

# SWAZILAND: GENDER STRATEGY FOR THE PEPFAR INTERAGENCY TEAM

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## ACRONYMS AND ABBREVIATIONS

AIDS	Acquired Immunodeficiency Syndrome
ANC	Antenatal care
ART	Antiretroviral therapy
ARV	Antiretrovirals
BCC	Behavior change communication
C-BLD	Community-Based Livelihoods Development project
CDC	(U.S.) Centers for Disease Control and Prevention
COP	Country Operational Plan
CSO	Central Statistics Office (Mbabane)
DOD	(U.S.) Department of Defense
FSW	Female sex worker
GBV	Gender-based violence
GEM	Gender Equitable Men
GHI	(U.S.) Global Health Initiative
GOKS	Government of the Kingdom of Swaziland
HIV	Human Immunodeficiency Virus
HTC	HIV testing and counseling
IPV	Intimate partner violence
MARP	Most at-risk population
MMC	Medical male circumcision
MOH	Ministry of Health
MSM	Men who have sex with men
NGO	Non-governmental organization
OVC	Orphans and vulnerable children
NERCHA	National Emergency Response Council on HIV and AIDS
PEP	Post-exposure prophylaxis
PEPFAR (U.S.)	President's Emergency Plan for AIDS Relief
PMTCT	Prevention of mother-to-child transmission
SBCC	Social and behavioral change communication
SDHS	Swaziland Demographic and Health Survey
S&L	Savings and loan
SMICS	Swaziland Multiple Indicator Cluster Survey

TB	Tuberculosis
USAID	United States Agency for International Development
USDF	Umbutfo Swaziland Defense Forces

## KEY DEFINITIONS

**Gender:** The attributes, constraints, and opportunities associated with being a man or a woman. Gender also refers to the array of socially constructed roles and relationships, personality traits, attitudes, behaviors, values, and the relative power and influence that society ascribes to the two sexes. Whereas biological sex is determined by genetic and anatomical characteristics, gender is an acquired identity that is learned, changes over time, and varies widely within and across cultures, religions, and class and ethnicity.

**Gender-Based Violence (GBV):** Violence directed at an individual based on his or her biological sex, gender identity, or perceived adherence to socially defined norms of masculinity and femininity. GBV includes physical, sexual, and psychological abuse; threats; coercion; arbitrary deprivation of liberty; and economic deprivation. Research studies on GBV typically focus on specific aspects of GBV.

**Gender Equality:** The concept that all human beings, whether male and female, are free to develop their personal abilities and to make choices, without limitations set by stereotypes, rigid gender roles, or prejudices. Gender equality involves equal access to resources and services.

**Gender Equity:** Connotes fairness in the distribution of opportunities and benefits. Equity is the means, and equality is the result.

**Gender Integration:** Identifying and addressing gender inequalities during strategy and project design, implementation, and monitoring and evaluation. Since the roles of and power relations between men and women affect implementation of an activity, it is essential that project managers address these issues on an ongoing basis.

**Gender Mainstreaming:** The process of assessing the implications for women and men of any planned action, including legislation, policies, or programs, in any area and at all levels. Gender mainstreaming aims to make women's as well as men's concerns and experiences an integral dimension in the design, implementation, monitoring, and evaluation of policies and programs in all political, economic, and social spheres, so that inequality between men and women will not be perpetuated.

**Gender Norms:** The roles, behaviors, and attributes that a society deems appropriate for men and women, thus defining masculinity and femininity. These norms are not static and may not be strictly adhered to at the micro-level.

**Gender-Sensitive Indicators:** Measures of gender-related change in society over time. The usefulness of these indicators lies in their ability to point to changes in the status and roles of women and girls, and men and boys over time, and therefore to measure whether gender equity is being achieved. Gender-sensitive health indicators can provide a powerful information base for policy and program action that can improve health outcomes and reduce health inequities.



# EXECUTIVE SUMMARY

## INTRODUCTION

The purpose of the PEPFAR Swaziland Gender Strategy is to provide guidance on how to strengthen the gender responsiveness of the HIV program supported by the U.S. Government in Swaziland. The recommendations in this report are in accord with the U.S. Government's gender policies and directives, the Swaziland Global Health Initiative Strategy, the gender and HIV/AIDS policies of the Government of the Kingdom of Swaziland (GOKS), and the GOKS and U.S. Government's Partnership Framework on HIV/AIDS.

A mixed-method approach was used to develop this Strategy. With USAID financial support, a consultant was engaged through the Global Health Technical Assistance Bridge Project to carry out the strategy development process. Discussions were held with members of the PEPFAR interagency team, key GOKS officials, implementing partners, and key stakeholders. The consultant visited select health service sites, observed social and behavioral change communication (SBCC) sessions, and read numerous documents. The results of this work informed the Strategy recommendations.

## GENDER ANALYSIS

With an estimated population of 1.185 million, Swaziland is struggling to mitigate the world's most severe HIV epidemic. The Swaziland Demographic and Health Survey reported HIV prevalence among adults aged 15–49 to be 31% for women and 20% for men.<sup>1</sup> Women are infected at a younger age than men, with HIV prevalence peaking at 49% among the 25–29 age group. The majority (62%) of new infections also occur in women, with HIV contributing to an escalating maternal mortality rate, which was reported in the SDHS as 589 deaths per 100,000 live births.

Gender norms underlie sexual behaviors and men's exertion of control in their sexual relationships with women. Having more than one steady partner, having casual partners, and having intergenerational sex are common. Men are more likely than women to have multiple partners, and their use of condoms is inconsistent. Data from the 2011 Swaziland Multiple Indicator Cluster Survey (SMICS) indicate that among men and women aged 15–59 years, 15% of the men and 3% of the women had sexual intercourse with more than one partner in the 12 months prior to the survey. Among them, 69% of men and 73% of women reported using a condom during their last act of intercourse.

Swaziland has a high rate of gender-based violence (GBV), including but not limited to sexual violence such as rape and coerced unprotected sex. GBV occurs within marriages, with casual and stable partners, and toward children. A national study on violence against children and young women found that the rate of sexual violence was 38% among 18–24-year-olds and 28% among 13–17-year-olds.<sup>2</sup> A major challenge is a perceived lack of accessibility and low uptake of HIV/AIDS prevention, care, and treatment services by men.

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<sup>1</sup> Central Statistical Office and Macro International, Inc. *Swaziland Demographic and Health Survey 2006–2007*. Mbabane, Swaziland: Central Statistical Office and Macro International Inc., 2008 [hereinafter SDHS 2007].

<sup>2</sup> UNICEF 2007.

## Gender and the PEPFAR Interagency Portfolio

The current PEPFAR portfolio in Swaziland includes attention to gender, but there is room for improvement. HIV prevention outreach services make HIV testing and counseling (HTC) more accessible and acceptable to men. A home-based HTC initiative aims to reach couples, which reduces the risk of GBV when a woman tests positive. For a similar reason, men are also encouraged to accompany their partners to antenatal clinics. To reduce the risk of HIV among women and girls, several indigenous organizations, with PEPFAR support, are engaged in social and behavioral change communications (SBCC) on gender norms and GBV.

The PEPFAR portfolio on HIV care, treatment, and support prioritizes decentralization of care and treatment services by the GOKS, which benefits women since they are the main users of health facilities. The portfolio also includes services to women identified as HIV-positive when attending antenatal clinics, and to their partners. Access to economic-strengthening activities for women, young girls, and vulnerable households is provided to mitigate the impact of HIV, with a focus on children. In addition, the PEPFAR program focuses on improving the access and quality of services for orphans and vulnerable children (OVC), including strengthening child protection and social welfare systems. This includes expanding the capacity of community structures in order to prevent and respond to child abuse, and increasing reporting of abuse cases, which are typically girls.

## Recommended PEPFAR Gender Strategy

The Recommended PEPFAR Gender Strategy is intended to be implemented within the framework of the proposed U.S. Government's Swaziland Mission gender goal, which has two objectives. The PEPFAR Gender Strategy focuses on the second objective: *reduced vulnerability of women and men, girls and boys, to HIV infection and its consequences*. The Strategy contains two parts. The first centers on program directions under PEPFAR's five gender strategy elements. The second focuses on program operations that crosscut the five elements.

### Mission Gender Goal and Objectives

#### Goal

Men and women contribute as equals to a healthy, stable, and prosperous society in Swaziland.

#### Objectives

- Greater gender equity under the law, in governance, the economy, and civil society.
- Reduced vulnerability of women and men, girls and boys, to HIV infection and its consequences.

Strategy recommendations include continuation of existing gender-focused activities, strengthening and/or expansion of ongoing activities, and the addition of new approaches and interventions. To increase gender equity in HIV/AIDS programs and services, PEPFAR should continue to ensure gender equity in prevention, care, treatment, and support services, as well as in its impact mitigation activities focused on children. The PEPFAR program should expand access to HTC outreach services, scale up educational outreach on medical male circumcision, and continue to encourage women to discuss male circumcision with partners and sons. In addition, PEPFAR should increase the number of support groups for HIV-positive persons and strengthen the groups' capacities to provide services to its members, including self-stigma. Support groups may be particularly helpful for women, who form the majority of those living with HIV in Swaziland, and can serve as platforms for addressing gender-related issues such as disclosure and GBV.

To reduce GBV and coercion, the PEPFAR program should strengthen the child-protection system, improve the handling of cases of physical violence and rape, and expand case monitoring. In addition, the program should continue to support the expansion of SBCC on GBV and sexual coercion, and improve the quality of communication sessions. Similarly, to better address gender norms and behaviors, PEPFAR should continue to support the expansion of SBCC sessions on norms and practices that increase women's and girls' vulnerability to HIV, with particular regard to strengthening the quality of the sessions and including communication aimed at reducing HIV stigma and discrimination.

To increase women's legal protections, PEPFAR should continue to support advocacy for changes to improve the legal status of women, as well as interventions to increase women's access to income and productive resources. Interventions should provide women and female youth access to business skills and self-directed savings and lending groups, which integrate discussions on gender norms and behaviors and GBV. In addition, the PEPFAR program should continue to support vulnerable households' access to financial literacy, income-generating activities, and links to commercial value chains, e.g. buyers who also provide inputs for specific commodities.

The operations section of the Gender Strategy covers elements that cut across and enhance the entire program. Recommendations include strengthening the capacity of women and female adolescents, in part by creating dedicated social spaces for vulnerable girls. Capacity of implementing partners also should be enhanced through gender mainstreaming at the organizational and program levels. In addition, PEPFAR should support key national-level partners to implement elements of the National Gender Policy, and future agreements between the U.S. Government and the GOKS should fully address gender.

To better inform and document implementation of the Recommended Gender Strategy, PEPFAR team operations should more fully integrate gender into monitoring, evaluation, and research. This includes adjustments to the current partner monitoring and reporting in light of the Gender Strategy. In addition, PEPFAR team members should consider gender issues as a priority topic for research or special study.

Gender should also be integrated into the procurement process. All new requests for assistance or programs should include a discussion on gender, and the award process should assess the adequacy to which responders have addressed gender dimensions in their proposed work. Also, annual workplans and Country Operational Plans (COPs) should pay greater attention to gender equity.

On an annual basis, the PEPFAR interagency team members should present to the team a verbal and written summary of its accomplishments, outputs, and outcomes related to the Gender Strategy, which would allow the team to assess its progress. Implementation of the Operations Strategy should also be reviewed on an annual basis.



# I. INTRODUCTION

## PURPOSE AND OBJECTIVE

The purpose of the PEPFAR Swaziland Gender Strategy is to provide guidance on how to strengthen the gender responsiveness of the HIV program supported by the U.S. Government in Swaziland. The recommendations in this report are informed by a gender analysis that focuses on the gender factors associated with the spread and burden of the HIV epidemic, as well as a review of the integration of gender in the current PEPFAR portfolio.

The ultimate purpose of the integration and implementation of gender initiatives in the PEPFAR Swaziland context is to improve health and social outcomes for women, men, boys, and girls. The recommendations in the Strategy are in accord with the U.S. Government's gender policies, the Swaziland Global Health Initiative Strategy, the Government of the Kingdom of Swaziland's (GOKS) gender policy and its National Multisectoral HIV and AIDS Policy, and the GOKS's and the U.S. Government's Partnership Framework on HIV/AIDS.

*Gender refers to the socially constructed roles, behaviors, activities, and attributes that a society considers appropriate for men and women, and these vary over time.*

## U.S. GOVERNMENT'S GENDER POLICIES AND GUIDANCE

The global PEPFAR Gender Strategy mandates a stronger focus on gender equality and women's empowerment. PEPFAR is committed to ensuring gender equity in its prevention, care, and treatment services (See Annex A). The concept of gender equity strives to integrate gender considerations within all programming, taking into account the ways in which gender norms and barriers contribute to the HIV/AIDS epidemic within country contexts. The PEPFAR Gender Strategy focuses on the following five crosscutting areas:

- Increasing gender equity in HIV/AIDS programs and services;
- Reducing violence and coercion;
- Addressing male norms and behaviors;
- Increasing women's legal protection; and
- Increasing women's access to income and productive resources.

*Gender equality is the concept that men and women are free to develop their personal abilities and to make choices, without limitations set by stereotypes, rigid gender roles, or prejudices. Gender equality connotes equal access to services and resources.*

*Gender equity connotes fairness in the distribution of opportunities and benefits. Equity is the means, and equality is the result.*

The Implementation Plan 2009–2013 of the U.S. Government’s and the GOKS’s Partnership Framework on HIV/AIDS centers on five key intervention areas. It states that *gender issues cut across all five pillars of the Framework, but will be addressed most directly within prevention and impact mitigation*. The five pillars are:

- Decentralized and improved quality of care and treatment services for adults and children, including HIV and TB testing;
- A coordinated and comprehensive approach to prevention of sexual transmission of HIV, using social and behavioral change communication (SBBC);
- Rapid expansion of medical male circumcision to reach males aged 15–24;
- Impact mitigation focused on vulnerable children (0–17 years) and their families; and
- Human and institutional capacity development to manage an effective HIV response, including aspects of strategic information and laboratory services.

Gender has been identified as a crosscutting strategic growth area in the U.S. Global Health Initiative (GHI) Country Strategy for Swaziland. Gender norms play a fundamental role in the vulnerability of women and girls to HIV infection and other diseases, as well as placing an enormous burden of care on them. Specifically, the GHI strategy states that the U.S. Government team will develop a gender strategy; support program and operational mainstreaming; implement special initiatives that expand activities benefiting women and girls; improve men’s access to HIV services; strengthen prevention and response efforts to gender-based violence (GBV); and enhance the measurement of gender-related outcomes.

Consistent with global PEPFAR and GHI guidance, the U.S. Agency for International Development’s 2012 gender equality and female empowerment policy centers on:

- Reducing gender disparities in access to, control over, and benefit from resources, wealth, opportunities, and services—whether economic, social, political, or cultural;
- Reducing gender-based violence and mitigating its harmful effects on individuals; and
- Encouraging women and girls to realize their rights, determine the course of their lives, and influence decision-making in their households, communities, and societies.

In line with the new USAID gender policy, the USAID automated directives system will be updated. The update will incorporate specific guidance, roles, and responsibilities for conducting mandatory gender analyses and for incorporating analysis findings across the program cycle; attribute funds to gender sub-key issues in the development of annual operational plans; and use the gender equality indicators in annual performance plans and reports.

## **METHODOLOGY**

A mixed-method approach was used to develop this Gender Strategy. With USAID financial support, Dr. Carolyn Barnes was engaged as a consultant through the Global Health Technical Assistance Bridge Project to carry out the strategy development process. The scope of work involved understanding the policies and objectives of the U.S. Government and the GOKS that underscore the need for a PEPFAR Swaziland Gender Strategy. It also included a gender analysis,

assessment of the current state of gender integration in the PEPFAR Swaziland program, and recommendations on how gender could be better integrated into the program.

The work was done through interviews and discussions with members of the PEPFAR interagency team, key GOKS officials, select implementing partners, and key stakeholders. The consultant visited various sites to observe prevention of mother-to-child transmission (PMTCT), medical male circumcision, and HIV testing and counseling (HTC) services. Field visits included observation of social and behavior change communication (SBCC) sessions with community men and women, including religious leaders and traditional doctors. Annex C lists the persons consulted. In addition, the consultant reviewed research reports; articles, and U.S. Government, GOKS, and project-related documents. Annex D lists references and other major sources used in preparation of the report. Annex E lists select resources on gender and related topics and gender-focused websites.

A session with U.S. Department of State staff in Swaziland resulted in the creation of a U.S. Government Swaziland gender goal, objective statements, and key elements of a proposed Department of State gender strategy (Annex B).



## II. GENDER ANALYSIS

### GENDER AND THE GOKS

The Constitution of Swaziland of 2005 guarantees women the right to equal treatment with men. The GOKS has endorsed the importance of gender equality in a number of policy documents. These instruments include, but are not limited to, the Convention on the Elimination of All Forms of Discrimination Against Women, eight core labor conventions of the International Labor Organization, the South African Development Community's Declaration on Gender and Development, its National Gender Policy, and its HIV/AIDS Policy.

One of the operating principles of the GOKS National Multisectoral HIV/AIDS Policy of 2006 is gender equality and equity. The elements in the policy related to this principle are as follows.

- The rights of women and girls to decide freely and responsibly on matters related to their sexuality, including sexual and reproductive health, shall be protected.
- Women and girls and other vulnerable groups shall be protected against gender-based violence, including domestic violence and sexual abuse, and including against traditional, cultural, and other practices that may negatively affect their health.

In the foreword to the Swaziland National Gender Policy of 2010, which aims to redress inequities between men and women, the Deputy Prime Minister noted that the GOKS recognizes the need to ensure the equitable and full participation of women and men at all levels of development.

The Gender Policy's four objectives are:

- To identify, conserve, and promote positive aspects of Swazi traditions and culture in order to promote equitable opportunities and rights for both males and females;
- To ensure equitable access by girls and boys, women and men, to education, training, and health services, and control over resources such as land and credit for improved quality of life;
- To ensure that gender-sensitive laws exist and are enforced; and
- To provide direction for the development of effective programs for the prevention of gender-based violence.

Three of the Policy's nine thematic program areas are directly related to the PEPFAR program in Swaziland. One thematic area is health, reproductive health and rights, and HIV/AIDS. Its objective is to promote, improve, and protect the sexual and reproductive health rights, and health status, of men, women, boys, and girls throughout their lives. Another area, the gender-based violence thematic program area, aims to take integrated measures to prevent and eliminate all forms of gender-based violence. A third area focuses on ensuring that women and girls have equitable opportunities with men in access to, and control over, resources such as credit, land, information, and services.

The Gender Policy and Multisectoral HIV and AIDS Policy acknowledge that gender issues create inequities that need to be addressed. The section below highlights the major disparities.

## COUNTRY CONTEXT AND GENDER DISPARITIES

### Select Demographic and Health Data

Swaziland is a landlocked kingdom with an estimated population of 1.185 million, with three-fourths of the population living in rural areas. The country is struggling to mitigate the world's most severe HIV epidemic. The Swaziland Demographic and Health Survey reported HIV prevalence among adults aged 15–49 to be 31% for women and 20% for men.<sup>3</sup> Women are infected at a much younger age than men: among 15–19-year-olds, 10.9% of women are infected compared to 1.9% of men. This pattern continues among 20–24 year-olds (38.4% of women and 12.4% of men) and 25–29 year-olds (49.2% of women and 27.8% of men). Differences in prevalence rates level off by age 30, with 45.2% of women and 43.7% of men in the 30–34 age group living with HIV. The majority (62%) of new infections occur in women.

The maternal mortality rate is estimated to be 589 deaths per 100,000 live births, and HIV is believed to be a major contributor. The total fertility rate is 3.74 children, with the rate in rural areas (4.64) exceeding that of urban areas (2.31). Life expectancy dropped from 60 in 1997 to 43 years in 2007.<sup>4</sup> It is estimated to have rebounded to 45.4 in 2011, thanks to scale-up of the national antiretroviral therapy (ART) program.<sup>5</sup>

Nearly 45% of the population is under 18 years of age and hence are classified as children. Only 22% of all children live with both parents. A little more than a third (36%) of children live with only their mother, and 6% live with only their father. A third of the children live with neither parent: the rate is higher in rural than urban areas, 36% and 20% respectively. Approximately 24% of the children are orphans, with one or both parents deceased. Overall, 45% of the children are defined as either orphaned or vulnerable children.<sup>6</sup>

### Economic Situation

With a gross domestic product of US\$3.65 billion, Swaziland is classified as a lower middle-income country. Swaziland's economy is based on agriculture, forestry, and mining, which account for about 13% of its gross domestic product (GDP); manufacturing (textiles and sugar-related processing) representing 37% of GDP; and services, particularly government services, constituting 50% of GDP. The majority of the population, however, is engaged in subsistence agriculture, off-set with income from microenterprises and remittances.<sup>7</sup>

Nearly two-thirds of the population (63%) are poor,<sup>8</sup> indicating that around 747,000 individuals are poor. Poverty exists primarily in rural areas—51% of the rural population, compared to 33% of urban residents. Households headed by women tend to be poorer than those headed by men:

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<sup>3</sup> SDHS 2007.

<sup>4</sup> *Id.*

<sup>5</sup> Swaziland U.S. Global Health Initiative Country Strategy. Mbabane, Swaziland: U.S. Embassy, January 2012.

<sup>6</sup> Central Statistical Office and UNICEF. *Swaziland Multiple Indicator Cluster Survey 2010: Final Report*. Mbabane, Swaziland: Central Statistical Office and UNICEF, 2011 [hereinafter CSO 2011]. Children are defined as OVC if (1) either parent is dead; (2) a parent is chronically ill; or (3) an adult (aged 18–59) in the household either died after being chronically ill or was chronically ill in the previous year of the survey. Swaziland Multiple Indicator Cluster Survey, 2010.

<sup>7</sup> World Bank. *Swaziland Country Brief*. April 2012.

<sup>8</sup> CSO 2011. A consumption measure was used to gauge the standard of living. The measure involved household expenditures on food and select non-food items.

two-thirds of the female-headed households, compared to 59% of the male-headed households, are poor.<sup>9</sup>

Food insufficiency, an indicator of poverty, has been linked to the risk of HIV. Research indicates that food insufficiency is associated both with women reporting intergenerational sexual relationships and a lack of control in sexual relationships.<sup>10</sup>

### **Governance, the Constitution, and the Legal Framework**

Swaziland is a monarchy, with the King as the ultimate authority. Swaziland's system of governance combines a blend of traditional and modern institutions. The dual system is enshrined in the Constitution of 2005.<sup>11</sup>

A strong traditional sphere of governance operates through chiefs. Chiefs are custodians of traditional law and custom, and are responsible for running their chiefdoms and maintaining law and order in rural areas. Traditional courts operating in rural areas tend to follow Swazi customary law. The modern judiciary operates separately from the traditional court system.

The Constitution includes provisions for the promotion and protection of human rights. It guarantees women the right to equal treatment with men, a right that “shall include equal opportunities in political, economic and social activities.”<sup>12</sup> However, the process of ensuring that women enjoy their constitutional rights has been slow. To date, several laws which pre-date the Constitution remain on the books, such as the Marriage Act and the Deeds Registry Act, which position women as legal minors. No new laws have been enacted further to delineate the rights of women enshrined in the Constitution.<sup>13</sup>

The Marriage Act of 1964 provides that for those married under civil rites, the marriage shall be governed by common law, subject to the marital power of the husband. Women cannot independently administer property, sign contracts, or conduct legal proceedings. When both parties are Swazis, the Act provides that the property rights of the spouses shall be governed by customary law. Under such law, women's access to communal land in rural areas is limited to user rights, with full land rights vested in men. The Deeds Registry Act of 1968, which applies to private land, does not allow women to own title deed to land.

Several new bills have been drafted. Two of these have been tabled in Parliament but not passed—the Sexual Offences and Domestic Violence Bill of 2009, and the Deeds Registry (Amendment) Bill, which would allow women married under civil law to legally register immovable property in their own name.

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<sup>9</sup> *Id.*

<sup>10</sup> MARPS Bio-Behavioral Surveillance Survey (BSS) Results: Men Who Have Sex with Men (MSM) and Sex Workers (SW). Mbabane, Swaziland: Stakeholders dissemination meeting, May 31, 2012 (PowerPoint presentation) [hereinafter MARPS 2012]. Weiser et al 2007 Blangenberg, David R., Lisa M. Butler, Michele Heisler, Zakhe Hlanze, Vincent Lacopino, and Karen Leiter. “Food Insufficiency is Associated with High-Risk Sexual Behavior Among Women in Botswana and Swaziland.” *PLoS Medicine*, 4(10):1589 (2007).

<sup>11</sup> Swaziland was without a Constitution for over 30 years.

<sup>12</sup> The Constitution does not prohibit discrimination on the grounds of marital status. Women's rights to equality in the cultural sphere are inadequately protected by the provision guaranteeing that “a woman shall not be compelled to undergo or uphold any custom to which she is in conscience opposed.” This formulation places the burden on the individual woman, whereas international human rights law stipulates that it is the responsibility of the state to prohibit and condemn all forms of harmful practices which negatively affect women. Amnesty International, September 2011.

<sup>13</sup> Doo, Alphane. “Gender Protocol Barometer Baseline Study: Swaziland.” Paper for the Southern Africa Gender Protocol Alliance. Undated. (Data collected in 2009).

## Health Services

The health system in Swaziland has three basic tiers: hospitals, health centers, and primary care centers (or clinics). Eighty percent of the population lives within eight kilometers of a facility that provides at least antenatal care (ANC), although access can be difficult for some rural communities due to the lack of public transport and persistent poverty.<sup>14</sup>

In addition to government facilities, private and non-profit health facilities exist. The Ministry of Health (MOH) has been successful in creating demand among women for PMTCT, HTC, ART, and maternity services. Women comprise nearly two-thirds of the users of the health facilities.

Beyond the modern health system, Swaziland is estimated to have over 5,000 traditional male and female healers.<sup>15</sup> Many Swazis rely on both traditional healers and modern health centers for care.<sup>16</sup> There are two basic types of traditional healers: the diviner healer and the herbalists. The diviners, using herbs and other traditional medicine, work with spirits who are said to help in diagnosis and treatment. The herbalists do not divine, but diagnose on the basis of physical or mental symptoms in order to determine the appropriate herbal medicines.<sup>17</sup> Nowadays both types of healers normally acknowledge that the modern health system can treat conditions, like HIV/AIDS, that they cannot.<sup>18</sup>

While not part of the traditional system, there are also Zionist faith healers who are associated with Zionist Christian sects. Zionist Christians are the largest religious group in Swaziland, accounting for about 40% of the population. Some of these healers are known to discourage their HIV-positive followers from taking pre-ARV and ARV medicines, instead advocating the power of prayer to address infection.

## GENDER NORMS AND BEHAVIORS

### Gender Roles

Gender norms are the roles, behaviors, and attributes that a society deems appropriate for men and women—hence, gender roles define masculinity and femininity. These norms are not static, may change through time, and, at the sub-group and individual levels in a society, may not be strictly adhered to. The sections above highlight the GOKS's efforts to change gender norms through its Constitution and its Gender and HIV/AIDS Policies.

Current gender norms in Swaziland are informed by a traditional Swazi social structure that was patriarchal, patrilocal, patrilineal, and polygamous. "Patriarchal" refers to male-dominated social structures in which male-centered norms are the standard. In Swazi patriarchal society, all members of a household were under the control of the senior man, who was the head. When sons married, their wives joined the husbands' household (patrilocal). Inheritance passed through sons, not daughters (patrilineal), and men could marry more than one wife

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<sup>14</sup> Physicians for Human Rights. *Epidemic of Inequality: Women's Rights and HIV/AIDS in Botswana and Swaziland: An Evidence-Based Report on the Effects of Gender Inequity, Stigma and Discrimination*. Cambridge, MA: Physicians for Human Rights, 2007.

<sup>15</sup> Gosh, Omar. Undated blog entry.

<sup>16</sup> Swaziland, National Multisectoral HIV and AIDS Strategic Plan 200 – 2008 and NERCHA Strategic Framework 2009-2014. full citations are in References Section.

<sup>17</sup> Green, Edward C. and Lydia Makhuba. "Traditional Healers in Swaziland: Toward Improved Cooperation Between the Traditional and Modern Health Sectors." *Social Science Medicine*, 18(12):1071–1079 (1984).

<sup>18</sup> Gosh, Omar. Undated blog entry.

(polygamous). Women were expected to be faithful in marriage relationships. These norms have been modified to varying degrees in response to economic realities, the education of girls, and exposure to globalization and technology, among other factors.

Under the customary land tenure system, men could obtain land rights on Swazi Customary Land. Although they did not own the land, they could pass on these rights to their sons and ask chiefs for more land. Wives could obtain use rights to parcels of land through their husbands, father-in-laws, or sons.

Women's roles included child-bearing, child-rearing, and producing food for the family. Men's roles centered on authority over and support of wives and children, economic activities, and involvement in community and "national" affairs. Children were socialized into performing their expected roles. These basic roles and responsibilities have been modified to some degree in relation to economic responsibilities, such as women engaging in non-agricultural activities to enable them to purchase food and provide for other family needs, to supplement their husbands' economic contributions.

In a traditional marriage, the groom's family pays bride wealth to the bride's family, normally in the form of cattle. Bride wealth symbolizes the transfer of the wife to the husband's family. As such, the wife will produce children for the husband's family. Bride wealth also cements social relations between the two families. Nowadays bride wealth in cattle has been officially limited to one cow, since cattle are expensive. When bride wealth has not been paid, however, the woman retains her rights to any children conceived.

The current practice of a married man having concurrent partners is often referred to in the literature as a "modification of polygamy." Under such an arrangement the man does not pay bride wealth. Sanction of men who fail to support children resulting from unions that involved the parents living together in semi-marriage are more severe than for failure to support children born from a casual relationship.<sup>19</sup>

A positive gender norm is the education of girls and boys. Nationally 97% of children aged 6–12 attend primary or secondary school. The net primary school attendance indicates gender parity, since there is only 1% difference between boys and girls.<sup>20</sup> National data from 2008 highlight that the pass rates for the primary school exam were the same among boys and girls, at 50%. That same year, O-level subject results indicate that boys accounted for slightly over half (52%) of those sitting for the exam.<sup>21</sup>

The high rate of school attendance is particularly notable given that free education has only been introduced in the last few years and on a graduated basis (it currently covers grades 1–4). Thus, the data reflect the high value placed on the formal education of both girls and boys.

Education of girls influences the age of marriage. Among women aged 15–24 at the time of the 2010 Swaziland Multiple Indicator Cluster Survey (SMICS), those with no education or with only primary schooling were much more likely than others to have married before age 18. The Swaziland Demographic and Health Survey (SDHS) in 2006–2007 found that among women aged

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<sup>19</sup> National Emergency Response Council on HIV and AIDS. *Swaziland Hearsay Ethnography Study: Final Draft Rreport*. Mbabane, Swaziland: 2011 [hereinafter NERCHA 2011].

<sup>20</sup> CSO 2011.

<sup>21</sup> Doo, Alphane. "Gender Protocol Barometer Baseline Study: Swaziland." Paper for the Southern Africa Gender Protocol Alliance. Undated. (Data collected in 2009).

45–49, 31% were married by age 20, compared with only 13% of those aged 20–24. The median age at marriage among women increased from 23.3 years among women aged 45–49 to 25.6 years among women aged 30–34.

## Sexual Relations

Swazi men, especially adult men, continue to regard themselves as the sole decision-makers about sexual matters.<sup>22</sup> This attitude contributes to men being highly sexual and having multiple partners. Eighteen different types of relationships were identified in a recent ethnographic study. Married persons may have one or more steady partners; similarly, a single person may have one or more steady partners. At the same time, people in these categories may have casual partners.<sup>23</sup>

Intergenerational sex is not uncommon and primarily occurs when young women are married to older men or engage in sexual relationships with older, wealthier men in exchange for financial or material support or gifts. In the SMICS, 14% of women aged 15–24 years had had sex with a man at least 10 years older. Among the married women, 22% of the women aged 20–24, and 31% of the women aged 15–19, had spouses at least 10 years older.

The data for all women aged 15–24, and for married women aged 20–24, indicate that women in the highest wealth quintiles are somewhat more likely to engage in intergenerational sex compared with those in the lower wealth quintiles. This might be interpreted as showing that wealth is acquired or enhanced through intergenerational sex.<sup>24</sup> Although it is practiced, however, intergenerational sex evokes critical comment and disapproval.<sup>25</sup>

The benefits of condom use both as a contraceptive and to protect against the spread of HIV are widely known. Nevertheless, among married women aged 15–49, only 23% report use of a condom as a contraceptive method.<sup>26</sup> The data suggest that the married women who do not report condom use are at risk of HIV if their husbands have other partners.

Sex with multiple partners is more common among men than among women. In the SMICS, 15% of men aged 15–59 had sex with more than one partner in the last 12 months, whereas only 3% of women in the same age range did so. Of those who had sex with more than one partner, 69% of men and 73% of women reported having used a condom during their last intercourse. A study in Shiselweni region sheds light on those who had unprotected sex: women and men who felt that men should control decisions in sexual relationships were nearly twice as likely to have unprotected sex with a non-primary partner than those who did not.<sup>27</sup>

The SMICS data indicate that the age category of 25–29, compared with other categories, shows the highest number of men and women having sex with more than one partner. Among those aged 25–29, 29% of the men and 4% of the women report having had sex with more than one

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<sup>22</sup> Ziyane, Isabella and Valerie J. Ehlers. "Swazi Men's Contraceptive Knowledge, Attitudes, and Practices." *Journal of Transcultural Nursing*, 18(1):5–11 (2007). Burtscher, Doris and Velibanti Dlamini. "You See It, You Know It, But You Don't Say It: Community Based Perception of HIV and AIDS Counseling and ARV Treatment, Shiselweni region, Swaziland." Paper prepared for Médecins Sans Frontières. 2011.

<sup>23</sup> NERCHA 2011.

<sup>24</sup> Intergenerational sex was found to be negligible for men aged 15–24.

<sup>25</sup> NERCHA 2011.

<sup>26</sup> CSO 2011.

<sup>27</sup> Burtscher and Dlamini 2011.

partner during the last 12 months. Among those with more than one partner, 75% of the men and 70% of the women reported having used a condom during their last intercourse.

The 2012 study on men who have sex with men (MSM) and female sex workers (FSWs) documents the heightened vulnerability of these groups to HIV infection. At the time of the survey, nearly half of the FSWs in the past month had had sex with five or more new clients; nearly two-thirds had had sex with five or more regular clients; and nearly all had had sex with a non-client. Almost three-quarters of the women reported that in the past month they always used condoms with new clients (74%), while nearly half reported that they always used condoms during the past month with regular clients. Slightly over half of the respondents reported a breakage or slippage of a condom during this period.<sup>28</sup>

In comparison, among the MSM in the most-at-risk population (MARPS) survey, approximately two-thirds of these men had had more than one partner in the past year. Half of the MSM reported that they used a condom with their regular partner. The study, which included seroprevalence testing, found that 70% of the FSWs and 17% of the MSM interviewed were HIV-positive.

### **Gender-Based Violence and Coercion**

There is a high rate of gender-based violence in Swaziland, which is linked to gender norms. It occurs within marriages, with both casual and permanent partners, and toward children.

Nearly 40% of the men and a third of the women respondents in the SMICS believe that there are circumstances under which a man is justified in beating his wife/partner. The most common justification provided was if the wife/partner has sex with another man, and the second most common justification was if she argues with her husband/partner. Interestingly, younger men and women were more likely than older ones to believe that certain circumstances justify a man beating his wife/partner. This pattern was also found in the SDHS. The data underscore the fact that socialization of children perpetuates the norm of male dominance in intimate social relations with women.

Perpetuation of the male dominance norm is further demonstrated in a qualitative study of urban men aged 18–29,<sup>29</sup> which reveals how intimate partner violence (IPV) is widespread and socially accepted. Types of sexual abuse include coercing women to have sex; coercing women to have sex without a condom; infecting female partners with HIV intentionally or through neglect; and intentional impregnation.<sup>30</sup>

Emotional and psychological abuse includes threats of abandonment and violence. Economic coercion involves using money to control women and/or using money to coerce them to have sex or have sex without a condom. Study respondents perceived female behavior that threatens men's control—such as a wife questioning her husband's authority—as a strong predictor of IPV. Many young men in the study noted that Swazi men traditionally had the right to demand sex from their wives.

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<sup>28</sup> MARPS 2012.

<sup>29</sup> The study was conducted among 45 men who had been medically circumcised in Masaptha. Shannon et al (2012) and Physicians for Human Rights (2007) also document the relationship between gender inequity norms and male perpetrated rape.

<sup>30</sup> Brear, Michelle and Dawn Bessarab. "Perspectives on Intimate Partner Violence in Swaziland Amongst 18–29-Year-Old Men Undergoing Medical Circumcision." *Culture, Health and Sexuality*, 14(1):31–43 (2012)

As regards sex as a right in boyfriend-girlfriend relationships, youth in the study stated that unmarried men need to secure their sexual partners through presents or giving money. A woman who accepts gifts when not in love or intending to have sex was regarded as forcing her partners to be violent. Respondents' remarks also suggest that peer pressure may encourage a man to use violence to prove that he is in control.<sup>31</sup>

The 2012 MARPS study, by the MOH and PEPFAR- supported Research to Prevention Project, JHBS (MARPS 2012) highlights GBV against FSWs and MSM. Nearly all of the FSWs (95%) had been raped beginning at age 18, and 37% of them had been raped three or more times. Perpetrators tended to be one-time clients (32%) and family members (21%). As a result of their occupation, more than half of the FSWs reported having been refused police protection, having been tortured, and having been subject to verbal and physical harassment. MSM reported discrimination and violence from a wide range of individuals—partners, families, the general public, and police during raids.

A national study on violence against children and young women (aged 13–24) documents the prevalence of GBV, the types of perpetrators, and associated risk factors.<sup>32</sup> Approximately one in three girls experienced some form of sexual violence; nearly one in four experienced physical violence; and approximately three in 10 girls experienced emotional abuse as a child.<sup>33</sup>

Sexual violence toward children is common. Prior to age 18, the prevalence of sexual violence was 38% among those aged 18–24 at the time of the survey and 28% among those aged 13–17. This includes coerced intercourse, unwanted intercourse, and rape. Among those who reported at least one incident of sexual violence prior to age 18, nearly a third had experienced three or more incidents in their lifetime.<sup>34</sup>

The incidents of sexual violence that occurred prior to age 18 were primarily perpetrated by a husband or boyfriend (36%), a man/boy from the victim's neighborhood (27%), or a male relative other than a father, stepfather, or husband (16%). Among incidents of sexual violence at ages 18–24, slightly more than half of perpetrators were husbands or boyfriends.

The following were found to be significant risk factors associated with childhood sexual abuse reported in the violence study:

- Not having a close relationship or no relationship with a biological mother, compared to those with a close relationship with mother;
- Having lived with a large number of people at any one time as a child;
- Having lived with three or more families as children, compared to those who had only lived with one family;
- Not attending school at the time of the survey;
- Having experienced physical or emotional abuse by an adult before the age of 13; and

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<sup>31</sup> *Id.*

<sup>32</sup> UNICEF. *A National Study on Violence Against Children and Young Women in Swaziland*. Mbabane, Swaziland: UNICEF, 2007 [hereinafter UNICEF 2007].

<sup>33</sup> "Child" is defined as an individual less than 18 years old.

<sup>34</sup> *Id.*

- Knowing of another child who had been sexually assaulted.<sup>35</sup>

Some study participants may not have been attending school at the time of the study because of having experienced sexual violence. The analysis of the data from the violence study also revealed that girls living in an urban environment were significantly more likely than their rural counterparts to report experiencing sexual violence before the age of 18.

### **Attitudes and Health-Seeking Behaviors**

Approximately two-thirds of health facility clients in Swaziland are women. Women normally (80%) give birth in a health facility. Ninety-seven percent of the women who were pregnant in the two years preceding the SMICS received antenatal care (ANC) at an antenatal clinic. Among those in the SMICS who received ANC services, 88% were offered an HIV test, were tested, and received their results. Most women (seven in 10) made the required four or more ANC visits to the clinic.

HIV testing and counseling is provided in health facilities and through outreach services. Data on the general population of 15–49-year-olds show a relatively low uptake of HIV testing: 36% of women and 17% of men reported having been tested and receiving test results at some time. One in five women (22%) and one in 10 men (9%) were tested and received their results in the 12 months preceding the SMICS. Studies suggest that the relatively low rate of testing among men is linked to their attitudes and fears of HIV, stigma, and discrimination.<sup>36</sup>

Among young women and young men aged 15–24 who had had sexual intercourse in the 12 months prior to the SMICS, the percentage who reported having had an HIV test in the past 12 months and receiving the test results was much higher among the women. Young women were about four times as likely as young men to have been tested for HIV (28% and 7%, respectively). While there were no substantial differences in HIV testing levels when the researchers examined most background characteristics, older youth and those who had been married were more likely than other youth to have been tested for HIV.

FSWs and MSM are an underserved population. Stigma and discrimination discourage them from seeking services at health facilities.<sup>37</sup> Furthermore, targeted HIV prevention, care, and treatment services for these high-risk groups are sparse. HIV-positive MSM mentioned challenges in ART adherence—stigma and discrimination within their families, and sometimes being too poor and hungry to get to a clinic.<sup>38</sup>

In general, men prefer to seek services from traditional healers than modern medical facilities. Men cite a number of reasons for this, saying that modern facilities are only for women, they lack toilets for men, and they are too crowded. Some men claim that modern health facilities are only interested in their sexual health, whereas traditional healers take a more holistic approach (personal interviews).

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<sup>35</sup> Breiding 2011.

<sup>36</sup> Burtscher and Dlamini 2011; Physicians for Human Rights 2007.

<sup>37</sup> One of the PEPFAR implementing partners, the Family Life Association of Swaziland (FLAS), was noted by FSWs as one of the few exceptions. FLAS clinics were known to be FSW-friendly.

<sup>38</sup> MARPS 2012.

Traditional diviner-healers and herbalists normally acknowledge that they are unable to treat HIV and refer clients to modern health facilities. However, since a healthy-looking person may be HIV-positive, it is often only when physical symptoms arise that such an individual will be referred to health facilities for testing, care, and treatment.

### **III. REVIEW OF GENDER AND PEPFAR INTERAGENCY PORTFOLIO**

#### **INTRODUCTION**

The PEPFAR portfolio covers all four regions of Swaziland. Programs are managed by an interagency office comprising USAID, the U.S. Centers for Disease Control and Prevention (CDC), the U.S. Department of State, and the U.S. Department of Defense. The Peace Corps is part of the Interagency PEPFAR Team, but the program is based in another location. The PEPFAR program is overseen by the U.S. Ambassador.

In recent years, major action has been taken to better integrate gender into the PEPFAR portfolio. As noted previously, the 2010 Partnership Framework and the 2012 Swaziland GHI Country Strategy include attention to gender. In September 2010, a U.S. Government gender expert provided technical assistance as part of the preparation process for applying for funds from PEPFAR's Gender Challenge Fund. The funds secured have supported gender-integrated SBCC, OVC, and economic strengthening activities.

In late 2011, all partners were trained to mainstream gender into project implementation and monitoring, and in making organizational self-assessments on the issue of gender. Those trained were then able to train their sub-partners to conduct the self-assessments. Good progress has been made by certain partners.

The new Peace Corps Swaziland strategy of May 2012 is aimed at the following: (a) Swazi youth are empowered to lead healthy and productive lives; and (b) Swazi people lead long and healthy lives. The youth program centers on healthy lifestyles, preparation of youth for the world of work, and literacy. Its community health program focuses on HIV prevention and mitigation, improvements in household and community health, and promotion of healthy lifestyles. Girls' education and empowerment cuts across the Peace Corps youth development program. The new strategy carries over some ongoing activities related to gender.

The sub-sections below highlight the attention currently given to gender within the PEPFAR program in Swaziland.

#### **PREVENTION OF HIV**

Prevention interventions are based on HTC, access to condoms, PMTCT, voluntary medical male circumcision (MMC), social and behavior change communication (SBCC), particularly related to gender norms and gender-based violence; and opportunities for increased incomes for women. The Gender Analysis underscores the importance of these areas of intervention since women and girls in Swaziland are at heightened risk of HIV infection. As implied in the Analysis section, gender equity in the use of health services means increasing men's and male youth's use of modern health facilities and services.

To make HTC more accessible to men, PEPFAR supports outreach services accessible to both men and women. These services are provided at community events, dip tanks (areas where men bring cattle to be fumigated), medical outreach camps, targeted HTC campaign events, the workplace, and other locations. Campaigns have targeted the most-at-risk individuals, as well as couples. The latter effort was dubbed the "love campaign," and in one month 194 couples were

tested in 12 sites throughout the country. There is also a small initiative that focuses on home-based HTC, in which both men and women provide HTC services, and their clients are offered free male and female condoms.

The DOD PEPFAR program supports the Umbutfo Swaziland Defense Forces (USDF) peer educators and a drama troupe that promote HTC as well as other positive behaviors. Some peer educators accompany individuals for HTC, which is provided at military clinics. Peer educators are given tools for one-on-one and small-group discussions. The USDF plans to update communication materials to promote couples counseling and testing, as well as other experienced-based best practices.

To eradicate pediatric AIDS, PEPFAR supports PMTCT, as well as care and treatment of HIV-infected women, in 103 health facilities across Swaziland. Men are encouraged to accompany their partners to ANC, which facilitates couples HTC and reduces the risk of GBV when women test positive for HIV. To promote behavior change, PEPFAR's partners conduct large, structured community outreach dialogues. In one instance, religious leaders and traditional healers were also targeted in order to increase their understanding of the progression of HIV infection and the need for diagnosis and treatment at health facilities. In the nine military clinics in the USDF network, the military intends to increase access to PMTCT services and provide a package of PMTCT, along with building capacity to implement these services.

Since traditionally Swazi men are not circumcised, PEPFAR supports a major effort promoting voluntary medical male circumcision (MMC) inside and outside the GOKS health system, including military clinics. Existing clinics of a PEPFAR-supported NGO provide MMC, and another implementing partner has established a small network of clinics to provide MMC, along with information and education communication outreach to communities and schools. Interview findings suggest that among those circumcised, some schoolboys regard MMC as a new sign of masculinity. Among men mainly aged 25–35, some come to be circumcised because they have been encouraged to do so by their wife or partner.

Since 2008, 36,453 Swazi males have been circumcised, including 11,170 MMCs during the accelerated saturation initiative launched in February 2011. Approximately 20% of the target population has thus been reached. Fear of pain, lack of information, and myths concerning MMC are the main barriers to demand for services.<sup>39</sup>

The PEPFAR portfolio also includes social and behavioral change communication on gender norms and GBV. SBCC is done through various means, such as community dialogues, mentoring, and psychosocial support clubs. The new Peace Corps rural youth program engages young men in discussions to define new norms on manhood and promotes debate on sexual coercion and GBV.

Under an umbrella grant mechanism, several indigenous NGOs, community-based organizations, and faith-based organizations are engaged in SBCC in rural areas. The age and sex composition of the target audience varies, and so the SBCC approach is adjusted accordingly, which is an evidence-based best practice.<sup>40</sup> For example, a traditional women's regiment, headed by the Queen Mother as patron, is actively engaged in addressing male norms and behaviors and GBV.

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<sup>39</sup> Swaziland COP Review 2012.

<sup>40</sup> Institute for Medicine. *Assessing Health Communication Strategies for Diverse Populations*. National Academies of Press. 2002.

Its SBCC activities engage men and women, including youth, to take part in a set of facilitated dialogues, with each dialogue devoted to one or two key topics. Participants are asked to comment on what should be done to address these topics. Another example is the inclusion of SBCC into the WORTH sub-project, which teaches women business skills and facilitates self-directed savings and loan groups among women. After a group's S&L operations have been established, SBCC sessions are incorporated on a regular basis into the group's normal meetings. Another partner is active in conducting SBCC on gender issues with women workers in textile firms, and tailors its communication to the women's needs and context.

Activities to improve women's economic status focus both on preventing HIV and on mitigating its impact. These are discussed below under the Impact Mitigation section.

## **HIV CARE, TREATMENT, AND SUPPORT**

The PEPFAR portfolio supports the decentralization of care and treatment services by the GOKS and the development of human and institutional capacity. This work includes systematizing services, so that, for example, tuberculosis (TB) patients would be tested for HIV, HIV-infected persons would be tested for TB, TB centers would offer fully integrated TB/ART services, and family planning would be integrated into routine HIV services. PEPFAR also supports strengthening pre-ART and ART systems. Because more women than men are HIV-positive, and more women than men use health facilities, these interventions would primarily benefit women's health.

PEPFAR has provided technical assistance for the implementation of post-exposure prophylaxis (PEP) services for survivors of GBV, as well as medical personnel. PEP services are a critical element in the system to treat survivors of sexual violence.

In addition, PEPFAR has also supported the bio-behavioral surveillance survey conducted among MSM and FSWs. The resulting report includes recommendations for the MOH to implement in order to fulfill its responsibility that all Swazis have access to HIV prevention, care, and treatment services that are tailored to their needs.

In 60 facilities across all four regions, an NGO offers support for HIV-positive pregnant women and new mothers. Following a peer education model, the NGO trains HIV-positive mothers, who benefited from PMTCT services, to become "Mentor Mothers." These mothers provide psychosocial services through facility-based counseling and support groups which they form. Initially these groups were formed among HIV-positive women attending ANC but has since expanded to include men's groups, composed of HIV-infected and affected men linked to PMTCT clients.

## **HIV MITIGATION WITH A FOCUS ON CHILDREN**

The PEPFAR Swaziland portfolio on impact mitigation with a focus on children includes support for economic strengthening and OVC activities, and child protection advocacy, systems strengthening, and service delivery. Services for children include access to education, psychosocial support, food and nutrition, health, and protection. The PEPFAR program also focuses on mitigation of the impact of HIV on households.

Since women are the primary caretakers of OVC and family members who are HIV-positive, PEPFAR supports economic activities to increase caretakers' finances. A sub-grant to Save the

Children enables women caretakers to form self-directed savings and loan groups and improve their business skills. An evidence-based best practice is used in operating these S&L groups.

In addition, the newly launched Community-Based Livelihood Development for Women and Children (C-BLD) project works to improve the livelihoods of vulnerable households by linking them with specific commercial value chains, taking into account constraints on women's time and access to land. The project also helps women establish household-level permaculture gardens and provides access to training in financial literacy.

Through an umbrella grant mechanism, the PEPFAR portfolio includes a small integrated program, the Bantwana School Integrated Program, which works to improve the well-being of OVC and their households. The integrated program includes community mobilization and capacity-strengthening, and physical and emotional development of OVC, taking into account gender differences.

Because the abuse of and sexual violence against children is a major problem, PEPFAR bolsters efforts to address these issues by improving community support and coordination of Child Protection Committees (known as *Lihlombe Lekukhaela* or Shoulders to Cry On). Such work involves increasing the reporting of child abuse cases (victims are typically girls) and strengthening the capacity of these committees and their associated trained Child Protectors. PEPFAR has also funded legal aid services and supports strengthening of the Social Welfare Department.

The CDC provided technical direction to the National Study of Violence Against Children and Young Women in Swaziland, which was implemented by UNICEF.<sup>41</sup> The results of the study were instrumental in helping pass a new Child Protection Act in Swaziland in May 2012.

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<sup>41</sup> UNICEF 2007.

## IV. RECOMMENDED PEPFAR GENDER STRATEGY

### INTRODUCTION

The Recommended Gender Strategy for PEPFAR Swaziland has two parts: the first covers interventions under PEPFAR’s five strategy elements, and the second covers program operations, which cut across the five strategy elements.

#### Mission Gender Goal

- Men and women contribute as equals to a healthy, stable, and prosperous society in Swaziland.

#### Mission Gender Objectives

- Greater gender equity under the law, in governance, the economy, and civil society.
- Reduced vulnerability of women and men, girls and boys to HIV infection and its consequences.

The PEPFAR Swaziland Gender Strategy is intended to be implemented within the framework of the proposed U.S. Government Swaziland Mission Gender Goal and Objectives (See Annex F.) In particular, the Strategy aims to achieve the following objective: *Reduced vulnerability of women and men, girls and boys to HIV infection and its consequences.*

The Recommended PEPFAR Gender Strategy includes continuing gender-focused activities, strengthening and/or expanding ongoing activities, and adding new interventions. The proposed timeframe is four to five years, taking into account that the Strategy may need to be modified or updated due to unforeseen changes in the environment.

### RECOMMENDED GENDER STRATEGY

*“Knowing is not enough; we must apply.  
Willing is not enough; we must do.”*

—Goethe

#### Increase Gender Equity in HIV/AIDS Programs and Services

PEPFAR should strive to ensure gender equity in its prevention, care, and treatment services, as well as in its activities focused on impact mitigation and children. The following recommendations for improving equity take into account gender norms and barriers that contribute to the HIV/AIDS epidemic in Swaziland and the current PEPFAR programs and services that address these norms and barriers.

Continue to use a three-pronged approach to ensure gender equity in prevention, care, treatment, and support services, as well in HIV mitigation in child programming and services. A three-pronged approach involves: (1) services dedicated to addressing women and girls; (2) services dedicated to increasing participation by men and improving their attitudes and behaviors; and (3) integration of gender equity issues into all programs and projects.

Continue to promote and provide access to male and female condoms, and expand men's and women's access to HTC services in order to prevent the spread of HIV. Male condoms are decidedly more in demand than female condoms. Female condoms have a very low use rate, but certain segments of the female population do use them, and they should thus be readily accessible.

Outreach services could be expanded to include more mobile teams in select rural areas and home-based HTC, if the results from the current initiative justify expansion. A major advantage of home-based HTC is that it reduces the risk of GBV when both partners consent and are tested. Home-based HTC also increases the likelihood that extended family members within the community are counseled and tested, reducing the risk of stigma and abuse.

To encourage greater receptivity to HTC and HIV treatment, especially among men and male youth, PEPFAR projects should strengthen efforts in the regions to invite traditional healers to specifically designed informational sessions on HIV, its progression, and pre-ART and ART that include an open discussion period. The aim would be to encourage healers to refer clients, especially those who have sex with more than one person, to be tested for HIV, stressing that a healthy-looking person can have the virus and that periodic re-testing among those who practice unsafe sex is important. These sessions should also urge traditional healers to encourage their clients to adhere to treatment regimes.<sup>42</sup> PEPFAR might consider ways to assess the outcomes of such efforts in order to provide potential evidence for scaling them up to the national level.

Enhance and scale up educational outreach on medical male circumcision, and continue to encourage women to discuss male circumcision with partners and sons. MMC decreases the risk of HIV infection in heterosexual men by over 60%. The prophylactic effect takes six weeks after the procedure to develop, so men should abstain from sex during this period. MMC does not directly decrease women's risk of HIV infection, although women receive many indirect benefits. A blend of messages that promote both the benefits of MMC and the benefits of educating women and men about the procedure should be strengthened and scaled up.

Evidence suggests that greater uptake of MMC might be achieved by reaching school boys aged 13 and above. The Swaziland national program has achieved the most success with this age group. An operations research could be conducted using select circumcised students as peer educators about MMC. This would result in deeper MMC coverage within the schools that are already reached by outreach workers during periodic school-based campaigns. The operations research could include competitions between schools, and involve the principals or head teachers holding educational sessions, possibly led by a nurse or outreach worker, for parents or guardians.

In addition, evidence suggests that women tend to be influential in their partners' decision to be circumcised. MMC education efforts should thus be redoubled to reach women as well as men. This could be done both through the current project activities that cover MMC and through appropriate information, education and communication (IEC) materials for use by facilitators and group leaders involved in SBCC on gender norms and GBV.

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<sup>42</sup> For such an approach to be successful, the skills and role of traditional healers must be acknowledged. These healers may also play an important role in addressing fears and promoting positive living among those who are HIV-positive.

Continue to support increasing the number of support groups for women and men living with HIV/AIDS, and strengthen the groups' capacities to provide vital services, and their linkages with health facilities. There are relatively few support groups for persons living with HIV/AIDS given the proportion of the population infected with HIV. The majority of those living with HIV are women, who risk stigma and discrimination as a result of their status. Stigma and discrimination is also a problem for HIV-positive men.

The capacity of the front-line workers who form and work with support groups for pregnant women living with HIV should be strengthened. These volunteers need to have the skills and confidence required to provide psychosocial counseling (which includes a focus on reducing self-stigma), promote prevention of unintended pregnancies and of the spread of HIV, and reinforce positive attitudes and behaviors.

PEPFAR should also consider providing similar services for groups of people living with HIV who are not associated with PMTCT. For example, the program should consider supporting the formation of support groups among FSWs.

Through PEPFAR advocacy and actions, the strengthening of two-way linkages between health facilities and support groups for HIV-positive individuals should include permitting a selected member of each group to obtain the ARVs for all members at the same time. Such an innovative approach would lessen the time and money that individuals have to spend returning to health facilities for medication. This approach or a similar one could be carried out within the framework of operations research to determine its acceptability and effectiveness.

### **Reduce Gender-Based Violence and Coercion**

As discussed in the GBV portion of the Gender Analysis, GBV is a major issue in Swaziland. Nearly 40% of women aged 18–24 report having been subjected to sexual violence prior to age 18. Gender norms are linked to violence against women and girls, which places them at great risk of HIV infection.

Another form of gender-based violence, which has not been adequately documented, occurs when a wife, girlfriend, partner, or daughter-in-law is found to be HIV-positive. Women's fear of verbal and physical abuse can lead them to fail to disclose their HIV status and continue having unsafe sex. The PEPFAR program has been addressing the reduction of GBV and coercion, and some aspects should be improved and strengthened.

***Strengthen the systems that protect children, improve the handling of cases of physical violence and rape, and monitor cases through the system.*** While some components of the child protection system are well-established in some parts of the country, individual components need to be strengthened and harmonized, and linkages between the components need to be established so that the system becomes more effective overall. The strengthened system should include, but is not limited to, protecting children from physical violence, rape, and coercion; reporting cases to select individuals within the community and/or the police; making sure that survivors of rape and sexual coercion have timely access to hospitals or designated centers with medical personnel trained to handle such cases and conduct DNA tests to standards within at least three days, so that PEP is effective; providing counseling services to standards; and monitoring cases as they progress through the system, using a method that prevents double-counting the recording of such cases.

Continue supporting the expansion of SBCC targeted to both male and female youth and adults regarding GBV and sexual coercion, and improve the quality of the communication sessions. Current PEPFAR support for SBCC on GBV involves a number of implementers who employ varying approaches based on their target audiences and desired outcomes. Generally the desired outcomes are a combination of changes in social acceptance of GBV and changes in individual behaviors. The weakness in this system is that the communication approach leaves out an important factor related to changes in individual attitudes and behavior—self-efficacy, which refers to a person’s perception that he or she can perform the behavior under challenging circumstances.

The quality of the sessions should be enhanced by using methods, including role-playing and sharing of experiences and testimonies, that help participants to feel more empowered to take steps to act as individuals. Initiating communication with a partner about safe sex and ways to handle unwanted sexual advances are examples of topics in which the use of techniques such as role-playing and sharing of positive experiences can build self-confidence. Provision of a set of modules, based on a behavior change communication (BCC) theory and evidence-based techniques, on key topics and training of facilitators in their use, are strongly recommended.

***Continue to advocate for and take action to reduce GBV, incorporating this as part of a broader focus on reducing stigma and discrimination of women with HIV/AIDS.*** The risk of GBV is reduced when couples receive counseling for HTC and PMTCT. Hence, encouraging couple counseling, especially among married couples and those in stable unions, should continue to be promoted.

Most behavior change theories suggest three critical determinants of a person’s intentions and behaviors:

(1) the person’s attitude toward performing the behavior, which is based on one’s beliefs about the positive and negative consequences (i.e., costs and benefits) of performing that behavior; (2) perceived norms, which include the perception that those with whom the individual interacts most closely support the person’s adoption of the behavior and that others in the community are performing the behavior; and (3) self-efficacy, which involves the person’s perception that he or she can perform the behavior under a variety of challenging circumstances.

*Excerpt from Institute of Medicine 2001*

PEPFAR should consider supporting targeted BCC<sup>43</sup> efforts to address stigma and discrimination against people with HIV, in order to reduce the real risk of verbal and physical abuse of women by immediate and extended family members. These efforts could be merged into the programs for ongoing SBCC activities, with the appropriate facilitator guides, tools, and training.

### **Address Gender Norms and Behaviors**

As highlighted in the Gender Analysis section, gender norms influence practices and behaviors that increase sexual risks for HIV infection. Furthermore, children are being socialized in these negative gender norms.

***Continue to support expansion of community outreach SBCC sessions on gender norms and practices that increase women’s and girls’ vulnerability to HIV, and strengthen the quality of the SBCC sessions. This recommendation is similar to the one above on SBCC***

<sup>43</sup> Behavior change communication is slightly different from social change communication since the former stresses individual change.

**regarding GBV.** The communication approaches used to change individual behaviors should focus attention on self-efficacy, which will help participants feel more empowered to take steps to act as individuals. Techniques for building self-efficacy, such as testimonies from respected role models and role-playing, ought to be integrated into SBCC sessions. It is strongly recommended that a set of modules, based on SBCC theory and evidence-based effective techniques, on key topics should be used, and facilitators should be trained in their use.

### **Increase Women's Legal Protection**

As highlighted in the Gender Analysis section, progress needs to be made in improving the legal protection of women. Their current status hinders them from realizing their constitutional rights and full potential.

**Support advocacy to improve the legal status of women.** Both directly and through civil society organizations, PEPFAR should continue to support advocacy to improve the legal status of women.

**Consider supporting elements in GOKS plans that (a) implement changes in laws that improve women's legal status; (b) increase men's and women's awareness of such changes; and (c) monitor implementation of this legislation.** When important legal changes have been made, PEPFAR Swaziland should work in cooperation with other donors and agencies to facilitate implementation and monitoring of these changes. The program should also support communication initiatives aimed at a broad-based understanding of the implications of such changes among key entities and the population.

### **Increase Women's Access to Income and Productive Resources**

Providing vulnerable women and girls with economic opportunities helps them to avoid high-risk behaviors, seek and receive health care services, and provide better care for their families. Poverty disproportionately affects women-headed households. Access to income and productive resources also help women and their households to mitigate the impact of HIV/AIDS.

**Continue to provide women and female youth, especially caretakers and child protection workers, with access to business skills and to self-directed savings and lending (S&L) groups, which integrate discussions on gender norms and behaviors and GBV. The S&L model currently being applied has been shown to be successful and has potential for sustainability.** Use of the model should continue to be supported so that more women and female youth will have access. It should be noted that participation of young unmarried women in S&L groups is still unusual in Swaziland, and strategies to reach this especially vulnerable population should be explored.

**Provide vulnerable households with access to financial literacy and income-generating activities, and link women and female youth to commercial value chains whose gender implications were taken into account when selected.** The selection of commercial value chains based on those most likely to be suitable for women and female youth, given their lack of control over land and demands on their time, demonstrates how a gender-focused approach can be used to increase women's income. For women who are unable to bear the financial risks of involvement in a commercial value chain, financial literacy and less risky income-generating opportunities remain helpful opportunities.

## OPERATIONS GENDER STRATEGY

The Operations Gender Strategy contains elements that crosscut and enhance the Program Gender Strategy, as well as strategic actions for the operation of the PEPFAR program in Swaziland.

### ***Strengthen the capacity of women and adolescent girls, and implementation partners.***

Strengthening human and institutional capacity is an element of PEPFAR and GHI policies and guidelines. The PEPFAR Swaziland team should give greater attention to strengthening the capacity of women within key institutions—such as hospitals, police forces, and the military—to enhance their potential to become leaders. In addition, the institutional capacity of implementing partners should be enhanced through gender mainstreaming at the organizational and program levels. While all partners received training in late 2011, more progress needs to be made on carrying out actions within the institutions/organizations. PEPFAR should consider allocating resources for expert gender services from an existing partner or consultant to advance this process.

Greater attention should be paid to adolescent girls across all five elements discussed in the Gender Program section, given the heightened vulnerability of these girls to HIV infection and abuse. Youth programming normally benefits older young people, and girls attending these programs are often put at greater risk of GBV.<sup>44</sup> Hence, PEPFAR should consider seeking additional funds for launching a safe-spaces approach to include schools and community locations. This approach should include BCC on HIV prevention, self-protection plans, knowledge of how to access health services, knowledge of community resources to manage and mitigate crises (e.g., forced marriage, rape, violence), and financial literacy and savings.

***Address gender more fully in future agreements with the GOKS or parts of the GOKS centered on HIV/AIDS, and support key national-level partners to implement elements of the National Gender Policy.*** Future agreements related to the PEPFAR program, whether at the highest levels of government or with specific agencies of the U.S. Government and the GOKS, should more fully address gender. Agreements should be in line with the U.S. State Department's and GHI's directive on women and girls, and USAID and PEPFAR gender policies, as well as the GOKS's National Gender Policy, HIV/AIDS Policy, the Constitution, and international agreements.

PEPFAR should also continue to support key national-level partners to implement the National Gender Policy in the thematic areas of (a) health, reproductive health and rights, and HIV/AIDS; and (b) gender-based violence.

***Continue to encourage cooperation between PEPFAR implementing programs and projects.*** Cooperation between programs currently occurs to some extent. For example, the Peace Corps has assigned some third-year volunteers to other U.S. Government agency-funded partners. The military's musical and skit group, which focuses on HIV and related themes and includes people living with HIV, participated recently in a large outreach event implemented by the Eliminating Pediatric AIDS in Swaziland project. A different partner provided technical support to the Combination Prevention Program during its gender mainstreaming training earlier in the year. Provision of HTC at SBCC community events, with partners playing complementary roles, is another example of cooperation.

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<sup>44</sup> Bruce, Judith, Miriam Temin, and Kelly Hallman. "Evidence-Based Approaches to Protecting Adolescent Girls at Risk of HIV." AIDSTAR-One Spotlight on Gender Paper. March 2012.

Despite these examples of collaboration between PEPFAR partners, there have been some missed opportunities, related particularly to the use of champions or positive role models. In the process of implementation of many partner activities, individuals emerge who are strong role models of positive behaviors, including those able to deliver strong, personal messages related to HTC, GBV, MMC, and stigma and discrimination. Implementers should be encouraged to identify persons willing to give testimonies at SBCC sessions and use these individuals within their activities. Since testimonies are an effective way to influence positive attitudes and self-efficacy, partners should also be encouraged to link these role models to other implementers with similar activities.

**Strengthen and expand monitoring, evaluation, and research centered on elements of the Gender Program Strategy.** All PEPFAR agencies should be required to review their programs and projects in light of the Program Gender Strategy and make adjustments to their monitoring and reporting directives to implementing partners. One place to start is monitoring and reporting sex-disaggregated data on training and other capacity-building actions based on their workers/volunteers/counterparts who interact with the target group/clients. The review should include reporting disaggregated data on male and female condoms distributed.

PEPFAR team members should propose (a) priority topics for research or special studies to provide evidence of the extent of progress toward addressing major gender issues; and (b) operations research to shape identification of feasible approaches to addressing specific gender issues. All future strategic information work should address gender dimensions.

Given USAID directives on performance evaluations, which include building into project designs measures for collection of baseline and endline data, USAID should help ensure that current and future tools appropriately capture the effects of the SBCC activities on desired outcomes.<sup>45</sup> Also, more consideration ought to be given to the balance between measuring changes in social norms and individual behaviors in light of the variations in SBCC activities. This is important since a person may agree that a particular behavior should not be practiced, but may behave counter to this belief (individual behavior). For example, a man might agree that men should not beat their wives, but might be motivated by circumstances to beat his wife.

The PEPFAR team, including the Peace Corps and DOD, should consider introducing participatory evaluation techniques or structured focus group sessions into their PEPFAR programs. The aim would be to build the capacity of organizations to obtain feedback from participants on their views about specific services or activities and the benefits derived from them. Results should be used to inform planning processes. If necessary, specialized technical services should be made available to provide training, including evidence-based best practices on who should participate in implementing these, and assist with development of the guides. Such methods should be used in full recognition that they do not substitute for the collection of data derived from monitoring instruments and the application of more rigorous pre- and post-evaluation instruments used for reporting to the U.S. Government.

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<sup>45</sup> The currently used Gender Equitable Men (GEM) module ought to be subject to an intensive review to identify any weaknesses in the wording of statements, the number of questions asked per category (e.g., violence), and its applicability across SBCC activities. The outcome should be a standardized GEM module, with guidance on what questions should be asked given the intent, content, and target group of the SBCC activity. In addition, the guidance should address issues related to the sample population and who should collect the endline data so that results are not biased.

***Integrate gender into PEPFAR team operations, including the procurement process, annual workplans and COPs, and reporting.*** All new requests for assistance and projects should include a discussion on gender, and the award process should assess the adequacy with which responders have addressed the gender dimensions of the proposed work. Furthermore, annual workplans and COPs should include attention to gender equity.

In periodic review meetings with partners, PEPFAR team members should integrate discussion of accomplishments vis-à-vis the Gender Strategy and ways to address challenges to implementation. The discussion should be based in part on their partners' own plans in relationship to the Gender Strategy. The discussions will enable the responsible PEPFAR team member to be aware of accomplishments and challenges, and point to areas requiring more attention to gender.

On an annual basis, PEPFAR interagency team members should present to the PEPFAR team a verbal and written summary of their accomplishments, outputs, and outcomes related to the Program Gender Strategy. The data should be derived from the implementing partners' reports. In addition, they should report on progress and accomplishments related to the Program Operations Gender Strategy. The presentation could be added to the annual portfolio review process.

## **ANNEX A. GLOBAL PEPFAR GENDER STRATEGY**

### **GENDER AND HIV/AIDS\***

Addressing gender issues is essential to reducing the vulnerability of women and men to HIV infection. PEPFAR proactively confronts the changing demographics of the HIV/AIDS pandemic, integrating gender throughout prevention, care, and treatment activities, with a focus on the five crosscutting gender strategic areas highlighted here.

### **PEPFAR GENDER STRATEGIES**

**Increasing gender equity in HIV/AIDS programs and services.** These programs are designed to provide equitable access to services for both women and men. Specific approaches include collecting disaggregated data by sex to monitor the number of women and men receiving services; designing treatment service delivery to reduce barriers to women's access and participation; reaching out to men through Prevention of Mother-to-Child HIV Transmission Centers and offering them HIV counseling and testing services; and mitigating the burden of care on women and girls by linking treatment and care programs with community efforts that provide resources such as food, support for school expenses, household help, farm labor, and child care.

**Reducing violence and coercion.** Sexual and other forms of abuse against women and girls fuel the spread of HIV. The practice or threat of sexual violence against women and girls puts them at increased risk of HIV infection by creating situations in which women are unable to voluntarily abstain from sex or negotiate condom use. PEPFAR supports the activities of community- and faith-based organizations to change social norms that perpetuate male violence against women; train couples in negotiation and conflict resolution; and strengthen policy and legal frameworks that outlaw gender-based violence. It also supports HIV post-exposure prophylaxis in clinical settings for survivors of violence; development of couples HIV counseling; partner notification strategies; health workers' awareness of and skills to address violence; and links with community and social services that provide protection and care for victims of violence.

**Addressing male norms and behaviors.** Practices such as multiple and concurrent sex partners, cross-generational sex, and transactional sex increase vulnerability to HIV infection, particularly among women and girls. To address these issues, PEPFAR supports community-based prevention programs and media messages with a focus on positive norms for boys and men; couples HIV counseling and testing as an opportunity to address gender norms and reach men; programs to address alcohol and substance abuse; and special programs with the armed services focusing on responsible male behavior.

**Increasing women's legal protection.** Many of the practices that increase women's vulnerability to HIV and limit their capacity to manage its consequences are reinforced by policies, laws, and legal practices that institutionalize discrimination against women. PEPFAR supports efforts to review, revise, and enforce policies that protect victims of sexual violence; support women's property and inheritance rights; enhance women's access to legal assistance; and eliminate gender inequalities in civil and criminal codes.

**Increasing women's access to income and productive resources.** PEPFAR recognizes that a lack of economic assets increases the vulnerability of women and girls to HIV infection.

PEPFAR supports efforts to provide women with economic opportunities to empower them to avoid high-risk behaviors, seek and receive health care services, and care for their families. Such efforts include micro-enterprise and micro-credit activities for HIV-positive women; programs to ensure that girls are given equal opportunity to attend school and vocational training; and skills and management training targeted to offer economic alternatives to prostitution. Additionally, links between PEPFAR and other U.S. Government-supported education, economic development, and microfinance programs are being strengthened.

## **ANNEX B. DRAFT MISSION GOAL AND OBJECTIVES**

### **MISSION GENDER GOAL**

- Men and women contribute as equals to a healthy, stable, and prosperous society in Swaziland.

### **MISSION GENDER OBJECTIVES**

- Greater gender equity under the law, in governance, the economy, and civil society.
- Reduced vulnerability of women and men, girls and boys to HIV infection and its consequences.

*(Department of State and the PEPFAR team will have separate gender strategies)*

### **INITIAL DRAFT OF DEPARTMENT OF STATE GENDER STRATEGY**

- Promoting legal protection and rights of women and girls by
  - Advocating and engaging high-level government officials around updating and thereafter implementing legislation, including Sexual Offenses and Domestic Violence Bill and Marriages Act.
  - Engaging with other members of the diplomatic corps and non-U.S. Government development partners.
  - Facilitating discourse among civil society.
  - Exposing key actors to promising models for implementing legal protection.
- Increasing women's civic and political participation by
  - Exposing women and female youth leaders to alternative models.
  - Building the capacity and creating opportunities for greater involvement of women and female youth.
  - Encouraging women to better understand and exercise their civil rights.
- Enhancing economic opportunities for women by
  - Seeking funding to support women's economic empowerment.
  - Integrating gender considerations into the Ambassador's Self-Help Fund and other grant opportunities.
  - Connecting women entrepreneurs to opportunities for enterprise growth.

- Advancing gender equity in mission programs and events by
  - Encouraging selection of women in the security sector for training and development opportunities.
  - Seeking a balance of men and women as program participants, exchange visitors, and speakers.

## **ANNEX C. PERSONS CONSULTED**

### **U.S. GOVERNMENT**

#### **Department of State**

Earl M. Irving, Ambassador

Craig Cloud, Deputy Chief of Mission

Holly M. Mackey, Political and Economic Officer

Molly M. Sanchez Crowe, Public Affairs Officer

Marjorie Balarin, Senior Cultural Affairs Assistant

Purity Gcebile Dlamini, Security Assistance Manager

Sipho S. Kunene, PEPFAR Program Assistant

#### **U.S. Agency for International Development**

Natalie Kruse-Levy, Country Director

#### **Centers for Diseases Control and Prevention**

George Bicego, Country Director

Peter Ehrenkranz, PEPFAR Care and Treatment Specialist

Peter Preko, PEPFAR Care and Treatment Specialist

#### **Department of Defense**

Patrick Kunene, HIV/AIDS Program specialist

#### **Peace Corps**

Steve Driehaus, Country Director

Stella Nkosi, Associate Peace Corps Director for Youth

Samukelisiwe Busika, Associate Peace Corps Director for Health Projects

Aiesha Volow, PEPFAR Technical Advisor

### **GOVERNMENT OF THE KINGDOM OF SWAZILAND**

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Gideon Gwebu, Gender Unit, Deputy Prime Minister's Office

Tembi Gama, Response Management Team, National Emergency Response for HIV/AIDS

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Irma Allen, C-BLD Project, Gender Specialist

## **Coordinating Assembly of Non-Governmental Organizations**

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## **Elizabeth Glaser Pediatric AIDS Foundation (EGPAF)**

Mohammed Ali Mahdi, Country Director

Zandile Nhleko, Senior Program Officer, Community Linkages

Lungile Simelane, Senior Program Officer, Clinical Services (PMTCT)

## **Family Life Association of Swaziland**

Dudu P. Simelane, Executive Director

## **Human Resources Alliance for Africa (ECSA)**

Futhi Mdrule, Country Director

## **ICAP Columbia University, Mailman School of Public Health**

Reuben Sahabo, Country Director

Joris Vandelanotte, Technical Director

Nosipho Storer, Adherence, Psychosocial and Community Linkages Advisor

## **Lutsango Lwaka Ngwane**

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Prisca Khumalo, Program Officer

Gugu Shongwe, Finance and Administrative Officer

Autillia Dlamini, National Executive Member

Baphetsile Mamba, National Executive Member

Observations of Community Dialogue, Emhlangeni community, Manzini region

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## **PACT**

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Victoria Masuku, HIV Prevention Systems Director

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Mirira Munamoto, Public Health Specialist, Prevention

**Technoserve**

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Alexandra Stanek, Technoserve

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**UNFPA**

Hassan Mohtashami, Representative

Emmanuel Tofoatsi, Technical Specialist, HIV Prevention and Integration



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For more information, please visit  
<http://www.ghtechproject.com/resources>

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