

# Technical Evaluation Reference Group

## **Position Paper – Adolescent Girls and Young Women and HIV March 2018**

### **Executive Summary**

#### **Context**

In 2008, the Global Fund committed to ensuring gender equality in its response to HIV/AIDS, tuberculosis and malaria<sup>1</sup>. Presently, through Strategy 2017-2022 and its third strategic objective in particular, the Global Fund has resolved to advance programming on women and girls. Due to this special interest, the Technical Evaluation Reference Group (“TERG”) commissioned a thematic review in 2017 focused on adolescent girls and young women (“AGYW”) and HIV<sup>2</sup>.

#### **Conclusions**

- A. The Review found that while progress has been made (especially in the Global Fund’s thirteen AGYW focus countries<sup>3</sup>), gaps and weaknesses remain in relation to programming at country-level to address HIV risk and services for adolescent girls and young women. The gaps and weaknesses identified can put achievement of the operational objectives, and the strategic thinking behind these, at a significant risk.
- B. To address this, the TERG recommends i) promoting the needs and inclusion of AGYW in designing and implementing Global Fund supported programs; ii) encouraging evidence-based responses to be delivered at scale; and iii) championing AGYW issues, while addressing challenges and building capacity within the Secretariat.

#### **Input Received**

The Review has been initiated and prepared with detailed contributions from the Community, Rights and Gender Department of the Global Fund.

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<sup>1</sup> [GF/B18/DP18](#)

<sup>2</sup> HIV/AIDS still drastically and disproportionately affects AGYW, especially in sub-Saharan Africa. Therefore, the TERG decided to focus the thematic review to assess the design and implementation of gender-responsive programming of AGYW and HIV at country level.

<sup>3</sup> Lesotho; Malawi; Namibia; Swaziland; Tanzania; Zambia; Zimbabwe; Mozambique; Botswana; South Africa; Uganda; Kenya; Cameroon.

# TERG Position Paper

1. Within the context of the Global Fund Strategy 2017-2022, the TERG commissioned a thematic review focused on AGYW and HIV. The Review built upon the 'Rapid Review of the current frameworks for implementing the Strategies - the Gender Equality Action Plan 2014-16 and Key Populations Action Plan 2014-17' that was commissioned by the Community, Rights and Gender Department of the Global Fund in 2016.

Despite the global gains in HIV, AGYW, especially those in sub-Saharan Africa, are still drastically and disproportionately affected. As per UNAIDS estimates in 2016, the number of new HIV infections among AGYW in sub-Saharan Africa remains exceptionally high (figures 1 and 2). In 2015, 450,000 new infections occurred among AGYW aged 15 to 24 years, which translates into 7,000-8,000 new infections per week.

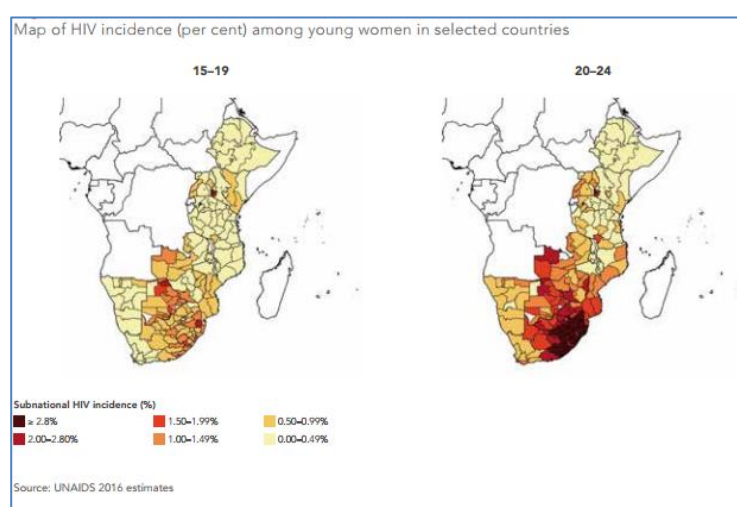


Figure 1. Map of HIV incidence in AGYW in selected countries in sub-Saharan Africa (UNAIDS 2016)

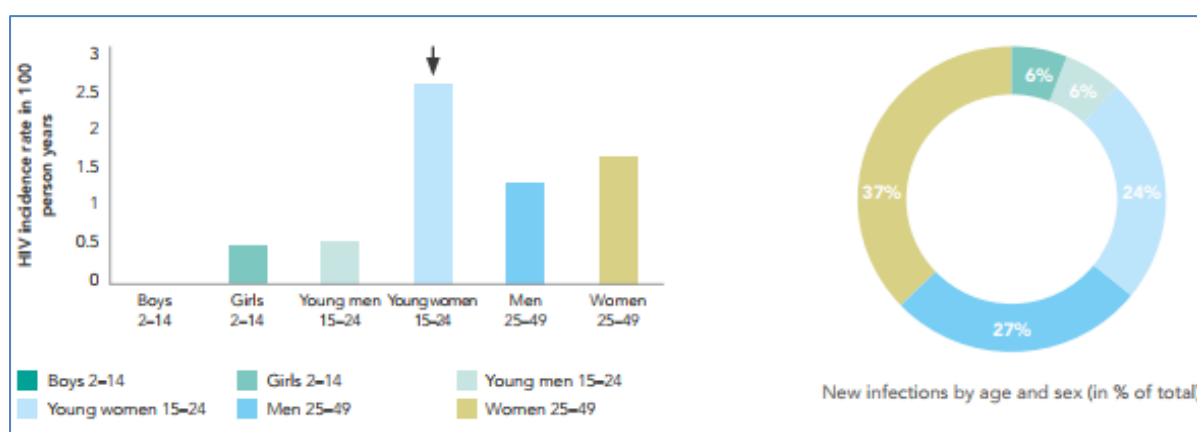


Figure 2: HIV incidence rates in different age/sex groups and their contribution to the total number of new HIV infections in South Africa (UNAIDS 2016)

Global Fund investments to achieve gender equality and address barriers have increased over time. The TERG commends the Global Fund for supporting a focus on AGYW, most recently,

through the HER initiative<sup>4</sup>. Despite the progress, serious gaps and weaknesses remain at the country-level in relation to use of sex and age disaggregated and population-based data, and program implementation.

## **What is the status?**

2. The TERG generally agrees with the findings and recommendations of the Review. The Prospective Country Evaluations, commissioned by the TERG, will complement this Review by applying a gender lens in the eight evaluation countries to further assess and monitor the extent and quality of gender-sensitive interventions included in Global Fund supported programs.

## **What are the findings and conclusions of the Review?**

3. The Review conducted global and country-level assessments to evaluate plans, policies and programs related to AGYW and HIV, and the extent to which AGYW-related interventions have been designed and implemented in accordance with AGYW's needs. The Review also included a comparison of the above between the developments of funding requests for the 2014-2016 vs 2017-2019 allocation periods.

The findings of the review were grouped into four themes, as given below.

### **Theme 1: How inequality faced by AGYW is addressed in respective country programs:**

- The legal institutional framework to promote gender equality exists in many of the review countries, but lacks mechanisms for practical implementation.
- Potential inequalities faced by AGYW are poorly understood, documented and addressed by respective country programs.

### **Conclusion:**

- Recognizing inequalities and translating gender-sensitive policies into programs to assist AGYW and program operationalization is a challenge in many countries.

### **Theme 2: How gender equality principles are identified and reflected in Global Fund grant designs and country processes:**

- There is a lack of analysis of gender-related issues in the assessed National Strategic Plans and funding applications. Although AGYW needs are better addressed in funding requests for the 2017-2019 allocation period (compared to those for the 2014-2016 allocation period), gender analysis remains inadequate with no age-disaggregated data across AGYW age groups.
- National Strategic Plans ("NSPs") and funding requests for the 2014-2016 allocation period maintain a strong vertical character with limited horizontal linkages and collaboration with other health and non-health platforms that specifically address women and adolescent girls.

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<sup>4</sup> The Global Fund and partners launched this initiative in early 2018, to build private sector support on AGYW and HIV in thirteen focus countries in sub-Saharan Africa.

- In many countries, the country dialogue process did not include AGYW or stakeholders with expertise and/or knowledge of gender inequities related to the HIV prevention-treatment-care cascades.
- Many CCMs lack engagement with government ministries responsible for overseeing critical programs that address AGYW needs, including programs that are gender-transformative and that advance gender equality<sup>5</sup>.
- CCMs would benefit from designated representatives with expertise in gender issues and capacity to oversee the implementation of interventions to address gender inequalities in the prevention and treatment cascades of the three diseases. Most CCMs lack meaningful engagement of AGYW.
- Involvement of young men and boys in the design and implementation of the AGYW programs varies across countries.

#### Conclusions:

- There are gaps and weaknesses in the reviewed NSPs and the Global Fund funding applications with respect to AGYW, and more broadly, gender analysis and gender-sensitive programming.
- AGYW are largely seen as “beneficiaries” rather than actors in program management and decision-making processes. Within the CCMs, there is inadequate participation of AGYW, or of government ministries overseeing AGYW activities.
- More effort is required to build support for an inclusive progress that will lead to the transformation of gender relations in the prevention of HIV among AGYW.

#### **Theme 3: State of the implementation process:**

- The Global Fund has played an important role in scaling-up programs to support AGYW in targeted countries.
- Coordination and collaboration between governments and different development partners as well as better alignment between PEPFAR and the Global Fund, significantly facilitates implementation of programs that address and reduce gender-related risks and barriers faced by women and girls. Additionally, in many countries in sub-Saharan Africa, the U.S. multi-donor program, DREAMS employs a comprehensive approach benefitting AGYW.
- Countries are not yet fully equipped to take advantage of the available Global Fund funding to implement gender-sensitive programming.
- Countries do not take full advantage of available technical assistance (“TA”).
- The extent and quality of TA to support the design and implementation of interventions that address gender-inequalities in the context of HIV prevention and treatment cascades vary within and between countries. Coordination of TA was particularly challenging.

#### Conclusions:

- Global Fund AGYW focus countries have been more successful at gender-sensitive programming, in comparison to non-focus countries.

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<sup>5</sup> Gender transformative programming attempts to re-define women and men’s gender roles and relations (UN Women [Gender Equality Glossary](#)).

- There is no systematic approach for identifying TA needs, accessing TA and coordinating and overseeing the quality of TA provision.
- Effective strategic partnerships and better coordination mechanisms between governments and development partners, with clear focus and accountability, increase efficiency and maximize the impact of gender-responsive interventions.

**Theme 4: Global Fund’s achievements to date in addressing HIV in AGYW:**

- Although much of the journey still lies ahead, promising results for HIV-positive women in countries where the Global Fund has strategically invested in women and girls are notable. For instance, since 2010, AIDS-related deaths among AGYW declined in Kenya (by 21.4%), South Africa (by 27.6%) and Uganda (by 51.4%). The number of women living with HIV on ART increased more than four times in the Democratic Republic of the Congo and Mozambique, although the number is still low in comparison to the percentage of women living with HIV.
- The performance results of most AGYW interventions in current grants are only mildly satisfactory. Intervention coverage is low due to a combination of implementation challenges, capacity and financing gaps. This is further exacerbated by challenges that countries are facing in monitoring the implementation of AGYW interventions.

**Conclusions:**

- Strong political will and government commitment are critical to explore innovative approaches.
- Thorough monitoring and rigorous assessments are needed to identify interventions that individually, and, in combination, have the highest impact on reducing gender-related risks and barriers faced by AGYW.

**What are the TERG’s recommendations?**

4. Based on the Review’s findings and recommendations, supplemented by other data sources and TERG deliberations, the TERG proposes a number of recommendations. The TERG is of the opinion that some of these should be acted upon in the short-term, and has underlined those recommendations accordingly.

**A. Promote needs and inclusion of AGYW in designing and implementing Global Fund-supported programs:**

- i. **Gender-responsive policy-making and programming** – Ensure that countries conduct in-depth analyses of relevant sources of available data to advance understanding of gender-responsive programming and implementation. Gender analyses will facilitate a better understanding of the different patterns of participation, involvement, behaviour and activities of AGYW in a given context. This in turn will support the identification of appropriate interventions and gender-responsive programming in general. In the context of the Review, it will guide AGYW-responsive policy-making and programming too. This should be supported with tools and TA. A number of gender assessment toolkits are available in the literature and with partners.
- ii. **Country buy-in** – CCM plays an important role. There is a need to build capacity and strengthen its ability to understand and address gender-related risks and barriers to services. Updating CCM policies and tools, encouraging inclusion of gender-specialists

in the CCM, as well as introducing training on gender and human rights for all CCM members, are some proposed interventions.

- iii. **Inclusivity** – Country Teams and CCMs should ensure and promote inclusion of AGYW in Global Fund processes including in the country dialogue and during grant implementation<sup>6</sup>. Attempts should be made to involve and inspire boys and men as positive agents of change. This should extend into implementation.
- iv. **Collaboration and Coordination** – Country Teams and CCMs should ensure and promote inclusion and collaboration with relevant local entities for an inter-sectoral approach (i.e. ministries of education and gender). The TERG recommends identifying mechanisms to strengthen horizontal linkages and collaboration with other health and non-health platforms that specifically address AGYW. This could include relevant integrated platforms prioritized by the 2017-2022 Strategy, for example, Antenatal Care, Integrated Community Case Management (iCCM), Sexual and Reproductive Health (SRH) and Adolescent Health. Additionally, working with countries and partners, explore possibilities to develop or integrate the Global Fund’s AGYW-specific funds into a common fund, to ensure a coordinated approach to AGYW.
- v. **Performance monitoring and accountability** – Relevant Secretariat teams should provide more substantial and specific guidance to countries on the development of performance frameworks for AGYW-focused grants, and support initiatives to strengthen country capacity for monitoring progress. At the same time, the Global Fund should decide on how to handle low-performing or non-performing indicators related to AGYW. The AGYW Measurement Framework/Operational Guidance currently being developed by the Technical Advice and Partnerships Department is an opportunity in this regard.
- vi. **Advocacy** – The Global Fund Country Teams should explore all avenues to cultivate public support and buy-in to work towards increased gender equality, together with a gradual change of structural barriers in countries. In this regard, the Secretariat should explore best practices of implementing advocacy initiatives within its country portfolio. The possibility of investing in regional advocacy grants could be another approach, e.g. a regional AGYW advocacy grant in sub-Saharan Africa.

**B. Encourage evidence-based interventions to be delivered at scale:**

- i. **AGYW-specific tools and guidance** – The Global Fund should continue to offer practical guidance on implementing and scaling-up evidence-based, gender-responsive interventions for AGYW, including interventions addressing men (targeting reduction of harmful masculinities), and facilitate identification of most at risk AGYW populations. As described below, the Secretariat should collaborate with partners to maximize the use of existing guidance and tools. The guidance and tools should cover, where appropriate, refocusing interventions to promising areas (pre-and post-exposure prophylaxis, access to social grants/cash transfers) and discontinuation of AGYW-focused interventions which are recognized to only provide limited results (i.e.

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<sup>6</sup> In 2014, the PACT and UNAIDS released a “[Youth Participation Tool](#)”, which shows how youth can be involved in Global Fund processes “from start to finish”. Global Fund Secretariat finds that the tool can be adapted to AGYW.

certain behavioral interventions). The AGYW information note recently developed by the Secretariat is useful in clarifying the spectrum of interventions<sup>7</sup>.

- ii. **Selection of interventions** – The selection of interventions should be based on an analysis of the HIV situation of AGYW in the context of other sub-populations, on the respective HIV incidences and absolute numbers and on cost-effectiveness. Different communication modalities, service packages, and delivery options (e.g. through schools for adolescents and through community- or health facility-based programs for both youth and adults) need to be considered for achieving HIV targets, especially in sub-Saharan Africa. Guidance should also be provided on estimating costs of delivering recommended interventions at scale in different local contexts in order to project accurate national and subnational budgets for a country.
- iii. **Consideration to Gender-based Violence (GBV)** – The Global Fund Strategy 2017-2022 notes, “Provision of age- and gender-appropriate prevention and treatment services is recognized as critical to address unmet and special needs of different age groups such as children, adolescents...” The TERG invites a reflection on whether the Global Fund wishes to give special consideration to sexual violence affecting children and adolescents (e.g. victims of child marriage, sex workers), given that currently such Global Fund-supported interventions are relatively sparse. The Global Fund may also wish to assess the degree to which, in some countries, focusing interventions only on AGYW may inadvertently provoke an increase in GBV (where boys and men feel excluded from special benefits) and see how this could be addressed.
- iv. **Reinforced partnerships** – Expansion of evidence-based, gender-responsive interventions will require close relations with the Global Fund’s development and technical partners. With the latter, it can more clearly define shared objectives and maximize the use of existing guidance and tools. Where appropriate, the Global Fund can align with the DREAMS program, which proposes interventions addressing social and structural limitations faced by AGYW, in order to maximize impact. The TERG also recommends sharing the Review with key partners, as part of an effort of engagement in this area of work.
- iii. **Strong data systems** – Strengthening the evidence-base necessitates country capacity to collect, analyze and use sex- and age-disaggregated data by disease. Collecting, storing, coding and analyzing national and sub-national data (the TERG also recognizes the significance of data on community-level interventions in this context), would also promote country ownership.
- iv. **Effective Technical Assistance** – Support quality TA initiatives to strengthen country capacity for and implementing and monitoring progress of AGYW-responsive programs. The TERG had previously recommended a shift to longer-term provision of TA, which goes beyond preparation of funding requests. This recommendation remains relevant, and the Review reinforces this recommendation. To ensure country ownership, CCMs and PRs should identify TA needs and plans, and access and oversee the quality of the TA provision.

### **C. Champion AGYW issues, address challenges and build capacity within the Secretariat:**

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<sup>7</sup> [Adolescent Girls and Young Women in High-HIV Burden Settings](#) (January 2017)



The Global Fund staff should be well equipped to champion AGYW issues and address AGYW in Global Fund grants, and Country Teams have a critical role to play. The TERG suggests developing relevant training for all Country Teams (starting with the AGYW focus countries), tailoring the training to the different professional profiles. Further, the TERG agrees with and reiterates the main recommendations of the Rapid Review conducted by the Community, Rights and Gender department in 2016<sup>8</sup>.

5. Strategic investments in gender equality and gender-sensitive programming constitute a major part of the Global Fund 2017-2022 strategy. The Global Fund recognizes that the battle against HIV/AIDS will be won or lost “based on whether we win or lose the battle to protect adolescent girls and young women from HIV over the next few years.”<sup>9</sup> Nevertheless, the gaps identified above can put at a significant risk achievement of the relevant operational objectives and the strategic thinking behind these.

## **What are the lessons for the future?**

6. There needs to be substantial and continuous engagement, as described above, across the Secretariat, the CCMs and in-country actors, to deliver on the Global Fund strategic operational objectives related to AGYW and HIV.
7. Given the Review’s limited scope, supplementary evidence is needed to help deliver against the Global Fund’s Strategic Objective 3. In addition to efforts at the Secretariat, TERG’s Prospective Country Evaluations will provide an in-depth assessment of gender-sensitive programming in the eight review countries.

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<sup>8</sup> See Annex 2.

<sup>9</sup> [HER initiative](#) (2018).



## Annexes

The following items are given in the annexes:

- [Annex 1](#): Relevant Past Board Decisions
- [Annex 2](#): Links to Relevant Past Documents & Reference Materials
- [Annex 3](#): Relevant Terminology

### Annex 1 – Relevant Past Decisions

Relevant past Decision Point	Summary and Impact
<b>GF/B36/DP06: Catalytic Investments for the 2017-2019 Allocation Period (November 2016)</b> <sup>10</sup>	The Board approved USD 800 million for catalytic investment priorities, including USD 55 million in matching funds for Adolescent Girls and Young Women.
<b>GF/B35/DP04: Global Fund Strategy 2017 – 2022: Investing to End Epidemics (April 2016)</b> <sup>11</sup>	The Board approved the Global Fund Strategy 2017 – 2022, which outlined four Strategic Objectives. The third Strategic Objective is to protect and promote human rights and gender equality.
<b>GF/B31/DP06: Special Initiatives (March 2014)</b> <sup>12</sup>	The Board decided that up to USD 100 million will be available over the 2014-2016 allocation period for a number of Special Initiatives, including USD 15 million for Technical Assistance on Community, Rights and Gender.
<b>GF/B19/DP34: Enhancing the Global Fund's Response to HIV/AIDS (May 2009)</b> <sup>13</sup>	Among other topics, the Board recognized that the Global Fund has a responsibility to use its influence to leverage a reduction in stigma, discrimination, criminalization of people due to their sexual orientation or gender identity and HIV+ individuals, travel restrictions and sexual and gender violence.
<b>GF/B18/DP18: Gender Equality Strategy (November 2008)</b> <sup>14</sup>	The Board approved "The Global Fund's Strategy for Ensuring Gender Equality in the Response to HIV/AIDS, Tuberculosis and Malaria".

### Annex 2 – Relevant Past Documents & Reference Materials

- [Results, Gaps and Lessons from Implementation of Strategies/Action Plans on Gender Equality and Key Populations](#) ("Rapid Review", Global Fund, 2016)
- [Gender Equality Strategy](#) (Global Fund, 2008)

### Annex 3 – Relevant Terminology

*Gender-sensitive programming* – Attempt to redress existing gender inequalities.

*Gender-responsive programming* – Attempt to substantially help to overcome historical gender biases and to empower.

*Additional definitions available through the UN Women [Gender Equality Glossary](#).*

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<sup>10</sup> <https://www.theglobalfund.org/board-decisions/b36-dp06/>

<sup>11</sup> <https://www.theglobalfund.org/board-decisions/b35-dp04/>

<sup>12</sup> <https://www.theglobalfund.org/board-decisions/b31-dp06/>

<sup>13</sup> <https://www.theglobalfund.org/board-decisions/b19-dp34/>

<sup>14</sup> <https://www.theglobalfund.org/board-decisions/b18-dp18/>

# Secretariat management response to TERG evaluation Adolescent Girls and Young Women and HIV

## **Introduction**

The Technical Evaluation Reference Group (TERG) is a critical component of the Global Partnership, providing independent review and evaluation of the Global Fund's business model, investments and impact to the Global Fund Board through its Strategy Committee. The Global Fund operates with a high degree of transparency and now publishes most non-advisory TERG reports on our website after they are reviewed by the Board and following the end of the internal deliberative process.

The Global Fund Secretariat and Community Rights and Gender (CRG) team appreciate the March 20-22, 2018 review of Thematic Review of Adolescent Girls and Young Women (AGYW) and HIV by the TERG. We agree with many of the findings and recommendations of the TERG report and the TERG Position Paper and are already implementing and working systematically to address many of the gaps identified in the report with respect to the Adolescent Girls and Young Women (AGYW) focus of Global Fund investments. We recognize the limitation of the Review in terms of its ability to capture all the nuances in relation to gender-responsive programming, and the impact of age/sex disparities and population diversity relative to the three disease areas addressed by the Global Fund. However, we would also like to point out a key area where the report's focus on AGYW seems limited in its findings and recommendations.

## **Areas of agreement**

We agree with the TERG's findings that there should be a concerted effort to ensure that disaggregated data and related gender analyses inform country priorities in National Strategies and Global Fund investments. We particularly appreciate the TERG noting that there are weaknesses in countries undertaking these analyses, and in their ability to design and implement gender-responsive programming. We also agree that the capacity of the Country Coordinating Mechanisms and implementing partners could be strengthened to ensure that they have the proper expertise to inform and support gender-responsive investments for better impact, including appropriate programs for AGYW. Related to this capacity is the ability to meaningfully engage AGYW in all aspects of Global Fund processes, including service delivery and community-based monitoring for quality.

Finally, we agree and are implementing many of the TERG recommendations on increasing inter-sectorial collaboration and coordination, as well as more systematic approaches for identifying and responding to technical assistance needs to enhance quality programming.

## **Areas of disagreement**

The focus on AGYW across diverse countries with very different HIV epidemic profiles is an opportunity to understand better how the Global Fund should invest differently for AGYW, understanding our unique role and mandate. While adolescent girls and young women within key populations were mentioned in the report, there are few findings or recommendations that recognize the distinct and worrisome situation of key population adolescent girls and young women (i.e. transgender girls and women, those who use drugs, those who engage in selling or exchanging sex, those who are disabled, etc.). The findings are mostly relevant to AGYW in extreme or very high HIV epidemic settings, where large scale programs are needed to address AGYW disproportionately impacted by HIV in contrast to their male peers. Very few countries have the epidemic profile that would merit large investments in AGYW programs, outside of key population investments. As such, we regret that the findings and recommendations do not adequately address how the Global Fund should better reach adolescent and young women in countries where the Global Fund's response should be largely targeting key populations. This lack of nuance and focus is throughout the findings and recommendations, and as such, we are left with very few recommendations and guidance that would be applicable for the vast majority of the Global Fund HIV investments.

## **Next steps**

In light of this review, the Global Fund is moving forward concerted actions to implement many of the recommendations in the TERG review. As noted, these recommendations are particularly relevant to the countries where the Secretariat made catalytic funding available to address disproportionate HIV burden amongst AGYW, and where KPI 8 measures HIV incidence decline in females aged 15-24. Some of the areas of focus for the Global Fund as relevant to responding to the TERG findings include:

**Data:** The Secretariat has launched the Strategic Initiative on data which provides funding and technical support to countries to improve their Health Management Information Systems, including ability of countries to report, collect and analyze sex and age disaggregated data. KPI 6e tracks countries' ability to report to the Global Fund on sex and age disaggregation for the core indicators in 50 countries. The Secretariat developed a monitoring and evaluation framework for the 13 AGYW focus countries, which outlines areas that are being tracked and identifies gaps for improving with the countries.

**Meaningful Engagement:** The Global Fund provided seed funding to the Eastern Africa National Networks of AIDS Services Organizations (EANNASO) and the Southern African AIDS Trust to launch HER Voice, which provides small grants for AGYW groups to engage in Global Fund related processes. The Secretariat has secured continued funding for years 2 and 3 from a private sector donor. HER Voice is part of a broader AGYW engagement plan supported through the CRG Strategic Initiative.

**Engaging men and boys:** The AGYW guidance includes support to programs to engage young boys and men, and we are funding in some countries boys' clubs as well as girls' clubs. Most of the gender-based violence support through the Global Fund includes approaches to address male involvement in reducing violence in communities, and adopting more positive

attitudes towards gender roles and norms. Initial KPI 8 reporting from the first 7 of 13 AGYW focus countries shows that more than 20% of the AGYW investments are going to boys- and men-focused programs.

**Scaling Up AGYW Programs:** The Secretariat has significantly scaled up investments in AGYW programs in the 13 focus countries for HIV incidence reduction. PEPFAR sits on the CCM in each of these countries, and there have been a number of alignment discussions to work towards complementarity in packages. Both PEPFAR and the Global Fund are supporting countries to develop national targets and strategies to AGYW under which all investments should align.

**Strengthening intra-sectorial partnerships:** The Global Fund has a contract and deliverables with UNICEF and WHO to support AGYW investments in 11 of the 13 focus countries. Discussions are continuing with UNAIDS, UNFPA, UNESCO and UN Women. The Secretariat has launched HER, a private sector campaign to engage private sector in supporting innovative partnerships that bring catalytic resources to the AGYW investments.

## **Conclusion**

We thank the TERG for our continued partnership to strengthen the impact of Global Fund investments. These recommendations will be helpful in strengthening the AGYW programs where we have catalytic funding and where the epidemic merits this investment focus.

September 13, 2018



EURO HEALTH GROUP

# Thematic Review on Adolescent Girls and Young Women and HIV

*How the needs of adolescent girls and young women are reflected in the Global Fund's support to prevent and treat HIV in countries.*

December 2017

FINAL REPORT

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**DISCLAIMER**

Views expressed in this report are those of the author. The author has been commissioned by the Technical Evaluation Reference Group (TERG) of the Global Fund to Fight AIDS, Tuberculosis and Malaria (the Global Fund) to conduct an assessment to provide input into TERG's recommendations or observations, where relevant and applicable, to the Global Fund. This assessment does not necessarily reflect the views of the Global Fund or the TERG. The Global Fund notes that the report was unable, due to timelines, to use new data from grants, which became available after July 2017. The information set forth in this report is from the time period(s) described in the methodology sections of the report. Relevant stakeholders should be consulted for the most up-to-date information. Please note that this report, which was prepared in 2017, refers to the Kingdom of Eswatini as Swaziland.

This report shall not be duplicated, used, or disclosed – in whole or in part without proper attribution.

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## ABBREVIATIONS AND ACRONYMS

AGYW	Adolescent girls and young women
AIDS	Acquired immune deficiency syndrome
ANC	Ante-natal care
ART	Antiretroviral therapy
ARV	Antiretroviral (drugs)
ASRH	Adolescent sexual and reproductive health
AYP	Adolescent young people
BBS	Behavioral surveillance surveys
BCC	Behavior change communication
CA (a)	Central Africa
CA (b)	Cooperation Agreement
CBO	Community-based organization
CCM	Country Coordinating Mechanism
CDC	U.S. Centers for Disease Control and Prevention
CEDAW	Convention on the Elimination of All Forms of Discrimination Against Women
CHAI	Clinton Health Access Initiative
CIDA	Canadian International Development Agency
CIHTC	Community-initiated HIV testing and counselling
CIS	Commonwealth of Independent States
CN	Concept Note
COE	Challenging operating environment
CONAC	National Anti-Corruption Commission (Cameroon)
COP	Country Operational Plan
CPI	Combination HIV Prevention Intervention
CRG	Community Rights and Gender
CSE	Comprehensive sexuality education
CSO	Civil society organization
CSS	Community Systems Strengthening
CSW	UN Commission on the Status of Women
CT	Country Team
DFID	Department for International Development (UK Government)
DHS	Demographic and health survey
DOH	Department of Health
DRC	Democratic Republic of the Congo
DREAMS	Determined Resilient Empowered AIDS free Mentored and Safe Initiative (Also see Glossary below)
EECA	Eastern Europe and Central Asia
EHG	Euro Health Group
E-IMPACT	Expanded Integrated Management of Pediatric HIV&AIDS Care and Treatment
eMTCT	Elimination of mother to child transmission
eNSF	extended National Multi-Sectoral Strategic Framework for HIV & AIDS
EW	Entertainment worker
FBO	Faith-based organization
FEW	Female entertainment worker

FGC	Female genital cutting
FGD	Focus group discussion
FM	Funding Model
FPM	Fund Portfolio Manager
FR	Funding Request
FSW	Female sex worker
GAC	Grants Approvals Committee
GAVI	The Vaccine Alliance
GBV	Gender-based violence
GDP	Gross domestic product
GIZ	Deutsche Gesellschaft für Internationale Zusammenarbeit
Global Fund	Global Fund for AIDS, Tuberculosis and Malaria
GPR	Gender Portfolio Review
HBV	Hepatitis B virus
HCV	Hepatitis C virus
HIV	Human immunodeficiency virus
HMIS	Health management information system
HRH	Human resource for health
HSS	Health systems strengthening
HTC	HIV testing and counselling
HTS	HIV Testing Services
IBBS	Integrated Biological and Behavioral Survey
IC	Investment case
ICW	International Community of Women living with HIV
IDP	Internally displaced persons
IEC	Information, education and communication
IOM	International Organization of Migration
IPT	Isoniazid preventive therapy
IPV	Intimate partner violence
IR	Inception Report
ITP	Implementation Through Partnership
JANS	Joint Assessment of National Health Strategies
KGIS	Keeping Girls in School
KII	Key informant interviews
KP	Key population
KPI	Key performance indicator
LFA	Local Fund Agent
M&E	Monitoring and evaluation
MC	Male circumcision
MCH	Maternal and child health
MDG	Millennium Development Goal
MDR-TB	Multi-drug resistant tuberculosis
MOH	Ministry of Health
MOPED	Ministry of Finance, Planning and Economic Development (Uganda)
MOU	Memorandum of Understanding
MSM	Men who have sex with men
MSP	Multiple sexual partner
MTR	Mid-term review
NFM	New Funding Model

NGO	Non-government organization
NPEGE	National Program on Ensuring Gender Equality for 2010-2015 (Moldova)
NSP	National Strategic Plan
OIG	Office of the Inspector General
OP	Operational Plan
OST	Opioid substitution therapy
OVC	Orphans and vulnerable children
PAAR	Prioritized above allocation request
PCE	Prospective country evaluation
PEP	Post exposure prophylaxis
PEPFAR	U.S. President’s Emergency Fund for AIDS Relief
PHC	Primary health care
PLHIV	People living with HIV
PMTCT	Prevention of mother-to-child transmission
PrEP	Pre-exposure prophylaxis
PR	Principal Recipient
PS	Private sector
PUDR	Program updates/disbursement requests
PWID	People who inject drugs
RBM	Roll Back Malaria
RFP	Request for Proposals
RH	Reproductive health
RMNCAH	Reproductive Maternal New-born Child and Adolescent Health
RMNCH	Reproductive, Maternal, New-born and Child Health
RSSH	Resilient and Sustainable Systems for Health
SAGE	Strategic Actions for Gender Equality
SBC	Social and behavioral change
SBCC	Social and behavioral change communication
SBN	Secretariat briefing note
SC	Strategic committee
SDC	Swiss Development Corporation
SDG	Sustainable development goal
SGBV	Sexual and gender-based violence
SO	Strategic objective
SR	Sub-recipient
SR2017	Strategic Review 2017
SRH/R	Sexual and reproductive health/and rights
SSR	Sub-sub-recipient
STI	Sexually transmitted infection
SW	Sex worker
TA	Technical assistance
TB	Tuberculosis
Team	This EHG thematic review team
TERG	Technical Evaluation Reference Group
TOR	Terms of reference
TRP	Technical Review Panel
TVET	TAFE delivered Vocational Education and Training
TWG	Technical working group
UNAIDS	Joint United Nations Program on AIDS

UNFPA	United Nations Population Fund
UNICEF	United Nations Children’s Fund
UNODC	United Nations Office on Drugs and Crime
UNPF	United Nations Partnership Framework
USAID	United States Agency for International Development
USG	United State Government
VMMC	Voluntary medical male circumcision
WB	World Bank
WHO	World Health Organization
WLC	Women’s Law Centre
YFHC	Youth friendly health centers

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## EXECUTIVE SUMMARY

The Global Fund to Fight AIDS, Tuberculosis and Malaria (the Global Fund) was among the earliest and strongest advocates for addressing the needs of women and girls, including addressing the gender-based inequalities that fuel the HIV epidemic. The Global Fund's commitment to advancing gender equality, and improving the health of women and girls in all their diversity is reflected in their Strategies: *the Gender Equality Strategy (2008)* and *Sexual Orientation and Gender Identities ("SOGI") Strategy (2009)*, and *the Global Fund Strategy 2012-16*. Further, the new Global Fund Strategy 2017 – 2022: *Investing to End Epidemics* maintains the focus and increases investments in rights to health and promotion of gender-sensitive interventions under the third strategic objective (SO3) 'Promote and protect human rights and gender equality'. SO3 includes two sub-objectives to: (a) scale-up programs to support women and girls, including programs to advance sexual and reproductive health and rights (SRHR); and (b) invest to reduce health inequities including gender and age-related disparities. The Global Fund acknowledges that, if SO3 is to be achieved, concerted and focused efforts are needed for tailored approaches aimed at one of the most vulnerable populations globally and especially in Sub-Saharan Africa: women, particularly adolescent girls and young women (AGYW).

Within the above context, in an effort to elaborate a more comprehensive picture of the actual situation of women in selected countries and to assess the achievements of Global Fund support to gender equality and equity, the TERG commissioned Euro Health Group to conduct the Thematic Review on Adolescent Girls and Young Women and HIV.

The objectives of the review were to:

- Evaluate plans, policies and programs related to HIV<sup>1</sup>, and the extent to which they have been designed and implemented in accordance with the needs of women and adolescent girls, in all their diversity, in countries receiving Global Fund support
- Link the review's findings to the objectives of the Global Fund Strategy 2017-2022, particularly SO3 (a) and (b), and other areas related to gender equality (such as data disaggregation, meaningful participation and key populations)
- Assess strengths and opportunities for improvement and document lessons learnt and their applicability to address the needs of women and girls in all their diversity, and advancing gender-responsive programming in countries
- Serve as an in-depth baseline study to inform forthcoming prospective gender evaluations within the TERG's Prospective Country Evaluations)

The review team used a mixed methods approach to collecting data. Throughout the assignment the team employed both qualitative and quantitative data collection methods and analysis. Data collected were triangulated and cross-referenced for accuracy to ensure their quality. Data sources included:

- Global Fund and recipient country documents as well as external literature, over 300 documents were reviewed
- Case study analysis: ten HIV country grants were examined in detail; five countries were visited to gain a deeper understanding of gender responsive and AGYW focused program implementation
- Gender portfolio review targeting ten additional countries – a select number of full and tailored funding requests (FRs) submitted under the current Window 1, 2018-2020 funding cycle were reviewed and compared with concept notes (CNs) submitted under the previous allocation

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<sup>1</sup> Original ToR intended to cover all three diseases (HIV, TB and malaria). At the TERG meeting held in February 2017 it was agreed that Review Team will focus only on AGYW in relation to HIV.



period (2012-2016) for the same ten countries

- Key informant interviews at global and country level: Global Fund Secretariat, Global Fund stakeholders and country stakeholders. Over 212 people were interviewed during the course of this review

The review was guided by 33 questions from the RFP linked to the above objectives and grouped under the following four themes:

- **Theme 1: How inequalities faced by women and adolescent girls are addressed in respective country programs** – examining how potential inequalities faced by AWYG were identified and documented by the respective programs, and national goals set to reduce gender inequalities in the context of HIV prevention and treatment cascades
- **Theme 2: How gender equality principles are reflected in the global fund grant design and country process** – to assess the extent to which national strategic plans (NSPs) and concept notes (CNs)/funding requests (FRs) from selected countries were evidence-based, included AGYW interventions, integrated and linked to other health (sexual and reproductive health and rights, adolescent, maternal and new-born child health) and non-health platforms, oversight of programs, etc.
- **Theme 3: Implementation process** – extent to which gender-related risks and barriers faced by AGYW related to HIV were addressed during implementation and the facilitating and constraining factors, capacity of the CCMs, PRs and SRs and related technical assistance needed/provided, partnerships at country level, etc.
- **Theme 4: Results and effectiveness** –key results from the implementation of gender-responsive programming, lessons learned, etc.

The findings, conclusions and recommendations are structured around the above themes.

**The overarching conclusion is that:** *the Global Fund guidance on addressing the needs of women and AGYW is timely and appropriate and the Global Fund is making a difference in terms of raising the profile of gender/AGYW-focused programming. However, countries are still facing challenges in understanding and using data for evidence-based planning and AGYW-focused programming, as well as for implementation and monitoring of evidence-based AGYW interventions.*

#### **Theme 1: How Inequalities Faced by Women and Adolescent Girls are Addressed in Respective Country Programs**

<b>Finding 1:</b>	The legal and institutional framework on gender equality is in place in many of the review countries, but is lacking mechanisms for its practical implementation.
<b>Finding 2:</b>	Potential inequalities faced by AGYW are poorly understood, documented and addressed by respective country programs.
<b>Conclusion 1:</b> Translating gender-sensitive policies into programs to assist AGYW and program operationalization is a challenge in many countries.	<b>Recommendation 1:</b> Strengthen country capacity to collect, analyze and use sex- and age- disaggregated data by disease, and implement evidence based interventions targeting AGYW.

#### **Theme 2: How Gender Equality Principles Are Reflected in the Global Fund Grant Design and Country Process**

<b>Finding 4:</b>	NSPs and CNs maintain a strong vertical character with limited horizontal linkages and collaboration with other health and non-health platforms that specifically address women and adolescent girls.
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<b>Finding 5:</b> Although AGYW needs are better addressed in FRs (compared to CNs) gender analysis remains inadequate with no age-disaggregated data across AGYW age groups.	
<b>Conclusion 2:</b> There are gaps and weaknesses in the reviewed NSPs with respect to AGYW, and more broadly, gender analysis and gender-related programming.	<b>Recommendation 2:</b> Update NSP Review Checklist <sup>2</sup> and strengthen country capacity to prioritize and budget for interventions and activities to address AGYW from broader, more inclusive interventions.
<b>Finding 6:</b> In many countries, the Country Dialogue process did not include AGYW or stakeholders with expertise and/or knowledge of gender inequities related to the HIV prevention-treatment-care cascades.	
<b>Finding 7:</b> Many CCMs lack engagement by the government ministries in overseeing critical programs to address AGYW needs, including gender-transformative programs and programs that advance gender equality.	
<b>Finding 8:</b> CCMs lack designated representatives with expertise in gender issues and with capacity to oversee the implementation of interventions to address gender inequalities in the prevention and treatment cascades of the three diseases. Most CCMs lack meaningful engagement of AGYW.	
<b>Conclusion 3:</b> AGYW are largely seen as “beneficiaries” rather than actors.	<b>Recommendation 3a:</b> Develop tools to support the meaningful inclusion of AGYW in Global Fund processes (e.g. existing youth participation tool can be adapted to AGYW).  <b>Recommendation 3b:</b> Update CCM policies and tools to ensure gender responsiveness in the CCMs, as well as AGYW engagement.
<b>Finding 9:</b> Involvement of young men and boys in the design and implementation of the AGYW programs varies across countries.	
<b>Conclusion 4:</b> More effort is required to build support for an inclusive process that will lead to the transformation of gender relations in the prevention of HIV among AGYW.	<b>Recommendation 4:</b> Strengthen efforts to engage young men and boys as positive agents of change.

### Theme 3: Implementation Process

<b>Finding 3:</b> The Global Fund plays a catalytic role in scaling-up programs to support AGYW in targeted countries.	
<b>Finding 10:</b> The Global Fund plays a significant role in health reform and RSSH in many countries, including its support to integrated service delivery (TB/HIV, RMNCAH) and establishes partnerships to better respond to the challenge of integrating disease programs with RMNCAH programs.	
<b>Conclusion 5:</b> Countries included in the Global Fund AGYW focus are more likely to effectively address risks and barriers to services faced by women and girls.	<b>Recommendation 5:</b> Consider expanding gender-specific initiatives in AGYW focus countries (e.g. by scaling up DREAMS packages).
<b>Finding 11:</b> Countries are not yet fully prepared to take advantage of the available funding provided by the Global Fund to implement gender-responsive programming.	

<sup>2</sup> The NSP Review Checklist that was developed for the Thematic Review of National Strategic Plans (NSPs) was proven as a useful tool, and could be further developed for this purpose.

<b>Finding 12:</b> Countries are not taking full advantage of available technical assistance (TA), and TA requests from a single country are not always coordinated.	
<b>Finding 13:</b> The quality and quality control of TA designed to support development and implementation of interventions that address gender-inequalities in the context of HIV prevention and treatment cascades vary within and between countries.	
<b>Conclusion 6:</b> There is no systematic approach for identifying TA needs, accessing TA and coordinating and overseeing the quality of TA provision.	<b>Recommendation 6a:</b> Develop a systematic approach to support CCMs and PRs to identify TA needs and to plan, access and overseeing the quality of TA provision.  <b>Recommendation 6b:</b> Introduce mandatory training on gender and human rights, for CCMs in countries targeted for gender support.
<b>Finding 14:</b> Coordination and collaboration between governments and different developing partners as well as better alignment between PEPFAR and the Global fund, significantly facilitates implementation of programs that address and reduce gender-related risks and barriers faced by women and girls.	
<b>Conclusion 7:</b> Effective strategic TA partnerships, with clear focus and accountability, increase efficiency and maximize the impact of gender-responsive interventions.	<b>Recommendation 7:</b> Strengthen collaboration with development and technical partners and ensure joint accountability for results.

#### Theme 4: Results and Effectiveness

<b>Finding 15:</b> The Global Fund focus on women and girls with the strategic investments to improve their health and support country driven gender-responsive programming is making a difference.	
<b>Finding 16:</b> Global Fund support has led to greater community involvement in the disease trajectory.	
<b>Conclusions 8:</b> Strong political will and government commitment provide a safe space to explore innovative approaches.	<b>Recommendations 8:</b> Continue to explore innovative approaches to gender-responsive programming, e.g. by investing in regional grants in Sub-Saharan Africa.
<b>Finding 17:</b> The performance results of most AGYW interventions in current grants are considered only mildly satisfactory. This is further exacerbated by challenges that countries are facing in monitoring the implementation of AGYW interventions.	
<b>Conclusion 9:</b> Thorough monitoring and rigorous assessments are needed to identify programs that individually, and in combination, have the highest impact on reducing gender-related risks and barriers faced by AGYW.	<b>Recommendation 9a:</b> Develop tools that offer practical advice on implementing programs for AGYW and promote peer-to-peer exchange.  <b>Recommendation 9b:</b> Support initiatives to strengthen country capacity for monitoring progress on AGYW program implementation.  <b>Recommendation 9c:</b> Provide more substantial and specific guidance to countries on the development of performance frameworks for AGYW-focused grants.

The report is structured to first provide background information regarding the review and the overall approach, methods and limitations. Then, the criteria used for choosing the review countries are

provided along with an analysis across countries. The subsequent three sections provide the overall findings, conclusions, and recommendations.

# 1 INTRODUCTION

## 1.1. Background

The Global Fund, acknowledging that gender inequalities and gender-related risks and barriers to care are strong drivers of the HIV and AIDS, tuberculosis (TB) and malaria epidemics, is committed to ensuring that grants support equal and equitable access to prevention, treatment, care and support for all those in need. Support is provided as grants, provision of expertise and technical assistance (TA) in accordance with countries' demonstrated goodwill to expand programs that advocate for, and address the removal of, human right- and gender-related obstacles to health care.

Its investments support countries to achieve gender equality and empower all women and girls, aiming at addressing the factors that contribute to gender inequities which impede women's and girls' access to health services. Despite considerable progress in advancing gender equality and addressing the needs of women and girls since the International Conference on Population and Development (ICPD) in 1995, gender inequalities persist and continue to impede the achievement of the collective mission of ending the three epidemics.

Global Fund investments to address gender inequalities and barriers to care have increased significantly in the past six years with 55-60 percent of total financial support now directed to women and girls in 2015.<sup>3</sup> The *Global Fund Strategy 2012-16 Investing for Impact* and the *Gender Equality Strategy Action Plan 2014-2016* provides a roadmap for how the Global Fund partnership should direct strategic and high-impact investments to prevent new infections and save more lives through gender responsive programming targeting Adolescent girls and young women (AGYW). At the same time, the Global Fund enforces the requirement to countries that were not already doing so, to report sex and age disaggregated data.

The midterm review (MTR) of the *Global Fund Strategy 2012-2016*, which was carried out by ITAD and Euro Health Group (EHG) in 2015, recommended, among others, that the new Global Fund Strategy should maintain the focus and increase investments in rights to health and promotion of gender-sensitive interventions as enablers to increasing impact.<sup>4</sup>

Gender equality takes a prominent position in the new *Global Fund Strategy 2017-2022: Investing to End Epidemics* and runs throughout all four strategic objectives (SO). Furthermore, it recognizes that 'Promoting and protecting human rights is essential to ensure that countries can control their epidemics, scale up where needed, and sustain their gains'.<sup>5</sup> Strategic sub-objective 3a is dedicated to addressing human rights of women and girls by scaling-up programs to support women and girls in 13 countries, including programs to advance sexual and reproductive health and rights (SRHR); while the strategic sub-objective 3b is focusing on investing to reduce health inequities including gender and age-related disparities.<sup>6</sup> While the scope of the Global Fund's efforts is global, the strategy SO3a has a specific focus on certain high-burden countries in sub-Saharan Africa and particularly on the issue of HIV among AGYW.<sup>7</sup>

In 2016, the Global Fund introduced the *Strategic Actions to Advance Gender Equality* (SAGE)

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<sup>3</sup> The Global Fund (2016a), *op. cit.*

<sup>4</sup> *Ibid.*

<sup>5</sup> The Global Fund (2016b), *The Global Fund Strategy 2017-2022, - Investing to End Epidemics*. Global Fund: Geneva.

<sup>6</sup> The Global Fund (2016b). *The Global Fund Strategy 2017-2022, - Investing to End Epidemics*. Global Fund: Geneva.

<sup>7</sup> UNAIDS (2016b), *Global AIDS Update* retrieved from [http://www.unaids.org/sites/default/files/media\\_asset/global-AIDS-update-2016\\_en.pdf](http://www.unaids.org/sites/default/files/media_asset/global-AIDS-update-2016_en.pdf) accessed on 22 March 2017.

program on how to promote gender equality and address gender-related disparities through addressing gender-related risks and barriers to care (including the needs of women and girls) by supporting relevant policies, programs and partnerships. Furthermore, the Global Fund is putting in place tools and mechanisms to encourage and support increased investments in AGYW aligned with strategic SO3a. The *Funding Forward for Girls* platform was established (now *HER Campaign*) by the Global Fund Secretariat to mobilize additional resources from the private sector to help address “above allocation” funding gaps in programming, technical support, community mobilization and advocacy related to AGYW in the 13 HIV high-burden countries in sub-Saharan Africa (Botswana, Cameroon, Kenya, Lesotho, Malawi, Mozambique, Namibia, South Africa, Swaziland, Tanzania, Uganda, Zambia and Zimbabwe).

For the new funding cycle (2018-2020), the Global Fund is increasing its investments in AGYW to an even greater degree. A total of US\$ 55 million has been made available for HIV and AGYW through the Catalytic Investment Funding mechanism. The Global Fund expects countries to match this equally or to a greater amount from matching funds within their country allocation. An additional requirement is that the funding dedicated to AGYW from within the country allocation must be greater than funding for AGYW under the current grant. According to the Global Fund Secretariat, of funding requests submitted to the Global Fund in Window 1 (20 March 2017) and Window 2 (23 May 2017), more than US\$ 100 million was proposed for AGYW through allocation- funds and matching funds, and more than US\$ 50 million in prioritized above allocation requests (PAAR).

Accordingly, with the aim of obtaining a more comprehensive picture of the actual situation of women in selected countries (in relation to HIV) and to assess the achievements of Global Fund support to gender equality and equity, the TERG commissioned EHG to conduct the Thematic Review on Adolescent Girls and Young Women and HIV.

## 1.2. Objectives of the Review

This thematic review primarily focuses on AGYW in relation to HIV, and is intended to facilitate the implementation of the *Global Fund Strategy 2017-2022* regarding the strategic SO3 and the two sub-objectives: (a) Scale-up programs to support women and girls, including programs to advance SRHR; and (b) Invest to reduce health inequities, including gender and age-related disparities.

The objectives of the review are to:

- Evaluate plans, policies and programs related to HIV<sup>8</sup> and the extent to which they have been designed and implemented in accordance with the needs of women and adolescent girls, in all their diversity, in countries receiving Global Fund support
- Link the review’s findings to the objectives of the *Global Fund Strategy 2017-2022*, particularly strategic SO3 (a) and (b), and other areas related to gender equality (such as data disaggregation, meaningful participation, key populations (KPs) and so on)
- Assess strengths and opportunities for improvement and document lessons learnt and their applicability to addressing the needs of women and girls in all their diversity, and advancing gender-responsive programming in countries
- Serve as an in-depth baseline study to inform forthcoming prospective gender evaluations within the TERG’s Prospective Country Evaluations (PCEs).<sup>9</sup>

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<sup>8</sup> Original ToR intended to cover all three diseases (HIV, TB and malaria). At the TERG meeting held in February 2017 it was agreed that Review Team will focus only on AGYW in relation to HIV.

<sup>9</sup> Prospective Country Evaluations (PCEs) are in-depth, country-level, prospective evaluations that utilise a variety of methods to provide a detailed picture of the implementation, effectiveness and impact of Global Fund-supported programs

The review was guided by the key questions from the RFP, which were further elaborated as presented in the review matrix. The review team (team) examined the extent to which countries respond to the basic needs of AGYWs, investigated the degree to which programs addressed structural drivers contributing to HIV among AGYW and identified potential inequalities faced by this target group related to the respective disease trajectory, prevention and treatment cascades. In addition, the team examined the extent to which Global Fund concept notes (CNs) and national strategic plans (NSPs) designated specific financial resources to address issues of women and girls and included gender-disaggregated data. The participation of AGYW in decision-making processes within the Country Coordination Mechanisms (CCMs), country dialogues and implementation of programs was also taken into consideration.

The review questions were used as the basis for the development of the review assessment tools. Each tool indicated the specific information to be collected, data sources and methods for data collection. The review questions were grouped under five categories:

- How inequalities faced by AGYWs are addressed in respective country programs
- How Gender equality principles reflected in the Global Fund grant design and country processes
- Implementation process
- Results and effectiveness
- Lessons learnt

### 1.3. Timeframe for the Review

The Global Fund commissioned EHG to conduct the review, utilizing a team of five consultants including EHG in-house staff. The study was conducted in four phases:

1. **Inception Phase:** This included collating and reviewing documents using standard review criteria and tools, developing and vetting the overall approach and specific methodologies (see Section 2); developing checklists and tools for standardized data collection, analysis and reporting; initial stakeholder consultations; clarifying issues with the Global Fund Secretariat, and attending the 31<sup>st</sup> TERG meeting.
2. **Review Development and Data Collection Phase:** This included a continuation of the desk review of documents, stakeholder and key informant interviews (KIIs) (at the global, regional and country level), in-country visits, and Gender Portfolio Review (GPR) for selected countries.
3. **Analysis and Synthesis Phase:** The team organized a data synthesis workshop to begin analysis of the qualitative and quantitative data. Findings were triangulated against different data sources and the team discussed the emerging findings, reducing the possibility of individual bias. From these findings, the team collaboratively derived its conclusions and recommendations. Finally, additional follow-up interviews (either because of the need for clarification or because of scheduling reasons) were conducted.
4. **Report Preparation Phase:** Each member of the team was assigned specific sections of the report to write. Quality review and assurance was provided by in-house EHG staff who were not directly associated with the previous phases of the review.

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in eight selected countries. PCEs are intended to establish country platforms that support dynamic, continuous monitoring and evaluation, learning, and problem solving.



## 2 METHODOLOGY

### 2.1 Overall Approach

The review applied a mixed method approach including desk reviews of relevant documents, KIIs at global and country level, and consultations/direct observation through country visits. The team worked closely with key stakeholders at both country and global level.

Purposeful sampling and chain sampling were conducted to identify respondents who could provide information relevant for the review. The National AIDS Commissions/Councils (NACs) or their equivalent, and CCMs, were the entry points for data collection. Based on their recommendations, additional interviewees were identified. Therefore, the data collection process was iterative in nature to enable the team to cover a sufficiently informed sample of key informants. The section below provides more detail regarding data collection methods and key stakeholders.

### 2.2 Selection of Countries for the Thematic Review

During consultations in Geneva (February 2017), the EHG team discussed and agreed with the Global Fund Secretariat, TERG focal point, the TERG support team and other key stakeholders, the following set of criteria for country selection (see Table 1 below):

**Table 1: Selection criteria for countries**

Criteria for Selection of Countries	Try to ensure
<ul style="list-style-type: none"> <li>Countries have been implementing grants under the New Funding Model (NFM) and are applying under the NFM Windows (allocations for 2018-2020)</li> <li>Countries/grants identified by Fund Portfolio Managers (FPMs) that have the potential to provide lesson learnt – especially related to good practice in implementation of gender initiatives</li> <li>Countries/grants identified by FPMs that have the potential to provide lesson learnt due to weak rationale or poor design, governance or performance, or limited sustainability. The team will also verify the status of these, based on performance reports.</li> <li>Countries/grants identified by the team based on their work and experience in those countries (good/best practice and lessons learnt or examples of poor implementation and lessons for improvement)</li> </ul>	<ul style="list-style-type: none"> <li>Focus on Africa (as noted by the RFP, p.4, and discussed with the TERG support team)</li> <li>Global Fund priority AGYW countries (<i>countries where the Global Fund will be measuring HIV incidence reduction among 15-24 females, KPI 8</i>)</li> <li>High impact country</li> <li>Possibility of joint review with the Strategic Review 2017</li> <li>One or more of the PCE-countries</li> </ul>

Following a preliminary document review and above criteria for country selection, the countries in Table 2 below were agreed for the thematic review (desk review and/or country visits).

Table 2: Selected countries

Country	Income Category	Global Fund Typology	Region	Rationale for Selection	Desk Review	Country Visited
<b>Cambodia</b>	Low income (LI)	High impact	Asia	<ul style="list-style-type: none"> <li>• PCE country</li> <li>• High TB burden country</li> </ul>	Yes	No
<b>Cameroon</b>	Lower middle income (LMI)	Core	Central Africa (CA)	<ul style="list-style-type: none"> <li>• Gender priority country</li> <li>• HIV and TB tailored reviews/Window 3</li> <li>• Application in Window 1</li> </ul>	Yes	24-28 April
<b>DRC</b>	LI	High impact, challenging operating environment (COE)	Africa 1	<ul style="list-style-type: none"> <li>• PCE country</li> <li>• One of most challenging countries for health service delivery</li> <li>• Application in Window 1</li> </ul>	Yes	No
<b>Kenya</b>	LMI	High Impact, COE	Africa 2	<ul style="list-style-type: none"> <li>• Gender priority country</li> <li>• DREAMS country<sup>10</sup></li> <li>• Possibility of joint review with SR2017</li> </ul>	Yes	27-31 March
<b>Moldova</b>	LMI	TBD	Eastern Europe and Central Asia (EECA)	<ul style="list-style-type: none"> <li>• One of the worst affected countries for trafficking of AGYW</li> <li>• Number of gender initiatives/good practices</li> <li>• Regional initiatives (e.g. Eastern European Regional Platform for Accelerated Action for Women)</li> <li>• Possibility of joint review with SR2017</li> <li>• Application in Window 1</li> </ul>	Yes	20-24 March
<b>Mozambique</b>	LI	High Impact	Africa 2	<ul style="list-style-type: none"> <li>• PCE country</li> <li>• DREAMS country</li> </ul>	Yes	No
<b>Senegal</b>	LMI	Core	Western Africa	<ul style="list-style-type: none"> <li>• PCE country</li> <li>• Application in Window 1</li> </ul>	Yes	No
<b>South Africa</b>	UMI	High Impact	Sub-Saharan Africa	<ul style="list-style-type: none"> <li>• Gender priority country</li> <li>• Number of gender initiatives/best practices</li> <li>• DREAMS country</li> <li>• Full review in 2018</li> <li>• Evaluator based in country</li> </ul>	Yes	8- 31 March
<b>Swaziland</b>	LMI	TBD	South-eastern Africa (SEA)	<ul style="list-style-type: none"> <li>• Gender priority country</li> <li>• Re-programming of grants to include gender initiatives</li> <li>• DREAMS country</li> <li>• Tailored review/Window 3</li> </ul>	Yes	13-17 March
<b>Uganda</b>	LI	High Impact	Africa 2	<ul style="list-style-type: none"> <li>• PCE country</li> <li>• Gender priority country/Application in Window 1</li> <li>• DREAMS country; Evaluator based in country</li> </ul>	Yes	No

<sup>10</sup> DREAMS is the title of an ambitious USD 385 million partnership to reduce HIV infections among AHYW in 10 sub-Saharan African countries, funded through the US President's Emergency Fund for AIDS Relief (PEPFAR).

At the request of the TERG, the team conducted a Gender Portfolio Review (GPR) of additional ten countries. Table 3 lists the countries, application components reviewed and selection criteria.

**Table 3: Gender portfolio review countries**

Country	Application Components Reviewed	Selection Criteria
Bangladesh	Malaria	Submission under NFM and FM rounds
Cuba	HIV	Submission under NFM and FM rounds
DRC	HIV/TB	PCE country, material change for FM
Laos PDR	TB	Submission under NFM and FM rounds, tailored application material change for FM round
Malawi	HIV/TB	Tailored application for FM round
Mauritius	HIV	Submission under NFM and FM rounds
Philippines	HIV/TB	Submission under NFM and FM rounds
Sudan	HIV/TB	PCE country
Uganda	HIV/TB and RSSH	PCE country, full application
Zimbabwe	HIV/TB and Malaria	Submission under NFM and FM rounds

## 2.3 Methodology for Data Collection and Analysis

### 2.3.1 Data Collection

In summary, six methods of data collection were employed to conduct the review:

- 1) **Desk review** of key Global Fund documents, various stakeholder's reports, country strategies, plans, policies, guidelines, research and evaluation reports etc., from ten selected countries (see Table 3); where possible and available, this included Principal and Sub-recipient (PR and SR) reports, Office of the Inspector General (OIG) reports, UNAIDS Global AIDS Response Progress Reporting (GARPR), data from demographic and health surveys (DHS) and integrated bio-behavioral surveys (IBBS), gender assessments and other data sources.
- 2) **Gender Portfolio Review** for additional ten countries (see Table 4) – a review of a selected number of Full and/or Tailored Funding Requests (FRs) submitted under the current Window 1 funding cycle, and CNs from the same countries that were submitted under the previous allocation period (2012-2016). The team reviewed gender analysis and content of applications related to gender-responsive programming and programming targeted to AGYW, and made a comparison between the two application periods. The team also compared the FRs and CNs with the respective NSPs, national health plans/strategies and other national policies, as well as guidelines and guidance from the Global Fund/UNAIDS and partners as appropriate.
- 3) **Stakeholders and Key Informant Interviews** - Using a set of questions developed in consultation with the TERG focal point and the Global Fund Secretariat, the team conducted phone/Skype interviews with stakeholders and key informants throughout the review. Issues for discussion included, but were not limited, to:
  - Role played in the implementation of AGYW initiatives
  - Observed best practices which have been supported by the Global Fund
  - Positive and negative factors that influenced programming for women and girls
  - Recommendations for improving the focus on AGYW
- 4) **Country Briefs** – The team visited five of the ten selected countries (Cameroon, Kenya, Moldova,

South Africa and Swaziland) to solicit information from key stakeholders in those countries and compiled country level data. Each country case study involved a focused document review, a country visit and production of a brief structured country visit output – country brief. Country visits were undertaken by one team member, focused on data collection via in-depth interviews of key informants (Table 4), and lasted approximately five working days. The team developed and used a practical set of instruments to facilitate internal information exchange between team members and to ensure the quality of the work. This included check lists, reporting templates, criteria and parameter lists for data collection, organization and analysis, and other tools to ensure consistency of work between countries and among different team members.

**Table 4: Key informants interviewed**

Key Informants	
External Level	National Level
<ul style="list-style-type: none"> <li>Global Fund Secretariat/Departments</li> <li>TERG members and focal points</li> <li>FPMs</li> <li>International and local partners of the Global Fund (International Planned Parenthood Federation (IPPF), Stop TB, UNAIDS, UNFPA, WHO, etc.)</li> <li>Global Fund Technical Review Panel (TRP) members</li> </ul>	<ul style="list-style-type: none"> <li>Key country stakeholders (ministries of health (MOHs), other ministries such as Education, Youth, Sport, Women, national disease program managers, etc.)</li> <li>CCM Chair/Vice Chairs, CCM members, PRs and SRs, and key stakeholders in addition to national human rights commissions, nongovernmental organizations (NGOs) and civil society organizations (CSOs), community and women organizations from visited countries</li> <li>DREAMS project managers and beneficiaries in selected countries</li> <li>Other key informants such as key populations (KPs), AGYW, others</li> </ul>

- 5) **Focus group discussions (FGDs)** with women and girls were held in four countries (Cameroon, Kenya, South Africa and Swaziland). The team conducted group interviews and FGDs with AGYW to gain a deeper understanding of their attitudes, beliefs and experiences. Key topics discussed included among others: (i) problems affecting girls in school and within communities, (ii) activities and roles in the girls' clubs, (iii) their sources of information on sexual and reproductive health and rights (SRHR), HIV prevention and service delivery, (iv) sources/type of support in cases of abuse, and (v) any suggestions they might have to improve the situation of girls in and out of school.
- 6) **Participation of team members in relevant meetings and events during the review** – In consultation with the Global Fund Secretariat and the TERG, the team identified relevant technical meetings and other events at the country level that occurred while the team was in-country, and in which the team could participate. This allowed the team to validate information and obtain additional insights into developments and decisions regarding gender-related planning and discussions in-country.

## 2.4 Analysis and Synthesis Approach

Analysis started with the initial desk review, followed by country visits and was a continual process throughout the review. Following the completion of the country briefs, the evidence was brought together during an internal workshop held at EHG headquarters in Copenhagen. As a first step, the preliminary findings were triangulated between different data sources, both qualitative and quantitative followed by discussion of the emerging themes and finally initial conclusions and

recommendations. During the implementation period of this review, the team was in regular contact with the TERG through bi-weekly update calls with members of the TERG Secretariat and email exchanges providing regular updates and feedback. The team's findings, conclusions and recommendations were presented and discussed with the TERG during the 32<sup>nd</sup> TERG Meeting, 8 and 9 June 2017. This final report incorporates the feedback received during and after the TERG meeting and specific feedback from the Secretariat.

## 2.5 Limitations

The team identified several limitations to the review:

- **Qualitative approach:** One of the main approaches was qualitative data collection via KIs and FGDs. The full capture and analysis of qualitative data is complex. Furthermore, the opinions of stakeholders are by nature subjective. However, the team sought to mitigate the subjectivity of opinions by triangulation of both methods and data.
- **Selection bias:** The selection of countries was not random, but based on several specific criteria (see Tables 2 and 3 above) that allowed representation of a range of countries. However, this is not a representative sample of countries and the findings and conclusions may not be generalized for all countries in all regions. Nevertheless, it is reasonable to state that the findings of the sample of countries that were reviewed, the GPR findings, and the associated conclusions and recommendations, provide adequate guidance to inform the future direction of the Global Fund programs.
- **Self-selection bias:** Interviewees may also self-select by either making themselves available for interviews or in the amount of time they allot for the interview. Persons with stronger vested interests in the results of the review (either negatively or positively) may spend more time with the interviewers, which may skew the review results in their favor.
- **Limitations in accessing programmatic documentation:** Whereas the team could access web-based information concerning Global Fund support, there was limited programmatic information available from the different countries. Information such as progress reports from PRs and SR was very sparse. There was also restricted availability of specific Global Fund progress and evaluation reports, which limited the team's ability to attribute Global Fund investments to interventions for AGYW.

Some of the limitations noted were mitigated by the number and scope of methods utilized, and the team believes that the robustness of these various methods allows the team to present judicious robust findings and conclusions.

### 3 ANALYSIS ACROSS REVIEWED COUNTRIES

#### 3.1 Gender Related Considerations in HIV epidemic in the Review Countries

In this section, the team describes the gender related considerations in HIV epidemic in the review countries identified through the desk review of available documents from ten selected countries and information from KIIs conducted in the five field visit countries. A summary of the structural, biological and behavioral factors that contribute to the vulnerability of AGYW to HIV infection in the review countries is presented in Table 6.

**Harmful gender stereotypes** regarding the roles and responsibilities of women and men are one of the root causes of women's disadvantaged position in different areas of life, including health. For example, in Moldova, patriarchal attitudes and stereotypes concerning the roles and responsibilities of women and men in society compromise women's position. Another example is related to the sharing of equipment when injecting drugs in groups: women will be the last to inject and thereby be at higher risk of HIV infection. In Cambodia, women from poor families are pressured to take care of their relatives. As a result, many young women are driven into sex work to escape from poverty. In Cameroon, harmful traditional practices, including female genital mutilation (FGM), breast ironing and early and forced marriages persist. FGM is still practiced in Kenya and some remote parts of Uganda. Swaziland has its unique cultural practices, including the contentious 'reed dance' where virgins dance before the King and adolescent girls' virginity is tested before marriage.

**Sexual and gender based violence (SGBV)** is one of the key factors associated with HIV infection among AGYW in all of the review countries. In Moldova, 63.4 percent of female respondents had experienced psychological, physical or sexual violence at least once since the age of 15 (NBS, 2011). In South Africa, sexual violence contributes to a quarter of all new HIV infections among women and girls (KPMG, 2014). In Swaziland, 68 percent of children experience physical violence and 31 percent of females aged 18-24 have experienced violence. In addition, 47 percent of youth aged 15-19 believe a husband is justified in beating his wife (Gender Directorate, 2017). Forced/unwanted sex is most prominent in Uganda and Zimbabwe and there is a marked and troublesome increase in child rape (Cameroon). SGBV is magnified in situations of conflict and crisis and exacerbated by forced migration and population movements both within and outside the country concerned (for example in Cameroon, DRC and Sudan).

**Early child marriage** continues in Kenya, Moldova, Mozambique, Senegal, South Africa, Swaziland and Uganda). In Mozambique 14.3 percent girls aged 20-24 were married before 15 years of age.<sup>11</sup> In Swaziland 38 percent of women aged 18-24 experienced sexual violence<sup>12</sup>, 10.6 percent girls aged 13-17 reported rape as their first sexual experience and 40 percent in the same age group reported that their first sexual experience was with someone 5-10 years older.<sup>13</sup> In Moldova early marriage results in high drop-out rates at the primary school level especially among Roma girls. These girls are ill equipped to make decisions affecting their sexual life and are therefore more at risk of early and unwanted pregnancy, and of contracting HIV and other sexually transmitted infections (STIs).

**Working migrants and their sexual partners are at higher risk of HIV infection.** Many of the review countries (Cameroon, DRC, Swaziland, South Africa and Moldova) experience **mass migration** due to poverty, a lack of adequate employment opportunities and low salaries. It is estimated that between 11 and 17 percent of Moldovan citizens live abroad.<sup>14</sup> One-third of working migrants in Cambodia

<sup>11</sup> UNICEF (2015). Child Marriage and Adolescent Pregnancy in Mozambique: Causes and Impact.

<sup>12</sup> UNICEF & ODPM (2017). A National Study on the Drivers of Violence Affecting Children in Swaziland.

<sup>13</sup> Ibid 2017

<sup>14</sup> Migration Policy Centre (2013). *Migration Profile Moldova*. Florence: MPC.

and Moldova have been identified as vulnerable to HIV. Vulnerability takes many forms when living and working abroad, including limited access to preventive and curative health services. In many countries this has resulted in (mainly) male migrants, who have been in short-term employment abroad, contracting HIV and returning to their families rendering their wives susceptible to HIV and other STIs. Furthermore, large ongoing migration of the workforce, particularly among rural populations, often means that children and adolescents are left without parental care and are therefore vulnerable to exploitation and engaging in risk-taking behavior.

**Low rate of and inconsistent condom use:** The younger age of sexual debut among adolescent females, as noted in many of the review countries, places them at greater risk of acquiring HIV. In Cameroon, according to UNFPA, 14 percent of adolescent girls aged 15-19 have had sex before the age 15.<sup>15</sup> In Mozambique, South Africa and Swaziland women, especially younger women partnering with older men, often lack the power to insist on safe sex practices; including fidelity and condom use, and are thus unprotected from HIV and other STIs.

**Lack of economic security** (including no inheritance rights or inadequate implementation of these rights) for women, coupled with lack of access to and control over other economic resources (e.g. employment) has resulted in women, especially those living with HIV, losing their homes, inheritance and livelihoods in many of the review countries (Cameroon, Kenya, Moldova, Senegal and Uganda). Consequently, women are forced to adopt survival strategies that increase their chances of contracting HIV (e.g. transactional sex). In Kenya income inequalities often lead to the economic dependency of women and AGYW on older men. Economic dependency and poverty among AGYW compromises their power to negotiate safe sex leading to coerced sex and reduced power in their relationships. In Uganda a study conducted in Kampala slums found that 18.1 percent of young people aged 13-14 years had sexual partners who were 10 years or older.<sup>16</sup> The latest evidence in South Africa suggests that men aged 25-40 were the primary source of HIV infection among adolescents, girls and young women aged 15-25.<sup>17</sup>

Table 5 below depicts the major factors associated with increased HIV and TB infection among AGYW in the reviewed counties.

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<sup>15</sup> UNFPA (2016), *op. cit.*

<sup>16</sup> Renzaho AMN, Kamara JK, Georgeou N, Kamanga G (2017) Sexual, Reproductive Health Needs, and Rights of Young People in Slum Areas of Kampala, Uganda: A Cross Sectional Study. PLoS ONE 12(1): 0169721

<sup>17</sup> De Oliveira, Kharsany, Gräf, Cawood, Khanyile, Grobler, Puren, Madurai, Baxter, Karim, & Karim (2017). Transmission networks and risk of HIV infection in KwaZulu-Natal, South Africa: a community-wide phylogenetic study. Lancet HIV. 2017 Jan;4(1): 41-50



**Table 5: Major factors associated with HIV infection among AGYWs in review countries**

	Cambodia	Cameroon	DRC	Kenya	Moldova	Mozambique	Senegal	South Africa	Swaziland	Uganda	Number
<b>BEHAVIOURAL</b>											
Age-disparate sex		✓		✓	✓	✓		✓	✓	✓	7
Multiple concurrent partnerships			✓	✓		✓	✓	✓	✓	✓	7
Sex work	✓			✓	✓	✓		✓		✓	6
Sexual exploitation	✓	✓	✓	✓		✓		✓	✓	✓	8
Transactional sex		✓	✓	✓		✓		✓	✓	✓	7
Early sexual debut			✓	✓		✓	✓	✓	✓	✓	7
Gaps in knowledge of HIV	✓	✓		✓		✓	✓		✓		6
Limited personal risk perception											0
Lack of awareness of available services		✓	✓								2
<b>BIOLOGICAL</b>											
Inconsistent/low condom use	✓	✓	✓	✓	✓	✓		✓	✓	✓	9
High HIV viral load among male sexual partners				✓		✓			✓		3
Low prevalence of male circumcision									✓		1
Harmful practices (intra-vaginal, sexual cleansing)						✓			✓		2
Existence of other sexually transmitted infections		✓	✓								2
Early pregnancy and child-bearing and/or unsafe abortions		✓	✓	✓		✓	✓		✓		6
Female genital cutting				✓			✓				2
<b>STRUCTURAL</b>											
Harmful social and gender norms	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	10
Low secondary school attendance		✓	✓			✓	✓		✓		5
Lack of economic empowerment		✓	✓	✓		✓	✓	✓	✓	✓	8
Labor migration	✓	✓			✓	✓					2
Spousal separation					✓	✓					2
Barriers to SRH services				✓		✓	✓	✓	✓	✓	6
Being an orphan			✓						✓		2
Limited parental guidance on sexuality				✓		✓			✓		3
Child sexual abuse	✓			✓					✓		3
Sexual and gender-based violence	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	10
Early marriages				✓		✓	✓	✓	✓	✓	6
Armed conflict			✓								1

Source: *Country Briefs*

### 3.2 Gender-related Risks and Barriers to Access Services Faced by Women and Girls in Review Countries

Women and girls face significant barriers in accessing information and services. These include individual barriers (knowledge and attitudes), interpersonal difficulties (partners, parental views and peer pressure), institutional obstacles (time, location and integration of services) and societal and legal barriers (social norms of the communities they live in and regulatory frameworks influencing issues such as parental consent). Other barriers noted include:

- Stigma and discrimination, gender-based violence (GBV), harmful practices (all review countries)
- Limited mobility and autonomy in making health decisions (DRC, Kenya, Malawi, Senegal and Swaziland)
- Prioritization of male and children family members' health needs over their own (Kenya and Moldova)
- Lack of access to economic resources (Cameroon, Kenya, Senegal and Uganda)
- Health services that are discriminatory and not designed to meet the needs of AGYW
- Persistence of a culture of silence related to SRHR, including HIV and AIDS (all review countries)

**Interpersonal factors** are still the major barrier due to stigma related to being sexually active while unmarried. In Cameroon, sex as a subject remains a taboo topic in families and this restricts the access of AGYW to sex education and sexual and reproductive health (SRH) services. A study from a health provider perspective conducted in Kenya asserted that peer attitudes toward contraception also have a significant impact on adolescent females' views and level of ease in seeking services from health facilities. The providers felt that peer attitudes could not be particularly harmful given the many stereotypes and myths regarding contraception believed by adolescents.<sup>18</sup>

**Societal/public policy factors** such as parental (legal) consent often constitute a barrier to accessing SRH services. Making parental involvement or notification mandatory affects adolescent decision-making, and reduces the likelihood that they will seek timely treatment. Laws that may inhibit women and girls from seeking services (e.g. laws which require spousal or parental notification for testing or treatment) are still in place in DRC, Mozambique, Senegal and Swaziland. However, it should be noted that although parental consent can be a considerable barrier to accessing services, some KIIs (Kenya) reported that occasionally having parents present at the health clinic could lead to a higher uptake of contraceptive services among adolescents.<sup>19</sup>

One of the most significant barriers to health-seeking behavior among AGYW living with HIV is the experience of **stigma, discrimination or victimization** by health care providers. Stigma around premarital sex perpetuated by parents, service providers and other community members has been shown to be the primary barrier to seeking SRH in resource-poor countries (Cameroon, Kenya, Senegal and Uganda). Lack of service integration adds time and cost to clinic visits and may be a further barrier to seeking care. In Cameroon and Uganda, criminalization of female drug users, female sex workers (FSWs) and young women and girls engaged in transactional sex impedes their access to health services and obstructs health service provision and legal protection. Even in settings where activities are not criminalized, female drug users, young women and girls engaged in transactional sex, FSWs and AGYW living with HIV may experience significant stigma, discrimination or police harassment because of both their group identity and their age (Cameroon, Moldova and Senegal). In Senegal, FSWs are subject to marginalization, violence, and condemnation. Laws and regulations on sex work in Senegal are flawed (or ill-equipped) regarding protecting FSWs against

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<sup>18</sup> Hagey JM et al (2015), *op.cit.* 3

<sup>19</sup> Hagey JM et al (2015), *op.cit.* 3

abuse by security forces. The multiple forms of discrimination, social exclusion and sexist violence make it difficult for young FSWs to access health services in Senegal and other countries.

In some of the review countries (Cameroon and Kenya), the effects of stigma, discrimination and violence are exacerbated by policy and legal barriers related to the age of consent for sex as well as for selected medical interventions. These policies further limit access to a range of health services that respond to the health needs of AGYW. In Cameroon, social stigma, discrimination and violence are prolific with harassment, threats to life and a generally hostile environment leading to a widespread fear of the Cameroonian police, the justice system and fear of accessing HIV services.<sup>20</sup> Because FSWs are perceived as being 'outside the law', they are not protected by police and have no access to justice. After experiencing violence, most FSWs in Cameroon feel they have no place to go for support. In Cambodia and Moldova, there are still some cases of groups of AGYW living with HIV being **refused treatment** by health providers (such as gynecologists) in certain institutions. In Moldova, similar cases were brought to the Council of Prevention and Elimination of Discrimination for the government to act against such practices. In Cambodia women living with HIV reported challenges in accessing gynecologists due to their HIV status.

The **prioritization of health needs of male and children family members over those of women** is another hindrance for women and girls in accessing health services (Moldova and Kenya). In Moldova, the belief that women should stay at home and take care of children and/or a sick husband means that their health needs are perceived to be less important when it comes to seeking necessary medical treatment. Moreover, the heavy burden of care for women in Kenya, South Africa and Uganda, and other countries where women bear the major responsibility of care-giving in the family, including for those living with and affected by HIV, can adversely affect women's health and access to care.

In Kenya, Malawi, Moldova, Mozambique, Swaziland and Uganda, **harmful gender norms** obstruct women's and/or girls' access to services, particularly when women experience **intimate partner violence (IPV)** and feel ashamed or afraid to seek help. As an example of this, IPV has been attributed to the lack of adherence to antiretroviral drugs (ARVs) among women in Malawi; women participating in a study in Malawi reported that domestic violence at the hands of their husbands and intimate partners, and the fear of such violence, had a negative impact on their ability to start and continue using ARVs.<sup>21</sup> A gender assessment in Uganda showed that harmful cultural norms and ideas undermine the status of women and negatively impact on women's and girls' access to information and services.

**Restrictions on women's mobility and lack of access to transportation and financial resources** restrict the ability of AGYW and HIV-positive pregnant women to seek contraceptive and prevention of mother-to-child transmission (PMTCT) services. In the DRC, Kenya, Malawi, Senegal and Swaziland, **a limited autonomy in health decision-making** is likely to influence access to preventive and curative care and is reflected by the fact that decision-making power rests primarily with men in terms of when care is sought within a household.<sup>22</sup> For example, in Senegal issues relating to sexuality and fertility are decided by males. It has been observed in Malawi's capital Lilongwe, and Senegal, that participation in PMTCT programs, including whether women undergo HIV testing, return for follow-up appointments and adhere to ARV regimens, is traditionally the husbands' decision.<sup>23</sup>

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<sup>20</sup> Cange et al., 2015; Decker et al., 2016; Lim et al., 2015; Nemande, 2013; Stewart, 2016

<sup>21</sup> Chinkonde JR, Sundby J, Martinson F. The prevention of mother-to-child HIV transmission program in Lilongwe, Malawi: why do so many women drop out. *Reprod Health Matters*. 2009;17(33):143\_51

<sup>22</sup> 'Health Seeking Behaviour for Childhood Malaria: Household Dynamics in Rural Senegal', *Journal of Bioscience*, 2008, Cambridge University Press.

<sup>23</sup> Chinkonde JR, Sundby J, Martinson F. (2009), 'The prevention of mother-to-child HIV transmission program in Lilongwe, Malawi: why do so many women drop out'. *Reproductive Health Matters*. 2009;17(33):143\_51

**Labor migration** (Cambodia and Moldova) and **forced migration** and population movement both within, and outside, the country (Cameroon, DRC and Sudan), affects women's access to services. In Moldova, the challenges of controlling tuberculosis (TB) in the presence of large-scale labor migration are well recognized, as is the situation of limited access to health facilities for migrants (mainly due to legal barriers). In the eastern provinces of DRC, such as North and South Kivu, the movement of large numbers of refugees and soldiers is resulting in a lack of access to testing and treatment and is fueling the spread of HIV. In Bangladesh, In comparison to the general population, Rohingya refugees generally have less access to health services. Sudan's funding request (FR) highlights the significant issue of mobility for two million internally displaced persons (IDPs) of which 50 percent are women and children, and the mass influx of South Sudanese refugees who present a potential increased case load and demand on services for all three diseases. Women and girls who are not living in a fixed place may find it difficult to use bed nets, avoid TB-infected contacts in crowded housing and to access health services.

**Lack of economic security** (as described in Section 3.1 on Key Drivers) is not only forcing AGYW to adopt survival strategies that increase their chances of contracting HIV, but also limiting their access to health services. In Uganda, despite laws that prohibit discrimination against women, the same inheritance rights are not applied to men and women. If a woman loses her husband, the property is likely to be taken over by other men in the family, frequently placing the woman in a difficult financial situation. In Kenya and Tanzania, income inequalities often lead to economic dependency of women and young people. Economic dependency and poverty among AGYW compromises their power to negotiate for safer sexual relations, leading to decreased access to education and services.<sup>24</sup> In Cameroon the social security system does not meet the needs of AGYW, particularly those with unemployed parents. All the girls who participated in the FGDs (Kenya, Swaziland and South Africa) raised the issue of lack of financial resources as the major obstacle to accessing health services.

**Lack of comprehensive education for girls** in some of the review countries (DRC, Senegal and Swaziland), as well as globally, often leads to AGYW's greater risk of contracting HIV. The girls miss opportunities in school to receive comprehensive, age-appropriate life-skills-based HIV and AIDS education that addresses gender norms, sexual decision-making and GBV. These life skills equip them to make better decisions affecting their sexual lives. In Kenya, the issue of comprehensive sexuality education (CSE) is controlled by the government who is adamant that only a limited scope of the CSE should be provided.

**High levels of girls dropping-out of school:** In Cambodia, while gender parity has been achieved in primary and secondary education enrolment, drop-out and non-completion rates for girls remain high, as do notable differences between urban and rural areas. In Tanzania there is currently an ongoing debate about the applicability of a 1940s law that prevents pregnant schoolgirls from returning to school, thus limiting their life opportunities and increasing their economic dependency. Beyond lower secondary level, girls' access to education is limited and completion rates remain low. Social norms that priorities boys' over girls' education also represent barriers to education for girls.<sup>25</sup> Parents' perceptions that daughters must help with household chores and take care of younger siblings undermine their ability to pursue higher education.<sup>26</sup> In Moldova, early marriage (especially for Roma girls) results in high drop-out rates at the primary school level. In Swaziland, 47 percent of children of secondary school age are attending secondary school or higher. At the secondary level in urban areas, 72 percent of out-of-school youth are girls.<sup>27</sup> There is a high drop-out rate largely due to

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<sup>24</sup> Kenya National AIDS Coordination Council. Kenya HIV Estimates. Ministry of Health, 2015

<sup>25</sup> Royal Government of Cambodia (2010). *Fourth and Fifth National Report on the Implementation of CEDAW in Cambodia*. Phnom Penh.

<sup>26</sup> Ministry of Women's Affairs (2011)...*op. cit.*

<sup>27</sup> UNICEF, Swaziland. Multiple Indicator Cluster Survey, 2014

pregnancy among adolescent girls in grades 5-7. Girls are more likely to drop-out of school to undertake work around the home or because they are married while still in their childhood.<sup>28</sup> In the DRC more than twice the number of boys has received schooling compared to girls (8.1 versus 4.0, respectively) because money for schooling must be spent on boys' education before it is used for that of girls.

### 3.3 Country National Strategic Plans, Concept Notes and Funding Requests - Strengths and Weaknesses

This section discusses the strengths and weaknesses of the selected countries' reviewed NSPs, CNs (submitted for allocation period 2015-2017) and FRs (submitted under Windows 1, allocation period 2018-2020) from a gender perspective. Key issues reviewed include the extent to which countries addressed gender-related inequalities, challenges and barriers to services for women and girls and included interventions to address inequalities faced by AGYW that affect their access and use of HIV prevention, treatment and care services.

#### 3.3.1 Strengths and Weaknesses of National Strategic Plans

In general, the NSPs reviewed are not always informed by the latest epidemiological evidence from a gender perspective. This varies from country to country, from some that do not address gender related inequalities (Bangladesh TB and DRC Malaria) to those where gender is mainstreamed throughout the NSP, including proposed interventions that specifically target harmful gender norms, GBV and other pertinent issues (Kenya HIV, Malawi HIV and South Africa HIV).

Although many of the NSPs contain sound epidemiological and situation analyses with data disaggregated for sex, age and geographic location, there is a lack of analysis of gender-related issues. Even when a robust gender analysis was undertaken (e.g. Kenya and Swaziland) this was not reflected in the NSP. The limited availability of recent data and/or use of evidence as the basis for the NSP are noted, both for gender and in general.

Presentation of costing and budgetary frameworks is weak in the majority of the NSPs. Although basic financial information is provided, few NSPs have clearly costed operational plans (OPs), which make it difficult to assess the resources needed or allocated for AGYW. No budgetary information for AGYW interventions was available in the NSP documents.

Table 6 below depicts the strengths and weaknesses of the NSPs in the selected countries.

**Table 6: Summary of strengths and weaknesses of reviewed NSPs with regard to AGYW**

Country/NSP	Strengths	Weaknesses
<b>Cambodia (HIV)</b>	<ul style="list-style-type: none"> <li>• Sound epidemiological and situation analyses with systematic use of references</li> <li>• Good coverage of PMTCT-related issues, including budgetary estimate</li> <li>• Strategic plan includes objectives related to the prevention for KPs (female entertainment workers)</li> <li>• Gender-related issues are one of the guiding principles of strategic planning</li> </ul>	<ul style="list-style-type: none"> <li>• Although claiming that all the data in the program monitoring and reporting system is gender-disaggregated, there are no such data</li> <li>• There is no gender-related analysis. Apart from the basic demographic data and PMTCT-related data there are no references related to gender issues</li> <li>• There are almost no references to gender-related inequalities; challenges and barriers</li> </ul>

<sup>28</sup> Equal Rights Trust (2016), *op. cit.*

Country/NSP	Strengths	Weaknesses
		<p>not addressed. Key drivers are not described</p> <ul style="list-style-type: none"> <li>• There are no interventions included to address inequalities faced by women and girls that affect access and use of prevention treatment and care or a budget for such interventions</li> </ul>
<b>Cameroon (HIV)</b>	<ul style="list-style-type: none"> <li>• Extensive description of epidemiological context and reference to data and evidence</li> <li>• Goals and eight priority areas clearly described, including main strategies</li> <li>• Comprehensive mix of interventions and specific attention to KPs in a very difficult policy environment. Geographic targeting explicitly mentioned</li> <li>• Issues of gender inequality and GBV addressed throughout NSP; gender-based approach mentioned as the NSP's first principle</li> <li>• Focus on most-at-risk adolescents and vulnerable youth explicitly mentioned</li> <li>• Costed OP budget provides a highly transparent overview of program financial need with detailed explanations related to calculations of activity cost for all three program years</li> </ul>	<ul style="list-style-type: none"> <li>• No age-disaggregated and/or data for different age groups within the population of AGYW</li> <li>• Socio-cultural norms and practices that contribute to increased risk of HIV transmission among AGYW are not described</li> <li>• Community systems context poorly described</li> <li>• Poor description of gender-specific interventions in Strategic Framework</li> <li>• Human rights approach is not strongly implemented in the action addressing access to services, stigma and discrimination</li> <li>• There is mention of the TB program but, otherwise, horizontal linkages and collaborative interventions are absent. Linkages to SRH, STIs, hepatitis B virus (HBV) or hepatitis C virus (HCV) not described</li> <li>• Given the cultural and socio-economic context, the NSP was developed through a sensitive approach that attempted to involve all key stakeholders, especially KPs; there is no mention of AGYW participation</li> </ul>
<b>DRC (HIV)</b>	<ul style="list-style-type: none"> <li>• The NSPs' Strategic Axis 4 is Promoting an enabling environment for PHLIV; the indicator is that 80% of women and girls (PLHIV, survivors of sexual violence and orphans and vulnerable children (OVC) aged under 18) are empowered through strengthening their economic status</li> <li>• Axis 4 also notes that 100% of persons affected, women and girls, and survivors of SGBV have access to protection services and promotion of their rights by 2017 and that gender inequalities are reduced by 60%</li> <li>• The NSP notes that women and girls who are victims of SGBV account for 35% of all women and are at high risk of HIV infection; HIV prevalence among rape victims is estimated at 20%, female IDPs at 7.6%</li> <li>• HIV among young people aged 15-24 is estimated at 0.8%, and twice as high among women compared to men.</li> </ul>	<ul style="list-style-type: none"> <li>• Limited description of demographic context</li> <li>• No gender-disaggregated data</li> <li>• Although the NSP includes interventions such as behavior change communication (BCC) to target 15-24 year olds of both sexes, AGYW not specifically mentioned.</li> <li>• Although there is recognition of the high proportion of young people among the population and the disparate infection rates between men and women, there are no interventions to address the gender differentials apart from PMTCT and some activities to address GBV.</li> <li>• AGYW are not mentioned at all.</li> </ul>

Country/NSP	Strengths	Weaknesses
<b>Kenya (HIV)</b>	<ul style="list-style-type: none"> <li>• Overall HIV trends; HIV trends by sex; by age; by KP (MSM, PWID, SWs; by region; number of new HIV infections by age and KP</li> <li>• Strategic Direction 3, which focuses on ‘using a human rights approach to facilitate access to services’ specifically addresses gender inequalities and cultural practices including wife inheritance, SGBV, early marriage and high attrition in school</li> <li>• Proposed interventions systematically address age- and disability-related inequalities, challenges and barriers that increase vulnerability and/or affect access to services. Specific attention is given to adolescent and young women</li> <li>• Integration of HIV, TB and SRH responses is mentioned in 2 of 7 strategies with reproductive and child health (RCH) aimed at AGYW</li> <li>• A human rights approach does come through strongly in the actions addressing access to services, stigma and discrimination, GBV and so on.</li> <li>• Synergies between HIV, TB and SRH are described throughout the NSP</li> </ul>	<ul style="list-style-type: none"> <li>• Brief and slightly superficial overview of key drivers</li> <li>• Very limited reference to ‘evidence’ from research, e.g. on risk behaviors, KPs etc.</li> <li>• At the level of proposed interventions, the gender aspect appears to be poorly operationalized: Lip service to gender but no specific interventions</li> <li>• Limited information on responsibilities, especially of NGOs/CSOs</li> <li>• Little mention of capacity building or potential TA needs</li> </ul>
<b>Malawi (HIV)</b>	<ul style="list-style-type: none"> <li>• Sound epidemiological and situation analyses, with systematic references to data/research</li> <li>• Proposed interventions are comprehensive and clearly focused on priorities and key and vulnerable populations (KVP). The proposed interventions address gender-related inequalities, challenges and barriers, including GBV</li> <li>• Human rights barriers are well addressed</li> <li>• References made to TB/HIV collaborative actions, as well as integration of HIV in SRH</li> <li>• Costing and budget methods and assumptions are clear and incorporate national lessons learnt and international evidence, allowing for efficiency gains to be identified</li> </ul>	<ul style="list-style-type: none"> <li>• No age-disaggregated and/or data for different age groups within the population of AGYW</li> <li>• Goals and objectives are not linked to the epidemiological, situation and response analyses</li> <li>• While the main gender-related vulnerabilities, are described, the description of the proposed interventions does not systematically highlight how the identified gender issues will be addressed</li> <li>• No clear reference to age and disability-related challenges</li> <li>• The NSP development process described as participatory, and KPs/PLHIV are prioritized throughout the NSP, but the extent to which their involvement is active remains unclear: they seem merely to be beneficiaries or target groups; there is no mention of AGYW involvement in the consultation process</li> </ul>
<b>Moldova (HIV)</b>	<ul style="list-style-type: none"> <li>• Systematic use of sex and age disaggregated data for the purpose of intervention planning</li> <li>• NSP based on multidisciplinary approach and interagency cooperation</li> <li>• Detailed list of indicators for program monitoring by target groups</li> <li>• Budget outlined by source of income and objectives.</li> </ul>	<ul style="list-style-type: none"> <li>• Limited situational analysis</li> <li>• No linkages between the proposed plan and situation</li> <li>• Scarce use of references</li> <li>• Key drivers and barriers not described</li> <li>• There are no interventions included to address inequalities faced by women and girls that affect access and use of</li> </ul>

Country/NSP	Strengths	Weaknesses
<b>Senegal (HIV)</b>	<ul style="list-style-type: none"> <li>• NSP 2014-2017 firmly situated in National Health and Social Development Plan</li> <li>• Integration of HIV interventions with those for TB and hepatitis co-morbidities; and linkages to SRH</li> <li>• Gender mainstreaming and respect for human rights stated</li> <li>• Good description of sociodemographic background</li> <li>• Virtually no difference between male and female transmission rates noted</li> <li>• High proportion of young people also noted</li> <li>• Significant social disparities between men and women; noted gender poverty and inequalities, also according to region</li> <li>• Special section on HIV infection among women and even talks about handicapped women</li> <li>• Section on HIV infection among young people, including pointing out their increased vulnerability and especially that of young women</li> <li>• Vulnerable populations identified as young women and men aged 15-24, and women aged 15-49</li> </ul>	<p>prevention treatment and care nor a budget for those interventions</p> <ul style="list-style-type: none"> <li>• Data on young representatives of KPs are not available, but feedback from the operational level suggests an increase in HIV infection at their level</li> <li>• Data on the various categories of young people (urban, rural, in- or out-of-school) are not available. Economic and sexual exchanges in intergenerational relations are still poorly documented</li> <li>• Despite the large proportion of young people, HIV among youth is not noted as a major challenge (presumably because prevalence rates are so low among general population)</li> <li>• Not one mention of AGYW specifically</li> </ul>
<b>South Africa (HIV-TB)</b>	<ul style="list-style-type: none"> <li>• Gender is mainstreamed throughout the NSP: addressing negative gender norms, GBV, gender identity, etc.; gender addressed in various sections of the NSP and specific interventions proposed</li> <li>• Human rights are highlighted throughout the NSP; sometimes specific issues, such as criminalization of SWs or SRHR, are mentioned</li> <li>• Linkages to overall national level planning framework described in detail. The NSP is aligned with the government's broader development plans which include the medium-term expenditure framework (MTEF) and Program of Action</li> <li>• The NSP explicitly highlights the importance of mainstreaming HIV in all sectors. HIV is also explicitly seen in the wider context of SRH and MCH</li> <li>• Excellent costing of NSP. Application of three costing tools and different approaches indicates considered thinking to obtain a robust result for the overall purpose</li> <li>• AGYW is one of the priority vulnerable populations for HIV and STIs (focus on economic empowerment, prevention programs, access to services, Human</li> </ul>	<ul style="list-style-type: none"> <li>• HIV and TB epidemics described in general terms, with very little actual data. KPs are 'presented' but with little evidence as to what makes them 'key'</li> <li>• Very limited reference to the plethora of available research and studies</li> <li>• Drivers of the epidemic are hardly described</li> <li>• No age-disaggregated data for different age groups within the population of AGYW</li> <li>• Little attention was given to integration with SRH</li> <li>• No description of health and community systems context</li> </ul>



Country/NSP	Strengths	Weaknesses
	Papilloma Virus (HPV) vaccination, She Conquers campaign)	
<b>Sudan (HIV)</b>	<ul style="list-style-type: none"> <li>• Extensive description of epidemiological context and reference to data and evidence</li> <li>• Comprehensive mix of interventions and specific attention to KPs in a very difficult policy environment. Geographic targeting explicitly mentioned</li> <li>• Issues of gender inequality and GBV addressed throughout NSP; gender-based approach mentioned as the NSP's first principle</li> <li>• Focus on most-at-risk adolescents and vulnerable youth explicitly mentioned</li> <li>• Costed OP budget provides a highly transparent overview of program financial need with detailed explanations related to calculations of activity cost for all three program years</li> </ul>	<ul style="list-style-type: none"> <li>• No age-disaggregated and/or data for different age groups within the population of AGYW</li> <li>• Community systems context poorly described</li> <li>• Poor description of gender-specific interventions in the Strategic Framework</li> <li>• There is mention of the TB program but, otherwise, horizontal linkages and collaborative interventions are absent. Linkages to SRH, STIs, HBV or HCV not described</li> <li>• Given the cultural and socio-economic context, the NSP was developed through a sensitive approach that attempted to involve all key stakeholders, especially KPs; but there is no mention of AGYW participation</li> </ul>
<b>Swaziland (HIV)</b>	<ul style="list-style-type: none"> <li>• Effective use of disaggregated data in intervention planning</li> <li>• Integration of HIV and AIDS services is listed as a major strategic opportunity</li> <li>• Good overview of key drivers and factors influencing the spread of the HIV, with prominence given to gender related issues</li> <li>• Among others, core programs dedicated to GBV, family strengthening and PMTCT</li> <li>• Intergenerational sex addressed with planned intervention</li> <li>• Political and legislative framework provided</li> </ul>	<ul style="list-style-type: none"> <li>• Community environment scarcely described</li> <li>• Disaggregation of data according to type of environment (urban/rural) is missing</li> <li>• It is not clear to which extent PLHIV and AGYW were included, although it is stated that the process of developing the plan was 'highly participatory'</li> </ul>
<b>Uganda (HIV)</b>	<ul style="list-style-type: none"> <li>• The epidemiological analysis includes trends in HIV incidence, HIV prevalence by KP, by sex, by region and comparison with the regional and global context</li> <li>• A good description of KPs with plenty of information about how women are most affected, and information provided by sex, region and compared to regional/global context</li> <li>• Many comprehensive and wide-ranging interventions to address AGYW across all the strategic objectives/strategies etc. are included and address structural drivers of the epidemic such as GBV, and links with SRH services</li> <li>• Disability, age and human rights are also addressed</li> <li>• Addresses TB/HIV services and integration, SGBV, STIs and SRH in many of the strategies/interventions. Of particular note are the comprehensive and wide ranging activities regarding AGYW</li> </ul>	<ul style="list-style-type: none"> <li>• Key drivers (behavioral, socio-economic, GBV and stigma/discrimination) briefly described with no reference to 'evidence' from research</li> <li>• No substantive discussion of the health sector and its impact on HIV service delivery and nothing on the community context</li> <li>• No formal monitoring and evaluation (M&amp;E) framework available</li> <li>• There are no detailed costs linked to each objective or activity.</li> </ul>

Country/NSP	Strengths	Weaknesses
	<ul style="list-style-type: none"> <li>Provides a results framework as well as separate sections after each thematic area with a table of baseline and target indicators</li> </ul>	

### 3.3.2 Strengths and Weaknesses of Reviewed Concept Notes and Funding Requests

Table 7 below summarizes the strengths and weaknesses of the reviewed CNs and FRs regarding the extent to which gender-related inequalities, challenges and barriers - including interventions to address these are addressed and costed.

In general, the reviewed FR applications (submitted in Windows 1, March 2017 for the allocation period 2018-2020), in comparison to the reviewed CNs (submitted in 2014 for the allocation period 2015-2017), demonstrate the increasing identification and analysis of gender-related issues and present sex-disaggregated data together with data on KPs. Discussions on gender-specific barriers for AGYW are included in most HIV applications. Linkages with reproductive, maternal new-born, child and adolescent health (RMNCAH) programs in the FR applications, although slightly improved, remain weak. The exception is PMTCT and Isoniazid preventive therapy (IPT) in antenatal care (ANC) when compared to the CNs.

Not surprisingly, the strongest AGYW programming content was reflected in applications from countries applying for AGYW matching fund grants (e.g. Kenya, Malawi, Uganda and Zimbabwe).

**Table 7: Summary of strengths and weaknesses of reviewed CNs and FRs with regard to AGYW**

Country	Strengths	Weaknesses
<b>Reviewed CNs (allocation period 2015-2017)</b>	<ul style="list-style-type: none"> <li>Some CNs increasingly present sex/gender-disaggregated data across the three diseases</li> <li>Gender-disaggregated data for KPs, particularly for those affected by HIV, is provided</li> <li>A few CNs provide a solid gender analysis and gender-responsive interventions</li> <li>New evidence-based approaches aimed at greater impact - programs focusing on AGYW are being used</li> <li>Innovative above allocation request for AGYW (South Africa)/Innovative HIV interventions for women and girls (South Africa)</li> </ul>	<ul style="list-style-type: none"> <li>No age-disaggregation for different age groups within AGYW</li> <li>Age- and gender-disaggregated data for TB treatment outcomes remain absent from most CNs</li> <li>Weak use of sex-disaggregated data</li> <li>Weak gender analysis</li> <li>Weak or absence of gender-responsive interventions and programming</li> <li>Lack of data and interventions for AGYW in most of CNs</li> <li>Women's organizations not included in descriptions of consultative processes and/or CCMs</li> <li>Interventions to address gender inequalities, where they exist, are often not adequately costed</li> <li>Lacking focus on the empowerment of women and girls</li> <li>Limited discussion of opportunities for linkages across the three diseases and across gender identities to include SRH including maternal and child health (MCH)</li> <li>Limited attention to mass media, and even less to Internet, social media, cell phones or e-learning</li> </ul>

Country	Strengths	Weaknesses
		<ul style="list-style-type: none"> <li>• In general, most of the interventions addressing AGYW are still dedicated to PMTCT or FSWs</li> </ul>
<b>Reviewed FRs, (allocation period 2018-2020)</b>	<ul style="list-style-type: none"> <li>• Shorter applications, more focus on gender</li> <li>• Better awareness of KPs, including AGYW</li> <li>• Increased presentation and use of sex-disaggregated data and data on KPs</li> <li>• Discussion of gender-specific barriers for AGYW included in HIV FRs</li> <li>• Increased discussion of gender in TB and malaria FRs</li> <li>• Increased attention to GBV in HIV funding requests</li> <li>• Progress in addressing GBV; especially using matching funds</li> <li>• Some applicants prioritized reaching AGYW</li> </ul>	<ul style="list-style-type: none"> <li>• Still gaps in gender analysis; little discussion of AGYW particularly in concentrated and low generalized epidemics; not enough analysis and interpretation of available data</li> <li>• Gender-specific barriers for AGYW not included in TB and malaria FRs</li> <li>• Limited discussion on harmful practices</li> <li>• HIV cascade not always well presented, gaps in prevention coverage not well addressed</li> <li>• AGYW and women's organizations generally not included in descriptions of CCM and consultative processes</li> <li>• Weak linkages with RMNCAH across all three disease programs, with exception of PMTCT and IPT in ANC</li> <li>• Under-developed integration of gender in human resources for health (HRH) and health system strengthening (HSS)</li> <li>• Absence of discussion of gender in HRH and HSS</li> <li>• Limited or no discussion of GBV in TB and malaria FRs</li> <li>• Limited scale of the response to GBV and to violence against women and children</li> <li>• For TB/malaria, gender-responsive interventions are generally not included in the FRs</li> </ul>

According to some KIIs, one of the main reasons for more and better consideration of gender inequalities in FRs is that national decision-makers have paid more attention to KPs and gender during the application process and proposal development. This is reportedly due to the Global Fund's increased focus on human rights and gender, particularly AGYW, and the development and dissemination of new AGYW guidelines to countries.

### 3.4 Participation and Voice of Women Organizations and AGYW in Global Fund Country Processes

The CCM's role in ensuring meaningful participation of women and girls (in all their diversity) as part of HIV responses is critical. The significant participation of women must be grounded in the five key principles of meaningful engagement that include: 1) voice; 2) information; 3) capacity; 4) decision-making power; and 5) accountability to the constituency being represented.<sup>29</sup> With these principles in mind, the team assessed how CCMs are ensuring: a) balanced gender membership; b) the active participation of KPs, including designated representatives with gender expertise; and c) that investments are directed at the structural causes of gender inequality.

In review countries the percentage of female membership in CCMs (member or alternate) ranges from 28.5 percent (Mozambique) to 45.5 percent (South Africa). Half of the CCMs do not have designated representatives with expertise in gender issues, and there is ambiguous evidence of efforts to ensure an active voice for women's issue in CCM (see Table 5 below). In Cambodia, Cameroon, Kenya, Moldova, Mozambique and Uganda, AGYW are not represented on the CCM. Interviews revealed that AGYW were not involved in the design of most CN/FR components, including the Young Women and Girls program supported by the Global Fund. Whereas representation of KPs in the CCMs can be seen, key quintessential women's advocacy organizations (beyond those living with HIV) are not represented. In Mozambique, there is reportedly a lack of technical skill in gender analysis and programming and no obvious women groups for potential representation in the CCM in the near future.

There are some exceptions with regard to gender expertise and action among CCMs. For example, in Moldova, expertise in gender was brought to the CCM through an umbrella NGO and collaborative partnerships between the Global Fund and other partners in the country. This resulted in women living with HIV becoming leaders and advocates for their rights (not just within the HIV community) and more broadly, for gender equality. The new guidelines on AGYW integration have had an impact in Swaziland, where an AGYW representative has just joined the CCM as a full member.

**Table 8: Participation, AGYW representation and the voice of women's groups in CCMs**

CCMs	% of Female Membership in CCMs (Member or Alternate)	Designated Representative with Gender Expertise (Representing Women's Organizations)	Participates Regularly in Meetings (Designated Representative with Gender Expertise)	AGYW as CCM Member and/or Alternate	AGYW as Member of Working Groups
Cambodia	39.4	Yes	Yes	No	n/k
Cameroon	44.6	Yes	Yes	No	No
DRC	38.2	No	n/a	No	n/a
Kenya	35	No	No	No	No
Moldova	46	Yes	Yes	No	Yes
Mozambique	28.5	No	n/a	No	No
Senegal	38.4	Yes	n/k	No	n/k
South Africa	45.5	No	n/a	Yes	Yes
Swaziland	39.5	Yes	No	Yes	No
Uganda	33,3	Yes	n/k	No	Yes

n/a – not applicable; n/k – not known

<sup>29</sup> W4GF Advocacy Brief: Meaningful Engagement of Women in the Global Fund's Funding Model: Recommendations from Kenya, Uganda and Zimbabwe, Oct 2016

The lack of designated representatives with gender expertise and the weak voice, capacity and decision-making power of women and girls in CCMs results in a CCM which lacks the ability to understand the structural causes of gender inequality and to develop appropriate interventions for FRs. However, in some countries, there is evidence of CCM efforts to ensure an active voice for women through a designated female representative with gender expertise who is able to represent women's organizations and participates regularly in meetings (Cambodia, Cameroon and Moldova). Also, with support of the German BACKUP initiative, women's organizations and gender advocates in Malawi, South Africa and Uganda actively participated in the development of CNs. In Uganda, a gender technical working group to address gender related barriers to services was established.

### 3.5 Global Fund Support to Countries to Address Risk to HIV for AGYW and their Access to Health Services

Investing for impact in gender and HIV means supporting priority interventions that will reduce AGYW risk to HIV and ensure access to health services. This includes advancing gender equality. In this context, the team reviewed NSPs, CNs (allocation period 2015-2017) modular frameworks, program updates/disbursement requests (PUDRs), and other available documents and reports from selected countries (Table 2), as well as selected FRs from Window 1, allocation period 2018-2020 (Table 2). The aim was to identify the extent to which gender-related risks and barriers faced by AGYW were addressed in countries' implementation of programs directly or indirectly funded through Global Fund grants.

The team looked for programs/interventions that focus on AGYW, addressing risks and barriers related to the HIV disease trajectories/prevention and treatment cascades, identified and described in Section 3.2 above. For example, these interventions might include approaches that respond to GBV and harmful gender norms, such as including post-exposure prophylaxis (PEP) in comprehensive post-rape care, or engaging in advocacy to ensure a better response to violence survivors. The team also examined access to services and whether or not interventions meet gender-differentiated needs, such as ensuring that HIV services are friendly to AGYW. Table 9 below outlines some possible interventions for AGYW.

**Table 9: Potential interventions to address the needs of AGYW**

Biological	Behavioral	Structural
<ul style="list-style-type: none"> <li>• Condoms and lubricants, including female condoms</li> <li>• ART/ART adherence</li> <li>• SRHR services</li> <li>• Pre-exposure prophylaxes (PrEP)</li> <li>• Voluntary male medical circumcision (VMCC)</li> <li>• HIV Testing Services (HTS)</li> <li>• PEP</li> </ul>	<ul style="list-style-type: none"> <li>• Psychological support</li> <li>• Social assets/skills</li> <li>• Comprehensive sexuality education</li> <li>• Information, education and communication (IEC); Interpersonal communication (IPC); Social Behavioral change communication (SBCC)</li> <li>• Stigma reduction</li> <li>• Counselling (peer to peer)</li> </ul>	<ul style="list-style-type: none"> <li>• Gender and SGBV</li> <li>• Social protection</li> <li>• Livelihoods</li> <li>• Cash transfer/incentives</li> <li>• Keeping girls in school</li> <li>• Further (post-secondary school) education</li> <li>• Laws and policies</li> </ul>
Foundation Package (the basis for all interventions): Training health providers in the complete packages of services for adolescents, rehabilitation of youth centers, strengthening coordination structures on AGYW issues at national, district and community levels, scale up the modified DREAMS package to additional districts; program evaluations/evaluation of AGYW intervention package and impact evaluations		

#### 3.5.1 Global Fund Investment in AGYW for the Allocation Period 2015-2017

From a historical perspective, it can be seen that the Global Fund has prioritized women and girls, increasing investments over recent years. In 2015, 55-60 percent of Global Fund spending was

directed to women and girls, an increase from about 46 percent in 2010.<sup>30</sup> Significant amounts of the grants are dedicated to HIV prevention activities among AGYW in several high-burden countries.

**Box 1: KII from Swaziland**

*“We have been conducting GF programs without any specific attention to gender. It is only with these new guidelines that we are now trying to focus towards it. We now have a representative of women organisations in the CCM. But so far nothing much is being done.”*

Interview in Mbabane, 16 March 2017

The appraisal of available documents from review countries showed that there are two diametrically opposite examples of country effort, namely the group of countries prioritized by the Global Fund for intensified efforts to introduce and scale up programs for AGYW with the aim of reducing HIV incidence, and

secondly, the group of countries whose attention to AGYW is weak or non-existent. In the latter countries, the team found that programs supported by Global Fund grants do not include specific interventions targeting AGYW, as opposed to activities aimed at women or young people generally (such as FSWs and female injecting drug users). Even in cases where countries had undertaken a solid gender analysis, the proposed interventions did not always follow. Where AGYW programming was mentioned narratively, it was often unaccompanied by costed interventions. Gender-responsive interventions were too often relegated to ‘above-allocation’ funding, which signals that they are a relatively low priority. Several stakeholders noted that gender-responsive programming was not a priority in their country, and that attention to gender and AGYW is relatively new to the Global Fund processes and to national programming as a whole (see Box 1).

Of all countries reviewed, six are receiving significant support for HIV prevention activities among AGYW (Cameroon, Kenya, Malawi, Mozambique, South Africa and Swaziland); see Figure 1.

**Figure 1: Global Fund investments in HIV prevention for AGYW in selected countries**

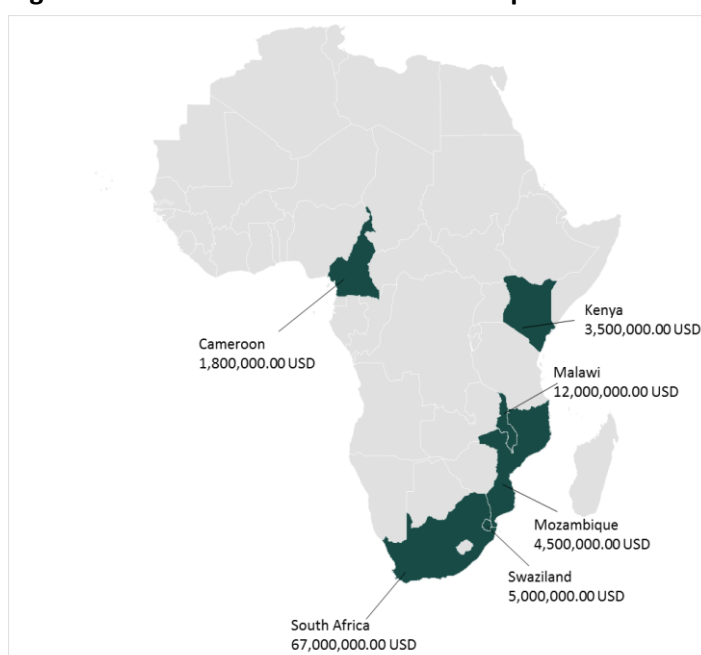


Table 7 below presents interventions that target women and girls (directly supported by the Global Fund or through partners) as identified by the team.

It should be noted that in majority of the review countries, no specific indicators related to AGYW

<sup>30</sup> Aidsplan (2017), *Global Fund steps up investments in women and girls*, Jan 2017

were found in CNs, PUDRs or other documents for monitoring the implementation of the AGYW-related activities within the grants. Documents that aim at presenting the results of AGYW interventions exist in some countries (e.g. the *Red Umbrella National Sex Work Program Report*, or the *Evaluation of the Global Fund Orphans and Vulnerable Children Program in South Africa*). However, these documents are limited and the achievements are not presented according to age groups (AGYW), but for women and youth in general. Therefore, interventions presented below (Table 10) mostly refer to women in general and, where possible to AGYW.

**Table 10: Interventions directly or indirectly supported by the Global Fund addressing women, including AGYW, for the allocation period 2015-2017**

		Cambodia	Cameroon	DRC	Kenya	Moldova	Mozambique	Senegal	South Africa	Swaziland	Uganda
Biological	Condoms										
	ART/Adherence										
	SRH Services										
	PrEP										
	VMCC										
	HTS										
	PEP										
Behavioral	Psychological Support										
	Social assets/life skills										
	CSE										
	IEC/IPC/SBCC										
	Stigma reduction										
Structural	Gender and GBV										
	Social protection										
	Livelihoods										
	Cash transfer/incentives										
	Keeping girls in school										
	Laws and policies										
Foundation Package											



Direct Global Fund support through grants



Global Fund support/funding through partners



Below we summarize the above interventions, addressing women, including AGYW, in the key thematic areas supported by the Global Fund.

### Addressing gender-based violence

The Global Fund is supporting GBV programs in several countries. The most comprehensive and detailed framework for combating GBV is in South Africa. Global Fund investments aim to support 28,000 women receiving comprehensive post-violence care, including PEP and psychosocial support, together with providing access to legal services.<sup>31</sup> However, the achievement ratio for GBV-related programs (2016-2017) is reportedly low (30-55 percent), due to delays in signing the Grant Framework agreement and identifying and determining the capacity of SRs.

In Uganda, the Global Fund is supporting country partners to identify and equip regional GBV survivor support sites in four regions with high HIV and GBV prevalence. In partnership with the Uganda Women Parliamentarian Association and with Global Fund support, the country intends to accelerate high-level political advocacy to publicize the extent of GBV within the country and its impact on HIV, TB and gender programs. Training for health workers, judicial and law enforcement officers under the HIV program addresses GBV. In DRC, TB/HIV grant engage with women-led community organizations addressing GBV. Starting in 2015, the Global Fund implemented a project to reduce GBV and HIV in the community, schools and health centers. Additionally, Global Fund is supporting comprehensive post-violence care. In Cambodia, the draft National HIV Health Strategic Plan incorporates plans designed to improve access for female survivors of sexual assault and transgender women to violence response services (including PEP services). Its rollout is envisaged to be a joint government-NGO exercise. National Guidelines for Managing Violence against Women and Children in the Health System, with funding from UNFPA and technical support from development partners (UN Women and WHO), were approved by the MOH in 2014. An analysis of linkages between HIV and GBV is integrated in the second National Action Plan on Violence against Women (NAPVAW) launched in February 2015.

In Moldova, a joint initiative by the International Organization for Migration (IOM), UNFPA and the Women's Law Centre (WLC) increased the capacities of 600 police officers through a multidisciplinary approach to protect victims of domestic violence. As a result, 204 protection orders for domestic violence survivors were issued during 2014.

There are also numerous examples of Global Fund-supported programs, addressing GBV and encompassing AGYW; however, unfortunately there were no disaggregated data and indicators to monitor the progress and coverage specifically related to AGYW.

### Education and social support to AGYW

The Global Fund is investing in education programs that address stigma, discrimination and harmful societal and cultural norms to empower women and girls and enable better dissemination of information to protect them. In countries with a high HIV burden of disease among AGYW, and lack of education for girls (such as Kenya, Malawi, Swaziland and South Africa), the Global Fund is supporting programs that aim to keep AGYW aged 14-22 in school and to offer them additional education and social support.

**The 'Cash Transfer Incentives'** approach was piloted as part of the Global Fund program to keep girls

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<sup>31</sup> Global Fund (2015), *Maximizing Impact through Strategic Investments Improving the Health of Women and Girl*. Geneva: The Global Fund.

in schools (Swaziland) and to stimulate health-seeking behavior and behavior change among AGYW to minimize their risk of HIV infection (Kenya and South Africa).

In Swaziland, the Global Fund is supporting the provision of 'dignity packs' (including sanitary pads, toothbrush, body lotion, shoe polish, roll-on deodorant, laundry soap and a face towel) to 4,800 adolescent girls aged 15-19. To qualify for the dignity pack, the girls must be enrolled in school and attending over 80 percent of their classes in each term. However, according to the Grant Performance Report from July 2017, for the period 2016-2017, the indicator 'Number of in-school adolescent girls (15-19) who receive nine dignity packs over nine months' is still at zero percent.

Combining cash transfers with additional care components has been shown to be even more effective at reducing HIV incidence than programs offering cash alone. In South Africa, direct cash transfers were piloted in high HIV prevalence districts in two provinces, as a part of the '**cash plus care**' program, devised as a combination of cash incentives and social support, with approximately 30,000 enrolled young women. The cash transfers are conditional rewards-based incentives that serve to stimulate health-seeking behavior and behavior change to minimize the risk of HIV infection. The 'care' element includes linking eligible young women to the appropriate health services as well as connecting the young women and their families to social protection, such as government welfare grants, as appropriate.

In three target districts in Malawi, an ongoing Global Fund program aims to provide a comprehensive package of interventions to 80 percent of girls enrolled in 322 schools and 80 percent of out-of-school girls located in 20 traditional chiefdoms. The package includes life skills and sexuality education, codes of conduct, girls' clubs, linkages, referral systems and services, HIV awareness, HIV testing services, hygiene and sanitation, social asset building, women's rights and empowerment, and addressing GBV. A slightly different package of interventions is provided for out-of-school girls, incorporating economic empowerment, condom distribution and family planning, couples' counselling and legal clinics. Economic empowerment activities include village savings and loans programs, as well as basic vocational skills such as the local production of sanitary pads.

The Kenya Red Cross is implementing a cash transfer program for AGYW as part of its current Global Fund grant. This includes cash transfers for about 9,000 girls<sup>32</sup>.

#### Scaling up prevention of mother-to-child transmission and other antenatal care services

The Global Fund is also encouraging countries to link RMNCAH interventions with HIV, TB and malaria programs to improve the overall health of women and girls, including AGYW. This has been a priority for the Global Fund since Round 7, which was dedicated to proposals that integrated SRHR with HIV. Within integrated service delivery for women, children and adolescents, the Global Fund has prioritized ANC. HIV-related key elements of ANC supported by the Global Fund include primary prevention of HIV during pregnancy, PMTCT and the screening, prevention, diagnosis and treatment of TB in pregnant women.

PMTCT services have seen major successes. Interventions that address all points in the cascade of PMTCT services, including a focus on pregnant and breastfeeding adolescents and young women, are supported in all Review countries. Most of the programs are related to the Global Fund's Strategy, Prongs 3 and 4 (prevention of transmission of HIV from mothers living with HIV to their infants and treatment, care and support for mothers living with HIV and their children and families) (Cambodia, Cameroon, Kenya, Swaziland and Uganda). In South Africa, Global Fund support has helped the National Department of Health to integrate HIV, PMTCT, SRH and TB interventions within provincial and district health facilities. In Sudan, integration of PMTCT into RH was rolled out in 2016 under the

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<sup>32</sup> The cash transfer started in 2017 and 9,000 girls were reached by December 2017.

HSS grant. The DRC, with the Global Fund support, extended PMTCT services into five priority provinces with the highest HIV prevalence. In Moldova, Global Fund is supporting interventions to scale up rapid HIV testing of pregnant women before delivery, access to treatment for PLHIV, including HIV-positive pregnant women and new-born children, and procurement of milk formula for children in some regions. PMTCT efforts in Swaziland are being rolled out by Médecins Sans Frontières (MSF) and the MOH in the southern part of the country. In all countries, the implementation progress is highly satisfactory (over 90 percent). However, data in all review countries are neither age-disaggregated, nor available for AGYW (15-24 years), only for women in general.

#### Integration across health Issues impacting women and children

The Global Fund supports integrated service delivery in RMNCAH. It is estimated that between 2003 and 2010 the Global Fund contributed US\$ 3.12 billion to MNCH.<sup>33</sup> To better respond to the challenge of integrating disease programs with RMNCAH programs, the Global Fund has entered into new partnerships with the World Bank, GAVI, Stop TB Partnership UNAIDS, UNICEF, UN Women and WHO. With the World Bank, the Global Fund supports selected countries to expand access to essential health services for women and children through facility-level performance-based financing. For example, in the DRC, partners are working together with the government to expand performance-based financing programs aimed to cover larger geographical areas, and to ensure that essential health commodities reach populations most in need, particularly women and children. The integration process has experienced challenges in many of the review countries. For example in Swaziland, the integration of health and community systems for TB, HIV and RMNCH has culminated in the duplication of services and their underutilization.<sup>34</sup> In Mozambique, linkages between the services within health facilities (HTS, care and treatment, TB/HIV, RMNCH) and between health facilities and community interventions are weak. As a result, opportunities to identify at risk clients or maintain patients in care are missed, similar to the situation in Uganda.

In DRC and Kenya, the Global Fund is working closely with key partners to end preventable maternal, new-born, child and adolescent (MNCA) deaths by 2030 through increased financing for RMNCAH. The Global Fund supports efforts to finance RMNCAH at scale through the mobilization of increased domestic financing. It also supports the vision to drive learning and innovation in relation to effective financing approaches, with the goal of financial sustainability for RMNCAH in particular and the health sector more broadly.

Addressing **institutional factors** by supporting youth-friendly services and the integration of contraception into HIV and prenatal care services to promote access for AGYW was supported by the Global Fund through their partners (UNAIDS and WHO) in several review countries (Cameroon, DRC, Kenya, Moldova, Mozambique and South Africa). Youth-friendly services, including serving youth on days separate from adults, created a more comfortable setting for girls and young women seeking contraceptive and other SRH services. In Kenya, integration of contraception and HIV care allows easier access to contraceptives by removing the stigma of coming to a clinic solely for contraceptive services.<sup>35</sup> KIIs indicated that many adolescents are fearful of other community members asking them why they are seeking health services. With integrated services, providers use the adolescent's appointment for HIV care to provide additional services such as contraception, which decreases the number of trips to the health facility. Integration of services has also allowed providers to reinforce counselling messages such as prevention of horizontal and vertical HIV transmission.

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<sup>33</sup> The Global Fund (2015), *Maximising Impact through Strategic Investments Improving the Health of Women and Girls*. Geneva: The Global Fund. (2015)

<sup>34</sup> Swaziland (2014). *TB-HIV Concept Note*, Swaziland)

<sup>35</sup> Hagey JM et al (2015), *op. cit* 3

### Community systems and responses to reduce vulnerability and to improve access for women and girls

Effective community systems and responses are an essential component of national efforts to respond to HIV. This is particularly the case for KPs in communities that have difficulties accessing public health clinics and hospitals, which, in many contexts, includes women and girls. For example, in Cameroon, with Global Fund support, members of the network of ‘Aunties’ associations and community actors are trained to promote the use of antenatal services through educational talks in small groups aimed at girls outside school. In DRC, the Global Fund provided additional technical support to ensure gender concerns were mainstreamed in the new TB/HIV grant. Particular attention was paid to addressing gender-based violence through effective engagement of women-led community organizations and peer education for women.

There are several barriers to community based systems and successful responses; these include the lack of guidelines, weak M&E capacities of community bodies, and the failure to include communities in more than the peripheral tier of health care.<sup>36</sup> In Moldova, the Global Fund is providing support to community system strengthening, including advocacy for social accountability, legal aid services and the community-based monitoring of legal rights. NGOs can tap into funds to research specific examples of rights violations to argue for changes in HIV legislation. Through regional grants that focus on advocacy, community mobilization and small grant programs, the Global Fund is also supporting harm reduction in Moldova. Specific harm reduction services are tailored to the needs of women who inject drugs, but they do not specifically address or priorities AGYW.

The Global Fund is continuing to invest in community system strengthening in Kenya, South Africa, Swaziland and other countries. For example, the Red Umbrella national sex work program in South Africa with a R118 million allocation by the Global Fund over the period of the grant focused on community empowerment and structural interventions (community-led services, addressing violence against SWs, condom and lubricant programming, clinical and support services, etc.). The goal of the program was to improve coverage and access to services for FSWs, including HIV prevention, treatment, care and support services, and increasing the capacity of government, community-based and NGOs to successfully implement FSW programs in their coverage areas. However, data on the number of AGYW FSWs reached by the program was not available.

#### **3.5.2 Global Fund Investment in AGYW for the allocation period 2018-2020 in review countries**

In line with the *Global Fund Strategy 2017-2022*, Strategic Objective 3a and 3b, the new Catalytic Investment Funding (the area of HIV and AGYW) has committed US\$ 55 million to HIV interventions, with an anticipated leverage of an additional US\$ 25 million from private sector (PS) donors to support the scale up of comprehensive interventions and programs aiming to reduce HIV incidence and TB co-infection among AGYW in 13 high HIV burden countries in sub-Saharan Africa (Botswana, Cameroon, Kenya, Lesotho, Malawi, Mozambique, Namibia, South Africa, Swaziland, Tanzania, Uganda, Zambia and Zimbabwe).

According to the data presented by the Global Fund, in July 2017 more than US\$ 100 million was proposed for AGYW (both allocation amounts and matching funds) in FRs submitted to the Global Fund under Windows 1 and 2 (March and May 2017). In addition, more than US\$ 50 million was proposed for AGYW in PAAR.

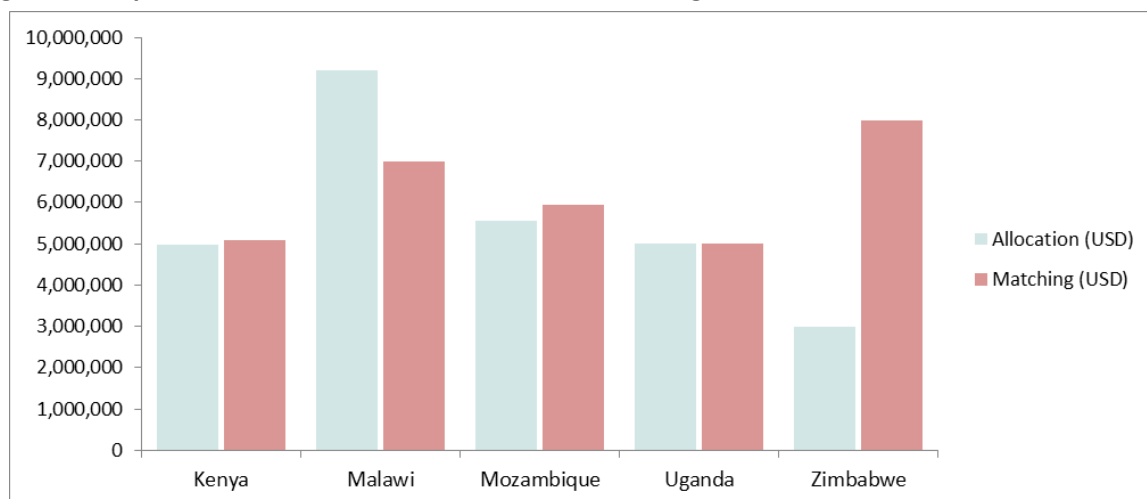
In December 2016, eight of the review countries (Cameroon, Kenya, Malawi, Mozambique, South Africa, Swaziland, Uganda and Zimbabwe) were notified of their eligibility for additional funding for

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<sup>36</sup> DRC (2014). *Concept Note TB-HIV, DRC*.

HIV programs for AGYW, above their allocation amount. At the time of writing, five countries (Kenya, Malawi, Mozambique, Uganda and Zimbabwe) had submitted their FRs to the Global Fund. Figure 2 below depicts the proposed investments in AGYW from these countries.

**Figure 2: Proposed investments in women and adolescent girls**



Kenya, Mozambique and Uganda proposed roughly the same amount of funding in their allocations as in their matching funds requests. However, Zimbabwe placed far more funding for AGYW in its matching funds request, although one of the Global Fund requirements for assessing the AGYW matching funds is that an equal or greater funding is dedicated for AGYW in the allocation funds and must be greater than in the current grant. In addition, Mozambique, Malawi and Zimbabwe proposed US\$ 6 million, US\$ 19 million and US\$ 28 million respectively for AGYW in their prioritized above allocation requests.

Countries are mostly focusing on addressing behavioral factors (Malawi, Mozambique, Uganda and Zimbabwe). GBV as a structural factor is a focus for direct Global Fund support in all review countries, except Uganda where the focus is on the legal and policy environment. Kenya continues to prioritize cash transfers within the allocation period 2015-2017. It is noteworthy that none of the countries prioritized PrEP, PEP or social protection (access to social grants/poverty reduction) activities.

Proposed activities to support AGYW include: training of health providers in the complete packages of services for adolescents (Mozambique and Uganda), rehabilitation of youth centers (Mozambique), adolescent and youth program evaluations (Kenya), expansion of the AGYW package to additional districts (Malawi) and strengthening of coordination structures on AGYW issues at national, district and community levels (various countries).

The table below shows AGYW interventions prioritized in selected countries under the new allocation period (2018-2020).

**Table 11: Interventions addressing women and adolescent girls prioritized by review countries for the 2018-2020 allocation period (Windows 1 and 2 FRs)**

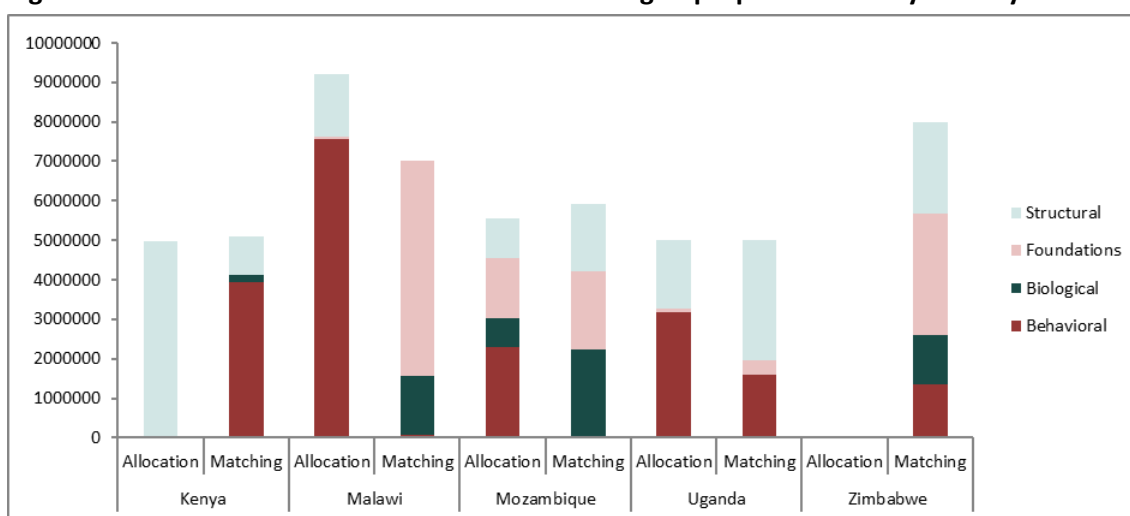
		Kenya	Malawi	Mozambique	Uganda	Zimbabwe
Biological	Condoms					
	ART/Adherence					
	SRH Services					
	PrEP					
	VMCC					
	HTS					

		Kenya	Malawi	Mozambique	Uganda	Zimbabwe
	PEP					
Behavioral	Psychological Support					
	Social Assets/ Life Skills					
	Comprehensive sexuality education					
	IEC, IPC, BCC					
	Stigma reduction					
Structural	Gender and GBV					
	Social Protection					
	Livelihoods					
	Cash Transfer/ Incentives					
	Keeping girls in school					
	Laws and policies					
Foundation Package						

Source: Global Fund Secretariat, CRG Department

Prioritized interventions through the matching funds complement those under the allocation funds and add to a fully articulated AGYW program (Figure 3).

**Figure 3: Prioritized investments for AGYW according to proposed funds by country**



### 3.6 Monitoring Global Fund Inputs to Scale up HIV Programs for AGYW

In an effort to measure the progress to date and the relationship between implementation and resources, the team looked for AGYW-specific indicators in the CNs and HIV grant modular frameworks, the latest grant performance reports and PUDRs in ten selected countries (for the 2015-2017 allocation period).

In the majority of the review countries there were no specific indicators to monitor the implementation of AGYW interventions. Table 12 shows the indicators for each of the review countries.

**Table 12: Review of AGYW Interventions and AGYW-related Indictors in 2015-2017 allocation period**

	Grant period	Indicators which incorporate AGYW (but data not disaggregated)				AGYW indicators			
		Total	Target achieved			Total	Target achieved		
			>90%	60-89%	<59%		>90%	60-89%	<59%
<b>Cambodia</b>	2015-2017	(36) PMTCT: 11, PWID: 8, SW: 4, Other: 13,	(15) PMTCT: 6, PWID: 2, Other: 7,	(17) PMTCT: 4, PWID: 4, SW: 3, Other: 6	(4) PMTCT:1, PWID: 2, SW: 1	0	0	0	0
<b>Cameroon</b>	2015-2017	(15) PMTCT: 3, SW: 3, YP: 3, Other: 6	(6) PMTCT: 1, Other: 5	(3) PMTCT: 2, Other: 1	(6) SW: 3, YP: 3	0	0	0	0
<b>DRC</b>	2105-2017	(58) PMTCT: 9, SV: 4, SW: 4, Other: 41	(23) PMTCT: 2, SV: 1, SW: 2, Other: 18	(10) PMTCT: 2, SV: 1, Other: 7	(25) PMTCT: 5, SV: 2, SW: 2, Other: 16	0	0	0	0
<b>Kenya</b>	2015-2017	(30) PMTCT: 9, PWID: 3 SW: 2, YP: 1, Other: 15	(21) PMTCT: 5, PWID: 3 SW: 2, Other: 11	(5) PMTCT: 4, Other: 1	(4) YP: 1, Other: 3	(1) Cash: 1	0	0	(1) Cash: 1
<b>Moldova</b>	2015-2017	(5) PWID: 3, SW: 1, Other: 1	(4) PWID: 3, SW: 1	(1) Other: 1	0	0	0	0	0
<b>Mozambique</b>	2015-2017	(25) PMTCT: 5, SW: 3, Other: 17	(15) PMTCT: 4, SW: 1, Other: 10	(8) PMTCT: 1, SW: 1 Other: 6	(2) SW: 1, Other: 1	(4) YG: 4	(2) YG: 2	0	(2) YG: 2
<b>Senegal</b>	2015-2017	(54) PMTCT: 7, PWID: 9, SW: 4, YP: 4, Other: 30	(38) PMTCT: 5, PWID: 5, SW: 4, YP: 3, Other: 21	(11) PMTCT: 1, PWID: 1, YP: 1, Other: 8	(5) PMTCT: 1, PWID: 3 Other: 1	0	0	0	0
<b>South Africa</b>	2016-2019	(34) PWID: 3, SW: 2 YP: 7, Other: 22	(2) SW: 2	0	(32) PWID: 3, YP: 7, Other: 22	(7) GBV: 2; Cash: 2; GS: 3	0	0	(7) GBV: 2, Cash: 2; GS 3
<b>Swaziland</b>	2015-2018	(14) PMTCT: 3, SW: 2, YP: 2, Other: 7	(9) PMTCT: 3, YP: 1 Other: 5	0	(5) SW: 2, YP: 1 Other: 2	(2) Dignity: 2	0	0	0
<b>Uganda</b>	2015-2017	(9) PMTCT: 2, SW: 2, YP: 1, Other: 4	(7) PMTCT: 1, SW: 2 YP: 1, Other: 3	(1) Other: 1	(1) PMTCT: 1	0	0	0	0

Cash – Interventions related to cash transfer to AGYW

Dignity – Interventions related to distribution of dignity packs to AGYW

GBV – Interventions related to GBV

GS – Interventions related to keeping girls in schools

Other - Interventions aimed at the general population or KPs, including AGYW

PMTCT – Interventions related to PMTCT

PWID – People who inject drugs

SV – sexual violence

SW – Interventions related to SWs

YG – Interventions related to reaching young girls with the defined service package

YP – Interventions related to reaching young people (not disaggregated according to sex)

The total number of indicators (in review countries) which incorporate females aged 15-24, for the period 2016-2017, is 279, of which half (140) showed a performance over 90 percent, one-fifth (56) between 60 percent and 89 percent and less than one-third (84) below 60 percent.

The number of specific AGYW indicators is 14 (seven in South Africa, four in Mozambique, two in Swaziland and one in Kenya). The indicators are divided thus: two for GBV, four for young girls, three relating to the 'keep in school' program, two covering dignity packs and three covering cash transfers. Only one country shows a performance of over 90 percent for two of its indicators (Mozambique: 'Number and percentage of young girls (15-19) reached with the defined service package' and 'Number of follow up contacts with young girls (15-19)'). The remaining 12 are performing at below 59 percent.

There are also 18 indicators related to 'young people' but not disaggregated according to sex. Out of those, five performed at over 90 percent, one between 60 and 89 percent and the rest (12) below 60 percent.

There are 49 PMTCT indicators (55 percent performed over 90 percent), 27 SW indicators (52 percent performed over 90 percent), 26 PWID indicators (50 percent performed over 90 percent) and 7 community-related indicators (71 percent performed over 90 percent). The total number of general population and other indicators is 155 (51 percent performed over 90 percent).

From the foregoing, it should be noted that the performance of AGYW indicators in relation to the other groups of indicators is weaker (only 14 percent AGYW of high performance in comparison to 55 percent PMTCT, 52 percent SWs, 50 percent PWID, 71 percent community and 51 percent general and other). It is the same situation regarding the 'young people' indicators (of which only 28 percent achieved a performance of over 90 percent).

The PRs have listed various reasons for this, such as:

- Delayed signing of the Framework Agreement (South Africa)
- Late start-up (including the recruitment and orientation of staff)
- Misrepresentation of the target population
- The introduction of a new program intervention for the PR, the Young Women and Girls component, for which programmatic work had not begun during this period
- Implementation challenges experienced including recruitment of suitably qualified staff, SR capacity building, delays in signing a Memorandum of Understanding (MOU) in new districts and setting up clubs in new districts

Moreover, the achievement ratio for GBV-related indicators is also low due to perceived challenges with the new IPV component. This is associated with start-up challenges pertaining to training, capacity building and implementing a new program with an extension of prevention services into communities'.

Apparently, one of the main reasons for weak performance to date is that the AGYW-related interventions were only recently introduced (some of them only started in 2017) as opposed to, for example, PMTCT activities, and that programs containing those interventions need time to be developed. It is still too soon to evaluate their performance and the relationship between resources and outcomes and impact, although the fact that they were slow start is worth noting.



### 3.7 Achievements - Overview of Main Indicators across Countries

This section presents the latest data for the review countries and demonstrates AGYW health gains to date to which the Global Fund contributed, either directly or indirectly. Where AGYW data were not available, the team has presented data for women in general.

The below analysis was performed based on available country data recognizing the limited availability of variations of the size of age cohort over time, mortality/case fatality rate, taking into consideration that the modeling denominator could not be calculated. However, it is assumed that factors which may influence the denominator remain constant over time among male and females.

#### HIV disease cascade

In an attempt to assess results of the implementation of programming for women and girls, the team looked for HIV disease cascade indicators (with a focus on AGYW) from review countries. The aim was to identify any changes or improvements in key indicators, such as the number of AGYW living with HIV, the number of AGYW linked to HIV care and retained in care, the number of AGYW receiving HIV treatment, and the number of AGYW with undetectable viral load. However, none of the review countries had, nor do they collect, data disaggregated by sex and age for all HIV disease cascade indicators. The only data available in all review countries is the absolute number of AGYW living with HIV. The one exception is Moldova where data for the total number of AGYW diagnosed with HIV and on HIV treatment are also available.

Below the absolute numbers of AGYW living with HIV are presented. There is no comparison across countries or over time due to different denominators and variations in the size of age cohort over time. Even though data did not allow for accurate comparison across countries, certain trends can still be observed.

**Table 13: AGYW living with HIV during the period 2010-2016**

Country	2010	2012	2014	2016
Cambodia	4,300 [3400-5700]	3,100 [2600-4100]	2,400 [2000-3000]	2,100 [1800-2500]
Cameroon	66,000 [25 000-100 000]	60,000 [23 000-95 000]	57,000 [23 000-91 000]	56,000 [23 000-91 000]
DRC	36,000 [14 000-59 000]	31,000 [12 000-51 000]	28,000 [12 000-45 000]	27,000 [12 000-42 000]
Kenya	150,000 [79 000-220 000]	160,000 [84 000-230 000]	160,000 [87 000-230 000]	160,000 [85 000-230 000]
Mozambique	140,000 [55 000-210 000]	140,000 [59 000-210 000]	140,000 [58 000-200 000]	130,000 [55 000-190 000]
Moldova	954	937	887	845
Senegal	4,300	3,100	2,400	2,200
South Africa	550,000 [190 000-820 000]	520,000 [180 000-760 000]	500,000 [180 000-730 000]	500,000 [190 000-720 000]
Swaziland	26,000 [13 000-36 000]	26,000 [13 000-35 000]	25,000 [13 000-35 000]	23,000 [12 000-32 000]
Uganda	160,000 [87 000-230 000]	160,000 [87 000-230 000]	150,000 [82 000-220 000]	140,000 [75 000-200 000]

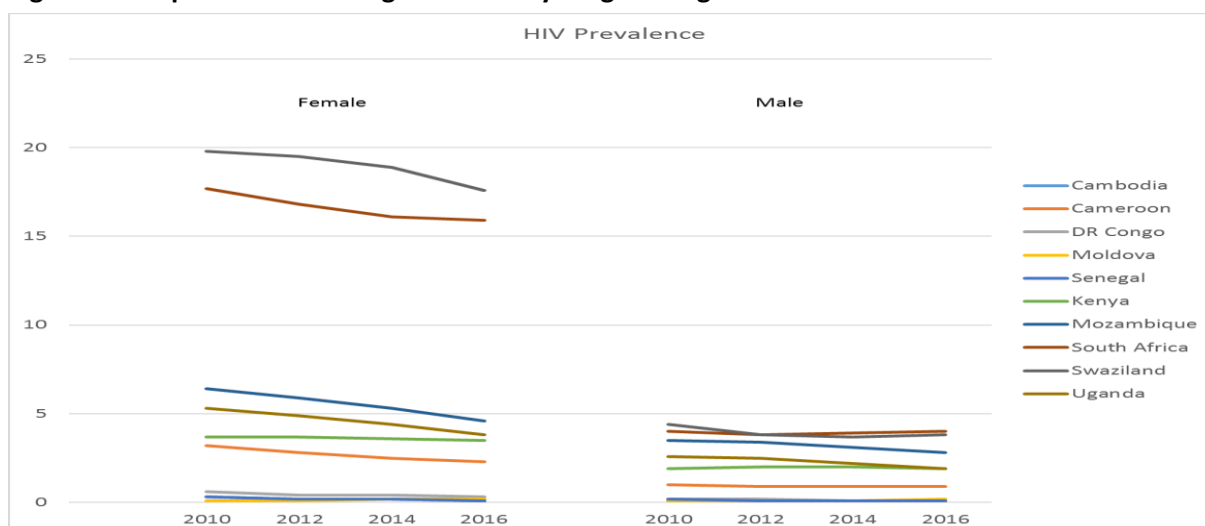
Source: Data collected by the team, 2017

HIV prevalence among AGYW

For analysis of HIV prevalence among AGYW over time, the review team assumed that factors which potentially influence the denominator (e.g. new infections, residual infections and AIDS-related deaths) remained constant over time among male and females.

Although showing a steady decrease since 2010, HIV prevalence is still notably higher among AGYW in all review countries, especially in Swaziland (17.6 versus 3.8) and South Africa (10.4 versus 4.0). Significant differences are also found in Mozambique (4.6 versus 2.8), Uganda (3.8 versus 1.9) and Kenya (3.5 versus 1.9). The exception is Moldova where HIV prevalence increasing amongst young men and AGYW.

**Figure 4: HIV prevalence among AGYW and young men aged 15-24**



Data source AIDSInfo 2016

Women living with HIV on treatment (ART coverage)

For analysis of ART coverage<sup>37</sup> the review team assumed that mortality/case fatality rates, which could influence the estimated number of people living with HIV (denominator), remain constant over time among male and females. Since modelled estimates were not calculated, the results should be interpreted with caution.

Antiretroviral therapy (ART) coverage is becoming available to more women, and more women are staying on treatment. However, the overall number in treatment is still low. The figure below presents ART coverage in the review countries in 2010 and 2016. Data are presented for women in general, as data for AGYW are not available.

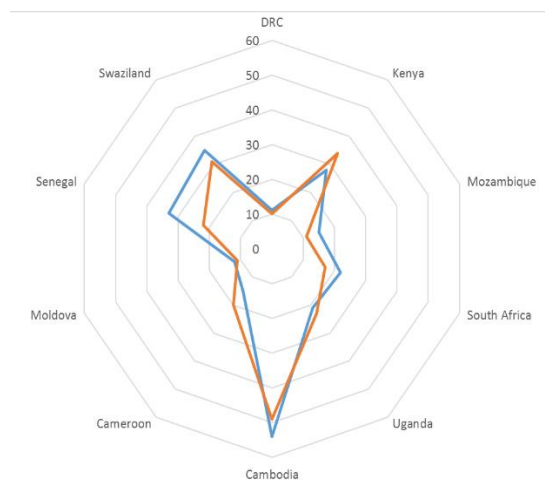
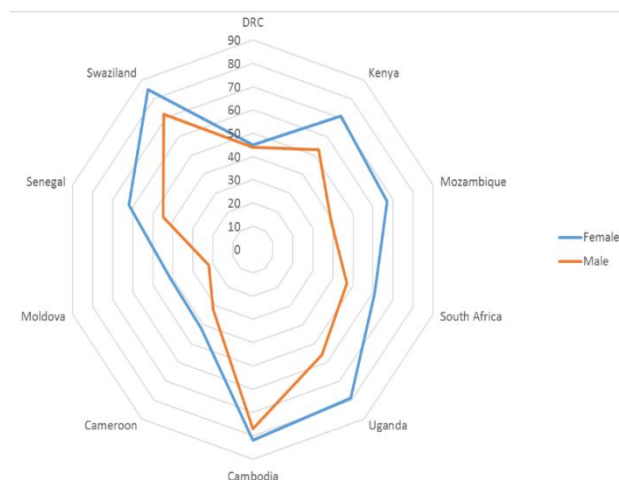
Since 2010, the number of women living with HIV on ART has increased more than four times in the DRC and Mozambique, although the numbers are still low. Swaziland and Cambodia reached over 80 percent of ART coverage for women (82 percent and 85 percent respectively). It should be noted that countries with a Global Fund gender focus show better results in ART coverage than other reviewed countries.

<sup>37</sup> ART coverage is defined as people reported to be on treatment at the end of the year divided by the estimated number of people living with HIV in the same year.

**Figure 5: Percentage of women living with HIV who accessed treatment in 2010 and 2016**

Data source AIDSInfo 2016

In several countries, ART coverage increased more for women than for men between 2010 and 2016. For example, in Cameroon, Kenya, and Uganda in 2010, ART coverage for men was higher than for women. However, in 2016 this situation had reversed, and ART coverage in those countries was higher for women than men. This could be attributed to country programs and interventions targeting women which took place during the observed period.

**Figure 6: ART coverage, men and women, 2010****Figure 7: ART coverage, men and women, 2016**

Data source AIDSInfo 2016

#### New HIV infections among AGYW (aged 15-24)

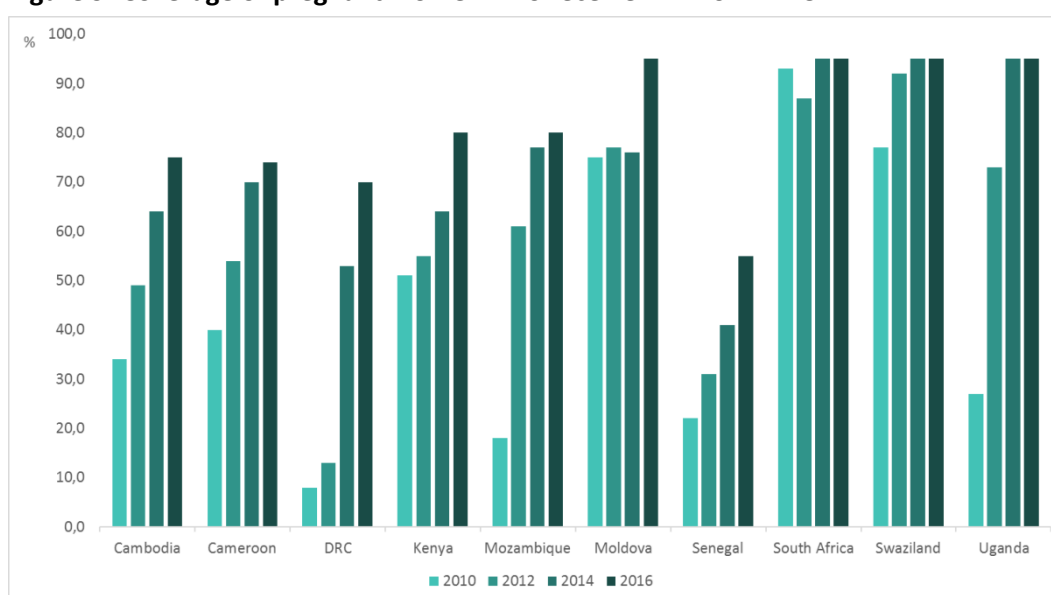
According to the Global Fund document “Focus on Women and Girls” (March 2017), new HIV infections rates have been dropping faster among men than women in many countries. However, in high burden countries in Africa supported by Global Fund new infection rates are declining equally

among men and women<sup>38</sup>. The absolute numbers of new HIV infections among AGYW in review countries support the above Global Fund report. That said, non-availability of data needed for adequate data comparison (i.e. variations in age cohort size) and differences in denominators needed for adequate data comparison prevents the team from drawing statistically accurate comparisons.

#### Coverage of pregnant women who receive ARVs for PMTCT

The Global Fund also encourages countries to link RMNCAH interventions with HIV, TB and malaria programs to improve the overall health of women and girls. In this regard, Figure 11 shows the available data for the coverage of pregnant women living with HIV who are enrolled in PMTCT programs and are receiving ARVs. Data are shown for women in general, as data for AGYW are not available.

**Figure 9: Coverage of pregnant women who receive ARV for PMTCT**



Data source AIDSInfo 2016

In 2016, ARV coverage among pregnant women varied significantly across review countries with more than 95 percent of women covered in Moldova, South Africa and Uganda to only 55 percent in Senegal, in 2016. Since 2010, the coverage of ARVs among pregnant women has increased in all review countries with the most significant increase in the DRC (from 8 percent to 70 percent), Mozambique (from 18 percent to 80 percent) and Uganda (from 27 percent to 95 percent). In Kenya in 2016, support by the Global Fund and partners contributed to an 80 percent coverage of pregnant women receiving PMTCT services; the aim being to reach 90 percent by 2018.

### **3.8 Contextual Factors (Enablers and Constraints)**

Based on desk reviews and in-country visits the team developed a framework that looked at external/environmental factors in which the AGYW programs were implemented. The criteria developed for assessing external factors included:

1. Political commitment – based on the role of the country leadership in spearheading messages for addressing risk factors among AGYW in the HIV response and supporting

<sup>38</sup> The Global Fund (March 2017). Focus on Women and Girls.

specific country interventions on adolescent girls and young women, or women in general

2. Legal and policy frameworks – advanced to address gender-related risks and barriers, including gender inequalities faced by AGYW, sexual and gender-based violence as it relates to HIV prevention, access to SRH among young people, teenage pregnancies, education, skills training and employment or income generation among young people
3. Access to services – using youth friendly platforms
4. Community engagement – in reaching out to young people, and in particular AGYW; advocacy and campaigns to reach out to AGYW
5. Partner collaboration – on issues of promoting AGYW and providing specific funding for addressing HIV issues among AGYW
6. Participation of AGYW in decision making in the HIV response – such as country dialogue, the development of NSPs and CNs
7. Capacity of implementers – PRs, SRs, SSRs and level of CCM technical skills and capacity to oversee implementation of gender and AGYW interventions

The facilitating factors addressing health risks and access to services for AGYW (as relevant to HIV) listed in Table 15 below, were identified by the team.

**Table 14: Facilitating factors at country-level addressing health risks and access to services for AGYW, as relevant to HIV**

Country	Political Leadership and Gov. Commitment	Enabling Legal and Policy Framework	Youth-friendly Media Platforms	Community Engagement	Partner Collaboration and Coordination	Participation of AGYW in Country Dialogue	Capacity of Implementers
Cambodia	✓		✓		✓		✓
Cameroon	✓	✓		✓	✓		
DRC	✓	✓			✓		
Kenya	✓	✓	✓	✓	✓	✓	✓
Moldova	✓	✓		✓	✓		✓
Mozambique	✓	✓	✓	✓	✓		
Senegal	✓	✓			✓		
South Africa	✓		✓	✓	✓		
Swaziland	✓		✓	✓	✓		✓
Uganda	✓		✓		✓		

**Political Leadership/Government Commitment to Gender Equality:** This was demonstrated through the ratification of different international conventions that promote an environment for equity and equality in general, country commitments to the Political Declaration on HIV and AIDS and UN Commission on the Status of Women (CSW), Resolution 60/2<sup>39</sup>, and the adoption and implementation of national programs focusing on ensuring gender equality (e.g. Cambodia, Cameroon, DRC, Moldova and Swaziland). In some of the countries, additional mechanisms were developed and capacities built to mainstream gender and the social determinants of health, and to integrate rights-based approaches into national health policies and programs. In Moldova, all ministries have established a gender focal point to ensure that gender-sensitive approaches are increasingly used during the development of national policies, regulations and programs, including disease specific strategies. Political leadership was mentioned as an important enabling factor in some of the review countries. In Cambodia, several ministries have developed and implemented

<sup>39</sup> The CSW Resolution 60/2 is specific to addressing HIV prevention and access to services among young women.

Gender Mainstreaming Action Plans. Women and Children Consultative Committees have been established at capital, provincial, municipality, district and khan levels. In South Africa in 2016, the President launched the *She Conquers* program based on DREAMS, targeting girls and young women and implemented by government departments<sup>40</sup>. The National Department of Health launched *Be-Wise*, an app which give young people access to a nationwide program providing correct information on HIV and linking young people to services. The Department of Higher Education and Training implements a national program *First Things First* nationally in universities and TVET colleges. In Uganda, the President is at the forefront of the HIV response. Though not specific to HIV, the government launched the Youth Empowerment Program and the Women's Empowerment program. These programs are supported by domestic resources and implemented through government structures at the local government level.

The use of **youth-friendly media platforms** (Facebook, mobile phones, internet, Twitter, WhatsApp, Instagram, smartphone applications, use of local music celebrities to reach out to young people) to promote access to HIV information and services is seen by country stakeholders and KIs as another important facilitator in HIV program implementation (Cambodia, Kenya, South Africa, Swaziland and Uganda).

**Community engagement:** Community engagement in the Global Fund grant design and country processes, as well as in the implementation of programs that address health risks and access to services for AGYW, is extremely important. In the review countries, community engagement varies from community participation (engaged as passive or active recipients), mobilization (engaged to support) or empowerment (engaged through a capacity-building process to plan, implement or evaluate activities). In Kenya, there is a vibrant civil society and community-based movement for the demand of quality services. In South Africa, community members assist PRs and SRs to devise solutions to problems that hinder the implementation of programs. For example, in the Western Cape, community leaders provide protection to SRs in high-risk security areas. Communities are involved in negotiating with suspected criminals to guarantee safety for life and property of PR and SRs. Communities also assist with mobilization of beneficiaries for the program (South Africa and Uganda). While in Uganda community is also engaged in the design of AGYW program, this is not the case in South Africa.

**Partner collaboration:** Coordination and collaboration between governments and development partners, especially better alignment between the U.S. President's Emergency Fund for AIDS Relief (PEPFAR) and Global Fund-supported programs, was seen as a strong facilitator for program implementation. In Kenya, Mozambique, South Africa, Swaziland and Uganda, the U.S. multi-donor program, DREAMS, complements the Global Fund-supported programs. There are promising examples of collaboration with donors such as UNFPA, whose portfolio includes gender equality and AGYW programming in all review countries. This partnership is already yielding results and Sudan is an excellent example of how the Global Fund supports UNFPA as a SR to provide SRHR to young women. In Moldova, one of the most important enabling factors for gender-responsive programming is the effort by international development partners, including the Global Fund, to align resources to support the MOH to build capacity for reform implementation. These efforts are further strengthened and coordinated by the Republic of Moldova-United Nations Partnership Framework 2013–2017. In Tanzania, PEPFAR's new 2017 County Operating Plan (COP) was shared with the CCM and also the umbrella organization representing non-state actors, prior to the development of the country's two FRs (HIV-AIDS and Malaria-RSSH) under Window 2. In many Sub-Saharan African countries, the increasingly strong partnership and alignment of Global Fund and PEPFAR

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<sup>40</sup> It should be noted that although launched by the president there has been no budget from South Africa (national budget) dedicated to 'She Conquers', or staff position to move this program forward. The funding comes from external sources.

programming promises to pay dividends in terms of complementarity, greater reach and a higher chance of being able to reach the most vulnerable populations – including AGYW, targeted by DREAMS.

In addition, the team identified external/environmental constraints/inhibiting factors to implementing programs addressing health risks and access to services for AGYW, as relevant to HIV in the review countries. Table 15 below summarizes the key criteria that were used, such as: operationalization of legal and policy commitments, institutional roles, participation in decision making and financial resources.

**Table 15: Constraints to implementing programs at country-level addressing health risks and access to services for AGYW, as relevant to HIV**

Country	Weak Operationalization of international commitments into national frameworks on HIV	Insufficient National Capacity/Knowledge and Technical Skills	Lack of Meaningful AGYW Engagement Programming/ Decision Making	Low Level of CCM Technical Skills and Capacity to Oversee Implementation of Gender and AGYW Interventions	Limited Financial Resources Allocated to AGYW Programs
Cambodia			✓	✓	✓
Cameroon	✓	✓	✓	✓	✓
DRC	✓	✓	✓	✓	✓
Kenya	✓		✓	✓	✓
Moldova	✓	✓	✓	✓	✓
Mozambique	✓	✓	✓	✓	✓
Senegal	✓	✓	✓	✓	✓
South Africa			✓	✓	✓
Swaziland	✓	✓	✓	✓	
Uganda			✓	✓	

**Weak operationalization of international commitments into national frameworks on HIV.** Although HIV regulatory frameworks have been in place in most of the review countries, in practice they have most often not been enforced. Human rights are integrated in national constitutions and HIV policies, but due to weak operationalization of policies discrimination (human rights violation) still have impacts on access to HIV services. In rural areas in Cambodia and Moldova, it still occurs that AGYW living with HIV are refused treatment by health providers (gynecologists). Another example includes reports of the failure of medical professionals to keep patients' health status confidential (Cambodia, Cameroon, DRC, Moldova and Senegal). In all review countries in Sub-Saharan Africa, customary norms and practices govern the daily lives of AGYW more than the statutory law. For example, although legislation criminalizing rape against women is in place in Cameroon, the perpetrators are declared innocent if the victim has reached puberty, and if the victim freely consents to marry the rapist. While laws protecting women are generally respected in urban areas of Senegal, rural areas are still dominated by customary and religious practices, and women are mostly unaware of the legal rights in place to protect them.



**Insufficient national capacity (knowledge and skills) in gender equality and gender equity.** Many KIIs highlighted the fact that, although the government has structures responsible for gender policy and program implementation (such as gender focal points appointed within ministries), there is a lack of knowledge and skills to successfully apply gender sensitive approaches. In Moldova, even though the country is categorized as Group 1 country regarding gender equality, the government still struggles with gender-sensitive programming (see Box 2). In DRC, an organizational and institutional analysis of the Ministry of Gender, the Family and Child found that it lacked the capacity to implement its mandate.<sup>41</sup> In Swaziland, the capacity of judicial institutions supporting law enforcement agencies needs to be strengthened as there is a lack of understanding of the law related to gender, as well as of the procedures employed.<sup>42</sup>

#### Box 2: KII from Moldova

*“The Government of Moldova understands what gender equality means but they don’t know how to apply and implement it.”*

**CCM technical skills and capacity.** According to the stakeholders and KIIs there is a lack, or low level of technical skills and capacity, among CCM members, to oversee the implementation of interventions which address gender related risks and barriers faced by women and young girls in the context of the HIV prevention and treatment cascades. The CCMs members interviewed expressed the need for TA and guidelines to be able to better fulfil their role in this regard. In Cambodia, the request for TA was focused on the development of the National Action Plan on Violence against Women. However other countries remain without assistance and lack the necessary capacity. According to KIIs the Mozambique CCM, for example, does not have the capability to effectively oversee grant implementation itself and there is limited engagement of senior MOH management in the CCM’s activities. Mozambique is not the only country to struggle with programming for AGYW (see Box 3).

#### Box 3: KII from Swaziland

*“We have been conducting GF programs without any specific attention to gender. It is only with these new AGYW guidelines that we are now trying to focus towards it. We now have a representative of women organisations in the CCM. But so far not much is being done.”*

**Lack of meaningful engagement of AGYW in decision making:** The team found that the participation of young people in decision-making with regard to the HIV response is weak. Where they did participate, they lacked the capacity for meaningful engagement. AGYW are largely targeted as “beneficiaries” rather than implementers (Kenya, Mozambique, South Africa, Swaziland and Uganda). In most of the review countries, young women are not represented on the CCM (see page 26). In South Africa, young people were not involved in the design of most of the components under the Young Women and Girls program supported by the Global Fund. Instead, adults decided what the AGYW’s program should contain and how it should be implemented. Furthermore, some of the women’s organizations in South Africa had never even heard of the CCM or of the Country Dialogue process. In Swaziland, the lack of women’s involvement in decision-making resulted in an absence of the requisite drive and interest in matters pertaining to women’s empowerment and gender equality.

## 4 KEY FINDINGS

This section outlines the key findings from the review. To respond to the review questions, the findings have been organized around the following four categories:

<sup>41</sup> Swedish Embassy, DFID, European Union Delegation (2014), *Gender Country Profile 2014, Democratic Republic of Congo*

<sup>42</sup> United Nations (2016), *United Nations Development Assistance Framework 2016-2020, Swaziland UNDAF 2016-2020*



1. How inequalities faced by women and adolescent girls are addressed in respective country programs
2. How gender equality principles are reflected in the global fund grant design and country process
3. Implementation process
4. Results and effectiveness.

## 4.1 How Inequalities Faced by Women and Adolescent Girls are Addressed in Respective Country Programs

### Overview of main findings (4.1)

**Finding 1:** The legal and institutional framework on gender equality is in place in many of the review countries, but it lacks mechanisms for its practical implementation.

**Finding 2:** Potential inequalities faced by AGYW are poorly understood, documented and addressed by respective country programs.

### Finding 1: The legal and institutional framework on gender equality is in place in many of review countries, but is lacking mechanisms for its practical implementation

All the Review countries have multiple policy documents in place that reflect various commitments to youth, women and gender and that adhere to international conventions addressing gender inequality and the rights of the child. However, policy implementation at the national level is reported as a challenge across countries, including the ways in which policies can be translated into programs to assist AGYW. Even in countries such as

#### Box 4. KII from Swaziland

*“Swaziland is very rich with policies. There is a policy for almost everything, but the problem is implementation. The policies offer little guidance on how the programs will be initiated”.*

Moldova, where each sector has an appointed gender focal point, most sectorial strategies are adopted without sufficiently considering the gender perspective, as the KIIs have highlighted. Moreover, even where the mechanisms are in place – for example, in the case of sector gender offices, staff lack training in gender-responsive programming. Indeed, many are unclear what ‘gender’ itself means.

There are significant challenges to improving gender equality. One challenge is the low degree of responsibility and accountability that public agencies/institutions take to implement gender-responsive activities and their poor ability to understand and formulate policies targeting women and men specifically. A second challenge comprises very weak monitoring mechanisms, including a lack of appropriate indicators. In Cambodia, Cameroon and Swaziland, KIIs expressed concern that there is weak knowledge and understanding of the ways in which policies can be interpreted and developed into programs to assist AGYW, as well as a lack of institutional structures for their practical implementation. In Cambodia and Cameroon, evidence indicates that government stakeholders, including ministry staff, do not fully understand what is meant by ‘gender’. This is despite the high attention it has been given during country consultations, in NSPs and other national policy documents, and in the Global Fund application guidance. Although the legal framework in many of the Review countries has been revised to address (if not remove)

legal barriers, in practice there are still cases of discrimination and refusal of care by service providers based on vulnerabilities and HIV status (Cambodia, Moldova, Tanzania).

There are promising examples in a few of the review countries. In South Africa, Strategic Objective 1 in the NSP on HIV and AIDS 2012-2016 seeks to address social and structural drivers of HIV and TB prevention, care and impact. South Africa's *She Conquers* campaign, the country's AGYW policy developed in 2016 on the basis of the DREAMS package, is a promising example of where policies can be developed to reinforce and complement donor efforts. However, without the appropriate instruments in place to support the policy's implementation and rollout, special provisions for AGYW will remain merely an abstract concept. In Mozambique, the 2013 Youth Policy focuses on technical and vocational education and fostering employment and entrepreneurship to address some of the underlying causes of HIV infection among young people.

**Finding 2: Potential inequalities faced by AGYW are poorly understood, documented and addressed by respective country programs**

While some of the NSPs reviewed systematically addressed gender-related inequalities, challenges and barriers, a considerable proportion did not adequately address gender and/or AGYW. Gender analysis and assessments have identified potential inequalities faced by AGYW, related to the respective disease trajectory/prevention and treatment cascades. However, these inequalities are poorly understood and/or documented by respective programs. In situation analyses or epidemiological sections, gender-related issues were often raised, but gender-specific interventions (including those related to AGYW) were poorly described at the level of prioritizing activities. Structural factors were not analyzed and were not prioritized for implementation (as was found in Kenya, Mozambique and Swaziland). Moreover, where specific gender-related activities were included, these were usually at the service delivery level. Only a few NSPs included activities that addressed the drivers of the epidemic or the sociocultural issues that exacerbated female vulnerability to the disease. And only a few contained comprehensive and wide-ranging interventions to address AGYW across all the strategic objectives/strategies (Kenya, South Africa and Uganda).

Recently conducted analysis of NSPs and national HIV targets for sex-disaggregation in 18 Sub-Saharan African countries<sup>43</sup> found that on average 31 percent of NSP targets included sex-disaggregation ranged from 0 percent (Botswana, Cameroon and Mozambique) to 92 percent (Zambia). Only the NSPs from South Africa, Swaziland and Zambia disaggregated a majority (>50 percent) of their targets by sex. The same study also found that sex-disaggregation in data-reporting was more common for targets related to the early phases of the HIV care continuum: 83 percent of countries included any sex-disaggregated targets for HIV prevention, 56 percent for testing and linkage to care, 22 percent for improving antiretroviral treatment coverage, and 11 percent for retention in treatment. The most common target to reduce gender inequality was to prevent gender-based violence (GBV is present in 50 percent of countries).

## 4.2 How Gender Equality Principles Are Reflected in the Global Fund Grant Design and Country Process

### Overview of main findings (4.2)

<sup>43</sup> Sherwood J, Sharp A., Cooper B., Blumenthal S. (2017). HIV/AIDS National Strategic Plans of Sub-Saharan African countries: an analysis for gender equality and sex-disaggregated HIV targets. *Health Policy and Planning*, czx101, <https://doi.org/10.1093/heapol/czx101>

**Finding 3:** The Global Fund plays a catalytic role in scaling-up programs to support AGYW in targeted countries.

**Finding 4:** NSPs and CNs maintain a strong vertical character with limited horizontal linkages and collaboration with other health and non-health platforms that specifically address women and adolescent girls.

**Finding 5:** Although AGYW needs are better addressed in FRs (compared to CNs), gender analysis remains inadequate with no age-disaggregated data across AGYW age groups.

**Finding 6:** In many countries, the Country Dialogue process did not include AGYW or stakeholders with expertise and/or knowledge of gender inequities related to the HIV prevention-treatment-care cascades.

**Finding 7:** Many CCMs lack engagement by the government ministries in overseeing critical programs to address AGYW needs, including gender-transformative programs and programs that advance gender equality.

**Finding 8:** CCMs lack designated representatives with expertise in gender issues and with capacity to oversee the implementation of interventions to address gender inequalities in the prevention and treatment cascades of the three diseases. Most CCMs lack meaningful engagement of AGYW.

**Finding 9:** Involvement of young men and boys in the design and implementation of the AGYW programs varies across countries

### **Finding 3: The Global Fund plays a catalytic role in scaling-up programs to support AGYW in targeted countries**

By placing gender issues and AGYW as a core area of the current strategy, the Global Fund is encouraging countries to focus on interventions to address the needs of AGYW in their NSPs and CNs. Country dialogues, supported by the Global Fund and partners (for NSPs and CNs/FRs development), combined with the provision of guidelines (technical briefs) for the development of gender-responsive programming and AGYW activities in country applications, have significantly improved country programming on gender inequality-related issues over the years. This is reflected in the most recent NSPs, which better address gender inequalities and priorities gender-responsive interventions, including AGYW, in comparison to their previous versions. For example, the new National HIV Program 2016-2020 in Moldova for the first time includes indicators to measure interventions for AGYW aged 10-24. The tailored support and guidelines also contributed to a better alignment of the Global Fund applications with NSPs. They include, and priorities, interventions related to AGYW in countries where the Global Fund is scaling up programs to support AGYW (Kenya, Mozambique, South Africa and Swaziland).

According to KII, until recently, programs addressing gender-related risks and barriers faced by women and girls were focused on combating effects rather than prevention: medical services were only reactive, not proactive. With the *Global Fund New Strategy 2017-2022* and the provision of strategic investments to reduce health inequities and scale up programs to support women and girls, more attention is given to prevention and to better addressing structural drivers. In Mozambique, the CN includes a significant allocation for HIV prevention activities among AGYW, while the country's National Program on Prevention and Control of HIV&AIDS and STI (NAP) 2011-2015 and its operational plan and budget (in place at the time when the country was developing CN), do not contain gender-related interventions for AGYW age 10-24. In Windows 1 and 2 (allocation period 2018-2020) several countries included evidence-based activities such as HIV self-testing and cash transfers and PrEP, although such activities had not originally been catered for in current NSPs.<sup>44</sup>

<sup>44</sup> W4GF...lessons learned.....

**Finding 4: NSPs and CNs maintain a strong vertical character with limited horizontal linkages and collaboration with other health and non-health platforms that specifically address women and adolescent girls**

While TB/HIV collaboration is often mentioned in the reviewed NSPs, only a few NSPs had concrete linkages (with specific interventions) with SRH or STIs programming (Kenya, Sudan and Uganda). There is limited discussion of opportunities for linkages across diseases or of encompassing gender identities to include sexual and reproductive, maternal, neonatal and child health.

As with NSPs, many CNs miss opportunities for integrating service delivery for women and young girls (for example, family planning linked to STIs and HIV services, promoting informed reproductive choices among women living with HIV). In the context of HIV, sexual health is rarely distinguished from reproductive health. The disproportionate gender issues were rarely addressed in the context of RSSH. This included human resource policies relevant to the health system: for example, community-based service providers. Moreover, in countries where new cadres of community health workers had been trained, such as Tanzania, they had still not been deployed.

Compared to CNs, new FRs emphasized the integration of service delivery for women and young girls. Lao PDR, Sudan and Zimbabwe in their FRs emphasized the integration of HIV and TB services within RMNCAH programs. However, many FRs also showed missed opportunities for integration with RMNCAH across HIV, TB and malaria. PMTCT and intermittent preventive treatment in antenatal clinics are exceptions and not yet fully developed.

**Finding 5: Although AGYW needs are better addressed in FRs (compared to CNs), gender analysis remains inadequate with no age-disaggregated data across AGYW age groups**

Many of the CNs from the review countries describe and acknowledge issues related to gender, including data disaggregated by sex, age and geographic location (for example, Kenya, Mozambique, South Africa and Swaziland). This is, in part, attributed to the fact that Global Funds has invested in health information systems and strengthened country capacities for M&E. However, age-disaggregated data for different age groups and within the population of AGYW are still missing, with the exception of data from the DRC. Moreover, analysis of gender data only looks at how the epidemics have a diverse effect on women and men, without addressing social and cultural factors. CNs reviewed from countries that are not prioritized to address AGYW by the Global Fund did not propose gender-responsive interventions and programming that recognized gender- and AGYW specific - needs and capacities. Where included, gender analysis and gender-responsive interventions were related to FSWs or women who inject drugs. A majority of the CNs reviewed, failed to include interventions focusing on the empowerment of women and girls. The exceptions were South Africa and Swaziland.

Compared to the reviewed CNs, FRs submitted in Window 1 (March 2017) show strengthened descriptions of KPs, increased references to the use of gender-disaggregated data for HIV and an improved understanding of human rights barriers to service provision. Countries are providing more and better quality data as a rationale for selecting KPs and have improved the description of the risks and vulnerabilities to which they are exposed. FRs also contain more sex-disaggregated data and gender-related barriers to services are better addressed. However, gender analysis remains inadequate in the majority of the FR applications. There are no age-disaggregated data for different age groups within the population of AGYW (10-14, 15-19 and 20-24) and no in-depth analysis, apart from a description of how the epidemics affect men and women differently. Analyses are missing of sub-populations of AGYW, including female KPs, married/unmarried AGYW, in- and out-of-school, rural/urban, access to services, and targeted interventions for AGYW aged 10-24 years. The strongest

AGYW programming content was reflected, not surprisingly, in the HIV applications of countries applying for AGYW matching- funds grants through the Catalytic Investment Funds.

**Finding 6: In many countries, the Country Dialogue process did not include AGYW or stakeholders with expertise and/or knowledge of gender inequities related to the HIV prevention-treatment-care cascades**

In most of the review countries the Country Dialogue process was inclusive and participatory and involved a broad range of stakeholders. However, the participation of stakeholders with experience and/or knowledge about gender inequities related to the HIV prevention-treatment-care cascades were neither mentioned in the reviewed NSPs, nor in interviews with country KIs. Moreover, some stakeholders interviewed stated that gender issues (including gender inequality) were not seen as a government priority during the development of NSPs and CNs. Exceptions are seen in countries that applied for matching funds (under the gender and human-rights themes). The team found that AGYW were not included in the Country Dialogue and/or FR development processes for the NSPs or CNs in most countries (Kenya, Moldova, Mozambique, South Africa, Sudan, Swaziland and Tanzania), with the exception of Cameroon.

Compared to the weak or complete absence of AGYW involvement in developing CNs, the team found that countries preparing funding requests for Windows 1 and 2 (Kenya, Malawi, Uganda and Zimbabwe) attempted to include all affected populations, including AGYW, in developing the funding requests. Women in Kenya pushed for more consultation time because they were uncomfortable with what was being submitted for AGYW. While there was political willingness in Malawi, and despite the Global Fund Secretariat making resources available for constituency dialogues, the resources were inadequate to ensure that all constituencies were included across the entire country, resulting in weak and unsatisfactory national dialogue.<sup>45</sup> During the country dialogue in Zimbabwe, the youth population were predominantly represented by young men. Thus, young women and adolescent girls missed the opportunity to directly shape their own programs.<sup>46</sup>

**Finding 7: Many CCMs lack engagement by the government ministries in overseeing critical programs to address AGYW needs, including gender-transformative programs and programs that advance gender equality**

The engagement of government ministries responsible for overseeing critical programs to advance gender equality in CCMs varies from country to country. In Moldova and Uganda, ministries responsible for youth/gender/women participate actively in the CCM. In South Africa, the representatives from the Department of Women and the Department of Social Development attend meetings. However, in other countries, gender and/or youth ministries have no meaningful engagement in the CCM. Though CCM members are the ones expected to attend the meetings, in Swaziland, the Directorate of Gender at the Deputy Prime Minister's office can be considered key stakeholders, and would benefit from attendance or involvement in related activities, and such engagement has not been noted. In Kenya the MOH provides support, guidance and oversight on critical programs to address AGYW needs and programs that advance gender equality. At the same time, the MOH's focal point on gender is also a relevant authority on these matters. The review team is of opinion that it would be beneficial for the focal point to be involved in related activities, and such engagement has not been noted. In some countries, the CCM was deemed as weak and had limited engagement with government stakeholders (Mozambique). However, it has been noted that in some of the countries eligible for catalytic/matching funds related to gender and human rights

<sup>45</sup> W4GF (2017), *W4GF Advocates Share Key Lessons and Reflections from Windows 1 and 2*

<sup>46</sup> *Ibid.*

(Mozambique and Uganda) the engagement and/or participation of ministries responsible for gender/women has increased.

**Finding 8: CCMs lack designated representatives with expertise in gender issues and with capacity to oversee the implementation of interventions to address gender inequalities in the prevention and treatment cascades of the three diseases; Most CCMs lack meaningful engagement of AGYW**

All CCMs from the review countries, with the exception of Mozambique (28.2 percent), fully comply with the Global Fund criteria for CCM female membership (at least 30 percent). However, half of the CCMs do not have a designated representative with expertise in gender; and in eight out of ten CCMs, AGYW have no representation (see Section 3.4, page 21). The team found that AGYW were not involved in the design of most CN/FR components. Whereas KPs are represented on the CCMs, key advocacy women's organizations (other than organizations for those living with HIV) are not represented. In Mozambique, according to KIIs, technical skills in gender analysis and programming are low and no obvious women's groups exist to field potential representatives on the CCM. An exception was seen in Moldova, where, although expertise in gender was brought to the CCM through an umbrella NGO, the collaborative partnerships of the Global Fund and other in-country donors/partners resulted in women living with HIV becoming leaders and advocates for their rights and gender equality. In Swaziland, with the new guidelines on AGYW integration, an AGYW representative has joined the CCM as a full member.

There are also examples from countries outside the scope of this review showing that the inadequate level of participation does not hold true for all African countries. In Tanzania, CCM discussions (related to FRs for Window 2) included AGYW representatives from a youth organization, and efforts were made to ensure youth participation and AGYW representation in the subsequent development of the HIV FR. This is because, in some countries with additional funds for Catalytic Investments under the FM, youth and women were particularly encouraged to participate in FR development.

According to KIIs, Global Fund guidelines on human rights, KPs and gender have helped to increase the representation of these constituencies on the CCMs and have encouraged countries to pay greater attention to these issues.

**Finding 9. Involvement of young men and boys in the design and implementation of the AGYW programs varies across countries**

A few countries reported that AGYW programs have been designed and implemented to include men with an objective of transforming existing notions of masculinity. According to many key informants interviewed boys and young men are still not included as a target group for prevention of HIV among AGYW in many of the review countries. For example, although accessible sexual and reproductive health services and rights for women are widely promoted through AGYW programs and interventions, engagement of young men and boys in transforming the rigid norms that shape sexual and reproductive health outcomes is still not sufficient (DRC, Malawi, Senegal, Swaziland). In Swaziland, there has been little or no involvement of boys in the AGYW interventions, and a new focus on boys and young men does not reach all communities.

There are also promising examples of involvement of boys and young men in some of the review countries. In Mozambique WHO as a Global Fund partner, and the national health services encourage the inclusion of male partners in ANC services to increase uptake of PMTCT in communities where women are restricted from making independent HIV-related health decisions<sup>47</sup>. Through various

<sup>47</sup> Audet C et al, 2016. Engagement of men in antenatal care services: Increased HIV testing and treatment uptake in a community participatory action program in Mozambique, *AIDS Behav.* 2016 September; 20(9): 2090–2100. doi:10.1007/s10461-016-1341-x.



initiatives a new type of male-to-male community health agent, “Male Champions” (MCs), are trained on counseling male partners to engage in spousal/partner support (Tanzania, Mozambique). In South Africa and Sudan it is evident that efforts are made to support young men and boys to take actions and advocate against domestic and sexual violence (One Man Can Campaign)<sup>48</sup>. However, the key informants interviewed pointed out that efforts to engage men in the prevention of HIV among AGYW have been mostly short-term projects, often only reaching relatively small numbers of men. Also, the International Men and Gender Equality Survey (IMAGES) carried out in several of the review countries (Moldova, South Africa, DRC) found that, although large numbers of men express supportive attitudes toward gender equality, there are still gaps between attitudes and behaviors.

### 4.3 Implementation Process

#### Overview of main findings (4.3)

**Finding 10:** The Global Fund plays a significant role in health reform and RSSH in many countries, including its support to integrated service delivery (TB/HIV, RMNCAH) and establishes partnerships to better respond to the challenge of integrating disease programs with RMNCAH programs.

**Finding 11:** Countries are not yet fully prepared to take advantage of the available funding provided by the Global Fund to implement gender-responsive programming.

**Finding 12:** Countries are not taking full advantage of available TA, and TA requests from a single country are not always coordinated.

**Finding 13:** The quality and quality control of TA designed to develop and implement interventions that addressed gender-inequalities in the context of HIV prevention and treatment cascades varies within and between countries.

**Finding 14:** Coordination and collaboration between governments and different developing partners as well as better alignment between PEPFAR and the Global fund, significantly facilitates implementation of programs that address and reduce gender-related risks and barriers faced by women and girls.

**Finding 10: The Global Fund plays a significant role in health reform and RSSH in many countries, including its support to integrated service delivery (TB/HIV, RMNCAH) and establishes partnerships to better respond to the challenge of integrating disease programs with RMNCAH programs.**

In general, programming has remained largely vertical, except for PMTCT/MTCT. However, there are attempts to integrate HIV, TB, SRH and GBV programs with successful examples. In South Africa, Global Fund support has helped the National Department of Health (NDOH) to integrate HIV, TB, SRH and PMTCT interventions within provincial and district health facilities. Sudan’s FR notes that PrEP for sero-discordant couples is being implemented and the integration of PMTCT into SRH was rolled out in 2016 within the HSS grant, to be further strengthened under the FM grant. The country’s proposed RSSH activities under the new FR are not gender-specific; however, they contribute to

<sup>48</sup> The One Man Can Campaign and Action Kit has been developed by the Sonke Gender Justice Network to support men and boys to take action to end domestic and sexual violence and to promote healthy, equitable relationships that men and women can enjoy.

improved child mortality and maternal mortality rates, which is the end goal of RSSH support for disease reduction.

In Cambodia, the Global Fund HSS grant component supports the integration of several vertical community systems – HIV, TB, malaria and MCH – through the development of integrated training curricula and health promotion tools, along with support for monthly meetings of the multi-task Village Health Support Groups. In Uganda, there appears to be a generally poor performance of the current HSS grant, which has recorded a low absorption of funds. The RSSH FR linked with gender intends to strengthen coordination between district-level, disease-specific networks. This will address bottlenecks related to access, care and retention in HIV, TB, malaria and RMNCAH services. It will also support the mobilization and institutional capacity-building of networks of people living with the diseases and other vulnerable groups (e.g. women). It will help with planning, mobilizing participants and resources, and implementing and monitoring programs across the three diseases and RMNCAH services. Global Fund support has complemented financial assistance from other donors to strengthen the Health Information System.

Malawi's RSSH FR addresses HRH shortages and describes the results of a Workload Indicator of Staffing Needs survey, which indicated shortages, a poor distribution of key health workers and vacancy rates at 75 percent across all cadres in some districts. Global Fund-supported recruitment of health workers is to continue under the new FR and includes the capacity building of the Health Service Commission to address the recruitment challenges encountered under the current grant.

In Moldova, through regional grants that focus on advocacy and community mobilization and small grant programs, the Global Fund is supporting harm-reduction interventions tailored to the needs of women who inject drugs. In Cambodia, the Global Fund is contributing to covering the funding gap related to ARV coverage: as a result, viral load is decreasing among AGYW as well as other PLHIV. In the DRC, the Integrated SRH Services Program increases the availability and use of integrated SRH services (including FP, MCH and HIV) that are gender-responsive and that meet human rights standards for quality of care and equity in access.

**Finding 11: Countries are not yet fully prepared to take advantage of the available funding provided by the Global Fund to implement gender-responsive programming**

At the country level, there is a lack of evidence-based knowledge on actual implementation and on the effectiveness of certain interventions and measures that lower the HIV incidence among the AGYW. In some of the countries reviewed, there was a delay in the implementation of interventions to address AGYW in HIV, including gender inequalities. This was due to the lack of knowledge and technical skills within the SRs (Kenya, South Africa and Swaziland,) and required capacity building and training before implementing the programs. KIIs underscored the fact that some PRs (especially government ones) would also benefit from capacity building prior to activity implementation. In many of the review countries, the role that the CCM should play in AGYW programming and directing investments to the structural causes of gender inequality is not yet clear to CCM members. As discussed within Finding 8, most CCMs lack the technical skills and capacity needed for gender-responsive programming and overseeing the implementation of interventions to address gender-inequalities in the context of the HIV prevention and treatment cascades. The CCM members interviewed expressed a need for more guidelines from the Global Fund to be able to better perform/fulfil their role in this regard, but no formal request has been submitted by the CCM Chair.

**Finding 12: Countries are not taking full advantage of available TA, and TA requests from a single country are not always coordinated.**

Both short- and long-term TA is available to countries, either directly from the Global Fund or through numerous partners. However, countries are not taking full advantage of available TA.



During 2014 and 2015, the Global Fund’s Community Rights and Gender (CRG) Special Initiative provided TA to enhance gender components in Country Dialogues and CNs. Gender-related TA was in high demand, featuring in 18 assignments. Nearly 25 percent of all short-term TA deployed through the CRG Special Initiative has been to support the inclusion of sound gender-responsive interventions in CN development. The Global Fund CCM Hub, together with the CRG team, recently piloted CCM induction training in Namibia. This comprised different modules, including a gender and human rights module. The gender module aimed to support CCMs to better understand what, how and why gender matters in HIV, TB and malaria responses. The online materials for the training are available for CCMs (upon request) to go through materials within a given time frame, before face-to-face modules are delivered. At the time of writing (August 2017), seven countries had completed the training and four more are to be completed by September 2017. However, only governance-related modules are rolled out for the face-to-face training, due to lack of funding, and none of countries that belong to the group of countries targeted by the Global Fund for support in gender programming and scaling-up programs to support AGYW have been included so far. It is not clear to the team if countries are even aware of this opportunity.

**Finding 13: The quality and quality control of TA designed to develop and implement interventions that addressed gender-inequalities in the context of HIV prevention and treatment cascades varies within and between countries.**

Global Fund partners also provide TA to countries to better understand data and to perform robust gender analysis, but the quality and quality control of TA varies. According to KIIs, the outcomes of the TA provided during the gender analysis and gender-responsive programming differed in their usefulness (from what some stakeholders considered successful to what they considered weak). Some countries found difficulties in identifying qualified consultants with sufficient technical understanding of the specific programs for AGYW, or with specific knowledge and expertise on gender inequalities in the context of the HIV prevention and treatment cascades, as well as the ability to integrate these inputs into a comprehensive holistic RHSS approach (DRC and Moldova).

Although various TA for countries is available from the Global Fund and partners,<sup>49</sup> coordination among TA providers has been identified by KIIs as a challenging area, with limited coordination to date between FPMs and efforts such as the CRG TA initiative. As an example of the complexity of TA activities, DRC CT members described a number of mechanisms for TA related to the FM application: engagement of the consultant for gender mainstreaming provided through the CRG, a TA consultant from Senegal for the creation of a task force with civil society and affected communities, then external consultant TA to determine whether a gender-based approach would fit into the DRC context, and another consultant for gender assessment for TB and HIV. The CT members described particular challenges in identifying TA resources for non-English speaking countries and a clear need for coordination of country-specific TA. In most of the review countries, CCMs failed to operate in their role in procuring and coordinating TA related to gender-responsive programming and the implementation of interventions to address gender-inequalities in the context of the HIV prevention and treatment cascades. In Tanzania during the FR’s development, there was little coordination between the donors and the CCM’s Proposal Development Task Force, and a lack of coordination between the TA provided for different themes.

**Finding 14: Coordination and collaboration between governments and different developing partners as well as better alignment between PEPFAR and the Global fund, significantly facilitates implementation of programs that address and reduce gender-related risks and barriers faced by**

<sup>49</sup> French 5% Initiative, GIZ BACKUP Health, the International HIV&AIDS Alliance, the Stop TB Partnership UNAIDS, UNICEF, UN Women and WHO.

## women and girls

Through partnership agreements with PEPFAR, Stop TB, UNAIDS, UNFPA, UNICEF, UN Women, Women4Global, WHO and others, Global Fund support is: promoting a better understanding of the drivers of the HIV/TB epidemics; supporting the use of gender assessment tools to identify gender gaps in HIV/TB programming; supporting women activists in multiple regions; strengthening linkages with HIV and SRH programs; and providing needed TA to country stakeholders, CCMs, CSOs, NGOs, PRs, SRs, SSRs community and women's organizations.

In partnership with UNFPA, the Global Fund is strengthening linkages with HIV and SRH programs (Cambodia, Moldova and Swaziland). In collaboration with the Stop TB and UNAIDS partnership, the use of gender-assessment tools is supported, so that countries can identify gender gaps in TB/HIV programming. From the review countries, both gender assessments and the use of the Gender Sensitive Monitoring & Evaluation Tools for SRHR and HIV was undertaken in Cambodia, Malawi, Mozambique, Senegal, South Africa, Tanzania and Uganda. Through partnership with Women4Global Fund and the International Community of Women living with HIV (ICW), the Global Fund supports women activists in different regions to access the knowledge and tools needed to make the case for investments at the country level to reduce gender-related barriers to services.

The Global Fund partnership with PEPFAR in the successful DREAMS districts in ten countries is showing positive results. DREAMS combines evidence-based approaches that go beyond the health sector to encompass innovative methodologies with the potential to be replicable and scaled up, addressing the structural drivers that directly and indirectly increase girls' HIV risk, including poverty, gender inequality, sexual violence and lack of education. It is being delivered in several countries (Kenya, South Africa, Swaziland, Tanzania, Uganda and Zimbabwe). Aligning with DREAMS is seen by many stakeholders as a promising practice to be continued or even expanded. DREAM packages, with Global Fund support could be scaled-up for other districts. KII respondents described close coordination between PEPFAR and the Global Fund in Uganda to map districts where DREAMS is being rolled out and a Global Fund-supported intervention scaled-up, to avoid duplication of effort. This successful partnership between the Global Fund and PEPFAR is evident in other countries (South Africa, Swaziland and Zimbabwe).

Through cooperation agreements with UNAIDS and WHO, Global Fund support has promoted a better understanding of the drivers of the HIV and TB epidemics in Moldova. In Tanzania, PEPFAR's new 2017 COP was shared with the CCM as well as the umbrella organization representing 13 NSA constituencies, prior to the development of the country's two FRs (HIV-AIDS and Malaria-RSSH) under Window 2. Sudan and Uganda's applications describe donor collaboration and the selection of complementary geographic targets as a useful practice that CTs could promote.

In seven provinces in the DRC, Gavi, the Global Fund, UNICEF and the World Bank, in collaboration with the MOH, are setting up a joint results-based financing (RBF) platform with the aim of improving the quantity and quality of essential healthcare services (including TB, HIV, malaria, and MNCH). Through funding, the full package of HIV, TB, malaria and MNCH services are defined by the National RBF Manual. This is expected to result in increased service utilization, which will lead to improved health outcomes for the population, in particular for women and children.

According to key informants, development partners' collaborative interventions in Moldova have resulted in women living with HIV becoming leaders; not only within the HIV community but within a wider society to advocate for their rights and gender equality. HIV-positive women are included in the anti-violence campaign supporting women affected by violence.

Partnerships and building in-country synergies has also helped to leverage existing resources in country (e.g., Moldova, South Africa, Swaziland and Uganda).

## 4.4 Results and Effectiveness

### Overview of main findings (4.4)

**Finding 15:** The Global Fund focus on women and girls with the strategic investments to improve their health and support country driven gender-responsive programming is making a difference.

**Finding 16:** Global Fund support has led to greater community involvement in the disease trajectory.

**Finding 17:** The performance results of most AGYW interventions in current grants are considered only mildly satisfactory. This is further exacerbated by challenges that countries are facing in monitoring the implementation of AGYW interventions.

### **Finding 15: The Global Fund focus on women and girls with the strategic investments to improve their health and support country driven gender-responsive programming is making a difference.**

According to the Global Fund document Focus on Women and girls (April 2016), AIDS-related deaths among women aged 15 years and above declined by 58 percent between 2005 and 2014 in 13 African countries where the Global Fund invests<sup>50</sup> and coverage of ART for women increased.<sup>51</sup> The results of this review (although to be interpreted with caution as explained in section 3.7) also support the premise that investment in women and girls, and in particular young women and adolescent girls, will reap benefits in terms of lowering the burden of disease and deaths related to HIV and TB.

Promising results for HIV positive women are notable. Since 2010, AIDS-related deaths among AGYW declined in Kenya (by 21.4 percent), South Africa (by 27.6 percent) and Uganda (by 51.4 percent). The number of women living with HIV on ART increased more than four times in the DRC and Mozambique, although the number is still low in comparison to the percentage of women living with HIV. Cambodia and Swaziland have reached over 80 percent ART coverage for women (82 and 85 percent respectively). In the review countries, ART coverage shows a higher increase in women than men (whereas in 2010 ART coverage was higher for men - by 2016 the trend had reversed and more women living with HIV were on ART compared to men). HIV prevalence has shown a steady decrease since 2010, but is still notably higher among AGYW than men aged 15-24 in all review countries with the exception of Moldova, where, like most countries in EECA, HIV prevalence is increasing in both young men and young women and adolescent girls. Moldova, South Africa and Uganda have more than 95 percent coverage of ARV drugs among pregnant women. PMTCT service uptake continues to rise as witnessed in Kenya where support from the Global Fund and partners has led to 80 percent coverage of pregnant women receiving PMTCT services in 2016. The DRC also shows an increase in PMTCT coverage from 8 percent in 2010 to 70 percent in 2016.

It is clear from both the Country Briefs and the GPR that the Global Fund is making a concerted push to increase attention on women and girls, making investments to improve their health and supporting country-driven processes grounded in equity and inclusiveness. It is also clear that the Global Fund is taking important steps to develop implementation guidelines and catalytic funding strategies to operationalize the new *Strategic Plan* and other policies for strengthening gender and human rights programming and results. The results speak for themselves: the improvement in women's and girls' health is visible however much of the journey still lies ahead.

<sup>50</sup> Global Fund (2016), Focus on Women and Girls, April 2016

<sup>51</sup> Global Fund (2015), *ibid*.

### **Finding 16: Global Fund support has led to greater community involvement in the disease trajectory**

Thanks to Global Fund support, including contributions through regional grants<sup>52</sup>, greater community involvement in the disease trajectory can be seen in many countries. In Kenya and South Africa, community engagement to identify issues affecting young people and in implementation of HIV programs is increasing as seen through community-based movements to demand higher quality services. In South Africa, community members assist PRs and SRs to solve problems that hinder the implementation of programs. For example, in the Western Cape, community leaders provide protection to SRs in high-risk security areas and several community campaigns implemented by CSOs exist (not all funded by the Global Fund): “The Teens Alliance to end Sexual Violence in School”; “Real men do not rape Women” (funded by Nisaa’s Institute for Women’s Development); and “Ending Discrimination in Schools” (supported by POWA), which focuses on young lesbians aged 13-18 years in high schools. In Uganda, strengthening community systems has contributed to seventy two percent of the population who now have access to health care within a five kilometer walking distance<sup>53</sup>.

Support to community systems strengthening (CSS) has become a focus for Global Fund investments. In Moldova, the Global Fund provided support to CSS including advocacy for social accountability, legal aid services and community-based monitoring of legal rights. Thanks to legal aid support from the Global Fund, NGOs were able to use specific examples of rights violations to argue for changes in HIV legislation. In addition, peer-driven interventions have been designed to consider the specific needs of KPs and gender diversity (for example, having peer educators, women delivering low threshold services to women and recruiting new clients). In Cambodia, the National Centre for HIV and AIDS, Dermatology and STD plans to emphasize the inclusion of PLHIV self-help and support-group mechanisms in the MOH’s CSS and PHC programs, and thereby strengthen community-based support for AGYW.

A recently announced list of Global Fund priorities for multi-country funding for the 2017-2019 cycle does not include funding for multi-country approaches for HIV in Sub-Saharan Africa. The Global Fund prioritized regions where country allocations have decreased overall. However, in 2017 under the CRG Strategic Initiative, the Global Fund has set aside resources for 13 countries in Africa, to support meaningful engagement of AGYW and CBOs (working with/on AGYW issues), into Global Fund and related processes for over a period of 12 months. These funds will address the financial access barriers limiting community-based organizations working on AGYW issues to fully participate in the Global Fund processes.

### **Finding 17: The performance results of most AGYW interventions in current grants are considered only mildly satisfactory. This is further exacerbated by challenges that countries are facing in monitoring the implementation of AGYW interventions**

There are two diametrically opposite examples of country effort: firstly, the group of countries prioritized by the Global Fund for intensified efforts to introduce and scale up programs for AGYW with the aim of reducing HIV incidence; and secondly, the group of countries whose attention to AGYW is weak or non-existent.

As attention to AGYW is relatively new to national programming, some of countries are facing

<sup>52</sup> “Regional grants provide value-added when they have a major focus on advocacy for policy change, especially related to HIV law and human rights.....regional grants sometimes provide the only real space in which to support advocacy for key populations”. – quote from the Report on Thematic Review of Regional/Multi Country Grants, June 2016

<sup>53</sup> Uganda National Household Survey Report, 2016

challenges with the introduction of “new” program interventions for AGYW. There is a lack of knowledge and technical skills among PRs and SRs and problems recruiting suitably qualified staff, leading to delays in signing the Grant Framework Agreement, slow starts and low performance. For example, in South Africa grant implementation started only in 2017 (instead of in 2016) due to: the introduction of a new program intervention for the PR; the need for capacity building of SRs to start the implementation; delays in signing of MOUs in new districts and setting up clubs; and delays in signing the Framework Agreement.

In the majority of the review countries, no specific indicators related to AGYW were found in CNs, PUDRs or other documents for monitoring the implementation of the AGYW-related activities within the grants. In ongoing grants,<sup>54</sup> performance frameworks are not well-conceptualized for grants supporting/addressing women and girls, and are lacking AGYW-specific indicators. Modular frameworks in most of the review countries do not contain AGYW-specific indicators. There are recent efforts (February 2017) made by the Global Fund to improve its modular framework for the new allocation period (2018-2020) by including indicators to better monitor and measure progress of the AGYW interventions in the future/new grants. However, there are still only three HIV impact indicators for which sex- and age-disaggregation (including AGYW) are required for selected countries. Four HIV outcome and three coverage indicators, from the new Modular Framework, require sex- and age-disaggregation, but the age-disaggregation required is limited to only <15; 15+, and does not show AGYW (age 15-24). Only three Global Fund HIV key performance indicators require sex- and age-disaggregation (including AGYW). It is still too soon to evaluate their performance.

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<sup>54</sup> 2015-2017 allocation period.

## 5. CONCLUSIONS

This section presents the conclusions based on the collective expert judgment of the team, the interpretation of evidence as presented in the findings, and summarizes the major lessons learned from the review. The conclusions have been organized around the same four categories as the findings and are used to establish the case for the recommendations.

The overarching conclusion is that

***The Global Fund guidance on addressing the needs of women and AGYW is timely and appropriate and the Global Fund is making a difference in terms of raising the profile of gender/AGYW-focused programming. However, countries are still facing challenges in understanding and using data for evidence-based planning and AGYW-focused programming, as well as for implementation and monitoring of evidence-based AGYW interventions.***

### 5.1 How Inequalities Faced by Women and Adolescent Girls are Addressed in Respective Country Programs

**Conclusion 1 – Translating gender-sensitive policies into programs to assist AGYW and program operationalization is a challenge in many countries** (*related findings 1 and 2*).

Inadequate (insufficient) use of the available evidence-based information on the drivers of the epidemic is seen as a barrier to formulating and successfully implementing national responses. There is evidence that these drivers are not yet sufficiently documented by country programs and therefore not adequately addressed in funding applications (CNs and FRs). Further, a lack of clarity on how to operationalize national policies and strategies and identify priorities through programming decisions, coupled with a lack of mechanisms for the practical implementation of legal framework documents, are paramount problems for some countries. Monitoring mechanisms and the accountability of public institutions when addressing and achieving gender equality are also weak.

### 5.2 How Gender Equality Principles Are Reflected in the Global Fund Grant Design and Country Process

**Conclusion 2 – There are gaps and weaknesses in the reviewed NSPs with respect to AGYW, and more broadly, gender analysis and gender-related programming** (*related findings 4 and 5*).

Specific areas of concern include:

- a) Poor reference to gender-related inequalities; challenges and barriers not identified and/or not addressed
- b) Poor evidence base and inadequate prioritization of interventions to address inequalities that affect access and use of services faced by women and girls; limited attention to the programmatic implications of gender inequity
- c) Weak linkages to the national health system, including: national health plans; other disease programs including SRHR; adolescent, maternal and new-born child health; and existing coordination platforms
- d) Varying levels of attention paid to human rights
- e) Budgeting and costing for interventions to address inequalities faced by women and girls, which is, by and large, missing.

**Conclusion 3 – AGYW are largely seen as “beneficiaries” rather than actors** (*related findings 6-8*).

AGYW have limited opportunities for participation in decision making to guide NSPs and CNs/FRs

development. The Global Fund needs to ensure that people with gender expertise and women in all their diversity, including AGYW, are present throughout the process, represented at CCMs and meaningfully involved in the program design, implementation and in decision-making bodies (for example, the CCM Technical Working Groups, Oversight and M&E sub-committees).

**Conclusion 4 – More effort is required to build support for an inclusive process that will lead to the transformation of gender relations in the prevention of HIV among AGYW (related finding 9).**

While empowerment of women and active engagement of men is recognized by the Global Fund as essential to address gender equality issues, engagement of young men and boys in prevention of HIV among AGYW and design and implementation of AGYW interventions, is still weak in many of the review countries. The progress of engaging young men and boys in AGYW program design and implementation has been uneven. Even in countries that focus on boys and young men, not all communities are reached. Despite some positive examples more efforts are required. Gender norms cannot change without the involvement of young men and boys.

### **5.3 Implementation Process**

**Conclusion 5 – Countries included in the Global Fund AGYW focus are more likely to address effectively risks and barriers to services faced by women and girls (related findings 3 and 10).**

The Global Fund's investment in addressing gender issues and particularly AGYW needs has helped to drive significant progress in this area in countries targeted by the Global fund for scaling-up programs to support women and girls. The strongest AGYW programming content was reflected in the HIV applications from Global Fund countries that are applying for AGYW matching-fund grants and there has been a significant progress prioritizing gender issues, human rights and RSSH in those countries/applications. However, in countries which are not included in the Global Fund AGYW focus, even if a robust gender analysis has been undertaken to inform the development of HIV NSP, the proposed recommendations and interventions are not then implemented. It is clear that countries need Global Fund 'push and support' in addressing gender-related risks and barriers faced by women and girls, both in gender-responsive programming, as well as in AGYW program implementation.

**Conclusion 6 – There is no systematic approach for identifying TA needs, accessing TA and coordinating and overseeing the quality of TA provision (related findings 11-13).**

There appears to be little to no systematic approach as to: which entities should take the lead in identifying TA needs; what mechanisms are utilized to access TA; who oversees TA; when/how effective measures are to be implemented; and when/how TA is identified to support operationalization of priorities and AGYW programmatic decisions. Lack of evidence-based knowledge on actual implementation and on the effectiveness of certain interventions and measures that lower the HIV incidence among the AGYW might lead to inadequate or incomplete TA requests. Although countries have several options to request TA through formal bilateral arrangements or multilateral partnerships, there is no clear indication of the type of concrete support available to address the needs of AGYW.

**Conclusion 7 – Effective strategic TA partnerships, with clear focus and accountability, increase efficiency and maximize the impact of gender-responsive interventions (related finding 14).**

The Global Fund has made substantial efforts to enhance TA partnerships at the global level for addressing gender inequalities and scaling-up programs for women and girls. This has led to better alignment between PEPFAR and the Global Fund-supported programs. However, this has not yet fully translated into effective and well-structured TA partnership models at the country level and has



resulted in haphazard approaches in the provision of TA in some countries.

Through different TA partnership models, at the country level, the following areas still need to be strengthened:

- TA needs to be given to countries to better understand the kinds of research that best highlight gender and AGYW needs, gaps and barriers
- TA needs to be given to build country capacity for translating data into effective multi-sectoral programming with efficient coordination across multiple sectors
- TA needs to be given for countries to translate gender-responsive frameworks including NSPs into well designed and monitored interventions
- Support needs to be given for operationalization of priorities and AGYW programmatic decisions, as well as for effective measures to be implemented.

## 5.4 Results and Effectiveness

**Conclusions 8 – Strong political will and government commitment provide a safe space to explore innovative approaches** (*related findings 15 and 16*).

When AGYW programs are backed by strong political will and government commitment, and supported by robust epidemiological evidence, they can provide a safe space to explore innovative approaches to gender-responsive programming and service delivery. Matching funds as catalytic investments present a significant opportunity that should be maximized for both catalytic effect and innovation.

**Conclusion 9 – Thorough monitoring and rigorous assessments are needed to identify programs that individually, and in combination, have the highest impact on reducing gender-related risks and barriers** (*related finding 17*).

All program implementers must carefully consider the cost-effectiveness of interventions. Currently, there is some information on program impact but limited information regarding cost-effectiveness. More attention should be given to increasing the evidence-base on cost-effective interventions from a national perspective, and to enhancing country capacity for monitoring progress on AGYW program implementation.

## 6. RECOMMENDATIONS

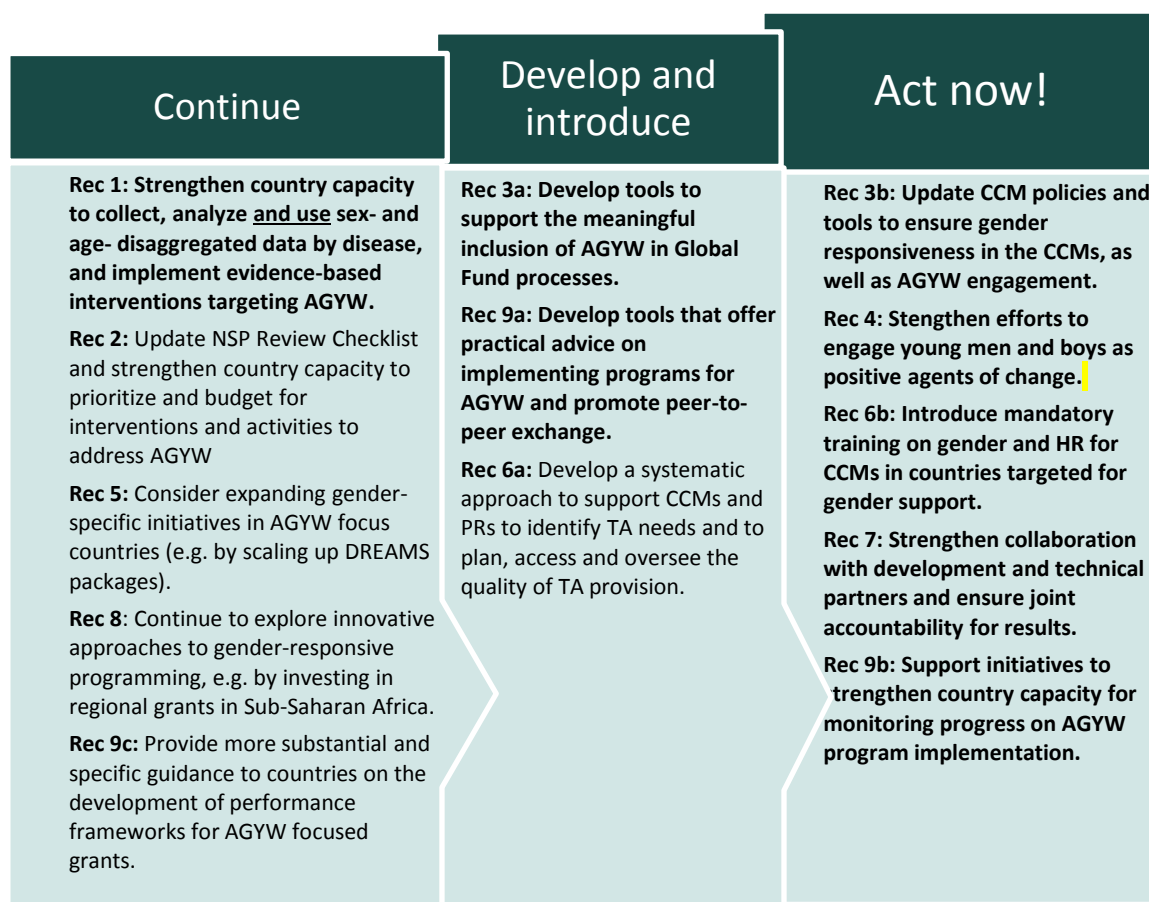
This section presents an overview of the specific recommendations that are derived directly from the main findings and conclusions. They are associated with the different focus areas (four themes) that were defined in the review questions generated from the TOR. The team applied the following principles when developing the recommendations:

- That they follow directly from the conclusions and support the findings
- That they are ‘actionable’
- That they identify the party that needs to act on the recommendation, and that they are within the manageable interest of the identified party.

The specific recommendations can be grouped into three main related categories as summarized in the figure below. The seven recommendations highlighted in bold, in our view, are the most critical recommendations for the Global Fund to address.



Figure 12: Overview of gender thematic review recommendations



There are five recommendations that promote the idea that the Global Fund should **continue with the work it is doing in gender-responsive programming targeting AGYW**. The priority recommendation in this category is to continue to support countries and build their capacity to collect, analyze and use sex- and age-disaggregated data in order to priorities and develop AGYW-responsive interventions, and to support implementation of those interventions.

There are three recommendations that are focused on the fact that **the Global Fund needs to develop systematic approaches and tools** to support meaningful inclusion of AGYW in Global Fund processes and needs to provide practical advice on implementing programs for AGYW.

The final recommendation category captures **those recommendations that call for action to be taken in the short to medium term**. There are four of these, which have all been prioritized by the team. The team has highlighted strengthening country capacity on gender-responsive programming and monitoring progress on AGYW program implementation.

The recommendations have been organized around the same four categories as the Findings and Conclusions.

## 6.1 How Inequalities Faced by Women and Adolescent Girls are Addressed in Respective Country Programs

**Recommendation 1: Strengthen country capacity to collect, analyze and use sex- and age-disaggregated data by disease, and implement evidence-based interventions targeting AGYW** (related Findings 1 and 2; Conclusion 1).

The Global Fund should support interventions aimed at strengthening country capacity to collect, analyze and use sex- and age- disaggregated data by disease in order to facilitate the prioritization and development of targeted AGYW-responsive interventions. The support should be directed at strengthening both systems and stakeholder capacity for collecting, analyzing and using data. In this way, the root causes and links between AGYW risks and access to, services can be better captured and addressed as can those of gender inequalities and HIV & AIDS, SRHR, TB and malaria at all levels. Further, the Global Fund should strengthen country capacity for implementation of those evidence-based interventions targeting AGYW and promote stakeholders' attention and engagement in the implementation process. Stakeholders should include civil society, CCMs, line ministries and respective relevant managers who are responsible for HIV&AIDS, SRHR, TB and malaria programming, health care providers and others.

## 6.2 How Gender Equality Principles Are Reflected in the Global Fund Grant Design and Country Process

**Recommendation 2: Update NSP Review Checklist<sup>55</sup> and strengthen country capacity to prioritize and budget for interventions and activities to address AGYW from broader, more inclusive interventions** (related Findings 3-5; Conclusion 2).

The Global Fund, through strengthened partnerships with UN agencies (for example, UNDP, UNAIDS or UN Women), should revise the NSP Review Checklist to better address gender and human rights, and encourage and support countries to further strengthen NSPs in these areas. Providers of TA for the development of NSPs and CNs should develop and deliver a training module on the use of the revised NSP Review Checklist to identify gaps and weaknesses, with more attention given to gender and AGYW and areas identified as weakest. Priority TA should focus on strengthening:

- Guidelines on how to best disaggregate data by sex and age (including for establishing baselines and targets)
- Analysis of gender- and age-specific barriers to service access
- Prioritization of interventions
- Budgeting capacity in order to ensure that funding for AGYW and other gender activities is easily identifiable

**Recommendation 3a: Develop tools to support the meaningful inclusion of AGYW in Global Fund processes (e.g. existing youth participation tool can be adapted to AGYW)** (related Findings 6-8; Conclusion 3).

The Global Fund should develop tools to support the meaningful inclusion of AGYW in Global Fund processes and gender-responsive programming (CCMs, Country Dialogue, FRs/program

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<sup>55</sup> The NSP Review Checklist that was developed for the Thematic Review of National Strategic Plans (NSPs) was proven as a useful tool, and could be further developed for this purpose.

development, grant making, implementation and monitoring). The existing youth participation tool<sup>56</sup> can be adapted to AGYW to support their involvement in Global Fund processes and in gender-responsive programming. Checklists should be developed for CTs and CCMs to ensure processes have specifically considered AGYW.

**Recommendation 3b: Update CCM policies and tools to ensure gender responsiveness in the CCMs, as well as AGYW engagement** (*related Findings 6-8; Conclusion 3*).

The Global Fund Secretariat should update CCM policies and tools, including those relating to CCM eligibility and performance, to ensure gender responsiveness in all CCMs and AGYW engagement and accountability in targeted counties/CCMs. Clear responsibilities should be assigned to CCM oversight bodies to ensure strategic supervision of the implementation of gender-responsive programs. For example, a sub-committee within the Oversight Committee could be established to oversee gender-responsive programs, including implementation of AGYW interventions in targeted countries. The ongoing development of a new CCM strategy offers a unique opportunity to set new directions and requirements to enhance AGYW engagement and accountability within CCMs.

**Recommendation 4: Strengthen efforts to engage men and young boys as positive agents of change** (*related Finding 9; Conclusion 4*).

Country Teams knowledge of successful models of gender programs engaging adolescent boys and young men as positive agents of change should be further strengthened. The Global Fund Country Teams should support country stakeholders to design interventions that educate and engage men in positions of leadership and power to act as positive models (change agents and male champions) related to gender equality and prevention of HIV among AGYW.

## 6.3 Implementation Process

**Recommendation 5: Consider expanding gender-specific initiatives in AGYW focus countries (e.g. by scaling up DREAMS packages)** (*related Findings 3 and 10; Conclusion 5*).

To make further progress on addressing AGYW needs, it is necessary for the Global Fund to collaborate even more closely with its technical and development partners that have a country presence and “political weight”. The Global Fund partnership with PEPFAR in the successful DREAMS districts in ten countries is showing positive results. Aligning with DREAMS is seen by many stakeholders as a promising practice to be continued or even expanded, scaling up DREAMS packages to other districts with Global Fund support. To further build up on the successful DREAMS partnership, the Global Fund should consider scaling up DREAMS packages to other districts to create a full package for AGYW including economic empowerment and changing social norms.

**Recommendation 6a: Develop a systematic approach to support CCMs and PRs to identify TA needs and to plan, access and overseeing the quality of TA provision** (*related Findings 11-13; Conclusion 6*).

The Global Fund CTs should actively support countries in applying this systematic approach and determine:

- a) Additional types of TA for addressing the needs of AGYW and, more broadly, gender analysis
- b) When technical support for implementation is needed

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<sup>56</sup> The Global Fund, The PACT and UNAIDS, 2014. Making the money work for young people: a participation tool for the Global Fund to Fight AIDS, Tuberculosis and Malaria

- c) Specific mechanisms and TA providers, looking first to resources in-country and then from outside
- d) Mechanisms for more actively linking countries with TA as well as AGYW and human-rights matching fund opportunities for which they are eligible.

**Recommendation 6b: Introduce mandatory training on gender and HR, for CCMs in countries targeted for gender support** (*related Findings 11-13; Conclusion 6*).

The Global Fund should take advantage of recently developed gender and human rights modules for CCM induction training<sup>57</sup> and priorities countries for training, starting with those targeted for gender support. Online materials and face-to-face training should be *mandatory* for CCMs for all countries targeted for scaling up programs to support AGYW, while at the same time available to CCMs from other countries.

**Recommendation 7: Strengthen collaboration with development and technical partners and ensure joint accountability for results** (*related Finding 14; Conclusion 7*).

The Global Fund should strengthen collaboration with development and technical partners for increasing effectiveness and efficiency and maximizing the impact of gender-responsive interventions, and ensure joint accountability for results. The Global Fund should tap into long-term TA provided by in-country development partners, with expertise in AGYW programs and gender, as a valuable resource to strengthen country responses to gender inequality during grant implementation. Lessons learned from the Global Fund's Implementation Through Partnership (ITP) initiative could be used as a platform to jointly assess the situation in-country, map investments and TA support, and priorities and coordinate required additional TA and potential providers. Technical partners should more clearly define shared objectives and maximize the use of existing guidelines and tools. Such initiatives could also serve as an important driver for the meaningful engagement of community networks in the Global Fund processes at all levels.

## 6.4 Results and Effectiveness

**Recommendation 8: Continue to explore innovative approaches to gender-responsive programming, e.g. by investing in regional grants in Sub-Saharan Africa** (*related Findings 15 and 16; Conclusion 8*).

The Global Fund should further invest in regional grants in Africa, particularly in Sub-Saharan Africa. This will ensure continued focus on AGYW and support AGYW organizations to strengthen their capacity to participate in advocacy and decision-making, as an essential intervention to ensure AGYW can effectively take up their crucial role in the HIV response. The Global Fund should also further promote attention on AGYW and related risks and barriers faced by women and young girls in the context of the HIV prevention and treatment cascades through innovative and multi-sectoral interventions, integrating health/prevention, education and social protection/gender empowerment. The Global Fund would need to be willing to tolerate an increased measure of risk for such grants.

**Recommendation 8a: Develop tools that offer practical advice on implementing programs for AGYW and promote peer-to-peer exchange** (*related Finding 17; Conclusion 9*).

Similar to existing tools for implementing programs for KPs, the Global Fund should develop tools that offer practical advice on implementing programs for AGYW. The Global Fund should also promote peer-to-peer exchanges to support knowledge-sharing between CTs regarding support to AGYW-led programs and interventions.

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<sup>57</sup> CCM induction training which includes gender and HR modules has been developed by the Global Fund CCM Hub in collaboration with the CRG department.

**Recommendation 8b: Support initiatives to strengthen country capacity for monitoring progress on AGYW program implementation (related Finding 17; Conclusion 9).**

Countries targeted for the Global Fund Support for scaling up AGYW programs should be guided, and provided with funding, to strengthen their existing data collection and data quality systems to monitor and evaluate progress of AGYW program implementation, including measuring the cost-effectiveness of interventions. This should include investing, in collaboration with research organizations or other partners, in community-based monitoring and targeted evaluations and research focusing on program quality. The Global Fund should require that targeted countries collect and report data on AGYW program implementation including disaggregated by sex and age group.

The PCE implementers, in their work with country stakeholders and focus on measuring impact in eight targeted countries, should place particular emphasis on disaggregation of data by key populations (this may include AGYW), based on the individual epidemics. The implementers should facilitate country stakeholders to identify key populations of interest including potential “missing” key populations which may be gendered (taking into consideration shifts in epidemics to pre-elimination in the case of malaria or change from HIV general population epidemics to focus on high risk groups) and further define, at a minimum, disaggregation levels that include at a minimum age and sex. The PCE implementers should work with the stakeholders to strengthen the routine data systems and where necessary fill in gaps to ensure robustness and quality of KP disaggregated data for analysis. To ensure program improvement where needed the PCE implementer should work with the stakeholders to analyze data for key populations including how to use the conclusions to guide policy recommendations, resource allocations recommendations, etc.)

**Recommendation 8c: Provide more substantial and specific guidance to countries on the development of performance frameworks for AGYW-focused grants (related Finding 17; Conclusion 9).**

The Global Fund should provide more substantial and specific guidance to countries on the development of performance frameworks for gender and AGYW-focused grants.