

# Linkages between Gender, AIDS, and Development

## Implications for U.S. Policy

A Report of the CSIS Global Health Policy Center

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# LINKAGES BETWEEN GENDER, AIDS, AND DEVELOPMENT IMPLICATIONS FOR U.S. POLICY

*Janet Fleischman*<sup>1</sup>

## Introduction

*“I will say that in Africa, in particular, one thing we do know is that empowering women is going to be critical to reducing the [HIV] transmission rate.”—President Barack Obama, August 3, 2010*

Global health, development, and gender are now understood to be dynamic and interlinked components of U.S. foreign policy. Given the emerging policy and programmatic debates on how these three domains are to be integrated to bring the greatest returns, especially in improving the health and welfare of women and girls, the CSIS Global Health Policy Center hosted a conference entitled “Linkages between Gender, AIDS, and Development: Implications for U.S. Policy” on June 11, 2010.

June 2010 was a particularly opportune moment to hold such a conference. In the preceding year, the U.S. government had launched its Global Health Initiative (GHI) and initiated the second phase of President’s Emergency Plan for AIDS Relief (PEPFAR), against the backdrop of the Obama administration’s high-level commitment to advance a women- and girls-centered approach. Within this context, the conference sought to highlight ways to maximize the opportunities and tackle the challenges in pursuing policies and programs to link HIV/AIDS initiatives with other health and development areas that particularly affect women and girls. The proceedings from the conference revealed that considerable innovation is taking place at the country level, that addressing these linkages is critical to meeting the needs of women and girls and can generate concrete results, and that there is strong interest within the Obama administration in applying the lessons learned from these programs to the development of its new global health strategy.

CSIS was honored to host a distinguished group of experts and practitioners on multisectoral linkages. The conference brought civil society activists from South Africa, Zambia, Kenya, and the United States together with representatives from international nongovernmental organizations, the United Nations, and U.S. officials from the Office of the Global AIDS Coordinator, the U.S.

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<sup>1</sup> Janet Fleischman is a senior associate with the Global Health Policy Center at CSIS.

Agency for International Development, the State Department’s Office of Global Women’s Issues, and the Congress.

The conference was the culmination of more than 15 months of work by Janet Fleischman, senior associate at the CSIS Global Health Policy Center, and a follow-up to her work in recent years on gender and HIV/AIDS and on the integration of HIV/AIDS and reproductive health (RH)/family planning (FP). In preparation for the conference, Fleischman traveled to South Africa, Zambia, and Kenya to identify programs that were linking gender, AIDS, and development, to visit program sites, and to interview program implementers and beneficiaries. Focusing on linkages between HIV/AIDS programs and education for girls, economic empowerment for women, and reproductive health, she was able to learn from a remarkable array of implementers—local, national, and international—as well as from U.S. officials, multilateral organizations, UN agencies, and private foundations.

The conference was divided into three panels, with Ambassador Eric Goosby, the U.S. global AIDS coordinator, providing the keynote address. The first panel addressed structural drivers of HIV risk, focusing on innovative programs linking economic empowerment for women and girls with HIV/AIDS; the second panel looked at “wraparound” approaches in PEPFAR, with lessons from programs linking AIDS with education for girls or family planning; and the final panel focused on new U.S. policy directions and where linkages fit with PEPFAR II and GHI. Each panel addressed three key issues:

1. *Making the case for linkages:* What are the advantages and challenges of linkages between HIV/AIDS and development? How do we define goals?
2. *Monitoring and evaluation:* What are we measuring, and how do we evaluate progress? Are there intermediate steps to mark meaningful milestones toward structural change?
3. *Overcoming obstacles:* To achieve greater innovation and sustainability, linkages will need to be constructed at different levels—in the field, in monitoring and evaluation, in programmatic planning and budgeting. How can innovation be encouraged, both at the national level and at the donor level?

The answers to these questions can help inform the administration’s evolving strategy to better link gender, AIDS, and development and will help ensure that issues related to women’s and girls’ health receive sustained policy attention to achieve real change.

While global attention to the importance of integrated approaches to address women’s and girls’ health is growing, many challenges remain. In particular, the new U.S. principle of ensuring a women- and girls-centered approach will have to address the challenges inherent in multisectoral programming, including how to demonstrate multisectoral impact, how to develop a multisectoral approach to gender indicators and outcomes, how to replicate and scale up promising programs, how to demonstrate that linkages are key to building cost-effective and sustainable approaches, and how to create space to learn from failure, given that innovation carries certain risks.

This report provides background on the programs represented at the conference, summaries of the speakers' presentations, and U.S. policy options that emerged from the conference. It is intended to help inform the discussions surrounding the implementation of GHI and PEPFAR II and to emphasize the importance of fully utilizing the opportunities to reach women and girls by addressing the health and development challenges that contribute to their risk of HIV. The report recommends that, to be successful, the U.S. government should:

1. systematically hold the implementing government agencies accountable to promote multisectoral linkages;
2. put in place better measurement tools to track progress in addressing women's health outcomes and achieving structural change and identify intermediate steps to capture impact; and
3. set out long-range plans to build sustainability, encourage innovation, and ensure U.S. global leadership.

## U.S. Policy Options

The current U.S. and global policy environments provide an unprecedented opportunity to develop a new approach to the linkages between women's and girls' health and global health and development, and to address head on the complexities that multisectoral programming present. These linkages are an essential element to the HIV/AIDS response, since they help address the structural, societal factors that shape women and girls' risk of HIV infection and complicate their situations once infected.

With GHI and PEPFAR II, the United States can better support and encourage innovative responses that place the HIV/AIDS crisis for women and girls within the context of broader development. In particular, U.S. policies and programs related to gender, HIV/AIDS, and development should focus on the following key areas.

1. Systematically hold the implementing government agencies accountable to promote multisectoral linkages:
  - Engage with national governments and civil society partners to promote multisectoral linkages on gender and HIV/AIDS. In particular, ensure that the PEPFAR Partnership Frameworks, the five-year agreements between the U.S. and partner governments focused on HIV/AIDS, contain explicit commitments on gender across sectors, including in education for girls, economic empowerment for women, reducing gender-based violence, and integrating reproductive health and family planning. The U.S. should use these frameworks as a tool to engage with partner governments about issues of gender and linkages between gender and development.
  - Disseminate among GHI countries promising practices about multisectoral and "wraparound" programs related to gender and HIV/AIDS and create a forum where

partners in GHI countries—governments, international donors, and nongovernmental organizations—can learn from actual program experience.

- Increase integration of family planning/reproductive health with HIV/AIDS services and clarify how this will be operationalized under GHI and PEPFAR II. In order to specifically link voluntary family planning outcomes to HIV/AIDS services, PEPFAR should develop new guidance to the field about integration of HIV/AIDS and family planning/reproductive health.
  - Develop strategies and support programs to increase the involvement of men and boys to increase their utilization of health services and that of their partners, notably to help increase men’s use of RH and HIV services.
2. Put in place better measurement tools to track progress in addressing women’s health outcomes and achieving structural change and identify intermediate steps to show impact:
- Develop explicit gender indicators to measure multisectoral interventions that link gender and HIV/AIDS and include indicators to monitor proximate changes in structural drivers of the AIDS epidemic, such as decreased levels of gender-based violence, women’s empowerment, and education for girls. Work with national partners and donors to harmonize an approach to adopting these indicators.
  - Provide technical guidance to encourage multisectoral linkages and “wraparound” programming under PEPFAR and GHI, with examples of innovative interventions.
  - Create incentives and extend program timeframes to capture the impact of multisectoral responses and to encourage innovative programming that links gender, AIDS, and development. Support efforts by HIV programs to build multisectoral linkages and to work with new partners in areas such as economic development, microfinance, reproductive health, and women’s empowerment.
3. Set out long-range plans to build sustainability, encourage innovation, and ensure U.S. global leadership:
- Continue high-level leadership from the Obama administration, including technical and financial support, to ensure the centrality of women and girls in U.S. global health and development policy under GHI and PEPFAR and to encourage and expand innovative approaches to linking gender, AIDS, and development throughout U.S. government-supported programs.
  - Publicize changes in U.S. global health and development policies that affect gender, HIV/AIDS, and development programs. For example, the U.S. Agency for International Development (USAID) is now requiring increased scrutiny of gender issues in the design of global health and development programs, and recent reforms in USAID procurement practices should ensure that more funding can flow to smaller bodies and local partners, who may not have been eligible in the past because they were too small.

- Enhance opportunities for cooperation and collaboration between the United States and other partners—bilateral, multilateral, nongovernmental organizations (NGOs), and faith-based organizations (FBOs)—to support programs focusing on increasing access to health services for women and girls and to build the capacity of government health services, as well as training of health service providers in the issues faced by women and girls.
- Capitalize on this unprecedented level of global interest in women’s health, which extends beyond GHI and PEPFAR to include the G-8, the G-20, the African Union, the Global Strategy for Women’s and Children’s Health, sponsored by the UN secretary general, to support and provide resources for programs linking gender, AIDS, and development that meet the needs of women and girls.

## Linkages between Gender, AIDS, and Development, and Implications for Programs

*Ambassador Eric Goosby, U.S. Global AIDS Coordinator*

A women- and girls-centered approach is an effective means of identifying and retaining individuals with varying health care needs. By targeting women and girls as the entry point for services, we will be more likely to identify their health needs and those of their children, family, and community. This is a key theme of the GHI, which is being coordinated by PEPFAR, USAID, and the Centers for Disease Control.

The gender norms that affect access to health services, including gender-based violence and risk-taking behaviors, affect both women and men. Men and boys, for example, are affected by gender expectations that may encourage risk-taking behavior and discourage accessing health services and playing an active role as partners and family members. It has become clear that tackling the structural drivers of the AIDS epidemic that lead to gender inequities are key to responding to the HIV/AIDS epidemic.

Gender and HIV converge in the epidemic, resulting in the disproportionate vulnerability of women. In low- and middle-income countries, HIV is the leading cause of death and disease among women of reproductive age (15 to 22), with 60 percent of those living with HIV in sub-Saharan Africa being female. Young women are at particular risk; in the nine countries in southern Africa most affected by HIV, young women aged 15 to 24 are infected at rates three times higher than men of their age. Child sexual abuse is also a critical issue, with the World Health Organization (WHO) reporting a prevalence range from 2 percent to 62 percent.

In PEPFAR’s experience, these are overwhelming issues that are usually not part of the clinical awareness of health care providers. With PEPFAR’s new strategy, there will be an expectation, which will be monitored and documented, that providers will be trained to identify and respond to gender-related issues.

With the new GHI, vertical programs should increase and enhance the health system's ability to respond to their clients who are already associated with vertical programs. One of the largest platforms is the HIV/AIDS medical platform, put in place by PEPFAR. The second-largest platforms are those of maternal and child health (MCH) and family planning. By medical platforms, we're referring to not only the bricks and mortar, but also the human resources—doctors, nurses, lab technicians, healthcare workers, community outreach workers etc.—and the other services that are linked to in the community, including TB and family planning services.

GHI will represent an expansion of the service constellation that HIV/AIDS clients need to access. The funding streams will remain vertical, but these resources will aggregate above the HIV/AIDS clinic, or the MCH site, creating the capacity for a PEPFAR HIV/AIDS clinic to provide a broader range of services—such as MCH, child immunizations, and family planning. Similarly, the MCH site will be able to test for HIV, diagnose, stage, and even begin to treat HIV from its platform. The idea is to move toward a one-stop shop wherever possible. Where such services are not provided, the site will be expected to link to or refer for services in a meaningful way, with transportation and child care issues as part of package.

These changes will increase the number of individuals with whom HIV services will interact—the number of individuals who will have access to testing; the number identified as HIV positive; the number who are negative but participating in high-risk activities and, therefore, will need continued and repeated prevention messaging. This is a good thing.

Most of the resources will continue to come from the vertical programs under GHI, but GHI will build from the vertical programs to make the linkages real and to create a more comprehensive service portfolio. This includes treatment for diabetes, coronary artery disease and high blood pressure, as well as family planning services from an HIV/AIDS platform. Altogether, this represents an expansion of service capabilities and a first step toward creating a set of core health care capabilities, thus making health care available more broadly in resource-limited settings.

Country ownership is a critical element of GHI and PEPFAR. This will allow us to save money by moving toward more public-sector and indigenous NGO involvement in the continuum of care and services. We will be able to monitor this process to answer questions about operational research, implementation, the role of management oversight, and how monitoring and evaluation can help improve a program's impact.

This approach—centering on women and girls, expanding integration, and improving monitoring and evaluation—will also help us focus on adolescent girls in the health system and the education sector.

PEPFAR has focused on women from very early on: some 62 percent of those on treatment in PEPFAR sites are women (1,534,600); 10,925,100 women received HIV testing, including 7.5 million pregnant women; and 509,800 HIV-positive women received antiretroviral (ARV) prophylaxis, preventing 100,000 HIV-positive births in the last nine months alone. PEPFAR has

also recently intensified its work on systems for preventing mother-to-child transmission (PMTCT).

PEPFAR has a strategic focus on five cross-cutting gender areas: increasing gender equity in HIV/AIDS activities, including maternal and reproductive health systems; addressing male norms and behavior, including at school and workplace; reducing violence and coercion; increasing women's and girls' access to income and productive resources and education; and increasing women's and girls' legal rights and protection. Some of these can involve difficult dialogues with partner governments, since there may be a disconnect between the PEPFAR strategies and government's or society's priorities. For example, the United States has taken an aggressive approach regarding dialogues on men who have sex with men (MSM) and sees the need to do the same thing with gender issues. Some of these issues have now moved into the U.S. diplomatic dialogue—including the ambassador directly and other forms of U.S. diplomatic activity, as well as programmatic resources. In the past, the United States has underutilized its diplomatic dialogue in this arena, but we are now seeing the utility of engaging governments about discriminatory laws and other issues that affect health outcomes. While the results of these efforts are somewhat slow to materialize, we believe they will be more sustainable.

Some of the PEPFAR initiatives on gender are ending in 2010 as scheduled, including those focused on male norms and vulnerable girls, although some will continue as country-based activities. The Gender-based Violence (GBV) initiative is also ending, but a new project will expand that focus and move to scale in a number of countries by increasing GBV coverage and associated services. PEPFAR will expand its GBV resources, and additional resources were identified for research and documentation and moving pilots to scale. PEPFAR launched a new \$30-million GBV initiative at a consultation in Washington in May 2010, looking at how GBV relates to hospitals, emergency rooms, clinic settings, and walk-ins, as well as how the police and social service entities help women access services.

Other new PEPFAR gender initiatives are also coming on line. The PEPFAR Gender Challenge Fund is an \$8-million program to strengthen gender programming on the five gender strategies. To incentivize PEPFAR country teams, PEPFAR will match funds that countries program from their own PEPFAR budgets. Updated guidance for country teams on FP/HIV integration is also being prepared.

Overall, the challenges involved in multisectoral programming and engaging our multisectoral colleagues are significant. One area of difficulty involves engaging U.S. government colleagues in different sectors and encouraging other national governments, multilaterals, bilateral donors, and foundations to promote and support multisectoral work, other than the Global Fund to Fight AIDS, Tuberculosis and Malaria. Multisectoral work is often perceived to be too unwieldy, and in many cases this work has fallen to the U.S. government in a way that has not been fully recognized.

It will be necessary for the United States to change its internal dialogue and to look for others to help. For the next two years, however, it will remain largely a U.S.-based response on these issues.

We are still aggressively engaging in a dialogue with our bilateral partners and foundation colleagues to see how we can use available resources so they are additive and can help move things to scale. We also need to talk to partner governments about moving these programs forward. It is no longer enough to provide parallel systems of care services by international NGOs that exclude ministries of health and the indigenous private sector. The U.S. government has to blend more with public-sector service sites as a more sustainable approach; otherwise, we run the risk of jeopardizing health systems that are fragile when external funding stops.

## Addressing Structural Drivers of HIV Risk: Innovative Programs Linking Economic Empowerment for Women and Girls with HIV/AIDS

### The IMAGE Program: Addressing the Structural Drivers of HIV through Microfinance and Community Action

*Lufuno Muvhango, IMAGE Program Manager, and Julia Kim, HIV/AIDS Practice, UNDP*

*What did the training do for me? It empowered me in being HIV+, and when it comes to issues involving women, I'm very much aware now of gender issues. I didn't used to think about it—issues of domestic violence and rape and gender issues in communities. I can say I have grown as a woman and as a person living with HIV... I'm at peace with myself, my body becomes light because I don't keep things inside... Now women have financial backup, so it helps... Also for me, I became financially independent, not dependent on him [my boyfriend] any more. He started going out with other women, opposite from me, so he could control them. After women get training with SEF [and SFL], especially those without husbands, they say they know better now because they know more about HIV. If her boyfriend refuses condoms or offers money to sleep without one, she has her own money, she doesn't have to sell her body. Either use a condom or you leave. Women say this and have more power because they have money.—Fleischman interview with Rachel Madondo, SFL Branch Manager, September 16, 2009, in Lethabo Center, Sekgagakgapeng village, Limpopo, South Africa*

*I've seen the change within myself—I used to be afraid to test for HIV. The trainer gave us information for HIV and VCT—I tested, and found that I was negative, so I encouraged my family to test. I feel empowered to talk to the community about HIV... I've seen a lot of changes with the women—now people are starting to talk about HIV and to talk to their children about sex and sexuality, to encourage family members to go for testing. Before I got [the SFL] training, I thought it was taboo to discuss these things with children. Microfinance is key because if you don't bring income in the household, it's hard to contribute to decisionmaking.*

*Now we help start conversations in families—husbands and wives discuss issues. The economic empowerment vehicle helps in the family. Economic empowerment helps contribute to decisionmaking... Violence is going down...with [SFL] training, we know how to approach the*

*situation so we don't escalate violence.*—Fleischman interview with Lina, from Pola Park, September 16, 2009

The IMAGE program (Intervention with Microfinance for AIDS and Gender Equity),<sup>2</sup> a community-based intervention that started in 2001 in rural Limpopo Province, South Africa, combines microfinance with a gender and HIV curriculum. It began as a partnership between the Rural AIDS and Development Research Program (RADAR) at the University of Witwatersrand, the London School of Hygiene and Tropical Medicine, and the Small Enterprise Foundation (SEF), a microfinance group based in Limpopo. IMAGE has shown that it is possible to address health and development together and to demonstrate measurable impacts in both areas—underscoring the need for future investments to support multisectoral programming to address women's social and economic empowerment and their vulnerability to HIV infection.

In the context of South Africa, HIV/AIDS and intimate partner violence (IPV) are major public health challenges: women and girls make up 55 percent of total HIV infections in the country; one out of four women in South Africa report having been in an abusive relationship; IPV profoundly impacts a woman's ability to negotiate safer sex; women with violent partners are 50 percent more likely to be HIV infected.

The IMAGE program uses microfinance loans as a vehicle for empowering the poorest women in rural villages. The microfinance partner, SEF (Small Enterprise Foundation), is based on the Grameen Bank model, whereby groups of five women aged 18 and older serve as guarantors for each other's loans, with all five having to repay before the group is eligible for more credit. Loans are used to support a range of small businesses. Loan centers of approximately 40 women meet fortnightly to repay loans, apply for additional credit, and discuss business plans.

In addition to the microfinance component, IMAGE includes a participatory learning program called "Sisters-for-Life" (SFL), which is integrated into routine loan center meetings. It focuses on issues such as gender roles, cultural beliefs, domestic violence, power relations, self-esteem, sexuality, and HIV/AIDS. The SFL sessions are aimed at strengthening communication skills, critical thinking, and leadership. In the second phase, program participants are encouraged to facilitate wider community mobilization to engage both youth and men in addressing gender norms.

Evaluated as a randomized control trial in eight villages, the program assessed the impacts of IMAGE on poverty, women's empowerment, and risk of IPV and HIV/AIDS.

After two years, the IMAGE study found that the risk of physical and sexual intimate partner violence among participants was reduced by 55 percent. Among young women participating in

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<sup>2</sup> IMAGE has received funding from Anglo American Chairman's Fund, Anglo Platinum, Ford Foundation, UK Department for International Development (DFID), Henry J. Kaiser Foundation, International Humanist Institute for Cooperation with Developing Countries (HIVOS), MAC AIDS Fund, South African Department of Health, and Swedish International Development Cooperative agency (SIDA).

the program, factors related to HIV risk were also positively affected, including increased communication about HIV, a 64 percent increase in voluntary counseling and testing (VCT), and a 24 percent reduction in unprotected sex. The study also documented positive changes in household economic well-being, including increased food security, expenditures, and household assets, and the women maintained high loan repayment rates. The evaluation also documented improvements across a range of indicators of women's empowerment, including increased self-confidence, autonomy, social capital, collective action, and an ability to challenge gender norms. The program was also interested in documenting whether positive changes might "diffuse" to young people not directly participating in the intervention, but it did not document changes in sexual behavior or HIV incidence among a random sample of young people in the study villages.

IMAGE is now in the process of scaling up from a research pilot, which began with 450 women, to a sustainable program, which has reached over 12,000 women in 160 villages. The microfinance program is financially sustainable, with the costs of delivering microfinance recovered through interest rates on the loans. The organizers plan to develop IMAGE as a learning site to support south-south learning and replication across different settings. Given that there are over a thousand microfinance institutions providing services to over 7 million people in sub-Saharan Africa, there may be important opportunities to expand such approaches.

As to whether microfinance without the SFL training would have been as effective, the IMAGE program conducted a cross-sectional analysis comparing microfinance alone against the combined IMAGE intervention. When compared against each other, although microfinance alone and IMAGE both produced similar economic impacts, only the IMAGE program documented additional benefits in terms of IPV, women's empowerment, and HIV risk behaviors. The study suggests that the combination of microfinance with gender training and community mobilization is important for generating synergy and broadening the social and health impacts of microfinance.

There are many lessons learned from the IMAGE program. To begin with, it presents encouraging evidence that it is possible to reduce IPV and to challenge gender norms and violence even when they appear to be "culturally entrenched" and resistant to change. Secondly, it shows the importance of meeting women's basic economic needs as part of a health intervention. Building on a preexisting poverty alleviation program allowed regular contact with a particularly vulnerable and difficult-to-reach peer group (impoverished rural women) for more than a year—an opportunity rarely afforded most stand-alone health or HIV interventions. Although this program focused on microfinance, other strategic entry points could also be explored, such as literacy programs and job skills training. Thirdly, it is important to choose strong sectoral partners and to allow each to focus on what they do well. There are risks involved in HIV programs attempting to deliver microfinance, and in this case, SEF focused on delivering the microfinance program, while partnering with the Rural AIDS and Development Research (RADAR) Program of the School of Public Health at the University of Witwatersrand to develop the gender and HIV aspects. Finally, IMAGE showed that programs can work "indirectly" to affect the most vulnerable groups. Recognizing that young women are particularly vulnerable to

HIV and IPV, the program worked with older women (who are often “cultural gatekeepers”), as well as their younger peers, to challenge existing gender norms and increase communication across generations. Similarly, given the economic vulnerability of young women, the program aimed to improve household economic well-being through loans given to more mature women rather than directly to adolescent girls—an approach that can raise financial and programmatic challenges. Finally, recognizing the importance of engaging men, the program worked directly with microfinance clients, in order to empower them to reach out and engage men during the community mobilization phase.

IMAGE also demonstrates that structural interventions take time and that programs need to focus simultaneously on quick wins and long-term change. Ultimately, programmatic approaches such as IMAGE need to be supported and complemented by policy-level interventions that create an enabling environment for sustained change. Mainstreaming gender and HIV within national AIDS and development plans is one way to embed structural interventions within this more long-term, policy-level approach.

Yet, the fact that so few HIV/AIDS programs are addressing structural drivers indicates that obstacles and challenges remain. To begin with, working across disciplines is challenging, made more so by the vertical funding and institutional structures that make cross-sectoral innovation difficult. Donors will need to incentivize and invest in cross-sectoral, cross-disciplinary work. Next, much HIV/AIDS research is geared toward evaluating biomedical and technological interventions. Greater investment is needed in evaluating structural approaches, and a growing number of studies show that it is possible to develop strong theoretical frameworks, which capture legitimate pathway variables, including women’s empowerment, IPV, and sexual behavior. This creates important opportunities and challenges for U.S. policy, notably for PEPFAR and USAID. Clearly, the new women- and girls-centered approach can champion innovation, and USAID and the GHI will be well-positioned to integrate an economic-empowerment and HIV focus into existing initiatives. The challenges involve how existing programs and funding streams can be aligned to encourage innovation and reward cross-sectoral collaboration, to develop multisectoral indicators to measure progress, to build the evidence base, and to scale up successful models while mobilizing for broader policy change.

## **Building Health, Social and Economic Capabilities among Adolescents Threatened by HIV and AIDS: The Siyakha Nentsha Program in KwaZulu-Natal**

*Kasthuri Govendar, IHDA, and Kelly Hallman, Population Council*

*Knowing how to save and invest helps their money grow and become bigger money. The girls are able to sustain their way of living as opposed to depending for money on boyfriends and getting HIV.*

*I am more confident now. I know what I want and what I’ll get if I work hard. It’s changed the way I think about HIV/AIDS, teenage pregnancy, and financial problems. With my boyfriend, we got*

*tested and are both negative. He said we don't have to use protection, and I said that condoms are also protection against other diseases. On budgeting—he used to give me money, and I used to use it to buy clothes, but now I've opened a savings account at the post office.*

*It's helpful to learners [students]—they learn how to get [government social] grants, what requirements are, and when to apply. One 16 year old already had a baby and wanted to access grants. We encourage learners on financial literacy—before they thought only those who work should save, but they learned to save what they have.*

*You should never listen to someone who says you can't achieve your goal. If you have a dream, rather try—better fail trying than never to try.*

—Fleischman interviews with program facilitators, Durban, South Africa, September 18, 2009

The Siyakha Nentsha program,<sup>3</sup> which means “building with young people” in Zulu, is set in semirural KwaZulu Natal, South Africa, an area characterized by high levels of poverty and income inequality, unemployment, early pregnancy, school dropouts, and HIV. The program was started in early 2008 and is run by the New York-based Population Council and the Isihlangu Health and Development Agency, a South African NGO.

The Population Council conducted formative research about the structural factors associated with adolescent HIV risk behaviors, including residing in relative poverty, few social connections, and orphanhood. The research also showed that female orphans (14 to 16 years old) have far more economically motivated sexual encounters than males their age and that those with less social capital are more likely to experience forced sex. In addition, that area of KwaZulu-Natal province had few programs focused on adolescent sexual and reproductive health or HIV that addressed the social, economic, and cultural underpinnings of risk behaviors and few livelihood programs that linked to health risk behaviors.

The program was designed as a randomized experiment to provide these vulnerable high school students living in poor, peri-urban, HIV-affected communities with protective strategies against HIV and early pregnancy, as well as to enhance their financial skills to address the real-life economic, social, and health challenges that these young people face. Specifically, the program seeks to improve the functional capabilities and well-being of adolescents at high risk for HIV and sexually transmitted infections (STIs), teenage pregnancy, and dropping out of school, and who lack knowledge about employment and training opportunities. The program provides context-specific strategies to enhance financial skills, knowledge about HIV/AIDS and reproductive health, social capital, and future life options for the adolescent participants. In particular, the program focuses on building skills to manage personal and family resources, including accessing social benefits, education and training opportunities, planning for the future, and building savings/assets over time.

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<sup>3</sup> The project is funded by ESRC/Hewlett Joint Scheme and DFID via the ABBA RPC.

Siyakha Nentsha is a secondary school-based program but is delivered by 19- to 23-year-old facilitators from the community, both male and female, who are trained for this purpose. The facilitators relate to the students as successful mentors who understand the local context, and the South African government has accredited the intervention.

The research has already shown some relevant impact on the students' knowledge and reported behavior. In particular, the second round of interviews indicated significant increases in the participants' awareness of social grants, knowledge about condom use, partner reduction, sense of power, and knowledge about reproductive health. Further work is underway, looking more in depth at outcomes related to sexual behaviors, gender attitudes, aspirations/future planning, financial behaviors, and empowerment/agency.

## “Wraparound” in PEPFAR: Lessons from Programs on Education for Girls and Family Planning

*I got sick, and went to the clinic, and found out that I had TB. They said I should have HIV test. I was scared, but my sister encouraged me. I found out that I was HIV positive, and they asked me if I had boyfriends. No! My sister knows me—I stay home, I only have friends at school. I don't engage myself in bad things. I want to be educated to have a better life. I want to look after my [younger] sister. They put me on drugs about three months ago, and now I'm feeling better... I want to be a journalist, to go to university. It's important to be in school—I want to be independent... If I get educated, I'll have a better life.—Fleischman interview with H, 16 years old, on CHANGES2 scholarship in 12th grade, Lusaka, Zambia, September 24, 2009*

### The HIV/AIDS-Girls' Education National Development Nexus: The Case of Zambia

*Daphne Chimuka, National Coordinator for the Forum for African Women Educationalists, Zambia Chapter*

Gender inequalities put women and girls at higher risk of HIV. In Zambia, HIV prevalence is 16 percent for females and 12 percent for males in the 16 to 49 age bracket. The education sector faces many challenges in responding to the issue of gender and HIV/AIDS, including high rates of teenage pregnancy among high school girls, weak mechanisms to address violence against girls in school and en route to school, and policies that have negatively impacted girls' education. All of these accentuate the importance of responding to HIV/AIDS and education for girls in a more comprehensive fashion.

Gender inequalities make women and girls directly and indirectly more vulnerable to HIV. In addition, girls' education has been affected by Zambia's dual legal system, with customary law negating sexual and reproductive rights provided by statutory law. For example, statutory law criminalizes having sex with a girl under the age of 16, while customary law allows parents to marry off their children (usually daughters) at puberty, who could be as young as 10 years old. Coupled with the value placed on child bearing, and tolerance for violence against girls,

pregnancies among schoolgirls in Zambia are high. And despite the reentry policy,<sup>4</sup> perhaps only one-third of these girls go back to school. Regrettably, Zambia also has very high rates of maternal mortality—the 2007 Ministry of Health report indicates that 449 women die in every 1,000 births.

Given that a key priority for the Ministry of Education is to expand overall access to education, little money is spent on such issues as education quality, developing curriculum for girls' education, and integrating HIV/AIDS into the curriculum. The Ministry of Education has integrated HIV and life skills information into the basic and high school curriculum, but implementation has not been harmonized. The ministry's policies against sex education and condom distribution in schools, combined with the cultural taboos, limit open discussion and information about sex and reproductive health. While there are some scholarships available for orphans and antiretroviral therapy (ART) for HIV-infected children, the packages are not comprehensive and lack structured counseling and nutritional support for HIV-infected children.

Through a partnership with the American Institutes of Research (AIR), funded by PEPFAR, CHANGES2 provided scholarships to close to 8,000 vulnerable girls and 3,000 boys in grades 10 through 12 from 2006 to 2009. CHANGES2 provided an integrated support package, which included a full scholarship package, with all education-related costs. The scholarships covered tuition, uniforms, boarding fees, and where necessary, a small stipend for personal expenses. In addition, FAWEZA provided mentoring to all scholarship beneficiaries and mobilized communities to construct four girls' hostels to address the risks of abuse and exploitation for girls in informal weekly boarding arrangements. This resulted in increased enrollment, retention, and completion rates for the girls involved in the program.

Most girls endure abuse in silence. They are taught not to assert themselves. As such, they fail to fight for their rights when forced to drop out of school because they are married off, or they are subjected to dangerous cultural practices such as sexual cleansing. Accordingly, FAWEZA started a mentoring program, called the Students Alliance for Equality (SAFE) Club, which provides peer support mechanisms for cultivating positive gender relations, engaging in community advocacy to address the cultural and traditional practices that impact negatively on girls' education, and empowering young women to make safe choices and decisions.

As a national strategy, education should be positioned at the frontline of the fight to prevent further spread of HIV and AIDS. This therefore calls for reform of the curriculum to provide age-appropriate adolescent and sexual and reproductive health information. USAID should work with the Ministry of Education to establish monitoring systems that track the impact of HIV/AIDS programs on girls' education and that support innovations to reduce girls' vulnerability to AIDS. In addition, NGOs must advocate for space in schools for communities to work with schools to address issues faced by their children. This includes mobilizing communities to advocate for education policy and legislation that protects girls' rights. If we link HIV/AIDS to gender, we

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<sup>4</sup> The Ministry of Education Reentry Policy of 1997 allows girls to reclaim their school places after delivery.

should look at reductions in schoolgirl pregnancy, which is linked to overall maternal and child mortality rates as critical indicators.

## **Operationalizing HIV-prevention Education in Schools: “Wraparound” Activities in CHANGES2 in Zambia**

*Bradford Strickland, American Institutes for Research (AIR)*

In order to operationalize HIV-prevention education in schools, we need to think about the impact that the education sector can make in terms of linkages. This involves a range of areas, including the sustainability of such linkages, the benefit of bringing HIV/AIDS technical specialists into the education sector, and how to build systems for the design and monitoring of HIV-prevention activities.

To begin with, we need to provide a rationale for why schools should be involved in HIV prevention. The new technical guidance on sexuality education, published last year by UNESCO, gives strong evidence for the effectiveness of programs in education for changing behaviors relevant to HIV reduction. The review highlights important results of prevention education programs for children in school and out of school: at least one-third of the programs led to reduced misinformation and increased correct information around HIV/AIDS, clarification and strengthening of positive values and attitudes, increasing skills to make informed decisions and act on them, improved perceptions about peer groups in schools and social norms, delay of sexual debut, and reduction in number of sexual partners. By assembling the evidence and reviewing studies that document these impacts, UNESCO and UNAIDS have made a strong case for HIV-prevention programs in schools. The benefits of prevention education, combined with issues around scale up by working with the education sector, and sustainability are all critical elements.

There is a global consensus on the benefits of doing HIV work in the education sector, including bringing HIV/AIDS technical specialists into the education sector to ensure high-quality programs in schools, systematizing these prevention activities within ministries of education, especially through teacher professional development, and building systems to measure the effectiveness of HIV-prevention education in schools.

The CHANGES2 program—Community Health and Nutrition Gender and Education Support—was a four-year cooperative agreement funded by USAID through the EQUIP 1 program, from June 2005 through September 2009. It was a mainstream education sector program, not a health program working in the education sector. CHANGES2 operated in five provincial offices across Zambia, with 55 field-based staff, including senior technical expertise in HIV and AIDS. The partners in providing scholarships and administering the small grants program were FAWEZA, the Copperbelt Health Education Project (CHEP), and Family Health Trust (FHT).

The main objectives of the CHANGES2 program were improving HIV/AIDS-prevention education, care, and support to pupils through strengthened teacher education; improving school outreach to communities on HIV prevention; and improving the quality of basic education delivery systems. CHANGES2 was designed to accommodate multiple funding streams, including

development assistance, Africa Education Initiative (AEI), the fast track initiative, and economic support funds (ESF). The HIV/AIDS teacher training and support for orphans and vulnerable children (OVC) brought HIV resources to education, notably from PEPFAR.

The school-level impacts of the program were significant: 2 million children were reached with prevention education, including more than 956,000 girls; 13,835 teachers were trained in HIV-prevention education, both pre-service and in-service; and 2,000 schools were reached with HIV-prevention education. The program helped establish systems for the long-term training of teachers and, importantly, built HIV/AIDS prevention resource centers in all the schools, which were critical for community-level outreach.

The community-level impacts were also considerable: some 1,840,300 community members were reached with HIV/AIDS-prevention programs, led by community members who were targeted by PEPFAR funding for community-level HIV-prevention education, and who were involved in mobilizing and designing actions plans, many supporting orphans and vulnerable children and HIV-affected people in communities. Over 1,600 communities were mobilized to implement action plans concerning HIV/AIDS prevention, and 33,380 individuals were trained to deliver HIV-prevention programs.

The OVC support scholarships represented a significant influx of resources to education to keep vulnerable kids from HIV-affected households in school and to help avoid the tragedy of them dropping out for lack of resources: 22,186 OVC scholarships were awarded during the project; 386 small grants were awarded to support the educational needs of OVC, including feed schemes, clothing, psychosocial outreach activities, and other areas; and 356,132 children benefitted from grant-aided services for OVC, including 180,787 girls.

The central question remains about what we should be monitoring in education systems to demonstrate the effectiveness of school-based HIV/AIDS-prevention programs. The Interagency Task Team on HIV/AIDS and Education (IATT), mandated by UNAIDS through UNESCO to lead the education sector globally in its response to HIV and AIDS, has noted that ministries of education need simple indicators for education information management systems that they can report on. The IATT, working with ministries of education, tried to identify a set of core indicators that would demonstrate significant behavior change in the health sector to our HIV/AIDS partners such as PEPFAR. After a lengthy consultation process, new indicators are being field tested now, designed to demonstrate changes in risky behavior, including: percentage of schools delivering HIV-prevention education; percentage of schools with co-curricular activities; percentage of educators receiving training about HIV; percentage of schools with zero tolerance for any form of stigma, discrimination, harassment, abuse; percentage of students identifying correct transmission; percentage of students who have had sexual relations.

As a final note, implementing these programs requires a champion at the country level and at the USAID mission level. Under the previous PEPFAR guidance, there was a lot of information about what you could not do and what you could not spend PEPFAR resources on. We now need to

actively look for opportunities to use PEPFAR resources for education sector activities that will help meet PEPFAR's HIV/AIDS goals.

## **Improving Service Access through RH and HIV Integration Experience from Kenya**

***Dr. Marsden Solomon***

*We are integrating family planning, so most clients are not referred to MCH as before, since they get all their services at the CCC... It's good to get everything under same roof.*—Fleischman interview with nurse (Sarah) at Comprehensive Care Center (CCC) at Malindi District Hospital, September 18, 2010

The basic reason that we should integrate reproductive health and HIV is that they share common concerns. Clients in both areas are sexually active. Clients at a reproductive health clinic often seek to plan the timing and spacing of pregnancies. But they should also be offered an opportunity to learn their HIV status, which has implications for their behavior and choices. Similarly, clients at the HIV service site often have a very high unmet need for family planning. The Kenya AIDS Indicator Survey (KAIS) of 2007 found that 60 percent of HIV-positive clients who are married or cohabitating have an unmet need for family planning. In addition, HIV-positive women have important needs for cervical cancer screening, for which they are at significantly higher risk.

The benefits of family planning for HIV-positive female clients involve enabling them to decide on the number and spacing of their children and to reduce unintended pregnancies and therefore unsafe abortions. We also know that family planning enhances maternal and infant health and that it reduces vertical transmission of HIV.

The history of integration in Kenya began in 2001, when counseling and testing was first connected with family planning. At the time, there were major concerns about whether integration would be feasible and accessible. Assessments were conducted that supported integration, which led to the development of the national FP/HIV strategy. Several models of integration were then developed, involving FP/VCT, CT/FP, FP/ART, STI/ART. A series of stakeholder meetings was held and indicators were developed, led by the Ministry of Health. All of this is culminated in the launch of a new strategy in 2010, known as the “National Reproductive Health and HIV and AIDS Integration Strategy.”

In the AIDS Population Health Integrated Assistance program (APHIA II), which is a PEPFAR- and USAID-funded project, Family Health International (FHI) takes the lead in two regions of Kenya—Rift and Coast provinces. The APHIA project includes integration of FP and HIV but is predominantly funded with HIV resources. In one of the regions where FHI takes the lead, 93 percent of the funds are for HIV programming and only 7 percent for family planning and MCH. Yet this takes place in a context of huge reproductive health needs: high maternal mortality (414 per 100,000), high infant mortality rate (52 per 1,000), low contraceptive prevalence rate and high unmet need for FP (25 percent). PEPFAR resources were directed to strengthen the infrastructure

and capacity development for HIV services, while the FP/MCH funds were used to enhance integration of RH services in the same sites. This is the essence of “wraparound” in this project.

There are several types of RH/HIV integration, including: VCT; ART; PMTCT; family planning; cervical cancer screening; youth friendly services; post-abortion care; and post-rape care. These can be provided as on-site services as well as through referral mechanisms to other sites. New data shows that one-third of family planning clients have been seen at integrated sites, which means that they were able to access the other services due to integration. There has been significant uptake of family planning services in HIV care and treatment from 36 to 50 percent.

But many challenges remain in implementing integrated programs. Despite the positive policy environment, there is inadequate funding for RH/FP programs. Ultimately, direct funding for integrated services will be required. The issue of commodity security continues to be a challenge, and appropriate data collection tools to capture data on integrated services is also lacking, although some indicators have been included in the new RH/HIV integration indicators. Other challenges include the acceptability and ownership of integration, human resource constraints, and inadequate infrastructure.

Still, important lessons have been learned. RH/HIV integration has been shown to be feasible, with different types of integration working better in different settings. Overall, the on-site model of delivery of integrated services is the most popular, although referrals will continue to be important. Advocacy and supervision are essential, and field experiences should lead to evidence-based decisionmaking. FHI’s experience in the Rift and Coast provinces can serve as learning models.

In terms of lessons for PEPFAR, it is now clear that FP services contribute directly to PEPFAR prevention goals and that it is possible for HIV programs to integrate FP/RH services. RH/HIV integration has the potential to enhance the public health impact of health services and to better meet the needs of the clients. Yet funding for integrated programming and research remains inadequate.

Recommendations for PEPFAR include: emphasize RH/HIV integration of services at all levels in policies and field guidance; support countries to adopt “wraparound” using integration or linkages of services; consider direct funding for RH/HIV integration and specific funding for contraceptive commodities for HIV programs; develop RH-related targets and indicators; and allocate public health evaluation funding for research to expand the evidence base of RH/HIV integration best practices.

# New U.S. Policy Directions: Where Linkages Fit with PEPFAR II and the Global Health Initiative

*Rachel Vogelstein, Office of Global Women's Issues, U.S. Department of State*

The post of ambassador-at-large for global women's issues was created by President Barack Obama to ensure that issues of women and girls are integrated throughout the State Department and U.S. foreign policy. Addressing gender inequity is essential to improving the health of women and girls and is key to GHI.

A core principle of GHI is implementation of a women- and girls-centered approach. The principle was adopted because it's the right thing to do and the smart thing to do. It's the right thing to do because women's unmet health needs are so significant. Due to their reproductive roles, as well as patterns of gender discrimination, the world's women and girls bear a disproportionate share of disease, violence, and mistreatment. But this approach is also the smart thing to do because women around the world are primarily responsible for the care of their families and for managing household resources, including water and nutrition, and serve as conduits for health care for their families and communities. Accordingly, improving their health enhances their productivity and their social and economic participation, and it acts as a positive multiplier for the health of their families and communities. This benefits the development and health of future generations.

GHI will do this in a few key ways. First, GHI will strengthen support for programs that primarily serve women and girls, including maternal and child health programs and family planning and nutrition programs. The president's 2011 budget request reflected significant increases in these areas, and GHI sets ambitious targets for scaling up high-impact women's health interventions.

GHI will also focus on building health systems to ensure that women and girls have access to an integrated package of essential services. To address the social determinants of health, GHI will also support long-term systemic changes to remove economic, cultural, social, and legal barriers to health care services and to increase the participation of women and girls in health care decisionmaking.

GHI will scale up evidence-based, proven interventions, including PMTCT, family planning, and comprehensive maternal health. But GHI will also introduce a new model of business, focusing on integration, coordination, and systems strengthening. Where possible, GHI will integrate FP and MCH with HIV/AIDS and will work with partner countries to strengthen health services for women. GHI will also seek to address the environmental and structural determinants of health, looking at linkages with education programs, property, agriculture, economic strengthening, and GBV screening and referrals. Part of this will involve a focus on adolescent girls, linking to programs that address the social determinants of their health, such as early and forced marriage and economic status. GHI will work to promote women as leaders and service providers and increase the number of female health workers, to improve monitoring and evaluation and

research, to involve men and boys in advancing gender equity, and to partner with civil society. Through this women- and girls-centered approach, we hope to reduce rates of HIV infection, unplanned pregnancy, and maternal and child mortality and to improve the overall health of women and girls.

The Office of Global Women's Issues (GWI) is committed to ensuring that this women- and girls-centered approach translates into real changes on the ground and results in tangible improvements for women's health. To this end, the GWI office is convening an interagency task force to help concretize and operationalize this approach. The task force will help to coordinate guidance to the field and to develop best practices on programs relating to women and girls. In addition, GWI will serve as a resource to GHI and will monitor progress on implementing a women- and girls-centered approach.

***Amie Batson, Deputy Assistant Administrator for Global Health, USAID***

The Obama administration and USAID recognize the importance of implementing a women- and girls-centered approach, since gender is integral to achieving our development goals, as well as our health specific goals.

USAID is making a range of investments to promote gender equality, some of which will be expanded through the GHI. To implement this approach, we need to address the systems that provide women with health care, as well as the social and economic determinants of health, which determine whether they can access that care. USAID is approaching this in a number of ways, one of which is recognizing that gender is multisectoral—it's not just a health problem. We need to be thinking creatively across different spheres. At USAID, we are now requiring that gender be integrated into the design, implementation, and monitoring of all projects and programs, including economic growth, education, governance, and health. USAID plays a critical role in the implementation of gender and HIV/AIDS strategy under PEPFAR, including providing technical leadership globally and support of a range of gender activities in the field. USAID is also developing its own expertise, with a group of gender experts meeting regularly. Members of this group already engage in a whole-of-government effort by participating in a task force convened by GWI.

USAID is looking for innovative ways to meet the special needs of women and girls within the different components of our health programs—family planning, reproductive health, maternal health, HIV/AIDS, child health, treatment for infectious diseases, etc. Where a woman's access to services is restricted as a result of traditional roles and related barriers, services can be provided through other means, such as trained community outreach workers. So USAID is working in a number of countries to train female outreach health workers to reach clients in non-clinic settings, providing treatment for anemia, education on nutrition, information and access to contraceptive methods for healthy timing and spacing of pregnancies, and HIV-prevention information and care. We're also looking to make commodities, such as condoms, contraceptive

pills, and other medications, more easily accessible, through traditional means such as pharmacies but also through other informal sites such as kiosks and beauty salons.

A gender-equitable, women-centered approach requires that health programs look at the broader societal environment that influences a woman's behavior. USAID has been investing in creative community mobilization efforts that involve peers, neighbors, teachers, religious leaders, and other influential stakeholders to help improve the health of women and girls and to address some of the harmful practices within different communities or cultures. For example, in India, we have programs that are supporting community theater and painting of murals with messages about the importance of delaying marriage and first pregnancy. These efforts complement community education sessions for adolescents, newlyweds, and mothers-in-law. In Ethiopia, USAID is working with school teachers, youth, and community elders to change the attitudes and practices around child marriage, and we have set up girls' advisory committees in more than 3,700 public schools to encourage both married and unmarried girls to attend school and to help limit the pressure for child marriage.

USAID is looking to tackle gender inequalities by looking at some of the building blocks of the health system and helping countries to review and analyze different aspects of their health programs. For example, in some countries having a female health worker is an essential component to ensure the provision of and access to health services for women. We are also helping countries collect necessary data, as in Rwanda, where USAID is supporting country counterparts to collect information about workplace violence and sexual harassment, so that the data starts to inform national plans and policy by creating the awareness of the problem and then how to best address it.

USAID is also engaged in training health personnel in many countries to ensure that they have state-of-the-art health care practices, such as training providers on fistula repair.

Another area on which USAID is focused is gender-based violence. Often this is a hidden problem, and if it is not addressed, health systems can't meet the needs of women and girls in a comprehensive, effective, and sustainable manner. USAID is working with community groups to mobilize efforts on prevention of GBV by increasing awareness of the problem and promoting reflection about the norms that perpetuate violence. In particular, we've been working with religious leaders, often the most respected and trusted in their communities, who are key catalysts for social change. For example, in Africa, we've been working to build the capacity of religious leaders and faith-based organizations to reduce gender-based violence and HIV among women and girls. In Yemen, we've been working with religious leaders to promote messages about the negative health effects of early marriage.

Men and boys are an extremely important component to women's empowerment and gender equality. We're supporting programs to better involve men and boys in supporting women and helping with their families. This work will be expanded under GHI. We're also working with providers to improve couples' communication, looking toward joint decisionmaking related to family size, child bearing, use of contraception, and safer sexual behavior. This involves working

with health workers to increase their comfort level communicating with couples and providing them with effective gender-equitable health messages.

Health programs also have to look at non-health related obstacles that may be limiting access to knowledge and services. So we're looking at many of the longer-term, systemic changes to remove barriers and improve access to quality health care. That can range from the hours and days that a health clinic is open, to financial incentives for families, to linking with services that promote different types of legal rights, access to educational opportunities, and economic empowerment. Sometimes these areas beyond the medical intervention itself can have the biggest impact in ensuring access.

USAID is also looking at logical linkages among health services to increase the efficiency and convenience of services for women and girls. USAID's nutrition portfolio collaborates with the social protection and agriculture sectors to ensure women's empowerment and access to assets like agriculture technologies, paving the way to greater income generation. Models for more integrated family planning and fistula care are also an example of linkages that serve women more efficiently. For example, in Africa we have eight sites that are linking these two areas, improving providers' knowledge and providing more skills in contraceptive technology, counseling, and access to contraceptive methods.

To meet the specific needs of very young mothers and women for contraceptive services, USAID is supporting integrated, youth-friendly, post-partum family planning services and putting them into existing family planning services in countries like Haiti. This includes training on youth-friendly services that address attitudes and community biases and ensures that we increase a young woman's access to family planning services.

Key to implementing a women- and girls-centered approach is making sure we have the right metrics and the data to learn the impact of various strategies and to identify where there are gaps in the programs. USAID has a significant focus in this area and sees this as a major component of GHI going forward. One of the ways we'll address this is through USAID's Demographic and Health Surveys (DHS) and specifically the information that the DHS is now providing on gender inequality, women's empowerment, domestic violence, and female genital mutilation. Through the DHS module on domestic violence, we now have some comparable information about the prevalence of domestic violence in over 25 countries, which provides a valuable base of information to impact policy, advocacy, and programmatic interventions.

We are also using a framework for gender integration programs, as well as specific recommendations for integration of efforts to address GBV in our population, HIV/AIDS, and nutrition programs. USAID is collaborating with a number of multilaterals and UN agencies—WHO, UNIFEM, UNFPA, UNAIDS—and other bilateral and country partners to develop a shared gender and health monitoring and evaluation framework that includes indicators on gender equality, women's empowerment, and health. As we've seen in other sectors, the value of having a few strong indicators, as well as shared indicators, has proven to be extremely important.

One of the big challenges in implementing a women- and girls-centered approach is increasing the sophistication in measuring gender equity and women's empowerment and outcomes, in addition to impact on health. We're supporting the development of reliable scales to better measure changes in gender norms, and we've been collaborating with a number of donors to develop a data model that illustrates the relationship between women's empowerment and health outcomes that might be used to help improve policy formulation.

USAID is working with a number of multilaterals and donors to include joint documentation on best practices in gender and health to be able to put forward some of the best models and ensure that they can be shared with other countries and, if appropriate, replicated. The task force out of GWI will play a very important role in collecting all of this information in one place and making it as widely accessible as possible.

***Ann Gavaghan, Chief of Staff, Office of the Global AIDS Coordinator (OGAC)***

The Obama administration takes a women- and girls-centered approach very seriously and is trying to figure out how best to operationalize it. A lot of questions have been raised about PEPFAR's role in the GHI. OGAC is extremely excited about GHI, because AIDS is a women's health issue. HIV/AIDS is the leading cause of death among women of reproductive age worldwide. We need to be focusing on the ways that AIDS is or is not seen as a women's health issue.

The term "person living with HIV" has focused on HIV, and now we need to look again at that person and focus on his or her health and development needs. If you have a woman living with HIV, her HIV status could be the fifth, sixth, or seventh thing on her list of priorities. She's going to be focused on how she feeds her kids and her family, on the malaria that her kids have, on her need for family planning. If she's not feeling sick that day, AIDS may not be the main thing on her mind. So if we're going to be doing her a service—and making sure she gets the HIV/AIDS services she needs—we need to find ways to package that with the other services she requires. And we need to do this beyond an individual basis, on a community-wide and then nation-wide basis, so there is support on all levels of the health system.

To date, PEPFAR has been doing this through what we term "wraparound" programming, where we try to leverage or link our investments to initiatives where we can provide HIV services and package those with other primary and secondary health care needs. But we face some real challenges in doing this, which is why we welcome the GHI. It's an emphasis from this administration across all the health programs to make smart integration and coordination a priority. This can now happen from the health perspective, but also from the diplomatic perspective, to look at how our programs can support this women- and girls-centered approach.

We have done a very poor job about linking our achievements in Millennium Development Goals (MDGs) 6 to the achievements in the other health MDGs. As we look at MDG 4 and 5, looking at increased investment in MCH, we need to be able to identify how the activities we've carried out in MDG 6, around AIDS, TB, and malaria, have helped to establish the health systems necessary

to allow women and children to get the services they need. It's a challenge to all of us: we could all help to document how our investments around HIV/AIDS over the past 10 years through PEPFAR and the Global Fund, through UNAIDS and other organizations, have helped to build those systems.

In order to build systems, we need to look at the platforms we've built, like PEPFAR. At the health clinic that PEPFAR supported, how do we use those investments or bring in additional investments, like hiring a doctor to deal with family planning or maternal health. Where PEPFAR can provide the seed investments, and provide a lot of the mechanisms through which to run the day-to-day operations at the clinic, with small additional investments we can leverage what we've already put in place to make sure that we're addressing broader health needs. The health worker that we train with PEPFAR money is not just going to be treating AIDS. It's time that we talk about all the things that we have done with PEPFAR money and the additional things we can do to achieve this women- and girls-centered focus.

We need to do a better job regarding integration and coordination, and this is something that GHI will let us do. We've seen some examples of where it's worked well in PEPFAR countries, with programs like the GHAIN project in Nigeria, where we're funding a hospital where HIV-positive women can receive comprehensive health care services tied to income support and income generation programs. This program is addressing not only their health needs for HIV services, but their health needs for family planning and reproductive health, while addressing some of the larger, structural issues.

As part of GHI, PEPFAR is looking at its gender investments. During the first five years of PEPFAR, there was some innovative work involving gender—including disaggregation of data, figuring out how our services were impacting women—and we had several programs with gender strategies addressing the involvement of men and boys and addressing young girls and HIV/AIDS education with things like the “You Go Girl!” initiative.

We're now trying to focus on several key areas. First of all, to make sure we're addressing the hidden epidemic of gender-based violence. We've starting programs in three countries and are looking to expand into other countries. Women who experience sexual and gender-based violence are at increased risk of HIV/AIDS, and we're working to ensure that they have the services they need in order to prevent new HIV infections, but also to help them get out of those situations of violence. We are going to help train and establish the larger mechanisms that address gender-based violence, so that we're training the police and law enforcement officials in ways that help them recognize GBV and its health and development impacts.

We're also establishing a Gender Challenge Fund, because the barriers to doing more in the field involve the challenges of operationalizing gender integration. With this new fund, we'll be able to gather some of our gender activities around specific projects. In addition to trying to integrate gender into everything we do, we hope to have specific projects to accelerate several of our gender initiatives in countries, working with our country teams who know what's happening on the ground, and to have them put some of their country budgets into those programs to ensure their

commitment. We hope to learn lessons and be able to apply best practices to a broader range of health programs.

PEPFAR is excited about GHI because it's a way we can move forward with integration and coordination to serve the needs of the majority of people we're trying to serve, who happen to be women and girls, and to make an impact and improve HIV outcomes, in addition to overall health outcomes.

***Pearl-Alice Marsh, Majority Professional Staff Member for the House Committee on Foreign Affairs***

We are in the process of rewriting the Foreign Assistance Act, and a significant piece of that will be the global health portion, which will include a very strong focus on women and girls. Addressing the needs of women and girls has become a major priority, with the intent to promote and improve the status of women and girls, guarantee their ability to access and utilize health services, without fear of gender-based violence, reprisal, discrimination, or other mistreatment. Specifically, we aim to promote the ability of women and girls to access reproductive health services, family planning, life skills, and livelihood programs. That's the purpose of trying to focus on how we integrate all of these initiatives and legislation to make them functional.

In order to do this, our legislation is relying on several things. First, it's intended to provide more flexibility for the administration to avoid the restrictions that have harmed the delivery of our programs. Second, we're trying to provide greater accountability to Congress. We can't provide flexibility without greater accountability. That includes making sure that we have measurable indicators of success that Congress can look to in order to ensure that the funds we are authorizing and appropriating are doing what we intended them to do, as well as to have strong monitoring and evaluation systems to provide data and evidence that the programs that we're supporting are moving us in the right direction. Third, to establish needs-based and performance-based systems for allocating development resources. For all our rhetoric, development assistance other than to those countries directly linked to our security interests gets quite anemic, so we want to establish a more rational basis for allocating those resources. Finally, we want to institutionalize a strategic planning and review process as a way to build on success and lessons learned, including learning from things that have failed.

In order to do this, we want these programs to be consistent with three principles: country ownership, where we listen to what the countries say they want and need; capacity building, where we can work with professionals on the front lines in Africa to increase their capacity so they can deliver on their promises and goals; and effective partnerships, involving learning from and teaching to our development partners.

An example of this is a meeting I just had with a Kenyan woman about a program involving education for adolescent girls. They realized that one reason we deal with so much adolescent/teen pregnancy is because girls have no money, so the program began doing life skills training helping girls develop their entrepreneurial skills. The program was able to place 80

percent of the girls in jobs. As for the remaining 20 percent, they asked the girls to think of something innovative that they could do, and the girls came up with a washable, sanitary napkin. The girls presented the program with the problem that girls miss school several days a month during their menstrual cycle. There are now four girls that make 50 napkins a day and sell them throughout the markets in their town, and the teachers are beginning to notice that girls are not missing as much school. This simple imaginative innovation came from the girls, not from someone in Washington or even Nairobi. The program was smart enough to invest in it, and now we're seeing an effect not only on the quality of those girls' lives, but on their education and on empowering them. So the idea of partnership, and in this case letting the students teach us as we teach them, is very important.

As authorizers in Congress, we have two major issues: maintaining the funding levels for global health programs at a time of increased competition for all of our programs in the midst of an economic crisis; and addressing the fact that global women's health has been used as a proxy for the antiabortion battles in this country, which has had a terrible impact on the provision of family health and reproductive health services in Africa.

On funding, advocates have to keep reminding Congress that we've made commitments through PEPFAR and GHI to fund health programs for women and girls in poor countries and that we have to start working with African countries to help them get a better handle on their own budgeting systems so that they can make better contributions to their own health systems. The Global Financial Institute did a study that found that an estimated \$854 billion in illicit financial outflows from Africa occurred between 1970 and 2009. Between 1970 and 1979, that figure was \$57 billion. But between 2000 and 2008, it increased to \$437 billion. What that last figure indicates is that most African economies are growing, at 5 to 8 percent. But they don't have the financial governance systems in place to control what happens to that money and then to use that money for social and economic investment in their own countries. This underscores the importance of assisting African countries in developing financial governance systems, so as we put funds into their programs, they have a way to assess what their capacities are and to contribute their funding as well.

On the issue of family planning and reproductive health, in most African countries, maternal mortality rates are as horrific as 1 out of 14 women dying, versus 1 in 3,000 in developed countries. Opposition to family planning in these countries is a form of femicide; what we're doing is deliberately letting ideology and politics get in the way of women's lives. We need to focus on making sure the funding is there and that we focus on the health care needs of women, not on ideology.



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