The Fourth Decade Of Women And HIV:

The Role Of Gender Equality In Reversing The HIV Pandemic

UN WOMEN
United Nations Entity for Gender Equality and the Empowerment of Women

Acknowledgements

This paper was prepared by Katherine Bourne with contributions from Nazneen Damji. UNIFEM (now UN Women) commissioned this paper as inputs for a Technical Advisory Group consultation, *Developing Harmonized Indicators for Monitoring Progress on Gender Equality Dimensions of HIV and AIDS* June 28-29, 2010.

A special thanks to the following colleagues for their suggestions and comments at various stages: Gabrielle Ross, Beth Fredrick, and Susana Fried.

Table of Contents

I. The Fourth Decade of Women and HIV

Attaining gender equality is a Millennium Development Goal (MDG) with widely recognized benefits for women and men and health and development. Although the MDGs are increasingly discussed as being interdependent, gender equality is not generally seen as being within the purview of the HIV field. Indeed, there has been resistance within parts of the HIV establishment to opening the door to programme elements that address gender inequality, due to a sense that any progress will be slow and that the urgency of the pandemic requires faster interventions. Others worry that a focus on women will divert attention from even more marginalized populations at risk. And some may be unsympathetic with the goal itself.

As the pandemic approaches the beginning of its fourth decade, prevention efforts have only slightly reduced the rate of new infections in many countries. Greater progress will require that we understand and anticipate the pandemic's next stages rather than chase behind it, and that we design prevention interventions accordingly. In sub-Saharan Africa, which hosts the vast majority of infections, being female is clearly a risk factor. Although the overall relationship between economic status and HIV infection is inconsistent, recent trends suggest that being a young woman who is socially disadvantaged by lower education or food insecurity carries an increasing level of risk.[1] As the importance of addressing structural factors becomes increasingly clear and urgent, there is a growing interest in investment in 'gender transformative' interventions that support those targeting behavioral change to gradually, but sustainably, reduce the spread of HIV. There is also now widespread recognition that a rights-based approach to the pandemic requires attention to the differential impact of HIV on women and girls. There remains, however, considerable debate over what gender comprises, and how it should be included within the HIV response.

UNIFEM is leading an effort by UN agencies and other experts to develop a revised set of global, national and programme indicators and other measures that capture key aspects of the complex interrelationship of HIV and gender inequality. This paper is intended to serve as a conceptual orientation for that effort. It draws directly from work over the past decade by researchers and scholars, gender experts, women's health activists, and HIV-positive women. The paper will present a framework for organizing and thinking about the myriad ways in which gender and HIV interact to the detriment of both women and men, the priority actions needed to address them, and the implications for monitoring and evaluation.

Addressing the global HIV pandemic requires understanding a multitude of national and

1 Hallman 2004, Kim 2008, Weiser 2004

sub-national HIV epidemics, and many of these are driven by the gendered relations between men and women. Because the vast majority of HIV-infected people and all hyperendemic countries are in sub-Saharan Africa, many of the issues discussed in this paper particularly pertain to that region. However, the same issues apply to women in other generalized epidemics and within concentrated epidemics. This paper will distinguish between the global pandemic and those epidemics that may vary depending on the national or sub-national context or that of a particular subpopulation. It will focus on gender inequality between women and men as it relates to HIV. The needs of women discussed in the paper apply equally to special populations of women such as those with other gender identities, injection drug users, and sex workers, although the paper does not comprehensively address all of the particular additional needs and circumstances of these groups.

Interventions that particularly seek to reduce the impact of HIV epidemics on girls and women require the knowledge and courage to address gender inequality. Measuring the impact of HIV epidemics on women, and the effectiveness of interventions that seek to reduce those impacts, requires a far more extensive application of the innovative thinking that is primarily evident today only in a minority of special research projects. In the early stages monitoring and evaluation efforts will need to track process measures, including resource allocation and implementation benchmarks. Then it will be necessary to measure the distal and proximate causes of HIV infection. Many of these, such as sexual behavior, gender norms and attitudes, or power in relationships will have to be assessed using social science methodologies. Finally, changes in HIV infection rates will be measured as the long-term outcome.

The next section of the paper explores the interrelationship between gender and HIV. Following that, Section III argues for a gender aware response to HIV. Section IV presents priorities for action drawn from a decade's worth of consensus statements by gender experts. Section V concludes the paper with some issues to consider in monitoring and evaluation.

II. Four Pathways through which Gender and HIV Interact

The relationship between gender and HIV is extremely complex and constantly evolving, and is further complicated by interaction with other equity variables such as education, income, ethnicity or race, or sexual orientation. A woman living in a context of severe gender inequality may face the added burden of racial discrimination, or she may avoid certain aspects gender discrimination due to high income or social class. Groups of people facing multiple inequities may form sub-epidemics with particular characteristics. Keeping in mind that these non-gender variables may also be at work, this paper identifies four primary pathways through which gender interacts with HIV. These are a guide for approaching a given epidemic in order to analyze the gender elements; design interventions; and plan for monitoring and evaluation. The four pathways are:

1. Gender inequality affects susceptibility to HIV infection

2. Gender inequality affects clinical outcome and quality of life for those infected and affected by HIV

3. Gender inequality influences the effectiveness of efforts to control the HIV pandemic

4. The HIV pandemic and the interventions in response may either exacerbate or mitigate gender inequality.

The next section will explore each of these pathways in greater detail, with selected examples.

Pathway 1: Gender inequality and susceptibility to infection

Whether a person is male or female affects his or her likelihood of being infected with HIV, with women, and particularly girls, having an enhanced biological susceptibility. Gender inequality affects susceptibility to infection differently across regional and country contexts, as well as differently among subpopulations within a given country. In one context, women's unequal status may translate into greater risk of becoming infected. In another, having rights that are severely circumscribed may be protective against infection (although posing other threats to wellbeing), such as in cultures where girls and women are not able to leave the house. Men are also put at increased risk by gender inequality. This does not mean that (heterosexual) men are not consistently in a position of dominance, but that the construct underlying that dominant role puts both sexes at greater risk than they would face in a situation of greater gender equality.

Gender inequality is at the root of many phenomena putting women at risk, often acting through several means. As one example, young girls who have sex with older men for

money or 'gifts' are greater risk of infection due to their own biological susceptibility, and the increased likelihood that the man has become HIV infected by a concurrent or previous partner. The widespread social acceptance of this and other risky partnerships by society and the participants is one manifestation of gender inequality. The girl's lack of other ways to earn money is another (likely compounded by broader economic disadvantage). The pressure on men to prove their virility through having sex with multiple partners, together with the girl's lack of understanding of her risk and inability to negotiate condom use, form yet a third.

Pathway 2: Gender inequality and outcomes for those infected or affected

Gender profoundly affects the impact and consequences for a woman confronting HIV infection, whether her own or others'. Positive status may also affect other variables, such as income or educational prospects, which then interact with gender to increase inequality. Women who are themselves infected may experience more severe stigma and discrimination than men. Often tested before their partners (due to prenatal testing), women may be blamed for 'bringing HIV into the family' and subjected to violence, expelled or shunned. Women and girls also bear the brunt of being affected by HIV. Widows of HIV-positive husbands may be left without legal (or de facto) rights to their property and children, and suffer extreme hardship as a result. When other family members are ill with HIV and AIDS, it is girls who are most frequently pulled out of school when money runs short or caregiving is required, leaving them at a disadvantage for the rest of their lives.

Pathway 3: Gender inequality and the effectiveness of HIV interventions

Prevention and treatment efforts can be rendered less effective by gender inequality. To ensure equitable access to the benefits offered by HIV interventions, a rights-based approach requires that programme designs take gender differences into account. For example, many resources have been allocated to ensure that testing and treatment are widely available. If women do not have sufficient information or autonomy to decide to access those services, however, the effectiveness of the programme is undermined, and their rights are not being upheld. Similarly, when girls and women are provided with the information and supplies needed to recognize their own risk and practice safer sex, but they do not have the power or skills to implement that knowledge, the intervention will not be an effective prevention strategy.

Pathway 4: The effect of the pandemic and the response on gender inequality

Gender inequality influences susceptibility to infection, the experience of those infected, and the effectiveness of the actions taken. But the pandemic and the response to it also have the potential to in turn influence gender inequality, either positively or negatively. A core commitment of the global response to the HIV pandemic has been to uphold the human rights of women and men infected and affected. This rights-based approach requires that we understand how a particular epidemic, and the actions taken in response to it, can themselves influence gender inequality, and ensure that the response reduces – or at least does not exacerbate – the disadvantages faced by women.

The pandemic exacerbates gender inequality in many ways. For example, women, and particularly sex workers, are often seen as 'vectors' and subject to multiple forms of discrimination, while fear of infection can lead men to seek increasingly younger women and girls in the belief that they are less likely to be HIV positive. Thus, the context of HIV leads to a worsening of status for several categories of women. It is possible to envision, however, that the presence of HIV could be used to catalyze increased openness to talk about prevention and therefore about sexuality and gender norms, thereby leading to greater gender equality.

Additionally, the HIV response itself may perpetuate or mitigate gender inequality. For example, many women's health advocates are concerned that the widespread promotion of adult male circumcision could lead men to believe that they are protected and have no need to use condoms, which puts women at risk of infection through unprotected sex if men do become infected, and could also increase the perception that women are to blame for introducing HIV into a relationship. As a very different example, despite women making up half of those who are HIV positive, HIV decision-making bodies deciding on programmes and interventions that profoundly affect many aspects of women's lives are overwhelmingly male-dominated. By denying women a voice the response is disempowering those whose health is at stake, and also undercutting its own effectiveness.

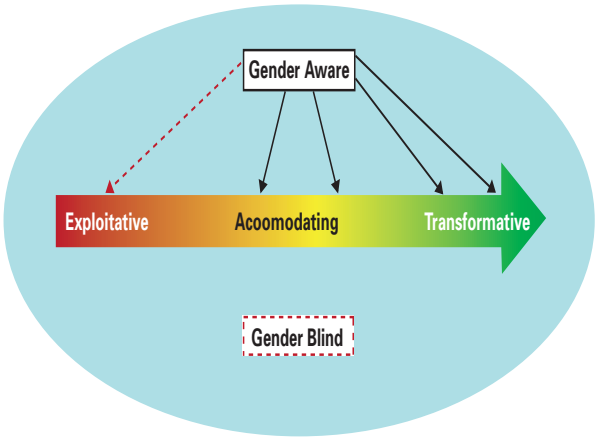
A more optimistic scenario can be imagined, however -- one in which the response itself fosters a transformation to greater equality as a means to reversing the pandemic, mitigating its harmful effects, while also promoting rights. The next section describes where such an approach fits in the continuum of current responses to HIV.

III. The Need for an HIV Response that is 'Gender Aware'

To date, the HIV response has not been predicated on a consideration of these (or similar) pathways, but rather has primarily emphasized individual behavior change and biomedical interventions. Widespread testing, antiretroviral therapy (ART) and other treatment have prevented millions of deaths; education and counseling and resulting changes in behavior, along with access to condoms, have averted many infections. There has been a considerable increase in research on technologies tailored for women. There have also been major efforts to reduce the social impact of HIV on orphans and caregivers. Each of these interventions can be made even more effective by increased investment that incorporates a stronger understanding of the influence of gender inequality. However, with new infections far outrunning access to treatment, and with global resources for HIV seeming to have reached a plateau, a very different approach will be needed over the coming decades.

Responses to the HIV pandemic may be gender blind or gender aware. Those that are gender blind do not explicitly take gender into consideration (although of course it is still affecting outcomes). If gender aware, the interventions may actually exploit or unintentionally exacerbate gender inequalities, they may be sensitive to or accommodate them, or they may seek to transform them. This continuum of responses is represented graphically in a diagram by the Interagency Working Group on Gender (Figure 1), and discussed in greater detail below.

Figure 1 The Gender Awareness Continuum[2]



Gender Blind

In the early years of the U.S. epidemic, because of the disproportionate number of gay men infected, the response was highly gender aware with respect to the particular needs of that population. As the world began to respond to huge, largely heterosexual epidemics in the developing world, however, the importance of a gendered approach was lost. Many early prevention, treatment and care programmes ignored deeply entrenched

2 Figure reproduced from the Interagency Gender Working Group's 2009 "Manual for Integrating Gender Into Reproductive Health and HIV Programs: From Commitment to Action." This publication provides a more detailed discussion of this topic than is provided here.

gender inequalities. Today, an overtly gender blind approach is no longer politically acceptable, although there are a few areas in which it still predominates, including clinical research and development.

In practice, however, many programmes and interventions do not actively seek to accommodate, much less transform, existing gender inequities. Many treatment and care programmes fall into this category.

Gender Aware: Exploitative

Although it is certainly no one's intention, some interventions are gender exploitative and may actually worsen inequality. For example, a number of campaigns have linked sex workers, or casual partners, with death imagery. Not only are scare tactics widely considered ineffective, but such an approach stigmatizes sex workers and women more generally, and perpetuates damaging norms of women as 'dirty' and responsible for transmitting HIV. Or, a testing programme whose counselors are instructed to urge women to disclose their status to their partners, without providing adequate counseling and support, may have the unintended consequence of women being subjected to violence or banishment. Many PMTCT programmes have routinely tested pregnant women for HIV, treated them in the perinatal period to reduce the risk of vertical transmission, and then failed to ensure that they received continuing treatment to save their own lives.

Gender exploitative interventions generally arise from a lack of expertise in gender issues and the experience of being an HIV positive woman. If local gender experts and women who are living with or affected by HIV are consistently included in the process of designing and implementing programmes, exploitative results are far less likely.

Gender Aware: Accommodating

A gender accommodating response acknowledges the existence of gender differences, and seeks to create equitable conditions. In such a program, clinics might provide child care services; men would be encouraged to share the tasks of caregiving; social marketing includes female as well as male condoms; and injection drug user (IDU) programmes reach out to female partners of male users. Such interventions, although they do not seek to change gender norms, are important for easing the unequal burden shouldered by women. But although all of the major donors and many programmes today strongly endorse gender sensitive (and even gender transformative) approaches in their organizational strategies, even basic efforts to reduce gender inequality are often not realized at the level of implementation. In an analysis of the actual programmes of The Global Fund, PEPFAR and the World Bank in three African countries, for example, although gender issues were mentioned, there were only a couple of interventions that could be even generously categorized as targeting gender, and no gender criteria were included in the monitoring or evaluation.[3]

Gender Aware: Transformative

A gender transformative intervention seeks to fundamentally improve existing gender inequalities both as a means to, and in the process of, addressing HIV. Such transformative approaches would change the underlying structural conditions that are associated with higher HIV infection rates. A programme might seek to: change laws that allow discrimination or infringe on the human rights of women; ensure that women have basic economic security through education and other livelihood interventions; change the gender norms of boys and girls to be more egalitarian; or reduce a community's acceptance of violence

3 Ashburn 2009, Tallis 2002.

against women (VAW). Programmes using these and other gender transformative approaches have been successful,[4] but to date most have only been implemented at a small scale.

The global HIV response remains mired in the center left of the Gender Awareness Continuum, although its rhetoric has staked out territory well into the Transformative zone on the right end of the arrow. Major donors' or countries' programmes do not yet have interventions or indicators for gender transformative (or even many gender accommodating) approaches. To reverse the pandemic, the world will need to rethink the HIV response, considering the multiple pathways through which gender and HIV intersect, as described in the previous section. In addition to the current emphasis on treatment and individual behavior change, countries will need to simultaneously undertake the slow work of structural change required to reduce the susceptibility of women and men that is rooted in gender roles. Not only does HIV present an opportunity for improvements in gender equality, with all of its wider benefits, but such improvements are essential to successfully stemming the spread of HIV. This requires a far greater awareness of gender in analyzing, planning interventions for and monitoring the epidemics around the world. What follows is a list of action areas that if undertaken could shift the HIV response to become more gender equitable and effective at achieving intended outcomes.

4 Gay, J., Hardee, K., Croce-Galis, M., Kowalski, S., Gutari, C., Wingfield, C., Rovin, K., Berzins, K. 2010. What Works for Women and Girls: Evidence for HIV/AIDS Interventions. New York: Open Society Institute. www.whatworksforwomen.org. This is an excellent resource for reviewing what is known. A late-stage draft of this document was very helpful in preparing the present paper.

IV. Essential action areas for a gender aware response

Having explored the Pathways through which gender and HIV interact, this section presents ten key areas of action to be taken in response to the HIV pandemic, and particularly to generalized epidemics such as that in sub-Saharan Africa, that are related to gender equality and women's rights. This is not a comprehensive list of all of the actions needed in response to the HIV pandemic, and omits elements that apply either to the entire population, such as blood safety, or particular settings with specialized requirements, such as prisons or the workplace, or populations with unique needs such as displaced persons. Rather, it contains the key areas of primary interest and impact for the majority of women. Many of the actions could, however, also be applied to improve the situation of women within particular settings and populations.

These key actions have been drawn from the consensus among gender experts, women's health advocates, and HIV-positive women regarding what needs to be done. Although these constituencies are not yet integrated in influential numbers into key HIV decision-making bodies, they have found other ways to make their priorities known. Over the past decade, at AIDS conferences and other international meetings, groups of women -- and some men -- with expertise in gender equality and HIV have come to consensus on priority actions for addressing the needs of women and girls within the HIV pandemic. These 'Calls for Action' and other documents serve as a solid guide for where to focus greatly enhanced efforts on women and girls and HIV. The consistency of the actions identified by these experts, especially in recent years, argues for increased attention and investment. (The table in Appendix A shows which consensus statements recommend each of the following actions.)

The key areas of action are divided into three groups:

Action that fosters an environment that supports improved outcomes for women
This area of action includes several components that have the shared objective of creating an environment in which success is more likely. Actions would ensure that existing policies do not promote inequality; that gender experts and HIV-positive women are involved in decision-making; that stigma and discrimination are vigorously combatted, and that planning and monitoring include a gender perspective. Although some of these areas are addressed in some country plans, they need to be uniformly included and adequately staffed and funded.

Actions that address direct needs arising due to the HIV pandemic, which have a gender dimension
These actions fall predominantly into the behavior change and biomedical areas and include services, research, and other efforts

that are intended to directly prevent, treat or ameliorate the consequences of HIV, and are today generally already accepted as important components of any comprehensive HIV response. The current HIV response has largely focused on these actions when it has considered gender, advocating a 'gender accommodating' approach, but there is much to do to make the interventions more effective for women.

Actions that address the most significant underlying structural gender inequalities that fuel the HIV pandemic.
The third group of interventions addresses structural drivers and represents a 'gender transformative' approach. The HIV community has been slow to reach consensus regarding the feasibility and desirability of addressing structural issues. More recently, however, as the nature of HIV epidemics is better understood, there have been growing calls for deeper action on gender as a means of reversing the pandemic.

The following section considers each area of action in general terms, with a few examples. Although not completely exhaustive for every circumstance, together the elements are intended to indicate the direction for a comprehensive approach to each area of action.

Action that creates a supportive environment:

Action 1: Creating an environment that supports improved outcomes for women and gender equality
The environment in which actions are taken is a fundamental determinant of their success. This means having the right people involved, equipped with the resources to be effective, backed by policies that are supportive, in an atmosphere of acceptance and tolerance.

Ensuring that knowledgeable women are in a position to participate effectively may be the most important of these.

'Knowing your epidemic' and matching the appropriate response is critically important not only at a national level, but at sub-national levels, and among subpopulations. This requires the engagement of a critical mass of women with diverse areas of gender expertise, as well as women living with and affected by HIV and AIDS, at each level of decision-making about HIV policies, budgets and programmes. This is crucial to being able to design programmes that will be effective for women and girls, and will avert misguided programmes and wasted resources. Furthermore, it is a violation of the rights of girls and women for their voices to not be included in decisions that so profoundly affect their lives. Gender aware monitoring and evaluation should be incorporated into all budgets and programmes.

Full representation may require specified percentages or numbers in national AIDS bodies such as National AIDS Commissions and Country Coordinating Mechanisms; changes in donor organizations' policies and staffing for their own organizations as well as for their programmes; and, where necessary, training that enables women to assume these roles.

a. Engage people with diverse gender expertise to participate in HIV decision-making and programming at all levels

- Specify numbers or percentages of seats on HIV national decision-making bodies such as National AIDS Committees and Global Fund Country Coordinating Mechanisms that should be held by women with diverse gender expertise
- Ensure that national and global HIV institutions and review bodies have diverse gender expertise

- Donor agencies need to be internally consistent with their rhetoric and ensure that they have staff with diverse gender expertise.
- Ensure that funding flows to women's organizations for programme design and implementation

b. Ensure representation of HIV-positive women on decision-making bodies

- Specify numbers or percentages of seats on national HIV decision-making bodies that should be held by HIV-positive women
- Ensure that global HIV institutions and review bodies have representation from HIV-positive women
- Conduct training programmes that will enable HIV-positive women to engage effectively as members

c. Create a supportive policy environment

- Review policies and regulations to ensure that they support and do not infringe on women's human rights or present obstacles to effective HIV prevention, treatment, care and support.

d. Reduce stigma and discrimination

- Campaigns and high-profile advocacy to reduce stigma and discrimination against women who are HIV-positive

e. Planning and Monitoring

- Ensure that national monitoring and evaluation bodies have gender expertise
- Ensure that national M&E frameworks are 'gender aware'

Monitoring and evaluation will need to track setting and meeting targets and then capacitating participants and diversifying decision-making bodies and monitoring and evaluation components. Qualitative evaluation should look at the effect on the content of policies, proposals and programmes over time of having stronger gender expertise engaged, as well as reduction of stigma and discrimination. Finally, the actual effectiveness of resulting programmes in reducing the unequal gender effects of the HIV epidemics will need to be evaluated over the long term.

Actions that address direct needs created by pandemic:

Action 2: Ensure that HIV/AIDS prevention and treatment interventions provide quality, gender-sensitive care that includes education, counseling, testing and treatment

A full range of HIV clinical and outreach services that provide education and information, empathic, non-judgmental counseling and psychosocial support, HIV testing and treatment with ART and for opportunistic infections are today widely recognized as the right of all HIV-positive people. All major HIV programmes include these elements, and many are searching for ways in which to make them responsive to the particular needs of women. These might include couples counseling or support for disclosure of status to a partner, or confidentiality in the case of not wishing to disclose; convenient locations, mobile services or child care facilities to accommodate mothers accessing treatment services; youth-friendly services for young women (and men). In some places, women access HIV care at a greater rate than men, due to having been tested as part of antenatal care, as well as better overall health-seeking behavior. This suggests that attention should also be given to how to more effectively reach men with treatment. Both women and men who face multiple discriminations due to sexual orientation, ethnicity, or engagement in sex work may need special attention to ensure access to prevention infor-

mation and health services. All women and men are more likely to make effective use of HIV services that are respectful, accessible, and meet their needs.

a. Prevention

- Campaigns that reach diverse women and provide straightforward information regarding the risks women face from concurrent or other multiple partnerships, intergenerational sex, and within marriage, as well as the benefits of condom use
- Widespread access to female condoms, including introduction programmes
- Couples testing, testing for men, and other testing approaches that meet the needs and circumstances of women
- Prevention of mother to child transmission for pregnant women
- Training for service providers to recognize and respond to gender-based violence
- Post-exposure prophylaxis and other services for victims of gender based violence
- Outreach and prevention information services and supplies for sex workers
- Outreach and prevention information services and supplies for female IDUs or female partners of male IDUs (in some countries includes clean needle exchange)

b. Treatment

- Training for service providers to ensure that they are able to ask and advise on HIV risks and sexuality questions and issues
- Equitable access to ARVs for all women who meet clinical criteria, regardless of ability to pay, disclosure, or childbearing status
- Comprehensive treatment for opportunistic infections and other complications of HIV
- Diagnosis and treatment of sexually transmitted infections
- Locations and service hours in treatment facilities that meet women's needs; some contexts may require mobile or outreach services
- Nonjudgmental service delivery environment that welcomes adolescents, sex workers, and others

c. Care and Support

- Comprehensive home and community-based care services that provide palliative care, psycho-social support and nutritional assistance

Ongoing monitoring and evaluation of HIV services will require continuing to track the provision and utilization of various types of services by sex, stratified by age, and ideally by other socioeconomic variables. In addition, there should be assessments of provider skills and attitudes regarding provision of care for all clients; and the level of patient satisfaction for both women and men, including young people.

Action 3: Integration of HIV and sexual and reproductive health (including maternal health) services for both HIV-positive and HIV-negative women

Integration of HIV services with the sexual and reproductive health (SRH) services that women are most likely to need and use serves both HIV-positive and HIV-negative women. In generalized epidemics, this provides another point of contact with HIV information, and in concentrated epidemics, SRH services may be the only way to reach most women with information about HIV. All women should be provided with the opportunity for confidential counseling and testing, and with the information and supplies, such as female condoms, that they need to stay nega-

tive, or to prevent transmission if they are positive. HIV-positive women should ideally be able to access SRH services at the same time as their HIV care, but wherever they receive care, providers need training and supervision to ensure that abuses such as forced sterilization and disrespectful treatment do not occur. Services should provide supportive information and supplies to avoid unwanted pregnancy, or if a pregnancy is desired, information on how to stay healthy and reduce the likelihood of transmission to the fetus or infant. Ideally, SRH services are accessed by men as well, providing the opportunity to provide them with the information, services and supplies that they need to keep themselves and their partners healthy. As with HIV services, above, it is essential to provide a nonjudgmental environment for women and men, regardless of their HIV status or any other attribute.

- Comprehensive HIV prevention counseling for all SRH clients including straightforward information about risks of concurrent or other multiple partnerships, intergenerational sex, and within marriage, as well as the benefits of condom use
- Access to female condoms, and training and support in their use
- Couples testing, testing for men, and other testing approaches that meet the needs and circumstances of women
- HIV testing in antenatal care, and provision of ARV prophylaxis and breastfeeding advice for positive women
- Link antenatal testing to access to ARVs and other HIV treatment for the woman before and after delivery
- Make available a range of family planning services and supplies appropriate to the needs of HIV-positive women.
- Comprehensive antenatal care for HIV-positive women, including malaria prophylaxis, TB treatment, and other services as needed
- Testing and treatment for sexually transmitted infections available to all women
- Training and monitoring to ensure skilled, rights-based, nonjudgmental counseling and services that enable HIV-positive women and their partners to meet fertility objectives
- Where not against the law, abortion services or referrals should be provided to all women who seek them
- Cervical cancer screening and treatment, particularly for HIV-positive women
- Training for service providers to recognize and respond to gender-based violence
- Training, protocols and supplies to provide post-exposure prophylaxis and other services for rape survivors
- Ensure that location and service hours meet women's needs; some contexts may require mobile or outreach services
- Adolescent and youth-friendly services using dedicated entrance or hours
- Establish male-friendly SRH services using dedicated entrance or hours

Monitoring and evaluation considerations will be similar to those listed for provision of HIV services. There are numerous models for SRH and HIV integration: integrating SRH content into existing HIV services; training SRH service providers to accommodate HIV positive clients; and others. Evaluation should include investigation into which models of integration are most acceptable and useful for various populations of women.

Action 4: Support household caregivers and home-based care volunteers

The greatest burden of care provision in the household for those dealing with AIDS and AIDS-related illness currently falls on women and girls, who already shoulder an inequitable proportion of household tasks. In addition to creating an unsustainable workload, the extra burden can lead to inability to engage in paid

employment, or to continue in school. National governments also rely on women who form the majority of volunteer home and community-based care providers, and therefore are bearing a disproportionate burden of the opportunity costs. Expanded support for caregivers and volunteer home-based care providers is crucial to prevent the pandemic from worsening gender inequality. Programmes should provide financial, food aid, or other needed assistance to caregivers and providers, particularly those living in poverty; make all efforts to prevent child caregivers from having to leave school; and support men through training and consciousness-raising to share the burden of caregiving.

- Training for household caregivers and home-based care providers in how to effectively and safely care for AIDS patients
- Counseling for volunteer home-based care providers
- Respite care and emotional support for household caregivers, especially child/youth caregivers and elderly women
- Daytime assistance so that child/youth caregivers can remain in school, earners/agricultural producers can work
- Stipends, counseling and ongoing training for community home-based care providers
- Programmes to encourage and enable men to share burden of caring so that it does not fall solely on women

The limited body of research on time use shows that in AIDS-affected households adult women have over two-thirds less time for agricultural work or childrearing than in non-affected households.[5] For children, school attendance declines before and after a household death due to AIDS, particularly for girls. Monitoring and evaluation will need to include not only the volume of assistance provided, but analysis of the impact of caretaking on the women and girls of the household, and which interventions to relieve and reallocate the burden are successful.

Action 5: Support for adolescent girls and young women who are orphaned or HIV-affected

Although the term AIDS orphans conjures images of babies and young children who need food and cuddling, most orphans and HIV/AIDS-affected children are adolescents that require a quite different set of interventions.[6] Girls who are orphaned or HIV-affected face a confluence of risks. They are likely to be the first to be pulled out of school to care for AIDS-afflicted parents or surviving siblings. With low skills and education, they are at risk for sexual exploitation and engaging in sex work. In addition, some of them will be HIV infected, either through vertical transmission, or in adolescence. A number of programmes for orphans and vulnerable children (OVC) have demonstrated effectiveness in keeping children in school, including girls. Many programmes, however, do not continue their support for OVC through adolescence and into young adulthood, despite the well-known vulnerability of adolescents, and particularly girls, to sexual exploitation and poverty necessitating engagement in sex work. This programmatic area is important to the effectiveness of the response and ensuring the rights of girls by interrupting the cycle of HIV vulnerability of girls.

- Material and psychosocial support for orphaned and other particularly vulnerable HIV-affected adolescent girls and those in their care
- Support to extended families that allows these girls/young women to be cared for within these networks where possible

5 Blackden 2006
6 UNAIDS 2005. "Children on the Brink"

- Comprehensive gender, sexuality and HIV education for orphaned and vulnerable adolescent girls and young women that present straightforward information about the risks of concurrent or other multiple partnerships, intergenerational sex, and within marriage, as well as the benefits of condom use
- For those adolescent girls and young women who are HIV positive, support to access and optimally maintain ART and other treatment
- Livelihood training and support for orphaned and vulnerable adolescent girls and young women
- Programmes to encourage and enable older boys to share burden of caring for affected parents or surviving siblings

Currently, WHO, UNAIDS and other major compilers of data do not disaggregate OVCs by sex.[7] Therefore an important first step for monitoring will be to disaggregate data collection and reporting in order to better assess the sex differential in the scope of the problem. Interventions to improve the situation of adolescent female OVCs will need to be evaluated to determine whether they are effective in reducing risk-taking behavior, unintended pregnancy and HIV infection. They should also assess longer-term life outcomes as the girls become adults. It will also be important to determine whether boys are picking up an increased share of the caregiving burden following interventions.

Action 6: Clinical and social science research for women

There have been several important streams of clinical research on prevention options for women, including microbicides and pre-exposure prophylaxis (PrEP). These would expand the ability of women to protect themselves against HIV, and possibly reduce infection rates. Treatment regimes, on the other hand, are seldom evaluated specifically for women, and principles of equity require that therapeutic regimens be appropriate to women's particular physiological and other needs. Social science research that seeks to better understand the structural drivers of the epidemic, and to evaluate interventions to reduce their effect, is woefully underinvested.

- Investment in research on prevention methods and treatment regimes that meet women's needs
- Social science research on gender inequality as a key driver of HIV epidemics
- Evaluation of interventions to reduce impact of gender inequality as a driver of HIV epidemics

Monitoring and evaluation will need to track the range and types of research and how priorities are determined, the level of resources invested, and long-term results.

Actions that address underlying gender inequities that fuel the pandemic:

Action 7: Mitigate the negative impact of violence against women, and reduce level of violence by addressing root causes

Violence perpetrated upon women because of their sex is a profound violation of their human rights. Furthermore, the same constellation of factors that put a woman at risk of violence from an intimate partner also put her at greater risk of HIV infection.[8, 9] Violence against women originates in men's desire for

7 Sherr, 2008.
8 Dunkle 2004.
9 Epstein and Kim 2007.

Box 1: Reducing intimate partner violence

The Intervention with Microfinance for AIDS and Gender Equity, or IMAGE project is one of very few randomized control trials to evaluate the effect of structural interventions. Conducted in rural South African communities, interventions included both microfinance loans and a gender training program. After two years, program participants in the intervention communities showed a 55% reduction in intimate partner violence, in addition to increased expenditures, assets and food security, and improved communication skills. Women who only received loans, without the gender training, saw improved economic circumstances but not the other benefits.

The researchers also looked at possible effects on HIV infection rates among young people in the intervention communities, hoping that changes in norms and behavior might have been passed to them from the loan recipients. Although changes in HIV incidence rates were not found, there were signs of positive changes in communication about sex and HIV between generations, and it is possible that this will have a future impact.

(adapted from Gay 2010 and Epstein 2007)

control, and may be exacerbated in contexts where social and gender roles are changing without positive new models,[10] as is the case in many countries where HIV is highly prevalent. In addition, women may be at greater risk of violence in the context of the epidemic itself, due to disclosure of status, worsening family well-being, or other hardships, and therefore a rights-based response requires intervention against VAW. Perhaps because of this, and the strength of the association between experience of violence and likelihood of HIV infection, the goal of reducing violence against women has been more readily accepted as being within the purview of the HIV response than have other efforts to improve women's status. However, the effort to reduce violence, a symptom of gender inequality, cannot be separated from efforts to address the root causes of that inequality. Actions in this area are therefore closely linked with actions to shift gender norms, empower women economically, and change and enforce legislation to support women's rights.

a. Mitigate the negative impact of violence against women

- Train police, lawyers and judges to enforce existing legislation against violence
- Train and equip clinics to recognize sexual violence and to comprehensively address rape with PEP, emergency contraception, counseling, and referral to legal aid
- Support for women and girls seeking redress for violations

b. Reduce the level of violence by addressing root causes

- Engage champions, spokespeople and mass media at all levels
- Ensure that legislation guarantees legal protections against all forms of violence including marital rape (see also Action 9)
- Educate communities, including schools, that VAW violates rights and laws
- Integrate VAW elements into HIV program areas including prevention of violence to women who are HIV-positive, and HIV prevention efforts

10 Jewkes 2002.

- Expand stay-in-school and economic training programmes such as Stepping Stones and IMAGE that lead to empowerment of women (see also Action 10)
- Expand promising programmes for in- and out-of-school youth such as Safe Schools Program and successful interventions such as Program H and One Man Can that support boys and men to rethink gender norms and renounce violence (see also Action 8)

Monitoring and evaluation is complex for this area. The association between HIV susceptibility and VAW seems to result from a shared precursor: a high degree of male control in the relationship (rather than HIV infection being a frequent direct result of rape).[11] The incidence of violence will need to be monitored, including violence to women who are HIV-positive when disclosing or at other times. Also, the ultimate outcome of reduction in HIV infection, should be measured, which may require other concurrent interventions as well. Qualitative, social science methodologies should be employed to track progress before the ultimate outcomes can be expected to be evident. As with other actions that will require long-term investment, tracking resource inputs and process indicators will be important in the near term.

Action 8: Provide gender, sexuality and HIV education that seeks to change gender norms and foster mutually respectful and healthy relationships

Progress toward the third MDG Goal, Gender Equality, is essential to the long-term control of the HIV pandemic in a wide variety of contexts. Providing equitable opportunities for girls and women in terms of school and employment is important, but at least as important is changing attitudes and beliefs about the human rights of women. Programmes addressing VAW are urgent, but target a symptom of dysfunctional gender norms. There is abundant evidence that simply informing young people about HIV and the ways to avoid infection has little impact on behavior, because the social context of male and female relationships in which that behavior occurs needs to change as well. Nonetheless,

Box 2: Changing young men's attitudes and behavior

Program H was initially implemented in several slum communities around Rio de Janeiro in Brazil. The program aims to change the attitudes and behavior of young men (15-24), using a combination of interactive group sessions and community-wide social marketing and mass media campaigns, with various combinations of the interventions in different communities. A quasi-experimental impact evaluation at six months found significant positive changes in attitudes about inequitable gender norms. Self-reported symptoms of sexually transmitted infections declined from 23% to 4% in one community and from 30% to 6% in another, with no statistically significant change in the control group. Although the social marketing campaign promoted condom use, changes in condom use were found only in the community that also included group sessions .

The program has also been adapted for use in India, with resulting positive changes in gender attitudes. Self-reported sexual harassment of girls and women declined from 80% in the three months prior to the intervention to 43% after.

(adapted from descriptions in Gay 2010 and Barker 2007)

11 Dunkle, 2004.

donors and countries have been slow to prioritize accelerating programmes to shift gender norms on a significant scale. The priority has traditionally been adolescents and young adults, but interventions should also be designed for adult men and women not only to change their own behavior, but also to reduce their resistance to changes in the next generation and to broaden impact.

- National programmes that incorporate comprehensive, factually accurate and age-appropriate gender, sexuality and HIV education for children, adolescents and young people both in and out of school.
- Implement programmes aimed at modifying gender norms for adults

There have been numerous promising and successful programmes, including many funded through SRH programmes, that have shown significant changes in attitudes and some change in behaviors. The challenge will be to expand to a far larger scale and evaluate the results. As with VAW, meaningful monitoring and evaluation will need to employ a variety of methods. Changes in HIV infection rates are one of the expected long-term outcomes, but even changes in sexual behavior may be slow. In the early stages M&E will need to track process measures such as developing curricula and having them approved; training teachers; implementing classes. Then it will be necessary to measure distal causes of HIV infection, such as gender norms and attitudes, and power in relationships.

Action 9: Improve and enforce legal protections for all women, including those living with HIV/AIDS

International law and human rights agreements and regional instruments obligate countries to promote gender equality and prohibit discrimination against women living with HIV and AIDS, and on the basis of sexual orientation. Many donor strategies contain lofty statements about the importance of gender equality as the most essential level of legal protection, but few have made it a programmatic priority, perhaps because it is a slow process, and legal change is an issue that raises concerns about respect for national sovereignty. However, those same agreements obligate donors to respect these rights in the implementation of their development assistance.[12]

Numerous countries are in violation of these laws and agreements, and have yet to bring their legal codes and customary laws into line. Even where legislation is present, lack of knowledge and enforcement often render it meaningless. Girls are subject to marriage while they are still children, women are denied the right to inherit property, and sexual orientation is a crime. Interventions to improve and enforce laws work both to mitigate the impact of the pandemic, and also to prevent its further spread. Thus these actions seek to ensure that women's inequality is not worsened by their own or their partners' HIV status; and also to establish and enforce equality under the law and reduce susceptibility to infection.

- Research and documentation of the extent and impact of unequal legal status
- Support work to enact legislation or regulations in line with international gender equality and human rights agreements and norms:
  - Property rights, inheritance and custody laws (including customary laws)
  - Equality in the workplace
  - Prevention of early marriage

12 For an excellent comprehensive discussion of international rights obligations and detailed illustrative recommendations (for Swaziland and Botswana) see Physicians for Human Rights 2007.

    - Protection against discrimination due to HIV status
    - Prevention or repeal of criminalization laws that specifically target HIV infection
    - Protection against discrimination due to sexual orientation
    - Decriminalization of sex work
    - Protection from gender based violence (see also Action 7, above)
- Train police, lawyers and judges to enforce existing laws that protect equal status
- Educate women and communities, including traditional leaders, about the legal rights of women
- Provide access and support for methods of redress

Monitoring and evaluation will need to track efforts and eventual outcome in enacting legislation or regulations. Where laws already exist, enforcement and access to redress should be monitored. Outcome measures of reduced harmful impacts on those with HIV will include whether discriminatory actions due to gender or HIV status are reduced. Longer-term outcome measures of susceptibility to infection will require, for example, looking at whether there have been changes in the degree of property ownership and whether those changes are associated with change in HIV infection rates.

Action 10: Ensure education and essential livelihood support

The provision of education for girls has many well-documented benefits for the women they become, their families, and society as a whole. There is growing evidence that it also protects against HIV infection, probably through several mechanisms including greater autonomy, economic self-sufficiency, and simply keeping girls occupied in a comparatively safe environment.

Research shows that the populations most at risk have changed since the early days of the epidemic. Poor, uneducated young women are increasingly likely to be infected, often at many times the rate of young men, or of wealthier, better-educated young women. Not surprisingly, girls and women who are struggling for the basic necessities of life such as food are more likely to turn to transactional or commercial sex, thereby raising their risk for HIV infection.[13] Addressing the next stage of many epidemics will require interventions that reduce

Box 3: Reducing sexually transmitted infections

The Stepping Stones program is an intensive intervention, working with both women and men, in separate groups. It was developed in South Africa, and has since been implemented in 40 countries around the world. Stepping Stones aims to transform gender norms using participatory methodologies that rely on critical reflection and dialogue. Its effectiveness was assessed using a randomized control trial in 70 villages in the Eastern Cape. Although there was no statistical impact on HIV incidence, there was a 33% reduction of herpes simplex infections. Since the same risk behaviors are involved for HSV-2 and HIV, this suggests that it could be of benefit in HIV reduction when implemented on a wider scale, or assessed over a longer period of time.

In addition, men's reports of perpetration of physical and sexual violence was significantly reduced.

(Adapted from description in Gay 2010)

13 Hallman 2004

the structural factors that put girls and young women at risk. Such interventions are complex, and highly context and population specific, but programmes to enhance women's ability to earn money have been shown to improve women's own and family economic circumstances.[14] In the case of extremely poor, uneducated women and families, particularly in rural areas, livelihood support may require food aid and/or cash transfers. Livelihood programmes need to be based on a deep understanding of the multivariate challenges particular groups of women face, and be tailored to their age and circumstances. Caution must be taken that they don't inadvertently increase women's task burden or financial pressures.

- Universal free primary education and increased access to secondary education
- Teacher and administrator training and infrastructure to ensure that schools are safe spaces for girls
- Food aid and cash transfer programmes for extremely poor women and families
- Agricultural extension projects for rural women and families
- Social science research to determine successful approaches to sustainable livelihoods, including microfinance
- Expansion of successful microfinance, savings, training and employment projects such as IMAGE and Stepping Stones that seek to improve women's economic well-being

Monitoring and evaluation for this area of action will need to occur on several levels. Monitoring will need to track inputs and achievements in terms of education and training. Evaluation of the success of interventions will need to be stratified for sex, age, rural/urban residence and other characteristics and consider whether a) educational, nutritional and/or economic status has been improved and b) whether changed status is associated with change in the likelihood of HIV infection. There is no universal guidance on how to help women be more successful economically. However, improved economic well-being is clearly linked to attaining greater gender equality and is closely intertwined with HIV risk, and to further build our knowledge base requires continuing work in this area.

Each of the ten actions listed above addresses one or more of the Four Pathways through which gender inequality and HIV interact. The actions have the objective of either reducing the gender inequitable impact of HIV, and/or changing the underlying gender inequality that fuels the spread of HIV. Together, the Pathways and the Actions are intended to serve as a framework for thinking about the gender context in which any HIV programme operates.

Table 1 provides a framework that can be used to analyze a country's HIV epidemic(s) with respect to gender inequality. The columns are the Four Pathways, and the rows are the Action areas. At the intersection of each pair, within a given country or context, one can identify ways in which a Pathway creates a problem, and the area of Action that might be implemented to solve it. In Table 1, for each intersection, an example of a Problem, and a Desired Outcome are presented. In Box 4, the concept is further illustrated showing the specific Actions that might be proposed to move from the Problem to the Desired Outcome.

14 Kim 2007

Table 1. Sample Problems and Desired Outcomes from Actions Targeting Pathways of Gender and HIV Interaction

	Pathways through which Gender Inequality (GIE) interacts with HIV pandemic			
Actions to mitigate influence of gender inequality (GIE)	**P1. GIE affects level of susceptibility to infection**	**P2. GIE exacerbates effects of being HIV-positive for infected/ affected**	**P3. GIE reduces effectiveness of HIV response**	**P4. Epidemic and response exacerbates GIE**
Action that creates a supportive environment				
A1. Supportive Environment	**Problem:** Infections among young teenage girls by older men is rising. **Desired outcome:** Intergenerational sex is socially no longer acceptable and declines.	**Problem:** The extent of a sex differential impact on HIV-positive women in terms of stigma, health outcomes, and social well-being are unknown. **Desired outcome:** Gender-sensitive national M&E systems include measurement of differences in how men and women are affected by being HIV-positive.	**Problem:** Despite expanded efforts, rates of infection for women are not declining. **Desired outcome:** Women's organizations are funded to develop programmes appropriate to meet women's needs for prevention and infection rates start to decline.	**Problem:** HIV-positive and susceptible women have no input to decision-making and design of programmes that affect many aspects of their lives. **Desired outcome:** Women are included on policy and programme boards and have a voice in activities affecting them, thereby upholding principles of gender equality and human rights.
Actions that address direct needs				
A2. Engender HIV health and education services	**Problem:** People do not understand the heightened risk from concurrent partnerships. **Desired outcome:** Comprehensive HIV education campaigns ensure that everyone understands the full range of risk factors and can modify behaviour to reduce them.	**Problem:** Women are afraid to tell their partners that they are HIV-positive, raising risk of passing on infection. **Desired outcome:** Couples' testing and counseling assists HIV-positive women in disclosing status.	**Problem:** Men do not feel comfortable seeking testing and care at existing delivery points. **Desired outcome:** Gender-sensitive services meet men's needs and draw them to seek services.	**Problem:** Men who have been circumcised are refusing to use condoms. **Desired outcome:** Comprehensive and gender sensitive adult male circumcision programmes mitigate potential negative impact on women.
A3. Integrate SRH and HIV services	**Problem:** Monogamous women not aware of their risk and are being infected by partners. **Desired outcome:** women attending SRH clinics gain knowledge, skills and supplies for prevention, leading to lower infection rates.	**Problem:** Under pressure to have children, HIV-positive women may put their health at risk. **Desired outcome:** HIV-positive women and their families understand how to shape and meet fertility desires with best health outcomes.	**Problem:** Women who are illiterate or without access to information don't understand risk or know where to access HIV services. **Desired outcome:** All SRH services - which are the most likely to be used by all women -- are able to share HIV prevention and treatment information and increase knowledge and behaviour change.	**Problem:** SRH service providers stigmatize HIV-positive women and violate their sexual and reproductive rights. **Desired outcome:** Sensitized service providers do not forcibly sterilize HIV+ women, but help them meet their RH needs.

	Pathways through which Gender Inequality (GIE) interacts with HIV pandemic			
Actions to mitigate influence of gender inequality (GIE)	**P1. GIE affects level of susceptibility to infection**	**P2. GIE exacerbates effects of being HIV-positive for infected/ affected**	**P3. GIE reduces effectiveness of HIV response**	**P4. Epidemic and response exacerbates GIE**
Actions that address direct needs (continued)				
A4. Support for caregivers	**Problem:** Women missing work to provide care for HIV-positive family members lose paid employment and rely on commercial or transactional sex increasing risk. **Desired outcome:** Alternate sources of care mean female family members don't lose paid work, or female caregivers who do lose paid employment will have financial support to avoid resorting to transactional sex for economic survival.	**Problem:** Because they are the traditional caregivers, it is women who bear the brunt of the burden of HIV care. **Desired outcome:** Community-based caregivers provide regular respite care and prevent burnout.	**Problem:** Since only women traditionally provide care, there is a shortage of caregivers. **Desired outcome:** Caregiver training programmes that target engagement of both men and women reduces caregiver shortage.	**Problem:** Women are first to give up paid employment when needed for caregiving tasks, lowering their status further. **Desired outcome:** Diversification of caregiving and support services means women do not lose income and autonomy.
A5. Support for adolescents and OVC	**Problem:** OVCs must resort to risky sex for survival. **Desired outcome:** OVC's have knowledge and financial resources to avoid risky sex.	**Problem:** Female OVC's schooling is considered less important compared to male. **Desired outcome:** Financial support allows female OVC's to stay in school and avoid sexual exploitation and dire poverty.	**Problem:** With tradition of only girls providing care, 50% of young people not available to help younger siblings. **Desired outcome:** boys are trained and sensitized to share responsibility so that quantity and quality of caregiving of younger children is improved.	**Problem:** National programmes rely on family members to provide care, and that means girls and women miss out on school or work opportunities. **Desired outcomes:** Other sources of home-based care for family members allows girl OVC's to stay in school and women to continue paid work.
A6. Invest in clinical and social science research for women	**Problem:** Women are at biologically elevated risk of infection. **Desired outcome:** Effective female prevention methods and approaches developed.	**Problem:** Gender-blind research has meant that optimized treatment regimens for women have not been a priority. **Desired outcome:** Women have treatment regimes appropriate to their needs.	**Problem:** Role of gender inequality on HIV pandemics is not widely understood. **Desired outcome:** Increased research on the interrelationship of gender inequality and HIV results in stronger global response.	**Problem:** Anecdotal evidence of adult male circumcision programmes having negative impact on women. **Desired outcome:** Investment in research resulting in better understanding of impact of adult male circumcision programmes on women.

continued on next page

Table 1 (continued)

	Pathways through which Gender Inequality (GIE) interacts with HIV pandemic			
Actions to mitigate influence of gender inequality (GIE)	**P1. GIE affects level of susceptibility to infection**	**P2. GIE exacerbates effects of being HIV-positive for infected/ affected**	**P3. GIE reduces effectiveness of HIV response**	**P4. Epidemic and response exacerbates GIE**
Actions that address underlying inequities				
A7. Reduce VAW	**Problem:** Women fearing violence are afraid to insist on condom use. **Desired outcome:** reduced fear of violence allows women to insist on condom use.	**Problem:** HIV-positive women are subjected to physical violence at home and in community. **Desired outcome:** Enforced penalties for violence reduces incidence of violence against all women.	**Problem:** Fear of violence leads women to refuse to disclose positive status. **Desired outcome:** Reduced levels of violence result in HIV-positive women being more willing to disclose their status and practice secondary prevention.	**Problem:** Men do not have alternate models for dealing with complex problems such as HIV infection in the the family, and resort to violence. **Desired outcome:** Programs to help men abstain from violence and deal with HIV-related conflict in other ways result in fewer women being beaten and improved relationships.
A8. Comprehensive gender and sexuality education	**Problem:** Young men feel that they must prove their sexuality by having many partners, putting both themselves and partners at increased risk. **Desired outcome:** Young men and women have mutually respectful relationships that increase practice of safer sex.	**Problem:** HIV-positive women are blamed for 'bringing HIV into the household' and suffer the consequences. **Desired outcome:** Adult HIV and gender education leads to a more balanced understanding of how HIV is transmitted and more accepting attitudes of HIV-positive women.	**Problem:** Female condom distribution programs are under-utilized. **Desired outcome:** Greater knowledge and comfort with female anatomy -- for both men and women -- reduces resistance to using female condoms.	**Problem:** The context of HIV is reinforcing the perceived desireability of harmful behaviours, such as intergenerational sex. **Desired outcome:** Shifting gender norms lead to greater gender equality and diminish exploitive and risky behaviours.
A9. Legal reform	**Problem:** Young women are vulnerable to sexual harassment by their bosses. **Desired outcome:** Increased equality in the workplace and access to redress reduces women's susceptibility to sexual exploitation by superiors.	**Problem:** HIV-positive women and widows are thrown out of their houses and lose access to property and children. **Desired outcome:** Legal rights are enforced to protect property and custody of HIV-positive women.	**Problem:** Criminalization of sexual behaviors prevents at risk populations from seeking HIV prevention and treatment services. **Desired outcome:** The rights of all people to safely access services are protected and uptake of services increases.	**Problem:** Women's weak overall legal rights create even greater discrimination and hardship in the context of an HIV epidemic. **Desired outcome:** Improvements in and enforcement of women's legal rights arising from HIV response can have broader impact to increase overall gender equality.
A10. Education & Livelihood support	**Problem:** Women with no other access to resources engage in transactional sex for their own and their children's economic survival, putting them at increased risk of HIV infection. **Desired outcome:** Women's and children's basic needs are met and they do not need to resort to transactional sex.	**Problem:** HIV-positive women and widows lose access to family support or external employment and fall into poverty. **Desired outcome:** Economic support and/or livelihood training are provided to ensure survival.	**Problem:** Women do not have the autonomy required to participate in livelihood training or savings schemes established to assist HIV-positive women. **Desired outcome:** Increased women's autonomy allows them to more successfully participate in such opportunities.	**Problem:** HIV-affected families have less money to spend on education, and girls are the first casualties, trapping them in poverty. **Desired outcome:** Education subsidies mean that girls can stay in school and have greater opportunities.

Box 4: Sample actions to move from Problem to Desired Outcome

Pathway 1 / Action area 1

Problem: Despite expanded efforts, rates of infection for women are not declining.

Desired outcome: National programme appropriate to meet women's needs for prevention starts to reduce infection rates.

Interventions in the A.1 Action area proposed to attain outcome:

- Actively recruit and fund women with gender expertise and knowledge of at-risk women to participate in all stages of programme design and implementation.
- Set a minimum quota of seats on the Country Coordinating Mechanism for women with requisite expertise.
- Fund organizations working with women and HIV to participate in advisory councils, etc.

Pathway 2 / Action area 7

Problem: HIV-positive women are subjected to physical violence at home and in community.

Desired outcome: Enforced penalties for violence reduces incidence of violence against all women.

Interventions in the A.7 Action area proposed to attain outcome:

- Sensitize police, lawyers and judges on the rights of HIV-positive women and on existing legislation against violence

(Adapted from description in Gay 2010)

V. Implications for Gender Aware Monitoring and Evaluation

The core set of UNGASS indicators in use through 2011 does not include any gender equality indicators, although indicators are disaggregated by sex, and there is an indicator for Prevention of Mother to Child Transmission. There are also some relevant questions in the National Composite Policy Index (NCPI), which measures countries' policy commitments on HIV, as reported by both governments and civil society. UNAIDS, through the Monitoring and Evaluation Reference Group (MERG), and the Technical Working Group on Indicator Standards, in 2010 undertook a process of reviewing and selecting indicators for the next cycle of UNGASS. The process included the convening of several topical consultation groups that considered the current indicators and any gaps, and made suggestions for refinement or changes. The MERG will decide on a final set in February 2011. During this process, a new gender equality indicator was proposed: Prevalence of Recent Intimate Partner Violence, and it is hoped that it will be included in the core set. In addition, recommendations were made for the NCPI to make it a stronger index for gender policies (see Box 4). At the same time, work is ongoing to develop a menu of national and programmatic indicators that can form the basis of a harmonized monitoring and evaluation approach, and strengthen the gender content of HIV programmes.

Box 5: Suggested changes to NCPI to increase gender content

- Questions on laws, regulations and policies that present obstacles to effective prevention and treatment for women should specify that relevant laws include those pertaining to property, inheritance, custody, customary law, etc.
- Questions on laws, regulations and policies that present obstacles to effective prevention and treatment should specify that relevant laws include those that pertain to the rights of young people to sexual and reproductive health information and services.
- Questions on the characteristics of the national multisectoral AIDS coordination body and other questions pertaining to participation of civil society should ask the numbers or percent of members who are women, how many are HIV-positive women, and how many have specific gender expertise.
- Questions on orphans and vulnerable children (OVC) should include questions relevant to older orphans, such as whether the strategy for OVCs includes age-appropriate SRH elements.
- Questions on post-exposure prophylaxis (PEP) should separate post-rape procedures from others.
- The extensive M&E section could be reworked to include whether M&E system has gender component

The specific interventions to be undertaken by programmes will need to be selected after careful analysis of the epidemic in the country or sub-national area, or in the sub-population. For some circumstances, there is robust evidence of what has been successful, for others, the evidence is partial or nonexistent.[15] However, lack of evidence for a specific approach should not be a barrier to further addressing the interrelationship of HIV and gender inequality. Close knowledge of the particular epidemic, expertise in gender, and experiences of HIV-positive women can be brought together to formulate promising interventions. Evaluation of various kinds, including those appropriate to assessing structural interventions, should be included in planning, thus adding to the evidence base.[16]

Ensuring that monitoring and evaluation are appropriate to a strengthened gender approach that includes these actions will not only measure what happens, but will in fact stimulate and accelerate the shift. Not only does 'what gets measured, gets done', but what gets measured gets fully defined.

The tasks for developing a gender aware M&E system are several:

- Shift expectations with respect to timeline for results and develop complementary sets of indicators. When engaged in a process that seeks to change structural factors, we need a different approach to monitoring and evaluation. The change will be slower than most funding cycles. We will need both interim and outcome measures.

- Track expenditures for programmes or components that have a specific gender-related objective

- Incorporate gender sensitive monitoring and evaluation approaches to capture differential impacts of the epidemic and the interventions on males and females. This is looking at how to change the "output" from the pandemic, and requires 'gender sensitive' M&E.

This does not require radically different measurement tools and approaches, but does require consistent disaggregation of data by sex, stratified by age and other social variables; attention to collecting the kinds of data that will particularly capture impacts on women; and including qualitative measures that can explicate the gender interactions underlying the data.

- Measure the effectiveness of gender-equality promoting measures on reducing HIV infection or the proximate causes of HIV infection. This is looking at how changing gender inequality as an "input" can change the pandemic itself. This requires a 'gender transformative' approach to interventions.

This requires identifying, for a particular epidemic, ways in which gender inequality is increasing susceptibility to HIV; developing plausible interventions; identifying information that can be collected. In addition to the occasional specific study, we will need to understand and accept evidence that does not result from a quasi-experimental design, but instead relies on social science methodologies.[17]

- Ensure that gender indicators are harmonized. With few major donors or countries having established sets of gender indicators, there is an opportunity for harmonization of global or macro-level indicators, a menu of

15 Gay, 2010
16 For more detail, see Auerbach 2009
17 Auerbach 2009

country or programme level indicators, and agreement about the approach to developing project level indicators.

- There are numerous guides to developing gender sensitive indicators and a number of gender composite indexes.[18] A list of selected resources for developing gender indicators appears in Appendix C.

Thirty years into the HIV pandemic, the global community has made valiant efforts to slow the spread of the disease and to treat those infected. But the effort has been hampered by a reluctance to recognize the long-wave nature of the pandemic, and the complex socio-economic and cultural factors that have aided its global reach. Now, perhaps, the world finally recognizes that no matter how successful our interventions, HIV is with us for at least another generation. There will be no silver bullet. We have, sadly, plenty of time to figure out how to tackle the underlying structural drivers of this pandemic.

18 An explanation of the two major indices, Gender-related Development Index (GDI) and Gender Empowerment Measure (GEM) can be found at http://hdr.undp.org/en/statistics/indices/gdi_gem/

Appendix A

Actions included in various Statements and Calls to Action

	Document in which included										
	ICW	**Barcelona**	**Buenos Aires**	**Mutapola**	**WWW**	**Johannes-burg**	**Panama**	**Blueprint**	**GCWA**	**Nairobi**	**OSI**
	1992	**2002**	**2004**	**2005**	**2006**	**2006**	**2006**	**2006**	**2006**	**2007**	**2008**
Area of Action											
Actions that address direct needs created by pandemic											
Engendered HIV/AIDS services	X	X		X	X	X		X	X	X	X
Integration of HIV and SRH services		X		X	X	X		X	X	X	X
Support caregiving	X	X		X	X	X		X	X	X	X
Support for vuln. adolescent girl		X								X	X
Research for women	X	X	X	X	X	X		X	X	X	X
Actions that address underlying gender inequalities that fuel the pandemic											
Involve women in decision-making	X			X	X	X	X	X	X	X	X
Reduce VAW		X		X	X	X		X	X	X	X
Gender and Sexuality education		X			X			X		X	X
Legislative reform		X		X		X			X	X	X
Ensure education, livelihood skills	X		X	X	X				X	X	

ICW= The twelve Statements of the International Community of Women Living with HIV/AIDS. 1992

Barcelona= Women and HIV/AIDS: The Barcelona Bill of Rights. 2002

Buenos Aires= Buenos Aires Declaration 2004: Human Rights, Women and AIDS

Mutapola= Knowing Mutapola: A Resource and Action Guide fro Women's Rights and HIV & AIDS in Africa. ActionAid: 2007

WWW= With Women Worldwide: A Compact to End HIV/AIDS. 2006

Johannesburg= the Johannesburg Position on HIV/AIDS and Women's and Girls' Rights in Africa. April 2006

Panama= The Panama Declaration of the Latin American International Community of Women Living with HIV/AIDS 2006: Nothing or Us Without Us.

Blueprint= Blueprint for Action on Women and Girls and HIV/AIDS. 2006

GCWA= Global Coalition on Women and AIDS, Keeping the Promise: An Agenda for Action on Women and AIDS. UNAIDS: 2006

Nairobi= Women's Leadership on HIV and AIDS: The Nairobi 2007 Call to Action

OSI= Human Rights and HIV: Now More Than Ever: 10 Reasons Why Human Rights Should Occupy the Center of the Global AIDS Structure, Open Society Institute: 2008

Appendix B: Resources for Gender in Monitoring and Evaluation

Ashburn, Kim, et al. 2009. "Moving beyond gender as usual." Washington, DC: Center for Global Development. See Appendix E.
Accessed at http://www.cgdev.org/content/publications/detail/1422358/

Auerbach, Judith D., et al. 2009. "Addressing social drivers of HIV/AIDS: Some conceptual, methodological, and evidentiary considerations." aids2031 Working Paper No.24. New York.

Caro, Deborah. 2009. "A manual for integrating gender into reproductive health and HIV programmes: From commitment to action." Interagency Gender Working Group. Washington DC: Population Reference Bureau. See chapters 4 and 5.
Accessed at http://www.igwg.org/igwg_media/manualintegrgendr09_eng.pdf

Thomson, Marilyn. 2009. "HIV and violence against women - monitoring and evaluation of programmes. Development Connections DVCN Critiques 2(3).

Marmot, Michael, ed. 2008. "Closing the gap in a generation: Health equity through action on the social determinants of health." Geneva: WHO. Accessed at http://whqlibdoc.who.int/publications/2008/9789241563703_eng.pdf See part 5.

Moser, Annalise. BRIDGE Cutting Edge Pack: Gender and Indicators: Overview Report. of Development Studies: July 2007. Accessed at
http://www.bridge.ids.ac.uk/reports/IndicatorsORfinal.pdf

Yinger, Nancy, et al. 2002. "A framework to identify gender indicators for reproductive health and nutrition programming." Interagency Gender Working Group, Subcommittee on Research and Indicators. Washington DC: Population Reference Bureau.
Accessed at http://www.prb.org/pdf/FramewkIdentGendrIndic.pdf

References

ActionAid. 2007. Knowing Mutapola: A resource and action guide for women's rights and HIV & AIDS in Africa. Nairobi.

AIDS Accountability International. 2009. "The AIDS accountability scorecard on women."

Ashburn, Kim, et al. 2009. "Moving beyond gender as usual." Washington, DC: Center for Global Development.

Auerbach, Judith D., et al. 2009. "Addressing social drivers of HIV/AIDS: Some conceptual, methodological, and evidentiary considerations." aids2031 Working Paper No.24. New York.

"Barcelona bill of rights, women and HIV/AIDS." 2002. Accessed at http://www.athenanetwork.org/barcelona_bill_eng.html

Barker, Gary, et al. 2007. "Engaging men and boys in changing gender-based inequity in health: Evidence from programme interventions." Geneva: WHO.

Blackden, C. Mark and Quentin Wodon, eds. 2006. "Gender, time use and poverty in sub-Saharan Africa." World Bank Working Paper No. 73.Washington, DC.

"Blueprint for Action on Women and Girls and HIV/AIDS." 2006. Accessed at http://www.athenanetwork.org/docs/Blueprint_Manifesto_2006_EN.pdf

"Buenos Aires declaration 2004: Human rights, women and AIDS." Accessed at http://www.icw.org/node/107

Canadian HIV/AIDS Legal Network. 2009. "Respect, protect and fulfill: Legislating for women's rights in the context of HIV/AIDS Volume One: Sexual and domestic violence."

Caro, Deborah. 2009. "A manual for integrating gender into reproductive health and HIV programmes: From commitment to action." Interagency Gender Working Group. Washington DC: Population Reference Bureau.

Commission on the Social Determinants of Health. 2008. "Closing the gap in a generation: health equity through action on the social determinants of health: final report of the commission on social determinants of health." Geneva: WHO.

Dunkle, Kristin L. et al. 2004. "Gender-based violence, relationship power, and risk of HIV infection in women attending antenatal clinics in South Africa." Lancet, 363: 1415-1421.

Epstein, Helen and Julia Kim. 2007. "AIDS and the power of women." New York Review of Books, February 15: 39-41.

Fleischman, Janet. 2008. "An analysis of the gender policies of the three major AIDS financing institutions: The Global Fund to Fight AIDS, Tuberculosis and Malaria, the World Bank, and the President's Emergency Plan for AIDS Relief." Geneva: UNAIDS.

Gay, Jill et al. 2010. "What works: evidence for HIV/AIDS interventions for women and girls." New York: Open Society Institute. www.whatworksforwomen.org

Gillespie, Stuart et al. 2007. "Is poverty or wealth driving HIV transmission?" AIDS 21(Suppl 7):S5-S16.

Global Coalition on Women and AIDS. 2006. "Keeping the promise: an agenda for action on Women and AIDS. Geneva: UNAIDS.

Glion call to action on family planning and HIV/AIDS in women and children. May 2004. Accessed at http://www.unfpa.org/public/publications/pid/1435

Global Fund to Fight AIDS, Tuberculosis and Malaria. 2010. "The Global Fund 2010: Innovation and impact." Geneva.

Global Fund to Fight AIDS, Tuberculosis and Malaria. 2009. "Gender Analysis of Round 8 HIV/AIDS proposals." Accessed at http://www.theglobalfund.org/documents/rounds/9/CP_Analysis_R8_Gender%20Responsiveness_en.pdf

Global Fund to Fight AIDS, Tuberculosis and Malaria. 2008. Fact sheet: Ensuring a gender sensitive approach." Accessed at http://www.theglobalfund.org/documents/rounds/8/R8Gender_Factsheet_en.pdf

Gupta, Geeta R., et al. 2008. "Structural approaches to HIV prevention." Lancet 372: 764-775. http://www.unfpa.org/public/publications/pid/1435

Hallman, Kelly. 2004. "Socioeconomic disadvantage and unsafe sexual behaviors among young women and men in South Africa," Population Council Working Paper #190. New York.

Hargreaves, James R. 2008. "Systematic review exploring time trends in the association between educational attainment and risk of HIV infection in sub-Saharan Africa." AIDS 22:403–414.

Higgins, Jenny A. 2010. "Rethinking gender, heterosexual men, and women's vulnerability to HIV/AIDS." American Journal of Public Health, 100:435-445.

International Community of Women Living with HIV/AIDS. "The twelve statements." 1992. Accessed at http://www.icw.org/twelvestatements

Jewkes, Rachel. 2002 "Intimate partner violence: Causes and prevention." Lancet 359:1423-1429.

"Johannesburg position on HIV/AIDS and women's and girls' rights in Africa." April 2006. Accessed at http://www.unifem.org/attachments/stories/currents_200606_JohannesburgPosition.pdf

Kim, Julia, et al. 2008. "The role of economic empowerment in HIV prevention." AIDS; 22 (suppl 4): S57-S71.

Kim, Julia, et al. 2007. "Understanding the impact of a microfinance-based intervention on women's empowerment and the reduction of intimate partner violence in South Africa." American Journal of Public Health 97: 1784-1802.

Lewis, Stephen, mod. "Food security, livelihoods and HIV: Challenges and responses." XVII International AIDS Conference Panel (transcript) August 3, 2008. Accessed at: http://www.kaisernetwork.org/health_cast/uploaded_files/080308_ias_sat_challenges_transcript.pdf

Moser, Annalise. 2007. "BRIDGE cutting edge pack: gender and indicators: overview report." London: Institute of Development Studies.

"Nairobi 2007 Call to Action, women's leadership on HIV and AIDS." Accessed at http://www.worldywca.org/en/Take-Action/Campaigns/Nairobi-2007-Call-to-Action-on-HIV-and-AIDS

Open Society Institute. 2008. "Human rights and HIV: Now more than ever: 10 reasons why human rights should occupy the center of the global AIDS structure." New York.

"Panama declaration of the Latin American International Community of Women Living with HIV/AIDS 2006: Nothing for us without us." Accessed at http://www.aidswomen-caucus.org/pdf/ICW_Panama_06_en.pdf

President's Emergency Plan for AIDS Relief. 2009. "Gender and HIV/AIDS." Accessed at http://www.pepfar.gov/pepfar/press/76365.htm

Physicians for Human Rights. 2007. "Epidemic of inequality -- women's rights and HIV/AIDS in Botswana & Swaziland: An evidence-based report on the effects of gender inequity, stigma and discrimination." Cambridge.

Rosenthal, Lisa and Sheri R Levy. 2010. "Understanding women's risk for HIV infection using social dominance theory and the four bases of gendered power." Psychology of Women Quarterly, 34 21-35.

Sherr, Lorraine, et al. 2008. "Evidence-based gender findings for children affected by HIV and AIDS: A systematic overview." AIDS Care 21, No. S1:83-97.

Tallis, Vicci. "BRIDGE Gender and HIV/AIDS: Overview Report." Institute of Development Studies: September 2002.

UNAIDS, UNICEF and USAID. 2005. "Children on the Brink 2004: A joint report of new orphan estimates and a framework for action." Washington, DC: USAID.

UNAIDS Inter-Agency Task Team on Gender and HIV/AIDS.2005. "Operational guide on gender and HIV/AIDS: A rights-based approach." Geneva: UNAIDS.

UNAIDS. 2008. Report on the global AIDS epidemic." Geneva.

UNAIDS. 2009. "UNAIDS second independent evaluation 2002-2008: Final report." Geneva.

UNAIDS. 2009. "Gender-based Violence and HIV." (DRAFT)

UNIFEM. 2008. "Transforming the national AIDS response: Mainstreaming gender equality and women's human rights into the 'Three Ones'." New York.

Watts, Charlotte, et al. 2007. "Financial resources required to achieve universal access to HIV prevention, treatment, care and support: Integrating the prevention of violence against women and PEP into the HIV programmes: preliminary framework and proposed next steps." Geneva: UNAIDS.

Weiser, Sheri D. et al. 2007. Food Insufficiency Is Associated with High-Risk Sexual Behavior among Women in Botswana and Swaziland, PLoS Medicine 4 (10): 1589-1598

WHO. 2002. Community home-based care in resource-limited settings: A framework for action. Geneva.

WHO. 2009. "Addressing violence against women and HIV/AIDS: What works?" (unpublished draft meeting report following a technical consultation.)

WHO. 2009. "Gender-based Violence and HIV." (unpublished draft background report for a technical consultation.)

WHO. 2009. "Integrating gender into HIV/AIDS programmes in the health sector: tool to improve responsiveness to women's needs." Geneva.

With Women Worldwide: A Compact to End HIV/AIDS. 2006. Accessed at http://www.iwhc.org/index.php?option=com_content&task=view&id=3318&Itemid=583

World Bank. 2003. "HIV/AIDS and gender equality." Accessed at http://www4.worldbank.org/afr/ssatp/Resources/HTML/Gender-RG/Source%20%20documents/Issue%20and%20Strategy%20Papers/HIV/ISHIV3%20HIV%20and%20Gender%20EqualityPREM2003.pdf

Yinger, Nancy, et al. 2002. "A framework to identify gender indicators for reproductive health and nutrition programming." Interagency Gender Working Group, Subcommittee on Research and Indicators. Washington DC: Population Reference Bureau.