

# Promoting Gender Equality through UNICEF-Supported Programming in HIV and AIDS

**Operational Guidance**



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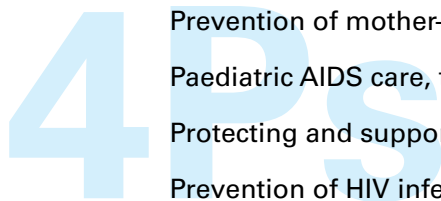
# EXECUTIVE SUMMARY

The 'Promoting Gender Equality through UNICEF-Supported Programming in HIV and AIDS: Operational Guidance' was developed in response to the pressing need to address persistent gender inequality and human rights violations that obstruct and undermine our concerted response for children and AIDS. These inequalities and the continued lack of age and gender-informed evidence threaten the gains that have been made in preventing HIV transmission, increasing access to antiretroviral treatment, and mitigating the impact of the epidemic on children.

This Operational Guidance is aimed at UNICEF staff, and its objective is twofold: to draw attention to evidence linking improvements in gender equality with the achievement of UNICEF goals and expected results on HIV and AIDS; and to provide specific guidelines and tools to promote gender equality. The document is not intended to be comprehensive in its analysis, nor all-encompassing in the proposed questions and tools to operationalize a gender-informed approach. Rather, it aims to instil a way of thinking and working among UNICEF staff and partners, who are confronted with the complex and interlinked challenges related to gender, human rights and HIV.

This document focuses specifically on issues relevant to HIV and AIDS. It is to be read in connection with *Promoting Gender Equality: An Equity-Focused Approach to Programming (Operational Guidance Overview)*, which reviews key concepts and definitions related to gender equality and provides a conceptual framework for operationalizing UNICEF's Gender Policy within the programming cycle.

Critical to achieving outcomes for children and AIDS will be the realization of human rights and gender equality through the generation of gender-informed evidence to improve access, coverage and impact across the 'Four Ps', which constitute the children and AIDS response:

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- Prevention of mother-to-child transmission of HIV;
  - Paediatric AIDS care, treatment and support, including for adolescents;
  - Protecting and supporting children affected by AIDS, including adolescents;
  - Prevention of HIV infection among adolescents and young people.

Success in placing gender and human rights front and centre in the children and AIDS response will come about by supporting national partners to achieve gender equality and HIV outcomes. Civil society plays a critical role, particularly women's rights organizations and HIV organizations; networks of women and young people living with HIV; human rights organizations; faith-based organizations; adolescents and young people; organizations of men and boys, especially those working for gender equality; traditional leaders, governments, donors and the private sector; and sports associations and United Nations organizations.

To realize improved outcomes for gender equality and HIV, UNICEF must engage partners in both programme and policy work, as well as strengthen national planning, implementation, monitoring and evaluation processes. UNICEF representatives must advocate for scaled-up action to improve access, coverage and impact of HIV programmes in concert with improving gender-equality outcomes; and ensure that budgets are allocated to this work. UNICEF staff must be a driving force for generation and documentation of gender-informed evidence for policy and programme actions; and UNICEF and its partners must work with children, women and families affected by HIV throughout the entire programme planning process – ensuring their right to participate and plan their futures.

## PRINCIPLES: GENDER EQUALITY AND HIV<sup>1</sup>

All UNICEF programmes focused on HIV and AIDS must:

- **Promote, protect and respect fundamental human rights, including gender equality.**
- **Require equal participation** of women and girls, and boys and men, including those with HIV, in the programme planning cycle, recognizing their contributions, experiences and expertise.
- **Utilize gender-informed evidence to guide policy and programmes**, based on relevant epidemiologic, economic, social and cultural contexts.
- **Acknowledge traditional and stereotypical views of women and men, and girls and boys**, and the relations among them, and also determine how these views contribute to the spread of HIV, avoidance of testing or accessing antiretroviral therapies and compliance with treatment regimes. **Use this knowledge** to develop more effective prevention and treatment programmes.
- **Empower women and girls** to be active agents in their own lives, questioning harmful and unequal gender norms and behaviours, and engage men and boys to achieve gender equality, question harmful definitions of masculinity and end all forms of violence, all of which drive the spread of HIV.
- **Prioritize budgeting to address gender, and leverage partner's resources and action at the appropriate coverage, scale and intensity** to improve access, coverage and impact of gender-informed evidence across the 'Four Ps', addressing both practical (immediate) and strategic (structural) barriers to achieving better HIV outcomes and gender equality.
- **Build partnerships to place gender and human rights more front and centre in the children and AIDS response**, with the goal of improving coverage, uptake and impact of HIV services, while promoting gender equality.
- **Recognize the need for new and improved access to technologies, research and innovation to achieve better HIV outcomes and promote gender equality**; yet be sensitive to how gender norms may bias scientific methods and application.
- **Acknowledge and act on the scientific evidence** that confirms the biological vulnerability of women, especially young women, to HIV and other sexually transmitted infections.

<sup>1</sup> 'Adapted from 'Intensifying HIV Prevention: UNAIDS Policy Position Paper', Joint United Nations Programme on HIV/AIDS, Geneva, August 2005.'

# WHY GENDER EQUALITY MATTERS TO CHILDREN AND HIV



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More than 25 years into the epidemic, gender inequality and the low status of women remain two of the principal drivers of HIV and main challenges in scaling up the children and AIDS response.<sup>2</sup>

Gender norms shape the status and roles of women and men; they determine attitudes towards sex, sexuality, sexual behaviour and relationships. The family greatly influences the development of gender identities during early childhood development, and is central to the social construction of gender. It is also

the place where girls' and boys' expressions of identity can be rendered safe and harmless. The family can lessen a child's vulnerability, or increase it by enforcing harmful norms and practices. The family nurtures morals, and it is a family's duty to shape the values of their children.<sup>3</sup>

Research on young children's perceptions of gender, risk-taking behaviours and HIV demonstrates that young children also possess the ability and capacity to grasp the risks and realities of HIV as well

<sup>2</sup> Joint United Nations Programme on HIV/AIDS, 'Framework on Women, *Girls and Gender Equality*', UNAIDS PCB Board Paper, December 2009.

<sup>3</sup> Bhana, Deevia, and Farhana Farook Brixen, 'Young Children, HIV/AIDS and Gender: A summary review', Early Childhood Development Working Paper, Bernard Leer Foundation, August 2006.

as comprehend gender roles.<sup>4</sup> Within the framework of the life cycle approach, children can differentiate men from women by the age of 2. Early childhood presents a window of opportunity to positively influence the attitudes, behaviours and practices that can keep boys and girls safe, healthy and HIV-free for life.<sup>5</sup> Supporting caregivers in exercising safe and equitable practices within their relationships reinforces the child's ability to do so.

Gender norms are also constructed by society, educators, mentors, religious leaders and children's peers, all of whom play a critical role in the exposure to risk and the consequences of HIV infection. The current AIDS response does not sufficiently tackle the social, cultural and economic factors that construct harmful gender norms and practices that put women and girls at increased risk of HIV, and that burden them with the epidemic's consequences. Neither does the response sufficiently address the masculine and feminine mores that inhibit men and boys from learning facts and practicing skills to prevent HIV infection.

Many of the ways in which we have defined masculinity, raised boys to be men and allowed men to exercise power over women directly contribute to the spread of HIV and the failure to seek treatment. For example, gender norms in many cultures:

- Equate masculinity with sexual conquest and encourage non-monogamy as a sign of virility;
- Support the view that it is a man's right to have sex when and how he wants, regardless of the wishes of his partner(s). The power relations between men and women encourage men to disregard women's needs, choices, bodily integrity and autonomy. Many countries turn a blind eye to sexual violence.

- Equate masculinity with risk-taking and the denial of physical vulnerability, increasing men's likelihood of contracting HIV and decreasing their likelihood of seeking treatment.
- Equate manhood with heterosexuality, thus pushing sex with other men into more furtive, and more dangerous, encounters. This leaves boys particularly vulnerable at the hands of older men. When safe-sex information isn't available for same-sex contact, men who have sex with men are more vulnerable to contracting HIV, affecting these men as well as any future male or female partners.<sup>6</sup>

Critical to achieving positive outcomes for children and AIDS are the following:

- Prevention of mother-to-child transmission of HIV (PMTCT);
- Paediatric AIDS care, treatment and support, including for adolescents;
- Protecting and supporting children affected by AIDS, including adolescents;
- Prevention of HIV infection among adolescents and young people.

Evidence from the first four years of Unite for Children, Unite against AIDS<sup>7</sup> indicates that access, coverage and impact of interventions for mothers, children and their families are improving and scaling up to achieve the goal of universal access.<sup>8</sup> In some settings, the epidemic is halting and even reversing. Tremendous work is ahead, however, if these gains are to be sustained and amplified. Continuous dialog and documentation of 'what works' and 'how it worked' is critical to understanding the many dimensions of a comprehensive intervention and will contribute to our collective success.

<sup>4</sup> Dunn, Alison, 'HIV/AIDS: What about the very young children?' in Early Childhood Development, Young Children and HIV/AIDS Sub-Series, Working Paper 35, Bernard van Leer Foundation, The Hague, 2005.

<sup>5</sup> Blakemore, J., 'Children's Beliefs about Violating Gender Norms: Boys shouldn't look like girls, and girls shouldn't act like boys', 'Sex Roles', vol. 48, no. 9/10, May 2003.

<sup>6</sup> These issues are explored in numerous sources. See, for example, Agardh, Anette, et al., 'AIDS and Gender Relations', Swedish International Development Cooperation Agency, Sweden, May 2007.

<sup>7</sup> <[www.uniteforchildren.org/index.html](http://www.uniteforchildren.org/index.html)>.

<sup>8</sup> <[www.unaids.org/en/PolicyAndPractice/TowardsUniversalAccess/default.asp](http://www.unaids.org/en/PolicyAndPractice/TowardsUniversalAccess/default.asp)>.

## PREVENTION OF MOTHER-TO-CHILD TRANSMISSION OF HIV AND PAEDIATRIC AIDS CARE, TREATMENT AND SUPPORT, INCLUDING FOR ADOLESCENTS

A comprehensive PMTCT programme can save the lives of hundreds of thousands of girls and boys, and men and women.<sup>9</sup> PMTCT services are a critical entry point for early diagnosis of HIV among infants and antiretroviral treatment for HIV-positive mothers and their partners. However, a majority of women, their partners, and children do not yet have access to basic PMTCT services, which include HIV testing and counselling, family planning, infant-feeding counselling and support, antiretroviral prophylaxis and antiretroviral therapies for mothers who need it.<sup>10</sup>

Studies have found that one third of all HIV-positive infants not diagnosed and initiated on treatment within the first three months of life are not likely to survive beyond their first birthday. Yet only 15 per cent of children born to mothers living with HIV<sup>11</sup> were tested within the first two months of life at the end of 2008. In addition, less than one quarter of all pregnant women were tested for HIV during the same time.<sup>12</sup> In 2008, of the estimated number of pregnant women living with HIV, only 45 per cent received antiretroviral prophylaxis for PMTCT. Globally, however, AIDS is the leading cause of death for young women and girls 15–24 years old; sixth for girls 10–19 years old; and ninth for girls 0–9 years old.<sup>13</sup> In sub-Saharan Africa, girls and young women 15–24 years old are three times more likely to be HIV-positive than their male counterparts.

PMTCT is also an opportunity for HIV prevention. Few young women use a contraceptive of any kind during their first sexual experience.<sup>14</sup> Their access to contraception is limited by their own lack of information and skills, and by the fact that most reproductive health services in developing countries are designed to serve the needs of married women.<sup>15</sup> Even so, half of the generalized epidemic countries with population-based survey results reported more than 25 per cent unmet need for family planning among married women.<sup>16</sup>

Access to services must be complemented by demand and follow-up on the part of clients. Yet inadequate community sensitization and knowledge of HIV and the services that exist, combined with stigma and the opportunity costs of seeking treatment, hinder service uptake. The number of women and girls who do not seek services, and who are lost in follow-up throughout the PMTCT cascade, is tragically high. Gender-informed evidence to explain loss to follow-up needs to be fully explored and understood in varying contexts, including the types of knowledge and skills that improve uptake and the underlying social and economic factors that influence both men and women's health-seeking behaviours.

There is some gender-informed evidence concerning barriers to PMTCT service uptake that can be gleaned from the literature on health-seeking behaviour. Studies in Zambia

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<sup>9</sup> PMTCTV has four interventions: 1) Prevention of HIV among women of reproductive age; 2) prevention of unplanned pregnancies among women living with HIV; 3) prevention of vertical transmission of HIV from mother to child; and 4) treatment, care and support for the mother and child living with HIV.

<sup>10</sup> United Nations Children's Fund, *Children and AIDS: Fourth stocktaking report*, UNICEF, New York, 2009, p. 4.

<sup>11</sup> In 41 countries reporting these data in 2008.

<sup>12</sup> World Health Organization and United Nations Children's Fund, *Towards Universal Access: Scaling up HIV services for women and children in the health sector – Progress report 2008*, WHO and UNICEF, Geneva and New York, July 2008, p. 108.

<sup>13</sup> World Health Organization, *Women and Health: Today's evidence, tomorrow's agenda*, WHO, Geneva, 2009.

<sup>14</sup> Lloyd, Cynthia B., editor, *Growing up Global: The changing transitions to adulthood in developing countries*, Population Council, Washington, D.C., 2009.

<sup>15</sup> Ibid.

<sup>16</sup> World Health Organization and United Nations Children's Fund, *Towards Universal Access: Scaling up HIV services for women and children in the health sector – Progress report 2009*, WHO and UNICEF, Geneva and New York, September 2009, p. 96.





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and India note that fear of rejection by husbands and stigma were among the factors preventing treatment uptake and adherence.<sup>17, 18</sup> Other studies have shown that fear of being ostracized by family members and husbands prevent women from even obtaining an HIV test, as do perceptions of the high cost of treatment.<sup>19</sup> Data from Demographic and Health Surveys indicate that knowledge of PMTCT drugs also plays a role in the uptake of services, including knowledge of PMTCT drugs among men.<sup>20</sup> Men's participation in PMTCT services is increasing in some settings, but is often not monitored or fully integrated as an essential component of PMTCT programmes, though men's participation

has been shown to diminish loss to follow-up at different points throughout the PMTCT cascade.<sup>21, 22</sup>

The relationship among household income, gender and health-seeking behaviour has also been examined. Various studies have shown that poor households tend to spend more money on medical expenditures for men living with HIV than on medical care for women living with HIV.<sup>23</sup> Women's comparative lack of access to household financial resources places them at a disadvantage in determining personal treatment options; thus it is important to support women living with HIV after their children are born,

<sup>17</sup> Murray, Laura K., et al., 'Barriers to Acceptance and Adherence of Antiretroviral Therapy in Urban Zambian Women: A qualitative study', *AIDS Care*, vol. 21, no. 1, January 2009, pp. 78–86.

<sup>18</sup> Rogers Alexandra, et al., 'HIV-Related Knowledge, Attitudes, Perceived Benefits, and Risks of HIV Testing among Pregnant Women in Rural Southern India' *AIDS Patient Care and STDs*, vol. 20, no. 11, 2006, pp. 803–811.

<sup>19</sup> Kumarasamy, N., 'Barriers and Facilitators to Antiretroviral Medication Adherence among Patients with HIV in Chennai, India: A qualitative study' *AIDS Patient Care and STDs*, vol. 19, no. 8, 2005.

<sup>20</sup> Madise, N., 'PMTCT Knowledge, Service Availability, and Service Utilisation: Are we on Track to 2010 UNGASS Targets?' United Nations Children's Fund (unpublished), 2009.

<sup>21</sup> Kakimoto, K., et al., 'Influence of the Involvement of Partners in the Mother Class with Voluntary Confidential Counselling and Testing Acceptance for Prevention of Mother to Child Transmission of HIV Programme (PMTCT Programme) in Cambodia', *AIDS Care*, vol. 19, no. 3, 2007, pp. 381–384.

<sup>22</sup> Bajunirwe, F., and M. Muzoora, 'Barriers to the Implementation of Programs for the Prevention of Mother-to-Child Transmission of HIV: A cross-sectional survey in rural and urban Uganda', *AIDS Research and Therapy*, vol. 2, no. 10, 2005.

<sup>23</sup> Joint United Nations Programme on HIV/AIDS, *Operational Guide on Gender and HIV/AIDS: A rights-based approach*, UNAIDS, Geneva, 2005, p. 41. (Multiple sources that support the footnoted statement are cited within the Operational Guide.)

as they may not prioritize their own health. A number of studies have shown that women who participate in microcredit and grant-making schemes have shown improvements in health, as have their children.<sup>24</sup>

Providing chronic disease care and support to manage HIV throughout a lifetime also poses considerable challenges. Children and young people living with HIV are faced with complex life choices, including decisions on sexuality and reproduction, which are not supported by sensitive health and social services or sympathetic communities.<sup>25</sup> Restrictive

masculine norms and homophobia may propel boys down paths that are risky for themselves and their partners, while restrictive feminine norms limit choices in health and reproductive independence among girls and young women.<sup>26</sup> Studies have shown that people living with HIV or AIDS may conceal their HIV status or seek care in distant locations to protect their anonymity.<sup>27</sup> The different challenges faced by boys and girls need to be better understood to address complex questions during early childhood, puberty and adolescence regarding HIV status disclosure, sex and relationships.

## PREVENTING NEW INFECTIONS AMONG ADOLESCENTS AND YOUNG PEOPLE

The prevention of new infections among young people in many societies is challenged by deeply entrenched norms and prohibitive social and religious environments that particularly heighten risk of infection among young women. Forty-five per cent of all new infections in 2007 in people age 15 and older were in young people (15–24 years old); in the two regions that bear the heaviest burden of infection and disease, women and girls are at least throughout times more likely to contract HIV than men and boys.<sup>28</sup> Even marriage, long assumed to be a protective factor, may heighten vulnerability to infection among adolescent girls.<sup>29</sup>

Contrary to popular belief, there is little evidence at the global level that girls today have their first

sexual encounters at younger ages than in the past. Almost everywhere in the world, girls' first sexual activity occurs during late adolescence, between the ages of 15 and 19.<sup>30</sup> Despite the fact that most people initiate sex in their adolescent years, effective school-based sex education is not available in most countries throughout the world,<sup>31</sup> nor are youth-friendly health services universally available and amenable to the needs of their young clients. Without these sources of information and services, young people may be denied access to the information and skills they need to build meaningful relationships based on equality and respect and to make informed decisions about sex and reproduction.<sup>32</sup> Analyses of data from 36 countries indicate that among young women who have had sexual

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<sup>24</sup> Yuan, J. H., and K. Legins, 'Community-Based Responses to Women Living with HIV and Their Families in three Provinces in China', United Nations Children's Fund (unpublished), p. 2008.

<sup>25</sup> Ferrand, Rashida A., et al., 'AIDS among Older Children and Adolescents in Southern Africa: Projecting the time course and magnitude of the epidemic' *AIDS*, vol. 23, no. 15, 24 September 2009.

<sup>26</sup> Global Network of People Living with HIV/AIDS, 'Advancing the Sexual and Reproductive Health and Human Rights of People Living with HIV: A guidance package', GNP+, Amsterdam, 2009.

<sup>27</sup> Mahendra V. S., et al., 'Factors Affecting Health Seeking Behavior of People Living with HIV/AIDS (PLHA) in New Delhi, India: Results of a qualitative study', *International Conference on AIDS*, 7–12 July 2002, no. 14.

<sup>28</sup> United Nations Children's Fund, *Children and AIDS: Fourth stocktaking report*, UNICEF, New York, 2009, p. 15.

<sup>29</sup> Clark, S., et al., 'Protecting Young Women from HIV/AIDS: The case against child and adolescent marriage', *International Family Planning Perspectives*, vol. 32, no. 2, June 2006, p. 79–88.

<sup>30</sup> Wellings, K., et al., 'Sexual Behaviour in Context: A global perspective', *Lancet*, vol. 368, 2006, pp. 1706–1728.

<sup>31</sup> United Nations Educational, Scientific and Cultural Organization, *International Guidelines on Sexuality Education: An evidence informed approach to effective sex relationships and HIV/STI education*, UNESCO, Paris, June 2009.

<sup>32</sup> World Health Organization, United Nations Population Fund and United Nations Children's Fund, *Programming for Adolescent Health and Development: Report of a WHO/UNFPA/UNICEF study group on programming for adolescent health*, WHO Technical Report Series 886, 1999, and accompanying 'Ready, Steady, Go' brief, <[www.unfpa.org/upload/lib\\_pub\\_file/639\\_filename\\_preventing\\_eng.pdf](http://www.unfpa.org/upload/lib_pub_file/639_filename_preventing_eng.pdf)>.



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intercourse,<sup>33</sup> fewer than half say they could get a condom by themselves.<sup>34</sup>

For many girls, early sexual activity is often associated with coercion or even violence. The younger the woman is when she first has sex, the greater the likelihood that her sexual initiation is forced.<sup>35</sup> Data from four countries show that nearly 1 in 4 young women reported that her first sexual intercourse was forced.<sup>36</sup> Female adolescents are exposed to unwanted pregnancy and to sexually transmitted infections, including HIV, and they experience long-term mental and physical health consequences.

Meanwhile, many boys grow up learning to equate manhood with sexual conquest. They learn not to ask for help or express any sort of vulnerability; risk-taking behaviour is often celebrated. The absence of men in primary nurturing roles teaches boys that manhood and nurturing or empathy are not compatible.

In some cultures, boys see much older men as having greater sexual access to young women, thus setting up a more competitive and even predatory sexual culture. Some boys experience sexual predation by older men. These factors together create enormous risks for boys and, through boys, for girls.

However, violence is only one risk that girls face. In generalized epidemics, evidence indicates there can be many outcomes of a 'combination prevention' approach, including: delayed sexual debut, increased knowledge of HIV serostatus, reduced numbers of sexual partners (particularly concurrent partners), reduced age-disparate sex, increased female and male condom use, male circumcision, and increased coverage and utilization of testing and counselling services by those at highest risk of HIV exposure.<sup>37</sup> The local context, including gender dynamics, will determine which outcomes a combination prevention intervention should focus on.

<sup>33</sup> Based on an analysis of Demographic and Health Surveys (DHS) and multiple indicator cluster surveys data.

<sup>34</sup> United Nations Children's Fund, *Children and AIDS: Fourth stocktaking report*, UNICEF, New York, 2009, p. 16.

<sup>35</sup> Garcia-Moreno, C., et al., *WHO Multi-Country Study on Women's Health and Domestic Violence: Initial results on prevalence, health outcomes and women's responses*, World Health Organization, Geneva, 2005.

<sup>36</sup> United Nations Children's Fund, *Children and AIDS: Fourth stocktaking report*, UNICEF, New York, 2009, p. 16.

<sup>37</sup> Joint United Nations Programme on HIV/AIDS, *Addressing the vulnerability of young women and girls to stop the HIV epidemic in southern Africa*, UNAIDS, Geneva, 2008.

Employing combination prevention in low and concentrated epidemics entails focusing on the young people who are most vulnerable to HIV infection and often practice several high-risk behaviours concurrently. Increased vulnerability, in many settings, is also due to the criminalization of sexual and other behaviours that deviate from local norms and may be illegal (injecting drugs, selling sex and male-to-male sex). This can impede access to sexual and reproductive health care and harm reduction services – the cornerstones of an efficient and effective response to HIV.<sup>38</sup>

In Eastern Europe and Central Asia, research shows that among injection drug users, boys who initiated sex at a young age were more likely to report multiple sex partners.<sup>39</sup> Studies in the Middle East, the Americas, Eastern Europe and South East Asia among young men who have sex with men indicate low levels of condom use and relatively high exposure to violence and exploitation.<sup>40, 41</sup>

Pregnant girls and women who practice high-risk behaviours, such as injecting drugs and selling sex, can benefit from integration of protection and health services, as is being done in Ukraine and other countries.<sup>42</sup>

## PROTECTING AND SUPPORTING CHILDREN AFFECTED BY AIDS, INCLUDING ADOLESCENTS

Support for children and families affected by HIV must take into account the gender dynamics of care, external support, extended family support and other factors influencing health and development of children and their families. Ninety-five per cent of children affected by AIDS live with extended family or community members, but very little is known about the experiences of girls and boys in alternative care, or the impact of cash transfers on girls and boys in foster care, adoption or other forms of community and family based care.<sup>43, 44</sup>

Within financially stressed families with limited access to functioning social welfare and health systems, young girls and elderly women

are by and large the primary caregivers for HIV-affected family members.<sup>45</sup> This role, in addition to having an impact on schooling, is uncompensated and can further stress the household and, by extension, the community.

School withdrawal, compounded by discrimination against people living with HIV and their families, heightens the risk of sexual exploitation, gender-based violence and HIV infection among girls.<sup>46</sup> Girls living outside of family care are particularly vulnerable to early sexual debut. In some settings, they are more likely to be taken out of school to care for sick relatives and be subjected to violence and abuse.<sup>47</sup> As household income levels drop due to

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<sup>38</sup> Inter-Agency Task Team on HIV and Young People Guidance Brief, 2008.

<sup>39</sup> Gore-Felton, C., 'The Influence of Gender on Factors Associated with HIV Transmission Risk among Young Russian Injection Drug Users', *American Journal of Drug and Alcohol Abuse*, vol. 29, no. 4, 2003, pp. 881–894.

<sup>40</sup> UNICEF data collection from Afghanistan, Central America, Montenegro and the Asia Data Hub.

<sup>41</sup> Joint United Nations Programme on HIV/AIDS, *UNAIDS Action Framework: Universal access for men who have sex with men and transgender people*, UNAIDS, Geneva, May 2009.

<sup>42</sup> United Nations Children's Fund, 'Report on the Injecting Drug Users and Pregnant Women', Ukraine Meeting, 2009.

<sup>43</sup> United Nations Children's Fund, *Children and AIDS: Fourth stocktaking report*, UNICEF, New York, 2009, p. 21.

<sup>44</sup> Sherr, Lorraine, Joanne Mueller and Rebecca Varrall, 'Evidence-Based Gender Findings for Children Affected by HIV and AIDS: A systematic overview', *AIDS Care*, vol. 21, no. 1, August 2009, pp. 83–97.

<sup>45</sup> Secretary-General's Task Force, 2004.

<sup>46</sup> United Nations Children's Fund, *Stopping the HIV Epidemic: Young women, girls and HIV in sub-Saharan Africa – What Must be done!*, UNICEF, New York, 2008.

<sup>47</sup> Communiqué for the Fourth Global Partners Forum on Children Affected by HIV and AIDS.

increased costs for health care, boys may also be pulled from school to make up for the loss of adult productivity.

In addition to school withdrawal, children in households with a parent living with HIV may experience trauma when caring for ill family members. Aggravated by stigma, losing school-based peer networks and sometimes being ill themselves, adolescent caregivers must also cope with increased adult responsibilities.

Child-centred and gender-informed social protection responses can improve coping abilities and catalyse household and community development in areas heavily burdened with AIDS.<sup>48</sup> Men can play a crucial role in

alleviating the burden of care and mitigating the impact of HIV on women. A gender-sensitive approach calls for redressing those social and cultural norms that contribute to imbalances in power between males and females, which result in exploitation of girls as household labourers, deny girls their rights to education and protection, and expose girls and boys to violence in their communities, schools and families. Such an approach also suggests programming directions, such as social-norms campaigns and social policies, to encourage men and boys to strive for gender-equitable relationships,<sup>49</sup> including for men to play a much bigger role as caregivers for the young.



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<sup>48</sup> Joint Learning Initiative on Children and AIDS, *Home Truths: Facing the facts on children, AIDS and poverty*, JLICA, 19 February 2009.

<sup>49</sup> Additional examples have been summarized and discussed in Barker, Gary, Christine Ricardo and Marcos Nascimento, *Engaging Men and Boys in Changing Gender-Based Inequity in Health: Evidence from programme interventions*, World Health Organization, Geneva, 2007, <[www.who.int/gender/documents/Engaging\\_men\\_boys.pdf](http://www.who.int/gender/documents/Engaging_men_boys.pdf)>, and Barker, Gary, et al., 'What Men Have to Do with It: Public policies to promote gender equality', International Center for Research on Women and Institute Promundo, 2010, <[www.icrw.org/files/publications/What-Men-Have-to-Do-With-It.pdf](http://www.icrw.org/files/publications/What-Men-Have-to-Do-With-It.pdf)>.

# ENTRY POINTS FOR PROMOTING GENDER EQUALITY AND IMPROVED HIV OUTCOMES

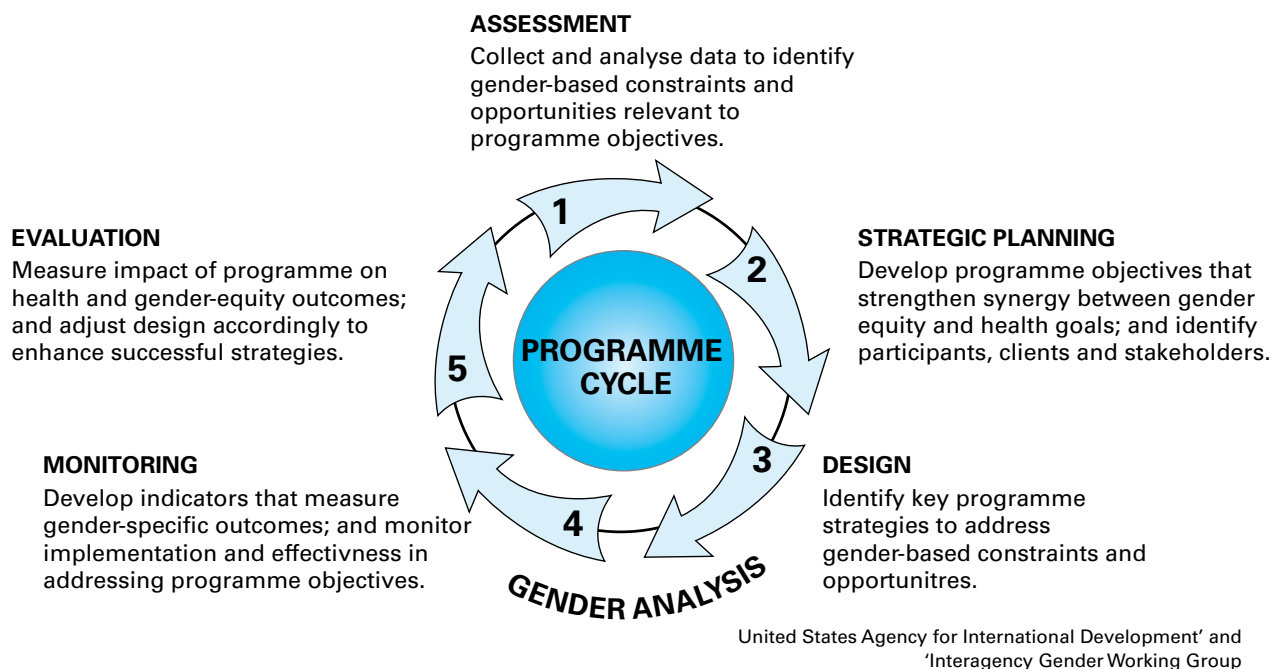


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UNICEF-supported programmes go through three distinct stages: assessment, analysis and action. The following model demonstrates several entry points for promoting gender-equitable results within the programming cycle, as well as the importance of gender analysis through each step (see *Figure 1*).<sup>50</sup> This model, adapted from the Interagency Gender Working Group, has more programming stages than UNICEF, but it will help to elucidate opportunities during the programme planning cycle. You are encouraged to use:

- the information in the annexes;
- the complimenting Operational Guidance from other UNICEF programme areas;
- internal and external communities of practice on gender and HIV, listed in Annex B; and
- a listing of UNICEF staff who may support your work.

<sup>50</sup> Caro, Deborah, et al., 'A Manual for Integrating Gender into Reproductive Health and HIV Programs: From commitment to action', 2nd ed., United States Agency for International Development and Interagency Gender Working Group, Geneva, August 2009. Model adapted from measure evaluation.

**FIGURE 1: STRATEGIC STEPS TO A GENDER-INTEGRATED PROGRAMME**

## ASSESSMENT

Assessment results will reveal practical (immediate) and strategic (structural) interests that affect outcomes. In clearer terms, some actions can be solved with practical interventions (provision of correct PMTCT drug regimen, free condoms or food subsidies) and other actions will require more strategic interventions, such as changing masculine and feminine norms that influence the use of condoms during sex; improving women's access to economic opportunities; and sharing the responsibility of caring for sick persons in a community. Some actions can address both interventions, such as microcredit to women, which addresses the immediate need of improving household income for out-of-pocket health expenses, as well as the strategic interest of supporting women's financial independence.

During the assessment phase, there are a number of questions that cut across policy, programme and project levels to reveal gender transformation needs. (See *Annex C* for tools and resources for assessing gender transformational needs.) These questions include the following:

- What are the different perspectives, roles, needs and interests of women and men in the project area, country, region or institution that affect health-seeking

behaviours? How do gender roles affect HIV testing and treatment adherence?

- What are the relations between women and men pertaining to their access to and control over resources, benefits and decision-making processes regarding sex; family planning; household expenditures and child-rearing?
- What are the social and cultural constraints, opportunities and entry points for defining masculine and feminine roles regarding care and support of people living with HIV?
- What are the capacities of individuals, communities and institutions to programme for gender equality?
- What class, race, caste, ethnicity, age-range and/or culture do the women, men, girls and boys belong to? How does this affect their risk to HIV and their access to the legislative, police, financial and health safeguards and educational opportunities that mitigate HIV risk?

In addition, some questions are relevant only to specific levels of intervention, as described below in *Table 1*.

**TABLE 1: GENDER ANALYSIS QUESTIONS AND TOOLS FOR CHILDREN AND AIDS ISSUES AT DIFFERENT LEVELS**

ASSESSMENT	SAMPLE QUESTIONS TO BE ASKED	EXAMPLE TOOLS (SEE ANNEX C)
<b>Policy*</b>	<ul style="list-style-type: none"> <li>• Are there scale-up plans for the 'Four Ps' that require age- and sex-disaggregated data to be reported on an annual basis?</li> <li>• Does the national plan of action for orphans and vulnerable children identify gender-specific needs?</li> <li>• Do national AIDS policies (and national plans of action) provide gender analyses?</li> <li>• Is the sexuality education guidance used in the country and endorsed by UNICEF?</li> </ul>	<p>Gender and HIV budget reviews United Nations Development Fund for Women (UNIFEM)</p> <p>Gender Planning Framework (Mosner)</p> <p>Social Relations Framework (Kabeer)</p> <p>Sexuality education guidance</p>
<b>National Programme</b>	<ul style="list-style-type: none"> <li>• How many women and men had access to PMTCT HIV testing?</li> <li>• What is the knowledge of PMTCT drugs among women/girls and men/boys?</li> <li>• What is the enrolment of boys/girls in school from households affected by HIV?</li> <li>• What is the age of first sex for boys/ girls and did they use a female or male condom?</li> </ul>	<p>Gender Planning Framework (Moser)</p> <p>Age- and sex-disaggregated data (Childinfo.org and other databases)</p> <p>Joint United Nations Programme on HIV/AIDS (UNAIDS) Gender Operational Guidance</p>
<b>Project</b>	<ul style="list-style-type: none"> <li>• How many facilities provide travel subsidies to women?</li> <li>• Are health facilities open after school hours?</li> <li>• What cultural customs prevent teaching about sex or sexual diversity in the classroom?</li> <li>• What are the reasons boys/girls from households affected by AIDS do not attend school? What are their experiences regarding HIV stigma?</li> <li>• Do sex and HIV education curricula place a strong and meaningful emphasis on issues of gender and rights?</li> </ul>	<p>Participatory tools for children and people living with HIV</p> <p>Harvard Analytical Framework</p> <p>Gender Planning Framework (Moser)</p> <p>Social Relations Framework (Kabeer)</p> <p>Women's empowerment framework</p>

HIV is an issue that affects all UNICEF focus areas. See *Table 2* for a listing of some key evidence-informed interventions for the 'Four Ps' that should be considered during the assessment phase of the programme planning

cycle across key areas of UNICEF-supported programming. See *Annex D* for a listing of UNICEF sector-specific guidance to promote HIV gender analysis across programmes.



**TABLE 2: EVIDENCE-BASED INTERVENTIONS AND STRATEGIES TO IMPROVE ACCESS, COVERAGE AND IMPACT ACROSS UNICEF FOCUS AREAS<sup>51</sup>**

UNICEF FOCUS AREA	PMTCT/ PAEDIATRICS	PROTECTION	PREVENTION
<b>HIV and AIDS</b>	<ul style="list-style-type: none"> <li>• Prevention of loss to follow-up throughout the PMTCT cascade</li> <li>• Improved maternal and newborn health systems</li> </ul>	<ul style="list-style-type: none"> <li>• Cash transfers</li> <li>• Psychosocial support</li> </ul>	<ul style="list-style-type: none"> <li>• Correct and consistent condom use</li> <li>• Male circumcision</li> <li>• Participation of most-at-risk adolescents in prevention programming</li> <li>• PMTCT for adolescent mothers</li> </ul>
<b>Education</b>	<ul style="list-style-type: none"> <li>• Knowledge of PMTCT among students</li> </ul>	<ul style="list-style-type: none"> <li>• Keeping children in school</li> <li>• Keeping children safe once they are in school</li> </ul>	<ul style="list-style-type: none"> <li>• Keeping girls in school longer</li> <li>• HIV knowledge and skills though life skills-based Education Plus</li> <li>• Sexuality and HIV education that prioritizes issues of gender and rights</li> </ul>
<b>Protection</b>	<ul style="list-style-type: none"> <li>• Health subsidies for pregnant girls/women</li> </ul>	<ul style="list-style-type: none"> <li>• Cash transfers</li> <li>• Psychosocial support</li> <li>• Community-based child protection committees</li> <li>• Safe alternative care options (fostering, adoption, etc.)</li> </ul>	<ul style="list-style-type: none"> <li>• Prevention of sexual violence, abuse and exploitation</li> <li>• Access to HIV information among high-risk marginalized groups (street children, etc.)</li> <li>• Prevention of early marriage</li> </ul>
<b>Health; water, environment and sanitation; and nutrition</b>	<ul style="list-style-type: none"> <li>• Prevention of loss to follow-up throughout the PMTCT cascade</li> <li>• Safe infant feeding</li> <li>• Access to clean water and adequate sanitation</li> <li>• Improved maternal and newborn health systems</li> </ul>	<ul style="list-style-type: none"> <li>• Food security</li> <li>• Keeping parents alive</li> <li>• Improving child survival among the most vulnerable populations</li> </ul>	<ul style="list-style-type: none"> <li>• Primary prevention of HIV among mothers</li> <li>• Youth-friendly health services</li> <li>• Male circumcision</li> <li>• Access to contraception and reproductive health care</li> </ul>
<b>Social policy</b>	<ul style="list-style-type: none"> <li>• Budgeting for children</li> </ul>	<ul style="list-style-type: none"> <li>• Budgeting for children</li> </ul>	<ul style="list-style-type: none"> <li>• Budgeting for children</li> </ul>

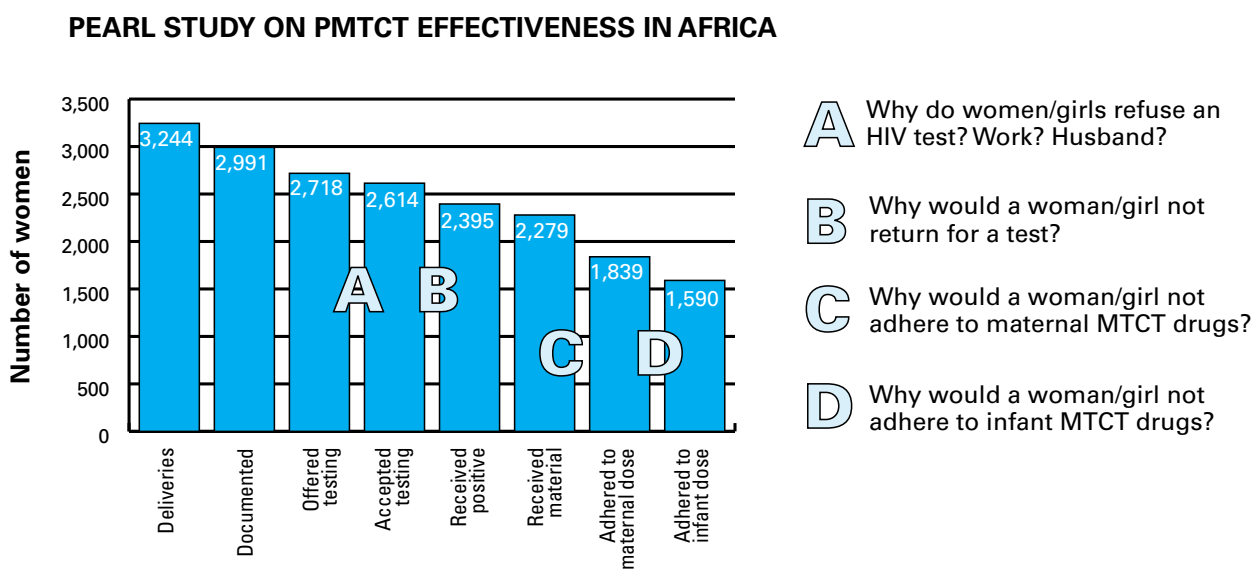
<sup>51</sup> United Nations Children's Fund, *Children and AIDS: Fourth stocktaking report*, UNICEF, New York, 2009.

## The value of gender analysis within PMTCT

In order for PMTCT to work, each mother-infant pair must negotiate a complex cascade of events, as detailed in the PEARL Study on PMTCT effectiveness in Africa (see *Figure 2*).<sup>52</sup> However, many mothers and infants drop out along the way: *The study reports that only 49 per cent of HIV-positive children born to women who entered PMTCT services received the drugs they needed.*

During PMTCT services, cascade failures can and do occur along each step of this pathway and should be systematically targeted because fixing the ‘coverage problem’ would prevent as many infant HIV deaths as would rolling out more effective regimens.<sup>53</sup> Many barriers to PMTCT scale-up are related to gender.

**FIGURE 2: UTILIZING A GENDER ANALYSIS TO IMPROVE GENDER EQUALITY AND HIV OUTCOMES THROUGHOUT THE PMTCT CASCADE**



UNICEF/NYHQ2010-1497/Shehzad Noorani

<sup>52</sup> Stringer, Jeff, ‘PMTCT Effectiveness in Africa: Research and linkages to care and treatment’, presentation delivered at the Regional Expert Consultation on Scaling up Prevention of MTCT of HIV and Paediatric HIV Care and Treatment in Eastern and Southern Africa, Nairobi, 21 May 2009.

<sup>53</sup> United Nations Children’s Fund, *Children and AIDS: Fourth stocktaking report*, UNICEF, New York, 2009.

The initial assessment can help to identify the local cultural, economic and political barriers that pose a challenge to scale-up, although it may take several tries to find the most efficient and effective means to achieve impact. Operational research can improve the efficiency and

effectiveness of interventions, as it offers the tools to learn by doing. See Annex E.<sup>54</sup>

Some example questions that can aid in the gender analysis of programmatic interventions for the 'Four Ps' are in Table 3.

**TABLE 3: SAMPLE QUESTIONS FOR A GENDER ANALYSIS OF THE 'FOUR PS'**

INTERVENTION	PROGRAMMATIC LEVEL GENDER-ANALYSIS QUESTIONS
<b>PMTCT and paediatrics</b>	<ul style="list-style-type: none"> <li>• Why do men and women choose not to get tested for HIV?</li> <li>• Why do women choose not to return to PMTCT services after an HIV-positive test?</li> <li>• Who has to pay for travel to the clinic?</li> <li>• What are men's perceptions of PMTCT services? Do they want their wives to attend?</li> <li>• Has the mother told her partner her HIV status? If not, why? Has the male partner told the mother his HIV status?</li> <li>• Are girls given the opportunity to take mothering classes? Are fathers?</li> <li>• How do boys/girls living with HIV experience drug adherence? First relationship? Sex?</li> <li>• Are youth-friendly health services available for boys and girls? Are they sensitive to the needs of adolescents most at risk for HIV infection?</li> </ul>
<b>Protection</b>	<ul style="list-style-type: none"> <li>• Does the death of a mother or father have different impacts on boys and girls?</li> <li>• What are the reasons boys and girls drop out of school at primary and secondary school? Are they the same or different?</li> <li>• What are the psychosocial needs and responses of girls and boys?</li> <li>• Who is caring for ill parents and who is responsible for income generation?</li> <li>• Who provides the majority of care for vulnerable children and what does this mean in terms of programming and targeting?</li> </ul>
<b>Prevention</b>	<ul style="list-style-type: none"> <li>• How often does a girl/boy experience forced sex? And what skills has s/he used to avoid unwanted sex? (See Annex C for more information on gender-based violence.)</li> <li>• What has been done to decrease perpetration of sexual coercion? What are the immediate causes of unprotected sex between girls and boys of different ages? Of the same sex?</li> <li>• Do family planning services offer HIV education or testing to girls? Boys?</li> <li>• Do sexuality and HIV education programmes/curricula examine the underlying issues of gender inequality, gender norms and rights?</li> <li>• Do sexuality and HIV education programmes/curricula have a sufficient focus on healthy relationships, respect and the communication of needs?</li> <li>• Do HIV educators have the correct information about sexuality?</li> <li>• Why do adolescents who have sex with other adolescents of the same sex not use female or male condoms or practice safer sex?</li> </ul>

<sup>54</sup> World Health Organization, *Guide to Operational Research in Programmes Supported by the Global Fund*, WHO, Geneva, April 2008.

Key HIV and AIDS data sources provide critical information regarding results for gender equality, health and HIV that will be useful in laying the groundwork for designing the programme. The formulation of the Common Country Assessment (CCA)/United Nations Development Assistance Framework (UNDAF) offers one important entry point for ensuring that gender equality and HIV issues are integrated into United Nations planning processes. (See *Table 4* for information on key data sources.) National and international

agencies can also provide invaluable national and sub-national assessment data. UNICEF maintains Childinfo.org, which is a repository of national-level data across the 'Four Ps'; multiple indicator cluster surveys (MICS) data; and DevInfo.org, a system that displays country-level data on the 48 Millennium Development Goal (MDG) indicators. In the Asia-Pacific region, the HIV and AIDS Data Hub provides national-level data on key indicators relating to HIV and AIDS and children's health.

## KEY MESSAGES AND RECOMMENDATIONS DURING THE ASSESSMENT PHASE

1. Assessment is the most critical step for generating gender-informed evidence to guide policy and programme work throughout the entire programme planning cycle.
2. Advocate for and produce gender-informed analyses of barriers, across the 'Four Ps', to improve access, coverage and impact, and to advise policy and programme work on gender-transformative interventions.
3. Examine disaggregated data to identify gender disparities and inequality, including among girls and boys most at risk of sexual coercion, early marriage or non-use of condoms, and among girls and boys who sell sex or are trafficked, live in abusive environments or are former children used by armed forces or groups. It is also necessary to examine programme data to assess whether current programmes are, in practice, actually reaching these vulnerable populations.
4. Assess stakeholders' values and beliefs towards gender, masculinity, sexuality and other issues as a precursor to developing and implementing relevant and appropriate programme and policy interventions.
5. Ensure age- and sex-disaggregated data are collected through UN processes and are available to inform policies and programmes.
6. Document gender analyses of HIV interventions in the UNICEF annual report and donor reports, highlighting the contributions they have made to improving access, coverage and impact; and share them with regional offices and headquarters as good practices.
7. Children, especially women/girls and children living with or affected by HIV, should be included in the assessment phase; utilize child-friendly methodologies.
8. Utilize operational research methodologies during the programme planning cycle to improve the efficiency, effectiveness and reach of interventions.

**TABLE 4: KEY DATA SOURCES TO SUPPORT PROGRAMME PLANNING AND HIV**

TOOLS	RESOURCES	COMMENTS
<b>CCA/UNDAF</b>	CCA/UNDAF – incorporating gender  Good examples of gender mainstreaming in CAA/UNDAF	Data are often broad. More focused surveys will be needed to address the issues of children and AIDS.
<b>UN Gender Theme Group harmonization tools</b>	Resource Guide for Gender Theme Groups, UNICEF, UNIFEM, UNDP, UNFPA and WHO	UN Gender Theme Groups can be an excellent opportunity to integrate gender throughout the planning process, but UN leadership is needed to ensure functionality.
<b>DHS</b>	DHS Gender Corner	Advocacy data for policy work, but more often used to monitor progress of the long term than for programme planning. <sup>55</sup>
<b>MICS, Child Info, DevInfo.org</b>	Analysing data regarding women, children and HIV	Advocacy data for policy work, but more often used to monitor progress of the long term than for programme planning. There are several modules within MICS, and choosing the correct ones could benefit both gender and HIV programming.
<b>Behavioural Surveillance Surveys</b>	Behavioural Surveillance Technical Brief, FHI	Reliability and validity of behavioral surveillance surveys data varies extensively. Involvement of key stakeholders is critical when looking at culturally sensitive issues (e.g., drug use, sex between men and sex work).
<b>Regional data sources</b>	Asia-Pacific AIDS Data Hub	Compiled by UNICEF, the Asian Development Bank and others with support of national counterparts.
<b>AIDS indicator surveys</b>	AIDS indicator surveys	Very valuable where available.
<b>UNGASS data/ MDG</b>	Global Response Database	Linked to UN planning processes, it serves as the main data repository for UNGASS 2003, 2005 and 2007 country data.
<b>UNFPA and Population Council</b>	Adolescent Data Guides	Provides up-to-date, sex-disaggregated data for more than 70 countries on the situation of adolescent girls and boys and young women. The age range covered is 10–24. The data are presented in graphs, tables and maps (wherever possible), providing multiple formats to make the information accessible to a range of audiences.

<sup>55</sup> DHS surveys include the following modules: child health; education; family planning; female genital cutting; fertility and fertility preferences; gender/domestic violence; HIV/AIDS knowledge, attitudes and behaviour; HIV prevalence; household and respondent characteristics; infant and child mortality; malaria; maternal health; maternal mortality; nutrition; household wealth/socio-economics; and women's empowerment.

## STRATEGIC PLANNING

Ensuring that all key stakeholders are involved throughout the programme planning cycle is critical. During the assessment phase, data are gathered, reviewed and analysed with stakeholders, and any gaps in data are identified. The data will inform the design, monitoring and evaluation components of the programme, while promoting long-term sustainability.

Table 5 includes a list of key HIV and AIDS stakeholders that should be considered as you assess the situation and analyse the gender dimensions of the programme you are planning or evaluating for continuation. The main objectives of involving key HIV and AIDS stakeholders in gender-sensitive HIV analyses are to:

- Peer-review data with academia, government, civil society, women/girls and men/boys affected by HIV and AIDS and get their perspectives on the implications of the data for gender equality and HIV.
- Build consensus on ways of responding to the data (there can be more than one) in manners that foster more equitable relationships and norms.
- Effectively plan with decision makers, so as to alleviate bottlenecks to programme implementation;
- Promote good practices and provide lessons learned for efficient and effective scale-up;
- Address specific cultural barriers to confronting sensitive issues, e.g., early marriage, injection drug use, men who have sex with men, child exploitation, sex work and other issues;
- Develop a long-term sustainability strategy if the programme is deemed important as part of the AIDS response.

Convening stakeholders during the assessment and strategic planning phases is critical for country ownership and capacity building. When deciding which stakeholders to involve, you should ask:

- Who needs to use the data, and what questions are they seeking to answer?
- Who has influence on policies and resources that can be brought to bear to aid this project?
- Who can mobilize affected communities to participate in the interventions?
- Who will be directly or indirectly affected by the outcome of this initiative?
- Who will support our plan? Who will oppose it? Why? How do we deal with it?
- What can all these parties bring to bear on the process?
- How can we best leverage their insights or assuage their objections?
- What local and international partners could help to utilize gender-informed evidence to inform the national AIDS strategy (and other relevant strategies, i.e., education and social protection)?

Effective stakeholder analysis answers these questions in a way that significantly improves a project design and the real-world value of the results. Many of these same questions and tools can be applied to policy development. See *Annex C* for stakeholder analysis tools.

See *Annex G* for a list of UN and partner organizations' gender strategies (a review of the strategies can aid you in choosing partners and advocating for gender analyses of children and AIDS programming).

**TABLE 5: INVOLVING KEY STAKEHOLDERS IN THE STRATEGIC PLANNING FOR GENDER EQUALITY AND HIV PROGRAMMES**

STAKEHOLDER	PMTCT AND PAEDIATRICS INCLUDING ADOLESCENTS LIVING WITH HIV	PREVENTION OF HIV AMONG ADOLESCENTS AND YOUNG PEOPLE	PROTECTION OF CHILDREN MADE VULNERABLE BY HIV
<b>Government</b>	Ministry of Health; National AIDS Programmes; Ministries for Children, Women and Young People; Parliamentarian groups	Ministry of Health, Education, Defence and Justice; Ministries for Children, Women and Young People; Ministries of Finance; National AIDS Programmes	Ministries for Children, Women and Young People; Ministries of Finance; Ministries for Social Welfare; National AIDS Programmes
<b>Financers</b>	National Government, GFATM, bilaterals	National Government, GFATM, bilaterals	National Government, GFATM, bilaterals
<b>UN</b>	WHO, UNFPA, UNFPA, UN Women, UNDP	UNFPA, WHO, UNESCO, UNHCR, ILO, UNODC, UNAIDS, WFP, UN Women, UNDP	World Bank, ILO, FAO, UNAIDS, UN Women, UNDP and UNFPA
<b>Non-governmental organizations (NGOs)</b>	Local NGOs, Clinton Foundation, EGPAF, World Vision, other IATT members, organizations of women and children living with HIV; women's coalitions; organizations of men living with HIV/AIDS; groups working to involve men in gender-equality efforts	Local NGOs, youth organizations, organizations of women and children living with HIV; women's coalitions.	Local NGOs, faith-based organizations, people working on violence; women's coalitions; youth peer groups; organizations of women and children living with HIV
<b>Community-based organizations</b>	Organizations of people living with HIV, including women living with HIV	Youth community groups; school groups; organizations of people living with HIV, including women living with HIV	Organizations of people living with HIV, including women living with HIV
<b>Other civil society</b>	Faith-based organizations; traditional and religious leaders	Faith-based organizations (ensuring not to force them to reach beyond their mandate); traditional and religious leaders	Faith-based organizations; traditional and religious leaders
<b>Private sector</b>	Private medical associations; innovative technologies	Cell phone companies, Internet, sports, (youth market)	Banking services

UNICEF is a leader in setting normative standards based on scientific evidence, implementation experience and political insights gained through country presence. As such, while national counterparts, including governments, NGOs, community-based organizations and others are responsible for implementing the programmes, it is UNICEF's role to guide that implementation, monitoring and evaluation; and to promote innovation in achieving access,

coverage and impact, while informing policy development.

UNICEF should advocate for national counterparts to conduct a thorough gender analysis of national AIDS policies and programmes across the 'Four Ps' as a critical component of operationalizing the gender equality and HIV operational guidance. This entails the provision of technical assistance to generate and apply gender-informed evidence.

## KEY MESSAGES AND RECOMMENDATIONS FOR STRATEGIC-PLANNING PHASE

1. HIV requires a multi-sectoral response, therefore a broad representation of stakeholders in the assessment and strategic planning phases are necessary to prevent bias and to achieve consensus or 'buy-in'.
2. UNICEF should act as a technical adviser in the generation of gender-informed evidence across the 'Four Ps' to overcome barriers to access, coverage and impact, and advise policy and programme on practical and strategic gender interventions.
3. People living with HIV, especially girls and boys, should be involved from the very beginning of the programme planning cycle by ensuring the use of child-friendly data collection tools. Meaningfully involve the communities that the programme aims to support.
4. Utilize stakeholder meetings strategically, as well as tools to identify which stakeholders can make the best contributions, and when (see *Annex C*).

## PROGRAMME DESIGN AND IMPLEMENTATION

The design and implementation phases are completely dependent on a robust, gender-informed assessment with key stakeholders and the accumulation of evidence to deliver locally specific interventions. Programming, either by design or by default, makes an impact on the human rights situation in a particular country or community.<sup>56</sup> Below are some key considerations when supporting governments, NGOs, community-based organizations and others to implement HIV programmes in ways that do not negatively affect gender and rights outcomes.

**Development programming can enhance, perpetuate or minimize those factors that make particular communities or social groups vulnerable to HIV infection.** For example, poverty reduction strategies aimed at enhancing the

income of households affected by AIDS may in fact increase the spending power of men without having the same effect on women, because household income is not necessarily shared equitably between all members of the household.

**HIV programming may unintentionally reinforce gender stereotypes and unequal gender relations.** For example, PMTCT programmes targeting pregnant women and mothers may, in fact, reinforce the notion that the responsibility for the health and well-being of a child rests only with a mother and that men do not have to take responsibility in this regard.

**Programming can aggravate or mitigate the impact of HIV and AIDS on women/girls and men/boys, as well as of households, communities, organizations and systems to**

<sup>56</sup> Joint United Nations Programme on HIV/AIDS, *Operational Guide on Gender and HIV/AIDS: A rights-based approach*, UNAIDS, Geneva, 2005.



**address health and development issues.**

Programmes that are responsive to the presence and needs of AIDS-affected persons and their families, rather than being exclusive to them (AIDS sensitive versus AIDS exclusive) may contribute to both health- and protection-system strengthening. Vertical programmes, while at times necessary to address immediate needs, have the risk of adding stigma at the individual and community levels, and compressing services at the institutional and system levels.<sup>57</sup>

**Lack of genuine participation of people living with HIV, children, mothers and other beneficiaries of services can lead to inefficient and ineffective programming.**

Participation, inclusion and empowerment are the main principles guiding all phases of the programming process. Gender and rights-based programmes are always driven by local concerns, so programmes must seek to adapt according to input from beneficiaries.

In the design phase:

- Integrate the findings of your gender analyses and gender-informed evidence, across the 'Four Ps', into the programme design.
- Build coalitions and advocate for gender equality in the design stages, partnering with civil society and organizations of people living with HIV, especially those who focus on girls and boys.
- Bring local organizations and those with expertise on gender equality into the design process.
- Develop a clear strategy and action plan for promoting gender equality, ensuring that adequate resources and the necessary expertise and leadership are in place.
- Establish clear benchmarks and gender-disaggregated indicators for success. (See the section on implementation, monitoring and evaluation.)
- Specify and plan to meet the capacity development needs of implementation partners in promoting gender equality.

- Ensure sufficient budgetary allocations for the implementation of programme and policy activities identified in the planning stages, as related to promoting gender equality through HIV programming.
- Require an appropriate level of gender expertise and experience in promoting gender equality within the terms of reference of implementing agencies and consultants.
- Draft contracts and terms of reference such that they clearly define roles, responsibilities and expected results in the area of gender equality.

As was discussed in the assessment phase, gender analysis needs to differentiate between practical needs and strategic interests. Meeting the practical or basic needs of women and girls is essential. It is not sufficient, however, to promote equality. Strategic interests refer to what is required to address unequal relationships or allocation of resources and opportunities between girls and boys, and women and men. Strategic interests include things like changing laws so that women can own or inherit land, ending impunity for domestic violence, ending early or forced marriage, making family planning accessible so that women can control their fertility, or initiating a quota system for parliamentary elections. See *Annex H* for examples of good practices that apply gender-informed evidence to improve children and AIDS programming and promote gender equality.

HIV programmes have a long history of identifying gender as a driver of the epidemic, but there are few examples of gender equality and HIV programmes with assigned budgets based on gender analyses which are monitored and evaluated by national authorities and brought to national scale. Posing the questions in *Box 2* during the implementation phase may ensure that initial momentum is not lost in practice.<sup>58</sup>

See *Annex D* for tools to promote budgeting for gender outcomes within the AIDS response.

<sup>57</sup> <[www.iasociety.org/Default.aspx?pageld=344](http://www.iasociety.org/Default.aspx?pageld=344)>.

<sup>58</sup> Adapted from African Development Bank, 'Checklist for Gender Mainstreaming in the Water and Sanitation Sector', African Development Bank, September 2009.

## QUESTIONS TO ASK TO PREVENT GENDER EVAPORATION

- Is gender expertise available within the programme personnel?
- Do the terms of reference for personnel take gender concerns into consideration?
- Which existing competent structures (providers, state, NGOs, associations, independent consultants) should be involved in staff and population sensitization?
- In case it does not exist, which interface structure should be created for dialogue between the project and partner structures (NGOs, women and youth associations) in order to take gender into account in programme implementation and monitoring?
- Is there a database on resource persons to be involved in the project?
- Which competent capacity-building structures currently exist?
- Are local authorities, spouses, family members and neighbours informed and sensitized about programme activities involving women and young people?
- Are they prepared to support women and young people in their participation in programme activities? Are they prepared to take part in a different discourse with men, one that challenges gender inequality, sexist attitudes and behaviour, and masculine norms that are destructive to men and boys? If not, what is the right approach to adopt to obtain their support during the assessment and design phases?
- How should effective participation be promoted, given illiteracy (obtaining visas, vaccination records, passports) and social restrictions (rites, customs, spouses' authority, family obligations, etc.)

## KEY MESSAGES FOR PROGRAMME DESIGN AND IMPLEMENTATION

1. The design phase is completely dependent on a robust analysis with key stakeholders and the accumulation of gender-informed evidence which can define locally specific interventions across the 'Four Ps'.
2. Programme implementation should have components that address the practical and strategic gender dimensions of HIV.
3. The implementation phase should be monitored to avoid exacerbating HIV stigma and discrimination and to ensure that the gender elements of the programme do not evaporate due to lack of programme staff capacity or budgets.
4. Good practices on gender-sensitive HIV programming should be shared in UNICEF annual reports, donor reports and with regional and headquarters offices.
5. HIV programmes should seek to strengthen health and protection systems, using gender-informed evidence, to achieve HIV outcomes and promote gender equality.

## MONITORING AND EVALUATION

Monitoring and evaluation must be considered at all points of the programme planning cycle if it is to improve the impact of the programme. Process indicators measure the gender-

sensitivity of the implementation process and outcome indicators measure access, coverage and impact of interventions with age- and sex-disaggregated data.

### Indicators

Promoting gender equality through HIV programming requires the collection of baseline data disaggregated by sex, as well as by age; socio-economic status and other variables; and monitoring and evaluation of both the programme and policies. (See **Annex I** for a sample listing of programme process indicators). In some settings, it may be appropriate to age disaggregate by five-year cohorts, geography or other demographic indicators.

Indicators should be chosen based on the availability of time to measure and by local and programming relevance. The meaningful participation of national and sub-national institutions and affected communities in choosing indicators will ensure they are locally relevant, appropriate and feasible. Indicators should be clearly defined, technically sound, measure trends over time and aim to measure outcomes and impact over outputs.

Quantitative and qualitative indicators are both critical in HIV programming. Qualitative indicators help to measure objectives that are hard to quantify (process indicators such as participation of adolescents living with HIV in decision-making) and in gauging local people's priorities and perspectives on empowerment and development. Qualitative analysis is used to understand social processes, why and how a particular situation came into being, and how this situation can be changed in the future. Qualitative analysis can and should be used at all stages of the project cycle, and should be used alongside quantitative indicators. See *Annex C* for a listing of monitoring and evaluation resources for the response for children and AIDS.

Social and cultural notions of gender can be difficult to measure. However, a number of tools and methods designed to capture

changes in norms and resulting behaviours that place people at risk of HIV infection have been developed and applied. These tools and methods contribute to the growing evidence base regarding the importance of explicit integration of gender-transformative approaches as a measurable component of HIV and AIDS programmes.

- The **Gender-Equitable Men** scale is a multifaceted tool that measures multiple domains within the construct of gender norms and helps us to measure the gendered determinants of HIV transmission. Among other things, research using this scale has shown that men who decreased their support for inequitable gender norms were more likely to report condom use with primary partners and a reduction in acts of physical violence against their partners.
- The **IMAGE** (Intervention with Micro Finance for Aids and Gender Equity) project in South Africa measured the association between education and community mobilization, in conjunction with micro-finance, on gender-based violence.<sup>59</sup>
- **Outcome mapping**, adapted from the private sector by the International Development Research Institute, tracks changes in the behaviours, relationships, actions or activities of the people, groups and organizations with whom a development programme works directly. The first stage, **intentional design**, helps a programme establish consensus on the macro-level changes it aims to bring about and plan the strategies it will use. The second stage, **outcome and performance monitoring**, provides a framework for the

<sup>59</sup> Kim, Julia, et al., 'Assessing the Incremental Effects of Combining Economic and Health Interventions: The IMAGE Study in South Africa', *Bull World Health Organization*, vol. 87, 2009, p. 824–832.

ongoing monitoring of the programme's actions and the partners' progress towards the achievement of outcomes. It is based largely on systematized self-assessment. It utilizes the following data collection tools for elements identified in the intentional design stage: an outcome journal (progress markers); a strategy journal (strategy maps); and a performance journal (organizational practices). The third stage, **evaluation planning**, helps the programme identify evaluation priorities and develop an evaluation plan. See *Annex D* for a link to the tools.

Determining the best indicators to address both HIV and gender equality is a decision for country-level stakeholders. UNICEF, however, must work to uphold commitments to both achieving results and attaining human rights, so as not to exclude certain populations, nor dismiss evidence-informed interventions, i.e., harm reduction strategies for injection drug users. Almost all governments report to the Committee on the Rights of the Child, which also offers indicators to measure the universality of rights (human, woman and child) (see *Annex C*).

## Building the capacity of staff and partners to monitor and evaluate

Enhancing the capacity of staff and partners to design, implement and monitor a gender-responsive response is critical in this phase. The box below contains some example considerations that should be regarded by programme managers to ensure that the monitoring and evaluation process remains gender-sensitive.

Building partnerships to monitor and evaluate is essential for building consensus on what works, and for gaining expertise. The Global Fund to Fight AIDS, Tuberculosis and Malaria and the

United States President's Emergency Plan for AIDS (PEPFAR), as well as other HIV and AIDS programmes and funders, all have required monitoring and evaluation components. UNICEF staff should identify local partners to support monitoring and evaluation of gender-sensitive responses for children and AIDS. See *Annex G* for partners' policies and frameworks on gender and HIV.

Questions that can help to ascertain if the evaluation phase, including the selection of indicators, is gender-sensitive include:<sup>60</sup>

### EXAMPLE QUESTIONS TO MONITOR THE GENDER SENSITIVITY OF THE MONITORING AND EVALUATION PHASE

- Are appropriate monitoring tools (monthly, quarterly and annual activity reports, impact studies, computerized slips to record sex-disaggregated data) available to determine the state of progress of sex-specific activities?
- Are there plans to conduct a gender impact study? What is the real impact (voicing views, representativeness, responsibility, decision-making, education, health, nutrition, income, savings, conflicts, dynamism, organization, domestic obligations, time distribution, commuting, rural migration) on the beneficiaries, as compared with women and young people?
- Have the short- and medium-term outcomes been achieved? If not, why not? What are the gaps in relation to the potential impact projected during the design phase?

<sup>60</sup> Adapted from African Development Bank, 'Checklist for Gender Mainstreaming in the Water and Sanitation Sector', African Development Bank, September 2009.

## Programme indicators<sup>61</sup>

For UNICEF's programmes, indicators can be broadly lumped into the following four

categories: input, output, outcome and impact (see Table 6).

**TABLE 6: DEFINITIONS OF PROGRAMME INDICATORS**

<b>Input:</b>	include resources, funds, training and supplies devoted to a programme.
<b>Outputs:</b>	measure delivery of activities, including training, and the expenditure of resources devoted to a programme. Outputs monitor achievement during implementation, serving primarily to track progress towards the intended results.
<b>Outcome:</b>	measures the achievement of intermediate objectives thought to contribute to overall positive impact on the health and welfare of participants (reduced poverty, increased educational attainment, etc.).
<b>Impact:</b>	measures long-term effects of programme(s) on participants' health and welfare (nutritional status, freedom from injury, longevity, etc.).

Sample HIV and AIDS indicators for all phases of the programme cycle are offered in *Annex I*. The sample indicators can be formulated during the assessment, planning and design phases

to evaluate gender-sensitive processes and outcomes (access, coverage and impact) and can be integrated into the results-based framework of the UNICEF programme planning cycle.

### KEY MESSAGES FOR MONITORING AND EVALUATION

1. Data pertaining to key indicators must be monitored and evaluated in each phase, but should be summarized at various points to determine opportunities for improvement.
2. People living with HIV, especially girls and boys, should be involved from the very beginning of the programme planning cycle by ensuring the use of child-friendly data collection tools, allowing them to contribute to monitoring and evaluation.
3. UNICEF must advocate for the monitoring and evaluating impact of interventions for all children. Children who are excluded from services due to legal, social or other reasons (i.e., injection drug users, women and girls who sell sex, ethnic minorities and others) must be accounted for through monitoring mechanisms, such as the Committee on the Rights of the Child.
4. UNICEF staff should identify national partners to support monitoring and evaluation of the gender-sensitive response for children and AIDS.
5. Gender-sensitive indicators should be selected based on the assessment phase, and can be used to monitor and evaluate programmes which aim to address both the practical and strategic needs of women and girls, and boys and men.
6. Good practices on gender-sensitive HIV evaluations should be shared in UNICEF annual reports, donor reports and with regional and headquarters offices. Utilize the UNICEF Evaluations Database.

<sup>61</sup> The Canadian International Development Agency (CIDA) has developed a comprehensive set of guidelines for developing gender-sensitive indicators. Some key elements are offered in a condensed form in 'Guide to Gender-Sensitive Indicators', 1997, <[www.acdi-cida.gc.ca/inet/images.nsf/vLUIImages/Policy/\\$file/WID-GUID-E.pdf](http://www.acdi-cida.gc.ca/inet/images.nsf/vLUIImages/Policy/$file/WID-GUID-E.pdf)>.

# POLICY DEVELOPMENT AND STRUCTURAL CHANGE



UNICEF/NYHQ2007-2484/Shehzad Noorani

This document recommends the HIV and related programmes collect gender-informed evidence and demonstrate results (coverage, access and impact) to inform policy development, as one way to influence structural change and transform gender norms. The human rights-based approach to programming is another important way to address structural change. (See *Annex C* for links to human rights-based approaches to programming and other approaches that can promote structural change, i.e., social mobilization and fostering political leadership, which are not covered in this document. You may also review the document for Medium-Term Strategic Plan Focus Area 5, ‘Promoting Gender Equality through UNICEF-

Supported Policy Advocacy and Partnerships for Children’s Rights: Operational Guidance’.)

Country offices will have to decide on the right combination of evidence and human rights-based programmatic approaches needed to influence national policies, strategies or laws that are designed to support women and children in achieving their full potential. UNICEF staff responding to AIDS should include in their annual planning, if relevant, actions to address the development of national laws, policies and strategies concerning health, education, social protection, justice, civil affairs, finance and other ministries and institutions that influence AIDS outcomes – many of whom should be on

the One Coordinating Body.<sup>62</sup> To ensure that HIV and gender are appropriately addressed within laws, policies and strategies, a number of toolkits have been designed to inform gender-sensitive processes (see *Annex C*), including the allocation of funding. The *Operational Plan for UNAIDS Action Framework: Addressing women, girls, gender equality and HIV* provides a set of policy measures to address women and girls' risk and vulnerability (see *Annex G*). A review of the utility of these proposed measures within your local context may inform your annual work planning and annual reporting.

Developing policies is central to UNICEF and UN partners' mandates; engaging at a programmatic level is also essential to demonstrate the implementation of gender-sensitive national strategies and policies.<sup>63</sup> Evidence from policy analyses indicates that while there is a good understanding of the linkages between gender and HIV, and while national policies are in place, implementation and follow-through are lacking.

Engaging global health initiatives to influence policy and provide funding for innovative ways to scale up good policies should be central to UNICEF's strategic role as convener. PEPFAR, the Global Fund, the International Health Partnership and related initiatives (IHP+), the World Bank, the International Monetary Fund and others all have gender strategies and should be engaged when working with the members of the One Coordinating Body, or other national AIDS planning mechanisms. (See *Annex G* for partners' gender strategies.) Given the impact of gender inequality and the sexual norms among men in many parts of the world, policies that explicitly address men and masculinities in the spread of HIV and AIDS are necessary.<sup>64</sup>

<sup>62</sup> Aid Effectiveness and Country Capacity Division. <[www.unaids.org/en/CountryResponses/MakingTheMoneyWork/ThreeOnes/default.asp](http://www.unaids.org/en/CountryResponses/MakingTheMoneyWork/ThreeOnes/default.asp)>, accessed 11 January 2010.

<sup>63</sup> Ashburn, Kim, et al., 'Moving Beyond Gender As Usual: How the U.S. President's Emergency Plan for AIDS Relief, the Global Fund to Fight AIDS, Tuberculosis and Malaria, and the World Bank's Africa Multi-Country AIDS Program are addressing women's vulnerabilities in the HIV/AIDS epidemic in Mozambique, Uganda, and Zambia', Center for Global Development, Washington, D.C., 2009.

<sup>64</sup> For examples of policies in various countries see: Redpath, Jean, et al., 'Masculinities and Public Policy in South Africa: Changing masculinities and working toward gender equality', Sonke Gender Justice Network, Johannesburg, 2008; Barker, Gary, Christine Ricardo and Marcos Nascimento, *Engaging Men and Boys in Changing Gender-Based Inequity in Health: Evidence from programme interventions*, World Health Organization, Geneva, 2007; Barker, Gary, et al., 'What Men Have to Do with It: Public policies to promote gender equality', International Center for Research on Women and Institute Promundo, 2010.

# SPECIAL CONSIDERATIONS DURING EMERGENCIES



UNICEF/NYHQ2010-0882/Christine Nesbitt

Emergencies often create new vulnerabilities or exacerbate pre-existing ones with regard to HIV and AIDS. Gender equality in emergencies requires that relief, protective, health, social and educational services are planned and implemented ways that benefit women, men, girls and boys equally; and that the response is sensitive to the different risks, behaviours and coping abilities of girls and boys, and men and women.<sup>65</sup> A number of preparedness actions should be taken to enable rapid implementation of a minimum response to gender-based

discrimination and violence, particularly sexual violence, in the early stages of an emergency:

- Ensure that learners, teachers and other education staff understand gender dynamics within the school settings and within the larger community, particularly as they relate to sexual violence, sexual exploitation and transmission of HIV. This includes understanding the different needs, potential barriers and issues of access to education for girls and boys.

<sup>65</sup> Inter-Agency Standing Committee, *Guidelines for Gender-Based Violence Interventions in Humanitarian Settings: Focusing on prevention of and response to sexual violence in emergencies*, IASC, Geneva, 2009.



- Also ensure that medical professionals understand gender dynamics, particularly as they relate to sexual violence, sexual exploitation and transmission of HIV. This includes understanding the different needs, potential barriers and issues of access to health services for girls and boys.
- Build understanding among multi-sectoral staff regarding the components of sexual and gender-based violence – what it is, how to recognize it, differences between targets, perpetrators and bystanders, etc. Ensure knowledge of connection to possible transmission of HIV.
- Include gender analysis and issues of gender-based violence (and potential impact on HIV risks and vulnerabilities) in assessments that are conducted within sectoral responses at the community level.
- Provide sexual and gender-based violence education to the members of the cluster team of emergency responders.
- Prepare contingency plans for components of safe spaces within which to access education, health and protective services.
- Conduct training programmes for the multi-sectoral staff and the community to promote safety, security and protection.<sup>66</sup>
- Make provisions for the availability of and training regarding post-exposure prophylaxis kits for survivors of rape.

During emergency situations, people living with HIV should be involved in the planning of programmes as described throughout this document. In emergency settings, contributions of people living with HIV, if they choose to be involved, could provide insights to antiretroviral stoppages, to discrimination and rights violations, and to identify HIV vulnerabilities.

More tools to apply gender and HIV in emergency situations can be found in *Annex D*.

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<sup>66</sup> This information was adapted from the *HIV in Education in Emergencies Manual*, developed by the Inter-Agency Standing Committee.

# ANNEXES



UNICEF/NYHQ2009-1978/Christine Nesbitt

# ANNEX A: UNITED NATIONS HUMAN RIGHTS COMMITMENTS

## HUMAN RIGHTS AND OTHER GENDER AND HIV INTERNATIONAL COMMITMENTS

Taken together, these documents represent a comprehensive and powerful articulation of commitment by member states to addressing and eliminating gender inequity and HIV and AIDS, a commitment which must be honoured and fulfilled. It is essential for policymakers and those seeking to engage in policy advocacy to understand the international and national legal frameworks within which their interventions are structured. The links below provide access to the full text of each of the documents (sites compiled from the United Nations Population Fund's *Gender and HIV Framework*):

- **Universal Declaration of Human Rights (1948)**
- **Convention on the Elimination of All Forms of Discrimination against Women (CEDAW) – (1979)**

Who made the commitment: UN member states

Although the Convention does not mention either gender equity or HIV and AIDS specifically, article 12 of the convention commits states parties to "...take all appropriate measures to eliminate discrimination against women in the field of health care in order to ensure, on a basis of equality of men and women, access to health care services, including those related to family planning." Article 12 is also being used by a number of countries to call for HIV and AIDS prevention and care services. The CEDAW Committee has also released a set of *General Recommendations on HIV/AIDS* (1990).

- **Convention on the Rights of the Child (1989)**

Who made the commitment: UN member states

Although the convention does not mention either gender equity or HIV and AIDS specifically, it recognizes "...the right of the child to the enjoyment of the highest attainable standard of health and to facilities for the

treatment of illness and rehabilitation of health." Furthermore, it commits states parties to ensuring "...that no child is deprived of his or her right of access to such health care services" (article 24). In particular, section 2(f) of article 24 commits states parties to developing "... preventive health care, guidance for parents and family planning education and services," which has broad-reaching implications for the issue of HIV and AIDS. In 2003, the Committee On The Rights Of The Child issued a general comment on HIV and AIDS and children's rights. This document articulates how governments should link child rights to aid responses.

- **World Conference on Human Rights Declaration and Programme of Action (Vienna Declaration) (1993)**

Who made the commitment: UN member states

While the declaration does not mention either gender equity or HIV and AIDS specifically, it "...recognizes the importance of the enjoyment by women of the highest standard of physical and mental health throughout their life span" (article 41) and makes several other significant statements relating to women's human rights and violence against women.

Vienna +5: five-year review of the implementation of the Vienna Declaration and Programme of Action (1998)

- **International Conference on Population and Development Programme of Action (1994)**

Who made the commitment: State representatives who attended the conference; the programme was subsequently endorsed by UN member states during a General Assembly.

In article C of chapter 7 (on reproductive rights and reproductive health), the International Conference on Population and Development's Programme of Action addresses sexually transmitted diseases and the prevention of HIV from the perspective of women's vulnerability to

the epidemic, setting out key recommendations for addressing HIV through reproductive health services. In article E on adolescents, the programme sets out how governments and civil society can work to meet the distinct HIV-prevention needs of adolescents. ICPD +5 (1999)

- **Fourth World Conference on Women ('Beijing') Declaration and Platform for Action (1995)**

Who made the commitment: State representatives who attended the conference; the Declaration and Platform were subsequently endorsed by UN member states during a General Assembly. The Beijing Platform for Action, through Strategic Objective C.3 – undertake gender-sensitive initiatives that address sexually transmitted diseases, HIV and AIDS, and sexual and reproductive health issues – addresses the issue of gender and HIV and AIDS quite comprehensively, setting out 16 'actions to be taken' in order to increase the gender sensitivity of programmes and projects that address HIV and AIDS. Beijing +5 (2000): Article 3 of the Beijing +5 Outcome Document re-states the importance of integrating a gender perspective into the HIV and AIDS response, highlights continuing problems relating to the epidemic, and recommends solutions for states and the international community.

- **UN General Assembly Special Session (UNGASS) on HIV/AIDS Declaration of Commitment (2001)**

Who made the commitment: Heads of State of UN member countries

By far the most comprehensive effort to address the HIV and AIDS pandemic, the Declaration of Commitment from UNGASS sets out a number of policy and programmatic resolutions and recommendations, many of which address both gender and women's vulnerability. *Article 14* of the Declaration stresses "...that gender equality and the empowerment of women are fundamental elements in the reduction of the vulnerability of women and girls to HIV/AIDS." This and other articles (see articles 4, 6, 23, 37, 47, 53, 54, 59–62, 68, 75, 78 and 94) carry with them significant gender-based implications for policies and programmes that attempt to address this global crisis.

- **Millennium Declaration and Development Goals (2000)**

Who made the commitment: Heads of State of UN member countries

- ***MDG 3 – Promote gender equality and empower women***

Target: Eliminate gender disparity in primary and secondary education preferably by 2005, and at all levels by 2015.

- ***MDG 6 – Combat HIV and AIDS, malaria and other diseases***

Target: Halt and begin to reverse the spread of HIV and AIDS. The Millennium Declaration also commits states to "promot[ing] gender equality and the empowerment of women as effective ways to combat poverty, hunger and disease and to stimulate development that is truly sustainable." On more than one occasion (e.g., International Women's Day), former Secretary-General Kofi Annan stated that MDG 3 was essential for the achievement of all of the other MDGs.

- **World Education Forum (2000)**

Who made the commitment: Governments, organizations, agencies and groups in attendance. In article 7, paragraph ii of the Dakar Programme for Action, the participants in the forum made a commitment to ensure "...that by 2015 all children, particularly girls, children in difficult circumstances and those belonging to ethnic minorities, have access to and complete, free and compulsory primary education of good quality." In article 8, paragraph vii, participants further committed to "implement as a matter of urgency education programmes and actions to combat the HIV/AIDS pandemic."

- **African Charter on Human and Peoples' Rights on the Rights of Women in Africa (2005)**

- **Political Declaration on HIV and AIDS (2006)**

# ANNEX B: INTERACTIVE COMMUNITIES ON GENDER AND HIV

UNICEF and partners facilitate the exchange of information on gender, sexuality, HIV and young people through Communities of Practice, among other platforms. These Communities of Practice encourage interactive engagement among skilled experts and newcomers alike. Knowledge on building partnerships and capacity, and on operationalizing policies and improving programme performance can be found here.

In addition to the groups listed below, local and regional email listserves on gender and AIDS are valuable means of information exchange. HealthDev.net includes groups that focus on gender and AIDS; AIDS in Africa; and AIDS in the Asia-Pacific region. A quick search through Yahoo groups can also yield a number of local discussion sites.

For a list of UNICEF topical experts, visit: Who's Who in UNICEF HIV and AIDS.

## COMMUNITIES OF PRACTICE:

<b>GENDER</b>	
<b>Facilitator topic</b>	
• UNICEF/UNDP	Gender
• UNICEF	Gender equality in humanitarian action
• Asia-Pacific Community of Practice	HIV, gender and human rights
• HealthDev.net	
<b>MONITORING AND EVALUATION</b>	
<b>Facilitator topic</b>	
• Linking to Results.org (Specific to Asia and the Pacific)	Monitoring and evaluation
• UN evaluation group	Evaluation
• UNICEF	Evaluation

# ANNEX C: HIV RESOURCES FOR THE PROGRAMME PLANNING CYCLE

## TOOLKITS TO CONDUCT GENDER ASSESSMENTS AND ANALYSIS AT ALL LEVELS

- UNIFEM web portal on gender and HIV: Section on tools, among many other resources.
- Resource pack on gender and HIV and AIDS: Developed by the UNAIDS Inter-Agency Task Team on Gender and HIV/AIDS. It aims to strengthen the impact of national HIV and AIDS programmes by tackling a key underlying factor that fuels the epidemic: gender inequality.
- 'UNICEF Gender Initiative Training Tool: Gender HIV and AIDS'. A UNICEF Americas and Latin America Regional Office publication.
- 'Developing a Causality Analyse Framework for UNICEF Programming in HIV: A guideline to analyze gender, HIV and adolescent girls' issues'. A UNICEF Americas and Caribbean region publication.
- Seen and Heard: Involving children in responses to HIV and AIDS
- Transforming the National AIDS Response: Mainstreaming gender equality and women's human rights into the 'three ones' (UNIFEM). This publication highlights approaches and examples that ensure that the three principles promote and protect gender equality as a key element in strategies to prevent and treat HIV and AIDS.
- Twubakane Gender-Based Violence/PMTCT Readiness Assessment: a toolkit to assess the readiness of service providers, service facilities, the community and the policy environment to respond to gender-based violence at antenatal care/ PMTCT service sites and in the community.
- Mande Limbu, Increasing and Improving Multilateral Development Banks' Funding for Reproductive Health & HIV/AIDS: A toolkit for advocacy. A toolkit for civil society groups to promote reproductive health and respond effectively to HIV and AIDS. Contains gender analysis assessment tools (Gender Action, 2009).
- 'A Manual for Integrating Gender into Reproductive Health and HIV Programmes: From commitment to action' – the Interagency Gender Working Group manual on gender and HIV integration.
- Stepping Stones Toolkits on Assessing the Impact of Gender on HIV Programmes.
- South Asian Gender Alliance: Norwegian Church Aid – HIV/AIDS and Gender Assessment Manual.
- *Integrating Gender Issues into HIV/AIDS Programs: An operational guide*: a publication of the World Bank from 2004.
- 'Self-Assessment Checklist: Meaningful involvement of women and girls living with HIV HIV/AIDS Stakeholder Mapping in Papua New Guinea' – includes tools to map partners, assets and strategies.
- *Gender Guidance for National AIDS Responses*, developed by UNAIDS, includes sample gender-equitable objectives for national programmes.
- Global Coalition on Women and AIDS website: includes numerous publications, toolkits, fact sheets, interactive maps and more.
- 'Gender, Sexuality, Rights and HIV' – This document is a resource for NGOs and community-based organizations to build greater understanding of how gender and sexuality determine vulnerability to HIV. This document examines the factors that contribute to the vulnerability and risk of HIV infection in men, women and men who have sex with men.
- Toolkits on Gender and HIV/AIDS: Eldis website.

## STAKEHOLDER ANALYSIS TOOLS

- To better understand how to involve different stakeholders in the HIV planning process, use The Stakeholder Engagement Tool or other tools provided by Measure Evaluation: Data Demand and Information Use Tools.

## INDICATOR TOOLS

- PMTCT report card
- 'Guidance Document: Developing and operationalizing a national monitoring and evaluation system for the protection, care and support of orphans and vulnerable children living in a world with HIV and AIDS', UNICEF working paper, September 2009
- Manual for the Measurement of Indicators for Children in Formal Care
- Violence Against Women and Girls: A compendium of monitoring and evaluation indicators
- Asia-Pacific AIDS Data Hub
- CIDA Guide to gender-sensitive indicators
- UNDP country gender scorecards
- HIV/AIDS Survey Indicators Database: this database allows the user to produce sex- and age-disaggregated tables for specific countries
- The Gender-Equitable Men (GEM) scale
- ChildInfo.org
- DevInfo.org
- AIDS Accountability Index

## MONITORING AND EVALUATION

- Outcome mapping: International Development Research Centre (IDRC)

## OTHER RESOURCES FOR THE PROGRAMME PLANNING CYCLE

- Gender, HIV/AIDS And Rights: Training manual for the media (Inter Press Service)
- Synergising HIV/AIDS and Sexual and Reproductive Rights: A manual for NGOs
- International Center for Research on Women and Institute: Property and inheritance rights policy assessments
- Gender in the Information Society: Emerging issues: Rooted in the ground realities of women, the publication provides frameworks of analyses and actions based on a range of experiences in the South Asian region. Key issues discussed included gender roles and needs in e-governance, the information and

communications technology industry, cyber regulation, freedom of expression, right to information and communication, and media.

- A Manual for Gender Audit Facilitators: The ILO participatory gender audit methodology. This manual provides gender audit facilitators with guidelines and practical instructions on how to plan and implement participatory gender audits in an organizational context.
- The François-Xavier Bagnoud Center for Health and Human Rights at Harvard University.
- Makunda, Vivian Nasaka, 'Gender and HIV/AIDS in East and Southern Africa: A review of literature and country programme actions', UNICEF ESARO, November 2009.
- The Oxfam Gender Training Manual: Extensive tool with many exercises, including gender assessments and tools for analysis.
- Common Gender Analysis Frameworks: New Zealand AID: An overview of limitations and advantages for: 1) Harvard Analytical Framework; Gender Planning Framework (Caroline Moser); Social Relations Framework (Naila Kabeer, IDS); and Women's Empowerment Framework. Review of the frameworks and listing of references
- Conceptual Frameworks for Gender Analysis: World Bank: contains checklists
- Gender Analysis in Health: A World Health Organization publication that reviews gender tools from the Canadian International Development Agency (CIDA), AusAID, the UK Department for International Development (DFID), the Pan American Health Organization (PAHO) and other organizations. The publication is from 2003, but the summary of the tools can be a resource for materials.

## HUMAN RIGHTS-BASED APPROACH TO PROGRAMMING

- What is a Rights-Based Approach to Programming? UNICEF Intranet Resource Page
- Office of the United Nations High Commissioner for Human Rights: Convention on the Rights of the Child

# ANNEX D: UNICEF GENDER PROGRAMMING RESOURCES

The UNICEF Intranet is organized to provide access to resources related to the 'Four Ps'. It contains numerous resources. Following are a few key websites and other key resources to inform gender programming:

## HEALTH, NUTRITION, WATER AND SANITATION

- World Health Organization, *Integrating gender into HIV/AIDS programmes in the health sector: Tool to improve responsiveness to women's needs*, WHO, Geneva, 2009.
- Women, Children and HIV: contains listings of the most up-to-date guidance on HIV, nutrition, PMTCT, paediatrics and other areas.

## EDUCATION

- United Nations Children's Fund, *Child-Friendly Schools Manual*, UNICEF, New York, 2009.
- United Nations Educational, Scientific and Cultural Organization, *Toolkit for Mainstreaming HIV and AIDS in the Education Sector: Guidelines for Development Cooperation Agencies*, UNESCO, Paris, 2008.
- UNAIDS Inter-Agency Task Team (IATT) on Education, *Review of the Evidence: Girls' Education and HIV Prevention*, UNAIDS, Geneva, 2006.
- UK Department for International Development, 'Planning and Evaluation for Gender Equality in Education in the Context of HIV and AIDS DFID, London, 2005.
- United Nations Educational, Scientific and Cultural Organization, *International Guidelines on Sexuality Education: An evidence informed approach to effective sex, relationships and HIV/STI education*, UNESCO, Paris, 2009.
- Population Council, 'It's all One Curriculum: Guidelines and activities for a unified approach to sexuality, gender, HIV, and human rights education', Population Council, New York, 2009.

## PROTECTION

- Better Care Network – Children Affected by HIV and AIDS
- Exchange Magazine on HIV/AIDS, Sexuality, and Gender: Orphans and vulnerable children: A series of articles focusing on livelihood-strengthening programmes for children affected by HIV/AIDS. Emphasis on 'AIDS sensitive but not AIDS specific' programming. Links to relevant resources, manuals and fact sheets.
- World Health Organization, *HIV Status Disclosure to Sexual Partners: Rates, barriers and outcomes for women*, WHO Document Summary, 2004.

## GENDER-BASED VIOLENCE AND HIV

- The Secretary-General's Database on Violence against Women
- Joint United Nations Programme on HIV/AIDS Draft Inventory of Major Global and Regional Initiatives and Campaigns on Violence against Women, 2009.
- Population Council, *Sexual and Gender Based Violence in Africa: Literature review*, 2008.
- Barker, G., and C. Ricardo, 'Young Men and the Construction of Masculinity in Sub-Saharan Africa: Implications for HIV/AIDS, Conflict, and Violence', World Bank Social Development Papers: Conflict Prevention and Reconstruction, no. 26, June 2005.
- Working with Men and Boys: Emerging strategies from across Africa to address gender-based violence and HIV/AIDS.
- Sonke Gender Justice Network, MenEngage Network, 'Compendium of Case Studies Mapping & Review of Violence Prevention Programmes in South Africa', 2009.
- Women's Commission for Refugee Women and Children, 'Masculinities: Male roles and male involvement in the promotion of gender equality: A resource packet', 2005.
- Information Bulletins on Violence Against Women and HIV/AIDS: Critical intersections



- Addressing violence against women and HIV testing and counseling: A meeting report, 2007.

## EMERGENCIES

- Inter-Agency Network for Education in Emergencies, Inter-agency Task Team on Education, Guidance Note on HIV in Education in Emergencies, INEE, 2010.
- Inter-Agency Standing Committee, 'Guidelines on Gender-Based Violence Interventions in Humanitarian Settings', IASC, Geneva, 2009.
- United Nations High Commissioner for Refugees, *Sexual and Gender-Based Violence against Refugees, Returnees and Internally Displaced Persons: Guidelines for prevention and response*, UNHCR, Geneva, 2003.

## COMMUNICATIONS FOR DEVELOPMENT (C4D)

- Inter Press Service News Agency, Gender HIV/AIDS and Rights: Training manual for the media, 2003.
- John Hopkins Center for Communication Programs, Gender Guide for Health Communication Programs, 2003.
- Annotated Bibliography of 100 References on Monitoring and Evaluation (ROSA) – 2006: This bibliography has a special emphasis on behavioural monitoring and participatory approaches.

## SOCIAL POLICY AND BUDGETING FOR CHILDREN AND HIV

- Handbook on Gender, Human Rights and HIV and AIDS: guide to advocating for an improved response to gender and HIV with Southern African Development Community parliamentarians.
- Taking Action Against HIV: A handbook for parliamentarians, 2007
- United Nations Development Fund for Women, *Gender Budgeting: Practical implementation handbook*
- United Nations Development Fund for Women, Related resources on budgeting for gender.

## EARLY CHILDHOOD DEVELOPMENT

- United Nations Children's Fund and Joint United Nations Programme on HIV/AIDS, Operational Guidelines for Supporting Early Childhood Development in Multi-Sectoral HIV/AIDS Programs in Africa, 2003.
- Child Care Information Exchange
- Children's House in Cyberspace
- Enabling Education Network
- Zero to Three

## ADOLESCENT DEVELOPMENT AND PROTECTION

- "Ready, Steady, Go"
- Child and Youth Participation Resource Guide

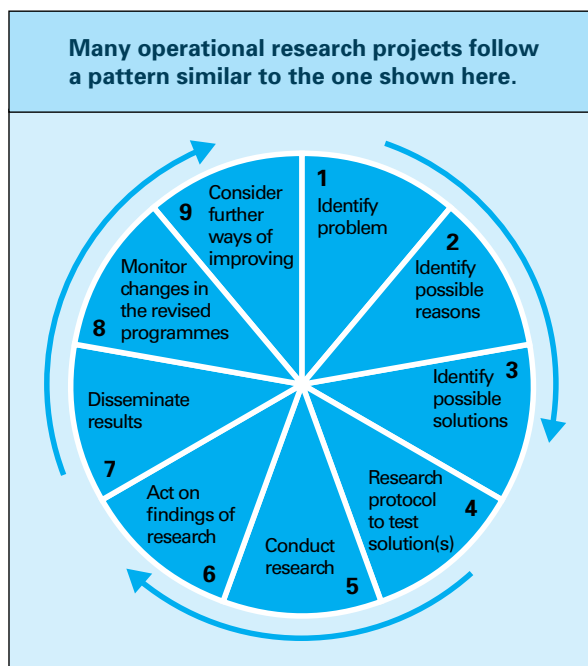
## SAFEGUARDING AND PROMOTING WOMEN'S RIGHTS AS A MEANS TO ADDRESSING HIV

- United States Agency for International Development, 'Microfinance and HIV/AIDS: Tools for making institutional changes in response to HIV/AIDS', USAID, Washington, D.C., 2004.
- International Center for Research on Women, 'To Have and to Hold: Women's property and inheritance rights in the context of HIV/AIDS in sub-Saharan Africa, 2004.
- ParliamentaryStrengthening.org, The Legislative Role of Parliamentarians in the Fight against HIV/AIDS.
- United States Agency for International Development, Fact Sheet on Youth Reproductive Health Policy, 'Early Marriage and Youth Reproductive Health', USAID, Washington, D.C., 2009.

## RELIGIOUS LEADERS AND OTHER PARTNERS

- Guidance in partnering with faith-based organizations to improve the AIDS response, UNAIDS
- What Religious Leaders Can Do About HIV and AIDS
- What Parliamentarians Can Do About HIV and AIDS

## ANNEX E: OPERATIONAL RESEARCH AND HIV



### Operational research is successful if its findings are used in making a programme decision

- Let the programme identify the problem to be solved or the decision to be made
- Know who will make the decision and when
- Include a results utilization and dissemination plan in the research proposal budget
- Identify programme stakeholders, their information needs, and the best way of providing information to each.

### OPERATIONAL RESEARCH AND HIV

Operational research provides decision makers with information to enable them to improve the performance of their programmes. Operational research helps to identify solutions to problems that limit programme quality, efficiency and effectiveness, or to determine which alternative service delivery strategy would yield the best outcomes. In simple terms, it is described as “the science of better.” Operational research focuses on factors which are under the control of programmes. It seeks to improve the number and quality of services and programme outputs and outcomes by optimizing programme inputs (e.g., personnel, supplies) and processes (e.g., training, supervision, promotion of services). Operational research can also determine cost-effective and sustainable ways to build service delivery capacity, test financing alternatives and make advocacy and communication strategies and tools more effective. For example, a study to increase condom use among patients on antiretroviral treatment might experiment with changes in provider training, such as client counselling in couples classes at the clinic or in a secondary location, as well as measure the impact on the number of condoms distributed, frequency of consistent condom use, or male attendance.

### RESOURCES

- Guide to operational research in programmes supported by the Global Fund, World Health Organization and the Global Fund, April 2008.
- The Horizons Operational Research on HIV and AIDS Toolkit: This toolkit contains the tools and information necessary to design a

successful HIV-related operations research study, from developing the research protocol to analysing and reporting on results. In addition to an introduction to operational research and the complete AIDSQuest survey library, the toolkit consists of four sections, each of which focuses on a particular aspect of the operational research process.

# ANNEX F: ETHICAL APPROACHES TO GATHERING INFORMATION FROM CHILDREN AND ADOLESCENTS AFFECTED BY HIV AND AIDS

Absolute requirements for a minimum package of responses service are summarized in an excellent publication by Schenk,<sup>67</sup> as follows:

- Providing children and guardians with the opportunity to give informed consent to their involvement in the activity;
- Consultation with community members regarding local acceptability of the activity; and
- Existence of functional referral systems to respond to the circumstances revealed by the activity.

Beyond these absolute requirements, key recommendations include:

- The need to balance children's participation by finding out their own opinions;
- Advance planning of the information-gathering activity;
- Discussions with the community, including children and adolescents; and
- Functional support systems in place to deal with adverse events.

## ADDITIONAL RESOURCES

- Society for Research on Child Development
- Rawizza, Holly, 'Ethical Issues, Community Perspective and Standards of Care for Clinical Research on Women & Children in Africa', International AIDS Society Presentation, December 2008.

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<sup>67</sup> Schenk, Katie and Jan Williamson, 'Ethical Approaches to Gathering Information from Children and Adolescents in International Settings: Guidelines and resources', Population Council, Washington, D.C., 2005, <[www.infoforhealth.org/youthwg/PDFs/FHI/childrenethics.pdf](http://www.infoforhealth.org/youthwg/PDFs/FHI/childrenethics.pdf)>.

# ANNEX G: GENDER POLICIES OF ORGANIZATIONS WORKING ON CHILDREN AND AIDS

## UNITED NATIONS GENDER POLICIES

- UNICEF Corporate Guidance in addressing gender and HIV and AIDS: Medium-Term Strategic Plan (2006–2013)
- UNICEF Gender Policy Evaluation: Results of 2007 evaluation of the implementation of UNICEF's gender policy
- UNAIDS Action Framework: Addressing women, girls, gender equality and HIV
- Operational plan for UNAIDS Action Framework: Addressing women, girls, gender equality and HIV
- The UNAIDS Action Framework: Universal access for men who have sex with men and transgender people
- Delivering on the Promise of Equality: UNFPA's Strategic Framework for Gender Mainstreaming and Women's Empowerment 2008–2011
- World Health Organization gender strategy
- World Health Organization gender mainstreaming strategy

## OTHER PARTNERS' GENDER POLICIES

- PEPFAR Gender Strategies Document
- The Global Fund for AIDS, Tuberculosis and Malaria
- Canadian International Development Agency Gender Strategy
- United States Agency for International Development Technical Issue Brief: Gender and HIV/AIDS

## ANNEX H: EXAMPLE OF GOOD PRACTICES FOR INCORPORATING GENDER INTO CHILDREN AND AIDS PROGRAMMES AFFECTED BY HIV AND AIDS

### EXAMPLE 1: ENCOURAGING MEN TO INCREASE CONDOM USE AND DECREASE GENDER-BASED VIOLENCE IN SOUTH AFRICA

“Stepping Stones [SS] is a programme for HIV prevention that aims to improve sexual health through building stronger, more gender-equitable relationships with better communication between partners. In a study in the Rural Eastern Cape, SS was used as an intervention to give men in the study (who disclosed themselves as perpetrators of violence with either an intimate or non-intimate partner) new ways of communicating that did not involve violence. It was also used as an intervention for men who did not report incidence of perpetration but were vulnerable because of their exposure to GBV in their community and the normalization of violence.

There was a measurable impact of SS on sexual behaviour and violent practices among men in the study. Men reported fewer sexual partners between 12 months and 24 months after the SS intervention by 2.7 per cent and 4.3 per cent, respectively. In addition, 4.3 per cent were more likely to report correct condom use at last sex at 12 months. The proportion of men who disclosed perpetrating severe intimate partner violence was lower at 12 months and 24 months (1 per cent and 5 per cent, respectively). Other evaluations of SS in other countries also show a reduction in male perpetration of intimate partner violence (Shaw, 2002; Wallace, 2006), which confirm the efficacy of SS.” - *Compendium of Case Studies; Mapping & Review of Violence Prevention Programmes in South Africa. UNICEF, 2006.*

### EXAMPLE 2: KENYA’S ORPHANS AND VULNERABLE CHILDREN CASH TRANSFER PROGRAMME ADAPTS TO GENDER NEEDS

The primary goal of Kenya’s orphans and vulnerable children cash transfer programme is to encourage the fostering and retention of children in communities, and to improve their health and education. The government-administered programme transfers Ksh3,000 every other month to poor households that include orphans and vulnerable children. Since 2007, the programme has reached approximately 21 per cent of households with orphans and vulnerable children in Kenya.

At the outset, attempts to mainstream gender considerations in the programme focused on recipient children – boys and girls. For example, a quantitative evaluation conducted in 2007 revealed that while girls make up half the orphan and vulnerable children population in Kenya, “the programme appears to have selected somewhat more boys than girls as recipients – 56 per cent, compared with 44 per cent girls.” Such a result made it incumbent upon programme designers to “assess what factors are driving the under-selection of girls and what can be done to address it,” which resulted in a change in targeting criteria.

Further gender analysis led to the understanding that 85 per cent of caregivers in the programme were female, an imbalance that reflects the feminine face of poverty in Kenya. Given this, the Government of Kenya and UNICEF responded to measure the impact of the programme on adult women. A focus group was conducted that asked a number of questions: *Has the transfer brought about any empowerment of the women? Does collecting the money carry any risks? Does collecting the money lead to jealousy or violence? Is there less need to engage in transactional sex?* Results indicated that, “Recipients and non-recipients feel that women’s standing in the community is improved if they are seen to be able to care for their children,” but it was much more difficult to assess issues regarding violence and sexual exploitation, and the programmers recommend improving the skills of interviewers to ask sensitive questions within close social networks.

### **EXAMPLE 3: MONTENEGRO HIV PREVENTION PROGRAMMES AMONG ESPECIALLY VULNERABLE ADOLESCENTS RECOGNIZE THE SPECIFIC VULNERABILITIES OF BOTH BOYS AND GIRLS**

The main objective of the project was to influence upstream policy initiatives to enhance governmental efforts to prioritize adolescents as well as to integrate specific issues related to most-at-risk adolescents and especially vulnerable adolescents into the National Montenegro HIV/AIDS Strategy 2010–2015.

Behavioural research with a national counterpart was conducted among Roma displaced adolescents 15–24 years old living in the capital, Podgorica, and other major towns. A gender analysis was conducted among Roma adolescents, which focused on questions about sexual experiences, income and living situation.

Results indicated that half of all girls and one quarter of all boys had never heard of HIV or AIDS; one quarter of the girls and one tenth of the boys reported having experienced forced sex, while 14 per cent of the boys reported experience with men having sex with men. Selling sex appears to be mainly a means of survival, as most Roma adolescents live in extreme poverty, rather than a lifestyle choice. Generally, boys were afraid to speak about engaging in sex with men in the survey, as stigma and discrimination of behaviour related to men having sex with men is severe. For girls, among whom underage marriage and childbearing are common, the survey data show wider sexual and reproductive health concerns than HIV pose a threat to their health and well-being. Other vulnerability factors identified are levels of formal education, which are extremely low among this population group - more than three quarters of the boys and half of the girls had ever enrolled in school.

UNICEF and its partners are now taking a step-by-step gender-sensitive approach in working with the young Roma in the settlements, including increasing their access to education and information; promoting basic hygiene, health and free access to youth-friendly health services; and then moving onto such topics as reproductive and sexual health and HIV.

### **EXAMPLE 4: THE INTERVENTION WITH MICROFINANCE FOR AIDS AND GENDER EQUITY STUDY**

Carried out in rural South Africa, IMAGE combined group-based micro-finance with a 12-month gender and HIV training curriculum. Women received the training at loan meetings held every two weeks. By addressing the immediate economic priorities of participants, IMAGE was able to gain access to a particularly vulnerable target group and to maintain sustained contact for more than one year – a critical opportunity rarely afforded to stand-alone health interventions.

After two years, IMAGE participants showed improvements in economic well-being and multiple dimensions of empowerment. Furthermore, levels of physical and sexual interpersonal violence were 55 per cent lower among IMAGE participants compared with controls, and young programme participants reported higher levels of HIV-related communication and HIV testing, as well as greater condom use with non-spousal partners.

### **EXAMPLE 5: PROGRAMME H: UNDERSTANDING MEN AND MASCULINITIES FOR MORE EFFECTIVE INTERVENTIONS**

A growing number of programmes are drawing on an understanding of men and masculinities in relation to HIV and AIDS in order to develop effective interventions. For example, Programme H has a component aimed at low-income, urban-based boys and young men (14–25 years old) in Brazil and low-income rural and urban men (16–24 years old) in India. The campaign included group education, community-wide social marketing campaigns, focus groups and videos. This led to declines of sexually transmitted infections (in one community from 23 per cent to 4 per cent, and from 30 per cent to 6 per cent in another), as well as a significant increase in condom use (from 58 per cent to 87 per cent in one community). (For evaluation data, see: <[www.who.int/gender/documents/Engaging\\_men\\_boys.pdf](http://www.who.int/gender/documents/Engaging_men_boys.pdf)>.)

### **EXAMPLE 6: HIV-POSITIVE WOMEN FOCUSED ON COMMUNITY AND FAMILY BASED CARE AND SUPPORT IN CHINA**

The project aim was to demonstrate innovative ways to scale up the 2006–2010 National HIV/AIDS Action Plan, and the national Four Frees and One Care AIDS policy. From 2006 to 2008, UNICEF supported the Government of China to establish a model of ‘HIV-positive women focused’ community and family based care, which met local needs through supporting grant-making for entrepreneurial endeavours, policy development with the Ministry of Health and Labour on husbandry and agricultural training, and technical guidelines for self-support groups. This was all leading to improved health and development outcomes for mothers and their children.

Within the two years, a total of six project areas supported 37 self-support groups, which provided care and support services to more than 2,700 women living with HIV and 600 children living with HIV. During the two years, more than 70 per cent of women living in the project sites accessed information on health care, which led to positive prevention and improved access to health services. Reported by the midterm review, the knowledge of women living with HIV greatly improved compared with the baseline and antiretroviral therapy adherence levels rose from 60 per cent to 90 per cent among women participating in the programme.

The income-generation activities provided an effective model to support. According to the midterm review result, families involved in income-generation activities demonstrated significant increases in household income levels. From 2006 to 2008, in some project counties, the per-capita annual income of affected families increased by 38 per cent (control group, by 20 per cent), and the gap between affected and unaffected families was lessened. Increased income led to financial security to manage household expenses due to HIV, as measured by women’s own perceptions.

# ANNEX I: SAMPLE CHILDREN AND AIDS GENDER EQUALITY AND HIV INDICATORS

INPUT	OUTPUT	OUTCOME	IMPACT
<b>AT THE PROGRAMME LEVEL</b>			
<p>Initial assessment has been conducted; key stakeholders are identified</p> <p>Sex- and age-disaggregated data collection processes are in place; indicators have been developed</p> <p>Amount of HIV and AIDS budget targeting gender-sensitive measures</p> <p>Personnel with appropriate skills available to assess gender sensitivity of programme and build capacity of programme team/ stakeholders</p> <p>Number of local organizations, service providers and community members trained in delivering services that are sensitive to gender-equitable results</p> <p>Level of participation of women and children's organizations in HIV and AIDS programme development, implementation and monitoring (qualitative indicator)</p>	<b>Prevention of mother-to-child transmission of HIV</b>		
	<p>Percentage of women receiving PMTCT services</p> <p>Percentage of women receiving PMTCT services who receive more efficacious medication regimens</p> <p>Percentage of PMTCT clients receiving appropriate and comprehensive follow-up care and support, including antiretroviral therapy, prevention and treatment</p> <p>Percentage of PMTCT clients linked to family planning/ reproductive health services, infant feeding and support, and basic necessities (as needed) such as nutrition, housing and financial and legal assistance</p> <p>Percentage of women's partners that have been engaged in PMTCT programmes (e.g., couples counselling and testing) at service delivery and community levels</p>	<p>Percentage of women and men with advanced HIV infection on antiretroviral therapy (age-disaggregated)</p> <p>Percentage of infants exposed to HIV who have been initiated on antiretroviral prophylaxis (sex- and age-disaggregated)</p> <p>Percentage of infants exposed to HIV who have been initiated on cotrimoxazole prophylaxis (sex- and age-disaggregated)</p> <p>Knowledge of PMTCT services and PMTCT drugs to prevent vertical transmission (sex- and age-disaggregated)</p>	<p>Rate of mother-to-child transmission</p>
	<b>Paediatric treatment, care and support</b>		
	<p>Number of facilities that offer a family centred approach, as appropriate</p> <p>Number of men participating in programmes to enhance family based care</p>	<p>Percentage of HIV-infected infants initiated on antiretroviral therapy within two months of birth (sex-disaggregated)</p> <p>Percentage of children with advanced HIV infection on antiretroviral therapy (age- and sex-disaggregated)</p> <p>Men's shared responsibilities for caring for HIV-positive children are emphasized (qualitative indicator)</p>	<p>Longevity and health (nutritional status, etc.) of children living with HIV or AIDS (age- and sex-disaggregated)</p>



# ANNEX I: SAMPLE CHILDREN AND AIDS GENDER EQUALITY AND HIV INDICATORS ... CONTINUED

INPUT	OUTPUT	OUTCOME	IMPACT
<b>AT THE PROGRAMME LEVEL</b>			
<p>Initial assessment has been conducted; key stakeholders are identified</p> <p>Sex- and age-disaggregated data collection processes are in place; indicators have been developed</p> <p>Amount of HIV and AIDS budget targeting gender-sensitive measures</p> <p>Personnel with appropriate skills available to assess gender sensitivity of programme and build capacity of programme team/ stakeholders</p> <p>Number of local organizations, service providers and community members trained in delivering services that are sensitive to gender-equitable results</p> <p>Level of participation of women and children's organizations in HIV and AIDS programme development, implementation and monitoring (qualitative indicator)</p>	<b>Preventing infection among adolescents and young people</b>		
	<p><b>General population</b></p> <p>Equitable access to gender-appropriate prevention messages and services by girls and boys, and women and men (qualitative indicator)</p> <p>Availability of comprehensive, integrated prevention programming to proactively change harmful gender norms that support and encourage multiple partnering, concurrent partnerships, cross-generational sex, transactional sex, gender-based violence, alcohol misuse, and lack of female and male condom use</p> <p>Policies and programmes in place to institutionalize and enforce girl's safety in schools</p> <p>Number of stigma reduction trainings/number of participants</p> <p><b>High-risk populations</b></p> <p>Availability of HIV prevention services and livelihood programmes that empower women and girls, particularly those at high risk (quantitative and qualitative)</p> <p>Provision of behaviour-change education on harmful gender norms, violence and alcohol misuse among military populations, uniformed services and mobile populations</p> <p>Number of stigma-reduction trainings related to men who have sex with men and transgender populations</p> <p>Availability of evidence-informed services for most-at-risk adolescents and especially vulnerable youth</p>	<p>Percentage of girls and women who have ever experienced physical violence by a partner or household member (age-disaggregated)</p> <p>Per cent of respondents who believe that if male partner has sexually transmitted infection, female partner can refuse sex or propose use of male or female condoms</p> <p>Number of people who know at least two methods of protection against HIV (age- and sex-disaggregated)</p> <p>Number of people who report using a male or female condom with a regular partner during the last 12 months (age- and sex-disaggregated)</p> <p>Delayed sexual debut among girls/boys (age-disaggregated)</p> <p>Reduction of number of sexual partners in response to perceived risk (age- and sex-disaggregated)</p>	<p>Prevalence among 15–24-year-olds, including pregnant women (age- and sex-disaggregated)</p>

# ANNEX I: SAMPLE CHILDREN AND AIDS GENDER EQUALITY AND HIV INDICATORS ... CONTINUED

INPUT	OUTPUT	OUTCOME	IMPACT
<b>AT THE PROGRAMME LEVEL ...CONTINUED</b>			
<p>Initial assessment has been conducted; key stakeholders are identified</p> <p>Sex- and age-disaggregated data collection processes are in place; indicators have been developed</p> <p>Amount of HIV and AIDS budget targeting gender-sensitive measures</p> <p>Personnel with appropriate skills available to assess gender sensitivity of programme and build capacity of programme team/ stakeholders</p> <p>Number of local organizations, service providers and community members trained in delivering services that are sensitive to gender-equitable results</p> <p>Level of participation of women and children's organizations in HIV and AIDS programme development, implementation and monitoring (qualitative indicator)</p>	<b>Protection, care and support for children affected by HIV and AIDS</b>		
	<p>Number of women and vulnerable children who have secured property and inheritance rights (age- and sex-disaggregated)</p> <p>Appropriate resources and support provided to women and girls to reduce inequitable burden of care. Greater participation of men in care activities</p> <p>Number of alternative care institutions with policies, standards and enforcement to ensure safety of girls (safer sex/life skills)</p> <p>Gender equality for enrolment/ attendance of girls/boys</p> <p>Reduced incidence of violence/ abuse in schools</p> <p>Post-exposure prophylaxis availability for survivors of sexual violence</p> <p>Social transfer empowers women and girls in households</p>	<p>Household poverty reduced (age- and sex-disaggregated) and capacity to care for vulnerable children increased</p> <p>Proportionate allocation of time and resources for girls' education (age-disaggregated)</p> <p>Orphaned girls' and boys' vulnerability to sexual abuse, exploitation and HIV decreased (quantitative and qualitative)</p> <p>Improved nutritional outcomes for boys and girls (age- and sex-disaggregated)</p> <p>Improved school enrolment/ attendance/ graduation (age- and sex-disaggregated)</p> <p>HIV infection rates among girls reduced (age-disaggregated)</p>	<p>Number of children affected by HIV and AIDS living without family support (age- and sex-disaggregated)</p> <p>Use gender-disaggregated outcome indicators to measure impact of care and support interventions</p>

# ANNEX I: SAMPLE CHILDREN AND AIDS GENDER EQUALITY AND HIV INDICATORS ... CONTINUED

INPUT	OUTPUT	OUTCOME	IMPACT
<b>BUILDING THE CAPACITY OF NATIONAL MINISTRIES TO ADDRESS GENDER INEQUITIES AND HIV AND AIDS THROUGH A COMPREHENSIVE RESPONSE FOR CHILDREN AND YOUNG PEOPLE</b>			
<p>Initial assessment has been conducted; key stakeholders are identified</p> <p>Sex- and age-disaggregated data collection processes are in place; indicators have been developed</p> <p>Strength of linkages among finance ministries, ministries for health, gender, children, young people and social welfare and key community-based organizations (at the decentralized level)</p> <p>Amount of HIV and AIDS budget targeting gender-sensitive measures [1]</p> <p>Number of gender HIV and AIDS trainings for government staff and peer educators and number of men and women, and boys and girls who attend [1]</p> <p>Per cent of line ministry staff, by sex, who are active in HIV and AIDS programmes [1]</p> <p>Participation of women's organizations in HIV and AIDS policy development, implementation and monitoring (quantitative and qualitative)</p> <p>Participation of young people and their representative organizations in HIV and AIDS policy development, implementation and monitoring (quantitative and qualitative)</p>	<b>Prevention of mother-to-child transmission of HIV</b>		
	Country has strategy to ensure equitable access to treatment for girls and women	<p>Percentage of women and men with advanced HIV infection on antiretroviral therapy (age-disaggregated) [4]</p> <p>Percentage of infants exposed to HIV who have been initiated on antiretroviral prophylaxis (sex-disaggregated)</p> <p>Percentage of infants exposed to HIV who have been initiated on cotrimoxazole prophylaxis (sex-disaggregated)</p>	Rate of mother-to-child transmission [5]
	<b>Paediatric treatment, care and support</b>		
	Country has strategy to strengthen male involvement in paediatric care	<p>Percentage of HIV-infected infants initiated on antiretroviral therapy within two months of birth (sex-disaggregated)</p> <p>Percentage of children with advanced HIV infection on antiretroviral therapy (age and sex-disaggregated)</p> <p>Men share caregiving responsibilities for HIV-positive children (qualitative indicator)</p>	Longevity and health (nutritional status, etc.) of children living with HIV or AIDS (age- and sex-disaggregated) [5]

# ANNEX I: SAMPLE CHILDREN AND AIDS GENDER EQUALITY AND HIV INDICATORS ... CONTINUED

INPUT	OUTPUT	OUTCOME	IMPACT
<b>BUILDING THE CAPACITY OF NATIONAL MINISTRIES TO ADDRESS GENDER INEQUITIES AND HIV AND AIDS THROUGH A COMPREHENSIVE RESPONSE FOR CHILDREN AND YOUNG PEOPLE ...CONTINUED</b>			
<p>Initial assessment has been conducted; key stakeholders are identified</p> <p>Sex and age disaggregated data collection processes are in place; indicators have been developed</p> <p>Strength of linkages among finance ministries, ministries for health, gender, children, young people and social welfare and key community-based organization (at the decentralized level)</p> <p>Amount of HIV and AIDS budget targeting gender-sensitive measures [1]</p> <p>Number of gender-HIV and AIDS trainings for government staff and peer educators and number of men and women, and boys and girls who attend [1]</p> <p>Per cent of line ministry staff, by sex, who are active in HIV and AIDS programmes [1]</p> <p>Participation of women's organizations in HIV and AIDS policy development, implementation and monitoring (quantitative and qualitative)</p> <p>Participation of young people and their representative organizations in HIV and AIDS policy development, implementation and monitoring (quantitative and qualitative)</p>	<b>Preventing infection among adolescents and young people</b>		
	<p>Strategy to increase girls' enrolment in schools is a part of the national AIDS response</p> <p>Interventions that reduce girls' and boys' vulnerability (including access to comprehensive services and information on risk) are included within the national AIDS response</p> <p>Country has laws and regulations to protect women and girls from rape and physical violence in all situations, including within schools</p>	<p>Percentage of girls and women who have ever experienced physical violence by a partner or household member (age-disaggregated) [2]</p> <p>Per cent of respondents who believe that if male partner has sexually transmitted infection, female partner can refuse sex or propose male or female condoms [3]</p> <p>Number of women and men, and boys and girls who know at least two methods of protection against HIV [4]</p> <p>Number of women and men, and boys and girls who report using a male or female condom with a regular partner during the last 12 months [4]</p> <p>Delayed sexual debut among girls/boys [4]</p> <p>Reduction of number of sexual partners in response to perceived risk [4]</p>	<p>Prevalence among 15–24-year-olds, including pregnant women</p>
	<b>Protection, care and support for children affected by HIV and AIDS</b>		
	<p>Country has laws and regulations to prevent discrimination against women and girls in marriage, divorce and property inheritance</p> <p>National social support systems have a strategy in place to evaluate the impact of social support programmes on girls and young women</p>	<p>Household poverty reduced (age- and sex-disaggregated) and capacity to care for vulnerable children increased</p> <p>Proportionate allocation of time and resources for girls' education (age-disaggregated)</p> <p>Orphaned girls' and boys' vulnerability to sexual abuse, exploitation and HIV lessened (quantitative and qualitative)</p>	<p>Life expectancy by sex</p> <p>Number of children affected by HIV and AIDS living without family support</p>



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