How to **Integrate Gender** into **HIV/AIDS** Programs:

Using Lessons Learned from USAID and Partner Organizations

May 2004

Gender and HIV/AIDS Task Force

Interagency Gender Working Group (IGWG)

United States Agency for International Development (USAID)

About the IGWG

The Interagency Gender Working Group (IGWG), established in 1997, is a network comprising nongovernmental organizations (NGOs), USAID, cooperating agencies (parts), and the Bureau for Global Health of USAID. The IGWG promotes gender equity within population, health, and nutrition programs with the goal of improving reproductive health/HIV/AIDS outcomes and fostering sustainable development.

About the Gender and HIV/AIDS Task Force

In the spring of 2001, the IGWG formed the Task Force on Gender and HIV/AIDS, a jointly-funded projec of USAID's Office of Population and Reproductive Health (OPRH) and Office of HIV/AIDS (OHA). The Task Force was charged with assessing how gender issues are currently being addressed within USAID and its partners' projects and programs related to HIV/AIDS and sexually transmitted infections (STIs). In doing so, the task force focused on gender and HIV issues that cut across population and HIV/AIDS programmatic areas, including integration of family planning/reproductive health and HIV/AIDS, dual protection, and the special needs of youth. This document reflects the findings of the task force.

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INTERAGENCY GENDER WORKING GROUP
TASK FORCE REPORT

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IGWG

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"The pandemic requires the transforming of relations between women and men to eliminate gender inequality and reduce the risk of infection."

~ UN Secretary-General Kofi Annan

Introduction

Of the estimated 42 million people living with HIV/AIDS (PLWHA) at the end of 2002, 19.2 million—or about 45 percent—were women (UNAIDS and World Health Organization [WHO], 2002). In many countries around the world, the majority of new infections are occurring in women, particularly adolescents and young adults. Developing appropriate responses to the gender issues that continue to make both women and men vulnerable to HIV is critical to all efforts to prevent HIV transmission, improve care and support for PLWHA and their families, and mitigate the impacts of the HIV/AIDS pandemic.

Why This Briefing Booklet

This briefing booklet provides program officers and staff within USAID and partner organizations with field-based insights on how to integrate gender into HIV/AIDS programs, in a practical sense. The ability to address gender issues is central to the success of programs and reducing women and men's vulnerability to HIV and its impacts. While this fact is often well-known by program planners and policymakers, what remains less clear is *how* to address gender issues when actually designing and implementing HIV/AIDS programs.

Inside are key gender issues and promising interventions as identified during in-depth interviews with nearly 60 program officers from USAID and its partners (see *Appendix C: Methodology*, for more details). Prior to this assessment by the Interagency Gender Working Group (IGWG) Gender and HIV/AIDS Task Force, USAID's Office of Population and Reproductive Health (OPRH) and Office of HIV/AIDS (OHA) did not have an overall picture of the main gender issues that were being faced and addressed by their programs. What is unique about this document is that it highlights and synthesizes the thinking within USAID and its partner organizations about what needs to be done in terms of understanding and addressing the intersection between gender and HIV/AIDS.

In doing this assessment, the IGWG Gender and HIV Task Force was struck by two trends: First, a number of programs have initiated promising responses to address gender issues. Yet, second, many of the promising interventions highlighted were noted only in one program intervention — not across programs. This means there is tremendous potential among USAID and its partner organizations to integrate existing "best practices" more systematically across programs.

In the current moment, under the new U.S. government initiative, the President's Emergency Plan for AIDS Relief (Emergency Plan), there exists great opportunity to strengthen program impact by implementing gender-informed programming. Failure to do so, especially as programs scale-up, runs the risk of programs and the Emergency Plan not being able to achieve intended goals. We hope that this briefing booklet can offer concrete suggestions and examples of how to integrate gender in order to increase program success.

How to Use This Booklet

This guide is designed to help program managers and policymakers:

- ***Review How Gender Affects HIV/AIDS Vulnerability and Program Responses:*** The overview presented in Section 1 summarizes key gender issues and how they impact vulnerability to HIV/AIDS and response to the epidemic.

- ***Identify Recommendations and Promising Interventions for Integrating Gender Related to Specific Areas of HIV/AIDS Programming:*** Section 2 provides recommendations for integrating gender into seven specific HIV/AIDS programs areas. We have organized program guidance along a continuum of responses, identifying those that may unintentionally *exacerbate* gender inequalities, that *accommodate* current gender norms, and that seek to *transform* gender relationships. This section also provides cross-references to examples of promising interventions, which are discussed in Section 4.

- ***Highlight Key Gaps and Emerging Issues:*** Section 3 outlines gaps and emerging issues identified in current responses that may need to be considered or addressed by your project.

Section 1:

Overview of Gender and Vulnerability to HIV/AIDS

Gender norms and inequalities influence all aspects of the HIV/AIDS epidemic. In particular, USAID and its partners' respondents noted that gender impacts vulnerability to HIV infection as well as the ability of women and men to access prevention, care, treatment, and support services and information. This section presents an overview of specific gender issues USAID and its partner organizations identified as contributing to the spread of the epidemic. Section 2 then reviews in greater detail how these issues need to be addressed in the context of specific program areas.

Gender Norms and Unequal Power in Sexual Relations

- **Norms of femininity inhibit knowledge and assertiveness, and decrease ability to negotiate safer sex.** Gender norms for femininity may place a high value on sexual innocence, passivity, virginity, and motherhood. Women and girls are not supposed to be knowledgeable about sex and generally have more limited access to relevant information and services. They often, therefore, remain poorly informed about sex, sexuality, and reproduction and are less able to discuss these issues with their sex partners. In addition, where virginity for girls is highly valued, some unmarried couples may engage in anal sex, which, when unprotected, increases risk of transmission of HIV/STIs. In most cultures, both women's and men's social value is often derived from their ability to have and raise children, leaving women vulnerable to HIV/STI transmission because condom use is perceived to be in direct conflict with procreation (Gupta, et al., 2002; Gupta, 2000).

- **Norms of masculinity inhibit knowledge and support for shared decision making, and promote aggression and risk-taking.** Gender norms for masculinity may often dictate that men and boys should be knowledgable, experienced, and capable of taking the lead in sexual relationships. Multiple partners for men are condoned, and even encouraged in many societies, as is sexual risk-taking and the early initiation of sexual activity. Boys and men sometimes remain uninformed about HIV/STI prevention because admitting their lack of knowledge in this area could be construed as a weakness. Emphasis on masculine norms of aggression and dominance also sanctions gender-based violence (GBV). The norms surrounding young men's sexual initiation and multiple partners are barriers to effective HIV/STI prevention for youth. Use of alcohol and drugs are also associated with traditional norms of masculinity, and both limit the ability to negotiate safer sex and increase the likelihood of violence (Barker, 2000; Cohen and Burger, 2000).

- **Gender and sexual identity.** Traditional gender norms of masculinity and femininity contribute to homophobia and the related silence, denial, stigma, and discrimination against males who have sex with males (MSM), transgender, and third-sex persons.[1] These norms affect access to accurate prevention information, power to negotiate consistent

[1] MSM is a term that refers to the behavior of males (both adult and younger) who have sex with other males. It recognizes that some MSM also have sex with female partners and that MSM may not necessarily identify as being "gay," "homosexual," or "bisexual." The term "transgender" is used to refer to attitudes, behaviors, and other characteristics that differ from the gender roles and norms the dominant society has assigned to a particular biological sex (e.g., this term may refer to males who dress and live as women while still being anatomically male). The term "third sex" refers to those individuals whose biological attributes and gender identities are neither those of a "woman" nor a "man," but rather another, "third" sex and gender identity (Herdt, 1994).

and correct condom use, and, if living with HIV/AIDS, access to treatment, care, and support. In particular, limited access to accurate, non-stigmatizing prevention information increases vulnerability for HIV infection among MSM, transgender, and third-sex individuals and their male and female sex partners (Gupta, 2002; Parker and Aggleton, 1999; Mayorga, et al., 2003).

- **Unequal power in relationships.** Gender norms related to sexuality often place men in dominant roles and women in subordinate or passive roles. These unequal relations, in turn, are often further reinforced by larger social, economic, and legal inequalities (see below). The result is that inequalities in power between men and women limit women's ability to control whether, when, and how to engage in sexual relations (Gupta, et al., 2002; Population Council, 2001).

Gender Roles in Households and Communities

- **Inequalities in decision making, mobility, and access to resources.** Within households, men often control decisions regarding use of household resources, which may make it difficult for women to get the resources needed to gain access to services. In addition, both women and men tend to put greater emphasis on men's health needs and devote household resources to meeting those needs. Women may also have limited mobility due to male and community norms that preclude women from leaving their household, or may have difficulty accessing health care services where they cannot go to a clinic without the permission or approval of their partner (Gupta, et al., 2002; Gupta, 2002).

- **"Women's work" and unequal care-taking responsibilities.** Within families and communities, gender norms assign women and girls the primary role of care-taking and do not view this as "work" but rather as a natural part of being female. In the context of HIV/AIDS, women's burden of care has increased, with women and girls generally assuming the primary burden of care for PLWHA. The increased burden of care, in turn, further limits women's and girls' access to productive resources. For instance, care-taking decreases women's time available for income generation and food production; it also hinders girls' ability to attend school (Gupta, et al., 2002; Lewis, 2003; UNIFEM, 2001).

Larger Social, Economic, and Political Inequalities

- **Lower socioeconomic status of women and girls.** The socioeconomic status of women and girls places them at greater risk for acquiring HIV and can also lead to harsher consequences of the HIV/AIDS epidemic. Women's and girls' lack of access to productive resources reduces their ability to negotiate condom use or leave abusive relationships. In some instances, lack of educational and economic opportunities may cause women to exchange sex for material goods (often called "transactional sex"). This may include relationships with visiting partners or older men or more formal sex work as a means for earning income. Many respondents noted the growing gap in ages between HIV infection in young women and men, especially in the African context, where data show that young women ages 15–24 have a rate of HIV infection that is 5–6 times that of their male counterparts (UNIFEM, 2003). Gender differences in the impact of the epidemic—in terms of time spent caring for others, girls' removal from school, or denial of inheritance rights—further decrease women's and girls' socioeconomic resources and increase their vulnerability to HIV.

- **Lack of legal rights to inheritance and property.** Under some legal systems and customary practices, women are denied the right to inherit land and property and, further, a woman herself may be inherited by her husband's male family members following his death. HIV/AIDS has increased the number of women widowed and has led to more widows at younger ages. Loss of property and inheritance decreases the access of women and their families to productive resources—increasing their vulnerability to HIV and compromising the ability to meet their basic needs, such as nutrition and housing. Thus, with the HIV/AIDS epidemic, the scope and impact of property rights violations on women, children, and communities has increased dramatically (Human Rights Watch, 2003).

- **Mobility and migration for work.** While social and economic inequalities tend to increase women's vulnerability to HIV, gender patterns in employment also impact men's vulnerability. Due to limited access to employment and income, men sometimes leave their communities to seek economic opportunities**.** Men who migrate for work (e.g., seasonal agricultural laborers) or have mobile jobs that take them away from their families (e.g., truck drivers) are in environments that increase their vulnerability to HIV through unprotected sex with female or male sex workers or injecting drug use with contaminated needles. In some cases, depending on the economic situation of the community and family, the family members left behind may have to engage in sex work to support themselves. Young women, too, are increasingly migrating for employment and face particular risks. As young migrating women may not have the skills needed in formal work sectors, they may be more likely to turn to sex work for income; other young women may face vulnerabilities related to being away from traditional support structures (Lewis, 2003; Rivers and Aggleton, 2001).

Cross-Cutting Gender Issues

- **Gender-based violence (GBV) affects both the risk of contracting HIV and the consequences of disclosing HIV status.** GBV is a leading risk factor for HIV as well as a feared consequence of disclosure for women. Research indicates that fear of violence limits women's ability to negotiate condom use or fidelity with their partners (Gupta, 2002; IGWG, 2002a). GBV limits women's ability to decide whether, when, and how to engage in sexual relations, as well as their ability to leave unsafe relationships (Gupta and Weiss, 1993). Sex workers also experience very high levels of violence, with limited recourse to protection from or prosecution of perpetrators, placing them at increased risk for HIV infection (Church, et al., 2001; Alexander, 2001). In mobile populations (e.g., refugees or displaced groups), GBV—and particularly rape—puts women and girls at an added risk for HIV/STIs. In addition, studies have shown that some women may face harsh consequences following disclosure of HIV-positive status, including the threat of violence (Maman, et al., 2001), at the same time that a majority of women may experience positive outcomes (USAID/Synergy, 2004).

  For young women, sexual coercion is a key factor limiting their ability to prevent HIV/STI transmission. Research shows that many young women's first sexual encounters may be coerced. For example, a study in Western Kenya of an intervention to improve adolescent reproductive health found that two-thirds of the girls reported that they had not wanted to have sex at last sexual intercourse, whereas almost all boys reported that last sexual intercourse was consensual (Warren, et al., 2001). Increased attention is also focusing on schools as a site of sexual coercion of girls and for boys, as well (Mensch, et al., 1998).

  GBV also affects males who have sex with males (MSM). Within MSM relationships, gender norms often dictate that one partner is dominant and the other submissive. The submissive partner may have less power within the relationship and may face the threat of or use of violence that can be associated with such lack of power. In addition, violence against MSM by communities and police drive MSM underground, which makes reaching MSM with prevention information and supporting conditions for safer sexual practices extremely difficult (Niang, et al., 2002).

- **Gender-based norms and stereotypes fuel stigma and discrimination.** Gender norms blame and shame women for being "vectors" and responsible for spreading HIV, and for having engaged in assumed "promiscuous" behavior. Gender norms often assume that if a woman has acquired HIV, it is because she has behaved in a way that has transgressed the norms of what proper women should do. These norms fuel stigmatizing responses of blame and shame directed toward HIV-positive women. In addition, women historically have been stigmatized as reservoirs of infection, responsible for potentially polluting their partners and households. Because voluntary counseling and testing (VCT) programs have often targeted women, especially in the context of prevention of mother-to-child transmission (PMTCT) of HIV, these programs have often unintentionally exacerbated the stigmatizing view that women are responsible

for HIV. Since women are often tested first, they are frequently the *first* ones in a relationship to be identified with HIV-positive status. Women thus may face the blame for bringing HIV into the household. In the context of decision making related to reproductive choices, HIV-positive women may also face negative judgment by community members and health care providers related to being sexually active and their desire to have children. Informants noted that the consequences of stigma and discrimination faced by HIV-positive women are often harsher than the consequences for men, including women being thrown out of their homes or experiencing GBV (Aggleton and Chase, 2001; Aggleton and Parker, 2002; Nyblade, et al., 2003; ICRW, 2002; ICW, 2002).

Gender norms also blame and shame MSM as responsible for HIV due to their perceived "immoral" sexual behaviors. MSM face the double stigma of being blamed for their sexual behaviors as well as for their serostatus within family, community, and health care settings and the broader social environment (Aggleton and Parker, 2002).

Section 2:

Gender and HIV/AIDS: Recommended Responses for Specific Program Areas

This section offers practical guidance on how to address the gender issues explored in Section 1. After briefly reviewing key foundations of program responses, this section covers seven HIV/AIDS program or intervention areas:

1. Key Foundations of Program Responses
2. Behavior Change Programs
3. Prevention Methods (Female Controlled and Dual Protection)
4. Integrated Family Planning and HIV/STI Services
5. VCT and PMTCT Programs
6. Care and Treatment for HIV-Positive Women
7. Social, Economic, and Political Inequalities
8. Policy Environment

For each program area, we include recommendations on how to address gender issues, as drawn from the insights and experiences shared by respondents; in several cases, we supplement recommendations shared by respondents with related publications and have included these citations. At the end of each program area, where identified, we also list the challenges that were identified by interviewees. Please note that gender issues and effective gender integration strategies will vary within and among each country or community setting and, thus, they need to be assessed and adapted to a particular program's context.

After reading the relevant recommendations for a specific program area in this section, we suggest reviewing Section 3 for gaps and emerging issues that the program may also want to address.

1. Building Blocks of Gender Integration

Almost all program staff interviewed highlighted two key foundations of their responses to gender issues in HIV/AIDS: promoting women's empowerment and encouraging male involvement. Taken together, these two approaches seek to change the gender-based norms and inequalities that make women and men vulnerable to HIV and its impacts. We thus highlight these approaches here, in addition to noting where they relate to specific program areas in the sections that follow.

- **Women's empowerment**. In many of the countries most affected by HIV/AIDS, women make up the majority of those infected. The importance of empowering women and girls at every level in the effort to reduce vulnerability and exposure to HIV cannot be overemphasized. Key elements of empowerment programming includes improving women's access to information, skills, services, and technologies; encouraging participation in decision making; and fostering a group identity that can serve as a source of collective power for women. Such interventions can be integrated into existing reproductive health and HIV/AIDS programs and can be either clinic or community based. Further, creating a supportive policy and legislative context for women is crucial for containing the spread of the HIV/AIDS epidemic and mitigating its impact. Policies that aim to decrease the gender gap in education, improve women's access to economic resources, increase women's political participation, and protect women from violence are essential for women's empowerment (Gupta, 2000).

- **Male involvement.** Developing responses that address norms of masculinity and involve men across the range of prevention, testing, care, and support programs is a key aspect of comprehensive HIV/AIDS programs. For instance, traditional norms of masculinity place men and their partners at risk for HIV. Norms of masculinity also make men less likely to seek health care services or information. And without men's support, women are often unable to negotiate condom use or refuse unsafe sex, access needed care and services, or share the burden of care.

  In promoting male involvement, USAID and its partners emphasized that policies and programs need to:

  – Address masculine gender norms that promote risk-taking and place men, boys, and their partners at increased risk for HIV;

  – Promote developing and strengthening positive masculine gender norms that support health-promoting behaviors and gender equity;

  – Identify and develop strategies that encourage men to seek health care services and information for their own health and well-being;

  – Improve men's support for women's reproductive health, discussions about sexuality and safer sex practices, and women's decision making and rights; and

  – Ensure that male involvement programs carefully evaluate gender relations and the impact of such involvement so these strategies do not cause unintended harm (e.g., reinforce men's control over decision making).

  For further information about male involvement approaches, see the resources available through the IGWG Men and Reproductive Health Task Force at www.rho.org/html/menrh_igwg.html.

Respondents also discussed what some have called a "continuum" of approaches to addressing gender issues. In particular, interviewees described how some of their programs respond to gender issues by accommodating, or seeking to minimize, gender norms and inequalities without directly attempting to change underlying gender inequalities. Other program approaches more directly seek to transform the underlying gender inequalities.

In each specific program area that follows, we have grouped together recommended responses that *accommodate* current gender norms and that seek to *transform* gender relationships. We also note responses identified by interviewees that may unintentionally *exacerbate* gender inequalities. (See Box 1 for more information.)

Box 1. Approaches to Gender Integration

Practitioners and researchers in the gender studies field have organized approaches to gender integration along a continuum.[2] While terms or categories may vary depending on the source, basically, the continuum of approaches ranges from those that cause harm to those that change underlying gender inequalities. The IGWG's Research/Evidence-Based Task Force outlines three distinct gender integration approaches that programs tend to fall into, when an explicit gender approach can be identified (IGWG [Boender, et al.], 2002).

The IGWG believes that focusing increasingly on transformative interventions has a positive impact both on gender equity and on reproductive health and HIV outcomes. Transformative interventions are those that attempt to promote gender equity through encouraging critical awareness of gender roles; improving the relative position of women; challenging the imbalance of power, distribution of resources, and allocation of duties between women and men; and addressing the power relationships between women and service providers. Change is, of course, a long process, and strategies that accommodate gender differences still play an important role, but transformative interventions will ultimately produce the most sustainable changes in gender equity and reproductive health outcomes.

These three approaches are as follows:

- **Those that exploit or exacerbate gender inequalities** in the pursuit of reproductive health and demographic goals. These strategies might emphasize male sexual dominance in marketing slogans aimed at men to use condoms, or inadvertently reinforce male dominant decision-making power by involving men in their female partner's health care services without training to counteract providers' tendency to direct information primarily to the man and not the woman.

- **Those that accommodate gender differences.** In some cases, accommodating inequitable gender norms may provide benefits more quickly than approaches that seek to change gender systems. An example of this type of strategy would be disseminating HIV prevention information door-to-door in communities where women's movement outside the home is limited. This outreach may increase access to information but, in most cases, door-to-door distribution of information does little to challenge the belief that women who leave the home without a male relative's permission are not respectable.

- **Those that seek to transform gender relations to promote equity.** In the case of accessing HIV-prevention information, a project might help a community examine its norms that inhibit prevention for women and men, and result in efforts to transform support for women's mobility and related empowerment efforts as a key element of HIV prevention. For instance, this approach would work to change gender relations so that men and women would support women's rights to be mobile outside of the home, and to attend a clinic without needing to secure her male relative's permission.

[2] This framework draws from a range of efforts that have used a continuum of approaches to understanding gender. Specific to HIV/AIDS, see Geeta Rao Gupta, "Gender, Sexuality and HIV/AIDS: The What, The Why and The How" (Plenary Address at the XIII International AIDS Conference), Durban, South Africa: 2000; Geeta Rao Gupta, Daniel Whelan, and Keera Allendorf, "Integrating Gender into HIV/AIDS Programs: Review Paper for Expert Consultation, 3–5 June 2002," Geneva: World Health Organization 2002; and World Health Organization/International Center for Research on Women, "Guidelines for Integrating Gender into HIV/AIDS Programmes," forthcoming.

2. Behavior Change Programs

Gender norms are fundamental to shaping men's and women's sexual relationships and their ability to gain access to the information and services that can help prevent HIV transmission. Data indicate that prevention programs that integrate gender show success in changing men's and women's attitudes toward, and adoption of, protective behaviors (IGWG, 2002b [Boender et al.]; Maman, et al., 2001; Nyblade, et al., 2001; and Rutenberg, et al., 2001.) Given this, it is essential that behavior change programs take into account—and tailor their programs to respond to—the gender norms and inequalities that affect men's, women's, boys', and girls' ability to adopt safer behaviors.

To prevent unintended harm, programs need to:

- ***Avoid stereotypes of femininity and masculinity***, such as showing men in roles of sexual domination or women in roles that reinforce passivity; and

- ***Assure that prevention strategies do not overlook key constraints*** that could cause harm (e.g. focusing on encouraging women to use condoms when they may face violence as a consequence).

To accommodate or transform gender relations, programs need to:

- ***Identify and use information channels and networks to which men, women, girls, and boys have access,*** including assessing differences in access (such as limitations in mobility) to sources of information, preferences for sources and formats of information, and when it is better to have different sex and age groups versus when it is better to combine groups.

- ***Support critical examination and transformation of gender norms in HIV-prevention and education programs,*** including the examination of norms of girls and women as passive and uniformed about sexuality; norms of men and boys having multiple sex partners; lack of communication and male support for women's decision making; and male aggression and violence. Key areas where this needs to happen include:

  – *Integrating critical examination of gender norms into HIV-prevention education* in formal and informal educational settings;

  – *Promoting community mobilization and participation of leaders* to reflect on the impact of current gender norms on HIV vulnerability and impact, and to identify and support needed changes in norms; and

  – *Building the capacity of those delivering prevention programs to address gender and sexuality*, with an emphasis on preparation and skills building for teachers, providers, and peer educators who themselves often do not have the awareness and capacity to facilitate activities that address gender issues.

See Promising Interventions "#1 Men as Partners," "#2 Climbing to Manhood," and "#5 EngenderHealth" in Section 4

- ***Develop multisectoral programs that address larger social and economic gender inequalities such as GBV, women's lack of income, limited access to education, and denial of legal rights,*** given that these gender inequalities are a root cause of vulnerability to HIV. In developing approaches, programs should consider building on the documented best practices of interventions with sex workers that have increased health outcomes by addressing GBV and by including access to income, education, and child care as part of programs (see the section on *Social, Economic, and Political Inequalities, p. 18*).

See Promising Intervention "#4 Sonagachi" in Section 4

Challenges highlighted by respondents include the following:

- ***Promoting correct and consistent condom use with regular partners.*** It remains a challenge to promote condoms within regular partnerships, for both men and women. Some specific gender norms that affect this include the fact that women are often accused of being unfaithful for suggesting condom use with their regular partners. While sex workers may have the negotiating power to use condoms with clients, they too often do not use condoms with their regular partners.

- ***Responding to the different gender norms and inequalities that affect women and men's ability to adopt ABC ("Abstinence, Be Faithful, Use Condoms") strategies.*** Abstinence (or delayed sexual initiation among youth), mutual monogamy and being faithful (or reduction in number of sexual partners), and correct and consistent condom use are three key behaviors that can prevent or reduce the likelihood of sexual transmission of HIV (USAID, 2003a).[3] For these strategies to be effective, they must be designed to account for the practical realities presented by the different gender norms for women's and men's behaviors. In particular, women frequently do not have the power to determine where, how, and when they have sexual relations. Furthermore, a woman who follows the "be faithful" message may still be at risk for HIV infection if her husband or partner is having unprotected sex with additional partners. When girls and women do have multiple partners it is often not by choice, but rather out of economic necessity. Women thus often have limited ability to enforce abstinence, being faithful, or correct and consistent condom use. For men, traditional norms of masculinity run counter to each of the ABC strategies. Traditional norms of masculinity promote early initiation of sexual activity and having multiple sex partners—and portray being abstinent or reducing the numbers of one's partners as unmasculine. To be most effective, ABC strategies thus need to develop approaches to target the different constraints that men and women face. For women, these strategies need to include empowerment so that they can refuse sex or sex without a condom and to promote women's socioeconomic advancement so they need not turn to sex work or stay in unhealthy relationships. For men, these strategies need to include changing gender norms around expectations of masculinity, sexual behavior, and use of violence.

3. Prevention Methods: Female-Controlled Methods and Dual Protection

Female-Controlled Methods

Respondents noted that providing women with access to female-controlled prevention methods is essential considering women's and girl's limited power to negotiate whether, when, and how they engage in sexual relations.

To accommodate or transform gender relations, programs need to:

- P***romote and improve access to the female condom,*** including assuring that it is included as part of HIV-prevention programs and that it is included as part of the range of contraceptive options made available to women; and

- ***Support advocacy for research, development, and use of microbicides.*** Advocacy must extend beyond merely ensuring that microbicides are produced. It must include research, policy work, and political activism to ensure that the products developed are widely available and correctly and consistently used by individuals at risk of HIV/STIs—especially women.

Challenges highlighted by respondents include the following:

- ***Increasing advocacy for availability of and access to female-controlled methods.*** Respondents stated that female condoms remain largely unavailable or difficult to access as a prevention option. The female

[3] For those interested in learning more about this approach, please see *The ABCs of HIV Prevention* (USAID, 2003a).

condom is more expensive than the male condom and, unless women have access to subsidized contraceptive programs, use may not be an option due to cost. Yet, there appears to be little advocacy to encourage programs and policies to prioritize access to female condoms. Similarly, advocacy is needed to lay the groundwork so that once microbicides are available they will also be integrated and available within programs.

- ***Despite being female-initiated, it is hard for women to assure and control use of female condoms.*** As with the male condom, women may not be able to insist upon the use of the female condom with their partners because it is seen as a barrier to conception and/or perceived as a sign of infidelity or lack of trust.

- ***Attaining consensus on intended users.*** Some interviewees also mentioned challenges associated with whether it is best to focus access to female condoms for sex workers or for a broader group of women. In particular, the potential stigma—if female condoms are specifically promoted for sex work—could limit use by other women. Yet, given the risks sex workers face, it is crucial that female condoms are made as accessible to them as possible.

Dual Protection

Respondents reported that programs are increasingly promoting dual method use (e.g., condoms and another method of contraception) or dual protection.[4] They identified dual protection as an important opportunity to reach women who might not usually have access to HIV-prevention information. Informants also noted that, especially for youth, dual protection where correct and consistent condom use is promoted for pregnancy prevention as well as STI/HIV prevention may have the potential to destigmatize correct and consistent condom use among sexually active youth. While recognizing the importance of preventing STIs/HIV and pregnancy, potential concerns about the promotion of dual protection were expressed.

To prevent unintended harm, programs need to:

- ***Assure that promotion of dual protection includes an assessment of potential harmful consequences due to power relations,*** especially related to the violence women could face if they suggest using a correct and consistent condom with a partner (e.g., where a partner could take the suggestion as a sign of unfaithfulness and respond with violence) or to the potential of unintended pregnancy if they are unable to use a visible form of protection correctly and consistently (e.g., a correct and consistent condom).

- ***Assure that promotion of dual protection does not limit other family planning options.*** It is important to address potential provider bias, where in the interest of promoting protection from HIV/STIs providers may only offer correct and consistent condoms without including a range of other contraceptive methods (and exploring what methods may best match a woman's or couples' priorities and ability to use a method correctly and consistently). Also, at the level of programs and policies, it is important to ensure that the focus on including correct and consistent condom use does not inadvertently limit the procurement and supply of a mix of contraceptive methods.

[4] "One of the most effective ways to achieve prevention of HIV *and* unintended pregnancy is for mutually monogamous, uninfected partners to practice effective contraception. Other 'dual protection' methods are:

- Abstinence and/or delay of sexual debut
- Correct and consistent condom use
- Correct and consistent condom use along with another effective FP method ('dual method use')

In all family planning/reproductive health and HIV/AIDS programs, clients need counseling to help them understand their risk of both unintended pregnancy and HIV/STIs in order to make choices which suit their individual circumstances. Condoms should be widely available, and both men and women should be counseled that correct and consistent condom use is needed in order to achieve the benefits of condoms in preventing HIV and pregnancy. At the same time, it is important to recognize that, particularly in terms of HIV prevention, condoms are most frequently used with non-regular partners and increasing correct and consistent condom use to very high levels may be an unrealistic behavior change outcome within the general population. Thus, promotion of condoms needs to be balanced with both 'A' ('Abstinence') and 'B' ('Be faithful') messages as well as access to a variety of effective family planning methods." USAID 2003b, p. 7.

To accommodate or transform gender relations, programs need to:

- ***Explore the opportunity, especially with sexually active youth, to destigmatize correct and consistent condom use*** through messages that promote correct and consistent condom use as an effective birth control as well as STI/HIV prevention method;

- ***Address family planning providers' potentially stigmatizing or discriminatory attitudes,*** especially with providers who may assume that certain female clients do not need to worry about HIV prevention (e.g., women who are married) or who believe that fertility control is the primary goal and, therefore, prioritize a more traditional family planning method;

See Promising Intervention "#5 EngenderHealth" in Section 4

- ***Build capacity with providers and clients to address gender, sexuality, and power dynamics,*** including assessing how power issues and the potential for GBV may affect women's protection choices, how to help clients critically assess their prevention needs, and how to tailor recommendations to these assessed needs rather than focusing exclusively on dual protection; and

- ***Build capacity with clients to address gender, sexuality, and power dynamics in their relationships*** and identify what types of counseling and sessions best foster this type of skills building.

Challenges highlighted by informants include the following:

- ***Dual protection programming may be ahead of the research.*** Given what is already known about the limited control women have over condom use, some informants emphasized that data are needed to show that dual protection can be used effectively for both HIV and pregnancy prevention—and without unintended negative consequences such as unwanted pregnancies, GBV, or limiting available method choices.

4. Access to Integrated Family Planning and STI/HIV Services

Respondents emphasized that integrating family planning and STI/HIV services offers another important prevention opportunity, especially for women who might not otherwise gain access to HIV-prevention information. At the same time, informants noted concerns that integrated services may not reach many of the most vulnerable groups who have not traditionally received family planning services. However, all informants agreed that whether services are integrated or not, it is important to increase access to respectful, nonstigmatizing reproductive health and STI/HIV services in a variety of settings, especially for men, MSM, PLWHA, sex workers, injecting drug users (IDUs), and youth.

To accommodate or transform gender relations, programs need to:

- ***Build provider capacity and develop protocols that provide assessment for HIV and STI risk as well as appropriate information and services, to <u>all</u> clients.*** Providers need training in order to be able to routinely assess all clients' risks, not just those whom providers "assume" need prevention information based on their stereotypes or biases. As part of this training, it is important to help providers identify how their own gender stereotypes may stigmatize or discriminate against clients in service settings, and to provide concrete skills building to help providers change their attitudes and practices.

See Promising Intervention "#5 EngenderHealth" in Section 4

- ***Develop approaches that reach men with needed information and services.*** It is often the behavior of the male partners of female clients whose behavior places the client at risk. Therefore, reaching male partners of female clients is crucial.

- ***Develop approaches that reach different vulnerable groups with needed information and services.*** Stigma, discrimination, and fear of harassment both in clinics and the larger community may prevent vulnerable groups such as MSM, PLWHA, sex workers, and IDUS from accessing services. Approaches are needed that find the best ways to reach vulnerable groups in light of the existing stigma and discrimination. As part of this, the greater involvement of vulnerable groups should be promoted at all levels of program decision making, including design, development, delivery, and evaluation of programs in addition to inclusion in peer education and outreach activities.

See Promising Intervention "#4 Sonagachi" and #13 ASICAL" In Section 4

- ***Support advocacy efforts to reduce stigma, discrimination, and human rights violations,*** including community and police harassment of marginalized groups—e.g. sex workers, IDUs, and MSM—that create barriers to accessing services. Health services programs are important allies in advocacy efforts to change the policy environment to reduce stigma and discrimination and promote human rights—and these changes are central to a program's ability to reach and serve clients from vulnerable groups.

Challenges highlighted by informants include the following:

- ***Determining how best to prioritize which client groups should be reached by integrated services.*** Informants noted the need for guidance on how best to focus integrated strategies. In particular, some expressed concerns that a focus on integrating services may detract funding and focus from known effective methods of reaching groups that practice high-risk behaviors, such as MSM, sex workers, IDUs, and youth (see USAID, *Family Planning/HIV Integration Technical Guidance for USAID-Supported Field Programs*, 2003b, for further guidance).

5. VCT and PMTCT Programs

Counseling and Testing in VCT and PMTCT

Respondents noted that women often face harsh consequences following disclosure of HIV-positive status, including abandonment and the threat of violence. Moreover, the person in a relationship that is *first* identified as HIV positive is often blamed for bringing HIV into the relationship (Maman, et al., 2001). Some more recent studies have found that women who have disclosed their HIV-positive status often encounter positive outcomes; these outcomes include less anxiety, fewer symptoms of depression, increased social support, and a strengthened relationship with partners. At the same time, it has been hypothesized that it may be only women who feel safe to disclose their HIV-positive status will do so (USAID/Synergy, 2004). In this context, especially as programs are scaled up, it remains crucial that VCT and PMTCT programs integrate protocols that respond to these constraints.

To prevent unintended harm, programs need to:

- ***Avoid messages and practices that reinforce the stereotype of women as vectors of HIV infection.*** This can be an unintended consequence of the focus on women in PMTCT programs and messages where it is often women who learn their serostatus first and are targeted solely as the potential infector of their children. For example, a current campaign in the United States reinforces these stereotypes. Its billboards ask, "What kind of mother could give her baby HIV? An untested one." The ad stigmatizes women by implying it is mothers who are solely to blame if her child is HIV positive. The ad fails to recognize the shared responsibility of men in HIV transmission, reproduction, and parenting. The ad also obscures the many factors beyond a woman's control—such as barriers to access to services, stigma, and discrimination—that may prevent a woman from seeking HIV testing. Finally, the ad fails to acknowledge a woman's right to make an informed decision about whether or not to get tested.

- ***Recognize and develop protocols that address the potential negative and often harsher consequences for women following testing or disclosure of HIV-positive status,*** including the threat of GBV and abandonment.

To accommodate or transform gender relations, programs need to:

- ***Integrate full assessments of potential risks to learning one's HIV status into counseling,*** including the threat of GBV, stigma, discrimination, and abandonment;

See Promising Interventions "#6 AIDS Information Center" and "#8 Horizons/UNICEF" in Section 4

- ***Assure fully informed consent and support women's right to decide whether or not to test,*** and to decide whether and when to disclose their status to partners and family members, in light of a woman's assessment of her own situation;

- ***Develop models to promote involvement of men in HIV testing and care*** in order to change the dynamic of women generally being the first to learn their status in the context of PMTCT, and to promote men's support of women's health choices, while assuring that models promote shared responsibility and do not inadvertently foster men's control over women's decision making. As part of this, consider strategies on how to reach men with information related to HIV and PMTCT outside of the antenatal clinic, which still remains a primarily female domain;

- ***Develop programs to provide psychosocial support to HIV-positive women,*** including information, support, and referral services for living as an HIV-positive woman, as well as information and support for reproductive and other health decision making; and

- ***Promote community-based participation, education, and mobilization*** to increase knowledge about PMTCT programs, promote understanding of PMTCT as the equal responsibility of men and the community as well, and transform the current norms, stigma, and discrimination that tend to blame women as being solely responsible for having HIV and potentially transmitting HIV to a child.

See Promising Interventions #"7 ICRW and Horizons Study" and "#9 HIV/AIDS Stigma Toolkit" in Section 4

Meeting the Needs of HIV-positive Women

Respondents emphasized that policymakers and program managers need to ensure that PMTCT initiatives, particularly as they begin to scale up, respond to the full range of HIV-positive women's needs.

To prevent unintended harm, programs need to:

- ***Include goals and outcomes that promote women's overall health and well-being,*** as opposed to viewing women only as a vessel for delivering babies; and

- ***Account for the stigma and discrimination as well as material constraints that affect women's breastfeeding options and choices.*** Women who do not breastfeed are often assumed to be HIV positive and are subjected to stigma and discrimination. Moreover, it may be very difficult to have access to a clean water source or the money for substitute feeding and, therefore, breastfeeding may be a better option in terms of practicality and minimizing chance of transmission.

To accommodate or transform gender relations, programs need to:

- ***Support the implementation of interventions that provide access to full treatment, care, and support*** (e.g., nutrition, opportunistic infection prophylaxis and treatment, ARVs, and long-term care) for women and their families beyond the use of ARVs to prevent MTCT;

- ***Assure women's access to the full range of clinical maternal reproductive health options,*** including access to health care services where women can deliver with a skilled provider, intermittent preventive therapy for malaria,

iron-folate supplements, syphilis screening and treatment, and counseling and information on family planning methods and birth spacing;

- ***Develop holistic programs that go beyond health care services alone*** and that provide links to psychosocial support and self-help groups, nutrition, food security, income generation activities, and services related to other needs (e.g., succession, orphan support, and inheritance rights);

See Promising Intervention "#12 Society for Women and AIDS in Kenya" in Section 4

- ***Build provider capacity to provide full information about support, and respect for infant feeding choices,*** including their capacity to help clients assess which options are most appropriate for their needs, considering issues such as material constraints and risk of stigma and discrimination associated with not breastfeeding; and

- ***Develop models to involve men and to promote community participation*** in order to enhance support for HIV-positive women, their partners, and their families (see the *Counseling and Testing in VCT and PMTCT* section above for details).

6. Access to Care and Treatment for HIV-Positive Women

Access to Reproductive Health Programs[5]

Respondents identified access to full reproductive health services as an important program area, and one that is currently not met. In particular, informants noted a need for capacity building with health care providers and communities to counteract the fact that once women and couples are identified as HIV positive, their sexuality and family planning needs are often stigmatized, ignored, or not integrated into available reproductive health services.

To prevent unintended harm, programs need to:

- ***Reduce stigma and discrimination against HIV-positive women and couples for being sexually active and bearing children.*** Currently, providers often make implicit and explicit recommendations that HIV-positive women should not engage in sexual relations, nor make choices about childbearing, especially the desire to have a child (Feldman, et al., 2002; International Center for Research on Women, 2002). Family and community members may also share these beliefs (Malawi Network of People Living with HIV/AIDS, 2003).

[5] USAID Policy on Family Planning and Reproductive Health: USAID's Office on Population and Reproductive Health provides assistance for family planning and related reproductive health activities, which may include linking family planning with maternity services, HIV/AIDS and STD information and services, eliminating female genital cutting, and post-abortion care. Any reference to reproductive health, reproductive health care and reproductive health services in this publication refers to such activities. USAID funds are prohibited from being used to pay for the performance of abortion as a method of family planning or to motivate or coerce a person to practice abortion.

USAID has defined family planning and reproductive health in Appendix IV of its Guidance on the Definition and Use of the Child Survival and Health Program Funds, dated May 1, 2002. Primary elements include: expanding access to and use of family planning information and services; supporting the purchase and supply of contraceptives and related materials; enhancing quality of family planning information and services; increasing demand for family planning information and services; expanding options for fertility regulation and the organization of family planning information and services; integrating family planning information and services into other health activities; and assisting individuals and couples who are having difficulty conceiving children. The word *choice*, as used in this publication, refers *exclusively to an individual's capacity to exercise options with regard to the elements contained within USAID's definition of Reproductive Health.*

To accommodate or transform gender relations, programs need to:

- ***Build capacity of health care providers and communities to respect HIV-positive women's and couples' reproductive health care needs and rights,*** especially their right to be sexually active; to decide freely and responsibly the number, spacing, and timing of their children, and to have the information and means to do so; and to attain the highest standard of sexual and reproductive health;

- ***Develop intervention models that address HIV-positive women's reproductive health needs*** and to have the information and means to do so; and to attain the highest standard of sexual and reproductive health;

- ***Develop intervention models that address HIV-positive women's reproductive health needs within the context of reproductive health services*** so that family planning providers are prepared to see HIV-positive women as part of their regular clientele; offer women the full range of contraceptive options; and provide services for HIV-positive women's other health care needs, or at least referral to other health care services; and

- ***Assure that reproductive health care for HIV-positive women meets clinical standards and that providers are knowledgable about current treatments and interactions for women,*** including, for instance, that services follow the recommendation that HIV-positive women have access to cervical cancer screening every six months, or that providers can provide counseling and current information about the interactions between oral contraceptives and different drugs used for treatment of HIV/AIDS.

Challenges highlighted by respondents include the following:

- ***Lack of reproductive health programs and services for HIV-positive women.*** Interviewees identified a current lack of dedicated programming in this area, although it is crucial for HIV-positive women's health and well-being.

- ***Lack of information and programming related to the reproductive health needs and perspectives of HIV-positive men***, both with regard to gender norms and expectations for men related to fathering children, as well as their relationship to their female partner's reproductive decision making and needs.

- ***Lack of programming and attention for sero-discordant couples,*** including information and support related to reproductive desires and choices and options for prevention of infection including correct and consistent use of condoms.

See Promising Intervention "#10 Voices and Choices" in Section 4

Gender Equity in Access to Treatment

Respondents suspected that, as access to treatment becomes more available, there will be gender inequities in access to and decision making about financing of treatment. Anecdotes related by interviewees, and emerging evidence, suggest that in the case of scarce resources, both men and women may prioritize male access to medication (Lewis, 2003). Key informants shared instances of families who have sold land in order to pay for treatment and funerals of male family members, limiting productive resources left for the family. Moreover, where access to treatment is tied to formal employment (e.g., health benefits and insurance provided in the workplace), men's greater participation in the formal sector potentially positions them with greater access to treatment than women. As access to treatment is scaled up, programs need to ensure that these potential inequities are identified and that strategies are developed to promote women's equal access to treatment.

To prevent unintended harm, programs need to:

- ***Address the dynamics of prioritization for and financing of treatment,*** including the development of strategies to mitigate the potential impact on family assets and resources.

To accommodate or transform gender relations, programs need to:

- ***Further assess and design strategies to address potential barriers to women's equal access to treatment,*** including gender dynamics related to household decision making, financing of treatment, and also the impact of gender differences in formal sector workforce participation on access to treatment (especially related to access to treatment that comes through workplace programs).

- ***Assure the meaningful involvement of women and men living with HIV/AIDS*** in all elements of program protocols, design, delivery, evaluation, and monitoring in order to maximize the opportunities to identify and respond to potential gender-based inequities and barriers, and to promote fair and equitable access for all.

Challenges highlighted by respondents include the following:

- ***Great need for more information, advocacy, and action.*** Interviewees noted that, in the context of their programs, attention to gender dynamics in access to treatment is only just emerging. Thus, formative research and strategies to translate research into policies and program models that will ensure equal access are needed.

7. Social, Economic, and Political Inequalities

Community Care and Support Programs

Respondents reported that the primary burden of community care and support falls to women and girls. This burden of care often further limits women's and girls' access to productive resources, including time for cultivating or attending school. Respondents also noted that most home-based care initiatives continue to be rolled out without accounting for the increased burden of care that will fall on women and girls (as they are the likely care-takers) and the negative consequences that could result (such as decreased time available for food production or girls having to withdraw from school).

To prevent unintended harm, programs need to:

- ***Assure that home-based care and other community programs account for the unpaid labor of women, and mitigate against worsening women's and girls' already unequal access to key resources,*** including time necessary for food production, income generation, and meeting other basic needs.

To accommodate or transform gender relations, programs need to:

- ***Identify models for care and support that include income generation, food security, and other activities designed to mitigate the impact of women's unequal burden of care;***

- ***Develop policies and programs that enable girls, along with all orphans and vulnerable children, to maintain access to education;*** and

- ***Explore how to transform community gender norms related to care-taking responsibilities,*** including strategies to help communities as a whole, with participation by men and boys as well as women and girls, to share care-taking responsibilities.

Challenges highlighted by respondents include the following:

- ***Lack of interventions developed to respond to women's unequal burden of care.*** For the degree of documentation of the unequal burden of care that women face, interviewees noted that, to date, there have been surprisingly few programs or promising interventions reported in this area.

See Promising Intervention "#11 Peace Corps Malawi" in Section 4

- ***Further research needed especially related to girls' and boys' burden of care.*** Respondents also noted that there has been little research to address how gendered norms affect the burden of care among girls and boys, especially for orphans and vulnerable children, and little programming interventions to address burden of care among girls and boys.

Multisectoral Responses to Increase Women and Girls' Access to Resources

Given the larger social, economic, and political inequalities that exacerbate vulnerability to HIV/AIDS and its impacts for women, informants highlighted the need for multisectoral programs that address these inequalities directly. In fact, when asked what the key gender and HIV/AIDS issues are for the next three to five years, respondents most often named the need to address these larger inequalities as the number one priority. In particular, respondents emphasized economic independence, access to education, legal reform, and food security.

To prevent unintended harm, programs need to:

- ***Ensure that HIV/AIDS programs do not further decrease women and girls' access to productive resources,*** for example, that the gendered burden of community-based or home-based care programs do not result in girls' removal from school or decrease women's available time for meeting basic needs of food and shelter.

To accommodate or transform gender relations, programs need to:

- ***Address women's need for economic independence*** through access to productive resources, such as income and credit, and develop interventions that link women to employment, micro-finance, credit, and livelihoods initiatives;

See Promising Intervention "#12 Society for Women and AIDS in Kenya" in Section 4

- ***Develop youth livelihood approaches for young men and young women*** in order to enhance overall life options, including access to jobs and income, as a key element of reducing risk for HIV;

- ***Increase girls' access to education,*** including ensuring that girls are not removed from school in the context of the burden of care, that barriers to girls attending school and needing access to resources (such as school fees and uniforms which contribute to transactional sexual relations) are reduced, and that opportunities to promote education and literacy are provided;

- ***Promote legal reform initiatives related to property grabbing, property rights, and wife inheritance*** to ensure women's ability to mitigate the impacts of the epidemic and also to reduce their own HIV vulnerability; and

- ***Incorporate gender and HIV/AIDS into food security programs,*** including recognizing and responding to women's decreased time for producing food when ill or caring for others and, in the case of being evicted from their homes or losing property, the lack of access to land for food production.

Challenges highlighted by respondents include the following:

- ***Developing and documenting successful program models that link health sector responses to HIV/AIDS with other sectors in order to meet needs for increased access to economic, educational, agricultural, and legal resources.*** Although identified as important, well-designed interventions that link HIV/AIDS programming with other sectoral interventions to address structural inequalities are still in their early stages. This is also true for youth livelihoods initiatives. Monitoring and evaluating the impact of such interventions on HIV vulnerability is another challenge. At the same time, best practices that address these larger inequalities have been documented among interventions with sex workers. The challenge is to continue to develop, document, and replicate successes with these interventions.

- ***Decreasing institutional barriers to collaboration.*** Within the context of USAID, respondents noted that USAID's institutional and financial structure constrains cross-sectoral programming. Interviewees particularly noted the importance of increased coordination and collaboration between the Bureau for Global Health and the Bureau for Economic Growth, Agriculture and Trade, and Office of Democracy and Governance. The importance of collaboration is heightened under the new Emergency Plan, which will require coordination among USAID and other U.S. government agencies such as U.S. Department of Health and Human Services (HHS), Centers for Disease Control and Prevention (CDC), Health Resources and Services Administration, (HRSA), and the Department of Defense (DOD).

8. Policy Environment

Gender Equity in Women's Participation and GIPA

Key informants noted that inequalities in women's participation in decision making extended to women's unequal participation at all levels of program and policy development. Respondents also noted the importance of the Greater Involvement of People Living with HIV/AIDS (GIPA) to promoting policies and programs that meet the needs of infected and affected individuals, and the need to promote gender equity as GIPA is implemented in order to ensure the full representation of both women's and men's needs.

To accommodate or transform gender relations, programs need to:

- ***Identify and respond to gender-based constraints to participation,*** including, for example, providing women with child care or providing women-only spaces to facilitate identification of priorities and needed capacity building by and for women;

- ***Promote capacity building within PLWHA groups to understand gender relations,*** including better identifying and responding to gender-specific needs of men and women, and fostering equitable participation and leadership by both women and men;

- ***Promote capacity building within HIV/AIDS interventions and policies to ensure implementation of GIPA,*** including attention to equal representation and decision making power of women as well as men; and

- ***Explore potential alliances between traditional women's groups and HIV/AIDS organizations,*** in order to strengthen understanding of shared agendas as well as facilitate increased participation of women in defining program and policy responses to HIV/AIDS.

Policy Support for Gender Equity and Human Rights

Respondents noted that the policy environment, including policies based on a strong gender equity and human rights framework, is crucial to ensure that programs are not exacerbating gender inequalities and, instead, are able to accommodate and transform gender relations.

To accommodate or transform gender relations, programs need to:

- ***Incorporate gender and human rights analysis into the development of policies and strategic plans,*** for example, ensuring that strategic plans include analysis of current gender norms and inequalities as they relate to HIV/AIDS, and include specific strategies and implementation plans to address these issues; and, as needed, reviewing and reforming laws and policies related to gender equity and human rights such as property and inheritance rights, legal age of marriage, GBV, mandatory testing of sex workers, and mandatory partner notification, among others.

See Promising Intervention "#14 Mainstreaming Gender in Kenya" in Section 4

- ***Build the capacity of key stakeholders in the policy process to understand how gender affects HIV/AIDS vulnerability and impact,*** including understanding how addressing these determinants can improve program effectiveness;

- ***Ensure the participation of affected groups in the policymaking process,*** including promoting gender equity in participation; and

- ***Allocate budget and technical resources for the development of gender-responsive interventions,*** including adequate provision of resources to build human capacity to understand and implement gender-responsive projects.

Section 3:

Moving Forward: Current Gaps, Emerging Challenges

The IGWG Gender and HIV/AIDS Task Force assessment found that programs within USAID and its partners demonstrate a clear understanding of the gender dimensions of the HIV/AIDS epidemic—from the ways in which gender shapes vulnerability to HIV infection to the impact of gender on individuals' and communities' abilities to access and provide care, support, and treatment. The assessment also identified a number of examples of promising gender-informed interventions, tools, and resources shared in Section 4 that are being carried out by USAID and its partners.

At the same time, the task force noted some identifiable gaps in responses. In this section, we explore the gaps and emerging issues as identified by the task force's analysis and by respondents in the interactive dissemination workshops. This list is not meant to be exhaustive, but it is meant to highlight areas where programs may want to focus future efforts.

Gap 1: While recommendations and lessons learned exist, they are not always put into practice.

There is a large gap between the existence of promising recommendations and responses—as detailed above in the specific program area recommendations—and their integration into programs.

- ***Promising interventions and lessons learned related to integrating gender are not consistently integrated across programs.*** In most program areas, promising interventions appear isolated and as special initiatives undertaken by a specific organization in a specific location. These interventions do not yet appear as approaches systematically integrated within programs.

- ***As with many areas of programming, expanding the reach of programs remains a challenge.*** A significant number of promising interventions, particularly those related to transforming gender relations, have yet to be expanded beyond smaller pilots or projects. Efforts to understand how to expand the reach of these interventions, especially with efforts that require significant investment to build staff capacity on gender to carry out a program, are needed.

Thus, there is much room for programs to benefit from consistently incorporating, adapting, and scaling up promising program responses that already exist.

Gap 2: Some vulnerable groups are not being adequately addressed, particularly when considering their needs in terms of gender and HIV/AIDS.

In reviewing the programs described by key informants, the Task Force realized that there are vulnerable groups whose issues related to gender and HIV/AIDS were rarely mentioned. These gaps may, in fact, not be representative for all programs. Nevertheless, the following groups could potentially benefit from programs that analyze and respond to the gender issues that may affect their ability to benefit from HIV/AIDS policies and programs:

- **HIV-positive youth.** In reviewing the program issues and key responses highlighted by interviewees, the Task Force noted an important gap in programming related to HIV-positive youth. In discussing gender issues specific to youth, respondents focused on prevention opportunities. Informants did not highlight the particular ways in which gender impacts the care and support needs of HIV-positive youth, or key program responses to address their needs. Given the profile of those most likely to be newly infected (e.g., youth), it is crucial that programs be developed to not only prevent infection but also to respond to the specific needs of HIV-positive young women and men.

- **MSM, transgender, and third-sex identities.** While some informants noted that this was a key area for programs to address, it is still an undeveloped focus. Needed areas of research and programming include: addressing the links between dominant norms of masculinity and homophobia; exploring the impact of gender norms and their effect on safer sexual relations among MSM; and better understanding of how gender norms affect relationships between MSM and their female partners.

- **Injecting drug users.** A few interviewees noted that they assumed that there were gender issues related both to male and female injection drug users, but that they could not identify what these were, much less highlight any promising gender-informed responses. Understanding how gender relations affect male and female drug users' risks of HIV and designing effective programming is a gap that needs to be addressed.

- **Eastern Europe and the former Soviet Union.** Interviewees from this region noted that more regionally specific gender analysis was needed in order to respond to gender norms and constraints affecting the vulnerability of both men and women to HIV infection, and the types of gender-informed programming that might best meet their needs.

Gap 3: Appropriate program responses need to be developed for emerging issues.

As many respondents noted, "The question is not so much *what* the gender issues are, but *how* we can respond." Not surprisingly, there are key areas where gender-informed interventions are limited or not yet developed—but need to be. We list those areas that interviewees emphasized as the most pressing priorities to address.

- **Developing gender-informed PMTCT programs.** Formative research has identified gender issues related to VCT and PMTCT that need to be addressed, especially related to GBV and stigma and discrimination faced by women. This research has also suggested promising responses, including strengthening counseling and informed consent procedures; developing protocols for GBV; involving men; and mobilizing communities to decrease stigma and discrimination directed toward women. However, to date, few gender-integrated interventions or models of PMTCT programs have been developed.

- **Developing strategies to ensure equal access to treatment.** Key informants argued that, as access to treatment becomes more available, there will be gender inequalities in access to and decision making about financing of treatment. As access to treatment is scaled up, programs need to ensure that these potential inequalities are identified and that strategies are developed to promote women's equal access to treatment. Yet, few policies or programs have had a plan of action to assess these concerns or design responses to ensure equal access.

- **Closing the gap between recognizing and responding to the unequal burden of care.** For the degree of documentation on the unequal burden of care that women face, respondents noted that, to date, there have been surprisingly few programs or promising interventions reported in this area. Interviewees also noted that there has been little research or programming to address how gendered norms affect the burden of care among girls and boys, especially for orphans and vulnerable children.

- **Integrating GBV programming across the continuum of prevention to care, and at multiple levels.** Respondents emphasized the importance of integrating strategies to address GBV across the continuum of prevention to care programs—for example, incorporating screening and referrals related to GBV into health services, especially in the context of the integration of family planning and HIV/STI services, dual protection counseling, VCT, and PMTCT programs. While some programs are just beginning to incorporate guidelines related to screening, there are a host of other areas related to GBV and HIV that have yet to be developed. Other areas where GBV programming could be linked to HIV/AIDS programs include efforts to change community norms; promote women's rights and supporting laws and policies related to sexual and physical violence; and further develop and fund community services for women facing violence.

- **Developing a comprehensive strategy to address economic and societal vulnerability to HIV/AIDS.** While it is well-known that lack of access to economic resources places women and girls, especially, at risk for HIV, informants reported that there is still no coherent strategy or programming approach to address this root cause. Given the entrenched nature of economic and societal vulnerability—and the pressure to show quick results—informants felt a sustained program strategy, with collaboration across sectors, may be needed to support the establishment of model programs to address societal vulnerability.

- **Explicitly addressing gender within projects to reduce stigma and discrimination, and building HIV-positive women's leadership capacity.** Informants also noted that gender has yet to be placed squarely on the agenda of stigma and discrimination interventions. They noted a current disconnect between research and program interventions related to gender and those related to stigma and discrimination, even though the two are influenced by each other. Furthermore, while programs recognize that inequalities in women's participation in decision making extend to women's unequal participation at all levels of program and policy development, this has yet to receive sustained attention within USAID and its partners' programs. Support for the capacity building and other interventions is needed to ensure gender equity in participation and decision making by and for those infected and affected by HIV/AIDS.

Section 4:

Examples of Promising Interventions, Tools, Research, and Resources

This section focuses on examples of promising interventions, tools, research, and resources from USAID and partner organizations that address some of the gender issues and responses discussed above. When appropriate, this section also reports on non-USAID program examples cited by informants as promising responses to the links between gender and HIV. Some examples highlight interventions that have had the benefit of systematic evaluation; other examples reflect newer interventions and resources which have generated excitement and promise, but for which no formal evaluation data are available. We included both in order to provide the widest representation of promising responses to the issues identified in the interviews.

Prevention Programs that Address Gender Norms and Inequalities

#1 Transforming Norms of Masculinity to Reduce GBV and Prevent HIV: *Men As Partners*. EngenderHealth and the Planned Parenthood Association, South Africa

What gender issues does the program address? Norms of masculinity impact the health of men and their vulnerability to HIV as well as increase women's vulnerability to GBV and HIV infection. The Men As Partners (MAP) Program seeks to build men's awareness and support for their partners' reproductive health needs and choices; increase men's responsibility for disease prevention; improve men's access to and use of reproductive health services; and reduce violence against women. The program is a joint effort of EngenderHealth and the Planned Parenthood Association of South Africa (PPASA).

How has the program addressed these gender issues? Using a curriculum designed specifically for the program, facilitators help men explore and discuss a range of issues, including gender roles, HIV/AIDS prevention and care, partner communication, and healthy relationships. While creating a safe space for men to discuss their own attitudes and behaviors, facilitators also work to challenge and transform attitudes that uphold gender inequality and GBV. In particular, MAP activities seek to raise men's awareness of the consequences of "manly" behavior for themselves and their partners (e.g., increased vulnerability to HIV infection) as well as understand the parallels between different forms of oppression, such as apartheid and gender inequality. To ensure a lasting impact, the MAP Program conducts follow-up sessions with respondents and has established partnerships with a variety of local organizations to encourage further community mobilization around GBV and prevention of HIV transmission. Evaluations have documented significant changes in attitudes. For example, interviewees are more likely than non-respondents to agree that it is *not* normal for men to sometimes beat their wives; they are also more likely to agree that women should have the same rights as men.

For more information:

- EngenderHealth. 2003. "Working with Men." Available at http://www.engenderhealth. org/ia/wwm/index.html

- Verma, M. 2003. "How can men work as partners in ending violence against women and in HIV/AIDS related prevention, care and support? An examination of The Men as Partners (MAP) program in South Africa." Available at http://www.awid.org/fridayfile/msg00136.html

- Peacock, D. 2003. "Men as Partners (MAP) program in South Africa: Reaching Men to End Gender Based Violence and Promote Sexual and Reproductive Health." Available at http://www.awid.org/article.pl?sid=03/04/24/1624224&mode=nocomment

#2 Addressing Young Men's Masculinity within Traditional Rites of Passage: Climbing to Manhood Chogoria Hospital, Kenya

What gender issues does the program address? Societal norms regarding masculinity often encourage adolescent males to engage in risk-taking sexual behavior. In central Kenya, the Chogoria Hospital's Climbing to Manhood program builds on traditional rites of passage to provide an opportunity to promote healthy behaviors among adolescent males.

How has the program addressed these gender issues? Circumcision, which generally happens when a Meru boy is around 15 years of age, is considered a rite of passage in some central Kenyan communities—one in which boys are expected to undergo physical, psychological, and behavioral changes. During this time, boys learn about the attitudes, behaviors, and skills associated with manhood in Meru society. In particular, they may be encouraged to begin engaging in sexual activity shortly after circumcision. Understanding that this rite of passage is a time when boys' attitudes and behaviors are expected to change, Chogoria Hospital recognized a unique opportunity to inform them about reproductive health and encourage healthy behaviors, particularly in regard to high-risk sexual behaviors. The aim of the Climbing to Manhood program is to improve boys' knowledge of "key health matters and to establish healthy attitudes, positive peer bonding, and a healthy lifestyle" (Brown, 2002). Incorporating the seclusion and bonding that take place in traditional circumcision rites, groups of boys participating in the Chogoria program spend 5–7 days together in a special ward following hospital circumcision. With men from the community—health care workers, pastors, teachers, and others—the boys explore a range of topics, including STIs and HIV/AIDS, community expectations of men, and issues surrounding violence.

While there is ongoing debate over the protective advantage of circumcision in terms of prevention of HIV transmission, the Chogoria Hospital seeks to adapt the traditions of communities that already practice circumcision in order to provide safe procedures in a hospital setting and, at the same time, promote healthy norms of masculinity among male youth.

For more information:

- Brown, J.E. 2002. *Integration of Traditional and Clinical Male Circumcision at Chogoria Hospital in Central Kenya.* Available at http://www.rho.org/men+rh%209-02/men_brown.pdf

3 Promoting Gender Equitable Approaches to Young Men's Involvement: *Men's Partnership in Women's Reproductive Health* Society for Integrated Development of Himalayas (SIDH), India

What gender issues does the program address? Gender norms often preclude women's participation in decision making and communication on health matters, while men are often expected to make these decisions. SIDH's program, Men's Partnership in Women's Reproductive Health, aims to motivate young men to become partners in improving women's reproductive health, so that women and men are equally involved in information gathering, joint communication, and decision making regarding family planning and child spacing; in seeking reproductive health care, pregnancy and delivery care, and support; and in preventing and treating STIs, including HIV/AIDS.

How has the program addressed these gender issues? After conducting a needs assessment in program villages, SIDH staff developed a four-day training module for young men and women. The training introduces the concepts of "gender" and "sex" for discussions of gender equity and women's reproductive health, incorporating cultural components such as traditional songs and films in these discussions. Participants learn about reproductive health—anatomy, reproductive cycles, and STIs/HIV. All of these issues are linked to personal responsibility, leadership, and justice. In the end, youth participants create personal work plans detailing how they will apply their newly learned attitudes toward men's involvement and gender justice to behavior change in their own villages and homes. Participants report that the training has changed their attitudes, as they have a better understanding of the complexities of gender issues, decision-making power within traditional families, and the benefit of men and women working together to improve both gender relations and women's reproductive health. Based on its documented success, this module is now a major component of a comprehensive educational curriculum, which is used in SIDH's non-formal village schools and in ongoing courses for young men and women.

For more information:

- http://www.sidh.org
- Interagency Gender Working Group (IGWG). 2003. *Involving Men to Address Gender Inequities.* Washington, DC: Published by Population Reference Bureau for the USAID IGWG. Available at http://www.igwg.org.

In addition to the SIDH case study, the resource *Involving Men to Address Gender Inequities* profiles two other programs—Salud y Genero and Stepping Stones—and their innovative strategies to involve men and youth in efforts to improve reproductive health outcomes for both men and women. In Mexico, Salud y Genero has worked with men in Latin America to reduce gender-based violence and improve men's support for women's reproductive health. The Stepping Stones program, first developed in Uganda, is a communication, relationships, and life skills training package, which has worked with men and women, including youth, to increase awareness of gender issues to prevent transmission of HIV. This document is available at http://www.igwg.org.

#4 Addressing Broader Gender Inequalities for STI/HIV Prevention: *Sonagachi STD/HIV Intervention Project*[6] *(SHIP),* India

What gender issues does the program address? Gender norms and inequalities greatly increase vulnerability to HIV and other STIs in the sex industry. While keeping the reduction of STI/HIV transmission as a principal objective, with the participation of female sex workers, the program over time has identified and responded to broader gender-based inequalities. The Sonagachi Project has sought to change the imbalances in power and gender norms, including GBV and harassment, that limit safer sexual practices and protective behaviors, and to increase access to social and economic resources, such as income generation, credit, literacy, and childcare in order to reduce sex workers' vulnerability to STI/HIV.

How has the program addressed these gender issues? The Sonagachi Project began in 1992 as a program to prevent the spread of HIV/STIs among brothel-based and floating sex workers in Calcutta, India. Early strategies involved providing information through sex worker peer educators, social marketing of condoms, and clinical services. With the participation of female sex workers to help better understand key barriers and promising strategies for increased prevention of HIV/STI transmission, the program has since expanded to recognize the many aspects of women's (and men's) lives that affect HIV vulnerability. Sonagachi program interventions have thus expanded to include multisectoral responses to address these broader gender inequalities related to sex workers' vulnerability to STI/HIV.

For instance, in addition to serving as peer educators, sex workers have received legal training, organized themselves as an advocacy group, and have initiated programs to address abuse and violence by different sectors of the sex industry (e.g., clients, brothel owners, and police). In order to increase access to alternative economic resources, the sex workers have formed a union; a credit, marketing, and production cooperative that provides short- and long-term loans; and a daycare center for the sex workers' children. Evaluation data show the project has been successful in reducing HIV/STI prevalence and facilitating sustainable changes in sex workers' ability to promote their health and well-being. The project has spread extensively throughout West Bengal and currently involves about 60,000 sex workers, including transgender and male sex workers.

For more information:

- UNAIDS. 2000. "Female Sex Worker HIV Prevention Projects: Lessons Learnt from Papua New Guinea, India, and Bangladesh." Available at http://www.unaids.org/publications/documents/care/general/JC-FemSexWork-E.pdf.
- "Case Study: Sonagachi—STI/HIV/AIDS Prevention in India (SHIP)," in IGWG. (Caro, et al.) 2002.
- "Intervention: Sex Workers in Sonagachi and Beyond," in IGWG. (Boender, et al.) 2002.

[6] The project is featured as a promising intervention because sex workers are one of the most at risk populations that the Office of HIV/AIDS works with in many countries to stem the transmission of the infection to the general population. The Sonagachi project is a well known case with very positive results, especially for some of the most vulnerable and poorest victims of the epidemic.

Dual Protection and Integration of Family Planning/HIV/STI Services

#5 Building Provider Capacity to Address Gender and Sexuality: Integration of HIV/STI Prevention, Sexuality, and Dual Protection in Family Planning: A Training Manual (EngenderHealth)

What gender issues does the program address? While providers' ability to communicate with clients about gender, sexuality, and power dynamics is essential to providing fully informed counseling and information that enables client's to assess their best options for STI/HIV and pregnancy prevention, many providers lack this capacity. In addition, many programs assume that providers will not be open to addressing these issues. EngenderHealth has developed various training materials which can be used to incorporate gender, sexuality, and power into training for providers in order to build their capacity. These include "Integration of HIV/STI Prevention, Sexuality, and Dual Protection in Family Planning: A Training Manual," "Men's Reproductive Health Curriculum," and an online mini-course "Sexuality and Sexual Health."

How has the program addressed these gender issues? EngenderHealth successfully worked to sensitize providers to gender power dynamics in sexual relations and the often limited ability of women to control these sexual relations by conducting capacity building training on HIV/STIs. The training has focused on gender and sexuality with providers in many cultural contexts, including countries such as Pakistan and Uzbekistan, where many doubt the appropriateness or feasibility of addressing sexuality and gender due to constraints of traditionally conservative cultures. Staff members note that the training was well received and shows that, with the right approach, sexuality training can be done in many contexts.

For more information:

- http://www.engenderhealth.org

VCT and PMTCT

#6 Changing the Timing of Test Results Notification with Couples: AIDS Information Center, Uganda

What gender issues does the program address? Women often face harsher stigma and discrimination following disclosure of HIV status. In the context of HIV testing, particularly as part of PMTCT programs, women are frequently the first to learn of their HIV status and, as a result, may face additionally harsh consequences and blame for bringing HIV into a family. The AIDS Information Center (AIC) of Uganda has changed its timing of notifying couples of their test results in order to address these dynamics.

How has the program addressed these gender issues? AIC, which provides VCT services for individuals and couples, discovered that a small procedural change can make a difference when it comes to the stigma faced by women affected by HIV/AIDS. AIC staff observed that when a couple comes in for HIV testing and the woman receives her result first, she is the one blamed for bringing HIV into the family. In response, AIC made it a policy to wait until both results are determined by the lab before providing post-testing counseling to the couple. In addition, AIC staff now always report the result of the male client's test first. Based on their observations to date, the staff feel that this small policy shift to accommodate the reality of gender relationships in Uganda has helped to reduce the potential for blame and physical violence that female clients may face following an HIV-positive result.

For more information: • http://www.aicug.org

#7 PMTCT, Community Dialogue, and Stigma: *Community Involvement in the Prevention of Mother-to-Child Transmission of HIV:* Insights and Recommendations (ICRW and Horizons/Population Council)

What gender issues does the program address? PMTCT programs have often assumed that once the technology (e.g., ARV treatment) to help reduce mother-to-child transmission was made available, women would use it without looking at other mitigating circumstances. Yet, as the ICRW research documents, the stigma women face if they are known to be HIV positive and the gender dynamics related to decision making, if unaddressed, limit access to PMTCT services and can result in unintended harm.

How has the program addressed these gender issues? The International Center for Research on Women (ICRW) and Horizons/Population Council undertook a short study to look at community and women's perspectives on PMTCT, entitled "Community Involvement in the Prevention of Mother-to-Child Transmission of HIV: Insights and Recommendations" (Rutenberg, et al., 2001). The research suggests that PMTCT programs need to consider several issues in order to address the gender- and stigma-related barriers that limit access to PMTCT programs. It is very important to have community dialogue on HIV/AIDS and PMTCT and to include these perspectives in program design and implementation. Community perceptions and levels of stigma (e.g., attitudes toward PLWHA) strongly influence PMTCT programs. Women's participation in PMTCT programs is influenced by the opinions of their spouses and partners, as well as other family members. Depending on the context in which they live and the program, the consequences of being HIV positive can have serious implications for women. For example, while the women may be tested confidentially, if they do not breastfeed, others in the community will assume they are HIV positive. The research has also raised awareness about the importance of psychosocial support in VCT and PMTCT prevention programs; as a result, other projects are testing new approaches.

For more information:

- Rutenberg et al. 2001. "Community Involvement in the Prevention of Mother-to-Child Transmission of HIV: Insights and Recommendations." Available at http://www.icrw.org/docs/mtct_2001.pdf

#8 Promoting Male Involvement in PMTCT: Findings from Horizons Operations Research Horizons, UNICEF, Network of AIDS Researchers in Eastern and Southern Africa (Kenya), and MTCT Working Group (Zambia)

What gender issues does the program address? In many cases, prevention of HIV infection in newborns is treated as the sole responsibility of women. Men have an important role to play both in preventing MTCT and also supporting women's access to and use of PMTCT services. Effective outreach to men, in "male-friendly" spaces, can help encourage them to support women at each step in the process, including the decision to and ability to get tested for HIV, return for the test results, take ARVs, and practice safe infant feeding techniques.

How has the program addressed these gender issues? Beginning in 2000, Horizons and UNICEF, along with local partners (the Network of AIDS Researchers in Eastern and Southern Africa [Kenya] and the MTCT Working Group [Zambia]), set out to evaluate a package of integrated PMTCT services. Pilot tested in nine sites, the integrated package included maternal and child health services, counseling, VCT, ARV treatment for HIV-positive women and newborns, infant feeding counseling, community mobilization, and referrals for additional care and sup-

port services. Evaluators of the program found that male involvement was a key factor in women's use of PMTCT services. They also found that successful strategies to involve men were often those that sought to reach men directly and outside of traditionally women-centric settings, such as antenatal or maternal and child health clinics. Program managers developed strategies to reach men with PMTCT information, such as "providing community education on PMTCT in places where men congregate, organizing support groups for men, and directly inviting men to the clinic for HIV counseling and testing" (Baek, et al., 2003, p. 9). Addressing men directly through community outreach efforts not only encourages greater male involvement, it also helps "remove the onus of responsibility from women for bringing up PMTCT" (Baek, et al., 2003, p. 8).

For more information:

- Baek et al. 2003. "Prevention of Mother-to-Child HIV Transmission: Assessing Feasibility, Acceptability, and Cost of Services in Kenya and Zambia."

- Rutenberg et al. 2003. "Evaluation of United Nations-Supported Pilot Projects for the Prevention of Mother-to-Child Transmission of HIV: Overview of Findings." Available at http://www.popcouncil.org/pdfs/horizons/pmtctunicefevalovrvw.pdf

Stigma and Discrimination

#9 Addressing Gender in Anti-Stigma and Discrimination Efforts: Modules from *Understanding and Challenging HIV Stigma: A Toolkit for Action* (CHANGE Project)

What gender issues does the program address? Gender norms and inequalities profoundly shape the dynamics of stigma and discrimination within communities responding to HIV/AIDS. Yet, few tools have been developed to address stigma and discrimination, much less to explore how gender affects stigma and discrimination. *Understanding and Challenging HIV Stigma: A Toolkit for Action* (Kidd and Clay, 2003), produced through a collaborative effort led by the Academy for Educational Development's CHANGE Project, is designed to deepen the understanding of stigma and facilitate processes to address it. Gender is integrated into many of the toolkit's activities.

How has the program addressed these gender issues? In different modules, activities include questions to reflect on how gender relates to stigma and discrimination. For instance, the activity "How Stigma Affects Different Groups" leads to reflection on differences in how stigma affects men and women. Another activity, titled "Double Standards," promotes reflection on how double standards—such as those related to sex and sexuality—can promote stigma and discrimination especially towards women, sex workers, and MSM. Similarly, the module on "How HIV/AIDS Affects the Family" considers how gender norms influence stigma, discrimination, and equity in care giving within affected families.

For more information:

- *Kidd, R., and S. Clay. 2003. Understanding and Challenging Stigma: Toolkit for Action. Available at* http://www.changeproject.org/technical/hivaids/stigma.html

HIV-Positive Women's Reproductive Health

#10 Promoting HIV-Positive Women's Health and Rights: Voices and Choices International Community of Women Living with HIV/AIDS, Thailand and Zimbabwe

What gender issues does the program address? Once women are identified as HIV positive, health care policies and programs, providers, and community members often stigmatize, ignore, or fail to respond to HIV-positive women's sexuality and reproductive health needs. HIV-positive women, as with PLWHA in general, also continue to be largely absent from involvement in decision making related to HIV/AIDS programs and policies. The International Community of Women Living with HIV/AIDS (ICW) undertook a participatory research and advocacy project designed by and for HIV-positive women to document their reproductive health experiences and needs as well as foster advocacy efforts.

How did the project address these gender issues? ICW conducted a three-year participatory research and action project in Zimbabwe and Thailand, in conjunction with UNAIDS, to assess the sexual and reproductive health experiences of HIV-positive women and then launch an advocacy campaign based on research findings. In the words of the *Voices and Choices* report, "In Zimbabwe [the project] has been quite outstanding in its process and outcomes. HIV-positive women, from resource-poor mainly rural communities, were elected by their support groups to be trained to collect data and analyze the findings. The process of teamwork gave the women skills and self-confidence and they are now strong advocates from their communities, representing the issues of HIV-positive women in many [forums] and making presentations at high-profile international events" (Feldman, et al., 2002).

For more information:

- http://www.icw.org
- Feldman, et al. 2002. Positive Women: Voices and Choices— Zimbabwe Report. Available at http://www.icw.org/tiki-index.php?page=Voices+and+Choices

Burden of Care

#11 Community Involvement to Shift the Burden of Care: Peace Corps Malawi

What gender issues does the program address? Women and girls often take on the primary burden of care for family members living with HIV/AIDS due to community gender norms that assign care-giving responsibilities to women and girls. In Malawi, the Peace Corps is trying to change community care-taking norms to promote broader community and male involvement as well.

How has the program addressed these gender issues? In Malawi, the Peace Corps has found that community mobilization programs are helping to spread care responsibilities among other members of the community. These programs emphasize that the whole community and the whole family needs to be responsible for the care of those affected by HIV/AIDS. Some communities have had a good response to this approach and household tasks have been divided so that, for example, a man watched the patient while the woman chopped firewood and prepared a meal. There has also been success with developing community volunteer teams—both non-positive and PLWHA groups—to help with household tasks.

For more information:

- Email malawi@peacecorps.gov

Multisectoral Approaches

#12 Access to Credit for Women Living with HIV/AIDS: Society for Women and AIDS in Kenya and Family Health International

What gender issues does the program address? Women have traditionally had difficulty accessing economic resources, including credit. Barriers to accessing credit and economic resources can be more severe for women who are living with HIV/AIDS. To increase HIV-positive women's access to credit, the Society for Women and AIDS in Kenya (SWAK) has advocated for and succeeded in changing lending practices to include HIV-positive women.

How has the project addressed these gender issues? A pilot project in one area of Kenya, initiated by SWAK, explores how to integrate income-generating activities with HIV/AIDS prevention and care activities. Before the advent of the project, micro-finance professionals would not give loans to HIV-positive women, believing that it would be a poor investment. Loans are now provided to HIV-positive women via their self-help groups. This project supports SWAK's goal of enhancing the capacity of women and girls to contribute to the prevention and control of HIV/AIDS, and provide care and support for PLWHA by mobilizing their own resources in an environment where economic empowerment is tailored to what women already do.

For more information:

- http://www.fhi.org or email services@fhi.org

Promoting an HIV/AIDS Enabling Policy Environment by Strengthening Gender Equity and Human Rights

#13 Advocacy to Address Stigma and MSM: ASICAL Network, Latin America

What gender issues does the program address? The silence and stigma often associated with MSM makes it difficult for them to access needed information and services, increasing their vulnerability to HIV infection. In many cases, MSM face the *double* stigma that relates to both their membership in a marginalized group and their (real or perceived) HIV status. However, attention to the gender and sexuality issues surrounding MSM is limited in HIV/AIDS programs and policies. The POLICY Project, through its support of the ASICAL network in Latin America, has supported advocacy efforts to increase attention to MSM issues in the context of HIV/AIDS policy and programming.

How has the project addressed these gender issues? The POLICY Project provides technical assistance to ASICAL to enhance the advocacy skills of local organizations that work on MSM issues across Latin America to strengthen HIV/AIDS programming responsive to MSM vulnerability to HIV/AIDS. ASICAL, La Asociación para la Salud Integral y Ciudadanía en América Latina (or Association for Full Health and Citizenship in Latin America), is a network of nine NGOs from seven Latin American countries.

In January 2003, the POLICY Project and ASICAL facilitated a training workshop for MSM on advocacy strategies to enhance HIV/AIDS prevention and care and support services. The training provided an opportunity for representatives from civil society to work together on the development of advocacy strategies and to exchange experiences with officials from various ministries of health. The general objective of the training was to provide a tool for building the local capacity of advocacy groups in Latin America and to develop and implement advocacy campaigns on

reducing the vulnerability to and impact of HIV/AIDS among MSM. As next steps, the participating organizations will replicate the advocacy training workshop in their home countries. With financial assistance through the Synergy Project, they will also implement the HIV/AIDS advocacy action plans they developed during the January workshop. A final version of the manual pilot tested during the training, entitled *Guia de incidencia politica en VIH/SIDA: hombres gay y otros hsh* (Mayorga, et al., 2003), is now available in Spanish and will also be translated in Portuguese.

For more information:

- http://www.policyproject.com
- http://www.asical.org
- http://www.sidalac.org.mx/asical/asical.html
- Mayorga et al. 2003. *Guia de incidencia politica en VIH/SIDA: hombres gay y otros HSH.* Available at http://www.policyproject.com/abstract.cfm?ID=1466.

#14 Mainstreaming Gender in the Kenya National HIV/AIDS Strategic Plan: Gender and HIV/AIDS Technical Subcommittee and the POLICY Project, Kenya

What gender issues does the program address? Gender issues, such as the lower socioeconomic status of women and the threat of GBV, are recognized as key contributors to the spread of HIV. Yet, few governments have explicitly addressed the gender issues that make both women and men vulnerable to infection. In Kenya, the National AIDS Control Council thus formed a subcommittee to mainstream gender into the National HIV/AIDS Strategic Plan.

How has the program addressed these gender issues? To analyze gaps in Kenya's National HIV/AIDS Strategy, in collaboration with the National AIDS Control Council (NACC), the POLICY Project co-founded, facilitates, and provides technical assistance to the Gender and HIV/AIDS Technical Subcommittee. In partnership with the government, a broad cross-section of more than 36 organizations and sectors supported and participated in the gender subcommittee, including SWAK, Women Fighting AIDS in Kenya, Kenya AIDS NGOs Consortium, and others. This marked the first time that HIV/AIDS groups and gender advocacy organizations had come together in an official forum to inform policymaking at the national level.

In 2002, the subcommittee completed a point-by-point analysis of Kenya's national plan, highlighted the gender concerns raised in each part of the plan, and provided recommendations for integrating gender sensitivity into the strategy. The findings of this analysis are contained in the document *Mainstreaming Gender into the Kenya National HIV/AIDS Strategic Plan: 2000–2005*, adopted by the NACC on November 27, 2002. This document can serve as a model for other countries seeking to integrate gender-sensitive approaches into national strategies.

For more information:

- www.policyproject.com
- National AIDS Control Council (NACC). 2002. *Mainstreaming Gender into the Kenya National HIV/AIDS Strategic Plan: 2000–2005*. Available at http://www.policyproject.com/abstract.cfm?ID=1203.

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a Gender Perspective into Reproductive Health Programs: Does It Make a Difference to Outcomes? Washington, DC: United States Agency for International Development (USAID)/IGWG.

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Appendix A:
Abbreviations

AIC	AIDS Information Center
AIDS	acquired immune deficiency syndrome
ASICAL	La Asociación para la Salud Integral y Ciudadanía en América Latina (Association for Full Health and Citizenship in Latin America)
ARV	antiretroviral
CA	cooperating agency
CDC	Centers for Disease Control and Prevention
DOD	Department of Defense
FHI	Family Health International
GBV	gender-based violence
GIPA	Greater Involvement of People Living with HIV/AIDS (Principle)
HHS	United States Department of Health and Human Services
HIV	human immunodeficiency virus
HRSA	Health Resources and Services Administration (United States)
ICRW	International Center for Research on Women
ICW	International Community of Women Living with HIV/AIDS
IDU	injecting drug user
IPPF–WHR	International Planned Parenthood Federation–Western Hemisphere Region
IGWG	Interagency Gender Working Group (of USAID)
IWG	Implementation Working Group (of USAID)
MAP	Men As Partners
MANET+	Malawi Network of People Living with HIV/AIDS
MSM	males who have sex with males
MTCT	mother-to-child transmission
NACC	National AIDS Control Council
NGO	nongovernmental organization
OHA	Office of HIV/AIDS (of USAID)
OPRH	Office of Population and Reproductive Health (of USAID)
PASCA	Central American HIV/AIDS Prevention Project
PATH	Program for Appropriate Technology in Health
PLWHA	people living with HIV/AIDS
PMTCT	prevention of mother-to-child transmission
PPASA	Planned Parenthood Association of South Africa
PSI	Population Services International
SAVE	Save the Children
STI	sexually transmitted infection
SWAK	Society for Women and AIDS in Kenya
TASO	The AIDS Service Organization
UNAIDS	Joint United Nations Program on HIV/AIDS
UNFPA	United Nations Population Fund
UNIFEM	United Nations Development Fund for Women
USAID	United States Agency for International Development
VCT	voluntary counseling and testing
WHO	World Health Organization

Appendix B:
Definitions of Key Terms

The following definitions are excerpted from the IGWG's *A Manual for Integrating Gender into Reproductive Health and HIV Programs: From Commitment to Action* (Caro, et al., 2002).

Gender: Refers to the economic, social, political, and cultural attributes and opportunities associated with being female and male. The social definitions of what it means to be female or male vary across cultures and change over time.[7] Gender is a socio-cultural expression of particular characteristics and roles that are associated with certain groups of people with reference to their sex and sexuality.

Gender equity: The process of being fair to women and men. To ensure fairness, measures must be available to compensate for historical and social disadvantages that prevent women and men from operating on a level playing field. Gender equity strategies are used to eventually attain gender equality. Equity is the means; equality is the result.[8]

Gender integration: Means taking into account both the differences and the inequalities between women and men in program planning, implementation, and evaluation. The roles of women and men and their relative power affect who does what in carrying out an activity, and who benefits. Taking into account the inequalities and designing programs to reduce them should contribute not only to more effective development programs but also to greater social equality/equity. Experience has shown that sustainable changes are not realized through activities focused on women or men alone.

Gender roles and identities: Vary across cultures and change over time. Women and men often differ in the activities they undertake, in access and control of resources, in participation in decision making, and in the power they have to manage their lives. The social positions ascribed to women and men are defined relative to one another. In most societies, women have less access than men do to resources, opportunities, and decision making. The social, political, and economic institutions of society—family, schools, industries, religious organizations, and government—are also gendered. They tend to incorporate and reinforce the unequal gender relations and values of a society. However, gender roles and identities have the capacity to undergo significant change.

Male participation: Gender roles often constrain men as well as women. Because the actions and behaviors of men affect both their own health and that of their partners and children, gender-equitable reproductive and sexual health programs help men to understand this impact. While promoting women's reproductive and sexual health decision making, such programs also work to increase men's support of women's reproductive and sexual health and children's well-being, and address distinct reproductive needs of men. Gender-integrated reproductive and sexual health programs take into account men's perspectives in program design, help men to feel welcome at clinics, provide a wide range of information and services to both women and men, and portray men positively. Most importantly, men's programs aim to promote gender equality in all spheres of life.[9]

Sex: Refers to the biological differences between women and men. Sex differences are concerned with women and men's physiology.

[7] DAC Guidelines for Gender Equality and Women's Empowerment in Development Cooperation (Paris: OECD, 1998).
[8] Canadian International Development Agency, *Guide to Gender-Sensitive Indicators* (Ottawa: CIDA, 1996).
[9] UNDP, 1994.

Definitions of Key Terms (cont.)

Women's empowerment: Improving the status of women also enhances their decision-making capacity at all levels, especially as it relates to their sexuality and reproductive and sexual health. Experience and research show that reproductive and sexual health programs are more effective when they take steps to improve the status of women.[10] Programmatic efforts that empower women provide an enabling environment for broadened, linked services that account for the social, political, psychological, economic, and sexual dimensions of women's health and well-being.

[10] International Conference on Population and Development, 1994.

Appendix C:
Methodology

How Was This Study Undertaken?

This booklet presents findings from an assessment conducted by the IGWG Task Force on Gender and HIV/AIDS. Between spring 2001 and spring 2002, members of the task force conducted in-depth interviews with 58 key informants from the USAID Global and Regional Bureaus, USAID Missions, and partners. The informants represent global and field-based perspectives. They are drawn from both OPRH- and OHA-funded projects from different regions. They also include organizations working with or run by PLWHA. Please see the Boxes 1 and 2 below for the distribution of respondents.

Box 1. Distribution of Informants

	USAID	CA/Other	Total
US	15	20	35
Field	7	16	23
Total	22	36	58

Box 2. Regional Representation among Field-Based Programs

	AFR	ASIA	LAC	E&E	Total
US Mission	4	7	0	2	7
CA/Other	10	2	3	1	16
Total	14	3	3	3	23
PLWHA*	2	1	1	0	4

*Note: All PLWHA organizations interviewed were field-based.

Methodology (cont.)

Key questions asked of each participant included the following:

- What are the key issues related to gender that your project faces in its HIV/AIDS/STI work?
- What current or recent activities is your project undertaking to address these gender issues?
- What have been the successes and lessons learned based on your project's activities to address gender?
- What have been the main supports and challenges in addressing the gender issues your project faces?
- Thinking about the current situation and the next 3–5 years, what do you see as the three most pressing issues related to gender and HIV/AIDS/STIs that a project like yours should address?

The task force analyzed the interview data to identify key gender issues affecting programs, summarize strategies to address these issues, and highlight examples of promising interventions. The task force also explored major challenges and cutting-edge issues facing programs as identified by respondents. Finally, the task force noted "gaps" in the identified gender issues and programs—that is, gender issues for which it appears programs and strategies are limited or have yet to be developed.

In addition to analysis by the task force, findings were validated, and further analyzed during several working sessions with USAID and its partners' members. These sessions included a workshop convened with an additional 30 partners and USAID representatives at the *XIV International AIDS Conference* held in Barcelona, Spain, in July 2002, and a subsequent presentation to another 10 partners based in Washington, D.C.

IGWG Support and Resources

- **Training.** Technical assistance and training from the IGWG, including a newly developed module on gender and HIV/AIDS, is also available to the USAID community. The objectives of the training component are as follows:

  – *Advocacy*, to promote interest and action for gender-sensitive approaches to programs and projects;

  – *Skills transfer*, to ensure that USAID and its partners are able to implement gender-sensitive approaches in their programs and projects; and

  – *Dissemination*, to share information and products from the IGWG task forces and its former subcommittees.

For more information on IGWG gender training workshops, please call Michal Avni, Training Component/IGWG, at 202-712-4094 or email him at mavni@usaid.gov.

- **Publications.** The IGWG offers a range of gender-related tools and materials. To access these materials online, please visit the IGWG website at http://www.igwg.org. To receive copies of IGWG publications, please email prborders@prb.org or contact IGWG/International Programs, Population Reference Bureau (PRB), at 1875 Connecticut Avenue NW Suite 520, Washington, DC 20009, 202-483-1100, (fax) 202-328-3937.

- **Listserv.** The IGWG maintains a moderated listserv for those interested in the IGWG and other gender-related news. Members of the IGWG listserv receive emails relating to the IGWG's progress—information and updates on our products and services, as well as minutes and meeting schedules for the IGWG Technical Advisory Group and the various task forces. Members are encouraged to submit emails such as gender articles in the population, health, and nutrition sector or conference announcements in order to expand the network of information. If you are interested in joining the listserv, or have any questions or concerns relating to the listserv, please contact Haruna Kashiwase at PRB or send an email to igwg@prb.org.

Other Important Resources

Following are two of the many important resources for gender and HIV/AIDS:

- The Gender-AIDS (AIDS and gender) listserv. GENDER-AIDS is an international forum on issues around gender and HIV/AIDS moderated by the Health & Development Networks Moderation Team. To subscribe to the listserv, go to www.hdnet.org.

- UNIFEM Gender and HIV Web Portal, accessible at http://www.genderandaids.org/index.php.