Strengthening HIV/AIDS Programs for Women

Lessons for U.S. Policy from Zambia and Kenya

A Report of the CSIS Task Force on HIV/AIDS

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Strengthening HIV/AIDS Programs for Women
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Janet Fleischman

Introduction
The President’s Emergency Plan for AIDS Relief (PEPFAR) completed its first full year of funding in January 2005. This provides a useful vantage point from which to analyze the program’s performance thus far, notably with regard to programs targeting women and girls. This paper, based on a CSIS field mission to Kenya and Zambia in February 2005 to assess PEPFAR implementation from a gender perspective, looks at this critical dimension of the HIV/AIDS epidemic—the disproportionate impact on women and girls—to suggest how PEPFAR can be adjusted and strengthened to better target and enhance its response moving forward.

One of the key challenges is that larger social and economic factors affect women and girls’ vulnerability to HIV infection and complicate their illness when infected. In fact, addressing these dimensions is fundamental to curbing the epidemic among women and girls, and promising models for doing so already exist. At this juncture, it is critical for the Office of the Global AIDS Coordinator (OGAC) to remedy this shortcoming, including by: issuing guidance specific to the needs of women and girls, strengthening linkages with programs working on women’s social and economic empowerment, establishing a technical working group to assist in this process as well as provide ongoing input to the field, documenting programs targeting women and girls, and monitoring program impact in each PEPFAR country. The CSIS visit to Kenya and Zambia found numerous innovative programs designed to address the nexus between women and girls’ risk of HIV/AIDS and their social and economic empowerment. These
kinds of strategies should be encouraged and strengthened as part of PEPFAR’s implementation.

PEPFAR, a $15-billion global program over five years with 15 focus countries, has clear goals: by 2008, to support treatment for 2 million people infected with HIV/AIDS, to prevent 7 million new infections, and to support care for 10 million people infected and affected by HIV/AIDS. These are laudable goals, and PEPFAR has already made remarkable headway, notably by providing treatment to 155,000 people and reaching 1.2 million women with services to prevent HIV transmission from mother to child (PMTCT). However, the 2008 targets run the risk of being unreachable unless PEPFAR strengthens its programs to target women and girls, which means addressing the factors that are fueling the epidemic among women by operationalizing strategies to reach them. In its initial start-up phase, OGAC’s emphasis has been on getting systems in place and meeting initial targets by focusing on the most accessible groups. It now has the opportunity to proactively address the gap on explicit program interventions targeting women and girls as it begins preparations for its FY 2006 activities and the 15 focus countries prepare their 2006 Country Operational Plans (COPs).

To reach women and girls under each of its goals, and to enhance its chances of meeting its goals overall, PEPFAR will need to address the key social and economic realities that put women and girls at risk for HIV infection and complicate their situation when infected. Leading PEPFAR officials have raised concerns that the social and economic dimensions of women’s risk are much broader than the HIV/AIDS epidemic and that addressing such dimensions would tax the limited HIV/AIDS resources available through PEPFAR. In addition, they argue that these entrenched and complex issues are being addressed by the larger development community. Though these concerns are valid, it is equally critical to understand that if these fundamental dimensions of women’s risk are not central to the U.S. approach to HIV/AIDS, it will be extremely difficult for PEPFAR to reduce risk for women and girls and provide them with treatment and care when infected. Moreover, the development community and select examples within the HIV/AIDS response have demonstrated that more integrated interventions addressing social and economic dimensions can be put in place and are not necessarily cost prohibitive.

The time has come to recognize and issue clear guidance and criteria to clarify how these imperatives, beyond HIV/AIDS or even the health sector, are directly linked to women’s vulnerability to infection and to their ability to access and adhere to care and treatment. Ultimately, the effectiveness and sustainability of PEPFAR requires it to meet this challenge.

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1 The 15 focus countries, accounting for more than 50 percent of the world’s infections, are primarily in sub-Saharan Africa (Botswana, Côte d’Ivoire, Ethiopia, Kenya, Mozambique, Namibia, Nigeria, Rwanda, South Africa, Tanzania, Uganda, and Zambia) but also include Guyana and Haiti in the Caribbean and Vietnam in Asia. PEPFAR also includes HIV/AIDS programs in an additional 96 countries.

**Status of PEPFAR’s Efforts to Address Women and Girls**

Public statements by Ambassador Randall Tobias, the U.S. global AIDS coordinator, and various OGAC publications have described the need to include programs and strategies to target women and girls. The five-year global strategy, issued by OGAC in February 2004, outlined a range of issues and interventions related to women and girls’ needs and PEPFAR goals. While there was some overlap, the five-year strategy fell short of what was envisioned under the authorizing legislation passed by Congress, the United States Leadership Against HIV/AIDS, Tuberculosis, and Malaria Act of 2003 (P.L. 108-25). That bill called for OGAC to report to Congress on specific strategies it would pursue to meet the unique needs of women.

In March 2005, OGAC’s first annual report to Congress, *Engendering Bold Leadership: The President’s Emergency Plan for AIDS Relief*, stated that PEPFAR “recognizes that social inequalities between women and men, in conjunction with harmful gender-based cultural norms and practices, not only perpetrate women’s vulnerability to HIV but also continue to fuel the HIV epidemic among both women and men.” The report summarized first-year activities that addressed gender issues following a framework of strategies that includes those in the authorizing legislation: reducing stigma, increasing gender equity in HIV/AIDS programs and services, addressing male norms and behaviors, reducing violence and coercion, increasing girls and women’s access to income and productive resources, and increasing women’s legal protection.

To date, however, OGAC has not reported any specific strategies addressing women and girls, either in its five-year strategy, its first report to Congress, or in other documents. The first report to Congress, for example, while providing overall data on women and girls, did not provide more substantive information on these activities and their outcomes. Although the report featured small, innovative projects from the 15 focus countries that addressed women and girls, there has been little explicit effort to tackle the needs of women and girls in a more systematic and comprehensive manner.

Program guidance on gender issues from OGAC to PEPFAR country program managers has been vague and intermittent. Guidance on the preparation of country five-year strategies and the FY 2005 COP requested that PEPFAR country teams describe how they will address gender. However, guidance on gender-specific interventions, indicators, and targets was not provided, which contributed to confusion in the field about funding expectations and parameters for interventions focused on women and girls. In addition, there was insufficient follow-up during the technical review process, where the guidance on gender components might have been clarified. This was due, in part, to the absence of an OGAC-led technical working group focusing on gender issues. Approximately

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five technical working groups have been formed to date to provide guidance on technical matters including recommendations for country program funding. Without a technical working group on gender to oversee this process within PEPFAR, the gender issues have not received adequate consideration.

Another opportunity that could have been used to provide guidance to PEPFAR teams is found in the January 2005 guidance issued by OGAC to in-country staff and implementing partners about how to implement the ABC (Abstinence, Be Faithful, Condoms) Approach. The guidance states that priority interventions should be preventing infection in the “most at risk populations.” However, no specific discussion of women and girls is provided. Given that the majority of those living with HIV/AIDS in the PEPFAR focus countries are female, that the vast majority of people in those countries do not know their status, and that women are frequently the ones who have remained faithful to husbands who have other sexual partners, there are strong reasons to consider women and girls in general to be a high-risk group. Indeed, the very social and economic vulnerabilities that drive women and girls into risky situations also lead some of them into commercial sex work.

Ultimately, PEPFAR’s prospects of achieving its prevention, care, and treatment goals will be greatly enhanced if it starts looking at women and girls as a special, high-risk group. This means figuring out the circumstances that are unique to them, determining how PEPFAR programs should be modified or supplemented to meet their needs, and creating opportunities to leverage other development resources to support mutual goals. In some cases, this may require

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6 Those most at risk are identified as sex workers and their clients, sexually active discordant couples or couples with unknown HIV status, substance abusers, mobile male populations, men who have sex with men, people living with HIV/AIDS, and those who have sex with an HIV-positive partner or one whose status is unknown.

7 The guidance further states that A, B, and C components to prevention should all be included, but clearly emphasizes abstinence, while recognizing that an integrated “ABC” approach is necessary for those young people who are sexually active “by choice or coercion.” Yet targeted programming for those coerced into sex—mainly women and girls—beyond encouraging abstinence and faithfulness is not described. Indeed, the guidance acknowledged that “in some communities, as many as 20 percent of girls aged 15 to 19 are infected, compared to 5 percent of boys the same age” and thus that “[p]revention approaches must then address the risks of cross-generational and transactional sex.” However, the guidance concludes that these trends should be addressed by abstinence programs for youth and be faithful programs for men.

8 Even programs focusing on “high risk” groups are facing new constraints. The Wall Street Journal reported on February 28, 2005 (Michael Phillips, “Bush Ties Money to AIDS Work to a Policy Pledge”), that the Bush administration is seeking to bar U.S. nongovernmental organizations from U.S. funding for health services overseas unless they pledge their opposition to prostitution. Many organizations are reluctant to issue such statements because they work closely with sex workers and do not want to further their stigmatization and isolation, which would increase barriers in access to HIV prevention, care, and treatment services. Previously, the Bush administration had only applied a 2003 law to overseas groups, but the Justice Department recently reversed its determination that applying the provision on U.S. groups would be an unconstitutional violation of free speech.
PEPFAR to strengthen linkages with the broader set of U.S. programs working on women’s social and economic empowerment; in other cases, this may lead to PEPFAR directly supporting activities focused primarily on women and girls. At a minimum, all program activities should be examined from a gender perspective and accorded appropriate funding to ensure first that women and girls are not left behind in PEPFAR programs, and second, that best practices are being applied systematically to curb the HIV epidemic among women and girls and to offer them equitable access to prevention, care, and treatment services. One embassy official summarized the negative impact of neglecting women and girls and the risks it poses for PEPFAR’s goals: “Without programs focusing specifically on women, we will be at a disadvantage to meet our targets. How could they have decided to leave such an essential group out of programming?”

As country teams prepare for the new round of funding, PEPFAR should adopt a more focused, explicit, and systematic approach to prevention, care, and treatment of women and girls. As John McWilliam of Family Health International in Kenya put it: “good [HIV/AIDS] programming means women.”

PEPFAR Strategies in Zambia and Kenya

Zambia and Kenya are among the 15 focus countries with serious, generalized epidemics, with HIV prevalence among women in Zambia estimated to be almost 18 percent\(^\text{11}\) and 8 percent Kenya.\(^\text{12}\) Both countries also have active civil society groups addressing a wide range of rights, development, and health-related issues, which could serve as important partnerships for PEPFAR, especially in the areas that extend beyond the health sector. In addition, the U.S. embassies in both countries have been relatively proactive in HIV/AIDS programs, and both have recognized the centrality of the gender dimension of the epidemic. However, the PEPFAR programs in these countries also reflect some of the constraints in targeting women and girls that CSIS has documented in other PEPFAR focus countries.\(^\text{13}\) OGAC should take the lead in providing the explicit guidance needed to encourage and support the PEPFAR teams’ efforts to take on the more complicated, sometimes controversial issues surrounding women and girls and HIV/AIDS.

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\(^9\) Interview in Lusaka, Zambia, February 26, 2005.
\(^{10}\) Interview in Nairobi, Kenya, February 22, 2005.
PEPFAR in Zambia

Overall HIV prevalence in Zambia is estimated to be 17.8 percent among females (19 percent in pregnant women) and 13 percent among males, with the rate in urban areas double that in rural areas. In FY 2004, Zambia was allocated $61 million in PEPFAR funding, and almost $85 million was approved for FY 2005. This figure was later raised to $115 million.

The PEPFAR strategy in Zambia generally recognizes gender inequities in prevention, care, and treatment of HIV/AIDS and states that it will seek to address factors that put young women and girls in risky situations. The strategy aims to reduce cross-generational sex and child sexual abuse, to address cultural norms and behaviors, and to develop institutional capacity to promote the ABC model for high-risk, vulnerable populations, lifeskills and livelihood training, male models, post-exposure prophylaxis (PEP), behavior change communication, and stigma reduction. There is no mention of gender under treatment.

Nevertheless, some members of the PEPFAR team in Zambia recognize that, despite the intentions of the HIV/AIDS strategy, there is no specific gender focus. As one put it: “Under PEPFAR, no programs are designed specifically for women. Women may benefit or participate, but the programs aren’t designed for them.” And another put it in even starker terms: “PEPFAR is a very medical model. We’re not working with women’s groups, although the sub-grants could. We’re focusing on the direct determinants of transmission—ABC.” This raises the important issue of how the PEPFAR programs define populations at risk, especially in light of OGAC’s definition in its 2005 ABC Guidance.

14 The prevention component of the 2005 COP ($15,819,077—26 percent of the budget) focused on expanding PMTCT; increasing abstinence and be faithful programs, especially among youth and discordant couples; establishing safe medical practices; and expanding programs for high-risk groups such as sex workers, truck drivers, and military personnel. The care component ($16, 559,303—27 percent of the budget) focused on expanding counseling and testing (CT) services, care for opportunistic infections (OIs), and care for co-infected individuals. For people living with HIV/AIDS, care includes treatment of OIs and support to home-based care providers. For orphans and vulnerable children (OVCs), services such as education, shelter, food, and training of caregivers reach some 140,000 but are largely uncoordinated. The treatment component ($17,631,111—29 percent of the budget) focuses on scaling up antiretroviral treatment (ART), with the goal of getting 120,000 patients on ART by 2008. Currently, some 14,000 people are receiving antiretrovirals (ARVs). Other activities ($11,678,450—19 percent of budget), focus on strategic information activities to monitor progress toward PEPFAR targets and identify best practices.


16 In recent years, the U.S. Agency for International Development (USAID) in Zambia had been more forward looking and incorporated HIV/AIDS into five of its strategic objectives: (5) economic growth, (6) education, (7) treatment and health, (8) democracy and governance, and (9) multisectoral responses. For example, strategic objective 9 (multisectoral) focuses on OVCs, PLWAs, care and support, which includes legal assistance for those living with HIV/AIDS.


Education has been an area where PEPFAR in Zambia has tried to move forward in integrating a particular focus on girls with HIV/AIDS. Since girls stood out in the demographic and health surveys insofar as being an orphan and being a girl greatly increased the risk of not staying in school, the embassy explored ways of making the PEPFAR funds “additive” so that PEPFAR money could be used to strengthen other accounts. A prime example of this complementary approach is the ambassador’s small grants program, which has established a girls’ scholarship fund using both African Education Initiative (AEI) funds and matching PEPFAR funds. PEPFAR funds are also being used in Zambia to train teachers, and some programs have incorporated training on gender-based violence. The PEPFAR team in Zambia has identified the ambassador’s fund and the PEPFAR sub-granting mechanisms as the ways to address the nonmedical issues.19

PEPFAR in Kenya

Prevalence among women and girls in Kenya is approximately 8 percent, with prevalence among pregnant women in some areas higher than 10 percent. In FY 2004, Kenya was allocated $71 million in PEPFAR funding, and in FY 2005, $115 million is planned.20 The PEPFAR program’s five-year strategy in Kenya puts a priority on youth and signals the importance of reaching Kenya’s young women. In prevention, this is supposed to include promoting behavioral norms and legal protections responsive to the vulnerability of girls, including young married women. In care and support, the focus is around orphans and vulnerable children (OVCs) and children caring for sick relatives. In treatment, it involves ensuring antiretroviral treatment (ART) for children. The five-year strategy identifies as a priority empowering women to participate in HIV prevention and states that the United States will help women access income-generating activities, support reforms in policy and inheritance laws, and help break the link between poverty, prostitution, and AIDS. The strategy goes on to state: “[W]e will design and implement programs in a way that responds to the increased vulnerability of women and girls and the increased need for services that result when they are infected or directly affected by HIV.”21

The strategy also identifies three key challenges, including: the fear of HIV testing, especially among women for PMTCT (prevention of mother-to-child transmission) services; the difficulties in extending services to rural and remote areas and to marginalized populations; and the complex social, cultural, and economic factors that contribute to HIV risk, particularly among women and girls.22

19 Interview with U.S. embassy staff, Lusaka, February 23, 2005.
22 Ibid., p. 10.
The CHANGES program in Zambia ( Communities Supporting Health, HIV/AIDS, Nutrition, Gender Equity, and Education in Schools) aims to improve access to and quality of basic education through capacity building and implementing multisectoral programs in school health, nutrition, girls’ education, and HIV/AIDS. CHANGES operates in 88 regular schools as well as 30 community schools. The idea is to involve chiefs, counselors, and headmen to address cultural factors that put children at risk, including the custom of forcibly eloping with young girls, and to advocate for civil law to prevent girls from being forced into marriage. The program reports that two out of the four chiefs in the area now support these changes. The program also looks at HIV/AIDS care and support, involving life skills, psychosocial skills, assertiveness, self-esteem, how to handle cases of abuse, and what to do in one’s leisure time to avoid risks. The program is also training some paralegals. 23

At Kaonga Basic School in Mazabuka, in Zambia’s Southern Province, a group of 14- to 15-year-old girls involved in CHANGES’s anti-AIDS clubs meet to learn about and discuss AIDS prevention and arrange performances about the dangers of HIV/AIDS. “HIV/AIDS is a killer disease, we are worried in Zambia today…” one sang. As each girl got up to sing her part, the broader realities of HIV/AIDS became apparent. “Father can rape me, brother can rape me, but they blame me. Society, help me.” And another sang: “She’s left with relatives, the parents don’t mind her, only other children.”24

Nearby, at the Mazabuka Girls High School, girls in grades 8 through 12 act as peer educators. They learn about HIV/AIDS, the “dangers of sex,” self-esteem, and stress management. While they initially focused on abstinence messages in a meeting with international visitors, upon further questioning, the picture became more nuanced. “It’s a fact that not everyone is abstaining,” said one. And another spoke up and said: “It’s difficult to adhere to the information on an empty stomach.”25

Despite the recognition of these challenges, the PEPFAR team in Nairobi acknowledges the gap in programming on women and girls. They argue that in some programs, women and girls are actually overrepresented, although they admit that this is not the result of program design. In fact, there were no proposals uniquely targeting women and girls for the 2005 COPs, and most of the proposals fell under the abstinence category, a reflection of a widely held perception that PEPFAR is about abstinence and treatment. Still, the PEPFAR team is planning to undertake more work on reducing the vulnerability of young girls in the future.26

The critical need for strategies to reach women and girls grows out of these stark statistics. In Nyanza province in Kenya, for example, girls aged 15 to 24 are up to six times more likely to be infected than boys their age. According to Centers for Disease Control (CDC) officials in Kenya, the challenge of reducing the vulnerability of young girls is linked to poverty, cross-generational sex, and

23 Interview with CHANGES coordinator, Mazabuka, Zambia, February 24, 2005.
24 Performance at Kaonga Basic School, Mazabuka, February 24, 2005.
25 Interview at Mazabuka Girls High School, Mazabuka, February 24, 2005.
vulnerabilities of female-headed households. This, in turn, affects young women’s ability to access health services and by extension, antiretroviral (ARV) treatment. “We haven’t looked at services for youth really,” said Dorothy Mbori-Ngacha of CDC in Kenya. “There are some pilots, but we haven’t reached out to youth proactively. Few services target them and meet their needs.”

One of the biggest obstacles for women and girls is voluntary testing and counseling (VCT), since they are often diagnosed first and blamed for bringing the virus home. CDC cites the alarming statistics of 70 to 80 percent of women getting tested at antenatal clinics, and then falling out of the system—effectively disappearing. Linked to this, studies indicate that some 30 percent of women in Nairobi experience violence, with slightly lower rates in rural areas. In addition, many factors inhibit women’s access to HIV services, especially when it includes financial costs.

Program Examples

OGAC has stressed that it will be driven by best practices and by evidence-based programs. Sufficient data and documented program experience exists for PEPFAR to reach women and girls at risk with HIV/AIDS information and services. In some cases, this will require that PEPFAR integrate social and economic protection strategies as part of its prevention, care, and treatment efforts. These are particularly critical strategies to reach adolescent girls living outside the protective structures of family and school, poor girls on their own who are heading households affected by HIV/AIDS, girls at risk of child marriage, and married girls in communities highly affected by HIV/AIDS.

Violence against women is increasingly recognized as a risk factor and has important implications for prevention, treatment, and care programs. The threat of violence undercuts women’s ability to negotiate safer sex, including condom use, and contributes to their vulnerability to infection due to physical assaults and sexual violence. Gender-based violence can also be an outcome of HIV infection, with women facing distinct risks of violence or abandonment upon disclosure.

27 Interview with Dorothy Mbori-Ngacha, CDC, Nairobi, February 22, 2005.
28 Ibid.
The following section identifies efforts to provide more integrated services for women and girls, including programs to improve the social status and reduce the economic dependence of women and girls and facilitate their access to treatment, prevention, and care. These examples illustrate innovative ways to address these issues, and some of them are already receiving PEPFAR funding.

Treatment
Women and girls make up a large proportion of those in need of treatment. In sub-Saharan Africa, women make up 60 percent of those living with HIV, and girls aged 15 to 19 are infected at rates up to five to seven times that of boys their age. Since key entry points for treatment have been antenatal clinics and PMTCT services, it is not surprising that women may face fewer barriers than men in knowing their status and may initially outnumber men on treatment, notably when the treatment is free of charge.31 Indeed, PEPFAR’s first annual report to Congress indicated that of those sites capturing the number of women and girls receiving treatment, 56 percent of the clients on ART were female. However, the ability for broader populations of women and girls to participate successfully in treatment programs will depend on their access to HIV/AIDS information, services, and social support, which require overcoming long-standing gender-related barriers, including fear of violence, stigma, and economic abandonment.

Recognizing the challenges of enrolling and retaining women and girls in care, the International Center for AIDS Care and Treatment Programs (ICAP) at Columbia University’s Mailman School of Public Health relies on a multidisciplinary family-focused model. ICAP promotes a comprehensive primary-care approach to HIV/AIDS treatment, including attention to psychosocial as well as biomedical issues, the involvement of individuals with HIV/AIDS in the care programs, and outreach to community resources. Columbia’s MTCT-Plus Initiative, one of ICAP’s major programs, is directly linked to antenatal care and PMTCT services, prioritizing pregnant women as the family’s entry point to HIV/AIDS treatment. At present, approximately 8,000 people are enrolled in MTCT-Plus programs in 13 countries; 70 percent of the adults are women. A further 20,000 people are enrolled in ICAP’s five-country Multicountry Columbia Antiretroviral Program (MCAP), which receives PEPFAR funding; at last analysis, 60 percent of the adults in MCAP were women. Lessons learned from both MTCT-Plus and MCAP include the need to address the practical barriers faced by many participants, such as distance from the site of care, cost of transportation, hunger, and stigma.32

Prevention
The area of prevention requires both a broad lens in order to expand women’s access to information and services and empower them to negotiate the terms of

31 For discussion of obstacles in access to treatment for women and girls, see Fleischman, Breaking the Cycle.
32 Dr. Miriam Rabkin, “The ICAP Approach to Multidisciplinary Care and Treatment Programs,” presentation at CSIS meeting, “PEPFAR and Gender.”
MTCT-Plus—The Chelstone Clinic in Zambia

The Chelstone Clinic in Lusaka provides ARVs through both the general clinic and the MTCT-Plus clinic, which receives PEPFAR funding. The program is relatively small, with 750 women participating as compared to approximately 1,000 women identified as HIV positive every month in Lusaka. About 70 percent of the women are tested in the antenatal clinic, and about half go on treatment. The program strongly encourages a home visit, which amounts to disclosure at home, and causes a considerable proportion of eligible women—some 60 percent—to opt out. According to Dr. Chibesa Wamalume, the medical director for the program: “It’s very stigmatizing, since they don’t want their husbands to know. The issue of disclosure is cardinal; they are scared they’ll be chased away if they’re found to be positive.”

The medical staff described the range of difficult and disturbing cases, where women were chased from their homes upon discloseing their status, suffered assaults, were cut off financially, and were blamed for bringing the virus to the household. The staff discussed their own limitations in being able to assist women who are eligible to participate in the program due to limited nonmedical staff, notably counselors, social workers, and outreach workers. As one doctor put it: “If we could put it in the PEPFAR budget, we’d hire someone.”

The staff described one case of a pregnant woman with a CD4 count of 91. She disclosed her HIV status to her husband, who proceeded to throw away her medications and warned her never to go back to the clinic. In another case, the woman’s husband asked the clinic workers if they had a program for women who will be divorcing, and then he said that the clinic should ask the women to first get permission from the men before being tested. One doctor explained the preponderance of social issues that are discussed during the weekly clinical staff meetings. “We don’t talk about clinical issues, but about social issues. We hear the stories of women chased from their homes, not drug problems. Why are they not taking their meds, and what am I supposed to do about that?” She continued: “We’re doctors. The next step—the socioeconomic part—someone else needs to do that. We can’t not treat people because we can’t find a job for them.”

Ida Mukuka, who had worked as a counselor at the PMTCT and MTCT-Plus programs at the Chelstone Clinic, explained that women went back home and faced serious problems: “They told their husbands that they had tested, and asked him to test. They were then beaten, physically abused—with swollen eyes and bruises—and then they withdrew from the program. When we did home visits, some of the neighbors would see us and tell the husbands. I saw a woman with a CD4 count of 8 in need of treatment, and she’d withdrawn because of physical abuse. It was painful for me to see someone treated like that.” She continued: “Women are scared to access treatment, so they give birth to infected babies, the child dies, the woman gets sick, and then she’s abandoned. I’ve been to their homes. The man tells her to pack or just leaves.”

The Chelstone staff described the supplementary food support that they give clients in the initial stages of ARV treatment. In some cases of discordant couples, the man has decided to come in because of the food support, although some stop

33 Interview at the Chelstone Clinic, Lusaka, February 25, 2005.
34 Interview with Elizabeth Stringer, chief of programs, Centre for Infectious Disease Research in Zambia (CIDRZ.), Lusaka, February 25, 2005.
37 Interview in Lusaka, February 27, 2005.
coming for treatment when the food stops. The World Food Program is going to provide food for adherence care packages, but the clients will have to agree to certain terms, such as multiple home visits. Overall, they believe that attaching benefits to care would assist in the long term, but they recognize the need for something more durable than food that would also lessen the burden of the dependency syndrome. High on this list would be greater links to income generating activities and the potential for microcredit loans. In addition, the lack of transport can present difficulties, especially when clients are too sick to get to the clinic. The lack of these linkages is seen by the staff to be a shortcoming of the program.

sexual contact, as well as more tightly focused programs to reach specific populations, such as 10- to 14-year-old girls versus married girls. This kind of targeting is necessary to design programs appropriate to specific risk factors, including those linked to social isolation and economic vulnerability, with aims such as reducing violence against women, promoting the enrollment and retention of girls in school and making schools safe, and protecting girls from child marriage. Given the rising infection rates among women, especially young women, the need to expand access to effective and targeted HIV prevention is a global imperative.

One of the challenges in prevention involves how to measure it, since it is difficult to design indicators that measure areas such as behavior change. These problems have been accentuated by the ideological gridlock and misconceptions that have plagued the prevention debates, especially surrounding the ABC approach. PEPFAR has the opportunity, and the obligation, to move beyond ABC into protection strategies that reach women and girls. Many involved in PEPFAR programs recognize that the ABC approach oversimplifies HIV-prevention messages, and that it reflects different moral standards for boys and girls. As one U.S. embassy officer put it: “When we’re talking about ABC, we’re talking about a perfect situation.” Put another way, Dr. Sam Thenya, the chief executive of Nairobi Women’s Hospital, noted: “ABC assumes an ideal lifestyle, but many women are exposed to violence and are at risk [of HIV]. Not more than 20 percent can really negotiate sex and are empowered.”

To be effective, prevention programs have to be designed with women and girls as targets. These can fall into two categories: direct or HIV-specific prevention programs, such as PMTCT, VCT, condoms; and indirect or structural programs, such as economic empowerment and education for girls. The latter

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38 PEPFAR puts property and inheritance rights and legal issues under the category of care, although they could equally be considered prevention interventions.
39 Bruce, “Social and Economic Protection Strategies.”
40 Interview in Nairobi, February 22, 2005.
41 Interview with Dr. Sam Thenya, chief executive, Nairobi Women’s Hospital, Nairobi, February 21, 2005.
category has huge implications for strategies, funding, and program design, and opens up new possibilities of entry points and providers.\textsuperscript{42}

The following are examples of structural programs that are targeting young women with prevention information and services:

- Liverpool VCT and Care (LVCT), a Kenyan nongovernmental organization (NGO), specializes in the scale up of HIV/AIDS services by establishing systems and quality-assurance mechanisms. It is also itself a service provider offering integrated services including VCT and care for HIV/AIDS, ARVs, treatment of opportunistic infections, and preventive medicine. In some of its centers, it also provides post-rape care, including forensic examination, sexually transmitted infection prevention, emergency contraception, post-exposure prophylaxis (PEP), counseling for trauma, HIV, and PEP adherence.\textsuperscript{43} It uses PEPFAR funds to improve infrastructure for integrating care, youth-friendly approaches, and follow-up services to counseling and testing. LVCT has been active in undertaking research regarding women’s access to services.\textsuperscript{44}

- In Kenya, the Nairobi Women’s Hospital Gender Violence Recovery Centre provides specialized medical and psychological treatment to survivors of domestic violence and sexual abuse. The center has served some 3,000 women with basic lab tests and medical examinations, PEP, medication, HIV tests, psychological care, and counseling. On average, they receive over 20 domestic violence cases per month and about 120 rape cases, with almost half of the rape cases involving girls under 15 years old. Other organizations, especially in Nairobi, frequently refer cases to the center, just as the center refers clients to a range of other NGOs for legal services, economic assistance, shelter, and police investigations. The center has received USAID funding to improve community responses to gender-based violence in the Western, Coast, and Rift Valley provinces and to create a friendly environment for rape management and PEP treatment at health facilities and police stations in those provinces.\textsuperscript{45}

- In Zambia, the Young Women’s Christian Association (YWCA) drop-in center and shelter provide important services for women and girls who have suffered abuse or are at risk. The youth drop-in center offers counseling, a transit center, and referral services, including referrals for PEP and ARVs. In some cases, they arrange food, shelter, school fees, legal assistance, and medical care. Providing safe shelter continues to present challenges, and the YWCA hopes to build a separate shelter for adolescent girls. They conduct HIV outreach to schools, with discussions including abstinence, economic

\textsuperscript{43} Interview at Liverpool VCT, Riruta, Kenya, February 22, 2005.
\textsuperscript{44} E-mail correspondence from Sarah Jones, Liverpool VCT, Nairobi, April 28, 2005.
\textsuperscript{45} Interview at Nairobi Women’s Hospital, February 21, 2005.
power relations, and sexual exploitation. They also sponsor programs on skills building, paralegal training, and police training.⁴⁶

- Kenya Girl Guides Association (KGGA) disseminates HIV/AIDS information to students and community members, using the Brownies, Girl Guides, Rangers, and Ranger Cadets between the ages of 6 and 25. KGGA provides HIV/AIDS education and information using peer-education activities focused on educational institutions, NGOs, religious bodies, the private sector, and local administrators. The peer educators have targeted 95 schools and have reached over 20,000 young people in five priority communities. KGGA receives PEPFAR funds.⁴⁷

- Corridors of Hope is a cross-border initiative that targets high-risk populations living in border towns and along high-transit corridors, including sex workers and their clients and truck drivers, and receives PEPFAR funds. The program works through 10 drop-in centers where services are provided, including outreach activities and prevention information, and through 15 trucking companies. The sites have integrated VCT, STI management, referrals for ART, and condom social marketing.⁴⁸

Education for girls must take a central place in the fight against HIV/AIDS, with respect to both access to primary and secondary schooling and providing HIV/AIDS information. The increased economic burdens on AIDS-affected households often force girls to provide for themselves and their families by engaging in relationships that might heighten their risk of HIV infection. Girls’ education is an important means of breaking these patterns of economic deprivation and dependence. According to a new report by UNICEF: “it is now clear that education, particularly for girls, has the potential to equip young people with the knowledge, attitudes and skills needed to reduce their risk.”⁴⁹ According to Dr. Ndugga Maggwa, the regional director for Family Health International: “If we focus only on the disease itself without looking at the surrounding issues, this may take a long time. We need to look at what is needed beyond treatment and care, to focus on ensuring access to education, keeping girls in school. When they finish primary school, that’s when the real risks kick in.”⁵⁰

As part of its prevention program focusing on ABC and behavior change, PEPFAR’s global strategy recognized the need to scale up skill-based HIV education and to train health care workers and teachers to identify, counsel, and refer young victims of sexual abuse for other health services. OGAC has made clear, notably in its January 2005 guidance on implementing the ABC approach, that PEPFAR funds may be used in schools to support programs that deliver age-appropriate information, although OGAC stipulates that young people ages 10 to 14 should receive “AB” information, while those over 14 may receive “ABC.”

⁴⁶ Interview at YWCA, Lusaka, February 26, 2005.
⁴⁷ Interview at Kenya Girl Guides, Nairobi, February 21, 2005.
⁴⁸ Interview at Corridors of Hope, Lusaka, February 25, 2005.
PEPFAR funds may also be used to support integrated ABC programs including condom provision for out-of-school youth at high risk.

- The Forum for African Women Educationalists (FAWE) is an NGO with national chapters in 33 African countries with the goal of increasing girls’ enrollment, retention, and progression at all levels of the education system. It works to create opportunities to increase girls’ access to school, including by: providing school fees; creating an enabling environment for girls in school; improving the retention of girls in education, including lobbying for bursaries; and increasing learning achievements of girls in school. FAWE receives PEPFAR funds.

- Umoyo (which means “life”) is a one-year school and training program for girls in Lusaka. Orphan girls are chosen by their communities to take part in the program, virtually all of them affected by HIV/AIDS and a few infected. More than 400 girls have participated in the program. After being given counseling, the girls enter an academic and vocational training program. More than 80 percent of the girls who graduate engage in further training, employment, or running small businesses. Girls who graduate often gain employment and become breadwinners, allowing them to provide food and school fees for their brothers and sisters. The Umoyo Training Centre demonstrates that girls who are empowered and able to start work and venture into businesses can take care of their families. They can also take their young brothers and sisters back to school.  

Care

Women and girls bear the greatest burden of care, with little or no support. Poverty and poor public services have also combined with AIDS to turn the care burden for women into a crisis with far-reaching social, health, and economic consequences. Girls are often pulled out of school to provide care for sick relatives or to take care of their siblings. Extensive programs are required for OVCs and need to be targeted to reach these girls, including psychosocial, education, prevention, health care, and income support. PEPFAR has a significant focus on OVCs, with over 100 programs in 27 countries that include education, microenterprise, psychosocial support, and property and inheritance rights. Nevertheless, specific programs focusing on girls are not necessarily included.

Some programs focused on care for women include:

- The Kenyan Network of Women Living with AIDS (KENWA), which was founded to improve the quality of life for women infected and affected by HIV/AIDS, as well as their children. The grassroots community organization is reaching some 470,000 people through a country-wide membership of some 2,500 women living with AIDS, and it cares for over 700 orphans. It serves as a forum to empower women to challenge stigma, discrimination, and isolation.

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51 Interview with Mwamba Mutali, Lusaka, February 28, 2005.
felt by women with HIV/AIDS; advocate for their rights and those of their children; support one another psychologically and materially; develop coping strategies; and offer care and support to women living with HIV/AIDS and their children. It also provides information about access to treatment.

- Women Fighting AIDS in Kenya (WOFAK), an AIDS support organization of some 3,000 women, supports caregivers conducting home-based care. The caregivers provide nursing care, nutritional support, counseling, and education for family members and communities. WOFAK is run largely by HIV-positive women.

- The University of Manitoba/Nairobi Strengthening STD/HIV Control Project, which works with commercial sex workers in the Kibera slum area of Nairobi. They have trained over 100 peer educators who provide home-based care, STD and HIV information and referral services, including for ARVs. The project works with the communities about safer sex and reducing stigma.53

Microfinance/economic empowerment gives women more power to avoid sexually risky or exploitative relationships. Research by the Population Council has shown the importance of providing a variety of financial products and services that allow girls at risk to protect themselves and build an economic base. This underscores the need for programs that attract younger and more vulnerable girls by establishing savings groups as safe spaces and bases for financial and legal literacy and that are designed with age and gender-specific financial literacy and business training approaches.54

Some examples of these kinds of interventions include:

- K-Rep in Kenya, which has been providing credit to people infected and affected by HIV/AIDS since 2000, with about 70 percent of its clients being women. It aims to provide microfinance to mitigate the economic consequences of HIV/AIDS by providing credit and business training to those infected and affected. It also has a program for adolescent girls.55

- Tap and Reposition Youth (TRY) Savings and Credit project, a partnership between K-Rep Development Agency and the Population Council. The project aims to improve the social and economic well-being of adolescent boys and girls participating, especially out-of-school adolescents aged 16 to 24 living in low income and slum areas of Nairobi. The program provides training in business management and life skills, promoting savings, credit to start

53 Interview February 23, 2005.
54 Bruce, “Social and Economic Protection Strategies.” This includes establishing girls’ spaces/savings clubs to facilitate girls’ ability to establish safe and independent control over savings and savings accounts and learning basic financial literacy skills, such as principles of money management and building and safeguarding assets.

- FINCA Village banking, which has programs in several countries including Zambia, seeks to empower women economically, while also providing the opportunity to disseminate health education. FINCA Uganda has worked with 35,000 women and estimates that 80 percent of its clients are caring for children orphaned by HIV/AIDS. These microenterprise interventions could develop important partnerships with health institutions to provide more comprehensive care to AIDS-affected communities.

Despite laws ensuring that women have equal property and inheritance rights, in many acutely affected countries they are denied this right. Many young widows—ranging in age from 16 to 56—find themselves disinherited, homeless, and HIV positive. They often suffer restricted economic options, reduced personal security, poverty, violence, and homelessness, contributing to both their and their children’s impoverishment. This can also lead to risky decisions that make women and girls vulnerable to HIV infection. In addition, they often have no right to sell property to get money for treatment. Angeline Siparo of the Policy Project in Kenya noted: “They can’t dispose of family property—it’s a tough block.”\footnote{Interview with Angeline Siparo, Nairobi, February 21, 2005.}

Some examples of programs focusing on this include:

- Women in Law in Southern Africa (WLSA), which is a regional organization with groups in seven southern African countries addressing the legal situation of women through social and legal action. WLSA works on issues such as property and inheritance rights, maintenance, gender-based violence, and justice delivery systems. WLSA also has a specific project on gender, HIV, and the law, which aims in part to address the lack of a legal framework.\footnote{Interview with Matrine Chuulu, acting regional coordinator, Women and Law in Southern Africa, Lusaka, February 24, 2005.}

- The Federation of Women Lawyers (FIDA), Kenya section, focuses on family law issues, including divorce, matrimony, property and inheritance, custody and wrongful dismissal, as well as rape, incest, and sexual assault. They have also been active in analyzing pending legislation from a gender perspective, including the proposed HIV/AIDS bill. FIDA also provides training to police and judges on women and the law.\footnote{Interview with Jane Onyango, executive director, Federation of Women Lawyers-Kenya, Nairobi, February 21, 2005.}

- Justice for Widows and Orphans in Zambia focuses on providing legal education to women and orphans at the community level, especially involving
property and inheritance rights. The project holds workshops with traditional leaders and communities and works with local NGOs and the police.\textsuperscript{60}

**Constraints**

PEPFAR holds tremendous promise and is beginning to show some results; nevertheless, the program is operating under some distinct constraints. Some of the constraints are self-imposed by the PEPFAR in-country teams, who are reading the political and ideological winds in Washington, D.C., and steer clear of programs that might be considered politically sensitive, including interventions that take a more holistic approach to addressing HIV among women and girls. Conflicting guidance, or the absence of definitive guidance on funding for gender-focused interventions, has created a reluctance among program managers to pursue opportunities that may in fact be critical to achievement of 2-7-10 goals.

Evidence that PEPFAR may be missing critical opportunities to advance its successes by not focusing on the unique situation of women and girls is reflected in the remarks of Monique Wanjala, regional administrator for ICW/WOFAK (International Community of Women Living with HIV/AIDS/Women Fighting AIDS in Kenya): “When we say ‘youth,’ then the girls disappear.” She continued: “We have to wait for them to come to us; we can’t proactively get to them.”\textsuperscript{61}

**Narrow Program Models**

Although some efforts are being made to address HIV/AIDS in women and girls, this is clearly a significant gap in the overall PEPFAR program. The limited program models upon which PEPFAR is predicated fall short of addressing the multitude of factors that determine the spread of the epidemic and its impacts. This limited program vision is especially dangerous for women and girls. “We can’t just use a medical model for a generalized epidemic that’s affecting every aspect of life,” said one embassy official. “OGAC was alarmed at the multisectoral response in Zambia, so we have to describe what we do differently, using leverages, linking, additive.”\textsuperscript{62}

The perception that PEPFAR operates with very narrow definitions of what constitutes care, prevention, and treatment poses a serious constraint, since it has engendered considerable uncertainty and concern on the part of embassy staff about what they can and cannot do relating to women and girls, especially regarding interventions outside the health sector (e.g., education, legal assistance, income generation, etc.) One U.S. embassy official acknowledged that it limits


\textsuperscript{61} Interview with Monique Wanjala, regional administrator for ICW/WOFAK (Women Fighting AIDS in Kenya), Nairobi, February 21, 2005.

\textsuperscript{62} Interview with U.S. embassy staff, Lusaka, February 23, 2005.
PEPFAR’s effectiveness: “Unless gender is integrated into the PEPFAR policies, it’s nonsensical. Groups are not being targeted who are most at risk.”

There are extensive opportunities within U.S. government programs for enhanced multisectoral coordination, as well as for PEPFAR funding for explicit AIDS interventions that go beyond the health sector. These areas reach into the traditional development agenda, including basic education, democracy and governance, microenterprise, child survival and maternal health, family planning and reproductive health, food assistance, and anti-trafficking. Unfortunately, these program areas have been flat funded in recent years. An embassy official in Nairobi noted: “The [HIV] interventions won’t succeed if other, critical interventions aren’t funded.”

**Emphasis on Abstinence Only**

Many observers expressed concern that the thrust of PEPFAR’s prevention programs for women focus on abstinence only, despite the reality that women all too often do not have the option to practice abstinence. While some considered it to be an example of the U.S. imposing a certain moral agenda, others criticized it on the grounds that it was simply an ineffective strategy.

Stella Goings of UNICEF in Zambia described how the compelling needs for prevention are being largely subsumed under the abstinence agenda. “We need less moral correctness and more public health; otherwise, we’ll miss the targets.” She continued: “We need a more concerted effort to bring in a more realistic public health approach, to work more effectively with local organizations, and bring clear strategies and approaches that would be more effective. We need to foster a dialogue that puts PEPFAR in more of a listening mode, since HIV is a complex problem in a complex society.” Other NGO representatives suggested that abstinence programs should be reinvented as “a continuum of choice.”

Young women ages 15 to 24 are the most highly infected, yet few programs target them with the skills, information, and ultimately options they need to make safe choices. As Angeline Siparo of the Policy Project in Kenya put it: “What happens to people who need to make choices? These are the contradictions of PEPFAR.” She continued: “If we’re talking abstinence, abstinence, abstinence, and people are already having sex at 16, what are we talking about?”

The problems with focusing on abstinence only were summarized by a recent briefing by the American Foundation for AIDS Research (amFAR): “[T]he scientific evidence does not support the U.S government’s current policy of making abstinence-only-until-marriage programs the cornerstone of its HIV-prevention strategy for young people. Nor does it support the rapid scale-up of resources to promote abstinence-only-until-marriage programs in the U.S. and

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63 Interview in Lusaka, February 26, 2005.
64 Interview in Nairobi, February 22, 2005.
66 Interview in Nairobi, February 20, 2005.
67 Interview in Nairobi, February 21, 2005.
globally. Rather, the scientific evidence to date suggests that investing in comprehensive sex education that includes support for abstinence but also provides risk-reduction information would be a more effective HIV-prevention strategy for young people.  

There is growing bipartisan recognition of the limitations of the ABC approaches for women and girls. In hearings on April 13, 2005, Representative Henry Hyde, the Republican chairman of the House International Relations Committee, stated: “The protection from AIDS infection associated with the ‘ABC approach’ evaporates in environments of sexual violence or coercion.” He continued: “We must expand programs to correct or prevent violent and coercive behaviors by men, include men as an essential part of the solution, and assist women and children who are or may become victims. Law enforcement and judicial systems must also be bolstered to prevent and respond to these circumstances.”

The ideological battles pitting abstinence against condoms exerts a chilling effect on discussing condoms for individuals other than those considered to be most at risk. As a result, even programs targeting such high-risk groups as truck drivers and sex workers are sometimes reluctant to mention condoms to international visitors. In describing their work, one such program went as far as to say that they offered condoms “as a last resort,” which attests to the extent of these fears.

Weak Linkages with Reproductive Health and Family Planning Programs

Despite rhetoric calling for strong linkages between HIV/AIDS programs and existing health services and systems, there is little connection being made with a key entry point for nonpregnant women and adolescent girls—reproductive health and family planning services. Just as PMTCT services are being better integrated with maternal and child health services, so too should HIV services be linked with reproductive health services.

One of the early casualties of PEPFAR was support for reproductive health and family planning. In Zambia, for example, one embassy official described a “firewall” between HIV and reproductive health, making it difficult to make the important synergies between the two. This is linked more broadly to the importance of increasing support to national STI and family planning programs, which are important entry points to reach women and girls with HIV/AIDS information and services. Too often, districts are not doing enough to get HIV

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70 Interview in Lusaka, February 25, 2005.
71 Interview in Lusaka, February 24, 2005.
messages into family planning clinics, and often these clinics don’t offer VCT. The more common scenario tends to be that one is referred from VCT to family planning, not the other way around.

The Alan Guttmacher Institute, in collaboration with UNAIDS, United Nations Population Fund, and International Planned Parenthood Association, produced a recent report on the important role of reproductive health care providers in HIV prevention: “Many women come into contact with the health care system seeking reproductive health services, either within clinical settings or through community-based distribution programs, and these points of contact are opportunities to reach women with HIV prevention information and services.” The report goes on to emphasize that reproductive health care providers often have the skills in counseling and testing, as well as education and STI management, that are essential for HIV-prevention information.

Recommendations

The United States has an unprecedented opportunity to ensure that PEPFAR’s treatment, care, and prevention programs include targeted programs to reach women and girls. At this critical juncture, PEPFAR should build on the bipartisan recognition that women and girls are especially vulnerable in the AIDS epidemic, address key gender issues in technical areas, and implement proactive strategies to respond.

- In preparing the COPs for 2006, OGAC should issue guidance to the field and implementing partners that it expects to see programs targeting women and girls under each program element and that these should include explicit issues and responses to gender considerations. This guidance should embrace a broader definition of what constitutes HIV/AIDS services outside the health sector and beyond abstinence only. The guidance should make clear that PEPFAR programs should respond to the sociocultural, institutional, and political barriers that women face.

- OGAC should issue guidance to the field regarding expectations for strengthening linkages and funding possibilities between PEPFAR and the broader set of U.S. programs working on women’s social and economic empowerment. These include basic education, democracy and governance, child survival and maternal health, family planning and reproductive health, microenterprise development, and development assistance programs.

- To establish a baseline about what PEPFAR is actually funding, OGAC should document the programs targeting women and girls in each country under each goal. By compiling these data on what is currently being funded, it will be easier to monitor the progress of the gender strategies and identify additional linkages with broader U.S. government programs.

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- PEPFAR programs should include benchmarks and indicators to monitor the access of women and girls, with the aim of reaching gender targets. The purpose is to measure progress and correct inequities in treatment, care, and prevention programs. Useful indicators could include:
  - links and referrals between HIV/AIDS services and gender-based violence services, including access to justice related to gender-based violence;
  - access to post-exposure prophylaxis for survivors of rape;
  - minimum standards on property and inheritance laws;
  - access for girls in primary and secondary schools to accurate information and support services on HIV/AIDS;
  - access for out-of-school girls, including married girls, to HIV/AIDS information and services;
  - integration of HIV/AIDS information and services with reproductive health and family planning;
  - income-generating activities and skills training for HIV-positive women and women from severely affected communities, including savings groups as safe spaces for financial literacy and business training approaches.

- OGAC should establish a PEPFAR technical working group on gender. This group should comprise technical experts on women, girls and HIV/AIDS from U.S. government partner agencies and function as part of the broader array of technical working groups that have been established in the past year. This technical working group on gender should develop program guidance, review COPs, assist in indicator development, and provide technical resources and assistance to field programs.

- Each PEPFAR focus country should be encouraged to establish a gender advisory group. The advisory groups would provide input and guidance for the development and implementation of PEPFAR plans, including treatment, care, and prevention programs. Their expertise can ensure that PEPFAR programs recognize and address the country-specific effects of the epidemic and disease on women and girls. The groups should include representatives from civil society, including women’s groups, networks of women living with AIDS, service providers, and other organizations with gender expertise. In addition, a gender adviser should be assigned to each PEPFAR program to enhance and accelerate its focus on women and girls.

- Violence against women, including sexual violence, continues to be a major factor in driving the HIV/AIDS epidemic in many PEPFAR countries. Development of PEPFAR guidance and program strategies for addressing gender-based violence should be a priority task for the gender technical working group. This guidance should include strategies to improve the prosecution of rape and to provide post-exposure prophylaxis for rape victims, and to strengthen support services for survivors of rape and sexual violence.
- PEPFAR should ensure that programs address the policy and legal factors that increase the vulnerability of women and girls to HIV infection, including: training of law enforcement and judicial personnel to recognize and act upon crimes of gender-based violence; training of paralegals in the area of property and inheritance rights; improving legislation and common law practices in property and inheritance law; improving access to education for girls linked to HIV prevention, care, and treatment; and increasing economic empowerment for women and girls to contribute to HIV prevention, care, and treatment.

- In addition to incorporating these issues into current and future procurements, PEPFAR should create a new request for proposals to ensure that these targets are adequately covered in U.S.-funded HIV/AIDS programs.

- PEPFAR teams in each country should proactively reach out to civil society groups, including those working in non-HIV/AIDS areas and with commercial sex workers, to support the development of strategies and programs to address women and girls, and to ensure that they have the appropriate information about how their programs might qualify for PEPFAR funding.

- PEPFAR should engage with the international and indigenous faith-based organizations to develop strategies and programs to address the structural issues that put women and girls at risk for HIV infection. This would provide an opportunity to build on their abstinence and be faithful programs by enlarging their prevention strategies.

- PEPFAR should ensure that its programs on women and girls complement and enhance the national HIV/AIDS plans, as well as those of other bilateral and multilateral donors, including UNAIDS and the Global Fund for HIV/AIDS, TB, and Malaria. To heighten engagement on the issue of women and girls, PEPFAR should increase coordination with its national and international partners and work toward an agreement on common approaches and principles on addressing women and girls in the context of HIV/AIDS. PEPFAR should participate in a high-level, public announcement on these principles and approaches with national and international partners, possibly linked to the XVI International AIDS Conference in Toronto.