UNAIDS Gender Assessment Tool for National HIV Responses

Interim Version

SUMMARY

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INTRODUCTION

The Gender Assessment Tool for National HIV Responses is meant for countries to review their HIV epidemic, context and response from a gender perspective, with the view to ensure that HIV responses become gender transformative and address the underlying socio-cultural factors that maintain gender inequality and gender based violence. The outcomes of the gender assessment aim to inform the development of gender-transformative HIV strategic plans, resource mobilization proposals, such as the Global Fund application, as well as investment cases, and national development frameworks. It is developed as a self-explanatory tool to address gaps in information, required to inform the above mentioned processes, while enabling different constituencies to take the lead in proposing strategies to address the identified gaps, including government, UN, development partners and civil society.

The Gender Assessment Tool is composed of four stages. The first is the preparation phase, convening the people, designing approach and logistics; the second and third stages are made up of a sequence of questions inquiring about the country HIV epidemic context and the country HIV response. The responses to these stages are the core of the assessment. The fourth stage focuses on analysing the results, defining priorities and planning on how to best take action based on the findings, towards a gender transformative HIV response.

The Gender Assessment Tool for National HIV Responses *Interim Version* includes a glossary, introduction to the gender assessment, lists of relevant documents to be reviewed, a basic communication directive, and link to several sample documents such as budget, terms of Reference and already proved gender sensitive programs and services on HIV.

The Gender assessment tool is part of a comprehensive package of tools to support countries to complete their planning cycle as needed. The package consists of the following tools:

- *Gender roadmap* (UNDP) – to advocate
- *Gender assessment tool (UNAIDS)* - to determine the gaps in the HIV response
- *WHO and UNFPA guidance/What works for women* – to recommend effective actions
- *Compendium of gender indicators (UNW)* – to measure results
- *Gender sensitive costing and budgeting (UNW/UNAIDS)* – for resource mobilization and tracking

They are brought together by the Gender roadmap clarifying the modular approach of the comprehensive package and explaining how each of the tools relates to the planning cycle. Countries are encouraged to assess which of the elements of the planning cycle for gender transformative HIV responses still need attention, to start with the gender assessment tool.

Stage 1
PREPARING FOR THE GENDER ASSESSMENT OF THE NATIONAL HIV RESPONSE

Step 1. SECURE HIGH-LEVEL COMMITMENT

While different constituencies can take the lead in advocating and raising awareness on the undertaking of the gender assessment, high level national commitment it's key to its success. The lead constituency should work closely together with key government representatives, to undertake the following tasks:

Task 1. Map out key government decision makers, particularly in the Ministries of Health, Gender, Education and Justice. Get their names and contact information.

Task 2. Identify challenges to high-level support and prepare strategies to overcome them.

Task 3. Prepare a brief one-page justification on why to undertake a gender assessment and share it, along with specific information about UNAIDS Gender Assessment Tool with key decision makers.

Step 2. ESTABLISH A COUNTRY ASSESSMENT TEAM

Task 1. In collaboration with the national government representatives, identify experts on HIV policies and services; experts on gender policies and services; and relevant stakeholders of both fields. The stakeholders should include, but not be restricted to, UN agencies, government, and civil society representatives. As appropriate, include stakeholders from other key sectors such as health, education, gender, justice, human rights, and finance. Please note that it is important to ensure country ownership and leadership, and that high-level government representatives should lead the process.

> Obs.: In line with the GIPA principle, the meaningful involvement of people living with HIV should be ensured. Civil society organizations working on gender, women's rights, youth, key populations, and sexual and reproductive rights must be engaged.

Task 2. Bring the Team together to share and review the term of references of the Country Assessment Team. It is important to emphasize the importance of the gender assessment, and how this process can support national efforts toward a gender transformative HIV response. Make it clear that additional opportunities for further engagement will appear later on in the assessment process.

Task 3. Agree on how the internal communication between the members of the Country Assessment Team will occur.

Step 3. DEVELOP A GENDER ASSESSMENT FRAMEWORK

Task 1. Request all members of the Country Assessment Team to read the Gender Assessment Tool and its accompanying guide, as needed. Any question regarding the

Tool should be addressed and clarified prior to data collection.

Task 2. Discuss within the Country Assessment Team what the goal of the gender assessment is.

Task 3. Agree on the objectives of the gender assessment, in terms of aiming for clear short-term results in support of the goal.

Task 4. Agree on guiding principles for undertaking the gender assessment process, as well as on ways to monitor the application of the guiding principles. UNAIDS directive includes such principles as:

- Working based on equity and fairness;
- Respect for different points of view;
- Respect for meaningful involvement of civil society, including people living with HIV and other key affected populations
- Respect for human rights and the principle of non-discrimination.
- Impartiality and transparency.
- Strategic and forward-looking HIV and gender-based policy and program development.

  * The country assessment team may add other principles as identified and write on how the principles should influence the gender assessment.

Task 5. Define communication approaches to raise awareness on the undertaking of the gender assessment.

5.1 Identify who are the external stakeholders and partners (who are not yet participating in the process) that should be reached and sensitized about the on-going assessment, to ensure their support.

5.2 Develop targeted advocacy messaging based on the need to undertake a gender assessment of the national HIV response, and aligned with the HIV investment approach

5.3 Plan on how to disseminate the messages. Decide who will be responsible for external communication to reinforce political commitment and buy in of stakeholders as well as external partners.

5.4 Summarize the above steps in a brief communication strategy

Task 6. Define a clear, feasible, and achievable timeline to prepare and undertake the Gender Assessment, including milestones and deadlines, considering concurrent activities.

6.1 Agree on monitoring mechanisms for the planning and undertaking of the gender assessment as per developed timeline.

Step 4. DEVELOP A RESOURCE PLAN FOR THE GENDER ASSESSMENT

Task 1. Please list and agree on the human resources it will be needed to conduct the gender assessment, such as consultants or assistants and their respective tasks in the process.

Task 2. Prepare a budget for the undertaking of the gender assessment, and cost the following requirements:

- Human Resources for the gathering and analysis of data, coordination and communication;
- Meetings and workshops, including lodging, travel and logistic costs, as needed;
- Administrative expenditures;
- Communication actions[1], including findings dissemination.

  * In case there is need for any other technical resources or activities required for the gender assessment process that must be acquired or created, please identify and budget for it.

Task 3. Prepare a proposal that can be used to approach prospective donors, if relevant.

Step 5. COLLECT, COLLATE AND STORE RELEVANT DOCUMENTS

Please collect the documents that you have access to in your country that will be relevant for the gender assessment.

Task 1. Please review and add to the list provided below other documents considered relevant, including international and regional documents the country is signatory of, or that are important to the specific national context.

- Plans, reports, assessments, reviews and evaluations of the country HIV response
- Previous Gender Assessments, Gender Reviews, and Gender Analyses of the country HIV response
- Gender Assessments, Gender Reviews, Gender Analyses from other related sectors (for example, gender-based violence, education, sexual and reproductive health, women's rights)
- Other response frameworks, strategic plans, operational plans and calendars for addressing gender from all relevant sectors (including HIV and AIDS, gender-based violence, education, sexual and reproductive health)
- Epidemiological data from all relevant sectors (including HIV and AIDS, gender-based violence, education, sexual and reproductive health)
- Political, social and economic contextual analysis in the country and sub region[2]
- Most recent CEDAW national report
- Beijing Platform for Action

Task 2. Agree on who is responsible for collecting the documents, as well as on a common digital storage place for the documents, e.g. Drop Box, blog, cloud servers, etc.

Task 3. Register and organize a list of all relevant documents and share the inventory with the external partners for their review and input.

Stage 2
KNOWING THE HIV EPIDEMIC AND CONTEXT IN THE COUNTRY

Step 1. HIV AND AIDS PREVALENCE AND INCIDENCE

Question 1. What is the prevalence rate of HIV, sex and age disaggregated, in the general population?

1.1 Please specify the trend over time in prevalence data among women and girls.

Question 2. What is the national HIV incidence rate, preferably sex and age disaggregated, in the general population?

Question 3: What is the prevalence rate of HIV in the key populations, sex and age disaggregated, identified as relevant to the country?

Question 4: What are the incidence rates among the different key population groups, sex and age disaggregated, if available?

Question 5. In case the country has undertaken a *modes of transmission* study, what are the modes of HIV transmission for women, girls, men, boys, and transgender persons?

Question 6. Where are the people who account for new infections geographically located and where are they geographically concentrated?

Step 2. SOCIAL, CULTURAL, AND ECONOMIC FACTORS

[Please cover women, girls, transgender people, and men and boys. Provide information disaggregated by age, if this data is available.]

Question 1. What is the percentage of young women and men aged 15–24 who both correctly identify ways of preventing the sexual transmission of HIV? [Disaggregated by sex (female, male) and age (15-19, 20-24)]

1.1 if available, what is the trend over the past 5 to 10 years?

Question 2: What is the percentage of young women and men who know where to access condoms?

2.1 if available, what is the trend over the past 5 to 10 years?

Question 3: Percentage of women aged 15-49 who has had more than one sexual partner in the last 12 months reporting the use of a condom during their last sexual intercourse. [Disaggregated by sex (female, male) and age (15-19, 20-24, 25-49)]

Question 4. Does the country have data on unwanted pregnancy among unmarried adolescents?)

4.1 If not, has the country made a link between prevention of unwanted pregnancies and HIV prevention?

Question 5. Is there any indication of domestic violence or intimate partner violence, including sexual violence? If yes, please describe and, if possible include sex and age-disaggregated data

Questions 6. Has the country collected data on stigma and discrimination toward people living with HIV?

6.1 If yes, is there gender difference identified in the results?

Question 7. What socio-cultural norms and practices may contribute to gender differences in any of the issues described above in this step (knowledge, condom use, stigma, discrimination, unwanted pregnancy)?

Question 8. What socio-cultural norms and practices may contribute to increasing the risk to HIV infection among women and girls, men and boys, and transgender persons?

8.1 In which way do they contribute to higher risk of HIV infection?

Question 9. Are there socio-cultural norms and practices that contribute to the risk of HIV infection among key populations?

9.1 If yes, what are these norms and practices?

Question 10. What are the factors or social determinants that contribute to maintaining these practices and behaviours, according to available data? Please inform it based on a) individual, b) community and c) society levels.

Step 3. KNOWING THE EPIDEMIC CONTEXT: POLITICAL AND MACRO-ECONOMIC FACTORS

Question 1. Is there any legal framework or policy that may impact negatively on women and girls, men and boys, and key populations in relation to HIV? Examples are:

- Criminalization of HIV status;
- Criminalization of vertical transmission
- Criminalization of sexual orientation and/or gender identity,
- Criminalization of drug use
- Criminalization of sex work
- Deny of access of young people (below 18 years old) to condoms
- Deny of comprehensive sexuality education below 18 years of age

Please add others considered relevant.

Question 2. Are there legal frameworks that specifically protect the rights of people living with HIV, women and girls, and other key populations in terms of

- Family and Property law (marriage, cohabitation, separation, divorce, child custody, property, inheritance, etc.)?
- Access to healthcare (health services, access to information about health, commodities, PreP and post-exposure prophylaxis, etc.)?
- Sexual and reproductive rights?
- Comprehensive sexuality education, non-stigmatizing and non-discriminatory education?

- Labour relations and Social Security?
- HIV testing and counselling voluntary and confidential?
- Intimate partner violence?

Please add others considered relevant

Question 3. Are there indications that these laws are not implemented equally, e.g. for women and men, for transgender, for key populations, for people living with HIV?

Question 4. Are the existing laws and policies translated into equal access to services for women, girls, men, boys, key populations, in terms of:

- Reproductive health and rights services?
- Information about health accessible in the services?
- Commodities, specifically male and female condoms?
- PrEP?
- Post-exposure prophylaxis?
- Psychosocial support?
- Comprehensive sexuality education?
- Social protection?
- Education?
- Labour?
- Social Security?

Please add others considered relevant and clarify your yes/no answers

Question 5. Is there any indication of discriminatory or coercive practices in health care settings that may impact utilization of HIV-related services by women living with HIV? Examples are:

- Coerced family planning;
- Coerced abortion;
- Forced sterilization;
- Stigma for women;
- Stigma and other forms of discrimination against key populations.

Question 6. Are there indications of discriminatory practices by the judiciary and law enforcement personnel (including police) that may prevent women, girls and/or any other key population from accessing their rights? If so, please describe

Stage 3
KNOWING THE COUNTRY HIV RESPONSE

Step 1. MEANINGFUL PARTICIPATION

Question 1. Are networks of people living with HIV, women's rights, sexual and reproductive health, gender equality, youth, and other key populations organizations e.g., MSM, sex workers, IDU, transgender) engaged in decision-making at different stages, levels, and sectors of the country HIV response?

Question 2. Are there formal mechanisms (e.g. partnership forum, joint HIV theme groups, CCM) to ensure that the views and opinions of these populations are taken into account in decision-making processes in the response to HIV? If so, please describe how this is ensured, and provide examples, if possible.

Question 3. What legal and policy provisions exist for these populations to access domestic and/or international funding to support the national HIV response?

Question 4. What (legal, political, financial) provisions exist for capacity building and allocation of resources to support the participation of women and girls in the HIV response?

Question 5. Are there key populations that are excluded - by laws, regulations and policies - from engaging in the national HIV response?

Step 2. NATIONAL HIV RESPONSE

2.1 THE OVERALL HIV RESPONSE

Question 1. Which populations are addressed in the HIV national response?
[Please disaggregate by age, race, sex, gender identity or sexual orientation.]

Question 2. To what extent is the national HIV response funded by domestic sources and to what extent from external sources?

2.1 Does the national HIV response fund interventions to address HIV and AIDS from a gender perspective? If so, please describe.

2.2 Is there a specific government program financed by multilateral or bilateral agencies to address HIV and AIDS from a gender perspective? If so, please describe.

2.3 What are the UN agencies that have programs and budget allocated to address HIV with gender perspective?

2.2 COORDINATION OF GENDER EQUALITY WITHIN THE HIV RESPONSE

Question 1. Which government sector undertakes the coordination of the HIV response (e.g. National AIDS Authority, Ministry of Health)?

1.1 Does the coordination mechanism include a dedicated focus on gender equality?

1.2 Are there additional coordination mechanisms at different government levels and sectors (gender, health, human rights, etc.) to facilitate the collaboration and promote gender equality in the national HIV response? If so, please describe.

1.3 How are they designed and implemented?

1.4 Does civil society participate and, if so, which groups participate?

Question 2. Besides the health sector, is there any other Ministry, sector or program to address HIV? If so, does it have a gender perspective?

Question 3. Is there any intergovernmental group that addresses HIV and AIDS from a gender perspective (local, district, provincial, national?)

Question 4. Is there any UN Theme Groups (TG) on AIDS and on gender in the country? If so, please inform:

4.1 Does the AIDS TG discuss gender?

4.2 Does it include civil society?

4.3 Does the Gender TG discuss HIV?

4.4 Does it include civil society?

Question 5. Are any formal or informal established communication mechanisms among UN agencies, different levels of government, and civil society in the country to address HIV from a gender perspective? What are these mechanisms?

2.3 HIV PREVENTION

Question 1. Which HIV prevention services are available? These may include:

- Access to information about HIV and where to get testing;
- Access to treatment;
- Harm reduction measures;
- Condom promotion (male and female;)
- Behaviour change communication, including delaying sexual debut, being faithful, reducing multiple partners and concurrent relationships;
- Male circumcision;
- Ensuring human rights;
- Reduction of stigma;
- Others.

Question 2. Are these services accessible for women and girls, including transgender women, men and boys, and key populations in the country?

2.1 What is the coverage rate of these services (if possible age and sex disaggregated and per population group)?

Question 3. Are HIV prevention services guided by policy, and if so, does the policy respect and promote the rights of women, girls, men, boys, and key populations, independent of marital status, age, and profession (e.g. sex workers, unemployed), in relation to:

- Sexual health and rights;
- Sexual orientation;
- Gender identity;
- Reproductive health and rights;
- Abortion;
- Voluntary testing and counselling, including confidentiality;
- Disclosure and acceptance of their HIV status, free of discrimination;
- Access to justice and benefit of the law; [describe]
- Protection against harmful norms and practices;
- Violence in all cases (including from their partners, family, community or state.)

Question 4. Do the policies translated into prevention services respect, promote, and protect the rights of women, girls, men, boys and key populations independent of marital status, profession and age, or are there indications of violation of these, in relation to:

- Sexual health and rights;
- Sexual orientation;
- Gender identity;
- Reproductive health and rights;
- Abortion;
- Voluntary testing and counselling, including confidentiality;
- Disclosure and acceptance of their HIV status, free of discrimination
- Access to justice and benefit of the law; [describe]
- Protection against harmful norms and practices;
- Violence in all cases (including from partners, family, community or state.)

2.4 TREATMENT

Question 1. What is the current treatment coverage in the country (preferably with data disaggregated by age and sex, and key population, if available)?

1.1 What is the overall percentage of people on first and on second line treatments?

1.2 Are the treatment services equally accessible for women, men, and key populations?

1.3 What are the *loss to follow-up* and the mortality rates?

1.4 Is there any insight on who is affected by non-adherence?

1.5 Is there any data on who is not being reached by the national treatment programme?

1.6 Are there gender-related barriers to these services, e.g. gender based violence?

1.7 Is there any indication or evidence of discrimination in treatment centres, e.g. against women, men, key populations based on gender identity, sexual orientation, age, ethnicity, or marital status?

1.8 Is the treatment package (goods and services) *affordable* to <u>all</u> women, girls, transgender women, men and boys, and key populations who need them?

Question 2. Are HIV treatment services guided by policy, and if so, does the policy respect and promote the rights of women, girls, men, boys, and key populations, independent of marital status, in relation to:

- Sexual health and rights
- Sexual orientation
- Gender identity
- Reproductive health and rights
- Abortion
- Voluntary testing and counselling:
- Disclosure and acceptance of their HIV status, free of discrimination
- Access to justice and benefit of the law [describe]
- Protection against harmful norms and practices
- Gender based violence (including from their partners, family, community or state.)
- Other

Question 3. Do the HIV treatment services for women, girls, men, boys, and key populations include:

- Voluntary HIV counselling and testing as entry point to treatment services
- Emphasis on consent and confidentiality
- Access to HIV treatment program for mothers living with HIV during the pregnancy and after birth
- Access to antiretroviral treatment for children
- Access to CD4 count and viral load services
- Screening and follow-up for chronic co-morbidities, including for cervical cancer
- Respect for the sexual and reproductive rights of women, men and key populations, including
- Screening and counselling for gender based violence
- Provision of or referral to social and psychological support for people living with HIV
- Provision of or referral to legal support for people living with HIV
- Other

[Please exemplify or quote sources.]

In case any of these elements are not offered, please clarify why not.

Question 4. What is the overall coverage of prevention of vertical transmission services?

4.1 What is its rate of efficiency (infant non-infection ratio)?

4.2 What is the *loss to follow-up* rate?

4.3 Is there any insight on non-adherence and who is affected by it?

4.4 Does the prevention of vertical transmission services include all four pillars[3]

4.5 Are these services equally accessible for women, and key populations?

[3]According to a program model developed by the U.N. in 2001, each of the four *pillars* represents a stage at which program services work to 1) prevent HIV in women of reproductive age, 2) prevent unintended pregnancy in women with HIV, 3) prevent HIV transmission from mother to child, and 4) provide ongoing care and support to mothers, their children, and families. Within the third stage antenatal, intra-partum, and postpartum/postnatal health services to mothers and infants is critical.

4.6 Are there gender-related barriers to these services, e.g. gender based violence?

4.7 Is there any data on who is not being reached by the national programme on prevention of vertical transmission?

4.8 Is there any indication or evidence of discrimination in treatment centres, e.g. against women, including those from key populations, based on gender identity, sexual orientation, age, ethnicity or marital status?

4.9 Is the prevention of vertical transmission service *affordable* to <u>all</u> women who need them?

[Please exemplify or quote sources.]

Question 5. Are there strategies for addressing non-adherence to HIV treatment in women and girls, including those from key populations? If the answer is yes, what are they, for example, in relation to

- Sexual and reproductive health services?
- Vertical transmission?
- Opportunistic infections?
- Prevent stigma and discrimination within and outside health related services?

[Please include other examples, if needed]

Question 6. Does the pre-service curriculum of health care workers include sensitivity training in gender, human rights, stigma and discrimination? If yes, what specific themes are addressed?

- Human rights
- Gender equity
- Stigma and discrimination
- Gender based violence
- Sexual rights
- Sexual health
- Reproductive rights
- Reproductive health
- Please add others, if needed

Question 7. Does the in-service curriculum of health care workers delivering HIV treatment services include sensitivity training in gender, human rights, stigma and discrimination? If yes, what specific themes are addressed?

7.1 How frequent do the trainings happen? How long, in average are the trainings?

Question 8. What are the available services of sexual and reproductive health for women and girls, including transgender women, and men and boys, and key populations in the country?

8.1 What is the coverage rate of these services?

8.2 Are the services integrated with HIV services?

8.3 Please identify any service that despite being necessary in your country is not offered and clarify why they are not available.

8.4 Please indicate if the available services are equally accessible, in particular, by key populations.

8.5 Is there any indication that during service delivery the clients' rights are not particularly respected (e.g. forced contraception, psychological distress)?

[Please provide sex and age disaggregated data where relevant/available.]

2.5 CARE AND SUPPORT

Question 1. Are HIV care and support services guided by policy, and if so, does the policy respect and promote the rights of women, girls, men, boys, and key populations, independent of marital status, in relation to:

- Sexual health and rights
- Sexual orientation
- Gender identity
- Reproductive health and rights
- Abortion
- Voluntary testing and counselling
- Disclosure and acceptance of their HIV status, free of discrimination
- Access to justice and benefit of the law [describe]
- Protection against harmful norms and practices
- Violence in all cases (including from their partners, family, community or state.)

Question 2. Does the policy guide the HIV *care and support* services in terms of:

- Reliable access to home-based care supplies
- Training and support for palliative care
- Clearly defined role and responsibilities for paid caregivers
- Financial compensation for primary and secondary caregivers
- Comprehensive (social and psychological) care for caregivers
- Recognizing and addressing the burden of care on women and girls and their impacts
- Other

[Obs. 1– Specify all identified types of unpaid caregivers: community members, faith-based organizations, NGOs, partners, family members, friends etc.

Obs. 2 – If possible inform care giving information by age: women and girls for example young girls pulled out school for care giving, (grandmothers) heading households of grandchildren, female (single) head of household.]

Obs. 3 – In case you can identify the existence of unpaid caregivers in the country, please inform if there are any projects or programmes to support them and what the source of this support is (i.e., governmental, NGOs, donors, etc.)]

Question 3. Is there a comprehensive care and support package (commodities and services) in place for women, girls, men, boys, and key populations, including (as relevant):

1.1 Home based care
1.2 Palliative care
1.3 Voluntary and confidential testing and counselling
1.4 Referral to services, including for co-infections and co-morbidities

1.5 Psychosocial support for people living with HIV
1.6 Social protection services
1.7 Legal support services
1.8 Sexual and reproductive health counselling
1.9 Other…

Question 2. Is there any evidence or indication that women, girls, men, boys, and key populations fail to access HIV care and support services because of fear of discrimination?, in terms of:

- Availability
- Accessibility
- Affordability

Step 3 GENDER EQUALITY IN POLICIES, PROGRAMMES AND PROJECTS

3.1. GENDER EQUALITY IN THE CONCEPTUAL FRAMEWORK AND DESIGN

Question 1. Is the national HIV response guided by the *UNAIDS Agenda for Women, Girls, Gender Equality and HIV*?

Question 2. Does the HIV response (strategies/ interventions/ programmes) address

- Inequality between women/girls (including transgender women) and men/boys?
- Stigma and discrimination toward women and girls living with or affected by HIV (including transgender women) in the provision of HIV and other health services as well as the social welfare and judiciary system?
- Equitable access to resources for women/girls and men/boys (including social, political, economic, and legal resources?)

If so, please describe how.

Question 3. Does the HIV policy reflect a commitment to gender equality and is this translated into gender sensitive/transformative services? Please justify with examples.

Question 4. Is disaggregated data on sex, age, sexual orientation and gender identity collected, used, and applied in the HIV response?

3.2 GENDER EQUALITY AWARENESS AND KNOWLEDGE

Question 1. Are there indications that those involved in the HIV response, including decision makers and services providers, demonstrate awareness and knowledge of the consequences of inequality between men and women and/or the marginalization of some populations in the HIV context?

If yes, how do they demonstrate it?

If no, why?

Question 2. Are there indications that those involved in the HIV response, including decision makers and services providers, demonstrate awareness and knowledge of the consequences of marginalization for specific populations in the HIV context?

If yes, how do they demonstrate it?

If no, why?

3.3 WOMEN AND GIRLS

Question 1. Do multi-sector gender policies recognize and address the specific HIV risks and vulnerabilities of women and girls, including those from key populations, and are they effective, in terms of

- Gender balance in intimate relationships
- Household decision-making
- Imbalance of unpaid household labour between men and women, boys and girls (i.e. in caring for children or the sick)?
- Access of women and girls to financial resources?
- Economic autonomy, including through microcredits or cash transfer
- Stigma and discrimination within the community
- Access to health services
- Access to social services
- Workplace policies
- Access to education institutions
- Access to legal/law enforcement institutions, in particular knowing and claiming their rights
- Religious institutions
- Traditional institutions
- NGOs

[Please fell free to add any other area that was identified as relevant in the previous section.]

Question 2. Have any of these policies translated in effective programmes for the above-mentioned issues? If so, what results have been achieved?

3.4 KEY POPULATIONS

Question 1. Do multi-sector gender policies recognize and address the specific HIV risks and vulnerabilities of women and girls, including those from key populations, and are they effective, in terms of

- Gender balance in intimate relationships
- Household decision-making
- Imbalance of unpaid household labour between men and women, boys and girls (i.e. in caring for children or the sick)?
- Access of women and girls to financial resources?
- Economic autonomy, including through microcredits or cash transfer
- Stigma and discrimination within the community
- Access to health services
- Access to social services
- Workplace policies
- Access to education institutions
- Access to legal/law enforcement institutions, in particular knowing and claiming their rights
- Religious institutions
- Traditional institutions
- NGOs

[Please fell free to add any other area that was identified as relevant in the previous section.]

Question 2. What are the gender barriers to programs and initiatives in the HIV response that address harm reduction for injected drug users?

Please clarify it for men injecting drug use, their partners, women using drugs, and transgender people.

2.1 How are their sexual and reproductive health needs and rights addressed and secured?

Question 3. Are these policies translated into programmes and initiatives for key populations?

3.1 Are they rights-based?
3.2 Do they reduce barriers to diagnosis, treatment and care?
3.3 Do they address stigma and discrimination?
3.4 Do the key populations know and claim universal human rights?
3.5 Do the policies address the violence against key population?

If yes, please describe how it happens.

3.5 MEN AND MASCULINITIES

Question 1. Are there policies, programs, and initiatives in the HIV response that work with men and boys to address historically constructed harmful masculinities and support them to

• Understand and respect the rights of women and girls, including those from key populations, such as men who have sex with men, LGBT population and sex workers?

• Acknowledge unequal power relations between men and women, boys and girls?

• Acknowledge the stigma and discrimination faced by women and girls (including those from key populations) in many facets of life, from domestic to labour relations?

• Address the impact of masculinity norms on men, in terms of health-seeking behaviour, including HIV services; risky sexual behaviour; and gender-based violence?

[Please describe how they are addressed and feel free to add other examples if applicable.]

3.6 GENDER BASED VIOLENCE (GBV)

Question 1. Has the link between VAW – violence against women – and HIV, in terms of violence increasing the risk of HIV infection, including in conflict and post-conflict situations, been recognized and addressed in policies, programs and services within the HIV Response?

1.1 If so, how is it addressed? If not, then why has it not?

1.2 Which populations benefit from these initiatives?

Question 2. Has the link between gender-based violence and HIV in terms of violence being a consequence of HIV infection, including among women living with HIV, been recognized and addressed in policies, programs and services within the HIV Response?

1.1 If so, how is it addressed? If not, then why has it not?

1.2 Which populations benefit from these initiatives?

Question 3. Is HIV addressed in the programs, initiatives, or services within the policies to address gender-based violence?

3.1 If so, what are the actions and what are the populations addressed? If not, then why isn't it being addressed?

[This could be done, for example, through offering HIV counselling, refer to voluntary testing and offer Post-Exposure Prophylaxis, in case of sexual violence]

Question 4. Are there laws in place to reduce violence against women and gender-based as part of the country HIV response?

4.1 If so, are these implemented? If not, is there advocacy for additional legislation and by whom?

Question 5. Does the HIV response address in any form of (stigmatizing/condoning) attitudes of society about violence against women and gender-based violence?

Question 6. Does the HIV response address in any (stigmatizing/condoning) attitudes of public service providers about violence against women and gender-based violence?

5.1 If so, how does it address?

[This could be done, for example, through IEC materials, including different kinds of campaigns, training and sensitizing healthcare workers, teachers, law enforcement personnel, media workers etc.]

5.2 If not, why not then?

Question 7. Are there partnerships with women's rights, women living with HIV and/or transgender and key population organizations and networks to develop and implement programs and initiatives that address GBV in the HIV response?

7.1 If so, please describe how it is done. If not, why aren't there?

Question 8. Are there partnerships between government sectors to develop and implement programs and initiatives on VAW and GBV in the HIV response?

8.1 If so, please describe how it is done. If not, why?

3.7 SEXUALITY, SEXUAL AND REPRODUCTIVE HEALTH AND RIGHTS

Question 1. Are there policies guiding the links between sexual health and rights and HIV services?

1.1 If so, which ones?
1.2 If so, how are the links being addressed?
1.3 Are referrals provided?

Question 2. Are the sexual and reproductive health and rights of women and girls, women living with HIV, and those from key populations (including the right to decide whether and when to have children), recognized and addressed by the HIV response?[4]

2.1 If so, how?

2.2 Is there any indication of coercion, discrimination, and or some kind of violence while accessing commodities or healthcare services?

Question 3. Are regional and international commitments on sexual and reproductive health and rights of women and girls incorporated in the HIV response? If so, how?

Question 4. Are there policies that recognize and address HIV, maternal health, and infant health as interlinked concerns? If so, how?

Step 3.8 ASSESSING BARRIERS, RISKS AND THREATS (challenges and opportunities)

Question 1. What are the most common gender-related barriers and challenges for accessing HIV and SRHR services and commodities in the ground?

1.1 How have these been identified?[5]

1.2 How have they been addressed in the national strategy?

Question 2. What actions have been taken to address the most common gender-related barriers?

2.1 What more needs to be done?

Question 3. What threats are faced by activists, advocates, political and community leaders, service providers, and organizations when, for instance:

- Working with key or criminalized populations?
- Working with women's rights for equality, dignity, and freedom?
- Working for sexual and reproductive health and rights?
- Defending human rights related to gender and HIV?

3.1 Are these (or others) risks and threats addressed by the HIV response? If yes, how are they addressed?

Step 3.9 INTERSECTING PRIORITIES FOR GENDER EQUALITY AND HIV

Question 1. Are the HIV related specificities (access to comprehensive sexuality education, access to quality SRH services etc.) of young women and young men, including key populations been recognized, planned for, and addressed in the country HIV response?

Question 2. Are the HIV related specificities (such as access to voluntary confidential HIV testing and counselling, friendly sexual and reproductive health and rights services including cervical screening) of older women been recognized, planned for, and addressed?

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[4] Examples of services and commodities could be the access to:
http://www.who.int/hiv/topics/vct/toolkit/components/supply/en/index1.html
- Support for safe conception, pregnancy, childbirth and breastfeeding;
- Access to a full range of contraceptive options free of coercion, discrimination and violence;
- Access to legal voluntary, safe, and comprehensive pregnancy termination care and services.

Question 3. Does the HIV response recognize, plan for, and address gender issues related to:

- Rural/urban specificities?
- Socio-economic status?
- Forced and/or voluntary migration?
- Race and ethnicity?
- HIV-related disabilities?

Question 4. Does the National HIV response include people with disabilities?

4.1 In case there are specific programs for people with disabilities in the response, is there a difference between the way the needs of men/boys and women/girls are addressed by it?

Question 5. Have issues of gender identity and sexual orientation been recognized within the HIV strategy? If yes, what is recommended in terms of HIV services regarding stigma, discrimination, and human rights?

Question 6. Has the discrimination of women and girls, including those from key populations, on the basis of socio economic status, been recognized, planned for, and addressed in the HIV response? For example through:

- Social protection
- Access to public and private health insurance
- Promotion of corporate social responsibility
- Promotion of workplace policies
- Property and inheritance rights
- Education and training
- Micro credit and economic empowerment

Step 3.10 ASSESSING EXPENDITURE TRACKING

Question 1. Is there an accessible system of information on expenditures on gender and on HIV in the country?

1.1 What challenges can be identified to the generation of information on allocation and spending on gender and/or HIV?

1.2 What factors do influence budgeting decisions on gender and/or HIV e.g. religion, socio-cultural factors, and legal environment)?

1.3 What are the challenges to the implementation of the gender and/or HIV budgets (capacity gaps, for example)?

Question 2. Are the specific needs of women, girls, men, boys, and transgender women considered in the budget allocated to the national HIV response?

2.1 Is the amount allocated sufficient to meet the needs of these communities in the context of HIV? Please breakdown your response per constituency.

Question 3. Does the HIV response disaggregate financial data collection and reporting by sex, age and/or key populations?

3.1 Does it also disaggregate data by gender?

Question 4. Does the budget allocated to the Ministry of Gender/Women's Affair include HIV?

Question 5. Is there a formal system of accountability for the HIV response that allows civil society, UN agencies, and citizens to monitor the spending on women, girls, and key populations?

Stage 4

ANALYSING AND USING THE FINDINGS OF THE GENDER ASSESSMENT FOR A GENDER TRANSFORMATIVE HIV RESPONSE

Task 1. Prepare a narrative report with the findings collected with the Gender Assessment Tool.

[This narrative report should provide support for a research-informed policy decision.]

Task 2. Convene the Country Assessment Team to analyse the findings and identify the gaps and opportunities for a gender transformative HIV response.

2.1 Summarize the analysis of the *HIV epidemic* from a gender perspective, in particular HIV prevalence and incidence, including sex and age disaggregated data, breakdown per key population, as well as trends.

a. Summarize the latest data on *knowledge, attitude* and *practices* among women and girls, men and boys and key populations, as well as trends

2.2 Summarize the data on the *context* from a gender perspective; including the most pertinent gender barriers, stigma and discrimination, and the underlying socio-cultural norms and practices.

a. Existing legal framework as part of HIV response and as part of gender equity efforts, including gaps
b. Current situation of the gender policies regarding HIV

2.3 Summarize the current *HIV response* regarding gender transformation, including gender equality, gender based violence and sexual and reproductive health and rights, with a particular focus on which the factors that contribute to the HIV vulnerabilities of women, girls, men, boys and key populations

2.4 Summarize the current *HIV prevention programmes and initiatives* in relation to meeting the specific needs of women, girls, men, boys and key populations, including:

☐ Sexuality education,
☐ Male and female condom promotion and distribution;
☐ Prevention of vertical transmission;
☐ General and targeted prevention campaigns,
☐ Prevention in prisons;
☐ Harm reduction programmes;
☐ Securing sexual and reproductive health and rights within prevention,
☐ Other(s)

2.5 Summarize the current HIV *treatment* programmes and initiatives (disaggregated by sex and age, and key populations), including:

☐Coverage of ART

☐ Management of co-morbidities, including access to treatment for opportunistic diseases;
☐ ART adherence from a gender perspective;
☐ Securing sexual and reproductive health and rights within treatment;
☐ Other(s)

2.6 Summarize the current *care and support* programmes and initiatives,

☐ Including psychosocial support and access to social protection for women, girls, men, boys and key populations, including those living with HIV;
☐ Support for care givers of people living with HIV and AIDS;
☐ Burden of care division of labour,
☐ Other

2.7 Please indicate the availability of gender specific research, reviews and reports regarding HIV, including gaps.

Task 3. Define the priorities to achieve a gender transformative HIV response based on the analysis of findings.

Once you reviewed your epidemic and context from a gender perspective and identified gaps in response related to the epidemic and context, priorities need to be articulated in such a way that they target the most affected populations, through specific interventions.

Another important consideration is that addressing the identified gaps requires particular engagement of stakeholders. For example, raising awareness alone rarely drives policy change, and will require building political strategies for specific actions.

Finally, meaningful participation of the key affected populations, including people living with HIV, is critical. It is also important to prioritize actions to support civil society, including organizational development and their engagement in advocacy, planning and implementation, monitoring and evaluation for accountability for results.

Social and political intervention should observe the following criteria:

- Realistic
- Achievable
- Focused
- Speed (how fast or slow)
- Innovation
- Leadership
- Mainstreaming
- Measurable
- Value for investment

[The country assessment team might want to add more criteria.]

Some of the key questions to be answered when defining the priorities are:

3.1 Is it necessary and timely?

3.1.1 Is there a genuine need for this decision?

3.1.2 Is it necessary now, or can it wait?
3.1.3 Will it benefit the people in need?

3.2 Is it based on or supported by sound science/facts?

3.3 How viable is it (e.g., technical feasibility, compatibility with decision-maker values)?

3.4 What is the cost-benefit? Is it applicable and transferable?
[Larger and more sustainable funding sources could be needed to scale up those interventions and broaden their impacts.]

3.5 Could this action be placed on the countries policy agenda (leadership)?

[The country assessment team might want to add more questions.]

Find below an example of matrix for building a list of priorities and opportunities for interventions.

Gaps	**Objectives**	**Process Prioritisation**	**Opportunities**	**Interventions**
There is no legal framework to protect women and girls from GBV.	Build legal framework that protects women, girls, men, boys, and transgender from GBV.	It should be a priority number 1. [Is it realistic?]	Partner with MPs who are keen to propose a bill as regards to GBV.	Incept GBV in every possible health and education campaigning.
Health service hours available are not suitable for men, women and transgender sex workers.	Include specific HIV and sexual and reproductive services or expand the ours to ensure the access of these populations a	Priority 2 (?)	Influence the authorities responsible to develop specific programmes aimed at attending in the evening hours.	Sensitize the decision-makers; To engage the key population in the advocacy actions; To publicize the new service for men, women, and transgender
				… And so forth.

Task 4. Now that you have identified the priorities, develop an advocacy plan.

Define strategies and activities that can support effective achievement of your priorities. This requires thinking comprehensively about what it will take to realize policy targets. Without this approach, the Country Assessment Team may form unrealistic expectations about what can be accomplished.

Entry points may be:

1. Advocacy for national AIDS Authority and decision making authorities
2. Inclusion in the National HIV Strategic Plan
3. Elaborating Global Fund proposals
4. HLM 2011 (UNGASS-AIDS) targets
5. National Gender Plan (or similar)

The advocacy plan should be based on the main findings and answer the following questions:

• What is needed to be done to achieve what?
• How will it be done?
[a] When will it be done?
• Who will do it?

Task 5. Design a communication strategy and its key actions (opportunity for campaigning)

1. Identify audiences – Considering the barriers and opportunities for your priorities' progress, decide which stakeholders and populations are needed to engage to address them.

2. Verify if the targeted audiences are aware of the advocacy priorities and the issues at hand.

3. Select media (communication channels according to context.)

4. Create or adjust (if existing) the messages on gender transformative HIV response to the specific audiences [appropriate for each media and each audience, for instance, the Ministry of Health apparatus, the Parliament, healthcare providers, law enforcement institutions, teachers, etc.]

5. Define how the message will be disseminated messages (through a web of communication tools, for instance)

Task 6. Budget for implementing the advocacy and communication strategies

1. Make the money work (cost effective.)

2. Foster partnering

Task 7. Develop a fundraising strategy

1. Government support (country, state, city levels)
2. Private sector funding
3. Global Fund to fight AIDS, Tuberculosis and Malaria
4. PEPFAR
5. International Cooperation Agencies
6. National and International Foundations

Task 8. Develop a Gender Assessment Monitoring process to follow-up the gender transformation of the HIV response in time, months and years in the future.

……..

The gender assessment of the national HIV response is now complete. The findings will support the achievement of gender transformative HIV responses.

GLOSSARY Main concepts used in the Gender Assessment Tool

ACCEPTABILITY: All health facilities, goods and services must be respectful of medical ethics and culturally appropriate as well as sensitive to gender and life cycle requirements.[5]

ACCESSIBILITY: Health facilities, goods and services accessible to everyone. Accessibility has four overlapping dimensions: non-discrimination; physical accessibility; economical accessibility (affordability); information accessibility.[6]

ACCOUNTABILITY: The obligation on the part of public officials to report on the usage of public resources and answerability for failing to meet stated performance objectives.

AFFECTED (People affected by HIV): The term *people affected by HIV* encompasses family members and dependents that may be involved in care giving or otherwise affected by the HIV epidemic.

AFFORDABILITY: The quality of something being affordable.

ANTIRETROVIRALS (ARV): The abbreviation ARV refers to 'antiretroviral'. It should only be used if referring to the drugs themselves and not to their use. Even then, it is best used as an adjective: antiretroviral drugs. 'Antiretroviral therapy', or "HIV treatment", is a more inclusive term and refers to a triple or more antiretroviral drug combination to maximally suppress the HIV virus and stop the progression of HIV disease[7].

AVAILABILITY: A sufficient quantity of functioning public health and health care facilities, goods and services, as well as programmes[8].

BUDGET: An itemized estimate of expected income and expenses. Terms such as 'gender responsive budgets', 'gender sensitive budgets', and 'gender budgets' are often used to refer to an analysis of the impact of expenditures on women and girls in comparison to expenditures on men and boys. Gender sensitive budgets should not only assess the different impacts of expenditures, but the extent to which these expenditures address gender inequalities.

CAREGIVER or CARER: Caregivers or carers are people who provide unpaid care by looking after an ill, frail or disabled family member, friend or partner, helping that individual with his or her activities of daily living.

CIVIL SOCIETY: Civil society includes groups and networks of people living with HIV, AIDS service organizations, people who use drugs and harm reduction networks, sex workers, men who have sex with men and transgender people, organizations of young people, women, health professionals and scientists, sports entities, national and international NGOs, faith-based, humanitarian and human rights organizations and academia[9].

CONCENTRATED EPIDEMIC: In a concentrated epidemic HIV has spread rapidly in one or more populations, but is not well established in the general population. Typically, the prevalence is over 5%

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[5] ***Source**: UN Committee on Economic, Social and Cultural Rights - General Comment on the Right to Health, 2000. http://www.unhchr.ch/tbs/doc.nsf/(symbol)/E.C.12.2000.4.En*

[6] ***Source**: UN Committee on Economic, Social and Cultural Rights - General Comment on the Right to Health, 2000. http://www.unhchr.ch/tbs/doc.nsf/(symbol)/E.C.12.2000.4.En*

[7] Source: UNAIDS Terminology Guide 2011 and WHO's website on antiretroviral therapy. (http://www.who.int/hiv/topics/treatment/en/index.html)

[8] ***Source**: UN Committee on Economic, Social and Cultural Rights - General Comment on the Right to Health, 2000. http://www.unhchr.ch/tbs/doc.nsf/(symbol)/E.C.12.2000.4.En*

[9] S***ource**: http://www.unaids.org/en/ourwork/managementandgovernance/partnershipsdepartment/civilsocietyandprivatesectordivision/*

in subpopulations while remaining under 1% in the general population, although these thresholds must be interpreted with caution.

COST-BENEFIT ANALYSIS (CBA): Cost-benefit analysis is a decision standard that is commonly used by policymakers to assist in determining whether a policy or project should be implemented. CBA monetizes the effects of a policy on individuals or groups in order to facilitate comparisons with the *status quo* or with other policies. In its basic form, CBA places primary weight on economic efficiency, but it can also be modified to account for adverse wealth distribution effects by appropriately weighting the costs and benefits to individuals or groups.

DECISION-MAKING SYSTEM: It is a clear plan for how decisions will be made, which includes the allocation of accountability for the decisions. Two key areas of decision-making should be considered: 1) leadership (those responsible for making political decisions on a topic within relevant institutions), 2) management (those responsible for ensuring that these decisions are implemented).

DISABILITIES: The preferred expression is *persons* or *people with disabilities*, in accordance with the Vocational Rehabilitation and Employment (Disabled Persons) Convention, 1983 (No. 159), namely that people with disabilities are individuals whose prospects of securing, retaining, and advancing in suitable employment are substantially reduced as a result of a duly recognized physical or mental impairment.

DISCRIMINATION: Discrimination refers to any form of arbitrary distinction, exclusion, or restriction affecting a person, usually but not only by virtue of an inherent personal characteristic or perceived belonging to a particular group—in the case of HIV, a person's confirmed, suspected or vulnerable to HIV-positive status.

DISCRIMINATION AGAINST WOMEN: Any distinction, exclusion or restriction made on the basis of sex which has the effect or purpose of impairing or nullifying the recognition, enjoyment or exercise by women, irrespective of their marital status, on a basis of equality of men and women, of human rights and fundamental freedoms in the political, economic, social, cultural, civil or any other field"[10].

EMPOWERMENT: Empowerment is action taken by people to overcome the obstacles of structural inequality that have previously placed them in a disadvantaged position. Social and economic empowerment, for instance, is a goal and a process aimed at mobilizing people to respond to discrimination and achieve equality of welfare and equal access to resources and become involved in decision-making at the domestic, local, and national level.

FEMININITIES: A collection of behaviours, traits and attributes often associated with women and girls. Traits associated with femininity depend on social and cultural context, and may change over time.

FRAMEWORK: A political and strategic document that outlines the rationale for 'what' needs to be done, 'why' it needs to be done, and 'who' is going to do it and "when" it will be done. The Framework is not the same as a plan but rather provides the details from which a more technical and detailed plan will emerge.

GENDER: Gender refers to the social attributes and opportunities associated with being male and female and the relationships between women and men and girls and boys, as well as the relations between women and those between men. These attributes, opportunities and relationships are socially constructed and are learned through socialization processes. They are context/time-specific and changeable. Gender determines what is expected, allowed and valued in a women or a man in a given context. In most societies there are differences and inequalities between women and men in

[10] Source: Convention on the Elimination of All Forms of Discrimination against Women – CEDAW, article 1, http://www.un.org/womenwatch/daw/cedaw/cedaw.htm)

responsibilities assigned, activities undertaken, access to and control over resources, as well as decision-making opportunities[11].

GENDER BASED VIOLENCE: Is the violence perpetrated against any individual because of their gender identity or sexual orientation, encompassing acts that inflict physical, mental or sexual harm or suffering, threat of such acts, coercion and other deprivations of liberty. This includes violence against women, however the term is often used to make a distinction between violence against women and violence against an individual who does not conform to a society's gender norms.

GENDER EQUALITY: Gender equality, or equality between men and women, entails the concept that all human beings are free to develop their personal abilities and make choices without the limitations set by stereotypes, rigid gender roles, and prejudices. Gender equality means that the different behaviours, aspirations, and needs of women and men, including transgender people, are considered, valued, and favoured equally. It signifies that there is no discrimination on the grounds of a person's gender in the allocation of resources or benefits, or in access to services. Gender equality may be measured in terms of whether there is equality of opportunity or equality of results.

GENDER IDENTITY: Gender identity refers to a person's deeply felt internal and individual experience of gender, which may or may not correspond with the sex assigned at birth. It includes both the personal sense of the body, which may involve, if freely chosen, modification of bodily appearance or function by medical, surgical, or other means, and other expressions of gender, including dress, speech, and mannerisms.

GENDER-SENSITIVE: Gender-sensitive policies, programs, or training modules recognize that both women and men, as well as transgender people, are actors within a society, that they are constrained in different and often unequal ways and that consequently they may have differing and sometimes conflicting perceptions, needs, interests, and priorities.

GENDER-TRANSFORMATIVE: The term seeks not only to address the gender-specific aspects of HIV but also to change existing structures, institutions, and gender relations into ones based on gender equality. Gender-transformative programs not only recognize and address gender differences, but go a step further by creating the conditions whereby people can examine the damaging aspects of gender norms and experiment with new behaviours to create more equitable roles and relationships.

GENERALISED EPIDEMIC: A generalized HIV epidemic is an epidemic that is self-sustaining through heterosexual transmission. In a generalized epidemic, HIV prevalence usually exceeds 1% among pregnant women attending antenatal clinics.

GREATER INVOLVEMENT OF PEOPLE LIVING WITH HIV/AIDS (GIPA PRINCIPLE): The GIPA Principle, declared at the Paris Declaration in 1994 and formally adopted by the UNAIDS in 1999, affirms that people living with HIV/AIDS (PLWHA) should be fully involved and integrated in the development of policies related to and programs providing HIV research, care, prevention, and treatment. PLWHAs contribute unique personal experiences and perspectives that are helpful to fighting the HIV/AIDS epidemic. Still, the GIPA principles' have not been acknowledged and PLWHAs continue to be excluded. The empowerment of positive people is essential to facilitate a constructive and enduring HIV and AIDS response.

HARM REDUCTION: It refers to policies, programs, and approaches that seek to reduce the harmful health, social, and economic consequences associated with the use of psychoactive substances. For example, people who inject drugs are vulnerable to blood-borne infections such as HIV if they use non-sterile injecting equipment. Therefore, ensuring adequate supplies of sterile needles and syringes helps to reduce the risk of blood-borne infections.

HARMFUL MASCULINITIES: Are social and cultural norms of masculinity that cause direct or indirect harm to women and men, for example, norms that contribute to women's risk and vulnerability to

[11] Source: UN Women - http://www.un.org/womenwatch/osagi/conceptsandefinitions.htm

HIV, and that hinder men from seeking information, treatment and support or assuming their share of the burden of care.

HEALTH CARE: Health care includes preventive, curative, and palliative services and interventions delivered to individuals or populations. In most countries these services account for the majority of employment, expenditure, and activities that would be included in the broader health sector or health system.

INCIDENCE: HIV incidence (sometimes referred to as cumulative incidence) is the number of new cases arising in a given period in a specified population. For instance, the number of adults aged 15-49 years or children (aged 0–14 years) who have become infected during the past year. In specific observational studies and prevention trials, the term *incidence rate* is used to describe incidence per hundred person/years of observation.

INTERSECTING PRIORITIES: Not only gender inequalities have a direct impact on HIV. Sometimes other social inequalities, such as race, class, age, disability, etc. can influence or change how gender inequalities affect HIV-related outcomes. Intersecting priorities therefore refers to prioritizing the ways in which gender intersects with these other social inequalities.

INTIMATE PARTNER VIOLENCE: One of the most common forms of violence against women is that performed by a husband or intimate male partner – independent if they share or not the same home. IPV includes acts of physical aggression, psychological abuse, forced intercourse, and other forms of sexual coercion, and various controlling behaviours such as isolating a person from family and friends or restricting access to information and assistance[12].

KEY POPULATIONS: K*ey populations* or *key populations at higher risk of HIV exposure* refers to those most likely to be exposed to HIV or to transmit it. In all countries, key populations include people living with HIV. In most settings, men who have sex with men, transgender persons, people who inject drugs, sex workers and their clients, migrants, people in prison, women, serum-negative partners in serum-discordant couples are at higher risk of HIV exposure to HIV than other people. Each country should define the specific populations that are key to their epidemic and response based on the epidemiological and social context – their engagement is critical to a successful HIV response.

LGBTI: LGBTI is an abbreviation that covers lesbian, gay, bisexual, transsexual, transgender, transvestite, and intersex people. Although it is preferable to avoid abbreviations when possible, LGBTI (or LGBT) has gained recognition because it emphasizes a diversity of sexuality and gender identities.

LOSS TO FOLLOW-UP: This term refers to patients who at one point in time were actively participating in a clinical research trial, but have become lost at the point of follow-up in the trial.

MASCULINITIES: Socially constructed definitions and perceived notions and ideals about how men should or are expected to behave in a given setting. Masculinities are configurations of practice structured by gender relations, and can change over time. Their making and remaking is a political process affecting the balance of interests in society and the direction of social change[13].

MEANINGFUL PARTICIPATION: Going beyond the inclusion of relevant populations in relevant debates, discussions, and decision-making processes, to ensure their active participation and voice in all levels of decision-making, from planning, implementation, to monitoring and evaluation.

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[12] Source: WHO http://www.who.int/violence_injury_prevention/violence/world_report/factsheets/en/ipvfacts.pdf
[13] Source: UNICEF, Masculinities: Male Roles and Male Involvement in the Promotion of Gender Equality - A Resource Packet, p. 5, http://www.unicef.org/emergencies/files/male_roles.pdf

MEN WHO HAVE SEX WITH MEN: The term 'men who have sex with men' describes males who have sex with males, regardless of whether or not they have sex with women or have a personal or social gay or bisexual identity.

OUTCOMES: The results an advocacy or policy change effort aims for with an audience in order to progress toward a policy goal.

PACKAGE (Sexual and Reproductive Health PACKAGE): It includes programs, supplies and multi integrated services to ensure that people are able to have a responsible, satisfying and safer sex life and the capability to reproduce and the freedom to decide if, when and how often to do so – free of any inequality based on socioeconomic status, education level, age, ethnicity, religion, and resources available in their environment. It aims to guarantee that men and women ought to be informed of and to have access to safe, effective, affordable and voluntary acceptable methods of birth control; access to appropriate health care services of sexual, reproductive care, treatment and support and access to a comprehensive sexuality education. The package includes also, but is not limited to, pregnancy related services (and skilled attendance and delivery), emergency obstetric care and post abortion care, STI and HIV prevention and diagnosis and treatment; prevention and early diagnosis of breast and cervical cancers; prevention of gender-based violence and care of survivors.

POINTS OF ENTRY: Areas of focus for an assessment to be 'entered' into or carried out. Since country-level assessments can be far-reaching, defining the point of entry for an assessment provides a means of isolating a particular focal point or opportunity to develop a specific an action or initiate a specific approach.

POLICY AGENDA: The list of issues to which decision makers pay serious attention.

POST-EXPOSURE PROPHYLAXIS (PEP): It refers to antiretroviral medicines that are taken after exposure or possible exposure to HIV. The exposure may be occupational, as in a needle stick injury, or non-occupational, as in unprotected sex with a partner with HIV infection.

PRE-EXPOSURE PROPHYLAXIS (PrEP): It refers to antiretroviral medicines prescribed before exposure or possible exposure to HIV. PrEP strategies under evaluation increasingly involve the addition of a post-exposure dosage.

POVERTY REDUCTION STRATEGY PAPER (PSRP): Poverty Reduction Strategy Papers are prepared by member countries through a participatory process involving domestic stakeholders as well as external development partners, including the World Bank and the International Monetary Fund. See www.imf.org/external/np/prsp/prsp.asp.

PREVALENCE: Usually given as a percentage, HIV prevalence quantifies the proportion of individuals in a population who are living with HIV at a specific point in time.

QUALITY: It aims to respond the question "do people get their needs fulfilled?" It means that the service must fits the needs and preferences of the people attended, do not cause them harm; that it is appropriated; is given without unnecessary delays; it includes access to all medical tests and procedures needed and is provided without any prejudice related to gender identity, language, colour, age or income of the person.

REPRODUCTIVE HEALTH: Reproductive health is a state of complete physical, mental and social wellbeing and not merely the absence of disease or infirmity, in all matters relating to the reproductive system and to its functions and processes. It implies that people are able to have a satisfying and safe sex life and that they have the capability to reproduce and the freedom to decide if, when and how often to do so. Implicit in this last condition are the right of men and women to be informed and to have access to safe, effective, affordable and acceptable methods of family planning of

their choice, as well as other methods of their choice for regulation of fertility that are not against the law, and the right of access to appropriate health-care services that will enable women to go safely through pregnancy and childbirth and provide couples with the best chance of having a healthy infant[14].

REPRODUCTIVE RIGHTS: Reproductive rights embrace certain human rights that are already recognized in national laws, international human rights documents and other consensus documents. These rights rest on the recognition of the basic right of all couples and individuals to decide freely and responsibly the number, spacing and timing of their children and to have the information and means to do so, and the right to attain the highest standard of sexual and reproductive health. It also includes their right to make decisions concerning reproduction free of discrimination, coercion and violence, as expressed in human rights documents. In the exercise of this right, they should take into account the needs of their living and future children and their responsibilities towards the community[15].

RESOURCE PLAN: A plan that outlines the resources needed for an activity to be carried out. Resources include human resources, technical resources, and financial resources.

SEXUAL AND REPRODUCTIVE HEALTH (SRH) PROGRAMMES AND POLICIES: Sexual and reproductive health programmes and policies include, but are not restricted to: services for family planning; infertility services; maternal and new-born health services; prevention of unsafe abortion and post-abortion care; prevention of mother-to-child transmission of HIV; diagnosis and treatment of sexually transmitted infections, including HIV infection, reproductive tract infections, cervical cancer, and other gynaecological morbidities; promotion of sexual health, including sexuality counselling; and prevention and management of gender-based violence.

SEXUAL HEALTH: Sexual health is a state of physical, emotional, mental and social wellbeing in relation to sexuality; it is not merely the absence of disease, dysfunction or infirmity. Sexual health requires a positive and respectful approach to sexuality and sexual relationships, as well as the possibility of having pleasurable and safe sexual experiences, free of coercion, discrimination and violence. For sexual health to be attained and maintained, the sexual rights of all persons must be respected, protected and fulfilled[16].

SEXUAL RIGHTS: Sexual rights embrace human rights that are already recognized in national laws, international human rights documents and other consensus statements. They include the right of all persons, free of coercion, discrimination and violence, to the highest attainable standard of sexual health, including access to sexual and reproductive health care services; to seek, receive and impart information related to sexuality; to sexuality education; to respect for bodily integrity; to choose their partner; to decide to be sexually active or not; to consensual sexual relations; to consensual marriage; to decide whether or not, and when, to have children; and to pursue a satisfying, safe and pleasurable sexual life[17].

SEX WORKER: The term 'sex worker' is intended to be non-judgemental and focuses on the working conditions under which sexual services are sold. Sex workers include consenting female, male, and transgender adults and young people over the age of 18 who receive money or goods in exchange for sexual services, either regularly or occasionally. Children selling sex under the age of 18 are considered to be victims of commercial sexual exploitation, unless otherwise determined.

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[14] **Source**: Programme of action of the ICPD Development, chap. VII, sect. A, para. 7.2; Report of the International Conference on Population and Development, Cairo, 5-13 September 1994, (United Nations publication, Sales No. E.95.XIII.18), chap. I, resolution 1, annex)

[15] **Source**: Programme of action of the International Conference on Population and Development, chap. VII, sect. A, para. 7.3; Report of the International Conference on Population and Development, Cairo, 5-13 September 1994 (United Nations publication, Sales No. E.95.XIII.18), chap. I, Resolution 1, annex.)

[16] **Source**: http://www.who.int/reproductivehealth/topics/gender_rights/sexual_health/en/ - it **does not represent an official WHO position, and should not be used or quoted as WHO definitions.**

[17] **Source**: http://www.who.int/reproductivehealth/topics/gender_rights/sexual_health/en/ - These working definitions are presented here as a contribution to on-going discussions about sexual health, but do not represent an official WHO position, and should not be used or quoted as WHO definitions.

STIGMA: 'Stigma' is derived from the Greek meaning a mark or a stain. Stigma can be described as a dynamic process of devaluation that significantly discredits an individual in the eyes of others. Within particular cultures or settings, certain attributes are seized upon and defined by others as discreditable or unworthy. When stigma is acted upon, the result is discrimination that may take the form of actions or omissions.

TRANSGENDER: A transgender person has a gender identity that is different from his or her sex at birth. Transgender people may be male to female (female appearance) or female to male (male appearance). It is preferable to describe them as 'he' or 'she' according to their gender identity, i.e. the gender that they are presenting, not their sex at birth.

TRANS PHOBIA: Trans phobia is fear, rejection, or aversion, often in the form of stigmatizing attitudes or discriminatory behaviour, towards transsexuals, transgender people, and transvestites.

TRANSVESTITE: A transvestite is a person who wears clothes associated with the opposite gender in order to enjoy the temporary experience of membership of the opposite gender. A transvestite does not necessarily desire a permanent sex change or other surgical reassignment.

TRANSSEXUAL: A transsexual person is in the process of or has undertaken surgery and/or hormonal treatment in order to make his or her body more congruent with his or her preferred gender.

UNAIDS INVESTMENT FRAMEWORK: Developed by an international group of experts, it draws on existing evidence of what works in HIV prevention, treatment, care and support in order to facilitate a focused and strategic use of resources. UNAIDS, 2011. A New Investment Framework for the global HIV response.

VIOLENCE AGAINST WOMEN: Any act of gender-based violence that results in, or is likely to result in, physical, sexual or psychological harm or suffering to women, including threats of such acts, coercion or arbitrary deprivation of liberty, whether occurring in public or in private life[18].

VOLUNTARY COUNSELLING AND TESTING (VCT): Voluntary counselling and testing is also known as 'client-initiated testing and counselling', in opposition to 'provider-initiated testing'. All testing should be conducted in an environment that adheres to and implements the three Cs: Confidentiality, informed Consent, and Counselling. See www.unaids.org/en/resources/policies.

[18] Source: Declaration on the Elimination of Violence Against Women, art. 1, http://www.un.org/documents/ga/res/48/a48r104.htm)