THE GLOBAL FUND

Reducing human rights and gender related barriers to HIV, TB and malaria services

Technical Brief

Grant Cycle 8

Core Guidance

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Introduction

The Global Fund partnership has made significant progress against HIV, tuberculosis (TB) and malaria. However, many communities who are most affected by the three diseases also experience reduced access to prevention, treatment and care services due to a combination of biological and socioeconomic factors, including marginalization, criminalization, stigma and discrimination, violence or other human rights-and gender-related barriers, which threaten the progress and sustainability of disease responses.

Funding Requests to the Global Fund should recognize and respond to these realities by rigorously prioritizing investments to focus on reaching people most at risk, particularly key, vulnerable and underserved populations, and women and girls, and investing in removing human rights- and gender-related barriers to health services.

This technical brief guides applicants preparing funding requests for Grant Cycle 8 (GC8) to:

1) Understand these specific Funding Request **requirements and standards** (section 2).
2) Select the most critical **evidence-based interventions** to reduce human rights- and gender-related barriers to HIV, TB and malaria services.

Refer to the HIV, TB and malaria information notes for additional guidance on key, vulnerable and underserved populations in the context of each disease.

Global Fund Requirements and Standards

2.1 At a Glance

Area	Requirement	Portfolio
Global Fund Human Rights standards	Demonstrate compliance with the five minimum human rights standards, as set out in the Code of Conduct for Recipients of Global Fund Resources.	• Required for all portfolios
Sexual exploitation, abuse and harassment	Mitigate the risk of sexual exploitation, abuse and harassment in connection with service provision, as set out in the Code of Conduct for Recipients of Global Fund Resources.	• Required for all portfolios
Assessments of equity, human rights and gender-related barriers to HIV, TB and malaria services	Attach an assessment, relevant to all components of the Funding Request, describing equity gaps and human rights- and gender-related barriers. Demonstrate how assessment findings have informed Funding Request design.	• **NEW:** Required for all High Impact Portfolios • Recommended for all other portfolios

Area	Requirement	Portfolio
Programmatic interventions to remove human rights and gender-related barriers to HIV, TB and malaria services	Include specific interventions from both the human rights and gender modules in the Modular Framework. Interventions should address the findings of equity, gender and human rights assessments.	• Recommended for all other portfolios
Modular Framework	Human rights and gender equality modules have moved to the Resilient and Sustainable Systems for Health (RSSH) component. Interventions that address human rights and gender barriers to health services should be included within: 1. HIV, HIV/TB, malaria and TB funding requests to address disease-specific barriers to lifesaving and essential services **AND** 2. RSSH funding requests to address systemic and cross-cutting human rights- and gender-related barriers to services.	• **NEW:** for all portfolios
Gender and Equity Indicators	Include **gender and equity indicators** in the performance framework. Indicators should track interventions identified through equity, human rights and gender assessments.	• Required for all High Impact and Core Portfolios • Recommended for all other portfolios
Gender Equality Marker (GEM) Assessment	All funding requests will undergo an independent **GEM assessment** after submission to the Global Fund, to assess levels of gender integration across Global Fund-supported programs. See Annex II for further information	• For information for all portfolios

2.2 Detailed requirements and standards

Funding requests to the Global Fund should establish a foundation for available, accessible, acceptable and quality health care, and reduce human rights- and gender-related barriers to health services.

2.2.1. Code of Conduct

- **Minimum Human Rights Standards.** All recipients of Global Fund resources are required to meet five minimum human rights standards,[1] as stated in grant agreements and the Code of Conduct: provide non-discriminatory access to services; use scientifically sound and approved medicines and medical practices; not use methods that constitute torture or cruel, inhuman or degrading treatment; respect and protect informed consent, confidentiality and the right to privacy; and avoid medical detention and involuntary isolation.

- **Protection from sexual exploitation and abuse, and sexual harassment**. All recipients of Global Fund resources are prohibited from engaging in sexual exploitation, abuse or harassment and must mitigate the risk of it occurring in connection with service provision. The Code of Conduct also requires the safeguarding of children's rights.

2.2.2. Assessments of equity, human rights and gender-related barriers to HIV, TB and malaria services

Programmatic decisions should be informed by robust and objective analysis, particularly when resources are limited. High Impact portfolios are therefore required to submit an assessment, relevant to all components of the Funding Request, describing equity gaps and human rights- and gender-related barriers to HIV, TB and malaria services.

They can be completed as part of national strategic plan (NSP) processes; integrated into mid-term or full program reviews; or conducted using frameworks from partners such as RBM, Stop TB and UNAIDS.

Communities should be meaningfully involved in the development and validation of assessments.

Assessments should cover every component included in the Funding Request. For example, if a Funding Request includes HIV, TB, malaria and RSSH modules, the analysis should examine equity gaps and human rights- and gender-related barriers across all three diseases as well as health and community systems.

Where possible, assessments should take an integrated approach that examines equity gaps and human rights- and gender-related barriers holistically across components.

Existing component-specific assessments, whether produced through NSPs, program reviews or other processes, may be used, provided that they collectively address equity gaps and human rights- and gender-related barriers across all elements of the Funding Request.

[1] Global Fund grant recipients are required to advise the Global Fund of risks to these human rights standards. The Global Fund's independent Office of the Inspector General (OIG) has established a mechanism to investigate complaints regarding the standards. The Global Fund (2015). The Global Fund Human Rights Complaints Procedure Responding to Community Concerns.

There is no standard template for the assessments, however they should:

- Analyze inequities in access to services and health outcomes for different populations.
- Describe social, political, environmental, human rights or legal contexts that influence HIV, TB and malaria outcomes, including social and gender norms; discrimination; power imbalances and different access to and control over financial resources; restrictive laws and policies.
- Summarize the key human rights- and gender-related barriers affecting access to services.
- Describe current programmatic responses and gaps;
- Outline costed strategies and actions to address identified gaps.
- Describe how communities have been engaged in the assessment process and how their input shaped the findings.

2.2.3. Interventions to remove human rights and gender-related barriers to HIV, TB and malaria services

- Include specific interventions from both the human rights and gender modules in the Modular Framework to address underlying inequities, vulnerabilities, and human rights- and gender-related barriers to HIV, TB and malaria services, as well as system-wide barriers.
- Interventions should address the findings of equity, human rights and gender assessments.

2.2.4. Gender and Equity Indicators

- Include gender-specific and equity-related indicators in performance frameworks to measure progress. This is a requirement for all High Impact and Core portfolios.
- Indicators should track interventions identified through equity, human rights and gender assessments.

Collect and analyze data disaggregated by sex and other relevant dimensions as per the requirements in the Modular Framework. Analysis of this data should inform program design, adaptation and monitoring and evaluation.

Evidence-Based Interventions supported by the Global Fund

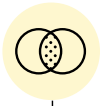
When investing in Global Fund-supported programs to remove human rights- and gender-related barriers to services, the following considerations are crucial:

Put communities at the center.

Meaningful leadership and engagement of communities, including key populations, PLHIV and TB survivor networks, in designing, delivering and monitoring health programs ensures stronger impact, sustainability and accountability for marginalized groups.

Move beyond one-off activities toward mature, comprehensive programs.

Isolated, one-off trainings and production of materials are insufficient; long-term integrated strategies are needed to shift attitudes, behaviors, and systems sustainably. Comprehensive and sustainable programing also requires dedicated funding, including from domestic sources, and a multistakeholder oversight mechanism that includes affected communities



Use integrated and complementary approaches.

While separate modules are defined within the modular framework, programs that integrate interventions from the community systems strengthening, human rights and gender modules with other programmatic areas produce greater and more lasting impact. Integration also ensures that priorities to remove barriers to access to health services related to human rights and gender reinforce one another, improving the quality of programs and increasing impact.

Strengthen local expertise for sustainability and ensure adequate human resources.

Lasting change depends on building capacity within institutions and communities. This includes embedding health-related human rights and gender equality content into health worker curricula, training peer educators, paralegals and community development professionals. Together with supporting their integration within national community health programs where appropriate and strengthening community organizations to lead implementation. Dedicated focal point or coordinator roles are essential for coordinating this work and ensuring momentum oversight and accountability.

Strengthen multisectoral coordination and financing.

Collaboration with justice, including national human rights commissions, education and social protection actors, as well as other sectors, can improve sustainability and impact through joint action plans, shared budgeting and reduced duplication

Protect the safety and security of health workers, community cadres and service users.

Programs should embed risk management, safe delivery protocols, emergency funding and psychosocial support, particularly when implementing programs for criminalized or marginalized populations, or delivering services in challenging operating environments, to maintain service continuity and trust in all contexts.

Ensure robust monitoring, evaluation and learning.

Integrating strong monitoring and evaluation of human rights- and gender-related barriers from the outset enables continuous improvement, accountability and scalable, high-quality interventions.

Promote and protect digital rights.

Safeguarding privacy and confidentiality, ensuring equitable and inclusive access to digital tools and information, combating misinformation, preventing and responding to online harm, and strengthening digital literacy are essential for fair and effective health responses.

3.1. Reducing Human Rights-related Barriers to HIV, TB and Malaria Services

Global Fund supports activities that reduce human rights-related barriers that prevent people from accessing life-saving and essential services for the prevention, testing and treatment of HIV, TB and malaria. Interventions targeted to populations affected by these barriers ultimately improve health outcomes and support strengthening systems for health.

The Global Fund's Modular Framework for GC8 lists a module (under the RSSH component) to **Reduce Human Rights-related Barriers to HIV, TB and Malaria Services**, with approaches that aim to:

1. Expand access to quality and discrimination-free health care;
2. Improve the legal and policy environment;
3. Improve legal empowerment and access to justice.

These approaches provide a package of evidence-based human rights programs that should be prioritized based on evidence, and implemented according to country context to reach those most in need. When human rights interventions are designed and scaled based on evidence and need, they reduce inequalities and strengthen the effectiveness, efficiency, and sustainability of national health responses.

3.1.1. Expanding Access to Quality and Discrimination-free Health Care

This area includes two specific interventions:

- **Ensuring non-discriminatory provision of health care.**
- **Eliminating stigma and discrimination in all settings.**

Stigma and discrimination are among the most damaging barriers to healthcare, resulting in social marginalization and exclusion, denial of services and substandard prevention, treatment and care.[2] [3]

Health facilities should be places of dignity and safety, but too often people living with HIV, TB patients, women and girls, young people, key populations and other marginalized populations face discrimination and/or exclusion. For example, for HIV, stigma remains one of the strongest predictors of delayed health seeking and disengagement from care. For TB, people may be viewed as contagious and face segregation practices,[4] and TB-related discrimination leads to delays in case finding. When it comes to malaria, unmarried pregnant women and girls may avoid antenatal visits if they expect judgmental care, and system-wide discrimination related to, for

[2] Stangl, A.L., et al. "The Health Stigma and Discrimination Framework: a global, cross-cutting framework to inform research, intervention development, and policy on health-related stigmas," BMC Med 17, 31 (2019). https://doi.org/10.1186/s12916-019-1271-3
[3] https://www.hhrjournal.org/2021/12/08/building-the-evidence-for-a-rights-based-people-centered-gender-transformative-tuberculosis-response-an-analysis-of-the-stop-tb-partnership-community-rights-and-gender-tuberculosis-assessment/
[4] https://www.hhrjournal.org/2021/12/08/building-the-evidence-for-a-rights-based-people-centered-gender-transformative-tuberculosis-response-an-analysis-of-the-stop-tb-partnership-community-rights-and-gender-tuberculosis-assessment/

example, migrants and displaced persons, urban poor and nomadic pastoralists, affects access to malaria treatment. Addressing these types of barriers, including stigmatizing language use in program strategies and planning,[5] is essential to ending the three diseases.

The Global Fund Strategy (2023–2028) recognizes this, aligning with the Global AIDS Strategy and the Global Partnership to End HIV-Related Stigma and Discrimination.[6] Applicants should therefore plan comprehensive, evidence-based interventions that make health services discrimination-free.

Priorities for Global Fund Investments

For GC8, the Global Fund has moved the above-mentioned interventions into the RSSH component of the Modular Framework, recognizing that addressing stigma and discrimination is not just about single-disease programs but about strengthening the entire health system to provide respectful, rights-based care for everyone. Interventions to improve the competencies of community health workers and health providers to provide people-centered, stigma-free and nondiscriminatory services should be included as part of any package for strengthening systems for health. At the same time, applicants should also continue to budget for and design interventions that respond to the specific stigma and discrimination dynamics associated with each disease.

- **Institutionalize rights in the health sector.** Ensure meaningful community participation in national and subnational governance and decision-making to inform the integration of health equity, human rights and gender equality in health responses. Training providers is important, but training must be built into curricula and reinforced in practice to ensure sustainability. All staff, from doctors to cleaners to security guards, need to understand public health and/or medical ethics, informed consent, confidentiality and non-discrimination. Practical skills are as important as principles: how to deliver respectful care, how to recognize and address bias and how to prevent exploitation, abuse and harassment.
- **Ensure accountability.** Codes of conduct, complaint procedures and performance evaluations that include stigma indicators help turn commitments into action. Patients need clear reporting channels. Community mediators and paralegals can help people navigate health systems and secure remedies if their rights are violated.
- **Measure stigma and discrimination.** Assessments provide the evidence base to address issues. Tools such as the People Living with HIV Stigma Index,[7] TB Stigma Assessment,[8] Malaria Matchbox Tool,[9] community-led monitoring[10] and adapted facility surveys can

[5] https://pmc.ncbi.nlm.nih.gov/articles/PMC4182829/
[6] The Global Partnership was convened in 2018 and involves UNAIDS, UN Women, the United Nations Development Programme, the Global Fund, the Global Network of People Living with HIV, the PCB NGO Delegation. "Global Partnership," UNAIDS, accessed 16 August 2022, https://www.unaids.org/en/topic/global-partnership-discrimination
[7] The People Living with HIV Stigma Index: https://development.stigmaindex.org/
[8] TB Stigma Index: https://www.stoptb.org/tb-stigma-assessment-tool
[9] Malaria Matchbox Tool: https://endmalaria.org/sites/default/files/Malaria%20Matchbox%20Tool_en_web.pdf
[10] A global exchange on the role of Community-led Monitoring (CLM in malaria programming: https://www.theglobalfund.org/media/13438/crg_2023-community-led-monitoring-malaria-meeting_report_en.pdf , CLM Hub, International Treatment Preparedness Coalition: https://clm.itpcglobal.org/

identify where and how stigma happens, which groups are most affected and whether interventions are working. As part of these assessments, data should be disaggregated by population, sex and age and collected periodically to track progress. Other disaggregation factors may include place of residence, economic status, nationality, ethnicity, disability or other information specific to targeted groups based on contextual vulnerability.

- **Address stigma and discrimination at multiple levels.** In the health sector, this may include health worker training, patient rights literacy and community-led monitoring. At the individual, household and community levels, this may include counseling to reduce self-stigma and empower patients, and dialogues with families and leaders (community, religious and others) to change restrictive norms. Outside the health system, it may also include efforts to build competencies and accountability in law enforcement and with educators or employers where discrimination outside health settings creates barriers to care.

Examples

HIV	TB	Malaria
A country in Eastern Europe and Central Asia (EECA) advanced training for health workers in human rights and medical ethics.[11] Initiatives targeted different populations, including programs to reduce stigma in services for LGBTQI+ persons and activities to address discrimination among medical providers. The Ministry of Health promoted a tool which emphasized both clinical care on HIV and STIs as well as sex worker rights. To institutionalize these efforts, a program on "Overcoming Stigma and Discrimination in Access to Health Services" was introduced at the National Professional Developing Training Institute. Civil society and key population groups also monitored health facilities, reporting challenges and recommending solutions to authorities.	TB survivors in a country in Asia are mobilized to serve as mentors and advocates in community settings, helping individuals and families navigate treatment while confronting the stigma that often surrounds the disease.[12] By sharing lived experiences, they challenge discrimination, foster understanding, and build supportive networks within communities. Their role goes beyond awareness – they reduce isolation, transform attitudes and strengthen the national public health response.	Respectful, confidential antenatal care has increased use of preventive malaria treatment in pregnancy. Integrating people-centered approaches in maternal and child health services ensures that women and girls return for regular visits and use insecticide-treated nets. A country in Southeast Asia, the recruitment and training of community malaria volunteers from different ethnic groups who speak the language, live in those communities, understand the culture and life of the communities they serve help to provide non-discriminatory care and are advocates for and peer navigators for people with malaria seeking care.[13]

[11] Breaking Down Barriers mid-term assessment (2021): Kyrgyzstan
[12] https://iris.who.int/server/api/core/bitstreams/e2d3bfb0-b160-4f57-882c-9b462fa00a38/content
[13] https://www.unops.org/news-and-stories/stories/stamping-out-malaria-for-good/towards-a-malaria-free-laos

HIV	TB	Malaria
Integrated		

In a country in southern Africa[14], the National Department of Health (NDOH) has developed a comprehensive training program to address stigma and discrimination in health care settings. This program includes pre-service education for health workers, focusing on human rights, medical ethics, and the provision of people-centered care. The training is designed to be integrated into existing health education curricula, ensuring that future healthcare providers are well-prepared to deliver inclusive and non-discriminatory services.

3.1.2. Improving the Legal and Policy Environment

Key investment areas

This area includes three specific interventions:

- **Ensuring rights-based law enforcement practices**
- **Improving laws, regulations and policies**
- **Supporting community mobilization and advocacy for health-related human rights**

The legal and policy environment plays a decisive role in shaping people's ability to access HIV, TB and malaria services. Supportive laws and rights-based enforcement create conditions where people feel safe seeking care. By contrast, punitive or discriminatory laws and practices push people away, increase vulnerability and directly undermine national responses to the three diseases.

Restrictive laws and practices include breaches of confidentiality, mandatory testing, demands for bribes or high fees, and policies that allow for discriminatory practices. Laws may require health workers to report certain clients to law enforcement, undermining trust in health services. People affected by TB may face immigration restrictions or exclusionary policies in workplaces. Adolescents may face age-of-consent barriers to accessing HIV or sexual and reproductive health services that prevent transmission of HIV and associated infections, while women and girls may require spousal consent that limits their autonomy to seek care, including antenatal care - a key delivery point for malaria services - or to seek timely care for sick children. Migrants and displaced populations are often impacted by citizenship or residency requirements for accessing health care.

Laws criminalizing sex work, drug use, same-sex sexual relations, gender diversity, and HIV transmission, exposure and non-disclosure, create fear and keep people from prevention, testing and treatment.[15] It also makes the concerned populations more vulnerable to sexual exploitation and abuse given their inability to report such incidents for fear of reprisals. Law enforcement

[14] https://resources.theglobalfund.org/media/14828/cr_2024-progress-assessment-south-africa_report_en.pdf?utm_source=chatgpt.com
[15] In Danger: Global AIDS Update 2022, UNAIDS, 2022, https://www.unaids.org/sites/default/files/media_asset/2022-global-aidsupdate_en.pdf

practices compound the problem, including harassment, extortion and arbitrary arrest. People in prisons or other closed settings are often denied access to condoms, harm reduction, and prevention, testing and treatment for HIV, TB and malaria.[16]

These barriers prevent effective responses to the three diseases in addition to violating the right to health. To build resilient and sustainable systems for health, laws and enforcement must support, rather than punish, those most in need of care.

Priorities for Global Fund Investments

Placing these three interventions within RSSH is intended to support laws and policies that strengthen systems for health more broadly, ensuring that services can reach the people who need them most. Legal environments that protect privacy, ensure non-discrimination and enable community engagement create a foundation for stronger health governance and accountability across diseases.

Still, law and policy barriers are experienced differently depending on the disease. For example, punitive laws against people who use drugs directly impact HIV and TB outcomes; restrictions on women and girl's health-seeking limit access to malaria and HIV prevention and treatment; weak prison regulations leave both HIV and TB untreated. Applicants should therefore also design interventions that explicitly address the legal and policy obstacles most relevant to each disease and population.

- **Reforming laws and policies that create barriers**. This includes: engaging law-makers and community-led advocacy to decriminalize consensual same-sex sexual relations, sex work, drug use and possession for personal use, and trans and gender-diverse people; removing restrictions on registration, accessing funding and operations of civil society organizations and on community-led responses; and eliminating laws mandating isolation, testing, disclosure or treatment. Other priorities may include reforming laws that block adolescents' access to services, addressing provisions that allow sterilization without informed consent, strengthening gender-based violence protections, removing travel restrictions for people living with HIV and/or TB and ensuring migrants and displaced populations can access services. Advancing digital rights[17] and equitable access to scientific innovations is also an important catalyst for extending accessible healthcare to all.
- **Promoting rights-based law enforcement practices**. Alongside legal reform, it is essential to improve enforcement practices. Programs can support training for police, judges, prosecutors and prison staff on health-related human rights, gender equality and public health. Pre- and post-training assessments should measure changes in knowledge and attitudes. Dialogue and joint activities between law enforcement and key and vulnerable

[16] Technical Brief: Prisons and Other Closed Settings: Priorities for Investment and Increased Impact, 2022 (https://www.theglobalfund.org/en/applying-for-funding/design-and-submit-funding-requests/applicant-guidance-materials/)
[17] Various resources exist to guide implementation of digital solutions for health, including https://stopaids.org.uk/wp-content/uploads/2025/09/Putting-People-and-Human-Rights-first-in-Digital-Health.pdf

populations can build trust. Developing institutional policies that endorse a rights-based public health approach and accountability mechanisms can further embed positive change.

- **Supporting community mobilization and advocacy for health-related human rights** strengthens disease responses by empowering communities to demand accountability, reduce stigma, and expand access to prevention, treatment and care. Activities may include building advocacy and literacy capacity; linking communities with legal and human rights institutions; developing peer or community paralegals; and establishing and scaling systems for monitoring human rights violations that impede the right to health using community-led tools. Programs should also proactively plan to protect the safety and security of health workers, community cadres and service users.[18]

Siloed or duplicative activities should be de-prioritized unless clearly essential, for example, creating new disease-specific legal frameworks where existing ones can be strengthened or holding one-off sensitization events without links to broader reforms.

Examples

HIV	TB	Malaria
In southern Africa, sex worker-led groups have documented abusive police practices that created barriers to HIV health services. Their efforts built a foundation for productive collaborations with law enforcement. A memorandum of understanding was established with the national police service, and a training program called 'Dignity, Diversity and Policing' (DDP) was developed in consultation with key population groups, including sex workers. A pilot demonstrated the receptiveness of police officers to the program, including engaging with people living with HIV and key population representatives[19]. The training was later scaled up under the National Human Rights Plan, with a recognized need to expand further to reach more of the	Litigation can be an important tool for challenging TB-related laws and practices. In a well-documented case in east Africa, a judgment established that TB patients should not be held in jail for non-completion of treatment.[20] A series of cases in Asia[21] laid the groundwork for further use of litigation to improve access to TB care for marginalized people. Collections of TB-related case law highlight issues such as employment discrimination, compulsory isolation, treatment or testing, practices in prison, insurance and compensation disputes, barriers faced by immigrants and asylum-seekers, and poor-quality care.	Removing user fees for malaria services has increased equitable access to services, particularly for migrants and displaced populations, urban poor, rural populations and nomadic pastoralists. Ensuring that women can access services without requiring spousal consent, and that there are no restrictions on adolescents seeking care, can improved maternal, newborn, child and adolescent health.

[18] https://www.civilsocietyhealth.org/website/wp-content/uploads/2022/12/2022_Security-Toolkit-EN_v04-1.pdf
[19] https://www.journalcswb.ca/index.php/cswb/article/view/107/228
[20] https://www.kelinkenya.org/journey-tb-not-crime-judgment-kenya/#:~:text=And%20the%20complexity%20of%20TB,resistant%20version%20of%20the%20disease.&text=noted%20Justice%20Mumbi%20Ngugi%20in,for%20the%20region%20and%20beyond.
[21] https://www.stoptb.org/sites/default/files/imported/page/assets/documents/communities/TB_Human_Rights_and_the_Law_Case_Compendium_%28First_Edition%29.pdf

HIV	TB	Malaria
155,000 officers in the country and integrate DDP into pre-service trainings.		

Integrated

A country in southeast Asia is reducing the burden of HIV, TB and malaria, including intentional efforts to delivering healthcare to migrant populations. Key policy levers include the Workmen's Compensation Act, ensuring migrants access treatment for work-related illness,[22] removing fees for specific testing and treatment services for malaria, and implementing a migrant health insurance scheme (MHIS)[23] covering diagnosis, and treatment for HIV and TB, as well as an alternative not-for-profit health protection scheme for undocumented migrants.[24] Migrant-sensitive services, including community health volunteers, were introduced in both community and workplace settings. Multisectoral coordination across Interior, Labor, Public Health, and Immigration ministries, as well as with civil society, supported these interventions, improving access to HIV, TB, and malaria services for documented and undocumented migrants.

Legal reform in a country in southern Africa[25] allowed a community-led organization to gain official registration after years of litigation. This recognition enabled the group to access funding, operate openly, and integrate services for marginalized populations, particularly around HIV. The case illustrates how changing laws to permit registration and access funding strengthens civil society's role in health, improves partnerships with service providers, and ensures communities can claim rights and deliver services effectively.

3.1.3. Improving Legal Empowerment and Access to Justice

Key investment areas

This area includes two specific interventions:

- **Increasing legal literacy ("know your rights")**
- **Increasing access to justice**

Legal empowerment and access to justice are essential for removing barriers to health services, supporting retention in care and ensuring that people can exercise their rights. Without knowledge of their rights or the ability to seek redress, people living with or at greater risk of HIV, TB and malaria often face discrimination, abuse and exclusion that prevent them from seeking or staying in care.

Women and girls may be denied access to sexual and reproductive health services - which are critical to reduce HIV, TB and malaria risk - without spousal consent. People who use drugs, sex workers or LGBTQI+ people may be harassed, arbitrarily detained or prosecuted. People living

[22] https://socialprotection-humanrights.org/legaldep/measures-to-ensure-equality-of-treatment-of-migrant-workers-in-case-of-work-related-accident-in-thailand/#:~:text=In%20previous%20observations%20on%20the,in%20accordance%20with%20the%20WCA.
[23] https://www.social-protection.org/%20gimi/Media.action?id=18734
[24] https://linitiative.expertisefrance.fr/en/projects-we-support/m-fund-head-insurance-for-migrants/#:~:text=Greater%20Mekong%20Subregion-,M%2DFund:%20A%20low%2Dcost%2C%20not%2Dfor,in%20the%20Greater%20Mekong%20Subregion&text=This%20project%20is%20the%20first,populations%20and%20poor%20border%20communities.
[25] https://international.coc.nl/wp-content/uploads/2018/08/LL-47-LEGABIBO-Botswana.pdf

with HIV may be fired from jobs or excluded from housing while TB patients may face stigma and discrimination in workplaces or schools. In prisons and other closed settings, people are often denied access to prevention and treatment altogether.

These violations not only cause harm but also drive people away from health services. Access to justice through legal literacy interventions, delivered in accessible formats and approaches, as well as through paralegals, legal aid or dispute resolution, enables communities to challenge discrimination, demand services and hold authorities accountable. When people know their rights and can enforce them, they are more likely to engage with prevention, testing and treatment, which strengthens health outcomes across HIV, TB and malaria.

Priorities for Global Fund Investments

The Global Fund has moved these two interventions under RSSH, acknowledging that linkages to rights-based justice mechanisms are essential for resilient systems for health. When communities can seek redress, challenge discrimination and demand accountability, the entire health system becomes more trusted and responsive. This benefits not only people living with or at greater risk of HIV or TB but also malaria-affected populations, women and girls, migrants and other groups who face barriers to care.

At the same time, it can be more efficient and effective to implement legal empowerment and access to justice for different populations in disease-specific responses. Applicants should still budget for and design tailored interventions that respond to the distinct legal barriers linked to each of the three diseases, for example, integrating legal literacy with TB treatment literacy and integrating community-led monitoring of human rights violations and referrals to paralegals into the work of peer outreach cadres and legal empowerment led by people living with HIV and TB survivors.

- **Legal empowerment programs should begin with legal literacy** to help people understand their right to health, non-discrimination, privacy and freedom from violence, including in digital spaces. People who know these rights can, for example, demand access to services, push back against police harassment, advocate for affordable medicines, or protection from gender-based violence, including sexual exploitation, abuse and harassment. Legal literacy is most effective when integrated into HIV, TB and malaria programs, for example, offering accessible and contextualized “know your rights” information at harm reduction sites, in community-based TB programs or through malaria prevention campaigns.
- Legal literacy should also be paired with **access to justice** mechanisms. This includes providing direct legal aid, supporting community-based paralegals, linking paralegals to pro bono attorneys and ensuring referral pathways to social or health services. Access to justice may also include rapid response hotlines, community mediators or alternative dispute resolution systems that are trusted by local communities. Strategic litigation can be a powerful tool to reform restrictive laws and set precedents for protecting rights.

Programs should be responsive to community preferences. Some people may feel safer working with traditional or religious leaders to resolve claims, while others may prefer specialized drop-in centers or peer paralegals. The goal is to create flexible, community-led systems of support that reduce fear and increase trust in justice pathways.

Examples

HIV	TB	Malaria
In a country in west Africa,[26] the number of assistants jurists (paralegals) expanded to cover over 50 healthcare sites. Their integration into HIV services allowed them to sensitize patients on their rights and redress options, which helped reduce fear with access and continued engagement. The holistic approach combining legal, psychological, and peer support enhanced the quality and accessibility of HIV prevention, testing, and treatment services.	In a country in west Africa,[27] TB-related legal literacy has been scaled-up through peer paralegals and the TB Voice Network's TB Champions. Paralegals are active in 154 facilities, providing basic TB and rights information, including direct legal support and referrals to essential social protections nationwide. TB Champions across 15 regions report improved awareness of health-related and employment-related rights, as well as access to legal aid."	Legal empowerment has been used to ensure pregnant women can access malaria treatment and prevention without spousal consent and to support migrants' rights to access malaria care regardless of nationality.
Integrated		
Programs that strengthen access to justice can achieve efficiencies and broader impact when they combine community-led and state-supported approaches. For example, community paralegals trained in HIV, TB, malaria and human rights can provide disease-specific support and guidance within their communities while referring clients to state-guaranteed legal aid services for issues requiring formal legal representation.		

3.2. Reducing Gender-related Vulnerabilities and Barriers to HIV, TB and Malaria services

People's health is shaped by biological factors, their sex-specific health needs, and by social factors, such as gender inequality and discrimination, which can increase people's risk and vulnerability to HIV, TB and malaria and create barriers to accessing health services. Biological and social factors can intersect to exacerbate vulnerabilities and barriers. This is particularly acute for women and girls, as well as trans and gender diverse communities. Men and boys can also face some gender-related risks and barriers to services. Many people have multiple and intersecting characteristics that exacerbate their health risks and challenges, such as sex, gender identity, age, disability, ethnicity, sexual orientation or key population status.

Biological changes during pregnancy, for example, mean that women and girls have decreased immunity to malaria, increased risk of acquiring HIV it being transmitted to their infants, as well as

[26] https://resources.theglobalfund.org/media/14544/cr_2024-progress-assessment-benin_report_en.pdf
[27] Breaking Down Barriers Progress Assessment (2023): Ghana

increased risk of developing TB. In addition to heightened biological risks, women and girls often face gender-based inequalities and discrimination, such as gender-based violence, lack of financial autonomy and lack of decision-making power over their health, which further compounds their vulnerability to infection and limits their ability to access health services.

To ensure HIV, TB and malaria services are high-quality, easy to access and meet people's needs, they should:

1) **Be gender-responsive,** by considering and responding to people's different sex- and gender-related vulnerabilities and health needs across all HIV, TB and malaria programs. While context-specific, this could include, for example:
    - Making provisions for women and girl's comfort and safety in healthcare settings, for example with spaces and amenities for breastfeeding and menstrual hygiene
    - Implementing measures to ensure privacy, confidentiality and first line support and care, if a woman or girl discloses violence
    - Training and supporting health workers to provide respectful, inclusive care for women and girls, for stigmatized or criminalized populations, and to create trusting environments that encourage men to seek care
    - Providing extended or flexible clinic hours and outreach to accommodate working and caring responsibilities

Gender-responsive services are important to do no harm and to avoid exacerbating existing gender inequalities. For example, without safeguards, HIV testing in antenatal care could lead to increased intimate partner violence for women and girls who test positive; likewise, approaches that are not properly designed for effective male-engagement in antenatal settings could inadvertently reinforce men's control over women's health decisions.

Interventions to increase the gender-responsiveness of health services are integrated across the modular framework and should be considered within both RSSH and disease-specific funding requests. An indicative list of activities and approaches are included in Annex I of this document.

2) Invest in specific **interventions that reduce gender-related vulnerabilities and barriers** to HIV, TB and malaria services

Implementation of interventions to address **gender-related vulnerabilities and barriers to health services** should be prioritized when gender-related disparities in HIV, TB and malaria outcomes are greatest. While context specific, this could include, for example, settings where:

- HIV incidence and intimate partner violence is high.
- Women and girls in key populations face additional barriers to HIV services due to stigma and discrimination, such as trans and gender-diverse people, adolescent girls and young women who engage in transactional sex, or women who use drugs.
- Where gender norms around masculinity exacerbate TB risk factors among men, such as smoking, alcohol use disorders, incarceration and lack of health-seeking behavior.

- High TB burden settings where pregnant or postpartum women and girls face barriers to accessing TB or maternal health services.
- Women and girl's lack of health decision-making power impacts their ability to seek malaria prophylaxis or seek prompt care for themselves or febrile children.
- Gender-related behaviors increase potential exposure to malaria such as gendered occupations, household roles or sleeping arrangements.
- In challenging operating environments, additional attention is needed to address greater risks of gender-based violence or barriers to HIV, TB or malaria services among women and girls who are refugees or internally displaced.

This section provides guidance to applicants on priorities for investments to reduce gender inequalities that increase vulnerability to HIV, TB and malaria and barriers to services.

3.2.1. Transforming Harmful Gender Norms and Reducing Gender Discrimination

Harmful gender norms[28] and gender discrimination can reduce women and girl's decision-making power over their health, restrict their financial autonomy and mobility when seeking health services, and prevent them from negotiating safe sexual relationships. They can exacerbate stigma and discrimination against trans and gender-diverse people and prevent them from accessing health services. They can also affect men – for example through delayed health-seeking behavior, exacerbating risk-taking behaviors, and as a factor in their perpetration of intimate partner violence.

Transforming these gender norms and reducing gender discrimination to improve HIV, TB and malaria outcomes requires long-term planning and investment, and coordinated action with other partners outside of the health sector. It is essential to engage communities in the design, implementation and monitoring of norms change programs to ensure that they are context-relevant and address specific barriers, behaviors and norms in the places where HIV, TB and malaria programs are being implemented.

Where resources are limited, it will be important to prioritize integrating gender norms change approaches into existing health outreach and education programs, where this can be done with quality, long-term planning and community participation in design and implementation.

[28] WHO (2019). Consolidated guideline on sexual and reproductive health and rights of women living with HIV.
WHO (2025). RESPECT women: preventing violence against women, second edition.

Priorities for Global Fund Investments

- **Systematic integration of gender norm-change approaches into services provided at the health facility, within health education initiatives,** or through community-level health outreach activities by trained community health workers or peer outreach workers.
- **Sustained and coordinated multi-level activities to transform harmful gender norms, that increase disease risk and/or restrict access to HIV, TB and malaria services, with community-based, couples-based and behavioral components.** This includes participatory training and skills-building of couples or same-sex groups, couples counseling, and awareness-raising, advocacy and engagement with local leaders to reinforce women and girl's health decision-making power, build healthy relationships and prevent violence.
- **Group or peer education programs and community-wide social marketing campaigns targeting men and boys** to transform rigid notions of masculinity to increase men's health-care utilization, improve treatment adherence, and reduce HIV, TB or malaria risk behaviors.
- **Community or peer-led social empowerment approaches for women and girls and trans and gender-diverse communities**, such as safe space programs that combine peer education, building self-efficacy, and community organizing and advocacy with linkages to HIV, TB, malaria and sexual and reproductive health services, and other social services.
- **Establishing referral networks for social protection, universal health coverage or services** to strengthen the economic independence of highly vulnerable women and girls. This could include, for example, activities to support women and girls to apply for government programs that provide health insurance, nutrition assistance, education support, or other social protection programs, or providing referrals to banking, livelihood, and training opportunities.
- **Participating in multisectoral coordination and collaboration** platforms to address social and structural drivers of gendered health inequalities, such as education, social protection, poverty reduction.
- **Supporting organizations led by women, adolescent girls and trans and gender-diverse people for service delivery, community engagement and advocacy**, including engaging in development and review of national strategies, plans and guidelines and in district, village and facility health and migrant camp health committees/councils.

An enabling legal and policy environment is essential to reinforce gender norm change, reduce discrimination and ensure sustainability over time. Activities to reform gender-discriminatory laws and policies that impact HIV, TB and malaria outcomes, such as laws related to consent for health services, restrictive practices, and property and inheritance, may also be necessary in some contexts. Also see section 3.1.2.

Examples

HIV	TB	Malaria
The Tsima community mobilization intervention in a country in Southern Africa aimed to increase women's and men's engagement in HIV testing, care and treatment by addressing gender norms and other social barriers to services. The intervention was implemented over three years and included workshops, door-to-door outreach, and young women's groups, combined with other activities to engage communities and local leaders. The intervention resulted in more equitable decision making and improved communication among couples, including on HIV testing and treatment, a significant reduction in reported intimate partner violence and contributed towards improved HIV testing uptake, linkage to care and treatment retention.[29] OBJ	An intervention co-designed with men to address gender-related barriers to TB services in peri-urban areas in a country in East Africa combined the provision of male-specific health services and training of health care workers to provide male-friendly care, with health education delivered through health facilities and at the community level. Health education focused on stigma reduction and addressing male risk behaviors, like smoking, alcohol use and cough hygiene, with the objective of increasing demand for TB services.[30]	The Tchova Tchova Stop Malaria community dialogue program in a country in Southern Africa improved malaria health-seeking behavior within households through a community dialogue intervention that encouraged more equitable decision making within households between men and women. As a result of the program, malaria health-seeking behavior and uptake of services improved among women and men.[31]
Integrated		
In a country in West Africa, Husbands' Schools (or Écoles de Maris) partner with a core group of husbands, known as Model Husbands (Maris Modèles), to reinforce their support for reproductive health services such as antenatal care and family planning. These men act as change agents in their homes and communities, encouraging better knowledge, behavior and attitudes towards reproductive health. The intervention has led to improved couple communication around family planning and antenatal care, shifts in power relations within couples and increased women's independence in decision-making and use of health services.[32]		

[29] Leddy AM, Gottert A, Haberland N, Hove J, West RL, Pettifor A, Lippman SA, Kahn K, Mathebula R, Rebombo D, Gómez-Olivé X, Twine R, Peacock D, Pulerwitz J. Shifting gender norms to improve HIV service uptake: Qualitative findings from a large-scale community mobilization intervention in rural South Africa. PLoS One. 2021 Dec 31;16(12):e0260425. doi: 10.1371/journal.pone.0260425. PMID: 34972113; PMCID: PMC871965; Gottert A, Pulerwitz J, Haberland N, Mathebula R, Rebombo D, Spielman K, et al. Gaining traction: Promising shifts in gender norms and intimate partner violence in the context of a community-based HIV prevention trial in South Africa. PLoS One. 2020;15(8):e0237084. doi: 10.1371/journal.pone.0237084

[30] Nidoi J, Pulford J, Wingfield T, Rachael T, Ringwald B, Katagira W, Muttamba W, Nattimba M, Namuli Z, Kirenga B. Finding the missing men with tuberculosis: a participatory approach to identify priority interventions in Uganda. Health Policy Plan. 2025 Jan 11;40(1):1-12. doi: 10.1093/heapol/czae087. PMID: 39215966; PMCID: PMC11724639.

[31] The Global Fund to Fight AIDS, Tuberculosis and Malaria. How to Strengthen Gender Approaches within Malaria Responses: Evidence and Practical Actions to Accelerate Progress Against Malaria. August 2024. Geneva: The Global Fund to Fight AIDS, Tuberculosis and Malaria.

[32] The Global Fund to Fight AIDS, Tuberculosis and Malaria. How to Strengthen Gender Approaches within Malaria Responses: Evidence and Practical Actions to Accelerate Progress Against Malaria. August 2024. Geneva: The Global Fund to Fight AIDS, Tuberculosis and Malaria.

3.2.2. Preventing and Responding to Violence Against Women and Girls in All their Diversity[33]

Sexual violence, intimate partner violence and other forms of gender-based violence, including sexual exploitation, abuse and harassment increases vulnerability to HIV, TB and malaria and worsens HIV, TB and malaria outcomes.[34] For example, women who experience recent physical or sexual intimate partner violence are more likely to acquire a HIV infection, are less likely to be on ART and less likely to be virally suppressed than those who have not. Intimate partner violence is estimated to be responsible for up to one in eight pediatric HIV infections in sub-Saharan Africa.[35]

Where resources are limited, priority should be given to strengthening health sector responses to intimate partner violence and providing immediate support for survivors.. At a minimum, intimate partner violence identification, first line support and care, and post rape care should be integrated into HIV prevention, testing, treatment and care services in line with the HIV program essentials [link].

In all cases, interventions included in funding requests to prevent and respond to gender-based violence should always be part of a coordinated, multisectoral approach to ensure scarce resources are being deployed where they are most needed. Parallel or standalone programs should be avoided.

Violence against women and girls increases in emergencies, during conflicts and in the aftermath of climate-related and other disasters due to the combination of stress, disruption of protective social networks, decreased access to services and increased economic deprivation. As such, gender-based violence prevention and response may need to be prioritized in challenging operating environments.

Priorities for Global Fund investments

- **Strengthening health sector responses to gender-based violence and supporting survivors** by increasing the availability and accessibility of post-rape and intimate partner

[33] The phrase women and girls in all their diversity recognizes that women and girls are not a homogenous group but are a varied population with diverse experiences shaped by factors like gender identity, ethnicity, race, socioeconomic status, age, religion, ability, and sexual orientation.
[34] García-Moreno, C. et al. Global and regional estimates of violence against women: Prevalence and health effects of intimate partner violence and non-partner sexual violence. 2013. Geneva: World Health Organization; World Health Organziation. World Malaria Report 2024. Geneva: World Health Organization; Paul, P., Mondal, D. Investigating the relationship between women's experience of intimate partner violence and utilization of maternal healthcare services in India. Sci Rep11, 11172 (2021). https://doi.org/10.1038/s41598-021-89688-1; Tura, H. & Licoze, A. Women's experience of intimate partner violence and uptake of Antenatal Care in Sofala, Mozambique. PLoS ONE 14, e0217407 (2019); Kuchukhidze S, Walters MK, Panagiotoglou D, Boily MC, Diabaté S, Russell WA, Stöckl H, Sardinha L, Mbofana F, Wanyenze RK, Imai-Eaton JW, Maheu-Giroux M. The contribution of intimate partner violence to vertical HIV transmission: a modelling analysis of 46 African countries. Lancet HIV. 2024 Aug;11(8):e542-e551. doi: 10.1016/S2352-3018(24)00148-6. Epub 2024 Jul 23. PMID: 39059403; PMCID: PMC12465746; Leddy, A.M., Weiss, E., Yam, E. et al. Gender-based violence and engagement in biomedical HIV prevention, care and treatment: a scoping review. BMC Public Health 19, 897 (2019). https://doi.org/10.1186/s12889-019-7192-4
[35] Kuchukhidze S, Walters MK, Panagiotoglou D, Boily MC, Diabaté S, Russell WA, Stöckl H, Sardinha L, Mbofana F, Wanyenze RK, Imai-Eaton JW, Maheu-Giroux M. The contribution of intimate partner violence to vertical HIV transmission: a modelling analysis of 46 African countries. Lancet HIV. 2024 Aug;11(8):e542-e551. doi: 10.1016/S2352-3018(24)00148-6. Epub 2024 Jul 23. PMID: 39059403; PMCID: PMC12465746; Leddy, A.M., Weiss, E., Yam, E. et al. Gender-based violence and engagement in biomedical HIV prevention, care and treatment: a scoping review. BMC Public Health 19, 897 (2019). https://doi.org/10.1186/s12889-019-7192-4

violence clinical care and medical management in line with WHO Clinical Guidelines;[36] facilitating immediate support for survivors of violence, sexual exploitation and abuse, including case management, psychosocial support, legal services and safe spaces, such as shelters; developing and implementing policies and protocols; training and supporting health workers, community health workers and peer outreach workers to identify and provide first-line support and referrals to survivors of violence (for example, the WHO LIVES Protocol);[37] and establishing referral networks for longer-term care and support. To the extent possible, identification and clinical care should be integrated into existing health services rather than established as standalone services.

- **Awareness raising and sensitization** in communities about violence against women and girls. Priority interventions include integrating gender-based violence awareness and sensitization interventions into **existing health outreach** implemented by community health workers, peers and community-led and community-based organizations, and **training for law enforcement and other duty bearers** on survivor-centered, gender-based violence prevention and response.
- **Violence prevention interventions**, such as those identified in the RESPECT framework,[38] should be implemented in contexts where there is significant overlap between vulnerabilities to HIV, TB and malaria and gender-based violence. While context specific, this could be, for example where HIV incidence among adolescent girls and young women is high, or where gender-based violence is a barrier to accessing HIV, TB, malaria or maternal health services. Violence prevention interventions should be linked to a broader multisectoral gender-based violence strategy.

Interventions that are critical for preventing and addressing gender-based violence, such as advocacy, legal and policy reform, and services to ensure access to justice for survivors should also be considered as part of a comprehensive response to gender-based violence in the context of HIV, TB and malaria. Also see section 3.1.2.

[36] World Health Organization. Responding to intimate partner violence and sexual violence against women: WHO Clinical and Policy Guidelines. 2013. Geneva: World Health Organization.
[37] World Health Organization. Caring for women subjected to violence: A WHO curriculum for training health-care providers. 2021. Geneva: World Health Organization. Available at https://www.who.int/publications/i/item/9789240039803.
[38] World Health Organization, UN Women, UNFPA, UNDP. RESPECT Women: Preventing Violence against Women. 2019. Geneva: WHO.

Examples

HIV	TB	Malaria
In a country in Southern Africa, the roll out of pre-exposure prophylaxis (PrEP) has been used to strengthen health sector responses to gender-based violence by: including training for PrEP service providers on identifying and providing first-line support to survivors; integrating gender-based violence screening into national guidelines; referencing gender-based violence in PrEP standard operating procedures and job aids; and integrating gender-based violence into monitoring and evaluation systems, including PrEP indicators and clinical data collection and reporting tools.[39]	When a TB gender assessment[40] in a country in Central Asia showed that women with TB face physical and emotional violence because of the disease, civil society organizations trained hundreds of village health committee members, health workers, teachers and religious leaders in detecting and addressing the need for psychosocial services for women with TB.[41] The intervention was designed to increase the identification of women with TB affected by violence, facilitate their access to response services, and increase TB treatment adherence.	An intervention to train malaria program implementers on gender-based violence response in a country in West Africa helped to close knowledge gaps on how gender-based violence affects health-seeking behavior, increased the capacity of health workers to identify, care for and support women experiencing violence, and led to increases in women seeking both gender-based violence care and malaria prevention services.[42]
Integrated		
The **Bandebereho** program in a country in East Africa uses fatherhood as an entry point to engage men, alongside their partners, in 17 sessions designed to prevent violence against women and children, support reproductive, maternal and child health, promote men's caregiving and build healthy couple and family relations. The program is reaching scale by training community health workers to deliver the program in their routine work. With more than 40,000 parents trained since 2020, the program has demonstrated long-term and sustainable reductions in gender-based violence. A supportive policy environment, government buy-in and leadership, and the sustainable pathway for scale through the community health worker program have been key drivers of success.[43]		

[39] Chileshi Bwalya, Florence Mulenga, Mercy Luwi Katoka, Mwiya Mutandi, Featherstone Mangunji, Edward Oladele, Morgan Garcia, and Giuliana Moralies. Leveraging pre-exposure prophylaxis (PrEP) product roll out to improve gender-based violence response in Zambia. 2024. Available at: https://www.svriforum2024.org/wp-content/uploads/2024/11/Mercy-Katoka.pdf

[40] Samanta Sokolowski. Gender Assessment in Kyrgyzstan. 2016. Geneva: Stop TB Partnership.

[41] The Global Fund to Fight AIDS, Tuberculosis and Malaria. Removing Human Rights-related Barriers to TB Services. 2023. Available at: https://resources.theglobalfund.org/media/14341/cr_removing-barriers-to-tb-services_technical-briefing-note_en.pdf.

[42] Management Sciences for Health. Tackling Gender-based Violence Against Women and Girls is Key to Achieving Universal Health Coverage. Dec. 5, 2022. Available at: https://msh.org/story/tackling-gender-based-violence-gbv-against-women-and-girls-is-key-to-achieving-universal-health-coverage/; Management Sciences for Health. PMI-S Gender Rapid Assessment, Strategy Development and Implementation, available at:

[43] Doyle K, Levtov RG, Karamage E, Rakshit D, Kazimbaya S, Sayinzoga F, Sibomana H, Ngayaboshya S, Rutayisire F, Barker G. Long-term impacts of the Bandebereho programme on violence against women and children, maternal health-seeking, and couple relations in Rwanda: a six-year follow-up of a randomised controlled trial. EClinicalMedicine. 2023 Sep 26;64:102233. doi: 10.1016/j.eclinm.2023.102233. PMID: 37781160; PMCID: PMC10539919.

Resources

Equity, Gender and Human Rights Assessment Tools

- Roll Back Malaria. Malaria Matchbox Toolkit.
- UNAIDS. Framework and Toolkit for understanding and addressing HIV-related inequalities.
- WHO. Innov8 Approach Technical Handbook and Facilitator's Manual for reviewing national health programmes to leave no one behind
- The Global Fund. Undertaking a Rapid Assessment of Information on Human Rights-related Barriers to HIV and TB Services: Guidance and Tools.
- UNAIDS. Gender Assessment Tool.
- Stop TB and UNAIDS. Gender Assessment Tool for National HIV and TB Responses.
- **Stop TB. TB CRG Assessment Tool**
- **Stop TB.** TB CRG Costed Action Planning Tool
- **Stop TB.** TB Stigma Assessment Tool

Global Fund Technical Briefs

- Gender Equality Technical Brief
- Removing Human Rights-related Barriers to HIV Services Technical Brief
- Equity, Human Rights, Gender Equality and Malaria Technical Brief
- Removing Human Rights-related Barriers to TB Services Technical Brief
- How to Strengthen Gender Approaches within the Malaria Response: Evidence and Practical Actions. to Accelerate Progress Against Malaria.
- Undertaking a Rapid Assessment of Information on Human Rights-related Barriers to HIV and TB Services

Technical Guidance and Tools

- Stop TB Partnership (2020). Gender and TB: Investment Package.
- CSIH-WCA & FHI 360 (2022) Security Toolkit: Protecting implementers and improving programme outcomes (updated version available soon)
- WHO (2013). Responding to intimate partner violence and sexual violence against women: WHO clinical and policy guidelines.
- WHO (2025). RESPECT women: preventing violence against women, second edition.
- WHO (2021). Caring for women subjected to violence: A WHO curriculum for training health-care providers.
- WHO (2025). Clinical management of rape and intimate partner violence in emergencies: a training curriculum for health workers.

- WHO (2019). Consolidated guideline on sexual and reproductive health and rights of women living with HIV.
- WHO (2022). Consolidated guidelines on HIV, viral hepatitis and HIV prevention, diagnosis, treatment and care for key populations.
- WHO (2023). Men and HIV: Evidence-based approaches and interventions.

Annex I: Considerations for Gender-Responsive approaches within the Modular Framework *(illustrative examples – not exhaustive)*

Module	Interventions	Considerations for gender-responsive approach
Health Sector Governance and Integrated People-centered Services	Planning, management, and delivery of integrated people centered services	• Where relevant, do HIV, TB and malaria interventions collaborate with sexual, reproductive, maternal, newborn and child health programs? For example, - Integration of TB screening/referrals/TPT in ANC and PNC services in high-burden TB settings - Integration of malaria prevention education/ITN distribution/IPTp in ANC services • Are governance, management and quality-improvement processes inclusive of women-led, youth-led and key population-led organizations, with mechanisms for them to hold providers accountable for gender-responsive services?
Community Systems Strengthening	Community-led monitoring and advocacy	• Do relevant interventions that include community-led involvement include women-led networks and organizations? • Do the activities include explicit support for women-led community networks, address gender-related discrimination and norms, and support the priorities of the networks (rather than using communities to carry out activities determined by others)?
	Community coordination and engagement in decision making	• Are there specific strategies to support the meaningful engagement and participation of women, adolescent girls, trans and gender-diverse communities in decision-making fora and processes, recognizing unequal power dynamics and historical underrepresentation?
RSSH/PP: Community health workers	RSSH/PP: Community health workers: selection, pre-service training, certification and equipping	• Do CHW selection processes intentionally include women - especially those from key and underserved populations - and address barriers that limit their participation and professionalization (for example, literacy requirements, childcare, safety, remuneration)? • Does pre-service training include competencies on respectful care, GBV, stigma reduction and rights-based approaches, including to identify and address gender and human rights-related barriers in communities, including harmful norms, unequal decision-making power, and risks of violence?
	RSSH/PP: Community health workers: Integrated supportive supervision	• Do in-service supervision and mentoring systems include reflection and continuous skills building on providing rights-based, gender-responsive respectful care?

Module	Interventions	Considerations for gender-responsive approach
HIV prevention	Condom and lubricant programing	• Does communication and demand creation for condom and lubricant use reinforce the importance of consensual sex, and support women and girls' ability to negotiate condom use? • Is communication and demand creation messaging tailored to consider sex, gender identity, sexual orientation, age, and key population status?
	Pre-exposure prophylaxis (PrEP) a nd post-exposure prophylaxis (PEP) pr ograming	• Are provider training, community engagement and service protocols designed to strengthen women's choice, informed consent and privacy? • Is PrEP/PEP counselling and follow-up adapted to gendered barriers such as partner opposition, fear of blame, safety concerns, financial dependence? • Do services link or signpost to family planning, SRH, GBV, mental health and social protection support?
	HIV prevention communication, infor mation and demand creation	• Does health communication and promotion around safer sex reinforce the importance of consent, healthy relationships and preventing intimate partner violence? • Are the particular needs of women and girls who are part of key populations considered (e.g., female sex workers, women who use drugs)? • Are people put in single boxes (e.g. 'sex worker') or are overlapping and intersectional identities recognized (e.g. sex worker who is living with HIV and pregnant; woman living with HIV who uses drugs who has children)?
	Sexual and reproductive health services, including STIs, hepatitis, post-violence care	• Do policies, protocols and service provision center the importance of choice, informed consent and privacy for all women and girls? • Do activities support holistic sexual and reproductive health needs, so that women key populations, AGYW and survivors of GBV can receive comprehensive, survivor-centered care?
	Sexual health education for AGYW and adolescent boys and young men (ABYM)	• Are curricula, materials and delivery approaches co-designed with AGYW and ABYM, and adapted to their different needs, realities and literacy levels? • Do programs create safe, inclusive spaces where AGYW and ABYM can question harmful masculinities, learn skills for healthy, equitable relationships and link to youth-friendly SRH, HIV and GBV services?
	Social protection for AGYW in high HIV incidence settings	• Do social protection eligibility criteria and enrolment processes consider gendered barriers such as lack of ID documents, unpaid care responsibilities, stigma, and risk of violence? • Are social protection interventions linked with HIV, SRHR and GBV services, education and livelihood opportunities?

Module	Interventions	Considerations for gender-responsive approach
Elimination of Vertical Transmission of HIV, Syphilis and Hepatitis B	Retention support for pregnant and breastfeeding women (facility and community)	• Is attention given to the mental and physical health and support needs of pregnant and breastfeeding women and AGYW, including peer support needs? • Do approaches include mentor mother and other psychosocial support that is tailored to the different priorities of pregnant adolescent girls and young women, women who use drugs and sex workers? • Are first line support services and referral pathways available for women who disclose violence?
Differentiated HIV Testing Services	Testing for key population (KP) programs Testing for high-risk adolescent girls and young women (AGYW) and their male sexual partners programs in settings with moderate and high HIV incidence	• Do testing policies and programs include provision for securing informed voluntary consent? • Can women and adolescent girls be tested without parental and partner consent? • Is testing linked to support services that are non-discriminatory for women and girls and people from key populations, such as peer support, GBV services, SRH, and mental health services?
Treatment, Care and Support	HIV treatment and differentiated service delivery – adults (15 and above) HIV treatment and differentiated service delivery - children (under 15)	• Are there specific actions relating to treatment and support for women living with HIV in all their diversities and throughout the life course, including as they age? For example, do treatment, care and support interventions address specific needs of sex workers, women who use drugs, trans women, AGYW, rural women, urban women? • Do treatment approaches consider how masculinities, stigma and norms around strength, risk-taking and breadwinner roles shape men's willingness to seek care, disclose status, or remain on treatment? • Are services tailored to men's schedules, mobility, and privacy concerns (e.g., workplace delivery, after-hours services, community pick-up points, peer groups for men), and do they include communication that supports positive, health-seeking masculinities?
TB Diagnosis, Treatment and Care	TB screening and diagnosis	• Do approaches recognize nuances in gender dynamics of TB in the local context – for example that overall rates of TB are higher in men than in women; that adolescent girls tend to be more susceptible to TB than adolescent boys; and extrapulmonary TB is more common in women than men and more difficult to diagnose? • Do case finding approaches recognize and adapt to how men's care-seeking may be delayed by masculinities, fear of appearing "weak," work obligations, and norms around risk-taking (e.g., workplace outreach, after-hours services, mobile or community-based screening)?

Module	Interventions	Considerations for gender-responsive approach
		• Are communication, counselling and provider interactions tailored to men's needs and preferences - promoting positive and health-seeking masculinities, and encouraging timely testing and disclosure without judgment or blame?
	TB treatment, care and support	• Do approaches respectfully listen to and support women who have concerns about drug safety during pregnancy and breastfeeding, and provide clear, evidence-based, non-judgmental counselling and information to support them through treatment?
Collaboration with Other Providers and Sectors	Linkage to social protection for KVP affected by TB	• Are information, enrolment and grievance mechanisms accessible and safe for women, AGYW and gender-diverse KVP (for example, confidential, stigma-free, available at flexible times, and not dependent on a male partner or family member)?
	Collaboration with other programs/sectors	• Do programs link or signpost to maternal health, sexual and reproductive health, and GBV services for pregnant women and AGYW affected by TB?
Key and Vulnerable Populations (KVP) – TB/DR-TB	KVP - Children and adolescents	• Do diagnosis and treatment approaches for children recognize the important role of women in managing their care, and support women's ability and autonomy to make these decisions? • Do approaches consider the specific barriers adolescent girls face, including gendered stigma, fear violence, or restrictions on independent health-seeking? • Are communication, counselling and adherence support tailored to adolescent girls' needs (for example confidentiality, digital and peer support, youth-friendly spaces and flexible service hours)?
	KVP - others	• Are pregnant and postpartum women screened and managed for TB in ways that respect autonomy, confidentiality and informed consent? • Is treatment, adherence and follow-up support adapted to pregnant and postpartum women's needs?
Malaria: Vector Control	Insecticide treated nets (ITNs) - mass campaign: universal	• Are women's, youth and women-led community organizations meaningfully engaged in planning, delivering and monitoring ITN distribution? • Do ITN distribution strategies proactively reach pregnant adolescents and marginalized pregnant women (for example, unmarried women, migrants, women with disabilities, women living with HIV or in humanitarian and climate-affected settings)?
	Insecticide treated nets (ITNs) - continuous distribution: ANC	• Do approaches to improve ANC attendance and uptake support efforts to end mistreatment and achieve respectful maternal and newborn care?

Module	Interventions	Considerations for gender-responsive approach
		• Do counselling and communication approaches support women's decision-making power over ITN use in the household and strengthen their ability to negotiate sleeping arrangements with partners and family members? • Does messaging around ITN consider and respond to gendered dynamics of whether and how ITNs are used by both men/boys and women/girls?
Malaria: case management	Social and behavior change (SBC)	• Are messages, channels and community engagement tailored for different groups (women, men, boys, girls, pregnant women, caregivers, underserved populations), including those living in remote, informal or climate-affected settings? • Do SBC activities consider gendered barriers to prompt care-seeking for women (both for themselves and on behalf of their children), such as women needing permission or money for transport or permission to access care, or men delaying care due to norms around "strength" or breadwinner roles?
	Integrated community case management (iCCM)	• Do case management approaches for children recognize the important role of women in prompt care-seeking when children are sick, and support women's ability and autonomy to make health decisions for themselves and their children? • Do strategies intentionally engage fathers and male caregivers to promote shared responsibility for child health, challenge norms that place caregiving solely on women, and address male decision-making roles that can delay timely care?
Malaria: Specific Prevention Initiatives (SPI)	Intermittent preventive treatment (IPT) - in pregnancy	• Do IPTp approaches respectfully listen to and support women who have concerns about drug safety during pregnancy and breastfeeding, and provide clear, evidence-based, non-judgmental counselling and information to support them through treatment? • Are male partners and other key influencers engaged in ways that support, rather than control, women's uptake of IPTp and related ANC/PNC services, and in ways that promote shared responsibility for malaria prevention in pregnancy?

Annex II: Gender Equality Marker

What is the Gender Equality Marker (GEM)?

- The GEM is a tool used by the Global Fund and many other organizations to assess the extent to which gender equality fundamentals are considered and addressed within Funding Requests.

How does it work?

- During their review of a Funding Request, the Technical Review Panel (TRP) undertakes a GEM assessment covering each component in the Funding Request.
- In addition to the GEM, the TRP also reviews whether the Funding REquest is technically sound, strategically focused on delivering impact and poised for sustainability in relation to gender equality.
- The Global Fund's GEM is based on the OECD-DAC GEM, which is a three-point scoring system that identifies whether gender equality is:

  0: Not targeted within the funding request
  1: A significant focus of the funding request
  2: A principal focus of the funding request

What is assessed?

- Whether integrated equity, human rights and gender assessments are attached to the Funding Request
- Whether the integrated assessment is of good quality and the findings have been used to inform the Funding Request
- Whether and to what extent the Funding Request includes interventions or activities that remove gender-related barriers to HIV, TB or malaria services, or reduce gender-related vulnerabilities to the diseases
- Whether and to what extent data and indicators are disaggregated by sex and/or gender (for example, to the minimum extent required through the Modular Framework; to track interventions focusing on female, trans and gender-diverse key populations; or for all indicators where sex and/or gender-related data could help to identify inequities, barriers, and strengthen program delivery)
- Whether there is a commitment to routinely collect and analyze sex and/or gender-disaggregated data to inform program design, adaptation and understanding of performance

What is it used for?

- GEM results are used by the Global Fund Secretariat to assess progress relating to gender integration within Global Fund grants.
- The results are communicated to applicants and provide an opportunity to strengthen gender equality considerations to maximize impact against HIV, TB and malaria.
- GEM results do not affect whether a funding request is recommended for grant-making.

What do applicants need to do?

- No action is required from applicants. The GEM assessment is undertaken based on the documents submitted as part of the Funding Request.