



UNAIDS AND STOP TB PARTNERSHIP

Gender assessment tool for national HIV and TB responses

Towards gender-transformative HIV and TB responses



Stop  Partnership

 UNAIDS

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Acronyms

ACSM	Advocacy Communication and Social Mobilization
AIDS	acquired immunodeficiency syndrome
ART	antiretroviral therapy
CCM	Country Coordinating Mechanism
CEDAW	Convention on the Elimination of All Forms of Discrimination against Women
CIDA	Canadian International Development Agency
DHS	Demographic and Health Surveys Program
DOT	Directly Observed Treatment
DR-TB	Drug Resistant Tuberculosis
GARPR	Global AIDS response progress reporting
GBV	Gender-based violence
GFATM	Global Fund to Fight AIDS, Tuberculosis and Malaria
GIPA	Greater Involvement of People Living with HIV(Principle)
GIPT	Greater? Incorporation of Patients with Tuberculosis
HIV	human immunodeficiency virus
IEC	information, education and communication
IPV	intimate partner violence
LBGT	lesbian, bisexual, gay and transgender
MDR-TB	Multidrug Resistant Tuberculosis
MSM	men who have sex with men
NSP	national strategic plan
PEP	post-exposure prophylaxis
PEPFAR	U. S. President's Emergency Plan for AIDS Relief
PrEP	pre-exposure prophylaxis
RST	regional support team
TB	Tuberculosis
SRHR	sexual and reproductive health and rights
UNAIDS	Joint United Nations Programme on HIV/AIDS
UNDAF	United Nations Development Assistance Framework
UNDP	United Nations Development Programme
UNFPA	United Nations Population Fund
UN WOMEN	United Nations Entity for Gender Equality and the Empowerment of Women
USAID	United States Aid Development Agency
WCA	West and Central Africa
WHO	World Health Organization

Introduction

While the HIV epidemic still poses a significant public health and development burden, Tuberculosis (TB) also remains a major global health problem with an estimated 9.6 million people who developed TB and 1.5 million deaths from the disease in 2014. There is a strong relationship between HIV and TB infections, an estimated 1.1 million (13%) of the 9.6 million were HIV positive.¹ According to WHO, people living with HIV are around 20-30 times more likely to develop TB than persons without HIV.² TB is the most common presenting illness among people living with HIV, including those taking antiretroviral treatment and is the major cause of HIV-related death³. Most TB cases and deaths occur among men, but TB remains among the top three causes of death of women worldwide. There were an estimated 480 000 TB deaths among women in 2014⁴, more than one third of whom were HIV-positive women.

Over 60% of TB incidences occur in men (2014). Despite higher HIV prevalence among women in Sub-Saharan Africa, incidence of TB is higher in men except in women who are 15-24 years old in areas of high HIV prevalence.⁵ Male-specific risks of becoming ill with TB, for example, they tend to have more social contacts, work in high-risk settings, smoke, possible higher alcohol consumption, and limited health seeking behavior. Female-specific risks include higher stigma, delayed diagnosis, less access to treatment services and the previous WHO policy of passive case-finding. High rates of extra-pulmonary TB among women also mean they are harder to screen and diagnose. Gender-responsive TB services are needed to capture these different needs.

In a study done to assess the gender variations in delay from symptom onset to help seeking, diagnosis and treatment of TB⁶ it is evident that compared with men, women experienced longer delays at various stages of the clinical process of help seeking for TB which warrants appropriate measures to improve the situation, while men seek help later.

In sub-Saharan Africa in 2014, women accounted for 58% of the total number of people living with HIV while young women, aged 15 to 24, face a heightened vulnerability to HIV, with almost twice the number of new infections as among young men. HIV remains the leading cause of death among women of reproductive age. Pregnant women living with HIV have a 10-fold higher risk of developing active tuberculosis compared with HIV-negative pregnant women⁷. At the same time, men generally benefit less from antiretroviral treatment, and face significantly higher risk of overall mortality, due to late presentation and non-adherence. Sub-Saharan Africa bears the brunt of the dual epidemic, accounting for approximately 80% of the estimated burden in 2013⁸.

Gender dynamics in TB enrolment, treatment and cure rates are not uniform. In some countries, men have better outcomes than women, while in other countries it is women who do. In most low and middle-income countries about two-thirds of reported TB cases are men and only one third women, and it is not well known whether this is due to a higher risk of developing TB among

¹ http://www.who.int/tb/publications/global_report/gtbr14_executive_summary.pdf?ua=1 accessed from the WHO Global TB report 2014

² <http://www.who.int/mediacentre/factsheets/fs104/en/> accessed from the WHO Fact sheet N°104 Updated October 2015

³ http://apps.who.int/iris/bitstream/10665/191102/1/9789241565059_eng.pdf?ua=1 accessed from the Global TB Report 2015

⁴ http://apps.who.int/iris/bitstream/10665/191102/1/9789241565059_eng.pdf?ua=1 accessed from the Global TB Report 2015

⁵ UNAIDS The GAP Report 2014 http://www.unaids.org/sites/default/files/media_asset/UNAIDS_Gap_report_en.pdf

⁶ Fazlul Karim et al. : Gender differences in delays in diagnosis and treatment of TB,

<http://heapol.oxfordjournals.org/content/22/5/329.full> ; accessed on 21, October 2014

⁷ UNAIDS 2014 Estimates

⁸ http://www.who.int/tb/publications/global_report/en/ accessed from the WHO Global TB report 2015

men or under-notification of TB among women with the evidence that women are less likely to be diagnosed with tuberculosis and successfully treated⁹.

It is thus evident that the health seeking and treatment behaviour of men and women living with HIV, HIV/TB co-infection or suffering from TB, requires a systematic assessment from a gender perspective to inform national planning and budgeting for gender-responsive and gender-transformative TB and HIV responses, including joint applications for the Global Fund New Funding Model.

The UNAIDS HIV Gender Assessment tool was developed recognizing the need for more systematic data collection on gender equality and HIV, as revealed by the mid-term review of the *UNAIDS Agenda for Accelerated Country Action for Women, Girls, Gender Equality and HIV 2010–2014*¹⁰ (hereinafter, the *UNAIDS Agenda for Women and Girls*), the UNAIDS Secretariat led a consultative, multi-stakeholder process to develop a gender assessment tool. The resulting *Gender Assessment Tool for national HIV responses* (hereinafter the *HIV Gender Assessment Tool*) aims to support countries with the assessment of their HIV epidemic, context and response from a gender perspective, to inform the development of gender-sensitive national strategic plans (NSP) and country investment cases.

Recognising the need for a similar tool for TB responses, the Stop TB Partnership and UNAIDS Secretariat established a partnership to develop the Gender assessment tool for national HIV and TB responses (hereinafter the ***HIV/TB Gender Assessment Tool***), building on the UNAIDS HIV Gender Assessment Tool.

The ***HIV/TB Gender Assessment Tool*** developed not only supports countries with the submissions of gender sensitive concept notes to the Global Fund to Fight AIDS, Tuberculosis and Malaria (GFATM) but is intended to assist countries to assess their HIV and TB epidemic context and response from a gender perspective, helping them to make their responses gender sensitive and reduce the dual burden of HIV and TB infection. This tool does not replace the HIV Gender Assessment Tool instead it is intended to work in areas of HIV and TB co-infection as one assessment or can also be conducted for each disease.

A gender assessment process, led by national stakeholders and partners, helps to identify gender-related barriers to services as well as specific needs of women, men, transgender people and key and vulnerable populations, in the context of HIV, TB or HIV/TB co-infection, in the process reinforcing political commitment and increasing civil society capacity, to better respond to these barriers and needs.

While different constituencies like country governments/ national TB programmes/CCMs/ Civil Society can take the lead in advocating for a gender assessment, it is recommended that the actual assessment is undertaken through country leadership such as the Ministry of Health or Gender and Development. This will ensure that outcomes are incorporated into relevant national strategic frameworks.

⁹ <http://www.who.int/tb/areas-of-work/population-groups/gender/en/>

¹⁰ http://www.unaids.org/en/media/unaids/contentassets/documents/unaidspublication/2010/20100226_jc1794_agenda_for_accelerated_country_action_en.pdf

Conceptual framework

The *HIV/TB Gender Assessment Tool* seeks to move the HIV and TB response along the continuum from gender-blind to gender-sensitive, and ultimately to gender-transformative (see *Table 1*). It makes use of a number of terms common to the HIV, TB and gender responses.

When referring to gender, the formulation of the *HIV/TB Gender Assessment Tool* is built upon the UNAIDS definition of gender as a socially constructed set of norms, roles, behaviours, activities and attributes that a given society considers appropriate for women and men, with the inclusion of people who identify themselves as transgender. The intricacy of the issue 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 identity or their sexual orientation.

Type of intervention	Impact	Example
Gender-negative or gender-blind	Fails to acknowledge the different needs or realities of women and men and transgender people Aggravates or reinforces existing gender inequalities and norms.	Lack of disaggregated data because of a failure to acknowledge that programmes and policies have different effects on women, men and transgender people
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 ensure that women, men and transgender people equitably benefit from the intervention.	Cash transfer programme provides funds to families to keep girls in school as one element to reduce girls’ vulnerability to HIV. Clinic operational hours are changed to early mornings and late evenings to reflect the needs of men and women who work. Outreach workers trained under Project Ashya of The Union have managed to convince 140 HIV positive women to get tested for TB and have counseled and guided these women to being cured for TB thereby improving health seeking behavior of women or girls ¹¹
Gender-transformative	Explicitly seeks to redefine and transform gender norms and relationships to redress existing inequalities.	Challenges and changes both sexuality norms and uneven access to resources in order to strengthen men and women’s ability to insist on condom use by their sexual partners.

Table 1: Gender Integration Spectrum Source: UNDP, 2014

To maximize gender-transformative responses, it is crucial to understand **key and vulnerable populations** by HIV and TB. UNAIDS and Stop TB call on countries to define the “specific populations that are key to their epidemic and response based on the epidemiological and social context¹².”

¹¹ See <http://www.axshya-theunion.org/images/documents/Axshya%20Activity%20Report%202012-13.pdf> for examples on country level ACSM efforts by Project Axshya of The Union accessed on 22nd October 2014

¹² http://www.unaids.org/sites/default/files/media_asset/JC2118_terminology-guidelines_en_0.pdf

Key populations for HIV are those most likely to be exposed to or transmit HIV (including people living with HIV). In most settings, gay men and other men who have sex with men, transgender persons, people who inject drugs, sex workers and their clients, migrant workers, people in prison, women and girls, and sero-negative partners in sero-discordant couples are at higher risk of exposure to HIV than other people

In the context of **TB** it is helpful to understand a more nuanced description of **key and vulnerable populations (KAPs)** (see annex E). We consider KPs under three distinct groups:

- 1. People who have increased exposure to TB bacilli** (due to where they live or work – overcrowding, poor ventilation) like healthcare workers, household contacts of TB patients, workplace or educational facilities contacts, people living in urban slums and shared living facilities such as orphanages, slums, retirement homes, etc. are at risk of increased exposure to TB bacilli for a range of reasons including poor living and sanitary conditions, poor ventilation, overcrowding, malnourishment etc. Overcrowding in healthcare facilities, congregate settings especially prison and mining increases exposure to the TB bacilli and risk of developing TB.
- 2. People who have limited access to health services** (due to gender, geography, limited mobility, limited financial capacity, legal status, stigma) like elderly and the mentally or physically disabled with limited mobility and support, remote population due to occupation like fishermen, miners, etc., the homeless, migrants, refugees, internally displaced, ethnic minorities and indigenous people who suffer stigma and discrimination. Also included are incarcerated people who may have limited access to health services.
- 3. People at increased risk of TB because of biological and behavioural factors that compromise immune function** like people living with HIV, people with diabetes, people suffering from silicosis and lung disorders, those on long term therapeutic steroids, those on immune suppressant treatment and people who are malnourished are vulnerable to TB because their compromised immune system are less able to fight infections. Certain lifestyle activities like smoking and harmful use of alcohol and drugs increase their risk of TB infection.

Each country must identify and engage the specific vulnerable populations that are central to their epidemic and response. This will be based on the epidemiological and social contexts of each country. The engagement of key and vulnerable populations is crucial to successful HIV and TB responses and for the gender assessment itself. It is essential that the gender assessment considers the full range of populations and takes a nuanced approach addressing the needs of key affected women and girls in all their diversity, as well as the key and vulnerable populations defined in this context. Political commitment should be built for undertaking the assessment and delivering action to respond to its outcomes.

For further information and clarification regarding key **terminology** used throughout this *HIV/TB Gender Assessment Tool*, please refer to **Annex E**, as well as UNAIDS terminology guidelines¹³ and the WHO Global TB Report¹⁴

In terms of the conceptual framework, the *HIV/TB Gender Assessment Tool* forms part of a comprehensive approach to gender-transformative HIV and TB responses. A list of complementary resources and documents designed to support countries to be gender sensitive in their HIV and TB responses at all stages can be found in **Annex A**.

¹³ See http://www.unaids.org/en/resources/documents/2011/name_63629_en.asp, accessed 1 April 2014.

¹⁴ See http://www.who.int/tb/publications/global_report/en accessed 10 September 2014.

STAGE 1

Preparing for the gender assessment of the national HIV/TB response

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

Step 1 • SECURE HIGH-LEVEL COMMITMENT

High-level national commitment to fostering the inclusion of gender in the HIV/TB response is key to the successful undertaking of the gender assessment of a national HIV/TB response. Dedicated steps need to be taken to ensure high-level commitment and to guarantee national leadership and ownership of the gender assessment.

In order to reach high-level agreement on the undertaking of the gender assessment, the following tasks might be considered by the lead organization and key government representatives.

Task 1.1. Map out the key government decision-makers for the undertaking of a gender assessment that will inform the national HIV/ TB response.

Task 1.2. Identify challenges and opportunities for building high-level support and prepare strategies to secure this support.

Task 1.3. Prepare a brief one-page concept note on why it is important to undertake a gender assessment and how the assessment will enhance the effectiveness of the national HIV/TB response. Share the concept note, along with specific information about the *HIV/TB Gender Assessment Tool*, with key decision-makers.

Step 2 • ESTABLISH A GENDER ASSESSMENT TEAM

The most important step in securing a proper division of labour for the gender assessment is the composition of the core gender assessment team (see Annex B). Typically, a consultant is also engaged in order to support the coordination and undertaking of the gender assessment (see Annex C). Ideally the consultant should be engaged in the whole process, from assessment through to implementing findings, rather than as a one-off intervention.

2.1. Establish a core gender assessment team comprised of the following:

- experts on HIV and TB, gender policies and services and human rights.
- key government representatives, particularly national AIDS and TB authorities, the Ministry of Health, Ministry of Social Services/Rural Development and the Ministry of Gender;
- relevant bi-lateral donors and private foundations;
- representatives of civil society working on TB and HIV, including individuals from the affected communities and representative of populations vulnerable to TB (for example miners, prisoners, migrants etc.), feminist groups, network of women living with HIV, women rights movement; men's groups, AIDS service organizations, Human Rights organizations and
- United Nations agencies and other strategic development partners.

The members of the core gender assessment team should be influential leaders in the fields of HIV/TB and gender, nationally recognized for their expertise and results-based professionalism. The core team should preferably be limited to five to seven members; this will ensure meaningful engagement of all members and facilitate timely decision-making and action.

Note that it is very important not only to ensure country ownership and leadership, but also to engage a diverse range of stakeholders.

Observation: In keeping with the principle of Greater Involvement of People Living with HIV (GIPA), the principle of the Great Incorporation of Patients with Tuberculosis (GIPT)¹⁵ and patient charter for TB care¹⁶ for the meaningful engagement of people living with HIV and TB affected communities and gender analysis capacity/expertise should be ensured.

2.2. Bring the identified members together to share and review the terms of reference of the gender assessment team. At the same time, agree on roles and responsibilities of the core gender assessment team.

2.3. Agree on how internal communication between the members of the gender assessment team will occur.

Step 3 • DEVELOP A GENDER ASSESSMENT FRAMEWORK

3.1. Request that all members of the gender assessment team read the HIV/TB *Gender Assessment Tool*. Any question regarding the *Tool* should be addressed and clarified prior to data collection.

¹⁵ See <http://www.aspb.cat/uitb/docs2/Patients%20Charter%20pdf.pdf> accessed 15 August 2014

¹⁶ http://www.who.int/tb/publications/2006/istc_charter.pdf accessed on 23rd February 2015

3.2. Discuss the goal of the gender assessment within the team, and clarify how it aligns with the concept note of the gender assessment.

3.3. Agree on the objectives of the gender assessment, aiming for clear short-term results in support of the over-arching goal.

3.4. Agree on guiding principles for undertaking the gender assessment process, as well as ways to monitor their application. Such principles include¹⁷:

- engagement of men and boys for gender equality;
- ethical responses based on equity and fairness;
- evidence-informed approach;
- human rights-based approach;
- impartiality;
- meaningful participation of women and girls;
- partnership with civil society, including people living with HIV and/or TB and other key affected populations;
- strategic and forward-looking approach;
- strong and courageous leadership; and
- transparency.

The country gender assessment team may add other principles that are relevant to the national context.

3.5. Review and agree on the root concepts of the assessment, such as what is meant by “gender”, “key populations”, and “populations vulnerable to HIV and TB”, using agreed UNAIDS, WHO and Stop TB terminology as the starting point and reflecting on the guidance provided by the Global Fund if the gender assessment is likely to relate to a proposal to the Global Fund.

3.6. Identify the relevant stakeholders and experts who should be engaged in the gender assessment. The stakeholders should include government, civil society representatives, affected community representative, relevant bi-lateral agencies, private sector and UN agencies. As appropriate, also include stakeholders from key sectors, including health, education, gender, justice, human rights and finance. Stakeholders should understand gender issues.

Observation: In keeping with the principle of Greater Involvement of People Living with HIV (GIPA), the principle of the Great Incorporation of Patients with Tuberculosis (GIPT), and the patient charter for TB care for the meaningful engagement of people living with HIV and TB affected communities should be ensured participation as stakeholders.

¹⁷ Derived from the *UNAIDS Agenda for women and girls*

3.7. Define communication approaches to raise awareness with stakeholders beyond the gender assessment team regarding the undertaking of the gender assessment and its results.

a) Identify key external stakeholders and partners who should be informed of the gender assessment as part of ensuring their support for the overall process and follow-up. This group of stakeholders differs from those in the previous step, in that the stakeholders in step (3.6) will be actively engaged in carrying out the gender analysis, while the stakeholders in this step (3.7) are the broader group of partners that should be kept apprised throughout the gender analysis process of its purpose, progress, outputs, and actions.

b) Develop targeted advocacy messaging based on the need to strengthen gender-responsive programming in the context of the national HIV/TB response. This messaging should outline how the gender assessment will enhance existing national processes and be aligned with a national HIV/TB investment framework.

c) Disseminate the messages. Decide who will be responsible for external communication to reinforce political commitment and buy-in of stakeholders.

d) 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 should be determined in such a way that the gender assessment will be completed in time for the findings to be used in support of relevant national processes and opportunities and to support applications to donors (e.g. the Global Fund) if relevant.

Agree on monitoring mechanisms for undertaking the gender assessment (as per the developed timeline).

Step 4 • DEVELOP A RESOURCE PLAN FOR THE GENDER ASSESSMENT

4.1. List and agree on the human resources that will be needed to conduct the gender assessment—including consultants and assistants—and their respective responsibilities in the process.

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

- administrative expenditures;
- communication (including dissemination of the findings);
- human resources for the systematization, analysis and communication of sex and age disaggregated and gender-

- based data, including the recruitment of the gender assessment and costing consultant (s);
- meetings and workshops (including lodging, travel and logistic costs, as needed); and
- other costs, as relevant to the national context.

4.3. Confirm the availability of funds to support the gender assessment, or prepare a proposal that can be used to mobilize necessary resources from prospective donors.

Note that the Country Coordinating Mechanism (CCM) can request the Global Fund Secretariat support the undertaking of the gender assessment with the CCM funding, or it can apply for specific technical assistance funding from the Technical Assistance partners.¹⁸

Step 5 • COLLECT, COLLATE AND STORE RELEVANT DOCUMENTS

Please collect documents that will inform the gender assessment in your country.

1. Country specific data:
 - a. relevant HIV /TB data that is age and sex disaggregated; and other relevant variables such as those outlined in the WHO Guide to Monitoring and Evaluation for Collaborative TB/HIV Activities.¹⁹
 - b. Additional data sources for gender issues linked to HIV /TB (i.e. DHS domestic violence module, Violence against Children surveys, etc.).
2. Global tools: members of the gender assessment team should also familiarize themselves with the available online tools. Refer to **Annex A** for a list of available resources.
3. international and regional documents of which the country is signatory, or documents that are important to the specific national context

5.1. Review the list of documents—which should be prepared by the consultant—to ensure it is complete and appropriate.

Review and add other documents that are considered relevant,

5.2. Agree on a digital storage method for the documents (e.g. Drop Box, blog, cloud servers, etc.). The chosen method should allow all team members to have common access.

¹⁸ An information note developed by the Global Fund and the Global Coalition on Women and AIDS (GCWA) on how to ensure that the New Funding Model concept note responds to the gender dimensions of HIV can be found at <http://www.womenandaids.net/CMSPages/GetFile.aspx?guid=af728b92-240f-4965-90e2-00707ddaeaa9&disposition=inline> (accessed 27 March 2014).

¹⁹ A Guide To Monitoring and Evaluation foer TB/HIV Collaborative Activities. WHO. 2015 http://apps.who.int/iris/bitstream/10665/150627/1/9789241508278_eng.pdf?ua=1&ua=1

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.

5.4 Familiarize yourself with online tools and guidelines for preparing to identify effective, evidence-based interventions. These tools will be crucial when the group identifies key interventions in Stage 4.

Step 6 • ORGANIZE A GENDER ASSESSMENT WORKSHOP WITH ALL RELEVANT STAKEHOLDERS

Organize a gender assessment workshop with all relevant stakeholders in order to undertake Stages 2, 3 and 4 of the *HIV/TB Gender assessment Tool*.

The national level workshop preferably should take place over a period of two to three days (see **Annex D** for a sample agenda for a gender assessment workshop).

The participants should be drawn from different constituencies, including government, bi-lateral donors, UN agencies, academia, civil society and local representatives from key populations. This ensures a wide range of perspectives that will enrich the discussion and reflection on Stages 2 and 3 of this *Tool*.

The workshop also includes the identification of strategic interventions to address the issues and gaps identified by the gender assessment, and to inform the move towards a gender-transformative HIV and TB response in the country.

STAGE 2

Knowing the national HIV and TB epidemic and its surrounding context

This stage provides key questions for understanding the HIV and TB epidemic from a gender perspective, the context surrounding behaviour, and any relevant socio-economic, political and economic factors. It provides important questions to assess gender equity, such as asking about meaningful participation of women, men, transgender people and key affected populations.

It is recommended that the sections below be pre-populated with the relevant data when preparing for the gender assessment workshop.

Step 7 • HIV and TB PREVALENCE, INCIDENCE AND BEHAVIOURAL INFORMATION

Question 1. What are the latest prevalence rate of HIV and of TB, disaggregated by sex, age at national level and by regions?

Question 2. What are the prevalence rates of co infection i.e. patients living with HIV and acquired TB disaggregated by sex, age at national level and by regions?

2.1 Please specify the trend over time in prevalence data (disaggregated by sex and age).

Observation: Consider presenting the trend (if it is available) in a graph in an annex in the narrative report.

Question 3. What is the latest national HIV incidence and TB notification rate (all new TB cases and all new smear-positive and where possible smear-negative cases), disaggregated by sex, age at national level and by regions

Question 4. What is the mortality rate from HIV and from TB disaggregated by sex, age at national level and by regions?

Question 5. Have population size estimations been performed for key affected populations?²⁰

²⁰ See Guidelines on estimating the size of populations most at risk to HIV http://www.unaids.org/sites/default/files/en/media/unaids/contentassets/documents/epidemiology/2011/2011_Estimating_Populations_en.pdf

the "Special 2013 *Global AIDS response progress reporting* (GARPR) questionnaire" in Appendix 3 of UNAIDS *Global AIDS response progress reporting 2013*, Geneva, 2013: 108-09 http://www.unaids.org/en/media/unaids/contentassets/documents/document/2013/GARPR_2013_guidelines_en.pdf, accessed 27 March 2014).

See also Global TB report 2013 http://www.who.int/tb/publications/global_report/gtbr13_annex_1_methods.pdf?ua=1 (accessed 15 August 2014)

Question 6. What is the prevalence rate of HIV in key affected populations? What information is available on estimated incidence in key affected populations disaggregated by sex and age, if available?

6.1 Please specify the trend over time in HIV prevalence in key populations (disaggregated by sex and age).

Observation: Consider presenting the trend (if it is available) in a graph as an annex.

Question 7. What is the prevalence rate of TB in key affected populations of TB? What information is available on case notification rates in key affected populations disaggregated by sex and age, if available?

7.1 Please specify the trend over time in TB notification data in key affected populations (disaggregated by age)

Observation: Consider presenting the trend (if it is available) in a graph in an annex.

Question 8. If available, what is the ratio of the case notification rate in men and women to the estimated prevalence in men and women?

Question 9. If a mode of transmission study or other similar transmission modelling has been undertaken, what are the modes of HIV transmission for women, girls, men, boys and transgender people or distribution of new infections?²¹

Question 10. Are there any locations of higher prevalence/incidence of HIV (e.g. rural, urban or specific geographic locations)?

Question 11. What percentage of young people aged 15–24 both correctly identifies ways of preventing the sexual transmission of HIV and reject major misconceptions about HIV transmission?²²

Question 12. What proportion of the population correctly identifies symptoms of TB and where to go for help?²³

Provide information disaggregated by sex (female, male and transgender), age and geographical location, if available.

²¹ A modes of transmission study determines the way a given population acquires HIV (through sexual transmission, vertical transmission, use of non-sterile injecting equipment of infected blood transfusion) For more information, see UNAIDS, *Modeling the expected short-term distribution of new HIV infections by modes of transmission*, Geneva, 2012 (available from http://www.unaids.org/en/media/unaids/contentassets/documents/document/2012/guidelines/JC2427_ModelingNewHIVInfectionsbyModesofTransmission_en.pdf, accessed 27 March 2014).

²² See *Global AIDS response progress reporting 2013*, Section 1.1., pp. 24–6 (available from http://www.unaids.org/sites/default/files/media_asset/JC2702_GARPR2015guidelines_en.pdf).

²³ See Global TB report 2013, page 35-37: available from http://apps.who.int/iris/bitstream/10665/91355/1/9789241564656_eng.pdf?ua=1

Question 13. What percentage of young women, men and transgender people have knowledge of whether a person can reduce the risk of getting HIV by using a condom every time they have sex?

13.1. What is the percentage of the population that has an accurate understanding of the relationship between TB and HIV?

Provide information disaggregated by sex (female, male, transgender), age, and geographical area, if available.

13.2. If available, what is the trend in knowledge and access to services (disaggregated by sex and age) over the past five to 10 years?

Observation: Consider presenting the trend (if it is available) in a graph in an annex.

Question 14. What is the percentage of women and men aged 15–49 who have had sexual intercourse with more than one partner in the past 12 months?

14.1 What percentage of women and men aged 15–49 who have had more than one partner in the past 12 months used a condom during their last incident of sexual intercourse?²⁴

Observation: Consider presenting the trend (if it is available) in a graph in an annex.

Question 15. Does the country have data on unwanted pregnancy among unmarried adolescents? Please describe.

15.1 Do the country policies and programmes link prevention of unwanted pregnancies and HIV prevention?

Question 16. Is data available on intimate partner violence (IPV)? Is data available on non-partner? sexual violence? If yes, please describe and include age disaggregated data (if possible).

Question 17. Does the country have any available data on stigma and discrimination within the health care system against people living with HIV, with TB, HIV/TB, or DR-TB? Please include data disaggregated by sex and age, where available.

Question 18. Does the monitoring and evaluation (M&E) systems (route recording and reporting or prevalence surveys) capture gender disaggregated information as well as other important demographics related to risk, such as place of work, incarceration, pregnancy status, etc.

²⁴ See *Global AIDS response progress reporting 2013*, Section 1.4, pp. 28–9 (available from http://www.unaids.org/en/media/unaids/contentassets/documents/document/2013/GARPR_2013_guidelines_en.pdf, accessed 27 March 2014).

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 summarize key issues based on the HIV and TB epidemic data available. This data will be used later in the document for the analysis matrix.

Step 8

SOCIAL, CULTURAL AND ECONOMIC FACTORS

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

Question 1. What socio-cultural norms and practices may contribute to increased risk of HIV and TB transmission among women and girls, men and boys, and/or transgender people? List them.

1.1 In what way do these socio-cultural norms and practices contribute to a higher risk of HIV? Be specific, based on evidence.

1.2 In what way do these socio-cultural norms and practices trigger the development of active TB? Be specific, based on evidence.

1.3 Does the country have any data on age-disparate sexual relationships between older men and younger women? Also add any data on age-disparate sexual relationships between older men and younger men, if it is available.

Question 2. Are there socio-cultural norms and practices that contribute to the risk of HIV and TB transmission among key affected populations that were not named in Question 1? If so, what are these norms and practices, and what populations do they affect?

2.1 In what way do these socio-cultural norms and practices contribute to a higher risk of HIV? Be specific by population, based on evidence

2.2. In what way do these socio-cultural norms and practices contribute to a higher risk of TB transmission? Be specific, based on evidence.

Question 3. What socio-cultural norms and practices may contribute to gender differences in any of the issues described in the answers you provided for Question 2 (e.g. knowledge, condom use, stigma, discrimination, early or unwanted pregnancy)?

3.1 In what way do these socio-cultural norms and practices contribute to a higher risk of HIV transmission? Be specific by population, based on evidence.

3.2 In what way do these socio-cultural norms and practices influence health-seeking behaviours of men, women and transgender people, who are living with HIV and/or acquired TB?

Question 4. According to available data, what are the factors or social determinants—such as economic vulnerability, multiple sexual partners, or alcohol or chemical dependence—that contribute to the continuation of these practices and behaviours? How? Please identify factors for a) individual, b) community and c) society levels.

Question 5. If data is available, what are the risk factors or social determinants—such as economic vulnerability, incarceration, malnutrition, smoking, indoor air pollution, silicosis, diabetes, drug and alcohol use, that contribute to increase vulnerability to TB. How? Please identify factors for (a) individual (b) community and (c) society levels.

You have now reached the end of Step 8. Please proceed to Step 9. After that is complete, you will be asked to analyse the two steps together.

Step 9 • LEGAL AND POLITICAL FACTORS

Question 1. Are there any legal frameworks or policy, basic health policies, and other general government policies that include any of the following: women and girls, men and boys, transgender people and key affected populations in relation to HIV, TB, HIV/TB, or DR-TB? If so, what aspect of their lives may be affected?

If so, what aspect of their lives may be affected? Please tick the relevant boxes:

- restrictions on women's or girls' movements or activities
- forced institutionalization for DR-TB treatment
- criminalization of drug use
- criminalization of HIV transmission or exposure (including vertical (mother-to-child) transmission)
- criminalization of sexual orientation
- criminalization of gender identity
- criminalization of sex work
- denial of access to condoms or sexual and reproductive health services for young people (younger than 18 years of age)
- denial of comprehensive sexuality education for young people (younger than 18 years of age)
- denial of inheritance and/or property rights to women
- denial/ restrictions of provision of safe abortions

- early and forced child marriage practices
- HIV-related travel restrictions
- non-recognition of sexual or gender-based violence within marriage
- polygamous marriages
- prisoner rights to healthcare
- access to care and right to compensation (TB diagnosis and treatment)
- laws on occupational exposure
- school screening programs for TB?

Add others, as relevant, and please elaborate.

Question 2. Are there legal frameworks that specifically protect the rights of people living with TB, HIV/TB, DR-TB, HIV, women and girls, and other key affected populations in the country?

If so, what rights are protected? Please tick the relevant boxes.

- criminalization of early and forced marriage
- criminalization of intimate partner violence
- family and property law (e.g. laws regarding marriage, cohabitation, separation, divorce, child custody, property, inheritance, etc.)
- gender identity laws
- country wide medical insurance schemes
- Universal access to medicines for treatment
- labour relations and social security legislation
- laws ensuring comprehensive sexuality education that is non-stigmatizing and non-discriminatory
- laws ensuring that TB & DR-TB services—including testing and treatment—are free of charge
- laws ensuring that HIV services—including testing and counselling—are voluntary and confidential.
- legal frameworks regarding sexual and reproductive rights
- migrant rights
- rights under national law regarding easy access to health care (including health services), access to information about health issues and appropriate care, antiretroviral therapy (ART), condoms, co-trimoxazole prophylaxis and isoniazid preventive therapy for people living with HIV, isoniazid preventive therapy for children of household contacts of TB infected person, pre-exposure prophylaxis (PrEP), and post-exposure prophylaxis (PEP).

Add other legal frameworks, as relevant, and please elaborate.

Question 3. Are all key affected populations protected equally? Please specify.

Question 4. Do the existing laws and policies translate into equitable access to services for women, girls, men, boys, transgender people and key affected populations?

If yes, what services are not equally accessed by....? Please tick the applicable boxes.

- access to TB diagnosis access to TB treatment and treatment support
- access to DR-TB diagnosis, treatment and support
- commodities for HIV prevention (male and female condoms, harm reduction practices)
- comprehensive sexuality education
- education
- information about available health services
- labour
- post-rape care, including post-exposure prophylaxis for HIV and STIs
- pre-exposure prophylaxis
- psychosocial support for people living with HIV, and TB affected communities
- sexual and reproductive health and rights services
- social protection

Add others, as relevant, and please elaborate.

Question 5. Do both the executive and legislative branches of government work towards implementing the international treaties and declarations on which the country is a signatory? Please give examples of laws approved and services provided according to the 2011 Political Declaration on HIV/AIDS, the Beijing Declaration and the Convention on the Elimination of All Forms of Discrimination against Women (CEDAW). Also consider regional commitments by governments i.e. AU, Southern African Development Community (SADC)

Please provide specific examples of laws approved and services provided.

Question 6. Is there any indication of discriminatory or coercive practices in health-care settings that may impact access and utilization of HIV and TB-related services by women living with HIV, including those from key and marginalized populations?

If yes, in what areas have discriminatory or coercive practices been seen? Please tick the applicable boxes.

- coerced abortion
- coerced family planning
- denial of access to abortion, where legal
- denial of access to contraception

- discrimination against transgender people
- forced sterilization of women living with HIV?
- discrimination based on sexual orientation
- stigma against people living with HIV or affected by TB
- stigma and discrimination against people who use drug
- job loss due to stigma
- denial or unavailability of treatment support

Add others in the space, as relevant, and please elaborate.

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 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 and TB epidemic, relating the analysis of Steps 8 and 9 to the epidemiological data and ensuring that the gender differences are clearly stated.

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

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

STAGE 3

Knowing the national HIV and TB response

This stage puts forward key questions to help understand the national HIV, national TB and national HIV-TB co-infection responses from a gender perspective. It is the core of the data gathering needed to engender the national response. By replying to these questions, the gender assessment team will be able to build a picture of the country situation and make an informed decision on a list of priorities for HIV/TB, and for gender investment and intervention.

Step 10 • GENDER EQUALITY IN HIV, TB POLICIES AND PROGRAMS

Step 10.1 • THE OVERALL HIV/TB RESPONSE

Question 1. Which populations are addressed in the HIV and TB national response? Please disaggregate by age and gender.

- 1.1** Does the national HIV, TB response include people with disabilities? If yes, are there specific programmes for people with disabilities in the response? Is there a difference between the way the needs of men/boys and women/girls are addressed by it?

Please document observations that are relevant from a gender perspective.

- 1.2** Does the national HIV, TB response include older people, in particular older women? If yes, are there programmes to address their needs (e.g. chronic care packages, including cervical cancer screening)?

Please document observations that are relevant from a gender perspective.

Question 2. Does the HIV, TB response recognize, plan for and address gender issues related to any of the following?

If yes, which gender issues are recognized, planned for or otherwise addressed? Please tick the applicable boxes.

- early and forced marriage
- access to health care services barriers to care-seeking based on religious or cultural beliefs and traditions
- barriers to care-seeking based on religious or cultural beliefs and traditions
- incarceration

- forced displacement, internal or international migration for work
- occupational risks (e.g. mining)
- disabilities
- race, ethnicity, indigenous status
- rural/urban specificities
- socio-economic status
- smoking and alcohol abuse

Question 3. Have issues of sexual orientation been recognized within the HIV policy/strategy? If yes, what is recommended in terms of HIV services regarding stigma, discrimination and human rights?

Question 4. To what extent is the national HIV and TB response funded by domestic sources? To what extent is it funded from external sources. Please indicate the source and percentage of funding.

4.1 Does the national HIV and TB response already include gender-equality interventions? If yes, how are these interventions funded?

Please provide a percentage using the table below (adding partners, if needed).

Funding for gender equality interventions in the country					
Funding	Domestic	External			
		GFATM, foundations, bi-lateral donors	UN	Civil society	Private sector
Total US\$					
100%					

Question 5. Is there a formal system of accountability for the HIV/TB response that allows civil society, UN agencies and citizens to monitor the spending on gender equality within the HIV and TB response? If yes, how does it work?

Step 10.2 • MEANINGFUL PARTICIPATION

Question 1. Are networks and organizations representing people living with HIV, women’s rights, sexual and reproductive health, gender equality, youth and key affected populations engaged in decision-making at different stages, levels and sectors of the country HIV response (including design and implementation)?

Please differentiate per constituency in responding.

Please document observations about the participation of civil society in the HIV responses and its linkages with gender equality.

Question 1.1. Are organizations representing TB affected populations meaningfully engaged in decision-making at different stages, levels and sectors of the country TB response (including design and implementation)?

Please differentiate per TB key population as relevant to the country context and TB burden. Please see TB KP definition on page 7.

Please document observations about the participation of civil society in the TB response

Question 2. Are there formal mechanisms (e.g. partnership forums, joint HIV theme group, TB technical working groups, National AIDS Councils/ Commissions and, National Stop TB Partnership, TB advisory committee and or CCM) that ensure the views, needs and rights of key affected populations are taken into account in decision-making processes in the response to HIV and TB? If so, please describe how this is ensured with a particular focus on gender issues (provide examples, if possible).

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

Question 4. What (legal, political and financial) provisions exist for capacity building and the allocation of resources to support the participation of key affected population (KAP) in the HIV and TB response?

Question 5. Is there any key affected population that is excluded—by laws, regulations or policies—from engaging in the national HIV/TB response? Are there gender aspects to this?

Step 10.3 • COORDINATION OF GENDER EQUALITY WITHIN THE HIV, TB RESPONSE

Question 1. Does the national HIV and TB coordination mechanism include a dedicated focus on gender equality? If yes, please describe.

1.1 Are there additional coordination mechanisms in different government sectors (e.g. gender, health or human rights) and levels for joint action on gender equality in the national HIV and TB response? If so, please describe.

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

Question 3. Are there civil society coordination mechanisms addressing HIV and gender and/or TB and gender? If so, which constituencies are involved?

Step 10.4 • GENDER EQUALITY IN THE CONCEPTUAL FRAMEWORK AND DESIGN

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

1.1 Is the development of the national HIV response guided by the UNAIDS *Agenda for women and girls*?

Question 2. Do the HIV policy /TB policy/national health policy reflect a commitment to gender equality?

Question 3. Is this commitment to gender reflected by addressing the following issues through the HIV and TB response?

3.1 Inequality between women/girls and men/boys and transgender people?

3.2 Stigma and discrimination toward people living with HIV and those who acquired TB, particularly women and girls living with HIV and who acquired TB (including transgender people)—in the provision of HIV and TB and other health services, as well as the social welfare and judiciary systems?

3.3 Stigma and discrimination against key affected populations?

Question 4. Is this commitment matched with a budget to undertake the implementation of gender-responsive and transformative initiatives and services? If yes, has this budget been translated into actual initiatives and services? Please provide examples.

Step 10.5 • GENDER EQUALITY AWARENESS AND KNOWLEDGE

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

Question 2. Does the pre-service curriculum of health-care workers include sensitivity training in gender, human rights, stigma and discrimination?

If yes, which themes are addressed? Please tick the appropriate boxes.

- health seeking behaviour in men, women and transgender people
- gender-based violence
- gender equity
- gender identity
- human rights
- reproductive health
- reproductive rights
- sexual health
- sexual rights
- stigma and discrimination
- voluntary counselling and testing (including for couples)

Please indicate other themes (if relevant).

Question 3. Does the standards of practice for health-care workers who deliver HIV and TB services include sensitivity training in gender, human rights, stigma and discrimination? If yes, which specific themes are addressed?

3.1 How frequently do the in-service trainings happen? Have they been evaluated? Please explain.

Step 10.6 • ASSESSING EXPENDITURE ALLOCATION

Question 1. Is there an accessible system of information such as the National AIDS Spending Assessment— that documents expenditures (national and external) on gender and HIV in the country?

1.1 What factors influence budgeting decisions on gender and HIV?
Possible factors include available resources, current priorities financed, religion, socio-cultural factors and legal environment.

Please list factors influencing budgeting decisions on gender and HIV.

1.2 What are the challenges to the implementation of the gender and/or HIV budgets? Possible challenges include political commitment, lack of evidence and capacity gaps.

Please list challenges to the implementation of the gender and/or HIV budgets.

Question 2. Is there an accessible system of information that documents expenditures (national and external) on gender and TB in the country?

2.1. What factors influence budgeting decisions on gender and TB? Possible factors include available resources, current priorities financed, religion, socio-cultural factors and legal environment.

Please list factors influencing budgeting decisions on gender and TB.

2.2 What are the challenges to the implementation of the gender and TB budgets? Possible challenges include political commitment, lack of evidence and capacity gaps.

Please list challenges to the implementation of the gender and TB budgets.

Question 3. Based on the type of epidemic and the affected populations groups, are the specific needs of women, girls, men, boys and transgender people considered in the budget allocated to the national HIV response?

3.1 Is the amount allocated to the national HIV response sufficient to meet the needs of these communities in the context of HIV? Please break down your response per constituency.

Question 4. Based on the type of epidemic and the affected populations groups, are the specific needs of women, girls, men, boys and transgender people considered in the budget allocated to the national TB response?

4.1 Is the amount allocated to the national TB response sufficient to meet the needs of these communities in the context of TB? Please break down your response per constituency.

Question 5. Does the HIV response disaggregate financial data collection and reporting by sex, age and/or key populations?

Question 6. Does the TB response disaggregate financial data collection and reporting by sex and age?

You have now reached the end of Step 10 of Stage 3.

Please review the data on the inclusion of gender equality in HIV and TB policies and analyse the main gaps in addressing gender differences.

Please recall the contextual factors relating to the HIV and TB epidemics from a gender perspective that were identified earlier in the *Tool*

Step 11 • A COMPREHENSIVE HIV and TB RESPONSE

Step 11.1 • HIV and TB PREVENTION

Question 1. Are the following HIV and TB prevention and supportive services generally available at no cost to the patient?

Please tick the boxes of the available services.

- access to information about HIV and TB
- BCG vaccination
- INH prophylaxis for people living with HIV and people with latent TB infection (please refer to the WHO TB/HIV Collaborative Activities Guidance)
- behaviour change communication
- peer education
- condoms (male and female)
- Antiretroviral treatment as prevention
- TB contact tracing and treatment
- drug use harm reduction measures
- male circumcision
- prevention of vertical transmission (also known as PMTCT, prevention of mother-to-child transmission)
- voluntary testing and counselling services

Please add others services as necessary, and provide observations that are relevant from a gender perspective.

Question 2. Identify gender-related impediments to accessing, using and/or adhering to prevention services for women, girls, men, boys, transgender people and key affected populations that should be considered and addressed.

Gender-related impediments may include stigma, discrimination, gender-based violence, harmful societal gender norms (such as gender imbalances and harmful definitions of masculinity or femininity), access to resources, and discrimination based on gender identity, sexual orientation, age ethnicity, occupation, or marital status.

Please indicate which of these factors may affect key affected populations. Be sure to specify the community or communities affected. Please discuss and provide examples.

Question 3. Do prevention services respect, promote and protect the rights in a way that is independent of marital status, profession and age, or are there indications that these principles have been violated?

If there are indications that the principles have been violated, please indicate the areas in which the violations appear to have occurred.

- access to justice and benefit of the law
- addressing violence in all cases (including from partners, family, community or 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
- TB counselling and treatment adherence support

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

Question 4. What is the percentage of coverage for services that prevent vertical transmission?

4.1 What is the estimated number of children born with HIV per year?

4.2 What is the overall loss to follow-up rate through the end of the breastfeeding phase?²⁵

4.3 What is the coverage rate for each stage in the provision of services for the prevention of vertical transmission?

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

4.5 Discuss who is not being reached by the national programme for prevention of vertical transmission. Please provide examples and/or quote relevant sources.

4.6 Does the prevention of vertical transmission 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 • TESTING AND TREATMENT

Question 1. What is the percentage of women and men aged 15–49 who received an HIV test in the past 12 months and know their results?²⁶

²⁵ Loss to follow-up is the rate of disconnection between patients and treatment. In the case of vertical transmission, it means babies treated at birth that were still infected, and the treatment continuation of mothers and babies.

²⁶ See *Global AIDS response progress reporting 2013*, Section 1.5, pp. 29–30 (available from http://www.unaids.org/en/media/unaids/contentassets/documents/document/2013/GARPR_2013_guidelines_en.pdf, accessed 27 March 2014).

1.1 What is the percentage of girls and boys, aged 10 to 14, who received an HIV test in the past 12 months and know their results?

1.2 What is the percentage of sex workers who received an HIV test in the past 12 months and know their results?²⁷

1.3 What is the percentage of men who have sex with men who received an HIV test in the past 12 months and know their results?²⁸

1.4 What is the percentage of transgender people who received an HIV test in the past 12 months and knows their results?

1.5 What is the percentage of people who use drugs who received an HIV test in the past 12 months and know their results?

1.6.What is the percentage of TB infected (women, men, transgender people) who received an HIV test in the past 12 months and know their results, disaggregated by sex?

1.7.What is the percentage of people newly diagnosed with HIV (women, men, and transgender people) who were screened for TB, desegregated by sex?

Question 2. What is the number of people (disaggregated by age and gender) diagnosed with HIV and started treatment in the past 12 months?

Question 2.1: What is the number of people (disaggregated by age and gender) diagnosed with TB and started treatment in the past 12 months?

Question 2.2: What is the number of people (disaggregated by age and gender) diagnosed with MDR-TB and started treatment in the past 12 months?

Question 3. What is the current antiretroviral treatment coverage in the country (preferably with data disaggregated by age, gender and location, if available)?

3.1. Are the HIV treatment services equally accessible for women, men and key populations? If not, what gender-related factors are limiting or impeding accesses? Please explain your answer.

²⁷ See *Global AIDS response progress reporting 2013*, Section 1.9, pp. 36–88 (available from http://www.unaids.org/en/media/unaids/contentassets/documents/document/2013/GARPR_2013_guidelines_en.pdf, accessed 27 March 2014).

²⁸ See *Global AIDS response progress reporting 2013*, Section 1.13, pp. 44–6 (available from http://www.unaids.org/en/media/unaids/contentassets/documents/document/2013/GARPR_2013_guidelines_en.pdf, accessed 27 March 2014).

Question 4. What is the current TB treatment success rate in the country (preferably with data disaggregated by age, gender and location, if available)?

Question 4.1. What is the number of patients started on MDR-TB treatment and treatment success rates in the country (preferably with data disaggregated by age, gender and location, if available)?

Question 5. What is the percentage of adults and children with HIV known to be on treatment 12 months after initiation of ART?²⁹

5.1 What is the percentage treatment success rate of adults and children with TB known to be on treatment 12 months after initiation of ART? In the last three years? (Include data source to collect this from TB disaggregated by age, gender, if available)

5.2 What populations are affected by treatment non-adherence and how does this relate to gender? (are there any factors in terms of TB treatment non adherence and gender, in which case we should specify HIV and TB treatment non adherence)

Question 6. What is the current national average viral suppression rate, if available?

Question 7. Do treatment services respect, promote and protect the rights of women, girls, men, boys, transgender population and key affected populations in a way that is independent of marital status, profession and age, or are there indications that these principles have been violated?

If there are indications that the principles have been violated, please indicate the areas in which the violations have occurred:

- access to justice and benefit of the law
- disclosure and acceptance of TB/HIV status, free of stigma and discrimination
- gender-based violence (including from their partners, family, community or state)
- gender identity
- protection against harmful norms and practices
- reproductive health
- safe abortion
- sexual health
- sexual orientation
- voluntary testing and counselling

²⁹ See *Global AIDS response progress reporting 2013*, Section 4.2, pp. 74–76 (available from http://www.unaids.org/en/media/unaids/contentassets/documents/document/2013/GARPR_2013_guidelines_en.pdf, accessed 27 March 2014).

Please add others (if necessary) and provide observations that are relevant from a gender perspective.

Step 11.3 • CARE AND SUPPORT

Question 1. Are there gender factors for the use of—and adherence to the following services among women, girls, men, boys, transgender people and key affected populations that should be considered and addressed?

If yes, indicate the service that **has gender factors** that should be addressed.

- HIV and TB treatment and support services
- palliative care
- psychosocial support for people living with HIV
- sexual and reproductive health counselling
- legal support services
- social protection services
- insurance schemes
- support for orphans and vulnerable children affected by HIV

Please add others (if necessary) and provide observations that are relevant from a gender perspective.

Question 2. Do care and support services respect, promote and protect the rights of women, girls, men, boys, transgender people and key affected populations in a way that is independent of marital status, profession and age, or are there indications that these principles have been violated?

If there are indications that the principles have been violated, please indicate the areas in which the violations appear to have occurred.

- access to justice and benefit of the law
- disclosure and acceptance of HIV and TB status, free of stigma and discrimination
- gender-based violence (including from their partners, family, community or state)
- gender identity
- protection against harmful norms and practices
- reproductive health
- safe abortion
- sexual health
- sexual orientation
- voluntary testing and counselling

Please add others (if necessary) and provide observations that are relevant from a gender perspective.

Question 3. Is there gender parity among providers of care and support at the community level? Please describe.

Question 4. Do the national HIV / TB /national health policy recognize the burden of care and support, and does it provide mechanisms for compensation for the providers of care and support?

4.1. 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 and TB and HIV treatment supporters
- financial compensation for primary and secondary caregivers
- recognition and effort to address the burden and impact of care on women and girls
- reliable access to home-based care supplies
- reliable access to a treatment supporter
- training and support for palliative care

Observation: If possible, provide caregiving information by age (e.g. young girls pulled out of school for caregiving, grandmothers heading households of grandchildren, female-headed households, etc.)

11.4 GENDER-BASED VIOLENCE (GBV)

Question 1. Do 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.

1.1 If so, how is it addressed within HIV programmes and services?

1.2 Which populations benefit from these initiatives, in particular are there programmes for transgender people and other key affected women?

1.3 If it is not addressed within HIV programmes and services, why?

Question 2. Do the national HIV and/or gender policy guide the HIV response in recognizing the link between gender-based violence and HIV, both in terms of increased risk of HIV transmission as a result of violence and persons living with HIV experiencing violence as a result of their HIV status? Please explain your answer.

2.1. If so, how is it addressed in programmes and services, and which populations benefit?

Question 3. Do the national TB and/or gender policy guide the TB response in recognizing the link between gender-based violence and TB, in terms of increased violence as a result of being infected by TB? Please explain your answer.

3.1. If so, how is it addressed in programmes and services, and which populations benefit?

Question 4. Is there a policy on addressing gender-based violence? If yes, does it address HIV, TB in sectorial programmes, initiatives or services on gender-based violence? Please explain, and indicate if the policy is multi-sectorial in nature.

4.1. If it does, what are the actions undertaken and which populations are addressed?

4.2. If it does not, why isn't it being addressed?

Question 5. Are there laws in place to reduce and condemn violence against women and gender-based violence? If so, please specify which laws have been established.

5.1. How are the laws upheld? If there are limitations, please describe them.

Question 6. Does the HIV response and TB response address condoning attitudes of society about violence against women and gender-based violence? If yes, please explain.

Question 7. Does the HIV response and TB response address attitudes of public service providers (such as health workers, uniformed services, teachers, etc.) about violence against women and gender-based violence?

7.1 If so, how does it address this issue?

Observation: For example, this issue could be addressed through information, education and communication (IEC) materials, including different kinds of campaigns focused on the training and sensitization of health-care workers, teachers, law enforcement personnel and media workers.

7.2 If it does not address the issue, then why?

Question 8. Are there partnerships between government and partners—such as UN agencies and networks or organizations representing women's rights, patients' rights, TB affected communities, women living with HIV, and key affected populations—to develop and implement programs and initiatives that address GBV and violence against women in the HIV response and TB response?

8.1 .If there are not, then why?

Question 9. If the country has a humanitarian crisis situation, is there a specific program to address gender-based violence and violence against women and girls? If so, please describe its relation to HIV and to TB

9.1 .If there is a program; does it offer health services to women, girls, men, boys, transgender people and specific key affected populations especially sexual and reproductive services in a humanitarian crisis situation? If so, please explain (listing supported populations).

11.5 SEXUAL AND REPRODUCTIVE HEALTH AND RIGHTS

Question 1. Does the country have a sexual and reproductive health and rights (SRHR) policy that recognizes and addresses linkages between HIV,TB/HIV, maternal/child health, and women’s health beyond their reproductive role as interlinked concerns (either as a stand-alone policy, or as part of the HIV policy)?

Question 2. Please indicate if SRHR services are equally accessible to young women, men, transgender people and other key affected population (e.g. special clinic timings, mobile units targeting specific groups, etc.)

Please provide sex and age disaggregated data where available.

2.1 Is there any indication of coercion, discrimination and/or violence while accessing commodities or health-care services for women, girls, transgender people, men, boys, or other key affected populations for HIV and TB?

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

Question 4. What are the most common gender-related barriers and challenges to accessing integrated HIV, TB and SRHR services and commodities?

4.1 How have these been identified?

4.2 How have they been addressed in the national strategy?

You have now reached the end of Step 11 of Stage 3. Please review and analyse the main gaps in addressing gender differences in HIV and TB programming, and then summarize them. Please recall both the gender issues and the contextual factors relating to the HIV epidemic, TB epidemic that were identified earlier in the *Tool*.

Step 12 • GENDER CONSIDERATIONS PER COMMUNITY

Step 12.1 WOMEN AND GIRLS

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

1.1 Does that policy effectively address any of the following issues in relation to increased HIV and TB vulnerability and hindering the use of—and access and adherence to HIV and TB 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 and health education) for women and girls
- access to financial resources (economic empowerment) for women and girls
- access to legal and/or law enforcement institutions for key affected populations, for HIV and TB, particularly to assist them with knowing and claiming their rights
- access to services to address gender-based violence
- access to social services i.e. access to nutrition support, social welfare schemes, transportation support
- equitable access to health services, including sexual and reproductive health and gender equality in household decision-making
- equitable access to MDR-TB treatment without medical detention
- gender equality in intimate relationships
- 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 behaviours

Please feel free to add any other area that is relevant in the national context.

Question 2. Does the gender policy guide the HIV and TB response in terms of recognizing and addressing both the gender aspects of the HIV and TB epidemic and the specific HIV and TB risks and vulnerabilities of women and girls (including those from key affected populations)? Please elaborate.

12.2 MEN AND BOYS

Question 1. Does the national HIV and TB and/or gender policy guide the HIV and TB response to work with men and boys in addressing gender-related cultural norms (e.g. smoking and alcohol abuse) and expectations

that may negatively impact both HIV and TB vulnerability and access/adherence to HIV and TB services?

If yes, how does it do so? Please tick the applicable boxes.

- acknowledge the stigma and discrimination from domestic and labour relations faced by many men and boys (including those from key affected populations) in various facets of life (social, economic, political and health)
- acknowledge unequal power relations between men and women, boys and girls
- address the impact of masculinity norms on key affected populations (such as men who have sex with men, the LGBT population and sex workers), in terms of health-seeking behaviour (including HIV services, risky sexual behaviour and gender-based violence)
- explore and address how concepts of masculinity can lead to increased risk of HIV for men, boys and their sexual partners for a number of reasons (including discouraging access to HIV services and encouraging risky sexual behaviour and gender-based violence)
- explore and address how concepts of masculinity can lead to increased risk of TB for men, boys and their families for a number of reasons (including discouraging access to TB services)
- promote positive forms of masculinity that encourage access to health
- understand and respect the rights of women, girls and key affected populations (such as men who have sex with men, the LGBT population and sex workers)

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

Question 2. Has this guidance resulted in national programmes or initiatives? If yes, please provide examples.

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

Step 12.3 TRANSGENDER

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

1.1 Does that policy effectively address any of the following issues in relation to increased HIV vulnerability 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 and health education) for transgender people
- access to financial resources (economic empowerment) for transgender people
- access to legal and/or law enforcement institutions for key affected populations, particularly to assist them with knowing and claiming their rights
- access to services to address gender-based violence
- access to social services i.e. access to nutrition support, social welfare schemes, transportation support
- equitable access to health services, including sexual and reproductive health and gender equality in household decision-making
- gender equality in intimate relationships
- gender equality in workplace policies
- protection against gender-based stigma and discrimination against people living with HIV or affected by TB
- transforming existing concepts of masculinity that encourage sexual risk-taking and discourage health-seeking behaviours

Please feel free to add any other area that is relevant in the national context.

Question 2. Does the gender policy guide the HIV response in terms of recognizing and addressing both the gender aspects of the HIV epidemic and the specific HIV risks and vulnerabilities of transgender people (including those from key affected populations)? Please elaborate.

Step 12.4 KEY AND VULNERABLE POPULATIONS (refer to definitions in Annex E)

Question 1. Are the specific HIV and TB risks and vulnerabilities of key affected populations recognized and addressed in the national gender policy, national HIV and TB policy or the national strategic plan on HIV and TB? If so, please explain.

Question 2. Does the HIV and TB policy guide programmes and initiatives for key affected populations? If yes, please indicate the activities by ticking the applicable box.

- address gender-based stigma and discrimination
- address gender-based violence against key affected populations
- empower key affected populations to know and claim their human rights
- reduce gender barriers to diagnosis, treatment and care

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

Step 12.5 YOUNG PEOPLE

Question 1. Does the country have a youth policy (either a stand-alone or as part of the HIV policy/TB policy)? If there is no youth-specific policy, are there regulations within the HIV and/or health framework that address the specific vulnerabilities of young people, in particular girls and young women? Please explain and describe.

Question 1.1. Does the country have a children's policy (either a stand-alone or as part of the HIV policy/TB policy)? If there is no TB and Children specific policy, are there regulations within the TB and/or health framework that address the specific vulnerabilities of children under age 15? Please explain and describe

Question 2. If yes, does the policy include guidance on any of the following issues?

Please tick the applicable boxes.

- access to condoms
- access to TB screening for children less than 15 years
- access to free TB diagnostic services for children less than 15 years, including sputum induction or gastric lavage, chest x-ray, and GeneXpert
- access to paediatric formulations of anti-TB drugs
- access to TB treatment support for children less than 15 years
- access to isoniazid preventive therapy for children of household contacts with active TB
- access to HIV counselling and testing for children less than 15 years
- access to family planning
- access to HIV prevention, care and support services
- access to HIV testing
- access to information on HIV and TB prevention, diagnosis, care and support
- access to HIV treatment
- access to information on sexual and reproductive health
- access to safe abortions access to sexual and reproductive health services
- access to sexuality education
- age of consent to access condoms
- age of marriage
 - age of treatment decision-making
 - gender equity in access
 - parental or spousal consent to medical treatment protection against gender-based violence
 - protection for different sexual preference
 - protection for multiple gender identity

- co-trimoxazole prophylaxis and isoniazid preventive therapy for children living with HIV

Question 3. How does the policy help young people protect their sexual and reproductive health, and avoid HIV transmission, gender-based violence and unwanted pregnancy? Please explain.

Question 4. Does the national HIV policy include programmes and services that specifically target the needs and rights of young key affected populations? Please explain.

Question 5. Please indicate if these programmes and services are accessible by girls, young women, boys and young men equally, including those from key affected populations.

5.1 Are young women, men and transgender people able to access HIV, SRHR services, TB services and commodities under the same conditions as any adult? Please explain.

5.2 Are there any gender barriers to their access? If so, what are they?

Step 12.6 ELDERLY/SENIOR CITIZENS

Question 1. Is there a national elderly/ senior citizen policy? If so, please indicate its name and the year it was established.

1.1 Does that policy effectively address any of the following issues in relation to HIV and/or TB vulnerability and hindering the use of—and access and adherence to HIV and/or TB services?

If yes, please tick the applicable boxes.

- easy access to financial resources (pension, income tax relief, extra interest on savings)
- access to legal and/or law enforcement institutions for elderly, particularly to assist them with knowing and claiming their rights
- access to financial support provided for Homes, Day Care Centres, Medical Vans, Help Lines etc through health insurances
- access to social services like integrated schemes, travel concession
- protection against gender-based stigma and discrimination against elderly women stemming from deep-rooted cultural and social bias
- access to special health care services for elderly women as they are more vulnerable

Please feel free to add any other area that is relevant in the national context

1.2 Does the gender policy (or senior citizen policy as referred above and their inter linkages guide the HIV and/or TB response in terms of

recognizing and addressing both the gender aspects of the HIV and/or TB epidemic and the specific HIV and/or TB risks and vulnerabilities of elderly women? Please elaborate

Question 2. Are the specific HIV and/or TB risks and vulnerabilities of the elderly recognized and addressed in the national gender policy, national HIV and/or TB policy or the national strategic plan on HIV and/or TB? If so, please explain

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 socio-cultural norms and determinants related to the HIV epidemic, TB 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 and gender responsive TB response

This stage provides guidance on how to use the findings of the gender assessment to shape and influence policy agendas. 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 post-assessment that should help the implementation of a four-prong strategy for a gender transformative HIV and gender responsive TB response. These four prongs include (1) advocacy and policy monitoring, (2) service delivery and access, (3) training and capacity building, and (4) stimulating research.

Task 1. Use your summaries from Stage 2 and Stage 3 to populate the columns of the analysis matrix below.

Table 2: Analysis matrix for the HIV/TB Gender Assessment Tool for national HIV/TB responses

Epidemiological and context analysis		Response and gaps analysis	
<u>Epidemiological data</u>	<u>Social-cultural, economic and political context</u>	<u>Current HIV/TB policy response</u>	<u>Current HIV/TB programming response</u>
<i><u>Present the summary analysis of the key gender differences in the HIV/TB epidemic</u></i>	<i><u>Present the summary analysis of the key contextual gender differences</u></i>	<i><u>Present the main gaps in addressing gender differences within national policy</u></i>	<i><u>Present the summary analysis of the key programming gaps, including those related to particular communities</u></i>
<i><u>Source: Stage 2, Step 7</u></i>	<i><u>Source: Stage 2, Steps 8 and 9</u></i>	<i><u>Source: Stage 3, Step 10</u></i>	<i><u>Source: Stage 3, Step 11 and 12</u></i>

Task 2. Interpret the data above and identify potential mismatches between epidemic, context and response, as well as gaps and opportunities in the HIV/TB response with regards to gender interventions.

Task 3. Identify priority interventions to address the identified gaps and opportunities in the HIV/TB response, and indicate how they build on promising existing interventions in the country.

You may wish to consider the following criteria when prioritizing interventions.

- Will the intervention have substantial impact?
- Will the intervention be a catalyst for change?
- Is the intervention informed by (or supported by) sound evidence and facts?
- Is the intervention viable (e.g. technically feasible)?
- Is the intervention applicable and transferable to allow scaling-up?
- Are national and international resources available to scale-up the identified interventions?
- Can this intervention be incorporated into ongoing programmes and/or be part of integrated service delivery?
- Could this action be placed on the country's policy agenda (leadership)?

The assessment team might want to add more questions for reflection.

The team should make sure that their discussion considers what gender-sensitive interventions would have the biggest effect on the HIV/TB epidemic, drawing on promising existing interventions in the country (where possible). This will help to focus on priority interventions.

There are several tools available for the identification of effective, evidence-informed gender equality interventions (Annex A).

Task 4. Prepare a brief and succinct narrative report using the summarized findings from Stages 2 and 3 and the suggested interventions identified using the *HIV/TB Gender Assessment Tool*. The narrative report should provide support for a research-informed policy decision.

Task 5. Now that priorities have been identified, develop an advocacy plan. Define strategies and activities that can support effective achievement of your priorities. This requires thinking comprehensively about what it will take to realize policy targets. Without this approach, the gender assessment team may form unrealistic expectations about what can be accomplished.

Entry points include the following:

- inclusion in the national HIV strategic plan (NSP), national TB strategic plan, national Health plan, health sector strategies, or midterm reviews of NSP;
- elaborating Global Fund concept notes, PEPFAR country plans or other resource mobilization opportunities;
- establishing a national gender plan (or similar); and
- inclusion in the UN Development Assistance Framework (UNDAF).

The advocacy plan should be based on the main findings of this *HIV/TB Gender Assessment Tool* and it must answer the following questions.

- a. Please list the goals and what needs to be done to achieve each of them.

- b. How will each be accomplished?
- c. When will they be complete?
- d. Who will perform the necessary tasks?
- e. With what means (resources) will this be accomplished? Is there a need to secure additional support?

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

- a. Identify audiences and define the ones with which to work. Consider the priorities emerging from the gender assessment process and determine the key stakeholders and populations that will need further engagement.
- b. Assess the awareness about gender-transformative actions among the target audiences.
- c. Select 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 on a gender-transformative HIV/TB response so that they are appropriate for both the media used and the intended audience (such as the Ministry of Health apparatus, the Parliament, health-care providers, law enforcement institutions or teachers).
- e. Define how the message will be disseminated, and identify the tools that will be used to do so.

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

- a. Make the money work (by making it cost-effective).
- b. Foster partnerships with civil society, other government bodies, universities, media outlets and so on.

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

- government support (country, state and city levels);
- international development and funding partners (including PEPFAR and the GFATM);
- private sector funding; and
- national and international foundations.

Task 9. Develop a gender assessment monitoring process to demonstrate the gender-transformation of the HIV/TB 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 and TB responses.

Annexes

Annex A

Gender equality and HIV/AIDS: Resources and links to tools and guidance

(a) Gender Assessment Tools

- UNAIDS. Gender assessment tool.
<http://www.unaids.org/en/targetsandcommitments/eliminatinggenderinequalities/>

(b) Gender Mainstreaming Tools

- Athena Network. NSP framework for gender equality and policy analysis tools developed/used at community level. <http://www.athenanetwork.org/ensuring-gender-equity-in-research/gendering-national-strategic-plans.html>
- PEPFAR. Updated gender equality strategy (2013).
<http://www.pepfar.gov/documents/organization/219117.pdf>
- UNDP. On course: Mainstreaming gender into national HIV strategies and plans—a roadmap.
<http://livelifeslowly.net/genderinghiv/>
UNDP. Checklist for integrating gender into the New Funding Model of the Global Fund to Fight AIDS, TB and Malaria.
<http://www.undp.org/content/dam/undp/library/HIV-AIDS/HIV%20MDGs%20and%20Development%20Planning/UNDP%20Checklist%20for%20Integrating%20Gender-WEB.pdf>

(c) Indicators

- Bloom SS, Negroustoueva S. Compendium of gender equality and HIV indicators.
<http://www.cpc.unc.edu/measure/publications/ms-13-82>
- WHO: Global TB Report 2014 http://www.who.int/tb/publications/global_report/en/
- WHO, PEPFAR, UNAIDS, The Global Fund. A guide to monitoring and evaluation for collaborative TB/HIV activities 2015 revision
http://apps.who.int/iris/bitstream/10665/150627/1/9789241508278_eng.pdf?ua=1&ua=1
- WHO, A practical tool for strengthening the gender-sensitivity of national SRH and HIV monitoring and evaluation systems.

(d) Gender and HIV

- UNAIDS. Agenda for accelerated country action for women, girls, gender equality and HIV.
http://www.unaids.org/en/media/unaid/contentassets/dataimport/pub/report/2010/jc182_5_community_brief_en.pdf
- UNFPA. The gender dimensions of the HIV/AIDS epidemic.
<http://www.unfpa.org/gender/aids.htm>
- UN Women Gender and HIV/AIDS. Main web portal. <http://www.genderandaids.org/>
- What Works for Women & Girls. Evidence-based gender-responsive interventions.
http://www.who.int/gender/hiv_aids/en/
- WHO. Engaging men and boys in changing gender-based inequity in health: Evidence from program interventions. http://www.who.int/gender/documents/Engaging_men_boys.pdf
- WHO. Linkages between sexual and reproductive health (SRH) and HIV.
<http://www.who.int/reproductive-health/hiv/index.html>

(e) Gender and TB

- Fazlul Karim¹, ^{3*}Md. Akramul Islam², AMR Chowdhury¹, Eva Johansson³ and Vinod K Diwan³ : Gender differences in delays in diagnosis and treatment of tuberculosis <http://heapol.oxfordjournals.org/content/22/5/329.full>
- Rangan, S. & Uplekar, M. (1998). Gender perspectives of access to health and tuberculosis care. In Gender and Tuberculosis (Diwan, V., Thorson, A. and Winkvist, A., eds.), The Nordic School of Public Health, Göteborg.
- Tackling TB and HIV in woman :an urgent agenda (The global Coalition on Women and AIDS) <http://www.womenandaids.net/CMSPages/GetFile.aspx?guid=aeee44f9-9a9d-4366-9ee4-89e4775cc798>
- Uplekar, M., Rangan S., Weiss, M.G., Ogden, J. Attention to gender issues in tuberculosis control. Int. J. Tuberc. Lung. Dis. 5(3):1-5. 2001 IUATLD.2001
- Borgdorff, M.W., Nagelkerke, N.J., Dye, C. & Nunn, P. (2000). Gender and tuberculosis: a comparison of prevalence surveys with notification data to explore sex differences in case detection. Int.J.Tuberc.Lung Dis. 4, 123-132. 2000
- Holmes, C.B., Hausler H. and Nunn P. A review of sex differences in the epidemiology of tuberculosis <http://www.ncbi.nlm.nih.gov/pubmed/9562118?dopt=Abstract> Int J Tuberc Lung Dis 1998 Feb;2(2):96-104. 1998
- Uplekar, M., Rangan, S., Ogden, J. Gender and Tuberculosis Control: Towards a strategy for research and action. [WHO/CDS/TB/2000.280](http://www.who.int/cds/tb/2000.280) : 2000
- Borgdorff, M. (1999). Gender and TB in Bangladesh: evidence for gender bias in TB case detection and proposals for further study. WHO/CDS/CPC/TB/99.266. 1999

(f) Gender and Violence

- AIDSTAR-One. Resources for the clinical management of children and adolescents who have experienced sexual violence. http://www.aidstar-one.com/focus_areas/gender/resources/prc_technical_considerations
- AIDSTAR-Two. Technical paper: Review of training and programming resources on gender-based violence against key populations. http://www.aidstar-two.org/upload/AIDSTAR-Two_Tech-Paper-Rev-Resources-GBV-Against-Key-Populations-FINAL-09-30-13.pdf
- UNAIDS. Unite with women Unite against violence and HIV. http://www.unaids.org/en/resources/documents/2014/name_91776,en.asp
- UNWomen. Virtual knowledge centre to end violence against women and girls. www.endvawnow.org
- Women's HealthVictoria; Durey R. Working Together Against Violence Final Project Report. Melbourne: 2011 [cited 24 October 2011]. Available from: http://whv.org.au/static/files/assets/8b4e9b75/Working_Together_Against_Violence_final_projectreport.pdf.
- WHO. 16 Ideas for addressing violence against women in the context of the HIV epidemic. http://www.who.int/reproductivehealth/publications/violence/vaw_hiv_epidemic/en/index.html
- WHO. Responding to intimate partner violence and sexual violence against women: WHO Clinical and policy guidelines. <http://www.who.int/reproductivehealth/publications/violence/9789241548595/en/>

Annex B

Model Terms of Reference for the country assessment team supporting the undertaking of the gender assessment of the national HIV/TB response

I. About the *Gender assessment tool for national TB/HIV responses*

The *Gender assessment tool for national HIV/TB responses* (hereinafter referred to as the *HIV/TB Gender Assessment Tool*) is a structured set of guidelines and questions that can be used to guide and support the process of analysing the extent to which national responses to *HIV/TB* in both generalized and concentrated epidemics—take into account the critical goal of gender equality. The *HIV/TB Gender Assessment Tool* has been adapted from the *UNAIDS gender assessment tool for national HIV responses*, which was developed with inputs from an expert Reference Group comprised of members from across the globe and from government, UN agencies and civil society organizations.

The *HIV/TB Gender Assessment Tool* is a planned, systematic and deliberate set of steps and processes that examine and question the status of the HIV response and TB response (plans and actions undertaken by national governments to address HIV and TB) with specific reference to its gender dimensions (the socially constructed roles, behaviours, activities and attributes that a given society considers appropriate for women and men, transgender people including members of key affected populations). Through the use of the *HIV/TB Gender Assessment Tool* we can learn the extent to which the national response recognizes gender inequality as a key determinant of HIV and TB and then acts upon that recognition. This will help us to ensure that gender equality is a goal of the national response to HIV and TB.

The gender assessment process of an HIV and TB response involves:

- knowing your HIV and TB epidemic and country context from a gender perspective;
- knowing your country response from a gender perspective; and
- using the findings of the gender assessment to identify evidence-based gender-sensitive interventions to strengthen the HIV and TB response.

The *HIV/TB Gender Assessment Tool* can be used by individuals and partners in government, civil society, the United Nations and other multilateral agencies to support key national processes, such as the development or review of a National Strategic Plan on HIV and TB, a Global Fund proposal, or another opportunity that has been identified in country. It is envisaged that a gender assessment should be nationally led.

II. Scope of the country assessment team

The country assessment team should be composed of government representatives, experts on HIV and TB policies and services, experts on gender policies and services, and stakeholders from the fields of HIV and TB and gender. The stakeholders should include government, civil society representatives including a representative from affected communities, relevant bilateral agencies, and UN agencies. As appropriate, stakeholders also can include those from key sectors, including health, education, gender, justice, human rights and finance.

Particular care should be taken to ensure the meaningful involvement of people living with HIV and TB affected communities at all stages, including in the country assessment team. Enabling their participation while ensuring their travel and per diem is being addressed. Also, please note that it is important to ensure country ownership and leadership of the entire process high-level government representatives should lead the process.

Civil society organizations working on gender, women's rights, youth, key affected 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.

The role of team member is voluntary and non-remunerated.

The team will be expected to closely familiarize itself with the *HIV/TB Gender Assessment Tool* and related materials. Online sessions (using WebEx, Skype et al.) are planned to help team members familiarize themselves with the *HIV/TB Gender Assessment Tool* prior to the assessment; all team members are 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 a number of key tasks.

1. Develop a gender assessment framework, including the following:
 - agreeing on the final goal of the gender assessment;
 - deciding on its guiding principles and methods of monitoring the application of these principles;
 - developing a communication plan; and
 - developing a resource plan.
2. Collect, collate and store relevant documents and data.
3. Use data previously collected to answer the different questions present in Stages 2 and 3 of the *HIV/TB Gender Assessment Tool*
4. Analyse and use the findings, drawing on the gender assessment to identify the gaps and opportunities in the HIV response and to establish evidence-based interventions, such as:
 - defining priorities and identifying key interventions to respond to the gaps;

-
- developing an advocacy plan to disseminate and use the findings of the gender assessment; and
 - preparing a report that summarizes the analysis of the HIV and TB epidemic and the data on the context, the current HIV and TB response, and the prevention programmes and initiatives (such as HIV and TB treatment, care and support from a gender perspective).

A workshop to analyse and use the findings is part of the gender assessment process. The workshop length typically lasts three days, with the core team meeting the day before in order to prepare and staying the day after to debrief and decide on the next steps.

Members

Name:

Organization:

_____	_____
_____	_____
_____	_____

Terms of Reference for consultancy for the undertaking of a gender assessment of the national HIV and TB response

About the Gender assessment tool for national HIV and TB responses

The *Gender assessment tool for national HIV and TB responses* (hereinafter referred to as the *HIV/TB Gender Assessment Tool*) is a structured set of guidelines and questions that can be used to guide and support the process of analysing the extent to which national responses to HIV and TB in both generalized and concentrated epidemics take into account the critical goal of gender equality. The *HIV/TB Gender Assessment Tool* has been developed by UNAIDS and Stop TB Partnership, which convened an expert Reference Group comprised of members from across the globe and from government, UN agencies and civil society organizations, to guide its development.

The *HIV/TB Gender Assessment Tool* is a planned, systematic and deliberate set of steps and processes that examine and question the status of the HIV and TB response (plans and actions undertaken by national governments to address HIV and TB) with specific reference to its gender dimensions (the socially constructed roles, behaviours, activities and attributes that a given society considers appropriate for women and men, including members of key affected populations). Through the use of the *HIV/TB Gender Assessment Tool* we can learn the extent to which the national response recognizes gender inequality as a key determinant of HIV and TB and then acts upon that recognition. This will help us to ensure that gender equality is a goal of the national response to HIV and TB

The gender assessment process of an HIV and TB response involves:

- knowing your HIV and TB epidemic and country context from a gender perspective;
- knowing your country response from a gender perspective; and
- using the findings of the gender assessment to identify evidence based gender-transformative interventions to strengthen the HIV and TB response.

Individuals and partners in government, civil society, the United Nations and other multilateral agencies can use the *HIV/TB Gender Assessment Tool*.

Scope of the consultancy

Consultants will be expected to closely familiarize themselves with the *HIV/TB Gender Assessment Tool* and related materials (including but not limited to the online presentations).

In close collaboration with UNAIDS/TBP, the consultant will undertake the following:

- onsite meetings with various stakeholders and delivery of the first session (date and time _____)
- preparation and delivery of a second online session (date and time ____)
- preparation and delivery of a third online session (date and time ____)
- support to the development of the gender assessment workshop and co-facilitation, along with a national consultant (date and time _____)
- support to the development of the gender assessment report, along with a national consultant and UNAIDS/TBP.

Timeline

The consultancy will take place from _____ to _____.

In agreement,

Signatures _____
 Institutional team leaders Consultant

City and date: _____, _____.

Annex D

Gender Assessment Sample Workshop Agenda

Objectives of the gender assessment workshop

1. Complement information used to reply to the *HIV/TB Gender Assessment Tool*
 2. Validate replies of Stages 2 and 3 of the *HIV/TB Gender Assessment Tool*
 3. Build Stage 4 (identify interventions, design strategies)
-

Day One

- 9:00** Welcome
- Official remarks from authorities: UNAIDS, National HIV/TB Programme, Health Ministry, Gender Department or Commission and community representative/s
- Quick overview of the gender assessment
- 10:00** National HIV and TB Programme presentation
- the National Strategic Plan for HIV / AIDS and National Strategic Plan for TB
 - question and answer period
- 10:30** Tea and coffee break
- 10:45** Laying out a strategy for the workshop (facilitator presentation)
- 11:00** Reacting to the answers to the *HIV/TB Gender Assessment Tool*
- Stage 2: Discussing the HIV/TB epidemic and context
- 12:30** Lunch break
- 14:00** Reacting to the answers to the *HIV/TB Gender Assessment Tool*
- Stage 3: Discussing the country response to HIV/TB
- 16:00** Tea and coffee break
- 16:20** Reacting to the country HIV/TB response
- Stage 3 (continued)
- 18:00** End of the day

Day Two

- 9:00** Quick evaluation of first day of work
- 9:20** Continue to react to the country HIV/TB response
- Stage 3 (continued)
- 10:30** Tea and coffee break
- 10:50** Continue to react to the country HIV/TB response
- Stage 3 (continued)
- 12:30** Lunch break (re-arrange 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** Tea and coffee 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 the day (summary of things to keep in mind for Stage 4)

Day Three

9:00 Stage 4

- planning (filling in the matrix of gaps and opportunities)
- defining a priority list

10:30 Tea and coffee break

10:45 Brainstorming and filling up the priorities matrix

12:30 Lunch

13:30 Key gaps and priorities based on the findings of the gender assessment

15:15 Tea and coffee break

15:30 Identifying next steps to integrate the findings in key national processes

16:30 Roles and responsibilities in follow-up

17:50 Acknowledgments and closing remarks



Annex E

Guiding terminology

For the purpose of the gender assessment guiding terminology is enclosed below, drawn principally from the UNAIDS Terminology Guidelines and WHO Global TB Report, unless otherwise indicated.

Caregiver or carer: Caregivers or carers are people who provide unpaid care by looking after a person living with or affected by HIV and/or TB.

Case notification rate: refers to new and recurrent episodes of TB notified to WHO for a given year, expressed per 100 000 population.

Close contact of TB affected: A person who is not in the household but who shared an enclosed space, such as a social gathering place, workplace, or facility, with the index case for extended daytime periods during the 3 months before the start of the current treatment episode.

Comprehensive HIV prevention, treatment, care, and support: Comprehensive HIV prevention, treatment, care, and support³⁰ 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, and respect for human rights and protective legal provisions and access to justice. HIV Care and Support require a comprehensive set of services including psychosocial, physical, social economic, nutritional and legal care and support. These services are crucial to the wellbeing and survival of people living with HIV and their care-givers as well as orphans and vulnerable children. Care and support services are needed from point of HIV diagnosis regardless of the ability to access ART.

Comprehensive sexuality education: Sexuality Education³¹ is defined as an age-appropriate, culturally relevant approach to teaching about sex and relationships by providing scientifically accurate, realistic, non-judgmental 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 comprehensive³² 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.

Discrimination against women³³: 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.

Empowerment: Empowerment is action taken by people to overcome the obstacles of structural inequality that have previously placed them in a disadvantaged position. Social and economic empowerment is a goal and a process aimed at mobilising 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 level.

³⁰ UNAIDS 2011-2015 Strategy: Getting to Zero, Joint United Nations program on HIV/AIDS (UNAIDS) 2010.

³¹ International Technical Guidance on Sexuality Education – Volume I, published by UNESCO in 2009 together with UNAIDS, UNFPA, UNICEF and WHO

³² IPPF's framework *From evidence to action: Advocating for comprehensive sexuality education*, p3

³³ [Convention on the Elimination of All Forms of Discrimination against Women – CEDAW, article 1, http://www.un.org/womenwatch/daw/cedaw/cedaw.htm](http://www.un.org/womenwatch/daw/cedaw/cedaw.htm)

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

Gender-based violence: It describes 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 persons because they don’t conform to or challenge prevailing gender norms and expectations (e.g. may have feminine appearance) or heterosexual norms. (WHO, http://apps.who.int/iris/bitstream/10665/95156/1/9789241506533_eng.pdf)

Gender equality: Gender equality, or equality between men and women, entails 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 is a recognized human right. It means that the different behaviours, aspirations, and needs of women and men are considered, valued, and favoured equally. It signifies that there is no discrimination on the grounds of a person’s gender in the allocation of resources or benefits, or in access to services. Gender equality may be measured in terms of whether there is equality of opportunity or equality of results.

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

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

Key Populations (KPs) in TB: In TB we can consider KP’s **under three distinct groups:**

1. People who have increased exposure to TB bacilli (due to where they live or work – overcrowding, poor ventilation)

Health Care Workers who may be exposed to TB bacilli through their day to day work of delivering care and support to people living with TB.

Contacts of TB patients (in households) are at increased risk of exposure because they might be the primary carer or living in a household prior to a family member being diagnosed. Contacts in workplaces or educational facilities are vulnerable both prior to a TB patient being diagnosed and during the early stages of treatment of TB patients in their environment.

Incarcerated people (prisoners) and staff working in correctional facilities are particularly vulnerable to TB because of the overcrowded nature of correctional facilities and the, very often, low standard of living conditions. Miners, peri-mining or mining-affected population, Slum dwellers in urban settings and people living in hostels are at risk of increased exposure

to TB bacilli for a range of reasons including poor living and sanitary conditions, poor ventilation, overcrowding, malnourishment etc.

2. People who have limited access to health services (due to gender, geography, limited mobility, limited financial capacity, legal status, stigma)

- Women and children in settings of poverty: Women suffer disproportionately the consequences of TB, and children, especially young children, could suffer from severe and fatal varieties of TB.
- Remote populations, deep sea fishermen, because geography and working lives limit access to health services, while those with limited mobility, the elderly and people living with physical or mental disabilities may not have anyone to help support and supervise their attendance at health services.
- Homeless, migrants, refugees and internally displaced people and Indigenous peoples and ethnic minorities often suffer increased stigmatisation and legal status problems making it difficult to access health services.
- Prisoners living in unhygienic conditions and overcrowded spaces increases transmission of TB infection. Especially vulnerable are female prisoners.
- Sex workers people who use drugs, men who have sex with men and victims of sex trafficking, are often outside of the law, which can be a major obstacle to accessing health services.

Many of these population groups benefit from community support and therefore it is important to understand what communities do in the context of the TB response.

3. People at increased risk of TB because of biological and behavioural factors that compromise immune function

- People living with HIV and those with other health conditions that decrease immunity for example those on long term therapeutic steroids, those on immune suppressant treatment and people who are malnourished are vulnerable to TB because their compromised immune systems are less able to fight infections.
- People with pre-existing medical conditions such as Diabetes, Silicosis and other dust related lung disorders are also particularly at risk and less able to fight exposure to TB.
- Certain lifestyle activities which compromise immunity include those who smoke and people who consume high quantities of alcohol (over 40gm or 50mL per day), people who use drugs, increasing their risk of TB infection.

TB Infection or LTBI: Infection with Mycobacterium tuberculosis may occur following exposure to a TB case and means that the person carries the bacteria inside the body. Many people have TB infection and remain well, while others develop disease. When infection has occurred but the infected individual is showing no signs or symptoms of disease from the standpoint of clinical recognition or diagnostic detection, the term “latent is often used.

Intimate partner violence (IPV)³⁴: Behaviour within an intimate relationship that causes physical, sexual or psychological harm, including acts of physical aggression, sexual coercion, psychological abuse and controlling behaviours. It is one of the most common forms of violence against women.

Masculinities³⁵: 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

³⁴ http://www.who.int/violence_injury_prevention/violence/world_report/factsheets/en/ipvfacts.pdf

³⁵ UNICEF, Masculinities: Male Roles and Male Involvement in the Promotion of Gender Equality - A Resource Packet, p. 5, http://www.unicef.org/emergencies/files/male_roles.pdf

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.

Men who have sex with men: The term *men who have sex with men* describes males who have sex with males, regardless of whether or not they have sex with women or have a personal or social gay or bisexual identity. This concept is useful because it also includes men who self-identify as heterosexual but have sex with other men.

Preventive therapy TB: Treatment offered to contacts who are considered to be at risk of developing TB disease following exposure to a possible source in order to reduce that risk. While this treatment is called “preventive therapy” by convention, it is actually treatment for latent TB infection.

Reproductive health³⁶: Reproductive health is a state of complete physical, mental and social wellbeing and not merely the absence of disease or infirmity, in all matters relating to the reproductive system and to its functions and processes. It implies that people are able to have a satisfying and safe sex life and that they have the capability to reproduce and the freedom to decide if, when and how often to do so. Implicit in this last condition are the right of men and women to be informed and to have access to safe, effective, affordable and acceptable methods of family planning of their choice, as well as other methods of their choice for regulation of fertility that are not against the law, and the right of access to appropriate health-care services that will enable women to go safely through pregnancy and childbirth and provide couples with the best chance of having a healthy infant.

Reproductive rights³⁷: Reproductive rights embrace certain human rights that are already recognized in national laws, international human rights documents and other consensus documents. These rights rest on the recognition of the basic right of all couples and individuals to decide freely and responsibly the number, spacing and timing of their children and to have the information and means to do so, and the right to attain the highest standard of sexual and reproductive health. It also includes their right to make decisions concerning reproduction free of discrimination, coercion and violence, as expressed in human rights documents. In the exercise of this right, they should take into account the needs of their living and future children and their responsibilities towards the community.

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

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

³⁶ Programme of action of the ICPD Development, chap. VII, sect. A, para. 7.2; Report of the International Conference on Population and Development, Cairo, 5-13 September 1994, (United Nations publication, Sales No. E.95.XIII.18), chap. I, resolution 1, annex)

³⁷ Programme of action of the ICPD Development, chap. VII, sect. A, para. 7.2; Report of the International Conference on Population and Development, Cairo, 5-13 September 1994, (United Nations publication, Sales No. E.95.XIII.18), chap. I, resolution 1, annex

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

Violence against women (VAW)³⁸: 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 with 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.

³⁸ Declaration on the Elimination of Violence Against Women, art. 1, <http://www.un.org/documents/ga/res/48/a48r104.htm>



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