Gender Mainstreaming Guidelines for HIV and AIDS, Tuberculosis and Malaria

Acknowledgements

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Table of Contents

FOREWORD

The analysis of the social cultural and economic situation in the Southern African Development Community (SADC) region shows that gender inequalities still exist in every sector.

Generally, women and girls continue to face challenges in accessing social and economic services. It is also evident that women constitute the majority of people infected and affected by communicable diseases. Poverty levels are high among women. It is also noted that women continue to have limited access to affordable and quality health services and information, and yet they are highly active in health care systems as both caregivers and clients seeking health services for family members. The burden of care on women denies them the right to engage in other productive economic programmes for their survival.

The SADC Heads of State and Government acknowledge these inequalities and have committed themselves to address gender issues in the process of regional integration agenda through the adoption of various instruments on women empowerment and gender equality.

Those instruments include the SADC Protocol on Gender and Development (2008), which provides a strong foundation for all gender equality initiatives. Among other things, the Protocol recognises the specific vulnerabilities women and men face when accessing health services, and it urges all Member States to address those inequalities. The SADC Protocol on Health (1999) and the Maseru Declaration (2003) also recognise the importance of gender mainstreaming in the implementation of all health initiatives, including those involving communicable diseases such as HIV and AIDS, Tuberculosis and Malaria.

The development of these Gender Mainstreaming Guidelines for communicable diseases is an important milestone in the health sector and in the history of gender mainstreaming in the SADC region. The Guidelines provide a unique opportunity for the health sector to systematically address the specific health needs and concerns of women and men beyond reproductive and sexual health issues. They therefore will enable the health sector to apply a gender perspective in policy development and implementation with a view to ensuring that service delivery is based on the specific health needs and concerns of men and women that stem from both biological and broader socioeconomic and cultural factors.

Gender mainstreaming in health implies strategic changes at managerial, organisational and programme levels to effectively deal with the existing historical and structural inequalities between men and women in accessing health services.

These Guidelines are forward-looking, and their implementation will lead to the realisation of gender equity in the health sector. The Guidelines will contribute to the achievement of universal access and health for all, since they will enable the health sector to address both biomedical and social cultural issues in order to deal effectively with the negative gender norms that determine the health risks, health-seeking behaviours, health care systems responses and health outcomes for men and women.

Dr Stergomena Lawrence Tax
SADC Executive Secretary

ACRONYMS & ABBREVIATIONS

ACSM	Advocacy, Communication and Social Mobilisation
AIDS	Acquired Immune Deficiency Syndrome
ANC	Antenatal care
ART	Antiretroviral therapy
ARV	Antiretroviral
CEDAW	Convention on the Elimination of All Forms of Discrimination Against Women
DOTS	Directly-Observed Therapy, Short-course
EPR	Epidemic Preparedness and Response
HIV	Human Immunodeficiency Virus
IDSR	Integrated disease surveillance and response
IEC	Information, education and communication
MDGs	Millennium Development Goals
MDR-TB	Multidrug-resistant Tuberculosis
M&E	Monitoring and evaluation
NAC	National AIDS Commissions or Councils
NGOs	Nongovernmental organisations
PEP	Post-exposure prophylaxis
PMTCT	Prevention of mother-to-child transmission
SADC	Southern African Development Community
SAFAIDS	Southern Africa HIV and AIDS Information Dissemination Service
STIs	Sexually transmitted infections
TB	Tuberculosis
UNGASS	United Nations General Assembly Special Session
VCT	Voluntary counselling and testing
WHO	World Health Organization
XDR-TB	Extensively drug-resistant Tuberculosis

KEY GENDER CONCEPTS

The following key concepts are used in this document; an additional list of concepts can be found in Annex 1.

Gender: Refers to socially constructed roles, responsibilities, privileges, status, opportunities and values that are assigned to men and women, and boys and girls in a given society (SADC Gender and Development Protocol, 2008). Gender is not only about women. These differences in roles and responsibilities for men and women determine vulnerability to illness and infections, health status, burden of ill health, quality of care, access to health resources, information and preventive and curative measures.

Sex: Refers to biological differences between females and males (SADC Gender and Development Protocol, 2008).

Gender analysis in health: A systematic process of examining the differences and interactions of biological and sociocultural factors, and highlighting how these interactions affect health behaviours, outcomes for men and women of different ages and social groups. Gender analysis in health can highlight the ways in which gender-based inequalities disadvantage women's or men's health, and it can help uncover the health risks and problems men and women encounter due to gender norms, roles and relations (WHO, 2010; www.who.int/gender).

Gender responsive budget: A budget that reflect the different needs, privileges, rights and obligations of women and men in society. A tool of analysis in which the government budget is disaggregated, and the effects of expenditure and revenue policies on women (especially poor women) are analysed (RISDP, 2003).

Gender equality: is the absence of discrimination on the basis of a person's sex in authority, opportunities, allocation of resources or benefits, access and services. It is therefore an equal valuing by society of both similarities and differences between men and women and the varying roles they play (Medical Women's International Association 2002).

Gender equity: The process of being fair to men and women in the distribution of benefits and responsibilities. The concept recognises that men and women have different needs and power, and that these differences should be identified and addressed in a manner that rectifies the imbalance between sexes (RISDP, 2003).

Gender mainstreaming: A systematic process that ensures that gender considerations are placed at the centre of policies, programmes, processes and activities. A strategy for making women and men's concerns and experiences an integral dimension of the design, implementation, monitoring and evaluation of policies and programmes in all political, economic and societal spheres so that women and men benefit equally. The ultimate aim is to achieve gender equality (SADC Gender and Development Protocol, 2008).

Gender-sensitivity: The ability to recognise and take into account the specific gender needs of both men and women at all levels planning, implementation, monitoring and evaluation (SADC Gender and Development Protocol, 2008).

Gender-sensitive indicator: An indicator that is designed to compare the situations of women and men over time and to highlight gender gaps. It facilitates comparisons between different groups of women and men, and makes it possible to identify and assess whether gender equality and health equity are being achieved. It takes into account the broad determinants of health and focuses on socioeconomic processes that influence health and wellbeing, and detects differences in the health experiences of men and women, and among other, specific vulnerable groups (WHO, 2000).

Affirmative action: A policy, programme or measure that is aimed at redressing past discrimination with measures to ensure equal opportunity and positive outcomes in all spheres of life (SADC Gender and Development Protocol, 2008).

1. INTRODUCTION

The Gender Mainstreaming Guidelines have been developed to provide guidance on gender mainstreaming in relation to HIV and AIDS, Tuberculosis (TB) and Malaria. The Guidelines also apply generally to all other communicable diseases and to public health policy developments, reviews, implementation, and monitoring and evaluation (M&E) for other diseases. The guidelines focusing on HIV and AIDS, TB and Malaria therefore can serve also as illustrations for gender mainstreaming in other disease-specific programmes (see Annex 2).

The document comprises the following eight sections:

- **Background:** This section provides a general overview of the Assessment findings on the status of gender mainstreaming in communicable diseases, which have informed these guidelines.

- **Rationale:** This outlines the justification for developing SADC Gender Mainstreaming Guidelines for Communicable Diseases in relation to the provisions of key regional and global instruments that guide gender mainstreaming in the SADC region.

- **Purpose and scope:** This section describes the purpose of the SADC Gender Mainstreaming Guidelines, which is to facilitate a harmonised approach to gender mainstreaming in the prevention and control of communicable diseases.

- **Basic foundation:** This section highlights some of the existing global commitments on gender, which have informed these Guidelines.

- **Guiding principles:** This section outlines the seven principles on which implementation of these guidelines need to be based.

- **Process for developing the guidelines:** This section outlines the consultative process that was followed.

- **The gender guidelines:** As the main body of this document, this section outlines the Gender Guidelines, focusing on nine major components of strategic plans. It highlights issues and challenges, provides guidelines to address the main issues and challenges that have been identified, and outlines monitoring indicators to track gender mainstreaming processes. The nine components are:

  - Policy and strategic plans review and/or development;
  - Research;
  - Surveillance, M&E;
  - Service delivery;
  - Institutional coordination mechanisms;
  - Advocacy, communication and social mobilisation;
  - Capacity building;
  - Decentralisation; and
  - Financing gender mainstreaming.

- **Implementation arrangements:** This section outlines the roles and responsibilities of key stakeholders that will facilitate implementation of the Guidelines.

These Guidelines are based on the findings of an assessment conducted in 2010 in Member States. For the detailed status of findings, please refer to the *Regional Assessment Report on the Status of Gender Mainstreaming in HIV and AIDS, Tuberculosis and Malaria Programmes in the SADC Region (2010)*. This document is also complemented by a checklist for verifying the level of implementation of the SADC Gender Mainstreaming Guidelines in HIV and AIDS, TB and Malaria programmes. The checklist is a self-assessment tool that allows disease programme managers and policy makers to measure the extent to which strategic policy frameworks, M&E frameworks, budgets and other aligned policies have been made gender-sensitive. This Checklist is being published as a separate document.

2. BACKGROUND

The Guidelines are informed by the findings of the Regional Assessment Report on the Status of Gender Mainstreaming in HIV and AIDS, Tuberculosis and Malaria Programmes in the SADC Region.

The Assessment reviewed policies, strategic plans and guidelines in 11 Member States. To complement the information, field visits were made to six Member States (Angola, Botswana, Democratic Republic of Congo, Malawi, Swaziland and the United Republic of Tanzania). The Assessment revealed a number of commendable practices that could be replicated, as well as issues and challenges that needed to be addressed at policy and implementation levels.

Some of the encouraging practices included the provision of services to specific, vulnerable groups, including:

- Pregnant mothers and children younger than five years were being prioritised for malaria interventions;

- Prisoners, refugees and miners were targeted for TB interventions in some Member States; and

- Commercial sex workers, injecting drug users, men who have sex with men, multiple concurrent partners and mobile populations were being targeted in some Member States for HIV interventions.

Generally, more progress has been made in mainstreaming gender in HIV policies, strategic plans and programmes, compared to TB and Malaria programmes. Specific areas that were found to be lagging included:

- Inadequate gender mainstreaming in most fundamental components of policies and strategic plans for communicable diseases;

- Limited coordination with institutions dealing with gender (such as Ministries of Gender) that could provide technical expertise on gender mainstreaming;

- Inadequate responses to the specific health needs of women and men that arise as a result of negative sociocultural practices in service delivery;

- Limited integration of gender and women's rights in advocacy, communication and social mobilisation work;

- Inadequate research on the gender dimensions of TB and Malaria, resulting in minimal interventions to address the specific health needs of women and men;

- Inadequate gender sensitivity of existing surveillance and M&E frameworks to collect sex-disaggregated data and other relevant socioeconomic data;

- Inadequate capacity for gender mainstreaming among health personnel;

- Centralised health services that complicate access to health services such as diagnostic services, especially in rural areas; and

- Limited budget allocations to implement complementary gender-related activities and a lack of implementation of gender responsive budgets in the health sector.

The identified gaps point to the need for more work by Member States to address structural issues that make women and men vulnerable to diseases, in order to comply with SADC's commitments on women's empowerment and gender equality. The Gender Guidelines will expedite implementation of the gender provisions, and support existing efforts by Member States to respond to the specific health needs of women and men with a gender perspective.

3. RATIONALE FOR DEVELOPING GENDER MAINSTREAMING GUIDELINES

Gender mainstreaming in communicable diseases has its foundation in the SADC Gender and Development Protocol (2008), which recognises (in article 27:2) the unique vulnerabilities of women and men to HIV and other communicable diseases, and which calls upon Member States to ensure that health policies and programmes take account of the unequal status of women, the particular vulnerabilities of the girl child, and the harmful cultural practices and biological factors that result in women constituting the majority of people infected and affected by HIV and other communicable diseases.

Gender mainstreaming is also required by the provisions of the SADC Protocol on Health (1999) and the Maseru Declaration (2003). The Protocol on Health recognises the need for a special focus on women and vulnerable groups. Article 3(g) calls upon Member States to develop common strategies to address the health needs of women, children and other vulnerable groups. The Maseru Declaration, in Article 4(a), calls for gender mainstreaming in community and national building initiatives as a way of combating HIV and other communicable diseases.

Member States have also committed themselves to address the specific vulnerabilities of women in the Abuja Declaration where they agreed to ensure that at least 60% of people at risk of Malaria (particularly pregnant women and children younger than five years of age) should benefit from insecticide-treated nets and other interventions for preventing Malaria.

Despite these strong commitments, assessments of the status of gender mainstreaming in communicable diseases reveal that both men and women continue to face challenges in accessing health services (as discussed elsewhere in this document). A gendered approach in communicable diseases therefore remains imperative.

4. PURPOSE AND SCOPE OF THE GUIDELINES

The purpose of the SADC Gender Mainstreaming Guidelines is to facilitate a harmonised approach to gender mainstreaming in the control of communicable diseases at policy and implementation levels.

Gender mainstreaming will promote universal access to health services in the SADC region for both men and women, regardless of their circumstances. Thus the Guidelines provide a framework for gender-sensitive policy and strategic development, programming, research, and M&E.

The Guidelines also serve as reference materials for capacity building initiatives and advocacy work on gender mainstreaming in public health. Furthermore, relevant ministries and other stakeholders (including development and implementing partners) can use the Guidelines to mainstream gender in communicable diseases. Finally, the principles espoused in the Guidelines apply also to the general health response.

5. BASIS AND FOUNDATION FOR THE GUIDELINES

The Gender Mainstreaming Guidelines are anchored in the global commitments on women's empowerment and gender equality, particularly in relation to the health of women and other vulnerable groups. Those commitments include the Millennium Development Goals (MDGs), which urge Member States to halt and reverse the incidence of HIV and AIDS, Malaria and other diseases, and to ensure universal access to treatment for HIV for all who need it. In addition, the MDGs urge Member States to promote gender equality across the entire development process.

The United Nations *Beijing Declaration and Platform for Action* (1995) also recognises women's differential and unequal access to, and use of, basic health services for the prevention and treatment of various illnesses, including communicable diseases. Like the SADC Gender Protocol, the Beijing Declaration recognises the unique vulnerabilities of women and girl children in accessing social services, and urges Member States to recognise and deal with inequalities and inadequacies in access to health and related services. Through this Declaration, Member States agreed to implement programmes to ensure the full realisation of all human rights and fundamental freedoms of all women as an essential component for the empowerment of women.

In addition, SADC Member States are party to the *United Nations Convention on Elimination of all Forms of Discrimination Against Women* (CEDAW, 1979). This "international bill of rights for women" urges Member States to take all appropriate measures to eliminate discrimination against women in order to ensure, among other things, equal access for men and women to health care and other services. Recommendation 15 specifically refers to HIV and AIDS, and urges Member States to place a gender perspective at

the centre of all policies and programmes affecting women's health, and to ensure their involvement in planning, implementing and monitoring such policies and programmes. The Recommendation also urges Member States to ensure the removal of all barriers to women's access to health services, education and information. In particular, it calls on Member States to allocate resources for programmes that are directed at preventing and treating sexually transmitted diseases, including HIV and AIDS, in adolescents.

Finally, the Guidelines are consistent with the *SADC Protocol on Gender and Development,* which reiterates the need to mainstream gender in all policies and programmes, and to address the respective vulnerabilities of women and men to HIV and other diseases. It also calls upon Member States to ensure that policies and programmes on health take account of the unequal status of women, the particular vulnerability of the girl child, and harmful cultural practices and biological factors that result in women constituting the majority of people infected and affected by HIV and other communicable diseases.

6. GUIDING PRINCIPLES FOR GENDER MAINSTREAMING

The Gender Guidelines are based on, and guided by the following principles:

- **Gender sensitivity:** Member States shall implement gender-sensitive policies, strategies and programmes that are guided by gender equality and non-discriminatory practices. These shall serve as fundamental values in the provision of services to control communicable diseases;

- **Right-based approach:** Member States shall ensure a rights-based approach to the delivery of services for communicable diseases;

- **Multisectoral approach**: Member States shall promote the collaboration of wider stakeholders at regional and national levels in response to HIV and AIDS, TB, malaria, and other communicable diseases;
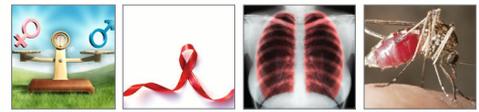
- **Enhanced participation:** Member States shall recognise the need for greater involvement of men, boys and those who are infected and affected in all disease prevention and control initiatives, and ensure the integration of men's and women's interests in all initiatives to combat communicable diseases;

- **Accountability:** Member States shall honour their commitments and ensure that they promote equity and gender equality in communicable diseases programmes;

- **Community-based approach:** Member States shall involve communities in various health initiatives to ensure the sustainability of those activities;

- **Affirmative resource provision to support gender mainstreaming:** Member States shall allocate adequate resources for gender mainstreaming in communicable diseases.

7. PROCESS FOR DEVELOPING THE GENDER GUIDELINES

The development of the SADC Gender Mainstreaming Guidelines involved extensive consultations at both regional and Member States levels. The process was participatory and involved Member States, the SADC Secretariat and various stakeholders, including civil society organisations and development partners. The process was also guided by internationally-recognised best practices on gender mainstreaming. The key stages of consultation are discussed below.

7.1   Desk review and country visits

A desk review was conducted of current national, regional and global policies and other relevant documents on gender mainstreaming with respect to HIV and AIDS, TB and malaria. This was followed by individual country assessments in six selected SADC Member States.

During the visits, key informants working in the respective programmes (including development partners, civil society organisations and the private sector) were consulted to provide information on the status of programmes and policies, with particular reference to gender mainstreaming. The respondents also shed light on notable issues, challenges and practices. In addition, a questionnaire was sent to the other Member States, in order to collect similar data. Each visit culminated in a country-level assessment report, which was reviewed and validated by Health Ministry officials from some of the visited Member States.

The country reports were then compiled to inform a regional picture of the situation and response analysis. The draft *Regional Assessment Report* was used as a basis for developing the SADC Gender Mainstreaming Guidelines for Communicable Disease.

7.2   Technical review meetings

The draft Regional Assessment Report and the Draft Gender Mainstreaming Guidelines were then reviewed by a technical team of experts for technical soundness at an *ad hoc* meeting held on 12-13 August, 2010, in Gaborone, Botswana.

The team comprised Member States and international cooperating partners. The task of the review team was to strengthen the quality of the documents. The team recommended that an expert team be set up to assist in further refinement of the draft documents.

Based on the recommendations of the August meeting, the Technical Expert Team reviewed the revised documents on 1-3 December, 2010, in Gaborone, Botswana.

7.3   Validation and consensus-building workshop

The SADC Secretariat convened a validation and consensus-building workshop involving 14 Member States, civil society organisations and international cooperating partners. The workshop was held on 14-16 June, 2011, in Johannesburg, South Africa.

The workshop made recommendations for improvement and finalisation of the draft Guidelines before they could be presented to Ministers. Following the validation and consensus-building workshop, the Technical Experts Team met again on 17-19 June, 2011, to finalise the Guidelines by incorporating feedback from the consensus-building workshop.

The final draft document was presented to NACA and TAC in October, 2011, for their input. Finally, the Project Steering Committee endorsed the document and advised the Secretariat to submit the document for Ministerial approval

8. SADC GENDER MAINSTREAMING GUIDELINES

The SADC Gender Mainstreaming Guidelines are a guide for SADC Member States to facilitate gender mainstreaming processes in relation to communicable diseases. The Guidelines use disease focus areas as an entry point for gender mainstreaming.

This section outlines the focus areas, and presents guidelines to be implemented by Member States in order to address the issues that have been identified. In addition, it provides monitoring indicators for tracking progress on gender mainstreaming.

The focus areas are:

- Policy and strategic framework review and development;
- Research;
- Monitoring and evaluation;
- Service delivery;
- Institutional coordination mechanisms for gender mainstreaming;
- Advocacy, communication and social mobilisation;
- Capacity development for gender mainstreaming; and
- Decentralisation and financing of gender mainstreaming.

8.1 Policy and strategic frameworks review and development

In all Member States, policies and strategic plans exist for the three diseases, either in draft or final form. The extent of gender mainstreaming in policies and strategic frameworks for the three communicable diseases differs across Member States. Gender mainstreaming is more advanced in relation to HIV and AIDS policies and strategic plans, compared with TB and Malaria.

8.1.1 Issues and challenges

The following issues and challenges were identified:

- Limited gender mainstreaming elements were reflected in the major components of strategic plans;

- References to SADC and international commitments on gender mainstreaming were limited or absent;

- A lack of capacity building in gender mainstreaming for staff;

- Limited sex- and age-disaggregated data, especially on TB and Malaria, for capturing gender disparities;

- Inadequate recognition of the care economy, where women are overburdened with provision of care for the sick, and a failure to strengthen care and support for women and girls to reduce their care burden.

8.1.2 Gender guidelines

It is recommended that Member States shall:

- Engender fundamental components outlined in the policies and strategic framework, such as the vision, target audience, strategic objectives, guiding principles, financing and M&E;

- Include an explicit goal or objective to address gender inequalities in communicable diseases;

- Take cognisance of gender equality provisions in SADC (regional), national and global instruments that support and guide gender mainstreaming in the health sector;

- Identify the economic, social and cultural issues that negatively affect the attainment of equity and equality in health with regard to issues of access to health services;

- Ensure that policies and strategic frameworks are informed by gender-sensitive, evidence-based research with sex-disaggregated data (on epidemiology, vulnerabilities and risks, access to preventive health services, treatment, care and support, and general health outcomes);

- Clearly stipulate deliberate measures to address specific health needs of disadvantaged and minority groups, such as people living with HIV, sex workers, men who have sex with men, injecting drug users, multiple concurrent partners, adolescent girls and boys, prisoners, mobile populations, among others; and

- Integrate reformatory programmes (particularly for post-conflict countries) on gender-based violence in relation to HIV and other communicable diseases, both for survivors and perpetrators of gender-based violence.

8.1.3   Monitoring indicators

The following monitoring indicators are proposed:

- Number of Member States with strategic plans whose fundamental components are gender-sensitive;

- Number of Member States whose strategic plans are informed by evidence-based, gender-sensitive research; and

- Number of Member States with a clear capacity building plan on gender mainstreaming for health personnel in both pre-service and in-service training.

8.2   Research

Gender-sensitive research in communicable diseases should take account of gender as a significant variable in order to reveal gender inequalities in various age groups and socioeconomic strata. Women and men fulfil different roles and responsibilities, have different experiences with health systems, and respond differently to health interventions.

The Assessment Report found that all Member States currently have research agendas. However, there are some gaps with regards to research related to gender mainstreaming in health, including:

8.2.1   Issues and challenges

The following issues and challenges were identified:

- Limited integration of gender issues in the research cycle. Most research agenda do not clearly stipulate the gender dimensions that require research, which results in inadequate identification of social and cultural issues that negatively affect health outcomes for women and men. This undermines a full appreciation of gender dimensions for health workers and policy makers;

- Inadequate representation of women in drug and vaccine trials, which can lead to incomplete understandings of different responses among women and men to new drugs and vaccines;

- Lack of collaboration between the Ministries of Health (communicable diseases) and the research institutions (especially in academia) that have investigated the gender and social determinants of health, and with Ministries of Gender and Women Affairs; and

- Limited data on gender and communicable diseases.

8.2.2   Gender guidelines

Member States shall:

- Ensure that national research agendas are gender-sensitive and include operations research for communicable diseases in order to achieve improved understandings of gender disparities;

- Carry out research on the communicable diseases knowledge, attitudes and practices of men and women in order to inform policy development;

- Support research studies that address gender gaps, and utilise research findings to enhance gender mainstreaming in communicable diseases policies and programmes; and

- Facilitate collaboration between Ministries of Gender and (academic) health research institutions on communicable diseases in order to conduct pertinent gender-focused research and generate findings that can inform the development of strategic disease prevention and control interventions.

8.2.3   Monitoring indicators

The following indicators are proposed:

- Number of Member States with research agendas that define relevant gender-focused research areas; and

- Number of Member States where health research institutions collaborate with Ministries of Gender and academia in health-related research.

8.3   Monitoring and evaluation

M&E is cardinal for strengthening the collection of sex- and age- disaggregated data, identifying and tracking of gender disparities in relation to HIV and AIDS, TB and Malaria, and informing strategies for enhancing gender mainstreaming.

Gender-sensitive M&E generates sex- and age-disaggregated data, which can reveal gender inequalities in various aspects of disease prevention and control programmes. Gender analysis in health examines the interaction of biological and social cultural factors, and highlights the ways in which this affects health behaviours, outcomes and services for women and men of different ages and social groups. It can reveal the extent and nature of gender inequalities, and uncover health risks and difficulties that women and men face due to gender dynamics (WHO, 2010).

The Assessment found that all Member States have M&E systems for HIV and AIDS, TB and Malaria, but gaps were noted in the current systems.

8.3.1   Issues and challenges

The gaps and challenges include:

- Inadequate collection, analysis and utilisation of sex- and age-disaggregated data (especially for TB and malaria) that can reveal gender inequalities and the factors causing those inequalities. Although some Member States collect sex-disaggregated data (especially based on TB smear-positives), there is limited analysis and utilisation of the information to inform policy development and implementation;

- Current M&E systems for HIV and AIDS programmes do not track gender equality results to reflect the current efforts on gender mainstreaming, even though some Member States are implementing programmes on women, girls and HIV and AIDS;

- Limited gender-sensitive indicators that can be used to compare the situation of women and men over time to highlight the gender gaps. Such indicators facilitate comparisons between different groups of women and men, and can help in identifying and assessing whether programmes are promoting gender equity in health; and

- Limited capacity in gender analysis among surveillance, M&E staff.

8.3.2   Gender guidelines

Member States shall:

- Develop and/or review the M&E systems (including health management information systems) to facilitate the capturing of sex-disaggregated and gender data;

- Collect, analyse and utilise sex- and age-disaggregated data to establish gendered dimensions and trends of disease-specific cases;

- Build the capacity of relevant health staff for gender-sensitive M&E; and

- Review surveillance systems and M&E frameworks to incorporate gender-sensitive indicators for the three diseases.

8.3.3   Monitoring indicators

The following indicators are proposed:

- Number of Member States with gender-sensitive surveillance and M&E systems to track and report on gender indicators;
- Number of Member States that have integrated capacity building plans in gender-sensitive M&E;

- Number of Member States that produce gender-sensitive reports:

  - HIV and AIDS annual reports with data disaggregated by sex, age and socioeconomic variables;
  - Malaria annual reports with data disaggregated by sex, age and socioeconomic variables; and
  - TB Annual Reports with data disaggregated by sex, age and socioeconomic variables.

8.4   Service delivery

Gender differences and inequalities are major causes of inequality in health and health care. Ideally, service delivery ensures the provision of effective, safe and quality personal and non-personal health interventions, irrespective of sex, age, socioeconomic status or location. It also ensures that sociocultural issues are taken into account, in addition to the biomedical issues that are the major focus for the health sector. Health services therefore should respond to the respective health needs, constraints and concerns of women and men, based on both biomedical and sociocultural factors.

The Assessment found that Member States are implementing a number of initiatives to improve service delivery, but key gender issues still need to be addressed.
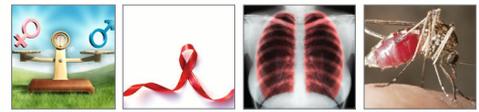
8.4.1 Issues and challenges

The following issues and challenges were identified:

- Limited access to diagnosis and treatment services for women, due to various cultural and socioeconomic factors;

- Low involvement of men in most prevention and control programmes on communicable diseases; and

- Inadequate provision of food and nutritional supplements to vulnerable groups (especially mothers with babies from food-insecure households), which contributes to treatment non-adherence (especially in TB programmes)

8.4.3 Gender guidelines

Member States shall:

- Develop and conduct periodic reviews of compliance with the Patients' Charter, which calls for ethical conduct, respect for patient rights and gender-responsive service delivery;
- Develop and implement strategies that promote the involvement of men in all strategies to prevent and control communicable diseases;

- Engage community and traditional leaders, and men generally, to take responsibility for the prevailing socioeconomic norms that reinforce gender inequities and increase women and men's vulnerabilities;

- Sensitise men and women through existing outreach programmes on behaviour change, sex and sexuality and safe sex, gender rights, and gender-based violence;

- Provide regular support to home- and community-based care, with a focus on gender economic empowerment programmes;

- Ensure cultural sensitivity towards men and women, irrespective of gender or sexual orientation; and

- Provide gender-sensitive messages that do not discriminate against female or male patients.

8.4.3 Monitoring indicators

The following indicators are proposed:

- Number of Member States that have reviewed their Patients' Charter in the previous 12 months in relation to the integration of gender concerns;

- Number of Member States that provide impact mitigation measures for:

  - Infected and affected households, and
  - Community-based care support services, especially home-based care centres.

8.5 Institutional coordination mechanisms for gender mainstreaming

Effective management of communicable diseases requires a multisectoral approach. Institutional coordination mechanisms with relevant stakeholders are essential for ensuring that both sociocultural and biomedical issues are addressed simultaneously.

SADC Member States have designated various sectors to deal with the crosscutting issues of poverty, gender, HIV and AIDS, among others. The Assessment revealed that some Member States have created structures (such as gender focal points) to facilitate gender mainstreaming in their programmes (notably for HIV and AIDS, and less so for TB).

8.5.1 Issues and challenges

The Assessment identified key issues that need to be addressed, including:

- Weak coordination mechanisms for gender mainstreaming with key stakeholders, such as institutions and ministries that are mandated to coordinate and provide technical expertise on gender mainstreaming);

- An absence of gender focal points at ministerial level to facilitate gender mainstreaming in communicable diseases, which results in *ad hoc* processes; and

- Inadequate capacity and lack of integration of gender responsiveness in job descriptions.

8.5.2 Gender guidelines

Member States shall:

- Facilitate coordination of multisectoral committees with various stakeholders and all ministries to address specific health needs of men and women;

- Establish gender focal points with clear terms of reference to oversee gender mainstreaming processes in health ministries;

- Review staff job descriptions and ensure that they include specific functions regarding gender mainstreaming, as well as and key results sections that need to be appraised periodically; and

- Establish strategic partnerships with relevant stakeholders that can influence policy change with regards to targeting vulnerable groups at all levels.

8.5.3 Monitoring indicators

The following indicators are proposed:

- Number of Member States with gender focal points at ministerial level; and

- Number of Member States where job descriptions for programme managers and M&E staff include gender functions.

8.6 Advocacy, communication and social mobilisation

Effective advocacy and social mobilisation is important for communicable disease control, since it can promote the empowerment and good health of women. Effective advocacy addresses negative gender stereotypes, gender-based violence, stigma and discrimination against women and men, as well as the harmful cultural practices that can increase vulnerability to illness and ill health.

The Assessment found that all Member States have programmes on advocacy, communication and social mobilisation. However, some shortfalls were also identified.

8.6.1 Issues and challenges

The following gaps and challenges were identified:

- Gender stereotypes still exist in some information, education and communication (IEC) materials on communicable diseases, thus perpetuating negative sociocultural practices that prevent women from accessing communicable diseases prevention and treatment services;

- Inadequate promotion of male involvement in most behavioural change communication initiatives;

- Inadequate consideration of low literacy levels among women in the SADC region when developing and distributing IEC materials, which undermines women's right to access to health-related information; and

- Lack of integration of gender sensitisations in behaviour change communication, which could deconstruct negative gender stereotypes that perpetuate negative gender norms and affect women's health.

8.6.2 Gender guidelines Member States shall:

- Develop and implement gender sensitive advocacy, communication and social mobilisation strategies;

- Promote the use of gender- and culturally-sensitive IEC and behaviour change communication materials to deconstruct stereotypes about feminine and masculine norms, while taking into account high illiteracy levels among women;

- Develop and implement community-based initiatives that raise awareness, transform gender norms around violence, and encourage men and women to adopt responsible approaches to the health and wellbeing of their families;

- Ensure the participation of men and women (including community leaders and traditional healers) in all community-based mobilisation campaigns to increase knowledge and understanding of disease prevention measures;
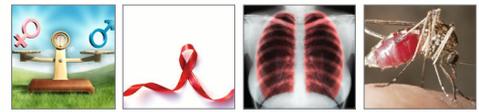
- Use existing international, regional and national commemoration days (such as SADC Malaria Week, World Malaria Day, World AIDS Day, Women's Day, 16 Days of Activism on Gender-Based Violence, and TB day) to educate communities on the gender dimensions of communicable diseases;

- Ensure that IEC and behaviour change communication materials and sessions target various groups of people (including traditional leaders, mothers, fathers, pregnant women, adolescent girls and boys, and school children), with a major focus on promoting timely health-seeking behaviour;

- Integrate information on malaria, TB and HIV co-infections and their effects on pregnant adolescents into education life-skills curricula, and

- Translate IEC materials into local languages and disseminate the Patients' Charter for communicable diseases to the communities to enhance their access to information.

8.6.3   Monitoring indicators

The following indicators are proposed:

- Number of Member States that implement gender-sensitive advocacy, communication and social mobilisation strategies;
- Number of Member States with a gender-sensitive Patients' Charter that is translated into local languages; and

- Number of Member States that integrate gender dimensions into international, regional and national days of commemoration.

8.7   Capacity development for gender mainstreaming

Capacity building in gender mainstreaming entails establishing and strengthening networks and linkages, implementing awareness and information campaigns, training and developing human resources, and strengthening training institutions to facilitate gender mainstreaming processes.

Such capacity building should facilitate change in health sector institutions and programmes, thus contributing to the achievement of health-for-all goals across the SADC region.

All Member States currently have capacity building programmes, but their focus on gender was found to be inadequate.

8.7.1   Issues and challenges

The following shortcomings and challenges were identified:

- Inadequate integration of gender in capacity building processes;

- Inadequate integration of gender in health training curricula for pre- and in-service training; and

- Absence of gender modules to guide capacity building in gender mainstreaming for health personnel.

8.7.2   Gender guidelines Member States shall:

- Engender health curricula for both pre- and in-service training;

- Develop gender modules and implement capacity building programmes on gender mainstreaming for all staff in pre- and in-service training;
- Train programme managers and their staff on gender mainstreaming to enable them to incorporate gender-responsive actions into their daily work;

- Re-orient health care providers with skills to deal with the particular gender needs of clients; and

- Integrate gender sensitisation into all training sessions (pre- and-in service) for health workers.

8.7.3   Monitoring indicators

The following indicators are proposed:

- Number of Member States that provide gender training for staff in both pre- and in-service training programmes; and

- Number of Member States whose programme managers and M&E staff for communicable diseases are trained in gender mainstreaming.

8.8 Decentralisation of health services

The decentralisation of essential health services is intended to bring health services closer to the people, especially in the SADC region where most health services are concentrated in and around urban areas. Such concentration complicates access to timely health services, especially for people living in rural areas where essential services often are unavailable. Women and children are especially affected, due to their inability to afford transport and other costs. Strong patriarchal norms in most Member States also restrict women's mobility, which limits their access to centralised services (as do the care and other burdens which women bear).

The Assessment revealed that all Member States have tried to decentralise certain health services in order to increase women and men's access to those services. However, some challenges were noted.

8.8.1 Issues and challenges

The following issues and challenges were identified:

- Some services are still centralised and this hampers access. For instance, centralised diagnostic and testing services limit access to health services for rural women and men; and

- Women and women are insufficiently informed about available health services.

8.8.2 Gender guidelines Member States shall:

- Decentralise diagnostic health services for communicable diseases to ensure wider access by women and men, especially those who cannot afford indirect costs attached to the services;
- Enhance awareness of available health services, by using multimedia approaches; and

- Expand and intensify the use of mobile clinics at community level to increase access to health services.

8.8.3 Monitoring indicators

- Number of Member States with decentralised diagnostic services for communicable diseases within a 5-8 kilometre radius;

- Number of Member States with mobile clinics in hard-to-reach areas.

8.9 Financing of gender mainstreaming

In order to mainstream gender in communicable diseases, adequate financial resources are required for activities that can have the greatest impact on reducing vulnerability to infection for both women and men. It is essential for Member States to allocate financial resources to all gender-related activities that cannot be implemented concurrently with other planned activities.

All Member States indicated that budget support is important for implementing gender mainstreaming initiatives that can facilitate equity in access to treatment and prevention services. However, several gaps were identified.

8.9.1 Issues and challenges

The following gaps and challenges were identified:

- None of the Member States currently have specific allocations for gender mainstreaming activities, such as capacity building of staff for gender mainstreaming;

- There is a lack of budget tracking around gender mainstreaming; and

- Knowledge of gender-responsive budgeting is lacking among health personnel, especially planners.

8.9.2 Gender guidelines

- Conduct training on gender responsive budgets and capacity building in gender mainstreaming for policymakers, programmers and implementers;

- Provide adequate financial resources to support gender-sensitive surveillance and M&E systems;
- Implement resource tracking for resources that have been allocated for gender mainstreaming activities for HIV and AIDS, TB and malaria.

8.9.3 Monitoring indicators

The following indicators are proposed:

- Number of Member States that track budgets for gender mainstreaming in health; and

- Number of Member States that provide financial resources for implementing gender mainstreaming activities.
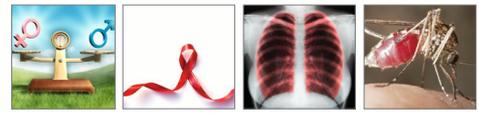
9. IMPLEMENTATION MECHANISMS FOR THE GUIDELINES

The implementation mechanism defines the key stakeholders and their respective roles in implementing the Guidelines. It also provides guidance on how implementation can be financed. In addition, it identifies the critical indicators that need to be monitored to ensure that the Guidelines are fully integrated into the work of Member States. This section maps a route for implementing, financing and monitoring the Gender Guidelines.

9.1   Stakeholder roles and responsibilities

Successful implementation of the SADC Gender Guidelines requires the involvement of all key stakeholders at national and regional levels. The following sections provide an outline of their respective roles.

9.1.1   Member States

- The SADC Ministers of Defence in collaboration with Health Ministers will oversee and monitor the implementation of these regional standards.

- Military Health Services shall take a lead role in ensuring that the minimum standards are integrated to the annual work plans of their military health programmes.

- Military Health Services shall ensure that military health programmes involve Ministries of Health and key stakeholders in the public and private sectors (for example, donors, WHO, partners, community-based organisations, Private Sector and training institutions) to identify their roles in the implementation of the various activities articulated in the minimum standards.

- Military Health Services shall identify challenges to implementation of each standard, and ways of overcoming them. They will also identify opportunities for each standard.

- SADC Military Health Services shall develop a detailed financial plan and avail resources for supporting the implementation of the harmonised minimum standards.

9.1.2   SADC Secretariat

The SADC Secretariat will coordinate the overall implementation and monitoring of these minimum standards on behalf of the Ministers of Defence and Health. Specific responsibilities will include:

- Advocating for implementation of effective Military Health programmes in the region in relation to the commitments made by Member States (such as the SADC Protocol on Health, and the Maseru Declaration on HIV and AIDS);

- Facilitating domestication of the minimum standards ;

- Facilitating skills transfer and sharing of good/ innovative practices, benchmarking of Member States among each other and provide a platform of sharing of good practices;

- Coordinating partners for resources mobilisation and technical support in the region; and

- Coordinating regional training programmes on gender mainstreaming in communicable disease programmes.

9.1.3   Other stakeholders

Other stakeholders include United Nations (UN) agencies, bilateral donors and development partners, local and international NGOs, community-based organisations, the private sector and research and training institutions. All are essential for the successful implementation of these Guidelines.

UN agencies and other development partners

Their roles will vary, but will include:

- Providing technical support for mainstreaming gender in communicable disease programmes;

- Assisting in updating and developing strategies for mainstreaming gender;

- Supporting resource mobilisation to assist in implementing the Gender Mainstreaming Guidelines; and

- Assisting Member States and the Secretariat to coordinate gender mainstreaming activities.

Local and international donors and NGOs

Their roles will include:

- Assisting in implementing the agreed Guidelines;

- Advocating for strengthening gender
  mainstreaming in communicable disease
  programmes;

- Augmenting resources to ensure implementation
  of the Guidelines;

- Assisting in disseminating best practices within
  the region;

- Providing additional human resources, as
  needed, to support implementation of the
  Guidelines;

- Providing feedback to Member States on
  progress in implementation of the Guidelines;
  and

- Advocating for legislation on harmful cultural
  practices that have a bearing on
  communicable diseases and on the full
  implementation of these Guidelines.

9.2   Financing mechanisms

Implementation of these Guidelines may require
additional financial resource allocation by each Member
State. Funding for activities that are required to meet
the minimum standards will be allocated within the
national budgets of each Member State.

Member States shall ensure that:

- Areas that need additional financial resources
  are identified, with the participation of all
  relevant stakeholders, including UN agencies,
  donors, development partners and NGOs; and

- Improvements (for example, implementing an
  advocacy, communications and social
  mobilisation strategy, performing research, or
  conducting training) are properly costed.

ANNEX 1: GENDER CONCEPTS

Affirmative action: A policy programme or measure that seeks to redress past discrimination through active measures to ensure equal opportunity and positive outcomes in all spheres of life.

Discrimination: Any distinction, exclusion or restriction which has the effect or purpose of impairing or nullifying the recognition, enjoyment or exercise by any person of human rights and fundamental freedoms in the political, economic, social, cultural, civil and any other sphere. This may be intentional or unintentional.

Fair discrimination: Refers to discrimination that is allowed based on inherent requirements of a particular situation; it may be allowed by law or may be based on affirmative action.

Gender responsiveness: Being able to respond to perceived needs of men and women, and taking into consideration the impact of policies, legislation and programmes on men, women, boys and girls.

Gender-responsive programming: Programmes where gender norms, roles and inequalities have been considered and measures have been taken to actively address them. Such programmes go beyond raising sensitivity and awareness, and tackle gender inequalities.

Gender perspective: The ability to analyse the socioeconomic, political, cultural and psychological implications of an issue in order to understand how differences between men and women affect and are affected by health policies, programmes and projects. It assesses how such factors relate to discrimination based on sex, and how these impose obstacles to a person's health.

Home-based care: Provision of health services by formal and informal caregivers in the home in order to promote, restore and maintain a persons maximum level of conform, function and health including care towards a dignified death.

Psychosocial support: A term usually used to encompass the range of services that address a person's psychological and social needs. For people affected by HIV and AIDS, psychosocial support generally refers to non-medical services.

Sex disaggregated data: Data that are collected for men and women to reveal differences in access to health services between men and women; differences in prevalence rates of a particular disease; differences in response to treatment among other issues.

Gender-sensitive M&E: Requires a mix of input, output, process, outcome and impact indicators that reveal the extent to which an activity addresses the needs of women and men.

Sexual reproductive health rights: Rights of all persons, free of coercion, discrimination and violence, to the highest attainable standard of health in relation to issues of sexuality, including access to sexual and reproductive health care services; information and education on sexuality; respect for bodily integrity; choice of sexual partner; the decision to be sexually active or not; consensual sexual relations and marriage; the decision of when and whether to have children; and to pursue a satisfying, safe and pleasurable sexual life.

Practical gender needs: Immediate needs that arise out of the customary gender division of labour. They are a response to immediate, perceived necessities identified with a specific context, and they are often concerned with inadequacies in living conditions.

Strategic gender needs: Reflect a challenge to the customary gender relations and imply change in the relationships of power and control between women and women. Strategic gender needs which women identify arise from women's recognition and challenge to their subordinate in relation to men in their society.

Stigma: The association of negative attitudes toward and disapproval of people in a particular group. Stigma and discrimination are major hindrances to scaling up prevention, testing, treatment and care for people affected by HIV.

Vulnerability: The likelihood of being exposed to HIV, TB and Malaria infection because of a number of factors or determinants in the external environment, which are beyond the control of the person or a particular social group.

Empowerment: The process of increasing the capacity of individuals or groups to make choices and to transform those choices into desired actions and outcomes.

Gender empowerment: A process of awareness and capacity building leading to greater participation in transformative action, and greater decision-making power and control over one's life and other processes. Empowerment of women as a policy objective implies that women legitimately have the ability, and should (individually and collectively) participate in decision-making processes that shape their societies and lives, especially those involving social priorities and development directions. It can be achieved through awareness-building self-confidence, expansion of choices, increased access to and control over resources and actions to transform the structures and institutions, which reinforce and perpetuate gender discrimination and inequality.

ANNEX 2:   APPLYING GENDER MAINSTREAMING TO HIV, TUBERCULOSIS AND MALARIA PROGRAMMES

Gender mainstreaming aims at facilitating equity in health, generally, and communicable diseases, in particular, by ensuring that issues that negatively affect access to health services and treatment outcomes for both men and women are addressed. The Regional Assessment Report on the status of gender mainstreaming in communicable diseases recommended that in order to mainstream gender in disease-specific programmes, focus areas for each disease should be used as entry points. This section discusses how this can be done.

a.   Gender mainstreaming guidelines for HIV and AIDS programmes

Some of the proposed strategies for mainstreaming gender in HIV programmes focus on HIV prevention and vulnerability reduction, prevention of mother-to-child transmission (PMTCT); HIV testing and counselling, treatment, care and support, and impact mitigation.

Key intervention area	Proposed gender mainstreaming strategies
1 HIV prevention & vulnerability reduction	Implement community-based sex education initiatives to promote dialogue and openness on sex and sexuality among couples and adolescents. Facilitate integration of social welfare and police services in all health centres for easy collaboration on issues of sexual violence in the context of HIV. Ensure that provision of comprehensive post-exposure prophylaxis (PEP) services inform emergency contraceptive, trauma counselling, timely and user-friendly legal aid services and support. Decentralise PEP to enable women and girls to access the services in rural and hard-to-reach areas. Implement PEP to survivors of sexual violence, without making a police report a condition for treatment, in situations where police services cannot easily be accessed. Develop and implement gender-sensitive HIV communication strategies and integrate training on gender, sexuality, human rights, and client care, into existing capacity building plans for health personnel.

2	Prevention of mother-to-child transmission of HIV	Ensure functional coordination mechanisms with non-formal service providers to track and provide PMTCT services to all HIV-positive pregnant mothers. Promote male involvement in PMTCT to help reduce gender-based violence, stigma and discrimination. Integrate gender sensitisation in all training programmes for lay counsellors and health workers who provide PMTCT services. Devise functional follow-up mechanisms through the community-based programmes to reach out to HIV-positive adolescent pregnant girls who might not use formal health services, and for all HIV-positive mothers who have used PMTCT services after delivery, in order to avoid rapid progression towards AIDS. Ensure functional coordination mechanisms with non-formal service providers to track and provide PMTCT services to all HIV-positive pregnant mothers, especially those that use non-formal service providers.
3	HIV testing & counselling	Ensure that HIV testing and counselling takes account of the specific needs and concerns of women and men to facilitate easy access. Integrate gender dimensions into HIV testing and counselling protocols. Provide training to health personnel on gender-sensitive counselling to deal with immediate psychosocial issues for clients, especially women who are prone to abandonment and discrimination. Intensify partner and couple testing and counselling to effectively deal with issues of gender-based violence, stigma and discrimination. Ensure that all protocols dealing with issues of disclosure and discordant couples are gender-sensitive. Integrate gender education and sensitisation to address cultural norms that perpetuate gender inequalities. Intensify door-to-door HIV counselling and testing services to increase access to HIV testing and counselling services. Implement reform programmes for survivors of gender-based violence (including sexual violence), especially in post-conflict Member States.
4	Treatment, care & support	Ensure gender mainstreaming of case management and drug procurement guidelines to increase equitable access to treatment. Mainstream gender into nutrition and home-based care guidelines.

		Conduct social mobilisation campaigns on negative cultural practices to transform community gender norms related to care-taking responsibilities, including strategies on promoting greater participation of men and boys in care-giving roles.
5	*Impact mitigation*	Implement gender-sensitive programmes to promote awareness of the ills of sexual violence and harassment. Encourage networking among institutions to share notable practices on how to address gender-based violence in relation to HIV and other sexually transmitted infections. Promote male involvement in the provision of home-based care. Provide information on legal rights through legal literacy on pertinent issues such as on property grabbing including having Will and other benefits to men, women, girls and boys especially the infected and affected people. Facilitate access to education for girls from affected households, and other vulnerable children.

b.   Gender mainstreaming guidelines for Tuberculosis programmes

The Gender Mainstreaming Guidelines for TB focus on the six main components of the WHO TB Stop Strategy, namely:

- Pursue high-quality DOTS expansion and enhancement;
- Address TB/HIV, multidrug-resistant TB (MDR-TB) and the needs of poor and vulnerable populations;
- Contribute to health systems strengthening based on primary health care;
- Engage all care providers;
- Empower people with TB and communities through partnerships; and
- Promote research.

	Key intervention area	Proposed gender mainstreaming strategies
1	*Pursue high-quality DOTS expansion & enhancement*	Conduct advocacy campaigns for policy and decision-makers and donors at all level to ensure adequate and sustained financing of gender mainstreaming activities. Decentralise TB and MDR-TB diagnostic and treatment services to make them easily accessible to everyone, especially in rural areas. Identify and deal with specific sociocultural barriers that hinder access to TB services for men and women. Collect, analyse and utilise sex-disaggregated data on TB and TB/HIV notifications, and ensure the data are cross- tabulated by age and other socioeconomic variables.
2	*Address TB/HIV, MDR-TB and the needs of poor and vulnerablepopulations*	Mainstream gender into TB case management guidelines. Create awareness on TB and TB services by using multifaceted channels of communication.

3	*Contribute to health systems strengthening based on primary health care*	Ensure that pre- and in-service curricula are gender-sensitive. Train health personnel in gender mainstreaming.
4	*Engage all care providers*	Ensure that public-private partnership policies and strategies in all aspects of TB care are gender sensitive. Enhance participation of all caregivers in planning, implementation and M&E of gender-sensitive TB interventions. Implement initiatives that encourage male and female involvement in the provision of care for TB patients.
5	*Empower people with TB and communities through partnerships*	Develop and implement gender-sensitive advocacy campaigns. Engender all IEC materials to deconstruct negative gender norms that affect women's access to TB services. Translate IEC materials into local languages and disseminate the Patients' Charter for Tuberculosis Care to communities to enhance access to information.

c.   Gender mainstreaming guidelines for Malaria programmes

The Gender Mainstreaming Guidelines for malaria control programmes focus on the priority areas of malarial control programmes in the SADC region, namely:

- Integrated malaria vector management;
- Malaria in pregnancy;
- Case management;
- Epidemic preparedness and response;
- IEC and behaviour change communication;
- Surveillance and M&E; and
- Operational research.

In all these focus areas, gender issues have to be identified and strategies have to be devised and implemented.

Key intervention area		Proposed gender mainstreaming strategies
1	*Malaria Integrated Vector Management*	Implement deliberate Integrated Vector Management measures for vulnerable populations, such as migrant populations, pregnant women, people living with HIV, the elderly, orphans and other vulnerable children, refugees, child and female-headed households, sex workers and uniformed forces (including watchmen) with malaria control measures, such as personal protection, repellents and mosquito nets. Facilitate and encourage community participation in Integrated Vector Management interventions, such as environmental management, indoor residual spraying and larvae control. Subsidise mosquito nets to users to ensure access by poor groups and households.

2	*Malaria in pregnancy*	Engender safe motherhood strategies and guidelines for vector control, insecticide-treated nets or long-lasting nets, IEC and behaviour change communication, and advocacy, community and social mobilisation (ACSM). Mainstream gender in all guidelines for management of malaria.
3	*Case management*	Accelerate scaling up of community-based diagnosis and treatment of malaria, using effective anti-malarial drugs to increase equitable access by all groups. Integrate gender issues in pre- and in-service training materials for health personnel to enhance understanding and appreciation of gender disparities in malaria diagnosis and treatment. Disaggregate and analyse routine and survey data for malaria treatments by sex, age, occupation and prevailing sociocultural practices (among others).
4	*Epidemic preparedness and response*	Mainstream gender in epidemic preparedness and response (EPR) policies and guidelines. Engender EPR and Integrated Disease Surveillance and Response (IDSR) guidelines. Engender surveillance systems.

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