HIV/AIDS Capacity Statement

1. Commitment to Global Health Initiative and Emergency Plan principles and goals

CARE is a leading humanitarian organization fighting poverty and addressing the health and wellbeing of marginalized individuals, families and communities worldwide. We place special focus on working alongside poor women because, equipped with proper resources, women have the power to help whole families and entire communities escape poverty. Since its founding in 1945, CARE has expanded programming to work in over 70 countries. Our organization's strategic focus in HIV/AIDS, sexual, reproductive health and family planning (SRH/FP), gender equality, and livelihoods dovetails neatly with the US Government's Global Health Initiative principles.

CARE's Mission

Our mission is to serve individuals and families in the poorest communities in the world. Drawing strength from our global diversity, resources and experience, we promote innovative solutions and are advocates for global responsibility. We facilitate lasting change by:

- Strengthening capacity for self-help
- Providing economic opportunity
- Delivering relief in emergencies
- Influencing policy decisions at all levels
- Addressing discrimination in all forms

Global Health Initiative principles

1. Focus on women, girls and gender equality
2. Encourage country ownership and invest in country-led plans
3. Build sustainability through health systems strengthening
4. Strengthen and leverage key multilateral organizations, global health partnerships and private sector engagement
5. Increase impact through strategic coordination and integration
6. Promote learning and accountability through monitoring and evaluation
7. Accelerate results through research and innovation

CARE is currently collaborating directly with PEPFAR in Africa (Kenya, Mozambique, South Africa, Zambia), South Asia (Bangladesh, India, Nepal), and Southeast Asia (Vietnam) to achieve PEPFAR goals of preventing 12 million new infections, providing antiretroviral treatment to six million individuals, and ensuring that 12 million people receive HIV-related care, including five million orphans and vulnerable children.

Across the diverse range of programs that CARE supports, there are three overarching and cross-cutting program areas that complement well with PEPFAR's increasing focus on women and girls, the structural drivers of HIV epidemics, the need for sustainable, local ownership of national responses, and client-centered, innovative community-based approaches. These include:

1. *Gender equality and women's empowerment*
2. *Community mobilization and community-based health initiatives*
3. *Livelihoods and land rights*

2. CARE capacity program areas

A. Gender equality and women's empowerment

CARE believes gender equality is fundamental in achieving rights and dignity for all, including people living with HIV and their families and loved ones. Women tend to be more vulnerable to the structural issues that increase their risk of acquiring HIV, including gender-based violence, trans-generational sex, educational and employment disparities, and commercial sex work. Poorer women in most societies, especially those living with HIV, face combined burdens from discriminatory practices and policies in obtaining education and employment, in accessing livelihoods, assets, and information, and basic civic participation. CARE is committed to supporting the empowerment of poor women and girls and addressing gender barriers where they live, work, and raise families.

Our organization has substantial experience and extensive capacity in addressing gender inequality and gender discrimination in varying contexts and levels, from engaging in research and action on women's empowerment, to assessing and refining impact measurement systems and metrics on empowerment, to developing approaches for engaging men and boys to build the momentum for greater women's and girls' empowerment in healthy decision-making. In recent years, we have developed strategies around priority issues such as addressing patriarchal expectations for masculinities and engaging boys and men. We have also built a strong reputation as an organization that recognizes the importance of continuous shared learning, organizational strengthening, communicating research findings, as well as outcomes and lessons learned from our initiatives.

Strengthening capacity, sharing and learning: CARE's Gender Analysis Toolkit

CARE has developed its own online **Gender Analysis Toolkit** containing a set of core resources focused on a host of programming and organizational gender issues. The Toolkit builds on decades of work in designing and conducting research, analysis, programming, impact measurement, and reflective and shared learning around gender and poverty. We know that contextual analysis that includes gender and power dynamics is critical to quality programming in HIV/AIDS. CARE staff and partners use the tools in the Gender Toolkit to analyze gender issues in contextual settings, monitoring and evaluation, impact measurement, and organizational reviews of program interventions. The Gender Analysis Toolkit is a resource for teams to use as they prioritize areas of analysis, facilitate discussions with program participants, conduct situation analyses, or plan and design programs, baselines, monitoring tools and evaluations. The site houses over 200 participatory tools, each one including contacts for resource people as well as users' experiences and tips. The materials contained in the site come from across the globe from CARE's past experiences and lessons learned on gender analysis. To visit the Gender Toolkit, go to: http://pqdl.care.org/gendertoolkit/default.aspx

*The **Good Practices Framework** is embedded in CARE's groundbreaking Gender Analysis Toolkit. It outlines a process for conducting gender analysis and includes 7 core areas of inquiry: division of labor; household decision-making; control of productive assets; meaningful participation in public spaces; control over one's body; violence and restorative justice; and aspirations for oneself.*

Code of Good Practice

As a lead member of a global steering committee of the "Code of Good Practice for NGOs Responding to HIV/AIDS", CARE developed a practical self-assessment checklist for NGOs to use to

strengthen their HIV work with women and girls. The checklist helps organizations assess their interventions, advocacy, and internal policies. For more info: http://hivcode.org/silo/files/women-and-girls-.pdf

Gender-based violence

CARE recognizes that GBV is embedded in cultural and societal norms that create and reinforce status and power differentials based on gender. CARE's programs to prevent GBV, therefore, work to address behavioral and institutional change simultaneously. This strategy aims to diminish harmful norms that fuel and sustain acts of GBV. To do this, projects create (or increase) awareness, understanding, and discussion of issues of gender, power dynamics, human rights, violence, and related themes. CARE facilitates safe and structured spaces for communities to openly debate gender norms and begin to renegotiate more equitable relationships. CARE also works with communities to build community-based protection structures including community watch groups.

*In Rwanda, the **Communities Allied against Violence and HIV (CAVA)** project addressed the socio-economic and cultural intersections between HIV/AIDS and GBV in partnership with two local organizations. Using CARE's social analysis approach that contributes to sustainability and local ownership, vulnerable groups were organized in Village Savings and Loan Associations. Coupled with economic empowerment, behavior change communication activities helped reduce discriminatory attitudes towards women and girls, reduce vulnerability and violence, improve access to HIV/AIDS and GBV services, and strengthen institutional, organizational, and technical capacity of the local partners to implement combined HIV and GBV prevention programs.*

In 2013, CARE's global programming in GBV spans 33 countries in Asia, Africa, Eastern Europe, the Middle East, Latin America and the Caribbean. This work spans all settings, from conflicts and natural disasters, to chronic instability, to stable development settings. Nearly all (93%) projects address multiple types of GBV, including domestic violence (physical, sexual, and psychological violence within the family); sexual violence (rape, forced prostitution, sexual exploitation and abuse, trafficking, and sexual harassment; early marriage, also referred to as forced or child marriage; harmful traditional practices (female genital cutting, dowry and related violence, bride price, bridge abduction, polygamy, witch hunting, and widow inheritance); psychological violence and stigma and discrimination.

Risk reduction targeting vulnerable women

In Vietnam, CARE worked through the Striving for Transformation through Empowered People (STEP) program to transform the lives of women (and men) at risk of infectious diseases, gender-based violence, and exclusion from their community. The project was selected for inclusion in AIDSTAR-One's compendium on HIV and Most-At-Risk Populations (MARPs). STEP's training workshop enabled government partners to reflect on and articulate the realities and needs of men and women who undergo treatment at government-run treatment and education centers for sex workers and drug users. STEP encouraged government staff to reflect on and change their own attitudes towards gender equity. The program help highlight that economic opportunities for women and men must reflect their aptitude, education level, interest, and skills – and that whatever skills are learned or businesses started must meet the needs of the local economy.

Women's empowerment and HIV prevention

In 2007 CARE launched a two-year collaborative global study on "*Gender, Sex, and the Power to Survive: the impact and implications of empowering women at risk of HIV and AIDS*" to understand

the factors that increase women's vulnerability to HIV, and to evaluate the impact of CARE's empowerment strategies on HIV outcomes. The study focused on women in six countries – Bangladesh, Burundi, Cambodia, India, Lesotho and Peru. The programs in the sites encompass a diversity of issues including sex work, transactional sex, gender-based violence, and power relationships. Data were collected and analyzed in collaboration with the International Center for Research on Women. In understanding the role that prevailing gender identities, roles and hierarchies play in shaping the dynamics of transmission and living with HIV, CARE has helped build its evidence base and apply for application in programming and advocacy. CARE has presented this work at various global forums, and is writing a book chapter for a graduate level textbook highlighting our research in Bangladesh with the University of California Centers of Expertise on Women's Health and Empowerment.

B. Community mobilization and community-based health initiatives

Integration of SRH, FP and HIV/AIDS services

Evidence suggests that improvements in SRH and FP - and health in general - are linked to economic and social development and must be addressed in order to obtain sustainable reductions in poverty. In resource-poor settings, there is also evidence that linking SRH/FP with HIV services reduces costs and increases positive health outcomes for people living with HIV. CARE's SRH program is part of a larger health portfolio, which consists of more than 200 projects in over 50 countries. The health portfolio includes child health, nutrition, sexual and reproductive health, HIV and AIDS, and infectious disease programs that strive to emphasize health rights and services for the poor and disenfranchised, particularly women and children.

CARE began its significant implementation of reproductive health programs in 1990, with an emphasis on family planning. By the mid 1990s, CARE had solidified programming efforts in a comprehensive package of reproductive health interventions, and was able to demonstrate to the international health and development community the value of community-based approaches to family planning. Today, CARE's SRH programs encompass activities to increase access to and use of high-quality family planning services, improve maternal and newborn health, prevent and manage sexually transmitted infections, including HIV/AIDS and address gender-based violence. New initiatives include measuring the impact of incorporating gender and sexuality activities on health outcomes, and building evidence to demonstrate the contribution of community mobilization to achieving improved and sustainable SRH impact.

CARE's programs are designed to target the most vulnerable groups in a given society, including people living with HIV/AIDS. As a result of this intentional focus on those most at risk, CARE's sexual and reproductive health interventions are reaching many individuals and communities who would otherwise not have access to essential services and information. SRH/FP/HIV activities are implemented in the context of CARE's overall approach to fighting poverty and improving social justice. They are often integrated with other activities like basic and girl's education, savings and micro-enterprise programs, and civil society strengthening, to maximize the benefits to communities and households.

While CARE is best known for empowering individuals and families at the community level, CARE also strengthens health systems by enhancing the skills of service providers, upgrading facilities and supporting institutions that deliver health care to provide comprehensive services, including SRH, FP and HIV. CARE also collaborates with government and non-governmental actors at the local and national levels to create or improve health policies.

Current community-based HIV interventions in the prevention-to-care continuum

CARE is currently supporting clinical and community-based HIV care and support programs in Kenya, Mozambique, South Africa and Zambia (including TB/HIV and EMTCT), cross-border prevention, testing and counseling and referral to care programs in Bangladesh, India and Nepal, and prevention outreach and referral programs for most-at-risk populations (MARPs) in Thailand and Vietnam.

***m*Health**

CARE works closely with the **mHealth Alliance** to ensure mobile health technologies are used effectively wherever relevant and feasible. Utilizing strong partnerships, CARE is incorporating communications technologies to fight poverty, improve health, and empower women and girls. In the field, CARE routinely partners with technological innovators. Currently, CARE is working on projects in Benin and India with software technology that builds on CARE's maternal and child health programming in those countries.

*As a member of the **mHealth Alliance**, CARE is working to integrate mHealth into multiple sectors. The Alliance serves as a convener for the mHealth community to overcome common challenges by sharing tools, knowledge, experience and lessons learned.*

In Bihar, India, CARE is partnering with the British Broadcasting Company World Service Trust (BBC-WST), the local NGO Dimagi, the Grameen Foundation, and Mathematica Policy Research on a 12- to 18-month controlled study that will compare 600 community health workers using *CommCare* communications/reporting software to a similarly-sized control group not using CommCare. The study will examine the impact of *CommCare* on knowledge, uptake of services, and health outcomes. It is part of a statewide initiative funded primarily by the Bill and Melinda Gates Foundation. Through this effort, *CommCare* and Mobile Technology for Community Health (MOTECH) platforms are being integrated as part of a comprehensive mHealth platform that will be expanded to include other technologies such as OpenMRS.

CARE is implementing and evaluating a mobile technology project in Benin as a part of '*Call for Life*', a program designed to decrease maternal and child mortality through a variety of interventions. In partnership with Dimagi and D-tree international, CARE is supporting the design and deployment of a mobile technology platform targeted at community health workers and nurses. Using two modules designed for facility- and community-based health workers, the program is enhancing registration, birth preparedness planning, antenatal care visits, post-delivery discharge planning, safe pregnancy counseling, post-partum evaluation of mothers and infants, and referral.

Social Analysis and Action (SAA)

Social and gender norms present critical, yet often unacknowledged or unaddressed barriers to sexual, reproductive and maternal health. For example, the balance of power in relationships has been found to influence use of condoms,[i] use of contraception,[ii] and use of health services.[iii] Fear of intimate partner violence and experience of gender-based violence are barriers to contraceptive use,[ivv] and a study from Bolivia found that experience of gender-based violence reduced demand for family planning and reproductive health services by 30 percent.[vi] Analyses in a number of African countries have shown that women's empowerment indicators, including decision-making autonomy, equitable gender norms, and control over assets, are associated with smaller ideal number of children desired and greater contraceptive use.

CARE pioneered the Social Analysis and Action (SAA) approach to assist communities to use regularly recurring dialogue to address how their social conditions perpetuate health challenges. It has been used in multiple countries to surface and stimulate reflection on gender and social norms, often leading to transformation and greater equality in families and communities. While many believe that norms are resistant to change, our experience suggests that meaningful change can occur in a relatively short period of time and that transforming norms can unlock demand, enabling program success.

SAA can be integrated into the traditional community-based program cycle, or parts of the process can be incorporated into existing projects. It utilizes a variety of participatory tools in an ongoing process of reflection, challenge, exploration, and learning. The goal of the process is to transform staff capacity and build the capacity of communities to challenge social norms. Some key elements of the Social Action process include:

- Exploring the social dimensions of health
- Empowering communities to understand the connections between health and socio-cultural factors
- Engaging communities to take action to improve their health and well-being

Evidence that the SAA model improves family planning outcomes

The SAA approach has been used as part of integrated family planning and reproductive health programming in Ethiopia, Rwanda, Kenya, Mali, Madagascar, and Honduras, among other countries. As part of the Social Change for Family Planning Results Initiative, family planning programming was integrated into a food security program in Ethiopia, women's Village Savings and Loan groups in Rwanda; and a prevention of mother-to-child transmission of HIV program in Kenya.[vii] SAA was complemented by health systems strengthening interventions that improved the quality of and availability of family planning information, referral and method provision at both the community and clinic levels. At midterm, community members in all three countries reported more communication in their household about sexuality and family planning, and more shared decision-making around household duties, finances, and family planning. In Kenya, the review suggested promising changes in health seeking behaviors, with more couples seeking family planning and voluntary counseling and testing services together— including women who had previously hidden use of family planning from their partners.[viii] Family planning utilization data at health posts and clinics showed an overall increase in use of family planning from 18 percent in 2008 to 56 percent in 2011.[ix]

In 2007 at the start of an initiative called ***Inner Spaces, Outer Faces (ISOFI)****, CARE surveyed women in rural Uttar Pradesh, India and found that the majority of the respondents believed their husbands had the right to beat them if they refused sex.*[1] *After a two-year community-based intervention designed to encourage communities and couples to discuss, reflect on, and question harmful gender and social norms, the proportion of women who held this belief had decreased by more than 80 percent, with no change in a nearby control district. In addition, the proportion of women in the intervention area who discussed contraception with their husbands more than doubled, from 42 percent to 90 percent.*[1]

C. Livelihoods and land rights

Village savings and loan associations (VSLAs)

Women have long been at the heart of informal, member-owned, rotating savings cooperatives – among the world's oldest and most prevalent savings mechanisms. These cooperative associations form the foundation for CARE's pioneering approach to microfinance. They are sustainable, self-funded credit sources at the village level, built by members through their own savings. Not only does microfinance enable the poor to build their assets and invest in income-generating activities, but it has also proved to be remarkably effective as a vehicle for human empowerment, especially for women who have been found to benefit most from microfinance services and to make the best use of them in lifting their families out of poverty.

CARE launched its first microfinance program in Niger in 1991 with a participatory, community-based approach. From the beginning, clients – predominantly women – defined their needs and put parameters around the process. In the 18 years since then, CARE has established more than 54,000 such groups in 21 African countries, serving over 1 million members.

In CARE's Village Savings and Loan Associations (VSLAs), each member contributes to a savings fund with small, regular and mandatory deposits. CARE's comprehensive training program supports the group for up to one year, and includes skills to succeed in saving as well as establishing new businesses. VSLAs are built entirely on member savings and interest from loans; they receive no direct capital investment from CARE. However, their members do receive a year of intensive training from CARE in group dynamics and governance and in money management. This training enables the groups to become self-supporting, to flourish and even to establish and train other groups.

The VSLA approach has unique features that make it a powerful tool for empowering marginalized people, including people living with HIV/AIDS, and improving health and development outcomes:

- It is simple and easily adapted to illiterate group members.
- It promotes group solidarity and learning and establishes a vehicle for addressing community development issues.
- It relies on no infusions of outside funds.
- It requires no physical infrastructure.

CARE's economic security program, Access Africa, currently organizes vulnerable people into successful *VSLAs* in twenty-one African countries. Access Africa serves 1.9 million clients, over 70% of whom are women, and its outreach has grown by over 40% annually in the last two years. For more on CARE's *VSLA* and *Access Africa* initiatives, go to http://www.care.org/campaigns/accessafrica/index.asp

> *Via **Access Africa**, CARE is now expanding the reach of VSLAs to 30 million Africans in 39 countries and linking them with microfinance institutions, banks and banking technologies.*

Food security and livelihoods: CARE's Pathways to Secure Livelihoods Program

In 2011, CARE launched the five-year "Pathways" program across six countries (Bangladesh, India, Malawi, Tanzania, Mali, and Ghana) to increase productivity and income for women smallholder farmers, who do not typically benefit from mainstream agricultural programs. Pathways undertook a one-year research and planning phase to identify key women's empowerment and gender equality issues and to outline an effective empowering response. The program's impact will be

measured by its ability to bring about direct, fundamental changes in the lives of 150,000 poor women farmers and 555,184 members of their households.

As a result of CARE's strategy to apply Pathways' lessons more broadly, the program will positively impact an additional 13 million smallholder farmers through positive changes in systems, policies, and gender relations. Pathways will allow CARE to bring together our experience in agricultural productivity with other successful approaches that support our agriculture strategy, including our work with village savings and loan associations (VSLAs), collectives, markets and value chains. Activities planned under Pathways include strengthening agricultural collectives; supporting value-chain approaches to improving income; promoting women's control in production; promoting sustainable approaches to agriculture; improving markets for agricultural inputs, such as improved-quality seed and fertilizer; engaging men and boys in the empowerment of female farmers; and building the strength of communities and local organizations and institutions. CARE is currently exploring ways that Pathways can be catered specifically to the needs of people living with HIV/AIDS.

Mainstreaming economic development and food security with HIV/AIDS

In addition to the Pathways program, CARE has supported programs that mainstream economic development and food security with HIV/AIDS in Malawi, Lesotho, Angola and Mozambique. In each case, country programs examined the two-way linkage between HIV/AIDS and livelihoods, recognizing that HIV/AIDS can undermine food and income security, and food and income security can heighten the risk of HIV infection and exacerbate the negative impacts of AIDS. CARE supported local organizations in each country to develop mainstreaming approaches to bring economic development considerations into HIV/AIDS work, and to bring HIV/AIDS considerations into economic development work. Positive results included increased prevention reach and efficacy, reduced stigma and discrimination, increased food and livelihood security, increased collaboration among local organizations, improved gender equity, and positive and sustainable individual, family and community economic outcomes.

Sustainable land tenure

CARE has long led advocacy efforts on the one of the key issues at the center of gender inequality, food insecurity, poverty and AIDS -- women's access to land and security of land tenure. Globally, CARE collaborates with its partners to provide coordinated approaches to addressing the agriculture, market and natural resource challenges that underlie poverty conditions in developing countries. In Ghana, the *Security of Land Tenure Component (SLATE)* has helped to address barriers in accessing and controlling land for agricultural purposes. The key beneficiaries of SLATE were poor landless farmers, farmers with no tenure security, and women dependent on agriculture and natural resources for their livelihoods.

As a result of the program, women reported feeling more empowered to negotiate with men for their land. Many had increased access to land and security of tenure, including land that was previously regarded as exclusively preserved for men. In cases where husbands had insufficient land, some began supporting their wives' efforts to acquire land elsewhere. In overcoming their fears, men became allies for women seeking access to land and appreciated how much their wives contribute to household income and other domestic commitments, including payment of children's school fees.

[i] Blanc, A. K. (2001). The effect of power in sexual relationships on sexual and reproductive health: an examination of the evidence. Studies in Family Planning, 32(3): 189-213

[ii] Harvey, S. M. et al. (2003). Sexual decision-making and safer sex behavior among young female drug users and female partners of IDUs. Journal of Sex Research, 40(1):50-60

[iii] Pulerwitz, J., Gortmaker, S. L., & DeJong, W. (2000). Measuring sexual relationship power in HIV/STD research. Sex Roles 42, nos. 7/8:637-660

[iv] Heise, L., Ellsberg, M., & Gottmoweller, M. (2002). A global overview of gender-based violence. Int J Gyneacol Obstet. 78 (Suppl1)S5-S14

[v] Pallito, C. C., & O'Campo, P. (2004). The relationship between intimate partner violence and unintended pregnancy: analysis of a national sample from Colombia. Int Fam Plann Perspect. 30(4):165-173

[vi] Pinto Aguirre, Guido ; Kincaid, Mary ; Murillo Gutiérrez, Beatriz. (2010). The Relationship between Domestic Violence and Reproductive Health and Family Planning Services in Bolivia, 2003. Población y Salud en Mesoamérica. 7(2): 1-13

[vii] For more information about the Results Initiative see: CARE. (2010). Social Change and Family Planning: Linking Social Norms to Family Planning Behaviors: Baseline Survey for the Results Initiative. Available at www.care.org/campaigns/mothersmatter/downloads/SCFP_Series_1.pdf

[viii] CARE. (2010). Midterm Review of Family Planning Results Initiative in Kenya.

[ix] Government of Kenya, Siaya District Development Plan Reports, 2008-2011 and 2011-2016