Analysis of the Implementation of the Global Fund Gender Equality Strategy in Round 8 and 9 HIV Programs

August 2012
EXECUTIVE SUMMARY

In 2008, the Board of the Global Fund to fight AIDS, Tuberculosis and Malaria (Global Fund) adopted the Global Fund Gender Equality Strategy (GES). The GES explores how the Global Fund can encourage a positive bias in funding towards programs and activities that address gender inequalities and strengthen the response for women and girls, because it is the needs and rights of women that are often marginalized, and so become key drivers of HIV epidemics. The GES states that the primary objective behind gender mainstreaming is to design and implement development projects, programs and policies that: 1) Do not reinforce existing gender inequalities (Gender Neutral); 2) Attempt to redress existing gender inequalities (Gender Sensitive); and 3) Attempt to re-define women and men’s gender roles and relations (Gender Transformative).

This portfolio analysis focuses on determining the breadth and extent of implementation of activities that contribute to gender equality in Global Fund programs, and captures key implementation successes and challenges. It seeks examples of Gender Transformative programming that will deliver the most effective programming for women and girls. The analysis consists of two parts: this desk review covering nine countries, looking at program documentation for rounds 8 and 9 (and including round 7, phase 2), a and a subsequent report documenting four country case studies. Documentation reviewed for each country includes the proposal form, performance framework, summary and detailed budget, progress update and disbursement request, and enhanced financial reporting forms.

This analysis shows very limited evidence of the implementation of gender-responsive programming in Global Fund documents. In all cases we anticipate that there is far more activity underway at country level, but the documentation is mostly gender-blind or gender neutral so cannot prove this. Therefore, we foresee a more nuanced analysis as a result of the country case studies that will take place in the second phase of this study. One of the main obstacles to the implementation of effective and efficient gender-responsive programs identified is the lack of disaggregated data by sex, age and at-risk populations, which begins with countries’ gender analyses in proposals and is reflected in performance indicators, budget allocations and progress updates.

This study identified weaknesses in the implementation of interventions focused on the integration of HIV and sexual and reproductive health (SRHR) services, the treatment, care and support for women and girls living with HIV, support for female caregivers, as well as for adolescent girls and young women who are orphaned or HIV-affected. Also, the level of implementation of interventions to ensure an environment that supports improved outcomes for women and gender equality appears to be low, particularly with regard to engaging gender experts in HIV decision-making, addressing stigma and discrimination, and having women living with HIV engaged in decision-making bodies.

The study shows some evidence of the implementation of gender responsive HIV prevention activities, including for example addressing HIV risk reduction within multiple and concurrent
partnerships and distributing female, as well as male, condoms. However, when it comes to the implementation of PMTCT\(^1\) programs, the approach appears to be partial so that there is a strong focus on pregnant women or pregnant women living with HIV with little consideration for comprehensive services that include, for example, the long-term treatment of mothers beyond giving birth, comprehensive reproductive health services, including family planning, and nuanced services, especially for women from key populations.

In respect of the implementation of activities addressing violence against women and girls, we found no evidence of activities being implemented that are designed to address the root causes of violence against women, such as society’s expectations of male prowess or control over women. Overall, programming to address the role of men and boys was weak. While most proposals recognized the importance of male involvement to enable effective programming for women and girls, implementation was mainly restricted to interventions focused on male circumcision.

This study demonstrates three key challenges for countries regarding the implementation of gender responsive programming are to:
1. Include a strong gender analysis in their Global Fund proposals, with data that is disaggregated by sex, age and vulnerability, especially for key populations; take a comprehensive approach to PMTCT interventions; and identify appropriate strategies for the involvement of men and boys;
2. Translate these gender-relevant interventions into corresponding gender-related indicators in the performance frameworks that then follow through in budgets;
3. Ensure that the follow-up of these interventions as described in the Progress Update/Disbursement Requests (PU/DRs) also includes a gender dimension and, ideally, is complemented with qualitative information, such as on changing gender norms.

This review highlights the following key recommendations addressed to the Global Fund, the technical partners and local stakeholders:
1. The Global Fund, as well as partners such as UN Women and other UNAIDS co-sponsors (eg UNFPA and UNICEF), should facilitate technical support to countries on how to address gender, as well as on how to translate this analysis into operational plans, activities, performance indicators and budget allocations; to maximize quality this technical support should be provided through partnerships with civil society and women living with HIV;
2. In order to develop a rounded understanding of the issues that need to be tackled to achieve gender equality, epidemiological information should be complemented by anthropological and sociological information, and local knowledge about sexuality, gender identity, and cultural norms about appropriate femininity and masculinity;
3. The Global Fund secretariat should require performance indicators, budgets and PU/DRs to include sex- and age-disaggregated data;

\(^1\) ASAP recognizes that many women living with HIV raise concerns about the terminology “PMTCT”, preferring “vertical transmission” or “virtual elimination”. However, for consistency with other reports we use the term PMTCT in this report.
4. All Country Coordinating Mechanism (CCM) members should be informed on the GES and be capacitated in developing gender-responsive implementing strategies;

5. CCMs need to take greater steps to engage actively with a broad range of civil society groups within the development sector, in particular those representing women’s rights organizations and especially women living with HIV;

6. Implementation of the GES should not only be the responsibility of individual staff members, such as Global Fund gender advisors, but also a joint responsibility across the Global Fund secretariat, including the Fund Portfolio Managers (FPMs) and country teams;

7. Operational plans for girls and women, sex workers and people who use drugs, linked to GES, should be prepared as part of the implementation of the new Global Fund strategy (2012-2016) and the Comprehensive Transformation Plan (CTP).
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1. INTRODUCTION

At the end of 2011 it was estimated that out of the 34.2 million adults worldwide living with HIV and AIDS, half are women.\(^2\) The AIDS epidemic has disproportionately affected women and girls. The impact has been exacerbated by their role within society and their biological and economic vulnerability to HIV infection. Gender inequality is a key obstacle to preventing HIV and providing treatment and care for women and girls living with HIV, and to reaching better family planning, maternal and reproductive health outcomes.

A multiplicity of factors affects women and girls in a disproportionate manner. Women and girls bear a disproportionate burden of caring for others, and may also experience greater discrimination when they, or are believed to be, living with HIV. Issues such as poverty, violence against women and girls, lack of access to land and property, conflict, and lack of access to comprehensive SRHR services, also exacerbate the impact of HIV on women and girls, as do cultural, structural and political factors. This underlines the need to address legal, social and economic inequalities that increase women and girls’ vulnerability to HIV. Examples include gender-based violence, sexual abuse and exploitation of girls, stigma and discrimination, barriers to access to services, denial of property and inheritance rights and lack of education for girls.

The impact of gender inequality does not only have negative impacts on women and girls. Unequal power relations between women and men can also influence men’s risk of infection. For example, traditional norms of masculinity may encourage men and boys to have multiple sexual relations, to engage in heavy drinking, increasing the risk of practicing unsafe sex, as well as expecting them to be knowledgeable, and limiting seeking health care when needed. An effective response thus requires engaging men and boys: as partners and family members of women and girls, as community leaders and decision-makers, as perpetrators of discrimination and violence, and as people with specific needs for HIV advocacy and services.\(^3\) A review of programs that have constructively engaged men has identified many that were effective in helping men to reduce behaviors that put themselves and their partners at risk.\(^4\)

**Gender responsive programming**

The diagram below shows a gender integration continuum illustrating ways to achieve gender equity in program or policy design and implementation. Levels of gender awareness are described as *gender exploitative*, *gender accommodating (or sensitive)*, and *gender transformative*.\(^5\)

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2. UNAIDS Action Framework. Addressing women, girls, gender equality and HIV (August 2009)


Responses that are gender blind fail to recognize that gender is an essential determinant of social outcomes impacting on projects and policies. Gender-neutral approaches are aimed at the general population and do not distinguish between the different needs of women and men. Gender aware programs and policies are developed with gender exploitative, accommodating or transformative objectives. Gender exploitative approaches take advantage of rigid gender norms and existing imbalances in power to achieve the health program objectives and should be avoided at all times. Gender accommodating/sensitive approaches acknowledge the role of gender norms and inequities and seek to develop actions that adjust to and often compensate for them. However, a gender accommodating approach does not purposely contribute to increased gender equity\(^6\), nor does it address the underlying structures and norms that perpetuate gender inequities. Gender transformative approaches, on the other hand, attempt to re-define women and men’s gender roles and relations and seek “to fundamentally improve existing gender inequalities both as a means to, and in the process of, addressing HIV. Such transformative approaches would change the underlying structural conditions that are associated with higher HIV infection rates.”\(^7\) Gender neutral, gender accommodating/sensitive and gender transformative approaches, however, are not mutually exclusive and should occur simultaneously.

**Gender equality and the Global Fund**

In 2008, the Board of the Global Fund adopted the Gender Equality Strategy (GES)\(^8\) to

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\(^6\) The term “gender equity” means fairness of treatment for women and men, according to their respective needs. “Gender equality” entails the concept that all human beings, both men and women, are free to develop their personal abilities and make choices without the limitations set by stereotypes, rigid gender roles, or prejudices. The term “equality” is used primarily in this analysis because of ease of understanding and translation. Where relevant, the term “equity” is used.

\(^7\) UN Women: *The 4th Decade of women and HIV: The role of gender equality in reversing the HIV pandemic*. (Draft)

Encourage a positive bias in funding towards programs and activities that address gender inequalities and strengthen the response for women and girls. However, the most vulnerable in society also includes people whose gender identity and sexual orientation defines their vulnerability, such as men who have sex with men (MSM) and transgender people. Recognizing that there is a gender dimension to the issues affecting these key populations, the Global Fund developed the Sexual Orientation and Gender Identity (SOGI) Strategy in 2009 focused on their specific needs.

The Gender Equality and SOGI strategies support countries’ efforts to ensure that gender dimensions are taken into account in their proposals and that subsequent program implementation includes the scale-up of services and interventions that reduce gender-related risks and vulnerabilities to HIV, decrease the burden of disease for those most at-risk, mitigate the impact of HIV, and addresses structural inequalities and discrimination. Implementation of the GES and SOGI strategies are tied to the implementation of the new Global Fund strategy 2012-2016 (Investing for Impact) - in particular Objective 4 Promote and protect human rights, - and delivering the Consolidated Transformational Plan (CTP) as a key element in improving Global Fund investments and optimizing value for money at this important moment in the Global Fund’s history.

The GES differentiates between gender neutral, gender sensitive, and gender transformative approaches and states that the primary objective behind gender mainstreaming is to design and implement development projects, programs and policies that: 1) Do not reinforce existing gender inequalities (Gender Neutral); 2) Attempt to redress existing gender inequalities (Gender Sensitive); and 3) Attempt to re-define women and men’s gender roles and relations (Gender Transformative).

In 2011, the Global Fund published the “Analysis of Gender-Related Activities on Global Fund Approved HIV Proposals from Rounds 8 and 9” which documented the level of gender dimensions in Global Fund proposals. The analysis focused on the extent to which proposals addressed the gender dimensions of AIDS and reflected the priorities of women and girls, as well as the most at-risk populations including sexual minorities. A key recommendation of the analysis was that further research should be undertaken to measure progress with implementing gender responsive activities, including more detailed case studies to capture country-level experiences and challenges in implementing gender-related interventions such as those addressing gender-based violence or maternal and child health.9

This portfolio analysis is a joint collaboration between the Global Fund and UN Women. It focuses on determining the breadth and extent of implementation of activities that contribute to gender equality in Global Fund programs, and captures key implementation successes and challenges. The analysis consists of a desk review, that will be followed by one initial in-country case study [expected to be followed by a further three] to assess the level of gender

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programming, and identify systematic challenges in bringing plans to implementation, the areas where investments and technical support can be improved, as well as identifying opportunities to move forward and support countries to enhance their gender transformative programming.

This analysis has been informed by UN Women’s analysis of how HIV and gender interact. UN Women has defined a conceptual framework identifying four primary pathways showing how gender inequality influences susceptibility to infection, the experiences and needs of girls and women living with HIV, the effectiveness of actions taken, and how the pandemic itself and the response to it influences gender inequality, either positively or negatively (see chapter 4).

2. OBJECTIVES

The overall goal of this review is to document the breadth and extent of country level implementation of the Board-mandated Gender Equality Strategy activities in Global Fund programs. The analysis consists of two parts: a desk review covering nine countries, looking at program documentation for rounds 8 and 9 (including round 7, phase 2) followed by 4 country case studies.

The objectives of the desk review are to:

1. Detail the extent to which gender responsive (neutral, sensitive and transformative) activities are being implemented, in particular those that were highlighted in the original proposal;
2. Document budgeted gender activities and;
3. Capture key implementation successes and challenges.

The objectives of the country case studies based on the above criteria are to:

1. Analyze strengths and identify weaknesses of country-specific gender programming\(^\text{10}\) (neutral, sensitive, transformative) that has played an important role in responding to HIV and making a difference in the lives of women and girls;
2. Assess whether resources are reaching gender responsive programs (neutral, sensitive, transformative);
3. Develop a greater understanding of which stakeholders are involved in the implementation of Global Fund supported programs especially from civil society and networks of women and people living with HIV;
4. Provide feedback on where the Global Fund and UN Women and their technical partners could strengthen their support to countries.

\(^{10}\) This includes the three actions as described in the UN Women Paper *The 4th Decade of women and HIV. The role of gender equality in reversing the HIV pandemic*. 


3. METHODOLOGY AND LIMITATIONS

The countries considered in the desk review were Armenia, Cambodia, DRC Congo, Ghana, Jamaica, Lesotho, South Africa, Tajikistan, and Zambia. The country selection was based on geographical distribution and to allow for variation of epidemiology and level of Global Fund support. The countries were selected from among the countries considered in the 2011 Global Fund analysis of Round 8 & 9 proposals. The analysis undertaken in this desk review used data collected from:

1. The submitted proposal forms from Round 8 and 9\textsuperscript{11}

   The analysis has looked at gender-related data provided throughout the proposals and in particular at the gender analyses included in the proposals. The analysis has further looked at ways countries have incorporated gender responsive approaches in Service Delivery Areas (SDAs) or specific activities of the proposal. All Global Fund programs are required to define the activities they will undertake with grants according to SDAs. These are broad categories of programmatic activities that describe how a proposed intervention fits into the overall Global Fund program strategy and complements existing interventions underway in a country; SDAs define the expected outcomes from Global Fund financing. For example, where a country includes SDAs for Condom Use Programs, a gender analysis expects that both male and female condoms will be provided and promoted; Behavioral Change Communication SDAs would emphasize the importance of partner reduction for both men and women, including through strategies such as voluntary and confidential couples-counseling, separate focus group discussions with women and men on changing patterns of sexual behavior, and strategies to promote positive models of masculinity.

2. The grant agreement including the performance framework (PF), and summary and detailed budget

   Separate grant agreements are signed with each of the Principal Recipients (PRs)\textsuperscript{12} after a proposal is approved. The grant agreements are fundamental to this analysis: they are legally binding documents that include clear indicators and time-bound targets to measure the performance of the grant as well as capacity-strengthening actions, intended to ensure good performance. These grant agreements articulate how Global Fund monies should be used to achieve the ambitions articulated in the proposals. It can take a number of months to move from the stage where a proposal is agreed for funding and the detailed grant agreement is signed with a PF. One of the key areas of enquiry for this desk review has been the chain of events from acceptance of proposal to implementation. This analysis looks, for example, at

\textsuperscript{11} CCMs are responsible for developing and submitting proposals to the Global Fund. Proposals that are deemed eligible for consideration by the Secretariat are passed on to the Technical Review Panel. The Global Fund awards grants on the basis of proposals submitted to the Fund that are approved for funding.

\textsuperscript{12} The Global Fund signs a legal grant agreement with a PR, which is designated by the CCM. The PR receives Global Fund financing directly, and then uses it to implement prevention, care and treatment programs or passes it on to other organizations (sub-recipients) that provide those services. Many PRs both implement and make sub-grants. There can be multiple PRs in one country. The PR also makes regular requests for additional disbursements from the Global Fund based on demonstrated progress towards the intended results.
whether interventions are designed with concrete budgets and targets to reach groups of women and men according to their specific needs. The PF is a statement of intended performance and forms the basis for future disbursements to the PR. The PF contains an overview of the program’s goals, objectives, indicators and targets. The grant budget consists of a summary budget and a detailed budget and reflects the costs by each cost category and SDA. The summary budget (SB) should be consistent with the detailed budget. Inevitably the PF and SB aggregate details of the overall program to a high level, making tracking of the gendered aspects of implementation important and often challenging. The PF and SB provide snapshots of what the country is legally committed to delivering with GF funds, and can be a blunt instrument for assessing the gendered aspects of implementation.

3. Progress Update and Disbursement Request (PU/DR)
During the lifetime of a grant, the Global Fund periodically disburses funds to the PR based on demonstrated program performance and financial needs for the next period of implementation. A PU/DR is both a progress report on the latest completed period of program implementation and a request for funds for the following period of implementation. The PU/DR forms the basis for the Global Fund’s disbursement decision by linking historical and expected program performance with the level of financing to be provided to the PR. The reason to include the PU/DR in this analysis is that it provides an update of the programmatic and financial progress of a Global Fund-financed grant, as well as an update on fulfillment of conditions precedent, management actions and other requirements. As PU/DRs describe progress and plans in greater detail, this could be expected to give further detail on the implementation underway than the PF.

4. Enhanced Financial Reporting (EFR)
Once a year, the PR is expected to submit the EFR as part of the PU/DR. The EFR data comprises breakdowns of program budgets and expenditures by cost categories, program activities and sub-recipients (SRs)\(^2\), as well as disbursements by SRs, the organizations who provide (and further sub-contract) the services that deliver the outcomes envisaged in the grant. The information collected is used (1) for external reporting and resource mobilization and (2) to support funding decisions. By collecting additional financial information through EFR the Global Fund expects to improve its ability to report on Global Fund activities, to increase institutional accountability and transparency, and, thereby, to enhance its ability to mobilize additional resources. By providing a further level of detail it could be anticipated that the gendered aspects of implementation may become more visible.

Assumptions

\(^{13}\) The detailed budget should provide: (i) General assumptions which may impact planned expenditures, for example, inflation and exchange rates; (ii) Budget items organized under objectives, SDAs and cost categories per quarter and per year; a description of the activity, a breakdown of unit costs, a description of assumptions and quantities.

\(^{14}\) The sub-recipient is contracted by the PR of the grant to assist in implementing program activities. The PR is responsible for the oversight of the implementation by the SR. SRs often play a pivotal role in the implementation of program activities, the management of grant resources and the timely achievement of grant results.
For a gender analysis, all data should at least be separated by sex in order to allow differential impacts on men and women to be measured. Ideally, a country includes relevant gender aspects in the gender analysis of the proposal, develops gender specific objectives together with overall objectives and ensures these are reflected in SDAs or activities as well as in the budget and included in PF indicators. Integrating gender aspects throughout the chain of the proposal, implementation, reporting cycle and its associated Global Fund documentation would allow the Global Fund and partners to follow up and measure the planned interventions and their impact. When, for example, gender responsive activities are mentioned in the main text of the proposal, but not reflected in the PF, or formulated as activities, but not reflected in the budget it becomes difficult to assess the level of implementation of these activities. However, absence of information in documentation does not inevitably mean absence of action.

We have understood gender as referring to the array of socially constructed roles and relationships, behaviours, values, relative power and influence that society ascribes to women and men on a differential basis. Gender is an acquired identity that is learned, changes over time, and varies widely within and across cultures. Gender refers not simply to women or men but to the relationship between them. For the purposes of this analysis, while we recognise that gender is about more than the female sex, we have focused principally on how Global Fund-supported programs are able to meet the needs of women and girls, including through working with men and boys. Women and girls, particularly from poor communities, are among those with enhanced vulnerability to HIV infection as a result of unequal gender relations and entrenched gender inequality.

We recognize that there is a broader definition of gender that recognizes that gender as a construct including sexuality and gender identity. Given that the Global Fund has both a GES and SOGI strategy, and that there have already been reviews of the SOGI strategy this report does not focus on men who have sex with men (MSM) and transgender people. Within the population groups we endeavour to address a broad range of women and girls, including adolescent girls, women who are pregnant, women who belong to “key populations”: including women who use drugs, women engaged in sex work and female partners of MSM. While we recognize the importance of addressing the needs of transgendered women and men, we could find no references in the documentation from the countries we reviewed.

We have analyzed Global Fund documentation from nine countries to assess countries’ implementation of gender responsive programming. Where appropriate we have triangulated

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17 In the Gender Equality Strategy, gender is defined as referring to the array of socially constructed roles and relationships, personality traits, attitudes, behaviors, values, relative power and influence that society ascribes to the two sexes on a differential basis. Whereas biological sex is determined by genetic and anatomical characteristics, gender is an acquired identity that is learned, changes over time, and varies widely within and across cultures. Gender is relational and refers not simply to women or men but to the relationship between them.
with evidence from UN and other technical sources, for example on epidemiological profiles. In all cases we were able to find extensive evidence of gender analyses in the proposals, but very limited evidence of gender in the documents referring to implementation. In all cases we anticipate that there is far more activity underway at country level, but the documentation does not prove that this is so. And where there is evidence of implementation, it is almost impossible to take a view on the quality of programming. It is for these reasons that during the course of this study the team has shifted direction to emphasize the importance of in country review and will focus on enquiry at a country level to understand the gendered dimensions of implementation, given that the documentation reviewed may conceal the quality of work underway.

**Limitations**

The Global Fund documentation reviewed may not provide sufficient information needed for this analysis – as hinted above. Limitations include:

1. Assessing the actual implementation of gender transformative programming based on PF and budgets is complex as these are documents provided for legal grant management purposes and necessarily aggregate a vast range of detail. Activities mentioned in PF may not be in budgets or vice versa, but in reality they may be implemented. To note that the Global Fund M&E toolkit\(^{19}\) states that the “PF isn’t able to provide information on the implementation of specific initiatives or activities - this would need to be done through specific survey or evaluations”.

2. Descriptions of activities in proposals often don’t match with descriptions in PF and budgets. The activities are often listed under broad SDA in the PF and budget and therefore it is challenging to find each activity as they are described in the proposal as well as the actual cost and allocated amount.

3. A huge amount of data is not sex disaggregated, notably most documents describe work with people living with HIV (PLHIV), key populations or most at risk populations (MARPs) and orphans and vulnerable children (OVC), but do not define the specificities of needs and focus on women and girls which is necessary in practice. PF and budgets descriptions are even less often sex disaggregated, but that does not necessarily mean that gender activities are not being implemented – merely that they are not reflected in the documentation.

4. The core principles of the Global Fund mean that countries decide their focus areas and this is not overly guided by the secretariat. Consequently proposals vary greatly in terms of the amounts of information provided.

5. PU/DRs provide either very quantitative or very detailed information that is rarely relevant for the sake of this analysis; the data was seldom sex disaggregated and rarely focused on women and/or girls specifically, and provides scant indications of the quality of implementation.

\(^{19}\) *Monitoring and Evaluation Toolkit; Fourth edition (November 2011).* The Global Fund to fight AIDS, Tuberculosis and Malaria.
4. ANALYTICAL FRAMEWORKS

The principle reference framework for this review is the UN Women paper “The fourth decade of women and HIV: The role of gender equality in reversing the HIV pandemic” acknowledges that non-gender variables, such as education, ethnicity or sexual orientation, may influence the relationship between gender and HIV. The paper describes four primary pathways through which gender interacts with HIV, and identifies the following key elements of each pathway:

1. Gender inequality affects susceptibility to HIV infection
   Women, and particularly girls and young women, have a greater biological susceptibility to HIV infection, which is further influenced by social, economical, regional and country contexts. For example, girls who have sex with older men (including for money or gifts) are at greater risk of infection due to their own biological susceptibility, and the increased possibility that the man has already been infected with HIV. In many countries and cultures, society’s pressure on men to prove their manhood through having sex with multiple partners, together with the woman or girl’s lack of understanding of her risk, potential lack of access to condoms and inability to negotiate condom use, are other manifestations of gender inequality.

2. Gender inequality affects clinical outcome and quality of life for those infected and affected by HIV
   A woman’s HIV-positive status may affect her income or educational prospects thereby increasing gender inequality. She may also be blamed for ‘bringing HIV into the family’, as a woman is often tested before her partner because of HIV testing offered at antenatal services, and women’s greater health seeking behavior; she may face violence or expulsion as a result. Furthermore, when family members fall ill, girls are most frequently pulled out of school when money runs short or caregiving is required, leaving them at a disadvantage for the rest of their lives.

3. Gender inequality influences the effectiveness of efforts to control the HIV pandemic
   Gender inequality may have a negative influence on HIV prevention and treatment efforts. For example, when women do not have sufficient information, financial resources or autonomy to decide to access those services, the effectiveness of the program is undermined, and their rights to prevention and treatment are not being upheld.

4. The HIV pandemic and the interventions in response may either exacerbate or mitigate gender inequality
   The pandemic also has the potential to influence overall gender inequality, either positively or negatively. For example, women, and particularly sex workers, are often seen as ‘vectors’ of the disease and subject to multiple forms of discrimination, while fear of infection may cause men to seek increasingly younger women in the belief they are less likely to be HIV infected. On the

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20 To note that this section summaries the UN Women paper and does not include other elements that could reasonably fit within these categories.
other hand, *The Fourth Decade* states that some believe that the widespread promotion of adult male circumcision could lead men to believe that they are protected and have no need to use condoms, which could put women at further risk of infection through unprotected sex. The paper also envisages a more optimistic scenario: one in which the response itself fosters a transformation to greater equality as a means to reversing the pandemic, mitigating its harmful effects, while also promoting rights.

This review uses the UN Women model as the principle framework of analysis, with the desk review structured according to *The Fourth Decade* paper. While using this as a framework, we are not bounded by the detail of the paper, and we acknowledge that there are many other important analytical frameworks. Our thinking and this review have also been influenced by a number of other approaches, for example, WHO states that “... gender-transformative interventions are a more sophisticated set of approaches that not only recognize and address gender differences but go a step further by creating the conditions whereby women and men can examine the damaging aspects of gender norms and experiment with new behaviors to create more equitable roles and relationships.”21 In addition, the International Planned Parenthood Federation further notes five key principles of gender-transformative programming:

1. Build equitable social norms and structure;
2. Advance individual gender-equitable behavior;
3. Transform gender roles;
4. Create more gender-equitable relationships;
5. Advocate for policy and legislative change to support equitable social systems.22

It is important to note that in the context of HIV, and also SRHR, gender-transformative programming needs to work with men and boys as key partners who play a vital role in transforming gender responses. Efforts to address men and boys must be linked to collective strategies that support women and girls, and so this review maintains a sharp focus on advancing women’s rights, while recognizing that gender is not a simple construct.

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5. RESULTS

The UN Women paper *The Fourth Decade* not only explores the four pathways through which gender and HIV interact, but also presents ten key areas of action to be taken in response to the HIV pandemic.\(^2\) The key areas of action are divided into three groups:

1. Actions that fosters an environment that supports improved outcomes for women;
2. Actions that address direct needs arising due to the HIV pandemic, which have a gender dimension; and
3. Actions that address the most significant underlying structural gender inequalities that fuel the HIV pandemic.

These key areas of actions prove a useful entry point for assessing the breadth and extent of country level implementation of the gender-related activities in Global Fund programs in line with the directions set in the GES. Furthermore, in the last two decades, different programs and research have shown that improving the health and well being of adult and young women also requires engaging men and boys in efforts to address gender equality. Therefore, ‘male involvement’ is added as eleventh key area of action. This chapter uses this structure to provide a review of actions in Global Fund supported activities that contribute to gender responsive programming in nine countries, and provide examples of how the Global Fund’s GES is being put into action.

5.1 Actions that create a supportive environment

*Action 1: Creating an environment that supports improved outcomes for women and gender equality*

The environment in which actions are taken is an important factor for their success. Making sure that women are well informed of their rights, are able to access health care services and to participate effectively in decision-making are among the most important of these. A supportive environment further means the engagement of the right people, especially women living with HIV, and backed by supportive policies, in an atmosphere of tolerance and understanding.

This section reviews in detail evidence of how a supportive environment can be created by engaging gender experts in HIV decision making; engaging women living with HIV on decision making bodies, such as the CCM; ensuring policies are supportive to women’s human rights; reducing stigma and discrimination; and ensuring that planning and monitoring are gender responsive.

1. Engaging gender experts in HIV decision making
   
   One of the countries considered in this desk review, South Africa, included actions in its proposal that ensure the involvement of a gender expert in the delivery of Global Fund

\(^2\) UN Women (2011). *The 4th Decade of women and HIV. The role of gender equality in reversing the HIV pandemic.*
programs. The action involved the appointment of a gender consultant to organize capacity building for gender focal points who will organize training in their SRs and improve gender programming. It is not clear from the proposal whether this gender consultant is supposed to be male or female or what qualities s/he should have.

Implementation
This activity is not reflected in the performance framework, but does follow through in the budget and appears to cost $9,000.

2. Women living with HIV on decision making bodies
One of the countries reviewed included actions that ensure that HIV-positive women are involved in decision-making. Cambodia describes in its proposal that the “HIV/AIDS NGO Working Group” includes the “National Community of Positive Women” and other non-health community interest groups to more strongly represent the voice of women living with HIV. As a national collective group, it is expected to have the capacity to address bottlenecks in programming, create a bridge to policy and use strategic information from its membership particularly in regard to key populations and in support of OVC.

Implementation
This action is not reflected in the performance framework or summary budget. This does not mean that women living with HIV were not included, but we could find no evidence in the documentation that they were.

3. Supportive policy environment
Ensuring a supportive policy environment means that policies and regulations support, rather than violate, women’s human rights and do not present obstacles to effective HIV prevention, treatment, care and support. There was a strong emphasis on actions to build supportive environments, with six of the nine countries reviewed including actions in their proposals that contribute to either a supportive policy environment or an enabling institutional environment.

Examples of actions that ensure a supportive policy environment include:
Lesotho: building knowledge to support evidence-based policy development;24
Zambia: conducting stakeholder workshops for gender responsive training and awareness with respect to relevant policies;
South Africa: developing policy on medical abortion; Developing policy and guidelines on VCT in pregnancy; Strengthening M&E capacity for and implementing national OVC programs;

24 The proposal adds that this activity supports efforts to widen the base of information necessary to facilitate informed policy development and demonstrate the impact of interventions. It is also essential for the development of a strong BCC program and to facilitate the development of targeted strategies and interventions aimed at those most at risk as very little research is available on specific population groups (including SWs) or on the drivers of the epidemic in the country (intergenerational and transactional sex, concurrent relationships, and so on)
Tajikistan: informing decision and opinion-makers on their role in responding to the HIV epidemic;

Cambodia: conducting case management visits by Ministry of Social Affairs, Vocational Training and Youth Rehabilitation social workers to children in foster and kinship care building and reintegration activities that target at-risk mothers; strengthening multi-sectoral technical working groups, civil society, especially CBOs, and the National AIDS Authority to ensure the supportive environment for enhancing linkages between key components of the proposal (MSM, IDU, OVC, SW) and policy and decision-making for scaling up action;

Armenia: organizing workshops, training-seminars and study tours for decision-makers, as well as for medical services providers aimed at raising their level of knowledge and building skills to expand the response to HIV and ensure its continuity.²⁵

**Examples of actions that ensure an enabling institutional environment include:**

Tajikistan: educating the general population on methods of prevention and the importance of supporting PLHIV; holding national and regional training workshops on vulnerability of women and girls to HIV for Committee of Women and Family Affairs and local CSOs;

Lesotho: strengthening the capacity of local community-based initiatives to improve health promotion (including gender sensitization, SRHR, STI and HIV) and link to and support youth resource centers; creating awareness among women and girls of a Sexual Offences Act and a Legal Capacity of Married Persons Act; providing training to local level authorities on legal and human rights protection and stigma reduction;

South Africa: BCC to communities to change social norms and acceptance;

Zambia: conducting stakeholder workshops for gender responsive training and awareness with respect to relevant policies; conducting regular gender sensitive organizational policy and program reviews;

Cambodia: Strengthen Ministry of Social Affairs, Vocational Training and Youth Rehabilitation staff to ensure that institutional care reaches a minimum standard of quality care and to promote and support community-based alternatives such as adoption, family, foster, and kinship care; providing performance based salary incentives to staff at both national and provincial levels to address problems posed by current shortages of skilled personnel; Supporting the “Women's Health Network” to enable peer educators and NGO workers to meet together and share work experiences.

**Implementation**

One of these actions, from Lesotho, is reflected in the budget, i.e. building knowledge to support evidence-based policy development, and amounting to $165,307 or 0.7% of the total budget for phase one.

4. **Reduce Stigma & Discrimination**

Stigma and discrimination are major constraints to effective responses to AIDS and have

²⁵ Activity is part of Behavior Change Communication SDA - most-at-risk populations. HIV activities will be implemented among IDUs, SWs, MSM, prisoners, the mobile population, aimed at raising their knowledge about HIV prevention and forming safer behavior.
substantial impacts on many spheres of the lives of people living with HIV, affected by HIV and at risk of HIV. Given that women, especially women living with HIV, are treated differently from men in some societies, the impact of HIV-related stigma and discrimination may reinforce further economic, educational, cultural, and social disadvantages and unequal access to information and services. Negative community and family responses to women with HIV include blame, rejection, and loss of children and home. Equally, in many settings, men are blamed for heterosexual transmission due to assumptions about male sexual behavior, such as multiple sexual partners.

All proposals recognized the importance of addressing stigma and discrimination, and included a relatively high number of actions. Tajikistan, for example, offers a three-prong approach to lower stigma and discrimination: 1) advocacy efforts to educate policymakers on HIV issues and promote promote new workplace legislation for adoption; 2) educational training sessions for opinion-leaders including religious leaders, community leaders, journalists and women’s associations to ensure that they have a better understanding of HIV and their role in ending discrimination; and 3) mass media campaigns to reach the general population, showing them that they, too, have a role to play in addressing HIV simply by being informed and supporting those already living with HIV. Most activities that address stigma and discrimination in the proposals of the nine countries generally do not have a specific, differentiated focus on women or gender equality, except for a number of activities of six countries.

Examples of activities addressing stigma and discrimination include:

- **Tajikistan**: Conducting workshops on HIV, prevention, and the role of religious leaders, mass media and law enforcement officers in decreasing stigma and discrimination towards vulnerable groups, vulnerable women and PLHIV;
- **Armenia**: conducting preventive activities and stigma reduction activities for sex partners of people who use drugs;
- **Zambia**: supporting advocacy on human rights and promotion of positive living and dissemination of gender sensitive messages against discrimination and stigma;
- **DRC**: including anti-discrimination and anti-stigmatization messages in mass-media campaigns and targeting the most vulnerable groups (such as young people, women, orphans, out-of-school children or child soldiers);
- **Lesotho**: Hold sensitization sessions to improve the knowledge and skills of women and girls with regard to legal and human rights protection and to address stigma and discrimination in communities;26
- **South-Africa**: Capacity building to address stigma, run by training organizations and service providers working with sex workers.

**Implementation**

Three countries allocated budget to addressing stigma and discrimination, while only one

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26 This country indicates women and girls as one of the target populations regarding its stigma reduction activities.
country included an indicator in its PF related to this item:

i. Lesotho ensures activities related to stigma and discrimination follow through in the PF, which includes an indicator to measure “sensitization to improve human rights literacy of women and girls and to address stigma and discrimination in communities”. Budget allocated to addressing stigma and discrimination was $158,217 or 0.6% of total budget for phase one.

ii. Tajikistan allocated budget to several actions to reduce stigma and discrimination\(^27\) amounting to EUR 59,825,23 or 0.6% of total budget for phase one.

iii. Jamaica allocated $316,064 or 1% of the total budget for phase two to identify and report acts of discrimination and ensure redress for PLHIV and those affected by HIV.

5. Planning & monitoring

Two of the countries reviewed included actions to ensure that national M&E frameworks are gender responsive. In Zambia, this included “conducting sector and sub-sector specific gender sensitive cost/benefit analysis of the HIV response”; and “conducting assessment reports on the national biological behavioral and social surveillance on gender and HIV”. In Tajikistan, this included the “development of the capacity of national, regional and district health departments to plan, implement, monitor and evaluate PMTCT programs”.

Implementation

These actions are not reflected in the performance frameworks or summary budgets.

5.2 Actions that address direct needs that have a gender dimension

Actions that address direct needs of women and girls (and men) fall mainly into the behavior change and biomedical areas; these include services, research, and other efforts that aim to directly prevent, treat or improve the consequences of HIV. For example, PLHIV should be able to access HIV services that provide non-judgmental and comprehensive HIV information, and HIV testing, care, support and treatment. To make these services responsive to the particular needs of women they should include, for example, voluntary and confidential couples counseling, mobile services or child care facilities to accommodate mothers accessing treatment services, and youth-friendly services.

\(^27\) These actions include: Hold national and regional training workshops on the vulnerability of women and girls to HIV for the Committee of Women and Family Affairs and local CSOs amounting to EUR 25,097.20; Conduct trainings on HIV and AIDS, prevention and the role of the mass media in decreasing and discrimination towards vulnerable groups, vulnerable women and PLWH amounting to EUR 23,871.00; Conduct trainings on HIV and AIDS, prevention and the role of law enforcement officers in decreasing stigma and discrimination towards vulnerable groups, vulnerable women and PLWH amounting to EUR 23,871.00; Conduct training on HIV and AIDS, prevention and the religious leaders in decreasing stigma and discrimination towards vulnerable groups, vulnerable women and PLWH amounting to EUR 9,178.23; Conduct training workshops for medical specialists on stigma and discrimination and creating a non-judgmental environment in the health service sector amounting to EUR 56,776.40.
This section reviews in detail evidence of how interventions can deliver quality, gender-sensitive care through direct services including education, counseling, testing and treatment, through prevention programs, prevention of vertical transmission, treatment, care and support.

**Action 2: Ensuring that HIV prevention and treatment interventions provide quality, gender-sensitive care that includes education, counseling, testing and treatment**

1. **Prevention**
Women and girls may face multiple discriminations due to age, class, ethnicity, HIV status, their profession or sexual orientation, and this may complicate access to prevention information and health services. All nine proposals included HIV prevention activities that addressed women and girls.

<table>
<thead>
<tr>
<th>Examples of prevention activities provided in the proposals can be divided into:</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>A) Actions specifically directed at key populations, such as:</strong></td>
</tr>
<tr>
<td>Tajikistan/ Lesotho/ Zambia: prevention interventions and community outreach to key populations including SW, male migrants and their wives, herd boys and vulnerable women28;</td>
</tr>
<tr>
<td>Tajikistan: establishing friendly clinics and several mobile medical units, specifically designed to provide basic medical services for the “most difficult-to-reach” SWs; increasing access of SW and female IDUs to a wide array of HIV/STI prevention, health, psycho-social, legal and support services at a number of different service delivery points;</td>
</tr>
<tr>
<td>DRC: mobilizing PLHIV and other community liaisons for their involvement in raising awareness in women and their families; Procuring male and female condoms, making them more available and accessible (through distribution at e.g. car parks, residential sites, areas where sex workers work);</td>
</tr>
<tr>
<td>South Africa: outreach to provide safer sex materials – male and female condoms, lubricants – and health awareness and risk-reduction techniques for SW;</td>
</tr>
<tr>
<td>Ghana: distribute condoms and lubricants to MSM and SW through existing peer outreach programs; Train peer educators among female porters (kayaye); Train and community peer educators for key populations - PLHIV, MSM, SW, young girls and boys;</td>
</tr>
<tr>
<td>Cambodia: running drop-in centers and/or safe spaces for entertainment workers; Conducting outreach and peer education on HIV prevention, care, support and AIDS treatment for entertainment workers and their clients in targeted sites; Addressing the different needs of SW and their male clients through BCC messages and addressing low levels of condom use with “sweethearts”, developing video spots on male sexual health and HIV prevention in “sex cafes” where MSM buy or sell sex; Improving access to health care treatment for SW; counseling on survival skills, positive living, discrimination, palliative care and bereavement, preparing wills and properly rights for survivors;</td>
</tr>
<tr>
<td>Jamaica: Promote female condom for SW and selected target groups; Outreach HIV and STI testing for SW;</td>
</tr>
</tbody>
</table>

| **B) Prevention activities focusing, e.g. on the environment or women in general, such as:** |

28 Proposal does not explain what is meant by “vulnerable women”.

Tajikistan: access to counseling, informational materials specific to the needs of women, peer-counseling, self-help groups, etc. through service delivery points; Client management approach for women to undergo a confidential consultation with a social worker who can lead them through the complicated healthcare system; Providing group counseling on SRHR issues to groups of vulnerable women in rural areas by supporting a medical outreach team;

DRC: Researching, developing and distributing gender responsive mass media for prevention communication;

Zambia: Scaling up CT sites by reviewing and printing engendered CT materials and guidelines; Community outreach including capacity building, training for peer educators and of trainers, youth, other community groups and traditional leaders, including strengthening community-based service delivery model for women in fishing communities, the inclusion of parent and elder fora in human rights and gender issues with the aim to reach young people 15-24 years with BCC messages and life skills; Design and implement gender responsive health promotion campaigns including those aimed at the youth;

Ghana: Train peer educators within key populations (MSM, SW, non-client partners of SW, PLHIV) to incorporate CT within their outreach practices; Procure and distribute male and female condoms in the public/private and NGO sector including community- based distributors for dual protection; Design and produce culturally appropriate materials on SRHR and HIV; Establish drop-in/resource centers that provide IEC, STI services, CT and community mobilization for SW; Support group meetings for SW who are living with HIV to encourage positive health, dignity and prevention;

Jamaica: Engaging trained community leaders from low-income communities to serve as peer “influentials” in their communities to instill self-efficacy, parenting skills, risk reduction and gender roles; Outreach testing in places where people meet sexual partners (entertainment and sporting events); Produce low literacy gender sensitive materials; national Business Council to produce material on gender roles and expectations, debunking myths relating to HIV transmission;

South Africa: HIV outreach to women entrepreneurs in beer/liquor trade; providing HIV testing and counseling specially for women who have been subjected to sexual violence and abuse;

Lesotho: Developing and distributing materials to address HIV risk reduction within multiple and concurrent partnerships focusing primarily on men and women between the ages of 15 and 49, with special emphasis on young women 15 to 24.

C) Bio-medical prevention interventions in particular PEP (post exposure prophylaxis) for women:
Zambia: scaling up post-exposure prophylaxis (PEP) and building capacity within and outside of the health workforce through review of existing guidelines and their dissemination, the procurement and distribution of PEP kits, training of police officers to deal with survivors of sexual violence, and training of health care providers who administer the kits;

DRC: Making PEP kits available and training for the care providers on prophylaxis measures;

Cambodia: Strengthening referral mechanisms for entertainment workers to access OI prophylaxis and treatment services; Providing and improving STI case management at targeted clinics (‘family health clinics’) for high and low risk populations and providing performance-based incentives to their staff.
Implementation
Assessing the level of implementation of gender responsive programming with regard to the above-mentioned prevention activities can be difficult, as most activities are not disaggregated by sex in the PF or budgets. For example, while six countries allocated money to condom distribution, they do not all distinguish between male and female condoms. Items included in the PFs and/or budgets that include a focus on women and/or gender equality include:

1. **Armenia, Tajikistan** and **South Africa** included indicators in their PF that measure the number of SW reached with HIV prevention programs;
2. **Armenia** allocated EUR 82,362 or 1.5% of grand total for phase one to condom distribution. According to the PU/DR, the target of 92% for female SW reporting the use of a condom with their most recent client was exceeded by 0.9%. Regarding the indicator “VCT services provided to MARPS, including female SW”, the PU/DR reports that the target was achieved by only 46%. According to the PR, such a low achievement was due to the fact that a) the government PR was not able to renovate/establish HIV testing laboratories in 4 regional military hospitals, therefore, no VCT has been provided among military personnel, and b) while this indicator was reformulated as not cumulative, the size of the target was not adjusted to the potential number of beneficiaries and remained too ambitious;
3. **Cambodia**’s PF included an indicator to measure the number and percentage of entertainment workers (brothel-based and non-brothel based) reached with outreach peer education activities, but did not allocate money to this item;
4. **DRC** included the indicator “percentage of young men and women aged 15-24 who report having used a condom during their last sexual intercourse”, and allocated $346,007 or 2% of total budget for phase 1 to condom distribution;
5. **Ghana**’s PF included an indicator to measure the number of female and male condoms distributed to the general population as well as to MARPs and vulnerable groups. The PU/DR stated that the target for distribution of male/female condoms to the general population by one of the five PRs was met by 87% thereby exceeding the semester's target. However, the percentage of female condoms distributed was 0.09% of total condoms distributed while the target was set at 1%. In addition, the target for distribution of male/female condom among MARPs and vulnerable groups was met by 58%. The low performance was due to: 1) Recent negative media hype about MSM, which has contributed to low condom distribution among the target population. 2) Competition among implementing partners in the distribution of condoms to MARPs and vulnerable groups 3) Clients complaints about poor quality of condoms. The PU/DR further stated that the number of male and female condoms distributed to the general population by a second PR was 33% and that the initial delay in procuring health products continues to hinder the progress of the program;
6. **Jamaica** included in the PF indicators “to measure the number of SW currently reached through prevention activities”; and the “percentage of SW that has received an HIV test in the last 12 months and who know their results”. The PU/DR stated that the number of SW reached through prevention activities was 164%, but that the completed sex work study (August -December 2011) revealed dozens of new venues where sex work occurs. With
these new venues documented, the BCC team and SRs were able to reach 5,070 female SWs. Jamaica’s budget includes budget lines to increase gender sensitive prevention services for vulnerable populations, including SW and high risk persons, at selected sites (club, bars, restaurants, bus terminals, malls, plazas, street) amounting to $3,172,679 or 12% of total budget for phase two; and to increase access to gender sensitive HIV counselling and testing amounting to $640,320 or 2% of total budget for phase two;

7. **Lesotho**’s PF included an indicator to measure the number of SW, migrant workers and herd boys reached through goodie bags\(^{29}\) that will be distributed through mobile clinics placed at the border posts. The budget included the item: developing materials to address HIV risk reduction within multiple and concurrent partnerships amounting to $ 1,506,126.15 or 6% of total budget for phase one. Lesotho also allocated $131,188 or 1.2% of grand total for phase one to condom distribution. The PU/DR states that at the end of phase one the Condom Policy had yet to be completed due to lack of capacity in the Ministry of Health and Social Welfare (MOHSW)\(^{30}\). The MOHSW has sought technical support from UNFPA. $18,165 or 0% of grand total for phase one was budgeted for printing and distributing of information on PEP. However, according to the PU/DR 49% of the budget was not spent on printing and distributing information on PEP, because the MOHSW did not print additional materials due to insufficient stock ready for distribution;

8. **South Africa**’s PF included an indicator to measure the number of peer educators, traditional leaders and SWs trained. The PU/DR stated that the number of SW reached was 97%, hence an underachievement of this target by three percent. Reasons included unrealistic targets, a monitoring system that did not capture all calls, the need for more marketing, and the need for quality control of counselling services. The budget included a budget line on scaling up prevention programs for MARPs, including SW, amounting to $465,770 or 3% of total budget for phase one;

9. The PF of **Tajikistan** included an indicator to measure the “number of migrants and vulnerable women reached by peer educators and/or receiving HIV education” and allocated EUR 901,839.51 or 9% of the total budget for phase one to this objective. The budget further reflected the following items: reducing high-risk sexual and injecting behaviours among populations most vulnerable to HIV infection including people who inject drugs, prisoners, and SW amounting to EUR 2,003,790.70 or 20% of the total budget for phase one\(^{31}\), and supporting 16 ‘Friendly Centres for vulnerable women to provide condom, STI treatment, client management services, and legal support’. No money was allocated to the latter. Tajikistan allocated EUR 56,000 or 0% of the total budget for phase one to condom distribution. The PU/DR indicates that 2,164,278 condoms (86.8%) were distributed to at-risk and vulnerable groups in January-June 2011 by SRs and other supported service providers and that the PR will consider targeting high risk areas like the disco and night clubs to improve this indicator in the future;

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\(^{29}\) Goodie bags are not further explained

\(^{30}\) Reason was that a meeting to develop the policy was scheduled for the second week of September 2011 but the officer was not available as claimed to be busy until Phase I came to an end.

\(^{31}\) Budget allocated to prevention activities among SW amounts to €53,781.12 or 0.5%: Budget allocated for prevention activities among prisoners is €326,555.74 or 3.3%: Budget allocated for prevention activities among people who inject drugs amounts to €1,623,453.89 or 16%. 

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10. **Zambia**’s PF included indicators to measure the number of service providers (i.e. police officers) trained in national standards for infection prevention and in dealing with victims of sexual abuse; and the number of male and female condoms distributed. Zambia allocated $547,649 or 0.8% to condom distribution under the budget line: Procure and distribute female condoms and Noristerat Injectable Contraceptive. According to the PU/DR this target was met by 45%, and the PR distributed mainly male condoms to end-users; the PF also included an indicator to measure the number of health workers trained (including training on PEP and PMTCT) and allocated $46,742 or 0.07% of the total budget for phase one to PEP.

**Prevention of vertical transmission**

Most children with HIV are infected during or after birth. In the absence of any interventions transmission rates range from 15-45%. This rate can be reduced to levels below 5% with effective interventions. UNICEF recommends four programmatic prongs of PMTCT:

1. Primary prevention of HIV infection among women of childbearing age,
2. Preventing unintended pregnancies among women living with HIV,
3. Prevention of HIV transmission from mother to child, and
4. Appropriate treatment, care and support to mothers living with HIV, their children and their families.

There has been weak uptake and coverage of PMTCT services, and in many contexts, women tend to access PMTCT services alone. Efforts are increasing to involve men to provide additional support for women, and to increase men’s knowledge of HIV and HIV testing uptake.

Proposals from most countries included activities to reduce vertical transmission, however we were only able to find evidence in the documents that one country included all four programmatic prongs of PMTCT. This might be because countries do not differentiate prevention activities for the adult population in general from PMTCT activities for women in the reproductive age (prong 1), or ART for those in need by gender (prong 4), or other prongs may be covered by other sources. Only South Africa included activities related to all the four programmatic prongs, but still had a principal focus on pregnant women living with HIV. Six countries included activities addressing PMTCT in their proposals.

**Examples of activities addressing vertical transmission of HIV include:**

DRC: Offering testing to all pregnant women; Organizing a referral and counter-referral system for ART and nutritional support to pregnant women living with HIV; Offering ARV prophylaxis and birthing kits to

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33 To note again that the term “Prevention of Mother-to-Child Transmission” of HIV is seen by some as stigmatizing language that appears to put the burden of responsibility on the woman, and so many prefer to use terms including “Vertical transmission” or “Virtual elimination of paediatric HIV”; we continue to use “PMTCT’ because the term is so commonly used in Global Fund documents

pregnant women living with HIV; Offering pediatric ARVs; actions to involve the partners of women living with HIV in relation to PMTCT, including couples counseling and testing; Cotrimoxazole for children; community education including partners and families on PMTCT and infant feeding.

Tajikistan: Procuring and distributing milk formula for newborns of women living with HIV as a substitute to breast-feeding; training of health personnel on HIV counseling and infant feeding; increasing PMTCT services; provide PMTCT prophylaxis therapy to HIV-positive pregnant women and their newborns.

South Africa: Training of nurses at provincial level on PMTCT; BCC to communities to change social norms and acceptance, including development and distribution of IEC materials for PMTCT; Provision of CD4+ T-cell count testing to pregnant women living with HIV; Supervision and monitoring of patient advocates and nurses trained on PMTCT; Ensuring that a nutritional component is part of PMTCT services and link to other care and support programs; Working with traditional and religious leadership to promote PMTCT in rural communities and informal settlements;

Ghana: HIV prevention & CT at FP service delivery points; Train service providers in PMTCT services; IEC/BCC materials for pregnant women; Establish systems for early infant diagnosis for HIV exposed babies;

Cambodia: routinely referring pregnant women for HIV testing and PMTCT service with support from community-based workers through information sessions, counseling of PLHIV and increased; providing active follow up of mothers with HIV and their infants by home-based care (HBC), making sure that infants are tested on time, referred to pediatric services; Training and supporting HBC teams on infant feeding education promoting exclusive breastfeeding, appropriate weaning and introduction of complementary foods; monitoring infant formula feeding, supporting health care staff.

Zambia: reported in the PU/DR that the target for the number of pregnant women living with HIV assessed for eligibility for ART was met by 37%. The reason for the under achievement was that women attending many PMTCT clinics were still being assessed by CD4 count only. The target number of pregnant women living with HIV receiving ARV to reduce vertical transmission was met by 72% - and the gap attributed to fewer mothers delivering in health facilities due to long distances. Additionally, the distribution of baby-mother packs was implemented late in the quarter. The PU/DR further noted a refresher training for staff on the revised WHO PMTCT 2010 Guidelines was pending due to delayed disbursement of funds.

**Implementation**

Seven countries included PMTCT indicators in their PFs and/ or allocated budgets to this objective:

1. **PF of Armenia** included indicators to measure the number of HIV tests performed among pregnant women; and the number of pregnant women accessing VCT services;

2. **Cambodia** allocated $176,612.61 or 0.75% of total budget for phase one to PMTCT, but did not include items related to PMTCT in its PF;

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35 This activity is also mentioned under Action 8
36 To note that each country established different indicators, and it is not clear from the documentation whether these indicators were designed to measure the impact of the full PMTCT program or simply an element or one or two prongs.
3. PF of DRC included an indicator to measure the percentage of infants born to women living with HIV who are HIV infected. The total budget allocated to PMTCT amounts to $1,307,178 or 6% of the total budget for phase one;

4. In Ghana’s PF, indicators were included to measure the number of pregnant women who were tested for HIV and know their test results; number of pregnant women living with HIV who received ARV to reduce vertical transmission; number of infants born to women living with HIV who received an HIV test within 12 months of birth. The PU/DR (PR MOH) indicated that the target regarding this latter indicator was met by 15% due to late installation of key equipment. The PU/DR added that, nevertheless, those screened revealed that only 6.6% were HIV positive indicating that the country’s PMTCT program is effective. Furthermore, procurement of ARVs for PMTCT was delayed due to late completion and approval of the PSM plan and bureaucracies in the PR’s procurement systems. Budget allocated to PMTCT amounted to $3,635,402 for PMTCT or 13% of the total budget for phase 1;

5. The PU/DR of Jamaica indicated that the number of PCR tests done on infants born to mothers living with HIV according to national standards was met by 120% adding that the performance on this indicator reflects the country’s strong PMTCT program. However, Jamaica did not include activities addressing PMTCT in the proposal, nor is there any indication of core support functions (eg management or human resources) being included. It is stated in the proposal that PMTCT is covered by UNICEF37;

6. Lesotho had budgeted for expanding ART, TB/HIV, PMTCT and pediatric HIV services within nationally accredited private, public, and NGO health facilities activities. However, the budget stated that all activities relevant to that objective are captured in the other activities within the ART SDA, which makes it difficult to calculate the amount specifically allocated to PMTCT;

7. South Africa’s PF included an indicator to capture the number of PMTCT patients supported by patient advocates. The PU/DR explained that the number of people reached through the PMTCT and ART programs by one of the PRs exceeded the target set as a result of the Government increasing the national eligibility threshold criteria for starting ART regimens, which led to increased numbers of people accessing clinics to start treatment. The PU/DR also indicated that the target reached by a second PR was 156% as the indicator was broadened to include the number of patients reached by health care professionals and not only patient advocates so as to better reflect the interventions by all relevant staff members involved. We found only one PR (NACOSA) that allocated $2,754,316 or 16% of total budget for phase one to PMTCT.

8. Tajikistan’s PF included indicators to measure the number of pregnant women receiving HIV tests, results and post-testing counseling in the last 12 months; and pregnant women living with HIV receiving a complete course of ARV prophylaxis to reduce MTCT in accordance with nationally approved treatment protocols. Budget allocated to PMTCT amounts to EUR 75,610.05 or 0.8% of the total budget for phase one;

37 “UNICEF to cover aspects of Prevention of Mother to Child Transmission, and vulnerable children who are orphaned by HIV/AIDS play a significant role particularly in supporting the PMTCT programme and contributes approximately US$250,000 per year and this is expected to be increased in the coming years as more funds become available to the organization”
9. **Zambia** included an indicator to capture the number of pregnant women living with HIV receiving complete course of ARV prophylaxis to reduce MTCT. All PMTCT budget lines amount to a total of $2,859,854 or 4.3% of the total budget for phase one.

2. **Treatment**
Gender-responsive programming also means that HIV testing and treatment with ART and for opportunistic infections are responsive to the particular needs of women and girls. It was extremely hard to find any gender sensitive information on this. Only one country included clear activities in their proposals that described targeting women’s treatment needs.

<table>
<thead>
<tr>
<th>Examples of activities ensuring treatment is responsive to the needs of women and girls include:</th>
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<tbody>
<tr>
<td>Cambodia: Strengthening referral mechanisms for entertainment workers to access OI prophylaxis and treatment services; Providing and improving STI case management at targeted clinics (‘family health clinics’) for high and low risk populations and providing performance-based incentives to their staff.</td>
</tr>
</tbody>
</table>

**Implementation**
While there were a number of related activities identified only one country ensured sufficiently direct actions with follow through in the performance framework and/or budgets to be included in this review:

0. **Tajikistan** allocated EUR 13,321,30 or 0.1% of the total budget for phase one to the procurement of STI medicines for treatment of migrants and vulnerable women.

3. **Care & support**
People living with and affected by HIV need to have access to comprehensive care and support, including psycho-social support positive living messages, nutritional guidance, counseling, and social support, as well as clinical and nursing care when needed. Effective care and support services need to take into account the different needs of men and women. The proposals of several countries include actions to ensure care and support for PLHIV or the chronically ill, but only Zambia included an activity with a clear focus on women and girls, i.e. providing direct support to clients on home-based care (nutrition, toiletries, clothing, shelter, clients referral), with a focus on women and girls.

**Implementation**
Most countries included indicators in their PF or allocated budget to care and support for the chronically ill or PLHIV, but without disaggregating data by sex.\(^{38}\) For example, South Africa includes indicators that measure the numbers of PLHIV receiving community home based care, while Lesotho allocated $1,575,712 or 6.3% of total budget for phase one to care and support for the chronically ill. None of the countries included a specific focus on women or girls in the implementation of care and support activities.

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\(^{38}\) Activities that ensure care and support for OVC are listed under Action 5 (chapter 5.2.4)
Action 3: Integration of HIV and sexual and reproductive health and rights (including maternal health) services for both HIV-positive and HIV-negative women

In most countries integration of HIV services with sexual and reproductive health and rights (SRHR) services may be the only way to reach certain groups of women. Integrating services is also an effective strategy that leverages existing and scarce resources, without placing a burden on health care systems providing the opportunity to also address the reproductive health and family planning needs of a client who visits a doctor for HIV services and vice versa. Ghana, for example, included the promotion of the integration of SRHR and HIV services with emphasis on PMTCT as one of its four main objectives. Zambia included actions to ensure integration of these services using three of the four programmatic prongs of PMTCT as recommended by UNICEF. Proposals of six countries in total included activities to ensure the integration of HIV and SRHR services.

Examples of activities addressing the integration of HIV and SRH reviewed included:

- DRC: systematically offering HIV testing to all people frequenting health care facilities including prenatal consultation services and maternity wards;
- South Africa: increasing coverage and quality of PMTCT services and its linkages with SRHR services; Training ART/ PMTCT ‘supporters/patient advocates’ and service providers to promote adherence to PMTCT and ART treatment regiments; integrating family planning and condom distribution in all ART, VCT and PMTCT services;
- Tajikistan: strengthening the M&E of PMTCT implementation in health and antenatal care facilities, and increasing VCT services among pregnant women;
- Lesotho: Training of existing community SRHR implementers, including community counselors, and mother-to-mother support group members who provide psychosocial support and advocacy for SRHR issues at community level, to incorporate information on HIV and AIDS; Expanding ART, TB/HIV, PMTCT and paediatric HIV services within nationally accredited public, private and NGO health facilities;
- Ghana: Providing SRHR services for PLHIV; Integrate SRHR and HIV services at health service delivery points; Provide SRHR education and services for females living with HIV and their partners; Train community-based youth service providers in integrated SRHR and HIV services including CT; Train uniformed services as peer educators in the integration of SRHR and HIV;
- Cambodia: Enabling the “NGO HIV and AIDS Working Group” to strengthen civil society on a “value added” agenda in support of inter alia integration of HIV and AIDS with SRHR. 39

Implementation

Three countries allocated budget to ensure the integration of HIV and SRHR service for HIV positive and HIV negative women, of which one also included an indicator in its PF.

39 Proposal adds that the NGO Working Group will also be the forum to support the cross-learning between AIDS NGOs and those working on other health issues: non-health NGOs in support of MARPs, and integration of HIV with Health specific NGOs (SRH, TB, MCH DU/IDU), and with those addressing gender and domestic violence issues.
1. **Ghana** allocated $11,997 or 0% to promoting the integration of SRHR and HIV services with emphasis on PMTCT and safe blood transfusion. The PU/DR indicated that some planned training of health workers and community-based service providers as peer educators in the integration of SRHR and HIV including are still outstanding;

2. **Lesotho** allocated budget to the following items, which also follows through in the PF, i.e. developing joint guidelines and training manuals for SRHR and HIV integration and training of health care providers; and expanding ART, TB/HIV, PMTCT and paediatric HIV services within nationally accredited public, private and NGO health facilities. Most of the actions on integrating SRHR and HIV services are included in the budget for SRH, which amounts to $290,260 or 1.15% of grand total for phase one.

3. **Zambia** allocated $679,119 or 1% of total budget for phase one to conducting integrated mobile services (PMTCT, RH, etc.).

   **Action 4: Support household caregivers and home-based care volunteers**
   
The social impact of HIV on caregivers can be enormous. In countries hardest hit, most of the care for people living with HIV takes place in the home, and is usually provided by women and girls. Therefore, expanding support for caregivers and volunteer home-based care (HBC) providers is crucial to prevent the pandemic from worsening gender inequality. Proposals of various countries include actions that ensure support to caregivers, but none of these actions specifically mention women or girls. Activities included in Zambia’s proposal included a gender aspect, i.e. increasing male involvement in HBC activities; and training of HBC trainer-of-trainers (including gender aspects of HIV) and pain management skills.

   **Implementation**

   None of the items mentioned in PFs or budgets have a gender focus. This does not mean there is no focus on girls and/or young women, but this is not clear form the information provided in the documentation.

   **Action 5: Support for adolescent girls and young women who are orphaned or HIV-affected**

   In addition to the large number of children living with HIV, millions more, who are not living with HIV themselves, have been made vulnerable by HIV as their family members and other adults in their lives become ill. In some countries, girls who are orphaned or HIV-affected are likely to be the first to be removed from school to take care of their family members, or forced to work in order to bring extra income into the household. Keeping children, particularly girls, in school is important to deliver a whole range of social and health outcomes (including reducing vulnerability to HIV). In addition, programs also need to ensure support for OVC through adolescence and into young adulthood, as adolescents, and particularly girls, are vulnerable to sexual exploitation and poverty. It is important to disaggregate OVCs by sex, even though this is quite difficult to do in practice. Armenia, for example, indicated most-at-risk adolescents (MARA) as one of the main beneficiaries and included MARA in MARPS. The approach consisted of adding specific activities for adolescent drug users to already existing harm reduction programs, and adding adolescent sex work activities to existing SW programs. Yet, in Armenia’s PF MARA are not sex disaggregated. Three countries included activities
ensuring support for adolescent girls and young women who are orphaned or affected by HIV in their proposals.

**Examples of actions that ensure the support for adolescent girls and young women include:**

Zambia: Provision of direct support to clients on HBC (nutrition, toiletries, clothing, shelter, clients referral, etc.), with a focus on girls and women;

Ghana: Recruit and train young boys, men, women and girls in high prevalence communities using adapted Life Planning Skills model; Train and support out-of-school youth, long distance truck drivers, truck/cart pushers (young males) and ‘kayaye’ (young female porters) as peer educators;

South Africa: Awareness and services for out of school and unemployed girls through workshops discussing sex, sexuality, gender issues and violence, risk situations and behaviors.

**Implementation**

While numerous countries included indicators that measure support to OVC and/ or youth in general in their PF and allocated budget to this objective, no country included a focus on adolescent girls or young women.

**Action 6: Clinical and social science research for women**

Clinical and social research for women includes, for example, research on prevention options for women, (eg microbicides), evaluation of treatment regimes, and research on the structural drivers of the epidemic. Six countries included actions to ensure such research is conducted.

**Examples of actions to ensure research for women include:**

DRC: collecting non-routine information (sero-prevalence among pregnant women, behavioral data e.g. in sex worker’s clients, etc), such as on behavior, the quality of care and treatment and among clients of SW;

Tajikistan: Conducting operational research among people who inject drugs and SWs to evaluate the effectiveness of project interventions;

Zambia: Conducting of gender and AIDS impact analysis in all sectors; Review of the National HIV and AIDS/STI/TB M&E Plan 2006-2010 and incorporation of gender responsive indicators; Documentation of best and harmful cultural and traditional practices;

Lesotho: Build knowledge on specific population groups (including herd boys, uniformed forces, SWs) to support evidence-based policy development; Conducting a situational analysis of cultural and traditional practices to understand gender norms that influence male and female behaviour;

Zambia/South Africa: Conducting operational research on PMTCT;

South Africa: conducting formative research on gender sensitive BCC materials and ensure translations into indigenous languages;

Cambodia: strengthening health systems by allowing for the strategic planning of the national response
Implementation
One country included an indicator in the PF to measure research conducted for women and two countries allocated budget to this action.

1. **Lesotho** allocated S71,000 or 0.3% of the total budget for phase one to ‘conduct situational assessment on cultural practices that treat women and men differently’. The PU/DR indicated there was a late start of the implementation of the situational analysis and that the first draft report was submitted in July 2011; however, as the research protocol was not submitted a validation workshop was pending approval from the committee;

2. **South Africa** included an indicator in the PF to measure operational research conducted on PMTCT;

3. **Tajikistan** allocated EUR 26,903.30 or 0.3% of the total budget for phase one to the implementation of national sentinel surveillance among IDUs, SW, prisoners, pregnant women, STI patients, and migrants.

5.3 Actions that address underlying gender inequities that fuel the pandemic
The third type of actions addresses structural drivers and as such represent a ‘gender transformative’ approach. Gender transformative approaches, not only address the needs, aspirations and capacities of females and males, they also challenge biased and discriminatory policies, practices, ideas and beliefs and attempt to change them. Such transformative approaches should be “inherently rights-based as they include attention to human dignity, the needs and rights of vulnerable groups, and an emphasis on ensuring that health systems are made accessible to all, free from discrimination on the basis of sex and gender roles.”

This section reviews in detail evidence of actions that can address the underlying drivers of HIV among women and girls, including efforts to mitigate the impact of violence against women and girls, to provide education to change gender norms, to improve and enforce legal protections for women, to ensure essential livelihood support, and to support male involvement.

**Action 7: Mitigate the negative impact of violence against women, and reduce level of violence by addressing root causes**
A rights-based response requires interventions addressing violence against women (VAW). In order to reduce VAW, a symptom of gender inequality, it is necessary to also address the root causes of that inequality, which also implies the involvement of men. Numerous actions to address VAW are reflected in proposals of six of the nine countries.

**Examples of activities addressing VAW include:**
- DRC: addressing sexual violence through educative material and local communication activities;
- Tajikistan: Providing legal and psycho-social support for vulnerable women through the provision of sub-

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三个方面包括指标，用于衡量受影响的女性数量；

莱索托：将 GBV 和 HIV 模块整合到警官和民间社会培训课程中；

赞比亚：举办研讨会和研讨会，让男性参与 GBV 和 HIV 问题；解决 HIV 测试和咨询服务，为受性暴力影响的人提供，这将被整合到其他支持 GBV 受害者的服务中；为妇女、女孩和男孩提供庇护所，他们因 GBV 而遭受暴力，且经历过暴力，需提高性侵犯和性暴力事件的法庭支持；

南非：让男性、传统和宗教领袖参与，减少传统有害实践和 GBV；与政治领袖、传统和宗教领袖合作，参与；参与正式定居点和酒馆（以及高迁移人口在农村社区）的 GBV 和 HIV 工作坊和研讨会；将 GBV 和 HIV 模块整合到警察和民间社会项目中；为受到 GBV 影响的妇女、传统和宗教领袖减害；

柬埔寨：认识到在其提案文本中性别权益和 GBV 是一个问题，但并没有将其认识到具体行动。

**实施**

三个国家包括在 PF 和/或分配预算以应对 VAW：
1. **莱索托**分配了预算给以下两个项目，其未反映在 PF：
   - 开发 GBV 和 HIV 整合的指南和课程，预算总额为 33,920 美元，占总预算的 0.1%，用于警察培训项目。根据 PU/DR，由于技术援助的获取及规定，程序的章程比预期更长。结果，培训被重新安排，开始时由于缺乏资金；
   - 《南非》的 PF 包括一个指标，用于衡量受到 GBV 影响的女性数量，她们接受过支持性咨询服务。PU/DR 显示，这个目标已达到 122%。超过目标的原因是，受影响的妇女数量很难控制，因为 SR 有一个开放政策，意味着所有的女性在申请时都会获得咨询服务。南非分配了预算用于减少 VAW 在预算线：通过行为改变项目，为处于 HIV 风险的女性提供 HIV 防治，包括受 GBV 影响的女性和通过职业，预算总额为 488,919 美元，占总预算的 3%；

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41 这项活动也提到 Action 11
3. **Zambia** included in the PF an indicator to measure the number of service providers trained in PEP to deal with victims of sexual violence or abuse and allocated $46,742 or 0.07% of the total budget for phase one to PEP\(^42\).

**Action 8: Provide gender, sexuality and HIV education to change gender norms and foster mutually respectful and healthy relationships**

It is important that programs not only provide information on HIV and equitable opportunities for girls and women, but also contribute to changing attitudes and beliefs about the human rights of women. This includes shifting gender norms, which appear to be one of the strongest social factors that influence sexual behavior. This makes the involvement of men and boys imperative - but it is not always clear from the proposals that they are. Actions that ensure the provision of gender, sexuality and HIV education are reflected in the proposals of four countries, though not always with the specific aim to change gender norms.

**Examples of actions to ensure the provision of gender, sexuality and HIV educations include:**

DRC: distribution of educative material, conceived through collaboration with basic communities and produced in national languages, focusing in particular on the promoting of low-risk sexual behaviors, RH, and addressing discrimination and stigmatization as well as sexual violence; Develop, produce and distribute healthy life-style education material for students and student teachers on HIV prevention and response education;

Lesotho: developing a series of participatory community dialogues on sensitive issues (including gender norms, GBV, and forced sex in school) for women and girls, mixed groups, men and boys;

South Africa: targeting men through education and awareness sessions to reduce GBV and harmful traditional practices among informal settlements and beer taverns and highly migrant population in rural communities\(^43\); BCC to communities to change social norms and acceptance, including development and distribution of IEC materials for PMTCT\(^44\);

Ghana: Establishing school based SRHR/ life skills/ HIV programs to support the school ALERT program\(^45\), while also giving added emphasis to issues of gender equity and harmonious family and community relationships; Training colt football clubs to disseminate SRHR and HIV information to facilitate behavior change; Engaging people in VCT through educational theatre involving knowledge, stigma reduction, sexual risk-reduction, transmission modes; providing BCC in communities and schools to address socio-cultural beliefs, attitudes and practices that promote and sustain gender inequality as well as forums in which gender-specific information about HIV transmission and prevention can be disseminated.

**Implementation:**

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\(^42\) This budget allocation is also mentioned in the implementation section under action 2 (10, pp. 23)

\(^43\) This activity is also mentioned under Action 11

\(^44\) This activity is also mentioned under Action 2a – prevention of vertical transmission

\(^45\) The ALERT Model seeks to reach teachers, schools and the community, hence the three ‘pillars’ of the ALERT Model: Teacher–Led Pillar, Child–Led Pillar and School community–Directed Pillar. It involves pre-and in-service training of teachers and training of students as peer educators as well as monitoring and certification of schools. Once the school has implemented a certain minimum package of interventions it raises its level of HIV response to a state of ‘ALERT’
Five countries included items that ensure HIV education to change gender norms in their PFs, while only two ensured such items followed through in the budgets:

1. The PF of DRC included an indicator to measure the percentage of young men and women aged 15-24 who both correctly identify ways of preventing the sexual transmission of HIV and who reject the major misconceptions of HIV transmission\(^{46}\);

2. Jamaica’s PF included indicators to measure the number and percentage of schools with at least one teacher trained in life skills based Health and Family Life Education (HFLE) and who taught it in the last year; and the number of students reached through HFLE interventions in schools. Jamaica allocated $1,231,406 or 5% of total budget for phase two to improving access to gender sensitive, age appropriate HIV, SRH information and services for adolescents (ages 10-14) through the delivery of HFLE;

3. Lesotho included as one if its outcome indicators the percentage of women and men aged 15-49 expressing accepting attitudes towards people with HIV. According to the PU/DR, the average performance on this indicator was 37% with the percentage of women showing accepting attitudes of 42.3% and the percentage of men of 32.2%, while the target was 90%. The PU/DR adds that, nevertheless, significant progress was made compared to the 2004 baseline information on this indicator.

4. Tajikistan allocated EUR 171,827.60 or 1.7% of its total budget for phase one to developing, producing and distributing healthy life-style education (LSE) material for students;

5. Zambia included in the PF an indicator to measure the number of 15-24 year olds (in-school and out-of-school) who receive life skills based HIV education including peer education.

**Action 9: Improve and enforce legal protections for all women, including those living with HIV**

Most countries have adopted international agreements that ensure gender equality and the rights of PLHIV. However, in many countries there remains a gap between policy and practice and even where legislation is present, lack of knowledge and enforcement often render it meaningless. Hence, the below actions seek to ensure that women’s inequality is not worsened by their own or their partners’ HIV status and to establish equality under the law and reduce vulnerability to infection. In a number of proposals, legal support consists of, for example, removing legal, social and cultural barriers to effective HIV interventions, protecting the rights of people living with or at risk of HIV or strengthening workplace policies (WPP). Also, legal support is often aimed at reducing stigma and/or discrimination. However, such actions are often not sex disaggregated, which makes it difficult to assess the gender dimension of these activities. Four countries have items included in their proposals that ensure legal support for women and other vulnerable people.

**Examples of activities that ensure legal support for women, among others, include:**

- Lesotho: Holding sensitization sessions to improve the knowledge and skills of women and girls with regard to legal and human rights protection, including by supporting the national Federation of Women’s Lawyers to scale up its efforts to create awareness among women and girls of the provisions of the Sexual Offences Act 2003 and the Legal Capacity of Married Persons Act 2006;

\(^{46}\) This action is also mentioned under Action 5
and materials to address legal and ethical issues raised by HIV specific to the country’s legal, cultural and social environment. Also, this country mentions a focus on women and girls as caregivers through workplace and community programs in the main text, but has not translated this into activities.

Armenia: Legal counseling to IDUs, SWs, MSM, MARA and PLHIV;

Tajikistan: providing a comprehensive service package including legal support for people who inject drugs and SWs; Providing legal and psycho-social support for vulnerable women through the provision of sub-grants to women’s centers on the grounds of local NGOs;

South Africa: Providing HIV testing and counseling services including socio-legal services to people affected by sexual violence; Support micro small and medium companies to develop HIV workplace policies, in which gender-equity is mainstreamed.

Implementation
Lesotho’s PF included an indicator to capture the number of sensitization sessions held for communities and families on legal and human rights of women and girls. Under the Stigma Reduction in All Settings SDA, Lesotho included the budget line ‘Hold sensitization sessions to improve knowledge and skills of women and girls with regard to legal and human rights protections’. Therefore, the various budget lines belonging to this SDA are placed under action 1d in this analysis.

Action 10: Ensure education and essential livelihood support
Girls and women who are struggling for the basic necessities of life such as food are more likely to be vulnerable to abuse and may turn to transactional or commercial sex, thereby increasing their HIV risks. Programs need to enhance women’s ability to earn money and provide livelihood support such as food aid and/or cash transfers to the extremely poor. These programs need to be tailored to the age and specific circumstances of these girls and women and ensure that they do not unintentionally increase women’s task burden. Three of the countries have included actions that ensure education and livelihood support.

Examples of actions that ensure education and livelihood support include:
Zambia: providing training to mainly women and girls in entrepreneurship and business skills;

DRC: ensuring nutritional support to PLHIV and their households;

Cambodia: Providing various trainings (including vocational training for older OVC) and links to income-generating activities and microfinance institutions to families; providing socioeconomic reintegration.

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47 To illustrate, in 2006 Lesotho passed the Legal Capacity of Married Person’s Act that provided equal status to married women, who had previously been considered minors under customary law. This alone has the potential to lead to a considerable improvement in the way women are treated as regards inheritance. However, although the legal framework may be moving in the right direction, this is a recent change. Traditionally women have been treated as minors not just legally, but socially and culturally; and, with cultural and societal values so deeply entrenched, change is likely to be slow. In addition, common law practices (polygamy, lobola, some practices in rural communities, and others) still exist.
Implementation
These actions did not follow through in performance frameworks or budgets.

Action 11: Supporting male involvement
It is often overlooked that cultural expectations and beliefs of what it means to be a man shape many of the attitudes and behaviors that fuel the HIV epidemic. Examples are: multiple and concurrent partnerships, viewing SRHR as a woman’s issue, limited health-seeking behaviors, no or inconsistent use of condoms, and homophobic attitudes. These behaviors and attitudes interact with structural factors such as poverty and increase men’s vulnerability to HIV. For example, men who migrate for work and spend long periods of time away from home may be particularly vulnerable to HIV. At the same time, men can have a major influence on women’s access to health services as, for example, in some parts of the world, men are more likely to be in control of economic assets and resources. Therefore, the international community, including the United Nations, has come to recognize the importance of a gender perspective and engaging men and boys in programs to address HIV. For example, according to the UNAIDS Agenda for Accelerated Country Action for Women, Girls, Gender Equality and HIV: “Men must work with women for gender equality, question harmful definitions of masculinity and end all forms of violence against women and girls. Men’s responsibility for children and the care of their families is key to HIV prevention work, as is their involvement in mitigating the effects of the epidemic. Changes in the attitudes and behaviors of men and boys, and in unequal power between women and men, are essential to prevent HIV in women and girls.” It is important to understand how social constructions of gender, including masculinities, put both women and men at risk of HIV as well as how these constructions can be transformed using rights-based approaches.

1. General engagement
As much data in the nine proposals and grant agreements is not sex disaggregated it is not always easy to assess to what extent men and boys are being involved. Some activities focus, for example, on “partners of MARPs”, without clarifying whether those are male or female partners. On the other hand, Ghana’s proposal, for example, stated that prevention programs were designed to both inform men, boys, women and girls of gender inequalities and make them amenable to concrete action. Seven countries have included actions specifically involving men in their proposals.

Examples of activities addressing the general involvement of men and boys include:
Lesotho: developing and distributing materials to address HIV risk reduction within multiple and concurrent partnerships focusing primarily on men and women between the ages of 15 and 49; developing a set of community dialogues on behavior change for men and boys;
Zambia: increasing male involvement in HBC activities; Conducting workshops and seminars on male

48 In many countries the gender balance of drug users is such that the majority of partners would be women, but this is not inevitable and local data is essential to capture gender aspects accurately.
involvement for GBV and HIV;

South Africa: targeting men through education and awareness sessions to reduce GBV and harmful traditional practices among informal settlements and beer taverns and highly migrant population in rural communities; Developing strategies to involve male partners in decisions regarding safer sex and optimal infant feeding;

DRC: testing and the counseling of couples and partners;

Cambodia: Supporting a male sexual health website and a phone hotline ensuring that “hidden” MSM who are concerned about stigma and discrimination can access information without disclosing their identity and sexual preference;

Ghana: Training of and supporting out-of-school youth, long distance truck drivers, truck/cart pushers (young males) as peer educators; and providing SRH education and services for females living with HIV and their partners.

2. Involving men in PMTCT programming

As noted above, there is increasing action to increase male involvement in PMTCT and evidence that this can contribute to greater uptake of services, reduce stigma and improve health outcomes. However, male involvement in PMTCT and partner support is interlinked with and influenced by issues related to gender violence, gender stereotypes, condom use, and alcohol. This means that male involvement must cover all 4 of the PMTCT prongs.

Two countries included activities in their proposals that ensure men’s involvement in PMTCT; involving the partners of HIV positive women in DRC; and conducting campaigns on PMTCT to women and men in Zambia. Ghana’s proposal acknowledged the need to address male partner involvement in PMTCT and couple counseling including discordant couples, but did not formulate specific activities to address this.

3. Male circumcision

According to the WHO, voluntary adult medical male circumcision (MC) reduces heterosexual transmission of HIV from women to men by approximately 60%. In countries that have a high HIV burden, MC can be a highly effective HIV prevention intervention available to men. Reaching men with voluntary adult MC services requires innovations, including simpler and quicker methods that are safe. MC promotion should always be provided as part of a comprehensive prevention package including condom promotion, safer sex counseling, HIV testing, and counseling and STI management, to reduce unintended negative outcomes for women and girls. Three countries included activities that focus on MC.

Examples of activities that focus on male circumcision include:

49 This activity is also mentioned under Action 7
50 This activity is also mentioned under Action 8
51 World health Organization (February 2012). Use of devices for adult male circumcision in public health HIV prevention programmes (Geneva, Switzerland).
Lesotho: the implementation of a new MC strategy using mass media to encourage men to request circumcision from trained health care providers; training providers from both public and private sectors to deliver MC services, proving them with MC kits and conducting formative operational research on uptake and impact; supporting the implementation of a national plan for MC; targeting female and male partners, and mothers of male infants for early intervention; integrating MC into key services such as SRH and STI services; conducting formative operational research on and uptake of MC;

Zambia: Procurement of relevant medical equipment for health facilities; Providing operational support to facilitate ongoing MC services to communities; training of health workers in counseling and surgical skills; Conducting a needs assessment on MC communication;

South Africa: Working with traditional and religious leadership and PHC Committees to promote MC.

Implementation
Lesotho and Zambia included indicators in the PFs that measure the number of men circumcised, which also follow through in the budgets.

1. Lesotho allocated $872,322 or 1.3% of the total budget for Phase one to MC and included the indicator that measures the number of health workers in CHIs trained in MC in the PF. However, according to the PU/DR activities for MC were not implemented due to the change of strategy from adult MC to neonatal. Request to reprogram funds to that effect was approved for Phase II activities. By the time the response was attained Phase I was coming to an end and there was not enough time left to sensitize HCWs and the community, including chiefs and traditional healers, on MC as a prevention strategy. In addition, the MOHSW decided not to implement this activity until the communication strategy was completed in October 2011, which is when the phase I ended. Hence, the target for the number of males circumcised was met by 29%.

2. Zambia allocated $119,535 or 0.5% of grand total for phase one to MC and allocated budget to developing and distributing IEC materials to encourage demand for MC amounting to $23,813.43 or 0.1% of total budget for phase one. Zambia also allocated budget to scaling up community dialogues with men and boys on behavior change, amounting to $28,400 of grand total or 0.1%.

3. Ghana included in the PF the outcome indicator that measures the percentage of male sex workers reporting the use of a condom with their most recent client.
6. DISCUSSION

Understanding gender related issues: to what extent is programming linked to “know your epidemic” processes

Effective responses depend on “knowing your epidemic and your response.” This includes clear sex and age disaggregated data to allow for nuanced analysis, particularly to understand who is most likely to become infected with HIV, and who carries the burden of disease. Ideally, epidemiological information should be complemented by qualitative evidence, anthropological and sociological information, and knowledge on sexuality, gender identity, and cultural norms about appropriate femininity and masculinity. Especially important for effective responses is that programs and activities born out of the analysis be designed, implemented and monitored by people who understand gender dynamics and all the complexities that women and girls face in their daily lives.

All proposals provided prevalence rates of the general population, including of some key populations. However, while the general population was usually disaggregated by sex, in most proposals key populations were not. This may be partially caused by lack of baseline data on the proportion of women in each of these populations. To address HIV and its underlying causes effectively, it is essential to improve data disaggregation by sex, age and key populations. For example, there was no inclusion of female partners of MSM or women who use drugs in the proposals and, consequently, there was no proof of implementation of these interventions in the documentations.

This analysis shows that the understanding of gender-related issues in the majority of proposals is often inadequate. For example, few countries were addressing the underlying causes of gender inequality in their country contexts. Particularly issues related to traditional norms or harmful practices, such as domestic violence, forced marriage, female genital mutilation, unsafe abortion, as well as socialization of boys and men were often left out of the gender analysis. This gap in understanding gender-related issues is reflected in the low presence of gender responsive indicators in performance frameworks, budget allocations and particularly in PU/DRs. Even in cases when countries include a strong gender analysis in their proposals, there was a gap in translating this data into activities, performance indicators and budget lines. A key issue that needs further exploration is whether women’s organizations and gender experts represented on CCMs are able to translate their analytical capacity into programmatic oversight.

Detailing the extent to which gender responsive activities are being implemented

This desk review shows that the level of implementation regarding Action 1 – creating an environment that supports improved outcomes for women and gender equality - appears to be low, particularly with regard to engaging gender experts in HIV decision-making, having women living with HIV in decision-making bodies, and planning and monitoring that includes a gender perspective. While all proposals included activities to reduce stigma and discrimination, most activities were not sex disaggregated, and only three countries ensured activities were followed
up in their budgets. It is, of course, important to recall that the Global Fund does not support the full national response, but rather is mandated to fund the “existing gaps” in programming. This means that there could be legitimate reasons for not supporting arrange of gender responsive activities – assuming they are funded by others or handled by technical partners. That said, some aspects, for example, the inadequate level of participation in Global Fund-related decision-making is of direct concern to this review. Other challenges found in this review may reflect issues that should be raised with the national program, technical partners of other funders – either to be assured that they are addressing the issues, or to challenge why they are not fully addressed.

Regarding prevention, treatment, and care and support activities, we note that all proposals reviewed included a large number of HIV prevention activities, many of which contained a focus on women and girls. A relatively large number also followed through in the performance frameworks and/or budgets, including for example to address HIV risk reduction within multiple and concurrent partnerships or to distribute female condoms. However, regarding the prevention of vertical transmission there appeared to be a strong focus on pregnant women and pregnant women living with HIV in the proposals with, for example, little consideration was given to the long-term treatment and support of mothers beyond giving birth, and very little attention to Prongs 1 and 2 (preventing HIV infection in women, and supporting women living with HIV to avoid unintended pregnancies). While seven of the nine proposals reviewed showed activities to ensure the integration of HIV and SRHR services, only three made sure these interventions were followed through in the budget and only one included an indicator in the performance framework.

Furthermore, while the proposals contained multiple activities focused on treatment, there was hardly any action that included a gender dimension. This was also reflected in the low number of the performance indicators and budget allocations, and complete absence of data disaggregation by sex. In all proposals that contained care and support interventions these were primarily directed towards the chronically ill or PLHIV. None of the countries had included items ensuring support and care services for women and girls in PFs or budgets.

This desk review further shows that there seems to be a low level of implementation of interventions that ensure support for female caregivers; no activities, PFs or budgets contained a focus on women or girls. Similarly, while all nine proposals contained activities to ensure support for OVC or youth affected by HIV, only three proposals included activities with a focus on adolescent girls and young women who are orphaned or HIV-affected – and none of these activities were reflected in the PF or budgets.

This analysis shows that six countries included activities to ensure research on women and HIV is conducted, including research on behavior, harmful cultural and traditional practices, and PMTCT. Three of those countries ensured activities followed through in PFs and/or budgets. However, the limited number of interventions addressing this action may be strongly influenced by pre-existing gaps in each country and the fact that most women-centered or women-focused clinical and social science research is funded by others.
Numerous actions addressing VAW were reflected in six of the nine proposals. Three of the six proposals included performance indicators to measure the level of VAW and two countries allocated budgets to address VAW, although implementation of one intervention was delayed. In the documentation, we could not find evidence of the implementation of interventions that address the root causes of VAW, such as ideals of masculinity that involve control of women and demonstration of male strength and toughness; however some performance indicators and/or budget allocations focused on behavior change. Proposals of five countries reflected actions that ensure the provision of gender, sexuality and HIV education in their PFs and/or budgets to address this issue. It is complex to assess whether these interventions will contribute to changing gender norms in practice, and this cannot be judged by reviewing the documentation alone.

A number of proposals included activities that ensure legal support with regard to HIV, but these are often described in general terms, such as legal support to reduce stigma and discrimination or legal support for PLHIV. Four countries included items in their proposals that included action to ensure legal support for women, but only one country ensured the particular intervention followed through in its PF and budget. In terms of structural drivers, the documentation revealed a low level of implementation of interventions to increase women’s empowerment through education and/ or essential livelihood support. Three countries included activities focused on income generating activities and trainings for women, but none followed through in PFs or budgets.

Finally, all proposals in general reflected recognition of the importance of male involvement, however they often used general terms, making it difficult to assess the actual involvement of men and boys. Seven of the nine proposals included interventions focused on general male involvement, while only three proposals included activities to involve men in PMTCT programs and also three countries included activities that focused on MC. PFs and budgets of two countries, and one country included an indicator in its PF that measures condom use among male SW.

**Quality and disaggregation of data by sex, age and vulnerability**
This study shows an overall lack of data in proposals and indicators disaggregated by sex and age, particularly among PLHIV, IDUs, SW, OVC and youth in proposals. In addition, issues such as sex workers’ environment (pimps, clients, partners etc.) are not addressed sufficiently. Performance indicators, budget allocations and data provided in the PU/DRs and EFRs reflect this lack of data disaggregation by sex, age and key populations which makes it difficult to assess the level of implementation of gender responsive programming. It does not mean that gender responsive activities are not being implemented, but the documentation reviewed does not provide proof for this.

**Capturing key implementation success and challenges**

*Key successes*
The proposals show a number of gender-related activities that could make a difference in the lives of women and girls and contribute to gender equality, as indicated by the “Analysis of Gender-Related Activities on Global Fund Approved HIV Proposals from Rounds 8 and 9”. However, in the documents reviewed for this study, we were unable to find much proof of implementation of gender responsive, in particular gender transformative, programming. It is important to stress that this does not necessarily mean that such activities are not underway in practice, but there is limited evidence in the documentation. Some encouraging observations include: a strong focus on sex workers in PFs (though not always specifically on female sex workers); the large number of prevention activities that follow through in PFs and budgets; the number of activities on PMTCT that follow through in PFs and budgets (even though these are partial and do not include all four prongs); and some focus either in PFs or budgets on facilitating behavior change.

Key challenges
This study shows that key challenges for countries regarding the implementation of gender responsive programming are:

1. Inadequate underlying gender analysis, with insufficient data disaggregated by sex, age and vulnerability, especially for key populations;
2. Insufficient structured attention to gender-transformative programming, with a lack of gender expertise and few women living with HIV sitting on decision-making bodies;
3. Insufficient qualitative information, such as on changing gender norms, and inadequate attention to structural drivers (such as women’s lack of access to resources);
4. Inadequate approaches to many key interventions, including insufficient approaches to PMTCT, lack of attention to women’s treatment needs, poor attention to the involvement of men and boys;
5. Gender-relevant interventions that are proposed are rarely translated into corresponding gender-related performance indicators that also follow through in the budgets;
6. A lack of measurable indicators, for example regarding if and to what extent women and girls are being reached as well as a lack of measures to improve tracking of resource flows to girls and women;
7. Inadequate follow-up to track implementation of the gender dimensions of interventions (described in the PU/DRs).

Other challenges to tackle include the lack of implementing activities that focus on human rights, such as rights for sex workers, as well as women’s economic empowerment, and comprehensive sexuality education. Our desk review found little evidence of countries implementing gender transformative interventions, and what we could detect tended to be gender neutral or gender sensitive interventions. There was scant evidence of action to explore the socialization of boys into men, the role violence plays in defining masculinity, and the links between alcohol, sexuality and violence as well as regarding changing gender norms.
7. CONCLUSION AND RECOMMENDATIONS

CONCLUSIONS
This analysis set out to determine the breadth and extent of implementation of activities that contribute to gender equality in Global Fund programs, and captures key implementation successes and challenges. In all cases we were able to find extensive evidence of gender analyses in the proposals, but very limited evidence of gender in the documents referring to implementation. Therefore, the main conclusions of the desk review are:

1. A lack of data disaggregated by sex, age and vulnerability in Global Fund performance frameworks as well as in budgets, which limits ability to analyse need and programming effectively;
2. While there is some gender responsive programming supported by the Global Fund, this tends to be gender neutral or gender sensitive, rather than gender transformative activities that would ensure a comprehensive approach;
3. A gap in translating gender-responsive activities into Global Fund performance indicators and budget allocations that can be used to track and secure gender responsive programming;
4. Weaknesses in measuring progress of gender-responsive interventions in Global Fund PU/DRs;
5. Weaknesses in this area that also need to be addressed by countries, technical partners and other donors; the review indicates that countries are overlooking underlying causes of HIV infection among women and girls, as well as broader drivers of vulnerability, and not tailoring programs to meet known needs.

However, it must be stressed that in all cases we anticipate that there is far more activity underway at country level, but that the documentation available does not prove this. It is anticipated that in-country reviews and case studies will reveal a more nuanced, and optimistic, analysis of the gendered dimensions of implementation of round 8 and 9 HIV proposals.

RECOMMENDATIONS
This review highlights the following key recommendations addressed to the Global Fund, the technical partners and local stakeholders:

1. The Global Fund, as well as key technical partners such as UN Women and other UNAIDS co-sponsors (eg UNFPA and UNICEF), networks of women living with HIV and women’s rights organizations in civil society, should facilitate technical support to countries on how to address gender, as well as on how to translate this analysis into operational plans, activities, performance indicators and budget allocations;
2. Epidemiological information should be complemented by anthropological and sociological information, and knowledge on sexuality, gender identity, and cultural norms about appropriate femininity and masculinity;
3. The Global Fund secretariat should require performance indicators and PU/DRs to include sex- and age-disaggregated data, and to then identify gender-sensitive budgeting measures, such as weighting budgets according to the disaggregation reflected in indicators;

4. All CCM members should be informed on the GES and be capacitated in developing gender-responsive implementing strategies;

5. CCMs need to take greater steps to actively engage a broad range of civil society groups within the development sector, in particular those representing women’s rights organizations and especially women living with HIV;

6. Implementation of the GES should not only be the responsibility of individual staff members, such as Global Fund gender advisors, but also a joint responsibility across the Global Fund secretariat, including the Fund Portfolio Managers and country teams;

7. Operational plans for girls and women, sex workers and people who use drugs, linked to GES, should be prepared as part of the implementation of the new Global Fund strategy (2012-2016) and the Comprehensive Transformation Plan (CTP).

8. ANNEXES

- Annex 1: Report of the country case study in Zambia
- Annex 2: Thought Piece The Global Fund’s New Funding Model: Steps to secure gender transformative responses to AIDS through Strategic Investment Frameworks

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