PEPFAR Gender Analysis:
Key Principles and Minimum Standards

PEPFAR Gender and Adolescent Girls

Technical Working Group

2015

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Overview

The purpose of this document is to provide PEPFAR Operating Units with simple, straightforward advice on how to conduct the required gender analysis. The 2014 Updated PEPFAR Gender Strategy states that "*Each interagency PEPFAR country team – with the input of government partners, local civil society organizations, bi-lateral and multilateral donors, and other partners – is now required to conduct a gender analysis specific to the HIV response, to inform the design of projects and activities."* **The deadline for completing the gender analysis is March 2016.** The information gathered through the gender analysis will help teams understand the program context and inform more intentional and strategic decisions to remove barriers, close gaps, and address harmful norms which may inhibit progress towards HIV epidemic control.

If your country has completed a PEPFAR-wide gender analysis in the past five years, you are not required to do a new one, but rather update the previously completed analysis with any new data available. We also encourage gender analyses completed as part of USAID's Country Development Cooperation Strategy to be used as part of or to inform a broader PEPFAR-wide gender analysis.

This document is arranged around **ten guiding principles and minimum standards** that Operating Units should use to decide how to conduct the analysis in a way that makes sense for their programs. The Gender and Adolescent Girls Technical Working Group (GTWG) has many gender analysis tools and resources available on www.pepfarii.net, several of which are also included as Appendices to this document. However, we have kept this document focused on a set of guiding principles and minimum standards to ensure the gender analysis produces information that the Operating Unit can use to consider gender-related constraints affecting the epidemic and inform programs and policies.

What is a gender analysis?

A PEPFAR-specific gender analysis focuses on the socio-cultural gender norms, inequities, and inequalities that put people at risk for acquiring or transmitting HIV, their ability to access HIV services, and efforts to achieve epidemic control. This includes: (a) access to and control over resources; (b) access to and utilization of HIV prevention, treatment, care, and support; and (c) differences in power among and between women, men, girls, boys, and gender and sexual minorities, as well as subgroups of these populations. PEPFAR teams are encouraged to use existing data, surveillance, special studies and assessments, and, to the extent feasible and appropriate, supplement these data sources with desk reviews, interviews, and site observations.

Guiding Principle #1: Be Realistic

Minimum Standard: Conduct the gender analysis in a way that reflects the PEPFAR program context, key and priority populations, and geographic prioritization, and that is manageable within the program budget.

It is important for PEPFAR Operating Units to develop a realistic plan to complete the analysis. This includes articulation of clear objectives and scope and approach that resonate with the team's overall programmatic goals. The OU should identify staff that will lead or be engaged in the process as well as in-country resources (consultants, partners, existing studies and data) that can be leveraged.

There are several tools that can assist Operating Units in determining how to plan, budget, and implement a gender analysis. Appendix 2 contains a sample scope of work that illustrates one of the most comprehensive approaches to conducting the gender analysis with either headquarters TWG or international consultant support. Appendix 3 contains some budget considerations to help determine how much funding is needed to conduct the analysis. And Appendix 4 lists a few additional gender analysis frameworks and resources that may be helpful.

It will be up to each Operating Unit to determine the most realistic way to conduct the gender analysis. Options include using PEPFAR staff, hiring a local or international consultant, or requesting technical assistance from the Gender and Adolescent Girls TWG (understanding that the TWG will not be able to assist with all requests). In addition, Operating Units may want to engage the Program Oversight, Accountability, and Response Teams (POART) or ask the Interagency Collaborative for Program Improvement (ICPI) to assist with some of the data analysis and review.

It is important to begin the process by clarifying the objectives and scope for the analysis, as well as key questions that will advance the team's programmatic priorities, especially those related to sustained epidemic control. For example, there is value in analyzing data at the national level – such as laws and policies around gender equality, stigma and discrimination, and the rights of lesbian, gay, bisexual, transgender and intersex (LGBTI) persons – as this will inform the overall program context. However, given PEPFAR's emphasis on geographic prioritization, particularly at the sub-national unit, it is essential to focus the analysis on the places where PEPFAR works. For example, in a given country, PEPFAR could be focused on urban settings because of disease burden, so it is of primary importance to understand gender issues in that context, but also to understand gender norms as they play out in the rural areas that are source regions for people who migrate to the urban settings. In the same way, if a country is primarily focused on key populations, the gender analysis should, for example, focus on how gender norms and gender-based violence put men who have sex with men (MSM), sex workers, and gender and sexual minorities at risk for HIV and the barriers they face to accessing care and treatment. This is not intended to limit the analysis or range of data that could be looked at. If the country team has national level data or data from a range of regions/districts that can elucidate the dynamics for specific populations and inform programming, it should be used in the analysis.

Guiding Principle #2: Use Reliable Data

Minimum Standard: Use existing PEPFAR program data, national and subnational epidemiological data, as well as data from regional, national, and/or subnational previously conducted qualitative and quantitative studies, as well as special studies and secondary analyses conducted by implementing partners.

The gender analysis should be informed by a review of existing quantitative and qualitative data, with a particular focus on PEPFAR program data. Reviewing available data will enable teams to describe the epidemiological context and current response to the HIV epidemic, identify gender disparities and harmful norms, and identify existing gaps in data. Operating Units may want to use the data collected for COP15 as a starting point.

At a minimum, the gender analysis should review the following sources of data and information (age- and sex-disaggregated, as appropriate):

1. PEPFAR APR, SAPR and COP Targets and Results
2. Other USG gender analyses (e.g., USAID CDCS)
3. National and/or program monitoring and evaluation data outside of PEPFAR MER indicators (e.g., for health service provision, training programs)
4. National and/or sub-national epidemiologic and surveillance data (e.g., HIV Epi-Profile, HIV Spectrum estimates, BBSS, ANC Surveillance, PMTCT Program data)
5. National level data on victimization and perpetration of gender-based violence (e.g., the Violence against Children Surveys (VACS), International Men and Gender Equality Survey (IMAGES), most recent Demographic and Health Survey (DHS) including the Domestic Violence Module if available, WHO Multi-Country Study on Women's Health and Domestic Violence against Women)
6. National and sub-national policies, laws, regulations, and strategies, e.g., gender-based violence (GBV), LGBTI rights, Land Rights, Gender Equality, Age of Marriage, and associated commentaries on the status of their implementation nationally and sub-nationally

Consider using the following quantitative and qualitative data sources to fill knowledge or data gaps:

- Gender analyses performed by Ministry of Health or other relevant government entities; other donors or academics; civil society; United Nations agencies; and regional intergovernmental organizations, (e.g. SADC Gender Barometer Studies), non-governmental organizations (NGOs), and implementing partners
- National data on health, crime and safety reports, employment, human resources, and gender division of labor
- National data on literacy, education, and training (e.g., aggregate national enrollment records for primary, secondary, tertiary, and higher learning institutions)
- Data on access to and control of resources and benefits (e.g., DHS, special surveys, national reporting, program data)
- Data on household decision-making (e.g., DHS, special surveys)

- Country level data and indices on gender domains from publicly available international sources and databases (e.g., the World Bank, MDGs, UNDP/HDRO - GII and GDI)
- Ethnographic studies
- Historical research or analysis of social and cultural traditions
- Socio-cultural studies, assessments, and analyses

Once the data have been assembled, the gender analysis should answer the following questions:

1. Have the different sources of data been disaggregated by sex and/or age? Why or why not?
2. If disaggregated, what do age and sex disparities in the data reveal about:
    a) Which sex and age cohorts bear a disproportionate burden of the epidemic? Who are the vulnerable or at-risk group?
    b) Who is receiving or accessing services and who is not across the prioritized geographic areas?
    c) Which sex and age cohorts have better testing, adherence and retention rates than others?
    d) Which data have not been disaggregated by age and sex? Are there steps that can be taken to address these gaps?
    e) What additional information or data are needed to understand the dynamics of the epidemic and the factors that affect HIV outcomes for different populations?

The answers to the questions outlined above form the foundation for the rest of the analysis—the critical exploration and consideration of issues underlying specific age and sex disparities seen in the epidemiological or programmatic data. To the extent possible with available data, these questions should be addressed across the cascade.

Data Confidentiality and Safety

For those countries considering collection of additional quantitative or qualitative data, these activities should emphasize ethical considerations for the people and communities of interest, and ensure protocols are in place to protect confidentiality and safety. This is especially important for key populations and for those experiencing gender-based violence. Protocols should include informed consent and confidentiality agreements, outline how data will be stored and who will have access to it, and explain how the information will be used and presented. Anyone engaged in data collection should be trained in ethical considerations related to data confidentiality and safety. Any research protocols for new studies will also need to go through IRB review processes.

Guiding Principle #3: Understand Laws and Policies

Minimum Standard: Identify how the legal and policy environment exacerbates and/or remedies gender inequalities, stigma, and discrimination, and the implications for achieving epidemic control.

Laws, policies, regulations, and institutional practices influence the context in which males, females, and gender and sexual minorities act and make decisions. Laws include formal statutory laws (i.e., legislation, acts) and informal or customary legal systems. Regulations are often referred to as subsidiary legislation and are issued to detail and implement broader legislation. Policies include formal and informal rules and procedures adopted by public institutions for making decisions and taking public action. The gender analysis should identify the extent to which laws, policies, and regulations contain explicit gender biases (e.g., provisions that treat males and females differently, lack of child protection laws, inequitable inheritance or land rights, absence of laws criminalizing marital rape) or implicit gender biases (e.g., the different impacts of laws, policies, regulations and practices on men and women). In addition, it is important to note any existing data on whether laws are actually being are implemented or not.

At a minimum, the analysis should identify laws and/or policies that explicitly discriminate against certain populations or people on the basis of sex, gender or sexual identity, with respect to access to HIV-related prevention, care and treatment services.

Some sample questions for this domain include:

- What specific laws, regulations, and/or policies does the country have in place to:
  - Prevent, monitor, and respond to gender-based violence?
  - Ensure access to Post Exposure Prophylaxis?
  - Promote equality of women and girls?
  - Address early and child marriage and trafficking in persons?
  - Address the legal context for gender and sexual minorities and key populations?
  - Protect and support the health and well-being of individuals who use drugs?
- How were gender disparities and inequities taken into account in the development of national plans or strategies?
- Do existing policies or laws criminalize sexual relations between same sex partners? Do laws specifically prohibit discrimination on the basis of sexual orientation, sexual behavior, or gender identity, including in the provision of HIV and health services?
- Are existing policies/laws
  - Being actively disseminated to civil society? If yes, by whom?
  - Disseminated throughout the health sector? If yes, by whom?
  - Known by clinicians? Are they aware of their roles and responsibilities?
  - At odds with customary law? And do constitutional protections o customary law?
- Who are the champions that can advocate for equitable policies (e.g., donors, government, citizens, coalitions, others)?

Guiding Principle #4: Identify Gender Norms

Minimum Standard: Articulate how gender norms define what is socially acceptable and unacceptable, how this changes throughout an individual's life, and the implications for HIV prevention, transmission and acquisition, and engagement in HIV care and treatment.

Gender norms expressed as gender stereotypes socially define what are appropriate qualities, life goals, and aspirations for males, females, and gender and sexual minorities. Gender norms and

beliefs are often supported by and embedded in laws, policies, and institutional practices. They influence how females and males behave and interact in both public and private life. These behaviors and interactions affect HIV risk and prevention as well as health-seeking behaviors related to HIV care and treatment and other health issues.

Among women and girls, restrictive and harmful gender norms can limit their ability to negotiate safer sex or lower their ability to test, disclose, and access HIV treatment because of fear of stigma, violence or abandonment. Among men, restrictive and harmful gender norms may discourage HIV testing and accessing health services, narrowly define roles as partners and family members, or encourage illicit drug use and sexual risk-taking. Gender norms defining masculinity and femininity also put gender and sexual minorities, sex workers, and others who express their sexual or gender identity are perceived as transgressing norms, at increased risk for HIV, and may impact uptake of essential services.[12] Gender norms should be explicitly identified in the gender analysis.

At a minimum, the gender analysis should identify any gender norms that influence, impact or serve as barriers to the specific HIV outcomes of interest for the PEPFAR country program, as identified using program and epidemiologic data.

Some sample questions for this domain include:

- What are the main cultural beliefs that shape what it means to be a man or woman and a boy or girl in your country?
- Are there differences by region? Urban or rural? Religion?
- What are societal attitudes towards same sex relationships and behaviors?
- How do gender norms influence sexual behavior, and how does this relate to HIV transmission in your country?
- How do gender norms affect access to HIV/reproductive health/family planning services and commodities?

Guiding Principle #5: Describe Engagement in Community and Public Life

Minimum Standard: Understand how gender roles shape an individual's participation in social, political, and economic structures; how they access information; their ability to participate in community structures; and their sense of social cohesion or connectedness.

The most fundamental division of labor within all societies is between productive (market) economic activity and reproductive (non-market) activity. This is a central social structure that frequently characterizes male and female activity. A gender analysis should examine what males and females do in these spheres including roles, responsibilities, and time use (paid work, unpaid work (including in the home), and community service) to get an accurate portrait of how people

[1] Globally, MSM are 19 times more likely to be HIV-positive compared to the general population. See: Baral S, Sifakis F, Cleghorn F, et al. Elevated risk for HIV infection among men who have sex with men in low- and middle-income countries 2000-2006: A systematic review. *PLoS Med*. 2007;4(12):e339.

[2] Transgender women are 48 times more likely to have HIV compared to others of reproductive age. See: Baral S, Poteat T, Strömdahl S, Wirtz A, Guadamuz T, Beyrer C. Worldwide burden of HIV in transgender women: a systematic review and meta-analysis. *The Lancet Infectious Diseases*. 2013;13(3):214-222.

lead their lives. It is also important to understand how individuals participate in community structures and the sense of social cohesion and connectedness they feel (or lack thereof) to others within their society. Such engagement and sense of community can have a profound impact on how individuals access and engage with HIV services, and their willingness and ability to reach other members of their community who may be isolated. If relevant, the analysis could go further to address the capacity to vote and run for office at all levels of government and examine the to which extent men and women are represented in senior level decision-making positions and exercise voice in decisions made by public, private, and civil society organizations.

At a minimum, the gender analysis should identify how these gender roles influence, impact or serve as barriers to outcomes of interest, including ability to access HIV services or participate in interventions being supported.

Some sample questions for this domain include:

- Do the ways in which men, women, boys, girls, and gender and sexual minorities earn income and participate in the formal or informal economy act as risk factors or protective factors for HIV?
- How are community structures being used to achieve epidemic control? Reduce GBV?
- How do the media (national/community) address gender issues? Are negative stereotypes reinforced? Do communities engage with media to address harmful gender norms, stigma, and discrimination? If so, what is the focus?
- Are there other donor programs addressing structural issues?
- How is the country mobilizing and building the capacity of women and men as health care providers, caregivers, and decision-makers throughout the health system, from the community to the national level?
- How does stigma and discrimination affect the ability for women and men, boys and girls, gender and sexual minorities, and key populations to access and engage with HIV services, as well as other related services?
- How are programs and services increasing the meaningful participation of women and girls, boys and men, and gender and sexual minorities in the planning, design, implementation, monitoring and evaluation of health programs?
- Are programs engaging key populations meaningfully in the planning, design, implementation, monitoring and evaluation of health programs and in capacity building efforts?

Guiding Principle #6: Understand who has Access to and Control over Resources

Minimum Standard: Determine who has access to and control over resources and the implications for HIV risk behavior and engagement in HIV care and treatment.

A key component of gender analysis is an examination of whether women and men own and/or have access to and the capacity to use productive resources – assets (land, housing), education, income, social benefits (social insurance, pensions), public services (health, water), technology – and information necessary to be a fully active and productive participant in society.

At a minimum, the gender analysis should outline how men and women, boys and girls, and gender and sexual minorities have access to and control over affordable, appropriate, and available resources to engage in HIV prevention, treatment and care services.

Some sample questions for this domain include:

- How do rights in land ownership, economic activities, social benefits and entitlements, public services, and access to technology differ between men and women, boys and girls, key populations, and gender and sexual minorities?
- How do women's and men's access to and control over community, household, and individual resources influence their health behaviors?
- How do issues around access to and control over resources specifically affect key populations and influence HIV-related outcomes?
- Do both male and female OVCs and child head- of- households have access to education?

Guiding Principle #7: Recognize Patterns of Power and Decision-Making

Minimum Standard: Understand how relational and family power dynamics influence HIV risk behaviors and health outcomes, and the ability to negotiate practices and meaningfully access HIV treatment and care.

Patterns of power and decision-making affect the ability of women and men to decide, influence, and exercise control over material, human, intellectual, and financial resources, in the family, community and country.

At a minimum, the gender analysis should consider relational and family power dynamics and how they influence specific HIV outcomes of interest, including HIV risk behaviors, the ability to negotiate practices and meaningfully access HIV treatment and care.

Some sample questions for this domain include:

- Who in the family makes decisions about health, such as getting tested for HIV, accessing ante/post-natal care, which health structure to access (traditional or government/ clinical?
- What are the power dynamics between men, women, boys and girls, and gender and sexual minorities in terms of decision making around sexual and reproductive health (e.g., family planning, condom use, contraceptive use)?
- What external power dynamics impact the ability of girls and women, boys and men, and gender and sexual minorities' decision-making power around sexual and reproductive health practices?
- What are some of the power inequalities that exist in interpersonal relationships between men, women, boys and girls, and gender and sexual minorities?

Guiding Principle #8: Engage Stakeholders

Minimum Standard: Engage a broad range of stakeholders in the analysis to raise awareness of the links between gender issues and HIV, and to build consensus around key findings from the analysis.

A key component of the gender analysis includes consulting and sharing the analysis plan with key stakeholders such as the PEPFAR country team, local academics, civil society organizations, and professional/trade associations. These groups will help to further elucidate the local context, potentially provide access to unpublished information, and can help to validate or further refine key findings.

It is recommended that the analysis team present the results of the analysis through both a written report and oral presentation *back* to stakeholders. Stakeholders may vary by country and context; however, *at minimum,* the results of the analysis should be presented to PEPFAR country team staff, other USG colleagues (including members of the POART), and national and local HIV technical area Working Groups or Task Forces.

The following are additional stakeholders to engage in the process and to whom the results could be presented:

- Gender analysis participants
  - Local government (including traditional/tribal government) personnel
  - Civil society representatives, including community- and faith-based organizations
  - Personnel from relevant bi-lateral or multi-lateral agencies
  - Personnel from relevant UN agencies
  - Stakeholders from key sectors (health, education, gender, justice, human rights, traditional medicine, child protection, social welfare and development and finance)
  - Beneficiaries and members of populations that are key to the direction and magnitude of the HIV epidemic
  - Implementing partners
  - In-country technical working groups and forums
- Headquarters TWGs

Guiding Principle #9: Prioritize Critical Gender Issues

Minimum Standard: Use a participatory process to prioritize which gender issues must be addressed in order to achieve epidemic control.

After data collection is complete, use a participatory process (one that engages as many stakeholders within the PEPFAR country team as possible) to synthesize and analyze the data in order to use the information to make decisions. Several data analysis and decision-making tools have been provided. For example, the table in Appendix 5 can assist in organizing the data by domain, thematic area, and analysis outputs. Operating Units may also want to consider engaging the ICPI to help with data analysis. Once all of the data has been organized around themes it

becomes possible to see trends and common issues. The table in Appendix 6 can guide the team through the process of (a) prioritizing which issues are most critical to address in terms of relevance to HIV and critical to epidemic control, and (b) developing an action plan to implement realistic, measurable activities to address these issues.

At a minimum the gender analysis should answer the following question: Based on country budget level, program context, key and priority populations, geographic prioritization, and the priorities of PEPFAR 3.0, what are the most important gender-related issues that must be addressed in order to achieve epidemic control?

It is recommended that the gender analysis also answer the following questions:

1. How will activities and services ensure equitable participation by women and men, boys and girls, and gender and sexual minorities?
2. What strategies will the program employ to address discriminatory laws, policies, regulations, and institutions?
3. What strategies will the program develop to address identified harmful gender norms and prevent and respond to GBV?
4. How will existing programs be adjusted to respond to identified inequities in areas such as access to and retention in care and treatment programs?

Guiding Principle #10: Take Action to Address Gender Disparities and Inequalities

Minimum Standard: Identify PEPFAR business processes, structures, and data streams that can be used to take action on key gender issues.

The results of the gender analysis should be used to improve program development, implementation, and service delivery in order to achieve PEPFAR objectives and sustained epidemic control. If this is the first analysis being undertaken by the country team, it can also be used as a baseline for comparisons with future analyses. During this step, teams may consider referring to the Gender Core/Near-Core Matrix (Appendix 7) to assist with prioritizing and applying the results. The results and recommendations should be straightforward, measurable, and clearly linked to the overall objectives of the country program and linked to MER indicators when such indicators are relevant. Otherwise, the use of custom indicators that have previously been validated is encouraged.

Once the PEPFAR OU Team has determined which issues must be addressed in order to align with the priorities of PEPFAR 3.0, the team should decide which PEPFAR business processes, structures, and data streams are best positioned to respond to these priorities. *At a minimum,* the country team should specify the following:

1. How the priority actions will inform COP and ROP planning, budgets, and priorities.
2. What issues are in need of additional data or research that can inform future programs and services?

3. What MER indicators[3] will be used to track progress, and how will the team ensure the data is sex-by-age disaggregated. If a MER indicator is not applicable, identify a custom indicator.
4. How the actions be monitored through SIMS[4] and with the POART.
5. How issues related to gaps in existing policies or laws will be addressed and monitored through the Sustainability Index.

[3] The two MER gender indicators are: GEND_GBV and GEND_NORM.
[4] Add a note about the updated SIMS gender domains – Jessie?

Appendices

Appendix 1: Glossary of Terms

Gender
It is a culturally-defined set of economic, social, and political roles, responsibilities, rights, entitlements obligations, associated with being female and male, as well as the power relations between and among women and men, boys and girls and people with other gender identities. The definition and expectations of what it means to be a woman or girl, or a man or boy, and sanctions for not adhering to those expectations, vary across cultures and over time, and often intersect with other factors such as race, class, age and sexual orientation. All individuals, independent of gender identity, are subject to the same set of expectations and sanctions. Gender is not interchangeable with women or sex. *(IGWG)*

Gender-based violence (GBV)
For PEPFAR, GBV is defined as any form of violence that is directed at an individual based on biological sex, gender identity (e.g., transgender), or behaviors that are not in line with social expectations of what it means to be a man or woman, boy or girl (e.g., MSM and Female Sex Workers). It includes physical, sexual, and psychological abuse; threats; coercion; arbitrary deprivation of liberty; and economic deprivation, whether occurring in public or private life. GBV is rooted in power differences, including social, economic and political inequalities. It is characterized by the use and abuse of physical, emotional, or financial power and control. GBV can occur across childhood, adolescence, reproductive years, and old age. It can affect all individuals, but women and girls, MSM and TG are often at increased risk. While GBV encompasses a wide range of behaviors, because of the links with HIV, PEPFAR is most likely to address physical and sexual intimate partner violence, including marital rape; sexual assault or rape; sexual violence against children and adolescents; female genital cutting/mutilation; child marriage; violence perpetrated by clients against sex workers *(Adapted from the US Strategy to Prevent and Respond to Gender-based Violence Globally, 2012)*

Gender-related barriers
A set of obstacles faced by women and men, boys and girls, or transgender individuals and people with other gender identities that limit their ability to access and benefit from social, economic, and political roles, responsibilities, rights, obligations, and entitlements. These barriers are based upon the culturally-defined gender roles ascribed to being male or female.

Gender equality
The state or condition that affords women, men and people with other gender identities equal enjoyment of human rights, socially valued goods, opportunities, and resources. Genuine equality means more than parity in numbers or laws on the books; it means expanded freedoms and improved overall quality of life for all people *(IGWG training resources; USAID Gender Equality and Female Empowerment Policy)*.

Gender-equality indicators
These refer to measures that track changes in the power dynamics between men and women, boys and girls and people with other gender identities, including individual norms or attitudes towards gender equality (i.e. gender norms), access to and control over economic resources, employment, household decision-making among women, women's status, community norms towards gender equality, and legal and policy frameworks for gender equality at the national level.

Gender-sensitive indicators
These are indicators that include quantitative measures that have been disaggregated by sex as well as other stratifiers (e.g., age) in order to show if there are differences in outcomes, behaviors, uptake of services and other gaps between and among sub-groups of women and men.

Gender equity
The process of being fair to women and men, boys and girls and people with other gender identities to ensure fairness, measures must be taken to compensate for cumulative economic, social, and political disadvantages that prevent women and men, boys and girls from operating on a level playing field *(IGWG training resources)*.

Gender integration
Strategies applied in programmatic design, implementation, and monitoring and evaluation to take gender considerations (as defined above, in "gender") into account and to compensate for gender-based inequalities *(adapted from IGWG training resources).*

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. *(PEPFAR Gender and Sexual Diversity Training)*

Gender norms
Gender norms refer to attitudes and practices associated with being a man or a woman, as well as power dynamics between and among men and women, boys and girls, MSM, transgender and people with other gender identities.

Intersex
A general term used for a variety of conditions in which a person is born with a reproductive or sexual anatomy that doesn't seem to fit the typical definitions of female or male. *(PEPFAR Gender and Sexual Diversity Training)*

MSM
MSM refers to men who have sex with men. The term includes men who have sex with men and women, and men who self-identify as heterosexual but have sex with men.

Sex
Sex is the classification of people as male or female. At birth, infants are assigned a sex based on a combination of bodily characteristics including: chromosomes, hormones, internal reproductive organs, and genitalia *(USAID March 2012 Gender Equality and Female Empowerment Policy).*

Transgender
Transgender is an umbrella term referring to individuals who do not identify with the sex category assigned to them at birth or whose identity falls outside of stereotypical gender norms. The term "transgender" encompasses a diverse array of gender identities and expressions, including identities that fit within a female/male classification and those that do not. Transgender is not the same as intersex, which refers to biological variation in sex characteristics, including chromosomes, gonads and/or genitals that do not allow an individual to be distinctly identified as female/male at birth.

Appendix 2: Sample Scope of Work for Conducting a Gender Analysis with Headquarters or International Consultant Support

FINAL SCOPE OF WORK
LESOTHO PEPFAR GENDER ANALYSIS

Introduction[5]
Gender inequality is a key driver of the HIV epidemic, and HIV disproportionately impacts those with less social status and power. In low and middle-income countries worldwide, HIV is the leading cause of death and disease in women in reproductive age (ages 15-44). In sub-Saharan Africa, 60% of those living with HIV are women. In the nine countries in southern Africa most affected by HIV, prevalence among young women aged 15-24 years is on average about three times higher than among men of the same age. These disparities are the result of biological, structural, and cultural conditions that place women and girls at greater risk for acquiring HIV, such as gender norms that impact expectations and behaviors, as well as differences in access to resources that limit prevention and mitigation of the disease. Men and boys are also affected by gender expectations that may encourage risk-taking behavior, discourage accessing health services, and narrowly define their roles as partners and family members. Often, gender norms around masculinity and sexuality not only create pressure to engage in risky sexual behavior, but also put men who have sex with men at increased risk for HIV by creating additional stigma and discrimination that can prevent them from seeking or accessing services. This demonstrates the need to target HIV programs at addressing underlying gender inequities and norms that leave those with gender-related vulnerabilities especially at risk to this disease. In order to reduce vulnerabilities that put people at risk of HIV infection, as well as mitigating factors of the disease, PEPFAR has outlined five key gender strategies:

- Increasing gender equity in HIV/AIDS programs and services, including reproductive health
- Preventing and responding to gender-based violence (GBV)
- Engaging men and boys
- Increasing women and girls' legal rights and protection
- Increasing women and girls' access to income and productive resources, including education

Through the Global Health Initiative (GHI), the United States is helping partner countries improve health outcomes through strengthened health systems and integrated services, with a particular focus on improving the health of women, newborns and children.[6] Programs aim to achieve sustainable health impact by addressing infectious disease, nutrition, maternal and child health, family planning, HIV/AIDS and safe water. The Women, Girls and Gender Equality Principle (WGGE) provides guidance on ten key program elements that seek to improve the overall health of women and girls and promote gender equality. As part of the guidance, all GHI countries are now required to conduct a gender assessment, a gender narrative, and include gender indicators in their M&E framework.

Purpose
The purpose of the gender assessment is to review key gender issues and gender-based constraints in Lesotho, assess the institutional context supporting gender integration into the PEPFAR country program, and offer conclusions and recommendations to strengthen the PEPFAR response in Lesotho. The USG will work with Lucille Bonaventure, Lesotho PEPFAR Country Coordinator as well as other staff from the PEPFAR Country Team to conduct the assessment process and develop the required deliverables. The assessment will address the following objectives:

[5] This section is taken from the Gender in PEPFAR Vision Document (2011-2012), which was developed by the three PEPFAR Gender Technical Working Group Co-Chairs, with input from key GTWG members and other PEPFAR colleagues.
[6] Text taken from the introduction to the GHI WGGE Principle.

1. To identify the gender-based constraints to and opportunities for equitable access to and participation in PEPFAR programs and services.
2. To identify strategies and approaches that PEPFAR can use to improve its programs to promote gender equality and improve the health and well-being of women, men, girls and boys.
3. To provide key recommendations that identifies and prioritizes how the PEPFAR country team can integrate the PEPFAR gender strategies and the WGGE elements into existing programs and strategies.
4. Linked to Objectives 2 and 3, review Gender Challenge Fund activities and identify gaps and opportunities to continue effective implementation.
5. To conduct gender training for members of the PEPFAR Lesotho country team.

Approaches and Tasks

The various approaches that will be utilized and tasks to be completed during the gender assessment are as follows:

1. Conduct a comprehensive literature review of pertinent documents, assessments, studies and reports including those conducted by the Government of Lesotho, PEPFAR (USAID, CDC, Peace Corps, and DoD), development partners, academic institutions, non-governmental organizations (NGOs) and community-based organizations (CBOs).
2. Prior to departure, a formative meeting of the USG team will be held to:
    - Share background, experience, and expectations for the assignment
    - Formulate a common understanding of the assignment, clarifying team members' roles and responsibilities
    - Agree on the objectives and desired outcomes of the assignment
    - Establish a team atmosphere, share individual work styles, and agree on procedures for resolving differences of opinion
    - Discuss initial findings from literature review
    - Review and finalize data collection tools and methodology
    - Finalize work plan and schedule, and strategy for achieving deliverables
    - Assess PEPFAR Country Team training needs
    - Review and finalize draft report outline
3. Hold in-brief meetings with PEPFAR country team to review the objectives of the gender assessment and training, scope of work, work plan and calendar, and finalize logistics.
4. Meet with PEPFAR team members, Government of Lesotho ministries, and implementing partner representatives in order to gain insight into gender issues, policies, and programs, and the different approaches taken to addressing gender issues within the country.
5. Visit PEPFAR project sites to meet beneficiaries and community-based organizations in order to gain insight into project activities.
6. Collate and analyze data collected during key informant interviews, program site visits, and literature review.
7. Conduct a two-day gender workshop for PEPFAR country team staff (*and selected partners? Country team to confirm*).
8. Debrief PEPFAR country team on key findings and recommendations of the gender assessment.
9. Prepare draft and final reports.

Deliverables

The following deliverables are expected from this SOW:

1. Written methodology, work plan, schedule and draft report outline.
2. A gender workshop agenda, objectives, materials and resources.
3. List of documents consulted for the literature review.

4. A list of sites/organizations/institutions visited and individuals and groups interviewed.
5. A two day gender training for PEPFAR country team members.
6. A debrief meeting for the PEPFAR country that will be held before the USG team's departure from Lesotho and prior to the submission of the draft report. A PowerPoint presentation will be prepared for the meeting.
7. A draft report addressing key findings, conclusions, recommendations shall be submitted within one week of the USG team departing Lesotho. The PEPFAR country will have 20 (twenty) work days from receipt of the draft report to provide written comments on the report.
8. A final report shall be submitted by the USG team 5 (five) days from the date of receipt of PEPFAR country team feedback on the draft report.

Composition of HQ Team

The gender assessment will be comprised of four USG staff members:

- Person A (USAID/OHA) will serve as the Team Lead and, in consultation with all team members, is responsible for the overall direction and management of the assessment and gender training, including the development of the methodology, work plan, schedule, literature review, data collection (qualitative and quantitative) and analysis, draft and final reports, PowerPoint presentations, and will co-facilitate the gender training.
- Person B (CDC), and Person C (S/GWI) will be responsible, in consultation with the Team Lead, for conducting a literature review, assessment data collection (qualitative and quantitative) and analysis, drafting sections of the draft and final reports, contributing sections of the debrief PowerPoint, as well as co-facilitating the gender training.
- Person D (USAID/OHA) will service as a Lesotho gender and culture expert reference to the assessment team, and will also review the draft gender assessment.

The PEPFAR country team focal point will provide technical and logistical assistance, participate in the key informant interviews, and accompany the USG team on site visits.

Estimated Performance Period

Ten working days in Lesotho: April 30 – May 11. Additional days pre- and post-travel will also be needed (see estimated LOE, pg. 4).

Logistics

The PEPFAR Lesotho Country team will:

- Provide Country Cable Clearance
- Reserve hotel /guest house accommodation in country
- Arrange in-country transportation logistics and set up meetings with Government representatives, implementing partners, and civil society
- Arrange gender workshop logistics (venue, lunch/tea breaks, stationary, projector and screen, flipchart paper and stands) for 20 people
- Confirm meeting time/location for in-brief and final debrief

Documentation

The Lesotho PEPFAR Country Team will supply the following documents to the USG team once the SOW is approved:

- PEPFAR Country Strategy
- GHI Strategy (if applicable)
- Government of Lesotho HIV/AIDS Strategy
- Recent (i.e. within the past five years) DHS or other epidemiological data or assessments of the HIV/AIDS epidemic

- National laws, regulations, and policies on women, gender and/or gender-based violence
- Formative research, assessments, or other studies that look at gender (in)equalities from a socio-economic or cultural perspective in Lesotho
- If available, studies or assessments that look at migration patterns and impacts on family structures and relationship formation
- Gender Challenge Fund reports, assessments, data, etc.
- Any other recommended reports that look at issues of gender (in)equality, women's and girl's empowerment, and MARPS (female sex workers, transgender, and MSM)
- Summary of other donor-funded health and HIV/AIDS programming in Lesotho

Estimated Level of Effort

Note that some of these tasks may overlap so the actual number of work days does not necessarily reflect the total number of days for the assignment.

Tasks	**Work Days**	**Location where task will be performed**			**Person(s) Responsible**
		US *(pre-travel)*	Lesotho	US *(post-travel)*	
Literature review	3	X			HQ team
Develop a work plan, schedule, final questionnaires and draft report outline	2	X			HQ team lead
Prepare gender training agenda, materials, and methods	2	X	X		HQ team
Hold formative team meeting	½	X			HQ team
Hold initial in-brief meetings with PEPFAR country team	½		X		HQ team and PEPFAR Lesotho focal point
Conduct interviews and site visits	~8		X		HQ team and PEPFAR Lesotho focal point
Analyze data and agree upon recommendations and conclusions	3		X		HQ team
Conduct gender training	2		X		HQ team
Conduct final briefing for PEPFAR country team	½		X		HQ team and PEPFAR Lesotho focal point
Draft preliminary report	5		X	X	HQ team lead, with HQ team inputs
PEPFAR country team review and comments on preliminary report	20		X		PEPFAR Lesotho country team
Prepare final report	5			X	HQ team lead, with HQ team inputs

Appendix 3: Budget Considerations

The following are some of the costs that Operating Units may need to budget for the gender analysis. Please note that not all of these line items may be relevant as it will depend on how the Country Team wants to staff the activity (i.e. having the gender focal point lead the analysis with support from Washington; contract an international consultant; contract a local consultant).

The starting point for budget considerations should be the team's collective agreement on the kind of data that are needed to answer critical questions with respect to the role and impact of gender on HIV outcomes of interest, especially as relevant to priority populations and geographic areas. This, along with an outline of existing data (i.e. CDCS gender analysis, other recent gender analyses or relevant surveys) as well as available in-Mission and in-country resources, should help inform budgeting decisions.

Staffing/LOE

- Identify Mission/Country Team gender advisor or focal point who can serve as lead, and outline needed LOE. If part of Mission staff, the LOE would not need to be budgeted.
- Identify local gender consultant(s)
- Determine if there is a need to bring in HQ gender advisor(s)
- Determine if there is a need to bring in international consultant(s) (if you go this route plan to budget approximately $500/day). The GTWG recommendation is to fully utilize in-country resources before considering bringing in HQ and international advisors and consultants.
- Administrative assistant/logistician (to support booking hotels and in-country transportation, arranging meeting requests, etc.)

Per Diem/M&IE

- This will be essential if international or local consultants are hired

Airfare and Local/Ground Transportation

- Airfare for international consultants (if one is hired) or HQ support (depending on hiring mechanism)
- Depending on what geographic areas the team may want to visit for the analysis, ground transportation will need to be arranged (local airfare or ground transportation).
- Ground transportation around capital city for meetings with partners and stakeholders

Appendix 4: Gender Analysis Frameworks and Resources

CARE. (2012). *Good Practices Framework on Gender Analysis*.
Available at: http://gendertoolkit.care.org/Pages/core.aspx

Greene, ME. (2013). *A Practical Guide for Conducting and Managing Gender Assessments in the Health Sector*. Washington, DC: Interagency Gender Working Group, USAID.
Available at: http://www.igwg.org/Articles/genderassessmentsguide2013.aspx

Joint United Nations Programme on HIV/AIDS. (2014). *UNAIDS Gender Assessment Tool; Towards a Gender-transformative HIV Response*. Geneva: UNAIDS.
Available at: http://www.unaids.org/sites/default/files/media_asset/JC2543_gender-assessment_en.pdf

World Health Organization, Department of Gender and Women's Health. (2002). *Gender Analysis in Health: A Review of Select Tools*. Geneva: WHO.
Available at: http://www.who.int/gender/documents/en/Gender.analysis.pdf

Appendix 5: Sample Table for Organizing Data from A Gender Analysis (with illustrative example)

Domain	Theme	Analysis Output	Quantitative Data		Qualitative Data - Document Review		Qualitative Data - Interviews			Conclusion
			Findings	Data Source	Information Collected	Data Source	Interview Question	Respondent	Response	
Laws, policies, regulations, and institutional practices	Gender-based Violence	The analysis should determine the national commitment to preventing GBV: • No Commitment (no laws/policies/ regulations exist at the national level) • Low Level of Commitment (some policies/laws exist, but they are not widely known or enforced) • Moderate Level of Commitment (policies/laws exist, they are widely known and enforced, but they are not sufficient to address the issues) • High Level of Commitment (policies/laws exist which are widely known and enforced, and they appropriately address the issues)	90% of women surveyed knew that violence against women was against the law; 95% of men surveyed knew that violence against women was against the law	Special Survey on GBV	There is a law created in 2003 that criminalizes physical and sexual violence against women and children, offering a penalty of jail time	Law to prevent violence against women and girls	Are you aware that violence against women and girls is against the national law? Do you prosecute persons for violence against women and girls in the tribal court?	Tribal Leader	- yes I am aware - no we do not, we immediately transport the perpetrator to the authorities	High Level of commitment
							Are you aware that violence against women and girls is against the national law? Have you ever reported violence perpetrated against you? If no, why not?	Female Sex Worker	- yes - yes, I reported to the police and they filed a report and apprehended the perpetrator	

Appendix 6: From Analysis to Action

The following tables can be used to help organize the findings of the gender analysis, identify what additional data or information may be needed, and prioritize interventions.

1. Summary of Key Findings

What are the key gender-related inequities or constraints identified during the gender analysis?	What are the consequences of these inequities or constraints on:		What data or information is missing or needed?
	Meeting PEPFAR objectives?	Improving the health of men, women, boys, girls, MSM, and transgender?	

2. Actions to Address Gender Issues

Prioritize the gender-related inequities or constraints that will be addressed	What actions (e.g., program activities, services, policies, or research) will help to achieve more equitable outcomes?	Measures of Progress	
		Outputs	Outcomes
1.			
2.			
3.			
4.			
5.			

Appendix 7: Matrix of Core and Near Core Gender Activities

CORE: Activities central to HIV/AIDS, critical to saving lives & preventing new infections – grounded in science
NEAR-CORE: Activities that directly support HIV/AIDS goals and cannot yet be done well by other partners or host government
Please see Updated PEPFAR gender strategy for additional examples: http://www.pepfar.gov/documents/organization/219117.pdf

Adult and Pediatric Treatment and Care

Core	Near Core	Justification/Talking Points	References
1. Ensure gender-equitable ART treatment and care by: • Reviewing sex-by-age disaggregated data to ensure service provision is reaching the population(s) identified (e.g. adolescent girls and young women, MSM, SW, and transgender) as priority and most vulnerable to the epidemic. • Address specific gender-related barriers that may prevent the priority population(s) from initiating and adhering to treatment and care. 2. Establish GBV screening in the context of treatment clinics only if minimum first line support can be offered (see pg. 12 of PEPFAR gender strategy for guidance on screening.) 3. If screening will take place (see point #2), train service providers in treatment clinics in how to screen, counsel and appropriately refer women and men who report experiencing GBV/IPV. 4. Provision of post-violence care services (see pg. 13 of PEPFAR gender strategy for specific guidance.) 5. If post-violence care will be provided to children and adolescents, please use the specific PEPFAR technical	1. Utilize clinic and community platforms to address harmful gender norms, stigma and discrimination, which act as a barrier to HIV status disclosure, adherence and retention to clinical care and treatment. • Clinic: training for service providers on the provision of non-discriminatory/non-stigmatizing care; creation of facility-based support groups; and linking clients to supportive community services • Community: Support community groups that provide counseling and adherence support; community mobilization and peer-to-peer efforts to address harmful gender norms, stigma and discrimination	• Structural factors, rigid gender norms, and gender inequities can hinder access, uptake and adherence to treatment for both women and men, including transgender individuals. • Harmful gender norms that prevent women and men from accessing and adhering to clinical care and treatment: ○ *Women:* Fear of violence from intimate partners; fear of other forms of retribution such as shunning from family members or withholding of monetary support; hiding ARVs from family members or selling them for needed cash; cost of ARVs; cost and/or availability of transport to clinic. ○ *Men:* expected to not be fearful, or show 'weakness' (such as being ill); fear disclosing HIV status because it may compromise their leadership position in family; feel embarrassed at having to visit a clinic as they are afraid it will impact their social status; only get on treatment after becoming quite ill. ○ *Transgender:* Fear of violence or other forms of shunning from the community; fear of judgmental and abusive attitudes form the health care provider; discrimination in service provision • Stigma is a harmful social process that devalues people or groups of people based upon a real or perceived difference (such as age, gender, or ethnicity) and discrimination	Machtinger, E. (2012). Recent trauma is associated with antiretroviral failure and HIV transmission risk behavior among HIV positive women. AIDS Behavior, 2160-2170. Nyamhanga, T. Masculine attitudes of superiority deter men from accessing antiretroviral therapy in Dar es Salaam, Tanzania. *Global Health Action* 2013, 6: 21812 - http://dx.doi.org/10.3402/gha.v6i0.21812 HIV Treatment for Women and Girls: A Summary of Issues, Interventions, and Evidence Clinical Management of Children and Adolescents Who Have Experienced Sexual Violence: Technical Considerations for PEPFAR Programs www.aidstarone.com/focus_areas/gender/resources/prc_technical_considerations

considerations to guide programs (www.aidstarone.com/focus_areas/gender/resources/prc_technical_considerations)		follows stigmatizing attitudes and beliefs, and can result in biased, harmful, or unjust attitudes, behaviors, laws and policies. • There is a strong link between gender inequality, gender-based violence and issues such as a lack of disclosure, shame, poor adherence to ART, and barriers to accessing services.	

VMMC

Core	Near Core	Justification/Talking Points	References
1. Integration or referral/linkage to/from other men's health services and programs that promote gender equitable norms 2. Engage men and women (mothers, female partners) in campaigns and education programs to promote VMMC and emphasize partial protectiveness of VMMC and other indirect benefits to women.	1. Strategies to reduce harmful male norms that promote high-risk behaviors (including GBV) and promote positive norms, including messaging and information provided in waiting rooms and in pre and post-VMMC counseling. 2. Mapping of sexual networks to target antiretroviral therapy (ART) to male sexual partners who infect young women (see DREAMS guidance).	• Gender norms, including masculine norms around sexuality, can influence uptake of VMMC services. • Young men may be concerned about the impact of circumcision on ability to engage in sex, especially in the period right after the intervention, and older men may be averse to participating in VMMC in the presence of younger men. • VMMC interventions provide a unique opportunity to engage men in addressing harmful gender norms and attitudes and promoting positive messages related to reducing HIV vulnerability, for them as well as their partners.	Colvin, C. (2009). Report on the Impact of Sonke Gender Justice Network's "One Man Can" Campaign in the Limpopo, Eastern Cape and Kwa-Zulu Natal Provinces, South Africa. Johannesburg: Sonke Gender Justice Network. CDC and Manila Consulting Group Inc. (2012). *Gender Equitable Access to Essential HIV/AIDS Health Services in Developing Countries. Volume VI: Evidence Synthesis--Surgical Male Circumcision.* McLean, VA: Manila Consulting Group Inc.

Prevention

Core	Near Core	Justification/Talking Points	References
1. Interventions designed to prevent gender-based violence and provide linkages to non-clinical post-violence care such as psychosocial and legal services through community-based platforms. 2. Interventions to empower young women and adolescent girls and engage men and boys to promote positive norms and behaviors using a	1. Structural interventions may include: policy work with government and civil society to reduce discrimination; actions to improve educational opportunities and to make school environments safer for girls; and advocacy to increase property and other legal rights and create	• Gender-based violence (GBV) is associated with HIV and is a public health concern across priority population. GBV contributes to the spread of HIV/AIDS by limiting ability to negotiate safe sexual practices, disclose HIV status, and access services due to fear of reprisal. Intimate partner violence is also linked with a range of risk behaviors on the part of male partners, including sex with multiple concurrent partners. Disabled	Jewkes, R. (2007). *A gender transformative HIV prevention intervention.* Pretoria: Medical Research Council. Barker G., C. R. (2007). *Engaging men and boys in changing gender-based inequity in health: Evidence from programme interventions.* Retrieved October 2013, from World Health Organization:

rigorously evaluated curriculum that have shown a significant impact on changing gender norms and related HIV risk behaviors. For examples of such curriculum please see the indicator reference sheet for the new GEND_NORM indicator (*Gender Norms within the Context of HIV/AIDS: Number of people completing an intervention pertaining to gender norms that meets minimum criteria*).	economic opportunities for women.	populations also face heightened risks of violence, including sexual violence. • Gender norms may discourage women and girls from asserting control over the timing and circumstances of sex, including negotiating protection against HIV and other sexually transmitted infections (STIs). • Men and boys are also affected by gender expectations that may encourage risk-taking behavior, discourage accessing health services, and narrowly define their roles as partners and family members. • Gender norms around masculinity and femininity also increases vulnerability to HIV among populations whose gender identity (e.g. transgender persons), sexual orientation (e.g., gay, lesbian), and/or sexual behavior (e.g. MSM, sex workers) does not conform to existing gender expectations. The stigma may also impact uptake of essential services.	http://www.who.int/gender/documents/Engaging_men_boys.pdf Pulerwitz, J. (2006). *Promoting more gender-equitable norms and behaviors among young men as an HIV/AIDS prevention strategy*. Washington, DC: Population Council, Horizons Project. Dunkle, K., & Decker, M. (2012). Gender-based violence and HIV: Reviewing the evidence for links and casual pathways in the general population and high-risk groups. *American Journal of Reproductive Immunology* , 1-7. Stepping Stones http://www.mrc.ac.za/gender/stepping.htm SASA! www.raisingvoices.org/sasa/

HTC

Core	Near Core	Justification/Talking Points	References
1. Training providers around screening for GBV/ IPV based on clear protocols that emphasize clients' safety and confidentiality. Screening should only be implemented if the service can ensure a minimum package of GBV services and referrals are available as per PEPFAR Gender Strategy and WHO recommendations (see pg. 12 of PEPFAR gender strategy for guidance on screening.) 2. Training HTC service providers in how to counsel and appropriately refer women and men who report experiencing GBV/IPV (see pg. 13 of	1. Structural interventions may include work with government and health managers at all levels to strengthen policies, laws and protocols around GBV – including for example, removing provisions that call for clients to have a police report before any GBV related referrals or services can be provided, dissemination and integration of GBV/IPV protocols across health systems.	• GBV/IPV (even the mere fear of GBV) may affect women's ability to access HTC as well as any related referral treatment, care and support, services, and adhere to any proposed treatment regimens. • A wide range of additional masculine and feminine gender norms and inequities may hinder uptake of HTC services, men's support of their female partners, disclosure, and ability to access related referral services.	Program Guide on the integration of GBV into HIV Programs www.aidstarone.com/focus_areas/gender/resources/pepfar_gbv_program_guide World Health Organization (2004). *Gender dimensions of HIV status disclosure to sexual partners: Rates, barriers and outcomes.* World Health Organization: http://www.who.int/gender/documents/women_and_girls/9241590734/en/index.html Obermeyer C, O. M. (2007). The utilization of testing and counseling for HIV: A review of the social and behavioural evidence.

PEPFAR gender strategy for guidance on post-violence care.) 3. Training providers in asking clients about potential concerns, including implications of fear of violence on disclosure, and how to be cognizant of power dynamics.	2. Activities that address dynamics of gender norms and inequities in decisions related to disclosure and encouragement of couples counseling, and. 3. Links to community based interventions aimed at constructive engagement of men in transforming harmful norms, supporting their female partners, and meeting their own HIV needs. 4. Addressing barriers men may face accessing HTC services through (for example) mobile testing sites and flexible clinic hours.		*American Journal of Public Health* , 1762–1774. Singh K, L. W. (2013). Gender equality and education: Increasing the uptake of HIV testing among married women in Kenya, Zambia and Zimbabwe. *AIDS Care.* 2013;25(11):1452-61.

PMTCT

Core	Near Core	Justification/Talking Points	References
1. Training PMTCT providers in how to counsel and appropriately refer women who report experiencing GBV/IPV, in the context of PMTCT or ANC and maternity services (see pg. 13 of PEPFAR gender strategy for guidance on post-violence care.) 2. Training providers around screening for GBV/ IPV based on clearly outlined protocols that emphasize clients' safety and confidentiality. Screening should only be implemented if the service can ensure a minimum package of GBV services and referrals are available as per PEPFAR Gender Strategy and WHO recommendations (see pg. 12 of PEPFAR gender strategy for guidance on screening.)	1. Ensuring that PMTCT protocols and relevant training emphasize the dynamics of gender norms and inequities, how they influence women's decisions on disclosure, and couples counseling. This could include encouraging providers to ask about concerns women have or barriers they face, and outlining specific questions that could be integrated into a session. 2. Constructive engagement of men and links to community based interventions aimed at	• A wide range of additional masculine and feminine gender norms and inequities may hinder uptake of PMTCT services, men's support of their female partners, adherence and retention, and ability to access related referral services. • GBV/IPV may affect women's ability to access PMTCT as well as any related referral treatment, care and support, services, and adhere to any proposed treatment regimens. • Meaningful and appropriate engagement of men in supporting their female partners, if done properly, can facilitate outcomes related to PMTCT uptake, adherence and retention, couples counseling, care and support.	Campbell JC, B. M. (2008). The intersection of intimate partner violence against women and HIV/AIDS: a review. International Journal of Injury Control and Safety Promotion , 221-231. Pulerwitz J, A. M. (2010). Addressing gender dynamics and engaging men in HIV programs: Lessons learned from Horizons Research. *Public Health Report* , 125(1): 282-292. Bajunirwe F, M. M. (2005). Barriers to the implementation of programs for the prevention of mother-to-child transmission of HIV: a cross-sectional survey in rural and urban Uganda. AIDS Research and Therapy, 1-10.

3. Meaningful and appropriate engagement of men in supporting their female partners in PMTCT services that prioritizes and emphasizes women's agency in any decisions related to interventions and who should be involved. 4. Addressing impediments to adherence and retention, including formative, qualitative work to identify gender related barriers that may affect women's ability or desire to remain on treatment, and support for or capacity building around strengthened data around long-term adherence and retention rates.	transforming harmful norms and encouraging men to support their female partners. Also engaging family members, "co-wives" and informal wives where they exist, and community support groups in PMTCT programs at service delivery and community levels. 3. Structural interventions include work with government and health managers at all levels to strengthen policies and protocols around PMTCT. For example policies aimed at encouraging engagement of male partners does not result in unintentional harm, especially for women who do not have male partners, or women who, for a range of reasons, may not want to engage their male partners.		Maman S, G. A. (2008). *HIV Testing During Pregnancy. A Literature and Policy Review.* Retrieved from AIDSLEX: http://www.aidslex.org/site˙documents/TP-0018E.pdf Sarkar, N. (2008). The impact of intimate partner violence on women's reproductive health and pregnancy outcome. *J Obstet Gynaecol* , 266-271.

Key populations

Core	Near Core	Justification/Talking Points	References
1. Specific epidemiological and behavioral research, and collection of other quantitative and qualitative information that elucidates the role and impact of gender on key populations, their risk and vulnerability, and barriers to service uptake. 2. Community mobilization efforts aimed at addressing and transforming harmful gender norms and inequities should ensure that the specific	1. Structural interventions may include work with government and health managers at all levels to strengthen policies, laws and protocols related to addressing the HIV needs of key populations, promoting their human rights and minimizing stigmatizing or discriminatory practices.	• Gender norms and inequities also affect key populations. MSM, FSW and transgender individuals, populations in particular have rates of GBV that are significantly higher than in the general population. Gender norms also affect overall HIV risk for these key populations. • Gender and sexual minorities face a range of barriers related to accessing HIV services and receiving meaningful care and support. • Gaps exist in data around epidemiology, dynamics of the epidemic in key populations.	Dunkle KL, J. R. (2013). Prevalence of consensual male-male sex and sexual violence, and associations with HIV in South Africa: a population-based cross-sectional study. PLoS Med , e1001472. Chris Beyrer, A. L. (2011). The Global HIV Epidemics among Men Who Have Sex with Men. Washington, DC: World Bank. Baral S, P. T. (2013). Worldwide burden of HIV in transgender women: a systematic

dynamics of harmful norms in key populations are integrated. 3. Training health care providers on needs and issues affecting key populations that foster non-stigmatizing attitudes in order to facilitate access and adherence to treatment among key pops.		Such data are critical in better understanding and addressing specific vulnerabilities and risk.	review and meta-analysis. The Lancet Infectious Diseases , Vol. 13, Issue 3, Pages 214-222. Shaw SY, L. R.-P. (2012). Factors associated with sexual violence against men who have sex with men and transgendered individuals in Karnataka, India. *PLoS One* , e31705.

Health Systems Strengthening

Core	Near Core	Justification/Talking Points	References
1. Ensuring gender dimensions of health are integrated into pre and in service training, including for example, protocols for addressing GBV, diminishing stigma and discrimination against MSM, transgender individuals and FSW, and M&E. 2. Addressing the specific barriers faced by men, women, and key populations in accessing services. For example, training staff in how to offer care that meets the unique needs of men, women, and key pops, and how to collect and analyze sex disaggregated data.	1. Ensuring that gender considerations are integrated into national strategic plans and operational budgets such as specifically addressing how to overcome gender inequalities that impede access to health services. 2. Improving laws, policies and protocols that address GBV, stigma, and discrimination in health system setting. 3. Identifying and ensuring gender-related issues in health financing are addressed, for example, adequate and proportionate financing for HIV related services and research to reach most at risk and marginalized populations, including adolescent girls and young women as well as those whose gender and sexual identify do not conform to norms.	• Gender dynamics in health play a significant role in service uptake and delivery and quality of care. Ensuring staff are both aware of these issues and trained in how to address them has a positive impact on quality of care, meeting care targets, advancing human rights.	Mahendra VS, G. L. (2007). Understanding and measuring AIDS-related stigma in health care settings: A developing country perspective. Journal of Social Aspects of HIV/AIDS , 616–625 UNAIDS. (2010). *We can remove punitive laws, policies, practices, stigma and discrimination that block effective responses to HIV.* Geneva: UNAIDS. World Health Organization. (2007). *Everybody's Business. Strengthening Health Systems to Improve Health Outcomes.* http://www.who.int/healthsystems/strategy/everybodys_business.pdf