Missing in Action:

COVID-19 Response Funding for Gender-Based Violence (GBV) and Sexual and Reproductive Health (SRHR) in Five Countries

The COVID-19 pandemic has contributed to skyrocketing gender-based violence (GBV) rates and reduced access to GBV prevention and response services and sexual and reproductive health and rights (SRHR) services. Countries reliant on foreign aid to fund some or all of these services face growing funding gaps for GBV and SRHR programming. As donor agencies redirect regular development and humanitarian aid budgets to COVID-19 response, GBV and SRHR programs have been pushed to the back of the queue. In 2020, GBV funding only accounted for $55.12 million out of $26.7 Trillion in COVID-19 response funding opportunities.[1] SRHR is not coded separately from other health sector funding in key global funding databases, making funding amounts impossible to track.

This rapid assessment[2] looks at international funding streams for GBV and SRHR programs between January and July 2020 in five countries: Colombia, Kenya, Nigeria, South Africa, and Uganda. It is part of a larger Columbia University study of the impact of the pandemic on GBV and SRHR services in these countries and the United States, conducted in collaboration with researchers in each country. The study uses self-reported data from multilateral and bilateral donors and private foundations, as well as interviews with donors and service providers.

KEY FINDINGS

International Financial Institutions (IFIs) were the largest source of COVID response financing but earmarked almost no funding for GBV or SRHR.

The IMF, World Bank, and African Development Bank extended $11.74 billion in COVID-19 response funding to the five countries. Only one World Bank project earmarked GBV or SRHR funds, a mere $235,000 for combined GBV programs and support to COVID-19 survivors in Uganda. Nigeria received some World Bank non-COVID health funding during this period but this financing did not earmark GBV or SRHR.

UN-led COVID-19 country appeals rarely earmarked GBV and SRHR projects and those projects did not appear to attract significant funding.

All five country appeals highlighted GBV and SRHR risks and vulnerable populations but included few projects that prioritized this work and no public tracking of funding toward these projects. Where more detailed project information was publicly available, it rarely disaggregated GBV and SRHR programming costs from other programming. In Nigeria projects with a clear GBV focus accounted for only 0.3% of the $1.08B revised Humanitarian Response Plan appeal; in Colombia, only 0.5% of the amended $284M COVID Response; and in Kenya, only 0.7% of $259.9M Emergency Appeal. In Uganda GBV and SRHR projects together accounted for less than 3% of $316.4M Emergency Appeal and in South Africa, less than 7% of the $136M Emergency Appeal.

The EU and most bilateral donors were slow to earmark new GBV and SRHR funding.

The EU's April Team Europe agreement required member states to fund their COVID-19 response out of existing budgets, creating pressure to scale back regular development programming. Canada delayed its first round of awards under its new flagship global SRHR program and then appeared to scale back its commitment.

[1]See the Devex COVID-19 funding tracker
https://public.tableau.com/profile/devexdevdata#!/vizhome/COVIDFundingvisualisation/COVID-19funding_dynamic

[2]This study was conducted by Terry McGovern and Clarisa Bencomo, Program on Global Health Justice and Governance, Mailman School of Public Health Columbia University, with support from the Ford Foundation.

KEY FINDINGS (continued)

The Global Fund for HIV, TB, and Malaria was the largest source of potential new SRHR funding through its COVID-19 Response Mechanism.

The Mechanism provided new funding to address the pandemic's impact on existing HIV, TB, and Malaria programs and a new flexible funding policy allowed up to 5 percent of unexpended existing allocations to be reprogrammed to COVID-19 response. Nigeria was the largest recipient globally, receiving $19.5 million in new funds. South Africa received $13.6 million; Kenya received $11 million; Uganda received $4.75 million; and Columbia received $807,000. Countries can choose how to allocate these funds across programs so the net impact on funds for HIV is not yet clear.

Private foundations earmarked almost no funding for GBV or SRHR in their COVID-19 responses.

Most GBV funding during this period was a mix of COVID-19 and non-COVID support, with the Ford Foundation emerging as a leading donor, followed by the Global Fund for Women and American Jewish World Services. The Bill and Melinda Gates Foundation led in SRHR funding, continuing its maternal health and HIV programming and adding affected populations to its new vaccine grantmaking. In South Africa, the Other Foundation was notable for its support of GBV work with LGBTQI communities.

GBV and SRHR programming lost ground within UN agencies.

UNFPA and UN Women, the two agencies with the clearest GBV and SRHR mandates, reported virtually no new external funding during this period and only modest transfers from pooled funds. UNICEF, IOM, and UNHCR all report significant new funding during this period, but self-reported almost no GBV or SRHR programming. In Uganda, UNICEF reduced GBV goals and indicators in its new country strategy.

Lack of clarity over essential GBV and SRHR services and limited transparency around COVID-19 funding reduced accountability for delivering on GBV and SRHR services.

Donors and recipient governments were slow to specify GBV and SRHR services as essential and to clarify what these services included. Failure to earmark and disaggregate funding for GBV and SRHR and to publish progress against clearly and consistently applied indicators in UN-led country appeals, pooled COVID-19 response funds, and donor funding self-reporting reduced accountability for how funding was allocated and spent.

WAYS FORWARD

Governments, UN agencies, IFIs, and donors should earmark funds for comprehensive GBV and SRHR services in all emergency response plans. At a minimum, these plans should

- **specify what these services include and who is responsible at all stages of the referral and care chain**
- **take concrete steps to anticipate and mitigate the impact of stay-at-home orders on SRHR services and GBV prevention and response**
- **be accessible to hard-to-reach and stigmatized people such as those in rural areas or without internet access, adolescents, sex workers, displaced people, LGBTQI people, and people with disabilities**
- **engage GBV and SRHR service providers in plan design, build on their innovations, and strengthen their ability to safely deliver services at the community level, coordinate with other parts of the referral and care chain, and monitor and adjust to emerging opportunities and constraints**

Donors and IFIs should improve transparency and accountability by **earmarking longer term, flexible funding for GBV and SRHR and providing timely public reporting** on disaggregated funding amounts, recipients, and impact indicators.