

FY 2014

UPDATED GENDER STRATEGY

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PURPOSE

The purpose of this strategy is to help PEPFAR country teams and implementing partners (a) develop country and regional operational plans (COPs and ROPs), (b) design programs that integrate gender issues and (c) work to advance gender equality throughout the HIV continuum of prevention, care, treatment and support. All HIV programs should identify gender-related issues and take concrete steps to address them throughout the program cycle.

NEW REQUIREMENT: Note that there is a new PEPFAR requirement to undertake a gender analysis related to HIV at the country-level by March 2016 (see page 24).

GENDER AND HIV: WHO, WHY, WHAT & HOW?

WHO?

Who benefits from gender integration in HIV programs?

Gender norms and inequalities increase women's and girls' vulnerability to HIV due to multiple factors, including limited ability to negotiate safer sex, engaging in transactional sex, and curtailed ability to test, disclose and access HIV treatment because of fear of violence and abandonment (World Health Organization, 2013). Among low- and middle-income countries worldwide, HIV is the leading cause of death and disease in women of reproductive age (World Health Organization, 2013). In sub-Saharan Africa, 60% of people living with HIV are women (World Health Organization, 2013). In some countries, HIV prevalence among young women aged 15-24 years is on average three times higher than men of the same age (UNICEF, 2009).

Men and boys are affected by gender expectations that may encourage risk-taking behavior, discourage accessing health services, and narrowly define their roles as partners and family members (Pulerwitz J, 2010) (Barker G., 2007). On average, rates of HIV testing and treatment are lower among men than women (Mills EJ, 2009). Gender norms around masculinity and sexuality also put men who have sex with men (MSM) at increased risk for HIV. In a review of low-and middle-income countries, MSM were found to be 19 times more likely to be HIV-positive compared to the men in the general population (Baral S S. F., 2007).

Gender-based violence (GBV) also fosters the spread of HIV by limiting one's ability to negotiate safe sexual practices, disclose HIV status, and access services due to fear of reprisal (Dunkle & Decker, 2012). An estimated one in three women worldwide has been beaten, coerced into sex, or otherwise abused in her lifetime, with intimate partner violence as the most common

form of violence experienced by women globally. Studies indicate that the risk of HIV among women who have experienced violence may be up to three times higher than among those who have not. Sexual violence can also directly lead to HIV infection (World Health Organization, 2013)

Norms around gender and sexual identity put transgender populations and others who are perceived to have transgressed those norms at greater risk for both GBV and HIV. In a review of the studies available to date, transgender women were found to be on average 48 times more likely to have HIV compared to the general population of reproductive age (Baral S P. T., 2013).

These disparities are the result of biological, structural, socio-economic, and cultural conditions, as well as stigma and discrimination that affect men and women, boys and girls, and people with other gender identities differently and impede access to resources that can prevent and mitigate HIV (Auerbach J, 2011).

WHY?

Why is integrating gender into HIV programs important?

Integrating gender into HIV programs is critical because:

- Gender norms, relations, and inequalities affect health outcomes for everyone (Barker G., 2007); enjoying the highest attainable standard of health regardless of sex, age, race, or disability status is a human right.¹
- Ignoring gender-related barriers can negatively affect prevention efforts, service utilization, treatment adherence, and health outcomes for everyone. (World Health Organization, 2013).
- Understanding the unique needs and vulnerabilities of men and women, boys and girls, and people with other gender identities helps identify target populations, tailor response and dedicate resources where they are most needed. Responding to these unique needs may improve health outcomes and enhance program sustainability.

¹ International Convention on the Elimination of All Forms of Racial Discrimination (1965): art. 5 (e) (iv). International Covenant on Economic, Social and Cultural Rights (1966): art. 12. Convention on the Elimination of All Forms of Discrimination against Women (1979): arts. 11 (1) (f), 12 and 14 (2) (b). Convention on the Rights of the Child (1989): art. 24. Convention on the Rights of Persons with Disabilities (2006): art. 25.

WHAT?

What does it mean to integrate gender into HIV prevention, care, treatment, and support?

Integrating gender into HIV programs means recognizing the critical role played by gender norms and inequality in the HIV epidemic and identifying and responding to the unique needs of men and women of all ages and abilities, boys and girls, and people with other gender identities so they are equally able to (World Health Organization, 2013):

- access and utilize HIV prevention, care, treatment, and support services
- initiate and practice healthy behaviors
- exercise their rights
- protect themselves and improve their health outcomes
- live lives free from violence, stigma and discrimination

Foundational Frameworks, Policy, and Guidance

PEPFAR gender activities, outcomes and impact are supported by a number of US government and agency-specific guidance and policies which collectively elucidate the United States' commitment to promoting gender equality as an integral component of foreign assistance and development efforts. These include:

- PEPFAR Guidance for the Prevention of Sexually Transmitted Infections (<http://www.pepfar.gov/documents/organization/171303.pdf>)
- PEPFAR Guidance on Prevention for Men Who Have Sex with Men (<http://www.pepfar.gov/documents/organization/164010.pdf>)
- PEPFAR Guidance for Orphans and Vulnerable Children Programming (<http://www.pepfar.gov/documents/organization/195702.pdf>)
- Supplemental Guidance on the Women, Girls and Gender Equality (WGGE) Principle of the Global Health Initiative (GHI) (<http://www.ghi.gov/resources/guidance/161891.htm>)
- Secretary's Policy Guidance on Promoting Gender Equality (<http://www.state.gov/documents/organization/189379.pdf>)
- USAID Policy on Gender Equality and Female Empowerment (http://transition.usaid.gov/our_work/policy_planning_and_learning/documents/GenderEqualityPolicy.pdf)
- United States Strategy to Prevent and Respond to Gender-based Violence Globally (<http://www.state.gov/documents/organization/196468.pdf>)
- United States National Action Plan on Women, Peace and Security (http://www.whitehouse.gov/sites/default/files/email-files/US_National_Action_Plan_on_Women_Peace_and_Security.pdf)
- United States Action Plan for Children in Adversity: A Framework for International Assistance 2012-2017 (<http://www.childreninadversity.org/>)
- Presidential Memorandum –Coordination of Policies and Programs to Promote Gender Equality and Empower Women and Girls Globally <http://www.whitehouse.gov/the-press->

[office/2013/01/30/presidential-memorandum-coordination-policies-and-programs-promote-gende](http://www.whitehouse.gov/the-press-office/2013/01/30/presidential-memorandum-coordination-policies-and-programs-promote-gende))

- Presidential Memorandum -- International Initiatives to Advance the Human Rights of Lesbian, Gay, Bisexual, and Transgender Persons <http://www.whitehouse.gov/the-press-office/2011/12/06/presidential-memorandum-international-initiatives-advance-human-rights-1>

Note that all activities funded by PEPFAR must ultimately serve an HIV prevention, treatment or care purpose.

Figure 1: The PEPFAR Gender Framework

Populations:

- Women and men, boys and girls
- All gender identities and sexual orientations
- Should reflect local epidemiology

PEPFAR Gender Activities

- Provide gender equitable HIV prevention, care, treatment & support
- Implement GBV prevention activities
- Provide services for post-GBV care
- Implement activities to change harmful gender norms & promote positive gender norms
- Promote gender-related policies and laws that increase legal protection
- Increase gender equitable access to income and productive resources, including education



Outputs

- Number of people reached with gender activities (see two PEPFAR gender indicators)
- Sex and age disaggregated indicators by specific technical areas (see all other PEPFAR indicators)



Outcomes

- Reduced gender-related inequities in HIV prevention, care & treatment (access, participation, adherence)
- Increased coverage of post-GBV care
- Improved gender norms
- Reduced gender-based disparities in rights, status & legal protections
- More equal access to productive resources and education



Impact

Reduced GBV



- Reduced HIV Incidence
- Reduced HIV Prevalence
- Reduced HIV Mortality
- Increased non-clinical HIV impact mitigation



Improved Gender Equality

Approaches

- Country ownership and multi-sectoral programming
- Integrated health service models
- Community and civil society engagement
- Meaningful participation of women, girls, boys, men, people with other gender identities and vulnerable groups
- Health systems strengthening to ensure capacity and quality for gender activities along the HIV continuum of care

Overview

The PEPFAR Gender Framework (see Figure 1) outlines the types of activities that PEPFAR programs should implement to integrate gender issues into HIV prevention, care, treatment, and support as well as the intended outputs, outcomes, and impacts that may result from these activities. Because the process for carrying out gender-related activities is critical, the framework also specifies principles for engaging in gender activities. In addition, the framework also identifies primary target populations to be considered for gender activities within HIV programming, and by technical area (see appendices). The remainder of this section elucidates each component of the framework – populations, activities, principles, as well as monitoring and evaluation considerations for the intended outputs, outcomes and impacts.

Populations

The activities in the PEPFAR Gender Framework reflect the commitment of the US government to women, girls, and gender equality. However, PEPFAR also recognizes that gender issues are relevant for HIV prevention, care, treatment, and support among men and boys. In addition, there needs to be consideration of populations that are vulnerable due to the fact that their gender identity (e.g. transgender persons), sexual orientation (e.g., gay, lesbian), and/or sexual behavior (e.g. MSM, sex workers [SW]) does not conform to existing gender norms. Disabled populations also face heightened risks of violence, including sexual violence (World Health Organization). Therefore, as PEPFAR programs integrate gender activities into their portfolio, consideration of all of these populations is critical.

In the process of applying the PEPFAR Gender Framework, each technical area will need to identify the populations it should engage and target. This should be done according to the epidemiological profile of the country.

Approaches

The following five approaches are critical in the design, implementation and monitoring of programs and should be considered in every gender-related activity.

- **Country ownership & multi-sectoral programing:** Advancing country ownership (Global Health Initiative) entails facilitating nationally and locally-led responses and to determining short, medium and long-term financial commitment to gender equitable programming. It also requires close partnership with national and local governments (beyond the Ministry of Health), civil society, UNAIDS and the broader United Nations (UN) family, the Global Fund to Fight AIDS, Tuberculosis, and Malaria (GFATM), bi-lateral donors, the private sector, other US government health and development programs, and other key stakeholders (PEPFAR Multilateral Cooperation Strategy). Multisectoral approaches involve building linkages to programs outside of the health sector, including with the legal system, community development, education, economic, and food security.
- **Community and civil society engagement:** A community-based approach allows community members and civil society organizations to use their skills and resources to

expand the reach of health messages and services through culturally accepted venues (USAID, 2012). This approach can help communities work locally to prevent and respond to social and health problems, including gender inequalities and HIV. Community members to be engaged can include role models, gate-keepers, and other leaders such as religious/tribal, school teachers, mothers-in-law and grandmothers, etc.

- **Integrated health service models:** Integrated health services, where appropriate, have the potential to improve access to critical health services, improve follow-up, and improve the quality and timeliness of service delivery. These include integration of services HIV services with other critical health services such as tuberculosis (TB), family planning (FP) and maternal, neonatal, and child health (MNCH) (Global Health Initiative 2010).
- **Meaningful participation of women, girls, boys, men, people with other gender identities and vulnerable groups in the planning, design, implementation, monitoring and evaluation of PEPFAR programs:** This approach refers to the participation of populations who have been marginalized and discriminated against due to prevailing gender inequality (e.g., women and girls) (WGGE Guidance, GHI), norms related to gender identity (e.g., TG), sexual orientation (e.g., MSM), and sexual behavior (e.g., SW) (Beyrer). Special attention to those persons within these populations who are living with HIV is warranted. In order to become agents of their own health and overall empowerment, programs must move beyond viewing these populations only as end-users and beneficiaries and acknowledge and support their roles as principal actors and decision-makers. In many cases, this will involve: reaching remote areas and finding innovative ways to solicit feedback from marginalized groups, addressing barriers that may impact on beneficiaries' ability to speak candidly, and establishing confidential and responsive mechanisms.
- **Health systems strengthening to ensure capacity and quality for gender activities along the HIV continuum of care:** This approach includes programming to address capacity building of both individuals and institutions to promote gender equality and improve gender-related outcomes (GHI 2010). Building capacity at the individual level includes focusing on health care providers, caregivers, decision-makers, teachers, school administrators, community outreach workers, parents and others who are responsible for implementing gender-related activities, from the community to the national level. Capacity building includes pre-service training, in-service training, developing the requisite skills and knowledge, and providing ongoing support and mentoring. Building capacity at the institutional level includes working with government and military facilities (national, state and district levels), health institutions, and community-based organizations. Strengthening the capacity of institutions includes setting policies, guidelines, norms and standards in support of gender-related programs.

Activities

Provide gender-equitable HIV prevention, care, treatment, and support. Strong PEPFAR-supported programs promote evidence-based and innovative strategies to ensure that men and women, girls and boys, and people with other gender identities have access to quality prevention,

care, treatment, and support services across the HIV continuum of care. This includes tailoring services to meet the unique needs of various groups, and decrease gender-related barriers—including in humanitarian emergencies and conflict settings. It also includes taking into account the specific, and often different, reproductive health needs of women and adolescent girls. Finally, this also includes expanding access to female-controlled prevention methods, such as female condoms and microbicides (when available).

Illustrative examples:

- Programs that provide male-friendly HIV and reproductive health services that promote positive and healthy male gender norms in order to encourage men’s participation in health care (e.g., provide services where men work/live/gather, include evening and weekend hours, if men request).
- Designing and implementing targeted interventions to overcome gender-related barriers to accessing services for sex workers, MSM and transgender populations, such as training of health providers to reduce stigma and discrimination.
- Programs that integrate HIV services into family planning, maternal health, and reproductive health clinics in order to facilitate access to services at a single location.
- Ensuring that providers are trained to meet the unique reproductive health needs of women and girls.

Box 1: GBV special considerations:

Gender-based violence programming requires special considerations. All programs seeking to address GBV must first and foremost protect the dignity, rights, and well-being of those at risk for, and survivors of GBV, as outlined in the *Program Guide for Integrating GBV Prevention and Response in PEPFAR Programs* (http://www.aidstar-one.com/focus_areas/gender/resources/pepfar_gbv_program_guide). Four fundamental principles for integrating a GBV response into existing programs are:

- Do no harm.
- Ensure privacy, confidentiality, and informed consent.
- Promote meaningful engagement of GBV survivors.
- Ensure accountability.

Implement GBV prevention activities and provide services for post-GBV care. GBV has implications for almost every aspect of health (Campbell, 2002). It can affect women and girls, men and boys, and other gender identities. Women, girls, sex workers (SW) (Decker MR, 2013), MSM (Dunkle KL, 2013) (Shaw SY, 2012) and TG are often at increased risk. (UNICEF Tanzania, Division of Violence Prevention, National Center for Injury Prevention and Control, Centers for Disease Control and Prevention, and Muhimbili University of Health and Allied Sciences, 2011) (UNICEF Kenya, Division of Violence Prevention, National Center for Injury Prevention and Control, U.S. Centers for Disease Control and Prevention, and the Kenya National Bureau of Statistics, 2012) GBV increases vulnerability to HIV (Campbell JC, 2008) and other reproductive health and obstetric conditions, including unintended pregnancy and fistula, (Sarkar, 2008) (Johnson, 2007) and negatively affects an individual's ability to adhere to

Box 2: Minimum requirement for GBV screening (World Health Organization, 2013)

Persons who disclose any form of violence by an intimate partner (or other family member) or sexual assault by any perpetrator should be offered immediate support. Health-care providers should, as a minimum, offer first line support when a person discloses violence.

First-line support includes:

- Respecting the confidentiality of all information shared, being non-judgmental and supportive and validating what the person is saying.
- Providing practical age-appropriate care and support that responds to the person's concerns, but does not intrude.
- Asking about his/her history of violence listening carefully, but not pressuring him/her to talk (care should be taken when discussing sensitive topics when interpreters are involved).
- Provide referrals to other resources, including legal, sexual and reproductive health, psychosocial, and other services that the survivor might think helpful which are not available at the health care location. **For survivors of sexual violence, it is imperative to ensure that certain health services, including HIV post-exposure prophylaxis be administered in the first 72 hours.**
- When appropriate, referrals to child protection services and specialists for child survivors and/or to help the survivor increase their safety and that of their children.
- Providing or mobilizing social support, including family support, as appropriate.

Providers should ensure:

- That the consultation is conducted in private.
- Confidentiality, while informing persons of the limits of confidentiality (e.g. when there is mandatory reporting).

If health-care providers are unable to provide first line support, they should ensure that someone else (within their health-care setting or another that is easily accessible) is immediately available to do so. In humanitarian emergencies, on-the ground partners should be able to refer GBV survivors to additional, follow-on services (through referral networks).

Note that the WHO does not recommend universal screening or routine inquiry for GBV. (World Health Organization, 2013). However, the WHO does recommend GBV screening when assessing conditions that may be caused or complicated by GBV. GBV, whether in the case of rape or intimate partner violence, can cause or complicate HIV-related disclosure and care. **Within PEPFAR platforms, GBV screening should ONLY be done if this minimum first line support can be offered.**

Box 3: Post-GBV care

Providing comprehensive and age-appropriate post-GBV care should include attention to the health, psychosocial, and justice needs of the survivor. From an HIV prevention perspective, including HIV post exposure prophylaxis (PEP) to survivors of sexual violence who seek care within 72 hours can help reduce the risk of HIV infection (World Health Organization, 2013) (World Health Organization, 2003). According to the World Health Organization (WHO), in the **immediate term**, comprehensive post-GBV care includes post-exposure prophylaxis (PEP) for HIV and other sexually transmitted infections (STI), emergency contraception (where legal and appropriate), assessment and treatment of injuries, client-centered care including referrals for psychosocial, mental health, and other immediate needs. If the survivor wishes to pursue criminal prosecution, health care providers can also play a critical role in collection and documentation of forensic evidence that can support criminal prosecution of perpetrators (World Health Organization, 2003).

Longer-term needs for survivors include support for adherence to PEP and mental health care (e.g. for depression, drug and alcohol use problems) (World Health Organization, 2013). Provision of comprehensive post-GBV care requires **strong coordination and referrals** between health, police, justice and social services. See the 2013 *Responding to intimate partner violence and sexual violence against women: WHO clinical and policy guidelines* (World Health Organization, 2013). Survivors who decide to pursue criminal charges may need referrals to legal services and support for navigating the criminal justice system (World Health Organization, 2010). Finally, offering care to children who have experienced sexual violence requires special considerations. See *Clinical management of children and adolescents who have experienced sexual violence: Technical Considerations for PEPFAR Teams* (2013) (PEPFAR, 2013).

NEW:

PEPFAR now requires that teams report on numbers of people reached with post-GBV care as a required indicator. There is a minimum package for post-GBV care services (based on WHO guidelines) that must be in place to count under this indicator. See www.pepfar.gov for full indicator reference sheet.

treatment and access care. (Machtinger, 2012) Although GBV encompasses a wide range of behaviors, PEPFAR priority and funding is predominantly focused on prevention and response to physical and sexual intimate partner violence, including marital rape; sexual assault or rape; female genital cutting/mutilation; sexual violence against children and adolescents; and child marriage, because of the links to HIV.

Illustrative examples:

- Implementing surveillance and special studies to monitor the incidence, prevalence, and impact of GBV—among various populations, e.g., children, adult women, SW, MSM, TG, and women who inject drugs. Examples include Violence Against Children survey, Domestic Violence (DV) module of the DHS, Behavior Surveillance Surveys of Key Populations.
- Working with partner country government and civil society to strengthen legal frameworks to monitor, prevent and respond to GBV.

- Integrating post-GBV care into health service delivery programs, including the provision of services (e.g., PEP, brief counseling interventions) to address sexual, physical, and/or emotional violence (Day K, 2013).
- Mobilization efforts to address GBV attitudes and behaviors within the community.

Implement activities to change harmful gender norms and promote positive gender norms.

Gender norms play a critical role in HIV outcomes by affecting sexual behavior and risk-taking, health-seeking, HIV disclosure, and violence experience and perpetration. Therefore, attention to gender norms has the potential to affect both individual outcomes and the overall impact of interventions (Dworkin SL, 2013) (Shannon K, 2012) (Singh K, Gender equality and education: Increasing the uptake of HIV testing among married women in Kenya, Zambia and Zimbabwe, 2013).

Illustrative examples:

- Programs that work with same- or mixed-sex groups to question harmful norms and attitudes about masculinity and femininity (including norms that promote risky sex, multiple partners, and violent behavior, and those that limit discussion and joint decision making around sex and condom use) in order to promote healthy lifestyles that reduce vulnerability to HIV (Pulerwitz, 2006) (Colvin, 2009) (Jewkes, 2007).
- Targeting health professionals to change norms, e.g., so that they will be more welcoming of men in health settings, including in prevention of mother-to-child transmission (PMTCT) of HIV and antenatal care (ANC), without penalizing women who are not accompanied by men, and young women seeking sexual and reproductive health (SRH) services.
- Working with teachers and other education professional to support participation in vocational training and livelihood programs equally by boys and girls to avoid limiting the participation of girls and boys to certain professions that reinforce traditional gender roles (e.g., girls trained to be hairdressers and boys to be mechanics).
- Engaging male religious and other male community leaders and well-known role models (sports or popular culture figures) to publicly speak out in support of gender equality, human rights, and women and girls' well-being, and to act as agents of change.
- Training health providers to reduce stigma and discrimination, including against MSM, TG, and survivors of GBV.

Promote gender-related policies and laws that increase legal protection. Policies, laws, and legal practices that discriminate against vulnerable populations (e.g. women, girls, TG, MSM, SW) may increase the negative impact of HIV and AIDS (Mukasa S, 2008) (UNAIDS, 2010). For instance, women denied enforceable legal rights and protections, including rights to education, health care, employment, property and equitable inheritance, are at greater risk of engaging in transactional sex and experiencing GBV, and are less likely to access HIV treatment and care for themselves and their children (Human Rights Watch, 2003). Similarly, legislation that criminalizes same-sex behavior can have a negative effect on HIV prevention and access to services for key populations (Chris Beyrer, 2011) (Beyrer C, 2012) (UNDP, 2010) (Manzelli H, 2002).

Illustrative examples:

- Interventions to promote and enforce equal rights to land, property, and other productive assets for women.
- Programs that work with governments, NGOs, and traditional authorities to eliminate gender inequalities in civil and criminal code, such as criminalizing all forms of rape, including marital rape.
- Policies that permit women access to available SRH services without permission of husbands/partners or other family members.

Increase gender equitable access to income and productive resources, including education.

Lack of access to productive resources such as education increases vulnerability to HIV, as well as other health issues. (Pettifor AE, 2008) Therefore, providing economic and educational opportunities may empower individuals to avoid high risk behaviors, seek and receive health care services, (Singh K, 2013) and provide better care for their families.

Illustrative examples:

- Programs to ensure that girls are given equal opportunity to attend school (e.g., support for tuition fees, uniforms & supplies, community mobilization to encourage families to value girls' education as highly as boys' education) and/or vocational training (to learn marketable skills).
- Working with teachers, school administrators and parents to promote gender-equitable teaching practices that model fair and positive student-teacher interactions that address gender based barriers to school success.
- Working with governments and NGOs to develop policies that increase women's access to economic resources, including credit, markets, land, savings, and social assistance.
- Programs to provide alternative income-generation activities, plus access to savings, credit, and other financial services, for sex workers, including male and transgender sex workers.

Outputs & Outcomes²

In monitoring gender outputs and outcomes within programs, it is important to consider indicators that are gender sensitive, as well as indicators that measure gender equality.

Gender Sensitivity: Country programs should at minimum disaggregate all epidemiological and programmatic data (to the extent available and possible) by sex and age categories. Sex and age-disaggregated data are critical for understanding how the epidemic may manifest or affect different segments of the population, and whether our programmatic efforts are responsive to the unique needs of the population. They are essential for any analysis of the role and impact of gender on HIV related outcomes across all technical areas. All countries, regardless of whether reporting on specific gender indicators, should disaggregate data by sex and age, and should advocate for and support national level disaggregated data as well. PEPFAR requires that most

² Please refer to the new PEPFAR Monitoring, Evaluation and Research Strategy document for a detailed description of required and recommended output and outcome indicators (www.pepfar.gov).

of its required output and outcome indicators be disaggregated by sex and age. (See list of all required PEPFAR indicators at www.pepfar.gov).

Gender Equality: In addition to the gender sensitive indicators outlined above, a variety of gender equality indicators should be integrated into program monitoring. Table 1 includes a summary of these indicators.

Table1: PEPFAR Gender Indicators

Indicator Name and Disaggregation	Indicator Type	Data Collection Method
Gender Norms within the Context of HIV: Number of people completing an activity pertaining to gender norms, that meets minimum criteria	Output	Routine program
Sex: Male, female		
Age: 0–9 years, 10–14 years, 15–19 years, 20–24 years, 25+ years		
Type of activity: Individual, small group, community-level		
GBV Care: Number of people receiving post-GBV care	Output	Routine program
Type of service: Sexual violence (post-rape care), Physical and/or emotional violence (other post-GBV care)		
Sex: Male, female		
Age: 0–9 years, 10–14 years, 15–17 years, 18–24 years, 25+ years PEP service provision (related to sexual violence services provided)		
Intimate partner violence: Proportion of ever-married or partnered women aged 15–49 that experienced physical or sexual violence from a male intimate partner in the past 12 months*	Outcome	Population-based survey
Age: 15–19 years, 20–24 years, 25–49 years (at the time of survey)		
HIV status (if known)		
Age at first marriage: Median age in years when women aged 15–49 first married or lived with a consensual partner	Outcome	Population-based survey
Age: 15–19 years, 20–24 years, 25–49 years (at the time of survey)		
HIV status (if known)		
Coerced or forced sex among children and adolescents: Number or percent of people reporting some form of coercion or forced sex during childhood or adolescence*	Outcome	Population-based survey
Sex: Male, female		
Age: 10–14 years, 15–17 years, 18–24 years		
Norms—Wife beating: Proportion of women and men who say that wife beating is an acceptable way for husbands to discipline their wives*	Outcome	Population-based survey
Sex: Male, female		
Age: 15–19 years, 20–24 years, 25–49 years (at the time of survey)		
Norms—STI and condom use: Proportion of respondents 15–49 years who believe that, if her husband has an STI, a wife can propose condom use*	Outcome	Population-based survey
Sex: Male, female		
Age: 15–19 years, 20–24 years, 25–49 years (at the time of survey)		

Family Planning and HIV Integration: Percentage of HIV service delivery points that are providing integrated voluntary family planning services**		Output	Routine program
	By service delivery type: Clinical, community		
Enrollment in school: Percent of children regularly attending school		Outcome	Special Survey
	Sex: Male, female		
	Age: Age: 5–9 years, 10–14 years, 15–17 years		
School progression: Percent of children who progressed in school during the last year		Outcome	Special Survey
	Sex: Male, female		
	Age: Age: 5–9 years, 10–14 years, 15–17 years		

*Indicates indicator is part of the Compendium of Gender Equality and HIV Indicators.

** PEPFAR funds cannot be used to procure contraceptives. Female and male condoms can be procured using PEPFAR funds.

In addition, countries and programs should select other relevant indicators for their specific programs. For additional recommended indicators: See Compendium of Gender Equality and HIV Indicators for full text and reference sheets (<http://www.cpc.unc.edu/measure/publications/>).

Impact

In the decade since PEPFAR’s launch, significant achievements have been made in the global response against HIV and AIDS (GHI 2010). With the scale up of HIV prevention, care, treatment, and support, lives have been saved, new infections have decreased and more people living with HIV are living better and longer lives. Effective integration of gender-related issues in the HIV response can help us, through both direct and indirect pathways, achieve the goal of an AIDS-free generation—as outlined in the *PEPFAR Blueprint* (PEPFAR, 2012).

Monitoring the epidemic depends on the use of various data sources at the national and sub-national levels across partner countries to evaluate change over time and assess our progress towards an AIDS-free generation. The desired impact of HIV programs and interventions includes (See www.pepfar.gov for how these impacts will be monitored):

- 1) Incidence– decrease in the number of new cases of HIV.
- 2) Prevalence– decrease in the proportion of population living with HIV.
- 3) Mortality– decrease in the number of deaths due to AIDS.

- 4) Non-clinical HIV Impact Mitigation—enhanced impact mitigation is a central element in the HIV/ AIDS response.³

In addition to the HIV-related impacts outlined above, effective integration of gender issues throughout the PEPFAR portfolio and implementation of the key activities outlined in the PEPFAR Gender Framework will also have an impact on two important non-HIV related goals of US government’s foreign assistance at large: (1) reduced GBV and (2) increased gender equality. (WGGE Guidance, GHI).

Reductions in GBV⁴ and increases in gender equality can be measured in a variety of ways. However, UNAIDS, as part of the *2013 UNAIDS Global AIDS Response Progress Reporting* guidelines, has selected one indicator that measures progress in reducing prevalence of intimate partner violence against women as an outcome itself, but also as a proxy for gender inequality. This indicator, also outlined above, is *Proportion of ever-married or partnered women aged 15-49 who experienced physical or sexual violence from a male intimate partner in the past 12 months.* (UNAIDS, 2013) Therefore, PEPFAR programs will align with UNAIDS to measure both outcomes outlined in this section via this single indicator.

PEPFAR Country and Regional Operation Plans (COPs and ROPs)

PEPFAR teams are required to code all relevant PEPFAR activities in their COPs and ROPs using the following secondary cross-cutting budget attributions. In the case of gender, these two budget attributions are mutually exclusive (should be coded as one or the other). However, there might be overlap with other cross-cutting budget attributions (e.g., education, LGBT, nutrition):

- 1. Gender: Preventing and Responding to Gender-based Violence (GBV).** This secondary cross-cutting attribution should capture all activities aimed at preventing and responding to GBV. While GBV encompasses a wide range of behaviors, because of the links with HIV, PEPFAR is most likely to address physical and sexual intimate partner violence, including marital rape; sexual assault or rape; sexual violence against children and adolescents; female genital cutting/mutilation; child marriage; violence perpetrated by clients against sex workers (United States Strategy to Prevent and Respond to Gender-

³ The majority of interventions in the continuum of response are aimed at either reducing mortality from infection or reducing risk of infection. However, outcomes that address the non-clinical effects of HIV are also a key priority for PEPFAR. For example, if an adolescent girl has a mother who is ill and must drop out of school as a result of HIV in her life, addressing this effect of HIV and keeping her in school is an outcome that is worthwhile in and of itself, whether or not it leads to a reduction in risk of infection or mortality. In addition, a life free from violence, stigma and discrimination for any person, including a person living with HIV, is also a worthwhile outcome in and of itself. This is the role of non-clinical impact mitigation interventions. Many of these types of interventions occur within—but are not limited to, Orphans and Vulnerable Children (OVC), Prevention with Youth, Gender, and Key Populations portfolios.

⁴ Note that this framework refers to actual reductions in GBV perpetration—not simply GBV reporting. GBV reporting may in fact increase when more GBV prevention and care programs are put in place. There are a variety of ways in which actual GBV perpetration and victimization can be ascertained—including through special surveys and studies.

based Violence, 2012). Examples of activities for *Preventing and Responding to Gender-based Violence* include:

- **Collection and use of gender-related strategic information:** (a) assessment of differences in power and gender norms that perpetuate GBV as well as gender and societal norms that may facilitate protective actions against GBV and changes in attitude and behaviors; (b) analysis of existing data on different types of GBV disaggregated by sex, age and geography, and in relation the HIV epidemiology in order to identify priority interventions and focus in the context of PEPFAR programs; (c) analysis of treatment, care and referral services data by sex and age to ensure the unique needs of actual and potential victims are being met; (d) employment of rapid assessment, situational analyses and other quantitative and qualitative methods to understand norms and inequalities perpetuating GBV.
- **Implementation:** (a) screening and counseling for GBV within HIV prevention, care, and treatment programs; (b) strengthening referrals from HIV services to GBV services and vice-versa; (c) strengthening post-rape care services, including the provision of HIV PEP; (d) interventions aimed at preventing GBV, including interpersonal communication, community mobilization and mass media activities; (e) programs that address societal and community norms that perpetuate violence against women and girls and other marginalized populations; (f) programs that promote non-violent conflict resolution skills for couples; (g) strengthening linkages between health, legal, law enforcement, and judicial services and programs to prevent and mitigate GBV; (h) interventions that seek to reduce sexual violence directed at children and related child protection programs; and (i) support for review, revision, and enforcement of laws and for legal services related to GBV, including strategies to more effectively protect young victims and punish perpetrators.
- **Capacity building:** (a) capacity building for US government staff and implementing partners on how to integrate GBV into HIV prevention, care and treatment programs; (b) capacity building for Ministry of Women's Affairs, Ministry of Health or other in-line Ministries to strengthen national GBV programs and guidelines; (c) pre and in-service training on the identification, response to and referral for cases of intimate-partner violence, sexual violence and other types of GBV; and (d) assist in development and implementation of agency, government-, or a portfolio-wide GBV strategy.
- **Operation research:** (a) research to better understand the associations and pathways between GBV and HIV; (b) research to identify promising practices in training and protocols for the effective delivery of GBV screening and services and of GBV prevention programs; (c) evaluation of comprehensive GBV programming on HIV and GBV outcomes of interest.
- **Monitoring:** (a) strengthening national and district monitoring and reporting systems to capture information on provision of GBV programs and services, including HIV PEP within health facilities.

2. Gender: Gender Equality (GE). This secondary cross-cutting attribution should capture all activities aimed at ensuring that men and women, boys and girls, and people with other gender identities have full rights and potential to be healthy, and benefit from the results of HIV interventions. The following activities of the PEPFAR Gender Framework should be coded as GE:

- Implement activities to change harmful gender norms & promote positive gender norms.
- Promote gender-related policies and laws that increase legal protection.
- Increase gender equitable access to income and productive resources, including education.
- Provide gender equitable HIV prevention, care, treatment and support.

Examples of these activities include:

- **Collection and use of gender-related strategic information:** (a) analysis of existing HIV prevention, care, and treatment portfolios and/or individual programs to understand and ensure appropriate response to gender norms, relations and inequities that affect health outcomes; (b) analysis of variation across populations and population subsets (by sex and age) in terms of gender norms, roles and resource needs; (c) mapping of differences in power that affect access to and control over resources between women and men, girls and boys, which are relevant to health objectives; (d) identification of key gaps and successful programs in gender integration across HIV prevention, care and treatment; (e) analysis of access and adherence to treatment that includes analysis of data by sex and age; (f) assessment of barriers to service by men and women; and (g) employment of rapid assessment, situational analyses and other quantitative and qualitative methods to understand gender norms and inequalities in the context of HIV prevalence and programming.
- **Implementation:** (a) HIV prevention interventions redressing identified gender inequalities; (b) legal, financial or health literacy programs for women and girls; (c) programs designed to reduce HIV that addresses the biological, cultural, and social factors that disproportionately impact the vulnerability of women, men or transgender individuals to the disease, depending of the setting and type of epidemic; (d) a PMTCT or HTC program that implements interventions to increase men's meaningful participation in and use of services; (e) specific programming for out-of-school adolescent and pre-adolescents who are often the most vulnerable, including males and married adolescent girls; (f) male circumcision programs that include efforts to reach female partners, mothers and other women in the community and incorporate messages around gender norms in pre- and post-counseling.
- **Capacity building:** (a) assist in development and implementation of agency-, government-, or portfolio-wide gender strategy; (b) conduct training for US government staff and implementing partners on women, girls, and gender equality issues, as well as capacity building on how to integrate gender into HIV prevention,

- care and treatment programs; (c) capacity building for Ministry of Women’s Affairs or the Gender Unit within a Ministry of Health; (d) capacity building interventions for HIV-positive women to assume leadership roles in the community and programs; and (e) training for health service providers on unique needs and risks of specific sub-populations such as adolescent girls and older, sexually-active men.
- **Operational research:** (a) research to better understand gender-related barriers and facilitators to HIV prevention, care and treatment programs; (b) research to identify HIV-related needs and risks specific to adolescent girls and young women; (c) research to promote constructive male engagement strategies to increase uptake of male circumcision, other prevention strategies, HTC, treatment, and care among adult men.
 - **Monitoring:** (a) monitoring of programs and services through the use of standardized indicators; (b) strengthening monitoring systems be able to document and report on accessibility, availability, quality, coverage and impact of gender equality activities; and (c) ensuring that relevant data is disaggregated by sex and age.

See Annex 5 and 6 for the application of the PEPFAR Gender Framework to HIV Counseling and Testing (HCT) and Voluntary Medical Male Circumcision (VMMC). Text on the application to other technical areas is forthcoming.

HOW?

How can the PEPFAR Gender Framework be applied to PEPFAR-supported programming?

Gender needs to be integrated in PEPFAR’s programmatic response as well as within institutional structures.

Gender in PEPFAR Institutional Structures

In order to ensure that gender is fully integrated into PEPFAR programming, all PEPFAR staff should have the knowledge, skills and abilities to analyze and take action on gender issues as part of their duties and responsibilities. For example, technical staff need to know how to execute the PEPFAR gender guidance; supervisors should ensure staff have the necessary training to meet their job competencies in gender; position descriptions and performance evaluations should include gender competencies. It is also important to have key staff at the country and headquarters’ level with specific gender-related expertise. Therefore, PEPFAR teams are responsible for:

1. Existence of both country and headquarters staff with gender expertise. This should be considered across PEPFAR technical areas and teams.

2. Hiring/nominating and training Gender Focal Points within each PEPFAR implementing agency.
3. Hiring/nominating and training (a) Gender Lead(s) for the PEPFAR team. This can include more than one person depending on the size of the portfolio. Determining the level of effort for the Gender Lead should be based on the size of the program.
4. As natural turn-over occurs, ensuring that expertise in gender issues is part of the requirements for filling positions across PEPFAR technical areas—including by writing this into scopes of work and job announcements is critical.

Gender Integration in PEPFAR Programs

Gender issues and considerations should be included throughout the steps of the program cycle. Among the range of tools that are available to support gender integration, the Gender Technical Working Group recommends two:

- *A Manual for Integrating Gender into Reproductive Health and HIV Programs: From Commitment to Action* (2009). (IGWG, A Manual for Integrating Gender into Reproductive Health and HIV Programs: From Commitment to Action, 2009)
- The *Gender Equality Continuum Tool* (IGWG, Interagency Gender Working Group, 2013) which can be found in Annex 4, reflects a two-tiered process of analysis that begins with determining whether interventions are “gender blind”⁵ or “gender aware,”⁶ and then considers whether the interventions are exploitative⁷, accommodating⁸ or transformative⁹.

Box 4: Training

In order to support PEPFAR teams acquire gender-related expertise, both in-person and on-line training is available. This includes both overall gender training, as well as on LGBT-specific issues. In-person training at the country level is strongly recommended. To schedule this, please contact your OGAC country support team lead (CSTL).

⁵ Gender blind policies and programs are designed without a prior analysis of the culturally-defined set of economic, social, and political roles, responsibilities, rights, entitlements, obligations, and power relations associated with being female and male and the dynamics between and among men and women, boys and girls. The project ignores gender considerations altogether.

⁶ Gender aware policies and programs examine and address the set of economic, social, and political roles, responsibilities, rights, entitlements, obligations and power relations associated with being female and male and the dynamics between and among men and women, boys and girls.

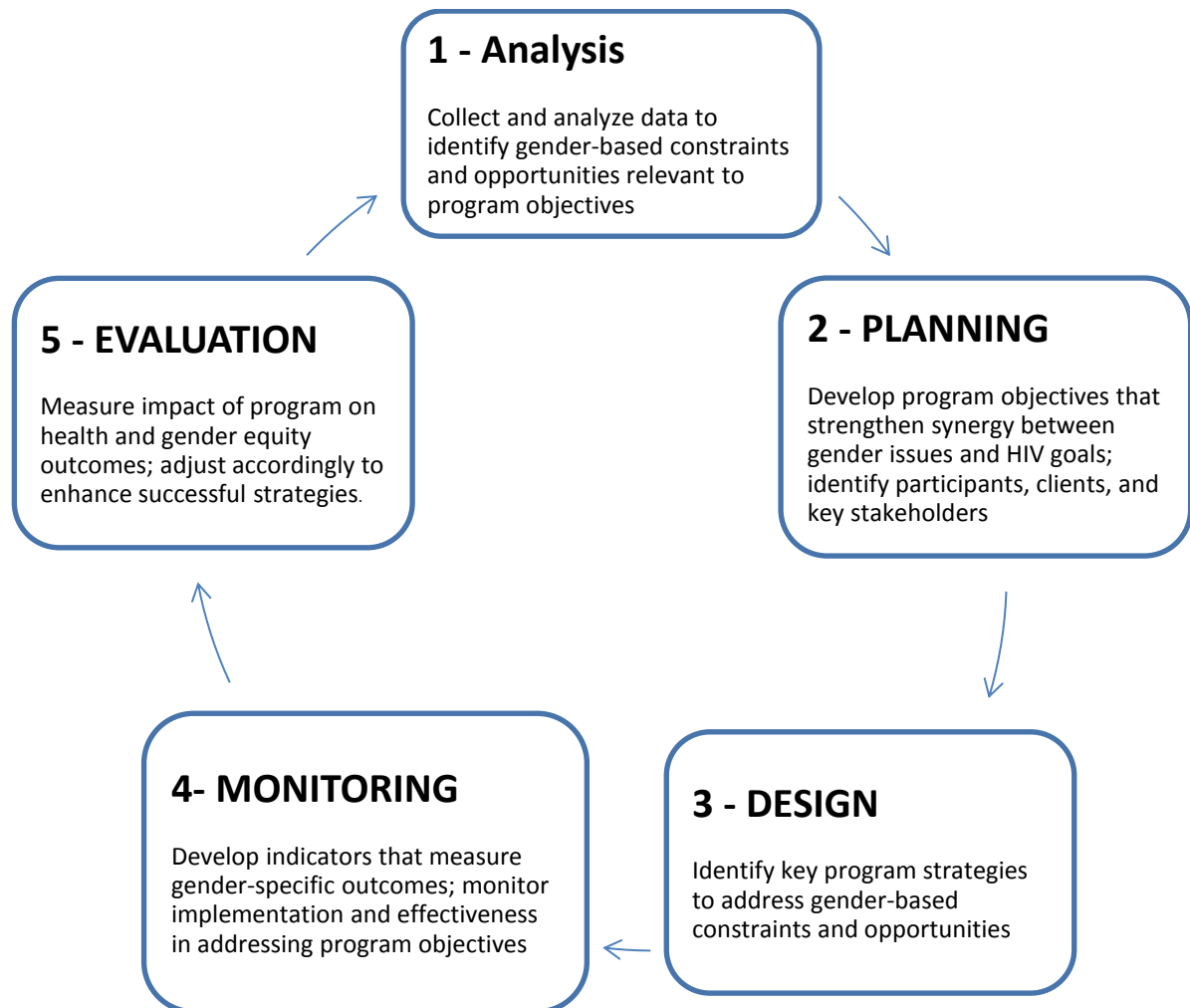
⁷ Policies and programs that intentionally or unintentionally reinforce or take advantage of gender inequalities and stereotypes in pursuit of project outcome, or whose approach exacerbates inequalities.

⁸ Policies and programs that acknowledge but work around gender differences and inequalities to achieve project objectives.

⁹ Policies and programs that seek to transform gender relations to promote equality and achieve program objectives. This approach attempts to promote gender equality by: 1) fostering critical examination of inequalities and gender roles, norms and dynamics, 2) recognizing and strengthening positive norms that support equality and an enabling

The Continuum can be used as a diagnostic tool or a planning framework tool to assess if and how well programmatic interventions are currently identifying, examining and addressing gender considerations and to determine how to move along the continuum toward more transformative gender programming.

Figure 2: Program Cycle



1. Analysis

Collect and analyze data to identify gender-based constraints and opportunities relative to program objectives. Such an analysis can also be as a baseline for future comparisons. As

environment, 3) promoting the relative position of women, girls and marginalized groups, and transforming the underlying social structures, policies and broadly held social norms that perpetuate gender inequalities.

an example, a gender analysis would help to identify gender differences in: (a) laws, policies, regulations, and Institutional practices; (b) cultural norms and beliefs; (c) gender roles, responsibilities, and time use; (d) access to and control over assets and resources; and (e) patterns of power and decision-making.

NEW PEPFAR REQUIREMENT: BY March 2016

Each interagency PEPFAR country team – with the input of government partners, local civil society organizations, bi-lateral and multilateral donors, and other partners – is now required to conduct a gender analysis specific to the HIV response, to inform the design of projects and activities. All PEPFAR implementing agencies should participate in the analysis. This will be monitored as part of the COP and ROP review process.

The analysis should identify age-specific gender roles and norms that affect: (a) access to and control over resources; (b) access and utilization of HIV prevention, treatment care, and support; and (c) differences in power among and between women and men, girls and boys. This analysis should be tailored to the specific context of the HIV epidemic, and should go beyond the health sector to describe broad structural issues within a country, as well as US government investments in other sectors—as they relate to the HIV response. Teams are encouraged to use existing data, surveillance, special studies and assessments, and to build on these as appropriate.¹⁰

2. Planning

The planning process should include:

- a. Develop program objectives that address the issues identified in the required gender analysis, as described by a gender aware approach (from the Gender Equality Continuum).
- b. Identify participants, clients, and key stakeholders.
- c. Ensure gender expertise and designated leads for the activities at the implementing partner level.

3. Design

Identify key program strategies to address gender-based constraints and opportunities related to HIV prevention, treatment and care. As PEPFAR teams

¹⁰ Note: The USAID Automated Directive System (ADS) requires gender analysis for all country development cooperation strategies (CDCS) and project design. Any analysis done through the ADS can be used as a resource for PEPFAR teams. UNAIDS is finalizing a new gender assessment tool to help in the development of the national HIV response that can also be used to meet this requirement. (See resources section).

work to determine program strategies and develop activities, it is critical that this be an evidence-informed process. Teams should prioritize evidence-informed interventions. (See Annex 3: Helpful Resources). Teams should also ensure that the program activities are not exploiting or exacerbating existing gender inequalities, and activities are being considered and developed to support gender transformative programming on the Gender Equality Continuum.

4. Monitoring

Use existing PEPFAR indicators to monitor both outputs and outcomes, and select additional indicators as appropriate, including from the *Compendium of Gender Equality and HIV Indicators*. Quality programming should always monitor for unintended consequences—this is particularly important in the context of addressing gender-related programming and ensuring that interventions are not exploitative of gender inequalities. Programs should also monitor how far and in what ways programs are moving along the continuum from accommodating to transformative gender programming, as well as tracking the differential impact of project activities on men and women.

5. Evaluation

Measure the effect of programs on HIV and gender-related outcomes; adjust design accordingly. In order to effectively conduct evaluations, the following should be considered:

- a. Planning for evaluation should occur early on in the program cycle.
- b. Clear definition of the desired impacts and outcomes.
- c. Selection the most appropriate and rigorous design possible.

At this stage of the program cycle the Gender Equality Continuum tool can be used as a framework to assess to what extent the program was gender blind or gender aware, and to what extent the program used accommodating or transformative approaches to achieve program goals.

Box 5: Note on evidence

Using evidence-informed programs, policies and practices has become an expectation of funders, policy-makers, and program managers. However, determining what is evidence-informed is not a simple matter. Evidence for effectiveness, or ‘what works’, exists on a continuum based on how the evidence was established. The level or quality of evidence comes from considerations such as the type of evaluation design, potential biases, how strong the effect is on the outcome, and how consistent the effects are across multiple studies or settings. Regarding evidence-based programming for gender-related activities it is important to highlight that:

- ✓ The evidence for interventions that address gender issues in the context of HIV and AIDS is still emerging. Few interventions have been rigorously evaluated. Those that have been rigorously evaluated and shown to be effective in one setting have rarely been replicated elsewhere to establish consistency of effects across different settings. Well-evaluated programs are often from high-income settings, with fewer examples from low and middle-income countries. (World Health Organization, 2013)
- ✓ There are many different ways to evaluate programs. The most rigorous design possible should be used in order to offer the most confidence that an intervention is making a difference. Randomized controlled trials (RCTs)¹, including cluster randomized controlled trials¹, are considered the most rigorous design and for that reason are sometimes called the “gold standard.” However, some quasi-experimental designs¹ are rigorous as well and can give us fairly high confidence in our results. In situations where the most rigorous designs are not possible (e.g., lack of resources), less rigorous designs may still offer formative information on the effectiveness of an intervention. For example, pre- post designs can give us an initial sense of whether or not a program is promising (e.g., if there are changes in the outcomes of interest over time and if the changes are occurring in the right direction). (World Health Organization, 2013)
- ✓ In addition to the evaluation design, a critical aspect of gathering evidence is the selection of an outcome. Similar to using the most rigorous design possible, evaluations of gender-related activities should examine outcomes that are as closely tied to HIV outcomes as possible (e.g., reduction of GBV). Teams can refer to the PEPFAR gender framework in Figure 1 for examples of outcomes that have been empirically or theoretically tied to HIV. When feasible and appropriate, collecting bio-markers such as HIV status can demonstrate that link directly.
- ✓ In many low-resource settings it is not always feasible to collect data on HIV incidence as it requires more financial resources and longer time frame to show change. Hence, many programs measure intermediate outcomes that are more realistic to achieve in the short to medium term time frame (e.g., norms, skills, knowledge). Intermediate outcomes can provide important information about potential pathways that lead to long-term outcomes, such as changes in perpetration or experience of GBV and HIV transmission. (World Health Organization, 2013)
- ✓ In addition to outcomes and impacts, it is critical to have quality measures of process and implementation.
- ✓ One type of intermediate outcome that is worth further exploration is the reduction of gender-related barriers to participation in highly effective HIV prevention care and treatment interventions. If gender activities are successful at removing these barriers and there is increased enrolment, participation, and adherence to HTC, VMMC, PMTCT, and treatment as prevention, then an indirect effect of the gender activity on HIV outcomes is more easily assumed, since these highly effective HIV interventions have already been linked to positive HIV outcomes.
- ✓ It is critical that evidence-informed approaches guide the integration of gender-related issues in our HIV response, and that PEPFAR teams invest in high quality evaluations with the most rigorous designs possible to continue building the evidence base.

ANNEXES

ANNEX 1: Acronyms

ANC	Ante-Natal Clinic
ART	Antiretroviral Therapy
ARV	Antiretroviral Drugs
BCC	Behavior Change Communications
CDC	Center for Disease Control
CHTC	Couples/Partner HIV Testing and
Counseling	
COP	Country Operational Plan
CSW/SW	Commercial Sex Worker/Sex Worker
CSTL	Country Support Team Lead
DHS	Demographic and Health Surveys
DoD	Department of Defense, United States
FP	Family Planning
FY	Fiscal Year
GAP	Global AIDS Program—CDC
GBV	Gender-based Violence
GHI	Global Health Initiative
HCW	Health Care Worker
HPV	Human Papillomavirus
HQ TWG	Headquarters Technical Working Group
HRH	Human Resources for Health
HSS	Health Systems Strengthening
HTC	HIV Testing and Counseling
KP	Key Population
L&D	Labor and Delivery
LGBT	Lesbian, Gay, Bi-sexual and Transgender
LTFU	Lost to Follow-Up
M&E	Monitoring and Evaluation
MARP	Most At-Risk Population
MCH	Maternal and Child Health
MDG	Millennium Development Goal
MNCH	Maternal, Newborn, and Child
Health	
MOH	Ministry of Health
MSM	Men who have Sex with Men
MTCT	Mother-to-Child Transmission
NACS	Nutrition Assessment, Counseling, and
Support	
NGI	Next Generation Indicators
NGO	Non-Governmental Organization
NIH	National Institute for Health
NSP	Needle and Syringe Programs
NBTS	National Blood Transfusion Service

OGAC	Office of the US Global AIDS Coordinator
OVC	Orphans and Vulnerable Children
PEP	Post-Exposure Prophylaxis
PEPFAR	President's Emergency Plan for AIDS Relief
PITC	Provider-Initiated Testing and Counseling
PLWHA/PLHIV	People Living with HIV/AIDS
PMI	President's Malaria Initiative
PMTCT	Prevention of Mother-to-Child Transmission
PPP	Public-Private Partnerships
PrEP	Pre-Exposure Prophylaxis
PWID	People Who Inject Drugs
PwP	Prevention with People Living with
HIV/AIDS	
PWUD	People Who Use Drugs
QA	Quality Assurance
QI	Quality Improvement
QM	Quality Management
RCT	Randomized Controlled Trial
RH	Reproductive Health
RTK	Rapid Test Kit
SBCC	Social and Behavior Change
Communications	
SCMS	Supply Chain Management System
SI	Strategic Information
SMME	Small, Medium, and Micro Enterprises
SOP	Standard Operating Procedure
STI/STD	Sexually Transmitted Infection/Sexually Transmitted Disease
SW (MSW, FSW)	Sex Worker (Male Sex Worker, Female Sex Worker)
TA	Technical Assistance
TB	Tuberculosis
TLC	Total Lymphocyte Count
TWG	Technical Working Group(s)
USAID	United States Agency for International Development
USG	United States Government
(VM)MC	(Voluntary Medical) Male Circumcision
WAD	World AIDS Day
WHO	World Health Organization

ANNEX 2: Definitions

Sex

Sex is the classification of people as male or female. At birth, infants are assigned a sex based on a combination of bodily characteristics including: chromosomes, hormones, internal reproductive organs, and genitalia (*USAID March 2012 Gender Equality and Female Empowerment Policy*).

Gender

It is a culturally-defined set of economic, social, and political roles, responsibilities, rights, entitlements obligations, associated with being female and male, as well as the power relations between and among women and men, boys and girls. The definition and expectations of what it means to be a woman or girl and a man or boy, and sanctions for not adhering to those expectations, vary across cultures and over time, and often intersect with other factors such as race, class, age and sexual orientation. All individuals, independent of gender identity, are subject to the same set of expectations and sanctions. (*IGWG*) Gender is not interchangeable with women or sex.

Gender identity

Refers to a person's internal, deeply felt sense of being a man or woman, or something other, or in between, which may or may not correspond with the sex assigned at birth.

Transgender

Transgender is an umbrella term referring to individuals who do not identify with the sex category assigned to them at birth or whose identity falls outside of stereotypical gender norms. The term "transgender" encompasses a diverse array of gender identities and expressions, including identities that fit within a female/male classification and those that do not. Transgender is not the same as intersex, which refers to biological variation in sex characteristics, including chromosomes, gonads and/or genitals that do not allow an individual to be distinctly identified as female/male at birth.

Gender-based violence (GBV)

For PEPFAR, GBV is defined as any form of violence that is directed at an individual based on biological sex, gender identity (e.g., transgender), or behaviors that are not in line with social expectations of what it means to be a man or woman, boy or girl (e.g., MSM and Female Sex Workers). It includes physical, sexual, and psychological abuse; threats; coercion; arbitrary deprivation of liberty; and economic deprivation, whether occurring in public or private life. GBV is rooted in power differences, including social, economic and political inequalities. It is characterized by the use and abuse of physical, emotional, or financial power and control. GBV can occur across childhood, adolescence, reproductive years, and old age. It can affect all individuals, but women and girls, MSM and TG are often at increased risk. While GBV encompasses a wide range of behaviors, because of the links with HIV, PEPFAR is most likely to address physical and sexual intimate partner violence, including marital rape; sexual assault or rape; sexual violence against children and adolescents; female genital cutting/mutilation; child

marriage; violence perpetrated by clients against sex workers (adapted from the US Strategy to Prevent and Respond to Gender-based Violence Globally, 2012).

Gender equity

The process of being fair to women and men, boys and girls to ensure fairness, measures must be taken to compensate for cumulative economic, social, and political disadvantages that prevent women and men, boys and girls from operating on a level playing field (*IGWG training resources*).

Gender equality

The state or condition that affords women, men and people with other gender identities equal enjoyment of human rights, socially valued goods, opportunities, and resources. Genuine equality means more than parity in numbers or laws on the books; it means expanded freedoms and improved overall quality of life for all people (*IGWG training resources; USAID Gender Equality and Female Empowerment Policy*).

Gender integration

Strategies applied in programmatic design, implementation, monitoring and evaluation to take gender considerations (as defined above, in “gender”) into account and to compensate for gender-based inequalities (adapted from *IGWG training resources*).

Gender analysis

Gender analysis is a subset of socio-economic analysis (Interagency Gender Working Group). It is a social science tool used to identify, understand, and explain gaps between males and females that exist in households, communities, and countries. It is also used to identify the relevance of gender norms and power relations in a specific context (e.g., country, geographic, cultural, institutional, economic, etc.). Such analysis typically involves examining:

- differences in the status of women and men and their differential access to assets, resources, opportunities and services;
- the influence of gender roles and norms on the division of time between paid employment, unpaid work (including subsistence production and care for family members), and volunteer activities;
- the influence of gender roles and norms on leadership roles and decision-making; constraints, opportunities, and entry points for narrowing gender gaps and empowering females; and
- the different impacts of development policies and programs on males and females, including unintended or negative consequences.

Gender-related barriers

Are those faced by women and men, boys and girls that limit their ability to access and benefit from social, economic, and political roles, responsibilities, rights, obligations, and entitlements. These barriers are based upon the culturally-defined gender roles ascribed to being male or female.

Men's engagement

Men's engagement is a programmatic approach that involves men and boys: a) as clients and beneficiaries, b) as partners and c) as agents of change, in actively promoting gender equality, women's empowerment and the transformation of inequitable definitions of masculinity. In the health context, this comprises engaging men and boys in addressing their own, and supporting their partners' reproductive, sexual and other health needs. Men's engagement also includes broader efforts to promote equality with respect to caregiving, fatherhood, and division of labor, and ending GBV.

Sexual orientation

Sexual orientation refers to one's sexual or romantic attractions, and includes sexual identity, sexual behaviors and sexual desires.

LGBT

(Lesbian, Gay, Bisexual, Transgender). Refers to a commonly used acronym used to refer to both sexual orientation (LGB) and gender identity (T).

Homophobia

Homophobia is the fear of, aversion to, or discrimination against homosexuals or homosexual behavior or cultures. Homophobia also refers to internalized heterosexism by homosexuals as well as the fear of men or women who transgress the socio-cultural definitions of what it is to be a "true man or woman" or embody "true masculinity or femininity" (adapted from *IGWG training resources*).

Heterosexism

The presumption that everyone is heterosexual and/or the belief that heterosexual people are naturally superior to lesbian, gay, transgender and bisexual people (adapted from *IGWG training resources*).

Gender-transformative HIV response

This response seeks to address the gender-specific aspects of HIV and AIDS and change existing structures, institutions, and gender relations into ones based on gender equality (Interagency Gender Working Group).

Gender-sensitive indicators refer to quantitative measures that have been disaggregated by sex as well as other stratifiers (e.g., age) in order to show if there are differences in outcomes, behaviors, uptake of services and other gaps between and among sub-groups of women and men.

Gender-equality indicators

These refer to measures that track changes in the power dynamics in how men and women, boys and girls relate, including individual norms or attitudes towards gender equality (i.e. gender norms), access to and control over economic resources, employment, household decision-making among women, women's status, community norms towards gender equality, and legal and policy frameworks for gender equality at the national level.

ANNEX 3: Helpful Resources

Evidence-informed Programming

- ***What Works for Women and Girls?*** www.whatworksforwomen.org
The *What Works for Women and Girls: Evidence for HIV and AIDS Interventions* is a helpful tool in this process. The purpose of this PEPFAR-supported website is to provide the evidence necessary to inform country-level programming. *What Works* is a comprehensive review, spanning 2,500 articles and reports with data from close to 100 countries, that has uncovered a number of interventions for which there is substantial evidence of success: from prevention, treatment, care and support to strengthening the enabling environment for policies and programming. *What Works* also highlights a number of gaps in programming that remain.

Monitoring and Evaluation

- ***Compendium of Gender Equality and HIV Indicators*** (<http://www.cpc.unc.edu/measure/publications/>). The *Compendium* of indicators covers programmatic areas vital to the intersection of gender and HIV. Each of these programmatic areas includes a number of indicators that may be used at national, regional or programmatic levels. The *Compendium* covers programmatic areas vital to the intersection of gender and HIV. Each of these programmatic areas includes a number of indicators that may be used at national, regional or programmatic levels. The indicators in the *Compendium* are all either part of existing indicators used in studies or countries or have been adapted from existing indicators to address the intersection of gender and HIV. The indicators can be measured through existing data collection and information systems (e.g. routine program monitoring, surveys) in most country contexts, though some may require special studies or research.

Gender-based Violence:

- ***Gender-based Violence and HIV: A Program Guide for Integrating Gender-based Violence Prevention and Response in PEPFAR Programs*** http://www.aidstar-one.com/gbv_program_guide
- ***Responding to intimate partner violence and sexual violence against women.*** 2013 WHO clinical and policy guidelines. <http://www.who.int/reproductivehealth/publications/violence/9789241548595/en/>
- ***16 ideas for addressing violence against women in the context of the HIV epidemic.*** WHO 2013. http://apps.who.int/iris/bitstream/10665/95156/1/9789241506533_eng.pdf

- ***Addressing violence against women and HIV and AIDS: what works?*** Geneva, World Health Organization. 2010.
<http://www.who.int/reproductivehealth/publications/violence/9789241599863/en/>
- ***Resources for the Clinical Management of Children and Adolescents Who Have Experienced Sexual Violence*** http://aidstar-one.com/focus_areas/gender/resources/prc_technical_considerations.

Gender Integration:

- ***A Manual for Integrating Gender into Reproductive Health and HIV Programs: From Commitment to Action*** http://www.igwg.org/igwg_media/manualintegrgendr09_eng.pdf
- ***UNAIDS Agenda for Accelerated Country Action for Women, Girls, Gender Equality and HIV Operational plan for the UNAIDS action framework: addressing women, girls, gender equality and HIV***
http://www.unaids.org/en/media/unaids/contentassets/documents/unaidspublication/2010/20100226_jc1794_agenda_for_accelerated_country_action_en.pdf
- ***Integrating Gender into Programs with Most-at-Risk Populations: Technical Brief***
http://www.aidstar-one.com/focus_areas/gender/marps_concentrated_epidemics_series
- ***USAID Guide to Gender Integration and Analysis.***
www.usaid.gov/policy/ads/200/201sab.pdf
- ***Integrating Multiple PEPFAR Gender Strategies to Improve HIV Interventions: Recommendations from Five Case Studies from Programs in Africa*** http://www.aidstar-one.com/focus_areas/gender/resources/compendium_africa
- ***IGWG Gender and Health Toolkit.*** <http://www.k4health.org/toolkits/igwg-gender>
- ***Integrating gender into HIV and AIDS programs in the health sector. WHO***
<http://www.who.int/gender/documents/hiv/9789241597197/en/index.html>
- ***AIDSTAR-One. Gender Technical Area Resources:*** http://www.aidstar-one.com/focus_areas/gender_technical_area
- ***UNAIDS Gender Assessment Tool*** (Forthcoming)

ANNEX 4: Gender Equality Continuum Tool

GENDER EQUALITY CONTINUUM

Ignores:

- the set of economic/social/political roles, rights, entitlements, responsibilities, obligations and associated with being female & male
- power dynamics between and among men & women, boys & girls

Gender Blind



Gender Aware

- Examines and addresses these gender considerations and adopts an approach along the continuum

Exploitative

Reinforces or takes advantage of gender inequalities and stereotypes

Accommodating

Works around existing gender differences and inequalities

Transformative

- Fosters critical examination of gender norms* and **dynamics**
- Strengthens or creates systems* that support gender equality
- Strengthens or creates equitable gender norms and dynamics
- Changes inequitable gender norms and dynamics

GOAL

Gender Equality and better development outcomes

* Norms encompass attitudes and practices

* A system consists of a set of interacting structures, practices, and relations

ANNEX 5: Applying the PEPFAR Gender Strategy to HIV Testing and Counseling (HTC)

The PEPFAR Gender Framework can be applied to all technical areas, including HTC. In this section, we discuss each component of the framework and how it can be applied to HTC programming, including specific gender-related activities that may increase HTC access and uptake to improve overall HTC outcomes (see Figure 1).

Principles

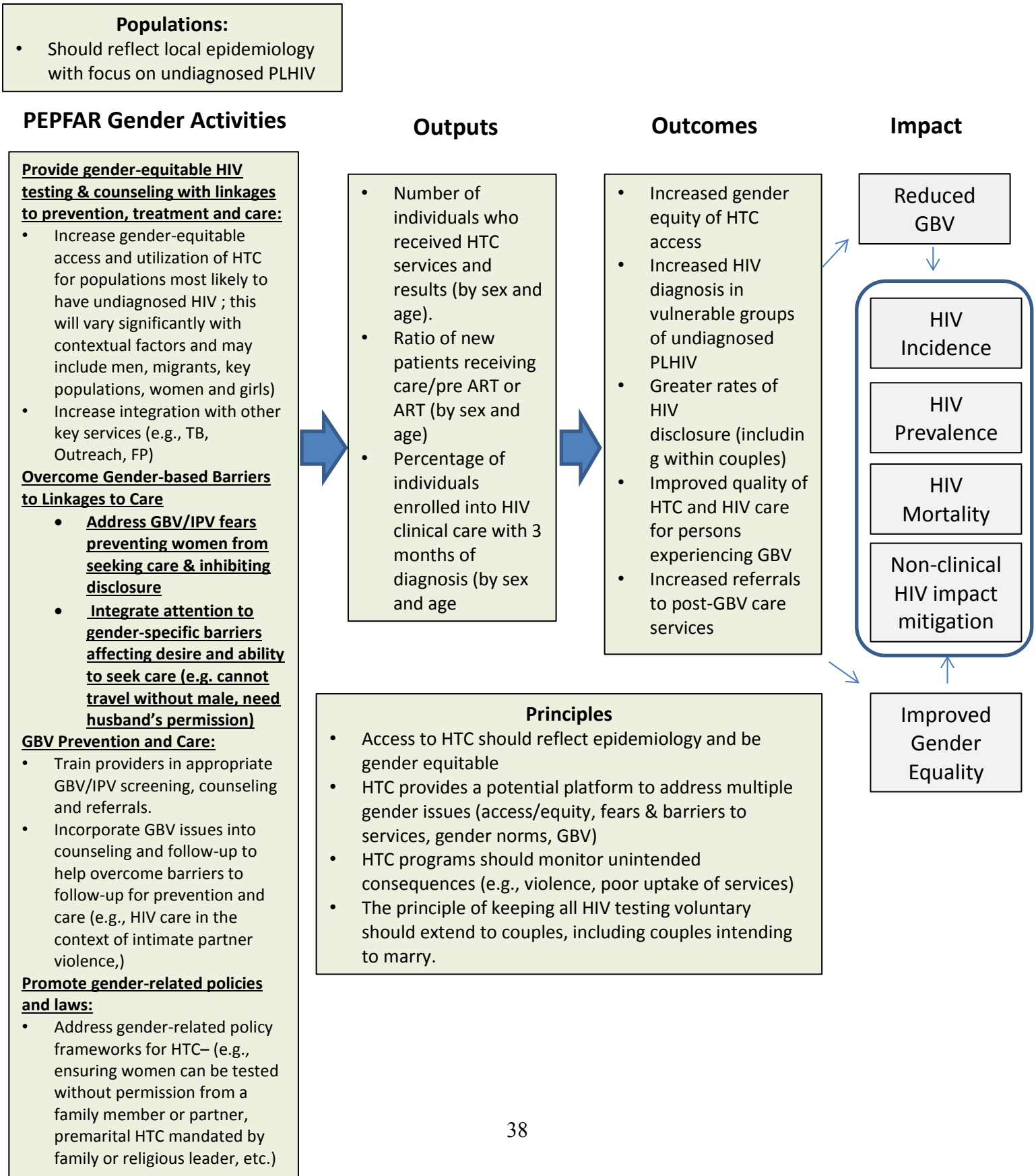
- Access to and targeting of HTC should reflect epidemiology and be gender equitable.
- HTC provides a potential platform to address gender issues (access/equity, gender norms, GBV).
- HTC programs, whether testing individuals, couples, or family members, should be cognizant of unintended consequences of HTC, including GBV.
- Both UNAIDS and WHO oppose mandatory HIV testing in any context. This extends to HIV testing for couples intending to marry, where the potential to exacerbate gender inequalities and violence makes mandatory HTC especially risky. It also extends to women engaged in sex work and/or drug use

Populations

The focus of gender-sensitive HTC outreach activities should be on reaching groups at risk who face greater barriers to accessing HTC and care, with attention to communities and settings with a higher proportion of undiagnosed people living with HIV (PLHIV). *In every population with high rates of HIV infection, gender issues shape access to and willingness to use HTC services and link to prevention, care and treatment for those found HIV-positive.* Identifying and, where appropriate, responding to these issues supports achievement of key PEPFAR targets and health outcomes.

Figure 1

PEPFAR Gender Framework – HTC



Activities

The activities from the PEPFAR Gender Framework that are most applicable to the HTC platform include: (1) provide gender-equitable HIV prevention, treatment and care, (2) provide GBV prevention and care, and (3) promote gender-related policies and laws. Illustrative examples of how country teams can include gender activities in HTC are presented below.

Provide gender-equitable HIV prevention, treatment and care.

- **Increasing gender-equitable access to HTC for populations with undiagnosed PLHIV.** Depending on the country and region, there are particular groups with high levels of undiagnosed HIV that are hard to reach with HTC activities. Although there is great variation, often times men, key populations (including MSM, SW, TG and PWID), married adolescent girls, and young women who are not pregnant fall into this category (Obermeyer C, 2007).
- Addressing the gender-related barriers to access and uptake of HTC services and subsequent follow up for prevention and care for these populations is critical. Illustrative activities include:
 - Adding gender-related questions through both quantitative and qualitative studies of barriers to HTC access and utilization.
 - Involve community leaders and other respected figures who exemplify positive male norms to deliver messages encouraging men to get tested and to support their wives and girlfriends to get tested.
 - Create safe spaces for MSM (Centers for Disease Control and Prevention, 2003), SW, TG individuals, taking into account their gender identity (e.g., male-to-female TG individuals may feel more comfortable in a setting that targets women, not men) (Wei C, 2011) and train health workers to provide non-discriminatory HTC (Mahendra VS, 2007).
 - Target adolescent girls and young women outside of ANC with a non-judgmental approach.
 - Apply quality improvement science to test approaches to improving the quality of HTC services, with attention to gender-related issues and barriers
- Increase integration with other key clinical and community services, including, but not limited to family planning (FP) and tuberculosis (TB). In order to reduce mortality through early detection of TB and support client-centered approaches to care, the integration of a variety of

Box 1: Women's decision-making regarding HIV testing

Research from various regions of the world has shown that male partners, either directly or indirectly, often have a significant impact on women's uptake of HIV testing in the context of PMTCT programs. For example, women's perception of their husband's approval of their taking an HIV test was the strongest predictor of women's willingness to accept an HIV test (Bajunirwe F, 2005). Opposition from male partners was one of the major factors to which low HIV counseling and testing uptake, as well as failure to return for HIV test results, can be attributed in some contexts (Sarker M, 2007).

In one Ugandan program, 31% of women refused HIV testing at ANC, 82% of them because they needed the permission of their male partner and 54% due to the fear of the male partner's reaction in case of a positive HIV test result (Dahl V, 2008). A comprehensive review of international studies examining individual-level factors influencing pregnant women's HIV testing uptake identified women's fear of negative reactions from their male partners as key in women's individual level reasoning for declining HIV testing (Maman S, 2008).

reproductive health, and other services with HIV services is critical. Illustrative activities include:

- Assess fertility intentions as part of HTC counseling within HIV platforms.
- Refer to voluntary FP and/or safe pregnancy counseling services (for HIV-positive or discordant couples who desire pregnancy).
- Offer HTC within FP platforms—especially in high HIV prevalence settings.

Provide GBV Prevention and Care. HTC can be an entry point for both the provision of GBV preventive and care services. For example, women who have experienced GBV can be identified through HTC and referred to appropriate services.

- **Identify GBV issues as part of HTC to improve long-term follow up and quality of care (e.g., disclosure in the context of intimate partner violence):** The recent 2013 WHO guidelines do not recommend “Universal screening” or “routine enquiry” (i.e. asking women in all health-care encounters) about GBV; screening must consider the context and availability of referral services. However, health-care providers should be trained and mentored to integrate counseling about exposure to intimate partner violence and when assessing conditions that may be caused or complicated by intimate partner violence in order to improve diagnosis/identification and subsequent care. For example, disclosure of HIV status to male partners, when possible, is considered important for ensuring that individuals are able to access a range of services, including services for prevention of vertical HIV transmission and HIV treatment and care (Kebaabetswe, 2007). However, a World Health Organization (WHO) study revealed that between 16-86% of women in developing countries choose not to disclose their HIV status to their male partners (Medley A, 2004). Recent studies have shown that HIV disclosure is not associated with increased levels of intimate partner violence (Harling G, 2010). However, HIV disclosure within the context of a violent relationship could trigger additional violence. In addition, intimate partner violence has important implications for HIV disclosure, as well as subsequent retention in care and treatment (World Health Organization, 2012). In order to screen for GBV minimum first line support must be available. (See Box 1).
- **Train providers in appropriate GBV and intimate partner violence (IPV) screening and referrals.** Note that the WHO does not recommend universal screening or routine inquiry for GBV. (World Health Organization, 2013). However, the WHO does recommend GBV screening when assessing conditions that may be caused or complicated by GBV. GBV, whether in the case of rape or intimate partner violence, can cause or complicate HIV-related disclosure and care (see Box 2).

Box 2: Minimum requirement for GBV screening (World Health Organization, 2013)

Persons who disclose any form of violence by an intimate partner (or other family member) or sexual assault by any perpetrator should be offered immediate support. Health-care providers should, as a minimum, offer first line support when a person discloses violence.

First-line support includes:

- being non-judgmental and supportive and validating what the person is saying
- providing practical care and support that responds to her concerns, but does not intrude
- asking about his/her history of violence, listening carefully, but not pressuring him/her to talk (care should be taken when discussing sensitive topics when interpreters are involved)
- helping him/her access information about resources, including legal and other services that she might think helpful
- assisting her to increase safety for herself and her children, where needed
- providing or mobilizing social support.

Providers should ensure:

- that the consultation is conducted in private
- confidentiality, while informing persons of the limits of confidentiality (e.g. when there is mandatory reporting)

If health-care providers are unable to provide first line support, they should ensure that someone else (within their health-care setting or another that is easily accessible) is immediately available to do so.

Note that the WHO does not recommend universal screening or routine inquiry for GBV. (World Health Organization, 2013). However, the WHO does recommend GBV screening when assessing conditions that may be caused or complicated by GBV. GBV, whether in the case of rape or intimate partner violence, can cause or complicate HIV-related disclosure and care. **Within PEPFAR platforms, GBV screening should ONLY be done if this minimum first line support can be offered.**

Promote gender-related HTC policies and laws.

- Address gender-related policy frameworks for HTC– e.g., ensuring women can be tested without permission from a family member or partner (World Health Organization , 2004); coercive testing; non-consensual disclosure.

ANNEX 6: Applying the PEPFAR Gender Framework: Voluntary Medical Male Circumcision (VMMC)

The PEPFAR Gender Framework (see Figure 1) can be applied to all technical areas, including VMMC (see Figure 2, below). In this section, we discuss each component of the framework and how they can be applied to VMMC programming, including specific activities that may reduce gender-related barriers to VMMC uptake and outcomes. These recommendations are based on a systematic review of the literature on barriers and facilitators to uptake of VMMC-related services (CDC and Manila Consulting Group Inc., 2012) as well as promising practices from field experience.

Principles

Health Systems Strengthening to ensure capacity to address gender-related barriers to VMMC

- Ensuring easy access (close proximity) to VMMC facilities
- Ensuring provision in safe and trusted medical facilities or other health facilities
- Ensuring that anyone implementing the gender-related activities is adequately trained

Community engagement

- Ensuring meaningful involvement of men who are being targeted for VMMC and their female partners/family members in the development and testing of gender-related activities (e.g., testing demand creation messages)
- Engaging community leaders as
 - Role models for uptake of VMMC
 - Promoters of positive male norms messaging, consistent with VMMC campaigns

Multi-sectoral involvement

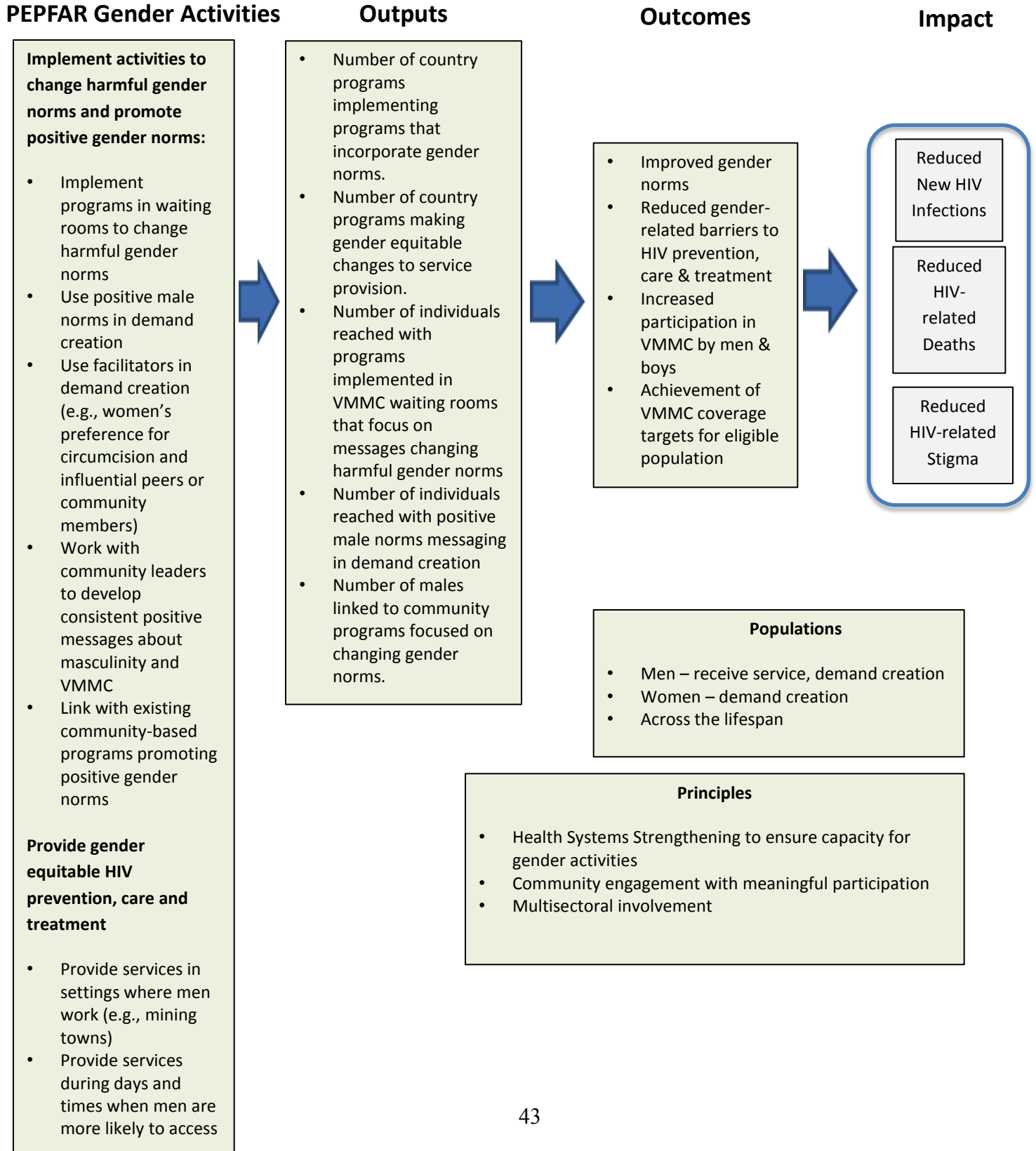
- Ensuring appropriate community stakeholders are involved in formative research and rolling out new programs and approaches
- Ensuring involvement from ministries of health as well as ministries of gender and women, where available

Populations

Although VMMC services are male-specific, women and girls have the ability to act as facilitators or barriers to both seeking services and successful recovery from the procedure. Therefore, both men and women can play roles in demand creation for VMMC services, and both need accurate information about the procedure itself, the recovery, and healing process. In addition, considering the prevalence of traditional male circumcision practices in many countries, it may be critical to work with community leaders and traditional healers in order to

Figure 1

PEPFAR Gender Framework -- VMMC



develop appropriate positive messages (consistent with any VMMC campaign messages) about masculinity (male norms).

Activities

The two activities from the PEPFAR Gender Framework that are most applicable to the VMMC platform include (1) Implementing activities to change harmful gender norms and promote positive gender norms, and (2) Providing gender equitable HIV prevention, care and treatment (i.e., responding to the unique needs of men and women, boys and girls). *Illustrative examples* of how country teams can include gender activities in VMMC are presented below.

Use positive male norms in demand creation. PEPFAR program data suggest that VMMC demand creation has been most successful among young men and boys (<18 years old) and many programs have struggled to reach men who are older than 18. To date, demand efforts have predominantly used messages focused on HIV prevention and other health benefits of VMMC. New approaches based on positive male norms as a strategy for increasing VMMC demand creation include:

- using the Demand Creation Toolkit for VMMC, a new resource available to VMMC programs that provides guidance on improving VMMC demand and includes non-medical message templates that reinforce healthy masculine ideals (Centers for Disease Control and Prevention (CDC), RTI International, and Population Services International (PSI), 2013);
- focusing on the positive portrayals of strength, leadership, and provider and protector, may resonate with men, especially those with families, and thereby increase VMMC demand; and
- engaging community, sports, traditional, and military leaders who exemplify positive male norms and speak out against GBV (e.g., coercive and forced sex), while simultaneously encouraging VMMC.

Using local formative work on messaging, engage women in demand creation (e.g., women's preference for circumcision, and wives, partners, and mothers as influencers) and planning for recovery and healing process. A recent systematic review identified a number of facilitators that can help increase men's access to VMMC, including women in men's lives. "Seven studies provided evidence that men's partners can influence willingness to obtain VMMC for themselves or their sons. Four of these studies emphasized the utility of communication between men and their wives in encouraging decisions to obtain VMMC. Another three studies highlighted the roles that both partners and family members can play in encouraging or pressuring males to obtain MMC (CDC and Manila Consulting Group Inc., 2012)." Specific ideas may include:

- engaging female partners, mothers, and other influential women and girls in education about the benefits of VMMC and the role they can play in encouraging the men and boys in their lives to go for VMMC;
- including female partners in developing a plan for the healing process (abstinence period—minimum of six weeks) that enhances the relationship and helps alleviate anxiety and fear; and
- developing a demand creation campaign that highlights women’s preferences for and benefits from circumcision.

Implement programs and/or integrate consistent messaging in waiting rooms/throughout VMMC clinics that focus on promoting positive male norms and changing harmful gender norms. While accessing VMMC services, boys and men may experience one or more waiting periods. These waiting times are opportunities to provide messages that promote positive masculinity and responsibility as men and boys (e.g., strength, leadership, provider). Specific ideas may include:

- using same messages (in print material form, e.g., posters and pamphlets) used during any VMMC campaigns and regular demand creation messaging, based on any existing local formative research;
- adapting/borrowing messages and visuals from existing programs that focus on shifting harmful gender norms and promoting positive male norms (e.g., Program H and others: http://genderjustice.org.za/resources/doc_download/101745-working-with-men-and-boys-emerging-strategies-from-across-africa-to-address-gbv-and-hiv-aids.html)—programs may want to consider choosing messages that are consistent with any demand creation messaging that is being used;
- developing/showing short videos that promote positive male norms and same consistent messages and themes; and
- facilitating conversations with small groups of men and boys who are waiting (i.e., if the facility generally sees individuals sitting around waiting).

Link with existing community-based programs that promote positive gender norms. After providing an introduction to positive gender norms messaging at a VMMC site, programs can use this opportunity to link men to gender transformative programs in the community (i.e., programs that work with participants to change existing attitudes, structures, institutions, and gender relations into ones based on gender equality). Taking advantage of large VMMC campaigns may be the best time for this type of recruitment and linkage to community-based programs. This would allow for concentrated recruitment (and a lessened burden for ongoing recruitment on the VMMC site) and coordinated efforts to link men with a community-based program that is about to begin around the time of the VMMC campaign’s conclusion. Community-based, gender transformative programs, with at least some evidence of effectiveness, include:

- Program H (<http://www.promundo.org.br/en/activities/activities-posts/program-h/>),

- Soul City (<http://www.soulcity.org.za/>), and
- Stepping Stones
(<http://www.steppingstonesfeedback.org/index.php/page/Resources/gb?resourceid=24>).

Provide VMMC services in settings where men work. Removing structural barriers such as transportation is a potential means of helping men access VMMC services. In addition, providing services near or at men's places of work has the potential to reinforce positive male norms about working and providing for the family. Specific efforts may include:

- collaborating with work-based health programs to create demand for VMMC and/or to train those health workers to provide VMMC services;
- establishing new VMMC clinics nearby large employers, e.g., in mining towns; and
- using mobile VMMC clinics that are focused on a circuit of specific employment locations.

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