The Global Fund

ADDRESSING GENDER INEQUALITIES AND STRENGTHENING RESPONSES FOR WOMEN AND GIRLS
INFORMATION NOTE

Introduction

Gender inequalities are a major driver of the HIV and tuberculosis epidemics, and they hinder effective responses to malaria. Programs must pay close attention to how these inequalities impact human rights, health and well-being.[1] The Gender Equality Strategy, adopted by the Global Fund Board in 2008, reaffirms the Fund's commitment to addressing the social, legal, cultural and biological issues that underpin gender inequality and contribute to poor health outcomes. The strategy encourages activities that address gender inequalities and strengthen the response to fulfil the right to health of women and girls in all their diversity, as well as men and boys. This includes paying particular attention to the rights of key affected women[2], including transgender people. While the Gender Equality Strategy focuses mainly on addressing specific needs and rights of women and girls, the Global Fund's Sexual Orientation and Gender Identities (SOGI) Strategy (2009) also captures a number of key gender-related issues especially from perspectives of key populations.

The Global Fund has transformed the process for countries to access funding and considerably strengthened its commitment to ensure that the new funding model requirements include a strong focus on gender, community responses and human rights. The Global Fund's strategy is to invest for impact by focusing on high-impact countries, interventions and populations, while also recognizing that strategic, high-impact, gender-responsive investments will prevent new cases of HIV, TB and malaria and save lives. Numerous opportunities exist to ensure that all grants adequately address the needs of women and girls in their all diversity, as well as promoting gender equality. Countries requesting funding must examine the gender dynamics within the epidemic and identify any existing gaps in the response. They are strongly encouraged to use their Global Fund grants to fill those gaps and can access financial and technical support to build capacity to design and implement gender-responsive programming.

The purpose of this information note is to provide guidance for applicants to ensure gender equality and the particular issues faced by women and girls in all their diversity are addressed in the development and implementation of Global Fund supported grants. Those seeking Global Fund resources are also

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[1] The Gender Equality Strategy, Global Fund for AIDS, TB and Malaria, p. 4

[2] Key affected women include transgender women, and women and girls who work as sex workers and/or inject drugs, and women living with HIV or tuberculosis.

encouraged to consult the Resources and Guidance at the end of this document for additional guidance on the development of concept notes, which are the basis for funding applications under the new funding model. Of particular relevance is the [Checklist for Integrating Gender into the New Funding Model of the Global Fund to Fight AIDS, TB and Malaria](#) (UNDP, 2013) for step-by-step guidance to ensure integrating gender considerations into the new funding model process.

How do gender inequality and gender norms impact HIV, tuberculosis and malaria?

Societal expectations of what is appropriate behavior for men and women affect health outcomes. Gender norms reflect a society's expectations of appropriate roles and behavior for women and men, girls and boys. These norms can change over time and they vary across cultures, but they very often create health vulnerabilities for both women and men. On the one hand, women do not enjoy the same rights, opportunities, and access to services as men, placing them at a greater risk and at a disadvantage with respect to treatment and care. Their access in many contexts is determined or controlled by men as heads of households with greater cultural and economic power. On the other hand, male gender norms in many contexts mean that men are often under pressure to avoid behaviors that are considered "unmanly," which encourages risk-taking behavior and discourages health-seeking or other positive health behaviors that may be perceived as weak or "feminine". Gender norms are particularly harmful to people who are not perceived to be adhering to traditional gender identities or roles, including transgender people; they often experience additional types of stigma and exclusion.

Gender inequalities, which are often enforced through legal and policy frameworks that are discriminatory against women and girls, cut across all three diseases and can impact health risks, health-seeking behavior and responses from health systems, leading to poorer health outcomes for everyone. Countries seeking Global Fund funding are required address the different needs of women and men in all their diversity in their applications. They can do this through gender-responsive programming: that is, programs and interventions that take gender into account by either adapting to prevailing gender norms to achieve health impacts (a gender-sensitive approach) or working to change harmful gender norms that are drivers of negative health outcomes (a gender-transformative approach).[3] It is up to countries to choose the mix of approaches that is most appropriate to their specific epidemiological and social context.

HIV: Women and girls in all their diversity experience an increased biological vulnerability to HIV, and are disproportionately exposed to violence and other forms of gender oppression that increase HIV risk. Women make up 52% of all adults living with HIV globally and 57% in sub-Saharan Africa.[4] Women and girls' vulnerability to HIV stems from a greater biological risk that is compounded by gender inequalities.[5] Approximately two-thirds of new cases of HIV in adolescents aged 15 to 19 were among girls.[6] A recent WHO report noted that one in three women worldwide have experienced either physical and/or sexual violence, and women who have experienced intimate partner violence were 50% more likely to have acquired HIV than women who have not experienced violence.[7] Key affected women including sex workers and transgender women are particularly at risk of violence. In addition, there is strong evidence that women who are most vulnerable to and affected by HIV are also more likely to be victims of

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[3] Exact definitions of these and other terms can be found in the Gender Equality Strategy, p. 17-18.
[4] UNAIDS. 2013. Report on the Global AIDS Epidemic. Geneva: Joint United Nations Programme on HIV/AIDS: http://www.unaids.org/en/media/unaids/contentassets/documents/epidemiology/2013/gr2013/UNAIDS_Global_Report_2013_en.pdf
[5] UNAIDS, 2013.
[6] UNICEF. 2013. Towards an AIDS-Free Generation. Children and AIDS Sixth Stocktaking Report.
[7] WHO, LSHTM and South African Medical Research Council. 2013. Global and Regional Estimates of Violence against Women.

violence. Furthermore, women who are affected by violence often face barriers in accessing health care services and support for HIV and gender based violence[8].

Gender norms and power dynamics that encourage multiple partnerships among men and submissiveness among women also put women and girls at greater risk of HIV. Additional drivers include unequal access to economic opportunities and lower levels of education and knowledge; in some societies male partners exercise considerable control over whether and how women can access health services, which also limits this access.

Gender inequalities and norms also substantially increase the risks faced by key affected women. In low and middle income countries worldwide it is estimated that female sex workers have over 13 times the odds of having HIV than the general population[9]. Transgender women are particularly vulnerable to HIV, having almost 50 times the odds of having HIV than the general population worldwide[10]. Similarly, women who inject drugs are at higher risk of HIV compared to men who use drugs[11]. Key affected women, in addition, are more likely to face stigma and to be discriminated against by health service providers and in some contexts are criminalized, creating further barriers to accessing health services.

Tuberculosis: Tuberculosis is one of the main causes of mortality for women of reproductive age in low income countries.[12] TB and HIV co-infection increases women's health risks: women living with HIV are highly susceptible to developing active TB during pregnancy or soon after delivery, making TB a leading cause of death during pregnancy and delivery, and thereafter. TB may also cause infertility, compounding the stigma faced by women living with TB, and is also associated with an increased risk of mother to child transmission of HIV[13]. In southern Africa, the region with the highest global HIV prevalence, women aged 15-24 have rates of TB 1.5-2 times greater than men of the same age, and the pattern is consistent across each of the countries in the region,[14]. These estimates are not always reliable since many countries do not report data that is disaggregated by sex[15]. There is no uniform pattern when it comes to TB: in some countries, men have better outcomes than women for TB enrollment, treatment and cure rates, while in other countries it is women who do.[16] Economic barriers and stigma against women with TB[17] hinder women's ability to access treatment and care. Other gender-specific issues include, for example, a lack of childcare services for women who may not be able to adhere to treatment if they have no one to watch their children while they access services; conversely women affected by drug-resistant

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[8] UNAIDS, 2014. Unite with women – Unite against violence and HIV.
http://www.unaids.org/en/resources/documents/2014/name,91776,en.asp

[9] Baral, et al. 2012. "Burden of HIV among female sex workers in low-income and middle-income countries: a systematic review and meta-analysis". *Lancet Infectious Diseases* 12(7).

[10] Baral, et al. 2013. "Worldwide burden of HIV in transgender women: a systematic review and meta-analysis". *Lancet Infectious Diseases* 13(3).

[11] Des Jarlais, et al 2012. "Are females who inject drugs at higher risk for HIV inection than males who inject drug: an international systematic review of high seroprevalence areas". *Drug Alcohol Depend* (124).

[12] World Health Organization 2013. Women's health: Fact sheet No334. http://www.who.int/mediacentre/factsheets/fs334/en/

[13] World Health Organization 2013. Tuberculosis in Women.
http://www.who.int/tb/publications/tb_women_factsheet_251013.pdf

[14] Deluca et al., 2009 cited in Smart, T. 2012. "TB, HIV, Mothers, and Children: Time for Action." HIV & AIDS Treatment in Practice 188: 2-10.

[15] Smart, T. 2012. "TB, HIV, Mothers, and Children: Time for Action." HIV & AIDS Treatment in Practice 188: 2-10, p. 3.

[16] Feng J, Huang et al.. 2012. Gender Differences in Treatment Outcomes of Tuberculosis Patients in Taiwan: A Prospective Observational Study. Clin Microbiol Infect 18 (9): E331-7; Jurvec-Savicevic A et al. 2013. Health System Delay in Pulmonary Tuberculosis Treatment in a Country with an Intermediate Burden of Tuberculosis: A Cross-Sectional Study. BMC Public Health 13: 250.

[17] Onifade, D. A. Bayer and C. Evans. 2010. Gender-related Factors Influencing Tuberculosis in Shantytowns: A Qualitative Study. BMC Public Health 10: 381.

forms of TB are often separated from their children for the duration of treatment, a major problem given the primary role women play in child care in many societies[18].

Malaria: An estimated 207 million cases of malaria occurred between 2011 and 2012 worldwide, with an estimated 627,000 deaths in 2012.[19] Women and girls are at particular risk for malaria during pregnancy with an associated increased risk of death or adverse birth outcomes.[20] Malaria and HIV co-infection is also of special concern for pregnant women – particularly in areas with unstable rates of malaria transmission where there is little acquired immunity.[21] Gender norms can impede women's ability to protect themselves from malaria in multiple ways. Traditional power dynamics among couples may make women not be able to utilize insecticide treated nets (ITNs), to receive antenatal care, or to take their malaria-stricken children to health services without their partner's permission. Reaching pregnant women and girls with health interventions including provision of intermittent preventive therapy (IPTp) for malaria can be effectively accomplished during multiple visits to antenatal care (ANC).[22] However, globally, between 2005 and 2010, though 81% of women received ANC at least once during pregnancy, only 55% attended the WHO-recommended four ANC visits.[23] Economic barriers can also prevent pregnant women from accessing IPTp when services require that women purchase IPTp or water to take IPTp[24] or transport to ANC services. While malaria is most deadly for pregnant women, men also suffer from malaria and are at higher risk if they work in mines, fields or forests at peak biting times. Health services that are only available during working hours and/or gender norms that discourage men from seeking health services in the first place can hinder men's access to timely treatment.

What is the Global Fund doing to address gender inequality and strengthen responses for women and girls?
The Global Fund promotes equitable and rights-based approaches to health as core principles and therefore recognizes that some population groups – such as women and girls, and in particular key affected women – require explicit attention. The Global Fund supports multiple approaches to achieve equality including: targeted services addressing rights and health needs of women and girls; community systems strengthening to support and mobilize community demand; and interventions to address socio-cultural and behavioral risk factors including harmful gender norms. Based on the Global Fund's Gender Equality Strategy, the Global Fund promotes programs and seeks proposals that scale up services and interventions that reduce gender-related risks and vulnerabilities to the three diseases and address structural inequalities and discrimination to improve the health and lives of all women and men.

Key steps to successfully integrating interventions addressing gender inequality and enabling a stronger response for women in all their diversity in Global Fund programs

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[18] Onifade et al., 2010

[19] World Health Organization. 2013. WHO Global Malaria Programme: World Malaria Report 2013. Geneva, Switzerland: www.who.int

[20] Pell C, Straus L, Andrew E, A. Menaca and R Pool. Social and Cultural Factors Affecting Uptake of Interventions for Malaria in Pregnancy: A Systematic Review of the Qualitative Research. PLoS One 2011 6 (7): e22452. http://www.mip-consortium.org/

[21] Gay, J., Croce-Galis, M., Hardee, K. 2012.*What Works for Women and Girls: Evidence for HIV/AIDS Interventions.*2nd edition. Washington DC: Futures Group, Health Policy Project. www.whatworksforwomen.org

[22] Hill, J., J. Hoyt, A. van Eijk, L. D'Mello-Guyett, F. ter Kuile, R. Skeketee, H. Smith and J. Webster. 2013. Factors affecting the Delivery, Access and Use of Interventions to Prevent Malaria in Pregnancy in Sub-Saharan Africa: A Systematic Review and Meta-Analysis. PLOS Medicine 10: 7, e10011488. http://www.mip-consortium.org/

[23] World Health Organization. 2013a. Monitoring the achievement of the health-related Millennium Development Goals. Executive Board, 132 Session, EB132/11, January 11.

[24] Mubayzi et al., 2010 cited in Hill et al., 2013

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This section provides detailed information on the steps to address gender inequality and to ensure strong responses for women in all their diversity in Global Fund programs, starting with the development of concept notes. Gender analysis and action should be incorporated throughout the grant development and implementation process, including: ensuring country coordinating mechanisms (CCMs) are endowed with strong gender expertise; carrying out gender assessments to identify programming gaps; ensuring gender-responsive programs are incorporated into national strategic plans (NSP) and concept notes, ensuring meaningful engagement of women, girls and key populations (including key affected women)[25] in country dialogues; integrating gender equality indicators in monitoring and evaluation to ensure gender-responsive programming is retained and measured; and following up on the outcomes of these steps.

Further information on the New Funding Model process, is available on the Global Fund website: http://www.theglobalfund.org/en/about/grantmanagement/fundingmodel/

Country dialogue and the role of CCMs
Ensuring that Global Fund programs are addressing gender inequality begins with the country dialogue. The country dialogue is the term used to refer to the ongoing process that occurs at country level to develop health strategies to fight AIDS, tuberculosis and malaria and to strengthen health and community systems. This approach is particularly important since it gives broad opportunities for women refer to the ongoing process that occurs at country level to develop health strategies and programs.

Meaningful engagement of women and girls in all their diversity is vitally important to ensure that all voices are heard and that proposed interventions meet the needs of those most affected by the three diseases. Networks and organizations advocating for rights of women and girls in all their diversity, including women directly affected by the diseases and other key affected women, are encouraged to proactively meet to identify unmet needs in their communities, priorities and principles for the country application, and then present the recommendations formally to the Country Coordinating Mechanism (CCM) and other stakeholders involved in the overall country dialogue.

To ensure meaningful involvement it is necessary to make sure that key affected women can participate safely, without fear of abuse, stigma or arrest, particularly if they come from criminalized or marginalized groups. This might involve creating safe consultation spaces for key affected women, as well as young women in Sub-Saharan Africa who are extremely vulnerable to, living with, or born with HIV, to anonymously participate in dialogues. Virtual or online platforms could also be considered.

CCMs are responsible for the development and submission of concept notes and for the oversight of grants through transparent and documented processes. They are also required to show evidence of membership of those living with, affected by, or representing those living with the three diseases, as well as key populations, and should have balanced representation of men and women.[26] By January 2015, CCMs have to have at least 30% female membership in order to be in full compliance of the Global Fund eligibility requirements, or at least 15% female membership with at least one designated female representative with expertise in gender issues who represents women's organizations in order to be

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[25] Key populations include groups that have a higher epidemiological impact of a disease, combined with lower access to services, and who belong to sub-populations that are criminalized or marginalized.
[26] CCM Requirements Guidelines, p. 13

eligible for funding[27]. However, a Global Fund analysis of CCMs in the third quarter of 2012 found that, almost one third of CCMs (37 CCMs across the world) have less than 30% of female membership.

CCMs should also possess strong expertise on gender and integrate this knowledge to create an effective response to the three diseases.[28] The Global Fund considers all members of CCMs to be equal partners and strongly supports the inclusion of organizations with specific gender expertise, including women's organizations and groups of women living with HIV, TB and those affected by malaria, ministry of women/gender, as well as representatives of organizations working on women's rights. The CCM requirements for key population representation also extend to the representation of key affected women. CCMs may request funds (CCM Funding) for technical assistance for capacity development and training to ensure that applications effectively address gender.[29] CCMs can also benefit from gender related training and capacities provided by a number of technical partners available at country level.

Gender Assessment Process

A robust analysis of the constraints imposed by prevailing gender norms is an essential first step in devising gender-responsive interventions for inclusion in concept notes to be submitted under the new funding model. In doing so it is important to consider the specific needs of women and girls and the effects of the social and structural environment with respect to violence, legal and policy frameworks, education, employment, income and livelihood opportunities, and stigma and discrimination that affect women's access to services.[30] The following steps and key questions are adapted from the UNAIDS Gender Assessment Tool for National HIV Responses (UNAIDS, forthcoming in 2014, draft available from UNAIDS country offices upon request) but many of the questions are useful for reviewing TB and malaria programs as well.

1. *Know the epidemic and context*

Use the available evidence to understand what groups of women and girls face barriers to accessing services, and to identify situations where men and boys face particular barriers. Sex- and age-disaggregated data is critically useful in analyzing the situation and efforts to collect such data are necessary for a comprehensive gender equitable response. While epidemiological studies and program statistics are an important source of numerical data, they are not always disaggregated by sex and even less often identify the specific issues relating to key affected women. It is therefore also important to use qualitative data based on anthropological or sociological methods, where appropriate, to add depth to the analysis of the epidemic and context.

> *Selected key questions[31] to consider:*
> - What is the disease prevalence rate, disaggregated by sex and age, in the general population as well as key

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[27] Throughout the year 2014, a 30 percent female membership on each Country Coordinating Mechanism will continue to be a minimum standard; as of 1 January 2015, it will become a requirement. For countries that do not meet the 30 percent requirement, the Country Coordinating Mechanism Performance Assessment Tool offers the option of complying with the requirement through (1) a 15-29 percent rate of female members, as well as (2) "clear evidence of efforts being made by the Country Coordinating Mechanism to ensure an active voice for women, through (3) a designated female representative with expertise in gender issues who represents women's organizations and participates regularly in meetings". Countries where there is a designated representative with expertise in gender issue *but no evidence of efforts to ensure an active voice for women's issues* will not be deemed compliant. CCM Performance Assessment Tool, The Global Fund

[28] Ibid.

[29] CCM Funding Guidelines, paragraphs 17 & 18

[30] Hardee K, Gay J, Croce-Galis M, Peltz A. 2014. Strengthening the Enabling Environment for Women and Girls: What is the Evidence in Social and Structural Approaches in the HIV Response? JIAS 2014:17:18619

[31], [32] Adopted from the UNAIDS Gender Assessment Tool for National HIV Responses.

populations? What is the latest incidence rate? Review trends over time. What are the modes and sources of transmission for women, girls, men, boys, and transgender persons?
- Is there (age-disaggregated) data available on intimate partner violence, including sexual violence?
- What socio-cultural norms and practices contribute to increased risk for women and girls, men and boys and transgender persons? Among key affected women?
- Are there any legal frameworks or policies that may impact directly women and girls, men and boys, and key affected women in relation to the three diseases (e.g., criminalization of HIV transmission, denial of inheritance and/or property rights to women, early and forced child marriage, marital rape, forced sterilization, access to justice for survivors of violence, etc.)?
- Does the policy and legal environment protect the sexual and reproductive rights of women living with HIV and/or TB?

2. *Know the country response*

Review national policy and programming documents to assess the national response.

Selected key questions to consider[32]:
- Do national responses recognize, plan for, and address gender issues related to rural/urban specificities? Socio-economic status? Early and forced marriage? Race and ethnicity?
- Does the national HIV response already include gender equality interventions? If so, are they funded?
- What national gender equality policy/guideline provides guidance to the national response to HIV? Is there a commitment to gender equality?
- Are networks and organizations of people living with HIV, key affected women, sexual and reproductive health, gender equality, youth, and other key populations' organizations engaged in decision-making at different stages, levels, and sectors of the country's response, including design and implementation of the response?
- Does a pre- or in-service curriculum include training in gender, human rights, stigma and discrimination?
- Is there a multi-sectoral policy on addressing gender-based violence?

3. *Analyze gaps and identify priority interventions for a gender-sensitive or gender-transformative response*

Once the epidemic, context and country response have been analyzed from gender perspectives, review the gaps in addressing the needs of women and girls including key affected women, and in meeting gender equality goals in the context of three diseases that have been identified, and plan priority interventions to address these gaps.
   a) Identify specific priorities, objectives and sets of interventions to address gender inequality and remove barriers, accessing services for women and girls to be included in the grants. Consider the benefits of integrating services for women across sectors to better meet their needs.
   b) Consult the evidence base on how best to advance gender equality through disease programs. A good resource with a comprehensive review of evidence for successful HIV interventions for women and girls is www.whatworksforwomen.org.
   c) Where there is no clear evidence on how best to tackle one of the identified gaps or issues, consider creating a pilot project with built in monitoring and evaluation to assess effectiveness and readiness for scale up.

d) Cost prioritized gender-responsive interventions that reflects steps a, b and c., for advocacy and negotiation of resource allocations during the national strategic planning or review, and/or concept note development to achieve the greatest impact.

Include and prioritize gender-responsive programming

Following the gender assessment and inclusive country dialogue process, gender-responsive[33] programming must be prioritized and included in the concept notes as well as in existing Global Fund supported programs.

Applicants requesting funding from the Global Fund have to submit the concept note with modular template, to describe the relationship between what is planned and what results are expected. It outlines the main goals, objectives, modules, interventions, associated indicators and targets, costs and cost assumptions for each disease and for HSS. The template replaces the performance framework and detailed work plan and budget previously used by the Global Fund. The modules and interventions have been drawn from the investment guidance of major agencies including the WHO and UNAIDS. There is no stand-alone module for gender-responsive interventions. Gender responsive action is described in the scope of services for HIV, TB and malaria and responding indicators, while gender-responsive delivery of services is encouraged for every intervention funded by the Global Fund. An illustrative list of gender-responsive programs in modules and interventions is included in Annex 1.

In addition, below are examples of potential gender-responsive programming that may be included in the concept notes using various interventions listed in the new funding model's modular template.

Country A: Addressing high levels of Gender-Based Violence (GBV) through HIV programs

An analysis of Country A's HIV epidemic finds high rates of GBV as well as acceptability of violence as a driver of the epidemic. Country A implements a number of behavior change programs related to safer sex, and programs targeting women can be adapted to include greater awareness on GBV and the medical and legal recourse survivors of GBV can access. In addition, HIV testing and VMMC programs present an opportunity to address the attitudes of large numbers of young men accessing these services which are a priority in the national program. They include educational components during counselling and during the follow-up post-operation period for VMMC. These male-oriented programs can focuses on preventing gender-based violence, use of male and female condoms, reduction of multiple partnerships, and linkages to HIV testing and treatment.

- *Outcome indicators*:
  - ✓ HIV O-2: Percentage of women and men aged 15–49 who have had sexual intercourse with more than one partner in the past 12 months (*Disaggregated by 15-19 and 20-24 age groups*)
- *Coverage and output indicators:*
  - ✓ GP-1: Number of women and men aged 15-49 who received an HIV test and know their results
- *Key interventions in the modular template:*
  - ✓ Prevention programs for general populations / RMNCH linkages and gender-based violence (GBV)
  - ✓ Prevention programs for general populations / male circumcision

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[33] As articulated in the Gender Equality Strategy, the primary objective behind gender responsive programming is to design and implement development projects, programs and policies that:
  1. do not reinforce existing gender inequalities (Gender Neutral)
  2. attempt to redress existing gender inequalities (Gender Sensitive)
  3. attempt to re-define women and men's gender roles and relations (Gender Positive/Transformative)

Country B: Exclusion of key affected women

HIV prevalence is very high among key affected women, particularly sex workers, transgender people and women who inject drugs in country B. Historically, programming with these groups has existed but only at a very small scale, and with a very narrow focus on HIV prevention through condom use and needle exchange. A more comprehensive program is introduced ensuring key affected women are systematically reached; moreover the program design is adapted to take a more holistic approach aimed at ensuring key affected women receive comprehensive sexual and reproductive health services, as well as specific support (including medical, social and legal support) in relation to gender based violence which is very prevalent.

- ▪ *Outcome indicators*:
    - ✓ HIV O-4b: Percentage of transgender people who sell sex reporting the use of a condom with their most recent client
    - ✓ HIV O-5: Percentage of sex workers reporting the use of a condom with their most recent client (disaggregated by sex male, female, transgender)
    - ✓ HIV O-6: Percentage of people who inject drugs reporting the use of sterile injecting equipment the last time they injected (disaggregated by sex)
- ▪ *Coverage and output indicators:*
    - ✓ KP-1b: Percentage of transgender people reached with HIV prevention programs – defined package of services
    - ✓ KP-2b: Percentage of transgender people reached with HIV prevention programs – individual and/or smaller group level interventions
    - ✓ KP-1c: Percentage of sex workers reached with HIV prevention programs – defined package of services
    - ✓ KP-2c: Percentage of sex workers reached with HIV prevention programs – individual and/or smaller group level interventions
    - ✓ KP-1d: Percentage of PWID reached with HIV prevention programs – defined package of services
    - ✓ KP-2c: Percentage of PWID reached with HIV prevention programs – individual and/or smaller group level interventions

Country C: Active Case Finding for Women Who Lack Resources for Tuberculosis Detection and Treatment

A gender analysis of Country C's tuberculosis epidemic finds that rural women lack the financial resources necessary for transport to TB testing and treatment services. Evidence has shown that providing treatment at a woman's home [with her consent] or in the community can increase her ability to complete treatment.[34] Under the *TB Care and Prevention* module for *Key Affected Populations* intervention, Country C plans to implement an intervention whereby community health workers undertake active case finding for women in remote areas, using mobile outreach to collect sputum samples; returning with results and treatment.

- ▪ *Outcome indicators*:
    - ✓ TB O-1a: Case notification rate of all forms of TB per 100,000 population- bacteriologically confirmed plus clinically diagnosed,, Disaggregated by age (0-14 and above 15), sex and HIV status

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[34] Khan K. 2013. Understanding the Gender Aspects of Tuberculosis: A Narrative Analysis of the Lived Experiences of Women with TB in the Slums of Delhi, India. Health Care for Women International 33(1): 3-18.

- ✓ TB O-2b: Treatment success rate- bacteriologically confirmed new TB cases, Disaggregated by age (0-14 and above 15) and sex
- ▪ *Coverage and output indicators:*
  - ✓ DOTS-2b: Percentage of bacteriologically confirmed new TB cases successfully treated among the bacteriologically confirmed new TB cases registered during a specified period
  - ✓ DOTS-6: Number of TB cases (all forms) notified among key affected populations/high risk groups
- ▪ *Key interventions in the modular template:*
  - ✓ TB care and prevention / Key affected populations

Country D: Addressing Power Dynamics Among Couples in Malaria Prevention

Country D is a malaria endemic country with persistent low use of long-lasting insecticide-treated nets (LLINs) among children and pregnant women. A gender analysis reveals rigid gender roles among couples where men are the head of the household and women cannot decide when to access health services for herself and for her children. Under the *Vector Control* module for *LLIN-Mass Campaign*, Country D implements community advocacy campaign with messages targeted to men and women highlighting the importance of couple communication about healthy family practices, including pregnant women sleeping under LLINs and accessing antenatal care (ANC) four times.

- ▪ *Outcome indicators*:
  - ✓ Malaria O-1c: Proportion of pregnant women who slept under an ITN the previous night;
- ▪ *Coverage and output indicators:*
  - ✓ VC-4: Proportion of pregnant women who received long-lasting insecticidal net
  - ✓ SP-1: Proportion of pregnant women attending ANC who received three or more doses of intermittent preventive treatment for malaria
- ▪ *Key interventions in the modular template:*
  - ✓ Vector Control / LLIN-Mass Campaign

Integrate gender indicators into monitoring and evaluation

Concept notes should include a budget for monitoring and evaluation that shall also reflect a focus on gender.[35] The Global Fund encourages applicants to invest 5-10% of their program budgets to strengthen monitoring and evaluation systems and capacities, including (but not limited) to gender-responsive monitoring and evaluation such as addressing weaknesses in age- and sex-disaggregated data collection, collection of data relating specifically to key affected women, or conducting operational research to better inform gender-responsive programming.

Guidance and technical assistance

A range of programmatic resources and guidance is available from technical partners (such as WHO, Stop TB partnership, Roll Back Malaria, UNAIDS, UNICEF, UNFPA, UNDP, UN Women) and civil society organizations to help applicants to select interventions and design programs that address the specific needs of women and girls, including key affected women, and that address gender inequalities in relation to the epidemiological and country context. These partners also provide technical assistance for proposal development.

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[35] WHO, World Bank, UNICEF, UNAIDS, PEPFAR, USAID, Alliance, Roll Back Malaria, Stop TB Partnership, Measure Evaluation. 2011. GFTAM Monitoring and Evaluation Toolkit: HIV, Tuberculosis, Malaria and Health and Community Strengthening.

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CCMs may request technical assistance to the Global Fund technical assistance partners such as German BACKUP or French 5% Initiative to strengthen their response to the three diseases by addressing the needs of women and girls and promoting gender equality. Both of these initiatives have a particular focus on addressing gender equality issues. Additionally, women's groups may ask for technical assistance for capacity building or core funding for networks and organizations through the Special Initiative (details to be announced in 2014). If participants in country dialogue do not feel that gender equality is being adequately addressed in either the proposal development process or in grant implementation, they may escalate their concerns to the Fund Portfolio Manager (FPM) at the Global Fund Secretariat so that adequate intervention is facilitated.

Resources and links to tools and guidance

(a) Global Fund Strategic Investment Guidance and Information Notes:
http://www.theglobalfund.org/en/fundingmodel/support/infonotes/

(b) WHO/UNAIDS Resources
* Toolkit for Global Fund HIV Proposals
http://www.unaids.org/en/ourwork/programmebranch/countryimpactsustainabilitydepartment/globalfinancingpartnercoordinationdivision/resourcekitforglobalfundhivproposals/
- Women and HIV/AIDS- links and publications: http://www.who.int/gender/hiv_aids/en/
- Linkages between sexual and reproductive health (SRH) and HIV
  http://www.who.int/reproductive-health/hiv/index.html;
- WHO Implementing comprehensive HIV/STI programmes with sex workers: practical approaches from collaborative interventions 2013 http://www.who.int/hiv/pub/sti/sex_worker_implementation/en/
- UNAIDS Gender Assessment Tool (forthcoming 2014)
  http://www.unaids.org/en/targetsandcommitments/eliminatinggenderinequalities/

(c) UNDP: Checklist for Integrating Gender into the New Funding Model of the Global Fund to Fight AIDS, TB and Malaria
http://www.undp-globalfund-capacitydevelopment.org/media/436501/ undp_checklist_for_integrating_gender-web.pdf

(d) Gender and HIV
- UN Women Gender and HIV/AIDS Portal: http://www.genderandaids.org/
- UNAIDS Agenda for Accelerated Country Action for Women, Girls, Gender Equality and HIV
  http://www.unaids.org/en/media/unaids/contentassets/dataimport/pub/report/2010/jc1825_community_brief_en.pdf
- Evidence-based gender-responsive interventions, including co-infection with TB and malaria:
  What Works for Women and Girls: Evidence for HIV Interventions. www.whatworksforwomen.org
- The Gender Dimensions of the HIV/AIDS Epidemic: http://www.unfpa.org/gender/aids.htm
- PEPFAR 2013 Gender Equality Strategy: http://www.pepfar.gov/documents/organization/219117.pdf
- 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

(e) Gender and Violence
- WHO. 2013. Responding to Intimate Partner Violence and Sexual Violence against Women: WHO Clinical and Policy Guidelines: http://www.who.int/reproductivehealth/publications/violence/9789241548595/en/

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- WHO. 2013. 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
- Resources for the Clinical Management of Children and Adolescents Who Have Experienced Sexual Violence: http: //aidstar- one.com/focus_areas/gender/resources/prc_technical_considerations
- UNWomen website with evidence, tools, etc.: www.endvawnow.org
- AIDSTAR-Two. 2013. Annotated Bibliography: Training and Programming Materials 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
- International HIV/AIDS Alliance. Sex work, violence and HIV: A Guide for Programmes with Sex Workers. http://www.eldis.org/go/home&id=38700&type=Document#.UxCQDPl_tEQ

(f) Gender and Malaria
- A Guide to Gender and Malaria Resources: http://www.rollbackmalaria.org/docs/advocacy/gm_guide-en.pdf
- Gender, Health and Malaria: http://www.who.int/gender/documents/gender_health_malaria.pdf
- Pregnancy in Malaria Consortium: http://www.mip-consortium.org/

(g) Gender and Tuberculosis
- Gender in Tuberculosis Research: http://www.who.int/gender/documents/TBlast2.pdf
- World Health Organization 2013. Tuberculosis in Women. http://www.who.int/tb/publications/tb_women_factsheet_251013.pdf
- The Global Coalition of Women and AIDS. 2010. Tackling TB and HIV in Women: An Urgent Agenda http://www.womenandaids.net/CMSPages/GetFile.aspx?guid=aaee44f9-9a9d-4366-9ee4-89e4775cc798

(h) Gender and health systems
- Guidance on integrating gender-specific issues into Health Systems strengthening activities http://www.genderingermandevelopment.net/files/images/pdf/Gender_Mainstreaming/giz2011-en-gender-dimensions-in-health-systems.pdf

(i) Gender Assessment and Mainstreaming Tools
- UNAIDS Gender Assessment Tool (forthcoming 2014)
- UNDP: On Course: Mainstreaming Gender into National HIV Strategies and Plans- A Roadmap. New York, NY: http://livelifeslowly.net/genderinghiv/
- UN Women, MEASURE Evaluation et al. (2014): Compendium of Gender Equality and HIV Indicators http://www.cpc.unc.edu/measure/publications/ms-13-

(j) A vast range of programmatic resources and guidance is also available from civil society organizations, including:
- Athena Network http://www.athenanetwork.org/
- Global Network of People Living with HIV and UNAIDS. 2013. Positive Health, Dignity and Prevention: Operational Guidelines. http://www.unaids.org/en/media/unaids/contentassets/documents/unaidspublication/2013/20130802_Positive_Health_Dignity_Prevention_Operational_Guidelines.pdf
- International AIDS Women Caucus: www.aidswomencaucus.org
- nternational Women's Health Coalition: www.iwhc.org
- Women4GF: Women in all their diversity for the Global Fund Gender Equality Strategy http://women4gf.org

The Global Fund

Annex 1: Illustrative list of how gender-responsive approaches can be integrated into the modular frameworks

Under the new funding model, applicants are required to present their program and funding requests in the concept note using the new "measurement frameworks". For each disease, and for health systems strengthening (HSS), the framework is made up of a series of modules which represent the major programming and outcome areas. Each module is made up of interventions – the specific packages of activities that contribute toward the module outcome. The tables below present the modules for HIV, tuberculosis, and malaria, with suggested gender-responsive approaches for each module/intervention.

HIV Modules

Module	Interventions	Scope and description of intervention packages: Illustrative gender-responsive programs that can be included
Prevention programs for general population	Behavioral change as part of programs for general population	Behavioral change programs tailored for different needs of men, women and girls in the general population, to support male and female condoms, addressing harmful gender norms
	Condoms	Promotion and distribution of female and male condoms; developing strategies to ensure condoms are accessible to women including young and unmarried women.
	Male circumcision	Use MC promotion and communication campaigns, as well as direct contact with men taking up MC, as an opportunity to address issues such as safe sex, gender norms, gender-based violence.
	HIV testing and counselling	Promotion of couple testing and counselling; link testing and counselling to support for discordant couples; use HTC promotion and communication campaigns as well as direct contact with men taking up HTC as an opportunity to address issues such as safe sex, gender norms, gender based violence; and opportunity to cross-refer women to other services eg related to gender based violence.
	Diagnosis and treatment of STIs	Use direct contact with men and women attending STI services as an opportunity to address issues such as safe sex, gender norms, GBV; and opportunity to cross-refer women to other services eg related to GBV.
	OVC package	Addressing young girls' vulnerabilities with comprehensive packages of OVC services and to ensure linkages to other services such as SRHR, GBV.
	RMNCH linkages and Gender Based Violence (GBV)	Designing, developing and implementing gender responsive, women and girls focused HIV services including prevention and responses to gender-based violence, provision of comprehensive package of care for GBV survivors, HIV service integration into RMNCH services, promotion of sexual and reproductive health
Prevention programs for key populations and for other vulnerable populations	All interventions	Providing comprehensive packages of services tailored to needs of key affected women. Referral and service integrations with other women and girls friendly and/or targeted services such as GBV and RMNCH services. Particular attention to be paid to ensuring key affected women have access to services, notably in areas where affected women have been shown to have unequal access (e.g. harm reduction services for women who inject drugs).
Prevention programs for adolescents and youth, in and out of school	All interventions	Providing comprehensive packages of services tailored to needs of young women. Referral and service integrations with other women and girls friendly and/or targeted services such as GBV and RMNCH services. For all adolescent and young people, focus on linkages with comprehensive sexuality education and SRHR, including identifying harmful gender norms. Focus on particular needs of young key affected women.
PMTCT	Prong 1: Primary prevention of HIV infection among women of childbearing age	Designing, developing and implementing programs aimed at primary prevention of HIV among women of reproductive age within services related to reproductive health such as antenatal care, postpartum/natal care and other health and HIV service delivery points, including working with community structures.

	Prong 2: Preventing unintended pregnancies among women living with HIV	Designing, developing and implementing reproductive health programs targeting women living with HIV including linkages and referrals.
	Prong 3: Preventing vertical HIV transmission	Designing, developing and implementing programs aimed at preventing vertical transmission this includes HIV testing and counselling, ARVs, interventions along the continuum pregnancy, delivery and breastfeeding. Please include provisions for option A and B.
	Prong 4: Treatment, care and support to mothers living with HIV and their children and families	Designing, developing and implementing programs aimed to provide HIV care, treatment and support for women found to be positive and their families including Early Infant Diagnosis (EID).
Treatment, care and support	Pre-ART Care; Antiretroviral Therapy (ART) ; Prevention, diagnosis and treatment of opportunistic infections	Designing, developing and implementing ART programs for all populations and ensuring equitable access for women including key affected women and other women who are marginalized or excluded. This includes, first, second and third-line for both adults and children, Treatment as Prevention and provisions for expansion to option B+ as well as Pre and Post-exposure prophylaxis (PrEP and PEP),.links and referrals to care and support.
	Treatment Monitoring; Treatment Adherence; Counselling and psychosocial support; Outpatient care; inpatient care	Ensuring mechanisms, both within health facilities and community based, pay particular attention to the barriers faced by women (including key affected women) in accessing care and support; recognize specific challenges women may face in adherence for instance in relation to high burden of child care.
TB/HIV	TB/HIV collaborative interventions	As per all HIV and TB interventions
	Engaging all care providers; Community TB Care delivery	Ensure equal access for women including key affected women; address barriers (e.g. societal, financial) to accessing care and support.
	Key affected populations	Active case finding among key affected populations and high risk groups with particular focus on key affected women. This includes adapting services to the needs of specific groups to make services people-centered and improve accessibility, appropriateness, and availability. Adapt diagnostic and treatment structures to meet needs of key affected women, e.g through community-based TB care and prevention, mobile outreach to remote areas, community-based sputum collection, sputum transport arrangements, etc.

Tuberculosis Modules

Module	Interventions	Scope and description of intervention packages: Illustrative gender-responsive programs that can be included
TB care and prevention and TB/HIV	Case detection and diagnosis	Ensure access to detection and diagnosis addresses inequalities in diagnosis rates between men and women
	Treatment	Includes standard, supervised treatment with first line drugs (FLDs) including pediatric preparations, with social support for patients with drug-sensitive TB and innovative patients-centered care. Specific support for pregnant women or women intending pregnancy.
	Prevention	Ensure appropriate gender sensitive prevention efforts with particular attention to needs of stigmatized or marginalized women and key affected women. Addressing financial barriers to access in particular where women have little access to or control over financial resources.
	Engaging all care providers; Community	Capacity building for community-level service delivery. This includes training and capacity-building of TB service providers, TB patients, community-based

	TB care delivery	interventions and outreach services for TB patients. Involve both men and women in community led service delivery and ensure equitable access for men and women.
	Key affected populations	This include Active case finding among Key Affected Populations and high risk groups such as prisoners, displaced people, migrants and ethnic minorities/indigenous populations, miners, children, urban poor, elderly and adapting models of TB care for high risk groups. This includes adapting services to the needs of specific groups to make services people-centered and improve accessibility, appropriateness, and availability; adapt diagnostic and treatment structures to meet needs of key populations, e.g through community community-based TB care and prevention, mobile outreach to remote areas, community-based sputum collection, sputum transport arrangements, etc. Particular attention to key affected women and ensuring equitable access.
	Collaborative activities with other programs and sectors	Collaborating with other service providers for patients with co-morbidities including Reproductive Maternal Neonatal and Child Health (RMNCH), diabetes and collaborative activities for TB prevention and care with other sectors beyond health such as justice, labor, mining, etc.
MDR TB	As above	As above; particular attention to issues that affect women in the context of MDR-TB such as burden of childcare and enforced absences from children – make linkages to ensure access to community/social support for such situations.

Malaria modules

Module	Interventions	Scope and description of intervention packages: Illustrative gender-responsive programs that can be included
Vector Control	LLIN – Mass campaign	Ensure safe and equitable access for women and girls during mass distribution; track equity of distribution. Ensure particular effort is made to enable key affected women (i.e., female refugees in endemic area) who are marginalized or excluded also have access to LLIN outside of mass campaigns.
	LLIN Continuous Distribution	This intervention encompasses efforts to start, strengthen or scale up continuous delivery of LLINs through antenatal care (ANC) clinics, the Expanded Programme on Immunization (EPI), or other routine services at public and private health facilities, to sustain high LLIN coverage. Particular focus on informing women on LLIN usage and in gaining support from fathers/male partners for this.
	IEC/BCC	It includes advocacy, communication and social mobilization activities related to vector control-training of community health workers and community volunteers on effective BCC and Community Mobilization on malaria; periodic sensitization meetings for opinion leaders at community and village level. Particular focus on informing women on LLIN usage and in gaining support from heads of household (mostly men) for this.
Case management	Facility based treatment; Integrated community case management	Ensure financial barriers to accessing facilities, including transport costs, are addressed, particularly where women have little access to or control over financial resources. Involvement of both women in men in provision of community case management and ensure equal access.
	IEC/BCC	It includes advocacy, communication and social mobilization activities related to vector control: training of community health workers and community volunteers on effective BCC and Community Mobilization on malaria; periodic sensitization meetings for opinion leaders at community and village level.
Specific prevention interventions	Intermittent Preventive Treatment (IPT) in Pregnancy; IPT in infancy	Includes procurement and provision of of intermittent preventive treatment with sulfadoxine-pyrimethamine during pregnancy. Address issues in unequal decision making between men and women to ensure women can safely take decisions on IPT for themselves in pregnancy and for infants.
	IEC/BCC	It includes advocacy, communication and social mobilization activities related to vector control-training of community health workers and community volunteers on

		effective BCC and Community Mobilization on malaria; periodic sensitization meetings for opinion leaders at community and village level. Particular focus on informing women and in gaining support from heads of households (mostly men).

Modules available under all diseases

Modules for community systems strengthening, removing legal barriers and program management are available under all three disease and are identical. In addition, health systems strengthening as well as being available within each disease, is also available as a "cross-cutting" stand alone program. The tables below present the modules with suggested gender-responsive approaches for each module/intervention.

Module	Interventions	Scope and description of intervention packages: Illustrative gender-responsive programs that can be included
Program Management	Policy, planning, coordination and management; Grant management	Ensure program management personnel include strong experience of working on gender equality and women's rights.
Removing legal barriers to access	Legal and policy environment assessment and law reform	Assessments of the legal and policy environment should pay particular attention to issues of gender inequality and to legal and policy barriers affecting transgender people. These priorities should be addressed in law reform plans.
	Legal aid services and legal literacy	Provide legal aid services for gender-related violation of rights, including cases against GBV, violation of reproductive rights of women living with HIV such as forced sterilization, etc., Particular focus on marginalized women, including recognition of low literacy and of language barriers (e.g. for migrant women).
	Training on rights for officials, health workers and police	Provide training for health officials, health workers and police who must implement rights-based laws and policies. Focus on gender based violence and interpersonal violence and on strategies and approaches for ensuring complaints are appropriately dealt with and for increasing reporting of and effective responses to complaints.
	Community-based monitoring of legal rights	Community-based organizations establish and implement mechanisms for ongoing monitoring of laws, policies and their implementation to document barriers to an effective response to the disease. Monitoring of gender related inequalities should be incorporated.
	Policy advocacy on legal rights	Community-based organizations and networks of women and key affected women implement a time-bound, measurable advocacy plan to advocate for either a) law and policy reform, b) better implementation of existing laws and policies, or c) to create and utilize platforms for social accountability, aimed at removing human rights barriers to accessing health services; particular focus on gender inequalities and exclusion of key affected women.
Community systems strengthening	Community-based monitoring for accountability	Particular focus on discrimination and gender-based inequalities and rights of key affected women, that constitutes barriers to an effective response to the disease and to an enabling environment.
	Advocacy for social accountability	Include issues such as discrimination, gender inequality, rights of key affected women.
	Social mobilization, building community linkages, collaboration and coordination	Ensure effective linkages with other actors providing services, for instance in relation to SRHR including GBV, and broader movements such as human rights and women's rights movements.

	Institutional capacity building, planning and leadership development in the community sector	Capacity building of community sector groups, organizations and networks in a range of areas necessary for them to fulfil their roles in service provision, social mobilization, monitoring and advocacy. Particular focus on women's groups (including key affected women) and on working with other community groups to ensure greater inclusion of women in governance and staffing. Also includes strengthening capacity to conduct assessments on gender-related issues.
Health Systems Strengthening (cross-cutting)		
Health Information Systems and M&E	Routine reporting; Surveys; Administrative and finance data sources; Vital registration system	Ensure epidemiological and service delivery data is disaggregated by sex and aim to monitor access for excluded and key affected women; use information to inform adaptation of programming to become more gender responsive.
Health and community workforce	Health and community workers capacity building' Scaling up health and community workers; retention and distribution of CHW	Equitable remuneration of female CHW, gender balance in staffing and management; integrate gender considerations into pre- and in-service training of health and community workers,
Service delivery	Service organization and facility management	Address overall barriers (e.g., transport cost, opening hours, absence of childcare, GBV, etc.) to access for healthcare affecting women and girls including key affected women; ensure gender sensitivity of service provision arrangements (male/female friendly services); promote voluntary male involvement in women-focused services; bringing service delivery to communities through mobile services.
Policy and governance	Development and implementation of health legislation, strategies and policies; Monitoring and reporting implementation of laws and policies	Ensure gender is mainstreamed into relevant health systems policies and strategies; ensure gender balance and representation of key affected women in policy and oversight bodies such as CCM and in the health sector in general; ensure meaningful involvement of women (including key affected women) in policy development processes.
Financing systems	Raising adequate funds and incentivizing appropriate responses	Ensure funding is available to women's / key affected women to engage in the response. Address financial barriers to accessing health care that disproportionately affect women.