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# STRENGTHENING GENDER PROGRAMMING IN PEPFAR: TECHNICAL EXCHANGE OF BEST PRACTICES, PROGRAM MODELS, AND RESOURCES

REPORT ON A TECHNICAL EXCHANGE IN  
JOHANNESBURG, SOUTH AFRICA, OCTOBER 28 TO 30,  
2009, CONVENED BY THE PEPFAR GENDER  
TECHNICAL WORKING GROUP

**AIDSTAR-One**  
AIDS SUPPORT AND TECHNICAL ASSISTANCE RESOURCES

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## **AIDS Support and Technical Assistance Resources Project**

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### **AIDSTAR-One**

John Snow, Inc.  
1616 Fort Myer Drive, 11th Floor  
Arlington, VA 22209 USA  
Phone: 703-528-7474  
Fax: 703-528-7480  
E-mail: [info@aidstar-one.com](mailto:info@aidstar-one.com)  
Internet: [aidstar-one.com](http://aidstar-one.com)

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# ACRONYMS

ANC	antenatal care
CDC	Centers for Disease Control and Prevention
CEDOVIP	Center for Domestic Violence Prevention
COP	country operational plan
DHS	Demographic and Health Surveys
DMSC	Durbar Mahila Samanwaya Committee
GBV	gender-based violence
GEM	Gender Equitable Men
GFATM	Global Fund to Fight AIDS, Tuberculosis and Malaria
GTWG	Gender Technical Working Group
HPV	human papilloma virus
HTC	HIV testing and counseling
ICRW	International Center for Research on Women
IMAGE	Intervention with Microfinance for AIDS and Gender Equity
IPV	intimate partner violence
M&E	monitoring and evaluation
MARP	most-at-risk population
MC	male circumcision
MSM	men who have sex with men
NACC	National AIDS Control Committee
NGO	nongovernmental organization
PEP	post-exposure prophylaxis
PEPFAR	U.S. President's Emergency Plan for AIDS Relief
PMTCT	prevention of mother-to-child transmission
PWID	people who inject drugs
SA	South Africa
SEF	Small Enterprise Foundation
STI	sexually transmitted infection
SW	sex worker

SWOT	strengths, weaknesses, opportunities, and threats
TG	transgender
UNAIDS	Joint U.N. Programme on HIV/AIDS
USAID	U.S. Agency for International Development
USG	U.S. Government
VGI	Vulnerable Girls' Initiative
WHO	World Health Organization

# EXECUTIVE SUMMARY

Gender norms, roles, and inequities are at the heart of the objectives and challenges of HIV prevention, treatment, and care and support programs. Without addressing the way that gender influences access to resources, information, individual agency, and social norms, efforts to curb the epidemic will remain constrained. The new U.S. President's Emergency Plan for AIDS Relief (PEPFAR) reauthorization bill (HR5501) is even more explicit than the original PEPFAR legislation in its call to address gender issues. "Gender issues are critical components in the effort to prevent HIV/AIDS and to care for those affected by the disease...The President shall establish a comprehensive, integrated, 5-year strategy to expand and improve efforts to combat global HIV/AIDS. This strategy shall...support partner country and community efforts to identify and address social, economic, or cultural factors...which directly contribute to the transmission [and] missions [should] integrate a gender perspective across prevention, care, and treatment programs."<sup>1</sup>

PEPFAR works to integrate gender across all program areas with a focus on the following five cross-cutting, gender strategic areas:

- Increasing gender equity into HIV programs and services
- Reducing violence and coercion
- Addressing male norms and behaviors
- Increasing women's legal rights and protection
- Increasing women's access to income and productive resources.

There are many innovative U.S. Government (USG) programs integrating one or more of these gender strategies into their work, but the evidence base on how best to integrate gender into HIV programs remains inadequate. Gender strategies are also included in far too few programs and are of insufficient scope, scale, and intensity.

To support the expansion of gender integration into USG programs, the PEPFAR Gender Technical Working Group (GTWG), in collaboration with AIDSTAR-One, convened a technical exchange from October 28 to 30, 2009, entitled "Strengthening Gender Programming in PEPFAR: Technical Exchange of Best Practices, Program Models, and Resources." The exchange took place in Johannesburg, South Africa, where local organizations have demonstrated their capacity and innovation in integrating gender into their HIV programs.

The purpose of this report is to share with a wider audience of PEPFAR field representatives and implementing partners the current directions and priorities of PEPFAR related to gender integration and to share new findings and analysis from select gender-focused programs and reports.

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<sup>1</sup> U.S. Congress. *Tom Lantos and Henry J. Hyde United States Global Leadership Against HIV/AIDS, Tuberculosis, and Malaria Reauthorization Act of 2008*. 110th Congress, 2nd session, 2008. Available at [www.gpo.gov/fdsys/pkg/BILLS-110hr5501enr/pdf/BILLS-110hr5501enr.pdf](http://www.gpo.gov/fdsys/pkg/BILLS-110hr5501enr/pdf/BILLS-110hr5501enr.pdf) (accessed November 2009)

Participants at the meeting included 37 gender focal points and technical advisors from 16 PEPFAR-supported countries<sup>2</sup> in Africa, Asia, and Latin America; staff from the U.S. Agency for International Development (USAID)/South Africa office, members of the GTWG from USAID/Washington, the Centers for Disease Control and Prevention/Atlanta, the Department of Health and Human Services, the Department of Defense, and the Office of the U.S. Global AIDS Coordinator; and staff from AIDSTAR-One.

The objectives of the meeting were to:

- Create a shared understanding of PEPFAR’s framework for gender for the next five years, including:
  - Partnership frameworks
  - Programming in support of the five cross-cutting gender strategies
  - Integration of gender within other PEPFAR program areas.
- Exchange good and promising programmatic practices in gender programming, including:
  - Those featured in the PEPFAR GTWG-supported AIDSTAR-One compendium of successful programs that implement multiple PEPFAR gender strategies
  - Innovative programs identified by country teams and the PEPFAR GTWG.
- Introduce gender strategic planning and program monitoring tools to assist with longer-term planning, preparation of the fiscal year 2010 country operational plan, and management of the gender program portfolio.
- Identify program and evidence gaps to inform partnership frameworks, program evaluation, and technical assistance priorities.

Invited experts made presentations on current experience and evidence analyzing, integrating, and evaluating gender-related programs. Participants took part in site visits to local programs with demonstrated success in integrating gender into their activities. Finally, facilitated breakout and small-group sessions generated inspiration and practical strategies for participants to use in their own programs.

The following is a brief summary of key themes that emerged from the meeting.

**Gender as a cross-cutting issue and an approach that is integral to program sustainability.**

The number of PEPFAR-funded programs integrating gender strategies has steadily increased over the last five years. However, many programs are small scale and lack rigorous monitoring and evaluation data that demonstrate impact on HIV risk behaviors, incidence, or mitigation. PEPFAR legislation language recognizes the importance of gender and requires that programs strengthen gender programming and requirements to set specific targets and strategies to address needs of vulnerable women and girls and address the underlying social and economic vulnerabilities of women and men in accessing services. But the evidence base for which strategies work best in specific social context is still limited, as are data that inform the cost-effectiveness of integrating gender into HIV prevention, treatment, and care and support programs.

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<sup>2</sup> The 16 PEPFAR-supported countries in attendance included Angola, Botswana, Côte d'Ivoire, Democratic Republic of the Congo, Guyana, India, Kenya, Lesotho, Mozambique, Namibia, South Africa, Swaziland, Tanzania, Uganda, Vietnam, and Zambia.

**Disaggregating data by sex is an essential step, but data should be more thoroughly analyzed to inform programming.** Women and men are differentially affected by HIV, and prevalence of HIV varies by age, wealth, and education. In order to understand the extent and severity of the HIV epidemic, which varies greatly both within and across countries, programs need to go beyond sex disaggregated data in order to “know your epidemic” and to understand who is affected and where intervention is needed.

**Integrating gender into program design, implementation, and monitoring can accomplish short-term outcomes, but making an impact on HIV incidence requires long-term support for gender awareness and transformative programs.** There are many innovative and promising programs working to change gender and social norms. Some models and interventions show that we can make some changes in a shorter amount of time. In order to address the challenges faced by programs working at the individual, family, community, and structural levels, and have an effect on sustained changes in social norms and gender equity, long-term funding and support is required.

**Community involvement, from initial planning through program implementation and monitoring, is essential, as are efforts to build local capacity to think critically about and change gender norms.** Programs should tap into communities’ understanding and perceptions of gender and gender equity and support long-term efforts for communities to accept, adapt, and embrace the benefits of gender equity and understand the costs—to men and women, boys and girls—of gender inequity. Programs should work not only with women and girls but with men and boys, parents and in-laws, religious and traditional leaders—the whole range of actors who uphold and influence social norms within a specific social context. It is important to think about the relationship between poverty, wealth, and HIV and the types of prevention interventions that need to be delivered in tandem with economic empowerment programs. As more women move successfully out of poverty, we need to think about what this means for HIV prevention. Programs can work with communities to think about different scenarios and develop innovative ways for the community to address these issues.

**Several countries have made significant progress in expanding access to services for most-at-risk populations (MARPs), but few programs integrate gender strategies into their activities.** Programs are not addressing how male and female gender norms influence risk behavior and the dynamics in relationships between and among men and women. Programs for people who inject drugs (PWID) are typically designed with male clients in mind without consideration of unique needs and barriers faced by females who inject drugs. In addition, programs do not recognize that individuals at high risk often have long-term intimate partners and as a result do not reach out to those partners. The most successful prevention programs for sex workers (SWs) focus not only on HIV education and condom distribution but also work to address the systemic vulnerabilities of SWs by negotiating with stakeholders and gatekeepers of the sex trade and mobilizing the community to support SWs’ basic needs. MARPs are still unrepresented on country coordinating mechanisms and in the design, implementation, and monitoring of programs meant for MARPs; new strategies are needed to ensure the greater involvement of MARPs in policies and programs affecting them.

**Partnership frameworks provide new opportunities for collaboration on gender.** Working with governments to foster an enabling environment to address gender inequality is critically

important. The Partnership Framework<sup>3</sup> and Partnership Framework Implementation Plan offers a new process through which to move gender work to the center of PEPFAR programming.

**PEPFAR is committed to ensuring appropriate levels of experience and expertise on country teams.** Developing this expertise includes capacity building of gender focal points to move country programs toward gender equity and transformation, to build in monitoring and evaluation plans, and to track budget allocations for gender-related activities.

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<sup>3</sup> Partnership Frameworks provide a five-year joint strategic framework for cooperation between the U.S. Government, the partner government, and other partners to combat HIV in the host country through service delivery, policy reform, and coordinated financial commitments.

# INTRODUCTION

Legislation for the first phase of the U.S. President's Emergency Plan for AIDS Relief (PEPFAR), launched in 2003, emphasized the importance of gender in addressing the proximal determinants of HIV risk behavior and access to treatment, care, and support services and programs. The second phase of PEPFAR elevates gender's priority, underscores the technical approach adopted under the first phase of PEPFAR, and outlines concrete gender planning, implementation, and reporting requirements. Achievement of the ambitious gender goals outlined in reauthorization legislation will require more systematic and strategic gender programming, more rigorous monitoring and evaluation (M&E), and enhanced technical and management capacity.

In service of these goals, the PEPFAR Gender Technical Working Group (GTWG) and AIDSTAR-One convened a meeting in Johannesburg, South Africa (SA), from October 28 to 30, 2009. The meeting brought together gender focal points and technical advisors from the field to review the PEPFAR gender programming framework, share program evidence and practical program experiences, and strengthen participants' skills to design and manage more strategic and evidence-based gender programs. Bringing colleagues together from the field along with technical experts from headquarters and other implementing agencies fostered increased south-to-south exchange of information and ideas, and built capacity of field staff to lead efforts for gender integration. The meeting addressed the longer-term planning horizon as well as shorter-term steps that country teams could take to facilitate fiscal year 2010 country operational plan (COP) preparations. Gender field representatives and PEPFAR coordinators in-country provided input into priority technical areas that informed the meeting content and agenda. The purpose of this report is to share with a wider audience of PEPFAR field representatives and implementing partners the current directions and priorities of PEPFAR related to gender integration and to share new findings and analysis from select gender-focused programs.

The objectives of the meeting were to:

- Create a shared understanding of PEPFAR's framework for gender for the next five years, including the following:
  - Partnership frameworks
  - Programming in support of the five cross-cutting gender strategies
  - Integration of gender within other PEPFAR program areas.
- Introduce gender strategic planning and program M&E tools to assist with longer-term planning, preparation of the fiscal year 2010 COP, and management of the gender program portfolio.
- Identify program and evidence gaps to inform partnership frameworks, program evaluation, and technical assistance priorities.
- Enable U.S. Government (USG) staff working on gender to better understand their role as gender focal persons and share experiences and lessons learned from other countries.

The three-day meeting benefited from the active participation of USG headquarters and field gender focal points and technical advisors, and representatives from implementing organizations in Africa, Asia, and Latin America. Thirty-seven participants from 16 PEPFAR-supported countries, PEPFAR GTWG members, and staff from the PEPFAR/SA office attended the meeting. The meeting agenda can be found in Appendix 1. The participant list can be found in Appendix 2.

In the sections that follow, each presentation is summarized in the order in which it was given during the three-day meeting. All emphases are in original presentation text.

# OVERVIEW OF THE PEPFAR GENDER FRAMEWORK

## PEPFAR AND GENDER

*Diana Prieto, Senior Gender Advisor at the U.S. Agency for International Development (USAID) Office of HIV/AIDS and co-chair of the GTWG, gave the introductory remarks on behalf of GTWG, noting that this was the first-ever meeting between headquarters and field staff on gender programming. She provided an overview of the PEPFAR gender framework and emphasized the overarching goals of the framework to address gender as a cross-cutting issue and as an approach that is integral to thinking about policy and program sustainability.*

Prieto began by sharing a message from Ambassador Eric Goosby, U.S. Global AIDS Coordinator. Ambassador Goosby declared his commitment to the work of integrating gender in HIV programs and emphasized PEPFAR's and the administration's focus on gender issues as critical to the fight against HIV. The legislative language authorizing PEPFAR recognizes the importance of gender. It requires that programs strengthen gender programming, sets specific targets, and address the needs of vulnerable women and girls, as well as address the underlying social and economic vulnerabilities of women and men as they apply to accessing services.

Prieto reviewed the definition of *gender* as the economic, social, and political attributes, constraints, and opportunities associated with being male or female. Social definitions of what it means to be a man or a woman vary among cultures, within cultures (by ethnic group, religion, and region), and by age. Gender is a relational concept, referring to the dynamics between and among men/boys and women/girls and with institutions. These dynamics also include issue of power in relationships. Gender affects women's/girls' and men's/boys' vulnerability to HIV and ability to mitigate the impact of the disease. The overarching goals of the PEPFAR gender framework are to:

- Facilitate achievement of program goals for treatment, prevention, and care
- Guarantee women's/girls' and men's/boys' equitable access to programs
- Strengthen program quality and sustainability
- Prevent or ameliorate program outcomes that may unintentionally and differentially harm women/girls and men/boys.

PEPFAR works to integrate gender across all program areas with a focus on five cross-cutting, gender strategic areas, which were articulated in PEPFAR authorizing legislation: 1) increasing gender equity in HIV activities and services; 2) addressing male norms and behaviors; 3) reducing violence and coercion; 4) increasing women's access to income and productive resources; and 5) increasing women's legal rights and protection.

Planners and managers must understand the local context and dynamics that exist between men and women, including issues of power, and the role of traditional and community leaders when integrating specific gender strategies into programs. Gender strategies belong in all HIV technical

areas and all programmers must ask, “How do women’s and men’s norms, roles, and relations affect this program’s ability to achieve its intended results?” and “How does a program’s implementation and results affect men and women?” In all PEPFAR programs, the basic principle of programming—do no harm—must be considered in gender programming.

## **INCREASING GENDER EQUITY IN HIV PROGRAMS AND SERVICES**

Gender equity does not mean an even split in services but reaching men and women in proportion to the epidemic in a specific context and considering the barriers men and women face in accessing services. PEPFAR is the first global HIV initiative to collect data disaggregated by sex. These data help to identify who is affected and who is accessing services, and can help ensure that gender equity is incorporated into programming.

## **ADDRESSING MALE NORMS AND BEHAVIORS**

Integrating gender into programming does not mean designing programs for women only. Men and boys play a critical role in HIV programming—as clients, as partners, and as active participants in gender equity strategies. PEPFAR encourages programs to promote the involvement of men and boys as well as the broader community and key stakeholders. Maintaining and expanding the involvement of men is important as programs scale-up and replication occurs.

## **ADDRESSING GENDER-BASED VIOLENCE AND COERCION**

Women who experience or fear violence may be less able to protect themselves from HIV, disclose their HIV status, or access services. PEPFAR is addressing this issue across different countries with programs aimed at preventing gender-based violence (GBV) and mitigating its effects. Both Secretary Clinton and Ambassador Goosby have made addressing GBV a priority, and have set clear expectations that USG will scale-up its work to prevent and treat the effects of GBV globally.

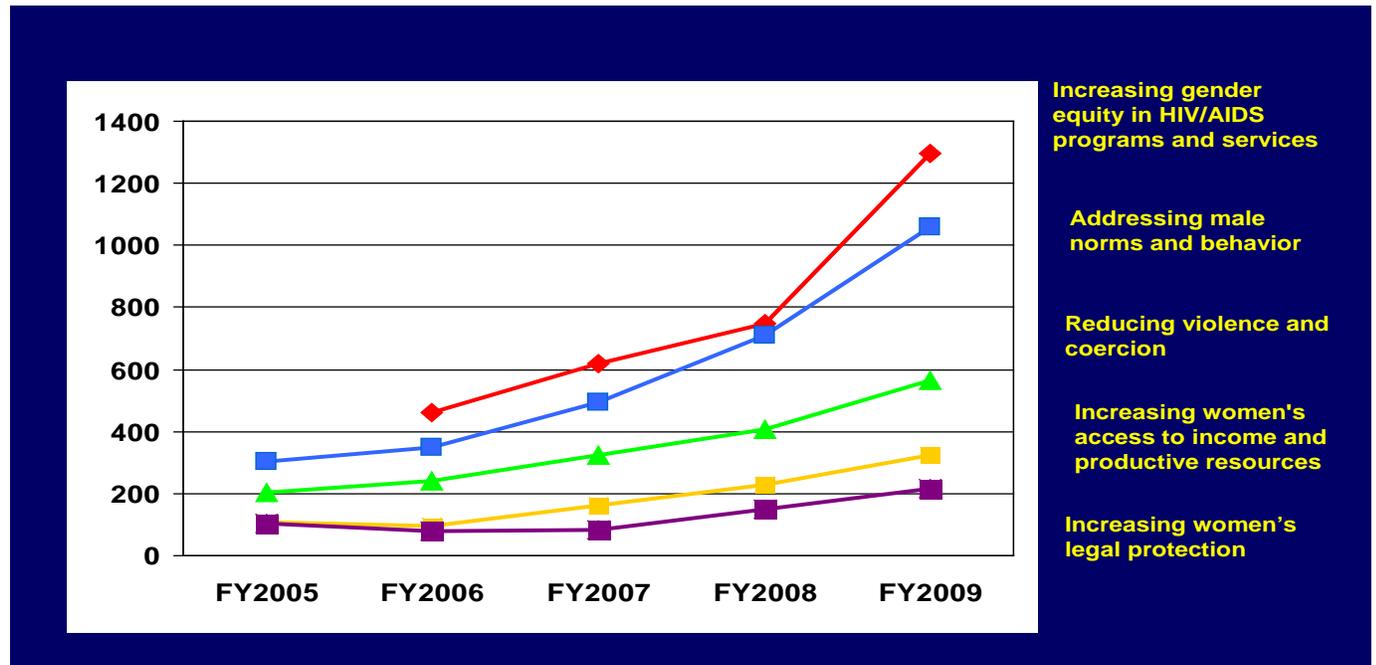
In addition to addressing the needs of women in the general population, programs are grappling with the problem of violence toward other marginalized populations such as men who have sex with men (MSM), people who inject drugs (PWID), and sex workers (SW).

## **STRUCTURAL INTERVENTIONS**

Addressing HIV requires addressing the root, structural factors contributing to gender inequity. Programs may develop structural interventions, including activities that address how the lack of economic resources hinders women’s and girls’ opportunities and increase their vulnerability to HIV or activities that focus on to what extent policies, legal processes, and laws might work against women or other marginalized populations and what it means for populations’ rights and accessing services.

As Figure 1 demonstrates, USG programs greatly increased their gender-specific activities over the first phase of PEPFAR, with the largest gains in increasing equity in HIV programs and services, addressing male norms and behaviors, and reducing violence and coercion.

**Figure I. COP Activities by Gender Strategy Area**



Source: PEPFAR Gender Framework, presented by Diana Prieto, USAID, October 28, 2009.

In addition to attention to gender within technical programmatic areas and along the five areas of focus, gender will be a key topic within partnership framework discussions and framework implementation plans, as discussed during Day 3 of the meeting.

Going forward, there are a number of priorities that must be addressed:

- More systematic and intensified gender programming, demonstrated through:
  - Putting a focus on gender issues in partnership frameworks (e.g., policy and legal frameworks around women’s rights, GBV, and MSM)
  - Technical guidelines for gender programming for most-at-risk populations (MARPs)
  - A more strategic and explicit focus on GBV prevention and response—given the magnitude of the problem and its prominence in PEPFAR reauthorization
  - Prioritized interventions to address structural drivers and social determinants of the epidemic, in partnership with programs outside the health sector
  - Technical input on gender factors provided for emerging programs, technologies, and partnerships (e.g., male circumcision [MC] and home-based counseling and testing).
- More rigorous strategic planning and monitoring of gender programming to promote:
  - Compliance with PEPFAR reauthorization legislation, which calls for goals, targets, and indicators for measuring and monitoring gender outcomes
  - Cost-effective targeting of resources
  - Synergies and linkages across program areas.

- Investment in program evaluation and data analysis, including:
  - Gender analysis of the epidemic to better target programs to specific populations in need and to inform program design
  - More rigorous program evaluation to build the evidence base around key gender strategies.
- Enhanced technical and management capacity, including:
  - Dedicated technical and management staff at headquarters and in the field
  - Financial resources and tools for research, program implementation, technical assistance, and capacity building
  - Technical leadership and participation within the broader gender and HIV community (e.g., the Global Fund to Fight AIDS, Tuberculosis and Malaria, the World Health Organization [WHO], the Joint U.N. Programme on HIV/AIDS [UNAIDS], and other multi- and bilateral organizations)
  - More systematic gender programming—GTWG members will provide better guidance on gender issues
  - Exploring ways to address gender issues within new programs and new technologies
  - More specific focus on GBV prevention and structural issues, and how to form linkages with other sectors
  - Gender analysis of the epidemic
  - Better allocation of resources for gender activities within a country portfolio
  - Identification of who is able to provide leadership and identify and access support in-country.

Rather than trying to prioritize which one or two of the five gender strategies to integrate into country programs, they should be considered in combination; to do one strategy well, the other strategies are needed. Understanding the context is critical to understanding what to do and how to integrate each strategic area. Increasing gender equity (disaggregation of data and performing analysis and planning accordingly) is a fundamental activity that all PEPFAR teams should be undertaking.

Understanding what the needs of a specific country are and what is missing are important for country planning. There is a delicate balance between the needs of the country and the battle for resources; efforts should not be competing but complementary. Within the COPs there are opportunities to expand on the different areas within the PEPFAR gender framework. The GTWG can provide support to USG teams to strengthen their gender programming within the context of the broader portfolio.

# DO YOU KNOW YOUR EPIDEMIC? ANALYZING DATA WITH A GENDER LENS

*Dr. Sunita Kishor, Senior Gender Advisor, Measure Demographic and Health Surveys (DHS), Macro International, provided a detailed analysis of how to use data to understand local epidemics and the role of gender analysis in interpreting that data.*

Kishor began by noting that we have to ask a set of basic questions to understand the epidemic in each country, the answers to which feed directly into what we do about HIV:

- Who is the disease affecting? Why are there differentials in who is being affected?

A foremost aspect of “who” is an individual’s sex. Asking the fundamental question, “Does the prevalence/incidence of HIV vary by sex?” reveals key cross-country differences. With a few exceptions, wherever there are high rates of HIV, women are more likely to be infected. Thus without disaggregating data by sex, there is no way the national HIV response is going to fit the problem. In addition to sex, people have many other characteristics that will affect the answer to “who.”

- What is the extent and severity of the problem?

Data show that the extent and severity of the epidemic varies greatly across countries but raw numbers do not indicate who is affected and where interventions should be targeted. Women and men are *differentially* affected by HIV, and the prevalence of HIV varies by age, wealth, and education. It is not enough to look at just one characteristic (i.e., age or wealth) without breaking it down by gender as well. The first lesson is that collecting sex-disaggregated data is key to knowing your epidemic.

- Why are some more at risk than others?

Women are in general not just treated differently from men, but are treated as *unequal and as subordinate*, which increases their risk for HIV through differential power, access, rights, and entitlements. These inequalities, which lead to disempowerment of women, are at the base of GBV and have important implications not just for women but also for men (e.g., the social acceptance of high-risk behavior for men). The consequences of women’s inequality on HIV transmissions are:

- Lack of sexual control
- Little control over decisions (e.g., when to access health care)
- Limited access to care

– Poor quality of care (limited ability to demand quality care and to know what quality care means).

- What does “know your epidemic” mean from a gender perspective?

It means using tools that show how gender and risk interact and enable programmers to tailor programs to fit the problem. Begin by applying a gender lens to common constructs. For example, a “household” is not just a collection of individuals; it is an environment within which access to and control of income and assets, reproductive and productive work and leisure, and decision making, including about health, are all differentiated by gender. Program managers and implementers have to ask questions such as, “Who owns what?” and “Who has rights within a couple to having or refusing sex or being responsible for the potential consequences of sex and disease?”

Similarly, a “respondent” or “patient” is not just a person, but a woman or man who represents a place in the *gender-age hierarchy*. When we describe a “child,” do we understand how gender biases within households influence which child has access to food, education, love, and health care. In countries where girls are less valued, a mother’s perception of gender worth may color her recognition of seriousness of illness, the amount of resources she (or her partner) is willing to expend on a particular child, and what kind of medicine is best for a child.

To attain equity in health, it is important to recognize that women and men have different needs and constraints due both to biology and gender that *must* be identified and adequately addressed. Gender analysis helps to identify the differences and disparities in the roles that men and women play; the power imbalances in their relations, their needs, constraints, and opportunities; and the impact of these differences on their likelihood of getting infected, accessing care, and recovering.

In order to “know your epidemic,” a gender analysis framework such as the one in Table 1 must be used to examine the gender structure of each community.

There are several possible data sources, most at the national level (some at state or department level, disaggregated by urban/rural). DHS are a key data source; most of the countries represented by participants at this gender technical exchange have DHS data available that include key gender information and data disaggregated by sex and age. What is needed now is greater use of the gender aspects of the data.

**Table 1. Gender Analysis Framework**

**Instructions: Fill in the matrix separately for women and men.**

<b>In relation to HIV:</b>	<b>How do gender norms/values/ roles/activities affect:</b>	<b>How does experience/ perpetration of GBV affect:</b>	<b>How do access to and control over resources affect:</b>	<b>How do biological differences between sexes affect:</b>
Vulnerability				
Prevention and treatment options				
Health-seeking behavior/access to services				
Experience with health services and providers				
Outcome of health problem				
Consequences				

Source: *Do You Know Your Epidemic? Analyzing Data with a Gender Lens*, presented by Sunita Kishor, MEASURE DHS/ICF Macro, October 28, 2009.

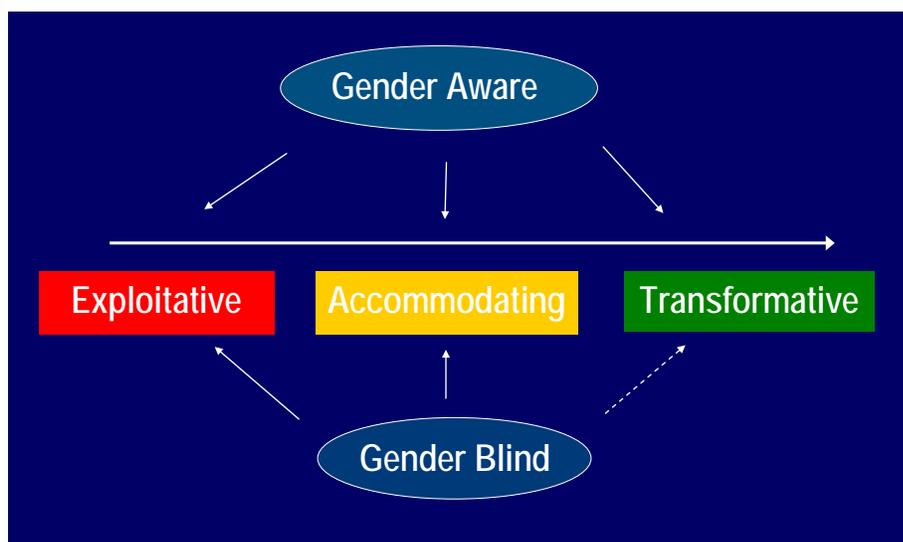


# THE GENDER CONTINUUM

*Diana Prieto, USAID, reviewed the gender continuum, a tool that helps programmers think critically about how responsive their programs are to gender dynamics and the impact their programs have on gender norms in a community. The presentation included a group activity, in which small groups placed programs along the gender continuum and discussed rationale for the placement (See Appendix 3).*

The gender continuum (Figure 2) is a tool that was adapted by the Interagency Gender Working Group from a framework originally proposed by Dr. Geeta Rao Gupta as a way of thinking about gender integration and how gender has been considered in programs.

**Figure 2. Gender Integration Continuum**



Source: PEPFAR Gender Framework, presented by Diana Prieto, USAID, October 28, 2009.

The terms *gender blind* and *gender aware* relate to the degree to which gender norms and inequities are analyzed and explicitly addressed during the design, implementation, and monitoring of a policy or program. When policies and programs are designed without a prior analysis of how differences in gender identities and relations will affect the achievement of objectives, or the way that program objectives will impact gender relations, they are considered to be gender blind. Examples of gender blind activities are:

- A poverty assessment that does not consider differences between male-headed and female-headed households.
- A voter registration campaign that relies on billboards and printed media but does not take into account that most women will not be reached because of their low literacy levels.

Many development projects could be described as gender blind. In contrast, a *gender aware* program examines and addresses the anticipated gender-related dynamics, barriers, opportunities, and outcomes of a particular program. Examples of gender aware activities are:

- A microfinance project that arranges services around times that are most convenient for women with household and family responsibilities.
- A mobile voluntary counseling and testing service setup to reach men who are less likely to visit stand-alone or clinic-based sites.

Once a gender analysis has been done, consideration must be given to the design of interventions. Interventions may fall along a continuum of exploitative, accommodating, or transformative programs, as follows.

**Exploitative:** Exploitative programs are those whose interventions exploit gender inequities and stereotypes in pursuit of project outcome. This approach is harmful and can ultimately undermine the objectives of the program in the long run. Examples include:

- A condom social marketing campaign using aggressive or violent imagery to reinforce male decision making power and control. This may undermine the shared responsibility and decision making between men and women around condom use and other healthy behaviors.
- A prevention of mother-to-child transmission (PMTCT) program distributing a poster that says, “What kind of mother gives her child HIV? An untested one.” The message implicit in this poster is to reinforce placing blame for HIV transmission on women and questioning women’s abilities to fulfill their roles as mothers, without consideration of their partners’ roles and involvement or women’s own potential difficulties with access to services.

**Accommodating:** Accommodating programs consider and design interventions around gender differences to achieve program objectives. This approach addresses certain aspects of women’s needs and may make fulfilling gender roles for women and men easier but does not attempt to reduce gender inequality. This approach may bring short-term benefits but does not necessarily address (or may even reinforce) the gender systems that contribute to the differences and inequities. A well-known example of this approach is a program in Bangladesh that distributed family planning commodities to women who, because of religious and cultural edicts, could not leave the house to visit the health clinic. While the program increased women’s access to family planning, it did not increase women’s autonomy or social mobility.

**Transformative:** Transformative programs seek to achieve program objectives by changing gender relations to promote equity. This approach attempts to promote gender equity through encouraging critical awareness of gender roles; promoting the relative position of women; challenging the imbalance of power, distribution of resources, and allocation of duties between men and women; or addressing the power relationships between women and service providers, traditional leaders, and other community actors. An example of a gender transformative program is income-generating activities that increase women’s economic resources and, as a result, give them more decision-making authority in the household.

A particular program may not fall neatly under one type of approach and may include, for example, both accommodating and transformative elements. The most important consideration, however, is to ensure that the program does not adopt an exploitative approach in keeping with the fundamental principle in development of “doing no harm.”

Integrating gender strategies does not necessarily mean that programs have to start over. Because changing gender equity is a long-term goal, program managers can think pragmatically, identify the “low-hanging fruit,” and begin by developing activities to address them. Transformative elements can be integrated in the beginning, knowing that it will take months or years to create sustained change in gender equity. Programs can draw on other models/curricula to adapt approaches to make their activities more transformative.

Importantly, there is a difference between what the intention of the project is and what the outcome is. That distinction is critical—whether it becomes transformative or not depends on the understanding of the norms to begin with and whether they are being addressing correctly within the context. Building strong evaluation components into programs is also essential to ensuring that outcomes are not exploitative and are achieving the health and gender objectives the program intends.



# APPROACHES TO COMPREHENSIVE GENDER AND HIV PROGRAMMING

*Katherine Fritz, Director HIV/AIDS Research, International Center for Research on Women (ICRW), provided a concise overview of the AIDSTAR-One document, “Integrating Multiple Gender Strategies to Improve HIV and AIDS Interventions: A Compendium of Programs in Africa.”*

The objectives of the compendium were to 1) serve as a potential resource for programs looking for models of programs that have successfully integrated gender strategies; 2) document programs’ goals, beneficiaries, operations, and evidence of effectiveness; 3) synthesize trends and findings across programs; and 4) develop recommendations for implementers and policymakers for maximizing the impact of gender strategies. The compendium summarizes programs that are implementing two or more of the five PEPFAR gender strategies and describes how implementers are putting the strategies together and why.

The project began with a global review of more than 160 programs identified through literature reviews, program reports, and recommendations from gender experts and by program implementers. To be included for review, a program had to:

- Address the link between gender and HIV
- Include at least two of the five PEPFAR gender strategies in its activities
- Be currently active in one of the 12 PEPFAR focus countries in Africa
- Have some degree of program evaluation
- Implement an HIV program in any technical area (i.e., prevention, treatment, and care and support).

Programs were scored based on the number of gender strategies used, evaluation rigor, including use of gender indicators, level of community involvement, and feasibility of replication or scale-up. Thirty-one programs met the criteria for inclusion in the compendium.

Overall findings included the following:

- Community involvement and participatory approaches are vital to program success and sustainability
- Addressing violence is a key gender strategy within many HIV programs
- Income-generation programs successfully attract and help sustain women’s involvement in HIV prevention

- Increasing women's legal protection was the least developed of the gender strategies
- Much more M&E is needed to know what works.

Overall conclusions and recommendations for other programs are the following:

- Programs should combine gender strategies to maximize impact
- Increasing the involvement of men and boys in gender-based programming should be a high priority
- Addressing GBV should be considered a key component in HIV programming
- Programs should incorporate a strong evaluation component
- Programs should begin to address women's legal protection issues.

DHS data can provide little information about what works programmatically. Only four programs in the compendium had rigorous enough evaluation to demonstrate that the program resulted in better outcomes for women. One major challenge across all programs is building the capacity of organizations to do M&E. Linking smaller, grassroots organizations with resources that will strengthen their M&E skills remains a challenge.

# THE IMAGE STUDY: EMPOWERING WOMEN THROUGH MICROFINANCE AND COMMUNITY ACTION TO REDUCE VIOLENCE

*Lufuno Muvhango, School of Public Health, University of the Witwatersrand, provided a summary of the Intervention with Microfinance for AIDS and Gender Equity (IMAGE) study, which is one of the few studies to provide empirical evidence of the effects of integrating gender strategies into HIV prevention programs.*

The IMAGE study, one of the programs described in the gender compendium, was a cluster randomized trial implemented from 2001 to 2004 through a collaboration between the University of the Witwatersrand, SA, and the Small Enterprise Foundation (SEF), an SA-based microfinance organization serving women in rural Limpopo Province. SEF has 15 years of experience in SA and has served more than 50,000 clients to date. SEF gives loans to the poorest women in rural villages and monitors their progress through twice monthly loan repayment meetings.

HIV and intimate partner violence (IPV) are major public health challenges in SA. Women and girls make up 55 percent of total numbers of infections, and one-quarter of women in SA report having been in abusive relationships, greatly increasing their risk for HIV infection. The study sought to evaluate if microfinance linked with gender and HIV training could empower women and reduce IPV, and thereby, reduce their risk for HIV infection. A formative research phase, in which a “Sisters for Life” gender/HIV training curriculum for groups of rural women and microfinance clients was developed and piloted, provided direction for how to implement the intervention. For example, researchers learned that it was important not to jump into the topic of HIV immediately or focus only on HIV “facts.” Instead, the program should appeal to women on a broad range of issues relevant to rural women’s lives such as their gender roles, women’s workloads, domestic violence, sexuality and the body, and improving communication with husbands and children. It was critical for the intervention to be participatory, not “lecturing” the participants, and each session should be no longer than one hour because women had businesses to run. Other important findings of the formative work were that the intervention:

- Cannot take place outside of fortnightly center meetings (women will not come)
- Should happen *before* loan repayments (or women will leave)
- Should build on existing SEF *structures* (loan groups center leadership) and *values* (respect, leadership, and accountability)
- Should be seen as *part* of the center meeting (not an optional “add on”). The following are used to this end:

- “Health talks” should be mentioned during initial client recruitment and orientation
- SEF staff must see HIV prevention as part of the organization’s mandate
- HIV trainers should be seen by clients as part of the SEF team by wearing SEF shirts or reciting the SEF pledge
- Men should be involved separately from women in the training or have a similar male-only workshop.

The first phase of the study entailed exposing SEF customers to 10 one-hour long gender and HIV sessions that were compulsory during loan repayment meetings over a period of six months. The sessions focused on gender and HIV norms, domestic violence, sexuality, HIV and communication, conflict resolution, solidarity, and leadership skills.

The second phase of the intervention focused on community mobilization with the goal of building on lessons learned and engaging men and youth in the communities. This component included selecting “natural leaders,” providing them with one-week training in leadership and community mobilization, identifying priority problems, and undertaking village level action plans.

The results of the study showed that the interventions were able to reduce poverty and increase women’s empowerment—measured through greater self-reported self-confidence, autonomy, challenging of gender norms, social capital, and collective action.

After two years of study implementation, there was a 55 percent reduction in risk of physical and sexual IPV, increased condom use, and greater communication about HIV and HTC by IMAGE participants younger than 35 years of age. Violence was reduced in women’s relationships through:

- Shifts in attitudes toward violence
- Gained income-earning status and negotiating power
- More confidence to leave abusive relationships
- Reduced conflicts over finances
- Improved communication and conflict resolution
- Change of norms around violence by women attending the loan.

A follow-on study sought to answer the question: Would microfinance without training have been as effective? The study compared three groups: IMAGE participants, a control group, and a microfinance-only group. Results showed that IMAGE and microfinance alone had similar impacts on poverty, but only IMAGE demonstrated benefits on women’s empowerment, reduction of IPV, and changes in sexual behavior.

Lessons learned from the IMAGE study include the following:

- Women’s empowerment is about more than just money
- Microfinance (without training) did not lead to broader social and health empowerment
- The importance of group education, tackling cultural beliefs, and community mobilization is paramount.

# AFTERNOON BREAKOUT SESSIONS

*Participants spent the afternoon in two concurrent sessions that provided more details on programs that have successfully integrated specific gender strategies: “Session One: Addressing GBV and Male Norms” and “Session Two: Engaging Men and Boys.” The breakout sessions included interactive exercises used by these programs. Due to technical difficulties, notes are available only for Session Two.*

## **BREAKOUT SESSION TWO: ADDRESSING MALE NORMS AND ENGAGING MEN AND BOYS**

*Facilitated by Bafana Khumalo, Sonke Gender Justice, and Andrew Levack, EngenderHealth.*

MenEngage is a consortium of organizations committed to addressing gender inequalities and transforming gender norms. Shifting male norms and gender inequalities are complex issues with no single answer and approach. It is possible to question traditional socialization of masculinity and gender, and this has increasingly become the focus of the MenEngage program. The Gender Equitable Men (GEM) scale (described in detail on Day 2 by Julie Pulerwitz, see “Measurement in PEPFAR II”) is used at the onset of the program to document the extent to which men and boys participating in the program endorse traditional rigid gender norms. Transformative interventions seek to question, examine, and transform these gender norms, explicitly looking at messages in society and challenging men and boys to think about if they need to subscribe to these norms or not.

Gender constructs play a role not only in HIV but in other health outcomes as well, such as use of family planning and maternal and child health services, as well to the extent to which men are engaged in parenting. There is a multiplier effect or benefit to looking at gender norms and their relationships to health outcomes. The MenEngage programs promote rights, equity, and fairness that help to address the question of gender norms and their effects. A common exercise is having men think critically about patriarchy and how it is harmful to men, and how it makes them vulnerable to HIV and other adverse health outcomes. For example, it is very common for men to wait until they are very sick before accessing health care (i.e., antiretroviral therapy). In SA, approximately 80 percent of HIV testing is among women, which is not entirely explained by access to PMTCT programs. During these exercises, men acknowledge the social norm that HTC is something women, not men, do. Programs have to adapt to encourage men to get engaged and access services. Programs supported by EngenderHealth now provide mobile counseling and testing vans to reach men who will not come to clinics. Issues of class and racism also have an impact on issues of gender.

It is unrealistic to assume that program interventions using only one model or approach can accomplish long-term outcomes in a short period of time. For example, a three-day workshop on gender norms is not likely to have a lasting effect—a combination of interventions is necessary to obtain skills and tools to make a lifestyle change. The MenEngage approach uses an ecological

model that posits that gender norms are reinforced by both men and women; therefore, both men and women must be engaged critically in changing gender norms.

There is value in workshops that are men-only (men-only clubs, support groups for men, certain workplaces), men and women together (provides an opportunity for men and women to hear reflections on gender and what it means for them in society), and women-only (provides a space to explore gender norms and issues like GBV). These workshops require skilled facilitators to avoid a gender exploitative approach. It is important to include values clarification when training facilitators. During the MenEngage workshops, participants are asked, “How do these constructs impact relationships and violence, and what can you do about it?” and “What are you prepared to do to promote gender equity in the community?” The workshops help participants look at underlying motivation for behaviors (e.g., gender norms in conservative settings focus on women satisfying men’s needs). Perceptions of social norms can be very different from the reality of social norms.

During the workshops, participants are challenged to use lessons from the training to change their behavior and then do something for themselves or their community. For gender norms to change, society must be transformed. If the community remains rigid, a man will be unable to change because both men and women will question his efforts to be more gender equitable. The way communities organize is a key issue to address to change gender norms. Systems need to be ready to be gender transformative and be responsive to the needs of men as well as women. For example, as part of the Men as Partners Program in Soweto, men were encouraged to accompany their partners to health services, but a majority of female clinic staff felt that antenatal care (ANC) is a woman’s space and wanted to keep men out. Programs must look at ways to engage men in PMTCT as well as help providers be more encouraging and willing to have men participate in ANC/PMTCT services. Programs need guidance and policies on how to provide services for men in order to avoid reinforcing gender stereotypes. For example, at one couples’ HIV service site, some providers were inadvertently deferring to the man and/or limiting the woman’s ability to make decisions during the session.

Participants can engage in community events and community action teams after the workshops. Larger events allow more people to be reached with messages and different activities are possible—a rally, a march, a presentation, or a performance. MenEngage use the arts in many ways to help people take messages to the community and can engage community members who did not participate in workshops, helping to further identify the important messages for the community. Groups of young artists translate messages into murals that are displayed in the community. Creating the murals gives youth a sense of pride, and the murals are longer-term reminders of the outreach messages. Another media used by MenEngage is digital storytelling. Women and men share their experiences and give personal testimonies by recording individual videos that provide important messages about confronting gender norms. These videos are easily shared on the Internet, at other workshops, and on television. (Two digital stories were shown for the participants at the session—one from EngenderHealth’s Men as Partners program, and one from Sonke Gender Justice Network’s One Man Can program.)

The following programs are designed to be gender transformative:

- Men Can Stop Rape in SA redefines what it means to be strong and to be a man; that strength is not for hurting but for being involved
- One Man Can transforms notions of fatherhood and role of the fathers
- Men As Partners redefines what partnership and men’s activism means

- The Male Norms Initiative objective is to build the capacity of PEPFAR implementing partners to make their programs more gender transformative
- The CHAMPION project uses an ecological model and more robust interventions to change male norms.



# ADDRESSING THE VULNERABILITY OF GIRLS AND YOUNG WOMEN

*A panel of three speakers, Ian Askew, Population Council; Carol Underwood, Johns Hopkins University Center for Communication Programs, Project Search; and Mary Ellen Duke, USAID/Mozambique, discussed their program approaches and lessons learned trying to reach vulnerable girls.*

## IAN ASKEW: IDENTIFYING AND REACHING VULNERABLE GIRLS

Programs managers need to be as specific as possible when defining the adolescents they want to reach with their program. Most programs reach the easiest-to-reach adolescents, which leaves many girls left behind. Who are the adolescent girls left behind?

1. Girls aged 10 to 19 years living outside the protective structures of family and school, especially 10- to 14-year-olds and girls in domestic service in poor urban settlements. In some PEPFAR countries, the majority of girls aged 10 to 14 living in urban areas are living with one or no parent. For example, in Malawi, 21 percent of girls in this age group are not living with either parent and are not in school. In Mozambique, 16 percent of girls are living apart from their parent(s) and not in school. There are intracountry differences as well. It is possible to do mapping to identify areas where large proportions of girls aged 10 to 14 reside who are not in school and not living with either parent—a group of highly vulnerable, often socially isolated girls.
2. Girls in the lower two quintiles of wealth and orphaned girls are much more likely to exchange sex for gifts or money, underscoring the vulnerability of poverty and orphanhood. Population Council research has shown that in some countries nearly one in five low wealth girls, while very few high wealth girls, have ever traded sex for money, goods, or favors. Orphaned girls are almost three times more likely to have ever traded sex for money, goods, or favors than non-orphaned girls. An overarching impediment for many girls and young women is their high degree of social isolation. For many girls, their body is their only asset. Consistently, across income groups, girls have smaller and less reliable friendship networks than boys and fewer safe and supportive spaces in which to meet their friends.
3. Girls most at risk of child marriage are those aged 10 to 19 years living in areas where early marriage is common. Child marriage is not itself a risk factor for HIV. However, it often represents a confluence of other risk factors in areas characterized by high HIV prevalence, including the following:
  - Little education and no schooling options

- Limited control over resources
- Restricted mobility, keeping girls from accessing programs and services
- Little or no power in their new household
- High frequency of unprotected sex, with pressure to become pregnant
- Large age gap with spouse (on average, a gap of seven to eight years), with many husbands in an age range with high prevalence of HIV.

Child marriage is very common in PEPFAR countries, and many of these countries have regional “hotspots.” For example, the percentage of girls married by age 15 in Ethiopia is 19 percent overall, but in the Amhara region, 50 percent of these girls are married. By age 18, 49 percent of all girls are married in Ethiopia, but in the Amhara region 80 percent of these girls are married. Likewise in Nigeria, 19 percent of all girls are married by age 15 and 43 percent are married by age 18. But in the northwest region of Nigeria, 41 percent of girls are married by age 15 and 79 percent are married by 18.

In PEPFAR countries where early marriage is common, the majority of adolescent girls’ sexual activity occurs within marriage. For example, in Ethiopia, 94 percent of sexually active girls aged 15 to 19 are married, while 80 percent of sexually active girls aged 15 to 19 in Uganda are married. Because married girls often have more frequent unprotected sex than unmarried girls, the statistics are even more dramatic when looking at unprotected sex in the previous week. In Ethiopia, 98 percent of girls aged 10 to 19 who had unprotected sex in the previous week were married, while 96 percent of girls who had unprotected sex in the last week in Uganda were married. This is a radical departure from the context of “teenage sex” in many western countries and therefore demands a radically different approach.

Programming opportunities for PEPFAR are as follows:

- a. Conduct context-specific research to map concentrations of highly vulnerable adolescent girls and define factors determining vulnerability
- b. Promote girls’ schooling, including strategies that ensure the inclusion of girls at risk of child marriage and poor girls under pressure to exchange sex for gifts and money
- c. Create girl-only safe spaces as a primary prevention strategy that offers health services and social support while building basic livelihood skills and providing savings opportunities
- d. Provide a variety of financial products and services that do not tie up all of a girl’s savings in collateral so that she is able to access her savings in emergencies, otherwise she may be more vulnerable than she was initially
- e. Improve the terms of work and provide safe spaces to high-risk girls in the informal sector, especially those in domestic service.

# CAROL UNDERWOOD: PEPFAR GENDER INITIATIVE ON GIRLS' VULNERABILITY TO HIV: GO GIRLS! INITIATIVE

The Vulnerable Girls' Initiative (VGI; also known as the Go Girls! Initiative), one of three PEPFAR gender initiatives supported by the PEPFAR GTWG, is being implemented in Botswana, Malawi, and Mozambique. It uses a conceptual framework based on the social ecological model, which recognizes the need to work at multiple levels—structural, community, family, and individual levels—to change the conditions that reproduce girls' vulnerability. This three-year initiative is implementing only a few interventions at a structural level, where it takes longer to achieve change. VGI focuses at the community level, which has failed to protect vulnerable girls, and at the family level to create socionormative change. An extensive literature review showed no agreed on definition of *vulnerable girl* and no study had included the community point of view when implementing programs.

Formative research was done first to look at the factors that made girls vulnerable. Themes that emerged were economic factors such as consumerism, peer/social pressure, the need to meet basic survival needs, and sexual violence in the form of coercion and forced sex. Other vulnerability factors include the following:

- Easy access to alcohol and sexual violence linked to alcohol consumption by both the perpetrator and the victim
- Decline in parental authority
- Perceived deterioration in adult/child communication
- Initiation rites (in Malawi)
- Exposure to sexually explicit or sexually suggestive material—video houses, television, and media
- Earlier sexual debut and early marriage in Malawi and Mozambique.

VGI defines *vulnerable girls* as those who are, or are likely to be, exposed to unsafe sexual encounters due to weaknesses in ideational, social, economic, or legal support and protection. In the program, two models to reduce vulnerability are being tested. Model I targets individuals, peers, family, and the community with communication interventions. These interventions promote community mobilization, community-based life skills programs for girls, improved adult-child communication, and a radio program. Model II introduces the same interventions as Model I and includes interventions at the societal level as well. Components of VGI include the following:

- Community mobilization targeting the entire community, assisting each community to form a “task force for girls' vulnerability,” develop an action plan, and implement that plan. The expected outcome is that communities will take collective action to protect girls and ensure a safe environment within which girls can thrive.
- Life skills courses targeting all out-of-school girls with a curriculum to address key factors of girls' vulnerability and guide the development of girls' clubs. The expected outcome is that girls develop life skills and increase self-efficacy to protect themselves from HIV infection.

- Improve adult-child communication by targeting parents or caregivers of adolescent girls using a curriculum to address key adult-child relationship factors. The expected outcome is that adults will have improved skills and increase self-efficacy to improve relationships with girls and protect them from HIV infection.
- A radio program targeting extended families with a regional- and country-specific reality program that ties together all the project activities and stimulates family and community dialogue as well as a collective response to addressing girls' vulnerability to HIV.
- School-based programs for teachers, school heads, administrators, and support staff comprised of a training workshop and follow-up meetings to encourage safe and supportive school environments for girls. For girls and boys at these schools, VGI has developed a curriculum that is integrated into an existing life skills program. The expected outcome is that boys and girls will build life skills and increase self-efficacy to protect themselves from HIV infection.
- Economic strengthening activities targeting vulnerable girls and their families, which helps them develop partnerships and facilitate linkages to existing services and programs. The expected outcome is that girls and/or their families have increased access to skills building, microfinance, and income-generation activities.

VGI has completed two years of the three-year study and has already learned many lessons from implementing this project. The lessons learned are as follows:

- Understanding the local context is time-consuming, particularly in multiple settings.
- Implementing multilevel interventions, in multiple sectors in multiple countries, requires more than three years of funding. Time is needed to deal not only with unanticipated delays but also to get a wide range of stakeholders on board, get appropriate ethical reviews, and other approvals, etc.
- Much of the formative work is sequential, not concurrent (i.e., literature review, then formative research studies, then program development and piloting baseline instruments). Each step is needed to inform program design.
- Differences among countries need to be recognized and accounted for in the program design timeframe. For example, school systems are different in different countries, and this should be accounted for in the school-based life skills component.
- Structural interventions are challenging. For example, VGI proposed implementing economic-strengthening activities for minors but found that in some situations minors are not allowed to get grants or loans.
- Programming with “a whole community” approach to GBV is a promising practice.

## **MARY ELLEN DUKE: EXPERIENCES FROM MOZAMBIQUE**

Duke gave an oral presentation during which she shared lessons learned from her many years of experience in the field as an implementer and as USG staff working at USAID/Mozambique, where she has worked since February 2009. Her recommendations are applicable beyond programs aimed at vulnerable girls and include that, as the funder, USG staff should implement the following: 1)

actively participate in projects and work with the local project directors in the planning stages in order to provide early input into which data should be collected to accurately report on programs; 2) visit project sites more than once if possible; 3) share information, ideas, and tools among programs and try to link programs where possible and appropriate; 4) recognize that M&E and data collection can be time-consuming and front load sufficient resources so that good M&E systems are in place; 5) budget for the translation of materials if working in local languages; and 6) be ready for the unexpected, be flexible, and have realistic expectations about what can be accomplished given the country context. Duke concluded that when developing budgets, programmers need to think long-term, at least three to five years into the future, to plan better programmatically.



# ADDRESSING GENDER WITHIN MOST-AT-RISK POPULATION PROGRAMMING

*A panel of three speakers, Kai Spratt, AIDSTAR-One Gender Advisor; Amitrajit Saba, Associate Director of Sexual and Reproductive Health, PATH/India; and Scott Berry, Regional Coordinator Asia Pacific, AIDS Program Management Group, focused on the gender issues that need to be addressed in programs targeting MARPs and examples of programs implementing innovative approaches to integrate gender into their services/programs.*

## KAI SPRATT: ADDRESSING GENDER IN CONCENTRATED EPIDEMICS

In many areas in Latin America, central Europe, and Asia, HIV epidemics are being driven by MARPs. In these concentrated epidemic scenarios, HIV prevalence is consistently over 5 percent in at least one defined MARP but is below 1 percent in pregnant women in urban areas. HIV disproportionately affects PWID, MSM, male-to-female transgender (TG) persons, and SWs. Several countries with generalized epidemics are also experiencing emerging concentrated epidemics in one or more of these MARPs, but few are running programs targeting these populations. In nearly all countries with concentrated epidemics, the behaviors that increase transmission risk are highly stigmatized, illegal, or both. Sixty-nine percent of countries with concentrated epidemics report having laws, regulations, or policies that pose barriers to use of HIV services for MARPs. PWID, MSM, and TG people have only recently been included in national surveillance programs, so current population size and prevalence estimations are inaccurate. Government response to rising HIV prevalence among MARPs has been slow and generally ineffective; across countries with concentrated epidemics, only 10 percent of all prevention spending is targeting MARPs.

**Injecting drug users.** There are approximately 3 to 4 million PWID living with HIV, and worldwide 10 percent of all new HIV infections occur among PWID. PWID are more likely to change sexual risk behaviors than injecting risk behaviors. PWID experience a wide variety of health problems (high prevalence of hepatitis B and C, sexually transmitted infections [STIs], chronic and acute physical health concerns) and have a lifetime prevalence of depression twice that of the general population. Despite growing evidence of sexual transmission of HIV among PWID and their regular same-sex or opposite-sex partners, few programs are designed to reach regular and casual sexual partners, who may also be injecting drugs or having unprotected sex, or both, with their partners who inject drugs. Gaps in gender programming are related to limited access to services for females who inject drugs and programs that fail to consider gender-specific factors related to drug use behaviors. For example, initiation into drug use and patterns of drug use differ between males and

females. Female drug users are more stigmatized for being injecting drug users, at the same time they bear the burden of traditional gender norms such as childcare. Male injecting drug users are constrained by constructs of masculinity that result in lower use of health services and are exposed to higher risk in prisons, as more male injecting drug users are incarcerated than female injecting drug users.

**Men who have sex with men.** Globally, MSM are 19 times more likely to be infected with HIV than the general population. However, fewer than 1 in 20 MSM had access to appropriate HIV infection prevention and care services in 2005. GBV against MSM is widespread but unaddressed, probably because men are seen as the perpetrators of violence but not the survivors of GBV. Recent U.S.-based studies report that 68 percent of young MSM reported ever experiencing threats or violence from either family or partners and 25 percent reported threats or violence by both family and partners. There is increasing evidence from studies in the United States and Europe of associations between GBV against MSM, HIV-risk behavior and HIV infection, poorer mental health, barriers to medical care, and substance abuse. Programs that do target MSM overwhelmingly focused on reducing individual sexual risk behavior with little emphasis on changing the context of violence, stigma and discrimination, and social exclusion that is the lived experience of many MSM and TG people.

**Male, female, and transgender sex workers.** Several countries have seen impressive decreases in HIV prevalence among SWs. In Cambodia, for example, HIV prevalence fell from 43 percent in 1998 to 13 percent in 2006 among brothel-based SWs. Even with this impressive reduction, with few exceptions, prevalence among SWs is disturbingly high in most countries. GBV is prevalent against SWs and probably plays a role in high levels of HIV infection. A longitudinal study in Canada found that over an 18-month period, 49 percent of female SWs experienced physical violence, 30 percent experienced client-perpetrated violence, and 25 percent had been raped. There are high rates of needle and syringe sharing and use of non-injecting drugs among some SWs. Drug and alcohol use by some SWs, a coping strategy to reduce the physical and psychological stress of sex work, contributes to SWs' vulnerability to HIV by decreasing their ability to engage in safe sex. Male and TG SWs are rarely included in research and HIV prevention or sexual health programs that target SWs.

How can gender strategies be integrated into MARP programming? Some examples include the following:

- Increasing gender equity in HIV programs
  - All program staff should participate in gender-sensitization training on the unique concerns and needs of each MARP.
  - Reduce access barriers to program services through flexible hours and drop-in and mobile services, as well as minimal rules, provision for childcare, and women-, TG-, or men-only spaces or hours.
  - Address financial, procurement, and logistical barriers to wide distribution of female condoms and lubricant to enable SWs and MSM to exercise more control over HIV prevention with partners unwilling to use a male condom.
- Reducing violence and coercion
  - Map service sites to which MARPs could be referred for GBV-related health, social, and legal support. If no such programs exist, develop GBV programs specifically for MARPs.

- Screen MARP clients for a history of child sexual abuse and GBV, and develop strategies and services to address the specific mental health needs of men and women drug users, SWs, TG people, and MSM.
- Programs working with PWID, MSM, and SWs should incorporate violence reduction, mitigation, and social support into all of their programs.
- Increasing legal protections
  - Support policy change and advocacy to decriminalize same-sex consensual sexual relationships, possession of condoms and/or injecting equipment, and to lower the cost of substitution drug therapy.
  - Advocate for policy changes that provide *voluntary* rehabilitation rather than incarceration for SWs and PWID.
- Increasing access to income and productive resources
  - Provide access to literacy and vocational training for female, male, and TG SWs.
- Addressing gender norms and behaviors
  - Implement interventions that include intimate partners of MARPs.

Stigma and discrimination pose a significant constraint on the effectiveness of HIV prevention, treatment, and care and support programs for MARPs. Legal and social contexts that are hostile and/or punitive toward risk behaviors among MARPs make it challenging for programs to move beyond ensuring access to basic services. Many program implementers recognize the need to integrate gender work into their activities and would greatly benefit from initiatives to 1) develop culturally adaptable tools and resources to address the HIV epidemics among MARPs, especially the intersecting sexual and needle sharing networks of injecting drug use, SWs and their partners/clients, and MSM; and 2) engage in advocacy with governments to strengthen the national response to MARPs and to strengthen the enforcement of policies and laws to mitigate stigma and discrimination against these vulnerable populations.

## **AMITRAJIT SAHA: LEARNING TO CHANGE: STORY OF THE SONAGACHI PROJECT**

The objectives of the presentation were to share the history of the Sonagachi Project, the phases of its development, lessons learned and adapted, and some recommendations for other programs working with SWs. The program was formally called the “STI/HIV Intervention Program” but is commonly known as the Sonagachi Project after Sonagachi, the largest sex work site in Kolkata, India, where the project began. Sonagachi encompasses two to three blocks in the northern or “old” part of the city. The project began as a conventional STI/HIV prevention program. The program components were behavior change communication, condom promotion and free condom distribution, and STI management services from site-based clinics. The behavior change communication activities and condom promotion and distribution were done by peer educators from among SWs. The core values of the project were “the three R’s”: *respect* toward SWs, *reliance* on the knowledge and wisdom of the community of SWs, and *recognition* of sex work as work and the need to protect SWs’ occupational and human rights.

The program sought to address the risk of STI/HIV infection within the framework of occupational health by engendering an environment of equity and dignity for SWs within the project, involving peer educators in project design and programmatic decision making, increasing aspirations of community workers—for example, a peer educator became the project director—challenging prevailing norms regarding gender and social power, and introducing affirmative action with regard to staff and office positions within the organization to assure greater opportunities of mobility for SWs and their children. Currently, the female-to-male ratio of the workforce of the Sonagachi Project is 70:30.

To reduce violence and coercion against SWs, the project undertook activities and advocacy to transform the subjectivity of SWs. For example, the project engendered faith in the community to increase SWs' self-worth and took sides by supporting SWs in disputes with gatekeepers, police, and hoodlums. The Sonagachi Project initiated education programs for children of SWs and involved SWs in interactions with civil society through advocacy campaigns, organized protests, and meetings with government ministers, intellectuals, women's rights groups, and trade union activists.

The program had to address the systemic vulnerabilities of SWs by negotiating with stakeholders and gatekeepers of the sex trade, holding meetings with local "youth clubs," and meeting with other stakeholders and gatekeepers (i.e., brothel owners and managers), and other intermediaries. Peer educators conducted sensitization activities for local police personnel and other SWs about STIs and HIV and involved *babus* (intimate partners of SWs) in efforts to support SWs. The project supports the human rights of SWs against unethical, coercive, or exploitative research/surveys, exploitative working conditions, and violence by local hoodlums, gatekeepers, and local police. The project empowers the SW community to mobilize itself and support SW organizations such as Durbar Mahila Samanwaya Committee (DMSC), Komol Gandhar, Usha Cooperative, and Binodini Srameek Union.<sup>4</sup> The project is facilitating the evolution of a SW community that is based on struggle against exploitation and marginalization.

In order to increase SWs' access to financial resources, the SW cooperative Usha was established, the first cooperative society wholly owned and run by SWs. Membership is restricted to SWs and their female children. It was started in 1995 after the provincial government made amendments to Cooperative Society Laws to allow DMSC to start a cooperative society and now has more than 10,000 members with a total loan level of more than U.S.\$2 million.

The project increases access to legal resources and protections through legal literacy sessions and pro bono legal aid. The project implements a crisis mitigation protocol that uses a combination of advocacy, judicious use of media, and street action to address incidents of violence against or eviction of SWs by landlords. In addition, SWs setup self-regulatory boards within project sites to prevent trafficking of young girls into sex work and to generate discourse around laws and bills that threaten the livelihoods of SWs.

The project undertook activities to address male norms and behaviors by establishing the Sathi Sangathan, a collaborative organization of intimate partners of SWs to engage them with the project and to mobilize them to prevent violence against SWs. In 2008, the project also setup customer care centers in the red light district to interact with clients coming to the sex work districts to increase their safer sex practices. At present, approximately 50 percent of the clients bring condoms when they come to a sex work site and, on average, around 200 clients visit the Sonagachi clinic for STI treatment every month. The customer care centers refer men to the integrated counseling and

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<sup>4</sup> DMSC is the SWs' organization that currently runs the Sonagachi Project. Komol Gandhar is a cultural forum for SWs and their children, while Usha Cooperative is the SWs' microcredit society. Binodini Srameek Union is the fledgling trade union organization of the SWs.

testing center, which is now seeing, on average, 75 to 100 clients every month. The condom use rate among clients of SWs is as high as 90 percent, and HIV prevalence was 2.4 percent in 2006 among clients and 5.2 percent in 2007 among SWs, rates that have remained stable since 1998.

What made the Sonagachi Project successful? The following contributed:

- Overarching values that put the affected community at the center of the response
- Processes informed by values and field realities
- Measuring outcome and impacts and modifying processes
- Egalitarian organizational culture and learning to change
- Constructing a community of struggle.

The Sonagachi Project evolved because of a shared understanding that SWs are vulnerable to STIs/HIV not because of individual behavior but because of social exclusion, gender inequality, stigma associated with sex and sexuality, etc. In the future, sustainable STI/HIV interventions among SWs must move from focus on individual risk to focus on social vulnerability. Programs need to address issues of inequality, injustice, and social discrimination both within and outside program organizations and create an enabling environment for SWs both within and outside the sex work sites, provide space for the community to grow and voice their concerns beyond STI/HIV issues, and ensure that all learning is a two-way dialogue, is equal, and challenges existing hierarchies. Effective prevention efforts with SW groups need to encompass collective empowerment and community mobilization; enable SW communities to form, lead, and sustain their own organizations; and use a rights-based approach and community ownership model.

## **SCOTT BERRY: FEMALE INJECTING DRUG USERS, GAY MEN AND MEN WHO HAVE SEX WITH MEN, AND TRANSGENDER PEOPLE**

This presentation provided a summary of key HIV issues related to MARPs, specifically females who inject drugs, gay men and MSM, and TG people, as well as a number of promising programs and interventions in the Asia Pacific region that try to integrate gender into HIV activities.

In concentrated epidemics, like those in the Asia Pacific region, vulnerability to HIV follows oppression, poverty, and marginalization, with women and girls particularly vulnerable and unable to access the means to prevent HIV. Females who inject drugs and SWs, MSM, and TG people are punished for transgressing gender expectations and stay hidden, if at all possible. Social and legal impediments to accessing services by these populations results in poor health outcomes. Females who inject drugs are at higher risk of acquiring HIV than their male counterparts, but few prevention or treatment programs target them. Gender applied to gay men, MSM, and TG people is a new area of gender application and is highly controversial. Approaches to gender in HIV have mainly focused on the inequity between men and women—evidence is scant on how gender inequity impacts on the HIV vulnerability of particular MARPs like TG people, gay men, and other MSM. Gay men and MSM (referring here to men who have sex with men and with women or men who do not identify as gay) lose some of their agency due to self-stigma and external stigma, resulting in low rates of HIV testing and referrals for treatment. Female partners of MSM are vulnerable to HIV as well due to their inability or reluctance to insist on condom use with intimate partners—the most

effective programs preventing HIV in female partners to date are not “gender transformative” but instead educate MSM to limit sex, which puts them and their partners at risk. The only way to reach these populations and prevent HIV is to meaningfully involve them at all levels of the HIV response.

Thinking about gender in development generally includes programs to:

- Reduce poverty and dependency
- Address the negative consequences of cultural norms
- Change sexual norms
- Reduce violence against women
- Improve laws and legal access
- Address psychological factors
- End female genital mutilation.

What does it mean to apply these strategies when targeting MARPs? Gender barriers for MARPs are not the same as those experienced by men and women who are not part of a most-at-risk population, but interventions used in the effort to reach non-MARP men and women may be used in programs targeting MARPs to achieve results.

**Female injecting drug users.** Female injecting drug users make-up 25 to 35 percent of the PWID population in several countries in the Asia Pacific region, but there is still little HIV and harm reduction research or programs for this population. Most services are still developed by and target male injecting drug users. Females who inject drugs may do sex work, independently or pimped by their male partners, and have very little control over condom use in transactional sex. Females who inject drugs are often injected by their male partners with the same equipment the male partners use; because of gender imbalance in intimate partner relationships, they have little power to insist on clean equipment (or condom use). These gender-specific constraints contribute to the higher prevalence of HIV among females who inject drugs being seen throughout the region.

**Gay men, men who have sex with men, and transgender people.** These MARPs transgress gender norms by having sex with other men, or by living as a “third gender” or as a woman. *Feminine* and *masculine* are fluid categories in TG and MSM social and sexual dynamics (e.g., TG people can be receptive, givers of oral sex, and submissive but may also be insertive, receivers of oral sex, and dominant). TG people and MSM may move fluidly between these sexual and social behaviors and categories. Even in societies that are perceived as being open to TG people or MSM, they are still marginalized and disempowered. As a result, gay men and MSM transmute and camouflage their sexuality in order to protect themselves from ridicule and abuse. Camouflaging in this way allows them to participate as fully as possible in society. In terms of HIV and STIs, MSM may not disclose aspects of their sexual behavior to health care providers in order to avoid stigma and discrimination that results in poor quality health care. Not disclosing their sexual behavior puts MSM at greater risk of HIV due to untreated STIs and other sexual health problems, limited access to information about HIV and STIs, and lack of support for risk reduction behaviors. The solution to improved HIV and STI outcomes in MSM is increased social acceptance, but the reality is that solution is a long way away. Non-disclosure about sexual behavior also puts MSM’s female partners at risk. In countries where marriage is normative, where men and women are segregated before marriage and/or where

male norms encourage men to have multiple female sexual partners, MSM who hide their sexual behavior with other men, like men who hide sex with SWs, risk infecting female partners.

There are multiple challenges at the national and local levels related to providing services to MARPs. At the national level, it is difficult for MARPs to participate in program planning and implementation when so many stay below the radar. A Global Fund to Fight AIDS, Tuberculosis and Malaria (GFTAM) report showed that of the 65 country coordinating mechanisms reviewed, only five had “easily identifiable lesbian, gay, bisexual, and [TG] members,” and a second GFTAM report noted that “marginalized groups (are) seldom discussed in country coordinating mechanisms.” Exclusion of MARPs at the national planning level results in limited advocacy for long-term, systematic collection of strategic information about HIV prevalence and the impact of programs targeting MARPs. In countries where same-sex sexual behavior, possessing a needle and syringe, or carrying condoms can result in arrest or intimidation, legal barriers limit the involvement of MARPs in planning and service delivery. In order to broaden the involvement of MARPs and to ensure their myriad voices are heard, new strategies to involve MARPs who are not associated with MARP-identified nongovernmental organizations (NGOs) or community-based organizations are needed.

At the local level, there are few programs with appropriate service goals: ongoing, lifelong connections with MARP communities. Programs have difficulties attracting MARPs and retaining them in ongoing care, and many MARP-focused community-based organizations require significant capacity building so that they can provide sustainable programs and services.

The following are two innovative programs working in the Asia Pacific region.

**Kios Atma Jaya** developed a specialized program for female injecting drug users engaged in sex work in West Java, Indonesia, supported by Atma Jaya Catholic University. Females who inject drugs are actively involved as women outreach workers, and the program takes a holistic approach to HIV prevention and care providing needle and syringe exchange programs, voluntary counseling and testing, case management, basic health services, reproductive health services, safety and legal access, drug counseling, peer education/support, and vocational options. The project is active during the late night/early morning hours (2:00 to 3:00 a.m.) so that services were convenient to target populations. Due to the control of many SWs by male pimps, these men were involved in the program as well to reduce barriers to SWs’ access to the program. The program involved local people associated with sex work such as venue owners and other female SWs who inject drugs.

**The Poz Home Center** in Bangkok, Thailand, uses a three-stage peer counseling model that is one of the only programs to incorporate gender analysis into its care and support programs and case management approach for gay men, MSM, and TG people. At intake into the program, case managers use “supportive questioning and inquiry” to explore gender and sexuality issues that may be affecting each individual’s life such as poverty, culture, sex, legal access, genital transformation, and psychosocial issues. With TG people, case managers explore whether the person is working toward gender reassignment, their understanding of HIV, if they have been diagnosed with HIV, involvement in sex work, and hormone treatment. With *kathoeys*,<sup>5</sup> case managers explore experiences

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<sup>5</sup> Kathoeys is “a gender identity (somewhat feminine), a sexual orientation (towards men) and social category (somewhat valorized in very specific situations, but more broadly stigmatized when placed against normative male-female identities) with a long history in local Thai, Cambodian and Lao cultures... [which] conjures a stereotype of highly effeminate transgender and yet, at the same time, is used to label anyone who predominantly enjoys sex with men. We also use the term kathoeys extensively to reflect this wide degree of local usage. Nonetheless, we stress that many men who fall within its broad parameters do not necessarily dress as women and can move readily within masculine modes of identification. An important point is that male-male sex can increasingly take place without one partner demonstrating overt femininity” (Lyttleton, C. 2008. *Mekong Erotics: Men Loving/Pleasuring/Using Men in Lao PDR*. Bangkok: United Nations Educational, Scientific and Cultural Organization Bangkok, p. 7).

of violence, intimidation, sexual violence, or their ability to negotiate safe sex in relationship(s). With MSM, case managers explore if MSM are experiencing difficulties “at home” and their experiences with violence, intimidation, sexual violence, and if they are able to negotiate safe sex in relationship(s). Each client is then linked to a peer buddy for ongoing support.

Lessons learned in successfully targeting PWID, gay men, and MSM are as follows:

- Involve MARPs in all aspects of programs targeting them: from policy development to service provision
- Protect the privacy and confidentiality of MARPs using those services
- Ensure flexibility in staffing and hours of operation
- Use a holistic approach to individuals’ needs—it is not just about preventing HIV transmission
- Go to where MARPs are living and operating—do not expect them to come to you.

# ADDRESSING GENDER WITHIN HIV PROGRAMS: HIV TESTING AND COUNSELING, PREVENTION OF MOTHER-TO-CHILD TRANSMISSION, AND TREATMENT AND CARE

*Avni Amin, Technical Officer, Department of Women, Gender and Health of WHO, introduced participants to a recently published tool developed by WHO to integrate gender into reproductive health. After describing the development of the tool, participants were divided into groups in order to use the tool to analyze case studies of health services in a number of countries. Each group reported their findings to the larger group.*

While the focus of the tool, “Integrating Gender into HIV/AIDS Programmes in the Health Sector,” is the health sector, WHO recognizes that actions to address gender lie in multi-sectoral approaches to mainstream gender throughout legal, policy, economic, and educational sectors.

The first module of the tool provides a method to analyze how well gender is incorporated into a clinic and the delivery of care and includes a checklist for health care program managers to see how well they are incorporating gender into their programs. The tool focuses on women and girls, recognizing that gender affects both men and women and requires strategies affecting both; within a conceptual framework of inequalities, gender disadvantage, or discrimination, however, women and girls are disproportionately affected. This should not be conflated with epidemiological-based analysis of which populations to focus on in different settings. For example, in concentrated epidemics, the needs of SWs and PWID should be addressed in a gender and rights framework; in generalized epidemic settings, approaches will be different. Regardless of the epidemiological setting, the overall focus is on women and girls.

The tool can be used to screen women for GBV and train health care providers to have a sympathetic attitude and not blame or judge women experiencing GBV. The tool can train health care providers to inform each woman of her rights, the services available to her, and to help each woman make her own choices about her relationships. Health care providers will be able to discuss the implications of violence a woman is experiencing with regard to risk of HIV, disclosing her HIV status, and living with HIV.

The tool was field-tested in five countries: Belize, Honduras, Nicaragua, Sudan, and Tanzania. In Tanzania, managers and service providers of HTC, PMTCT, and treatment, care and support services were trained to use the tool. WHO partnered with civil society, the U.N. Population Fund,

the Ministry of Health, and *Deutsche Gesellschaft für Technische Zusammenarbeit* and provided six months of follow-up support. In Sudan, gender assessments of HTC centers were conducted, gaps identified, and national operating procedures for counseling and testing revised. In Belize, Honduras, and Nicaragua, joint teams of women's groups and Ministry of Health and WHO staff conducted assessments on how HTC centers could address violence against women. The tool can be used in capacity building of national HIV programs, contribute to the development of national HIV plans, and be used with GFATM-supported programs.

# EMERGING ISSUES: GENDER AND MALE CIRCUMCISION

*Kelly Curran, Director, HIV and Infectious Diseases, JHPIEGO, provided an overview of the research literature on the impact of MC on HIV acquisition and program and service delivery issues that should be considered when providing circumcision services.*

MC is the complete surgical removal of the foreskin of the penis. Traditionally, MC is performed either in infancy or in adolescence as a rite of passage to adulthood. Researchers first noted that MC was correlated with lower HIV prevalence rates in the late 1980s; the data was published in *The Lancet* a decade later in 1999. Uncircumcised men are more vulnerable to STIs, especially the ulcerative STIs, which researchers theorized contributed to HIV vulnerability. A meta-analysis by Weiss and colleagues in 2000 found consistent evidence of a protective effect at the population level as well as among high-risk groups.<sup>6</sup> Three randomized clinical trials conducted from 2005 to 2006 in Kisumu, Kenya; Rakai, Uganda; and Orange Farm, SA, were all stopped early when analysis showed a 60 percent reduction in HIV acquisition among newly circumcised men. In March 2007, WHO and UNAIDS issued guidance that MC should be scaled up in high HIV prevalence countries where the rate of MC was low (i.e., eastern and southern Africa) as part of a comprehensive HIV prevention strategy. Concern about behavioral disinhibition or risk compensation (i.e., men who were circumcised might engage in unprotected sex or increase their number of partners) arose soon after these recommendations were issued; subsequent analysis has shown a slight increase in risk behaviors in the SA cohort, but not in the cohorts in Kenya or Uganda. MC is currently being rolled out as part of a WHO-defined minimum package of services that includes HIV risk reduction counseling, STI screening and treatment, HIV testing and counseling, and condom promotion.

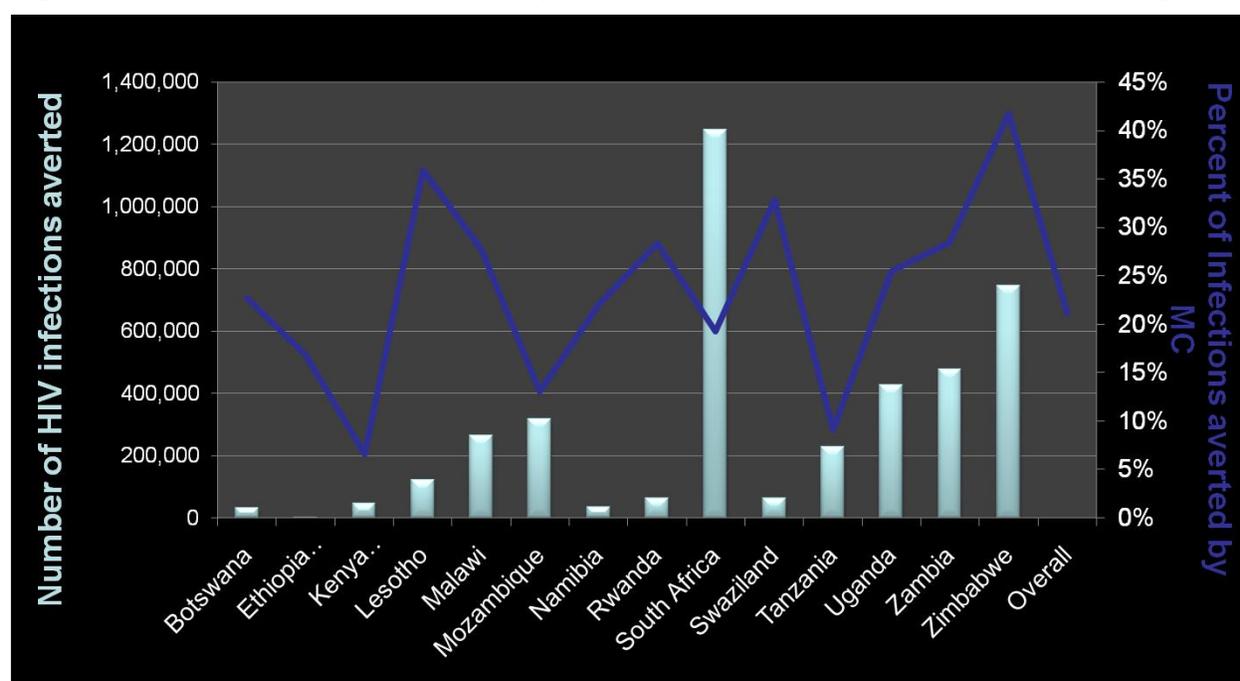
## INFECTIONS AVERTED AND COST OF MALE CIRCUMCISION

MC has been shown to reduce the acquisition of human papilloma virus (HPV), herpes simplex virus-2, and genital ulcer disease among men and acquisition of HPV and cervical cancer, bacterial vaginosis, and genital ulcer disease among women. Estimation models have shown that, at an 80 percent coverage level, more than 4 million new HIV infections could be averted and MC could avert 40 percent of new HIV infections by 2025 (see Figure 3). To achieve this result will require that 28 million MCs are performed between 2009 and 2014, costing approximately U.S.\$1 billion. But spending these funds on MC will save U.S.\$20.2 billion in treatment costs through 2025, at a cost of less than U.S.\$750 per infection averted.

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<sup>6</sup> Weiss, H.A., M.A. Quigley, R.J. Hayes. 2000. Male circumcision and risk of HIV infection in sub-Saharan Africa: a systematic review and meta-analysis. *AIDS*. 14(15):2361-70.

**Figure 3. New HIV Infections Averted (Cumulative 2009 to 2025; 80 Percent Coverage)**



Source: *Male Circumcision: Review of the Evidence and Gender Issues*, presented by Kelly Curran, JHPIEGO, October 29, 2009.

Randomized clinical trials have been conducted in Rakai, Uganda, to assess if MC would reduce the transmission of HIV from men living with HIV to their female partners not living with HIV. Extensive risk reduction counseling was provided to the men and their partners, who were also provided with condoms and STI treatment. The trial was stopped early as there was no evidence that continuing would result in a statistically significant effect size (significantly reduced transmission to female partners). The study showed that MC is safe in men living with HIV with CD4 above 200; however, wound healing takes slightly longer. One concerning trend noted by the researchers was that some couples resumed sex before wound healing was complete.

In countries where female genital cutting is practiced, the message must be reinforced that MC and female genital cutting are not related and female genital cutting offers no health benefits to women (or men) but instead puts women at significant health risks. Whether or not MC is protective for MSM is still not known; risk for MSM is primarily from being the receptive partner. MC offers a good opportunity to engage young men and young couples seeking services, in counseling about reproductive health issues as well as MC.

## **WOMEN AS PROVIDERS OF MALE CIRCUMCISION**

JHPIEGO and other partners providing training and support to service delivery sites report that medical MC clients accept female providers; their primary concern is the skill level, not the sex, of the provider. It was helpful to let men know during counseling if they will have a female provider or assistant so there are no surprises in the procedure room. When conducting outreach on MC to initiation schools (to link initiation rites with safe medical MC) all male, all circumcised teams are needed, as all traditional circumcision is done by circumcised men.

## **WOMEN AS PARTNERS AND PARENTS**

In many settings, men are encouraged to come for MC by their female partner (or mother in the case of adolescents). Some women attend MC counseling with their partner and a few women have accompanied their husbands into the procedure room. Female partners should be invited to the MC clinic as sometimes this is the first time young couples have had the chance to ask questions about sexual and reproductive health. However, many MC clients are too young to have a steady partner. For infants, in some settings, mothers can consent for infant MC by themselves; in other communities, fathers also need to be involved (for cultural reasons).

Programmatic implications of MC include the following:

- Target men not living with HIV (but men living with HIV will not be denied services)
- Provide counseling on the risks of resuming sex prior to wound healing for all men, but especially men living with HIV
- Invite female partners of MC clients to the clinic for couple counseling; women also need to know about abstinence during wound healing and risk reduction strategies thereafter
- Develop MC communication materials specifically for women.

MC is a highly effective intervention to reduce HIV infection and, assuming high coverage rates, could prevent four million new HIV infections among men, women, and children in eastern and southern Africa in the next 15 years. MC services provide an opportunity to engage men and couples in HIV prevention and sexual and reproductive health, and women have a key role to play in MC as partners, parents, and service providers.



# MEASUREMENT IN PEPFAR II

## EVALUATING GENDER-BASED PROGRAMS: A FOCUS ON ENGAGING MEN/BOYS FOR GENDER EQUITY

*Dr. Julie Pulerwitz, Director HIV/AIDS and Tuberculosis Global Program, PATH, gave a presentation on the development and testing of the GEM scale which was developed and pilot tested through a collaboration between PATH, Population Council, Promundo (Brazil), Committee of Resource Organizations (India), Academy for Educational Development, Johns Hopkins University Center for Communications Programs, EngenderHealth, LifeLine/ChildLine, Hivot, RFS, and Miz-Hasab (Namibia and Ethiopia).*

There is increasing support for explicitly addressing gender dynamics and engaging men in HIV prevention programs because common male gender norms can increase HIV risk behaviors and partner violence (e.g., male norms of having multiple sexual partners and entitlement to sex). There is also growing evidence of effective interventions, evaluation strategies, and measures. There are, however, a number of key challenges related to measuring change in gender norms. First, while there is much agreement on the importance of gender in HIV prevention and other services, there is no consensus on how to operationalize gender. Second, the most effective research or program design(s) may not have been identified. There may be many programs going on at the same time in a site or area, so it is difficult to attribute change in gender norms to a specific program. And third, rigorous evaluation designs are rare and resource-intensive, and instruments and tools to explicitly measure gender focus are lacking. From 2001 to 2009, a number of researchers and programs have been collaborating on a series of studies to answer the following questions: How can we measure gender norms and social change in support for equitable norms? What is the relationship between support for gender equity and HIV risk/other health outcomes? How can we promote gender-equitable norms and HIV and violence risk reduction, for both men and their partners? How successfully can we adapt strategies and measures to different cultural contexts?

A literature review was completed, followed by qualitative research conducted in Brazil; findings from these activities informed the development of numerous survey items, which became the GEM scale.<sup>7</sup> The GEM scale measures support for (in)equitable gender norms in key areas: sexuality, violence, reproductive health, and domestic life. Examples of items in the scale include the following: “There are times that a woman deserves to be beaten”; “Men are always ready to have sex”; “Women who carry condoms are ‘easy’”; and “A man should have the final word about decisions in his home.” A study was conducted with a representative sample of 749 men aged 15 to 60 years of age in a number of communities in Rio de Janeiro to assess the validity and reliability of the GEM scale. After analysis of the data in Brazil, the final scale had 24 items with an internal consistency of  $\alpha = 0.81$ , showing it to be internally reliable.

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<sup>7</sup> Pulerwitz, Julie, and Gary Barker. 2008. Measuring attitudes toward gender norms among young men in Brazil: Development and psychometric evaluation of the GEM Scale. *Men and Masculinities*. Vol. 10, No. 3. 322-338.

The GEM scale was then adapted to other cultural contexts. In India, culturally relevant items were developed and added to the original survey. The adapted survey was administered to a sample of men. After analysis, the scale contained 15 items: 11 original items and 4 India-specific items. An example of one of the India-specific items is as follows: “A married woman should not need to ask her husband for permission to visit her parents/family.” The internal consistency of the Indian version of the GEM scale was  $\alpha = 0.75$ . The GEM scale was then adapted for Ethiopia. Original and Ethiopia-specific items were included in a survey administered to 522 married Ethiopian men. An example of a new item for Ethiopia is as follows: “A woman who has sex before she marries does not deserve respect.” After analysis, 24 items remained: 18 original and 6 new ( $\alpha = 0.88$ ).

These pretests of the GEM scale showed support for inequitable gender norms and health outcomes but with variations between countries. For example, Brazilian urban young men were more likely to report partner violence and less contraceptive use, Indian rural young men were more likely to report multiple partners and partner violence, and Ethiopian married men were less likely to report discussing and using contraceptives and condoms, and waiting for consensual sex with their wives.

With this background, collaborating organizations developed an intervention framework based in the ecological model and focused on facilitating critical reflection by men of gender norms in intimate relationships and the “costs” of inequity. The intervention included a number of integrated components: interpersonal group education, community-based behavior change communications to reinforce messages, community mobilization, and the participation of target audiences.

The intervention, called Program H, was conducted with the collaboration of Promundo, an NGO based in Brazil. It was a quasi-experimental design with three arms: group education, group education plus community-based behavior change communication, and a comparison group. Pre- and post-test surveys were conducted with three groups of young men aged 15 to 24 years followed over one year (a total of 780 men at baseline with a more than 75-percent response rate). In-depth interviews were conducted with a subset of young men and their partners, monitoring forms were developed, and an intervention implementation cost analysis was performed. Results showed that in both intervention arms, young men were significantly less likely to support inequitable gender norms (GEM scale) at the 6- and 12-month follow-up. There were no changes in gender norms in the comparison group. Men who decreased their support for inequitable norms were also significantly less likely to report STI symptoms and more likely to report condom use with primary partners over time. The intervention also increased condom use at last sex to 58 percent at six-month follow-up in one site (Bangu) that had the combined intervention with no significant change in the other intervention site, nor in the comparison group. At one year, positive change in the combined intervention arm site (Bangu) was maintained and improved (87 percent), and positive change occurred in the other intervention site (Mare) as well (87 percent). No one-year follow-up data were collected from the comparison site.

A similar quasi-experimental, three-arm design study, called Yari-Dosti, was conducted in India with interventions adapted for the Indian context. The interventions consisted of community campaign plus group education, group education alone, or no intervention in the comparison sites. Pre- and post-surveys and in-depth interview data were collected. The study population were young men aged 16 to 29 years of age ( $n = 537$ ) living in Mumbai. The study saw a significant increase in the percent of men with overall high gender equity norms among respondents in the two intervention arms (with the greatest increase in the community campaign plus group education arm). Respondents in both intervention arms also reported a decrease in violence against any partner at three months postintervention.

The PEPFAR Male Norms Initiative was launched in Ethiopia, Namibia, and Tanzania to provide technical assistance to local groups to engage men to address GBV and increase HIV risk reduction behaviors. The Male Norms Initiative is currently conducting process and outcome evaluations in the three countries.

In Ethiopia, the Male Norms Initiative is a quasi-experimental intervention study, adapted from the Program H and Men as Partners studies, with three groups of young men aged 15 to 24 years of age recruited from HIV clubs. The intervention arms consist of community mobilization (e.g., theater and marches) plus group education, community mobilization alone, and a comparison group. Baseline surveys were conducted with 729 men and end-line surveys conducted with 647 men. In-depth interviews were done with a subgroup of participants and their primary partners (n = 23 couples). Key informant interviews were also conducted with intervention staff. At baseline, there was substantial support for inequitable norms: 58 percent agreed that “a woman should tolerate violence in order to keep her family together”; 12 percent agreed that “a man should be outraged if his wife asks him to use a condom”; 50 percent agreed that “a woman should obey her husband in all things”; and 35 percent agree that “a man needs other women, even if things with his wife are fine.”

By the end of the study, support for gender equity had increased in both intervention arms; young men were less likely to support inequitable gender norms at six-month follow-up while there was no change in the comparison group. After controlling for key variables (e.g., age and education), only the combined intervention resulted in significant change in equitable gender norms. There was also significant reduction in self-reported episodes of violence against intimate partners in the last six months in both intervention groups.

These studies support the reliability and validity of the GEM scale to measure changes in gender norms. The tools, interventions, and strategies were successfully used and adapted in each country and show evidence that programming which addresses gender norms is associated with reduced HIV/STI risk and partner violence. Interactive group education was a key strategy for increasing support for gender equity; combined interventions with a community-based component was often most successful in leading to change.

## **MONITORING AND EVALUATING GENDER-RESPONSIVE HIV PROGRAMS**

*Arni Amin, Technical Officer, Department of Gender, Women and Health, WHO, shared some of the strategies, indicators, and tools being used by WHO to strengthen the gender-responsiveness of programs and service.*

There are a number of challenges related to adding new gender indicators: defining them, piloting them, and controlling the burden on programs to collect them. Despite these challenges, it is important to have a way of capturing the gender components of a program and documenting the effects of gender programming on outcomes.

Gender-responsive programming is often about the process of changing how programs are instituted, and qualitative indicators may be needed to capture the implementation process, which is often context-specific. One place to start is to look at existing gender indicators or indicators in another area that, while not necessarily gender-specific, can also capture gender programming. Examples of such indicators include:

- Health status indicators or gender-responsive or -sensitive health indicators (e.g., percentage of young women and men 15 to 24 years of age who are living with HIV)
- Health system performance indicators/quality of care indicators (e.g., percentage of pregnant women whose partners were tested for HIV, either individually or as part of a couple)
- Determinants of health indicators—gender equality indicators (e.g., measure of prevalence of violence against women or attitudes toward violence against women).

Monitoring and evaluating gender-responsive HIV programming requires collaboration across a spectrum of areas:

- Policy and planning for gathering, analyzing, and using disaggregated data
- Health information systems to enable appropriate disaggregation of routine program indicators
- Clinic staff and managers for collecting, compiling, and using disaggregated data
- Trainers to strengthen the capacity of staff to collect, compile, interpret, and analyze gender-responsive indicators
- Communities to participate in the M&E process.

**Developing gender-responsive HIV testing and counseling M&E indicators.** If one of the main objectives of a program is to increase the uptake of HTC services by young women (aged 15 to 24 years), staff should ask questions such as, “What barriers do young women face in accessing HTC services?” “How can counselors better address the counseling needs of young women?” “What kinds of resources, staffing, and policies are needed to increase uptake of counseling and testing?” “Should targets be set for reaching young women with information about HTC services that is tailored to their needs?” and “How can young women be involved in design and implementation of the program?”

Gender-sensitive indicators are needed at various levels of monitoring. Examples include the following.

- **Process** (training, logistics, management, and education): Number of male and female counselors who have undergone training to address violence against women; availability and display of youth-friendly HIV education materials in publicly accessible areas of the facility.
- **Output** (includes young women receiving quality HTC services): Number of providers who discuss safer sex negotiation and prepare disclosure plan with young women; proportion of young women referred to support groups, sexual and reproductive health services, and prevention programs.
- **Outcomes** (UN General Assembly Special Session indicators): Percentage of young women (aged 15 to 24 years) who have had sex with a non-marital, non-cohabiting sexual partner in the past 12 months; percentage of young women (aged 15 to 24 years) reporting condom use the last time they had sex with a non-marital, non-cohabiting partner.
- **Impact:** Percentage of young women (aged 15 to 24 years) who are living with HIV.

WHO has developed checklists that country programs can use to monitor how gender-responsive programs are. The checklist for counseling and testing services servicing young women (Figure 4) is one example of the tools available.

**Figure 4. Checklist for Monitoring Progress**

Questions to measure gender-responsive characteristics of service delivery	No (score = 0)	Yes (score= 1)
<p>2.2.6 <i>Provider encourages partner testing and involvement as follows:</i></p> <ul style="list-style-type: none"> <li>a. Supports and facilitates involvement of male partners with female partners' request or permission.</li> <li>b. Promotes HIV testing for partners as part of an effort to improve the health of entire families.</li> <li>c. Provides clients with information about HIV services offered for male partners and family members.</li> <li>d. Conducts community sensitization on testing, treatment and care services available for men.</li> <li>e. Offers the client the option of returning with her partner for couple testing and counselling, thus possibly reducing the burden of blame on the partner who tests first.</li> <li>f. Asks each person in a couple to separately and voluntarily consent to HIV testing.</li> <li>g. Emphasizes the confidentiality of the results, and that disclosure of the individual results to the other partner will be done with the consent and involvement of each member of the couple.</li> <li>h. Emphasizes the shared responsibility of the members of each couple for health decisions.</li> <li>i. In post-test counselling, depending on the results of one or both members of a couple, assists with managing feelings of blame, anger and anxiety and preventing escalation to physical or verbal abuse.</li> </ul>		

Source: WHO Tool to Integrate Gender into HIV/AIDS Programs in the Health Sector: Its Development and Use in Countries, presented by Avni Amin, WHO, October 30, 2009.

## **INDICATORS FOR PRIMARY PREVENTION: SASA! STUDY ON PREVENTING VIOLENCE AGAINST WOMEN AND HIV IN KAMPALA**

*Sara Siebert, Raising Voices, described the Me&E methods for the new SASA! Activist Kit for Preventing Violence against Women and HIV developed by Raising Voices. SASA! is being piloted in Kampala by the Center for Domestic Violence Prevention (CEDOVIP). Through a collaboration with the London School of Hygiene and Tropical Medicine, Makerere University, and CEDOVIP, Raising Voices developed indicators to track incremental changes in knowledge, attitudes, skills, and behaviors related to violence against women and HIV, and is undertaking a cluster randomized trial to measure the success of the SASA! methodology in action. On this panel, the cluster randomized trial was discussed briefly, along with two simple data collection forms that collect meaningful data to inform quality violence against women prevention work.*

Social change takes time, but it is not sufficient to wait until the end of a multi-year program to track progress toward change. Intermediate indicators are needed to monitor trends in knowledge, attitudes, skills, and behaviors in order to understand if long-term change is occurring.

SASA! activities are organized into four phases to influence community norms: *Start*, *Awareness*, *Support*, and *Action*. The overall objective of the start phase is to increase knowledge and change attitudes about HIV and GBV among staff and community activists. The objective of the awareness phase is to increase knowledge and change attitudes about HIV and GBV among members of the community. In the support phase, skills to address GBV are built, and the objective of the action phase is to realize behavior change. As the program is implemented, there are indicators to monitor changes or “shifts” in these four domains. For example:

**Knowledge**—Shifts toward understanding that:

- Violence may be physical, emotional, sexual, and economic
- Violence against women has negative consequences
- Women who experience violence are at risk for HIV.

**Attitudes**—Shifts toward agreeing that:

- Violence against women is never acceptable
- Women and men should balance power in a relationship
- Women and men should share roles in their families and community.

**Skills**—Shifts toward ways to:

- Use alternatives to violence in relationships
- Reach out to support women experiencing violence
- Support activists who speak out against violence against women.

**Behavior**—Shifts toward couples who:

- Balance power in their relationships
- Do not use/experience violence
- Promote nonviolence in their community.

The project created easy-to-use tools to fill the gap in process and outcome monitoring for primary prevention and can be used at different points to assess progress. The tools include an outcome tracking form, an activity report form (see Figure 5), a rapid assessment survey, among others. It also includes formats and templates for timelines, focus group discussions, exit interviews, most significant change documentation, and case studies.

**Figure 5. Activity Report Form and Rapid Assessment Survey**



### Community Activity Report Form



Strategy: \_\_\_\_\_ Phase: \_\_\_\_\_

Activity	Date	Parish/Zone	Attendance Breakdown:			Total Number of People Attended
			Women	Men	Youth/ Children	

Main Activity Topic(s): .....

Facilitator Name(s): .....

Type of facilitator (circle): CA    Drama group    Ssenga    LC    SASA! Activist    Staff

<p><b>Ranking Scale: 1 = poor, 2 = fair, 3 = good, 4 = very good, 5 = excellent</b></p> <p><b>1. Activity Analysis</b></p> <p>a. Quality of mobilization    Rank.....</p> <p>b. Relevance to phase    Rank.....</p> <p>c. Level of interest    Rank.....</p> <p>d. Level of Participation</p> <p style="padding-left: 20px;">Men    Rank.....</p> <p style="padding-left: 20px;">Women    Rank.....</p> <p>e. General response to ideas    Rank.....</p> <p>f. Dynamic/ Exciting activity    Rank.....</p>	<p><b>2. Facilitator Skills</b></p> <p>a. Content mastery    Rank.....</p> <p>Comment:</p> <p>b. Probing/ Creating good learning environment    Rank.....</p> <p>c. Positive feedback to group    Rank.....</p> <p>d. Respect to the group    Rank.....</p> <p>e. Involve all    Rank.....</p> <p>f. Confidence    Rank.....</p> <p>g. Can focus discussion    Rank.....</p> <p>h. Summary    Rank.....</p>
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Successes/ Challenges: \_\_\_\_\_

Community comments: (1-3 comments maximum)

**SASA! Rapid Assessment Survey Questions:**  
Baseline / Start Phase

Questionnaire Number \_\_\_\_\_ Date \_\_\_\_\_

Hello, my name is \_\_\_\_\_ and I work for \_\_\_\_\_. If you don't mind, I would like to ask you a few questions about your thoughts about men and women's relationships, and your attitudes toward violence against women. This should not take much of your time, and you can choose to stop the interview at any time, or to skip any questions if you like. Yes responses are confidential, and your name will not be written down. We will use the information that you provide to plan activities and to see how well we are doing in our project.

Do you have any questions? \_\_\_\_\_

Are you happy to proceed with the interview? Yes  No

(IF NO, THANK AND SAMPLE SOMEONE ELSE)

Please feel free to tell me your honest views. There are no right or wrong answers.

Sex of Respondent (circle one): Female    Male    Age of Respondent: \_\_\_\_\_

**Knowledge**  
Please answer yes or no to the following questions as honestly as possible.

1	Is violence against women normal in relationships?	Yes ..... 1	No ..... 0
2	Can a woman refuse her partner if she doesn't want to have sex?	Yes ..... 1	No ..... 0
3	When men discipline their wives does it make their families stronger?	Yes ..... 1	No ..... 0
4	Should a woman tolerate violence in order to keep her family together?	Yes ..... 1	No ..... 0
5	Are women experiencing violence from a partner at higher risk for HIV infection than other women?	Yes ..... 1	No ..... 0

**Attitude**  
Please answer yes or no to the following questions as honestly as possible.

6	Do you think that a man has a good reason to hit his partner if she does not do the housework to his satisfaction?	Yes ..... 1	No ..... 0
7	Is violence against women a community concern?	Yes ..... 1	No ..... 0
8	Do you think that women are to blame for the violence against them?	Yes ..... 1	No ..... 0
9	Does balanced power in a relationship benefit both the woman and the man?	Yes ..... 1	No ..... 0
10	Would you laugh at a man doing housework?	Yes ..... 1	No ..... 0

Source: *Linked Outcomes: Prevention of Violence Against Women and HIV*, presented by Sara Siebert, Raising Voices, October 30, 2009.

# STRATEGIES FOR THE INTEGRATION OF GENDER IN NATIONAL HIV PLANS AND LEGAL REFORMS

*Angeline Siparo, Senior Technical Advisor, Eastern Africa Region, USAID Health Policy Initiative/Futures Group, summarized findings from a recent gender audit in Kenya that was undertaken to understand the extent to which gender is integrated into the national structures and the processes through which HIV initiatives are prioritized, monitored, and evaluated. Siparo highlighted the important contribution PEPFAR could make by ensuring gender is on the table during partnership framework discussions.*

There are many pressing issues facing governments, and it is critical to obtain consensus from different stakeholders on policy issues that have achievable goals, have high impact solutions, are easily understood, and will have an impact on many people. Most countries have national strategic plans aligned to policy priorities and strategic focuses. Partnership frameworks are meant to align priorities into the national framework plan, but in the past PEPFAR priorities have not always been a perfect fit with national priorities. This problem is exacerbated by resentment by some in government that the USG does not contribute to basket funding structures used by other donors and that USG funding goes primarily through NGOs.

Alignment between PEPFAR and governments requires a multi-step process:

- Agreement on the key policy issues:
  - Advocacy during the planning sessions and prioritization is required
  - Leadership on the part of PEPFAR is necessary.
- PEPFAR must be seen as a genuine partner, committed to meeting the goals of the country not just USG interests:
  - Good advocacy skills are essential, especially in consensus building.
- Clarity on the gender-related needs of the country:
  - PEPFAR to be part of the team doing the analysis
  - Cooperating agency(ies) leading the effort must be seen by government as a respected, genuine partner(s)
  - PEPFAR needs to negotiate space at the table.

Advocacy is a process that is implemented over time, is strategic, and uses well-designed activities. Advocacy efforts seek to influence decision makers, whether public or private, national, regional, or local, regarding the enactment and implementation of policy, laws, regulations, programs, and/or allocation of funding.

In terms of gender integration, there are currently two key elements missing: planning and resources. These are possible points of entry for PEPFAR as it begins developing partnership frameworks with governments.

## FINDINGS FROM THE GENDER AUDIT IN KENYA

The goal of a recently published gender audit in Kenya was to understand to what extent gender is integrated into the national structures and the processes through which HIV initiatives are prioritized, monitored, and evaluated. Findings from the audit may inform future proposals for effective gender integration. The target audiences for this report included HIV policy makers, program managers, researchers, implementers, development partners in public and private sectors, and civil society. The audit suggested that the biggest challenge facing Kenya today is creating an enabling environment for gender equality, translating commitments into action with concrete strategies to eliminate persistent gender inequality, and recognizing the roles of women and men in the development of the country.

The audit showed that most stakeholders and implementers working in HIV do not have basic gender awareness and sensitization and very limited capacity on gender in general, gender in relation to HIV, and gender integration in the national HIV response. There is inadequate capacity on gender among organizations at the community level as well. Moreover, there is considerable resistance toward the term *gender* as it is perceived to be championing women's rights, which disrupts the social order.

The audit showed there is weak coordination between the National AIDS Control Committee (NACC) and government ministries. The gender desks are largely non-functional and have weak linkages with HIV control units and/or NACC. There is little coordination between women rights organizations, human rights organizations, and intersectoral and interagency organizations. The roles of departments of reproductive health, the National AIDS and STI Control Programme, and other stakeholders are not harmonized; such harmonization (in terms of who is responsible for what) is critical for PMTCT programs. However, PMTCT and reproductive health reporting systems are not integrated.

Despite outstanding work by the gender technical committee with technical assistance from various partners, there is still a lack of adequate financial commitment to mainstream gender within the NACC. There is no specific budget line for gender under the Total War Against HIV and AIDS, the four-year multimillion dollar World Bank/Department for International Development/Government of Kenya-funded project. Government funding is not commensurate to the gravity of the epidemic and has not cascaded effectively to the decentralized levels in most sectors. While there is much discussion about the importance of gender, other donors have yet to seriously commit their funding to gender-responsive programs.

To support the development of the national HIV response, gender-sensitive indicators are needed that monitor change in structure and process, programs, and financing.

In order to integrate gender into the national response, an enabling environment will require the following:

- Legal and policy frameworks that support advancement of gender equality and equity
- Political and administrative will and commitment to gender equality and equity among the highest levels at NACC
- Capacity building for all stakeholders
- Women and gender expertise represented at the highest levels of decision making
- Adequate human and financial resources for gender integration

- Creation and adoption of gender-sensitive indicators.

## **THE WAY FORWARD IN PARTNERSHIP FRAMEWORKS**

Government and implementing partners must feel like true partners and that their collaboration with PEPFAR addresses the local context and the government's priorities. Unless they are made to feel like they have input in the planning, stakeholders will not participate. To strengthen collaboration with the government of Kenya (and with other governments entering into partnership frameworks with PEPFAR), PEPFAR might consider the following:

- Focusing on true empowerment of local actors and organizations
- Deepening its understanding of gender issues in the country
- Establishing a regional gender technical assistance center similar to the UNAIDS' technical support facility
- Providing assistance to countries to develop gender indicators
- Gaining expertise in the advocacy processes and linking advocacy to empowerment
- Clarifying gender concerns with in-country host governments (e.g., put gender language into partnership frameworks)
- Strengthening gender integration by allocating resources to build capacity in gender programming and expertise in gender-responsive programming at the national, district, and local levels.

Finally, commitment and funding to develop gender indicators that reflect the far-reaching impact of HIV in Kenya are greatly needed. Current indicators do not capture the differential impact of HIV on men and on women. For example, when women are illegally denied their family property after the death of their husbands, ensuing poverty exacerbates women's HIV risk. When women are denied their legal property rights, women experience both epidemics of HIV infection and human rights violations.

# PEPFAR NEXT GENERATION INDICATORS

*Clint Liveoak, Public Health Advisor, Global AIDS Program, Centers for Disease Control and Prevention (CDC), acting co-chair of the GTWG, provided an update on reporting requirements, new indicators, and tools and resources to assist USG teams.*

The PEPFAR reauthorization bill recognizes the importance of gender, elevates its priority, underscores the technical approach described in the initial PEPFAR authorization bill, and outlines concrete gender planning, implementation, and reporting requirements. This includes “specific targets, goals, and strategies... to address the needs and vulnerabilities of women and girls to HIV/AIDS,” and a “study of progress toward achievement of policy objectives,” that includes “an assessment of efforts to address gender-specific aspects of HIV/AIDS including gender-related constraints to accessing services and addressing underlying social and economic vulnerabilities of women and men.”<sup>8</sup>

To accomplish the activities described in the reauthorization bill, PEPFAR will be enhancing its planning, implementation, reporting, and evaluation activities:

## **COUNTRY OPERATIONAL PLAN GENDER TECHNICAL NARRATIVE AND GENDER-BASED VIOLENCE BUDGETARY ATTRIBUTION REQUIREMENTS**

The requirement of a gender program technical narrative in the fiscal year 2009 COP helped country teams think about gender in a more data-driven and strategic manner. This also allowed the GTWG to identify gaps, trends, and areas for increased attention in the near term. A priority of the GTWG will be to assist countries to do further gender analyses and use results to guide programming. Key tools that the GTWG will use in supporting PEPFAR programming include use of the gender programming assessment as well as logic frameworks developed for each of the key PEPFAR gender strategies.

In addition, in fiscal year 2010 COP, countries were asked to include a new cross-cutting budget attribution indicator: reducing violence and coercion/GBV. This information will allow PEPFAR to better address this important issue. The COPs will also continue to track other gender-related areas (increasing women’s legal rights and protection, increasing gender equity in HIV activities and services, addressing male norms and behaviors, and increasing women’s access to income and productive resources) through selection of “priority areas” checkboxes in the COP.

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<sup>8</sup> U.S. Congress. Tom Lantos and Henry J. Hyde United States Global Leadership Against HIV/AIDS, Tuberculosis, and Malaria Reauthorization Act of 2008. 110<sup>th</sup> Congress, 2<sup>nd</sup> session, 2008. Page 11. Available at [www.gpo.gov/fdsys/pkg/BILLS-110hr5501enr/pdf/BILLS-110hr5501enr.pdf](http://www.gpo.gov/fdsys/pkg/BILLS-110hr5501enr/pdf/BILLS-110hr5501enr.pdf) (accessed November 2009)

# PEPFAR NEXT GENERATION INDICATORS AND PARTNERSHIP FRAMEWORK

The PEPFAR next generation indicators and establishment of partnership frameworks reflect USG’s strategy to increase country ownership of HIV efforts and ensure that host countries are at the center of decision making, leadership, and management of their HIV programs. In addition, the next generation indicators and partnership frameworks seek to strengthen country programs with the inclusion of “coverage” and “quality” measurements, as well as a several policy-level indicators.

The next generation indicators include a set of required and recommended indicators. The only required gender-related indicator is for provision of post-exposure prophylaxis (PEP). Provision of PEP is an important component of comprehensive GBV programming, and this indicator will enable PEPFAR to track progress in this area (see Figure 6).

**Figure 6. PEPFAR’s New PEP Required Indicator**

Prevention Sub Area 6: Post-Exposure Prophylaxis					
P6.1. D	PEPFAR Output	Routine Program	1	Number of persons provided with post-exposure prophylaxis (PEP)	PEPFAR Gender and Injection Safety TWGs
				By exposure type: Occupational, Rape/Sexual Assault Victims, or Other Non-Occupational	
P6.2. N	National Outcome	Intermittent: Facility survey, special study	2	Percentage of health facilities with HIV post-exposure prophylaxis (PEP) available	UNAIDS Additional #1; GF Prevention #HIV-P15
				By exposure type: Occupational and Non-Occupational	

Source: *Measurement in PEPFAR II*, presented by Clint Liveoak, CDC, October 30, 2009.

The next generation indicators also include a set of “recommended” indicators that PEPFAR country teams can use to monitor and track progress in several key gender strategies (Figure 7). While these are considered “recommended” indicators, the GTWG does encourage their use by country teams seeking to enhance and improve their gender programming.

In addition to these program-related measurements, gender is also one of seven priority policy areas that was selected for inclusion in the partnership framework and next generation indicators guidance documents. Measuring progress toward the achievement of policy reform goals and objectives is a relatively new focus for PEPFAR. Six stages are proposed to track this progression, starting from initial conceptualization and assessment of policy change and continuing through to evaluation of policy implementation. Illustrative gender policy reform areas include the following:

- Addressing policy factors placing women and girls at greater risk for HIV infection, including policies related to concurrent partners, male norms, GBV, and high-risk behaviors of male partners. The approach should take a comprehensive view of these factors and strive to address facilitators and barriers unique to the country context in order to decrease the risk of HIV infection among women and girls.

**Figure 7. Recommended Gender Indicators**

Prevention Sub Area 12: Gender					
P12.1.D	PEPFAR Output	Routine Program	3	Male Norms and Behaviors: Number of people reached by an individual, small-group, or community-level intervention or service that explicitly addresses norms about masculinity related to HIV/AIDS.	PEPFAR Gender TWG
			3	By sex: Male and Female	
			3	By Age (0-15, 15-24, 25+)	
P12.2.D	PEPFAR Output	Routine Program	3	Gender Based Violence and Coercion: Number of people reached by an individual, small group or community-level intervention or service that explicitly addresses gender-based violence and coercion related to HIV/AIDS.	PEPFAR Gender TWG
			3	By sex: Male and Female	
			3	By Age (0-15, 15-24, 25+)	
P12.3.D	PEPFAR Output	Routine Program	3	Women's Legal Rights and Protection: Number of people reached by an individual, small-group, or community-level intervention or service that explicitly addresses the legal rights and protection of women and girls impacted by HIV/AIDS.	PEPFAR Gender TWG
			3	By sex: Male and Female	
			3	By Age (0-15, 15-24, 25+)	
P12.4.D	PEPFAR Output	Routine Program	3	Number of people reached by an individual, small group, or community-level intervention or service that explicitly aims to increase access to income and productive resources of women and girls impacted by HIV/AIDS.	PEPFAR Gender TWG
			3	By sex: Male and Female	
			3	By Age (0-15, 15-24, 25+)	

Source: *Measurement in PEPFAR II*, presented by Clint Liveoak, CDC, October 30, 2009.

- Addressing policy factors that influence men, including the role of men in terms of gender norms, access of men to treatment and, if applicable, opportunities for medical MC.
- Addressing policy and legal reforms needed to increase gender equity in land and property inheritance rights. Specifically, legal and policy interventions to safeguard the inheritance rights of women, particularly women in African countries, due to exponential growth in the number of young widows, orphaned girls, and grandmothers becoming heads of households.
- Institutional capacity building of government ministries, universities, NGOs, and civil society to improve women's legal rights and indigenous women's access to justice, such as:
  - Legal and policy interventions that inform lawyers, prosecutors, law enforcement, and service providers on the legal rights of women, and encourage these groups to enforce these rights through the judicial and legal process.
  - Working with governments and civil society to eliminate gender inequalities in the civil and criminal code.
- Addressing policy and legal reforms related to GBV, specifically:
  - Existence of national anti-GBV/sexual violence laws
  - Attention to GBV within national HIV policies
  - Capacity building of government ministries, institutions (education, health, legal, etc.), NGOs, and civil society to prevent and respond to GBV
  - Policies and laws that address norms that perpetuate GBV.



# CONCLUSION

PEPFAR will continue to promote and scale-up effective gender interventions. Moving forward, PEPFAR will engage in rigorous and expanded evaluation of gender-focused programs and initiatives. The GTWG will work to increase attention to evaluation of gender initiatives and programs, either through stand-alone evaluations or as a component of evaluations and research within other program areas. The PEPFAR partnership frameworks provide new opportunities for collaboration on gender equality, as the Partnership Framework and Partnership Framework Implementation Plan move gender norms to the center of PEPFAR programming and can help build enabling environments to address gender inequality. To accomplish these goals, PEPFAR will strive to ensure appropriate capacity—experience and expertise—is present at the country level. PEPFAR and partners will work to integrate a gender perspective across all program areas with a focus on the following five cross-cutting, gender strategies:

- Increasing gender equity into HIV programs and services
- Reducing violence and coercion
- Addressing male norms and behaviors
- Increasing women’s legal rights and protection
- Increasing women’s access to income and productive resources.

This three-day meeting was a first step towards addressing harmful gender norms, roles, and inequities in HIV programming throughout PEPFAR countries. The level of engagement of the USG headquarters, field staff, and implementing partners through the sharing of their experience and innovative program approaches was an indication of the enthusiasm and dedication to addressing gender inequality under PEPFAR.



# APPENDIX I: AGENDA

## STRENGTHENING GENDER PROGRAMMING IN PEPFAR: TECHNICAL EXCHANGE OF BEST PRACTICES, PROGRAM MODELS, AND RESOURCES

JOHANNESBURG, SOUTH AFRICA, OCTOBER 28–30, 2009

Day One: Wednesday, October 28

Time	Session
8:00–8:30 a.m.	Breakfast
8:30–9:15 a.m.	<b>Welcome</b> <i>Kai Spratt, AIDSTAR-One</i> <ul style="list-style-type: none"> <li>• Introduction of participants</li> <li>• Expected outcomes</li> </ul>
9:15–9:45 a.m.	<b>PEPFAR and Gender</b> <ul style="list-style-type: none"> <li>• Message from Ambassador Goosby, U.S. Global AIDS Coordinator</li> <li>• PEPFAR Gender Framework</li> </ul> <i>Diana Prieto, USAID/Washington, GTWG Co-Chair</i>
9:45–10:45 a.m.	<b>Do You Know Your Epidemic? Analyzing Data with a Gender Lens</b> <i>Sunita Kishor, Macro International/DHS</i> Discussion
10:45–10:55 a.m.	Break
10:55–11:40 a.m.	<b>Gender Continuum</b> <i>Diana Prieto, USAID/Washington, GTWG Co-Chair</i> Presentation followed by group work
11:40 a.m.–12:30 p.m.	<b>Approaches to Comprehensive Gender and HIV Programming</b> <ul style="list-style-type: none"> <li>• Findings and recommendations from AIDSTAR-One Gender Compendium <i>Katherine Fritz, ICRW</i></li> <li>• Case Study from the Compendium: IMAGE Study <i>Lufuno Muvhango</i></li> </ul> Discussion
12:30–1:30 p.m.	Lunch
1:30–3:30 p.m.	<b>Breakout Sessions</b> <ol style="list-style-type: none"> <li>1. Responding to and Preventing GBV               <ul style="list-style-type: none"> <li>• <i>Ian Askew, Population Council</i></li> <li>• <i>Sara Siebert, Raising Voices</i></li> </ul> </li> <li>2. Addressing Male Norms and Engaging Men and Boys               <ul style="list-style-type: none"> <li>• <i>Bafana Khumalo, Sonke Gender Justice</i></li> <li>• <i>Andrew Levack, Engenderhealth</i></li> </ul> </li> </ol>
3:45–5:45 p.m.	<b>Repeat of Breakout Sessions</b>

## Day Two: Thursday, October 29

Time	Session
8:00–8:30 a.m.	Breakfast
8:30–9:15 a.m.	<p><b>Addressing the Vulnerability of Girls and Young Women</b></p> <ul style="list-style-type: none"> <li>• <i>Ian Askew, Population Council</i></li> <li>• <i>Carol Underwood, Johns Hopkins University/Project Search</i></li> <li>• <i>Mary Ellen Duke, USAID/Mozambique</i></li> </ul> <p>Discussion</p>
9:15–10:30 a.m.	<p><b>Addressing Gender within MARPs Programming</b></p> <ul style="list-style-type: none"> <li>• <i>Kai Spratt, AIDSTAR-One</i></li> <li>• <i>Amitrajit Saha, Sonagachi Project</i></li> <li>• <i>Scott Berry, AIDS Project Management Group</i></li> </ul> <p>Discussion</p>
10:30–10:40 a.m.	Break
10:40–11:30 a.m.	<p><b>Addressing Gender within HIV Programs: Counseling and Testing, PMTCT, Treatment, and Care</b></p> <p>WHO tool: Integrating Gender into HIV/AIDS Programmes in the Health Sector</p> <ul style="list-style-type: none"> <li>• <i>Avni Amin, WHO</i></li> </ul> <p>Small group work</p>
11:30 a.m.–12:20 p.m.	<p><b>Emerging Issues: Gender and MC</b></p> <ul style="list-style-type: none"> <li>• <i>Kelly Curran, JHPIEGO</i></li> </ul> <p>Presentation Discussion</p>
12:30–1:30 p.m.	Lunch
1:30–6:00 p.m.	<b>Field Visits</b>
7:30 p.m.	<b>Group Dinner</b>

### Day Three: Friday, October 30

Time	Session
8:00–8:30 a.m.	Breakfast
8:30–9:00 a.m.	<b>Debrief on Field Visits</b>
9:00–10:15 a.m.	<b>Addressing Gender within Policy and Advocacy</b> <ul style="list-style-type: none"> <li>Gender in PEPFAR Partnership Framework/Implementation Plan Guidance <i>Clint Liveoak, CDC/Atlanta, GTWG Acting Co-Chair</i></li> <li>Strategies for the Integration of Gender in National HIV/AIDS Plans and Legal Reforms <i>Angeline Siparo, Health Policy Initiative/Futures Group</i></li> </ul> Discussion
10:15–10:25 a.m.	Break
10:30 a.m.–12:00 p.m.	<b>Gender Indicators</b> <ul style="list-style-type: none"> <li>PEPFAR Next Generation Indicators <i>Clint Liveoak, CDC/Atlanta, GTWG Acting Co-Chair</i></li> <li>Illustrative Program-level Gender Indicators and Other Measures <i>Julie Pulerwitz, PATH, with Andrew Levack, EngenderHealth</i> <i>Avni Amin, WHO</i> <i>Sara Siebert, Raising Voices</i></li> </ul> Discussion
12:00–12:30 p.m.	<b>Open Discussion</b>
12:30–1:30 p.m.	Lunch
1:30–4:00 p.m.	Internal sessions for USG staff

### Day Three: Friday, October 30

#### USG-only Sessions

Time	Session
1:30–2:15 p.m.	<b>Review of Gender in PEPFAR Structure</b> <ul style="list-style-type: none"> <li>COP gender narrative</li> <li>Gender technical considerations</li> <li>GBV secondary budget attribution</li> <li>Gender assessment tool</li> </ul>
2:15–3:45 p.m.	<b>SWOT Analysis</b> <ul style="list-style-type: none"> <li>Small group/country team analysis of portfolios</li> <li>Plenary discussion of key opportunities identified, by technical area and gender strategic area</li> </ul>
3:45–4:30 p.m.	<b>Debrief Discussion</b> <ul style="list-style-type: none"> <li>Identification of gaps</li> <li>Future technical assistance needs</li> <li>Mechanisms for sharing information, resources, and lessons learned</li> </ul>
4:30–5:00 p.m.	<b>Evaluation and Closing</b>



## APPENDIX 2: PARTICIPANT LIST

Name	Email	Country
Anna Johansen	<a href="mailto:ajohansen@usaid.gov">ajohansen@usaid.gov</a>	Angola
Bilibela Billy Paul	<a href="mailto:PaulBB@state.gov">PaulBB@state.gov</a>	Angola
David Kelapile	<a href="mailto:KelapileD@state.gov">KelapileD@state.gov</a>	Botswana
Panda Pankaja	<a href="mailto:PandaP@bw.cdc.gov">PandaP@bw.cdc.gov</a>	Botswana
Irene Ramatala	<a href="mailto:Iramatala@bw.peacecorps.gov">Iramatala@bw.peacecorps.gov</a>	Botswana
Djeneba Coulibaly-Traore	<a href="mailto:coulibalyt@ci.cdc.gov">coulibalyt@ci.cdc.gov</a>	Côte d'Ivoire
Joseph Beugre-Trika	<a href="mailto:trikaj@ci.cdc.gov">trikaj@ci.cdc.gov</a>	Côte d'Ivoire
Oliver Kalombo	<a href="mailto:KalomboO@state.gov">KalomboO@state.gov</a>	Democratic Republic of Congo
Robert Kolesar	<a href="mailto:rkolesar@usaid.gov">rkolesar@usaid.gov</a>	Democratic Republic of Congo
Alemnesh Hailemariam	<a href="mailto:AHailemariam@usaid.gov">AHailemariam@usaid.gov</a>	Ethiopia
Edris George	<a href="mailto:egeorge@usaid.gov">egeorge@usaid.gov</a>	Guyana
Geetha Joseph	<a href="mailto:josephg@in.cdc.gov">josephg@in.cdc.gov</a>	India
Anne Gaven	<a href="mailto:agaven@usaid.gov">agaven@usaid.gov</a>	Kenya
Boaz Nyunya	<a href="mailto:BNyunya@ke.cdc.gov">BNyunya@ke.cdc.gov</a>	Kenya
Makojang H Mahao	<a href="mailto:MahaoMH@state.gov">MahaoMH@state.gov</a>	Lesotho
Antonio J Langa	<a href="mailto:langaaj@state.gov">langaaj@state.gov</a>	Mozambique
Mary Ellen Duke	<a href="mailto:meduke@usaid.gov">meduke@usaid.gov</a>	Mozambique
Magdalena van der Westhuizen	<a href="mailto:mvanderwesthuizen@usaid.gov">mvanderwesthuizen@usaid.gov</a>	Namibia
Ochi Ibe	<a href="mailto:oibe@usaid.gov">oibe@usaid.gov</a>	Namibia
Eugene Zimulinda	<a href="mailto:ZimulindaER@state.gov">ZimulindaER@state.gov</a>	Rwanda
Robert Mason	<a href="mailto:rmason@usaid.gov">rmason@usaid.gov</a>	South Africa
Zanele Mophosho	<a href="mailto:MophoshoZT@state.gov">MophoshoZT@state.gov</a>	South Africa
Lauren Marks	<a href="mailto:lmarks@usaid.gov">lmarks@usaid.gov</a>	South Africa
Roxana Rogers	<a href="mailto:rrogers@usaid.gov">rrogers@usaid.gov</a>	South Africa
Wendy Benzerga		South Africa
Jill Thompson		South Africa
Nonsikelelo Nyoni	<a href="mailto:nyoninn@state.gov">nyoninn@state.gov</a>	Swaziland
Laura Skolnik	<a href="mailto:lskolnik@usaid.gov">lskolnik@usaid.gov</a>	Tanzania
Catherine Muwanga	<a href="mailto:cmuwanga@usaid.gov">cmuwanga@usaid.gov</a>	Uganda
Vincent Bagambe	<a href="mailto:bagambev@state.gov">bagambev@state.gov</a>	Uganda
Stephen Kusasira	<a href="mailto:kusasiras@yahoo.com">kusasiras@yahoo.com</a>	Uganda
Erin Patterson	<a href="mailto:epatterson@peacecorps.gov">epatterson@peacecorps.gov</a>	Ukraine
Jodi Charles	<a href="mailto:Charlesj@vn.cdc.gov">Charlesj@vn.cdc.gov</a>	Vietnam
Nisha Gupta	<a href="mailto:GuptaN@vn.cdc.gov">GuptaN@vn.cdc.gov</a>	Vietnam
Beatrice Hamusonde	<a href="mailto:bhamusonde@usaid.gov">bhamusonde@usaid.gov</a>	Zambia
Cornelius Chipoma	<a href="mailto:cchipoma@usaid.gov">cchipoma@usaid.gov</a>	Zambia

Patricia Sitimela	<a href="mailto:psitimela@usaid.gov">psitimela@usaid.gov</a>	Zambia
<b>PRESENTERS</b>		
Scott Berry (Duncan)	<a href="mailto:scottberry@y7mail.com">scottberry@y7mail.com</a>	Thailand
Carol Underwood	<a href="mailto:cunderwo@jhucpp.org">cunderwo@jhucpp.org</a>	United States
Sunita Kishor	<a href="mailto:Sunita.Kishor@macrointernational.com">Sunita.Kishor@macrointernational.com</a>	United States
Ian Askew	<a href="mailto:iaskew@popcouncil.org">iaskew@popcouncil.org</a>	Kenya
Sara Siebert	<a href="mailto:sara@raisingvoices.org">sara@raisingvoices.org</a>	Uganda
Andrew Levack	<a href="mailto:ALevack@engenderhealth.org">ALevack@engenderhealth.org</a>	United States
Bafana Khumalo	<a href="mailto:Bafana@genderjustice.org.za">Bafana@genderjustice.org.za</a>	South Africa
Lufuno Muvhango	<a href="mailto:lufunok@gmail.com">lufunok@gmail.com</a>	South Africa
Avni Amin	<a href="mailto:amina@who.int">amina@who.int</a>	Switzerland
Kelly Curran	<a href="mailto:KCURRAN@jhpiego.net">KCURRAN@jhpiego.net</a>	United States
Julie Pulerwitz	<a href="mailto:jpulerwitz@path.org">jpulerwitz@path.org</a>	Kinshasa
Amitrajit Saha	<a href="mailto:asaha@path.org">asaha@path.org</a>	India
Angeline Siparo	<a href="mailto:ASiparo@futuresgroup.com">ASiparo@futuresgroup.com</a>	
<b>GTWG MEMBERS</b>		
Nina Hasen, Office of the Global AIDS Coordinator	<a href="mailto:hasenns@state.gov">hasenns@state.gov</a>	
Clint Liveoak, CDC	<a href="mailto:cxq6@CDC.gov">cxq6@CDC.gov</a>	
Diana Prieto, USAID	<a href="mailto:dprieto@usaid.gov">dprieto@usaid.gov</a>	
Emily Osinoff, USAID	<a href="mailto:eosinoff@usaid.gov">eosinoff@usaid.gov</a>	
Talya Karr, USAID	<a href="mailto:tkarr@usaid.gov">tkarr@usaid.gov</a>	
Kimberly Konkel, Department of Health and Human Services	<a href="mailto:kimberly.konkel@HHS.gov">kimberly.konkel@HHS.gov</a>	
Cynthia Simon-Arndt, Department of Defense	<a href="mailto:cynthia.SimonArndt@med.navy.mil">cynthia.SimonArndt@med.navy.mil</a>	
<b>AIDSTAR-ONE</b>		
Kai Spratt	<a href="mailto:kspratt@jsi.com">kspratt@jsi.com</a>	United States
Heather Bergmann	<a href="mailto:hbergmann@jsi.com">hbergmann@jsi.com</a>	United States
Katherine Fritz	<a href="mailto:kfritz@icrw.org">kfritz@icrw.org</a>	United States

# **APPENDIX 3: HANDOUT FOR GROUP EXERCISES**

## **GENDER CONTINUUM: PROJECT EXAMPLES**

### **HIV PREVENTION IN THAILAND**

This HIV prevention project provided education, negotiation skills, and free condoms to SWs in Thailand. Although knowledge and skills among SWs increased, actual condom use remained low. After further discussions with the SWs, project managers realized that SWs were not successful in using condoms because they did not have the power to insist on condom use with their clients. The project then shifted its approach and enlisted brothel owners as proponents of a “100-percent condom-use policy.” Brothel owners, who did have power and authority, were able to insist that all clients use condoms. Because the vast majority of brothels in the project region participated in the project, it resulted in significant increases in safe-sex practices.

### **FEMALE CONDOM PROMOTION IN SOUTH AFRICA**

A pilot program was designed to increase the acceptability and use of the female condom in SA. Historically, female condoms have been promoted to women. After acknowledging that in the African context, men dictate the terms of heterosexual encounters, the program decided to try an innovative approach: the promotion of the female condoms to men by male peer promoters. This involved 1) male promoters demonstrating to men the use of the female condom; 2) explaining to them that self-protection and sexual pleasure are completely compatible with the use of the female condom, especially when compared to currently available barrier alternatives; and 3) giving men female condoms to use with their female partners. Staff based their programmatic approach on research that found that “men are preponderantly concerned with retaining control over the means of protection (while remaining) ambivalent about female controlled methods; they wanted their women to be protected from [STIs] including HIV but the threat of infection was seen as ensuring that women remained faithful.”

### **CAMPAIGN TO INCREASE MALE INVOLVEMENT IN ZIMBABWE**

In an effort to increase contraceptive use and male involvement in Zimbabwe, a family planning project initiated a communication campaign promoting the importance of men’s participation in family planning decision making. Messages relied on sports images and metaphors, such as “Play the game right, once you are in control, it’s easy to be a winner,” and “It is your choice.” The campaign increased the use of contraceptive methods. When evaluating impact, the project asked male respondents whether ideally they, their partners, or both members of the couple should be responsible for making family planning decisions. The evaluation found that, “Whereas men were far more likely to believe that they should take an active role in family planning matters after the campaign, they did not necessarily accept the concepts of joint decision-making. Men apparently misinterpreted the campaign messages to mean that family planning decisions should be made by men alone.”

## **INTEGRATING REPRODUCTIVE HEALTH INTO SERVICES FOR WOMEN LIVING WITH HIV IN BOTSWANA**

Staff in an HIV clinic in carried out a situation assessment to better understand the reproductive health priorities of women living with HIV at their clinic. One of the primary issues women living with HIV expressed was their desire to be able to control their fertility so that they could choose if and when they wanted to become pregnant. However, women expressed a major barrier continues to be the ability to use either condoms or other forms of birth control that might be discovered by their partners, as many of their partners are opposed to either and may even take the suggestion of using such methods as a sign of infidelity and grounds to beat a woman. Based on the information they collected, clinic staff have thus decided that starting next year, their clinic will prioritize offering Depo-Provera shots (longer acting injectibles) to all women, and de-emphasize (and also reduce their supplies for) other types of STI or pregnancy prevention methods.

## **YOUTH OUTREACH IN THE DOMINICAN REPUBLIC**

A health project in the Dominican Republic was concerned about rising STI and pregnancy rates among youth. Unable to convince the predominantly-Catholic public school system to incorporate a reproductive health and HIV curriculum in the high schools, the program decided to instead recruit volunteer peer educators to conduct *charlas*, or informal discussion groups. Peer educators ran after-school neighborhood youth *charlas* in mixed-sex groups to discuss issues related to dating, relationships, reproductive health, contraception (including condoms), and STI/HIV testing. They also provided information on where contraceptives (including condoms) and STI/HIV testing could be obtained.

## **HIV PREVENTION IN BRAZIL**

An HIV prevention project in Rio de Janeiro, Brazil, worked with low-income young men aged 14 to 25 to promote healthier sexual behavior. Adult men led weekly workshops using videos, role plays, discussions, individual reflections, and other participatory activities. Through these activities, the participants were supported in questioning norms related to manhood, the health and other “costs” of inequitable gender-related views to themselves and their partners, and the advantages of gender equitable and safer sex behaviors. The program hopes that outcomes will include young men participating in this program reporting more respect for and understanding of women and girls, improved relationships with their partners, and improved attitudes and behaviors toward safer sex.

For more information, please visit [aidstar-one.com](http://aidstar-one.com).

**AIDSTAR-One**

John Snow, Inc.

1616 Fort Myer Drive, 11th Floor

Arlington, VA 22209 USA

Phone: 703-528-7474

Fax: 703-528-7480

Email: [info@aidstar-one.com](mailto:info@aidstar-one.com)

Internet: [aidstar-one.com](http://aidstar-one.com)