SECTION 4

HIV/AIDS treatment and care

Objectives

This section highlights gender inequalities that affect women's access to and experience of HIV/AIDS treatment and care programmes. It describes actions to improve the gender-responsiveness, and thus the quality, of the HIV/AIDS treatment and care components of comprehensive national HIV/AIDS programmes. This section may be most useful to health-care providers and supervisors of HIV/AIDS treatment and care services.

4.1 Background

The increasing availability of ART in many resource-poor settings provides a critical opportunity to prolong the lives of people living with HIV, and may encourage people to learn about their HIV status. It has been estimated that by December 2007 some 3 million people living with HIV were receiving treatment in low-income and middle-income countries, representing 31% of the 9.7 million estimated to be in need. More than 2.1 million people in sub-Saharan Africa are receiving ART, a coverage rate of 30%, whereas three years ago the coverage rate was only 2% (*4*). At the June 2006 United Nations General Assembly Meeting on HIV/AIDS, Member States agreed to work towards the goal of universal access to comprehensive prevention, treatment, care and support programmes by 2010.

Equity in access to HIV/AIDS treatment and care is a critical element in the scaling up of programmes towards universal access. Current evidence from 57 low-income and middle-income countries suggests that approximately 58% of adults receiving treatment in these countries are women, while women represent 52% of adults living with HIV. Overall, the ratio of women to men receiving treatment is broadly in line with regional sex ratios for HIV prevalence (*4*). Nonetheless, gender inequalities remain a significant barrier to access to HIV/AIDS treatment and care, and must be monitored, identified and addressed in order to improve the quality of care and treatment outcomes for women, especially those belonging to marginalized groups, such as sex workers and injecting drug users (IDU), who face additional discrimination. Factors limiting men's access to treatment and care are also poorly understood and addressed. Limited evidence from a few countries on men's use of HIV/AIDS and other health services suggests that men are socialized not to admit readily that they are sick, that they tend to underestimate their risk for HIV infection more than women do, and, therefore, may not come forward for testing until they show symptoms of HIV (*54*, *154–155*).

4.2 Addressing gender inequalities in some components of HIV/AIDS treatment and care services

WHO and UNAIDS recommend that to promote equitable access to ART for women, there needs to be: a supportive policy, an overall strengthening of health systems to make them responsive to women's needs, a reduction in barriers to access, and targets and indicators to monitor progress (*67*). Gender-responsive actions related to several of these recommendations are covered in **SECTION 1** (pages 1 to 30). In addition, selected programme components at the service delivery level, where gender inequalities may be most relevant, are outlined below.

4.2.1 Determine eligibility for initiating ART.
4.2.2 Initiate prophylaxis or treatment for opportunistic infections.
4.2.3 Initiate ART.
4.2.4 Support adherence to ART.

Gender-responsive actions in HIV testing and counselling are covered in **SECTION 2** (pages 31 to 48), and gender-responsive actions in reproductive choices and nutrition counselling for women living with HIV are covered in **SECTION 3** (pages 49 to 56). Gender-responsive actions in home-based care, which is important for providing comprehensive HIV treatment and care to women living with HIV, are covered in **SECTION 5** (pages 67 to 74). Managers or supervisors and health-care providers of HIV/AIDS treatment and care services will, therefore, need to read the present section in conjunction with **SECTIONS 2, 3 AND 5**.

4.2.1 Determine eligibility for initiating ART

Current eligibility criteria suggested by WHO prioritize access to ART for people living with HIV whose CD4 cell counts are below 200,[1] or who meet the WHO-defined clinical stages of advanced or severe HIV disease. In determining eligibility for initiating ART, a more equitable criterion is based on clinical eligibility (*104*, *156–157*). In reality, however, governments, programme managers and health-care providers are already making, or may need to make, decisions based on explicit or implicit social criteria for providing access to, or excluding certain groups from enrolling in, HIV treatment services (*158–160*). Such criteria may have implications for ensuring equity in access to HIV treatment for women, as highlighted below (*160–161*).

KEY ISSUES

- Some HIV treatment and care programmes may use criteria such as the ability to pay or co-pay for the costs of diagnostics, treatment and care, or the insurance status of patients. Such criteria compromise adherence to treatment for everyone, especially in poor households. The disadvantage may be compounded for women, who typically have less access to and control over financial and other resources, and are less likely to be insured than men (*82*, *162*).

- In some settings, criteria are used such as requiring persons who initiate treatment to disclose their serostatus to at least one person, or the ability to adhere to treatment protocols as ascertained by proxy measures (e.g. having stable social networks or families, resident/citizenship status, or no substance abuse) (*158–159*). Such criteria may limit access to treatment and care for women who do not want to disclose because of fear of, or experience of, violence from partners, and for single women, migrant women, and women who inject drugs.

- Several countries have identified HIV-positive pregnant women and new mothers as groups eligible for priority access to ART for their own health needs, apart from receiving ARV prophylaxis for preventing transmission of HIV to their infants (*158*, *161*). While this benefits pregnant women and mothers, it may result in the exclusion of women who are not pregnant, including younger women or older women who have completed their childbearing.

- In some settings, particularly in South Asia, resources are preferentially invested in some members of a family as compared to others simply on the grounds of sex and lower social status (e.g. valuing men more than women, and boys more than girls). In such settings it may not be easy for women to access health services and diagnostic facilities in general, except for pregnancy-related reasons. Consequently, women's eligibility for ART may not be determined, and they may not have access to HIV/AIDS treatment, even if they are identified as a priority group for the provision of ART (*162*).

- Communities, including women and their families, may not be aware of established criteria for prioritizing access for certain groups.

[1] See WHO guidance on eligibility criteria in IMAI guidelines on chronic HIV care with ART and prevention (*120*), and on ethics and equitable access to HIV treatment and care (*156*).

4.2.1 Determine eligibility for initiating ART

ACTIONS

- If social criteria, such as requirements for disclosure and the ability to adhere to treatment protocols (using proxies such as having stable social networks or citizenship status), exclude certain groups of women (e.g. single women, migrant women), find alternative ways to include them.
  - This could involve providing ongoing pre-ART and adherence counselling, or providing peer support (treatment buddies). If women have difficulty in identifying a treatment supporter, the health facility should help to identify a suitable person. Moreover, where disclosure is required for access to treatment, the principles of confidentiality should be guaranteed, and every effort should be made to avoid stigma and discrimination against the client.
- The current WHO recommendation is for countries to consider providing free access to ART at the point of service delivery (*90*, *156–157*). Therefore, where there are criteria such as the ability to pay or co-pay for the costs of diagnostics or treatment, women may need to be referred to community-based programmes that could provide financial support for accessing treatment.
- Educate communities and people living with HIV, especially women, about the availability of diagnostic tests for the CD4 count and the eligibility criteria for initiating ART, so that they will know if they qualify for treatment and can seek services (*163*).

4.2.2 Initiate prophylaxis or treatment for opportunistic infections

While not all women living with HIV are eligible to begin ART, many more are in need of medications to prevent or treat common opportunistic infections. WHO recommendations are to offer prophylaxis or treatment for opportunistic infections (e.g. co-trimoxazole, isoniazid) as part of the HIV chronic care package (*120*, *164–165*).

KEY ISSUES

- Women living with HIV may not be aware of the need for prophylaxis against opportunistic infections, or of other elements of early HIV care (*163*).
- Women living with HIV, especially those who have not disclosed their serostatus, may not have the community and family support they need for access to prophylaxis or treatment for opportunistic infections.
- Women living with HIV often experience specific illnesses related to their reproductive systems. They are more at risk of vaginal fungal infections, genital warts, pelvic inflammatory disease, menstrual irregularities and cervical cancer than HIV-negative women (*166*).
  - In many settings, sociocultural norms contribute to women failing to recognize that these conditions are abnormal, and to delays in seeking appropriate care. Women feel a sense of shame associated with gynaecological symptoms, perceive that menstrual symptoms or vaginal discharge are a normal part of being a woman, and are embarrassed to discuss these symptoms with health-care providers (*167–168*).

ACTIONS

- Provide education to women living with HIV about the benefits of, need for, and timing of prophylaxis against opportunistic infections, and about other key elements of early HIV care.
  - Such education should also include information on recognizing and seeking timely treatment for symptoms and conditions associated with the reproductive system, and on obtaining regular pap smears for cervical cancer screening.[1]
- Health-care providers may need to proactively ask women living with HIV if they are experiencing gynaecological symptoms, in order to address the shyness or reluctance that some women may feel about mentioning such symptoms.
- Address the underlying norms, shame and embarrassment experienced by women related to their reproductive symptoms.
- Provide information about sexual and reproductive hygiene practices in order to prevent, mitigate and manage gynaecological symptoms over the long term.
  - For example, women may need advice regarding diet, douching, wearing comfortable underwear, etc., in order to manage and prevent symptoms of vaginal fungal infections.

[1] See WHO guidelines on the sexual and reproductive health of women living with HIV/AIDS and their children (*133*).

4.2.3 Initiate ART

KEY ISSUES

- Women's willingness and readiness to initiate and continue ART may be affected by various factors.
  - For example, they may not have access to family finances for transport that would enable them to make regular follow-up visits (*49*, *140–141*). In households where several family members, including children, are sick, women may prioritize care and treatment for their children and other family members.
- Given women's multiple roles and responsibilities in the household, family and community, they often have high workloads. Therefore, some women may find that the dosage of ARVs does not suit their lifestyle.
  - For example, working women may find it inconvenient to adopt regimens that require multiple doses during the day, especially if they are busy working in the fields, taking care of children, cooking and taking care of the sick and doing other household chores. **FIGURE 4.1** provides an example of barriers to ART experienced by women.

ACTIONS

- Assess clients' readiness to start ART, including their social support, before initiating treatment.[1]
  - For example, help women identify people to whom they can safely disclose their status and who can support them in accessing and continuing with treatment.
- Provide basic information on medication, dosage, adherence, side-effects, drug interactions, and dietary requirements in simple lay language, so that women who are less literate can understand the information and advice.
  - For example, use visual aids where possible. Reinforce the information through peer or treatment supporters and lay counsellors.
  - See **BOX 4.1** on page 62 for a treatment literacy toolkit to empower women living with HIV.
- Consider providing free or subsidized treatment and care. Arrange with community-based organizations to support women's access to treatment, e.g. assistance with transport or childcare.
- Help women make treatment plans for the recommended treatment regimens and dosages, taking into account women's daily life, work patterns and workloads.

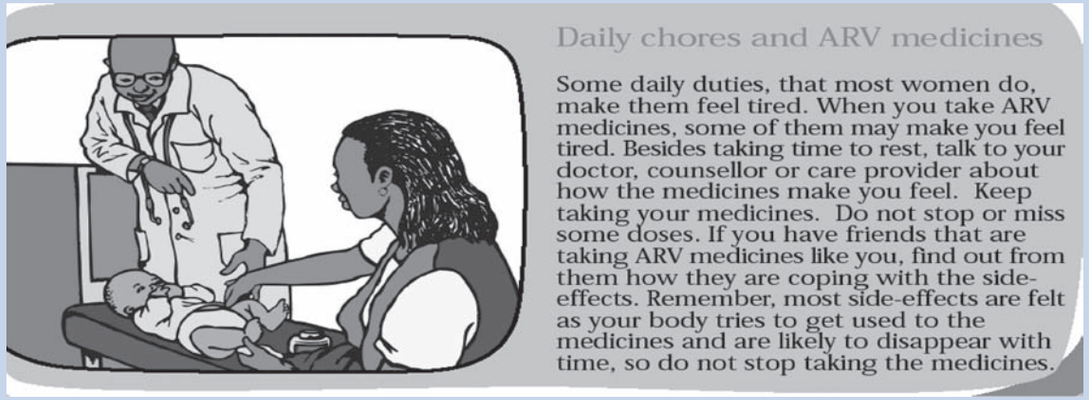
FIGURE 4.1 EXAMPLE OF ISSUES EXPERIENCED BY WOMEN IN INITIATING ART (*163*)

[1] See WHO guidelines on antiretroviral drugs for treating pregnant women and preventing HIV infection in infants (*104*), and IMAI guidelines on chronic HIV care with ART and prevention (*120*).

BOX 4.1

Treatment literacy toolkit to empower women and girls: SAfAIDS (*163*)

In 2006 the Southern Africa HIV/AIDS Information Dissemination Service (SAfAIDS) launched a treatment literacy toolkit for AIDS treatment. The aim was to empower women and girls in southern Africa to: make informed choices about HIV/AIDS treatment and care; demand their right to full participation in HIV/AIDS treatment programmes; strengthen their coping mechanisms in adhering to ART; and support their peers who were also on ART.



The toolkit includes practical gender-sensitive communication materials (i.e. posters, stickers, discussion cards and treatment calendars) that provide accurate and relevant information about HIV treatment and care for women and girls, including:

- what women and girls need to know about ARV medicines and HIV infection
- why and when women should begin taking ARV medicines
- how ARV medicines affect women's life cycles
- how taking ART can fit into women's daily routines and tasks
- helping women to adhere to antiretroviral medicines
- preventing and treating women-specific opportunistic infections and conditions
- safer satisfying sex for women
- what women must know about parent-to-child transmission of HIV
- supporting women who are taking ARV medicines
- becoming a "treatment buddy" for a woman on ART
- helping women to disclose their HIV serostatus ("Let's share cards.")
- ART for children
- how to stay healthy and live longer without ART.

BOX 4.2

Example of gender-responsive adherence counselling and support (*171*)

CLIENT	GENDER-RESPONSIVE ADHERENCE SUPPORT COUNSELLOR 1	GENDER-BLIND ADHERENCE SUPPORT COUNSELLOR 2
Good morning, Sister. I've come for my monthly.	Good morning, Mary. It's two months since you began ART. How are you doing?	
Fine thanks, Sister. It's not easy, but I'm managing.	Do you want to tell me a bit about how it's been going? (*Open-ended question*)	Have you been taking your medication all the time?
Well, I've been taking my medication as I'm supposed to ... I just feel very nauseous, tired all the time and then I want to sleep. I can't cook and clean like before. I'm so tired when I wake up that I'm scared that I'll sleep through my morning dose.	It sounds like it's been difficult for you. Do you think your tiredness could be a side-effect of the medication?	It's very important that you don't miss any doses. You know that you have to take your medication at the same time every day!
Yes, I think it is. The doctor told me that I might feel like this. He also said that I might get diarrhoea from the AZT/3TC.	Has knowing this made it any easier for you to cope – knowing that what you're experiencing is common?	I'm sure it will go away soon. Just keep taking your medication.
(*Laughing*) Yes! But, Sister, some days I'm tempted not to take my medication. I don't like the way it's making me feel.	Perhaps you have days when you wonder if it's worth it. Maybe the side-effects make you feel worse than the HIV was making you feel before you started treatment?	You know that it's really important to keep persisting. Everyone feels that way.
Yes. (*Starts crying*) I know it's really important for me to take the drugs every day, and I'm scared that I'll forget, and then the drugs won't work any more and I'll get sick and die. There'll be nothing left for me.	I can see that you realize how important it is to adhere to your medication, but it seems like you're putting a lot of pressure on yourself, too. Would you like to spend some time looking at how you can manage these side-effects more easily?	You have to pull yourself together, otherwise you'll make yourself sicker than you are now. Do you want that?
Yes, please. I really need to see if there are things that will help me to get through this.	Tell me more about your nausea. When do you feel it most?	
Usually in the morning when I reach the market to sell my wares. I get late in preparing breakfast for my husband and getting my children ready for school, then I have to hurry to the market. I barely have time to eat breakfast myself. (*Gender role*)	One reason for your nausea could be that you don't get time to eat breakfast. One suggestion is that you keep some dry bread or crackers next to your bed. You could eat a few in the morning and wait for a few minutes before getting out of bed. This can help to reduce nausea. Do you think you could enlist your husband's help in getting your children ready for school and get some time to eat something yourself? (*Addressing gender role*)	Your nausea is because you are not eating breakfast. You have only yourself to blame. Eat breakfast and your nausea will go away.

4.2.4 Support adherence to ART

Antiretroviral therapy (ART) requires regular use of health services and long-term compliance with multiple treatment schedules. Maintaining adherence to these is one of the main challenges related to the effectiveness of ART. Research has indicated that the main barriers in adhering to ART are related to: finding and paying for transport to return for more medication, lack of time, lack of food, and fear of inadvertent disclosure (e.g. through family members finding the pills) (*49*).

KEY ISSUES

- With a few exceptions, ARVs have to be taken with food. The lack of food may particularly affect adherence for women because in many settings women are expected to eat after feeding their children and families, or nutritionally rich foods are preferentially given to male members of the household.

- Pregnant women may face additional barriers in adhering to ART due to worries about the effects of drugs on their babies, additional nutritional requirements associated with pregnancy, and conditions such as nausea and vomiting that may be exacerbated as side-effects of ARVs.

- The side-effects of certain ARVs are specific to women and may differ between puberty, the teen years, childbearing age and the postmenopausal years. Coupled with the social norms and expectations associated with women's sexuality and reproductive functions, these side-effects can affect adherence to treatment.
  - For example, some ARVs may, in the long term, cause fat accumulation, especially in certain parts of the body (*169*). This could potentially affect adherence, particularly in cultures where women's sexual attractiveness is linked to a certain body image.

- Women may face difficulties in adhering to ART because of a lack of autonomy. Reports from some settings suggest that HIV-positive pregnant women have returned their drugs because their husbands believed that the drugs might harm their unborn children (*161*).
  - Research has also indicated that some women may be forced to share their drugs with their partners who use their wives' HIV status as a proxy for their own (*170*).

- Factors such as substance abuse (i.e. alcohol and drugs), migrant status or non-resident status, and an absence of social support from family members, friends or communities also present barriers to adherence for women.

FIGURE 4.2 EXAMPLE OF SOLUTIONS TO SUPPORT ADHERENCE (*163*)

4.2.4 Support adherence to ART

ACTIONS

- While obtaining information about missed doses, recognize and acknowledge difficulties in adherence without making any judgement (see example in **BOX 4.2** on page 63, adapted from the adherence resource pack for anti-retroviral treatment) (*171*).
- Identify barriers to adherence, probing for factors related to women's roles and norms.
  - For example, where women find it difficult to make frequent visits to health facilities because of childcare responsibilities or lack of transport, arrange to make home visits, or deliver drugs closer to where clients live through peripheral facilities, community outreach workers, or home-based care volunteers.
- Pregnant or breastfeeding women may need support for adherence that addresses the cultural beliefs and practices associated with food intake during pregnancy.
- Help clients plan their medicine intake if they are expecting changes in routine, e.g. travel, coping with a new baby, or starting a new job.
- Emphasize the importance of not sharing ARVs with anyone, including family members.
- Offer adherence support tools that protect the confidentiality of clients.
  - For example, offer reminders such as calendars, marked pillboxes, diaries or alarm clocks, ensuring that they can be hidden and are non-stigmatizing in form. Provide suggestions for storing ARVs discreetly in the home or at work (see **FIGURE 4.2** on page 64 for an example of practical solutions to support adherence).
- Address women's worries about the side-effects of drugs on their body shape and weight, fertility, pregnancy, sexuality and menstrual cycle.

SECTION 5

Home-based care for people living with HIV

Objectives

This section highlights gender inequalities that affect women's involvement in the provision and experience of home-based care and support for people living with HIV. It assumes that the health sector plays a critical role in interfacing with, supporting and strengthening the provision of home-based care. It also describes actions in the health sector to improve gender-responsiveness and, thus, the quality of home-based care and support services. This section may be most useful to health-care providers and supervisors involved in supporting and facilitating access to home-based care and support services.

5.1 Background

Up to 80% of AIDS-related deaths occur in the home, and 90% of care is provided in the home and is linked to health services (*172*). Home-based care programmes were developed with a view to assisting family caregivers in providing AIDS-related care, because public health services could not cope with the increasing demand for treatment and care. These initiatives have evolved, and they vary in the types of care and support they provide. Some home-based care services focus on providing social and psychological support, with some nutritional support and basic nursing care. Others also dispense ARVs and treat opportunistic infections. These services, whether provided through NGOs, government health clinics, or community groups, are essential in supporting people living with HIV and AIDS, as well as people who provide care and support within families.

Gender inequalities affect men and women's experience of AIDS-related illness differently. They also affect the provision of care and support within households as regards who provides care, which activities are undertaken, and how caregivers are supported. This section, therefore, also describes key issues and gender-responsive actions to support caregivers, the majority of whom are women and girls.

5.2 Addressing gender inequalities in some elements of home-based care programmes

Selected components of home-based care programmes where gender inequalities may be most relevant are outlined below:

5.2.1 Involve men and communities in providing care and support.
5.2.2 Provide palliative care.
5.2.3 Provide support to caregivers.
5.2.4 Provide care and support to children.
5.2.5 Address stigma and discrimination in families and communities.

Gender-responsive actions related to provision of psychosocial support, and referrals to HIV treatment, care and support programmes, are covered in **SECTIONS 2.2.3** (page 35) and **2.2.7** (page 46). Gender-responsive actions related to provision of nutrition counselling are covered in **SECTION 3.2.5** (page 55), and are not revisited here. Gender-responsive actions for supporting adherence to ART are covered in **SECTION 4.2.4** (page 64), and are not revisited here.

5.2.1 Involve men and communities in providing care and support

KEY ISSUES

- Women and girls provide the majority of HIV/AIDS-related care, this being seen as a continuation of their role as care providers in families. Duties that are related to home-based care are seen as domestic and are, therefore, considered to be women's work. Men are traditionally associated with earning income for their families and seldom perform unpaid work.

- Men may not have the skills to provide home-based care and support, such as cooking, washing clothes, childcare, and treating and washing insecticide-treated nets for malaria prevention. These tasks are usually learnt and performed by women.

- Men are more likely to listen to, accept, discuss and share issues related to HIV/AIDS, including care and support, with other men rather than with women (*173*).

ACTIONS

- Conduct community education with men living with HIV, young men, community leaders and male opinion leaders on the importance of male involvement, providing concrete information to encourage them to assume caregiving roles.
  - For example, encourage men to take over some household tasks and fuel collection, or to perform some basic nursing activities. Train male household members to wash and re-treat insecticide-treated nets for malaria prevention.

- Involve community outreach workers, peer counsellors and other lay health workers in conducting home-based care activities, and in supporting caregivers.
  - For example, recognizing that many of these workers are women, address this imbalance by also involving men living with HIV, and male community leaders and members of youth groups, support groups, faith-based groups, and other community service organizations.

- Provide information about caregiving, and provide opportunities to discuss barriers, challenges, experiences and solutions in support groups for men and couples living with, or affected by, HIV.

- Avoid messages that reinforce negative stereotypes to the effect that only women or girls can provide care or conduct activities such as bathing sick people or cooking for sick family members, or that only men can interact with government authorities on behalf of sick people.

- **BOX 5.1** on page 69 describes an intervention to involve men in home-based care activities.

BOX 5.1

"Man enough to care?": Africare's male empowerment project *(174)*

Africare's male empowerment project, "Man enough to care?", is designed to address the imbalance in rural Zimbabwe between male and female caregiving for people living with HIV, by expanding men's roles in home-based care. The project has trained 120 men to be home care volunteers and to provide basic nursing care, infection control and psychosocial support. Carers also encourage positive living, assist in the preparation of wills, and offer bereavement counselling. It was found that associating values and activities such as caring, nursing and the protection of families from HIV transmission with traditionally male characteristics like strength, machismo and power encouraged men to play a more active part in HIV prevention and AIDS-related care. By supporting male volunteers as secondary carers, the project sought to increase men's willingness and ability to provide primary care to their own family members, reduce the burden on women, and increase the quantity and quality of support and care for people living with HIV in rural communities.

The volunteer empowerment caregiving duties men were encouraged to adopt include:

- attending five-day training courses and quarterly refresher courses, or clinical debriefings every year;
- conducting a minimum of five home visits a week, totalling 15 hours;
- visiting clients in hospital;
- assisting clients to perform the activities of daily living, i.e. bathing, dressing, feeding and going to the toilet;
- providing basic nursing care to assigned clients when primary caregivers are not available;
- providing health education, home-based care training and emotional support to primary caregivers and other members of families of identified clients or people living with HIV;
- encouraging and assisting clients to write wills and resolve child custody issues;
- providing bereavement counselling and supplementary and post-test counselling;
- making referrals to additional services;
- referring clients to clinics and hospitals if necessary, and assisting in arranging transport if possible;
- speaking on behalf of clients and their families to local government, traditional authorities, the extended family and the community at large;
- keeping written records of clients and home or hospital visits, using forms provided by Africare;
- maintaining confidentiality and respect at all times.

5.2.2 Provide palliative care

Home-based palliative care activities include: keeping patients clean; preventing bedsores; preventing malaria; managing symptoms such as nausea, diarrhoea and weight loss; managing pain and symptoms; helping to cope with worries and fears; preparing meals; dispensing treatment for opportunistic infections; supporting adherence to treatment; providing spiritual and religious support and end-of-life care and support.

KEY ISSUES

- Caregivers, usually female, may not know how to care for sick family members, may not understand how treatment works, and may not know how to support adherence. Moreover, they may not know when follow-up care should be sought from health facilities, nor where to seek such care (*175–176*).
- Caregivers may not have been trained in universal precautions or may not observe them when providing care. Some women have expressed concern that using gloves and other protective clothing would show a lack of love for their family members (*177*).
- The provision of nursing care usually includes bathing patients and cleaning their private parts. Men and women living with HIV may not want such care to be provided by someone of the opposite sex.
- Lifting and carrying sick relatives can be difficult for females, especially girls.
- Certain symptoms related to AIDS may affect women and men living with HIV differently.
  - For example, women may experience specific pain and symptoms associated with their reproductive systems, including conditions such as pelvic inflammatory disease, genital warts and ulcers, and cancer of the cervix (*166*).
- There may be differences between women and men in how they cope with pain.
  - Research has indicated that while men may have a better tolerance for pain, partly determined by cultural expectations of them to be strong, women usually have a better ability to cope with, seek help for, and manage pain (*178–180*).

ACTIONS

- In providing education to community outreach workers and caregivers about universal precautions, symptom management, ART, side-effects and end-of-life care, take into account the multiple roles, responsibilities and constraints faced by women in the household, family and community.[1]
- Provide essential supplies to caregivers, e.g. gloves, basic first aid, cleaning products, and cooking supplies, or refer households to services or community-based organizations that provide these items.
- Arrange for women and girl caregivers to be assisted with tasks such as lifting and moving patients, bathing them, and helping them to go to the toilet.
- Provide information to caregivers about the specific symptoms experienced by women and men living with HIV and how to manage them.
  - For example, women living with HIV may need culturally appropriate information about preventing and managing symptoms of vaginal thrush (e.g. relief for itching, or using sanitary napkins for discharges).
- In teaching caregivers how to assess pain and give medication for it, sensitize them to the potential differences between men and women in the expression of pain, which may depend on the cultural context.
  - In some cultures, for example, men may not readily admit that they are in pain, and in others, women may consider pain in the abdomen or pelvis to be normal.

[1] See WHO IMAI guidelines on palliative care (*181*), patient education flip chart for HIV prevention, treatment and care (*115*), and guide for caregivers (*182*).

5.2.3 Provide support to caregivers

KEY ISSUES

- In addition to responsibility for basic nursing, home hygiene, and preparing food for family members, many women also have to find water and fuel in order to carry out these activities on a daily basis.
- Poor women in households affected by AIDS become even less economically secure and face food insecurity.
- Many women providing care and support in the home to sick family members are themselves HIV-positive and receive little or no care.
- Caregiving places considerable strain on caregivers, and women and girls commonly experience depression, exhaustion and anxiety, as well as malnourishment (*177*).
  - For example, providing end-of-life care and support to sick family members is an emotionally challenging task for caregivers, and it requires tremendous sensitivity and patience.
  - Both female and male caregivers may experience sadness, grief and anxieties when a family member is dying. For women who are providing such care to a partner or a child, there are additional considerations related to the fear of losing economic, livelihood and family support, as they may be deprived of their rights to housing, property or inheritance.
  - In some settings, women may be blamed for the death of male family members or children, and may have to contend with the associated stigma (*183*).

ACTIONS

- Refer families experiencing acute food shortages to community-based groups or programmes that provide food support and micronutrient interventions. Women in particular may need such support, as they have to balance multiple roles as caregivers and as the main persons responsible for procuring and preparing food and feeding children and family members.
- Offer or arrange for counselling to be given to caregivers on recognizing signs of burnout and how to cope with it. Encourage caregivers to take periodic breaks and engage in leisure activities so as to alleviate depression and burnout.
- Encourage caregivers, volunteers and community outreach workers conducting home-based care activities to form their own support groups, where they can share and exchange experiences and ideas for coping with and caring for sick family members.
- Support caregivers who are providing end-of-life care by arranging for additional home visits from appropriate health-care providers, counsellors or community outreach workers.
  - For example, health-care providers can help caregivers to make practical arrangements through available community resources for issues such as will preparation, spiritual or religious support, funeral arrangements and children's custody and school fees.

5.2.4 Provide care and support to children

KEY ISSUES

- Families more readily take girls out of school to assist in caregiving or income generation activities than boys (*68*).
- Girls are at particular risk of sexual exploitation when trying to secure income to support a household (*68*).
- In households headed by children, girls often assume responsibility for looking after their families, performing household tasks, caregiving and raising income.

ACTIONS

- Counselling and providing information to children requires specialized skills. Arrange for community outreach workers or lay counsellors who have such skills to reach out to children in affected households. Provide counselling to prepare children to cope with the illness and death of their parents.
- Where girls are engaged in home-based care activities, provide information and skills specifically targeted to them.
- Help orphan-headed households to identify community-based resources for assistance with house rent, school fees and the provision of meals. This could help to keep young people, especially girls, in school, and potentially reduce their vulnerability to sexual exploitation.

5.2.5 Address stigma and discrimination in families and communities

Stigma and discrimination are faced not only by people living with HIV but also by their family members, including caregivers and children.

KEY ISSUES

- Family members caring for people living with HIV may show judgemental attitudes that can reinforce feelings of self-blame and depression (*56*).
- Judgemental attitudes are often informed by negative stereotypes of what is considered appropriate behaviour for women and men.
  - For example, women are often accused of bringing HIV into families and passing it on to their husbands or children (*53*, *183*). Women in sex work who are HIV-positive experience multiple stigmas related to engaging in "immoral" or "bad" activities and being diagnosed as HIV-positive.
- In several settings, women living with HIV are abandoned, or sent to their natal home, or stripped of their possessions by relatives, when their husbands die (*184*).
- People living with HIV may find themselves particularly isolated if they do not have a social network, friends or family from whom they can receive support.
- Caregivers of people living with HIV also face stigma from family members, relatives, friends, neighbours and other community members. This adds to their burden by making them feel isolated and unsupported.

ACTIONS

- Ask about the stigmas that patients and their families face, and offer suggestions on how to cope with them. Offer or arrange for ongoing psychosocial support through counselling, including lay counselling offered by community-based or support groups.
- Sensitize community leaders, religious leaders, family members and caregivers about the importance of showing compassion, care and support to people living with HIV.
- Address harmful gender norms and practices that result in women being blamed for bringing HIV into the family, or in women being abandoned or subjected to other discriminatory practices.
- Provide referrals to support groups of people living with HIV, religious groups, women's groups, youth groups and other networks.

Annexes

ANNEX 1

Managers' checklist: Assessing a gender-responsive programme or service

Introduction

This checklist has been developed to accompany **SECTION 1** of the tool on integrating gender into HIV/AIDS programmes in the health sector. It is intended to be used in assessing progress made by programme managers in designing, delivering and managing gender-responsive HIV/AIDS programmes and services. It can be used by managers at the district, regional or health facility/hospital level, or by those who are responsible for the overall planning, management and implementation of all types of HIV/AIDS services and programmes in the health sector. The checklist should be used biannually, or at least annually, for assessing progress towards the integration of gender-responsive actions on the basis of the suggested actions in this tool. It should be integrated into programme or service quality assurance structures and reporting mechanisms so that it is included in feedback meetings at regular intervals.

The checklist should be used as a management instrument to facilitate the integration of gender, as detailed in the rest of the document, rather than as an evaluation instrument. In this way, programme managers will be more objective in answering the questions that it contains, and it can lead to more sustainable adjustments in programmes. Challenges in integrating gender-responsive actions into programmes that emerge from the use of this checklist should be fed into appropriate reporting mechanisms at the health facility, programme, district, regional and national levels.

The checklist comprises questions for assessing whether particular aspects of programme or service delivery have incorporated gender-responsive actions as recommended in the tool. The questions can be answered either "yes" or "no", scoring 1 or 0, respectively. For each question, the data sources for gathering information to help answer the question are identified (the key defined before the start of the checklist explains the methodology for the data sources). The data sources are context-specific and will have to be developed on the basis of specific recommendations that are found in the tool and adopted by programmes. The structure of the checklist mirrors **SECTIONS 1.3.1 to 1.3.6** of the tool document. Gender-responsiveness is represented by the total score expressed as a fraction of the total number of responses. The "Comments" column alongside the checklist should be used for recording challenges or constraints in the implementation of gender-responsive actions, or for making other remarks.

The checklist, like the tool, is based on the premise that addressing gender inequalities is a complex process, and that the ability of HIV/AIDS programme managers and service providers to do so may be limited by their primary mandate of delivering medical and public health services. Moreover, institutional structures, priorities, values and processes in the health sector may constrain the ability of programme managers to make all aspects of programme design and service delivery more gender-responsive. The checklist therefore focuses on aspects of programme planning, management and service delivery that are within the scope of district, regional, health facility, programme, or specific programme managers' responsibilities.

Users can refer to entire parts of the checklist, depending on the programme context, or to specific components, in a piecemeal or a phased manner, i.e. it may not be possible to complete the entire checklist initially. Programme managers should focus their assessments on the relevant programme components where gender-responsive actions have been incorporated (e.g. reducing barriers to access to services, mobilizing community participation).

As with the rest of the document, the checklist should be adapted to specific country, sociocultural and programmatic contexts. Questions should be considered to be applicable if they are relevant to the planned institutional, service delivery or programmatic changes towards gender-responsiveness, or if they are relevant to the minimum package of services or essential components of the quality of care to be provided. Questions may be inapplicable if specific recommendations are not relevant in particular settings.

If, for example, user fees are not being implemented in a particular setting, then the questions about them can be deleted.

The design of this checklist has been influenced by similar tools, including: the PRIME II gender sensitivity assessment tools for reproductive health service providers and managers (*185*); the International Planned Parenthood Federation tools on the gender sensitivity of HIV and family planning services (*186*); and the manual for evaluating quality of care from a gender perspective (*187*).

Key for the column on data sources in the checklist below*

1. Review of Health Information Systems (HIS).
2. Document review (e.g. review of: clinic/programme policies; programme plans; protocols; guidelines; clinic/programme registers; monthly, bimonthly, quarterly, biannual and/or annual reports; information, education and communication (IEC) materials; minutes of meetings attended; reports of special studies conducted; budgets and financial outlays).
3. Interviews and/or self-assessments by programme managers (e.g. clinical/medical officers-in-charge, supervisors, district health and AIDS officers, district planning officers, regional health/AIDS officers, programme officers of national HIV/AIDS programmes).
4. Interviews and/or self-assessments by programme/service delivery staff (counsellors, nurses, medical/clinical officers, etc.).
5. Interviews with programme beneficiaries or users of HIV/AIDS services.
6. Interviews with community members (e.g. community leaders, people living with HIV, youth group members, members of women's groups, staff of community-based organizations).
7. Observations (e.g. programme premises, facilities, provider-client interactions, provider-provider interactions, provider-supervisor interactions).
8. Participatory methods (e.g. social mapping of resources, group discussions with communities, brainstorming or other interactive information-gathering methods).

MANAGERS' CHECKLIST FOR ASSESSING GENDER-RESPONSIVENESS OF HIV/AIDS PROGRAMMES AND SERVICES

Questions to measure gender-responsive characteristics of programme or service	No (score = 0)	Yes (score= 1)	Data sources*	Comments/challenges/constraints
1.3.1 Integrate gender analysis and actions into programme design				
Programme/service has conducted a needs assessment that includes a gender analysis as follows:				
a. Has collected disaggregated data on illness patterns, underlying factors, and the use of health services.			1,2,3	
b. Has explored how harmful sociocultural norms, practices and unequal power dynamics between men and women contribute to who gets sick, and where, how, when, why and with what consequences.			2,3,6,8	
Programme/service has developed explicit gender-related goals and objectives as follows:				
a. Has examined how inequalities experienced by women, harmful sociocultural norms and practices, and unequal power dynamics between women and men affect existing programme/service goals and objectives.			2,3,4	
b. Has developed objectives to address the barriers resulting from inequalities between women and men.			2,3	
1.3.2 Build the capacity of programme staff to respond to the gender dimensions of HIV/AIDS				
Staff have been trained in gender, sexuality and human rights in relation to HIV/AIDS as follows:				
a. Staff have been trained to understand the links between gender inequalities and women's vulnerability to HIV.			3,4	
b. Institutional and personal barriers faced by staff in addressing gender inequalities, sexuality and human rights have been identified and addressed.			3,4	
c. Staff understand their role and responsibilities in addressing gender inequalities, sexuality and human rights issues affecting their clients' lives.			3,4	
d. Staff are able to examine their own values and beliefs about gender roles and sexuality, and to reflect on their own prejudices and behaviours towards their clients.			3,4	
e. Staff are comfortable in discussing issues of sexuality, including demonstrating condom use to clients.			3,4,7	
f. Staff are aware of patient and human rights, including the reproductive rights of all clients, including those of people living with HIV.			2,3,4	

MANAGERS' CHECKLIST FOR ASSESSING GENDER-RESPONSIVENESS OF HIV/AIDS PROGRAMMES AND SERVICES

Questions to measure gender-responsive characteristics of programme or service	No (score = 0)	Yes (score= 1)	Data sources*	Comments/challenges/constraints
g. Staff are empathetic and non-judgemental, and assist clients to make informed choices and decisions about their health.			3,4,7	
h. Support is provided to staff to enable them to obtain information, share experiences, and solve problems in connection with providing gender-responsive care to their clients.			3,4	
i. Follow-up support, supervision, and periodic peformance appraisals are provided for staff who have undergone training.			3,4	
Programme/service capacity has been developed to respond to violence against women as follows:				
a. Staff, clients and communities have been sensitized to understand the links between violence against women and HIV/AIDS.			2,3,4,5,7	
b. Staff are able to identify signs of violence experienced by clients and provide appropriate treatment and psychological support.			2,3,4,5,7	
c. Staff are able to respond to fears of, or potential for, violence, while providing HIV testing and counselling and safer sex or risk-reduction counselling.			2,3,4,5,7	
d. Women at risk of, or who experience, violence are referred to available community resources, including NGOs, women's or peer support groups and domestic violence shelters.			4,5,7	
e. Protocols for the management of rape and sexual abuse have been developed and are being implemented.			2,3,4	
f. Staff are supported in addressing violence in their own lives, including through access to confidential health and psychosocial services.			3,4	
Programme/service is able to provide gender-responsive interpersonal communication as follows:				
a. Staff are trained in interpersonal communication skills that include listening, validating client feelings, and showing empathy and respect to clients in both verbal and non-verbal ways.			3,4,5,7	
b. Staff recognize power differences between themselves and clients, and avoid manifesting judgemental attitudes and personal biases to clients.			3,4,5,7	
c. Staff explain medical and technical terms in lay language and check that these are understood by clients.			4,5,7	

MANAGERS' CHECKLIST FOR ASSESSING GENDER-RESPONSIVENESS OF HIV/AIDS PROGRAMMES AND SERVICES

Questions to measure gender-responsive characteristics of programme or service	No (score = 0)	Yes (score= 1)	Data sources*	Comments/challenges/constraints
d. Confidentiality in provider-client interaction is ensured by using separate spaces for counselling, and ensuring that the client's condition and concerns are discussed only with the client and other staff members directly providing care to the client.			3,4,5,7	
e. Clients are offered additional counselling through peer or lay counsellors from the community.			3,4,5,7	
1.3.3 Reduce barriers to access to HIV/AIDS services				
Gender issues in creating awareness about programme/service have been addressed as follows:				
a. Messages about HIV/AIDS and available services are conveyed through different media to make them accessible to women with different levels of literacy.			2,4,5,6,8	
b. Messages about prevention, treatment and care do not reinforce harmful stereotypes about women, men or any marginalized groups.			2,4,5,6,8	
c. Messages about HIV generate knowledge of the different risks faced by young, pregnant and older women, sex workers, injecting drug users, adolescent girls, and married women who may not perceive risk to themselves.			2,4,5,6,8	
d. Communication messages and materials are targeted to male partners and influential community leaders.			2,4,5,6,8	
e. HIV prevention, treatment and care messages show the shared responsibility of women and men for sexual, reproductive and health decisions.			2,4,5,6,8	
f. Affected communities, including women and men living with HIV, are involved in designing communication strategies about HIV/AIDS and available services.			3,6,8	
g. Home-based care messages acknowledge the contribution of women and girls as caregivers, and raise awareness of the problems they face.			2,4,6,8	
h. Clients and communities are given information about services available to support women, e.g. legal services, microcredit schemes, food and nutrition programmes, and support groups.			2,4,5,6,8	
i. The community has been sensitized about harmful sociocultural norms that increase women's vulnerability to HIV and undermine their access to services, e.g. violence, early marriage, sexual coercion, and limited mobility and autonomy in the household.			4,6,8	

MANAGERS' CHECKLIST FOR ASSESSING GENDER-RESPONSIVENESS OF HIV/AIDS PROGRAMMES AND SERVICES

Questions to measure gender-responsive characteristics of programme or service	No (score = 0)	Yes (score= 1)	Data sources*	Comments/challenges/constraints
Physical access to services has been improved as follows:				
a. Services have been brought closer to the community, including through primary and peripheral health facilities and community-based mechanisms (e.g. mobile or door-to-door services).			3,4,5,6,8	
b. Appropriate opening hours have been identified in consultation with the community.			3,5,6,8	
c. The number of visits to facilities that clients need to make in order to receive treatment and care has been reduced.			3,4,5,6,8	
Physical infrastructure of services has been improved as follows:				
a. Client flow has been streamlined to reduce crowding and waiting times.			3,4,5,6,7,8	
b. The waiting space and the cleanliness of facilities have been improved, and separate toilets have been provided for women and men.			3,4,5,6,7,8	
c. Procedures for procurement and inventory have been improved to ensure reliable supply and availability of essential medicines and commodities.			3,4,5	
Stigma and discrimination within services has been eliminated as follows:				
a. A policy to protect people living with HIV from discrimination has been developed and enforced.			2,3,4,5,7	
b. Measures related to client confidentiality, informed consent, and patient rights have been developed and enforced.			2,3,4,5,7	
c. Clients are given information about their rights and entitlement to discrimination-free care.			2,4,5,7	
d. Staff are trained to clarify their values and attitudes towards people living with HIV, and to respect the rights of their clients, including the reproductive rights of people living with HIV.			4,5,7	
Comprehensive care is provided to clients through linkages with and integration of an appropriate constellation of services as follows:				
a. The programme has identified the full range of services that women need.			3,4,5,6,8	
b. Linkages have been developed or strengthened among services for HIV testing and counselling, PMTCT, HIV treatment and care, and home-based care.			2,3,4,6	

MANAGERS' CHECKLIST FOR ASSESSING GENDER-RESPONSIVENESS OF HIV/AIDS PROGRAMMES AND SERVICES

Questions to measure gender-responsive characteristics of programme or service	No (score = 0)	Yes (score= 1)	Data sources*	Comments/challenges/constraints
c. Linkages have been developed or strengthened between HIV/AIDS and sexual and reproductive health services (e.g. family planning, STI screening and treatment, screening for cervical cancer).			2,3,4,6	
d. Linkages have been developed or strengthened between HIV/AIDS and TB screening and treatment, and malaria prevention and treatment programmes and services.			2,3,4,6	
e. A formal or informal referral mechanism has been developed among the various programmes and services referred to above.			2,3,4,5,6	
Psychosocial needs of clients are addressed as follows:				
a. Linkages have been developed with, and referrals have been provided to, support groups for people living with HIV.			2,3,4,5,6,8	
b. Linkages have been developed with, and referrals have been provided to, programmes that provide psychosocial support, counselling, nutrition services, home-based care services, legal services, income-generation schemes, food security initiatives, orphan care, and domestic violence programmes, where available.			2,3,4,5,6,8	
1.3.4 Promote women's participation				
Women living with HIV are meaningfully involved as follows:				
a. The involvement of women living with HIV is based on the principle of voluntary disclosure of HIV status.			3,4,6	
b. Representatives of women living with HIV, young women, women's groups, and marginalized groups have been consulted; inputs have been sought and changes have been made to reflect their concerns in all aspects of programme design, planning, service delivery and monitoring.			5,6,8	
c. Where women living with HIV are involved as staff, the value of their input is recognized and remunerated, instead of reliance being placed on them to work only in a voluntary capacity.			3,4,6	
d. A policy has been developed and enforced to prevent and redress discrimination against staff living with HIV.			2,3,4	

MANAGERS' CHECKLIST FOR ASSESSING GENDER-RESPONSIVENESS OF HIV/AIDS PROGRAMMES AND SERVICES

Questions to measure gender-responsive characteristics of programme or service	No (score = 0)	Yes (score= 1)	Data sources*	Comments/challenges/constraints
Men are involved as partners, fathers, and beneficiaries as follows:				
a. Communities have been sensitized about the ways in which harmful norms related to masculinity make men and boys vulnerable to HIV and undermine their access to services.			4,5,6,8	
b. Messages on male involvement have portrayed men as positive role models.			2,6,7	
c. Messages on male responsibility and equal decision-making between women and men have been developed and disseminated in communities and to clients.			2,6,7	
d. Men have been reached with messages about their vulnerability and available services, in work settings, bars, sports events, or places of worship.			2,4,5,6,8	
e. Services related to HIV/AIDS and sexual and reproductive health have been made more male-friendly through materials targeted to men, opening hours convenient to men, or the employment of male counsellors to interact with men.			2,3,4,5,6,7,8	
e. Male health workers and volunteers have been involved in providing home-based and community-based care to people living with HIV.			3,4,5,6	
1.3.5 Develop gender-sensitive monitoring and evaluation				
Programme has developed and implemented gender-sensitive monitoring and evaluation as follows:				
a. A policy and plan have been developed and implemented for collecting, analysing and using disaggregated data (e.g. by sex, age and other relevant variables) to guide programme modifications.			1,2,3,4	
b. Health information systems have been developed/revised to collect and analyse relevant programme data disaggregated by sex, age and other variables, as appropriate.			1,2,3,4	
c. Process indicators to reflect progress in addressing gender inequalities have been identified and are being used for monitoring.			1,2,3,4	
d. Periodic small studies using qualitative data have been conducted to better understand observed differences in programme outputs and outcomes for women as compared to men.			3,4	
e. Communities have been involved in the monitoring and evaluation process to reflect their needs, priorities and experiences.			6,8	

MANAGERS' CHECKLIST FOR ASSESSING GENDER-RESPONSIVENESS OF HIV/AIDS PROGRAMMES AND SERVICES

Questions to measure gender-responsive characteristics of programme or service	No (score = 0)	Yes (score= 1)	Data sources*	Comments/challenges/constraints
f. Staff have been sensitized about the relevance of disaggregated data, and have been trained to collect, compile and use them.			3,4	
g. Target-setting for reaching specific populations with services has taken account of the requirement for equitable access for women and men.			2,3,4	
1.3.6 Advocate for gender-responsive health policies				
The gender dimensions of human resources have been addressed as follows:				
a. Health-care workers, especially women at the lower levels of decision-making, are routinely involved in all relevant programme decisions.			2,3,4	
b. Policies to ensure the safety of staff and protect them from sexual harassment, coercion and exploitation in the workplace have been developed and enforced.			2,3,4	
c. Health care provided by community workers is remunerated.			3,4,6,8	
d. Both male and female health-care workers are recruited, trained and retained at appropriate levels, so that clients have the option of obtaininng services from providers of the preferred sex.			2,3,4	
e. Equal opportunities for training, continuing education and skill development are provided for female and male health workers.			2,3,4	
f. Policies related to non-discrimination in recruitment, remuneration and benefits with respect to the sex, ethnicity, caste, sexual orientation and HIV status of potential candidates have been developed and enforced.			2,3,4	
Gender-sensitive health services financing mechanisms have been promoted as follows:				
a. Services are provided free at the point of delivery.			2,3,4,5	
b. The financial and social vulnerabilities of women are taken into account in developing and applying criteria for determining who should be exempt from user fees, who should pay subsidized rates, and who should pay the full amounts.			2,3,4	
c. Communities and clients are given information about exemptions from user fees.			3,4,5,6,8	
d. Clients and communities are given referrals to and information about community-based programmes that can provide/facilitate financial support for accessing services.			3,4,5,6,8	

MANAGERS' CHECKLIST FOR ASSESSING GENDER-RESPONSIVENESS OF HIV/AIDS PROGRAMMES AND SERVICES

Questions to measure gender-responsive characteristics of programme or service	No (score = 0)	Yes (score= 1)	Data sources*	Comments/challenges/constraints
e. An analysis of resource allocation to HIV/AIDS programmes and services has been conducted to examine how resources benefit women.			2,3	
f. Financial, technical and human resources have been allocated for developing and implementing strategies that reduce women's vulnerabilities to HIV.			2,3	
Gender issues have been mainstreamed into national and operational HIV/AIDS policies as follows:				
a. Policy-makers have been sensitized to understand the links between gender inequality and HIV/AIDS.			2,3	
b. Advocacy has been conducted to align operational policies that affect the uptake of services – such as informed consent, partner notification and others – to principles of gender equality and human rights.			3	
Advocacy has been conducted to promote gender equality in policies that have a bearing on HIV/AIDS as follows:				
a. Advocacy to promote gender equality in various laws and policies affecting women's status has been conducted.			3	
b. Advocacy has been conducted to encourage the enforcement of existing laws protecting the rights of women, e.g. those prohibiting early marriage, eliminating violence against women, and giving women equal rights to property and inheritance.			3,6,8	
c. Advocacy has been conducted for gender-responsiveness in multisectoral strategies developed to combat HIV/AIDS (e.g. educational, agricultural, legal).			3	

[Potential maximum score: 85]

ANNEX 2

Providers' checklist: Assessing gender-responsive service delivery

Introduction

This checklist has been developed to accompany **SECTIONS 2 TO 5** of the present document. It is intended to be used in assessing progress made by service providers in delivering gender-responsive HIV/AIDS testing and counselling, PMTCT, treatment and care, and home-based care programmes and services. Parts of the checklist can be used by service providers for self-assesment of their performance with respect to gender-responsiveness, or it can be used by programme managers to assess the extent to which providers or health-care workers of HIV/AIDS services are able to deliver gender-responsive services. The checklist should be used biannually, or at least annually, for assessing progress towards the integration of gender-responsive actions on the basis of the actions suggested in the tool. It should be integrated into programme or service quality assurance structures and reporting mechanisms so that it is included in feedback meetings at regular intervals.

The checklist should be used as a management instrument to facilitate the integration of gender as detailed in the rest of the document, rather than as an evaluation instrument. It should be made clear to service providers that the results of using the checklist will be used for professional development and service improvement, and not for administrative actions such as promotions or dismissals. In this way, service providers and programme managers will be more objective in answering the questions, leading to more sustainable adjustments in programmes. Challenges in integrating gender-responsive actions into programmes that emerge from the use of this checklist should be fed into appropriate reporting mechanisms at the health facility, district, regional and national levels.

For each type of HIV/AIDS programme or service, i.e. HIV testing and counselling, PMTCT, treatment and care, and home-based care, the checklist comprises questions aimed at assessing whether particular aspects of programme or service delivery have incorporated gender-responsive actions as recommended in the tool. The questions can be answered either "yes" or "no", scoring 1 or 0, respectively. For each question, the data sources for gathering information to help answer the question are identified (the key defined before the start of the checklist explains the methodology for the data sources). The data sources are context-specific and will have to be developed on the basis of the specific actions in the tool that are adopted by programmes. The structure of the checklist mirrors **SECTIONS 2.2.1 to 2.2.7, 3.2.1 to 3.2.5, 4.2.1 to 4.2.4 and 5.2.1 to 5.2.5** of the document. Gender-responsiveness is represented by the total score expressed as a fraction of the total number of responses. The "Comments" column alongside the checklist should be used for recording challenges or constraints in the implementation of gender-responsive actions, or for making other remarks.

The checklist, like the rest of the document, is based on the premise that addressing gender inequalities is a complex process, and that the ability of HIV/AIDS service providers to do so may be limited by their primary mandate of delivering medical and public health services. Moreover, institutional structures, priorities, values and processes in the health sector may constrain the ability of service providers to deliver gender-responsive services. The checklist therefore focuses on aspects of service delivery that are within the scope of service providers' responsibilities.

Users can refer to entire parts of the document, depending on the programme context, or to specific steps, in a piecemeal or a phased manner, i.e. it may not be possible to complete the entire checklist initially. Service providers should focus their assessments on the relevant programmatic components where gender-responsive actions have been incorporated (e.g. ensuring gender-responsiveness in supporting HIV status disclosure, or in supporting safer infant feeding practices).

The checklist should be adapted to specific country, sociocultural and programmatic contexts. Questions should be considered to be applicable if they are relevant to

planned institutional, service delivery or programmatic changes towards gender-responsiveness, or if they are part of the minimum package of services or essential components of quality of care to be provided. Questions may be inapplicable if specific recommendations are not relevant in particular settings. If, for example, pretest counselling is not being offered in a particular setting the questions on that subject can be deleted.

Key for the column on data sources in the checklist below*

1. Review of Health Information Systems (HIS).
2. Document review (e.g. review of: clinic/programme policies; programme plans; protocols; guidelines; clinic/programme registers; monthly, bimonthly, quarterly, biannual and/or annual reports; information, education and communication (IEC) materials; minutes of meetings attended; reports of special studies conducted; budgets and financial outlays).
3. Interviews and/or self-assessments by programme managers (e.g. clinical/medical officers-in-charge, supervisors, district health and AIDS officers, district planning officers, regional health/AIDS officers, programme officers of national HIV/AIDS programmes).
4. Interviews and/or self-assessments by programme/service delivery staff (counsellors, nurses, medical/clinical officers, etc.).
5. Interviews with programme beneficiaries or users of HIV/AIDS services.
6. Interviews with community members (e.g. community leaders, people living with HIV, youth group members, members of women's groups, staff of community-based organizations).
7. Observations (e.g. programme premises, facilities, provider-client interactions, provider-provider interactions, provider-supervisor interactions).
8. Participatory methods (e.g. social mapping of resources, group discussions with communities, brainstorming or other interactive information-gathering methods).

PROVIDERS' CHECKLIST FOR ASSESSING GENDER-RESPONSIVENESS OF SERVICE DELIVERY

Questions to measure gender-responsive characteristics of service delivery	No (score = 0)	Yes (score= 1)	Data sources*	Comments/challenges/constraints
2. HIV testing and counselling				
2.2.1 During pretest information or counselling, provider:				
a. Offers clients the option of choosing the preferred sex of the counsellor so that they are comfortable about discussing sensitive issues related to sexual behaviour.			3,4,5	
b. Discusses disclosure of serostatus to help women understand the implications of taking the test, and prepares them to take necessary actions when they receive the results.			4,5,7	
c. Discusses the benefits of testing as well as potential risks, e.g. discrimination, abandonment or violence by partners or family members.			4,5,7	
d. Emphasizes through community education that HIV testing is part of a basic package of health care in order to minimize stigma experienced by women who are tested.			4,6,8	
e. Avoids reinforcing harmful gender and sexual stereotypes, or sexual beliefs about, or prejudices towards, people living with HIV.			4,5,7	
f. Assesses women's sexual power dynamics with partners (e.g. coercion, fear, lack of communication, trust).			4,5,7	
2.2.2 Provider conducts the HIV test as follows:				
a. Emphasizes the voluntary nature of the test and clients' right to decline the test without jeopardizing access to services that are not dependent on knowledge of HIV status.			4,5,7	
b. Ensures privacy during the consultation, reassures women and takes steps to protect the confidentiality of test results.			3, 4,5,7	
c. Provides women advice on safekeeping of the records where their HIV status is recorded.			3,4,5,7	
d. Obtains informed consent while taking into account national laws and policies related to the age and ability of the person to provide independent consent to testing.			3,4,5,7	
e. Supports women offered HIV tests during labour to make informed decisions, taking into account their sensitive emotional state at this time.			4,5,7	
2.2.3 Provider offers psychosocial support as follows:				
a. Explains technical or scientific terms related to test results in simple or lay language and checks whether clients understand the explanations.			4,5,7	

PROVIDERS' CHECKLIST FOR ASSESSING GENDER-RESPONSIVENESS OF SERVICE DELIVERY

Questions to measure gender-responsive characteristics of service delivery	No (score = 0)	Yes (score= 1)	Data sources*	Comments/challenges/constraints
b. Gives women sufficient time to consider the test results and helps them to cope with the emotions arising from them.			4,5,7	
c. Provides emotional support by listening, giving hope and emphasizing that despite a diagnosis of HIV a person can live a healthy life.			4,5,7	
d. Takes into account women's roles and specific needs in the household as part of providing counselling on nutrition, substance abuse (e.g. tobacco, alcohol, drugs), exercising and preventing opportunistic infections, including those related to gynaecological infections.			4,5,7	
e. Arranges for ongoing follow-up counselling, including through peer or community-based lay counsellors.			4,5,7	
f. Assesses for signs of depression and provides referrals to appropriate services, support groups and crisis counselling where available.			4,5,7	
g. Helps women to identify support mechanisms for coping with the test results.			4,5,7	
2.2.4 *Provider supports clients to disclose test results as follows:*				
a. Reassures women of the confidentiality of their results and explains that disclosure is voluntary.			3,4,5,7	
b. Discusses the benefits of disclosure, including receiving social and emotional support, being able to access prevention, treatment and care services, and being able to lead a more healthy and productive life.			4,5,7	
c. Explores possible risks of disclosure, including the potential for negative outcomes, e.g. abandonment, loss of economic support, and violence perpetrated by partners or family members.			4,5,7	
d. Helps women decide to whom and when, where and how they will disclose their status.			4,5,7	
e. Gives women the opportunity to rehearse how they will disclose their status, using role-playing and other behavioural rehearsal techniques.			4,5,7	
f. Assist women at risk of violence with planning for safety during disclosure.			3,4,5,7	
g. Where necessary, offers assistance with disclosure (e.g. mediated disclosure).			4,5,7	

PROVIDERS' CHECKLIST FOR ASSESSING GENDER-RESPONSIVENESS OF SERVICE DELIVERY

Questions to measure gender-responsive characteristics of service delivery	No (score = 0)	Yes (score= 1)	Data sources*	Comments/challenges/constraints
2.2.5 Provider facilitates prevention of sexual transmission of HIV as follows:				
a. Explores women's risk of HIV without making a judgement about their sexual behaviour, including about women living with HIV being sexually active.			4,5,7	
b. Provides information on how to have a safer and healthy sex life, including information on sexual activities that pose no risk of infection (e.g. mutual masturbation and massage).			2,4,5,7	
c. Discusses with pregnant women and new mothers the implications of HIV for themselves and their unborn or breastfeeding children, and of becoming infected with HIV or acquiring an STI during pregnancy.			4,5,7	
d. Offers condoms as dual protection, and trains women to use them.			4,5,7	
e. Offers female condoms to women, or refers women to sources of these, and trains women to use them.			3,4,5,7	
f. Assists women to develop a plan for risk reduction by helping them to identify barriers to practising safer sex, and to solve problems.			4,5,7	
g. Promotes and respects the sexual rights (including the right to have sex free of coercion and violence) of all people, including women, people living with HIV, young people and marginalized groups.			4,5,7	
h. Promotes messages on shared responsibility between men and women for sexual decision-making.			2,4,5,7	
i. Provides accurate information about the risks associated with practices such as dry sex, douching and anal sex.			2,4,5,7	
j. Provides referrals to ongoing prevention programmes in the community (e.g. social marketing, peer education).			4,5,6,7	
k. Discusses the implications of an HIV-positive diagnosis on sexuality and refers for appropriate counselling.			4,5,7	
l. Encourages women to bring their partners for services, and offers safer sex counselling to them either individually or as part of a couple.			4,5,7	

PROVIDERS' CHECKLIST FOR ASSESSING GENDER-RESPONSIVENESS OF SERVICE DELIVERY

Questions to measure gender-responsive characteristics of service delivery	No (score = 0)	Yes (score= 1)	Data sources*	Comments/challenges/constraints
2.2.6 Provider encourages partner testing and involvement as follows:				
a. Supports and facilitates involvement of male partners with female partners' request or permission.			4,5,7	
b. Promotes HIV testing for partners as part of an effort to improve the health of entire families.			2,4,5,7	
c. Provides clients with information about HIV services offered for male partners and family members.			2,4,5,7	
d. Conducts community sensitization on testing, treatment and care services available for men.			4,6,8	
e. Offers the client the option of returning with her partner for couple testing and counselling, thus possibly reducing the burden of blame on the partner who tests first.			4,5,7	
f. Asks each person in a couple to separately and voluntarily consent to HIV testing.			4,5,7	
g. Emphasizes the confidentiality of the results, and that disclosure of the individual results to the other partner will be done with the consent and involvement of each member of the couple.			4,5,7	
h. Emphasizes the shared responsibility of the members of each couple for health decisions.			4,5,7	
i. In post-test counselling, depending on the results of one or both members of a couple, assists with managing feelings of blame, anger and anxiety and preventing escalation to physical or verbal abuse.			4,5,7	
j. Offers mediated disclosure if necessary.			4,5,7	
2.2.7 Provider gives referrals to HIV treatment, care and support programmes and other social services as follows:				
a. Identifies the range of both medical and psychosocial needs of clients.			4,5,7	
b. Maintains an updated directory of all resources and services needed by clients that are available in the community.			2,3,4,6,8	
c. Provides/arranges for referrals as necessary to HIV treatment, care, support and PMTCT programmes, and to other health programmes and medical services.			4,5,7	

PROVIDERS' CHECKLIST FOR ASSESSING GENDER-RESPONSIVENESS OF SERVICE DELIVERY

Questions to measure gender-responsive characteristics of service delivery	No (score = 0)	Yes (score= 1)	Data sources*	Comments/challenges/constraints
d. Provides/arranges for referrals as necessary to psychosocial services available through community-based or faith-based organizations, including legal support, post-test clubs, religious and spiritual support, income generation opportunities, and services for women who experience domestic violence.			4,5,7	
e. Follows up with clients on their ability to access referred services, and on services and care received, and facilitates/supports access as necessary.			4,5,7	
f. Supports women living with HIV in their reproductive decisions and choices by offering family planning or providing referrals to these services.			4,5,7	
g. Provides/arranges for referrals to home-based care programmes.			4,5,7	
h. Helps family members with information and support for providing care to clients diagnosed with HIV.			2,4,5,7	
3. Prevention of mother-to-child transmission of HIV				
3.2.1 Provider offers ARV prophylaxis to prevent HIV infection in infants as follows:				
a. Provides women and their partners with clear information and counselling on ARV prophylaxis dosage and any expected side-effects.			2,4,5,7	
b. Recognizes and addresses women's concerns about side-effects, their desire to be good mothers, and their limited autonomy with respect to making decisions related to pregnancy.			4,5,7	
c. Sensitizes communities, including leaders, about harmful norms and practices that present barriers to women's uptake of ARV prophylaxis.			4,6,8	
d. Provides adherence counselling that takes account of fears about inadvertent disclosure.			4,5,7	
3.2.2 Provider assists women with birth planning as follows:				
a. Educates partners of women living with HIV and communities about the necessity of supporting women to access skilled care during childbirth.			4,5,7	
b. Assists women and their partners to develop a plan for childbirth before the onset of labour.			4,5,7	

PROVIDERS' CHECKLIST FOR ASSESSING GENDER-RESPONSIVENESS OF SERVICE DELIVERY

Questions to measure gender-responsive characteristics of service delivery	No (score = 0)	Yes (score= 1)	Data sources*	Comments/challenges/constraints
3.2.3 Provider supports safer infant feeding practices as follows:				
a. Discusses the risks of transmission of HIV through breastfeeding and the risks associated with mixed feeding with women and their partners.			4,5,7	
b. Gives complete information on the benefits and difficulties of both feeding options to women and their partners, discussing the feasibility of both.			4,5,7	
c. Supports women in making informed choices based on a realistic appraisal of their situations.			2,4,5,7	
d. Sensitizes communities about safer infant feeding practices in order to create an enabling environment for women.			4,6,8	
e. Supports women in adhering to their choices regarding infant feeding with ongoing counselling.			4,5,7	
f. Refers women to community-based programmes that can support their choices regarding infant feeding.			4,5,7	
3.2.4 Provider supports women living with HIV to make informed reproductive choices as follows:				
a. Assists women living with HIV to make informed reproductive choices and decisions by providing complete information about potential pregnancy outcomes associated with HIV infection, all appropriate contraceptive methods for those who wish to delay or prevent pregnancies, and PMTCT interventions for those who wish to have children.			2,4,5,7	
b. Promotes and respects the reproductive rights of women living with HIV, including the right to safe abortion in contexts where it is not against the law.			4,5,7	
c. Supports women living with HIV to consult their partners about their reproductive decisions, and provides them with the necessary information.			4,5,7	
d. Sensitizes communities about the importance of preventing unwanted pregnancies where one partner is, or both are, living with HIV.			4,6,8	
3.2.5 Provider offers nutrition counselling for women living with HIV as follows:				
a. Identifies causes of household food insecurity and works with communities and households to address them.			4,5,6,7,8	

PROVIDERS' CHECKLIST FOR ASSESSING GENDER-RESPONSIVENESS OF SERVICE DELIVERY

Questions to measure gender-responsive characteristics of service delivery	No (score = 0)	Yes (score= 1)	Data sources*	Comments/challenges/constraints
b. Identifies and discusses with women and communities the sociocultural norms related to food intake for women, as part of providing information about appropriate diet for HIV-positive women, including pregnant women.			4,5,6,7,8	
c. Refers pregnant women who are unable to gain weight during pregnancy, are losing weight, or are experiencing acute food insecurity, to programmes that provide food assistance or supplementation.			4,5,7	
d. Provides counselling for women living with HIV and their families on food safety, preparation, and storage, in order to minimize their risk of becoming sick from food-related infections.			4,5,7	
e. For women who are taking ARVs, provides counselling on managing side-effects that have nutritional implications, such as nausea, diarrhoea and vomiting, and on the food and water requirements of the relevant drug regimens.			4,5,7	
4. HIV/AIDS treatment and care				
4.2.1 Provider determines clients' eligibility for initiating ART as follows:				
a. Identifies alternative ways to provide ART to eligible women who are excluded on the basis of certain social criteria (e.g. requirements for disclosure of serostatus, and the ability to adhere to treatment).			3,4,5	
b. Provides ongoing pre-ART and adherence counselling by arranging for peer support to facilitate access to ART for those who might face difficulties in meeting the eligibility criteria.			4,5,7	
c. Where policy allows, provides free ART or otherwise refers clients to programmes, that can help with financial support for meeting treatment and ancillary costs.			3,4,5	
d. Sensitizes communities and educates people living with HIV about the availability of tests to determine eligibility for ART and about eligibility criteria, so that they know if they qualify for treatment and should seek services.			4,5,6,8	
4.2.2 Provider initiates prophylaxis or treatment for opportunistic infections as follows:				
a. Provides education to women living with HIV about the benefits of, need for, and timing of, prophylaxis for opportunistic infections, and about other key elements of early HIV care.			4,5,7	

PROVIDERS' CHECKLIST FOR ASSESSING GENDER-RESPONSIVENESS OF SERVICE DELIVERY

Questions to measure gender-responsive characteristics of service delivery	No (score = 0)	Yes (score= 1)	Data sources*	Comments/challenges/constraints
b. Provides information to women living with HIV on recognizing, and seeking timely treatment for, symptoms and conditions associated with the reproductive system, and on obtaining regular pap smears for cervical cancer screening.			4,5,7	
c. Proactively asks women living with HIV about symptoms of the reproductive tract, in order to identify women who need treatment and are embarrassed about discussing them.			4,5,7	
d. Provides information about sexual and reproductive hygiene practices in order to prevent, mitigate, and manage gynaecological symptoms in women living with HIV.			4,5,7	
4.2.3 Provider initiates ART as follows:				
a. Assesses readiness to start ART and the availability of support systems before initiating treatment.			4,5,7	
b. Helps women to safely disclose their serostatus to persons who can support them in accessing and continuing with treatment.			4,5,7	
c. Assists those who face barriers in attending services regularly for follow-up visits through referrals to community-based programmes and support.			4,5,7	
d. Provides information in simple lay language about drugs, medications, side-effects, the management of side-effects, adherence to treatment, dietary requirements and potential drug interactions; uses visual aids in order to meet the needs of women who are less literate.			2,4,5,7	
e. Assists women to access treatment and care services in terms of transportation, childcare and other needs, including through arrangements with community-based services, where available.			4,5,6,8	
f. Helps develop treatment plans that are incorporated into women's daily lifestyles and work patterns.			4,5,7	
4.2.4 Provider supports adherence to ART as follows:				
a. Obtains information about missed doses, recognizing and acknowledging difficulties in adherence to treatment without making any judgements.			4,5,7	
b. Identifies barriers, including probing for factors related to women's roles and socio-cultural norms that could affect adherence.			4,5,7	

PROVIDERS' CHECKLIST FOR ASSESSING GENDER-RESPONSIVENESS OF SERVICE DELIVERY

Questions to measure gender-responsive characteristics of service delivery	No (score = 0)	Yes (score= 1)	Data sources*	Comments/challenges/constraints
c. Offers practical tips to address barriers in adherence to treatment protocols, taking into account women's roles and norms.			4,5,7	
d. Sensitizes communities about cultural beliefs and practices associated with food intake during pregnancy that could compromise nutritional intake and adherence.			4,6,8	
e. Assists women to adjust their medicine intake if they are expecting changes in routine.			4,5,7	
f. Emphasizes the importance of not sharing ARVs with anyone, including family members.			4,5,7	
g. Offers tools to support adherence to treatment while remembering to protect the confidentiality of clients (e.g. calendars, marked pillboxes, diaries or alarm clocks, and suggestions for storing ARVs discreetly in the home or at work).			2, 3,4,5,7	
h. Addresses women's worries about, and experiences of, the side-effects of ARV drugs on the body, including effects on fertility, pregnancy, sexuality and the menstrual cycle.			4,5,7	
5. Home-based care for people living with HIV				
5.2.1 Provider involves men and communities in care and support as follows:				
a. Conducts community education with men living with HIV, young men, and male opinion leaders on the importance of male involvement in caregiving roles.			4,6,8	
b. Invites community outreach workers, peer counsellors and other lay health workers, including men and women's male partners, to conduct home-based care and support activities and to support caregivers.			4,6,8	
c. Provides information about caregiving and discusses barriers, challenges, experiences and solutions with men in communities to encourage them to get involved.			4,6,8	
d. Encourages men and couples living with HIV to form support groups to exchange information and share experiences in caregiving.			4,5,7	
e. Reinforces the notion of shared responsibility between men and women for providing care or conducting activities such as bathing sick people or cooking for sick family members.			2,4,5,7	

PROVIDERS' CHECKLIST FOR ASSESSING GENDER-RESPONSIVENESS OF SERVICE DELIVERY

Questions to measure gender-responsive characteristics of service delivery	No (score = 0)	Yes (score= 1)	Data sources*	Comments/challenges/constraints
5.2.2 Provider supports palliative care as follows:				
a. Recognizes and addresses women's multiple roles and constraints when providing education to community outreach workers and caregivers about universal precautions, symptom management, side-effects of ART, and end-of-life care.			4,6,8	
b. Encourages family members and community outreach workers to assist women or girl caregivers in families with lifting and moving patients, as well as with bathing and helping patients to go to the toilet.			4,5,6,8	
c. Provides information to caregivers about the specific symptoms experienced by women and men living with HIV and how to manage them.			4,5,6,8	
d. Educates caregivers about assessing pain and giving pain medication, while sensitizing them to the cultural and other differences between how men and women experience and express pain.			4,5,6,8	
e. Arranges for caregivers to obtain essential supplies, e.g. gloves, basic first-aid and cleaning products, and cooking supplies, to help them in caring for sick family members.			3,4,5,6,8	
5.2.3 Provider supports caregivers as follows:				
a. Refers families experiencing acute food shortages to community-based groups or programmes that provide food assistance and micronutrient interventions.			4,5,6,8	
b. Offers or arranges for counselling to be given to caregivers on the recognition of signs of burnout and how to cope with it.			4,5,7	
c. Encourages caregivers and outreach workers to form support groups to share and exchange experiences and ideas for coping with and caring for sick family members.			4,5,6,8	
d. Supports caregivers who are providing end-of-life care by arranging for additional home visits from relevant health-care providers, counsellors or community outreach workers.			4,5,6,8	
5.2.4 Provider supports children in affected households as follows:				
a. Arranges for counsellors with specialized skills to counsel children in affected households to prepare them to cope with the illness and death of their parents.			3,4,6,8	

PROVIDERS' CHECKLIST FOR ASSESSING GENDER-RESPONSIVENESS OF SERVICE DELIVERY

Questions to measure gender-responsive characteristics of service delivery	No (score = 0)	Yes (score= 1)	Data sources*	Comments/challenges/constraints
b. Supports children in affected households by providing specific information and skills so as to help them to prepare for and better cope with the illness and death of adult family members.			2,3,4,5,6	
c. Helps orphan-headed households to identify community-based resources to assist them with house rent, school fees and the provision of meals.			3,4,5	
5.2.5 *Provider helps clients to cope with stigma and discrimination as follows:*				
a. Asks about stigma faced by clients and their families, and offers suggestions on how to cope with it.			4,5,7	
b. Offers or arranges for ongoing psychosocial support, including that obtained through lay counselling by community-based or support groups, religious groups, women's groups, youth groups and other community-based resources.			4,5,6,7	
c. Sensitizes community leaders, family members and caregivers about the importance of showing compassion to people living with HIV and about harmful norms and practices that discriminate against people living with HIV and their families.			4,5,6,8	

[Potential maximum score: 119]

ANNEX 3

Feedback on using this tool

This tool, which has been developed with inputs from various institutions and individuals working in the field of gender and HIV/AIDS, will be revised on the basis of feedback received from users. Annex 3 provides an opportunity for users to give feedback that will contribute towards updating the tool, in order to better meet the constantly evolving needs of stakeholders involved in designing, planning and implementing HIV/AIDS programmes and services.

We are relying on your frank assessment of what aspects of this tool have been useful and have worked in your setting and of what has not worked, and on concrete suggestions for improving this document. We would also appreciate a short description of how you have integrated gender in your programme, and an indication of lessons learnt from using this document. This will provide us with practical examples that we can share with others. Please answer the following questions and make additional comments where requested.

1. This tool is divided into five sections: Basic steps in gender-responsive programming; HIV testing and counselling; PMTCT; HIV/AIDS treatment and care; home-based care for people living with HIV. Was the overall structure of the document useful? How?
2. Each section is divided into key programme steps and each step describes key gender issues and suggests actions for addressing them. What did you find useful about this approach? What did you not find useful about it?
3. Was the content of the tool useful, as follows?
   a. Clear?
   b. Concise?
   c. Technically accurate?
   d. Practical?
   e. Relevant to your setting?
   f. Applicable to your daily work?
4. Were Annexes 1 & 2 useful? If so, please describe how.
5. Were the examples and case studies throughout the document useful? If so, please describe how.
6. Please briefly describe your programme.
   a. What type of HIV/AIDS programme is it?
   b. Who are the beneficiaries of the programme (i.e. what are the socio-demographic characteristics of the users of the programme/services)?
   c. Describe the setting in which you operate (country, region, rural or urban, HIV risk and vulnerability profiles).
   d. Are you a government institution, nongovernmental organization or community-based organization?
   e. What are the main gender inequality considerations affecting the HIV/AIDS vulnerability of the populations you serve?
   f. What are the main gender inequality considerations affecting the uptake of your programme/services?
   g. Which sections and suggested actions did you prioritize for integrating into your own programme?
   h. What challenges did you experience in adopting/adapting various suggestions in this document?
   i. What lessons were learnt in adopting the suggested actions in your programme?

7. What suggestions do you have for improving this tool with regard to:

    a. Structure?
    b. Technical content?
    c. Relevance?
    d. Tools?
    e. What is missing?

8. Additional comments/feedback.

Thank you for taking the time to complete this questionnaire and for your thoughtful feedback. Please send your feedback to either: genderhealth@who.int

or:

Integrating gender into HIV/AIDS programmes in the health sector – Feedback
ATTN: Technical Officer
Department of Gender, Women and Health
World Health Organization
20 Avenue Appia
1211 Geneva 27
Switzerland

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