HIV
Prevention
Toolkit

A Gender-Responsive Approach

OFFICE ON WOMEN'S HEALTH

Suggested Citation:

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Letter of Introduction

Dear Colleague:

On behalf of the Office on Women's Health (OWH), within the U.S. Department of Health and Human Services, we thank you for your interest in this *HIV Prevention Toolkit: A Gender Responsive Approach* (Toolkit). You are taking a step toward increasing your individual and organizational capacity to provide gender-responsive human immunodeficiency virus (HIV)-prevention programs for the women and girls you serve. As we continue to see HIV infection rates among women climb, we must develop the skills and knowledge needed to better serve those who are most affected by this epidemic. It should be noted that because transmission of HIV among women in the United States (U.S) is predominately attributed to heterosexual sex, gender and sex are a key focus in this document and intravenous drug use, a common driver in other parts of the world, is only briefly discussed. The Toolkit contains three parts: this resource document, training slides and an accompanying facilitator manual, and participant manuals. It is advised that these items are used in tandem to best support the learning of this content.

Strong evidence in the public health literature shows that gender inequality, the condition of women being unequal to men, and inequity, the unfair and avoidable differences that exist between genders, contribute to women's and adolescent girls' vulnerability and risk for HIV infection. For more than a decade, the international public health community has led the way in integrating gender into HIV/AIDS programs. The Joint United Nations Programme on HIV/AIDS (UNAIDS), the World Health Organization (WHO), the Pan American Health Organization (PAHO), and the U.S. Agency for International Development (USAID), among others, have made commitments to integrate gender considerations into their programs. They have supported the development of a number of resources, tools, and manuals focused on gender integration in the health, reproductive health, and HIV/AIDS sectors.

In the U.S., federal agencies have begun to recognize the importance of gender as a key driver of the AIDS epidemic. As a result, they have taken steps to promote the development and implementation of more gender-responsive HIV/AIDS programs and services for women and girls. For example, the U.S. *National HIV/AIDS Strategy* (NHAS) was updated in 2015 to reflect an increased effort and understanding of the intersection of gender disparities, violence against women, and HIV/AIDS.

In June 2010, OWH sponsored a Gender Forum titled *Bringing Gender Home: Implementing Gender-Responsive HIV/AIDS Programming for U.S. Women and Girls*. The Forum brought together over 200 experts in gender and HIV/AIDS from the United States, Africa, the Caribbean, Latin America, and Europe who represent global and national, governmental, nongovernmental, and community-based HIV/AIDS and public health organizations. The purpose of the Gender Forum was to promote leadership in gender-responsive HIV prevention programming for women and girls in the United States and to apply the lessons learned from the experiences in gender integration from global nongovernmental organizations to the U.S. context. As part of a domestic response to international mandates, this Toolkit offers guidance in integrating a gender perspective into HIV/AIDS programs and services for women.

Sincerely,

The Office on Women's Health

Acronyms

ADAP	AIDS Drug Assistance Program
AIDS	Acquired Immunodeficiency Syndrome
ART	Antiretroviral Therapy
CDC	United States Centers for Disease Control and Prevention
CSDH	World Health Organization's Commission on the Social Determinants of Health
GBCs	Gender-based constraints
GBOs	Gender-based opportunities
GBV	Gender-based violence
HIV	Human Immunodeficiency Virus
IDU	Intravenous drug use
IGWG	Interagency Gender Working Group
IPV	Intimate partner violence
M&E	Monitoring and evaluation
MSM	Men who have sex with men
MSMW	Men who have sex with both men and women
OWH	Office on Women's Health, U.S. Department of Health and Human Services
PEP	Post-exposure prophylaxis
PLWHA	People living with HIV/AIDS
PMTCT	Prevention of mother-to-child transmission of HIV
PrEP	Pre-exposure prophylaxis
PTSD	Post-traumatic stress disorder
SDH	Social determinants of health
SES	Socioeconomic status
STD	Sexually transmitted disease(s)
TasP	Treatment as prevention
TIC	Trauma-Informed Care
Toolkit	*HIV Prevention Toolkit: A Gender Responsive Approach*
UNAIDS	Joint United Nations Programme on HIV/AIDS
U.S.	United States
VAW	Violence Against women
WHO	World Health Organization
WSW	Women who have sex with women

Section 1

Introduction

Section 1: Introduction

1.1 About the HIV Prevention Toolkit: A Gender-Responsive Approach

The HIV Prevention Toolkit is designed to help program planners and managers understand key concepts, processes, and steps needed to integrate gender into HIV prevention programs and support services for U.S. women and adolescent girls. Taking into account current public health mandates to address the social determinants of health (SDH) [1,2] this Toolkit focuses on gender as an overarching social determinant.[3,4]

While gender affects the HIV/AIDS risks and vulnerabilities of women and girls as well as men and boys, including those of different sexual orientation or gender identities, this Toolkit is not intended to be a comprehensive guide on gender and HIV. Instead, it is designed to raise awareness and promote greater understanding of how gender norms, roles, relations, and inequalities affect the HIV risk-related behaviors of heterosexual women and adolescent girls. These are largely sexual behaviors and so other high-risk behaviors, such as intravenous drug use (IDU), are only briefly mentioned. The Toolkit is designed to support their ability to negotiate safer sex, access to HIV-related prevention and health services, and improve their health outcomes.

> *Gender:* The social, cultural, or community designations of masculinity or femininity.
>
> *Sex:* The biological and physiological characteristics that define human beings as female or male.
>
> *Social Determinants of Health:* The mechanisms that produce or reinforce social stratification in a society and create inequities.

The gender and HIV issues covered in this Toolkit may also be applicable to lesbian, bisexual, women who have sex with women (WSW), and transgender women and adolescent girls. However, they may experience added layers of stigma and discrimination and specific constraints related to their sexual orientation and sexual identities. These factors, which increase their vulnerability of acquiring HIV/AIDS and further constrain their access to quality and responsive prevention and support services, require more extensive consideration.

Gender norms, roles, and relations vary among different cultural and social groups. Recognizing this is critical to successfully implementing gender responsive HIV programming, as gender norms, roles, and relations can increase a person's vulnerability to HIV/AIDS. When organizations comprehend the impact of gender norms, roles, and relations, they are better prepared to develop prevention and support services that are responsive to the specific needs of diverse groups of heterosexual women and adolescent girls. Understanding, appreciating, and interacting with women and girls who come from different cultures, cherish different beliefs, and express their identity, in different ways help organization develop cultural competency. This Toolkit highlights the importance of cultural and linguistic competence in the design, implementation, monitoring, and evaluation of HIV prevention programs and support services. OWH hopes this Toolkit will help program planners and managers address gender issues and inequalities, and thereby enhance the effectiveness of HIV prevention and support services for U.S. women and adolescent girls.

1.2 Who should use this Toolkit?

This Toolkit is designed for health departments and clinical staff, as well as academics, program planners and managers, and community providers who are involved in planning, designing, implementing, monitoring, and evaluating HIV prevention programs for women and adolescent girls. The Toolkit may also be of interest to and useful for policy makers who make decisions about the focus, scope, and resources allocated to HIV prevention programs.

1.3 Why Integrate Gender in HIV/AIDS Programs and Services?

Integrating gender consideration into HIV prevention programming is important because the HIV epidemic significantly affects women and adolescent girls who acquire HIV primarily through heterosexual contact. Worldwide, women and adolescent girls account for half of the people living with HIV.[6] In the U.S., nearly a quarter of those living with HIV are women and adolescent girls.[7] Heterosexual contact is the major mode of transmission in many regions of the world, including Africa, the Caribbean, and parts of Asia.[6] It is also an increasingly important transmission factor in the U.S., where heterosexual contact accounts for more than 25% of all new HIV infections and 86% of new infections in women.[7]

Social and economic inequalities, including those based on gender, are key social determinants of health and play a major role in driving the HIV/AIDS pandemic worldwide.[3,5,6,8] Gender inequalities disadvantage women, negatively affecting their health and increasing their vulnerability and risk of HIV infection and AIDS.[3,5] Women and men do not have the same access to health information, protection, treatment and prevention interventions. They also have different HIV infection patterns and rates. These differences are the result of biology, physiology, socially constructed gender norms and roles, and unequal power relations.[6,8,9,10]

1.4 What Is in the Toolkit?

Sections 1, 2, 3, and 4 provide users with background information on how gender influences HIV vulnerability of U.S. women and adolescent girls. These sections also cover basic concepts and principles related to gender and gender-responsive HIV prevention programming. Sections 5 and 6 describe gender analysis and how it is applied throughout the program cycle. Tools are provided to help users integrate gender in the design, implementation, monitoring, and evaluation of HIV prevention programs and support services.

Endnotes

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Section 2

HIV/AIDS Among Women and Adolescent Girls in the United States
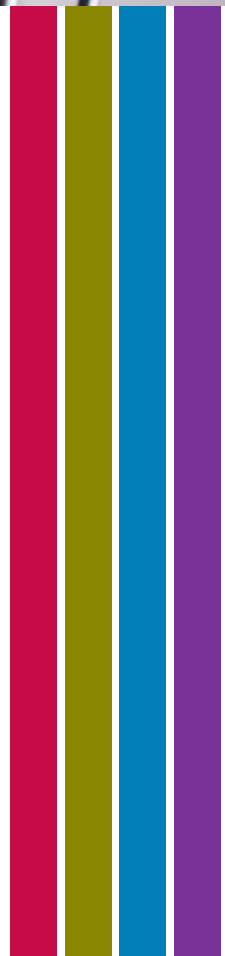
Section 2: HIV/AIDS Among Women and Adolescent Girls in the United States

In 2013, women and adolescent girls in the U.S. accounted for 25% of all adults and adolescents living with HIV, 20% of all new diagnoses of HIV infection, and 24% of all AIDS diagnoses among adults.[1] Although men represent the majority of new diagnoses of HIV infections and AIDS cases as well as the majority of people living with the disease in the U.S., the impact of the epidemic on women and girls has grown steadily since 1985. Between 1985 and 2013, the proportion of U.S. females diagnosed with HIV has nearly tripled, moving from 7% in 1985 to 20% in 2013.[1,2,3]

2.1 Prominence of Heterosexual Transmission

In the U.S., sexual contact is the main mode of exposure to HIV infection for adult and adolescent males and females.[1] In 2013, 90% of the diagnoses of HIV infection were attributed to sexual contact: 65% through male-to-male sexual contact and 25% through heterosexual contact.[1] Among adult and adolescent females, exposure through heterosexual contact accounted for 86% of infections.[1]

However, sexual transmission has not always been the major driver of HIV infection. In 1986, the primary mode of HIV transmission among women was intravenous drug use (IDU) (47%), followed by heterosexual contact (31%).[4] By 2013, IDU accounted for only 12.5% of reported HIV diagnoses among women and adolescent girls, while heterosexual exposure accounted for 86%.[1]

2.1.1 Concentration in the South and Northeast Regions

Cases of HIV among women were initially concentrated in the Northeast, with New York accounting for the highest number of cases.[5,6] However, trends in the HIV/AIDS epidemic among women and adolescent girls have also shifted geographically, with the center of the epidemic moving over time from the urban Northeast to the South, a region that historically has some of the highest sexually transmitted disease (STD) rates in the country.[5] This shift began in the early 1990's and by 2011, the South accounted for over half of all new HIV cases, followed by the Northeast (19 percent).[1] In 2013, the South led the country in the number of new AIDS cases diagnosed within the general population and also led the country in the number of new AIDS cases diagnosed among women.[1]

2.1.2 Concentration in High-Poverty Areas

Poverty plays a major role in HIV/AIDS risk among women, with a significantly higher proportion of infections occurring among women living in impoverished areas. Studies have demonstrated that HIV is more prevalent among individuals of lower socioeconomic status (SES). One study showed that HIV prevalence was significantly higher among participants with annual household incomes at or below the poverty level, those with less than a high school education, and those who were unemployed.[7] A U.S. Centers for Disease Control and Prevention (CDC) report similarly found that individuals living below the poverty line in low-income urban areas were more than twice as likely to be infected with HIV as their counterparts living above the poverty line.[8]

2.1.3 Disproportionate Impact on Women of Color

The HIV/AIDS epidemic among women and adolescent girls is disproportionately concentrated among women of color, especially black/African-American women in the United States. In the mid-1980's, more than 50% of the women who were diagnosed with HIV/AIDS were black/African American.[4] By 2013, black/African American women accounted for an estimated 63% of all HIV cases among females although they comprised only 13% of the population.[1] In contrast, White females accounted for 17% of diagnoses of HIV cases among females, but made up 65% of the female population.[1]

Trends in mortality rates among women living with HIV/AIDS also show a disproportionate impact on women of color throughout the history of the epidemic. In 2013, the HIV/AIDS mortality rate was highest among black/African American females (16.7 deaths per 100,000 population), nearly 17 times as high as the rate of death for Whites (1.0 death per 100,000 population), and more than 4 times as high as the rate for Latinas (3.2 deaths per 100,000 population).[9] While HIV incidence was relatively low among American Indians/Alaska Natives, the mortality rates were also more than twice as high as that for White females.[9]

2.2 Why Gender Matters

As mentioned in Section 1, sex is the biological and physiological characteristics that define human beings as female or male, while gender is the social, cultural, or community designations of masculinity or femininity. Gender is a cross-cutting social determinant of health that interacts with other social determinants, such as race/ethnicity and SES, to produce inequitable HIV/AIDS outcomes for women and adolescent girls, as well as men and adolescent boys. Inequalities based on gender and other determinants are serious obstacles to HIV prevention and must be addressed to reduce the number of sexually-acquired HIV infections among women and adolescent girls.

Societal expectations and patriarchal structures (discussed later as gender norms, roles, and relations) influence women's and adolescent girls' sexual relationships with their male partners. These expectations and structures also influence women's and adolescent girls' ability to exercise control over their own bodies, and to make choices and take actions to avoid HIV infection. Gender also affects men's and adolescent boys' sexual risk-taking and health-seeking behaviors and places them and their sexual partners at risk of infection. By addressing gender differences and inequalities, HIV prevention programs and support services can greatly enhance the impact they have on preventing infection.

2.2.1 Violence against Women and HIV Risk

Gender-based violence (GBV) is any act of aggression carried out against an individual based on their gender. Violence against women (VAW) is a type of gender-based violence and includes physical, sexual, emotional, and psychological abuse. Nearly 50% of women in the U.S. have experienced sexual violence, such as sexual coercion or unwanted sexual contact in their lifetime.[10] These acts are frequently committed by intimate sexual partners, with 35.6% of women reporting intimate partner violence (IPV).10 All forms of VAW put a woman's sexual and reproductive health at risk. HIV risk is increased when women endure forced sex or have a limited ability to negotiate safe sexual practices.[10]

Trauma-Informed Care: an approach for treatment and care that is sensitive and responsive to individuals who have experienced any form of trauma through providing safe, supportive environments that identify and holistically address the impacts of traumatic experiences.

An integral component of HIV prevention is trauma-informed care (TIC). TIC helps programs identify and address the impact of unaddressed trauma and post-traumatic stress disorder (PTSD) on the health of women living with HIV. Offering TIC to address VAW strengthens the comprehensive strategies used to address disparities in HIV transmission and treatment outcomes among women and adolescent girls.

2.3 Integrating Gender in HIV Prevention Programs for Women and Adolescent Girls

Over the past two decades, behavioral interventions have begun to specifically target women and adolescent girls to reduce their risk of HIV. Reviews of such interventions demonstrate the effectiveness of taking gender issues into account.[11,12,13] Academic and service organizations have developed a variety of gender-specific, evidence-based behavioral interventions to reduce women's and adolescent girls' sexual risks for HIV infection. These behavioral interventions aim to:

- improve women's safer sex negotiation skills;
- expand women's range of options beyond using the male condom, which can include female-initiated methods (female condom), non-penetrative contact (outercourse), and skills for refusing unprotected sex;
- increase awareness that women's own monogamy does not guarantee their partners' fidelity;
- expand awareness of the importance of knowing a partner's status and provide couples-based counseling and testing;
- address traditional gender norms, roles, and relationship dynamics among heterosexual couples; and
- address the dilemmas that arise from the competing desires of preventing HIV and other STDs and having children.[14]

Many of these interventions incorporate theories of gender and power to address how the interrelated domains of sexual division of labor (paid and unpaid), power and authority in decision-making, and emotional investments shape the HIV risks of women and adolescent girls.[14]

More recently, academic and service organizations have developed interventions for heterosexually active men and adolescent boys that address how gender relations and norms regarding masculinity, such as multiple sexual partnerships, contribute to HIV risk.[14] These interventions focus on the negative effects on men and women when men conform to narrow and limiting definitions of masculinity, and they are designed to create more gender-equitable norms, while reducing VAW.[14]

2.4 Types of Interventions that Work for Women and Adolescent Girls

The following are highlights of the types of interventions that have been shown to work for women and adolescent girls in reducing their risk of HIV infection and improving outcomes for women living with HIV.

2.4.1 Promotion of Male and Female Condom Use

Interventions that promote using male or female condoms, reducing concurrent and serial sexual partnerships, and treating sexually STDs are all important components of prevention efforts among women and adolescent girls. Condom use also reduces transmission of STDs, so STD prevention counseling, diagnosis, and treatment can provide opportunities to assess HIV risk and offer HIV prevention and testing services.[15]

> **_Concurrent sexual relationships:_** sexual relationships that overlap in time.
>
> **_Serial sexual relationships:_** sexual relationship with only one partner and no overlap with subsequent partners.

2.4.2 Interventions Targeting Vulnerable Groups

Interventions can target specific groups of women who are at particular risk for HIV infection because they or their partners inject drugs, or are sex workers, prisoners, migrants, or transgender women.[15]

2.4.2.1 Females who Inject Drugs

Prevention approaches that can be effective in reducing HIV risk behaviors among females who inject drugs include:

- opioid substitution therapy, particularly maintenance programs with methadone and buprenorphine;
- comprehensive harm reduction programs, including needle exchange, condom distribution, substitution therapy, and outreach; and
- peer education.[15]

2.4.2.2 Sex Workers

A number of approaches can be implemented to help sex workers prevent HIV infection and adopt safer sex practices, including condom use. These approaches include the following:

- comprehensive prevention programs with components such as peer education, medical services, and support groups;
- use of outreach workers in clinic-based interventions;
- policies that involve sex workers, brothel owners, and clients in developing and implementing condom use;
- the provision of accessible, routine, high-quality, voluntary, and confidential STD clinical services that include treatment and condom promotion; and
- interventions targeting male clients.[15]

2.4.2.3 Female Prisoners

Prevention strategies for female prisoners include opioid substitution treatment and harm-reduction strategies such as education, peer distribution of clean needles, and the provision of condoms.[18] These approaches should also be coupled with community re-entry support to prevent or reduce recidivism and the risk of HIV exposure in the community.[16]

2.4.2.4 Prevention for Young People

Providing young people with information and services, and addressing gender norms, can reduce their risk of HIV infection. Effective behavior change and risk reduction strategies include:

- comprehensive sex and HIV education prior to the onset of sexual activity aimed at increasing the age at which girls first engage in sexual activity, increasing condom use, and reducing the number of concurrent and serial sexual partners for sexually active girls;

- teacher training on age-appropriate HIV/AIDS education that improve students' knowledge and skills; and

- promotion of communication between adults and young people about HIV and reproductive health.

Strategies to increase access to services include providing clinic services that are youth-friendly, conveniently located, affordable, confidential, and non-judgmental.[15]

2.4.3 HIV Testing and Counseling

Providing HIV testing and counseling in ways that allow choice, consent, and confidentiality is important to increase the number of women and adolescent girls who know their HIV status and are linked to treatment or prevention services. Approaches include:

- providing voluntary counseling and testing to women and adolescent girls;

- incorporating voluntary counseling and testing into other health services (e.g., sexual and reproductive health services, STD screening and treatment services);

- conducting mass media campaigns to promote testing; and

- providing community outreach and mobilization.[15]

2.4.4 Prevention of Vertical HIV Transmission

Women and adolescent girls also face gender-based constraints in the transmission of HIV from mother to child, also known as vertical HIV transmission. To prevent vertical HIV transmission, HIV medical providers should support prenatal care for pregnant women living with HIV and should also recognize that mental illness, substance use, and stigma can be barriers to care for some women living with HIV, including those that are pregnant. CDC recommends HIV testing for all women during pregnancy. Additional interventions include providing care and support to HIV-positive women and adolescent girls, their children, partners, and families to ensure HIV-positive women and adolescent girls receive treatment before and after the risk of transmission to their children has ended.[15]

2.4.5 HIV Treatment and Care: The HIV/AIDS Care Continuum

To achieve optimum health outcomes, persons living with HIV must know they are infected, be linked to and engaged in care, receive antiretroviral therapy (ART), and follow their doctor's guidance on when to take ART, with the goal of achieving an undetectable viral load. This is known as the HIV/AIDS Care Continuum.[17] Several interventions, such as active case management and peer support networks, seek to increase the life expectancy of HIV-positive women and adolescent girls by providing linkages to care, support in care, access to treatment, and help with ART adherence.[15]

2.4.5.1 Treatment as Prevention

The term "treatment as prevention (TasP)" describes HIV prevention methods that use ART to decrease the risk of transmitting the virus by reducing an person's viral load.[18] In addition to using ART as treatment, ART becomes a prevention strategy that HIV-positive individuals can use to reduce the risk of transmitting HIV to their sexual partners, or, on a large scale, to reduce transmission among a population. TasP is an emerging approach that may provide another tool to reduce new infections among women and adolescent girls. Although ART can reduce transmission through reduced viral load, it takes time for viral load to drop to low or undetectable levels. Male and female condom use is still recommended to increase protection for both HIV-positive and HIV-negative sexual partners.[18]

2.4.5.2 Pre-Exposure Prophylaxis

Pre-exposure prophylaxis (PrEP) is an HIV prevention strategy that involves the daily use of ART by HIV-negative persons to prevent infection.[19] Available evidence from clinical trials shows that, when used consistently by an HIV-negative person, PrEP is effective in preventing transmission of the virus from an infected person to their uninfected partner.[19]

PrEP is not intended to be used in isolation; it should be used in combination with counseling to reduce risk behaviors, encourage adherence to the daily pill regimen, promote condom use, and encourage STD management.[19] CDC is currently working with partners to ensure safe and effective PrEP use and to begin to address key questions about acceptability, access, adherence, behavioral risks, and patient outcomes in community settings.[19] In May 2014, CDC issued the first comprehensive clinical guidelines on the use of PrEP among heterosexually active women and men that address use in women who are pregnant or trying to conceive.[19]

2.4.6 Transforming Gender Norms

Gender norms play a key role in increasing vulnerability to HIV/AIDS among women and adolescent girls. However, a limited number of prevention interventions are designed to change harmful gender norms.[15] Programs and activities that seek to change gender norms include: peer and partner discussions; community-based education; and mass media campaigns on gender equality as part of comprehensive and integrated services.[15]

2.4.7 Addressing Violence against Women

Many programs address VAW through community-based participatory learning approaches that involve men and women. These approaches encourage more gender-equitable relationships, which result in: decreased violence; comprehensive post-rape care protocols, including post-exposure prophylaxis (PEP); and the creation of microfinance programs integrated with participatory training on HIV, gender, and violence.[15]

2.4.8 Promoting Women's Employment, Income, and Livelihood Opportunities

Programs can address women's poverty and economic dependence on men by providing interventions that increase employment, microfinance opportunities, or small-scale income-generating activities. These activities can reduce HIV risk behaviors, particularly among young people.[15]

2.4.9 Advancing Education

Increasing educational attainment can help reduce HIV risk among girls. In addition, providing life skills-based education can complement formal education in building knowledge and skills to prevent HIV.[15]

2.4.10 Reducing Stigma and Discrimination

Reducing stigma and discrimination can be accomplished through training for healthcare and community service providers, as well as community-based interventions that provide accurate information about HIV transmission (especially that casual contact cannot transmit the virus).[15]

2.4.11 Care and Support

Interventions that provide care and support include continued counseling (either group or individual) and peer support groups for women and adolescent girls, help relieve psychological distress and are highly beneficial to women living with HIV.[15]

2.4.12 Tailoring Healthcare Services to Meet the Needs of Women and Adolescent Girls

Women often need multiple services, including reproductive health and family planning services, in addition to HIV prevention, treatment, and care. However, most healthcare facilities are not structured to provide integrated services. Interventions to address these issues include:

- integrating HIV testing and services with family planning, maternal healthcare, or within primary care facilities to increase the use of HIV testing and other reproductive health services;
- promoting contraceptives and family planning as part of routine HIV services to increase use of condoms and contraceptives and to avert unintended pregnancies;
- incorporating voluntary counseling and testing into routine health services to increase its uptake;
- offering clinic-based interventions with outreach workers to increase condom use among at-risk women;
- providing accessible, routine, high-quality, voluntary, and confidential STD clinical services that include condom promotion for at-risk women;
- training providers to reduce discrimination against people living with HIV/AIDS;
- establishing comprehensive post-rape care protocols, which include post-exposure prophylaxis;
- providing emergency contraception; and
- providing clinic services that are youth-friendly, conveniently located, affordable, confidential, and non-judgmental to increase the use of clinic reproductive health services, including voluntary counseling and testing.[15]

2.4.13 Addressing Gaps in Programming

While great strides have been made in HIV prevention, treatment, and care, a number of gaps have been identified in HIV programming for women and adolescent girls. These include:

- the provision of HIV/AIDS information;
- availability of programs that strengthen negotiation skills, develop job skills, or provide credit and financial assistance;
- the integration of sexual and reproductive health needs with HIV/AIDS prevention for both male and female migrants;[17]
- interventions that create change by influencing legal reforms, economic opportunities, and stigma reduction; and
- prevention for HIV-infected heterosexuals partnered with uninfected individuals (sero-discordant couples).[15]

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Section 3

Social Determinants of HIV/AIDS
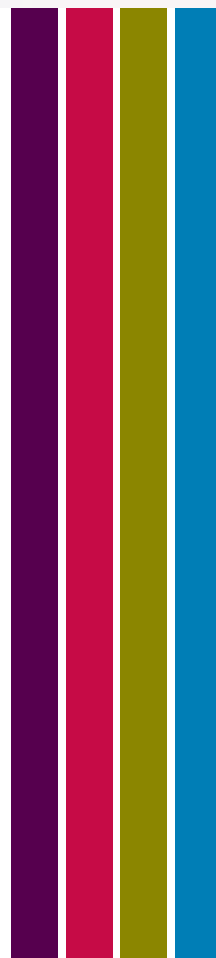
Section 3: Social Determinants of HIV/AIDS

3.1 Gender: A Key Determinant of HIV/AIDS among Women

Gender is an overarching determinant of health. Gender accounts for significant differences between individuals in terms of their biological make-up, socialization, roles, status, and power in society. These differences significantly influence health behaviors, health outcomes, well-being, and access to and utilization of health services.

Women and adolescent girls are biologically and physiologically more vulnerable to HIV infection through heterosexual transmission than men and adolescent boys. Yet these differences only partly explain their increased vulnerability. Social determinants including gender and other social statuses such as race, ethnicity, SES, sexual orientation, immigrant status, and age play a greater role in determining vulnerability.[1,2]Biological and physiological factors link to and interact with these social determinants, but it is these social determinants that mainly account for which sub-populations of women and adolescent girls are at greater risk for HIV infection and for developing AIDS.[2]

Highly marginalized individuals and groups who face multiple forms of stigma, discrimination, and accompanying inequality are more vulnerable.[3] Among women in the U.S., women of color, particularly black/African American women, young women, and those who are poor, use drugs, and live in the South, Northeast, Puerto Rico, and the U.S. Virgin Islands experience heightened vulnerability to HIV/AIDS.[4]

3.1.1 HIV/AIDS Vulnerability and Social Determinants of Health

In the late 1980s, the understanding of HIV infection among women and adolescent girls focused on their unique biological risk factors and "high risk" behaviors.[1] However, the 1990s brought a shift in the HIV paradigm with a growing recognition of the role social determinants played in increasing a woman's risk of HIV/AIDS. This growing recognition fostered changes in prevention strategies from those that primarily focused on reducing individual risk-taking behaviors to those that also included reducing vulnerability.[1]

Reducing vulnerability focuses on addressing the social determinants of HIV/AIDS that shape individual risk-taking behaviors.[1] These determinants, largely outside the control of individuals, minimize individuals and communities ability to avoid exposure to HIV infection and, once infected, to receive appropriate care and support services.

The WHO's Commission on the Social Determinants of Health (CSDH) developed a conceptual framework to understand health inequities and issued a report in 2008 specifying

> ### HIV Risk and Vulnerability
>
> **Risk** is the likelihood that an individual may acquire HIV infection. Behaviors such as having unprotected sex with a partner whose HIV status is unknown, engaging in multiple unprotected sexual partnerships, and injecting drugs with contaminated needles and syringes produce, increase, and maintain risk for infection (UNAIDS 1998).
>
> **Vulnerability** results from a range of factors outside the control of the individual that negatively affect the ability of individuals and communities to avoid the risk of HIV infection. They include personal, service-related, and societal factors (UNAIDS 1998).

actions to tackle structural and social determinants of health (SDH).[5] In recent years, this SDH framework has been adopted in the U.S. to address inequities in health, including HIV/AIDS and other infectious or communicable diseases.[6] The conceptual framework defines SDH as "the social, economic, political, cultural, or environmental conditions in which people are born, grow, live, work, and age, that shape their health, including the health system."[5] These conditions place people at risk for, or protect them against, disease, by shaping their options and choices. Structural determinants are defined as mechanisms that produce or reinforce social stratification in a society. These mechanisms of social stratification produce inequities.

3.2 Social Determinants of HIV/AIDS Risk: A Gender Perspective

The SDH framework provides a useful way to analyze and understand the ways broader social, cultural, economic, political, and legal factors influence the vulnerability to and risk for HIV/AIDS of diverse groups of women and adolescent girls.

Figure 1: Social Determinants of HIV/AIDS Risk: A Gender Perspective
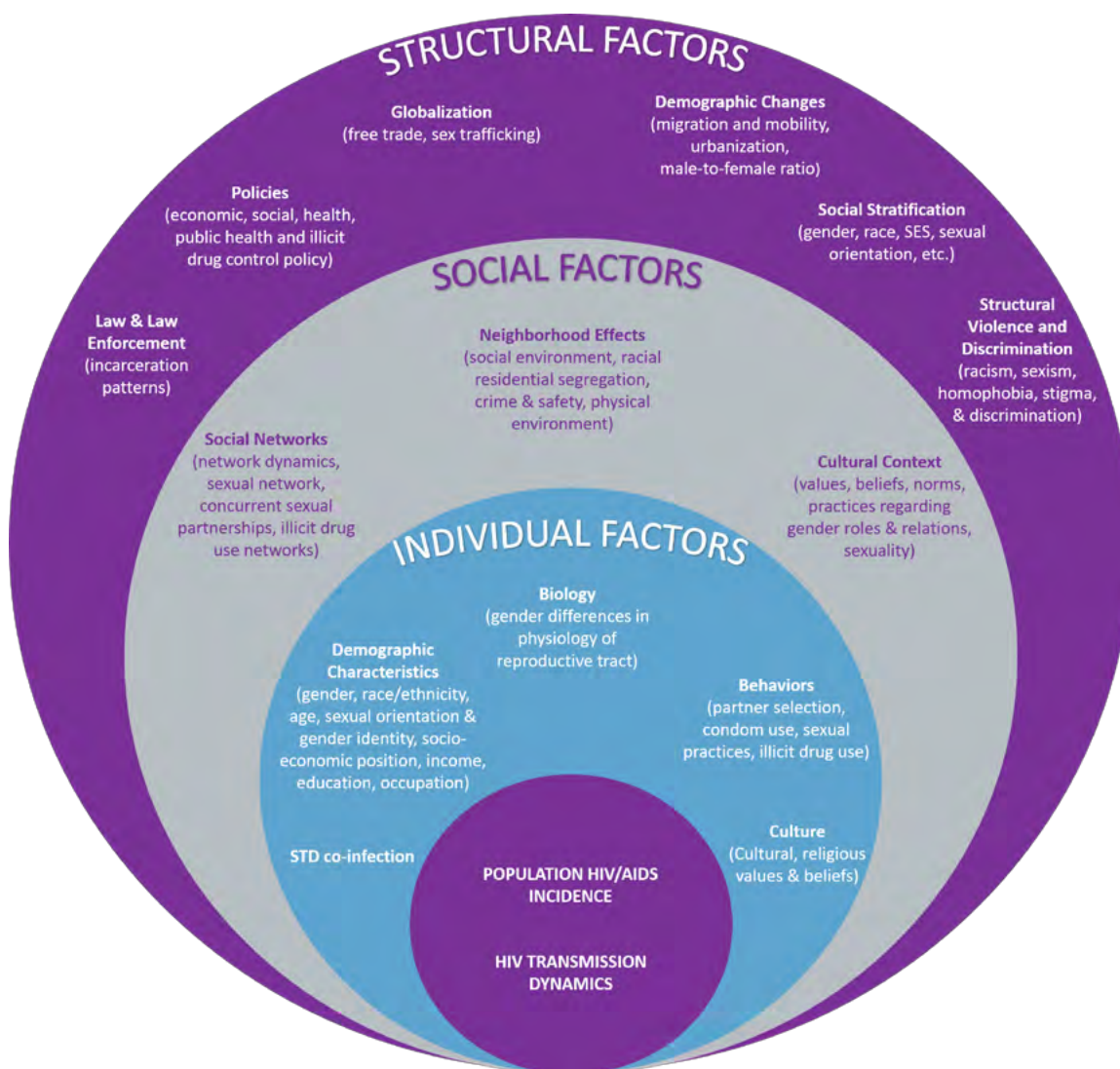
Adapted from model developed by K. E. Poundstone, S. A. Strathdee, and D. D. Celentano. "The Social epidemiology of Human Immunodeficiency Virus/Acquired Immunodeficienty Syndrome." Epidemiologic Reviews. 26 (2004): 22-35.

Figure 1, *Social Determinants of HIV/AIDS Risk: A Gender Perspective*, presents a model that applies a SDH framework to HIV/AIDS, integrating a gender perspective. It is adapted from an HIV-specific model developed by Poundstone, Strathdee, and Celentano (2004). The model depicts women's and adolescent girls' HIV/AIDS vulnerability as the result of the dynamic interplay of determinants at multiple levels: structural, social, and individual.[7] The model shows that HIV risk behaviors do not occur in a vacuum. These behaviors are shaped by factors related to living and working conditions that can influence risk both directly (e.g. sexual coercion) and indirectly (e.g., low male-to-female ratio).[8]

The model also highlights how HIV vulnerability and risk is shaped by even more distant social, cultural, economic, legal, and political forces that influence the social and economic resources and opportunities of women and adolescent girls. These forces, in turn, influence their access to health-promoting living and working conditions and their capacity to make healthy choices. The SDH approach can help program planners and managers identify and understand underlying gender-based and other socioeconomic factors that contribute to disparities in HIV/AIDS among women and adolescent girls in the U.S. The SDH approach also helps program planners and managers to consider interventions at multiple levels to reduce vulnerability and risk.

3.2.1 Structural Level Factors

In Figure 1, the outer circle identifies structural factors. Structural factors include broad social, cultural, economic, and political forces, social stratification, and structural violence. Broad social, cultural, economic, and political forces such as economic, social, and health policies and laws; the criminal justice system; globalization; migration; and cultural values influence social divisions and inequalities.[7]

3.2.1.1 Globalization

Globalization is a process by which nations, businesses, and people become more connected and interdependent across national borders. This process is driven by economic integration through removal of barriers to free trade and the movements of goods and services, capital, technology, and labor across national borders. Globalization also facilitates advances in technology and communications (e.g., cell phones, the internet, and teleconferencing).

Globalization has had positive and negative effects on the lives of women and girls. Global communication networks and cross-cultural exchanges have provided women with increasing opportunities to network, share ideas about gender equality, and work together at national, regional, and international levels to demand equal rights.[9] The forces of globalization have also led to an increase in the number of women and children trafficked for sexual exploitation. Although sex trafficking in the U.S. is generally associated with women and children from foreign countries, significant numbers of victims are U.S. citizens.[10]

Women and girls who are victims of sex trafficking are more vulnerable to HIV infection because they often do not have access to male or female condoms; their clients may refuse to use condoms; and they may not be able to access testing and treatment.[11] Sex trafficking victims are more vulnerable to sexual assault and rape, and may be forced to engage in highly risky sexual practices (e.g., anal sex and violently abusive sex). These high risk sexual practices can result in genital abrasions and cuts that facilitate HIV transmission.[11]

3.2.1.2 Migration

Immigration and internal migration patterns also contribute to the spread of HIV. A good number of individuals immigrating to the U.S. come from areas of the world such as Africa, Asia, and the Caribbean, where HIV prevalence is higher and access to testing and treatment may be

quite limited.[12] Immigrants often cluster in racially or ethnically segregated neighborhoods and communities where others from their country of origin live. This clustering facilitates the spread of HIV through segregated sexual networks.[13]

The spread of HIV also occurs through "bridging" when individuals from one community acquire HIV infection from members of another community and then transmit within their own community. The effects of bridging are seen in the relationship between migration and HIV risk among diverse populations, including Latino populations in the Caribbean and Mexico who travel back and forth to cities in the U.S. One study of intravenous drug users migrating between Puerto Rico and New York revealed that the total number of moves between the two locations was related to higher drug injection risk behaviors.[14]

3.2.1.3 Policies

Complex social, cultural, economic, and political forces influence the decisions that governments make about health, social, and economic issues. These policies directly affect the resources and supports that are available to people to promote their health and well-being. The effects of global financial crises have trickled down to national economies.

In response, governments at every level often choose to enact laws and policies to either reduce public expenditures for education, health, and social welfare programs or to privatize these public services.[9] For example, many states facing fiscal crises have attempted to cut funding or implement cost-cutting measures in the AIDS Drug Assistance Program (ADAP).[15] These measures have devastating effects on HIV-positive persons who rely on the ADAP to receive life-saving HIV medications. These measures also have negative short- and long-term consequences for prevention and treatment.

3.2.1.4 Laws and Law Enforcement

A society's laws and law enforcement policies and practices can have positive and negative impacts on different groups within that society. For example, many states have enacted laws that criminalize "knowingly" exposing another person to HIV infection. HIV-positive persons have been prosecuted and imprisoned for consensual sex, often without having transmitted HIV to their partners.

Women living with HIV/AIDS may be more likely to be charged and prosecuted under these laws because they often learn their HIV status before their partner. Many women are routinely tested for HIV infection when they receive gynecological or prenatal services.[16] HIV-positive women may find it difficult to disclose their status for a number of reasons, including fear of violence or abandonment by their partners, loss of child custody, and familial or community rejection. They are also in danger of prosecution for child neglect when their children contract HIV during pregnancy, childbirth, or while breastfeeding.[17]

3.2.1.5 Social stratification

Social stratification is the system by which society ranks groups of people on the basis of social categories such as gender, race/ethnicity, age, SES, sexual orientation, and other statuses. The ranking of social groups results in patterned inequalities, giving some groups greater power, prestige, and wealth than others. Social stratification determines an individual's socioeconomic position within the social hierarchy. Socioeconomic position in turn influences an individual's opportunities and resources.

3.2.1.5.1 Gender

Gender is a key social stratifier that cuts across and interacts with other stratifiers such as race, ethnicity, and SES. In most societies, men generally have higher income, more job opportunities, higher education, greater political power, and fewer constraints on their behavior than women.[18] Men's advantaged position allows them to exercise power over women by making decisions for them, controlling their access to and use of resources, including healthcare and HIV prevention services, and monitoring and controlling their behavior through socially condoned violence or the threat of violence.[19] Gender norms, roles, and relations influence women's and adolescent girls' HIV vulnerability and risk.

3.2.1.5.2 Socioeconomic status

SES is another important stratifier. Differences in individuals' SES are influenced by many factors including gender, race/ethnicity, age, and marital status. SES is a key determinant of health, including HIV/AIDS. A recent study of heterosexuals in urban areas in the U.S. that had high prevalence of AIDS underscored the strong association between HIV prevalence and SES.[19] HIV prevalence was higher among those who had less than a high school education, who were unemployed, and who were living with annual household incomes at or below the poverty level.[20]

Gender differences in SES are clearly evident in the U.S. Women experience significant disadvantages in income, educational attainment, employment, occupational status, and health insurance coverage.[20] Women also have higher poverty rates than men, and female-headed households are among the poorest in the country.[21]

For example, U.S. women earn about 77 cents for every dollar that men earn.[21] The wage gap varies by race and ethnicity. The wage gap is largest among Latina women who earn 53 cents for every dollar White men earn and smallest among Asian women who earn about 82 cents.[21] White women earn 75 cents, and black/African American women earn 62 cents for every dollar earned by White men.[22]

Gender differences in SES are also found among people living with HIV/AIDS (PLWHA). In the U.S., women living with HIV/AIDS, and women most affected by the epidemic tend to be poor and primarily from communities of color. They are nearly twice as likely as men to have annual household incomes of less than $5,000.[22] HIV-positive women are also more likely than HIV-positive men to have lower educational attainment, to be unemployed, and to be uninsured.[23]

Economic dependence on men as a consequence of women's relative SES disadvantage has serious implications for women's vulnerability to HIV. For example, a study of U.S. women found that staying in sexual relationships for economic reasons and having transactional sex with non-regular partners was common among unmarried women.[23] Black/African American women were more likely than White women to report starting a relationship due to economic considerations and having transactional sex with someone who was not a regular partner.[24]

These risk-related behaviors were all associated with lower levels of education, economic hardship, need to care for dependents, and increased levels of risk of HIV and STDs.[24] Transactional sex with non-regular partners was associated with concurrent sexual partnerships, binge drinking, drug use, perceiving their main partner was in a concurrent relationship, and having high-risk sexual partners.[24]

3.2.1.6 Structural Violence: Society's Damaging Inequalities

Structural violence refers to preventable harm resulting from unequal distribution of power

and resources that limit the life opportunities of a group of people.[7] Poverty, sexism, racism, homophobia, and HIV-related stigma and discrimination are forms of structural violence. Because structural violence is based on institutionalized discrimination, it prevents people from realizing their basic needs and potential. Structural violence leads to conflict and can be manifested in direct violence such as VAW, racial violence, and hate crimes against homosexuals and immigrants.[7] The effects of poverty, racism, sexism, homophobia, and HIV-related stigma and discrimination can heighten a woman's HIV/AIDS vulnerability and risk. It is important for programs that work to prevent, reduce or mitigate structural violence to include trauma-informed care (TIC), which includes providing sensitive and inclusive environments where individuals can access relevant services that are considerate of their traumatic experiences.

3.2.1.6.1 Homophobia

Societal and interpersonal homophobia are harmful to all women, as they impact the lives of lesbian and bi-sexual women and can also increase HIV risk among women in heterosexual relationships with men. There is little research on the impact of social determinants, including homophobia, on the HIV risk for women who have sex with women (WSW), such as lesbian and bisexual women. However, homophobia and the accompanying stigmatizing attitudes toward women and men who engage in same-sex behaviors are prevalent in the U.S. and particularly strong in some racial and ethnic minority communities.[26,27] Several studies have shown that internalized homophobia, the fear of stigma, discrimination, and rejection among men who have sex with men (MSM) is common and consequently, many MSM do not identify as gay or bisexual. This fear may lead them to also have sex with women to hide their same-sex behaviors.[27,28,29] They may have steady or casual sexual relationships with women but not disclose that they also have sex with men.[27] Stigma and discrimination may lead them to engage in unprotected sex and riskier sexual practices with both male and female partners, placing themselves and their partners at heightened risk of HIV infection.[27,28,29,30] The interplay of homophobia and racism may increase the vulnerability of MSM because prevention messages are often targeted to gay men or White gay men and do not address the HIV-related risks of men who have sex with both men and women (MSMW).[27,28]

3.2.1.6.2 HIV-related stigma and discrimination

HIV-related stigma and discrimination are still prevalent in the U.S. despite stigma-reduction efforts and anti-discrimination measures. HIV-positive women face strikingly high levels of stigma. A Foundation for AIDS Research sponsored survey revealed pervasive negative views of HIV-positive women and a high level of discomfort in interacting with them.[30] Despite the availability of medication to prevent mother-to-child transmission, more than 80% of respondents felt that HIV-positive women should not have children.[31] People who have been infected through consensual sexual activity or drug use are often blamed for, and considered deserving of, their illness.[31]

HIV stigma reinforces negative stereotypes. For example, women with HIV are often viewed as promiscuous.[32] The stigma associated with HIV may deter some people from seeking testing, prevention, and treatment services as well as discourage those who are HIV-positive from disclosing their status to their partners.[32]

3.2.1.6.3 Racism

Racism is another form of structural violence that has contributed to disproportionately high rates of mortality and incarceration among black/African American males. In turn, these factors have lowered the male-to-female ratio (also known as the sex ratio) in black/African American communities. Male shortages, particularly in black/African American communities with high rates

of male incarceration, increase the chances that black/African American males will have multiple female sex partners.[33] This demographic situation gives black/African American men more potential partners than women and limits women's power to determine the types of relationships to enter. It also diminishes black/African American women's bargaining power to insist on monogamous relationships and condom use.[26,28,34]

3.2.1.6.4 Gender-based violence

Gender-based violence (GBV) is a serious health, human rights, and social welfare problem. It takes many forms and can include physical, emotional, or sexual abuse. While both males and females can suffer from GBV, women, girls, and boys are most often the victims.

Gender-based violence against women and girls, including intimate partner violence (IPV) and child sexual abuse, is a pervasive issue in the U.S. impacting nearly half of all women.[34] A number of studies have shown that IPV increases risk for HIV infection: One in two HIV-positive women has a history of sexual and/or interpersonal violence compared with one in three HIV-negative women with similar histories.[35] A number of studies show a relationship between childhood sexual abuse and later sexual risk-taking, as well as drug and alcohol use.[36] This association likely contributes significantly to the higher prevalence of HIV among women with histories of sexual or intimate partner violence.[36]

Sexual assault and rape can increase the chances of women and girls contracting HIV infection because vaginal tearing and trauma can provide portals for the virus. The experience or threat of violence can prevent women, even those in consensual relationships, from insisting on condom use or refusing unwanted sex. Fear of violence can discourage women from accessing HIV/AIDS information, being tested, disclosing their HIV status to partners, accessing services to prevent transmission of HIV to their infants, and receiving treatment, care, and support services.[37] Programs addressing gender-based violence, including intimate partner violence, should include trauma-informed care (TIC) components that provide responsive care to victims of trauma. These programs should also offer relevant HIV prevention services, such as Pre-Exposure Prophylaxis (PrEP) for pro-active protection against potential HIV exposure or Post-Exposure Prophylaxis (PEP) for protection after potential exposure to HIV during consensual or non-consensual sex.

3.2.2 Social-Level Factors

In Figure 1, the gray middle circle represents how relationships, communities, and culture affect HIV vulnerability and risk. Social-level factors include the neighborhoods, material circumstances, and cultural contexts in which people live, and the social and sexual networks in which they interact and form relationships.

3.2.2.1 Neighborhood Effects

Neighborhood effects refer to neighborhood-level factors that directly and indirectly shape HIV/AIDS patterns at the population level. *Direct factors* are those that increase the likelihood of a person coming in contact with someone who is HIV positive, such as residential segregation and social isolation of marginalized populations.[7] Indirect factors include those that increase population vulnerability to HIV/AIDS, such as exposure to poor socioeconomic conditions, high unemployment, or a high concentration of illicit drug trafficking.[7]

Many racial and ethnic minority groups in the U.S. live in racially or ethnically segregated neighborhoods.[37] These segregated neighborhoods are often characterized by high poverty, inadequate educational and employment opportunities, poor housing quality, and high levels

of substance use and crime. These neighborhoods are also more likely to lack grocery stores and medical services, be targeted for marketing by alcohol and tobacco advertisers, and have increased exposure to environmental hazards. People living in such neighborhoods are subjected to a multiplicity of conditions that increase their levels of stress and adversely affect their health and well-being.[38] Factors such as these indirectly influence HIV risk as they often contribute to a lack of education on HIV prevention, inadequate access to HIV screening and treatment, and engagement in behaviors that can increase HIV risk, such as sex work or substance use.

3.2.2.2 Social Networks

Social networks are composed of individuals who are connected to each other through social ties such as kinship, friendship, work, or the exchange of information or services.[38] Social networks can influence HIV transmission and prevention through behavioral norms that may encourage safer or riskier behaviors. They also provide a way to disseminate information on HIV prevention methods, technologies, and services and to promote risk reduction.[39] Social networks provide individuals with social support, which can help to reduce the negative effects of stigma and discrimination. Such support can also promote social inclusion and their psychological well-being.[40]

3.2.2.3 Sexual Networks

Sexual networks are groups of individuals who are linked directly or indirectly through sexual contact. They overlap with but are distinct from social networks. Sexual networks are key factors in the rapid spread of HIV and STDs because they connect individuals to the larger population.[25,40]

A high prevalence of HIV and STDs within the pool of potential sex partners will increase an individual's chances of being exposed to infection. Being in a network of individuals who change sexual partners frequently will increase the rapidity of the spread of HIV. More frequent sexual mixing between individuals with few sexual partners and those with many partners can increase the spread of infection to more subgroups within a population. Sexual mixing (the overlapping of sexual networks) within racially or ethnically segregated populations where there is an already high prevalence of infection also contributes to the spread of HIV and STDs within a population. Concurrent sexual partnerships can spread infection more rapidly through a sexual network than serial sexual relationships.[25,41] For women who have only one sexual partner, the risk of HIV and STDs still exists if their sexual partner has multiple concurrent partnerships.

3.2.2.3.1 Concurrent Sexual Partnerships

The low sex ratio in low-income black/African American communities has been identified as an important factor contributing to the prevalence of concurrent sexual relationships within these communities.[42] Concurrent partnerships were noted to be higher among men than women, and highest among black/African American men, followed by Latinos. Concurrent sexual partnerships were noted to be about twice as common among black/African American women than White women, and lowest among Asian and Latina women.[42]

Marriage patterns also influence concurrent partnerships. In the U.S., unmarried women are more likely than married women to be in concurrent sexual relationships.[42] The higher rates of concurrent sexual partnerships in some black/African American communities may be related to lower marriage rates and fewer available partners. Compared to Whites and Latinos, the proportion of men and women who have ever married is lowest among blacks/African Americans. The proportion of black/African American women who have never married is twice that of White women.[28]

3.2.2.4 Cultural Context

Cultural context is the setting within which behavior occurs, is shaped, and is transformed. Culture reflects the shared values, beliefs, attitudes, norms, rituals, and language of a social group. It shapes perceptions of health and illness; influences the nature of gender relations, power, and sexuality; and defines the possibilities and conditions for action within a social group.[43] Individuals' behaviors also shape their cultural context. The cultural contexts that shape sexual behavior and HIV-related risks are different for various social groups of women and girls and men and boys.

3.2.3 Individual-Level Factors

In Figure 1, the inner blue circle identifies individual-level factors such as biological, demographic, and behavioral characteristics that may influence the risk of acquiring HIV and progression to AIDS. Women's and girls' vulnerability to HIV/AIDS varies, depending on such factors as age, race/ethnicity, sexual orientation, gender identity, SES, immigrant status, and whether they have an STD other than HIV. Variations in their social, cultural, and religious beliefs and values may also influence the extent of their vulnerability. Finally, variations in their behaviors—including their selection of sexual partners, sexual practices, condom use, and illicit drug use— will affect the degree to which they are vulnerable to HIV/AIDS. These factors generally work in combination to heighten or lessen their vulnerability.

3.2.3.1 Biological and Physiological Factors

Women and adolescent girls in the U.S. are more vulnerable to HIV infection through unprotected heterosexual intercourse than men and adolescent boys because of the biological and physiological makeup of females. During unprotected vaginal sex, the risk of HIV transmission from a male to a female in the U.S. is estimated to be 2 to 8 times higher than the risk of transmission from a female to a male.[44,45]

The female reproductive tract provides a larger surface area through which transmission can occur than does the male reproductive tract.[46] The soft tissue in the female reproductive tract tears easily, producing a transmission route for the virus. Vaginal tissue absorbs fluids more easily, including semen, which can have a higher concentration of HIV than vaginal secretions. When ejaculation occurs during vaginal sex, women are exposed to larger amounts of infectious seminal fluids that remain in the vagina for hours following intercourse. In both women and men, tears in sensitive anal tissue and the high concentration of inflammatory cells increase the risk of HIV transmission during anal sex.

The risk of contracting HIV infection may be significantly higher for adolescent girls than adult women because they have less mature reproductive tracts.[47] The vaginal linings of adolescent girls are thinner than those of women and may easily tear during sexual activity. It is especially likely during forced sex. In some cultural contexts, social expectations may also lead adolescent girls to engage in anal sex to preserve their virginity. Women with lower estrogen levels, especially post-menopausal women, may also be more susceptible to infection because of the thinning of their vaginal linings.[48]

3.2.3.2 Other Sexually Transmitted Diseases

A woman's vulnerability to HIV infection is further increased if she or her male partner has another STD.[49] The same biological factors that heighten women's susceptibility to HIV heighten their susceptibility to other STDs, including those that cause genital lesions. Having another

STD greatly increases the chances of both acquiring and transmitting HIV.[50] Ulcerative STDs (e.g., syphilis, herpes, or chancroid) cause breaks in the genital tract lining or skin that are portals of entry for HIV. In addition, inflammation resulting from genital ulcers or non-ulcerative STDs (e.g., chlamydia, gonorrhea, and trichomoniasis) increases the concentration of cells in genital secretions that can serve as targets for HIV (e.g., CD4+ cells).[51]

Women and adolescent girls are more likely to have untreated STDs than men and adolescent boys. Females are less likely than males to show symptoms of common STDs such as chlamydia and gonorrhea. The painless genital ulcers caused by syphilis that occur in the vagina are less visible in women, while in men these ulcers are more visible on the penis. Women with asymptomatic STDs may not seek treatment, which can result in serious long-term consequences such as infertility, pelvic inflammatory disease, ectopic pregnancy, and cervical cancer. Moreover, syphilis and HIV can be passed to babies during pregnancy and at delivery.[52]

The striking disparities in the distribution of STDs in the U.S. by sex, age, race/ethnicity, and geographic region further increase the vulnerability of certain groups of women and adolescent girls to HIV infection. Women, especially those of color, and adolescent girls have higher rates of chlamydia and gonorrhea than men and adolescent boys.[52] The rates for both these STDs are markedly higher for adolescent girls, young adult women (15–24 years old), and African American women. The highest rates of syphilis in women are found among black/African American women, and young women ages 20-24 years old.[52] In terms of geographic area, the rates of chlamydia, gonorrhea, and syphilis are highest in the Southern region of the U.S.[52]

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Section 4

Four Domains of Gender

Section 4: Four Domains of Gender

4.1 Gender, Sex, and Sexuality

Gender is a complex concept that is shaped by an individual's sex, sexuality, identities, and social relations. The terms sex and gender are sometimes used interchangeably, yet they each have distinct meanings that are important to keep in mind. Gender, sex, and sexuality are key factors influencing vulnerability to sexual transmission of HIV for women and adolescent girls as well as men and adolescent boys. Thus, understanding both the differences and interrelationships between sex, gender, and sexuality is important in making HIV programming decisions.[1] Targets and strategies for intervention may vary depending on whether identified vulnerabilities to HIV are attributed to sex, gender, or a combination of both, and also how they relate to sexuality.

> *Gender:* Defines what it means to be masculine or feminine in a given society, culture, or community. Gender is defined by cultural values and beliefs. It is reflected in specific norms, expectations, roles, relations, behaviors, and practices within households, communities, and cultures
>
> *Sex:* The biological and physiological characteristics that define human beings as female or male.

4.1.1 Sex

Sex refers to the biological and physiological characteristics that define human beings as female or male. People are defined as female or male based on their sex chromosomes, gonads (ovaries or testes), hormonal levels and reproductive anatomy, or secondary sex characteristics (e.g., voice pitch, body hair, physique).[2] Sex is generally constant, unless changed through surgical and hormonal interventions.

4.1.2 Gender

Gender is more than biological or physiological differences between men and women, boys and girls. Gender defines what it means to be masculine or feminine in a given society, culture, or community. Gender is defined by cultural values and beliefs. It is reflected in specific norms, expectations, roles, gender relations, behaviors, and practices within households, communities, and cultures.

> *Gender relations* are a type of social relation between women and men, girls and boys. They include the routine ways in which men and women interact with each other in families, sexual relationships, friendships, workplaces, and different sectors of the economy. They are discussed further in *Section 4.4.3, Domain Three; Gender Relations.*

These characteristics will differ from culture to culture, may vary within cultures, and change over time. These differences mean that men and women face different situations regarding the social, economic, and political opportunities that are open and accessible to them; the constraints they encounter; and the social, economic, and political status they hold.[2,3]

While sex is about genetic, biological, and hormonal characteristics, gender is about social values, beliefs, norms, expectations, roles, and relations. For example, being able to bear a child is essentially a function of biology. The expectations about having children, the nature of parenting, or the status associated with being a mother are more closely linked to gender and vary from culture to culture.

4.1.2.1 Components of Gender

The concept of gender includes six important components: socially constructed, relational, hierarchical, contextual, dynamic, and institutional.[4,5]

4.1.2.1.1 Socially constructed

Socially constructed components of gender include sociocultural values, beliefs, attitudes, norms, and expectations that determine what is valued in women or men, how women and men are perceived, what behaviors are allowed, and how women and men are expected to think, feel, act, and relate to each other. Individuals learn what it means to be a woman (feminine) and a man (masculine) through processes of social, cultural, and political socialization. Thus, gender is an acquired identity.[3]

4.1.2.1.2 Relational

Relational components of gender are the relationship structures between and among women and men.[4] These structures are based on what society believes are the appropriate roles, duties, rights, responsibilities, behaviors, statuses, and powers for women and men.[3]

4.1.2.1.3 Hierarchical

Hierarchical aspects of gender include the ways in which gender often creates hierarchies between and among groups of women and men that can lead to unequal power, disadvantaging one group over another. In most societies, women and girls have lower status and less power relative to men and boys.[4] As a result, women and girls face greater constraints; have fewer social, economic, and political opportunities; have less access to and control over resources; and are afforded fewer decision making opportunities.

4.1.2.1.4. Contextual

Contextual aspects of gender include the social definitions of what it means to be a woman, man, girl, or boy that are specific to historical contexts. These aspects vary widely within and across societies and cultures, and they are affected by age, SES, race, ethnicity, and religion. They are also affected by geographical, social, cultural, economic, and political environments.[2,3,6]

4.1.2.1.5 Dynamic

Dynamic components of gender refers to the ways in which definitions of gender change over time despite being specific to historical and social contexts.[2,3,4] The term implies that gender norms, roles, and relations have the potential to be modified through interventions.

4.1.2.1.6 Institutional

Institutional components of gender are the ways in which gender goes beyond the relations between women and men at the private and personal level. They cut across society at all levels: families, households, communities, organizations, and institutions.[4]

4.1.3 Sexuality

Sexuality is distinct from, but intimately related to gender.

The definition shows that sexuality is a complex multidimensional concept that includes both sex and gender. The definition makes the distinction between sex and sexuality in that the sexuality is socially constructed while sex is based on biological characteristics.

> #### *Sexuality*
>
> The WHO defines sexuality as a central aspect of being human throughout life and encompasses sex, gender identities and roles, sexual orientation, eroticism, pleasure, intimacy, and reproduction. Sexuality is experienced and expressed in thoughts, fantasies, desires, beliefs, attitudes, values, behaviors, practices, roles, and relationships. While sexuality can include all of these dimensions, not all of them are always experienced or expressed. Sexuality is influenced by the interaction of biological, psychological, social, economic, political, cultural, ethical, legal, historical, religious, and spiritual factors.[7]

4.2 How Gender, Sex, and Sexuality Intersect

There are deep interconnections between gender and sexuality. Both gender and sexuality are socially constructed. Gender is instrumental in defining sexuality for women and men as well as girls and boys.

Gender influences the way people feel sexually and the ways they are expected to act sexually.[8] The way people understand categories of sexuality is also dependent on the existence of categories of sex (female/male) and gender (woman/man).[8] Human experience is diverse, and many people do not fit neatly into the binary conceptions of gender (woman/man) and sex (female/ male) found in many Western cultures.

Human beings can experience variation in chromosomal sex and hormonal levels. For example, intersex persons are born with gonads, genitals, internal sex organs, secondary sex characteristics, hormones, or sex chromosomes or some combination of these characteristics that are not exclusively male or female.[9] As such, they cannot be identified as exclusively male or female.[9] When the two distinct categories of female and male are imposed on these biological realities, a number of assumptions are made about what it means to be dichotomously categorized, including what it means to be in those categories sexually.

The complexities of sex and gender identity are also reflected in the experiences of transsexual persons, who choose to undergo surgical or hormonal interventions or both to change their birth sex to conform to their sense of gender identity.[2,9]

The social and cultural concepts of gender shape the complex interrelationships of one's sexual characteristics; gender identity; gender expression gender roles; gender relations; and sexuality.

People respond to the expectations of their sex in a variety of ways. Some people may not conform to the gender norms associated with their biological sex. Others may behave in at least some ways that are contrary to society's expectations for their gender. Still others may challenge gender norms by identifying with gender norms of the opposite sex or by creating new identities that confound normative, binary constructions of gender. Transgender persons have gender identities, expressions, or behaviors that are not traditionally associated with their birth sex.

Some persons may feel they possess both or neither gender. For example, two-spirit person is a contemporary term used by Native Americans and Canadian First Nation people to describe the existence of masculine and feminine spirits within one person.[10] Two-spirit persons traditionally carried out mixed gender roles, including wearing the clothing and performing the work associated with both men and women.[10] When individuals or groups do not "fit" or conform to dominant gender norms, they often face stigma, discriminatory practices, or social exclusion—all of which adversely affect health and their vulnerability for HIV/AIDS.

Sexuality and gender are interconnected because ideas about what it means to be a woman or a man are created through expectations of what it means biologically to be female and male.[8,11] Different assumptions are made about the sexuality of women and men. For example, in cultural contexts in which heterosexuality is assumed to be the norm, masculinity is equated with being heterosexual, and power and privilege is distributed to those who are heterosexual rather than to those who are not.[8] The assumption that "real" men are heterosexual leads to the labeling of homosexual men as "unmasculine" and to stigma and discrimination that often results in violence against them.[8]

Heterosexuality also functions to ensure men's physical, emotional, and economic access to women and plays an important role in reinforcing gender inequality.[8] The sexual desire of men is often assumed to be natural, strong, beyond control, and greater than that of women. Men are viewed as powerful sexual subjects who act upon others rather than being acted upon.[8] While women are also seen as sexual beings, they are often sexualized and made into *sexual objects*.[8]

> ### *Gender Identity*
>
> One's innermost concept of self as male or female or both or neither—how individuals perceive themselves and what they call themselves. One's gender identity can be the same or different than the sex assigned at birth.
>
> ### *Gender Expression.*
>
> Refers to the ways in which people externally communicate their gender identity to others through behavior, clothing, haircut, voice, and other forms of presentation. Gender expression also works the other way as people assign gender to others based on their appearance, mannerisms, and other gendered characteristics. Sometimes, transgender people seek to match their physical expression with their gender identity, rather than their birth-assigned sex.
>
> *http://www.genderspectrum.org/understanding-gender*

4.3 Four Domains of Gender

The *four key domains of gender* are: gender norms, gender roles, gender relations, and access to and control over resources. These domains influence women's and men's, girls' and boys' sexual beliefs, attitudes, behaviors, interactions, and relationships. They also influence their access to HIV information, prevention, treatment, care, and support services as well as health outcomes.[13] The interplay of gender and other sociocultural and economic factors determine inequalities in sexual relationships, including the possibilities for violence and coercion, negotiation of safer sex, and risk-reduction strategies.[14] Together these factors influence women's and adolescent girls' ability to make choices, have control over their sexual interactions and relationships, leave abusive relationships, and protect themselves against infection.[15]

4.3.1 Domain One: Gender Norms- Dominant Ideologies of Femininity and Masculinity

Dominant gender ideologies (systems of ideas) determine what are seen as appropriate masculine and feminine behavior, characteristics, and roles. These ideologies produce sharp differences between women's and men's roles, their decision making authority, and their access to and control over resources.[16]

Dominant ideologies of femininity and masculinity negatively affect and increase men and women's vulnerability to HIV infection.[13] In most societies, these ideologies strongly influence how sexuality is interpreted by and for women and men. They determine how and what women and men know about sexual matters and sexual behavior. Dominant ideologies of femininity and masculinity also give rise to risk behaviors that contribute to risk of and vulnerability to HIV for individuals.

> ### Gender Norms
>
> *Gender norms* are a set of social expectations of the roles and behaviors widely considered to be appropriate for women and girls and men and boys, within specific groups, communities, cultures, or societies. Gender norms assign distinct productive and reproductive roles to women and girls and men and boys, and differentially influence their access to such vital resources as information, education, employment, income, and wealth. Gender norms define gender roles and relations.

Gender norms are shaped by dominant gender ideologies and influence the behaviors of women, men, girls, and boys.

4.3.1.1 Influence of Dominant Ideologies of Femininity and Gender Norms on HIV Vulnerability

Dominant ideologies of femininity characterize ideal women and girls as subordinate, obedient, and dependent on men and boys; naïve and passive in sexual relations; chaste, virgins, and monogamous; and favoring motherhood as the primary reason for having sex.[13,15]

Women and girls who are expected to be passive and naïve about sexual matters are often poorly informed about sex and reproduction. These gender norms limit their ability to seek sexual health and HIV prevention information. The same gender norms also prevent women from being proactive about reducing their risk for infection.[3,12,15]

The high value placed on virginity and chastity before marriage in many cultures may lead countless adolescent girls and young women to conform to these norms by engaging in high-risk behaviors such as anal sex.[12] Moreover, the emphasis on virginity and the silence surrounding sexuality may also deter adolescent girls and young women from seeking treatment for STDs because of the fear of disclosure of their sexual activities and the stigma attached to such services.[12]

In cultures where motherhood is considered a feminine ideal, having children provides many women with a sense of social identity and status within their kinship groups and communities.[13] However, values and norms regarding motherhood pose serious dilemmas for women and adolescent girls. Protecting themselves against HIV infection entails using methods that also prevent conception, such as abstinence, non-penetrative sex, or consistent condom use.[3,12,,13] Gender norms that expect women and girls to please men and boys and defer to male authority also constrain women's ability to negotiate safer sex and insist on condom use. These norms may place some women and girls in danger of sexual coercion and violence.

4.3.1.2 Influence of Dominant Ideologies of Masculinity and Gender Norms on HIV Vulnerability

Dominant ideologies of masculinity characterize ideal men and boys as providers, independent, dominant, strong, brave, risk-takers, invulnerable aggressors, virile, sexually active, and unemotional.[13,15,17] Dominant ideologies of masculinity and social norms create an environment where risk-taking by men and boys is acceptable and encouraged.[16] In many cultures, men are believed to have a much stronger sexual drive than women, and boys and young men are socialized to become sexually active at an early age and to have multiple partners.[17] Even after marriage, having multiple partners is condoned for men while condemned for women in some cultures.[17] Men are also encouraged to continuously reaffirm their masculinity by engaging in multiple sexual exploits, by demeaning men or boys who are considered effeminate, and by ridiculing real or assumed homosexuality.[17]

> ### _Masculinity_
>
> Masculinity refers to the qualities, virtues, or characteristics considered appropriate for men and boys. Conceptions of masculinity depend on the cultural context and time. They also vary depending on factors such as class, age, race, ethnicity, culture, and other social differences. This means that there are multiple masculinities.

The pressure to prove their manhood through sexual conquest may lead many men and adolescent boys to have multiple female sex partners. Adolescent and young men may engage in unsafe sexual experimentation.[12] This behavior increases their risk for HIV infection and counters HIV/AIDS prevention messages that promote delaying the onset of sexual activity in young people, reducing the number of sexual partners, and maintaining fidelity in a relationship.[3]

Ideologies of masculinity that endorse heterosexism as the norm and the sexual domination of women as the key feature of manhood tend to promote homophobia and stigmatize men who have sex with men (MSM).[12] These gender ideologies and norms increase the vulnerability and risk of MSM to HIV and that of their sexual partners, whether male or female. To avoid stigma and discrimination, some MSM may feel compelled to hide their same-sex behavior, engage in sex with women or adolescent girls, deny their sexual risk, engage in risky sexual behavior, and avoid accessing services or seeking information that can help them protect themselves and their sexual partners.[3,12]

Homophobia also compels many men and boys to prove they are "real" men and may lead to violence against those who are sexual minorities or presumed to be, such as gay men, MSM, and transgender persons.[16] In places where homosexuality is criminalized, the vulnerability of MSM and their sexual partners, whether male or female, is heightened.[3]

Norms of masculinity that expect men to be more informed and experienced in sexual matters may cause men, particularly young ones, to avoid seeking information about sex and safer sex for fear of admitting their lack of knowledge.[13] Their misconceptions or limited knowledge about sexual and reproductive health may increase their risk of HIV infection and that of their female partners.[13] Norms expecting men and boys to be self-reliant and invulnerable may also prevent them from seeking health and other information and services they may need and thus increase their vulnerability to HIV.[16]

Men and adolescent boys may also attempt to affirm their manhood by consuming alcohol and using illicit drugs. These behaviors are more common in men than women. Men who inject drugs are at risk of contracting HIV infection by using contaminated needles and syringes. They can

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transmit HIV to both their drug-sharing and sexual partners through unsafe drug injecting and unsafe sexual practices.[16]

Fortunately, dominant ideologies regarding femininity and masculinity evolve and can be changed. These ideologies and associated gender norms are amenable to HIV interventions that seek to change them and promote more equitable gender relationships and safer sex.[13,15]

4.3.2 Domain Two: Gender Roles

In many societies, gender norms influence the types of responsibilities, tasks, activities, and work of women and men. Specific types of work and household duties may confer specific sets of opportunities, constraints, and status for individuals.

> ### Gender Roles
>
> Gender roles are learned behaviors in a given society, community, or cultural group that determine which activities, tasks, and responsibilities are perceived as male and female. Gender roles are affected by age, class, race, ethnicity, and religion as well as by the geographical, economic, and political environment.
>
> Gender roles change in response to changing economic, social, or political circumstances.

In most societies, gender roles are defined through a division of labor based on the sex of the individual and their productive and reproductive roles.

Productive roles include work that can be done by both men and women to produce goods and services in return for payment in cash or kind to meet the needs of the household or family.[4]

Reproductive roles include activities that ensure the reproduction of the society's labor force. Activities include childbearing and rearing, providing care for family members—children, the elderly and sick, and those who provide income—and domestic tasks to maintain the household.[4] These tasks are mostly done by women and girls.[4]

Women's and adolescent girls' *reproductive work* within the home is generally unpaid and less valued because it is not thought of as "real" work but rather as a "natural" part of being female.[18] When women engage in *productive work* within or outside of the home, it is generally less valued even though it provides additional resources for the household.

Community work is another category of activities assumed by women and men. It involves participation, organization, and action on a collective basis to contribute to the spiritual, social, cultural, and political development of communities.[19]

Both women and men engage in this type of work, but the gender division of labor also plays a role here.[19] Women may be more likely to participate in community management work. This work is performed as an extension of their reproductive role; they maintain stable community relations and ensure resources are used by the community as a whole.[19] Community management work is generally unpaid, voluntary, and carried out during women's "free time."[19] Men may be more likely to participate in community politics, which includes leadership and organizing activities at the formal political level.[19] Although women may participate in community politics, this work is usually performed by men, who may be paid in cash or benefit indirectly through status or power.[19]

While men are likely to carry out productive and community politics' roles sequentially, women are more likely to carry out reproductive, productive, and community management roles

simultaneously.[19] Because women's reproductive and community management work is often viewed as "natural" and effortless, the severe constraints they face in balancing the triple burden of their work is often not recognized by men or society at large.[19]

4.3.2.1 Influence of Gender Roles on HIV Vulnerability

In the context of HIV/AIDS, traditional gender roles that place the burden of caregiving and domestic work within households on women and adolescent girls adversely affect them in a number of ways. Women and adolescent girls who have major responsibility for caregiving, domestic work, and productive work in the home may be unable to benefit from educational and employment opportunities. These constraints in turn limit their ability to be financially independent.[3,13] The burdens of reproductive and productive work also limit their time and reduce their ability to seek and use health and HIV information and services.[3,13] For women and adolescent girls living with HIV, the extra burden of care they provide within the family may limit their ability to continue to care for their own illness and could result in HIV progressing to AIDS more quickly than expected.

4.3.3 Domain Three: Gender Relations

Gender relations are the social relationships between and among women and men, girls and boys of different groups. Gender relations reflect how power is distributed between and among women and men of different groups. Gender relations produce and reproduce systemic differences in women's and men's position in a given society.[19] In most societies, socially determined gender roles give women less access to and control over resources, which leads to unequal gender relations where men hold the balance of power.[13]

4.3.3.1 Influence of Unequal Power in Gender Relations on Condom Use

Inequality in the power dynamic within relationships has important implications for the prevention of heterosexually transmitted HIV infection because women and adolescent girls must rely on the cooperation of men and adolescent boys to practice safer sex.[22]

> ### Gender Relations
>
> Gener relations are types of social relation between women and men, girls and boys. They include the routine ways in which men and women interact with each other in families, sexual relationships, friendships, workplaces, and different sectors of the economy.
>
> These relations are simultaneously characterized by cooperation, connection, and mutual support; conflict, separation, and competition; and difference and inequality.*
>
> Gender relations are shaped and reinforced by social, cultural, political, and economic institutions, including the family, religion, legal and governance structures, and markets. Gender relations are linked to other social relations such as race, ethnicity, class, age, and sexual orientation. They are socially determined, culturally based, historically specific, and change over time. (USAID Value Chains)
>
> *March, C., Smyth, I. A., & Mukhopadhyay, M. (1999). A guide to gender-analysis

Although efforts have been made to develop HIV prevention methods that women can control or initiate, the female condom is still not widely used in the U.S., and development of effective and acceptable microbicides is still underway.[20,21] Thus, the male latex condom, a male-controlled device, remains the major barrier method available to women and adolescent girls to prevent sexually transmitted HIV infection and other STDs.[22]

In order to protect themselves against exposure to HIV infection in heterosexual relationships, women must ask or persuade their male partners to use condoms, engage in non-penetrative sex, or refrain from having sex with them.[23] Women's ability to negotiate condom use may be influenced by social and cultural norms related to:

- the high value placed on motherhood and desire to have children;
- expectations that women be sexually passive, naïve, or both; and
- expectations that males will be sexually free, have multiple sexual partners, and control sexual activities.[17]

Requesting that a male partner use a condom requires a woman or adolescent girl to assert a more dominant role during a sexual encounter.[26] Asserting a more dominant role may present difficulties for women and adolescent girls who have been socialized to be passive and naïve in sexual interactions.[26] Some women and adolescent girls may also lack the communication skills and attitudes to effectively negotiate safer sex.[26]

Research shows that male willingness is a key factor in actual condom use,[23] including the use of the female condom. For example, a study of ethnically diverse women attending family planning clinics found that male partners' favorable attitudes about the female condom were strongly associated with its use among women.[24] The need for male cooperation places women and adolescent girls at a serious disadvantage if their male partners are unwilling to use condoms.

4.3.3.2 Influence of Male Violence against Women (VAW) and Girls on Condom Use

Unequal power relations between women and men contribute to gender-based violence. Some women and adolescent girls experience physical, sexual, and emotional violence in their homes, often from intimate partners, and in their communities. Gender norms that condone male VAW encourage it as an accepted problem-solving technique and exercise of legitimate control over others. Male VAW is an extreme manifestation of unequal power in gender relations. Men and adolescent boys may use violence to exert their control and coerce women and adolescent girls to comply with their sexual desires.[13]

Studies show that women in relationships with abusive partners are significantly less likely to use condoms.[23] For example, a study of young African American women found that women in abusive relationships with a male primary partner were less likely than other women to use condoms. In addition, they were more likely to experience verbal abuse, emotional abuse, or threats of physical abuse when they discussed condoms.[25]

The threat of violence also affects the use of the female condom. For example, a study of female sex workers found that those who reported current physical or sexual abuse by a client were less likely to use the female condom than those who did not experience abuse.[26] A study of women using methadone found that some women experienced physical abuse following attempts to use the female condom with their male sex partners. Even women who attempted covert use of the female condom experienced violence when their male partners uncovered it.[27] The partners' abusive reactions were tied to their beliefs that condom use in a steady relationship implies infidelity on the part of the women. These findings imply that, even though the female condom is a female-initiated device, its use still requires some degree of male involvement and cooperation, and it has the potential to provoke violent reactions by male partners.[27,28]

4.3.3.3 Influence of Economic Dependence on Men and Safer Sex

The degree of inequality in gender relations may be greater for women who are economically dependent on men. Economic dependence on men contributes to women's and adolescent girls' vulnerability to HIV infection because they lack bargaining power in sexual relations and are less able to negotiate condom use or fidelity with non-monogamous partners.[13] Women who have limited educational and employment opportunities may rely on men to support them and their families.[3,13] Their economic dependence may compel them to stay in sexually risky or abusive relationships with men.[3,12,13]

Women may also be compelled to trade sexual favors with men for money or gifts

in order to meet their basic needs and those of their families.[3,12] Sex in this type of exchange, referred to as transactional sex, becomes a commodity used as a means of survival.[3] Among adolescent girls and young women, *transactional sex* often takes place with older men, who are more likely to be HIV-positive and who have the money and means to support them.[3,13]

4.3.4 Domain Four: Access to and Control over Resources

Gender roles and relations shape how resources are allocated between women and men of different races, ethnicities, and socio-economic statuses. In some cases, women have less access to and control over resources than men in a household, which leads to unequal gender relations. For instance, a woman who stays at home to care for her children may rely on her husband for income. Sometimes in these situations, where a woman is not compensated monetarily for the work she does, the husband controls how much, at what time, and under what circumstances his wife may access resources, creating an environment of complete economic reliance. In circumstances where women have less access or control over financial resources, men may hold the balance of power over a number of other resources, including income, employment, information, education, political assets, benefits, health and social services, time, and intrapersonal assets (e.g., self-esteem, self-confidence, and ability to express own interests).

There are important differences between *access to resources* and *control over resources. Access to resources* means that an individual has the opportunity to make use of a resource. *Control over resources* means that an individual has the power to decide who can access a resource and how the resource is used.[19] For example, women and adolescent girls may have access to male and female condoms. However, because they must rely on the cooperation of their male partners to use condoms, women and adolescent girls have little or no control over the use of this important HIV prevention resource.

> ***Access to Resources:***
> the opportunity to use a resource.
>
> ***Control over Resources:***
> the power to decide who has access to a resource and how it is used.

Access to and control over resources determines who uses services, the ease with which these services can be used, who decides which services to offer, and how resources are used for HIV prevention, care, and treatment. Time is an important resource that allows individuals to use other resources such as HIV prevention services and health care. For example, women and adolescent girls may find accessing prevention services or healthcare difficult because they have other responsibilities, such as work and caregiving, which demand a lot of their time. Accessing health promotion and care services becomes more difficult if the services are inconveniently located, fragmented, or do not provide child care.

4.4 Gender Inequality and HIV Vulnerability among Highly Marginalized Women

Highly marginalized women, including women of color, sex workers, drug users, transgender women, lesbians, bisexual women, and other women who have sex with women (WSW), face multiple layers of stigma and discrimination. Gender and other contextual factors such as sexual orientation and identity, race, ethnicity, age, and SES contribute to the heightened HIV vulnerability and risk of these different groups of women. The interaction and effects of these factors are important to consider when designing and implementing effective HIV prevention interventions and support services, so the particular vulnerabilities and needs of these women are addressed.

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Section 5

Integrating Gender into
HIV Programs

Section 5: Integrating Gender into HIV Programs

5.1 Gender-responsive Programming in HIV Prevention

Gender-responsive programming addresses the interrelationships of sex, gender, sexuality, and HIV risk, while confronting sexual taboos, detrimental sociocultural norms, and stereotypes regarding femininity and masculinity. It takes into account the particular vulnerabilities and needs of individuals related to both sex (biological) and gender (sociocultural) differences. This programming also considers how gender norms, roles, and relations create inequalities that affect an individual's HIV/AIDS vulnerabilities and risks. Such programming should systematically integrate gender concerns in every step of the process, going beyond raising sensitivity and awareness to taking actions to promote gender equality and health equity.[1]

HIV prevention programs targeted to women and adolescent girls can be effective only if they take into account and address the ways gender interacts with other socioeconomic inequalities. It affects females' ability to abstain from sex, rely on the fidelity of their male partners, or negotiate condom use. Program planners and managers can improve the gender-responsiveness of their HIV prevention programs and services through gender analysis and gender integration.

5.2 What are Gender Integration and Gender Analysis?

Gender issues are central to HIV vulnerability and risk for women and adolescent girls. *Gender integration* is the process of systematically applying gender analysis in every step of the programming process. Some of these steps include:

- Define the problem;
- Identify potential solutions, methodologies, and approaches;
- Implement the program;
- Perform a needs assessment;
- Analyze community capacity and the choice of community partners;
- Define the program's goals, objectives, outcomes, outputs, activities, and inputs;
- Determine the composition of the implementation and management staff;
- Develop a budget;
- Undertake the monitoring and evaluation (M&E) process; and
- Make policy recommendations.[1]

Gender analysis is an analytic approach that helps program planners and managers understand how differences in the life experiences of women and men contribute to their differences in vulnerability and risk of HIV infection. Gender analysis helps to improve program effectiveness by:

- Understanding how gender influences an HIV prevention program;
- Assessing the potential positive and negative impact of program interventions and activities on women and men, girls and boys;

- Assessing the capacity of institutions to address gender issues; and

- Making recommendations for strengthening the HIV prevention program by addressing gender issues.

5.3 Gender Integration

Gender integration is an internationally recognized strategy to address gender-based inequalities, promote empowerment, and reduce vulnerability and risk for HIV/AIDS. Gender integration involves identifying and addressing both the differences and inequalities between and among women and men, girls and boys, of different social groups during program planning, design, implementation, monitoring, and evaluation.[2] This process is important in HIV prevention programming. Gender roles and relations of power, in combination with other socioeconomic inequalities, influence the differential patterns, impact of infection, and progression to AIDS among and between women and men of different social groups. Gender differences and inequalities also influence how HIV prevention programs and activities are carried out and how individuals participate in and benefit from these programs and activities. Identifying and addressing these gender issues on an ongoing basis throughout all phases of programming is important to ensure program success.

Gender integration is based on gender analysis. Gender analysis findings inform the development of each step of the program cycle, and help programs better address gender-based inequalities and constraints that impede HIV prevention goals.

5.4 Gender Analysis

Gender analysis is a systematic process that entails collection, analysis, and interpretation of data and information to gain an understanding of how the experiences of women and men are similar and how they are different. In the case of HIV/AIDS, gender analysis examines differences in the patterns of HIV incidence, prevalence, modes of transmission, health outcomes, and access to and use of prevention, support, treatment, and care services as well as addressing the needs of women and men.

Gender analysis also takes into account and examines the diversity among people, recognizing that all women and girls are not the same and that all men and boys are not the same. It analyzes the differential social, cultural, economic, political, and biological circumstances of women and men, girls and boys of different social groups. It also examines how gender, sex, and sexuality can independently or in combination produce different constraints or opportunities for women and men, girls and boys that differentially impact their HIV-related risk factors, risk- and health-seeking behaviors, participation in programs and services, and the benefits they receive from these programs. Gender analysis helps to identify the potential positive and negative impacts of program activities and interventions on women and men of different social groups. It considers the implications of the differences identified for the design and delivery of HIV strategies and interventions.[2,4]

Gender analysis stresses the importance of addressing the relationships between women and men as a way of responding to women's and girls' increased vulnerability and risk of HIV/AIDS. This is important because all individuals are made vulnerable by gender-related factors that put them and their sexual partners at risk.[4] The actions of one partner will likely have direct or indirect consequences for the other partner(s). For example, an HIV-positive woman living in an abusive

relationship with a male partner might not disclose her status to him for fear of violence. As a consequence, she may infect him with HIV.[4]

Gender analysis applied at the organizational level assesses the commitment and capacity of organizations to address gender issues. It helps to determine how organizations themselves are "gendered" in terms of recruitment and hiring practices and divisions of labor and decision making. Gender analysis examines an organization's policies, processes, and practices in terms of gender outcomes or potential differential impacts on the women and men who are members of its board of directors, staff, and program participants. Gender analysis at this level can also improve program quality and effectiveness by strengthening organizational commitment to gender-responsive HIV prevention planning and programming as well as organizational capacity to identify gender equality issues and strategies.

Program planners and managers consider many factors in program planning, implementation, and evaluation, including existing services, gaps, geographical location, and availability of resources. Gender is another key dimension that must be integrated throughout the HIV prevention programming process.[4]

During program design, gender analysis assesses the impact that HIV prevention activities and interventions might have on women and men of different social groups and on gender relations between and among them. By anticipating any direct or indirect effects, program planners and managers can proactively design interventions, strategies, and activities to ensure that these women and men, girls and boys are not disadvantaged by prevention activities.

Gender analysis can also help program planners and managers to identify and understand obstacles to the empowerment of women and girls. They can then proactively address them in the program design and seek out opportunities to promote female leadership and participation. This information can also be used to enhance the quality and effectiveness of activities and interventions or identify priority areas for promoting HIV prevention goals and gender equality.

During program implementation, monitoring, and evaluation, gender analysis assesses the differences in participation, benefits, and impacts between and among women and men of different social groups, including progress toward gender equality and changes in gender relations. Based on the information and insights derived from gender analysis, program planners and managers can take actions to adapt HIV program strategies and activities to facilitate participation, ensure participants benefit equally from prevention activities, and improve program impact.

Gender analysis and gender integration help program planners and managers avoid the pitfalls of poor program design that can cost time, effort, money, and goodwill. If gender analysis and gender integration are not undertaken in HIV prevention programming, the following may occur:

- Women/adolescent girls or men/adolescent boys or both may not benefit equally from the program;
- Program may have unintended adverse impacts on women/adolescent girls or men/adolescent boys or both;
- Programs may not address the needs of women/adolescent girls or men/adolescent boys or both;
- Activities and outreach strategies may not be appropriate or effective for women/adolescent girls or men/adolescent boys or both;
- Activities, messages, and practices may reinforce gender stereotypes;

- Women/adolescent girls and/or men/adolescent boys may not be able to access services or information;

- Gender roles may negatively influence the ability of women/adolescent girls or men/adolescent boys to participate in the program;

- Program results may not be achieved;

- Ownership of the HIV prevention program/activity by communities may be undermined; and

- Conflicts and disagreements may arise between women and men, adolescent girls and boys, which may lead to violence.

By applying gender analysis and gender integration, program planners and managers can design or tailor HIV interventions and support services to address the specific gender-based issues and needs of the target population for which they are intended. Integrating a gender perspective helps enhance the *gender-responsiveness* and improve the quality and effectiveness of HIV prevention programs and support services for women and adolescent girls. It identifies and addresses the following:

- Underlying gender and sexual norms and inequalities in the roles, relations, and status of women and men, girls and boys that will constrain achievement of HIV prevention program goals;

- Other social determinants of health that will impede achievement of HIV prevention goals;

- Gender bias in HIV prevention programs and services;

- Gender-based constraints to service delivery experienced by diverse groups of women and men, girls and boys;

- Gender inequalities in participation in programs and services and the benefits received by women and men, girls and boys, of different social groups;

- The unique HIV prevention and support needs of women and girls of diverse social groups and promoting their empowerment throughout the programming process; and

- Organizational constraints and capacity-building needed to respond to gender issues, support gender-responsive programs and support services, and promote gender equity and equality.[2,4,5]

Ultimately, gender integration contributes to the health and well-being of women and men, girls and boys, of different social groups, by ensuring actions are taken to promote and protect their human rights, including the rights to health and gender equality.

5.5 Why are Gender Analysis and Gender Integration Important in HIV Prevention Programming?

Efforts to prevent sexually acquired HIV infection among women and adolescent girls have mainly focused on promoting abstinence, monogamy, and consistent use of male and female condoms. However, adoption of these risk-reduction strategies does not happen in isolation from other factors. Sexual interactions between women and men, girls and boys take place within the context of gender norms, roles, and relations. Within the context of unequal power in gender relations and other socioeconomic disadvantages, women and adolescent girls often do not have absolute control over whether, when, or with whom to have sex; the fidelity of their male partners; or the use of condoms (male or female).

Gender norms and relations also shape HIV vulnerability for men and adolescent boys. Norms of masculinity that encourage risk-taking, multiple sexual partners, and violence as well as those that discourage health-seeking behaviors place them and their female or male sexual partners at increased risk of HIV infection. Homophobia and the resulting stigma and discrimination place many MSM and transgender persons at risk of violence from men because their gender and sexual identities, same-sex behaviors, or both challenge dominant ideologies and norms of masculinity. Some MSM also have sex with women to hide their same-sex behaviors and avoid ostracism. This can lead to an increase in riskier sex and drug use behaviors.

5.6 What are Gender Analysis Frameworks?

A number of different frameworks have been developed by gender experts, primarily in the field of development, and then adapted by practitioners to guide the gender analysis process. Each framework is based on particular sets of assumptions about gender and why it is important to understand gender issues to achieve successful program outcomes.

Gender analysis frameworks generally focus on specific aspects or "domains" of social and cultural relations within a given context. Common domains of gender include gender differences in roles and responsibilities (sexual division of labor), access to and control over resources, power, decision making, and empowerment at different levels (interpersonal, communal, institutional, and societal). Program planners and managers can select a specific gender analysis framework, adapt a combination of elements from different frameworks, or develop appropriate methods that are suitable to their organizational and programmatic contexts and needs.

> *Resource for Gender Analysis Frameworks*
>
> *A Guide to Gender- Analysis Frameworks* by Candida March, Ines Smyth, and Maitrayee Mukhopadhyay provides a review of the main gender analysis frameworks, step-by-step instructions for using them, and summaries of advantages and disadvantages of each

This Toolkit draws on concepts from a number of different frameworks and uses the domains of gender norms, gender roles, access to and control over resources, and power and decision making in the gender analysis process described below.

Table 1, *Assessing Key Gender Issues: Gender Framework to Explore*, summarizes key issues considered in gender analysis and identifies some gender analytical frameworks for analyzing these issues. This table may be helpful to program planners and managers when considering frameworks that would be most applicable to their particular program and organizational contexts.

Table 1: Assessing Key Gender Issues: Gender Framework to Explore		
Domains	**Issues to Consider**	**Framework(s) to Explore**
Norms • How do gender norms influence constraints for women/girls or men/ boys or both? • How do gender norms influence opportunities for women/girls or men/ boys or both?	*Gender division of labor* *Access to and control over resources*	Harvard Analytical Framework
Roles and Responsibilities • What do women/girls ormen/boys or both do? • Where? At what location? What are the patterns of mobility? • When? What are the daily patterns?	*Productive roles:* paid work, self-employment *Reproductive roles:* domestic work; childbearing; care of children, the sick, and the elderly *Community management:* participation or self-help or both; voluntary work for the benefit of the community as a whole *Community politics:* decision making or representation or both on behalf of the community	Harvard Analytical Framework *Moser's Gender-Planning Framework* (focus on practical and strategic needs)
Access to and Control over Resources • What assets, resources, and opportunities do women/girls or men/boys or both have access to? • What constraints do they face?	*Human:* health services, education, social services, knowledge, skills *Social:* institutions, organizations, social networks *Physical:* housing, neighborhood *Economic:* poverty, income, occupation, employment	*Social Relations Approach* (focus on distribution of resources)
Power and Decision Making • What decisions do women/ girls and/or men/boys participate in? • What decision-making activities do women/girls and/ or men/boys usually control? • What constraints do women/girls and/or men/boys face?	*Household/Family level:* decisions over household expenditures *Community level:* decisions over management of community resources	*Social Relations Approach* (focus on distribution of responsibilities and power) *Women's Empowerment Framework* (focus on 5 levels of equality useful in looking at power)
Needs, Priorities, and Perspectives • What are women's/girls' or men's/boys' needs and priorities? • What perspectives do they have on appropriate ways of addressing their needs?	*"Practical" gender needs:* in the context of existing roles and resources, e.g., more convenient location of healthcare services, childcare services *"Strategic" gender needs:* requiring changes to existing roles and resources to create greater equality of opportunity and benefit Experience and views on improved services-delivery systems; prioritized services, location, type, and cost of services; systems of operation, management, and maintenance, etc.	*Moser's Gender Planning Framework* (focus on practical and strategic needs)

Source: New Zealand's International Aid and Development Agency. *NZAID Gender Analysis Guideline* (1997). *http://nzaidtools.nzaid.govt.nz/sites/default/files/tools/1195062.pdf*

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5.7 What are the Steps in Gender Analysis?

The gender analysis process entails a series of key steps that are illustrated in Figure 2, *Steps in Gender Analysis*. They include identifying gender differences in the patterns of HIV/AIDS within a specific context, analyzing the underlying gender relations and inequalities contributing to these gender differences, and assessing the consequences of gender inequalities for HIV prevention programming and gender equality. While these steps are presented in a linear fashion, it is important to keep in mind that gender analysis is a complex process that is neither linear nor unidirectional. The description may not capture all of its complexities and nuances. However, it does provide the rationale for and gives guidance to assist program planners and managers in undertaking gender analysis.

Figure 2: Steps in Gender Analysis

1. Identify Gender Differences in HIV/AIDS

2. Analyze Underlying Gender Relations & Inequalities

3. Assess the Consequences for HIV Prevention
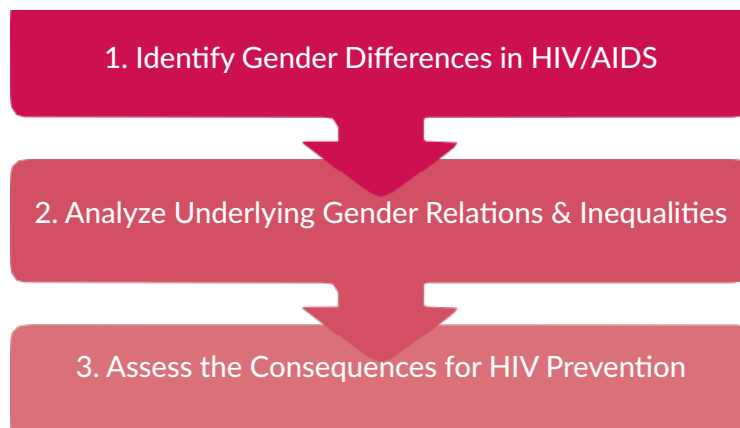
5.7.1 Step 1: Identify Gender Differences in Patterns of HIV/AIDS

This step focuses on the *"what"* of gender analysis and lays the foundation for subsequent steps in the process. During this step, sex-disaggregated epidemiological data, behavioral data, and service utilization data are collected and examined to determine differences in the patterns of HIV vulnerability, risk, infection, and impact between women and men. Consider the difference in what is revealed about an issue by data not disaggregated by sex as compared to sex-disaggregated data in Table 2, *What Do Sex-Disaggregated Data Reveal?*

Table 2: What Do Sex-Disaggregated Data Reveal	
Data Not Disaggregated By Sex	**Sex-Disaggregated Data**
According to 2010 estimates, 46,913 diagnoses of HIV infection were reported among adults and adolescents in the U.S.	Females accounted for 9,868 and males for 37,045 of the estimated 46,913 diagnoses of HIV infection among adults and adolescents reported in the U.S. in 2010.
Heterosexual transmission accounted for an estimated 12,875 of the 46,913 diagnoses of HIV infection among adults and adolescents reported in the U.S. in 2010.	According to estimates, females accounted for 8,459 and males for 4,416 of the 12,875 diagnoses of HIV infection due to heterosexual transmission reported among adults and adolescents in the U.S. in 2010.
Source: Centers for Disease Control and Prevention. *HIV Surveillance Report*, 2010 22 (March 2012). http://www.cdc.gov/hiv/topics/surveillance/resources/reports/	

What differences between females and males do the data disaggregated by sex reveal? How can this information help in planning HIV prevention programs?

If available, data are also disaggregated by race, ethnicity, age, SES, sexual orientation, immigrant status, and any other relevant social groupings. Disaggregating data in this way provides a fuller picture because it also differentiates among women and men, girls and boys. See Table 3, *What Do Data Disaggregated by Race and Ethnicity Reveal?*

Table 3: What Do Data Disaggregated by Race and Ethnicity Reveal?	
Data Not Disaggregated By Race/Ethnicity	**Data Disaggregated By Race/Ethnicity**
According to 2010 estimates, 46,913 diagnoses of HIV infection were reported among adults and adolescents in the U.S.	Of the estimated 46,913 diagnoses of HIV infection among adults and adolescents in the U.S. in 2010: • 225 American Indians/Native Americans • 812 Asians • 21,712 Blacks/African Americans • 9,620 Hispanics/Latinos • 64 Native Hawaiians/Other Pacific Islanders • 13,844 Whites
According to estimates, females accounted for 8,459 of the 12,875 diagnoses of HIV infection attributed to heterosexual transmission among adults and adolescents reported in the U.S. in 2010.	Of the estimated 8,459 diagnoses of HIV infection due to heterosexual transmission reported among female adults and adolescents in the U.S. in 2010: • 46 American Indians/Native Americans • 125 Asians • 5,539 Blacks/African Americans • 1,34 Hispanics/Latinos • 1,295 Whites
Source: Centers for Disease Control and Prevention. *HIV Surveillance Report*, 2010 22 (March 2012): Table 3a. *http://www.cdc.gov/hiv/topics/surveillance/resources/reports/*. Published March 2012.	

What do data disaggregated by race and ethnicity reveal about:

• Groups most affected by HIV infection in the U.S.?

• Groups of women and adolescent girls most affected by HIV infection in the U.S.?

• Groups of women and adolescent girls most affected by heterosexual transmission?

The data collected during this step are primarily quantitative. Analysis of quantitative data will help point to critical disparities in the patterns of HIV infections, AIDS, and access to services. Findings will help to prioritize: those most affected by, and those most vulnerable to, HIV infection and AIDS; what the focus of intervention efforts should be; and what the focus of gender analysis will be. The findings of the analysis may reveal the fact that there are some things occurring that vary in their effect on women and men of different social groups. They will also suggest where to further investigate dynamics causing these differences. Qualitative information can also be collected by program planners and managers to support quantitative data and provide context for analysis using in-depth interviews or focus groups with community leaders, program clients, staff, and stakeholders.

5.7.1.1 The "Know Your Epidemic" Approach

The "Know Your Epidemic" approach can be used to focus the gender analysis during Step 1, Identify Gender Differences in HIV/AIDS." [6] This approach promotes HIV prevention strategies that are tailored to the local contexts of epidemics based on evidence gained from analysis of epidemiological and behavioral data. HIV/AIDS epidemiological and behavioral data as well as data related to access to services, treatment outcomes, and burden of care, must be disaggregated by sex and other social categories in order to identify key patterns of the epidemic.

5.7.1.2 Sources of Data

Data to inform the analysis of underlying sociocultural, economic, political, and legal conditions and factors may be collected from secondary sources such as census and other government reports as well as social and economic research studies. Relevant data should be gathered on other health issues related to HIV/AIDS, such as drug and alcohol abuse, mental health, gender-based violence including VAW and IPV (see Section 2.2.1), child abuse, health insurance coverage, healthcare access, and service utilization. Information should also be collected on related issues such as income and employment, occupation, educational attainment and literacy levels, housing and homelessness, residential segregation, immigration and citizenship status, cultural patterns, commercial sex work and sex trafficking, and arrests and incarceration rates, among others.

Qualitative data provide more nuanced information about particular groups of women and men, girls and boys, including those who are more vulnerable and marginalized. This type of information is better suited to inform analysis of underlying gender norms, roles, and relations because the data help to explain why people behave in particular ways or make particular choices. Through in-depth interviews or focus groups, women and girls can be asked about their perceptions of the problems they face and can offer possible solutions. Through interviews and focus groups, researchers can learn more about the participants' values, beliefs, gender norms, gender roles and responsibilities, access to and control over resources, power and decision making, opportunities and constraints, sexual relationships, behaviors, practices, needs, and priorities. The information obtained through these discussions provide context and a deeper understanding for gender analysis.

5.7.1.2.1 Using Secondary Data Sources

Secondary data sources such as HIV/AIDS surveillance reports, behavioral surveys, and service utilization reports can provide information about HIV/AIDS incidence and prevalence rates; risk factors and behaviors; health status; and access to and utilization of HIV testing, prevention, treatment, care, and support services. Examples of relevant secondary data sources can be found in Table 4, *Examples of HIV/AIDS-related Secondary Data Sources*. Existing data may not provide a full picture of the local context in which programs will be offered. There will be gaps in information where appropriate sex-disaggregated data are not available, and unintentional biases in data may misrepresent the overall situation.

It is important to expand data collection beyond existing official statistics as they may ignore or undercount certain populations. Those populations may include sub-groups of Native Americans, Hispanics, Asian-Americans/Pacific Islanders, Black/African Americans, immigrants, and sexual minorities such as lesbians, bisexual women, other WSW, and transgender persons, etc.). Local surveys may be needed to address gaps and biases in data and capture the nature and extent of HIV/ AIDS and patterns of utilization of HIV-related services among historically undercounted groups.

Table 4: Examples of HIV/AIDS-related Secondary Data Sources		
Data Source	Description	Indicators of Interest
CDC's HIV Surveillance Reports *http://www.cdc.gov/hiv/library/reports/surveillance/.*	These annual reports have been produced since 1982 to describe the HIV burden in the U.S. disaggregated by age, sex, race, transmission category, and geographic area (state and metropolitan areas).	HIV diagnoses, people living with HIV, AIDS (stage 3) diagnoses, AIDS-related deaths
CDC's National Center for HIV/AIDS, Viral Hepatitis, STD, and TB Prevention Atlas *http://gis.cdc.gov/GRASP/NCHHSTPAtlas/main.html*	An interactive platform to access CDC surveillance data at the state and county level on disease burden. Data can be disaggregated by year of interest, age, sex, race, and transmission category.	HIV diagnoses, people living with HIV, AIDS (stage 3) diagnoses, AIDS-related deaths, gonorrhea, chlamydia, syphilis, hepatitis c, tuberculosis
Behavioral Risk Factor Surveillance System *http://www.cdc.gov/brfss/index.html*	Annual cross-sectional telephone survey on health-related risk behaviors, chronic health conditions, and use of prevention services. Data is available at the state and county level.	HIV knowledge and prevention, substance use, mental illness, health care coverage
Youth Risk Behavior Surveillance System *http://www.cdc.gov/healthyyouth/data/yrbs/data.htm*	A bi-annual survey conducted in high schools from a representative sample of 9th through 12th graders on sexual risk behaviors, substance use, and health and lifestyle indicators. Data is available at the National, State, and Metropolitan area level.	Sexual risk behaviors, condom use, HIV/AIDS knowledge, substance use, HIV prevention education, HIV testing, sexual health service access
National Survey on Drug Use and Health *http://www.samhsa.gov/data/population-data-nsduh*	Annual face-to-face interviews of a representative population sample collecting data on substance use, mental illness, co-occurring morbidities, and treatment in people aged 12 years and older. Data is available at the national, state, and metropolitan area level.	Mental illness, substance use, drug/alcohol dependence, co-occurring morbidities, substance use treatment, mental health treatment, unmet needs

5.7.1.2.2 Methods for Collecting Data

There are a number of ways to collect the qualitative information needed for gender analysis. Qualitative data may be obtained from secondary sources such as focus group reports, community-needs assessments done by other agencies or organizations, and research studies regarding knowledge, perceptions, attitudes, behaviors, and influencing factors. Qualitative data may also be collected directly by conducting surveys, focus groups, in-depth individual interviews, key informant interviews, and field observations. The combination of sources and types of data used, as well as methods of collection employed, will depend on the purpose and focus of the gender analysis and the balance between the need for in-depth information and the resources available to collect the data.

5.7.1.2.3 Factors Influencing Accuracy and Inclusiveness of Data

Gathering qualitative sex-disaggregated data that is specific to the local context and program requires consultation with women and adolescent girls for whom the program is intended as well as with other key stakeholders and local groups, including women's groups. Participatory methods provide opportunities to hear from women and men, girls and boys, separately and jointly, so all perspectives are heard.

A number of factors may influence the accuracy and inclusiveness of data collected. Program planners and managers should consider the factors discussed below to determine how they might reduce bias and gender stereotyping and increase the accuracy and inclusiveness of the collection and analysis of data:

- *Who is Present:* Gender norms and unequal power relations among participants may affect the willingness of some individuals to speak up and express their opinions, beliefs, attitudes, or feelings openly. Sex, racial or ethnic background, SES, age, sexual orientation, gender or sexual identity, legal status, and other factors may inhibit individuals' participation in mixed groups. For example, depending on their cultural background, women or girls may respond very differently to questions about sexuality and sexual behaviors, their social activities, and views about gender relations if men or boys are present. Men or boys may talk more or answer questions first, and women or girls may be reluctant to speak up or disagree even if the information provided is inaccurate. Young persons may be intimidated and unwilling to speak up in front of adults. These dynamics may result in biases in the information gathered.

- *Time of Day and Location:* Women or girls may not be available at certain times of day, and men or boys may be less likely to be present at other times. It is important to choose both a time and place that is convenient for all involved, so individual and group interviews or other participatory information-gathering activities can be conducted. Women and men may be less available during work hours, and girls and boys during school hours. Women may also have difficulties participating because of childcare responsibilities.[9]

- *Who is the Facilitator/Interviewer:* In some cultures and situations, responses to questions will be more accurate if facilitators or interviewers and respondents are matched by gender or other factors such as age, race or ethnicity, or sexual orientation. For example, women or adolescent girls may be more willing to provide information, especially regarding sexual behaviors, attitudes, gender norms, and practices to a female interviewer, while men or adolescent boys may be more comfortable providing such information to a male interviewer. Training and supporting women and men to collect and interpret data from their peers is one way of involving them in program planning, implementation, and monitoring. It may increase the accuracy and quality of data and its analysis.[9]

- *Language Difficulties:* There may be differences in language proficiency between women and men who speak English as well as in those who speak a language other than English. There may also be gaps between women and men in language proficiency where gaps in education and literacy between males and females are significant.[9]

Program planners and managers should take these and other factors that may affect the accuracy and inclusiveness of information collected into account and take actions to reduce bias. The following are examples of some steps that can be taken:

- *Collect Information on All Relevant Work:* Overlooking unpaid work will result in under-reporting and misrepresentation of both women's and men's workload. Without this information, it can be difficult to identify constraints. Women's work is typically undervalued or "invisible" to men and outsiders. Men may not give accurate information about what women do, how long it takes to do it, where the work is done, or who benefits from different activities. [9]

- *Engage Local Women's Organizations or Groups:*
  Women's organizations and groups, especially those for HIV-positive women, can be accurate sources of information about the gender division of labor; patterns of decision making; access to resources; women's and men's needs, priorities, and strengths; how gender relations are changing; and the factors causing changes in gender relations. Women's organizations may have a rich knowledge of how current HIV prevention activities and trends are helping or hindering women and men. With adequate resources, these types of organizations can be effective in encouraging the participation of women and men, girls and boys, of different social groups.[9]

> **_Considerations for Data Collection_**
>
> • Did data collection allow for full participation of women and men, girls and boys, of different socioeconomic, racial, and ethnic groups, including those living with and affected by HIV/AIDS?
>
> • Did data collection occur in a safe and supportive environment?
>
> • Do data include information from women and men, girls and boys, including those living with HIV/AIDS, civil society, community leaders, etc.?

- *Cross-check Data:* Regardless of the data collection method used, it is always necessary to cross-check data for accuracy and bias, including gender bias. Local women's groups and female researchers, as well as other key community informants, may assist with the analysis of data and may indicate differences in perceptions about social and economic conditions. Using a range of reliable informants' knowledgeable about the target group and women's and men's experiences is important.[9]

- *Engage Technical Experts:* When possible, it is helpful to include a social scientist with expertise in participatory data collection and gender analysis on the program planning team.[9]

5.7.2 Step 2: Analyze Underlying Gender Relations & Inequalitie

Step 2 focuses on the "why" behind the sex differences in the patterns of HIV and AIDS that were identified in Step 1. Step 2 is at the heart of gender analysis. During this step, gender analysis seeks to uncover the underlying gender norms and relations as well as sociocultural, economic, political, and legal factors that drive gender differences in the patterns of HIV/AIDS in the local context in which the program and services will be offered. This step is consistent with the "Know Your Epidemic" approach. It emphasizes the importance of analyzing the complex relationships between the epidemiology of HIV infection, the risk behaviors that transmit HIV, and the cultural, institutional, and structural factors (or SDH) that contribute to the differences in women's and men's vulnerabilities and risks for HIV/AIDS.[6]

The process of analysis during Step 2 helps program planners and managers identify the gender-based opportunities (GBOs) but more so the gender-based constraints (GBCs) that shape differential vulnerability to and risk of HIV and AIDS.

Gender-based opportunities (GBOs) are factors that facilitate women's or men's equitable participation; rights; exercise of power and decision making; use of time; and access to and control over resources, based on their gender identity.

Gender-based constraints (GBCs) are factors that limit or restrict women's or men's behaviors, participation, rights, exercise of power decision making, use of time, and access to and control over resources or opportunities, based on their gender identity. Gender-based constraints include

the inequalities that are revealed by sex-disaggregated data collection and gender analysis as well as the broader environmental factors and processes that contribute to a specific condition of gender inequality.[7]

During Step 2, the statistical data collected in Step 1, in combination with qualitative information collected by a program, are systematically analyzed to identify the principal practices that are causing gender differences in patterns of HIV infection and AIDS, the context in which these practices occur, and the major underlying forces that motivate and sustain these practices. Some gender differences identified in Step 1 may not be relevant to HIV prevention. Step 2 entails identifying relevant GBCs and considering the underlying factors creating those constraints.

More contextualized descriptive and analytic information is needed during this step to examine and understand how gender relations as well as sociocultural, economic, political, and legal factors increase certain women's and men's, girls' and boys', vulnerability to HIV and AIDS. Inferences can be made about the gender issues, risk factors, behavior patterns, and conditions that need to be explicitly addressed in order for HIV prevention programs and services to succeed.

The domains of gender described in Section 5 and depicted below in Figure 3, *Gender Analysis Domains*, provide a framework to analyze the underlying gender relations influencing vulnerability to and risk of HIV for women and adolescent girls.

Figure 3: Gender Analysis Domains

Levels of Analysis

- Partnerships
- Households
- Communities
- Health Services
- Organizations/Institutions
- Goverment
- Economic Markets
- International

Environment
(Living and working conditions shaped by social determinants of health)

Gender Norms
(Behavioral expectations shaped by gender ideologies - values, beliefs)

Biological

WOMEN'S AND GIRLS' VULNERABILITY FOR HIV/AIDS

Gender Roles
(Responsabilities and activities assigned to woman and men, girls and boys)

Power and Decision making

Access to and Control over Resources

Adapted from: Eckman, A.,D. Luciano, and K. Boyd-Lewis. Office on Women's Health (OWH) Gender-Based Programming: What does this mean? How do we know when we "see it"/do it? (PPT presentation, 2010).

The domains are the environment (sociocultural, economic, political, legal factors), gender norms, gender roles, access to and control over resources, and power and decision making. While power and decision making are presented as a distinct domain, it is important to keep in mind that the different relations in each of the other domains influence the different levels of power to which women and girls, and men and boys, have access in a specific context. Thus, power is also a cross-cutting dimension.

For each domain, gender analysis focuses on examining the GBOs and GBCs women and men, girls and boys, face that influence their vulnerability to HIV/AIDS.

Tool 1, *Gender Analysis Matrix: Underlying Influences on Gender Relations*, provides a framework to consider and analyze the underlying environmental and gender-related factors that may affect women's and men's differential vulnerability to and risk for HIV infection and AIDS. This matrix can be used flexibly, allowing for consideration of a wide range of factors in a particular context that influence HIV/AIDS vulnerability and risk.

Tool 1: Gender Analysis Matrix: Underlying Influences on Gender Relations				
	Levels of Analysis			
Why do different groups of women and men, girls and boys, acquire HIV infection and develop AIDS?	Sexual Partnerships	Households	Communities	Government, Economic Markets, International Relations
How do biological factors affect differences in patterns of HIV infection and AIDS between women and men, girls and boys?				
How do factors in the environment influence patterns in HIV/AIDS?				
How do gender norms affect patterns in HIV/AIDS?				
How do gender roles affect patterns in HIV/AIDS?				
How does access to and control over resources influence patterns in HIV/AIDS?				
How does power and decision making influence patterns in HIV/AIDS?				
Adapted from: Gender Analysis Framework. Gender and Health Group, Liverpool School of Tropical Medicine. *http://www.lstmliverpool. ac.uk/research/academic-groups/international-health/gender-and-health-group/*				

5.7.2.1 Using the Gender Analysis Matrix: Underlying Influences on Gender Relations

Many factors influence and help to explain why there are gender differences in HIV and AIDS between and among different groups of women and men. In addition to the environmental factors and the gender-related domains illustrated in Figure 3, *Gender Analysis Domains*, this matrix also includes a row to consider biological factors that influence vulnerability to and risk for HIV/AIDS.

For each domain listed in the left-hand column of the matrix, identify and examine the underlying factors that contribute to the related gender-based constraint within the specific context where the program or services will be offered. Since GBCs vary across social relationships that occur at different levels and sociocultural contexts, it is important to examine each GBC at the different levels of analysis listed in the columns across the top of the matrix. These levels are partnerships;

households; communities; and bodies such as government, civil society organizations, economic markets, and international relations. Sociocultural contextual factors include race, ethnicity, age, SES, sexual orientation, and residence. The analysis should identify existing disparities and determine why such disparities exist and whether they are harmful.

Partnerships refer to the intimate and sexual relationships between women and men, girls and boys.[8]

Households refer to family groups and what goes on in the home.[8]

Communities refer to groups of people whose association is based on geographical locations with some recognized structure or cultural links such as race, ethnicity, sexual, or gender identities.[7]

Governments, civil society, markets, and i*nternational relations* refer to the wider context such as national and international laws, government structures and services, the private sector, community-based organizations, and the services they provide.
The focus goes beyond health and public health policies and services. It can include other policies relevant to HIV/AIDS such as those addressing employment, education, social welfare, criminal justice, VAW, substance abuse, mental health, housing, and homelessness.[8]

5.7.2.2 Description of Gender Domains for Gender Analysis

The Gender Analysis Matrix is intended to stimulate appropriate questions regarding the different gender domains and how they are interrelated at different levels to broaden understanding of the influence of gender on HIV infection and AIDS patterns as well as health.[8] The gender domains in the matrix are interrelated, and there is some overlap between them.[8] It is not necessary to repeat information that has already been covered in a specific domain if it is applicable to another domain.[8]

Program planners and managers work in different contexts and therefore have varying needs for detailed information. The matrix does not have to be fully completed. It should be used creatively to meet the need for information to complete the gender analysis and to apply that information in planning and delivering HIV prevention programs and services within a particular local context.[8]

Gender Domain: Biological Factors

This domain takes into account biological and physiological differences between women and men, girls and boys, and how these factors may interact with gender norms and relations to explain differences in the patterns of HIV infection and AIDS between women, men, girls and boys. For this domain, consider the following:

- Do biological factors explain why women and men, girls and boys, are affected differently by HIV and AIDS?

- Does the sex of the individual increase risk or vulnerability for HIV infection or developing AIDS?

- Do age or physiological factors such as hormone levels explain differences?

- Do biological and physiological factors interact with gender norms and relations to produce the observed differences?

Gender Domain: Environment

This domain focuses on factors in the larger social, cultural, economic, and political contexts that produce constraints and opportunities in women's and men's living and working conditions.

Gender analysis examines how constraints and opportunities resulting from these macro-level forces are different for women and men, girls and boys, and how they might explain the different patterns of HIV infection and AIDS among women and men of different social groups. These factors are social determinants of health. For example, poverty affects living conditions, women and girls are disproportionately represented among the poor, and women living with HIV in the U.S. are more likely to be poor. For this domain, consider the following:

- Do significant gender differences exist in women's and men's, girls' and boys' living conditions (e.g., food, shelter, etc.) and working conditions (e.g., working hours, terms and conditions, holidays, benefits, etc.)?

- Do environmental, structural (demographic, social, economic, legal, and institutional), cultural, religious, and attitudinal factors influence the status and living and working conditions of women and men, girls and boys, differently?

- Do environmental factors produce different constraints and opportunities for women and men, girls and boys, that, in turn, affect their living and working conditions (e.g., social stratification, laws, policies, regulations, values, etc.)?

- Do gender differences vary by such factors as race, ethnicity, sexual orientation, gender identity, age, education, income, occupation/employment, substance abuse, immigration, homelessness, or geographical location?

- Which factors differentially shape HIV vulnerability and risk for women and men, girls and boys, of different social groups?

Gender Domain: Gender Norms

This domain refers to behavioral expectations of women and men that are based on values and beliefs about their different capacities, characteristics, roles, and interests. Gender norms are rules or guidelines for behavior that are usually unspoken. Gender norms vary by social group and context but are influenced by the interests and values of the most powerful groups in society (e.g., men, heterosexuals, Whites). For example, in social groups where having children is highly valued and tied to what it means to be a man or woman, using condoms during sex may be perceived as a barrier to fulfilling the expectation to have children for women and men.

For this domain, consider how gender norms related to the issues listed below (and others program planners and managers may identify) might influence HIV risk factors and behaviors differently for women and men, girls and boys:

- Expression of sexuality
- Sexual knowledge and experience
- Sexual communications
- Sexual decision making
- Initiation of sexual interaction
- Reproduction (i.e., motherhood, fatherhood, contraception)

- Health-seeking behaviors
- Sexual behaviors
- Sexual risk-taking
- Dominance
- Aggression and violence
- Monogamy
- Virginity

Gender Domain: Gender Roles

Gender roles are influenced by gender norms and encompass the roles, responsibilities, tasks, and activities considered appropriate for women and men, girls and boys. They include the following:

- *Productive roles* – paid work generally outside the home or the production of goods for subsistence or sale.

- *Reproductive roles* – domestic tasks such as cooking, cleaning, washing, and caring for children, the elderly, and the sick.

- *Community roles* – participating in various tasks related to managing community organizations, operating and maintaining community services, or participating in formal political activities.

Different roles, responsibilities, tasks, and activities carry different risks for HIV infection and health. For example, women and girls often have major responsibility for reproductive roles and community management work. Women who work outside of the home may be overburdened if they are also expected to carry full responsibility for housework and care giving, as well as community work. This work burden may limit their time to seek HIV prevention information and services and to participate in prevention programs.

For this domain, consider the following:

- Do daily activities of women and men, girls and boys, affect risk of and vulnerability to HIV infection and AIDS?

- Do paid and unpaid work of women and men, girls and boys, affect risk for and vulnerability to HIV infection and AIDS?

- Do excess burdens of work of women and men, girls and boys, affect risk for and vulnerability to HIV infection and AIDS?

- Does lack of paid work affect women's and men's, girls' and boys', risk of and vulnerability to HIV infection and AIDS?

Gender Domain: Access to and Control over Resources

This domain refers to gender differences in women's and men's, girls' and boys', access to and control over resources such as income, information, education, employment, transportation, time, services, benefits, and political power and influence. Access to refers to the ability to access or use a resource, while control over refers to the ability to make decisions about how a resource will be used. For example, laws or policies restricting schools from providing comprehensive sexuality education limit adolescents' access to and use of information on sexuality, reproductive health, and HIV prevention that will help them to protect their own health.

For this domain, consider the following:

- Are there gender differences in women's and men's, girls' and boys' access to and control over resources that affect their ability to avoid HIV infection and thus protect their own health?

- Will educational opportunities influence women's and men's, girls' and boys', vulnerability to and risk of HIV infection and AIDS?

- Does paid employment opportunities influence women's and men's, girls' and boys', vulnerability to and risk for HIV infection and AIDS?

- To what degree will people conform to or breach gender and sexual norms related to sexuality and how can their actions and decisions affect their access to and control over resources?

Gender Domain: Power and Decision Making

This domain concerns the extent to which women and men, girls and boys, are in a position to act in their own best interests to protect themselves from HIV infection and ill health related

to HIV. It depends on personal perceptions of self-interest but also on an individual's ability to make decisions, command resources, and influence the behavior of others. Often women's and girls' power and decision making is limited by gender norms, which constrains their ability to act in their own best interests. It is gender norms that influence who makes decisions and who has access to and control over resources in partnerships, households, and communities.

For example, a woman may be aware that her husband has other sexual partners, but she may not be in a position to insist that he use a condom or that he cooperate so she can use a female condom. Her husband's behavior may be influenced by gender norms that encourage men to have multiple sexual partners to exhibit their sexual prowess and masculinity. Gender norms that expect women to be monogamous and that condone male violence as a way to control women may fuel her fear of accusations of infidelity, violence, or abandonment. In turn, these fears can limit her power to negotiate condom use and thus increase her risk of HIV/STD infections.

For this domain, consider the following:

- Are women and men, girls and boys, able and willing to avoid HIV infection due to power imbalances?

- Are there significant gender differences in women's and men's, girls' and boys', ability to avoid HIV infection and thus protect their own health?

- Can women and men, girls and boys, make independent decisions regarding HIV risk reduction and use of HIV-related services and thus protect their own health?

- Are there gender differences in the ability of women and men, girls and boys, to negotiate with others about HIV risk reduction and use of HIV-related services?

5.7.2.3 Formulating Gender-Based Constraint Statements Based on Gender Analysis

Once the gender analysis has been completed, it is important to organize the information and findings in a way that will help identify the steps that need to be put in place. Some ways to organize the information follow:

- Identify the types of inequalities existing in the communities in which the program or services will be offered;

- Distinguish the areas of inequalities that are relevant to HIV prevention programs and services;

- Link these areas of inequalities to the underlying factors that cause the inequalities; and

- Formulate GBC statements

A GBC statement describes the causal relationship between the identified gender inequality and the underlying factors that cause the inequality. GBC statements can serve as the basis for identifying action steps that need to be put in place to achieve HIV prevention and gender equality goals at each level of social relationships (partnerships, households, communities, etc.). A GBC statement has three parts:

1. Who is being affected (the who)?
2. What result is being limited (the condition)?
3. What causes that limitation (the factor)?

Tool 2, *Formulating Gender-based Constraint Statements*, provides a framework to organize the information and findings of the gender analysis and formulate GBC statements. Under Column 1, the environmental and gender relations domains are listed. For each domain, moving across the matrix from left to right, list the observed unequal condition (Column 2) and the underlying factors leading to the observed gender inequalities (Column 3). In Column 4 write a gender-based constraint statement that includes who is being affected, the gender inequality (condition), and the underlying causes (factors) of the gender inequality.

Tool 2: Formulating Gender-based Constraint (GBC) Statements			
1) Domain	2) Observed Unequal Condition(s)	3) Factors Leading to the Observed Gender Inequalities	4) Gender-based Constraint Statement
Environment			
Gender Norms			
Gender Roles			
Access to and Control over Resources			
Power and Decision Making			
Adapted from Development & Training Services, Inc. (dTS). Promoting Gender Equitable Opportunities in Agricultural Value Chains: Handbook (2009), 94. *http://pslforum.worldbankgroup.org/docs/USAIDPromotingGenderOpportunities.pdf*			

In Step 2 of Gender Analysis, Analyze Underlying Gender Relations & Inequalities, the qualitative information collected from individual interviews and focus groups can be used to prioritize the GBCs. Keep in mind that there may be multiple factors leading to the observed conditions of gender inequality. There may also be a series of factors that build on one another to create gender inequalities. For example, concurrent sexual partnerships in minority communities place women at increased risk of HIV infection. The factors that contribute to this problem occur at multiple levels (societal, community, partnerships, individual).

Discriminatory practices and criminal sentencing policies lead to disproportionately higher rates of incarceration among minority men. The removal of large numbers of men from minority communities creates a low sex ratio in these communities. The remaining men have a larger pool of women from which to choose partners, which enables them to engage in overlapping sexual partnerships with two or more women. The shortage of men gives women in these communities less bargaining power in sexual relationships with men who are also involved with other women. Women who want to keep their male sexual partner may be more tolerant of the infidelity and less inclined to insist on condom use because they may fear their partner will leave them.

Tool 3, *Consequences of Gender-based Constraints or Opportunities for HIV Prevention and Gender Equality*, shows which factors contribute to the GBC operating at different levels. Consequently, actions may be required at multiple levels to address the constraint. The GBC statement identifies underlying factors contributing to the constraint and suggests possible areas of action at varying levels that might be incorporated into program interventions and activities to address the specific GBC.

Tool 3: Consequences of Gender-based Constraints or Gender-based Opportunities for HIV Prevention and Gender Equality			
1. Gender-Based Constraint or Opportunity	How Will the Gender-Based Constraint or Gender-Based Opportunity Affect:		4. Prioritizing Gender-based Constraints or Opportunities
Domain	2. The Achievement of HIV Prevention Program Goals	3. The Relative Status of Women/Girls and Men/Boys	
Environment			
Gender Norms			
Gender Roles			
Access to and Control over Resources			
Power and Decision Making			
Adapted from Development & Training Services, Inc. (dTS). Promoting Gender Equitable Opportunities in Agricultural Value Chains: Handbook (2009), 98. *http://pslforum.worldbankgroup.org/docs/USAIDPromotingGenderOpportunities.pdf*			

5.7.3 Step 3: Assess the Consequences for HIV Prevention

The final step in the gender analysis process is to translate the findings from Step 1, Identify Gender Differences in HIV/AIDS, and Step 2, Analyze Underlying Gender Relations & Inequalities, into implications for HIV prevention and gender equality. Step 3 is the "so what" of gender analysis and will be the basis for developing or adapting HIV prevention programs and services. Analysis during this step will help program planners and managers connect GBCs or GBOs with the goals and objectives of the prevention program and assess the implications of the constraints or opportunities for different aspects of the program.

Gender inequalities can be relevant to HIV prevention goals either because they contradict one or more of those goals or because they can act as constraints to accomplishing prevention goals. This step in the gender analysis process is focused on examining the consequences of gender relations in each domain for HIV prevention. Specifically, during this step, the analysis seeks to understand how gender relations in each domain present a potential opportunity or constraint to achieving the proposed HIV prevention program or services outcomes, and how the HIV prevention program's interventions or activities might affect identified GBOs or GBCs and, ultimately, the relative status of women and men, girls and boys, of different groups.

In drawing conclusions regarding the implications of gender issues for HIV programming, it is important to consider the following:

- Do the methods used to collect and analyze the information encourage inclusion and participation of the diverse stakeholders, in particular women and adolescent girls and other vulnerable and marginalized groups?

- Which levels contribute to gender differences (individual, family, community, organizational and institutional responses, policies, etc.)?

- Which level of intervention is needed to address gender differences and inequalities?

- Who within the organization is capable of responding, and do other organizations, institutions, or sectors need to intervene to address the differences and inequalities identified?

- What are the obstacles and threats, as well as the strengths and opportunities, afforded by the context (institutional, political, stakeholders involved with the problem/issue)?

Tool 3, *Consequences of Gender-based Constraints or Gender-based Opportunities for HIV Prevention and Gender Equality*, also provides a framework for examining the consequences of GBCs and GBOs in achieving HIV prevention goals and promoting gender equality. The tool is intended to help program planners and managers think through the implications of the GBCs and GBOs in the two areas listed above. Since GBCs have the potential to affect HIV prevention programs negatively and hinder gender equality, program planners and managers should consider the potential consequences if the program does not address the identified GBCs. Consideration should also be given to the GBOs that might facilitate achievement of HIV prevention goals and promote gender equality.

Program planners and managers should refer to the GBC statements formulated during Step 2 of Gender Analysis, Analyze Underlying Gender Relations & Inequalities, to identify potential consequences of GBCs and to complete the matrix. The conditions of disparity identified in the GBC statements point to the potential consequences of the GBCs for achieving HIV prevention goals. The underlying factors causing the conditions identified in the GBC statements point to the potential consequences for the relative status of women and men, girls and boys.

Column 1, Gender-based Constraint or Opportunity, identifies the domains of environment, gender norms, gender roles, access to and control over resources, and power and decision making. Use the following guidance to implement the tool.

- For each domain list the GBCs and GBOs.
- In Column 2, How Will the Gender-based Constraint or Gender-based Opportunity Affect the Achievement of HIV Prevention Program Goals, state how each gender domain will affect the achievement of HIV prevention goals.
- In Column 3, How Will the Gender-based Constraint or Gender-based Opportunity Affect the Relative Status of Women/Girls and Men/Boys, state how each gender domain will affect the relative status. Laying out the GBCs and GBOs in this way will help identify which GBCs or GBOs have the potential to affect the program negatively or positively.
- In Column 4, Prioritizing Gender-based Constraints or Opportunities, identify the most crucial issues to address. A range of factors should be considered to prioritize the GBCs and GBOs such as the program's timeline, budget, and short-term and long-term goals. The effects of addressing the GBCs should also be taken into account, and more priority should be given to GBCs which, if addressed, will have greater direct and indirect benefits. In Column 4, indicate the priority given to each GBC or GBO by assigning a number, with 1 signifies the top priority.

5.8 Checklist for Gender Analysis

Resources and expertise are needed to conduct gender analysis. Depending on the situation, various individuals or groups might be responsible for conducting gender analysis. In-house staff members, including those managing a particular program or service unit, or outside consultants who have expertise in gender and research methodologies, might be responsible for conducting gender analysis.

An assessment of in-house resources and expertise will help to make decisions about whether the in-house program planner or manager conducts the gender analysis as part of his or her duties. It may not always be desirable or possible for staff to conduct the gender analysis. The following are some of the skills required for an individual to conduct gender analysis related to HIV/AIDS:

- *Subject matter* expertise on HIV/AIDS issues;
- *Gender expertise*, including professional or academic training (or both) in gender theory as it pertains to program planning or the development of interventions;
- *Specific technical expertise* in research methods such as surveys, focus groups, and key informant interviews; and
- *Credibility* in the eyes of all stakeholders

Table 5: *Resources/Expertise Needed to Conduct Gender Analysis*, provides a checklist of issues that program planners and managers should consider before deciding who should conduct the gender analysis.

Table 5: Resources/Expertise Needed to Conduct Gender Analysis	Yes	No
1. Access to the necessary information for performing gender analysis (e.g.-data and information and data disaggregated by sex and socioeconomic factors)		
2. Time and/or other necessary resources needed to perform the gender analysis adequately		
3. An understanding of gender theories in relation to the proposed or existing program(s) and service(s)		
4. Credibility with stakeholders		

If staff do not have the combination of capacities and resources to conduct gender analysis on their own, an alternative is to form a gender analysis team made up of both staff, outside consultants, and stakeholders to work together to conduct the gender analysis.

Endnotes

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Section 6

Gender Integration for Program Design

Section 6: Gender Integration for Program Design

6.1 Gender Integration: Getting Started

This section addresses key issues for program planners and managers to consider as they move forward to integrate a gender perspective in HIV programming throughout the program cycle. Gender-responsive programming requires integration of a human rights-based approach, a SDH approach, and cultural and linguistic competency. The SDH approach has been discussed in **Sections 3.1 and 3.2,** which emphasizes how it can be applied to understanding gender as a cross-cutting social determinant of HIV/AIDS that interacts with other determinants at multiple levels to increase women's and adolescent girls' vulnerability and risk.

The following sections emphasize the importance of integrating the human rights principle of meaningful inclusion and participation in HIV prevention planning and of respecting and addressing the cultural and linguistic diversity of women and adolescent girls in the planning process and program cycle. An overview of this, gender integration into the program cycle, can be seen in **Figure 4.**

Figure 4: Gender Integration in the Program Cycle
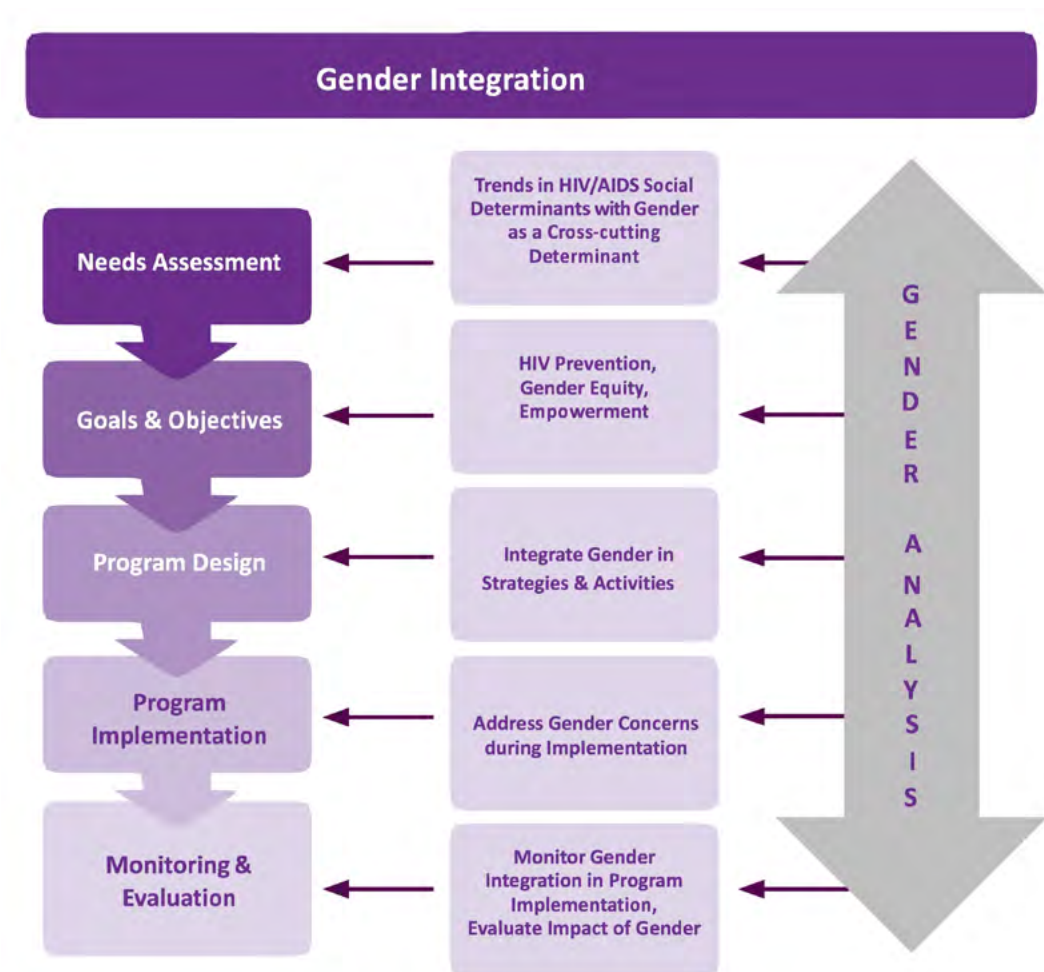
6.1.1 Meaningful Inclusion and Participation of Women and Adolescent Girls

Integrating gender into HIV prevention programming begins by involving the women and adolescent girls for whom the programs and supportive services are intended in the planning process. Those programs and support services will be more responsive to the unique needs of its participants, will address the GBCs that they face, and promote their ownership of the program. Women and adolescent girls living with and affected by HIV and AIDS who are recruited to participate in the planning process should live in the community in which the program/support services will be delivered. In addition, they should reflect the characteristics of the priority populations to be served by the program/support services (e.g., age, race/ethnicity, SES, culture, language spoken, sexual orientation).

6.1.2 HIV Prevention Program Planning Group

One way to ensure the meaningful involvement of women and adolescent girls is to set up a program planning group. A program planning group is made up of a number of people who plan and guide the process throughout the program cycle. In keeping with the principle of meaningful inclusion and participation, women and adolescent girls at risk for HIV or who are living with HIV/AIDS should be included in the program planning group. Other key stakeholders include program planners, managers and implementers, other community residents (including men and adolescent boys), representatives of relevant community organizations and institutions that will collaborate with the program, and key decision makers. Persons who have expertise in gender and HIV research and evaluation should also be included in the program planning group. The mix of individuals in the planning group should be broad and diverse enough to bring multiple perspectives, experiences, and expertise to bear on the process. By sharing their diverse perspectives and experiences, planning group members can contribute rich information and insights that can enhance the development of gender-responsive HIV prevention programs and support services for women and adolescent girls.

It is important for program planners and managers to consider and plan to address gender-related and power issues that may affect the meaningful participation and inclusion of women and adolescent girls in the planning process. The following questions raise a number of issues for program planners and managers to consider:

- How might differences in potential program participants' and other stakeholders' sex, age, SES, race or ethnicity, cultural background, and language affect their ability to voice their opinions, make decisions, or access information and resources?

- Are there differences in the roles and responsibilities of women/adolescent girls and men/adolescent boys that might affect their ability to participate in the program planning group (e.g., balancing productive, reproductive, and community work)?

- Are there differences in women's/adolescent girls' and men's/adolescent boys' access to and control of resources that might affect their participation in the program planning group?

- How might gender expectations, stereotypes, and power relations affect the participation of women/adolescent girls and men/adolescent boys?

- What steps can be taken to address the effects of these differences on women's/adolescent girls' and other stakeholders' participation in the program planning group?

6.1.3 Considering and Attending to Cultural and Linguistic Diversity

Women and adolescent girls affected by and living with HIV come from diverse racial, ethnic, socioeconomic, and cultural backgrounds. Cultural and linguistic competency is critically important to effectively plan gender-responsive programs and services. Planning programs and support services with individuals from diverse cultural backgrounds and experiences will be challenging but also enriching.

Individuals tend to see the world through the lens of who they are rather than how the world is. Individuals from different cultures will view and experience the world differently and attach different meanings to words, body language, interactions, events, situations, and symbols. They may also have different perspectives of what it means to be a woman or a man within their specific cultural context. Even individuals who share the same culture may have diverse perspectives.

Achieving cultural and linguistic competency is an ongoing developmental process that begins with self-awareness. Program planners and managers will need to examine their own cultural values, beliefs, attitudes, biases, and the stereotypes they have of different groups. They will then need to determine how their perspectives may affect their relationships with other members of the program planning group as well as their understanding of the problems, needs, and main concerns of the groups and communities for which the programs and services are intended. They will also need to actively seek to learn about, understand, and respect the different values, beliefs, experiences, and perspectives of these women and adolescent girls as well as other members of the planning group.

Having a diverse program planning group means there may be conflicting interpretations of the problems, needs, and proposed solutions among members. Program planners and managers will therefore need to ensure that the planning group develops and agrees to abide by a process for resolving conflicts and building consensus. The planning group will also need to consider adopting procedures that will facilitate the completion of their planning tasks and the ways to address group maintenance and team-building issues. These issues include maintaining relationships among members, group norms, predictability of procedures, and handling issues of inclusivity, trust-building, and participation.

Tool 4, *Program Planning Group Checklist: Ensuring Meaningful Inclusion and Participation of Women and Other Stakeholders*, provides a checklist of questions designed to help program planners and managers think about gender and cultural/linguistic issues that may affect the meaningful inclusion and participation of women and adolescent girls as well as other key stakeholders in the planning group. Factors to consider include the composition of the planning group; gender or cultural biases affecting communication and decision making among members; and strategies to enhance inclusion and participation of members.[1] Program planners and managers can use the checklist to assess potential barriers to meaningful inclusion and participation of women and adolescent girls in the program planning process. Assessing the barriers that are highlighted by the responses to the questions in the checklist can also guide them in formulating and taking appropriate actions to address and eliminate those barriers.

Tool 4: Program Planning Group Checklist: Ensuring Meaningful Inclusion and Participation of Women and Other Stakeholders		
Issues to Consider	Yes	No
1. Has a program planning group been established?		
2. Are women/adolescent girls and men/adolescent boys and members of key groups who are potential program participants included in the program planning group?		
3. Do members of the planning group represent a cross-section of the community where the programs/services will be delivered (e.g., sex, age, race/ethnicity, SES, sexual orientation)?		
4. Are representatives of key organizations in the community included in the planning group (e.g., health, social services, mental health, substance abuse treatment, housing, violence prevention providers, community-based, AIDS service, faith-based, women's organizations, etc.)?		
5. Are women and adolescent girls and other members of the planning group encouraged to participate and voice their perspectives and opinions?		
6. Are there any biases stemming from unequal power relations among different members of the planning group due to gender, age, ethnicity, SES, sexual orientation, expertise, or other differences that might affect the participation of women, adolescent girls, and others in the planning process (e.g., women/girls may be reluctant to express their opinions in front of men/boys; younger members may feel intimidated and therefore silenced by older members.)?		
7. Have strategies been developed to address the issues raised in question #6?		
8. Has the planning group set up procedures for decision making that include all members on equal footing?		
9. Is training planned and provided to equip women and adolescent girls and other community representatives with the knowledge and skills needed to participate effectively in the planning group?		
10. Are women and adolescent girls and other community representatives on the planning group provided with resources to support and facilitate their participation (e.g., child care, transportation, mentoring)?		
11. Are the meetings held at a time and place that facilitates participation by women and adolescent girls and other vulnerable groups?		
12. Have provisions been made to ensure inclusion of persons with limited English proficiency?		

6.1.4 Steps in Integrating Gender in the Program Cycle

Integrating a gender perspective in the HIV program cycle is a process that is both iterative and progressive. As is illustrated in **Figure 5,** *Gender Integration throughout the HIV Prevention Program Cycle*, each step is based on the completion of previous steps.[3]

Step 1. Conduct a needs assessment.

Step 2. Set program goals and objectives.

Step 3. Design evidence-based interventions.

Step 4. Implement the program.

Step 5. Monitor implementation and effectiveness in addressing program objectives.

Step 6. Evaluate program outcomes and adjusting design as needed to enhance successful strategies.

Gender-responsive HIV prevention program planning begins with gender analysis. The findings of the gender analysis will inform and guide decisions made at each step in the program cycle. During the needs assessment phase, findings from the gender analysis help program planners and managers identify GBCs and GBOs that may affect, impede, or facilitate achieving HIV prevention goals and addressing gender inequalities. Based on the needs assessment, the priority populations for whom the program and services are intended are selected. Program goals and objectives are then developed to address the identified GBCs and maximize GBOs. During the design phase, key program strategies and activities are identified to address GBCs and GBOs and achieve the program's goals and objectives. Program planners and managers then make decisions, choosing those strategies and activities that would contribute most to achieving both HIV/AIDS and gender-equity objectives.

Gender analysis is applied to program implementation to determine how performance of program activities is affecting the participation of women and men, girls and boys, in the program and gender relations. To monitor program implementation, performance indicators disaggregated by sex are developed that measure gender-specific as well as HIV/AIDS prevention outcomes. The effectiveness of program elements designed to address GBCs and GBOs are also evaluated.

Monitoring is important to assess the progress made in achieving HIV/AIDS outcomes, the impact of the program on women and men, girls and boys, and the contribution the program makes towards achieving greater gender equity. The information gained from program monitoring will assist program planners and managers in making needed revisions and adjustments in the program goals and objectives as well as design. Program evaluation conducted at mid-term and completion helps review progress and achievements of the program against planned HIV/AIDS prevention and gender-equity outcomes. Findings from monitoring and evaluation are used to adjust program design and activities; to strengthen elements of the program that contribute to more equitable HIV/AIDS and gender outcomes; and to modify those that do not. Program planners and managers can also draw on the lessons learned from program monitoring and evaluation to design future programs.

As program planners and managers move through the steps in the gender integration process, they will obtain feedback and gain new knowledge and insights about the gender roles, relations, identities, and gender-specific needs of program participants.

They will also get feedback and learn about the effects of program activities on the participation of, and benefits received by women and men, girls and boys. They can use this information and draw on theories and research findings to revisit, revise, and fine-tune decisions made in previous steps.[1] Feedback and new information on progress and problems, as well as changes in interpersonal relationships, resources, and access to information, should be used to re-examine and revise program objectives, strategies, interventions, and activities.[1,2]

Figure 5: Gender Integration throughout the HIV Prevention Program Cycle
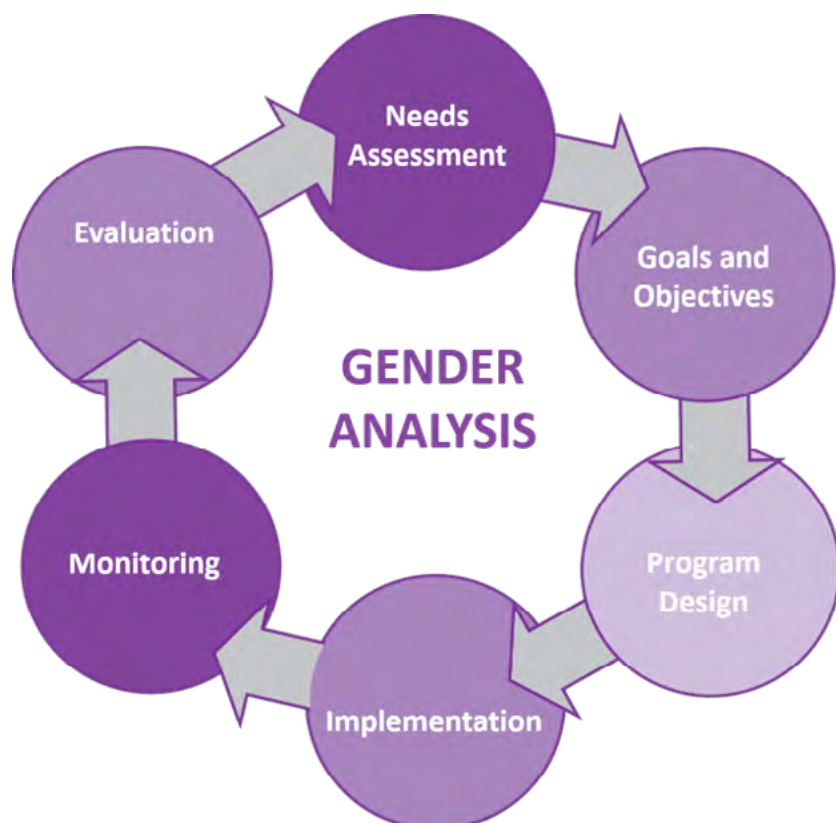
The sections that follow address how program planners and managers can apply the information derived from gender analysis to integrate gender at each step in the HIV program planning cycle.

6.2 Needs Assessment

Conducting a needs assessment is the first step in the program planning process and sets the stage for the remaining steps. During the needs assessment step, it is important for program planners and managers to link the findings of the gender analysis to program needs. The needs assessment forms the basis for setting priorities and making decisions about the targets, goals, objectives, and levels of intervention as well as the design of intervention strategies and activities. Table 6, *Linking Gender Analysis to Needs Assessment*, shows the linkages between the information required for the needs assessment and the findings of the gender analysis.

Table 6: Linking Gender Analysis to Needs Assessment	
Needs Assessment	**Gender Analysis**
• Nature and extent of HIV/AIDS incidence, prevalence, and identification of the most vulnerable groups in the community where the program will be delivered. • Major risk factors and behaviors. • Knowledge, attitudes, and practices.	**STEP 1: Identify Gender Differences in Patterns of HIV Infection and AIDS** Sex-disaggregated epidemiological data, behavioral data, and service utilization data are collected and examined to determine differences in the patterns of HIV vulnerability, risk, infection, and impact between women and men, girls and boys, and among different social groups. Critical gender disparities can then be seen in patterns of HIV infections, AIDS, and access to HIV services that are revealed in the gender differences.
• Key factors influencing the situation, including the underlying sociocultural, economic, political, and health factors that contribute to vulnerability to HIV infection.	**STEP 2: Analyze Underlying Gender Relations** Analysis uncovers the underlying gender norms and relations as well as sociocultural, economic, political, and legal factors that drive gender differences in the patterns of HIV/AIDS in the local context in which the program and services will be offered. GBOs (gender-based opportunities) and GBCs (gender-based constraints) that shape differential vulnerability to and risk for HIV/AIDS are identified based on analysis of the domains of gender norms, roles, access to and control over resources, and power and decision making.
• Needs, interests, capacities, and constraints of the different program participants and stakeholders. • Human, organizational, and community resources available to respond to the problems/needs. • Gaps between identified problems/needs and available services/resources to address them. • Possible solutions to address the identified problems/needs.	**STEP 3: Assessing Consequences for HIV prevention Programming and Gender Equality** Analysis reveals: 1) How gender relations in each domain present a potential GBC or GBO to achieving the proposed HIV program or services outcomes; and 2) How the proposed HIV prevention program's interventions or activities might affect identified GBCs or GBOs. The analysis also considers the relative status of women and men, girls and boys, of different groups to determine if program interventions worsen inequalities or accommodate or transform gender relations.

Needs assessment is a systematic way for program planners and managers to determine the following:

• Nature and extent of HIV/AIDS incidence, prevalence, and identification of the most vulnerable groups in the community where the program will be delivered;

• Major risk factors and behaviors;

• Knowledge, attitudes, and practices;

• Key factors influencing the situation, including the underlying sociocultural, economic, political, and health factors that contribute to vulnerability to HIV infection;

- Needs, interests, capacities, and constraints of the different stakeholders;
- Human, organizational, and community resources available to respond to the problems/needs;
- Gaps between identified problems/needs and available services/resources to address them; and
- Possible solutions to address the identified problems/needs.

Women and men, girls and boys, and other stakeholders should be actively involved in the needs assessment process, so they can express their needs, interests, priorities, constraints, and perspectives on what factors contribute to HIV infection. They should also play a role in developing solutions. Focus group discussions and other participatory methods should be used to ensure their active involvement.

Problems identified in needs assessments rarely stem from one social or economic issue. The nature of a problem identified should be examined at different levels. Problems may be caused by constraints imposed at the macro level such as the legal system or the policy environment. Problems may also arise at the meso (or mid-) level from constraints imposed by regulations that restrict certain individuals' access to services. Problems at the community level may stem from norms that limit women's or girls' participation in decision making and at the household level from gender roles that limit women's or girls' time to participate in programs or receive services. Therefore, problems cannot be examined outside the context in which they are embedded. Applying the information gained from gender analysis to the needs assessment should show how problems arising from GBCs are influenced by a multitude factors at different levels and the interdependence of these levels. Solutions to problems may therefore require multilevel strategies and activities.

Tool 5, *Integrating Gender in Needs Assessment*, is structured as a checklist that program planners and managers can use to make sure they consider and integrate gender issues identified in the gender analysis. It is intended to remind program planners and managers of some important issues they should consider to ensure the needs assessment process is inclusive, the data collected are as complete as possible, and the data are examined through a gender lens.

Tool 5: Integrating Gender in Needs Assessment			
Issues to Consider		Yes	No
Meaningful Inclusion and Participation of Women and Girls	1. Have women and girls and members of the community been involved in the data collection process? If so, have any key groups been left out? Have strategies been developed to engage these groups in the process?		
	2. Have women and men, girls and boys been involved in establishing a hierarchy of cause and effect of the identified problems or the ranking of problems in order of importance? Was there consensus or disagreement among women and men, girls and boys?		
	3. Have women and men, girls and boys, been involved in identifying possible solutions to the identified problems?		
Data Collection	4. Are the data used in the needs assessment disaggregated by sex, age, race/ethnicity, sexual orientation, etc.?		
	5. Are there gaps in the information required to assess the problems/needs of any group of women and girls for whom the program is intended?		
	6. Have supplementary data sources been used to fill the gaps in information (e.g., local surveys, focus group discussions, key informant interviews, in-depth individual interviews)?		
	7. Have qualitative methods have been used to collect information that will help to interpret the meaning of quantitative data and trends from the point of view of women and men, girls and boys, and members of the community for whom the services are intended?		
	8. Do differences in sex, age, SES, race/ethnicity, sexual orientation, gender identity, cultural background, language, or other social status constrain participants or other stakeholders from involvement in data collection activities (e.g., focus groups, in-depth interviews, key informant interviews)? For example, are women and men, girls and boys, more willing to respond to questions as individuals or in groups? Will focus groups mixed by sex or age limit women's or girls' participation? Does it make a difference whether an interviewer or focus group facilitator is a man or a woman (of a particular race/ethnicity, age, socioeconomic class, sexual orientation, gender identity, etc.)?		
	9. Have measures been taken to ensure the women and men, girls and boys, of different social groups can participate freely in the data collection process?		
Nature and Extent of HIV/AIDS	10. Does the needs assessment include local epidemiological data documenting the extent of HIV/AIDS among women and men, girls and boys, and specific groups within the community where programs and services will be delivered (e.g., HIV/AIDS incidence, prevalence, mortality, survival)? Have the findings from the gender analysis been linked to the needs assessment to determine differences between women and men, girls and Boys, based on their gender and other statuses such as age, race/ethnicity, sexual orientation, etc.?		
	11. Does the needs assessment include information on access and barriers to HIV prevention, care, and support services? Have the findings from the gender analysis been linked to the needs assessment to determine differences in access and barriers experienced by women and girls, men and boys, based on their gender and other statuses such as age, race/ethnicity, sexual orientation, immigration, or citizenship status, etc.?		

Tool 5: Integrating Gender in Needs Assessment–continued		
Issues to Consider	Yes	No
Other Health and Social Factors 12. Does the needs assessment include information on health services and other health issues that may affect vulnerability to HIV (e.g., other STDs, alcohol and drug abuse, mental health, unintended pregnancy)? Have the findings from the gender analysis been linked to the needs assessment to determine differences in how women and girls, men and boys experience these problems based on their gender and other statuses such as age, race/ethnicity, sexual orientation, immigration, or citizenship status, etc.?		
13. Does the needs assessment include information on the quality of life in the community, e.g., housing, homelessness, family size and composition, socioeconomic status, employment, income and poverty, quality of education, prevalence of substance abuse, violence, intimate partner violence (sexual, physical, emotional), safety and fire/police protection services, parks and green space, etc.? Have the findings from the gender analysis been linked to the needs assessment to determine differences in quality of life experienced by women and girls, men and boys based on their gender and other statuses such as age, race/ethnicity, sexual orientation, immigration, or citizenship status, etc.?		
14. Does the needs assessment include findings from the gender analysis regarding underlying gender and other sociocultural, economic, and political factors that explain differences in the patterns of HIV/AIDS between and amongst women and girls, men and boys of different social groups?		
15. Does the needs assessment apply the findings from the gender analysis regarding the different GBCs faced by women and girls, men and boys of different social groups and make distinctions between the practical and strategic gender-based needs of women and girls, men and boys?		
Community Capacity 16. Does the needs assessment include findings from the gender analysis regarding underlying gender and other socio-cultural, economic, and political factors that explain differences in the patterns of HIV/AIDS between and amongst women and girls, men and boys of different social groups?		
17. Does the needs assessment identify gaps in services or resources? Have the findings from the gender analysis been linked to the needs assessment? It would help determine if there are gaps in resources and services that address the gender-related needs and GBCs that women and girls, men and boys of different social groups face?		
Possible Solutions 18. Does the needs assessment include possible solutions to the identified problems?		
19. Do the possible solutions address GBCs or GBOs? Do they require a change in gender norms, roles, or relations?		
20. Are there gender-related problems for which no solutions, services, or resources were identified?		

The results from the gender analysis and needs assessment help inform a program's approach. However, the following questions are useful to ask to further define programmatic elements and solutions:

- What are the different ways in which women and men, girls and boys, are affected by HIV/AIDS?
- What are the different gender-based interests, needs, and priorities of women and men, girls and boys?
- Who will be more directly affected by the gender-related HIV/AIDS problems that are revealed through the needs assessment?
- Were problems identified by both women/girls and men/boys (or men/boys only or women/girls only)?
- What are the problems identified by women and men, girls and boys? How do they differ?
- How do women and adolescent girls view such problems?
- What causes the problem for women and adolescent girls?
- Which problems result from gender norms, roles, gender-based division of labor, inequitable access to and control over resources, or unequal power in relationships and decision making?
- Which problems are shared by both women and men, or girls and boys?
- What are the different problems identified by different social groups that vary by race, ethnicity, age, SES, sexual orientation or gender identity, immigrant status, or other relevant status?
- Which problems result from poverty, discrimination, or stigma?
- How are the problems related to one another?
- What are the underlying causes of the problem(s)? Do any relate to gender issues? Do any link to laws or policies; cultural, economic, political, and social factors at the societal or community level; or intermediaries (such as government agencies or other service providers)?
- What are the effects of the problem? Do any relate to gender issues?
- Are there differences in the needs, interests, capacities, priorities, and constraints of women and men, girls and boys? Do these differences vary by social group?
- If the problems relate to gender issues, have practical and strategic gender needs been identified?
- Is there any overlap of causes, effects, or solutions for priority problems of different groups (including women and men, girls and boys)? Among the different groups?

6.3 Integrating Gender in Goals and Objectives

The information gathered during the needs assessment process is used in this step of the program cycle to identify the intended participants and intended results of the program. This step includes input from the program planning group, including the women and adolescent girls for whom the program/service is intended and other relevant stakeholders. Program goals and objectives are developed or revised to ensure that they address the GBCs and maximize the GBOs that were identified from the gender analysis integrated into the needs assessment process. Goals and objectives should be stated so that they strengthen the synergy between gender and HIV prevention goals.

6.3.1 Identify Priority Populations

Before the program goals and objectives can be developed, the groups for whom the program or services are intended (priority populations) must be identified. The priority populations are generally selected based on the information discovered during the needs assessment, which indicates who is at risk and what groups are the most vulnerable in a given community. The findings from Step 1 and Step 2 of the gender analysis will inform the selection of the priority population(s). It is important to specify the priority populations by sex (i.e., women and girls, men and boys) as well as other key social statuses such as race/ethnicity, SES, sexual orientation, gender, and sexual identity. Program goals and objectives must address the target population's unique needs and the specific GBCs and GBOs they face.

6.3.2 Address Gender-based Constraints and Gender-based Opportunities

Integrating gender in HIV prevention programming at this step requires developing or re-examining existing program goals and objectives to ensure they attend to gender norms, roles, and relations as well as the identities of program participants. It is important to determine if there are aspects of the HIV prevention goals and objectives that will be affected by local gender norms, roles, relations, and identities. They should be formulated to reinforce the synergy between gender and HIV prevention goals and objectives. One way to do this is to formulate goals and objectives that seek to reduce the GBCs or to maximize the GBOs identified during Step 3 of the gender analysis process.

The findings of the needs assessment can be used to determine the high-priority GBCs or GBOs to address. This is important because program goals and objectives guide planning decisions regarding the design of new programs and services or the adjustment or redesign of existing ones. If program goals and objectives do not address the GBCs and GBOs identified in the gender analysis, then it is unlikely that the program designed will be responsive to the needs of the women and girls, or men and boys, for whom it is intended.

For example, a program may have an HIV prevention goal of reducing new infections among women and adolescent girls in a specified local context. One of the objectives to achieve this goal may be to increase the consistent use of condoms by women and adolescent girls during sexual intercourse with their male partners.

During Step 2 of the gender analysis, program planners and managers may have found that IPV is an underlying factor associated with HIV risk among women and adolescent girls. The findings of the gender analysis may have shown that women and adolescent girls who are in abusive relationships with a male partner may be less likely to insist on consistent condom use because they fear their partner might react violently.

During Step 3 of the gender analysis, program planners and managers may have selected IPV or the fear of violence as a high-priority GBC that impedes the ability of women and adolescent girls to negotiate safer sex with their male sexual partners and insist on condom use when they have sex. Based on the analysis, program planners and managers should develop goals and objectives to address IPV as a GBC. Failing to address the GBC of IPV will impede the achievement of the HIV prevention objective (i.e., increasing consistent condom use during heterosexual intercourse) and goal (i.e., reducing new HIV infections).

6.3.3 Specify Program Goals

A goal is a broad statement of program purpose that describes its expected long-term effects of

the program, and it sets its overall direction. For example:

- To reduce new diagnoses of HIV infection among black/African/American women ages 25-44 at high risk through heterosexual contact in County X.

Integrating gender into HIV prevention programming requires the development of goals that address the underlying gender norms and relations the program intends to target. It also requires the identification of GBCs in each domain that the program intends to reduce, in order to better benefit the women and adolescent girls served. The following are program goals that address GBCs related to IPV:

- To reduce IPV among black/African American women ages 25-44 at high risk of HIV infection through heterosexual contact in County X.
- To increase the economic independence of black/African American women ages 25-44 at risk for IPV and HIV infection through heterosexual contact in County X.
- To increase support for gender norms that condemn VAW among men ages 18-64 in County X.
- To increase the ability of black/African American women ages 25-44 at risk for IPV and HIV infection through heterosexual contact to make decisions that will protect themselves against HIV infection and IPV.

Once program goals have been set, it is important to assess their feasibility. This will be discussed in **Section 6.3.5** and supported through the use of **Tool 7**.

6.3.4 Specify Program Objectives

An objective is a concise statement specifying the desired effect of the program. It is specific, measurable, and time-phased. An objective identifies the following:

- What change is going to occur?
- Whose condition or behavior is going to change as a result of the program?
- Where (geographic location) will the change to occur?
- How much change will occur as a result of the program?
- When (by what date) will the change will occur?

It is important to develop measurable objectives that can guide the program design and implementation process as well as program monitoring and evaluation. Gender-responsive programs are based on objectives that take into account gender relations and issues, and gender-related needs and constraints. Factors that influence HIV vulnerability and risk occur at the intrapersonal, interpersonal, community, organizational, and societal levels. These factors are revealed through the gender analysis that identifies priority GBCs and GBOs. In considering high-priority GBCs and GBOs, it is useful to consider the different domains of gender relations examined in the gender analysis (i.e., gender norms, gender roles, access to and control over resources, and power and decision making) as they cut across the different levels of social determinants.

The following are some examples of objectives that address GBCs or GBOs in the different domains of gender relations and at different levels.

- By the end of 2015, increase by 50% the perception of risk for HIV infection among Latinas ages 24-45 who are in steady sexual relationships with a male partner in the program's geographic area. Provide HIV prevention education workshops. (Domain: Gender norms)

- By the end of 2015, increase by 25% the number of Asian-American women ages 24-35 at risk for HIV infection in the program area who are able to discuss HIV/AIDS, safer sex, and condom use with their male sexual partners. Provide HIV prevention workshops that address sexual communication. (Domain: Gender norms)

- By the end of 2017, increase by 30% the number of Native American women ages 34-45 at risk for HIV infection and IPV in the program area who are enrolled in vocational training. Provide HIV prevention and vocational education counseling services. (Domain: Access to and control over resources)

- By the end of 2015, increase by 25% the number of black/African American men ages 24-35 who are partners of black/African American women at risk for HIV infection in the program's specified geographic area and who share childcare, care giving, and household work responsibilities. Engage men in HIV prevention education and parenting workshops initially with other men and then with their female partners. (Domain: Gender roles)

- By the end of 2015, increase by 50% the number of women living with HIV/AIDS who participate in an anti-GBV advocacy network in a specified community. (Domain: Power and Decision Making)

Tool 6, *Developing Program Objectives Based on Priority Gender-based Constraints and Opportunities,* provides a framework for program planners and managers to formulate program objectives by addressing priority GBCs or GBOs. Column 1 lists the domains of gender analysis. In Column 2, list the most important GBCs for the program. In Column 3, list the most important GBOs for the program as prioritized in Step 3 of the gender analysis process. In Column 4, write a program objective to address each GBC listed or to maximize each GBO listed for each domain.

Tool 6: Developing Program Objectives Based on Priority Gender-based Constraints and Opportunities			
1) Domain	2) List the Most Important Gender-based Constraints for the Program	3) List the Most Important Gender-based Opportunities for the Program	4) Write a Program Objective to Address the GBC or GBO
a) Environment			
b) Gender Norms			
c) Gender Roles			
d) Access to and Control over Resources			
e) Power and Decision making			

6.3.5 Assess the Feasibility of Program Goals & Objectives

Assessing the feasibility of the objectives, with the participation of the program planning group and members of the priority population(s), is an important part of the planning process. A number of factors influencing the feasibility of the objectives should be examined, such as available financial, human, and technical resources; organizational climate and capacity to address gender issues; the priority population's buy-in; community buy-in; and a supportive enabling environment—the social, cultural, political, and legal conditions that influence gender equality.

Tool 7, *Assessing the Feasibility of Program Goals and Objectives*, is a checklist of key factors that program planners and managers can consider when assessing the feasibility of program goals and objectives. In the planning considerations column, findings from the feasibility assessment can be aggregated, interpreted, and applied to the planning process. For instance, if a program identifies a lack of qualified staff with knowledge of gender issues and skills, as well as a lack of organizational support, the planning considerations column could include ways to increase organizational support and staff knowledge through trainings on the importance of gender considerations to build support, knowledge, and skills.

Tool 7: Assessing the Feasibility of Program Goals and Objectives				
	Issues to Consider	Yes	No	Planning Considerations
Priorities	Are there GBCs and GBOs identified in the gender analysis that are priorities to address because of their importance or scale for achieving HIV prevention and gender-equity goals?			
	Are there intermediate steps that address GBCs or GBOs that will enhance program effectiveness and contribute to a more equitable distribution of its benefits? Was there consensus or disagreement among women and men, girls and boys?			
Resources	Does the program have qualified staff in place?			
	Does the staff have the necessary gender knowledge and skills to achieve the objectives?			
	Are resources available to carry out staff training?			
	What financial resources are available to address the program objectives (GBCs and GBOs), and who controls them?			
	What is the likelihood that resources can be allocated to address GBCs through intermediate objectives and activities? Who needs to be influenced and how?			
	Are resources available for program materials?			
	Is equipment available for the program?			
	Does the program staff have access to science-based information?			
	Does the staff have the time necessary to achieve the objectives?			
	Are resources available for training community members and other key leaders?			
	Are resources available to provide incentives for program participants?			
	Are other program services available (e.g., transportation, childcare)?			

Tool 7: Assessing the Feasibility of Program Goals and Objectives, Continued				
	Issues to Consider	Yes	No	Planning Considerations
Space	Is space available to carry out the program objectives?			
Organizational Climate	Do key leaders in the organization support addressing gender issues?			
	Do staff in the organization buy into the program objectives?			
	Does the organization have the capacity to address gender issues?			
Division of Labor	What tasks (formal and informal) are essential to accomplish the objectives? Which tasks do women perform, and which do men perform?			
	Is a gendered division of labor among the program staff, service providers, or government personnel likely to affect the organization's ability to achieve gender equity in its program?			
Priority Population	Does the organization have access to the priority population?			
	Are the program objectives relevant to the priority population's culture and demographics (e.g., gender, age, sexual orientation, race/ ethnicity, etc.)?			
	Does the priority population buy into the program objectives?			
	Do the program objectives fit with existing prevention efforts?			
	Does the program have access to a referral network for program participants?			
Community Climate	Do key community leaders and stakeholders buy-in to the program objectives?			
	Does the organization have a favorable history (e.g., previous program success) in the community?			
Supportive Policies and Partnerships	Are there existing laws or policies that are supportive of the program's HIV and gender- equity objectives?			
	Does the program have champions or advocacy partners that are supportive of its gender and HIV outcomes?			
	Are there key stakeholders who might not support the program's HIV and gender objectives? Have they been consulted?			
	Is support likely from government, community institutions, or community-based organizations?			
	What types of other organizations have the technical skills, knowledge, and gender expertise to assist the program in achieving gender equity results?			

6.4 Integrating Gender in Program Design

Once program goals and objectives have been developed, the next step is to design the program to achieve the objectives. Integrating gender into program design entails identifying and determining the key strategies and activities best suited to address the priority GBCs, and maximize GBOs that were identified through the gender analysis and needs assessment processes.

The choice of program strategies and activities is important and should be considered carefully. These decisions have important implications for the achievement of program goals and objectives and should involve the program planning group, including women and adolescent girls and other relevant stakeholders to ensure that the program is responsive to their needs. The program planning group can play an important role in ensuring the involvement of potential program participants as well as other relevant stakeholders to obtain their feedback and recommendations.

At this step in the program cycle, program planners and managers—with the involvement of women, adolescent girls, and other key stakeholders—make decisions about program strategies and activities as well as the scope, sequence, and implementation of the program. The major challenge during this step is to match strategies and activities to program objectives in order to address the GBCs that impede, and maximize GBOs that facilitate women's and adolescent girls' abilities to adopt safer sexual and/or drug using behaviors. Program planners and managers can engage in the following tasks to identify strategies and activities:

- Brainstorm about strategies;
- Use existing evidence-based interventions;
- Link the strategies to the objectives;
- Design new strategies; and
- Provide justification for the strategies.

One of the main principles of gender-responsive HIV programming is that programs should be based on theory-driven evidence. Program planners and managers should consider evidence-based interventions and best practices that integrate gender into HIV prevention.

The gender implications of the program design may be classified along the *Gender Integration Continuum*. The Gender Integration Continuum is a helpful conceptual framework to categorize program approaches by how they treat gender norms and inequities in the design, implementation, and evaluation. The Continuum is described in the sections that follow. In addition, examples are presented of some best-evidence and promising-evidence interventions that incorporate gender accommodating and/or gender transformative approaches designed to address GBCs faced by women and adolescent girls.

A *gender accommodating approach* includes activities that acknowledge gender norms and inequities in gender relations and often seek to develop actions that adjust to and compensate for them.

A *gender transformative approach* includes activities that seek to transform gender norms and roles and promote more equitable gender relations in order to achieve program objectives.

Most of these interventions are included in the CDC's *Compendium of Evidence-Based HIV Behavioral Interventions.*[3] Program planners and managers can use the compendium and other resources to identify evidence-based interventions that address gender-based issues and have

been effective in HIV prevention for women and girls. For example, in the report *What Works for Women and Girls: Evidence for HIV/AIDS Interventions*[4] presents a review and summary of the base of evidence to support successful interventions in HIV programming for women and girls. The review covers evaluated interventions in 90 countries (focusing on developing countries) and identifies interventions that work and/or can be seen as promising for women and girls in the continuum of HIV and AIDS, from prevention to treatment, care, and support, and strengthening social, cultural, political, and legal conditions for effective gender-inclusive policies and programming. When considering existing interventions, program planners and managers should select those that address the identified priority program objectives. For in-depth information on HIV interventions for women and adolescent girls, see:

> Gay, J., K. Hardee, M. Croce-Galis, S. Kowalski, C. Gutari, C. Wingfield, K. Rovin, and K. Berzins. 2010. *What Works for Women and Girls: Evidence for HIV/AIDS Interventions*. New York: Open Society Institute. This document can be accessed at *http://www. whatworksforwomen.org/ chapters/7/sections/9*

A number of gender strategies, which are described in the sections that follow, represent a menu of options that program planners and managers can consider as they decide what interventions will best respond to the priority GBCs and GBOs they have identified. Strategies should address changing knowledge, attitudes, beliefs, norms, behaviors, and skills as well as the underlying social, economic, cultural, and political determinants that contribute to GBCs and GBOs that increase women's and adolescent girls' vulnerability to and risk for HIV/AIDS.

After program planners and managers have brainstormed strategies or selected existing evidence-based interventions, they should identify which strategies and activities address the identified priority program objectives. Existing interventions may address part of the objectives but not all. As a result, program planners and managers may need to develop new strategies and activities or adapt existing ones to address those objectives not covered by existing interventions. They will also have to provide justification for the strategies and activities by thinking critically about 1) how the strategies and activities would contribute to a change in knowledge, attitudes, beliefs, norms, behaviors, skills, and underlying socioeconomic and political conditions; and 2) whether the selected strategies and activities would be the most effective in doing so.

In selecting program strategies and activities from the available options, program planners and managers should assess their strengths and weaknesses based on the degree to which they address the program goals and objectives and the social and economic context of the program. They should consider all possible actions and then determine how they can be appropriately implemented in the specific socioeconomic context and within the overall resources and constraints of the program. Considerable weight should be given to those proposed program strategies and activities that might have the greatest impact on achieving both HIV prevention and gender-equity goals and objectives.

Tool 8, *Considerations in Selecting Program Strategies and Activities*, is a list of some questions program planners and managers should consider when selecting strategies and activities that address GBCs or GBOs for women and adolescent girls.

Once the program strategies and activities are selected, program planners and managers can make decisions regarding the scope, sequencing, and implementation of the program. Scope refers to the comprehensiveness of the intervention, while sequence refers to the order in which the intervention or components of the intervention will be delivered across time.

Tool 8: Considerations in Selecting Program Strategies and Activities	
Gender Relations Domain	**Considerations**
Gender Norms	What strategies and activities are aimed at changing harmful gender norms that increase women and adolescent girls' or men's and adolescent boys' vulnerability to HIV?
	What strategies and activities are aimed at creating more equitable gender relations for women and adolescent girls with their partners to reduce GBV/ VAW, unwanted pregnancies, and HIV transmission?
	How can strategies and activities aim to reduce HIV-related stigma and discrimination experienced by women and adolescent girls, men and adolescent boys, or transgender persons?
	What strategies and activities are aimed at addressing discriminatory laws, policies, regulations, and institutions?
Gender Roles	What strategies and activities are aimed at addressing inequitable gender roles?
	What strategies and activities are aimed at creating time-saving approaches (including a more equitable allocation of tasks between men and women) or new technologies to allow women time for community involvement (e.g., to serve on HIV program oversight committees, planning councils, etc.)?
Access to and Control over Resources	In what ways will program strategies and activities benefit women and men?
	How will the program ensure that strategies and activities benefit women and men equitably?
	How will activities and services ensure equitable participation by women and men, girls and boys?
	What strategies and activities are aimed at ensuring that women and men have equitable access to and control over HIV prevention and health resources (information, education, training, outreach, products) and services?
	What strategies and activities are aimed at reducing the gender-based economic constraints that increase the vulnerability of adolescent girls to HIV transmission?
	What strategies and activities are aimed at reducing the gender-based educational constraints that increase the vulnerability of adolescent girls to HIV transmission?
	What strategies and activities are aimed at addressing institutional inequities that limit women's and adolescent girls' access to and control over resources?
	What strategies and activities are aimed at addressing discriminatory laws, policies, regulations, or institutions?
Power and Decision Making	What strategies and activities address GBV/VAW as a barrier to HIV risk reduction and access to HIV/AIDS services?
	What strategies and activities are aimed at increasing women's and adolescent girls' ability to negotiate safer sex and condom use with their male partners?
	What strategies and activities are aimed at increasing women's and adolescent girls' autonomy to participate in HIV prevention, treatment, care, and support services?
	What strategies and activities are aimed at increasing women's ability and authority to make decisions to improve access to HIV prevention and healthcare in their communities?

Tool 8: Considerations in Selecting Program Strategies and Activities- Continued	
Gender Relations Domain	**Considerations**
Cross-cutting	What strategies address social, cultural, and language preferences of participants (i.e., cultural and linguistic competency)?
	How do strategies and activities address the specific HIV-related health needs/ behaviors of women and adolescent girls, and men and adolescent boys?
	What strategies and activities are aimed at empowering women and adolescent girls?
	What gender approach predominates in the strategies and activities: gender accommodating (section 6.4.1.1.2), transformative (section 6.4.1.1.3), or both?
	What resources will be needed to carry out the strategies and activities to accomplish each objective?
	Does the organization have the resources needed? If not, can other resources be identified and secured to support the program?
	Can the strategies and activities be successfully conducted during the specified timeframe?

6.4.1 Gender Integration Continuum

One method to choose strategies and activities to address GBCs and maximize GBOs to achieve the program objectives is to use a continuum of different approaches to gender integration. The *Gender Integration Continuum*, developed by the Interagency Gender Working Group (IGWG), is a helpful conceptual framework that can assist program planners and managers in thinking about how gender relations and dynamics have been considered in planning their HIV prevention programs.[2] It can help program planners and managers to prioritize objectives and design, implement, and evaluate the outcomes of HIV prevention programs and support services.

Figure 6, depicts the *Gender Integration Continuum*. The large gray oval in the graphic represents the program environment. Approaches to integrating gender into HIV/AIDS programs are divided into two broad categories, "gender blind" and "gender aware." They relate to the degree to which gender relation, roles, norms, and inequities are analyzed and explicitly addressed during the design, implementation, monitoring, and evaluation of a program. Gender-blind approaches are shown at the bottom of the oval enclosed within a broken line. Gender-aware approaches are shown at the top of the oval enclosed within a solid line.[2]

Gender-blind approaches are those that do not proactively consider and analyze 1) how differences in gender identities, gender norms, roles, and unequal power relations will affect the achievement of program objectives; or 2) the way that program objectives and activities affect gender relations. These approaches make no distinction between the needs and special circumstances of women and men, girls and boys.[5] HIV prevention interventions using messages that are not targeted to any one sex, such as those that promote monogamy (i.e., "be faithful"), are examples of gender-blind approaches.[5] HIV care programs that do not differentiate between the specific needs of women and men, girls and boys, and offer the same services to both sexes are another example of gender-blind interventions. Such programs do not recognize that female

clients may need more social support and supportive services than male clients or that women or adolescent girls may prefer female healthcare providers or counselors rather than male providers and counselors.[5]

Many early prevention efforts were gender blind in that they provided the same intervention to women and men in mixed groups.[7] Evaluations of these interventions showed that they were not effective in changing adult heterosexual women's sexual risk behaviors.[6] Most mixed-group interventions for adults involve people who inject drugs. These interventions were more effective in changing drug-use risk behaviors in females than their sexual-risk behaviors.[5,6]

Figure 6: Gender Integration Continuum
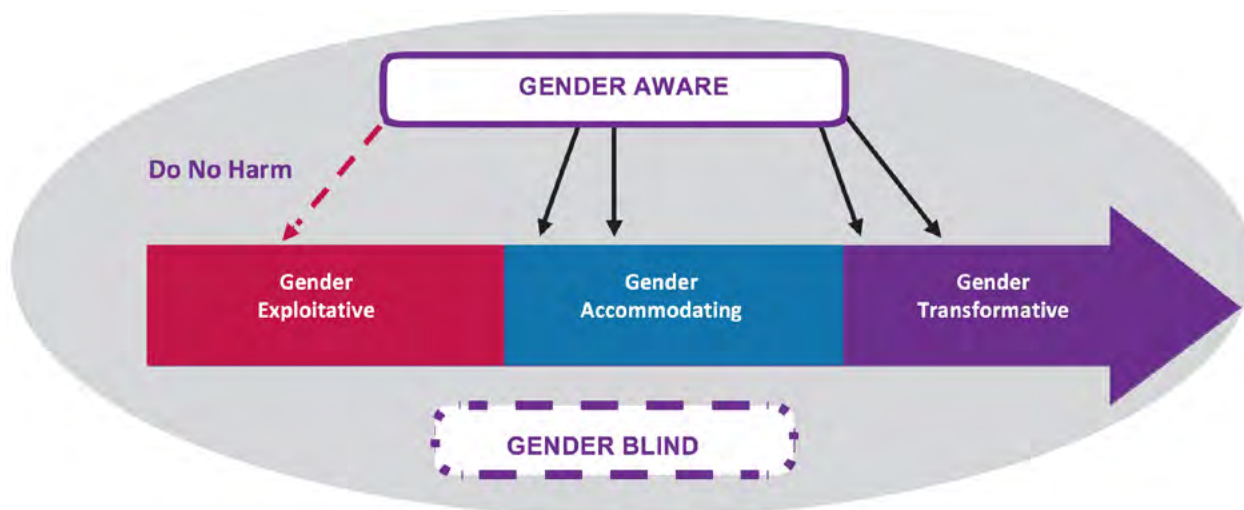
Source: PRB. (2009). A manual for integrating gender into reproductive health and HIV programs: From commitment to action, (2nd edition), p. 9. Retrieved from *http://www.igwg.org/igwg_media/manualintegrgendr09_eng.pdf*

Gender-aware programs are designed with explicit gender accommodating or transformative intentions. As shown by the multiple arrows in the *Gender Integration Continuum* graphic, gender-aware programs may have both accommodating and transformative components that fall at various points along the continuum. Gender-aware approaches intentionally consider and address the anticipated gender-related dynamics, barriers, opportunities, and outcomes of a particular program. Awareness of the gender context is generally based on gender analysis that is undertaken prior to designing the program. It informs design, implementation, monitoring, and evaluation. Applying the findings of gender analysis allows program staff to deliberately address GBCs, maximize GBOs, and plan their gender objectives. Gender-aware approaches also consider how program objectives, strategies, and activities affect the status of women and girls relative to men and boys. They allow staff to address any harmful effects. Integrating gender into HIV prevention programs and support services necessarily requires gender awareness.

6.4.1.1 Types of Gender-Aware Approaches

Designing a gender-responsive HIV program is based on considering and addressing the GBCs and GBOs identified through the gender analysis and needs assessment. Gender- aware approaches fall into three types that move across the continuum depicted in the center of the oval in **Figure 6, *Gender Integration Continuum***: gender exploitative, gender accommodating, and gender transformative.

6.4.1.1.1 Gender exploitative

Gender exploitative approaches, shown in the graphic at the left end of the continuum, are those that intentionally manipulate or take advantage of rigid gender norms, existing inequalities in power, and negative stereotypes to achieve program objectives. Such approaches make discriminatory distinctions between women and men and reinforce gender stereotypes.[2] For example, early condom marketing campaigns that portrayed men as violent, irresponsible, sexual predators and women as passive and powerless victims of male domination reinforced negative gender stereotypes.[7]

Gender exploitative approaches undermine women's decision making as well as sound HIV prevention activities that are based on promoting responsible, respectful, consensual, and mutually satisfying sexual partnerships.[7] While using gender exploitative approaches may produce short-term gains, in the long run such approaches may actually undermine the program's intended objectives. Gender exploitative approaches are unacceptable ones to use in integrating gender into HIV/AIDS programming; they reinforce unequal power in the relations between women and men and have the potential to exacerbate existing inequalities.[7,8] Gender-responsive HIV prevention programming requires the elimination of assumptions and stereotypes that are harmful to women's and men's ability to benefit from interventions. As indicated in the *Gender Integration Continuum* graphic, HIV prevention programs should "do no harm," and under no circumstances should programs adopt an exploitative approach.

6.4.1.1.2 Gender accommodating

Gender accommodating approaches, shown in the graphic in the middle of the continuum, acknowledge gender norms and inequities in gender relations and often seek to develop actions that adjust to and compensate for them.[2] Such approaches do not seek to change the underlying gender norms and social structures that perpetuate gender inequities. Instead, they take into account gender differences and inequities in the design, implementation, monitoring, and evaluation of programs.

Services and interventions are designed to meet the distinct needs of women and men and limit any harmful impacts of gender relations. For example, the male condom is a prevention method whose use is controlled by men. In sexual relationships where there is an imbalance of power disadvantaging women or adolescent girls, they may have difficulty negotiating condom use with their male partners. By acknowledging this reality, gender accommodating programs might promote and distribute female condoms whose use is female-initiated to give women and adolescent girls more control over condom use in their sexual encounters with men or adolescent boys. However, doing so does not address the fact that women and adolescent girls still need the cooperation of their male partners to use female condoms. Such an intervention is gender accommodating because it attempts to minimize the harm to women and adolescent girls resulting from unequal power in sexual relationships. However, it does nothing to change the power imbalances.

Most HIV/AIDS programs and services incorporate gender accommodating approaches.[5] Many of these programs have been focused on the individual and delivered one-on-one or in small groups.[6] Gender accommodating HIV prevention interventions for women that are most effective tend to focus on the specific circumstances and issues faced by women in the priority population and on the relationship and sexual negotiation skills necessary to ensure condom use with a male partner.[6] While gender accommodating programming is necessary and essential, it is not sufficient to change the balance of power in gender relations.[7] Such approaches do not contribute to increased gender equity. By themselves, these approaches do little to alter the larger socioeconomic and cultural conditions that perpetuate strict gender norms and power

imbalances at the heart of women's and adolescent girls' vulnerability to HIV.[2,7] They do, however, represent an important step in the process of gender integration, particularly in situations where gender inequities are deep-rooted and all-encompassing.[2]

6.4.1.1.3 Gender transformative

Gender transformative approaches, shown in **Figure 6, *Gender Integration Continuum***, seek to transform gender norms and roles and promote more equitable gender relations in order to achieve program objectives.[2,5] These approaches are more advanced than gender accommodating approaches because they are designed to alter the underlying conditions that give rise to gender inequities.[5] Gender transformative approaches recognize that both women and adolescent girls, and men and adolescent boys, are critical players in effective HIV prevention programming. They reach out to and involve both females and males in programs and interventions.[7] Gender-transformative approaches use a variety of methods to encourage women and adolescent girls, and men and adolescent boys, to critically examine gender and sexuality and how gender norms and roles impact female and male sexual health and relationships. Such programs help women/girls and men/boys to think about, question, and alter the rigid gender norms and institutions that reinforce these inequities as a means of achieving HIV prevention and gender-equity objectives.[2,7]

Gender transformative programs promote the equal status of women and girls. They challenge the unequal distribution of resources and allocation of duties between women and men. In addition, these programs and interventions work to reduce GBV/VAW and address unequal power relationships between women and others such as service providers and community leaders.[2]

The most advanced forms of gender transformative approaches seek to empower women and girls or free women and men from the impact of harmful gender and sexual norms.[5] Empowerment occurs on many levels. Power ultimately involves collective actions that generally seek to affect or change policies and broader socioeconomic, cultural, or political conditions that have an impact on HIV/AIDS.[6] Programs using empowering approaches work to improve women's and girls' access to information, skills, education, services, and technologies to protect themselves against HIV infection.[5] Empowerment approaches also go a step further and seek to equalize the imbalances in power between women and men in order to reduce their vulnerability to HIV/AIDS.[5]

Such empowerment approaches encourage women's participation in decision making to shape their own destinies and provide women with opportunities to develop their leadership skills, organize, and problem-solve as means of increasing their political power.[7] These approaches ultimately facilitate the formation of a group identity among women that becomes a source of power.[5,7] This group identity is separate from that of the family because, for many women and girls, the family is often the very social institution that pressures them to comply with traditional gender norms.[5] Through collective action, women and girls can work to change the conditions that constrain their rights and choices.[6]

- Empowerment approaches seek to change or design policies in order to:
- Decrease the gender gap in education, employment, and income;
- Improve women's access to economic resources;
- Increase women's civic and political participation; and
- Protect women from GBV. Such policies are central to the empowerment of women.

It is therefore important that program planners and managers also facilitate the participation of women and adolescent girls in advocacy efforts to create a supportive policy and legislative environment that supports women's empowerment.[6]

> ## *Empowerment Theory*
>
> Empowerment theory addresses the dynamics of power and unequal power relationships within a broader social, economic, and cultural context. Empowerment is a multidimensional concept operating at the intrapersonal, interpersonal, community, organizational, and political levels. The theory addresses the interactions between these five levels of power and links personal empowerment to social action. Empowerment theory has multidisciplinary roots evolving from conceptions of power in such diverse fields as sociology, psychology, political science, and pedagogy.
>
> Empowerment is conceptualized as both a process and an outcome. As a process, empowerment entails engaging individuals, organizations, and communities in dialogue and reflection as a way to "gain mastery over their lives in the context of changing their social and political environment to improve equity and the quality of life."*
>
> Empowerment interventions in public health have incorporated Brazilian educator Paulo Freire's popular education model, which seeks to help individuals and groups develop critical consciousness or "conscientization." Through a process of problem-posing that involves a cycle of listening–dialogue–action, groups examine their social reality and gain a better understanding of the root causes and connections of the social, economic, and cultural forces that impact their lives and health.
>
> Groups also examine their own ability to challenge and change the oppressive conditions that keep them powerless and come up with joint strategies to transform these conditions. In this conception of empowerment, developing critical consciousness is a key precursor to social action. This approach promotes health by increasing people's feelings of power and control over their lives.
>
> Empowerment has been identified as a critical component of HIV prevention and care strategies aimed at reducing women's and girls' gender-based vulnerabilities and risks. Interventions that promote and facilitate empowerment are the most advanced gender transformative approaches on the Gender Integration Continuum precisely because they aim to challenge gender norms, roles, and relations.
>
> *Minkler, M., & Wallerstein, N. (2005). *"Improving health through community organization."* Community Organizing and Community Building for Health, pg. 34.

Examples of gender transformative programs include:

- Working with heterosexual couples as the unit of intervention rather than with individual women or men;

- Providing couple counseling at HIV testing sites to help couples deal with test results; and

- Working with couples in family planning programs to promote the use of dual protection (male latex condoms or female condoms and other contraceptive methods, such as birth control pills) against both unwanted pregnancy and HIV/STD infections.[5,7]

Other examples are programs that seek to foster constructive roles for men in sexual and reproductive health by targeting men, especially young men, and working with them and women to redefine gender norms, encourage healthy sexuality, and reduce violence against women.[5]

Programs that treat HIV/AIDS within a broader social and economic context and seek to empower women as a goal in of itself as well as a way to prevent the spread of HIV are on the far end of the gender transformative continuum. Programs that treat HIV/AIDS within a broader social and economic context and seek to empower women as a goal in and of itself as well as a way to prevent the spread of HIV are on the transformative end of the gender integration continuum.

6.4.1.2 Examples of Gender Accommodating and Gender Transformative Approaches

Although the continuum may seem linear, programs may actually use more than one approach. In some cases, a gender transformative approach may have unintended harmful consequences and actually worsen gender inequities. In other cases, a gender accommodating approach may contribute to a transformative outcome, even if that was not the explicit intent. It is therefore important to consider the full range of interventions and activities in each program and assess them to determine where they fall along the *Gender Integration Continuum*.[2,7] Monitoring and evaluating gender outcomes against the continuum allows program planners and managers to reconsider and modify program strategies and activities as needed to ensure they are gender-responsive.[2]

The ultimate goal of gender integration in HIV prevention programming is to reduce HIV infections and achieve positive health outcomes while moving toward transforming gender norms, roles, and relations to attain greater equality between women and men. Changing entrenched gender norms, roles, behaviors, and unequal power in relationships is a long-term process. While gender accommodating approaches are essential, it is important to keep in mind that they compensate for, rather than change, gender differences and inequities. HIV prevention programs that seek to transform gender norms and relations may take more time to bring about changes. However, it is such changes that are more likely to result in beneficial HIV/AIDS-related health and gender-equity outcomes that will have long-term benefits for women and men as well as their families.[2]

The Women's Co-Op is an example of a gender accommodating intervention aimed at black/African American women who use crack cocaine and are at least 18 years of age. It is an evidence-based intervention included in the CDC's *Compendium of Evidence-Based HIV Behavioral Interventions*.[3] The intervention is grounded in empowerment theory and black/African American feminism and includes gender- and culture-specific skills training. It acknowledges specific barriers facing black/African American women and how these barriers affect daily experiences and choices. The intervention addresses drug dependence as a form of "bondage," and it is designed to facilitate greater independence and increase personal power and control over behavior choices as well as life circumstances. The intervention contains psycho-educational information and skills training on reducing HIV risk and drug use. It is presented within the context of black/African American women's lives in the inner city, where pervasive poverty and violence limit women's options and increase the likelihood of poor (i.e., high-risk) behavior choices.[9]

6.4.2 Using Gender Strategies to Design the Program

A number of strategies specifically address inequities arising from gender norms, roles, and relations. They are referred to as gender strategies. Program planners and managers can consider a number of gender strategies when deciding among strategies and activities to address GBCs and maximize GBOs for women and adolescent girls that they have identified through the gender analysis and needs assessment processes and prioritized in the program goals and objectives. Because multiple and interrelated social, cultural, economic, and political factors contribute to

HIV infection among women and adolescent girls, programs that use multiple rather than single strategies may be more effective.

Table 7, *Gender Strategies to Consider in Planning HIV Prevention Programs and Services*, presents a list of gender strategies as a menu of options that planners and managers can consider as they make program design decisions. The table links the gender strategies to the domains of gender relations they address and provides illustrations of the related strategies and activities.

Table 7: Gender Strategies to Consider in Planning HIV Prevention Programs and Services		
Domain	Gender-Based Constraints	Illustrative Gender Strategies and Activities
Dominant Norms of Femininity and Masculinity	Harmful gender norms and practices	Addresses harmful gender norms and practices
Dominant Norms of Femininity and Masculinity	Stigma and discrimination against gender expression	Reduce stigma and discrimination
Gender Roles	Burden of Care	Reduce the burden of care
Access to and Control of Resources	Low educational attainment, low literacy, or lack of training	Increase women's/adolescent girls' access to educational and training opportunities
Access to and Control of Resources	Lack of access to and control over economic resources	Increase women's access to income and productive resources
Power and Decision Making	Violence and coercion	Reduce violence against women and coercion
Cross-Cutting	Barriers in access to services	Reduce barriers in access to services

In choosing from different options, program planners and managers should consider whether the gender strategies are likely to be effective in achieving both HIV prevention and gender-equity objectives. The *Gender Integration Continuum* can help program planners and managers assess how responsive existing or proposed program strategies and activities are to gender dynamics. They can determine whether the strategies and activities are gender accommodating or gender transformative or a combination of both.

Tool 9, *Using the Gender Integration Continuum and Gender Strategies to Design Gender-Responsive HIV Prevention Programs*, provides a matrix for program planners and managers to determine where their proposed or existing program falls on the Gender Integration Continuum and assess the degree to which the strategies and activities respond to the priority GBCs and GBOs identified through the gender analysis and needs assessment processes. This assessment will help program planners and managers to determine if they need to adapt existing or design new strategies and activities to fall under a different type of approach along the *Gender Integration Continuum*.

To complete the assessment, in Column 1, list the domains of gender relations. In Column 2, list the existing or proposed corresponding program goals and objectives that address the priority GBCs or GBOs identified through gender analysis and needs assessment. In Column 3, list the existing or proposed gender strategy. In Column 4, list the proposed corresponding program strategies or activities to address the objectives. In Column 5, list the gender integration approach(es) that best reflect(s) the existing or proposed strategies and activities.

Tool 9: Using the Gender Integration Continuum and Gender Strategies to Design Gender-Responsive HIV Prevention Programs				
1) Gender Domain	2) Program Objective	3) Gender Strategy	4) Program Strategies or Activities	5) Gender Integration Continuum Category
Gender Norms				
Gender Roles				
Access to and Control over Resources				
Power and Decision-making				

An example of the completed tool is presented in Table 8, *Using the Gender Integration Continuum and Gender Strategies to Design Gender-Responsive HIV Prevention Programs*. The strategies and activities in this example are intended to be illustrative rather than exhaustive. There may be other strategies and activities that are not included but could correspond to a particular gender-integration approach. HIV prevention programs intended to be responsive to the needs of women and adolescent girls should not have goals or objectives, or employ strategies and activities, that are gender exploitative. However, in this example, gender exploitative strategies or activities are presented to underscore the fact that programs may have unintended consequences that may result in gender exploitative outcomes. Keep this in mind as program goals and objectives are being developed or revised and think about ways to avoid gender exploitative outcomes.

Table 8: Using the Gender Integration Continuum and Gender Strategies to Design Gender-Responsive HIV Prevention Programs - Example				
1) Gender Domain	2) Program Objective	3) Gender Strategy	4) Examples of Program Strategies or Activities	5) Gender Integration Continuum Category
Gender Norms	Goal: Reduce new HIV infections among at-risk women and men. Obj.: Increase the proportion of women and men who have knowledge of the risks of HIV infection. Obj.: Increase the proportion of women and men who have knowledge of consistent condom use as a risk-reduction method. Obj.: Increase the proportion of women and men who correctly and consistently use condoms when having sex with a male or female partner.	N/A	Conduct a condom promotion campaign designed to motivate women and men to protect themselves against HIV and encourage condom use, capitalizing on cultural values that focus on male virility, sexual conquest, and control and depicting men having multiple female partners and women as sexually naïve and passive.	Gender Exploitative (Exploits harmful gender norms to achieve project objectives)
Access to and Control over Resources	Goal: Reduce new HIV infections among at-risk women and men. Obj.: Increase the proportion of women and men, adolescent girls and boys who have knowledge of the modes of HIV transmission, HIV risk behaviors, and risk-reduction methods.	N/A	Provide HIV outreach, prevention information, and education targeted to general audiences that include both women/ adolescent girls and men/ adolescent boys (e.g., workshops on HIV prevention with mixed groups).	Gender Blind
Access to and Control over Resources	Goal: Reduce new HIV infections among women at risk of HIV and IPV. Obj.: Increase the proportion of women at risk for HIV infection and IPV who receive violence prevention and protection services. Obj.: Increase the proportion of women at risk for HIV infection and experiencing IPV who receive medical services and PEP.	Reduce VAW/ GBV Increase Access to Services	Provide screening for IPV among women at risk for HIV infection; provide education and counseling to women at risk of IPV regarding safety planning; provide referrals to violence-prevention services and domestic-violence shelters, medical services including post-exposure prophylaxis (PEP), etc.	Gender Accommodating

Table 8: Using the Gender Integration Continuum and Gender Strategies to Design Gender-Responsive HIV Prevention Programs - Example, Continued				
1) Gender Domain	2) Program Objective	3) Gender Strategy	4) Examples of Program Strategies or Activities	5) Gender Integration Continuum Category
Gender Norms	Goal: Reduce new HIV infections among at-risk heterosexual couples. Obj.: Increase the proportion of heterosexual couples who can communicate effectively about their sexuality and their sexual relationships. Obj.: Increase the proportion of heterosexual couples who can articulate the harmful effects of norms of masculinity and femininity on their sexual relationships and decision making. Obj.: Increase the proportion of heterosexual couples who engage in more gender-equitable sexual decision making. Obj.: Increase correct and consistent condom use among heterosexual couples.	Address Harmful Gender Norms	Conduct weekly relationship-based counseling sessions for heterosexual couples focusing on relationship factors (respect, trust, fidelity, love, gender norms, imbalance in power and sexual decision making, control of resources) that may present barriers to condom use; importance of safer sex in intimate relationships; sexual communication skills; men's role and responsibility for HIV risk reduction and condom use, etc. Provide counseling and education on sexual health and sexuality; coaching and skills- building on use of male and female condoms; sexual communication skills; recognizing personal and couple triggers for unsafe sex within relationship context; problem-solving skills to negotiate high-risk situations; and identifying sources of social support for individual/couple to maintain safer sex/risk-reduction behaviors.	Gender Transformative

SUMMARY OF GENDER AWARE APPROACHES

Gender blind approaches are those that do not consider local gender differences, norms, roles, and relations in program design, implementation, and evaluation. These approaches do not take into account how gender norms, roles, and unequal power relations affect the attainment of program objectives or how program objectives impact gender relations.

Gender aware approaches are those that explicitly recognize and consider local gender differences, norms, roles, and relations in program design, implementation, and evaluation. This recognition is generally derived from a gender analysis that is conducted prior to designing and implementing the program. All programs and services that integrate gender must at a minimum be gender aware. The following are three types of gender aware approaches that form the gender integration continuum:

- *Gender exploitative* approaches are those that take advantage of existing gender norms, stereotypes, and unequal power relations to achieve HIV prevention and health outcomes. Such approaches reinforce unequal power in the relations between women and men, and potentially worsen existing inequalities.

- *Gender accommodating* approaches are those that adjust to or compensate for gender differences, norms, and inequities in gender roles and relations in program design, implementation, and evaluation. Such approaches respond to the different roles, identities, and needs of women and men. They do not deliberately challenge unequal relations of power or address underlying structures that perpetuate gender inequalities.

- *Gender transformative* approaches are those that explicitly engage women and men to examine, question, and change gender norms, roles, relations, and institutions that reinforce gender inequalities. Such approaches promote more equitable gender relations and as a result achieve both HIV prevention and gender-equality objectives.

Source: Population Reference Bureau (PRB). 2009. *A Manual for Integrating Gender into Reproductive Health and HIV Programs: From Commitment to Action* (2nd ed.). United States Agency for International Development (USAID).

6.5 Integrating Gender in Program Implementation

Integrating gender in the implementation phase involves translating the program design into an effectively operating program. During this phase, the program is actually conducted and the planned strategies and activities are carried out as designed. Effective program implementation is the test of good program design. At all levels of implementation, program planners and managers should ensure that program goals and objectives that address gender equity and equality are linked to strategies, activities, budgets, and timelines that clearly identify the persons responsible for each task.

Integrating gender into the implementation of the program requires program planners and managers to assure that policies and operational procedures are in place to support staff in addressing identified gender and social diversity issues. They must also examine the extent to which continued attention is paid to identified gender and social diversity issues and to assess progress

made in implementing planned actions to address them. It requires developing an implementation plan and monitoring the execution of the plan.

6.5.1 Assess Organizational Commitment and Capacity for Gender Integration

Implementation of gender-responsive HIV programs and services occurs within the organizational context in which the program is embedded. It can be facilitated or constrained by the organization's commitment to, readiness for, and capacity for gender integration. When planning for program implementation, include the perceptions and attitudes of staff, skills for gender programming, management support for integrating gender issues, and the gender balance in the overall staffing and decision making processes. The following sections cover these issues in more detail.

6.5.2 Implementation Issues Related to Staff, Partner Organizations, and Participants

The sections that follow highlight some gender-related implementation issues that should be taken into account regarding program staff, partner organizations, and the participation of women and adolescent girls.

6.5.2.1 Program Staff

It is important to ensure that the program has the personnel necessary to achieve the program objectives. Program planners and managers should ensure that staff has sufficient gender knowledge, understanding, and skills to implement the program effectively. Gender expertise should be included as a qualification in staff job descriptions. In addition, the specific responsibilities for implementing gender-equality objectives, strategies, and activities through every stage of the program cycle should be explicitly stated in job descriptions, staff evaluation criteria, and scope of services' documents for all program staff and consultants. This will significantly increase the chances that gender-equality issues will be seriously addressed.

Program planners and managers may decide to use gender specialists to advise and assist them in program design and implementation. To be effective, gender specialists need good strategic assessment and planning, communication, advocacy, and negotiation skills. Progress in gender integration is more likely to occur when gender specialists are effective resource people, motivators, and facilitators who mentor and support their colleagues in addressing gender-equality issues in their areas of work.[10]

Training should be provided to both women and men through all levels of the organization to ensure they understand the gender implications of the HIV-related issues addressed by the program. Ongoing training should be periodically provided to staff involved in implementing the program to develop and strengthen their knowledge and skills in gender analysis, gender integration, and gender strategies and interventions. The training should address the gender implications for HIV prevention programming.

The program budget should include funding for gender awareness; gender analysis; gender integration training; and recruiting and hiring staff or consultants (including gender specialists) with the requisite gender background, knowledge, and expertise. Using female staff and women's groups facilitates women's participation in programs and helps ensure that women have access to program resources. If women and adolescent girls cannot be effectively reached by male staff, provisions need to be made in the budget to cover the costs of recruiting and hiring the female staff required, and vice versa if men and adolescent boys are also program participants.

6.5.2.2 Partner Organizations

Effective implementation of gender-responsive HIV prevention programs and support services requires building and maintaining partnerships with other organizations and stakeholders, including women's organizations. Partner organizations should share a vision and explicit consensus on the gender-equity and -equality goals of the program. It is important for program planners and managers to know and understand their partner organizations and their context to build a shared vision and consensus on the gender objectives of the program. This work begins from the onset of the planning process as program planners and managers engage in the assessment of needs and community capacity. Part of this assessment includes examining partners' backgrounds in, commitments to, and capacities for gender integration and gender equity.

To develop a shared vision and consensus, program planners and managers need to engage partners in dialogues about the gender-equity and -equality goals of the program. Discuss the relevance of these goals for the HIV prevention work they will do together and for the overall health and well-being of women and adolescent girls, and men and adolescent boys. A shared vision and consensus entails articulating in very concrete ways how women's and adolescent girls', and men's and adolescent boys', needs, benefits, and rights are relevant to the HIV prevention activities being planned and implemented, taking into account the social, economic, and political context. This process will facilitate the development of a shared vision and explicit consensus on gender-equality objectives among partners and agreement on investments and activities needed as well as a clear understanding of how benefits for both women and men will be realized.

Program planners and managers should include approaches to working with partner organizations in the program implementation plan. Partnerships with local women's organizations should be included in the plan if the program design includes such partnerships as part of the strategy to empower women and adolescent girls, strengthen their group identity, and increase their capacity to take collective actions to improve their health and well-being.

Because partnerships are based on shared decision making and mutual accountability, it is important that specific roles, responsibilities, and accountabilities among partners are mutually agreed upon. They should be specified informally or formally in partnership agreements. Formal agreements usually take the form of memoranda of understanding, which should specifically delegate each organization's roles, responsibilities, and deliverables, including those related to accomplishing the gender goals and objectives and carrying out the gender strategies and activities. This helps establish accountability for the gender-related activities as well as major decisions not only to the lead organization, other organizations, and funders, but also to the communities where the program will be delivered.

6.5.2.3 Participation of Women and Adolescent Girls

Gender-responsive HIV programming requires that program planners and managers ensure the participation of women and adolescent girls when implementing the program, not only as beneficiaries but also as implementers, managers, and decision-makers. The program implementation plan should include strategies and activities to facilitate these roles. Factors constraining participation should be considered in the plan. Make sure that women's and adolescent girls' participation does not incur additional work or burdens without providing needed supports or compensation. The program budget should allocate funding to address barriers to their participation such as childcare and transportation. If peer educators or volunteers are part of the program design, then the budget should also allocate funding for their recruitment and training as well as to support their ongoing participation (e.g., stipends, travel expenses).

Providing leadership training is important to enhance women's and adolescent girls' meaningful participation and capacity in decision making. If the program design includes leadership development, then the program budget should also allocate funding to provide the resources to carry out leadership development activities and support women's and adolescent girls' participation in these activities. The program implementation plan should also describe activities that ensure women's and adolescent girls' participation in managing the program and their equal access to information, resources, and opportunities to carry out their responsibilities. Gender-awareness training may be needed to change negative stereotypes and attitudes among staff, management, partner organizations, and other stakeholders regarding women's participation in decision making and their management capacities. The program budget should reflect provisions for activities related to including women in program management such as special recruitment, management and leadership development training, and gender-awareness training addressing negative stereotypes and attitudes regarding female managers.

Gender integration during the implementation phase requires program planners and managers to identify and address gender differences and inequalities in program implementation processes. This requires that gender analysis and planning occur throughout the implementation process. **Tool 10,** *Considerations for Gender Integration in Program Implementation*, is a checklist designed to assist program planners and managers in identifying and addressing GBCs and GBOs during program implementation.

Tool 10: Considerations for Gender Integration in Program Implementation				
Component		Yes	No	If NO, what actions are needed to address this issue?
Program Staff and Consultants				
Qualifications, Hiring, and Pay	Are knowledge of how gender affects HIV vulnerability, risk, and prevention, and knowledge, experience, and skills in gender analysis included as required qualifications in staff job descriptions?			
	Do staff job descriptions clearly spell out responsibilities and expectations for carrying out the gender components and activities of the program and gender integration			
	Do annual performance evaluations take into account staff performance in carrying out the gender components and activities of the program and gender integration?			
	Are knowledge of how gender affects HIV vulnerability, risk, and prevention, and knowledge, experience, and skills in gender analysis included as required qualifications in consultant agreements or contracts?			
	Are responsibilities and expectations for carrying out the gender components and activities of the program and gender integration clearly spelled out in consultant agreements or contracts?			
	If women and adolescent girls cannot be effectively reached by male staff, are provisions made to recruit and hire the female staff required?			
	If men and adolescent boys are program participants and cannot be effectively reached by female staff, are provisions made to recruit and hire the required male staff?			
	Is there a commitment in program policy and practices to achieve an equal balance among female and male program staff at all levels, including management?			
	Is there a commitment in program policy and practices to provide men and women staff at all levels with equal pay for work of equal value?			
Training	Is gender-awareness training provided to program staff at all levels on a regular basis to strengthen their commitment to gender integration?			
	Is training provided to program staff at all levels on a regular basis to strengthen their capacity in gender analysis and planning?			
	Is training provided to program staff at all levels on a regular basis to strengthen their capacity to implement gender strategies and activities?			
	Is training provided to program staff at all levels on a regular basis related to sexualities, gender, and sexual identities?			
	Is training and technical assistance provided to women in management and leadership skills to support their role as managers in the program?			

Tool 10: Considerations for Gender Integration in Program Implementation - Continued				
Component		Yes	No	If NO, what actions are needed to address this issue?
Supervision and Reporting	Does the program have procedural manuals that incorporate gender-equity considerations into policies and methods to be followed by staff?			
	Does staff supervision include review and discussion of problems encountered in implementing gender strategies and activities? Are the changes that need to be made in the implementation plan to address factors that impede effective implementation of gender strategies and activities discussed and agreed upon?			
	Do program managers consult with program staff, consultants, participants, volunteers, partner organizations, and other stakeholders on a periodic basis regarding implementation challenges and progress related to gender strategies, activities, and achievement of objectives? Is the feedback received incorporated in revisions of the program implementation plan, activity calendar, logic model, and budget?			
	Do program staff, consultants, and volunteers submit periodic written reports to program managers on progress in implementing gender-related strategies and activities and achieving program goals and objectives?			
	Are data collected on the implementation of program actions and activities disaggregated by sex (women/girls and men/boys) and other relevant social statuses?			
Partner Organizations				
	Do partner organizations have expertise in gender and/or sexuality?			
	Are the responsibilities and expectations of partner organizations for the gender components of the program and gender integration clearly spelled out in memoranda of understanding?			
	Does the implementation plan include actions, activities, or methods that make sufficient use of existing women's organizations and networks such as women's clubs, church organizations, political organizations, or organizations of women living with HIV/AIDS?			
	Are the female staff members of partner organizations as actively involved in the management of the program as male counterparts?			
	Does the implementation plan include actions and activities to strengthen the capacity of partner organizations in gender, sexuality, and gender analysis and integration (e.g., trainings, etc.)?			

GENDER INTEGRATION FOR PROGRAM DESIGN

Tool 10: Considerations for Gender Integration in Program Implementation - Continued				
Component		**Yes**	**No**	**If NO, what actions are needed to address this issue?**
Participation of Women and Adolescent Girls				
	Are the female staff members of partner organizations as actively involved in the management of the program as male counterparts?			
	Does the implementation plan include actions and activities to strengthen the capacity of partner organizations in gender, sexuality, and gender analysis and integration (e.g., trainings, etc.)?			
	Are program activities that involve women and adolescent girls carried out at times and locations convenient for them?			
	Does the implementation plan specify the actions/activities that will be undertaken to reduce gender-related constraints to women's and adolescent girls' participation in the program?			
	Does the implementation plan specify actions/activities to include and support women and adolescent girls as implementers of program activities, e.g., as peer educators, volunteers? (Does it provide training, stipends, travel expenses, childcare?)			
	Does the implementation plan include actions/activities to include and support women and adolescent girls as decision-makers in the management of program activities, e.g., as members of advisory councils or committees? (Does it provide leadership training, travel expenses, childcare?)			
	Does the implementation plan include actions/activities to ensure women's and adolescent girls' participation in the program does not result in additional work for them? (For example, does it provide for childcare or compensate them for work in the program)?			

Tool 10: Considerations for Gender Integration in Program Implementation - Continued				
Component		Yes	No	If NO, what actions are needed to address this issue?
Budget				
	Does the program budget allocate sufficient funds for staff recruitment and training and development in gender, sexuality, and gender analysis, planning and integration?			
	Does the program budget allocate sufficient funds for management and leadership training and technical assistance for women?			
	Does the program budget allocate sufficient funds to carry out the gender components and activities of the program?			
	Does the program budget allocate sufficient funds to facilitate women's and adolescent girls' participation in program activities and eliminate any constraints to their participation (e.g., childcare, travel expenses, etc.)?			
	Does the program budget allocate sufficient funds to facilitate and support women's and adolescent girls' participation as implementers of program activities (e.g., recruitment, training, stipends, travel expenses, childcare)?			
	Does the program budget allocate sufficient funds to facilitate and support women's and adolescent girls' participation as decision- makers in the management of program activities (e.g., leadership training, travel expenses, childcare)?			

6.6 Integrating Gender in Program Monitoring and Evaluation

Gender-sensitive monitoring and evaluation (M&E) is fundamental to an evidence-based approach to the decision making necessary for designing and implementing effective, gender-responsive HIV prevention programs and support services. M&E is the process of acquiring, analyzing, and making use of relevant, accurate, timely, and affordable information from multiple sources for the purpose of program improvement.[11] M&E are important functions for reviewing the extent to which programs have considered and addressed gender issues in their program design and implementation. M&E may also facilitate opportunities to incorporate gender concepts in ongoing or future programs or both. Gender-sensitive M&E considers gender issues in developing the M&E plan; gathering and managing information during implementation; regularly analyzing information and reflecting critically with program partners to improve action; and communicating and reporting results.[12]

It is important to take gender into account in program M&E because women and adolescent girls, and men and adolescent boys:

- Experience different vulnerability and risk factors for HIV infection and experience the impact of HIV/AIDS differently;

- Face different constraints in their efforts to reduce their vulnerability to and risk of HIV infection and improve their health and socioeconomic conditions;

- Have different roles, responsibilities, access to, and control over resources and power and decision making authority and therefore face different GBCs and have different GBOs related to HIV prevention;

- May have different needs and priorities regarding programs to prevent and reduce HIV infection; and

- Are differently affected by HIV prevention programs.

Regular M&E often does not capture gender differences in participants' access to and benefits from a program or service and a program's impact on gender relations. Gender- sensitive M&E is based on gender awareness and gender analysis. Applying gender analysis in M&E ensures that gender-equality concerns are addressed throughout program planning and implementation, regardless of whether the program explicitly targets the empowerment of women and adolescent girls or gender equality. HIV prevention efforts are hampered by gender inequalities in roles and responsibilities; access to and control over resources and opportunities; and power and authority in decision making. Ignoring women's and adolescent girls' needs and capacities will significantly reduce the efficiency and impact of HIV prevention programs and services and may worsen inequalities.

Designing a gender-responsive HIV program and developing a gender-sensitive M&E plan are inseparable activities. M&E planning starts at the time that program goals and objectives are set and the program design is developed. These activities are carried out together. **Figure 7,** *Gender Integration in Program Monitoring and Evaluation*, illustrates how gender analysis is integrated in the evaluation M&E process and the program logic model.

Gender-sensitive M&E will help ensure that 1) a program is well-researched and clearly defined; 2) it addresses GBCs and GBOs faced by different subgroups of women and adolescent girls and men and adolescent boys; and 3) it can be objectively measured and verified with sound data collection methods. Gender-sensitive M&E will also allow program planners, managers, funders, and other stakeholders to determine whether the program is meeting its gender-related goals and objectives and to take action to improve program effectiveness.

6.6.1 Involve Women and Adolescent Girls and Other Relevant Stakeholders

Women and adolescent girls who are the intended participants of the program and other relevant stakeholders, including funders, planners, managers, and implementers, should be actively involved in M&E activities. If an external evaluator is used, then it is also important to have the commitment of the implementing organization from the beginning of the process. The external evaluator should be fully briefed about the program, the planning process, and the intervention, as well as the gender-related issues and components of the program. The program planning group and other stakeholders, including funders, should be involved from the onset to enhance their commitment to and ownership of the process and the findings. Involvement may include using women and adolescent girls as research assistants, asking for their input on the research, and monitoring questions and methods as well as their advice on the best ways to collect information from the priority population(s).

Figure 7: Gender Integration in Program Monitoring and Evaluation

Program Logic Model

Goal ← HIV Prevention, Gender Equity, Empowerment

Gender-Sensitive M&E

Objectives ← Eliminate GBCs & Maximize GBOs ← Evaluation of Impact

Outputs ← Benefits of Outputs for Women & Men

Implementation Activities ← Integration of Gender into Implementation Plan ← Monitoring Progress in Gender Integration

Resources & Inputs ← Gender Equity in Allocation of Program Resources

Program Identification ← Information on HIV Prevention, Social & Gender Issues

GENDER ANALYSIS

Adapted from World Bank. n.d. *Integrating a Gender Dimension into Monitoring & Evaluation of Rural Development Projects*, p. 3. Retrieved from *http://siteresources.worldbank.org/INTGENDER/Resources/metoolkit.pdf*

6.6.2 Benefits of Gender-Sensitive Monitoring and Evaluation

Gender-sensitive M&E can help program planners and managers:

- Identify whether they have overlooked important gender concerns in program design,
- Understand why they have not addressed these gender concerns during design,
- Take stock of gender differences in needs and responses to proposed program activities, and
- Take steps to adjust or revise proposed program objectives, strategies, and activities.

Even if gender concerns have been explicitly incorporated in the program design, gender-sensitive M&E can be used to determine if gender concerns were adequately addressed during program implementation. It can also determine whether the program as designed actually contributes to the promotion of gender equality and achievement of HIV prevention goals. Failing to adequately address gender concerns may have negative consequences for the relevance, effectiveness, and sustainability of a program.

Gender-sensitive M&E provides program planners and managers with an essential feedback mechanism to determine whether the program as designed actually addresses GBCs and GBOs that different subgroups of women and adolescent girls, men and adolescent boys, face and whether it is achieving its HIV prevention goals and contributing to gender equality. Through gender-sensitive M&E, program planners and managers can learn how program strategies and activities affect women and adolescent girls and men and adolescent boys differently and impact gender relations. Program planners and managers can use this information, if required, to reformulate objectives, strategies, activities, or indicators in order to address GBCs to implementation, improve the program's effectiveness in addressing the different needs of women and adolescent girls, men and adolescent boys, and in achieving HIV prevention and gender-equality goals.

6.6.3 Interrelationships of Monitoring and Evaluation

Monitoring and evaluation are interrelated and complementary yet distinct processes that differ in purpose and design.[15] Monitoring provides real-time information on ongoing program implementation required by program managers. It can provide a "snapshot" of the status of the program or situation.[15] Evaluation provides more in- depth assessment of whether a specific program is achieving its objectives and why objectives or targets are or are not achieved. The monitoring process provides important information for program evaluation, including baseline data, information on the program implementation process, and measurements of progress toward the planned results through indicators. It can also generate questions to be answered by evaluation. When monitoring indicates that program efforts are off track, evaluation can complement monitoring by clarifying why the program is not working.

Evaluation activities build on the findings from monitoring activities, providing additional information to determine the scope, quality, intensity, efficiency, effectiveness, and overall impact of a program.[15] Special evaluations studies can help program managers identify and understand factors that facilitate or impede the achievement of the objectives or specific targets of HIV prevention programs and support services. See Table 9, *Complementary Functions of Monitoring and Evaluation.*

Table 9: Complementary Functions of Monitoring and Evaluation	
Monitoring	**Evaluation**
Clarifies program objectives	Analyzes why intended results were or were not achieved
Links activities and their resources to objectives	Assesses specific causal contributions of activities to results
Translates objectives into performance indicators and sets targets	Explores implementation process
Routinely collects data on these indicators and compares actual results with targets	Explores unintended results
Reports progress to managers, policy- makers, or funders, or all of them, and alerts them to problems	Highlights accomplishments or program potential; provides lessons learned; offers recommendations for improvement
Source: UNAIDS (Joint United Nations Programme on HIV/AIDS). 2010. *Basic Terminology and Frameworks for Monitoring and Evaluation: UNAIDS Monitoring and Evaluation Fundamentals*. *http://www.unaids.org/en/media/unaids/ contentassets/ documents/document/2010/7_1-Basic-Terminology-and-Frameworks-MEF.pdf*	

6.6.4 Gender-sensitive Monitoring

Monitoring is an internal program management activity that helps determine whether the program has been implemented as designed. It is an ongoing process that entails routine data collection, tracking, and reviews of program implementation to determine whether resources are being mobilized as planned within budgetary requirements, whether services or products are being delivered as scheduled, and whether any adjustments may be needed to achieve program objectives. Using a gender-sensitive monitoring approach can help program planners and managers determine the following:

- Whether the program is being delivered to the persons for whom it was intended (e.g., women and adolescent girls);

- Whether the program is being delivered in a form that is consistent with its original design (e.g., has the staff carried out the activities as originally planned?);

- To what extent the program's outputs benefit women and adolescent girls, men and adolescent boys;

- To what extent the program's outputs address women's and adolescent girls' or men's and adolescent boys' respective HIV prevention needs and issues, taking into account the different GBCs and GBOs that women and adolescent girls, men and adolescent boys may face; and

- Corrective actions that may be needed to address GBCs, maximize GBOs, and address gender-based inequalities.

Monitoring also helps to determine the programmatic, organizational, and implementation factors related to why a program is implemented in a certain way. For example, an HIV prevention education program can be well-designed but not well-implemented because the staff has not been trained well enough to carry out certain activities or because intervention planners have misconstrued the actual needs of the women or adolescent girls that the program is intended to serve. For example, staff may have underestimated the extent of intimate partner violence experienced by program participants and its influence on condom use during sex with an abusive partner. Women under the threat of violence may be constrained from using female condoms consistently, even if the program made them available free of charge and provided education and skills-building to ensure their proper use.

6.6.5 Gender-sensitive Evaluation

Program evaluation is the periodic, systematic, and in-depth assessment of the relevance, performance, and success of an ongoing and completed program. Evaluation is undertaken selectively to answer specific questions that will guide decision-makers or   program managers or both. It will provide information on whether underlying theories and assumptions used in program design were valid, what worked, and what did not work and why. Evaluation entails systematic collection of information about the particular behavior or environmental condition the program intends to change. It will compare outcomes at two or more points in time, usually before the program is delivered (baseline) and at various points in time after it has been delivered as well as at the end of the program. Information is also collected on the activities, characteristics, and outcomes of a program to make judgments about the program's effectiveness, improve its effectiveness, and inform decisions about future program development.

Gender-sensitive evaluation measures progress in achieving HIV prevention and gender- equity goals and objectives. The findings of an evaluation should be used both to make decisions about program implementation and to improve program effectiveness.

M&E results can inform program planners and managers to adjust program design and activities, enhance aspects of the program that contribute to more equitable HIV prevention and gender outcomes, and reformulate those that do not. Specific study designs and special studies are used to measure the extent to which changes in desired outcomes are attributable to the program's interventions. Program evaluation may be conducted by the organization implementing the program or by an external organization or consultant.

A gender-sensitive evaluation process uses a mix of quantitative and qualitative methods to assess the roles of women and men in the program and how gender issues affect whether outcomes are achieved. Some important issues to consider in evaluating the outcomes of a gender-responsive HIV prevention program follow:

• How the program's outputs have affected women and adolescent girls, men and adolescent boys;

• To what extent the program addressed the different needs and priorities of women and adolescent girls, men and adolescent boys;

• How women and adolescent girls, men and adolescent boys, directly benefit from the program;

• Whether the program has reduced power differences in relations between men and women;

• Whether and how the program has reduced the use of VAW by men and adolescent boys;

• Whether and how program outputs empower women/adolescent girls;

• To what extent the program challenged traditional norms and power relations, introduced practices that promote equity, and reduced gender inequalities;

• How addressing gender issues has contributed to HIV prevention goals;

• Whether the program has reduced stigma and discrimination against women/girls and people who do not follow traditional gender norms and behaviors (e.g., transgender women, lesbians, bisexual women, sex workers);

• Whether the program has reduced the burden of care for women and adolescent girls;

• Whether men and adolescent boys have become more involved in caring for children, the elderly, sick, or disabled within the family;

• Whether the removal of GBCs has contributed to improved health outcomes;

• Whether the program has contributed to an increase in support for gender equity by institutions and organizations and a decrease in discriminatory practices;

• Whether the program has contributed to increasing women's and adolescent girls', or men's and adolescent boys', health-seeking behavior;

• Whether the program has contributed to increasing women's and adolescent girls', or men's and adolescent boys', access to HIV prevention, treatment, care, and supportive services; and

• Whether the program has contributed to reducing women's and adolescent girls', or men's and adolescent boys', vulnerability to and risk for HIV infection.

Evaluation can also help to identify the strategies or activities that did not work and provide some insights into why. Conducting gender analysis during this phase can help to uncover important aspects of gender relations that may have been overlooked when the program was originally designed. It can also help program planners and managers identify the program activities that need to be redesigned in order to more effectively address gender inequalities

and achieve program outcomes. Program participants should be engaged in examining why the program is not achieving its intended outcomes since they may be aware of important factors that program staff may not recognize.

Program participants and staff can consider the following questions as they work together to identify the obstacles to achieving the program objectives and improve program effectiveness:

- Does the program adequately address the specific gender needs of the participants?

- Are there any gender-based obstacles to achieving the objectives of the program that were not adequately addressed by the original program design?

- Does the program's staff have the appropriate knowledge and skills to address the gender issues and the needs of participants?

- Are the indicators used in monitoring and evaluation adequately measuring the impacts of the program? Do these indicators need to be revised or refined to better capture the program's impact on gender relations?

6.6.5.1 Evaluation of Program Performance

Assessing program performance goes beyond the implementation process and focuses on the results of inputs delivered and the work done. The outcome of performance evaluation determines whether the program has achieved or is likely to achieve its outputs and contribute to achieving program outcomes and impact. Performance evaluation is concerned with the relevance, efficiency, effectiveness, impact, and sustainability of a program. It is important to assess the program's performance in addressing gender concerns in the areas described below.

6.6.5.1.1 Relevance

Relevance measures the degree to which the program responds to the needs of the participants or beneficiaries. The analysis of relevance determines whether the program continues to make sense and identifies any changes that may have occurred in its context during implementation. In gender-sensitive evaluation, relevance measures the degree to which the program responds to the different needs of women and adolescent girls and men and adolescent boys. It also considers the extent to which the program is responsive to gender-equality and empowerment issues. Appropriateness is an important subcategory of relevance: Is the program as it is implemented culturally acceptable and feasible within the local context? In applying the criterion of relevance, evaluations should explore the extent to which the planning, design, and implementation of a program take into account the local context.

Considerations regarding relevance in a gender-responsive program address the following:

- Whether a gender analysis was included in the initial needs assessment of the program;

- Whether the different needs of women and adolescent girls and men and adolescent boys have been identified and met or whether these needs still exist;

- Whether the program has taken into account the views of women and adolescent girls and women's organizations on the usefulness of the program in meeting their needs; and

- Whether alternative ways of meeting the needs of women and adolescent girls and men and adolescent boys within the priority populations are needed and have been considered.[16]

6.6.5.1.2 Efficiency

Efficiency measures how economically resources or inputs (such as funds, expertise, and staff time) are converted into results. A program is efficient when it uses resources appropriately and economically to produce the desired outputs. Efficiency is important in ensuring that resources have been used appropriately and in highlighting more effective uses of resources. Gender considerations related to efficiency may include the following:

- How much of the allocated resources were spent on female and male participants or beneficiaries;

- How such expenditures compare to the results achieved for women and men;

- Whether the resources were allocated strategically to achieve gender-related objectives;

- Whether the resources have been used to fully develop the potential of women and adolescent girls as well as men and adolescent boys; and

- Whether there are alternative ways of promoting gender equality in the program that are more efficient.[16]

6.6.5.1.3 Effectiveness

Effectiveness measures the extent to which the program's intended results (outputs or outcomes) have been achieved. Evaluating program effectiveness involves an assessment of cause and effect—that is, attributing observed changes to program activities and outputs. Assessing effectiveness involves 1) measuring change in the observed output or outcome; 2) attributing observed changes or progress toward changes to the program; and 3) judging the value of the change (positive or negative). Gender considerations related to effectiveness may include the following:

- Whether changes or progress can be observed in the identified gender-related outcomes or outputs (e.g., changes in GBCs or GBOs, harmful gender norms, sexual division of labor, unequal power in gender relations and decision making, unequal access to and control over resources);

- Whether changes or progress can be attributed to the program; and

- Whether changes have contributed positively or negatively to gender equality. If negatively, what were the obstacles.[16]

6.6.5.1.4 Impact

Impact measures the extent to which the program contributes to its goal (e.g., reducing HIV infections), directly or indirectly, intended or unintended. Assessing impact generates useful information for decision making and supports accountability for delivering results. The main gender question related to this criterion is whether there are possible long-term effects on gender equality.[16]

6.6.5.1.5 Sustainability

Sustainability measures the extent to which benefits of the program continue after external funding has come to an end. Assessing sustainability involves evaluating the extent to which relevant social, economic, political, institutional, and other conditions are present and, based on that assessment, making projections about the organization's capacity to maintain, manage, and ensure the program's results in the future. Gender considerations related to sustainability may include the following:

- Whether the gender-related outcomes are likely to be sustainable;

- Whether the organization and priority populations have the long-term commitment and technical and financial capacity to continue the promotion of gender equality; and

- Whether the required human, physical, and financial resources will be made available to continue and further develop activities for the promotion of gender equality.[16]

6.6.5.1.6 Assumptions and Risks

Assumptions and Risks assess the likelihood of external factors positively or negatively affecting the program. Gender considerations in this area may address:

- Whether gender concepts and the effects of gender socialization, norms, and social values have been factored into the assumptions and risks; and

- Whether social, political, legal, cultural, or religious factors support or hinder promotion of gender equality.[16]

6.6.5.2 Types of Program Evaluations

Program evaluations generally fall into three categories: process, outcome, and impact.

6.6.5.2.1 Process evaluations

Process evaluations measure the quality and integrity of the program by assessing how well the program has been implemented as planned. Process evaluations focus on program implementation and assess coverage, rather than on desired results or outcomes. The information from a process evaluation can be used to make adjustments in a program to improve its effectiveness. In order to be useful, process evaluations must be planned to occur at frequent enough periods to allow for changes to be made, but after a long enough time to demonstrate what is needed. Process evaluation is generally easier than measuring results or outcomes.

6.6.5.2.2 Outcome evaluations

Outcome evaluations measure whether the desired change or result has been achieved. Outcome evaluation focuses on demonstrating whether program objectives have been reached. Data used for this type of evaluation usually come through a special study and are collected periodically, rather than on a routine basis. The goal of an outcome evaluation is to show that the changes observed in the priority population occurred as a result of the program being implemented. Outcome evaluations are used to assess changes in knowledge, behavior, skills, community norms, utilization of services, and health status indicators in the population such as the prevalence of HIV infection. In order to measure change, baseline data from the priority population are collected before the program is implemented. Baseline data must be available to compare with data collected after the program has taken place.

6.6.5.2.3 Impact evaluations

Impact evaluations show how much of the change can be attributed to the program. These evaluations are harder to conduct and require very specific study designs to measure the extent of the observed change in the desired HIV prevention outcome that can be attributed to the program. These evaluations often require the technical expertise of someone who specializes in their design and analyses.

6.6.6 Develop a Gender-sensitive Monitoring and Evaluation Plan

Program planners and managers should develop a gender-sensitive M&E plan to guide program monitoring and evaluation. The M&E plan is a tool for program management and supervision that describes a system which links strategic information obtained from various data collection systems to decisions that will improve HIV prevention programs and support services. A gender-sensitive

M&E plan ensures that program information is available to make decisions and adjustments as necessary. It also ensures that progress is documented, lessons are learned, and information is provided to program participants, funders, partners, and other stakeholders to demonstrate accountability.

Monitoring and evaluation plans help:

- Clarify assumptions about the causal relationships in the program design;
- Show how program components will operate to influence outcomes;
- Guide identification of indicators; and
- Guide analysis of program impact.

The plan will guide the design of monitoring and evaluation and highlight what information remains to be collected and how best to collect it. It will also suggest how to use the results to achieve greater program effectiveness and efficiency. A gender-sensitive M&E plan should be completed shortly after the program's "gender-conscious" logic model is finalized and before program activities are implemented.

In addition to considering gender-related issues when developing a gender-sensitive M&E plan, the plan should include the following components:

- *Description of the Program* – The plan should describe the overall goals and specific objectives, intended participants, geographic location, strategies, and activities to achieve the objectives, resources, timelines for completion, and persons responsible. The description should include the gender-related objectives, explain the gender issues faced by program participants, and describe the program's strategy to address them in design and implementation. An "gender-conscious" logic model should be included to describe the causal relationships of the program design. The logic model facilitates the planning and execution of the program, but it also helps in setting priorities for M&E. The conceptual framework integrates the inputs, activities, outputs, outcomes, and impact and establishes realistic expectations for what monitoring and evaluation can produce. The conceptual framework should recognize the gendered nature of HIV vulnerability and risk as well as the contribution gender equality makes to reducing infections.

- *Specific M&E Questions* – These questions define the information that the evaluation will generate. Program planners and managers, with the participation of the women and adolescent girls for whom the program is intended and other relevant stakeholders, should develop consensus on the main questions the evaluation will address and determine how those answers meet the information needs of those who will use the evaluation findings. The evaluation questions should be written and included in the M&E plan, taking into account the implementation of the program and its outcomes. Evaluation questions should be worded in a gender-sensitive manner and require sex-disaggregated information to answer. In addition, they should address key gender issues such as the sexual division of labor, access to and control of resources and power, and decision making, which will be assessed in program design and implementation.

- *Stakeholder Involvement and Participation* – The plan should describe the process used to include women and adolescent girls as well as other relevant stakeholders, in determining the scope of the evaluation. Including funders in this process is important because most require that organizations monitor and evaluate their programs. It is helpful to have an idea of what the funder would like to have covered in the evaluation. Participation of stakeholders in M&E

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is particularly useful when there are questions about implementation difficulties, program effects on different participants, beneficiaries, and other stakeholders, or when information is wanted on stakeholders' knowledge of program goals or their view of progress. Participation of program stakeholders in program design, implementation, and M&E improves program quality and helps address local HIV prevention needs. Stakeholder involvement increases the sense of local ownership of program activities and ultimately promotes the likelihood that the program activities and their impact would be sustainable.

- *Scope of the Evaluation* – The plan should describe the scope of the evaluation, which defines the time period, phase-in implementation, geographical area, dimensions of stakeholder involvement, and which components, outputs, or outcomes will be assessed by the evaluation. This description should include gender-related outputs or outcomes that will be assessed. The limits of the evaluation are also acknowledged within the scope.

- *Methodological Approach* – The approach determines the process and methods used to monitor the implementation of the program and evaluate its effects. The plan should spell out the following:

  ◦ how data will be collected to answer the monitoring and evaluation questions;

  ◦ the monitoring and evaluation methods;

  ◦ key indicators to measure progress and achievement of objectives;

  ◦ information needs and sources; and

  ◦ methods by which the data will be collected, recorded, processed, reported, maintained, and analyzed.

Sex-disaggregated data should be collected to assess gender issues in the evaluation. If they are not available, the plan should spell out the strategies that will be undertaken to develop appropriate databases so better gender analysis can be conducted in future studies and program planning.

The plan should also describe the data collection and analysis methods to be used to assess the possibly different effects of the program on women and adolescent girls, men and adolescent boys. Gender-inclusive methods should be used when necessary. Data should be collected about and from both female and male program participants/ beneficiaries. Interviewers and information sources should adequately represent women and adolescent girls as well as men and adolescent boys.

The needs assessment or baseline study should include analysis of relevant gender concerns. The plan should include a baseline study that incorporates gender analysis, so a starting point can be determined against which progress is monitored and assessed. It can also be used to determine whether objectives have been achieved and how the program affects women and adolescent girls, men and adolescent boys, and the advancement of gender equality efforts in the community. Both qualitative and quantitative gender-sensitive indicators and milestones/targets should be included in the plan. If the indicators are not gender-sensitive, then they should be revised or refined to better capture the program's potential for having different effects on women and adolescent girls, men and adolescent boys.

If special evaluation studies are used, the plan should describe the study design and whether qualitative and quantitative methods or a combination of both will be used. Ethical considerations and measures to ensure gender equality, should be included in this description.

- *Monitoring and Evaluation Resources* – The resources that will be used for monitoring and evaluation, including funds and staff or consultants with M&E experience who can assist in planning and conducting M&E activities. The plan should describe the program's capacity to manage and link various databases and computer systems as well as plans to strengthen staff's M&E capacity.

  The plan should describe special budget provisions that have been made for gathering gender-sensitive information, if necessary. It should also describe the capacities in place for gathering gender-sensitive information and conducting gender analysis, including staff expertise and technology such as databases. It should indicate whether there is a balance in the number of women and men on the evaluation team. The description should include what will be done if sufficient staff and technical capacity are not in place (e.g., contracting gender experts as consultants; developing databases to capture gender information; capacity-building; and training for staff, etc.)

- *Implementation* – The activities that will be undertaken to implement the M&E plan, delineating roles and responsibilities, and developing a timetable to accomplish the identified activities with realistic expectations of when data will be analyzed and when the results will be available. The plan should specify who will report the process data and who will collect and analyze it; who will oversee any quantitative or qualitative data collection and who will be responsible for its analysis; and whether M&E specialists/ consultants will be used. The plan should specify the process for regularly analyzing information on the effect of the program on gender relations and its contribution to HIV prevention. It should also reflect the ideas that partners might have on how to improve the program. It should specify who will be responsible for this process.

- *Dissemination of and Use of Findings* – Who will translate the results into terms understandable to program planners, managers, program participants/beneficiaries, other stakeholders, and decision-makers; how findings will be shared and used (e.g., written papers, oral presentations, program materials, community, and stakeholder feedback sessions); and the implications for future monitoring, evaluation, and programming. The plan should include how M&E results will be used, translated into language supportive of HIV prevention policy, and disseminated to program participants and other relevant stakeholders and decision-makers. It should include a description of how M&E will be used to inform program improvement, decision making, and the mechanisms for providing feedback to program planners and evaluators. It is important to ensure that the lessons learned can be applied to future programming and evaluation efforts.

The plan should describe the process in place to share and discuss evaluation findings on gender relations and gender integration with key program partners, stakeholders, and participants/beneficiaries. It should also describe how relevant knowledge generated by the evaluation on gender relations and gender integration will be shared and made available to the interested public. The plan should also describe how the gender-related recommendations will be used and translated into language supportive of HIV prevention policy, and disseminated to program participants, other relevant stakeholders, and decision-makers. It should specify how management will follow-up on the gender-related recommendations.

- *Adjustments to the M&E Plan* – How changes to the program (e.g., objectives, strategies, and activities) will be made if information collected during implementation reveals unintended or harmful effects or if women's or men's needs or priorities are being overlooked. The plan should describe how these changes will be integrated into the M&E plan. The plan should

include a description of how changes will be made in the program design in response to gender-related unintended consequences.

6.6.7 Gender Equality Principles

Gender-equality principles should guide the evaluation planning and implementation process. Program planners, managers, evaluators, and other relevant stakeholders should give explicit attention to these principles when designing and conducting evaluations. In order to ensure inclusiveness, safeguard the rights of participants, and ensure their safety, evaluations should be carried out in a participatory and ethical manner. The following ethical considerations should be taken into account.

6.6.7.1 Respect

Respect for individuals requires that program staff and evaluators affirm each participant's or stakeholder's dignity, independence, and freedom to make his or her own decisions.

Provide him or her with the necessary information to make informed decisions about whether to participate in evaluation activities.[13] Evaluations should be designed and conducted to respect and protect the rights and welfare of program participants and stakeholders involved in every step of the process, in accordance with human rights conventions and standards for the protection of human subjects.

Evaluations must be gender- and culturally sensitive. Throughout the evaluation process, program staff and evaluators must respect the dignity and diversity of the participants and stakeholders.[14] Program planners, managers, and evaluators should understand how vulnerable and marginalized groups often face multiple and intersecting forms of discrimination that undermine their rights. Take actions to ensure that their dignity and rights are respected and protected.[17] Evaluation instruments should be used that are appropriate to participants' cultural setting.

Respect for individuals also means that staff and evaluators are aware of differences in power between them and participants and take measures to balance unequal power.[18]

Program planners, managers, and evaluators should ensure that participants feel comfortable expressing their own opinions, even if they contradict those of the evaluators or other participants.[17] Participants should have the right to freely express that they do not want to answer any questions or do not want to participate in a discussion.[17]

6.6.7.2 Informed Consent

Respect requires giving participants the opportunity to make an informed decision about whether to participate in any data collection and evaluation activities.[18] Information, comprehension, and voluntary consent are the three elements of informed consent.[18]

Prospective evaluation participants should be treated as autonomous, be given time and information to decide whether they wish to participate, and be able to make an independent decision without any pressure.[17] They are entitled to comprehensive information on the evaluation, including its purpose and the feedback they will receive after the process is completed.[17] Evaluators should make sure participants are aware of the potential implications of their participation in the evaluation process, and they sufficiently comprehend the evaluation, their role in it, and any implications it may have to make informed and voluntary decisions about their participation.[17]

6.6.7.3 Confidentiality and Privacy

Confidentiality refers to how the information revealed by individuals to program staff is treated during the course of their participation in evaluation activities.[18] It is essential to protect participants' privacy and ensure their information is kept confidential because disclosure of sensitive information has the potential to put participants or others at risk.[18]

Program planners, managers, and evaluators should ensure that participants and stakeholders are able to provide information in a private setting.[17] They should also assure participants of the confidentiality and anonymity of any information they provide.

Anonymity means that names and addresses are not recorded, so specific information cannot be traced back to any particular participant.[17] In situations where tracing back to an individual is necessary for credibility or follow-up purposes, those participants should be informed, so they can decide if they want to participate.[17]

6.6.7.4 Safety

The safety of participants, stakeholders, and staff is paramount and should guide all decisions regarding evaluation.[18] Particular safeguards are needed for evaluations that address socially sensitive issues, including HIV/AIDS and VAW/GBV.[31] Program staff or evaluators can be as much at risk as participants. It is important to take measures to ensure the psychological and physical safety of staff as well as participants and stakeholders.[17]

6.6.7.5 Inclusion

In collecting data, evaluators should ensure that women and adolescent girls as well as disadvantaged and marginalized groups are adequately represented and that participatory and qualitative methods are used to ensure that their voices and concerns are heard.[17] Data should be disaggregated by sex, gender, age, disability, race, ethnicity, SES, and other relevant differences where possible and analyzed through multiple lenses.[17]

Tool 11, *Gender Concepts in the Monitoring and Evaluation Plan*, provides a list of questions that program planners and managers should consider when developing an M&E plan to be sure it integrates gender concerns.

Tool 11: Gender Concepts in the Monitoring and Evaluation Plan				
Component	Gender Concepts	Yes	No	If NO, what actions are needed to address this issue?
Program Description	Does the description of the program explain gender issues faced by the program and describe the program's strategy to address them in design and implementation?			
Monitoring and Evaluation Questions	Are key gender issues such as gender norms, sexual division of labor, access to and control over resources, and power and decision making incorporated into program monitoring and the evaluation design?			
	Does the evaluation assess the program's performance in addressing GBCs and GBOs?			
	Are all monitoring and evaluation questions worded in a gender-sensitive manner, and do they call for sex-disaggregated information?			
Methodology	Does the methodology call for gender issues to be addressed in the program design, monitoring, and evaluation?			
	Does the plan include participatory methods to ensure that program participants and other relevant stakeholders play an active role in monitoring and evaluation activities?			
	Does the plan include measures to ensure the human rights of participants and stakeholders, including gender equality, participation, informed consent, confidentiality, and safety, will be respected and protected?			
Data Collection	Does the plan include qualitative and quantitative methods and tools to collect gender-sensitive data?			
	Does the plan call for all data to be sex- disaggregated?			
	If sex-disaggregated data are not available, does the plan define strategies for developing appropriate databases to make it possible to conduct better gender analysis in future studies and program planning?			
	Do methods for data collection and analysis generate information from and about both women and adolescent girls, men and adolescent boys on key gender issues?			
	Does the plan call for gender balance in interviewers and data sources?			
	Do the interviewers and data sources adequately represent women and adolescent girls, men and adolescent boys, of different subgroups?			
	Are conventional data collection methods complemented with methods that will ensure the inclusion of women and adolescent girls?			
	Does the plan include needs assessment data or baseline studies that analyze relevant gender concerns?			

Tool 11: Gender Concept in the Monitoring and Evaluation Plan - Continued				
Component	Gender Concepts	Yes	No	If NO, what actions are needed to address this issue?
Indicators	Does the plan include program indicators (qualitative and quantitative) and milestones/ targets that are gender-sensitive? Do they need to be revised to better capture the program's impact on gender relations?			
Resources and Capacity	Does the plan include support for data gathering (e.g., databases) appropriate to capture gender-related information?			
	Does the plan include special budget provisions for gathering gender-sensitive information, if necessary?			
	Does the plan describe the program's capacity to gather gender-sensitive information and conduct gender analysis? (Is there someone on staff with the necessary expertise? If not, has external expertise been tapped?)			
	Do the staff or consultants conducting monitoring and evaluation activities have adequate expertise in gender and HIV prevention issues?			
	Is there a gender balance in staff/consultants carrying out monitoring and evaluation?			
Monitoring and Reporting	Does the plan call for information to be collected and analyzed that assesses the possibly different effects of the program/ intervention on women and adolescent girls, men and adolescent boys, of different subgroups and how the plan impacts gender relations?			
	Does program monitoring require reporting on the differential effects of the program on women and adolescent girls, men and adolescent boys, and on how the plan impacts gender relations as part of every progress report?			
	Does program monitoring require reporting progress on the performance of the program in addressing GBCs and GBOs and reporting progress on improving gender equality?			

Tool 11: Gender Concept in the Monitoring and Evaluation Plan - Continued				
Component	**Gender Concepts**	**Yes**	**No**	**If NO, what actions are needed to address this issue?**
Dissemination and Use of Findings	Does the plan call for routine review, analysis, and discussion of information on both the intended and unexpected effects of the program/intervention on gender relations? Is someone specifically assigned to do this?			
	Does the plan call for regular discussion of observations on the effects of the program/ intervention on gender relations with key program partners?			
	Does the plan include internal mechanisms to share knowledge and lessons learned within the organization on M&E findings and recommendations related to gender issues in HIV programming and gender equality? To influence policy and programming? To monitor implementation of recommendations?			
	Does the plan call for dissemination and discussion of gender-related findings and lesson learned with key program stakeholders, funders, and partners to fulfill accountability requirements?			
	Does the plan include management follow-up to respond to gender-related evaluation recommendations?			
	Does the plan include follow-up by management and key decision makers to use gender-related evaluation findings and recommendations to influence policy and programming and to monitor their implementation?			
	Does the dissemination plan include sharing of relevant gender-related knowledge generated and lessons learned with the interested public?			
Adjustments to the Program	Does the plan include a mechanism to adapt or revise the program/intervention to improve its performance on gender-related issues based on M&E findings?			

6.6.8 Gender-sensitive Indicators

Gender-sensitive M&E requires the development of gender-sensitive indicators. An indicator is a pointer, a number, a fact, an opinion, or a perception that measures changes in a specific condition or situation over time.[14] Indicators specify how the achievement of program objectives will be measured and verified. They are an important component of a program's logic model

(see **Section 6.6, Figure 7**) and provide the basis for monitoring program progress in implementation—completion of activities and the delivery of outputs—and evaluating the achievement of outcomes—goals and objectives. Indicators measure the level of program performance, and they can be described in terms of 1) the quality to be reached; 2) the quantity of something to be achieved; 3) the priority population that is affected by or benefits from the program; and 4) the timeframe for the achievement of the objectives.

A gender-sensitive indicator measures changes over time in the roles, relations, or status of women and girls, men and boys, relative to some agreed upon norm or benchmark.[15] Gender-sensitive indicators therefore measure whether gender equity is being achieved and how HIV programs have met their gender-related objectives, providing direct evidence of change over time in the roles and status of women and men.[15]

Collecting sex-disaggregated data is necessary but not sufficient for gender analysis. Sex-disaggregated data presents information separately for women and men, boys and girls, about their roles and status, and they may show gender differences. Gender-sensitive indicators are disaggregated by sex. They should also be disaggregated by race/ethnicity, age, SES, sexual orientation, gender identity, immigration status, and other relevant social statuses to capture variations across different subgroups of women and adolescent girls, men and adolescent boys.

6.6.8.1 Importance of Gender-sensitive Indicators in HIV Prevention Programming

Gender-sensitive indicators are needed to demonstrate changes in gender relations and program impacts, and they should be developed during the design stage to track performance throughout the implementation of the program. Gender-sensitive indicators can be developed to measure changes in gender differences in sexual behavior and social determinants of HIV risk and vulnerability for females and males such as race/ethnicity, age, and SES as well as physiological, cultural, and legal factors.

Using gender-sensitive indicators allows for effective M&E of gender-responsive HIV programs. It helps track and document the benefits and costs of gender integration in order to build knowledge about how gender differences affect HIV prevention outcomes and how prevention programs contribute to gender equity. Applying gender analysis throughout the planning process helps identify the indicators needed to monitor the differential impact of program activities on women and girls, men and boys, and on gender relations as well as identify the contributions of HIV prevention programs to gender equity. Gender-sensitive indicators also provide the analytical basis for making informed adjustments or revisions to programs during implementation and when designing future activities.

Gender-sensitive indicators are important in the following ways:

- Determining if a program has achieved its gender objectives;
- Assessing if the program has increased women's and adolescent girls,' men's and adolescent boys' participation in and benefits from the program;
- Assessing if the program has reduced gender inequalities (e.g., increased access and control over resources; power and decision making) or exacerbated gender inequalities (e.g., increased VAW);
- Knowing if a program has impacted efforts towards gender equality;
- Communicating program achievements toward meeting gender objectives;

- Better understanding how gender-equity results can be achieved;

- Informing and enabling future planning and program delivery to more effectively achieve gender equity;

- Generating evidence on how paying attention to gender in programs contributes to more equitable and sustainable outcomes;

- Making the case for the importance of achieving gender equality; and

- Holding organizations, institutions, and agencies accountable for their commitments on gender equality.

6.6.8.2 Types of Gender-Sensitive Indicators

Gender-sensitive indicators can be quantitative or qualitative. Gender-sensitive program M&E requires using a mix of qualitative and quantitative indicators that are directly tied to program activities, goals, and objectives and that measure program inputs, processes, outputs, outcomes, and impacts.

Quantitative indicators are measures of quantity such as the number or percentage of women and men with HIV infection in a given community or male and female income levels or educational attainment.[15]

Qualitative indicators are measures of people's experiences, behaviors, opinions, attitudes, or feelings, for example, women's and men's views on the causes of intimate partner violence or attitudes regarding condom use. Qualitative indicators focus on people's own experience and therefore play an important role in promoting and understanding stakeholder perspectives, particularly those relating to women, and in fostering participation.[15]

Quantitative and qualitative indicators can overlap because qualitative indicators can also be quantified. However, these two types of indicators can be distinguished by their source of information and the way in which this information is interpreted and used.

Quantitative indicators focus on topics such as rates of HIV infection or educational attainment.[15] Quantitative indicators can be drawn from HIV surveillance data, census data, or administrative records. In many instances, they are generated from more formal surveys.

In contrast, because qualitative indicators measure people's perceptions and viewpoints, they are typically obtained from sources such as public hearings, attitude surveys, focus group discussions, interviews, participant observation, and field work.[15] Qualitative indicators are thus generated from less formal surveys.

Quantitative and qualitative indicators can also be differentiated by the ways in which they are interpreted and used.

Quantitative indicators are usually interpreted using formal methods such as statistical tests and the results of these tests. They are usually presented in a way that is quite removed from the events or people they are describing. For example, examining increases in the rates of heterosexually transmitted HIV infection among women reveals little about the constraints women face in negotiating safer sex with their male partners. Because quantitative indicators have this degree of distance and because they are expressed in terms of numbers, they are often considered "objective" or "hard" indicators.

Qualitative indicators, by contrast, are usually generated by informal studies, and the findings of these studies are often presented in a descriptive manner. While qualitative indicators can be quantified, they describe people's viewpoints or perceptions. As a result, these types of indicators are considered "subjective" or "soft" indicators.

Despite these differences, quantitative and qualitative indicators actually complement each other and both are important for effective M&E. A combination of quantitative and qualitative indicators allows for cross-checking results.

The use of qualitative indicators and analysis is best suited to understand social processes such as sexual and gender relations and inequality. Qualitative indicators are useful in understanding people's experiences, views, perceptions, motivations, and priorities in relation to HIV prevention programs. Well-developed and well-interpreted qualitative indicators can play a significant role in identifying constraints to program implementation and obstacles to success, which would otherwise not be readily visible.[15] The use of qualitative indicators can play an important role in promoting and understanding the perspectives of relevant stakeholders, including women and adolescent girls and other vulnerable and marginalized groups.

Qualitative analysis is needed to make sense of and interpret the information provided by gender-sensitive qualitative and quantitative indicators.[15] For example, using qualitative analysis can help program planners and managers acknowledge how gender relations influence caregiving; how to think about ways that programs can help change gender norms, roles, and relations; and how to promote more equitable caregiving arrangements. The advantage of using qualitative analysis is that it helps to interpret the information provided by a gender-sensitive indicator. It provides more nuanced information and sheds light on why the particular situation measured by a gender-sensitive indicator came about and how this situation can be changed in the future.[15] Qualitative analysis should be used along with gender-sensitive qualitative and quantitative indicators at all stages of the program cycle.

6.6.8.3 Selecting Gender-sensitive Indicators

Selecting indicators can be a challenging process for a number of reasons. Measuring change is often a political process because the choice of what to measure can reflect the priorities of funders or politicians who control funding rather than those implementing the program or those intended to benefit from the program.

Factors other than the program or intervention may contribute to positive or negative change in a given situation, which makes it difficult to know why particular changes have happened. While it can be seen as a problem, it can also be seen as an opportunity to recognize that multiple factors, including local resistance, political will, and pressure from the media, can all contribute to shifts in gender equality. They need to be taken into account to gain a more accurate and balanced picture.

Relevant stakeholders should be included in the development of gender-sensitive indicators. Examples include: women and adolescent girls, men and adolescent boys, who are living with HIV/AIDS and who are from the community where the program will be delivered; local organizations of women living with HIV/AIDS; and other women's organizations, community-based organizations, and funders, as appropriate. Indicators should be closely tied to program objectives.

6.6.8.4 Matching Gender Indicators to Program Objectives

Gender indicators should be matched to the program objectives related to the GBCs and GBOs that women and adolescent girls experience in protecting themselves against HIV infection. Each indicator should measure the impact of taking advantage of a GBO or whether the associated GBC has been reduced or eliminated. For example, if women cannot practice safer sex because their male partners refuse to use condoms, one indicator could measure whether making female condoms available to these women has enabled them to practice safer sex. Since women still need the cooperation of men to use the female condom, making them available may not

necessarily result in their being used. Another indicator could measure whether teaching women how to use the female condom properly and how to encourage their partner to agree to use those condoms increases their actual use.

Tool 12, *Developing Gender-sensitive Indicators Matched to Objectives*, is designed to help program planners and managers develop gender-sensitive indicators by linking them to the priority GBCs or GBOs and objectives. In Column 1, list the priority GBCs or GBOs. In Column 2, list the program objective. In Column 3, list the gender-sensitive indicator. In Column 4, list the type of indicator (input, process, output, outcome, impact). Keep in mind the criteria for gender-sensitive indicators listed in the previous section when selecting the indicators.

Tool 12: Developing Gender-sensitive Indicators Matched to Objectives			
1) Priority Gender-based Constraints or Opportunities to Address	2) Program Objective	3) Gender-sensitive Indicator	4) Type of Indicator

The following questions highlight some issues for program planners and managers to consider when developing gender indicators to monitor and evaluate their programs:

- Are indicators disaggregated by sex, racial/ethnic group, age, and SES?

- Are baseline data collected on women and men of different ages, SES, and ethnicity?

- Are there specific indicators that measure changes in gender relations, gender norms, gender roles, access to services and resources, and power and decision making?

- Does the program have a systematized way of collecting and analyzing the information on a regular basis?

- Does the program have policies about what to do when M&E data reveal gender inequities?

- How do gender-specific objectives link to impact on HIV infection?

The program M&E plan should specify the indicators and the terms for their analysis and interpretation. By developing gender-specific indicators or disaggregating most indicators by sex, the M&E plan can help point out gender differences in program implementation and impact. Quantitative indicators only highlight differences and do not explain why or how differential outcomes happen. Qualitative indicators provide information that helps to analyze the reasons for the differences, which is why it is important to include women and adolescent girls and other relevant stakeholders in the M&E process. They can help to identify issues the M&E plan should address that would help explain gender differences, counteract gender and institutional biases in deciding what to measure, and explain how to use monitoring information to increase participants' control over program activities and results.

Table 10, *Examples of Gender-sensitive Indicators*, shows sample indicators that are grouped according to the domains of gender analysis (gender norms, gender roles, access to and control of resources, and power and decision making).

Table 10: Examples of Gender-sensitive Indicators		
Domain of Gender Analysis	Program Objective	Gender-sensitive Indicator
Gender Norms	Increase the proportion of heterosexual couples who engage in more gender-equitable sexual decision making.	Proportion of heterosexual couples who report joint decision making regarding condom use.
	Increase the proportion of men and boys articulating gender-equitable norms.	Proportion of men and boys ages 15-24 who agree that women and girls should have the same rights as men and boys.
		Proportion of men and boys ages 15-24 who believe that men can prevent physical and sexual violence against women and girls.
Gender Roles	Increase the proportion of men living with an HIV-positive female partner who assume greater responsibility for childcare and caregiving within their families.	Proportion of men ages 25-44 living with an HIV–positive female partner who report providing care to their children.
		Proportion of men ages 25-44 living with an HIV-positive female partner who report providing care to sick individuals within their household.
	Increase the proportion of women at risk of HIV infection who are employed.	Proportion of women ages 25-44 at risk of HIV infection reporting steady full- time employment in the past 3 months.
Access to and Control Over Resources	Increase the proportion of women at risk of HIV infection who are accessing HIV prevention services.	Proportion of women ages 20-34 reporting participation in HIV prevention workshops within the past 3 months.
		Proportion of women ages 20-34 attending HIV prevention risk reduction counseling sessions in the past 3 months.
	Increase the proportion of HIV prevention programs providing onsite childcare services.	Proportion of HIV prevention programs providing onsite childcare services.
Power and Decision making	Increase the proportion of women living with HIV who are able to refuse unsafe sex with a male partner.	Proportion of women ages 35-44 living with HIV who report refusing unprotected sex with a male partner within the past month.
		Proportion of women ages 35-44 living with HIV who agree they have a right to refuse unprotected sex with a male partner.
	Increase the proportion of HIV-positive women and women at risk of HIV infection who participate in local HIV- related planning councils or advisory committees.	Proportion of women ages 18-65 living with HIV who served as members of local planning councils within the last 6 months and within the last 12 months.
		Proportion of women ages 18-65 at risk for HIV who served as members of local planning councils within the last 6 months and within the last 12 months.
		Proportion of women ages 18-65 living with HIV who served as members of local planning councils within the last 6 months and within the last 12 months who report receiving leadership training.
		Proportion of women ages 18-65 at risk of HIV who served as members of local planning councils within the last 6 months and within the last 12 months who report receiving leadership training.

6.6.9 Components of an Evaluation Report

The outcomes of an evaluation are used for different purposes, depending on its objectives. Outcomes can be used to promote the further adoption and dissemination of the program on a wider scale and used to advocate for increased funding to support similar programs. Outcomes can also be disseminated to participants in the evaluation and to other program stakeholders, including funders. If the evaluation shows that particular program elements need improvement, then evaluation outcomes can be used to target mid-course adjustments.

The evaluation report should include the following:

- **Executive Summary:** a clear, concise synopsis that highlights the key points, findings, and recommendations of the final report, including implications for gender- responsive HIV programming;

- **Introduction:** background information that includes a description of the program and the goals and objectives dictating the evaluation;

- **Methodology and Study Design:** description of the methods used to collect the information (data), including sex-disaggregated data and measures, to ensure respect for and protection of participants' and stakeholders' human rights;

- **Findings:** a summary of the results, including specific gender-related outcomes (e.g., reductions of harmful gender norms; of violence against women and adolescent girls; in gender-related barriers to services; in the burden of care for women and adolescent girls; and in stigma and discrimination);

- **Conclusions and Recommendations:** information based on the results regarding program lessons learned, accomplishments, improvements, and uses for the report; and

- **Appendices:** supplementary materials such as references, statistical tables, questionnaires, data collection instruments, etc.

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