



Investing in the Future: Women and Girls in All Their Diversity

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1. Background

1.1 Introduction

Activists, alongside UN and bilateral partners, created the Global Fund in 2002 to realize the commitment to the right to quality healthcare for all. Since that time, the global community has adopted the Sustainable Development Goals, and countries have made bold commitments towards achieving Universal Health Coverage (UHC). Global Fund investments must continue to be responsive to these shared targets, and the Fund's mandate to end HIV, TB and malaria. This is only achievable by addressing the inequities and disparities that put people at risk and keep them out of critical services. While gender-related risks and barriers to services affect everyone, this report focuses on the work the Global Fund is supporting to advance the health and rights of girls and women in all their diversity.

A commitment to human rights and equitable access to quality services is enshrined in the [Global Fund Strategy 2017-2022: Investing to End the Epidemics](#), and integral to the way we work. The current strategy commits to advancing human rights and gender equality, and reducing gender and age disparities in health. This includes the intent to scale-up of programs to support women and girls, including programs to advance sexual and reproductive health and rights. In many countries, girls and women continue to bear a disproportionate burden of disease risk, and the burden of caring for those that are sick, while also lacking access to quality services. To reach our targets, the Global Fund invests in gender transformative approaches for equitable access to life-saving services and advance gender equality. We work with communities of women and girls not as beneficiaries of Global Fund supported programs, but as the agents of change and leaders that will bring us closer to our shared goal of health care for all.

We have a long way to go to ensure that all women and girls can protect themselves from health risks and ensure their own well-being. However, this report demonstrates strong results due to a more gender-responsive, woman and girl-centered approach.

1.2 Helpful Definitions

Gender refers to the socially constructed characteristics of women, men, boys, and girls – such as the norms, roles and relationships that exist between them. Gender is distinct from sex, although both are both important determinants of health. Biological sex and socially-constructed gender interact to produce differential risks and vulnerability to ill health, and differences in health-seeking behavior and health outcomes. 'Gender' describes those characteristics of women and men that are largely socially created, while 'sex' encompasses those that are biologically determined.

Gender norms are standards and expectations to which women and men generally conform, within a range that defines a society, culture and community at that point in time. This includes how they should interact: with others, of the same or opposite sex, within households, in communities and workplaces (gender relations) and which functions or responsibilities they should assume in society (gender roles).

Gender-sensitive programming refers to programs where gender norms, roles and inequalities have been considered and awareness of these issues has been raised, although appropriate actions may not necessarily have been taken.

Gender-responsive programming refers to programs where gender norms, roles and inequalities have been considered, and measures have been taken to actively address them. Such programs go beyond raising sensitivity and awareness and do something to address gender inequalities.

Health equity implies that everyone should have a fair opportunity to attain their full health potential and that no one should be disadvantaged from achieving this potential. Gender plays a major role in both addressing and creating health inequities.

Gender equality refers to the equal rights, responsibilities and opportunities of women and men and girls and boys. Gender equality implies that the interests, needs and priorities of both women and men are taken into consideration, recognizing the diversity of different groups of women and men.

Women in all their diversity refers to all who identify as women including transgender women.

A woman and girl-centered approach

- Sees women as active participants in, as well as beneficiaries of, trusted health systems that respond to their needs, rights and preferences in humane and holistic ways;
- Emphasizes the promotion of gender equality as central to the sexual and reproductive health of all women, and promotes gender-responsive health services which examine critical gender norms and support gender equality;
- Requires that women are empowered – through education and support – to make and enact decisions in all aspects of their lives, including in relation to sexuality and reproduction;
- Calls for strategies that promote women’s participation in their own health care;
- Is organized around the health needs and priorities of the women themselves rather than disease management and control.

2. Action, Impact and Challenges



The Global Fund has been a major contributor to the health and well-being of girls and women globally, driven by a focus on equity and equality as a critical component of one of the four strategic pillars. Having a gender-responsive approach across the three diseases has driven specific investment approaches for women and girls, sometimes across a region and sometimes in a locally specific way.

The Global Fund is committed to addressing gender inequality and this requires a focused effort that spans the design, implementation, and monitoring of grants. Supporting the development and implementation of gender-responsive national health strategies, the improvement of data systems to gather and analyze sex- and age-disaggregated data, and the identification of vulnerable or at-risk populations are strategies that are supported at country level. Further, the Global Fund is part of a larger community of important donors supporting countries to deliver on National Strategic Plans.

What is clear is that when there is a global commitment to solve a challenge, and resources are mobilized to realize the solutions. We have seen success when there is commitment. For example, when the world committed to ensuring that pregnant women had access to HIV treatment services for the dual purpose of keeping them alive and preventing HIV in their babies – there were tremendous results. According to UNAIDS 2018 estimates, across sub-Saharan Africa, median coverage of programs to prevent vertical HIV transmission from mother to child (PMTCT) increased from seven percent in 2005 to 66% in 2017. In Sierra Leone, for example, PMTCT coverage went

from two percent in 2005 to 89% in 2017. This was achievable even as the country struggled to respond and then recover from the Ebola crisis. Similarly, many countries have seen a huge scale-up in pregnant women receiving at least two doses of intermittent preventive therapy (IPTp) for malaria. According to data published by WHO in 2018, in Ghana, IPTp coverage of two doses went from less than one percent in 2003 to 78% in 2016, and in Senegal from 12% in 2005 to 61% in 2017.

The Global Fund has been one of the major contributors to the global scale-up of access to HIV care and treatment for women and girls. In 2017 alone, the Global Fund supported 2.2 million women and girls to access these critical services.

Being part of a network of decision makers, activists, communities, and program implementers that realized a global commitment to improve services for pregnant women showed that when there is political will along with dedicated and pooled resources – financial and technical – progress on even the most difficult challenges can be made. This same commitment is now urgently needed to invest in gender transformative programs that will go a long way to reduce persistently high rates of HIV in adolescent girls and young women (AGYW) in many parts of sub-Saharan Africa. In 2017, the Global Fund launched a catalytic funding effort focused on 13¹ countries facing the highest burden of HIV amongst AGYW. Trend data shows that HIV infection rates are declining amongst this population.

However, despite the impressive progress, entrenched inequities and inequalities continue to threaten the health and lives of girls and women around the world. In the countries with the largest HIV epidemics, HIV incidence in women and girls is declining less rapidly than in men. According to UNAIDS data, on average in 2017, 70% of new HIV infections between age 15 and 24 were in women and 30% were in men among the 13 focus countries. Gender inequality and intimate partner violence are contributing to women's vulnerability to HIV infection and women living with HIV who experience intimate partner violence were significantly less likely to start or adhere to antiretroviral therapy and had worse clinical outcomes.²

In Malawi, Zambia, and Zimbabwe, 2016 research showed that 46% of people ages 15–24 were aware of their HIV status, and of those who were aware, only 82% were on treatment and 79% of these were virally suppressed.³ In sub-Saharan Africa, 42% of women living in urban areas aged 15–24 had a pregnancy before the age of 18. In rural areas, more than 50% of women aged 15–24 had a pregnancy before the age of 18. With the burgeoning youth population in Africa, expected to reach 293 million by 2025, new infections among adolescents and youth will likely increase even if HIV incidence rates remain stagnant or decline only slightly.⁴

With elevated risk to HIV, comes elevated risk to the co-morbidity of TB. Globally more men develop TB than women - 5.8 million men compared to 3.2 million women in 2017. However, of the 260,000 HIV-related TB deaths among adults globally in 2017, 43% were among women, and approximately 90% of these deaths were in Africa.⁵ In Africa, TB rates are up to 10 times higher in pregnant women living with HIV than in pregnant women without HIV. Close to half a million women died from TB in 2017, including some 111,000 deaths among women with HIV. TB in pregnant women living with HIV increases the risk of maternal and infant mortality by almost 400%.⁶ There is growing evidence

¹ The 13 catalytic funding focus countries included Botswana, Cameroon, Eswatini, Kenya, Lesotho, Malawi, Mozambique, Namibia, South Africa, Tanzania, Uganda, Zambia, Zimbabwe.

² Hatcher AM, Smout EM, Turan JM, Christofides N, Stöckl H. Intimate partner violence and engagement in HIV care and treatment among women: a systematic review and meta-analysis. *AIDS*. 2015;29 (16):2183–94.

³ ICAP. Summary Sheet: Preliminary Findings: Malawi population-based HIV impact assessment MPHIA 2015–2016. 2016.

ICAP. Summary Sheet: Preliminary Findings: Zambia population-based HIV impact assessment ZAMPHIA 2015–2016. 2016. Justman J. Real Progress in the HIV epidemic: PHIA findings from Zimbabwe, Malawi and Zambia. Seattle, WA: CROI; 2017

⁴ Economic Commission for Africa. *The Demographic Profile of African Countries*. Addis Ababa, Ethiopia: 2016

⁵ Global Tuberculosis Report. World Health Organization. 2018

⁶ Global Tuberculosis Report. World Health Organization. 2018

that discrimination from TB disproportionately affects girls and women, keeping them out of services for fear that the diagnoses will mean that they won't be able to marry or stay with their families. Women and girls also bear a disproportionate burden of being the care givers for their families and communities suffering from TB.

Like TB, globally more men are at risk to contracting malaria than women. However, gender does impact on risk and how women and girls receive services and should be taken into consideration in malaria programming. This includes gender differentiated access to information, division of labor that affects exposure to malaria, access to and use of bed nets, and barriers to access preventive measures, such as the indoor residual spraying (IRS). There is some evidence that when spray teams are made up of men, there are barriers to these preventive services for female-headed households due to the need to have male permission. Women are more likely to lack resources to pay for transportation and have restricted mobility to access necessary health care services.^{7,8}

Pregnant women are more vulnerable than other adults to malaria, which can cause severe anemia and death. Women who are pregnant and HIV co-infected have been shown to have two-fold higher HIV viral concentrations than women who do not have malaria, and some research has found an associated increased risk of mother-to-child transmission of HIV.⁹ Although IPTp for malaria is recommended at each prenatal visit beginning early in the second trimester, WHO estimates that only 19% of women received the recommended three doses during each pregnancy and there is a declining effort to scale up IPTp in a number of African countries.¹⁰ According to UNICEF, 86% of pregnant women access antenatal care with a skilled health personnel at least once, only three in five (62%) receive at least four antenatal visits. In regions with the highest rates of maternal mortality, such as sub-Saharan Africa and South Asia, even fewer women received at least four antenatal visits (52% and 46%, respectively).¹¹

⁷ UNDP, Discussion Paper Gender and Malaria, Making the investment case for programming that addresses the specific vulnerabilities and needs of both males and females who are affected by or at risk of malaria, December 2015

⁸ The Global Fund to fight AIDS, Tuberculosis and Malaria, Technical Brief, Malaria, gender and human rights, Jan. 2017

⁹ Roll Back Malaria Partnership, 'A Guide to Gender and Malaria Resources', Roll Back Malaria Partnership, Geneva, 2007

¹⁰ WHO, https://www.who.int/malaria/areas/preventive_therapies/pregnancy/en/, update from June 2018

¹¹ UNICEF. Only half of women worldwide receive the recommended amount of care during pregnancy (online fact sheet), 2016, at: <http://data.unicef.org/maternal-health/antenatal-care.html>

3. Walking the Walk: Gender-Responsive Policies and Processes



The Global Fund actively promotes gender equitable investments at country level. This isn't one policy or practice, but rather a conscious and sustained approach to address equity in grant design, implementation and monitoring. Sex-disaggregated data can reveal if women or girls are experiencing negative health outcomes, and if it's disproportionate to male counterparts. Analyses examining why these disparities exist often reveal gender and human rights issues that either increase their risk or keep people from receiving the services they need. Country and sub-national processes that meaningfully engage women and girls in responding to these issues are more relevant, effective, and sustainable.

3.1 Gender-Responsive Materials

Global Fund processes support countries to develop funding applications and programs to respond to gender and human rights related barriers and put communities at the center of the response. Countries were obliged to identify in funding applications the gender-related barriers that hinder achieving targets and how investments address these issues. In many cases, the Technical Review Panel (TRP), the external body responsible for reviewing the technical merit of funding applications, used this information and other documents provided such as national strategies and sex/age disaggregated data, to analyse whether proposals adequately address gender-related disparities

and barriers to services. In many instances, this resulted in recommendations for countries to improve an approach or to add an intervention. Notably, there was a substantial increase in the 2017-2019 funding cycle (from the 2014-2016 cycle) in TRP comments related to gender for malaria and TB components.

The Secretariat has produced several materials to help articulate an evidence-based, gender-responsive approach. This includes technical briefs on programs targeting high-risk adolescent girls and young women and their male partners; human rights and gender-responsive programs in malaria, TB and Challenging Operating Environment (COE) settings.

3.2 Catalysing Investments in Adolescent Girls, Key Populations and Human Rights

With the 2017-2019 grant cycle, the Global Fund launched an innovative matching funds program in HIV grants in 27 countries. Eligible countries could access additional funding to address human rights barriers, and HIV incidence for key populations and adolescent girls and young women (AGYW) if they matched the amount with funds dedicated in their allocation. This unique funding mechanism used US\$55 million dollars to catalyze an additional US\$120 million dollars in programs to reduce the HIV incidence rate, unintended pregnancies, and violence for AGYW in the 13 priority countries.

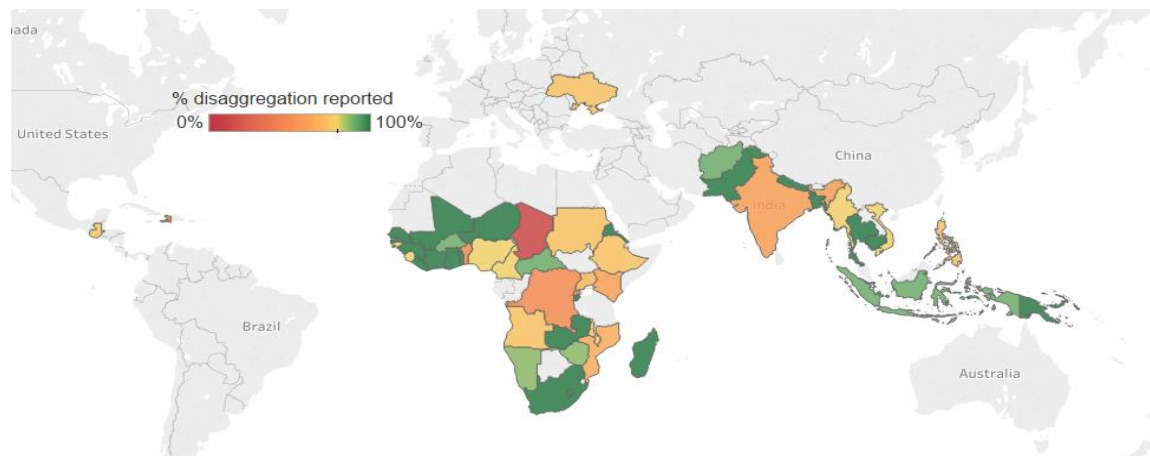
Catalytic investments enabled the launch of a bold initiative called “Breaking Down Barriers”, where countries fund programs to remove human rights-related barriers to health services for women and girls and other key and vulnerable populations. Twenty focus countries research and quantify the barriers to services, who is affected by them, and what it will take to overcome them and develop a national plan. In many countries, the human rights investments went to interventions to address the barriers to services faced by girls and women. In Botswana, the human rights matching funds provided support for programs aiming to reduce HIV-related discrimination against women. Efforts include interventions in schools and communities to challenge and transform gender norms, such as girls’ empowerment programs, gender sensitization training, and interventions with men and boys to understand and transform traditional notions of masculinity.

3.3 Gender Responsive Data and Learning

The Global Fund is continually working to improve countries capacity to know their epidemics with investments in Health Management Information Systems (HMIS) and encouraging the use of sex and age disaggregated data. The organization has set a target that by the end of 2022, at least 32 of a cohort of 51 countries will have 80% of health facilities reporting for combined set of sub-indicators and functional HMIS. At the end of 2018, the target was met; 13 of these 51 countries had fully deployed and functional HMIS.

The organization also set a target to ensure that countries were reporting on the required sex and age disaggregation across the three diseases. At the end of 2018, 43%, or 22 of the 51 cohort countries, were able to report with all required and relevant sex and age breakdowns. This improves the ability of countries, and the Global Fund, to know which populations are at increased risk to HIV, TB and malaria and invest accordingly.

3.4 Country Cohort for Reporting on Sex/Age Disaggregation



One glaring gap that continues to hamper appropriate responses is the quantity and quality of data for key and vulnerable populations. In addition to often not having robust size estimates for program design, there is a lack of sex or gender disaggregation in reporting of coverage of key interventions for these populations. For example, very few countries have necessary data and strategic information critical to inform tailoring of HIV program for transgender women. Whilst there is confusion about population size and HIV prevalence everywhere, the existing data on HIV prevalence indicates alarming trends: HIV prevalence among transgender women can range from 1.1% in Bangladesh to 24.8% in Indonesia and 38.5% in the Dominican Republic. This underscores the importance of developing a complex, focused public health program specifically tailored to the needs of this population.

Even if programs do collect sex or age disaggregated data, they are either not systematically used for tailoring services, nor reported upwards to the Global Fund. As a result, the programs fail to address the specific gender-related risks and barriers to services and may decrease access to services for particular communities.

The Global Fund has long been a key contributor to strengthening data availability and quality for key populations, particularly in the context of HIV. In 2012-2016, the Global Fund invested heavily in ensuring the availability of nationally adequate key population size estimation for HIV program design. The Global Fund also invested in systematically mapping and updating site-level prevalence, behavioral, coverage and estimation data by group, working closely with UNAIDS to produce the Key Population Atlas. Notable progress was seen through this effort as some countries started to use disaggregated data for program design (e.g. male sex workers in Thailand, female people who inject drugs in Nepal, among others).

The Global Fund's investments have enabled national programs to better understand the size of populations and prevalence through strategic information. At the end of 2016, the Global Fund invested in programmatic mapping and size estimates for key populations at risk to HIV. This resulted in 22 countries producing robust size estimates for transgender women and using it for program design. Further, due to Global Fund investments, of the 65 countries that have size estimates for key populations at the end of 2018, all except Jordan and Lebanon, have good quality size estimates for female sex workers based on a rigorous methodology. Having accurate size estimates allowed countries to invest more resources in focused programs. This notably contributed to increased investments in programs for female sex workers in Cuba, Eritrea, Papua New Guinea, Nepal, Cape Verde, Kenya, Cameroon and Bhutan in the 2017-2019 allocation period. This is against the backdrop of a decrease in the overall HIV allocation available for these countries for 2017-2019. Additional Integrated Bio-behavioral Survey (IBBS) and size estimation exercises are planned for key populations in 40 countries in the next two to three years.

3.5 Gender-Responsive National Plans and Strategies

Using sex and age disaggregated data is critical to knowing the epidemics and identifying who may be left out of critical services. However, it is equally critical to investigate why these disparities exist and how to address the disproportionate health risks and barriers to services. A gendered analysis of these risks and barriers is key. The Global Fund aligns to and supports the implementation of national strategies and plans in TB, malaria, HIV, health and community system strengthening, and related cross-sectorial plans such as sexual and reproductive health, gender-based violence, and adolescent health. If these plans are gender-responsive and address the inequities and inequalities that undermine successful programs, the Global Fund is a more efficient and effective investor. The Global Fund works closely with technical partners including UNAIDS, the RBM Partnership to End Malaria, and the Stop TB Partnership to develop and implement assessments and plans to address these gender and rights-related barriers to services.

UNAIDS finalized and disseminated the HIV Gender Assessment Tool (GAT) in 2014 and is supporting the process in more than 50 countries. An updated version of the GAT was relaunched in February 2019. The GAT supports a comprehensive process to identify the needs of women and girls in all their diversity and in the context of HIV at the country level. Countries use the compiled and analyzed information to elaborate and review strategic planning processes, increase the capacity of women's organizations, and leverage political commitment to address these needs. In many cases, the GAT informs both the National Strategic Plan and the Global Fund country dialogue and funding applications. In Chad, the Global Fund supported the roll-out of an HIV/TB gender assessment, which was used by the Country Coordinating Mechanism (CCM) and the writing team to articulate priorities for the funding application.

To support countries to identify gender and rights-related risks and barriers to services, the Global Fund supported the Stop TB Partnership to undertake community, human rights and gender (CRG) assessments in seven priority countries as part of a broader "Finding the Missing Cases" initiative. The countries included Democratic Republic of Congo (DRC), Indonesia, Mozambique, Myanmar, Pakistan, Philippines and South Africa. USAID supported CRG assessments in an additional seven countries.

Country partners are now developing CRG TB Costed Operational Plans to inform national strategies as well as future Global Fund funding requests. The CRG country assessments highlight that in contrast to the HIV response where more progress has been made in incorporating gender-related considerations into NSPs – gender-responsive policies, guidelines, and programming for TB are limited but could make programs more efficient and effective. In some countries, gender-disaggregated data have indicated that while more men who screen positively for TB do not reach diagnosis, more women are lost to follow-up between diagnosis and treatment. Knowing this kind of data helps implementers to design tailored programs that address the specific barriers to services that women and girls face.

With the RBM Partnership to End Malaria, the Global Fund developed and piloted the Malaria Matchbox – an equity assessment tool to determine who is being left out of malaria services, and how to better reach them. Niger was the first country to pilot the Malaria Matchbox. Malaria is endemic in Niger, with an estimated 7.7 million malaria cases in 2017 and 17,000 malaria deaths. The Global Fund currently supports the national malaria response with a US\$60 million grant through 2020. Through the equity analysis process, the National Malaria Control Program worked with the civil society organization Malaria No More and local communities to identify populations, including pregnant women and women in rural areas, that faced unique barriers to access health services. As a result, the country has created an action plan to better reach these populations and to integrate community participation in the malaria response. This includes hiring more female community health workers, as women were often not accessing health services due to gender norms and practices.

4. Women and Girls as Change Agents: Meaningful Engagement



The Global Fund's investment approach relies on affected communities being active players in the prioritization, design, and implementation of programs. The advent of the Country Coordinating Mechanism (CCM) was an innovation in country ownership of investment strategies, with the active involvement of all stakeholders including civil society and community actors. In the context where women, girls and gender non-conforming people face enormous gender-based inequalities, efforts to create a space and the possibility for their meaningful engagement requires sustained energy, capacity building and supportive policies.

4.1 Country Coordinating Mechanisms

Much of the Global Fund's success is in living the principle of country ownership. The CCM is a mechanism, grounded in stakeholder collaboration and participatory decision-making, for country level oversight and governance body for Global Fund grants. It includes representatives from both the public and private sectors, such as governments, multilateral or bilateral agencies, non-governmental organizations, academic institutions, private businesses and people living with and affected by the diseases. It is critical that the CCM's reflect the diversity of communities affected with

and responding to the diseases, including gender parity and diversity. In 2018, 43% of the CCM membership globally identified as female, and one percent as transgender. Some sectors are better at ensuring female participation, such as civil society which reaches 46% women, while faith-based representation is only 24% female.

Notably, the progress is also seen in the participation of transgender individuals in CCMs. As of 2015, there were 21 individuals who self-identify as transgender sitting on 17 CCM committees either in Latin America or Asia.¹² Improved data collection on trans issues, visible organizing efforts by trans advocates and the Global Fund support for prioritizing key populations contributed to the increased engagement of 35 transgender individuals participating in 23 CCMs across regions, including in Africa (Lesotho, Liberia, Mozambique, Malawi, Mauritius) and Eastern Europe (Belarus) as of the end of 2018.¹³

The Global Fund has worked with partners like UN Women, [Women4Global Fund](#) (W4GF) and the Network of Sex Work Projects (NSWP) to strengthen the capacity of diverse communities of women and girls to engage in CCMs. In addition to strong gender advocates and experts on the CCMs, community and civil society networks and organizations that support CCM representatives are essential to what CCM representatives can achieve. W4GF and NSWP have held seminars and trainings for constituents to explain the Global Fund and CCM process. These trainings had tangible results, such as community activists being nominated onto writing teams or becoming a CCM representative.

In South Sudan, a W4GF advocate who attended a workshop briefed the staff from the National Empowerment of Positive Women United on gender transformative programming and discussed how to involve more men in implementation. The advocate said: *“A strong request was made to the CCM to ensure more female CCM members given that we now know this is part of the CCM eligibility criteria and this was agreed to be addressed. I also discussed the representation of the different diseases, which is lacking in our CCM and it was agreed that both the TB and malaria constituency must elect male and female representatives.”* In 2018, this advocacy led the South Sudan CCM to request UNDP to support a gender training for all members focused on addressing gender inequities, with an emphasis on women and girls given the enormous gender-related inequalities.

4.2 Community, Rights and Gender Strategic Initiative – Country Dialogue and Beyond

The Global Fund has created processes and policies to amplify the spaces for the meaningful engagement of civil society and affected communities throughout the funding cycle. The country dialogue is a process meant to inform all aspects related to setting priority areas for funding request, as well as to the design, implementation, monitoring, reprogramming and close-out of grants funded by the Global Fund. The Global Fund policy requires that the CCM spend at least 15% of its budget in supporting the engagement of communities in the country dialogue process. This means that the role of communities goes beyond participating in the initial phases of funding cycle. Several other spaces, including the grant-making process as well as community-based monitoring initiatives, inform program quality and are critical to the success of Global Fund investments.

To promote meaningful engagement, particularly amongst the communities most affected by HIV, TB and malaria, the Secretariat launched the Community, Rights and Gender Special Initiative (CRG SI) in 2014. This was a three-year Secretariat-run program with the main goal of strengthening the meaningful engagement of civil society and community groups in Global Fund and related processes. In 2017, the program, renamed the CRG Strategic Initiative, was extended for another three years. Since its inception, the CRG SI has delivered more than 180 short community and civil

¹² Global Network of Transgender Women & HIV (IRGT). Most Impacted, Least Served: Ensuring the Meaningful Engagement of Transgender People in Global Fund Processes, 2015 p.10

<https://mpactglobal.org/wp-content/uploads/2016/02/Transgender-Engagement-in-Global-Fund-Process.pdf> page 10

¹³ The data is directly extracted from the CCM Hub’s database and is based on self-reporting which may be underestimated as a requirement to specify key population affiliation is not yet mandatory.

society-led technical assistance assignments across more than 50 countries eligible for Global Fund allocation; strengthened communication and coordination with civil society in six regions through the CRG Civil Society Platforms, and supported networks of key populations for HIV and affected communities for TB and malaria operating at the global and regional levels to build the capacity of their members to better engage with Global Fund-related processes.

The work of the CRG SI benefits both community constituencies and national programs to shape and drive a more responsive gender and human rights agenda in the fight against the three diseases. GNP+ receives funding to support the engagement and development of Women Living with HIV (WLHIV) networks given they are active constituencies within its network. This work includes adapting training tools to address the specific needs of WLHIV, providing trainings on Global Fund processes and advocacy, and convening community WLHIV forum in such countries as Jamaica, Indonesia, Pakistan, Uganda, and Ukraine.

The short-term technical assistance program has been particularly relevant to meaningfully engage communities in key processes that foster national commitment to strengthen gender-responsive policies and programs. In Zimbabwe, the support to Youth Engage and Katswe Sistahood was instrumental in facilitating the engagement of AGYW groups in the grant design process through convenings and consultations with youth-led and community-based groups, as part of the country dialogue process under the HIV/TB 2017-2019 allocation. The process led to the creation of an AYGW-led accountability framework to monitor and feedback the delivery of key interventions to reduce HIV incidence among AGYW in 30 districts.

In South Africa and Kenya, technical assistance focused on strengthening the knowledge of AGYW groups about national policies and processes that influence the design of programs funded by the Global Fund, as well as, on how they could engage in these processes. The consultations carried out with AGYW groups in Kenya and South Africa resulted in the elaboration of life skills and prevention packages of services that are tailored to AGYW specific needs and aspirations in those countries, essential for service adherence and program performance.

The 2014-16 CRG SI cycle also provided funds to support networks of HIV key populations to advance the capacity of their constituencies to engage with the Global Fund at national, regional and global levels. In the 2017-2019 cycle, there was an emphasis on invigorating networks of TB advocates in their fight to advance gender and human rights approaches that contribute to the global TB response. The African Coalition to Fight TB (ACT Africa) fosters a human rights and gender-responsive agenda to fight TB in countries that have the highest number of TB unreported cases in sub-Saharan Africa, namely DRC, Ghana, Kenya, Mozambique, Nigeria, South Africa and Tanzania. In those countries, ACT has placed important emphasis on raising community voices within National TB programs, training communities in the use of gender and human rights assessment tools, and related response planning, as well as advanced community – led strategies for finding missing people with TB – a key programmatic priority to the global health community in the fight to end TB.

The 2017-20 CRG SI cycle increased the allocation to networks of HIV key populations, in comparison to the previous cycle. From 2014 to 2016, the CRG SI provided approximately US\$ 140,000 in long-term capacity development of transgender-led global and regional networks. The 2017-20 cycle has increased this amount four-fold to support the consortia of transgender-led networks to deliver more targeted capacity development programs led by and for transgender advocates at global level.

4.3 HER Voice Fund

When the Global Fund committed to increasing investments in adolescent girls and young women (AGYW) to address the critical health risks they were facing, including HIV, there was a recognition that their intimate involvement in the programs was critical to success. HER Voice Fund was launched in November 2017 with an initial investment of US\$500,000 provided by the CRG SI. HER Voice Fund model is based on the provision of small grants to support AGYW-led groups and

organizations to overcome logistical, administrative and language barriers to participation in country processes linked or supported by Global Fund investments. AGYW have a vital role to play in driving and shaping the HIV response. Their experiences and needs must be central to policy making, program design and implementation. Regionally based civil society networks Southern African AIDS Trust and Eastern Africa National Network of AIDS Service Organizations (EANNASO) were contracted to manage the fund, and launch a leadership and outreach program with HER Voice Ambassadors.

Since its launch, HER Voice Fund has given 195 small grants of up to US\$2000 to AGYW networks and AGYW-led organizations in all 13 AGYW focus countries. The grants supported communities to raise their voices to influence national level policies and programs that impacted them. Most of the grants were used in activities related to advocacy, participation, community mobilization and consultations. The Facilitators of Community Transformation (FACT), a youth network based in Malawi is one of the several beneficiaries of HER Voice Fund. With small grant support, the network organized consultations with AGYW groups, in collaboration with the CCM, to discuss the design of AGYW clubs, one of the key interventions funded by the Global Fund grant. The network also prepared AGYW groups to participate in an annual civil society forum about Global Fund processes. As a result, more than 500 young women and girls engaged on the I-Speak out campaign of the Global Fund to ensure accountability and transparency of Global Fund Grant implementation processes.

“HIV/AIDS is the leading cause of death among adolescents and young people in Kenya. It has been proven that young women are the ones mostly affected by this because their voices are not heard when it comes to making decisions concerning their bodies. For this reason, I believe that investing in women today is investing in our future in combating the spread of HIV/AIDS, because we cannot win this war when some of us are held back.” Beverly Mutindi, 23, HER Voice Ambassador in Kenya

HER Voice Ambassadors became the face of HER Voice Fund. Youth activists were identified in each of the 13 countries and tasked to engage in advocacy and mobilization of their peers, not only focused on HER Voice Fund itself, but also on overall policy engagement in national policies affecting adolescent health. While working with local networks and peers, ensuring that their voices are raised, these young women also engaged in high level advocacy by actively participating in meetings with authorities, as well as regional and global gatherings.

5. No Women or Girl Left Behind: Investing in People



To reach our shared targets, programs must serve those that are most vulnerable to HIV, TB and malaria. In many contexts, poverty, gender discrimination, criminalization and other factors keep women and girls out of services and increase their risk. Across the three diseases, the Global Fund tailors prevention and treatment programs to sub-populations, and supports respectful, comprehensive services that help them to live healthy lives, often in difficult circumstances. Below are some examples of how we are supporting diverse communities to protect and advance their health and access to services.

5.1 Transgender Women

The risk of acquiring HIV is 13 times higher for transgender women than adults aged 15–49 years.¹⁴ The lack of more specific data, failure to record genders other than male and female, and other issues related to data collection system are associated with the violence, stigma, and discrimination experienced by this population, as well as a long-standing failure by the public health community to recognize transgender and gender non-conforming women as a population distinct from men who have sex with men (MSM). Most importantly, transgender women are still not officially recognized

¹⁴ UNAIDS. Miles To Go: Closing Gaps, Breaking Barriers, Righting Injustices. Global AIDS Update 2018, p.14
https://www.unaids.org/sites/default/files/media_asset/miles-to-go_en.pdf

by many countries outside Latin America and Asia-Pacific and therefore they remain without packages of services designed to meet their needs.

The Global Fund is one of the key donors for transgender women. In the 2017-2019 allocation period, of all countries where the Global Fund operates, 49 countries are implementing a specific program for transgender people through Global Fund's support. Noticeably, West and Central Africa (Cameroon, Cote d'Ivoire, DRC, Benin, Mali, Sierra Leone, Liberia) and Eastern Europe and Central Asia (Ukraine) are starting to invest in the delivery of combination HIV prevention and differentiated testing for transgender women, whilst continuing to strengthen data systems to better understand risks, vulnerabilities, prevalence and size of transgender populations (e.g. through IBBS and programmatic mapping and size estimates).¹⁵ Sizeable investments for transgender programming are observed for South Africa, Indonesia, Nicaragua and Jamaica bringing a combined investment of US\$17 million for these 4 countries alone in 2017-2019 allocation.¹⁶

The Global Fund resources also catalyzed the development of service packages specific to transgender women as part of the national disease plans and funding request to the Global Fund. Out of 65 countries assessed, 24¹⁷ have identified transgender women as a key population in the national plans, 18 of which recognize the importance of comprehensive packages for transgender people (e.g. male condoms, lubricants, IEC, BCC, HTC, ART, STI, Hepatitis and TB services). Global Fund investments also contributed to the development of robust data systems to track services across the prevention and treatment cascade. Finally, Global Fund resources are used to support demand generation for program services either by strengthening of transgender-led, community groups or NGOs delivering services for transgender people. Sri Lanka, Nicaragua, Nepal, Bangladesh, and South Africa all included specific support to address stigma, discrimination and human rights violations (including gender-based violence) as part of the service package for transgender populations in the Global Fund-supported program (2017-2019).

In Indonesia, the Global Fund PR provides HIV services for transgender women or *Waria*. The package of services for *Waria* includes condoms, lubricant, IEC brochures, and HIV and STI testing referrals. It is important to note that many of the organizations that provide services to the *Waria* population also provide services to the population of men who have sex with men. Many of the implementation details and challenges are similar, however, the needs of *Waria* are not the same as those of men who have sex with men and many *Waria* face difficulties in completing school education and finding work due to high levels of stigma, discrimination and violence. There is also significant variation in risk context, needs and vulnerability within *Waria* populations. Additional interventions (psycho-social, legal aid, sensitization of law enforcement, among others) are also being implemented to address barriers to services for *Waria*.

5.2 Female and Transgender Sex Workers

The risk of acquiring HIV for female sex workers is 13 times higher than adult women aged 15-49 years.¹⁸ This increased risk sex workers face is due to unsafe working conditions and barriers to protecting their own health such as the ability to negotiate condom use. The stigma, discrimination

¹⁵ Notes and limitations: Data can only be tracked for interventions that align with the way countries submit their funding applications, and the Secretariat cannot account for the different approaches to naming and budgeting various activities. All data is from 2017-2019 funding cycle, unless otherwise indicated. The Secretariat has worked to verify all data presented, but there may inadvertently be some errors and variances from the actual budgets being implemented.

¹⁶ It is important to note that it was not possible previously to disaggregate investment data in men who have sex with men and transgender persons in the 2014-2016 allocation period, thus data is unavailable for comparison. Data mentioned is retrieved through Global Fund information system (GOS) as of March 2019. The amount is indicative and only includes direct investment in the HIV module Comprehensive HIV program for transgender, excluding any cost related to program management.

¹⁷ 10 in Asia-Pacific, 2 in Eastern Europe and Central Asia, 3 in East and Southern Africa, 9 in Latin America and the Caribbean.

¹⁸ UNAIDS. Miles To Go: Closing Gaps, Breaking Barriers, Righting Injustices. Global AIDS Update 2018, p.14

https://www.unaids.org/sites/default/files/media_asset/miles-to-go_en.pdf

and violence faced by sex worker communities puts them at increased risk to HIV and keeps them out of the services that could help them to protect themselves from the virus. All too often, the people entrusted to protect their safety and health, such as police and health care workers, are the very perpetrators of these human rights abuses.

Only 62 countries have provided population size estimates for sex workers. Amongst these, the HIV prevalence varies widely from 0.3% in Afghanistan and Bangladesh, to 24.2% in Mali, 24.3% in Cameroon and 71.9% in Lesotho. HIV prevalence is also recorded extremely high in South Africa (57.7%), Botswana (61.9%), and Uganda (34.2).¹⁹ Countries have recognized the severe health risks facing sex workers, and many have developed national packages and strategies to support programs. The coverage rates, whereby countries are providing a defined package of prevention services, vary from 98.4% in Cambodia and 86.5% in the Seychelles to 0.7% in Pakistan and 6.7% in Cameroon.

The Global Fund is investing in comprehensive HIV services for female and/or transgender sex workers in 83 countries in the 2017-2019 funding cycle, representing an increase from 69 countries in the previous funding cycle. Egypt, Solomon Islands, Kazakhstan, Namibia, and Guatemala saw the Global Fund either starting or returning to invest in prevention programming for female sex workers

South Africa, Nigeria, Cameroon, Indonesia, Myanmar and Kenya are the countries with the largest Global Fund investments in sex worker programs, with a total investment of US\$53.3 million in the 2017-2019.²⁰ In these countries, services target mostly female sex workers with health- and non-health sector interventions aligned with the WHO recommended comprehensive package. Programs also reach clients of sex workers. For instance, in Mozambique the Global Fund-supported program includes truck drivers along the border and provides them with condoms, lubricants, risk reduction interventions, interventions to address gender norms and gender-based violence as well as linkages to HIV and STI testing.

5.3 Women Who Use Drugs

The Global Fund is the largest funder of harm reduction programs in the world, investing over US\$250 million on interventions over the last allocation period. Like other female key populations, women who use drugs remain a hidden, under-counted and under-served population even in contexts where extensive harm reduction services exist. Few countries report sex-disaggregated data to UNAIDS on people who inject drugs, but most of publicly available data suggest that women who inject drugs have a greater vulnerability than men to HIV, hepatitis C and other blood-borne infections.²¹ In 16 of the 21 countries that reported such data since 2013, women who inject drugs were more likely to be living with HIV than their male peers. In Uganda and Uzbekistan, HIV prevalence among women who inject drugs was almost twice as high as among their male peers.²² Women who use drugs may be engaging in selling or exchanging sex, may be pregnant or needing sexual and maternal care, and are often facing extremely high levels of violence, including intimate partner violence and police violence. They face double discrimination from care providers, that of being a woman, sometimes a mother, who uses drugs.

In a sub-set of countries, the Global Fund is supporting specific programs to target the needs of females who use drugs. In Georgia, Kenya, Myanmar, Nepal and Ukraine, for example, the Global Fund is supporting drop-in centers and safe spaces for women using drugs – in addition to integrating

¹⁹ UNAIDS Key Population Atlas <http://www.aidsinfoonline.org/kpatlas/#/home>

²¹ World drug report 2018. Vienna: UNODC; 2019 (<https://www.unodc.org/wdr2018/>, accessed 18 February 2019). <https://www.unaids.org/en/resources/fact-sheet>

²² Health Rights and Drugs: Harm Reduction, Decriminalization and Zero Discrimination for People Who Use Drugs. Geneva: UNAIDS 2019. <https://www.unaids.org/en/resources/fact-sheet>

gender-responsive services into mainstream harm reduction and HIV care. In Georgia, the Global Fund supports harm reduction sites for female drug users that provide case management as well as legal support, sexual and reproductive health services, PMTCT, psycho-social support, and linkages to community-based health professionals (gynecologist, addictology specialist, STI specialist, psychologist, infectious disease specialist, etc.). A group of the mainstream harm reduction services adjusted their operation to be more attuned to the concerns and needs of women: methadone treatment sites were reorganized to ensure that female drug users have a separate entrance, and the needle and syringe program sites adopted special hours to serve female IDUs.

5.4 Adolescent Girls and Young Women

In many countries, HIV infections remain extremely high among adolescent girls and young women. Despite great progress made against HIV globally, adolescent girls and young women continue to be disproportionately affected by the epidemic, especially in sub-Saharan Africa. In 2017 it is estimated that every week, around 7000 young women aged 15–24 years become infected with HIV.²³ In sub-Saharan Africa, the region most affected by HIV, three in four new infections among adolescents aged 15-19 years are in girls and young women aged 15–24 years are twice as likely to be living with HIV than men. Similarly, the HIV prevalence among girls and young women is as much as 5-14 times higher and age at incident infection about 5–7 years earlier than their male counterparts.²⁴ Human rights and gender-related barriers, including gender inequalities and gender-based violence, drive new infections and reduce uptake and retention of health services. In some countries in Africa, young women aged 15-24 are up to five times more likely to be HIV positive than young men.

The Global Fund is currently investing more than US\$200 million dollars, mostly in sub-Saharan Africa, to support national, cross-sectorial responses to reduce health risks for adolescent girls and young women. In the 13 countries with catalytic funding for AGYW, these investments will reach nearly 1,000,000 girls with comprehensive HIV, GBV, Sexual and Reproductive Health, and empowerment programs over a 3-year period.²⁵ Tied to these investments, the Global Fund has set a target to reduce the number of new HIV infections among adolescent girls and young women by 58% by 2022. A significant share of overall investments targeted at adolescent girls and young women have been allocated to interventions relating to comprehensive sexuality education, keeping girls in school, reducing gender-based violence, livelihood and economic empowerment interventions such as vocational skill training and savings groups.

Importantly, the Global Fund is working with countries to ensure that they adopt sustainable and cross-sectorial strategies to address and finance AGYW interventions. In Botswana, Global Fund investments towards HIV prevention programs for AGYW amount to US\$2.3 million and support 5 districts and cut across social protection, service delivery, social and sexual behavior change as well as social norms change. The package of interventions is derived from the national package and as such, a core package is specified per age group, and made available to adolescents and youth populations in-school and out-of-school; with the core being given to all, and the 'layered' interventions being offered against need.

²³ UNAIDS. AIDSinfo <http://aidsinfo.unaids.org/>

²⁴ UNAIDS. AIDSinfo <http://aidsinfo.unaids.org/>

²⁵ The 13 countries are Cameroon, Uganda, Kenya, Tanzania, Malawi, Mozambique, Zambia, Zimbabwe, Botswana, Namibia, Eswatini, Lesotho and South Africa.

5.5 Women and Girls Living with HIV

UNAIDS estimates that 19.1 women and girls live with HIV, or more than half of the global population of people living with HIV.²⁶ There are an estimated 18.2 million girls and women aged 15 years and older living with HIV who need to be supported to stay on treatment and meet their reproductive and sexual health needs.²⁷ Women living with HIV are five times more likely than women without HIV to develop cervical cancer. To date, Global Fund investments in cervical cancer have been guided by the co-morbidities policy, as well as national policy guidelines. A key strategy has been to foster innovative partnerships with national and global partners such as Gavi, UNICEF and WHO to ensure that comprehensive GBV prevention, screening and treatment programs are available, particularly for women living with HIV. In Zambia, Malawi and Tanzania, the Global Fund invested to integrate cervical cancer screening in HIV and broader RMNACH programs, including support to training of service providers and their supervision. In Zambia, these investments led to an expansion of cervical cancer screening to more than 100,000 women or 28% of women living with HIV, over a period of five years.

Many people living with HIV face challenges with adherence. There are many reasons that women and girls may stop taking their HIV medication, including fear of discrimination and violence. The Global Fund has increased funding to treatment adherence programs, particularly in countries with a focus on services for AGYW. In Lesotho, Global Fund worked with PEPFAR, Sentebale, and Skillshare to support the Baylor Center to provide community and clinical adherence support options to adolescents living with HIV. In addition to the clinical care, adolescents are grouped into clubs according to their individual needs, age and circumstances. With regular meetings, the clubs provide a safe space for sharing, caring, and psychosocial support through the development of supportive relationships and sustainable social networks. In turn, this supports medication adherence and management of side effects and psychosocial trauma and/or depression. It also ensures regularity of dispensing and uninterrupted access to medication regardless of stock-outs. Attendance of community or facility-based adherence groups has been linked with positive change in health outcomes associated with improved ART adherence and secondary outcomes. This includes, for example, school retention of adolescents living with HIV and pregnant adolescents.

The global commitment to prevent vertical transmission has had tremendous results: 80% of pregnant women living with HIV in 21 priority countries received services.²⁸ In 2017, Global Fund investments meant that 696,000 women received PMTCT services, over 30 million women reported knowing their HIV status, almost 6 million pregnant women attending antenatal clinics received intermittent preventive treatment for malaria, and over 2.2million girls and women were provided with HIV care and support services. The Global Fund is currently investing in PMTCT in 64 countries and has invested more than US\$315 million since 2014.

²⁶ UNAIDS. Women and HIV: A Spotlight on Adolescent Girls and Young Women. UNAIDS, 2019.

https://www.unaids.org/sites/default/files/girls-and-women-living-with-HIV_en.pdf

²⁷ UNAIDS. AIDSinfo. <http://aidsinfo.unaids.org/>

²⁸ WHO. Progress Report 2016: Prevent HIV, Test and Treat All. Geneva, Switzerland: World Health Organization; 2016

6. Systems for Health that Meet the Needs of All Women and Girls



Women are central to the HIV, TB and malaria responses – not as populations that need to be targeted, but as agents that drive change. They play crucial roles as community leaders and advocates, in knowledge dissemination, service delivery and as caregivers. They are NGO leaders, community health workers, peer educators, nurses, doctors, program managers and technical assistance providers. Women are the power and change agents for health - seven out of ten health and social workers globally are women. Progress on resilient and sustainable systems for health and universal health coverage cannot be made without consideration of the gendered aspects of the workforce.

The Global Fund has invested over US\$7 billion since 2014 to improve health systems, and in the 2017-2019 grant cycle, more than seven percent of Global Fund investments went to provide comprehensive sexual and reproductive health care, not including the cost of HIV treatment.

6.1 Person-Centered Services for Women and Children

The Global Fund recognizes that resilient and sustainable systems for health (RSSH) which are able to respond to emerging epidemics and provide more integrated, people-centered health services²⁹ are fundamental to fostering healthy, prosperous and stable communities. This is clearly articulated in the Global Fund 2017-2022 Strategy and is critical for achieving disease-specific goals, as well as helping countries and communities improve a broader set of health outcomes including achieving universal health coverage (UHC). Systems for health, differently from health systems, do not stop at a clinical facility but run deep into communities and can reach those who do not always go to health clinics, particularly the most vulnerable and marginalized which includes women and children.

Systems for health focus on people, not issues and diseases. There is now a push to accelerate the directional shift in investments from parallel, disease-specific delivery modalities to the delivery of integrated health services that place the individual at the center of care. Community participation must be a foundational principle of UHC and therefore active engagement of women and adolescent girls in the conceptualization, design, implementation and monitoring of programs are critical contributions to improved health outcomes.³⁰

In practice, this means ensuring that efficient and effective health care services are designed and provided through innovative models of care that prioritize primary and community care services. This encompasses the shift from inpatient to outpatient and ambulatory care and from curative to preventive care for women and children. As Global Fund understanding continues to evolve, we view formal health systems and community systems not as separate silos but as two evolving, dynamic subsystems, that interact and complement each other in a myriad of ways as part of one overall ecosystem for health. The Global Fund supports diverse types of community responses from those closely linked with the formal health system to those fully self-directed. This includes cadres of community health workers, as well as community-led and community-based organizations and groups, including those representing women, AGYW and key populations.

For example, with support from Global Fund, antenatal clinics in Kenya serve as ‘one-stop shops’ for pregnant women to address their healthcare needs, including sexual and reproductive health and cervical cancer screening. Integrating services is critical to advancing the continuum of care, from pregnancy and delivery for women, to childhood and adolescent care. It has positive effects across the services provided and can improve coverage and the effectiveness of services. Similarly, in Afghanistan, the Global Fund supports health and community workforce development through building capacity of female community health nurses. This workforce supports scaling-up the provision of a basic package of health services, including HIV, TB and malaria and maternal and child health services for women and girls who otherwise could not access health services unless they were escorted by male family members. The Global Fund’s investments in Afghanistan aim to increase access to services for vulnerable populations and to improve the quality of care.

6.2 Nexus of Education and Health

According to UNESCO estimates, 130 million girls between the age of 6 and 17 are out of school, and 15 million girls of primary-school age – half of them in sub-Saharan Africa – will never enter a

²⁹ Integrated health services are health services that are managed and delivered so that people receive a continuum of health promotion, disease prevention, diagnosis, treatment, disease-management, rehabilitation and palliative care services, coordinated across the different levels and sites of care within and beyond the health sector, and according to their needs throughout the life course. To complement this, people-centered care is an approach to care that consciously adopts individuals’, carers’, families’ and communities’ perspectives as participants in, and beneficiaries of, trusted health systems that are organized around the comprehensive needs of people rather than individual diseases, and respects social preferences. (WHO framework on people-centred and integrated health services, Service Delivery and Safety, WHO – HQ. Available at: <https://www.who.int/servicedeliverysafety/areas/people-centred-care/en/>)

³⁰ WHO. Towards a Global Action Plan for Healthy Lives and Well-Being for All. 2018

classroom.³¹ A World Bank study found that every year of secondary school education is correlated with up to a 10% increase in a girl's future earning power.³² The nexus of education and health is both a challenge and an opportunity. Every child should have the opportunity for a quality education, and schools must be an enabling and supportive environment for promoting health and well-being. This way, schools are important platforms for delivering health-care services and information.

The most common school-related investments that the Global Fund makes are programs to support girls to stay in school (13 countries, all AGYW catalytic funding focus countries), and comprehensive sexuality education (CSE) in 38 countries. The approaches countries take to keep girls in school vary, but there are some commonalities. Most countries support schools to provide sanitary pads and dignity packs, which provide essential commodities for feminine hygiene, so girls don't miss school when they are menstruating. Eight of the countries are funding educational subsidies. Countries implement locally relevant approaches to support girls to stay or return to school. One country used Global Fund investments for workshops to orientate teachers and social workers on how to support girls whilst pregnant and in school and once they have delivered and returned to school.

CSE is a curriculum-based process to equip children, adolescents and young people with knowledge, skills, attitudes and values to protect their own health and consider how their actions impact on the health and well-being of others.³³ CSE is critical in the preparation of young people for a safe and productive life as they overcome barriers and challenges dealing with HIV or pregnancy as well as violence and various forms of gender discrimination and inequities. Generally, CSE programs benefit boys and girls between the ages of 10-24 years, in school, out of school and in tertiary institutions. Additionally, parents, caregivers and the broader community are also reached. Other activities include delivery of CSE through peer educators, distribution of information, education and communication materials, use of mobile health applications and media platforms, community dialogues, delivery of CSE through adolescent friendly and youth friendly centers and debates on the CSE topic among others.

6.3 Addressing Sexual and Gender-Based Violence for Women in All Their Diversity

Sexual and gender-based violence (SGBV) refers to any act that is perpetrated against a person's will and is based on gender norms and unequal power relationships. Sexual and gender-based violence is one of the worst forms of human rights violations, which is linked to increased HIV risk amongst SGBV survivors, as well as HIV positive women facing a greater threat of violence. Men, women, boys, girls and gender-non-conforming communities all suffer SGBV. However, evidence shows that women, children, and transgender communities bear the overwhelming brunt of gender-based violence. In 2006, the World Health Assembly declared violence against women a "leading worldwide public health problem"; an estimated one in every three women in the world is likely to experience violence in her lifetime, mostly by an intimate partner.³⁴

Addressing harmful cultural norms and inequalities are necessary structural interventions to reduce and prevent violence. Once violence has occurred, emergency and health care providers must be equipped with how to support violence survivors, including availing HIV testing and post-exposure prophylaxis (PEP). Survivors must also be linked to psycho-social support and counselling. The Global Fund is investing more than US\$25 million in 37 countries to support gender-based violence prevention and treatment services for women, children and transgender communities. The biggest proportion of this investment, more than US\$15 million dollars, is in violence prevention programs

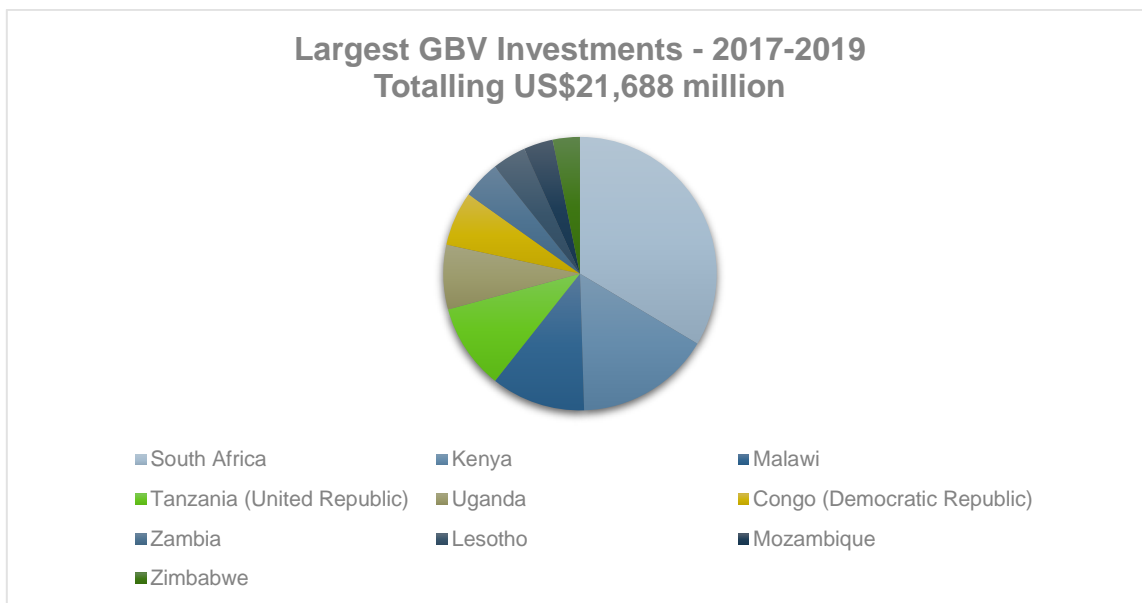
³¹ <https://blogs.worldbank.org/voices/build-brighter-future-invest-women-and-girls>

³² Education counts: towards the Millennium Development Goals. UNESCO. 2010
<https://unesdoc.unesco.org/ark:/48223/pf0000190214>

³³ UNESCO (2017) Guidance: International Technical Guidance on Sexuality Education: An Evidence Informed Approach

³⁴ WHO website: Supporting Elimination of Gender Based Violence <https://www.who.int/westernpacific/activities/supporting-elimination-of-gender-based-violence>

for in-school and out of school adolescents. Ten countries account for 83% of the Global Fund’s investments in SGBV, with South Africa making the largest investment to address SGBV at more than US\$7 million in the HIV grant.



Since 2016, the Global Fund has funded a project focused on adolescent girls and young women in two provinces of DRC – Kinshasa and Kasai Oriental – with the aim to reduce HIV prevalence and gender-based violence (GBV). The project seeks to change behaviors and reinforce gender equality in the community by creating safe environments in schools and communities where all students, teachers and community members are sensitized to the issues of GBV, HIV and sexual and reproductive health. The program also improves the delivery of adolescent responsive health services in 30 health centers through an approach called "collaborative learning". The Global Fund, WHO, the National Program against HIV and the National Program for Adolescent Health are working to strengthen the skills of health providers to meet the specific needs of adolescents and create an environment for ongoing learning, problem-solving and peer support.

6.4 Human Rights and Gender-Responsive Approaches in Health Care Settings

Bringing services to people in communities is a critical approach to reducing barriers to care. However, this doesn’t diminish the importance of ensuring that clinics and other health care settings are places where everyone can access quality care. Discrimination in health care settings keeps women and girls – particularly those that are marginalized or criminalized such as adolescent girls, transwomen, sex workers, migrant women, women who use drugs and women living with HIV – out of services. To address this issue the Global Fund has increased funding to decrease discrimination and increase the quality of care by training care providers in human rights and ethics. For example, in Uganda, the Global Fund supported the community-based organization Uganet to provide human rights and medical ethics training for 450 health workers, with a focus on young key populations.

7. Strengthening Partnerships and Innovative Collaboration



The impact of the Global Fund on the well-being of women and girls relies on robust and innovative partnerships at national, regional and global levels and across sectors. In all countries where we work, the national governments are an essential partner. Their leadership and ownership of Global Fund investments is the foundation of our strategy. The Global Fund also enjoys a broad spectrum of other partnerships, including community members and community-based organizations, civil society, UN and other technical partners, academia, private sector, religious communities, and bilateral donors. Below are some examples of how these partnerships have contributed to the Global Fund's impact for women and girls.

7.1 Civil Society Accountability – Women4GlobalFund

The Global Fund supports and partners with a wide range of civil society organizations and networks. The CCM and country dialogue process count on the meaningful participation of civil society actors, and many of the grants at country level are implemented by civil society organizations. As already noted, the CRG Strategic Initiative provides direct funding to civil society networks and organizations to build their capacity to engage with Global Fund related processes.

However, at the regional and global level, the Global Fund also relies on civil society organizations and networks to hold us accountable to our shared commitments. The civil society network Women4GlobalFund (W4GF) works with the Global Fund as an interface with women and girls in all

their diversity³⁵. Many of these women are leading Global Fund community related work and discussion in their own countries. In 2018 and 2019, W4GF worked with the Secretariat to organize a monthly webinar series on pertinent topics, which enabled community members to engage directly with the Secretariat and receive updates on relevant policy and program issues. W4GF has also developed a community-based monitoring and accountability feedback toolkit to support communities to track and review the impact of national programs and services supported by the Global Fund. This was adapted from technical assistance work provided by the CRG SI. W4GF is supported by ViiV Healthcare to bring together women’s rights advocates, especially women living with HIV, and directly affected by TB and malaria — to advance gender equality through the Global Fund. Community-based monitoring is a means for service users and/or local communities to gather, analyze and use information to improve access to and quality of services on an ongoing basis. This can include monitoring human rights or gender related-barriers to accessing services as well as barriers related to service delivery, governance, budget tracking, performance-based financing, domestic financing and procurement and supply chain. It can be focused on a specific area such as the quality of programs for adolescents.

Given that the Global Fund has no country presence, strategic partnerships and strong capacity of women are critical to ensure impact and investment that promotes and protects human rights and gender equality. This is the bedrock of effective programming. It is essential that women from diverse communities and constituencies are empowered and able to provide effective oversight of programs and their quality that are supported by the Global Fund, in a transparent and systematic manner.

The W4GF Accountability Toolkit (dependent on funding) will be rolled out in three AGYW focus countries to provide qualitative data to implementers on whether they are fulfilling the rights and meeting the needs of women and girls in all their diversity and what they could do to improve services and programs.

7.2 Bringing the Know-How: Technical Partnerships with UNICEF and WHO

In an effort to ensure the quality of the scale-up of programs for adolescent girls and young women in the 13 focus countries, the Global Fund has worked closely to align with the ground-breaking work of PEPFAR/DREAMS. In addition, to ensure the program quality of grants, Global Fund works with UNICEF and WHO to deploy direct technical assistance to Global Fund implementing partners. This supported inclusion of evidence-informed interventions and approaches in funding requests and grant implementation plans, implementation program review/research, and disseminating evidence and good practices.

Through the Global Fund Strategic Initiative for RSSH – “Technical support, south-to-south collaboration, peer review and learning”, which seeks to support health systems and effective HIV, TB and malaria programming, the Global Fund has signed a joint Memorandum of Understanding (MoU) with UNICEF and WHO. The MoU has a specific component that aims to provide technical assistance and strengthen quality design and implementation of grants as well as integrate implementation science and document lessons across the focus countries on addressing the needs of adolescent girls and young women.

³⁵ Women in all our diversity are those of us who are engaged at global; regional and national levels in Global Fund processes and structures in key regions most affected by HIV, TB and malaria. We are not homogenous, and we include women living HIV, affected by TB and malaria; heterosexual; lesbian and bisexual; transgender; women who use drugs; sex workers over 18 years old; adolescent girls and young women; Indigenous; sometimes displaced; migrants and are/have been incarcerated; and women with disabilities.

7.3 Private Sector Partnerships

The Global Fund launched “HER” (HIV Epidemic Response) at the World Economic Forum in Davos in January 2018, as a collective effort to involve and leverage commitments of the private sector to combat HIV among adolescent girls and young women in support of the Global Fund Strategy 2017-2022. Private sector partners have a unique capacity to mobilize additional resources for programs including funding, and to infuse skills, insights, solutions and financing mechanisms to increase program performance. They also fulfil a key role as advocates for the Global Fund, amplifying awareness for the three diseases and related causes vis-à-vis governments, other partners and influencers, and the wider public. HER aligns with the 13 AGYW focus countries and brings operational support along with financial contributions. Current partners include (RED), Standard Bank, The Coca-Cola Company, Unilever, and ViiV Healthcare (ViiV).

Since its founding, (RED) and its partners have generated more than US\$600 million for the Global Fund, investing in smart, innovative HIV/AIDS programs that help empower and support young women and girls. As part of their partnership with (RED), Durex has committed a minimum of US\$5 million to the Keeping Girls in School program in South Africa. To combat the increasing rates of new HIV infections and unwanted pregnancies, this program provides lifesaving sexual reproductive health education and services to young women and girls in South Africa and supports school retention. (RED)’s partners like Durex understand that continuing to invest in women and girls is crucial to ending AIDS by 2030.

Through its Positive Action programs, ViiV supports community-led responses around the world that are aiming to tackle the HIV epidemic in their local communities. As a HER partner, ViiV will co-invest over a three-year period financing and capacity building of AGYW groups to improve programmatic effectiveness, strengthen participation in Global Fund country processes and build the capacity of organizations and networks of young women, primarily in partnership with the HER Voice Fund. ViiV will also mobilize networks of community-based organizations to engage in the Global Fund processes at country level and encourage youth-led innovations to increase uptake of HIV and SRHR services.



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