

# SYNOPSIS

HIV/AIDS PREVENTION AND CONTROL SERIES

## Gender-Sensitive Initiatives



Project 936-5972.31-4692046  
Contract HRN-5972-C-00-4001-00  
The AIDS Control and Prevention  
(AIDSCAP) Project, implemented by  
Family Health International, is  
funded by the United States Agency  
for International Development.

SERIES EDITOR

***M. Ricardo Calderón***

Latin America and Caribbean Regional Office  
AIDSCAP/Family Health International

Family Health International (FHI) is a non-governmental organization that works to improve reproductive health around the world, with an emphasis on developing nations. Since 1991, FHI has implemented the AIDS Control and Prevention (AIDSCAP) Project, which is funded by the United States Agency for International Development (USAID). FHI/AIDSCAP has conducted HIV/AIDS prevention programs in more than 40 countries, and the Latin America and Caribbean Regional Office (LACRO) has implemented interventions in 14 countries within the region.

December 1997

For further information, contact:  
Latin America and Caribbean Regional Office  
AIDSCAP/Family Health International  
2101 Wilson Blvd, Suite 700  
Arlington, VA 22201  
Telephone: (703) 516-9779  
Fax: (703) 516-0839

The HIV/AIDS Prevention and Control SYNOPSIS Series

# GENDER-SENSITIVE INITIATIVES



Series Editor:  
**M. Ricardo Calderón**  
AIDSCAP/Family Health International  
Arlington, VA, USA



Prepared by:  
**E. Maxine Ankras**  
AIDSCAP/Family Health International  
Arlington, VA



Project Coordinator:  
**Mary L. Markowicz**  
AIDSCAP/Family Health International  
Arlington, VA, USA



Published by the Latin America and Caribbean Regional Office of  
The AIDS Control and Prevention (AIDSCAP) Project  
Family Health International

*The opinions expressed herein are those of the writer(s) and do not necessarily reflect the views of USAID or Family Health International. Excerpts from this booklet may be freely reproduced, acknowledging FHI/AIDSCAP as the source.*

## TABLE OF CONTENTS

Acronyms	ii
Acknowledgements	iii
Prologue	v
Holographic Overview	ix
Introduction	1
The Shifting Pandemic	3
Susceptibility of Women to HIV/AIDS	5
Increasing the Focus on Gender: A Worldwide Trend	9
Women Taking Action	9
New Directions within AIDSCAP	12
Gender-Sensitive Initiatives: A Technical Strategy	13
Sex and Gender	13
Gender-Sensitive Initiatives	14
Background to Implementation in Latin America	15
Key Components to Successful GSIs	17
Top-level Management Training	17
Dialogue	21
Research	26
Gender Advocacy	29
Evaluation from a Gender Perspective	37
Future Challenges	39
Lessons Learned	41
Recommendations	43
References	45

## ACRONYMS

AIDS	acquired immune deficiency syndrome
AIDSCAP	AIDS Control and Prevention Project
AWI	AIDSCAP Women's Initiative
BCC	behavior change communication
CBO	community-based organization
CSW	commercial sex worker
FHI	Family Health International
GSI	gender-sensitive initiative
HIV	human immunodeficiency virus
LAC	Latin America and the Caribbean
LACRO	Latin America and Caribbean Regional Office
MIPP	men in partnership for prevention
MOH	Ministry of Health
NACP	National AIDS Control Program
NGO	non-governmental organization
PAHO	Pan American Health Organization
PVO	private voluntary organization
RRF	rapid response fund
STD	sexually transmitted disease
USAID	United States Agency for International Development
WHO	World Health Organization

## ACKNOWLEDGEMENTS

We would like to acknowledge and recognize the contributions, work and efforts of the Implementing Agencies — NGOs, PVOs, CBOs, NACPs/MOH, Social Security Institutes, and private sector enterprises — with whom LACRO has worked and for all that we have learned and accomplished together in HIV/AIDS prevention and control.

We are especially grateful to E. Maxine Ankrah, Associate Director of the Family Health International/AIDSCAP Women's Initiative for preparing this booklet. We appreciate the efforts of Stephanie Russell, Consulting Writer, Molly Strachan, Associate Program Officer for AIDSCAP/LACRO, and Jann Mouer, for contributing to the completion of this document.

We take this opportunity to also thank all of the staff members of AIDSCAP/LACRO, including former staff members, for their overall support and assistance to LACRO activities: Joseph Amon, Lee Arnette, Mimi Binns, Oly Bracho, Marianne Burkhart, Rebecca Coleman, Mark Chorna, Genie Liska, Cathy Mamedes, Mary L. Markowicz, Robert Martínez, Mary Kay McGeown, Steve Mobley, Manuel Mongalo, Polly Mott, Sara Padilla, Marvelín Parsons, Amparo Pinzón, Luis Rodríguez, Melissa Rosenberger, Diana Santos, Isabel Stout, and Oscar Viganó. In addition, we express our appreciation to the AIDSCAP LAC Resident Advisors: Catherine Brokenshire, Jamaica; Martha Butler de Lister, Dominican Republic; Eddy Génécé, Haiti; Gale Hall, Jamaica; Jorge Higuero Crespo, Honduras; and Maria Eugênia Lemos Fernandes, Brazil; and other AIDSCAP staff for their insights and contributions. We are grateful to Peter Lamptey, FHI Senior Vice President of AIDS Programs and Project Director of AIDSCAP, and Tony Schwarzwald, Deputy Project Director of AIDSCAP, for their continued support of LACRO activities.

Finally, we wish to extend our gratitude and appreciation to the USAID Global Bureau's HIV/AIDS Division, field Missions in Latin America and the Caribbean, and to the Population, Health and

Nutrition Team in the Office of Regional Sustainable Development of the LAC Bureau, particularly James B. Sitrick, Jr., for the support and funding of the Information Dissemination Initiative and other LACRO programs.

## PROLOGUE

The HIV/AIDS Prevention and Control SYNOPSIS Series is a summary of the lessons learned by the Latin America and Caribbean Regional Office (LACRO) of the AIDS Control and Prevention (AIDSCAP) Project. AIDSCAP is implemented by Family Health International (FHI) and funded by the United States Agency for International Development (USAID). The series is a program activity of the LACRO Information Dissemination Initiative and was created with several goals in mind:

- to highlight the lessons learned regarding program design, implementation, management and evaluation based on five years of HIV/AIDS prevention and control experience in LAC countries
- to serve as a brief theoretical and practical reference regarding prevention interventions for HIV/AIDS and other sexually transmitted infections (STIs) for program managers, government officials and community leaders, non-governmental organizations (NGOs), private voluntary organizations (PVOs), policy and decision makers, opinion leaders, and members of the donor community
- to provide expert information and guidance regarding current technical strategies and best practices, including a discussion of other critical issues surrounding HIV/AIDS/STI programming
- to share lessons learned within the region for adaptation or replication in other countries or regions
- to advance new technical strategies that must be taken into consideration in order to design and implement more effective prevention and control interventions
- to advocate a holistic and multidimensional approach to HIV/AIDS prevention and control as the only way to effectively stem the tide and impact of the pandemic

AIDSCAP (1991-1997) was originally designed to apply the lessons learned from previous successful small-scale prevention projects (1987-1991) to develop comprehensive programs to reduce the sexual transmission of HIV, the primary mode of transmission of the virus. AIDSCAP applied three primary strategies — Behavior Change Communication (BCC), STD Prevention and Control, and Condom Programming — along with supporting strategies of Behavioral Research, Policy Development and Evaluation.

The success of this approach, based on the combination of strategies and targeted interventions, has been widely documented. The AIDSCAP Project, in fact, has been recognized as among the best and most powerful international HIV/AIDS prevention programs to date.<sup>1</sup> AIDSCAP has worked with over 500 NGOs, government agencies, community groups and universities in more than 40 countries; trained more than 180,000 people; produced and disseminated some 5.8 million printed materials, videos, dramas, television and radio programs, and advertisements; reached almost 19 million people; and distributed more than 254 million condoms.<sup>2</sup>

However, the pandemic continues to escalate at a rate that outpaces our successes. Thus, we need to build upon these successes, learn from our experiences, and determine what has worked and what is missing in order to respond with added effect in the future. The magnitude and severity of the HIV/AIDS pandemic calls for boldness, flexibility, wisdom and openness. The world cannot afford to continue to fight HIV/AIDS only with current thinking and tools. We must look toward new thinking and strategies that complement and carry the current state-of-the-art approaches forward in the fight against HIV infection.

Therefore, LACRO endorses, promotes and elevates *Gender Sensitive Initiatives* (GSIs), *Civil-Military Collaboration* (CMC), *Religious-Based Initiatives* (RBIs), and *Care & Management* (C&M) as the new prototype of technical strategies that must be incorporated on par with the strategies that have been implemented to date. Walls, barriers and biases have to come down in

order to unlock the strengths, benefits, potential, synergy and/or resources of GSIs, CMC, RBIs and C&M.

More importantly, approaches that compartmentalize strategies can no longer be justified. Despite the efforts to integrate and coordinate amongst and between technical strategies and different sectors of society, prevention programming is barely scratching the surface of what a real comprehensive effort should be. One of the most important lessons learned about HIV/AIDS is that it is not only a medical problem, nor is it exclusively a public health problem. Rather, the pandemic is in addition a socioeconomic problem and, as such, threatens the sustainable development of developing countries and challenges the ethical foundations of the developed world. HIV/AIDS has become a challenge to health, development and humanity.

For lasting success, a genuine multidimensional approach is urgently needed. One that demands new forms of wealth distribution, educational opportunities and development; attempts to resolve the inequalities in gender and power; acknowledges the individual, environmental, structural and superstructural causes of and solutions for the pandemic; and aims to balance the disparity between the “haves” and the “have-nots,” resulting in more sustainable, equitable, effective and compassionate efforts.

Therefore, the SYNOPSIS Series reaffirms that current HIV/AIDS prevention and control strategies work, and contends that new technical strategies are needed and can be effective and complementary. The Series also strongly advocates for, and will discuss in a separate issue, the Multidimensional Model (MM) for the prevention and control of the pandemic. This model must guide national, regional and international planning and programming in order to achieve measurable and significant gains that can truly effect changes at the individual, societal, environmental and structural levels.

We trust the reader will be open to our futuristic thinking and will contribute to the further development of the strategies presented here as well as others. We hope the SYNOPSIS Series will

stimulate discussion and reflection, propel continued dialogue, and encourage the pioneering of new combinations of innovative approaches.

A handwritten signature in black ink, reading "R Calderón", with a long horizontal line underneath.

*M. Ricardo Calderón, MD, MPH, FPMER.*  
Regional Director  
Latin America and Caribbean Regional Office  
AIDSCAP/Family Health International

## HOLOGRAPHIC OVERVIEW:

This SYNOPSIS booklet discusses the importance of Gender-Sensitive Initiatives (GSIs) through a holographic approach. Holography is a special photographic technique that produces images of three dimensional objects. This photographic record is called a hologram, and one of its main applications is that any fragment of the hologram can regenerate the entire image, even if the fragment is extremely small. In other words, if a negative from an ordinary picture is cut into two, the print from each half would only show half of the picture. Conversely, if a holographic negative is cut in two, the print from each half would show the entire picture. If these halves are cut again, the print from any one of the pieces will reconstruct the whole picture.<sup>3,4,5</sup>

Utilizing the holographic model, this booklet was written such that any one of the sections (holograms) will provide the reader with an understanding of the whole subject matter. First, we describe the entire strategy or topic of discussion in one sentence, the widespread definition and/or our own definition of the subject (Hologram 1). Next, we present a one-paragraph abstract of the topic (Hologram 2), expanding upon the original definition. Then, we present the topic by providing a summary or recapitulation of the main points of each of the sections of the booklet (Hologram 3). Finally, the entire strategy is again presented by virtue of the complete text of the booklet (Hologram 4).

We anticipate that the Holographic Overview of Gender-Sensitive Initiatives will benefit both the seasoned professional and the novice. It provides a quick, general overview of GSIs as well as context and background. It also directs the reader to specific sections that may be of greatest interest or that the reader would like to review first or at a later date. Thus, we hope this approach will enable the reader to make fuller use of the booklet as a reference guide, as it provides a simple and concise definition of GSIs, a brief description of the topic, a summary of the discussion, and finally, the complete text — all in one document.

The reader should note that while we have tried to include the key issues surrounding GSIs in this SYNOPSIS, the booklet is not meant as an exhaustive discussion of all of the issues regarding the critical role of gender-sensitive strategies in the fight against HIV/AIDS.

---

## **The Whole Strategy**

### *Hologram 1: The Definition*

---

Gender-Sensitive Initiatives in HIV/AIDS refers to a strategy of actions planned and implemented from the perspectives and needs of men and women that address the imbalance in power in their relationship, benefit them equally and contribute holistically to their full potential and well-being.

---

## **The Whole Strategy**

### *Hologram 2: The Abstract*

---

An understanding of gender must be an integral part of every HIV/AIDS project, from conception to implementation. The key to introducing and institutionalizing a gender-sensitive perspective in HIV/AIDS programs and projects is to train top-level management, provide the resources and support for training staff and point people in field offices, and then monitor and evaluate all activities for gender sensitivity. HIV/AIDS initiatives should target both men and women and focus on improving communication between couples in order to support sustained behavior change to prevent the transmission of HIV and other sexually transmitted diseases (STDs). Men should be addressed not just as sexual beings but as fathers, husbands and members of the community and must be encouraged to work in partnership with women for the prevention and control of the epidemic. HIV/AIDS programming should collaborate with women's groups, especially those that focus on health and development issues, to help empower women and promote a more integrated approach to prevention. Ultimately, HIV/AIDS programs can most effectively help fight the epidemic by educating people at

all levels that gender-sensitive initiatives are a key component to changing minds and behaviors in relation to HIV/AIDS.

---

## **The Whole Strategy**

### *Hologram 3: The Summary*

---

#### **Introduction**

Since 1994, 90 percent of newly infected persons have acquired HIV through heterosexual contact, and between 1990 and 1995, the percentage of infected individuals who were women rose from 25 to 45 percent. It has been well established that women are *more* vulnerable to HIV infection than men because of biological, social, cultural and economic factors. Worldwide, epidemiologists predict the number of women with HIV/AIDS will equal or surpass the number of men by the year 2000. Although there has been a significant increase in awareness of HIV/AIDS in Latin America and the Caribbean (LAC), there is still a lack of knowledge about transmission of the disease and the synergistic relationship between STDs and HIV. Furthermore, myths, unsafe practices and low self-perception of risk persist. Lack of accessibility to health care, especially in rural areas, compounds the vulnerability of women and men to STDs and HIV/AIDS. Moreover, there has been virtual neglect of the gender dimensions in treating STDs. Culturally, women in both developed and developing countries suffer from a lack of empowerment in their relationships that prevents them from negotiating safer sex with their partners. However, poverty is perhaps the most significant factor that puts women in grave risk of contracting HIV/AIDS.

#### **Increasing the Focus on Gender: A Worldwide Trend**

The international community officially acknowledged women were increasingly becoming infected with HIV in 1990 when World AIDS Day focused on women for the first time. The international grassroots women's health movement laid the groundwork for the creation of a new international agenda that looked at population and health based on the concepts of women's health, rights and empowerment, including men's roles and responsibilities in conception, childbearing and childrearing. In 1994 at the

Cairo International Conference on Population and Development, a Platform of Action was adopted by 130 countries making note of the gender dimension of HIV/AIDS prevention. A year later, the Platform for Action of the Fourth World Conference on Women in Beijing promoted gender-sensitive HIV/AIDS/STD and reproductive health initiatives. Further development of a gender-informed perspective continued at the XI International Conference on AIDS in Vancouver in 1996, in a satellite meeting called “A Dialogue Between the Sexes.” However, a recurring refrain in development circles is that gender is often discussed but seldom applied. Experts believe there is relatively little specific gender planning experience in the population, planning and nutrition sector, and, particularly, in HIV/AIDS. International organizations have begun to define a more gender-sensitive approach to prevention based on a deeper understanding of the economic, legal and social factors that fuel the epidemic.

### **Gender-Sensitive Initiatives: A Technical Strategy**

The swift rise in HIV prevalence and AIDS cases among women is a dramatic indication that gender is a critical cornerstone in prevention and control efforts. As it became evident that the recognized technical strategies for preventing HIV/AIDS had not integrated gender, AIDSCAP began the process of incorporating a gender perspective throughout its programs. This meant a strong institutional commitment to incorporate gender, both within its own operational organization as well as other HIV/AIDS prevention collaborating agencies, at every level — from policy makers within governmental and non-governmental organizations to program implementers within communities. The focus in AIDSCAP on women and men from a gender perspective, therefore, is intended to address the imbalance in power in the relationship and to initiate actions that contribute holistically to the full potential of both. With that goal in mind, AIDSCAP developed five technical components of GSIs — *top-level management training, dialogue, research, gender advocacy and evaluation*— that could effectively insert gender into HIV/AIDS interventions as a key technical strategy.

## Key Components to Successful GSIs

The GSI strategy comprises five essential components to institutionalize gender in HIV/AIDS prevention programs. Component One, **Top-level-Management**, targets men and women at the highest leadership levels who shape the orientation of policies and programs and determine the extent to which these incorporate gender issues. Component Two, **Dialogue**, represents a process or tool designed to give women and men the gender awareness and skills they need to communicate openly and honestly about sex and other issues that affect their sexual health, at the interpersonal, community and policy levels. Component Three, **Research**, includes women in the design and development of research as well as in the dissemination of results. Because “gender” is about men and women — not solely women — increased attention has been called to a research agenda that includes men’s sexual behavior, their power in relationships with female partners, and their roles as members of the family and community. Component Four, **Gender Advocacy**, augments the number and nature of programs that reach men to include them in its present activities, and extends its efforts to be responsive to the welfare, strategic empowerment and policy needs of both women and men. Finally, in order to fully integrate and orient HIV/AIDS prevention with and from a gender perspective, **Evaluation**, Component Five, is essential to the GSI strategy. Evaluation is needed to measure the progress and results related to the integration of gender issues.

## Lessons learned

The introduction of gender and GSIs is weakened when seen as a separate concern from the overall policy, program or strategy of HIV/AIDS prevention. Gender is a technical strategy that can and should be measured and integrated in the planning as well as in the implementation of prevention efforts. With training of top-level management, gender and GSIs are more rapidly institutionalized throughout the entire system. Dialogue is a process more easily operationalized than negotiation, and is adaptable to different populations, settings and situations. Men are not “add-ons” or “buy-ins” in the efforts to institutionalize changes in sexual behaviors, nor can they be “involved” by women. They are often will-

ing partners and advocates that must be treated as such in all GSIs. Research, particularly operations research, begins with women, men and their issues, and this should be a high priority in HIV/AIDS prevention. Group peer support for introduction of GSIs may achieve greater impact than primarily individualized approaches.

### **Recommendations**

Human, physical and economic resources for GSIs should be available and balanced with the other technical strategies. Research and development of women-initiated protective methods is needed. Programs should work together to make the female condom more available and affordable to women and men in developing countries. Interventions should focus on improving understanding and communication between men and women. Additional operations research should be conducted to explore the use of dialogue for improving sexual communication between men and women and promoting HIV risk reduction. Prevention efforts should be continually examined and expanded to include new populations at risk. Gender should become an explicit policy of any organization and GSIs should be integrated into all central headquarters and field actions. Organizations should collaborate with women's groups, particularly those that address other health and development issues, to empower women and promote a more integrated approach to prevention. Finally, empowerment of women should involve their appointment to senior positions available in organizations implementing health, development and HIV/AIDS programs.

# The Whole Strategy

## Hologram 4: *The Detailed Description*

---

### INTRODUCTION

Women have had quite unique but similar experiences with HIV/AIDS. Consider these three stories from women who contracted HIV/AIDS:

Margarida, 34, nanny:

“I moved to Rio de Janeiro 10 years ago and started working as a nanny. I am from a little village in Bahia. There, things are different. I never had to worry about AIDS or getting sick from sex. Then, six years ago, I met Antonio. For a long time we did not go to bed together. He was the only man I had sex with, yet I am infected.”

Wangoi, secretary and housewife:

“I did not know anything about AIDS. I had never paid any attention to the campaigns on condoms — after all, how could it affect me? I thought that condoms were only for women who had many sexual partners. It did affect me: I now have AIDS.”

Karen, student:

“What really hurts me about having AIDS is the fact that I had very few boyfriends and that I never behaved wildly. I’ve studied hard to get where I am, so that I would have a good, secure future. I had just one boyfriend and caught this disease. It seems as if it was God’s punishment.”

Margarida, Wangoi and Karen have life stories that are reflected by millions of women throughout the world today. These are women married or involved in what they think are monogamous and safe relationships. They do not have numerous sexual partners; they are not intravenous drug users. They may not know about the protective value of condoms or be empowered to insist that their partners use them. Even if they are aware condoms help prevent sexually transmitted diseases, the fact that they are in committed relationships makes using them seem pointless. Perhaps, like Margarida, they are poor and have little access to adequate health care; or, like Wangoi, they have been married and faithful to one partner for years and did not think they were at high risk of getting HIV/AIDS. Perhaps their story is like Karen's, the story of a young woman excited about her future, but who did not comprehend the necessity of consistent sexual protection. And now these "typical" women are among the burgeoning number of AIDS cases in which transmission has occurred through heterosexual contact.

The purposes of this SYNOPSIS booklet are to promote gender-sensitive initiatives (GSIs) as a technical strategy in HIV/AIDS prevention and control and to focus on the development of gender strategies in Latin America and Caribbean (LAC) countries, with reference to similar developments in Africa and Asia.

The first section of this booklet looks at the shift of the pandemic to women, both globally and specifically in LAC. The second explores the increasing worldwide focus on gender and includes a summary of the international conferences in Cairo, Beijing and Vancouver that led to the formation of a gender-sensitive approach to HIV/AIDS prevention in some countries and greatly strengthened activities in others. The next section examines the implementation of GSIs as a technical strategy and its key components — top level-management training, dialogue, research, gender advocacy and coalition-building. Following this framework, the process of incorporating gender into the project activities of the LAC country programs is described, along with specific examples from the region. The booklet concludes with lessons learned of the critical importance of including gender-sensitive initiatives

in the fight against the AIDS pandemic and makes recommendations for future programs.

### **The Shifting Pandemic**

When HIV/AIDS began to spread worldwide in the early 1980s, it was initially viewed by many as a disease that only affected homosexual men and people who engaged in such high-risk behavior as injecting drug use and commercial sex work. But then the pandemic began to shift. Transmission of HIV/AIDS through heterosexual contact became rampant in Africa and parts of Asia. As of June 1996, there were an estimated 21.8 million adults and children living with HIV/AIDS worldwide. Of these, an estimated 1.3 million are in Latin America and the Caribbean. Since 1994, 90 percent of newly infected persons acquired HIV through heterosexual contact.<sup>6</sup> Furthermore, between 1990 and 1995, the percentage of infected persons who were women rose from 25 to 45 percent.

The Latin America and Caribbean region has a disproportionate number of the world's HIV-infected people; with only 8.4 percent of the global population, the region has an estimated 11 percent of the HIV-infected population and 13 percent of cumulative AIDS cases. The World Health Organization (WHO) estimates by the turn of this century, there will be 30 million people infected by HIV with a major shift toward greater infection among women.<sup>7</sup>

The dominant modes of transmission vary from one country to the next, ranging from some epidemics that are predominantly related to homosexual and/or bisexual behavior to epidemics connected to injecting drug use and to others that are primarily attributed to heterosexual transmission.

But it is clear that throughout Latin America and the Caribbean, the heterosexual transmission of HIV/AIDS is growing, placing both sexually active women and their children at risk. Recent epidemiological studies of the region document this shift in the pandemic:

- One of every three people infected with HIV in Latin America is a woman, up from 1 in 40 in the early 1980s, according to world health officials who met in Rio de Janeiro in November 1997.
- During the past decade, the male to female ratio of reported AIDS cases in Latin America and the Latin Caribbean has steadily declined from 35.6:1 (1984) to 3.2:1, with some countries, such as Haiti, reporting a ratio as low as 1.7:1.
- In Central America, more than 64 percent of all reported AIDS cases are related specifically to heterosexual transmission. Honduras accounts for more than 46 percent of the AIDS cases in this subregion. By early 1990, sentinel surveillance indicated the prevalence of HIV infection among pregnant women in San Pedro Sula was between 2.5 and 3.6 percent.
- In Guatemala, a country in the early stages of the epidemic, HIV prevalence is higher in women than men for the 15 to 19 year-old age group.
- In the Dominican Republic, heterosexual transmission is responsible for more than 70 percent of the total number of reported AIDS cases to date. The male to female ratio has declined from 7:1 to 2.5:1 in the last eight years.
- Brazil reported 110,845 AIDS cases as of September 1997. Currently, AIDS is the leading cause of death among women ages 20-34 in the state of São Paulo.

With increasing numbers of women becoming infected with HIV, the male to female ratio of reported AIDS cases is expected to continue to narrow. Worldwide, epidemiologists predict the number of women with HIV/AIDS will equal or surpass the number of men by the year 2000. The change in the male to female ratio in the LAC region alone indicates the HIV/AIDS pandemic has spread to the general population and poses a grave threat to the well-being of families, communities and countries as a whole.

As the HIV/AIDS pandemic shifted to the general population, it has moved to the two groups who are traditionally the most vulnerable to infectious diseases in the developing world: women and children.

### **Susceptibility of Women to HIV/AIDS**

As the HIV/AIDS pandemic shifted to the general population, it has moved to the two groups who are traditionally the most vulnerable to infectious diseases in the developing world: women and children. In the United States, the shift is seen most clearly to be moving from middle-class, upper-income gay white males to minority populations, people already the most vulnerable to disease.

“The evolution of AIDS in the USA should be a warning sign for the rest of the world,” said M. Ricardo Calderón, Regional Director of AIDSCAP’s Latin America and Caribbean Regional Office

(LACRO) during an AIDSCAP in-service presentation, “The Shift of the Pandemic to Women in Latin America and the Caribbean,” organized by the AIDSCAP Women’s Initiative (AWI). “The serious lesson learned is that HIV/AIDS takes hold of communities that are twice as vulnerable due to their socioeconomic disadvantage and their lack of information.”

“A woman’s reliance on monogamy as an effective means of preventing HIV/STD infection is incongruent with the behavior of men who are, in many societies, not expected to hold to a monogamous standard,” expressed Dr. Calderón. An additional factor that puts many women in the region at greater risk is the Latin attitude toward bisexuality. Since most men in the region do not consider bisexual behavior to be homosexuality, but rather a manifestation of machismo, bisexual men tend to deny they are at risk for HIV/AIDS. They perceive themselves to be heterosexu-

It has been well established that women are more vulnerable to HIV infection than men because of biological, social, cultural and economic factors.

al and, therefore, think they are safe. In addition, the early sexual experimentation that young men in the region go through as part of their socialization, such as sexual initiation with commercial sex workers (CSWs), puts women partners at higher risk.

Although there has been a significant increase in awareness of HIV/AIDS in LAC, there is still a lack of knowledge about transmission of the disease, particularly that it can be passed by asymptomatic individuals. Likewise, there is only limited knowledge of STDs and their relationship to HIV. “Although awareness of HIV/AIDS is over 80 percent in many countries, there are still many misconceptions regarding the transmission of HIV through casual contact,” reports “The Status and Trends of the Global HIV/AIDS Pandemic.” Even in populations with high levels of knowledge of HIV/AIDS, myths, unsafe practices and low self-perception of risk persist. Lack of accessibility to health care, especially in rural areas, compounds the vulnerability of women and men to STDs and HIV/AIDS.<sup>8</sup>

In populations where STD interventions have been introduced, they have generally targeted symptomatic women and men, men and women with multiple partners, men who have sex with men (MWM), and CSWs. These interventions, however, have largely ignored the majority of monogamous women and the large number of men who seek treatment from health care providers, traditional healers and/or local pharmacies. Furthermore, there has been virtual neglect of the gender dimensions in treating STDs.

Culturally, women in both developed and developing countries suffer from a lack of empowerment in their relationships that prevents them from negotiating safer sex with their partners. But poverty is perhaps the most significant factor that puts women in grave risk of contracting HIV/AIDS. Even in the United States, one of the wealthiest countries in the world, the majority of

Culturally, women in both developed and developing countries suffer from a lack of empowerment in their relationships that prevents them from negotiating safer sex with their partners. But poverty is perhaps the most significant factor that puts women in grave risk of contracting HIV/AIDS.

women diagnosed with HIV/AIDS are predominantly poor, African American or Hispanic. Of the almost 72,000 U.S. women diagnosed with AIDS in 1995, 75 percent were poor women of color.<sup>8</sup>

Often these women fall prey to alcohol, drugs and the commercial sex industry in their efforts to survive and are, thus, pulled more deeply into high risk behaviors that can lead to STDs and HIV/AIDS. The percentage of women living in poverty is greater in the developing countries of Latin America and the Caribbean than in the United States. These women often have no choice in avoiding situations and behaviors that put them at a higher risk for HIV/AIDS/STDs.



## INCREASING THE FOCUS ON GENDER: A WORLDWIDE TREND

### Women Taking Action

The international community did not officially acknowledge the fact that women were increasingly becoming infected with HIV until 1990 when World AIDS Day focused on women for the first time. The gradual awareness of the threat of HIV/AIDS to women and children began to first take shape in the global women's health movement, which demanded new approaches and a more realistic understanding of the health problems, issues and concerns facing women worldwide.

According to Elizabeth Reid, former Director of the HIV and Development Programme of the United Nations Development Program, the international grassroots women's health movement laid the groundwork for the creation of a new international agenda. It looked at population and health from a broader perspective, "founded on the concepts of women's health, rights and empowerment and by men's roles and responsibilities in conception, childbearing and childrearing."<sup>9</sup>

With their inclusive and communal approach, grassroots activists have "introduced an ethics of caring and compassion rather than individualism into the dialogue on population and health issues," stated Reid. Before the women involved in these grassroots organizations arrived in Cairo in 1994 for the International Conference on Population and Development (ICPD), they had already moved beyond their immediate communities to influence national preparations, revised texts of conference papers and lobbied at preparatory meetings. "No other social constituency or coalition has so influenced the discourse, the analysis or the strategies of a global initiative," noted Reid.

At Cairo, women began to reshape the entire dialogue about population. "It could have been a conference just on population change and growth," recalls Dr. E. Maxine Ankrah, Associate Director of the Family Health International/AIDSCAP Women's

Initiative, “but women forced a broader dialogue, and included the issue of reproductive health on the agenda.”<sup>10</sup> By the time the 1994 ICPD meeting in Cairo came to a close, the Programme of Action was adopted by 130 countries and made note of the gender dimension of HIV/AIDS prevention.

The major obstacles to safer sex are the social vulnerability of women and the unequal power relationships between men and women, thereby resulting in women’s lack of power to insist on safe and responsible sexual practices.

A year later, the Platform for Action of the Fourth World Conference on Women in Beijing included a three-page section on HIV/AIDS, calling for full attention to the “promotion of mutually respectful and equitable gender relations.” The HIV/AIDS section identified the major obstacles to safer sex to be the social vulnerability of women and the unequal power relationships between men and women, thereby resulting in women’s lack of power to insist on safe and responsible sexual practices. Moreover, the platform called for gender-sensitive initiatives that address sexually transmitted diseases, HIV/AIDS, and sexual and reproductive health issues.

Further development of a gender-informed perspective continued at the XI International Conference on AIDS in Vancouver in 1996, where AIDSCAP/AWI held a one-day satellite meeting called “A Dialogue Between the Sexes.” The purposes of the meeting were to foster constructive dialogue between men and women about gender and to provide a forum where men and women could openly confront issues of sexuality and target directions towards power and change.

Women cannot succeed in preventing HIV/AIDS without men's cooperation, and vice versa.

It is necessary to focus on both men and women in relationship to one another, rather than as separate social segments, in HIV/AIDS prevention programs.

One of the most significant results of all these conferences was the enhanced attention and support given to the inclusion of gender as a critical component of any HIV/AIDS prevention project. It became clear that women cannot succeed in preventing HIV/AIDS without men's cooperation, and vice versa. The meetings helped cement the consensus that it is necessary to focus on both men and women in relationship to one another, rather than as separate social segments, in HIV/AIDS prevention programs.

Despite increasing awareness of the critical role that gender plays in HIV/AIDS prevention, the gender-informed approach is not widely

accepted. A "recurring refrain in development circles is that gender is often discussed but seldom applied," according to Susan Pfannenschmidt and Arlene McKay in "Through a Gender Lens." They note that the population, health and nutrition sector "faces a great challenge because addressing gender is invariably complicated and difficult, and to date, there is relatively little specific gender planning experience in our sector." For the HIV/AIDS sector, the challenge is even greater, the authors conclude. "Nowhere . . . are the consequences of gender inequity more vividly illustrated than in the area of HIV/AIDS prevention," continue Pfannenschmidt and McKay. "Because social structures circumscribe the choices people make, eradicating HIV/AIDS requires the elimination of the barriers that deny women control over their own sexual decisions."<sup>11</sup>

### **New Directions within AIDSCAP**

During the past six years, AIDSCAP and other international organizations have begun to define a more gender-sensitive approach to prevention that addresses some of the root causes of the rapid spread of HIV among women. Based on a deeper understanding of the economic, legal and social factors that fuel the epidemic, the gender-sensitive approach aims to:

- educate policymakers about the deadly consequences of gender inequities
- empower women to protect themselves from unwanted and unprotected sex
- develop and test prevention methods women can initiate and control
- improve communication between the sexes
- give boys and girls positive models of mutually supportive relationships between women and men

The reach and scope of the activities and interventions described in this SYNOPSIS reflect the success of AIDSCAP's efforts to institutionalize a gender perspective in its own programs and those of its partners. Through its Women's Initiative, established in 1994 with support from USAID's Office of Women in Development and the HIV/AIDS Division, AIDSCAP expanded a number of existing interventions to address broader issues of gender inequality and women's social and economic empowerment, and developed dozens of new projects and activities.

With the creation of the Women's Initiative, AIDSCAP staff and their partners were challenged to take a critical look at their projects and programs to ensure they addressed the needs of women. The results ranged from the development of regional and national gender and HIV/AIDS strategies to the incorporation of some seemingly small, but critical design features.

## **GENDER-SENSITIVE INITIATIVES: A TECHNICAL STRATEGY**

As it became evident that the recognized technical strategies for preventing HIV/AIDS, i.e., the treatment of STDs, behavior change communication (BCC) and condom social marketing, had not integrated gender as a critical cornerstone of HIV/AIDS interventions, AIDSCAP began the process of incorporating a gender perspective throughout its programs. This meant a strong institutional commitment to incorporate gender, both within its own operational organization as well as other HIV/AIDS prevention collaborating agencies, at every level — from policymakers within governmental and non-governmental organizations to program implementers within communities. With that goal in mind, AIDSCAP developed five technical components that could effectively insert gender into HIV/AIDS interventions as a key technical component.

### **Sex and Gender**

The swift rise in HIV prevalence and AIDS cases among women is a dramatic indication that gender is a critical, though neglected issue, in prevention efforts. While “sex” denotes biological differences, “gender” concerns the differing attributes attached to being “male” or “female.” Gender roles are ascribed to the social and cultural context through the socialization process. Universally, females are assigned by society to a subordinate position to males. This becomes a disadvantage to women with respect to the distribution of power and with implications for increased vulnerability of women to HIV/AIDS.

### **Gender-Sensitive Initiatives**

The focus in AIDSCAP on women and men from a gender perspective, therefore, is intended to address the imbalance in power in the relationship and to initiate actions that contribute holistically to the full potential of both. This situation suggests the need for approaches that are highly sensitive to gender. These are referred to here as gender sensitive initiatives.

A GSI more precisely refers to a strategy of actions planned and implemented from the perspectives and needs of men and

A GSI implicitly and explicitly is concerned with empowerment through processes that facilitate a protective relationship between men and women.

women with the aim of benefiting them equally. A GSI recognizes that women and men differ in some fundamental ways, psychologically as well as biologically. Effective and efficient responses must take these differences into account through policies and programs that address gender issues concretely.

Operationally, a GSI goes beyond increasing women's awareness about their vulnerability and how to access and negotiate the use of male condoms, or even how to meet survival needs. A

GSI implicitly and explicitly is concerned with empowerment through processes that facilitate a protective relationship between men and women. Thus, the AIDSCAP Women's Initiative has promoted the mainstreaming of a gender perspective throughout the AIDSCAP project and introduced GSIs as a technical strategy with several key components.

### **Background to Implementation in Latin America**

The efforts to develop and implement a regional gender strategy were far-reaching. After AIDSCAP established its Women's Initiative in 1994, LAC project staff reviewed activities in the region to determine how to reach a broader range of women and how to address the needs of both women and men. This new emphasis on gender sensitivity was soon reflected in the strategies, plans and activities of AIDSCAP programs in the region — and even in the language staff used to describe them.

To strengthen the capacity of HIV/AIDS programs in LAC to address the gender issues that make women as well as men so vulnerable to infection, AIDSCAP/LAC Resident Advisors and their colleagues from the region met in 1995, 1996 and 1997 to develop strategies that encompass training in gender analysis, research, and pilot interventions as well as to share lessons learned.

## KEY COMPONENTS TO SUCCESSFUL GSIS

The discussion below focuses on the five essential components currently believed to be the best mix to institutionalize gender in HIV/AIDS prevention programs. These are:

- Top-level Management Training
- Dialogue (communication)
- Research
- Gender Advocacy
- Evaluation

Each of the components are defined, and the AIDSCAP experience in using them (particularly in Latin America and the Caribbean, but with some reference to Africa and Asia) are discussed.

### **Component One: Top-level Management Training**

The first and fundamental component is training. Experience shows that the applications of gender are impossible without technical training. There is consequently a growing body of knowledge and specialists in this field. AIDSCAP has specifically given priority to targeting the top levels in organizations. The training of “top-level management” refers to the training of men and women at the highest levels of leadership in an organization. With respect to AIDSCAP’s HIV/AIDS prevention efforts, this category includes persons who influence policy, who design and monitor programs, and who oversee or provide resources for implementation. Top-level management is that level which ultimately shapes the orientation of policies and programs and determines the extent to which these incorporate gender issues.<sup>12</sup>

The training of “top-level management” refers to the training of men and women at the highest levels of leadership in an organization, that level which ultimately shapes the orientation of policies and programs and determines the extent to which these incorporate gender issues.<sup>12</sup>

Gender-sensitive training aims to equip top-level management with an understanding of gender differences and how these differences impact responses of women and men to their environment. The purpose of the training is to help managers learn the skills to integrate this understanding into the policies and programs of their organizations. In order for a gender perception to permeate institutional thinking and actions, gender must become an implicit consideration demonstrated explicitly in the design and implementation of HIV/AIDS prevention efforts. Lower-level staff require support from top-level management to operate from a gender-sensitive frame of reference and incorporate GSIs in their ongoing activities.

AIDSCAP first introduced top-level management gender training at a five-day session in Mombassa, Kenya, in October 1995. The targeted participants were top-level management who influence or make policies and who direct program planning and implementation. The training strategy followed a process of moving the analysis of HIV/AIDS-relevant gender issues from the personal to the social level and from the social to the institutional level. The results of this training session were later documented in the report, “A Transformation Process: Gender Training for Top-level Management of HIV/AIDS Prevention.”<sup>12</sup>

Gender training is a means of teaching individuals a process called gender analysis and how to use the resulting information to develop gender-sensitive initiatives.<sup>13</sup> “Gender analysis,” as defined by Pfannenschmidt and McKay, “is the systematic study of the differences in condition and position of women versus men in a

“Gender analysis is the systematic study of the differences in condition and position of women versus men in a given population.”<sup>13</sup>

given population. Gender analysis provides important contextual information that can be used as a community-based needs assessment to plan projects or to evaluate their progress or impact.” Such training and analysis have been at the heart of AIDSCAP’s efforts to orient programs in the Latin America and Caribbean region.

The Resident Advisors of the LAC countries met in May 1995 and again in August 1996 at AIDSCAP headquarters in Arlington, Virginia, to review gender issues and to plan a joint strategy for sharing the AIDSCAP experience with countries that were not previously included. As a result of these initial contacts, models for gender training, as well as interventions and research, were introduced. Priority was given to training of top-level management.

In January 1997, LACRO and AWI convened a one-and-a-half day gender training session for Resident Advisors and Program Officers from three priority countries: Brazil, the Dominican Republic and Honduras. This session was the second phase of the LAC Regional Gender and STD strategy. The first was the creation of high-impact STD research, intervention and policy pilot projects for implementation in the priority countries. The second phase, top-level management gender training, aimed to reinforce the gender perspective of the pilot projects through gender analysis skills-building.

In introducing the program, consultants with vast experience in the region presented a gender model to illustrate the importance of a multi-dimensional approach, which includes gender sensitization and awareness, gender analysis in programming, gender training, and the incorporation of institutional policies and their implementation throughout the organization. This gender training reinforced the commitment of AIDSCAP program managers to gender-sensitive programming. It also strengthened their capacity to plan,

implement and evaluate such programs as they began to make the transition from managing AIDSCAP programs to running their own indigenous NGOs working in HIV/AIDS prevention and control.

During the two-day workshop, "Gender and STDs: Challenges to Partners in the LAC Region," AIDSCAP staff had the opportunity to share what they had learned about integrating a gender perspective into HIV/AIDS programs with colleagues from other countries in the region. The twenty-five top level managers from six LAC countries discussed strategies for addressing gender issues in HIV/AIDS prevention and developed mechanisms for sharing their experiences in the future. Partnerships were formed between organizations in Brazil and Bolivia, Honduras and Nicaragua, the Dominican Republic and Brazil, and Honduras and the Dominican Republic, to ensure that AIDSCAP's strategy for gender and HIV/AIDS continues to influence prevention efforts throughout the LAC region.

The purpose of these activities was to strengthen the capacity of the LAC countries to develop and implement a gender-sensitive regional response to HIV/AIDS/STD prevention. The training provided senior managers with the knowledge and skills needed to facilitate the incorporation of gender into their on-going HIV/AIDS/STD prevention activities. Participants were challenged and trained to build their own gender perspective and awareness, apply gender concepts and tools to their HIV/AIDS/STD interventions, and incorporate gender considerations into institutional practices and policies.

As the LAC gender training was conducted relatively recently, the full impact of the training on programs in Latin America is not yet known. However, it is worthwhile to note that the top-level management training carried out by AIDSCAP in Africa in 1995 brought about national level impacts in some instances.

The AIDSCAP/Tanzania country team, for example, succeeded in training one man and one woman from each of the 18 NGOs in the Iringa region in leadership skills for gender-focused interventions. Heartened by its success in Iringa, the Tanzania team decided to replicate this effort in the national Tanzania AIDS Program using the cluster NGO structure. The experience showed that top-level management training could be replicated in other national HIV/AIDS programs and globally, if due attention is given to the context.

### **Component Two: Dialogue**

HIV/AIDS must be de-mystified by getting more people on board who are willing to talk openly about it. This is more than talking about sex. Women must talk about the impact of the epidemic on their lives, and men must also talk about HIV/AIDS. Then, together, they can talk about HIV/AIDS with the policymakers and say, “We must be involved in our protection from HIV/AIDS.” Dialogue has a versatility that negotiation per se does not.

The dialogue approach to communication between men and women holds great promise for stimulating and supporting sustained behavior change to prevent the transmission of HIV and other STDs.

#### *The Concept of Effective Dialogue*

In every culture people engage in some form of communication that can be described as dialogue. This is first defined as *talking about issues until a satisfactory level of understanding is achieved*. Especially in resource-poor settings, such communication is perhaps the most common and cost-effective approach to HIV prevention.

“Open dialogue among community members constitutes a powerful strategy that facilitates a focus on sexuality, condom use, gender and AIDS as a step toward protective behavior against HIV infection,” expressed Penina Ochola, AIDSCAP Resident Advisor, Tanzania, speaking at the Tanzania AIDSCAP Lessons Learned Forum (October 1997).

Dialogue is manifested in a variety of HIV/AIDS prevention efforts. However, it is not usually identified, organized or integrated as a central process or strategy. This way of communicating is perhaps so commonplace it is often overlooked entirely. Having no place in HIV/AIDS literature, and with a largely biomedical and technical approach to prevention, the body of research and programming necessary to give dialogue high visibility has not yet evolved. Nevertheless, dialogue remains the core of much human exchange within HIV/AIDS programs.

Dialogue is a process and tool designed to give men and women the gender awareness and skills needed to communicate openly and honestly about sex and other issues that affect sexual health at the interpersonal, community and policy levels.

How, then, is *dialogue* defined? This SYNOPSIS defines it secondly as a *process or tool*, depending on its use. As a process and tool, it is designed to give men and women the gender awareness and skills needed to communicate openly and honestly about sex and other issues that affect sexual health at the interpersonal, community and policy levels. Used as a component of the technical strategy of GSIs, dialogue helps women and men share information, challenge established values and practices, and bring about changes in their behaviors, belief structures, and environments. Activities are developed using this component with the overall HIV/AIDS prevention goal of reducing the risk of HIV infection in an effective and sustained manner.

### *Dialogue and Discussion*

As a literary term, *dialogue* is often used interchangeably with *discussion*. As a technical concept, however, there is a distinct difference in meaning. *Discussion* is used to examine a subject through discourse with the emphasis on the topic under consideration. By contrast, *dialogue* goes beyond the subject to a concern for people participating in the process, to a concern for “sharing their perceptions of a problem, offering and having their

Discussion is used to examine a subject through discourse with the emphasis on the topic under consideration. By contrast, dialogue goes beyond the subject to a concern for people participating in the process, to a concern for “sharing their perceptions of a problem, offering and having their opinions and ideas examined, and having the opportunity to make decisions or recommendations.”

opinions and ideas examined, and having the opportunity to make decisions or recommendations.”

This difference between discussion and dialogue, appearing at first to be insignificant, is actually an important contrast within the framework of HIV/AIDS prevention. The details of HIV transmission have often been highlighted in health education campaigns. Tragically, even though people are able to knowledgeably discuss HIV/AIDS in most regions, it has been documented that information alone fails to influence the behavioral changes necessary to halt the disease. Consequently, dialogue facilitates the integration of information into people’s everyday conduct for mutual protection and responsible actions. However, the potential for dialogue to be woven into the fabric of lives has only received the most marginal attention in HIV/AIDS prevention, research and programs.

### *Dialogue and Negotiation*

*Negotiation* refers to an effort to obtain agreement between partners to adopt safer protective sexual practices. Using *dialogue* to construct mutual understanding between sexual partners would improve the success of peer education, a tool already widely promoted. Dialogue is integral to both negotiation and peer education, and would promote the discussion of safer sexual practices as an exchange between equals. Because dialogue coupled with negotiation could empower all sexually active parties, it is a process of communicating that can strengthen other prevention strategies.

Dialogue, thus, holds exciting promise for dealing with political and personal topics, such as gender roles, fidelity, power, resource needs, changes in social norms, changes in policy, and changes in national programming.

### *Dialogue Initiatives*

To address the need to break down the barriers to dialogue in HIV/AIDS prevention, AIDSCAP organized a one-day satellite meeting, “A Dialogue Between the Sexes: Men, Women and AIDS,”<sup>13</sup> to encourage participants to identify and seek ways to overcome the obstacles that prevent direct discussion about the responsibilities of women and men in stemming the HIV/AIDS epidemic. “Long overdue,” was the enthusiastic response of representatives from 27 countries who helped field-test the methodology of this component at the Satellite Meeting at the XIth International Conference on AIDS in Vancouver. One woman noted that dialogue is “the only way that women can approach men in my culture. We cannot [make independent decisions about sex] with our men.”<sup>13</sup> After the meeting, groups from around the world requested assistance in obtaining models of the dialogue among policymakers, in communities and between couples. This request resulted in the development of a woman-friendly resource guide, *Dialogue: Expanding the Response to AIDS — A Resource Guide*.<sup>14</sup>

Dialogue can be successfully combined with other approaches to bring about behavior change. For example, in Port-au-Prince, Haiti, the Centre de Promotion des Femme Ouvri\_res (CPFO), used dialogue to get families and adolescent children talking about HIV/AIDS/STDs in a constructive manner. Dedicated to the improvement of the health and social conditions of poor women, CPFO has focused specifically on meeting the needs of women working in Haiti’s industrial and assembly sector. Between 1994 and 1996, CPFO organized five educational sessions that included women factory workers, their partners, and their teenage children to educate them about HIV/AIDS/STDs, while at the same time encouraging dialogue on prevention. These mixed sessions resulted in creating an open atmosphere where sexual partners, mothers, fathers and teenagers were able to share a basic understand-

ing of sexual risk and how STDs and HIV can effectively be avoided — without any of the adversarial tension so often typical of such encounters with reluctant partners when there has been no preparatory dialogue.

In Haiti, AIDSCAP worked with HIV/AIDS and women's organizations to ensure that gender concerns would be addressed in the country's future prevention strategies. In May 1995, a "Day of Reflection on Women" brought 30 representatives from 18 organizations together to develop consensus on goals and strategies for preventing the spread of HIV/AIDS among Haitian women.

This dialogue was continued during the final year of AIDSCAP's program in Haiti through a series of forums in four regions of the country organized by a coalition of 34 women's organizations. The recommendations of forum participants were reported to the new Haitian National AIDS Commission for incorporation into its five-year National Plan of Action.

In Rio de Janeiro, Brazil, a project designed to generate dialogue about HIV and STDs among women in the waiting room of a busy gynecological clinic was expanded to reach the men who were attending the STD clinics at the same health care center.

In the Dominican Republic, AIDSCAP worked with the government's department of women's affairs, the national STD control program and local NGOs to develop a strategy for preventing HIV and other STDs among young women. This strategy included a mass media campaign modeled after AIDSCAP's successful campaign for adolescents. Local and cable television stations began airing the public service announcements created for the campaign in May 1997 and continued to broadcast them after other AIDSCAP activities in the country ended.

Initiatives beyond the Latin American experience have shown that the "dialogue strategy" can be readily implemented in diverse ways. One example follows:

Most participants in the first operations research project to test the dialogue strategy — a series of facilitated sessions with truck drivers and their spouses (Jaipur, India, 1997) — reported the experience made them feel comfortable discussing sexual matters with their spouses and with friends. Many of the truck drivers said they had started to use condoms with their spouses for the first time. These encouraging results convinced the John D. and Catherine T. MacArthur Foundation to fund a two-year pilot intervention using the dialogue process with Indian truck drivers and their wives.

Whether applied in Latin America or in another region, these examples show that dialogue as an HIV/AIDS prevention component is an empowering approach adaptable to a variety of circumstances and environments. It is applicable at the individual and community levels as well as at the national or international levels. It can be successful whether it involves only two participants or a large group. The critical requirement to ensure effectiveness is that it must remain relevant to the needs and perspectives of men and women and benefit, in equal measures, both of the sexes.

### **Component Three: Research**

Research is a necessary but often neglected GSI component, particularly where women's issues are concerned. Much of the clinical research on HIV/AIDS has been conspicuous for the little attention given to the defining conditions of women. When women did become the focus of research, this was largely to answer questions related to their roles as mothers, CSWs and "core transmitters." <sup>11</sup> In 1993, when the epidemic was well established in many countries, particularly in Africa, certain gynecological complaints then became indicators of HIV infection.

Sensitivity to gender differences dictates a research agenda that gives priority to women's biological and social needs. Gender-sensitive research, the aim set by AWI, not only focuses on women — it includes them in the design and development as well as in the execution of the research. The results are also disseminated among women, since it is conducted to improve the quality of their lives. Because "gender" is about men and women — not

Sensitivity to gender differences dictates a research agenda that gives priority to women's biological and social needs, includes men's sexual behavior, their power in relationships with female partners, and their roles as members of the family and community.

solely women — increased attention has been called to a research agenda that includes men's sexual behavior, their power in relationships with female partners, and their roles as members of the family and community.

Research is the critical component in GSIs that is necessary for understanding how to effectively intervene from a gender perspective. Several studies were conducted in Latin America with this goal in mind and are described below.

One of the most significant of the AWI projects was the intervention research concerned with the adoption of the female condom in two countries, Kenya and Brazil.<sup>15, 16, 17</sup> Using an innovative approach, this exploratory study examined the perceptions, responses, and

sustained use of the female condom when introduced into the partner relationship as a method of HIV/AIDS prevention and contraception. In this data collection spanning a period of over three months, 100 Kenyan and 103 Brazilian women respondents accepted and continually used the female condoms. They were given individual initial and exit interviews and participated in focus-group discussions. The intervention component of the research consisted of two sessions called "peer-support group discussions." In these, the women shared experiences related to the use and impact of the female condom on the partner relationship. Forty-six and 28 male partners were recruited for focus-group discussions in Kenya and Brazil, respectively.

Overall, the women were positive about the female condom; 75 percent liked the device very much and nearly half of the women preferred it to the male condom. Of the male partners, almost 77 percent liked it. The women viewed it as an option when the male partner refused to use the male condom, an option for

women who have frequent changes of partners, and an option for persons in extramarital relationships. Many women in both sites reported being “empowered” by the female condom in their relationship with their male partner. The peer-support group sessions appeared to have had an important influence on women’s acceptance of the female condom and its continued use.

AIDSCAP undertook a number of other studies related to addressing and increasing the attention to gender issues. In the Dominican Republic, a knowledge, attitude, belief and practice

Research has revealed that while women had a high level of knowledge of basic facts regarding HIV/AIDS, they lagged behind men in information about STDs and in awareness of how to access services for treatment. This negatively affected decision making in relation to their sexual lives and contributed to their risk of contracting STDs and HIV/AIDS.

(KABP) survey was conducted with college students. Given that many students will become future professionals and leaders in their communities, AIDSCAP’s country office targeted this population for research on the level of HIV/AIDS/STD prevention and education provided by their institutions. To assess the needs of students, the study sought to determine their knowledge, beliefs, attitudes, practices, risk perceptions, ability to negotiate safer sex as well as skills and the most effective channels for reaching the students.

The results of the research revealed that while women had a high level of knowledge of basic facts regarding HIV/AIDS, they lagged behind men in information about STDs and in awareness of how to access services for treatment. This negatively affected decision making in relation to their sexual lives and contributed to their risk of contracting STDs and HIV/AIDS. These findings, buttressed by gender analysis, led the project directors to conclude that condoms should be sold to both men and women, college students

should be advised about STDs irrespective of their gender, and equal treatment should be given to patients of both sexes.

Also in the Dominican Republic, during 1995-1996, the AIDSCAP country office conducted a study to identify barriers to adopting safer sexual practices among female adolescents, ages 15-24, from squatter settlements in Santo Domingo. Focus-group discussions conducted with young women were held to determine the influence of gender on their sexual roles and the inability to insist on safer sex practices. The research also attempted to identify the information needed to influence change in their sexual behavior.

The research from the squatter settlements showed that perception of sexual roles varied according to age and social condition. The majority of young women interviewed preferred older and more experienced health promoters. They also preferred education in small groups without the presence of males. Results of the study were used to improve educational strategies for youth programs and to develop the Dominican Republic strategy for HIV/AIDS/STD prevention for young women.

#### **Component Four: Gender Advocacy**

AIDSCAP has begun to move in two directions in its attempt to advance gender advocacy, mainly as a major component of its GSI strategy. AIDSCAP has augmented the number and nature of programs that reach men to include them in its present gender-sensitive activities. In addition, AIDSCAP has extended its efforts to be responsive to the welfare, strategic empowerment and policy needs of both women and men.

#### ***Men in Partnership for Prevention (MIPP)***

Although it is critical to empower women so they are better able to protect themselves from HIV, prevention interventions for women must also address men's behavior and communication between the sexes. Research data from around the world consistently demonstrate that many women's risk of contracting HIV stems from their partners' unsafe behavior, not their own.

“Because men in most cultures dominate decision making and have greater independent control over sexual relations it is imperative that efforts to respond to the epidemic and promote behavior change place greater emphasis on men.”<sup>18</sup>

In developing countries, where 90 percent of HIV infections occur, current public policies and family planning programs often focus exclusively on educating women and rarely incorporate what men think, say, feel, can or should do. “Because men in most cultures dominate decision making and have greater independent control over sexual relations,” wrote Kathryn Carovano for the United Nations Development Programme,<sup>18</sup> “it is imperative that efforts to respond to the epidemic and promote behavior change place greater emphasis on men.”

In some instances, gender-sensitive HIV/AIDS prevention projects targeted to women can be modified to include men in the program as well. In Rio de Janeiro, Brazil, the Grupo Pela Vidua conducted an HIV/STD prevention project for women attending the Catete Health Care Center. It was based on a “waiting room” intervention. During the one-hour period the patients waited to see the physician, Grupo Pela Vidua volunteers began discussions on HIV/STD prevention. The women reported having great difficulties in negotiating safer sex practices because men have minimal awareness of HIV/STD and because of the strong machismo culture. As the organization realized the urgent need to address the increasingly heterosexual transmission of the disease, it decided to expand the “waiting room” intervention concept to men as well. The result was that the project conducted safer sex workshops for 410 people in clinic waiting rooms, reaching 261 women and 149 males.

Another example of involving men in the HIV/AIDS programs was carried out in Jamaica by a group called VIBES, in which young men and women between the ages of 8 and 19 acted out allegorical themes related to HIV/AIDS. Among the messages delivered by the actors was: “Don’t feel pressured to engage in sexual relations until you’re ready; if you’re sexually active, use a condom.”

In the Dominican Republic, the AIDSCAP country office included male university students in the research project on HIV/AIDS/STD knowledge, beliefs, attitudes, and practices within student populations in order to ensure that programs addressing these topics are gender-sensitive and that STD clinics provide more equitable services to both men and women.

In Honduras, the Asociación de Municipios de Honduras, a civil non-profit organization involved in leadership training for women, included the women’s partners in focus group discussions to assess men’s and women’s knowledge of sexually transmitted diseases. It is noted that programming focus on the broader issues concerning men (not only on their use or non-use of condoms) is essential.

Other activities that specifically focused on men include:

- a conference on dialogue held in New Delhi in June 1997 where an equal number of men and women were brought together to discuss issues of HIV/AIDS prevention
- training for male “matatu,” or pleasure vehicle drivers about the impact of the epidemic on women in Kenya
- training that included men and women working in both the formal and informal private sector in Zimbabwe

### *Collaboration/Coalition-Building Among Women*

Women's organizations are effective partners for empowering their members to protect themselves from HIV/AIDS and integrating HIV/AIDS prevention in other health and development programs. Both collaboration and coalition-building are being encouraged as elements of GSIs for resource mobilization. In particular, women's organizations and related groups have been targeted and provided skills for advocacy in order to influence policies and programs. AIDSCAP has incorporated this component in several activities.

### *The LAC Partnering Model*

The "partnering" approach was created based on recommendations made by AIDSCAP field staff as well as government and NGO officials from Latin America and the Caribbean. AWI and LACRO developed a strategic plan for a regional response to the spread of HIV/AIDS among women. This plan included the regional conference for AIDSCAP (Dominican Republic, Honduras, Brazil) and non-AIDSCAP (Bolivia, Peru, Nicaragua) countries, during which examples of gender-sensitive activities conducted at the country level were presented in an effort to stimulate gender-sensitive thinking and to exchange ideas across the region. Regional guidelines for the implementation of gender-oriented HIV/AIDS/STD prevention activities were also developed at the conference. Additionally, partnerships were established between the countries. The concept of partnering as a means of strengthening resources and sharing experiences was discussed and confirmed as a valid element of the GSI strategy. The partners also emphasized the success of integrating components to approach HIV/AIDS from the perspective of gender.

Another example of collaboration was the Commercial Sex Workers' Convention held in the Dominican Republic in 1995 and organized by the Centro de Orientación e Investigación with support from AIDSCAP. The aim of the convention was to alert all sectors of Dominican society to the social conditions and problems affecting CSWs. More than 350 participants attended the convention, including health messenger volunteers, CSWs, and students and professionals from the health field.

The Rapid Response Fund (RRF), an AIDSCAP mechanism through which small grants of less than \$5,000 are given for a period of less than six months, has shown that even limited resources enable women through their groups and organizations to initiate HIV/AIDS prevention activities. In Brazil, the Grupo de Trabalho e Pesquisa em Orientação Sexual (GTPOS), through a RRF, implemented a unique collaborative initiative among newly elected councilwomen throughout the state of São Paulo. Convinced the activities of NGOs alone would not suffice to help expand the information network on the HIV/AIDS epidemic, GTPOS decided it was necessary to secure local or city funding for sustained health programs for women. With that end in mind, GTPOS developed educational material on HIV/AIDS to help São Paulo councilwomen devise legislation to address HIV/AIDS/STD prevention with a special focus on actions to protect women.

Collaboration can also be carried out through leadership training. In Haiti, the Centre de Promotion des Femme Ouvrières (CPFO) trained both men and women in communication skills and group facilitation techniques — including how to persuade others to negotiate safer sex behavior. These health promoters then organized and conducted nearly 125 round-table educational sessions on HIV/AIDS/STD which were designed to reach 2,500 workers during a three-year period. CPFO Director Djènane Montas says the messages advocating safer sex appear to have been heeded: a sero-prevalence of factory workers showed a reduction in HIV prevalence from 10 percent in 1992 to 6 percent in 1995.

Beyond Latin America, collaboration was carried out in a number of other international activities. Three main activities were:

*An Asian Network, promoted by the AIDSCAP Asia Regional Office.* A satellite workshop was held before the third International Conference on AIDS in Asia and the Pacific in Chiang Mai, Thailand, to explore the potential for and constraints to creating networks on women and HIV/AIDS in the Asia region. The meeting was organized by the AIDSCAP Asia Regional Office with technical assistance from AWI. It included south-to-south sharing of women's understanding of their

roles in the epidemic and advocacy efforts by participants from the Society for Women and AIDS in Africa and a local women's network sponsored by the Women's Studies Center of Chiang Mai University. Participants recommended networks be developed at local or national levels as well as for entire regions. Proposed projects coming out of the meeting included a subregional seminar on HIV/AIDS, where representatives from five neighboring Indian states would meet to create multi-state strategies and coordinate the allocation of scarce resources, and strengthening of an existing network of HIV-positive persons in northeast Thailand by increasing information sharing, income-generation activities, and outreach.

*A coalition created to highlight AIDS at the Fourth United Nations World Conference on Women in September 1995.* AWI collaborated with numerous organizations, including the National Minority AIDS Council, Academy for Educational Development, International Center for Research on Women, International Council of Women Living with AIDS, Society for Women and AIDS in Africa, United Council for Negro Women, World Health Organization, United Nations Development Programme, International AIDS Society Women's Caucus, and United States Agency for International Development and others to highlight issues, concerns and lessons learned related to the AIDS epidemic as it affects women and girls. These activities included a Women and AIDS Day, international panels and networking sessions, a film festival, two major press briefings, interactive youth activities, and coordinated outreach with a booth for distribution of materials.

*An international journalist award.* As one of several actions launched to highlight women and HIV/AIDS at the Fourth United Nations World Conference on Women held in Beijing, AIDSCAP and UNAIDS jointly sponsored and presented an international "Award for Excellence in Writing on Women and AIDS" at the XI International Conference on AIDS in Vancouver in July 1996. This award recognized the journalist who wrote the most compelling article about women's issues related to the epidemic. The Latin America and Caribbean region was

well represented; in fact, the 2nd Runner-Up award went to a Brazilian journalist. Both AIDSCAP and UNAIDS donated funds to carry out this global project for journalists, and following the presentation, UNAIDS announced it would continue with the award at future international AIDS conferences.

### *Gender as a Development Concern*

Women, through conferences mentioned earlier in this report, have pushed planners and program developers toward taking a holistic approach to reproductive health. This holistic approach includes not only family planning, but also issues of education, small businesses and credit, violence, and advocacy for increased

roles of women in policy making and governance. These issues are basic to development at the individual and community levels.

Women have pushed planners and program developers toward taking a holistic approach to reproductive health. This holistic approach includes not only family planning, but also issues of education, small businesses and credit, violence, and advocacy for increased roles of women in policy making and governance.

Yet, women are often excluded or marginalized in decision making, power sharing and other actions that shape the development process. Gender, as a development issue, recognizes the critical contributions that women make and the importance of reducing those factors that minimize women's involvement, including the risk of disease and ill-health. GSIs seek to increase women and men's choices and control over their own circumstances through development efforts. However, actions that have a wide development agenda remain marginal, if considered at all, in HIV/AIDS prevention efforts.

Despite this, some noteworthy initiatives were started to bridge the gap between HIV/AIDS and development. In Honduras, the non-profit civic organization AMHON conducted a five-month

Gender, as a development issue, recognizes the critical contributions that women make and the importance of reducing those factors that minimize women's involvement, including the risk of disease and ill-health.

project that trained 50 women in two towns in leadership, reproductive health and HIV/AIDS/STD issues. During this time, AMHON studied women's lack of access to health services, trained the women leaders to empower themselves to help them take control of their own reproductive rights, and researched the attitudes and practices of both men and women on HIV/AIDS/STDs. The 50 women who were trained in leadership, gender, self-esteem and HIV/AIDS/STD prevention then returned to their towns to act as multipliers in their homes and communities.

In Brazil, the Grupo de Trabalho e Pesquisa em Orientação Sexual developed educational material to help more

than 500 newly-elected councilwomen throughout the state of São Paulo devise legislation to address HIV/AIDS/STD prevention with a special focus on actions to protect women.

Among other collaborative activities in the region that specifically incorporated broader development concerns were the credit programs for CSWs in the Dominican Republic, and the training of 20 women leaders of community banks and solidarity groups of the Honduran Association for the Development of Youth and Rural Women (AHDEJUMUR) on effective preventive measures against HIV/AIDS/STD.

Examples beyond Latin America that showed the impact of the gender-sensitive approach include the following:

- The Devidassis of India were trained for income generating through weaving.
- In Senegal, market women were educated within an integrated credit and literacy program.
- One project in Kenya focused on issues in the workplace, and another was related to care issues.

### **Component Five: Evaluation from a Gender Perspective**

The integration of gender in policy and programs is facilitated by regular monitoring and evaluation of HIV/AIDS activities. All HIV/AIDS prevention efforts should have an evaluation plan. The necessary gender analysis skills for evaluating progress in integrating gender issues, policies and programs, however, need to be developed through gender training.

In order to fully integrate and orient HIV/AIDS prevention with and from a gender perspective, gender specific indicators must be developed which guide monitoring and evaluating the results and impact of gender on the programs. One result of top-level management training in gender is that the leadership within the organization facilitates more gender-sensitive plans and implementation of programs. Another way to institutionalize, sharpen and sustain a focus on gender issues is to create specific mechanisms, such as units, staffing and targeted resources, and built-in systems to monitor and evaluate programs and progress within the organization.

The fact that AIDSCAP's programs are becoming more gender specific is clearly shown by the number of changes to projects in the Latin America and Caribbean region. Evaluation reports from the LAC country offices reflect the impact of gender training and the increasing awareness about gender, thereby implying an evaluation process is necessary — especially to serve as an effective basis for future decision making.

In one project in Haiti, the evaluation and subsequent introduction of broader gender concerns resulted in switching the focus of an HIV/AIDS/STD program from CSWs to all women at risk. In another example, the Dominican Republic AIDSCAP country office sponsored a three-month training program in gender issues for 37 health messenger leaders and volunteers in the workplace project of the Centro de Orientación e Investigación. After the trainings, these leaders and volunteers incorporated gender issues into their educational and outreach programs. In Honduras, following an evaluation of its BCC materials, the AIDSCAP country office revised the materials to include a gender perspective and to avoid sexism in graphics and other documents that were disseminated. AIDSCAP/Honduras also incorporated gender-sensitive language in communications with other agencies, both governmental and private sector, following the examination of its materials.

The systematic development of an evaluation strategy and GSI indicators remains a major task confronting AIDSCAP, other HIV/AIDS organizations and women's/gender-approach advocates in the 21st century. It is expected that the same activism and mobilization referred to in the earlier section of this SYNOPSIS, as well as those mentioned in the remainder, will see that the challenges are fully met.

## FUTURE CHALLENGES

### Future Challenges

- Understanding Stable Relationships
- Increasing Women's Options
- Integrating Reproductive Health
- Empowering Women
- Institutionalizing Gender at the Organizational Level

The challenges faced by Latin America are, in effect, applicable to all men and women AIDSCAP has sought to help. While it is essential that an open eye is kept for challenges that may develop, it is urgent that adequate attention be paid to the challenges detailed below:

### Understanding Stable Relationships

Few studies have explored the dynamics of sexual communication and control between couples. More research is needed to understand how to help couples develop safe, respectful, mutually satisfactory sexual relationships.

### Increasing Women's Options

The enthusiastic response to the female condom in studies and pilot projects throughout the developing world confirms the urgent need for HIV/STD preventive methods that women can initiate and control. Female condoms are a promising option, but their cost has limited their availability to all but a handful of countries. Research to develop microbicides that protect women against HIV and other STDs as well as simultaneous efforts to improve access to affordable female condoms must be a top priority for prevention programs.

### Integrating Reproductive Health

The promise of integrating family planning, HIV/AIDS/STD prevention, and STD treatment services to reach millions of women through family planning, maternal-child health and primary health care clinics has yet to be realized. As a result, there is continued isolation of the epidemic, which contributes in turn to persistent denial, stigma and lack of commitment to HIV/AIDS prevention. Obstacles include inadequate resources, providers' reluctance,

lack of clear technical guidance on how to provide integrated services in different settings, and an emphasis on treating and counseling women rather than couples. Operations research is needed to address these constraints in order to achieve a truly integrated approach to reproductive health.

### **Empowering Women**

In many developing countries, women's vulnerability to HIV/AIDS will continue without fundamental changes in their social, economic and legal status. Income-generating activities linked with HIV/AIDS prevention can empower some women to protect themselves from infection, but the scope of such activities is far too small to have a significant impact on the status of women in society as a whole or on the spread of the epidemic among women. Political commitment, human and financial resources, and true collaboration among health and development agencies and organizations are required to empower women through legal reform, education and greater access to employment and credit.

### **Institutionalizing Gender at the Organizational Level**

Gender orientation of policy and programs and the development of GSIs should be explicit policies of an organization from its inception. HIV/AIDS prevention programs should integrate GSIs in the field and ensure the monitoring of all activities for their gender sensitivity in design and implementation. Resources for GSIs, including staff, budgets and structures, should also be available in measures equal to other strategies. In addition, an organization's HIV/AIDS prevention efforts should be continually examined and expanded to include new populations touched by the epidemic. Moreover, effective dissemination of epidemiological trends (i.e., in ways local people can understand and utilize for decision making) that present the gender dimensions of the epidemic are needed for policy and program development at all levels.

## LESSONS LEARNED

Many useful lessons have been drawn as AIDS field workers attempt to implement the GSI strategy through its worldwide network and in collaboration with other national and international organizations in Latin America and the Caribbean as well as in Africa and Asia. The most salient of these are listed below:

- Introduction of gender and GSIs is weakened when seen as a separate concern from the overall policy, program or strategy of HIV/AIDS prevention.
- Gender is a technical strategy that can and should be measured and integrated in the planning as well as the implementation of prevention efforts.
- With training of top-level management, gender and GSIs are more rapidly institutionalized throughout the entire system.
- Dialogue is a process, a tool, and a viable strategy, more easily operationalized than negotiation, and is adaptable to different populations, settings and situations.
- Men are not “add-ons” or “buy-ins” in the efforts to institutionalize changes in sexual behaviors, nor can they be “involved” by women. They are often willing partners and advocates and must be treated as such in all GSIs.
- Research, particularly operations research, begins with women and men and their issues. This should be a high priority in HIV/AIDS prevention.
- Group peer support for introduction of GSIs may achieve greater impact than primarily individualized approaches.

## RECOMMENDATIONS

Based on its experiences in Latin America and the Caribbean as well as in developing countries throughout the world, AIDSCAP can confidently recommend several actions to organizations that intend to institutionalize GSIs as a fundamental strategy in HIV/AIDS prevention programs:

- Resources for GSIs, including staff, budgets and structures, should be available and equal to other strategies.
- Increased resources for research and development of women-initiated methods, especially microbicides, should be made available.
- HIV/AIDS efforts should be continually examined and expanded to include new populations at risk.
- Additional operations research should be conducted to explore the use of dialogue for improving sexual communication between men and women and promoting HIV risk reduction.
- Gender should be made an explicit policy of an organization from the inception of its HIV/AIDS efforts.
- GSIs should be integrated into all central headquarters and field actions, not as an option at the discretion of field staff, but a measure of staff performance.
- HIV/AIDS interventions should not target just women or men, but should focus on improving understanding and communication between them. Men should be addressed not only as sexual beings, but in their roles as fathers, husbands, workers and community members.
- HIV/AIDS programs should work together to make the female condom more available and affordable to women and men in developing countries. Efforts to increase availability should

begin with the large-scale introduction in a few countries. Efforts to improve affordability should include expediting research on whether the female condom can be used more than once and providing incentives for alternative, less expensive product designs. The device should be promoted among men as well since they control resources needed to purchase the female condom.

- HIV/AIDS organizations should collaborate with women's groups, particularly those that address other health and development issues, to empower women and promote a more integrated approach to prevention. HIV/AIDS organizations should also continue to promote a better understanding among these groups of the threat that HIV poses to health and development efforts and of the need to work together for women's empowerment and gender equity.
- Empowerment of women should be a goal explicitly pursued through the distribution of senior positions available in organizations implementing health, development and HIV/AIDS programs.

## REFERENCES

1. Development Associates, Inc. (1995). *Management Review of the AIDSCAP Project*. Washington: Development Associates.
2. Family Health International/AIDSCAP. (1997). *Making Prevention Work: Global Lessons Learned from the AIDSCAP Project 1991-1997*. Arlington, VA: Family Health International/AIDSCAP.
3. "Holography." *Colliers Encyclopedia*. 1996 ed.
4. "Holography." *Encyclopedia Americana*. 1997 ed.
5. Babbie, Earl. (1992). *The Practice of Social Research*. 6th ed. Belmont, CA: Wadsworth Publishing Co.
6. Irwin, Kathleen, MD, MPH. (1997). Congressional Task Force on International HIV/AIDS. Centers for Disease Control and Prevention, Division of HIV/AIDS Prevention.
7. Calderón, M. Ricardo. (1995). "The Shift of the Pandemic to Women in Latin America and the Caribbean," AIDSCAP in-service presentation organized by AWI.
8. Family Health International/AIDSCAP. (1996). *Status and Trends of the Global HIV/AIDS Pandemic*, Final Report, XI Conference on AIDS. Arlington, VA: Family Health International/AIDSCAP.
9. Reid, Elizabeth. (1995). "Population and Development Issues: The Linkages to HIV and Women." In *Cairo and Beijing: Defining the Women and AIDS Agenda*. Arlington, VA: AIDSCAP/Women's Initiative.
10. Ankrah, E. Maxine. Associate Director of the AIDSCAP Women's Initiative. (1997). Private communication.

11. Pfannenschmidt, Susan, and Arlene McKay. (1997). *Through a Gender Lens* (draft). Family Health International.
12. AIDSCAP Women's Initiative. (1997). *A Transformation Process: Gender Training for Top-Level Management of HIV/AIDS Prevention*. Report and Manual. Arlington, VA: AIDSCAP Women's Initiative.
13. AIDSCAP Women's Initiative. (1996). "A Dialogue Between the Sexes: Men, Women and AIDS Prevention", Satellite Meeting at the XI International Conference on AIDS, Vancouver, Canada.
14. Ankrah, E.M. and Attika, S. (1997). *Dialogue: Expanding the Response to AIDS — A Resource Guide*. Arlington, VA: AIDSCAP Women's Initiative.
15. AIDSCAP Women's Initiative. (1997). *The Female Condom: From Research to the Marketplace*. Conference proceedings from "The Female Condom: From Research to the Marketplace." Arlington, VA: AIDSCAP Women's Initiative.
16. Kabira, Wanjiku et al. (1996). *The Female Condom as a Woman-Controlled Protective Device*. Kenya Final Report.
17. Kalckmann, Suzana et al. (1997). *The Female Condom as a Woman Controlled Protective Method*. Brazil Final Report.
18. Carovano, Kathryn. (1995). "HIV and the Challenges Facing Men," paper for UNDP HIV and Development Programme.

**Functional Organizational Chart  
Latin America & Caribbean Regional Office,  
FHI/AIDSCAP**



**Priority  
Country  
Programs**  
Honduras  
Haiti  
Jamaica  
Brazil  
Dominican  
Republic

**Associate  
Country  
Projects**  
Mexico  
Guatemala  
Nicaragua  
El Salvador  
Costa Rica  
Colombia  
Ecuador  
Peru  
Bolivia

**Public and Private Implementing Agencies**

**Target Populations**