STUDY FINDS A MAJOR GAP BETWEEN POLICY AND PRACTICE IN EFFORTS BY THE GLOBAL FUND TO ADDRESS GENDER INEQUALITY

"The Global Fund's gender strategy is strong in its commitment to addressing gender inequalities that fuel the HIV epidemic (with a focus on women and girls), yet evaluation of its implementation and monitoring indicators suggests a major gap between policy intent and practice with too few grant agreements found to specify, fund or monitor gender-sensitive or transformative activities."

This is one of the findings of an analysis of 18 "global public private partnerships for health (GPPPH)" conducted by Sarah Hawkes, of the Institute for Global Health, University College, London, and two co-authors. A report on the results of the analysis was published in the journal Globalization and Health on 12 May 2017.

The authors define GPPPH as "global institutions with a formal governance mechanism which includes both public and private for-profit sector actors." In addition to the Global Fund, the 18 partnerships that were part of the study included, among others, Gavi, the Stop TB Partnership and Roll Back Malaria.

The authors stated that the majority of GPPPH are gender blind in their approach to health and lack simple mechanisms for enhancing gender accountability. They identified three notable omissions and gaps to gender transformative global health policies and programs, as follows:

1. The vast majority of partnerships are governed by boards with unequal gender ratios.
2. The majority of GPPPH fail to report or publish sex-disaggregated data on the coverage, outcomes or impact of the programs they fund.
3. The gender-related work of the GPPPH is, for the most part, narrowly focused on maternal health,

child health and communicable/infectious diseases.

(See section below on gender ratios on the Global Fund Board.)

With respect to disaggregated data, the authors said that where gender-specific outcomes are reported, they are largely restricted to presenting what percentage of beneficiaries are women and girls.

"Such a view is not only limiting, but may be counterproductive to tackling the underlying determinants of the global burden of disease," the authors said. "Sex and age data disaggregation on risk exposure, prevention and treatment coverage and outcomes are essential for understanding ill health, ensuring investments are reaching those with highest need, and monitoring impact – including impact on reducing gender-based gaps in coverage and outcomes."

The authors said that such information is vital to the work of ensuring that no one is left behind in global health. For example, they said (citing a study in The Lancet), a systematic analysis of global incidence and mortality associated with HIV, TB and malaria over more than two decades found that mortality rates were higher in males than females for all three infections, while incidence rates were higher in females for malaria, higher in men for TB, and approximately equal for HIV. A gendered interpretation of this picture, the authors said, may conclude that programs concerned with gender norms around treatment seeking and health care coverage will need to include a focus on higher mortality rates in men (as an indicator of lower access to care). However, among the partnerships studied, they said, only Stop TB seems to be concerned with this dimension of gender.

"Holding GPPPH to account for gender and health outcomes means, at a minimum, having up-to-date sex disaggregated data on coverage and outcomes," the authors stated.

Regarding the focus of work, the authors said that the GPPPH had largely failed to address the highest burdens of disease which, they said, was non-communicable diseases and violence and injuries. In the opinion of the authors, this represents a failure to recognize "the gendered nature of health risks and suffering." This lack of attention, they said, "echoes the wider criticism of GPPPH that the business-orientation endorsed by them has a bias for 'safe issues' and narrow technical or 'magic bullet' approaches over tackling structural and more complex upstream determinants, including gender power relations."

The authors concluded that the GPPPH need to become more serious about how they "do gender."

"It is not sufficient to mention girls and women in advocacy documents," the authors stated. "Instead, a relational perspective on gender needs to be mainstreamed through [the organizations'] regular activities, deliverables and systems of accountability." From boardroom to delivery of and access to health services, gender needs to be fully taken into account, they said.

Gender ratios on the Global Fund Board

Currently, on the Global Fund's 26-member Board, there are 17 men and nine women. Among the 23 alternates, 11 are men and 12 are women. The Board has not established a goal with respect to gender representation on the Board. The Global Fund's Gender Equality Strategy states that achieving a gender balance in membership of the Board (and its committees) is challenging because of the representative nature of the Board.

The study in The Lancet mentioned in this article is available here (see "Global, regional, and national incidence and mortality for HIV, tuberculosis, and malaria during 1990–2013: a systematic analysis for the Global Burden of Disease Study 2013.")

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