UNAIDS STRATEGY DEVELOPMENT

UNAIDS STRATEGY REVIEW:
Focus Group Synthesis template

Country: **Global Discussion**

Organizer: **Women4GlobalFund (W4GF)**

Date: 24 August 2020

Copyright © 2020
Joint United Nations Programme on HIV/AIDS (UNAIDS)
All rights reserved.

The designations employed and the presentation of the material in this publication do not imply the expression of any opinion whatsoever on the part of UNAIDS concerning the legal status of any country, territory, city or area or of its authorities, or concerning the delimitation of its frontiers or boundaries. UNAIDS does not warrant that the information published in this publication is complete and correct and shall not be liable for any damages incurred as a result of its use.

UNAIDS STRATEGY REVIEW: Focus Group Synthesis template

Please use the template to organize your feedback from the session. Please keep responses succinct and as clear as possible to ensure our synthesis is a reflection of the focus groups hosted.

You can enter your report directly into a form on SurveyMonkey:

https://www.surveymonkey.com/r/3HC9Q6M

If you are not able to enter it on line you can send us a copy via e-mail ***strategyteam@unaids.org***

Would you accept for UNAIDS to make your report publicly available: **Yes** / No

SECTION 1: Information about the focus group (to be completed by host of Focus Group)

Organization leading discussion: Women4GlobalFund (W4GF)

Date of discussion: 27 July 2020

Theme to be discussed: Defining a Global AIDS Strategy that upholds rights through a women centred approach.

The W4GF Global Fund Strategy Working Group will generate ideas throughout this process to advocate for concrete ways to keep gender equity central to the Global AIDS Strategy, and ultimately the Global Fund, which bases its targets and strategy on the global strategies on HIV, TB and Malaria.

"Woman-centred health services involve an approach to health care that consciously adopts the perspectives of women, their families and communities. This means that health services see women as active participants in, as well as beneficiaries of, trusted health systems that respond to women's needs, rights and preferences in humane and holistic ways. Care is provided in ways that respect women's autonomy in decision-making about their health, and services must include provision of information and options to enable women to make informed choices. The needs and perspectives of women, their families and communities are central to provision of care, and to the design and implementation of programmes and services. A woman-centred approach is underpinned by two guiding principles: promotion of human rights and gender equality." Consolidated guideline on sexual and reproductive health and rights of women living with HIV, World Health Organization, 2017.

Participants (types of organizations participating): The participants who engaged in this three hour consultation are listed below and represent women in all our diversity. Of the 42 participants the majority come from Africa (18) and Asia and the Pacific (9); Europe (8); Latin America and the Caribbean (2); USA (2). Participants represented both local, regional and global networks and organizations and included: women living with HIV; young woman; women who use drugs; the Global Fund Communities and Developing Country NGO delegations to the Global Fund Board (2); and Transgender women that we are aware of (1). Key technical partners such as Stop TB Partnership and UN partners also engaged (4).

	Name	Organisation or network	Email address	Country
Africa				
1	Henriette Yougang Tame Nafissa	Women Organization for Worldwide Islam	Nafisatame96@gmail.com	Cameroon
2	Cecilia Lodonu-Senoo	Hope for Future Generations	ceciliasenoo@gmail.com	Ghana
3	Diana Ondato	Youth Alive Arise/Lean on Me	ondatodiana@yahoo.com	Kenya
4	Florence Anam	Medicine Sans Frontier	floriako@gmail.com	Kenya
5	Joyce Ouma	Communities Delegation	oumajoyce2@gmail.com	Kenya
6	Kristine Yakhama	ICW-Kenya	kristineyakhama@gmail.com	Kenya
7	Lucy Wanjiku Ngena	Women4GlobalFund	Lucy@women4gf.org	Kenya
8	Martin Mary Flalana	Kids & Teens Resource Centre	martinmaryfalana@gmail.com	Nigeria
9	Anna Versfeld, PhD	Independent Medical Anthropologist	annaversfeld@gmail.com	South Africa
10	Colleen Daniels	Harm Reduction International	Colleen.Daniels@hri.global	South Africa
11	Lesley Odendal	Developing Country NGO Delegation to the Global Fund Board	l.odendal@developingngo.org	South Africa
12	Yvonne Kahimbura	The Eastern Africa National Networks of AIDS and Health Service Organizations (EANNASO)	kahimbura@eannaso.org	Tanzania
13	Onesmus Mlewa Kalama	EANNASO	kalama@eannaso.org	Tanzania
14	Olive Mumba	EANNASO	mumba@eannaso.org	Tanzania
15	Tumainiel Mangi	Child Watch	childwatchtz@gmail.com	Tanzania
16	Claire Mthonsi	Consultant	clairemathonsi@gmail.com	Zimbabwe
17	Talent Madziva	Katwse Sisterhood	talentjumo@yahoo.co.uk	Zimbabwe
18	Sophie Dilmitis	Women4GlobalFund	sophie@women4gf.org	Zimbabwe
Asia and the Pacific				
19	Abhina Aher	Alliance India	aaher@allianceindia.org	India
20	Anupama Srinivasan	REACH (Resource Group for Education and Advocacy for Community Health)	anupamasrinivasan.reach@gmail.com	India
21	Mercy Annapoorani	Blossom Trust	mercyannapoorani@gmail.com	India
22	Baby Rivona	Indonesian Positive Women Network	babyrivona@gmail.com	Indonesia
23	Sanjeeb khadka	7street	Sevenstreetevent@gmail.com	Nepal
24	Sita Banjade Shahi	International Community of Women Living with HIV Asia Pacific (ICWAP)	shahisita@gmail.com	Nepal
25	Nenita L. Ortega	International Development for Leaders hip and Learning Inc (IDLLC)	nenetgem@yahoo.com	Philippines
26	RD Marte	APCASO	rdmarte@apcaso.org	Philippines
27	Jude Byrne	Australian Injecting and Illicit Drug Users League (AIVL)	judeb@aivl.org.au	Australia
Latin America and the Caribbean				
28	Olive Edwards	Jamaica Community of Positive Women	lovehope2015@gmail.com	Jamaica
29	Gracia Violeta Ross Quiroga	REDBOL	graciavioleta@gmail.com	Bolivia
Europe				
30	Soren Warthoe	AIDS-Fondet in Denmark	soren@aidsfondet.dk	Denmark
31	James Malar	Stop TB Partnership	jamesm@stoptb.org	Geneva
32	Chris Malloris	UNAIDS	MallourisC@unaids.org	Geneva
33	BORZINI, Elisabetta	UNAIDS	BorziniE@unaids.org	Geneva

34	Dr. Karen BADALYAN	Eurasian Key Population Health Network (EKHN)	badalyan@ekhn.pl	Poland
35	Sara Österlund	RFSU – Riksförbundet för sexuell upplysning/The Swedish Association for Sexuality Education, Medlem i IPPF	sara.osterlund@rfsu.se	Sweden
36	Alice Welbourn	Salamander Trust	alice@salamandertrust.net	United Kingdom
37	Judy Chang	International Network of People Who Use Drugs	judychang@inpud.net	United Kingdom
38	Luisa Orza	Frontline AIDS	lorza@frontlineaids.org	United Kingdom
39	Seri Wendoh	International Planned Parenthood Federation	swendoh@ippf.org	United Kingdom
40	Monica Ciupagea	UNODC	monica.ciupagea@un.org	Vienna
USA				
41	Jill Gay	What Works Association	jillgay.rh@gmail.com	DC
42	Emily Bass	AVAC	emily@avac.org	New York

Country, regional or global focus: This session had a global focus.

Introducing the theme *Please enter the main characteristics of the theme being explored in 5 sentences (please share the presentation if possible by email)*

The W4GF team set up a Strategy Working Group to advocate to keep gender-based approach and gender equity central to the work of UNAIDS and the Global Fund as these two global strategies are developed. W4GF organised this consultation for women in all our diversity to find common positions so our voices are heard. The discussion identified what can be improved, what must shift to enable gender sensitization and transformation that is needed for women to equally access services, reduce vulnerability to HIV, and contribute to a larger societal change. The participants focused on the Global Strategy as the foundation, and the UNAIDS strategy as the next result to support the Global AIDS Strategy.

The first three sections offered space for people to brainstorm and share their ideas whilst the last section provides more focused input around what we should stop; start and continue to do. These comments have been framed using the Action Linking Initiatives on Violence Against Women and HIV Everywhere, ALIV(H)E framework change matrix.[1] It shows how two intersecting fields create four areas for potential change. The vertical line refers to people; moving from the individual at the top, to the whole society at the bottom. The horizontal line refers to spaces; moving from those governed by thoughts, beliefs, customs and practices (more unwritten or 'informal' areas), to those governed by rules, regulations and policies (more written or 'formal' areas). In each quadrant we can see examples of how gender inequality and other forms of discrimination and marginalization occur. Ultimately, all the quadrants are interconnected and influence each other. All four areas are interconnected and influence each other both 'positively' and 'negatively'. There is a constant tension between the quadrants and it is this tension that creates the space for change.

[1] adapted from matrixes used by Gender at Work' the Global Fund for Women, Association for Women in Development (AWID) and AmplifyChange

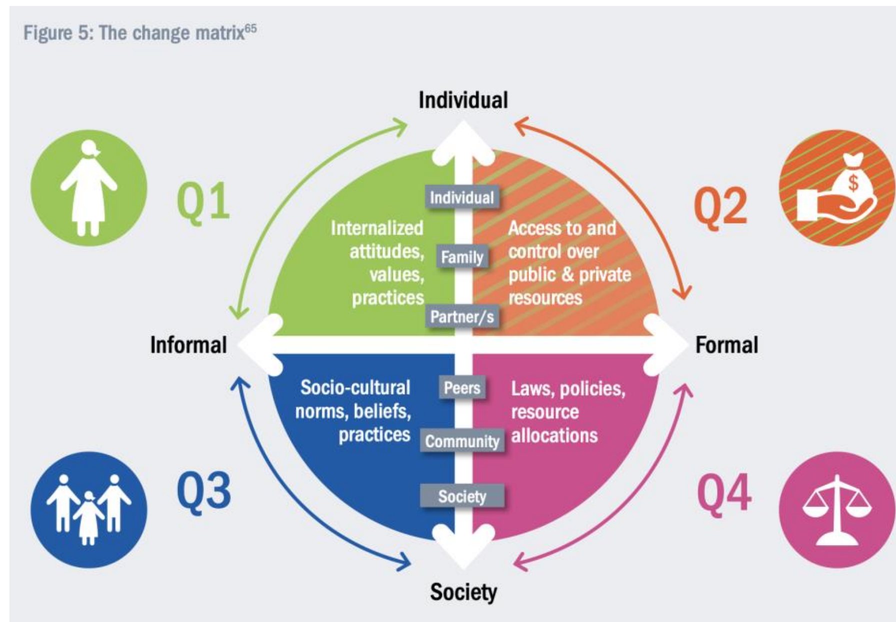

Figure 5: The change matrix[65]

W4GF works hard to ensure that women in all our diversity are engaged. We define this as women who are engaged at global; regional and national levels in Global Fund processes and structures in key regions most affected by HIV, TB and malaria. We are not homogenous, and we include women living HIV, affected by TB, , hepatitis and malaria; heterosexual; lesbian and bisexual; transgender; intersex and non-binary; women who use drugs; sex workers over 18 years old; adolescent girls and young women; Indigenous women; women who are sometimes displaced; migrants and are/have been incarcerated; and women with visible and invisible disabilities.

We are now 40 years into the HIV epidemic and although many gains have been made we still see the same vulnerability of women to HIV, but we also see some way forward in terms of HIV as an entry point to affect the changes we need around inequalities including gender inequalities. HIV – just like COVID-19 has magnified all the social and systemic ills in our society that continue to marginalise communities and keep women oppressed by patriarchy. The needle is moving but it is too slow and time is running out. Although we need more disaggregated data there is already clearly enough of an evidence base but what we lack is the political will to end inequalities for all!

It is widely acknowledged that gender inequalities are a key driver of the HIV epidemic and influence the vulnerability and marginalization of women and girls. Despite this fact and that it has been a priority in some settings of the HIV response for decades, we have not seen the progress we expected to move countries towards achieving gender equality or even equity. We have seen little or no progress in reducing HIV vulnerability and addressing the human rights violations faced by women. Not enough countries are meaningfully addressing this and capturing adequate data to assess whether programmes are effectively responding to the needs and rights of women and girls.

COVID-19 has further drawn into focus the inequities and uneven vulnerabilities with specific threats for the safety of women and their ability to make decisions about what happened with and to their bodies and their ability to access essential medications and services – for HIV, TB and Malaria. Because of this we demand more accountability for all women.

The next global AIDS strategy must push governments, the UN and donors especially the Global Fund to address inequities through a woman centred approach that addresses the reality faced by women. This means that health care: consciously adopts the perspectives of women, their families and communities; welcomes women as active participants and responds to their needs, rights and preferences in humane and holistic ways; respects autonomy

in decision-making; provides women with information and options to make evidence-based and informed choices; and this means approaches that are underpinned by human rights and gender equality.

We believe that the HIV response can be catalytic and address deeply rooted socio-cultural gender norms that create more vulnerabilities and marginalisation but for that to happen the HIV response needs to truly be women-centred and rights-based. The next UNAIDS strategy cannot move forward based on a single set of global targets without moving forward all the other pieces around women's lives that are not related to biomedical approaches.

SECTION 2: People-centered response to HIV – key emerging messages

Please enter the main messages coming out, up to 5 points maximum per section

REACHING THE PERSON	
How do we see the current situation?	**Decision making ability** • Women are not always able to make decisions about their health, their lives and their bodies. Many women lack decision-making power especially at the household level and this is compounded by economic insecurity and poverty. • Women and girls lack of bodily autonomy. This includes the right l to make autonomous decisions about their bodies and reproductive life – which is at the very core of fundamental right to equality and privacy, concerning intimate matters of physical and psychological integrity.[2] **The reality: access to services, treatment and support** • At the individual level there is a lack of access to services for women in all their diversity – women especially from key populations face violence, stigma and discrimination as well as no access to social and legal services- coming from a history of 'not being believed'. Women from key populations face even higher levels of stigma, and even poorer quality of services. • In the context of COVID-19 there are few and inadequate social protection mechanisms that take into consideration gender inequalities (access to employment, care givers, etc.) and even in the few cases that such programmes exist, women who have no identity documents and sex workers, among others, are not able to and/or allowed to access these- leading to further loss of livelihoods and deterioration of quality of life. **Violence against women** • Globally 1 in 3 women experience some form of violence in their life time and in the rare occasions it is reported often results with impunity. Violence against women (VAW) exacerbates women's vulnerability to HIV and there is strong evidence for VAW as a consequence of HIV. This includes research that shows women living with HIV experience high levels of violence from partners following disclosure of HIV-status and markedly heightened levels of violence in healthcare settings.[3] All of this is now being compounded by COVID-19 and experienced more by women – across ages and diversities – having to be at home due to the lock downs.

[2] Women's Autonomy, Equality and Reproductive Health in International Human Rights: Between Recognition, Backlash and Regressive Trends
[3] "Violence. Enough Already": Findings from a global participatory survey among women living with HIV

	Siloed approaches and no comprehensive approach • There are too many siloed approaches between women and gender which seems to only focus on the prevention of HIV amongst adolescent girls and young women and on the prevention of mother to child transmission (PMTCT) or prevention of vertical transmission to babies. In many countries where key populations are addressed and not invisible some programmes that focus on key populations do not address gender dynamics and inequalities. For example, they focus on sex work, but not on gender inequalities faced by sex workers irrespective of their work and how these inequalities also affects their ability to access services. There seems to be a real lack of a holistic, women-centred approach – adolescent girls and young women will age and therefore need to address gender across a continuum of age, sex workers and transgender women will not only need their rights because of sex work or gender identity but will need to live in a society with persistent gender inequalities. • Women are invisible in concentrated epidemics. For example, in Latin America and the Caribbean 70% of the disease burden is among MSM, and not enough resources and programmes are available for women who are also deeply affected by HIV and fall on the 'outside' of the response.
What concerns us?	Lack of political will • There is a great deal of research that makes it possible to justify why the AIDS response must have a focus on women but this is not well utilised. There is strong evidence to act but the political will is lacking. • Despite acknowledgments that women are vulnerable, the only real progress we have seen around women in the HIV response is in the scale up of biomedical approaches to the PMTCT. These have not been matched by efforts to ensure that all women are able to fully enjoy their sexual and reproductive health and rights in the process. • In some countries we don't even see countries addressing gender inequalities – especially outside of East and Southern Africa where the focus is again mostly on adolescent girls and young women to prevent HIV transmission. Lack of support for community work and advocacy led by women across diversities • Women's rights networks and groups are not adequately funded and this leaves women disconnected, vulnerable and voiceless. Vertical approaches to specific aspects of women's health • COVID-19 could be an opportunity to strengthen integration (in a way that makes sense for the person, not the system). We feel the danger of disruption because of vertical approaches countries have to health.
What gives us hope?	• COVID-19 has shone a light and magnified the inequalities which need to be addressed. • Connection: Meetings like this when we are able to come together and get to know each other, organise, network, connect and share vision and confidence, and help to create women's leadership and solidarity. • Leadership: WAVE 7 of the Stop TB Programme project funded by Canada, requires that projects take a women's empowerment approach; every grantee has a woman's empowerment advisor. • Getting the data right: Qualitative engagement with quantitative data shows that the 'we' approach has a positive impact on project outcomes.

	• **Gender and age intersectionality**: Working together as women and identifying skills and strengthening the capacity of young women by older 'veteran' activists is important and we need to create more space for younger women.
What constrains our ability to achieve our goals?	• A lack of funding for women's rights organizations to conduct advocacy as well as to provide community led services including peer support; and community-based responses such as evidence-based programmes to reduce IPV.[4] • A strong unified feminist voice of women from across the globe is missing from the global AIDS response. We lack connectivity in the women's movement – There is a real need for funds to build capacity and strengthen ability through networking and creating a strong global women's movement.
THE STRUCTURES THAT RESPOND TO HIV	
How do we see the current situation?	**Not enough focus on women-centred approaches across diversities** • Very little is women-centred; and most services are generalised with no differentiated service delivery for women unless this is around PMTCT. • Some programmes (DREAMS) create divisions between those living with HIV and young women who are HIV negative. Whilst we understand the need to focus on prevention this division is problematic and can be stigmatising and cuts out young women living with HIV who might need support. **Not enough focus on human rights and redress of violations** • Assisted partner notification services (aPNS – also referred to as 'index testing') has led to a breach of confidentiality, forceful disclosure and increase in intimate partner violence (IPV) for many women. These are examples of exposure to violence at home and in healthcare, exacerbated and sanctioned policies that women from communities have raised the alarm on. • There is not enough focus on preventing violence. Women are offered services to mitigate against HIV or VAW, but not equal community-led or community-based services to reduce vulnerability that leads to HIV or VAW. We need to address these systemically rooted issues that would then impact their need to access services to address violence. **Not enough investment in national implementation of policies** • Gender equality policies do not translate into action at the national level and often never reach the person to create any change.
What concerns us?	• **A lack of clarity on what 'woman-centred programmes'** mean and what to/what not to fund that results in impact and positive health outcomes grounded in human rights. • **National Strategic Plans 'cherry pick'** aspects that they want to do and then articulate them as gender responsive interventions.
What gives us hope?	• **Good guidelines** which need to be fully implemented by governments and translated at national levels to reach communities. • **Women standing up and supporting each other** and key partners focusing on women and girls.

[4] RESPECT women: Preventing violence against women, WHO, 2019

What constrains our ability to achieve our goals?	**A lack of sufficient resources to:** • support the work of women-and young-women led rights-based networks and organisations and this inhibits the sustainability of the gains made. • link HIV programming for women with larger societal-level programmes to reduce gender inequality • enable mentorship to ensure the continuum and sustainability of women in the AIDS response.

CONTEXTUAL ENVIRONMENT	
How do we see the current situation?	**Women's rights are not considered human rights** • The world is not addressing the underlying causes of entrenched gender norms that make all vulnerable to VAW and to HIV. For decades we have been talking about equality and equity yet how much have things really changed? There are many policies not in practice with the real issues not being addressed at all. Women's rights continue to be dismissed and women are not yet able to make decisions about their own bodies, health and lives. • Addressing the role of gender norms and how hard it is to shift the status quo and certain agendas when women and girls can't break out of cycles of oppression to shift from the 'empowering women' mantra, to *enabling* women to change their own lives – which is a very different concept. Let alone change laws to decriminalise sex work and health systems to consider gender reassignment as essential, affordable and acceptable services for transgender people. • COVID-19 has increased violence and inhibited access to services and essential lifesaving commodities and medication that women depend on including condoms to contraceptives. • There has been a global backlash on the rights of women and this further impacts the ability of women to engage in decision making tables and access education and entrepreneurship opportunities and have autonomy over their bodies. • The global response has failed to address the ongoing violence including: female genital mutilation, rape, forced marriage, unequal property and inheritance rights and lower salaries. Harmful gender norms are so entrenched that parliamentarians, elected from communities, perpetuate them by enacting laws that are harmful to women in all their diversity. • Backward growth, discrimination, suppression, and denied access to services and amenities including hygiene, water, reproductive health commodities, breast and cervical cancers for many women especially those who are more marginalised by migration and their profession. • We have seen that when people are required to examine what the quantitative data actually says (ideally complemented by qualitative data) people start to realise that taking women's rights into account matters for everyone, as they should also take into account issues related to key populations (who also are our women, our community) **A lack of understanding of key issues affecting women** • Globally there is conflation of sex work and trafficking, which is harming women who are trafficked and also hurting sex workers rights. • transgender women and how gender reassignment therapies are not considered as essential services

- Sex workers and transgender women – especially those who are women of colour face extreme violence and vulnerability.
- Sexuality education – the ministries of education may agree on policy, but there is almost no ‘comprehensive sexuality education’ that reaches students who are young men and women entering into their sexual lives. The barriers are religious beliefs, attitudes towards sex, attitudes towards sexuality – this is the time, not later, to challenge traditional gender norms and challenge attitudes towards sexual orientation, identify and expression.
- Women who use drugs face more danger, harsher punishments and ill treatment than their male peers. Available harm reduction services are generally tailored towards men and, as a result, often fail to address the specific needs of women. For example, harm reduction programmes rarely support women’s personal safety and confidentiality, and/or do not provide sexual and reproductive health services and/or prevention of vertical transmission services and/or child care. Staff are often not trained to provide specific services for women who use drug who are also sex workers or often survivors of gender-based violence (GBV). GBV and intimate partner violence (IPV) are intrinsically linked to the causes and effects of drug use in women. All of this has detrimental effects on their mental and physical health and creates barriers to accessing support, and treatment.

COVID-19 and Universal Health Coverage (UHC)

- How will COVID-19 affect the sustainability of the HIV response? We have data showing expected stockouts of ARVs, and contraceptives, not only from country reassignment of supply systems, but that COVID-19 has also affected the global supply chain through restrictions on movements. We need a global AIDS strategy that imagines a world where risk mitigation strategies are addressed to avoid losing momentum where crises such as conflicts or national disasters arise – especially around medicine restrictions.
- Defining UHC in the context of HIV. There has been more of a call to end HIV exceptionalism and broader health, with very limited plans on how HIV and TB will be addressed by countries without donors support. It has been a discussion of ‘either/or’ instead of ‘we need both’. We need a global AIDS strategy that advocates and holds governments accountable to domestic financing and UHC that is not only about financing. This will be even harder for LMICs hard hit by COVID-19.
- Lack of equitable access to vaccines – there should be no global north-south divide.

Criminalised communities

- With the exception of a few countries, the rest of the world criminalises one aspect if not all of sex work. Sex workers face discriminatory attitudes when accessing services, sometimes arrested for carrying condoms and used as evidence of sex work, they face abuse and violence by law enforcement, not protection. They are left out of social relief programmes (the sad reality made more apparent by COVID-19), they are ostracised in their own communities.
- The connection between the impact of gender inequality on women who use drugs and the impact of punitive legal frameworks must be understood as reinforcing each other. Structural gender inequality impedes the development of effective drug policies that adequately understand and address the rights of women who use drugs. Additionally, punitive legal frameworks under current drug policy regimes

	reinforce gender inequality and the negative impact of criminalization is visible in police violence, stigma and stereotyping faced by women who use drugs. **Other important issues which will affect women** There are massive overarching issues which need to be considered such as: • **Fertility**. The growing global fertility collapse in the Global North (Lancet article)[5] – Huge women's rights issues over migration to the Global North, social protection, rights, labour laws etc and consequences for the spread of HIV. *"As nations come to recognise the challenges of fertility rates lower than the replacement level and the potential for demographic contraction, they have four options to pursue: attempt to increase the fertility rate by creating a supportive environment for females to have children and pursue their careers, restrict access to reproductive health services, increase labour force participation especially at older ages, and promote immigration. It is worth considering how each of these options might play out in different countries."* • **Climate Change.** There is a serious increase in violence against women exacerbated by COVID-19 and due to climate change and food insecurity[6] and this is felt by women across diversities. UNDPs research found that the impact of climate change also exacerbates the risk of violence against women- in periods of prolonged drought, women and girls make more frequent and longer journeys to obtain food or water, which makes them vulnerable to sexual assault.[7] • **Financing.** There are challenges with current global financing, which focuses on all states going for relentless year on year increase in GDP, which require annual increases in resource extraction, production and sales of goods: unsustainability of this model, which has detrimental effects on climate change and its consequences (see UN SG Mandela speech 2020] and Hickel 2019)[8]. The compound interest on debt that LMICs have to pay every year, thanks to the models set up by the World Bank and the IMF means that annual debt repayments of LMICs far outstrip what they receive in 'development' grants.[9],[10] So reform of the current debt architecture is also critical to all our sustainable futures.[11], [12]
What concerns us?	• **Injustice and inequality** facing all women and women from key populations facing intersectional vulnerabilities. • **No shift in social norms** –people in households and at the societal level view gender equality, sex work, and the spectrum of sexual orientation and gender identity. • **No real progress in law reform** and no commitment to protect women in all their diversity and even when there is a law that protects, law does not equal safety at the person level.

[5] Fertility, mortality, migration, and population scenarios for 195 countries and territories from 2017 to 2100: a forecasting analysis for the Global Burden of Disease Study, July 2020
[6] How can food security interventions contribute to reducing gender-based violence?, 2017
[7] Why climate change fuels violence against women, Jan 2020
[8] The 'girl effect': liberalism, empowerment and the contradictions of development (Jason Hickel) October 2014
[9] Declining Aid, Rising Debt Thwarting World's Ability to Fund Sustainable Development, Speakers Warn at General Assembly High-Level Dialogue
[10] The Audacity to disrupt African Feminist Macroeconomic Academy
[11] A healthy economy should be designed to thrive, not grow Kate Raworth, Oxford University economist;
[12] The true extent of global poverty and hunger: questioning the good news narrative of the Millennium Development Goals, Jason Hickel, Feb 2016

	• **Lack of leadership** across the UN **to keep countries accountable** to not fulfilling their commitments on gender equality in the numerous declarations and conventions they have signed. • **Racism** continues to violate the human rights of large parts of populations, throughout the world – when sexism is also faced by women subjected to racism, their access to livelihoods, education, services are diminished further. Moreover, it leads to fewer women from groups discriminated based on race being able to engage in decision-making roles. • Little attention has been paid to gender differences in drug use which is essential to develop treatment approaches that work for women. One third of all people who use drugs are women and girls, yet only one in five of those women receive treatment.[13] Although men are more likely to use drugs, the combined social, institutional, health and cultural effects and risks carried with drug use, are disproportionately higher in women.[14] Women living with HIV who experience violence are less likely to access HIV care and participate in HIV prevention and drug and treatment services.[15] In addition to this, data suggests that women progress from use to dependence faster than men; experience more severe emotional and physical consequences of drug use compared to men and underutilize treatment.[16] Women who use drugs are under-represented in drug related clinical trials and in research, which is also heavily centred on men.[17]
What gives us hope?	• Ability to achieve our goals. • Availability of International laws and treaties that can be used as leverage to demand rights. • Growing movements of collective voices across the world and growing intersectoral collaboration • The #MeToo movement holding leaders accountable. • The Black Lives Matter movement may be an opportunity to transform how women of colour globally are treated including in the 'development' space, taking over the decision-making on what most affects women and girls.[18],[19]
What constrains our ability to achieve our goals?	• COVID-19. • The compound global debt burdens faced by LMICs.[20] • Climate change. • Future fertility imbalances, consequential restrictions on women's rights to fertility control, global migrations to provide health and social care and consequences of these for women's rights and health.[21]

[13] The International Narcotics Control Board (INCB)
[14] Sex and Gender Differences in Substance Use
[15] Gilbert et al. and Wechsberg et al.
[16] COMPARATIVE PROFILES OF MEN AND WOMEN WITH OPIOID DEPENDENCE: RESULTS FROM A NATIONAL MULTISITE EFFECTIVENESS TRIAL
[17] Women who use or inject drugs: an action agenda for women-specific, multilevel and combination HIV prevention and research
[18] I've seen first-hand the toxic racism in international women's rights groups
[19] Collective statement on systemic racism and white supremacy in the uk international aid sector
[20] The G20 continues to ignore calls to cancel the debts of the world's poorest countries and stop funding fossil fuels
[21] Regional Planning Meeting for Promoting ASEAN Women Migrant Workers' Rights through Organizing

EMERGING PATTERNS:

- Persistent laws and policies that are not women-centred, nor protective for women. Even when laws are meant to protect women this does not always result in societal change or point of care. Investments in women HIV services without investments in societal change on gender equity are not giving results – they do not reduce HIV vulnerability.
- There is not enough focus on addressing gender-based needs and social norms to prevent violence against women[22].
- The treatment and prevention divide must end. We must ensure that there are different prevention options for women in all their diversity.
- The key populations versus women divide must stop. We all face vulnerabilities and we all have a right to access services we need. As noted at the top of this document women are diverse and this includes women who are young, gay, women who engage in sex worker, women who use drugs and transgender women. All women are women, and all women deserve the same rights as anyone in society.
- The HIV response can be transformative and can be a catalyst – we just need to transform HIV-gender blind actions through women-centred HIV actions.
- We require a data revolution that responds to our diverse realities – the current status quo around how data is collected and how it influences reprograming needs to change. The way that the world is working with indicators is harming communities as they are too rigid and do not measure the qualitative aspects of the difference services are making.
- Many of the issues raised by the group show that the identified challenges and required shifts go beyond the HIV response and is more about gender at societal level. We believe the HIV response can be a catalyst for much needed real change in the lives of women.

SECTION 3: RECOMMENDATIONS World Café

Please enter the main messages coming out, up to 5 points maximum per section

Using the Action Linking Initiatives on Violence Against Women and HIV Everywhere, ALIV(H)E framework change matrix the recommendations have been grouped into the four different quadrants below with additional sections on research and funding.

- Q1: Individual/informal: internalized attitudes, values and practices
- Q2: Individual/formal: access to and control over public and private resources
- Q3: Society/informal: socio-cultural norms, beliefs and practices
- Q4: Society/formal: laws, policies, resource allocations.

What are the key recommendations back to UNAIDS in terms of the strategy specifically?	
CONTINUE	*What is working that we must continue to do?* Q1: Individual/informal: internalized attitudes, values and practices

[22] The global politics of the age–gender divide in violence against women and children

	• Focusing on adolescent girls and young women but do not deprioritise work on women in all their diversity and for all ages. • Expanding spaces that enable women's dialogue, expanding access to resource and opportunities for networks of women in all their diversity. • Expanding peer support services. Q2: Individual/formal: access to and control over public and private resources • Strengthening access to safe sexual and reproductive health and rights and Reproductive, Maternal, Newborn, Child and Adolescent Health (RMNCAH) services AND strengthening HIV services for women and integration of the two when and if appropriate – it is not about either or, but both. • Expanding access to safe abortion services, STI diagnosis and treatment (including of HIV), and all of this underpinned by protecting women's rights. Whilst we have seen some progress, we must continue to expand. Q3: Society/informal: socio-cultural norms, beliefs and practices • Supporting community based monitoring and documenting. Community advocacy around redress is important as well as to reduce the risk of assault and this must continue. • Focusing on community perspectives: with more realistic strategies that align to actual community's needs. Including e.g. funding evidence-based IPV reduction programmes, to complement/improve safe access to and use of contraceptive/STI and prevention services. • Focusing on linkages between VAW and HIV – it's not just about services after violence, it's not just about HIV transmission – focus on the intersection and work on both societal level to stop violence and offer HIV services for all women in all their diversity at the same time Q4: Society/formal: laws, policies, resource allocations • Speaking with women and girls as global health advocates and listening to what works for women. • Ensuring domestic resources support on community led organisations of women supporting women at national levels. • Ensuring more action on gender inequality, in documents and language across the UN, placing focus on gender inequalities – HIV and gender inequity are indivisible, the Global AIDS Strategy can be a catalyst for larger societal gender norms shifts. Research • Demanding accountability for women and girls. • Researching interventions that work for women – including our meaningful involvement as peer researchers. • Providing feedback at all levels so that women and girls are continuously informed of what happens in their communities and at global levels. Funding • Capacity building and funding to strengthen different layers of skills and mentoring (national, regional and global levels). • Funding for all of the above.
STOP	*What must we stop doing, that if we don't stop will ensure failure?*

<table>
<tr>
<td></td>
<td>Q1: Individual/informal: internalized attitudes, values and practices
• BLAMING: Compartmentalising good women vs bad women, ‘homogeneous’ vs heterogeneous. We must recognise that women are diverse and we must value and recognise vulnerabilities are intersectional. We must discontinue structures and situations that perpetuate dilution and division and also lead to chronic mental health issues.
Q2: Individual/formal: access to and control over public and private resources
• Mainstreaming gender and women’s issues which just get lost – we must keep gender equity as a strong focus – In addition to mainstream work on gender we must continue women-focused actions that will keep the pressure on and not allow mainstreaming to result in inaction.
• Addressing only the surface of gender and women centred challenges.
• Siloed, diluted and voiceless: Talking for women and working in silos.
• Perpetuating the notion of ‘expert voices’ that do not come from communities which dilutes the community voices. We must acknowledge that expert voices’ from women in all their diversity is not equal to one woman representing all. ‘Expert voices’ should mean ‘expert voices from women in all their diversity and should come from ‘expert voices of diversity.’
Q3: Society/informal: socio-cultural norms, beliefs and practices
• Gender Blindness: Supporting programmes and services that do not look through a gender lens to address inequity issues.
• Promoting technology (such as PrEP) without relating these to social protection without any contribution to women’s rights organisations and community-led and community-based responses.
Q4: Society/formal: laws, policies, resource allocations
• Tokenistic engagement – just to fill the diversity slots in policy or discussions – this does not doesn’t translate into meaningful engagement, resources, partnerships and solutions.
Research
• Stop research that does not meaningfully involve those most affected and which does not include the viewpoints of those whose lives it is intended to improve; which does not have practical outcomes; which focuses just on top-down, bio-medical, short-term responses; which does not ask ‘how’ and why’ as well as ‘what’; which does not disaggregate data (at least by gender and age); and which prioritises quantitative targets over people.
Funding
Short-term results-focused top-down funding:
• The ‘carrot and stick’ approach to accessing funds. Activities should not be driven by funding rather by the need.
• Short-term- project-driven approach vs long-term-programme-approach as it hinders our sustainability in the long run.
• Donors and others should stop making evidence hard to share, understood and used by communities – make it accessible and support/resource communities on how to use the evidence and convert to advocacy and services.</td>
</tr>
<tr>
<td>START</td>
<td>Q1: Individual/informal: internalized attitudes, values and practices</td>
</tr>
</table>

	• Using a stronger intersectionality and vulnerability lens - bolstering analysis to our work with key populations; We need to re think the language around key population to include women. • Providing more visibility to women's diversity that aims to support all women. • Closing the gender technology gap through training and educational opportunities in IT services. This will help to enable girls and women to feel empowered, as well as help with advocacy in safe online spaces and raising awareness, allowing organisations and networks to exchange information. • Consider using different indicators such as those linked to household decision making.[23] Q2: Individual/formal: access to and control over public and private resources • Learning from other sectors. Use private sector tools that evaluate respect to diversity – those can be adapted for gender equality and diversity within gender equality – those tools convert diversity to a strength, and hold companies accountable – they can make us more diverse and stronger- from the individual to organisational levels. We must be open to learning from the private sector – if they have tools that make their companies more respectful of diversity even if it is to make them more profitable – those tools will work for women too if they can be adapted to our context. • Revisiting the roots of what we started- Services must go beyond HIV and think of people in their own system who face barriers to accessing services and treatment. Q3: Society/informal: socio-cultural norms, beliefs and practices • Providing a holistic sector development approach responding to the needs and concerns of women that enable more integrated approaches towards HIV, SRHR, broader health, gender based violence, IPV and domestic violence. Q4: Society/formal: laws, policies, resource allocations • Joining and working as equal partners with the #Metoo and the Black Lives Matter movement to demand accountability for women and girls and everyone who faces discrimination for simply who they are. • Develop better communication to ensure that all women have access to information. • Global health coordination of UN, Foundation to ensure a coherent approach to the demands and needs of women in relation to HIV and COVID-19, etc… • Stronger commitment from UNAIDS to steer leadership that addresses gender more deeply and that starts by defining what gender means for UNAIDS. • Ensuring the gender team is well supported and strong. • Addressing gender equality as a political issue. • Enabling equal respect for public health interventions and human rights. Research • Starting to pay equal attention to non-biomedical targets – this group wants to remind UNAIDS that there are 3 zeros guiding the current strategy – one zero is on rights, and another zero is on prevention with non-biomedical targets. It is time the Global AIDS Strategy START prioritising all three zeros so that we think about people and their needs beyond biomedical targets. We need to continue setting ambitious goals, where people are not the targets and so that targets become a part of a comprehensive strategy.

[23] Participation of women in household decision-making index

	• Focusing on regional and population targets that result in a clear accountability mechanism from communities on gender and women centred approaches at the global and national level. • Enabling evaluation/reflection/accountability of response and within organizations (feminist practices imbed – thereby implementation). • Investing in technology initiative for gender innovative solutions to advance gender equity in communities: I.e. mobile health care. mapping tool to report sexual harassment and cases of violence to enhance health service delivery and outcomes for women and young girls. Funding • Funding women's rights work at the national level; (only 0.5% of funding is reaching women's organisations in the global south). • Demanding accountability for how funds are used – to generate and utilise nuanced data • Investing in funding for women's organizations. • Shifting how data is collected so that all global indicators have an equity component to their tracking.
What is the one key recommendation you want to reiterate for strong consideration?	WOMEN-CENTRED: • The UN must do more to uphold women's rights and move the world towards gender equity and bring women back to the centre. • Focus on community perspectives: with more realistic strategies and policies that align to actual community's experiences, needs and priorities. • Follow through guidelines from networks of diverse women to inform policy – syndemic approach to HIV, VAWG, mental health issues (intersectionalities of women's experiences and diversities, how these issues connect with each other and have a consequent compounded effect on our lives) HOLISTIC: • UNAIDS to have a clear articulation of what gender is to the response. Make a stronger commitment to steer leadership on gender and women centred approaches. A well-resourced gender team at UNAIDS is a start. • Stop working in silos and ensure a women-centred approach is woven throughout. FROM LANGUAGE TO ACTION: • Move to implementation beyond language – implementation takes into account reality of the context – the patriarchy that is indivisible with the structures of services/donors/etc. • Language that goes beyond being politically correct – Speaking about equality and equity can be achieved by saying it. If we are going to use the language then implement it – we can't use language about a utopian environment and not be ready to support those who will be on the frontline who are trying to put that language into practice. FROM PERCENTAGES TO PEOPLE: • Sometimes science takes away people – numbers vs people. • A loss of global woman's movement will be a loss to the AIDS response – support a platform that unites and brings women together.

Please share with us any references you think would be useful for the Strategy Development, such as examples of case studies that illustrate the challenges or recommendations you outlined in the discussion report.

You can send us additional documents via e-mail ***strategyteam@unaids.org***

UNAIDS

20 Avenue Appia

CH-1211 Geneva 27

Switzerland