INTEGRATING PEPFAR GENDER STRATEGIES INTO HIV PROGRAMS FOR MOST-AT-RISK POPULATIONS

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ACRONYMS

ASPIDH	Solidarity Association to Promote Human Development
GBV	gender-based violence
MARP	most-at-risk population
MSM	men who have sex with men
NGO	nongovernmental organization
PEPFAR	U.S. President's Emergency Plan for AIDS Relief
PRASIT	Project for HIV/AIDS Strategic Technical Assistance
PWID	people who inject drugs
SANGRAM	*Sampada Grameen Mahila Sanstha* (Rural Women's Organization)
SIDC	*Soins Infirmiers et Développement Communautaire*
STEP	Striving for Transformation through Empowered People
STI	sexually transmitted infection
TG	transgender
UNAIDS	Joint U.N. Programme on HIV/AIDS
USG	U.S. Government

INTRODUCTION

Gender inequity[1] is a fundamental driver of risk for and vulnerability to HIV infection in all populations (de Bruyn et al. 1995). For most-at-risk populations (MARPs)—female and male sex workers, people who inject drugs (PWID), transgender (TG) people, and men who have sex with men (MSM; Joint U.N. Programme on HIV/AIDS [UNAIDS] 2007)—who are at higher risk of acquiring HIV, gender inequality and gender discrimination also prevent access to HIV prevention, care, and treatment. The number of HIV programs that address gender inequality and seek to change harmful gender norms is growing in countries with generalized epidemics in Africa. This is not the case in countries with concentrated epidemics, where HIV primarily affects MARPs.[2]

In concentrated epidemics, HIV prevalence is consistently over 5 percent in at least one defined MARP, but below 1 percent in pregnant women in urban areas (UNAIDS 2008a). MARPs are often driven underground by discrimination, which is often gender-based, and by HIV-related stigma: a double blow. In all countries with concentrated epidemics, behaviors that make MARPs more vulnerable to HIV are highly stigmatized, illegal, or both, impeding access to HIV prevention, treatment, care, and support.

The 2008 *UNAIDS Report on the Global AIDS Epidemic* found that most prevention programs in concentrated epidemics fail to reach those at highest risk of HIV exposure (UNAIDS 2008b). Although some remarkable results have been achieved following the scale-up of HIV programming in countries such as Thailand, Cambodia, and Brazil, the level of prevention, care, and treatment coverage among MARPs "remains dismally low" (Rerks-Ngarm et al. 2010, 438). According to the UNAIDS report, 69 percent of countries with concentrated epidemics report having laws, regulations, or policies that create barriers to use of HIV services by MARPs, or services are not sensitive to and appropriate for the health and gender-specific needs of individual MARPs. Many programs work with female sex workers but do not address male norms that drive the demand for sex work, and there is much lower coverage of male sex workers and TG sex workers. Widespread stigma and discrimination for transgressing male and female gender norms sustain gender-based violence (GBV), denial of legal protections, loss of property, and barriers to employment and educational opportunities, which are experienced by many MARPs (UNAIDS 2008b). An expanded response that changes gender norms, lessens stigma, and increases commitment to address deep-seated gender disparities can replace this dynamic with risk and vulnerability reduction and impact mitigation (UNAIDS 2001).

The U.S. President's Emergency Plan for AIDS Relief (PEPFAR)'s Five-Year Strategy 2009–2013 calls for expanded prevention, care, and treatment in both concentrated and generalized epidemics, as well as for encouraging partner country governments to address structural issues, such as GBV, stigma and discrimination, and low male partner involvement. The PEPFAR strategy supports

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[1] *Gender* refers to the socially constructed roles, responsibilities, and relationships ascribed to people with particular sexual identities. *Gender inequity* refers to disparities in power and decision-making authority; access to resources, including education and economic opportunities; resource allocation; and any other treatment, based on gender. Equal opportunities for persons with all sexual identities should be ensured and, if necessary, differential treatment and attention should be provided to guarantee equality of results and outcomes and to redress historical and social disadvantages experienced by women or men. See www.unfpa.org/gender/index.htm.

[2] Where HIV has spread rapidly among specific groups but is not well established in the general population.

increasing access to high-quality, low-cost prevention, care, and treatment services for "marginalized communities including injecting drug users, persons in prostitution, and men who have sex with men" (Office of the U.S. Global AIDS Coordinator 2009, 16).

In an effort to mainstream gender-sensitive approaches into all HIV prevention, care, and treatment programs it supports, PEPFAR has identified five key strategies for addressing the unique needs of women and girls. These strategies are 1) increasing gender equity in HIV programs and services, including reproductive health; 2) reducing violence and coercion; 3) addressing male norms and behaviors; 4) increasing women's legal protection; and 5) increasing women's access to income and productive resources, including education.

There is growing awareness that addressing gender inequity requires employing more than one gender strategy as well as using a "gender synchronization" approach, whereby programs targeting women and girls or targeting men and boys work together in "an intentional and mutually reinforcing way that challenges gender norms, catalyzes the achievement of gender equality, and improves health" (Greene and Levack 2010, iv). Where this kind of collaboration occurs, the effectiveness of HIV programs is greatly enhanced (Coates, Richter, and Caceres 2008; Gupta et al. 2008). For example, programs that address GBV against women are likely to be more successful if they also attempt to transform harmful male norms and behaviors. Scientific evidence of the efficacy of using multiple gender strategies in a coordinated programming approach is emerging (Jewkes et al. 2006; Pronyk et al. 2008).

In 2009, at the request of the Gender Technical Working Group, AIDSTAR-One compiled a compendium of case studies on HIV programs in sub-Saharan Africa that integrate multiple PEPFAR gender strategies, with a focus on women and girls. The compendium aimed to provide U.S. Government (USG) staff and field program implementers with promising practices to design and implement HIV programs that reduce women's and girls' gender-based vulnerability to HIV infection. That compendium, *Integrating Multiple Gender Strategies into HIV and AIDS Interventions: a Compendium of Programs in Africa* (AIDSTAR-One 2009), includes detailed descriptions of 31 programs, each of which integrates at least two PEPFAR gender strategies.[3]

In 2009, AIDSTAR-One developed a technical brief, *Integrating Gender into Programs with Most-at-Risk Populations*, to explore the research and program literature on the extent to which HIV programs are addressing the unique gender-related needs of MARPs in concentrated epidemics (Spratt 2010). While there is emerging literature on the gender-related needs of MARPs, how programs are addressing these needs or integrating gender strategies into their activities is not well documented or disseminated. AIDSTAR-One developed nine case studies that expand on the technical brief, providing an in-depth look at HIV programs working with and for MARPs in South and Southeast Asia, Eastern Europe, Latin America, and the Middle East.

The specific objectives of these case studies are to:

- Identify programs in countries with concentrated epidemics that address one or more of the five PEPFAR gender strategies as they intersect with HIV prevention, care, and treatment programs for MARPs.
- Describe and analyze these programs to build a knowledge base for innovative strategies for integrating the PEPFAR gender strategies into MARPs programs.

[3] Case studies for five of the programs in the compendium are currently being produced to provide further detail about the programs. They will be available at www.aidstar-one.com/gender.

- Draft evidence-based recommendations for program managers on how to develop, implement, and evaluate the effect of PEPFAR gender strategies in MARPs programs. This report includes findings and recommendations that apply across all nine case studies.

METHODOLOGY

Planning for the case studies began in December 2009, and field work occurred between June and October 2010. Methods included a data collection phase, an assessment phase, and a compilation phase.

DATA COLLECTION

To identify programs to review for developing a case study, the AIDSTAR-One team established minimum criteria to guide the identification of potential programs. These included the following:

- The program must work with MARPs in countries with concentrated epidemics.[4]
- The program must address HIV (prevention, care, treatment, mitigation, or other type of HIV programming) as one of its program components.
- The program must use at least one of the PEPFAR gender strategies.
- The program could be funded by the USG or by other donors.

The team conducted a systematic search for eligible programs using an Internet-based search engine and online databases, including PubMed, POPLINE, Plusnews, Google, and Google Scholar. Web searches looked for programs in published reports, evaluations, peer-reviewed and grey literature, and organizational websites, using over 20 keywords in multiple combinations within and across target countries, including *equity*, *violence*, *coercion*, *property*, *rights*, *programs*, *HIV*, *women*, *female*, *male*, *men*, *male sex workers*, *female sex workers*, *transgender sex workers*, *queer*, *homosexual*, *transsexual*, *services*, *outreach*, *prevention*, *advocacy*, *community-based*, *drop in centers*, *support groups*, *income generation*, *alternative income*, *gender*, *concentrated epidemics*, *most-at-risk populations*, *gender equity*, *gender norms*, *male behaviors*, *legal protection*, *empowerment*, *access to income*, *transgender people, sex workers*, *injection drug users*, *men who have sex with men*, *stigma and discrimination*, *gender-sensitive*, *gender-based violence,* and many others.

Literature searches found few programs that described integrating gender strategies into their work with MARPs. The next approach was to directly contact organizations working for MARPs as well as gender experts by phone, by email, or through their websites to seek nominations for programs they knew about that integrate gender into their work.

A flier to elicit program nominations (see Appendix 1) was sent via email (in English, Spanish, Russian, and Arabic) by AIDSTAR-One to bilateral, multilateral, and

The five PEPFAR Gender Strategies, modified for work with MARPs are:

- Increasing gender equity and access to HIV programs and services
- Reducing violence and coercion
- Addressing harmful gender norms and behaviors
- Increasing legal rights and protection
- Increasing access to income and productive resources.

[4] A deliberate decision was made not to look for programs in mixed epidemics.

other international organizations; distributed by the PEPFAR Gender Technical Working Group to USG missions; and posted on the AIDSTAR-One website. Because many organizations addressing gender norms may not be familiar with the PEPFAR gender strategies, examples of activities for each gender strategy were provided.

SELECTING PROGRAMS

Each nominated program was contacted to assess if the program met the selection criteria. Potential programs were sent a standard survey tool to gather details about how the PEPFAR gender strategies were integrated (see Appendix 2).

Table 1 displays the number of organizations that were contacted (a total of 248), that received the survey (a total of 102), and that returned the survey (a total of 35), as well as the number of case studies done in each region.

Table 1. Response Rate of Nominated Programs

Region	Number of organizations contacted	Number of organizations that received the survey	Number of surveys returned or completed by phone (%)	Number of programs that scored high enough for inclusion (%)	Number of case studies completed
Eastern Europe and Middle East	23	9	5 (56)	3 (60)	2
Latin America	184	79	24 (30)	5 (21)	3
Asia	41	14	6 (43)	5 (83)	4
TOTAL	**248**	**102**	**35 (34)**	**13 (37)**	**9**

Limitations of the data collection process included possible under-representation of very small or localized programs that, due to their limited visibility, may have been missed by the sampling method and Internet search. Furthermore, some programs' limited resources or staff time may have impeded their capacity to respond to the survey. Strategies to minimize these limitations included extensive follow-up by email and telephone and the offer to conduct the survey interview by phone.

It is important to note that these case studies are not an exhaustive list of all gender and HIV programs in operation at the time of the survey. Instead, it seeks to provide a sample of programs using innovative approaches and to identify common challenges among MARP programs integrating the PEPFAR gender strategies.

ASSESSMENT

An evaluation tool that was developed by the AIDSTAR-One Gender Team for the compendium of programs in Africa was adapted for the MARPs survey. The tool offered an objective measure by which to determine which programs could be considered as a case study. Survey responses were assessed on five criteria (see Appendix 3):

1. Comprehensiveness of approach in addressing PEPFAR gender strategies
2. Evaluation rigor

3. Extent to which gender indicators were included as program outcomes
4. Sustainability
5. Feasibility for replication and/or scale-up.

Two members of the Gender Team independently assessed each returned survey to measure reliability between raters and increase objectivity. The members resolved discrepancies in the ratings and reached agreement on the final score (see Appendix 4). Of the 35 programs scored, 22 were excluded from consideration because they did not meet the minimum criteria for inclusion.

The team contacted directors of the programs that met the minimum criteria for inclusion as a case study to explore their interest in participating and to provide more information about the case study process. The Gender Technical Working Group contacted USG missions in countries where organizations had agreed to participate to ask for permission to conduct the case study. Where permission was not forthcoming, a program in another country was selected. Once USG concurrence arrived, dates were finalized with the programs, and the case study was conducted. The site visits were conducted over a period of three to five days to allow interviews with a variety of stakeholders and to observe relevant program activities. The case studies were conducted by one AIDSTAR-One staff and a local consultant, or by a local consultant only.

The AIDSTAR-One team developed standardized site visit protocols, focus group discussions, and in-depth interview guides to use across all case study sites for consistency of content and data collection methods. The case study process consisted of on-site review of documents, interviews, focus group discussions with project staff and participants, and direct observation of program activities, when appropriate. Content of the guides included questions to collect the following information:

- History of the program and factors influencing the integration of PEPFAR gender strategies into program approaches
- Description of target population, program/service usage, outreach, referrals, quality assurance, and training activities
- Strengths of the program/service approach
- Challenges faced in integrating gender into programs/services
- Key strategies and approaches employed to integrate PEPFAR gender strategies
- Innovations incorporated into the programs/services as they matured
- Opportunities to expand the integration of gender into their programs
- How the impact of integrating gender into the program/services is being monitored and evaluated
- Program outcomes as a result of integrating gender into its programs/services
- The need for technical assistance to strengthen the organization's capacity to integrate gender into MARPs programs
- The effect integrating PEPFAR gender strategies has had on program beneficiaries

- Lessons learned that other organizations should consider before integrating one or more PEPFAR gender strategies into their program/services.

Table 2 shows the locations and names of programs for which case studies were conducted from June to October 2010.

Table 2. Programs Chosen for AIDSTAR-One Case Studies on Integrating PEPFAR Gender Strategies into HIV Interventions for MARPs

Region	Program and location	MARPs addressed
Central and South America	Lesbian, Gay, Bisexual, and Transgender Community Center, Colombia	MSM
	Sex Work, HIV, and Human Rights Program, Peru	Sex workers
	Solidarity Association to Promote Human Development (ASPIDH), El Salvador	TG people
Middle East	SIDC *(Soins Infirmiers et Développement Communautaire),* Lebanon	MSM, TG people, sex workers
Eastern Europe	Follow the Voice of Life, Russia	MSM
South and Southeast Asia	Project for HIV/AIDS Strategic Technical Assistance (PRASIT), Cambodia	MSM, TG people, sex workers
	STIGMA Foundation, Indonesia	PWID
	Striving for Transformation through Empowered People (STEP) Program, Vietnam	PWID, sex workers
	SANGRAM (*Sampada Grameen Mahila Sanstha*; Rural Women's Organization), India	Sex workers, TG people, MSM

FINDINGS

The nine case studies were conducted across three continents, yet programs share common successes and challenges in integrating gender-sensitive strategies into their work. The programs arose, for the most part, from efforts started by small groups of MSM, TG people, PWID, or sex worker activists determined to defend the rights of men and women who challenge social and gender norms and to demand dignity and tolerance for marginalized populations.

Among the significant findings is that HIV is an important issue among MARPs, but given the myriad survival issues they face, it is not always the most important issue. Violence, poverty, stigma, and discrimination are pervasive in their lives. Even though the programs profiled are implemented across a range of political, economic, and cultural systems, they have one thing in common: the social and cultural environments within which these programs are implemented are hostile to the people these programs serve.

To some extent, these programs are pioneers in the area of gender integration and have much to share with other organizations working with MARPs. They may also inspire programs working in generalized epidemics in Africa, where there is growing evidence of increased HIV prevalence among MARPs (Smith et al. 2009; van Griensven et al. 2009).

The following sections summarize the common issues that influence how these programs evolve and how PEPFAR gender strategies contribute to the work they carry out on behalf of their communities. The findings also reveal a common issue between programs for MARPs and HIV programs for general populations. Programs still struggle to get funding and technical assistance to integrate gender and other structural barriers to do more than provide basic services.

Violence against MARPs is endemic.

In most of the nine case studies, governments, faith-based groups, and civil society are doing very little to address violence against MARPs. High-level advocacy and leadership within governments on behalf of MARPs is absent in Russia and weak in the Asian countries where case studies were done.

> *Violence against gays is said to be common and under the guise of "social cleansing." Many gays have been murdered by paramilitary groups and death squads.*
>
> –Bogota, Columbia
>
> *When we are arrested, women drug users are sexually harassed and violated; the men are tortured.*
>
> –Jakarta, Indonesia

But in other regions, there are encouraging trends. In Colombia, Peru, and Lebanon, the government attitude, while not yet fully supportive of MARPs, may be described as tolerant. In El Salvador, the president recently led a series of policy initiatives to outlaw discrimination against TG people in public sector organizations, a noteworthy exception to pervasive discrimination against this group in many countries. A fundamental success of all the programs is developing advocacy strategies with local governments and communities that challenge the violence, stigma, and discrimination experienced by MARPs and that attempt to hold governments accountable for ensuring the rights and services that policy documents promise. Most of the programs developed their advocacy strategies with limited or no technical assistance.

This advocacy is fundamental to MARP programs; persecution of MARPs is widely tolerated because these groups do not embrace the sexual and social lifestyle perceived as "normal" for women and men. All programs described in the case studies reported violence and abuse against their staff and beneficiaries committed by the police, general society, and within families. Individuals who behave in a way that transgress conventional codes of conduct are seen by many as deliberately giving up claims to human rights. This perspective leads to unequal treatment within communities and by social institutions. According to Deidre Stewart (2008, 7):

> There is a popular belief that the rape of a prostitute is less traumatic than that of a woman outside the trade…thus a rapist targeting sex workers can feel himself justified, even righteous, when referencing his actions as the logical endpoint of legislation and policy that deems sex workers [and other at-risk populations] aberrant and inhuman.

People who live within "uncategorizable" gender roles are a danger to the social order, which is defended through physical, psychological, and sexual violence and is slow to expand to accommodate "the diversity of what it is to be human and gendered" (Stewart 2008, 7–8, quoting Butler).

People most at risk for HIV face a hierarchy of survival needs that must be met before HIV programs can be more widely accessed.

Homelessness, poor housing, unemployment, police brutality and coercion, poverty, gender inequality, low educational attainment, and stigma and discrimination are forms of structural violence that many MARPs experience frequently and that increase vulnerability to HIV. Yet many programs targeting MARPs do not focus on the context that drives vulnerability and risk behaviors, but rather on the risk behaviors themselves: drug injection, unprotected sex, multiple and concurrent sex partners, and so on.

What these MARP programs could do to address these larger structural issues is constrained by vertical funding streams and inadequate funding overall. Programs for MARPs that focus on condom distribution, peer education, and mandatory screening for sexually transmitted infections (STIs) are likely to have a limited impact if they do not also include community development approaches that address structural issues (Greenall and Rasoanaivo 2008). As the SANGRAM program in Maharashtra, India, has demonstrated persuasively for more than a decade, empowering MARPs to meet their basic survival needs creates the space for people to make long-term plans and to act collectively to protect themselves against HIV, other STIs, and GBV.

Most organizations working with MARPs see the challenges they face in terms of rights, not gender.

Understandably, the first issue for many nongovernmental organizations (NGOs) is protecting the right of their community to be free from violence and persecution. MARPs are persecuted because they engage in behaviors that are considered immoral or illegal. But few NGOs are able to locate that persecution within a larger analysis of gender and gender norms; they have not explored the fact that gender inequality is the reason why those behaviors are considered immoral or illegal. Staff at NGOs working with MARPs do not necessarily see through the "tyranny of heterosexuality" to question or reject gender norms. Most programs have not analyzed how the rights of MSM, TG people, PWID, and sex workers are intimately linked to equality and equity for women. In some cases, these populations and women's organizations are not collaborating well together because they are competing for the same, very small pot of funding for "social issues." When asked about gender

integration, many organizations define gender as a "women's issue," not a fundamental driver underlying the persecution of sexual minorities per se.

Addressing gender norms is a new idea for nearly all of the NGOs.

During the initial search for programs to be profiled, it was difficult to identify MARPs-focused programs integrating gender into their programming strategies. Many organizations that were contacted indicated they were "integrating gender" because they were disaggregating data by gender identify or were focusing on MSM or TG people. With the exception of PRASIT in Cambodia and STEP in Vietnam, none of the programs were overtly addressing gender norms. Staff at two of the four programs in Asia responded, "We don't 'do' gender. It's too complicated…[and] too theoretical." A similar response was, "Gender…is about women—we are focused on men." However, when asked directly to describe what they were doing to address equity in access to services, reduce GBV, change harmful gender behaviors, increase access to economic opportunity, or strengthen legal protections, program staff could respond easily. Programs that integrate gender strategies into their work are in the very early stages and thus have no data to identify promising practices, and none had funding for process evaluation to understand how gender norms may be changing as a result of their program.

Most programs have precarious funding.

In all of the countries where case studies were conducted, HIV prevalence among MARPs equals or exceeds HIV prevalence found in countries with generalized epidemics. Yet funding, for the most part, follows the number of people affected, not prevalence; MARPs are a minority of the overall population in any country, and countries in which the HIV epidemic is concentrated among MARPs continue to have underfunded programming for MARPs.

Many of the programs highlighted work on shoestring budgets with dedicated volunteers. The smallest programs, like the STIGMA Foundation in Jakarta and ASPIDH in El Salvador, are led by peers who have developed their programs with little technical assistance and limited organizational capacity. These programs received limited, if any, funding from government, and inconsistent levels of funding from donors can negatively affect the quality and coverage of the programs. Larger programs led by international development organizations, such as Family Health International's (now known as FHI360) PRASIT in Cambodia and CARE's STEP in Vietnam, are relatively better funded, with access to longer-term funding, technical assistance, and well-designed materials; the capacity to do some level of monitoring; and the sophistication to write reports that meet the requirements of donor programs. Long-term planning is problematic for all programs, as none is self-sustaining, and governments have yet to commit to long-term support once multilateral and bilateral funding ends.

Increasing equity and access to services is the gender strategy that the programs most commonly implement, while increasing access to income and productive resources, including education, is the least employed strategy.

During the case study process, program staff, beneficiaries, and other key informants were asked how and to what extent the program is integrating one or more of the PEPFAR gender strategies:

1. *Increasing gender equity and access to HIV programs and services, including reproductive health*

All of the programs strive to provide basic prevention services (condoms, lubricant, and needle and syringe exchange), education about HIV and STIs, and peer outreach and solidarity with their target

population(s). Programs provide or refer people to HIV testing, STI treatment, and reproductive health and needle and syringe exchange services at fixed and mobile sites; most work to educate and sensitize health care providers about the needs of MARPs. Many projects provide separate safe spaces for sex workers, TG people, MSM, and PWID to meet, get counseling, and access more information about HIV and STIs and about sexual identity.

2. Reducing GBV and coercion

Most programs profiled address GBV at the community level by trying to reduce stigma and discrimination against MARPs, but only SANGRAM in India and STEP in Vietnam have activities to reduce GBV within a family or between a couple. PRASIT in Cambodia and SIDC in Lebanon include messages about GBV in their program content. Viewing health care providers as having a central role in changing societal norms, New Life in Russia hopes that by changing their attitudes about MSM, providers can model acceptance of MSM and thereby reduce the vulnerability of MSM to GBV and HIV. PRASIT is unique in that it tries to address the overlap between male group behaviors of alcohol use and risky sexual behavior, but none of the programs working with MSM, sex workers, PWID, or TG people are directly addressing the links between alcohol abuse, risk behaviors, and GBV.

3. Addressing gender norms and behaviors

For the most part, programs working with MSM and TG people address gender norms by supporting the rights of individuals to express their sexual identities. Only two programs—PRASIT and SANGRAM—use interventions and activities to address harmful gender norms as part of HIV prevention, treatment, or care and support programs targeting MARPs. This is a critical missing element in the other programs.

> During a focus group in San Salvador, one TG participant noted that some TG women like to experience violence so that they "feel more like a woman."
>
> –ASPIDH Case Study

Organizations working with MSM are committed to building this population's resilience to address stigma and discrimination, access services, and accept and express their sexual orientation. None of the programs engage MSM in critical conversations about how male norms and definitions of masculinity influence their risk behaviors. For example, none of the MSM organizations ask their members to reflect on why some men perceive condom use as a sign of weakness, how machismo may influence both unprotected insertive anal sex and excessive consumption of alcohol at bars and clubs, or why GBV occurs within MSM relationships.

Organizations working with PWID may understand that male and female drug users need different services, yet do not engage their communities to address GBV within relationships, or explain how drug-using behaviors are gendered and often, but not always, favor men (e.g., men being "first on the needle"). Organizations working with TG people are not challenging their clients to see how the embrace of female gender norms might make TG people more vulnerable to HIV in the same way that gender norms place all women at more risk to HIV infection than men. Programs working with sex workers do seek to increase self-esteem and self-efficacy of this community to refuse unsafe sex and demand more control over interactions with their clients. But sex workers continue to engage in high-risk sex with regular partners as a way of differentiating intimacy from work.

4. Increasing legal rights and protection

This is a core intervention of MARPs programs, and nearly all of the programs highlighted in the case studies are trying to address the legal and human rights of their target audiences. One of the biggest challenges programs face is the scarcity of legal professionals willing to advise clients on or pursue legal action against human rights abuses of MARPs.

Interestingly, increasing legal rights and protections was the strategy least used in the five case studies highlighted in the *Africa Gender Compendium of Case Studies* (AIDSTAR-One forthcoming). Perhaps this difference reflects the fact that many HIV programs in Africa have not yet conceived of HIV vulnerability, gender inequality, and risk among women as legal issues. For the programs highlighted in this portfolio, it is a fundamental issue.

5. Increasing access to income and productive resources, including education

Given that economic stress plays a significant role for many in pursuing sex work, very few programs use this strategy. SANGRAM empowers sex workers to use savings banks, and STEP is beginning to work with the local government to provide microloans to PWID. SIDC and PRASIT make referrals to vocational training programs. For PWID and people who engage in commercial sex to support a drug habit, being able to benefit from income-generating activities depends on the extent to which people have access to humane, voluntary, and affordable drug rehabilitation services or to opioid substitution therapy, which enables people to have less chaotic lives.

RECOMMENDATIONS

Changing sexual and drug-injection practices in response to HIV is fundamentally a social process. At the level of the individual, change involves talk. At the community or network level, it means reaching consensus about how to achieve objectives that lead to change. At the political level, it requires a public commitment to support communities as they develop new norms and values to transform behaviors and produce new cultural forms (Kippax 2008)

Donors and governments should prioritize and fund the integration of gender strategies into MARPs-focused programs.

Governments and donors in the countries in Asia, Eastern Europe, and the Middle East where these case studies were done have not prioritized gender inequity as a key driver in the HIV epidemic. Governments in the three Latin American countries where case studies were done are supporting efforts to provide services and reduce GBV through supportive policy initiatives with limited funding. Despite stated commitments to gender equality and equity, none of the donors funding the nine programs required the integration of gender sensitivity or strategies into their implementing partners' HIV program approaches, beyond support of "gender mainstreaming" and sex disaggregation of data.

The way gender is prioritized in some of the case study countries is reflected somewhat in the three Partnership Frameworks[5] signed in 2010 between the USG and countries with concentrated epidemics: Vietnam, the Eastern Caribbean Region,[6] and the Central American Region[7] (no Partnership Framework has been signed yet with countries in Eastern Europe or the Middle East). The Partnership Framework from Vietnam does not even mention the word gender. The Caribbean document mentions MARPs and states that gender is a cross-cutting issue, gender-sensitive approaches are needed, harmful cultural norms must be addressed, and laws against GBV must be enforced.

The Central American Framework document is the most detailed, stating that "the signatories to the Partnership Framework recognize that integrating gender issues into all activities is critical to the quality and sustainability of HIV/AIDS prevention, treatment, and care interventions" (Government of the United States and the Governments of the Central American Region 2010, 15). This Partnership Framework recognizes the need for interventions focused on MARPs as well as the need for women's empowerment and for interventions that target men and boys. "As appropriate, the Framework Implementation Plan should take gender issues into account and address how the proposed activities may affect aspects of gender discrimination, stigma, violence, and changing societal norms that place certain groups at higher risk of HIV" (Government of the United States and the Governments of the Central American Region 2010, 15).

[5] Partnership Frameworks provide a five-year joint strategic framework for cooperation between the USG, the partner government, and other partners to combat HIV in the host country through service delivery, policy reform, and coordinated financial commitments.

[6] Antigua and Barbuda, the Bahamas, Barbados, Belize, Dominica, Grenada, Jamaica, St. Kitts and Nevis, St. Lucia, St. Vincent and the Grenadines, Suriname, and Trinidad and Tobago.

[7] Belize, Costa Rica, El Salvador, Guatemala, Honduras, Nicaragua, and Panama.

Donors and governments should fund technical assistance to build the capacity of MARPs-focused organizations to integrate gender into their programs.

Defined activities—supported by dedicated funding—to make the integration of gender-sensitive programming meaningful and measurable are lacking in the nine programs. Nearly all programs want technical assistance to build their capacity to do more detailed analysis of gender norms and develop gender-sensitive programming. There is a real need to develop the capacity of promising organizations to provide technical assistance in gender to other organizations through south-to-south collaboration.[8] However, there is very little funding available for short-term technical assistance or long-term capacity building in gender in countries experiencing concentrated epidemics.

Donors and governments should expand their programming beyond providing HIV prevention information, individual behavior change communication, and commodity distribution.

Programs that include strategies to address the structural causes of vulnerability among MARPs are needed urgently. A potential direction for programming is to work toward creating self-sustaining MARPs-focused programs that include components that improve economic stability and opportunities.

Programs should develop strategies and activities that reflect the context of MARPs' lives.

It seems that programs have lost sight of the fact that MARPs are not just their risk behavior(s): unprotected anal sex, injecting drug use, multiple and concurrent sex partners. They are individuals embedded in relationships and social networks that reinforce gendered roles. They are husbands and wives, mothers and fathers, sisters and brothers, friends and partners, reproducing socially defined practices that emerge from the sociocultural, economic, and political structures in which they are situated. Programs must develop strategies and activities that are implemented within the networks of MARPs to change group norms and reduce risk behaviors.

Programs should incorporate a strong evaluation component.

Formative research, process evaluation, and program monitoring to understand how MARPs are responding to programming strategies and activities are decidedly absent from the majority of the nine programs. A lack of strong evaluation is an opportunity lost for the donor, the implementers, and, especially, program beneficiaries. Donors should therefore provide funding to develop the capacity of programs working with MARPs to undertake these activities across the life of their programs.

Specific tools should be developed with MARPs-focused programs to help them integrate gender analysis and gender strategies into their programs.

Current gender analysis and gender mainstreaming tools and materials discuss gender inequality in a way that targets primarily heteronormative, mainstream male and female audiences. These tools should be adapted or new tools should be developed that adequately articulate how gender inequalities and norms are perceived and experienced by MARPs.

[8] South-to-south refers to an exchange of expertise and resources between governments, organizations, and/or individuals in developing nations. AIDSTAR-One has developed a framework and toolkit for facilitating south-to-south technical support. It is available at www.aidstar-one.com/facilitating_south_to_south_technical_support_toolkit.

REFERENCES

AIDSTAR-One. Forthcoming. *Africa Gender Compendium of Case Studies*. Arlington, VA: USAID's AIDS Support and Technical Assistance Resources, AIDSTAR-One, Task Order 1.

AIDSTAR-One. 2009. *Integrating Multiple Gender Strategies to Improve HIV and AIDS Interventions: A Compendium of Programs in Africa*. Available at www.aidstar-one.com/sites/default/files/Gender_compendium_Final.pdf (accessed August 2011)

Coates, T. J., L. Richter, and C. Caceres. 2008. Behavioural Strategies to Reduce HIV Transmission: How to Make them Work Better. *The Lancet* 372(9639): 669–684.

de Bruyn, M., H. Jackson, M. Wijermars, V. C. Knight, and R. Berkvens. 1995. *Facing the Challenges of HIV, AIDS, STDs: A Gender-based Response*. Amsterdam, The Netherlands: Royal Tropical Institute, Southern Africa AIDS Information Dissemination Service, and World Health Organization. Available at http://data.unaids.org/Topics/Gender/facingchallenges_en.pdf (accessed August 2011)

Government of the United States and the Governments of the Central American Region (Belize, Costa Rica, El Salvador, Guatemala, Honduras, Nicaragua and Panama). 2010. *Partnership Framework Document to Support Implementation of the Central American Regional HIV/AIDS Response: A Five-Year Strategy to Jointly Implement Regional Goals to Reduce Transmission of HIV and to Mininize Negative Impacts on the People of the Central American Region*. Available at www.pepfar.gov/documents/organization/138938.pdf (accessed August 2011)

Greenall, M., and B. C. Rasoanaivo. 2008. Sex Worker Organising in Madagascar. *Research for Sex Work* 10:21–23. Available at www.nswp.org/sites/nswp.org/files/research-for-sex-work-10-english-espanol.pdf (accessed August 2011)

Greene, M. E., and A. Levack. 2010. *Synchronizing Gender Strategies: A Cooperative Model for Improving Reproductive Health and Transforming Gender Relations*. Washington, DC: Population Reference Bureau.

Gupta, G. R., J. O. Parkhurst, J. A. Ogden, P. Aggleton, and A. Mahal. 2008. Structural Approaches to HIV Prevention. *The Lancet* 372(9640): 764–775.

Jewkes, R., M. Nduna, J. Levin, et al. 2006. A Cluster Randomised Controlled Trial to Determine the Effectiveness of Stepping Stones in Preventing HIV Infections and Promoting Safer Sexual Behaviour Amongst Youth in the Rural Eastern Cape, South Africa: Trial Design, Methods and Baseline Findings. *Tropical Medicine and International Health* 11:3–16.

Joint U.N. Programme on HIV/AIDS. 2001. *The Global Strategy Framework on HIV/AIDS*. Available at http://data.unaids.org/publications/IRC-pub02/jc637-globalframew_en.pdf (accessed August 2011)

Joint U.N. Programme on HIV/AIDS. 2007. *Practical Guidelines for Intensifying HIV Prevention: Towards Universal Access*. Available at http://data.unaids.org/pub/Manual/2007/20070306_prevention_guidelines_towards_universal_access_en.pdf (accessed August 2011)

Joint U.N. Programme on HIV/AIDS. 2008a. *Practical Guidelines for Intensifying HIV Prevention: Towards Universal Access: Five steps to HIV prevention planning and implementation*. Geneva, Switzerland: UNAIDS. Available at

www.unaids.org/en/media/unaids/contentassets/dataimport/pub/manual/2008/jc1581_big_card_en.pdf (accessed August 2011)

Joint U.N. Programme on HIV/AIDS. 2008b. *Report on the Global AIDS Epidemic*. Available at www.unaids.org/en/dataanalysis/epidemiology/2008reportontheglobalaidsepidemic/ (accessed August 2011)

Kippax, S. 2008. Understanding and Integrating the Structural and Biomedical Determinants of HIV Infection: A Way Forward for Prevention. *Current Opinion in HIV and AIDS* 3:489–94.

Office of the U.S. Global AIDS Coordinator (OGAC). 2009. *The U.S. President's Emergency Plan for AIDS Relief: Five-Year Strategy*. Washington, DC: OGAC.

Pronyk, P. M., J. C. Kim, T. Abramsky, et al. 2008. A Combined Microfinance and Training Intervention can Reduce HIV Risk Behavior in Young Female Participants. *AIDS* 22(13):1659–65.

Rerks-Ngarm, S., P. Pitisuttithumm, N. Ganguly, et al. 2010. Defining the Objectives of the AIDS Vaccine for Asia Network: Report of the WHO-UNAIDS/Global HIV Vaccine Enterprise. Regional Consultation on Expanding AIDS Vaccine Research and Development Capacity in Asia. *Current Opinion in HIV and AIDS* 5:435–52.

Smith, A. D., P. Tapsoba, N. Peshu, E. J. Sanders, and H. W. Jaffe. 2009. Men Who Have Sex with Men and HIV/AIDS in Sub-Saharan Africa. *The Lancet* 374:416–22. Available at www.thelancet.com/journals/lancet/article/PIIS0140-6736(09)61118-1/abstract (accessed July 2009)

Spratt, K. 2010. *Technical Brief: Addressing Gender in Concentrated Epidemics*. Arlington, VA: USAID's AIDS Support and Technical Assistance Resources, AIDSTAR-One, Task Order 1. Available at www.aidstar-one.com/focus_areas/gender/resources/technical_briefs/gender_MARPs (accessed August 2011)

Stewart, D. 2008. Sex Worker Activists: Embodying Aberrance. *Research for Sex Work* 10: 7–8.

van Griensven, F., J. W. de Lind van Wijngaarden, S. Stefan Baral, and A. Grulich. 2009. The Global Epidemic of HIV Infection Among Men Who Have Sex with Men. *Current Opinion in HIV and AIDS* 4:300–7.

APPENDIX I:

E-FLIER TO ELICIT PROGRAM NOMINATIONS

AIDSTAR-One (www.aidstar-one.com) is Looking for Programs that Integrate Gender in HIV Programming for Most-at-Risk Populations

AIDSTAR-One is currently looking for programs working with and for most-at-risk populations (MARP) that are integrating gender into their programmatic approaches. If you know of innovative MARP programs integrating gender, we want to know about it!

The USAID-funded AIDSTAR-One project is compiling a compendium of case studies on programs that have successfully integrated gender strategies into their work with most-at-risk populations (MARPs), including:

- People who inject drugs (PWID)
- Male and female sex workers (SW)
- Transgender (TG) women
- Men who have sex with men (MSM)

The compendium will document and disseminate good and promising programmatic practices for integrating gender into MARP programs and will focus on programs in Eastern Europe and Central Asia, the Middle East and North Africa, Central and Latin America, and South Asia and Southeast Asia.

We are looking for programs that incorporate an understanding of how gender norms influence risk behaviors and influence access to, and use of, HIV prevention, care, support, and treatment programs and services. Programs can use a number of approaches to address or influence gender norms including, but not limited to:

Increasing gender equity and access to HIV programs and services:

- Conduct studies to understand the unique needs of men and women who inject drugs, TG, or male and female sex workers and tailor services to address those needs.
- Disaggregate data by male, female, and transgender beneficiaries.

Reducing gender-based violence (GBV) and coercion:

- Provide appropriate medical services to MARPs experiencing GBV such as, but not limited to: post-exposure prophylaxis, providing HIV/STI testing and treatment or referral services, and providing referral to legal, counseling, and support services.

- Strengthen policies/laws and legal/judicial systems to create disincentives for perpetrators of GBV against MARPs.

Addressing gender norms and behaviors:

- Change norms, attitudes, and behaviors that support harmful behaviors.
- Foster male involvement in the health seeking process for themselves or for their partners who may be SW, MSM, TG, or PWID (i.e., in prevention of mother-to-child transmission, HIV testing and counseling, HIV care and treatment, etc.).
- Train TG and male and female sex workers to negotiate condom use with clients and intimate partners.

Increasing legal rights and protection:

- Change norms, attitudes, and beliefs which support discrimination against MARPs' legal rights and protection.
- Increase awareness of existing laws that protect the rights of MARPs.
- Advocate to enforce anti-discrimination policies and laws.

Increasing access to income and productive resources:

- Create opportunities for male, female, and TG sex workers and PWID to seek education/skills development.
- Remove legal barriers to MARPs employment, control of resources, property ownership, and access to credit.

To nominate a program (or for more information) please send the name, contact information, and a sentence or two about why you are nominating the program to the appropriate person listed below. We may contact you to ask you a few questions about the program. AIDSTAR-One will contact the program for more detailed information using a standardized survey.

ASIA: Kai Spratt (kspratt@jsi.com)

EASTERN and CENTRAL EUROPE, and MIDDLE EAST AND NORTH AFRICA: Diane Gardsbane (dgardsbane@encompassworld.com)

LATIN AMERICA AND THE CARIBBEAN: Myra Betron (mbetron@icrw.org)

APPENDIX 2:

AIDSTAR-ONE QUESTIONNAIRE FOR PROGRAM IMPLEMENTERS

Integrating Gender Strategies into HIV Programs with Most-at-Risk Populations

1. Lead implementing organization	Please spell out the full name of your organization.
2. Contact information	a. Person(s) to contact: b. Phone/email:
3. Please tell us about your organization. For example, how it was founded and how it has evolved	*Use as much space as you need to describe your organization.*
4. Name of program/project with most-at-risk populations	Please spell out the full name of program/project for most-at-risk populations (MARPs) your organization is implementing.
5. Partner organization(s)	a. Which other organizations do you collaborate with to implement the MARP program? b. ____ Check here if no other organizations
6. Region	Where is the program implemented? ____ Central America ____ South America ____ Eastern Europe ____ Middle East/N. Africa ____ South Asia ____ Southeast Asia
7. Country or countries	List country where program is implemented (check √ all that apply).
8. Level of implementation	At what level is the MARP program implemented? (√ all that apply) _____ National _____ Provincial/State _____ District _____ Community _____ Other: _____
9. Setting	In which setting is the program implemented (√ all that apply) ____ Urban area ____ Peri-urban area ____Rural area ____ Other: _____

10. Environment	Where is the program implemented? (√ all that apply) _____ Community level _____ Clinic or other/health facility _____ Drop-in center _____ Sex work venues _____ Schools _____ Workplace _____ Other: _____
11. Target populations	a. What age group does your MARP program target? (√ all that apply) ___ Adults (over 18 years) ___ Adolescents (13–17 years) b. Which most at risk populations does your program target? (√ all that apply) Sex workers (SW) ___ Female sex workers ___ Male sex workers ___ Transgender sex workers People who inject drugs (PWID) _____ Men only _____ Women only _____ Both men and women ____Men who have sex with men (MSM) ____Transgender (TG) people ____Clients of sex workers ____Sex partners of SW, PWID, MSM, TG people ____Other: _____
12. Program start date	Enter the month (if known) and year that the program began.
13. Scope	How many individuals were reached by your program in 2009? _____ <100 _____ 100–500 _____ 500–1,000 _____ 1,000–5,000 _____ 5,000–10000 _____ 10,000–25,000 _____ 25,000–50,000 _____ >50,000 _____ Don't know/not sure
14. Government partnership	a. What level of government does your organization work with to implement the MARP program? (√ all that apply) _____ National _____ Provincial/State _____ District _____ Municipal/City _____ Other: _____ _____ We do not work with the government b. Describe the government's involvement in the program:
15. Participation of target group(s)	*Use as much space as you need to.* a. Describe how the target population(s) was involved in <u>designing</u> the program: b. How is the target population(s) involved now in <u>implementing</u> the program?
16. Gender strategy	Which gender strategy or strategies is your program integrating into its activities: (√ check all that apply) _____ Increasing gender equity and access to HIV programs and services _____ Reducing violence and coercion _____ Addressing harmful gender norms and behaviors _____ Increasing legal rights and protection _____ Increasing access to income and productive resources _____ Other: _____

17. Technical assistance	Did your organization receive any training or technical assistance (TA) on how to integrate gender strategies into your MARP program? _____ Yes _____ No _____ Not sure/Don't know *Use as much space as you need* If YES: Who provided that TA? How many times was TA or training on gender provided to your organization? In your opinion, was the TA sufficient or is more needed?
18. Strategy integration	*Use as much space as you need to.* Describe how you are integrating the gender strategy chosen in question 16 into your program, that is, what practices or activities are you using to integrate gender into your program? FOR EXAMPLE: 1) providing training to health care providers on how to screen sex workers for experiences of violence and coercion; 2) sponsoring separate peer support groups for women or men who inject drugs; 3) advocating for the enforcement of laws that protect the human rights of your beneficiaries; 4) holding community sessions with MSM to think through how male gender norms influence their HIV risk behavior.
19. Choice of practice	*Use as much space as you need to describe.* Why did your organization decided to implement these particular practice(s) or activity/activities?
20. Goals of the practice	*Use as much space as you need to.* List one or more goals you hoped to reach by implementing the practice/activities.
21. Innovation	*Use as much space as you need.* a. Has the way the practices or activities are implementing changed since first introduced into your program? If yes, how so? What innovations were introduced? b. Which practices or activities were dropped, and why?
22. Challenges in implementing the gender strategies and/or practices	*Use as much space as you need to:* Please describe any challenges encountered implementing the gender practices or activities and how your organization tried to address the challenges.
23. Noteworthy results	*Use as much space as you need*: What outcomes have your program seen as a result of introducing the gender strategy (FOR EXAMPLE: 80% of MSM seen at public health clinic sites are not being screened for gender-based violence).
24. Collaboration	*Use as much space as you need.* Do you work with other projects or programs to coordinate or complement gender strategies? Give the name of other projects/programs and describe how you collaborate with each project/program.
25. Lessons learned	*Use as much space as you need.* What lessons have you learned from your organization's efforts to introduce gender strategies into your program activities?
26. Advice to other organizations	*Use as much space as you need.* What advice would you give to other organizations trying to integrate gender into their programs with similar target populations?
27. Monitoring	a. What measures or indicators are being used to track the outcomes of the gender practice(s) your organization is implementing? (please write out specific indicators) b. Has any evaluation of the program been done since you introduced the gender practices into your program? _____ Yes ____ No c. If Yes, who conducted the evaluation? d. If No, is an evaluation planned in 2010?

28. Sustainability	a. Will your organization continue to integrate gender into its activities in the future? ____ Yes _____ No *Use as much space as you need.* b. If No, why not? c. How have donors/funders supported your organization's efforts to incorporate gender into your program activities?
29. Replication	*Use as much space as you need.* What kind of training or resources would other organizations need in order to replicate/adapt the practices your organization is using to integrate gender into its programs?
30. Other programs	*Use as much space as you need.* Can you recommend any other organizations integrating gender into their work with MARPs that we should contact? Please provide program name, contact person, and contact info for these programs so we can contact them.
31. Other comments	Please add any further comments or observations.

Thank you for taking time to share your experience with us. The information provided will be extremely helpful in documenting how your organization is integrating gender into its work with most-at-risk populations

Section II

Please share the following supporting documents if available (email attachment or link). **If not available, please indicate.**

Supporting Documentation	Document Name
Program Monitoring Plan with most recent reporting data (program indicators)	_____ Attached/link: _____ _____ Not available
Quality Improvement Plan (program document)	_____ Attached/link: _____ _____ Not available
Work Plans and/or Annual Reviews (quarterly, semi-annual, annual, or other reports documenting at least two years of program implementation experience)	_____ Attached/link: _____ _____ Not available
Evaluation Report (summative, midterm, or final project evaluation detailing results and identifying positive effects)	_____ Attached/link: _____ _____ Not available
External Evaluation Report (with rigorous evaluation methodology)	_____ Attached/link: _____ _____ Not available
Success Stories Publications regarding the practice (i.e., peer-reviewed articles, commissioned reports, manuals, tools)	_____ Attached/link: _____ _____ Not available
Pictures you would like to share	_____ Attached/link: _____ _____ None

APPENDIX 3: PRE-SCORE ASSESSMENT OF MOST-AT-RISK POPULATION HIV PROGRAM

Program Name:					
Country:					
Implementing Organization:					
Target Population: *(Circle all that apply)*	MSM PWID: Men Women TG Sex Workers: Female Male TG				
Type of HIV Programming: *Circle one*	Prevention	Care	Treatment	Mitigation	Other (describe)
Questions:					
Additional comments:					

Criteria for Pre-scoring Assessment of Programs that Address Gender in the Context of MARP HIV Programming

Criterion	Level 1						Level 2						Level 3						Comments[9]
Comprehensiveness of approach in addressing gender strategies *Note: Under each strategy, rank the intensity of activities specifically addressing the strategy as follows: (0 = not addressing; L = low intensity; H = high intensity[10])*	Addresses one gender strategy						Addresses two gender strategies						Addresses three (or more) gender strategies						
	EA[11]	GBV	GN	LP	IPR	O[12]	EA	GBV	GN	LP	IPR	O	EA	GBV	GN	LP	IPR	O	
Level of evaluation	Formative data collected and/or at least one year of monitoring on program reach						Moderately rigorous: weaker evaluation design which may be more descriptive than analytical; quantitative data lacking one of the elements required for level 3, may include unsystematic qualitative data						Highly rigorous: pre/post and/or with control group or time series data and/or systematic qualitative data with clear analytical discussion						
	Describe:						*Describe:*						*Describe:*						

[9] In comments column, please provide any clarification necessary regarding your descriptions (i.e., for row one, could provide more information on specifically how the project indirectly addressed a particular strategy and/or provide an assessment of the quality of the activities, etc.).

[10] More specifically, if the program does not address a particular strategy, it would receive a zero. If the strategy was addressed through low-intensive activities (i.e., through linkages/referrals to other organizations working directly to address that strategy or address directly but only in one session, etc.), it would receive an "L." If the program addressed the strategy through highly intensive activities, it would receive an "H."

[11] EA = Equity and access to services; GBV = Reducing gender-based violence and coercion; GN = Addressing gender norms and behaviors; LP = Increasing legal protection; IPR = Increasing access to income and productive resources; O = other gender strategy (i.e., addressing gender equity, etc.)

[12] Please note what the "other" gender strategy is in the comments box.

Program outcomes	Collecting or planning to collect gender indicators	Conducted/-ing analysis on gender indicators (results may be pending)	Has demonstrated positive change in gender indicators (based on either qualitative or quantitative data)	
	Describe:	*Describe:*	*Describe:*	
Sustainability	Stakeholder involvement is demonstrated in program objectives, goals, or project descriptions	Stakeholder participation in program is evident (community or participants involved in design, implementation, feedback)	Stakeholder ownership in program is evident (contribution of community resources; clear financial support)	
	Describe:	*Describe:*	*Describe:*	
Feasibility for replication/scale-up *Note: We should be keeping track of what we're putting in level 1 and 2 so we can decide if these criteria are appropriate.*	Planning to replicate or exploring possibilities	Evidence indicates program is suited for replication/scale-up; lessons for replication/scale-up are available	Program or part of the program has been successfully replicated and/or scaled-up	
	Describe:	*Describe:*	*Describe:*	
Program data disaggregated by gender?	*Yes* *No*	*Yes* *No*	*Yes* *No*	
Any measurement of change in gender norms, etc.?	*Yes* *No*	*Yes* *No*	*Yes* *No*	

APPENDIX 4:

FINAL SCORING RUBRIC

Program Name:

Country:

Final Score:

Programming Type:

Implementing Organization:

Contact Person:

Email Address:

Criteria for Scoring Programs that Address Gender Factors in the Context of MARP HIV Programming

Criterion	Level 1	Level 2	Level 3	Final Score	Comments
Comprehensiveness of approach in addressing gender strategies	Addresses one gender strategy 1	Addresses two gender strategies 2	Addresses three or more gender strategies 3		
Level of evaluation	Formative data collected and/or at least one year of monitoring on program reach 1	Moderately rigorous: weaker evaluation design which may be more descriptive than analytical; quantitative data lacking one of the elements required for level 3, may include unsystematic qualitative data 2	Highly rigorous: pre/post and/or with control group or time series data and/or systematic qualitative data with clear analytical discussion 3		
Program outcomes on gender	Collecting or planning to collect gender indicators 1	Conducted/-ing analysis on gender indicators (results may be pending) 2	Has demonstrated positive change in gender indicators (based on either qualitative or quantitative data). 3		
Sustainability	Stakeholder involvement is demonstrated in program objectives, goals, or project descriptions 1	Stakeholder participation in program is evident (community or participants involved in design, implementation, feedback) 2	Stakeholder ownership in program is evident (contribution of community resources; clear financial support) 3		
Feasibility for replication/scale-up	Planning to replicate or exploring possibilities 1	Evidence indicates program is suited for replication/scale-up; lessons for replication/scale-up are available 2	Program or part of the program has been successfully replicated and/or scaled-up 3		
Final Score (15 possible)					

For more information, please visit aidstar-one.com.

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