1. Introduction

Scope and Objectives of this Manual

This reference Manual provides an overview of some of the major gender issues in the HIV/AIDS pandemic and offers suggestions for a multisectoral response. It is intended to enhance the capacity of Commonwealth countries in both the South and the North to develop gender-sensitive national HIV/AIDS strategies, programmes and policies. It encourages the building and fostering of community, government, clinical and academic partnerships which respect the perspectives and needs of people living with HIV/AIDS (PLHA). It also aims to assist countries in establishing ongoing and upgraded national monitoring and evaluation mechanisms to review past and present programming initiatives and policy directions related to HIV/AIDS prevention, care, treatment and support. It outlines some of the main issues in a variety of sectors and makes recommendations for future programme and policy priorities that are inclusive of HIV/AIDS stakeholder groups.

The factors affecting health outcomes involve many spheres, including genetic and biological, and social and economic conditions, the environment, individual choices and behaviours, as well as gender.

A primary objective of the Manual is to demonstrate the application of gender-based knowledge in the campaign against the HIV/AIDS pandemic. It uses case studies infused with the social, economic, cultural and gender dimensions of health that are relevant to individuals, families and communities. The factors affecting health outcomes involve many spheres, including genetic and biological, and social and economic conditions, the environment, individual choices and behaviours, as well as gender. Selected to display the influences and significance of relations between the sexes, the studies provide insights into the dynamic interplay between biology, gender and culture; the challenges and benefits of accommodation for numerous determinants of health; and the dynamics of promoting changes in health outcomes. A list of HIV/AIDS websites and a gender-sensitivity checklist provide ways of accessing more information and an example of a policy tool. Appendices include UN guidelines on HIV-related human rights and some of the global and Commonwealth mandates

At the end of 2001, UNAIDS and WHO estimated that the number of people living with HIV had grown to 40 million and there were 3 million deaths due to HIV/AIDS-related causes during that year.

that call on governments to take action to develop gender-inclusive education, policies and programmes for HIV/AIDS prevention and intervention. There is an extensive bibliography.

The Manual is the first in a new series on gender mainstreaming in critical development issues. This new series is an offshoot of the internationally recognised 11-volume series of Gender Management System manuals that focused on specific sectors. The GMS is explained most fully in the *Gender Management System Handbook*. An important objective of all these publications is to assist governments in advancing gender equality in their countries. However, they are also intended to be of use to other stakeholders that are involved in determining and formulating policy, applying it and ensuring its enforcement. These include international and regional agencies, the academic community, NGOs, other non-state organisations, and individual gender experts and trainers. The Manual specifically promotes the participation and inclusion of NGOs and community consultation in the development of HIV/AIDS policies, plans and programme delivery.

The Manual is also intended to serve as core curriculum reference material for the International Institute on Gender and HIV/AIDS – a partnership programme of the Maritime Centre of Excellence for Women's Health (Dalhousie University and the IWK Health Centre) and the Commonwealth Secretariat.

HIV/AIDS: An Overview

The incidence of and risk factors for HIV/AIDS worldwide

The number of HIV/AIDS cases continues to grow throughout the world despite efforts to distribute information on avoidance and/or management of risk behaviours and situations. At the end of 2001, UNAIDS and the World Health Organisation (WHO) estimated that the number of people living with HIV had grown to 40 million and there were 3 million deaths due to HIV/AIDS-related causes during that year (see Table 1). The cumulative number of deaths attributed to HIV/AIDS in the period from the onset of the pandemic to December 2001 stood at 24.8 million. AIDS is now the fourth

Table 1: Global HIV/AIDS Statistics, December 2001

		2001	1996
People newly infected with HIV	Total	5,000,000	3,100,000
	Adults	4,300,000	2,700,000
	Women	1,800,000	(no. unavailable)
	Children	800,000	400,000
People living with HIV/AIDS	Total	40,000,000	22,600,000
	Adults	37,200,000	21,800,000
	Women	17,600,000	9,200,000
	Children	2,700,000	830,000
Total AIDS deaths since the beginning of the epidemic	Total	24,800,000	6,400,000
	Adults	19,900,000	5,000,000
	Women	10,100,000	2,100,000
	Children	4,900,000	1,400,000

Source: UNAIDS/WHO, 2001.

biggest killer in the world, after heart disease, stroke and respiratory disease, and kills more people than any other infectious disease.

Sub-Saharan Africa remains by far the worst affected – and most poorly resourced – region in the world. More than 28 million Africans are HIV positive and a further 17 million have already died of AIDS. The death toll claimed by the epidemic in 2000 was ten times that caused by the region's wars and civil conflicts (UNAIDS, 2001b). If current trends do not change, there will be more than 40 million AIDS orphans in Africa by 2010 (Human Rights Watch, 2001a). In the Caribbean, according to the Director of the Caribbean Epidemiology Centre, AIDS is the leading cause of death for people aged 15–45 and the number of cases is doubling every two or three years (De Young, 2001). Asia, where more people live than any other region, is seeing alarming increases in the number of infections (see Table 2).

While AIDS was originally diagnosed in homosexual men in the USA, and there is still a widespread belief in industrialised countries that it is a 'gay disease', the first case in a woman was actually identified a mere two months after that in a man. By 1991, "AIDS was the leading killer of young women in most large US cities" (Farmer, 1999). Factors in the spread of the disease include risky behaviour such as sharing drug-

Table 2: Regional HIV/AIDS Statistics, December 2001

Region	Adults and children living with HIV/AIDS	Adults and children newly infected with HIV/AIDS	Adult prevalence rate (%)	Percentage of HIV-positive people who are female (%)
Sub-Saharan Africa	28,100,000	3,400,000	8.4	55
North Africa & Middle East	440,000	80,000	0.2	40
South Asia & South-East Asia	6,100,000	800,000	0.6	35
East Asia & Pacific	1,000,000	270,000	0.1	20
Latin America	1,400,000	130,000	0.5	30
Caribbean	420,000	60,000	2.2	50
Eastern Europe & Central Asia	1,000,000	250,000	0.5	20
Western Europe	560,000	30,000	0.3	25
North America	940,000	45,000	0.6	20
Australia & New Zealand	15,000	500	0.1	10
TOTAL	40,000,000	5,000,000	1.2	48

Source: UNAIDS/WHO, 2001.

injection equipment, transfusion of blood that is HIV infected, an injection with an unsterilised needle, and exposure to HIV in the womb or during birth or breastfeeding. However, the source of infection for the majority of people is sexual intercourse.

Worldwide, the populations now being most affected by HIV/AIDS are those socially and/or economically marginalised by income, employment, ethnicity, culture and gender. HIV/AIDS spreads most rapidly when civil and political rights are violated. It flourishes "where women are unable to negotiate the terms of their sexual relations, where gay men and sex workers are marginalised and excluded from services, and where sexual violence is prevalent" (Human Rights Watch, 2001b). The Executive Director of UNFPA has stressed the fact that, "HIV, in poor and rich countries alike, is linked to discrimination, poverty, and insecurity as well as a culture of silence about the disease and refusal to take preventive action" (Obaid, 2001).

Inequality and marginalisation put people at greater risk of infection, isolation and bearing an excessive share of the responsibility for caring for self and others, as well as of premature death. In industrialised countries, where antiretroviral therapy is helping HIV-positive people to live productive lives,

In Malawi, 65-year-old Maritas Shaba stands with six of the nine grandchildren whose guardian she has become since the death of both their parents from AIDS.
UNICEF/HQ93-2043/
Cindy Andrew

the epidemic is shifting towards poorer people, especially ethnic minorities. In Canada, for example, those at high risk of becoming HIV positive may represent 'hard to reach' or 'forgotten' populations who are excluded from the mainstream. Since 1984, the number of AIDS cases among aboriginal Canadians has risen steadily – most alarmingly among women and those under 30 (Dodds et al., 2001) (see Box 1).

The major challenge for governments and communities is to develop policies and programmes that meet the needs of the entire population. Education and treatment approaches which neglect gender, cultural or social disparities have little effect at the individual level and may be unsustainable at the policy level because they are failing to improve long-term health outcomes. Methods of intervention that do not recognise and address these inequalities fail to use resources efficiently or effectively to ameliorate underlying conditions. Such inequalities contribute to the development of epidemics and are likely to affect their enduring presence.

Box 1: HIV/AIDS and Aboriginal Women in Canada

Aboriginal women are over-represented in HIV/AIDS statistics in Canada. Research shows that those at greatest risk of HIV are most likely to be the products of families and communities devastated by the long-term effects of cultural disruption (including residential schooling) and multigenerational abuse. These factors, combined with widespread poverty, racism, sexism and the loss of traditional ways of life, have given rise to a range of pressing social problems that include alcoholism, substance abuse, high suicide rates, violence against women and family violence.

First Nations women living with HIV/AIDS experience gender discrimination as women in addition to the stigma that HIV-positive men face. Women's social role as primary caregivers and nurturers in the family constitutes a fundamental difference in their experience of HIV/AIDS compared to that of men. Aboriginal women living with HIV/AIDS are more likely to be single parents, living below the poverty line and responsible for the health and wellbeing of their children, in addition to their own, with fewer resources. Aboriginal women assume the burden of caregiving for Aboriginal people with HIV/AIDS with few supports. High rates of sexually transmitted infections (STIs), alcoholism and substance abuse, together with low rates of condom use and high rates of teenage pregnancy, continue to increase vulnerability to HIV, particularly among Aboriginal young people, who are also over-represented in high-risk groups, such as runaways, sex trade workers and intravenous drug users.

Source: Ship and Norton, 2001

Why gender and HIV/AIDS?

Mariah, a 35-year-old with three young children, found out that she was HIV positive because her husband became ill and they

went for a test together. When he subsequently died and his relatives insisted she be inherited by one of his brothers, she informed them of her HIV-positive status. She was then accused of killing their son and forced out of their residence without her children.

Summarised from Nath, 2001a

An examination of the realities of women's and men's lives reveals variations in personal, physical, social and economic powers and capacities. These differences are expressed at many levels of human activities and result in differential rates of risk, infection patterns, access to health knowledge and protection, intervention and management of illness.

Across the world, there has been a changing pattern in rates of male/female HIV/AIDS infections. As the epidemic has spread there has been a progressive shift towards heterosexual transmission and increasing infection rates in women. Today, more women than men are dying of HIV/AIDS, and the age patterns of infection are significantly different for the two sexes. In sub-Saharan Africa women constitute 55 per cent of all HIV infected adults, while teenage girls are infected at a rate five to six times greater than their male counterparts (Commission on the Status of Women, 2001). In the Caribbean, women made up half of those newly infected in 2001.

In Tanzania, the third of three wives in an area where polygamy is common is left to care for all the offspring after her husband and his two other wives died of AIDS.
UNAIDS/Louise Gubb

Box 2: Women's Vulnerability to HIV/ AIDS

Although HIV/AIDS affects both men and women, women are more vulnerable for biological, epidemiological and social reasons:

- Women are more susceptible to HIV infection because of the vulnerability of the reproductive tract tissues to the virus, especially in young women.
- Men and women have a greater risk of acquiring HIV in the presence of sexually transmitted infections (STIs). STIs in women are less noticed and often go undiagnosed. The stigma of STIs in women can also discourage them from getting treatment.
- Cultural, social and economic pressures make women more likely to contract HIV infection than men. Women are often less able to negotiate safer sex due to factors such as their lower status, economic dependence and fear of violence.
- There is a big difference in attitudes towards men's and women's sexuality before or outside marriage. Promiscuity in men is often condoned and sometimes encouraged, while it is usually frowned upon in women.
- Young women and girls are increasingly being targeted for sex by older men seeking safe partners and also by those who erroneously believe that a man infected with HIV/AIDS can get rid of the disease by having sex with a virgin.
- Women and girls tend to bear the main burden of caring for sick family members, and often have less care and support when they themselves are infected.
- Women known to have HIV/AIDS are more likely to be rejected, expelled from the family home and denied treatment, care and basic human rights.
- There is a strong gender difference in the age-related prevalence of HIV/AIDS, with the average age of infected women in Africa typically being several years lower than that of men.

Source: Matlin and Spence, 2000

Beyond the statistics of sex-based differences in infection rates, there are profound differences in the underlying causes and consequences of HIV/AIDS infections in men and women, reflecting differences in biology, sexual behaviour, social attitudes and pressures, economic power and vulnerability (see Box 2). In general, male–female transmission of HIV is more efficient than female–male transmission, both because infected semen contains a higher concentration of the virus than female sexual secretions and because the exposed surface area of women's reproductive tract tissue is larger than the vulnerable surface area in men (Kumar, Larkin and Mitchell, 2001). Gender analysis of past attempts to address HIV/AIDS reveals significant sex and gender differences in the patterns of infection and access to information, prevention, treatment and care-giving supports. It is common in all cultures that responsibilities for management of sexual behaviour and sexual health are affected by gender. There is evidence that health promotion efforts everywhere are limited by conditions related to poverty, with high-risk behaviours and literacy levels severely reducing the delivery of health information.

. . . there are profound differences in the underlying causes and consequences of HIV/AIDS infections in men and women, reflecting differences in biology, sexual behaviour, social attitudes and pressures, economic power and vulnerability.

It is now widely recognised that gender-based inequalities in the treatment of women and men permeate health systems in all parts of the world and this situation is mirrored in the specific area of HIV/AIDS. Examples of gender biases can be found in women's access to services for diagnosis, counselling and treatment; in the training of health professionals and their responses to patients; and in the nature and focus of research into new drugs and treatments, including the greatly disproportionate use of men as research subjects to establish the pharmacological effects and efficacy of drugs.

Redressing these biases is not simple. Countries have been struggling for years with health sector reforms in response to a variety of external and internal forces, including structural adjustment, globalisation, economic contraction and shrinkage of state support for the social sector. As of December 2000, 95 per cent of all AIDS cases have occurred in developing countries (UNAIDS, 2001a), and health systems that were previously fragile are now being stretched far beyond their limits by the pandemic. It is therefore vital to ensure that the meagre resources available are used in a cost-effective and equitable way. Culturally appropriate gender-based strategies

HIV/AIDS is not solely a health problem but requires a more broadly based response going beyond biomedical models.

have been clearly shown by Canadian case study economic analyses to be highly cost effective, producing enormous savings in direct health care costs and retained productive capacity (Dodds et al., 2001). Action must be taken to ensure that women and girls have adequate access to sexual and reproductive health services and that there is equality in the provision of drugs for treating HIV/AIDS and opportunistic infections and care of those infected.

At the same time, it has been recognised that HIV/AIDS is not solely a health problem but requires a more broadly based response going beyond biomedical models. At the international level, the Joint United Nations Programme on HIV/AIDS (UNAIDS) was established in 1996. More recently, at the regional level, the UNAIDS co-sponsors and other partners have initiated an International Partnership on HIV/AIDS in Africa and the World Bank has launched its strategy on Intensifying Action Against HIV/AIDS in Africa. In the Caribbean, a regional government coalition has been launched to fight the epidemic (see Box 3). At the national level, many governments have adopted a multisectoral approach to addressing the pandemic, with the involvement of many government departments, NGOs and the private sector.

To successfully address the HIV/AIDS pandemic, a gender perspective has to be mainstreamed into these broad-based and multisectoral responses. Taking gender into account when designing policy promotes the development of options to accommodate sex and gender differences. It also brings to light cultural and economic differences, how gender roles affect the responsibilities of women and men, as well as current deficits in gender-related data and information.

A Gender Framework

What is the difference between sex and gender?

"'Gender' refers to socially constructed roles of women and men ascribed to them on the basis of their sex, whereas the term 'sex' refers to biological and physical characteristics. Gender roles depend on a particular socio-economic, political and cultural context, and are affected by other factors, including age, race, class and ethnicity. Gender roles are learned and

Box 3: Governments Come Together to Fight HIV/AIDS in the Caribbean

A coalition to fight HIV/AIDS in the Caribbean was launched in February 2001 at the CARICOM Heads of Government meeting in Barbados. The region has the highest prevalence of HIV/AIDS outside sub-Saharan Africa. In a population of just over 6 million, an estimated 420,000 people are infected, and AIDS is a major cause of death for the 15–44 age group in several countries.

The new Caribbean Regional Strategic Plan of Action for HIV/AIDS is designed to give governments the tools to intervene quickly to prevent the spread of the disease, with programmes focused on high-risk groups as well as treatment for those living with AIDS. The coalition's goal is to reduce the number of new HIV infections, provide care for people already infected, reduce AIDS-related discrimination and increase the ability of communities, NGOs and others to respond to the epidemic.

Specific targets include cutting HIV transmission from mother to child by 50 per cent by 2003 and reducing by 25 per cent HIV/AIDS prevalence among 15- to 24-year-olds by 2005. By 2005, 90 per cent of young people aged 15–24 should have access to information, education and services to help reduce their vulnerability to HIV infection. The Plan of Action takes into account what has and has not worked elsewhere to prevent and contain the AIDS epidemic. In particular, the coalition recognises that the health sector cannot cope with the disease alone and emphasises the need for a broad-based alliance and strong political leadership.

Source: Epstein, 2001

vary widely within and between cultures … [and] can change. Gender roles help to determine women's access to rights, resources and opportunities." (*'Implementation of the Outcome of the Fourth World Conference on Women', A/51/322, paras. 7–14*).

Women and men do not generally have equal access to resources such as money, information, power and influence.

Included in the construct of gender are the unequal power relations (social, political, economic) between women and men; the stereotyping of women as inferior; and the greater value that is put on men's roles and functions in society (Chinkin, 2001). Women and men do not generally have equal access to resources such as money, information, power and influence. The sexual division of labour means that women do less highly paid and more socially under-valued work. For example, construction and garbage collection, traditionally male jobs, are better paid than traditionally female jobs such as child care, secretarial work and nursing.

What is gender analysis?

Gender analysis is a tool that uses sex and gender as an organising principle or a way of conceptualising information. It helps to bring out and clarify the nature of the social relationships between men and women and their different social realities, life expectations and economic circumstances. In the area of HIV/AIDS, it identifies how these conditions affect women's and men's susceptibility to infection and their access to, and interaction with, treatment and care. Gender analysis provides a framework for analysing and developing policies, programmes and legislation, and for conducting research and data collection. This framework should also recognise that women and men are not all the same and consider factors such as race, ethnicity, level of ability and sexual orientation.

Gender analysis is a systematic process that takes place throughout the course of a given activity. It is thus involved in development, implementation, monitoring and evaluation. It challenges the assumption that everyone is affected in the same way by, for example, policies, programmes and legislation. It probes concepts, arguments and language used, and reveals and makes explicit the underlying assumptions and values. Where these are shown to be biased or discriminatory, gender analysis points the way to more equitable, inclusive options. It thus involves the collection and use of sex-disaggregated data that reveals the roles and responsibilities of women and men. This data is fed into the policy process to enable assessments of how existing and proposed policies and programmes may affect women and men differently and

A family visits the AIDS centre in Mbale, Uganda.
Michael Jensen, 2001

unequally. In the area of HIV/AIDS, data needs to be qualitative rather than quantitative if it is to provide useful information about the socially constructed experiences that increase the risk of exposure to infection (Loppie and Gahagan, 2001). Gender analysis also involves assessing how gender roles and gender-inequitable power relations may affect the achievement of a range of development goals, including the goal of gender equality and equity.

Gender analysis is crucial to understanding HIV/AIDS transmission and initiating appropriate programmes of action. It forms the basis for the changes required to create an environment in which women and men can protect themselves and each other. The Commonwealth Secretariat has produced a publication, as part of a programme for the training of health workers in the gender analysis, planning and implementation of health interventions, which includes a valuable section on "Understanding HIV and AIDS: a Global, National and Gender Perspective" (Commonwealth Secretariat, 1999a).

What is gender mainstreaming?

"Mainstreaming a gender perspective is the process of assessing the implications for women and men of any planned action, including legislation, policies or programmes, in any area and at all levels. It is a strategy for making women's as well as men's concerns and experiences an integral dimension in the design, implementation, monitoring and evaluation of policies and programmes in all political, economic and societal spheres so that women and men benefit equally and inequality is not perpetuated. The ultimate goal is to achieve gender equality."

(Agreed conclusions of the UN Economic and Social Council 1997/2)

Gender mainstreaming does not automatically remove the need for women-specific programmes or for projects targeting women. These will often remain necessary to redress particular instances of past discrimination or long-term, systemic discrimination. At the 43rd Session of the UN Commission on the Status of Women (March 1999), member states called for governments "to ensure that the integration of a gender perspective in the mainstream of all government activities is part of a dual and complementary strategy to achieve gender equality. This includes a continuing need for targeted priorities, policies, programmes and positive action measures [for women]" (*Agreed Conclusions on Institutional Mechanisms*). This was endorsed by the UN General Assembly on 1 April 1999. Whenever separate programmes, projects or institutions are set up for women in the context of mainstreaming gender, however, it is vital to ensure that they are accompanied by concrete measures for integration and co-ordination.

Because gender mainstreaming cuts across government sectors and other social partners, it requires strong leadership and organisation. The Commonwealth approach to this is through the Gender Management System (see below).

Why mainstream?

"Gender mainstreaming is based on the recognition that gender equality and equity are: central to national development; a human rights issue that speaks to fairness and social justice for women and men in society; a contributor to good governance

in respect of people-oriented, participatory management; and an enabling factor in current efforts at poverty alleviation."

Commonwealth Secretariat, 1999b

Gender mainstreaming is the most efficient and equitable way to use existing resources for combating HIV/AIDS by focusing on the real needs of the whole population.

Gender mainstreaming is the most efficient and equitable way to use existing resources for combating HIV/AIDS by focusing on the real needs of the whole population. It is required to implement a number of Commonwealth and international mandates. This includes the 1995 Commonwealth Plan of Action on Gender and Development and its Update, in particular the objective of accelerating the achievement of women's empowerment. Through gender mainstreaming, governments will be meeting their commitments to the Nairobi Forward Looking Strategies, agreed to at the Third UN World Conference on Women (1985), and the Beijing Platform for Action (PFA), agreed to at the Fourth UN World Conference on Women (1995). The Beijing PFA urges governments to "promote an active and visible policy of mainstreaming a gender perspective in all programmes and policies" (para. 229).

The need to accelerate the process of mainstreaming a gender perspective was recognised in the Outcome Document adopted at the 23rd Special Session of the General Assembly: 'Women 2000: Gender equality, development and peace for the twenty-first century' (June 2000). Governments are required to: "[d]evelop and use frameworks, guidelines and other practical tools and indicators to accelerate gender mainstreaming, including gender-based research, analytical tools and methodologies, training, case studies, statistics and information" (para. 80).

The Gender Management System

The Commonwealth Secretariat is encouraging the establishment of Gender Management Systems at national and sectoral levels. The Gender Management System is an integrated network of structures, mechanisms and processes put in place in an existing organisational framework in order to guide, plan, monitor and evaluate the process of mainstreaming gender into all areas of an organisation's work. It is intended to advance gender equality and equity through promoting political will; forging a partnership of stakeholders including gov-

The goal of a Gender Management System for HIV/AIDS is to ensure gender equality in all government policies, programmes and activities that impact on the epidemic.

ernment, private sector and civil society; building capacity; and sharing good practice. The GMS is described most completely in the *Gender Management System Handbook* (Commonwealth Secretariat, 1999b).

The goal of a Gender Management System for HIV/AIDS is to ensure gender equality in all government policies, programmes and activities that impact on the epidemic. Within the GMS, the design, implementation, monitoring and evaluation of such policies and programmes should not only ensure equality and justice for all regardless of sex and gender, but should also take into account the contributions that can be made by all stakeholders working in the area.

For HIV/AIDS, stakeholders will come not only from the health sector but from a very broad range of ministries and agencies; non-governmental organisations (NGOs), particularly women's organisations; development agencies; the media; trade unions; professional associations; the private sector; and people living with HIV/AIDS. This is because many of the factors that have a major impact on HIV/AIDS lie outside the health sector. For example, within government, decisions about agriculture, finance, education, transport, water and sanitation, employment and social welfare policies all have major and often different effects on women and men. In all these areas, programmes have to deal with such issues as economic power imbalances and social marginalisation. Cultural and traditional attitudes to social roles can also be very important, both in encouraging or condoning practices that increase the vulnerability of men or women and in denying or downgrading the importance of underlying issues such as discrimination.

Objectives

Objectives of the GMS in the context of HIV/AIDS include:

- To promote systematic and consistent gender mainstreaming into HIV/AIDS policies, plans, programmes and activities at all levels.
- To assist state and non-state actors to acquire gender sensitisation, analysis and planning skills necessary for development and implementation of national HIV/AIDS strategies, policies, plans and programmes.

- To strengthen the capacity of National HIV/AIDS Co-ordinating Agencies to direct, advise and co-ordinate national gender mainstreaming efforts in the area of HIV/AIDS.
- To create an enabling gender-inclusive environment in the fight against HIV/AIDS and address the differential impact of the pandemic on women and men at all levels.

The enabling environment

There are a number of interrelated factors that determine the degree to which the environment in which the GMS is being set up does, or does not, enable effective gender mainstreaming. The enabling environment includes the following:

- political and administrative will and commitment at the highest level to gender equality and equity;
- willingness of those stakeholders and implementers who have never been exposed to issues related to gender to acquire knowledge and skills in gender awareness, and gender analysis and planning;
- a legislative and constitutional framework that is conducive to advancing gender equality;
- a 'critical mass' of women in decision-making bodies;
- adequate human and financial resources; and
- an active civil society.

Structures

Enabling all the key stakeholders to participate effectively in the mainstreaming of gender into governments' policy and programming requires the establishment and/or strengthening of formal institutional arrangements within and outside government. These arrangements can be summarised as follows:

- a **Lead Agency** (possibly a National HIV/AIDS Co-ordinating Committee) which initiates and strengthens the GMS institutional arrangements, provides overall co-ordination and monitoring and carries out advocacy, communications, media relations and reporting;

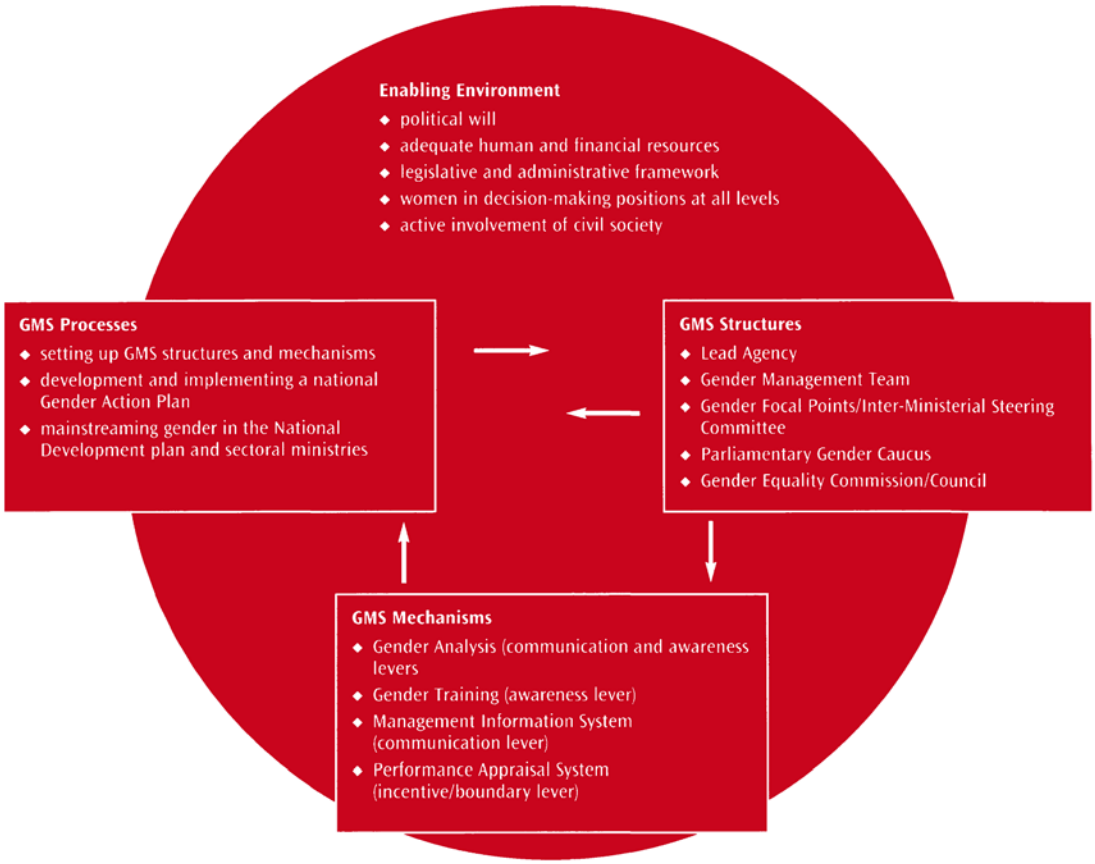

Figure 1: The Gender Management System

- a **Gender Management Team** (consisting of representatives from the Lead Agency, key government ministries and civil society) which provides leadership for the implementation of the GMS; defines broad operational policies, indicators of effectiveness and timeframes for implementation; and co-ordinates and monitors the system's performance;
- an **Inter-Ministerial Steering Committee** whose members are representatives of the Lead Agency and the Gender Focal Points (see below) of all government ministries, and which ensures that gender mainstreaming in government policy, planning and programmes in all sectors is effected and that strong linkages are established between ministries;
- **Gender Focal Points** (senior administrative and technical staff in all government ministries), who identify gender

concerns, co-ordinate gender activities (e.g., training); promote gender mainstreaming in the planning, implementation and evaluation of all activities in their respective sectors; and sit on the Inter-Ministerial Steering Committee;

- a **Parliamentary Gender Caucus** (consisting of gender-aware, cross-party female and male parliamentarians) which carries out awareness raising, lobbying and promoting the equal participation of women and men in politics and all aspects of national life and brings a gender perspective to bear on parliamentary structures and procedures, legislation and other matters under debate; and
- **representatives of civil society** (a National Gender Equality Commission/Council, academic institutions, NGOs, professional associations, media and other stakeholders), who represent and advocate the interests and perspectives of autonomous associations in government policy-making and implementation processes.

Mechanisms

There are four principal mechanisms for effecting change in an organisation using a GMS:

- **Gender analysis:** This clarifies the status, opportunities, etc. of men and women. It involves the collection and analysis of sex-disaggregated data which reveals how development activities impact differently on women and men and the effect gender roles and responsibilities have on development efforts.
- **Gender training:** Many of the stakeholders in a GMS will require training in such areas as basic gender awareness and sensitisation, gender analysis, gender planning, the use of gender-sensitive indicators, monitoring and evaluation. Training should also include segments on overcoming hostility to gender mainstreaming and may also need to include conflict prevention and resolution and the management of change.
- **Management Information System:** This is the mechanism for gathering the data necessary for gender analysis and

sharing and communicating the findings of that analysis, using sex-disaggregated data and gender-sensitive indicators. More than just a library or resource centre, it is the central repository of gender information and the means by which such information is generated by and disseminated to the key stakeholders in the GMS.

- **Performance Appraisal System:** Based on the results of gender analysis, the GMS should establish realisable targets in specific areas. For example, one target might be to reduce vulnerability to HIV/AIDS by ensuring that at least 90 per cent of young men and women have access to prevention methods by 2005 (indicator adopted at ICPD +5, see Appendix 2). On achievement, further targets should be set. The achievement of these targets should be evaluated both at the individual and departmental level through a gender-aware Performance Appraisal System. This should not be separate from whatever system is already in place for appraising the performance of employees; rather the present system should be reviewed to ensure that it is gender-sensitive. The Performance Appraisal System should also take into account the level of gender sensitivity and skills of individuals (for example, as acquired through gender training or field experience).