Gender Scan of UNDP HIV, TB and Malaria Programmes Funded by the Global Fund to Fight AIDS, Tuberculosis and Malaria

United Nations Development Programme
United Nations University International Institute for Global Health

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ABBREVIATIONS AND ACRONYMS

AGYW	Adolescent girls and young women
ANC	Antenatal care
ART	Antiretroviral therapy
BPHS	Basic package of health service
CCM	Country Coordinating Mechanism
CENESEX	National Centre for Sex Education
CHW	Community health worker
COE	Challenging operating environment
CSO	Civil society organization
FSW	Female sex workers
GBV	Gender-based violence
IDP	Internally displaced people
IOM	International Organization for Migration
IPT	Intermittent preventive therapy
IPV	Intimate partner violence
IRS	Indoor residual spraying
ITN	Insecticide-treated nets
JICA	Japanese International Cooperation Agency
KP	Key population
LGBTQI	Lesbian, gay, bisexual, transgender, queer or questioning and intersex
LLIN	Long-lasting insecticidal net
M&E	Monitoring and evaluation
MDR-TB	Multidrug-resistant TB
MoH	Ministry of Health
MOPH	Ministry of Public Health
MSM	Men who have sex with men
NGO	Non-governmental organization
NSP	National strategic plan

PLHIV	People living with HIV
PMTCT	Prevention of mother-to-child transmission
PPTS	People who practise transactional sex
PR	Principal Recipient
PWIDs	People who inject drugs
RR-TB	Rifampin-resistant TB
RSSH	Resilient and sustainable systems for health
SDGs	Sustainable Development Goals
SPI	Specific prevention intervention
STD	Sexually-transmitted disease
STI	Sexually-transmitted infection
TB	Tuberculosis
UHC	Universal health coverage
UNAIDS	The Joint United Nations Programme on HIV and AIDS
UNHCR	The United Nations High Commissioner for Refugees
UNODC	The United Nations Office on Drugs and Crime
USAID	United States Agency for International Development
WHO	World Health Organization

1. EXECUTIVE SUMMARY

1. Objective, methodology and limitations

In 2019, UNDP commissioned a review to assess the gender-responsiveness of its current portfolio of programmes funded by the Global Fund to Fight AIDS, Tuberculosis and Malaria (Global Fund). The objectives of the review were to analyse the implementation of gender-responsive activities, identify gaps in the response and capture key implementation successes and challenges. The aim was also to recommend strategies and interventions that will help UNDP in its support to national entities and partners at country level to prioritize gender-responsive programmes in the context of national HIV, tuberculosis (TB) and malaria responses.

The work included a desk review and analysis of key documents from 31 grants[a] and a deeper dive into five countries through in-depth case studies in Afghanistan, Chad, Cuba, Djibouti and Kyrgyzstan.[b] These countries were selected based on eligibility for funding in the next Global Fund allocation round, UNDP's expected continuation as Principal Recipient (PR) and the perceived capacity of the UNDP country team to participate in the study and implement gender-responsive programming, current disease programming and regional representation.

The analysis had several limitations, including availability of data within the funding requests, grant agreements and progress update documentation, and the fact that most applications were for programme continuation, which requires less information in the application documentation than a full review. Most documentation included a basic level of information on grant goals and strategies, yet provided minimal description of the implementation details, scale and investments of individual activities and programme modules. While findings were more complete for identified gender issues and gender-responsive interventions, the data limitations meant that the scan could not determine how well the gender-responsive interventions have been resourced and implemented.

2. Rationale and terminology

There are several arguments for ensuring that health programmes are gender-responsive. The two key ones are 1) rights-based: health programmes are intrinsically mandated to contribute towards gender equality and 2) for efficiency purposes: addressing gender inequalities in health risk, behaviour, service uptake and care will enhance the efficiency of the programme and improve health impact.

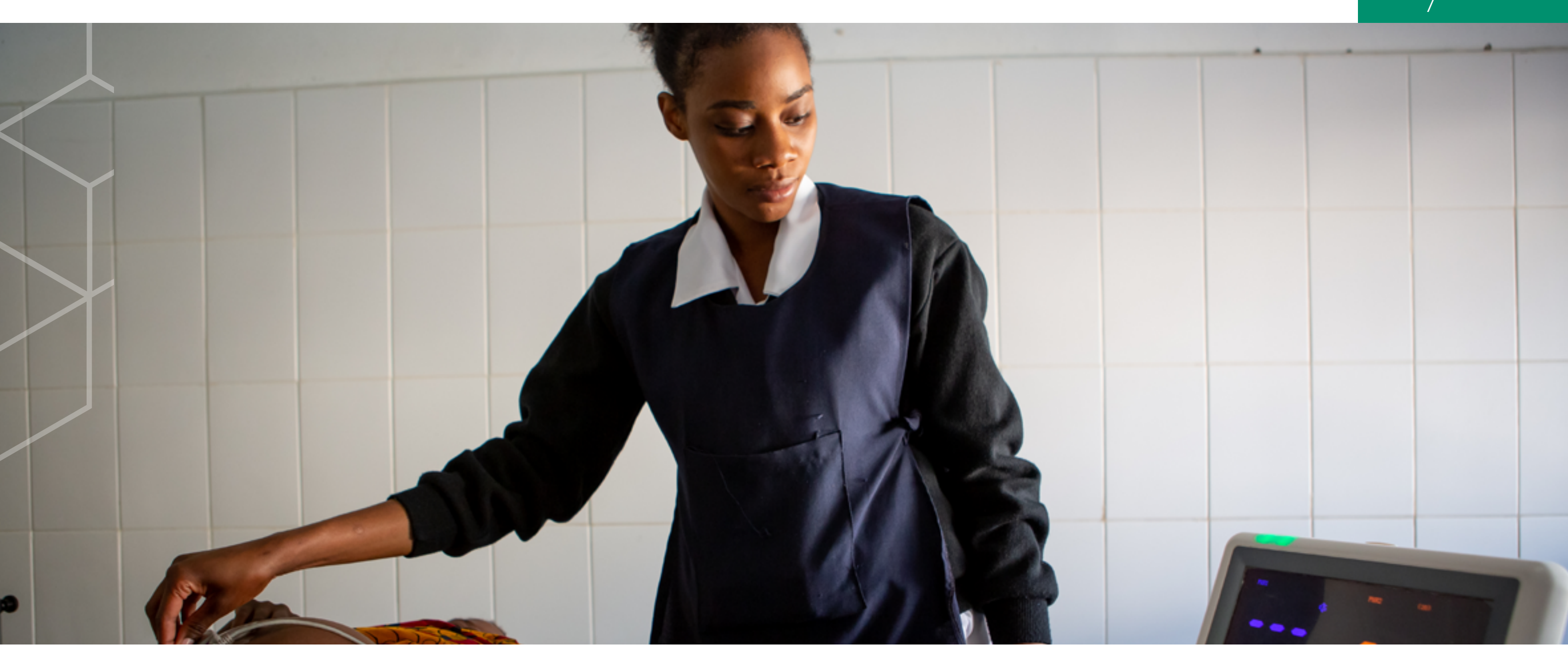
A range of gender-responsive interventions have been designed and implemented across health programmes to date. While most have focused on providing services that address the gender-specific needs of women and men, e.g. for pregnant women or men who have sex with men , some have sought to factor in gender-related differences in their design (gender-sensitive) and a smaller subset have sought to address and transform the causes of the inequalities (gender-transformative).

The terminology used in this review includes:

- **Gender unequal** = perpetuates gender in-equalities;
- **Gender blind** = ignores gender norms and inequalities;
- **Gender sensitive** = acknowledges but does not address gender inequalities;
- **Gender specific** = addresses specific needs of a gendered group;
- **Gender transformative** = addresses the causes of gender-based health inequalities and works to transform gender norms, roles and relations.

[a] Country funding requests, grant agreements, Performance Frameworks, progress updates and disbursement requests. It covered 31 grants: 10 HIV grants, 7 HIV/TB grants, 6 TB grants, 7 malaria grants, 1 joint HIV,TB and malaria [26 single country (with 1-3 disease specific or integrated) grants, 5 multi-country grants].

[b] The objective of the case studies was to obtain a realistic understanding of the process, experiences and complexities of implementing gender-responsive programming at country level, particularly within fragile or challenging operating environments.



Credit: UNDP Zambia / Karin Schermbrucker for Slingshot

3. Main findings

Desk review

The desk review found that reviewed grant applications to the Global Fund are largely gender-blind, with some variation across grants and diseases. In grants that take gender into consideration, there is often a gap between the gender-related issues and the subsequent prioritization of interventions to address them, with declining levels of responsiveness to gender along the grant cycle.

Design and implementation of grant activities consider and integrate gender to different extents, even within the same country context. HIV grants generally perform better than TB and malaria grants. Ninety-four percent of HIV grants documented gender disparities in HIV risk, service use and/or treatment outcomes. A majority of these grants included gender-responsive interventions in the prioritized modules. Two-thirds of the HIV grants also prioritized gender-transformative approaches.

Across the three diseases, grants tend to prioritize gender-specific interventions for pregnant women or key gendered populations (in HIV),[c] while investments in approaches to actively promote gender equity and transform gender inequities and power dynamics are negligible. Although around 25 percent of the grants acknowledged gender-related inequities, none of the malaria grants and only 21 percent of the TB grants included interventions that address the causes of gender-based inequalities in health and works to transform gender norms. Most of the modules in the grants that do not target specific gendered groups can be categorized as gender-blind, with some potentially perpetuating gender inequities. The lack of gender analysis in programme planning in conflict-affected and fragile contexts, in the case of HIV and beyond, is a gap that could inadvertently cause significant harm and should be taken into consideration for future grants.

There appears to be a general perception that gender programming relates to women and girls, or to sex-specific modules. Male-disproportionate epidemics or generalized epidemics were in some cases used as a rationale for not prioritizing gender equity as an objective. Though there was recognition and articulation of gendered issues, such as one group — e.g. men in the context of TB — being identified as more vulnerable, this was not reflected in the overall goals of the grant, subsequent interventions or investments.

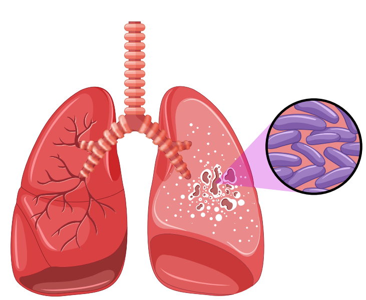
Sex-disaggregation was the only measure of gender-responsive monitoring and evaluation that was identified. Overall, there was some level of compliance with the Global Fund requirement for including sex-disaggregated monitoring and reporting in the performance framework, but not across all relevant indicators suggested by the Global Fund's Modular Framework.

[c] Gendered key population (KP): sex-specific KPs defined in HIV policy (Men who have sex with men, female sex workers, transgender people)

Some of the disease-specific findings include:

HIV: The HIV grants contained interventions that could be replicated and scaled up. These include comprehensive programming and specific focus on the most vulnerable key populations (KPs) as well as holistic and layered interventions that go beyond the biomedical intervention and use a multi-pronged approach, including community engagement. Despite better gender-responsiveness of the HIV grants compared with TB and malaria, gender is still approached by many from a binary perspective (men/women), which excludes vulnerable populations with gender identities besides 'woman' and 'man'. There was also little recognition of the intersection of gender with other social factors, such as age, migrant status and marital status, and how this affects people in the context of HIV.

TB: The review found that the TB epidemics responded to via grants were predominately male-disproportionate but that this did not translate into gender-specific or gender-transformative interventions targeting men. The review found some grants that included gender-responsive interventions in female-disproportionate settings. This included, for example, patronage visits to ensure patient intake of drugs while enabling women to stay with their families during treatment, increases in the number and training of family and community health workers (CHWs) and recruitment of female health counsellors. It further noted that many countries still do not have sex-disaggregated data,[d] and that while some countries identify the role of stigma in access to service and treatment uptake, few recognize the differential impact for men, women and transgender populations.



Malaria: A majority of the malaria grants were gender-specific in that they recognized that pregnant women are at a higher risk of malaria, and they included targeted efforts to safeguard this group. Beyond this, there was hardly any recognition of other gendered factors. The malaria grants analysed could be categorized as gender-blind with one exception, which was the explicit recognition of the role that gender norms play in placing barriers to service access for women and the subsequent inclusion of a case management approach through both a male and female CHW network. This programming oversight could be explained by the notable gap in relevant international policy and academic guidance for the analysis and programming of gender and malaria interventions. Applying a deliberate gender lens in designing and implementing malaria interventions would address these gaps, and could result in better focused interventions and more efficient investments.

[d] For example, Egypt, Kyrgyzstan, Sao Tome and Principe and the multi-country grants (Western Pacific and South Asia)

Country Case Studies

Cuba	Chad	Djibouti	Afghanistan	Kyrgyzstan
HIV Grant	Malaria Grant	Malaria Grant	HIV, TB, Malaria Grant	HIV &TB Grant

Afghanistan

There is a clear difference in how gender-responsive interventions were prioritized across the different disease components in the grants. The HIV grant includes gender-specific modules and gender-transformative components, while gender does not feature in the goals of the TB grant and the malaria grant has a focus on "all of the population." The performance framework is found to be relatively gender-blind and there is a notable absence of sex-disaggregation in the impact, outcome and coverage indicators. The UNDP country team noted that the performance framework is negotiated and determined by the Global Fund Country Coordinating Mechanism (CCM), and that the required level of disaggregation presented in the performance framework was based on country-level discussions. At the implementation level for all three diseases, stakeholders' perceptions suggest that many implementing partners are gender-blind in their approach.

Chad

The malaria concept note included analysis of key gender inequalities and vulnerabilities but grant documents do not provide or analyse sex-disaggregated data. The documentation communicates a perception that there are no gender differences in access to malaria services, but data is lacking to support this. The concept note also included misconceptions around gender-responsive programming, with all programming for vulnerable populations being considered gender-specific. The grant includes gender-specific and gender-sensitive interventions, however none of the modules include efforts to transform gender norms or inequities.

Cuba

Progress has been made in addressing gender within HIV prevention programmes nationally and with support from the Global Fund grant. In particular, this includes the inclusion of KPs, across multiple sectors, in the design, implementation and evaluation of the grant, which has resulted in better performance, empowerment of KPs and impact of the projects. Gender has also been integrated into the HIV programming, indicators and budgeting. Despite the historical binary conceptualisation of gender, in the context of the Cuban HIV response, gender has been considered non-binary. The role of the National Center for Sex Education (CENESEX) and the National Center for the Prevention of STDs and HIV/AIDS have been key in this aspect. Additionally, UNDP's technical support has helped develop a broader understanding, which has informed gender-transformative programming for different groups. Despite such achievements, only 13 percent of the total Global Fund grant budget was allocated to sex-specific modules. The lack of details in the budget prevents determination of the level of investment in gender-responsive programming.

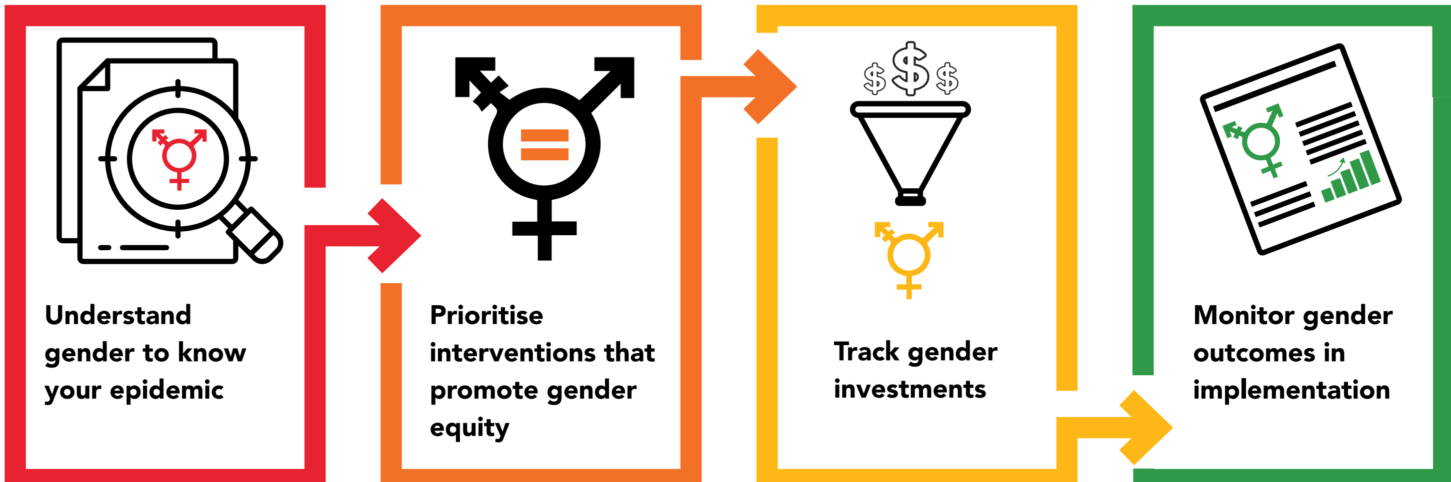
Djibouti

The concept note includes sex-disaggregated data on malaria prevalence and highlights vulnerable populations, but it lacks analysis of underlying causes and the potential role of gender norms as drivers of risk. The funding request includes gender-responsive priorities, however men are not a specific focus despite the disproportionate incidence of malaria in men. The grant includes gender-specific or gender-sensitive activities in the vector control module. The grant component on health system strengthening includes no specific efforts to incorporate gender, although there is a commitment to engage with and leverage community resources. There are major challenges in national health data reporting and data quality. It is critical to reinforce the importance of gender-disaggregated data.

Kyrgyzstan

The grant documentation provides age and sex-disaggregated data, although gender is not visible in the grant goals, objectives and activities. The HIV modules are more gender-responsive than the TB modules. Gender equality goals within the grant include the pursuit of equal opportunity and outcomes for both women and men, but only for populations identified as target beneficiaries. Gender features well in the planning and design stage and is articulated in grant application documentation but less so in implementation or in the performance monitoring. There are no gender-responsive budgeting processes or principles used in developing the budget. Some stakeholders within the country context consider the level of sex-disaggregation in the performance framework sufficient, while some external stakeholders consider it as gender and human rights-blind, instead prioritizing a biomedical perspective.

4. Recommendations



While the gender scan identified engagement with gender across the grants and a number of efforts to address gender-specific needs or to overcome gender-related barriers to service access, it also noted that several grants still do not explicitly consider gender or respond to gender inequities in their implementation.

The main lessons and recommendations from the scan relate to the early phases of the grant cycle, including the analysis, programme design and prioritization of interventions. In addition, accountability mechanisms are required to ensure adequate investment in gender-responsive programmes and to monitor their implementation and impact.

Grant design: knowing your epidemic includes understanding gender-related risks, barriers and inequities

- Grants should be based on gender and intersectional analysis of disease risk and service access (including age, mobility status, KP status, where most relevant), particularly in TB and malaria grants, where gender considerations are less prominent than in HIV grants. In some countries, there is a need to address data gaps even in HIV, such as for women in neglected and non-gendered KPs[e]. Although this is a Global Fund requirement, gender analyses are often missing from funding requests, or are inadequate to understand gender-related barriers to inform effective programming. For a quality and useful gender analysis, the following three components are required:
  1. Documentation of sex-disaggregated data of disease risk, service access and treatment outcomes in the country;
  2. Identification of the socially-constructed gender norms and inequities that explain any gender differences in disease risk, service access and treatment outcomes in each country's context (and/or drawing on relevant regional evidence);
  3. Identification of effective interventions and approaches to address the identified gender inequities as drawn from the local context, and/or from international literature and experiences.
- As part of the grant development phase, UNDP country teams could be instrumental in advocating for investment in local gender data and primary research, by engaging with local experts, academics, community researchers and KP communities to commission prioritized data collection, evidence generation and research.
  - Utilize the practice-based knowledge of programming partners, as well as international research, to gain a formative understanding of gender-related barriers and to inform more systematic documentation, local research design and data analysis. These could draw on expert consultation, community surveys, participatory action research and in-depth qualitative interviews, among others.

[e] Non-gendered key population: populations that include men, women and transgender individuals such as people who inject drugs.

- Leverage UNDP's regional networks and platforms to enable South-South learning, exchange of knowledge and adoption of good practices.

In consultation with the CCMs, countries could then consider sustaining these initiatives for ongoing performance monitoring and learning through the resilient and sustainable systems for health (RSSH) grant modules on health information and community systems.

Grant planning: prioritize interventions that address gender inequities and promote greater equity

- UNDP can increase efforts to help countries develop an in-depth understanding of what gender-responsive programmes entail, and help develop and prioritize – through expert advice, workshops and guidance – gender-transformative actions.
  - In grant applications and implementation, there need to be clear linkages between identified gender disparities in health outcomes; gender-responsive grant objectives and strategies; the selection, scope and scale of module activities and focus populations; and matched investments. This is particularly missing in grant modules that are not women or men-specific, such as those serving people who inject drugs, refugee and migrant populations and populations in prisons and closed settings and those that relate to health system strengthening.
- UNDP can use its programmatic entry points and organizational strengths to address underlying causes of gender inequity in the grants. For example, legal and policy frameworks can create gendered disadvantage within countries. This is an area of UNDP's comparative advantage because of its expertise in addressing women's rights, social and economic empowerment. UNDP Global Fund country teams can consider working in close partnership with UNDP Governance and Rule of Law programmes to support countries and partners. By leveraging experts at various levels in the organization, and between partner organizations, country teams can contribute to strengthening non-health interventions, including legal and policy frameworks, to address the more complex root causes of gender inequalities, as outlined in UNDP's Gender Equality Strategy 2018-2021.
  - Grants should be clear about the distinction between gender equality programming and human rights programming, because there is currently a tendency to subsume the former under the latter, which risks rendering invisible gender equality actions.
  - Human rights modules provide a unique entry point to address structural inequities and legal barriers to gender equality, especially where they intersect with gender-related barriers to access HIV, TB and malaria services. However, gender inequities have not been explicitly or consistently considered in past human rights programmes for KPs in the context of HIV. UNDP could proactively support the integration of a greater focus on gender within these modules by expanding activities to cover areas such as gender-based violence (GBV), gender discrimination, women's sexual and reproductive rights, marital rape, child marriage, etc.
- UNDP can support countries to consider specific programmes that:
  - Target structural/policy, cultural and religious barriers to health services, including those that affect women's autonomy to seek care;
  - Tackle GBV and discrimination at household, community, institutional and structural levels;
  - Target the social and economic empowerment of women.
- UNDP can provide quality control and gender-proofing to ensure that none of the grant interventions are harmful and perpetuate gender inequity. In efforts to address gender-

related barriers to healthcare and improve health outcomes there is a risk of reinforcing men's power over women, for example by working with men to give permission to their wives to access healthcare. There is also risk of reinforcing inequitable gender roles, for example through CHW programmes that take women's volunteering for granted because of their societal role of providing unpaid care work.

- Grants should also be gender-responsive in contexts where men are disproportionately affected. This is most relevant in TB and malaria programmes.
  - Efforts should be made to engage men, and to address and transform gender-inequitable power dynamics and norms around masculinity that adversely affect health risks and uptake of health services. Such interventions go beyond accommodating, for example, men's different working times, and focus on tackling norms and power, which will likely have benefits across the three diseases and beyond.
- Leverage the RSSH modules: use modules to build in a greater focus on gender within health information systems, community systems and human resources for health, including CHWs.
  - Promote prioritized sex-disaggregation in health information systems.
  - Promote use of CHWs: this intervention was not acknowledged as being gendered in several grants, although female CHWs in particular can be critical to raise awareness and support early detection, diagnosis and referral to health facilities. However, programmes must ensure that female CHWs receive adequate support, remuneration and recognition.

Grant performance: be accountable to promoting gender equity

- A prioritized set of key performance indicators (impact, coverage and outcome) must be sex-disaggregated and also included in continuous monitoring and progress reporting. This would generate real-time data on how grant activities are reaching and affecting men, women and transgender people within the key or focus populations.
- Explicit gender-responsive budgeting and expenditure tracking processes are important to ensure that the prioritized activities are appropriately resourced. To enable such accountability in budgeting and investments requires a common understanding of which modules and activities can be considered gender-responsive, and the introduction of a tracking system.
  - The Global Fund's 2019 Modular Framework, which is more specific on gender, is considered helpful and will make it easier to accurately account for budgets that promote gender equity going forward.
  - UNDP can leverage its institutional efforts to establish a gender marker (as mentioned in the Gender Equality Strategy 2018-2021) for gender-responsive expenditure tracking, and go beyond the Global Fund requirements to enable budgeting and tracking that are explicit about investments in gender equality.
- In the grant development and monitoring process, UNDP can advocate for the meaningful engagement of civil society organizations (CSOs) that represent population groups with gender-related vulnerability, as well as gender experts, to advise on effective gender-responsive implementation.
- Promote the use of available tools and guidelines: The gender scan found that not all UNDP partners in countries are aware of the various tools available, in particular the UNDP gender checklist for Global Fund grants and the Global Fund gender equity note. In addition, there are disease-specific gender/equity assessment and planning tools that have been successfully applied in a number of grants (Malaria Matchbox, Stop TB Gender assessment tool, UNAIDS Gender assessment tool). Links to additional reading and resources are available at the end of the report.

5. Post-analysis note on programming for gender equality in the time of COVID-19

This report was finalized in the first quarter of 2020, amidst the unprecedented global experience of, and response to, the COVID-19 pandemic. There is recognition that this pandemic will influence national and CCM decision-making, priority-setting and resource allocation, and all future Global Fund-financed programming strategies. The Global Fund has issued guidelines to PRs and implementers to strictly follow WHO recommendations and guidelines, mobilized additional emergency funding and enabled grant flexibilities of up to 10 percent of approved grant funding[f] for countries to redeploy underutilized assets, repurpose grant savings and, in exceptional cases, reprogram funding from existing grants in the national pandemic response. [1,2]

The pursuit of, and programming for, gender equality should not be neglected or deprioritized during pandemic response.

Several gendered dimensions and unintended consequences of the pandemic are reported from around the world.[3–5] These include anticipated effects within the scope of programming for HIV, TB, malaria and health systems. Altered patterns of housing, sexual contact, migration, incarceration, school attendance and poor access to health care, food and economic resources are joint factors that can increase vulnerability to both HIV and COVID-19. Key and vulnerable populations, adolescent girls and young women and their partners are likely to be disproportionately affected.[6] These dynamics could 'deepen existing inequalities' and 'reverse the limited progress that has been made on gender equality'[3]

"COVID-19-related modifications to Global Fund-supported programmes should strive to ensure that human rights and gender-related barriers to health services are not exacerbated and that the health needs and human rights of those most vulnerable to COVID-19, as well as to HIV" [6]

In the newly issued technical guidance and information notes for Community, Rights and Gender,[7] HIV, TB, malaria and health systems strengthening, the Global Fund highlights anticipated challenges and the need to continue ensuring a human rights and gender-based approach in the response to Covid-19 funded by the Global Fund. The overall messaging in these information notes is to support country-based planning, engage civil society and community actors, and not interrupt or deprioritize current and ongoing programming needs, as much as possible. Adaptive programming that is responsive, assessed through a lens of human-rights, gender, and key and vulnerable populations, amongst others, is required. Examples of how programming (as outlined in the technical and information notes) can be gender-responsive include:

1. **Tackling GBV:** A risk of increased domestic and intimate partner violence, with limited access to services or opportunities for alternative shelter, is anticipated from policies restricting population movement. [3–5]

f Where there are no savings possible in existing grants or in other exceptional circumstances, an existing grant may be re-programmed up to an additional limit of another 5% of its total value" -The Global Fund Guidance Note on Responding to Covid-19.

Credit: UNDP Djibouti/ Aurelia Rusek

The *Global Fund guidance includes:* [7]

- Advocate for domestic violence and other GBV response mechanisms, including safe shelters, to be included in definitions of essential services to enable them to continue operating.
- Increase funding for social media, radio and other internet-based tools to raise awareness around intimate partner violence (IPV) and GBV, encourage use of violence response services.
- Increase funding for and the capacity of helplines for IPV/GBV reporting/referrals, including capacity strengthening for addressing IPV/GBV among KPs.
- Maintain the availability of safe shelters that are inclusive of LGBTQI communities, GBV police complaint departments, or other means of protection for people facing violence in the home.
- Ensure the availability of and inform IPV survivors and communities of the need to seek HIV post-exposure prophylaxis, emergency contraception and other emergency services, including psychosocial support and mental health and trauma services, through virtual platforms.

2. **Ensuring access to contraception:** Spikes in HIV incidence amongst newly out of school girls and sex workers are predicted.[6] Access to essential sexual and reproductive health and rights services packages, including family planning, dual protection methods and maternal health care, is essential.[7]

The *Global Fund guidance includes:*

- Intensify health information/communication for adolescents in high incidence locations; focus on COVID-19 and on HIV prevention and sexual health. Access to HIV, safe sex and sexual health information for adolescents will need to be adapted for online platforms.
- Continued supply of condoms and lubricants is critical. Support for efforts to distribute condoms to different locations is needed, with a focus on marginalized people, young women and men in high incidence locations, people living with HIV , transgender people, sex workers, men who have sex with men , people who use drugs and people in prisons and other detention facilities.

3. **Human resources for health, including community systems and CHWs:** country teams should consider if sufficient personal protective equipment are available for human resources for health at all levels, including CHW groups,[6] which tend to be women disproportionate. Additionally, risk-mitigation against COVID-19 related stigma, harassment and occupational violence should be considered to protect all human resources for health.

4. **Continued malaria prevention for pregnant women:** access to intermittent preventive therapy (IPT) for pregnant women must continue and is critical in pregnancy services, regardless of whether pregnant women are determined to be at increased risk for complications from COVID-19 infection.[8]

2. BACKGROUND

2.1 Policy context

In 2015, the international community committed to an ambitious set of Sustainable Development Goals (SDGs) and the universal 2030 agenda to transform the world we live in through a whole-of-society approach, centred on people, planet and partnerships, which aims to leave no one behind. The SDG for healthy living and well-being for all includes the bold target of ending the epidemics of AIDS, TB and malaria by 2030. The SDG framework represents a stark paradigm shift towards an integrated approach to development that recognizes complex linkages, interconnectedness and structural determinants of human and social development. Gender equality and women's empowerment is both a standalone SDG and inextricably linked to the achievement of the other SDGs, including the health SDG and its targets.

In addition to this overarching framework, global health stakeholders have reinforced their commitment to promoting gender equality and women's empowerment. The recent 2019 Political Declaration of the UN High-Level Meeting on Universal Health Coverage (UHC) stipulates that signatories will "mainstream a gender perspective on a systems-wide basis when designing, implementing and monitoring health policies, taking into account the specific needs of all women and girls, with a view to achieving gender equality and the empowerment of women in health policies and health systems delivery."[9]

Previously, the 2018 UN Political declaration on TB committed "to developing community-based health services through approaches that protect and promote equity, ethics, gender equality and human rights in addressing tuberculosis […] recognizing that reaching undetected and untreated men, as well as empowering women and girls through community health care and outreach, is a critical part of the solution." The 2016 UN Political declaration on HIV makes the even bolder commitment "to achieving gender equality and the empowerment of all women and girls, to respecting, promoting and protecting their human rights, education and health, including their sexual and reproductive health, by investing in gender-responsive approaches and ensuring gender mainstreaming at all levels, supporting women's leadership in the AIDS response and engaging men and boys, recognizing that gender equality and positive gender norms promote effective responses to HIV", among others. Noteworthy is that the Global Technical Strategy for Malaria (2016-2030) makes no reference to gender.[10–12]

Global organizations working on health, including UNDP as part of the UN system, and the Global Fund, have adopted gender equality strategies to mainstream gender throughout their institutions, programmes and operations. The UN system adopted gender mainstreaming as a key strategy to promote gender equality in the late 1990s, and has advanced it with renewed impetus since 2006, when it was mandated by a UN General Assembly resolution. The UN System-Wide Action Plan on Gender Equality and the Empowerment of Women provides an overarching and coordinated accountability framework to systematically and measurably mainstream gender into all major functions in UN entities. UNDP's current Gender Equality Strategy (2018-2021) emphasizes four priority areas: 1) Removing structural barriers to women's economic empowerment (including unpaid care work), 2) Preventing and responding to GBV, 3) Promoting women's participation and leadership in decision-making, 4) Strengthening gender-responsive strategies in crisis prevention, preparedness and recovery.[13]

The Global Fund, which disburses about US$3.2 billion annually in global health investments, adopted its Gender Equality Strategy in 2009 to catalyse country efforts and fund programmes that address gender inequalities in relation to the three epidemics.[14] The Global Fund's current 'Ending the Epidemic' 2017-2022 strategy includes explicit objectives to "promote and protect human rights and gender equality," scale up programmes to support women and girls, and increase investments to reduce health inequities, including gender and age-related disparities, across programming for HIV, TB, malaria and RSSH.[15] There is a strong emphasis on the needs of and inequalities faced by women and girls, as they are more often marginalized and do not enjoy the same rights and opportunities as men in many societies. The Global Fund commits to championing and funding proposals for the scale-up of interventions that reduce gender-related risks and vulnerabilities to infection, decrease the burden of disease for those most at risk, mitigate the impact of the diseases and address structural inequalities and discrimination.

A 2016 analysis of the Global Fund's investments estimated that $150 million was allocated to three gender-related (and gender-specific) programme areas, i.e. GBV, prevention of mother to child transmission (PMTCT) and male circumcision, across 91 grants in 28 countries.[17,18] The Global Fund is also scaling up investments to reduce HIV incidence among adolescent girls and young women in 13 high burden countries in East, Southern and Central Africa. Amongst the challenges reported by the Global Fund in the implementation of its gender strategy were the translation of evidence into programme funding and implementation, which is limited by national policy and political commitments, and consequent matched investments and implementation scale-up. Other notable constraints included data limitations, the extent of meaningful engagement of vulnerable groups and the quality of representation in decision-making on which interventions to fund.

In 2017, UNDP conducted a review to assess the gender aspects of the proposals made to the Global Fund in its portfolio. It found that 25 percent of grants had planned or implemented programmes to address GBV and 38 percent had implemented programmes to sensitize police, judges, magistrates, religious leaders or health workers on the gender dimensions of their responses.[17] Common implementation barriers and challenges included insufficient financial and human resources, a lack of understanding of gender-responsive approaches and a need to better collect, report and analyse quality disaggregated data, i.e. including sex and age and showing the nuances across gender.

In response, UNDP commissioned this gender scan to take stock of the progress in implementing gender-responsive interventions within its current Global Fund portfolio. This assessment sought to identify gaps in the response and capture key implementation successes and challenges to inform future planning and gender-responsive implementation.

2.2 Purpose and study objectives

UNDP is nominated as the PR for Global Fund grants in countries with challenging operating environments (COEs), such as conflict-prone areas, or where the Global Fund and the CCM[9] are unable to find a suitable local entity for the role. In its role as PR, UNDP is expected to develop capacity of local entities to assume this role in the future.[10]

As of January 2020, UNDP is managing 32 Global Fund grants, covering 19 countries (single country grants) and four multi-country regional programmes that cover 24 countries. UNDP's work involves implementing large-scale programmes, building capacity of health systems to make them more resilient and sustainable and supporting countries to strengthen laws and policies to ensure that no one is left behind.

[9] The Country Coordinating Mechanisms (CCMs) are national committees that submit funding applications to the Global Fund and oversee grants on behalf of their countries, and include representatives of all sectors involved in the response to the diseases: academic institutions, civil society, faith-based organizations, government, multilateral or bilateral agencies, non-governmental organizations, people living with the diseases, the private sector and technical agencies. Their role is to coordinate the development of the national request for funding, nominate the Principal Recipient, oversee the implementation of approved grants, approve any reprogramming requests, and ensure linkages and consistency between Global Fund grants and other national health and development programmes.

3. METHODOLOGY

The specific objectives of this gender scan of the UNDP's Global Fund portfolio were to analyse:

1. The gender disparities in health outcomes, behaviours and access to services that have been identified and that grants are aiming to address
2. The types of gender-responsive interventions that have been included
3. The extent to which these interventions have been implemented
4. Success factors and barriers to implementation.

The study was conducted in two phases: 1) a desk review of UNDP's current Global Fund grant portfolio, and 2) five country case studies.

3.1 Phase 1: Desk review of grant documentation

The desk review involved analysis of key grant documents, namely country funding requests, grant agreements, performance frameworks and progress update and disbursement requests. Thirty-one grants were reviewed: ten HIV grants, seven HIV/TB grants, six TB grants, seven malaria grants and one joint HIV, TB and malaria grant, spanning 26 single-country and five multi-country grants.

At the point of the desk review analysis, the portfolio included four grants in transition (as indicated on grant documentation) that were considered to be ineligible for funding in future grant cycles.[h] Six countries are classified as COEs, which are characterized by weak governance, poor access to health services and natural or political crises. One application was categorized as a 'full review', i.e. a comprehensive review of strategic priorities and programming in higher burden countries. Three applications were classified as 'material change', i.e. where changes were expected to the scope and scale of the grant that would result in material changes in the overall strategic focus, technical soundness and potential for impact of investments in a disease programme. All others are classified as programme continuation applications, i.e. those that enable well-performing programmes requiring no significant changes to continue implementation.

[h] Cuba, Belize and Turkmenistan have been allocated funding in the next funding cycle (2020-2022).

Table 1. Matrix of grants reviewed

Disease Grant	Arab States	East Asia & Pacific	Europe & Central Asia	North America, Latin America & Caribbean	South Asia	Sub-Saharan Africa
HIV	Sudan		Tajikistan[MC]	Cuba[T] Multi-country America	Iran	Angola[MC] South Sudan Africa Regional Grant Zimbabwe
HIV/TB	Egypt	Multi-country Western Pacific	Kyrgyzstan	Belize[T] Panama[T]		
TB	Sudan[COE]		Turkmenistan[T]	Bolivia	Multi-country South Asia	South Sudan[COE]
Malaria		Western Pacific (Vanuatu)		Bolivia		Chad[COE] Guinea-Bissau[COE]
All	Djibouti (HIV/TB, malaria)				Afghanistan[COE] (HIV, TB, malaria)	Burundi (HIV/ TB,malaria)[COE] Sao Tome and Principe[MC] (HIV, TB, malaria)

Note: COE= challenging operating environment; FR= full review; MC=material change; T= transition.

For the analysis, a guiding analytic framework was conceptualized that involves a focus on four I's (see Figure 1):

i. **Issues identified:**
Which gender-related issues did the grant application documents identify and document?

ii. **Interventions and included populations within modules:**
What interventions or programmes did grants prioritize, and for which populations?

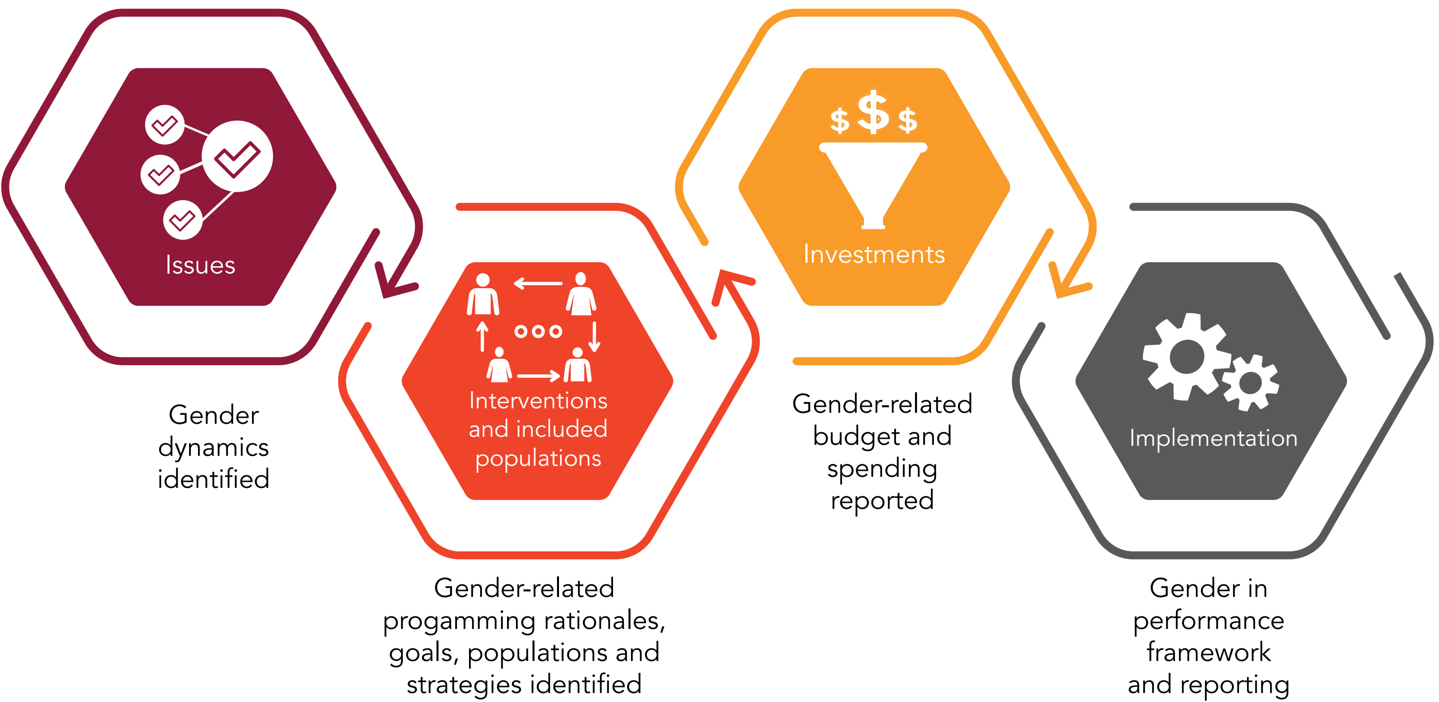
iii. **Investments:**
What were the resources allocated to and spent on the proposed gender-responsive interventions?

iv. **Implementation:**
What was the level of implementation of the gender-responsive interventions/ programmes and how where they monitored and tracked?

An extraction template was developed and included the following categories:

- Gender-related differences in health outcomes (prevalence, incidence, mortality) and gender inequities discussed as drivers of disease risk, service uptake, treatment adherence and health outcomes, as well as gender issues at a systems/structural level (context, norms, health systems, legal barriers, etc.)
- Response and rationale for the need for increased gender programming in funding request applications for the current funding cycle
- Inclusion of gender in the grant objectives, intervention module planning and included populations
- Level of investments (budgeting) on gender-responsive modules
- Implementation performance tracking of gender-related outcomes and indicators

Figure 1: The UNU-IIGH 4-I's Analytic Framework for review



For the analysis, we applied the gender-responsiveness framework (Figure 2) by Pederson et al (2015)[19] to assess the discussions of gender issues and types of interventions. This framework is similar to the WHO Gender-Responsiveness Assessment Scale and can be considered an adaptation of the scale used by UNDP and the Global Fund, as it further differentiates the categories of 'gender-specific' and 'gender-sensitive'. Gender-specific programming may not necessarily be gender-sensitive, and vice-versa.

Figure 2. Gender Assessment Scale[19]

Approach	**Gender Unequal**	**Gender Blind**	**Gender Sensitive**	**Gender Specific**	**Gender Transformative**
Features	Perpetuates gender inequalities	Ignores gender norms	Acknowledges but does not address gender inequalities	Acknowledges gender norms and considers/ addresses women's and men's specific needs	Addresses the causes of gender-based health inequalities and works to transform harmful gender norms, roles and relations

Exploit → **Accommodate** → **Transform**

3.2 Phase 2: Country case studies

Five country case studies were conducted to obtain a deeper contextual understanding of the process, experiences and complexities of implementing gender-responsive programming at country level, particularly within fragile or challenging operating environments.

The following sampling criteria was applied in the selection process:

Sampling Criteria

CRITERIA 01

- Countries had to be eligible for funding in the next cycle, and UNDP expected to continue as PR

CRITERIA 02

- Interest in the UNDP country office to participate in the study, capacity to support more gender-responsive programming and favourable policy climate and socio-political context

CRITERIA 03

- Disease representation

CRITERIA 04

- Geographical representation across regions

CRITERIA 05

- At disease level, grant themes and narratives from desk review provide reasons to probe deeper

COUNTRIES
Afghanistan
Chad
Cuba
Djibouti
Kyrgyzstan

Table 2 summarises which countries and disease grants were selected.

Table 2. Country selection for case studies

Country	Disease Grants	Context
Afghanistan	HIV, TB, malaria	Least developed country category; COE
Chad	malaria	Least developed country category; COE
Cuba	HIV	Upper middle-income country; Transition grant
Djibouti	malaria	Least developed country category
Kyrgyzstan	HIV, TB	Lower middle-income country

Case studies involved a review of key national and grant documents and relevant literature (national policy and strategy documents, published academic research and reviews, programme reports of non-governmental organizations [NGOs]) and remotely conducted key informant interviews with 4-14 key stakeholders per country, including:

- UNDP country office Global Fund team
- Ministry of Health programme coordinators/managers
- Implementing partners/sub-recipients
- NGO representatives
- Gender champions
- Global Fund portfolio managers

A topic guide was developed and used for the interviews and discussions.

Topics included:

- Gender-related disparities, inequities and barriers to services
- Challenges of gender-responsive health programming in the grant and country
- Gender-responsive components of grant modules and activities, at planning and implementation stages
- Gender considerations in investment/budget planning, module implementation, grant performance monitoring and evaluation

The case studies identified actionable recommendations to strengthen the gender-responsiveness of the country grants in the next grant cycle. Full case study reports are available in the Annex.

3.3 Study limitations

The desk review was limited by the data provided in the funding requests, grant agreements and performance update documentation. This was further exacerbated by the fact that most applications were for programme continuation, which requires less detail than full programme assessments. Many grant agreements only included a basic level of information on grant goals, strategies and activities, and did not provide specific details on programme modules. Findings are therefore more complete for the identified gender issues and gender-responsive interventions and less conclusive for the level of investment and rate of implementation.

The UNU-IIGH 4I analytic framework used implies that gender issues need to be identified for the right gender-responsive interventions to be prioritized, but in fact some gender-sensitive and gender-specific interventions were being implemented even though the gender issue or inequity they were addressing had not been articulated, which is why we did not always identify a clear cascading effect from issues to implementation.

For the case studies, the primary limitation was the available time for data collection and analysis, which compounded the response rate and level of engagement with country stakeholders. The scope and depth of programme descriptions during interviews and in grant documentation often only provided partial insights into how programmes were being implemented, at what scale and with what resources.

4. GENDER CONCEPTS, EVIDENCE AND GENDER-RESPONSIVE PROGRAMMING

Gender refers to the "socially constructed characteristics of women and men, such as norms, roles and relationships of and between groups of women and men."[20] Although gender interacts with biological sex, it is distinct from it. As a result of both biological and social differences, women and girls, men and boys are vulnerable to different health risks, adopt different health-seeking behaviours, comply differently with treatment, and are impacted differently by their or their household's ill health. Health systems often respond differently to women and men, leading to sub-optimal health outcomes and in some cases human rights violations. Gender-responsive programming considers and addresses gender norms, roles and responsibilities in the design and implementation of programmes.

While gender is a distinct social determinant of health, it intersects with several other factors to exacerbate health risks, behaviours and outcomes. Gender does not operate in isolation and intersects with various social axes to create unique experiences for individuals both in the context of the three diseases and beyond. Applying an intersectionality lens enables us to examine multifaceted power structures and processes that produce and sustain unequal health outcomes.[21] In practice, an intersectional approach considers the subgroups of women and men, and the interaction of other categories with gender such as socio-economic status, race, life course, disability, etc. An example of this is the consideration of the health risks, disease experience and progress, as well as access to health care of migrant men and women including, of different age groups, occupations and ethnicities, as well as migration status, such as internal, cross-border, irregular, regular, low-skilled work, forced, asylum seekers, refugees and returnees, at different points in their migration journey.[21]

4.1 Gender and HIV

Gender inequality has long been acknowledged as a structural driver of the global HIV epidemic, because of its role in shaping HIV-related risk, service uptake and impact. For example, in sub-Saharan Africa in 2017, 70 percent of new HIV infections in the 15-24 years age group among the 13 countries with the largest epidemics occurred among adolescent girls and young women.[15] This is largely attributed to intergenerational and transactional sex, resulting from unequal power dynamics, unequal access to economic resources and education, and GBV.[22] Women who experience IPV have a 50 percent higher risk of acquiring HIV.[23] In South Africa, women who experienced high levels of gender power inequality in male-female relationships had a 56 percent higher risk to test HIV positive.[23] Although women and girls are more likely to access HIV testing and treatment, women who experience violence have lower levels of testing, linkage to care and adherence to treatment.

Transgender communities are also particularly affected by HIV. Transgender women are up to 49 times more likely to live with HIV compared to the general worldwide population of adults of reproductive age.[25,26] In some countries, prevalence amongst transgender women is up to 80 times that of the general adult population.[25] The burden and experience of HIV in transgender communities is amplified by GBV, social stigma and structural discrimination, which results in interconnected outcomes such as poverty, isolation and reduced health-seeking.[27]

Men who perpetrate violence are also more likely to engage in a range of risk behaviours, including having multiple sexual partners, abusing alcohol and other substances, engaging in anal sex and visiting sex workers – all of which are proximal determinants of HIV risk.[23] The same harmful norms of masculinity that drive the perpetration of violence, condom non-use and number of partners, also contribute to lower uptake of HIV testing, lower linkage to care, higher loss-to-follow-up and lower adherence to treatment. This is reflected in higher rates of new infections and AIDS-related deaths among men in all regions, except sub-Saharan Africa.[28]

Evidently, gender inequalities and harmful gender norms affect all stages of the HIV prevention and treatment cascades.[29] The impact of the epidemic continues to fall disproportionately on women and girls, who are the primary caregivers when family members are ill or when children are orphaned. Widows, orphans and other children and women made vulnerable by AIDS continue to be stigmatized and denied their right to property inheritance in many countries.[30] These dynamics cumulatively contribute to further risk of transmission.

4.2 Gender and TB

About 60 percent of TB infections are among men, as well as two-thirds of estimated TB deaths.[31] In high burden low-income settings, particularly in Africa, men's health, masculinity and gendered male role/identity dynamics that contribute to the epidemiology of TB are largely overlooked within research, policy and programming.[32] However, globally more women die every year of TB than any other infectious disease and all-cause maternal mortality.[31] Women with TB and HIV co-infection are more likely to die of TB than co-infected men. However, there are variations in epidemics across countries, with more women than men detected with TB in some settings.[31]

A review of the evidence suggests that there are certain biological differences in women and men's susceptibility to TB, clinical manifestation and severity of the disease.[31] Some studies find that men may be biologically more vulnerable to pulmonary TB, while women have a higher prevalence of extra-pulmonary TB than men, particularly for genital TB. Other studies indicate that TB is more difficult to diagnose in women and progresses more quickly in women of reproductive age.

Pregnancy presents heightened risk for women living with TB and their children. The risk of premature birth is doubled and the risk of neonatal mortality is up to six times higher.[31] In addition, women living with HIV are 10 times more likely to develop TB during pregnancy, and their HIV co-infection makes them twice as likely to die.[31]

Occupational risks, such as deep pit mining, and other risk factors, such as smoking and alcohol use, partly explain men's increased exposure to TB infection.[33,34] In terms of access to services, men tend to delay seeking care longer than women, but women tend to face greater barriers when seeking appropriate medical care, because they first access less qualified providers and delay access to appropriate diagnosis and care.[35] Moreover, in some contexts this is exacerbated by women's financial dependence, lower prioritization of their health by family members and gender-specific stigma about TB. When on treatment, men are on average more likely to default and die, whereas women on average have better adherence, despite more serious adverse events.[35]

Health system factors also impact gender-related differences in access to services. For example, most countries rely on passive case-finding approaches, although it has been argued that active case-finding may be a more effective and gender-sensitive strategy to reach women.[36]

4.3 Gender and malaria

Despite the limited body of evidence, both sex-based and gender-related differences can explain the different vulnerabilities of women and men, boys and girls to malaria.[37] Due to lower literacy rates, women in certain settings have a lower understanding of malaria prevention and treatment. Studies show that gendered household roles/activities and dress codes

can affect women and men's exposure to malaria, such as women cooking outdoors during peak mosquito-biting hours and men working in forestry, fishing, mining or agriculture. In addition, women are less likely to sleep under long-lasting insecticidal nets (LLINs) in some settings, due to cultural and social pressures.[37]

Pregnancy is also a key risk factor, with pregnant women being more vulnerable than other adults to malaria, which can cause severe anaemia and death. This risk is further exacerbated for young, poor and rural women and women living with HIV.[37]

In terms of access to healthcare services, studies indicate that women could face additional barriers due to their restricted mobility and need for spousal consent of financial support to access medical care. In addition, men and women seek different types of health services for malaria, driven by economic necessity, i.e. poor women are more likely to rely on traditional remedies than men, and even when they are prescribed the correct course of treatment, their adherence can be further compromised by the financial costs or their care-giving responsibilities, leading to lower dosing, sharing pills and/or not completing the course of treatment.[37]

4.4 Gender, health systems and informal care

Women currently make up 70 percent of the health and social workforce, but continue to face a range of barriers and biases, including unequal pay, recognition and career progression; unequal access to education, training and technology; sexual harassment; unequal engagement and participation in decision-making processes.[38] In the context of UHC, there is increased reliance on CHWs to expand coverage to health promotion and education, treatment administration and monitoring and referrals, yet this largely female health cadre remains underpaid, undertrained and undervalued.[39,40]

Restrictive and harmful gender norms in most societies are further reinforced within and by health systems, leading to rights violations, disrespect and abuse of women healthcare providers and users, and less effective and responsive health systems.

The burden of informal care for sick family members also falls disproportionately on women and girls, across the three diseases. For example, when a family is affected by malaria evidence suggests that while the disease burden is greater for adult males, the economic burden is greatest for female family members, who need to provide food, medicines and care.[37]

4.5 Rationale for gender-responsive programming

There are two approaches to justifying the need for gender-responsive programming. The first is fundamentally a rights-based argument and principle whereby health programmes are intrinsically mandated to contribute towards the achievement of gender equality. Doing so is simply the 'right' way to do health programming. There is an implicit 'do no harm' principle, but also a strong underlying equity objective, which lies at the heart of public health programmes, UHC and the SDGs. Gender equity in health "is manifested in the effort to eliminate every avoidable, unjust, and remediable inequality between women and men in the state of health, health care and participation in health sector work."[15]

The second rationale for gender-responsive programming is an instrumental or efficiency argument. This means that it is necessary to reduce all causes, consequences and categories of inequities, including gender, to achieve the desired set health outcomes through programming. Addressing gender inequalities in health risk, behaviour, service uptake and informal care will enhance the efficiency of health programmes, in terms of time and resources invested to yield improved health impacts.[41] In practice, this instrumental approach tends to dominate in the health field.

For example, the HIV treatment cascade is a programmatic interventionist approach that takes effective treatment coverage as its endpoint and breaks this down into distinct steps along the client/patient pathway, from needing a service or an intervention, to making full use of it and reaping its benefits. Gender inequality and GBV are viewed as barriers and factors that cause attrition along the cascades. Implementing gender-responsive interventions that address these barriers will therefore optimise coverage across the cascade.

4.6 Which gender-responsive interventions work?

There are a range of gender-responsive interventions that have been designed and implemented to address gender inequalities in health. While most have focused on providing services that address the gender-specific needs of women and men, e.g. for pregnant women, or men who have sex with men, some have sought to factor in gender-related differences in programme design (gender-sensitive) and a smaller subset have sought to address and transform the causes of the inequalities (gender-transformative).[42–44] Some examples of effective gender-sensitive programming include mobile outreach models to accommodate women's care work or men's work times[45] and cash transfers for adolescent girls to keep them in school and reduce exposure to HIV.[46,47] To meet the SDGs and commitments to transform gender norms, and not just accommodate them, will require more than gender-sensitive programme tweaks. Rigorously evaluated gender-transformative approaches that engage women and men, in the form of group education or community mobilization, have been found to reduce violence, reduce number of sexual partners and increase HIV service uptake (see Box 1).

Box 1: Examples of Effective Gender-Transformative Interventions

Stepping Stones – Group gender education, South Africa

Stepping Stones is a gender-transformative approach designed to improve sexual health through building stronger and more gender-equitable relationships among partners, including better communication. Stepping Stones uses participatory learning approaches to increase knowledge of sexual health and build awareness of risks and the consequences of risk taking. In South Africa, the intervention was found to be effective in reducing sexual risk taking and violence perpetuation among young, rural men. Findings showed that men reported fewer partners, higher condom use and less transactional sex and perpetration of intimate partner violence. The evaluated intervention included a 50-hour programme (with a comparison group receiving a 3-hour intervention on HIV and safer sex).[48,49]

IMAGE – Microfinance and gender training in South Africa

The IMAGE intervention in South Africa combined microfinance for women with a gender and HIV training. A significant 55 percent reduction in the risk of experiencing physical or sexual violence by an intimate partner was observed two years after introduction of the intervention. This reduction was linked to a range of empowerment indicators and attributed to various responses enabling women to contest the tolerability of violence, leave abusive relationships, have expectations of and receive better treatment from intimate partners and promote public awareness of intimate partner violence.[50]

SASA! – Community-based violence prevention and HIV intervention, Uganda

SASA! is a community mobilization intervention that seeks to change community attitudes, norms and behaviours around power imbalances between men and women, to reduce gender inequality, violence and HIV vulnerability. A randomized controlled trial in Uganda found that the intervention was associated with significantly lower social acceptance of IPV among women and men; significantly greater acceptance by women and men that women can refuse sex; and lower levels of past year experience of sexual and physical IPV. Women experiencing violence in intervention communities were more likely to receive supportive community responses. Reported past year sexual concurrency by men was significantly lower in intervention compared to control communities. An analysis of who holds power and how it may be misused ultimately led to discussions of gender inequality and violence.[51]

5. FINDINGS

5.1 Key findings across the portfolio

As summarized in the Appendix, there is a certain degree of engagement with gender issues across the grants managed by UNDP, and a number of efforts to address gender-specific needs or even overcome gender-related barriers to accessing services, but several grants still do not explicitly consider gender or respond to gender inequities. Where gender issues are identified in funding requests, there is often a gap between the gender-related disparities and issues identified and the subsequent prioritization of gender-responsive interventions to address them. These declining levels of responsiveness to gender along the grant cycle span were observed from: the documentation and analysis of sex-disaggregated data for the identification of gender issues related to the three disease programmes; the prioritization of gender equity in grant objectives and interventions; the levels of investment and implementation; and finally, from performance monitoring.

Issues, interventions and included populations

Conversely, just under two-thirds of TB and malaria grants included sex-disaggregated data when analysing disease risk, service use and health outcomes within the national context. These grants were much less likely to include gender equity in their grant objectives (especially the TB grants), and only 36 percent of TB grants and 50 percent of malaria grants prioritized some form of gender-responsive intervention.

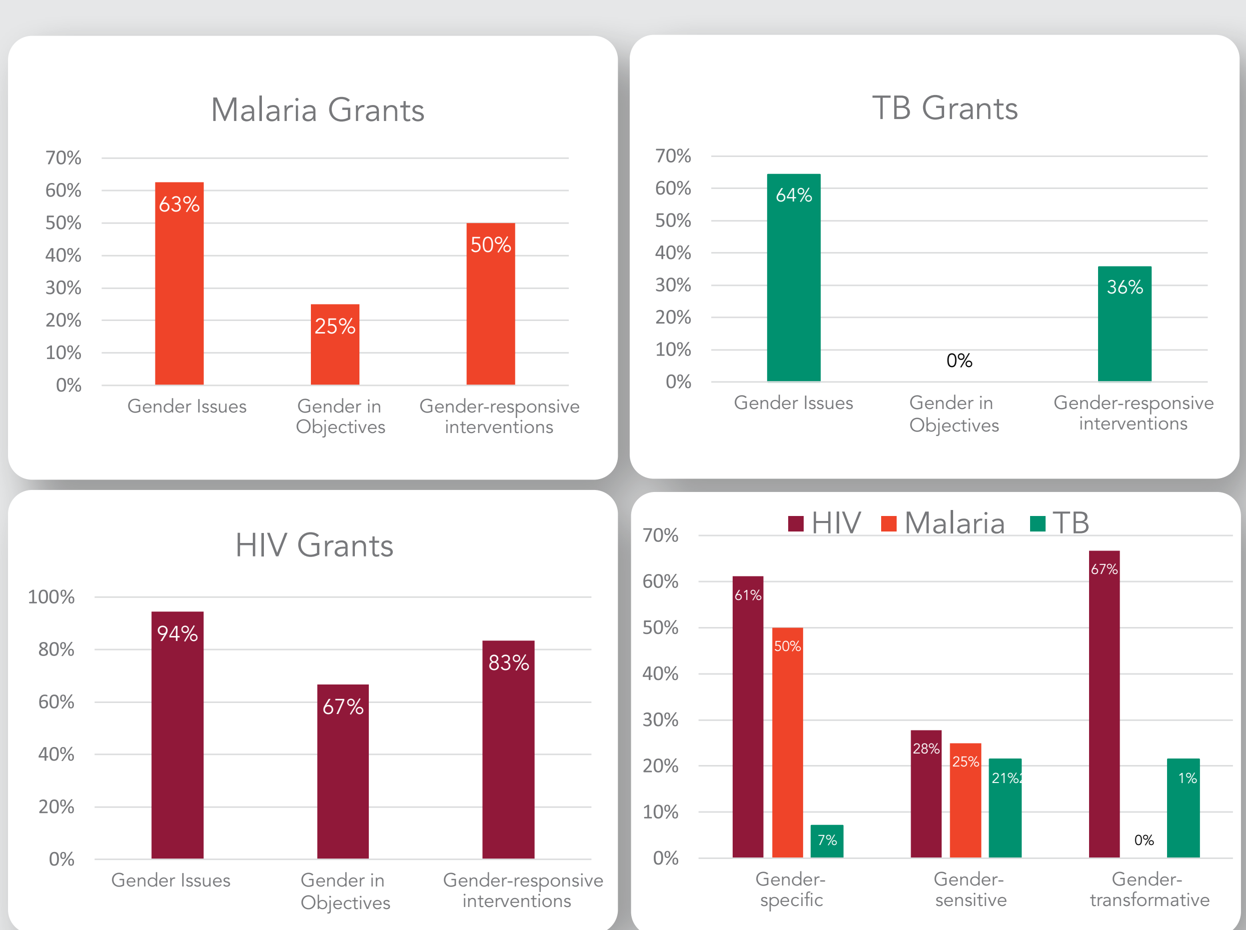
The types of gender-responsive interventions included in these grants are primarily gender-specific for HIV and malaria, targeting pregnant women or gendered KP groups (female sex workers , adolescent girls and young women, men who have sex with men, transgender populations). Around 21-28 percent of TB, malaria and HIV grants included gender-sensitive programming that acknowledged and accommodated gender-related inequities, yet none of the malaria grants and only 21 percent of the TB grants included interventions to transform the underlying inequities in gender norms, roles and relationships. Encouragingly, two-thirds of the HIV grants did prioritize gender-transformative approaches. It was assumed that modules focused on structural, human rights and legal barriers, such as those that address stigma and discrimination, education and legal reform, included gender-transformative intervention components. However, this could not be fully ascertained, as it was not explicit.

Only two multi-country HIV grants (Africa regional and Americas) did not include gender-specific prevention modules, because of the systemic and legal focus of these grants (focus on removing legal barriers and enhancing technical and advocacy skills). These modules are potentially gender-transformative in that they could address the legal, institutional and systemic gendered dynamics that lead to stigma, discrimination and gender inequalities. An evaluation of the grant found that there were some strategic litigation activities that addressed the gender dimensions and inequities. (See Box 6)[52,53] In single country grants, interventions that targeted the legal and policy frameworks that perpetuate gender discrimination and disadvantage were only apparent in HIV grants (Afghanistan, Belize, Panama, Tajikistan, Zimbabwe). This is surprising, given UNDP's expertise and comparative advantage in this area.

Most modules that were not gender-specific could broadly be categorized as gender-blind, with some potentially being gender-unequal and perpetuating gender inequities. Strikingly, there was a clear difference in how gender was considered in HIV grants, in comparison to TB and malaria, even within the same country context (e.g. Afghanistan).

The descriptions in the funding requests indicated a general understanding that gender programming relates to women and girls, or to gender-specific modules, such as for pregnant women in malaria or female sex workers and men who have sex with men in HIV responses. This was then provided as a rationale for not prioritizing gender equity as an objective with associated programming in countries with male-disproportionate epidemics or generalized epidemics (see Box 2). Other narratives suggested that the equity focus of the grant precluded the need for a gender lens, or that the need to prioritize the 90-90-90 targets in the HIV response left limited scope for investments in gender-responsive interventions.

Figure 3. Gender-responsiveness across grants: the identification of gender issues, gender in grant objectives and gender-responsive interventions



Note: Grants with gender-responsive interventions had at least one gender-specific, gender-sensitive or gender-transformative intervention in their modules.

Box 2: Why did grants not prioritize gender-responsive programming?

In each grant application, countries were asked to describe whether and how their programme would contribute to promoting gender equality (Strategic objective 3). Below are some of the explanations provided for not including a focus on gender:

- Equity & equal delivery focus: grant seeks to provide services in 'equal manner regardless of gender, ethnicity and religion' (malaria, Afghanistan)
- Adequate gender-specific programming: programming for pregnant women deemed adequate and higher priority placed on providing services to other vulnerable populations (malaria, Burundi)
- Priority given to other vulnerable populations: higher priority to provide services to 'other'/non-female vulnerable populations (malaria, Burundi)
- Gender is likely associated with women-focused programming: increased gender programming not deemed necessary because epidemic was male-disproportionate (TB, South Sudan)
- Conservative and delicate national context: service delivery for key and vulnerable populations in general are challenged by conservatism and socio-cultural dynamics (TB, South Sudan)
- The pursuit of 90-90-90 targets and focus on key populations is a greater priority, even though there is recognition of room for more intensive rights-based and gender-appropriate training (HIV, Iran)

Investments

Overall, the Global Fund budget format limits the visibility of gender-responsive spending, as it is based on cost categorization by grant module and by resource use categories, i.e. cost of human resource, travel, health products, etc., across the grant. Additionally, there were no available descriptions of the scale of implementation of each activity, unit costs or expenditure reports with sub-categorization based on spending by specific activity or sex-disaggregated populations. Importantly, there was no information to determine whether and how gender was addressed in modules with the largest budget allocations, such as the treatment and care modules within HIV grants.

As a limited proxy, gender-specific HIV modules were used to calculate the total and proportion of grant budgets allocated to gender-specific programmes (see Table 3). These include comprehensive prevention programme modules for PMTCT, adolescent youth in and out of school (that were focused on adolescent girls and young women), men who have sex with men and transgender populations.

In countries where disaggregated budget data were available, between 4-18 percent of HIV grant budgets were allocated to gender-specific prevention modules, with a higher proportion allocated to men who have sex with men and sex worker modules and comparably less to transgender and adolescent girls and young women modules. For example, in the Zimbabwe HIV grant, the proportion allocated towards gender-specific modules (PMTCT, female sex workers, men who have sex with men and adolescent girls and young women) in the budget was about 4.6 percent of the total. Despite the comprehensive gender data and analysis on prevalence and incidence in this grant, there was still limited investment in gender-responsive prevention modules. Nearly 70 percent of the budget was allocated to treatment and care, where gender-related barriers were not analysed in the grant documents, and no gender-responsive interventions were visibly prioritized.

Programme modules for TB and malaria were not explicitly gender-specific, but rather contained elements that were gender-specific, such as programmes for pregnant women in malaria grants. The grant budgets for gender-specific groups in the TB and malaria grants were not directly visible, and thus calculations were not performed. Similarly, in the RSSH modules budget categories were based on types of resource inputs, not on activities.

Table 3: Total and percentage of budget allocated to fully gender-specific modules in HIV grants

Country	Disease	Duration	Grant amount ($ million)	Total gender-specific module (%)	MSM (%)	FSW (%)	PMTCT (%)	AGYW (%)	TG (%)
Afghanistan	HIV	2018-2020	8.9	12.1	7.3	4.8	0	0	0
Angola	HIV	2018-2021	23.1	14.4	0.9	1.7	9.4	2.4	0
Belize	HIV/TB	2019-2021	1.9	15.0	14.9	0	0	0	0.1
Burundi	HIV/TB	2018-2020	35.6	8.8	0.7	5.0	2.6	0.5	0
Cuba	HIV	2018-2020	13.3	13.0	9.0	3.0	0	0	1.0
Egypt	HIV/TB	2019-2022	2.1	15.8	11.3	4.5	0	0	0
Iran	HIV	2018-2021	10.7	4.4	0	3.8	0.6	0	0
Kyrgyzstan	HIV/TB	2018-2021	21.0	4.9	2.2	2.5	0.2	0	0
Multi-country Western Pacific	HIV/TB	2018-2020	11.4	9.0	2.0	1.2	0.4	1.3	4.1
South Sudan	HIV	2018-2020	32.7	4.4	0.1	2.0	1.7	0.6	0
Sudan	HIV	2018-2020	16.6	17.7	11.4	5.0	1.3	0	0
Tajikistan	HIV	2018-2020	12.9	8.4	2.8	5.6	0	0	0
Zimbabwe	HIV	2018-2020	426.4	4.6	0.3	2.0	0.3	2	0

*Only modules with fully gender-specific target populations were included in this table

Implementation and impact

Documentation such as the performance frameworks[i] and management actions from Global Fund project managers after annual grant performance reviews were reviewed to analyse the extent to which gender domains and analysis featured in the process of the grant implementation and impact assessments.

Sex-disaggregation was the only measure of gender-responsive monitoring and evaluation that was identified. As such, the impact, outcome and coverage indicators in the performance frameworks were reviewed to assess how gender featured in implementation tracking and grant accountability mechanisms.

Overall, there was some level of requirement for sex-disaggregated monitoring and reporting, but not across all indicators. The Global Fund's Modular Framework suggests where sex-disaggregation (female, male and transgender in HIV modules) of impact, outcome and coverage indicators is beneficial. However, not all indicators that potentially could be sex-disaggregated are suggested by Global Fund to be sex-disaggregated. For instance, no sex-disaggregation is suggested for any of the impact indicators for TB in the October 2019 Modular Framework, including for TB incidence and mortality rate. Again, for gender-specific modules, such as men who have sex with men programmes, performance indicators were gender-specific as well (e.g. the proportion of men who have sex with men who were reached with HIV prevention programmes).

Since a focus on gender was not prominent in grant objectives and modules across all reviewed grants, it

[i] Performance Frameworks (PF): a statement of intended performance and impact, to be reported to the Global Fund over the grant term. It includes an agreed set of indicators and targets consistent with the programmatic gap analysis submitted by the country in the funding request.

also did not feature strongly within the performance frameworks. In some cases, the performance frameworks do not include a requirement for sex-disaggregation, even for indicators where sex-disaggregation has been suggested by the Global Fund (see Table 4, Table 5 and Table 6). Additionally, reporting of sex-disaggregated indicator data was often not included in annual performance reporting. Very rarely did management action letters include recommendations related to gender.

5.2 Malaria grants

Issues and included populations

Most of the grants (Afghanistan, Burundi, Chad, Guinea-Bissau, Sao Tome and Principe, and Western Pacific-Vanuatu) recognized that pregnant women are at a higher risk of malaria and included deliberate efforts to safeguard them. In this regard, these grants would be considered gender-specific since they considered the health needs of a specific sub-population of women. Beyond this, there was hardly any recognition of other gendered factors, such as varied roles and responsibilities that could result in differential exposure to disease risk or impact service uptake, treatment adherence and care burden.

Overall, the malaria grants analysed could be categorised as gender-blind, with the exception of pregnant women. Various gendered mobile populations were highlighted as vulnerable in several grants, but deliberate interventions to reach them and address their specific needs were often lacking. In Djibouti, for example, although the grant took gender considerations for men and women into account in their analysis, this did not translate to gender-responsive interventions in the programme planning.

Afghanistan was an exception, where there was explicit recognition of the role played by gender norms (including restricted mobility) in placing barriers to early access to health services for women. The gender analysis also informed intervention design, with community-based management of malaria being supported in the current grant to address obstacles to the accessibility of malaria services for women and girls. This case management approach delivered through an extensive community health worker network, and by assigning both male and female workers at a community level, is considered gender-sensitive.

Interventions

Unsurprisingly, following on from the primary identified gendered issue in the context of malaria, most of the gender-specific interventions were focused on pregnant women. There were insufficient descriptions in the documentation of two of the eight grants (Bolivia and Djibouti) to ascertain the inclusion of interventions for pregnant women.

The exact package of interventions varied from country to country, but broadly comprised:

- Targeted distribution of LLINs to pregnant women and women with young children, including during antenatal care (ANC) and child immunisation visits (all countries except Djibouti and Bolivia);
- Targeted strategies to ensure pregnant women sleep under LLINs, including establishing homes in Guinea-Bissau where women in the late stages of pregnancy can stay close to health facilities, both for easier access to care and to ensure that they are protected by LLINs;
- Provision of IPT to pregnant women (Sao Tome and Principe, Republic of Chad, Guinea-Bissau and Afghanistan);
- Use of CHWs and increasing the number of female CHWs to address issues of women's access to malaria services (Afghanistan). A number of countries, like Guinea-Bissau, also included training of CHWs to expand access to malaria services and community case management, although this was not explicitly a gender-responsive intervention;
- Capacity-building for CSOs providing services to women (Afghanistan).

Performance frameworks

Table 4 outlines the indicators that the Global Fund has recommended for sex-disaggregation, which of these indicators have been included within country performance frameworks for the three malaria grants studied and whether these country grants required their sex-disaggregation. Encouragingly, most of the impact and outcome indicators recommended for disaggregation are included in the performance frameworks of Chad and Djibouti, including insecticide-treated net (ITN) access and use.

In addition, in Afghanistan the impact indicators did not require disaggregation by sex for the number of reported malaria cases. Although the outcome indicators for the proportion of population who slept under a net required sex-disaggregation, it was not included in progress updates. This could perhaps be explained by the timing or availability of survey results, since this is not routine programme data.

Similarly, in Bolivia's malaria grant baseline figures revealed sex-disproportionate testing in public sector and community settings, where more women accessed testing in community settings and more men in public health facility settings. The performance framework required some sex-disaggregated reporting, but these indicators were not reported against in the performance updates.

Table 4: Requirement for sex-disaggregation in performance frameworks for malaria grants by country

Indicator with sex-disaggregation suggested in Global Fund **2019 Modular Framework**	**Countries with required sex-disaggregation in Performance Framework**		
	Afghanistan	*Chad*	*Djibouti*
Impact indicators			
Malaria I-5 Malaria parasite prevalence: Proportion of children aged 6-59 months with malaria infection	Not included in PF	**Yes**	**Yes**
Malaria I-6 All-cause under-5 mortality rate per 1000 live births	**No**	**Yes**	**Yes**
Outcome indicators			
Malaria O-1a Proportion of population that slept under an ITN the previous night	**Yes**	**Yes**	**Yes**
Malaria O-3 Proportion of population using an ITN among those with access to an ITN	Not Included in PF	**Yes**	**Yes**
Coverage indicators			
SPI-2 Percentage of children aged 3–59 months who received the full number of courses of seasonal malaria chemo-prophylaxis - SMC (3 or 4) per transmission season in the targeted areas	Not Included in PF	**Yes**	Not included in PF

Gaps and entry points

There were opportunities for further gender-responsive programming for the following identified vulnerable populations:

- Mobile populations: Several grants highlighted population movements, particularly external migrant workers, refugees, IDPs and nomads as being at higher risk of malaria morbidity and mortality. In Djibouti, the grant specified that it was migrant men who were at higher risk, whilst Afghanistan highlighted that women and children made up the large majority of refugees and IDPs;
- Occupational groups: Those identified as at high risk included Brazilian nut harvesters in the Amazon, in Bolivia, and mining workers in Burundi, but the grants did not state the gender composition of these occupational groups, or how programming addressed any gender dynamics;
- CHWs may also be more exposed to certain risks in their line of work, such as GBV, but there were no gender discussions in how programme modules addressed these gender dynamics;
- Indigenous communities and people living in hard-to-reach locations;

- People sleeping outdoors (street children, homeless migrants);
- People living in close proximity (prisons, boarding schools, retirement homes).

In all eight grants, there were no gender-responsive interventions or investments targeted at the above identified groups. A good example of how gendered norms, roles and activities impact malaria is in the South-East Asia region, where forest workers and people who spend significant amounts of time outdoors during the day – often men – are at an increased risk of getting drug-resistant malaria, but benefit less from ITNs than pregnant women and young children.[50]

The Afghanistan grant identified prisoners and street children as gendered population groups that were potentially at higher risk of malaria morbidity and mortality, but there was no sex-disaggregation of these groups, no analysis of how gender norms or inequities influenced these risks or barriers to services and no interventions responding to their needs.

In the interventions discussed, further engagement with gender dynamics, particularly at a household level, may further inform the uptake and success of interventions. For example, some grants indicated a target of providing one ITN per household, and pregnant women were provided with an additional net in some cases. The grants did not discuss household composition, gender dynamics and the decision-making around who sleeps under the 1-2 ITNs available. This is an important consideration that has implications on performance indicators and outcomes, such as the number of pregnant women who sleep under ITNs.

Box 3 The need for sex-disaggregated data to better understand gender-differentiated health outcomes in Chad

Capturing sex-disaggregated data is critical for an appropriate malaria policy and intervention response. Hitherto, especially at health facilities, sex-disaggregated data for malaria cases were not being collected, making it difficult to ascertain gender disparities (if any) in access to healthcare facilities for suspected cases, diagnosis and case management in Chad.

In the last quarter of 2019, data collection tools at the health facility level have been revised to collect sex-disaggregated data for case management. This provides opportunities to identify any significant gender disparities, their underlying causes and to inform the design of appropriate evidence-based interventions to address them.

Box 4: Mobilizing women community leaders and community networks for prevention in Djibouti

In Djibouti, the commitment to engaging with and leveraging community resources – women leaders, youth and migrant groups – is a critical entry point for mobilizing and ensuring that malaria prevention strategies such as distribution of ITNs reach women, refugees and migrants where they are. As women mobilizers are respected community members and are entrusted to represent their communities in health facility management committees, they are a critical link to engage at-risk men and understand community needs and concerns, as well as to understand what is working or not in ongoing malaria interventions.

For migrants, engagement is through peers in order to mitigate the challenge of language barriers, while also ensuring the likelihood that awareness messages reach them considering that most work during the day, when health campaigns are often conducted.

5.3 TB grants

Issues

The TB epidemics in the grants reviewed were predominantly male-disproportionate. For example, in South Sudan men were more affected than women, with the male-to-female ratio of TB prevalence at nearly 3:1 for the most affected age group (25-34 years). The funding request discussed gender-related drivers of exposure, including how men spent more time together in groups, which could increase the risk of TB transmission. This was exacerbated by the adoption of poor eating habits, resulting in an unbalanced diet and, ultimately, malnutrition. It was also found that women had better health-seeking behaviour, which could explain better treatment outcomes.

In the epidemics that were female-disproportionate (Afghanistan and Djibouti), women's high risk of GBV, domestic abuse, low decision-making power, psychosocial and cultural barriers to care within settings of conflict, or limited knowledge of their rights were identified as gender-related risks and barriers to using services.

Three countries – Afghanistan, Belize and Kyrgyzstan – specifically recognized the role of harmful gendered sociocultural norms and dynamics in access to care and adherence to treatment. In Afghanistan, the grant documented women's low decision-making authority and lack of access to household/financial resources, high levels of violence against women and girls and very low education levels amongst women and girls. In Belize, sociocultural norms and religious values impede men who have sex with men and transgender women from accessing TB services, due to related stigma. In Kyrgyzstan, the grant described that even though substantial progress had been made in addressing gender inequalities and violence, stigma and discrimination remain a barrier to health access (see Box 5).

Box 5. Gender Assessment of TB in Kyrgyzstan

In a 2016 Assessment, the Global Fund found that there was little programming that addressed the gender-related barriers to accessing health services for TB, except for a TB gender and legal assessment that was conducted by the Stop TB Partnership. Both assessments provided a formative evidence base required to initiate negotiations around the need for further gender-responsive programming for both men and women.

The Stop TB gender and TB assessment found multiple areas that affected the prevention, treatment and quality of life of people with TB, which could be addressed through targeted programming:

- Low levels of public information about TB (including public services, social entitlements and free access to healthcare) especially amongst women in rural areas, which also contributes to widespread stigma and reports of mistreatment (including family abandonment and losing access to children) following a TB diagnosis
- Economic consequences of TB, with insufficient legal employment protection for people with TB
- Insufficient access to timely and continuous treatment for women in rural areas.

Interventions

The number, scale and scope of gender-responsive interventions within TB grants is still low, but some of the gender-sensitive and gender-transformative interventions identified in the grant activities include:

- Gender-sensitive patient support for women in Turkmenistan, who benefit particularly from patronage visits to ensure/encourage daily intake of TB drugs, psychological counselling and patient empowerment through education about the disease. The patient-centred ambulatory model is promoted by the National TB Programme to enable women to stay with their families during their treatment course;
- The application of the TB Gender Assessment Tool for vulnerable populations, including refugees and IDPs in Pakistan and Afghanistan, as part of the Multi-Country South Asia TB grant;
- Increasing the number, and training, of female health care workers at the community level and establishing female health and social counsellors to reduce gender disparities and increase access in Afghanistan, where women have restricted mobility and there are strict social norms dictating interactions between women and men;
- Working with CSOs and National TB Programmes to ensure appropriate targeting and advocacy for vulnerable and high-risk groups, including gender-specific groups;
- Systematic TB screening and active case identification;
- Inclusion of GBV training within TB modules.

Performance framework

The two country case studies with TB grants (Afghanistan and Kyrgyzstan) included very few of the recommended indicators with sex-disaggregation (see Table 5). The coverage indicators for all-form and multidrug-resistant TB (MDR-TB) case notification did require sex-disaggregation. However, treatment coverage and treatment success are not sex-disaggregated, despite international evidence suggesting differences between women and men.

Table 5: Requirements for sex-disaggregation in performance frameworks for TB grants by country

Indicator with sex-disaggregation suggested in the Global Fund 2019 Modular Framework	Countries with required disaggregation in Performance Framework	
	Afghanistan	Kyrgyzstan
Outcome Indicators		
TB O-7 Percentage of people diagnosed with TB who experienced self-stigma that inhibited them from seeking and accessing TB services	Not Included in PF	Not Included in PF
TB O-8 Percentage of people diagnosed with TB who report stigma in health care settings that inhibited them from seeking and accessing TB services	Not Included in PF	Not Included in PF
TB O-9 Percentage of people diagnosed with TB who report stigma in community settings that inhibited them from seeking and accessing TB services	Not Included in PF	Not Included in PF
Coverage Indicators		
TCP-1 (M) Number of notified cases of all forms of TB (i.e. bacteriologically confirmed + clinically diagnosed), new and relapse cases	**Yes**	**Yes**
TCP-2 (M) Treatment success rate - all forms: Percentage of TB cases, all forms, bacteriologically confirmed plus clinically diagnosed, successfully treated (cured plus treatment completed) among all TB cases registered for treatment during a specified period, new & relapse cases	Not Included in PF	Not Included in PF
TB/HIV-5: Percentage of registered new and relapse TB patients with documented HIV status	Not Included in PF	**No**
TB/HIV-6 (M). Percentage of HIV-positive new and relapse TB patients on antiretroviral therapy (ART) during TB treatment	Not Included in PF	**No**
TB/HIV-3.1 Percentage of PLHIV initiated on ART who are screened for TB in HIV treatment settings	Not Included in PF	**No**
TB/HIV-7 Percentage of PLHIV on ART who initiated TB preventive therapy among those eligible during the reporting period	Not Included in PF	Not Included in PF
MDR TB-2(M) Number of TB cases with Rifampin-resistant (RR-TB) and/or MDR-TB notified	**Yes**	**Yes**
MDR TB-3 (M) Number of cases with RR-TB and/or MDR-TB that began second-line treatment	Not Included in PF	**Yes**
MDR TB-9 Treatment success rate of RR TB and/or MDR-TB: Percentage of cases with RR and/or MDR-TB successfully treated	Not Included in PF	Not Included in PF

Gaps and entry points

Countries that did not indicate sex-disaggregated data include Egypt, Kyrgyzstan, Sao Tome and Principe and the multi-country grants (Western Pacific and South Asia). In Kyrgyzstan, the grant indicated that TB incidence is much higher in prisoners and labour migrants, but this was not sex-disaggregated. Similarly, the Multi-Country TB South Asia grant, which covered Afghanistan, Iran and Pakistan, highlighted the vulnerability of migrant, refugee and IDP populations, but data was not sex-disaggregated.

Beyond sex-disaggregated data, there was some level of consideration of gender dynamics in the TB grants analysed. Although sex-disaggregation is a good start to inform a gender analysis of the problem, it is not sufficient, and there is need for an explicit analysis to interrogate how gender norms and inequities impact on TB disease risk, service uptake and outcomes. In the South Asia multi-country grant, the application of the TB gender assessment tool proposed in the current grant cycle is a positive entry point, which could be an opportunity for capacity development to design and implement more gender-responsive programming.

The role of stigma in access to services and treatment uptake, both at societal and health system level, was also highlighted in Egypt and Kyrgyzstan, but unlike in Belize there was no recognition of the differential impact of stigma for men, women and transgender populations.

Importantly, although most countries had a male-disproportionate TB epidemic, this did not translate to gender-specific interventions targeting men, and even less to gender-transformative interventions working with men to transform the harmful gender norms around masculinity that may influence their heightened exposure and poorer treatment outcomes. Given the high rates of incidence and mortality among men, gender-sensitive interventions are needed to facilitate early diagnosis in men. This could be through workplace interventions, for example, or through adapted service provision (mobile, adapted clinic times, etc). Beyond these adaptations and targeting platforms, gender-transformative programming could include community and peer-based trainings that address norms of masculinity and health-care seeking, in addition to power dynamics and the perpetration of violence.

5.4 HIV grants

Issues

In comparison to the malaria and TB grants, there was more nuanced articulation of gendered issues related to drivers of HIV disease risk and access to HIV services in the HIV grants. These included:

- Sex-disaggregated data on HIV prevalence, incidence, mortality and treatment outcomes in some, though not all, of the grants;
- Explicitly identifying and targeting gendered KPs, such as female sex workers, men who have sex with men and HIV-positive pregnant women for PMTCT;
- The role of gender norms, gendered power hierarchies and differential stigma levels, based on gender, in hindering access to treatment and disclosure of HIV status;
- Normalization of harmful norms and practices, such as violence against women and harmful hegemonic masculinities, which perpetuate gender inequities and act as drivers of disease risk;
- Inadequate legal and policy structures, including in the context of GBV;
- Inadequate law enforcement, implementation and actual change in social norms, despite enabling policy environments, national health strategies and political commitments. For example, in Sao Tome and Principe, laws were passed decriminalising sexual relations between consenting adults, including same-sex couples, whether paid or not, in relation to sex workers. Nonetheless, affected groups still recounted experiencing extensive stigma and discrimination, both socially and from the health system, which in turn affects care-seeking and disclosure of HIV status.

Interventions

Overall, the HIV grant tended to include several gender-specific interventions that addressed the needs of gendered population groups at higher risk of HIV, as well as increasing responsiveness to gender norms, power dynamics and inequities. Specifically, most HIV grants included at least one of the following gender-specific interventions:

- PMTCT targeting pregnant women, primarily to prevent HIV infection in their infants, but also including treatment objectives for the mothers, and sexual and reproductive health services for women living with HIV (Iran, Western Pacific region, Sao Tome and Principe, South Sudan, Zimbabwe);
- Comprehensive prevention programming for high-risk KPs, including condoms, HIV counselling and testing, screening and treatment of STIs, and behavioural interventions through peer education (Afghanistan, Egypt, Kyrgyzstan, Western Pacific region, Panama, Sao Tome and Principe, Sudan, Zimbabwe). Depending on the context, these programmes engaged people who inject drugs, men who have sex with men, female sex workers, adolescent girls and young women, transgender people and prisoners, and their specific components varied.

A number of grants with KP programmes used these gender-specific interventions as entry points for more transformative programming that sought to change gender norms and perceptions among communities, healthcare providers and/or law enforcement officers, etc. The three regional grants (Africa, Americas and Western Pacific) and several country grants included programming to remove legal barriers faced by KPs in accessing HIV and TB services. In some cases, these human rights programmes served as entry points to address structural barriers that were affecting specific gendered populations, and in some cases to transform norms and laws that perpetuate gender inequity. Specific examples of such interventions include:

- Training of KPs, duty bearers and healthcare providers on gender identity, human rights, non-discrimination, GBV and medical ethics (Afghanistan, Belize, Cuba, Egypt, Tajikistan);
- Advocacy on human rights and removing legal barriers, strategic litigation, legal literacy training that includes support for women and girls in KPs or living with HIV (African region, Americas, Tajikistan, Panama, Zimbabwe);
- Comprehensive programmes for adolescent girls and young women with layered interventions that went beyond biomedical interventions and used a multi-pronged approach, including multisectoral collaboration and coordination; deliberate community and stakeholder engagement with a gender focus and targeting key groups such as religious leaders, the media and traditional birth attendants (Angola, Zimbabwe). In Zimbabwe, the layered approach included targeting the most vulnerable adolescent girls and young women with education subsidies, provision of family planning commodities, post-violence care and livelihood programmes.

Seven grants included some programming to address GBV, as a driver of HIV risk and a human rights violation. Most of the interventions involved advocacy and awareness-raising on violence against women and girls, as well as institutional violence against men who have sex with men, minors and transgender people. Angola included Post-Exposure Prophylaxis (PEP) for rape survivors; but none of the grants included training of healthcare providers to respond to GBV.

Box 6: Lessons from the Africa Regional HIV Grant on 'removing legal barriers' to access

A multi-country programme was developed to strengthen various national legal and policy processes to reduce the impact of HIV and TB on KPs across 10 countries in Africa (Botswana, Côte D'Ivoire, Kenya, Malawi, Nigeria, Senegal, Seychelles, Tanzania, Uganda and Zambia). Financed by the Global Fund, the programme was implemented from January 2016 to December 2019.[39] UNDP was the PR of the grant, while four established organizations with demonstrated experience served as sub-recipients: the AIDS and Rights Alliance for Southern Africa, Enda Santé, Kenya Legal & Ethical Issues Network on HIV and AIDS, and the Southern Africa Litigation Centre.[44] Activities included legal environment assessments, regional trainings, advocacy and strategic litigation on cases involving KPs (men who have sex with men), male/female/transgender sex workers, transgender people, people who inject drugs and prisoners).[44]

Legal environments are crucial determinants of health, which can undermine or promote access to services and effective programme implementation.[1] The core focus and objectives of the grant were to strengthen the enabling environment, support access to justice and prevent or address human rights violations through a strong network of regional NGOs and key country stakeholders, including KPs themselves.

The programme was successful in:[39,40]

- Creating strong peer networks and 'safe spaces' for supportive civil society groups, parliamentarians, judges, civil servants and others to exchange knowledge and share learning, develop advocacy strategies and strengthen their capacity on KP issues, especially for stakeholders from countries with particularly severe stigma and/or criminalization;
- Supporting South-South learning and accelerated dissemination and adoption of good practice, through governance and leadership of regional stakeholders in programme design and implementation;
- Developing technically strong, evidence-informed strategies and guidelines for working with KPs;
- Nurturing close partnerships with local champions and advocates, and capacity-building for local NGOs to increase scope and scale of their advocacy and programming;
- Catalyzing and supporting improved human rights standards and law reform at the country level.
- Strategic litigation.

The programme addressed the legal and policy barriers faced by KPs because of their gender identity (in the case of transgender people), their sexual orientation (men who have sex with men), their HIV status, drug use or transactional sex activities. For some KPs, the stigma, discrimination and barriers to services they encounter are often the result of intersecting gender and other identities, and reflect patriarchal gender norms and inequities. By intervening at a structural level, the programme contributed to removing legal and policy barriers that prevent access to health services for KPs that reinforce inequitable gender norms around masculinity, heteronormativity and criminalization of primarily women's sex work. Some examples of how the programme addressed intersecting forms of discrimination and contributed to positive legal precedents for supportive gender-sensitive laws, include:[39]

- **Recognition of transgender marker in Botswana:** The Botswana High Court (2017) held that the refusal of the Registrar of National Registration to change an applicant's gender marker from female to male was unreasonable and violated his rights to dignity, privacy, freedom of expression, equal protection of the law and freedom from discrimination, and constituted inhumane and degrading treatment.
- **The breastfeeding case in Malawi:** The Zomba High Court (2017) held that the applicant, a woman living with HIV on ART who was accused of accidentally breastfeeding another person's child, did not have the knowledge or belief that breastfeeding the complainant's child was likely to transmit HIV. This was a landmark ruling on the application of criminal law to cases of HIV transmission, exposure and non-disclosure.

Gender was not included in the objectives of the grant. Nevertheless, some of the activities under this grant focused on gendered KPs (women living with HIV, transgender people, men who have sex with men), and some of the outcomes of strategic litigations included positive impacts on how gender discrimination is addressed and managed at a structural level. This also includes a focus on addressing women living with HIV, female sex workers and women who use drugs, as well as stakeholders who are women, including parliamentarians, judges, lawyers and healthcare workers. Future implementation or grant design could be strengthened with greater attention to the intersection between the legal barriers faced by KPs and gender-related barriers to access health services and justice.[39]

Performance frameworks

In the three HIV grants included in the country case studies, there is limited sex-disaggregation required at the impact level, even for the included indicators on HIV prevalence among sex workers and people who inject drugs (Table 6). At the outcome and coverage levels, only ART coverage, sex worker condom use and sterile equipment use among people who inject drugs were required to be sex-disaggregated.

Table 6: Requirement for sex-disaggregation in performance frameworks for HIV grants by country

Indicator with sex-disaggregation suggested in Global Fund 2019 Modular Framework	Countries with required disaggregation in Performance Framework		
	Afghanistan	Cuba	Kyrgyzstan
Impact Indicators			
HIV I-13 Percentage of PLHIV	Not Included in PF	Not Included in PF	Not Included in PF
HIV I-14 Number of new HIV infections per 1,000 uninfected population	Not Included in PF	Not Included in PF	Not Included in PF
HIV I-4 Number of AIDS-related deaths per 100,000 population	Not Included in PF	Not Included in PF	**Yes**
HIV I-10(M)- Percentage of sex workers (SWs) who are living with HIV (female, male, transgender)	**No**	**No**	**No**
HIV I-11(M) Percentage of PWIDs who are living with HIV (female, male, transgender)	**No**	Not Included in PF	**No**
Outcome Indicators			
HIV O-10 Percent of respondents who say they used a condom the last time they had sex with a non-marital, non-cohabiting partner, of those who have had sex with such a partner in the last 12 months	Not Included in PF	Not Included in PF	Not Included in PF
HIV O-5 (M) Percentage of SWs reporting the use of a condom with their most recent client (female, male, transgender)	**Yes**	**Yes**	**Yes**
HIV O-6 (M) Percentage of PWIDs reporting the use of sterile injecting equipment the last time they injected (female, male, transgender)	**Yes**	Not Included in PF	**Yes**
HIV O-9 Percentage of PWIDs reporting condom use that last time they had sex	**Yes**	Not Included in PF	Not Included in PF
HIV O-11(M) Percentage of people living with HIV who know their HIV status at the end of the reporting period (female, male, transgender)	Not Included in PF	Not Included in PF	Not Included in PF
HIV O-12 Percentage of PLHIV and on ART who are virologically suppressed (female, male, transgender)	Not Included in PF	**No**	Not Included in PF
HIV O-16c Percentage of SWs who avoid health care because of stigma and discrimination (female, male, transgender)	Not Included in PF	Not Included in PF	Not Included in PF
HIV O-16d Percentage of PWIDs who avoid health care because of stigma and discrimination (female, male, transgender)	Not Included in PF	Not Included in PF	Not Included in PF
HIV O-17 Percentage of PLHIV reporting their rights were violated who sought legal redress	Not Included in PF	Not Included in PF	Not Included in PF

Indicator with sex-disaggregation suggested in Global Fund 2019 Modular Framework	Countries with required disaggregation in Performance Framework		
	Afghanistan	Cuba	Kyrgyzstan
HIV O-21 Percentage of PLHIV not on ART at the end of the reporting period among PLHIV who were either on ART at the end of the last reporting period or newly initiated on ART during the reporting period	Not Included in PF	Not Included in PF	Not Included in PF
Coverage Indicators			
KP-1c(M) Percentage of SWs reached with HIV prevention programmes - defined package of services (Gender - female, male, transgender)	**No**	**No**	**No**
KP-1d(M) Percentage of PWIDs reached with HIV prevention programmes - defined package of services	**No**	Not Included in PF	**No**
YP-1a Percentage of young people aged 10–24 years attending school reached by comprehensive sexuality education and/or life skills–based HIV education in schools	Not Included in PF	Not Included in PF	Not Included in PF
YP-1b Percentage of young people aged 10–24 years reached by comprehensive sexuality education and/or life skills–based HIV education out of schools	Not Included in PF	Not Included in PF	Not Included in PF
HTS-3c(M) Percentage of SWs that have received an HIV test during the reporting period and know their results	Not Included in PF	Not Included in PF	Not Included in PF
HTS-4 Percentage of HIV-positive results among the total HIV tests performed during the reporting period (non-specified population group)	Not Included in PF	Not Included in PF	Not Included in PF
HTS-5 Percentage of people newly diagnosed with HIV initiated on ART (non-specified population group) (female, male, transgender)	Not Included in PF	Not Included in PF	Not Included in PF
TCS-1.1(M) Percentage of people on ART among all PLHIV at the end of the reporting period (female, male, transgender)	**Yes**	**Yes**	**Yes**
TCS-1b(M) Percentage of adults (15 and above) on ART among all adults living with HIV at the end of the reporting period (female, male, transgender)	Not Included in PF	Not Included in PF	Not Included in PF
TB/HIV-5 Percentage of registered new and relapse TB patients with documented HIV status	Not Included in PF	Not Included in PF	Not Included in PF
TB/HIV-6 (M) Percentage of HIV-positive new and relapse TB patients on ART during TB treatment	Not Included in PF	Not Included in PF	Not Included in PF
TB/HIV-3.1 Percentage of PLHIV initiated on ART who are screened for TB in HIV treatment settings	**Yes**	Not Included in PF	**Yes**
TB/HIV-7 Percentage of PLHIV on ART who initiated TB preventive therapy among those eligible during the reporting period	Not Included in PF	Not Included in PF	Not Included in PF

Gaps and entry points

Despite the more detailed discussion of gendered issues in the context of HIV, a number of gaps and entry points were identified. In many of the countries (with the exception of Cuba and Panama), gender was viewed from a primarily binary perspective, i.e. men and women. This has the potential to exclude other vulnerable populations with different gender identities, such as the transgender community, and therefore needs to be considered in future grants and programme planning.

Besides the higher vulnerability among adolescent girls and young women referred to in some country contexts (Zimbabwe, South Sudan and Djibouti), there was limited explicit recognition of the intersection of gender with other social factors, such as age, refugee/migrant status, marital status, etc; and how this in turn affects individuals differently in the context of HIV, as well as impacting on interventions. For example, in Zimbabwe although the number of men who underwent voluntary medical male circumcision tripled during the grant period, coverage was highest in men aged 15-29 and dropped significantly among older men, underscoring the importance of considering other factors that intersect with gender (in this case age), to ensure that interventions are appropriately targeted and no one is left behind.

Although protracted conflicts were described as a contextual driver of HIV risk and outcomes in some settings (e.g. Afghanistan), there was no explicit discussion of the gendered effects of such conflicts and how they impact men, women and other genders differently. The gendered impact of protracted conflict and crisis is well-documented. For example, destruction of health facilities and shortage of health workers and medical supplies has a disproportionate impact on women, due to their reproductive roles; and women and girls are at increased risk of sexual and GBV, such as rape, torture and slavery, both during and after conflict, leading to increased rates of STIs and pregnancy. Although men are not immune to sexual violence during conflict, women are much more vulnerable. Other consequences of conflict and crisis that further intensify inequalities between women and men include restricted mobility and greater inability to pay for healthcare, both of which impact access to health services and treatment. As such, the lack of gender analysis in programme planning in conflict-affected and fragile contexts (both in relation to HIV and beyond) is a gap that could inadvertently cause significant harm.

Box 7: Programming for transgender community in Cuba

With UNDP's technical support to combat gender inequality, Cuba has shifted from conceptualizing gender as a binary construct to encompassing different sexual and gendered identities, via:

- Surveys that accurately assess transgender and men who have sex with men populations;
- Evidence-informed HIV programmes led by KPs recognising their sexual and gendered identities;
- Addressing gender challenges in these populations such as GBV, homophobia and gender discrimination.

Cuba acknowledges the gender inequality issues among LGBTQI people and their impact on health care access, and exemplifies how the right to health for all address stigma and discrimination. Progress has been made in addressing gender within HIV prevention programmes nationally and, with support from the Global Fund grant, via participatory engagement of KPs and across multiple sectors in the design, implementation and evaluation of interventions, which has resulted in better performance, empowerment and impact of the projects. The Global Fund grant supported the capacitation of KPs' networks (people living with HIV, men who have sex with men, people who practise transactional sex and transgender people) on legal rights to better address discrimination, and strengthened their leadership and sustainability to conduct peer education on HIV prevention and care for people living with HIV , including assertiveness training to foster condom use and self-care.

5.5 Cross-cutting gaps

In some grants, although there was recognition and articulation of gendered issues, such as one group being identified as more vulnerable (e.g. men in the case of TB), this was not always reflected in the overall goals of the grant and subsequent interventions or gender-specific investments. In some cases, there was a mismatch between identified vulnerable populations and the targeted groups.

One potentially gender-sensitive intervention that was identified in several of the grants in all disease areas, but not acknowledged as being gendered, was the use of CHWs to raise awareness, early detection and diagnosis and referral to health facilities for malaria, HIV and TB. The 'feminized' nature of the formal and community health workforce and the role of women in human resources for health is extensively documented. Furthermore, CHWs face additional challenges around safety in the course of undertaking their duties and are also subject to the gender norms of the communities within which they work. As such, it is important to be cognizant of the gendered nature of any intervention that draws on human resources for health and health workforce strengthening, both in the formal and community health systems.

Importantly, although there were some gender-specific interventions across all diseases, the gender-transformative interventions were predominantly found within HIV grants. These interventions had an explicit goal of challenging gender inequities by addressing the root causes of such inequities, and worked towards transforming harmful gender norms, roles and relations by shifting power inequalities, attitudes and mindsets. As such, beyond the gender-specific interventions that acknowledge gender norms and accommodate women's and men's specific needs, future grants should aim for more transformative approaches, which are more likely to result in more meaningful and sustainable change and greater impacts.

Box 8: Key affected/vulnerable populations in grants

The HIV/TB grants in Afghanistan and Kyrgyzstan identify populations such as people who inject drugs and prisoners, as KPs or high-risk groups for HIV and TB, but grant investments and programming suggest male-centric focus and programming. Discussions from interviews identify a scarcity of suitable implementing partners, for instance within women's prisons, as well as grant funding, as challenges. Similarly, in Kyrgyzstan migrants were identified as a KP at higher risk of HIV and TB, but there was a lack of gender-related programme interventions in this area. More women-inclusive financing, which also targets the various neglected populations, has been highlighted as an area that requires attention in the next grant funding cycle.

Box 9: CHW programme in Afghanistan

The Afghanistan grant funds localized CHW programmes for case management at the community level, including access to anti-malarial treatment through an extensive trained CHW network. The CHW network has been established across the country by the Ministry of Public Health, with a predominant focus on maternal and child health. Due to cultural, geographical and security-related travel limitations, women are more likely to access health services in community settings.[13] Assessments of the national programme show some level of increase in antenatal and post-natal care attendence,[14] and is seen by policymakers as a contributor to the reduction of maternal morbidity rates in the country.

There is typically one male and one female CHW at the health post at the village level and other CHWs appointed at the district hospital, who are nominated by the village health councils and are subsequently trained, supervised and supported by the implementing organization delivering the national essential health service package in the area. CHWs are unpaid volunteers nominated by their communities, who receive token amenities such as toothpaste and towels and reimbursements for travel costs to health facilities.[9] Additionally, CHWs are not able to address all conditions, such as those that have strong societal stigma attached, e.g. mental health and TB. These discussions are mostly avoided by CHWs, and reported as not prevalent.

6. COUNTRY CASE STUDIES: KEY FINDINGS

Afghanistan

There is a clear difference in how gender-responsive interventions were prioritized in the HIV grant, in comparison to TB and malaria. The HIV grant includes gender-specific modules and gender-transformative components that work to change the dynamics that cause disadvantage at socio-structural levels. However, modules for people who inject drugs and prisoners have been prioritized and implemented only in male prisons, and for men who use drugs.

Gender does not feature in the main goals of the TB grant. Gender-sensitive programming includes support to female CHWs in under-served communities, and active case finding through CHWs.

The malaria grant has a focus on 'all of the population' despite reports that more women access malaria care then men. Stakeholders view gender-responsive programming as equivalent to gender-specific programming. The focus on community-level delivery of treatment and training of CHWs can be considered gender-sensitive.

The performance framework is found to be relatively gender-blind, with a notable absence of sex-disaggregation in the impact, outcome and coverage indicators.

Overall, there is buy-in to gender-responsive work at various levels. Gender-transformative structural interventions are found at legislation and policy levels, but changes are slow. At the implementation level for all three diseases, stakeholders' perceptions suggest that many implementing partners are gender-blind in their programming approach and understanding of gender dynamics.

The recommendations include to:

- Consider gender in research, population estimates and the performance framework. This includes updated sex-disaggregated data across all data categories, which will increase visibility of both the gender-responsiveness of epidemic control and programming. Further in-depth gender analysis of women's barriers to health care access needs to be funded, and more research is required to understand why TB affects women more, and why they tend to not seek healthcare;
- Increase programming for women in neglected or hidden populations, including women-inclusive financing in the next funding cycle as the current HIV grant excludes programming for women people who inject drugs and prisoners;
- Develop and leverage community resources through capacity-building, including more focus on capacity-building and gender training for women CHWs, CSO staff and implementing partners at institutional and community levels;
- To further integrate programming that addresses GBV within disease modules. GBV is identified as a cause and consequence of HIV, TB and malaria diagnosis and treatment outcomes and a barrier to health service uptake.

Chad

The initial concept note for the malaria grant included an analysis of key gender inequalities and vulnerability of nomadic and migrant pregnant women due to regional conflicts, but the grant documents do not provide or analyse sex-disaggregated data. The study found a general perception that there are no gender differences in access to malaria diagnostic and treatment services, but data is lacking to support this.

There are also misconceptions around gender-responsive programming, with all programming for vulnerable populations being considered gender-specific. Overall, there is room to strengthen the gender-responsiveness but also efforts to build on. There are gender-specific interventions targeting pregnant women under the vector control and specific prevention interventions modules, as well as gender-sensitive activities under other modules. The facility-based case management is gender-blind. None of the modules are being implemented to transform gender norms or inequities.

The national policy requires gender parity in the CHW cadre, yet a vast majority are men. These CHWs are selected by their communities and while they are volunteers, under this grant they have been receiving a stipend. Experiences from other countries show that when CHWs are remunerated and more valued, the cadre tends to be more male-dominated.[40] While international evidence suggests that community-based care for uncomplicated malaria is an effective and gender-sensitive strategy that reaches more women by overcoming gender-related barriers to access, the CHW component of this intervention is also gender-unequal as it reinforces exclusion of women from positions of prestige in the community and from remuneration.

The RSSH module includes efforts to incorporate gender considerations, and the facility data collection tool has been revised to collect sex-disaggregated data for case management.

Under the procurement and supply chain management module, there are some instances of gender considerations, including in supply-side investments to improve the quality of ANC and increase uptake by pregnant women, and the procurement of gender-specific supplies for CHWs. In programme management, however, gender has not been a consideration.

Due to a lack of detail in the grant agreement budget, it is not possible to determine the level of investment in gender-responsive programming, and the study could not determine whether the gender-sensitive interventions have been adequately budgeted for, or to hold the programme accountable to this investment.

The recommendations include to:

- Strengthen the understanding and monitoring of gender-related barriers to health service use through sex-disaggregated data collection and quality gender analysis;
- Engage gender champions and community leaders to promote gender equity and uptake of ANC among pregnant women and to increase ITN use and IPT coverage;
- Promote gender equity in the CHW programme that ensures equal selection of women and equal remuneration.

Cuba

Progress has been made in addressing gender within HIV prevention programmes nationally and with support from the Global Fund grant via participatory engagement of KPs and across multiple sectors in the design, implementation and evaluation of the grant. This engagement has resulted in better performance, empowerment and impact of the projects, and gender has been integrated into HIV programming, indicators and budgeting.

Despite the historical binary conceptualization of gender, in the context of the Cuban HIV response, gender has been considered non-binary. The roles of CENESEX and the National Center for the Prevention of STDs and HIV/AIDS have been key in this respect. Additionally, UNDP's technical support has helped develop a broader understanding that has informed gender-transformative programming for different groups.

Despite such achievements, only 13 percent of the total Global Fund grant budget was allocated to sex-specific modules. The lack of details in the budget prevents determination of the level of investment in gender-responsive programming. The study found that not all activities addressing gender inequalities are being captured in the funding request and grant agreement. The Global Fund's 2019 Modular Framework, which is more specific on gender, is considered helpful and will make it easier to accurately account for budgets that promote gender equality in the future.

The Global Fund grant has supported the training of health workers on gender diversity as well as on health management information systems that disaggregate by KPs, and Cuba has initiated some of this training and survey disaggregation.

Recommendations include to:

- Collect sex-disaggregated data across the treatment cascade and perform quality gender analysis to identify and address the underlying reasons for gender differences;
- Scale up gender training of technical experts and service providers;
- Ensure that GBV prevention and response interventions and services also support KPs (transgender women, people who practise transactional sex , men who have sex with men, women living with HIV).

Djibouti

While the concept note includes sex-disaggregated data on malaria prevalence and highlights the specific vulnerability of pregnant women and migrant populations, it lacks analysis of underlying causes of this disparity and the potential role of gender norms and gender-related drivers of risk.

In the funding request, gender-responsive priorities include the prevention and control of malaria in men, especially adults, vulnerability of pregnant women and migrant populations. However, men are not a specific focus despite the disproportionate incidence of malaria in men.

Apart from the vector control module, where some programme activities could be described as gender-specific or gender-sensitive, none of the remaining modules implicitly or explicitly addressed gender-related issues.

In health system strengthening, modules on procurement and supply management, financial management and health and community resources, there are no specific efforts to incorporate gender considerations. However, there is a commitment to engage with and leverage community resources, including women leaders, youth and migrant groups, as critical entry points for ensuring that the distribution of ITNs reach women, refugees and migrants.

In programme management, at the malaria grant level the majority of staff are women but at the national programme the staff is male dominated.

There are major challenges in national health data reporting and data quality. It is critical to reinforce the importance of gender-disaggregated data.

Overall, it is difficult to assess the gender-responsiveness of the investments under each of the modules, largely due to a lack of detail in budget documents. The only gender-sensitive expenditures (2019) and forecast for 2020 identified in the budget are activities related to vector control.

The recommendations include:

- Investment research to understand gender-related exposure and risk factors and barriers to malaria services;
- Targeted interventions for migrant populations;
- Inclusion of representatives from migrant populations in the CCM and at the health systems level.

Kyrgyzstan

The grant documentation provides age-and sex-disaggregated data and indicates a process of engagement with gender champions, although gender is not visible in the grant goals, objectives and identified activities within the modules.

Stakeholders agree that gender is integrated into the grant by virtue of its target populations being gender-specific (i.e. KPs, female sex workers and men who have sex with men modules), the focus on stigma, discrimination and other human rights-related barriers, and UNDP's organizational mandates to be proactive in gender-related issues. The HIV modules appear to be more gender-responsive than the TB modules, mainly due to the lack of national priority to consider the gender dimensions in the TB response.

Gender equality goals within the grant include the pursuit of equal opportunity and outcomes for both women and men, but only for populations identified as target beneficiaries. There was a strong focus on female sex workers, but in fact this is the group with the most stable and lowest prevalence rate in an epidemic experiencing increasing prevalence in other KPs. Gender in prisons, women who inject drugs, men who have sex with men and transgender communities were not discussed.

While there is communication and awareness about gender in the grants, there are no clear frameworks that conceptualize how gender is operationalized. Implementing partners note that their involvement is limited to specific modules within their scope of work, but not in promoting gender equity in the rest of the grant.

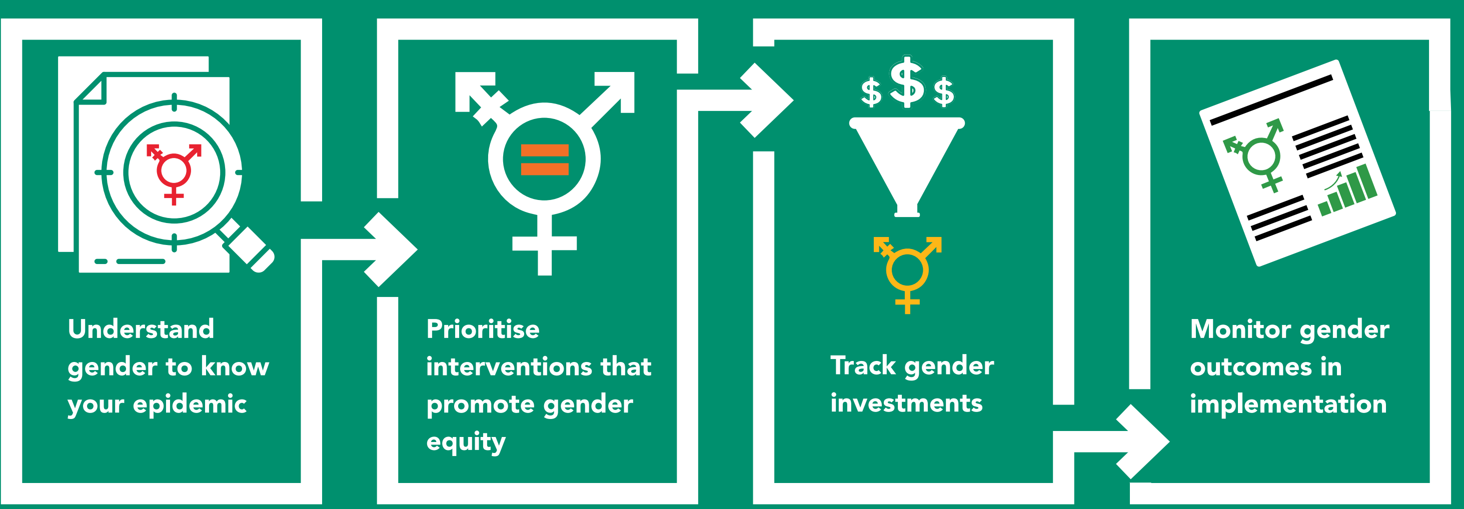
Stakeholders identified several challenges and contextual factors that are barriers to more gender-responsive programming. There was a sense that gender features in the planning and design stage and is better articulated in grant application documentation, than in implementation or through the existing performance monitoring documentation.

Apart from the number of AIDS-related deaths, the performance framework has no requirement for sex disaggregation of impact and coverage indicators. Requirements for sex disaggregation are indicated for more outcome indicators that relate to HIV than TB. Some stakeholders consider the level of sex-disaggregation in the performance framework as sufficient, while others define it as gender and human-rights blind, and prioritizing a biomedical perspective.

The recommendations include to:

- Address data and research gaps, including the need for more research and programming attention on women, particularly in neglected and non-gender-specific KPs;
- Promote the integration of interventions that reduce the identified gender-related barriers to TB prevention and treatment among men and women.

7. RECOMMENDATIONS



This review of UNDP's current HIV, TB and malaria programmes, funded by the Global Fund, suggests that there is space for future country grants to increase the scale and scope of gender-sensitive and transformative programming, especially for TB and malaria. HIV grants are considerably more gender-responsive than TB and malaria grants. Where grants have considered and sought to address gender inequities, they tend to prioritize gender-specific interventions for pregnant women (across the three diseases) or key gendered populations, in the case of HIV, but there are only negligible investments in approaches to actively promote gender equity and transform gender inequities and power dynamics. Due to limited data on the implementation of programme modules, it is not clear how well the gender-responsive interventions that have been included in grant modules have been resourced and implemented.

Based on further analysis in five countries (Afghanistan, Chad, Cuba, Djibouti, Kyrgyzstan), ongoing efforts were identified to strengthen the grants' gender data and develop a better understanding of how gender is affecting disease risk and service uptake. In addition, some countries had prioritized and implemented gender-sensitive, disease-specific and health systems level interventions.

Overall, there are several recommendations for country teams to consider to enhance the gender-responsiveness of the programmes in their next grant applications. Several of these recommendations echo the recent Technical Review Panel's Observations on the 2017-2019 Allocation Cycle,[55] the Global Fund's recent gender-focused grant review of 17 Funding requests (2016-2018) and the Global Fund's recent review of, and guidance on, human rights and gender programming in COEs.[52,53]

While the gender scan identified engagement with gender across the grants, and a number of efforts to address gender-specific needs or to overcome gender-related barriers to service access, it also noted that several grants still do not explicitly consider gender or respond to gender inequities in their implementation.

The main lessons and recommendations from the scan relate to the early phases of the grant cycle, including the analysis, programme design and prioritization of interventions. In addition, accountability mechanisms are required to ensure adequate investment in gender-responsive programmes and monitoring of their implementation and impact.

Grant design: knowing your epidemic includes understanding gender-related risks, barriers and inequities

- Grants should be based on gender and intersectional analysis of disease risk and service access (including age, mobility status, KP status, where most relevant), particularly in TB and malaria grants where gender considerations are less prominent, compared to HIV grants. In some countries, there is a need to address data gaps even in HIV, such as for women in neglected and non-gendered KPs. Although this is a Global Fund requirement, gender analyses are often missing from funding requests, or are of limited quality to understand gender-related barriers to inform effective programming. For a quality and useful gender analysis, the following three components are required:

    1. Documentation of sex-disaggregated data of disease risk, service access and treatment outcomes in the country;
    2. Identification of the socially-constructed gender norms and inequities that explain any gender differences in disease risk, service access and treatment outcomes in each country's context (and/or drawing on relevant regional evidence);
    3. Identification of effective interventions and approaches to address the identified gender inequities from the local context, and/or from international literature and experiences.

- As part of the grant development phase, UNDP country teams could be instrumental in advocating for investment in local gender data and primary research, by engaging with local experts, academics, community researchers and KP communities to commission prioritized data collection, evidence generation and research.

    - These efforts could utilize the practice-based knowledge of programming partners, as well as international research, to gain a formative understanding of gender-related barriers and to inform more systematic documentation, local research design and data analysis. These could draw on expert consultation, community surveys, participatory action research and in-depth qualitative interviews, among others.
    - Country teams could leverage UNDP's regional networks and platforms to enable South-South learning, exchange of knowledge and adoption of good practices.

In consultation with the CCMs, countries could then consider sustaining these initiatives for ongoing performance monitoring and learning through the RSSH grant modules on health information and community systems.

Grant planning: prioritize interventions that address gender inequities and promote greater equity

- UNDP can increase efforts to help countries develop an in-depth understanding of what gender-responsive programmes entail, and help develop and prioritize – through expert advice, workshops and guidance – gender-transformative actions.

    - In grant applications and implementation, there need to be clear linkages between identified gender disparities in health outcomes; gender-responsive grant objectives and strategies; the selection, scope and scale of module activities and focus populations; and matched investments. This is particularly missing in grant modules that are not women or men-specific (such as in people who inject drugs, refugee and migrant populations, populations in prisons and closed settings) and that relate to health system strengthening.

- UNDP can use its programmatic entry points and organizational strengths to address underlying causes of gender inequity in the grants. For example, legal and policy frameworks can create gendered disadvantage within countries. This is an area of UNDP's comparative advantage, including expertise on addressing women's rights and social and economic empowerment. UNDP Global Fund Country Teams can consider working in close partnership with UNDP Governance and Rule of Law programmes to support countries and partners. By leveraging experts at various levels in the organization, and among UNDP's partner organizations, country teams can contribute to strengthening the non-health interventions, including legal and policy frameworks, to address the more complex root causes of gender inequalities, as outlined in UNDP's Gender Equality Strategy 2018-2021.[54]
    - Grants should be clear about the distinction between gender equality programming and human rights programming, because there is currently a tendency to subsume the former under the latter, which risks rendering invisible gender equality actions;
    - Human rights modules provide a unique entry point to address structural inequities and legal barriers to gender equality, especially where they intersect with gender-related barriers to access HIV, TB and malaria services. However, gender inequities have not been explicitly or consistently considered in past human rights programmes for KPs in the context of HIV. UNDP could proactively support the integration of a greater focus on gender within these modules, by expanding module activities to cover areas such as GBV, gender discrimination, women's sexual and reproductive rights, marital rape, child marriage, etc.
- UNDP can support countries to consider specific programmes that:
    - Target structural/policy, cultural and religious barriers to health services, including those that affect women's autonomy to seek care;
    - Tackle GBV and discrimination at household, community, institutional and structural levels;
    - Target the social and economic empowerment of women.
- UNDP can provide quality control and gender-proofing to ensure that none of the grant interventions are harmful and perpetuating gender inequity. In efforts to address gender-related barriers to healthcare and improve health outcomes, there is a risk of reinforcing men's power over women (for example by working with men to give permission to their wives to access healthcare), or reinforcing inequitable gender roles (for example through CHW programmes that take women's volunteering for granted because of their societal roles of providing unpaid care work).
- Grants should also be gender-responsive in contexts where men are disproportionately affected. This is most relevant in TB and malaria programmes.
    - Efforts should be made to engage men, to address and transform gender-inequitable power dynamics and norms around masculinity that adversely affect health risks and uptake of health services. Such interventions go beyond accommodating, for example, men's different working times, and focus on tackling norms and power, which will likely have benefits across the three diseases and beyond.
- Leverage the RSSH modules: use modules to build in a greater focus on gender within health information systems, community systems and human resources for health, including CHWs.
    - Promote prioritized sex-disaggregation in health information systems;
    - Promote use of CHWs: this intervention was not acknowledged as being gendered in several grants, although in particular female CHWs can be critical to raise awareness and for early detection, diagnosis and referral to health facilities. However, programmes must ensure that female CHWs get adequate support, remuneration and recognition.

Grant performance: be accountable for promoting gender equity

- A prioritized set of key performance indicators (impact, coverage and outcome) must be sex-disaggregated and also included in continuous monitoring and progress reporting. This would

generate real-time data on how grant activities are reaching and affecting men, women and transgender people within the key or focus populations.

- Explicit gender-responsive budgeting and expenditure tracking processes are important to ensure that the prioritized activities are appropriately resourced. To enable such accountability in budgeting and investments, there is need for a common understanding of which modules and activities can be considered gender-responsive, and the introduction of a tracking system.
    - The Global Fund's 2019 Modular Framework, which is more specific on gender, is considered helpful and will make it easier to accurately account for budgets that promote gender equity going forward;
    - UNDP can leverage its institutional efforts to establish a gender marker for gender-responsive expenditure tracking, and go beyond the Global Fund requirements to enable budgeting and tracking that is explicit about investments in gender equality.
- In the grant development and monitoring process, UNDP can advocate for the meaningful engagement of CSOs that represent population groups with gender-related vulnerability and gender experts who can advise on effective gender-responsive implementation;
- Promote the use of available tools and guidelines. The Gender Scan found that not all country partners are aware of the various tools that are available, in particular the UNDP gender checklist for Global Fund grants or the Global Fund Gender equity note. In addition, there are disease-specific gender/equity assessment and planning tools that have been successfully applied in a number of grants (Malaria Matchbox, Stop TB Gender assessment tool, UNAIDS Gender assessment tool).

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Further Reading and Resources

UNDP

UNDP Gender equality strategy

UNDP Discussion paper on Gender and TB

UNDP Discussion paper on Gender and Malaria

Checklist for Integrating Gender into the New Funding Model of the Global Fund to Fight AIDS, TB and Malaria

UNDP's work on Human Right, Key Populations and Gender

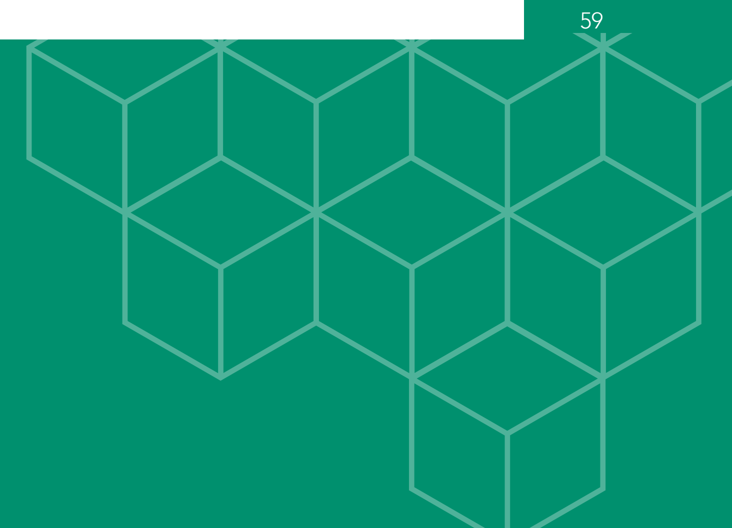
The Global Fund

Global Fund Gender Equality strategy

Implementation of the Global Fund Gender Equality Strategy

Gender Equality and Key Populations Results, Gaps and Lessons From the Implementation of Strategies and Action Plans

Global Fund Technical Brief- Gender Equity (October 2019)



ANNEXES

ANNEX 1 SUMMARY TABLES
ANNEX 2 LIST OF KEY INFORMANTS
ANNEX 3 INTERVIEW TOPIC GUIDE
ANNEX 4 COUNTRY CASE STUDIES

In "Gender Scan of UNDP HIV, TB and Malaria programmes funded by Global Fund to Fight AIDS, TB and malaria"

United Nations University International Institute of Global Health
United Nations Development Programme

Annex 1 Summary tables

MALARIA GRANTS

Country (grant type)	Gender Issues Identified	Gender in Planning, Objectives and Included Populations	Gender in Intervention Modules
Afghanistan (COE grant)	**Epidemiological, access to services issues** • Women need to be accompanied by men or elderly women to travel to health facilities and access to out-patient care. **Social and structural issues** • Right to health limited by gender norms.	**Objectives:** No, focus on equal *service delivery* to all populations living in malaria endemic areas regardless of their gender, ethnicity, religion etc. LLINs are distributed to all returnees who settle down in endemic areas including nomad populations. Gendered populations: pregnant women; CHWs.	**Gender-specific:** Pregnant women receive additional LLIN. **Gender-sensitive:** • Case management through extensive CHW network with 1 female and 1 male CHW. • Wide-scale implementation of community-based management of malaria to address access obstacles for women and girls.
Bolivia (Programme Continuation)	**Epidemiological, access to services issues** • Male disproportionate case load (2014 data). • Only 64% of the suspected female cases received parasitological test at public sector health facility. • Higher proportion of suspected cases in women received tests within community (92% vs 88% in males).	**Objectives:** No discussions. **Gendered populations:** None included.	No details of individual modules provided to enable gender assessment. Gender specific modules not described in grant agreement.
Burundi (Programme Continuation)	**Epidemiological, access to services issues** • Pregnant women and children particularly vulnerable. • LLIN ownership is 89%, but only 79% amongst pregnant women.	**Objectives:** The funding request identifies that free malaria control supplies are already provided to pregnant women, and higher priority is required for KPs with low levels of service access. **Gendered populations:** pregnant women.	**Gender-specific:** Provision of IPT among pregnant women.
Chad (Programme Continuation)	**Epidemiological, access to services issues** • Funding request identifies that human rights and gender equality issues are taken into account but service coverage to certain groups is insufficient – Koranic schools, street children, nomads and refugees and IDPs where a large majority are women, children and the elderly.	**Objectives:** No.	No details of individual modules provided to enable gender assessment, but performance indicator and targets that address gender are gender-specific, and include prevention focused on pregnant women: • 80% of pregnant women accessing ANC are provided with a minimum package of interventions including intermittent preventive treatment with sulfadoxine-pyrimenthamine. • Proportion of pregnant women who slept under a LLIN the night before. • Proportion of pregnant women who attended ANC who received 3 or more doses of IPT for malaria.

Country (grant type)	Gender Issues Identified	Gender in Planning, Objectives and Included Populations	Gender in Intervention Modules
Djibouti (Programme Continuation)	**Epidemiological, access to services issues** • Pregnant women are at high risk for malaria morbidity and mortality. • Affects men who are migrants from other countries with malaria, such as Ethiopia.	**Objectives:** No discussions. **Gendered populations:** None included.	**No gendered descriptions.**
Guinea-Bissau (Programme Continuation)	**Epidemiological, access to services issues** • 79% use of LLIN among pregnant women. • Inadequate IPT coverage among pregnant women due to late ANC enrolment. • Government and partners established homes for mothers, where women in late pregnancy stay close to health facilities for prompt medical attention and LLIN protection.	**Objectives:** Yes, indicated as response in Funding Request; no gender considerations in goals, strategies and planned activities. **Gendered populations:** pregnant women; staff and CHWs.	**Gender-specific:** IPT for pregnant women. **Gender-sensitive:** • Case management in public facilities, and community-awareness raising interventions. • Delay in implementing community case management identified since not all health regions have trained CHWs and community kits are not available.
Sao Tome and Principe (Material Change)	**Epidemiological, access to services issues:** • Particular attention to pregnant women.	**Objectives: No.** **Gendered populations:** Pregnant women.	**No descriptions.**
Western Pacific (Vanuatu)	Overall no engagement with gender in descriptions.	**Objectives:** Yes, goals include ensuring pregnant women sleep under LLIN. **Gendered populations:** Pregnant women.	**No descriptions.**

TB GRANTS

Country (grant type)	Gender Issues Identified	Gender in Planning, Objectives and Included Populations	Gender in Intervention Modules
Afghanistan (COE)	**Epidemiological, access to services issues** • Unusual female to male ratio of 1.7:1 • Psychosocial and cultural barriers limiting women's decision-making power including decisions regarding their own health and the need for women to travel with male approval and escorts (Maharam). • Physical and geographic barriers include limited modes of transportation for women, long distances to health facilities, physical insecurity, severely harsh terrain and road blockages. **Social and structural issues** • Women report very high levels of violence - 48% of women and girls over 15 years reported physical violence in the previous year. • Women have low decision-making authority with 80% living in rural areas with difficult access to care, and reproductive care. • Gender disparity in income and education. • Health care workers report low comfort levels in providing curative and preventive services to patients regarding gender-sensitive issues such as physical and sexual violence. • Challenges for women victims of violence in disclosing cases of domestic abuse, including unsupportive institutional response and insensitive attitudes of health care providers.	**Objectives:** Not in main goals but new priorities described include innovative efforts to expand the female health workforce to address gender disparities for providing increased access to services for women and girls. **Gendered populations:** Not indicated.	**Gender-specific:** Increase female health care workers at community level. **Gender-sensitive:** Family Health Houses where female health workers provide health services for women in under-served communities; female Health Social Counsellors who will receive comprehensive training and will then be deployed to those health facilities and Comprehensive Health Centres where they will be available to serve women's needs and actively advocate for women's and children's rights to access and utilize health services; and Capacity Development for CSOs, support for women's NGOs.
Belize (Transitional) (HIV/TB)	**Epidemiological, access to services issues** • Slightly male disproportionate epidemic. • Male: female TB ratio is 1.3 in 2017, with the total number of cases being 50 female and 67 male. **Social and structural issues** • Sociocultural norms and religious values, along with stigma and discrimination highlighted as barriers for uptake of TB services.	**Objectives:** Gender-related goals and objectives in TB programming is not described in grant agreement, but there is indication of use of gender and human rights driven planning and programming in NSP and grant application. **Gendered population:** TB patients in difficult socio-economic situation.	Not much descriptions in Grant Agreement documentation, but strategies include the following: **Gender-Transformative:** Training of trainer sessions for KP groups on human rights and medical ethics to HIV and TB and GBV.
Bolivia	**Epidemiological, access to services issues** • No gender issues were identified, but sex-disaggregated baseline outcome indicators provided for number of notified and number of cases with RR-TB and/or MDR-TB that began 2nd line treatment.	**Not indicated:** No gender or gender-specific descriptions in goals, strategies and main planned activities in grant agreement.	**None**.

Country (grant type)	Gender Issues Identified	Gender in Planning, Objectives and Included Populations	Gender in Intervention Modules
Burundi	**Epidemiological, access to services issues** • Male-to-female ratio was 1.8. • Lower level of TB detection in women was noted (67% of cases are male). • No research has shown the factors which underline this imbalance but it is known that women's low spending power and lower participation in the economy are likely to limit their access to TB treatment and prevention services.	**Objectives:** No gender descriptions in goals, strategies and activities; increased gender programming indicated in grant but more focused on human rights descriptions. **Gendered populations:** contacts of TB patients.	**Gender-transformative:** CHWs with training on GBV, malnutrition, and children. **Gender-sensitive:** Provision of nutritional support and transport for MDR-TB patients; Systematic TB screening.
Djibouti	**Epidemiological, access to services issues** • Male to female ratio is 1 to 1.19 in 2013. **Social and structural issues** • GBV. • Lack of knowledge of rights.	**Documentation describes:** Incorporate gender aspect into care" but with no explanation of how to do this. **Gendered populations**: No specific descriptions for TB.	**No descriptions.**
Egypt (HIV/TB)	No discussions of gender for TB programming.	**Objectives and Increased Gender in Planning:** None Gendered populations: None	**None.**
Kyrgyzstan (HIV/TB)	**Social and structural issues** • Stigma and discrimination remain large barrier to health access. • Law on TB provides rights, obligations and social protection of people with TB.	**Objectives:** No gender descriptions in goals but indicates need for increased gender programming. **Gendered populations:** none	**None.**
Panama (Transitional) (HIV/TB)	**Epidemiological, access to services issues** • In 2016, 66% of all cases affected men and 34% women. However, the burden is greater in girls aged below 15 than boys, with 53% of cases affecting girls.	**Objectives:** None. **Gendered populations:** No specific descriptions for TB.	**None.**
Sao Tome and Principe	None.	**Objectives:** No. **Gendered populations:** None.	**None.**
South Asia	None.	**Objectives:** No. **Gendered populations:** None.	**Gender-sensitive:** TB/HIV gender assessment tool amongst refugees and IDP camps in Pakistan, and one for IDP/returnees in Afghanistan.
South Sudan	**Epidemiological, access to services issues** • Male to female ratio of new cases is 2.1. (grant agreement); 2016 analysis- 90% of TB patients aged between 15 – 54 years. • Males were generally more affected than females at a ratio of 1.5:1. **Social and structural issues:** Lack of a coordinated and integrated delivery of health services for women, children and adolescents.	**Objectives:** No. **Gendered populations:** None.	**None.**
Sudan	**Epidemiological, access to services issues** • Higher prevalence among young people, in urban settings and among the male population.	**Objectives:** No. **Gendered populations:** None.	**None.**
Turkmenistan	**Epidemiological, access to services issues** • New TB cases (2016), about 60% are males and 40% females (male / female ratio 1.5).	**Objectives:** No. **Gendered populations:** None.	**None.**
Western Pacific	**None.**	**Objectives:** No. **Gendered populations:** None.	**Gender transformative:** Regional activities: TB lab refresher training that includes GBV meeting/training.

HIV GRANTS

Country (grant type)	Gender Issues Identified	Gender in planning, objectives and included populations	Gender in intervention modules
Afghanistan (COE)	**Epidemiological, access to services issues** • Less than 0.1% in general population in 2015; PLHIV 6,900 (3,800-16,000) with 28% women (male disproportionate epidemic), less than 7% children. • Men with high risk behaviour play larger role than previously estimated, and they encounter high stigma and discrimination, punitive laws, prosecution, lack of access to prevention services, limited support from and/or violence in the family and community. Social and structural issues • Protracted conflict situation. • Social acceptance of violence against women - 25% of human rights issues reported are based on physical violence with honour killing being the most extreme manifestation. • High stigma and discrimination, punitive laws, prosecution identified. • (enabling) National Health Policy 2015-2020, National Health Strategy 2016-2020 and most importantly "Policy for Protecting People Living with HIV from Stigma and Discrimination in Healthcare Settings" National Health Policy emphasizes the right to health, especially for women, children and other vulnerable groups. • the lack of most recent gender and age disaggregated data on HIV, size-estimation and prevalence of HIV among KPs hinders evidence-based approaches to advocacy.	**Objectives and need for Increased gender in planning: Yes**, Yes, gender dynamics and inequalities are known, although there is a lack of gender and age disaggregated data. Additionally, inclusion of human rights and gender equality issues in strategies outlined but not directly included in programmes or investments ('assessment and design of strategies and interventions to address human rights and gender equality issues') • Priority area in the current NSP III "Create supportive and enabling environment for a sustained and effective national response to HIV and AIDS" explicitly elaborates the measures the country has to embark on: promoting supportive social, legal and policy environments for promoting and protecting human rights and gender equality among PLHIV and KPs. The policy on "Protecting People Living with HIV from Stigma and Discrimination in Healthcare Settings" is envisaged to be implemented during 2017.	**Gender-specific:** Comprehensive prevention programme for MSM, PWIDs and partners, sex workers and clients: condoms + lubricants, HIV testing, STI screening and treatment, and behavioural interventions (only for sex workers indicated in list). **Gender-transformative:** Programmatic interventions such as intervention for female drug users, addressing sexual violence towards minors, sensitization of law enforcement agents, religious leaders and establishment of PLHIV networks and multi-sectorial coordination meetings, which will be implemented through the HIV grant provide opportunities to address issues related to human rights and gender.
Africa regional grant (Botswana, Cote d'Ivoire, Kenya, Malawi, Nigeria, Senegal, Seychelles, Tanzania, Uganda)	**Epidemiological, access to services issues** • Prevalence disproportionately higher in KPs - in prisons about 2-50 times higher than general populations, MSM about 11-25%, transgender about 6-68%.	**Objectives and need for increased gender in planning:** No gender dimension but focus of grant has potential impact on gender dynamics in national settings. **Focus populations:** KKPs: MSM, male/female/transgender sex workers, transgender people, people who inject/use drugs, prisoners, PLHIV. Key Stakeholders: judiciary, parliamentarians, lawyers, law enforcement, cultural Leaders, civil society, NGOs, media, experts, National Aids Commission. Regional Organizations: African Union Commission, Regional Economic Communities.	**Gender-transformative:** Grant focus on removing legal barriers-regional training, technical and advocacy events, strategic litigation and advocacy involving KP focus.

<table>
<tr><th>Country (grant type)</th><th>Gender Issues Identified</th><th>Gender in planning, objectives and included populations</th><th>Gender in intervention modules</th></tr>
<tr><td>Angola (Material change)</td><td>Epidemiological, access to services issues
• Higher prevalence reported in women (2.6%) compared to men (1.2%).
• HIV prevalence of 7.8% among FSWs and 2.4% among MSM in Luanda and Benguela provinces.
• 50% of pregnant women in Angola report having been tested for HIV and 37% report having received their test result. PMTCT coverage (HIV infected pregnant women on ARVs) remains low at 44% and mother-to-child transmission of HIV rate is unacceptably high, at 25%.</td><td>Objectives and need for increased gender in planning:
Specific objectives in grant agreement include PMTCT focus, and strategies include: redefining, enhancing and expanding the package of HIV prevention services focusing on adolescent girls and young women, FSWs, MSM, truck drivers and miners.

Gendered populations: Vulnerable men and women, HIV+ pregnant women.</td><td>Gender-sensitive: The expansion of community-based HIV counsellors; and the establishment of functional partnerships between health facilities and CSOs.
Comprehensive prevention programmes for KPs (Sex workers & clients, and MSM

Gender-transformative:
• GBV interventions are included in this application, including HIV testing and Post Exposure Prophylaxis, which will be provided to all GBV survivors.
• Programmes to address stigma and discrimination will be included in the package of services offered to KPs (MSMsMSM and FSWs) and vulnerable populations (PLHIV, adolescents and youth, especially girls).
• Prevention programmes for adolescents and youth, in and out of school- reaching out adolescents and young girls out of school with a defined package of services including provision of services for GBV including STI/ HIV services and PEP; support to peer and community support groups including sports activities and skills training; support CSOs and other partners to promote empowerment, sexual and reproductive rights of adolescent and young girls out of school.</td></tr>
<tr><td>Belize</td><td>Social and structural issues
• Sociocultural norms and religious values pose a significant challenge to the HIV/AIDS response and stigma and discrimination against KPs (particularly MSM and transgender women) significantly impedes uptake of HIV and TB services.</td><td>Objectives and need for increased gender in Planning:
Yes, the following gender-related objectives are included:
1. “New infections amongst MSM account for a maximum of 30% of all new infections”.
2. Develop and strengthen a human rights framework for KPs.
There is indication of use of gender and human rights-driven planning and programming in NSP and grant application.

Gendered populations: MSM, Transgender women, FSWs.</td><td>Gender-transformative:
• Training of trainer sessions for KP groups and CSO hub on human rights and medical ethics related to HIV and TB and GBV.
• Support to the implementation of advocacy plans for enactment of the non-discrimination legislation and other relevant legislation. including consultation sessions
• Training to improve stigma and discrimination; and collection of data from the human rights observatory.</td></tr>
</table>

Country (grant type)	Gender Issues Identified	Gender in planning, objectives and included populations	Gender in intervention modules
Burundi	**Epidemiological, access to services issues** • The average prevalence of HIV in the adult population was 1.4% (1.7% among women, 1.0% among men; 4.1% urban areas, 1.0% rural areas). • According to the modes of transmission study (UNAIDS 2013), new HIV infections are particularly high among heterosexual couples (stable and casual partnerships), followed by sex workers (sex workers) and their clients, and MSM. HIV prevalence is estimated at 21.3% among sex workers and 4.8% among MSM (PLACE study, 2013). • Based on Spectrum estimates, the rate of mother-to-child transmission is estimated at 6.4% in 2016, with 81% of women received ARVs for PMTCT, and 10% of infants received HIV testing (early infant diagnosis) within 2 months of birth (2016).	**Objectives:** Goals include reduction of HIV prevalence and increased condom use in KPs – PMTCT, MSM, SW. **Gendered populations:** Pregnant women, MSM, sex workers.	**Gender-sensitive:** Peer education, distribution of condoms (male and female) and gels, and access to HIV testing among sex workers and MSM. Referrals and linkages to STI and HIV services among these same groups, community-level HIV, TB, malaria and awareness and prevention activities on reproductive maternal and child health by CHW groups (GASC). **Gender-transformative:** Addressing GBV through awareness-raising activities.
Cuba (Transitional)	**Epidemiological, access to services issues** • PMTCT practically eliminated, and 10% of women living with HIV had a pregnancy in the last 5 years. • The prevalence in MSM at the end of 2016 was 5.82%, with this being the vulnerable group where the highest number of cases of HIV is diagnosed (71.2% of the total). Among men, MSM represent annually more than 80% of all new HIV infections at the national level.	**Objectives and need for increased gender in planning:** Yes: but with gender-specific and KP focus. Goal of grant is to reduce the incidence of HIV and STIs among KPs, with an emphasis on MSM. **Gendered populations:** MSM, Transgender groups, PPTS and their clients.	**Gender specific:** Comprehensive prevention programmes for MSM, transgender and sex workers. **Gender sensitive:** Peer education, distribution of condoms, gels and educational material, and access to HIV testing for MSM, transgender and sex workers. **Gender-transformative:** Prevention and response to GBV through Observatories; surveys on HIV prevention including monitoring the existence of stigma and discrimination associated with gender, support to management tools for gender mainstreaming in health policies (ex. HIV National Strategic Plan).
Djibouti	**Social and structural issues** 90% of women have undergone FGM; GBV; Lack of knowledge of rights; No legal guidelines for survivors of GBV; Women living with HIV are rejected by society; Husbands do not inform their wives if they are living with HIV; No legal support for PLHIV; Child marriage and forced marriage; In 2013, of 82 women who tested HIV positive, only 32 received ART.	**Objectives and Need for Increased Gender in Planning:** Not indicated. **Gendered populations:** Not indicated.	Not indicated.
Egypt	**Epidemiological, access to services issues** • Epidemic concentrated in key and vulnerable populations. • An overall prevalence of 0.5% among street boys and girls 6.1% among MSM, and 7.2% among PWIDs. • Programmatic data on FSWs in 2010 indicated an average of 2.9% HIV prevalence.	**Objectives and need for increased gender in planning:** Yes, through focus on KPs. **Gendered populations:** MSM, FSWs and PWIDs.	**Gender-specific:** Activities targeting increasing the access of KPs to HIV services and especially testing and treatment for MSM and FSWs. **Gender-transformative:** Stigma-reduction interventions targeting the general population through advocacy; Conducting advocacytrainings for key religious leaders and media personalities on topics related to PWIDs, MSM, FSWs and PLHIV in general.

Country (grant type)	Gender Issues Identified	Gender in planning, objectives and included populations	Gender in intervention modules
Iran* updated information not included in current funding request and grant agreements	**Epidemiological, access to services issues** • Main drivers – Injecting drug use, with increasing role of sexual transmission • HIV prevalence among vulnerable women – 2.1%. • Male disproportionate epidemic (21,635 people diagnosed with HIV, mostly men). • Adherence to treatment among women living with HIV is more than men (94.7% for women and 88.4% for men). **Social and structural issues** • Cultural and social barriers constrain women to access services. • Cultural barriers hinder the system to reach easily to women living with HIV and at-risk women. • Stigma and discrimination hinder the access of PLHIV and HIV KP to necessary services, including women. • The number of women centres and outreach teams that are providing HIV prevention service packages for women is not enough in the country.	**Objectives and need for increased gender in planning:** Yes, one goal and one objective are directly focused on vulnerable women. **Gendered populations:** Vulnerable women, pregnant women.	There is one module specifically for vulnerable women (testing and service packages). PMTCT is also included in the care and treatment module of the project. The national system has a comprehensive programme for PMTCT.
Kyrgyzstan	**Epidemiological, access to services issues** • Women-disproportionate epidemic. • Increase in HIV prevalence compared to 2013 Integrated Biological and Behavioral Survey (IBBS)in PWIDs (from 12.4% to 14.5%), in MSM (from 6.3% to 6.7%) and prisoners (from 7.6% to 11.4%); a stable prevalence has been notified in sex workers from 2.2% to 2.1%. **Social and structural issues** • Stigma and discrimination remain a major barrier to accessing TB and HIV services, among medical professionals and society in general. As a result of stigma and discrimination, or fear of it, members of vulnerable groups are reluctant to disclose their status and follow up on the results of testing/ survey/medical examinations, even if they have access to services.	**Objectives and need for increased gender in planning:** Yes, indicated for increased gender programming. **Gendered populations:** Sex workers, MSM, pregnant women.	**Gender-specific:** Comprehensive prevention programme for sex workers and clients, MSM.
Multi-country America	**Epidemiological, access to services issues** • Prevalence in MSM is between 5-33%; there is limited data for transgender community but where available, it is high (52% in Jamaica, and 27% in adolescents in Jamaica). • Female sex workers compromise about 2-10% infections.	**Objectives and need for increased gender in planning:** Yes, but KP focus-goal of grant is to reduce stigma and discrimination towards PLHIV and KP **Gendered populations:** MSM, Transgender people, sex workers	**Gender-transformative:** Enhancing technical and advocacy skills, empowering KP and communities; Legal aid literacy and services; community-based monitoring; social mobilization, up-scaling CHWs, community systems to reduce stigma and discrimination.

Country (grant type)	Gender Issues Identified	Gender in planning, objectives and included populations	Gender in intervention modules
Multi-country Western Pacific, HIV/TB (11 countries)	**Epidemiological, access to services issues** • Populations of MSM and transgender people ranging from 20 (in Tuvalu) to 25,000 (in Samoa). • FSWs from 10 (in Tuvalu) to 2,000 (in Vanuatu). • Widespread high risk behaviours, such as multiple sexual partners and unprotected sex, and low access to prevention and testing services. **Social and structural issues** • KPs are the most vulnerable and have limited access to prevention and diagnostic services due to stigma, discrimination and other social barriers. • HIV vulnerability is still high due to factors such as widespread migration and mobility, dense sexual networks, a large caseload of untreated STIs, low knowledge about HIV and STIs, high levels of transactional sex and significant levels of IPV.	**Objectives and need for increased gender in planning:** No gender-related goals in grants. **Gendered populations:** MSM, transgender people, sex workers.	**Gender-specific:** PMTCT: prevention of HIV infection among women of childbearing age; treatment, care and support to HIV positive mothers and their children; Prevention programmes for MSM, transgender people, sex workers and their clients, and other. **Gender-transformative:** Advocacy programmes to address violence against women and girls; Address legal barriers, advocacy & structural drivers of the HIV epidemic, including GBV.
Panama (Transition Grant)	**Epidemiological, access to services issues** • In 2016, there were 20,873 people with HIV in Panama (69% men and 31% women), which translates to a prevalence rate of 0.7% of the population over 14, one of the highest in Latin America. • The populations with the highest HIV prevalence are transgender women (37.9%), MSM (21.5%) and independent FSWs (1.6%).	**Objectives and need for increased gender in planning:** **Gendered populations:** Transgender women, MSM, informal FSWs.	**Gender-specific:** Comprehensive prevention programmes for MSM; for sex workers and their clients; for transgender people. **Gender-transformative:** Removal of legal barriers – curb institutional discrimination against KPs, particularly at health services, in addition to human rights violations due to institutional violence, especially at the hands of the security forces.
Sao Tome and Principe (Material Change)	**Epidemiological, access to services issues** • HIV prevalence in 0.5% between men and women adults aged 15-49 with no gender variations (grant agreements). • There are no disparities between the genders. In the most affected age group (40-49 years), however, prevalence is higher among men (3%) than among women (1.7%) (Funding request). **Social and structural issues** • Due to stigma and discrimination, MSM do not reveal their sexual orientation, even to health workers. The situation analysis showed that MSM experience self-stigma. This leads some of them to live as bisexuals. • The law does not penalize consensual sex between individuals of the same gender, but people have recounted experiencing social discrimination. This primarily concerns people being rejected by family and friends due to their sexual orientation. However, the country does not have any LGBTQI organizations.	**Objectives and need for increased gender in planning:** No indication but goals include elimination of PMTCT. **Gendered populations**: FSWs and clients, men who have sex with men, prisoners.	**Gender-specific:** Programme for PMTCT, MSM and sex workers and clients. **Gender-sensitive:** Community systems, health workers, awareness-building. **Gender-transformative:** Adolescents and young people in and out of school.

Country (grant type)	Gender Issues Identified	Gender in planning, objectives and included populations	Gender in intervention modules
South Sudan (COE)	**Epidemiological, access to services issues** • Concentrations in individuals in uniformed services, sex workers, truck drivers, MSM prisoners, and youth. • Most of the new HIV infections were clients of sex workers (42.6%), men and women involved in casual sexual relationships (14.5%), FSWs (11.2%) and couples in stable relationships (9%). • MSM (3.9%), partners of the KPs (0.6%) and partners of those who engage in casual sex (1.6%) also contribute to new infections. Medical injections and blood transfusion are estimated to contribute 0.02%. Prevalence in the military is 5.8%, double that of the general population due to low awareness and multiple sexual partners. **Social and structural issues** • Low status of women and girls, widespread sexual and GBV, misconceptions about HIV, high levels of stigmatization and discrimination. • GBV remains one of the most prevalent and persistent issues facing women and girls in South Sudan. Young girls are at an increased risk of contracting HIV due to a lack of negotiation power for safe sex and are more likely to experience domestic violence. • With continuing insecurity and massive displacement of a large proportion of population compelled to live in protection of civilian (POC) sites, sexual and basic human rights violations in different forms will continue to rise and require urgent attention. • Existing legal obligations and political commitments for human rights and gender equality—especially the rights to access health-related information and services, autonomy in decision-making and non- discrimination—have not been translated into concrete strategies, programmes and actions.	**Objectives and need for increased gender in planning:** Yes, within KP. **Gendered populations:** Sex workers and their clients, MSM and refugees.	**Gender-specific:** PMTCT. **Gender-sensitive:** Community engagement and health workers. **Gender-transformative:** None.
Sudan	**Epidemiological, access to services issues** • Stable and low epidemic, with slightly higher prevalence in FSWs and MSM. **Social and structural issues** • Delivery of interventions to key and vulnerable population challenging due to conservative context and sociocultural barriers that stigmatize and discriminate against the populations. • FSWs and MSM are criminalized, but ongoing advocacy and sensitization of key government stakeholders have enabled access to interventions.	**Objectives and need for increased gender in planning:** Goals do not include gendered dimension beyond focus on KPs. **Gendered populations:** FSWs & MSM; PLHIV; Pregnant women who are HIV positive and children born to HIV positive women.	**Gender-specific:** Prevention programmes for MSM, sex workers and clients.

Country (grant type)	Gender Issues Identified	Gender in planning, objectives and included populations	Gender in intervention modules
Tajikistan (Material change)* *updated information not included in current funding request and grant agreements*	**Epidemiological, access to services issues** • Male disproportionate epidemic – prevalence 8,750 people (67% male; 33% female). 2018: 7,812 (4,689 men & 3,123 women) (AIDS Center). • Among PLHIV, 41% (98% male; 2% female) had a history of injecting drugs; 48% (43.5% M; 56.5% F) had a history of unprotected sex; 3.51% were infected by mother to child transmission. In 2018, 2.9% of sex workers are living with HIV; 76.6% of sex workers reported the use of a condom with their most recent client; 52.3% of women who inject drugs reported the use of sterile injecting equipment the last time they injected; 97.3% women received ARTs to reduce the risk of mother-to-child transmission. • Among women in prisons, 70% were imprisoned for drug offenses. In 2017: 30 women were convicted for committing drug-related crimes, which is 9 people or 42.9% more than 2016. • There are 2,220 women living with HIV. From 2009 to 2016, the number of new infections among women has increased roughly four times. 3,123 women in 2018 vs. 659 in 2011 (373% increase); 3,123 women in 2018 vs. 2,318 in 2016 (35% increase). • For MSM population, late diagnosis and entry into care is also a major issue. Many continued into care but quit during the process due to social, cultural, and familial stigma. MSM community still report stigma and discrimination from society, healthcare workers and law enforcement. **Social and structural issues** For women, stigma and discrimination persist at the family level, societal level and self-stigma, preventing them from seeking service. Gender inequality, teenage marriages and violations against women and girls are prevalent throughout the country. Due to these issues, testing among women is significantly lower than their male counterparts.	**Objectives and need for increased gender in planning:** Yes indicated: goals and strategies focus on KPs, but also critical enablers and removing legal barriers. **Gendered populations**: PWIDs, sex workers, MSM, PLHIV, Pregnant women and newborns, patients with HIV, prisoners.	**Gender-transformative:** • Programmes to reduce human-rights related barriers to HIV services. • Legal support for girls and women will prevent sex-based violations. • Respondent driven recruitment will also be utilized for recruitment of KP into services to solve cultural social, and ethnic barriers. Through initiatives such as peer outreach, smartphone applications and social media. • Legal/patients' rights literacy trainings for women, girls and KPs. • Training of health care providers on non-discrimination, duty to treat and rights-based approach. • Human rights roundtable and workshop for parliamentarians, ministry of justice, judges, prosecutors, police, law experts and religious leaders.
Zimbabwe (Full review)	**Epidemiological, access to services issues** • Women disproportionate prevalence – 16.7% women vs 10.5% men in population; women disproportionate incidence: 0.67% women and 0.28% men (15-49 years). • FSWs: 57% prevalence in sub-population. • Greatest number of new infections occur in never married women (16,000/year). • Young women (20-24) have prevalence 2.78 times higher than male peers. • High rates of prevalence in young women who engage in transactional sex (32% vs 10% in those that don't). • HIV prevalence among the wider LGBTQI community has been linked to risks associated with forced sex, a key gender-related consideration. • Among prisoners, HIV prevalence is estimated at 28% in 2015 (26.8% among male detainees and 39% among female detainees). **Social and structural issues** • Criminalization, stigmatization and marginalization drive both higher rates of infection and lower uptake of services.	here is no specific section in the FR but gender equality and gender-specific discussions feature strongly in it and the grant agreement. However, this is not translated into high-level objectives of the grant. **Gendered population:** PMTCT, sex workers and their clients, MSM.	**Gender-specific:** PMTCT, comprehensive prevention programmes for sex workers and their clients, MSM. **Gender-sensitive:** Peer and community mobilization support. **Gender-transformative:** Prevention programmes for adolescents and youth, in and out of school – condom negotiation and use (using gender-transformative models), demand-generation for health services, addressing social norms within communities, school-based HIV prevention, peer and community mobilizationsupport, and educational subsidies to keep girls in school and address structural drivers of the epidemic.. Interventions that address stigma, discrimination and violence against MSM through legal support and legal/patients' rights' literacy training.

Annex 2

LIST OF KEY INFORMANTS

Afghanistan

Name	Position
Dr Alim Atarud	Programme manager, UNDP
Dr Mohammad Zubair Harooni	HIV/AIDS project officer, UNDP
Dr Ahmad Walid Siddiqi	Malaria project officer, UNDP
Dr Abdul Wali Yousofzai	TB/RSSH project officer, UNDP
Dr Najibullah Safi	Programme manager, Health System Development WHO Country Office; First vice-president CCM

Chad

Name	Position
Zacharie Fotso	M & E Specialist, UNDP
Gael Ollivier	Coordinator, GF Programme, UNDP
Dr Mahamat Saleh Issakha Diar	Deputy coordinator, National Malaria Programme, MoH
Mme Koumalebidja PAH	Coordinator of the Association des Femmes Tchadiennes pour la lutte contre la Pauvreté

Cuba

Name	Position
Katia Cobarrubias	Project manager UNDP
Inalvis Rodriguez	Gender analyst, UNDP
Otto Reinaldo Peláez	Director, National Center for the Prevention of STDs and HIV/AIDS
Yoire Ferrer Savigne	Prevention of STDs and HIV/AIDS Director of the sub-beneficiary M2M National coordinator of the PLHIV Network Vice president of MCP
Mirna Villalón	Specialist, National Center for the Prevention of STDs and HIV/AIDS, Línea 50 y más of the PVV Network
Yandy Alberto Betancourt	M2M Network specialist, National Center for the Prevention of STDs and HIV/AIDS,
Maritza Aguilera	People who practise transactional sex specialist, National Center for the Prevention of STDs and HIV/AIDS
Gustavo Valdés Pi	Specialist, National Center for Sex Education (CENESEX) National coordinator of the M2M Network
Andy Aquino	Specialist, National Center for Sex Education (CENESEX) Director of the sub-beneficiary Transcuba
Malú Cano	National coordinator of Transcuba Network
Rosaida Ochoa	Former director, National Center for the Prevention of STDs and HIV/AIDS
Juan Raúl Valdés Triguero	Administrative assistant (UNDP) Former national coordinator of the PVV Network
Lilian Pedrosa	Fund portfolio manager, Global Fund
Dr Mayda Álvarez Suarez	Director of the Women Study Center of the Cuban Women Federation Coordinator of the National Gender Equality Survey

Djibouti

Name	Position
Angela Anna de Tommasi	Project coordinator, UNDP
Emina Rye-Florentz	Fund portfolio manager, Global Fund

Kyrgyzstan

Name	Position
Itana Labovic	Programme manager, UNDP
Inga Babicheva	HIV/TB Coordinator / Deputy programme manager, UNDP
	Gender focal point, UNDP
Ilim Sadykov	Public Health programme Coordinator in Soros Foundation Kyrgyzstan (implementing partner)
Alla Bessonova	Public Association 'Women's Network of Key Communities,' Board chair (gender champion)
Irena Ermolaeva	Head of PF Asteria (NGO, implementing partner)
Alexandrina Iovita	Fund portfolio manager, Global Fund
Alexey Bobrik	Fund portfolio manager, Global Fund

Annex 3

INTERVIEW TOPIC GUIDE

1 Gender and its place in grants, and the country context

a) In your experience and perspective, how do the planning and implementing teams view gender, gender-responsiveness and gender equality as a concept, process and goal?

b) What have been the country dynamics — how responsive are policy makers, ministries, the public to advocacy towards more gender-sensitive or transformative programming and investments, from domestic sources, as well as international ODA?

c) Who are your gender and disease stakeholders, who are the advocate/champions and who are the opposing voices? What are the reasons for support and opposition? What are the power dynamics at play?

d) Can gender-focused policy and programming be openly advocated for within the operating and policy context? What is the general public and policy standpoint?

e) Where do you think gender does not need to be included in planning and implementation, and why? What should be done instead? (with justifications)

2 Interventions

a) In what way do you think gender is currently addressed in the planning and implementation of modules? (all modules, not just those that have a gender-specific KP or target population identified)

b) What are your thoughts on how the gender issues identified through prior lessons and research are translated into programming, investment and the Performance Framework?

c) (using the proforma) What do you see as gender-specific, sensitive or transformative in the work you have done for the GF in your country? Are there any gender-blind or unequal interventions?

d) (building on descriptions in previous question) In your opinion, what aspects of these interventions/implementation makes them sensitive, transformative or blind/unequal?

e) How have specific activities/modules been implemented? Can you describe using 1) treatment and care, 2) a gender-specific module as examples?

f) Is there documentation related to the implementation that can be shared privately for use in the case study?

3 Use of UNDP checklist

a) How is this used in the process?

b) How much does gender feature in the national strategic plan, country dialogue process, FR design and approval, reviews by TRP, GAC and how does the Global Fund Board respond? Has there been feedback or rejection based on insufficient engagement with gender in content and process?

c) If it has been used for current grants, to what extent have the items on the checklist been achieved?

d) Which are the components where gender is strongly included, where least? What have been the enabling factors and barriers?

4 Investments

a) Have there been discussions for gender-responsive/ transformative budgeting? Has it been integrated into the final budget, and in what way? (checklist mentions weighting budgets according to disaggregation reflected in indicators).

5 Implementation, performance monitoring and evaluation

a) How is gender integrated into the Performance Framework? How are decisions made reflecting the need for sex-disaggregated (SD) data? How well do current reporting mechanisms work to capture and report SD data?
b) In terms of considering gender in grants, what would you consider as the benchmark for success? What metrics and evaluation criteria would you use?
c) Beyond the performance monitoring framework and reporting, have there been any other country-level assessments of gender-responsiveness/ gender-specific, population-focused programmes that you can share with us for use in the analysis?

6 Moving gender-sensitive/transformative programming forward

a) What is on the horizon for the next grant cycle? Has there been an increase or decrease in gender-responsive activities? What factors or initiatives have led to this increase or decrease?
b) Do you have suggestions on how you would like to see gender work addressed and tracked differently?
c) If we need to modify perspectives and actions, what strategies, motivations or goals do you think the teams will respond to in a positive way?
d) What are the resources and which stakeholder buy-ins are required to move for more gender-transformative processes, activities and investments in your next Funding Request to GF?

Credit: UNDP Afghanistan/ Sayed Omer and Igor Ryabchuk

Annex 4 Country case studies

AFGHANISTAN

(HIV, TB, malaria grant)

GENERAL & GENDER[1,2]

Indicator	Value
Population:	37 million
Urban residency:	25%
Net ODA as share of govt exp:	51%
Net migration:	-314,600
GDP per capita:	$521
Poverty rate:	55%
Female % labour force:	36%
Adult literacy rate:	30%

HEALTH[1,4]

Life expectancy:	MMR:	IMR:	Fertility rate:	Contraceptive use:	Pre-natal care coverage:	Skilled birth health staff:
61(M); 64 (F)	638 per 100,000 pop	48 per 1,000 pop	4.6	23%	59%	51%

HEALTH SYSTEM[1,3]

Indicator	Value
UHC index:	37
Domestic public as % THE:	5%
ODA as % THE:	19%
Total OOP as % THE:	75%
Hospital Beds:	0.5 per 1,000 pop

Total Health Expenditure of GDP: **12%**

Notes: Data are for the most recent years between 2015 and 2018. GDP: Gross domestic product; IMR: Infant mortality rate; MMR: Maternal mortality; ODA: Overseas development assistance; OOP: Out of pocket THE: Total health expenditure; Rate; UHC: Universal health coverage.

1. Background

Country context: Afghanistan is a low-income mountainous country that has faced about 30 years of externally and internally driven conflict and frequent natural disasters such as severe drought, flooding, earthquakes, avalanches and landslides that are exacerbated by the extreme terrain, temperatures and environmental degradation.[1]

Health system context: A basic package of health service (BPHS) delivery is contracted out to NGOs in the majority of provinces.[2] While the BPSH has been instrumental in improving health outcomes, and health systems strengthening, there remains multiple serious barriers to access, namely gender, security, finance and geography.[3] While private sector fees are capped at a policy level, in practice this is not systematically enforced across the country.[3] Access to health care is unequally distributed and largely a determinant of wealth.[4] Due to nomadic lifestyles and insecurity, there are large numbers of mobile, internally and internationally displaced Afghans, who are often hard to reach.[3] Geographical access is problematic, with only about 10 percent of the population living within one hour walk from a health facility, and about 75 percent living in rural areas with bad transport infrastructure.[3] Other health system challenges include inadequate financing for health, inadequately trained health workers, lack of female health workers in rural areas, quality compromised referral services and constrained national capacity for planning and management.[5]

HIV: Afghanistan has a concentrated HIV epidemic, with an estimated 6,900 people living with HIV, of which 28 percent are women (male-disproportionate epidemic), and less than seven percent are children. People who inject drugs are the main driver of the epidemic. Figure 1 presents the country's 2019 progress towards the UNAIDS 90-90-90 targets. Data on incidence and protective behaviour in KPs are missing. UNAIDS data 2019 reports that Afghanistan is one of 11 countries with an incidence to prevalence ratio of above 10, with rising mortality rates, wavering prevention programmes and poor linkage to care (more than 50 percent of people with HIV have unmet access to care).[6]

TB: The TB epidemic is unusually female-dominated (female-to-male ratio of 1.3:1) and treatment coverage is 69 percent, with a success rate of 91 percent.[7]

Malaria: Malaria prevalence was exacerbated during the conflict, which brought a 5-10-fold rise in malaria cases.[2] The burden and transmission of malaria is high in rural areas, river valleys that are used for rice cultivation and amongst cattle owners.[2] About 27 percent of the population live in high transmission areas (south-eastern provinces).

Gender Equality: For women and girls, conservative ethnocultural and religious beliefs have been a long-standing barrier to healthcare access. The Taliban regime used gender cultural ideology as part of their resistance, made it hard for women's rights-based advocacy[10] and imposed restrictions on women's participation in social, economic and political domains.

While gender outcomes in health have improved since the fall of the Taliban in 2002,[10] consequences of these gendered restrictions are still prevalent and gender inequality still pervasive. The literacy rate in women over 65 is about 3.5 percent, and in women aged 15 and above is nearly 30 percent.[8,113] Women and girls experience avoidable morbidity and mortality due to gender-based discrimination and harmful practices.[12] GBV, including early and/or forced marriage and honour killing, contributes to higher disease prevalence amongst women.[10] In 2016, two out of three women and girls above the age of 15 reported physical or sexual violence from an intimate partner in the past year. The culture of maintaining 'purdah', or gender segregation, is still practised at various levels within the country.[13] Women are often required by their families and communities to be escorted or chaperoned by male or senior family members when they attend health clinics or require hospitalization.[3]

Due to their traditional caregiving roles, and hence greater exposure, communicable diseases are more common in women.[10] For instance, it has been suggested that women's cultural lifestyle of being indoors and in smoke-filled places (from cooking and heating) could be a contributing risk factor for TB.[10]

Many women still prefer and request to be attended by female healthcare professionals, but female health professionals prefer not to be posted to rural areas.[3] Cultural, security and historical barriers to women's education have limited the supply of women health professionals to the rural areas in which they are required. The provision of sexual and reproductive health services continues to be undermined by conservative politics, religious and cultural groups, and faith-based NGOs.[3] For boys and men, risk-taking behaviours, including unprotected sex and substance

Table 1: Population data on HIV, TB and malaria

HIV[1,2]		TB[1,9,10]		Malaria[11,12]	
Incidence:	0.02 (0.01-0.04)	**All-form** **Incidence rate:**	189 per 100,000[61,62]	**Incidence:**	23.0 per 1,000
Prevalence:	<0.1%	**Mortality rate:**	29 per 100,000[62]	**Area of high transmission:**	27%
Change in new HIV infections since 2010:	+49%	**Total new and relapse cases:**	48,800 *(M:33%; F:46%; children:21%)*	**Malaria funding per person at risk:**	<$2
Change in AIDS-related deaths since 2010:	+45%	**Pulmonary:**	71%	**Households with one ITN:**	26%
		Treatment coverage:	69%	**Population with access to ITN:**	13.2%
Number of WLHIV:	2,000	**Treatment success rate:**	91%	**Households with one ITN for every 2 persons (survey):**	3%
OST coverage:	3.2%	**TB financing:**	$17 million *(3% domestic, 76% international)*		
Needles & syringes distributed per PWIDs:	52	**PLHIV:** **Incidence rate:**	0.87	**Population who slept under ITN previous night (survey):**	3.9%
Pregnant WLHIV accessing ART:	11%	**Mortality rate:**	0.26		
		Treatment success:	29%		
		MDR-TB: **Incidence rate:**	6.8		
		Mortality rate:	29		
		Treatment success:	62%		

Notes: ART: Antiretroviral therapy; ITN: Insecticide-treated nets; OST: Opioid substitution therapy; PWID: People who inject drugs; W/PLHIV: Women/people living with HIV

abuse in HIV, and occupational exposure for malaria and TB, contribute as gendered risks for malaria, TB and HIV.

Policy frameworks and health system: Stakeholders indicate a high-level political will and policy support for gender-sensitive health policies and programming. The ministry of public health (MOPH) appears to be a committed stakeholder in gender equality, as evidenced by its gender strategy, dedicated gender department and research and policy attention to reducing gender-related barriers to healthcare. At the leadership level, two out of three deputy health ministers are women, and there are reported government efforts to increase the participation and leadership of women in other sectors, including the military.

While stakeholders understand gender to include the needs of women and girls, men and boys, the historical and contextual systems have been particularly unequal for women, and therefore much of the policy attention is on the needs of women and girls. One of the successful gender-sensitive programmes identified by stakeholders is the CHW programme, which engaged female volunteers as health workers at the community level to overcome the cultural, geographical and security related restrictions on women's access to facility-based health services.[14] Assessments of the CHW programme find some increases in attendance of antenatal and post-natal care,[15] and stakeholders attribute the reduction of maternal morbidity rates, in part, to the programme.

2. Global Fund grants

Afghanistan is categorized as a COE due to its post-conflict context and health system strengthening needs. Currently, the country receives funding for HIV, malaria, TB and RSSH programme modules (approximately $43 million; January 2018-December 2020). As with all Global Fund grants, the funding targets areas with technical and resource gaps within the national context, and the design and implementation of programming is country-led and aligns with the national strategies for the three diseases.

UNDP Afghanistan has been the PR since 2015. Reasons include UNDP's experience, relationships and resources within the country and internationally in operating within emergency or COE settings. Of particular relevance is its track record in addressing financial management and procurement challenges, especially at the community health post levels, which has previously been a challenge faced by Global Fund grants in the country. Several adaptations have been made to Global Fund modules in consideration of cultural and religious sensitivity and to ensure implementation success.[2] At present, the UNDP country team is working to build capacity within the MOPH to take over as the PR.

A large focus of the MOPH is to increase the participation of female health workers, including CHWs, especially in rural areas. Historically, many female health professionals avoided rural areas, largely due to security threats, and during the Taliban regime they left the workforce due to fears of reprisal and recriminations.[3] Currently 83 percent of BPHS and essential package of health services (EPHS) health facilities have at least one female health worker.[16] The focus of the CHW programme, which operates at various levels in the health system, is maternal and child health. There is typically one male and one female CHW at the health post at the village level, and other CHWs appointed at the district hospital, who are nominated by the village health councils and are subsequently trained, supervised and supported by the implementing organization delivering the BPHS in the area. CHWs are unpaid volunteers nominated by their communities, who receive reimbursements for travel costs to health facilities.[13]

Afghanistan also receives additional Global Fund funding through a South Asia multi-country grant that focuses on TB among Afghan refugees who move into neighbouring countries (Iran and Pakistan) and are returning (up to $5 million; 2019-2021). The proposal was jointly submitted by UNDP, WHO, UNHCR and IOM.[10] The multi-country grant is excluded from this analysis, which focuses on the three single disease grants (see Table 2).

Other multilateral organizations that work within the disease areas include WHO, UNAIDS, UNODC, USAID, JICA and the World Bank. Gender is reportedly prominent in the programming by these organizations, where gender-sensitive planning and implementation are considered at supply and demand levels. Women networks and gender and human rights advocates appear to be involved in the engagement and delivery planning process. In terms of malaria, however, the Global Fund is the only donor that supports vector control and treatment, with a focus on addressing gaps within the national BPHS and EPHS systems. It also targets community level interventions, namely malaria treatment and training of CHWs.

Figure 1: Afghanistan UNAIDS 90-90-90 treatment target data[2]

First 90: percentage of PLHIV who know their HIV status; Second 90: percentage of PLHIV who know their status and who are on treatment; Third 90: percentage of PLHIV on treatment who have suppressed viral loads (data unavailable).

Table 2: Gender-related SDG Indicators for Afghanistan

SDG Indicator	Data
Legal frameworks for gender equality and non-discrimination	Universal suffrage to women granted in 1965[1]
	No non-discrimination clause in the constitution mentioning gender
	Law does not specifically prevent or penalize gender-based discrimination in the hiring process[1]
Violence against women from an intimate partner	67.75% of women >15 years experienced physical or sexual violence by an intimate partner in the last 12 months[1]
Women in political positions	27.70% women in national parliaments
Women decision-making on contraceptive use and healthcare	42.10% of married women's (aged 15-49) demand for family planning satisfied by modern methods
Female and equal land rights or ownership	30.90% of men, compared with 9.60% of women (aged 15-49) solely own land legally registered to their name[1]
	Legal framework does not guarantee women's equal rights to land ownership[1]

Note: Data ranging from 2015 to 2019

Table 3: Global Fund priority investment areas in HIV, malaria and TB & RSSH in Afghanistan

TB & RSSH		HIV		Malaria	
TB care and prevention	$3,407,582.00 [25.4%]	Treatment, care & support	$1,389,690.00 (15.7%)	Vector control	$8,936,032.00 (43.0%)
MDR-TB	$531,873.00 (4.0%)	CPP for PWIDs and their partners	$2,317,133.00 (26.1%)	Case management	$2,735,577.00 (13.1%)
RSSH: HR for health including health workers	$204,322.00 (1.5%)	CPP for sex workers and their clients	$423,986.00 (4.8%)	RSSH: HMIS and M&E	$346,378.00 (1.7%)
RSSH: Community responses and systems	$100,816.00 (0.8%)	CPP for MSM	$647,702.00 (7.3%)	Programme management	$8,786,879.00 (42.2%)
RSSH: Procurement and supply chain management	$1,393,432.00 (10.4%)	CPP for people in prisons & other closed settings	$426,353.00 (4.8%)		
RSSH: HMIS and M&E	$216,510.00 (1.6%)	RSSH: HMIS and M&E	$206,358.00 (2.3%)		
RSSH: Integrated service delivery and quality improvement	$1,877,965.00 (14.0%)	Programme management	$3,450,669.00 (38.9%)		
Programme management	$5,696,962.00 (42.4%)				
TOTAL $13,429,462.32		**TOTAL $8,861,891.00**		**TOTAL $20,804,867.00**	

Note: CPP = Comprehensive Prevention Programme, HMIS = Home-management information system, HR = Human Resources

3. Gender-responsiveness of the grants

3.1 Gender issues

HIV: With some of the KPs being gender-specific (female sex workers and men who have sex with men), there were some gender dynamics and inequalities discussed in the grant documentation (highlighted above), although there was a lack of gender and age-disaggregated data. Discussions of gender were missing in populations that were not gender-specific, such as women who use drugs, or in prison. Additionally, inclusion of human rights and gender equality issues are outlined, but not directly identified in programmes or investment categories.

The grant describes one of the national priority areas in the current national strategic plan (NSP III)- "to create a supportive and enabling environment for a sustained and effective national response to HIV and AIDS" that focused on the social, legal and policy environments for promoting and protecting human rights and gender equality among people living with HIV and KPs. The policy on "Protecting People Living with HIV from Stigma and Discrimination in Healthcare Settings" was envisaged to be implemented during 2017.

The grant funding request also identifies that men with high-risk behaviour play a larger role in the epidemic than previously estimated, and they encounter high stigma and discrimination, punitive laws, prosecution, lack of access to prevention services and limited support from and/or violence in the family and community. The grant also discusses the social acceptance of violence against women — 25 percent of human rights issues reported are based on physical violence, with honour killing being the most extreme manifestation. Within the socio-structural context, high stigma and discrimination against female sex workers and men who sex with men, alongside punitive laws and prosecution, have been identified.

While gender is discussed more in the HIV grant than in malaria and TB grant documents, a higher level of gender analysis across all target populations, especially those that are not gender-specific — such as people who inject drugs and people in prisons — can provide more useful insights to inform effective programming.

Malaria: The malaria grant indicates that no further increase in gender-oriented work is necessary, because of a focus on equal service delivery to all populations living in malaria endemic areas regardless of their gender, ethnicity, religion, etc. In interviews, stakeholders do not perceive malaria as a gender-disproportionate epidemic in terms of exposure risk. While there is no data available, stakeholders discussed that more diagnosed women receive treatment than men. There is recognition that pregnant women have higher risks from malaria and need to be targeted. This is achieved through distribution of LLINs during their first ANC visit at health facilities. The grant identifies overall health-seeking barriers, such as women's need to be accompanied by men or elderly women to travel to health facilities, and that their right to health is limited by gender norms.

TB/RSSH: Similarly, the TB grant identified psychosocial and cultural barriers limiting women's decision-making power, including decisions regarding their own health and the need for women to travel with male approval and escorts. The grant application notes that up to 80 percent of women live in rural areas and as such, physical and geographic limitations, including limited modes of transportation for women, long distances to health facilities, physical insecurity, severely harsh terrain and road blockages, are notable access barriers. The TB grant also identifies that women report very high levels of violence — with 48 percent of women and girls over 15 years having reported physical violence in the previous year — have low levels of decision-making, and that there are vast gender disparities in income and education. From a supply side, the TB grant discusses how health workers report low comfort levels in providing curative and preventive services to patients regarding gender-sensitive issues such as physical and sexual violence. This adds to the challenges of disclosing experiences of domestic abuse, including unsupportive institutional response and insensitive attitudes of health care providers.

There are reports that TB incidence in women is rising. Although there is limited research, stakeholders suggested that contributing factors could be lack of service access, experience of stigma, the lack of diagnostic services for TB at community level, and a delayed or missed referral process. Stakeholders further deliberated on potential reasons why access to diagnosis and treatment for malaria is higher for women, while it is lower in TB. Malaria is an acute illness, and the availability of treatment at a community level is gender-sensitive, while TB is a chronic illness, where diagnostic services are only available in health facilities, and treatment can require long-term hospitalization within a challenging cultural context

(requiring chaperones and gender-segregated waiting areas). Nevertheless, there are women-only MDR-TB wards in the regions.

3.2 Interventions and implementation

There was a clear difference in how gender-responsive interventions were prioritized in HIV grants, in comparison to TB and malaria.

HIV: In the HIV grant, gender-specific modules included comprehensive prevention programmes for men who have sex with men, people who inject drugs and partners and female sex workers and clients, which include condom distribution, HIV counselling and testing, STI screening and treatment and behavioural interventions (module only indicated for sex workers not clients). There were some gender-transformative components, including interventions addressing sexual violence towards minors, sensitization of law enforcement agents and religious leaders, and establishment of people living with HIV networks and multisectoral coordination meetings, which provide opportunities to address issues related to human rights and gender. Nevertheless, depending on the interventions and populations of focus, human rights programming is not necessarily always gender-responsive programming. Modules for people who inject drugs and prisoners have been prioritized and implemented only in male prisons, and for men who used drugs, reportedly due to lack of funding for female populations.

TB/RSSH: Although gender does not feature in the main goals of the TB grant, priorities described include innovative efforts to expand the female health workforce. Gender-sensitive programming includes the establishment of Family Health Houses, where female health workers provide health services for women in under-served communities. There are also female health social counsellors, who receive comprehensive training and are deployed to those health facilities and comprehensive health centres, where they serve women's needs and actively advocate for women's and children's rights to access and to utilize health services.

Additionally, active case finding is also implemented and funded via the grant through CHWs. Active case-finding in Afghanistan is a gender-sensitive intervention. Studies at community level of known contacts and IDPs found that more women than men were identified through this strategy, even though similar numbers of men and women were screened.[17] The study also found that the confirmed positive cases showed similar female/male ratios in health facilities, IDP camps and community settings of approximately 2.0.[17]

Malaria: The grant documentation highlights a focus on "all of the population," although there appear to be reports that more women access malaria care than men. Stakeholders primarily view gender-responsive programming as equivalent to gender-specific programming. Nevertheless, gender-specific interventions include the delivery of additional LLINs during ANC visits, and gender-sensitive interventions include case management at the community level, including access to anti-malarial treatment through an extensive trained CHW network.

Past studies on the implementation of GF grants in the country have noted that staff routinely screen programmes to ensure that no logistical, operational, cultural, religious, social or economic challenges are faced, and support simple and easily implemented interventions, such as ITN and LLIN distribution.[2] In prior studies on pregnant women, the uptake of LLIN was found to be a more effective preventive strategy due to their higher preference and hesitance to use prophylactic medicine during pregnancy.[18] For pregnant women, while utilization of ANC has been increasing in the last 10 years, the proportion of women who attend four or more visits is less than 18 percent.[19] Likelihood of ANC visits is also influenced by factors including the educational levels of both women and their husbands, wealth and location (urban vs rural).[19]

Additionally, a focus on community-level delivery of treatment and training of CHWs are attributes that can be considered gender-sensitive. Separate male and female information sessions are considered appropriate in a cultural context that strongly separates gender groups on social, cultural and religious grounds. Activities that include separate male and female sessions ensure that women can access services without social exclusion or gender bias. In these sessions, female staff conduct training or activities and communicate messages. Female staff also report easier entry into households to monitor uptake and adherence.

Overall: Adequate buy-in at various levels, as well as the infrastructure and resources to establish gender-sensitive health services, have been identified as key top-down implementation challenges. Similarly, gender-transformative structural interventions are

found at legislation and policy levels, but changes in gender norms that restrict women's empowerment, choice and access to equal resources at systemic and cultural levels is slow. For instance, from the demand side, the need for chaperones is a barrier to women's timely healthcare seeking, and from the supply side the lack of female health professionals and designated female only waiting areas in facilities are some of the resource and infrastructure barriers of access.

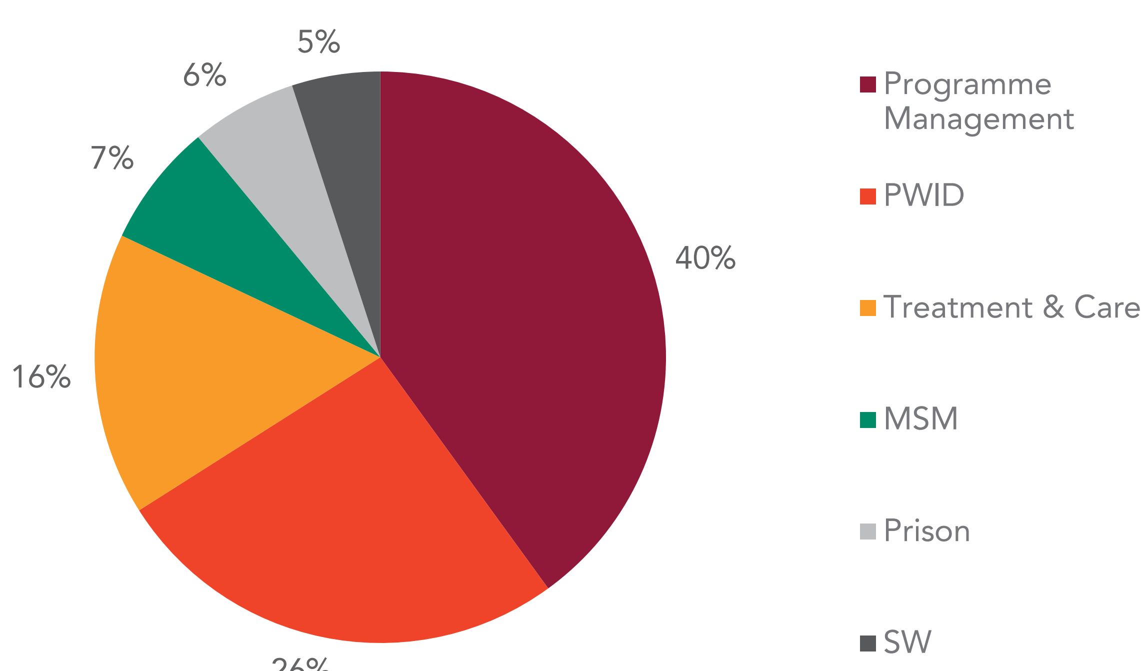
3.3. Gender in investments and performance frameworks

Budget and investments: In the current format of reported budgets, the categorization by module and resource use does not provide visibility of gender-sensitive or gender-transformative activities. Nevertheless, for the HIV module, allocations for gender-specific populations (i.e. men who have sex with men and female sex workers) were 12 percent of the total. Stakeholders indicated a disproportionate spending on male persons who inject drugs and on male prisons, due among others to the absence of suitable service providers that had access and capacity to provide necessary services in female prisons and amongst women who use drugs (a hidden community). Moreover, the above allocation requests were not approved in the current grant cycle, leading to insufficient resources for spending on some populations, namely the female prison population and women who use drugs. However, within the people who inject drugs module, there were one to two female outreach workers who were supported to work with a small number of female persons who inject drugs, but this was not deemed sufficient. Information on the population size of women who use drugs, and women in prison, was not available to consider the size of the population neglected.

Budgeting has been based on population size estimation and resource needs calculations. For instance, in the next grant cycle, initiation of programmes for female persons who inject drugs will require increased budgets. There is national commitment to consider this extension in future grant cycles. Principles of gender-responsive budgeting do not appear to have been considered. For TB, stakeholders indicated that although spending on gender-sensitive activities was not formally included within the budget, more was spent on women and gender-sensitive activities at the implementation stage, but this could not be confirmed through available documentation.

Performance monitoring: Stakeholders described performance frameworks as a negotiated agreement with the government, to align with national priorities and needs. However, the performance framework itself remains relatively gender-blind. The targets chosen in the HIV grant are biomedical in nature and do not adequately capture the experience on the ground of human rights and gender-based discrimination.

Figure 2: Proportion budget for modules in HIV grant



In the HIV grant, there was a sense that inclusion of further sex-disaggregation in outcome and coverage targets was not feasible. Although sex-disaggregated data was reportedly collected and available from implementing partners, it was not required for impact and coverage indicators: coverage indicators focus on prevention and treatment interventions received (no disaggregation requirement indicated), outcome indicators on uptake of protective behaviours (sex-disaggregation required) and impact indicators on the size of KPs who live with HIV (no sex-disaggregation required). There is a large number of human rights violations and incidents of GBV, including fatal attacks on female sex workers and men who have sex with men. These dynamics, as well as stigma and discrimination, affect service delivery to the target populations but are not being monitored under the grant.

For malaria and TB, there was a sense that no further change to performance frameworks was required. Stakeholders identified that the indicators align with the NSP targets, which may not require sex-disaggregated data, a view that might emerge from this national lack of requirements. Nevertheless, there is a notable absence of sex-disaggregation in the impact, outcome and coverage indicators in the performance framework presented in the grant confirmation documentation. In the current framework, age has been identified as an important data category. Greater prioritization of sex-disaggregated data in performance reporting will provide greater visibility of the gender-related issues and gender-responsiveness of current strategies.

At the implementation level for all three diseases, stakeholders' perceptions suggest that many implementing partners are gender-blind in their approach and even reinforce or perpetuate gender biases in cultural norms. For TB, there were no perceived challenges at a policy or health system governance level, but rather with implementation and service uptake or demand for utilization. Stakeholders strongly felt that the socio-economic and community level issues are the main barriers to health service access, i.e. transportation (demand side), and these challenges are not specific to TB. In the most recently available progress update (Jan-June 2018), targeted distribution of LLINs to targeted risk groups exceeded the set target by 20 percent, but distribution to at-risk populations in general has been the least successful indicator area (target achievement of 60 percent).

4. Recommendations

4.1 Gender in research, population size estimation and performance framework

The lack of recent gender and age-disaggregated data on HIV, size estimation and prevalence of HIV among KPs hinders evidence-based approaches to advocacy and programming. Updated sex-disaggregated data across all data categories, including within the performance framework spanning the prevention and treatment cascades (of all three diseases), will increase visibility of the gender-responsiveness of the national response. Further in-depth gender analysis of women's lived experiences and barriers to healthcare access, especially in TB and malaria, and within non-gender-specific KP groups, needs to be funded. Specifically, more research is required to understand why TB affects women more, and why they tend to not seek healthcare. Some hypotheses to explore include the chronicity of TB affecting the potential need for hospitalization, and also women's potentially higher risk of extra-pulmonary TB.[20] A gender analysis and population size estimation of women in all population groups, as well as a needs assessment, will support the planning and delivery of services in the future.

4.2 Increased programming for women in neglected or hidden populations

More women-inclusive financing has been raised as an area that requires attention in the next grant funding cycle. Discussions highlighted that the current HIV grant excludes programming for women persons who inject drugs, and prisoners. Similarly, there may be other neglected populations of women that do not receive treatment in time. For instance, a recent screening at mental health facilities (five public and one private), where over 8500 patients were screened, found a confirmed diagnosis of TB (all forms)) in approximately 17 percent (n=275), of whom about 91 percent were women (n= 250). The study found that TB incidence was about 20 times higher than the national incidence rate.[21]

4.3 Developing and leveraging community resources through capacity-building

Community systems in rural and urban settings, as well as the relationships that CSOs and implementing organizations have with target communities, appear to be key aspects of the grant programming and national health system. To further harness the potential of this resource requires greater focus on capacity-building and gender training for women CHWs, CSO staff and implementing partners at institutional and community levels. From CHWs, to leadership positions within NGOs and implementing partner organizations, women seem to be missing from supervisory, decision-making and leadership roles, especially within mid-level roles in the health system, and within communities.

4.4 Further integration of programming that addresses GBV within disease modules

GBV is identified as a cause and consequence of HIV, TB and malaria diagnosis and treatment outcomes, and a barrier to health service uptake. Given the high prevalence of GBV in all forms in the country, there needs to be further assessments of-healthcare seeking barriers and patterns of women who experience violence, and programming on how these barriers can be addressed. An assessment of the enabling and restrictive conditions within households, communities, health facilities and national environments (such as supportive resources and services that survivors have access to, their privacy and dignity upon disclosure and health-seeking, and safe entry points to reach them) is necessary in order to be more responsive to women's needs.

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UNDP Chad/ Aurélia Rusek

CHAD

(Malaria grant)

GENERAL

Population:
16.9 million

Life expectancy:
55.4 (F)
52.6 (M)

GDP per capita:
$823

Population below poverty:
46.7%

Maternal Mortality Rate:
860
per 100,000 pop

Infant Mortality Rate:
74
per 1,000 pop

MALARIA

Incidence:
193
per 1,000 pop

% of all-cause under-5 mortality:
60%

Household Insecticide-treated nets ownership:
42%
per 1,000 pop

HEALTH SYSTEM

Doctor density:	**3.7 per 100,000 pop**
Nurses/midwives:	**3.7 per 100,000 pop**
Ante-natal care (4 visits):	**26%**
Universal Health Coverage index:	**28**

Total Health Expenditure:

$79
per capita

Notes: GDP: Gross domestic product.

1. Background

Country context: Chad is a landlocked, low-income country in Central Africa,[1] with a largely rural population (78.1 percent) and women constituting more than half the total population (50.6 percent).[2] The oil sector currently drives the economy, accounting for 80 percent of exports, and 70 percent of government revenue.[3] Although economic growth has improved, nearly half of Chadians live below the national poverty line, with pockets of high poverty in both rural and urban areas.[3] Progress has been made on some human development indicators — for example, between 1990 and 2018 life expectancy at birth increased from 47 to 54 and average years of schooling rose from 3.2 to 7.5, albeit with a large difference between females (6 years) and males (8.9 years).[4]

After decades of armed conflict and socio-political instability, Chad has transitioned to a relatively peaceful and stable situation.[5] Recent economic gains and political stability remain fragile as insecurity and terrorism in surrounding countries rise,[3] resulting in an influx of refugees, estimated at about 450,000, mostly women (55.5 percent), from Sudan, Central African Republic and Nigeria.[6,7] Despite its decentralized governance structure, administrative and basic social services remain concentrated in the capital city.

Health: Population health is a major challenge, although progress has been made. The maternal mortality rate has declined significantly but remains very high. Similarly, infant and neonatal mortality continued to fall from 106 to 72 deaths per 1,000 live births between 2010 and 2015. While more than half (65.8 percent) of pregnant women have accessed ANC at least once during their most recent pregnancy, coverage remains sub-optimal, with only 24.7 percent completing the recommended 4 ANC visits.[8,9] The fertility rate is high (6.4), in part due to low contraceptive use, estimated at 5 percent and 6 percent for all women and those in a union respectively. Health service delivery suffers from very serious constraints.

The number of health personnel is inadequate, with one doctor for every 24,188 of the population, one nurse for every 3,837, while for women of childbearing age the ratio is 5,441 women for every one nurse.[8] This situation is further compounded by long distances that many people must travel to health facilities, poor health facility infrastructure — including a lack of electricity and clean water — as well as inadequate funding of the health sector, which is heavily donor-dependent.[8,10]

Malaria: Chad's disease profile is characterized by a high burden of malaria, which affects nearly half (40.9 percent) of the population and is the leading cause for hospital admissions (42 percent) and deaths (39 percent).[11] In 2018, 12 percent of malaria-related hospital deaths occurred among pregnant women, and malaria caused 60 percent of all-cause mortality among under-fives. Chad's health system response to malaria emphasizes access to preventive and curative care to reduce its morbidity and mortality. The use of ITNs and IPT are widely promoted, while indoor residual spraying is less prominent. IPT coverage has improved, with 76.1 percent of pregnant women receiving at least one dose. While 42 percent of households owned at least one ITN, only 57.1 percent of the people in these households slept under them, including only 34 percent of pregnant women.[1]

Gender equality: In spite of legal and statutory regulations to advance women and girls' rights, women continue to face risks due to weak laws and harmful social practices, including female genital mutilation and wife inheritance. A large proportion of women (44.2 percent) have experienced physical and/or sexual violence from an intimate partner in their lifetime,[13] but only 29 percent and 11.6 percent of women report physical and sexual violence, respectively. Few women and girls (10 percent) make their own decisions about sexual intercourse, contraceptive use or healthcare access.[13] Indeed, the overwhelming majority of Chadian women and girls lack access to and control over financial resources and decision-making power to access health services.[14] Given that only 22 percent of women are literate,[1] female illiteracy can be a major obstacle to women's labour force participation, as well as to their access to malaria prevention and treatment strategies. Moreover, women are overburdened with household chores, childcare and — in rural areas — agricultural activities. More women than men work in the agriculture sector (92.4 percent v 82.9 percent), with potential implications for their exposure to mosquito bites and susceptibility to malaria.

Policy framework: Chad's national development plan ("Vision 2030: The Chad we want" (2017-2021), prioritizes human and social capital needs, social protection and economic empowerment, aligns with the SDGs and emphasizes gender mainstreaming in programmes to reduce gender-related inequalities. Malaria control is one of the three (along with HIV and TB) primary priorities in the national health strategy,[15]

and the revised National Malaria Strategy (2019-2023) aims to contribute to "an economically strong country without the risk of dying of malaria," through quality data, behavioural changes and health system capacity strengthening.

Although a policy of free access to care was introduced in 2008 for pregnant women and children under five, emergencies and specific diseases and inadequate legal, financial and human architecture have hampered its implementation,[16] and this has been further constrained by a decline in oil revenues.

2. Global Fund malaria grant

UNDP is the PR under the current Global Fund malaria grant (2018-2021). As such, it is responsible for overall grant management and capacity strengthening of the national counterparts (namely the Ministry of Health [MoH] Central Programme Management Unit; National Malaria Control Programme; central drug purchasing agency and 15 regional procurement pharmacies). The MoH Central Programme Management Unit is already the PR for the TB and HIV grants, and UNDP is supporting the transition to designate it PR for the malaria grant through an ambitious multi-donor MoH capacity-building plan.

While the Global Fund is the largest contributor to malaria prevention, other donors include WHO, UNICEF, UNHCR, France, China, Switzerland and international NGOs (e.g. Jhpiego and Malaria Consortium). The current grant provides $64.5 million to support eight priority prevention interventions (e.g. specific prevention intervention, vector control), treatment and control (e.g. case management) of the burden of malaria, and to strengthen health system capacity and national institutional capacity for effective administration, management and implementation of malaria interventions. Other agencies working to prevent malaria include UN institutions (e.g. UNCHR, WFP), as well as civil society and women's groups (e.g. SWED NGO and ACELIAF).

Internal and external assessments indicate improving grant performance, albeit with some challenges. For example, malaria incidence fell from 112.5 to 99.74 per 1,000 between 2014 and 2016 and declined further to 67 per 1,000 in 2018. Also, the programme successfully distributed ITNs, covering 13 out of its 19 prioritized regions in 2016-2018.[17] In 2018, coverage for either ITN or indoor residual spraying (IRS) exceeds 50 percent, and the percentage of suspected cases tested in public hospitals also exceeds 60 percent, though access to ANC services continue to be a major barrier.[18] at the grant level, performance for IPT of malaria in pregWhile the World Malaria Report indicates coverage for IPT is increasing[18] at the grant level, performance for IPT of malaria in pregnancy was low, only reaching 63 percent of pregnant women, partly due to inadequate support for pregnant women to access services and sociocultural barriers limiting access to health.

3. Gender-responsiveness of the grant

3.1 Gender issues

The funding request for grant continuation did not provide sex-disaggregated data on malaria incidence, hospitalization, mortality or treatment coverage, nor did it explicitly mention pregnant women's heightened vulnerability in its justification. However, the initial concept note included an analysis of key gender inequalities that were impeding access to health care: early marriage and lower levels of formal education among women and girls, which was associated with lower health knowledge and IPT coverage among less-educated pregnant women; women's financial dependence and the need for spousal and parental authorization to access health services, delaying their access to care; and parental control of marriage decisions for their daughters, limiting women and girls' autonomy. In addition, the specific vulnerability and health care access of nomadic and migrant pregnant women, as a result of regional conflicts, was implicitly highlighted as a gender issue.

The concept note, and funding request did not provide or analyse sex-disaggregated data on ITN use or malaria diagnostic and treatment coverage to assess gender-related barriers to services. There appears to be a general perception that there are no gender differences in access to malaria diagnostic and treatment services, that women and men are accessing health facilities equally and that when women and men arrive at a health facility, they receive the same care. While this may be the case, there is no data to support it.

Table 1: Gender-related SDG Indicators for Chad

SDG Indicator	Data
Legal frameworks for gender equality and non-discrimination	Universal suffrage to women granted in 1960[12]
	There is a non-discrimination clause in the constitution which mentions gender[12]
	Law specifically prevents or penalizes gender-based discrimination in the hiring process[12]
Violence against women from an intimate partner	44.24% of women aged 15 years and older experienced physical or sexual violence by an intimate partner in the last 12 months[12]
Violence against women from people other than an intimate partner	No data for this indicator
Women in political positions	15.30% women in national parliaments
Women decision-making on contraceptive use and healthcare	17.50% of married women's (aged 15-49) demand for family planning satisfied by modern methods
	27.10% of women aged 15-49 years (married or in union) make their own decision on all three selected areas, i.e. can say no to sexual intercourse with their husband or partner if they do not want; decide on use of contraception; and decide on their own health care[12]
Female and equal land rights or ownership	51.50% of men, compared with 13.60% of women (aged 15-49) solely own land legally registered to their name[12]
	Country's legal framework does not guarantee women's equal rights to land ownership[12]
Mobile telephone ownership	No data on proportion of women who own a mobile telephone

Table 2: Global Fund priority investment areas in malaria in Chad

Priority Investment Areas	Total
Vector control	$35,766,370.55 (55.52%)
Specific prevention interventions (SPI)	$8,647,096.55 (13.42%)
Case management	$7,438,261.09 (11.55%)
RSSH: HMIS and M&E	$2,989,043.53 (4.64%)
Programme management	$9,345,058.55 (14.51%)
RSSH: HR for health, including CHWs	$211,323.37 (0.33%)
RSSH: Purchasing and supply chain management	$17,517.46 (0.03%)
Total Allocation	**$64,400,518.78**

Note: HMIS: Health Management Information System; HR: Human Resources; RSSH: Resilient & Sustainable Systems for Health

Moreover, given that available data is based on public sector facility records, and only 54 percent of fever patients went to health facilities for treatment, it would be important to identify whether there are gender differences in who is not reaching health facilities and whether gender inequality is a barrier to getting to the facility, or to the timeliness, quality and outcomes of malaria treatment.

There are some misconceptions around gender-responsive programming, with all programming for vulnerable populations (including children under five and IDPs) being considered gender-specific. This may be exacerbated by the fact that human rights and gender equality are in one module and the distinctions are not clear. Indeed, activities targeted at vulnerable populations, such as pupils in Koranic schools, street children, nomads, refugees and IDPs are listed in the funding request as interventions to promote and protect human rights and gender equality. However, they appear to be mainly focused on meeting the needs of these vulnerable populations, with no consideration of gender-specific issues among them.

The primary gender issue that this grant is currently seeking to address is the specific vulnerability of pregnant women. Given this national priority and need to target pregnant women as a KP, there is no resistance to more gender-sensitive programming, as opposed to the gender issues in HIV programming, for example, which stakeholders consider to be more culturally sensitive. This suggests that gender-responsive programming in the form of interventions to increase access and use of malaria prevention and treatment interventions among pregnant women would be accepted and receive political buy-in, providing an entry point to address gender-related barriers to ANC and facility-based care. However, it is less clear whether more gender-transformative approaches would be considered favourably by stakeholders if they challenge unequal gender norms and power dynamics that limit women's autonomy to make decisions about their healthcare seeking.

3.2 Gender in interventions and implementation

Overall, there is substantial room to strengthen the gender-responsiveness of this grant, but also efforts to build on. There are gender-specific interventions targeting pregnant women under the vector control and specific prevention interventions modules, as well as some gender-sensitive activities under the community-based case management programme, information management, procurement and programme management. The facility-based case management is gender-blind. None of the modules are being implemented to transform gender norms or inequities.

Vector control and specific prevention interventions – gender-specific and gender-sensitive

Under the specific prevention interventions and the vector control modules, pregnant women have been prioritized as a key vulnerable population for IPT and ITN distribution (both through mass campaigns and ANC) respectively. This appears to have contributed to an increase in the proportion of pregnant women sleeping under a net in the beneficiary districts. However, very low ANC utilization remains a major constraint to increased IPT and ITN use among pregnant women. Planned grant activities included advocacy and engagement of community (women's organizations) and religious leaders/groups for training workshops on awareness-raising targeting 900 women across 9 regions, and mass media campaigns (focusing on the role of men in supporting women). While the planned workshop can broadly be considered both gender-specific (i.e. focuses on women), opportunities exist to more proactively promote gender equity in future activities and terms of reference. For example, it was unclear what gender issues need addressing in the awareness-raising workshop, beyond women's access to malaria prevention and treatment information, especially considering that only 1 in 3 slept under mosquito nets, and 73 percent of malaria patients do not go to the hospital or to a health centre. There is opportunity for the resource materials (e.g. The Ten Golden Rules Against Malaria, Information Sheet, Malaria Guidelines) to emphasize the role of gender-related barriers (if any) that may act as a disincentive for ITN use or ANC visits.

In 2017, the mass distribution campaigns changed their targeting approach to a more gender-sensitive one that identified women as the head of a household to receive the household ITNs, rather than the men. This was done to address the fact that overall nearly two in five women live in a polygamous union, and ITN use rates for women with at least two co-wives in the target districts range from 2.9 percent (in Kanem) to 18.5 percent (Mayo Kebbi Est).[1] Targeting men as the household heads meant that some wives and their children were not being reached.

Human resources for health, case management and community systems – gender-sensitive

Under this grant, Chad has been piloting a community-based case management programme delivered by a cadre of 930 trained CHWs in two regions (Mandoul and Moyen Chari). International evidence suggests that community-based care for uncomplicated malaria is an effective and gender-sensitive strategy that reaches more women by overcoming the gender-related, geographical and financial barriers they face.[9]

Importantly, although the national policy requires gender parity in the CHW cadre, a majority of the CHWs in this pilot are men. It is worth noting that these CHWs are selected by their communities and while they are volunteers, under this grant they have been receiving a stipend of $25. Evidence from other countries in the region has found that when CHW are remunerated, and more valued, the cadre tends to be more male-dominated due to prevailing gender norms that men should be the ones earning incomes as well as to male-dominated community governance structures that appoint them. The CHW component of this intervention is therefore gender-unequal as it reinforces the exclusion of women from positions of prestige in the community, and from remuneration.

Information management, procurement, programme management – considerations and progress

Under other RSSH modules, there have been some efforts to incorporate gender considerations. Overall, previous grant audits suggest major weaknesses in the national health data reporting system and challenges with data completeness. Few routine indicators have been sex-disaggregated, and when they were, they have not been consistently recorded and reported.

The grant's performance framework itself includes indicators and targets for pregnant women, namely proportion of pregnant women who slept under an ITN. However, none of the other indicators are sex-disaggregated or reflect gender-related objectives. For seasonal malaria prevention, sex-disaggregated data was collected and analysed for under-fives, suggesting no significant gender differences. This is in line with other international evidence for this age group. However, sex-disaggregated data for malaria cases that present to health facilities was not being collected, making it difficult to ascertain whether there were gender disparities in access to health facilities for suspected cases, diagnosis and case management. Under the information management module activities, data collection tools at the health facility level were revised in the last quarter of 2019 to collect disaggregated data for case management, and tools are expected for use by health facilities in 2020. This is a promising initiative, and provides opportunities to identify any significant gender disparities, their underlying causes and to inform the design of appropriate evidence-based interventions to address them.

To address gaps in understanding and monitoring ITN use and access to diagnosis and treatment services, there is a need for non-facility data, as well as undertaking non-routine impact surveys to consider gender in relation to ITN use (beyond pregnant women) and healthcare utilization when sick. This will allow for more effective planning through a better understanding of whether women or men are more likely to seek healthcare if they experience malaria symptoms, and any differences in which health services women and men are most likely to access (public health dispensary/centre/hospital, private facility, informal providers like pharmacies or traditional healers).

Under the procurement and supply chain management module, gender considerations were difficult to assess. Under UNDP's core resources for country-level programmes, stakeholders highlighted some gender considerations, which provide an example for reflecting on gender in the procurement and supply chain management module. For example, supply-side investments have been made to improve the quality of ANC and increase uptake by pregnant women, such as a pilot UNDP intervention that is procuring solar kits for 150 facilities to address the lack of reliable electricity supply, which affects the quality of care and thus demand. One of the selection criteria for the facilities was high delivery rates and malaria incidence, to optimize the intervention's impact on pregnant women's access to malaria prevention services. Another example is the procurement of supplies for CHWs, where the programme is considering gender-specific needs in relation to shoes and bicycles (including safety issues).

In programme management, gender has not been a consideration. In terms of staffing, for example, of the 25 people newly recruited to staff the grant management unit, only two are women. However, it is encouraging that at the governance level of the CCM, women are represented, and constitute a third of members. In particular, there is a representative from

the national women's association for poverty reduction (Association des Femmes Tchadiennes pour la lutte contre la Pauvreté), and while their participation and oversight of the grant is critical, opportunities exist to increase women representations, especially for bilateral, multilateral, and religious institutions, where overall, members are overly skewed towards males.

3.3 Gender investments

While the budget highlights investments made across the modules, it is not possible to determine the extent and nature of gender-responsiveness of activities. The only gender-specific budget line that could be accessed separately was IPT for pregnant women (under vector control and under the SPI models), which represented 2.2 percent of the total budget (€54,730,002).

Other gender-specific interventions and gender-sensitive activities are subsumed under the broader budget categories, namely vector control (e.g. ITN distribution for pregnant women), and human resources for health (including CHWs) for the integrated community case management initiative. For example, a total of €782,000 was budged for CHWs, with the rest dedicated for the purchase of work equipment such as bicycles work kits, training and supervision to enhance service delivery.

Stakeholder interviews revealed that women's groups were an entry point to raising awareness at the community level to increase the uptake of IPT and the use of ITNs among pregnant women. Yet, these activities were allocated about €22,500 (0.04 percent of the total budget).

The overall lack of granular descriptions of the specific activities in the budget or module descriptions makes it difficult to assess the gender-responsiveness of interventions, in particular to hold the programme accountable to such investments or assess how expenditures under modules reflect or took account of gender-specific barriers and norms and addressed underlying drivers of disparities that shape malaria risk, treatment and management.

4. Key entry points for further gender-responsive programming

4.1 Strengthen the understanding and monitoring of gender-related barriers to health service use through sex-disaggregated data collection AND ongoing quality gender analysis

The lack of quality gender data is a major constraint to the gender-responsiveness of the programme. Without sex-disaggregated malaria outcome and output data, it is not possible to identify gender-related barriers to malaria services, and to subsequently act on them. Investments are needed in gender data and information systems that can collect and use sex-disaggregated data to respond effectively to the epidemic. The recent initiative to include sex-disaggregation in routine facility data collection forms is a critical entry point. Measures should be taken to ensure that this data is regularly analysed with a gender lens, to identify any significant gender disparities in case management. Where disparities exist, further gender analysis will be required to understand their underlying causes and to inform the design of appropriate evidence-based interventions to address them.

In addition to informing gender-responsive interventions for case management at the facility-level, there is need to identify and understand any gender disparities in prevention measures and/or for patients who do not seek care at health facilities. This will require that surveys conducted to measure ITN uptake and use explicitly consider who within a household is more or less likely to be sleeping under a net (women, men, girls, boys); as well as patterns of health-seeking behaviour when experiencing malaria symptoms (utilisation rates, public/private providers, pharmacies or traditional healers, etc) and expenditures. Gender disparities would need to be further investigated by collecting data on household decision-making on the use of household income, and accessing healthcare, as well as gender norms.

Opportunities exist to better understand and ascertain the need for more gender-responsiveness case management. For example, the programme team, both at the grant and PLNP level could draw on the Malaria Matchbox tool, which highlights some key considerations, such as the availability and sufficiency of malaria services to population, adequacy of laboratory supplies for testing, availability of diagnosis, treatment protocols, and compliance by healthcare providers – as a starting point to contextualize how to make this module more gender-responsive and thus effective.

4.2 Engage gender champions and community leaders to promote gender equity and uptake of ANC among pregnant women to increase ITN use and IPT coverage

Although gender norms and power dynamics are considered more sensitive in the context of HIV programming, malaria is viewed as less culturally sensitive and stakeholders would be more open to gender-responsive interventions that could improve service coverage among pregnant women, a key priority population in the national malaria strategy.

Specific awareness-raising activities and accountability measures are being envisaged that would work with high-level leaders, including the President and the First lady (who is a gender champion), and traditional leaders at the community/block level. They would both promote the use of ANC during pregnancy, as well as provide an accountability and monitoring mechanism between the President's office and traditional block heads who would have to report how many pregnant women they have identified in their blocks and convinced to go for ANC. This could be a promising approach, but there is a risk that it could be implemented in a manner that would jeopardise women's autonomy and freedom of choice, and/or reinforce their spouses' power as the decision-maker for their health and bodies. Other efforts by the MoH (not under this grant) are also working with local authorities and community leaders to engage men to allow their wives to seek care at health facilities. International evidence suggests that such approaches have often had perverse consequences for gender outcomes, as they consolidate unequal gender power relations, even though they may improve health outcomes. It is therefore recommended that such an intervention receive support from local gender experts and women's groups to prevent any gender-unequal messaging or negative consequences.

As the grant is already working with women's and religious groups (e.g. Agreement of Churches and Evangelical Missions) at the community-level to strengthen capacity through training to deliver awareness-raising activities, future training of women could be an opportunity to leverage and invest in their capacity, specifically related to gender and health issues. At the grant level, training resources, and workshops could also highlight gender-related barriers to ANC use, or compliance to ITN use. Additionally, stakeholders referred to a number of NGOs in Chad advancing gender equality agendas, engaging more with them from a health perspective provides opportunities to leverage their networks to eliminate malaria.

4.3 Promote gender equity in the national CHW policy and community-based case management scale-up programme

Community-based case management of malaria is a potentially gender-sensitive intervention to increase access by women and their children, thereby potentially reducing the burden of unpaid care that disproportionately falls on women and girls. The pilot integrated Community Case Management (iCCM) programme in Chad would need to be scaled up from the current two regions it is operating in (out of 19 regions with active malaria transmission) to have meaningful population health and gender equity impact. However, the way in which that programme is delivered by CHWs also has the potential to promote or impede gender equity through the health workforce. The policy on gender parity among CHWs is not being followed, and women are not given equal opportunity to take on this role, and its related monetary and non-monetary benefits.

The financial incentives provided to CHW are considered unsustainable and are limiting the scalability of the current implementation model, especially given that other health personnel often do not receive their salaries. Other models are being considered whereby communities remunerate their CHWs. In 2019, the MoH has been working with UNDP and other partners to revise its National Community Health Strategy.

A new CHW strategy is under development, with technical assistance from UNICEF expected in early 2020. As part of the process, a country exchange visit was undertaken to Mali in late 2019 to identify best practices around implementing malaria prevention and care at the community level, mechanisms for the selection, recruitment and care of CHWs, collaboration, and monitoring and training needs, with the view of scaling up community-based care in the country. This is a key opportunity to promote a more gender equitable CHW policy that ensures equal selection of women as CHW and equal remuneration. Also, priority should focus on strengthening training received by CHWs, and to continuous supervision, which are critical to ensuring quality of their services.[16,22] This should be accompanied by a monitoring, evaluation and learning component to provide opportunity for self-assessments of what is working well, and what ought to change in order to reach the goals of eliminating malaria.[16]

While financial sustainability challenges have often been identified as a barrier in research,[19] this should not jeopardise the gender equity of CHW approach. Alternative financing models need to be considered based on their ability to value the work and care provided by CHWs, to provide professionalisation and career development opportunities, and to provide measures to accommodate gender-specific needs (specifically of female CHWs' needs, family care responsibilities, and safety). International literature suggests, in the absence of salary, some CHWs have received other benefits such as training stipends, or preferential access to health care or microcredit.[20,21] Stakeholder interviews revealed other context-specific considerations including access to free land or education for CHWs or their dependent(s).

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Credit: UNDP Cuba/ Claudio Peláez Sordo

CUBA

(HIV grant)

GENERAL & HEALTH CONTEXT [3,5]

Population:
11.3 million

Life expectancy:
80.4 (F)
76.5 (M)

GDP per capita:
$7,480

Human Development Index
72/189 countries

Maternal Mortality Rate:
39 deaths per 100,000 pop

Infant Mortality Rate:
4.8 deaths per 1,000 pop

HIV INDICATORS[1]

Incidence:
0.3 per 1,000 pop (15-49 years)

Prevalence:
0.4 per 1,000 pop (15-49 years)

Transmission:
99% via sexual contact

Number of people living with HIV:
31,000

HEALTH SYSTEM [2,4]

Doctor density:
7.5 per 1,000 pop

Nurse Density:
8 per 1,000 pop

Total Health Expenditure:
$988 per capita

Notes: GRP: Gross domestic product.

1. Background

Country context: Cuba is the largest Caribbean island, and became a socialist state after the 1959 revolution[2] that enacted universal health care and free education.[3] Extreme weather conditions and the long-term US economic blockade have impacted food security and access to goods. Cuba has comprehensive social protection programmes, focusing on the most vulnerable groups (children, women and the rural population). [4,5]

Health: Healthcare is a universal human right within the Cuban Constitution and the state is responsible for guaranteeing free access to quality healthcare.[6] Cuba's UHC system is focused on prevention and delivered via decentralized community-based poly-clinics providing comprehensive services informed by intersectoral participation (including civil society). This has produced impressive public health gains compared to countries with more resources, such as a lower infant mortality rate than the United States,[7] suggesting a very efficient health system. Cuba addresses scarcities in health supplies affecting the quality of health services with ongoing social policies and community work.[8]

HIV epidemiology: HIV is largely concentrated in urban areas, with 99 percent of cases contracted through sexual relations. The early predominance of heterosexual transmission shifted over 30 years ago to men who have sex with men, who constitute over 70 percent of all diagnosed cases, and 87.4 percent among all men.[9] Only 100 children under 15 years have ever been diagnosed, with just over half by vertical transmission.[10,11,12] Cuba was the first country to eliminate vertical transmission in 2015.[8]

From 2010 to 2015, the number of Cubans diagnosed with HIV increased from 11,674 to 20,019 (1.7 times increase), and those living with HIV increased from 17,236 to 26,659 (1.5 increase)[13], and 2017 estimates of HIV prevalence are highest among the transgender population (19.7 percent, rising trend in the last decade), followed by men who have sex with men (5.6 percent) and people who practise transactional sex (2.8 percent).[9] Cuba's early mandatory quarantine and treatment in so-called sanatoriums shifted to rights-based, community-based health care in 1993.[13] Despite financial challenges, Cuba provides free comprehensive care to people living with HIV, including domestically manufacturing ARVs.[10] A pilot programme led by Cuban authorities in conjunction with the Pan-American Health Organization in March 2019 distributed free pre-exposure prophylaxis to high risk populations in the municipality of Cárdenas (Matanzas province). While the prophylaxis reduces by 90 percent the probability of acquiring the virus, Cuban authorities are also promoting condom use to prevent the spread of HIV and other STIs.[14] Figure 1 outlines Cuba's 2019 achievement of the 90-90-90 targets.

Gender equality: Cuba's 2019 Constitution remains committed to UHC, and explicitly protects vulnerable populations regarding gender, sexual orientation and gender identity.[6,15] It notes that the state should promote women's development and full social participation, ensure their sexual and reproductive rights and protect them from any forms of GBV.[6] The contributions of the Federation of Cuban Women with its legislative initiative and as the National Mechanism for the Advancement of Women in the development of laws and actions to achieve these advances are highlighted.

It is expected that civil society consultation regarding a new Families Code will determine the way in which marriage between spouses (defined in article 82 of the new Constitution) will be regulated. The new definition no longer alludes to marriage between man and woman. It is also expected that the code will state that a change of gender identity does not depend on a change in sex.[10] The National Strategy for Comprehensive Attention to Transsexual People, adopted in 2001 provides free, voluntary and comprehensive health services to transgender people and their families, including sex reassignment surgery, under the MoH 2008 Resolution 126.[16]

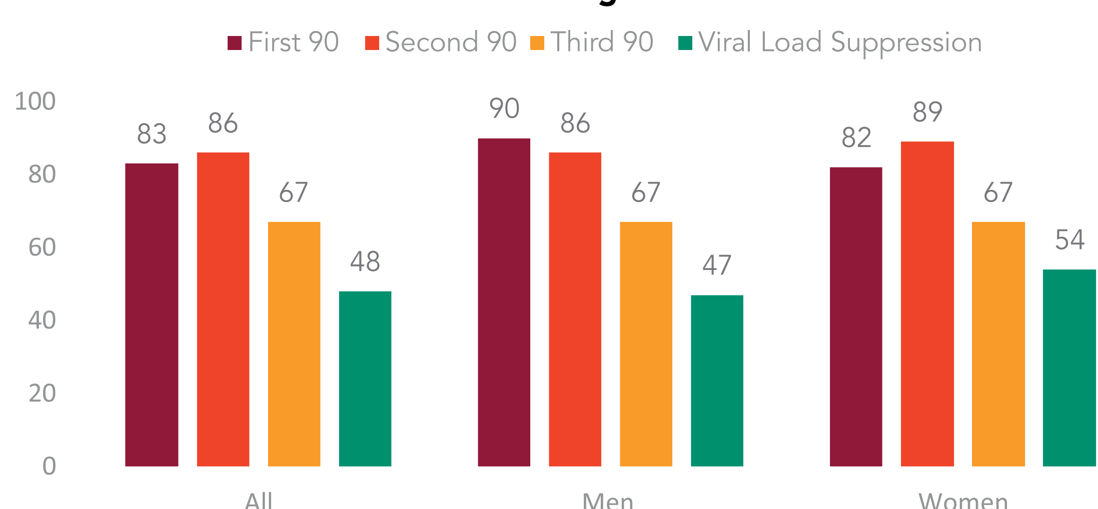
Universal health care and universal education have advanced gender equality in Cuba. Free perinatal check-ups, family planning and safe abortion ensures women's sexual and reproductive health and rights. Cuban women represent over 53 percent of members in parliament and over 70 percent of employees in the legal sector. Despite progress, Cuban women remain disadvantaged and underrepresented in certain sectors: they represent just over 35 percent of personnel in management positions; 16.7 percent of vice prime ministers and 28.6 percent of ministers.[13] Traditional patriarchal stereotypes persist, and

women remain the primary carers of vulnerable family members.[8] The patriarchal culture also discriminates against LGBTQI, replicating harmful traditional gender constructs and biases.[16] As an extreme manifestation of gender inequality, GBV remains an issue in Cuba, particularly among KPs: 70 percent of transgender people experienced IPV in the past year, followed by 22 percent of people who practise transactional sex, 11 percent of men who have sex with men, 9.9 percent of black women, 7.8 percent of black men and 6.8 percent of other ethnic groups.[17]

GBV has long been on the public agenda. GBV was included in the 1997 National Action Plan of the Republic of Cuba for the implementation of recommendations from the 4th UN Conference on Women. That same year the National Group for the Prevention and Attention of Family Violence was created, coordinated by the Federation of Cuban Women, who implement the annual action plans.[13] The 2013-2017 Gender Strategy in the National HIV Response focuses on the objectives to address prejudices and GBV.[18] A GBV Observatory managed by the National Center for the Prevention of STDs and HIV/AIDS provides legal support to survivors.[13] The Observatory includes representation from lawyers, a legal provincial representative, a designated person from the Grupo Operativo para el Enfrentamiento y Lucha contra el SIDA (GOPELS) who provides counselling regarding stigma, discrimination and GBV. The National Centre for Sex Education, CENESEX, provides legal advice service to KPs. Service beneficiaries include men who have sex with men and transgender people, among other groups experiencing GBV. In the absence of a specific GBV law, individuals can be protected from all forms of violence via the Penal Code, the Family Code and the new Constitution.[15] GBV is addressed through awareness-raising activities and general training of health, education and legal service providers. A key challenge is to strengthen these programmes by promoting the use of specific protocols by sector.[13,19]

Gender issues related to HIV: The 2013-2017 Gender Strategy and HIV Response noted that stigma and discrimination against sexual diversity persist; the rights of women and men are not always enforced in prevention activities (e.g. homophobia is a barrier to accessing HIV services); women do not always negotiate the use of condom in sexual relationships for fear of their partner and are twice as likely as men to mention 'partner objection' as one of the reasons not to use condoms.[18] Women receive information via social communication channels, including mass media and health institutions, and are less likely than men to access sources of personalized information that may provide emotional support such as a friend, family or partner. These findings align with other research showing that most women, of different ages, living with HIV did not receive any information about sexuality during their childhood or adolescence from their relatives, largely because it is considered an inappropriate topic for family conversation.[13] The HIV epidemic mainly affects populations whose risky sexual behaviour and identities are discriminated against, including men who have sex with men, transgender women and people who practise transactional sex (mainly men).[9,20,10]

Figure 1: Cuba UNAIDS 90-90-90 treatment target data[1]



First 90: percentage of people living with HIV who know their HIV status; Second 90: percentage of people living with HIV who know their status and who are on treatment; Third 90: percentage of people living with HIV on treatment who have suppressed viral loads; Viral load suppression: percentage of people living with HIV who are virally suppressed

Table 1: Gender-related SDG Indicators for Cuba

SDG Indicator	Data
Legal frameworks for gender equality and non-discrimination	Universal suffrage for women since 1934[21] The Constitution, and respective legal codes and decrees, provide the legal frameworks for gender equality, including: the Penal Code; the Family Code; the Work Code and the Law of Maternity of the Female Worker.
Violence against women from an intimate partner	18% of women aged 15 years and older experienced physical or sexual violence by an intimate partner in the last 12 months[21] The National Gender Equality Survey noted that among women aged 15-74, the 2.2% experienced sexual violence and 2.4% experienced physical violence in the last 12 months. [22]
Violence against women from persons other than an intimate partner	No data
Women in political positions	53% women in Parliament [23]
Women decision-making on contraceptive use and healthcare	88.4% of married women's (aged 15-49) demand for family planning satisfied by modern methods[23]
Female and equal land rights or ownership	No data
Mobile telephone ownership	No data

Note: Data ranging from 2016 to 2019.

Traditionally, men have exhibited poor health seeking behaviours, which in the context of HIV programming, translates into differential acceptance of testing and adherence to medical treatment,[20] leading to late diagnosis linked to early mortality from AIDS, particularly for men who have sex with men and male-to-female transgender people.[24] These groups also experience stigma and discrimination from health service providers,[25] who share the general population's belief that sexual orientation is linked to gender and attraction to another man is considered feminine, and thus, negative or less important. This affects the opportunities for prevention, access to appropriate resources and the probabilities of survival.[20]

Sex workers are seen neither by themselves nor society as professional sex workers, thus there are no formal or informal organizations representing them (either men, women, or transgender), which makes it difficult to work with them directly. For this reason, this population is approached through peer strategies in a transversal way in the men who have sex with men and transgender people groups.[31] They are captured in surveys as people who practice transactional sex, with 2016 estimates noting a HIV prevalence of 2.4 percent for both sexes, higher in males (2.9 percent) than in females (1.4 percent).[31] UNAIDS's open database, noted that in 2015, only 24 percent of men who have sex with men and 35 percent of female sex workers had been tested for HIV.[32]

Policy framework: The national health system prioritizes universal healthcare, improving the quality of services via training and research, strengthening epidemiology and microbiology, enforcing health regulation and increasing efficiency and sustainability.[26,27] Since 1986, GOPELS is the national, provincial and municipal intersectoral mechanism coordinating the HIV response, and overseeing the implementation of the national STI/HIV-AIDS strategic plans.[28] It is led by the MoH and includes governmental, non-governmental and civil society entities.[10,29] The current national strategy (2019-23) focuses on surveillance/early detection, increasing accessibility to treatment, building service providers' capacity, strengthening community participation and

multisectoral alliances, and prevention to reduce incidence and meet the 90-90-90 goals.[30,9]

The Gender Strategy for HIV programming[9] will be updated in 2020. This new strategy covers the period 2020-2024,[13] and focuses on: a) gender mainstreaming in the HIV response; b) the inclusion of targeted actions to identify and mitigate gender gaps; and c) preventive actions to transform the structural determinants of gender inequalities regarding sexual orientations and gender identities. Since 2008, the National Center for the Prevention of STDs and HIV/AIDS coordinates, designs and implements preventive activities with a gender perspective.[18]

Cuba is applying a health-based approach to sexuality and sexual identity, where any kind of discrimination is seen as damaging health.[15] Gender is being prioritized and integrated in political processes, with new indicators to monitor gender-sensitive responses.[13] This work is supported by several networks, including the *Red de Género y Salud Colectiva ALAMES*-Cuba, a network advocating for the integration of gender-transformative multisectoral action and acceptance of sexual diversity within the national health care system.[33]

2. Global Fund HIV grant

The US economic blockade restricting foreign funds to Cuban organizations led to UNDP becoming the principal recipient (PR) since 2003 and for the HIV Global Fund (GF) transitional grant (2015-2017, extended until December 2020). However, due to the GF eligibility criteria, Cuba will be eligible to apply for the next funding cycle, with no predetermined transition to country ownership.[13,25,34] The current grant running from 1 January 2018 to 21 December 2020 provides USD 13.2 million to support several priority areas and to fill gaps identified in previous grants.[35] The prevention modules in the grant are focused on reducing HIV and STI incidence among key populations (KP), particularly men who have sex with men, transgender people, people who practice transactional sex and their clients, and people living with HIV through targeted HIV counselling and testing, improving knowledge of diagnostic results, increasing levels of ART adherence and providing differentiated ART services. The grant has been performing well, with most indicator targets either met or exceeded in 2018.[36]

Table 2: Global Fund priority investment areas in HIV in Cuba

Priority Investment Areas	Total
Comprehensive prevention programmes (CPP) for MSM	$1,203,448.00 (9.1%)
CPP for sex workers and their clients	$423,853.00 (3.2%)
CPP for transgender people	$106,947.00 (0.8%)
Treatment, care and support	$4,728,642.00 (35.7%)
RSSH: Community responses and systems	$1,067,294.00 (8.1%)
RSSH: Procurement and supply chain management systems	$513,476.00 (3.9%)
RSSH: Integrated service delivery and quality improvement	$2,747,837.00 (20.7%)
Programme management	$2,461,730.00 (18.6%)
Total allocation	**$13,253,227.00**

Note: CPP: Comprehensive prevention programme; RSSH: Resilient and sustainable systems for health

3. Gender-responsiveness of the grant

3.1 Gender issues

The funding request indicated the need for more gender equality and human rights-based programming to address the traditional harmful gender norms and behaviours that limit access to health services by KPs.[24] The HIV/AIDS technical teams, along with people living with HIV, men who have sex with men and Transcuba Networks, identified in late 2016 the main gaps in HIV programming via multidisciplinary workshops. The gender-related gaps included: insufficient prevention of HIV in KPs and late diagnosis affecting early mortality caused by AIDS, particularly for men who have sex with men and transgender people; access to KPs with HIV to be improved by outreach community services; the need for more training in legal rights for people living with HIV, men who have sex with men , transgender people and people who practise transactional sex networks to better address discrimination, stigmas, gender inequality and sustainable funding for their actions as social transformation networks.[24] Funding was requested for strengthening the response towards the HIV epidemic within social sectors and civil society by promoting gender equality and respect for various sexual orientations and gender identities, and to promote responsible sexual conduct in key high-risk groups and in the general population through information, education and communication.[24]

While some progress indicators listed in the performance framework were sex specific (those related to men who have sex with men), the indicators related to transgender people and sex workers, and those related to the final 90 in the treatment cascade (virally suppressed), were not sex disaggregated. It is unclear whether this lack of disaggregation results from prior analysis that found no differences by sex and no gender-specific issues among the transgender and sex worker groups. However, this was not stated in the performance framework. Moreover, in this monitoring tool, treatment indicators ought to be disaggregated by KP and gender in order to identify and monitor disparities. However, UNDP noted that Cuba collects gender disaggregated indicators for programming and budgeting that were not requested as part of the Global Fund performance indicators. The National Survey on Gender Equality now includes transgender, although collecting disaggregated data on transgender and other LGBTQI populations has been reported as challenging, due to their small numbers.[13]

Gender has been integrated into HIV programming, indicators and budgeting both in the grant and nationally.[13] The new National Strategy Plan (NSP i.e. Plan Estratégico Nacional) demonstrates the integration of gender into national HIV programming. Fundamental aspects of gender relations were also noted in the previous NSP, and the Gender HIV Strategy was reinforced, which includes, since 2013, gender diversity (women, men, transgender) to identify gender inequalities and barriers that limit a more effective response. Correspondingly, the Global Fund grant also demonstrates a non-binary understanding of gender, including men who have sex with men and transgender women, and addresses key gender aspects.[13]

While gender has mainly been considered binary in many sectors in Cuba, in the Cuban HIV response gender has been considered non-binary. The role of the CENESEX, the National Center for the Prevention of STDs and HIV/AIDS and men who have sex with men networks have been key in this aspect. UNDP's technical support has also translated into a broader understanding by technical experts.

UNDP technical support on gender mainstreaming in Global Fund grants responds to its role as a grant PR. The Project Management Unit includes the office's Gender Programme Officer on a part-time basis. This technical support incorporated a more contemporary gender approach addressing the need for greater understanding and respect for the various gender identities. UNDP's strategic alliances with the leading national institutions (CENESEX and National Center for the Prevention of STDs and HIV/AIDS) has generated spaces for theoretical and practical multisectoral discussions (including academia and CSOs) that enabled the shift from a binary conception of gender to one encompassing different sexual and gendered identities and a deeper deconstruction of stigma and discrimination. UNDP also provided technical support to other projects and actors working with various aspects of sustainable development in order to eliminate sexist barriers that reproduce inequalities.[13]

Gender-transformative programming included: the prevention of and response to GBV; identification of

stigma and discrimination indicators for HIV based on gender (systematic studies are conducted on the indicators of HIV infection and prevention, including monitoring the existence of stigma and discrimination associated with gender); the approach to stereotypes and sexist prejudices in initiatives that promote gender equality; the development and implementation of management tools for gender mainstreaming in health policies and regulations, such as the Gender Strategy and the NSP with gender addressed in a transversal and specific manner; innovative initiatives that focus on institutional, personal and group changes (these identify and mitigate gender gaps and sociocultural patterns that negatively influence women, men and people with non-conforming gender identities).[13]

UNDP convened in late 2019 key institutional stakeholders working beyond the HIV response, such as the Federation of Cuban Women, to achieve a common understanding and move beyond the historical binary conceptualization of gender and eliminate gender inequality.[13]

3.2 Gender in interventions and implementation

While KPs face serious barriers to participating in budgeting and implementation of Global Fund grants in many countries,[37] in Cuba they feel included in the decision-making regarding HIV programming.[25] Evidence of the enabling context to address the needs of KPs is that their representatives participate in GOPELS and the National Strategy Plan recognizes the role of KP organizations in the provision of services and in decision-making processes. The leadership provided by CENESEX on gender equality and the LGBTQI rights agenda is further evidence.

The main implementation strategies in the current grant relate to HIV programming and RSSH.[24,35] Specifically, the grants include the following:

- Promoting behavioural changes for KPs (men who have sex with men, transgender people, people who practise transactional sex and people living with HIV) through innovative strategies and a minimum package of services, including information, education, communication and awareness activities and materials, as well as delivery of condoms and lubricants.
- Implementing HIV testing and counselling interventions as part of programmes for KPs, and improving knowledge of diagnostic results to improve the detection of new cases and reduce the gap in the treatment cascade.
- Providing care and assistance to KPs by reinforcing counselling, increasing the levels of ART adherence and performing an analysis of resistance to treatment; providing differentiated services for ART treatment; improving the outreach to people living with HIV for viral load tests and acquisition of reagents; strengthening drug resistance surveillance; and performing an analysis of resistance to treatment.
- Strengthening leadership and sustainability of key groups and generating institutional capacity for these population networks.
- Training men who have sex with men, transgender men and women and people who practise transactional sex to conduct peer education on HIV prevention and care for people living with HIV, including assertiveness training to foster condom use and self-care.
- Fostering gender equality and respect for sexual diversity by changing constructs of gender in the general public via non-formal education through social and behaviour change communication with information, education and communication on LGBTQI issues and GBV from a rights-based approach, and other activities to address homophobia and discrimination of people living with HIV, men who have sex with men and transgender people.
- Fostering sexual and reproductive rights to ensure that women living with HIV feel supported in their right to become pregnant[25] in line with recent WHO guidelines on the sexual and reproductive rights of women living with HIV.[38]
- Collecting sex-disaggregated survey data, including data on transgender populations as distinct from men who have sex with men .
- Training for health providers to promote gender equality and transform norms in service delivery.

An identified risk in the funding request was a potential reduction in activities focused on preventing gender discrimination and the absence of visibility of women in programme activities, despite the fact that they represent 18 percent of new infections. Mitigation actions noted the inclusion of female representatives from people living with HIV in the discussions of the new NSP; activities specifically centred on women living with HIV in the NSP; and ensuring the continuity of the gender strategy during the transition period.[24] Women continued to be reached through prevention programmes funded with national resources.

By the end of 2019, all the actions mentioned above as part of the Global Fund grant were implemented as planned. The activities corresponding to the third year are already being implemented.[13] Six strategic processes are being developed as part of the Gender Component Action Plan of the 2018-2020 grant as follows:[13]

1. Update of the gender strategy 2020-2024.
2. Construction of theoretical and practical consensus on three key categories for the national response to STIs/HIV: gender, gender identity and sexual diversity.
3. Attention to sexist stereotypes and norms of discrimination based on sexual orientation and gender identity that limit the response to STIs / HIV-AIDS.
4. Gender awareness as a tool for non-discrimination between key groups.
5. Strengthening of attention to GBV.
6. Strengthening of innovative initiatives that support gender institutionalization in the national response to STIs/HIV and viral hepatitis.

The systematic monitoring of the processes, the decisive participation of members of the Management Group for the Promotion of Gender Equality in the Response to HIV, and the technical support provided by UNDP for its development, account for the progress of the processes, which will be completed in 2020. One of the lessons learned to date is the need to continue strengthening capacities, since in the vast majority of processes it has been necessary to devote more time and technical support than originally planned.[13]

The planning is developed with a focus on KPs. The new grant shows a greater participation of KPs starting from the country analysis. Leaders of the transgender, men who have sex with men and people living with HIV networks participate directly in the thematic technical teams training. The information generated from the spaces of reflection, debate, prioritization and consensus, and decision-making for these networks is integrated into the strategies and annual programmatic meetings. This ensures the incorporation of the needs, concerns and suggestions of KPs to address rights and gender-related barriers. These networks representing civil society are members of GOPELS and participate in strategic programming at the municipal, provincial and national levels. They have participated in the programming since the country analysis was conducted, and network representatives also participate in the formulations of the grant document, implementation of the project and allocation of remaining / additional resources. The strategy planning process and the formulation of the 2019-2023 National Strategy Plan incorporates the particularities of each KP.

However, further work is required to address discrimination against LGBTQI persons, particularly by health providers.[34] There were no substantive updates on gender following submission of the 2015-2017 grant.

UNDP has been supporting the Cuban Government with the following activities funded by the Global Fund grant[13]:

- Conducting activities under the National HIV Plan and the Gender Strategy for HIV programming with interventions that accelerate change and monitor progress linked to other SDGs.
- Development of comprehensive gender-transformative interventions to address inequalities across the lifespan through multisectoral participation that produces changes in institutional norms in the legal, health care and employment sectors.[34] These include, for instance: the generation of greater opportunities for social insertion, empowerment, self-esteem and equity of women and men from key groups (such as incorporating transgender populations into sources of employment and study for better professional performance). As a measure of the empowerment of human resources, the MoH has a policy on the active inclusion of

KPs and people living with HIV in decisive jobs to contribute to addressing the structural gaps of gender inequalities. There is a focus on improving access to health services, employment and key professional spaces from a rights and gender approach to address discrimination based on sexual orientation and gender identities. The rights of workers living with HIV or patients with AIDS were extended with updated legal and regulatory frameworks.

- Training health care providers on gender equality (including LGBTQI issues) to eliminate stigma and discrimination towards non-heterosexual populations in HIV prevention and care.

UNDP supports these activities, and with the National Strategy Plan and the gender strategy processes, all work in a collaborative manner with the national and local institutions that lead the implementation of the programme. UNDP's technical expertise was highlighted in interviews with key stakeholders and UNDP is integrated into the analyses and decision-making processes regarding each intervention and the related methodologies for their implementation.[13]

3.3 Gender in investments and performance frameworks

About 10 percent of the total Global Fund budget was allocated to gender-specific modules in the grant, with 9 percent accounting for prevention programmes for men who have sex with men , and 1 percent for transgender people. A further 3 percent for people who practise transactional sex was not disaggregated by sex. The lack of further details in the budget within the grant agreement prevents determination of the level of investment in gender-responsive programming.

UNDP's own gender policy requires that 15 percent of its programmatic budgets integrate gender equality. UNDP's commitment, gender policy and the quality standards in the programming for equality in sustainable development reflects on its performance as the Global Fund grant's PR and the technical support it provides for its implementation. Although UNDP does not determine the content of the grants, its impact is key to promoting analysis and decision-making on the necessary financing for gender-related results, particularly in supporting the national response to HIV.

However, UNDP identified as a challenge (for the grant and for all UNDP programmes and projects) the lack of tools that facilitate: 1) the effective monitoring of the budget follow-up and expenditures destined to contribute to gender equality in actions / results that are not "specific" of gender but address gender transversally or as one of the integrated components; and 2) better accountability for gender policy compliance in terms of substantive financing for equality. The UNDP Gender Focus Group in Cuba is currently working on developing these tools to better track what is being utilised for: 1) specific gender activities, such as staff training; 2) contributions supporting the national gender strategies; and 3) work focusing on eliminating harmful gender norms.

However, grant activities on gender or their impact are not always reflected in budget and expenditure analysis.[34] UNDP collects gender indicators for programming and budgeting that were not included in the submissions to the Global Fund.[13] It is expected that the new grant, which incorporates a specific module to address human rights and gender barriers, will facilitate the monitoring of gender-related investments and results.[13]

The gender-transformative initiatives undertaken and being implemented within the grant's framework include those highlighted in the modules: reduction of stigma and discrimination through the systematic implementation of studies of prevention indicators linked to human rights and gender barriers that limit access to HIV services; capacitation of KPs on their legal rights; reduction of HIV-related gender discrimination, harmful gender norms and GBV; implementation of programmes (pilot initiatives) to address unequal gender norms and harmful traditional practices and GBV.[13]

The funding request noted a particular focus on each GOPELS's sector to use their own resources for activities intended to reduce stigma, discrimination and GBV and to increase respect for sexual orientation and gender identity diversity, which was operationalized via an action plan for each sector that reflects the contribution of each agency. For this, the already integrated work lines (men who have sex with men and people living with HIV) will continue to become funded and the necessary links established with the different social and political sectors within GOPELS (with national and territorial scope) for channelling, analysing and studying all aspects of the HIV response.[24]

The 2018-2020 Plan of Action of The Gender Component of The Project: Sustainability of the HIV Response in the Republic of Cuba was designed and is being implemented. This plan was developed specifically to make the contribution of gender equality to the transition project visible. The plan also allows the monitoring of the gender results in the NSP for the transition period.

Cuba measures the goal of gender equality by several mechanisms:[13]

- Transformational changes in policy development and implementation, which are monitored through systematic reports and network meetings on, for example: who accesses the social Integration opportunities of KPs; level of empowerment, self-esteem and equity achieved between women and men of key groups (in particular, of transgender populations, which are inserted in sources of employment and professional study); the data monitoring access to health services (including service satisfaction); and strengthening the design and operation of violence observatories.
- Changes in gender stereotypes, such as changes in attitudes measured via population surveys, the GBV Observatory and the HIV Register.
- Access to sexual and reproductive rights.
- Improvement in the number of solved legal cases concerning GBV and discrimination against LGBTQI persons. UNDP noted that there is still a need to continually measure incidence of GBV and acceptance of KPs.[13]
- Adherence to best practices.
- Leadership by KPs is being monitored via: implementation of strategic plans (they have undertaken two strategic planning exercises); increasing the number of network memberships; increased participation in capacity-building spaces, and in empowerment and leadership; level of participation in decision-making spaces, and greater participation in strategic planning processes.

All activities listed have been implemented with the Global Fund grant. Additionally, not all activities addressing gender inequalities are being captured in the funding request and grant agreement.[13] The MoH, in collaboration with a group of volunteers for gender equality, have piloted methodologies to identify links between gender and HIV to inform programme implementers. There are mechanisms for individuals to note any discrimination (including gender-based discrimination) experienced by service providers. The National HIV Center has an observatory that provides legal support to KPs. The 2017 performance report identified a recent strategy to cover female people who practise transactional sex.[39]

4. Lessons learned

Cuba demonstrates how UHC can meet UNAIDS' 90/90/90 goals[40] by providing an enabling environment. The strengths of the National HIV Strategy include: 1) political will to support its implementation, 2) the National Health System providing free and accessible testing and treatment, 3) the establishment and operation of GOPELS to oversee the intersectoral response, 4) active participation of KPs, 5) ensuring sexual and reproductive health rights services for women and eliminating vertical transmission since 2015 by integrating maternal services with HIV services,[28,41] and 5) attention to key gender dimensions through the design and implementation of a public policy related to gender and HIV (the gender strategy).

The Cuban government has a comprehensive budget where the outcome is gender equality from a human rights perspective (equal rights for every human, regardless of their gender, sexual identity or orientation should be protected and promoted by the state) as part of the National HIV Strategy.[9] Within the framework of GOPELS, each sector has an action plan that incorporates gender-related activities with their corresponding follow-up.[13] But without a specific budget tool to disaggregate funds spent on gender, it has been challenging to assess the amount spent on gender equality. However, UNDP staff noted that the Global Fund's 2019 Modular Framework, which is more specific on gender,[42] would make it easier to accurately account for budgets that promote gender equality.[13]

Cuba acknowledges the gender inequality issues among LGBTQI people and its impact on health care access, and exemplifies how the right to health for all can address stigma and discrimination.[43] Progress has been made in addressing gender within HIV prevention programmes nationally and with support from the

Global Fund grant via participatory engagement of KPs and across multiple sectors[20] in the design, implementation and evaluation of the grant, which has resulted in better performance, empowerment and impact of the projects.[24]

While understanding of gender diversity and LGBTQI issues among the general public is still limited, Cuba has led the shift from conceptualising gender as a binary construct to encompassing different sexual and gendered identities to combat gender inequality regarding LGBTQI via: 1) surveys to accurately assess transgender and men who have sex with men populations, 2) evidence-informed programmes led by KPs recognizing their sexual and gendered identities, and 3) addressing gender challenges in these populations such as GBV, homophobia and gender discrimination.[13]

The National Center for the Prevention of STDs and HIV/AIDS and the CENESEX are leading educational campaigns and multisectoral trainings of the welfare, education, legal, media and civil society sectors on gender equality, promoting acceptance of sexual diversity, the prevention of sexual transmission of HIV and the new Constitution.[13,44] NGOs and KP networks are being trained to provide peer to peer education and support with testing, legal and social counselling and access to treatment to affected groups that have been hard to reach.[34] Campaigns and training programmes are developed on these issues with national and local reach based mainly on networks and promoters of KPs. In 2020, it is expected that additional financing (Global Fund portfolio optimization) will enable new training and dissemination processes with emphasis on the elimination of stereotypes and the prevention of and response to GBV.

In the absence of a network representing people who practise transactional sex in Cuba, this KP is being reached through peer-based strategies for men who have sex with men, transgender and young people.[31] The Global Fund grant has supported the training of health workers on gender diversity, as well as a health management information system that disaggregates by KPs, and Cuba has initiated some of this training and survey disaggregation. Moving forward, UNDP could support the promotion and systematisation of best practices and mechanisms in gender mainstreaming or integration. One such instrument is the Sistema de Gestion de Igualdad de Genero en Salud, led by ProSalud (Cuban government), which emphasizes participatory development as public policy.[13] Another pilot project on an institutional diagnostic/audit tool to identify the gender gaps in diverse settings (family, work and health care for HIV), rated institutions on a scale of 1-4 (with 4 referring to advanced gender equality). This tool could be used as an institutional incentive to accelerate and sustain changes.[13] A gender approach could also be incorporated into the epidemiological tool for health system projections (Análisis de la Situación de Salud or ASIS), to establish strategies that attenuate or transform structural gender inequalities to reduce health inequities in HIV programming.[44] UNDP could lead, in collaboration with the Cuban government, the application of gender-transformative approaches in every module of Cuba's next funding request to the Global Fund.[25]

5. Recommendations

The progress and results achieved in institutionalizing gender within the national response to HIV demonstrate Cuba's strengths and good practices, which can be capitalized upon with the support of the next grant. The current HIV context in Cuba requires continued work to achieve a more effective response to reduce the incidence among men who have sex with men (accounting for most of the new infections), transgender women and people who practise transactional sex populations. The following recommendations could support the objectives of the Global Fund grant in reducing HIV incidence and accelerating the achievement of the treatment cascade targets among KPs.

5.1 Strengthen the performance of quality gender analysis to identify and address underlying reasons for gender differences

A review of 2007-15 literature noted limited evidence linking gender, sexual diversity and HIV in the Cuban context.[20] A gender analysis gap was identified in the treatment cascade in particular. There is a need to analyse sex-disaggregated data collected across the prevention and treatment cascades by KPs (including people who practise transactional sex) to identify gender-related barriers to accessing health services.[34] If any sex differences are found, a quality gender analysis should be performed by experts to identify the underlying reasons for these gender differences. This in-depth analysis of gender inequalities and sociocultural patterns will provide further understanding of processes

that determine differential infection risk and access to health services in KPs, so they can be addressed in HIV programming.[20,45]

Additionally, grant activities should consider an increased focus on women, particularly female people who practise transactional sex. While the current grant focuses on men who have sex with men, including male people who practise transactional sex, it is important to also address the prevention and treatment needs of female people who practise transactional sex,[34] particularly since it is estimated that only 35 percent of female people who practise transactional sex were tested for HIV in 2015.[32]

Implementers of HIV programming, such as STI/HIV nurses at area health centres in prioritized municipalities,[31] who are capturing interventions, users and locations, could be further trained in analytical skills to identify gender issues and bottlenecks, review progress and course-correct for more effective implementation.[34] Developing appropriate indicators for monitoring the impact of gender-transformative activities in particular would facilitate accountability to more gender-responsive programming.[20]

Cuban stakeholders noted that the Global Fund's 2019 Modular Framework is more specific on gender,[42] and would enable better accounting and tracking of budgets that promote gender equality.[13] As part of the next Global Fund grant, UNDP could provide technical assistance to improve the design and integration of the different gender categories, and ensure that data are analysed regularly at the implementation level to address LGBTQI issues.[34]

5.2 Scale up training of technical experts and service providers informed by the quality gender analysis

There is a need to improve service providers' (health, welfare, law enforcement sectors) understanding of different gender identities and to better integrate training within the HIV response.[20] Cuban stakeholders identified a resistance to fully incorporating gender within HIV programming, particularly within the law enforcement sector, and a need to train health service providers, the police and the judicial system on HIV, GBV, gender and human rights to reduce discrimination against LGBTQI groups.[25] Additional scaling up of training for service providers and peer support networks in topics informed by the quality gender analysis could support a reduction in stigma and discrimination towards LGBTQI communities and improve their access to services.

Due to the sociocultural nature of the resistance that persists on the subject of gender equality, there is need for systematic awareness processes, in addition to information and knowledge, to influence a change in attitudes and behaviours; regular training to address staff turnover; a continuous strengthening of capacities with periodic reviews to address new identified barriers related to human rights and gender in changed HIV services, or ways in which such barriers to rights and access are masked.

5.3 Ensure that the existing GBV prevention and response interventions and services also support KPs (transgender women, people who practise transactional sex, men who have sex with men and women living with HIV) and strengthen the gender observatories

Continued efforts are required to address gender inequalities within KPs, particularly the high rates of GBV among transgender people, people who practise transactional sex and men who have sex with men.[17] Existing mechanisms, such as the gender observatories, could be strengthened. There is a need to consider these KPs within the GBV response. The primary healthcare setting is an entry point for GBV screening for KPs[19] and best practices should be applied, such as WHO's GBV training guidelines.

Some elements could be drawn from evidence-based multisectoral and structural interventions to address stigma, violence and barriers to accessing services and prevent violence among KPs, such as the Avahan India AIDS Initiative,[46] a community mobilization programme with gender empowerment activities to increase the self-efficacy among female sex workers (including transgender women) and men who have sex with men.[47] This initiative could provide some relevant learnings for addressing GBV among people who practise transactional sex and men who have sex with men.

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Credit: UNDP Djibouti/ Aurélia Rusek

DJIBOUTI

(Malaria grant)

GENERAL & GENDER[2,8]

Population:
958,920

GDP per capita:
$3082.5

Poverty line:
21.1%

Maternal Mortality Rate:
228
per 100,000 pop

Infant Mortality Rate:
50
per 1,000 pop

HEALTH [15,24]

Life expectancy:	Malaria Incidence:	Population sleeping under ITN:	Pregnant women slept under ITN:
68 (F) **64 (M)**	**36**	**42%** **per 1,000 pop**	**61%**

HEALTH SYSTEM

Doctor density:	**2.3 per 10,000 pop**
Nurses/midwives:	**5.3 per 10,000 pop**
ANC (4 visits):	**25.7**
UHC index:	**47**

Total Health Expenditure:

$338

per capita

Notes: ANC: Antenatal care; GDP: Gross domestic product; ITN: Insecticide treated nets; UHC: Universal health coverage.

1. Background

Country context: The Republic of Djibouti is one of the smallest countries in Africa, with more than 70 percent of people residing in urban centres around its capital – Djibouti City.[1] Its GDP per capita has steadily been rising, with economic growth largely driven partly by the tertiary sector, particularly the construction, transport and storage sectors,[2] though growth and development are unevenly distributed.[3] Extreme poverty is high (21.7 percent), unemployment is pegged at 39 percent and almost half of the population (aged 15-64) has never attended school.

Moreover, its arid climate, coupled with high water scarcity, presents significant challenges for its pastoral population residing outside of Djibouti City. This has resulted in internal migration to urban centres. Adding to this pressure is the growing waves of asylum seekers, refugees and migrants. In 2018, the UNHCR estimated there were 27,366 migrants from neighbouring countries (e.g. Somalia, Eritrea, Ethiopia) who live without shelters, most in slum communities characterised by poor sanitary conditions, and most without essential needs such as shelter, water and food.[4]

Health: Though life expectancy has improved, maternal and infant mortality figures remain high. The total fertility rate is one of the lowest in the continent (2.8 births/woman), although contraceptive use (of any type) is also low (19 percent of women aged 15-49 years). Similarly, only 25.7 percent of pregnant women have used ANC services (at least four visits) between 2007 and 2012.[5]

Malaria: In 2012, the malaria epidemic was at a pre-elimination stage (less than 1 case per 1,000 inhabitants), but it has since resurged, with confirmed cases rising from only 24 in 2012 to 1,674 in 2013.[6] Stakeholder interviews revealed that this has now reached epidemic proportions, with an alarming 40,000 cases recorded from January to June 2019. Also, malaria predominantly affects males (more than 70 percent of cases), particularly adults, with pregnant women and children under five constituting only three percent of all cases. As sex-disaggregated data on malaria has historically been lacking, it is unclear if the higher rate in men is new or has been the case since malaria resurgence. Interviews suggest that men's occupations and cultural habits around staying out late likely exposes them to mosquitoes and partially explains their higher rates. Beyond this, the general surge is also partly attributed to poor sanitary conditions, chronic floods in urban areas and migration to and from malaria endemic countries, as well as inadequate and weak health systems infrastructure.

Following health system investments between 2005 and 2013, there has been an increase in health infrastructure, namely basic health facilities (from 35 to 43) and community pharmacies (from 5 to 12). The health workforce has also steadily increased, with the number of physicians rising from 43 to 173 (between 2007 and 2013), and the numbers of nurses and midwives also increased to 253 and 191 between 2010 and 2012 respectively.[2] The population most at risk, both nationals and mobile groups — asylum seekers, refugees and migrants — have free access to care at healthcare centres. More than half (51.2 percent) of rural households own an ITN, compared to 21.4 percent in urban areas, although utilization rates are reportedly low.[2] While access to malaria treatment and prevention is free, gender norms around sleeping arrangements and financial and decision-making power can affect optimum use of health services and adherence to prevention strategies.[7]

Gender equality: There is parity in enrolment in primary and secondary school, with a gender disparity index of 1.[8] While the proportion of women (44.9 percent) who make decisions over contraceptive use and healthcare[9] seems high, cultural norms, patriarchal attitudes and stereotypes and harmful social practices contribute to violence against women.[10] Nearly half of women (45.88 percent) report experiencing physical and/or sexual violence from an intimate partner in their lifetime. Despite its criminalization, female genital mutilation is highly prevalent (94.7 percent) with low rates of reporting or successful prosecution.[2,11] Most unemployed persons are women (67 percent), and of new jobs created, only 19 percent were taken by women compared to 81 percent for men.[2] Such inequalities can affect women's ability to access malaria prevention and treatment strategies.

Policy framework: The Djiboutian government has adopted national development policies to improve health and well-being. Some progress towards the SDGs has been made, with a recent assessment[12] indicating that some health-related SDG indicators (e.g. traffic deaths and adolescent fertility rate) are on track to being met. A national development plan (2015-2019) embedded within the SDG framework

emphasizes human and social capital development, with commitments towards inclusive and participatory development, and gender mainstreaming. Also, the National Gender Policy commits to initiating policies and programmes for women's empowerment, through the creation of opportunities for social and economic advancement.

Djibouti's National Malaria Strategy, which is currently under development (2020-2024), aims to ensure effective control and management of malaria cases for all, including among cross-border nomadic populations, in refugee camps and among migrants by building and strengthening surveillance and health systems and diagnostic services, as well as mobilizing community resources to eliminate malaria.[13]

Table 1: Gender-related SDG Indicators for Djibouti

SDG Indicator	Data
Legal frameworks for gender equality and non-discrimination	Universal suffrage for women since 1977[9]
	Law specifically prevents or penalizes gender-based discrimination in the hiring process[9]
Violence against women from an intimate partner	45.88% of women aged 15 years and older experienced physical or sexual violence by an intimate partner in the last 12 months[9]
Violence against women from people other than an intimate partner	No data available for this indicator
Women in political positions	26.2% women in national parliament
Women decision-making on contraceptive use and healthcare	44.90% of married women's (aged 15-49) demand for family planning satisfied by modern methods
Females have equal land rights or ownership	No data on the percentage of men and women (aged 15-49) who solely own land legally registered to their name
	Country's legal framework guarantees women's equal rights to land ownership[9]
Mobile telephone ownership	51.57% of females own a mobile telephone, compared to 61.32% of men[9]

Table 2: Global Fund priority investment areas in malaria in Djibouti

Priority Investment Areas	Total
Vector control	$1,146,737.00 (35.7%)
Case management	$785,645.00 (24.4%)
Programme management	$968,604.00 (30.1%)
RSSH: purchasing and supply chain systems	$33,191.00 (1.0%)
RSSH: integrated service delivery and quality improvement	$237,939.00 (7.4%)
RSSH: health information management systems and M&E	$42,548.00 (1.3%)
Total Allocation 2018-2020	**$ 3,214,665.00**

Note: RSSH: Resilient & Sustainable Systems for Health

2. Global Fund malaria grant

UNDP is the PR of the Global Fund malaria grant, as well as the HIV and TB grants. During the current cycle (2018-2020) and as PR, UNDP is responsible for the overall governance and monitoring of the grant's implementation. In addition, it is strengthening national institutional capacities for a gradual transfer of management responsibilities to one or more institutions that will be selected by the CCM as PR for future grants. Several agencies implement activities in this grant namely: the National Malaria Control Programme, CAMME (a National Drug Warehouse) and the National Institute for Public Health.

The Global Fund remains the largest contributor to malaria prevention in Djibouti, with current grant priorities focused around vector control, case management, programme management and health system strengthening for M&E (see Table 2). Under these modules, specific activities seek to increase testing and treatment of malaria, vector control (e.g. through IRS in endemic communities and ITN distribution), and to strengthen epidemiological surveillance and interventions to monitor resistance of the vector to control measures. Following the upsurge of malaria cases in 2019, the Global Fund supported the country with the allocation of an emergency fund to cover the gap on treatment and provide additional resources for LLIN distribution in the most affected areas, where more than 60 percent of malaria cases are reported. This also led to an increase in the total allocation to $3,214,664.

Available information[14] suggests good grant performance, with most indicators either exceeding or meeting expectations. For example, under the case management module both the proportion of suspected malaria confirmed by a test (in both public and private facilities) and the proportion of confirmed cases who received first-line antimalaria treatment in a public health facility exceeded expectations. For vector control, ITN to targeted groups through continuous distribution was rated average, suggesting room for improvement to reach key beneficiaries. IRS was implemented in 2019, with a second round of spraying expected in 2020, and an assessment of initial results is expected to be reported to the Global Fund in 2020.

3. Gender-responsiveness of the grant

3.1 Gender issues

The concept note presented sex-disaggregated data on prevalence during the 2013 malaria epidemic, which disproportionately affected men (78 percent of all cases), while also highlighting the specific vulnerability of pregnant women and migrant populations. There was no analysis to understand the underlying causes of this disparity, or the potential role of gender norms and gender-related drivers of risk, as well as access to preventive interventions.

This gap may be explained by the fact that it was previously established that there are no significant gender disparities in these indices. For example, in the 2009 Malaria Indicator Survey (MIS), participants reported no gender-related differences in healthcare access. Indeed, this result seems to inform the general perception that there are no gender inequalities in access to healthcare services. However, such interpretation must be done with caution, and not generalized to all other health indicators. As an example, data also reported in the concept note shows that nationally, almost half (49 percent) of households have at least one ITN, but only 61.2 percent[15] of pregnant women report sleeping under one. There is good evidence that levels of formal education, health knowledge, lack of autonomy in decision-making and financial dependence impact men and women's access to health services differently.[16]

Similarly, there is overall little to no explicit analysis in the funding request of sex-disaggregated data in malaria hospitalization, mortality or treatment coverage among specific vulnerable populations (e.g. people living in the most affected areas, refugees, migrants). There was also no discussion of gender issues in diagnostic and treatment services, which may lead to an assumption that these groups have equal access to treatment and care.

In the funding request, and confirmed in stakeholder interviews, the key priorities that may be categorised as gender-responsive coalesced around the prevention and control of malaria in men, vulnerability of pregnant women and migrant populations. Surprisingly, men are not a specific focus despite the disproportionate incidence in men. Given the high rates, it would be

important to understand whether and how norms around masculinity may contribute to men's heightened exposure in order to address risk. It is unclear why men bear higher incidence, but an anthropological study is being planned to provide insights of some of the drivers and risk factors. However, stakeholder interviews and the Malaria Review Report 2019 by the Ministry of Health (MoH) suggest that sociocultural habits, such as men's traditional outdoor activities (going to the mosque, chewing khat and drinking tea), and not being fully covered by clothing, along with migrant men's lack of shelter and sleeping outdoors, may be contributing to their higher exposure to mosquitoes, and subsequent risk of being sick with malaria. Other opportunities to explore the role of gender include: understanding disparities in ANC utilization between pregnant women in the Djiboutian and migrant population and the identification of gender-related underlying mechanisms that may account for increasing performance or optimising service coverage in malaria endemic communities. It is also encouraging that the funding request also emphasizes the difficulties faced by women in terms of access to information, education and communication activities, in order to ensure programming success.

3.2 Interventions and implementation

Apart from the vector control module, where some programme activities could be described as gender-specific or gender-sensitive, none of the remaining modules implicitly or explicitly addressed gender-related issues.

Vector control and specific prevention interventions – gender-specific and gender-sensitive

This module (with the largest budget) prioritizes two main strategies for malaria control, namely the distribution of ITNs and IRS. In the former, both in routine and mass campaign-based distribution, pregnant women, nomads, refugees and migrants living in risk areas (Ali Sabieh, Arta, Dikhil, Obock and Tadjoura) have been specifically targeted. Surprisingly, despite a larger proportion of new malaria cases in men, the grant documents did not specify if the interventions targeted this specific risk group, though stakeholder interviews indicate men are partially addressed in LLIN distribution.

In the context of pregnant women and migrants, by identifying specific entry points (e.g. ANC, PMTCT sessions), engaging community women leadership, peer networks and organizations (e.g. community-based organizations, IOM), the general sense is that such a strategy may have contributed to the increase in ITN possession rate of 77 percent among migrant populations. The most effective channels for awareness-raising include word-of-mouth diffusion, community theatre and mass media. Community theatres have proved particularly helpful to demonstrate how to install, repair, wash and clean ITNs, as well as to stress the importance of their usage. However, the unpredictable socio-political changes in surrounding countries, coupled with constant flows of new migrants and inadequate shelters for them, present a challenge for controlling mosquitoes.

With respect to IRS, a pilot intervention is being implemented targeting 6,000 households in Boulaos, one of the most malaria-affected neighbourhoods in Djibouti City. Led by the MoH, and in consultation with community leaders and women and youth associations, the first round of IRS was undertaken in 2019, with a second round expected in early 2020. Though stakeholder interviews indicate improved coverage, an assessment of the intervention is still pending, and it is therefore not possible to report on its gender-responsiveness or outcomes overall. Nonetheless, this evaluation could be an opportunity to gain important insights into gender-related issues related to the uptake and effectiveness of IRS in the affected areas. For example, the effectiveness of IRS may differ in male and female-headed households, and the underlying mechanisms of impact may differ for men, migrant men, women and pregnant women. While the literature suggests that geography of places, entomology, human behaviour and social acceptance[17] are issues that may influence IRS success, social norms and values around hierarchies and economic and health decision-making are also factors that affects women's participation in IRS campaigns[18] and should be considered in IRS interventions.

Health system strengthening module

Under this intervention, modules centre on procurement and supply management, financial management and health and community resources. Of the activities outlined in the funding request, there do not appear to be specific efforts to incorporate

gender considerations under this module. However, it is encouraging to highlight, especially under the health system module, the commitment to engaging with and leveraging community resources – women leaders, youth and migrant groups – as critical entry points for mobilizing and ensuring that the distribution of ITNs reaches women, refugees and migrants where they are.

As community women mobilizers are respected and trusted community members, and representatives on management committees of community health facilities, they have been identified as a critical link for the programme to both engage at-risk men and to understand community needs and concerns, as well as what is working (or not) in ongoing malaria interventions. For migrants, engagement is through their peers, as the programme attempts to mitigate the challenge of language barriers while also ensuring that awareness messages reach them considering that most work during the day, when health campaigns are often conducted.

Evidence suggests that health interventions can often miss opportunities to reflect on the inequities sustained by health systems and how systems can reproduce societal and gender norms to minimize better health outcomes.[19] Without attention to gender, the ability of health systems to effectively deliver care and improve health may be jeopardized. While the engagement strategies through women's organizations provide an opportunity to target behaviour change messages that addresses social norms affecting malaria risk, and access to health services, more can still be done. For example, although community volunteers, mainly women, are remunerated daily for their health promotion, mobilization and community engagement services (during ITN campaigns), their time and services at community health facility management meetings are unpaid. Evidence already shows the burden of unpaid care disproportionately affects women,[20] and this needs to be considered to prevent the possibility of maintaining the status quo or validating social norms around unpaid care work.

Programme Management

The capacity development plan of the programme prioritizes designing and implementing a planning, management and administration strategy, as well as strengthening human resources both at the national programme and Global Fund grant level. Overall, it is difficult to assess the gender-responsiveness of ongoing actions to strengthen institutional, technical and management capacities (e.g. at sub-recipient (SR) or hospital level) to deliver on malaria prevention and control interventions due to data challenges.

Stakeholder consultations reveal that while at the PR grant level the majority of staff are women (9 out of 12), progress is low at the national programme level, a predominantly male-dominated programme, which provides an opportunity for shaping future efforts to achieve gender parity in the health workforce.

Also, it is important to note that women's groups are represented at the CCM level, which provides a critical pathway for women's voices to be represented in malaria control. A malaria elimination committee is also envisioned as an accountability mechanism to monitor intervention. This is an opportunity to ensure greater gender parity in committee composition and representation of key vulnerable groups, particularly migrants.

Monitoring, evaluation and information management

Overall, the grant documents and stakeholder consultations paint a picture of major challenges in national health data reporting and data quality. While efforts are ongoing, including, but not limited to actions to identify and develop internet accessible databases for integrating HIV, TB and malaria databases and investments in the District Health Information System (DHIS2), it is critical to reinforce the importance of gender-disaggregated data. While there is no specific expertise for conducting gender analysis of the programme, indications are that data for key programme indicators, both at the national malaria and grant level, are age and sex disaggregated. At the grant level, the performance management framework includes impact, outcome and coverage indicators, although the age and sex-disaggregated data is not consistently applied across these domains. For example, under coverage indicators there are provisions for age-disaggregated data (but not sex) for proportion of suspected malaria cases tested for parasites in public and private health facilities and confirmed malaria cases receiving first line treatment at public and private health facilities in line with national guidelines. However, there is no age or sex-disaggregated data for households receiving IRS or LLINs distributed to at-risk populations during mass

campaigns or regular distribution channels. While sex-disaggregated data is required for use of ITNs by people owning an ITN under outcome indicators, there is neither age or sex disaggregation for the number of malaria-attributed deaths at hospitals, or cases of recorded, confirmed or suspected malaria. This can make it difficult to determine gender disparities (if any) in access to health facilities for suspected cases, diagnosis and case management.

3.3 Gender investment

Overall, about 90 percent of the budget is devoted to vector control, case management and programme management, although the lack of details makes it difficult to assess the gender-responsiveness of investments under each of the modules. The only gender-sensitive expenditures (2019) and forecast for 2020 identified in the budget are activities related to vector control (e.g. ITN distribution, IRS). As the budget lines do not disaggregate expenditures and forecast, it was also difficult to identify gender-specific interventions, such as ITNs for pregnant women or migrant groups or for community mobilizers during mass campaigns for ITN distribution.

4. Key entry points for further gender-responsive programming

4.1 Data and research to understand gender-related exposure and risk factors and barriers to malaria services

To maintain and consolidate gains in addressing malaria, adequate data and robust research is needed to better target the Global Fund's investments to support national actions to eliminate malaria. Comparative analysis of international evidence of global research investment for malaria between 1997 and 2015 found Djibouti was one of eight countries where there were no allocated research investments.[21] While the Global Fund is investing in strengthening the DHIS2 and surveys (e.g. IBBS nomads survey), further investments would improve data collection, quality, sharing and analysis to inform decision-making for effective programming.

Unlike other countries, malaria predominantly affects men in Djibouti, and research into the underlying sociocultural drivers is critical to inform interventions to address men's risk factors and tailor behaviour change communication messages. Given the limited research in Djibouti, the current planned anthropological study into malaria in men and their underlying risk behaviours is an important step towards developing strategies, targeting health promoting and preventive behaviours to mitigate men's exposure to malaria. Analysis should consider intersectional issues of behavioural risk factors and vulnerabilities (e.g. gender, ethnicity, social class, mobility), as well as analyse norms and barriers among Djiboutian men and migrant men, as some may be very different.

Despite refugees and asylum seekers representing a key vulnerable group, they are not a major focus of the current grant. Current initiatives to assess perception, behaviour and risk factors, as well as barriers to access, prevention and treatment in the context of HIV, TB and malaria will provide useful insights to responding to the specific needs of refugees and asylum seekers. It is encouraging that this study places emphasis on risk factors, vulnerabilities and barriers to services, both within population groups – particularly as they relate to age and sex differences – and intra-group dynamics that may be driven by cultural and gender norms. The malaria, HIV and TB programmes would benefit significantly from engaging with societal norms and power dynamics around gender, and masculinities around healthcare seeking and exposure to risk in the first place. For malaria, a critical tool is the Malaria Matchbox, which provides useful entry points to address a broad range of upstream gender norms and inequalities, and barriers, in order to work with affected communities and populations. Useful lessons can be transferred to HIV and TB programming to optimise service uptake and coverage.

It is hypothesized that differences in traditional clothing worn by women and men could minimize the risk of mosquito bites for women, but robust evidence is needed to understand how this modifies malaria risk exposure and prevention. Other areas of interest include analysis of the gender-related barriers that explain the low proportion of pregnant women sleeping under an ITN, a major constraint to maximizing the effectiveness of ITN for malaria prevention and control.

4.2 Targeted intervention for migrant populations

The burden of malaria among the migrant population is significant, and prevention can be challenging, especially considering their lack of shelters (or living in poor and inadequate shelters) and frequent mobility, making protection against outdoors mosquito-borne bites challenging.[22] The specific dynamics and needs of populations at risk requires targeted and adapted interventions. For example, it remains difficult for most migrants to find places where they can hang their mosquito nets. There is an opportunity for more effective programming for malaria prevention in this population by supplying more appropriate ITNs for migrants, which are more portable and adaptable to their mobility. This is a promising strategy but given that portable ITNs are more expensive and are not prequalified by WHO, further consultations on their financial and technical feasibility are needed. Nonetheless, the programme could consider designing and implementing a pilot to assess the effectiveness of such nets for mobile groups.

4.3 Inclusion of representatives from migrant populations in the CCM, and at the health systems level

The CCM is a critical forum for engaging multiple constituencies and promoting partnership for malaria prevention and control. While the current CCM constitution reflects key national health stakeholders (e.g. MoH, national medicine warehouse, research institutes), international organizations (e.g. IOM, UNHCR) and civil society, including women's representation, there is room for improvement, especially given the context of migration and mobility in Djibouti. While there is some engagement of migrant groups through the IOM, UNHCR and women community mobilizers, migrants themselves or their representatives appear to be excluded, with interventions planned for rather than with them. As gaps may arise in migrants or displaced populations' expectations of "appropriate" malaria treatment,[23] there is need to expand and strengthen cooperation with refugees, asylum seekers and migrants through the CCM mechanism. Considering its role in prioritizing and developing programming needs for funding, such engagement provides an entry point to appropriately respond to migrant needs, especially given the potential for differences in sociocultural beliefs around risk and treatment behaviours and perceptions of disease risk between migrants and their host populations.

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Credit: UNDP in the Kyrgyz Republic

KYRGYZSTAN

(HIV &TB grant)

GENERAL CONTEXT[1,2,3]

Population: **6 million**

Urban Residency: **36%**

GDP per capita: **USD $1,281**

Net Migration: **-20,000**

Net Overseas Development Aid: **23% of govt exp**

Poverty rate: **25%**

HEALTH[1]

Life expectancy:	Death rates- Drug use:	Death rates- Substance use:	Maternal Mortality Rate:	Infant Mortality Rate:	Fertility Rate:	Contraceptive use:	DALYs from communicable, neonatal, maternal & nutritional diseases:
71 years (F:75; M:67)	**2.4**	**9.25**	**211** per 100,000 pop	**18** per 1,000 live births	**3.0**	**42%**	**5,331.34**

HEALTH SYSTEM [2,4,5]

Doctor density:	**2.4 per 1,000 pop**
Pop contributing to social insurance:	**74%**
Hospital beds:	**4.5 per 1,000 pop**
Universal Health Coverage index:	**70%**
Completeness of death registration:	**96%**
Domestic public as % THE:	**38%**
Total OOP as % THE:	**56%**

Total health expenditure (THE): **6%** of GDP

Notes: Data are for the most recent years between 2013 and 2018. GDP: Gross domestic product; OOP: Out-of-pocket; IMR: Infant mortality rate; DALY: Disability-adjusted life years

1. Background

Country context: The Kyrgyz Republic (or Kyrgyzstan) is a land-locked, lower-middle income country that has been experiencing instability, political volatility, corruption, ethnic conflict and in recent years, stagnating economic growth, with high levels of poverty.[1,3]

HIV: The HIV epidemic is concentrated in KPs, namely in populations of people who inject drugs, female sex workers and men who have sex with men. The epidemic is increasingly feminized, with a prevalence of more than double the number of women living with HIV since 2010 (1,200 vs 2,700).[7] HIV prevalence in KPs is rising, particularly among people who inject drugs, prisoners and men who have sex with men, but has stabilized in the sex worker population. The predominant mode of transmission is through sharing of intravenous equipment in people who inject drugs, but there is also increasing transmission through heterosexual sex. Figure 1 presents the 2019 country progress on the UNAIDS 90-90-90 targets.

TB: Kyrgyzstan is one of the 30 high MDR-TB burden countries globally, and one of 18 high priority countries in WHO's European Region. There has been a steady downward trend and stabilization of prevalence over the 2001- 2015 period.[8] All-form TB incidence is considered to be particularly high in the penitentiary system and amongst migrant populations, with prevalence being about 18 times higher in prisons than in the general population, and about 10 percent of new cases occur among migrant populations.[9,10]

Gender Equality: After the dissolution of the Soviet Union, the Kyrgyz Republic emerged as a nation with an open and progressive culture towards women's rights and gender equality.[11–13] However, there is still a gender gap in many health, economic and social domains, and manifestations of GBV, including domestic violence, bride kidnapping, trafficking, early marriages and physical abuse.[14,15] Women's labour force participation is lower than men's (48 percent vs 76 percent), and women are less represented in political positions (19 percent of members in the national parliament and 14 percent of ministerial positions).[2] About 12 percent of girls marry before the age of 18, and 1 percent before 15 years.[11] Kyrgyzstan also has the highest number of widows in Central Asia (26.8 percent of women).

Table 1: Population data on HIV and TB

HIV[7]		TB[8,16]	
Incidence:	0.09% (49% reduction since 2010)	All-form	
Prevalence:	0.2%	Incidence:	145 per 100,000
Incidence/prevalence ratio:	7%	Mortality rate:	7.2 per 100,000
Number of women living with HIV:	2,700 (40% of total)	Total new & relapse cases:	57% (M), 39% (F) 4% (children)
		Pulmonary:	79%
Prevalence in KPs:		Treatment success rate:	82%
PWIDs:	12.4% (2013) to 14.5% (2016)	TB financing:	$19 million (60% domestic, 40% international)
Prisoners:	7.6% (2013) to 11.4% (2016)		
MSM:	6.3% (2013) to 6.7% (2016)	PLHIV:	
Sex workers:	2.1% (stabilized)	Incidence rate:	116 per 100,000
		Case fatality rate:	6%
Coverage of HIV prevention services:		MDR-TB:	
SWs who know their HIV status:	58%	Incidence rate:	47%
Condom use among SWs:	97%		(found in 29% of new cases, 68% of prior cases)
Coverage of prevention programme for MSM:	39%	Treatment coverage:	<50%
Coverage of prevention programme for PWIDs:	40%	Treatment success:	53%
Condom use among PWIDs:	59%	Cost per patient treated:	>$10,000

Notes: Data are for the most recent years between 2013 and 2018. PWID: People who inject drugs; MSM: men who have sex with men; PLHIV: people living with HIV

Cultural and social practices increasingly restrict women's health care access and rights to make decisions,[14] but also influence women's own perceptions of gender norms and expectations. There is also growing risk of women's radicalization through religious groups, which results in women becoming proponents and believers of conservative views.[14]

For example, a third of women and half of men questioned in 2012 believed that wife-beating was justified.[15] Moreover, while sex work and same-sex relationships are not criminalized or subjected to punitive laws,[17] there are increasing and widespread accounts of harassment against the populations involved, including exposure and extortion from members of the community. Stigma and discrimination of individuals with HIV is still high, with up to 70 percent of women indicating that they would not buy vegetables from an individual with HIV.[7] In TB, gender norms and roles also influence care-seeking for TB diagnosis, and social consequence of TB disclosure. Men tend to delay health seeking by underplaying the gravity of their symptom experience, while women report accounts of GBV when they disclose a TB diagnosis to their sexual partners or family.[9,10]

Policy frameworks and health system: In the 2000s, Kyrgyzstan was known as a regional frontrunner in the Central Asia region in HIV policy and programming, and through implementation of a multisectoral cooperation approach, it was able to obtain international donor funding for much of the programming.[18] There has been about a 49 percent decline in new HIV infections from 2010 to 2018.[7,19] More recently, HIV policy and laws have become increasingly fragmented and highly politicized, with many institutions pursuing their own agendas, patterns of engagement and competing for limited power and resources.[18] Increasing radicalization towards conservative values may hamper future efforts towards gender-responsive health policy and programming and overall gender equality, at socio-political, community and individual levels.

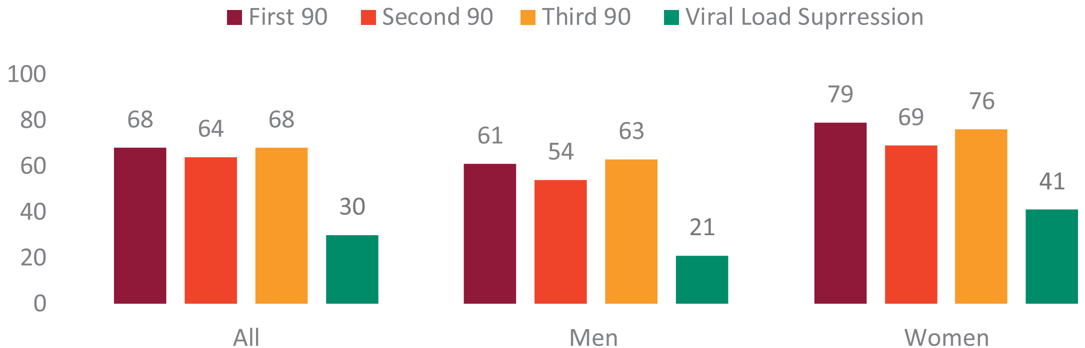
Constitutionally and legislatively, Kyrgyzstan has civil, penal, labour and family codes to uphold equal rights for men and women, and has ratified over 50 international covenants.[14] It has been implementing its own gender equality strategy (2012-2020) that addresses women's economic empowerment and development, education for women and girls, access to justice and women's political empowerment.[3,14]

Table 2: Gender-related SDG Indicators for Kyrgyzstan

SDG Indicator	Data
Legal frameworks for gender equality and non-discrimination	Universal suffrage for women since 1991[1]
	Non-discrimination clause in the constitution mentions gender[1]
	Law does not specifically prevent or penalize gender-based discrimination in the hiring process[1]
Violence against women from an intimate partner	30.5% of women aged 15 years and older experienced physical or sexual violence by an intimate partner in the last 12 months[1]
Women in political positions	19.2% women in national parliaments
Women decision-making on contraceptive use and healthcare	62.1% of married women's (aged 15-49) demand for family planning satisfied by modern methods
	76.6% of women aged 15-49 years (married or in union) make their own decision on all three selected areas – i.e. can say no to sexual intercourse with their husband or partner if they do not want; decide on use of contraception; and decide on their own health care[1]
Female and equal land rights or ownership	18.8% of men, compared with 2.8% of women (aged 15-49) solely own land legally registered to their name[1]
	Country's legal framework guarantees women's equal rights to land ownership[1]

Notes: Data are for the most recent years between 2013 and 2018. PWID: People who inject drugs; MSM: men who have sex with men; PLHIV: people living with HIV.

Figure 1: Kyrgyzstan UNAIDS 90-90-90 treatment target data[7]



*First 90: percentage of people living with HIV who know their HIV status; Second 90: percentage of people living with HIV who know their status and who are on treatment; Third 90: percentage of people living with HIV on treatment who have suppressed viral loads; Viral load suppression: percentage of people living with HIV who are virally suppressed

Within the national health system, all citizens are provided access to free emergency care, primary care (including a limited selection of medicines), outpatient specialist care with referral, and inpatient care with referral and co-payments.[5] A mandatory health and benefits package only includes about 61 outpatient medicines at reduced prices or with co-payments.[5] Although public spending on health meets international benchmarks, out-of-pocket costs have been rising from about 39 percent in 2009, to 56 percent in 2017.[4,20] HIV and TB programmes are considered priority areas, and are still addressed through vertical programmes.[21] Citizens, including some Tajik refugees, are entitled to free primary health care services, regardless of their insurance status and enrolment with primary care providers.

However, Kyrgyzstan still continues to use a version of the 'propiska' or 'internal registration system', where an internal passport (tied to area of residency) is required to access basic state-provided public services.[11,22]

Except for some categories of patients, laboratory and diagnostic tests, outpatient specialist and hospital care require patient co-payments – depending on referral and insurance status, exemption category, intervention type (such as delivery, surgery or medicine). People with TB are eligible for free access to TB treatment and care, but many patients do not know of these entitlements within the public system.

Table 3: Global Fund priority investment areas in HIV and TB in Kyrgyzstan

Priority Investment Areas	Total	Priority Investment Areas	Total
Treatment, care & support	$3,434,038.00 (16.38%)	Prevention programme for other vulnerable populations	$2,951.00 (0.01%)
CPP for people who inject drugs (PWID)	$1,852,254.00 (8.84%)	TB/HIV care and prevention	$11,148.00 (0.05%)
CPP for FSWs and their clients	$530,149.00 (2.53%)	MDR-TB	$7,940,469.00 (37.88%)
CPP for men who have sex with men (MSM)	$467,238.00 (2.23%)	RSSH: HMIS and M&E	$135,302.00 (0.65%)
CPP for people in prisons and other closed settings	$94,771.00 (0.45%)	RSSH: Community responses and systems	$61,761.00 (0.29%)
PMTCT	$36,385.00 (0.17%)	Programme management	$5,302,763.00 (25.30%)
Programmes to reduce human rights barriers to HIV services	$1,090,595.00 (5.20%)		
Total Allocation			**$20,959,822.00**

Note: CPP: Comprehensive prevention programme; MSM: Men who have sex with men; PWID: People who inject drugs; RSSH: Resilient and sustainable systems for health

2. Global Fund grants

While the MoH has consistently been making efforts in health systems strengthening, UNDP remains the PR of the Global Fund grants. UNDP was identified in 2011 as an appropriate PR and has continued in this role during the current grant cycle. Nevertheless, there are ongoing capacity-building efforts to prepare for a future transition. Other multilateral agencies that work and sometimes partner with UNDP on the Global Fund grant are USAID, UNICEF, UNAIDS (active collaboration), WHO, UNODC and UNFPA.

UNDP has a strong implementation record, and good relationships with stakeholders, implementing partners and target communities. All the stakeholders also identified the local civil society movement as vocal and influential, which has been a crucial aspect of development progress in Kyrgyzstan. This factor has been previously recognized in assessments and studies.[5] The CCM encourages community participation as a process in grant design and implementation. Stakeholders feel that their voices are well represented and their agendas well integrated. NGOs have strong ties, trust and communication with the communities they work with. For example, the relationships built by paralegals in an implementing organization that provides legal services and education to members of KPs was observed to be an enabling dynamic in their programming work. In the current grant cycle, goals include the reduction of the incidence and mortality of HIV by 50 percent to eliminate the epidemic by 2030, and to achieve treatment success of 85 percent for all-form and 67 percent for MDR-TB by 2020. Some grant objectives that could relate to gender include:

- Reduction of vertical transmission of HIV, and elimination of this mode of transmission;
- Reduction of stigma and discrimination in government organizations that provide healthcare services (for female sex workers);
- Reduction of laws, regulations and practices that discriminate against people living with HIV and KPs.

Grant performance for the current grant cycle was below expectation on targets related to sex workers reached with HIV prevention programmes (79 percent), and people who inject drugs reached with HIV prevention programmes (85 percent), individuals receiving opioid substitution therapy (71 percent), previously treated TB patients receiving drug susceptibility testing (79 percent) and number of RR/MDR-TB cases that commenced second line treatment (84 percent). There was also a higher number of documented human rights violations in KPs (exceeded projection by 20 percent).[23] While the outreach can be perceived as a success at a programme implementation level, the higher number of cases signifies the extent of human rights violations, stigma and discrimination against KPs.

3. Gender-responsiveness of grants

As part of the Breaking Down Barriers initiative, the Global Fund conducted a baseline assessment of the national situation of human rights-related barriers to HIV and TB services in Kyrgyzstan and found notable gender-related barriers.[11] Kyrgyzstan is identified as 1 of 20 countries where needs, opportunities, capacities and partnerships provide real possibilities for scale-up programming that will result in important gains for the health of those affected.[24] In this assessment, the Global Fund found that relatively little funding was allocated for gender-responsive programming, and where available it was for programmes with limited scale and scope.[11] Barriers of access to health services identified in this assessment include police practices of harassment and violence, population stigma and discrimination and fear of GBV within populations of sex workers, gay and bisexual men and women and men who inject drugs.[11]

Kyrgyzstan applied for and received approximately $1 million in matching funds to address these barriers. A priority area identified in the grant is to address the gender dynamics in the population (programmes for reducing HIV-related discrimination of girls and women).

3.1 Gender issues

Overall, the current grant documentation provides a fair amount of age and sex disaggregated data, and indicates a process of engagement with gender champions. Gender is not prominent or visible in the grant goals, objectives and identified activities within the modules. Nevertheless, there is consensus among stakeholders that gender is not ignored in the grant and is most prominent in the programming that focuses on the 90-90-90 goals and KPs.

Within the disease areas, gender was discussed as culturally ingrained in traditional hierarchies, with unequal gender roles well defined. In TB, stakeholders discussed how women are missed by the healthcare system because there is a perception that men are at greater risk and that the older generation of healthcare providers tend to carry biases. Women's access to healthcare is influenced by systemic and cultural dynamics that are not unique to the country. For instance, nearly 60 percent of married women report health-seeking behaviour as a joint decision with their husbands, while only about 31 percent of married women make health-seeking decisions by themselves and some women, especially in the rural areas, are not able to make decisions on health-care seeking by themselves.[15]

Conceptually, gender equality goals within the grant do encompass the pursuit of equal opportunity and outcomes for both women and men, but only for populations identified as target beneficiaries. There was a strong focus on female sex workers, but in fact this is the group with the most stable and lowest prevalence rate in an epidemic with increasing prevalence in other KPs. Gender in prisons, women who inject drugs, men who have sex with men and transgender communities were not discussed.

Several key stakeholders indicated that while there is communication and awareness about gender as a priority in the grants, there are no clear overarching frameworks that conceptualize how gender is operationalized. Implementing partners also discussed that their involvement is limited to specific modules within their scope of practice, such as in the female sex workers module that is fully female-specific, but they are not involved in promoting gender equity in the rest of the grant.

At an organizational level, the influence of UNDP and the Global Fund's focus on gender mainstreaming and gender equality is also translated into focused programming at a country level. Some stakeholders also felt that there were key implementation gaps and bottlenecks, where gender was not as important as other pressing and competing priorities, such as the availability of medicines in dispensaries.

Within a national policy context, gender is integrated into the national development plan and Kyrgyzstan is more open and progressive compared to many other countries in the region. However, several stakeholders shared their views that respect of gender-related rights is an issue within the country, well beyond the scope of the grant. Stakeholders highlighted that the active and vocal civil society movement has been pivotal for the development process, but its role within gender-responsive areas appear to be under threat due to resistance from nationalist and radicalized sectors that view gender-responsive programming as 'external ideologies' that go against local culture and traditions.

3.2 Interventions and implementation

Overall, there is a sense from the stakeholders that gender is integrated into the grant, at least by virtue of populations being gender-specific (i.e. KP, female sex worker and men who have sex with men modules), the focus on stigma, discrimination and other human rights-related barriers and organizational mandates of UNDP to be proactive in gender-related issues. The HIV modules appear to be more gender-responsive than the TB modules. The stakeholders suggested that this is mainly due to the lack of national priority to consider the gender dimensions in the TB response (Global Fund grant priorities are encouraged to align with the national strategy objectives and targets).

HIV-related programming activities, described in the grant confirmation[10] document, which potentially have gender-responsive elements include:

- Uphold and scale-up behavioural change within programmes for sex workers and clients;
- Promote behavioural change within programmes for men who have sex with men;
- Contribute to removing human-rights related barriers to HIV services.

Activities under the Matching Fund application that have a gender focus include:

- Assisting people living with HIV and KPs in preventing GBV;
- Advocating for increased access to information and services regarding HIV infection and sexual and reproductive health for adolescents, including through removing age of consent-related barriers;
- Introducing gender-sensitive programming for women's empowerment for the prevention of sexual transmission of HIV for discordant couples of people living with HIV.

It is unclear from the discussions and available documentation how gender dynamics are addressed in these activities, or how gender is addressed in non-gender-specific groups, such as women who use drugs, women in prison and female partners of men who have sex with men. There is one women's prison, which has needle exchange and opioid substitution therapy points, but there are no women-specific or women-sensitive sites for prevention programmes/harm reduction activities. Through the matching funds, two women-focused centres implement activities aimed at providing comprehensive services to women from KPs (including those who have been released from the penitentiary system) who have experienced any kind of violence, or are in a difficult life situation.

The funding request[9] also describes an assessment by the technical review panel from the previous grant cycle identifying a similar need for HIV prevention and care programming for women who inject drugs and female partners of men who (1) have sex with men, (2) are clients of sex workers, and (3) are injecting drug users. While there is a module on human rights (in HIV), it is not clear how much of the interventions specifically target women or can be considered gender-responsive. The HIV female sex workers module performs adequately based on the performance framework (A2-B1), but the experience on the ground is that there are still widespread accounts of stigmatization and harassment by religious activists and nationalists, so it is difficult to increase action while maintaining cultural sensitivity.

Additionally, the grant identifies that HIV and TB are challenges in migrant communities, including internal migrants, but programming descriptions have neglected to include how outreach to this population is achieved. During the interviews, stakeholders identified that there are difficulties in finding appropriate strategies and activities to provided targeted services. Additionally, travel restriction laws lead to irregular means of migration where there is a diagnosis, which in turn lead to less access to health services and treatment in the receiving country.[11] The baseline assessment refers to a draft bilateral agreement between Kazakhstan and Tajikistan to ensure that migrants have access to TB services while they work outside their home countries. This agreement has not yet been signed.[11] The baseline assessment also discusses the uncertainty of the legal protection of the population of about 16,000 refugees and asylum seekers who were present in the country in 2014, as reported by the UN High Commissioner for Refugees.[11]

While outgoing and incoming international or cross-border migrants are identified as a programming challenge, a large proportion of migrants affected include internal (presumably rural-urban) migrants. Internal and cross-border migrants make up about 45 percent of national TB cases (2012-2013), with 27 percent of this group being cross-border migrants.[25] Kyrgyzstan still continues to use a version of the 'propiska' or 'internal registration system', in which participation is required in order to access basic state-provided public services such as health care.[11,22] Prior assessments have identified that women's migration for work is higher than that of men, but TB treatment success rates and other data on diagnosis and treatment are not disaggregated by sex, making it likely that women are lost to follow-up over the course of a required 18-month course of TB treatment.[11]

Barriers and challenges to gender-responsive programming

Stakeholders identified several challenges and contextual factors that are barriers to more gender-responsive programming. There was also a sense that gender features well in the planning and design stage, and is better articulated in grant application documentation than implementation or through the existing performance monitoring documentation. This was also compounded by a sense that there has been insufficient meaningful change in practice, and that programmatically the focus is relatively narrow, with more focus on GBV than on the gender-responsiveness of programmes more broadly.

Despite these known gender dynamics within the two disease areas, key stakeholders shared the view that there was a perception in the past that gender in TB was not highlighted as a priority at country level as opposed to the grant or organizational level. There is still insufficient attention on gender within the national TB response. In contrast, the importance of addressing gender norms and gender-related barriers to healthcare is more accepted within the national HIV response, but there seems to be a greater focus on human rights issues rather than gender dynamics, other than GBV.

At the national level, the document review and stakeholders identified that there are increasingly high sensitivities that need to be managed. These include:

- Potential turnover of leadership (e.g. elections in the next year, high turnover in government and ministry positions, frequent political revolutions, political interest to focus on

the short term and political campaigns that exploit nationalist sentiments);

- MoH focus on biomedical interventions and perspectives;
- The legal position of the LGBTQI community has been threatened (a potential law that curbed their rights was halted, but key men who have sex with men have been targeted for exposure and extortion);
- Social deterioration since 2012 (social unrest, high push back against western values, increasing radicalization of women).

Antagonism towards the international donor sector and NGOs is rooted in sentiments that they represent 'outside interests', rather than addressing local needs. This is particularly the case for programming on women's rights and gender equality. Donors have historically brought new ideas and ways of development that were deemed to be necessary for the country's transition to a functioning democracy and market economy.[5] There are increasing calls from within government and nationalist politicians to introduce measures to restrict NGO involvement in programmes funded through foreign donations. Similar trends are observed in other republics in central Asia, such as Uzbekistan and Turkmenistan where NGO activities are illegal, rather than restricted such as those in Kazakhstan and Tajikistan. There is also criticism that NGOs prioritize the agendas of donor organizations and are not flexible or open enough to address local needs. An example of this criticism is the NGO sector's focus on gender equality and domestic violence, which is driven by funding availability and international funders' priorities, rather than addressing local challenges such as religious radicalism among young women in Southern Kyrgyzstan.[5]

3.3 Gender in investments and performance frameworks

Budget and investments: Key stakeholders believe that budgets are allocated based on proposed activities and size of target beneficiary groups and distributed equally between men and women groups. There do not appear to be any other gender-responsive budgeting processes and principles used in developing the budget.

Performance framework: Apart from the number of AIDS-related deaths, the performance framework indicates no requirement for sex disaggregation for impact and coverage indicators. Requirements for sex disaggregation are indicated for more outcome indicators that relate to HIV than TB. Inclusion of sex-disaggregation for indicators pertaining to people who inject drugs and the prevalence of MDR-TB can support population size estimation, the financial case for increased gender-responsive programming and the design of interventions for these populations. From the interviews, stakeholders consider the level of sex-disaggregation in the performance framework to be adequate, as it has been jointly determined by a team of experts and community voices, including those of women's groups. Others consider the performance framework to be gender and human-rights blind, and prioritizing a biomedical perspective.

4. Recommendations

4.1 Addressing data and knowledge gaps for better programming for women, particularly in neglected and non-gender-specific KPs

The 2018 Global Fund Baseline Assessment highlighted the lack of data as a key gap in the design and implementation of gender-sensitive TB prevention messaging and service delivery.[11] Through interviews, country stakeholders have also highlighted that there is insufficient research and funding for particular groups of women, such as women who use drugs, even though they are part of a KP with the largest prevalence of HIV in the country. In a recent evaluation, the Global Fund also identified transgender populations and male sex workers as vulnerable populations.[11]

Further research on internal migration patterns and impact of registration or loss of documentation on health and social protection access is required to inform programming design. This aligns with and supports a recommendation in the Global Fund baseline assessment to increase advocacy around policy reform on the 'change of address' documentation as a requirement for health access.[11]

A potential way to fund the implementation of this recommendation could be through the use of the RSSH: health management and information systems module, which specifically identifies processes to collect, store and analyse sex-disaggregated programming data for non-gender-specific KPs, and in TB treatment. Additionally, this module could also be

used to conduct qualitative studies and quantitative surveys within populations for which little or no data is available, such as women who use drugs and women in prisons. Additionally, the RSSH: Community systems strengthening module could be used to fund community-led research by NGOs or KP networks, or to mobilize marginalized, under-served and key and vulnerable populations, such as women who use drugs or female partners of men who have sex with men.

4.2 Promote interventions that reduce identified gender-related barriers to TB prevention and treatment among men and women

Targeted programming is required that includes components seeking to transform unequal gender dynamics to overcome service barriers identified in the grant, which remain unaddressed in the implementation of the modules. However, the need for a gender lens within TB policy and gender-sensitive TB programming is not identified as a priority focus within national policy or by policymakers. In the 2016 Baseline Assessment, the Global Fund found that nothing was done to address gender-related barriers to health services access for TB in Kyrgyzstan, except for a TB gender and legal assessment that was conducted by the Stop TB Partnership.[11] These assessments provide a formative evidence base required to initiate negotiations around the need for further gender-responsive programming for both men and women.

The Stop TB gender and TB assessment found multiple areas that affected the prevention, treatment and quality of life of people with TB, which could be addressed through targeted programming: [26]

- Low levels of public information about TB (including public services, social entitlements and free access to healthcare) especially among women in rural areas, which also contributes to widespread stigma and reports of mistreatment (including family abandonment and losing access to children) because of a diagnosis;
- Economic consequences of TB, with insufficient legal employment protection for people with TB;
- Insufficient access to timely and continuous treatment for women in rural areas.

Many of these barriers can be addressed with funding for modules and interventions focused on removing human rights and gender-related barriers to TB services. These include stigma and discrimination reduction through activities such as media and 'edutainment' activities on TB, the integration of non-stigmatizing language into TB communication materials and radio shows, as well as engagement with religious and community leaders and celebrities. Additionally, specific interventions within the reducing human rights-related barriers to HIV/TB services module, such as legal literacy and reducing gender discrimination and harmful gender norms and violence, could also be tailored towards addressing the barriers to TB prevention, treatment and improved quality of life. Other entry points are the RSSH human resources for health, including CHWs, and the TB care and prevention and community TB care delivery modules. Future grants could design, pilot and implement programmes at the community level to ensure gender-sensitive dissemination of public information and referrals to timely treatment, especially in rural areas.

Specific TB modules for mobile populations could be used to target mobile groups, including internal migrants. Outreach to communities can also involve community-based capacity-building for advocacy and health messaging that encourages health-seeking and explicitly tackles gender-specific barriers. These are included in Table 4.

Table 4: Modules and activities for TB

Module	Activities
TB Care and prevention MDR-TB or TB HIV on KPs (mobile populations, refugees, migrants and IDPs)	Active case finding, contact tracing, and screening of migrants for TB prior to resettlement and immigration Provision of mobile outreach services including regular screening (using X-rays, Xpert, microscopy) Provision of clinical diagnosis, radiological investigation, sputum smear and culture and drug susceptibility testing in line with partner government protocols Activities to strengthen cross-border referral processes Provision of treatment and support Linkage with national TB information system and referral Development of appropriate linkages with social and humanitarian services (for example, nutritional support, social housing) and other health promotion and emergency health programmes.
Removing human rights and gender related barriers to TB service	Community mobilization and advocacy Community-led outreach campaigns to address harmful gender norms and stereotypes and other human rights-related barriers Community-based monitoring of service delivery quality, including stigma, discrimination, confidentiality and privacy and informed consent Patient group mobilization and building capacity/supporting community-led advocacy efforts.

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