Background: The board of the Global Fund to Fight AIDS, TB and Malaria at its 16th meeting in Kunming, China in November 2007 recognized the importance of addressing gender issues, with a particular focus on the vulnerabilities of women and girls and sexual minorities, in the fight against the three diseases. It therefore decided that for applicants should be encouraged “to submit proposals that address gender issues, with reference to the vulnerability of women and girls and sexual minorities.”

This brief provides technical information to support proposals to improve the access to and quality of HIV prevention, treatment and care programmes for women and girls through approaches that address gender inequalities. HIV/AIDS programming issues related to sexual and reproductive health and prevention of mother-to-child transmission of HIV are covered in separate technical briefs referenced at the end of this document.

Rationale for addressing gender inequalities in the proposal

Women constitute a majority (60%) of adults living with HIV in sub-Saharan Africa, and in several countries of this region young women (15–24 years) are three to four times more likely to be infected than men in the same age group. Young women consistently have lower comprehensive knowledge about HIV/AIDS than young men. Rates of infection in women are rising in the Caribbean, Latin America, Asia, and Eastern Europe including among female sex workers and injecting drug users (IDU), and female partners of clients of commercial sex, IDU and men who have sex with men (MSM). In many countries, a significant proportion of women are infected in the context of marriage. Addressing spousal transmission and discordant couples are important challenges for HIV prevention, treatment and care programmes.

There is strong evidence that gender inequalities increase vulnerability of women and girls to HIV, compromise the effectiveness of HIV prevention strategies, and create barriers to effective HIV treatment and care. Addressing gender inequalities can contribute to improved uptake and quality of HIV/AIDS programmes and services, and create an enabling environment to support individual behaviour change and risk-reduction.

Elements to be considered in the situation analysis

Effective programming for women and girls must be based on understanding the local cultural and social contexts of the AIDS epidemic in the country, and adapting HIV strategies and programmes accordingly. Recognizing the unique nature of every country context, the following are key elements in conducting a gender analysis of women and girls’ vulnerability to HIV/AIDS. These considerations are important whether the local epidemic is concentrated or generalized.
| 1. Harmful gender norms and practices: Gender norms refer to learned and evolving beliefs and customs in a society that define what is “socially acceptable” in terms of roles, behaviours and status for both men and women. In many places, gender norms related to masculinity allow men to have more sexual partners than women, and encourage older men to have sexual relations with much younger women. Norms related to early marriage and femininity prevent women and girls from having control over their own bodies and a say in sexual and reproductive decisions. This can prevent women and girls from accessing HIV information and services and from negotiating safer sex with their partners. In some places, traditional practices such as "widow inheritance" and "dry sex" can increase women's vulnerability to and risk of HIV. | Operations research in 3 countries shows that social norms related to masculinity influence sexual risk taking behaviours of young men. **Involving Young Men in HIV Prevention Programs** Operations research on gender-based approaches in Brazil, Thailand, and India. **Horizons Report, Washington DC:** The Population Council, December 2004. |
| 2. Violence against women: Violence (physical, sexual and emotional) increases their vulnerability to HIV in several ways: forced sex can contribute to HIV transmission due to tears and lacerations resulting from the use of force; violence or fear of violence can prevent women from asking their partners to use condoms or refusing unwanted sex, and from learning and/or sharing their HIV status if the results turn out positive. Some women living with HIV may also experience violence as a consequence of disclosing their status. | Globally, between 29 and 62% of women have experienced intimate partner violence including sexual abuse by a partner. **WHO Multi-country Study on Women's Health and Domestic Violence against Women. World Health Organization Geneva:** Switzerland, 2005 |
| 3. Barriers in access to services: Women and girls face many barriers in accessing HIV/AIDS information and services, including: limited mobility and autonomy in making health decisions; prioritization of health needs of male family members and children over their own; lack of access to economic resources; child-care and care giving responsibilities; and, a culture of silence related to sexual and reproductive health, including HIV/AIDS. | DHS data from several countries shows that many women (ranging from 7 to 62%) require permission from husbands to travel outside their homes. **The United Nations Children's Fund (UNICEF). The state of the world's children 2007: Women and children, the double dividend of gender equality. New York:** UNICEF; 2006. |
| 4. Burden of care: Women assume the major share of care giving in the family including for those living with and affected by HIV. This is often unpaid, unsupported and is based on the assumption that this is a role that women "naturally" fill. The heavy burden of care can affect the caregiver's and family's health and nutrition. | Research conducted in seven countries shows that over 50% of orphans are cared for by women in the household especially grandmothers. **The United Nations Children's Fund (UNICEF). The state of the world's children 2007: Women and children, the double dividend of gender equality. New York:** UNICEF; 2006. |
5. **Stigma and discrimination:** Women living with HIV may be blamed for bringing HIV into the family, and for being immoral and breaking sexual norms. They may also face particular stigmas related to pregnancy and childbirth - for example, to be held responsible for infecting their children. Negative consequences of HIV disclosure for women include abandonment by their partners and violence. Some women may also be tested and their results disclosed without their consent, which could further contribute to stigma and discrimination against them.

Research conducted in 3 countries shows that women are more likely to be blamed for bringing HIV into the family. *International Center for Research on Women. Disentangling HIV and AIDS stigma in Ethiopia, Tanzania and Zambia. Washington DC: ICRW; 2003.*

6. **Lack of economic security:** In many countries, women do not have property and inheritance rights, and lack access to and control over other economic resources (e.g. land ownership, assets, employment, household wages). Many women, especially those living with HIV, lose their homes, inheritance, possessions, livelihoods and even their children when their partners die. This forces many women to adopt survival strategies that increase their chances of contracting HIV.

A study in 2 countries shows that not having enough food to eat over the previous 12 months is associated with inconsistent condom use, the exchange of sex for money and other manifestations of risky sex among women. *Weiser S, et al. Food insufficiency is associated with high-risk sexual behaviour among women in Botswana and Swaziland. PLoS Medicine 2007;4(10):1-10.*

7. **Lack of education for girls:** Attending primary school makes young people significantly less likely to contract HIV. When young people stay in school through secondary level, the education's protective effect against HIV is even more pronounced. This is especially true for girls, who, with each additional year of education, gain greater independence, are better equipped to make decisions affecting their sexual lives, and have higher income earning potential – all of which help them stay safe from HIV. Schools also provide an opportunity to teach comprehensive, age appropriate life-skills based HIV/AIDS education that addresses gender norms, sexual decision-making and gender-based violence.

Several studies show that girls completing secondary education have a lower risk of HIV infection and are more likely to practice safer sex than girls who only finish primary education. *Girl power: The impact of girls’ education on HIV and sexual behaviour. Hargreaves J and Boler T. ActionAid International, 2006.*

### Target population(s)

A sound evidence-based response to the HIV/AIDS epidemic in any given situation is based on the “Know your Epidemic” approach. Addressing gender inequalities is an essential part of the “Know your Epidemic” approach because it requires that programming is based on understanding whether women or men and which sub-groups of women or men are at risk, the behaviours that place them at risk, and the underlying socio-cultural and structural factors that aid or impede their abilities to access and use HIV information and services. Therefore, it is vitally important to disaggregate data by sex, age and other parameters to identify the sub-groups of women and girls that are most likely to be at risk of becoming infected and whether they have equitable access to services; it is equally important to analyse this data and use it to design programmes of intervention to address the specific needs of these sub-groups. This includes pregnant women, young, single or married women, sex workers, female injecting drug users (IDU), female partners of IDU and men who sex with men (MSM), women who face marginalization because of other factors such as race, ethnicity, migration and women in populations of humanitarian concerns.

### Activities to be considered
Addressing gender inequalities in HIV/AIDS programming can be done in at least two ways: a) through specific interventions that promote gender equality in sectors such as health, education, and legal affairs; or, b) by integrating gender into standard HIV/AIDS interventions such as PMTCT, HIV testing and counselling, and health systems strengthening. Where countries already have national HIV/AIDS strategies or plans that specifically address gender inequalities and/or national plans or strategies to address gender inequalities more broadly, these should be taken into account in programme design. The following are essential elements for gender-responsive programming:

1. **Collect and use sex and age disaggregated data** for all key epidemiological and programme indicators in order to shape programming and facilitate better monitoring and evaluation of the impact of programmes on women and girls. Conduct gender analysis of the underlying factors driving the epidemic as described above. These are a minimum requirement for sound evidence-based gender-responsive HIV/AIDS programming.

2. **Build capacity for understanding and addressing links between gender inequalities and HIV/AIDS** at various levels (regional, national, sub-national) targeting various stakeholders (e.g. civil society, CCMs, various line ministries responsible for HIV/AIDS programming, HIV programme managers and health care providers). Establish linkages among various Ministries and with civil society organizations working in areas such as education, poverty reduction, violence prevention, and legal reform;

3. **Meaningfully involve** women’s groups, young people, people living with HIV, especially women living with HIV, and people with gender expertise in the programme design, project implementation and in decision-making bodies such as CCMs;

4. **Specify activities, costs and indicators** for those elements of the programmes that specifically address gender inequalities, matching these to the issues identified through a gender analysis of the epidemic;

5. **Include operations research** to identify gender-responsive approaches to programming that are most effective; and;

6. **Specific activities to address gender inequalities**, which could include the following (this is not an exhaustive list, but provides examples of interventions or efforts that promote gender equality):

   - **Gender-responsive strategies in standard HIV/AIDS interventions:**
     a) providing skills to women and girls to negotiate safe sex (e.g. condom promotion efforts that emphasize safe sex skills among target groups including sex workers, young women) (**linked to prevention SDA**);
     b) behaviour change communication strategies that target harmful gender norms and practices (e.g. mass media or community outreach campaigns that target practice of older men seeking sexual relationships with young girls) (**linked to prevention SDA**);
     c) strategies that expand access to HIV/AIDS treatment and care for women living with HIV (e.g. those that are not typically reached through maternal and child health services including single women, migrant women, sex workers, and young women (**linked to treatment SDA**);
     d) HIV testing and counselling strategies that address women's fear of violence and other negative consequences in disclosure support through safety planning, mediated disclosure and couple counselling and testing;
     e) PMTCT programmes that include strategies to increase male involvement, offer reproductive choices to women living with HIV and provide comprehensive treatment, care and support for the mother (**linked to prevention and treatment SDA**);
     f) supporting women in their caregiving role (e.g. community support for women care providers, efforts to involve men in providing care to AIDS affected households) (**linked to care SDA**);
     g) reducing barriers faced by women in accessing HIV/AIDS services (e.g. lowering or eliminating
user fees, addressing stigma and discrimination in health care settings) *(linked to health systems strengthening SDA)*;

g) Post-Exposure Prophylaxis (PEP) interventions that provide comprehensive medico-legal services to victims of sexual violence including emergency contraception, PEP, trauma counselling, legal services *(linked to prevention SDA)*;

h) sex work interventions that support community mobilization of sex workers for their rights and that include strategies to enable sex workers to be safe from violence;

i) increasing young girls and women's access to comprehensive sexual and reproductive health information and services (e.g. strengthening linkages between sexual and reproductive health services such as family planning and HIV/AIDS services) *(linked to health systems strengthening SDA)*; and,

j) implementing comprehensive, age-appropriate and gender-sensitive AIDS education curricula for reaching young people in schools that also addresses gender roles, norms and decision-making *(linked to prevention SDA)*.

*Interventions that promote gender equality (gender-transformative) - these are linked to the supportive environment SDA*:

k) working with men and boys to promote gender equitable norms and attitudes (e.g. those related to fatherhood, sexual responsibility, gender-based violence);

l) community-based interventions to change harmful gender norms and practices and unequal gender relationships including working with women to provide life skills training (e.g. interventions such as IMAGE in South Africa, and Stepping Stones);

m) working with law enforcement authorities to eliminate and respond to violence against women, including sex workers;

n) advocacy with policymakers to change, develop and/or enforce laws and policies that promote gender equality and human rights of women and girls including marginalized groups and those living with HIV (e.g. laws related to violence against women, property rights and inheritance, criminalization of HIV and of sex work);

o) promoting economic opportunities for women (e.g. through mechanisms such as microfinance and micro-credit, literacy, vocational and skills training, and income generation);

p) providing women and girls with information and services to protect and promote their rights including sexual, reproductive and other rights; and,

q) strategies to keep girls in school and to make schools safe for them.

**Approach to (or tools for) costing these activities**

Experience from across the globe suggests that a key barrier to the initiation and successful scaling-up of interventions to address gender inequalities is that they are not often adequately costed and incorporated into proposals, plans and budgets for AIDS. The financial resources guidelines to achieve universal access to HIV prevention, treatment, care and support produced by UNAIDS in 2007 provide an approach to costing interventions on gender equality and prevention of violence against women to strengthen existing HIV/AIDS programmes. Please refer to this report (Annex 5) for further information. [http://data.unaids.org/pub/Report/2007/20070925_advocacy_grne2_en.pdf](http://data.unaids.org/pub/Report/2007/20070925_advocacy_grne2_en.pdf)

**Considerations in defining indicators**

The Global Fund Monitoring and Evaluation Toolkit includes programme outcome indicators. These
indicators must be disaggregated by sex and age and interpreted appropriately in order to monitor and evaluate gender interventions. Gender-sensitive output indicators will depend on the type of interventions implemented. For example, a PMTCT programme with a male involvement component can be monitored by the number of male partners of PMTCT clients who undergo HIV testing and counselling.

**Linkages with SDAs in the proposal**

Addressing gender inequalities in HIV/AIDS programmes is a cross-cutting issue for all SDAs (please see above list of activities for appropriate linkages to SDAs).

**Key implementing partners to be considered**

These include National AIDS Control Programmes or Councils, line ministries (e.g. ministries of women's or gender affairs, education, legal affairs, health), civil society such as women's groups, youth groups, PLHIV networks, institutions working on women's rights, gender equality, and violence against women. It also includes donor and UN agencies involved in programmes for HIV/AIDS and/or women and girls.

**Type and sources of technical assistance which might be required during implementation**

Technical assistance can be provided through UNAIDS Secretariat and WHO country and regional offices, UN country support teams, national or regional NGOs, and other institutions that have gender expertise. Technical assistance may be required to build the capacity of principal recipients and implementing partners to integrate gender in proposals.

For further resources, refer to the following:


**Integrating gender into HIV/AIDS programmes in the health sector:** Tool to improve responsiveness to women's needs. WHO. *Forthcoming.*

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