APPLYING GENDER RESPONSIVE BUDGETING TO THE HIV RESPONSE

A CASE STUDY OF CAMBODIA, INDONESIA AND THAILAND

June 2017

Produced by UN Women Regional Office for Asia and the Pacific.

Text: Emma Wretbland
Editor: Emma Wretbland
Production Coordinator: Smriti Aryal, Devikara Devakula
Design: Scand-Media Corp., Ltd.
Published by: UN Women Regional Office for Asia and the Pacific
ISBN 978-974-680-416-5

APPLYING GENDER RESPONSIVE BUDGETING TO THE HIV RESPONSE

A CASE STUDY OF CAMBODIA, INDONESIA AND THAILAND

June 2017

CONTENTS

Acknowledgements 4

Acronyms 5

1. Introduction 6

2. Methodology and Limitations 8

2.1. The Analytical Framework 8

2.2. Data Sources 10

2.3. Limitations 11

3. Overview of Gender Situational Analysis within the HIV Epidemic (Step 1) 13

4. Country Assessments of HIV Policies, Plans, Programming and Budget Analysis (Steps 2, 3, and 4) 18

4.1 Cambodia 18

4.1.1. Policies, Programs, and Budgets 18

4.1.3. Enabling Environment (Checklist 2) 21

4.2 Indonesia 23

4.2.1. Policies, Programs, and Budgets 23

4.2.2. Enabling Environment (Checklist 2) 26

4.3 Thailand 27

4.3.1. Policies, Programs and Budget 27

4.3.2. Enabling Environment (Checklist 2) 29

5. Discussion 32

5.1 Care work 32

5.2 Women living with HIV, female key populations and transgender people's full participation in decision-making 33

5.3 Missing allocations 33

6. Recommendations for applying GRB to HIV response 35

List of Tables, Text Boxes and Annexes

Figure 1 Timeline graph of the documents analysed 11

Figure 2 Advancements in establishing a favourable context for GRB in the HIV response in Asia-Pacific 39

Table 1: Policies and budget documents included in the analysis 10

Table 2: Modes of HIV transmission in women living with HIV 14

Table 3: Common consequences of gender norms in the HIV epidemic for the three countries 15

Table 5: Estimation of Cambodian budgetary allocations for gender programming 20

Table 6: Favorable GRB context in Cambodia 22

Table 7: Summary of gender responsiveness of Indonesian HIV policies and programs (Checklist 1) 24

Table 8: Estimation of Indonesian budgetary allocations for gender programming 25

Table 9: Favorable GRB context 26

Table 10: Summary of gender responsiveness of Thailand HIV policies and programs (Checklist 1) 28

Table 11: Favorable GRB context Thailand 30

Text box 1: Challenges to inclusion of gender in the HIV response 6

Text box 2: Applying GRB to the HIV response 7

Text box 3: The GRB Five-Step Approach 8

Text box 4: Analytical framework for gender responsive HIV policies and budgeting 9

Text box 5: Key strengths of each country in applying GRB in the HIV 32

Annex 1: Main GRB tools and methodologies, and their application to the HIV response 37

Annex 2: Checklist 1 and 2 Questions 39

Annex 3: Key informant interview questions 44

ACKNOWLEDGEMENTS

A special thanks to Smriti Aryal from UN Women's ROAP, Iriantoni Almuna from UN Women's Country Office (CO) in Indonesia, Sothun Nhem and Silja Rajander from UN Women's CO in Cambodia, and Ryratana Rangsitpol from UN Women's CO in Thailand for supporting the preparation of the report. Thank you to the members of the Asia-Pacific regional offices of UN Women, UNDP and UNAIDS who contributed to this report, as well as staff in country offices of Cambodia, Indonesia, and Thailand. Thanks to those that gave their time for interviews including:

Cambodia

1. Chamreun Choub Sok, Executive Director, Chief of Party, HIV/AIDS Flagship Project, KHANA, 14/07/2015
2. Dalish Prum, National Coordinator, Cambodian Community of Women Living with HIV/AIDS, 27/06/2015
3. Lina Ngin, Former Program, Monitoring and Evaluation Department Director, NAA (currently works at Ministry of Environment), 01/07/2015
4. Ly Penh Sun, Director, National Center for HIV/AIDS, Dermatology and STD (NCHADS), 09/07/2015
5. Nirmita Hou, Director Health Department, Ministry of Women's Affairs, 03/07/2015

Indonesia

1. Heru Kasidi, Political, Social and Legal Deputy, Ministry of Women's Empowerment and Child Protection, 19/06/2015
2. Christine Mester, Director of Indonesian Positive Women Network, 10/07/2015 (answers submitted by written)

Thailand

1. Dr. Taweesap, Director of the National AIDS Management Center, Department of Disease Control, Ministry of Public Health, 12/07/2015
2. Ms. Patcharee Arayakul (and her team), Director Division for the Gender Equality Promotion, Department of Women's Affairs and Family Development, Ministry of Social Development and Human Security, Indonesia (answers submitted by written)

Emma Wretblad prepared the original report in August 2015 for UN Women. Sarah Zaidi prepared the current summary report with updates to the analytical framework.

Questions, comments or corrections should be directed to Smriti Aryal at UN Women, smriti.aryal@unwomen.org.

ACRONYMS

AOP	Annual Operative Plan
ART/ARV	Anti-Retroviral Therapy
CCM	Country Coordination Mechanism (Global Fund)
CN	Concept Note
CSO	Civil Society Organization
F/MSW	Female/male Sex Worker
F/MEW	Female/male Entertainment Worker
F/MMW	Female/male Migrant Worker
F/MDIU	Female/male Drug Injecting User
FY	Fiscal Year
GARP	Global AIDS Response Progress Reporting
GBS	Gender Budget Statement
GBV	Gender-Based Violence
GEWE	Gender Equality and Women's Empowerment
GF	Global Fund to Fight AIDS, Tuberculosis, and Malaria
GRB	Gender Responsive Budgeting
HIV	Human Immune Deficiency Virus
KII	Key Informant Interview
KP	Key Population
LFA	Logical Framework Approach
M&E	Monitoring and Evaluation
MoH	Ministry of Health
MoEF	Ministry of Economic and Finance (Cambodia)
MoF	Ministry of Finance
MoP	Ministry of Planning
MoWA	Ministry of Women's Affairs (Cambodia)
MOWE	Ministry of Women's Empowerment and Child Protection (Indonesia)
MSM	Men having Sex with Men
MTCT	Mother to Child Transmission of HIV
MTEF	Medium Term Expenditure Forecasting
NAC	National AIDS Commission
NASA	National AIDS Spending Assessment
NCHADS	National Center for HIV/AIDS, Dermatology and STD Control (Cambodia)
NGO	Non-Government Organization
NSP	National Strategic Plan for HIV/AIDS
NWM	National Women's Machinery
OBI	Open Budget Index
PEP	Post-Exposure Prophylaxis
PrEP	Pre-Exposure Prophylaxis
PLHIV	People Living with HIV
PMTCT	Program Mother-to-Child Transmission
PWID	People Who Inject Drugs
ROAP	Regional Office for Asia Pacific
STI	Sexual Transmitted Infections
SRHR	Sexual and Reproductive Health Rights
TG	Transgender Persons
UNAIDS	Joint United Nations Program on HIV and AIDS
UN Women	United Nations Entity for Gender Equality and Women's Empowerment
VAW	Violence against Women
WHO	World Health Organization

INTRODUCTION

1

The Asia-Pacific region has witnessed progress in ending the HIV epidemic, with a decrease in AIDS-related deaths, increased access to treatment, higher domestic financing, and notable improvements in addressing stigma and discrimination. Yet, challenges related to ending the HIV epidemic persist with respect to gender relations and inequalities (Text box 1). An adequate response to the gender dimension of the HIV epidemic requires public policies that include and prioritize women's equality, and that of women and girls belonging to key populations[1] including transgender women.[2]

Gender Responsive Budgeting (GRB) is budgeting that integrates a gender perspective, and tracks how budgets respond to gender equality and women's rights requirements. The use of gender responsive budgeting in the HIV response can facilitate equality and fairness in terms of HIV budget allocations and expenditures to ending the HIV epidemic, while also increasing transparency, accountability and efficiency (Text box 2). The emphasis on HIV budget allocations and expenditures is crucial, as inadequate funding hinders governments and other relevant actors from successfully implementing any policy or program.

Text box 1: Challenges to inclusion of gender in the HIV response

Key challenges related to the gender dimensions of the HIV response in Asia and Pacific

- Recognizing the vital link between gender-based violence (GBV) and HIV[3].
- Eliminating the punitive legal policy environment for gay men and other men who have sex with men (MSM), transgender people (TG), sex workers (SW) and people living with HIV (PLHIV)[4].
- Developing HIV policies and program that include and prioritize gender equality[5].
- Expanding women-specific program that have often been limited to prevention of mother-to-child transmission and female sex workers.
- Ensuring the collection and availability of sex- and age-disaggregated data to facilitate the effective monitoring of progress[6].
- Guaranteeing the inclusion, representation, participation and voice of key affected women and other key populations in national HIV responses[7].
- Undertaking gender responsive budgeting (GRB) of the HIV response, to improve the transparency, accountability, efficiency, equality and fairness of HIV budget allocation and expenditure.

1 UNAIDS considers gay men and other men who have sex with men, sex workers transgender people, and people who inject drug as the four main key population groups, but it acknowledges that prisoners and other incarcerated people are also particularly vulnerable to HIV and frequently lack adequate access to services. UNAIDS (2015). "Terminology Guidelines". Geneva. UNAIDS.

2 Governments in Asia-Pacific, reaffirmed the commitments made in the 2011, specifically Target Seven calling for elimination of gender inequalities and gender-based violence, as well as for increasing the capacity of women and girls to protect themselves from HIV, at the intergovernmental Meeting on HIV and AIDS in January 2015.ESCAP (2015a) "Overview of progress in achieving universal access to HIV prevention, treatment, care and support in Asia and the Pacific", Note by the Secretariat, Asia-Pacific Intergovernmental Meeting on HIV and AIDS, Bangkok, 28-30 January 2015. UNAIDS (2013a) *HIV in Asia and the Pacific: Report 2013*.

3 ESCAP (2015a) and ESCAP (2012) "HIV-APCoP's Summary of E-discussion on Key Affected Women and Girls in Asia and the Pacific", 1-23 February 2012; ASEAN Foundation, UN Women, UNAIDS, UNZIP the Lips Platform, et al. (2013) Cambodia Country Brief - HIV and Key Affected Women and Girls; Indonesia Country Brief - HIV and Key Affected Women and Girls; Thailand Country Brief - HIV and Key Affected Women and Girls.

4 ESCAP (2015a), ASEAN Foundation, UN Women, UNAIDS, UNZIP the Lips Platform, et al. (2013).

5 ASEAN Foundation, UN Women, UNAIDS, UNZIP the Lips Platform, et al. (2013).

6 ESCAP (2015a) and UNAIDS (2013a), ASEAN Foundation, UN Women, UNAIDS, UNZIP the Lips Platform, et al. (2013).

7 UNAIDS (2013a), ASEAN Foundation, UN Women, UNAIDS, UNZIP the Lips Platform, et al. (2013).

Text box 2: Applying GRB to the HIV response

Applying GRB to the HIV response entails:

- Recognizing that gender equality commitments must be resourced;
- Tracking how HIV budgets respond to gender equality and women's empowerment (GEWE) by analysing budget revenues, allocation and expenditure;
- Examining budget systems and process, as well as the roles of various actors throughout this process, and ensuring the equal participation and voice of women, men and transgender people in all their diversity; and
- Making available mechanisms, guidelines, data, and indicators that enable gender equality advocates to track progress, benefit incidence, and show how budgets affect women, men and transgender people.

The main objectives of the study are:

Objective 1: To assess and take stock of the extent to which the national HIV responses in Cambodia, Indonesia and Thailand have prioritized gender equality interventions, including the empowerment of women and girls; and

Objective 2: To identify strategic entry points and opportunities for further strengthening investments on gender equality in the HIV response.

The research examines the following questions:

1. What is GRB and what does it means to 'apply' GRB to the HIV response?
2. What is the current gender dimension of the HIV epidemic in the Cambodia, Indonesia, and Thailand?
3. To what extent do the plans and programming consider the gender dimensions of the HIV epidemic in these three countries?
4. What budget allocations exist to respond to the policies/plans and thus to ultimately tackle the gender dimension of the HIV epidemic?
    a. Are the HIV interventions applying GRB? If so, to what extent?
    b. Which gender equality interventions are funded? What are the allocations (and expenditures)?
    c. Where are the gaps, i.e. which interventions are not funded or are non-existent in the agenda?
5. What are suggested ways forward?

The cumulative experiences and lessons learned from the three countries will be highlighted to pave a way forward for other countries in the region to undertake similar analyses and apply GRB in their national responses to HIV.

METHODOLOGY AND LIMITATIONS

2

2.1. The Analytical Framework

Budgeting is an essential component of any effective program or policy, outlining its priorities and determining impact of its resources. Most budgets are gender blind, failing to include gender equality considerations and ignoring the different social roles and capabilities of men and women such as the contribution made by women in the unpaid, 'care', economy.[8] Gender blind budgets can further amplify the discrimination faced by women with respect to economic, social and political power. A GRB approach aims to transform planning and budgeting processes by addressing a number of critical issues that includes the care economy and changes in legislative environment, both of which are important in the HIV response.

Since GRB was first employed in the 1980s, several GRB tools and methodologies have been developed including *Rhonda Sharp's three expenditure categories, gender-disaggregated beneficiary assessments, gender-disaggregated public expenditure incidence analysis and Rwanda's gender responsive budget statements* and others, which are discussed in more detail in Annex 1. The GRB tool selected for this analysis is the **Five-Step Approach** (sometimes also referred to as "gender aware policy appraisal") presented in Text box 3 below.[9] The Five-Step Approach rests upon a human-right framework as well as a result-based approach to budgeting and prioritizes the analysis of policies, plans and programmatic interventions and then reviews how budget allocations and expenditures support the fulfilment of established goals.

Text box 3: The GRB Five-Step Approach

STEP 1	• A situation analysis of women, men, and gender non-conforming people within the HIV epidemic (from a gender and human rights perspective)
STEP 2	• An assessment of the extent to which HIV policies, plans and programmes address the situation described in Step 1.
STEP 3	• An assessment of the HIV budget allocations for implementing the gender responsive actions identified in the policies/plans assessment in Step 2.
STEP 4	• An assessment of whether the planned budget allocations were spent/converted into budget expenditures. That is, what was delivered and to whom was it delivered.
STEP 5	• An assessment of whether the situation described in Step 1 changed for the better, remained the same, or worsened (e.g. increased gender inequalities).

8 In current economic models, the gross national product (GNP) of countries does not recognize the contributions made by women in care work (child care, elderly care, and for the sick), voluntary or civil society activity, and subsistence production and work in informal sectors. These activities are ignored when making policy decisions or creating budgets.

9 UNFPA, UNIFEM (2006) Gender Responsive Budgeting and Women's Reproductive Rights: A Resource Pack; Budlender Debbie and Hewitt Guy (2003), Engendering Budgets A Practitioners' Guide to Understanding and Implementing Gender Responsive Budgets; Commonwealth Secretary, UK; Hofbauer, H. (2003) Gender and Budgets, Overview Report. UK, BRIDGE (development - gender) Institute of Development Studies.

An analytical framework was created (Text box 4). It includes a review of HIV policies and programs areas and programming and an assessment of an enabling environment for construction of a gender transformative budget.

Text box 4: Analytical framework for gender responsive HIV policies and budgeting

Gender responsive HIV policies and programs (Checklist 1)

- Laws, policies and legislation - gender equality laws, decriminalization of key populations, measures for gender based violence, social protections for those living with HIV
- Prevention - condoms, prevention of mother-to-child transmission, pre- and post-exposure prophylaxis, community-led services (peer educators), harm reduction programs
- HIV testing and treatment - voluntary and confidential testing, counselling for youth and sero-discordant couples, equal access to antiretroviral treatment and monitoring, screening and treatment for co-morbidities
- Care and support - psycho-social support (violence), protections for orphans, recognition of women's contribution & compensation
- Sexual and reproductive health services - family planning, screening and treatment for sexually transmitted infections, information and skills building on sexual and reproductive health, services for transgender persons
- Economic empowerment and social protections - employment and livelihood, access to social services and protections (cash transfers, food assistance, shelter etc.)
- Human rights and gender equality - legal rights (including legal literacy and access to justice), stigma and discrimination, training for law enforcement, judiciary and health care providers, services to address gender-based violence (especially intimate partner violence)

Enabling environment for GRB (Checklist 2)

- Budgetary planning and development - alignment of HIV policy and budget, pro-gender budget framework, care economy inclusion, sex disaggregated data, and targeted investments GEWE
- Actor's Capacities - GEWE knowledge and capacity of government officials, parlimentarians, judiciary, service providers, and civil society including WLHIV, KP, and women groups
- Community Participation - processes and mechanisms for engaging above groups in GEWE budgetary planning and their decision-making power

In this report, **Step 1** refers to reviewing the situation of women, men and transgender people in the HIV policies, plans and programs for each country. **Step 2** assesses if there is a gender perspective, and if so it then results in promoting gender equality or women's empowerment. If the gender dimension of HIV is not recognized and addressed, HIV policies can have a negative impact on certain groups due to inequitable gender relations and existing inequalities. For example, HIV prevention, treatment, care and support services may not reach these groups further exacerbating gender inequalities. For Step 2, a checklist of questions was developed that focused on the gender responsiveness of HIV policies, plans, and programming (Annex 2: Checklist 1).

It is essential that there is coherence between political commitments and budget allocations and expenditures. **Step 3** reviews the HIV budget allocations in relation to national HIV policies and plans, and includes analysis of budgets for the most recent Global Fund Concept Note under the New Funding Model. **Step 4** of the Five-Step Approach, budget expenditure, is combined with Step 3 as a consequence of data limitation. Information on the National AIDS Spending Assessment (NASA) is not always available, and in some cases it doesn't reflect changes in HIV policies and plans. A second checklist of questions (Checklist 2) was developed to assess if an enabling environment for a GRB process is present (Annex 2: Checklist 2). **Step 5** is not included because comparisons between the years to assess improvement were beyond the scope of the report.

2.2. Data Sources

The analysis employed a mixed method methodology, combining qualitative (interviews) and quantitative methods (budgets) through primary and secondary data collection methods. All data was collected and analyzed in 2015.

Secondary data entailed a literature review of relevant background documents on the HIV response, as well as a gender analysis of policies, programs, and budgets connected to the HIV response in Cambodia, Indonesia, and Thailand (see Table 1 below and Figure 1).

Primary data included interviews with key informants involved in the HIV response in Cambodia, Indonesia, and Thailand (see Annex 3 for the questions which guided the interviews and the list of the key informants). The purpose of these interviews was to crosscheck and validate findings from the secondary source analysis, and to gather additional information on budgets, which had been difficult to access. UN Women's Regional Office and Country Offices (Cambodia, Indonesia and Thailand) as well as the AIDS Data Hub in UNAIDS Regional Support Team for Asia and the Pacific provided fundamental information and input for this report. Combining the policy and budget analysis with interviews significantly enhanced the reliability of the report's findings.

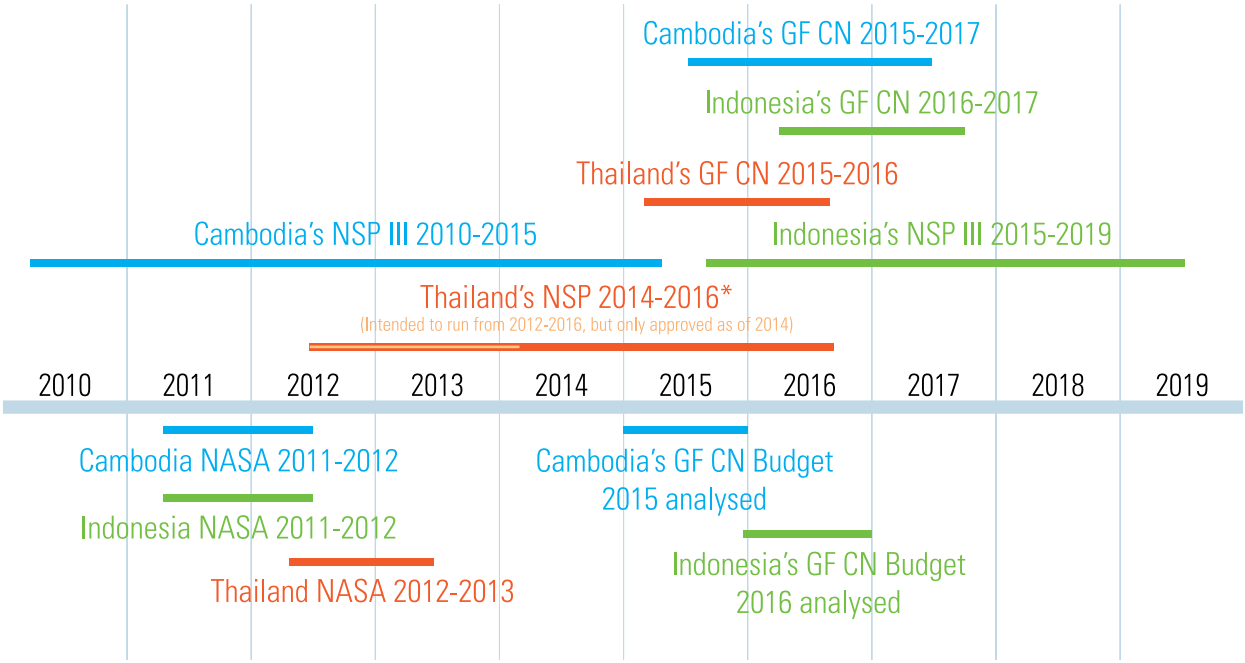
Table 1: Policies and budget documents included in the analysis

Documents reviewed	Cambodia	Indonesia	Thailand
National Strategic Plans on HIV/AIDS (NSP)	NSP III 2010-2015 (costed version[10])	NSP 2015-2019	NSP 2014-2016 Logical Framework Matrix[11] (intended to run from 2012 onwards, but only approved as of 2014)
National AIDS Spending Assessment (NASA)	2011-2012	2011-2012	2012-2013
Global Fund Concept Note and Program Budget (GFCN)	2015-2017	2016-2017	2015-2016

10 The costed version of Cambodia's NSP III 2010-2015 (Excel document) was shared by UN Women's CO in Cambodia via email on 7 April, 2015.

11 The Logical Framework Matrix of Thailand's NSP 2014-2016 was shared by UN Women's CO in Thailand via email on 3 February 2015.

Figure 1 - Timeline graph of the documents analysed



2.3. Limitations

There are a number of limitations in the analysis. National governments' budget allocations and expenditures for the HIV response were not available in English, beyond the countries' National AIDS Spending Assessment (NASA) reports.[12] While the NASA reports are included for all countries, the National Strategic Plans for HIV (NSP) III 2010-2015 budget was only included for Cambodia[13], and Global Fund Concept Note (GF CN) budgets were only included for Cambodia and Indonesia. The final versions of several documents were still pending and the analysis may not reflect the latest development.[14]

Disaggregated budget allocations and expenditure data was limited and often not sex-disaggregated. When program names, indicators and/or actions referred to gender issues, e.g. care work or human rights for transgender individuals, then these were labelled as gender responsive. This may have made the results of the budget analysis seem more positive than they actually are. The lack of disaggregated budget information also relates to the limitation of actions being lumped together within the same budget item. This makes it impossible to distinguish the exact amounts allocated for gender equality therein. For example, the Global Fund budget for Indonesia includes various actions related to the budgeted intervention "policy advocacy on legal rights", within which the provision of comprehensive post-rape care is found. However, the USD 82,104 allocated for this intervention is bound to other actions as well, which are not necessarily gender responsive. This is also a recurrent issue for Cambodia's GF budget.

12 For Indonesia detailed budget allocation documents/sheets are available to download in Bahasa Indonesian from government entities' websites. These documents include indicators and results, which would facilitate a budget analysis of Indonesian national HIV budget allocations for a consultant fluent in this language.

13 Although the Cambodian NSP III 2010-2015 includes a costed budget, the Excel sheets feature various "errors" and consequently cannot provide unequivocally accurate data. Therefore only those costed budget items that do not contain "errors" are considered. For Indonesia and Thailand no final NSP budgets were available in English and thus were not included.

14 The GF CN for Indonesia was shared by UN Women's CO in Indonesia on 3 April 2015, while the Programme Budget was shared on 7 April 2015. The GF CN and Program Budget for Cambodia was shared by UN Women's CO on 7 April 2015. The GF CN and Programme Budget for Thailand was shared by UN Women's CO on 7 April 2015 and correspond to the final and approved version (available to download on GF's webpage).

There are incompatibilities in analysis when policy and plans cover different years than budget allocations and expenditures. For example, in the case of Indonesia's NSP, which was developed this year (2015), and the Indonesian NASA, which corresponds to 2012. Hence, budget expenditures in the NASA included in this analysis correlates to the country's previous NSP. It is worth noting that the Thailand NSP 2014-2016 intended to run from 2012 onwards was approved as of 2014. The Thai NASA 2013 therefore corresponds to this plan.

The lack of costed versions of plans and strategies was a recurrent issue. Due to limitations regarding the availability of budget documents, Step 3 includes both the budget allocation and budget expenditures, if available.[15]

15 This was also done since budget allocations are provided in the Global Fund Concept Note Programme budget (a document only available for Cambodia and Indonesia) and expenditures are provided in the National AIDS Spending Assessment (NASA) (available for all three countries).

3 OVERVIEW OF GENDER SITUATIONAL ANALYSIS WITHIN THE HIV EPIDEMIC (STEP 1)

There are an estimated five million persons living with HIV in Asia and the Pacific, and an estimated 350,000 new HIV infections per year.[16] The HIV epidemic is concentrated in key populations,[17] defined as those "most likely to be exposed to HIV or to transmit it"[18] and includes gay men and men who have sex with men, transgender persons, people who use drugs, sex worker and their clients, migrants, and persons living in closed settings. However, each country has its own definition of key populations, which are contextually bound.

Female key populations include female sex/entertainment workers, women who inject drugs, transgender women, and women who have intimate partners engaging in high-risk behaviours.[19] Young girls (14-24 years old) and migrant women (in ASEAN context[20]) have also been included as a key population by civil society groups in the certain settings, and in the three countries.[21]

Women are increasingly vulnerable to HIV infection through sexual transmission, not only due to biological factors[22], but also because of the gender norms and relations in the societies in question. The percentage of women living with HIV has increased in the region, and in all three countries women living with HIV account for one-third to one-half of all HIV infections. Women also account for up to 30 percent of new infections.[23] For example, in Indonesia the percentage of WLHIV increased from 20 percent in 2006 to 30 percent in 2012, seen as an indicator of restrictive gender norms, which leave women with little or no power to negotiate safe sex, even with their intimate partners, and limit their access to contraceptives.[24]

16 UNAIDS (2013a) *HIV in Asia and the Pacific: Report 2013*
17 An exception is Tanah Papua in Indonesia where HIV/AIDS is a generalized epidemic (ASEAN Foundation et al. 2013).
18 UNAIDS (2011), *UNAIDS Terminology Guidelines.*
19 UNDP (2015) *Preventing HIV Transmission in Intimate Partner Relationships: Evidence, strategies and approaches for addressing concentrated HIV epidemics in Asia.* Bangkok, UNDP.
20 UN Women, ASEAN Foundation, UNAIDS, UNZIP and Evidence to Action (2013) *Country Briefs on HIV and Key Affected Women and Girls in ASEAN.* http://unwomen-asiapacific.org/docs/CountryBriefs_HIV/Country%20Brief%20Introduction.pdf
21 ASEAN Foundation, UN Women, UNAIDS, UNZIP the Lips Platform, et al. (2013) *Cambodia Country Brief - HIV and Key Affected Women and Girls; Indonesia Country Brief - HIV and Key Affected Women and Girls; Thailand Country Brief - HIV and Key Affected Women and Girls*, Peer-review comments from UN Women's CO in Cambodia.
22 Women's sexual organ has a larger surface area exposed to the virus.
23 UNAIDS (2016). Data Hub Analysis (shared with author by UN Women).
24 UNAIDS (2013a) *HIV in Asia and the Pacific: Report 2013.*

Table 2 summarizes the number of women living with HIV in the three countries and modes of HIV transmission.[25] Surveys of condom use by men living with HIV and analyses of modes of transmission "seem to support the hypothesis that a majority of women in the region are acquiring HIV, not because of their own sexual behaviour, but because their intimate male partners have been engaged in high-risk behaviours."[26]

Table 2: Modes of HIV transmission in women living with HIV

Country	Women living with HIV	Trends in new infection rates
Cambodia	36,000 (48%)[27]	80% of HIV transmission is due to unprotected sexual relations (sex/entertainment work, spousal/intimate partner relations, casual sex, and MSM)[28]
Indonesia	230,000 (35%)[29]	72% of HIV transmission is due to unprotected sexual relations (sex work, spousal/intimate partner relations, casual sex, and MSM)[30]
Thailand	190,000 (42%)[31]	90% of HIV transmission is due to unprotected sexual relations (sex work, spousal/intimate partner relations, casual sex, and MSM)[32]

Vulnerability to HIV is compounded by structural inequalities between women and men, which leaves women with less control over decisions regarding their sexuality. Inequalities also exist in terms of transgender people, who often face heightened stigma and discrimination with respect to their sexuality. Legislation further reproduces these inequalities by limiting women's, transgender people's, girls' and boys' access to sexual and reproductive health information and services, as well as by not criminalizing marital rape.[33] Such inequitable gender norms also reinforce HIV risk among men, for instance harmful conceptions of masculinity bolstered by social/peer pressure to engage in transactional sex or low condom use with intimate partners.

Table 3 discusses the persistent gender norms and their consequences in relation to the HIV epidemic.[34] These norms particularly apply in communities or sections of society with strong views and entrenched practices concerning traditional gender perspective, and are not necessarily prevalent throughout the entirety of the three countries.

25 UNAIDS (2013a) *HIV in Asia and the Pacific: Report 2013 and UNDP (2012) Asia Pacific Community of Practice on HIV, Gender and Human Rights*

26 ASEAN Foundation, UN Women, UNAIDS, UNZIP the Lips Platform, et al. (2013) *Cambodia Country Brief - HIV and Key Affected Women and Girls; Indonesia Country Brief - HIV and Key Affected Women and Girls; Thailand Country Brief - HIV and Key Affected Women and Girls*, p. 23.

27 http://www.aidsdatahub.org/Country-Profiles/Cambodia

28 Cambodia's National Aids Authority, GARPR 2014.

29 http://www.aidsdatahub.org/Country-Profiles/Indonesia

30 Indonesia's National Aids Committee, GARP 2012-2013.

31 http://www.aidsdatahub.org/Country-Profiles/Thailand

32 Thailand's AIDS Zero Portal (2013).

33 Ibid., p. 24.

34 Neary Rattanak IV; ASEAN Foundation et al. (2013); Richter (2010); Aidsdatahub (2011); Boonmongkon (2009); National AIDS Management Center et al. (2014); WAPN+ (2012); UNESCO (2013), KIIs; Nirmita Hou, Director Health Department, Ministry of Women's Affairs, 03/07/2015; Ly Penh Sun, Director, National Center for HIV/AIDS, Dermatology and STD (NCHADS), 09/07/2015, Lina Ngin, Former Program, Monitoring and Evaluation Department Director, NAA (currently works at Ministry of Environment), 01/07/2015 and Heru Kasidi, Political , Social and Legal Deputy, Ministry of Women's Empowerment and Child Protection, 19/06/2015.

Table 3: Common consequences of gender norms in the HIV epidemic for the three countries

Gender norms	Consequences
"Good women" are innocent, inexperienced and not knowledgeable about sex, while "real men" are driven by sexual needs and urges	• In certain communities, strong traditional gender norms mean that women have less power, or no power at all, to negotiate safe sex, including condom use, with their regular sexual partners • Rape within marriage, sexual violence and intimate partner violence • Purchase of sex • Women have less access to information and sex education • Gender-based violence, especially female sex workers/female entertainment workers and violence against transgender women • More availability of male contraception methods (male condoms) than female contraception methods (female condoms, intrauterine devices, and oral or injectable hormones)
WLHIV, females who use drugs and FSW-FEW are not "good women"	• Stigma, discrimination and VAW in different spheres, both private and public (health care centres, employment opportunities, etc.) • Registered violence against WLHIV, including forced sterilization, abortion and caesareans • Punitive approaches including the criminalization of sex work and drug use • A lack of respect for women's right to informed consent and confidentiality, which influences women's health care choices, e.g. many WLHIV avoid seeking health care during pregnancy
Transgender women and are not "real women"; homosexual/ bisexual/ transmasculine men are not "real men"	• Stigma, discrimination and gender-based violence/violence against women are justified by many in society • An absence of laws or regulations recognizing these groups (being transgender is criminalized in many countries) • Homosexual/bisexual men may live in heterosexual relationships (hiding and/or not recognizing their sexual preferences) • Transmasculine men are not considered "real men" and suffer gender based violence
Women are the primary care-givers and are responsible for domestic work in the private sphere; men are the primary breadwinners and the main actors in the public sphere	• Girls in HIV-affected households dropping out of school to provide care and support • Female unemployment • Prevention of mother-to-child transmission focus only on the child, and child healthcare centres often exclude men's participation • Economic dependency and the feminization of poverty, which also influences power relations and women's ability to negotiate safe sex and avoid sexual violence • The involvement of women and girls' in developing and monitoring policies and programs that affect them is rare
Young and unmarried people, especially females, should not be interested in (nor encouraged to engage in) sexual relations	• Limited access to family planning and SRHR service centres • Less access to contraceptives, including condoms • Legal barriers, including age of consent • Services are not young people-friendly • Stigma, including social restrictions and control over the sexuality/ sexual identity of young girls (and boys), as well as punishment and rejection for perceived "promiscuity"

Gender-based Violence

Gender inequalities relate to gender based violence (GBV), which appears heightened when women are not open to sex when the men are, or when women insist on condom use so as to protect themseleves from HIV and other STI infections. Transgender people are also at high risk of GBV, particularly to violence which is 'sexualized'. That is, they are "punished" through forms of sexual violence for their sexual identities and are often reluctant to report such incidents for fear of further discrimination and victimization.[35] Such violence compounds their risk of HIV exposure and negatively affects their likelihood of seeking treatment. The fear of stigma and discrimination, legal or social repercussions, or violence also often dissuades gay men and men who have sex with men and transgender people from seeking out HIV and health services.[36]

Access to Health Services

ASEAN studies in the three countries show that, overall, both key affected female populations as well as women living with HIV face more barriers and stigma in relation to HIV and health services than their male counterparts. HIV positive women are at a higher risk of experiencing violence compared with men living with HIV. This includes structural violence such as forced sterilization, economic and physical violence, influencing their choices when seeking support and services.[37] Stigma and discrimination against women living with HIV in healthcare settings affects women's access to care, and as a result, many WLHIV avoid health care during pregnancy even though the countries have advanced prevention of mother-to-child transmission services.[38] There are a few sexual and reproductive health rights service centres, and health care workers' continue to have negative attitude towards people living with HIV.[39]

Emerging New Trend of Intimate Partner Transmission

It is important to highlight the emerging challenge of Intimate Partner Transmission (IPT), which negatively affects women and girls. HIV transmission to men from their female intimate partners is well noted, but new data collected by UNDP indicates that, "male risk behaviours continue to drive HIV transmission in the region, including intimate partner transmission,"[40] and accounts for an estimated one-third of new infections in the region.[41] In Cambodia, the National Centre for HIV/AIDS, Dermatology, and STDs (NCHADS) and partners approximated that 37% of new infections would occur via spousal transmission both in terms of wife-to-husband and vice versa).[42] In Thailand, it is predicted that intimate partner transmission will account for 23% of new infections between 2012 and 2016[43] and it is the second most prevalent infection source after gay men and other men who have sex with men transmission. In Indonesia, the second largest numbers of new infections are expected to occur in "low-risk" women, largely a consequence

35 UNHCR (2011) *Action against Sexual and Gender-Based Violence: An Updated Strategy.* http://www.unhcr.org/4e1d5aba9.pdf
36 UNAIDS (2013a) *HIV in Asia and the Pacific: Report 2013.*
37 WAPN+ (2012) "Positive and Pregnant? How dare you!" Bangkok: WAPN+.
38 ASEAN Foundation, UN Women, UNAIDS, UNZIP the Lips Platform, et al. (2013) *Cambodia Country Brief - HIV and Key Affected Women and Girls.*
39 Ibid.
40 UNDP (2015) *Preventing HIV Transmission in Intimate Partner Relationships: Evidence, strategies and approaches for addressing concentrated HIV epidemics in Asia.* Bangkok, UNDP. p. 16.
41 Ibid. p. 24.
42 National Centre for HIV/AIDS, Dermatology, and STDs and partners (2011), HIV Estimation and Projection 2011, Cambodia (Phnom Penh).
43 UNDP (2015), p. 31.

of intimate partner transmission.[44] "Housewives" are now the fifth largest groups of people living with HIV in Indonesia, and without an effective response, they will by 2020 become the largest group together with gay men and other men who have sex with men and sex-workers' and their clients.

Structural Issues including Gender-based Violence, Social Protection and Empowerment

A range of 'critical enablers' and structural interventions have been recommended by several United Nations agencies such as UNDP, WHO, and UNAIDS to address gender-based violence. With respect to addressing gender-based violence, communities need mechanisms to document and monitor violence, countries need to undertake legal and policy reform, trainings for key populations on human rights ('know your rights') and for law enforcement need to be considered, and law enforcement accountability in preventing and responding to violence needs to be promoted.[45]

Social protection measures can mitigate HIV transmission risks by reducing inequalities that heighten susceptibility to HIV. These can broadly be defined to include financial protection, policies and legislation that uphold rights, and programs that support access to affordable quality services.[46] Programs that address economic empowerment are especially needed given higher unemployment among women living with HIV than men living with HIV, and girls from HIV-affected households dropping out of school to provide care and support.[47]

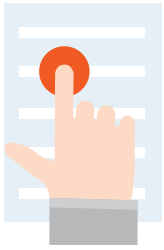
44 Ibid and Indonesia's Ministry of Health (2013) *and The Case for Increased and More Strategic Investment in HIV in Indonesia* (2015)

45 WHO (2014) *Consolidated Guidelines on HIV Prevention, Diagnosis, Treatment and Care for Key Populations.* Geneva: WHO. Available: http://apps.who.int/iris/bitstream/10665/128048/1/9789241507431_eng.pdf?ua=1 p. 105.

46 Sabates-Wheeler (2004) *Transformative Social Protection*, IDS.

47 ASEAN Foundation, UN Women, UNAIDS, UNZIP the Lips Platform, et al. (2013) *Cambodia Country Brief - HIV and Key Affected Women and Girls.*

4 COUNTRY ASSESSMENTS OF HIV POLICIES, PLANS, PROGRAMMING AND BUDGET ANALYSIS (STEPS 2, 3, AND 4)



The aim of public policies is to support human development and the wellbeing of citizens in all their diversity, whether women, men, or persons of differing sexual orientation or gender identity. The national HIV responses must consider gender inequalities identified in the situation analysis (Step 1) and propose actions (Step 2) correspondingly to change and reverse the HIV epidemic.

Furthermore, actions (Step 2) need budgets (Step 3 and 4) to be implemented. Hence, steps 3 and 4 review budget allocation and budget expenditures[48]. For each country, the gender analysis reviews the relevant document and its accompanying budget. Additionally, an analysis of budgetary development and planning, actor's capacity, and community participation was carried out as to assess the extent of an enabling environment for GRB.

4.1 Cambodia

4.1.1. Policies, Programs, and Budgets

The following three documents were included in the policy, planning, program, and budget analysis for Cambodia: NASA (2011-2012), NSP III (2010-2015) and GF CN (2015). Table 4 summarizes and aligns gender responsive HIV interventions stated in these documents in terms of priorities (or not).

48 Refer to methodology section 2.1 The Analytical Framework for why steps 3 and 4 are combined.

Table 4: Summary of gender responsiveness of Cambodian HIV policies and programs (Checklist 1)

Gender Responsive HIV Interventions, Cambodia	Summary of all documents –NASA (2011), NSP III (2010-2015) and Global Fund Concept Note (2015)
Laws and Policies	Include reviews of laws and policies and their effect on key populations, but without focus on women and girls Include steps to decriminalize key populations behaviour Discuss the importance of engagement and empowerment of key populations Do not make reference to international commitments
Prevention	Include condom and lubricants programming (but not female condoms) Do not highlight young people or other demographic factors (age, religion, gender) that might affect condom use Prioritize community engagement for services but without focus on women and girls No mention of P(r)EP /even in terms of rape Highlight prevention of mother-to child transmission, and the involvement of men in the program Do not include post-natal care or women's use of treatment after childbirth Include harm reduction program, recognizing the specific needs of female drug users
HIV Testing and Treatment	Permit HIV testing for minors and includes their access to services Do not highlight the 5'C- consent, confidentiality, counselling, correct results and linkage to care No mention of testing or treating co-morbidities
Care and Support	No recognition of women's share of care-giving responsibilities No mention of psycho-social support or AIDS orphans
Sexual and Reproductive Health	Sexually transmitted infections prevention, screening and treatment is not included, including for female key populations and transgender persons Reference to integrating HIV and sexual and reproductive health and rights services No family planning or mention of abortion including post-abortion care
Economic Empowerment and Livelihood	Consider some social protection measures Include economic empowerment, employment, income and livelihoods, but without a focus on women
Human Rights and Gender Equality	Include steps to decriminalize key population behaviour Include training for health workers, commune councils and those in the justice system Include community in anti-stigma campaigns (but no details are provided) Women living with HIV specific situations are not highlighted in terms of discrimination by health services Include access to justice and legal support for key population Do not highlight legal literacy Mixed response to gender-based violence (included in NSP/GF CN)

Based on NASA 2012, NSP III 2015, and the Global Fund Concept Note, the budgeting analysis reveals that there is a disconnection between policy rhetoric, e.g what is written on paper, and planned budget allocations. The NASA 2012 and NSP III 2015 have similar structures in terms of budgetary items such as prevention of mother-to-child transmission, social protections and home based care. Table 5 presents the total amounts with description on allocation for women and girls including key populations (allocations for transgender women are under men who have sex with men).

> *"In Cambodia, we have good policies but there is a lack of connection between budgeting and actions. Our community and CSO are not very strong to undertake monitoring and evaluation, and [so] it [response] is very fragmented. Women living with HIV are not knowledgeable enough to undertake GRB."*
>
> **Choub Sok Chamreun, Executive Director/Chief of Party, HIV/AIDS Flagship Project KHANA**

> *"In Cambodia, it is crucial to involve the Global Fund and other main donors for a gender aware response and for doing GRB (90% of our budget is donor funded). I also believe that it is important to involve local and provincial health departments."*
>
> **Ly Penh Sun, Director, NCHADS**

Table 5: Estimation of Cambodian budgetary allocations for gender programming

Budget	Percent of total expenditures *assumed to* focus on women and girls	Priority budget items noted *to specifically include women*
NASA 2012	15.40	Prevention of mother-to-child transmission (4.80%) AIDS specific program (0.60%) Programs to reduce gender-based violence (0.01%) Human rights program (0.09%)
NSP III 2010-2015 (costed version[49])	6.35	Prevention of mother-to-child transmission (2.60%) Violence against women, development of guidelines (0.20%) Training of police and service providers in gender-based violence/violence against women (0.07%) Post-exposure prophylaxis (0.02%)

49 The costed version of Cambodia's NSP III 2010-2015 (Excel document) was shared by UN Women's CO in Cambodia via email on 7 April 2015.

Budget	Percent of total expenditures *assumed to* focus on women and girls	Priority budget items noted *to specifically include women*
Global Fund Concept Note 2015-2017	8.63	It is the most detailed in terms of description but budget allocations are lumped together making it impossible to determine what percent of allocations include gender transformative programming. The goals, objectives or impact and outcome indicators are not sex-disaggregated. *Three budget items include the term gender (0.8%) –legal aid services and legal literacy, policy advocacy on legal rights, and social mobilization, building community linkages, collaboration and coordination. *Counselling and psychosocial support (4.9%) *MSM and TG programming (check up for sexually transmitted infections, free condoms, pillow talk) (2.10%) *Sex workers and clients (condoms and check ups for sexually transmitted infections) (0.68%) *Pregnancy related (treatment and prevention of unintended pregnancies (0.27%) *note: majority of the budgeted prevention of mother-to-child transmission is not gender responsive and can be classified as gender blind*

In these budgets, it is difficult to determine if any of the line items actually target gender equality and even if budgets are gender responsive. The macro-level analysis can only assume that there is a gender component. Cambodia's Global Fund Concept Note budget description is one of the most detailed in this report, and has a focus on key populations. However, a micro-level analysis is required to determine what percent of actual allocation is gender responsive.

In summary, Cambodia's HIV budget allocates a small amount (less than 10 to 15 percent of total HIV allocation) to gender equality and women's empowerment, and often fails to finance the barriers that prevent access to health, social and legal services for female key populations and transgender women.

4.1.3. Enabling Environment (Checklist 2)

In the analytical framework, three fundamental categories for GRB were included: budget planning, actor's capacity, and community participation. Table 6 presents a short summary. Cambodia's HIV budgeting scenario provides both opportunities and challenges for the application of GRB. In general, budgets are not prepared from a gender perspective. As one key informant noted, current budget statements consider both women and men, as it is 'important to treat everyone equally' with no distinction based on gender.[50] No pro-gender budget framework exists, such as a budget law recognizing gender relations, or regulations, which oblige or recommend the incorporation of a gender perspective in HIV budgeting. The care economy and women's share therein is not recognized in the HIV response, but one of the key informants noted that it will be considered in the next National HIV Strategic Plan.

50 Ly Penh Sun, Director, National Center for HIV/AIDS, Dermatology and STD (NCHADS), 09/07/2015.

Table 6: Favorable GRB context in Cambodia

Strategic GRB Area	Summary of (un)favorable context
Budgeting framework/planning	• Budget books and documents related to HIV are difficult to obtain and understand • No laws recognizing gender relation or obligation to incorporating gender in budgeting • Care economy is not considered in the HIV investment • Sex-disaggregated data and indicators are included • Targeted investments for equal society are specified
Actor's Capacities	• Gender training and sensitization has been undertaken with government actors working on HIV • There is staff in ministries working on HIV responsible for gender equality and women's empowerment • Donor agencies are not knowledgeable in GRB for HIV
Community Participation	• Women living with HIV and key populations are not involved in budget planning and formulation • There are no mechanisms to ensure equal citizens' participation • Communities are not involved in budget implementation and evaluation

Budget books and documents related to HIV are not easy to obtain, nor are they easy for the public to understand. Key informants from CSOs note that it is not possible to obtain budget documents/books from ministries managing HIV budgets.[51] One key informant highlighted that obtaining detailed budget documents from GF is problematic for both CSOs and women living with HIV. Even if obtained, they are difficult to understand.

On actor's capacities, there are personnel within the National AIDS Authority who are knowledgeable about gender equality and women's empowerment. Numerous training and sensitization on gender equality have been undertaken with governmental actors working on HIV, including:

- A UN Women-funded program, which supported workshops to introduce the National AIDS Authority to GRB concepts and methods;
- An assessment of the National AIDS Authority and the Ministry of Women's Affairs' (MoWA) institutional capacity for gender responsive planning, coordination and budgeting[52]; and
- One key informant noted that training-of-trainers workshops were held at local (district) level but progress has been slow and it is expected that local leaders will support the development of gender responsive HIV investments and advocate for proper budget allocations.[53]

51 KIIs; Chamreun Choub Sok, Executive Director, Chief of Party, HIV/AIDS Flagship Project, KHANA, 14/07/2015 and Dalish Prum, National Coordinator, Cambodian Community of Women Living with HIV/AIDS, 27/06/2015.
52 UN Women (2012) *Terms of Reference: Applying GRB to the HIV response.*
53 KII, Nirmita Hou, Director Health Department, Ministry of Women's Affairs, 03/07/2015.

There are no trainings or capacity development actions in relation to other parts of government such as the Ministry of Health and the National Center for HIV/AIDs, Dermatology and STD Control (NCHADS) that manages a large portion of the HIV funds.[54] The main donor, Global Fund has limited knowledge of gender responsive budgeting in preparation of concept notes. There is also limited capacity amongst civil society organizations. The National Coordinator for the Cambodian Community of Women Living with HIV/AIDS, Dalish Prum, commented, "Women living with HIV and female from key populations have limited knowledge of budgeting, which limits their watch-dog capacity for budget implementation and evaluation".[55]

Participation in the budget cycle is very low[56] even though the Implementing Guidelines for the HIV/AIDS law (2005) states that:

> *"People living with HIV should be involved in all aspects of responding to the epidemic, including the design, delivery, and evaluation of policies and programs for HIV/AIDS prevention, treatment, care and support."*

The lack of capacity and participation makes community feel that there is limited space for influencing the budget at any given stage of development and implementation, and that tracking expenditures is equally challenging. The only stage for possible influence, as highlighted by key informants from both civil society organizations and government bodies, is the planning stage.[57]

4.2 Indonesia

4.2.1. Policies, Programs, and Budgets

For Indonesia the following documents were included in the policy, planning, program and budgetary analysis: the NASA 2012 costed expenditures, National Strategic Plan (2015-2019) but without the Operational Plan (as it was unavailable at the time of writing)[58], and the Global Fund Concept Note 2015 (GF CN 2015).

Women representative from the Indonesia Positive Women's Network (IPPI) and OPSI (Sex Worker's Organization) were involved in the development of the NSP 2015-2019 and the Global Fund Concept Note. Table 7 summarizes the interventions based on checklist 1 and Indonesia's NSP (2015-2019) and the Global Fund Concept Note 2015.

54 In 2012 , the MoH managed 92% of the government funds (estimated at 53%); and within the MoH, NCHADS managed most of these funds. Cambodian NASA 2011-2012 (2014), p. 27-29.

55 KII, Dalish Prum, National Coordinator, Cambodian Community of Women Living with HIV/AIDS, 27/06/2015.

56 KIIs Chamreun Choub Sok, Executive Director, Chief of Party, HIV/AIDS Flagship Project, KHANA, 14/07/2015, Dalish Prum, National Coordinator, Cambodian Community of Women Living with HIV/AIDS, 27/06/2015. It is a vicious circle with limited knowledge resulting in limited participation, and limited opportunities to building capacity.

57 Dalish Prum, National Coordinator, Cambodian Community of Women Living with HIV/AIDS, 27/06/2015.

58 NSP 2015-2019 draft version from 20 April 2015.

Table 7: Summary of gender responsiveness of Indonesian HIV policies and programs (Checklist 1)

Gender Responsive HIV Interventions, Indonesia	Summary of all documents (NSP 2015-2019 and Global Fund Concept Note 2015)
Laws and Policies	Include a review of laws and policies and how these can affect key populations, but do not mention specific measures to decriminalize the behaviour of key populations
	Emphasize key population engagement and empowerment in the HIV response
	Do not refer to policies on violence against women or gender-based violence in the HIV response
Prevention	Make reference to condom and lubricant programs but lack gender responsiveness of condoms as strategic area (also anti-trafficking law of 2007 can impede use and possession of condoms)
	Mixed response to pre-exposure prophylaxis, included in NSP only in relation to men who have sex with men but not in the Global Fund Concept Note
	Include prevention of maternal-to-child transmission, but not post-natal care – focus is on women as child-bearers and no inclusion of men
	Include harm reduction programs with a focus on female drug users
HIV Testing and Treatment	Do not include voluntary testing for key populations
	Do not include the 5'C of HIV testing and counselling
	Do not prioritize couple's counselling and testing
	Do not make reference to laws on parental consent
	Highlight treatment for all PLHIV, and integrating within general health services
Care and Support	Do not recognize the cost of caring for PLHIV by women and girls
Sexual and Reproductive Health	Highlight importance of integrating HIV and sexual and reproductive health services
	Do not mention specific needs of transgender in NSP but included in the Global Fund Concept Note
	Do not prioritize STI prevention, screening and treatment
	Do not mention abortion
	Mention cervical cancer for women in the NSP but no mention of anal cancer (common amongst males living with HIV)
Economic Empowerment and Livelihood	Highlight PLHIV's access to social services and social protection mechanisms, e.g. cash transfers and microfinance, but without a focus on women living with HIV needs
	Do not include female key populations or women living with HIV in economic empowerment, employment, income, or livelihoods
	Include social protection measures but without focus on women and girls
Human Rights and Gender Equality	Review laws and policies that affect key populations, but do not include any measures to decriminalize behaviour of key populations
	Recognize the need for training and sensitizing health workers, local leaders and justice system on gender and women's issues
	Do not mention gender equality laws, e.g. equal property, inheritance, custody, etc., or their influence on the situation of women, men, and transgender people within the HIV response
	Do not include gender equality programs for men and boys in order to change gender norms
	Mixed response NSP refers to policies on violence against women and gender-based violence in the HIV response especially for female key populations but not in the Global Fund Concept Note

Indonesia's budget analysis of HIV allocations and expenditures presented in Table 8 includes only the NASA 2012 and the GF CN 2015. NASA is an established instrument with pre-defined categories for classifying national AIDS spending, and it is not disaggregated to provide information presented in the policy and plan checklist.

Table 8: Estimation of Indonesian budgetary allocations for gender programming

Budget	Percent of total expenditures *assumed to* focus on women and girls	Priority budget items noted *to specifically include women*
NASA 2012	1.6	Prevention of mother-to-child transmission (highest allocation of 0.14%) AIDS specific program (0.10%) Programs to reduce gender-based violence (0.003%) *No policy, program or budget explicitly mentions rape. The focus is on post-exposure prophylaxis and don't address the root causes and power relations connected to rape or recognized the psychological support that is needed as a post-rape strategy.* Human rights program (0.10%) Income generation/social protection (1.00%)
Global Fund Concept Note 2015-2017	9.35	It is the most detailed in terms of description but budget allocations are lumped together making it impossible to determine what percent is allocated to gender responsive programming. It should be noted that none of the goals, objectives or impact and outcome indicators are sex-disaggregated. *MSM and TG programming (1.76%) *Sex worker and their clients (3.36%) *People who inject drugs (1.84%) *Prevention of mother-to-child transmission (4.86%)

The NASA 2012 is not gender responsive. For example, are programs on prevention of mother-to-child transmission enhancing women's empowerment or merely focusing on women's roles as child bearers? Similarly, it is difficult to ascertain whether other items such as gender-based violence, social protection or human rights are actually gender responsive as no detailed information is available for such an analysis. Furthermore, three specific budget items included in Indonesia's NASA—female condoms, PrEP, and orphans and vulnerable children/home support—have no attached expenditures.

The Global Fund Concept Note Program Budget contains more detailed budget information, and has a focus on key populations including several references to gender responsive actions such as post-rape care, training for sexual and reproductive health services, and transgender (Waria) friendly services. However, allocation of funds for these gender responsive activities is small (5 percent), with remaining funds for prevention of pregnancy among HIV positive women of childbearing age and prevention of mother-to-child transmission. Investments in prevention of mother-to-child transmission focus on successful birth outcomes rather than increasing woman's decision-making over her own body.

The NASA and GF CN budgets do not allocate resources to legal reform or support communities that advocate for rights of sex workers, drug users or those subject to gender-based violence even though these issues are mentioned as important issues. No budget is allocated to supporting those

under the age of 18 years for HIV testing and counselling, especially in terms of laws on parental consent.[59] In both instances, it is difficult to determine the true extent of gender responsiveness.

4.2.2. Enabling Environment (Checklist 2)

The analytical framework's three categories for GRB—budgeting framework, actors' capacity, and community participation–are discussed in Table 9. The HIV budget process provides opportunities as well as challenges to the application of GRB in Indonesia's HIV response.

Table 9: Favorable GRB context

Strategic GRB Area	Summary of (un)favorable context
Budgeting	• There is pro-gender framework and budget laws recognizing gender relations • There are regulations that establish obligations on incorporating gender equality in budgeting • Budget books are easy to obtain but difficult for citizens to understand • Sex-disaggregated data and indicators are included • Targeted investments for equal society are specified • Parliamentarians are involved in HIV budgeting to promote gender equality and women's empowerment • The care economy is not considered in the HIV investment • No research is undertaken from a gender perspective to inform the new fiscal year policy
Actor's Capacities	• Gender training and sensitization has been undertaken with government actors and civil society working on HIV • There are no staff in ministries responsible for gender equality and women's empowerment except for in the national women's machinery • Donor agencies are not knowledgeable in GRB for HIV
Community Participation	• Women living with HIV and key populations are involved in budget planning and formulation, but not in implementation and evaluation • There are no mechanisms to ensure equal participation

There is an established pro-gender framework and regulations related to GRB that is applied through the *National Strategy to Accelerate Gender Mainstreaming through Gender Responsive Planning and Budgeting* and used by Ministry of Health and the National AIDS Commission[60]. Budget books and documents related to HIV are relatively easy to obtain in Bahasa Indonesia, and most annual operational plans from Ministries can be directly downloaded from their home pages.

Nonetheless, there are challenges as no previous research on HIV budgets from a gender perspective has been undertaken, nor have there been any gender audits that can guide planning and policymaking. As the UN Women's Program Officer noted, "Many institutions only conduct gender budget statements as a form of formality so that their budget can be approved, without carrying out a proper gender analysis in their activity or program".[61]

59 http://www.aidsdatahub.org/sites/default/files/publication/creating_an_enabling_legal_and_policy_environment_2015.pdf

60 KII, Heru Kasidi, Political, Social and Legal Deputy, Ministry of Women's Empowerment and Child Protection, 19/06/2015.

61 Iriantoni Almuna, email communication 01/11/2015.

Budget planning doesn't address the care economy in the HIV response, and the national insurance schemes don't consider all HIV-related expenses. Ongoing user fees (out-of-pocket expenses) tend to deter those with lower incomes, such as women living with HIV who are also widowed.

The capacity of actor's—government officials, parliamentarians, and civil society—is generally favourable. The National AIDS Commission (NAC) through a UN Women-backed program develops capacity of professionals involved in the HIV response at the local level.[62] There are personnel responsible for gender mainstreaming in the health sector, including for issues related to HIV at the Ministry of Women's Empowerment and Child Protection (MOWE). The National AIDS Commission and MOWE support and coordinate policy development and implementation,[63] but as one key informant noted that for MOWE, "HIV is not their priority yet."[64] There is a lack of personnel responsible for and knowledgeable in gender mainstreaming and women's empowerment. The Global Fund Concept Note (2015) included gender sensitive interventions, but analysis of the concept note and Global Fund internal procedures indicate that GRB knowledge among those preparing the Concept Note is limited.

The Indonesian government has established mechanisms known as MUSRENA (Musyawarah Rencana Aksi/ Deliberation for Action Plan) that is specifically for women's involvement in budget planning and formulation. But this initiative is more of a formality and the recommendations from the participating women are rarely translated into higher level planning or put into practice.[65] Although civil society participates in the planning of HIV interventions, the capacity of PLHIV CSOs is weak in terms of budget planning, tracking expenditures, monitoring implementation and evaluation. While the Ministry of Health manages 83 percent of the government's HIV funds, of which 89 percent are spent on drugs, civil society organizations, such as non-profits and faith-based organizations implement a large chunk of the HIV activities and their knowledge and participation in budgeting need to be strengthened including in monitoring, implementation, and evaluation.

The **Indonesian** Positive Women's Network contributed to the NGO shadow report as part of the country's reporting to the Committee on the Elimination of Discrimination against Women (CEDAW). This resulted in a change of government policy, which moved to stop coerced sterilization.

4.3 Thailand

4.3.1. Policies, Programs and Budget

For Thailand, three HIV documents—Thai NSP 2014-2016, Logical Framework Approach Matrix, and Global Fund Concept Note--were available for planning and programmatic interventions in relation to gender. The results of the analysis are presented in Table 8. For the budget analysis only the NASA 2013 was available. Unfortunately it did not provide sufficient information on budget expenditures to assess gender equality. Therefore no data is presented and only summary comments are made in relation to the budget analysis.

62 Report from the Workshop "Progress and Challenges in Ensuring GRB for HIV Interventions", 11-12 December, 2014, Indonesia.
63 KII, Heru Kasidi, Political, Social and Legal Deputy, Ministry of Women's Empowerment and Child Protection, 19/06/2015.
64 KII Christine Mester, Director of Indonesian Positive Women Network, 10/07/2015 (answers submitted in writing).
65 Iriantoni Almuna, email communication 01/11/2015.

Table 10: Summary of gender responsiveness of Thailand HIV policies and programs (Checklist 1)

Gender Responsive HIV Programmatic Intervention	Summary of all documents
Laws and Policies	Include the review of laws and policies that can affect key populations and Global Fund Concept Note includes steps towards decriminalizing key population behaviour) Do not make reference to policies on gender-based violence or violence against women Include modifications of laws for minors (NSP 2014-16)
Prevention	Include sex education but without reference to young women Do not prioritize young peoples access to condoms Do not include post-exposure prophylaxis for women Include pre-exposure prophylaxis for men who have sex with men Consider women as child-bearers (or vectors of disease) in discussing prevention of mother-to-child transmission and includes men's engagement (in NSP) but the Logical Framework Approach and the Global Fund Concept Note do not include prevention of mother-to-child transmission Encourage couples testing if woman entering services for prevention of mother-to-chid transmission is HIV+ Mixed approach on harm reduction NSP and GF CF include but no focus on female drug users
HIV Testing and Treatment	Do not recognize social and psychological barriers, especially for women, to continuous care Testing and counselling issues do not take into account a gender perspective Include provision of ART but do not mention gender related barriers Integration of HIV and AIDS treatment into general health services, but no mention of increasing access for women beyond perinatal settings
Care and Support	Do not include references to women's roles and responsibilities as primary care-givers for PLHIV
Sexual and Reproductive Health	Do not include discussion of SRHR overall, or specifically for transgender people's need in prevention of sexually transmitted infections Do not include prevention, screening and treatment for female key populations and transgender persons
Economic Empowerment and Livelihood	Include social services and social protections for key population, but without focus on women Do not consider female key populations and women living with HIV access to resources or economic empowerment, employment, income and livelihoods
Human Rights and Gender Equality	Do not consider gender equality laws, e.g. equal property, inheritance, custody, etc. Do not include gender equality programs for men and boys, designed to change gender norms Do not make reference to GBV/VAW or include support and care for key populations experiencing violence Recognize need for training and sensitization Include access to justice and legal support, but without focus on women's needs including KP women

Even though the documents do not always highlight key areas for a gender responsive HIV response, Thailand's response to HIV has been widely applauded as one of the world's greatest success stories. The accolade is based on a medical approach to the AIDS epidemic of advocating for 100 percent condom use in sex work, providing free antiretrovirals for HIV treatment, and ensuring that women access prevention of maternal-to-child transmission services. There has, nevertheless been limited effort to change societal views and social stigma associated with HIV.

The Thai government policies criminalize drug use and sex work, and do not promote legal gender recognition laws. Anyone carrying or distributing condoms faces legal consequences and is associated with sex work. There is also no reference to laws and policies related to gender-based violence or violence against women or parental consent for SRH services in youth. The country has taken positive steps towards recognition of gender non-conforming person, and in September 2015 passed the Gender Equality Act that prohibits discrimination on the basis of sexual orientation or gender identity.[66]

Young girls, and youth in general, have limited access to sex education and prevention methods. Despite being the capital of gender affirming surgery, there is little programming for transgender persons including on sexual and reproductive health. New infections are rising in women who are married or in long-term relations, but prevention efforts do not appear to focus on gender relations.

Thailand's NASA 2013 includes some information on budget functions for gender equality such as female condoms accounting for 0.02 percent of the total budget. There are items that are noted but not accorded expenditures such as PrEP, family/home support, program to reduce GBV and AIDS programming focusing on women. Furthermore, there is no budget for changing laws and policies for decriminalizing KP behaviour or for reducing stigma and discrimination in society. Thailand's budget is largely self-financed through the national budget, and while data being collected is disaggregated by sex and age, the approach to budget planning does not include a gender perspective.

4.3.2. Enabling Environment (Checklist 2)

The opportunities and challenges facing Thailand in terms of the three categories for applying GRB to the HIV response are discussed next. In the budget planning, the favourable factors for applying GRB to the HIV response include: collection of sex and age disaggregated data and indicators and the fact that the Thai HIV budget is not donor-driven, and as much as 78 percent corresponds to the national budget.[67] But at the same time, Thailand is missing a pro-gender budget framework that establishes obligation to incorporate a gender perspective.

66 Thailand Gender Equality Act. B.E.2558 (2015). The Act was in draft at time of writing of this report and no analysis is available.

67 AIDS Zero Portal, 2013.

Table 11: Favorable GRB context Thailand

Strategic GRB Area	Summary of (un)favorable context
Budgeting framework	• No pro-gender framework and budget laws recognizing gender • Difficult to obtain budget books • No gender audit of HIV spending • Sex-disaggregated data and indicators are included • Targeted investments for equal society are specified • No engagement of parliamentarians in HIV budgeting to promote gender equality and women's empowerment • The care economy is not considered in the HIV investment • No research is undertaken from a gender perspective to inform the new fiscal year policy
Actor's Capacities	• Gender training and sensitization has been undertaken with government actors working on HIV • There are no staff in ministries responsible for gender equality and women's empowerment except for in the national women's machinery • Donor agencies are not knowledgeable in GRB for HIV
Community Participation	• No civil society engagement including women living with HIV and key populations in budget planning and formulation or in implementation and evaluation • There are no mechanisms to ensure participation

There is a need to consider the care economy and targeted investment in women's empowerment. A gender audit on HIV spending is required. Budget books and documents should be made easier for citizens to obtain and understand, especially those from key populations.

Although funds for combating HIV are predominantly domestic, funding for prevention activities in key populations comes from international donors (86 percent), mainly from the Global Fund. Therefore it would be highly worthwhile to sensitize them on GRB. The capacity and participation of Thai government actors and civil society in understanding and preparing GRB are low.

> *"Promotion for government agencies to adopt GRB will lead to accountability, [and] transparency in the allocation and distribution of budget of the country, which will lead to reduction of disparity and creation of equality in society."*
>
> **Department of Women's Affairs and Family Development, Thailand**

The Department of Women Affairs and Family Development (DWF) with support from Thammasat University developed a GRB module and through it developed capacity on GRB with Gender Focal Points in Line Ministries and Departments (a total of 133 agencies) for two consecutive years (2014-2015), including the Ministry of Public Health. In collaboration with the King Prajadhipok Institute, DWF has also developed the training course "Governance for Gender Equality, for mid-level and high-level Government Executives". This promotes GRB among executives with budgetary decision-making power, so that they will understand, promote, and apply GRB.[68]

68 Patcharee Arayakul (and her team), Director Division for the Gender Equality Promotion, Department of Women's Affairs and Family Development, Ministry of Social Development and Human Security, Indonesia (answers submitted in writing).

There is no information on civil society knowledge and capacity on GRB, but participation of females from key populations and transgender people is very low. There is no specific or formal mechanism to ensure civil society participation in HIV budget allocation, implementation, and evaluation. According to the National AIDS Management Center Director, consultation with stakeholders, particularly CSOs, including women living with HIV, is a vital part of developing the NSP. Two national umbrella organizations for HIV/AIDS are always invited to participate therein, and are requested to invite representatives from smaller organizations as well. On occasion, invitations are also sent to specific organizations to ensure the participation of sex workers and men who have sex with men.[69]

> *DWF encourages government agencies to apply GRB in their whole budget process. The Gender Focal Point of the Ministry of Public Health should now have knowledge on prioritization and allocation of budget which addresses differential needs of all groups of people, including women and children who are often in a position of care givers and are often neglected. [There] should be subsequent measures to address and relieve [the] burdens of those women and men (who are main care-givers). We hope the Ministry of Public Health will see the importance of GRB and apply it to the work on HIV.*
>
> **Department of Women's Affairs and Family Development, Thailand**

69 Taweesap, Director of the National AIDS Management Center, Department of Disease Control, Ministry of Public Health, 12/07/2015.

DISCUSSION

5

As observed throughout the GRB Step Analysis, certain areas pertaining to the gender dimension of the response, such as prevention of mother-to-child transmission, and condoms for key populations, receive more attention and budgets than other areas. Opportunities to advance gender equality in each country relate to male involvement in pregnancy and delivery, especially in Cambodia; training on gender equality issues for key actors; and harm reduction programs including females who use drugs, especially present in Indonesia; and couple's testing in Thailand.

In this analysis, it has not been possible to establish the exact amounts of gender responsive allocations or expenditures in any of the critical areas highlighted in checklist 1 on strategic HIV programs, but key strengths of gender responsiveness are highlighted in Text box 5. Further micro budget analyses are needed, and these should involve accessing more disaggregated budget data, if possible. This could include analyses of programs and project implementation documents, operational plans, and budgets.

Text box 5: Key strengths of each country in applying GRB in the HIV

Cambodia: has a generally gender responsive HIV response in terms of policy (i.e. on paper). KII reveal that government agencies and NGOs are committed to gender equality, and willing to apply GRB to the HIV response.

Indonesia: has a notably transparent and enabling general planning and budgeting environment. It also has specific regulations on GRB, which provide a favorable context for applying GRB to the HIV response.

Thailand: has significant domestic funds allocated to the HIV response, demonstrating government commitment to reversing the HIV epidemic, and an enabling environment for applying GRB to their HIV response.

Two areas, home-based care and the participation of women living with HIV and female key populations in the response, crucial for applying GRB to HIV responses, are largely absent from programming and budgeting processes. These are discussed in more detail below.

5.1 Care work

The lack of explicit recognition of women's care work (bearing, rearing and caring for family members living with HIV) as well as unaccounted forms of women's voluntary work, in planning documents (including in the National Strategic Plans and Global Fund Concept Notes) is worrying from a GRB perspective. Such voluntary work is intimately connected to care work, and is often undertaken by women. Although the policy, plans and programs include "volunteers", these documents don't explicitly recognize who these volunteers are, nor do they identify who is responsible for home-based care, and whether the care is community-based or family-based.

> *Women and girls are the main [groups] responsible for care work in Cambodia. Although this has not been recognized in previous NSPs, or in NSP III, it will be included and empathized [with] in the new NSP IV that is currently being developed.*
>
> **Lina Ngin, former Program, Monitoring and Research Department Director at NAA**

Care work by women and girls provides invisible economic contributions to the formal economy-- contributions that need to be visualized and recognized within the political sphere. The centrality of care work becomes of particular importance as the countries' HIV responses move towards community-based systems, which depend to some degree on voluntary work. The recognition will ensure that HIV responses avoid transferring the real costs of caring to these invisible caring costs and that women and girls' care work is not disproportionately increased when funds are scarce and responses must aim to "do more with less", as this may imply that women *do more for less*.

5.2 Women living with HIV, female key populations and transgender people's full participation in decision-making

Women's participation and leadership in the planning and M&E of each country's response and budget has been a persistent challenge, especially for Cambodia and Thailand. Opinions about women's capacity to influence planning and budgeting differ according to each key informant interviewed. Most government actors believe that the capacity exists and is relatively strong in women living with HIV, while CSOs believe the opposite. Previous research confirms that the participation and engagement of women living with HIV and females from key populations including transgender persons is scarce, and the building of capacity has not been prioritized lacking budget allocations.[70] It is also clear that there are no established mechanisms for women's full participation in any of the three countries.

5.3 Missing allocations

Another common issue is a lack of coherence between the situation analysis (Step 1; i.e. what is happening on the ground), policy, plans and programs (Step 2; i.e. how should this be addressed) and budgets (Step 3; i.e. how this should be changed). Issues highlighted in the situation analysis are not identified in policies, plans and programs, while other issues are included in policies but not present in plans and programs. Furthermore, the linkages between budgets and policy, plans and programs are not always consistent. Issues highlighted in the situational analysis are not assigned budgets, and for most parts budgets are gender blind. These disconnections are a matter of grave concern, since without proper budget allocations real actions and change cannot take place.

Crucial issues to highlight that are common for the three countries include:

- A predominant focus on women as child-bearers (pregnant women) or sex workers and entertainment workers as vectors of HIV within policies, plans, and/or programs. There is no regard for the preferences of, and empowerment of women themselves.
- Condom programs, and post-exposure prophylaxis programs, are gender blind and don't make any reference to unequal gendered power dynamics in sexual relationships. This lack of analysis affects violence against women and gender-based violence programs.

70 ASEAN Foundation, UN Women, UNAIDS, UNZIP the Lips Platform, et al. (2013) *Cambodia Country Brief - HIV and Key Affected Women and Girls; Indonesia Country Brief - HIV and Key Affected Women and Girls; Thailand Country Brief - HIV and Key Affected Women and Girls.*

- There is no understanding of the need to align HIV responses with laws and policies related to gender-based violence and violence against women with other gender equality laws, such as inheritance and property laws, fundamental for a gender responsive HIV response.
- The situational analyses in the areas of sexual and reproductive health and right, policies, plans, and programs highlight the needs of women and transgender women. Yet, the corresponding budgets that are developed do not always include these priorities.
- There is an absence of disaggregated information in terms of community-led anti-stigma campaigns. For example, what is the focus of such campaign, who they are led by, and whether they involve key populations and transgender women, and especially women living with HIV. This makes it impossible to assess whether these campaigns are gender responsive.

The lack of disaggregated data and the lumping together of programmatic items within the same budget function provide a challenge when reviewing budgets from a gender perspective. It has therefore not been possible to establish how much of the budget analysed in this report are actually (and truly) gender responsive.

6 RECOMMENDATIONS FOR APPLYING GRB TO HIV RESPONSE

The following section provides recommendations concerning HIV budgets so as to improve their gender responsiveness and the ability to apply GRB to the HIV response. Two urgent and immediate recommendations are:

- Data collected on results and indicators should always be disaggregated by sex, gender, and age.
- There be an agreed upon common HIV gender budget classifications, so as to facilitate the analysis of budget functions and items, as well as to compare gender responsive allocations and expenditures from year to year, or between countries.

Specific recommendations are presented according to each area of GRB analysis:

Budgeting and Planning

- Align HIV budgets to policies, plans and programs, which in turn should correspond to real situations, in order to improve the lives of women living with HIV, women in key populations and transgender people, and men while promoting gender equality within the HIV response. Gender responsive budget analyses should consider power dynamics and societal structures. For example, how do interventions support women in all their diversity, empowerment and autonomy?
- Develop specific budget regulations on how gender should be considered within the HIV budget. And prepare more detailed budget documents with further disaggregation of allocations and how they contribute to gender transformative approaches.
- Request baseline study on gender relations in budget planning guides, formats and sheets (both for international and national funds) and align actions explicitly to the country's gender equality policy (or law, if existent).
- Periodically carry out gender responsive budget analyses in order to feed into decision-making processes related to allocations and expenditures. These analyses should be carried out both by government actors and CSOs (such as shadow reports).
- Undertake a study on the economic contributions of women's care work within the HIV response, so that this will be considered in policy documents *and* budgets. Thailand provides a specific entry point for this work, and key informants mentioned that the new Cambodia NSP IV explicitly includes the care economy.
- Include specific budget functions that promote gender equality in the HIV budget catalogue and NASA report, or at least ensure these are registered in the budget narrative of these reports.

- Make HIV budget books *available and accessible* for all citizens. These should be understandable (citizens' budgets) so that they may be consulted by PLHIV with varying educational backgrounds. Budgeting should not be considered a technical or difficult subject, as it connects to governmental institutions' commitment to good governance.
- Review and consider Indonesia's general pro-GRB regulatory framework as a good example for use in the region.

Actor's capacity

All three countries have made efforts to undertake training on GRB for government personnel, but the role of civil society and women living with HIV, as 'watch-dogs', is important.

- Include CSOs' (women and key populations) capacity to apply GRB within the HIV response. CSOs' capacity to apply GRB connects to their role as watchdogs as part of a good governance agenda, enhancing transparency and accountability. Indonesia's experience with their GRB and HIV network provides a good example in this sphere.
- Increase the commitments of finance and planning ministries to apply GRB to the HIV response, and enhance collaboration and cross-linkages with ministries of health (and relevant departments working on HIV) for successful application of GRB to the HIV response.
- Develop donors' awareness and understanding of gender budgeting, so as to ensure that their planning and budget cycles become gender responsive. This is especially necessary for cases where the Global Fund is the main donor (such as Cambodia and Indonesia).

Citizen's participation

- Establish formal mechanisms on participation for women living with HIV, female key populations and transgender in all stages of the HIV response, from planning, to budgeting, and monitoring and evaluation.
- Increase women's budget participation by taking advantage of already established budget mechanisms within the countries, e.g. local participatory budget mechanisms such as *Musrenbang* in Indonesia.
- Consider the care economy and women's share therein as a possible obstacle to their full participation in the public sphere and in all stages of the HIV response.
- Ensure that the prioritization of certain elements, such as prevention of maternal-to-child transmission, sexual and reproductive health rights, and human rights programs, in light of scarce resources, is discussed and agreed upon with the people most affected by the HIV epidemic, such as women living with HIV, females in key populations and transgender people.

Annex 1: Main GRB tools and methodologies, and their application to the HIV response

Applying GRB to the HIV response entails:

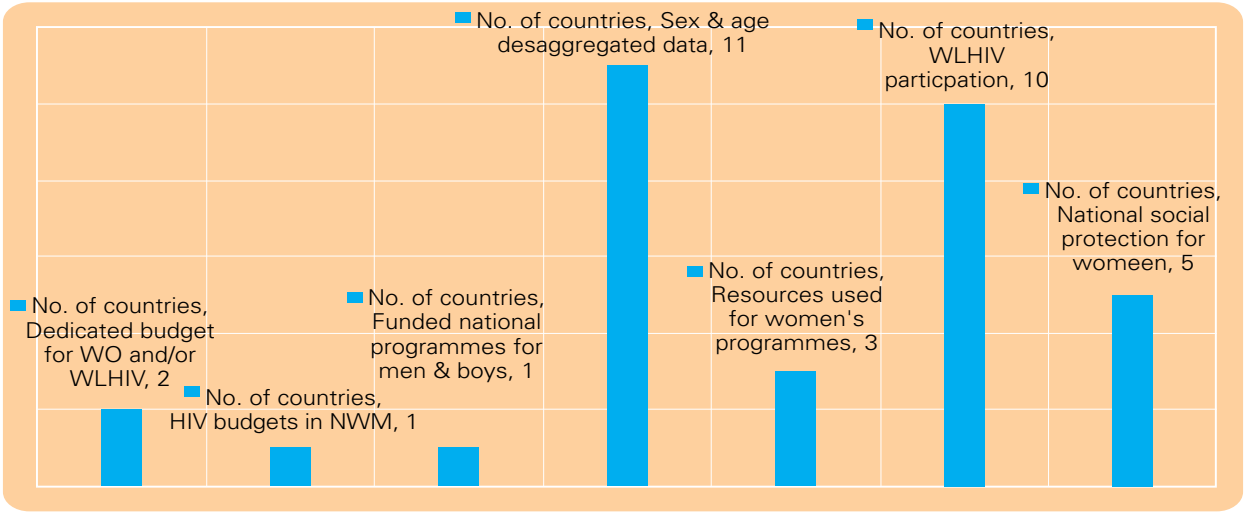
- Recognizing that gender equality commitments must be resourced;
- Tracking how HIV budgets respond to gender equality and women's empowerment (GEWE) by analysing budget revenues, allocation and expenditure;
- Examining budget systems and process, as well as the roles of various actors throughout this process, and ensuring the equal participation and voice of women, men and transgender people in all their diversity; and
- Making available mechanisms, guidelines, data, and indicators that enable gender equality advocates to track progress, benefit incidence, and show how budgets affect women, men and transgender people.

Tools and methodologies	Experiences:
Budlender's Five-Step Approach Gender Responsive Policy Appraisal	These two tools have been used for assessing **Rwanda**'s HIV response. A main barrier for GRB of the HIV response in this country was the existence of two separate NSPs: one on HIV in general and a specific one on gender and HIV. Having two separate NSPs has created practical implementation issues, even though their aim is good in theory. Even more fundamentally, this has put into question the fundamental role gender equality plays in the HIV response in general (UNAIDS, 2013d, UN Women 2013). The tools have also been used in: • **Papua New Guinea** to review the gender dimension of donors' HIV policies, investments in the national HIV response, and the mechanisms through which these resources are allocated. • **India**, where a gender analysis of the HIV/AIDS policies and budgets revealed the budget has not been disaggregated in a detailed way, e.g. to distinguish, for example, income and nutritional support for WLHIV. • **Jamaica**, where a review of the gender dimensions of HIV policies and programs was carried out in 2012. • **South Africa**, where a review of HIV policies and programs and their budget allocations was conducted, including a specific focus on allocations for women and children. • **Kenya**, where a review of the country's NSP and associated budget allocations was undertaken from a gender perspective (UNFPA, 2009). • **Argentina, Chile, Ecuador, Mexico and Nicaragua**, where a three step analysis was carried out in each of the five countries – situation analysis, policies and budget allocations. In some cases, expenditures were also included (FUNDAR, 2004).
Sex-disaggregated Beneficiary assessment	A monitoring tool on access to care, treatment and support, SRHR, and VAW created by and for HIV positive women, and including budget allocations. It has been used in **Swaziland, Lesotho, South Africa, Uganda, Namibia, Mozambique, Kenya, Botswana** and **Tanzania**. The advantage of this tool is that it focuses on women living with HIV opinions and attitudes concerning HIV programming (ICW, 2008).
Sex-disaggregated public expenditure incidence analysis	No specific example on the use of this tool has been found. However, this tool can be useful within the "investment framework for the HIV response" developed by UNAIDS (which has been criticized for not recognizing the fundamental role gender plays in the HIV response).
Revenue incidence analysis	In **India**, studies regarding HIV/AIDS and gender budgeting have been carried out by Aasha Kapur Mehta (2007). These have revealed, for example, the implications of user fees in ARV. As women have lower-income generating jobs than men, in general, user fees affect women more. Furthermore, since many WLHIV are also widows, they are often the main (and only) income-generating source in their households, making these households even more acutely affected by user fees.
Impact analysis on time use	Many studies have shown the impact HIV/AIDS has on women's time use (for example, in **India** and **East Africa**). Due to gender roles, women are primarily responsible for caring (including all kind of care-work) for PLHIV, diminishing their free time for participating in remunerated work, politics, community activities, etc. Within this context, it is important to highlight how budget allocations towards care and support are spent, how care is seen within the HIV response, and how governments can "save" or re-allocate funds by transferring care-costs to women's invisible and non-remunerated care-economy.

Tools and methodologies	Experiences:
Gender responsive medium term economic policy framework	This tool goes beyond the analysis of impact by focusing on the medium term budget process, and includes good governance issues such as participation, recognizing people not only as beneficiaries, but also as agents of development. In the HIV response, this would include inviting WLHIV or affected by HIV (as well as other PLHIV) to participate in the MTEF.
Gender responsive budget statement	GBS for HIV/AIDS has been developed in: **Rwanda**, which drafted a GBS that is still to be implemented. The Rwanda Biomedical Center/ IHDPC has proposed to introduce a GBS to all actors involved in the HIV response as a mandatory tool to undertake gender gap analysis, and identify and address these gaps in budgets. **India**, where the GBS, which is released as part of the overall budget, considers budget allocation to the HIV/AIDS budget.
Rhonda Sharp's three expenditure categories	These categories offer a way to classify the expenditures, once you have the budget documents/book in your hand. It has often been used to analyse how gender responsive the complete governmental budget is. It can also be used to analyse sectoral budgets, or offer ways to further classify expenditures within these.
The Bolivian categories	
The Andean methodology	In **Cambodia**, the capacity of the National AIDS Authority and the Ministry of Women's Affairs to ensure gender responsive HIV allocations was assessed. This assessment included the institutional capacity for GRBP, pre-existing conditions for GRBP, actors within the HIV response, the processes and mechanisms for budget allocations and tracking. **Rwanda** published a manual for GRB in HIV/AIDS operational and costed plans. It provides guidelines for how to conduct a GRB analysis using a 6-step analytical tool (UN Women, 2012).

Progress by countries in the region in providing a favourable context for GRB in the HIV response has been limited to the collection of sex- and age-disaggregated data. Significantly less advancement is seen with regard to actual budget allocations and expenditure for GEWE within the HIV response. The graph below offers a summary of UNAIDS Scorecard (2013)[71], illustrating the advancement of countries in the region in establishing such a context for GRB in the HIV response.

Figure 2. Advancements in establishing a favourable context for GRB in the HIV response in Asia-Pacific



71 UNAIDS Scorecard 2013 (unpublished).

Annex 2: Checklist 1 and 2 Questions

Checklist 1 and its accompanying questions review if HIV prevention, care, and treatment services are gender responsive. The key areas selected have been identified through an analysis of the *WHO Consolidated Guidelines on HIV Prevention, Diagnosis and Treatment and Care for Key Populations* (2014), as well as *UNAIDS Key Programs to Reduce Stigma and Discrimination and Increase Access to Justice in National HIV Responses*.

Checklist 1: Gender Responsive HIV Prevention, Care and Treatment Services

(Highlighted questions were not addressed and are suggested for future consideration.)

Programmatic Area	Intervention	Questions related to specific services? Or programmatic response?
Law and Policy	Key Populations	1. Is there a review of laws and policies, and how these can positively or negatively affect key populations?
		1.1. Is the situation of women, girls, and transgender women highlighted in this review?
		2. Are steps taken to decriminalize the behaviour of key populations?
		3. Do HIV policies have principles of engagement and empowerment of key populations, and PLHIV?
		3.1. Is the engagement of women and girls promoted?
		4. Are policies on violence against women and gender based violence referenced in HIV policies.
	Youth	5. Is there an age of consent for adolescents and young people to access needed health and HIV services?
	International Treaties and Policies	6. Is there a reference to international human rights law or policies on gender equality?
		7. Is there a reference to international guidance on gender equality and human rights of women and key populations?
Prevention	Condoms	8. Is comprehensive condom and lubricant programming included in policy?
		8.1. Are women and girls prioritized in these programs?
		9. Are sexual health education and awareness programs such as the Comprehensive Sexuality Education Program provided for young people and adolescents, especially young girls?
		10. Is there a focus on empowering adolescents and young persons, especially young girls, through life-skills based education, awareness and other skills building programs?
	PMTCT	11. Are PMTCT services available and accessible for all women, including female key populations (drug users, sex workers, migrants)?
		12. Is earlier attendance of antenatal care by pregnant female key populations promoted and supported including addressing gender-related barriers?
		13. Is postnatal care (PNC) for HIV+ mothers included, e.g. continued ART/ARV as well as breastfeeding and nutritional information?
		14. Does PMTCT include male engagement as a strategy in PMTCT response?
		15. Is PMTCT for enhancing women's mobilization, awareness and outreach included in the response?
		16. Are there referral linkages or integrated SRHR or GBV services for women who come to PMTCT services?
	Community-led prevention services	17. Are women and girls participating in a meaningful in prevention services?
		17.1. Are key populations, especially women, girls and transgender women, participating in design, implementation and evaluation?

Programmatic Area	Intervention	Questions related to specific services? Or programmatic response?
Prevention	P(r)EP	18. Is PEP available and accessible?
		18.1. Are women and girls especially targeted for PEP interventions?
		19. Is PrEP available and accessible?
		19.1. Are key populations, especially women, girls and transgender women, being targeted?
	Harm Reduction Services	20. Are there harm reduction programs for people who inject drugs?
		21. Do these programs explicitly consider gender, particularly the exposure of women who inject drugs to HIV and gender related barriers in accessing these services?
		22. Are gender responsive harm reductions services offered in closed settings?
HIV Testing and Treatment	Testing and Counseling	23. Is voluntary HTC offered to all key populations, both in the community and in clinical settings, especially focusing on women and girls?
		24. Does such HTC include young girls and boys?
		25. Does HTC emphasize the 5 Cs of HTC: consent, confidentiality, counselling, correct results and linkage to care?
		26. Is couple's counselling and testing promoted?
		27. Are social and psychological barriers connected to continuous care, especially for females, recognized?
		28. Is community engaged in developing and monitoring testing protocols?
		28.1. Is there community-led testing?
	Treatment	29. Is ART provided to all PLHIV and are gender-related barriers noted and addressed?
		30. Are HIV/AIDS treatment services integrated into the general health services, so as to avoid stigma and discrimination?
HIV Testing and Treatment	Treatment	31. Are interventions that increase women's access to HIV treatment outside the perinatal setting included?
		32. Is there access to routine viral load testing for women living with HIV, especially those in key populations?
	Co-morbidities (excluding STI)	33. Is there screening for HIV co-morbidities such as tuberculosis, hepatitis, and other infections for women and girls from key populations?
		33.1. Is there accessible treatment available for these co-morbidities?
Care and Support	Psycho-social support (Gender based violence)	34. Are there programs (including those led by community itself) providing counseling to HIV positive women, girls, and transgender women?
		35. Is there a connection between GBV and HIV-related services that is included in HIV plans?
		36. Is prevention of violence against key populations, especially female sex workers, female drug users and transgender women) and women living with HIV included in HIV planning?
		37. Is support and care for key populations experiencing violence provided, especially focusing on women and girls?
	Orphans	38. Is there financial or social support for HIV positive orphans and vulnerable children, especially adolescent girls?
	Contribution & Compensation	39. Are there programs recognizing and supporting women and girls in care of HIV positive family members?
		40. Is the mutual/shared responsibility of women and girls included?
Sexual and Reproductive Health	Family Planning	41. Is there information and counseling available on family planning for women living with HIV or women and girls in key populations?
		41.1. Is engagement of husbands or intimate partners in family planning included as a key program strategy?
		42. Are contraceptive methods provided free or at subsidized costs?

Programmatic Area	Intervention	Questions related to specific services? Or programmatic response?
Sexual and Reproductive Health	Family Planning	43. Are HIV and SRH services integrated, or at least, is there some strong referral linkages between SRH and HIV services, particularly for women and girls?
		44. Are conception, pregnancy, childbirth and breastfeeding information and services provided for all key populations?
		44.1. Do these specifically prioritize female key populations, including WLHIV?
		45. Is safe termination of a pregnancy included in the package of services?
		45.1. Is post-termination care included?
	STI testing and treatment	46. Are sexually transmitted infections (STI) prevention, screening and treatment for females in key populations and transgender persons included?
		47. Is cervical cancer screening and treatment included?
	Knowledge of SRH	48. Are there programs for empowering women and girls on SRH related decision-making?
		49. Is information on conception, pregnancy, childbirth and breastfeeding and HIV provided for to women and girls including those in key populations?
		50. Are there programs on social norm changes related to sexual reproductive health and rights such as engaging religious leaders, male head of the family, local community leaders that promote active participation of women and girls?
	Transgender persons	51. Are the specific SRHR needs of transgender persons prioritized and addressed?
		52. Are HIV positive transgender persons informed about sexual health and wellbeing?
Economic Empowerment and Social Protections	Employment and livelihood	53. Is economic empowerment included, specifically targeting women living with and affected by HIV and transgender persons?
		54. Is employment, income and livelihood support, especially targeting women living with HIV and transgender persons included?
	Social protection	55. Do women living with HIV and women in key populations have access to social services and social protection mechanisms (e.g. cash transfers and micro-finance)?
		56. Are there any programs on food assistance, material or financial support for shelter, particularly for female-headed HIV households and transgender persons?
Human Rights and Gender Equality	Legal rights and literacy	57. Are there legal services available for violations of gender equality laws such as laws and policies on intimate partner violence, equal access to property, inheritance and custody, etc?
		57.1 Is access to justice and legal support services provided for women and girls, including those in key populations?
		58. Are gender equity programs for men and boys, including those geared towards changing gender norms, highlighted?
		59. Are communities working on legal literacy programs, 'know your rights'?
	Stigma and discrimination	60. Are community led anti-stigma campaigns, media advocacy, etc. included in programme plans?
		60.1. Are these programmes led by women and targeted to end intersecting stigma and discrimination including violence against women and girls?
		61. Are key populations friendly (free of stigma and discrimination) health services promoted?
		62.1. Is there a specific focus on women and girls and transgender women in these health services?

Programmatic Area	Intervention	Questions related to specific services? Or programmatic response?
Human Rights and Gender Equality	Stigma and discrimination	62. Is training/sensitization and partnership with health workers on gender and women's/girl's issues and rights is implemented?
		63. Is training/sensitization and partnership with social workers and local leaders on gender and women's/girl's issues included in policy and plans?
		64. Is training/sensitization and partnership with the justice system, including law enforcement and lawmakers, on gender and women's/girl's issues included in policy and plans?
	Gender-based violence	65. Do HIV programs address intimate partner violence (IPV)?
		66. Are HIV service providers trained in to handle and counsel persons experiencing IPV?
		67. Are there any services (such as safe spaces, shelters, hotlines, counseling for persons who experience GBV and also referral to health services?

Checklist 2 and its accompanying questions review if HIV investments are using gender lens on budgetary allocations. It is based on various research related to GRB including *Engendering Budgets: A Practitioners' Guide to Understanding and Implementing Gender-Responsive Budgets* by Debbie Budlender and Guy Hewitt and UNFPA-UNIFEM training tools: *Gender Responsive Budgeting and Women's Reproductive Rights: A Resource Pack* and *Gender Responsive Budgeting in Practice: a Training Manual*, as well as *Adjusting the Lens: fiscal policies from a gender perspective* by Raquel Coello.

Note: **Checklist 2: GRB and HIV Investment**

Strategic GRB area	Questions related to a favourable GRB context	
Budgeting (planning, implementation and evaluation)	1. Has HIV policy and budget research from a gender perspective been undertaken (that can feed into new FY and analysis)?	
	2. Is there a pro-gender budget framework in the country, such as a budget law explicitly recognizing gender?	
	3. Do any regulations exist that establish the obligation to incorporate gender in budgeting?	
	4. Is the care-economy considered in the HIV investment?	
	5. Are gender budget statements for HIV developed?	
	6. Do the guides, formats and sheets used for budget planning (including those of donors) allow for the incorporation of gender?	6.1 Is there a baseline study, which takes gender into consideration requested?
		6.2 Are gender responsive objectives and/or results included?
		6.3 Are sex-disaggregated data/indicators included?
		6.4 Are specific actions to advance gender included?
		6.5 Are actions that explicitly align to the national Gender Equality Plan requested?
		6.6 Is information on the investment's impact on time use requested?

Strategic GRB area	Questions related to a favourable GRB context	
Budgeting (planning, implementation and evaluation)	7. Are there specific budget functions in the budget catalogue that promote gender equality?	7.1 Do the functions to be included and monitored target investments for women's empowerment and capacity development?
		7.2 Are there targeted investments for an equal society?
		7.3 Are there targeted investments to promote social and public co-responsibility for reproduction?
	8. Are there actions with parliamentarians involved in HIV budgeting to promote human rights and gender equality?	
	9. Are budget books and documents related to HIV easy to obtain?	
	10. Are budget books and documents related to HIV easy for citizens to understand?	
	11. Are there gender audits of HIV spending?	
Capacities	12. Has gender training and sensitization, including GRB, been undertaken with government actors working on HIV?	
	13. Has gender training and sensitization, including GRB, been undertaken with civil society actors working on HIV?	
	14. Are there staff/personnel responsible for gender equality within National AIDS Authority (NAA) and/or Ministry of Health (MoH)?	
	15. Are there staff/personnel responsible for HIV within the national women's machinery (NWM)?	
	16. Do the NWM and agency responsible for HIV, including MoH, coordinate and collaborate in all stages of the response (planning, implementation, evaluation)?	
	17. Are donor agencies involved in the HIV investment knowledgeable in GRB?	
Participation	18. Are there mechanisms to ensure key populations', especially female key populations', participation in the planning stage of the response?	
	19. Do HIV policies include principles of engagement for women, girls and key populations?	
	20. Are key populations, including women, involved in budget planning and formulation?	
	21. Are there mechanisms to ensure key populations', especially female key populations, participation in the budget implementation and evaluation?	
	22. Are KP, including women, involved in budget implementation and evaluation?	
	23. Are there laws that criminalize behaviour of key populations?	
	24. Has the state signed and ratified international or regional treaties on gender equality and human rights?	
	25. Are policies on violence against women and gender-based violence referenced in the HIV policies and/or included in general policies?	
	26. Are there policies or guidelines on the age of consent for adolescents and young people to access HIV prevention services?	
	27. Is there a favourable legal framework for harm reduction?	

Annex 3: Key informant interview questions

Key Informant Guiding Interview Questions

The aim of the interview is to:

- Gather qualitative perspectives on existing methodologies/tools being used by countries on gender responsive budgeting (GRB) of the HIV response, and look for opportunities, challenges, and any other issues including country level future actions which can further help enrich/validate the finding and analysis and formulate recommendations.
- Gather missing information/budget details and any other relevant documents, which have been difficult to access.

Gender responsive budgeting (GRB) is budgeting that integrates a gender perspective and tracks how budgets respond to gender equality and women's rights requirements. This entails examining not only budget allocations and revenue raising measures, but also budget systems, budget processes, and roles of various actors throughout the process. It also entails investing in making available mechanisms, guidelines, data, and indicators that enable gender equality advocates to track progress, benefit incidence, and show how supposedly gender-neutral budgets impact women.

Warm-up question

1. Let the KI present her/himself.
2. Please explain your institutions' view on what GRB is?
    - What approach is your institution pursuing to GRB?
    - What are the priorities?

Guiding questions

- Ask for key documents and budgets not yet obtained.
- Has your country used any GRB tools or methodologies for HIV planning and budgeting? (national and/or sub-national levels)
    - Please explain
- Have any previous reports, research or other knowledge product been produced on HIV and GRB?
- Are there any legislation, policies or guidelines to address gender equality and women's empowerment (GEWE) within HIV planning and budgeting, or in general? Give examples if necessary, such as:
    - *Use and presentation of sex-disaggregated data*
    - *Including or consulting national women's machinery and/or any mandated body on overall budget priorities and allocations*
    - *Translating priority actions or specific missions regarding GEWE within HIV into budgetary programs.*
    - *Conducting gender responsive policy evaluations and/or policy and expenditure reviews.*
    - *Specifying % of budgetary allocations targeting gender specific, gender equality focused measures. If so, are there any guidelines accompanying these measures?*
    - *Performance audits and budget reporting formats and/or performance measures*

- *Reporting to parliament, parliamentary sub committees on any of these above listed exercises*

- Are there technical staff at NAM and/or MoH (and/or other important agency for the national HIV response) that are:
  - ✓ Dedicated to GEWE?
  - ✓ Knowledgeable about GRB?
    i. Do they have any influence over budgeting (planning, implementation, audit)
    ii. What is their role in budgeting (planning, implementation, audit)
- Do any formal or informal mechanisms exist for public participation throughout the HIV planning and budget cycle, either at the national or at the sub-national (commune) level?

HIV PLANNING AND BUDGET CYCLE:	MECHANISMS:
Formulation	
Approval	
Implementation	
Audit – evaluation	

- Do these mechanisms ensure equal participation of women and men, as well as women and men living with HIV and other key populations?
- What are the possibilities for women and girls living with HIV and other female key populations to influence:
  - ✓ Planning
  - ✓ Budgeting?
  - What are your perceptions of their capacity to influence the budget?
- Has the home-based care component in your HIV response taken into consideration women and men's responsibilities related to care-work?
  - How?
- Do you know or have any numbers on budget allocations (and expenditures) for GEWE within the HIV response?
  - Are these allocations domestic or foreign?
  - Did the costing of your HIV response include a gender dimension?
    i. In what way?
- Within the national HIV budget, are there any allocations to women's organizations, and especially WLHIV and/or key population organizations?
- How are budget statements developed in your country? Are gender issues taken into consideration and if yes, how?

- How are audits on spending of HIV budgeting carried out?
    - Are there any audits of spending related to GEWE within the HIV response?
- Does your macroeconomic and fiscal policy-framework recognize women and men's different roles and responsibility in society (and in the informal/ formal economy, as well as remunerated and non-remunerated work)? If yes, how?
- How easy is it /is it possible to access budget documents/books on HIV allocations and expenditures?
    - How easy is it for CSO to access these documents?
- What role does the NWM play in the country's HIV response?
    - Which department in NWM is primarily responsible for HIV? Do other departments also have a role? How does coordination across departments on HIV issues take place?
- How do you track budget expenditures and achievements of results?
    - Do these mechanisms/tools provide you the possibility to track benefits, effects and impacts on women and men at different levels?
- What strengths and limitations do you see in applying GRB to the HIV response in your country?

UN Women Regional Office
for Asia and the Pacific
United Nations Building, 5th Floor.
Rajdamnern Nok Avenue
Bangkok 10200, Thailand
Tel: +66 2 288-2093
Fax: +66 2 280-603

http://asiapacific.unwomen.org

@unwomenasia

@unwomenasia