ANNEX 3. SAMPLE GENDER ANALYSIS MATRIX: HIV

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<tr>
<th>Factors that influence health outcomes: Health-related considerations</th>
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<tbody>
<tr>
<td><strong>Risk factors and vulnerability</strong></td>
<td>Vulnerability to HIV may be higher in settings where there is more poverty and migration. For women and girls, poverty may increase vulnerability to HIV infection and force them to exchange unprotected sex for food, money, school fees or other basic needs. Gender norms about sexuality, masculinity and peer pressure may promote unprotected intercourse and contribute to acceptance of promiscuity and multiple partners for some young men and to a lack of voice for women in terms of if, when, where and with whom they have sex.</td>
<td>Gender norms about interpersonal relationships between women and men may decrease women’s access to and control over essential resources (such as condom negotiation skills, legal recourse for experiences with violence and information on preventing HIV infection) that could increase risk factor exposure and vulnerability to HIV infection.</td>
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<tr>
<td>Biological factors</td>
<td>Both men and women are at risk for HIV. Men who have sex with men (MSM) are at increased risk because the virus is readily transmitted through unprotected anal intercourse. Women are at greater risk than men of acquiring HIV through heterosexual contact due to: 1. larger surface area of the mucous membrane exposed during intercourse; 2. the introduction of an infectious fluid (semen); and 3. the fragility of the vaginal mucosal membrane (especially among women younger than 18 years).</td>
<td>See also the intersection between “risk factors and vulnerability” and “sociocultural factors”. Discrimination and stigma against MSM and norms related to masculinity may prevent men from seeking information and services related to HIV prevention.</td>
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<td>Sociocultural factors</td>
<td>In many parts of the world, the prevalence of HIV infection is higher along major trucking routes and highways. Truck drivers, mostly male, are considered a most-at-risk population. MSM may be reluctant to get tested due to stigma and discrimination, which is often caused by attitudes against homosexuality and/or bisexuality. Such attitudes reflect an emphasis on heterosexual sex as a norm. As a result, infected men may continue to have unprotected sexual relations and unknowingly pass on the disease to their partners (male or female). Gender norms relating to sexuality and masculinity tend to privilege heterosexual relations.</td>
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<td>Access to and control over resources</td>
<td>Adolescents, especially girls, are particularly vulnerable to HIV. The exact reasons depend on the region: 1. In some places, adolescent girls either engage in premarital sex or marry early. Young girls may be married to older men and lack the power to negotiate safer sex. 2. In many settings, adolescent girls lack access to information and services for HIV prevention because of social norms that dictate that young women should not be sexually active. 3. Peer pressure may play a role in some settings, influencing young girls and boys to engage in unprotected sex with multiple partners. 4. Older men in some areas sometimes seek to have sex with young girls in the belief that their young partners are more likely to be virgins or otherwise free of HIV. The false belief that sex with a virgin cures HIV infection or AIDS may also lead older men to have unprotected intercourse with a girl or young woman.</td>
<td>For more information, see the intersection between “risk factors and vulnerability” and “sociocultural factors”.</td>
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1. See also the intersection between “risk factors and vulnerability” and “sociocultural factors”. Discrimination and stigma against MSM and norms related to masculinity may prevent men from seeking information and services related to HIV prevention. 2. Poverty and economic resources, including paid employment, may affect exposure to risk factors and vulnerability differently for women and men.
### Factors that influence health outcomes:
**Health-related considerations**

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In some Asian and African countries, married women account for a large proportion of people newly infected with HIV even though their only risk factor is having unprotected sex with their husbands. Social norms may encourage the belief that men are entitled to have unprotected sex with their wives. This indicates that gender norms about intimate partner relations, such as marriage, may increase women’s vulnerability to HIV infections in several ways:

- Married women or women in long-term relationships often do not perceive the risk of HIV infection and therefore may not take necessary preventive actions, thereby increasing vulnerability.
- If married women or women in long-term relationships do perceive a risk within their relationships, they may not have the power to negotiate safe sex or they may be reluctant to raise the issue of HIV risk with their partner for fear of disrupting a relationship of trust or risking a violent reaction by their partner.
- Wives or regular partners of migrant men and of men in the trucking industry are often unaware of or unable to address their partner’s risk behaviour.
- Many women cannot refuse sex (protected or not) with their partners even when they know there is a risk of acquiring HIV. In many societies, rape within marriage is not recognized as a criminal offence. **Violence against Women (VAW)** is both a cause and a consequence of the HIV epidemic. Women experience increased vulnerability to both HIV infection and violence due to various sociocultural norms.
- Women who experience physical violence and sexual coercion are often afraid to negotiate condom use with their partners. A study in South Africa\(^1\) showed that women who reported forced sex were less likely to have used condoms and, in turn, were more likely to be HIV infected compared with women who used condoms.
- In some settings, women face violent reactions from partners or community members after disclosing their HIV-positive status.

The way HIV symptoms unfold may place intimate partners of a person living with HIV at risk: during the years between initial infection and symptom visibility, the person and/or his or her sexual partner or partners may not know that the person is living with HIV.
Gender mainstreaming for health managers: a practical approach / Annex 3. Sample Gender Analysis Matrix: HIV

Factors that influence health outcomes:

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| **Access and use of health services** | Women’s ability to bear children may increase their access to and use of health services for HIV treatment. In some settings, women are more likely to be tested for HIV in the context of pre- or antenatal care. As a result, pregnant women may be diagnosed and access HIV-related services more often than men. | Men’s role in the paid, formal economy may increase their access to and use of HIV services. In some settings, men may have better access to HIV services, including testing, due to **formal employment benefit packages** that may allow greater access to private services. Men often prefer the anonymity offered by private services, which may also be of higher quality than public services in some settings. Norms related to female roles, sexual relations and marriage can prevent women – especially young women – from accessing HIV information and services. | HIV treatment requires facilities at **primary, secondary and tertiary levels**. Yet primary health care (PHC) services in resource-poor settings are not always equipped to provide the full range of HIV services, especially treatment and care requiring follow-up or complicated tests. This affects both women’s and men’s ability to access and use effective HIV treatment. **Indirect costs** associated with HIV services disproportionately affect women:  
- Community services such as home-based care, support networks, legal or social support often complement health services delivered through PHC centres for HIV treatment. Gender norms, roles and relations often dictate that women provide these complementary services, free of charge.  
- People receiving antiretroviral therapy must drink lots of water and eat three balanced and nutritious meals per day. Poor households have reduced access to resources such as clean water and nutritious food; when the household sets priorities, male roles of authority and breadwinning often take precedence.  
- There are financial costs associated with obtaining water, food and fuel to cook meals. Time may also be at a premium, especially for women who bear the responsibility for fetching water, gathering fuel, obtaining food and preparing meals.  
- Poverty or lack of access to and control over financial resources may hinder women’s and men’s ability to access and use health services for HIV treatment. This is expressed in the following ways in different settings:  
  - People living with HIV require expensive treatment, including lifelong drug therapy. Several countries are making antiretroviral therapy available free of charge or cover part of the associated cost for individuals from certain vulnerable groups. However, few people living with HIV have their medication paid for in full, and **even the subsidized costs can be prohibitive for poor people**.  
  - User fees for antiretroviral drugs, diagnostic tests (such as CD4 counts) and treatment of opportunistic infections are greater than what many women and men can afford. However, women are confronted with additional challenges related to economic resources, including the lack of control over family expenditure, the higher prevalence of poverty among female-headed households and the fact that the treatment needs of men in the family (especially those of the breadwinner) may be given a higher priority. |

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2. Women’s ability to bear children may increase their access to and use of health services for HIV treatment. In some settings, women are more likely to be tested for HIV in the context of pre- or antenatal care. As a result, pregnant women may be diagnosed and access HIV-related services more often than men.2

4. Women’s ability to bear children may increase their access to and use of health services for HIV treatment. In some settings, women are more likely to be tested for HIV in the context of pre- or antenatal care. As a result, pregnant women may be diagnosed and access HIV-related services more often than men.2
### Factors that influence health outcomes:

#### Health-related considerations

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| **Access and use of health services** | Gender norms often hinder women from accessing health services in a timely fashion (whether HIV related or not). These play out differently in each setting:  
- Some women need permission from their partners and family members to seek health care.  
- Some women are prevented from accessing services due to child care and household responsibilities.  
- Some women cannot attend health care facilities without being accompanied, the presence of a female doctor or their partner’s consent for certain types of treatment and examinations. | |
| **Health-seeking behaviour** | Due to the lack of visible symptoms in early stages of the condition, men and women may only be compelled to seek health care long after getting infected.  
- Fear of stigma and discriminatory consequences may affect HIV-related health-seeking behaviour for women and men differently:  
  - Regardless of sexual orientation, men may be reluctant to be tested or treated for HIV due to the fear of being stigmatized by peers and the community for having sex with other men. Many countries consider sexual relations between men to be a criminal offence.  
  - Women may avoid seeking testing or treatment for HIV, even in the context of preventing the mother-to-child transmission of HIV, out of fear that their partners and the community will reject, abandon or act violently towards them and/or blame them for bringing HIV into the family. | |
| **Treatment options** | In general, antiretroviral therapy for HIV as well as treatment for opportunistic infections due to HIV infection is the same for women and men.  
- Different roles and needs of men and women tend to affect HIV treatment compliance:  
  - Instructions for taking medicine may need to be adapted for people who are illiterate; this affects both men and women, but more women are illiterate in many settings. | |

#### Gender-related considerations

- Access and use of health services
- Health-seeking behaviour
- Treatment options
### Factors that influence health outcomes: Health-related considerations

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<td>People receiving antiretroviral drugs must eat three balanced and nutritious meals per day. In Zambia, a single mother of five spoke about how food was an issue in her home: “On most occasions we go without food as women, we eat last and there usually is not enough to go around. So how can we go on the medication? We need food to go with it. I tried to take the medication on a stomach full of water and I vomited everything.”</td>
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<td>Advice for taking medicines may need to take into account differences in daily routines, working environments, budgets and the need for social care. Men may require treatment support in terms of opportunities, time and spaces at workplaces, whereas women may need household- or community-based treatment support, including care for children, other family members that test positive or for older household members. Some gender norms relating to communication and problem-solving patterns may affect how and how often men and women seek support for HIV treatment. Norms for masculinity that tend to downplay help-seeking may discourage men and boys from revealing their HIV status and/or asking for support. Women and girls, in contrast, may be encouraged to share and seek help. These norms may influence their willingness to participate in HIV groups and other support networks. Access to information may affect people’s experiences. In some settings, women are told about their HIV status only after health care personnel inform their husband or male in-law.</td>
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<td>Experiences in health care settings</td>
<td>Women may require counselling on the fear of and/or potential side effects of antiretroviral drugs. For example, in some settings, pregnant women fear that antiretroviral drugs will harm the fetus and therefore refuse to take them. Some gender norms relating to communication and problem-solving patterns may affect how and how often men and women seek support for HIV treatment. Norms for masculinity that tend to downplay help-seeking may discourage men and boys from revealing their HIV status and/or asking for support. Women and girls, in contrast, may be encouraged to share and seek help. These norms may influence their willingness to participate in HIV groups and other support networks. Access to information may affect people’s experiences. In some settings, women are told about their HIV status only after health care personnel inform their husband or male in-law.</td>
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#### Biological factors

- There may be additional considerations related to the type and dosage of antiretroviral drugs used for women and girls due to their reproductive systems: Certain first-line antiretroviral drugs are contraindicated for pregnant women. Treatment options for certain reproductive tract infections are different for women than for men. The full implications of women’s treatment for viral load and CD4 count are not yet known. Clinical trial data on HIV treatment among women are limited, and most studies that included women have not been geared to detect sex differences in viral and immune success rates.

#### Sociocultural factors

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#### Access to and control over resources

- People receiving antiretroviral drugs must eat three balanced and nutritious meals per day. In Zambia, a single mother of five spoke about how food was an issue in her home: “On most occasions we go without food as women, we eat last and there usually is not enough to go around. So how can we go on the medication? We need food to go with it. I tried to take the medication on a stomach full of water and I vomited everything.”
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<td>Experiences in health care settings</td>
<td>Men and women differ in the physiological manifestations of HIV and AIDS. For example, women with AIDS may experience vaginal thrush and require screening for cervical cancer; pregnant women with HIV are more susceptible to malaria. In sub-Saharan Africa, young women 15 – 24 years old account for 75% of infections in their age group and up to 90% in South Africa. The ways HIV is transmitted can put an entire family at risk because:  - HIV infections are transmitted sexually between partners.  - HIV can be transmitted from mothers to children.</td>
<td>Some studies reveal that women’s feelings of stigmatization depend on the specialty of the physician. The timing of being diagnosed as being HIV-positive can cause emotional stress among both men and women. Women who have never considered an infection may be traumatized when being informed at an antenatal clinic, especially if tested without consent.</td>
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<td>Health and social outcomes and consequences</td>
<td>As HIV infection is a chronic and debilitating condition, entire families (and especially women) are significantly burdened by the need to care for infected individuals. In many countries in sub-Saharan Africa, older women often care for grandchildren who have been orphaned because their parents died from HIV/AIDS. Boys and girls are likely to undergo emotional stress when their parents reveal their HIV-positive status, fall sick or die. In many countries, especially in sub-Saharan Africa, an increasing number of orphans whose parents died from HIV/AIDS live in child-headed households. This pressures girls to leave school to take over family roles and puts them at risk for abusive relationships. HIV-related communication problems, stigma and social exclusion negatively affect the men and women themselves and their entire core and extended family. However, women more often than men experience physical assault, abandonment by spouse or family, violent threats and property being taken away. The consequences of living with or supporting someone living with HIV may have a greater economic impact on women as they are more likely to lose their job in the formal sector if they are seropositive.</td>
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References


This tool/document is part of the larger WHO Gender Mainstreaming Manual for Health Managers: a practical approach. All modifications or uses should reference this source.