets, including to 'reduce the number of new HIV infections among adolescent girls and young women by 58% in 13 African countries by 2022'. Global Fund asserts that up to 55-60% of total current investments are directed towards women and girls, amounting in total to about US$ 16 billion since 2002 (as reported by Global Fund). A 2016 analysis found that US$ 150 million was allocated to three gender-related (and gender-specific) programmeareas (gender-based violence, PMTCT and male circumcision) through 91 grants across 28 countries. Moving forward, an additional US$ 55 million has been earmarked to catalyse effective investments in AGYW in 13 high burden countries, including Kenya, Tanzania, Swaziland and South Africa (the HER Initiative). Nevertheless, the proportion of gender-transformative investments at the country level appears to be relatively low, as evidenced by the Kenya case example (see Box 4 and Appendix). Indeed, gender-responsive financing (excluding gender-specific spending) forms a minimal share of the 2019-2021 funding requests.

Amongst the challenges reported by the Global Fund in the implementation of its gender strategy are the translation of evidence and identified challenges into funding, limited by national commitments, and consequent matched investments and implementation scale-up. Other notable constraints include limitations to data, the extent of meaningful engagement, the quality of representation, in decision-making on which interventions to fund.

BOX 4

The Global Fund in Kenya

The 2019-2021 Funding Requests from Kenya do not include specific goals that relate to women and girls, or gender equality by key national recipients. Within allocations funding requests from principle recipients identify gender and social norms (such as intergenerational sex), early marriages and GBV among young women and girls as contributing factors to new infections.

Nevertheless, only 2% of the total requested US$ 216 million were solicited for prevention programmes for adolescents and youth in and out of schools, and programmes to reduce human rights-related barriers to HIV services respectively. Additionally, GBV prevention and response were included as above allocation requests. However, this may be accounted for by investments by other funders within the national

2.5.3
Gender equality financing in overseas development assistance

Given the lack of tracking data for gender equality in international HIV funding, we looked at other sources of overseas development assistance tracking. The OECD Development Assistance Committee (DAC) gender equality policy marker is a monitoring and accountability tool that tracks bilateral aid that targets gender equality and women's rights. In the 2015-2016 period, only 4% (US$ 4.6 billion) of bilateral aid had a primary gender equality target, and 33% (US$ 37.1 billion), a secondary or significant gender equality target.[48] Almost half of aid that identified gender equality as either a principle or significant target was committed to low-income countries, and most of the top-ten recipient countries were in Africa and Asia. While the amount of aid that integrates gender equality goals as secondary targets is increasing from previous years, there is still a dearth of funding for programmes that have gender equality as a primary target.[48] Within the 4% of programmes where gender equality was a primary objective, approximately 14% were for health (US$ 625 million), 9% for education, 28% for government and civil society, which includes allocations for women's institutions and organisations, and programmes that target the elimination of

BOX 5

OECD DAC Gender Marker

Programmes and activities are categorised as either having 'principal' (primary), 'significant' (secondary) or 'no' gender equality policy objectives. Using a qualitative statistical tool to track these activities, donor countries are able to identify gaps between policy and financial commitments, and support transparency and accountability in donor financing for gender equality and women's rights.[47]

Aid categories screened include funds allocated to 'sector budgets, NGOs, international organisations, pooled funding, projects, donor country personnel, other technical assistance, and scholarships programmes in donor countries', and excludes 'core contributions to multilateral organisations, general budget support, imputed student costs, debt relief, administrative costs, development awareness and refugee costs in the donor country'.[48]

GBV (which received US$ 161 million in 2016), and 26% on population programmes and reproductive health (US$ 1.2 billion).[48]

There is little reporting on focussed gender equality funding within aid for HIV.Financing for gender-responsive programmes in national responses While global financing data on gender equality spending within HIV responses is not available, it is possible to re-analyse national-level HIV spending data to separate and estimate gender-responsive expenditure. Indeed, applying GRB can facilitate the tracking of how HIV budget allocations and expenditures respond to gender equality and women's rights requirements to ending the HIV epidemic, while increasing transparency, accountability and efficiency.

2.5.4
National spending on gender equality interventions in HIV response

Forty of 157 countries reported the availability of a dedicated budget for gender transformative interventions in their National AIDS strategy or policy in 2017 or 2016.[46] Figure 4 presents the proportion and number of countries by region.

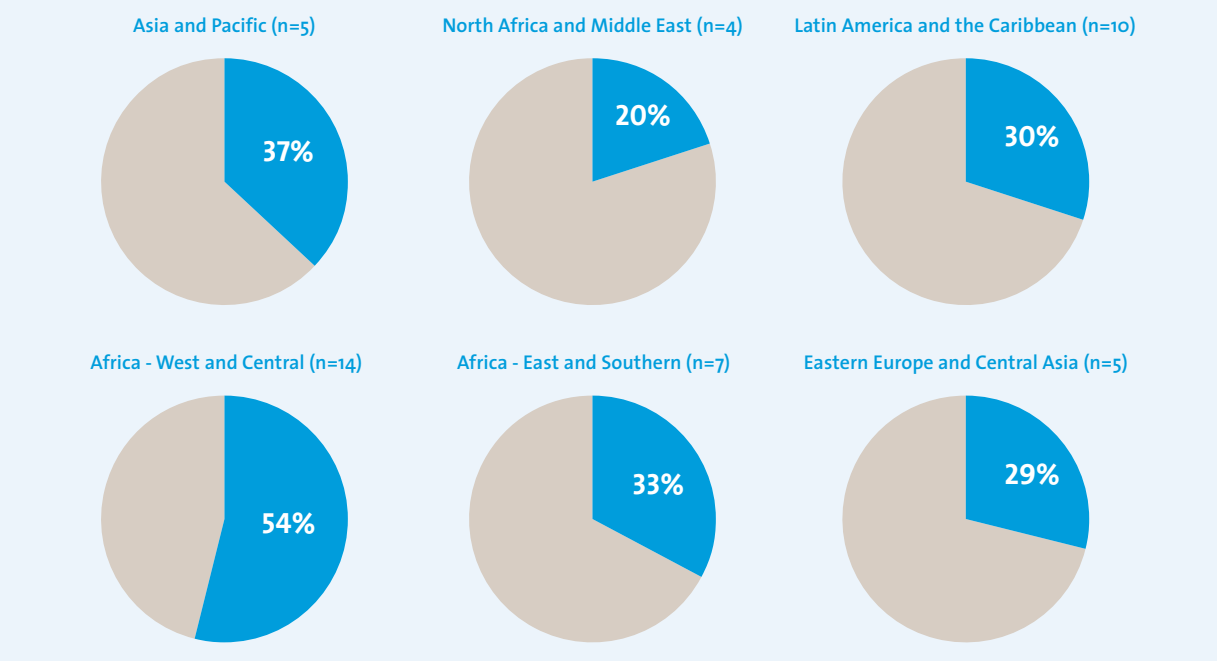
Beyond this, there is little and fragmented information on the size of the allocations, or details on actual spending in the public domain. In the UNAIDS 2018 report, the most recent available total expenditure data presented by many countries was not recent (2015-2017), going as far back as 2005 for Tanzania.[1] The report also does not include data beyond total national expenditure and source of financing. While there are data sub-indicators, such as total expenditure for five pillar combination prevention, and cash transfers for women and girls, this data was not presented in the report. In the absence of GAM data on national expenditure on gender equality, we undertook a search for other studies, and alternate sources of reported expenditure data.

A gender-responsive budget analysis was conducted in 2017 in Cambodia, Indonesia and Thailand,[49] using the limited data sources available, including the National HIV/AIDS Strategic Plan for Cambodia, the Global Fund Concept Notes reporting budget allocations for Cambodia and Indonesia, and the latest NASA data for all three countries. The estimated budgetary allocation and total expenditure assumed to focus on women and girls from the different data sources are summarised in Table 3.

Gender-responsive allocations and expenditures were mainly focused on PMTCT and condom distribution among key populations. Home-based care and the capacity building of – and the mechanisms for – engaging women's participation in the HIV response (particularly from women living with HIV and female

FIGURE 4

Proportion of countries in UNAIDS regions with dedicated budget for gender transformative interventions in National AIDS strategy or policy in 2017 or 2016[46]



key populations) appeared absent in the programming and budgeting processes. Additionally, a time and coherence mismatch were noted between policy and plans (often lacking any costing), and budgets and expenditures.

To explore how gender-responsive HIV spending is in other regions, we conducted a similar analysis for selected countries where HIV is disproportionally affecting women and girls, in the sub-Saharan Africa region characterised for generalised HIV epidemics and selected Central American countries. Gender equality expenditure in HIV responses was assessed through the latest NASA reports for Kenya, South Africa, Nigeria, Swaziland, Tanzania, Jamaica, Guatemala and Haiti by using the categories corresponding to WHO's gender-sensitive HIV indicators[50] (see Table 4 and Table 5).

This analysis corroborated the lack of disaggregated data of programmatic items in the NASA reports identified by the previous GRB analyses in South-East Asia[49] Again, PMTCT spending represented the largest proportion of the reported total expenditure on gender-specific programmes for women and girls in all selected countries (ranging from 1.9% in Haiti to 9.2% in Nigeria), except in South Africa and Tanzania,

BOX 6

She Conquers Campaign in South Africa[46]

Launched in 2016, this government campaign targets adolescent girls and young women aged 15-24, through awareness-building and practical interventions, and is being rolled out in 22 districts with high HIV rates.

Target outcomes include decreased HIV infections and teen pregnancies by 30%, decreased sexual violence by 10%, and increased school retention and economic opportunities by 10%.

She Conquers is funded by the South African government, and three major donors - PEPFAR, the Global Fund and the German Development Bank (approximately US$ 220 million). Government funding was mobilized through reprioritization of existing funding, rather than increased domestic funding.

TABLE 3

Percentage of budgetary allocation and total expenditure assumed to focus on women & girls in Cambodia and Indonesia[49]

	Cambodia	Indonesia
National Strategic Plans		
% budgetary allocation & expenditure assumed to focus on women & girls	6.35%	--
Priority budget items noted to specifically include women	* PMTCT (2.6%) * VAW guideline development (0.2%) * GBV training of police and service providers (0.07%) * PEP (0.02%)	
Global Fund Concept Notes		
% budgetary allocation & expenditure assumed to focus on women &girls	8.6%	9.4%
Priority budget items noted to specifically include women*	*Legal aid services and legal literacy, policy advocacy on legal rights, and social mobilization (0.8%) *Counselling and psychosocial support (4.9%) *MSM and TG programming (2.1%) *FSWs and clients (condoms, STIs) (0.7%) *Treatment and prevention of unintended pregnancies (0.3%)**	*MSM and TG programmes (1.8%) *FSWs and their clients (3.4%) *PWID programmes (1.8%) *PMTCT (4.86%)
NASA reports		
% budgetary allocation & expenditure assumed to focus on women & girls***	15.4%	1.6%
Priority budget items noted to specifically include women	* PMTCT (4.8%) * AIDS specific program (0.6%) * Programmes to reduce GBV (0.01%) * Human rights program (0.09%)	* PMTCT (0.1%) * AIDS specific program (0.1%) * Programmes to reduce GBV (0.003%)**** * Human rights program (0.1%) * Income generation/ social protection (1.0%)

* Since budget allocations are not sex-disaggregated, it is not possible to determine the proportion allocated

** Most of the budgeted PMTCT is not gender responsive and can be classified as gender blind.

*** This total is not the sum of the percentages listed in the row below.

**** This category captures all post-exposure prophylaxis provided, without mention of rape.

BOX 7

The National AIDS Spending Assessment (NASA)

The UNAIDS NASA is a framework to track and report country level HIV expenditure from their source (government, donor, NGO and private) to beneficiary populations.[54] NASA data categorises expenditure data by either:

- AIDS spending catego ries (prevention, treatment, OVC, programme management, human resources, social protection & services, enabling environment, and research);
- Beneficiary populations;
- Financing sources and financing agents; or
- Programmatic service providers.

Total HIV Expenditure can be estimated and disaggregated by financing sources and by these mutually exclusive AIDS Spending Categories (ASC) related to the programmes/services/interventions that exist in any given country. NASAs have been conducted in over 70 countries, and have been published at different time points and durations between countries spanning 2003 to 2016.

where home-based care represented the largest gender-related expenditure (12% and 2% respectively).

Expenditure on gender-transformative programmes remained under 1% in all selected countries. Expenditure on spending categories where we surmised that there may be potential gender equality components ranged from 0.2% in Tanzania to 9.2% in Jamaica.

These results should be interpreted with caution, due to the very limited available disaggregated data across the categories of interest reported by NASAs in the selected countries. While the potential gender equality components are likely over-estimates, these categories were expected to capture efforts to address contributing factors for gender equality. While the latest available NASA report were considered for each country, some were relatively outdated with reports from 2009 to 2015. Despite these limitations, NASA data remains the most comprehensive standardised reporting tool for HIV expenditures, although the reporting categories are not disaggregated enough to provide an accurate assessment of gender-specific, and particularly, gender-transformative spending.

TABLE 4

NASA categories included in Gender Spending Analysis

Women/girls-targeted programmes	Gender-transformative programmes	Potential gender equality components
Proportion of the HIV funding/ expenditure attributed to programmes focused on women/ girls, extracted from following AIDS Spending Categories (ASC): • Prevention programmes for sex workers and their clients ASC.01.08 • PMTCT ASC.01.17 • PEP ASC.01.22 • PEP after high risk exposure (violence or rape) ASC.01.22.02 • Home-based care ASC.02.01.09 • AIDS-specific programmes focused on women ASC.07.04	Proportion of the HIV funding/expenditure attributed to programmes focused on transforming inequitable gender norms (for women and/or men), addressing inequitable access to resources, including empowering women and girls. Data was extracted from sub-categories of women and girls populations from the ASC below. These were chosen based on relevance/ inclusion of gender transformative/ gender equality programmes. • Public and commercial sector female condom provision ASC.01.14 • Programmes to reduce gender-based violence ASC.07.05	Proportion of the HIV funding/ expenditure attributed to programmes with more generic descriptions, which could potentially capture programmes targeted at broader inequities. Data was extracted from the following ASC and sub- categories based on relevance to GE-related spending: • Community mobilization ACS.01.02 • Prevention – youth in school ASC.01.05 • Social protection and social services (excluding OVC) ASC.06 • Advocacy ASC.07.01 • Human rights programmes ASC.07.02

TABLE 5

Gender related NASA expenditure from selected countries

	Kenya	South Africa	Swaziland	Nigeria
NASA reporting year	2009/10-2011/12	2013/14	2012/2013	2014
Total HIV Expenditure in US$ of reporting year	2,466,000,000	2,189,938,541	104,485,929	632,378,599
Percentage of total expenditure by AIDS spending categories				
Prevention programmes for sex workers and their clients	0.2	0.6	--	0.9
Prevention of mother-to-child transmission (PMTCT)	4.1	2.2	3.8	9.2
Post-exposure prophylaxis (PEP)	0.1	0.4	0.0	--
PEP after high risk exposure (violence or rape)	--	--	--	--
Home-based care	0.7	12.0	0.2	3.9
AIDS-specific programmes focused on women	--	--	0.1	--

	Kenya	South Africa	Swaziland	Nigeria
Total % of gender targeted programmes to women and girls	5.1	15.2	4.1	14
Public and commercial sector female condom provision	--	--	0.0	0.1
Programmes to reduce Gender Based Violence	0.0	0.0	0.0	--
Total % of gender transformative programmes with a view to achieving equality	0.0	0.0	0.0	0.1
Total % potential gender equality components	2.8 *(mainly community mobilisation)*	--	2.6 *(mainly advocacy)*	3.9 *(mainly community mobilisation)*

	Tanzania	Jamaica	Guatemala	Haiti
NASA reporting year	2013/14	2014/15	2015	2015
Total HIV Expenditure in US$ of reporting year	472,300,000	15,073,726	50,464,374	127,773,951
Percentage of total expenditure by AIDS spending categories				
Prevention programmes for sex workers and their clients	0.0	0.7	0.4	0.5
Prevention of mother-to-child transmission (PMTCT)	1.1	--	6.2	1.9
Post-exposure prophylaxis (PEP)	--	--	0.0	0.7
PEP after high risk exposure (violence or rape)	--	--	0.1	--
Home-based care	2.0	--	--	1.3
AIDS-specific programmes focused on women	--	--	--	--
Total % of gender targeted programmes to women and girls	3.1	0.7	6.7	4.4
Public and commercial sector female condom provision	--	--	--	--
Programmes to reduce Gender Based Violence	--	0.8	--	0.0

	Tanzania	Jamaica	Guatemala	Haiti
Total % of gender transformative programmes with a view to achieving equality	--	0.8	--	0.0
Total % potential gender equality components	0.2	1.5	2.2	3.5

*Not reported data has been noted as --

2.6

INNOVATIVE FINANCING

Despite strong commitments and growing evidence on what works to promote gender equality in HIV responses, it remains a challenge to ensure adequate financing for these investments. This begs the question of *how* to change this, building on lessons and approaches that have been used to resource structural interventions for HIV and health. Clearly, the financing strategies and mechanisms will depend on the rationale for financing gender equality and the type of intervention considered.

Traditional levers to increase financing for any programme or intervention fall within three broad categories:

- grow the overall HIV pie, and thereby the total volume of resources available for gender-responsive investments;
- increase the prioritisation of gender equality interventions within the HIV resource envelope; and
- spend the current gender equality resources more efficiently.

Given the flatlining of HIV funding overall, and the very limited resource envelope currently being allocated to gender equality, we focus on strategies that involve greater prioritisation of gender equality from a financing perspective.

In addition, it is useful to consider options along the innovative financing value chain framework, which breaks down the process of rapidly channelling additional funding to health in LMICs into 5 steps: **resource mobilisation, pooling, channelling, allocation, and implementation.**[51] We explore innovations in how gender equality (and other structural interventions) can be or have been better prioritised at the allocation step, as well as innovative approaches when mobilising and pooling HIV resources with non-HIV resources, or public and private funding streams at the global and country level.

Intervening at the structural level requires shifts in thinking, governance and resourcing. Where the objective is to promote gender equality alongside health objectives, a tested strategy has been to **set financing targets**, or a percent allocation to the structural issue.

Following an instrumental rationale, the strategy to increase prioritisation will require making the value

TABLE 6

How to increase financing for structural interventions and gender equality

Type of intervention	Financing strategy
HIV+ / Gender+	Set financing target Bring into the mainstream
Gender / Gender+	Cross-sectoral co-financing Dedicated financing Outcome-based financing

for money case for gender equality components that enhance the impact of biomedical HIV interventions (*HIV+*). When compellingly demonstrated to increase the efficiency of HIV programmes to deliver on HIV outcomes, specific gender equality intervention components can and have been **integrated into the HIV mainstream** and financed as part of a comprehensive package for key populations, for example. This may also work for certain HIV-specific intervention components that are delivered through non-HIV programmes or platforms (*Gender+*), and need to demonstrate direct HIV benefits.

For upstream gender equality programmes with no HIV-specific component but significant HIV impacts (*Gender*), matters are complicated by an externality problem. Gender or women's empowerment programmes are likely to have multiple multi-sectoral outcomes, including gender equality, improved health, education and/or economic livelihoods. These additional benefits may not be factored in when governments or other funders decide how much of them to produce.

For example, there is increasing evidence that cash transfers to poor households can transform gender norms, and reduce women's experiences of partner violence.[52] However, many of these cash transfer programmes have been set up without considering these benefits, and are therefore potentially under-provided. In the HIV space, this was evident when cash transfers for adolescent girls were found to be effective at preventing HIV in certain settings with low school attendance, but were not considered cost-effective from an HIV perspective,[53] regardless of the multiple additional positive outcomes for school attendance, mental health, early marriage and teen pregnancies. Budgeting based on HIV-specific outcomes alone could therefore lead to suboptimal resource allocation.[20]

Solving this inefficiency requires two shifts: (1) payers and sectors need to focus on the outcomes they are trying to achieve, rather than the interventions or services they are mandated to deliver through their sectoral platforms and within their sectoral boundaries; and (2) cross-sectoral or cross-budget financing mechanisms will be required to leverage and pool resources from multiple sources with different objectives and then channel them through to implement multi-sectoral interventions. This may involve **co-financing**, **outcome-based financing** and/or **dedicated financing mechanisms**.

2.6.1
Set a gender equality financing target within the HIV response

The gender field has embraced the need for multi-sectoral action for optimal impact, and adopted a twin track approach to governance and financing, whereby:

- Gender equality is 'everyone's business' and all sectors are mandated to act on it within their core business (and therefore leverage their own sectoral resources)
- The coordination role is assigned to a 'national gender machinery' or line ministry responsible for gender equality or women's affairs.

The argument that gender equality is 'everyone's business' implies that each sector should intrinsically value gender equality, and therefore elevate its achievement as an additional core sectoral objective. In theory, sectoral resources should then be allocated to interventions, based on their impacts on both the primary sectoral objective and the objective of gender equality.

This is arguably the strategy the HIV response took when advocating for HIV mainstreaming in other non-health sectors. In some countries, this led to mandated allocations from non-HIV sector budgets to HIV activities. For example, Zimbabwe continues to levy a 3% tax on employee income and employers' profits, which is channelled through the Aids Trust Fund to finance the national response (in particular ARVs).[54] This earmarked tax has been an effective strategy to mobilise additional government resources for the HIV response. Other countries in sub-Saharan

Africa, such as Malawi, Tanzania and Kenya have similarly mandated government departments to allocate a fixed proportion of their recurrent budgets to HIV mainstreaming activities.[54,55] However, in some of these cases, the government ministries were both the payers and the purchasers, who then decided how to spend these resources, which may have led to inefficient fragmented interventions.

The HIV response has adopted an increasingly outcome-focussed approach to investments, which was at the core of the investment framework in 2011 and continues to guide global funders and national responses. This translates into a vertical siloed paradigm, with its evident strengths and successes, as well as important limitations. Investments are assessed based on their impact on HIV morbidity and mortality alone. Any positive externalities on other social outcomes are increasingly ignored when prioritising what to spend HIV budgets on.

However, stigma and discrimination is the only outcome that was seemingly elevated to an impact-level indicator of success under the Three Zeros, alongside new HIV infections and AIDS-related deaths averted.[56] This suggests that HIV funds would be spent on reducing stigma and discrimination in its own right, irrespective of its instrumental value in preventing HIV transmission, morbidity and mortality. Despite this explicit target, it is not clear whether this meant more funding/prioritisation of stigma reduction interventions. This may partly have resulted from limitations around the measurement of stigma for tracking and accountability purposes, at least initially).[57] Gender equality faces a similar problem, given the lack of clarity and consensus around what interventions represent an investment in gender equality.

In a world of single-issue funding streams, it continues to be challenging to make the case for using HIV funds to invest in gender equality in its own right, but this may be an effective strategy to consider. It is unclear why the global HIV response has not set financing targets for gender equality to date, although it has done so for prevention and social enablers. If this is to be pursued, the following will need to be agreed upon:

- Which interventions will be counted as gender equality interventions;
- How much should be invested in gender equality; and
- Integrating expenditure tracking in national and global AIDS tracking systems (including GAM), OECD-DAC and other SDG-related financing for development expenditure tracking initiatives.

Currently, the SDG target 5.c.1 requires that governments establish "systems to track and make public allocations for gender equality and women's empowerment", but it does not state a quantity/level of financing, as opposed to other SDG financing targets in other sectors that measure proportion of government budget allocated to specific areas. The reason for this focus on effort rather than allocations is that it is more directly under the control of governments than outcomes and can be used to hold them accountable. It is debatable whether this will be a more effective commitment strategy than a financing target.

The development and use of HIV-adapted gender markers could be a possible way to track the progress in meeting set targets. Examples of the use of gender markers include the OECD DAC gender marker for overseas development assistance. This gender marker has actually informed the development of other gender markers within the UN system.[58] In the HIV field, UNAIDS developed and applied a gender marker against all of its workplans (2016-2017), and set a target to spend 15% of UNAIDS Secretariat expenditure in support of actions that contribute to gender equality and women's empowerment as a primary programmatic aim.[59] Nonetheless, there are challenges to using gender markers in expenditure tracking. Without careful design and implementation of data reporting at institutional and operational levels, results may be overly subjective or prone to reporting bias, and over-classified as gender-responsive, which prevents accurate and real-time representation of progress.

2.6.2
Bring into the mainstream

Another approach to enable investments in gender equality components that enhance the efficiency of basic HIV programme activities has been to mainstream them into population-focussed packages, or what is known as combination prevention. This was first done for key population programmes, specifically FSW programmes, which included biological and behavioural intervention components and later added on structural intervention components. For example, a gender empowerment and community mobilisation intervention was added on to the Avahan HIV prevention programme for FSW in India, and found to be extremely effective and cost-effective.[60]

By internalising the structural into comprehensive population-focussed packages, the HIV response has been able to take control of these intervention components and increase the allocation of HIV resources towards them. The combination prevention packages for AGYW, including DREAMS and the programmes supported by the Global Fund, are another example of this financing strategy.

To date, this is how the more gender-transformative interventions within the HIV response have been prioritised and financed at scale. This approach follows an instrumental rationale to gender equality programming, and is pragmatic in its limited need for cross-sectoral engagement. However, it may also come at the risk of trying to implement activities through the HIV programming platform that are beyond the scope and capacity of HIV implementers, with resulting inefficiencies.

To make the case for this, it will be important to continue building the evidence base on the incremental effectiveness and cost-effectiveness of gender-transformative interventions for HIV. This will allow these interventions to be considered alongside other HIV intervention options during the prioritisation process.

It is worth noting that there is controversy about whether gender mainstreaming as an approach is a modern strategy for gender equality. Indeed, it can be viewed to have a conservative tendency of focusing on techniques and finding overlap between gender equality and mainstream agendas, thereby avoiding confrontation around power. There may be tension between integrating gender into the mainstream and changing the mainstream.[61–63]

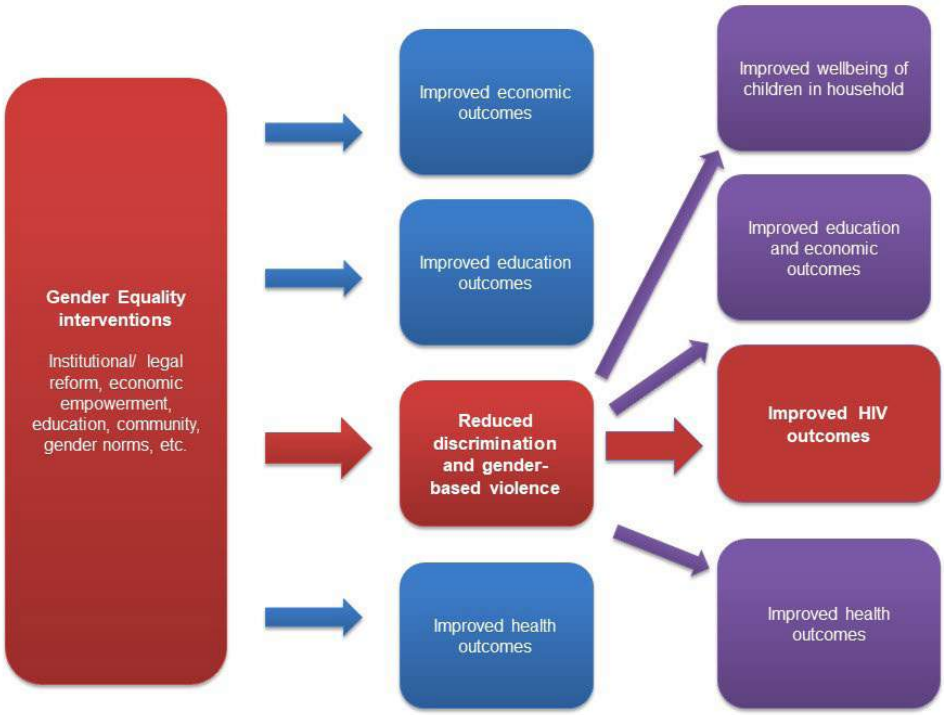
2.6.3
Cross-sectoral co-financing

The externality problem is accentuated when considering whether to invest HIV resources into interventions that are delivered through other development and gender equality platforms, with no HIV focus. HIV resource allocation decisions are conventionally expected to rely on an assessment of value for money that compares the value of the HIV outcome to the full cost of the intervention (illustrated as the red value chain in Figure 5). This would mean ignoring all the other direct economic, health and/or educational outcomes of a specific intervention (in blue), as well as the indirect impacts mediated by the reduction in gender inequality (in purple). Based on this simple value chain, certain interventions that aim to tackle broader structural inequalities and development challenges may not appear to be good value for money from the perspective of achieving HIV outcomes alone. The same may be true when looking at this equation from other single sector or single-issue perspectives, leading sector budget holders to decide not to fund or scale up such interventions despite their significant overall societal benefits. This would represent a welfare loss for society.[20]

Approaches to promoting gender equality are likely to tackle several overlaying vulnerabilities and thus generate HIV and non-HIV outcomes.[64] For example, a study using Demographic and Health Survey data in Malawi found significant associations between indicators of gender inequality (including IPV) and most health and development outcomes.[65] Even after

FIGURE 5

Illustrative potential chains of benefit associated with gender equality programmes



Adapted from: *Remme et al (2014)*[20]

Note: *Benefits in the second column are likely to have further impacts in the third column, or at least to link to each other.*

controlling for socio-demographic characteristics, indicators of gender inequality remained significantly associated with HIV infection, early pregnancy, high fertility, unplanned pregnancy, home delivery and indicators of poor child health. Put differently, an intervention that would impact positively on gender inequality could reasonably be expected to have spill over effects on women's reproductive and sexual health, as well as their children's health. This resonates with the place of SDG 5 within the SDG agenda. Merely incorporating the intervention's direct effect on HIV may therefore considerably underestimate the true societal value of investing and scaling it up.

It has been suggested that to overcome the inefficiency associated with such siloed budgeting, sectors could adopt a co-financing approach, whereby they would consider contributing to interventions with other benefiting sectors, up to the point that it is cost-effective for them to achieve their specific outcome.[20] A 'co-financing approach' minimises the risk that cross-sectoral benefits are foregone and could potentially be incorporated into a system where sectors budget separately. In some cases, assessing interventions delivered through non-HIV platforms without considering that their costs could be shared with other budgets, could lead to investment decisions that generate less HIV impact, as well as less impact on other development outcomes.

The approach has been explored based on data from a cash transfer trial conducted in Malawi to keep girls in school that generated multiple reproductive and sexual health, mental health, education and gender equality outcomes (see Figure 6). Where sectors would make financing decisions in isolation based on

their own cost-effectiveness analysis (or the single value chain), the intervention would not be funded, but where they considered contributions from other sectors based on their willingness to pay for their own outcomes, the intervention would be fully funded and could potentially be taken to scale.[20,34]

Cross-sectoral co-financing would be a strategy to overcome this inefficiency while recognising the reality that most HIV payers are most interested in achieving HIV outcomes and view any gender equality outcomes as welcome spill overs, rather than core objectives that they are focussed on and are held accountable to. It does not require any sector to take on gender equality as an additional mandate, alongside its core business.

Such approaches can be found in the health promotion field that has adopted a health-in-all-policies framework. It has been clear that once political will for inter-sectoral action is in place, the availability of resources is pivotal, and the availability of multiple sources of funding may be particularly beneficial if it increases participation across government.[66] To deal with the inefficiencies, fragmentation and missed opportunities of vertical funding silos, examples can be found particularly in high-income countries where sectors have been co-financing integrated care and health promotion interventions that aim to generate multiple cross-sectoral benefits.[67]

Joint budgeting mechanisms have been developed in Australia, Canada, England, Italy, the Netherlands and Sweden, whereby budgets across government departments or tiers are shared or integrated to address shared goals. These can be either voluntary or mandatory, and may be one-off initiatives or long-term processes of organisational change. Joint budgeting can take various forms:[66]

- *Budget alignment*, whereby one budgetary authority manages multiple budgets for agreed goals;
- *Dedicated joint funds* that multiple departments contribute for specific joint activities;
- *Joint-post funding* whereby a position funded by multiple departments with cross-sectoral responsibilities;
- *Fully integrated budgets* whereby resources and workforce come together under one 'host' department; and
- *Policy-orientated funding* whereby resources are allocated by a central or local authority to policy areas rather than to sectors

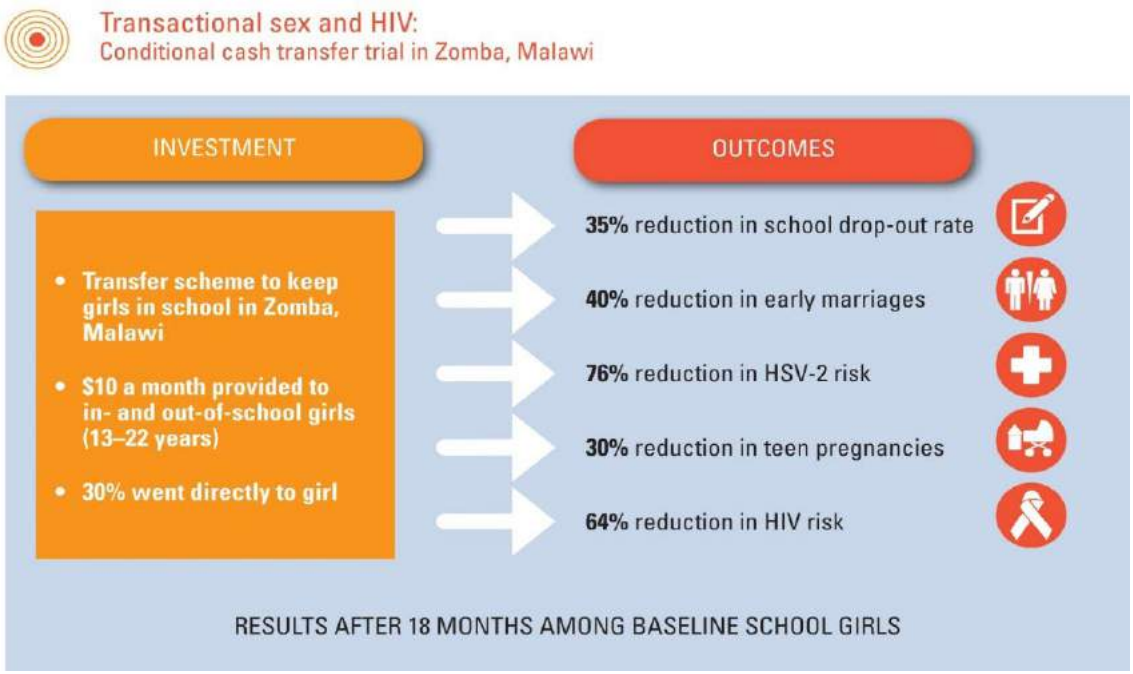
These initiatives have tended to focus on easily identifiable beneficiary groups that require more than health care for their well-being and would benefit from a continuum of social services, including social care, education, housing and employment.[67] Well-documented examples from Sweden include a rehabilitation programme for people with musculoskeletal disorder, an elderly safety promotion programme and a diabetes prevention programme.[68] These were evaluated in the context of Sweden's trial legislation in 1994, allowing social insurance, social welfare and health care services to pool budgets under joint political steering. In their evaluation, Hultberg and colleagues found positive results on the perceived quality of interdisciplinary and inter-organisational collaboration in the co-financing model, but no positive impacts on patient outcomes, such as number of sick days taken by people with musculoskeletal disorders, or health care costs.[69,70]

In the UK, joint budgeting has been undertaken for health and social care services for older people, and for health, education and social services for children that were jointly managed by NHS primary care trusts and local councils.[71,72] The latter were perceived to improve the efficiency of services and care pathways.[71,72] In New Zealand, regulation was put in place to allow for joint budgeting of 'clustering projects', with some evidence of success when pooling resources from local health boards, nutrition agencies, NGOs and the fitness and food industry to promote healthy lifestyles.[67]

These cases have highlighted potential enablers for co-financing. Compelling evidence of multi-sectoral impacts and expected cost savings are potentially influential.[66,67] Another important lever is strong political will and some form of top-down directive mandating a co-financing scheme. Although high-level buy-in and champions will undoubtedly be vital, the literature suggests an important trade-off between the sustainability of co-financing and top-down

FIGURE 6

Multiple outcomes of the Zomba cash transfer scheme



Direct Image from Source: *STRIVE (2012)*[5]

mandatory schemes that may increase sectoral resistance.[66,67] The implementation of co-financing approaches is often not straightforward, even when there is a strong economic justification for it. Limited resources and budgets could very well heighten each budget holder's anxiety and grip over its limited resources, especially if these decision-makers are more likely to be maximising their budgets rather than social welfare, as argued in political economy theories.[66,67] It is also important to consider the significant transaction costs associated with cross-sectoral coordination, alongside credible evidence of cost savings or increased impact.

An important finding for the HIV field is that there may be more flexibility among payers with a strong results and population focus. In particular, donors that are not constrained by the sectors or services they can invest in, could function as 'purchasers' of outcomes, and could potentially be attracted to fund programmes with multi-sectoral benefits in their own right, or through a fee-for-output or outcome mechanism, akin to the results-based financing schemes being rolled out for health facilities.[66] Similarly, evidence suggests that there could be more potential for cross-sectoral thinking and planning at the decentralised level, where sectoral siloes are less dominant and officials are more focused on delivering benefits to particular populations (Tanzania, Sweden and UK).[66]

2.6.4
Delegated financing

Another financing model is delegated financing, which has been primarily implemented through health promotion foundations, which are statutory bodies with long-term and recurrent public resources dedicated to funding cross-sectoral health promotion programmes. Initially established in Australia from a dedicated tobacco tax, this model was replicated in Austria and Switzerland, tapping various funding sources, such as an additional levy on top of compulsory health insurance premiums or a dedicated sum from sales-tax revenue.[73]

This could be an effective strategy for mobilising and pooling non-HIV resources with other resources being invested into gender equality and women's empowerment programmes. At the global or country level, there are a number of ring-fenced funds for women's rights organisations and gender equality exist (such as the UN Women Fund for Gender Equality, UN Trust Fund to End Violence against Women, the Global Fund for Women, among others), and they represent an entry point for the HIV response to leverage upstream gender programmes for greater impact.

2.6.5
Output-based financing and Social Impact Bonds

There is increasing interest in various fields in linking the disbursement of financial resources to outputs or results, rather than allocating resources for expenditures on inputs. Such approaches are coined differently in different sectors and settings, as output-based, performance-based, results-based financing, pay-for-performance, or cash on delivery.[74] They are all aimed at using a financial mechanism to incentivise recipient governments, programme implementers or service providers to focus on producing pre-defined outputs or outcomes, while giving them the flexibility to determine how best to use resources to generate these results.

Social Impact Investments are a specific type of results-based financing tool and refer to investments "made into companies, organizations, and funds with the intention to generate a measurable, beneficial social or environmental impact alongside a financial return".[75] Social and Development Impact Bonds are getting increasing attention as an innovative financing mechanism, and are being tested in high-income as well as low and medium income countries.[76,77]

There are currently over 100 contracted impact bonds, including the first development impact bond that was set up in 2015 to address girls' education in Rajasthan, India. The Education Girls DIB was designed with the UBS Optimus Foundation providing the upfront working capital (US$ 270,000) to the Indian NGO Educate Girls to increase girls' school enrolment and improve learning outcomes. The outcome payer, the Children's Investment Fund Foundation (CIFF), committed to paying fixed amounts for each unit of improved learning and every percentage point increase in the enrolment of girls out of school. Reported results after 3 years suggest that the DIB targets were surpassed.[78]

Although this could be a promising financing mechanism to tap private investments, the evidence on the effectiveness and cost-effectiveness of social and development impact bonds is lacking, and there are important concerns about the implications for public service provision.[79]

2.7.

CONCLUSIONS AND RECOMMENDATIONS

2.7.1
Summary findings

Overall, it is not possible to determine at the global level whether policy commitments to actively promote gender equality and women's empowerment in HIV responses have been matched with sufficient budgets or spending. These expenditures are not marked and tracked separately, which may be telling. Rather they appear to be subsumed under the social enabler expenditures, which are on average between 3-12% of total HIV spending. Although more recently there have been important initiatives by global funders and in some national responses to prioritise gender-responsive programmes, specifically for adolescent girls and young women in sub-Saharan Africa, there is still inadequate spending on structural interventions to transform gender norms and promote gender equality. According to the last AIDS spending assessments in selected countries, between 0.7% and 15.2 % was spent on women-specific programmes, and less than 4% appears to have been invested in interventions that would be expected to promote gender equality.

Within existing HIV programmes and accountability mechanisms, there is a striking lack of definitional and conceptual clarity on which interventions promote gender equality; relatedly, there are no specific action-oriented targets or impact goals at the policy and programme levels that capture contributions to gender equality. With the lack of conceptual and target clarity, there is also limited visibility of existing spending on gender equality related programmes. Current expenditure tracking methodologies and mechanisms have not been adapted to include or assess this area of spending, which constrains the response's accountability to gender equality programming and outcomes in individual countries.

2.7.2
Recommendations for innovative financing strategies

Structural and cross-cutting issues are notoriously underfunded and require increased attention, evidence of impact, and intersectoral coordination mechanisms of governance and financing. We propose a strategic set of actionable recommendations to increase and track financing for gender equality in the HIV response.

1. Set a financing target for gender equality expenditures within HIV responses to compel increased prioritisation of gender equality financing within the HIV resource envelope

Specific and timed international and country targets in HIV responses have been useful drivers of action and investment. Examples include the '3 by 5' and '15 by 15' targets – the goals of achieving 3 million people with HIV on ART treatment by 2005, and 15 million by 2015 respectively. Although the 3 by 5 target was

not fully achieved, the 15 by 15 target was achieved half a year early.[80,81] Relatedly, the Fast-Track targets of 90-90-90 have galvanised investments along the treatment cascade and are nearly being achieved in some regions and countries.[1] In terms of financing, the 2016 Political Declaration on HIV and AIDS involves a target of 25% for prevention and 6% for social enablers. To focus attention and resources on gender equality, a financing target for national responses and global funders may be an important tool. Additional analysis would be required to determine what this target should be ('5 for 5' or 5% for SDG5).

2. Prioritise the right gender-transformative interventions within HIV platforms and combination packages of services

Build evidence base on incremental effectiveness and cost-effectiveness for HIV of gender-responsive interventions and allow these interventions to be considered alongside other HIV interventions.

3. Leverage non-HIV platforms and resources through cross-sectoral co-financing

Gender and HIV advocates should promote cross-sectoral co-financing for pure gender equality programmes and contribute HIV resources to such pools. This is where the 'how' is financed and the mechanism to enable cost-sharing between payers with different outcomes could actually influence the types of interventions that could be funded and expand the set of options available to an HIV payer.

4. Ensure greater accountability of gender equality financing through gender-responsive expenditure tracking

Some form of gender-responsive budgeting should be institutionalised within HIV budget tracking processes to ensure accountability to existing commitments and get further support for gender equality allocations. This strategy has been embedded in the SDG targets and could be used to advocate for similar mechanisms and processes within the HIV response. This will require clearly defining and marking key gender equality interventions within the social enabler category and revising NASA methodology accordingly to capture these, as part of the ongoing process of updating NASA guidance.

5. Consider channelling resources through ring-fenced financing or outcome-based financing

HIV resources could be used to contribute towards specific ring-fenced funds for gender equality and women's organisations, based on the contribution of those investments to HIV outcomes.

2.8

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2.9.

APPENDIX

2.9.1
WHO Gender Responsive Assessment Scale

WHO Gender Responsive Assessment Scale: criteria for assessing programmes and policies[33]

Level 1: Gender-unequal

- Perpetuates gender inequality by reinforcing unbalanced norms, roles and relations
- Privileges men over women (or vice versa)
- Often leads to one sex enjoying more rights or opportunities than the other

Level 2: Gender-blind

- Ignores gender norms, roles and relations
- Very often reinforces gender-based discrimination
- Ignores differences in opportunities and resource allocation for women and men
- Often constructed based on the principle of being "fair" by treating everyone the same

Level 3: Gender-sensitive

- Considers gender norms, roles and relations
- Does not address inequality generated by unequal norms, roles or relations
- Indicates gender awareness, although often no remedial action is developed

Level 4: Gender-specific

- Considers gender norms, roles and relations for women and men and how they affect access to and control over resources
- Considers women's and men's specific needs
- Intentionally targets and benefits a specific group of women or men to achieve certain policy or programme goals or meet certain needs
- Makes it easier for women and men to fulfil duties that are ascribed to them based on their gender roles

Level 5: Gender-transformative

- Considers gender norms, roles and relations for women and men and that these affect access to and control over resources
- Considers women's and men's specific needs
- Addresses the causes of gender-based health inequities
- Includes ways to transform harmful gender norms, roles and relations
- The objective is often to promote gender equality
- Includes strategies to foster progressive changes in power relationships between women and men

2.9.2
HIV Strategic Investment Framework (2011)

The Investment Framework (IF) was a global HIV investment programme that guided impact-based resource allocation and use, which advocated for tailored programmes based on country context and epidemiology.[44,45] It also facilitated a more efficient gaps-based financing approach of overall national HIV strategic plans by global and domestic funders, rather than silo-ed individual projects by various actors.[44,45] Prior to the implementation of the IF, there was success in mobilizing unprecedented amounts of resources, but spending was predominantly focussed on 'targeted scale-up' of large discrete interventions, which led to fragmented and disparate response between and within countries. The IF identified a set of programmes and approaches with an expanded focus on three levels of initiatives

Type	Description	Examples
Basic HIV programmes	Programmes and activities that directly reduce HIV transmission, morbidity and mortality.	PMTCT, Condom promotion, Key Population Programmes, Treatment and Care, Male circumcision, Behaviour Change
Critical enablers	Activities that are required to enhance the effectiveness and efficiency of basic programme activities	**Social Enablers:** advocacy, political commitment, law and legal frameworks, community mobilization, stigma reduction
		Programme: design, delivery, communication, management incentives, procurement and distribution, research and innovation
Development synergies	Investments in other sectors that have positive effects on HIV outcomes.	Social protection, gender equality, education, legal reform, poverty reduction, income generation community systems and employer practices

2.9.3
Percentage spending on Social Enablers (from total HIV expenditure)

TABLE 7
Percentage spending on social enablers within total national HIV expenditure

Country	Income Status	Year	Social Enabler Expenditure (% of Total HIV Expenditure)
Asia and Pacific			
Bangladesh	Lower-Middle	2017	4%
Kiribati	Lower-Middle	2017	32%
Lao's People Democratic Republic	Lower-Middle	2017	5%
Micronesia, Federated States of	Lower-Middle	2017	13%

Country	Income Status	Year	Social Enabler Expenditure (% of Total HIV Expenditure)
Malaysia	Upper-middle	2017	1%
New Zealand	High	2017	1%
Samoa	Upper-middle	2017	27%
East and South Africa			
Comoros	Low	2017	3%
Kenya	Lower-Middle	2017	5%
Madagascar	Low	2017	22%
Malawi	Low	2017	11%
Rwanda	Low	2015	5%
South Africa	Upper-middle	2017	8%
Eastern Europe and Central Asia			
Armenia	Upper-middle	2017	9%
Belarus	Upper-middle	2017	2%
Georgia	Lower-Middle	2017	2%
Kazakhstan	Upper-middle	2017	3%
Kyrgyzstan	Lower-Middle	2017	15%
Moldova	Lower-Middle	2017	9%
Tajikistan	Low Income	2017	2%
Ukraine	Lower-Middle	2016	2%
Latin America and The Caribbean			
Antigua & Barbuda	High	2017	6%
Brazil	Upper-middle	2017	6%
Chile	High	2017	5%
Costa Rica	Upper-middle	2014	2%
Dominica	Upper-middle	2017	5%
Dominican Republic	Upper-middle	2017	1%

Country	Income Status	Year	Social Enabler Expenditure (% of Total HIV Expenditure)
El Salvador	Lower-Middle	2017	2%
Guatemala	Upper-middle	2017	2%
Haiti	Low Income	2016	2%
Mexico	Upper-middle	2015	1%
Middle East and North Africa			
Algeria	Upper-middle	2017	2%
Morocco	Lower-Middle	2017	4%
West and Central Africa			
Benin	Low	2016	6%
Cote d'Ivoire	Lower-Middle	2013	22%
Guinea	Low	2017	2%
Nigeria	Lower-Middle	2015	7%
Senegal	Low	2015	15%
Togo	Low	2016	1%

2.9.4
International donor's budget and spending on gender equality in HIV response

TABLE 8
PEPFAR's DREAMS partnership funding by country, FY 2016-2017 implementation

Country	Funding (US$)	Largest AGYW targeted intervention	# AGYW targeted
Kenya	39,485,340	Community mobilization & norms change	162,004
Lesotho	14,035,320	HIV testing & counselling	121,159
Malawi	14,035,581	Community mobilization & norms change	182,571
Mozambique	20,391,540	Increase contraceptive method mix & condom promotion and provision	79,525

South Africa	66,646,763	School-based HIV & violence prevention	327,567
Swaziland	10,019,391	HIV Testing & Counselling	3,254
Tanzania	16,326,356	Expand/improve contraceptive method mix & Condom promotion and provision	62,392
Uganda	31,434,805	HIV testing & counselling	150,454
Zambia	16,248,416	School-based HIV & violence prevention	204,786
Zimbabwe	20,621,571	School-based HIV & violence prevention	68,850
Total	249,245,083		

TABLE 9

The 2019-2021 Funding Requests from Kenya: Programmes with Gender-Equality Relevance

Source: The Global Fund

Funding and Programme Categories	Amount (US$)	% of total allocation
Within Allocation: Prevention programmes for adolescents and youth in and out of schools; **Interventions:** continuation of the current pilot cash transfers and provision of dignity kits to 9000 young women in Turkana County	4,971,640	2%
Within Allocation: Programmes to reduce human rights-related barriers to HIV services; **Interventions:** • Stigma & discrimination reduction through sensitization and capacity-building for PLHIV, community leaders, HCPs, unions and private sector leaders; • Integrating HIV/ and human rights issues in faith sector messages; • Advocacy among law enforcers and county government on the punitive legislations and municipal by-laws that inhibit key populations from accessing health services.	3,814,042	2%
Above allocations: GBV prevention and treatment program **Intervention:** Supply of Post Rape Care kits (PCR)	101,962	<0.001%

3. Lessons to Increase the Gender-Responsiveness of HIV/AIDS National Strategic Plans: A Qualitative Inquiry in Eswatini, South Africa, and Zambia

Background Paper

Bergen Cooper, Center for Health and Gender Equity (CHANGE) & Jennifer Sherwood, amfAR, The Foundation for AIDS Research

3.1.

INTRODUCTION

National Strategic Plans (NSPs) for HIV/AIDS are critical planning documents that set priorities and targets for a country's response to the HIV epidemic, influence donor funding priorities, and guide data collection for domestic and international monitoring and evaluation. HIV/AIDS NSP development is primarily supported by national governments, with international funding and technical assistance (TA) offered through various branches of the Global Fund to Fight AIDS Tuberculosis and Malaria (the Global Fund), the United States President's Emergency Plan for AIDS Relief (PEPFAR), and the United Nations. Endorsement of a strong gender equity agenda is part of a cohesive national HIV response and includes high levels of sex and age disaggregated data collection, reporting, and target setting in NSPs, as well as the inclusion of targets and specific funding to improve gender inequality across various HIV outcomes. Gender issues interact with age over time to create specific concerns at different life stages such that age-disaggregation is equally fundamental to creating gender-responsive plans.

Specific processes and resource dedication to the development of gender-responsive national planning differ significantly by country, which may lead to variation in outcomes. A recent review of general population HIV targets from NSPs found an overall inconsistent incorporation of sex-disaggregated HIV targets within NSPs of sub-Saharan African countries with some of the highest HIV burdens in adolescent girls and young women (AGYW).[121] For the eighteen countries included in this review, the proportion of general population targets that were sex-disaggregated ranged from 0% (Botswana, Cameroon, and Mozambique) to 92% (Zambia), with an average of 31% across countries. Only the NSPs from Eswatini, South Africa, and Zambia disaggregated a majority (>50%) of their targets by sex. These ongoing gaps in sex disaggregation of national HIV targets — despite being a long-time recommendation for best practice and explicitly endorsed by the global community — prompted the need to examine the reasons for such wide country variation.

For the purposes of this analysis, *sex* is defined as a biological binary determination of male or female, whereas *gender* is defined as the spectrum of learned characteristics of people (men, women, gender non-conforming individuals, etc.) which create a diversity of gendered experiences — including those whose sex differs from their gender presentation. *Sex-disaggregation* therefore refers to data/targets which are set separately for men and women, and *gender equality* targets/funding refer to work specifically aiming to decrease a gender-related gap in HIV/health outcomes. *Gender-responsiveness* refers to the ability of NSPs to respond to the differences in the HIV outcomes driven by gender expectations, roles, relations, and performance.

121 Sherwood, J., Sharp, A., Cooper, B., Roose-Snyder, B., & Blumenthal, S. (2017). HIV/AIDS National Strategic Plans of Sub-Saharan African countries: an analysis for gender equality and sex-disaggregated HIV targets. *Health policy and planning, 32*(10), 1361-1367.

3.2.

METHODOLOGY

The current analysis utilizes in-depth interviews among key informants (KIs) involved in the design of the NSPs from high-performing countries; Eswatini, South Africa, and Zambia, as well as colleagues from the Global Fund and the Joint United Nations Programme on HIV/AIDS (UNAIDS). Interviews explored the participant's role and key recommendations for the NSP process, with a heavy focus on the financing of NSP development and gender equality target setting. Interview data was supplemented by a desk-review of each country's publicly available NSP budgeting materials to examine national resource allocation to gender programming. Key findings from eight semi-structured KI interviews and review of budgeting materials are discussed.

3.3.

KEY FINDINGS BY COUNTRY

3.3.1
Eswatini

NSP Development and Funding

Eswatini has been disaggregating targets by sex for over a decade. The Ministry of Health (MOH) established a Strategic Information Department (SID) that housed the Health Management Information System and the Monitoring and Evaluation Department Donor networks. The Global Fund and PEPFAR supported the government's initiative to improve disaggregation of data, requiring disaggregation by both sex and region, such that high levels of disaggregation became the standard.

However, Eswatini does not have an equally long history of disaggregating all targets by age. More recently, since the Sustainable Development Goals (SDGs), there has been a greater focus on age and region, and funding models have followed that approach by investing in high HIV volume sites, sometimes at the detriment of interventions targeting gender issues. KIs noted that with the PEPFAR public-private Determined, Resilient, Empowered, AIDS-free, Mentored, and Safe women (DREAMS) partnership in place, age-disaggregation became normalized for 15- to 24-year-olds; however, other age groups have not necessarily benefited. While DREAMS was advantageous, it shifted PEPFAR funding to focus on adolescents and did not address the underlying harmful gender dynamics throughout the country. Additionally, PEPFAR's epidemiologically focused approach means that funding tends to go to areas with the highest HIV burden. Clinics in areas with lower burdens, but perhaps equally as damaging gender dynamics, do not benefit from PEPFAR TA for monitoring and evaluation (M&E) and, in turn, their data collection and ability to do gender analysis lag behind.

Successes in sex-disaggregation and gender programming were propelled by multi-stakeholder consultations and leadership on gender issues. Thematic working groups had long existed throughout the NSP process and KIs noted that attempts were made to bring a gender lens to the consultative groups. Introducing a gender lens worked well for treatment, however, KIs noted that it was more difficult with prevention. The complexity of prevention includes behavioral and social change topics, which were difficult to assign as they touched on multiple thematic areas. This led to confusion on group structure and oversight, and generally poor coordination. Of particular note, specific funding streams are critical not just to NSP development and data collection, but also to data analysis. KIs noted that Eswatini collects disaggregated data but they do not have the funding for analysis, limiting the ability to influence target setting.

While patriarchy is harmful throughout the world, KIs in Eswatini placed a greater comparative emphasis on the burden of cultural patriarchal values. It was noted that there are different values within the small radius of the country and that a one-size-fits-all approach to gender analysis would not necessarily be successful. It is recommended that there be an ongoing focus on men: male involvement, indicators for men, and targeted programmes for men to address underlying social issues. KIs strongly recommend that ongoing work moves beyond treatment to focus on social and behavioral change.

Financing Gender Programming

Swaziland extended the Multisectoral National Strategic Framework for HIV and AIDS (NSF 2009-2014) to 2018, also known as the eNSF. It states that resources will focus on high impact areas including the core programme, which includes addressing gender-based violence.[122] The eNSF also notes that there are high drivers of the epidemic and that strategies within the core programme are designed to alleviate the burden of the threats. Gender inequality and gender-based violence are specifically named as high drivers of the epidemic. The eNSF does not discuss the exact level of funding that goes into gender programming or how gender is incorporated into all of the programming.

122 See https://www.infocenter.nercha.org.sz/sites/default/files/eNSF%20Evaluation%20Report%20Final%20Framework_Final.pdf

Key findings

- In Eswatini sex, age, and regional disaggregation became routine early in reporting procedures and is therefore an expected norm.
- Disaggregating targets by age is a gender issue. Moving forward, age-disaggregation should be prioritized.
- Leadership and coordination are key to the success of thematic working groups.
- Addressing behavioral and social drivers of HIV/AIDS can be difficult due to overlaps in thematic areas.
- Capacity for in-country analysis is currently insufficient and should be financially supported.
- Patriarchy and gender dynamics are not monolithic across or even within countries. Approaches that address gender dynamics must be nuanced, flexible, and include programming for all genders.
- The eNSF discusses the importance of funding gender programmes but does not offer actual proof of allocations for the work. Moving forward, the eNSF should clarify how and to what extent gender programming is funded.

3.3.2
South Africa

NSP Development and Funding

The most recent South African NSP (2017-2022)[123] was led by the South African National AIDS Council (SANAC), a multi-stakeholder steering committee composed of government, civil society, private sector, development partners, and donors. The process described by KIs was one of broad and frequent consultations that started soon after the last NSP was published. TA was provided by national, provincial, and community stakeholders, as well as supported by strategic specialists from UNAIDS. SANAC was the primary funder of the NSP process, and additional support was provided by GiZ, the Global Fund, The Bill and Melinda Gates Foundation, and in-kind support from WHO and UNAIDS. While there was no specific TA or external financial support for the inclusion of gender equality targets in the NSP, the United Nations Development Programme (UNDP) offered specific support to bolster the inclusion of human rights, which included some gender issues. All KIs agreed that specific external funding streams were necessary to drive work in specific areas above and beyond what was available through general government support, drawing examples from specific available human rights funding.

Unique to the South Africa process for NSP development was the launch of the *She Conquers Campaign* (SCC),[124] a multi-stakeholder plan developed by the Deputy President of SANAC for how the country would respond to the HIV epidemic among AGYW. The SCC developed a package of interventions, M&E, and communication strategy based on specific and focused consultations with young women and other gender specialists, the outcomes of which were transferred directly into the larger NSP. These focused consultations were seen as highly effective compared to the general consultations, which were often unfocused and too broad to produce new and innovative measurement techniques/targets. By contrast, the SCC was highly focused, allowing for a concentration not only on developing biomedical targets but the social and structural drivers of HIV for AGYW such as staying in school, gender-based violence, and economic stability.

KIs credit much of the success of the recent NSP to the integration of targets to address these social and structural drivers of HIV on their external development as part of the SCC. However, the SCC has not received sufficient buy-in from other areas of government, such as the Department of Social Development or Department of Basic Education. This broad buy-in would be required to move the campaign outside of the health sector to be a truly multi-sectoral initiative and ensure that all government departments disaggregate their data by sex. Additionally, the sustainability of the SCC is limited by lack of funding for continued monitoring and promotion.

123 See https://sanac.org.za/the-national-strategic-plan/
124 See http://sheconquerssa.co.za/

Financing Gender Programming

Budget allocations are presented by goal and specific objective for South Africa's NSP. Goal 3: 'to reach all key and vulnerable populations with customized and targeted interventions', is allocated US$ 68 million (3% of total). Populations included in this definition are AGYW, transgender people, men who have sex with men (MSM) and other lesbian, gay, bisexual, transgender and intersex populations. Without further disaggregation, it is not possible to know what funding is going to which population. However, funds are specifically allocated to increase the engagement of key and vulnerable populations in health services (see Table 1).

Goal 4: 'to address the social and structural drivers of HIV, TB and STIs', is allocated US$ 113 million (5% of

total) to support the full array of programming. These programmes include the package of interventions identified by the SCC, namely; action to decrease teenage pregnancies, prevent gender-based violence, keep girls in school, and increase economic opportunities for young people, especially young women. Specific budget lines are available for economic strengthening and gender-based violence prevention programmes (see Table 1).

TABLE 1

Budget by Objective for Gender Programming in South Africaís NSP (USD millions)

Goal	Objective	2017/18 budget (% of total)
3	Increase engagement, collaboration and advocacy of key and vulnerable populations in the development and implementation of social and health support activities	26.5 (.08%)
3	To provide an enabling environment to increase access to health services by key and vulnerable populations	32.5 (.09%)
4	Implement social and behaviour change programmes to address key drivers of the epidemic and build social cohesion	63.6 (.18%)
4	Increase access to and provision of services for all survivors of sexual and gender-based violence in the 27 priority districts by 2022	8.8 (.02%)
4	Implement economic strengthening programmes with a focus on youth in priority districts	2.0 (<.01%)

Overall, there is evidence of budgeting for gender programming in South Africa's NSP, specifically to address the social and structural drivers of HIV among women and girls. However, it is not possible to discern the total resource allocation for gender programming without further disaggregation, and it is unclear whether this level of resource allocation is sufficient to address gender inequity in HIV outcomes.

Key findings

- NSP development must be multi-stakeholder-driven, but the process has to be focused, with separate and specific consultations that identify and respond to the gender-related barriers to services proving the most effective.
- Integrating local data is critical, as not all epidemics follow international trends. Stakeholders must be shown the importance of disaggregation at the local level.
- Cross-cutting areas (such as gender) create specific challenges because they require more engagement across sectors. TA should focus on what it means to develop programmes from a human rights and gender-responsive perspective; this literacy needs to be increased for leaders at all levels of government. UNAIDS specifically can play an increased role promoting this work and sharing with local stakeholders.
- It is hard to change existing systems, with one of the greatest challenges being that national governments are unwilling to commit to anything new that will require extra resources in the beginning or that will provide better information for advocacy. Buy-in from governments on gender priorities must therefore start early and be driven by civil

society, who needs to be funded to actively engage in this work.
- Engagement with PEPFAR (specifically developing DREAMS proposals) was helpful in promoting sex-disaggregated target setting and establishing the government buy-in for addressing social and structural drivers of HIV among AGYW.
- Increased disaggregation of budget lines by populations and social/structural intervention in South Africa's NSP would allow further gender financing analysis.

3.3.3
Zambia

NSP Development and Funding

In Zambia, stakeholder engagement was essential to the formation of new NSPs. Multi-sectoral technical and steering committees were established to support the development of the National HIV & AIDS Strategic Framework (NASF).[125] The steering committees were positioned to provide strategic direction, facilitate high level engagement, and mobilize resources. The technical committee facilitated with stakeholder groups and ensured the process was technically sound. Consultations included but were not limited to PEPFAR, USAID, the United Nations Population Fund (UNFPA), civil society, faith-based organizations, government ministries, and the private sector.

Unique to Zambia was the review of previous NASFs commissioned by the National HIV/AIDS/STI/TB Council (NAC). The review was described as "critical," as it aided in setting a progressive strategy and targets for the new NASF. NAC hired a consultant who conducted a literature review, collected primary data, and considered recent studies to assess gaps in previous NASFs. The consultant found that most policy reporting systems and programme implementation now include the disaggregation of sex. Based on this, the review was able to say that consistent sex-disaggregation in the NASF was not only possible but also necessary to align with other country data systems.

The focus on gender and youth in the NASF was championed by the Ministry of Higher Education, Ministry of Health, the NAC, and UNFPA. As one KI described, "Target setting was not a major challenge; this is because individual line ministries had already formulated data collection tools which had taken into consideration disaggregated indicators by sex including gender equality targets." KIs emphasized again that leadership on specific issues (such as gender) from within the government was key to their final inclusion in the national strategy.

Moving forward, KIs recommend supporting inclusive gender-responsive programming to advance sexual and reproductive health and rights. This can include access to services as well as comprehensive sexuality education. Community groups require funding both to combat harmful gender norms as well as to engage with their government and push for more gender integration. Combating harmful gender norms involves addressing toxic masculinity and negative stereotypes. Engaging with governments is critical in order to influence the policies and practices that impact HIV risk.

125 Zambia National HIV & AIDS Strategic Framework 2017-2021. Available at: https://www.nac.org.zm/sites/default/files/publications/NASF%202017%20-%202021.pdf

Financing Gender Programming

To achieve NASF goals, the NAC set forth a budget of required resources by intervention type. No specific budget lines were available for AGYW, gender-based violence (GBV), or gender programming. However,

several categories of NASF interventions may have gender components, including; *youth focused interventions* and *cash transfers*. Budget lines for youth-focused interventions increased from US$ 6.64 million in 2017 to a projected US$ 7.90 million in 2021 (1.6% of total budget). Budgeting for cash transfers increased from US$ 3.33 million in 2016 to US$ 7.78 million in 2021 (1.5% of total budget).[126] In the absences of greater specification, it is not clear if these interventions will be implemented in a way that advances gender equity. While Zambia does include targets to address some gender equity issues, such as the prevention of GBV, there is no evidence of this in the budget materials included in the NASF.

126 Zambia National HIV & AIDS Strategic Framework 2017-2021 (p. 67). Available at: https://www.nac.org.zm/sites/default/files/publications/NASF%202017%20-%202021.pdf.

Key findings

- Both technical and steering committees are necessary collaborative processes for the development of the NASF.
- Using an outside consultant to assess past NASFs can inform and strengthen future NASFs.
- Policy reporting systems and programme implementation that disaggregate by sex can be influential in leading to sex-disaggregation in the NASF.
- Ministries, stakeholders, and multilateral agencies can be impactful in influencing demographic focuses with the NASF.
- A focus on gender is incomplete if gender is a code word for "women and girls." Working on gender norms must include masculinity, and address gender-related disparities for men.
- Funding is necessary for civil society to engage with their own community and with the government. Funding to evaluate past plans is crucial for the development of new plans.
- While Zambia leads on the sex-disaggregation of targets, few targets address gender inequality and it is unclear if budget allocations are put towards gender programming/interventions.

3.4.

GLOBAL FUND AND UNAIDS

All in-country interviews pointed to the importance of the Global Fund and UNAIDS as funders and influencers of NSPs. The Global Fund offers funding for NSP development in the form of small grants to civil society to support their meaningful engagement in the NSP process. These funds come from 15-million-dollar TA programme.

The Global Fund also offers TA for NSP development; however, due to the organizational structure, KIs felt that their ability to influence the process and increase disaggregation was limited. The Global Fund is investing to strengthen existing data systems and analytical capacity to increase availability of age/sex-disaggregated data for planning and programme management at all levels. To ensure there is accountability toward this effort, Global Fund's key performance indicator (KPI 6e) monitors the number and percentage of countries that report disaggregated data. Global Fund

KIs emphasized that while data-disaggregation may be taking place during the data collection phase, it is commonly aggregated during the reporting process, or lost when fed into forward projection models. For example, there were concerns about the ability of UNAIDS HIV models to accommodate local age- and sex-disaggregated data, such that the resulting projections are based on limited data from adults (i.e., women ages 15 to 49 in antenatal clinics).

Indeed, KIs mentioned that in specific high-capacity cases where countries have undertaken their own modelling work, such as South Africa, models can utilize disaggregated data and higher epidemiological accuracy can be achieved. In the case of South Africa, the integration of local age- and sex-disaggregated data into projection models highlighted the need to address HIV in youth and drove resources to that population.

UNAIDS is the primary body offering TA for HIV/AIDS NSPs. This brief analysis does not offer a comprehensive review of UNAIDS involvement in NSPs, nor does it seek to describe their complex process of target setting, which includes their use of international models. Further inquiry with the Strategic Information sector of UNAIDS would be warranted to better understand the challenges and necessary next steps in promoting sex- and age-disaggregated target setting.

To advance gender equity, UNAIDS offers US$ 10,000 to fund gender assessments in various high-burden countries, and over 70 countries have been supported to date. The total price of gender assessments was quoted to be US$ 20,000 to 50,000 and the gaps in funding these assessments were normally filled by UNFPA, UNDP, UN Women or Global Fund. KIs from UNAIDS echoed the sentiments of many country informants — mainly that is much more difficult to address/integrate targets for the social and structural drivers of HIV. Special emphasis and increased engagement of social and behavioral experts must be undertaken in order to ensure the inclusion of these topic areas in NSPs.

3.5.

CONCLUSION

While the NSP development process was different in some important ways across the three case study countries, many key themes ran through the interviews. Firstly, multi-stakeholder engagement was critical. This includes local ministries, civil society, consultants, bilaterals, and multilaterals. All of these stakeholders have the opportunity to be champions across issues of gender, age, data-disaggregation, transparency, gender-based violence, prevention, treatment, and care. What matters is not necessarily the topic, but that there is an individual or organization that is able to lead on the issue. Secondly, funding was necessary to do the work of the NSP. Funding supported TA, focused on gender and age, and consultant review. Time and again, the work that got done, the work that had leadership, was work that was funded. Thirdly, there is some evidence of budgeting for gender; however, it is unclear if the financing is proportionally related to need. Moving forward, countries should be encouraged to disaggregate and be transparent about how their NSPs finance gender programming.

3.6.

RECOMMENDATIONS MOVING FORWARD

- Continue to fund civil society to engage with governments on issues of gender.
- Disaggregate by age as a means to achieve gender equity.
- Pay special attention to social and structural drivers of HIV/AIDS and think strategically about how to fund and support champions of this work.
- Facilitate learning initiatives among governments, civil society, and multilaterals on the use of models to inform indicators and targets.
- Balance international models and data collection with local models and data.
- Engage in cross-country NSP development learning sessions to share best practices.
- Include budgets in all NSPs that disaggregate funding for gender programming and/or targets.

3.7.

APPENDIX: KEY INFORMANT IN-DEPTH INTERVIEW GUIDE: GOVERNMENT

1. NSP development:

    a. Please describe the process for the development of your NSP

        i. Prompts: Who did you consult? Who provided TA? What does the approval process entail? Did you have any specific technical working groups (i.e. for gender, monitoring & eval etc.)?

    b. Please describe your target making process for NSP targets?

        i. Prompts: Who did you consult? Who provided TA? What does the approval process entail?

    c. Do you have external funding support for NSP development?

        i. Prompt: From who? How do they influence the process?

2. Sex-disaggregation in NSPs:

a. The majority of your targets are disaggregated by sex. Can you tell us what went into that target-making process?

i. Prompt: Who did you consult both internally and externally? Who/ What influenced the process? Has the level of sex-disaggregation changed from previous NSPs? If so, how and why?

b. What were the challenges?

i. Were there targets that you wanted to disaggregate by sex but were unable to?

c. What were the successes?

i. What contributed to those successes?

ii. Who were the champions who helped you reach success?

d. Was the development of sex disaggregated externally funded?

i. By whom?

e. What do you see as the key things that need to be in place to support sex disaggregated target setting in NSPs?

3. Setting and monitoring targets for gender equality:

a. You have been setting and monitoring targets to increase gender equality in your NSPs. For example, targets to reduce gender-based violence or improve access to resources and education for women and girls. Can you tell us what went into that target-making process?

i. Prompt: Who did you consult both internally and externally? Who/ What influenced the process? Has the level of sex-disaggregation changed from previous NSPs? If so, how and why?

b. What were the challenges?

i. Were there targets for gender equality that you wanted to set but were unable to?

c. What were the successes?

i. What contributed to those successes?

ii. Who were the champions who helped you reach success?

d. Was the development of gender equality targets externally funded?

i. By whom?

4. Other national plans that contain gender targets

a. Does your country also have other national plans that address gender such as NSP for gender-based violence or gender equality?

i. If yes - do you think having these other plans has influenced your NSP for HIV/AIDS? If so, how?

5. Recommendations

a. Do you have any other recommendations for making more gender-responsive HIV NSPs?

4. Financing the Engagement and Participation of Women Living with HIV in the HIV and Health Response

Background Paper

Lillian Mworeko, International Community of Women Living with HIV – Eastern Africa

4.1.

INTRODUCTION

World over, HIV has been having and continues to have a female face. By 2017, there were an estimated 18.2 million women living with HIV (aged 15 and older), constituting 52% of all adults living with HIV. Of the total estimated 1.6 million new HIV infections among adults globally in 2017, almost 48% were among women.[127] Meaningful participation and leadership of women, particularly those most affected by the HIV epidemic, are essential components of an effective and comprehensive response to HIV and AIDS. The participation and leadership of women dates back to the 1980s when women living with HIV started mobilizing, forming and organizing their participation in the HIV response. Since 1983, several organisations[128] focusing on women living with HIV were formed demanding for inclusion of women, their issues and priorities in the HIV response.

In 1991, there was an international meeting of the global network of people living with HIV (PLHIV) in London, UK. It was a gathering that was predominantly made of and for men. It focused on men's realities and discussed only the issues they were facing in relation to HIV. It was also men who had the power to make all decisions about the HIV response. This was the first time in the history that a group of women got together and used a gender perspective to challenge patriarchy and discuss their experience with HIV. Each woman who went to the meeting in London had their stories to tell, their own questions, fears and so many uncertainties in relation to their experiences. Many of them came from different countries, spoke different languages, and belonged to different cultures. This did not prevent them from understanding one another and sharing the exclusion they felt from the HIV movement.

What grew out of their passion for injustice and being silenced was unveiled at the International AIDS Conference held in Amsterdam in 1992. The formation of the International Community of Women Living with HIV (ICW) was a manifestation of their collective desire to bring the issues of women living with HIV to the centre of the discussion. The networks of women living with HIV have transformed into an important structure that influences the HIV response beyond demanding information, priority inclusion and inclusion into policy processes.

"Women including women living with HIV have for decades been saying that they are not sufficiently financed to engage and participate in the HIV and Health response at all levels (a report prepared by ATHENA in 2010, based on 100 responses from a global survey, includes lack of funding as a key barrier to our engagement and involvement in decision-making)."[129]

The 2016 United Nations Political Declaration on HIV and AIDS[130] committed to achieving gender equality and the empowerment of all women and girls, to respect, promote and protect their human rights, education and health, including their sexual and reproductive health, by investing in gender-responsive approaches and ensuring gender mainstreaming at all levels, supporting women's leadership to promote effective responses to HIV. However, despite these commitments, the gap between policy and reality

127 UNAIDS AIDS info. See: https://aidsinfo.unaids.org/

128 Such as The Women's AIDS Network (1983); AIDS Resource Network (WARN) (1986); Sister-Love, Inc. (1989); International Community of Women Living with HIV (ICW) founded in 1992; the Women Alive (1991); BABES, founded by HIV-positive women in Seattle under the philosophy that HIV-positive women are uniquely qualified to understand and encourage one another. Other networks that have since been formed include but are not limited to ICW-Eastern Africa (2005); ICW-West Africa (2007); ICW-Southern Africa (2004); National Community of Women Living with HIV/AIDS in Uganda (NACWOLA) (1992); Women Fighting Aids in Kenya (WOFAK) (1992) and ICW-Latina (1992).

129 UN Women (2010). Transforming the national AIDS response: Advancing women's leadership and participation. Available at: https://www.unwomen.org/en/digital-library/publications/2010/1/transforming-the-national-aids-response-advancing-women-s-leadership-and-participation

130 United Nations, General Assembly (2016): Political Declaration on HIV and AIDS: On the Fast Track to Accelerating the Fight against HIV and to Ending the AIDS Epidemic by 2030. Available at http://onusidalac.org/1/images/2016-political-declaration-HIV-AIDS_en.pdf

on the ground is of concern. In order to achieve the Sustainable Development Goals (SDGs) and Goal 3 which targets ending the AIDS epidemic by 2030, policy commitments must be adequately resourced, and funding must be translated into action and disbursed to organizations and networks that support the rights of women living with HIV and women's health. A strategy discussion on gender equality and HIV/AIDS, *Putting Gender Justice at the Centre of the Fast Track to End AIDS*, convened by UN Women in 2016, shared important contextual challenges to women's participation and gender equality such as: the lack of support, commitment and resources for work on women's human rights, gender equality and women's empowerment; lack of political will to finance gender equality and women's empowerment in the context of HIV; and lack of sustainable funding for organizing and mobilizing at all levels in the HIV response.

Drawing from the above UN Women's discussion participants from a wide variety of constituencies agreed that there is an urgent need to examine and advocate for increased financing for gender equality in the HIV response and financing for women's organizations involved in the HIV response, particularly networks of women living with HIV. The objective of this paper is to present specific experience, evidence and challenges relating to financing the engagement and participation of women living with HIV and their networks in the HIV and health responses. The paper highlights key issues, best practices, challenges, lessons, conclusions and policy recommendations.

4.2.

METHODOLOGY

The methodology included a desk review of existing literature, mapping of existing experiences, and evidence of access to resources for networks of women living with HIV to participate and engage in the HIV and health responses. Additionally, a questionnaire was sent out to 57 key informants (responses received from 44 people), i.e., women leaders, organizations of women and experienced women in the fields of gender equality, financing, advocacy and human rights and women living with HIV in key decisions of power and representation roles.

4.3.

FINDINGS – KEY ISSUES

Available evidence from both the literature review and key informants across countries has revealed a number of issues related to the financing the engagement and participation of women living with HIV in the HIV response. These include: limited funding for advocacy and bias towards service delivery; losing the gains made due to inadequate funding and participation of women; limited funding for institutional capacity building of women networks and individuals; over expectations from women living with HIV yet with limited resources; limited programmes focusing on engagement of women living with HIV in policy processes; limited and/or lack of investments in empowerment programmes and transformation leadership for women living with HIV and their organizations; and insufficient funding for representatives on key national and international platforms. Below we provide details about the highlighted issues.

4.3.1
Limited funding for advocacy and bias towards service delivery

Evidence shows that there has been overconcentration of funding on HIV care and treatment at the cost of advocacy and community mobilization, even though civil society engagement has also been critical in advocating for new resources, demanding access to treatment and HIV services, calling for the respect of human rights and supporting community-led HIV services. Despite the wide recognition of this important role, community organizations including those of women living with HIV are not funded to effectively play/execute this function.[131]

A key informant from Kenya noted that her work involves evidence-based advocacy and policy shaping, which most donors no longer fund. She further says that "*some activities are self-funded and that's because networks for women continue to be expected as it has traditionally been to work as volunteers, and where they are funded, it's more a project mode with no funding for staff positions and institutional/organizational capacity strengthening.*"

Evidence from Tanzania reveals the same situation like in other countries. A key informant from Tanzania, stated:

"So much expectation is put on us but with very little resources. The zeal and passion of women to solve issues is not met with adequate resources, hence we always have to struggle to achieve our potential. Despite the fact that the world has adequate evidence on what women's networks can do, the male dominated nature of our national and regional platforms give very little opportunity for women to acquire resources."

The HIV response has evolved from just saving lives to ending the epidemic. There are SDGs and universal health coverage milestones; but achieving them requires resilient and sustainable community and health systems. Financing women's networks and movements is therefore a must do.

131 See https://www.unaids.org/sites/default/files/media_asset/20181203_UNAIDS_PCB43_Item%208_Financing_Community-led_Responses_EN.pdf

4.3.2
Limited funding for networks of women living with HIV

In 2014, the International Community of Women-Eastern Africa (ICW-EA) conducted a study on whether women are accessing funding for HIV and AIDS,[132] and found that to a large extent, organizations of women living with HIV and women's rights organizations are not adequately accessing funding, particularly organizations dealing with human rights and advocacy. Although a total of 1,109 billion Uganda shillings (US$ 586.6 million) and 1,167 billion shillings (US$ 579.7 million) were spent on HIV and AIDS in 2008/9 and 2009/10, respectively, increased funding nationally did not result in increased access to funding for women's organizations. It was also noted that since women constitute a big proportion of Uganda's population (50%) and that HIV prevalence is higher among women than among men, the increasing HIV prevalence and incidence rates in the country implied an increasing impact of the epidemic on women. This could be partly associated with disproportionate allocation of resources to women.

The Association for Women's Rights in Development (AWID) found that, while women and girls are recognized as key agents in development, a large majority of women's organizations are underfunded. Specifically, AWID mapped 170 initiatives that committed US$ 14.6 billion in total under the broad umbrella of 'women and girls', yet in 2010, the average income of over 740 women's organizations around the world was

132 https://www.icwea.org/publications/download-info/report-are-women-organisations-accessing-funding-for-hiv-aids/

just US$ 20,000.[133] In 2014, a survey of 104 countries found that only 57% had an HIV strategy that included a specific budget for women.[134] A key informant from Rwanda remarked that *"the networks of women living with HIV are not efficiently financed to engage and participate in the HIV and health response at national, regional, and global levels."*

This is further confirmed by evidence from the Organization for Economic Cooperation and Development (OECD) report on gender-focused aid to civil society organizations (CSOs) and women's rights organizations. The table below shows that as little as US$ 180 out of the US$ 33,864 billion for gender-related work went to women's organizations.

Adapted from Donor Support to Southern women's rights organizations - OECD Findings (2014) Report

By Development Assistance Committee (DAC) member (2013-14 average) – Commitments, USD billion

According to UNAIDS,[135] countries are failing to sustain the gains made in the HIV response. "We are sounding the alarm," said Michel Sidibé, Executive Director of UNAIDS. "Entire regions are falling behind, the huge gains; women are still most affected, resources are still not matching political commitments."

Total gender-focused aid	Gender-focused aid to CSOs	Aid to CSOs as a % of total gender-focused aid	Aid to womenís rights organizations
US$ 33,864	US$ 8,840	24%	US$ 180

One key informant from Nigeria also remarked *"Every day I find new reminders that women with HIV are the true Most Valuable Players in the movement. Many women took this on and led the fight with sweat, tears and blood before a dime became available in funding. As the big funding streams dry out, women are still in the trenches working hard to preserve the gains made."*

Similarly, in Jamaica and according to the National AIDS Spending Assessment (NASA) 2016 report, women noted that there was little spent on specific projects for women living with HIV, which according to the report was attributed to the little understanding of the needs of women living with HIV. This confirms what most women alluded to – they are expected to deliver but receive no compensation for their time spent on the project.

133 Association for Women's Rights in Development (AWID) (2014) Beyond Investing in Women and Girls: Mobilizing Resources. Available at https://www.awid.org/publications/beyond-investing-women-and-girls-mobilizing-resources

134 UNAIDS (2015) Empower young women and adolescent girls: Fast-Track the end of the AIDS epidemic in Africa. Available at https://www.unaids.org/sites/default/files/media_asset/JC2746_en.pdf

135 UNAIDS (2018) Miles To Go: Closing Gaps, Breaking Barriers, Righting Injustices. Available at https://www.unaids.org/en/resources/documents/2018/global-aids-update

4.3.3
Limited sustainability of programmes for networks of women living with HIV

In Southern Africa for example, most women networks are unable to make critical investments in their organizations to become more resilient and thus are more susceptible to losing ground during tough times. A key informant from ICW-Southern Africa remarked that,

"We often lament the varying and sometimes onerous requirements that organizations must follow in applying for and reporting to grant applications. From duplicative grant applications to demand for arbitrary impact indicators, many funders place enormous burdens on grantees — even those that receive relatively small amounts of money or funding from the same funders every year. In addition, funders typically ask for the same data from repeat grantees year after year, which is time consuming and expensive."

4.3.4
Passive and inadequate participation/representation

For too long, women living with HIV or their networks have been invited only after agendas have been set or policy decisions taken, placing them in the role of reaction, disappointment and complaint rather than in a position of proactive, constructive and creative contribution. Moreover, women are invited to speak to 'women's issues' only and are rarely asked to address broader policy directives under consideration. Participation is seen as a privilege, rather than as a right, as meaningful, sustained engagement. As the Honorable Charity Ngilu, former Kenyan Minister for Health, stated at the 2007 International Women's Summit, *"My dear sisters, where policies are being made, our faces are not at those tables."*[136]

For example, critical stakeholders and representatives such as women living with HIV, community-based care-givers or women's rights advocates are largely absent from powerful agenda-setting mechanisms such as development of country HIV/AIDS plans, the AIDS coordinating authorities that dictate national AIDS policies or the Country Coordinating Mechanisms (CCMs) of the Global Fund to Fight AIDS, Tuberculosis and Malaria (Global Fund) that largely control Global Fund processes and access to its resources at the national levels.

As urged by the Executive Director of UNAIDS, Michel Sidibe, at the 54th session of the Commission on the Status of Women, *"...we need to invest much more in the participation and leadership of women and girls living with HIV, so that they can gain access to decision-making spaces and become 'agents of change' to guide all stages of planning and implementation of our response to AIDS"*.[137] Some platforms include space for young women but mentoring them to perform effectively is still a big gap.

Respondents in a study by UN Women and ATHENA[138] consistently reported that even when women do hold a 'seat at the table' – whether it be in formal decision-making forums such as the CCM or at a meeting of CSOs – their presence is frequently contested or their expertise is looked to as only relevant to 'women's issues', instead of as having a critical role to play as both speaking to issues of particular importance to women and informing discussion around HIV and AIDS policy and agenda setting in general. For example,

"Challenges faced by women in Namibia are that they are rarely involved in policy-making unless it is specifically on women's issues. When involved, their work often goes unrecognized and they have difficulty gaining access to or being taken seriously by policy makers. [The] involvement of positive women at country level CCM has been very difficult to secure any representation of women to get their voices heard and their concerns addressed."[139]

This perception of women's 'expertise' as limited not only denies women's right to participate, but also perpetuates a gendered understanding of 'expertise' and involvement that fails to incorporate women's realities and needs in policy and programme responses. Women living with HIV have therefore boldly embraced the position of *"nothing for us without us"*. At the opening of the International Women's Summit in Nairobi, Kenya, in July 2007, Musimbi Kanyoro, speaking as the then World Young Women's Christian Association General Secretary, said, *"the leadership of positive women is not negotiable."*

If women are leading the response in important ways, and if calls for women's full participation in the AIDS response have been made for over 15 years, why is so much of women's involvement invisible? And why are women, particularly the most affected women, still absent from formal and informal decision-making forums?

136 UN Women (2010). Transforming the national AIDS response: Advancing women's leadership and participation. Available at: https://www.unwomen.org/en/digital-library/publications/2010/1/transforming-the-national-aids-response-advancing-women-s-leadership-and-participation

137 Ibid.

138 Ibid.

139 Ibid.

One of the key informants from Rwanda remarked, "*There is not sufficient funding for representatives on such platforms. There are no resources allocated towards organizations and networks of women to mentor young women to take up from older women so that they can effectively participate in platforms that are already in place.*" A key informant from Kenya further says that for women's networks to function effectively, they need core funding that will enable them run their day-to-day work: *"We need constant capacity strengthening of institutions and individuals to keep up with the ever-changing HIV landscape."*

4.3.5
Lack of meaningful participation of networks for women living with HIV

A respondent from Southern Africa indicated that there is lack of meaningful participation, consultation and feedback in Southern Africa. She noted that organizations of women living with HIV do not get adequate funding towards building capacities for women to articulate their priorities and the organizational agenda. Most of the resources and support towards women living with HIV is towards their participation in conferences and meetings without supporting consultative and feedback process. Women in those platforms therefore end up speaking about their views, their opinions and priorities rather than those of the constituency of women.

4.3.6
Under-representation of adolescent girls and young women

Evidence and responses from respondents reveal that even where representation of women is noticeable, adolescent girls and young women are often underrepresented, and sometimes plainly absent from the forums where decisions relating to HIV prevention, care and treatment are made and resources are allocated. Many interventions are developed for, rather than by and with, girls and young women. Where participation occurs, it is often tokenistic, for example involving testimonials rather than opportunities to truly influence decision making.[140]

140 See https://athenanetwork.org/assets/files/General%20-%20publications/ATHENA-WRI%20Exec%20Summary-August%202015%20FINAL.pdf

4.4.

CHALLENGES RELATED TO FINANCING FOR NETWORKS OF WOMEN LIVING WITH HIV

- Most development partners have specific funding priorities that are not in line with the objectives (leadership, advocacy, and accountability) of most of the organizations of women living with HIV;
- There are limited funding opportunities set aside for the institutional and organizational development of women living with HIV to compete with other bigger organizations. Technical assistance provided is limited to institutional level and not wider members of the networks. Most of the funding that is common for women living with HIV is for travel to conferences and any preferred forum that donors are interested in;
- There are limited financial resources to follow up on the priority advocacy issues for networks of women living with HIV and AIDS. Consequently, the priority advocacy issues are highjacked by other organizations with better funding and structure even if their mandate is not relevant to such issues;
- A 2016 study by OECD Development Assistance Committee (DAC) Network on Gender Equality (GENDERNET) indicated that the majority of women's civil society funding goes to organizations based in donor countries or to international NGOs, implying that those (organizations) based in Africa – the epicenter of the HIV epidemic – remains underfunded.

4.5.

BEST PRACTICES RELATED TO FINANCING FOR NETWORKS OF WOMEN LIVING WITH HIV

- Some donors like the Global Fund to Fight AIDS, Tuberculosis and Malaria, UN Women, African Women's Development Fund (AWDF), Robert Carr Fund and OECD DAC have dedicated funds

to support women and women's organizations participation and engagement, and to strengthen the technical, financial, management and governance capacity of women's organizations.

- Some partners are putting resources towards supporting people living with HIV and their networks to participate and influence funding mechanisms like the United States President's Emergency Plan for AIDS Relief (PEPFAR) Country Operation Plan processes and the Global Fund, conferences and high-level meetings like the Commission on the Status of Women, and for inclusion and participation of young women. Some of the organizations that were mentioned were: AIDSFONDS, American Jewish Worldwide Services (AJWS), the AIDS and Rights Alliance for southern Africa (ARASA), AIDS Vaccine Advocacy Coalition (AVAC) and Robert Carr civil society Networks Fund (RCNF), WHO, UNAIDS, UN Women and UNFPA.
- Since its inception (2005), the International Community of Women Living with HIV in Eastern Africa (ICW-EA)[141] (as part of the global network of women living with HIV) has been and continues to advocate (participate and engage) for the human rights (including to health services (HIV inclusive)) of women living with HIV in their diversity at sub national, national, regional and global levels.
- Some agencies like Robert Carr Network Funds, AIDSFONDS, Ford Foundation and NORAD (Norwegian Agency for Development Cooperation) have provided funds for technical and institutional development (core funding) of organizations of women. Core funding has enabled organizations like ICW-EA to be meaningfully represented at relevant tables and events.

141 See https://www.icwea.org/

4.6.

LESSONS RELATED TO FINANCING FOR NETWORKS OF WOMEN LIVING WITH HIV

- Political commitments and good laws/policies without corresponding committed resources will not change the status quo for women's participation and engagement.
- Committing resources without a deliberate effort to ensure that organizations of and/or women and girls themselves directly benefit is no means to promote women's participation and engagement.
- Non-responsive or limited financing of women living with HIV impacts the HIV and health response, leading young women to most likely be discouraged to participate and engage once they notice that there is limited financing. Additionally, the national targets towards ending AIDS are also greatly affected once there is a gap in community engagement; communities play a very vital role in the HIV response since they are the beneficiaries.

4.7.

RECOMMENDATIONS

- Networks of women living with HIV and other likeminded organizations should initiate and implement a global campaign for a special fund for women's organizations and their participation in policies processes, including in engagement in the HIV response and gender equality programmes.
- Networks of women living with HIV should advocate for the provision of long-term core funding as well as programme implementation for women's rights organizations.
- HIV development partners should invest in empowerment programmes and transformation leadership trainings for women living with HIV and their organizations.
- HIV development partners should establish a funding mechanism for women living with HIV. One funding mechanism for the networks of women would help reduce this burden and enable networks spend more time on implementation.
- Women's organizations need to develop a common agenda in the HIV response and communicate it though a coordinated mechanism at national, regional, and international levels.

5. Financing Women's Organizations & Mobilization for Gender Equality: One of the Keys to Ending AIDS

Background Paper

Alessandra Nilo, Gestos,
with Claudio Fernandes and
Juliana Cesar Tavares

5.1.

EXECUTIVE SUMMARY: INVESTING IN WOMEN IS ESSENTIAL TO END AIDS. PERIOD.

Although United Nations resolutions, governments, and United Nations agencies' guidelines affirm that ensuring strong community-based-systems to effectively respond to HIV epidemic is important, we still lack implementation of their commitment. And although in the past years more data on the effectiveness of the work done by communities in the AIDS responses has been produced, as well as more attention has been given to the challenge of accessing funds, at this stage civil society organizations (CSOs) do not have the financial capacity to properly monitor the implementation of these commitments, especially through a gender lens.

- So far, the need for funding women and girls remains invisible in current debates on strengthening community systems. In addition, there are few disaggregated data on specific investments for women and AIDS, especially in relation to women's role as advocates.
- The "integrated approach" in the AIDS response, although important, is hiding women and girls' demands, and the existing tools to monitor the AIDS response do not have indicators (yet) to give us accurate information. The investments are in general mixed through different programmes and even when it comes to key populations (KP), almost no data on funding for women and girls is disaggregated.
- Existing funds for AIDS response are decreasing and under dispute, so more strategic alliances must be put in place, including with women from KP. We need to continue to make the case that KP are prominent actors in the response to HIV; thus far, their 'women' perspective remains invisible.
- Developing and including specific indicators in the existing monitoring tools of donors, governments and United Nations Agencies for reporting investments for women and AIDS, including for advocacy actions, is a matter of urgency. It is also necessary to calculate what is needed to adequately fund women's work to respond to the AIDS epidemic. In order to do so, it is necessary to have a clear definition for women-led organizations, women's organization and women's services for HIV.
- At a time when the world is increasingly discussing gender equality as an essential goal for sustainable development, a radical change in women's narrative is needed. This new era of movements such as *#MeToo* offers opportunities to unite our diverse voices in collective ways, but no new idea or existing initiative was identified in this paper as an emerging "innovative funding mechanism" aiming to support the work related to women and AIDS.
- An effective strategy to increase AIDS resources for promoting women's rights and gender equality in the AIDS response will require creating our own (women) fundraising models for continued and sustained investments.
- After centuries of exclusion and invisibility, and after three decades dealing with AIDS, the reality women face is clear: we need to better organize ourselves because no government and no donor will fundraise for us.

5.2.

INTRODUCTION AND METHODOLOGICAL APPROACH

Although strong United Nations policies and frameworks aimed at gender equality and women's empowerment exist, when it comes to HIV and AIDS response, there is increasing 'lip service' and rhetoric around commitments. Concerned with this reality, in 2016, UN Women convened a Strategy Discussion on gender equality and HIV/AIDS, *Putting Gender Justice at the Centre of the Fast Track to End AIDS,* in order to reflect on opportunities and escalate actions and advocacy for putting gender justice at the centre of the 'Fast Track to End AIDS'. Participants identified collective challenges and the meeting ended with a list of key recommended actions.

In order to continue the dialogue, in August 2018, UN Women commissioned this paper to contribute to the design of specific strategies toward mobilizing for increased financing for gender equality and for women's organizations in the context of the HIV response. *Gestos* conducted a desk review on the issue, complemented by an online survey to map existing challenges on women's organizing roles in advocating for gender equality in the HIV response. In addition, thirteen interviews were conducted and took place between September and October 2018, in order to refine the analysis. The survey has targeted very specific respondents and received forty responses from twenty-seven countries from all regions of the world. More than 80% of the respondents were individual organizations and 76% of the respondents' organizations had been founded from the year 2000 onwards.

Two important points:

a) for the purpose of this paper, when mentioning 'women', I am referring to 'women in all their diversity': age, race, gender identity, sexual orientation, ethnicity, language, marital status or partnership status, health status, (im)migrant status, job status, educational level, living in conflict or post-conflict settings, surviving violence or other human rights violations, etc.;

b) As UN Women has also commissioned other papers to inform the debate, I have not looked for information on existing resources from UNFPA, UNDP, UN Women and other United Nations agencies, opting to obtain data from the Joint United Nations Programme on HIV/AIDS (UNAIDS) through a desk review. The information on existing and invested resources throughout the text, and in the Annex 3, was not the main objective of this paper; however, it was needed to support subsequent analysis and recommendations.

Finally, I would like to express my gratitude to all the great women and organizations that contributed with their time, knowledge and insights to the ideas shared in this paper.

5.3.

WHAT WE KNOW: FUNDING FOR AIDS IS NOT ENOUGH FOR WOMEN

Many United Nations resolutions and guidelines have been approved aiming to respond to both gender inequalities and the unequal access to health. They have been reinforced by data showing that respecting women and girl's human rights and investing in gender equality contribute to economic and social development, whether in the macroeconomic level of a country growth or in the microeconomic level whether in a privately owned or a publicly traded corporation.

The 2030 Agenda for Sustainable Development specifically calls for gender equality and to ensure better health outcomes for all, including ending AIDS by 2030.[142] However, according to UNAIDS,[143] in 2018 women represent almost half (49%) of all adults living with HIV, and HIV is still among the leading causes of death among women of reproductive age. Gender inequalities, differential access to service, and different types of violence continue to increase women's vulnerability to HIV, and women, especially young women, are biologically and socially more susceptible to HIV.

Indeed, women affected by and/or living with HIV should be part of the solution: investing in women's health has been proven to promote growth in several areas, also ranging from wellbeing to Gross Domestic Products. Unfortunately, no matter how many multilateral commitments are made, and despite the fact that gender inequality is recognized as a key element to fuel the AIDS epidemic, the amount of investments in gender-based approaches to respond to the AIDS epidemic is still below what is needed.

This affirmation, though, is not based on any hard data, because the information about the specific financial resources invested and what would be the resources needed to stop the advancement of the HIV among women and girls, is still not available. The existing data on financing for AIDS is general and mixed within different programmes, and there is almost no women-related disaggregation. The information related to KP does not present data on funds directed at women and/or implemented by women's organizations, including actions in the field of advocacy. In fact, as a general observation, the fact that the AIDS story still needs to be addressed under the perspective of contributions and leadership provided by women's groups and women living with AIDS is another indicator of how we still remain invisible.

It is well documented that one of the factors that made the most difference in the response to the AIDS epidemic was the impressive capacity of civil society to organize and advocate, targeting governments, scientists, and donors.[144] Besides, it has been acknowledged that communities-based organizations play an essential role, including in reaching populations that the existing systems in countries usually, and for different reasons, do not reach in the same way. "The uptake of HIV treatment and prevention services is greatest when community-based organizations (CBOs) are active," is a conclusion the World Bank arrived at in 2013.[145]

142 https://sdgs.un.org/goals

143 UNAIDS AIDSInfo. See: https://aidsinfo.unaids.org/

144 For example, The Essential Role of Civil Society, chapter 9 of the UNAIDS Global AIDS Response 2006, https://data.unaids.org/pub/report/2006/2006_gr_en.pdf

145 Rodriguez-García R, Bonnel R, Wilson D, & N'Jie N. (2013). *Investing in communities achieves results: findings from an evaluation of community responses to HIV and AIDS*. In: Directions in Development Series. Washington, DC: World Bank.

Even when formally recognized, community work has never been fully funded, and funding has become scarcer as of 2011. In face of shrinking space for civil society, HIV organizations increased their pressure for UNAIDS to provide financial estimates on what has been invested in community-based initiatives and what are the projections about what is the need of civil society, so that it can continue to be a 'critical enabler' and 'critical partner' of an effective HIV/AIDS response. As an initial result, in 2014, UNAIDS estimated that "resources for community mobilization will increase from 1% of global resource needs in 2014 (US$ 216 million) to 3.6% in 2020 and 4% in 2030. This includes antiretroviral therapy and HIV testing and counselling."[146]

In 2016, two important paragraphs were adopted in the 2016 Political Declaration on HIV and AIDS, on global-level goals for expenditures in and on communities for HIV:[147]

(60 d) "expanding community-led service delivery to cover at least 30% of all service delivery by 2030;

(64 a) "ensuring at least 6% of all global AIDS resources are allocated for social enablers including advocacy, community and political mobilization, community monitoring, public communication, outreach programmes to increase access to rapid tests and diagnosis, as well as human rights programmes such as law and policy reform, and stigma and discrimination reduction".

Following that, the Non-Governmental Organizations (NGOs) Delegation to the UNAIDS Programme Coordinating Board (PCB) tabled a report at the 39th meeting in 2016, focusing on the chokepoints and innovative ways in funding communities.[148] Finally, in 2018, at the 43th meeting of the PCB, UNAIDS reported the following data on the UNAIDS Secretariat only funding to civil society: 2016-2017 core spending to CSOs was US$ 4.4 million (18% of total core programme funds or 2% of total core spending); and non-core funds to CSOs was US$ 28 million which represents 32% of total non-core funds.[149]

As it happens with available data from the Global Fund to Fight AIDS, Tuberculosis and Malaria (Global Fund) and the United States President's Emergency Plan For AIDS Relief (PEPFAR), the data available was not disaggregated for any specific population, indicating that the community-based approach can make difficult the necessary focus on specific populations, women included. Therefore, what we know so far about funding for AIDS in general is not enough for closing data gaps on both the allocated funds so far and on what is still needed for effectively finance women's organizations, particularly to mobilize and advocate for gender equality and friendly services in the HIV response.

It is important to point out that, at this stage nothing suggests that future investment will increase (see Annex 3), especially considering the current international political economy landscape where, according to Christine Lagarde, Managing Director of the International Monetary Fund, there is "*a fading commitment to international cooperation (...) and we are now facing new, post-crisis, fault lines—from the potential rollback of financial regulation, to the fallout from excessive inequality, to protectionism and inward-looking policies, to rising global imbalances.*"[150]

This context, more than ever, requires understanding about where resources for women's organization in the AIDS field come from, where they go, and how they align with our advocacy needs. This means that to inform our future strategies we need: 1) to better identify the trend of investments aimed at women

146 UNAIDS, Stop AIDS Alliance. (2015). *Communities deliver: the critical role of communities in reaching global targets to end the AIDS epidemic*. Hove, UK: International HIV/AIDS Alliance.

147 Political Declaration on HIV and AIDS: On the Fast Track to Accelerating the Fight against HIV and to Ending the AIDS Epidemic by 2030. https://www.unaids.org/en/resources/documents/2016/2016-political-declaration-HIV-AIDS

148 UNAIDS. (2016). Agenda item 7 Report by the NGO representative. Available at http://www.unaids.org/en/resources/documents/2016/PCB39_16-23

149 UNAIDS. (2018). Agenda item 8. Best Practices on Effective Funding of Community-led HIV Responses https://www.unaids.org/sites/default/files/media_asset/20181203_UNAIDS_PCB43_Item%208_Financing_Community-led_Responses_EN.pdf

150 International Monetary Fund. (2018). Ten Years After Lehman—Lessons Learned and Challenges Ahead. IMFBlog. Available at https://blogs.imf.org/2018/09/05/ten-years-after-lehman-lessons-learned-and-challenges-ahead/

and girls within the AIDS response; and 2) to calculate or estimate the amount of the financial resources needed for women and girls, which includes supporting women's organizations to face structural and social barriers in their role as advocates to influence policies, to claim their rights, and to demand and access quality services.

5.4.

WOMEN'S ORGANIZATIONS CHALLENGES TO RESPOND TO AIDS

We have plenty of data on the burden of HIV on women's shoulders and souls, but we still lack political will to invest effectively in the AIDS response through a gender perspective. The challenges faced by women in the AIDS field are multiple; as multiple and diverse is the work done by them. The survey and interviews conducted by Gestos confirmed previous research and papers: it is concerning that the same problems remain.

5.4.1
Survey participants

The 40 organizations that answered our survey were almost evenly distributed between women/feminist organizations that address HIV/AIDS (17) and HIV/AIDS groups that address gender equality (20). Three organizations did not see themselves prioritizing one or the other. 64% of them develop work at the national level, while 46% work at the local level, be it on urban or rural areas. 43% also develops work at the regional level, while 24% have a global reach.

51% of them focus in conducting research and 48% provides direct services (health, psychosocial and/or legal support) for people living with HIV. 10% provide re-granting. One quarter of them also focus in other activities. When asked to specify what were the other activities, respondents named 'harm reduction', 'the development of training programs' and 'work on violence against women'.

As for organizational budgets, almost one third of the organizations (27.27%) indicated that their annual budget is between 100,000 and 300,000 US dollars – the most common tier. In the second tier (21.21%) came the organizations that develop their activities with annual budgets up to 10,000 US dollars. 18.18% had annual budgets between 30,000 and 50,000 US dollars. From between 50,000 and 100,000 US dollars we had 12.12%, and from 300,000 to 500,000 US dollars, 9.09%. Only 6.06% had annual budgets of more than 500,000 US dollars.

5.4.2
Key findings

1. When asked to rate their main needs, "having funds available for advocacy" and "women's empowerment" were the options chosen by 92% of the organizations, followed by capacity building (79%) and monitoring of public policies towards HIV (69%).

Although global donors and multilateral agencies acknowledge the importance of advocacy as a critical component of the AIDS response, our survey has confirmed that **the lack of funds for advocacy work** is a consistent concern among CSOs in general, across regions and constituencies. As the 2016 UNAIDS PCB NGO Delegation Report stated:[151]

"Advocacy helps improve political environments, open up new areas of funding, and advance human rights. But a combination of political sensitivity and difficult-to-have short-term outcomes means that advocacy is often a "nice-to-have" rather than a "need-to-have" for funders. (....) CBOs must squeeze money for their advocacy activities out of other programme budgets or do the work on a completely voluntary basis."

Some mentioned that although the support for women's organizations to engage, lead, advocate and be key decision makers is, in theory, considered critical, funding for advocacy is scarce and restricted, including through different restrictions put in place by the donors or governments themselves.

2. When looking specifically at women's groups, one of the women interviewed for this paper, summarized a common challenge found among the survey respondents:

"Many times I hear that the **issues facing women are so entrenched** *that unless we are talking to a women's rights funder, usually the answer is that they need to focus on HIV investments that will bring immediate impact and not wait 20 years to show any results."*

The general perception was that AIDS donors and governments still insist that the needs of women and girls, especially in high burden countries, are so vast, that *"they could invest every dollar they have to address women's issues and still not have an impact on HIV".*

3. It was also highlighted that gender is a concept still ill-defined and it does not refer to "women and girls" only. So, while countries are getting better at disaggregating data by sex and age, they rarely analyse why data inequities exist.

"And even if they do the analysis, often with the support of technical partners, **they rarely use the analysis to develop gender-responsive programmes with adequate funds.** *This is a deficiency that continues to impact everyone in terms of reducing gender-related health risks, and gender-related barriers to essential health services."*

It seems contradictory when there is a consistent call for more gender-oriented approaches by governments. As some of the respondents said:

"What we learned is that in order to make funding to women's groups more efficient in the HIV response, it is essential to combine the provision of services with programmes that promote an enabling environment for CSOs and the realization of women, girls and adolescent's human rights."

"Our agenda is political and it is "messy" - we see that holistic approaches matter and that our solutions cannot be simply put on a PowerPoint. In the "app for that" era to development and health - we are talking about rights and long-term systemic change, about building power and building movements - not (only) about mosquito nets or "things" that can be counted in traditional ways."

4. In relation to fundraising with traditional women's donors that seem to be more flexible to finance advocacy, almost 100% of the people interviewed highlighted that, in general, HIV is currently not among their priorities, and that **we need advocacy work to convince womení donors to invest in HIV**.

"I went to a women's funders meeting this past year and there were really few HIV activists there. And as already noted, the HIV spaces have very much marginalized issues on women's rights and broader issues."

151 UNAIDS. (2016). Agenda item 7 Report by the NGO representative. Available at http://www.unaids.org/en/resources/documents/2016/PCB39_16-23

BOX 1

The Global Fund for Women's report 2017 informed that the organization granted more funding in 2017 than ever before – US$ 10.2 million – to support movements advancing human rights for women, girls and lesbian, bisexual, transgender, queer and intersex people. They offered 89 multi-year grants, an increase of 40% compared to 2016 and almost 30% of the grants went to organizations with a budget of less than US$ 50,000 a year. But the report did not detail GFW investments in AIDS.

5. When asked about *what percentage of their annual budget had been allocated to address gender equality in the HIV response in the last three years,* the average of the responses to the survey were 38.7% for 2015, 40.74% for 2016 and 42.58% for 2017. Almost 20% of the organizations have dedicated between 80% and 100% of their funds to respond AIDS on the last three years.

The organizations that responded our survey progressively increased their percentage of investments in women and girls from 2015-2017, but it was a small growth and one fifth of them stated that **they have no funding** and rely on volunteer work, especially organizations working with women living with HIV.

Most of interviewees were aware of at least one women's group that had closed their doors in the past 3 years or was responding to AIDS with minimum capacity. Two organizations mentioned that they have **not received any funding for the past 4 or 5 years**, being thus unable to do any – or next to none – work, unless it was voluntary.

6. Survey respondents said their main sources of funding are donor organizations (62%), United Nations agencies (35%), individual donations (32%), international cooperation agencies and national governments (21% each), local governments (12%), multilateral agencies (9%) and corporations/corporation donor institutions (6%). Many of them mentioned that **the fundraising field has changed drastically** in the past two years:

"Entities like Bill and Melinda Gates Foundation or the United States Government are large in size and only accessible to large entities such as FHI360."

"The PEPFAR's Determined, Resilient, Empowered, AIDS-free, Mentored, and Safe (DREAMS) public private

BOX 2

In 2014, GFATM approved a Special Initiative allocating US$ 15 million for 2014-16 to ensure that, within the rollout of the Funding Model, a) Communities and CSOs were meaningfully engaged in the design, implementation and monitoring of supported programmes; b) Technically sound interventions to address HR, gender equality and CSS. The evaluation conducted in 20016 was based on 3 components:

1. Short-term technical assistance (TA) for Country Dialogue and Concept Note development (allocated approx. US$ 4.25 million). 65 TA assignments were approved, delivered by pre-qualified Community, Rights and Gender TA providers, predominantly CSOs. From 34 pre-qualified TA providers, only one was a women's organization.

2. Long-term capacity development of KP networks through partnership with the Robert Carr Civil Society Networks Fund - RCNF (approx. US$ 5.3 million). Two rounds of one-year grants had been channelled through the RCNF to eight networks/consortia that incorporated 33 global and regional networks by and for KP. Only one member of the consortia was a women's organization.

3. Regional Coordination and Communication Platforms for communities/civil society: This was allocated approximately US$ 4.4 million. Six host organizations were selected to serve as Regional Coordination and Communication Platforms for Anglophone Africa, Asia and the Pacific, EECA, Francophone Africa, LAC and MENA. No women's organizations were selected.

partnership was intended to be an innovative mechanism for smaller women led entities to receive US government money. It was not and it was an administrative nightmare due to JSI's[152] failed management of the fund."

"The funding that UNAIDS was once able to invest in convening, catalytic efforts, and thought leadership was the most impactful funding source I know as they were flexible, responsive, with minimal administrative requirements. Nowadays funding is inaccessible to smaller entities as the reporting requirements are too steep."

"The UNAIDS diminished financial strength affects us all and funders like Robert Carr haven't invested enough in feminist leadership. Foundations such as Ford Foundation or OSF have walked away."

"Mama Cash and the Global Fund for Women fund women's groups that may do advocacy on HIV but it is not a focus of their overall investments."

7. When asked about barriers for accessing funding and/or grants to address gender equality within the HIV response, 71.79% of the survey participants mentioned the **decrease in international cooperation funding**.

8. A concern shared by almost all interviewees is that the political environment has been impacted by **the increase on the biomedicalization of the response in the field of prevention**, and that **the increasing wave of conservative governments** is heavily impacting the capacity of women to respond to the AIDS epidemic.

"Given the geopolitical landscape at present - there is a move to depoliticize the HIV agenda including the gender equality one."

"I'm not sure how UNAIDS/Global Fund are being swayed by PEPFAR."

"(...) the PEPFAR Gag Rule is jeopardizing our work on sexual and reproductive health and, as a consequence, diminishing our capacity to respond to AIDS (...)."

9. 35.9% of the survey respondents referred to **technical difficulties/challenges to access sources of funding**; 33.33% due to eligibility requirements and staff time to write proposals; 28.21% to staff expertise needed to write proposals; 20.51% to donor requirements for monitoring and evaluation; 17.95% to language barriers; and 15.38% to staff capacity to financially manage grants.

BOX 3

Existing Funds for communities respond to AIDS do not always reach women's organizations.

In 2014, the Global Fund Special Initiative allocated US$ 15 million for 2014-2016 to ensure that, within the rollout of the Funding Model, a) Communities and CSOs were meaningfully engaged in the design, implementation and monitoring of supported programmes; and b) Technically sound interventions were in place to address HR, gender equality and community systems strengthening. According to our respondent, the component "Long-term capacity development of KP networks", through partnership with the Robert Carr Civil Society Networks Fund had approximately US$ 5.3 million. Two rounds of one-year grants had been channelled to eight networks/consortia that incorporated 33 global and regional networks by and for KP. **Only one member of the consortia was a womenís organization**. Also, for the component "Regional Coordination and Communication Platforms for communities/civil society", which allocated approximately US$ 4.4 million, **no womenís organizations were selected** among the six host organizations to serve as Regional Coordination and Communication Platforms for Anglophone Africa, Asia and the Pacific, Eastern Europe and Central Asia, Francophone Africa, Latin America and the Caribbean and the Middle East and Northern Africa.

152 See https://www.jsi.com/project/supply-chain-management-system-scms/

Organizations reinforced that too many stringent requirements established by existing public calls[153] prevent most networks of women living with HIV from accessing the funds and they complained about donors demanding an unrealistic capacity to respond to bureaucracy even if the organizations are playing an effective role on the ground. The networks of women living with HIV are considered to lack capacity to be granted the funds, but donors rarely support capacity building and institutional development of organizations of women living with HIV. The Global Fund was mentioned as an interesting example of both opportunities and difficulties in accessing technical support.

10. The resources of **our respondents are profoundly dependent on non-local sources of funding,** depending to a great extent on funding from outside their countries. Most of the countries (54.17%) where the organizations are based do not make public calls for public funding. Where there are public calls, 50% said that they occur annually, while the other half stated that they are not regular. They take place when funds are available (such as when the country is eligible for the Global Fund grants) or when the countries want to develop specific actions.

A high number of respondents (64.1%) indicated the **lack of information about funding opportunities,** closely followed by challenging political and/or social environments (61.54%), divergence between donor thematic priorities/approaches and the organization's priorities, as well as insufficient/lack of government funding in the area (both with 56.41%) and insufficient funding available (51.28%) as major challenges.

11. Barriers to transfer funds to small groups of women usually are resolved by using intermediary organizations that, in turn, deduct a high percentage of administration cost, generally allocated – according to the interviewees' perception – in multilateral organizations or groups from rich countries. *"AIDS cannot be a business, but it is."*

153 The examples were varied. During the interviews, respondents cited both calls for government projects and private donors. Several cited the impossibility of accessing the Global Fund for AIDS TB and Malaria, for example.

Moreover, AIDS donors are interested in project results. Guaranteeing organizational development and a sustainable women's response to AIDS in the ground seems to be outside of their "interest". Although donors themselves have overhead expenses, the **funds for women are mostly project-based** and linked to programmatic outputs. In general, the budgets approved can cover some co-related percentage of core expenses, such as office costs and utilities.

"We never had core funding and we've always cobbled together funding from one initiative to the next. The challenge we face is a drop in actual dollars and a massive increase in the administrative requirements of the funds that we are able to acquire."

"What we see is diminished flexibility – more and more competition to receive smaller grants – and current grants having large administrative requirements or very specific donor agendas that do not facilitate our ability to 'keep the lights on' or build new areas of work."

Another barrier identified is that when it comes to the duration of grants, 62% of our interviewees informed they were for up to one year, 24% for in between 1 and 2 years, 12% for between 3 and 4 years, and 2% for five years or more.

12. With the decrease of investments in AIDS, and the changes of priority of governments and donors, and under the allegation that there are "many demands", **womenís groups are facing growing competition over resources**.

"We are now in competition with mainstream actors, including with entities such as UNAIDS and the Global Fund, where we were once funded partners of these very entities."

"The lesbian, gay, bisexual, transgender and intersex movement has had investment from wealthy individuals and donors who have been willing to seed new initiatives and who have not placed the same high administrative burden."

This is particularly concerning in a context where donors are "transitioning" out of countries and speaks to the fact that we need more analysis on impact of transition for women and girls in the AIDS response.

In Appendix 4 graphic, it is possible to see how US NGOs, foundations and international NGOs[154] have been prominent in intermediating the flow of AIDS resources from donor to recipient countries, meaning that perhaps many resources ended up more in office and paperwork activities than on the ground, where it is most needed. In Appendix 3, in the Development Assistance for Health (DAH) in 2017, you can see the substantial support systems available to transfer funds among states, United Nations Agencies, bilaterals, and foundations.

13. Slow implementation responses, **lack of political will** and **lack of coordination** between United Nations partners, donors, countries and women's groups are two other major obstacles mentioned during the interviews.

"(...) the data on the burden of new infections among adolescent girls and young women (AGYW) in many countries has been there for well over a decade, and yet there was no technical guidance on preventing new infections amongst them until 2016 from UNAIDS."

"All the policies state gender equality now, something all of us fought so hard for, yet no $ going to women's groups."

"Now we see the US Government's PEPFAR leaders aligning themselves with conservative, abstinence-only evangelical Christians."

Some platforms that have the potential to address women's financing gaps in the AIDS epidemic were mentioned, as well as the existing lack of coordination among them, although their members sometimes overlap.[155]

"UNAIDS has a guidance with a package of key interventions to efficiently invest to reduce new infections and to keep women and girls on treatment. But the funds to engage women's groups in advocating for its implementation is still missed."

"The Global Prevention Coalition has been an organizing framework, along with Stay Free, but they are largely HIV spaces and remain largely devoid of discussions on structural factors such as women's rights, violence..."

"Nobody is leading the push for funding women's response to AIDS."

14. The financing disputes are also related to the **disputes of the areas where to invest for women.** This concern is summarized below:

"There are many within World Health Organization (WHO) and UNAIDS who would argue (and do) that we should be investing money not in programs to keep girls in school, social support, gender-based violence, women's empowerment... but rather in voluntary medical male circumcision and putting men on treatment. (...) Epidemiologically, one could argue that voluntary medical male circumcision and putting men on treatment (male partners of women) would be a more efficient route to decreasing AGYW new infections. But that is a bit short-sighted potentially, and raises questions of sustainability. Of course, it's not necessarily an either/or but in the funding envelope context it often does boil down to choosing one intervention over another."

15. Finally, although United Nations resolutions and guidelines have been approved aiming to contribute to closing the gaps and respond to gender inequalities, when asked about how to use these resolutions to fundraise for women, many women interviewed pointed out **that grassroots awareness about existing United Nations guidance is still low** and, in particular, many do not know how to use them.

This indicates that we all still need improve our work on transforming United Nations resolutions in (r) evolutionary tools for advocacy toward more sustainable and effective response for women in the AIDS response.

154 To reflect more on disparities: although it is not directed related to HIV and it is from 2010, a global survey from AWID (over 1,100 responses of women's organizations from 140 countries) showed that the combined income of 740 organizations for 2010 was close to US$ 106 million while the income for Save the Children Int. and World Vision Int. was US$ 1.442 billion and US$ 2.611 billion respectively. See https://www.awid.org/news-and-analysis/20-years-shamefully-scarce-funding-feminists-and-womens-rights-movements

155 Examples mentioned: Start Free, Stay Free, AIDS Free, ACT!2030, All In to #EndAdolescentAIDS, DREAMS, Global Coalition for Women and AIDS, What Women Want.

5.5.

PLACES TO INFLUENCE, INNOVATIVE WAYS AND RECOMMENDATIONS

The global HIV response has inspired a number of innovative funding models, like UNITAID that, in the last five years, has raised over half of its funds in ten countries through the air ticket levy, a tax on plane tickets. Another example is the Global Fund's Debt2Health programme, launched in 2007 to generate additional domestic resources for health financing through debt swaps. Under this programme, developing countries can forgo repayment of a portion of their sovereign debt on the condition they invest an agreed amount in their health system through the Global Fund.[156]

In the field of social protection, cash transfers have been proven to work towards preventing new infections among women. According to the UNAIDS report *When Women Lead Changes Happens*,[157] cash transfers have been found to help girls remain in school, which in turn leads to reduced HIV prevalence and incidence. In several randomized control trials, school attendance and safer sexual health were directly incentivized through a cash transfer, and there was a positive effect on HIV-associated outcomes.

Despite years of debates, no new idea or existing initiative was identified as an innovative funding mechanism to support, specifically, the work done by women to respond to HIV and AIDS. However, there are opportunities, since the advancement of financing for gender equality has been seriously considered as a strategic contributor to the reduction of inequalities in general, under the guidelines offered up by the 2030 Agenda for Sustainable Development,[158] and the cultural uprising brought about by the *#MeToo* movement.

Gender equality has become such a hot topic in the *zeitgeist* that, in 2017, new financial instruments were created for that. The so-called exchange-traded funds are based on a database of companies with good grades on gender equity under several criteria, including equal pay for equal function. Equileap Global Gender Equality Index, a composite index of over three thousand companies in twenty-seven countries, has served as the database for Lyxor and the global firm UBS to support their higher-than-usual return exchange-traded funds.[159]

In the same trend, the World Bank has included gender equality as a principle, considering that multilateral Development Banks can help design and coordinate approaches relating to core global and regional development issues such as gender equality and youth, and excluded populations, trade and integration. "No country, community, or economy can achieve its potential or meet the challenges of the 21st century without the full and equal participation of women and men, girls and boys."[160] These banks are trying to adapt to the new equality-driven reality.

Investing and promoting gender equality is currently at the forefront of implementing the sustainable development agenda. To effectively design future

156 To date, debts swapped under Debt2Health agreements total around US$ 212 million, involving Australia and Germany on the creditor side; Côte d'Ivoire, Egypt, Ethiopia, Indonesia and Pakistan on the beneficiary side. See https://www.avert.org/professionals/hiv-around-world/global-response/funding

157 UNAIDS. (2017b). When Women lead change happens. Available at: http://www.unaids.org/sites/default/files/media_asset/when-women-lead-change-happens_en.pdf

158 Manandhar, Mary et al. (2018). Gender, health and the 2030 agenda for sustainable development, Bulletin of the WHO; *Policy & practice*, Article BLT.18.211607, pp. 13-14.

159 See https://equileap.com/indices/

160 See https://www.worldbank.org/en/topic/gender

strategies to increase resources for promoting women's rights and gender equality within the AIDS responses will require all types of resources and expertise, from domestic and international, private and public actors.

Therefore, instead of continuing repeating the call for doing more with fewer resources, donor strategies must focus on securing a steady stream of financing and resources based on long-term solutions. Both for women's civil society associations and for the very response to HIV developed by the United Nations as a whole, it is not sustainable to rely mainly on unpredictable voluntary donations from governments and a few large foundations[161] so it will be strategic that the next Expert Group Meeting develop strategies and identify partners to implement innovative financing mechanisms aiming to raise funds for women's advocacy work towards a gender sensitive AIDS response.

In this regard, some **recommendations** are:

1. Build an inclusive architecture for follow-up and review on financing for women, with women's community-based monitoring being part of collecting the evidence and holding donors accountable and positively engaged and mobilized.

2. Design and establish fundraising mechanisms for consistent revenue collection for women to bring *new* donors on board, including donors from the private sector. This must be supported by campaigns to transmit the relevance of women in the global AIDS architecture, properly communicating its values, results, and comparative advantage for contributions – a narrative still to be developed.

3. Develop an advocacy plan aiming to convince governments and private organizations to invest in women's groups in the AIDS response.

4. Develop a bold narrative to deconstruct the claims that there are not enough resources to invest in AIDS. The world has never had so many resources, nor so much liquidity, and this condition produced yet another boom in 2018. Though it is a concentrated financial bubble, it is an out-of-proportion revenue source that is not tapped into because of lack of governmental will. Taxing financial transactions, for instance – and UN Women is a strong advocate for taxing financial transactions – is a highly advantageous albeit double-edged sword of revenue collection and capital markets regulation. For instance, in 2016, the UK raised £2.8 billion on Stamp Duty on Shares and Securities; Brazil raises an average of thirty billion Reals yearly on a broad FTT legal framework.

5. Model a cost exercise to estimate the needs of women's groups for medium and long-term advocacy work in the AIDS response and define specific fundraising goals. However, is necessary first to establish clear definition for "women-led" organizations; women's groups and women's services in the HIV field.

6. Considering the demand for increased domestic funding for HIV, it is necessary to strengthen the capacity of women's national groups and align them with any fundraising campaigns and mechanism designed at the global level. They also need to be trained to identify in-country fundraising opportunities.

7. Advocate for enhanced reporting mechanisms on women's access to funding by improving existing global indicators to monitor the HIV response with disaggregated data on women, including resources directed to women's advocacy work. Some opportunities are:

a) The data from the Global Fund on investments for women and girls[162] should be updated soon – the last report is from 2015. It is advisable to explore opportunities to improve their indicators on financing for women and girls.[163]

Also, it would be interesting to approach their Community Rights and Gender Strategic Initiative", which invested in HER Voice to support the meaningful engagement of AGYW in national policy and program processes supported by or linked to the GFTAM. The HER Voice funding is going to be

161 Ten donors are responsible for 86% of funds for AIDS assistance. https://reliefweb.int/sites/reliefweb.int/files/resources/Report-Donor-Government-Funding-for-HIV-in-Low-and-Middle-Income-Countries-in-2018.pdf

162 See https://www.theglobalfund.org/en/women-girls/

163 The information available (October 2018) was that they were finalizing a report on the investments on AGYW in sub-Saharan Africa and planning to commission an update on the gender analysis of grants (from 2015 or maybe 2016).

continued with funding from ViiV Healthcare (the first year was funded with the Global Fund catalytic funds).

b) Open debate on how to improve the Global AIDS Monitoring[164] indicators to allow appropriate analysis on the existing funds for women's organizations to provide HIV-related services and to implement advocacy work on gender and HIV.

c) Partner with Funds Concerned About AIDS[165] for the inclusion of more disaggregated data on funding for women and girls in their next reports.

8. Inform and provide capacity building for women's groups to influence UNAIDS decisions at the national level, including on the allocation of UNAIDS country envelopes.[166]

9. Establish an updated communication channel for the community of women working with HIV and AIDS for disseminate regular information on funding for AIDS, to share international and national calls for opportunities for women in the AIDS response, including for advocacy on the gender field, etc.

10. Link the debate about funding women's organization in the AIDS response to the commitment to the Sustainable Development Goals. Plan events and campaigns targeting the High-Level Political Forum and the Commission on the Status of Women.

11. Provide guidance to funders for developing new frameworks for risk assessments in funding for women-led HIV response and on good practices for the monitoring and evaluation of funds to grassroots and women's organizations.

164 See https://www.aidsdatahub.org/sites/default/files/highlight-reference/document/UNAIDS_Global_AIDS_Monitoring_2018.pdf

165 See https://www.fcaaids.org

166 UNAIDS. (2017). Implementation of the UNAIDS Joint Programme Action Plan. Agenda Item 4, 41st meeting of the UNAIDS Programme Coordinating Board. December 12-14. Available at http://www.unaids.org/sites/default/files/media_asset/20171213_UNAIDS_PCB41_Implementation_JP_Action-Plan_PPT.pdf

5.6.

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5.7.

APPENDIX 2: SURVEY RESPONDENTS AND ORGANIZATIONS INTERVIEWED

5.7.1
Survey Respondents

Sampada Grameen Mahila Sanstha.	Christ Soldiers Foundation
WHRIN – Women and Harm Reduction International Network	Association Aide aux Femmes et Enfants
Women for Health	Womenplus Against HIV & TB in Kenya
Association of WLWHIV WITH HIV ZAMFARA	The PANGEA Network
International Community of Women Living with HIV (ICW) - Kenya Chapter	ASEPO – Asociación de Ayuda al Sero Positivo

ICW-Zimbabwe	Eurasian Women's Network on AIDS (EWNA)
EVE for Life	Women's Empowerment Center NGO
SHAPLA MOHILA SANGSTHA (SMS)	India HIV/AIDS Alliance
Raising Voices	Positive Women
Jamaica Family Planning Association	Balance
Pan African Positive Women's Coalition-Zimbabwe	Red de Trabajadoras Sexuales de Latinoamérica y el Caribe - RedTraSex
Salamander Trust	Mrs.Thanita Samakkee
People Serving Girls at Risk	Compartiendo Retos, A.C.
Jamaica Community of Positive Women/ICW Caribbean Secretariat	Gestos–Soropositividade, Comunicação e Gênero
Indonesia Positive Women Network / Ikatan Perempuan Positve Indonesia (IPPI)	Movimento Nacional das Cidadãs Posithivas
Hwupenyu Health and Well-being project	Rede Nacional de Pessoas Vivendo com HIV/AIDS
WECARe plus	VIVO POSITIVO
Aware Girls	Movimento Nacional das Cidadãs PositHIVas
What Works Association	Asociación Cambiando vidas
Young Women Empowerment Network	FEIM - Argentina

5.7.2
Organizations Interviewed

Global Fund to Fight AIDS, Tuberculosis and Malaria	What Works Association
Salamander Trust	GUYBOW* - Guyana Rainbow Foundation
ATHENA Network	Guyana Sex Work Coalition
Together for Girls	AINSW – All India Network of Sex Workers
Women4GlobalFund	FEIM – Fundación para Estudio y Investigación de la Mujer
The Independent Accountability Panel for Every Woman, Every Child, Every Adolescent and the Partnership for Maternal, Newborn and Child Health (PMNCH)	International Planned Parenthood Federation (IPPF)

* Works with women social issues, not exclusively HIV.

5.8.

APPENDIX 3: BUT... WHERE ARE THE FUNDS FOR WOMEN AND AIDS?

According to the DAH Focus Areas, in 2017, US$ 9.1 billion or 24.2% of total DAH went to HIV/AIDS: 31.9% on treatment, 16.8% on prevention (excluding prevention of vertical transmission), and 13.6% for HIV/AIDS system support.

The US government is the largest source of the development assistance for HIV/AIDS, providing over 50% of this assistance annually since 2008. It is channelled through many international agencies, including international NGOs (7.3% in 2017) and the Global Fund (21.4% in 2017)[167]

Since 2000, funding for treatment (which includes antiretrovirals) increased 30% annually; funding for prevention, excluding vertical transmission, increased 6.6%; and funding for health systems strengthening increased 14.6%. Despite its prominence against other health focus areas, and the 20% annual growth observed between 2000 and 2012, DAH for HIV/AIDS has decreased 5.4% annually since 2012. Additional cuts could hasten this decline and risk slowing or reversing progress towards an AIDS-free generation.

It is clear that moving toward having disaggregated data on funding for women and girls in the AIDS response is not an easy task and one must consider that it will be necessary to prepare for resistance, including reporting burdens, whether by governments, United Nations and multilateral organizations.

"(...) funds going to gender – and gender related issues– are considered to be mainstreamed and difficult to pin down specifically. Donor budgets that go to general budget supports for health are often assumed to cover gender, as well as HIV specific and other health components, since system wide investments are expected to support all aspects of interventions; it is expected that, when they support comprehensive sexual and reproductive health or sexual and reproductive health and rights they are, at least in theory, supporting HIV" (...). (from one of Gestos' interviewers)

In relation to what is needed to end AIDS as a public health threat by 2030, UNAIDS[168] estimates that in 2020 alone the global HIV response will require US$ 26.2 billion, steadily decreasing to US$ 23.9 billion by 2030. This means that the resources available must increase by US$ 1.5 billion each year until 2020. However by the end of 2017, the international and domestic resources available for the HIV response reached an estimated US$ 21.3 billion in low and middle-income countries, and in recent years high-income countries have reduced funding for the HIV response in low and middle-income countries, with a 7% decrease between 2015 and 2016.

International investment in the AIDS response of these countries peaked in 2013 at nearly US$ 10 billion and, although domestic investments increased by an average of 11% a year from 2006 to 2016, the rate of that increase decreased to 5% between 2015 and 2016. Donor government disbursements to combat HIV in low and middle-income countries increased 16%, from US$ 7 billion in 2016 to US$ 8.1 billion in 2017. This increase follows two years of decrease, but it does not indicate a change in previous trends: it was a result from a boost in the investment made by the US, which increased its disbursement from US$ 4.9 billion in 2016 to US$ 5.9 billion 2017, including funds appropriated but not spent from previous years, as the report from the Kaiser Family Foundation and UNAIDS points out.[169]

167 In 2016, 58.1% (US$ 5.6 billion) of DAH for HIV/AIDS went to sub-Saharan Africa (77.1% of the AIDS disease burden was there) Southeast Asia, East Asia, and Oceania received US$ 316.0 million (3.3%); Latin America and the Caribbean got US$ 295.3 million (3.1%); South Asia, US$ 148.3 million (1.5%); Central Europe, Eastern Europe, and Central Asia, US$ 130.5 million, or 1.4%.

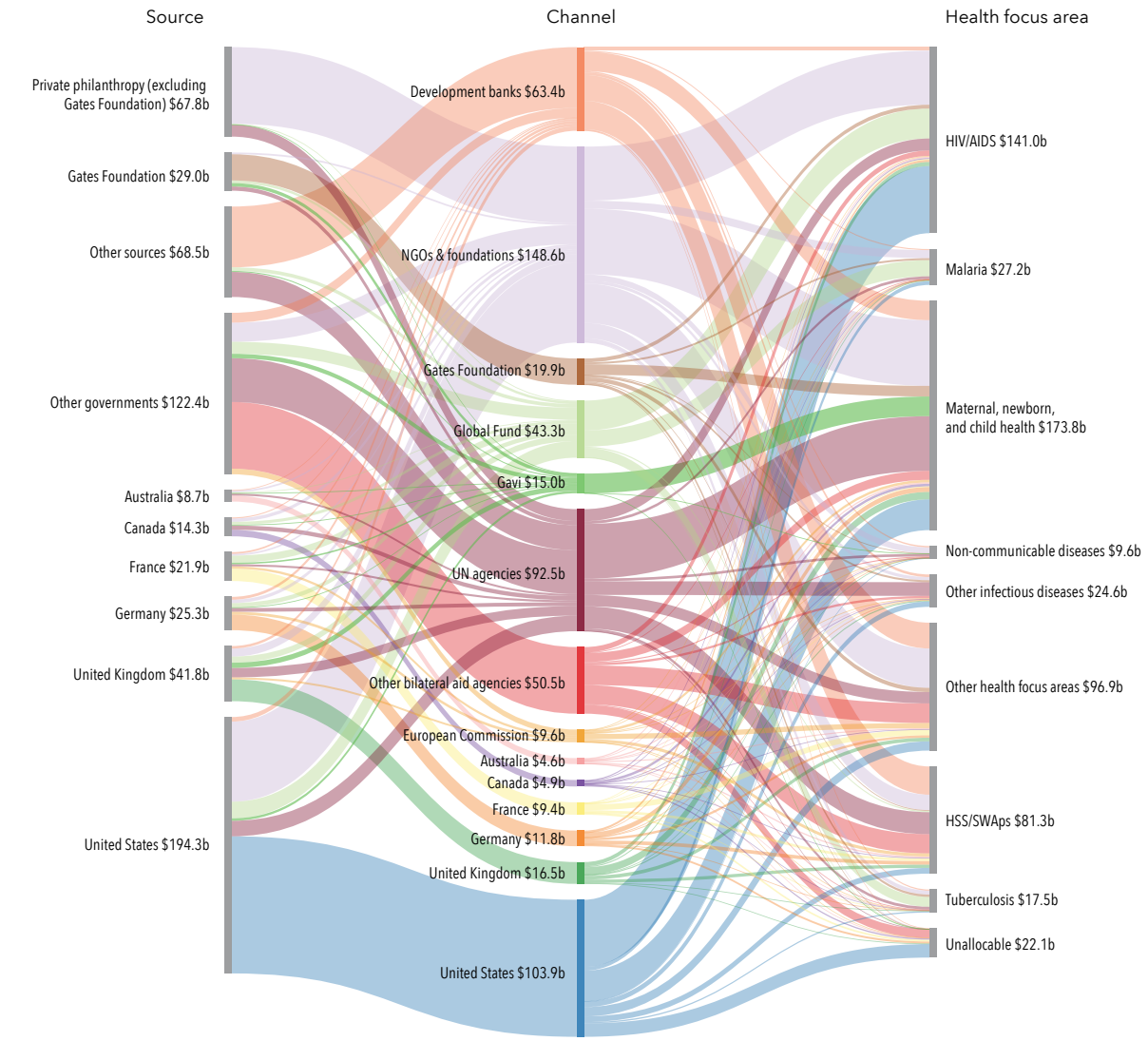
168 UNAIDS itself disbursed a total of US$ 288.1 million in 2017.

169 See https://www.aidspan.org/en/c/article/4679

5.9.

APPENDIX 4: DEVELOPMENT ASSISTANCE FOR HEALTH

FLOWS OF DAH FROM SOURCE TO CHANNEL TO HEALTH FOCUS AREA, 1990ñ2017



From the Financing Global Health 2017: Funding Universal Health Coverage and the Unfinished HIV/AIDS Agenda (page 46).[170]

170 See http://www.healthdata.org/sites/default/files/files/policy_report/2018/IHME_FGH_2017_fullreport.pdf

6. Financing the Role of Care Work Sector in the HIV and Health Response

Background Paper

Violet Shivutse,
Huairou Commission

6.1.

INTRODUCTION AND DEFINITION OF CARE WORK IN HIV AND HEALTH RESPONSE

HIV/AIDS remain one of the greatest social and economic challenges that continue to undermine world development. The role of women in providing care and support to families living with and affected by HIV and AIDS has demonstrated that women are a strong and critical component in social health and social wellbeing. Studies have shown that in communities where HIV prevalence is high, grassroots women have stepped up in big numbers to shoulder the burden through care and support to people living with HIV (PLHIV). The main function of community caregivers in HIV and health response generally include physical care (which includes bed bathing, wound dressing and cleaning those patients with frequent bouts of diarrhoea); training family members on home-based care; providing emotional support; administering medicines; making referrals to clinics and hospitals; monitoring and ensure adherence to treatment.[171] Caregivers also provide the much-needed support for women pre- and post-birth monitoring, referring mothers, orphans and vulnerable children to hospital for medical and nutritional support. In addition to direct service provision, caregivers facilitate a process that enhances a continuum of care between communities and health facilities.

The role of a caregiver is not restricted to medical support, but often extends into areas of counselling and advisor; extends to children living with and affected by HIV and AIDS; to deal with the growing incidence of drug resistance and other issues around adherence. Often, with extensive training, some women caregivers are taking on more complicated roles. In short, women caregivers provide key links between people living with and affected by HIV and AIDS and health systems, while ensuring a strong social support system is available for them at household and community level. These unremunerated functions are performed at the expense of women caregivers' time, finances and families.

This paper adopts the UN Women definition of unpaid care work and other key terms as follows:[172]

- The term **ëunpaidí** differentiates this care from paid care provided by employees in the public and non-governmental organisation (NGO) sectors and employees and self-employed persons in the private sector.
- The word **ëcaæí** indicates that the services provided nurture other people.
- The word **ëwσrkí** indicates that these activities are costly in time and energy and are undertaken as obligations (contractual or social).

To minimize the huge negative social and economic impact of HIV/AIDS on poor households and communities, including the need for provision of care work by women caregivers, the global community is implementing several commitments and obligations to fast track the end of AIDS and achieve gender equality by 2030. Such commitments include the comprehensive

171 Legal Resource Centre. (2013). Submission to the special rapporteur on extreme poverty and human rights. Unpaid work, poverty and women's human rights. South Africa.

172 United Nations Development Fund for Women (UNIFEM). 2000. Progress of the World's Women 2000, A UNIFEM Biennial Report. https://www.unwomen.org/-/media/headquarters/media/publications/unifem/152preface.pdf?la=en&vs=1003

and ambitious Sustainable Development Goals (SDGs) in support of the Agenda 2030 for Sustainable Development, currently under implementation by UN member states. It is the position of this paper that targeting funding towards and uplifting the leadership of the caregivers who are playing these vital roles would provide a huge opportunity to advance the global development commitments towards gender equality and end AIDS by 2030.

6.2.

BACKGROUND

Women's rights are enshrined in the Universal Declaration of Human Rights (UDHR), the International Covenant on Economic, Social and Cultural Rights, the Convention on the Elimination of All Forms of Discrimination against Women (CEDAW) and several International Labour Organization (ILO) conventions. The burden of care work in HIV/AIDS and health sector responses underscores the struggle by most caregivers globally, most of whom are women, to secure national health and labour policies that recognise their work, provide needed finances for remuneration of care workers including those living with HIV, ensure respect and dignity for those living with and affected by HIV and AIDS at household or community level.

Globally, there were 36.9 million people living with HIV, including 1.8 million children.[173] The burden of HIV is most felt in Africa; where 69% of people living with HIV are.[174] At the end of 2015, the number of people on HIV treatment reached 17 million, exceeding the 2015 target of reaching 15 million people. Nearly 8 million people are providing care for family members without pay, while the number of people caring for a family member has reached 7.6 million, a sharp increase of one million compared with a decade ago.[175] According to the Special Rapporteur on extreme poverty and human rights submission to the 68th session of the UN General Assembly,[176] unpaid care work involves domestic tasks like meal preparation, cleaning, washing clothes, collecting water and fuel; and direct care of persons including children, older persons and persons with disabilities carried out in homes and communities.

It is widely acknowledged that care work is essential for households and economies to function, but is often not recognized, valued or financed for by governments and local authorities. Data analysis by the Social Market Foundation, an independent think tank, shows that millions are now giving up their time to for free to look after elderly relatives, a partner or a sick or disabled child – with the number spending 20 hours or more per week caring for a relative going up by 4% between 2005 and 2015.[177] Women perform 75% of the world's unpaid care work, thereby subsidizing the global economy and reducing the amount of time they have to devote to paid employment. Among women who do participate in paid labour, many are confined to the informal economy, where they lack social protections, receive lower wages, and are often subjected to lower safety standards and harassment.

173 Steve Leumi, Jean Joel Bigna, Marie A Amougou, Anderson Ngouo, Ulrich Flore Nyaga, Jean Jacques Noubiap. (2019). Global Burden of Hepatitis B Infection in People Living With Human Immunodeficiency Virus: A Systematic Review and Meta-analysis, *Clinical Infectious Diseases*, Volume 71, Issue 11, https://doi.org/10.1093/cid/ciz1170

174 Ibid.

175 The Guardian. 2018. 'Nearly 8 Million People Providing Care for Family Members Without Pay.' https://www.theguardian.com/society/2018/jul/16/nearly-8-million-people-providing-care-for-family-members-without-pay

176 The Special Rapporteur on extreme poverty and human rights submission to the 68th session of the UN General Assembly.

177 The Guardian. 2018. 'Labour to Promise Unpaid Carers 17% Allowance Increase.' https://www.theguardian.com/society/2017/apr/17/labour-to-promise-unpaid-carers-17-allowance-increase

6.3.

GLOBAL COMMITMENT TO END AIDS BY 2030

The global call for financing the role of care work in HIV and health responses received a major boost following the adoption of the 2016 United Nations Political Declaration on HIV and AIDS: On the Fast Track to Accelerating the Fight against HIV and to Ending the AIDS Epidemic by 2030.[178] Acknowledging the challenge of HIV in achieving SDGs and the role of local communities in the fight and eradication of AIDS, Member States pledged to ensure that 90% of people (children, adolescents and adults) living with HIV know their status, 90% of people living with HIV who know their status are receiving treatment and 90% of people on treatment have suppressed viral loads. Embodied in a shared vision, the 2016 Political Declaration on HIV and AIDS calls on the world to achieve the following targets in support of the 2030 Agenda for Sustainable Development:

- Reduce new HIV infections to fewer than 500,000 globally by 2020.
- Reduce AIDS-related deaths to fewer than 500,000 globally by 2020.
- Eliminate HIV-related stigma and discrimination by 2020.

The 2016 Political Declaration on HIV and AIDS affirms that these targets can only be realized with strong leadership and the engagement of people living with HIV, communities and civil society hence the role of care work cannot be forsaken. Access to sustainable financing is therefore critical to ensure success and sustainability of efforts towards ending AIDS and achieve the SDGs. With these targets at hand, it is time for countries to rethink their HIV and health response finance policies and strategies by putting the care work at the heart of fiscal planning, implementation and monitoring.

The 2016 Political Declaration on HIV and AIDS also recognizes care work, as leaders placed strong emphasis on addressing the immense burden of the epidemic on women, especially young women and adolescent girls in sub-Saharan Africa. Countries further committed to urgently address low treatment coverage rates among children living with HIV; accelerating prevention outreach; doubling the number of people on treatment; stopping new HIV infections among children; a reinvigorated focus on women, adolescent girls, young people and gender equality.

As highlighted in the 2016 Secretary-General's report on 'Women's Economic Empowerment in the Changing World of Work,' women's economic empowerment and the realization of women's rights to and at work are essential for the achievement of the Beijing Declaration and Platform for Action, the 2030 Agenda for Sustainable Development and the New Urban Agenda (NUA). The report highlighted the particular relevance to the SDG5 to achieve gender equality and empower all women and girls and the SDG8 to promote sustained, inclusive and sustainable economic growth, full and productive employment and decent work for all, but also the SDG 1 to end poverty in all its forms everywhere, the SDG2 to end hunger, achieve food security and improved nutrition and promote sustainable agriculture, the SDG3 to ensure healthy lives and promote well-being for all at all ages, the SDG4 to ensure inclusive and equitable quality education and promote lifelong learning opportunities for all, and the SDG10 to reduce inequality within and among countries.

178 United Nations. (2016). Political Declaration on HIV and AIDS: On the Fast Track to Accelerating the Fight against HIV and to Ending the AIDS Epidemic by 2030. https://www.unaids.org/en/resources/documents/2016/2016-political-declaration-HIV-AIDS

6.4.

THE CHALLENGE OF CARE WORK SECTOR IN THE HIV AND HEALTH SECTOR RESPONSE

Despite billions of dollars invested to fight against HIV/AIDS, women living in poverty still shoulder the major burden of the disease in impoverished communities. Presently, care work for PLHIV is generally done by women who volunteer their time and resources without any form of remuneration, out of a sense of caring and obligation towards their families, friends and neighbours who otherwise would have no one to care for them. PLHIV are often supported by family members, mainly women and girls, and member of organised groups of women including those living with HIV. Care workers often have limited or no training on health matters and often are trained by CSOs and/or government health institutions on how to care for PLHIV and provide other basic health care needs including family planning and care for orphans and vulnerable children (OVC). Care workers are often identified as either community caregivers; community-based workers, home-based care givers, community health volunteers and/or community health workers mainly attached to a health facility.

Although care work has been done since time immemorial at household and community levels, the HIV/AIDS scourge has stretched the capacity to ensure adequate response due to the underlying lack of health infrastructure in poor communities, high levels of poverty associated with the disease, and the lack of remuneration for caregivers who need to balance provision of care work with fending for their families. Action Aid[179] reported that every day most women spend time – and often very long hours – cooking, cleaning, and caring for children, the ill and the elderly. Caregivers often train and provide supports that ensure prevention, treatment, care and support for PLHIV as part of health systems strengthening. Through this support, hard to reach areas including rural communities with poor infrastructure, informal settlement and conflict prone areas are accessed and health services are not guaranteed. The plight of PLHIV is often left in the hands of care workers for support and well-being.

Government health systems, national governments and UN agencies would not meet their goals and commitments to end AIDS without this investment from unpaid women caregivers. While the UN and its member states, private foundations and global health organizations spend massive amounts of money and are rightly recognized for their contributions, unpaid caregivers sacrifice their own time and their limited financial resources to caring for their communities even as they can often barely keep their own families and households afloat. Investing in care work will not only accelerate the achievement of the SDG3 and its target on ending AIDS, it will also reduce gender inequality and accelerate achievement of multiple SDGs.

Lack of recognition of care work and quantification of services rendered in monetary terms have left governments and other policy makers less concerned about the plight of caregivers. If data was collected for purposes of planning and policy decision-making, the role and investments in support of caregivers would become much clearer. It is perceived to be less valuable than paid work and it is ignored and not considered to

179 Action Aid. (2013). Making Can Visible: Women's Unpaid Care Work in Nepal, Nigeria, Uganda and Kenya.

be "work" even by the women and men who engage in and benefit directly from these activities. In part because it is invisible in national statistics and less valued, local and national authorities generally fail to design social and economic policies that can reduce women's primary responsibility for unpaid care work. As underscored in the Secretary-General's Report on Women's Economic Empowerment in the Changing World of Work in 2016,[180] recognizing and valuing unpaid care and domestic work means measuring it through regular, periodic time-use surveys across countries. Disaggregated time-use data — by sex, income, age, location and other relevant factors — can inform policies that aim to improve women's economic empowerment and help design HIV/AIDS and health policies and interventions that are sustainable in the fight against the disease. Most governments do not have health or labour policies that address care work and related financial needs.

Policies that reduce and redistribute women's and girls' unpaid care for HIV and health response needs to be backed up with strong and sustainable social protection mechanisms including cash transfers and access to health care services for PLHIV and OVCs. The SDGs recognize social protection policies as key in recognizing the role of unpaid care work. Social protection, as defined by the United Nations Research Institute for Social Development,[181] is concerned with preventing, managing, and overcoming situations that adversely affect people's wellbeing. Social protection consists of policies and programmes designed to reduce poverty and vulnerability by among others diminishing people's exposure to risks and enhancing their capacity to manage economic and social risks, such as unemployment, exclusion, sickness, disability and old age.

Failure to recognize the care work sector and related services towards HIV and health responses and lack of clear health policies and earmarked national budgets in support of caregivers continue to challenge governments' ability to meet the 2016 Political Declaration on HIV and AIDS, which provides a global mandate for all countries to fast-track the AIDS response over the next five years and end the AIDS epidemic by 2030. The year 2019 being the fourth year of implementation of SDGs, most Member States are yet to commit financial resources to fast-track key targets in the AIDS response scheduled to be met by 2020 and accelerate the fight against HIV and end the AIDS epidemic by 2030. For the global commitment to end AIDS by 2030 to be successful, financing the role of caregivers in HIV and health responses is not an option but a mandatory, cost effective and efficient action needed by governments. Failure or further delay in financing the role of caregivers in the war against AIDS will not only subject governments to health risks but will reverse the gains made and have high cost implications.

Furthermore, women caregivers are nearly invisible in decision-making spaces, and their work is uncounted in economic analyses and statistics relating to poverty and health care. These gender gaps are rooted in historically unequal power relations between women and men in the household and society more broadly, as defined by culture and religion. Inadequate representation of care workers and/or PLHIV in policy spaces related to health, labour and budgeting processes at local and national levels and the shrinking space of CSOs continue to challenge the ability to profile the need for governments to allocate earmarked funds for care work in HIV and health response and to mobilize political support. Despite this glaring challenge, care work in the context of HIV and health response continues to save lives and contribute to a healthy economy and eventual increase in GDP.

180 UN Economic and Social Council. (2016). *Women's economic empowerment and the changing world of work: Report of the Secretary-General*. E/CN-6/2017/3, December 30. New York: United Nations.

181 United Nations Research Institute for Social Development (UNRISD). 2010. Combating Poverty and Inequality: Structural Change, Social Policy and Politics. Geneva.

6.5.

CAREGIVERS' STRENGTH IN MOBILIZING AND ORGANISING

Building collective voice and agency has been a challenge to organising around HIV and other health challenges. This can be attributed to high level of stigma associated with HIV/AIDS and the fear of taking on related financial burden by caregivers and family members due to lack of financing. However, there has been increasing need for better organisation and coordination of caregiving efforts to connect, link and creating strategic platforms for engagement with PLHIV and policy makers, while sharing experiences.

Despite challenges in accessing resources, caregivers and people living with HIV have continued to mobilize and organize themselves in big numbers, enabling them to consolidate their voice and facilitate collective action including lobbying for recognition and policy influencing. One of such movement of caregivers including people living with HIV is the Home-Based care Alliance in Africa,[182] which includes over 1,436,000 women secondary caregivers in over 34 countries. The platform enables sharing of best practices and connects caregivers across continents. Examples include initiatives such as the Chisomo home-based caregivers in Kabwe district in Zambia around production of nutritional food for PLHIV to supplement nutritional needs, or the Health Mutual Fund (HMF), a community-owned health insurance fund by Swayam Shikshan Prayog caregivers in Maharashtra state in India. Membership in the fund, affordable at only 100 rupees (US$ 2) per year, guarantees discounted outpatient services, partial-claim reimbursement for emergency hospitalization, free or discounted access to preventative health camps and a community-run health referral system. HMF also established partnerships with various government and private health service providers through creation of a service providers' network, which is maintained and managed by the federation and community health workers. The caregivers' innovation in financing response to HIV has contributed significantly to reduced death associated with AIDS and to alleviation of poverty.

CSOs including faith-based organisations (FBOs) have stepped in to fill the gap in care work in support of HIV and health responses. Some organizations are able to provide care through private funding and donations, but this is also not very secure as it is mostly dependent on the generosity of the funders and the continuation of funding for the specific programme, subject to the whims of trends in funding. In recent years, the lack of funding as a result of the global economic crises has had a devastating impact on many programmes that provide care. Unreliable funding streams to support CSOs, including FBOs, have challenged continuity and sustainability of such care work, for example in cases where a stipend is used to motivate caregivers, provide facilitation costs for transport, food supplies for PLHIV and other related costs.

In some cases, governments have provided CSOs with some funding to support PLHIV. This shows a deliberate move by governments to avoid absorbing caregivers into the civil service by choosing CSO-led support systems for caregivers. Often stipends paid to home-based caregivers under the extended health care programmes are lower than those paid to men engaged in infrastructure development, essentially formalising the gendered stigmatisation of care work in the context of a government program. As such, caregivers work is not sustained, and women caregivers do not become government employees. Quality in care services for PLHIV is inextricably linked to working conditions for care workers, whether

182 See https://gcwa.unaids.org/huairou-commission-aids-campaign/home-based-care-alliance

public or private. The care work sector in HIV and heath responses is characterized by poverty and absence of decent work, mainly for women. Donors, implementing governments, and non-governmental organisations have finally begun to recognise the importance of paying and extending social protection to caregivers. For too long caregivers within the HIV sector have been excluded from the broader discussion about the potential benefits of large-scale community healthcare worker programmes.

Statistics have shown that 10.3 million additional health workers (physicians, nurses and midwives) are required to ensure the effective delivery of universal health care, the majority in Asia (7.1 million) and Africa (2.8 million).[183] This presents a major opportunity to create decent, good quality jobs for women in these sectors including caregivers in HIV and health responses towards ending AIDS by 2030. The report highlighted the challenges created by most government austerity measures and reductions in public sector spending, coupled with the privatization of public companies and of social services, which have caused shrinking public sector employment in many countries, creating downward pressure on wages and employment conditions. This is particularly critical for women because the public sector has historically provided good quality jobs in large numbers for women, including care work. Recent studies have shown that investment in care economy of 2% of GDP in just seven countries would create over 21 million jobs and help countries overcome the twin challenges of caring for ageing populations and tackling economic stagnation. The study demonstrates that investing in care work can narrow the gender pay gap, reduce overall inequality and redress the exclusion of women from decent jobs. Up to 70% of the directly created jobs would be taken up by women and the employment multiplier effect from these new jobs would also increase men's employment overall by up to 4% in some countries.[184]

To make this happen and guarantee economic inclusivity, governments must put in place polices addressing care work and financing for HIV and health responses. The stigma and prejudice experienced by those affected by the pandemic means that PLHIV are often discriminated against and neglected by their families at a time when they are most in need of care and support. Many HIV/AIDS patients who are discharged from hospitals usually do not have family members to care for them and/or are ignorant about the treatment required, while many family members are unwilling to provide care fearing that they themselves will get infected. A study conducted in 2012 by the National AIDS Research Institute (NARI) and the Maharashtra Association of Anthropological Sciences (MAAS) in Pune city in Maharashtra in India showed that PLHIV preferred home-based care owing to affordability, freedom from stigma and convenience compared to hospital; which was also cited as expensive.[185]

However, lack of recognition of care work for HIV and health responses has been demotivating for caregivers despite their continued commitment to conduct work that does not usually yield financial benefit or recognition. As they remain at the frontlines of work, persistent images of women as 'supporters' rather than 'actors' continue to make women's contributions invisible to policy makers.[186] The impact of unrecognized work on women's ability to engage with the economy and provide and advance financially can often have devastating consequences, and perpetuates women living in poverty and vulnerable situations. The work is stressful, not paid, inadequately resourced and done by poor women, many of whom are themselves living with HIV and AIDS.

183 World Health Organization. (2016). Health workforce requirements for universal health coverage and the Sustainable Development Goals. (Human Resources for Health Observer, 17).

184 Berger, T., & Frey, C. B. (2016). Structural transformation in the OECD: Digitalisation, deindustrialisation and the future of work.

185 Kohli, R., Purohit, V., Karve, L., Bhalerao, V., Karvande, S., Rangan, S., ... & Sahay, S. (2012). Caring for caregivers of people living with HIV in the family: A response to the HIV pandemic from two urban slum communities in Pune, India. PLoS One, 7(9), e44989.

186 Legal Resource Centre. (2013). Submission to the special rapporteur on extreme poverty and human rights. Unpaid work, poverty and women's human rights. South Africa.

Numerous research studies confirm that the burden of care is borne on a voluntary basis by women and girls in private household and community settings, placing considerable added strain on already resource-limited and poor households. It is estimated that a staggering 90% of people with HIV/AIDS are cared for at home and 80% of HIV-related deaths occur in the home.[187] It is time governments and other policy makers and practitioners join forces to ensure success in integration of care work in health and financial systems at country level to fast track ending AIDS by 2030.

187 UNAIDS DATA. (2018). State of the epidemic.

6.6.

COSTS AND FINANCING CARE WORK IN HIV AND HEALTH RESPONSES

The costs and burden of care work in response to HIV/AIDS prevention, management and treatment are unequally borne across gender and class, mainly by women and girls. Studies have shown that the time, financial burden, and risks associated with care of people living with HIV have direct links with increased levels of poverty for care takers or providers. The submission by the Special Rapporteur on extreme poverty and human rights to the 68th session of the UN General Assembly in 2013 estimated that if unpaid care work were assigned a monetary value, it would constitute between 10% and 39% of Gross Domestic Product (GDP) and could surpass manufacturing, commerce, transportation and other key sectors. Unpaid care and domestic work support the economy and often make up for lack of public expenditure on social services and infrastructure. In effect, it represents a transfer of resources from women to others in the economy.[188]

Unpaid care is more difficult to do in the context of poverty as basic amenities and access to public services are lacking.[189] When financial support is required, these carers usually sacrifice their own limited financial resources to assist. Because of the nature of the work, they are often called upon to assist in bereavement, counselling, and funeral arrangements. This is a heavy burden to place on people who receive little to no support either financially or with respect

TABLE 1

Percentage of caregiver resources spent on caregiving in a month

Country	%
Cameroon	37
Kenya	43
Malawi	40
South Africa	30
Uganda	39

Source: The changing trend of HIV AIDS and its impact on grassroots caregivers (Groots International 2014)

188 United Nations Secretary General's High-Level Panel on Women's Economic Empowerment. (2016). Leave No One Behind: A Call to action for gender equality and women's economic empowerment.

189 Action Aid. (2013). Making Can Visible: Women's Unpaid Care Work in Nepal, Nigeria, Uganda and Kenya.

to their own wellness. A study conducted by Groots International in 2014 found that women caregivers spent up to 40% of finances and other resources supporting members of their households and other members in their communities living with and affected by HIV and AIDS.[190] Table 1 highlights the findings.

190 Groots International. (2014). The changing trend of HIV AIDS and its impact on grassroots caregivers.

In much of the developing world, and particularly in sub-Saharan Africa, health systems are too limited; this is particularly true in rural and remote communities, where hospitals and clinics are few and far between. Because hospitals and clinics are generally located in towns and cities, and transportation is too expensive for most families to use unless there is an emergency, caregivers and community health workers are the first people others turn to when they fall sick. See more details in Table 2.

TABLE 2

The three top activities on which caregivers spend most of their resources

Country	Top 3 Expenditures	%
Cameroon	Travel to homes and hospital visits	52
	Buying food for people living with HIV and families	35
	Providing scholastic support to orphans	13
Kenya	Travel to homes and school visits	40
	Buying food for people living with HIV	38
	Paying legal fees to follow on property inheritance	22
Malawi	Renting space to organize events that promote care for and rights of PLHIV and orphans	40
	Travel to homes and hospitals visit	35
	Buying seeds and farm inputs for nutrition	25
Nigeria	Travel to homes and health facility visits	55
	Supporting the welfare of people living with HIV, e.g. rent and water	22
	Paying legal fees	23
South Africa	Supporting the People living with HIV welfare e.g. rent and water	38
	Travel to homes and health facility visits	34
	Paying for spaces to organize trainings and awareness	28
Uganda	Travel to homes and health facility visits	56
	Buying seeds and farm inputs for nutrition	25
	Buying food for people living with HIV	19

Source: The changing trend of HIV/AIDS and its impact on grassroots caregivers (Groots International 2014).

This two tables show how grassroots **women are using their own resources in responding to HIV needs at household and community level**. There are best practices implemented by caregivers to support those living with and affected by HIV. This includes improving access to nutrition through locally produced food, which is crucial to people living with HIV and on treatment. Across Africa and Asia, caregivers continue to support food security initiatives including the development of collective crop farms and individual household kitchen gardens which enable access to vegetables, cereals and fruits for people living with HIV. These efforts are mainly initiated by groups of PLHIV and/or caregivers with financing from international NGOs and other well-wishers.

On the other hand, there are instances where care workers are employed, mainly by government health facilities and CSOs who provide them with a stipend often less than US$ 20 per month for work done. Lack of remuneration and/or pay below a living wage for caregivers' affects their motivation and ability to navigate changing economic times, often finding themselves within the poverty cycle. The challenge for most governments remains to ensure that care and support systems are fully funded and present equal opportunity to women and men to provide care services in a sustainable manner without entrenching gender inequality. This requires several considerations including the need for an expanded national health budget that meets the needs of the care work sector in HIV and health responses, and other services including social protection services for more efficient and sustainable responses.

While statistics show that the GDP of advanced economies grew by 5.3% on average between 2012 and 2016,[191] they further reveal deep seated issues concerning the low rate of economic inclusion; which increased by only 0.01% within the same period. These findings support the argument that economic growth does not necessarily correlate with a rise in standard of living for everyone—or for 50% of the world's population. The low rate of inclusion underscores the unrecognized role of women caregivers and the need for financing of care work in HIV and health responses which remains largely unrecognised and under-valued by policy makers and legislators. Governments' readiness to finance care work on HIV and health responses will have far-reaching implications for gender equality and the success in the fight against HIV/AIDS globally envisioned in the 2016 Political Declaration on HIV and AIDS.

Ending AIDS by 2030 requires commitment by governments to ensure that set targets are achieved. Global leaders made ambitious and concrete commitments for financing and effective budget allocations to implement a fast-tracked AIDS response by 2020.[192] Member states committed to increase and front-load investments to close the resource gap by investing at least US$ 26 billion a year in the AIDS response by 2020. Member States also called for US$ 13 billion for the Fifth Replenishment of the Global Fund to Fight AIDS, Tuberculosis and Malaria. Member States encouraged the enhanced strategic engagement of the private sector to support countries with investments and service delivery for strengthening supply chains, workplace initiatives and social marketing of health commodities and behaviour change.

Member States also committed to invest at least a quarter of AIDS spending on HIV prevention and invest at least 6% of all global AIDS resources for social enablers, including advocacy, community and political mobilization, community monitoring, outreach programmes and public communication by 2020, and ensure that at least 30% of all service delivery by 2030 is community-led. The 2016 Political Declaration on HIV and AIDS had leaders commit to achieve gender equality, to invest in women's leadership, and to end all forms of violence and discrimination against women and girls, in order to increase their capacity to protect themselves from HIV. CSOs and other practitioners have warned that carers are losing out in terms of work, finances and health, calling on governments to provide sustainable funding for enhanced HIV and health responses and other care work services.

191 World Economic Forum. (2018). The Inclusive Development Index.

192 2016 United Nations General Assembly Political Declaration on HIV and AIDS: On the Fast Track to Accelerating the Fight against HIV and to Ending the AIDS Epidemic by 2030. Available at: https://www.unaids.org/en/resources/documents/2016/2016-political-declaration-HIV-AIDS

6.7.

ENHANCING CARE WORK IN HIV AND HEALTH RESPONSES

For an efficient and sustainable care work sector in support of HIV and health responses, governments must provide adequate finances including remuneration and facilitation of the caregivers' work. This kind of work is not yet sufficiently acknowledged as an essential service needed to end AIDS by 2030. In view of the challenge of care work, it will take legislative and policy measures to recognize, quantify and place equal economic value on the work of women in support of HIV and health responses done at home and in communities compared to that performed in the formal public sector. Deliberate efforts must be put in place to deal with gender stereotyping and the categorization of work on the basis of sex and gender. In line with human, women's, and labour rights standards, secondary caregivers must be given the choice to be remunerated for the work they do. We must debunk the notion that paying women caregivers will interfere with the spirit of community volunteerism. Volunteerism should always be an active choice, one that few secondary caregivers have.

Further, the unpaid work of caregivers must also not be seen as a cost saving or programme efficiency during this protracted economic downturn. On the contrary, introducing paid employment for women caregivers makes sound social, political, and economic sense particularly during economic crises, which impact severely on women.[193] Economic policy definitions of what constitutes economic activity must therefore include all women's work, including unpaid care work. As stakeholders continue to engage and call for action to finance care work in HIV and health responses, it is worth noting that dialogue alone will not break the barriers to economic participation and lack of recognition of care work. However, more efforts to influence policy reform is needed to have formal recognition of care work in HIV and health responses and reduce the burden of unpaid work mainly on women and girls.

This paper affirms the solutions proposed by Action Aid in its 2013 report,[194] which pointed to three key areas that need attention to lessen the burden of care work:

- **Recognition** of unpaid care work means that the work done by (mainly) women is "seen" and acknowledged. It also means that it is recognised as being "work" and "production." Recognition can take several forms, including provision of compensation for the work, recognising it when determining other benefits, such as pension payments, or measuring unpaid care work in national statistics.
- **Reduction** of unpaid care work means that the burden is reduced for individual women and for society more generally. This can happen through the service being provided in a different way. For example, women's childcare responsibility would be reduced if governments provided accessible and affordable childcare services. Similarly, unpaid care work would be reduced if services were provided closer to where people live and work so that less time is spent accessing health care and the like.
- **Redistribution** of unpaid care work means that the overall amount of unpaid care work remains

193 Parliament UK. (2012). International Development Committee: Written evidence submitted by UK Consortium on AIDS and International Development. www.parliament.uk. https://publications.parliament.uk/pa/cm201213/cmselect/cmintdev/657/657vw61.htm

194 Tessa B., Jessica H., & Melissa B., (2017). Beyond caring: Enabling women's leadership in disaster risk reduction by breaking down the barrier of unpaid care work. Action Aid International.

the same, but it is more fairly shared among different people. One example of this is where male household members take on a greater share of housework and childcare. Another example is where government takes on a greater share of healthcare provision by setting up an effective public healthcare system.

6.8.

CONCLUSION

The 2016 Political Declaration on HIV and AIDS and its key targets will not be achieved without financing for the role of caregivers in HIV and health responses. This paper confirms that HIV/AIDS responses rely heavily on community-based caregivers to meet the prevention, treatment, care and support needs, a reality that governments and other policy makers cannot wish away. Caregivers are predominantly made of female cadre of health foot soldier providing a range of health services and with incredible reach in rural and poor communities. Their work remains largely unrecognized and unaccounted for in economic terms, further entrenching gender inequality and poverty. Financing for care work is needed to improve caregivers' working conditions and remuneration and ensure protection under labour laws. Financing of caregivers in HIV and health responses is a global challenge that requires global commitments and governments champions especially in Africa and Asia, two continents that bear the brunt and burden of the epidemic. This paper further concludes that the targets set in the 2016 Political Declaration on HIV and AIDS are feasible and attainable, but only if women caregivers' role is mainstreamed in health care policies and financed including by providing remuneration.

Current methods of compensating caregivers vary hugely but can include salaries, social protection, stipends, and in-kind payments in the form of uniforms and supplies, access to credit and economic development opportunities, and various other incentive programmes for volunteers. All of these are critical for caregiving work because they ensure that caregivers are, at a minimum, not made poorer by the work they do. However, a growing body of evidence demonstrates that community-based secondary caregivers are essential human resources for achieving HIV and primary healthcare goals, and an emerging movement of health advocates argues that they should be paid salaries.

Any measure of economic success that overlooks indicators of gender equality in the economy – factors such as women's unpaid work in HIV and health responses and the underrepresentation of women in leadership and at decision-making tables – not only fails to tell the whole story, but also undermines our ability to devise economic policies that make the most of our entire talent pool to fight HIV/AIDS. Women's collective voice and active participation in economic leadership and decision-making are essential for shaping the changing world of work to achieve gender equality and women's economic empowerment. Policies that support the recruitment, retention, and promotion of women caregivers will help ensure income security and poverty reduction.

Both social protection and remuneration for caregivers are investments in strengthening health and community systems. As the OECD reports,[195] it is widely recognised that social protection reduces poverty, stimulates the involvement of poor women and men in the economy and contributes to social cohesion and stability. Remuneration of caregivers will be a critical contribution to the quality of health and social care and long-term sustainability of community systems. Lack of remuneration for secondary caregiving work should be considered a form of struc-

195 Voipio, T. (2007). Social protection for poverty reduction: The OECD/DAC/POVNET

tural discrimination against women that exacerbates their vulnerability to poverty and ill health.

Recognising and compensating caregivers for their work will lead to better care for people living with HIV, and a more sustainable workforce with the potential to contribute to strengthening health systems overall. It will also address the right to fair wages long denied to the women who provide care and support services to most people living with HIV around the world. Recognition and regulation of home-based care effectively promotes the rights of women who provide this care; it protects and respects their ability to make this choice; and it protects their dignity and equality as professionals and as women whose work is generally marginalized and undermined. Inadequate State policies and practices regarding unpaid care in HIV and health responses may also undermine or violate women's rights to the highest attainable standard of health and an adequate standard of living. Women's organizing is crucial for upholding fundamental labour rights, ensuring decent work, and defining policy priorities in HIV and health responses. By making caregivers' work visible, governments are pushed to rethink how they understand the economy and how they prioritise the allocation of public resources towards ending AIDS by 2030.

6.9.
RECOMMENDATIONS

In view of the issues discussed in this paper and the conclusions above, the following recommendations are made for consideration by governments and other policy makers towards financing the role of care work in HIV and health responses. Although these recommendations are applicable globally, governments and other development actors in Africa and Asia need to urgently implement them and lessen the high burden of HIV/AIDS. The recommendations are addressed to governments and other policy makers, health providers in public and private sector, CSOs including FBOs, PLHIV and the caregivers.

6.9.1
Recommendations for Governments and other Policy Makers

- Review progress against the 2016 Political Declaration on HIV and AIDS and fast track achievement of its key targets by 2020, in line with overall progress to achieve SDGs.
- Facilitate comprehensive and efficient integration of caregivers into health systems to ensure their recognition, quantification, and remuneration for continuity of care in HIV and health responses at household and community levels.
- Include costs and strategies for the remuneration of caregivers in budgets, programme plans, and technical guidance related to their role in the response to HIV. Compensation for primary caregivers should take the form of social protection and remuneration for secondary caregivers should take the form of salaries.
- Establish data and information management systems for better sex disaggregated data on the care work sector in HIV and health for planning and policy decisions; track progress on women's unpaid care work and measure the impact this has on different segments of society. Such data can benefit from accreditation processes driven by the caregivers themselves and recognized by governments and development agencies.
- Formalise and standardise caregivers' training curriculum and programmes on HIV and health responses, integrating this work into governmental

comprehensive care, management, and treatment programmes. Provide clear definition and elaboration of the roles that home-based carers can perform which could potentially improve the treatment and attitude towards this work by other health professionals. Make such trainings accessible and tailor made for grassroots women.
- Develop structures for on-going, formal, and meaningful inclusion of PLHIV and their caregivers in decision-making including health sector budgeting and resource monitoring by governments, private sector and NGOs (rather than on an ad hoc basis).
- Establish health and development funds that are controlled by home-based caregivers in support of PLHIV and related health responses including income generating activities.
- Support and provide sustainable funding for organizing for caregivers, locally, nationally and across borders to enable experience sharing, advocacy, and policy influencing.
- Build the capacity of caregivers to engage actively in implementation of the SDGs related to gender equality, poverty, health and inequality and in tracking progress on key commitments enshrined in the 2016 Political Declaration on HIV and AIDS.
- Recognize and value unpaid care and domestic work through the provision of public services, infrastructure and social protection policies, and the promotion of shared responsibility within the household and the family by men and women.

6.9.2
Recommendations for CSOs including FBOs

- Embrace program design and strategies that promote recognition and accountability in care work in HIV and health responses for all those who need such services.
- Strengthen caregivers organising including groups of PLHIV for better planning, representation of caregivers, advocacy and influencing of policy decisions at all levels.
- Serve as 'watch dog' providing governments with check and balance, monitoring provision of care work in HIV and health responses and provide recommendations on how to recognise, reduce and redistribute unpaid care work.
- Continue mobilizing finances from national and international partners in support care work in HIV and health responses including capacity building for caregivers; while ensuring transparency and accountability to communities, PLHIV and caregivers; governments and donors.

6.9.3
Recommendations for PLHIV and their Caregivers

- Strengthen organising for better coordination and advocacy for financing of the role of caregivers in HIV and health responses at local, national, and global levels, until it is done.
- Maintain a clear account of caregivers' work including data on the number of caregivers disaggregated by sex, location and institutions of collaboration including public and private for ease of reference, coordination, and accessibility.
- Take advantage of caregivers' training and other learning opportunities offered by various agencies to enhance knowledge and skills on current developments and trends in HIV and health responses and increase capacity to deliver quality services to people living with HIV.
- Develop the leadership capacities of PLHIV and caregivers in general for effective participation and representation in decision making in health, finance and economic issues affecting the care work sector in HIV and health responses at all levels.

6.10.

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7. Financing the Engagement and Organization of Young Women, including those Living with and Affected by HIV, in the HIV Response

Background Paper

Unami Jeremiah

7.1.

EXECUTIVE SUMMARY

HIV/AIDS is a public health threat that requires billions of dollars if it is to be eliminated by the end of the 2030 Agenda for Sustainable Development and the Sustainable Development Goals (SDGs). However, even with financial commitments being made to respond to HIV, very little actually translates to empowering young women and girls who are living with and disproportionately affected by HIV. This paper found a number of notable initiatives through the support of the United States President's Emergency Plan for AIDS Relief (PEPFAR), the Global Fund to Fight AIDS, Tuberculosis and Malaria (the Global Fund) and private donations led by the Bill and Melinda Gates Foundation that are targeting adolescent girls in Sub-Saharan Africa.

Even though there is support, the paper identified several gaps with regards to effectively and efficiently supporting young women to lead the HIV response. These gaps include limited funding, constrained funding, limited transparency, tokenism and a tendency to make decisions that affect young women without their input and presence. These challenges can be addressed when young women are truly supported to be leaders and partners in the HIV response. This paper advocates support in terms of unrestricted funding specifically for young women, seats at the decision-making tables and addressing the HIV response using an intersectional approach.

7.2.

INTRODUCTION

The world today has the largest population of girls in human history, with 1.1 billion girls.[196] These girls face a lot of life challenges that threaten their health and their existence. Globally, one in three women report experiencing physical or sexual violence in their lifetime, undermining their autonomy over their health and putting them at a higher risk of contracting HIV and other diseases. This, along with many other factors, make HIV the third leading cause of morbidity among young women. This presents a strong case for protecting young women and using relevant services to mitigate this risk.

Successfully addressing the challenge of HIV among young women requires an investigation into how economic factors contribute to their vulnerability to infection. Secondly, recognising that young women exist in different demographic and economic situations must be at the foundation of every policy and program. It is worth highlighting that the economic empowerment of young women is much more than them having authority and opportunities to control the financial resources available. Young women and girls must be able to build economic assets that will establish and enhance economic security and funding must be channelled to such programmes to ensure sustainability.

If prevention of HIV transmission is to be effectively carried out to achieve the 2030 target of eliminating HIV/AIDS as a public health threat, funding and mobilisation of young women is key. However, evidence shows that there is a shrinkage of the civil society space for women's rights, health and well-being related work, and advocacy, and funding seems to be shrinking at the same time as the civil society space. This paper seeks to assess the funding situation with

196 World Health Organization. (2013) Global and regional estimates of violence against women: prevalence and health effects of intimate partner violence and non-partner sexual violence. Available at https://www.who.int/publications/i/item/9789241564625

regards to the HIV response. Millions of dollars have been pledged towards the response on HIV, but how much of this funding is dedicated to funding young women-led interventions? The paper looks at what is currently being funded, at what magnitude, what are the gaps, and what recommendations are in place to rectify them.

7.3.

BACKGROUND

In 2016, global leaders and development partners came together and endorsed the **2016 Political Declaration on HIV and AIDS.**[197] They agreed to accelerate efforts towards all-inclusive preventative care, treatment and support programming in order enhance life expectancy, improve quality of life, and safeguard human rights and dignity for all those affected and living with HIV. This pledge recognised that HIV/AIDS is the leading cause of death among women and adolescent girls of reproductive age (15–49). Two of the important notes from the 2016 Political Declaration on HIV and AIDS were recognising that the spread of HIV was linked to poverty and inequality, which means that the HIV response must be linked to economic empowerment and sustainable livelihoods in order to address infection rates. The second note was recognising that HIV affects young women more than the rest of the population. Young people between the ages of 15-24 account for more than one third of all new HIV infections and this makes AIDS the third leading global killer of adolescents and youth.[198]

The 2016 Political Declaration on HIV and AIDS called for more transformative AIDS responses to contribute to gender equality and the empowerment of all women and girls. However, in order to implement any progressive strategies, sustainable funding is required. This is why there was a call for countries to fundraise more domestically and reduce their dependency on international donors. This is because there has been a sharp decrease in international funding towards the HIV response. Developing countries continue to bear the burden of funding HIV/AIDS prevention efforts but, due to unfavourable economic and fiscal conditions in these countries, there is a lot of dependence on international donors for funding.

The Joint United Nations Programme on HIV/AIDS (UNAIDS) 2016-2021 Strategy indicates that ending the HIV pandemic is possible through joint efforts and making connections to several goals in the SDG agenda.[199] This is articulated by recognizing that poverty increases vulnerability to HIV infection and it thus becomes imperative to end extreme poverty and reduce hunger. Complex societal issues make young women vulnerable to getting HIV because they are burdened with care responsibilities that sometimes call on them to provide financially for the household. When the young woman has no income, she is subjected to transactional sex, mostly with older men, who dictate the terms of the sexual relationship. In some cases, families 'marry off' their daughters in order to get dowry.

197 United Nations, General Assembly. (2016) Political Declaration on HIV and AIDS: On the Fast Track to Accelerating the Fight against HIV and to Ending the AIDS Epidemic by 2030. Available at http://onusidalac.org/1/images/2016-political-declaration-HIV-AIDS_en.pdf

198 See https://www.un.org/sustainabledevelopment/health/

199 UNAIDS. (2016) On the Fast-Track to end AIDS: UNAIDS 2016-2021 strategy. Available at https://www.unaids.org/en/resources/documents/2015/UNAIDS_PCB37_15-18

7.4.

FINANCING THE HIV RESPONSE

In recent times, a lot of emphasis has been placed on countries carrying the HIV burden to finance their **HIV response** with more cost-effective means.[200] This financing requires a significant amount of money, that is sustainable and without conditions. In 2015 there was some progress in mobilizing domestic resources, but a significant number of low- and middle-income countries were still heavily dependent on international donations.[201]

Private donors such as the Bill and Melinda Gates Foundation have been leading the philanthropic funding of international HIV response efforts. Most of these private donations have been in East and Southern Africa for research related work. This unsustainable donor driven funding model motivated the Association for Women's Rights in Development (AWID) to suggest an alternative to funding women through what she called the **'Feminist Funding Mechanism'**.[202] She highlights that the funding landscape is currently characterized by unsustainable funding models and disconnected funding sectors. This feminist funding mechanism can be adopted and implemented towards the HIV response since it focuses more on the needs and priorities of the movement driving the change. These needs are the primary focus and at the core of business. With this approach, funders are active agents that support existing priorities instead of their own agenda and thus helping support and strengthen the funding security to ensure that the staff and project needs are sustained over the long term.

AIDS is a public health threat that will need more funding if it is to be eliminated by 2030.[203] UNAIDS estimated that US$ 26.2 billion would have been needed by 2020 to finance the HIV response if this goal was to be met. Its ambitious targets include the 90–90–90 treatment target of 90% of people living with HIV knowing their status, 90% of people who know their HIV status accessing treatment, and 90% of people on treatment having a suppressed viral load, reducing new HIV infections to fewer than 500,000 and elimination of HIV-related discrimination. However, there is a sharp decline in funding HIV responses compared to the last 15 years.

There are several strong calls to fully fund prevention and care activities, but the panel meeting at the United Nations General Assembly High-Level Meeting on Ending AIDS in 2016 emphasized robust funding for key populations and young people in those populations. There was no explicit call for adolescent girls and women except if they were sex workers. Remme and others (2016) call for a more holistic approach to domestic resource mobilization, with country specific strategies that are aligned to broader development goals. They emphasize health prioritization in the name of universal health coverage. This will ensure that the "*leave no one behind"* agenda is realized.

In 2016, a total of US$ 1.5 billion international HIV assistance was provided through multilateral organisations such as the Global Fund, UNITAID and other United Nations agencies. The Global Fund has engaged through two notable initiatives targeting adolescents and young women, including the PEPFAR's Determined, Resilient, Empowered, AIDS-free, Mentored, and Safe (DREAMS) public private partnership and the Global Fund's HER Voice fund, as described below.

200 Avert. (2020) Funding for HIV and AIDS. Available at https://www.avert.org/professionals/hiv-around-world/global-response/funding

201 Remme et al (2016) Financing the HIV response in sub-Saharan Africa from domestic sources: Moving beyond a normative approach. *Social Scient & Medicine*, Vol. 169, pp. 66-76. https://doi.org/10.1016/j.socscimed.2016.09.027

202 Arutyunova A (2018): Why we need a feminist funding ecosystem. AWID. Available at: https://www.awid.org/news-and-analysis/why-we-need-feminist-funding-ecosystem

203 UNAIDS. (2016) Financing the end of AIDS. Available at http://www.unaids.org/en/resources/presscentre/featurestories/2016/june/20160608_panel2

7.5.

YOUNG WOMEN'S ENGAGEMENT EFFORTS

In order to look at how young women organize, we have to shift from perceiving young women as participants in the response, to seeing them as leaders within the response. If many young women are vulnerable to HIV infection, they surely must be at the helm of every conversation on the response from local to global level. A bottom-up approach where young women are leading the change is key. This approach has been adopted by the following efforts in addressing the engagement of young women.

7.5.1
HER Voice Fund

HER Voice Fund is a US$ 500,000 investment by the Global Fund through HER – HIV Epidemic Response initiative, which aims to reduce the number of new HIV infections among adolescent girls and young women by 58% in 13 African countries over the next five years.[204] The investment is meant to support meaningful engagement of adolescent girls and young women in national policy and program processes. This youth engagement is built on the notion that young women's voices and ideas matter and must be heard. It is meant to strengthen their influence that will shape the very programmes that are meant to respond to their needs. It works in a way that complements and collaborates with existing interventions that are geared towards empowering adolescent girls and young women.

The grants are dispersed through an online application and are set at US$ 2,000, which could be less depending on the quality of the application. Grant recipients are encouraged to make frequent applications for other activities; however, funding mechanisms like this can be unsustainable and act like a 'quick fix' instead of ensuring sustainability. Perhaps also giving young people such limited funds says a lot about the level of trust institutions have in supporting youth mobilization and advocacy efforts. It would be great to see the funding increase with substituent applications so that advocacy efforts have a chance to be long term.

It is also worth suggesting that proper consultations should be done with adolescent girls who are implementers of advocacy projects. It is their voice that is key is determining how much, how frequent, and what kind of support works for them in implementing and evaluating advocacy projects. Adolescents are experts, they understand their challenges and what works best for their circumstances and that is something we ought to learn and respect when discussing and issuing funding. It is a way of meaningfully engaging them and regarding them as partners instead of 'beneficiaries'.

204 See https://www.hervoicefund.org/

7.5.2
DREAMS

DREAMS, led by PEPFAR is an ambitious partnership, worth US$ 385 million, which is committed to helping girls develop into determined, resilient, empowered, AIDS-free, mentored, and safe women.[205] What is innovative about this partnership is that the funding

205 See https://www.state.gov/pepfar/

is directed towards evidence-based approaches that speak to structural drivers that directly or indirectly increase girls' risk to HIV. These factors include poverty, gender inequality, sexual violence, and lack of education. The DREAMS funding has targeted sub-Saharan countries that have more than half of all new HIV infections in the world: Kenya, Lesotho, Malawi, Mozambique, South Africa, Swaziland, Tanzania, Uganda, Zambia, and Zimbabwe.

The Center for Health and Gender Equity conducted an evaluation in 2016 looking into the program in Kenya and South Africa.[206] The program wanted to reduce HIV incidence by a quarter in 2016/2017. Although the program has been well received and has a huge following and support from host countries, civil society organizations (CSOs) and adolescent girls and young women, there is still room for improvement to maximize the initiatives. Firstly, there is an issue that technical support offered by the sponsor towards implementing partners is limited. CSOs flagged that there is some level of disorganization before, during, and after stakeholder engagement meetings with US government officials. For example, there were instances where documentation and meeting agendas were not shared prior to meetings, making it difficult for CSOs to have an informed dialogue.

Secondly, the PEPFAR funds are limited only to condom supply and distribution, and other contraceptives remain unfunded. This is an issue because HIV prevention and re-infection is key, and young women also want an opportunity to prevent unplanned pregnancies and contraceptives such as intrauterine device, oral pill, patch, or implants remain unfunded. It is worth exploring the opportunity to open that budget line to support double contraception[207] usage. Thirdly, PEPFAR requires that CSOs are data savvy and most lack that capacity and skills. Although PEPFAR has the room to develop this expertise, they have not done it. PEPFAR also has a prescriptive approach to implementing DREAMS, rather than engaging adolescents and young women within their in-country teams on any level, which diminishes the voices of young women, the very people that are affected by HIV and structural challenges.

Many CSOs, because they are dependent on the funding, are unable to openly criticise PEPFAR because of fear that future funding will be withdrawn. On another note, the support offered by PEPFAR does not include support for when participants are supposed to show up for meetings and consultations, which means their ability to travel and stay where meetings are remains unsupported. Lastly, it is very blurry how DREAMS deal with young women who are already living with HIV, sex workers and sexual minorities. If the "leave no one behind" principle is to be realised, all adolescent girls and young women must be included and engaged.

206 See http://www.genderhealth.org/files/uploads/change/publications/CHANGE_Dreams_Report_Updated.pdf

207 Corinna H. (ND) The Buddy System: effectiveness rates for backing up your birth control with a second method. Scarlet Teen. Available at https://www.scarleteen.com/article/sexual_health/the_buddy_system_effectiveness_rates_for_backing_up_your_birth_control_with_a_

7.5.3
#WhatWomenWant

In 2016, Athena Network launched a campaign called #WhatWomenWant,[208] with the aim of amplifying young women's voices, issues, and power to solutions. The platform creates spaces for young women to be seen and heard as leaders and engaged meaningfully to achieve gender equality, address HIV, end gender-based violence, and realise sexual and reproductive health and rights (SRHR) for all women. These rights include equal access to comprehensive sexuality education programmes with an explicit focus on gender

208 See https://whatwomenwant.format.com/about

rights and gender power dynamics. They are proven to be five times more effective than those that do not.[209]

When the campaign was launched through Twitter, it asked young women what they want, and young women want power, tools, and an opportunity to be the change. This means that in order for the HIV response to be effective, young women must be at the helm; it means young women living with HIV must dictate what care support means to them. Young women face multiple forms of discrimination and positive youth even more so. The campaign also captured the stories and voices of young women and through the "Young Feminist Blog"[210] series and this is what some had to say:

"The WhatWomenWant has enabled young women living with disabilities to be heard through multi-platform consultations, a blog series and a photo campaign. It leverages on social media channels that they are comfortable with. They are calling for a seat at the table." - Sally Nyakanyanga, Zimbabwe

"Sexual gender-based violence still very rampant, and lately on the rise in my community. I believe that cash transfers are a great idea and very helpful to young women. But It would be better if the amount is increased (currently they give Ksh.2000 - equivalent to USD20)."- Winnie Obure, Kenya

"I believe in collaboration, sustainable funding beyond 5 years and investment and resourcing community based and young women led organisations in Malawi."- Umba Zalira, Malawi

Prior to the #WhatWomenWant campaign, Athena Network was part of LINKUP,[211] an ambitious five-country project that ran from 2013-2016, to improve SRHR of one million young people most affected by HIV. Its aim was to strengthen the integration of HIV and SRHR programmes and service delivery for high risk adolescent youth in Bangladesh, Ethiopia, Burundi, Uganda and Myanmar. At its core were the ideals of meaningful youth engagement which was illustrated by internal governance, consultation, financially support participation and input, community mobilization, peer-to-peer education, and mentoring among others. This engagement went beyond the normal discussion, but acknowledged young people's time, skills, expertise and intellectual input.

209 UNAIDS. (2017) When women lead change happens: women advancing the end of AIDS. Available at http://www.unaids.org/sites/default/files/media_asset/when-women-lead-change-happens_en.pdf

210 See https://whatwomenwant.format.com/feministblog

211 Athena Network. (ND) Aiming High: 10 strategies for meaningful youth engagement. Available at https://athenanetwork.org/assets/files/Link%20Up%20mentoring%20programme/Aiming%20High_ENG_HiRes.pdf

7.6.

EXISTING YOUTH ENGAGEMENT EFFORTS

There are other young engagement efforts that fund the engagement of young people, including young women. Some of these efforts fund HIV response indirectly, while others are skewed towards engaging young men from key populations.

7.6.1
Women Deliver

Women Deliver has positioned itself as a leading advocate for women and girls' rights, health and wellbeing. It believes in meaningful engagement of young people and has demonstrated that through its award-winning young leaders' program.[212] Since its inception in 2010, it has trained and engaged over 700 youth advocates from 138 countries. There is a variety of themes that young women engage in, including HIV response, which is blended with SRHR. Women Deliver supports young women with seed grants, capacity building and speaking engagements to grow their leadership, networking, and fundraising skills. These engagements have allowed over 185 meetings to be held with local and national policy makers and directly engage over 53,000 young people. From 2016, 83 grants worth US$ 400,000 have been given to young people.[213]

212 See Women Deliver young leaders' program: https://womendeliver.org/youth/young-leaders-program-detail/

213 See https://womendeliver.org/youth/supporting-youth-advocacy/

7.6.2
Robert Carr Fund

Robert Carr Fund supports community networks that aim to combat AIDS, especially the inadequately served populations within communities.[214] It is supported by PEPFAR, Bill and Melinda Gates Foundation, NORAD, and UK Aid. It funds initiatives that exist to advance human rights advocacy for these communities. It has currently allocated US$ 2,312,776 in grant money towards youth engagement. This engagement is for young men who have sex with other men, trans youth, sex workers, and youth that use drugs. Youth LEAD from Bangkok is the recipient youth network, with 57 focal points in 20 countries to date. There is no specific grant allocated to young women, unless they are sex workers. The fund mostly supports these key populations, even when young women continue to be infected and affected by HIV in alarming numbers.

214 See http://www.robertcarrfund.org/

7.6.3
The FRIDA Fund

The Young Feminist Fund (FRIDA) was established to provide resource support and network opportunities for young feminists who are trusted as experts of their own reality in order to make a change.[215] FRIDA recognises girls, young women and trans youth as its target population for funding and other opportunities. Unlike other funders, FRIDA gives flexibility on how the funds are used in accordance to organisational needs, including staff compensation. It also funds unregistered entities because it believes that registration should not limit the change that a movement is driving. It is no specified if they fund HIV response related initiatives, but they support youth that are using an intersectional approach and combining issues.

215 See https://youngfeministfund.org/

7.6.4
UNAIDS Youth Programme

The UNAIDS youth programme was established in 2012 following a recommendation from consulting over 5,000 youth.[216] It is centred around core principles of

216 See http://www.unaids.org/en/topic/young-people

youth participation, influencing policy, and partnerships. It engages young people as leaders and participants with leadership skills that can lead the HIV response. However, there is limited information on how this programme is funded and scaled. It can be assumed that it is left at the discretion of individual country offices.

7.6.5
UNICEF

The United Nations Children's Fund (UNICEF) intends to make sure that structural barriers such as poverty and inequality do not hinder care and treatment of HIV for infants to adolescents (10-19 year olds), especially those that have a high risk of exposure to HIV.[217] UNICEF as a co-sponsor to UNAIDS supports country level evidence-based interventions that will reduce HIV vulnerability. This investment is geared towards prevention of mother-to-child transmission, HIV treatment, key populations interventions, condom distribution, voluntary medical male circumcision, and behavioural change interventions. What can be noted is that the cost of this support and what portion of it would be for young adolescent girls and young women remain unclear.

217 UNICEF. (2013) *Achieving an AIDS-free generation: UNICEF'S HIV/AIDS vision 2014-2017*. Available at https://www.unicef.org/files/VisionPaper_Interactive_ENG.pdf

7.6.6
Faith-Based Organisations

Many FBOs tend to lead the advocacy piece of the HIV response. They are seen more as influencers that work hard to engage and encourage governments to implement the commitments they make at high level events. They tend to play the role of counselling and discouraging stigma and discrimination about HIV. They also encourage HIV testing,[218] but some are conservative when it comes to contraceptive usage, including condoms. But these organisations are increasingly adopting a secular approach in order to keep up with current trends. Organisations that initially where faith-based but slowly evolved, like the World Young Women's Christian Association (World YWCA), have been creating safe spaces for young women for the past 160 years. This movement exists in over 20,000 communities globally and each has its own fundraising mechanisms to finance projects. HIV-related activities are funded through bilateral means between local YWCAs and donor countries.

218 UNAIDS. (2017) Faith-based organizations vital to the response to HIV. Available at http://www.unaids.org/en/resources/presscentre/featurestories/2017/june/20170619_nigeria

7.7.
CONCLUSION AND RECOMMENDATIONS

We have established that gender equality is a solution to the HIV response. However, less funding is channeled towards preventative strategies and initiatives led by young women. The next paragraphs

explore the challenges impeding engagement of young women in HIV response:

- **Visibility:** Although young women are most affected and infected by HIV, they are still missing from the decision-making tables at all levels. Their absence sometimes comes at a cost for actual representation, when programmes and policy decisions are taken without meaningful engagement.
- **Constrained Funding**: When young women led initiatives are funded, they are bound by terms and conditions. It is worth relaxing the terms and allowing unrestricted funding patterns.
- **Governance**: There are many pledges and financial commitments that have been made towards youth engagement, including the HIV response. However, there is still a gap in terms of accountability systems that track and monitor when, how and which cohort of young people receives this money. There needs to be oversight committees that are diverse, inclusive and young women led.
- **Oversight**: There is lack of transparency on spending. Most financial statements which would indicate how organizations are spending their budget lines in terms of the HIV response remain in private domains. This lack of transparency makes it difficult to know how and when the money is spent. There is a pressing need to be more open and honest in such dealings, especially since the funding is for the public.
- **Tokenism**: Young women are still treated as beneficiaries, as recipients of initiatives, and are often excluded from the decision-making table; if they are included, it is on a tokenistic approach. This has to change, not only in theory, during speeches and gatherings, but going the extra mile to meaningfully engage young women.

The following are some of the recommendations, based on the challenges explored:

- In order to effectively respond to the call for more transformative response to HIV among young people, **young women have to be fully involved and engaged** in HIV response efforts, including being accountability agents. This means that for every committee, expert group, or board, young women must have more than one seat. Their presence must speak to the diversity and inclusiveness of young women.
- **Young women led approaches must be funded** to ensure that young women can confidently speak up about issues and connect with others. A deeper level of trust is important and needs to be developed when engaging young women. It has to go beyond creating 'safe spaces with ice breakers' and encourage peer-to-peer engagement, using social media and contracting youth skills in paid work. Peer-to-peer engagement means young women are supported to create and lead initiatives that will be for the good of other young women. In addition, supporting young women means recognizing their skills and expertise and actually hiring them to be consultants and professional staff.
- **Community informed interventions** must matter and should take precedence over donor and state motives. One intervention that seldom gets attention is defining male engagement in the HIV response; to do that, there needs to be open dialogue on issues surrounding male privilege. This would strengthen male engagement to actively collaborate with young men so as to break the cycle of perpetuating harmful social norms.
- Partnerships that are created to empower girls and young women must **recognise intersecting issues related to HIV** such as poverty, economic justice, and sexual violence. For example, sustainable partnerships with the private sector can resource programmes that will create employment and promote financial independence. This calls for intensified mobilization, building and strengthening young women's movements for the HIV response and leadership. This is equally important if we are to achieve any mandate, any strategy, and even the sustainable goals agenda.

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UN Women supports UN Member States as they set global standards for achieving gender equality, and works with governments and civil society to design laws, policies, programmes and services needed to ensure that the standards are effectively implemented and truly benefit women and girls worldwide. It works globally to make the vision of the Sustainable Development Goals a reality for women and girls and stands behind women's equal participation in all aspects of life, focusing on four strategic priorities: Women lead, participate in and benefit equally from governance systems; Women have income security, decent work and economic autonomy; All women and girls live a life free from all forms of violence; Women and girls contribute to and have greater influence in building sustainable peace and resilience, and benefit equally from the prevention of natural disasters and conflicts and humanitarian action. UN Women also coordinates and promotes the UN system's work in advancing gender equality.

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