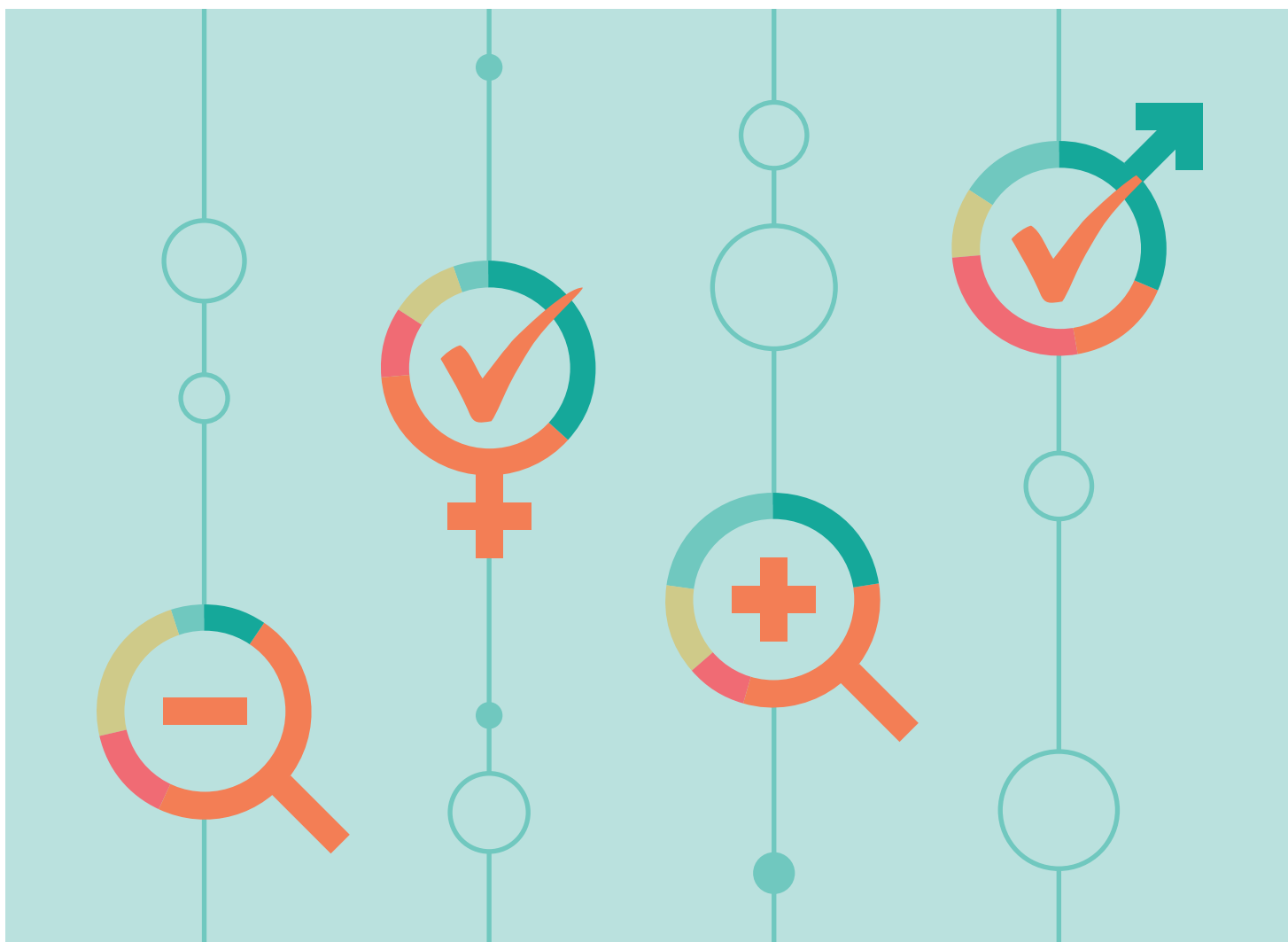


UNAIDS Gender Assessment Tool

Towards a gender-transformative HIV response



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Introduction

Launched in 2010, the UNAIDS Agenda for Accelerated Country Action for Women, Girls, Gender Equality and HIV 2010–2014 (the Agenda) (1) presented a set of strategic actions to better respond to the needs and uphold the rights of women and girls within HIV responses. Structured around three recommendations, the Agenda focused on country-level implementation. A mid-term review of the Agenda (2), presented to the UNAIDS Programme Coordinating Board in December 2012, revealed that a more systematic approach to data collection was needed for evidence-informed planning and budgeting for gender-transformative HIV responses.

As such, the UNAIDS Secretariat led a consultative, multistakeholder process to develop a gender assessment tool to facilitate the undertaking of gender assessments. Led by national stakeholders and partners, gender assessments are comprehensive initiatives that set out to identify the needs of women and girls in all their diversity in the context of HIV at the country level. The information and data are then compiled and analysed to elaborate and review strategic planning processes, to increase the capacity of civil society, including women's organizations, and to leverage political commitment to address these needs.

Purpose

The gender assessment tool for national HIV responses (GAT) is intended to assist countries in assessing the HIV epidemic, context and response from a gender perspective and in making the HIV responses gender transformative, equitable and rights based and, as such, more effective. The GAT is designed to support the development or review of national strategic plans and to inform submissions to country investment cases and the Global Fund to Fight AIDS, Tuberculosis and Malaria (Global Fund). Both the Sustainable Development Goals (3) and the UNAIDS Strategy 2016–2021 (4) emphasize the need for a holistic approach, integrating the full spectrum of people's needs on health and rights. More specifically, the UNAIDS Strategy commits to implementing HIV-sensitive universal health coverage, stressing the need for access to integrated services, including for HIV, tuberculosis, sexual and reproductive health, maternal and child health, hepatitis, drug dependence, food and nutrition support and noncommunicable diseases, including preventing and controlling cervical cancer, especially at the community level.

The GAT also enables gender equality to be integrated into other strategic, planning and implementing processes, such as United Nations Development Assistance Frameworks to address the gender-related barriers and challenges in the HIV response. Further, it serves as a tool for technical capacity-building for national authorities, civil society organizations and other key stakeholders. The GAT is a valuable tool for stakeholders who may have their own requirements for gender analysis. For example, countries supported by the United States President's Emergency Plan for AIDS Relief (PEPFAR) are required to complete such an analysis. The GAT is also valuable in

designing or evaluating policies, programmes and/or projects in sectors considering the approach of the UNAIDS Strategy 2016–2021, which focuses on collaborating across sectors and investing at the intersections of AIDS and other health and development challenges.

Government agencies and civil society may also use the GAT to collect and analyse information to be included in national and shadow reports on implementing international instruments and treaty bodies, such as the Convention on the Elimination of All Forms of Discrimination against Women (5); the Commission on the Status of Women; the Report on Women, the Girl Child and HIV and AIDS (6); and the 2016 United Nations Political Declaration on Ending AIDS (7).

The process of developing the GAT

The GAT was developed through a robust process, guided by a multipartner and multilevel reference group. Before it was finalized, the GAT underwent testing in various settings. UNAIDS partnered with Gestos-HIV, Communication and Gender, a Brazil-based nongovernmental organization (NGO), to pilot the GAT in five countries across five regions in 2012.¹ This resulted in valuable lessons, including how applicable the GAT is in diverse contexts.² It reaffirmed the critical importance of leveraging diverse multistakeholder engagement for country ownership and ensuring diversity in inputs.

In 2013, UNAIDS held a training-of-trainers workshop to build the capacity of a pool of potential consultants to conduct national gender assessments. By 2015, gender assessments had been conducted using the GAT in more than 30 countries. In the same year, UNAIDS undertook a stocktaking exercise to review and identify the strengths, weaknesses, best practices and challenges of the GAT and the gender assessment process and reports (8).

The Stop TB Partnership, in collaboration with UNAIDS and partners, launched the first gender assessment tool for national HIV and tuberculosis (TB) responses in July 2016 to support countries in Global Fund applications, which builds on the UNAIDS HIV GAT and is adapted to include TB. Leveraging the lessons learned, UNAIDS reviewed the HIV GAT in 2017 within the new political and funding landscape. The review was conducted against the backdrop of the Sustainable Development Goals (3), the 2016 Political Declaration on Ending AIDS (7), the UNAIDS Strategy 2016–2021 (4) and the Global Fund Strategy 2017–2022 (9) to align the GAT with the global instruments guiding and supporting the HIV response as part of the 2030 Agenda for Sustainable Development. Although various constituencies can take the lead in advocating for gender assessments, the country (national authorities) is recommended to lead the actual assessment. This supports country ownership and ensures that outcomes are incorporated into relevant national strategic frameworks and processes.

¹ The Plurinational State of Bolivia, Djibouti, Jamaica, Rwanda and Tajikistan.

² The three recommendations in the Agenda are: (1) generate and use evidence; (2) translate political commitments into action; and (3) create an enabling environment.

Key features of the GAT

Combines gender analysis and assessment of policy and programme gaps. The GAT enables countries to better understand how gender inequality shapes their HIV epidemic, which gender-related barriers hinder access to HIV services, how well their national HIV responses are performing in addressing this inequality and the optimal strategic steps forward to meet the needs of women and girls and of key and vulnerable populations. Data generated from assessing gender inequalities, identifying the contributing factors and determining the responsiveness of policies and programmes to gender inequality, norms and barriers can identify entry points for strengthening the integration of gender into the HIV and sexual and reproductive health response for policy development, advocacy and planning and programme implementation and monitoring.

Alignment and harmonization. The indicators and questions on the HIV epidemic, context and response in the GAT are interdependent and complementary with other tools, indicators and policy questionnaires. These include Global AIDS Monitoring, including the National Commitments and Policy Instrument (10); the World Health Organization (WHO) consolidated guideline on the sexual and reproductive health and rights of women living with HIV (11) and consolidated guidelines on HIV prevention, diagnosis, treatment and care for key populations (12); and resources to support gender-responsive programming. Sourcing data from these resources will help to reduce the burden of collecting information in the countries while increasing the programmatic utility of the GAT.

Adaptability and flexibility. The scope of a gender assessment can vary according to the context and the intended objectives. Although the GAT is divided into four successive stages or modules (depending on the HIV context, users and the purpose of gender assessment), these can be used separately and/or adapted to fit the country context.

Combination of data sources and types of measures. The GAT enables existing databases on epidemiological and behavioural information and on laws, policies and programmes to be used. Because of the nature of the gender assessment, combining quantitative measures with qualitative data provides deeper insight into the intersecting gender equality dimensions of the HIV epidemic, context and response.

Qualitative methods record people's experiences, opinions, attitudes and feelings. These cannot be measured with quantitative methods but are often required to understand the quantitative observations. Qualitative studies complement quantitative findings and should be undertaken for a culturally sensitive and more comprehensive response (13).

Likewise for selected indicators and questions, the GAT promotes the complementary use of alternative data sources and programming data, including community-driven data collection such as the Global Values and Preferences Survey regarding sexual and reproductive health and the human rights of women living with HIV (14), the People Living with HIV Stigma Index (15), national and regional studies on violence against transgender people and others collected through social media and online surveys (16).

Conceptual framework

The GAT uses terms common to the responses to HIV, to sexual and reproductive health and rights and to gender. It seeks to move the HIV response along the continuum from gender blind to gender sensitive and, ultimately, to gender transformative (Table 1).

Key concepts

Gender. A socially constructed set of norms, roles, behaviour, activities and attributes that a given society considers appropriate for women and men and that are attached to masculinity and femininity and to the people identifying themselves as transgender or gender queer or expressing gender in various other forms. The issue's intricacy expands with the understanding of diverse gender identities: a person's deeply felt internal and individual experience of gender that may or may not correspond with the sex assigned at birth. Gender-based prejudice includes any kind of stigma, discrimination or violence against somebody because of their gender, gender expression, gender identity or sexual orientation. Other important criteria for sociocultural analysis include class, race, poverty, ethnicity, disability and age. Gender inequality refers to unequal opportunities connected to gender, gender roles and expectation and gender expression to obtain and control social, economic and political resources, including protection under the law (such as health services, education and voting rights). Importantly, gender inequality often specifically determines differential, unequal and negative development and health outcomes for women and men and for girls and boys (17). Gender equality is a cross-cutting principle and integral to achieving the Sustainable Development Goals, the 2016 Political Declaration on Ending AIDS and the UNAIDS Strategy 2016–2021.

Gender-responsive programming. Policies or programmes that explicitly consider and address unequal gender norms and roles, power dynamics and the distribution of resources according to gender and that counter discrimination faced by people in societies based on their gender or gender expression and improve their access to services (17).

Gender-responsive budgeting. Gender-responsive budgeting is a method of determining the extent to which government expenditure has detracted from or come nearer to the goal of gender equality. A gender-responsive budget is not a separate budget for women but rather a tool that analyses budget allocations, public spending and taxation from a gender perspective and can be subsequently used to advocate for reallocating budget line items to better respond to women's priorities as well as men's, making them, as the name suggests, gender-responsive (19).

Social determinants and HIV. Addressing the determinants of vulnerability and responding to the holistic needs of people living with and at higher risk of HIV infection are critical to ending the AIDS epidemic as a public health threat (4). As such, the GAT addresses gender as a structural determinant that interacts with other parameters, such as social class, race, ethnicity, sexual orientation, disabilities and immigration status (20).

Table 1. Gender integration spectrum

Type of intervention	Impact	Example
Gender- negative or gender-blind	Fails to acknowledge the different needs or realities related to gender and gender expression, including differential treatment of women versus men and boys versus girls; aggravates or reinforces existing gender inequalities and norms. Transgender and intersex people may have very specific gender discriminatory experiences in gender-blind contexts.	The failure to acknowledge that programmes and policies have different effects on women and men and on transgender and intersex people has led to a lack of disaggregated data.
Gender-sensitive or gender-responsive	Recognizes the distinct roles and contributions of different people based on their gender; takes these differences into account and attempts to address gender norms, roles and access to resources, including equal access and equitable benefits for women and girls in specific contexts.	<p>A cash transfer programme that provides funds to families to keep girls in school is one element that can reduce girls' vulnerability to HIV infection.</p> <p>Services are required to be provided for women and girls without husbands or other third-party authorization.</p> <p>Programmes can be developed that consider the needs and rights of transgender people, such as in the context of accessing education and health services.</p>
Gender-transformative	Seeks to redefine and transform gender norms and relations to redress existing inequalities to promote shared power, the control of resources, decision-making and support for women's empowerment.	It challenges and changes harmful gender norms and uneven access to resources to strengthen women's skills and ability to negotiate safer sex, including through HIV-sensitive social protection and economic empowerment programmes and through investment in women-initiated prevention commodities.

Sources: Checklist for integrating gender into the new funding model of the Global Fund to Fight AIDS, Tuberculosis and Malaria (18).

These intersections produce multiple and distinct experiences among people living with HIV in different contexts, shaping their social identities, vulnerabilities, access to services and well-being. The interactions among social stratifiers also play a key role in the levels of stigma and discrimination against people living with HIV and/or those affected by it. In that sense, a comprehensive gender-transformative HIV response should identify key interventions that address micro (personal and interpersonal), meso (societal, communal and provincial) and macro (national and policies) causes and effects of social and health inequities in the context of HIV (21–23).

Intersectionality (or **intersectional analysis** or **intersectionality theory**). An analytical tool for understanding and responding to intersecting inequalities. Intersectionality helps to understand multidimensional inequalities and how different identities (gender, sex, gender identity, sexual orientation, health status, disability, race, ethnicity, religion, age and political or other opinions) affect the access to rights, opportunities and services.

Key populations. Understanding the specific contexts and needs of key populations is crucial to maximizing gender-transformative responses. UNAIDS considers gay men and other men who have sex with men, sex workers and their clients, transgender people, people who inject drugs and prisoners and other incarcerated people as the key populations. They often suffer from punitive laws or stigmatizing policies and are among the most likely to be exposed to HIV. In some settings, women and girls, migrant workers, people affected by humanitarian emergencies and seronegative partners in serodiscordant couples are at higher risk of being exposed to HIV than other people. Their engagement is critical to a successful HIV response everywhere—they are key to the epidemic and to the response. Countries should define the specific populations that are key to their epidemic and response based on the epidemiological and social context. The term “key populations at higher risk” may also be used more broadly, referring to additional populations that are at higher risk of acquiring or transmitting HIV, regardless of the legal and policy environment. Countries conducting a gender assessment should identify and engage specific populations that are key to the epidemic and response based on the epidemiological and social context. The meaningful engagement of key populations is not only crucial to successful and context-relevant gender assessment but also to ensuring a comprehensive and sustainable HIV response.

For further information and clarification regarding key terms used in the GAT, see Annex F and the UNAIDS terminology guidelines (24). In terms of the conceptual framework, the GAT forms part of a comprehensive approach to gender-transformative HIV responses. Annex A lists complementary resources and documents designed to support countries in developing their HIV responses at all stages.

A four-stage approach to developing a gender-transformative HIV response

The GAT consists of four stages that use evidence-informed approaches to respond to the HIV epidemic (Fig. 1). They are grounded in knowledge from research and the perspectives of various stakeholders; decision-makers and experts (such as from government); key populations, including women living with and/or affected by HIV; gay men and other men who have sex with men; transgender people; civil society organizations; international agencies; and academia. The GAT guides the gender analysis of the HIV epidemic, context and response, aiming to generate information to set priorities for interventions, including gender-responsive budgeting, and to address the specific needs of women and girls and of key populations. Although the stages are clearly defined, gender assessment is not a linear process but iterative, flexible and dynamic, with some substeps and tasks feeding into each other. The national gender

assessment process must be underpinned by country leadership and ownership, with the national AIDS councils and health and gender ministries as well as key civil society partners leading the process.

Gender assessment has four stages.

1. Preparing for the gender assessment. The participatory process and successful outcomes of gender assessment depend on robust and detailed preparation. This includes building country ownership; establishing a multidisciplinary working team and the mechanisms for meaningful engagement; advanced notification and early engagement of key stakeholders; drafting work plans, timetables and budgets; preparing an advocacy and communication strategy; and building capacity to manage the process while keeping track of progress. Further, basic reference data and information should be compiled and relevant analysis initiated.

2. Knowing the national HIV epidemic and context. This encompasses defining the problem, the groups at risk and the associated factors (determinants) and effects by systematically collecting information on (25,26):

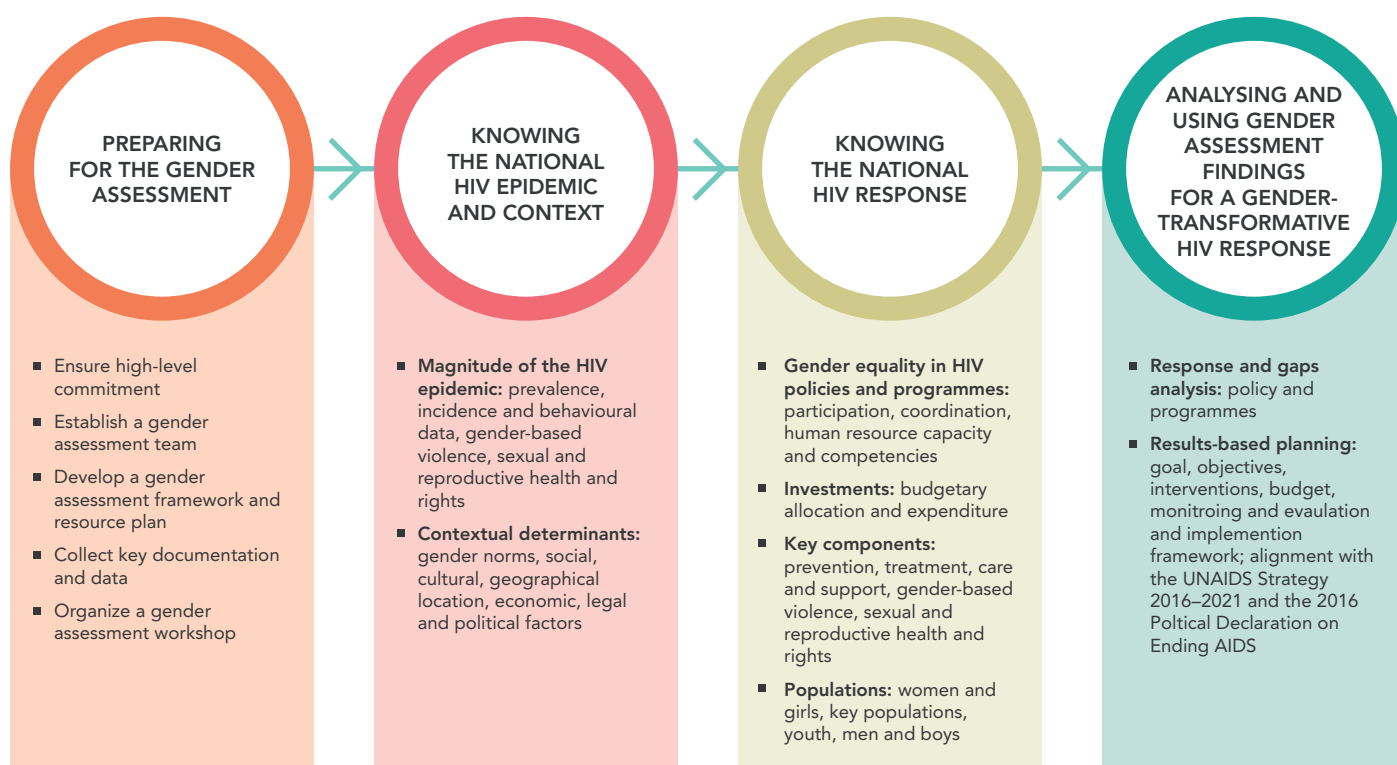
- Who: which groups of people, based on sex, gender and gender expression—including women and girls, gay men and other men who have sex with men, transgender people and other key populations—face greater risks of acquiring HIV and not accessing treatment and are at risk of dying from a lack of access to essential health-care services. Further, the question of who requires collating and analysing data on the rates of HIV mortality, morbidity and transmission and on the responses in specific places (geographical locations) and/or among specific populations.
- Why: which gender norms and sociocultural, political, legal and economic factors place people at risk and how they aid or impede people’s ability to access and use HIV and sexual and reproductive health and rights services. This information is critical to inform gender-responsive programming and budgeting that address people’s vulnerabilities and the causes of the HIV epidemic.
- How: impact and effects—the pathways through which these underlying factors shape or influence HIV outcomes for women, men and key populations.

Understanding who and why and how gender inequality is linked to other inequalities, inequities and increased HIV risk is required to develop an effective, efficient and sustainable response.

3. Knowing the national HIV response. Although women, girls and other key populations, in all their diversity, are disproportionately affected by HIV, they are underserved by current policies and programmes related to HIV and sexual and reproductive health and rights in many countries. Examining the response entails identifying gaps; the progress and outcomes of laws, regulations, policies, budget allocations, partnerships, participation, institutional and human resource capacities; and the intersections of HIV and other gender equality problems, such as sexual and reproductive health and rights and gender-based violence.

4. Analysing and using gender assessment findings for a gender-transformative HIV response. This requires consolidating information on the HIV epidemic, context and national response and including internationally supported programmes as well as analysing the barriers, gaps and facilitators that can strengthen the response. The process requires assessing options for efficiently investing in gender equality and establishing expected monitoring and evaluation.

Figure 1. Four stages of the gender assessment process



Sources: UNAIDS.

Stage 1. Preparing for the gender assessment of the national HIV response

This stage provides guidance for preparatory work towards guaranteeing the quality of the gender assessment process and outlining the necessary steps.

Step 1. Secure high-level commitment

High-level national commitment and leadership, from but not limited to national AIDS councils and the ministries responsible for gender and health, to include gender, gender equality, the empowerment of women and girls and sexual and reproductive health and rights in the HIV response is critical to conducting a successful gender assessment of the national HIV response. Dedicated steps to ensure high-level commitment from key stakeholders in governments, civil society, academia and other development partners, including donors and funders, are needed to guarantee national leadership and ownership. The lead organization and key government representatives might consider the following tasks to reach high-level agreement to conduct the gender assessment.

- 1.1** Map out crucial government and other decision-makers to engage in the entire gender assessment. The list of participants and entities can be created from existing national working groups and networks of civil society and by reviewing relevant documentation.
- 1.2** Identify challenges and opportunities for building high-level support and prepare strategies to secure this support.
- 1.3** Prepare a one-page concept note on why gender assessment is important and how the assessment will enhance the effectiveness of the national HIV response. Share the concept note and specific information about the GAT with key decision-makers.

Step 2. Establish a gender assessment team

The composition of the core gender assessment team is the most important step in securing a proper division of labour, collecting accurate data and ensuring the participation of diverse stakeholders for comprehensive assessment (Annex B). Typically, two consultants (international and national), with expertise and understanding of the full range of HIV, gender, gender equality, women's, sexual and reproductive health and rights and lesbian, gay, bisexual, transgender and/or intersex (LGBTI) rights are engaged to support coordinating and undertaking the assessment (Annex C). The team's range of stakeholders will ensure that the process not only reflects a spectrum of perspectives

and issues in each stage but is also inclusive,³ transparent and informed by evidence from research along with expertise, existing public resources and knowledge about the local context and community (27).

2.1 Establish a core gender assessment team comprising:

- Experts on HIV, sexual and reproductive health and rights, women's empowerment and gender policies and services.
- Key government representatives, especially national AIDS authorities, the ministries or national mechanisms responsible for health, gender equality, women's empowerment and young people.
- Relevant bilateral donors.
- Representatives of civil society, including networks of women living with HIV and the women's rights movement, key populations, young women and traditional and community leaders.
- Other development partners and NGOs working on gender, sexual and reproductive health and rights and HIV.
- The United Nations.

The core gender assessment team members should be influential leaders in HIV, sexual and reproductive health and rights and gender, nationally recognized for their experience and expertise. The team should preferably be limited to five to seven members and should include members of the technical working groups on gender; this will ensure meaningful engagement of all members and facilitate timely decision-making and action. The gender assessment team members should be brought together:

- To share and review the team's terms of reference, with timelines.
- To agree on roles and responsibilities.
- To establish the mechanisms for internal communication.
- To present an overview of the GAT and address preliminary questions and concerns on its potential use at the national and local levels: content, structure, participants, process, expected results and other pertinent matters.
- To revise and adapt the gender assessment to the country context based on the team's feedback and guidance.

Step 3. Develop a gender assessment framework

3.1 Discuss the goal of the gender assessment within the team and how it aligns with the gender assessment's concept note and its added value and complementary nature in relation to other guidance documents, resources and tools addressing gender equality in the HIV response.

³ The principle of greater involvement of people living with HIV.

- 3.2** Agree on the gender assessment's objectives, aiming for clear short-term results that support the overarching goal.
- 3.3** Agree on guiding principles for undertaking the gender assessment process and on how to monitor their application. In accordance with the Sustainable Development Goals, the 2016 Political Declaration on Ending AIDS, the UNAIDS Strategy 2016–2021 and other global and regional commitments made to advance non-discrimination and the rights and health of women, girls and key populations, such principles should include:
- Respecting and protecting the rights of women and girls.
 - Respecting and protecting the rights and engagement of key populations.
 - Adapting a non-discrimination framework.
 - Making ethical responses based on equity and fairness.
 - Using an approach informed by evidence.
 - Using a human rights-based approach.
 - Practising impartiality.
 - Ensuring the meaningful participation and leadership of women and girls.
 - Partnering with civil society, including people living with HIV and other key affected populations.
 - Using a strategic and forward-looking approach.
 - Engaging men and boys.
 - Exercising strong and courageous leadership.
 - Ensuring accountability and transparency.
 - Respecting diversity.
- 3.4** Review and agree on the scope of the gender assessment's key concepts, such as gender, gender equality, non-discrimination, gender-transformative responses, key populations, sexual and reproductive health and rights, intersectionality, social determinants and gender-responsive programming using agreed UNAIDS terms as the starting-point.
- 3.5** Identify the relevant stakeholders and experts who should be engaged in the gender assessment. Stakeholders should include government, civil society representatives, traditional and community leaders, relevant academic and national and regional research institutions and bilateral and United Nations agencies. As appropriate, stakeholders from key sectors should also be included, such as from health, education, gender, sexual and reproductive health and rights, justice, youth, employment, migration, human rights, finance and others pertinent to the national context. Further, the links between HIV and gender-based violence and especially relevant comorbidities, such as TB, cervical cancer and female genital schistosomiasis, emphasize the need to engage experts and actors working in these areas.

- 3.6** Define advocacy and communication approaches for raising awareness among stakeholders beyond the gender assessment team about implementing the gender assessment and for disseminating the results.
- 3.7** Identify key external stakeholders and partners who should be informed of the gender assessment to ensure their support for the overall process and follow-up. In contrast to the group in the previous step (3.6) who will carry out the gender analysis, the stakeholders in this step are the broader group of partners who should be kept informed of the gender assessment's purpose, progress, outputs and actions throughout the process.
- a) Develop key advocacy messaging based on the need to undertake HIV gender assessment. This messaging should outline how the gender assessment will support existing national processes, including integration with other relevant sexual and reproductive health and rights and development issues, and will be aligned with the HIV investment framework.
 - b) Disseminate the messages. (Decide who will be responsible for external communication to reinforce political commitment and stakeholder support.)
 - c) Summarize the above steps in a brief communication road map.
- 3.8** Define a clear, feasible and achievable timeline to prepare and undertake the gender assessment, including milestones and deadlines. Deadlines are important so that the gender assessment will be completed in time for the findings and recommendations to support relevant national processes and opportunities—for example, developing or reviewing the national strategic plan for HIV or the Global Fund grant cycles.
- 3.9** Agree on monitoring mechanisms to track the gender assessment process according to the developed timeline.

Step 4. Develop a gender assessment resource plan

- 4.1** List and agree on the human resources needed to conduct the gender assessment, including consultants and assistants and their respective responsibilities.
- 4.2** Prepare a budget to undertake the gender assessment and determine the cost of the following requirements:
- Budget for the gender assessment consultants and national and international administrative expenditure.
 - Advocacy and communication, including disseminating the findings.
 - Human resources for systematizing, analysing and communicating sex- and age-disaggregated data and other data related to gender.
 - Convening the inception and validation meetings and workshops, including lodging, travel and logistics costs, as needed.
 - Other costs relevant to the national context.

- 4.3** Confirm the availability of funds to support the gender assessment or prepare a proposal for mobilizing the necessary resources from prospective donors. The country coordinating mechanism can request support from the Global Fund Secretariat to undertake gender assessment with the country coordinating mechanism funding, or it can apply for specific technical assistance funding from the technical assistance partners.

Step 5. Collect relevant documents

Collect documents that will inform the national gender assessment. These include national surveys, reports, laws, policies and strategies, published research and studies, grey literature, regional and global treaties and declarations, state party and NGO reports on the treaty monitoring process, the process of Universal Periodic Review of human rights progress, relevant regional treaty and policy monitoring processes and:

- Country-specific data:
 - a) Relevant HIV and sexual and reproductive health and rights data, laws, policies, strategies and standards-of-care data that are disaggregated by age and sex.
 - b) Data at the subnational level (if available) that may help to better understand the gender aspects of the epidemic's geographical distribution and the local and regional response.
 - c) Additional sources with relevant data on issues (early, forced and child marriage and gender-based violence) and comorbidities (for example, TB, cervical cancer, human papillomavirus and female genital schistosomiasis) linked to HIV. These sources include sexual and reproductive health and behavioural surveys, the domestic violence module of the Demographic and Health Survey, Violence against Children surveys, the International Agency for Research on Cancer research on human papillomavirus and research and analysis by civil society, academia and development partners.
 - d) Innovative methods for collecting quantitative and qualitative information that can be used when data are lacking on key issues, populations or geographical areas and that include key informant interviews, focus group discussions and workshops held at the national and subnational levels (8).
 - The sharing of relevant tools, resources and guidance material with the gender assessment team (Annex A includes a list of available resources).
- 5.1** Review the list of documents prepared by the consultants to ensure that it is complete and appropriate. Review and add other relevant documents, including international and regional documents to which the country is a signatory or documents important to the specific country context.
- 5.2** Agree on how to digitally store the documents (such as Dropbox, blog or cloud servers). The chosen method should allow team members to have common access.

- 5.3** Share a list of all compiled documents with the stakeholders and partners for their review and input before the gender assessment workshop. These documents will form the basis for stages 2 and 3.

The gender assessment team should become familiar with the online tools and guidelines to prepare for the gender assessment process and to identify effective, evidence-informed interventions. This is crucial when the group identifies key interventions in stage 4.

Step 6. Organize a gender assessment inception workshop with all relevant stakeholders

Organize the workshop with all relevant stakeholders to undertake stages 2, 3 and 4 of the GAT, considering the following:

- a) Duration: preferably it should last two to three days (Annex D includes a sample agenda for a gender assessment workshop).
- b) Participants: they should be drawn from diverse constituencies, including government, bilateral donors, United Nations agencies, academia, research institutes, NGOs and civil society (women living with HIV, sexual and reproductive health and rights advocates, transgender people, sex workers, gay men and other men who have sex with men and other key populations, young people, community leaders and others). Geographical, socioeconomic, and ethnic and gender diversity should be considered. This ensures a range of perspectives that will enrich the discussion and reflection on stages 2 and 3 of the GAT.
- c) Methods: the workshop may adopt different interactive methods to engage a diverse group of participants in reviewing the information collected on the HIV epidemic and national response. The agenda should enable participants to examine the gender dimensions and identify strategic interventions to address the issues and gaps identified by the gender assessment and to provide guidance on the way forward for a national gender-transformative HIV response (28).

The gender assessment team should internally validate the data collected in stages 2 and 3 before the workshop to ensure accuracy, adequacy of data sources and appropriate disaggregation. See the WHO/UNAIDS tool for strengthening gender-sensitive national HIV and sexual and reproductive health monitoring and evaluation systems as an important resource at this stage (17). This tool provides very useful step-by-step guidance on the process to analyse data on the epidemic and identify contributing factors to the current situation by analysing disaggregated data and analysing jointly with data on potential explanatory factors (data on laws and policies or other relevant indicators), to identify potential reasons for differences. This could be helpful to guide the completion of GAT stages 2 and 3. Considering the workshop's duration and the complexity of analysing problems and setting priorities for interventions, the agenda should consider:

- a) The topics and specific issues to be discussed to achieve the workshop objectives.
- b) Appropriate methods and facilitation techniques.

- c) Facilitating team preparations and training of the support team.
- d) The draft programme and timing and the output of the sessions.
- e) Including relevant issues not previously considered, based on the country realities and context.
- f) Logistics, considering the methods to be used and the type and number of participants.

The expected deliverables of this workshop are: (1) an inception report containing a detailed work plan, roles and responsibilities for the entire consultancy; and (2) a finalized programme and presentations for the gender assessment workshop.

Stage 2. Knowing the national HIV epidemic and context

This stage provides key questions for understanding the HIV epidemic from a gender perspective, the context surrounding behaviour and any relevant socioeconomic, cultural, political and economic factors. It provides important questions for identifying inequalities between subgroups of women and girls and of men and boys that influence their vulnerability to HIV.

It is recommended to prepopulate the sections below with the relevant data when preparing the gender assessment workshop.

Some key elements of a gender analysis of the country's epidemic and context are:

- **Disaggregation.** The data should be broken down by sex and age and other relevant social stratifiers (income, race, ethnicity, key populations and urban versus rural). Although most of the data required are for national-level indicators, understanding the geographical distribution of the epidemic and response may be crucial. Likewise, some indicators are usually grouped into two age segments, 0–14 years and 15 years and older, but others, such as the numbers of people newly infected with HIV and the numbers of people dying from AIDS-related causes, should be disaggregated by age (younger than 5 years, 5–14 years and 15 years and older) or by five-year age groups until 24 years and then 25–49 years.
- **Measuring changes over time.** Indicators on prevalence and incidence should be analysed as a time series for examining trends over time. Trends in other indicators, including the prevalence of recent intimate partner violence, could also be analysed. Consider presenting the available trends in graphs.
- **Sources of data.** Country data for selected indicators may be available through AIDSinfo (<http://aidsinfo.unaids.org>) and/or the Demographic and Health Survey STATcompiler (www.statcompiler.com).

Step 7. HIV prevalence and incidence and behavioural information

Question 1. What is the latest national prevalence of HIV, disaggregated by sex, age and other relevant stratifiers, in the general population and extended to the subnational level?

Question 2. What is the latest national incidence of HIV in the general population, disaggregated by sex, age and other relevant stratifiers?

Question 3. What is the number of people newly infected with HIV, disaggregated by sex, age and other relevant stratifiers?

Question 4. What is the number of people dying from AIDS-related causes, disaggregated by sex, age and other relevant stratifiers?

Question 5. Has the size of key populations been estimated?

Question 6. What is the prevalence of HIV in key populations?

Question 7. If a mode-of-transmission study has been conducted, which populations had the majority of people newly infected with HIV?

Question 8. Are there any locations with a higher incidence of HIV, such as rural, urban or specific geographical locations or cities and other administrative areas of importance?

Question 9. What percentage of women and men 15–24 years old correctly identify both ways of preventing the sexual transmission of HIV and reject major misconceptions about HIV transmission?

Question 10. What proportion of women 15–24 years old had sex in the previous 12 months with a partner who was 10 or more years older than them?

Question 11. What percentage of respondents reported using a condom as follows?

- Percentage of sex workers who report using a condom with their most recent client.
- Percentage of men who report using a condom the last time they had anal sex with a male partner.
- Percentage of people who inject drugs who report using a condom the last time they had sexual intercourse.
- Percentage of transgender people who report using a condom during their most recent sexual intercourse or anal sex.
- Percentage of young people (15–24 years old) who used a condom the last time they had sex with a non-marital, non-cohabiting partner, of those who had sex with such a partner in the past 12 months.

Question 12. How many people received oral pre-exposure prophylaxis (PrEP) at least once during the reporting period?

Question 13. What proportion of ever-married or partnered women 15–49 years old experienced physical or sexual violence from an intimate male partner in the past 12 months (10)?

Question 14. What proportion of women 15–49 years old and living with HIV experienced at least one of the following before, because of or after being diagnosed with HIV (14)?

- Violence by an intimate partner
- Violence by a family member other than a partner
- Violence by a community member (neighbour)
- Violence within the health sector
- Violence by the police, in prison or in detention
- Fear of violence

Question 15. Does the country have data on unwanted pregnancies among adolescents and the unmet need for contraception?

Question 15.1 Do the country's policies and programmes link preventing unwanted pregnancies and preventing HIV infection?

Question 16. Has the country collected data on stigma and discrimination towards people living with HIV? If so:

- a) What percentage of people living with HIV report experiencing HIV-related discrimination in health-care settings (disaggregated by sex [female and male] and age [15–19 years, 20–24 years and 25–49 years])?
- b) What percentage of key populations (gay men and other men who have sex with men, transgender people, sex workers and people who use drugs) report having avoided health-care services because of stigma and discrimination (10)?

Question 17. Does your country have laws requiring parental consent for adolescents to access:

a) Sexual and reproductive health services?

- Yes, for adolescents younger than 18 years
- Yes, for adolescents younger than 16 years
- Yes, for adolescents younger than 14 years
- No

b) HIV testing?

- Yes, for adolescents younger than 18 years
- Yes, for adolescents younger than 16 years
- Yes, for adolescents younger than 14 years
- No

c) HIV treatment?

- Yes, for adolescents younger than 18 years
- Yes, for adolescents younger than 16 years
- Yes, for adolescents younger than 14 years
- No

Question 18. Does your country have laws requiring spousal consent for married women to access sexual and reproductive health services?

- Yes
- No

Question 19. Does your country have laws requiring spousal consent for married women to access HIV testing?

- Yes
- No

You have now reached the end of step 7. Please review and analyse the data gathered above. In a limited set of bullets, identify gender differences and inequities, briefly describing the nature and scope of the gender inequalities underlying the HIV epidemic in the country and summarize key issues based on the HIV epidemic data available. These data will be used later in the document for the analysis matrix.

Step 8. Social, cultural and economic factors

When you answer the following questions, please refer to women, men and transgender people, disaggregated by age (if possible).

Question 1. What sociocultural norms and practices may contribute to increasing the risk of HIV transmission among women and girls, among men and boys and among transgender people? The following are examples of indicators on gender norms and practices influencing HIV outcomes documented in some countries:

- a) Proportion of people 15–49 years old who believe that a wife can refuse to have sex with her husband or can propose condom use if the husband has a sexually transmitted infection.
- b) Percentage of currently married women 15–49 years old who usually decide about their own health care: (1) by themselves; (2) jointly with their husbands; or (3) based on their husband's decision.
- c) Percentage of women 20–24 years old who were married or in union before age 18.
- d) Proportion of women and men who say that wife-beating is an acceptable way for husbands to discipline their wives.
- e) Percentage of people who agree with the following cultural norms on sexuality and gender roles:
 - A man has a right to assert power over a woman and is socially and economically superior.
 - A man has a right to “correct” or discipline women's behaviour.
 - Wife-beating is an acceptable way for husbands to discipline their wives.
 - A woman's freedom should be restricted.
 - Physical violence is an acceptable way of resolving conflicts within a relationship.
 - Women and girls should be passive, obedient, care about others and put others' needs before their own.

- Being a man or boy means being tough, brave, taking risks, being aggressive and not caring for one's body.
- Having different expectations about what is appropriate sexual behaviour for boys and girls.

Question 1.1 How do these sociocultural norms and practices contribute to creating barriers for HIV prevention, contributing to increasing the risk of HIV transmission and reducing adherence to antiretroviral therapy?

Question 2. Do sociocultural norms and practices contribute to the risk of HIV transmission among key populations that were not named in question 1?

Please examine the norms and practices prevailing in the country. Examples of these norms documented in some countries in relation to key populations are:

- Cultural intolerance, intense dislike and stereotyping of groups perceived as being different within society.
- Perceptions of homosexuality, sex work and multiple partners as diseases or sins or as abnormal, unacceptable and/or shameful behaviour.
- Women drug users considered to be aggressive and manipulative, acting without feelings or suppressing them in favour of getting drugs, being sexually promiscuous and failing as partners and mothers.
- Attitudes towards female sex workers: (1) they are bad mothers, (2) women who sell sex deserve to experience violence because they are acting immorally, (3) sex workers are cursed and (4) transgender people are immoral.
- Ethnic minority groups, immigrants and displaced people considered responsible for transmitting HIV or sexually transmitted infections and/or less sexually responsible than other population groups.
- Transactional sex, for example a blesser and blessee culture.

Question 2.1 How do these sociocultural norms and practices contribute to increasing the risk of HIV transmission? Be specific by population, based on evidence.

Question 3. According to the available data, what are the main social determinants of HIV risk and vulnerability of and impact on women, men, boys, girls and key populations? This may include such factors as poverty, lack of income security, social protection services, food security, housing, water and sanitation and access to education.

You have now reached the end of step 8. Please proceed to complete step 9, after which you will analyse the two steps together.

Step 9. Legal and political factors

Your country may have reported data for some of the questions below through the National Commitments and Policy Instrument, a component of Global AIDS Monitoring

that aims to measure progress in developing and implementing policies, strategies and laws related to the HIV response. It has two parts: Part A, completed by national authorities; and Part B, completed by civil society representatives and other NGO partners involved in the HIV response (29). (See the National Commitments and Policy Instrument database at <http://www.aidsinfoonline.org/ncpi> to view your country's data for these questions.)

Question 1. Do any of the following laws or policies that may directly affect women and girls, men and boys and key populations in relation to HIV exist in your country? Add others, as relevant, and please elaborate.

- Criminalization of drug use
- Criminalization of HIV transmission, exposure (including mother-to-child transmission) or non-disclosure
- Criminalization of sexual orientation and/or gender identity
- Criminalization of sex work
- Denial of access to condoms or sexual and reproductive health services for people younger than 18 years
- Denial of comprehensive sexuality education for people younger than 18 years
- Denial of inheritance and/or property rights to women
- Early and forced child marriage practices
- Restrictions on entry, stay and residence for people living with HIV
- Non-recognition of sexual or gender-based violence within marriage
- Polygamous marriages

Question 2. Does the country have any of the following laws or policies that specifically protect the rights of people living with HIV, women and girls and other key populations?

- Does your country have any of the following legal protections for transgender people (please select all that apply)?
 - Constitutional prohibition of discrimination based on gender identity
 - Prohibition of discrimination in employment based on gender diversity
 - Legal recognition of a third gender
 - Other non-discrimination provisions specifying gender identity
- Does your country have legislation on domestic violence? If so, indicate what this legislation addresses (please select all that apply):
 - Physical violence
 - Sexual violence

- Emotional violence
- Economic violence
- Explicit criminalization of marital rape
- Protection of former spouses
- Protection of unmarried intimate partners
- Does your country have any of the following to protect key populations and people living with HIV from violence (please select all that apply)?
 - General criminal laws prohibiting violence
 - Specific legal provisions prohibiting violence against people based on their HIV status or belonging to a key population
 - Programmes to address intimate partner violence
 - Programmes to address workplace violence
 - Interventions to address police abuse
 - Interventions to address torture and ill treatment in prisons
- Does your country have education policies that guide the delivery of life skills-based HIV and comprehensive sexuality education, according to international standards, in any of the following?
 - Primary school
 - Secondary school
 - Teacher training
 - Out-of-school youth
- Is there a law, regulation or policy specifying that HIV testing:
 - Must be solely performed based on voluntary and informed consent?
 - Is mandatory before marriage?
 - Is mandatory to obtain a work or residence permit?
 - Is mandatory for certain groups?
- Is there a law, regulation or policy that criminalizes transmission, non-disclosure of or exposure to HIV?
- Does your country have any of the following legal protections for sex workers?
 - Constitutional prohibition of discrimination based on occupation
 - Sex work recognized as work

- Other non-discrimination provisions specifying sex work
- Does your country have any laws or other provisions specifying protections based on sexual orientation?
 - Constitutional prohibition of discrimination based on sexual orientation
 - Considering hate crimes based on sexual orientation as aggravating circumstances
 - Prohibition of incitement to hatred based on sexual orientation
 - Prohibition of discrimination in employment based on sexual orientation
 - Other non-discrimination provisions specifying sexual orientation

Question 3. Are the existing laws and policies identified above implemented, and does this translate into equal access to services for women, girls, men, boys and key populations?

If yes, what services are affected? Please tick the applicable boxes.

- Commodities for HIV prevention (male and female condoms and harm reduction)
- Comprehensive sexuality education
- Education
- Information about available health services
- Formal or informal employment
- Post-rape care, including post-exposure prophylaxis for HIV and sexually transmitted infections
- Pre-exposure prophylaxis (PrEP)
- Psychosocial support for people living with HIV
- Sexual and reproductive health and rights services
- Social protection
- Strategic litigation to advance human rights in health care

Add others, as relevant, and please elaborate.

Question 4. Do both the executive and legislative branches of government work towards implementing the international treaties and declarations ratified by the country? Please give examples of laws approved and services provided according to the 2016 Political Declaration on Ending AIDS (7), the Beijing Declaration of the Fourth World Conference on Women (1995) and the Convention on the Elimination of All Forms of Discrimination against Women (31).

Question 5. Have women living with HIV, including those from key and marginalized populations, reported any of the following discriminatory practices in health-care settings in the past 12 months? Please tick the applicable boxes. Also, please include any available data on the percentage of women living with HIV who experienced each of these practices in the past 12 months.

- Coerced abortion
- Forced abortion
- Denial of access to abortion, where legal
- Denial of access to contraception
- Forced sterilization
- Forced or coerced HIV testing
- Denial of health services because of HIV status
- Verbal abuse
- Physical abuse
- Forced or coerced use of a specific type of contraception

Add others, as relevant, and please elaborate.

Question 6. Have any transgender women living with HIV reported discriminatory practices in health-care settings in the past 12 months?

Question 7. Is there any indication of discriminatory practices by the judiciary or law enforcement personnel (including the police) that may prevent women, girls or any other key or marginalized populations from accessing their rights? If so, please describe.

Question 8. What is the percentage of women in the national legislative body or bodies (such as parliament or congress)? What is the percentage of women in the cabinet (or secretariat or ministerial body)?

You have now reached the end of step 9. Please analyse the key contextual factors contributing to the HIV epidemic, relating the analysis of steps 8 and 9 to the epidemiological data and ensuring that the gender differences are clearly stated. In a limited set of bullets, identify: (1) the underlying sociocultural factors, social determinants and political factors that explain the differences and inequities in the HIV epidemic between women and men, or among subgroups of women and men, including key populations; and (2) the pathways through which these factors influence different vulnerabilities and inequities in the context of HIV.

If issues in the sociocultural, economic, legal and political context analysis indicate a need for further data, ensure that they are reflected.

Summarize the key contextual factors contributing to the gender differences reflected in the HIV epidemic and highlight the gaps in the available data.

Stage 3. Knowing the national HIV response

This stage poses key questions to help understand the national HIV response from a gender perspective and represents the core of the data needed to assess the national response based on gender. From the replies to these questions, the gender assessment team will be able to build a picture of the country's situation and make an informed decision on a list of priorities for HIV, gender investment and intervention.

Step 10. Gender equality in HIV policies and programmes

Step 10.1 The overall HIV response

Question 1. Which populations does the HIV national response address? Please disaggregate by age, sex, gender identity and sexual orientation and any other status as appropriate.

Question 1.1 Does the national HIV response include people with disabilities? If yes, does the response have specific programmes for people with disabilities? Does it address the needs of men and boys versus women and girls differently? If yes, please describe.

Question 1.2 Does the national HIV response include older people, especially older women? If yes, are there programmes to address their needs (such as chronic care packages)?

Question 1.3 Is cervical cancer screening and treatment for women living with HIV recommended in (please tick the applicable boxes):

- The national strategy, policy, plan or guideline for cancer, cervical cancer or the broader response to noncommunicable diseases?
- The national strategic plan governing the HIV response?
- The national HIV treatment guidelines?

Question 2. Does the HIV response recognize, plan for, budget for and address gender issues related to any of the following (please tick the applicable boxes):

- Enrolment in primary and secondary education?
- Early and forced marriage?
- Forced and/or voluntary migration?
- HIV-related disabilities?
- Race and ethnicity?
- Rural and urban specificities?
- Socioeconomic status?

Question 3. Has the HIV policy or strategy recognized issues of gender identity and sexual orientation?

Question 3.1. If yes, do any programmes address the stigma, discrimination and human rights of people living with HIV and key populations?

Question 4. What was the total expenditure on HIV in the last calendar year?

Please provide a breakdown of domestic and international expenditure on HIV by categories and funding sources:

- Expenditure on the five pillars of combination HIV prevention: key populations, voluntary medical male circumcision, condoms, pre-exposure prophylaxis (PrEP) and adolescent girls and young women
- Expenditure on preventing the mother-to-child transmission of HIV
- Expenditure on social enablers
- Expenditure on cash transfers for young women and girls
- Expenditure on HIV testing and counselling
- Expenditure on antiretroviral therapy

Please describe the components of each category that address gender inequalities.

Question 5. What is the government HIV budget execution rate (percentage of the approved budget that was actually spent) in each of these categories?

Question 6. If the country has a national strategy or policy that guides the HIV response, does it include gender-transformative interventions, including those that address the intersections of gender-based violence and sexual and reproductive health and rights, including human papillomavirus vaccination, preventing and controlling cervical cancer and HIV? If yes, does the national strategy or policy guiding the HIV response include a dedicated budget for implementing gender-transformative interventions?

Question 7. Does a formal system of accountability for the HIV response exist that enables civil society, United Nations agencies and citizens to monitor the priority-setting process and spending on gender equality within the HIV response? If yes, how does this work?

Step 10.2 Meaningful participation

Question 1. Are networks and organizations that represent people living with HIV, women's rights, sexual and reproductive health, gender equality, youth and key populations (gay men and other men who have sex with men, sex workers, people who inject drugs, and transgender people) engaged in decision-making at different stages, levels and sectors of the country's HIV response? Please differentiate by constituency in responding.

Question 1.1 Do women living with HIV, sex workers, transgender people, people who inject drugs, former and/or current prisoners and gay men and other men who have sex with men in your country participate in developing policies, guidelines and strategies relating to their health?

Question 1.2 Do women living with HIV in your country participate in developing policies, guidelines and strategies relating to preventing the mother-to-child transmission of HIV?

Question 1.3 Does civil society participate in the HIV response? If so, please document observations about its participation and its links with gender equality.

Question 2. Are there formal mechanisms (such as partnership forums, joint HIV theme groups, national AIDS councils or commissions and country coordinating mechanisms) ensuring that decision-making processes in the HIV response consider the views, needs and rights of key populations? If so, please describe how this is ensured, focusing on gender issues (provide examples, if possible).

Question 3. Do any of the following safeguards in laws, regulations or policies provide for the operation of civil society organizations or community-based organizations in your country?

- HIV civil society organizations can be registered
- Civil society organizations and community-based organizations working with key populations can be registered
- Civil society organizations and community-based organizations can provide HIV services
- Civil society organizations and community-based organizations can provide services to key populations
- The reporting requirements for civil society organizations and community-based organizations delivering HIV services have been streamlined

Question 4. Do any laws, policies or regulations enable civil society organizations and community-based organizations to access funding?

- From domestic funding (social contracting or other mechanisms allowing service delivery by communities to be funded)
- From international donors

Question 5. What legal and policy provisions exist for these populations to access domestic and/or international funding to support the national HIV response?

Question 6. What legal, political and financial provisions exist for capacity-building and allocating resources to support the participation of women, girls, transgender women and sex workers in the HIV response?

Question 7. Is any key population excluded—by laws, regulations or policies—from engaging in the national HIV response?

Step 10.3 Coordination of gender equality within the HIV response

Question 1. Does the national HIV coordination mechanism include a dedicated working group or other mechanism focusing on gender equality? If yes, please describe.

Question 1.1 Do various government sectors (such as gender, health, justice, education, social development and human rights) have additional coordination mechanisms and levels for joint action on gender equality in the national HIV response? If so, please describe.

Question 2. Is civil society—especially networks of people living with HIV, representatives of identified key populations and groups working on gender equality and women’s rights issues—officially included in any of the above coordination mechanisms?

Question 3. Do civil society coordination mechanisms address HIV and gender? If so, which constituencies are involved?

Question 4. Do mechanisms exist for community accountability processes led by civil society organizations? If so, what are they?

Step 10.4 Gender equality in the policy framework

Question 1. What national gender equality policy or guideline provides guidance to the national HIV response?

Question 2. Does the HIV policy include interventions addressing the following issues through the HIV response?

Question 2.1 Inequality between women and girls versus men and boys?

Question 2.2 Inequality between transgender women and transgender men?

Question 2.3 Stigma and discrimination towards people living with HIV—especially women and girls living with or affected by HIV and key populations, including transgender people, sex workers and gay men and other men who have sex with men—in providing HIV and other health services and the social protection, work and labour and judiciary systems?

Question 3. Are the interventions matched with adequate budgetary allocations for implementing gender-sensitive and transformative initiatives and services? If yes, what are the main results of implementing interventions?

Step 10.5 Awareness and knowledge of gender equality

Question 1. Are there indications that the people involved in the HIV response, including decision-makers and service providers, demonstrate awareness and knowledge of the consequences of inequality between men and women and/or the marginalization of some populations in the context of HIV? Please provide examples of how this is put into practice.

Question 2. Does the pre-service and in-service curriculum of health-care workers include training?

If yes, which cross-cutting issues are addressed? Please tick the appropriate boxes.

- Gender equality
- Human rights
- Sexual and reproductive health and rights
- Addressing and preventing gender-based violence and violence against women and girls and key populations
- Stigma and discrimination

Please indicate other themes if relevant.

Question 2.1 How frequently does this training happen? Has it been evaluated? Please explain.

Question 3. Does the country have training programmes on gender equality and HIV for human resources, including decision-makers from key sectors that should be involved in the HIV national response (health, education, justice, work and labour, national mechanism for gender equality or women's affairs, law enforcement and police, youth and social protection)?

Step 10.6 Assessing expenditure allocation

Question 1. Is there accessible information, such as the national AIDS spending assessment, that documents expenditure (from national and external funding sources) on gender and HIV in the country?

Question 1.1 What factors influence budgeting decisions on gender and/or HIV? Possible factors include available domestic and international resources; the decline of donor funding; economic crisis; competing funding demands, such as humanitarian emergencies, natural disasters and current priorities funded; religion and sociocultural factors; low investment in gender equality policies; and the legal environment. Please list factors influencing budgeting decisions on gender and/or HIV.

Question 1.2 What are the challenges to implementing the gender and/or HIV budgets? These could include political commitment, lack of evidence and capacity gaps. Please list challenges to implementing the gender and/or HIV budgets.

Question 2. Based on the type of epidemic and the affected population groups, does the budget allocated to the national HIV response consider the specific needs of women, girls, men, boys and transgender people?

Question 2.1 What are the current gaps in ensuring that the national HIV response sufficiently meets the needs of these communities in the context of HIV? Please break down your response by constituency.

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

You have now reached the end of step 10 of stage 3.

Please review the data on including gender equality in HIV policies and analyse the main gaps in addressing gender inequalities. Please recall the contextual factors relating to the HIV epidemic from a gender perspective identified earlier in the GAT.

Step 11. A comprehensive HIV response

Step 11.1 HIV prevention

Question 1. Are the following HIV prevention and support services operating? Please tick the boxes of the available services and programmes.

- Access to information about HIV
- Behaviour change communication
- Female condoms
- Male condoms
- Pre-exposure prophylaxis (PrEP)
- Voluntary medical male circumcision
- Preventing the mother-to-child transmission of HIV
- Voluntary testing and counselling services
- Social protection, including cash transfers for young women
- Post-exposure prophylaxis
- Harm reduction interventions, such as needle-syringe programmes and opioid substitution therapy
- Social and behavioural change communication and demand creation
- Primary prevention programmes for gender-based violence and violence against women
- Comprehensive sexuality education

Please add other services as necessary and provide relevant observations from a gender perspective.

Question 2: What is the trend over the past 5–10 years in access to prevention options?

- Condom use among key populations
- Coverage of HIV prevention programmes among key populations

- Percentage of people injecting drugs who report using sterile injecting equipment the last time they injected
- Percentage of people injecting drugs who receive opioid substitution therapy
- HIV prevention and treatment programmes offered to prisoners while detained
- Number of people receiving pre-exposure prophylaxis (PrEP)
- Percentage of men 15–49 years old who are circumcised
- Proportion of women living with HIV 30–49 years old screened for cervical cancer
- Human papillomavirus vaccination
- Screening for other sexually transmitted infections

Question 3. Do HIV prevention services respect, promote and protect the rights of women, girls, men, boys and key populations independent of marital status, profession and age, or are there indications that these rights have been violated? If indications exist, please indicate the areas in which the violations appear to have occurred.

- Access to justice and law enforcement
- Addressing violence in all cases (including from partners, family, the community or the state)
- Disclosure and acceptance of HIV status, free of discrimination
- Gender identity
- Protection against harmful gender norms and practices
- Reproductive health and rights
- Sexual health and rights
- Sexual orientation
- Voluntary testing and counselling

Please add other items considered applicable to the gender assessment and provide relevant observations from a gender perspective.

Question 4. What percentage of women living with HIV receive antiretroviral medicine to reduce the risk of mother-to-child transmission of HIV?

Question 4.1 What is the estimated percentage of children (0–14 years old) newly infected with HIV from mother-to-child transmission among women living with HIV who have given birth in the past 12 months?

Question 4.2 What is the overall loss to follow-up through the end of the breastfeeding phase?⁴

⁴ Loss to follow-up is the rate of disconnection between the people being treated and the treatment. For mother-to-child HIV transmission, it means babies treated at birth who were still infected with HIV and the treatment continuation of mothers and babies.

Question 4.3 What is the coverage rate for each stage in providing services to prevent mother-to-child transmission?

Question 4.4 Is there any insight into reasons for non-adherence from a gender perspective? Who is affected by it?

Question 4.5 Discuss who is not being reached by the national programme for preventing the mother-to-child transmission of HIV. Please provide examples and/or quote relevant sources.

Question 4.6 Does preventing the mother-to-child transmission of HIV encourage partner involvement? If yes, what are the results? Are there indications that these programmes hinder access for women? Please provide relevant data and/or examples.

Step 11.2 Treatment

Question 1. What percentage of people living with HIV know their HIV status?

Question 2. What is the coverage of antiretroviral therapy? [add other populations where relevant]

Population living with HIV	% receiving antiretroviral therapy in the past 12 months (disaggregated by sex and age, if applicable)
Sex workers	
Men who have sex with men	
People who inject drugs	
Transgender people	
Prisoners	

Question 3. What number and percentage of adults and children are receiving antiretroviral therapy among all adults and children living with HIV at the end of the reporting period?

Question 4. What number and percentage of people living with HIV have suppressed viral loads at the end of the reporting period (disaggregated by sex and age)?

Question 5. What percentage of adults and children living with HIV are known to be receiving antiretroviral therapy 12 months after starting?

Question 5.1 Does retention on antiretroviral therapy differ by sex and age?

Step 11.3 Care and support

Question 1. What underlying factors related to gender inequality influence or shape the use of and adherence to the following services among women, girls, men, boys and key populations should be considered and addressed?

Service (32)	Underlying factors influencing the use of and adherence to services
Clinical care (including TB, cancer, cervical cancer prevention and screening for and treatment of cardiovascular disease)	
Mental health and substance abuse services (including alcohol)	
Social support	
Physical care and support	
Legal support	
Pain and symptom management and end-of-life care	
Nutrition assessment, counselling and support	
Sexual and reproductive health and rights counselling	
Prevention, care and protection against violence in the family, community and services	
Social protection services	
Support for orphans, vulnerable children and young people living with or affected by HIV	
Other (please specify)	

.....

Please identify common and specific factors related to gender inequality that shape the use of the services mentioned in the table.

Question 2. Is there gender parity among providers of care and support at the community level? Please describe.

Question 3. Does the national HIV policy recognize the gender inequalities in care and support at the home and community levels?

Question 3.1 Does the national HIV policy include support and compensation mechanisms for the providers of care and support? If yes, what does it include? Please tick the appropriate box.

- Clearly defined roles and responsibilities for paid caregivers
- Comprehensive (social and psychological) care for unpaid caregivers
- Financial compensation for primary and secondary caregivers
- Recognition of and effort to address the burden and impact of care on women and girls
- Reliable access to home-based care supplies
- Training and support for palliative care

Question 3.2 Does the national HIV policy include actions at the community level to promote men's involvement in care and support (33)? If yes, what does it include? Please tick the appropriate boxes.

- Educating men living with HIV, young men, community leaders and male opinion leaders on the importance of male involvement, providing concrete information to encourage them to assume caregiving roles
- Involving community outreach workers, peer counsellors and other lay health workers in conducting home-based care activities and supporting caregivers
- Providing information about caregiving and opportunities to discuss barriers, challenges, experiences and solutions in support groups for men and couples living with or affected by HIV
- Avoiding messages that reinforce negative stereotypes: for example, only women or girls can provide care or conduct activities, such as bathing sick people or cooking for sick family members, or that only men can interact with government authorities on behalf of sick people
- Educating on healthy behaviour, beliefs and attitudes towards women and girls, focusing on gender equality, safety and autonomy

Step 11.4 Gender-based violence and violence against women and girls

Question 1. Does the national HIV and/or gender policy guide the HIV response in recognizing how the link between gender-based violence and HIV increases the risk of HIV transmission, including in conflict and post-conflict situations? Please explain your answer.

Question 2. Does the national HIV and/or gender policy guide the HIV response in recognizing the link between gender-based violence and HIV, both the increased

risk of HIV transmission as a result of violence in some contexts and people living with HIV experiencing violence as a result of their HIV status? Please explain your answer.

Question 2.1 If so, how do programmes and services address this, and which populations benefit?

Question 3. Is there a policy on addressing gender-based violence? If yes, does it address HIV in sectoral programmes, initiatives or services on gender-based violence? Please explain and indicate whether the policy is multisectoral.

Question 3.1 If there is a policy on addressing gender-based violence, what actions are undertaken and which populations are addressed?

Question 3.2 If there is no policy on addressing gender-based violence, why is it not being addressed?

Question 4. Are there laws that reduce and condemn violence against women and gender-based violence? If so, please specify which laws have been established.

Question 4.1 How are the laws enforced? If there are limitations, please describe them.

Question 5. Does the HIV response address condoning attitudes of society about violence against women and gender-based violence? If yes, please explain.

Question 6. Does the HIV response address the attitudes (such as regarding workplace sexual harassment and violence) of service providers, such as health workers, law enforcement personnel and teachers, about violence against women and gender-based violence?

Question 6.1 If so, how does the HIV response address this? (For example, this could be addressed through information, education and communication materials, including various efforts focused on training and sensitizing health-care workers, teachers, law enforcement personnel and media workers.)

Question 6.2 If the HIV response does not address this, why not?

Question 7. Does your country have service delivery points that provide the following appropriate medical and psychological care and support for women and men who have been raped or experienced incest (in accordance with the recommendations of the 2013 WHO clinical and policy guidelines for responding to intimate partner violence and sexual violence against women (34))? Please tick the appropriate boxes.

- First-line support: psychological first aid
- Emergency contraception for women seeking services within five days
- Safe abortion if a woman becomes pregnant as a result of rape, in accordance with national law

- Post-exposure prophylaxis for sexually transmitted infections and HIV (within 72 hours of sexual assault) as needed

Question 8. Does your country have training programmes on preventing violence against women and gender-based violence for the following groups?

- Police and other law enforcement personnel
- Members of the judiciary
- Elected officials (lawmakers or members of parliament)
- Health-care workers
- Teachers

Question 9. Are there partnerships between government and United Nations agencies, NGOs, networks or organizations representing women's rights, women living with HIV and key populations, among others, to develop and implement programmes and initiatives that address gender-based violence and violence against women in the HIV response?

Question 10. If the country has a humanitarian crisis, does a programme address gender-based violence and violence against women and girls? If so, please describe how HIV and other relevant sexual and reproductive health and rights services are integrated.

Step 11.5 Sexual and reproductive health and rights

Question 1. Does the country have a policy on sexual and reproductive health and rights that recognizes and addresses links between HIV, maternal and child health and women's health beyond their reproductive role (either as a stand-alone policy or as part of the HIV policy)?

Question 1.1 Has your country adapted the recommendations from the 2017 WHO consolidated guideline on sexual and reproductive health and rights of women living with HIV (11)?

- Yes, fully
- Yes, partly
- No

Question 2. Please indicate which of the following sexual and reproductive health and rights services are equally accessible to girls and young women, boys and young men and key populations (especially sex workers, transgender women and gay men and other men who have sex with men) (35).

- Access to condoms
- Screening, diagnosis and treatment of sexually transmitted infections
- Contraceptive services, including condoms
- Safe abortion and post-abortion care
- Post-exposure prophylaxis
- Pre-exposure prophylaxis (PrEP)
- Human papillomavirus vaccination
- Cervical cancer screening, treatment and palliative care
- Screening for anal cancer
- Conception
- Pregnancy and delivery
- Voluntary medical male circumcision

Please provide disaggregated data for sex and age if available and information on the geographical availability of the services.

Question 3. Does the HIV response incorporate regional and international commitments on sexual and reproductive health and rights, with special attention to the sexual and reproductive health and rights of women and girls? If yes, how?

Question 4. What are the most common gender-related barriers and challenges to accessing integrated HIV and sexual and reproductive health and rights services and commodities?

Question 4.1 How have these been identified?

Question 4.2 How has the national strategy addressed them?

Question 4.3 If there is a programme, does it offer sexual and reproductive health services to women, girls, men, boys and specific key populations in a humanitarian crisis situation? If so, please explain (listing the type of services provided and supported populations).

Step 11.6 Violations of human rights in services and programmes

Question 1. Do services respect, promote and protect the rights of women, girls, men, boys and key populations? Are there indications that these rights have been violated? If so, please indicate the types of rights violated in each type of service (36).

Rights	Services in which violations have occurred				
	HIV prevention	Treatment	Care and support	Gender-based violence	Sexual and reproductive health and rights
Non-discriminatory access to services					
Respect for and protection of informed consent, confidentiality and the right to privacy concerning medical testing, treatment or health services rendered					
Not being subjected to methods that constitute torture or cruel, inhumane or degrading treatment, such as forced practices					
Programmes put in place that address their specific vulnerabilities and needs					
Mechanisms for monitoring, making complaints and redress when rights are violated					
Participation in decision-making processes that concern them					

Question 2. What are the underlying factors (cultural, economic, political and institutional, as well as norms) that contribute to these violations of human rights?

You have now reached the end of step 11 of stage 3. Please review and analyse the main gaps in addressing gender inequalities in HIV programming and then summarize them.

Please recall both the gender issues and the contextual factors relating to the HIV epidemic that were identified earlier in the GAT.

Step 12. Gender considerations according to the community

Step 12.1 Women and girls

Question 1. Is there a national gender policy or policy for women and girls? If so, please indicate its name and the year it was established.

Question 2. Does this policy effectively address any of the following issues in relation to increased vulnerability to HIV infection and hindering the use of and access and adherence to HIV services? If yes, please tick the applicable boxes.

- Access to economic empowerment opportunities, including microcredits or cash transfers
- Access to educational opportunities (including comprehensive sexuality education) for women and girls
- Access to legal and/or law enforcement institutions for key populations, especially to assist them in knowing and claiming their rights
- Access to services to address gender-based violence in the public and private spheres
- Access to social services and social protection
- Gender equality in intimate relationships and within the family
- Gender equality in workplace policies
- Protection against gender-based stigma and discrimination against people living with HIV
- Transforming existing concepts of masculinity that encourage sexual risk-taking and discourage health-seeking behaviour

Please add any other relevant area in the national context.

Question 3. Does the gender policy guide the HIV policy, strategy and response by recognizing and addressing both the gender aspects of the HIV epidemic and the specific HIV-related risks and vulnerabilities of women and girls (including those from key populations)? Please elaborate.

Step 12.2 Men and boys

Question 1. Does the national HIV and/or gender policy guide the HIV response to work with men and boys in addressing gender-related cultural norms and expectations that may negatively affect both vulnerability to HIV infection and access or adherence to HIV services? If yes, how does it do so? Please tick the applicable boxes.

- Acknowledges the stigma and discrimination from domestic and labour relations many women and girls face, including those from key populations and in various facets of life (social, economic, political and health)
- Acknowledges unequal power relations between men and women and between boys and girls
- Addresses the impact of masculinity norms on women, girls and key populations (such as gay men and other men who have sex with men, transgender people and sex workers) in terms of health-seeking behaviour, including HIV services, risky sexual behaviour and gender-based violence

- Explores and addresses how concepts of masculinity can lead to increased risk of HIV infection for men, boys and their sexual partners for several reasons, including discouraging access to HIV services and encouraging risky sexual behaviour and gender-based violence
- Promotes positive forms of masculinity that encourage access to and use of sexual and reproductive health and rights services, including HIV prevention, testing, care and treatment
- Understands and respects the rights of women, girls and key populations, such as gay men and other men who have sex with men, transgender people and sex workers

Please describe how these issues are addressed and add other examples as necessary.

Question 2. Has this guidance resulted in national programmes or initiatives, such as a gender and/or HIV policy and strategy? If yes, please provide examples.

Question 3. How effective are these policies in fostering social change? Please provide examples.

Step 12.3 Key populations

Question 1. Does the national gender policy, national HIV policy or national strategic plan on HIV recognize and address the specific HIV risks and vulnerabilities of key populations? If yes, please indicate which populations and explain.

- Transgender people
- Sex workers
- Gay men and other men who have sex with men
- People who use drugs

Question 2. Does the HIV policy guiding programmes and initiatives for key populations address critical enablers or structural interventions (12)? If yes, please indicate the activities by ticking the applicable boxes.

- Addressing gender-based stigma and discrimination
- Addressing gender-based violence against key populations
- Empowering key populations to know and claim their human rights
- Reducing gender barriers to prevention, diagnosis, treatment, care, social protection and economic empowerment
- Reviewing laws and policies that limit access to HIV services, constrain how these services are delivered and diminish their effectiveness and the exercise of all human rights (for example, criminalizing drug use and diverse forms of gender identity and sexuality)

- Having groups and organizations led by key populations participate as essential partners and leaders in designing, planning, implementing and evaluating services, programmes and policies

Please add any other areas identified as relevant and describe the operation of initiatives and programmes.

Step 12.4 Young people

Question 1. Does the country have a policy on young people? If there is no policy specific to young people, are there regulations within the HIV and/or health framework that address young people’s vulnerabilities and needs in sexual and reproductive health and rights? Please explain and describe the pertinent issues related to HIV and sexual and reproductive health and rights included in that policy.

Question 2. How does the policy on young people address the following issues? Please explain.

- Parental consent for adolescents to access sexual and reproductive health and rights services and HIV prevention, testing and treatment, including post-exposure prophylaxis and pre-exposure prophylaxis (PrEP)
- Education policies that guide the delivery of life skills–based HIV and comprehensive sexuality education, according to international standards, in primary and secondary school
- Human papillomavirus vaccination for girls (9–14 years old)
- Focused treatment for preventing female genital schistosomiasis with the medication praziquantel in schistosomiasis-endemic areas in sub-Saharan Africa
- Early or forced child marriage

Question 3. Does the national HIV response include programmes and services that focus on the needs and rights of young members of key populations? Please explain.

Question 4. Please indicate whether these programmes and services are equally accessible to girls, young women, boys and young men, including those from key populations.

Question 4.1 Are young women, young men and transgender people able to access integrated HIV and sexual and reproductive health and rights services and commodities under the same conditions as any adult? Please explain.

Question 4.2 Do any sociocultural and gender barriers block their access? If yes, what are they?

Question 5. Are any social protections being implemented in the country: for example, cash transfer programmes for women 15–24 years old?

Question 6. Do young people participate in any of the following decision-making spaces in the national HIV response? If yes, please indicate by ticking the applicable boxes.

- Technical teams for developing, reviewing and updating national AIDS strategies and plans
- Technical teams for developing or reviewing programmes related to young people's access to HIV testing, treatment, care and support services
- Expanded Joint United Nations teams on AIDS
- United Nations thematic teams on legal and policy reform and review
- National AIDS coordinating authority or the equivalent, with a broad-based multisectoral mandate
- Global Fund country coordinating mechanism
- Civil society coordination spaces of populations most severely affected by HIV
- Other: please specify _____

You have now reached the end of step 12 of stage 3. Please review and analyse the main gaps in addressing gender differences related to the specific communities, remembering the gender issues and sociocultural norms and determinants related to the HIV epidemic that were identified earlier. This information will highlight and complement the policy and programmatic section of the response.

Stage 4. Analysing and using the findings of the gender assessment for a gender-transformative HIV response

This stage provides guidance on how to use the gender assessment findings to shape and influence policy strategies, agendas and budgeting. At this stage, the stakeholders engaged in the assessment should use the matrix provided to identify major gaps and opportunities that emerged from the findings.

This stage also provides guidance for building an advocacy and communication plan for after the assessment that should help in implementing a four-pronged strategy for a gender-transformative HIV response. The four parts of the strategy are: (1) advocacy and policy monitoring; (2) service delivery and access; (3) training and capacity-building; and (4) documentation and research.

Task 1. Use your summaries from stages 2 and 3 to populate the columns of the analysis matrix (Table 2).

Table 2. Analysis matrix for the UNAIDS GAT

Epidemiological and context analysis		Response and gap analysis	
Epidemiological data	Sociocultural, economic and political context	Current HIV policy response	Current HIV programming response
Present the summary analysis of the key gender inequalities in the HIV epidemic	Present the summary analysis of the key contextual gender inequalities	Present the main gaps in addressing gender inequalities within national policy	Present the summary analysis of the key programming gaps, including those related to particular communities
Source: Stage 2, step 7	Source: Stage 2, steps 8 and 9	Source: Stage 3, step 10	Source: Stage 3, steps 11 and 12

Sources: UNAIDS.

Task 2. Interpret the data from Table 2 and identify potential mismatches between epidemiology, context and response and gaps and opportunities in the HIV response.

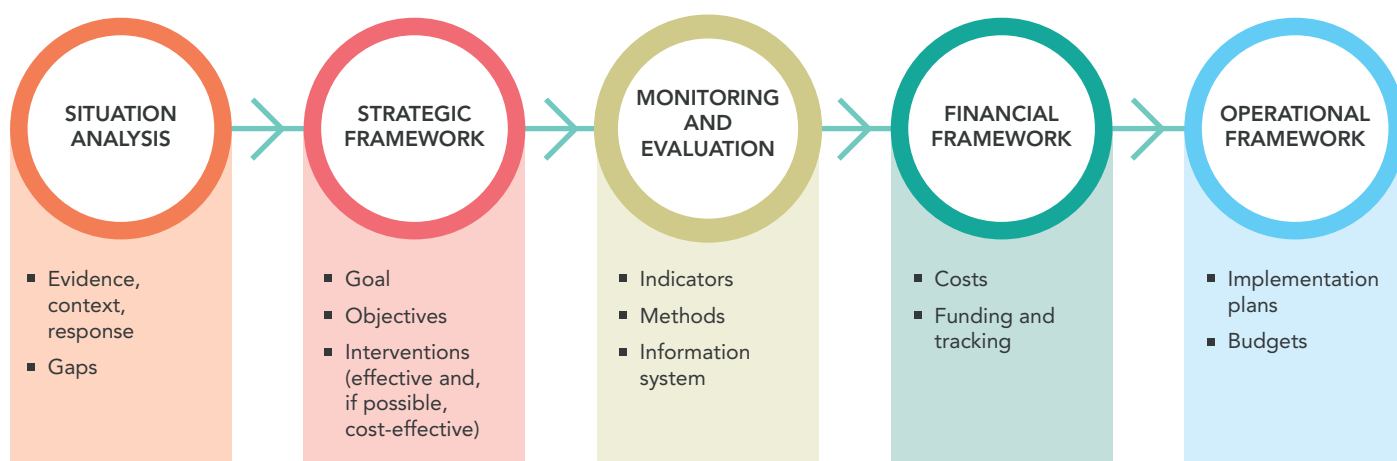
The team should ensure that its discussion considers which gender-transformative interventions would have the greatest impact on the HIV epidemic, drawing and building on promising existing interventions in the country if possible. This will help them to focus on priority interventions.

Several tools are available to identify effective, evidence-informed gender equality interventions (Annex A).

Task 3. Prepare a brief and succinct narrative report using the summarized findings from stages 2 and 3 and the suggested interventions identified using the GAT. The report should provide support for concrete recommendations for policy and programme actions required, informed by available epidemiological data and research.

Task 4. Develop a results-based plan. Based on the gaps identified, the expected results should be identified as part of a strategic planning process. This should aim to achieve significant and concrete results that contribute to the long-term outcomes in the HIV response related to gender equality (37). The findings from stages 2 and 3 provide a rationale for the priorities and their corresponding indicators and data collection. Likewise, implementation plans and costing of the effective interventions should be linked to the identified priorities and capacity required to deliver and measure them (38). Existing databases on what works, guidelines for gender-responsive programming, monitoring and evaluation indicators and budgeting will help with coherent results-based planning (Fig. 2; see also Annex A).

Figure 2. Results-based planning



Sources: adapted from: *Planning guide for the health sector response to HIV/AIDS* (38).

The gender-responsive interventions should be based on the best-available evidence on the situation and the effectiveness of interventions. They should also define clear and measurable results to be achieved (impact, outcomes and outputs) and define appropriate implementation plans and a framework for accountability.

The SMART way to select the objectives and indicators of gender-responsive interventions

The objectives should meet the following criteria: specific, measurable, achievable, realistic and time-bound (SMART).

Specific. Is it clear exactly what is being measured? Has the appropriate level of disaggregation been specified (women, girls, men, boys, key populations)? Do the objectives capture the essence of the desired result related to gender equality?

Measurable. Are changes objectively verifiable? Will the selected indicators show change in gender inequalities in the context of HIV? Do the indicators reliably and clearly measure results? Are the objectives and the corresponding indicators sensitive to changes in policies and programmes?

Achievable. What changes are anticipated as a result of the interventions? Are the results realistic? For this, a credible link between outputs and outcomes is indispensable.

Realistic. Are the objectives achievable? Do the selected indicators capture the essence of the desired results? Are the indicators relevant to the intended outputs and outcomes? The objectives of the interventions should not aim too high but should be achievable given the available resources and competencies.

Time-bound. Can the objectives be achieved within a manageable time frame?

Alignment between interventions and the UNAIDS Strategy 2016–2021

The gender-responsive interventions will contribute to the investment case on three levels—basic programme activities, critical enablers and development synergy—and should be aligned with the eight areas of results of the UNAIDS Strategy 2016–2021 (25,39).

- 1) Children, adolescents and adults living with HIV access testing, know their status and are immediately offered and sustained on affordable quality treatment.
- 2) New HIV infections among children are eliminated, and their mother's health and well-being is sustained.
- 3) Young people, especially young women and adolescent girls, access combination prevention services and are empowered to protect themselves from HIV.

- 4) Tailored HIV combination prevention services are accessible to key populations, including sex workers, gay men and other men who have sex with men, people who inject drugs, transgender people, prisoners and migrants.
- 5) Women and men practice and promote healthy gender norms and work together to end gender-based, sexual and intimate partner violence to mitigate risk and the impact of HIV.
- 6) Punitive laws, policies, practices, stigma and discrimination that block effective responses to HIV are removed.
 - > Punitive laws, policies and practices are removed, including overly broad criminalization of HIV transmission, travel restrictions, mandatory testing and those that block key populations' access to services
- 7) The AIDS response is fully funded and efficiently implemented based on reliable strategic information.
- 8) People-centred HIV and health services are integrated in the context of stronger systems for health.
 - > HIV-sensitive universal health coverage schemes are implemented.

Critical to the interventions will also be:

- The country's progress in rolling out human papillomavirus vaccination for adolescent girls 9–14 years old.
- Screening and treatment for cervical cancer for women living with HIV.
- Achieving the goals and targets of the UNAIDS Strategy 2016–2021, which requires working in new ways; scaling up comprehensive packages of programme interventions for prevention, care and treatment known to work for women, girls and key populations; collaborating across sectors; and investing at the intersections of HIV and other development challenges.

Effectively implementing the gender-responsive priorities requires strategic alliances and financial commitments from development partners, various ministries (those responsible for health, gender or women's affairs, youth, education, justice, law enforcement and economic and social development), local authorities as well as NGOs and community-based organizations.

Entry points for integrating priority gender-responsive interventions

- Inclusion in the HIV national strategic plan or midterm reviews of the national strategic plan.
- Elaboration of Global Fund proposals, reprogramming of Global Fund funds, PEPFAR country plans or other opportunities to mobilize resources.
- Establishment of a national gender plan (or similar).
- Inclusion in the United Nations Development Assistance Framework.

Task 5. Develop an advocacy plan, defining strategies and activities that can help to effectively achieve priorities. This requires comprehensively thinking about what is required to realize policy targets. Without this approach, the gender assessment team may form unrealistic expectations about what can be accomplished.

The advocacy plan should be based on the main findings of the gender assessment and must answer the following questions.

- a) What are the goals?
- b) How will each goal be accomplished?
- c) When will the tasks be completed?
- d) Who will perform the necessary tasks?
- e) What resources are required to accomplish the tasks? Is additional support required?
- f) How will civil society be included in the development, promotion and implementation?

Task 6. Design a communication strategy to disseminate the key priorities emerging from the gender assessment.

- a) Identify audiences and define the ones with whom to work. Consider the priorities emerging from the gender assessment process and determine the key stakeholders and populations requiring further engagement, including civil society partners.
- b) Assess the awareness about gender-transformative actions among the priority audiences.
- c) Select the media to be used, adjusting the use of communication channels according to context and audience.
- d) Create (or adjust, if they already exist) the messages for a gender-transformative HIV response that are appropriate for both the media used and the intended audience, such as the apparatus of the ministries responsible for health and gender, the parliament, health-care providers, law enforcement institutions, education, social protection institutions and LGBTI, women's rights and youth movements.

Define how the messages will be disseminated and identify the tools required.

Task 7. Budget for implementing the advocacy and communication strategy.

- a) Make the money work by making the strategy cost-effective.
- b) Foster partnerships with civil society, other government bodies, universities and media outlets, among others.

Task 8. Develop a fundraising strategy to support the implementation of the gender assessment findings and priority interventions. Consider the following sources:

- Government support at the country, regional and city levels.
- International development and funding partners, including PEPFAR, Unitaid and the Global Fund.
- Private-sector funding.
- National and international foundations.

Task 9. Develop a gender assessment monitoring process to demonstrate the gender transformation of the HIV response over time.

You have now completed the gender assessment. Please keep these findings and corresponding priority interventions in mind when undertaking future work. Gender is a cross-cutting issue in the HIV response.

Annex 1. Gender equality and HIV: resources and links to tools and guidance

a) Gender assessment tools

- Topic: gender [website]. UNAIDS
<http://www.unaids.org/en/targetsandcommitments/eliminatinggenderinequalities>

b) Gender mainstreaming tools

- Gendering national strategic plans. Athena Network.
<http://www.athenanetwork.org/ensuring-gender-equity-in-research/gendering-national-strategic-plans.html>
- The President's Emergency Plan for AIDS Relief: updated gender strategy, 2013
<http://www.pepfar.gov/documents/organization/219117.pdf>
- On course: mainstreaming gender into national HIV strategies and plans: a roadmap. New York: UNDP; 2012
<http://asapltd.com/wp-content/uploads/2013/07/UNDP-Roadmap-12-11-2012-final.pdf>
- Checklist for integrating gender into the processes and mechanisms of the Global Fund to Fight AIDS, Tuberculosis and Malaria. New York: UNDP; 2015
<http://www.undp.org/content/undp/en/home/librarypage/hiv-aids/checklist-for-integrating-gender-into-the-new-funding-model-of-t.html>

c) Monitoring and evaluation

- Global AIDS monitoring 2018: indicators for monitoring the 2016 United Nations Political Declaration on Ending AIDS. Geneva: UNAIDS; 2017
http://www.unaids.org/sites/default/files/media_asset/global-aids-monitoring_en.pdf
- Bloom SS, Negroustoeva S. Compendium of gender equality and HIV indicators. Chapel Hill (NC): MEASURE Evaluation, 2013
<http://www.cpc.unc.edu/measure/publications/ms-13-82>
- Global AIDS monitoring 2017: indicators for monitoring the 2016 United Nations Political Declaration on HIV and AIDS. Geneva: UNAIDS; 2016
http://www.indicatorregistry.org/sites/default/files/2017-global-aids-monitoring_en.pdf

- WHO and UNAIDS. A tool for strengthening gender-sensitive HIV and sexual and reproductive health (sexual and reproductive health) monitoring and evaluation systems. Geneva: WHO; 2016
[http://www.unaids.org/sites/default/files/media_asset/tool-sexual and reproductive health-monitoring-eval-systems_en.pdf](http://www.unaids.org/sites/default/files/media_asset/tool-sexual-and-reproductive-health-monitoring-eval-systems_en.pdf)

d) Gender, human rights and HIV

- Agenda for accelerated country action for women, girls, gender equality and HIV: how civil society, governments and the UN system can together create an effective response. Geneva: UNAIDS; 2010
http://www.unaids.org/en/media/unaids/contentassets/dataimport/pub/report/2010/jc1825_community_brief_en.pdf
- Gender dimensions of HIV/AIDS [website]. UNFPA
<https://www.unfpa.org/resources/issue-1-gender-dimensions-hivaids>
- Gender equality and HIV/AIDS [website]. UN Women
<http://genderandaids.unwomen.org/en>
- Gay J, Hardee K, Croce-Galis M. What works for women and girls: evidence for HIV/AIDS interventions. 2nd edition. Washington (DC): Futures Group, Health Policy Project; 2012
<http://www.whatworksforwomen.org>
- Barker G, Ricardo C, Nascimento M. Engaging men and boys in changing gender-based inequity in health: evidence from programme interventions. Geneva: WHO; 2007
http://www.who.int/gender/documents/Engaging_men_boys.pdf
- HIV prevention among adolescent girls and young women. Putting HIV prevention among adolescent girls and young women on the Fast-Track and engaging men and boys. Geneva: UNAIDS; 2016
https://hivpreventioncoalition.unaids.org/wp-content/uploads/2018/01/20180702_JC2868_AGYWReport.pdf
- Linkages between sexual and reproductive health and HIV/AIDS [website]. Geneva: WHO
<http://www.who.int/reproductivehealth/publications/linkages/en>
- Zero discrimination in health-care settings. Geneva: UNAIDS; 2017
http://www.unaids.org/sites/default/files/media_asset/20171129_UNAIDS_PCB41_Zero_discrimination-health-care-settings_17.27_EN.pdf

e) Gender and violence

- AIDSTAR-One project. Resources for the clinical management of children and adolescents who have experienced sexual violence [website]. AIDS-Free
<https://aidsfree.usaid.gov/collections/resources-clinical-management-children-and-adolescents-who-have-experienced-sexual>

- Middleton LS. Technical paper: review of training and programming resources on gender-based violence against key populations. Arlington (VA): USAID's AIDS Support and Technical Assistance Resources, AIDSTAR-Two Task Order 2 and the International HIV/AIDS Alliance; 2013
https://www.hivgaps.org/wp-content/uploads/2013/10/AIDSTAR-Two_Tech-Paper-Rev-Resources-gender-based-violence-Against-Key-Populations-FINAL-09-30-13.pdf
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http://www.unaids.org/sites/default/files/media_asset/JC2602_UniteWithWomen_en_0.pdf
- Virtual knowledge centre to end violence against women and girls [online database]. UN Women
<http://www.endvawnow.org>
- WHO and UNAIDS. 16 Ideas for addressing violence against women in the context of the HIV epidemic: a programming tool. Geneva: WHO; 2013
http://apps.who.int/iris/bitstream/handle/10665/95156/9789241506533_eng.pdf;jsessionid=A96631D2D137D2E8B0D4B62448C79A93?sequence=1
- Responding to intimate partner violence and sexual violence against women: WHO clinical and policy guidelines. Geneva: WHO; 2013
<http://www.who.int/reproductivehealth/publications/violence/9789241548595/en>
- STRIVE: Greentree II. Violence against women and girls, and HIV. Report on a high-level consultation on the evidence and implications. 12–14 May 2015, Greentree Estate, New York. London: STRIVE; 2015
<http://strive.lshtm.ac.uk/resources/greentree-ii-violence-against-women-and-girls-and-hiv>
- (ALIV[H]E) Framework. Action Linking Initiatives on Violence Against Women and HIV Everywhere. London: Salamander Trust; 2017
http://salamandertrust.net/wp-content/uploads/2017/11/ALIVHE_FrameworkFINALNov2017.pdf

Annex 2. Model terms of reference for the country assessment team supporting the gender assessment of the national HIV response

About the GAT

The GAT is a structured set of guidelines and questions that can be used to guide and support the process of analysing to what extent the national responses to HIV—in both generalized and concentrated epidemics—consider the critical goal of gender equality. UNAIDS developed the GAT by convening an expert reference group comprising members from around the globe and from government, United Nations agencies and civil society organizations to guide its development.

A planned, systematic and deliberate set of steps and processes, the GAT examines and questions the status of the HIV response (plans and actions undertaken by national governments to address HIV), specifically referring to its gender dimensions: the socially constructed roles, behaviour, activities and attributes a given society considers appropriate for women and men, including members of key populations. The GAT enables users to learn the extent to which the national response recognizes gender inequality as a key determinant of the trajectory of the HIV epidemic and then acts based on that recognition. This will help to ensure that the national HIV response has gender equality as a goal.

The gender assessment process of an HIV response involves:

- Knowing your HIV epidemic and country context from a gender perspective.
- Knowing your country response from a gender perspective.
- Using the gender assessment findings to identify evidence-informed gender-transformative interventions to strengthen the HIV response.

Individuals and partners in government, civil society, the United Nations and other multilateral agencies can use the GAT to support key national processes, such as developing or reviewing a national strategic plan on HIV, a Global Fund proposal, the review or reprogramming of funds or another opportunity that has been identified in the country.

Scope of the country assessment team

The country assessment team should comprise government representatives, experts on HIV policies and services, experts on gender policies and services and stakeholders from the HIV and gender fields. The stakeholders should include government, civil society representatives, relevant bilateral agencies and United Nations agencies. As appropriate, stakeholders also can include those from key sectors, such as health, education, gender, justice, labour or work, social protection, migration, human rights and finance.

Particular care should be taken to ensure the meaningful involvement of people living with HIV and women at all stages, including in the country assessment team. Further, country ownership and leadership must be ensured for the entire process, with high-level government representatives providing the lead.

Civil society organizations working on gender, women's rights, youth, key populations, and sexual and reproductive rights also must be engaged. Once brought together, the present terms of reference should be shared and reviewed by the entire team.

Information should be shared as early on in the process as possible and made available in the main languages of the United Nations.

The role of team members: voluntary and not remunerated

The team must become closely familiar with the GAT and related materials. Before the assessment, online sessions using, for example, WebEx and/or Skype are planned to help team members in this process, with all members expected to participate.

The team is the core of the gender assessment. Indeed, team members will be asked to work together, with the strong support of a national consultant, to perform several key tasks.

Developing a gender assessment framework

This includes:

- Agreeing on the final goal of the gender assessment.
- Deciding on its guiding principles and methods for monitoring how they are applied.
- Developing an advocacy and communication plan.
- Developing a resource plan.

Collecting, collating and storing relevant documents and data

This includes identifying needs for additional data and select methods for collecting information, such as key informant interviews, focus group discussions and workshops held at the national and subnational levels.

Using previously collected data to answer the questions from stages 2 and 3 of the GAT

Analysing and using the findings, drawing on the gender assessment to identify gaps and opportunities in the HIV response and to establish evidence-informed interventions

Interventions include:

- Using gender analysis guidelines to help understand the gender inequality dimensions underlying the HIV epidemic, context and response.
- Defining priorities, identifying key interventions to respond to the gaps and preparing a results-based plan.
- Developing an advocacy plan to disseminate and use the gender assessment findings.
- Preparing a report summarizing the analysis of the HIV epidemic and the data on the context, the current HIV response and the prevention programmes and initiatives (such as HIV treatment, care and support) from a gender perspective.

The gender assessment process includes a workshop to analyse and use the findings. It typically lasts three days, with the core team meeting the day before to prepare and staying the day after to debrief and decide on the next steps.

Members

Name:

Organization:

_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

Annex 3. Terms of reference for an inception meeting before the gender assessment

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The GAT is a structured set of guidelines and questions that can be used to guide and support the process of analysing to what extent national responses to HIV—in both generalized and concentrated epidemics—consider the critical goal of gender equality. UNAIDS developed the GAT by convening an expert reference group comprising members from around the globe and from government, United Nations agencies and civil society organizations to guide its development.

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- Using the gender assessment findings to identify evidence-informed gender-transformative interventions to strengthen the HIV response.

Individuals and partners in government, civil society, the United Nations and other multilateral agencies can use the GAT.

Purpose of the inception meeting before the gender assessment

These terms of reference are meant to guide the inception meeting before the gender assessment.

Objectives

The objectives of the meeting are:

- To provide a platform for introducing the gender assessment team.
- To provide a platform for the team to discuss and agree on the objectives of the gender assessment.
- To identify gaps in the data, process and partners and to take steps to rectify them.
- To provide a platform for the team to collectively understand the gender assessment methods.
- To discuss different roles and responsibilities for team members.
- To discuss deliverables and delivery timelines after the gender assessment.

Expected deliverables

- a) An inception report containing a detailed work plan, roles and responsibilities for the entire duration of the consultancy
- b) A finalized programme and presentations for the gender assessment workshop

The agenda

- Welcome and introductions
- Objectives of the inception meeting
- Objectives of the gender assessment workshop
- Gender assessment methods
- Workshop agenda
- Overview of roles and responsibilities
- The way forward

Annex 4. Terms of reference for consultancy to undertake a gender assessment of the national HIV response

About the GAT

The GAT is a structured set of guidelines and questions that can be used to guide and support the process of analysing to what extent national responses to HIV—in both generalized and concentrated epidemics—consider the critical goal of gender equality. UNAIDS developed the GAT by convening an expert reference group comprising members from around the globe and from government, United Nations agencies and civil society organizations to guide its development.

A planned, systematic and deliberate set of steps and processes, the GAT examines and questions the status of the HIV response (plans and actions undertaken by national governments to address HIV) specifically referring to its gender dimensions: the socially constructed roles, behaviour, activities and attributes a given society considers appropriate for women and men, including members of key populations. The GAT enables users to learn the extent to which the national response recognizes gender inequality as a key determinant of the trajectory of the HIV epidemic and then acts based on that recognition. This will help to ensure that the national HIV response has gender equality as a goal.

The gender assessment process of an HIV response involves:

- Knowing your HIV epidemic and country context from a gender perspective.
- Knowing your country response from a gender perspective.
- Using the gender assessment findings to identify evidence-informed gender-transformative interventions to strengthen the HIV response.

Individuals and partners in government, civil society, the United Nations and other multilateral agencies can use the GAT.

Scope of the consultancy

Consultants will be expected to closely familiarize themselves with the GAT and related materials, including but not limited to the online presentations. In close collaboration with UNAIDS, the consultant will undertake the following:

- Deliver online sessions with the gender assessment team and other relevant stakeholders (if needed).
- Develop key informant interviews, focus group discussions and workshops at national and subnational levels (if needed).
- Collect, collate and store documents, including data from databases on epidemiological information, laws, policies and other sources.
- Carry out gender analysis of the information collected in stages 2 and 3 and validate the data and analysis with the gender assessment team.
- Support the development of the gender assessment workshop and co-facilitate it, along with a national consultant (date and time).
- Develop the gender assessment report, with a national consultant and United Nations agency supporting the assessment.

Expected deliverables

- a) An inception report containing a detailed work plan for the consultancy's entire duration
- b) A draft report of the gender assessment with data collected (stages 2 and 3) before the workshop
- c) A final report of the gender assessment with the input from the workshop
- d) An advocacy brief consisting of a summary report

The key competencies, technical background and experience required are:

- Proven knowledge and experience in HIV, sexual and reproductive health and rights and gender.
- Proven knowledge and experience in research and analysis, including in analysing and synthesizing quantitative data.
- Knowledge and experience in HIV-related monitoring.
- Proven experience in writing and editing reports, with a strong track record of producing similar publications for dissemination.
- Experience in and commitment to working in sexual and reproductive health and rights.
- Substantial knowledge of global health policy, health funding, gender budgeting and universal health coverage.
- A good understanding of the primary audience of the advocacy report resulting from the gender assessment.
- Excellent writing, research and analytical skills.

- Experience in preparing and presenting clear and concise oral and written communication.
- The ability to analyse data, summarize information and innovatively depict information, such as through infographics.

Duration

The consultancy is scheduled to last no more than 50 non-consecutive days.

Timeline

The consultancy will take place from _____ to _____.

In agreement,

Signatures:

Institutional team leader

Consultant

City and date: _____

Annex 5. Sample agenda for a gender assessment workshop

Objectives of the gender assessment workshop

- 1) Complement information used to reply to the GAT
- 2) Validate the replies for stages 2 and 3 of the GAT
- 3) Build stage 4: identify interventions, design strategies and design a results-based plan

Day 1

9:00 Welcome

Official remarks from authorities: UNAIDS, national HIV programme, health ministry, gender department or commission, youth ministry or office
Quick overview of the gender assessment

10:00 National HIV programme presentation
National strategic plan for HIV and AIDS
Question and answer period

10:30 Break

10:45 Laying out a strategy for the workshop (facilitator presentation)

11:00 Reacting to the answers to the GAT
Stage 2: discussing the HIV epidemic and context—the nature of the gender inequality underlying the HIV epidemic and contributing factors

12:30 Lunch

14:00 Reacting to the answers to the GAT
Stage 3: discussing the country's HIV response—analysis of the key programming gaps

16:00 Break

16:20 Reacting to the country's HIV response
Stage 3 (continued)

18:00 End of day 1

Day 2

9:00 Quick evaluation of first day of work

- 9:20** Continue to react to the country's HIV response
Stage 3 (continued)
- 10:30** Break
- 10:50** Continue to react to the country's HIV response
Stage 3 (continued)
- 12:30** Lunch (rearrange the room for group work)
- 14:00** Reacting to challenges and building constructive criticism
Stage 3: group work (defining challenges and proposals)
Flip chart and note writing
- 15:30** Break
- 15:40** Continue to work in groups
Stage 3: group work (defining challenges and proposals) (continued)
Flip chart and note writing
- 16:00** Working in groups
Assessing expenditure tracking
- 17:00** Plenary session: synthesis of work group discussions
In-depth discussion of challenges and proposals
- 18:00** End of day 2 (summary of things to keep in mind for stage 4)

Day 3

- 9:00** Stage 4
Planning (filling in the matrix of gaps and opportunities)
Defining a priority list
- 10:30** Break
- 10:45** Brainstorming and filling up the priorities matrix
- 12:30** Lunch
- 13:30** Preparing the results-based plan using the gender assessment findings
- 15:15** Break
- 15:30** Identifying the next steps to integrate the findings into key national processes
- 16:30** Roles and responsibilities in follow-up
- 17:50** Acknowledgements and closing remarks

Annex 6. Guiding terms

For the purpose of the gender assessment, guiding terms are provided below, based on the *UNAIDS terminology guidelines* unless otherwise indicated.

Caregivers or carers: People who provide unpaid care for a person living with or affected by HIV.

Comprehensive HIV prevention, treatment, care and support: Includes tailored HIV strategies, including clinical care, adequate nutrition, psychological support, social and economic daily living support, involvement of people living with HIV and their families, respect for human rights, protective legal provisions and access to justice. HIV care and support require a comprehensive set of services, including psychosocial, physical, socioeconomic, nutritional and legal care and support. These services are crucial to the well-being and survival of people living with HIV and their caregivers as well as orphans and vulnerable children. Care and support services are needed from the time HIV is diagnosed regardless of the ability to access antiretroviral therapy (40).

Comprehensive sexuality education: An age-appropriate, culturally relevant approach to teaching about sex and relationships by providing scientifically accurate, realistic and non-judgemental information. Sexuality education provides opportunities to explore one's own values and attitudes and to build decision-making, communication and risk reduction skills about many aspects of sexuality. The term "comprehensive" indicates that this approach to sexuality education encompasses the full range of information, skills and values to enable young people to exercise their sexual and reproductive rights and to make decisions about their health and sexuality. It is important to understand that comprehensive sexuality education offers the full range of possibilities for young people to practice safer sex and does not just promote messages about abstinence (41,42).

Discrimination against women: Any distinction, exclusion or restriction made on the basis of sex which has the effect or purpose of impairing or nullifying the recognition, enjoyment or exercise by women, irrespective of their marital status, on a basis of equality of men and women, of human rights and fundamental freedoms in the political, economic, social, cultural, civil or any other field (43).

Economic violence: Acts of controlling and monitoring of the behaviour of an individual in terms of the use and distribution of money and the constant threat of denying economic resources. Control mechanisms may also include controlling the victim's access to, for example, health-care services and employment.

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

Gender: The social attributes and opportunities associated with being male and female and the relationships between women and men and girls and boys as well as the relations between women and those between men. These attributes, opportunities and relationships are socially constructed and are learned through socialization processes. They are context- and time-specific and changeable. Gender determines what is expected, allowed and valued in a woman or a man in a given context. In most societies, there are differences and inequalities between women and men in responsibilities assigned, activities undertaken, access to and control over resources and decision-making opportunities.

Gender-based violence: Violence that establishes, maintains or attempts to reassert unequal power relations based on gender. The term was first defined to describe the gendered nature of men's violence against women. Hence, it is often used interchangeably with "violence against women". The definition has evolved to include violence perpetrated against some boys, men and transgender people because they do not conform to or challenge prevailing gender norms and expectations (for example, may have feminine appearance) or heterosexual norms (44).

Gender equality: The concept that all human beings, both men and women, are free to develop their personal abilities and make choices without any limitations set by stereotypes, rigid gender roles and prejudices. Gender equality, a recognized human right, means that the differences in behaviour, aspirations and needs of women and men are considered, valued and favoured equally. It signifies no discrimination based on a person's gender in allocating resources or benefits or in access to services. Gender equality may be measured in terms of equality of opportunity or equality of results.

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

Gender-related barriers: Legal, social, cultural or economic barriers to accessing services, participation and/or opportunities, imposed based on socially constructed gender roles.

Intimate partner violence: Behaviour within an intimate relationship that causes physical, sexual or psychological harm, including acts of physical aggression, sexual coercion, psychological abuse and controlling behaviour. It is one of the most common forms of violence against women (45).

Masculinities: Socially constructed definitions and perceived notions and ideals about how men should or are expected to behave in a given setting. Masculinities are configurations of practice structured by gender relations and can change over time. Their making and remaking is a political process affecting the balance of interests in society and the direction of social change (46).

Men who have sex with men: Men who have sex with men, regardless of whether they have sex with women or have a personal or social gay or bisexual identity. This concept is useful because it also includes men who self-identify as heterosexual but have sex with other men.

Reproductive health: A state of complete physical, mental and social well-being and not merely the absence of disease or infirmity, in all matters relating to the reproductive system and to its functions and processes. Reproductive health therefore implies that people are able to have a satisfying and safe sex life and that they have the capability to reproduce and the freedom to decide if, when and how often to do so. Implicit in this last condition are the rights of men and women to be informed and to have access to safe, effective, affordable and acceptable methods of family planning of their choice as well as other methods of their choice for regulating fertility that are not against the law and the right of access to appropriate health-care services that will enable women to go safely through pregnancy and childbirth and provide couples with the best chance of having a healthy infant (47).

Reproductive rights: Certain human rights that are already recognized in national laws, international human rights documents and other consensus documents. These rights rest on the recognition of the basic rights of all couples and individuals to decide freely and responsibly the number, spacing and timing of their children, to have the information and means to do so and to attain the highest standard of sexual and reproductive health. It also includes their right to make decisions on reproduction free of discrimination, coercion and violence, as expressed in human rights documents. In exercising this right, they should consider the needs of their living and future children and their responsibilities towards the community (47).

Sexual and reproductive health and rights: Women's sexual and reproductive health is related to multiple human rights, including the right to life, the right to be free from torture, the right to health, the right to privacy, the right to education and the prohibition of discrimination. The Convention on the Elimination of All Forms of Discrimination against Women and the United Nations Committee on Economic, Social and Cultural Rights have both clearly indicated that women's right to health includes their sexual and reproductive health. This means that states are obligated to respect, protect and fulfil rights related to women's sexual and reproductive health. The Special Rapporteur on the right of everyone to the enjoyment of the highest attainable standard of physical and mental health maintains that women are entitled to reproductive health-care services, goods and facilities that are: (a) available in adequate numbers; (b) accessible physically and economically; (c) accessible without discrimination; and (d) of good quality (48,49).

Despite these obligations, violations of women's sexual and reproductive health and rights are frequent and take many forms, including denying access to services that only women require, poor-quality services, subjecting women's access to services to third-party authorization and performing procedures related to women's reproductive and sexual health without the woman's consent (such as forced sterilizations, forced virginity examinations and forced abortions). Women's sexual and reproductive health and rights are also at risk when they are subjected to female genital mutilation and early marriage.

Sexual and reproductive health programmes and policies: Include, but are not restricted to, services for family planning; infertility services; maternal and newborn health services; preventing unsafe abortion; post-abortion care; preventing the mother-to-child transmission of HIV; diagnosing and treating sexually transmitted infections, including HIV infection, reproductive tract infections, cervical cancer and other diseases of the female reproductive system; promoting sexual health, including sexuality counselling; and preventing and managing gender-based violence.

Sexual health: A state of physical, emotional, mental and social well-being in relation to sexuality and not merely the absence of disease, dysfunction or infirmity. Sexual health requires a positive and respectful approach to sexuality and sexual relationships and the possibility of having pleasurable and safe sexual experiences free of coercion, discrimination and violence. Attaining and maintaining sexual health requires respecting, protecting and fulfilling the sexual rights of all people.

Transgender people: People with a gender identity different from their sex at birth. Transgender people may be male to female (female appearance) or female to male (male appearance). It is preferable to describe them as he or she according to their gender identity: the gender they present and not their sex at birth.

Violence against women: Any public or private act of gender-based violence that results in or is likely to result in physical, sexual or psychological harm or suffering to women, including threats of such acts, coercion or arbitrary deprivation of liberty within the family or general community. It includes sexual, physical or emotional abuse by an intimate partner (known as intimate partner violence), family members or others; sexual harassment and abuse by authority figures, such as teachers, police officers or employers; sexual trafficking; forced marriage; dowry-related violence; honour killings; female genital mutilation; and sexual violence in conflict situations (50).

Annex 7. Guidance and outline for a concise gender assessment report

The gender assessment report should provide key stakeholders with an overview of the gender inequalities in the HIV epidemic, context and response and actionable recommendations to address the gaps identified.

The report should strategically focus on presenting and analysing quantitative and qualitative research that helps to understand how and why gender inequality shapes HIV vulnerability and inequities in HIV outcomes and which interventions for gender-responsive action are effective or promising.

Using visual representations to present data makes them easier to understand. Bar graphs, pie charts, line graphs and histograms are excellent ways of illustrating differences in prevalence, risk behaviour and access to services. They can also show the pathways through underlying factors that influence HIV outcomes for women, men and key populations and for subgroups among them. The report should not exceed 50–55 pages in length, excluding references and annexes.

The following table describes the recommended structure, contents and length of each of the report's sections.

Section	Contents	Length (in pages)
Cover	Title of the document, participating organizations, place and date	2–3
	Abbreviations, table of contents, acknowledgements, consultants	
Executive summary	Findings of stages 2 and 3, response and gap analysis, key priorities for gender-responsive action	2–3
Introduction and methods	<p>Background and rationale</p> <p>The relevance of undertaking the GAT in the country, goal and objectives</p> <p>Methods: brief description of the four stages, data collection methods and sources and gender analysis process</p>	5

Section	Contents	Length (in pages)
Context: sociodemographic, demographic, economic and health indicators for the country	<p>General description of the country: geographical location, total population, rural versus urban distribution, gross domestic product per capita, population living in poverty, life expectancy by sex, maternal mortality rate, contraceptive prevalence and fertility rate. Pertinent structural processes should also be mentioned: migration, political conflict, violence and crime (gang violence) and emergencies caused by natural disasters</p>	2
National HIV epidemic and context	<p>Prevalence, incidence and behavioural information</p> <ul style="list-style-type: none"> ▪ <i>HIV prevalence</i> in general and size of key populations, modes of transmission, and the number of people dying from AIDS-related causes. Analysis of pertinent trends, including the number of people newly infected with HIV, percentage of people living with HIV by age and sex and the dynamics of the national and local epidemics (if data are available) ▪ <i>Knowledge about HIV</i> (young people and key populations) ▪ <i>Sexual behaviour and condom use practices</i> (general population, young people and key populations) ▪ <i>Pregnancy among adolescents</i> ▪ <i>Gender-based violence</i> (including intimate partner violence, sexual violence, violence in the family, honour crimes, violence against key populations, violence in emergencies and institutional violence) <p>Social, cultural and economic factors</p> <ul style="list-style-type: none"> ▪ <i>Acceptance of gender norms</i> (women and girls, men and boys and key populations) ▪ <i>Stigma and discrimination</i> towards people living with HIV, women, girls, men, boys and key populations ▪ <i>Social determinants</i> (such as poverty, lack of income security, social protection services, food security, housing, water and sanitation and access to education) <p>Legal and political factors</p> <ul style="list-style-type: none"> ▪ <i>Laws or policies</i> that may directly affect women and girls, men and boys and key populations in relation to HIV ▪ <i>Legal frameworks</i> that protect the rights of people living with HIV, women and girls and other key populations ▪ <i>Discriminatory practices</i> in health-care settings and/or by judiciary or law enforcement personnel and other service providers 	15
National HIV response	<p>Gender equality in HIV policies and programmes</p> <ul style="list-style-type: none"> ▪ Gender equality in the national strategic plan; specific needs of women, girls and key and vulnerable populations addressed in the national strategic plan; and other pertinent policies ▪ Expenditure, total breakdown by categories, sources of funding and execution rate; this should reveal the current investment in gender equality ▪ Meaningful participation, intersectoral coordination, gender equality awareness and knowledge among service providers <p>Comprehensive response</p> <ul style="list-style-type: none"> ▪ Availability and coverage of services: prevention, treatment, care and support, gender-based violence and sexual and reproductive health and rights ▪ Gender considerations according to community: women and girls, men and boys and key populations ▪ Gender aspects of community- and home-based care and support for people living with HIV ▪ Human rights violations in services and programmes 	12–15

Section	Contents	Length (in pages)
Gender-responsive interventions— results-based plan	<p>Key programming gaps identified in stages 2 and 3, including those related to particular communities</p> <p>Evidence-informed priority interventions and their alignment with the 2016 High Level Meeting Political Declaration on Ending AIDS, the UNAIDS Strategy 2016–2021 and the HIV strategic investment approach</p> <p>Results-based plan</p> <ul style="list-style-type: none"> ▪ Strategic framework: goal, objectives and interventions ▪ Monitoring and evaluation: indicators, data collection methods and information system ▪ Financial framework: costs, funding and tracking ▪ Implementation framework: implementation plan and budgets <p>Advocacy plan and communication strategy</p>	5
References	References cited in the report	
Annexes	<p>List of participants (workshops, interviews, validation meetings, other pertinent activities)</p> <p>Protocol synopsis for the focus groups, interviews and/or other data collection methods used</p>	

Annex 8. Guidance and outline for an advocacy brief

The advocacy brief comprises a summary report of the gender assessment that aims to facilitate policy-making towards gender-transformative interventions in the HIV response. It synthesizes evidence on the national HIV epidemic, context and response, leading to a results-based plan that addresses the gaps identified. It may have tables and graphs and should not exceed 5–6 pages in length, including a short list of references. A box in the right side of the summary section should briefly describe the gender assessment team, the methods and the stakeholders involved, such as government agencies, civil society organizations, United Nations agencies, development partners and academia.

The following table describes the contents and length of each section.

Section	Contents	Length (in pages)
Summary		0.5
	<ul style="list-style-type: none"> ▪ Goal of the gender assessment ▪ Description of the problem addressed ▪ Statement on why the current programmes and policies need to integrate gender-transformative interventions ▪ Main recommendations for action included in the results-based plan 	
Section 1: Knowing the national HIV epidemic and context		2
Gender dynamics of the HIV epidemic	HIV prevalence by sex, age and key populations; trends (past five years); number of people newly infected with HIV; geographical distribution; modes of transmission; number of people dying from AIDS-related causes; and behavioural information	
Socioeconomic and cultural factors	<p>Gender-based violence: prevalence of sexual or physical intimate partner violence, sexual or physical violence during childhood, genital mutilation, honour killings, violence against key populations and violence in emergencies (if applicable)</p> <p>Gender norms: related to sexuality, early marriage, women’s and men’s social roles and acceptance of gender-based violence, decision-making in the household, requiring the husband’s permission to seek health care and attitudes about sexuality, fidelity, homosexuality, drug use and sex work</p> <p>Women’s socioeconomic status: gender disparities in access to education, participation in the labour force and employment rate</p> <p>Stigma and discrimination: discriminatory attitudes towards people living with HIV, women, girls, key populations, avoiding HIV services because of stigma and discrimination among women, men and key populations</p>	

Section	Contents	Length (in pages)
Legal and political factors	<p>Discriminatory laws and policies on sex education, HIV testing, HIV transmission or exposure, sex work, sexual orientation, gender identity, drug use, migration and travel, gender-based violence, sexual and reproductive health and rights and child marriage</p> <p>Legislation protecting the rights of women, men and key populations</p>	
Section 2: Knowing the national HIV response		2
HIV policies and programmes	<p>Gender equality in the national strategic plan and other policies</p> <p>Specific needs of women, girls and key and vulnerable populations</p> <p>Expenditure: total breakdown by categories and sources of funding and execution rate</p> <p>Meaningful participation, intersectoral coordination, gender equality awareness and knowledge among service providers</p>	
Comprehensive response	<p>Availability and coverage of services: prevention, treatment, care and support, gender-based violence, sexual and reproductive health and rights</p> <p>Gender considerations according to community: women and girls, men and boys and key populations</p> <p>Gender aspects of community and home-based care and support for people living with HIV</p> <p>Human rights violations in services and programmes</p>	
Section 3: Gender-responsive interventions—results-based plan		1
Response and gap analysis	Key programming gaps, including those related to specific communities	
Results-based plan	Strategic framework, monitoring and evaluation, financial and operational frameworks	

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