AIDS Support and
Technical Assistance Resources

AIDSTAR-One

INTEGRATING MULTIPLE GENDER STRATEGIES TO IMPROVE HIV AND AIDS INTERVENTIONS:

A COMPENDIUM OF PROGRAMS IN AFRICA

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AIDS Support and Technical Assistance Resources Project

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ACRONYMS

AED	Academy for Educational Development
AEMCI	Epouses des Militaires de Côte d'Ivoire
AIDS	Acquired immunodeficiency syndrome
AMREF	African Medical and Research Foundation
AOSCI	AIDS Orphans Skills Centers, Inc.
ART	Antiretroviral therapy
BKB	Bega kwa Bega
CAB	Community advisory board
CAT	Community action team
CEDOVIP	Center for Domestic Violence Prevention
CFK	Carolina for Kibera
CSO	Civil society organization
CDC/GAP	Centers for Disease Control and Prevention/Global AIDS Program
COH II	Corridors of Hope II HIV/AIDS Prevention Initiative
DFID	UK Department of International Development
DHS	Demographic and Health Surveys
FBO	Faith-based organization
FCS	Family and Community Strengthening
FHI	Family Health International
FIDA	Association of Uganda Women Lawyers
GBV	Gender-based violence
GenARDIS	Gender, Agriculture and Rural Development in the Information Society
GPI	Girl Power Initiative
HIV	Human Immunodeficiency Virus
ICRW	International Center for Research on Women
IEC	Information, education, and communication
IGWG	Interagency Gender Working Group
IHDC	Institute for Health and Development Communication
IMAGE	Intervention with Microfinance for AIDS and Gender Equity
IPPF	International Planned Parenthood Federation
ITC	International Trade Cooperative
JHHESA	Johns Hopkins Health and Education in South Africa
JOHAP	Joint Oxfam HIV/AIDS Program
JSI	John Snow Inc.
KAIPPG	Kenya AIDS Intervention Prevention Project Group
KAPB	Knowledge Attitudes Practices Behaviors
KDA	K-Rep Development Agency
LVCT	Liverpool VCT, Care & Treatment
LSHTM	London School of Hygiene and Tropical Medicine
MER	Monitoring, evaluation, and research
M&E	Monitoring and evaluation
MOH	Ministry of Health
MOST	Management and Organizational Sustainability Tool
MRC	Medical Research Council
NACC	National AIDS Control Council
NACWOLA	National Community of Women Living with HIV/AIDS
NFS	Nutritional field schools
NGO	Nongovernmental organization

OGAC	Office of the U.S. Global AIDS Coordinator
OHP	Operation Haute Protection
OPRIFS	Organisation for the Prevention Rehabilitation and Integration of Female Street Children
OVC	Orphans and vulnerable children
PATH	Program for Appropriate Technology in Health
PEP	Post-exposure prophylaxis
PEPFAR	The U.S. President's Emergency Plan for AIDS Relief
PI	Pathfinder International
PMC	Population Media Center
PMTCT	Prevention of mother-to-child transmission
PPTCT	Prevention of parent-to-child transmission
PSO	Private sector organization
RADAR	Rural AIDS and Development Action Research Program
SAFA	South African Football Association
SEF	Small Enterprise Foundation
SIDA	Swedish International Development Agency
SLA	Savings and loan association
SLFHE	Sexuality, Family Life and HIV/AIDS Education
SSTOP	Survival Skills Training for Orphans
TAC	Treatment Action Campaign
TAI	Targeted AIDS Interventions
TASO	The AIDS Support Organization
T-MARC	The Tanzania Marketing and Communications for AIDS, Reproductive Health, Child Survival and Infectious Diseases Project
TIOS	Training Internationally for the Orphans and their Survival
TPOI	Toward Preventing Orphaning Initiative
TRY	Tap and Reposition Youth
UNAIDS	The Joint United Nations Program on HIV/AIDS
UNIFEM	United Nations Development Fund for Women
UNDP	United Nations Development Program
UNFPA	United Nations Population Fund
UNICEF	United Nations Children's Fund
USAID	United States Agency for International Development
VCT	Voluntary counseling and testing
WHO	World Health Organization

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EXECUTIVE SUMMARY

The public health and international development communities have known for nearly two decades that gender—the way in which societies define acceptable roles, responsibilities, and behaviors of women and men—strongly influences how HIV spreads and how people respond to the epidemic. Because of the interrelated factors that contribute to HIV infection, there is growing recognition that using multiple approaches in HIV/AIDS programming is more effective than single strategies.

That said, we know little about how implementers use gender-based programs to improve HIV services, and even less about how programs integrate multiple gender strategies to mitigate women's and men's vulnerability to infection.

To begin filling these gaps, the United States Agency for International Development (USAID) AIDSTAR-One project created this compendium of selected HIV programs in sub-Saharan Africa that integrate multiple gender strategies. Technical oversight in developing the compendium was provided by the USAID AIDSTAR-One partner organization, the International Center for Research on Women (ICRW). Featured programs address at least two of the following gender strategies: 1) reducing violence and sexual coercion; 2) addressing male norms and behaviors; 3) increasing women's legal protection; and 4) increasing women's access to income and productive resources. The compendium describes each of the 31 selected programs, and synthesizes trends and findings to provide initial insights on using multiple gender strategies in HIV programming, including how strategies are employed together, where gaps exist, and what lessons and experiences are common across programs. Though not meant to be exhaustive, the compendium represents the depth and breadth of current HIV programming that includes multiple gender strategies.

Overall, we found that many innovative programs exist in sub-Saharan Africa and that implementers are successfully integrating multiple gender approaches into HIV programs. Program implementers report numerous benefits of combining gender strategies, including ensuring project salience and relevance, extending project reach, and reflecting the multiple, interrelated needs of beneficiaries.

The overall findings summarize how people are integrating gender strategies, how the four specific gender strategies are being used and are working, and how people are learning from and sharing their experiences toward strengthening programs and expanding successes. A summary of findings follows:

- Community involvement is vital to programs that address multiple gender strategies because these approaches often require changing interconnected and sensitive gender norms. National policy and government involvement also are important to sustaining and scaling up combined approaches.
- Of the four gender strategies:
    - Reducing gender-based violence was the most common.
    - Increasing women's legal protection was the least common.
    - Programs often addressed male norms and behaviors in combination with gender-based violence efforts, successfully engaging men with innovative approaches.
    - Strategies to increase women's income were combined with other strategies to sustain women's capacity to address a range of issues in their lives, including violence and HIV.
- Most programs lack rigorous data collection and evaluation, often because implementers do not have sufficient resources or technical capacity. Though all the programs featured here are gender-focused or have strong gender components, few collect findings related to gender outcomes.

Next, we will be conducting case studies from among the programs described here, delving more deeply into program design and implementation to learn more about successes and challenges of

combining gender strategies within HIV programming. Results of these case studies will be available in late 2009.

INTRODUCTION

The public health and development communities have known for nearly two decades that gender influences people's vulnerability to HIV and how societies respond to the epidemic.[1,2] Gender is a social construct and refers to how societies define acceptable and customary roles, responsibilities, and behavior of women, girls, men, and boys.[3] Although gender norms vary among societies, there are several common ways in which they affect how HIV spreads and how individuals cope with and obtain care for the disease.

For example, around the world, social norms discourage women from asserting control over the timing and circumstances of sex, including negotiating HIV protection.[4] At the same time, social norms around masculinity put men at risk of HIV by encouraging them to have multiple partners and unprotected sex, while also discouraging their routine use of health care for early treatment of sexually transmitted infections.[5,6] Often, cultural norms of masculinity encourage male domination of women's sexuality, leading in extreme cases to violence and sexual coercion, which is often exacerbated by criminal justice and legal systems that do not adequately protect women from abuse. Systemic inequalities in the distribution of resources, which favor male access to land, education, credit, and employment, further contribute to women's vulnerability to HIV by reinforcing their economic dependence on men. These systemic inequalities are bolstered when women's rights to own, sell, and inherit land are not legally protected.

PEPFAR AND GENDER

In 2003, President Bush launched the U.S. President's Emergency Plan for AIDS Relief (PEPFAR) to combat the global AIDS epidemic in partnership with host nations. The legislation, which was reauthorized in 2008 for five additional years, supports prevention of 12 million new HIV infections, treatment for at least 3 million people, and care for 12 million people, including 5 million orphans and vulnerable children.

PEPFAR seeks to ensure that its programs address the changing demographics of the AIDS epidemic, including those shaped by gender and gender-related drivers of the epidemic. Gender issues affect all aspects of PEPFAR programming and are influenced by each country's social, cultural, political, and economic circumstances as well as by the nature of its epidemic and national program response. The overall goals of PEPFAR gender programming are to: 1) facilitate achievement of program goals for treatment, prevention, care, and support, 2) strengthen program quality and sustainability, 3) guarantee women's and men's equitable access to programs, and 4) prevent or ameliorate program outcomes that may unintentionally and differentially harm women and men.

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[1] E. Reid, *Gender, Knowledge and Responsibility,* HIV and Development Programme, Issues Paper no. 10 (New York: United Nations Development Program, 1992).
[2] K. Carovano, "More Than Mothers and Whores: Redefining the AIDS Prevention Needs of Women," *International Journal of Health Services* 21, no. 1 (1992), 131–142.
[3] N. Krieger, "Genders, Sexes, and Health: What Are the Connections and Why Does It Matter?," *International Journal of Epidemiology* 32, no. 4 (Aug. 2003), 652–7.
[4] G. Rao Gupta, "Gender, Sexuality, and HIV/AIDS: The What, the Why, and the How," Plenary Address, XIIIth International AIDS Conference, Durban, South Africa, July 12, 2000, http://www.icrw.org/docs/Durban HIVAIDS speech700.pdf.
[5] G. Barker, C. Ricardo, and M. Nascimento, *Engaging Men and Boys in Changing Gender-Based Inequity in Health: Evidence from Programme Interventions (*Geneva: World Health Organization, 2007).
[6] G. Barker, *Dying to Be Men: Youth, Masculinity and Social Exclusion (*New York: Routledge, 2005).

Gender norms also affect how women and men cope with the effects of the epidemic for themselves, their families, and their communities. Because of their culturally assigned roles as caregivers, women of all ages bear a disproportionate burden of caring for family members who are ill as a result of AIDS, and they typically do so with very few material resources at their disposal.[7] In different ways, gender norms prevent men and women from seeking HIV testing, counseling, and treatment, as well as from disclosing their status.[8] Women may be reluctant to be tested, disclose a positive diagnosis, or access treatment for fear of a violent reaction from an intimate partner. Men have more limited access because these services are provided most commonly through antenatal services to pregnant women.[9]

Recognizing the many links between gender and the continuing global AIDS epidemic, the U.S. President's Emergency Plan for AIDS Relief (PEPFAR) advocates for including the following five gender strategies in HIV prevention, treatment, and care and support programs around the world:[10]

1. Increasing gender equity in HIV/AIDS programs and services
2. Reducing violence and coercion
3. Addressing male norms and behavior
4. Increasing women's legal protection
5. Increasing women's access to income and productive resources

While the inclusion of any one of PEPFAR's five gender approaches into HIV programs is laudable, programs that integrate multiple strategies can be even more effective[11,12] due to the complex web of social, economic, and legal factors that contribute to HIV infection for women and men. For example, programs that address gender-based violence by providing care for abused women are likely to be more successful if they increase women's legal protection while also working to transform male norms and behaviors. Scientific evidence demonstrating the benefits of delivering HIV prevention programs using multiple gender strategies is starting to emerge.[13]

Despite increased understanding of the link between gender and HIV and, more recently, the value of using multiple gender strategies to mitigate women's and men's vulnerability, little is known about how HIV programs are applying these insights to improve programs and services. To expand this knowledge base, PEPFAR's Gender Technical Working Group commissioned AIDSTAR-One[14] to compile a compendium of HIV prevention, treatment, and care and support programs in sub-Saharan Africa that are integrating multiple gender strategies into their work. As an AIDSTAR-One partner organization, ICRW provided technical oversight on this compendium project.

The specific objectives of the compendium are to:

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[7] Global Coalition on Women and AIDS, http://womenandaids.unaids.org
[8] S. Maman et al., "The Intersections of HIV and Violence: Directions for Future Research and Interventions," *Social Science and Medicine* 50, no. 4 (2000): 459–78.
[9] A. Greig et al., "Gender and AIDS: Time to Act," *AIDS* 22, suppl 2, (2008): S35-S43.
[10] The President's Emergency Plan for AIDS Relief, http://www.pepfar.gov/pepfar/press/76365.htm
[11] T. Coates, L. Richter, C. Caceres, "Behavioral Strategies to Reduce HIV Transmission: How to Make Them Work Better," *Lancet* 372(9639) 669 (Aug. 23, 2008): 84.
[12] G. Gupta et al., "Structural Approaches to HIV Prevention. *Lancet,* 372 (9639) (Aug. 23, 2008) : 764–75.
[13] P. Pronyk et al., "A Combined Microfinance and Training Intervention Can Reduce HIV Risk Behavior in Young Female Participants," *AIDS* 22, no. 13 (Aug. 20, 2008): 1659–65
[14] AIDSTAR-One is USAID's global HIV and AIDS project that provides technical assistance services to the Office of HIV/AIDS and U.S. government country teams in PEPFAR nonfocus countries.

- Identify current, promising programs in sub-Saharan Africa countries where PEPFAR resources are concentrated[15] that address at least two PEPFAR gender strategies as they intersect with HIV prevention, treatment, and care and support programs. Programs considered for inclusion encompassed both PEPFAR-funded programs and non-PEPFAR-funded programs, multidonor-supported programs, and public-private partnerships. Programs could be stand-alone or integrated into larger initiatives.
- Describe the identified programs in terms of their goals, beneficiaries, operations, evidence of effectiveness, gender outcomes, community and government involvement, findings and lessons, implementation challenges, and recommendations.
- Use this information to synthesize trends and findings across programs, including how gender strategies are used together, common lessons learned by implementers, and systematic weaknesses or gaps that tend to occur across programs.
- Provide recommendations for maximizing the impact of combining gender strategies within HIV programs based on the experiences of the programs examined.

As the first of its kind, the compendium was conceived as an initial step in exploring the feasibility and usefulness of conducting this type of programmatic review. If the compendium proves useful, it could later be expanded to include other regions of the world.

In the second phase of the project, the ICRW research team will conduct four to six case studies of the programs described in the compendium. The case studies will provide an opportunity to delve more deeply into program design and implementation and learn in more detail about successes and challenges of combining gender strategies in HIV programming. Cases with demonstrated measurable, positive outcomes will receive priority in the selection process. Results of these case studies will be available in late 2009.

[15] PEPFAR works in 120 countries but concentrates resources in 15 focus countries, 12 of which are in sub-Saharan Africa. Sub-Saharan focus countries include Botswana, Côte d'Ivoire, Ethiopia, Kenya, Mozambique, Namibia, Nigeria, Rwanda, South Africa, Tanzania, Uganda, and Zambia.

METHODOLOGY

The compendium was created between April 2008 and October 2008. Methods included a **data collection phase**, an **assessment phase,** and a **compilation phase**. Details of each phase are described below.

DATA COLLECTION

To guide the identification of potential programs, minimum inclusion criteria were established. These included the following:

- The program must operate in a sub-Saharan Africa country where PEPFAR resources are concentrated.
- The program must address HIV (i.e., prevention, treatment, care and support, or other types of HIV programming).
- The program must have some level of data collection and/or program evaluation.
- The program must address at least two of the following four PEPFAR-identified gender strategies:[16] 1) reducing violence and coercion, 2) addressing male norms and behaviors, 3) increasing women's legal protection, and 4) increasing women's access to income and productive resources.

A search for eligible programs was conducted using the following strategies:

- An Internet-based search for programs addressing gender within HIV programming. The search used more than 20 key words in multiple combinations within and across target countries, including: *HIV, AIDS, gender, combined, cross-cutting, comprehensive, gender, gender equity, male norms, male behaviors, legal protection, empowerment, cross-generational sex, access to income, income generation,* and *gender-based violence* (see Appendix 1 for a complete list of search terms). Searches were also conducted for references to programs in published reports, evaluations, and peer-reviewed and grey literature using the following sources:
  - Search engines and online databases, including PubMed, POPLINE, Plusnews, Google, Google Scholar
  - Websites of program and donor organizations, including CARE, Centers for Disease Control and Prevention/Global AIDS Program (CDC/GAP), country National AIDS Commissions, Family Health International, Interagency Gender Working Group (IGWG), International HIV/AIDS Alliance, PEPFAR, Population Council, Population Reference Bureau, the Joint United Nations Program on HIV/AIDS (UNAIDS), United Nations Development Fund for Women (UNIFEM), USAID, and World Health Organization (WHO) (see Appendix 1 for a complete list).

[16] A fifth PEPFAR-identified gender strategy, *increasing gender equity in HIV/AIDS programs and services*, was not part of the minimum inclusion criteria because this strategy was initially viewed as broad enough to encompass the other four strategies. However, where gender equity was specifically addressed by programs in ways that did not overlap with the other strategies, we included it in an "other" category in the Gender Strategies Addressed section of program descriptions.

- Snowball sampling of gender and HIV technical and program experts who were contacted by e-mail or telephone and asked for suggestions of programs that met the inclusion criteria. The experts were also asked to suggest the names of other experts who could identify programs. Queries were sent to:

    - Gender technical experts identified through ICRW and PEPFAR Gender Technical Working Group networks
    - U.S. government gender experts in countries where PEPFAR resources are concentrated
    - Umbrella and network HIV organizations
    - HIV/AIDS program managers identified by technical experts, on Web searches and at professional conferences (the 2008 PEPFAR Implementers' Meeting and the XVII International AIDS Conference)

The contact person for each program identified was sent an e-mail to introduce the compendium project and request completion of a self-administered structured survey about the program (see Appendix 2). Follow-up communication was conducted by e-mail and telephone to answer questions and encourage participation in the survey. Program representatives who indicated a lack of time to fill out the survey were given the opportunity to complete the survey by phone. Upon receipt of completed surveys, follow-up was conducted to clarify information or request further documentation. A total of 160 programs were identified and 63 surveys completed, representing a 40 percent response rate. Of the 63 surveys received, seven were completed through phone interviews.

ASSESSMENT

Using an evaluation tool developed by the ICRW research team and the PEPFAR Gender Technical Working Group, programs were rated on five criteria:

1. Number of gender strategies addressed:[17]
    - ***Low:*** Addresses two gender strategies.
    - ***Medium:*** Addresses three gender strategies.
    - ***High:*** Addresses four or more gender strategies.

2. Evaluation rigor:
    - ***Low:*** Pilot/formative data collected and/or at least one year of monitoring on program reach.
    - ***Medium:*** Data gathered and evaluated using evaluation design that is more descriptive than analytical; quantitative data lacking one of the elements required for a high rating; may include unsystematic qualitative data.
    - ***High:*** Pre/post data and/or with control group or time series data and/or systematic qualitative data with clear analytical discussion.

3. Extent to which gender indicators[18] were included as program outcomes:

[17] Programs were required to address at least two of the PEPFAR gender strategies. Additional points were awarded for addressing more than two strategies, including gender strategies that fit into an "other" category.

[18] Gender indicators may include a wide variety of measurements such as individual attitudes and beliefs that are discriminatory, actual experiences of sex-based discrimination or gender-based violence, access to monetary resources/capital/credit by sex, educational attainment by sex, utilization of health services by sex, and experiences of social marginalization/stigma by sex.

- ***Low:*** Collecting or planning to collect gender indicators.
- ***Medium:*** Conducted/conducting analysis on gender indicators (results may be pending).
- ***High:*** Program has demonstrated positive change in gender indicators (based on either qualitative or quantitative data).

4. Community involvement:
   - ***Low:*** Community members are involved in establishing program objectives, goals, or project descriptions.
   - ***Medium:*** Community members are involved in program design, implementation, feedback.
   - ***High:*** Community members express ownership, as demonstrated through contribution of community resources or clear financial support.

5. Feasibility for replication and/or scale-up:
   - ***Low:*** Planning to replicate or exploring possibilities.
   - ***Medium:*** Evidence indicates program is suited for replication/scale-up;[19] lessons for replication/scale-up are available.
   - ***High:*** Program or part of the program has been replicated and/or scaled up.

A team of five ICRW technical experts rated programs systematically and consistently according to the criteria listed above. The team first rated three programs together as a group to ensure common understanding of the rating process and to refine the criteria for evaluation. Once clear definitions had been determined, each program was rated by one team member who assigned a score of one (low) to three (high) for each of the five criteria. The maximum cumulative score for each program was 15 points. Twenty-five percent of programs, randomly selected, were rated by two team members to measure inter-rater reliability and ensure consistent assessment of all programs. Discrepancies in ratings were resolved as a group, and all final scores were discussed as a group. Of the 63 programs assessed, 11 were excluded because they did not meet the minimum criteria for inclusion in the compendium, leaving a total of 52 that were considered for inclusion.

COMPILATION

Of these 52 programs, 32 scored at least eight out of fifteen points and were considered for inclusion; however, in order to ensure that all sub-Saharan Africa countries where PEPFAR resources are concentrated were represented, one program that scored less than eight was included, and two programs that scored more than eight but were from countries with large numbers of similar programs were excluded. As a result, this compendium includes 31 programs. The 21 programs that were not included are listed in Appendix 3.

The research team wrote a detailed description of each program selected for the compendium, using information available through program reporting. Program representatives then had multiple opportunities to review and revise descriptions to ensure accuracy and clarity.

Finally, the compendium was sent to a panel of international expert reviewers, who were asked to consider the following:

- Completeness of the compendium (in terms of programs represented)
- Validity of compendium findings
- Usefulness of compendium content

[19] Evidence of suitability for replication or scale-up may include factors such as strong track record of obtaining funding, long-term established relationships with partner or other implementing organizations, strong community involvement/buy-in, investment by governmental authorities, and strong program documentation.

LIMITATIONS

This compendium is limited in scope to countries in sub-Saharan Africa where PEPFAR resources are concentrated. The snowball sampling method and Internet search may have missed small or localized programs. Furthermore, some programs' limited resources or staff time may have impeded their capacity to respond to the survey. Finally, all information in the program profiles is self-reported by the programs, including information on partners and funders, and is assumed to be a good-faith and accurate description. In some instances, information about the programs has been verified where independent published sources made it possible to do so, but this was not possible for most of the programs.

The compendium is not designed to be an exhaustive list of all HIV programs in the target countries that use multiple gender approaches; rather, it includes a variety of programs that represent the depth and breadth of current programming.

FINDINGS

The research team reviewed all program descriptions to identify lessons for program and policy audiences, such as:

- How multiple gender strategies were employed together (see Appendix 4 for a summary table)
- Gaps in programmatic efforts
- Similar and dissimilar approaches, experiences, and lessons across programs

Below, some of the common themes and patterns among the programs are discussed, exploring why and how certain strategies, in combination, may hold promise for reducing gender-related vulnerabilities to HIV. These findings relate to how people are integrating gender strategies, how the four specific gender strategies are being used and are working, and how people are learning from and sharing their experiences toward strengthening programs and expanding successes.

INTEGRATING GENDER STRATEGIES

1. **Many organizations with HIV programming have begun integrating multiple gender strategies.** The number and variety of programs we were able to identify for the compendium greatly exceeded expectations. As a result, the programs here represent an array of approaches, target populations, and size. Programs use a wide range of techniques to integrate gender strategies, including individualized counseling, group workshops, live theater, television and radio serial drama, community mobilization, peer education, mentorship, income generation, and clinical services, among others. These programs also serve a great diversity of populations, including migrant girls, boys' soccer teams, rape survivors, orphans and other vulnerable children, businesswomen, truck drivers, pregnant women, mothers living with HIV, and women and men at large.

   The compendium also features programs of different sizes. Large programs operate nationwide and are coordinated by international organizations, such as the Tanzania Marketing and Communications for AIDS, Reproductive Health, Child Survival and Infectious Diseases Project (T-MARC) program, which works with Tanzanian businesses to develop or expand markets for health products, uses campaigns to address male norms and reproductive health issues, and provides grants to women involved in transactional sex and sex work. Medium-size programs are cross-district or provincial in scope and work on a range of issues and sectors. For example, Kenya's Engendering Equality program works in 24 project sites in six districts, and helps program beneficiaries access health and other information through education materials and outreach activities, supports women starting small businesses, and teaches skills to improve household food security. Similarly, Côte d'Ivoire's Operation Haute Protection (OHP) has reached nearly 500,000 uniformed services personnel and their families through behavioral change communication, HIV counseling and testing, palliative care, peer education, and other activities. Small district- or community-level programs work in a limited number of communities or with select target groups, and often lack visibility despite providing innovative services. Nigeria's Comprehensive Sexuality, Family Life, and HIV/AIDS Education program, for example, provides a three-year intensive curriculum on HIV prevention, sexual and reproductive health, and sexuality and life skills to adolescent girls in four centers.

   Funding sources for the programs featured in this compendium are also diverse and include national AIDS control commissions within the countries themselves as well as private foundations and international bilateral and multilateral agencies. Twelve of the 31 programs receive funding from PEPFAR. These include large-scale programs such as the multicountry Male Norms Initiative, medium-scale programs such as the Uganda HIV and AIDS Counseling Services

program, and small-scale programs such as Mozambique Survival Skills Training for Orphans (SSTOP).

This diversity in program approaches, target populations, and size increases the likelihood that the compendium will be useful to a range of HIV service practitioners.

2. **Programs reported numerous benefits of using gender strategies in combination.** Most programs (24 of 31) deployed three or more gender strategies. Strong synergies among the strategies also are evident. Some program implementers reported that combining gender strategies was a part of program design, an indication that programs see the value of combined gender programming. Other implementers said that gender strategies or components were added during implementation as gender-based constraints and their effect on program efforts were identified, sometimes by communities themselves. These programs were flexible enough to tailor program activities to the specific needs of program recipients.

   The mutually reinforcing nature of gender strategies can easily be seen within program descriptions, where it is often impossible to separate where one strategy ends and another begins. One frequently mentioned benefit of combining gender strategies was that calling attention to one gender issue helped lend salience to others. For example, staff from the South Africa Intervention with Microfinance for AIDS and Gender Equity (IMAGE) program write, "Raising issues such as gender-based violence adds relevance to HIV prevention messages, while the risk of HIV adds immediacy and legitimacy to tackling gender inequalities."

   Other programs found that using multiple strategies allowed programs to function more efficiently and reach more people. This was particularly evident in the case of combining microfinance or income generation activities with HIV or gender-based violence prevention activities. The income-generating activities helped participants maintain interest and sustain their capacity to address other program issues, such as violence and HIV. As staff from the Mozambique Women First (Mulheres Primero) program write, "Groups that received HIV and gender-based violence education without the income generation component attracted low levels of participation in comparison to groups that had income generation as well." Many programs also made use of the synergies between gender-based violence prevention and addressing male norms and behaviors. These two strategies were typically seen as mutually reinforcing, and some programs that began with the mandate to focus on reducing violence and sexual coercion ultimately included a complementary component that addressed male norms and behaviors. In the South Africa Shosholoza AIDS Project, the reverse occurred—a program that initially set out to address male norms and HIV risk behaviors among young men in soccer clubs found itself drawn into discussions of how to prevent violence against women. It is interesting to note that the young men participants themselves identified violence against women as an issue interlinked with the men's efforts to reduce HIV risk and reinforce positive male behavior.

3. **Multiple gender strategies are most common in prevention, care and support programming. They are least common in treatment programs.**[20] Most of the programs (28 of 31) featured in this compendium are HIV prevention programs while 18 of 31 are care and support programs. While many programs provide information on antiretroviral therapy (ART) and some also make referrals to medical facilities for treatment, only four HIV treatment programs directly integrate multiple gender strategies into their services. Of these, three programs—Kenya's Nuru ya Jamii, Uganda's HIV & AIDS Counseling and Services Program, and Rwanda's Polyclinic of Hope Care and Treatment Project—provide medical and other direct treatment services to people who also receive gender-related programming. A fourth program, Kenya's Maanisha, addresses gender in treatment services by providing technical support and grants to civil society and private sector organizations that provide these services.

[20] Because many programs addressed HIV in more than one way, numbers on type of HIV program add up to more than 31.

The notable absence of gender strategies within treatment programs may point to a lack of understanding about the extent to which gender influences people's access and adherence to treatment. Opportunities for integrating gender strategies into treatment programs may include ensuring that treatment is facilitated in ways that consider women's concerns, such as childcare, privacy and time constraints, as well as supporting women's adherence by teaching skills to safely navigate disclosure with intimate partners and other family members. Treatment programs could also take steps to address men's specific needs, including expanding access to treatment by providing services at times and locations that are convenient and welcoming for men, offering outreach activities to raise men's awareness about the benefits of treatment, and promoting men's involvement in PMTCT activities.

EXAMINING SPECIFIC GENDER STRATEGIES

4. **Addressing gender-based violence is a key strategy for many programs focused on reducing HIV risk.** Interventions addressing violence and sexual coercion were used more commonly than any other gender strategy we examined. Thirty of 31 programs addressed this topic in some way, reflecting a burgeoning interest among HIV programmers and community members in the role gender-based violence plays in women's vulnerability to HIV infection. The experience of these programs indicates that efforts to reduce gender-based violence are closely linked with the other gender strategies. In fact, some programs that initially focused on other gender strategies later integrated gender-based violence efforts during implementation in response to realities on the ground.

   Many different approaches were used to address gender-based violence depending upon the type of HIV programming. Care and support and treatment interventions often address the needs of survivors of domestic and sexual violence by linking them with health, social welfare, or justice services. They also sometimes provide temporary safe havens as well as psychological, medical and legal services. The Kenya Post Rape Care program, for example, ensures that women who have been sexually assaulted are offered post-exposure prophylaxis (PEP). In addition, the program educates religious leaders, teachers, the police, and community health workers about sexual violence to respond constructively when violence occurs and to reduce stigma. As staff at the program write, "Sexual violence is highly stigmatized…the survivor has pressure not to report it as it could reduce chances of getting married and increase the possibility of being ostracized by the rest of the community."

   In contrast, HIV prevention programs use a diversity of interventions to focus on changing gender norms and behaviors around violence. Some programs, for example, work to sensitize society at large, recognizing that broader social norms around violence need to change to support individual behavior change. Mass media campaigns such as Ethiopian Radio Serial Dramas to Prevent HIV/AIDS and the South Africa Soul City Institute for Health and Development Communication project address social norms through their broad reach and "edutainment" model of behavior change communication.

   Other prevention programs concentrate on promoting dialogue around gender-based violence with different groups of community members. For example, Uganda's SASA! Activist Kit for Preventing Violence against Women and HIV uses theater, murals and community conversations to engage community members in violence prevention. The Kenya Binti Pamoja program specifically targets adolescent girls, some of whom are survivors of violence, by providing refuge, training them in financial literacy, linking them with HIV support services and conducting self-empowerment workshops using peer education. In South Africa, Laphum' Ilanga's prevention activities use community-based theater, with survivors of abuse performing to promote community discussion of violence, gender power relations and HIV. These community education and mobilization activities may help to overcome stigma, which was frequently mentioned by programs as a barrier to addressing gender-based violence.

   Many HIV prevention programs have recognized that violence prevention needs to involve men as well as women. The Male Norms Initiative in Ethiopia and Namibia and the Fatherhood and

Child Security Project in South Africa are both good examples of this approach. In these programs, men participate in group workshops and dialogues that promote understanding of gender norms as an underlying cause of violence, and are encouraged to develop violence prevention strategies for themselves and their communities. In the South Africa Shosholoza AIDS Project, for example, young men who play soccer in clubs were recruited to participate in skills-building workshops focused on gender norms. These young men subsequently initiated forums with other soccer players to talk about what constitutes forced sex and what they could do to eliminate it.

5. **Increasing women's legal protection was the least developed of the four gender strategies.** Increasing women's legal protection was addressed by 19 of 31 programs and was most commonly used as a complement to reducing violence and coercion. Compared with other strategies, this was the least developed; it typically was addressed indirectly, through referrals to the police or legal service organizations, rather than as a central program initiative. The most developed initiatives in this area addressed legal literacy, which was promoted through care and support services. The Uganda Memory Book program, for example, helps families prepare themselves for the death of a family member from AIDS through will-writing and helping parents understand how to legally protect their loved ones' land rights. Some programs, such as Nigeria's Community Care in Nigeria program, coordinates with state agencies and community institutions to establish Protection Committees to address issues of violence and inheritance matters as well as to advocate for access to social services and the rights of women and children. Few programs, however, included robust legal service provision or advocacy for women's legal rights. This may be because programs that focus explicitly on increasing women's legal protection do not do so in combination with other gender strategies, and thus were not captured in this compendium. One notable exception is the Kenya Nuru ya Jamii program, which addresses all four gender strategies as well as the three types of HIV programming. This program trained community members to become mediators in Alternative Dispute Resolution. These mediators helped to resolve civil disagreements at the community level and ensure appropriate referrals were made to law enforcement.

STRENGTHENING GENDER STRATEGIES

6. **Community involvement and participatory approaches may contribute significantly to program sustainability.** Program sustainability can be difficult to define and measure because many factors contribute to it, including cost of operation, level of skill required to implement the program, matching of program objectives with a community's perceived needs, and investment by stakeholders in the program's success. Furthermore, most of the programs included in the compendium do not yet have long enough track records to draw definitive lessons about what characterizes sustainable program models. For this compendium, we rated programs on the extent to which community members were involved in the design, implementation and resourcing of their programs, as one indication of potential sustainability. We hypothesized that greater degrees of community involvement would result in greater likelihood of program sustainability because community buy-in is a crucial component of addressing sensitive issues around HIV and gender norms and sustaining changes around these norms. Although there was no way to test this hypothesis, in reporting their key findings and "lessons learned" many programs spoke about the importance of community buy-in and even ownership in making their programs feasible to implement over time. Facilitating this type of ownership is not always easy, however. As staff from the Uganda SASA! program write, "Community members are used to having nongovernmental organizations (NGOs) take the lead and act as experts. Some community members find it unusual and difficult to become the activists and drivers of change."

   Despite these challenges, most projects enthusiastically embraced very active involvement of community members. For programs whose objectives included women's empowerment, involvement of program beneficiaries in planning and implementation was a logical and necessary component of their work. As the Uganda Mama's Club program found, "We have learned that women need to be involved in decisions affecting their lives and need to be part of designing the programs that affect them." Similarly, the Uganda Family and Community

Strengthening (FCS) program used a community empowerment model, only working "where invited by the community to ensure that communities are committed, active partners in program activities."

Models for involving community members varied widely. One model, common in research studies, is the community advisory board. The Stepping Stones – Adapted for South African Youth program established an advisory board of community members who helped guide the conception and implementation of the project, which involved a rigorous level of evaluation. Another model involves community members directly in service provision, such as the Ethiopia Biruh Tesfa project, in which community members serve as mentors to out-of-school girls. In another model, as exemplified by the Mozambique SSTOP program, local community church, school and government administrators help select individuals to be part of the program.

Participatory methods also help to ensure a tight match between program objectives and perceived community needs, particularly in explaining locally relevant links between gender-related factors as well as between gender and HIV. As staff from the Zambia Corridors of Hope II write, "It is important to help individuals and groups analyze their situations and develop solutions that are relevant and meaningful for them … It is critical to use participatory approaches and understand the cultural norms and behaviors that drive the epidemic in target locations."

7. **Involving men is a challenge that can be met with innovative approaches.** Addressing male norms and behaviors was a popular gender strategy, used by 24 out of 31 programs and implemented in a variety of ways, from peer education to sensitization workshops to community mobilization. Program staff commonly cited the challenge of overcoming initial reluctance among adult men to participate in gender-based programs (engaging adolescent boys was reportedly somewhat easier). It is worth noting a number of interesting insights on how programs overcame this reluctance and ultimately were able to build successful programs that actively involved men. The Botswana Targeting and Involving Men in HIV Prevention Activities program found it important to broaden the discourse about gender so that it appeals to men. This "broadening" often means sensitizing men about what the concept of gender means—that it is not simply about "women's rights" but also entails understanding how men, like women, are at times constrained and made vulnerable by social norms of masculinity. The multicountry Male Norms Initiative suggests using an asset-based model where men are not viewed solely as perpetrators of gender inequality who need to be reformed, but as assets who can influence changes in norms and behaviors around gender in their communities. A similar model is used by the Uganda Mama's Club, which has recruited and trained a group of mentor fathers who promote the idea that men can be actively involved in the prevention of parent-to-child transmission (PPTCT) of HIV.

   Several programs highlighted the need to create a more supportive social environment so that men are encouraged when they deviate from traditional male behaviors—thus making behavior change easier to sustain. For this reason, staff of South Africa's Fatherhood and Child Security Project write about the importance of involving men who are community leaders to learn about gender from the onset of the program. They write, "While it's easier to reach men on the street corner, it's more important to work with men who can influence community attitudes."

8. **Microfinance or income generation programs attract and help sustain women's involvement in HIV prevention.** The compendium includes 18 programs working to increase women's access to income, using approaches ranging from financial literacy (for example, Binti Pamoja in Kenya) to microfinance (for example, IMAGE in South Africa). Programs also provide entrepreneurship and vocational training, savings clubs, scholarships, and improved access to markets. Several programs cited the power of income generation to attract and sustain women's involvement in programs that also address HIV and other gender strategies. Staff of the South Africa IMAGE program write, "Through microfinance…vulnerable populations can maintain intensive contact with an HIV intervention over months to years." The results-oriented nature of this strategy seems to be appealing over and above programs that focus primarily on education and communication, or strategies that ask women to change gender-related practices without providing complementary access to income services. An added benefit of incorporating income generation is that some of the funds generated can help sustain the program and its gender-

related efforts. The Mozambique SSTOP program is an example of such a program. Vulnerable adolescent girls are provided with vocational training that includes the production of anatomically correct dolls, which are sold to other HIV prevention programs for educational uses. Proceeds from the sales are shared between the girls and the program—enhancing both the program's sustainability and the girls' economic situation.

While all income generation and microfinance programs considered economic empowerment to be an HIV prevention tool because it enables women to resist sexual coercion, insist on condom use and refuse sex, some programs also experienced unintended consequences. For example, women who received entrepreneurial training through the Mozambique Women First program needed help learning how to manage their new-found wealth without causing tension that could lead to violence in relationships with their husbands. The program teamed up with a theater group to create an interactive drama that helped women learn how to defuse potential conflicts, such as situations in which unemployed husbands might feel emasculated by their wives' earning potential or women are accused of shirking familial duties as a result of their income-generating activities. The Mozambique SSTOP program also discovered the need to provide self-defense and family law classes when it became clear that adolescent girls who began to earn money through the program became more attractive to potential male partners—potentially putting the girls at risk for exploitation. Staff of the program write, "Even though the program improved self-esteem and gave girls an income-generating skill, participants still viewed marriage and motherhood as the most important things in a woman's life. This could be dangerous as their new skills made the girls more attractive to men…The family law classes helped them become aware of the legal difficulties of having a child without being married."

The Kenya Tap and Reposition Youth (TRY) program also provides a useful lesson for programmers interested in increasing vulnerable adolescent girls' access to resources. This program works with very poor girls in a slum area of Nairobi. It found that a classic microfinance model failed with the most vulnerable girls because their main needs were not initially for entrepreneurship but for physical safety, social support, friendship, and mentorship. Only after receiving this support were girls able to think constructively about making and saving money.

9. **Supportive national policy and government involvement are additional keys to sustainability and scalability**. Many programs also acknowledged the key role governmental institutions played in ensuring the stability, sustainability and scalability of their programs. Often, national governments provided the policy frameworks within which organizations developed their programs. For example, the Botswana Targeting and Involving Men in HIV Prevention Activities program worked closely with the national "men sector" committee that is responsible for ensuring the coordination and delivery of male-focused programming in the country. While the committee does not provide financial support, it facilitates community entry and provides an overarching nationwide policy framework that helps guide the program's content and gives it visibility and validation. In the case of other programs, the government provided resources. For example, Kenya's Nuru ya Jamii program partnered with the Ministry of Health, which provided free antiretroviral drugs to all clients in the program. The Ministry of Health also donated a five-acre piece of land to Nuru ya Jamii, which the project developed as a high-yield modern farm, producing an average of 1.7 tons of fresh vegetables per week. Other programs were developed at the request of the government, such as the Ethiopia Radio Serial Dramas to Prevent HIV/AIDS, which were created after the government of Ethiopia put out a request for organizations to develop a radio-based media strategy. In the case of Mozambique's Geração Biz program, the project was designed to be implemented at the national level and the Ministries of Health, Education, and Youth and Sports are the key implementers.

   National policy frameworks are especially important for programs seeking to reduce violence and coercion and increase women's legal protection. According to the South Africa Women's Health CoOp, Pretoria, "These frameworks typically ensure that national and global initiatives related to gender become implementation priorities and provide adequate resources to translate them into programs." The Kenya Post Rape Care program identified the need for a national policy framework on gender-based violence to establish linkages between post-rape services with other relevant programs. The stigma that is often attached to sexual violence, and the ill-preparedness

of law enforcement and the legal system to solve and prosecute cases, make such national policies even more important.

10. **Rigorous program evaluation was a challenge for most programs.** Rigorous evaluations of featured programs were somewhat rare. Most programs (18 of 31) displayed a low level of evaluation rigor. Not surprisingly, evaluation methodology and results were weakest among smaller programs operating at the grassroots level, where funding for and capacity to conduct rigorous evaluation is constrained. For these programs, many of which are highly innovative and promising, evaluations were limited to routine monitoring of activities, such as counting numbers of beneficiaries reached, and/or collecting unsystematic (anecdotal) qualitative data from program beneficiaries. Funders often require such data to document progress toward meeting targets and to help determine the extent to which a program is reaching its target audience. Unfortunately, these less rigorous evaluation methods do not generate insight into whether a given approach is effective in achieving a stated goal.

11. **Some programs showed significant positive change in gender indicators.** Thirteen programs reached a medium or high level of evaluation rigor. These programs had mounted, often in partnership with professional researchers, more elaborate evaluations, including pre- and post-surveys of knowledge, attitudes and behavior or, at times, randomized-controlled trials with behavioral or biological outcome measurements. For the purposes of this compendium, we were particularly interested in identifying programs that showed significant positive change in gender indicators. Gender indicators include a wide variety of measurements, such as individual attitudes and beliefs about gender, actual experiences of gender-based discrimination or physical/emotional abuse, access to monetary resources/capital/credit, educational attainment, utilization of health services, or experiences of social marginalization/stigma, among others.

    Most programs did not measure specific gender indicators, even though all the programs were gender-focused or had strong gender components. However, several programs among those with the highest level of evaluation rigor stand out. The South Africa IMAGE program, which included microfinance, gender-based violence reduction and addressing male norms/behaviors, conducted a cluster randomized evaluation trial in which several cohorts of individuals were followed over a two-year period. Results indicate that levels of intimate partner violence were reduced by 55 percent among women who participated in the intervention. Likewise, the Kenya TRY program followed a cohort of young women and matched controls for a four-year period. Young women who had participated in the microfinance and violence reduction program had significantly higher levels of income, owned more assets, and demonstrated more equitable gender attitudes. Two other South Africa-based programs, Stepping Stones – Adapted for South African Youth and the Women's Health CoOp, Pretoria program also reported statistically significant reductions in gender-based violence in randomized-controlled trials.

12. **Addressing gender successfully in target communities requires technical expertise, but not necessarily high costs**. In phone interviews and questionnaires, program implementers reported that adding a gender component to ongoing work in HIV is not significantly expensive. Though few programs have conducted cost studies, implementers report from their experiences in implementation that many gender activities are low cost because they rely extensively on volunteers such as peer mentors, tools such as participatory methods with communities, and delivery of skills and information through workshops held in communities. Since combining gender strategies often enhanced HIV program efforts, they viewed gender as a cost efficient complement to their ongoing work. However, they also reported the need for technical expertise in designing and implementing gender programming—from developing the capacity of program staff to address gender issues, to understanding and responding to local gender-related constraints—and that this expertise was sometimes difficult to find. At the same time, sometimes program staff viewed gender as an issue that only gender experts could understand or address. As staff of the multicountry Male Norms Initiative reported from their experience training local implementing partners, gender had an "aura" around it and program staff required time to become comfortable with, understand and address gender issues.

RECOMMENDATIONS

1. **Programs should combine gender strategies to address the specific gender constraints of target audiences.** Programs that seek to initiate gender-based programming for the first time or to expand their current gender programming should be encouraged to include gender strategies in combination. These strategies are mutually reinforcing, and the costs of adding new gender components may be relatively low. However, funders and program implementers should determine which strategies to combine, and how best to combine them, based on the specific gender constraints experienced by target audiences. Context-specific consequences of combining programming—both positive and negative—also must be considered and addressed. For example, program implementers have described increased spousal violence experienced by women who participated in income generation activities. Formative research to understand these constraints and possible consequences, including local norms and attitudes, should be part of program concepts from the beginning and should inform program design. When locally relevant and appropriate, combining gender strategies to address interlinked constraints can increase the ability of individuals to engage in and benefit from HIV programming.

2. **Funders and program designers should provide implementers adequate flexibility to adapt programming based on new findings about gender.** Important connections between gender constraints are sometimes identified during program implementation. Many programs featured in the compendium addressed additional gender constraints only after beginning implementation, when realizing multiple gender issues were interlinked and needed to be addressed together in order to ensure the success of their initial objectives. These programs adapted their efforts to include new gender components for more effective programming. Thus, funders should allow for the flexibility necessary to make mid-stream modifications. Ultimately, programs tailored to context- and audience-specific gender constraints are likely to be more effective and efficient, and achieve greater community buy-in because gender components complement and reinforce each other.

3. **Increasing the involvement of men—especially young men—in gender-based programming should remain a high priority.** Programs must recognize the role men play in women's experiences and constraints, as well as men's own gender-related constraints, and integrate activities to address male norms and behaviors into HIV and gender programming. The compendium includes numerous examples of innovative programming to increase the involvement of men in HIV programming. These "asset-based" approaches to men's involvement (i.e., treating men as part of the solution versus part of the problem) should be considered when integrating gender in HIV programming. Furthermore, while the inclusion of all men is important, some programs have seized the opportunity to effect change among a new generation of young men who are establishing what will be lifelong patterns of behavior with women. Interventions at early stages in their life may have profound impacts on the future course of the HIV epidemic and offer an important contribution to HIV programming.

4. **Addressing gender-based violence should be considered a key component in HIV programming.** A number of programs featured in the compendium found that violence contributed to women's and girls' vulnerability to HIV and also was as a barrier to accessing care, support, and treatment. These programs found that integrating violence prevention activities and support to survivors of violence into HIV programming contributed to overcoming these barriers. In addition, programs found that addressing women's legal protection, male norms and behaviors, and economic empowerment activities alone could have negative consequences for women and girls if they did not integrate violence

prevention. For example, programs report that women's participation in income generation could lead to increased violence. Programs used a variety of innovative approaches that reached out not just to women and girls, but also engaged other actors, including men and boys, religious leaders, health providers, police and other decision-makers. HIV programs should integrate violence reduction with other gender strategies, adapting interventions according to type of program and engaging all sectors of society.

5. **Programs should incorporate a strong evaluation component into all programs.** The lack of evaluation information was notable among most programs. Resources—both human and financial—are rarely available for formative research to understand and respond to local gender concerns, as well as for systematic evaluations that address key gender indicators. Not to learn from and to improve programming as a result of strong evaluations is an opportunity lost for the donor, the implementers and, especially, program beneficiaries. It is, therefore, recommended that both donors and programmers advocate for programs to include plans and resources to evaluate key outcomes, including gender-related indicators.

6. **Community buy-in, involvement, and leadership in program design and implementation should be part of efforts to change gender norms.** Changing sensitive gender norms requires community involvement, feedback and buy-in to be relevant, accepted and sustainable. Community support also helps ensure that target beneficiaries are able to fully participate in and benefit from program activities. Thus, funders should identify optimal processes for community involvement and incorporate participatory approaches when developing programs that seek to address gender-related issues.

PROGRAM DESCRIPTIONS

TARGETING AND INVOLVING MEN IN HIV PREVENTION ACTIVITIES

LEAD ORGANIZATIONS: Pathfinder International (PI)
Botswana Council of Churches
Humana People to People
True Men

COUNTRY: Botswana

HIV PROGRAM AREA: Prevention

OVERVIEW:
Targeting and Involving Men in HIV Prevention Activities has two interlinked goals: 1) to reduce risk for sexually transmitted infections among Botswana men and their partners, and 2) to improve men's attitudes about and behaviors related to gender equity and HIV prevention. The project uses a male-focused peer education curriculum covering HIV prevention and gender issues such as multiple concurrent partnerships, drug abuse, sexual violence, and prevention of mother-to-child transmission (PMTCT). Men from the community who wish to participate meet one-on-one with peer educators, who are selected by local officials and community members in collaboration with the implementation team. An initial interview with each participant helps peer educators identify and address specific issues of concern, along with the standard curriculum. After completing the one-on-one curriculum, clients can participate in group sessions. On average, each client meets with a peer educator twice and attends two or more group sessions. Although most participants associate the idea of gender with "women's rights," after the sessions most were comfortable discussing gender issues.

BACKGROUND	
HIV & AIDS Program Goals	Targeting and Involving Men in HIV Prevention Activities aims to reduce the risk of sexually transmitted infections among Batswana men and their partners and to encourage more positive, gender-equitable attitudes and behaviors related to HIV prevention within the family and community.
Gender Strategies Addressed	✓ Reducing violence and coercion ✓ Addressing male norms and behaviors ☐ Increasing women's legal protection ☐ Increasing women's access to income and productive resources ✓ Other: gender equity
Description of Intervention	In 2006, PI developed a peer education curriculum for men that promotes HIV prevention while simultaneously addressing topics of gender norms, including gender-based **violence** and harmful **male norms and behavior**. Specifically, the curriculum addresses issues such as multiple concurrent partnerships, alcohol/substance abuse, sexual violence, safer sex practices, basic information about HIV and antiretroviral therapies (ART), prevention of mother-to-child transmission, and HIV testing. The curriculum also addresses **gender equity** in health services, including HIV testing and uptake of ART. Participants first undergo an assessment to identify their specific risks and concerns regarding gender and HIV. Sample questions

	include: “What do you know about multiple concurrent partnerships?”; “How many partners have you had in the last 12 months?”; and “Have you been tested for HIV in the last 12 months?” Then, in one-on-one meetings with a peer educator, each participant receives information and help in developing strategies to address these issues.
Target Audience	Males age 15 and above residing in communities that report high HIV prevalence and concentration of high-risk behaviors such as alcohol and/or substance abuse
Level of Intervention	▪ Community (village and town) ▪ Family ▪ Individual
Geographic Location	▪ Francistown Town ▪ Tati and Mupani Mines ▪ Serowe Village ▪ Palapye Village ▪ Kang Village ▪ Maun Village ▪ Toteng Village ▪ Tati Village ▪ Otse Village
Timeframe	2006–2009
Funders	▪ The U.S. President’s Emergency Plan for AIDS Relief (PEPFAR) through the United States Centers for Disease Control and Prevention (CDC)
Partner Organizations	*Implementation partners:* ▪ Botswana Council of Churches ▪ Humana People to People ▪ True Men
IMPLEMENTATION AND RESULTS	
Start-up and Implementation Process	PI began working in Botswana in 2000 as part of the African Youth Alliance project. In 2004, PI launched a peer project with Batswana mothers, and in 2006 began Targeting and Involving Men in HIV Prevention Activities to reach the male partners of these mothers. To prepare for this program, PI staff participated in a three-day gender sensitization workshop run by the South Africa-based Men As Partners program. PI then developed a Setswana-language male-focused training manual that can be covered in a 10-day period, and used this curriculum to train its implementation partners: the Botswana Council of Churches, Humana People to People, and True Men. PI and its partners identified villages that reported high HIV prevalence and high levels of risky behavior as potential intervention sites. In each, organizers met with senior town officials to discuss risk factors for HIV

	transmission and explain how the proposed intervention could help fight HIV in their community. Local officials who agreed to participate helped the implementation team identify men to recruit as peer educators. The implementation team trained each willing recruit over a period of days using the training manual. An implementation team member also served as a supervisor and information source for the peer educators. On average, each supervisor was responsible for four peer educators. At the same time, PI and local officials launched a promotional campaign to generate interest in the male peer education approach. The campaign emphasized that seeking peer education is voluntary and that it provides an opportunity for men to discuss issues concerning gender and HIV privately with their peers. Each community member who wanted to participate met with a peer educator, who administered an intake survey covering knowledge, behaviors, and beliefs related to gender and HIV. Using a checklist, the peer educator identified priority issues to address in sessions. In subsequent weekly sessions, the peer educator and participant worked through the curriculum with particular attention to these priority issues. After completing the curriculum, participants had the opportunity to participate in issue-specific group sessions for extended discussions.
Local Involvement/ Ownership	PI reports program activities to the "men sector" committee of Botswana's National AIDS Coordinating Agency each quarter. While the committee does not provide financial support, it does help PI secure access into communities. Community leaders then help select peer educators from within the community.
Evaluation Methodology	▪ *Monitoring data:* Data are collected upon registration for each participant and include basic demographic data (name, age, residence, etc). In addition, during the intake survey, data are collected from each participant on issues the client and peer educator identify for intervention, and noted against a checklist of the various curriculum topics. ▪ *Process data (checklist):* The checklist is then used to track participants' progress in knowledge and understanding of each identified area.
Evaluation Results	▪ *Monitoring data:* 4,006 men have participated since the project commenced. Participants identified 7,626 different messages/topics during the assessment process (some participants identified more than one priority topic). There have been 10,128 one-on-one peer counseling sessions, with each participant, on average, meeting with a peer educator at least twice. There have been 9,673 participants in group sessions (some men participated in more than one session; on average, participants attend two or more group sessions upon curriculum completion). ▪ *Process data (checklist):* The data show that the project is meeting 70 to 90 percent of the set targets. Attrition among the male peer educators is higher than expected. However, with the increase of the volunteer stipend, the project anticipates better results. Anecdotal information suggests change in behaviors among some participants, including reduction in alcohol intake and better communication between

	men and their partners.
Replication and Scale-up Activities	▪ The Botswana government has added the program to its national operation plan. PI will spearhead replication nationally by involving additional implementation partners, who will be selected through a competitive bidding process. Although extensive community participation keeps expenses relatively low, the project requires external funding to expand into other communities and to be sustainable.
LESSONS LEARNED AND CHALLENGES	
Key Findings and Lessons	The project has been successful in broadening perceptions of gender beyond the idea of "women's rights." After the sessions, anecdotal data suggest that most men are comfortable talking about gender issues and better understand the association of gender norms and behaviors that increase HIV risk. Project implementers have noticed change at the family, peer, and community levels. For example, one participant stated after the sessions, "The society has put us in the box, which makes us either spread HIV or contract HIV. We as men now need to get out of the box and use these opportunities that we have in a more positive way…We need to be more caring, loving, listen, trustworthy, emphatic, etc., so as to nurture our relationships with our partners and even at the family level."
Challenges and Unforeseen Outcomes	Some peer educators had left the program because they perceived it as a low-paying and unreliable job opportunity. Consequently, the peer educator allowance amount was increased.
Recommendations for Replication	▪ Coordination at all levels is key in this project. ▪ Supervisors should work with peer educators day-to-day to ensure quality of reporting. ▪ It is crucial for the project to work with existing local structures so that it is accepted. ▪ The program requires existing national coordinating mechanisms that are efficient and effective.
ADDITIONAL INFORMATION	
Program References and Resources	Pathfinder International, "The Expansion of Psychosocial and Peer Counseling Services to HIV-infected Women, Their Partners, and Families." http://www.pathfind.org/site/PageServer?pagename=Programs_Botswana_Projects_PeerCounseling, accessed July 2, 2008.
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OPERATION HAUTE PROTECTION (OHP)

LEAD ORGANIZATIONS: Population Services International (PSI)

COUNTRY: Côte d'Ivoire

HIV PROGRAM AREA: Prevention, Care and Support

OVERVIEW:
OHP seeks to reduce HIV prevalence among uniformed services personnel and their families. The program implements behavioral change communication activities, provides HIV counseling and testing (including rapid tests in military health facilities and mobile units), and offers palliative care services through community-based and health facility-based interventions. OHP also seeks to delay the debut of sexual intercourse and promotes condom use, in part by improving women's abilities to negotiate sex. With peer education sessions, the program seeks to improve knowledge of the link between HIV transmission and high-risk behaviors. OHP also is trying to mitigate the perception that male infidelity is proof of virility, and to improve awareness of harmful masculine behaviors, such as cross-generational and transactional sex, multiple concurrent partnerships, and substance abuse. The program reached nearly 500,000 people from October 2006 to March 2008. Challenges have included overcoming HIV-related stigma, which can make it difficult to provide support to HIV-positive uniformed personnel; working within military hierarchies; and overcoming men's resistance to considering how certain gender norms contribute to HIV risk.

BACKGROUND	
HIV & AIDS Program Goals	OHP seeks to reduce HIV and AIDS prevalence and impact among uniformed personnel and their families.
Gender Strategies Addressed	✓ Reducing violence and coercion ✓ Addressing male norms and behaviors ☐ Increasing women's legal protection ☐ Increasing women's access to income and productive resources ✓ Other: gender equity
Description of Intervention	In response to high HIV prevalence, low risk perception, and a low rate of awareness of HIV status, OHP works with uniformed personnel and their families to reduce the impact of HIV. The program implements behavior change communication activities through peer education and community-based activities. It also provides HIV counseling and testing, including rapid tests through mobile units and fixed centers integrated into military health facilities. OHP offers palliative care services through community-based and health-facilities-based interventions. For peer education sessions among adults, male service personnel speak with other male uniformed services personnel, while female partners of uniformed personnel speak with other female partners. For certain sensitization activities, the uniformed service personnel and their partners come together in small groups to discuss specific prevention themes. Youth leaders are trained to be peer educators as well, conducting small-group education sessions that seek to delay the debut of sexual intercourse and, when appropriate, promote correct and consistent use of condoms.

	Sessions center around small group activities. Groups are determined by two criteria. The first is age, with groupings of 7- to 10-year-olds, 11- to 14-year-olds, and 15- to 24-year-olds. The communication messages are adapted according to age and sexual habits of the age group. The second criterion is by sex, with groups of only girls, only boys, or a mix of the two. The division between sexes allows the children to speak without inhibition. Members of the Epouses des Militaires de Côte d'Ivoire *(*AEMCI), a military wives association, are trained to conduct sessions with parents, particularly mothers, on how to discuss sexual and reproductive health issues with their children. Peer educators use information, education, and communication (IEC) materials and educational kits to cover issues such as mutual fidelity and other means of prevention such as correct and consistent condom use. Discussions around the fight against stigma and discrimination also occur. HIV mobile and fixed counseling and testing sites deliver services based on national norms. Clients are also referred to health centers, local associations, and nongovernmental organizations for palliative care services. Peer educators help ensure that uniformed service personnel and their families are aware of and use available services. Gender-related activities were planned for and included at the beginning of the program. OHP addresses **gender equity** by working with AEMCI to improve women's abilities to negotiate condom use, to advocate for orphans and vulnerable children, and to advocate for the rights of women who test positive and are rejected by their spouses. In small-group peer education sessions, the program also seeks to improve knowledge of the link between HIV transmission and high-risk behaviors, such as gender-based **violence**. OHP also uses sessions to target **male norms**, such as the perception that infidelity among males is a proof of virility, as well as improve awareness of harmful masculine behaviors, such as cross-generational sex, transactional sex, multiple concurrent partnerships, and substance abuse.
Target Audience	Uniformed personnel, their partners, and their children
Level of Intervention	▪ Individual ▪ Family ▪ Community ▪ District ▪ National
Geographic Location	Nationwide
Timeframe	October 2005–September 2009
Funders	▪ The U.S. President's Emergency Plan for AIDS Relief (PEPFAR) through the United States Centers for Disease Control and Prevention (CDC)

Partner Organizations	*Implementation partners:* ▪ Côte d'Ivoire Ministries, including Ministry of Defense; Ministry of Interior Security; Ministry of Environment, Water Resources and Forests; Ministry of Public Health; Ministry of the Fight Against AIDS; Ministry of Transportation; Ministry of Tourism and Handicrafts ▪ Network of Ivorian Associations Living with HIV (RIP+) ▪ Caritas Côte d'Ivoire ▪ Ivorian Agency for Social Marketing (AIMAS) ▪ Espoir Fanci ▪ Epouses des Militaires de Côte d'Ivoire *(*AEMCI) ▪ Bouake Eveil ▪ Lumière Action Korogho ▪ ADA Man ▪ Pompon Rouge ▪ Johns Hopkins Bloomberg School of Public Health/Center for Communication Programs (JHU/CCP) ▪ Jhpiego ▪ Family Health International (FHI) ▪ Elizabeth Glaser Pediatric AIDS Foundation ▪ Academy for Educational Development (AED) ▪ International HIV/AIDS Alliance ▪ ACONDA ▪ HOPE worldwide *Evaluation partners:* ▪ Cabinet de Consultants Associés C.Y. (CCACY)
IMPLEMENTATION AND RESULTS	
Start-up and Implementation Process	The support of unformed personnel hierarchies is essential for program work with this target population. Sites, including military camps, were selected in collaboration with the related Ministries and unformed personnel branches. OHP then worked with the branches to develop criteria for training participants. Senior military personnel identified liaison officers and site supervisors to plan and implement activities. Peer educators were identified and trained, and receive yearly refresher trainings from trained unformed personnel. Uniformed personnel as well as members of the Military Wives Association have been trained as trainers, and OHP's national trainers are used when the unformed personnel trainers are unavailable. When a peer educator departs, a replacement is trained. Messages are evidence-based and appropriately targeted to address desired behavior change outcomes. Key partners, including the armed services and PEPFAR, have validated OHP's monitoring and evaluation tools. Baseline and follow-up survey findings are conducted to ensure the program is maximizing resources and health impact. OHP partnered with local nongovernmental organizations to ensure provision of services that it cannot offer. For example, OHP provides information on antiretroviral treatment facilities in the area for HIV care and treatment.

	Supervision occurs on two levels: site supervisors trained by OHP visit each site monthly, and OHP staff and select liaison officers conduct quarterly supervision visits.
Local Involvement/ Ownership	Communities are involved in project management at the central and local levels, and all program employees and members of target groups receive training in conducting program activities. Communities also identify trainers and peer educators.
Evaluation Methodology	▪ *Baseline survey*: A qualitative and quantitative survey was conducted in the first quarter of 2008 to measure baseline key determinants of HIV risk among uniformed personnel and their partners. A follow-up survey is expected in 2009. ▪ *Monitoring data collection*: Data on program activities are regularly collected through monthly and quarterly reports that measure the number of people trained, number of people reached by services, and number of sites/centers delivering services.

Evaluation Results	▪ *Baseline survey*: The report on survey findings has not yet been released. Impact cannot be determined until a follow-up survey is conducted in 2009.
	▪ *Monitoring data collection*:
	  ▪ 474,519 people were reached by program activities from October 2006 to March 2008 (390,727 men and 83,792 women).
	  ▪ As of June 2008, 25,961 people have participated in HIV counseling and testing (15,452 men and 10,507 women).
	  ▪ More than 1,430 individuals have been trained to conduct education sessions on sexual and reproductive health.

Replication and Scale-up Activities	▪ The program originally was limited to 40 sites. In the second year, it was scaled up to 50 sites. ▪ The target group originally was military personnel, their partners, and child soldiers. In the second year, the program was expanded to all uniformed personnel (police, customs, water, and forests) and their partners and children. Child soldiers were demobilized and integrated back into their families and communities. All services (prevention, counseling and testing, and palliative care) have progressively been expanded to all program sites.
LESSONS LEARNED AND CHALLENGES	
Key Findings and Lessons	▪ Creating a liaison office with personnel designated by uniformed branch hierarchies promotes buy-in, better coordination across all levels, and sustainability. ▪ Commitment of the uniformed personnel hierarchy is crucial and can be facilitated by formal memorandums of understanding. ▪ Peer educators should be selected based on distinct criteria and should

	be self-motivated to inform their peers rather than being motivated by incentives. ▪ Working with associations of uniformed personnel spouses can facilitate message dissemination and help ensure that women are included as key decision-makers in the fight against HIV. ▪ Baseline and follow-up surveys are crucial for identifying key behaviors and issues. ▪ Referral networks ensure that target populations have access to a full range of prevention, care, support, and treatment services. ▪ Activities geared specifically toward couples help to address gender norms.

Challenges and Unforeseen Outcomes	▪ Some men resist viewing and addressing gender issues as contributing to HIV risk.
	
	▪ Peer education sustainability has been a challenge, as peer educators can view HIV education as additional work instead of as a regular part of their required duties.
	
	▪ Hierarchy is a barrier to uniformed personnel involvement if leaders do not prioritize HIV education as a staff task.
	
	▪ Community mobilization for HIV counseling and testing has been challenging due to fear of stigma and discrimination.
	
	▪ Confidentiality in the context of the armed forces was a concern in implementing intervention activities. This was addressed in the following ways:
	  ▪ At the time of HIV screening and counseling, a code attributed to the person is used in lieu of his or her name.
	  ▪ The counselors who work in the counseling and screening services take a confidentiality oath regarding client results.
	  ▪ In Côte d'Ivoire, the state does not demand that OHP hand over the list of people who tested HIV-positive.
	  ▪ Community counselors, who track people who screened positive, are strictly required to respect their confidentiality.

Recommendations for Replication	▪ Conduct a baseline survey to identify key determinants of HIV risk that should be addressed by behavior change activities. ▪ Train volunteer peer educators in prevention activities. ▪ Train uniformed health personnel for service delivery (counseling and testing, support, care, and treatment). ▪ Distribute free condoms within military camps and create sales points around program sites. ▪ Implement a mass communications campaign among uniformed personnel to promote safer behaviors. ▪ Organize peer education events to address prevention and other key

	issues. ▪ Involve uniformed personnel at all levels of the hierarchy in all program development activities, from proposal writing to monitoring and evaluation. ▪ Involve representatives of target groups in all coordination and planning mechanisms. ▪ Have the ministries that oversee the various uniformed personnel, such as the Ministry of Defense, develop a specific HIV policy that considers the needs and realities of uniformed personnel. ▪ Conduct midline and endline surveys for impact evaluation.
ADDITIONAL INFORMATION	
Program References and Resources	The 2008 Tracking Results Continuously report will be available in 2009. Please contact PSI directly for further information.
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BIRUH TESFA (BRIGHT FUTURE)

LEAD ORGANIZATIONS: Population Council
Ethiopia Ministry of Youth & Sports

COUNTRY: Ethiopia

HIV PROGRAM AREA: Prevention, Care and Support

OVERVIEW:
Biruh Tesfa addresses vulnerabilities of migrant adolescent girls who have relocated to urban areas and are at risk of coerced sex, transactional sex, and exploitative labor. The program seeks to protect these girls by reducing their social isolation and providing them with health information, including HIV prevention, and services to address sexual exploitation and abuse. Through the program, female community leaders mentor out-of-school girls ages 10–19, addressing issues such as reproductive health and violence. Program services ensure that girls have access to health care; rape victims can obtain support services; and a shelter is available for evicted domestic workers (many of whom are migrant girls). Girls also can get identification cards along with vocational training and job placement. Challenges include negotiating with employers to allow girls to participate and dealing with the general mobility of this population. Evaluation results from an endline survey are forthcoming.

BACKGROUND	
HIV & AIDS Program Goals	Under the HIV Prevention for Vulnerable Adolescent Girls Program, Biruh Tesfa addresses vulnerabilities of migrant adolescent girls who have relocated to urban areas and are at risk of coerced sex, transactional sex, and exploitative labor. Biruh Tesfa seeks to protect these girls by reducing their social isolation and providing them with health information, including HIV prevention, services to address sexual exploitation and abuse, and functional literacy skills.
Gender Strategies Addressed	☑ Reducing violence and coercion ☐ Addressing male norms and behaviors ☐ Increasing women's legal protection ☑ Increasing women's access to income and productive resources ☐ Other:
Description of Intervention	The Population Council, under Biruh Tesfa, works with *kebele* administrations, the lowest administrative unit in Ethiopia, to mentor out-of-school girls ages 10–19, most of whom have migrated from rural areas to the city. The core of Biruh Tesfa is its mentorship program. Adult mentors address topics such as HIV and AIDS, reproductive health, and violence and coercion. The mentorship program also provides participants with social support to deal with situations where violence or coercion might take place. The mentorship training manual also covers nonformal education (Ministry of Education material), communication skills, psychosocial skills and self-esteem, common health problems and how to prevent them, HIV transmission and prevention, reproductive health, gender-based violence and rape, condoms and other family planning methods, financial literacy and savings, and entrepreneurship. When one of the girl participants disclosed to her mentor that she had been raped four months earlier, the Population Council provided participants with

	a new bridge to the health care systems by establishing a relationship between the program and government health clinics. Partnered with a local female entrepreneur who makes washable, reusable pads, Biruh Tesfa hosts discussions on menstruation, a subject about which many participants are not knowledgeable. In addition to these partnerships, the program funds a local nongovernmental organization, the Organisation for the Prevention Rehabilitation and Integration of Female Street Children (OPRIFS), to provide support services to participants who have been raped. In June 2008, Population Council funded OPRIFS to expand services at its shelter in Addis Ababa to domestic workers who have been evicted from their homes or abandoned. Biruh Tesfa also provides valid ID cards, signed by the *kebele*. Because of their vulnerable status and distance away from home, it is difficult for these girls to acquire government ID cards. Biruh Tesfa ID cards have helped make the program well known at the local level, and afforded girls some level of identity, affiliation, and protection in these dangerous urban environments. Biruh Tesfa has also recently partnered with another local nongovernmental organization, the Nia Foundation, to provide vocational training and job placement services to program participants, especially those who are orphans or vulnerable children. The program works to **reduce violence and coercion** through the mentorship program, in which mentors are trained in and discuss these issues with girls; and by providing girls with access to social support through the mentorship program and local partner OPRIFS. The program seeks to **increase access to income and productive resources** by providing training in financial literacy, savings, and entrepreneurship through the mentorship program, and by working with the Nia Foundation to provide girls with vocational skills and job placement services.
Target Audience	Adolescent girls in urban areas
Level of Intervention	▪ Community ▪ District
Geographic Location	Addis Ababa and Amhara region, specifically Bahir Dar and Gondar
Timeframe	2006–ongoing
Funders	▪ UK Department for International Development (DFID) ▪ Nike Foundation ▪ The U.S. President's Emergency Plan for AIDS Relief (PEPFAR) through the United States Agency for International Development (USAID) ▪ United Nations Population Fund (UNFPA) ▪ United Nations Foundation (UNF) ▪ United States Agency for International Development (USAID)

Partner Organizations	*Implementation partners:* ▪ The Organisation for the Prevention Rehabilitation and Integration of Female Street Children (OPRIFS) ▪ Nia Foundation ▪ Ethiopian Women with Disabilities Association ▪ *Kebele* administrations ▪ Ethiopia Ministry of Youth, Sports and Culture ▪ Addis Ababa Youth and Sport Commission ▪ Bahir Dar Youth and Sport Office
IMPLEMENTATION AND RESULTS	
Start-up and Implementation Process	The Population Council conducted qualitative and quantitative research on differing vulnerabilities for adolescent girls in urban (slums) and rural areas. Findings indicated there were a large number of female migrants in Addis Ababa in comparison to male migrants. However, adolescent girls reported that they had had no interaction with intervention programs. In response to this need, the Population Council designed Biruh Tesfa to provide girls with a female mentor within a safe space. The program trains female community leaders who mentor the girl participants. These mentors go from house to house to recruit girls, many of whom are in domestic work to avoid early marriage. Population Council decided to partner with *kebele* administrations, which also have the ability to provide meeting spaces. Building on the original mentorship program, additional components such as the linkage with the local health clinics and vocational training were added as the needs of participants became apparent. After low uptake and retention among disabled girls was observed, the Population Council also began working with the Ethiopian Women with Disabilities Association.
Local Involvement/ Ownership	Local women leaders are identified and trained to serve as mentors for program participants. *Kebele* participation is key to community ownership and evident in the contribution of space for program activities.
Evaluation Methodology	▪ *Baseline survey*: In 2004, a population-based study was conducted with about 1,200 adolescent girls in experimental and control areas. Indicators assessed many gender aspects including attitudes, autonomy, agency and friendship networks. Using in-depth interviews, data were collected every five to six months to monitor quality and perception of the intervention. ▪ *Endline survey*: Data collection and analysis is currently in progress.
Evaluation Results	▪ *Project reach*: More than 3,700 out-of-school adolescent girls are participating in the program, 2,400 from Addis Ababa slums and 1,300 from Bahir Dar. ▪ *Baseline survey*: Results indicate that 43 percent of girls in slum areas were migrants from rural areas, compared to 29 percent of boys; 15 percent of female adolescents in the survey were domestic workers;

	and among working girls, 77 percent engaged in domestic work. Ten percent of girls had never been to school, the vast majority of these being migrants. ▪ *Endline survey*: Results are forthcoming.
Replication and Scale-up Activities	Biruh Tesfa will be expanded to Gondar and eventually will include sites in smaller towns of Ethiopia.
LESSONS LEARNED AND CHALLENGES	
Key Findings and Lessons	▪ Working with girls helps keep programs in touch with the needs of the community. ▪ Partnership with local government promotes acceptance and sustainability.
Challenges and Unforeseen Outcomes	▪ Negotiation with employers was a big challenge. In a typical scenario, an instructor might notice that a girl participant has not shown up for class. It turns out that girl, who had been employed as a live-in domestic worker, was evicted for attending school and as a result is now living on the street. To prevent such a scenario, the program now tries to coordinate better communication between the girl's mentor and her employer. ▪ The target population is highly mobile.
Recommendations for Replication	▪ The program model is not expensive to replicate. It costs about US $40, per beneficiary, per year to implement at the field level. This includes setting up staff with one field coordinator paying the mentors. Further costs include subsidies to health centers and feminine hygiene products. It is cost-saving to work in partnership with local administrations.
ADDITIONAL INFORMATION	
Program References and Resources	Erulkar, A.S., T. Mekbib, and M. Tegegne. *Biruh Tesfa: Creating a 'Bright Future' for Migrant Girls in Urban Areas of Ethiopia.* New York: Population Council, 2008. Erulkar, A.S., and T. Mekbib. "Invisible and Vulnerable: Adolescent Domestic Workers in Addis Ababa, Ethiopia." *Vulnerable Child and Youth Studies* 2, no. 3 (2007): 246–256. Erulkar A.S., T. Mekbib, T., N. Simie, and T. Gulema. "Differential Use of Adolescent Reproductive Health Programs in Addis Ababa, Ethiopia." *Journal of Adolescent Health* 8, no. 3 (2006a): 253–60. Erulkar, A.S., T. Mekbib, N. Simie, and T. Gulema. "Migration and Vulnerability Among Adolescents in Slum Areas of Addis Ababa, Ethiopia."

	Journal of Youth Studies 9, no. 3 (2006b): 361–74. Erulkar A.S., T. Mekbib, N. Simie, and T. Gulema. *Adolescent Life in Low Income and Slum Areas of Addis Ababa.* Ethiopia: Population Council, 2004.
Contact Information	Population Council, Ethiopia Heritage Plaza, 1st Floor, PO Box 25562, Code 1000, Bole Road, Addis Ababa, Ethiopia Tel: + 251 0 116 631 712/14/16/20 / Fax: + 251 0 116 631 722 Website: http://www.popcouncil.org/projects/PGY_EthiopiaHIVPrevAdolGirls.html Annabel Erulkar, Country Representative Email: aerulkar@popcouncil.org

ETHIOPIAN RADIO SERIAL DRAMAS TO PREVENT HIV/AIDS

LEAD ORGANIZATIONS: Population Media Center (PMC)

COUNTRY: Ethiopia

HIV PROGRAM AREA: Prevention

OVERVIEW:
In Ethiopia, PMC is using radio serial dramas to promote reproductive health, provide information about preventing HIV and sexually transmitted infections, and encourage gender equity. Formative research is used to develop long-running serial radio dramas that are appropriate to the local context and encourage positive social change. In the dramas, key characters navigate real-life challenges and eventually adopt positive behaviors. Themes include living with HIV and high-risk behaviors such as multiple sex partners, drug abuse, and violence against women. Monitoring evaluation showed a continuous increase in reproductive health clients who cited the radio program as the primary motivating factor for accessing services. Further, an independent evaluation showed that female respondents reported increased communication with their partner on HIV and AIDS issues, and both men and women reported being more comfortable with the idea of using condoms. The project found that it is important to address both female and male attitudes and behavior. Also, by addressing multiple issues, the dramas were able to raise awareness around an array of cultural attitudes and behaviors that fuel the spread of HIV.

BACKGROUND	
HIV & AIDS Program Goals	Through evidence-based media communication, PMC uses radio serial dramas in Ethiopia to promote the use of reproductive health services, provide information about preventing HIV and AIDS and sexually transmitted infections, and encourage gender equity.
Gender Strategies Addressed	✓ Reducing violence and coercion ✓ Addressing male norms and behaviors ☐ Increasing women's legal protection ☐ Increasing women's access to income and productive resources ✓ Other: women's empowerment, female access to education and reproductive health
Description of Intervention	PMC developed and broadcast two radio serial dramas. *Yeken Kignit* ("Looking Over One's Daily Life") was a 257-episode radio serial drama produced and broadcast nationwide in Amharic. It was broadcast twice a week in the evenings and rebroadcast in the afternoons. *Dhimbibba* ("Getting the Best Out of Life") was a 140-episode, Oromiffa language radio serial drama. Both dramas were created using the Sabido methodology for entertainment-education. This methodology, grounded in social and theoretical research, is used to develop mass media serial dramas that are reality-based and adapted to local context. A formative research process identifies community values and norms and informs the development of three types of characters: positive characters (good role models), negative characters (bad role models), and transitional characters. Throughout the course of the drama, transitional characters navigate real-life challenges and eventually adopt positive behaviors (Teffera, 2008).

	In *Yeken Kignit,* Fikerte, who is a positive character, educates her family and friends on the benefits of family planning while Damte, the key negative character, has multiple sex partners and is involved in drug trafficking. Damte, who is a nightclub owner and pimp, also abuses alcohol and in the past has committed numerous crimes against women, including rape. Toward the end of the drama, Damte learns that he is HIV-positive. Wubalem (Fikerte's sister), is a transitional character. She suffers from fistula and is torn between satisfying her husband's desire to have another child and taking her sister's advice on birth spacing. Eventually, Wubalem is able to convince her husband that they should wait to conceive again and in the meantime use contraception. The story line is enhanced by the diverse and realistic settings in which these and other characters reside. Wubalem lives in Tena Adam, a densely populated town with deep roots in traditional practices, such as child marriage and bride abduction. Other scenes take place in Asqual, a big town where the prevalence of drug abuse and other high-risk behaviors is high. *Dhimbibba's* story lines similarly addressed issues such as reproductive health, HIV and AIDS, early marriage, women's empowerment, girls' education, and the use of family planning. These two dramas use the interaction between characters who display positive, negative, and neutral behaviors to address HIV and AIDS, family planning, and a range of gender issues. Both dramas address **violence and coercion**—rape in the case of *Yeken Kignit* and verbal abuse in the case of *Dhimbibba*. The shows also address traditional **male norms**, such as high-risk behaviors among men that increase their risk of HIV infection. The shows also speak to a range of **other gender-related issues,** such as assumptions about men's and women's roles in making family planning decisions and contributing to household tasks. They also challenge assumptions about gender norms through positive portrayals of female characters who are educated and hard-working, and other characters who promote healthy reproductive health behavior or advocate for better treatment of women. Negative characters who treat the women in their lives poorly, or who perpetuate harmful gender norms, experience unhappy endings, while positive characters are rewarded with happy endings. Thus the dramas are used as an educational tool to promote positive behaviors around HIV and AIDS, reproductive health, and gender.
Target Audience	18- to 49-year-old Amharic and Oromiffa speakers
Level of Intervention	National
Geographic Location	Nationwide
Timeframe	2002–2004
Funders	▪ The David and Lucile Packard Foundation ▪ Ethiopian National HIV/AIDS Prevention and Control Office
Partner Organizations	*Implementation partners:* ▪ Ethiopia Radio and Television Agency

	▪ Ministry of Health *Evaluation partners:* ▪ Birhan Research and Development Consultancy ▪ Family Guidance Association of Ethiopia ▪ Marie Stopes International clinics ▪ Government hospitals ▪ Ethiopian Government Disaster Prevention and Preparedness Agency ▪ Ministry of Health ▪ 50 established Listeners' Groups
IMPLEMENTATION AND RESULTS	
Start-up and Implementation Process	In 1999, the Ethiopian government formally invited PMC to develop and implement a radio-based media strategy. PMC selected an expert advisory committee comprising government officials, representatives of nonprofit and community-based organizations, target audience opinion leaders, and target audience members at large to provide oversight and guidance. Formative audience research identified the issues the program would address, the population groups most vulnerable in relation to these issues, the services and programs currently in place to address the target issues, the country's media infrastructure, and the beliefs, behaviors, and media consumption patterns of the target audience. Findings of this formative research were disseminated during a daylong meeting held in Addis Ababa for the advisory council and project writers and producers. During a three-week workshop, creative staff and the country representative, following the Sabido methodology, used these findings to design settings, characters, and story lines around the major themes of the drama. They produced and tested four pilot episodes to ensure that the program was entertaining, educational, and culturally appropriate. Simultaneously, a promotional campaign to raise awareness about the forthcoming program was launched, and an in-country research institution was selected to independently evaluate the project's effect on knowledge, attitudes, and behaviors around sexual and reproductive health. Health service providers were recruited to ask new clients what motivated their decision to seek services and whether the client was listening to a PMC program, as well as to report to PMC the number of clients they received each month.
Local Involvement/ Ownership	The Ethiopian radio serial dramas rely on the involvement of an expert advisory committee of target audience members, government officials, and nongovernmental organization representatives. Furthermore, the serial dramas are pilot tested with actual audience members to determine if the content is suitable and culturally appropriate. While community involvement is high, this approach is dependent on the implementer to provide the initial training for drama content development and external funding to sustain the project.
Evaluation Methodology	▪ *Facility assessments (client exit interviews)*: Three rounds of client exit interviews were conducted in 48 health clinics during 2003 and 2004. The first round, completed in February 2003, consisted of interviews with 4,084 clients. The second round, which included interviews with 4,858 clients, was completed in April 2004. The third round was completed in November 2004 and included interviews with 3,649

	clients. These interviews assessed use of family planning and reproductive health services and the impact of the radio drama in increasing uptake of these services. ▪ *Pre-/post-evaluation*: A quantitative survey, using pre/post methodology, was administered to evaluate program exposure and the project's effect on changing 1) HIV knowledge, attitudes, and behavior, 2) contraceptive knowledge, attitudes, and practices and 3) perceptions of gender and social norms. Using a stratified, multistage sampling design, data were collected from residents in two Amhara and Oromiya regions and the city of Addis Ababa. Amhara and Oromiya regions served as proxies for all Amharic- and Oromiffa-speaking populations in Ethiopia. Sample size at baseline was 2,250 households and 1,875 at endline. Baseline and endline data were compared using cross-tabulations. Also, multivariate analyses using logistic regression were conducted to further assess the relative importance of certain characteristics in explaining key indicators, such as spousal communication about HIV and AIDS. Differences between listeners and nonlisteners on key indicators also were examined. ▪ *Ethiopian government evaluation*: The Disaster Prevention and Preparedness Agency and the Ministry of Health of Ethiopia spent three weeks in four major regions appraising the project.
Evaluation Results	▪ *Project reach:* Approximately half of Ethiopia's population has listened to at least one of PMC's radio dramas—about 40 million listeners. ▪ *Facility assessments (client exit interviews)*: Each succeeding assessment report showed an increase in the percentage of male and female clients citing radio as the primary motivating factor in seeking health services. Between the first assessment (February 2003) and the third assessment (November 2004), the proportion of all clients citing radio as their primary motivation for seeking services rose from 6.3 percent to 18.8 percent. Among those who cited radio as the primary motivation to seek services, there was a 16 percentage point increase in clients who cited the *Yeken Kignit* radio drama by name. By the time of the third assessment, 84 percent cited *Yeken Kignit* as their primary motivation for seeking services. ▪ *Pre-/post-evaluation*: At endline, female respondents reported increased communication with their spouse/partner on HIV and AIDS issues. Significant differences were reported between listeners and nonlisteners of *Yeken Kignit* on condom use: 78 percent of male listeners of *Yeken Kignit* felt comfortable in suggesting condom use, compared to 57 percent of male nonlisteners ($p < .05$). Likewise, 85 percent of female listeners of *Yeken Kignit* reported that it is okay for a wife to ask her husband to use a condom if she suspects he may have HIV, compared to 76 percent of female nonlisteners ($p < .05$). Compared with nonlisteners, male listeners of *Dhimbibba* were less likely to support older men marrying girls—14 percent of male listeners compared to 17 percent of nonlisteners ($p < .05$). Data also were collected on norms and beliefs, particularly around violence. Female and male respondents were asked if they thought a husband is justified in beating his wife given certain circumstances. This information serves as a proxy for respondents' perceptions of the status of women. At endline, about 85 percent of the females surveyed believed it is unjust for a husband to beat his wife when she refuses sex, compared to

	64 percent at baseline. ▪ *Ethiopian government evaluation*: The Disaster Prevention and Preparedness Agency and the Ministry of Health of Ethiopia concluded that the project fulfilled its objectives and is a role model for other agencies using the media for HIV prevention and reproductive health promotion.
Replication and Scale-up Activities	▪ With the *Yeken Kignit* and *Dhimbibba* story lines concluded, a new series is now on the air. *Sibrat* (Trauma) is part of a three-year campaign produced in collaboration with the Norwegian government and aimed at combating harmful traditional practices, especially female genital mutilation. ▪ PMC has produced five radio serial dramas, a radio phone-in, and panel discussion program aimed at youth, two radio magazine programs, a full-length play, and various publications including a youth magazine, four collections of Ethiopian short stories, and one collection of 'real-life,' nonfiction stories, all with the goal of improving the status of women, improving reproductive health, and preventing the spread of HIV.
LESSONS LEARNED AND CHALLENGES	
Key Findings and Lessons	▪ It is important to address both female and male attitudes and behaviors. Particularly in a society that is dominated by men, it is important to appeal to men and show them the benefits of, for example, educating daughters, having discussions with their wife about the size of their family, limiting sexual partners, treating women with dignity and respect, and valuing women and girls in society. At the same time it is important to develop female role models that can exemplify the benefits of education, delaying marriage and childbearing, starting their own businesses, and advocating for women's rights. ▪ The dramas addressed multiple issues, including gender equity, reproductive health, and HIV and AIDS, in the story lines. This helps the program connect with the audience on a variety of levels and demonstrate a range of positive behaviors and benefits. ▪ Pre- and post-intervention data collection for this project was based on the standard Demographic and Health Surveys (DHS) questionnaire, with several questions directly related to PMC's radio serial drama programs. Creating a program-specific questionnaire would have allowed PMC to better explore how messages are received, shared, and discussed, and how they impact the target population. PMC has since implemented the use of program-specific questionnaires in other projects.
Challenges and Unforeseen Outcomes	▪ An unforeseen outcome of the project was the increase in the percentage of female and male listeners reporting that they were tested for HIV. ▪ One challenge in project implementation was creating a strong promotional campaign and organizing listening groups, particularly for

	those who do not have access to radio. ▪ While PMC chose the two most widely spoken languages in Ethiopia, it would be useful to have the program produced in more languages to reach more people.
Recommendations for Replication	▪ Begin with a consensus-building workshop. Invite concerned government, nongovernmental and media agencies, including media and theater arts experts, scriptwriters, and radio program producers. ▪ Conduct a literature review. This will help identify research and information gaps, explore the effectiveness and capacity of other implementing agencies, understand the status of social-content radio serial dramas in the country, and determine whether any audience research has already been conducted. ▪ Conduct a media assessment to explore the strengths and weaknesses of existing social-content radio and television drama programs. Check the target audience's preferred broadcast time. ▪ Conduct formative research to assess the knowledge, attitudes, and behaviors regarding, for example, reproductive health and family planning, HIV and AIDS, and other social issues among the target audience. The research also can be used to identify the primary and secondary audiences for the serials, and determine socioeconomic and cultural issues to be addressed. ▪ Conduct a capacity-building workshop for scriptwriters and program producers. Train them on the methodology and skills of radio serial drama scriptwriting, and present the sociocultural aspects of the issues to be covered. ▪ Establish a technical advisory committee composed of scriptwriters, radio program producers, a creative arts adviser, a senior research officer, a gender expert, a communication expert, and a representative from the Ministry of Health. The committee should help check the accuracy of material presented, keep the balance between entertainment and education, and refine the scripts as needed. ▪ Develop and discuss the story line, including character profiles and settings, based on the issues identified in the formative research. ▪ Develop and discuss the plots for each scene before starting to write the full script. Make sure the cliff-hangers are well done at the end of each scene and in particular at the end of the episode. ▪ Write an epilogue suitable for each episode. ▪ Pretest the pilot episodes with target audiences using standard pretesting tools. ▪ Conduct a baseline survey as a benchmark for the final evaluation of the dramas. ▪ Monitor programs through an analysis of listener letters, listener-group diaries, quarterly focus group discussions, and a health facility assessment.

	▪ Conduct a post-intervention survey for impact evaluation.
ADDITIONAL INFORMATION	
Program References and Resources	*Print resources*: Teffera, N. ”Hearing Is Believing: Creating Radio Serial Dramas to Help Educate Ethiopian Listeners About Key Health Issues Proves a Stunning Success.” *Communication World* 25 (2008): 33–36. *Online resources*: Barker, K., and M. Sabido. *Soap Operas for Social Change to Prevent HIV/AIDS – A Training Guide for Journalists and Media Personnel*. 2005. http://www.unfpa.org/upload/lib_ pub_file/538_filename_training_guide.pdf. INFO Project, Center for Communication Programs, Johns Hopkins Bloomberg School of Public Health. ”Communication Motivates Behavior Change.” *Population Reports,* January 2005. http://www.populationmedia.org/wp-content/uploads/2008/04/ethiopia-yeken-kignit-in-population-reports.pdf. Population Media Center. *Ethiopia Final Report on ‘Yeken Kignit’ and ‘Dhimbibba.’* 2007. http://www.populationmedia.org/wp-content/uploads/2007/11/ethiopia_final_report.pdf.
Contact Information	Population Media Center P.O. Box 547, Shelburne, Vermont 05482 USA Tel: + 1 802 985 8156 (US) Tel: + 251 115 552 0990 (Ethiopia) Websites: http://www.populationmedia.org, http://www.populationmedia.org/where/ethiopia/ Negussie Teffera, Ph.D., Country Representative, Population Media Center – Ethiopia Email: n.teffera@ethionet.et

BINTI PAMOJA

LEAD ORGANIZATIONS: Carolina for Kibera (CFK)

COUNTRY: Kenya

HIV PROGRAM AREA: Prevention

OVERVIEW:
Binti Pamoja (Daughters United) is a reproductive health and women's rights center for adolescent girls living in a slum area of Nairobi. The center helps adolescent girls confront serious issues that are part of their daily lives, such as violence, abuse, poverty and HIV. It facilitates discussions on these issues; provides information on HIV prevention and reproductive health; offers monthly speakers and field trips; organizes community service projects; offers a two-year peer education training program for girls to work at the center and in their community; provides victims of violence with a safe space and testing and counseling referrals; raises community awareness on issues of concern to the girls; and offers financial literacy training. Evaluation results show that participants enjoy increased confidence and self-esteem, and the community perceives the program positively. The program implementers found that the girls' needs were greater than the scope of the original project, and the program needed to adapt accordingly by broadening services.

BACKGROUND	
HIV & AIDS Program Goals	The Binti Pamoja *(*Daughters United) Center is a reproductive health and women's rights center for adolescent girls in a slum area in Nairobi. The center assists adolescent girls to confront the many serious issues that are part of their daily lives, such as violence, abuse, poverty and HIV.
Gender Strategies Addressed	✓ Reducing violence and coercion ☐ Addressing male norms and behaviors ✓ Increasing women's legal protection ✓ Increasing women's access to income and productive resources ☐ Other:
Description of Intervention	The Binti Pamoja Center provides a safe space for adolescent girls within the slum area of Kibera, Nairobi. Through photography, drama, writing and group discussion, Binti Pamoja helps girls confront issues such as violence against women, rape, prostitution, HIV and AIDS, female genital mutilation, poverty, sexual abuse, unequal access to education, lack of reproductive health care and information, and demanding domestic responsibilities. The center also offers technical information about reproductive health and financial literacy. The center hosts monthly speakers and field trips, community service projects, family events, and peer education programs to further empower the girls and provide an outlet for them to educate their communities through drama, a newsletter and youth forums. A new group of girls is recruited into the center each year. After two years they graduate into the alumni group, where they take on leadership roles in the center and start new girls' groups in the community. Binti Pamoja addresses the issues of **violence** and legal protection by providing victims of gender-based violence with a refuge and referring them to testing, counseling, and legal and other support resources. The center

	promotes HIV prevention through peer education and empowerment workshops, which in turn promote the confidence and ability of girls to negotiate safer sex. Through newsletters and drama skits, girls in the program build awareness of HIV-related stigma and other gender issues for the wider community. The program increases girls' **legal protection** by providing various educational programs that teach the young women about basic rights and referring girls to legal resources for any specific legal consultation or action. One of Binti Pamoja's main subprograms increases girls' **access to income** through a Financial Literacy Curriculum, written in conjunction with the Global Financial Education program. Participants are educated on savings, budgeting skills, banking services, and earning money, and program alumni are trained to be facilitators of the curriculum. Binti Pamoja also provides educational scholarships to some members.
Target Audience	Girls ages 11–18 in Kibera, Nairobi
Level of Intervention	Community
Geographic Location	Kibera Slums – Nairobi
Timeframe	2002–ongoing
Funders	▪ American Jewish World Service ▪ The Global Fund for Children ▪ Nike Foundation ▪ Population Council ▪ Private and in-kind donations
Partner Organizations	*Implementation partners:* ▪ Population Council ▪ K-Rep Development Agency (KDA) *Evaluation partners:* ▪ Population Council
IMPLEMENTATION AND RESULTS	
Start-up and Implementation Process	Having identified a lack of adolescent girl-specific youth programming, program founders Karen Austrian and Emily Verellen received a small grant from Columbia University and worked with Carolina for Kibera to recruit a group of 12 young women between the ages of 13 and 18. This group, named *Binti Pamoja* ("Daughters United" in kiSwahili) by the members, met three to five times a week in a donated classroom at Kibera primary school. These meetings became Phase One of the Binti Pamoja Center. The Binti Pamoja curriculum was not pre-set; rather, it was determined by the questions, concerns and crucial issues that the young women in the group raised. The first issue they raised was violence against women. Subsequent discussion topics included sex, contraception, sexually

	transmitted infections and ethnic conflict. The group made a field trip to the Coalition on Violence Against Women, a local nongovernmental organization that provides counseling and advocacy on domestic violence. In addition, a reproductive health nurse from the Family Planning Association of Kenya came to a group meeting to speak about contraception and sexually transmitted infections. Members were given disposable cameras and assignments that paralleled discussion topics. The first assignment was "A Day in the Life of a Young Woman in Kibera" and the second was "Reproductive Health Issues." The group used the photos as a tool, together with role-playing and drama, to discuss sensitive issues such as rape, prostitution, and HIV and AIDS. Photography provided a degree of detachment, so the girls could respond to questions such as, "What would you do if you were the girl in the picture?," by exploring alternatives in an impersonal way, even when discussing problems that they likely were facing themselves. Phase One culminated with a photo exhibition in Nairobi that drew more than 300 people, ranging from the girls' friends and families to members of the CFK Board of Trustees and representatives from local women's rights nongovernmental organizations. Each girl chose four photos to be enlarged and displayed and wrote an essay to accompany each. Two members also spoke at the reception, and each girl participated in one of three short skits reflecting the issues discussed throughout the program. Early in the project, it became clear that both the interest and need were present to expand Binti Pamoja into a long-term, sustainable program. From August 2002 to August 2003, Binti Pamoja entered a scaled-back Phase Two, in which the members met twice a week for group discussions, and also had occasional educational speakers and field trips.
Local Involvement/ Ownership	The need is ongoing for reproductive health information and for safe spaces for adolescent girls in Kibera. The peer education model, in which alumni girls become group leaders and share the Binti program in their communities, ensures community ownership of the program. Most importantly, the program has the support of the community.

Evaluation Methodology	▪ *Monitoring data*: Binti Pamoja collects ongoing monitoring data as girls attend meetings, as well as qualitative feedback from participants. Specifically, program evaluators track the number of girls participating in specific activities, the topics addressed, the number of events conducted, the benefits of the event, the effectiveness of the planning process, challenges faced at the implementation process and program successes. The program officer, volunteers and the young women themselves document this information, mostly in the form of reviews, reflections, feedback, and attendance sheets. ▪ *Feedback from facilitators and beneficiaries:* On an ongoing and regular basis, program staff gather feedback in formal meetings from alumni program members facilitating the Safe Spaces program, and in informal discussions with program beneficiaries. ▪ *Qualitative process*: A qualitative process evaluation was conducted in January 2006 on the implementation of the new Financial Literacy Curriculum and Safe Spaces programs. ▪ *Baseline survey*: In March 2008 a quantitative baseline survey was conducted with 66 new members of both core program activities and the Safe Spaces program. A follow-up survey is planned for the spring of 2009.
Evaluation Results	▪ *Monitoring data:* Findings from monitoring data include: ▪ 50 girls participate in Binti Pamoja core program activities. ▪ 350 girls participate in the Safe Spaces program. ▪ Through outreach activities, including field trips and community forums, the program reaches more than 1,000 girls ages 10–22 years every quarter. ▪ *Feedback from facilitators and beneficiaries*: Feedback gathered over time by program staff indicates the following reported changes among beneficiaries: ▪ Increased number of girls wanting to register as members in the center ▪ Increased knowledge of reproductive health and sexuality, and an increased number of adolescent girls making informed decisions ▪ Increased confidence and positive self-esteem among members ▪ Increased number of potential young women leaders and mentors for other adolescent girls in the community ▪ Better parent-child communication around reproductive health ▪ Positive community perception of the program ▪ High level of community participation, promoting ownership of the program in the community. ▪ *Qualitative process*: A six-month Evaluation Report for the two programs is pending publication. Results are not yet available. ▪ *Baseline survey*: Results are not yet available.
Replication and Scale-up Activities	▪ Binti Pamoja has scaled up its activities through its Safe Spaces program. This program trains alumni members of Binti Pamoja to be mentors in the community and start their own girls' groups. After graduating from Binti Pamoja, alumni go through an intensive training

	and then attachment period, in which they observe and learn from an alumni leader of an established Safe Spaces group. Once ready, they identify a safe meeting place in the community and recruit and form their group. Alumni members receive monthly stipends and are supervised by the Binti Pamoja program coordinator and two part-time field officers, who are also Binti Pamoja alumni. To date, the Safe Spaces program has 18 groups and almost 400 girls. ▪ Binti Pamoja's program structure has been put forth as a model through the Kenya adolescent girls learning network (in partnership with Population Council). ▪ The program's Financial Literacy Curriculum is being adapted to local contexts in Bolivia, Peru, Morocco, Nepal, and Uganda, and will serve as the basis for a universal financial literacy curriculum for youth.
LESSONS LEARNED AND CHALLENGES	
Key Findings and Lessons	▪ The program initially focused on reproductive health and HIV leadership-building. However, it became clear that girls needed help in other areas, such as economic empowerment skills and scholarships. ▪ A safe space allows adolescent girls not only to learn important health information, but also to take on leadership roles, develop self-esteem and build communication skills. ▪ It is important to address the issues that girls face in the context of their own experiences, feelings and opinions. For example, when having a workshop on HIV prevention, it is important to answer questions participants have submitted (often anonymously is best), so that you are speaking directly to their experiences and not just hypothetically.
Challenges and Unforeseen Outcomes	▪ Initial funding was a challenge, as was the ability to address the multitude of issues that girls experienced.
Recommendations for Replication	▪ Youth have to be interested in being involved and eventually taking on leadership positions. There needs to be buy-in from the youth. ▪ The program requires facilitators with substantive expertise, training and experience leading youth programs in comparably challenging communities. ▪ Funding is necessary, particularly in the initial phase. ▪ The support of the community is necessary for sustainability. It may not come immediately and certainly can be one of the biggest challenges of the program, but is essential to making an impact.

ADDITIONAL INFORMATION	
Program References and Resources	*Print resources:* Carolina for Kibera. *Tuungane Tuangaze (Let's Unite and Shed Light).* 2006 annual report. Chapel Hill, NC, 2007. *Online resources:* Aid for Africa, "Caroline for Kibera." n.d. http://www.aidforafrica.org/members.php?id=11 (accessed October 17, 2008). Global Giving, "Empowering Girls in Kibera." n.d. https://www.globalgiving.com/pr/1800/proj1771a.html (accessed October 17, 2008).
Contact Information	Carolina for Kibera FedEx Global Education Center The University of North Carolina at Chapel Hill Campus Box 5145, Chapel Hill, NC 27599–5145 USA Tel: +1 919 843 6842 Website: http://cfk.unc.edu Caroline Sawka, Deputy Director Email: bintipamojany@yahoo.com

ENGENDERING EQUALITY

LEAD ORGANIZATIONS: Kenya AIDS Intervention Prevention Project Group (KAIPPG)

COUNTRY: Kenya

HIV PROGRAM AREA: Prevention, Care and Support

OVERVIEW:
The Engendering Equality project seeks to improve the status of rural women, children and youth by increasing their access to information about the links among HIV, AIDS, and general health; agriculture and nutrition; gender inequality; and poverty. The project encourages change through activism, giving community members tools to articulate and advocate for their needs. For instance, it holds open forums where vulnerable women and girls advocate against ideologies and practices that enhance the spread of HIV, and it helps women access information on health, agriculture and property/inheritance laws to improve their understanding of and ability to advocate for their rights in these realms. The project also establishes food gardens in homes of HIV and AIDS-affected households to help these families eat better and to provide income-generating opportunities. Finally, the project has established Nutritional Field Schools to teach basic farming, nutrition and care-giving skills. Evaluations show a broad range of success, from improved knowledge about nutrition, HIV prevention and care-giving, to increased support among men for gender equity, to women's improved abilities to engage in national debates on issues of importance to them. The project has learned the importance of involving men, who otherwise may resist women's participation, and of involving the community at all stages of the project.

BACKGROUND	
HIV & AIDS Program Goals	KAIPPG's mission is to combat the spread and impact of HIV and AIDS, improve rural livelihoods and promote sustainable, grassroots-based development. It focuses its work on improving the status of women, children and youth living in rural areas through increased access to information about the links among HIV, AIDS, and general health; agriculture and nutrition; gender inequality; and poverty. It fosters an approach of self-empowering activism, which helps ensure that projects address community needs.
Gender Strategies Addressed	☐ Reducing violence and coercion ✓ Addressing male norms and behaviors ✓ Increasing women's legal protection ✓ Increasing women's access to income and productive resources ✓ Other: gender equity
Description of Intervention	The Engendering Equality project addresses the information needs of women and girls because access to knowledge and information helps women advocate for their needs and express their views on issues of concern to them, their families, and their communities. The project improves women's access to information on health, agriculture, women's rights, nutrition and HIV and AIDS. To address women's **legal protection**, it also provides women with access to information on property inheritance. The project collects resources, selects and prioritizes the most appropriate information for each group's needs, translates it into appropriate languages

	and produces materials in media that rural women can use easily. Information on each thematic area is recorded on tape and also burned onto compact discs for wider use and readership. Some information also is repackaged into radio scripts for local radio stations. Engendering Equality works to improve **gender equity** by conducting open forums for vulnerable women and girls to advocate against cultural and religious ideologies and practices that enhance the spread of HIV. These include outreach activities such as public gatherings, church meetings, women's group meetings, workshops and seminars. Women and girls learn about such forums through public announcements, during weekly meetings of Nutritional Field Schools (NFS), and through home visits conducted by community care givers and project volunteers. The meetings are participatory and facilitated by project staff and volunteers. In these forums, people living with and affected by HIV learn about their rights, and women learn about safe and affordable female-controlled prevention methodologies, such as the female condom. Participants are encouraged to learn their HIV status and discuss the role of gender in HIV transmission and prevention. The sessions also equip women with skills in leadership, group formation and information gathering and analysis. Engendering Equality helps increase women's **access to income and productive resources** by initiating and managing sustainable income-generating activities at the household level. The project helps women understand how poverty increases their risk of being infected by HIV, and vice versa. For instance, poor women are more vulnerable to men's sexual demands (for example, through financial inducements), which increases their HIV risk. On the other hand, an HIV-positive woman may not be able to engage in productive work, which can lead to financial hardship. The project educates women on these interrelationships and helps them start small businesses and microenterprises. KAIPPG provides direct financial assistance and also links women to microfinance banks/institutions. Engendering Equality addresses food and nutrition security by establishing food gardens in HIV/AIDS-affected households. These gardens help to improve the household's nutritional status and overall food security, and provide income-generating opportunities for whole families. The project also establishes community-based nonformal learning centers, called Nutritional Field Schools (NFS), in selected sites to teach a variety of skills. Vulnerable women, including older orphans and girls, are selected out of the larger project groups to participate in the NFS through a process jointly developed by KAIPPG and group representatives. Demonstration training gardens are centrally established at each NFS. The participants are taught relevant skills and techniques, including nutrition and patient care skills and how to maximize crop harvests. Small group meetings are held to share experiences, strengthen teams, maintain motivation and relieve stress. When group members harvest their crops, they donate 5 percent of their produce to established cereal banks. Groups are also provided with simple food-processing equipment, such as chippers and oil pressers, to process food products for their own consumption and for sale to improve household income. Finally, the project involves a smaller number of men to encourage women's participation and enhance joint ownership of the project. In addressing **male norms** with male beneficiaries, the project sought the buy-in of men to support women's access to information, participation in project activities, and involvement in income generating activities. Project

	activities also address male norms around gender equity in wealth distribution, attitudes about monogamy, and knowledge and use of HIV-related services.
Target Audience	Primarily women, but also youth and a smaller number of men
Level of Intervention	▪ District ▪ Community
Geographic Location	▪ Teso ▪ Busia ▪ Bungoma ▪ Kakamega ▪ Mumias
Timeframe	▪ Phase 1: 2003–2006 ▪ Phase 2: 2007–2009 (The scale-up of phase 1. Project scope and geographic coverage has been increased in this phase.)
Funders	▪ Gender, Agriculture and Rural Development in the Information Society (GenARDIS) Small Grants Fund ▪ National AIDS Control Council (NACC) ▪ Stephen Lewis Foundation
Partner Organizations	*Implementation partners:* ▪ Masinde Muliro University of Science and Technology ▪ Kenya Agricultural Research Institute ▪ Ministry of Health ▪ Ministry of Agriculture ▪ K-Rep Bank *Evaluation partners:* ▪ The Commonwealth of Learning (COL) ▪ The Association for Progressive Communications (APC)
IMPLEMENTATION AND RESULTS	
Start-up and Implementation Process	The project began with stakeholder mobilization and community mapping through sensitization workshops. Baseline surveys determined current community needs and set baseline indicators. Then, survey findings were disseminated, and KAIPPG and the communities determined project priorities and objectives. The curriculum was then designed with participation of the local community resource persons and project partners. The next step was to establish community learning centers (field schools). Each site serves about 30 beneficiaries using demonstration gardens, microenterprises initiatives and on-site training. Gardens and other micro-enterprises were later established for individual households. Community members contribute plots both for establishment of family gardens and the field schools. They also contributed their labor in tilling the gardens and their time to participate in the training workshops.

	During implementation, participants undergo weekly, participatory one-day classes for 24 weeks. Training topics include food production, preservation and storage; nutrition and drug intake; home care, treatment and support; human and women's rights advocacy; HIV counseling and testing and post-test club formation; economic empowerment; and stigma reduction. Beneficiaries are then linked to other sources of support, such as microfinance institutions, faith-based organizations, hospitals, and market outlets. There is continuous follow-up and monitoring at community and household levels.
Local Involvement/ Ownership	Community members participate extensively in shaping the project and setting project objectives, as well as designing the training curriculum. The income generation portion of the project engages beneficiaries in implementation and provides financial benefit, which ensures some project sustainability.
Evaluation Methodology	▪ *Quantitative baseline survey*: As part of its standard project implementation procedure, KAIPPG conducts baseline surveys at the beginning of each project. The Engendering Equality baseline survey was conducted in 2003 to measure knowledge, attitudes, and practices related to gender. ▪ *Qualitative midterm and final evaluations*: The Commonwealth of Learning conducted a midterm evaluation in 2004, using qualitative participatory approaches involving discussion with communities, staff and collaborators. The Association for Progressive Communications conducted the final evaluation in 2006, using participatory qualitative methods. The evaluations focused on knowledge, attitudes, and practices around HIV, reproductive and sexual health, gender equity, and household well-being. ▪ *Program evaluation*: KAIPPG also had its own internal monitoring and evaluation processes. Beneficiaries provided feedback on interventions through ongoing visits and during focus group discussions with staff, volunteers, and other stakeholders, as well as in their recorded stories and testimonies. Questionnaires were placed in information kiosks to elicit beneficiary comments about project activities. Staff meetings were held weekly to share field experiences and develop weekly action plans. Field reports from field workers and community-based volunteers were analyzed weekly and used as a basis for project implementation. The executive director prepared quarterly reports for the KAIPPG Board, donors and other interested parties. Project results and experiences were shared through local community radio, listservs and print media, as well as through workshops and conferences.
Evaluation Results	▪ *Quantitative baseline survey*: No results provided. ▪ *Qualitative midterm and final evaluations*: Results showed the following: ▪ Increased numbers of women of childbearing age reported that they understood how to reduce their vulnerability to infection within marriage. ▪ Increased numbers of married men reported support for gender equity in the distribution of family wealth. ▪ Increased numbers of men reported their commitment to, and

	advocacy for, monogamy and fidelity in marriage among their peers. ▪ Increased numbers of women reported improved capacity to resist traditions of widow inheritance upon the death of their husbands. ▪ Increased numbers of young men and women reported that they tested for HIV and have sought treatment for STIs. ▪ Increased numbers of women reported that they actively advocated for use of condoms and other means of safer sex. ▪ Households reported improved gardening practices, nutritional habits, and methods of caring for people living with HIV. ▪ Households reported improved income levels, family livelihood capacity, and general long-term economic and social standing, a result of women's linkage to microfinance institutions and marketing outlets. ▪ Men and women reported improved knowledge of HIV counseling and testing services as well as antiretroviral therapy availability. ▪ Women's groups reported increased ability to influence national debates toward greater inclusion and equality. ▪ *Program evaluation:* KAIPPG has 24 project sites spread across six districts of Teso, Busia, Butere, Mumias, Kakamega, and Bungoma in Western Kenya. The KAIPPG project reaches about 50,000 people annually, either directly or indirectly. In 2007, 2,449 adults and 1,649 orphans and vulnerable children benefited from mitigation interventions, while 26,300 people received education on gender-based HIV/AIDS prevention.
Replication and Scale-up Activities	The project has been replicated in six districts in Western Kenya.
LESSONS LEARNED AND CHALLENGES	
Key Findings and Lessons	▪ Multiple approaches to gender programming reduce resistance to change by those who feel threatened (men) when women are empowered. Multiple approaches also make the project more appealing to youth, who are generally more adaptive to change. ▪ Capacity-building for beneficiaries and volunteers is core to project sustainability. This includes involving beneficiaries in all aspects and stages of the project, training participants in project concepts, and developing skills among community resource persons. ▪ Using culturally defined gender roles to design the project, and gradually educating women on equality and their rights, helps the project to have a stronger impact. ▪ Women's projects become more sustainable with male involvement, since men strongly influence the participation of women. Although this project specifically aimed to improve the capacity and welfare of rural women, KAIPPG included a small number of men during implementation to guarantee maximum participation of women. ▪ Projects have longer-term impact when they have an economic empowerment component. This lesson led KAIPPG to integrate a number of income-generating activities alongside the HIV/AIDS project.

	▪ Communities claim ownership of the project when they are involved in all stages of its design, implementation, monitoring, and evaluation. The KAIPPG project continues to benefit the community even after the funding comes to an end because participants have learned new skills throughout the process.
Challenges and Unforeseen Outcomes	▪ Men still wield power over women and initially resisted women's participation in the project. It may be important to discuss women's involvement with their husbands. ▪ Many women were initially afraid to take on roles that are culturally reserved for men, until they received adequate training and education. ▪ Much reverence is attached to local leaders, making it difficult to work without including them in the project. ▪ Membership in support groups for people living with HIV changes often, due to death and relocation. This poses a challenge for project evaluation.
Recommendations for Replication	▪ It is crucial to have a favorable legislative framework. ▪ Significant financial resources are essential. ▪ Personnel with expertise in holistic and multidimensional programming are crucial.
ADDITIONAL INFORMATION	
Program References and Resources	The Communication Initiative Network. *Health and Agriculture Radio Network.* http://www.comminit.com/en/node/132850 (accessed October 17, 2008). Onyango, J. *Urban Micro-farming and HIV/AIDS in Kenya: The KAIPPG Experience*. 2005. http://www.ruaf.org/files/paper4.pdf. Women's Networking Support Programme. *GenARDIS*. http://genardis.apcwomen.org/en/project/ab4ff212318a3729451147b3526391fb (accessed October 17, 2008).
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MAANISHA

LEAD ORGANIZATIONS: African Medical and Research Foundation (AMREF)

COUNTRY: Kenya

HIV PROGRAM AREA: Prevention, Treatment, Care and Support

OVERVIEW:
Maanisha helps civil society organizations (CSOs) design and implement HIV and AIDS interventions. As part of this effort, the project has developed a gender mainstreaming strategy that includes a manual to help partners design and implement HIV and AIDS activities targeted to women and men. The strategy also includes guidelines on how to respond to male norms and behaviors and to foster men's involvement as community health workers in home-based care, prevention of mother-to-child transmission (PMTCT) efforts, and counseling. Maanisha also trains men as caregivers; provides legal support for women, including around their property and inheritance rights; and provides grants to CSOs supporting women and girls. Findings show the benefits of a multisectoral approach to HIV prevention: comprehensive HIV interventions are more effective than single interventions. The project also found that responding to HIV as it relates to other issues such as gender and human rights appeals to more project beneficiaries, and gender mainstreaming should be integral rather than an "add-on." Capacity building among CSOs is crucial, though challenging when resources are limited.

BACKGROUND	
HIV & AIDS Program Goals	Maanisha aims to strengthen the capacities and capabilities of CSOs, private sector organizations (PSOs), and Government of Kenya structures to provide comprehensive HIV and AIDS prevention, care, support, and treatment.
Gender Strategies Addressed	✓ Reducing violence and coercion ✓ Addressing male norms and behaviors ✓ Increasing women's legal protection ✓ Increasing women's access to income and productive resources ☐ Other:
Description of Intervention	Maanisha helps enable CSOs and PSOs to design and implement quality HIV and AIDS interventions through two main pillars: capacity building and grant making. Capacity building strengthens PSOs and CSOs to better promote safer sexual behavior and practices among at-risk and vulnerable groups, and to improve facilitation, harmonization and coordination mechanisms between CSOs and the government structures of Kenya. By linking CSOs to the Ministry of Health, Maanisha also helps them increase access to quality health care services for people living with HIV. In addition, the program educates CSOs and PSOs in how to influence policy and adopt best practices in the field of HIV and AIDS. Maanisha builds the capacity of CSOs and PSOs to address cross-cutting issues that fuel the HIV epidemic, such as gender inequality, disregard for human rights, harmful cultural practices and social norms, poverty and food insecurity, stigma, and lack of participation of vulnerable groups such as people living with HIV and widows. Its gender mainstreaming strategy is focused specifically on reducing gender-based **violence and coercion**. As

	part of this strategy, Maanisha has developed a manual to guide partners in designing and implementing gender strategies such as the reduction of gender-based violence into HIV and AIDS prevention, care, treatment, and support activities. The program also provides CSOs with support in addressing risk factors that contribute to violence, such as alcoholism. In addition, a set of male involvement guidelines specifically help partners respond to harmful **male norms and behaviors** in the context of the epidemic, and show CSOs how to encourage men to participate as community health workers in home-based care, PMTCT, and counseling. Maanisha also helps to train men, particularly young men, in providing care to people living with HIV, which can help ease the care-giving burden on girls and women. In partnership with the Federation of Women Lawyers in Kenya, Maanisha helps women in need of **legal protection** reach competent legal authorities. In addition, since 2007, the program has been working to help women in Nyanza own and inherit resources, especially land, together with the reform organization Governance, Justice, Law and Order Sector and in consultations with the Luo Council of Elders. In addition to capacity building, Maanisha's grants-making program provides partners with funding for HIV-related activities. These partners include women-led CSOs and networks, such as the Women Action Forum for Networking and Western Women Empowerment Network. The program also strengthens and improves these partners' financial management and reporting systems, and provides financial monitoring. Maanisha also works to improve women's **access to income** by linking people living with HIV and AIDS, particularly women, to microcredit to enable them to engage in small businesses to help increase their income and improve their livelihoods. For example, it links women to Kenya Women Finance Trust for microfinancing. The program implementation team also works with a variety of partners to ensure that girls and women, including those living with HIV, have access to resources. For example, Maanisha partners with Kenyan decentralized funds structures such as the Constituency Development Funds, the Local Authorities Trust Fund, and the Constituency Bursary Funds to provide education and health care for orphans and vulnerable children.
Target Audience	CSOs, PSOs, people living with HIV, orphaned and vulnerable children, adolescents, youth, men, and women
Level of Intervention	▪ *Implementation:* Community ▪ *Advocacy:* District, Provincial, National
Geographic Location	Nyanza, Western, Eastern and Lake Victoria Basin Districts of the Rift Valley Province
Timeframe	2004–ongoing
Funders	▪ Swedish International Development Agency (Sida) ▪ UK Department for International Development (DFID)

Partner Organizations	*Implementation partners:* ▪ 300 CSOs and PSOs, e.g., Women Action Forum for Networking (WAFNET) and Western Women Empowerment Network (WWEN) ▪ Ministry of Health, Kenya ▪ National AIDS Control Council (NACC), Kenya *Evaluation partner*: ▪ Swedish International Development Agency (Sida)
IMPLEMENTATION AND RESULTS	
Start-up and Implementation Process	Program start-up included a formative assessment, program design and planning, baseline survey, development of project management structures (grants technical review committees, program implementation team), establishment of field offices, and an initial call for grant applications. The program has provided technical support to more than 300 prevention, treatment, care and support grant recipients. Grants are awarded based upon capacity assessment of applicants and review and approval of applications by program teams and external grants technical review committees. CSO and PSO capacity is enhanced using the organizational development and systems strengthening approach, help with contract management, and strengthening of financial systems. Funded organizations are monitored through periodic visits and review of submitted reports. The program also works to strengthen linkages among programs and between programs and government structures to enhance overall HIV and AIDS programming.
Local Involvement/ Ownership	Maanisha maintains strong partnerships with government structures, including the Ministry of Health and the NACC. By transferring skills through capacity-building activities with both individuals and organizational systems, the program aims to be sustainable. Within the capacity-building strategy, community members who are part of CSOs design and implement HIV and AIDS interventions of their choice.
Evaluation Methodology	▪ *Formative needs assessment, 2004:* Program implementers employed a participatory approach in conducting a formal needs assessment. They involved key stakeholders at all stages of study design, and data collection and in generating the conceptual framework for the five-year program. The needs assessment covered the following areas: 1) assessing the technical and organizational capacities of all organizations and agencies (health facilities and institutions, non-governmental organizations, CSOs, and faith-based organizations) involved in HIV and AIDS activities in Nyanza and Western provinces of Kenya; 2) identifying the needs of vulnerable groups, such as people living with HIV, orphans, youth, widows and widowers; and 3) conducting stakeholder analysis to identify HIV and AIDS implementers to participate in the five-year program. ▪ *Baseline assessment, 2005:* Maanisha has a full-fledged monitoring and evaluation framework nested in the monitoring and evaluation framework of the NACC. Evaluators administered cross-sectional Knowledge, Practice and Coverage surveys using household questionnaires to the adult and youth populations. Surveys investigated

	the cultural practices and sexual behavior that increase risk of HIV infection. Evaluators also assessed the institutional capacity of key government implementing agencies. In addition, evaluators used qualitative techniques, including focus group and key informant interviews, to collect information on factors that increase people's vulnerability to HIV. ▪ *Midterm evaluation, 2007:* Sida conducted an external evaluation in 2007 to determine and document the program's overall progress, outcomes and impacts arising from implementation of community-based capacity building and grants making. The midterm evaluation included process measures and a client satisfaction survey. Results from the baseline survey served as a reference database by which to track indicators and measure impact.
Evaluation Results	▪ *Formative assessment, 2004:* This assessment helped in developing indicators for Maanisha's national monitoring and evaluation framework indicators. These indicators also were shared with key government structures, including the NACC Field Officer, Ministry of Health, and District Technical Committees. ▪ *Baseline assessment, 2005:* This baseline survey indicated that awareness of HIV transmission and prevention is high; however, this knowledge is not translating into behavior and practice. In addition, most sexually active people are not seeking HIV testing. Women were shown to be more willing than men to disclose their sero-status after testing positive; however, men occasionally respond with violence. Evidence also indicated that certain social norms and cultural beliefs and practices were related to the spread and impact of HIV, including plural marriages, widow cleansing practices, and ritual sex. Above all, the baseline assessment confirmed that CSOs are interested in playing a meaningful role in responding to HIV and AIDS, but lack the capacity to do so. ▪ *Midterm evaluation:* Process data show that monthly monitoring visits to CSOs are feasible and significantly help them to report progress each month. The evaluation also shows that CSOs need more help with monitoring and evaluation. Maanisha intends to simplify and tailor standard monitoring and evaluation techniques to help each CSO improve planning and local decision-making processes. There is also a need to mentor the CSOs using a training-of-trainers approach. The client satisfaction survey data have not yet been fully evaluated. However, select initial findings indicate that funded CSOs are mainstreaming social and cultural factors that fuel the spread of HIV into their programming. The proportion of widows undergoing cleansing (a practice in which a widow must have sex with her husband's brother or other relative, or with a village cleanser) has declined from 50 percent to 40 percent, and the proportion of couples seeking HIV testing before marriage has increased from 9 percent to 13.8 percent. Further, 100 percent of participating CSOs now have elected leadership with at least one female as an official, compared to 20 percent at baseline, and compliance with approved financial procedures has risen from 22 percent to 91 percent.
Replication and Scale-up Activities	The project started in the Lake Victoria Basin Region and in 2008 was scaled up to Eastern Kenya and parts of the Rift Valley Province.

LESSONS LEARNED AND CHALLENGES	
Key Findings and Lessons	▪ Capacity building and grants provision are mutually reinforcing. ▪ Comprehensive HIV and AIDS interventions work better than single interventions. ▪ Responding to HIV and AIDS cross-cutting issues such as gender, human rights and culture appeals to project beneficiaries. ▪ Capacity building targeting top-level CSO and PSO leadership is a crucial strategy in promoting gender-sensitive initiatives in an HIV and AIDS response. ▪ Gender mainstreaming should be an integral part of a project design rather than being treated as separate issue. ▪ Gender mainstreaming is a process and should be accompanied with concerted advocacy. ▪ While building gender-specific knowledge and skills is necessary, organizational institutional development and systems strengthening is also vital to the success of gender mainstreaming in HIV and AIDS programming.
Challenges and Unforeseen Outcomes	Overwhelming numbers of CSOs and PSOs require support against limited resources.
Recommendations for Replication	▪ Program resources for gender mainstreaming in HIV and AIDS activities should be the same as for other strategies. ▪ Gender mainstreaming approaches need to be reviewed from time to time to ensure that all key vulnerable populations are included in the gender mainstreaming efforts. ▪ Gender mainstreaming should be part of the project design from inception and should be accompanied by gender-sensitive indicators.
ADDITIONAL INFORMATION	
Program References and Resources	Kireria, A., G. Muriithi, G., and K. Mbugua. "Maanisha Community Focused Initiatives to Control HIV/AIDS in Lake Victoria Region, Kenya: Sida Evaluation 07-33." Stockholm: Swedish International Development Agency. August 2007. http://www.sida.se/shared/jsp/download.jsp?f=Utv07-33_SIDA40263en_web.pdf&a=35263 (accessed August 12, 2008). For program guidelines and tools, e-mail Meshack.ndirangu@amref.org
Contact Information	American Medical and Research Foundation

	Langata Road, P.O Box 27691 – 00506, Nairobi, Kenya Tel: + 254 20 699 3000 / Fax: +254 20 609518 Website: http://www.amref.org Dr. Festus Ilako, Deputy Country Director Email: Festus.Ilako@Amref.org Dr. David Ojakaa, Director of Programs Email: David.Ojakaa@amref.org

NURU YA JAMII

LEAD ORGANIZATIONS: Family Health International (FHI)

COUNTRY: Kenya

HIV PROGRAM AREA: Prevention, Treatment, Care and Support

OVERVIEW:
Nuru ya Jamii works to prevent HIV-driven orphaning by providing assistance and care to HIV-positive caregivers and their children. The program provides clinical care for both adults and children and creates linkages between health care facilities and key supporting institutions, such as faith-based organizations, community-based organizations and schools. Gender activities include collaborating with the legal and health sectors to address gender-based violence; encouraging HIV-positive men to be more active participants in health-seeking behavior and to strengthen their family relationships; improving legal protection for women by cultivating community mediators to expedite resolution of civil disagreements; and improving financial security among single women-headed households. Key lessons learned are that multiple approaches to problem-solving better effect change than a single approach, and the benefits realized from gender-based programming are worth the initial difficulties that come from introducing a new approach.

BACKGROUND	
HIV & AIDS Program Goals	Nuru ya Jamii (originally Toward Preventing Orphaning Initiative, TPOI) works to prevent, delay, and mitigate orphaning by promoting the health of HIV-positive parents and caregivers while concurrently providing the full continuum of HIV prevention, treatment, care and support for their children and other family members.
Gender Strategies Addressed	✓ Reducing violence and coercion ✓ Addressing male norms and behaviors ✓ Increasing women's legal protection ✓ Increasing women's access to income and productive resources ☐ Other:
Description of Intervention	Nuru ya Jamii is a comprehensive HIV and AIDS care program that integrates several strategies. It provides HIV clinical care, antiretroviral therapy, and pediatric HIV and AIDS treatment and support. It also strengthens linkages between health facilities and community- and home-based prevention and support services, including faith-based organizations, community-based organizations (CBOs), and schools. Partnerships with these organizations, together with community volunteer networks that FHI facilitates through community drop-in centers, ensure service coordination at the community, health facility, and household levels. Within the Nuru ya Jamii program, various activities address gender. The program has established a close working relationship with law enforcement agencies and health facilities to refer cases of gender-based **violence** for further redress. In addition, the program specifically reaches out to men to address **male norms** around HIV. For example, it makes an effort to involve male participants in health-seeking behavior such as HIV counseling and testing and HIV care and treatment. Men are involved in

	developing memory books, scrapbooks that use stories, photos, and important documentation to help HIV-positive parents ensure that their children will have some linkage to their past. Men are also trained as "Ambassadors of Hope," individuals who publicly acknowledge their HIV status to fight stigma in the community. To increase the **legal protection** of women, the program trains paralegals and community mediators in alternative dispute resolution. These community mediators work closely with village elders and chiefs to resolve civil disagreements at the community level instead of going through the expensive and time-consuming court processes. Aggrieved parties are referred to the appropriate law enforcement agencies for information and support. The program also works to increase **access to income and productive resources** for single women household heads, offering them training on basic business skills, providing access to business products, and creating linkages with microfinance institutions. The program also offers household food security trainings to women to ensure they can produce enough food to feed their families (as opposed to depending on relief food), which includes skills in multi-story gardens, kitchen gardens and organic farming. This training is supported with the provision of seeds and farm equipment. In addition, the program provides vocational training, including hairdressing, fashion and design, and information technology, to young girls who have dropped out of school.
Target Audience	Orphans, vulnerable children, and their families
Level of Intervention	Community
Geographic Location	Nakuru Municipality, Nakuru District, Rift Valley Province
Timeframe	▪ *Pilot phase:* October 2005–September 2007 ▪ *Currently:* October 2008–ongoing
Funders	▪ *Pilot phase:* FHI ▪ *Currently:* The U.S. President's Emergency Plan for AIDS Relief (PEPFAR) through the United States Agency for International Development (USAID)
Partner Organizations	*Implementation partners:* ▪ Ministry of Health, Kenya ▪ Baraka Agricultural College ▪ Child Care International ▪ Family AIDS Initiative Response (FAIR) ▪ Kenya Girl Guides Association (KGGA) ▪ Learning and Development Kenya ▪ SafeWater and AIDS Project ▪ Society for Women and AIDS in Kenya (SWAK) ▪ Tumaini na Fadhili ▪ Appropriate Grass Roots Interventions (AGRI) ▪ Muslim Association of Nakuru

	▪ Mwangaza College ▪ WorldView Kenya
IMPLEMENTATION AND RESULTS	
Start-up and Implementation Process	As a first step, the program cultivated local buy-in through several stakeholder meetings. The program assessed all CBOs offering services to children and selected 12 to offer services to clients through a contractual agreement with FHI. Drop-in centers were identified within community facilities. Community volunteers were selected through interviews and trained on the program requirements. Clients then were recruited to participate in the program, and service delivery and monitoring were started. The Ministry of Health (MOH) is a key partner in this program. In the initial stages, before anti-retroviral therapy became free in Kenya, the MOH offered free anti-retroviral therapy to all clients in the program. The MOH also donated five acres of land to the project, which became a high-yield modern farm producing an average of 1.7 tons of fresh vegetables per week. The vegetables are used to feed HIV-positive families within the program as well as in-patients at the provincial general hospital. Also in collaboration with the MOH, the program built a pediatric comprehensive care center at the provincial general hospital, where the number of children receiving anti-retroviral therapy has increased from about 30 in 2006 to 1,478 as of August 2008. Through the government's Children's Department, a networking committee was formed to support the services being given to children. Nuru ya Jamii also leverages FHI's strong working relationship with the Provincial Administration Office, especially in the areas of legal support, food and nutrition. The Provincial Administration, including the local chiefs and district officer, supplemented the farm-raised vegetables Nuru ya Jamii produced with dry foods, such as rice and beans, to ensure the community drop-in centers could provide food rations for the neediest families.
Local Involvement/ Ownership	The program was designed so that the community plays a key role. Community members and local CBOs implement most of the program components. Drop-in centers, the hubs of activities, were all selected from community churches and halls. Community volunteers serve clients within their own residential areas. Resources are leveraged from the community, churches and chiefs offices within the area. In addition, the program builds CBO capacity to run the program with little initial support. More and more components are being handed over to local CBOs to run.
Evaluation Methodology	▪ *Monitoring:* Each trained volunteer has a diary to document daily progress within each household they visit. Volunteers leave the diary in the houses of the clients to show that the clients were visited and what action was taken as a result of the visit. All information is collated and analyzed in monthly reports.

	▪ *Quantitative data collection:* During the pilot phase, three quantitative quality-of-life surveys were conducted, within intervals ranging from six to nine months, to determine the program's impact. The respondents were the repeat adult index clients enrolled into the program; children were excluded from the survey due to ethical review protocols. Outcomes that were monitored include improvement of health status, retention of children in school, and general improvement in quality of life and well-being of the family.
Evaluation Results	▪ *Project reach:* The program served 1,000 families with a total of 4,435 individuals (2,015 adults and 2,420 children). ▪ *Monitoring:* Findings from analysis of data collected in diaries indicate that household incomes increased; women were economically empowered through training on small enterprise development and business skills to strengthen or start small businesses; and women now play an active role in decision-making and providing for their families. ▪ *Quantitative data collection:* Findings show that very few HIV-positive clients were bedridden; for those who were, it was for shorter periods of time than before the program. Also, more children enrolled and stayed in school, and the general health of family members improved markedly during program participation.
Replication and Scale-up Activities	▪ Many other countries where FHI currently operates are planning replication of this model. ▪ The pilot project operated only within Nakuru municipality but was scaled up to new sites, including the Njoro division in Molo district of Rift Valley province. In the latter site, 245 families have been recruited, bringing the total number of families recruited in the program to 1,245. The family-centered approach for orphans and vulnerable children and people living with HIV is being replicated with PEPFAR funding in 15 districts in the province. ▪ New clients were recruited within the existing sites, increasing the number of beneficiaries from 2,338 during the pilot phase to 4,435 currently.
LESSONS LEARNED AND CHALLENGES	
Key Findings and Lessons	▪ Program staff and volunteers need to be prepared to work with multiple approaches and to remain flexible. Sometimes, approaches that had previously worked cease being effective. For example, the program initially worked successfully with paralegals, but later found that community mediators became more effective. ▪ Gender-based programming is usually difficult at first because this is a new way of programming, but in end, the benefits are worth the effort. The programs using gender-based programming are more solid and sustainable because they address issues that, if left unaddressed, will recur.

Challenges and Unforeseen Outcomes	▪ The initial challenge was identifying and partnering with qualified CBOs. ▪ CBOs within the partnership can be at different levels of capacity and getting them to work together as one is, at times, a challenge. ▪ Overly high expectations lead to disappointments. Follow-up to the pilot phase and monitoring was too intense, and staff had to log long and hard hours of work. ▪ Many issues not originally anticipated in the planning phase can emerge as the implementation progresses. The staff was permanently on their toes thinking of new ways of addressing emerging issues. This was exciting and challenging at the same time.
Recommendations for Replication	▪ Do not "reinvent the wheel" and expend resources where they already exist; rather, use the existing community and government structures to support the project. ▪ Involve the beneficiaries as much as possible in the project planning. ▪ The project must have adequate resources and the flexibility to change and meet the needs of the beneficiaries. ▪ To ensure that the project is comprehensive enough to address the needs of HIV-vulnerable households, it must have adequate funding. ▪ Government support is crucial. ▪ It is important to have community support for and ownership of the project. ▪ Consider partnering with other organizations that offer a variety of key services within the project area; encourage collaboration and networking.
ADDITIONAL INFORMATION	
Program References and Resources	An end-of-pilot project executive summary, write-ups, two-page activity briefs and DVD produced during the pilot phase can be obtained by contacting FHI.
Contact Information	Family Health International, Kenya P.O. Box 13208 Nakuru, Kenya Tel: + 254 51 221 5568 Website: http://www.fhi.org/en/CountryProfiles/Kenya/index.htm Ruth Odhiambo, Deputy Director Email: rodhiambo@aphiarift.org

POST RAPE CARE

LEAD ORGANIZATIONS: Liverpool VCT, Care & Treatment (LVCT)

COUNTRY: Kenya

HIV PROGRAM AREA: Care and Support

OVERVIEW:
Post Rape Care seeks to address gaps in comprehensive post-rape care service delivery by offering an array of post-rape services in government health facilities and improving community awareness about sexual violence, women's rights and available services. In addition to providing free post-rape services to women, the program seeks to change norms condoning sexual violence through trainings for clinic staff on sexual violence, women's rights and trauma counseling, and trainings for police on sexual violence and how to link women to legal and other support services. The program also includes a training curriculum on gender dynamics, gender norms, and power relations between men and women. Finally, LVCT provides technical assistance to local government bodies working on health and HIV to mainstream gender. Since the project started in 2004, it has scaled up from three sites to twelve districts. Lessons learned include the value of early counseling for post-rape clients and the need to develop guidelines to work with survivors of sexual violence. Also, because sexual violence is highly stigmatized, many survivors do not report incidents of violence.

BACKGROUND	
HIV & AIDS Program Goals	Through the Post Rape Care program, LVCT seeks to address gaps in comprehensive post-rape care service delivery by making services available in government health facilities.
Gender Strategies Addressed	☑ Reducing violence and coercion ☐ Addressing male norms and behaviors ☑ Increasing women's legal protection ☐ Increasing women's access to income and productive resources ☑ Other: gender mainstreaming
Description of Intervention	Partnered with the Government of Kenya, the Post Rape Care program addresses gender-based **violence** by providing free post-rape care services at government health facilities. Services include clinical evaluation and documentation (including forensic examination, evidence collection, specimen analysis, and legal documentation); clinical management (including management of injuries and pregnancy, testing and treatment for sexually transmitted infections [STIs], and HIV prevention using post-exposure prophylaxis [PEP]); and counseling services (including crisis prevention and trauma counseling for survivor and family, HIV counseling and testing, HIV PEP adherence counseling, and preparation of survivors for the criminal justice system). The program also sensitizes key stakeholders, including community members, religious leaders, school teachers, the police, and community health workers, on issues of rape and sexual violence. For example, a three-day training curriculum educates health care workers and trauma counselors on gender dynamics, gender norms, and power relations between men and women. The training curriculum aims to improve service

	delivery, strengthen referrals, inform national policy, and create awareness on available services to reduce gender-based violence and improve specific national policies. Health facility staff trainings specifically cover: ▪ Comprehensive clinical care (management of physical injuries, HIV prevention, pregnancy prevention, management of STIs) ▪ The law as it relates to sexual violence (including concepts of gender and gender-based violence, legal definitions of sexual violence, gaps in the law, and legal procedures in managing survivors) ▪ Counseling (definition of counseling, types of counseling, intersecting counseling and clinical care) ▪ Referral systems, supervision, monitoring and evaluation ▪ Messages on gender-based violence, including: - Anyone can be a perpetrator and a survivor of sexual violence - No one is to blame for being violated - There is no justification for violating anyone - Sexual violence should be treated as an emergency in all health facility settings The program also increases women's **legal protection** by offering trainings to police and local chiefs on issues of rape and how to link women to existing legal services. In addition, health care providers and the community at large are informed about the Sexual Offences Act and available legal services. LVCT emphasizes **gender mainstreaming** in national policy formulation and provides technical assistance in this area to government bodies such as The National AIDS Control Council, Ministry of Health/Division of Reproductive Health, and National Commission of Gender and Development, among others. Gender mainstreaming support is also provided to sub-grantees and other partner organizations. The project is contributing to specific policy activities, including: ▪ Assessing the cost of comprehensive post-rape care ▪ Including gender in the national HIV response ▪ Developing National guidelines for medical management of rape and sexual violence and training of clinicians to provide post-rape care ▪ Advocating for the new Sexual Offences Act (LVCT is advising the task force drafting rules and regulations for the act)
Target Audience	Health care workers, survivors of sexual violence and their families and communities
Level of Intervention	▪ National ▪ District ▪ Province
Geographic Location	Post Rape Care operates at the following hospitals: Embu Provincial Hospital, Thika District Hospital, Gatundu District Hospital, Malindi District Hospital, Rachuonyo District Hospital, Kitui District Hospital, Nyandarua District Hospital, Naivasha District Hospital, Ol'kalou District Hospital, Siaya District Hospital, Gucha District Hospital, The Kenyatta National Hospital, Riruta Health Centre, Kisumu Provincial General Hospital (New Nyanza), Ruiru Sub-District Hospital
Timeframe	2004–ongoing

Funders	▪ Trócaire ▪ The U.S. President's Emergency Plan for AIDS Relief (PEPFAR) through the United States Agency for International Development (USAID) and the United States Centers for Disease Control (CDC) ▪ United Nations Children's Fund (UNICEF) ▪ United Nations Population Fund (UNFPA) ▪ The William and Flora Hewlett Foundation ▪ Canadian International Development Agency (CIDA) – Gender Equity Support Programme
Partner Organizations	*Collaboration partners:* ▪ Komesha Unajisi network (Stop Rape Network) convened by Amnesty International ▪ Gender-based Violence Prevention Network, hosted by Raising Voices, Uganda ▪ Sexual Violence Research Initiative, hosted by Medical Research Council, South Africa ▪ The Division of Reproductive Health, Kenyan Ministry of Health ▪ National Commission on Gender and Development, Kenya ▪ Ministry of Public Health and Sanitation, Kenya
IMPLEMENTATION & RESULTS	
Start-up and Implementation Process	Three phases of operational research were conducted. First, a situational analysis was undertaken. This analysis informed the development of an intervention model, which was tested in three health facilities. Lessons learned in this pilot phase informed the scale-up of the project.
Local Involvement/ Ownership	All community activities are undertaken through various gatekeepers, including local chiefs. Key stakeholders, including local chiefs, religious leaders, teachers and other community leaders are sensitized through a one-day training. Post Rape Care also uses community participatory theater to sensitize the general community. The government is also a primary partner through the Ministry of Public Health and Sanitation Division of Reproductive Health.
Evaluation Methodology	*Monitoring:* LVCT captures numerical data from all survivors of sexual violence attended to at partner health facilities. It analyzes data for the 16 sites it supports (which include one national referral hospital, two provincial hospitals, twelve district hospitals and one health center). Data collected include number of survivors seen, number of health care workers trained, and various policy indicators, including number of policy meetings and outcomes. A monitoring and evaluation officer oversees the process in collaboration with program staff. Records are kept on survivors of sexual violence who seek services at the various health facilities.

Evaluation Results	*Project reach:* LVCT monitoring data from 2004 show that: ▪ 4,000 survivors of sexual violence have been seen at partner health facilities. ▪ 802 health care workers have been trained (490 female, 312 male). ▪ 202 police officers have been trained (59 female, 143 male). ▪ 101 local administrators have been sensitized (36 female, 65 male). ▪ 482 community stakeholders have been sensitized (269 female, 213 male).
Replication and Scale-up Activities	From the three original sites the project has scaled up to 12 districts. Also, a costing study has been finalized in conjunction with the Ministry of Public Health and Sanitation Division of Reproductive Health, which demonstrates the ability of government to take on the program and scale up services.
LESSONS LEARNED AND CHALLENGES	
Key Findings and Lessons	▪ Using multiple gender strategies enhances referrals and replicability and ensures gender is addressed in all trainings. Accounting for gender issues ensures that sexual violence is not seen as a "women's issue," but as a societal issue that affects all. ▪ In addition to direct services for survivors, it is important to consider targeted interventions for the community, the police, health providers, and policymakers. ▪ Gender-based programming is a long-term issue that needs to be integrated broadly in various trainings and education institutions. ▪ Community support of the program is crucial. ▪ Post-rape clients who access counseling early are more likely to adhere to HIV prevention drugs. ▪ There is a need to develop health care and legal guidelines for managing survivors of sexual violence. ▪ A national policy framework on gender-based violence is necessary to link post-rape services with other relevant programs.
Challenges and Unforeseen Outcomes	▪ Survivors of sexual violence may be reluctant to seek health services out of fear that the case may end up in the formal courts. ▪ Many survivors do not report incidents of sexual violence. Reporting such an experience could reduce a woman's chances of getting married and increase the possibility of being ostracized by the rest of the community. ▪ There are minimal reliable and relevant data on sexual violence.

Recommendations for Replication	▪ The following resources are required for replication: trained personnel, trained policy-makers, laws governing sexual violence and, more broadly, gender-based violence. ▪ Government agencies, particularly the Ministry of Health, should be included from the beginning of the program. ▪ Learn from the existing systems and document the process. ▪ Organizations are increasingly interested in addressing legal and policy issues on sexual violence
ADDITIONAL INFORMATION	
Program References and Resources	Kilonzo, N. *Comprehensive Post-rape Care in Resource-poor Settings: Lessons Learnt From Kenya*, Policy Briefings for Health Sector Reform. Nairobi: Liverpool VCT, Care & Treatment, 2005.
Contact Information	Liverpool VCT, Care & Treatment P.O Box 19835 – 00202, Nairobi, Kenya Tel: + 254 020 271 4590/5308 / Fax: + 254 020 272 3612 Website: http://www.liverpoolvct.org Dr. Nduku Kilonzo, Director Email: Nduku@liverpoolvct.org Dr. Paul Wekesa, Deputy Director Email: pwekesa@liverpoolvct.org Muchela Hadley, Post Rape Care Program Coordinator Email: hadley@liverpoolvct.org

TAP AND REPOSITION YOUTH (TRY)

LEAD ORGANIZATIONS: Population Council

COUNTRY: Kenya

HIV PROGRAM AREA: Prevention, Care and Support

OVERVIEW:
TRY worked to improve adolescent girls' reproductive health outcomes by improving their livelihood options. The project primarily targeted out-of-school adolescent girls and young women ages 16–22 in low-income areas of Nairobi. It focused on microfinance, offering savings, credit, business support and mentoring related to small business management, as well as counseling around reproductive health issues such as HIV prevention and mitigation, drug and substance abuse, relationships, child rights and violence against women. TRY also convened workshops with legal experts to educate women about their rights. Three male-only groups addressed male norms and behaviors. By earning and saving, some participants were empowered to resist sexual coercion, insist on condom use and refuse sex. By the project's end, participating girls had significantly higher incomes and more assets than the control group. However, only the least vulnerable girls strongly benefited from microfinance: most needed social capital (friendships, support groups, safety, etc.) before they could benefit from microfinance assistance.

BACKGROUND	
HIV & AIDS Program Goals	TRY improved the economic and social well-being of adolescent girls in Kenya through efforts to increase income, improve control over income, build economic skills, and provide safe and supportive social networks.
Gender Strategies Addressed	✓ Reducing violence and coercion ✓ Addressing male norms and behaviors ✓ Increasing women's legal protection ✓ Increasing women's access to income and productive resources ☐ Other:
Description of Intervention	The overall aim of the project was to reduce adolescents' vulnerability to adverse social and reproductive health outcomes by improving their livelihood options. The project targeted out-of-school adolescent girls and young women ages 16–22 residing in low-income and slum areas of Nairobi. It sought to increase their **access to income** by using a modified group-based microfinance model to extend integrated savings, credit, business support and mentoring to out-of-school adolescents and young women. While most existing adolescent HIV prevention efforts educate about reducing risky premarital sexual behavior and encourage participants to "just say no to sex," these efforts overlook the context of sexual behavior. The Population Council and K-Rep Development Agency (KDA) developed and tested a model to reduce economic vulnerability and increase social connectedness among girls residing in low-income and slum areas of Nairobi. The model used savings, group-based credit and adult mentors to reach young women with livelihoods and social support, as well as reproductive health information. Mentors also periodically organized large

	seminars with invited guest speakers on topics including HIV and AIDS, prevention of mother-to-child transmission (PMTCT), voluntary HIV counseling and testing, the role of nutrition in HIV management, drug and substance abuse, relationships, child rights, violence against women, vital registration and documentation, and business management. Adolescent girls and young women accessed loans through the group lending scheme and started businesses to increase their income. By earning and saving, as well as through the female mentorship provided by the program, participants were empowered to resist sexual **coercion**, insist on condom use and refuse sex. Through workshops and group meetings, participants also were informed about gender-based **violence** and sensitized on their **legal rights**. When the project was introduced, some community members raised concerns about the choice to focus only on girls. The community felt there was also a need to equip boys with information on HIV. In response, three male-only groups were formed, which addressed **male norms and behaviors**, including sexual coercion, gender-based violence, condom negotiation, and perceptions around HIV risk and risky behavior.
Target Audience	Adolescent girls and female youth, ages 16–22, living in low-income areas of Nairobi
Level of Intervention	District
Geographic Location	Nairobi
Timeframe	June 2001 – May 2004
Funders	▪ K-Rep Development Agency (KDA) ▪ Ford Foundation ▪ UK Department for International Development (DFID)
Partner Organizations	*Implementation partners:* ▪ K-Rep Development Agency (KDA) ▪ Community churches, schools and government officers, such as chiefs *Evaluation partners:* ▪ Population Council staff from Nairobi and New York ▪ K-Rep Development Agency (KDA) staff ▪ External consultants

IMPLEMENTATION & RESULTS	
Start-up and Implementation Process	KDA and the Population Council launched the project in 1998. The pilot phase of TRY took place from 1998 to 2000, during which the microfinance model was developed and tested. At the end of the pilot phase, a microfinance expert evaluated the project and the model was adjusted and scaled up. TRY was based upon the adult *"juhudi"* (meaning "effort" in Kiswahili) group-lending model developed in Kenya by KDA. Like adult group-based microfinance schemes, TRY participants formed groups of 15 to 25 members, known as KIWAs (an acronym for the Kiswahili term *kikundi cha wanabiashara*, or "group of entrepreneurs") and further subdivided into 5-member *watano* ("five" in Kiswahili). Each KIWA elected its own chairwoman, treasurer, and secretary, and was registered as a self-help group with the Kenya Ministry of Gender, Sports, Culture and Social Services. Following registration, the group opened a savings account under its registered name. KDA provided each KIWA with a six-day training in basic business management, record keeping, marketing, pricing, budgeting, business plan development, and customer relationships, as well as life skills and reproductive health information. Immediately after training, participants were required to begin saving a minimum of 50 Kenyan shillings (about US$ 0.65) each week, with these savings serving as cash collateral against eventual loans that were distributed after eight weeks of savings. Group members met weekly with a KDA credit officer, usually in a public space near the girls' homes or workplaces. During these meetings, the loan officer reinforced loan policies and procedures, collected and recorded weekly savings and gave business advice. The group meetings also became an occasion for members to share intimate experiences of their lives, including their relationships with partners or parents. Girls used their loans to start businesses or expand existing ventures. Activities included hairstyling, vegetable selling, tailoring, battery charging, welding, and operating a telephone bureau. To strengthen the social support component of the TRY project, KDA and the Population Council also established a cadre of part-time adult mentors drawn from various professions, including counseling, social work, business, health care, and community development. Mentors were given a five-day training on team-building, communication, gender issues, adolescent reproductive health, life skills, and HIV and AIDS. Based on the needs expressed by group members, the mentors organized group discussions, educational sessions, recreation, excursions, and sports and fitness. These activities generally took place after the TRY group meetings with the credit officer. During the pilot phase, it became clear that the group savings and credit scheme tended to be more successful with older, more financially experienced girls. In contrast, younger adolescents expressed interest in savings and other rudimentary financial services, and in opportunities to meet friends, but were somewhat less ready to take loans. A number of TRY participants left the project because of the rigidity of the savings requirement, the lack of access to their savings in the event of an emergency, and the pressure to continually take out and repay loans. In an attempt to meet the needs of these girls, Young Savers Clubs were established in 2004. Rather than working toward receiving loans, girls in the Young Savers Clubs were given a safe place to save their money and the opportunity to meet other girls every week for discussion, support, advice and mentoring.

Local Involvement/ Ownership	Community leaders initially were involved in mobilizing participants and providing meeting venues, such as social halls and chiefs' camps. Throughout the project, community stakeholders provided moral support. Some community members, particularly the chiefs, participated by following-up on defaulters. This negatively affected the project, as the pressure to repay their loans may have increased the girls' vulnerability. Local leaders currently support the Young Savers Clubs but have no direct implementation role. The government was involved through the local provincial administrators who conducted mobilization. They also participated in disseminating results and recruiting girls.
Evaluation Methodology	▪ *Longitudinal study with control group:* TRY included a monitoring and research component that allowed managers to track the performance of the project and measure changes associated with the intervention. The impact of the project was assessed by comparing project participants to a group of suitable controls who had not been exposed to the project. Each participant was matched to a control who lived in the same neighborhood and had approximately the same age, education, marital status, parenthood status, and employment status. Controls were identified through a house-to-house survey in the vicinity of the participant's home. In all, 326 participants and their matched controls were interviewed at baseline in 2001, and 222 pairs were interviewed at endline in 2005. Experimental respondents and their matched controls were compared on economic and financial indicators, gender attitudes, and reproductive health knowledge, behavior and negotiation. The evaluation went beyond financial performance to include the impact of participation across social and reproductive health dimensions.
Evaluation Results	▪ *Project reach*: The project reached 535 adolescent girls and young women. ▪ *Longitudinal study with control group:* Results from the 2001 baseline show that TRY participants and their controls had comparable income levels and comparable attitudes toward most gender issues. An aggregate score was computed using responses to eight gender attitude statements, with one point given for each progressive attitude held. In two of the eight issues raised, girls in the control group were significantly more liberal in their thinking than TRY girls.* ▪ Results from the 2005 endline show that participants had a significantly higher level of income compared to controls. Further, while their household assets had been similar at baseline, at endline, participants owned considerably more assets than controls. Girls who participated in TRY also demonstrated more liberal gender attitudes compared to controls. In particular, TRY girls were significantly more likely to say that wives should be able to refuse their husbands sex, that marriage is not the only option for an unschooled girl, and that it is not necessary to have a husband to be happy. There were also some indications that participant girls had greater ability to refuse sex and insist on condom use. * "More liberal" gender attitudes stress gender equality or equity, as opposed to traditional conservative stereotypes and beliefs about male

	superiority.
Replication and Scale-up Activities	▪ The project was expanded in 2004 when Young Savers Clubs were established independent of TRY. KDA regularly meets with young savers to collect and keep savings in a safe place. Young Savers Clubs are continuing in the Kibera slums, with more than 600 girls currently participating in the project.
LESSONS LEARNED AND CHALLENGES	
Key Findings and Lessons	▪ Reliable and safe group structures should form the core of programs for vulnerable girls, with participation constructed as a positive experience. The most vulnerable girls need a place apart from their family for dialogue, support, crisis intervention, the protection of their savings, and development of rudimentary livelihood skills.
Challenges and Unforeseen Outcomes	▪ The main challenge was that of girls dropping out of the project. Delays in receiving loans often were cited as reasons to leave the project, as were nonflexible savings schemes that locked up girls' savings as group collateral and did not allow them access, even in an emergency. ▪ The project underscored the vulnerability of girls and highlighted their diversity despite their common residence in a poor urban community. The initially rigorous microfinance model piloted for TRY was appropriate for only a small subset of the least vulnerable girls. For the majority, entrepreneurship and repeated borrowing were not primary concerns. Instead, their fundamental needs related to acquiring social capital, including social support groups, friendships, mentorships, physical safety, and the opportunity to save their money in a safe, accessible place. For most, entrepreneurship and credit opportunities follow provision of these more basic services.
Recommendations for Replication	▪ Girls require a strong group structure as a base. The model should be constructed as a positive experience, with benchmarks of success based on their capabilities and goals, such as individual voluntary savings or goal-oriented savings. ▪ Infrastructure, staffing, and funding are needed. ▪ Girls' capacity for developing livelihoods for self-protection grows and evolves over time. Programs should therefore be structured to provide some form of individual identification to foster self-esteem and a sense of belonging and identity.

ADDITIONAL INFORMATION	
Program References and Resources	*Print resources:* Erulkar, A. and E. Chong. *Evaluation of a Savings and Micro-credit Program for Vulnerable Young Women in Nairobi*. New York: Population Council, 2005. *Online resources:* Erulkar, A., J. Bruce, E. Chong, A. Dondo, J. Sebstad, J. Matheka, A.B. Khan, and A. Gathuku. *Tap and Reposition Youth (TRY): Providing Social Support, Savings, and Micro-credit Opportunities for Young Women in Areas With High HIV Prevalence.* 2006. http://www.popcouncil.org/pdfs/TABriefs/PGY_Brief15_TRY.pdf.
Contact Information	Population Council P.O. Box 17643-00500, Nairobi, Kenya Tel: + 254 20 271 3480/3 / Fax: + 254 20 271 3479 Website: http://www.popcouncil.org Ben Ochieng, Program Officer, Poverty Gender and Youth bochieng@popcouncil.org James Matheka, Program Coordinator, Poverty Gender and Youth jmatheka@popcouncil.org

GERAÇÃO BIZ

LEAD ORGANIZATIONS: Pathfinder International (PI)
Mozambican Ministry of Health
Mozambican Ministry of Education & Culture
Mozambican Ministry of Youth & Sports
United Nations Population Fund (UNFPA)

COUNTRY: Mozambique

HIV PROGRAM AREA: Prevention

OVERVIEW:
Geração Biz works to prevent HIV among young people in Mozambique by promoting adolescent sexual and reproductive health. Peer activists reach out to both in-school and out-of-school youth with information and services, and youth-friendly health services are being integrated into the national health system. Gender-specific activities include raising awareness of a policy banning pregnant students (and the responsible male) from attending school, advocating for legal protection for female victims of sexual abuse and violence, and promoting female peer activists through targeted recruitment and financial incentive schemes. The program has been successful in recruiting and retaining female peer activists, particularly those not attending school. Also, some peer activists have demonstrated new leadership skills, going beyond the scope of their program roles by providing managerial and technical assistance in various program areas.

BACKGROUND	
HIV & AIDS Program Goals	The key objective of Geração Biz is to promote adolescent sexual and reproductive health, including HIV prevention.
Gender Strategies Addressed	✓ Reducing violence and coercion ☐ Addressing male norms and behaviors ✓ Increasing women's legal protection ✓ Increasing women's access to income and productive resources ☐ Other:
Description of Intervention	Geração Biz ("busy generation") is a comprehensive program to address the sexual and reproductive health needs of in-school and out-of-school youth. The program encompasses three components: youth-friendly clinical services, school-based interventions and community-based outreach. Geração Biz engages peer activists to provide information and services in schools and in communities to reach out-of-school youth, and has established and integrated youth-friendly health services into the national health system. The Ministries of Health, Education, and Youth and Sports are the key implementers, with support from UNFPA and technical assistance from Pathfinder International. The multi-sectoral design of Geração Biz relies on the coordination and collaboration of its three implementing government partners and civil society (i.e., youth nongovernmental organizations and associations). The Ministry of Health is responsible for establishing a network of youth-friendly health facilities where young people can receive sexual and reproductive health services such as counseling, contraception, prevention, and

	treatment of sexually transmitted infections, antenatal and postnatal care and post-abortion care, and voluntary counseling and testing (VCT) and antiretroviral therapy in some instances. The Ministry of Education oversees the in-school interventions, including peer education, adolescent counseling corners in primary and secondary schools, and intra- and extra-curricular sexual and reproductive health and HIV education. Referral linkages are established among teachers, peer activists, adolescent counseling corners and youth-friendly service facilities to increase service utilization and maximize impact. The Ministry of Youth and Sports manages the community outreach component, which includes out-of-school peer activists and community-based youth centers. Youth associations and nongovernmental organizations also provide support to networks of in-school and out-of-school peer activists. Geração Biz also includes an advocacy component, in which the program trains youth activists to raise awareness about the harmful impacts of a national education policy that bans pregnant students, and the male students by whom they became pregnant, from attending school. One thousand two hundred students at 26 schools in Maputo City attended activities led by these youth activists. Furthermore, pregnant students and their parents led debates and drama sessions to promote change in norms and attitudes. Geração Biz also addresses gender-based **violence** and seeks to increase women's **legal protections** by working with UNAIDS, WHO and Forum Mulher to support women who have experienced sexual abuse and/or violence through the development of a protocol for HIV prophylaxis, emergency contraception, shelter and "humanization" of existing legal procedures for such violations. The program works to increase women's **access to income and productive resources** by partnering with nongovernmental organizations to offer Geração Biz female peer activists income-generating opportunities. It also helps both male and female peer activists to obtain scholarships for university or short-term learning opportunities. The program has a recruitment/retention protocol as well, to foster greater involvement of female peer activists.
Target Audience	Young people, ages 10–24
Level of Intervention	▪ National ▪ Province ▪ District ▪ Community
Geographic Location	Nationwide (includes all 11 provinces and 90 of the 146 districts)
Timeframe	1999–ongoing
Funders	▪ Danish International Development Agency (DANIDA) ▪ United Nations Population Fund (UNFPA) ▪ Swedish International Development Cooperation Agency (Sida) ▪ Embassy of Norway

Partner Organizations	*Implementation partners:* ▪ 444 schools ▪ 193 youth-friendly clinics *Evaluation partners:* ▪ Danish International Development Agency (DANIDA) ▪ Embassy of Norway ▪ External consultants
IMPLEMENTATION & RESULTS	
Start-up and Implementation Process	In 1998, an intersectoral committee was formed to implement Mozambique's national plan for adolescent and youth development activities. From this grew Geração Biz ("busy generation"). The project was designed from the outset to be implemented at the national level. The program began in 1999 in two pilot sites, the city of Maputo and the province of Zambézia. So that lessons learned from this pilot phase would inform expansion to other provinces, the program design included extensive monitoring and evaluation activities as well as a flexible management style.
Local Involvement/ Ownership	Geração Biz builds on existing governmental structures, emphasizes multisectoral coordination and has a strong training component for peer activists to build local capacity. Furthermore, youth associations, young people, parents, and community leaders participate in several stages of program development, including design and implementation; conducting assessments and operational research; educational activities and social mobilization. The program relies on external funding and coordination to continue operations.
Evaluation Methodology	▪ *Formative evaluation process:* Each implementation activity begins with a formative evaluation, which may include community mapping and/or a needs assessment for youth-friendly services. Community mapping is used with out-of-school programs. Community members plot existing locations for recreation, entertainment, and education activities, health services clinics, and sites where young people like to congregate. This information can be used to devise new activities, such as the establishment of a youth center. A needs assessment for youth-friendly services involves a baseline assessment of each health clinic and center providing youth services to determine how services could be improved. ▪ *Client exit interviews:* These interviews provide a cross-sectional study of youth clients to measure quality of care and client satisfaction. A baseline survey was implemented in 2000 at the Central Hospital adolescent clinic with 600 individuals. ▪ *Knowledge Attitudes Practices Behaviors (KAPB) survey:* Data are collected at two-year intervals in intervention school-based and out-of school programs. This survey measures changes in knowledge, attitudes, practices, and behaviors of young people around sexual and reproductive health. A limitation of this design is that changes identified are not necessarily attributable to the program.

	▪ *National Survey on the Reproductive Health and Sexual Behavior of Young People and Adolescents (INJAD):* This is a nationally representative, population-based survey of youth ages 15–24 designed to provide estimates at the national, regional, and provincial levels. Baseline data were collected in 2001; a follow-up survey is proposed for 2010. Data are collected on attitudes toward sexuality and gender; reproductive history and maternal outcomes; and sexually transmitted infections and HIV and AIDS-related knowledge, attitudes, and behaviors. ▪ *Management and Organizational Sustainability Tool (MOST)*: Developed by Management Sciences for Health, this tool provides a qualitative assessment of the effectiveness of program activities and recommendations for improvement. It addresses, for example, strategic planning and use of data for decision-making purposes. This tool is used to assess the effectiveness of program management in each of the three components: school-based program, out-of-school program and youth-friendly sexual and reproductive health services. ▪ *Focus groups (community-based or program-based):* Conducted biennially as part of the KAPB survey, focus group discussions identify the range of attitudes and beliefs on relevant topic areas that are later addressed in outreach materials. These are conducted to facilitate materials development and evaluation, and can be used to explore the perceived need for services, barriers to care, quality of care, and program improvement ideas. This tool assesses all programmatic activities: the school-based program, out-of-school program, and youth-friendly sexual and reproductive health services. ▪ *Recall studies for mass media activities:* In these studies, a population sample is selected and surveyed to assess if the media activity was remembered and how well, if key messages were understood and retained, and if any action was taken as a result of exposure. This is used to assess all mass media programs.
Evaluation Results	▪ *Formative evaluation process:* No results provided. ▪ *Client exit interviews:* Data currently are being analyzed using EPI INFO and SPSS. A follow-up survey will be conducted by March 2009. ▪ *KAPB survey:* A steadily increasing proportion of respondents report obtaining information about sexual and reproductive health from activists (44 percent in 2003, compared to 66 percent in 2005 and 87 percent in 2007). Results show an inconsistent pattern over time among respondents who agree with the statement that a woman who carries a condom is interested in having sex (19.5 percent in 2003, compared to 13 percent in 2005 and 18 percent in 2007). ▪ *INJAD:* Results are pending the follow-up survey in 2010. ▪ *MOST*: The implementers involved at the national and local level have good information about the objective, mission, and values of the program. Strategies, systems, and monitoring and evaluation are in place. Results indicate that some areas for improvement include logistics, human resource policies, and integration of the financial procedures of the Mozambique government and those requested by

	the donors. ▪ *Focus groups (community-based or program-based):* Focus groups highlighted the need to develop behavior change materials in local languages. Based on this recommendation, a Portuguese-language radio program was replicated by local radio stations in different languages. ▪ *Recall studies for mass media activities:* Geração Biz has introduced many campaigns and mass media interventions, including The National Contest of Songs and the Mama Biz radio program. The National Contest of Songs about preventing HIV infection had a recall of 92 percent among students in schools where the program had been implemented. More than 60 percent have heard of the Mama Biz radio program.
Replication and Scale-up Activities	▪ The program expanded nationwide from the initial two districts in two provinces, reaching more than 90 (of 146) districts in all 11 provinces. By 2009, the program is expected to reach at least 40 percent of all young Mozambicans between the ages of 10 and 24 with information and services. ▪ Many countries have visited Geração Biz and some, for example Brazil's "Saúde e Prevenção nas Escolas," have incorporated the program's specific approaches.
LESSONS LEARNED AND CHALLENGES	
Key Findings and Lessons	▪ The Geração Biz program developed an operations research study to test new strategies for improving female peer activist recruitment, participation and retention in program activities. The study identified ways to improve young women's comfort, security, skills acquisition, support and mentorship. Changes made as a result of the study resulted in increased recruitment of female peer activists, particularly those that are out-of-school, and a 70 percent reduction in the number of female peer activists dropping out of the program. ▪ Two Geração Biz peer activists were named Youth Ambassadors for Africa (in 2006). Some peer activists are now providing managerial and technical assistance on program issues. These examples reflect a new type of leadership emerging among young people in Mozambique. ▪ Combining a number of approaches and activities to facilitate improved adolescent sexual and reproductive health is key to the program's success.
Challenges and Unforeseen Outcomes	▪ Many health facilities have a shortage of condoms and youth-specific educational materials. ▪ The overall response to gender-based violence within the youth-friendly service facilities is insufficient, highlighting the need for protocols, specialized training and support. ▪ Intergenerational sex is an important factor that influences a young

	woman's ability to negotiate and use protection. While youth-friendly services can provide counseling, information, and condoms, normative change also is needed to address this issue. ▪ Substance abuse is directly linked to gender-based violence, vulnerability, and often HIV infection or unwanted pregnancy. While efforts have been made to integrate this issue into various aspects of the program, including youth-friendly services, additional human resources (e.g., psychologists) often are required to address it adequately. Given the human resource constraints of public-sector health services, it is difficult to provide these additional support services without external funding.
Recommendations for Replication	▪ An evidence-based monitoring and evaluation system is important to suggest the best means for effective implementation. ▪ Multi-sectoral coordination is a must, and government involvement at the central and local levels is needed. ▪ Youth participation needs to occur at all phases of implementation.
ADDITIONAL INFORMATION	
Program References and Resources	Ali , A. B. B., et al. *Using Incentives in the Mozambican Education Sector to Sustain and Intensify HIV Prevention Among Youth.* XVII International AIDS Conference: Abstract no. TUPE0959, 2008. Badiani, R., et al. *Improving Female Recruitment, Participation, and Retention Among Peer Activists in the Geração Biz Program in Mozambique*. Maputo: Pathfinder International, 2006. Banze, E., et al. *An Education Sector Strategy to Reduce Alcohol and Other Drug Use Among Youth in Mozambique Shows Commitment to the Sexual Health of Youth Especially HIV Prevention.* XVII International AIDS Conference: Abstract no. TUPE0953, 2008a. Banze, E., et al. *Being Together: An Inclusive Approach to HIV Prevention in Mozambican Schools.* XVII International AIDS Conference: Abstract no. MOPE1037, 2008b. Chichava, N., et al. *The Role of Youth Associations in Implementing Youth to Youth Programs: 'The Geração Biz Experience.'* XVII International AIDS Conference: Abstract no. CDE0010, 2008. do Carmo Sales Monteiro, M., et al. *Increasing Access to HIV/AIDS Treatment and Care for Youth and Adolescents in Mozambique.* XVII International AIDS Conference: Abstract no. WEPE0561, 2008. Feliciana, M., et al. *In Cama Wa Kutiva – Time to Know Campaign: Improving Access to VCT for Adolescents and Young People in Mozambique.* XVII International AIDS Conference: Abstract no. CDC0520, 2008. Folige, A., et al. *No Dark Sarcasm in the Classroom: Teachers Deciding How to Face HIV and SRH Issues Among Youth in Mozambique.* XVII

	International AIDS Conference: Abstract no. THPE0536, 2008. Hainsworth, G., et al. *From Inception to Large Scale: the Geração Biz Programme in Mozambique.* Geneva: World Health Organization, 2008. The International Bank for Reconstruction and Development/ The World Bank. *Education and HIV/AIDS: A Sourcebook of HIV/AIDS Prevention Programs*. Washington, DC. 2003. Silva, C., et al. *Multisectoral Coordination Paves the Way for Sustainable Development in Youth and Adolescent Sexual and Reproductive Health Programming.* XVII International AIDS Conference: Abstract no. TUPE1026, 2008. *Resources available from Geração Biz:* Educational videos: address HIV prevention at schools and at community level, VCT, gender-based violence and intergenerational sex (available with subtitles in English) Geração Biz Protocol: a series of steps that guides program implementation at the local level National Contest of Songs: a CD containing 11 selected songs addressing HIV prevention MAMA BIZ Radio broadcast: two CDs and a manual covering programs recorded and sent to community radio stations nationally Manual to Health Providers: a training manual focusing on how to promote health and ensure confidentially, privacy, friendly approaches and counseling for young people Manual for Home Visitation Peer Educators: useful for educators working with people living with HIV Manual on VCT for Trainers and Health Providers: a manual on how to provide HIV tests and counseling to young people Manual and Video to Strengthen Drama Session Interventions: a “how-to” manual and video on using drama sessions to enhance discussions about sexual reproductive health, gender issues, violence and more Monitoring software: software to monitor peer educator activities Peer Educators’ Manual: used by peer educators in the field; comprises all content addressed by Geração Biz as well as guidance on working with peer educators in different settings Photo soap opera brochures: discuss HIV prevention, contraception, life skills and gender issues Scenes Without Doubts (Cenas sem Dúvidas): a series of six books in a CD format discussing contraception, HIV prevention, abortion, and gender Training Manual for Trainers: topics covered include sexual and reproductive health, HIV/AIDS prevention, adolescence, gender, gender-based violence, living with HIV and AIDS, alcohol and other drugs, life

	skills, human rights, and monitoring and evaluation
Contact Information	Pathfinder International – Mozambique No. 1919, 6 Andar, Avenida Ahmed Sekou Toure, Maputo, Mozambique Tel: + 258 (1) 313 547 / Fax: + 258 (1) 313 546 Website: http://www.pathfind.org/ Julio Pacca, Country Representative Email: jpacca@pathfind.org

SURVIVAL SKILLS TRAINING FOR ORPHANS (SSTOP)

LEAD ORGANIZATIONS: Training Internationally for the Orphans and their Survival (TIOS)

COUNTRY: Mozambique

HIV PROGRAM AREA: Prevention, Care and Support

OVERVIEW:
SSTOP mitigates risk of involvement in transactional sex among orphans and vulnerable teenage girls. Through the production of anatomical dolls, the project provides participants with income-generating skills and a way to support themselves and their families without resorting to transactional sex. At the same time, the dolls assist with the provision of accurate HIV information. In addition, the program training manual covers behavior change in sexual practices, basic health and safety, self-defense and women's rights. Anecdotal evidence shows positive changes in participating girls' lifestyles. Though the project has met some resistance for excluding boys, it maintains this policy because girls lack many opportunities that boys have. A key lesson learned is the need to couple attempts at behavior change with viable alternative options to generate income.

BACKGROUND	
HIV & AIDS Program Goals	SSTOP targets orphans and vulnerable teenage girls who may be compelled to participate in transactional sex to support themselves and their family members. The objective is to provide them with an income-generating skill and accurate HIV information.
Gender Strategies Addressed	✓ Reducing violence and coercion Addressing male norms and behaviors ✓ Increasing women's legal protection ✓ Increasing women's access to income and productive resources Other:
Description of Intervention	SSTOP produces anatomical dolls to be used as a tool for improved HIV awareness training. Simultaneously, the "Five Components of HIV" Program Training Manual promotes behavioral change in sexual practices and aims to break through educational and language barriers. The program is implemented by the AIDS Orphans Skills Centers (AOSCI), known in Mozambique as TIOS. TIOS conducts training sessions using this manual monthly or bimonthly, depending on the students' semester schedule. Public and adult sessions are normally held every month. Also, a week-long "training of trainers" course is offered quarterly. The training manual teaches facts about HIV in a simple manner and uses memory techniques so that participants can comprehend, remember and repeat accurately the facts of HIV transmission. In addition to HIV education, SSTOP addresses several gender-related issues. The project seeks to increase girls' **access to income** by introducing income-generating and small business skills to participants. Many of the girls are having transactional sex to survive and help feed their families. Providing an opportunity for them to learn skills that can generate income in a positive way eliminates the need for transactional sex and

	empowers them to make healthier choices. For girls ages 9–13, a girl's club offers training in income-generating "household activities," such as making soap or candles, sewing, and knitting. Older girls (14–19) can attend sewing classes where they learn to make the anatomical dolls used in the HIV education and awareness training. The girls are paid based on quality production of the dolls. The project also organizes apprenticeships within the training center, with, for example, the accountant, the sewing teacher, or the bread teacher. This provides a substitute teacher if a regular teacher leaves, while also training the girls in marketable job skills. The SSTOP program manual also provides basic health and safety/first aid training so that women can take control of their own health. It also includes information about family law and women's rights to increase girls' awareness of **legal protections** for women. In addressing gender-based **violence**, a separate self-defense course, offered in two three-hour sessions, covers what to do when a girl *can* fight back (a situation with a thief, intoxicated person, etc.) as well as when she may *not* be able to physically fight back (such as when dealing with a policeman, teacher or family member). In the latter case, girls are shown how to "talk your way out of the situation" rather than physically fight back. This course also covers the process of filing a police report in an abusive situation with a man and recommends organizations that support women who have been raped or sexually abused. Men are never permitted to participate in this course.
Target Audience	Adolescent girls, ages 14–19 who are responsible for caring for younger siblings, and other disadvantaged girls
Level of Intervention	▪ Community ▪ District
Geographic Location	Chimoio district/city of the Manica province, Western Mozambique
Timeframe	June 2006–ongoing
Funders	The U.S. President's Emergency Plan for AIDS Relief (PEPFAR)
Partner Organizations	*Implementation partners:* ▪ Church World Service ▪ Columbia University ▪ Foundation for Community Development (FDC) ▪ Health Alliance International (HAI) ▪ Peace Corps ▪ Population Services International (PSI) *Evaluation partners:* ▪ Ilene Speizer, Department of Maternal and Child Health, University of North Carolina School of Public Health, Chapel Hill

IMPLEMENTATION AND RESULTS	
Start-up and Implementation Process	In developing the SSTOP project, TIOS wanted to combine HIV awareness with basic safety and first aid. TIOS also knew that they needed a visual tool that would be understood and accepted by the local culture. Because women are traditionally allowed to produce domestic products, sewing dolls could be considered a "girl's" career. Initial classes also showed participants how to manage the money a family uses for their daily needs, find ways to improve their living situation, and identify ways to generate more income in the future. The self-defense and family law classes evolved organically as additional needs were identified. For example, after the income-generating classes, participants felt empowered yet still placed great importance on attracting men. The family law classes helped them become aware of the legal difficulties of having a child without being married to the father of the child.
Local Involvement/ Ownership	Local community and church leaders, as well as school administrators and local *bairro* officials, helped SSTOP select girls to join the project. SSTOP also works in partnership with the National Council to Combat AIDS and Accao Social, a local organization that helps orphans and widows.
Evaluation Methodology	▪ *Qualitative and anecdotal evidence:* An evaluator from the University of North Carolina, Chapel Hill conducted a site visit and used qualitative methods to gather girls' testimonials and observe lifestyle changes. ▪ *Monitoring:* Data were collected by TIOS on the number of participants trained and how many participants tested for HIV after attending prevention sessions. TIOS also collected data on the number of adolescent girls who are direct and indirect program beneficiaries.
Evaluation Results	▪ *Qualitative and anecdotal evidence*: Findings indicate that participants are better organizing their home finances and gaining vocational skills for income generation in the future. In interviews, family members said that the girls would now be able to choose their own husbands rather than having to say yes to any proposal offered. Girls also are delaying marriage, choosing to support themselves longer through the project's income-generating activities, and not engaging in early sexual activity without protection. ▪ *Monitoring:* At the TIOS training center, more than 500 participants have been trained in HIV training, self-defense and more. Typically, about 10 percent of participants have tested for HIV by show of hands at the beginning of a 90-day course, and more than 75 percent have tested by the end. Also, nearly 2,000 adolescent girls are direct program recipients and 29,415 adolescent girls are indirect recipients (indirect includes five family members of direct program recipients, as well as recipients who have received training from more than 500 trainers that TIOS has trained).
Replication and Scale-up Activities	▪ Several organizations have expressed interest in replicating the SSTOP project, and TIOS is currently working with Church World

	Service on replication. TIOS is also adding to the HIV training and income-generating activities. In August 2008, SSTOP began a series of income-generation seminars with instructions on how to make cement water filters, anti-itch and anti-bacterial soaps, and insect-repellent candles. In November 2008, the project will offer classes on computer graphic arts in which participants will make manuals, posters and safety training materials to complement the survival skills curriculum. SSTOP hopes to have a comprehensive training center by 2009 to train new trainers and produce all materials needed to teach safety and survival skills throughout Mozambique. ▪ The International Trade Cooperative (ITC) has received the SSTOP training and experienced a big change in behavior among the trainees of their project. ITC also will work with TIOS as they create a "school farm" and girls center in a rural community outside of Chimoio.
LESSONS LEARNED AND CHALLENGES	
Key Findings and Lessons	▪ Efforts to elicit behavior change must also provide girls with alternative choices. Nobody chooses to live a marginal life; a marginal life comes from a perceived or real lack of options.
Challenges and Unforeseen Outcomes	▪ Finding girls who were not pregnant or already mothers was a challenge. ▪ Even though the project improved self-esteem and gave girls an income-generating skill, participants still viewed marriage and motherhood as the most important things in a woman's life. This could offset project efforts around safe sex, as their new skills made the girls more attractive to men. ▪ TIOS applied for funding in August but the funds arrived in December when prices were 20 percent higher. This is especially challenging, as TIOS is a small organization and cannot begin programs without the funding. Once the funding arrives there is a short time frame to complete the project. It is a bit of a struggle to find a teacher and students for the courses within such a short time frame. If the date of the arrival of the funds were guaranteed, TIOS could have received applications for students and hired teachers in advance. ▪ The project occasionally meets pressure to allow boys access to the unique opportunities at the training center. However, TIOS holds to the original design because undereducated girls typically have more responsibilities than boys, and because undereducated boys have many income-generating possibilities unavailable to girls. However, the project has been careful to choose activities for girls that can be considered "home" or "domestic" products. Recently, SSTOP has begun to challenge gender bias by offering girls computer training courses, which is possible because TIOS has built up trust since it has been a part of the community for three years. ▪ Finding trustworthy, reliable personnel can be a challenge.

Recommendations for Replication	▪ Hire personnel who are intelligent, organized, and practical. Ideally they should have some kind of salary to cut down on corruption, and good training. ▪ The community must take ownership of the project, investing their time and support. Otherwise, the organization starting the training center will have to run it independently for many years. ▪ It is necessary to have a very organized accounting/purchasing person to run operations efficiently. ▪ It is helpful to have knowledge of local family law and local cultural practices, and to know what other local organizations are doing to share ideas and avoid repetition of project activities. ▪ It is important to ensure that the project meets the community's actual needs, and to show the community the benefits and incentives of the project. Often people are not aware that they are missing valuable information, like basic first aid, and how it can be a tremendous advantage for them and decrease poverty within families.
ADDITIONAL INFORMATION	
Program References and Resources	KCFR News. "News Feature: AIDS Dolls." Feb. 18, 2008. http://www.kcfr.org/index.php?option=com_content&task=view&id=94&Itemid=234&target_pg=com_day&date=02/18/2008. Accessed October 17, 2008. Lang, J. "How Did Amy End Up in Africa." 2007. http://denver.yourhub.com/Englewood/Stories/Faith/General-Faith/Story~292624.aspx. Accessed October 17, 2008. "Nonprofit Teaches African Orphans Survival Skills." 2006. http://www.easychairmedia.com/Colorado_Springs/2006_CS_Noodles/pdf_files/06.pdf. Accessed October 17, 2008. Stachura, S. "Amy Gillsepie's Mozambique." 2006. http://minnesota.publicradio.org/display/web/2006/07/26/amygillespie/ Accessed October 17, 2008. TIOS. *TIOS Mozambique* 2, no. 1 (Aug. 15, 2008). http://aosci.org/downloads/Aug%2015%202008.pdf.
Contact Information	Training Internationally for the Orphans and Their Survival C.P. 412, Avenida Samora Machel, Chimoio, Mozambique Tel: + 258 82 854 2584 Website: http://aosci.org/programs/programs.htm Amy L. Gillespie, Founder, AOSCI Email: aosci.tios@gmail.com TIOS is registered as 501(c) 3 nonprofit in the U.S. as AOSCI _ AIDS Orphans Skills Centers, Inc.

WOMEN FIRST (MULHERES PRIMERO)

LEAD ORGANIZATIONS: International Relief and Development (IRD)

COUNTRY: Mozambique

HIV PROGRAM AREA: Prevention

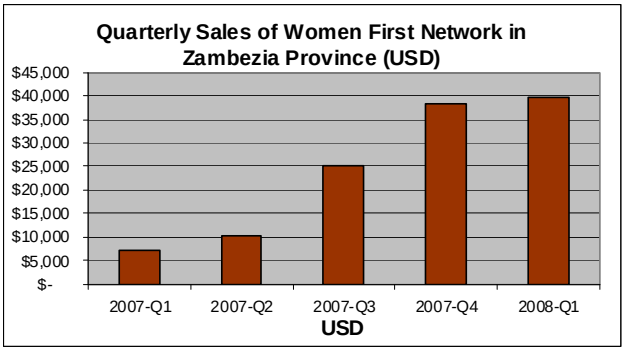
OVERVIEW:
Women First aims to increase knowledge of healthy behaviors in the community and improve women's economic capacity. The program combines health, HIV/AIDS and entrepreneurial training with the establishment of sustainable businesses for rural women. IRD provides existing women's groups with intense training on health and HIV and AIDS, and partners with private sector companies to create a supply chain of items that women entrepreneurs will sell. In response to feedback from beneficiaries, Women First also addresses women's economic empowerment and gender-based violence. To encourage dialogue on gender-based violence, IRD collaborates with a local theater group and other community members. Combining education around HIV and violence with an income-generation component has been key to the program's success. Another key finding is that women's commitment to the program is more important to retention than previous entrepreneurial experience. An external evaluation shows that the program improves women's health outcomes and income, that women put their income to good use, and that participants are healthier and therefore better able to earn and to care for their families.

BACKGROUND	
HIV & AIDS Program Goals	Women First aims to increase knowledge of healthy behaviors, particularly HIV prevention, in the community, and to increase women's economic capacity so they are better able to practice healthy behaviors. The program uses a public-private partnership to promote program sustainability and increase market access in rural areas to affordable basic goods.
Gender Strategies Addressed	✓ Reducing violence and coercion Addressing male norms and behaviors Increasing women's legal protection ✓ Increasing women's access to income and productive resources Other:
Description of Intervention	Women First combines health and HIV/AIDS activities with entrepreneurial training sessions and the establishment of sustainable businesses for rural women. IRD provides women's groups with intense training on health and HIV and AIDS. In addition, to increase women's **access to income**, IRD partners with private sector companies to create a supply chain for basic consumption items that women entrepreneurs sell. The program works with existing women's groups in target districts. First, districts are selected by mapping locations where women's groups already exist and there is limited market coverage of products produced by private sector partners. This helps to ensure that the program will be able to create a sustainable entrepreneurial business. Women's groups are then selected from among those involved with World Vision's food security program, OVATA. IRD staff present the program to the selected groups, and those that agree to participate receive entrepreneurial training as stock-keepers and sellers. Health and HIV trainings take place in conjunction with weekly monitoring

	of sales of the entrepreneurial component. The program also works with women to manage accumulated wealth. Gender-based **violence** was not an initial focus area of the program. However, during discussions about managing wealth generated by women's entrepreneurial activities, as well as during discussions of HIV and sexually transmitted infections, it became clear that violence was a cross-cutting issue. Therefore, Women First began to work on changing norms that fuel gender-based violence. One way in which dialogue around violence occurs is through a theater initiative. Local theater group *Astros da Zambézia* engages women as part of their initial entrepreneurial training. Through a performance, *Astros da Zambézia* chronicles a woman's daily activities, focusing particularly on the interaction between husband and wife upon the wife's return home with her newly earned income. The performance is interactive, with the actors encouraging participation from the audience. The audience members identify problems that can lead to an increase in violence within the household, such as paucity of disposable income for exclusive use by the husband; feelings of emasculation among unemployed or underemployed husbands; and accusations that woman are shirking familial duties as a result of their out-of-home income-generation activities. Audience members and actors then collaborate to develop strategies women can employ in response, such as integrating husbands into women's business models. The most common practice is to assign husbands specific neighborhoods in which to sell goods: in return, husbands keep a percentage of the profits. Another strategy is sharing familial responsibilities. Though balancing business and familial duties can be a challenge, a number of women noted that their husbands are willing to assume a more prominent role in household duties. However, women also noted the importance of acknowledging traditional gender roles. In the Health and HIV component of the Women First program, gender-based **violence** is addressed through group dialogue during sessions on HIV testing and status disclosure. Participants are divided into groups and each group is provided with a picture of a family. Groups make up a story about the family and are then asked to reflect on how family dynamics will be affected if one of the family members is identified as having HIV. Women often report that husbands become angry and violent as a result of disclosure. The groups collaborate to develop techniques to counteract violence, such as couples testing.
Target Audience	Female youth and adult women in rural areas with limited access to markets
Level of Intervention	District
Geographic Location	▪ *Phase I*: Southern Mozambique: Zavala, Inharrime, Homoine, Maxixe, Morrumbene and Massinga districts within Inhambane Province ▪ *Phase II:* Northern Mozambique: Nicoadala and Namacurra districts within Zambézia province
Timeframe	▪ *Phase I:* July 2005–September 2006 ▪ *Phase II:* November 2006–ongoing

Funders	▪ Canadian International Development Agency (CIDA) ▪ United Nations Development Program (UNDP) ▪ United States Agency for International Development (USAID)
Partner Organizations	*Implementation partners:* ▪ Unilever ▪ World Vision ▪ United Methodist Church in Mozambique *Evaluation partners:* ▪ George Washington University, Washington, D.C., USA ▪ Deloitte Development, LLC
IMPLEMENTATION AND RESULTS	
Start-up and Implementation Process	IRD and the Women's Society of United Methodist Church of Mozambique designed the health education component of the program. The Women's Society recognized that their existing peer health education program needed a stronger health education component and an income-generation activity that would attract women to the sessions. The idea for the entrepreneurial component of the program emerged in 2005 during a joint IRD-Unilever visit to rural markets. Peter Van-As, director of Unilever Mozambique at the time, said: "We are the largest company in our sector, but we cannot reach the rural areas of Mozambique. Middlemen buy our products at the provincial capitals and resell them at very high prices in the rural areas. We are not able to provide access to products at affordable prices to the bottom of the pyramid, the poorest, but largest, socioeconomic group." With Unilever, IRD developed the Women First model to provide people in rural areas of Mozambique, access to basic consumption products at affordable prices.
Local Involvement/ Ownership	In consultation with community-based women's groups over 18 months, the program was adapted to meet the needs of target communities. All the guidelines for the entrepreneurial component were designed at the field level, while the health and HIV manual remains a living document that undergoes constant revision in response to community input. In addition, women's groups are selected in consultation with local communities. The program can only begin with a particular group if the local community leader is consulted and gives approval. The local community leaders then participate in the initial training and in monitoring activities. With regard to government participation, IRD has a memorandum of understanding with the Ministry of Woman and Social Action. At the provincial level, a number of officials from the Woman and Social Action Department and from the Health Department have visited the program and have participated in its evolution. Local authorities provide constant support to the program's expansion and have intervened to help women sellers increase their geographical coverage. At the conclusion of the project, IRD plans to hand over the supply chain of products to a private sector distributor. Under the UNDP's Growing Sustainable Business initiative, Deloitte conducted a viability study of the

	program's exit strategy and determined that the current plan to sustain the established businesses is feasible.
Evaluation Methodology	▪ *Quantitative behavior, knowledge, attitudes and practices (KAP) study:* The health and HIV component was evaluated through a baseline study and follow-up survey on behaviors and attitudes among program participants. Outcome measures include program participation and adherence, HIV prevention knowledge, uptake of HIV testing among women in the last six months, condom use during their last sex with a nonmarital partner, and use of income earned in the program. ▪ *Health and income evaluation*: External evaluators from George Washington University evaluated the program. The evaluation looked specifically at women's income and health outcomes. ▪ *Monthly monitoring:* Monthly program monitoring data reflect average monthly sales of Women First participants and average monthly income of entrepreneur graduates.
Evaluation Results	▪ *Quantitative KAP study:* Since the beginning of the program, almost none of the participants (3 percent) have considered quitting Women First, and 99 percent said they would be willing to mentor other women. In a province where the latest behavioral study revealed that only 34.9 percent of women knew at least one method of HIV prevention, 97.5 percent of those in the Women First program cited condom use as a prevention method. Half of the women used their new disposable income (Figure 1) from the program to buy food, while 54 percent bought household items and 44 percent bought school supplies for their children. ▪ *Health and income evaluation*: The evaluation concluded that "[Women First] demonstrably improves women's health outcomes and income levels in ways that individual programs targeting only one component do not. The women learn how to put their income to good use, and because they are able to more effectively utilize information about disease prevention and nutrition, they are healthier and therefore better able to earn and care for their families" (Brown et al., 2008). Evaluators recommend specific improvements to enhance the program. These include providing ongoing business training to sellers, providing ongoing monitoring and more support for graduates, developing a stronger long-term focus on capacity building, and expading market flexibility. To enhance the linkage between health education and income generation, the assessment suggests that program materials and strategies should emphasize the link between higher income and better health. Evaluators also recommend reaching out to health-related private sector partners. ▪ *Monthly monitoring:* Figure 1 below shows quarterly sales figures for Women First participants for four quarters in 2007 and the first quarter in 2008.

	 **Figure 1**. 2007 Quarterly Sales of the Women First Program
Replication and Scale-up Activities	This program has not yet been replicated or scaled up.
LESSONS LEARNED AND CHALLENGES	
Key Findings and Lessons	▪ The most important lesson is the value of the income-generation component. This results-oriented component attracted women and shaped program identity. It showed that changes in women's lives can happen, and when coupled with peer support and increased knowledge, they can alter gender norms. Economic power in the hands of women was the catalyst for Women First's success. ▪ Groups at the beginning of the program that received HIV and gender-based violence education without the income generation component attracted low levels of participation compared to the groups that had this component. This suggests the importance of including income generation in future approaches to address gender. ▪ The program has the best results when applied to women's groups that have strong solidarity and low levels of internal conflict. Through implementation, IRD staff learned to select groups that have high levels of coherence even if their commercial potential seemed lower. These are the ones that end up having a high level of sales and high peer-to-peer assistance. ▪ Because the local markets in Zambézia province sell products that are included in the Women First portfolio at very high prices, the Women First program can save families as much as 35 percent for products that households use daily.
Challenges and Unforeseen Outcomes	▪ Willingness for change can be a better predictor of success than experience. At the beginning of the program, women with entrepreneurial experience were selected on the assumption that they were more likely to succeed. However, women who had no previous entrepreneurial experience ended up achieving the highest level of commercial success. These women were the ones that needed the program the most and invested a lot of time and effort to improve their economic status.

Recommendations for Replication	▪ Before replicating Women First, a thorough market study should be performed in the target geographical area, along with interviews with distributors and producers. Women First can be successful in areas with low market penetration, but if market penetration is high, then women will not be able to have a sustainable income source.
ADDITIONAL INFORMATION	
Program References and Resources	Brown, B., et al. *Women's Income and Health Outcomes in Mozambique: Evaluating the Women First Program*. Washington, D.C.: The Elliott School of International Affairs, George Washington University, 2008. International Relief and Development (IRD), Investment Promotion Centre (CPI), and UNDP. *Determination of the Viability of a Commercial Company for the Distribution of Basic Commodities in Zambézia Province – Mozambique, Final Report,* 2008.
Contact Information	International Relief and Development, Inc. 1621 North Kent Street, Fourth Floor, Arlington, VA 22209 USA Maputo Office: Avenue Base N'Tchinga 567, Bairro Coop, Maputo, Mozambique Tel: +1 703 248 0161 (US) / + 258 21 415 953 (Mozambique) Fax: +1 703 248 0194 (US) / + 258 21 417 591 (Mozambique) Website: http://www.ird.org/womenfirst.html Themos Ntasis, MPH, PhD, Regional Program Development Southern Africa Email: tntasis@ird-dc.org

MALE NORMS INITIATIVE

LEAD ORGANIZATIONS: EngenderHealth
Instituto Promundo

COUNTRY: Ethiopia, Namibia

HIV PROGRAM AREA: Prevention, Care and Support

OVERVIEW:
Based on the Men As Partners Program (developed by EngenderHealth) and Program H (developed by Instituto Promundo), the Male Norms Initiative seeks to increase the capacity of organizations to address negative gender norms that affect HIV and AIDS prevention, care, and treatment. The program achieves this by increasing capacity of existing programs to integrate male engagement strategies at all levels (individuals, community, family, service provider, policy and advocacy), depending on the focus of each organization's HIV/AIDS program. This can include, for example, training in how to reach out to men using a group education process, training health care providers in male-friendly services related to HIV and AIDS, or helping organizations develop curricula that address male engagement. The program also addresses gender-based violence in the context of HIV and AIDS. The program to date has assisted 50 organizations and institutions in Namibia and 10–12 in Ethiopia. The program has learned that to effect change, it is important to avoid labeling men solely as perpetrators. Also, working with different stakeholder levels is essential to creating change. If work is done only with individual men while the larger community is unaware or has not bought in to new norms, the men will face pressure to revert to the previous gender norms.

BACKGROUND	
HIV & AIDS Program Goals	The Male Norms Initiative is a subprogram under the Access, Quality, and Use in Reproductive Health (ACQUIRE) Project. Its main goal is to increase the capacity of organizations and institutions to change harmful gender norms that put men and women at risk of HIV transmission, and to promote the positive engagement of men in this process.
Gender Strategies Addressed	☑ Reducing violence and coercion ☑ Addressing male norms and behaviors ☐ Increasing women's legal protection ☐ Increasing women's access to income and productive resources ☐ Other:
Description of Intervention	The Male Norms Initiative provides technical assistance (through EngenderHealth and Instituto Promundo) to organizations and institutions to strengthen their capacity to address gender-related issues within pre-existing HIV/AIDS prevention, care, and treatment programs. The Male Norms Initiative uses principles drawn from the Men As Partners program and Program H to teach specific, evidence-based strategies to address male norms, reduce gender-based violence, and promote gender equity within existing community-level programs. At a national policy level, the program advocates for including attention to male norms within HIV programming. The program helps organizations encourage men and communities to understand how existing gender norms contribute to gender-based

	violence and what men can do in their communities and households to decrease its occurrence. Organizations are taught to facilitate group workshops, dialogues, and community mobilization activities that help men understand the concept of gender, how norms are created, and how they contribute to negative reproductive health outcomes, including gender-based violence. Through these activities, men are enabled to take a stand against gender-based violence and personally speak out when they witness it. Men also are encouraged to think about how **male norms**—for example, multiple sexual partners, inconsistent condom use, alcohol, substance abuse, violence, and not seeking health services in a timely way—put them and their families at risk for HIV. The community also is engaged through various outreach and mobilization activities, including dramas, mobile fairs, and community action teams. Without this component to transform norms at the community level, men who have attended an education session away from the influences of the community may face peer pressure to resume typical behaviors when they go back to their home environment. The Male Norms Initiative also works with health care providers to provide male-friendly services that encourage men to access health services either alone or with partners. To increase men's demand for services, the initiative stresses the personal benefits of such health-seeking behaviors and highlights the subsequent benefits for their partners and families.
Target Audience	The U.S. President's Emergency Plan for AIDS Relief (PEPFAR) partners (CBOs, NGOs and government agencies). These partners are encouraged to target men of all ages.
Level of Intervention	▪ Community ▪ District ▪ National
Geographic Location	Nationwide
Timeframe	March 2007–ongoing
Funders	▪ The U.S. President's Emergency Plan for AIDS Relief (PEPFAR) through the United States Agency for International Development (USAID), the United States Centers for Disease Control (CDC) and the United States Department of Defense (DOD).
Partner Organizations	*Implementation partners:* ▪ Lifeline/Childline, Namibia ▪ Hiwot, Ethiopia *Evaluation partners:* ▪ Program for Appropriate Technology in Health (PATH)

IMPLEMENTATION AND RESULTS	
Start-up and Implementation Process	The Male Norms Initiative uses the Men As Partners program (developed by EngenderHealth) and Program H (developed by Instituto Promundo). It began its technical assistance with sensitization sessions for all PEPFAR country partners on the concept of gender, male norms, the link between gender norms and risky behaviors, and how best to address these norms. Each organization interested in learning more then received a five-day training specifically tailored to its needs. Participating organizations were asked to develop action plans, where they may detail, for example, a timeline for the launch of new curricula incorporating gender issues or for staff training. Each organization received a technical assistance contact at EngenderHealth or Instituto Promundo, who helps facilitate the conceptualization process, implementation plans, and workplans to integrate strategies into existing program activities. Technical assistance, e.g., providing input on existing materials, is provided through a variety of media—in-person consultations, over the Internet, through phone discussions, and so forth. Two partner organizations also receive monetary support—Lifeline/Childline to provide technical assistance in Namibia, and Hiwot Ethiopia to help implement an intervention.
Local Involvement/ Ownership	Although the Male Norms Initiative does not work with communities directly, community-based organizations (CBOs) seek the program's help in integrating gender strategies into their work because many gender-related issues arise from the community. At the government level, the Male Norms Initiative brings together key agencies to discuss gender strategies and how they were developed. In Namibia, the Ministry of Defense, the Ministry of Safety and Security, and Ministry of Education are engaged in the initiative

Evaluation Methodology	▪ *Needs assessment:* In 2007 a needs assessment, using key informant interviews, was conducted in each country. The assessment sought to identify male norms related to HIV and AIDS (concerning use of health services, use of alcohol, gender-based violence, multiple concurrent partners, etc.) and how they are being addressed.
	
	▪ *Process and outcome evaluation:* An external evaluation will be conducted by PATH beginning in December 2008 at the conclusion of the program in Namibia and Ethiopia.
	  ▪ The process evaluation will focus on the capacity-building/strategic planning process related to incorporating a focus on gender and engaging men in HIV prevention, care, and treatment among participating organizations. It will assess ways that organizations have integrated male engagement into their programs as a result of technical assistance from the Male Norms Initiative, and how technical assistance has contributed to staff skills with respect to male engagement and HIV.
	  ▪ The outcome evaluation will consist of a quantitative (pre-/post-) evaluation of the impact of gender/male engagement activities for HIV (and violence) prevention on men who have participated in specific interventions, such as participatory group education or community-based mobilization activities. This evaluation will measure: 1) condom use (by partner) at last sex and over the last

	six months; 2) number of partners over the last month; and 3) support for gender-equitable norms as measured by the GEM (Gender-Equitable Men) scale. Secondary outcome measurements include: 1) intimate partner violence (physical and sexual); 2) communication with partner over the last six months about condoms, sex life and HIV; and 3) communication with peers over the last six months about condoms, sex life and HIV. The outcome evaluation also will include qualitative data collection with a group of participating men and (in Ethiopia only) their sexual partners, which will provide richer information to enhance the findings of the quantitative surveys.
Evaluation Results	▪ *Project reach*: The Male Norms Initiative reaches thousands of men through 50 partner organizations in Namibia and 10 partner organizations in Ethiopia. ▪ *Needs assessment:* The needs assessment showed that, at the start of the project, Ethiopia and Namibia were addressing gender issues superficially. That is, strategies to curb gender inequity tended to highlight men as perpetrators only. There was little focus on existing gender norms and their relationship to HIV and AIDS or on challenging inequitable gender relationships that put both men and women at risk. This assessment helped shape how the Male Norms Initiative sought to create change—by helping programs use an asset-based model where men are not seen as perpetrators of gender inequity, but instead as assets who can change norms and behaviors around gender-related issues. ▪ *Process and outcome evaluation*: Endline data collection is scheduled for February 2009.
Replication and Scale-up Activities	The Male Norms Initiative has been asked to implement a similar program at a national scale in Tanzania and to provide technical assistance in other countries, including Rwanda and Angola.
LESSONS LEARNED AND CHALLENGES	
Key Findings and Lessons	▪ Working with different stakeholder levels (individual, community, policy, and service delivery) at the same time to create change is essential. Otherwise, when individuals go back to their communities after attending a program, they tend to readopt original gender norms. Norms must be changed at the community, policy and service delivery levels, not just at the individual level.
Challenges and Unforeseen Outcomes	▪ Some partners require more assistance than others to understand gender-related work. Some organizations required repeated trainings before they fully understood key concepts. ▪ Funding cycles between the Male Norms Initiative and CBOs did not coincide. Consequently, partners interested in integrating strategies did not always have the funding necessary to begin the process. ▪ Capacity building to a point where external support or technical

	assistance is no longer necessary is a time-consuming process. ▪ Work on gender issues has created an aura around "gender" so people think that it requires specialists. It does take time for people to become comfortable with gender issues and internalize them. ▪ Different organizations are at different stages of gender integration—some already have incorporated gender-related strategies into their programs, while others are exploring this topic area for the first time. The latter will require more effort and time.
Recommendations for Replication	▪ Dedicated personnel are necessary at the leadership and support staff levels. Partners need to set aside funding to acquire strong leadership and committed staff.
ADDITIONAL INFORMATION	
Program References and Resources	*Forthcoming:* A needs assessment packet will be published through the EngenderHealth and Instituto Promundo websites.
Contact Information	EngenderHealth 440 Ninth Avenue, New York, New York 10001 USA Tel: + 1 212 561 8000 Instituto Promundo Rua México, 31 / 1502, Centro, Rio de Janeiro – RJ, Cep. 20031-144, Brazil Tel/Fax: + 55 21 2544 3114 Websites: http://www.engenderhealth.org/, http://www.acquireproject.org/, http://www.promundo.org.br/ Manisha Mehta, Gender Team Leader, the ACQUIRE Project Email: MMehta@engenderhealth.org

COMMUNITY CARE IN NIGERIA

LEAD ORGANIZATIONS: Association of Women Living with HIV and AIDS in Nigeria (ASWHAN)

COUNTRY: Nigeria

HIV PROGRAM AREA: Care and Support

OVERVIEW:
Community Care in Nigeria improves community and household capacity to respond to the needs of women and children affected by HIV and AIDS. Specific services include psychosocial support for orphans and vulnerable children, educational services, strengthening household economies, health and medical support, and legal support around child custody and women's property and inheritance rights. Also, the project has established community Protection Committees that address male norms and behavior and coordinate with state agencies to provide legal protection for women and children. To improve household economic security, the project provides resources to support women entrepreneurs. Evaluation data show that the project has reached 2,550 women. In the course of implementation, ASWHAN has learned that economic empowerment increases women's decision-making power, and that involving the community in efforts to protect women's and children's rights helps ease community tensions.

BACKGROUND	
HIV & AIDS Program Goals	Community Care in Nigeria aims to strengthen community and household structures to respond to the needs of women affected by HIV and AIDS. The project also attempts to mitigate the impact of HIV on households' ability to care for orphans and vulnerable children.
Gender Strategies Addressed	✓ Reducing violence and coercion ✓ Addressing male norms and behaviors ✓ Increasing women's legal protection ✓ Increasing women's access to income and productive resources ☐ Other:
Description of Intervention	ASWHAN helps form and provides oversight to member support groups of women living with HIV, who work within their communities to design and implement protection and care activities for women and children affected by HIV. Each support group conducts baseline needs assessments, offers psychosocial support for orphans and vulnerable children, provides educational services, strengthens household economies, offers health and medical support, and assists with child protection and succession planning. Support groups remove barriers to services by, for example, securing waivers in tuition and health care expenses. The project addresses gender-based **violence** and harmful **male norms**, and seeks to increase women's **legal protection** by establishing protection committees in each community. Each committee is made up of key stakeholders including local government officials, community and women leaders, the police and the social welfare department to address issues of child abuse, inheritance matters, gender-based violence and other injustices, as well as to advocate for access to social services. In

	collaboration with relevant government agencies and community institutions, protection committees address specific incidents of violence, advocate for the enforcement of the rights of women and children, and work to change behavior around male dominance. The project seeks to increase women's **access to income and productive resources**. Each support group sets up savings and loan associations (SLAs), self-selecting groups of 15 to 30 female caregivers that mobilize and organize funds for group savings and support women-led business enterprises. SLAs meet weekly to collect money and undergo training in areas including food and nutrition, education, child/legal protection, health, and psychosocial support. Each SLA also has five counselors who work with protection committees to help caregivers address personal, financial, and business-related challenges. By increasing women's access to income and productive resources, the SLAs strengthen the economic stability of women and their families and give female caregivers a measure of financial independence. These efforts translate to increased decision-making, assertiveness, and knowledge of where and how to obtain legal support.
Target Audience	Adult women and caregivers
Level of Intervention	Community
Geographic Location	Federal Capital Territory, Edo, Anambra, Adamawa, Lagos, Benue, Kano, and Niger states
Timeframe	June 2007–ongoing
Funders	▪ Christian Aid ▪ The U.S. President's Emergency Plan for AIDS Relief (PEPFAR) through the United States Agency for International Development (USAID)
Partner Organizations	*Implementation partners:* ▪ Partners in Adamawa State: Spring of Hope ▪ Partners in Anambra State: Save the World Organization; Hope Givers Organization; Formative Alliance Against AIDS ▪ Partners in Benue State: Positive Media Support Group; Tabitha Support Group (Women Wing) ▪ Partner in Edo State: Owan East Support Group ▪ Partners in Federal Capital Territory: Unique AIDS Foundation ▪ Partners in Kano State: Council of Positive People Support Group; Wazobia Support Group; Voice of the Hopefuls ▪ Partners in Lagos State: People Against HIV/AIDS in the Barracks; Women and Children HIV/AIDS Positive Support Foundation ▪ Partner in Niger State: Niger Women Against AIDS

IMPLEMENTATION AND RESULTS	
Start-up and Implementation Process	ASWHAN generated proposals from potential support groups by advertising through multiple channels, including Internet forums, a network of various civil society groups, the Network of People Living with HIV and AIDS in Nigeria, and religious organizations. A committee made up of various stakeholders reviewed proposals, and once support groups were selected, ASWHAN provided them with an orientation on the Community Care in Nigeria strategy. Throughout implementation, ASWHAN provides grants, information, infrastructure, coordination, oversight, and technical assistance on good practices to the implementing support groups.
Local Involvement/ Ownership	Members of each implementing support group involve the community leadership in the implementation process. At the national level, the Ministry of Women Affairs coordinates activities addressing women and children's welfare. Local representatives of this ministry and other government agencies are briefed and are represented in the various protection/welfare committees. Participation in the SLAs is voluntary, and communities select the SLA facilitators. This level of community involvement should ensure that activities outlive the project life cycle.
Evaluation Methodology	▪ *Monitoring*: ASWHAN regularly collects data on service coverage. Indicators include number of women and children served by the project, number of caregivers trained to care for orphans and vulnerable children, number of protection committees established, and number of households benefiting from SLAs.
Evaluation Results	▪ *Monitoring:* Data indicate the project has reached 2,550 women, 3,675 orphans and vulnerable children, and 1,130 households. The project has established 49 SLAs, 37 Kids Clubs, 33 Youth Clubs, and 6 protection committees.
Replication and Scale-up Activities	▪ Community Care in Nigeria is operating in eight states, but has not yet been replicated or scaled up. However, there is demand from neighboring communities to expand the project.
LESSONS LEARNED AND CHALLENGES	
Key Findings and Lessons	▪ Addressing women's economic, legal, health care, and other needs benefits other constituencies in the community and makes the project more widely accepted and easier to implement. ▪ Women's economic empowerment increases their power to choose a school for their children, helps them keep their children in school, and helps them hold on to their residence. ▪ Establishing protection committees and facilitating community

	involvement in protecting the rights of women and children help ensure equity in the transfer of inheritance.
Challenges and Unforeseen Outcomes	▪ Communities are sometimes skeptical about the workability of the project. ▪ Participants are sometimes suspicious that their loans will not be repaid. ▪ Community members sometimes have reservations about the project based on religious sentiments.
Recommendations for Replication	▪ Introducing gender-based initiatives requires creative and careful assessment of the community and securing community leaders' approval. ▪ Implementers should have a good knowledge of relevant activities being carried out by other organizations and of how to incorporate gender into operations. ▪ The focus of a project may not be gender; however, gender issues can be built into the project by carefully studying the project and identifying linkages.
ADDITIONAL INFORMATION	
Program References and Resources	None provided
Contact Information	Association of Women Living With HIV and AIDS in Nigeria Suite 1, Wing D, First Floor, Bassan Plaza, Plot 759 Independence Avenue Central Business District, Abuja, Nigeria Tel: + 234 (0)803 723 0764 / + 234 (0)802 742 3159 Website: www.aswhan.com Ndueso Eno, Monitoring and Evaluation Officer Email: nduesoeno@gmail.com Anthonia Elanu, National Coordinator Email: el4gee@yahoo.com

COMPREHENSIVE SEXUALITY, FAMILY LIFE, AND HIV/AIDS EDUCATION

LEAD ORGANIZATIONS: Girls Power Initiative (GPI)

COUNTRY: Nigeria

HIV PROGRAM AREA: Prevention

OVERVIEW:
Comprehensive Sexuality, Family Life and HIV/AIDS Education (SLFHE) is a three-year program that trains adolescent girls in HIV prevention, sexual and reproductive health, sexuality, and life skills. GPI trains teachers to implement the curriculum at schools and local centers. The curriculum topics are personal empowerment, body image, and violence the first year; sexual and reproductive health and rights, gender-based violence, and HIV and AIDS the second year; and girls' and women's rights, political application of feminist theory, and women in society and culture the third year. Program graduates can then seek to qualify to work as peer educators. In addition to this three-year program, SLFHE offers girls life skills training. Evaluation results show that participants are better able to take on leadership roles and make informed decisions in their relationships, and that the program has helped reduce harmful traditional practices and increase knowledge of sexuality issues among youth. The program has benefited from its "training-of-trainers" model by building sufficient local capacity to implement the curriculum, thereby meeting demand and relieving the burden on GPI to conduct all trainings.

BACKGROUND	
HIV & AIDS Program Goals	The Comprehensive Sexuality, Family Life and HIV/AIDS Education (SLFHE) is a three-year program that trains adolescent girls in HIV and AIDS prevention, sexual and reproductive health, human sexuality, leadership, and life skills.
Gender Strategies Addressed	✓ Reducing violence and coercion ✓ Addressing male norms and behaviors ✓ Increasing women's legal protection ✓ Increasing women's access to income and productive resources ✓ Other: girls' empowerment and gender equity
Description of Intervention	The SLFHE program is a three-year program that educates in-school adolescent girls ages 10–19 about HIV and AIDS, human rights, gender equality and life skills. Sessions are conducted in schools, led by teachers trained by GPI, and in three-hour weekly educational sessions held at GPI's four centers, led by trained youth facilitators (GPI program staff and others). Eight current facilitators are former SLFHE graduates who now work for GPI after completing their university degree. Girls can enter the program at any point during their schooling years after age 10. Participants are divided into four age groups: ages 10–12, 13–14, 15–16, and 17–18. At registration, each girl completes a survey to assess her knowledge about gender roles in terms of what roles she and her male siblings play in their homes, and her knowledge, attitudes, and beliefs on topics such as personal empowerment, body image, self-esteem,

	assertiveness, puberty and gender-based **violence** (the topics covered by the first-year curriculum). Her progress is noted through periodic checks against this baseline assessment. The second-year curriculum addresses sexual and reproductive health and rights, gender-based violence, and HIV and AIDS. During this year, the program addresses gender-based **violence** and **male norms** as girls learn more about the norms, attitudes and beliefs that facilitate gender-based violence, how to negotiate safe sex, and male involvement in health-seeking. The third-year curriculum addresses girls' **legal protection** as well as **gender equity** by presenting legal information about girls' and women's human rights, political application of feminist theory, and women in society and culture. Girls' understanding of all aspects of the curriculum is tested periodically and compared to baseline. If a girl's understanding remains unchanged, she repeats that year's curriculum. After a girl has completed the three-year curriculum, she can become a peer educator and join the GPI Alumnae Association, which receives support from GPI. To do so, she must design a mini-intervention that applies the information obtained from the classroom in a real-world setting. This involves selecting a community, conducting a needs assessment, analyzing data, producing educational materials to address the health-related challenges of women and girls, and using these materials to hold educational talks, seminars, or dramas in the community. Through anecdotal evidence (i.e., reports from community members), she is assessed on how well she addressed the problem and from there can be named a peer educator. Peer educators carry out workshops and seminars in urban and rural schools to share what they learned in GPI with their peers. Graduates also participate on a weekly television program started by GPI to raise awareness around these issues. The SLFHE program helps **empower girls** not only through the sessions, but also by offering life skills training outside of the classroom to arm girls with the knowledge and abilities to make informed decisions about their bodies and lives. These trainings also foster collaboration among the girls, balancing the individual focus necessary to master the educational curriculum. GPI also increases girls' **access to income** by providing girls with economic skills trainings. Earning income can help girls resist being exploited by men who offer gifts or provide for basic needs.
Target Audience	Adolescent girls, ages 10–18, in school and out of school, residing in areas with high prevalence of gender-based violence, harmful traditional practices, female genital cutting practices, HIV, etc.
Level of Intervention	▪ National ▪ State ▪ Community ▪ Individual
Geographic Location	GPI Centers: Calabar Center in Cross River State; Uyo Center in Akwa Ibom State; Benin Center in Edo State; and Asaba Center in Delta State.
Timeframe	1994–ongoing

Funders	▪ African Women's Development Fund (AWDF) ▪ EMpower ▪ Ford Foundation ▪ International Women's Health Coalition (IWHC) ▪ MacArthur Foundation ▪ Oxfam Novib
Partner Organizations	*Implementation partners:* ▪ Action Health International (AHI) ▪ Butterfly Works ▪ Cross River State, Ministry of Education ▪ Dance4Life ▪ Education as a Vaccine Against AIDS ▪ Federal Ministry of Education HIV/AIDS Unit ▪ Federal Ministry of Health Adolescent Reproductive Health Unit ▪ MTN Foundation ▪ Nigerian Education Research and Development Council (NERDC) ▪ One World UK ▪ State Agency for the Control of AIDS (SACA) in Cross River State *Evaluation partners:* ▪ EMpower ▪ International Women's Health Coalition (IWHC) ▪ MacArthur Foundation
IMPLEMENTATION AND RESULTS	
Start-up and Implementation Process	SLFHE registration is held annually from the end of August to early September. Before registration, GPI holds publicity activities. In particular, current students, graduates, and parents (of students and graduates) appear on a weekly television program to promote the program and raise awareness of its activities. Also, gender-sensitive trainings are conducted for media personnel, who then can facilitate publicity for the SLFHE curriculum.
Local Involvement/ Ownership	The SLFHE curriculum is reviewed and updated to ensure that it is presenting the most up-to-date information each year. Program participation is free, and stakeholder participation is evident at all levels. For example, the government asked GPI to train other instructors in its curriculum, and the graduates participating in the program have continued their involvement by serving as peer educators. However, the program requires donor funding for continued implementation.
Evaluation Methodology	▪ *Registration monitoring (survey-based):* At registration, each girl completes a survey on her knowledge, attitudes, and beliefs around gender roles, personal empowerment, body image, self-esteem, assertiveness, puberty, and violence. This information is used as baseline data by which to assess her progress as a result of the course. The same information is collected six months later, and again at the end of the year. The program thus measures change over time on a range of indicators, including empowerment (e.g., girls' reported leadership and decision-making capacity), attitudes around harmful

	traditional practices, and knowledge about sexuality. ▪ *Qualitative data:* Testimonials are collected from enrollees, parents, teachers, and the media at the end of each year regarding perceived impact of the program on attitudes and behaviors.
Evaluation Results	▪ *Registration monitoring and qualitative data:* Findings from monitoring activities and qualitative data collection indicate the following: - Girls in the program are able to take up leadership roles in their various institutions of learning. - Girls in the program are able to make informed decisions on issues of interpersonal relationships, especially abusive and exploitative sexual relationships. - The number of harmful traditional practices in communities where GPI has carried out the program has decreased. - Both in- and out-of-school youth have increased knowledge about sexuality issues.
Replication and Scale-up Activities	▪ GPI began offering the SLFHE curriculum at two locations, Calabar and Benin-City. Over time, the organization scaled up the program to all four of its sites. ▪ GPI trained female representatives from a Cameroonian organization on the curriculum to replicate at their locale. ▪ As part of a Ford Foundation effort, GPI trained Mozambican officials on the in-school curriculum for replication purposes. ▪ As part of a pilot, participatory exercises based on the SLFHE curriculum were distributed on a CD-ROM targeting parents and teachers with the intention of encouraging uptake, expansion and scale-up of program activities. ▪ In 2000, Nigeria adopted the National Sexuality Education Curriculum, which mandated the provision of sexuality education, including that concerning HIV, in upper primary and secondary schools. GPI has made many contributions to the content of this curriculum and has coordinated trainings for instructors with the Nigerian government for the purpose of encouraging replication of program content and methods in government efforts.
LESSONS LEARNED AND CHALLENGES	
Key Findings and Lessons	▪ Training teachers in the SLFHE curriculum allows for many more girls to participate.
Challenges and Unforeseen Outcomes	▪ At times, funding is inconsistent. This presents challenges to expanding coverage for areas in need and recruiting and training new personnel. ▪ Political instability may affect program implementation.

Recommendations for Replication	▪ The implementing organization needs to be familiar with the particular needs of the target population, and must involve the target population in the planning process to give them a sense of belonging. ▪ It is important for the implementing organization to become acquainted with the content of government policies that address issues involving the target population.
ADDITIONAL INFORMATION	
Program References and Resources	International Women's Health Coalition (IWHC), "A New Generation of Empowered Women." http://www.iwhc.org/programs/africa/nigeria/gpiat10.cfm?language=1. Accessed October 21, 2008.
Contact Information	Girls Power Initiative, Nigeria 44 Ekpo Abasi Street, Calabar P.O. Box 3663, UNICAL Post Office, Calabar Cross River State, Nigeria Tel.: + 234 703 920 1983 / + 234 803 357 8595 Fax: + 234 872 395 65 / + 234 872 362 98 Website: http://www.gpinigeria.org/ Bene Madunagu, Chairperson, GPI Executive Board Email: gpi_hqcal@yahoo.co.uk, mumsybe@yahoo.co.uk

POLYCLINIC OF HOPE CARE AND TREATMENT PROJECT

LEAD ORGANIZATIONS: Rwanda Women Network (RWN)

COUNTRY: Rwanda

HIV PROGRAM AREA: Prevention, Treatment, Care and Support

OVERVIEW:
The Polyclinic of Hope Care and Treatment Project (PoH CTP) provides comprehensive HIV and AIDS prevention, care, support, and treatment to 2,500 HIV-positive women genocide survivors, other women victims of violence, and their families. To this end, the project seeks to provide quality HIV and AIDS care and treatment for women victims of violence and their families; initiate productive activities for families of women genocide survivors infected by HIV; and ensure that women genocide survivors and their families can access government services and participate in broader community programs. PoH CTP also addresses gender-based violence by providing services and training to women victims of violence, and by advocating for change in harmful male norms through trainings, theater, and other activities. The project helps women realize their rights through training workshops on women's rights and relevant laws and through community paralegal programs. Finally, the program provides training and start-up funds for income generation. To date the project has been replicated in three areas in Rwanda, and plans are underway to replicate it in other post-conflict countries. As the project has progressed, RWN has learned that it needs to adapt it to meet unanticipated needs, such as support and counseling for women and conflict resolution strategies.

BACKGROUND	
HIV & AIDS Program Goals	PoH CTP provides comprehensive care and support, including HIV and AIDS prevention, care, and treatment, for women who were victims of violence during the 1994 genocide or under other circumstances. PoH CTP offers family-based care, including antiretroviral therapy, to 2,500 HIV-positive women genocide survivors and their families.
Gender Strategies Addressed	☑ Reducing violence and coercion ☑ Addressing male norms and behaviors ☑ Increasing women's legal protection ☑ Increasing women's access to income and productive resources ☐ Other:
Description of Intervention	Three clinics across Rwanda are implementing the Care and Treatment project (CTP) to help women genocide survivors and other women violence victims. One of these is the Polyclinic of Hope Care and Treatment project, implemented by RWN, a national nongovernmental organization working in Rwanda since 1997 to improve the ability of women to meet basic socioeconomic needs. PoH CTP is a five-year program implemented through the Polyclinic of Hope, a center that provides comprehensive care and support for women victims of **violence**. The program works to: 1) enhance the capacity of Polyclinic of Hope to provide quality HIV and AIDS care and treatment for women raped and infected during the genocide, and for their families; 2) strengthen community-based care and initiate productive activities for families of women genocide survivors infected with HIV; and 3) ensure that

	women genocide survivors and their families are able to access government services and participate in broader community programs. RWN collaborates with government institutions, including the National Commission on HIV/AIDS and local HIV and AIDS authorities, on sensitization, training and advocacy. This project promotes a family approach, which means also providing treatment and support to other family members (sexual partners and children at risk). Rwandan policy encourages service providers to use a family-centered approach when responding to HIV. Some 2,500 women and their families form the primary target group. An estimated 10,000 dependents are expected to benefit indirectly from health care and family support services. The center provides: ▪ HIV voluntary counseling and testing ▪ Trauma and HIV and AIDS counseling and support ▪ Basic medical care and support ▪ Comprehensive ART services and follow-up ▪ Education and vocational training ▪ Income-generating activities support ▪ Sensitization, education and awareness on different issues ▪ Medical referral services ▪ Community/home-based care and support In addition to gender-based violence services and training, PoH CTP addresses harmful **male norms** by advocating for behavior change through trainings, theater, male testimonies, empowering women to be independent and showing that women can contribute to the well-being of the family. The project works to increase women's **legal protection** through training workshops on women's rights and on new laws that have gender implications, such as land and inheritance laws. Also, community paralegal programs provide legal assistance at the community level. Finally, the program increases women's **access to income and productive resources** by providing vocational training and education, as well as start-up funds for income-generating activities.
Target Audience	▪ Women survivors of sexual and gender-based violence, including their families and communities ▪ Widows ▪ Orphans and vulnerable children ▪ People living with HIV and AIDS
Level of Intervention	▪ Community ▪ District
Geographic Location	Kigali city, Huye District in Southern Province, Bugesera District in Eastern Province
Timeframe	2005–March 2010
Funders	▪ UK Department for International Development (DFID) ▪ United Nations Voluntary Fund for Victims of Torture

Partner Organizations	*Implementation partners:* ▪ Association des Veuves du Génocide (AVEGA – Agahozo) ▪ IBUKA – Mémoire et Justice ▪ Solace Ministries ▪ Survivors Fund *Evaluation partners:* ▪ Association des Veuves du Génocide (AVEGA – Agahozo) ▪ IBUKA – Mémoire et Justice ▪ Solace Ministries ▪ Survivors Fund ▪ UK Department for International Development (DFID)
IMPLEMENTATION AND RESULTS	
Start-up and Implementation Process	The Polyclinic of Hope, established in 1995, is a center for women victims of rape and other violent crimes suffered during the 1994 genocide as well as other vulnerable groups, including women living with HIV. The center reaches more than 655 women and their families. In total PoH reaches more than 2,508 people. RWN implemented the Care and Treatment project at the Polyclinic of Hope after extended advocacy efforts called upon various stakeholders to support women who became HIV-positive due to the mass rape committed during the 1994 genocide. For its intervention sites, CTP selected locations where high rates of mass rape occurred during the genocide.
Local Involvement/ Ownership	PoH CTP helps transform women from being victims of violence to being agents of change. Victims seeking services in turn become project volunteers to help other women. Overall, program activities are led and driven by women who participate in and benefit from program activities. For example: ▪ Women become volunteers to help other women go through the same project in their homes, neighborhoods and communities. ▪ The women talk freely about what happened in the genocide and call for it to never happen again. ▪ The women are willing to facilitate the judicial system by giving information and evidence about what happened. ▪ The women are willing to forgive when asked for forgiveness by perpetrators. District authorities are supportive of the program, referring clients to the center, donating land for women's housing and donating medical supplies.
Evaluation Methodology	▪ *Monitoring data*: Data are collected each time a client at the PoH receives a service. When a client first comes to the clinic, a file is opened detailing information about her background, what she encountered during the genocide, her needs, etc. The social worker regularly updates this file. A separate medical file is opened and updated every time the client seeks medical care at PoH. ▪ *Community monitoring*: Community user groups were set up to monitor quality of services provided at clinics.

	▪ *Annual reviews*: An annual review was conducted in 2007 for 2006 program activities and in March 2008 to examine 2007 program activities. Two external consultants conducted the 2008 review, which included: 1) reviewing key project and other relevant documents; 2) analyzing data from various available surveys; 3) interviewing senior management, staff and strategic partners; 4) visiting programs, interviewing implementing partner staff and other informants; and 5) holding discussions with the advisory committee and executive board members. Data reviewed included social and economic data and studies, clinic reports and records, national survey data and beneficiary surveys.
Evaluation Results	▪ *Project reach*: Monitoring data indicates that the project serves 655 HIV-positive women and their families. In total, PoH reaches more than 2,508 individuals. An estimated 10,000 dependents are expected to benefit indirectly from health care and family support services. Monitoring data also shows that women's health status has improved; families are better off due to the availability of a range of health and social services; and those receiving ART have increased CD4 counts. ▪ *Community monitoring*: Community monitoring through user groups show that, at first, there was a misunderstanding of the project by the community; in particular, community women thought that the project had come to provide monetary and nutritional supplements. Over time, community monitoring demonstrated that community approval of the PoH CTP had increased as the value of services provided was recognized. ▪ *Annual reviews*: The 2008 annual review of PoH CTP found the following results: - The project is counseling and testing a large proportion of women genocide survivors, who can now be offered prophylaxis and treatment for opportunistic infections arising from HIV, and ART as appropriate. - By the second year of the project, a total of 1,114 people were enrolled in the ART program. Of these, 573 were women and children, representing 73 percent of the target goal. - All clinics have a community-based program and 22 income-generating activities have been started. - Beneficiaries are using government services—for example, 541 beneficiaries are receiving ART from government services. These beneficiaries continue to receive psychosocial aspects of their care from PoH CTP. - There were 496 beneficiaries receiving educational support (materials and/or payment of tuition and fees) by the end of 2007.
Replication and Scale-up Activities	To date the program has been replicated in three areas in Rwanda (Bugesera, Huye, and Gasabo Districts). The RWN Village of Hope program replication in Kigali, Gasabo District, won the 2007 UN-Habitat Dubai International Award in "recognition of best practices to improve the living environment" for child-headed households and genocide widows and their families. RWN is engaged in efforts to take the Polyclinic of Hope to other countries, especially countries that have undergone recent war and conflict. An

	international workshop was convened to discuss and plan for the replication of the PoH CTP. Sudan, Ethiopia, Burundi, the Democratic Republic of Congo, and Eritrea participated in the workshop, which produced a plan of action for a network consisting of these five countries, documentation of the PoH process, and a plan to conduct exchange visits and provide subsequent support.
LESSONS LEARNED AND CHALLENGES	
Key Findings and Lessons	▪ In addressing the health needs of women, RWN quickly learned that psychosocial support and counseling were needed for the health of the women to improve, leading to the current integrated holistic approach used at the center. ▪ During implementation, RWN learned it is crucial to integrate conflict resolution strategies into all program activities in post-conflict situations. ▪ When the Polyclinic of Hope was established, it was reacting to an emergency situation and implications of the aftermath of genocide. Over time, the focus in Rwanda has changed to long-term development goals. This has required streamlining and professionalizing the center, a stronger emphasis on beneficiary active participation, and the widening of the target population.
Challenges and Unforeseen Outcomes	▪ Maintaining momentum has posed a challenge. Women are the drivers of the advocacy program; they provide testimonies and sensitization sessions in the community. When these women do not get the support they need or change does not occur, fatigue sets in. ▪ Getting long-term funding for holistic services at the center has been difficult. ▪ The program has struggled with the tendency of women to become dependent upon the center and its services.
Recommendations for Replication	▪ Rehabilitation of a human being is a long-term process. PoH CTP links pre-conflict, the conflict and post-conflict, and draws information from the women to identify their potential, their weaknesses and available opportunities that can be tapped to promote healing, development, peace and reconciliation. ▪ The Polyclinic of Hope does not have to be replicated wholesale: components can be adapted to strengthen existing programs. What is important to keep in mind is the four pillars on which the center stands strong: - Space for women to share and find solutions together. - Holistic services that address individual, household and community needs. - Long-term active engagement with clients. - Adaptability. The entry point to providing services does not necessarily have to be gender-based violence.

ADDITIONAL INFORMATION	
Program References and Resources	Belis, K. *2007 Annual Review PACFA – SURF: Care and Treatment Project (CTP).* Kigali: DFID Rwanda, 2007. Care and Treatment Project (CTP). *Baseline Results for Care and Treatment Project.* Kigali: CTP, n.d. Elliott, L. and Mbithi, P. *2008 Annual Review IMBUTO Foundation – SURF: Care and Treatment Project (CTP).* Kigali: DFID Rwanda, 2008.
Contact Information	Rwanda Women Network P.O. Box 3157, Kigali, Rwanda Tel: + 250 583 662 Website: www.rwandawomennetwork.org Mary Balikungeri, Director Email: rwanet@rwanda1.com, info@rwandawomennetwork.org

THE FATHERHOOD AND CHILD SECURITY PROJECT

LEAD ORGANIZATIONS: Sonke Gender Justice Network

COUNTRY: South Africa

HIV PROGRAM AREA: Prevention, Care and Support

OVERVIEW:
The Fatherhood and Child Security Project encourages and supports men to play a more active role in the lives of their families, to work to eliminate violence against women and children, to prevent the spread of HIV, and to promote support for orphans and vulnerable children. The project uses focus group discussions to elicit attitudes and assumptions about men's roles and works with local non-governmental organizations (NGOs) and government officials to devise grassroots strategies to help men and boys prevent violence and respond to HIV. Evaluation results indicate substantial shifts in gender- and *HIV/AIDS*-related knowledge and attitudes among those participating in the project workshops. Key lessons include the importance of involving men who are leaders and can influence community attitudes, and the need to work across levels (government, media, local leaders, etc.) to build strong relationships for project success.

BACKGROUND	
HIV and AIDS Program Goals	The Fatherhood and Child Security Project supports men and boys in playing a more active role in the lives of their families, especially orphans and vulnerable children affected by HIV and AIDS. The project also develops boys' and men's capacity to be advocates and activists in efforts to eliminate violence against women and children. The initiative is part of Sonke's One Man Can Campaign, which encourages men and boys to take action to end domestic and sexual violence, respond to HIV and AIDS, and promote healthy, equitable, and mutually respectful relationships.
Gender Strategies Addressed	☑ Reducing violence and coercion ☑ Addressing male norms and behaviors ☐ Increasing women's legal protection ☐ Increasing women's access to income and productive resources ☐ Other:
Description of Intervention	The Fatherhood and Child Security Project has two primary objectives. First, it aims to increase men's involvement in the lives of their own children and families, and their commitment to ensuring that children (particularly orphans and vulnerable children) have access to essential social services. Second, it develops men's capacity to be advocates and activists to eliminate **violence** against women and children, prevent the spread of HIV and AIDS, and promote health, care and support for orphans and vulnerable children. Both objectives seek to transform harmful or nonsupportive **male norms and behaviors** into positive practices that improve their own and their families' lives. Through this work in rural parts of KwaZulu-Natal and the Eastern Cape, Sonke Gender Justice Network (Sonke) has developed a model for working with men to increase their involvement in meeting the needs of children affected by HIV and AIDS. These needs include access to social services,

	attending school, psychosocial and educational needs, benefiting from school feeding schemes, living without fear of violence, and receiving care and support from men. The model consists of five overlapping, complementary components: 1. Formative research into the lives of men and children, including children's participatory needs assessments, men's community surveys, children's photojournals; and further research into issues that arise through project implementation. 2. Capacity building for and ongoing technical support to local NGOs to ensure strengthened capacity and demonstrated commitment of men to end violence against women and children, reduce the spread and impact of HIV/AIDS, and promote care and support for orphans and vulnerable children (OVC). 3. Engagement, training, and technical assistance to local stakeholders, in particular, local government officials, religious and traditional leaders, and local institutions responsible for meeting the needs of children (e.g., schools and Child Care Forums), and embedding the project in local processes and structures, to ensure sustainability. 4. Innovative use of arts and new media, such as photography and video to engage and empower children and youth and raise awareness among men and other community members about the realities of children's lives. 5. Continuous monitoring and evaluation of project progress, including case studies, end of project consultative seminars at local, provincial and national levels, and compilation of a step-by-step manual to facilitate replication of the project model by other partners in other locations. The project works with men in a range of capacities—as fathers, family members, neighbors, traditional leaders, teachers, municipal government officials, NGO staff and volunteers, and others. These men are targeted with messages about children and HIV using a range of methodologies. These include building men's capacity to be advocates and activists to eliminate violence against women, to prevent the spread of HIV, and to promote health, care and support for orphans and vulnerable children. It also includes using innovative information, education and communication (IEC) materials developed by children, such as the Photovoice Project, in which photos that children take are used to create awareness of and dialogue around issues of concern to them, including whether men are involved in caring and supporting them. Other IEC materials include digital stories, where children create short videos about personal life experiences that are used to stimulate discussion in communities. Both the Photovoice project and the digital stories involve leaders and parents in discussing and making commitments to changing practices and policies that affect children. The Sonke model is unique because it supports men to play a more active role in the lives of their families, and also helps vulnerable children bring the realities of their daily lives to the attention of the leaders in their communities. Sonke also provides training and support to build the capacity of community organizations and local government to ensure that Sonke's work continues in the long term.
Target Audience	▪ Men and boys ▪ Adolescents ▪ Youth ▪ Adults

	▪ Community leaders including traditional religious and municipal leaders, teachers, etc.
Level of Intervention	▪ Individual ▪ Family ▪ Community ▪ Municipality
Geographic Location	▪ Eastern Cape Province – OR Tambo municipality ▪ KwaZulu-Natal Province – Nkandla municipality
Timeframe	November 2006–November 2008
Funders	United Nations Children's Fund (UNICEF)
Partner Organizations	*Implementation partners:* ▪ Sizanani Village Trust ▪ Nkandla HIV/AIDS Network ▪ Umtata Child Abuse Resource Centre ▪ Siyakhanyis
IMPLEMENTATION AND RESULTS	
Start-up and Implementation Process	The project conducted a participatory needs assessment with focus group discussions with male, female, and youth stakeholders, between the ages of 14 and 65, in Mthatha in 2006. These discussions focused on attitudes, feelings, beliefs, and experiences about men's roles regarding gender roles and relations, HIV and AIDS, and child protection. They particularly focused on identifying strategies that men could use to prevent violence and respond to HIV and AIDS, and the ways in which these issues affect children. One part of the discussion identified the barriers that prevent men from participating more in fatherhood, care and support, or advocating against violence against women and gender inequality. A common theme among these discussions was that men must speak out and act against violence in their community. Findings were used to shape the design of the project. In the initial phase of project implementation, local baseline research was conducted around violence against women and children, health promotion, HIV treatment and prevention, and care and protection of orphans and vulnerable children. Sonke also trained partner organizations in using the One Man Can methodology, which emphasizes community action for social change through the formation of community action teams (CATs) in both Nkandla (KwaZulu Natal Province) and in OR Thambo district (Eastern Cape Province). In addition, in the first nine months, project activities focused on 1) developing new materials suited to encouraging men in rural areas to take action, and 2) establishing support for and collaboration on the project among a number of different stakeholders from government and civil

	society. This has been achieved through the formation of project advisory panels and partnership agreements with local community-based organizations.
Local Involvement/ Ownership	Sonke has established relationships with local implementing partners and integrates activities in local community structures and processes so the project can continue without Sonke involvement. The project has also provided input into, and thus been embedded into, local Integrated Development Plan (IDP) processes. The project engages, trains and provides technical assistance to local stakeholders, in particular government officials, religious and traditional leaders, and local institutions to ensure project sustainability. Community participation in the program occurs through a project advisory panel and the involvement of youth in the development of IEC materials.
Evaluation Methodology	▪ *Pre-/post-knowledge and opinion surveys*: Pre-/post-surveys were conducted with participants on a range of indicators that determine whether men are in fact playing a more active role in meeting the care-related needs of orphans and vulnerable children. The surveys assessed the amount of time men spend actively parenting their children; whether they assist their children with homework; use of physical punishment of children; understanding of alternatives to corporal punishment; use of violence against children and their mothers; understanding of their children's nutritional needs; what they do to ensure that children's nutritional needs are met; and involvement in local childcare centers. Improvements on these indicators should lead to an increased number of orphans and vulnerable children accessing social grants, attending school and demonstrating improved nutrition. ▪ *Case studies*: Program staff plan to conduct and write up in-depth interviews/case studies with five men, five women, and five children per site at the beginning and end of the project to explore their perceptions of the intervention and understand its impact on their lives.
Evaluation Results	▪ *Project reach*: A total of 989 people participated in training sessions in Nkandla (Kwazulu-Natal Province) and 1,079 in OR Tambo District (Eastern Cape Province). ▪ *Pre-/post-knowledge and opinion surveys*: Evaluation results indicate substantial shifts in gender- and HIV/AIDS-related knowledge and attitudes among those participating in project training sessions. For example, before the session with the Chwezi Traditional Court, 100 percent of respondents believed that they had the right, as men, to decide when to have sex with their partners. After the training, 75 percent believed that they did *not* have the right to decide when to have sex with their partners. The proportion of respondents who believed that they could get HIV from a deep kiss fell from 67 percent to 0 percent. Before the training session conducted with the Ekukhanyeni Tribal Authority, 63 percent of respondents believed that, under some circumstances, it is acceptable for men to beat their partners. Post-session, 83 percent of respondents disagreed with this statement. Before the training, 96 percent of respondents believed that they should not interfere in other people's relationships, even if there is violence.

	After the session, 100 percent believed that they should interfere. Pre-/post-test results for participants in a training-of-trainers session for partner organizations in the Eastern Cape and Kwazulu-Natal Provinces show that before the training, 88 percent of trainers from partner organizations believed that men should have the final say in their relationships. After the session, 100 percent believed that men do not have the final say in their relationships. Ninety-four percent of respondents believed that it was not their business to interfere in other people's relationships, even if there is violence. At the end of the session, 100 percent felt it was their business to interfere. ▪ *Case studies*: These are currently in development.
Replication and Scale-up Activities	▪ There are plans to replicate this project once the model has been fully developed, implemented and tested, though this will in part depend upon funding.
LESSONS LEARNED AND CHALLENGES	
Key Findings and Lessons	▪ There has been significant support from key members of the municipality in Nklanda, and the mayor in particular has helped enormously in marketing the project. Support was also gained from traditional and religious leaders. Strong relationships were built with local media in OR Tambo, including the local community radio and newspaper. ▪ In Nkandla, the municipality has explicitly acknowledged the importance of male involvement in addressing issues of HIV and AIDS and violence against women and children, and expressed a commitment to establish projects that support men's role in these issues. Municipality staff report that the project enabled them for the first time to understand the importance of male involvement to community and child development. ▪ Gender transformative and ecological approaches are important aspects of an HIV gender program. In other words, Sonke's work focuses not just on reaching men but on changing men's perceptions of gender roles to promote greater gender equality and social justice. Sonke's work is based on an understanding that individuals are shaped by a range of forces—culture, tradition, religion, family, the media, the workplace, government laws, and policies—and that to effect and sustain change, interventions have to address many of these forces simultaneously.
Challenges and Unforeseen Outcomes	▪ Sonke, established in August 2006, is a relatively new organization. As a recent start-up, Sonke had to work hard to set up financial and administrative processes and procedures while also implementing project work. This challenge was compounded by the fact that few donors are willing to provide core support to new programs—a phenomenon that makes it extremely difficult for new NGOs to survive.

Recommendations for Replication	▪ It is important to involve men who are leaders (religious leaders, community leaders, etc.) in thinking about issues of gender-based violence from the onset of the project. While it may be easier to reach men on the street corner, it is more important to work with men who can influence community attitudes. ▪ Success is more likely when interventions draw on a range of social change strategies that simultaneously address the many institutions shaping individual and community attitudes and practices. In this sense, Sonke sees workshops as just a starting point to educate and motivate men and women to take action in their communities to address gender and HIV-related challenges. Sonke encourages workshop participants to join CATs that then identify potential solutions to community problems and work together to achieve change. CAT members might, for instance, join school governing bodies to ensure that schools are more proactive in addressing gender and HIV. They might join a community policing forum to strengthen the criminal justice system response to domestic and sexual violence; they might set targets for the number of men who should be involved in home-based care; or they might conduct community education and outreach on issues related to safe sex or domestic and sexual violence. In other words, the organization stresses the importance of taking action beyond just holding workshops.
ADDITIONAL INFORMATION	
Program References and Resources	Palitza, K. "Sometimes I Don't Feel Safe: The Sonke PhotoVoice Project Allows Children to Talk About Their Wants and Needs." *Mail & Guardian* (Oct. 24, 2008), 38. Sonke Gender Justice Network. "Digital Stories." n.d. http://www.genderjustice.org.za/resources/digital-stories/5.html. Accessed October 21, 2008. Sonke Gender Justice Network. "Fatherhood and Child Security Project." n.d. http://www.genderjustice.org.za/projects/child-security-project.html. Accessed October 21, 2008. Sonke Gender Justice Network. "One Man Can Campaign." n.d. http://www.genderjustice.org.za/projects/one-man-can-campaign.html Accessed October 21, 2008. Sonke Gender Justice Network. "PhotoVoice Project." n.d. http://www.genderjustice.org.za/projects/digital-stories.html. Aaccessed October 21, 2008. Sonke Gender Justice Project. *Engaging Men to Reduce Children's Vulnerabilities to HIV and AIDS and Gender based Violence in Nkandla, KwaZulu-Natal and OR Tambo, Eastern Cape: quarterly report to UNICEF, November 2006–January 2007*. 2007. http://www.genderjustice.org.za/resources/reports/17.html, Sonke Gender Justice Project. *Engaging Men to Reduce Children's Vulnerabilities to HIV/AIDS and Gender Based Violence in Nkandla,*

	KwaZulu-Natal and OR Tambo, Eastern Cape: 2nd Quarterly Report, February–April 2007. http://www.genderjustice.org.za /resources/reports/17.html. Sonke Gender Justice Project. *Engaging Men to Reduce Children's Vulnerabilities to HIV/AIDS and Gender Based Violence in Nkandla, KwaZulu-Natal and OR Tambo, Eastern Cape: Final Report to UNICEF, November 2006–August 2007*. 2007. http://www.genderjustice.org.za/resources/reports/17.html.
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IMAGE (INTERVENTION WITH MICROFINANCE FOR AIDS AND GENDER EQUITY)

LEAD ORGANIZATIONS: Rural AIDS and Development Action Research Program (RADAR)
School of Public Health, University of the Witswatersrand
The Small Enterprise Foundation (SEF)

COUNTRY: South Africa

HIV PROGRAM AREA: Prevention

OVERVIEW:
IMAGE is a community-based intervention in South Africa that combines a microfinance program with a gender and HIV curriculum. IMAGE aims to reduce HIV vulnerability and gender-based violence among women and promote women's empowerment, improve family well-being, and raise awareness about HIV. After two years, evaluation results show a significant decrease in intimate partner violence for participating women and a significant decrease in risky sexual behavior among younger participants. The project shows the value of an integrated approach, where addressing poverty (through microfinance), gender issues, and HIV yield broader health and social benefits than addressing any of these issues in isolation. Other key factors in project success were the establishment of multisectoral partnerships; outreach to the community (including men and youth) beyond program participants; and strong partners and sustained mentorship.

BACKGROUND	
HIV & AIDS Program Goals	IMAGE (Intervention with Microfinance for AIDS and Gender Equity) aims to empower women, improve household economic well-being, increase women's social capital, reduce intimate partner violence and HIV vulnerability among women, and raise awareness of these issues among the broader community.
Gender Strategies Addressed	✓ Reducing violence and coercion ✓ Addressing male norms and behaviors ☐ Increasing women's legal protection ✓ Increasing women's access to income and productive resources ☐ Other:
Description of Intervention	IMAGE is a community-based structural intervention that combines a microfinance program with a participatory gender and HIV curriculum. *Microfinance component*: In increasing women's **access to income,** and based on the Grameen Bank model, groups of five economically vulnerable women ages 18 and older guarantee each other's loans. All five must repay their loans before the group qualifies for more credit. Loan centers of approximately 40 women meet every two weeks to repay loans, apply for additional credit and discuss business plans. SEF, a South African non-governmental organization (NGO), implements this component of the program.

	Gender and HIV component (Sisters-for-Life curriculum): A two-phase participatory learning program called Sisters-for-Life (SFL) was developed and integrated into the microfinance component of the intervention during a 12-month period. In the first phase, trained staff provided 10 one-hour trainings to participants in the microfinance program on gender roles, cultural beliefs, relationships, communication, gender-based **violence** and HIV infection. The sessions also aimed to strengthen communication skills, critical thinking and leadership. The second phase focused on community mobilization, including reaching youth and men to address community and **male norms** around gender and HIV. Members of the microfinance group elected "natural leaders" to participate in a further week of training to lead their loan centers as community mobilizers. These leaders subsequently organized more than 60 community events, including meetings with village chiefs, police, schools, clinics, and soccer clubs, as well as marches to raise awareness about gender-based **violence** and HIV. Leaders also established two new village committees to address rape and alcohol use among youth.
Target Audience	Women who reside in low-income households within villages selected for the program
Level of Intervention	▪ Province ▪ Community
Geographic Location	Sekhukhuneland, Limpopo Province
Timeframe	▪ September 2001–March 2005 (IMAGE pilot program and evaluation) ▪ 2005–ongoing (IMAGE program continuing to scale up in Limpopo Province)
Funders	▪ Anglo American Chairman's Fund ▪ Anglo Platinum ▪ Ford Foundation ▪ UK Department for International Development (DFID) ▪ The Henry J. Kaiser Family Foundation ▪ International Humanist Institute for Cooperation with Developing Countries (HIVOS) ▪ South African Department of Health ▪ Swedish International Development Cooperation Agency (SIDA)
Partner Organizations	*Implementation partners:* ▪ Rural AIDS and Development Action Research Program (RADAR), School of Public Health, University of the Witwatersrand ▪ Small Enterprise Foundation (SEF) *Evaluation partner:* ▪ London School of Hygiene and Tropical Medicine (LSHTM)

IMPLEMENTATION AND RESULTS	
Start-up and Implementation Process	RADAR and SEF staff first held joint knowledge-sharing and planning workshops. They then conducted formative research to gauge how to integrate a gender and HIV approach into an existing microfinance program. RADAR, drawing on experience designing and implementing training curricula on gender, gender-based violence, and HIV/AIDS, created the SFL curriculum in consultation with ADAPT, a South African gender-based violence NGO. Facilitators—RADAR staff—were first trained in the curriculum as participants. RADAR then pilot tested the curriculum with a group of people living with HIV, a women's agricultural group, a women's church project and a local youth group.
Local Involvement/ Ownership	The communities contribute facilities (such as community buildings, the chief's house, local shops, etc.) for the fortnightly microfinance and HIV training meetings. The Small Enterprise Foundation's microfinance component recovers all operational costs and is therefore financially sustainable (Pronyk et al., 2005). However, the gender and HIV component requires inputs from an organization with expertise in gender and HIV. An economic evaluation estimated the additional cost of the gender and HIV component at $43/client in the pilot phase and $13/client in the initial scale-up phase (Jan et al., 2008).
Evaluation Methodology	▪ *Cluster randomized trial*: Eight villages were pair-matched and one village in each pair was randomly selected to receive the intervention. Within each intervention or control village, three cohorts of participants were recruited: 1) direct participants—women participating in the IMAGE program (or matched controls); 2) household youth—young men and women (age 14–35) residing in the households of loan recipients (or those of controls); and 3) community youth—young men and women (age 14–35) residing in randomly selected households within the intervention or control site. Participants in the first two groups were followed for a two-year period, while those in the third group were followed for three years. The cohort of direct participants included 430 loan recipients and an equal number of age- and income-level matched controls ranging in age from 18 to 96 years (mean age was 42 years). Outcome measures among this group included past-year experience of physical or sexual intimate partner violence, household economic well-being, and nine indicators on gender equity/empowerment (including self-confidence, financial confidence, challenging gender norms, autonomy in decision making, perceived contribution to the household, communication within the household, relationship with partner, social group membership and participation in collective action). In addition, sexual risk behavior was compared among young (<35 years) direct program participants and controls. Because the program also sought to explore whether impacts might diffuse beyond direct participants to reach youth in IMAGE households and communities, the evaluation assessed changes in sexual behavior and HIV risk among cohorts 2 and 3. ▪ *Qualitative data:* Data were collected through focus group discussions, nonparticipant observation and key informant interviews among intervention participants to deepen understanding of observed changes and to assess potential pathways for intervention effects.

Evaluation Results	▪ *Cluster randomized trial*: "There was evidence for an intervention effect on household economic well-being, social capital, and empowerment. Furthermore, we estimated that, over a two-year period, levels of intimate partner violence were reduced by 55 percent in women in the intervention group relative to those in the comparison group" (Pronyk et al., 2006, p. 1981). There also were promising effects on HIV risk behavior among young IMAGE participants. "After 2 years of follow-up, when compared with controls, young participants had higher levels of HIV-related communication (adjusted risk ratio 1.46, 95 percent confidence interval 1.01–2.12), were more likely to have accessed voluntary counseling and testing (adjusted risk ratio 1.64, 95 percent confidence interval 1.06–2.56), and less likely to have had unprotected sex at last intercourse with a nonspousal partner (adjusted risk ratio 0.76, 95 percent confidence interval 0.60–0.96)." (Pronyk et al., 2008, p. 1659). However, there was little effect on sexual behavior and HIV infection rates among young people who were not directly exposed to the intervention (Pronyk et al., 2006). ▪ *Qualitative data:* "Qualitative data suggest that these reductions in violence resulted from a range of responses that enabled women to challenge the acceptability of such violence, expect and receive better treatment from partners, leave violent relationships, give material and moral support to those experiencing abuse, mobilize new and existing community groups, and raise public awareness about the need to address both gender-based violence and HIV infection," (Kim et al., 2007, p. 1798). Among young program participants, "qualitative data suggest a greater acceptance of intrahousehold communication about HIV and sexuality. Although women noted challenges associated with acceptance of condoms by men, increased confidence and skills associated with participation in the intervention supported their introduction in sexual relationships" (Pronyk et al., 2008, p. 1659).
Replication and Scale-up Activities	The project has been scaled up to reach 6,000 additional participants, and plans to reach 15,000 by 2011.
LESSONS LEARNED AND CHALLENGES	
Key Findings and Lessons	▪ Addressing gender issues alongside HIV can provide important synergies: raising issues such as gender-based violence adds relevant context to HIV prevention messages, while the risk of HIV adds immediacy and legitimacy to tackling gender inequalities. ▪ It is important to address basic material needs through income-generation activities alongside raising awareness about gender and HIV. Microfinance can provide a strong foundation for maintaining sustained contact with a gender and HIV intervention. Combining the two allows vulnerable populations to maintain intensive contact with a peer-based health intervention over months to years. ▪ HIV interventions can (and should) target the broader risk environment by forging multisectoral partnerships. Microfinance, by addressing poverty, is one vehicle; other opportunities for integrating gender and HIV interventions into related programs (e.g., job skills retraining,

	literacy, water and sanitation programs) should be explored. ▪ It is important to mobilize community members not directly targeted by the intervention. For example, IMAGE targeted men and youth through community mobilization even though they were not the primary targets of the intervention. ▪ Women can work with influential community leaders to reach men indirectly.
Challenges and Unforeseen Outcomes	▪ Training staff often experienced the same challenges as the participants (poverty, domestic violence, HIV risk); participating in the training process brought training staff's own personal issues to the forefront. Consistent support and mentorship to work through these issues and understand how to bring them into the training process is necessary. ▪ The SFL gender and HIV training was not well-received if the microfinance component was undergoing difficulties. It was necessary to work closely with staff from the microfinance component to align implementation/operational mechanisms and to present the intervention as a unified package.
Recommendations for Replication	▪ Implement the project in a location that is supportive of microfinance activities. ▪ Choose partner organizations that have the capacity to implement the microfinance and gender and HIV training components with high quality.
ADDITIONAL INFORMATION	
Program References and Resources	Epstein, H., and J.C. Kim. "AIDS and the Power of Women." *The New York Review of Books* 54, no. 2 (Feb. 15, 2007), 39–41. Jan, S., G. Ferrari, G., C.H. Watts, J.R. Hargreaves, J.C. Kim, L.A. Morison, L.A., et al. "Economic Evaluation a Combined Microfinance and Gender Training Intervention for the Prevention of Intimate Partner Violence in Rural South Africa." *The Lancet* (in submission, 2009). Kim, J.C., C.H. Watts, J.H. Hargreaves, et al. "Understanding the Impact of a Microfinance-based Intervention on Women's Empowerment and the Reduction of Intimate Partner Violence in South Africa." *American Journal of Public Health* 97, no. 10 (2007): 1794–1802. Kim, J. "Putting Money Into Women's Hands." *Sixteen Days of Activism [Mail and Guardian]* 22, no. 47 (2006). Pronyk, P.M., J.C. Kim, J.R. Hargreaves, et al. "Microfinance and HIV prevention – emerging lessons from rural South Africa." *Small Enterprise Development* 16, no. 3 (2005): 26–38. Pronyk, P.M., J.R. Hargreaves, J.C. Kim, et al. "Effect of a Structural Intervention for the Prevention of Intimate-Partner Violence and HIV in

	Rural South Africa: A Cluster Randomised Trial." *Lancet* 368 (2006):1973–1983. Pronyk, P.M., J.C. Kim, T. Abramsky, et al. "A Combined Microfinance and Training Intervention Can Reduce HIV Risk Behaviour in Young Female Participants." *AIDS* 22 (2008): 1–7. Urdang, Stephanie. *Change, Choice and Power: Young Women, Livelihoods and HIV Prevention*. International Planned Parenthood Federation (IPPF), United Nations Population Fund (UNFPA), Young Positives. 2007. http://www.unfpa.org/publications/detail.cfm?ID=319&filterListType=1. Accessed November 6, 2008.
Contact Information	IMAGE Program Small Enterprise Foundation, 42 Boundary Street, Tzaneen, Limpopo Province, 0850, South Africa Tel: + 27 15 307 5837 Website: http://web.wits.ac.za/Academic/Health/PublicHealth/Radar/ Dr. Julia Kim Clinical Research Fellow, Department of Public Health and Policy, London School of Hygiene and Tropical Medicine Senior Researcher, School of Public Health, University of the Witwatersrand Email: jkim@agincourt.co.za

LAPHUM' ILANGA (SUNRISE)

LEAD ORGANIZATIONS: Mothertongue

COUNTRY: South Africa

HIV PROGRAM AREA: Prevention, Care and Support

OVERVIEW:
Laphum' Ilanga ("sunrise" in Xhosa) uses participatory arts, primarily community-based theater, to explore the links among violence against women, gender norms and HIV. The program aims to raise awareness and build capacity among women to explain their own HIV and AIDS and violence experiences. Women create and perform dramas, engaging the audience in an analysis of the gendered dynamics of HIV and the hard realities the women have experienced, such as rape, partner abuse, poverty, unemployment, living with HIV and disclosing their HIV status. In addition to drama, the program uses creative writing, visual arts, photography and movement to help participants share their perceptions about the causes of violence against women in their community. Evaluation results show that the positive community response has bolstered women's confidence in their abilities to serve as change agents and that women are leaving abusive relationships. A key lesson is the need to involve other organizations doing similar work (on HIV and/or violence) to coordinate messaging to reinforce positive changes begun through the Laphum' Ilanga project.

BACKGROUND	
HIV & AIDS Program Goals	Laphum' Ilanga explores the intersections between violence against women and the spread of HIV. It aims to raise awareness and build capacity among women to articulate HIV and AIDS and violence issues, and to help them come to terms with their HIV-positive status.
Gender Strategies Addressed	✓ Reducing violence and coercion ✓ Addressing male norms and behaviors ✓ Increasing women's legal protection ✓ Increasing women's access to income and productive resources ☐ Other:
Description of Intervention	Laphum' Ilanga, a one-year project implemented in 2006, served low-income women living in Khayelitsha, a former township area on the outskirts of Cape Town. The program started from the premise that gender, power, and HIV and AIDS transmission are linked. The project employed participatory arts methodologies, primarily community-based theater, to explore these linkages. Using drama, women performers and the audience analyzed the gendered dynamics of HIV and AIDS and the lived realities of the women participants. This included poverty, unemployment, living with HIV and disclosing their HIV status. The performances also addressed gender-based **violence**, particularly rape and physical abuse, as well as traditional **male norms and behaviors** that were harmful to men, women and the larger community. The program used various forums and methods for mobilizing audiences through performance. For example, one technique involved women performing a show in a public space such as a shopping mall, clinic or taxi rank. They began with songs that were thematically linked to the show,

	accompanied by *djembe* drumming. Once the music drew in a large enough audience (usually 50 people or more), the lead facilitator signaled for the performers to begin. Other performances took place at schools or during community events and the audience came specifically to see the performance. The program also used the Forum Theater method, in which facilitated discussions take place during and throughout the performance. The women performed a play in which a character is oppressed in a situation that would be familiar to the audience. After playing it once, the actors began the play again and, at any point during this second performance, any audience member could call out "stop!" and take the place of the actor playing the oppressed character. The audience member then attempted to change the situation, while the performers playing the oppressors improvised to attempt to bring the production to its original ending. If this audience member failed to change the situation, the performer resumed her role and continued until another audience member called out "stop!" and tried a different intervention. The audience members could also replace the oppressors, and find new ways of challenging the oppressed character. In this way, Forum Theater encouraged dialogue rather than a didactic depiction of a situation, enabling the participants to construct dramas and plays based on their own experiences. The program also used a variety of arts-based exercises, including creative writing, photography, visual arts and movement, to help participants discuss the causes of **violence** against women in their community. The discussion around power relations in the home, for example, led to the investigation of women's sexual agency. Most women had accepted that it is the man's role to initiate sex, out of concern that men will be mistrustful or feel insecure if a woman initiates or suggests new methods in the bedroom. Participants saw the cultural process of assigning gender norms and roles to women and men as the main factor that exacerbates men's notions of superiority. For example, during the amaXhosa *ulwaluko* initiation process for young men, boys are taught that men are heads of families and stronger than women. During the *Ntonjane* process for young women, girls are taught that a married woman must submit to the will of the man of the house. A married woman's *umakoti* (duty) is to safeguard the problems of her home; she must place the family's needs before her own and must not question her husband's authority. The project raised awareness through outreach performances conducted within schools, religious institutions and advocacy events. The goal was to develop and document community-oriented strategies that could be implemented programmatically in partnership with local organizations. Project activities peaked during the annual 16 days of activism against gender-based violence, which is supported by community media and challenges South Africans to declare an end to violence against women and children. The project's women performers were invited to perform at events organized by various organizations and schools involved in the 2006 16 Days of Activism campaigns. One of the functions of the performances was to address women's **legal protection** by raising awareness around legal resources and recourses that are available to women. At the end of each performance, the lead facilitator provided the names of various organizations the women could consult to learn about and access legal protection. The theater performances also helped participants increase their **access to income**, as

	they were paid a stipend. The communication skills women acquired in the theater training could also be used outside the theater context, such as in job interviews and in communications-related work tasks, and thus equipped women with transferrable vocational skills.
Target Audience	▪ Low-income women living in Khayelitsha community ▪ The Khayelitsha community
Level of Intervention	▪ Community ▪ District
Geographic Location	The township of Khayelitsha
Timeframe	January 2006–December 2006
Funders	United Nations Trust Fund in Support of Actions to End Violence Against Women
Partner Organizations	*Implementation partners:* ▪ Treatment Action Campaign (TAC), Khayelitsha District ▪ Wola Nani (Khayelitsha) ▪ Simelela Rape Survivors Centre
IMPLEMENTATION AND RESULTS	
Start-up and Implementation Process	The Laphum' Ilanga project grew out of discussions with a range of community-based organizations and the Rape Crisis Center about the need to raise awareness of the link between gender-based violence and HIV transmission. Laphum' Ilanga drew specifically on Forum Theater, an interactive participatory theater form developed in Latin America in the 1960s by Augusto Boal. Support groups, volunteers, and counselors within three organizations, Simelela Rape Clinic, Treatment Action Campaign (TAC) and Wola Nani, identified a group of 28 women to participate in a two-week training workshop. The women were introduced to Forum Theater and the process of creating plays that would lead to audience participation, and recounted and explored their own experiences with violence, power relations, and HIV and AIDS, among other things. The women then performed eight different plays at twelve outreach performances between June and August 2006. They performed to diverse audiences in Khayelitsha at a variety of venues: church events, taxi and bus terminals, shopping malls, and advocacy events organized by local partners and local community centers. The women also participated in outreach activities around the 16 Days campaign, including appearances on community radio.
Local Involvement/ Ownership	Community involvement was high at the grassroots level; however, indications of ownership by partner organizations did not emerge. Project

	staff intended for partner organizations to continue activities at the end of the project, but they showed little initiative to take on board the skills their employees or volunteers had gained. A longer program (three years) may have better ensured partner ownership by enabling program staff time to work more closely with decision-makers at partner organizations.
Evaluation Methodology	▪ *Process evaluation*: Mothertongue collected qualitative data on the project through focus groups, semi-structured interviews, and monitoring workshops that were conducted with women participants and community members during project implementation. A process of appreciative inquiry (an organizational development process or philosophy that engages individuals in changing an organizational system [see Cooperrider and Whitney, 2005]) was also integral to the evaluation process. Documentation includes evaluation reports, project reports, activity reports documenting outreach work, and video documentation. ▪ *Impact assessment report:* A former program manager of Mothertongue conducted an impact assessment. In feedback sessions held with participants after each performance, the women discussed and compiled reports that reflected the responses to the debates in the performance on gender, culture, gender-based violence and experiences with HIV transmission. Also, 45-minute semi-structured interviews were conducted with five participants.
Evaluation Results	▪ *Program reach*: 28 participants were involved in the project, which reached approximately 5,000 community members as audience members. ▪ *Process evaluation*: Results from analysis of qualitative data collected indicate the following: - The responsibility to create plays independently within group situations prepared participants to direct and design their own plays for future outreach performances. - Some participants repeatedly said that the work has had effects on their own lives. - The women performers felt confident in their abilities as change agents as a result of receiving a positive response from the community. - Partner organizations expressed enthusiasm for the project outcomes and requested continued involvement as the project evolved. However, when the project officially ended, they did not continue its activities. ▪ *Impact assessment report:* Results indicate that, as a result of the performances: - Women were choosing to leave abusive relationships. - HIV-positive people were finding the strength to disclose their status to their partners and families. - Community members had begun to use counseling support centers in the area.
Replication and Scale-up Activities	The Mothertongue Project has subsequently relocated to Johannesburg, and plans are in place to replicate this project in Gauteng and North West Provinces.

LESSONS LEARNED AND CHALLENGES	
Key Findings and Lessons	▪ To ensure sustainable impact on the participants, it is necessary to build partnerships and networks with local organizations already working on the intersections between HIV and violence against women to ensure that they incorporate the same messages and language into their work. ▪ It is clear that instead of having two parallel lines of work—fighting HIV on the one hand and violence on the other—it is much more productive to have approaches that combine the two.
Challenges and Unforeseen Outcomes	▪ Other organizations in the community misperceived the program as a threat despite efforts to position it as a complementary, rather than competing, activity. ▪ The funding the program received covered only one year. Long-term funding (of at least three years) would have ensured far greater reach. ▪ Participants indicated that after their performances, spectators approached them with queries on their next performance, showed interest in being part of the project, and on occasion, sought assistance from the women on problems they were facing in their homes. Unintentionally, participants became peer counselors. ▪ The plays opened up vibrant discussions on the socio-cultural issues at the heart of the twin issues of violence against women and HIV. The discussions questioned the traditional roles of women, particularly within the Xhosa tradition. ▪ The plays provided a safe means for women to actively challenge their traditional position. This is the first step in social transformation. ▪ The impact assessment conducted at the end of the first year indicated that reception and impact of the program surpassed program expectations. ▪ For the participants, the project promoted their ability to actualize their dreams of acting and to re-enact moments of their lives through the plays. The process of translating a lived experience into a theatrical narrative, first in a workshop space and subsequently for the community, involves a complex process of reflection, release and healing that occurred for most of these women.
Recommendations for Replication	▪ It is important to have a resource team of gender-sensitive people who are skilled and trained (or can be trained) in participatory theater methodologies as well as expressive arts therapies. ▪ Funding is vital to sustain the project. ▪ It is vital to identify partner organizations that are prepared to collaborate and work in a complementary manner.

ADDITIONAL INFORMATION	
Program References and Resources	All reports and additional information can be found on www.mothertongue.co.za under the resources link. Cooperrider, D.L., and D. Whitney. *Appreciate Inquiry: A Positive Revolution in Change*. San Francisco: Berrett-Koehler Publishers, Inc., 2005.
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SHOSHOLOZA AIDS PROJECT

LEAD ORGANIZATIONS: Targeted AIDS Interventions (TAI)

COUNTRY: South Africa

HIV PROGRAM AREA: Prevention, Care and Support

OVERVIEW:
The Shosholoza AIDS project encourages preventive behavior among young men by helping them discuss the male norms and behaviors that exacerbate the HIV and AIDS epidemic. The project trains and supports young men on local soccer teams to conduct peer education sessions aimed at preventing HIV and reducing violence against women. The sessions are participatory and offer young men a safe space to discuss sensitive topics. The project has found that involving young men throughout the process and giving them responsibility for shaping the discussions is an effective strategy with the potential to generate positive social change. Failure to involve young men's parents and other adult stakeholders in the process inhibits adult support for the project, and can lead to a generational knowledge gap (which the program is now addressing though workshops).

BACKGROUND	
HIV & AIDS Program Goals	The primary aim of the Shosholoza AIDS project is to motivate young men to protect themselves from HIV infection and to become involved in discussion and community organizing to mitigate the negative impact of the epidemic.
Gender Strategies Addressed	✓ Reducing violence and coercion ✓ Addressing male norms and behaviors ☐ Increasing women's legal protection ☐ Increasing women's access to income and productive resources ☐ Other:
Description of Intervention	Like TAI's "Action by Young Men" project, the organization's Shosholoza AIDS project works with young men on local community soccer teams to conduct education sessions with their peers (other soccer players) that promote HIV prevention, reduction of gender-based **violence**, and addressing harmful **male norms and behaviors**. TAI collaborates with the South African Football Association (SAFA) to identify soccer teams. Selected peer educators participate in an intensive two- or three-day knowledge and skills-building workshop that addresses traditional and cultural gender norms and their impact on the community, especially women. Subsequently, young men redefine male norms for themselves in monthly small-group discussions. The peer educators then help develop educational materials to train their peers, focusing on issues they have identified as being important in their communities. The peer educator soccer players organize role-playing and other creative activities, such as drama and art, to help peers understand different issues, such as the effects of rape. They may discuss, for example, their differing understandings of what constitutes "forced sex" and "rape." The sessions provide safe spaces for young men to share information and ideas outside the framework of traditional cultural norms.

	Young men also build knowledge around HIV prevention, the effects of AIDS, puberty, sexually transmitted infections (STIs) and domestic violence through participatory workshops, monthly group discussions, and the process of researching and developing materials for their peers. They receive training and peer education sessions to build skills, including negotiation and communication skills, proper condom use, activity planning, reporting, lobbying and advocacy, and creating and realizing a joint vision. The young men develop dramas, songs, poems and traditional dances as outlets for creative expression. Finally, during soccer matches the players engage the crowd or the opposing team in discussions around rape, HIV prevention, drug abuse and violence against women.
Target Audience	▪ Youth ages 15–24 who play soccer in community clubs ▪ Female partners of soccer players ▪ Community networks involved in the project
Level of Intervention	▪ District ▪ Municipal
Geographic Location	Seven communities in KwaZulu Natal: Zondi Store, Hopewell, Mafakathini, Mandeni, Escourt, Greytown and Mpolweni
Timeframe	1998–ongoing
Funders	Joint Oxfam HIV/AIDS Program (JOHAP) – Oxfam Australia
Partner Organizations	*Implementation partner:* South African Football Association (SAFA)
IMPLEMENTATION AND RESULTS	
Start-up and Implementation Process	The first phase of the project was to establish a relationship with the executive committee of SAFA. Early engagement with SAFA helped provide access to community soccer teams and ensured the support of these key stakeholders. The soccer players are responsible for program implementation. The players hold monthly meetings, which serve as mentoring sessions as well as opportunities to monitor the implementation of each team's program plans. The participants also discuss challenges and successes, gender issues, HIV prevention issues, and more. Group activities focus on education, condom distribution and events.
Local Involvement/ Ownership	Young men's ownership of the project has been established. Young men decide what activities to conduct in the community, what topics they will address and how they will implement these. This may help sustain changes in attitudes over time. Also, TAI holds annual feedback sessions during which teams provide input into proposal writing.

Evaluation Methodology	▪ *Gender analysis*: In 2005, an external evaluator conducted a gender analysis of TAI programming for the Joint Oxfam HIV/AIDS Program (JOHAP). ▪ *Project completion report*: In 2001, Oxfam Community Aid Abroad (now Oxfam Australia) compiled a completion report for the Australian Agency for International Development, funder of the project from 1998 to 2001, that reviews program objectives, outcomes and performance, as well as successes, difficulties and lessons learned. The report also discusses findings from data collection efforts during this time period, including questionnaires and focus group discussions, as well as analysis of data. ▪ *Qualitative data collection*: Qualitative data are collected mostly through structured focus group discussions at various points throughout the project year. Issues covered include rape, HIV (e.g., one discussion was on the topic "Are Women to be Blamed for the Spread of HIV/AIDS?"), love, communication, male norms, and drug and alcohol use. Anecdotal evidence and self-reported stories also are collected as indicators of change in perceptions of masculinity. ▪ *Annual survey*: The Shosholoza project plans to develop a yearly internal evaluation, using both qualitative and quantitative methods, similar to that used by the Action by Young Men project. Importantly, Action by Young Men shares evaluation results with the participants so they can see how they have progressed throughout the year. Young men analyze the data using a participatory process so they can decide where they want to focus in the following year. Findings from 105 young men in seven participating teams will be compared with findings from a control group of 45 young men from three nonparticipating teams. The same teams, and preferably the same individuals, will be followed over the three years to determine change over time. Indicators include those relating to gender, HIV knowledge, HIV prevention practices, and sexual and reproductive health.
Evaluation Results	▪ *Gender analysis*: Although findings were on overall TAI activities and focused more specifically on other programs, one finding on "sport as a site of gender construction" reviewed the Shosholoza project's use of soccer clubs to change male norms: "The use of league soccer structures provided by SAFA was an appropriate and efficient way for TAI to initiate their Shosholoza project. Although less to do with identifying soccer as a powerful site for the construction and maintenance of masculinity than the practicality of 'piggy-backing' existing structures, TAI staff were also aware that both the SAFA structure and those it served were predominantly male. Their desire to challenge and change male behavior made this an appropriate, and smart choice" (Lindegger, 2005).

	▪ *Project completion report*: The following are select, gender-relevant findings from the report. - The report reviewed a study that was conducted to assess the effectiveness of peer educator education on soccer players. The study used a questionnaire and focus group discussions to compare the knowledge, attitudes and practices of the groups who attended these workshops to groups who had not. Results indicated that soccer players who attended peer education workshops showed significant reduction in number of sexual partners compared to the control group; a significant increase in regular use of condoms and knowledge of the use of condoms; and increases in knowledge of STIs, their diagnosis and treatment and their impact on increased vulnerability to HIV infection. Also, there was a significant reduction in soccer players who reported having had an STI in the past two months. The control group did not show significant differences between pre-intervention test and post-intervention test (conducted two months after the intervention). - The report reviewed the third year of the project with respect to the level of communication between peer educators and their partners in decision-making about sexual practices. Many peer educators talked about increased communication with their partners on safer sex and sexuality. The report also reviews findings from a questionnaire and focus group discussions held with partners of three out of the eight groups of peer educators, conducted in February 2001. Results showed that female partners of peer educators had retained the information they had learned from the peer educators: 93 percent reported that their partner had spoken to them about HIV and AIDS, and 100 percent could cite three reasons for using condoms (prevention of HIV, STIs, and pregnancy). The survey also showed that 34 out of 44 partners indicated that they had increased communication about sexual issues, and 41 out of 44 felt the training had improved their relationship. Information from focus group discussions with the partners also indicated that many peer educators were initiating communication related to sexual matters. ▪ *Qualitative data collection*: Findings indicate that community members, such as older men and traditional leaders, are seeking out soccer players involved in the project to learn about AIDS and HIV prevention. Young women also have been encouraged to form their own groups and now are educating other women and children. Some soccer players also report committing to ending drug and alcohol use and setting an example of being drug-free for young people in the community. ▪ *Annual survey*: Results are pending data collection and analysis.
Replication and Scale-up Activities	▪ TAI has conducted training for two other organizations that work with young men so they can replicate select program activities. ▪ Though similar models exist now, it is unclear to what extent they were influenced by the Shosholoza model. ▪

LESSONS LEARNED AND CHALLENGES	
Key Findings and Lessons	▪ TAI provides tools that young men can use to access knowledge and resources they need to talk about among themselves that they cannot discuss at home. ▪ It is important to create ownership of the program and engage the young men themselves in its inception and implementation. In the "Action by Young Men" project (elements of which are being replicated in Shosholoza), the young men themselves came up with issues concerning violence against women that they wanted to prioritize. ▪ Holding one large conference per year with all of the soccer teams to share what they have accomplished helps young men feel like they are a part of something larger. Teams report back on what they are doing, and each is motivated to do more as they see the progress of other teams.
Challenges and Unforeseen Outcomes	▪ There was a temporary backlash from parents who did not see the usefulness of the program. They did not see it as a program promoting safety, and one of the program staff was accosted by a boy's father who felt the project had "emasculated" his son by encouraging him to have only one partner. Parents needed to be involved in program efforts as well. ▪ Parents became less knowledgeable than their children, which created a knowledge gap. In this way, the project changed power dynamics in families. To solve this problem, the project engaged parents in workshops, for which some parents wrote letters thanking the program officers. ▪ Initially, because TAI was made up primarily of women who openly discuss sex and sexuality, which are taboo topics, collaboration with the mostly male SAFA was challenging to establish. Once established, however, men's involvement has been high. ▪ SAFA members were supportive; however, the actual structure of SAFA and elected positions change. New members are elected regularly so the challenge is to constantly re-engage the newly elected SAFA leadership. ▪ Politics is a challenge with community work. It is important to be in constant communication with community leaders and to avoid misunderstandings. Having a ward council member on hand is useful.
Recommendations for Replication	The model/process is feasible for replication in other communities, but TAI itself is currently focusing on organizational consolidation rather than on expansion.

ADDITIONAL INFORMATION	
Program References and Resources	Lindegger, G., and J. Maxwell. *A Gender Analysis of Targeted AIDS Interventions (TAI): A Report for the Joint Oxfam HIV/AIDS Programme (JOHAP).* Carlton, Australia: Oxfam Australia, 2005. Makhaye, G. “Shosholoza's Goal: Educate Men in Soccer.” *Agenda* 39 (1998): 93–96. Oxfam Community Aid Abroad. *Project Completion Report: Shosholoza AIDS Project, South Africa.* Carlton, Australia: Oxfam Australia, 2001.
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SOUL CITY INSTITUTE FOR HEALTH AND DEVELOPMENT COMMUNICATION PROJECT

LEAD ORGANIZATIONS: Soul City Institute

COUNTRY: South Africa

HIV PROGRAM AREA: Prevention

OVERVIEW:
The Soul City Institute for Health and Development Communication (Soul City IHDC) project aims to improve the health status of South Africans, including through the reduction of HIV, by promoting social change through mass media, social mobilization and advocacy. Soul City IHDC is a 16-year-old South African–based regional health and development communication project that implements the following activities: 1) Soul City, which promotes health and social change among adults through television, radio and print; 2) Soul Buddyz, a similar intervention that targets children ages 8 to 12, their teachers and their caregivers; and 3) advocacy campaigns to promote social change and influence legislation. It also recently has launched the "OneLove" campaign to discourage the norm of multiple concurrent partnerships. Evaluation results show that the various programs have led to shifts in knowledge, attitudes, social norms, and sexual behaviors, and that exposure to Soul City and Soul Buddyz has changed self-perception of risk among youth and adults and helped them resist peer pressure. Lessons learned include the importance of obtaining community buy-in and of collaborating closely with the government, and the need to be careful not to undermine men when using public messaging.

BACKGROUND	
HIV & AIDS Program Goals	The Soul City IHDC project aims to improve the health status of South Africans by promoting social change through mass media, social mobilization and advocacy, and to contribute to reductions in HIV incidence in line with national goals over a five-year period.
Gender Strategies Addressed	✓ Reducing violence and coercion ✓ Addressing male norms and behaviors ✓ Increasing women's legal protection ☐ Increasing women's access to income and productive resources ☐ Other:
Description of Intervention	Soul City IHDC aims to establish and maintain effective and efficient program management capacity to undertake quality health and development communication; build institutional and human capacity to undertake quality health and development communication; and scale up mass media communication and social mobilization programs and activities across the region to reach 35 million people during the current five-year timeframe. Activities include: *Soul City:* Aimed at adults (over 16 years), this multimedia "edutainment" vehicle includes television drama, radio drama and print to promote health and social change. Since its inception, Soul City has addressed aspects of HIV and AIDS in each series. Series 4, broadcast during 1999, dealt with HIV and AIDS, gender-based **violence**, and personal finance. A female

	character, Matlakala, is in an abusive relationship and she struggles, along with her neighbors, to stop the abuse (Goldstein et al., 2005). Another character in Series 4, Mandisa, realizes that she had been raped by her boyfriend, Tuko, when her friend Thembi tells her that it not okay to have sex when you do not consent. Series 8 dealt with HIV and AIDS, alcohol abuse and **male norms**. These story lines, along with informational print materials, allow people of different backgrounds and literacy skills to obtain crucial lifesaving information. *Soul Buddyz:* Aimed at children ages 8 to 12, their teachers and their caregivers, Soul Buddyz also uses an edutainment model that includes television drama, a radio program and a life skills booklet targeting grade 7 students. Soul Buddyz promotes healthy behaviors and attitudes and raises awareness about development issues. Series 1, broadcast in 1999, explored topics such as child abuse, HIV and AIDS-related stigma and interpersonal communication about sex. In one television episode, a female character, Avril, deals with sexual abuse from a relative. In another, two characters, Zandi and All-Star, have issues communicating with each other about sex. At the conclusion of each television episode, young people from around the country comment on the recently aired subject matter. In response to Series 1, Soul Buddyz clubs were initiated in schools and libraries to create a safe space for children to engage in in-depth discussions and activities on those topics. The clubs are facilitated by trained educators. *Advocacy campaigns:* Advocacy is key to Soul City IHDC social mobilization activities. In working to increase women's **legal protection**, its Campaign for the Speedy and Effective Implementation of the Domestic Violence Act, together with its Soul City programming, helped expedite implementation of the Domestic Violence Act, which helps remove structural barriers that prevent victims of gender-based violence from taking action. Soul City partnered with the National Network on Violence against Women to accelerate implementation. Building on the 1999 series of Soul City, which focused on domestic violence, the campaign conducted awareness-raising activities that included the publication of one million booklets on domestic violence, Soul City actors serving as advocates for the accelerated implementation at national meetings, and Soul City's embedding of the new legislation in the series. The South African government implemented the Domestic Violence Act in December 1999. Since then, Soul City has been involved in a number of advocacy campaigns, such as promoting access for children to social security and encouraging road safety. *One Love – Talk, Respect, Protect Campaign:* The South African Development Community identified multiple concurrent partnerships, a practice among men and women but particularly a high-risk **male norm and behavior**, as a key issue that must be addressed in HIV prevention efforts and jointly devoted resources toward this effort. Soul City IHDC will launch the One Love campaign in early 2009 to address multiple concurrent partnerships, aiming to challenge social norms that reinforce this high-risk behavior and promote safer sexual behavior. Formative research has been conducted, and it is expected that the media strategy will be rolled out in late 2008/early 2009. The One Love campaign in South Africa is part of a nine-country campaign. *Social mobilization activities:* These activities are part of the Soul City IHDC model and encourage target population members to think critically about barriers to and facilitators of social or behavior change. For an HIV

	prevention campaign on multiple, concurrent partnerships, social mobilization activities will be conducted in the school environment, such as raising awareness about Soul Buddyz Clubs; producing a toolkit that organizes community dialogue on social norms and multiple, concurrent partnerships; and organizing a skills workshop on how parents communicate with their children about sex.
Target Audience	▪ Soul City: Adults (individuals over age 16) ▪ Soul Buddyz: Children age 8 to 14, their teachers, and their caregivers ▪ One Love Campaign: Adults
Level of Intervention	▪ National ▪ Community
Geographic Location	Nationwide
Timeframe	1992–ongoing
Funders	▪ British Petroleum (BP) ▪ The ELMA Foundation ▪ European Union ▪ The Global Fund to Fight AIDS, Tuberculosis and Malaria ▪ Irish Aid ▪ Royal Netherlands Embassy ▪ South African Department of Health ▪ South African Broadcasting Corporation ▪ UK Department for International Development (DFID) ▪ The U.S. President's Emergency Plan for AIDS Relief (PEPFAR) through the United States Centers for Disease Control and Prevention (CDC)
Partner Organizations	*Implementation partners (in countries other than South Africa)* ▪ Action (Zimbabwe) ▪ Choose Life (Botswana) ▪ Desert Soul (Namibia) ▪ Fema (formerly Femina) (Tanzania) ▪ Kwatu (Zambia) ▪ Lusweti (Swaziland) ▪ N'weti (Mozambique) ▪ Pakachere (Malawi) ▪ Phela Health and Development Communications (Lesotho) *Implementation partners (South Africa):* ▪ AIDS Consortium ▪ Cell-Life ▪ Department of Education ▪ Department of Health ▪ Department of Public Service and Administration ▪ Johns Hopkins Health and Education in South Africa (JHHESA) ▪ LoveLife ▪ National Department of Social Development

	▪ The Presidency ▪ Society For Family Health ▪ Treatment Action Campaign (TAC) *Evaluation partners:* ▪ Health and Development Africa (HDA) ▪ Johns Hopkins Health and Education in South Africa (JHHESA) ▪ Khomanani
IMPLEMENTATION AND RESULTS	
Start-up and Implementation Process	All Soul City IHDC (drama and radio) serials and information print materials undergo a rigorous research and development process including consulting with key stakeholders and affected people. First, Soul City IHDC consults with key stakeholders (including activists, non-governmental organizations (NGOs) and government representatives) and technical experts on the topics to be addressed for a particular serial. Target population members are then asked what they know about these issues and what impedes or facilitates addressing them. Expert consultants and stakeholders help synthesize these findings and develop a message brief that guides the creative team of producers, directors and screenwriters as they develop content. Content material is tested, feedback is incorporated, and subsequently, serials are broadcast or materials are published. Preceding the release of serials and materials, Soul City IHDC launches a marketing campaign to increase audiences for the television and radio dramas, and to tie into advocacy efforts. Lastly, Soul City IHDC evaluates each series for impact and reach. Lessons learned are integrated into future productions
Local Involvement/ Ownership	Before the launch of a Soul City project, Soul City IHDC conducts target audience research to ensure that programming reflects local norms. Soul City IHDC solicits input from stakeholders to ensure that content is accurate and addresses issues of community interest. However, communities do not contribute resources or provide financial support to the project; Soul City IHDC is highly dependent on external funding.
Evaluation Methodology	All Soul City IHDC serials undergo some type of evaluation; only select evaluations are presented here. ▪ *National survey – Soul City Series 4:* Published in 2005, this evaluation was conducted to examine aspects of Soul City Series 4 as it relates to AIDS (Goldstein et al., 2005). Using a pre/post methodology, the impact of Soul City Series 4 on a cross section of South Africans was measured, with respect to AIDS messaging at the community level; knowledge, attitudes, and perception of risk; social norms; and discussion of HIV and AIDS. A multistage stratified national random sample design was used. Baseline data were collected from 1,979 individuals in 1999 and endline data were collected from 1,981 individuals in 2000. Significant differences were assessed using Chi-squared tests and multivariate analysis, with binary logistic regression to look at a dose-response effect for program exposure.

	▪ *National qualitative impact assessment – Soul City Series 4:* 31 focus group discussions, and individual interviews were conducted among Soul City target audience members, as well as 30 semi-structured interviews among community members representing civil society and leadership (Goldstein et al., 2005). This accompanied the aforementioned pre-/post-evaluation.
Evaluation Results	▪ *National survey – Soul City Series 4*: There were statistically significant shifts in social norms, particularly those that are sexual in nature. The proportion of respondents disagreeing with the statement that a man is right to expect a woman to have sex with him without a condom increased significantly, to 65 percent compared to 59 percent at baseline (p<.05). At endline, significantly more respondents disagreed that a woman is dependent on her partner for a better life—68 percent, compared to 61 percent at baseline (p<.05). ▪ *National qualitative impact assessment – Soul City Series 4:* Findings show that exposure to the programming changed self-perception of risk and encouraged young people to resist peer pressure. Findings also suggest that civil society and leadership participants in the assessment saw Soul City not simply as entertainment, but were also personally influenced by it with respect to awareness-raising and attitudinal change (Goldstein et al., 2005).
Replication and Scale-up Activities	▪ In 1999, Soul City IHDC established the “Choose Life” project, which successfully adapted Soul City-South Africa materials for Botswana, Lesotho, Namibia, and Swaziland. ▪ In 2001, a five-year regional program in partnership with local NGOs was established in Botswana, Lesotho, Swaziland, Namibia, Zambia, Zimbabwe, Mozambique and Malawi.
LESSONS LEARNED AND CHALLENGES	
Key Findings and Lessons	▪ Obtaining community buy-in and collaborating closely with the government normally provides the necessary support for successful implementation. ▪ It is important to not emasculate men in public messaging. Clear messages directed to both men and women could assist the target group in knowing how to change. ▪ Positive messaging works most effectively when people have skills and tools on how to change.
Challenges and Unforeseen Outcomes	▪ Initially, in the regional program, partner organizations in some countries were weak, unstable or unsustainable. An organizational development capacity-building program can address this, in addition to ongoing technical support to organizations. ▪ To prevent poor integration with national programs, it is vital to ensure ongoing consultation and engagement with government and civil

	society stakeholders. ▪ While every effort is made to operate strategically within the existing political climate, addressing political instability within the region is beyond the scope of the program.
Recommendations for Replication	▪ Know and be involved with all relevant stakeholders in the project area. ▪ Hold project consultations with the targeted communities, and disseminate impact results.
ADDITIONAL INFORMATION	
Program References and Resources	Goldstein, S., S. Usdin, E. Schleepers, G. Japhet, et al. "Communicating HIV and AIDS, What Works? A Report on the Impact Evaluation of Soul City's Fourth Series." *Journal of Health Communication* 10, no. 5 (2005): 465–483.
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STEPPING STONES—ADAPTED FOR SOUTH AFRICAN YOUTH

LEAD ORGANIZATIONS: Medical Research Council (MRC), South Africa

COUNTRY: South Africa

HIV PROGRAM AREA: Prevention

OVERVIEW:
Stepping Stones is an HIV prevention training package that was first implemented in Uganda and recently replicated and tested in South Africa by the MRC. The training uses participatory learning activities to cultivate healthier intimate relationships and behavior change that ultimately will help improve sexual health and reduce HIV incidence. The 13-session curriculum covers topics such as relationship skills, communication, contraception, motivations for sexual behavior, risk-taking, dealing with grief and loss, and preparing for the future. Impact assessment evaluations of the South Africa program show that it did not reduce the incidence of HIV, though it is associated with a reduction in herpes simplex virus-2 (HSV-2) incidence. Results also show that the South Africa program significantly reduced male-reported intimate partner violence, transactional sex, and problem drinking. Lessons learned include the importance of matching the facilitator to participants by age and sex to encourage open and honest communication, and the need to allow sufficient time to train and support local staff and fieldworkers.

BACKGROUND	
HIV & AIDS Program Goals	Stepping Stones seeks to decrease gender-based violence, improve sexual health and decrease the incidence of HIV infection by establishing and strengthening gender-equitable relationships.
Gender Strategies Addressed	✓ Reducing violence and coercion ✓ Addressing male norms and behaviors ✓ Increasing women's legal protection ☐ Increasing women's access to income and productive resources ✓ Other: gender equity
Description of Intervention	Stepping Stones (Welbourn, 1995) is an HIV prevention program that aims to improve sexual health by building stronger, more gender-equitable relationships that foster better communication between partners. It uses an HIV prevention training package that employs participatory learning activities to increase knowledge about sexual health and risk-taking, improve communication skills, and facilitate self-reflection on sexual behavior. It was originally developed in 1995 for use in Uganda and was adapted by MRC for South African youth in 1998. In the South Africa adaptation of the program, the training addresses how to discuss HIV, sex and other issues in the local language and in the local context. Participants, recruited from schools, are divided into single-sex groups and attend 13 three-hour sessions over the course of a few weeks. Facilitators are the same sex as the participants and are only slightly older. The curriculum covers a wide range of topics: 1. Listening and communication 2. How we act and what shapes it 3. Sex and love

	4. Contraception, conception and menstruation 5. Taking risks, sexual problems, and unwanted pregnancy 6. STDs and HIV 7. Safer sex and condoms 8. Gender-based violence 9. Motivations for sexual behavior 10. Communication skills (two sessions) 11. Dealing with grief and loss 12. Preparing for the future 13. Final community meeting Specific issues that are discussed for each topic vary by training group, depending on what youth participants raise as their interests and concerns. After the third, eighth, and ninth sessions, young men and women come together in three peer group meetings to share the dialogue they engaged in separately, and compare and understand the issues from the perspective of the other sex. For example, in the first peer group meeting, as young women share their constraints and concerns with young men and vice versa, participants are able to self-reflect and develop a better understanding of what it means to be a man or a woman and how to be a better partner or member of one's family. The program ends with a communitywide meeting, where participants share lessons learned across the sessions and communicate any concerns or requests that emerged from these lessons that they can work on with the community. Participants are referred to local clinics for further care and support during and after the end of the implementation. In developing the South Africa adaptation of Stepping Stones, editors found gender-based **violence** to be an issue fundamentally interconnected with HIV prevention and sexual health. As the training package in Uganda did not specifically address violence, the South Africa program added a gender-based violence session to the training package. This session uses open dialogue and role play as techniques to encourage communication and understanding of violence. Issues covered include identifying and responding to different types of violence, identifying formal and informal sources of help, and legal protections against violence. It also explores questions such as "Why do men rape?" and "Why do men and women mistreat each other?" Other sessions also touch upon violence, including discussions on social expectations of and pressure on young men and women, happy and unhappy sexual relationships, and sex and love. The session on violence also seeks to increase young men's and women's knowledge of **legal protections** by reviewing South Africa's Domestic Violence Act. This discussion seeks to raise awareness about legal rights and protection for violence against women, as well as violence against children and men. Throughout the training package, participants reflect upon and discuss **male norms and behaviors** that are harmful or beneficial for young men, young women, their families, and their communities. For example, in the session on societal expectations, young men discuss how society values them and the pressure they face to engage in "masculine" activities, even when risky, such as sex with multiple partners. Young men identify these issues themselves, thus shaping the discussion based on their own concerns and experiences. Once the men have identified their concerns, the facilitator guides the discussion around how realistic these expectations are and the challenges of living up to these expectations. The men then discuss among themselves their options to change risky behavior or

	reinforce positive behavior. This discussion becomes emphasized in a later session exploring why people behave the way they do, in which participants use a spider diagram to look at causes and consequences of risky behavior, role play a scenario of people taking risks, and explore how the characters in the role play could behave differently. Across sessions, participants also discuss **gender equity** in a range of contexts. The discussions around societal expectations, for example, help young men and women stand in the shoes of the other gender. The session on gender-based violence raises awareness among the men about how violence affects women in general and their partners specifically, and also helps change perceptions among young women about how they should be valued and treated. A discussion of happy and unhappy sexual relationships also looks at gender equity, including power dynamics and inequity in sexual relationships.
Target Audience	Youth, ages 15–24
Level of Intervention	District
Geographic Location	Eastern Cape Province, Gauteng Province, North West Province, Western Cape Province, KwaZulu-Natal Province, Limpopo Province
Timeframe	1998–ongoing
Funders	▪ The Harry Frank Guggenheim Foundation ▪ World Health Organization (WHO) ▪ Medical Research Council of South Africa ▪ National Institute of Mental Health (NIMH), part of the United States National Institutes of Health (NIH)
Partner Organizations	*Implementation partners:* ▪ Planned Parenthood Association of South Africa *Evaluation partners:* ▪ Biostatistics Unit, Medical Research Council, Pretoria, South Africa ▪ Department of Behavioral Sciences and Health Education, Rollins School of Public Health, Emory University ▪ Department of Psychology, University of the Witwatersrand, South Africa ▪ International Center for Research on Women (ICRW) ▪ Gender and Health Research Unit, Medical Research Council, Pretoria, South Africa ▪ School of Public Health, University of the Witwatersrand, South Africa ▪ Virology, National Institute for Communicable Disease, Sandringham, South Africa

IMPLEMENTATION AND RESULTS	
Start-up and Implementation Process	Stepping Stones was initiated in South Africa because of its proven success in Uganda, the ease of replicating its methodology, and its adaptability to any age group. The original Stepping Stones program, created in Uganda in 1995 by Alice Welbourn, includes a community development piece as well as sessions for adults and youth. In South Africa, MRC initially adapted it to focus on the community at large. MRC also adapted the program to meet specific community needs, for example, by adding a session on gender-based violence. In 1998 and 1999, MRC trained facilitators in six provinces in South Africa. Project staff received three weeks of training before beginning the facilitation process. Facilitators were then deployed to facilitate the program with their constituencies in their communities. During that period, Stepping Stones in South Africa reached older women and men in rural areas, and youth in urban and rural areas. Based on a program evaluation and facilitator input, the program was revised for a second edition, which MRC and the Planned Parenthood Association of South Africa, a sexual and reproductive health nongovernmental organization, implemented in Eastern Cape Province from 2002 to 2006. Due to Planned Parenthood's implementation mandate to work with youth, the target audience for the program shifted from the community at large to youth in particular.
Local Involvement/ Ownership	Because the community expressed interest in the evaluation of the program, MRC established a Community Advisory Board, which is chaired by a local chief and involves the government through the Departments of Education, Health, and local municipalities. These agencies endorse the program and allow access into the communities. A similar group of stakeholders was part of the Planned Parenthood Association of South Africa during the initial implementation of Stepping Stones, although at that time a community advisory board was not formed.
Evaluation Methodology	▪ *Evaluation study*: From 2005 to 2007, MRC conducted a behavioral intervention trial to assess the impact of the Stepping Stones program in South Africa on the incidence of HIV and HSV-2, as well as on sexual behavior. The cluster, randomized-controlled trial was conducted in 70 villages in Eastern Cape Province in partnership with the Planned Parenthood Association of South Africa. Study participants included 1,360 men and 1,416 women ages 15–26 years, most of whom attended school. Villages were randomly selected to receive the Stepping Stone program or a control intervention. The Stepping Stones arm was a 50-hour program, facilitated over a period of three to twelve weeks, aimed at improving sexual health by using participatory learning approaches to build knowledge, risk awareness, and communication skills and to stimulate critical reflection. In the control arm, individuals attended a single three-hour session on HIV and safer sex. Interviewers administered questionnaires at baseline and 12 and 24 months, and blood was tested for HIV and HSV-2. Qualitative research methods also were used to understand how youth responded to the program, particularly in their own individual context (Jewkes et al., 2008).

Evaluation Results	▪ *Project reach*: The program has reached 2,772 youth ages 15–26 years (1,412 women and 1,360 men). ▪ *Evaluation study*: There was no evidence that Stepping Stones lowered the incidence of HIV (adjusted incidence rate ratio 0.95, 95 percent confidence interval 0.67 to 1.35). The program was associated with a reduction of about 33 percent in the incidence of HSV-2 (0.67, 0.46 to 0.97; P=0.036)—that is, Stepping Stones reduced the number of new HSV-2 infections over a two-year period by 34.9 (1.6 to 68.2) per 1,000 people exposed. Stepping Stones significantly improved a number of reported risk behaviors in men, with a lower proportion of men reporting perpetration of intimate partner violence across two years of follow-up, and less transactional sex and problem drinking at 12 months. In women, desired behavior changes were not reported, and those in the Stepping Stones program reported more transactional sex at 12 months. Conclusion: Stepping Stones did not reduce incidence of HIV but had an impact on several risk factors of HIV – notably HSV-2 and perpetration of intimate partner violence. (Abstracted from Jewkes et al., 2008: 1).
Replication and Scale-up Activities	Stepping Stones originally was developed for use in Uganda and over the last decade has been used in more than 40 countries, adapted for at least 17 settings, and translated into at least 13 languages (Wallace 2006).
LESSONS LEARNED AND CHALLENGES	
Key Findings and Lessons	▪ Matching the facilitator to the participants by age and sex is important so that they may feel free to communicate. ▪ Rural communities will support such a program if it addresses an issue that they are concerned about and will be of value to them. Researchers must invest time in explaining the proposed study and should build a strong Community Advisory Board. ▪ Community mobilization should be seen not as a discrete task, but as a process. Though the latter requires more resources, this activity should be prioritized because it is key to establishing the program locations and obtaining community cooperation. ▪ Research instruments validated in other settings must have their validity established in the local settings. Involving field workers in validating and translating instruments greatly increases their depth of understanding of the instrument and resultant data quality. ▪ Informed consent is a process, not merely a written agreement to participate. The program first used a group consenting process where the study was fully explained. Later, individual participants also had opportunities to address private questions and concerns. ▪ All training in the program should be ongoing; continual training of fieldworkers and intervention facilitators is recommended. Facilitators had consistent training support that also provided them a means to raise concerns, and the coordinators helped resolve facilitation problems before more sessions were implemented in other areas. This occurred monthly.

Challenges and Unforeseen Outcomes	▪ Retention of evaluation participants was a challenge; it fluctuated around 70–75 percent in the intervention group. Some participants had other commitments and sometimes did not prioritize workshop attendance. Some participants did not attend because they were unwilling to travel in the dark. ▪ Giving incentives may be perceived as undue inducement to participate in research. ▪ Programs of this nature in rural areas often employ many staff who have not worked in the formal sector before. Extra time is needed for problem solving and team building with inexperienced staff.
Recommendations for Replication	▪ The program can be implemented in both rural and urban settings, and with different languages (there are 11 official languages in South Africa) and age groups. ▪ Training expertise, personnel, funding, training material, salaries and local transportation support (monetary) are essential. Funds and personnel are needed for the revision of the program to update policies and laws communicated in the sessions. ▪ The Gender and Health Research Unit of the Medical Research Council of South Africa is willing to provide advisory support to any implementers interested in using the program.
ADDITIONAL INFORMATION	
Program References and Resources	*Published articles:* Dunkle, K., R. Jewkes, M. Nduna, N. Jama, J. Levin, Y. Sikweyiya, M. Koss, et al. “Transactional Sex with Casual and Main Partners Among Young South African Men in the Rural Eastern Cape: Prevalence, Predictors, and Associations With Gender-based Violence.” *Social Science & Medicine* 65 (2007): 1235–48. Dunkle, K., R. Jewkes, M. Nduna, J. Levin, N. Jama, N. Khuzway, M. Koss, N. Duvvury, et al. “Perpetration of Partner Violence and HIV Risk Behavior Among Young Men in the Rural Eastern Cape.” *AIDS* 20 (2006): 2107–14. Jewkes, R., K. Dunkle, M. Nduna, J. Levin, N. Jama, K. Dunkle, A. Puren, N. Duvvury, et al. “Impact of Stepping Stones on Incidence of HIV and HSV-2 and Sexual Behavior in Rural South Africa: Cluster Randomised Controlled Trial.” *BMJ* 337, no. 71 (2008): a506. Jewkes, R., K. Dunkle, M. Nduna, J. Levin, N. Jama, N. Khuzwayo, M. Koss, A. Puren, N. Duvvury, et al. ”Factors Associated With HIV Sero-positivity in Young, Rural South African Men.” *International Journal of Epidemiology* 35 (2006a): 1455–1460. Jewkes, R., K. Dunkle, M. Nduna, J. Levin, N. Jama, N. Khuzwayo, M. Koss, A. Puren, N. Duvvury, et al. ”Factors Associated With HIV Sero-status in Young Rural South African Women: Connections Between Intimate Partner Violence and HIV.” *International Journal of Epidemiology*

	35 (2006b): 1461–1468. Jewkes, R., K. Dukle, M. Koss, J. Levin, M. Nduna, N. Jama, and Y. Sikweyiya, et al. “Rape Perpetration by Young, Rural South African Men: Prevalence, Patterns and Risk Factors.” *Social Science and Medicine* 63 (2006): 2949–61. Jewkes, R., M. Nduna, J. Levin, N. Jama, K. Wood, N. Duvvury, K. Dunkle, N. Khuzway, and M. Koss, et al. “A Cluster Randomized Controlled Trial to Determine the Effectiveness of Stepping Stones in Preventing HIV Infections and Promoting Safer Sexual Behaviour Amongst Youth in the Rural Eastern Cape, South Africa: Trial Design, Methods and Baseline Findings.” *Tropical Medicine and International Health* 11, no. 1 (2006): 3–16. *Policy brief:* Jewkes, R., M. Nduna, J. Levin, N. Jama, K. Dunkle, K. Wood, M. Koss, A. Puren, and N. Duvvury, et al. “Evaluation of Stepping Stones: A Gender Transformative HIV Prevention Intervention.” 2007. http://www.mrc.ac.za/policybriefs/steppingstones.pdf
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WOMEN'S HEALTH COOP, PRETORIA

LEAD ORGANIZATIONS: RTI International

COUNTRY: South Africa

HIV PROGRAM AREA: Prevention

OVERVIEW:
The Women's Health CoOp, Pretoria intervention seeks to empower at-risk women, particularly drug users and sex workers, through education and skills training on reducing HIV risk and drug use. This includes one-on-one counseling sessions on risk and safer behaviors, as well as life skills training to build assertiveness, improve partner communication skills, and teach violence prevention strategies. The program also teaches women about the link between drug use and risk of sexual violence. Program evaluations show a statistically significant decrease in overall drug and alcohol abuse among participants, and an increase in the percentage of women using condoms with their main partner. Key findings include that staff should be at similar education, income, and class levels as those of the clients targeted by the program, and links should be made with local community service providers for referrals.

BACKGROUND	
HIV & AIDS Program Goals	The Women's Health CoOp, Pretoria project seeks to equip female sex workers and other at-risk women with increased knowledge about the links between alcohol and drug use and sexual risk and victimization. It also works to help women reduce substance use, improve communication with their partners, use condoms more effectively, and use specific violence prevention strategies.
Gender Strategies Addressed	✓ Reducing violence and coercion ☐ Addressing male norms and behaviors ☐ Increasing women's legal protection ☐ Increasing women's access to income and productive resources ✓ Other: women's empowerment
Description of Intervention	The Women's Health CoOp, Pretoria intervention was an empowerment-based HIV intervention designed to reduce sexual risk, substance use, and victimization among at-risk and underserved women, including female sex workers and other vulnerable women in South Africa. The intervention contained education and skills training on reducing HIV risk and drug use within the South African context (Wechsberg et al., 2005). During two one-hour individualized sessions held within two weeks, enrollees were offered counseling on personal risk and contextual issues of risk identified from their baseline interviews. During these sessions, a counselor used cue cards to present information on HIV, drug use and associated sexual risk, risk reduction methods such as male and female condoms, and communicating with partners on safer sex practices. The counselor also discussed the HIV antibody test and steps the participants could take to prevent the spread of HIV (Wechsberg et al., 2005).

	Women who participated had an opportunity to design an individualized behavioral plan that would address each woman's specific risks. It sought to **empower women** by offering specific communication and negotiation strategies to help reduce these risks. For example, women were taught to negotiate around and communicate on the importance of condom use with sex partners. The counselor also role-played and rehearsed verbal assertiveness with each enrollee (Wechsberg et al., 2006). The intervention specifically addressed gender-based **violence**: participants learned violence prevention strategies, such as staying sober, communication techniques for a range of situations, and ways to exit volatile situations (Wechsberg et al., 2005). The counselor also demonstrated and rehearsed proper male and female condom use (Wechsberg et al., 2006). Groceries and a toiletry kit were provided to enrollees upon session exit, as well as referral resources.
Target Audience	Female sex workers and at-risk women who use alcohol or drugs and reside in areas reporting high substance abuse
Level of Intervention	▪ Province ▪ Community ▪ Individual
Geographic Location	Pretoria, Gauteng Province
Timeframe	September 2003–July 2008
Funders	National Institute for Alcohol Abuse and Alcoholism (NIAAA), part of the United States National Institutes of Health (NIH)
Partner Organizations	*Implementation partners:* ▪ Sizanang Centre for Research and Development
IMPLEMENTATION AND RESULTS	
Start-up and Implementation Process	This intervention was originally designed to address the needs of inner-city African-American female crack users in the U.S. (Wechsberg et al., 2004), and was adapted to serve female sex workers and other vulnerable women in South Africa. Researchers, in partnership with local outreach workers, used a sampling strategy to identify communities in Pretoria and recruit program participants among women conducting sex work in hotels, apartments, and informal settlements as well as those working the streets of Pretoria (Wechsberg et al., 2005). A community advisory board (CAB) comprising representatives from the government, nonprofit organizations, service providers and researchers was established to provide input and support where necessary. The mayor's office established a task force to locate housing and education services for sex workers. The Department of Health provided free male and

	female condoms to distribute in communities where outreach activities were conducted. Women also received donated clothes and healthy meals. "The adaptation process also involved revising and pretesting the questionnaire, modifying and pretesting the intervention, developing outreach strategies, and setting up field operations. CAB members helped revise the questionnaire and offered feedback to the research team. Items from the original US study that demonstrated reliability and relevance to the target population were selected (Wechsberg et al., 2003). A field manual was developed to address daily operations, including participant referrals to available resources. Full-time field staff who speak Afrikaans, English, Zulu and Sesotho were trained to conduct outreach, collect urine samples and test for substance use, conduct baseline and follow-up interviews, and deliver the two-session intervention" (Wechsberg et al., 2005).
Local Involvement/ Ownership	A community advisory board provided technical guidance and support. Furthermore, linkages were established with local community service providers to ensure continuity with referral services. Local government authorities provided the intervention team with some resources *pro bono* (i.e., condoms from the Department of Health). The intervention is dependent on both external funding and a trained team of researchers and implementers.
Evaluation Methodology	▪ *Randomized controlled trial*: Women who met the study criteria were randomized into two interventions: the standard program, which consisted of two one-on-one sessions focused on drug use, sexual risk, and the proper use of condoms; and the Women's Health CoOp, Pretoria intervention, which also included life skills training to build assertiveness, improve partner communication skills and teach violence prevention strategies. Both interventions provided HIV testing and information on HIV, HIV testing and the use of condoms. Quantitative assessments were conducted at baseline and three- and six-month follow-ups. Bivariate analyses were conducted to measure changes within each intervention arm. Statistical significance was assessed with ANOVA, linear regression, and paired t-tests to assess changes in alcohol use, protected sex with main and causal partners, and victimization (Wechsberg et al., 2006). ▪ *In depth interviews*: Interviews were conducted with 19 study participants.
Evaluation Results	▪ *Randomized controlled trial:* Women in the intervention significantly reduced their levels of alcohol, marijuana and crack cocaine use at three- and six-month follow-ups. At the six-month follow-up there was a significant increase in the percentage of women who were using condoms with their main partner at last sex, as well as in the proportion who used condoms in the past 90 days even under the influence of drugs (Wechsberg et al., *Prevention and Intervention in the Community,* in press). Women reported a continued decrease in main partner violence at three- and six-month follow-ups (Wechsberg et al., 2006; Wechsberg et al., *International AIDS Conference*, 2008). ▪ *In depth interviews*: Results suggest that the women were grateful to learn about HIV and AIDS and risks related to drugs and alcohol use. They reported they are more assertive about carrying condoms and

	negotiating condom use. Some stopped sex work or minimized it by earning money through small business ventures.
Replication and Scale-up Activities	▪ A similar Women's Health CoOp project is being replicated in the Western Cape. ▪ An adaptation of the project is being piloted in Russia.
LESSONS LEARNED AND CHALLENGES	
Key Findings and Lessons	▪ Do not hire staff that are too far removed socially or demographically (e.g., of a different education or income class level) from the community you want to reach. ▪ Hire and cross train a multilingual field staff and establish linkages with local community service providers for referrals. ▪ Provide staff with the opportunity to debrief, because the subject matter in counseling sessions can be difficult (high rates of HIV and stories about rape in affected communities).
Challenges and Unforeseen Outcomes	▪ The women needed many referrals for job training, job placement, education and substance abuse treatment services. Staff worked hard for better service linkages, but women needed help to negotiate services and fees. ▪ HIV prevalence and need for medical treatment were high. The women felt stigmatized seeking treatment at regular clinics and often were turned away. At their request, a medical program to offer services at the program site is now underway to meet these needs.
Recommendations for Replication	▪ Scale up interventions that help women and men protect themselves against HIV by transforming harmful gender-based attitudes and behaviors. Interventions also should teach about the intersection among drugs, sex and violence. ▪ Promote the implementation of appropriate gender-based HIV prevention interventions. ▪ Ensure that national and global initiatives related to gender become implementation priorities, and provide adequate resources to translate them into programs.

ADDITIONAL INFORMATION	
Program References and Resources	Luseno, W.K., and W.M. Wechsberg. "Correlates of HIV Testing in a Sample of High-risk South African Women." *AIDS Care,* in press, 2009. Wechsberg, W.M. "Adapting HIV Interventions for Women Substance Abusers in International Settings: Lessons for the Future." *Journal of Drug Issues*, in press, 2009. Wechsberg, W.M., W.K.K. Lam, W.A. Zule, G. Bobashev, et al. "Efficacy of a Woman-Focused Intervention to Reduce HIV Risk and Increase Self-Sufficiency Among African American Crack Abusers." *American Journal of Public Health* 94, no. 7 (July 2004): 1165–1173. Wechsberg, W.M., W.K. Luseno, W.K. Lam, et al. "Violence Against Substance-abusing South African Sex Workers: Intersection With Culture and HIV Risk." *AIDS Care* 17(S1) (2005): 55–64. Wechsberg, W.M., W.K. Luseno, F.A. Browne, T.L Kline, R. Middlesteadt-Ellerson, W.A. Zule, et al. "The Effect of an Adapted Evidence-based Woman Focused HIV Intervention on Condom Use and Negotiation Among At-risk Women in Pretoria, South Africa: Preliminary Findings." *Journal of Prevention & Intervention in the Community,* in press, 2009. Wechsberg, W.M., W.K. Luseno, T. Kline, F.A. Browne, R. Middlesteadt-Ellerson, W. Zule, et al. "The Women's Health Coop in South Africa: Efficacy of an Adapted Evidence-based Woman-focused Intervention." Oral Satellite Session presented at the XVII International AIDS Conference, Mexico City, Mexico, 2008. Wechsberg, W.M., W.K. Luseno, W.K. Lam, C.D.H. Parry, and N.K. Morojele, et al. "Substance Use, Sexual Risk, and Violence: Findings From an HIV Prevention Pilot Intervention With Sex Workers in Pretoria." *AIDS and Behavior* 10, no. 2 (2006): 131–137. Wechsberg, W.M., W.K. Luseno, K. Riehman, R. Karg, F. Browne, C. Parry, et al. "Substance Use and Sexual Risk Within the Context of Gender Inequality in South Africa." *Substance Use and Misuse* 43 (2008): 1186–1201.
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T-MARC

LEAD ORGANIZATIONS: Academy for Educational Development (AED)

COUNTRY: Tanzania

HIV PROGRAM AREA: Prevention

OVERVIEW:
T-MARC (the Tanzania Marketing and Communications for AIDS, Reproductive Health, Child Survival and Infectious Diseases Project) uses business partnerships and campaigns to prevent the further spread of HIV in highly affected communities. To directly improve health, T-MARC is working with Tanzanian businesses to develop or expand markets for health products for HIV and AIDS prevention and care, family planning, child survival, and infectious diseases. T-MARC also is using campaigns to address problems that the program implementer identified as exacerbating the epidemic, such as certain male norms (e.g., multiple partners), limited reproductive health knowledge, and low rates of condom use. The program also includes a grants component for female sex workers and women involved in transactional sex. Evaluations indicate that the campaigns have had wide reach: 1.2 million people through the condom initiative, 600,000 through the "be faithful" campaign and 20 million through radio outreach. In the course of program implementation, T-MARC has learned the importance of addressing men and women separately, particularly when discussing sensitive issues, and that repackaging messages for different communities is crucial.

BACKGROUND	
HIV & AIDS Program Goals	T-MARC seeks to improve the health of Tanzanian families and reduce the transmission and impact of HIV and AIDS by developing or expanding markets for health products, improving access to affordable health products, and developing and managing a broad-based communications initiative to enhance knowledge about core issues related to HIV and AIDS.
Gender Strategies Addressed	✓ Reducing violence and coercion ✓ Addressing male norms and behaviors ☐ Increasing women's legal protection ✓ Increasing women's access to income and productive resources ☐ Other:
Description of Intervention	T-MARC works with Tanzanian businesses to develop or expand markets for health products for HIV/AIDS prevention and care, family planning, child survival, and infectious diseases that will achieve demonstrable and sustainable health impacts. T-MARC works with commercial partners to support, develop or launch new or existing products (such as a new male and female condom) and to cost-effectively build upon existing marketing, sales and distribution networks. At the same time, T-MARC seeks to develop and manage a broad-based communications initiative that enhances the knowledge of Tanzanians about core issues related to HIV and AIDS, including accurate information about relevant products and services as well as persuasive information to encourage and sustain healthy behaviors. Through qualitative research, AED discovered that **male norms** including multiple partners, limited knowledge on reproductive health, lack of access

	to contraceptives (particularly condoms) and poverty all contributed to the AIDS epidemic in Tanzania. T-MARC addresses male norms through various campaigns, including Sikia Kengele, Vaa Condom and Mama Ushauri. Sikia Kengele (Listen to the Bell) is a national communications initiative to encourage fidelity. Using various forms of media (radio, road shows, print materials), the campaign targets men who choose younger partners, particularly along major transportation corridors and in mining and plantation regions. The campaign also addresses gender-based **violence** by including violence-related messages in the materials and information shared. Through the symbolism of the bell, T-MARC hopes to sound a wake-up call for sexual behavior change. The Vaa Condom (Wear a Condom) campaign developed "DUME," a male condom for men. The campaign focuses on correct and consistent use of condoms as well as making condoms widely available through local commercial outlets and public events. Mama Ushauri (Mama's Advice) is a three-year weekly television drama series. The episodes, 15 minutes each, cover a range of topics such as reproductive health and prevention of mother-to-child transmission. T-MARC also improves women's **access to income** by providing a grants program for female sex workers and women involved in transactional sex (i.e., engaged in sexual barter, usually irregularly). This program provides education and offers economic opportunities so that girls and women have other ways to support themselves and their families. Earning income could also help women resist pressure to have sex without a condom for a higher price. The grants program also supports Risk Reduction Days, which bring new and creative methods of interpersonal communication in the workplace to the highest risk regions and communities of Tanzania. AED partners with Africare and through the T-MARC Company on the grants program, reaching 15 partners at the community level.
Target Audience	▪ Men ▪ Women ▪ Female sex workers ▪ Women who engage in transactional sex
Level of Intervention	▪ National—messaging on male social norms and access to contraceptives ▪ District—messaging on family planning
Geographic Location	▪ Nationwide ▪ 10 (out of 21) regions with highest HIV prevalence
Timeframe	October 2004–September 2009
Funders	▪ The U.S. President's Emergency Plan for AIDS Relief (PEPFAR) through the United States Agency for International Development (USAID) and the United States Centers for Disease Control and

	Prevention (CDC) ▪ The United States Agency for International Development (USAID)
Partner Organizations	*Implementation partners:* ▪ Africare ▪ Ministry of Health, Tanzania ▪ T-MARC Company Ltd. ▪ 15 partners at the community level
IMPLEMENTATION AND RESULTS	
Start-up and Implementation Process	Start-up included formative research to explore the factors that affect HIV transmission in Tanzania, including the dynamics of sexual relationships. The project then wrote creative briefs for the various campaigns, sometimes targeting different messages to different groups. For example, in the Sikia Kengele and Vaa Condom campaigns, different messages were created for men and women, as women generally wanted to be monogamous while men generally are not obligated to be monogamous. The project then contracted various creative agencies to develop materials for these campaigns.
Local Involvement/ Ownership	A key part of T-MARC's mandate is to form partnerships with Tanzania's nascent but growing commercial sector. T-MARC has established an expanding partnership with one of the largest and most successful conglomerates in East Africa, the Sumaria Group, specifically with its subsidiaries Shelys Pharmaceuticals, which produces and markets ethical pharmaceutical products, and its sister company Beta Healthcare, which markets over-the-counter health products. Consistent with the mission of T-MARC, Shelys and Beta Healthcare strive to serve the low-income Tanzanian market with affordable, quality health products. Generally, Shelys and Beta products are leaders in their categories due to their affordability, strong distribution, and vigorous marketing. Currently, T-MARC and USAID are teaming with Shelys and Beta in marketing three subsidized products: Dume brand male condoms, Lady Pepeta brand female condoms and Flex-P oral contraceptive pills. T-MARC employs a "total market approach" that involves multiple partners from the private commercial sector, NGOs, and the public sector in a comprehensive effort to decrease risky behaviors, increase preventive health behaviors, and generate and fulfill demand for an affordable and accessible range of preventive health products.
Evaluation Methodology	*T-MARC monitoring, evaluation, and research (MER*). The principal purpose of T-MARC MER is to track information that will help guide decision making for the program and its partners. MER also involves gathering information for improving the behavioral change campaign and increasing product sales of partners. T-MARC collects data through periodic household surveys, routine sales data and low-cost studies such as retail audit surveys. In addition, T-MARC uses data from other research groups, such as Demographic and Health Surveys (DHS), when available. These sources provide T-MARC with additional information to monitor impact and progress regularly.

	▪ *Periodic household surveys*: A baseline Knowledge, Attitudes, Practices and Behavior (KAPB) survey was completed in 2006. A mid-term KAPB is to be conducted in 2008. The 2006 baseline was a cross-sectional survey conducted among 3,040 high-risk individuals from different parts of the country along the major transport corridors. Multi-stage sampling was used to select subjects in this study. A pre-tested questionnaire was used to collect information including demographic and socio-economic information, data on sexual behavior, condom use and brand preference, source of condom purchases, recall of HIV/AIDS campaigns, media exposure, family planning issues and more. ▪ *Sales data*: These data are routinely collected from participating, contributing and collaborating partners to inform decision-making around product sales.
Evaluation Results	▪ *Project reach*: According to the T-MARC's program monitoring report: - 1.2 million people were reached through the Vaa Condom campaign - 600,000 people were reached through the "be faithful" Sikia Kengele campaign - 20 million people have been reached by radio programs funded through the project ▪ *Periodic household surveys*: - Male respondents were asked if they had engaged in sexual acts with multiple partners in the period of one week before the day of the baseline interview. This period was chosen for reliable recall. Only 8.5 percent of all males reported having been involved in sexual acts with multiple partners, the highest proportion being among truck drivers (15.5 percent). Forty-eight percent reported not having been involved in sexual acts with multiple partners, while 43.5 percent reported having been involved with at least one casual partner. These results are slightly different from other studies on the same high-risk groups but the difference is attributed to the reference period. It is very likely that the proportions of men with multiple partners would be higher if the reference period were up to 12 months before the day of the interview. - Female sex workers, police officers, barmaids and truck drivers were also asked if they had engaged in sexual acts with multiple partners in the period of one week before the day of the baseline interview. Female sex workers reported having multiple partners (80.2 percent) while none of the female police officers reported having multiple partners. About 22 percent of barmaids reported having more than one partner during the reference period. From field notes, three reasons were given for this relatively low rate among barmaids: 1) the reference period of one week might have influenced the proportion of female barmaids who reported multiple partners; 2) some barmaids were reluctant to answer this question for fear of being labeled a sex worker; and 3) some barmaids reported menstruation or an ailment during the period of reference. There was only one female truck driver who reported having more than one partner in the reference period. ▪ *Sales data*: Sales data from April 1, 2008 to June 30, 2008 show that 2.7 million Dume condoms, 113,970 Lady Pepeta female condoms, and 196,488 cycles of FlexiPs were sold.

Replication and Scale-up Activities	A model similar to T-MARC has been implemented in Nepal (N-MARC); Uganda is operating a social marketing project under a similar model; and in Ethiopia a similar model is being expanded.
LESSONS LEARNED AND CHALLENGES	
Key Findings and Lessons	▪ It is important to understand the value of addressing men and women separately, especially around more controversial issues such as faithfulness. The program has designed most of radio and print media materials with this lesson in mind. ▪ Community dialogues should happen through faith-based organizations and community-based organizations at "big bell" events that bring together many organizations and offer HIV testing and tents, festival atmosphere, and use of games to explore and challenge prevalent norms in communities. Nongovernmental and community-based organizations should engage the crowd to discuss what they are learning and what they would like to address. ▪ Repackaging messages to suit different communities is crucial because risk perception and HIV knowledge among target groups vary greatly. ▪ Collaborating with other projects and organizations will allow the program to expand in scope and reach and avoid duplication of activities.
Challenges and Unforeseen Outcomes	▪ The lack of social or legal penalties in East Africa for having multiple partners undermined the Sikia Kengele initiative, as few people are interested in the message of being faithful to one partner. ▪ Marketing of female condoms is challenging due to a lack of interest among men, women and retailers. This is due to a lack of investment to properly introduce and maintain female condom promotions, which may stem from viewing female condom promotion as an alternative, not a core message.
Recommendations for Replication	▪ Providing a mentoring environment and training in procurement and financial management are essential elements of small grants management. ▪ A successful model depends on the openness of government and commitment of leaders to talk about prevention. ▪ Designing a public-private partnership model and the commitment to total market approach allows for project sustainability.
ADDITIONAL INFORMATION	
Program References and	Academy for Educational Development (AED). "The Fourth Season of the Mama Ushauri Radio Serial Drama Begins: Health-focused Radio Program

Resources	Promises an Exciting Year." April 8, 2008. http://pshi.aed.org/news_tmarcushauri4.htm. Accessed October 22, 2008. Academy for Educational Development (AED). "Tanzania Marketing and Communications: AIDS, Reproductive Health and Child Survival Project (T-MARC) (2004–2009)." 2008. https://www.globalhealthcommunication.org/projects/t-marc. Accessed October 22, 2008. Academy for Educational Development (AED). "Vaa ('Put it On') Kondom: Enabling Tanzanians at Risk to Protect Themselves From HIV and AIDS." 2005. https://pshi.aed.org/news_tmarcvaakondom.htm. Accessed October 22, 2008. USAID Tanzania. *T-MARC: The Tanzania Marketing and Communications for AIDS, Reproductive Health, Child Survival and Infectious Diseases Project*. n.d. https://pshi.aed.org/tmarccard.pdf. Accessed October 22, 2008.
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FAMILY AND COMMUNITY STRENGTHENING PROGRAM (FCS)

LEAD ORGANIZATIONS: Bega kwa Bega (BKB)

COUNTRY: Uganda

HIV PROGRAM AREA: Prevention, Care and Support

OVERVIEW:
The FCS program works with HIV-affected communities, providing a package of activities that it tailors based on community needs. Services and activities include basic health services, HIV counseling, HIV testing facilitation, home visits, income-generating activities, property and inheritance protection, water access assistance, and education scholarships. The program also addresses gender-based violence and harmful male norms and behaviors throughout various program activities, for instance through couples conflict trainings, health services for women victims of violence, and involvement of men in workshops to influence positive behavior change around reproductive health, violence, HIV prevention, and other health issues. Program activities have directly benefited more than 4,000 orphans, schoolchildren, their families, caregivers, and neighbors. Also, more women are seeking health services, and income-generating activities have given women more power and respect in the family. Sustainability is high because the multisectoral approach provides a variety of services, meeting a large range of family and community needs.

BACKGROUND	
HIV & AIDS Program Goals	The mission of BKB is to work together with communities affected by HIV and AIDS to improve the living conditions of orphans, vulnerable children and the women who care for them. The FCS program tailors a package of intervention activities based on community needs, including basic health services, HIV counseling, HIV testing facilitation, home visits, income generation, property inheritance protection, water access assistance, and education scholarships.
Gender Strategies Addressed	✓ Reducing violence and coercion ✓ Addressing male norms and behaviors ✓ Increasing women's legal protection ✓ Increasing women's access to income and productive resources ✓ Other: gender equity
Description of Intervention	Based on a needs assessment in each new community, program staff tailor a package of intervention activities to accommodate community resources and needs. These activities include: ▪ *Mobile health clinic:* A health clinic conducts two visits per week to provide rural communities that have little or no access to health care with health services (examinations, diagnosis, treatment for basic illnesses, HIV testing) and health education through community workshops. Bringing health services directly to the community increases **gender equity** in health, especially in the delivery of HIV services, as women are often least mobile and benefit most from locally available services. ▪ *Home visits:* Staff assist people living with HIV and other critically

	stressed families in their home environment with a range of services, including life skills support, nutrition assistance, basic health services, school funding, addressing sexual violence, training couples in negotiation and conflict resolution, and more. ▪ *Income generation:* These activities aim to increase women's **access to income and productive resources**. Women's and girls' groups receive training and materials for activities including knitting (18 groups), making local crafts, rearing livestock, and market gardening. ▪ *Property inheritance protection:* BKB staff identify and work with community leaders to protect the property of widows and children orphaned by AIDS to help women and children hold on to their homes, retain family assets, and maintain a sense of family identity. ▪ *Water access activities*: Program staff build water sources (protected springs, bore holes, and water tanks) to provide families and communities with a clean water source and protect girls from having to travel long distances for water, which leaves them vulnerable to sexual assault and rape. ▪ *Education*: The program provides scholarships for girls to attend primary, secondary, and vocational schools. FCS also equips and improves early childhood education facilities owned by women. FCS addresses gender-based **violence** in multiple program activities. The mobile clinic workers address violence in workshops during community visits, and also provide health services to women in the aftermath of rape or assault. Home health visitors address violence (physical and sexual) directly with families. Program staff provide couples with negotiation and conflict resolution training, and home visit staff address alcohol and substance abuse as a main source of gender-based violence. Coaching also empowers women to negotiate with partners regarding family income and intimacy rights and responsibilities, and individual counseling for women and men is available at the clinic and during home visits. The program also addresses **male norms and behaviors** that increase health risks. The mobile clinic has increased men's participation in community workshops to influence male knowledge and behavior around reproductive health, gender-based violence, HIV and AIDS, and other health issues. The income-generation project also works to change male norms and attitudes around women generating income. With growing numbers of male participants, FCS plans to begin men-only seminars to explore harmful male norms affecting family health and welfare. FCS aims to increase women's and children's **legal protection** by working with community leaders to help widows and children orphaned by AIDS keep their land and homes. Property protects children from becoming second-class citizens in someone else's home or being out on the street, both circumstances in which girls are particularly vulnerable to sexual exploitation. The program also helps girls and women affected by HIV and AIDS increase their **access to income and productive resources**. FCS income-generation projects provide basic business management training, skills training, and starter capital plus ongoing business support as needed, allowing girls and women to generate income. Activities include market gardening, livestock rearing, knitting, crafts, and nursery schools.

Target Audience	Orphans and at-risk children, their families and/or caregivers, vulnerable girls and women, and communities greatly affected by HIV and AIDS
Level of Intervention	▪ Individual ▪ Family ▪ Community
Geographic Location	More than 122 villages in seven districts (Kibale, Lira, Masaka, Mityana, Wakiso , Mubende, and Hoima)
Timeframe	1998–ongoing
Funders	▪ Banana Tree Project, Scotland ▪ Bega kwa Bega, UK ▪ Moyera Ness Trust, Scotland ▪ The Uganda Orphans Fund, USA ▪ Individual donors
Partner Organizations	*Implementation partners:* ▪ AMESCO, Kibale District ▪ Daughters of Mary, Masaka District Ministry of Health, Uganda ▪ District government offices of Wakiso, Mpigi, Masaka, Hoima, Kibale, Lira, Mityana, Mubende, and Nakaseke districts ▪ Uganda Farmers Association, Mpigi District ▪ Uganda Society for Disabled Children (USDC) ▪ Subcounty government offices including Katabi, Kakiri, and Namayumba subcounties in Wakiso district; Amach subcounty in Lira district; Nalweyo subcounty in Hoima district), Kalangaalo subcounty in Mityana district; Kassanda subcounty in Mubende district); and Karuguza subcounty in Kibale district. ▪ Women's community-based organizations: Wakiso Women's Development Association, Munaku Kama Women's Group, Mirembe Women's Group, Kivamukuteesa Women's Group, Ogutateganya Women's Group, Kyowola Otudde Women's Group, Zinunula Omunaku Women's Group, Byanana Kwekulakulanya Farmers Group *Evaluation partners:* ▪ Banana Tree Project, Scotland ▪ Bega kwa Bega, UK ▪ External consultants
IMPLEMENTATION AND RESULTS	
Start-up and Implementation Process	Communities were identified for interventions based on their HIV rate, number of orphans, and level of remoteness. Once a community was identified, a needs assessment was conducted to determine what services are needed and by whom. Program staff then put together packages of services, some targeting the entire community (e.g., mobile health clinic) and others targeting individuals or individual families (e.g., income-

	generating activities and home visits). The set of services is continually adapted as community needs change.
Local Involvement/ Ownership	BKB works only where invited by the community, to ensure that communities are committed, active partners in program activities. Communities select the at-risk families that receive assistance. Community leaders organize, schedule, and mobilize participation in health education and other community sessions. Community members provide resources including land, materials, and labor, and take responsibility for the maintenance of protected springs, bore hole, and water tank equipment.
Evaluation Methodology	▪ *Needs assessment*: At the start of the program, external consultants use surveys to identify needs and gaps in project communities. Also, at the start of every program activity, BKB meets with community leaders, women's groups, and community-based organizations to discuss and document community resources and needs. Needs are assessed using a range of tools. For example, the need for a clean water source can be measured by the cost of a jerrycan of water in a given community, and the quality of water by the incidence of water-borne diseases. BKB then works with communities to prioritize needs and select program activities to address the most pressing concerns among the most vulnerable families. ▪ *Baseline, monitoring and endline data collection for village market project*: In 2000, the FCS program conducted a baseline survey to measure the need for a village market in Kitala Village. Indicators measured included income and literacy levels, level of buying and selling, available products and goods and their costs, gaps and needs for products and goods, cost of buying and transporting goods wholesale and mark-up rates, and number of women engaged in productive activities. Data were analyzed and used to develop a market structure, which was implemented in 2000. BKB provided business and skills training, land, facilities and start-up in-kind materials for women entrepreneurs operating 100 businesses. Monitoring data were collected annually from 2001 to 2005. Endline data were collected in 2006. ▪ *Monitoring data collection*: BKB collects monitoring data on an ongoing basis and annually, as well as periodically as needed to reassess and revise project activities. BKB collects data through attendance registers and treatment records (mobile health clinic), visitation forms (home visits), school records and reports (education projects), and construction records (water projects) on a range of indicators, including number of: - Mobile health clinic beneficiaries - Women attending mobile health clinic antenatal care - Beneficiaries receiving mobile health clinic voluntary counseling - Home visit beneficiaries - Students receiving school sponsorships - Water sources constructed and number of beneficiaries of water sources - Income-generating projects - People who directly benefited from program activities ▪ *Program reviews and evaluation:* Donors and external consultants have reviewed and evaluated FCS using a range of methods and tools.

	Banana Tree Project conducts an annual review of water and income-generating activities to determine project reach and identify successes and barriers to success. BKB UK conducts periodic reviews of all program activities to assess project reach and identify program gaps.
Evaluation Results	▪ *Needs assessment*: Needs assessments show that while priorities vary by community, the greatest call for services across communities is among the most at-risk families, particularly those affected by HIV; income-generating activities for women and girls; clean water; basic health services; and quality education. ▪ *Baseline, monitoring and endline data collection for village market project*: Findings from the endline survey showed that 70 percent of women's businesses in the Kitala Village market were still operating, and 60 percent of women saw an increase in household income. Women who participated in the project report that the increase in income had a corresponding impact on quality of life indicators, such as the number of children attending school, improvements in household structure and access to health care. ▪ *Project reach*: Monitoring data show the reach of the project: - 9,191 people per year benefit from the mobile health clinic. - 282 women attended mobile health clinic antenatal care from Feb. 2007 to Feb. 2008. - 169 individuals received mobile health clinic voluntary counseling from Feb. 2007 to Feb. 2008. - 1,500 families or about 10,500 individuals benefit from home health visits per year. - 132 students receive school sponsorships. - 59 public wells provide clean water to about 99,120 people. - 128 income generating projects were started between 1999 and 2007. - Altogether, more than 100,000 people directly benefit from program activities. Also, findings from mobile health clinic records, qualitative data gathered at community meetings, and anecdotal evidence gathered by mobile clinic nurses, home visitors and program staff show that: - More women are seeking health services and are more open about their health during the mobile clinic seminars compared with the beginning of the program. - The boreholes and springs have reduced the amount of time women spend walking long distances looking for water and this time has been reallocated to income generation. - The income-generation activities have empowered women in the home and increased their respect within the family. ▪ *Program reviews and evaluation:* Findings are pending publication.
Replication and Scale-up Activities	The program started in one village (Kisubi) in one district and was scaled up to more than 122 villages in seven districts over 10 years. Project villages are also sharing skills and knowledge with neighboring villages.

LESSONS LEARNED AND CHALLENGES	
Key Findings and Lessons	▪ Sustainability is high because of a multisectoral approach in which a range of services are provided and tailored based on individual community and family needs. ▪ Women are the best change agents. They are reliable, with high participation and sustained involvement rates. At the same time, male involvement is increasing and is crucial to changing social norms that are barriers to women's well-being. ▪ It is important to understand a community's social and cultural context when developing health services. Local superstitions and myths must be addressed before community members will change harmful behaviors and practices or access health services.
Challenges and Unforeseen Outcomes	▪ Funds are limited and there is very high demand for program services. ▪ Creating the network for mobilizing communities is challenging. ▪ Local myths and misconceptions are a barrier to uptake of health services. For example, virgins are believed in some communities to be a cure for AIDS. Others believe that amulets will prevent and cure illnesses, making medical treatment unnecessary. ▪ The demand for water exceeded program expectations, and a spring or borehole built for one village often is used by neighboring villages as well. ▪ Income-generating activities are more sustainable then expected.
Recommendations for Replication	▪ Community ownership is crucial. ▪ It is vital to collaborate with the Ministry of Health for information exchange and provision of resources. ▪ A good local network for community mobilization and home visits needs to exist or be set up by the program. ▪ Ongoing funding is required to purchase drugs and medical equipment for the mobile health clinic. ▪ It is important to work with other health communication organizations to share information, education and communication materials and approaches.

ADDITIONAL INFORMATION	
Program References and Resources	Annual and periodic reports are distributed to funders and are available upon request from BKB.
Contact Information	Bega kwa Bega P.O. Box 28009, Kampala, Uganda Tel: + 256 (0) 782 225 787 / + 256 (0) 772 519 570 Website: www.begakwabegaugandaorphans.org.uk Conche McGarr, Director Email: begakwabega99@hotmail.com, conchemcgarr@yahoo.com David Ssagala, Project Manager Email: begakwabega99@hotmail.com, butale003@yahoo.co.uk

HIV & AIDS COUNSELING AND SERVICES

LEAD ORGANIZATIONS: The AIDS Support Organization (TASO)

COUNTRY: Uganda

HIV PROGRAM AREA: Prevention, Care and Support, Treatment

OVERVIEW:
The HIV & AIDS Counseling and Services program provides counseling and prevention services to individuals, couples, groups, and family members, and also offers other community-based services to help mitigate the impact of HIV and AIDS in affected communities. These include community capacity building to manage HIV/AIDS-related challenges, community sensitization and education, assistance with treatment for HIV and related medical needs, and general social support such as provision of food, skills training, and support for children. The program also works to prevent gender-based violence, offering care and support for victims and broad community sensitization on the issue. Work with men includes sensitizing them to high-risk norms and behaviors and involving them in prevention-of-parent-to-child transmission and family planning efforts. TASO has learned that including men in program work yields success, such as increased condom use and more effective management of family conflicts. In addition, sensitizing key community leaders can magnify the impact of work to address gender issues affecting the AIDS epidemic.

BACKGROUND	
HIV & AIDS Program Goals	TASO is a nongovernmental organization founded in 1987 that aims to prevent HIV, restore hope, and improve the quality of life of persons, families, and communities affected by HIV and AIDS. The HIV & AIDS Counseling and Services program provides counseling and prevention services (including trauma counseling) to individuals, couples, groups, and family members.
Gender Strategies Addressed	✓ Reducing violence and coercion ✓ Addressing male norms and behaviors ✓ Increasing women's legal protection ✓ Increasing women's access to income and productive resources ☐ Other:
Description of Intervention	The HIV & AIDS Counseling and Services program builds community capacity to handle HIV/AIDS challenges through community sensitization and education. It also helps people manage medical treatment of opportunistic infections, sexually transmitted infections (STIs), antiretroviral therapy, family planning, and PPTCT. The program also facilitates social support for people affected by HIV, including food support, income-generating activities, skills training, agricultural inputs, nonagricultural grants, child support, and support for formal education and vocational training. It advocates as well for meaningful and greater involvement of people living with HIV in policies and programs. To address gender-based **violence**, the program first assesses the nature, scope, and magnitude of the problem within each TASO catchment area—about 75 kilometers around a TASO center. Information is collected in community surveys, counseling, and medical sessions, client exit

	interviews, and community discussions during sensitization and education activities. TASO staff then conduct sensitization sessions on relevant issues of gender and gender-based violence, targeting particular categories of people (such as community leaders and youth) as well as TASO peer support groups. TASO staff themselves also receive sensitization training on violence. The program also provides survivors of gender-based violence with counseling, treatment of STIs, care for those who become pregnant, and start-up capital for income-generating activities. The program addresses **male norms** in educational workshops for men on the drivers of the HIV epidemic, such as multiple partners, unprotected sex, and cross-generational sex. Men are encouraged to undergo HIV testing, and TASO provides home-based counseling and testing for clients' partners and family members (65 percent of TASO clients are female). Male clients started a Positive Men's Union (POMU), which works to involve more men in HIV testing and seeking HIV-related services. TASO increases women's **legal protection** by helping clients understand their rights and inviting legal partners to give talks. Women clients are encouraged to seek legal help from civil leaders at various levels (village, parish, subcounty, and district). TASO also has linked clients to the Association of Uganda Women Lawyers (FIDA) to facilitate legal and police help in cases of property grabbing or rape. Poverty is a key driver of the HIV epidemic in Uganda, and most TASO clients are very poor women. To increase women's **access to income and productive resources**, TASO works in partnership with community-based, national, and international organizations including the World Food Program (WFP), ACDI/VOCA, Heifer International, World Vision, the Foundation for Credit and Community Assistance (FOCCAS) Uganda, microfinance institutions, women's organizations, and more. Through these partnerships, women have received entrepreneurship training, start-up capital, agricultural training, seeds, cows, goats, and poultry. TASO also supports formal education activities. At the national level, TASO works to develop policies and guidelines in counseling and provides support supervision, monitoring and evaluation, and resource mobilization. At the district level, TASO service centers provide monitoring and support as well as supervision to community volunteers.
Target Audience	▪ TASO clients and family members ▪ Client communities
Level of Intervention	▪ National ▪ District ▪ Community ▪ Family ▪ Individual
Geographic Location	Nationwide: TASO works directly through the TASO service centers and indirectly through Mini-TASOs in 74 out of the 81 districts

Timeframe	1987–ongoing; the current strategic plan runs from 2008 to 2012
Funders	▪ Danish International Development Agency (DANIDA) ▪ Irish Aid ▪ The Republic of Uganda ▪ Swedish International Development Cooperation Agency (Sida) ▪ UK Department for International Development (DFID) ▪ The U.S. President's Emergency Plan for AIDS Relief (PEPFAR) through the United States Agency for International Development (USAID) and the United States Centers for Disease Control and Prevention (CDC)
Partner Organizations	*Implementation partners:* ▪ AIDS service organizations, including AIDS Information Center (AIC), Mildmay International Charity and UGANDA CARES ▪ Civil society, including WFP, ACDI/VOCA, Heifer International, World Vision, FOCCAS Uganda, and Uganda Red Cross Society ▪ Communities affected by HIV ▪ Ministry of Health, Uganda ▪ People living with HIV ▪ Uganda AIDS Commission
IMPLEMENTATION AND RESULTS	
Start-up and Implementation Process	TASO was founded in 1987 by a group of people directly living with or affected by HIV who were unified by common experiences of stigma, ignorance and discrimination. The founders met informally in each other's homes or offices to provide mutual psychological and social support, and voluntarily used their time and other resources to visit AIDS patients, carrying them to the hospital and sometimes providing basic material and counseling support. Currently, 11 TASO centers provide services, within center facilities and at outreach clinics and home visits. Four TASO regional centers provide oversight to the TASO service centers within the region and build the capacity of mini-TASOs, which provide services in districts beyond the main centers. Between the TASO centers and the mini-TASOs, the program works in 74 of Uganda's 81 districts.
Local Involvement/ Ownership	Communities and the government recognize the benefits of the program and therefore are interested in and supportive of it. Stakeholders, including client representatives, participate in the strategic plan design. Clients are also part of TASO governance, with representatives on the Board of Trustees, the Regional Advisory Council and the Center Advisory Council. Clients who qualify to be counselors are given priority to participate in providing counseling services. Clients also provide feedback on the quality of services through client exit interviews conducted every quarter.
Evaluation Methodology	▪ *Program reach*: Service providers collect qualitative and quantitative data on program reach. Forms are computerized for entry of

	quantitative data, which are then periodically analyzed as part of the TASO Management Information System. Qualitative data periodically are analyzed by staff to inform decision-making. ▪ *Service access*: There are plans to evaluate services with the goal of increasing access and utilization, particularly regarding services addressing gender-based violence.
Evaluation Results	▪ *Program reach*: - TASO centers provided services to 90,000 people in 2007. - TASO centers provided counseling to 59,949 people (41,962 female and 17,987 male) in 2007. - TASO center drama groups conducted 928 performances reaching 239,884 people (101,444 female and 138,440 male) in center communities. - Mini-TASOs provided counseling to 115,142 people (79,983 female and 35,159 male). - From the 88 TASO supported-communities, community volunteers educated 370,458 people on HIV and AIDS (208,397 female and 162,061 male) and counseled 53,135 clients (20,748 female and 24,387 male). Data collected indicate the following: - Increasing numbers of new people are seeking services. - More women than men are seeking services (65 percent female and 35 percent male). - More than 60 percent of TASO clients are in discordant. partnerships, suggesting a need for greater emphasis on protecting HIV-negative partners. ▪ *Service access*: This evaluation has not yet taken place.
Replication and Scale-up Activities	▪ TASO is subgranting to mini-TASOs to provide TASO-like services in different districts where TASO service centers are not available. ▪ By building the capacity of communities to handle HIV and AIDS challenges through AIDS education and sensitization and training in basic HIV and AIDS counseling skills, TASO broadens its impact beyond services it can provide directly.
LESSONS LEARNED AND CHALLENGES	
Key Findings and Lessons	▪ Involving men has improved progress in some activities, including condom use, family planning, and PPTCT. Activities that have brought the most benefits include couples counseling, PPTCT, work with discordant couples and peer-to-peer education. ▪ Couples counseling is more effective than individual counseling for addressing conflicts within a marriage. ▪ Sensitizing cultural leaders, religious leaders and communities to address gender issues affecting the transmission of HIV creates more impact than working with individuals. ▪ Addressing gender-based violence issues effectively requires a

	multisectoral approach and that responsibility is shared by all men and women at all levels of TASO service delivery points including Headquarters, TASO service centers and the communities. ▪ Men, women, boys and girls experience different barriers to accessing TASO services. Barriers include stigma, cultural values and practices, waiting time to access services, economic limitations and lack of transport fare. ▪ Gender disparities affect programming in different ways. Women tend to be economically dependent on their partners and may be more vulnerable to HIV infection. At the same time, however, more women than men use TASO services. ▪ Management must be willing to provide adequate financial and human resources for gender-based programming to succeed. ▪ Adequate statistics and research are necessary to promote evidence-based decision-making. ▪ Successful gender-based programming demands continuous engagement of agencies, communities and local leaders.
Challenges and Unforeseen Outcomes	▪ TASO systems do not necessarily capture all of the organization's gender-focused work. The current strategic plan identifies gender mainstreaming as a specific goal and attempts to better articulate work in this area. ▪ It has been a challenge to persuade various stakeholders, including program staff and volunteers, to acknowledge the importance of mainstreaming gender.
Recommendations for Replication	▪ Community involvement is crucial. ▪ Strengthening partnerships is essential.
ADDITIONAL INFORMATION	
Program References and Resources	Additional information and publications about the HIV & AIDS Counseling and Services program are available on TASO's website.
Contact Information	The AIDS Support Organization Uganda Old Mulago Complex, P. O. Box 10443, Kampala, Uganda Tel: + 256 41 532 580/1 / Fax: + 256 41 541 288 Website: http://www.tasouganda.org/ Tina Achilla, Deputy Director PM, Psychosocial Email: achillat@tasouganda.org

MAMA'S CLUB

LEAD ORGANIZATIONS: Mama's Club

COUNTRY: Uganda

HIV PROGRAM AREA: Prevention, Care and Support

OVERVIEW:
Mama's Club trains HIV-positive mothers as peer educators to sensitize and train community members in life skills, prevention of mother-to-child HIV transmission (PMTCT), infant care, and human rights. The program also seeks to improve the economic status of HIV-positive mothers by training them in life skills and income-generating activities. The peer educators' community outreach activities include giving HIV prevention talks at schools, conducting outreach to encourage men to be supportive of their partners, and using song, dance and drama to engage community members. A violence-reduction component involves counselors and human rights lawyers in working with the women, and enlists supportive men to sensitize other men. The program has found that first-hand testimonials from HIV-positive women can catalyze social change, and that men need to be involved in gender-based programs.

BACKGROUND	
HIV & AIDS Program Goals	The primary aim of Mama's Club is to empower HIV-positive mothers to become community peer educators who encourage women to attend antenatal clinics, where they can access antiretroviral medication to prevent PMTCT. The program also seeks to improve the quality of life of HIV-positive mothers through psychosocial support and teaching of life skills and income-generating skills to improve their economic status.
Gender Strategies Addressed	☑ Reducing violence and coercion ☑ Addressing male norms and behaviors ☑ Increasing women's legal protection ☑ Increasing women's access to income and productive resources ☐ Other:
Description of Intervention	Mama's Club trains HIV-positive mothers as peer educators to sensitize and train communities in life skills, PMTCT, infant care and human rights. Peer educators use song, dance and drama to reach out to women. They also encourage men not to reject their HIV-positive partners and to get involved in family-based PMTCT programs. Peer educators talk about their experiences on radio and TV shows, calling for a reduction in stigma and discrimination in health facilities and in communities, and give prevention talks in schools. Mama's Club addresses gender-based **violence and coercion**, which characterize the lives of most of the peer educators, through testimonials and counseling sessions. Female lawyers and human rights activists train peer educators in dealing with violence. Peer educators also make home-based visits and organize group interactions, which provide opportunities to discuss violence and related issues with men.

	Peer educators also aim to increase women's **legal protection**. They are trained in legal issues that affect women and talk to communities about human rights abuses against women. The program also works in partnership with women's organizations involved in human rights, and has a plan to find free legal aid for women in need of legal assistance. The program helps women increase their **access to income** by teaching HIV-positive mothers how to look after their finances and how to generate income through tailoring, farming, and making handicrafts. The women also farm and keep small livestock. In addition, the program seeks to change **male norms and behaviors** around fatherhood and PMTCT. It partners with groups like Positive Men's Union to train men to become mentors who value fatherhood and are involved in PMTCT.
Target Audience	HIV-positive mothers who have attended PPTCT programs and have children less than three years of age
Level of Intervention	District
Geographic Location	Districts of Masindi, Kampala, Katakwi, Bukadea, Jinja and Masaka
Timeframe	September 2003–ongoing
Funders	▪ The AIDS Support Organization of Uganda (TASO) ▪ Collaborative Fund ▪ German World Day of Prayer ▪ Steven Lewis Foundation
Partner Organizations	*Implementation partners:* ▪ ATHENA ▪ Health Rights Action Group ▪ The International Community of Women Living with HIV/AIDS (ICW) ▪ The Market Vendors AIDS Project ▪ National Community of Women Living with HIV/AIDS (NACWOLA) ▪ The National Forum of People Living with HIV/AIDS ▪ Positive Men's Union ▪ Positive Women Leaders of Uganda ▪ Safe Motherhood Program ▪ Single Mothers' Association, Uganda ▪ TASO Uganda
IMPLEMENTATION AND RESULTS	
Start-up and Implementation Process	Mama's Club was started by 50 HIV-positive mothers who had attended PMTCT programs and had children younger than 3. The mothers decided to hold monthly meetings and seek training in life skills and other aspects of HIV that concerned them and their children. Since September 2003,

	members of the founding group have mobilized other mothers at PMTCT clinics and in the community to form similar groups. In 2007, 30 adolescent mothers joined the Club and were trained in adolescent reproductive health services, family planning and how to go out in the community and be change agents for prevention. The project began with a needs assessment in which program participants came together to discuss if they wanted the program and exactly how they wanted to run it. An advisory board, which later became the executive board, meets regularly to advise club members.
Local Involvement/ Ownership	The women formed the club as a community-based project and are responsible for its maintenance. They are the owners of the project. They also have income-generating activities that have helped sustain the program.
Evaluation Methodology	*Program reach:* The program collects data on program reach. It currently is measuring impact of the program on families but results are not yet available.
Evaluation Results	▪ The program has trained a total of 100 peer mothers, approximately 20 from each branch. Mama's Club now has five branches in five districts. ▪ About 300 families have been reached. The father mentor program has 25 supportive partners of members who are reaching out to other men in the communities.
Replication and Scale-up Activities	The project was replicated in Masdindi, Uganda and in Zimbabwe (Zimbabwe Mama's Club). Three more clubs are being formed in Uganda.
LESSONS LEARNED AND CHALLENGES	
Key Findings and Lessons	▪ It was initially difficult to convince partners and donors of the need for this program. Over time, however, donors recognized that the program could increase use of PMTCT services. ▪ Empowering women with knowledge and life skills can build a critical mass for social change. ▪ Women can influence men by fighting against human rights abuses. By creating partnerships with male groups like Positive Men's Union and using mentor fathers, it is possible to change men's thinking about fatherhood and the importance of seeking PMTCT for their wives and children. ▪ HIV-affected women can create change by telling their stories. ▪ Women need to be involved in decisions affecting their lives and need to be part of designing the programs that affect them. ▪ Men need to be involved in gender-based programs as well.

Challenges and Unforeseen Outcomes	▪ Adolescent mothers need more support. Young mothers should go back to school, but school fees and child care services are expensive. ▪ Most of the mothers live in slums, and gender-based violence and property grabbing have forced them out of their married homes. ▪ Getting a permanent office and fully paid staff has been a big challenge, as has obtaining transport fares for mothers to come for training.
Recommendations for Replication	▪ The mothers should initiate and design the program. ▪ Income-generating activities are the sustaining lifelines of the project. ▪ Support from donors is necessary to strengthen the program's administrative infrastructure and fund the various projects.
ADDITIONAL INFORMATION	
Program References and Resources	TASO, *The AIDS Support Organization (TASO),* from http://www.taso.org. ICW, *The International Community of Women Living with HIV/AIDS,* from http://www.icw.org. Scheier, R. "HIV-positive Women Talk It Over in 'Mama's Club." *Women's eNews*. July 23, 2006. http://www.womensenews.org/article.cfm/dyn/aid/2835/context/archive. Accessed October 21, 2008. "Ugandan Women Scoop Award at AIDS Meeting." *The Citizen*. Aug. 8, 2008. http://www.thecitizen.co.tz/newe.php?id=7214. Accessed October 21, 2008.
Contact Information	Mama's Club P.O. Box 27796, Kampala, Uganda Dr. Lydia Mungherera Email: lydiamng@yahoo.co.uk

MEMORY BOOK

LEAD ORGANIZATIONS: National Community of Women Living with HIV/AIDS (NACWOLA)

COUNTRY: Uganda

HIV PROGRAM AREA: Care and Support

OVERVIEW:
The Memory Book project aims to minimize the trauma of parental loss by improving communication between HIV-positive parents and their children. It strives to strengthen the parent-child relationship by encouraging communication, involving children in inheritance planning, and documenting important family history and memories for the children. Gender strategies include mitigating gender-based violence, promoting women's and children's legal rights, and reducing stigma against HIV-positive women. Violence-reduction strategies include improving family communication and making men aware of violence as a problem. The project also collaborates with legal organizations to raise awareness of women's and children's rights, and helps with will-writing to protect women's inheritance rights. Evaluations show increased family intimacy and communication, and significantly reduced family conflict and violence. Key lessons include the need to involve the community and to realize that participants' time constraints may hinder program activities. Limited literacy among participants also hindered the memory book activity.

BACKGROUND	
HIV & AIDS Program Goals	The Memory Book project aims to improve family communication, especially between HIV-positive parents and children, by teaching skills to enable HIV disclosure at the family and community levels. The project also promotes the legal rights of women and children.
Gender Strategies Addressed	✓ Reducing violence and coercion ✓ Addressing male norms and behaviors ✓ Increasing women's legal protection ☐ Increasing women's access to income and productive resources ☐ Other:
Description of Intervention	The Memory Book project aims to empower HIV-positive parents in supporting their children to survive parental loss with minimal trauma. Parents are trained in the four pillars of the Memory Project, which include 1) bridging the communication gap between parents and children, 2) disclosing HIV status to children supportively through counseling, 3) involving children in succession/inheritance legal planning, and 4) documenting and storing, in the form of memory books, important family history and precious childhood memories for future use by the children. To reduce **violence** and change **male norms** around violence, the project builds communication skills among family members and partners with other organizations and government structures that support reducing gender-based violence. Through meetings and sensitization seminars with cultural, traditional, and local leaders, the project also builds men's awareness of gender-based violence, especially as it stems from culture and traditional practices.

	In collaboration with legal organizations and to increase women's **legal protection**, the Memory Book project also helps organize legal clinics to sensitize community leaders to the needs and legal rights of women and children. The project teaches and assists families in will-writing to protect women's and children's property rights. The program also works to reduce stigma and discrimination directed toward HIV-positive women by improving the community's understanding of the situation these women are in.
Target Audience	▪ Women living with HIV as parents ▪ Guardians of children affected by HIV and AIDS ▪ Children from families affected by HIV and AIDS
Level of Intervention	Community
Geographic Location	Districts of Busia, Luwero, Lira, Soroti, and Iganga
Timeframe	1997–ongoing
Funders	Healthlink Worldwide, UK
Partner Organizations	*Implementation partners:* ▪ ActionAid in Palisa, Arua, Jinja, Rukungiri, and Kabale districts ▪ AIDS Communication Education and Training (ACET) ▪ TASO in Mbarara, Masaka, Jinja, Kampala, Mulago, Tororo, and Mbale districts ▪ Bushnet (Busia HIV/AIDS Network) ▪ Christian Children's Fund (CCF) in Soroti, Busia, and Wakiso Districts ▪ Friends of Christ Revival Ministry (FOC – REV) in Busia district ▪ Goal International in Bugiri ▪ Happy Children Foundation (HCF) in Busia ▪ Integrated District HIV/AIDS Committee (IDHAC) in Iganga district, a local government initiative ▪ Plan International in Luwero and Kawempe Districts ▪ Reach the Child Uganda in Rakai and Wakiso District ▪ Save the Children in Kasese District ▪ St. Paul Health Center in Njeru District ▪ Ufumi Village Community in Busia District, where Busia Human Rights Defenders' activists started their operations ▪ Legal Aid – Uganda ▪ Association of Uganda Women Lawyers (FIDA)
IMPLEMENTATION AND RESULTS	
Start-up and Implementation Process	The project started in Palisa and Kampala with a "Training of Trainers" for 36 parents and 36 children in each district. Participants were parents living with HIV who were interested in planning for the future of their children and in improving their communication at the family level. As it would be necessary to openly discuss HIV during the training and implementation, it

	was important for participants to have come to terms with their status, to some extent. Fundraising to cover program activities also took place during the start-up phase. Trained participants then carried out the Memory Book work activities, with follow-up by the program officer. In turn, dedicated trained beneficiaries formed a strong team to follow up with other participants and spearhead other Memory Book work activities. Trained people living with HIV are thus themselves both beneficiaries and owners of the project. This is important because passing on knowledge about the Memory Book project involves sharing experiences as well as information.
Local Involvement/ Ownership	Parents, guardians, and children gain skills that remain in the community and within families. Community participants share and teach these skills to others. The project also uses local materials.
Evaluation Methodology	*Community report card*: The report card is a qualitative data collection tool used by NACWOLA to solicit information from participants and community members about the perceived performance of the program. Information about communication within the family, noted change in behaviors, and use of legal services are recorded on the report card.
Evaluation Results	*Community report card*: Analysis of data from report cards shows the following: ▪ Training by NACWOLA (in collaboration with Legal Aid – Uganda and Association of Uganda Women Lawyers) on the rights of women has enabled members to seek legal redress on issues that affect them. ▪ The Memory Project improved communication between HIV-positive women and their family members. There has been improved family intimacy, with significant reduction of family conflicts and violence against women. More than 80 percent of the 828 HIV-positive women trained in the Memory Project reported they had experienced no violence in their families since they received the training. ▪ Of the 285 men trained in the Memory Project, 100 percent have reported changes in male norms toward gender-based violence stemming from traditional practices. Men also report they communicate freely with their wives and children about planning for the family's future and making plans to generate income to provide for their families. ▪ Participants felt prepared to engage in will-writing, and many had drawn up wills. ▪ About 30 percent out of those trained are active in the sensitization programs in their various districts, fighting stigma and discrimination through testimonies, drama, and radio talk shows. At the same time, 60 percent felt capable of identifying stigma and discrimination and raising them to the perpetrators and policy makers through dialogue. ▪ NACWOLA members continue to engage in income-generating activities to claim their position economically.

Replication and Scale-up Activities	▪ The program was started in 1997 in two piloted districts of Palisa and Kampala. It was scaled up to Busia, Luwero, Lira, Soroti, and Iganga Districts under Comic Relief funds. ▪ The Memory Book project is now being replicated in the districts of Arua, Nebbi, Kasese, Rukungiri, and Masindi through involvement of other partners mentioned above. ▪ By 2007 it had been replicated in Ethiopia, Kenya, Zimbabwe, Tanzania, Nigeria, Burundi, and Malawi. In 2008 it was replicated in India, Ghana, and South Africa.
LESSONS LEARNED AND CHALLENGES	
Key Findings and Lessons	Community members should be involved right from the initiation state through to monitoring and evaluation to ensure their acceptance and buy-in when dealing with gender programming.
Challenges and Unforeseen Outcomes	▪ The project requires a minimum literacy level to write the memory books, at least among the members. This is a scarce resource at the community level. ▪ The project also requires time, especially for writing the memory books and will-making. At the grassroots level, individuals are often too busy with family responsibilities to participate. ▪ The project requires funding to manage the many activities that fall under it, which include trainings for beneficiaries and trainers, follow-up support visits, memory book printings, trainings and clubs for children and youth, and meetings with community leaders.
Recommendations for Replication	This project should be community-owned, and beneficiaries must be involved in all planning activities.

ADDITIONAL INFORMATION	
Program References and Resources	NACWOLA. “NACWOLA's HIV Experience in Uganda.” 2008. Messages posted to http://www.nacwola.blogspot.com.
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THE SASA! ACTIVIST KIT FOR PREVENTING VIOLENCE AGAINST WOMEN AND HIV

LEAD ORGANIZATIONS: Raising Voices
Center for Domestic Violence Prevention (CEDOVIP)

COUNTRY: Uganda

HIV PROGRAM AREA: Prevention

OVERVIEW:
The SASA! Activist Kit for Preventing Violence against Women and HIV aims to mobilize communities to change the power imbalance between women and men as it relates to violence against women and women's increased HIV risk. The Activist Kit is structured in four phases. The first phase (Start) provides background information on violence against women and HIV and AIDS and suggests ways organizations can lay the groundwork for community mobilization work; the second phase (Awareness) encourages communities and individuals to examine how and why men use power over women and girls; the third phase (Support) increases skills of community members and institutions to support women experiencing violence and/or HIV, men seeking to change, and activists within the community; and the fourth phase (Action) teaches community members how to take action to prevent violence against women. Lessons learned include the need to address violence against women holistically by examining its root causes, and the need to recognize that long-standing social norms can be changed only gradually and when a cross-section of community members are involved. Evaluation results were not available at the time of this publication.

BACKGROUND	
HIV & AIDS Program Goals	The SASA! Activist Kit for Preventing Violence against Women and HIV aims to change the imbalance of power between women and men as it relates to two specific human rights abuses: violence against women, and women contracting HIV as a consequence of that violence.
Gender Strategies Addressed	✓ Reducing violence and coercion ✓ Addressing male norms and behaviors ☐ Increasing women's legal protection ☐ Increasing women's access to income and productive resources ☐ Other:
Description of Intervention	The SASA! Activist Kit is a comprehensive tool for organizations to mobilize their community to prevent gender-based violence and HIV. *Sasa* means "now" in Kiswahili; it is also an acronym for the four phases presented in the activist kit: *Start, Awareness, Support, Action.* Organizations can use SASA! to design, plan, implement, and monitor their community mobilization work. It includes a wide variety of tools, including training modules, activity guides, and a variety of ready-to-use materials for each phase. This approach builds on the Stages of Change model that recognizes that one must go through a process before lasting change is possible (Michau, 2008). Four strategies—local activism, media and advocacy, communication materials, and training—are used within each phase to reach a cross-section of community members. When

	organizations roll out SASA! in their community, they encourage and provide opportunities for as many individuals, groups, and institutions to become involved as possible. The *Start* phase provides background information on **violence** against women and HIV and AIDS to prepare and train the SASA! team, helps organizations begin building relationships in the community with potential activists and leaders, and provides suggestions and tools that organizations can use to gather information about community knowledge, attitudes, and behaviors related to violence against women, HIV, gender, and power. A small team from the implementing organization helps the community understand what it is capable of with respect to change. For example, in Kampala, a group of grassroots activists (women and men) who went through the Start phase decided to officially launch SASA! in their communities. They used a variety of approaches. Some activists introduced the SASA! ideas to community leaders through one-on-one meetings and community meetings; others organized large public events, which included marches through the community and speeches of support from prominent community members and leaders, including members of Parliament; others went door-to-door sharing the SASA! ideas with neighbors and friends. Because SASA! promotes activism and involvement from community members themselves, activists decide how and when to share and discuss the program in their communities. The *Awareness* phase addresses **male norms** by encouraging communities and individuals to examine men's use of power over women and girls and why this occurs. The *Support* phase builds skills of community members to reach out to women experiencing violence, to women and men seeking to create more equitable relationships, and to activists speaking out on the issue. The *Action* phase encourages community members to make practical changes in their personal and professional lives that prevent violence against women and HIV. For example, beauty salon owners might provide support and referrals to women experiencing violence, or health care institutions might adopt a standardized protocol for discussing HIV and violence with clients. Each community will implement the program in its own way, depending on the community's starting point, organizational capacity, and scale and intensity of efforts. Planning, monitoring, and assessment occur within each phase, using quantitative and qualitative data collection to gauge impact and effectiveness.
Target Audience	For the implementation in Kampala, the target audience is adults residing in low-income, densely populated areas with high HIV prevalence and a high incidence of violence. The Activist Kit can be used by organizations in other communities who work on the link between violence against women and HIV.
Level of Intervention	▪ Community ▪ Individual
Geographic Location	Kampala: Makindye and Rubaga Divisions

Timeframe	2008–ongoing
Funders	▪ Ford Foundation ▪ International Humanist Institute for Cooperation with Developing Countries (HIVOS) ▪ Irish Aid ▪ Sigrid Rausing Trust
Partner Organizations	*Evaluation partners:* ▪ Makerere University ▪ London School of Hygiene and Tropical Medicine (LSHTM) ▪ PATH
IMPLEMENTATION AND RESULTS	
Start-up and Implementation Process	In 2004, Raising Voices surveyed more than 25 organizations working on either violence against women or HIV in Uganda to learn more about the availability of programs that link the two areas and foster broad-scale social change (Michau, 2008). None of the organizations were working specifically on these links. Some did not recognize or understand the linkage between the two issues, some lacked the conceptual and practical skills to design and implement such a program, and some were concerned about organizational identity. Violence groups were reluctant to venture into the medical world of HIV, and HIV organizations did not want to venture into women's rights. In response, Raising Voices developed SASA! based on lessons learned from implementation and technical support around its other methodology, *Mobilizing Communities to Prevent Domestic Violence: A Resource Guide for Organizations in East and Southern Africa* (Michau and Naker, 2003), and through an extensive process of design and testing with CEDOVIP and the Kawempe community. A baseline assessment and community asset mapping exercise was conducted to identify prospective communities for intervention, and NGO staff and select community activists were trained before implementation began.
Local Involvement/ Ownership	The SASA! approach depends on community involvement at all levels, but an NGO needs to be involved as a supporter and facilitator of community activities. The Activist Kit was developed through extensive community and NGO involvement. Also, community activists are not given any incentives or funding to participate. They volunteer their time and their community spaces and contribute financially (e.g., the launches described above were entirely financed by activists themselves).
Evaluation Methodology	▪ *Rapid assessments and process evaluation:* Within each of the four phases, data are collected on knowledge, attitudes, skills, and behaviors regarding violence against women and HIV and AIDS, and change is measured against these baseline indicators. **Start** includes rapid assessment dialogues and surveys addressing knowledge about relationships between women and men and violence against women,

	gender, and power. In **Awareness,** assessment dialogues and surveys cover attitudinal issues with a focus on men's use of power over women—for example, whether a man can force his partner to have sex; the negative consequences of violence; whether men can do things that are usually thought of as women's activities, and vice versa; and opinions on whether or not women who experience violence are at risk of HIV. **Support**'s rapid assessment surveys and dialogues query about skills and ability to reach out to survivors of violence; holding men using violence accountable; and public actions against socially prescribed harmful gender norms. In **Action,** the focus is on behavior change, specifically around individual choices in relationships, as well as professional and public actions to prevent violence against women and HIV. Questions include: *"In the last 12 months have you talked with your partner about how to improve your relationship?"* and *"In the last 12 months, have you told someone that violence against women is not okay?"* ▪ *Cluster randomized design*: A baseline survey in 2008 assessed the impact of the intervention on residents of Rubaga and Makindye Divisions. Two cross-sectional surveys—one in 2008, the other planned for 2011—will measure intervention impact on the balance of power in relationships, past-year experience/perpetration of partner violence, past-year HIV risk behaviors (by men), and past-year actions in response to violence (by women). The survey also will examine processes and causal pathways for relationship dynamics and the levels of violence and HIV. The baseline sample size was 1,875 community members, residing in four intervention and four control sites. ▪ *Qualitative research to complement cluster randomized design*: Focus group discussions, timelines, and in-depth interviews with community activists, leaders, and service providers (police, health workers, etc.) will be conducted twice a year to document the intervention's impact on community members and volunteers (Raising Voices, 2008).
Evaluation Results	▪ *Cluster randomized design*: Analysis is ongoing as of publication. ▪ *Qualitative research to complement cluster randomized design*: Analysis is ongoing as of publication.
Replication and Scale-up Activities	▪ In January 2009, five organizations in Northern Uganda will begin using the SASA! Activist Kit (methodology). ▪ In March 2009, activities will be scaled up to 10 countries in the Horn, East Africa, and Southern Africa.
LESSONS LEARNED AND CHALLENGES	
Key Findings and Lessons	▪ Violence against women is best addressed not by focusing on one form or manifestation of violence, but by working on the root causes of violence—power imbalances between women and men. ▪ Changing social norms is a process that takes time. We need to be comprehensive in our approach by working systematically through a process of change.

	▪ Engaging a cross-section of actors helps build the critical mass to change social norms.
Challenges and Unforeseen Outcomes	▪ Developing relationships of trust with community members takes time. ▪ Community members are used to having NGOs take the lead and act as experts. Some community members find it unusual and difficult to become the activists and drivers of change. ▪ While it is important to be comprehensive and holistic, activities should be conducted within organizational capacity. Organizations should be encouraged to partner with others to implement SASA! and to choose carefully the strategies and stakeholders they will work with, rather than over-reaching by trying to implement a variety of activities with a large number of groups.
Recommendations for Replication	▪ For successful replication, committed staff members and established connections to the community are needed, and there must be a willingness and ability to foster positive and respectful relationships with community members. ▪ A rights-based approach to violence against women must be understood by staff and promoted by leadership within the implementing organization. A rights-based approach recognizes that a life free of violence is a fundamental human right. ▪ Adequate funding to support the scope and context of activities needs to be committed from the outset as once intense community engagement begins, it is essential to sustain the process. ▪ Often, implementers want to skip through phases—e.g., begin with the action phase to find solutions to violence against women. But it is important to stress the process and invest time in helping communities systematically through this effort.
ADDITIONAL INFORMATION	
Program References and Resources	Michau, L. *The SASA! Activist Kit for Preventing Violence Against Women and HIV*. Kampala: Raising Voices, Dec. 2008. Michau, L. *The SASA! Way to Preventing Violence Against Women.* 2008. http://www.kit.nl/net/KIT_Publicaties_output/ShowFile2.aspx?e=1465. Accessed October 21, 2008. Michau, L., and D. Naker. *Mobilizing Communities to Prevent Domestic Violence: A Resource Guide for Organizations in East and Southern Africa.* Kampala: Raising Voices, 2003. Raising Voices. *Preventing Violence Against Women: SASA Study*. 2008. http://www.raisingvoices.org/sasa/sasa_study.php. Accessed October 21, 2008.

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CORRIDORS OF HOPE II

LEAD ORGANIZATIONS: RTI International
Family Health International (FHI)

COUNTRY: Zambia

HIV PROGRAM AREA: Prevention

OVERVIEW:
The Corridors of Hope II HIV/AIDS Prevention Initiative (COH II) aims to decrease HIV transmission, morbidity, and mortality among the general population in seven of the highest-prevalence border and corridor communities in Zambia. The initiative engages local leaders and local governmental and nongovernmental organizations (NGOs) to play a central role in the project's design, implementation, and evaluation. Its primary strategy is to change community norms of sexual behavior, especially among groups at greatest risk. COH II's prevention services include behavior change communication and social mobilization interventions, diagnosis and treatment of sexually transmitted infections (STIs), expanded HIV counseling and testing services, and strengthened referral networks. All activities closely involve the border and corridor communities themselves to help change the key social norms affecting HIV transmission. The project also links women with organizations that help with legal protection and that assist aspiring women entrepreneurs. The program has seen broad successes in behavior change to decrease HIV risk.

BACKGROUND	
HIV & AIDS Program Goals	COH II aims to decrease HIV transmission, morbidity, and mortality among the general population in seven of the highest-prevalence border and corridor communities in Zambia.
Gender Strategies Addressed	✓ Reducing violence and coercion ✓ Addressing male norms and behaviors ✓ Increasing women's legal protection ☐ Increasing women's access to income and productive resources ☐ Other:
Description of Intervention	COH II builds on COH I (originally know as the Cross-Border Initiative), which was implemented from 2000 to 2006 in 10 communities in Zambia. COH I initially provided behavior change and STI services to female sex workers and their clients—particularly long-distance truck drivers and uniformed services personnel. Secondary targets included men in the targeted border and corridor communities who procured the services of sex workers. In 2004, coverage for youth ages 15–19 was added and services were expanded to include counseling and testing for HIV. Over time, COH I staff recognized that the more general population was also at risk for HIV. Thus, COH II works with all people in the border and transit towns and surrounding communities. Within this population, the project pays attention to the particular needs of youth, women, and men, as well as high-risk groups such as commercial sex workers, young girls engaging in transactional sex, young girls and older men engaging in cross-generational sex, victims of sexual violence, and sero-discordant partners. COH II also works with transient populations such as long-distance truck

	drivers, traders, uniformed personnel, money changers, customs officials, migrant workers, and the partners of these groups. The project aims to address high rates of HIV transmission by changing community norms around sexual behavior. COH II offers behavior change communication and social mobilization interventions, diagnosis, and treatment of STIs, expanded counseling and testing services, including static and mobile counseling and testing clinics, and strengthened linkages and referral networks. The project also links women with organizations that provide training and/or provide financial assistance to women starting income-generating activities. COH II engages local leaders, local NGOs, community- and faith-based organizations, and structures such as District Health Management Teams and District AIDS Task Forces to catalyze behavior change within their communities and to play a central role in program design, implementation, and evaluation. At the national level, the project works under the auspices of the National AIDS Council and the Ministry of Health. The primary tools used in behavior change program activities come from the Reflect methodology (Freire, 1970; ActionAid, 2006) and from Participatory Rural Appraisal. These include Stakeholder Analysis, Social Mapping, Transect Walk, Timeline, Trend Analysis, Seasonal Analysis, Daily Activity Schedule, Pair-wise Ranking, Venn Diagram, Cause/Effect Diagram, Matrix Ranking, and the use of pie charts. These tools will eventually be developed into a toolkit by program staff. The program addresses gender-based **violence** as part of its efforts to change behaviors that put women at risk for HIV infection. Behavior change teams at each site lead groups—including groups of police officers, women's groups, church groups, groups of sex workers, town councilors, employees of organizations, and others—through activities to help them identify key drivers of the HIV epidemic and ways to change behaviors that put women at risk for infection. When group members raise the issue of violence, program staff help them identify causes and solutions. Program activities also address harmful **male norms and behaviors** that put men at risk for HIV infection, such as multiple concurrent sexual partnerships, alcohol and drug abuse, and certain traditional practices. The program works with the police to address **legal protection** for women by referring victims of sexual and gender-based violence, as well as minors engaged in commercial sex work, to their Victims Support Units. The police provide clients with legal services, while COH II provides psychosocial support and linkages to post exposure prophylaxis. COH II also links women with other organizations that are concerned with women's legal protection.
Target Audience	Community members in border and transit towns in Zambia
Level of Intervention	▪ Individual ▪ Community ▪ District

Geographic Location	Seven towns: Kazungula, Livingstone, Chirundu, Chipata, Kapiri-Mposhi, Solwezi, and Nakonde
Timeframe	October 2006–September 2009
Funders	▪ The U.S. President's Emergency Plan for AIDS Relief (PEPFAR) through the United States Agency for International Development (USAID)
Partner Organizations	*Implementation partners:* ▪ Afya Mzuri ▪ Zambia Health, Education, and Communication Trust (ZHECT) ▪ Zambia Interfaith Networking Group on HIV/AIDS (ZINGO) *Evaluation partners:* ▪ External consultants (evaluation of COH I)
IMPLEMENTATION AND RESULTS	
Start-up and Implementation Process	COH was launched in 2000 as the Cross-Border Initiative, intended to reduce HIV transmission among sex workers and long-distance truck drivers by bringing them behavior change information and STI treatment and services. In the initial stages of implementation, the project worked to build project understanding and support among key stakeholders including police, traditional rulers, and political leadership. This was important in gaining support for work with sex workers in particular, as they are a stigmatized group and their profession was not legalized in Zambia. The project expanded from five sites in 2000 to 10 sites in 2006. The services and target groups expanded as well: In 2004, HIV counseling and testing was added, and youth were added as a target group. Both COH I and COH II hired qualified health care providers and counselors, behavior change coordinators, and outreach workers to work with youth and other at-risk populations. Also, sites have peer educators from different categories of target groups. Basic and enhanced knowledge and skills training for different categories of staff have been integral to the project. To gain entry into the sex worker community, the project first identified leaders, known as "queen mothers," for initial training as peer educators. Through the queen mothers, the project can recruit permanent and mobile sex workers in each project district to volunteer as peer educators.
Local Involvement/ Ownership	From the start, the participation of various stakeholders, from the Ministry of Health and National AIDS Council to community members, has been crucial.

	The government has agreed to provide supervision and resources for HIV testing and STI management. At site level, COH II works in close collaboration with the District Health Management Teams, who supply HIV testing kits and drugs to treat STIs and provide monthly external quality control on HIV testing. In turn, COH II reports to the Ministry of Health the number of people diagnosed and treated. COH II works with the National AIDS Council through District AIDS Task Forces, who coordinate the HIV awareness and prevention activities of all the organizations involved in the district. COH II staff, mainly site managers, chair some District AIDS Task Force subcommittees and are directly involved in planning, coordinating, and organizing district events. COH II has established Behavior Change Steering Committees, made up of individuals from various organizations and groups in the district including political, religious, and traditional leadership, at each site. These committees are a think tank and guide COH II in selecting activities and locations. Traditional village leaders help choose dates for COH II events and mobilize villagers to attend. COH II also works with religious leaders, school authorities, and other community leaders to identify appropriate activities, plan events, and review the outcomes of the events. Local officials and community members value the program highly, though it requires external funding for implementation.
Evaluation Methodology	▪ *Qualitative assessment*: A team of program staff and external consultants conducted an assessment at the end of COH I in 2006. Methods included observations, focus groups (140 participants total), in-depth interviews, and discussions with COH beneficiaries and partners to assess the overall impact that COH has had in the communities visited (75 total). ▪ *Behavior surveillance surveys*: To monitor and measure relative outcomes of interventions, a team of program staff and external consultants conducted three rounds (2000, 2003, 2006) of behavioral surveillance surveys among long-distance truck drivers and female sex workers. The 2000 and 2003 surveys among sex workers included biologic tests for syphilis, gonorrhea, chlamydia and trichomoniasis infection. In 2003, the project also conducted a survey among uniformed personnel (police, revenue authority, and immigration officers), and bus/minibus and light truck drivers. In 2005, surveys were conducted in Ndola among sex workers (including a biologic component screening for STIs, including HIV), long-distance truck drivers, uniformed personnel, and bus/minibus drivers. Survey questions focused mainly on knowledge of HIV prevention, incorrect beliefs about HIV transmission, type of sex partners, condom use at last sex with different sex partners, voluntary HIV counseling and testing, and exposure to interventions. ▪ *Monitoring data collection*: Program staff regularly collect basic data on COH II participants and activities.
Evaluation Results	▪ *Qualitative assessment*: Select findings include: - Trained peer educators and queen mothers effectively reached sex workers with behavior change messages centering on the benefits

	of HIV counseling and testing and the use of condoms. - Outreach programs helped reduce stigma around sex workers and created openness to discussing risky sex and prevention of HIV. - Free treatment for STIs seemed to be valued the most by female sex worker participants, followed by education on condoms and free condoms. - Truck drivers reported changing their sexual behavior after becoming more aware of the risks they were subjecting themselves to with each sexual partner. Most said that they would now be more likely to use condoms if they have sex with a nonmarital partner. - Most of the sex workers who visited COH were influenced by peer educators and outreach workers rather than advertisements or signposts. Many said that they found out about COH in bars, nightclubs, and on the streets through peer educators. The use of peer educators from the subpopulation is an effective avenue for reaching out to such a hidden population. - Edu-sport and other entertainment activities seem to add value and provide alternative entertainment and opportunities to meet and share ideas. ▪ *Behavior surveillance surveys*: Findings vary by survey. See references for links to more information. Changing trends across all surveys in two communities include the following: - There was a decline in the proportion of sex workers aged 20 years and below, from 31.7 percent in 2000 to 19.1 percent in 2006. - The proportion of sex workers who reported having attained a secondary or higher level of education increased from 10.1 percent in 2000 to 53 percent in 2006. - Among the high-risk groups, knowledge about HIV transmission is high. Among sex workers and truck drivers, use of condoms is increasing. Among truck drivers, the number of partners is decreasing. - One negative trend was that the proportion of respondents who reported consuming alcohol every day in the past four weeks increased from 14.9 percent in 2000 to 34.2 percent in 2006. ▪ *Monitoring data collection*: Between October 2007 and June 2008, 31,000 individuals tested for HIV, and 500,000 people received behavior change messages.
Replication and Scale-up Activities	▪ When COH was part of the Regional HIV/AIDS Program (up to 2004), some COH activities were replicated in other countries in the region. ▪ Under COH II (2006–2009), activities have been scaled up to reach beyond female sex workers and long-distance truck drivers. Overall, the project has been scaled up and down, depending on available funding.

LESSONS LEARNED AND CHALLENGES	
Key Findings and Lessons	Important lessons learned during COH I that have been applied to COH II include: ▪ Targeting only groups that tend to exhibit risk behavior (such as unsafe sex) is not an effective way to reduce the prevalence of STIs. ▪ Making services more accessible and involving community leaders in key decisions strengthen program participation. ▪ Providing employment alternatives to sex workers helps them sustain positive behavior change. ▪ Promoting counseling and testing services in the community and involving sex workers in program activities help change stereotypes of, and reduce stigma against, sex workers. ▪ Establishing strong links among project partners is crucial to sustaining activities. ▪ Building in research-to-practice and monitoring studies is necessary to inform and strengthen implementation. Lessons learned in COH II include: ▪ It is crucial to involve real peers (individuals who are members of the intervention target group). ▪ Information and options should be provided without judgment. ▪ It is important to help individuals and groups analyze their situations and develop solutions that are relevant to and meaningful for them.
Challenges and Unforeseen Outcomes	▪ Local communities and authorities were suspicious of and prejudiced toward services provided to sex workers and other high-risk groups. ▪ There was a local perception that the blood drawn for HIV testing was for use in rituals. ▪ Program sites had difficulty obtaining drugs for treating and managing STIs from the government store due to depleted supply.
Recommendations for Replication	▪ Replication requires official support at the national and local levels. ▪ It also requires financial support for the necessary equipment and infrastructure. ▪ Program implementers must be experts in HIV and STIs as well as in behavior change theories and approaches. ▪ It is crucial to use participatory approaches and understand the cultural norms and behaviors that drive the epidemic in target locations. ▪ It is important to establish close working relationships with a variety of stakeholders.

ADDITIONAL INFORMATION	
Program References and Resources	*General references:* Freire, P. *Pedagogy of the Oppressed*. New York: Continuum, 1970. ActionAid. "Reflect: The Innovative Approach to Adult Learning and Social Change." 2006. http://www.actionaid.org/main.aspx?PageID=128. Accessed October 21, 2008. *Summaries and final reports:* Family Health International (FHI). "Corridors of Hope I." 2008. http://www.fhi.org/en/CountryProfiles/Zambia/res_COHI.htm. Accessed October 21, 2008. Family Health International (FHI). "Program Helps Communities in Transport Corridor." 2008. http://www.fhi.org/en/CountryProfiles/Zambia/res_COHII.htm. Accessed October 22, 2008. Kamwanga, J., J. Simbaya, and C. Luhana. *Corridors of Hope Project: Final Evaluation Report.* 2006. http://www.fhi.org/en/HIVAIDS/pub/res_COHfinaleval.htm. Accessed October 21, 2008. RTI International. *Stopping HIV/AIDS in High-risk Transport Corridors and Border Towns in Zambia*. 2008. http://www.rti.org/brochures/zambia_hiv_coh2.pdf. Accessed October 22, 2008. *Behavior surveillance tools and reports:* Institute of Economic and Social Research (INESOR), Tropical Diseases Research Centre (TDRC), National HIV/AIDS Council, FHI/Impact. *Behavioral and Biologic Surveillance Survey in the City of Ndola, Zambia Among Female Sex Workers, Round One.* 2005. http://www.fhi.org/en/CountryProfiles/Zambia/zambiatools.htm. Accessed October 21, 2008. Kapungwe, A., P. Ndubani, S. Siziya, S. Chanda, J. Kamanga, et al. *Round Three, Behavioral Surveillance Survey Zambia, 2006: Long Distance Truck Divers in Transportation Routes with Trend Analysis 2000*–2006. 2006. http://www.fhi.org/en/HIVAIDS/pub/res_ZambiaBSSround3TruckDrivers.htm. Accessed October 22, 2008. Ndubani, P., J. Kamwanga, A. Kapungwe, M. Musoni, C. Mulenga, L. Kaetano, et al. "Behavioral Surveillance Survey Zambia, 2003: Long Distance Truck Drivers, Light Truck and Minibus Drivers and Uniformed Personnel in Transportation Border Routes." 2005a. http://www.fhi.org/en/CountryProfiles/Zambia/res_zambiabssmale.htm. Accessed October 22, 2008. Ndubani, P., J. Kamwanga, A. Kapungwe, M. Msoni, C. Mulenga, L. Kaetano, et al. "Behavioral and Biologic Surveillance Survey in Selected

	Transportation Border Routes, Zambia: Assessment Between 2000 and 2003 Surveillance Studies Among Female Sex Workers." 2005b. http://www.fhi.org/en/CountryProfiles/Zambia/res_ZambiaBSS.htm. Accessed October 22, 2008. Ndubani, P., A. Kapungwe, S. Siziya, C. Mulenga, L. Kaetano, M. Tembo, et al. *Behavior Surveillance Survey, Ndola, Zambia Among Long Distance Truck Drivers, Light Truck and Minibus Drivers and Uniformed Personnel in Transportation Border Route, Round One.* 2005. http://www.fhi.org/en/HIVAIDS/pub/res_ZambiaBSS2005Round1Truckers.htm. Accessed October 21, 2008. Ndubani, P., A. Kapungwe, S. Siziya, S. Chanda, J. Kamanga, et al. *Round Three, Behavioral Surveillance Survey Zambia, 2006: Female Sex Workers in Border and Transportation Routes with Trend Analysis 2000–2006.* 2006. http://www.fhi.org/en/HIVAIDS/pub/survreports/res_ZambiaBBSS_FSW2006.htm. Accessed October 22, 2008. Tropical Diseases Research Centre (TDRC), National AIDS Council, FHI/Impact. *Behavioral and Biologic Surveillance Survey Zambia: Female Sex Workers, Round One*. 2000. http://www.fhi.org/en/HIVAIDS/pub/survreports/bbssZambia/index.htm. Accessed October 21, 2008. Tropical Diseases Research Centre (TDRC), National AIDS Council, FHI/Impact. *Behavioral Surveillance Survey, Zambia, Long Distance Truck Drivers, Round One*. 2000. http://www.fhi.org/en/HIVAIDS/pub/survreports/BSSzambia/index.htm. Accessed October 21, 2008. *Qualitative assessment:* Mitchell, V., C. Chilangwa, F. Kapapa, L. Long, et al. *Qualitative Assessment/Documentation, Corridors of Hope Project, Zambia, 2006*. 2006. http://www.fhi.org/en/HIVAIDS/pub/res_QA_COH_Zambia.htm. Accessed October 22, 2008.
Contact Information	Corridors of Hope II 55 Independence Ave., Plot 560, P.O. Box 30323, Lusaka, Zambia Tel: + 260 21 1156 453/5 Websites: http://www.fhi.org, http://www.rti.org Leslie Long, Chief of Party/Project Director, Corridors of Hope II Email: llong@coh.org.zm Shawn Aldridge, COH II Technical Manager, RTI International Email: saldridge@rti.org

APPENDIX 1: ONLINE SEARCH PROCESS TO IDENTIFY HIV/AIDS PROGRAMS THAT INTEGRATE GENDER

Online searches conducted in May 2008 included the following methods, resources, and sources. This list is not exhaustive.

I. Keywords used in Google for references to relevant programs

Primary keywords

- Gender (or women or girls or men or boys or youth)
- HIV (or AIDS)
- Country name
- Program or project or intervention or activities
- Combined or comprehensive
- Services or accessing services or service providers or health care providers
- Prevention or care or treatment
- Gender equity
- Male norms or male behaviors
- Violence or coercion or gender-based violence or abuse or domestic violence
- Legal protection
- Access to income or productive resources

Secondary keywords

- *Gender equity:* stigma, discrimination, education, school, law, legal, empowerment
- *Male norms, behaviors:* masculinity, cross-generational sex, transactional sex, control, substance abuse or misuse, violence, domestic violence, gender-based violence, decision-making, decisions, communication, empowerment
- *Violence, coercion:* forced sex, protection, self-efficacy, negotiate, negotiation, control, fear, policies, law, perpetrators, empowerment
- *Legal protection:* traditional norms, community norms, traditional practices, rights, laws, policies, equality, discrimination, enforcement, legal services, judicial system, penal system
- *Access to income, productive resources:* economic opportunities, economic participation, education, skills, skills development, vocational skills, job skills, training, gender roles, women's roles, men's roles, employment, property ownership, credit, access to credit, loans, microfinance, microlending, empowerment

II. Search engines for peer review and gray literature

- Google Scholar
- Google
- PubMed
- PlusNews
- POPLINE

III. Organizational websites visited for references to relevant programs

- AED
- ACTAlive
- Africare
- CARE
- CDC/GAP
- National AIDS Commissions of project countries
- FHI
- The Global Fund to Fight AIDS, Tuberculosis and Malaria
- IGWG
- ICW
- International HIV/AIDS Alliance
- IPPF
- Johns Hopkins Bloomberg School for Public Health
- UNAIDS
- National AIDS Commissions across PEPFAR focus countries in Africa
- MRC
- Oxfam International
- PATH
- Pathfinder International
- PLUS News
- Population Council
- Population Reference Bureau
- Social Science Research Council
- United Nations Economic Commission for Africa
- UNIFEM
- UNDP
- UNFPA
- USAID
- PEPFAR
- Women's Information for Development Network
- WHO

APPENDIX 2: SURVEY INSTRUMENT

BACKGROUND

The International Center for Research on Women (ICRW) is collaborating with the Gender Technical Working Group to compile a Compendium of approaches[21] that address gender and HIV in a comprehensive or combined manner. The Compendium will focus on PEPFAR focus countries in Africa, but we are interested in including both PEPFAR and non-PEPFAR funded approaches. The purpose of the Compendium is to showcase promising approaches, enhance sharing of ideas and strengthen gender and HIV/AIDS programming.

For the purposes of the Compendium, we are defining a comprehensive approach as one that combines HIV/AIDS programming with 2 or more of the following four gender strategies. That is, we are looking for programs or program components in which a specific population is receiving multiple gender strategies. Please note that this may also be referred to by others as a combined approach.

Gender strategies:

- Reducing violence and coercion
- Addressing male norms and behaviors
- Increasing women's legal protection
- Increasing women's access to income and productive resources

We identified your approach as a potential candidate for inclusion in the Compendium and would greatly appreciate it if you could complete the attached questionnaire.

Note: For larger programs that may include several components/activities, we request that you focus on those components/activities that meet the criteria outlined above. Please feel free to complete several questionnaires if you have more than one program component/activity that meets these criteria.

[21] 'Approaches' can include programs, program components, projects, interventions and/or pilot projects.

INTERNATIONAL CENTER FOR RESEARCH ON WOMEN (ICRW) GENDER IN HIV PROGRAMMING – QUESTIONNAIRE FOR IMPLEMENTING PARTNERS

Please answer the questions below as briefly or extensively as is convenient. You are welcome to attach relevant project descriptions or summaries, if available, to save you time. Please reference these documents in the table below where appropriate.

Section 1: OVERVIEW		
1.1	Project[22] name	
1.2	Implementing organization's name and contact information	
1.3	Brief description of organization, including mission statement	
1.4	Partners, sub-partner organizations and funders on this project	
1.5	Country in which project is implemented	
1.6	Overview of project and key activities/initiatives	
1.7	Has the project been evaluated or has any data been collected on project? YES/NO. Please describe. If no M&E, have any data been gathered on number of persons reached by the project? Has qualitative data been collected from participants? Have any other data been collected?	
1.8	Does the project address *reducing gender-based violence and coercion*[23]*?* YES/NO. Please describe.	
1.9	Does the project address *male norms and behaviors*[24]? YES/NO. Please describe.	

[22] We are interested in gathering information on comprehensive, gender-based programming, which could include: projects, project components, programs, interventions, approaches and/or wraparounds. To save space in the tables, we have used the word 'project' to capture all of these, but please feel free to clarify which type of activity your organization is implementing.
[23] Please see annex for examples.

1.10	Does the project address *increasing women's legal protection*[25]*?* YES/NO. Please describe.	
1.11	Does the project address *increasing women's access to income and productive resources*? YES/NO. Please describe.	
1.12	Does the project address *other gender strategies?* YES/NO. Please describe.	

Section 2: PROJECT DETAILS		
2.1	Target audience	
2.2	Location of project [country, district/state/province, community name(s)]	
2.3	Duration/timeframe of project	
2.4	Problem(s) addressed by project	
2.5	Purpose/rationale/motivation of project	
2.6	Reasons for selecting intervention site(s) (i.e. context of situation in community with respect to project and target audience)	
2.7	At what levels did the intervention take place (national, district and/or community)?	
2.8	Was the local community interested/involved in the project? YES/NO Please describe.	
2.9	Was the government (national, district, local) interested/involved in the project? Please explain.	

[24] Please see annex for examples.
[25] Please see annex for examples.

Section 3: IMPLEMENTATION PROCESS, CHALLENGES AND LESSONS		
3.1	Process of starting up and implementing project	
3.2	Challenges and pitfalls during start up and implementation (please describe)	
3.3	How did the inclusion of different approaches/strategies to gender occur within the project? (i.e. were they strategically included or did they develop organically?) Please describe process.	
3.4	What lessons have you drawn from using multiple approaches to address gender?	
3.5	What lessons have you learned for gender-based programming?	
3.6	Does the project work with other projects/implementing partners in project communities to coordinate or complement efforts? Give name of other projects/partners and describe the collaboration/coordination.	

Section 4: EVALUATION AND IMPACT		
4.1	How were the outcomes and/or impacts of project determined? Describe M&E process.	
4.2	What outcome indicators were monitored and/or evaluated? Please list.	
4.3	Please list the key results/findings from M&E	
4.4	Number of people reached by project	
4.5	Unforeseen outcomes	

Section 5: LESSONS LEARNED AND FEASIBILITY		
5.1	Is project sustainable? Please describe why or why not.	
5.2	Has project been replicated and/or scaled up?	
5.3	What is needed for replication (i.e. if project were replicated by another organization or in another country, what type of environment or resources are critical to success? Resources might include infrastructure, expertise, personnel, funding, law & policies, etc?)	

Section 6: ADDITIONAL INFORMATION		
6.1	Recommendations for other programs doing similar work or wanting to replicate your project	
6.2	Sources for additional information on project (e.g. published reports, online articles, evaluations, etc).	
6.3	How might you use a compendium featuring comprehensive gender and HIV programming?	
6.4	Is there anything you can suggest that would make such a compendium more useful to program managers such as yourself?	
6.5	Are there other programs that should be considered for the compendium? Please provide program name, contact person and contact info.	
6.6	Do you feel that any modification to the way we have defined 'comprehensive' is necessary based on your own experience? (i.e. are more, less or different elements necessary for a program to really be 'comprehensive')	
6.7	Other comments/information	

Thank you for taking time to share your responses with us. The information provided will be extremely helpful in documenting the work you are doing in a Gender and HIV Compendium of Programs.

ANNEX

Please find below examples of approaches to gender-based violence (GBV) and coercion, male norms and behaviors, increasing women's legal protection and or increasing women's access to income and productive resources. This is not meant to be an exhaustive list, rather we hope it provides some clarity if needed.

Gender-based Violence and Coercion:

- Changing norms, attitudes and beliefs that condone GBV
- Improving awareness and knowledge of GBV problems
- Reducing stigma associated with experiencing GBV
- Mitigating harmful relationship dynamics
- Providing GBV medical services for victims of sexual violence such as but not limited to: post-exposure prophylaxis, providing HIV/STI testing and treatment or referral services, providing referral to legal, counseling and support services, and collecting forensic evidence for victims of sexual violence.
- Strengthening policies/laws and legal/judicial systems to create disincentives for perpetrators of GBV
- Building GBV victim's self-efficacy to negotiate safe-sex
- Removing barriers to HIV care and treatment for GBV victims
- Removing barriers to HIV counseling and testing for GBV victims

Male Norms and Behaviors

- Changing norms, attitudes and behaviors that condone harmful masculine behaviors
- Improving awareness of harmful masculine behaviors, such as cross-generational sex, transactional sex, multiple concurrent partnerships, substance abuse, harmful peer relationships, etc.
- Fostering male involvement in the health seeking process (i.e. in PMTCT, HIV counseling and testing, HIV care and treatment, etc.)

Increasing Women's and Girls' Legal Protection

- Changing norms, attitudes and beliefs which condone discrimination against women's legal rights and protection
- Increasing awareness of existing laws that protect the rights of women, including those related to inheritance and property rights
- Developing anti-discrimination policies and laws
- Working with police and local legal representatives to ensure that anti-discrimination laws are enforced
- Linking women to existing legal services
- Strengthening the judicial and penal systems

Increasing Women's and Girls' Access to Income and Productive Resources

- Changing norms, attitudes and beliefs that restrict women's economic role
- Creating opportunities for women to seek education/skills development
- Providing information to women about existing economic opportunities
- Enhancing male participation in care giving to allow women more time to engage in economic opportunities
- Removing legal barriers to women's employment, control of resources, property ownership and access to credit
- Fostering better business/employment/lending practices that enhance women's economic participation
- Improving girls' access to educational opportunities and/or making schools safer for girls
- Providing alternative economic activities for women and girls engaging in formal and informal transactional sex, having multiple sex partners, and marrying at an early age to gain economic security

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APPENDIX 3: ADDITIONAL PROGRAMS INTEGRATING MULTIPLE GENDER STRATEGIES INTO HIV/AIDS INTERVENTIONS

Country	*Program Name*	*Lead Organization(s)*	*Contact Information*
Côte d'Ivoire	Ma Vie Ma Décision	Johns Hopkins Bloomberg School of Public Health/Center for Communication Programs (JHU-CCP)	Régina Traore Serie, rtserie@gmail.com Tel: + 225 22 41 95 23
Kenya	AMKENI project	EngenderHealth, FHI, Intrahealth, and PATH	Ken Odera, KOdera@aphianyanza.org EngenderHealth, Tel: 212-561-8000
Kenya	Highlighting Marital HIV Risk and Promoting Premarital VCT in Nyanza, Kenya	Population Council	Ben Ochieng, bochieng@popcouncil.org
Kenya	Women and OVC Property Ownership & Inheritance Rights	Health Policy Initiative	Dan Wendo, dwendo@policy.or.ke Dorothy Odhiambo, dodhiambo@policy.or.ke
Multi-country	Men to Men Project	The African Women's Development and Communication Network	Therese Niyondiko, mentomen@femnet.or.ke Tel: +254 20 3741301/20
Nigeria	HIV Prevention Project for Vulnerable Youth in Northern Nigeria	Population Council	Andrew Karlyn, akarlyn@popcouncil.org
Nigeria	Women's Initiative for Sex Education and Economic Empowerment (WISE)	Africare	Shike Adekeye, sadekeye@africarenigeria.org
Rwanda	Rwanda Land Law and Policy	Rural Development Institute	Elisa Scalise, elisas@rdiland.org
Rwanda	WE-ACTx Hope for Legal Project	WE-ACTx	Simon Ntare Tel (US): 415 8634676 x3 (Rwanda) +25008302089

Country	Program Name	Lead Organization(s)	Contact Information
South Africa	loveLife	loveLife Trust	David Harrison, davidh@lovelife.org.za
South Africa	Refentse (phase 2)	Tshwaranang Legal Advocacy Center	Anneke Meerkotter, anneke@tlac.org.za Jill Keesbury, jkeesbury@popcouncil.org
Tanzania	Mwanza Urban Livelihood Programme (MULP)	Agency for Cooperation and Research in Development (ACORD)	Donald Kasongi, donaldkasongi@netscape.net acordtz@africaonline.co.tz
Tanzania	UJANA ("Youthfulness")	FHI	Jane Schueller, jschueller@fhitz.org Tom Ventimiglia, tventimiglia@fhitz.org Tel: +255 22 266 7815/05
Tanzania	VICOBA (Village Community Banking)	Pathfinder	Nelson Keyonzo, nkeyonzo@pathfind.org
Tanzania	The WORTH Initiative	Pact	Marcia Odell, modell@pacthq.org
Uganda	African Transformation	Johns Hopkins Bloomberg School of Public Health/Center for Communication Programs (JHU-CCP)	Jane Brown, jbrown@jhuccp.org
Uganda	Be a Man	YEAH (Young Empowered and Healthy) Initiative	Anne Gamurorwa, anne@cdfuug.co.ug
Uganda	Enhancing Traditional Sex Counseling Techniques in the Control of HIV/AIDS among Young People in Rural Uganda – [Senga model]	MRC Program on AIDS	Herbert Muyinda, Muyinda@chdc-muk.com, Tel: +256 41 321137
Uganda	ROADS (Regional Outreach Addressing HIV/AIDS through Development Strategies)	FHI	Gail Goodridge, ggoodridge@fhi.org Dorothy Muroki, dmuroki@fhi.org Tel: + 254 20 271 3914
Uganda	The Wayo Program	The Liu Institute for the Study of Global Issues	Herbert Muyinda, muyindaherbert@hotmail.com
Zambia	Linking the Health & Police Sectors in Sexual and Gender-based Violence Response	Population Council	Jill Keesbury, jkeesbury@popcouncil.org

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APPENDIX 4: PROGRAMS BY GENDER STRATEGY AND TYPE OF HIV/AIDS PROGRAM

	Country	Program Name	Gender Strategy Addressed						Type of HIV Program		
			Reducing violence and coercion	Addressing male norms and behaviors	Increasing women's legal protection	Increasing women's access to income and productive resources	Other	Total No. Addressed	Prevention	Treatment	Care & Support
1	Botswana	Targeting and Involving Men in HIV Prevention Activities	✓	✓			✓	3	✓		
2	Côte d'Ivoire	Operation Haute Protection (OHP)	✓	✓			✓	3	✓		✓
3	Ethiopia	Biruh Tesfa (Bright Future)	✓			✓		2	✓		✓
4	Ethiopia	Ethiopian Radio Serial Dramas to Prevent HIV/AIDS	✓	✓			✓	3	✓		
5	Kenya	Binti Pamoja	✓		✓	✓		3	✓		
6	Kenya	Engendering Equality		✓	✓	✓	✓	4	✓		✓
7	Kenya	Maanisha	✓	✓	✓	✓		4	✓	✓	✓
8	Kenya	Nuru ya Jamii	✓	✓	✓	✓		4	✓	✓	✓
9	Kenya	Post Rape Care	✓		✓		✓	3			✓
10	Kenya	Tap and Reposition Youth (TRY)	✓	✓	✓	✓		4	✓		✓
11	Mozambique	Geração Biz	✓		✓	✓		3	✓		
12	Mozambique	Survival Skills Training for Orphans (SSTOP)	✓		✓	✓		3	✓		✓
13	Mozambique	Women First (Mulheres Primero)	✓			✓		2	✓		
14	Multi-country	Male Norms Initiative – Ethiopia and Namibia	✓	✓				2	✓		✓
15	Nigeria	Community Care in Nigeria	✓	✓	✓	✓		4			✓
16	Nigeria	Comprehensive Sexuality, Family Life, and HIV/AIDS Education	✓	✓	✓	✓	✓	5	✓		
17	Rwanda	Polyclinic of Hope Care & Treatment Project	✓	✓	✓	✓		4	✓	✓	✓
18	South Africa	Fatherhood and Child Security Project	✓	✓				2	✓		✓

	Country	Program Name	Gender Strategy Addressed						Type of HIV Program		
			Reducing violence and coercion	Addressing male norms and behaviors	Increasing women's legal protection	Increasing women's access to income and productive resources	Other	Total No. Addressed	Prevention	Treatment	Care & Support
19	South Africa	IMAGE (Intervention with Microfinance for AIDS and Gender Equity)	✓	✓		✓		3	✓		
20	South Africa	Laphum' Ilanga (Sunrise)	✓	✓	✓	✓		4	✓		✓
21	South Africa	Shosholoza AIDS Project	✓	✓				2	✓		✓
22	South Africa	Soul City Institute for Health and Development Communication Project	✓	✓	✓			3	✓		
23	South Africa	Stepping Stones – Adapted for South African Youth	✓	✓	✓		✓	4	✓		
24	South Africa	Women's Health CoOp, Pretoria	✓				✓	2	✓		
25	Tanzania	T-MARC	✓	✓		✓		3	✓		
26	Uganda	Family and Community Strengthening Program	✓	✓	✓	✓	✓	5	✓		✓
27	Uganda	HIV & AIDS Counseling and Services	✓	✓	✓	✓		4	✓	✓	✓
28	Uganda	Mama's Club	✓	✓	✓	✓		4	✓		✓
29	Uganda	Memory Book	✓	✓	✓			3			✓
30	Uganda	The SASA! Activist Kit for Preventing Violence against Women and HIV	✓	✓				2	✓		
31	Zambia	Corridors of Hope II	✓	✓	✓			3	✓		
TOTAL			**30**	**24**	**19**	**18**	**9**		**28**	**4**	**18**

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