Creating an Enabling Context to Prevent HIV Infection among Women and Girls

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Abstract

The paper discusses the gender-based social and economic inequalities that fuel the spread of HIV among women and girls, and make it particularly difficult for them to adopt such prevention behaviors as abstinence, being faithful, and using condoms – behaviors that are widely promoted by many AIDS programs. The paper argues for the need to spend AIDS-related funding on creating a more gender equitable context to enable women to achieve the above behavioral outcomes. This involves altering the ways in which HIV services and programs are provided, putting in place community processes to bring about lasting normative changes in the definitions of masculinity and femininity, and creating a policy and legislative context and effective enforcement mechanisms that promote gender equality and the empowerment of women. Drawing on research and program experiences, the paper provides concrete examples of effective initiatives that need to be scaled up in order to prevent HIV infection among women and girls, and healthy and sustainable social and economic development overall.

Introduction

At the 2006 International AIDS Conference in Toronto, speaker after speaker acknowledged what research has demonstrated for more than a decade – gender inequality is a key driver of the HIV epidemic among women and girls. Yet, the solution that received center stage was microbicides – a critical technical solution, but one that fails to fundamentally alter the social and economic inequalities between women and men that increase women's vulnerability to

HIV. Microbicides serve to address an important need by providing women what men have always had: a prevention method they can control. Increased investments in the development and testing of microbicides, therefore, are essential. However, microbicides alone are not a sufficient solution to rectify the unequal balance of power in gender relations that social and economic inequalities create. Ultimately, it is that unequal balance of power that makes it difficult for women and girls to control the conditions under which sex takes place, compromises their ability to practice HIV prevention behaviors, and may even stand in the way of women accessing and using microbicides.

The focus of this paper is on what is known about creating the conditions that will enable women and girls to protect themselves from the heterosexual transmission of HIV infection. Drawing on research findings and program experience, the paper begins by reviewing the ways in which gender differences between women and men in the social and economic spheres contribute to inequalities in sexual relations and constrain women's ability to adopt preventive behaviors. The next section lays out a framework for addressing gender inequalities within the context of HIV prevention programming. The paper concludes by advocating for policymakers to apply the lessons learned and bring to scale gender-based, comprehensive responses to HIV prevention.

Gender and HIV Prevention

Gender refers to the widely shared expectations and norms within a society about appropriate male and female behavior, roles and responsibilities. Gender is a culture-specific construct—there are significant differences in what women and men can or cannot do in one culture as compared to another. But what is fairly consistent across cultures is that there is always a distinct difference between women's and men's roles, obligations and privileges, particularly in terms of access to productive resources, and decision-making authority (UNAIDS, 1999). Over twenty–five years of research on women's roles in development has shown persistent gender gaps in education, employment, income, ownership of land and housing, and access to credit (UN Millennium Project, 2005).

Predictably, the inequality that characterizes the social and economic spheres of society, in which women have less access to productive resources than men, is often mirrored in sexual interactions. As a result, many women have less control than men over when, where, why, with whom, and how sex takes place. This inequality in sexual decision-making limits women's sexual autonomy and expands men's sexual privilege, places greater emphasis on male pleasure over female pleasure, and casts women in the role of passive recipient rather than active actor.

For adolescent girls, this inequality is further compounded by age. Because in most societies, the young are granted less power in shaping their own destinies than their older counterparts, adolescent girls are at the bottom of the power totem pole just when they are experiencing key life transitions, such as marriage and initiation into sexual activity often with older men, and motherhood. As a result, age and gender interact to increase the vulnerabilities that make HIV infection more likely for females, in both adolescence and early adulthood

Of the many ways in which gender contributes to women's and girls' vulnerability, there are four factors that are key.

Norms of femininity and masculinity

In many societies, constructions of ideal feminine attributes and roles emphasize sexual ignorance, virginity and motherhood (Carovano, 1992; UNAIDS, 1999). This culture of silence and stigma that surrounds women and girls being informed about sexual matters can negatively impact their access to information and services. For example, a study in southeast Nigeria found that norms against premarital sex by single women limited their access to contraceptive information and methods (Ozumba, Obi, & Ijioma 2005). Such gender norms may also affect women's access to information about HIV prevention. Demographic and health survey data from six African countries show that women tend to have less HIV prevention knowledge than men (Glick & Sahn, 2005). Moreover, data from 35 of 48 countries in sub-

Saharan Africa reveal that, on average, young men were 20 percent more likely to know how to prevent the sexual transmission of HIV than young women (UNAIDS/WHO, 2005).

Norms of masculinity that define men as being more knowledgeable and experienced about sex, for example, put men, particularly young men, at risk of infection because these norms discourage them from seeking information or admitting their lack of knowledge about sex or protection. Such norms also pressure men into experimenting with sex in unsafe ways, and at a young age, to prove their manhood (UNAIDS, 1999; WHO, 1999). Gender norms in many societies also reinforce the belief that variety in sexual partners is essential to men's nature as men and that men must seek multiple partners for sexual release. Such beliefs make following prevention messages that call for fidelity in partnerships or a reduction in the number of partners a significant challenge (Mane, Rao Gupta, & Weiss 1994; Heise & Elias 1995; Rivers & Aggleton 2001; Barker, 2000). In creating a case for the need to understand the role of men's vulnerabilities in fueling the AIDS epidemic, Mane and Aggleton (2001) point out that "cultural and societal expectations and norms create an environment where risk is acceptable, even encouraged, for 'real' men."

Overall, support for these norms of masculinity are strongly associated with a wide range of risk-taking behavior among men. For example, a national survey of adolescent males aged 15 to 19 in the U.S. found that young men who adhered to traditional views of manhood were more likely to report substance use, violence, delinquency, and unsafe sexual practices (Courtenay, 1998). Findings from a study among young men in Brazil showed that support for inequitable gender norms was significantly associated with reported STI symptoms, lack of contraceptive use, and both physical and sexual violence against a current or most recent partner (Pulerwitz et al., 2006). In addition to their own risk, adherence to such norms of masculinity greatly increases the vulnerability to HIV of their female partners (Rao Gupta, 2002).

Gender gaps in education

Although the gap between girls and boys in enrollment and completion rates for primary education has diminished significantly in all regions over the past three decades, in sub-Saharan Africa and South Asia, in particular, girls still lag far behind boys. The picture for secondary education is far less hopeful. With the exception of Latin America and the Caribbean, girls in all regions of the world fare poorly as compared to boys in secondary school enrollment rates, and where data exist, in completion rates (UNESCO, 2004).

Gender gaps in education, overall, are of concern because of the strong negative correlation between the number of years of schooling and HIV prevalence, particularly in countries with a high prevalence of HIV (Hargreaves & Boler, 2006). The persistent gender gaps in secondary education, in particular, are of grave concern because recent analysis has established the link between secondary schooling and women's empowerment–a key ingredient to equalize the power balance between women and men (Malhotra, Pande, & Grown, 2003). Moreover, a recent review of 600 articles showed a stronger association of completion of secondary education with lower HIV risk, more condom use, and fewer sexual partners, as compared to primary education (Hargreaves & Boler, 2006). The same review also showed that females who received more education were more likely to start having sex at a later age.

Economic dependency and vulnerability

Although women's economic activity rates have increased everywhere except in sub-Saharan Africa and parts of Europe and Central Asia, women's status in the labor market remains significantly lower than men's. Women continue to be segregated in lower status jobs, earn less than men, and tend to be concentrated in informal employment which is characterized by insecure, seasonal, and low-paying work (UN Millennium Project, 2005).

The resulting economic vulnerability and dependency on men for economic security makes it difficult for women to negotiate condom use or fidelity with a non-monogamous partner. It also makes it less likely that they will leave a relationship that they perceive to be risky because they

lack bargaining power and fear abandonment and destitution. (Heise & Elias 1995; Mane, Rao Gupta, & Weiss, 1994; Weiss & Rao Gupta 1998). One study conducted on a random sample of 580 women in the U.S. showed that women with lower incomes were less likely to use condoms than those with higher incomes (Peterson et al., 1992).

Poverty and a lack of economic alternatives have repeatedly been identified as the reasons that many women become involved in sex work, either because they are sold or trafficked into the sex industry or feel that they have no other option to economically sustain themselves and their children (Wojcicki, 2002; Dunkle et al., 2004a; Harcourt & Donovan, 2005).

In addition, women's lack of access to and control over economic assets, such as land and housing, makes them particularly vulnerable in the AIDS epidemic and can fuel a vicious intergenerational cycle of morbidity and mortality. Increasing women's economic security through ownership of and control over land and housing is an HIV prevention and control strategy in multiple ways. First, when women own and control land and housing, it serves as a poverty alleviation measure because secure tenure to land and shelter protects women in poor households against economic shocks and enables them to take the economic risks that are necessary to climb out of poverty – and alleviating women's poverty reduces their vulnerability to HIV infection through the pathways described above. Second, ownership of property and housing protects women from complete economic devastation when husbands or fathers fall sick and die of AIDS. Without a guarantee of property and inheritance rights, the woman left behind is at risk of losing her home, inheritance and possessions either because the laws of her country do not give her the right to own or inherit land or housing, or because of "property grabbing" by relatives and community members, with no accessible legal recourse to regain ownership of that property. Thrust into these difficult economic situations, women and girls may be forced into risky and unsafe sexual behaviors just to meet their own and their children's basic needs, or may fall prey to sexual predators, thereby perpetuating a vicious cycle of HIV infection, disease and death (Strickland, 2004).

It has also been known for many years that control over land and housing can give women greater bargaining power within households, which may translate into greater leverage to negotiate HIV prevention behaviors, though this relationship is yet to be tested. Control over land and housing in some circumstances, however, may protect women against the risk of domestic violence thereby indirectly reducing vulnerability to HIV (see the section on violence against women below). Research in Kerala, India, found that 49 percent of women with no property reported physical violence compared to only 7 percent of women who owned property (Panda, 2002).

Yet, there are many countries in which women still do not have the right to own or inherit land and property – and even where such laws exist, most land and property is owned by men because of the poor enforcement of the laws or because of a conflict between statutory laws and customary laws. In sub-Saharan Africa, women suffer disproportionately from the effects of discriminatory and oppressive laws, customs and traditions regarding access to and control of housing and land (COHRE, 2003). Although there are no reliable statistics on land ownership by sex, it has been estimated that worldwide, women own less than 10 percent of land (Crowley, 1998; Göler von Ravensburg & Jacobsen, 1999).

Violence against women

Data from more than 24,000 women interviewed in 10 countries revealed that as many as two-thirds of women in some sites reported ever experiencing physical and/or sexual violence by an intimate partner (WHO, 2005). Violence is the most extreme form of gender inequality and is the direct result of gender norms that make male violence against women a socially acceptable way to control an intimate partner.

Violence contributes directly and indirectly to women's vulnerability to HIV (Maman et al., 2000). Individuals who have been sexually abused are at immediate risk of HIV infection, but they are also more likely to engage in unprotected sex, have multiple partners, and trade sex for money or drugs (Heise, Ellsberg, & Gottemoeller, 1999). Data from a Tanzania study suggest

that for some women, the experience of partner violence could be a strong predictor of HIV. Maman and colleagues (2002) found that among women who sought services at a VCT center, those who were HIV positive were 2.6 times more likely to have experienced violence in an intimate relationship than those who were HIV negative. A similar association was found among women attending antenatal care centers in South Africa. After controlling for age, current relationship status, and women's risk behavior, intimate partner violence was significantly associated with HIV seropositivity (Dunkle et al., 2004b).

Limitations of Traditional HIV Prevention Prescriptions: A Mismatch

There is no doubt that the traditional package of HIV prevention prescriptions advocated by some donors –abstain or delay sexual debut, be faithful or reduce the number of sexual partners, and use condoms consistently and correctly (ABC) – are proven prevention behaviors. In other words, if individuals do not have sex, or have sex with a mutually monogamous uninfected partner, or use condoms during every act of intercourse, then they will be protecting themselves from HIV infection. Treatment of other sexually transmitted infections (STIs), HIV testing and counseling, antiretroviral treatment for those who are infected, and more recently, male circumcision are also HIV prevention strategies, but for the purposes of this paper the discussion is limited to the ABC behaviors. The four gender-related factors described above, however, show that these behavioral prescriptions are not always suited to women's needs or daily realities nor do they take into consideration the powerful influence of gender norms in shaping male sexual behavior, which in turn affect women's risk of infection.

In fact, many women who have complied with their expected roles –have married early, become mothers, and remain faithful to their spouses– are becoming infected with HIV. A case control study of women attending a family planning clinic in Nairobi, Kenya, for example, found that most of the 216 seropositive women, among the 4404 studied, were married and reported having only a single sex partner in the last year (Hunter et al., 1994). In another study involving 4500 women in Zimbabwe and South Africa, 40 percent of women who reported low risk behaviors were HIV positive (Meehan et al., 2004). Married adolescent girls may be at

particular risk. Data from sub-Saharan Africa show that HIV prevalence tends to be higher among married adolescent girls than their sexually active, unmarried peers (Clark, 2004).

Creating an Enabling Context

To create the enabling conditions to make the ABCs realistic behavioral options for women, additional actions are needed. If programs are serious about making the ABCs viable behaviors for women and girls, they must address the root causes of women's inability to abstain from sex, reduce the number of partners, ensure their own and their partner's fidelity, and use condoms. This entails spending AIDS-related funds on more than just promoting A, B, and C; it requires altering the ways in which HIV and AIDS services are provided and programs are run to make them more gender responsive and women-friendly; it requires putting in place the community processes and programs to bring about necessary and lasting normative changes in the definitions of masculinity and femininity; and finally, it requires the creation of a policy and legislative context and effective enforcement mechanisms that promote gender equality and the empowerment of women. With these conditions in place, the probability of a greater number of women and girls, as well as men and boys being able to adopt A, B, or C could increase substantially.

Principles Underlying a Gender-Based Response

There are two principles that must guide the implementation of any or all actions taken to respond to gender-based vulnerabilities of women:

1) Women's vulnerabilities vary and are context-specific. Although for purposes of argument women's vulnerabilities are described in this and other publications as being predominantly true, in reality women's needs, constraints and particular vulnerabilities are differentiated based on age, marital status, sexuality, socio-economic status, ethnicity, race, place of residence, and many other variables. It is well known, for example, that gender inequalities are much greater among the poor than the non-poor and that particular gender inequalities, such as in

education or economic opportunity, are greater in some regions than others (UN Millennium Project, 2005). Thus, there are many women in the developing world who are not vulnerable or disempowered and who are in gender equitable partnerships, but may nevertheless become infected with HIV.

The important first-step in designing a gender-based response to contain the epidemic, as is true for any public health response, is to find out what is true for the majority of the population. This can be done through a context-specific gender analysis that maps the particular gender inequalities and sources of vulnerability that affect women and girls (as well as men and boys, as an important reciprocal), so that the response meets the needs of women and girls in that particular context. The analysis must also be informed by the stage of the epidemic and its particular epidemiological context in order to determine which women and which of their particular vulnerabilities receive priority attention.

2) Effective HIV prevention requires services and community mobilization. The second principle, which is true for all HIV prevention programs but much more so for ones that seek to alter behavior by changing gender norms, is that creating an enabling context requires two simultaneous responses: first, basic HIV/AIDS interventions and services that are facility or community based; and second, actions that catalyze community-driven responses. The first is key to providing information, services, and technologies (e.g., male and female condoms), and for building skills. The second is instrumental in building social capital, developing local leadership, and mobilizing the community to take action, which may include grassroots educational campaigns or advocating for changes in broader laws and policies. For the best results in implementing a gender-responsive AIDS program, both of these sets of responses – AIDS services and community mobilization– must occur concurrently.

A Framework for a Gender-Based Response

The framework described below distinguishes between four levels of strategies that fall on a continuum of increasing degrees of responsiveness to gender inequality: do no harm, address

gender differences, trigger transformations in gender roles and relationships, and empower women and girls. All four can be undertaken within AIDS programming, as traditionally defined, but the success of the fourth strategy, empower women, requires broader economic and social development actions.

Do No Harm: To effectively address the intersection between HIV/ AIDS, gender, and sexuality requires at a minimum that interventions not reinforce damaging gender and sexual stereotypes. Many efforts have fostered a predatory, irresponsible image of male sexuality and portrayed women as powerless victims or as repositories of infection. Posters in which a sex worker is portrayed as a skeleton, bringing the risk of death to potential clients, is an example of the latter which may do little other than stigmatizing sex workers, thereby increasing their vulnerability to infection and violence.

Another example is programs that provide adolescents with "abstinence-only" prevention education that withholds any information on other methods of protection. These, too, can do damage first, by denying that for many reasons (for example, coercion or economic need) sexual activity is a reality in the lives of many adolescent girls (Weiss, Whelan & Rao Gupta 2000) and second, by presuming that the provision of comprehensive sexuality education will increase sexual activity when research evidence has proved otherwise (Kirby, Laris, & Rolleri, 2005; Grunseit et al., 1997).

Address Gender Differences: A step-up from merely doing no harm is to address the differential needs and constraints of individuals based on their gender. Providing a woman with a female condom or a microbicide is an example of such programming. It recognizes that the male condom is a male-controlled technology and that women need alternatives that they can initiate or control. Efforts to alter the timing of the provision of a service to better match women's daily schedules or provide services through a community-outreach program in order to reduce the time and monetary impediments to women's use of services are examples of such an approach. Another is to integrate STI treatment and HIV prevention services with family

planning services to help women access such services without social censure. Fleischman (2006) cites many positive program examples to make a powerful push for integrating reproductive health and HIV/AIDS programs, arguing that it makes practical sense to do so for reproductive age women, for whom both sets of services are critical.

While such gender-responsive programming responds to felt needs and improves women's access to information, technologies, and services, by itself it does little to change fundamental social and economic inequalities or the larger contextual issues that lie at the root of women's vulnerability to HIV.

Trigger Transformation in Gender Roles and Relationships: These approaches aim to trigger transformation in gender roles and create more gender equitable relationships, and can be divided into three categories: first, those that link HIV programs to services that increase women's access to economic and social resources; second, those that provide HIV and AIDS services in a way that fosters equitable partnerships; and third, those that use community-based, participatory processes that allow for critical analysis and reflection among community members in order to trigger transformations in gender roles and norms. Transformative approaches can be conducted within facilities or within community settings.

Linking HIV programs to other services: This involves referring female clients to other programs or services that increase women's access to information/education, economic resources, social networks, or protection against violence. Referring poor women to a local microfinance program, for example, may help to reduce one source of vulnerability to HIV and set in place the momentum for change in that woman's roles and status within the household as a result of having access to credit (Cheston & Kuhn ,2002; Mayoux, 2000). Linking HIV programs to community-based efforts to secure widows' ownership of their land or housing by providing will-writing help or paralegal services, is another way to transform women's roles to help reduce their vulnerability to infection. Such a linkage ensures that women's property rights are

protected and that they are not put into a situation in which they have to sell sex in unsafe ways to ensure economic security.

Encouraging gender-equitable partnerships through service provision: The second way to trigger transformation in gender roles and relationships is to change the way in which HIV-related services are provided so as to encourage partner communication and equitable gender interactions. One example is couple counseling within prevention of mother-to-child transmission (PMTCT) programs to promote that idea that both parents have a role to play in preventing vertical transmission of HIV. A study conducted to test the effectiveness of couple counseling in a PMTCT program in Nairobi found that of the 314 seropositive women enrolled, Nevirapine use was reported by 88 percent of those who were couple counseled, 67 percent of those whose partners came with them but were not couple counseled, and 45 percent of those whose partners were not present – a statistically significant difference (Farquhar et al., 2004). Moreover, seropositive women who received couple counseling were five times more likely to avoid breast feeding than those who were individually counseled. The findings suggest that couple counseling has a powerful impact on prevention behaviors. Again, although the provision of couple counseling by itself is unlikely to change gender norms, by deliberately fostering partner communication, it may trigger changes in gender norms in the long-run; a hypothesis that needs to be tested.

Fostering changes in gender roles and norms through group processes: A third approach is to use community-based, participatory, group processes to trigger changes in gender norms and roles. Three excellent examples of this type of intervention are Program H, Men as Partners, and Stepping Stones. These programs seek to foster constructive roles for men (in the case of Program H, and Men as Partners) and men and women (in the case of Stepping Stones) in sexual and reproductive health. The curricula for these programs use a wide range of activities –games, role plays, and group discussions– to facilitate an examination of gender and sexuality and its impact on gender roles and relationships.

Research conducted in Brazil to evaluate Program H found that support for inequitable gender norms had decreased among young men who participated in the program, whereas there was no change in the control group. In addition, increases in condom use at last sex with primary partners and decreases in reported STI symptoms tended to be greater over time among young men who participated in group sessions and were exposed to a social marketing campaign that championed gender-equitable men, compared to young men who just participated in the group sessions or were in the control group (Pulerwitz et al., 2006).

The Men as Partners program created by EngenderHealth and implemented in South Africa to combat the dual and synergistic epidemics of gender-based violence and HIV, was designed to mobilize men to question deep-seated patriarchal attitudes and beliefs that put the health of men, women and children at risk. Its implementation requires the involvement of men and women in male-only and mixed-gender groups. Pre- and post-intervention interviews with 200 males in the intervention and control groups showed that after the intervention, 71 percent of participants believed that women and men should have the same rights compared to 25 percent of the control group; 82 percent of participants believed that it was wrong to rape a sex worker compared to 33 percent of non-participants; and 82 percent of participants believed it was not right to beat their wives compared to 38 percent of men in the control group (White, Greene & Murphy, 2003). In addition, the evaluation found that adolescent males were more willing than older men to accept views that challenged prevailing norms of masculinity.

In South Africa, the Stepping Stones program is being evaluated through a randomized control trial. The study collected data from 1400 young women and young men from 35 villages who participated in 17 group sessions over a period of 3-12 weeks and a similar number of youth from 35 control villages at baseline and one year later (Jewkes et al., 2006). Quantitative analysis of outcome data, including HIV incidence, is ongoing. But preliminary results from qualitative data suggest that the intervention may have had a greater effect on men than women, in terms of condom use, sexual negotiation, and conflict resolution (Wood et al., 2006), which may have positive implications for women's vulnerability as well.

In each of these instances, evaluation data indicate that changes in gender attitudes and beliefs are possible. While there is also some evidence to suggest that such programs lead to changes in behavior (for example, Program H), more research is needed to establish this link. Moreover, facilitating such group processes is time-intensive work, and by definition is therefore small-scale. The challenge is to know how to take the principles behind these successes and replicate them on a large scale, through, for example, communications campaigns, for the same impact. Soul City, a HIV/AIDS communication intervention in South Africa that reaches more than 80 percent of the population through mass media and interpersonal communications, is one of the largest efforts undertaken to foster caring and nurturing roles among men. It challenges social norms that promote men's right to sex and condone sexual violence and intergenerational sex. An evaluation of the impact of Soul City on attitudes toward violence against women posted on the Soul City website (www. Soulcity.org.za) indicates that men's attitudes toward beating women has changed. The website does not, however, indicate what the baseline comparison was or by how much those attitudes had changed. In order to know whether programs like Soul City are the way to scale-up the transformation of gender roles and relationships will require more rigorous evaluation studies and impact assessments.

Empowering Approaches: These strategies aim to address the broader risk environment that constrains women's behaviors and choices and often go beyond the purview of traditional HIV programming. While transformative approaches are important for triggering changes in gender roles and interpersonal gender dynamics, including among men, empowering approaches are critical to reinforcing women's ability to protect themselves and to take charge of their own destinies. In a recent review of the empirical and theoretical literature on women's empowerment, Malhotra and Schuler (2005) argue that, 'empowerment' is a process that engages women as active agents in the use of a range of resources, which brings about positive changes in women's environment, from one that undermines women's wellbeing to one that promotes it. Resources that are key for bringing about women's empowerment are information and education, economic opportunities and assets, decision-making opportunities, and security.

Women's access to these resources can be increased through policies and programs that foster women's participation and decision-making.

Two programs highlighted below –the IMAGE Project and the Sonagachi Project– illustrate the feasibility and relevance of empowering women by addressing important structural and contextual barriers to HIV prevention, namely partner violence, limited social capital, and economic vulnerability. Both programs focused on HIV prevention as a goal while providing women with needed resources through an empowering process, and showed measurable results in terms of their vulnerability to HIV.

The IMAGE (Intervention with Microfinance for AIDS and Gender Equity) Project highlights the importance for women of combining interventions that address individual and contextual barriers to behavior change with actions to stimulate community responses that foster an enabling environment. This initiative provided micro-loans to women and integrated a 10-part gender and HIV training program called "Sisters for Life" into fortnightly loan repayment meetings over a 6-month period. More importantly, the IMAGE Project mobilized microfinance participants, who tended to be older women in the community to be agents of change in their households and communities (RADAR, 2002).

Using a randomized cluster design, the researchers found that after two years, those in the intervention group compared to the control group (matched for age and poverty status) experienced greater improvements in assets, expenditures, and membership in informal savings groups. The intervention group also demonstrated improvements in empowerment indicators, such as challenging established gender roles and communication with household members about sexual matters, and in social capital measures, including participation in social groups and collective action. Indeed, as proof of increased empowerment and greater social capital IMAGE participants organized over 60 community events (e.g., workshops, marches, and meetings with leadership structures) that addressed HIV, violence, rape, and abuse, and which engaged traditional leaders, police, school principals, and soccer clubs. The study also found

that among participants, the risk of physical and/or sexual intimate partner violence in the past year was reduced by 55 percent, from 11 percent to 6 percent. Among comparison group respondents the rate actually increased from 9 percent to 12 percent (Pronyk et al., 2006). Qualitative data suggest that the intervention and the social mobilization that occurred enabled women to challenge the acceptability of such violence, to expect and receive better treatment from partners, and to leave abusive relationships (IMAGE Project, 2006). The researchers concluded that "given the linkages between violence and HIV, existing development initiatives, such as microfinance, may provide an important entry point for addressing HIV in areas where poverty and gender inequalities continue to confound prevention efforts" (Kim et al., 2006).

A second example of an empowering program is the Sonagachi Project. It began by providing standard HIV services –behavior change communication, condom distribution, and STI management– to women who were sex workers. Over time, project leaders and participants recognized that sex workers' exclusion from access to material resources, civic participation, and decision-making contributed to a lack of power in their sexual relationships and their lives in general. This led the project to implement a wider variety of activities in order to develop a sense of community among sex workers, decrease their perceived powerlessness and insecurity, increase their access and control over material resources, increase their social participation, facilitate the social acceptance of sex workers, and stimulate community activism. Specifically, as the project evolved, literacy classes, a loan service, and a trade union were organized. (Jana et al., 2004).

As a result of the interventions and community responses, there was a significantly greater increase in condom use among sex workers living in the Sonagachi area compared to sex workers in the control sites (Basu et al., 2004). The Sonagachi Project highlights the importance of combining core prevention services that are of high quality, with community processes that foster community ownership. It is only when the two are combined that changes in the normative context can occur.

In recognition of this important lesson learned, the Gates Foundation-funded program in India, Avahan, has adopted an approach that combines the provision of HIV prevention services with community mobilization processes. In a recent article in the Lancet on Avahan, which reviewed the epidemiological and socioeconomic context in India, and prevention programming to date, Chandrasekaran et al., (2006) concluded that to change the behavior of high-risk groups:

"…it is essential to supplement the one-to-one service delivery approaches that characterize current models of targeted intervention with more efficient, scalable methods. Such methods should include: 1) leveraging existing social networks and community structures for reaching large numbers of individuals. 2) reducing vulnerability of marginalized groups by addressing structural barriers, and 3) catalyzing changes in social norms and environmental conditions."

Fortunately, the Avahan program has integrated the necessary metrics to measure the impact of such an approach, which in a few years should provide the field of HIV prevention with invaluable insights for future programming, particularly for women and other vulnerable groups.

Conclusions

As all of the above discussion illustrates, there is adequate conceptual clarity, programmatic experience, and sufficient evidence to show how the HIV prevention prescriptions of abstinence or delayed sexual debut, be faithful, and the correct and consistent use of condoms can be better made to work for women. An ABC-plus approach, as described here and by other researchers and advocates (see Dworkin & Ehrhardt, 2007), with a particular emphasis on transformative and empowering approaches, within a comprehensive prevention response that includes community mobilization and an equitable policy context, can create an enabling environment for women. Gender inequality and damaging norms of masculinity and femininity have been addressed in different contexts and within HIV/AIDS programming. We have blueprints that describe what programs and polices should be developed and how they should carried out for

reducing key barriers to prevention for women, including gender based violence (Division for the Advancement of Women, 2005; World Health Organization, 2005), property and inheritance rights (Dohrn, 2006; World Bank, 2005), and economic empowerment (UN Millennium Project, 2005). The time has come to apply what is known and put in place policies and programs, and the necessary metrics and systems to measure their impact, that create a more gender equitable environment that fosters HIV prevention among women and men, and healthy and sustainable social and economic development overall.

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