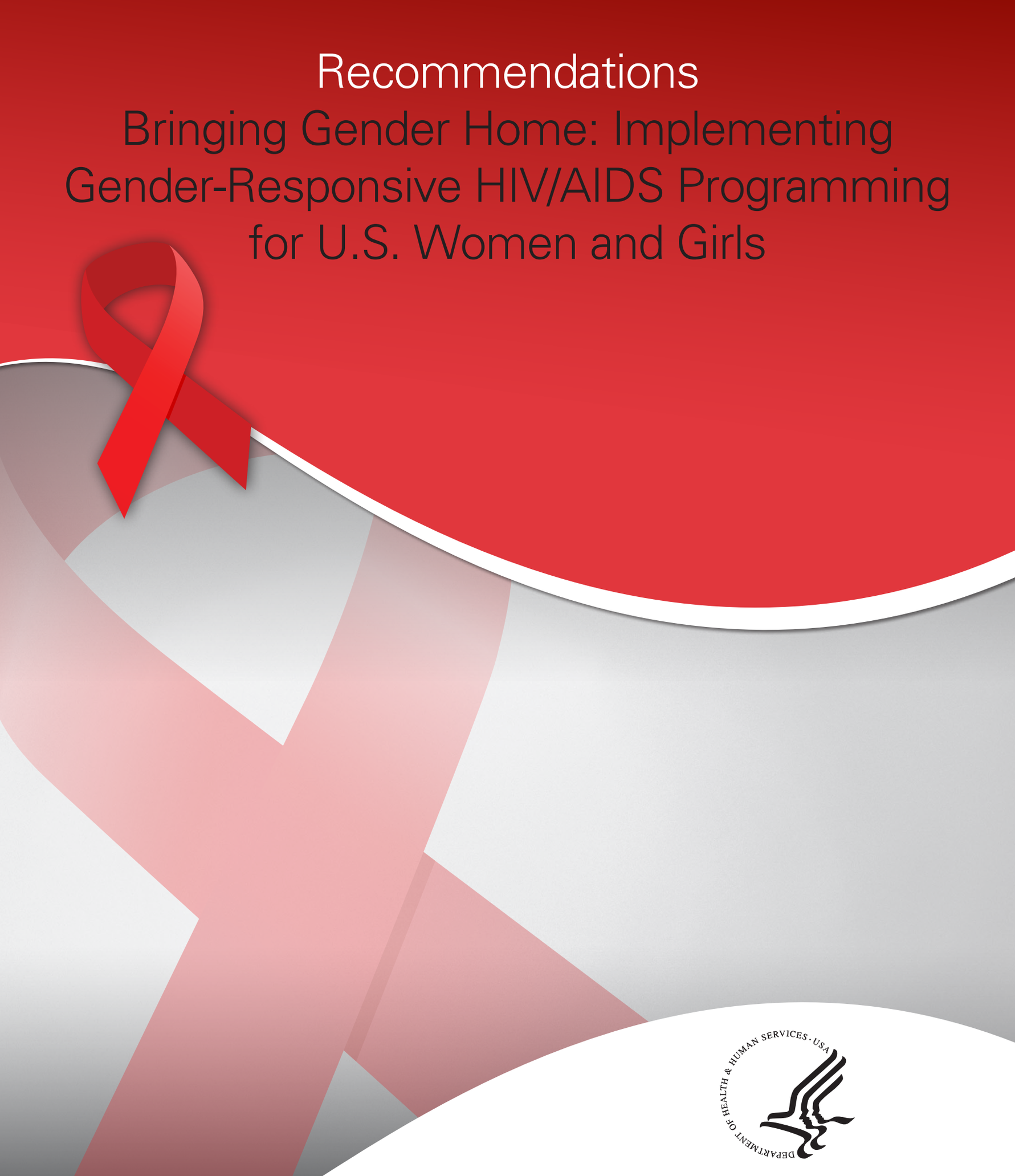
Recommendations

Bringing Gender Home: Implementing Gender-Responsive HIV/AIDS Programming for U.S. Women and Girls



Dear Gender Forum Participants,

It has been a busy few months since we all met in Washington, DC, in June 2010 for the Gender Forum. Shortly after we met, the National HIV/AIDS Strategy (NHAS) and Federal Implementation Plan for the United States were released. In order to fully take advantage of these energized times and opportunity for change, we aligned your recommendations with the NHAS goals of reducing new HIV infections, increasing access to care and improving health outcomes for people living with HIV, and reducing HIV-related health disparities.

The NHAS vision is: *The United States will become a place where new HIV infections are rare and when they do occur, every person, regardless of age, gender, race/ethnicity, sexual orientation, gender identity or socioeconomic circumstance, will have unfettered access to high-quality, life-extending care, free from stigma and discrimination*. You may read the NHAS and learn more about the Federal HIV/AIDS response at www.AIDS.gov.

The recommendations show how every recommendation we made can be fit into implementation of the NHAS. In most cases, our recommendations expand on points raised in the NHAS Implementation Plan and suggest specific aspects of implementation that, if adopted, would benefit women and girls and ultimately the wider communities in which we live. Some of our recommendations go beyond the contents of the NHAS and call for attention to issues that the NHAS may not explicitly address. These are listed in the summary under the NHAS chapters to which they refer and are indicated by a yellow block of text noting that they address issues not specifically mentioned in that NHAS chapter.

In addition, the Office on Women's Health, together with invited experts from the field, is writing a set of articles slated as part of a special supplement of *Women's Health Issues* that will be devoted to covering issues raised at the Gender Forum. Once it is published, we will send you a link to the completed issue.

Many thanks to the Forum Planning Committee members and breakout group facilitators who provided input and editing guidance on initial drafts of the attached Gender Forum recommendations. You may watch the Gender Forum first day here: http://videocast.nih.gov/summary.asp?Live=9371.

Thank you,

Gender Forum Core Planning Committee:
Mary L Bowers, Pauline Muchina, Vera Yakovchenko, Sarah Sippel, & Dazon Dixon Diallo

Special Acknowledgement

We would like to express our deepest gratitude to the following individuals for their contribution toward the success of the 2010 Gender Forum Recommendation Report.

A special thank you is extended to Pauline Muchina, Ph.D., senior partnership advisor, UNAIDS, for her global linkages and input in the success of the Gender Forum.

Co-Sponsors: MAC AIDS Fund & Advocates for Youth, Center for Health and Gender Equity, and Sister Love.

Federal partners: National Institute of Health, Office of AIDS Research; National Institute of Health, National Institute of Allergy and Infectious Diseases, Division of Extramural Activities, Office of Special Populations and Research Training; National Institute of Health, Office of Research on Women's Health; Health Resources and Services Administration, HIV/AIDS Bureau; Centers for Disease Control & Prevention, Division of HIV/AIDS Prevention; Substance Abuse and Mental Health Services Administration.

Recommendation Report Collaboration

The Report was compiled and edited by Anna Forbes, M.S.S., an independent consultant and writer specializing in HIV/AIDS, women's health, and sexual and reproductive health and rights, with consultation from Vera Yakovchenko, M.P.H., Public Health Analyst with the Office of HIV/AIDS Policy, and Mary L. Bowers, M.S.W., Public Health Advisor with the Office on Women's Health.

Planning Committee

Diane Adger-Johnson
Office of Special Populations and Research Training
National Institute of Allergy and Infectious Diseases
National Institutes of Health

Jennifer Augustine, M.P.H., CHES
Advocates for Youth

Angela Bates, M.B.A.
Office of Research on Women's Health
U.S. Department of Health & Human Services

Mary L Bowers, M.S.W.
Office on Women's Health
U.S. Department of Health & Human Services

Anissa J. Brown, Ph.D.
Office of Director, Office of AIDS Research (OAR)
National Institutes of Health

Gina Brown, M.D.
Microbicides and Women and Girls Research
National Institutes of Health

Lauren Broussard, L.G.S.W., M.P.H.
Office of HIV/AIDS Policy
U.S. Department of Health & Human Services

Victoria Cargill, M.D., M.S.C.E.
Office of AIDS Research
National Institutes of Health

Melinda Coles
DC Rape Crisis Center

Sarah Craven
United Nations Population Fund

Dazon Dixon Diallo, M.P.H.
SisterLove, Inc.

Diana Echevarria
North American Programs M·A·C AIDS Fund

Judith Ellis, M.S.
HIV/Hepatitis/Methamphetamine/
Native American Programs
Center for Substance Abuse Prevention
Substance Abuse and Mental Health Services Administration

Juan C. Espinosa Charriez
PROGRESAH
Iniciativa Comunitaria

Susana T. Fried
HIV/AIDS Practice
Bureau for Development Policy

Beri Hull
The International Community of Women Living
with HIV/AIDS

Katie Kramer, M.S.W., M.P.H.
The Bridging Group, LLC

Linda J. Koenig, Ph.D., M.S.
Centers for Disease Control and Prevention

Aleisha Langhorne, M.P.H., M.H.S.A.
Office on Women's Health
U.S. Department of Health & Human Services

Tamara Lewis Johnson, **M.B.A., M.P.H.**
Office of Special Populations and Research Training (OSPRT), DEA
National Institute of Allergy and Infectious Diseases
National Institutes of Health

Pauline Muchina, Ph.D.
UNAIDS

Jacqui Patterson, **M.S.W., M.P.H**
Women of Color United

Diana C. Prieto
Office of HIV/AIDS
U.S. Agency for International Development

Claudia Richards, M.S.W., L.I.C.S.W.
Branch Chief, Community Grants and Program

Amber L. Sastry, M.P.P.
International AIDS Vaccine Initiative

Nicole S. Schiegg
International AIDS Vaccine Initiative

Serra Sippel
Center for Health and Gender Equity (CHANGE)

CAPT Sylvia Trent-Adams, Ph.D., M.S., RN
HIV/AIDS Bureau
Office of the Associate Administrator
Health Resources and Services Administration

Ann Warner
International Center for Research on Women (ICRW)

Vera Yakovchenko, M.P.H.
Office of HIV/AIDS Policy, OPHS
U.S. Department of Health & Human Services

Workgroup Lead Facilitators

Prevention/Risk Reduction
Moderator: **Dazon Dixon Diallo, M.P.H.**
Workgroup Note-Taker: Paul Phelps

Territorial Perspectives
Moderator and Expert: **Juan C. Espinosa Charriez, M.S.W., L.C.S.W.**
Workgroup Note-Taker: Karen Elliott Greisdorf

Human Rights
Moderators and Experts: **Susana T. Fried, Ph.D.,** and **Jacqui Patterson**
Workgroup Note-Taker: Leonard Rickman

Criminal Justice
Moderator and Expert: **Katie Kramer, M.S.W., M.P.H.**
Workgroup Note-Taker: Elizabeth Sheley

Violence
Moderators: **Aleisha Langhorne, M.P.H., M.H.S.A.,** and **Linda J. Koenig, Ph.D., M.S**.
Workgroup Note-Taker: Carren Kaston

Care/Treatment
Moderator: **CAPT Sylvia Trent-Adams, Ph.D., M.S., RN**
Workgroup Note-Taker: Daria Steigman

Reproductive & Sexual Health
Moderator: **Kimberly Whipke** and **Vera Yakovchenko, M.P.H.**
Workgroup Note-Taker: Al Staropoli

RECOMMENDATIONS FROM "BRINGING GENDER HOME: IMPLEMENTING GENDER-RESPONSIVE HIV/AIDS PROGRAMMING FOR U.S. WOMEN AND GIRLS"

Compiled, written, edited by Anna Forbes with consultation from Vera Yakovchenko and Mary Bowers

INTRODUCTION

On June 10–11, 2010, the Department of Health & Human Services (HHS) Office on Women's Health (OWH), in partnership with UNAIDS, convened a 2-day Forum in Washington, DC, entitled "Bringing Gender Home: Implementing Gender-Responsive HIV/AIDS Programming for U.S. Women and Girls." The meeting was designed to engage health care providers, U.S. policy makers, and governmental and nongovernmental organizations (NGOs) functioning in the United States in identifying gaps, highlighting needs, and cultivating increased capacity for implementation of gender-responsive HIV/AIDS strategies.

The stated purpose of the OWH Gender Forum was to promote increased leadership in gender-responsive programming for women and girls. Participants at the Forum were charged with recommending strategies for developing, integrating, and modifying existing interventions and programs for the prevention of sexually transmitted diseases (STDs) and HIV/AIDS to make them more responsive to the needs of women and girls. Forum participants also were asked to identify and address the various roles and behaviors of women and girls that increase their risk for contracting and or transmitting STDs and HIV/AIDS.

The Forum started with a wide range of plenary presentations, which provided an overview of existing programming and prevention challenges in the United States and abroad. International gender experts were invited to present lessons learned and best practices developed in international programs, many of which the United States has supported and underwritten since 2004.

After these plenary presentations and discussion, Forum participants divided into breakout groups to discuss the needs, strengths, and challenges faced by women and girls at high risk for HIV in the United States. The breakout groups focused on:

- Prevention/Risk Reduction
- Care/Treatment
- Violence
- Reproductive/Sexual Health
- Human Rights
- Criminal Justice
- Territorial Perspectives (i.e., Puerto Rico and the U.S. Virgin Islands)

The diverse knowledge and expertise within these groups led to the development of specific recommendations for incorporating gender/sex-responsive approaches into HIV prevention, care, and treatment programming, as well as identifying gaps where such approaches are needed. The following summary of these recommendations will be submitted to the HHS Office of HIV/AIDS Policy for use in their development of an HHS National HIV/AIDS Strategy (NHAS) operational plan due to the White House on December 9, 2010. These recommendations reflect the opinions of the Forum participants and do not necessarily represent the views of the Federal employees who facilitated this meeting or the Federal agencies that sponsored it. An in-depth report on the Forum and its outputs is being written for publication in a peer-reviewed journal in 2011.

HOW TO USE THIS DOCUMENT

Released by the White House Office on National AIDS Policy on July 13, 2010, the United States *National HIV/AIDS Strategy* "is intended to be a concise plan that will identify a set of priorities and strategic action steps tied to measurable outcomes."[1] As noted in its accompanying Federal Implementation Plan, it is designed to "serve as a catalyst for all levels of government and other stakeholders to develop their own implementation plans for achieving the goals of the *National HIV/AIDS Strategy*."[2]

In an effort to contribute as directly and unambiguously as possible to the work of implementing this plan, we organized the Forum recommendations to correspond directly to the format of the NHAS. In the chart below, each recommendation or set of recommendations is preceded by the NHAS Implementation Plan Category and the NHAS Direction/Action to which the recommendation(s) refers.

In most cases, these recommendations expand on points raised in the Implementation Plan and highlight aspects of implementation that, if adopted, would benefit women and girls.

Some recommendations made during the Forum refer to issues not addressed in the NHAS. These are listed under the NHAS chapters to which they refer and are indicated by a yellow block of text noting that they address issues not specifically mentioned in that NHAS chapter.

IN-DEPTH DISCUSSION OF THE FORUM TO FOLLOW IN PUBLISHED FORM

Clearly, a simple listing such as this one cannot address the nuances inherent in each of these complex issues. An in-depth and nuanced discussion will be provided by the Forum papers published in 2011.

The need, for example, to allow local jurisdictions to incorporate social and structural determinants data in their assessments of HIV services needs *(see recommendation A in Chapter 1 below*) was emphasized by Forum participants who felt that we must move beyond data collection systems that focus on demographics and personal risk as the primary factors shaping HIV service needs. More about their reasoning in this area will be explored in the papers to follow.

Similarly, the issue of cultural competency training for primary care providers (*see Chapter 2, recommendation G)* was identified as essential to improving their capacity to deal effectively with patients' health care needs. Forum participants emphasized that a provider's ability to listen and elicit information effectively, and make accurate assessments around the sensitive issues of sexuality and interpersonal violence, are *as important* to patients' well being as the provider's biomedical skills, and must be cultivated as rigorously.

With regard to the need for gender-responsive standards of care and quality measures for the delivery of sexual and reproductive health (SRH) and HIV care (*see Chapter 2, recommendation I*), participants flagged for particular attention the issue of the amount of time patients have with providers during primary care visits. The amount of time allocated to general checkups with healthy, HIV-negative patients is unlikely to be sufficient for the management of complex medical conditions such as HIV. More research is needed to develop an adequate standard in this area for HIV care.

[1] National HIV/AIDS Strategy (page vii) at www.WhiteHouse.gov/ONAP.
[2] National HIV/AIDS Strategy: Federal Implementation Plan (page 1) at www.WhiteHouse.gov/ONAP.

Chapter 1: Reducing New HIV Infections

NHAS Implementation Plan Category	NHAS Direction/Action	Forum Recommendations
Introduction	**NHAS commits to** "testing and growing our portfolio of interventions that incorporate such issues as sexual networks, income insecurity, and other social factors that place some individuals and populations at greater risk for HIV infection than others" (*see page 10 of Implementation Plan*).	**A.** Explore how States and local jurisdictions currently record data on structural determinants such as income insecurity, food insecurity and homelessness so that they can be factored into calculations of the need for public services. Use this information to develop standardized reporting mechanisms that States and localities can use to collect and record social and structural determinants data for use in assessing HIV services needs and gauging the appropriateness of available interventions for their populations.
1.2.1 Prevent HIV among gay and bisexual men and transgender individuals	**NHAS directs** the CDC to "expand its work evaluating adaptations of specific interventions for transgender populations and issue a fact sheet recommending HIV prevention approaches for transgender persons."	**B.** To develop a clearer understanding of how to shape appropriate interventions for transgender populations, modify all Federal reporting systems—including those used in the provision of HIV, sexual and reproductive health (SRH) and gender-based violence (GBV) prevention services— to capture, track, and analyse data on transgender individuals' met and unmet needs. This can be accomplished by adding "transgender MTF" and "transgender FTM" as accepted alternatives to "male" and "female" in all systems that record gender as a data element.
1.2.4 Prevent HIV among substance users	**NHAS directs** SAMHSA to "implement ways to improve integration of substance abuse and mental health screening into programs that serve communities with high rates of new HIV infections."	**C.** Integrate HIV prevention, testing, and treatment services, as well as substance abuse and mental health screening, into the SRH and GBV services provided to communities with high rates of new HIV infections – with highest priority placed on service integration in regions currently experiencing the greatest health care disparities. **C-i.** Replicate and scale up programs integrating HIV, SRH, and/or GBV services that have already been proven effective in the United States and elsewhere[3,4,5,6,7]

[3] Druce N, Dickinson C, Attawell K, et al. "*Strengthening linkages for sexual and reproductive health, HIV and AIDS: progress, barriers and opportunities for scaling up*" August 2006. UK Department for International Development. Health Resource Center. See "Annex 4: SRH HIV and AIDS: Approaches, Experiences and Effectiveness." Available online at http://www.dfidhealthrc.org/publications/srh/Annex%204%20SRH%20and%20HIV-AIDS%20Oct.pdf

[4] WHO. *Sexual & reproductive health and HIV Linkages: evidence review and recommendations.* 2008. Geneva/New York/London/San Francisco: World Health Organization/Joint United Nations Programme on HIV/AIDS/United Nations Population Fund/International Planned Parenthood Federation/University of California, San Francisco.

[5] Fleischman J. Integrating reproductive health and HIV/AIDS programs. Strategic opportunities for PEPFAR [a report of the CSIS Task Force on HIV/AIDS, CSIS 9]. 2006. Washington, DC: Center for Strategic and International Studies.

[6] Caro D, *A Manual for Integrating Gender Into Reproductive Health and HIV Programs: From Commitment to Action (2nd Edition).* November 2009 Washington DC: Interagency Gender Working Group. Available online at http://www.prb.org/igwg_media/manualintegrgendr09_eng.pdf

[7] Ringheim K, Yeakey M, Gribble J, et al. "Supporting the Integration of Family Planning and HIV Services." September 2009. [a Population Reference Bureau Policy Brief]. Washington. DC: Population Reference Bureau. Available online at http://www.prb.org/pdf09/fp-hivintegration.pdf.

		C-ii Where services integration does not already exist, develop a range of suggestions (*see above references*) for providers on how to form integrative collaborations and link services. These could include co-location of services, providing coordinated care through interagency collaborative agreements, and referral systems that monitor client follow-through and delivery of referred services.
		C-iii. Create collaborative grants to promote community partnerships for delivery of HIV, SRH, and GBV prevention services.
2.1 Design and evaluate innovative prevention strategies and combination approaches for preventing HIV in high risk communities	**NHAS states** that "CDC, HRSA, SAMHSA will collaborate with States and localities on pilot initiatives for expanding the most promising models for integrating HIV testing, outreach, linkage and retention in care in high risk communities."	**E.** Demonstrable ability to retain the participation of women and girls in HIV and SRH programs should be considered as a positive factor in funding decisions. In addition to encouraging programs to re-engage consumers "lost to followup" (those absent from medical appointments after treatment has been initiated), incentivize providers to design and implement programs that keep consumers engaged by meeting their specific needs effectively (e.g., the provision of childcare and "one stop shopping" health services for women with children).
	NHAS directs NIH and CDC to "develop and implement a plan for evaluating promising community-generated ('homegrown') HIV prevention interventions."	**F.** Involve local experts from the outset in the design of mechanisms for evaluating locally developed interventions, as they are the most knowledgeable about indicators that are likely to accurately reflect whether an intervention meets the needs of women and girls where they are in their communities.
2.3 Expand access to effective prevention services	**NHAS directs** agencies to "make recommendations for scaling up access to post exposure prophylaxis (PEP), with priority given to high prevalence jurisdictions. Consideration will be given to the role of emergency departments (if any), standardized treatment guidelines, and regimen selection."	**G.** Give high priority to expanding awareness of, and access to, PEP for sexual assault survivors. The roles of emergency departments, police, other first responders, and primary care providers in this effort are critical. Targeted education to these gatekeepers regarding this important option is essential and should be highlighted in AETC trainings (*see recommendation G-ii in Chapter 2*).
	NHAS states that "BOP will expand access to HIV, STD, viral hepatitis screening to prisoners on entry, and CDC and BOP will promote risk reduction interventions for healthy reintegration of ex-prisoners back into community settings."	**H.** The Bureau of Prisons (BOP) should incorporate accurate, comprehensive HIV prevention education into all incarceration and post-incarceration re-entry health programming.
		H-i. BOP should ensure that all post-incarceration release kits include male and female condoms, hygiene items and specific information about available local HIV and other health resources, including current contact numbers for accessing those resources.

3.2 Promote age-appropriate HIV and STI prevention education for all Americans	**NHAS directs** the CDC to "develop a toolkit and work with States, localities and school boards to implement age-appropriate HIV health education programs."	**I.** Require States and local jurisdictions to engage HIV and gender experts to evaluate their sexual and reproductive health-education curricula to assure that they are comprehensive, involve the family appropriately, and deliver age- and gender-appropriate HIV prevention and sexual health education. These could be analogous to the HIV Materials Review Panels[8] that CDC grantees are required to convene but be comprised of panelists with specific expertise in education and gender issues.

Important additional prevention issues not covered in the NHAS Implementation plan

Female condoms	The need to expand the uptake and use of female condoms, a highly effective HIV prevention tool, is not mentioned in the NHAS.	**J.** Expand education about, public dissemination of, and use of female condoms through media and social marketing. Include training on female condom introduction and promotion as one of the first topics addressed in trainings provided to primary health care providers (*see recommendation G in Chapter 2 below*).
Gender-Based Violence Prevention	Although gender-based violence is mentioned in the NHAS, no mention of GBV prevention services or monitoring appears in the NHAS Implementation Plan.	**K.** To address the demonstrable linkage between GBV and HIV risk among women in the U.S.[9,10], integrate provision of HIV and GBV prevention services, increase funding for services to prevent GBV, and increase investment in shelter services and transitional support programming for survivors of GBV. **L.** Standardize definitions and measures of GBV[11,12] to facilitate identification and data collection regarding its incidence and prevalence in the United States, societal drivers, and its connection to HIV risk and transmission among women and girls in the United States. **M.** Create a Federal plan within DHHS for measuring, documenting, and reducing the number of violent acts against women and girls annually. Add these benchmarks to Healthy People 2020. **N.** Create a joint Department of Justice (DOJ)/DHHS mandate addressing GBV as both a public health and a legal issue.

[8] CDC. Annual Report Guidance and Templates: Funding Opportunity Announcement DP08-801 – 02 Year 2 Annual Report. 2010. Available online at http://www.cdc.gov/dash/reporting_guidance/guidance_templates.htm.

[9] Sareen J, Pagura J, Grant B. Is intimate partner violence associated with HIV infection among women in the United States? *General Hospital Psychiatry*. 2009; 31(3):274-8. Epub 2009 Mar 27. Full text available on line at http://www.cfah.org/hbns/archives/viewSupportDoc.cfm?supportingDocID=782

[10] Wyatt GE, Myers HF, Williams JK, et al. Does a history of trauma contribute to HIV risk for women of color? Implications for prevention and policy. *American Journal of Public Health*. 2002;92:1-7.

[11] USAID. A Guide To Programming Gender-Based Violence Prevention And Response Activities. April 2009. [Draft for Discussion Purposes]. Washington DC: USAID Gender-Based Violence Working Group. See Appendix 1: Gender-Based Violence Terms and Definitions. Available online at http://pdf.usaid.gov/pdf_docs/PNADO561.pdf

[12] OneResponse,info. Handbook for Coordinating Gender-based Violence Interventions in Humanitarian Settings July 2010. Gender-based Violence Area of Responsibility Working Group. Available online at http://www.gbvnetwork.org/_attachments/4637582/GBV%20Handbook%20Sept2010.pdf.

O. Package and disseminate GBV data, with "best practices" information on its reduction.

P. Require States to reassess their HIV/STD partner notification processes to assure that women receive adequate support to reduce their risk of GBV as a result of partner notification.

Q. Incorporate HIV and substance abuse prevention services language into the Violence Against Women Act (VAWA) during its 2011 reauthorization process. Specifically:

- Provide incentives for programs that cross-train providers of GBV, mental health, and HIV services to build their capacity for appropriate client screening, education, and referral across all three areas.

- Include earmarked funding for educational programming in jails, schools and community venues on GBV, HIV, and mental health to raise awareness of the interconnectedness of GBV, mental illness, and HIV risk; break down stigma; and change cultural norms and expectations.

- Establish a link between access to VAWA funding and States' compliance with the provision of comprehensive sexual health education, including a GBV education component in their public schools.

Gender-Sensitive Programming

The NHAS acknowledges that negotiating safer sexual practices can be especially challenging for women who may be vulnerable to physical violence, or who may be emotionally or economically dependent on men." (*see page 12*). It does not, however, include plans for creating gender-sensitive programming to address this and other gender-related barriers. A growing evidence base documents the effectiveness of well-designed interventions in this area.[13,14,15,16]

R. Fund peer-led and community-based programming that promotes open and expanded communication on issues of sex and gender among:

- women and girls
- men and women
- men and boys transgender individuals in the categories in which they self-identify

R-i. Include elements of GBV awareness training, sexual health promotion, HIV risk reduction, and nonviolent communication methods in this programming.

[13] Gay J., Hardee K., Croce-Galis M., Kowalski S, Gutari C, Wingfield C, Rovin K, Berzins K. 2010. *What Works for Women and Girls: Evidence for HIV/AIDS Interventions.* New York: Open Society Institute. Available online at www.whatworksforwomen.org

[14] International Center for Research on Women. 2009. *Integrating multiple gender strategies to improve HIV and AIDS interventions: a compendium of programs in Africa.* Washington, DC: International Center for Research on Women. May 2009. Available on line http://www.aidstar-one.com/focus_areas/gender/resources/compendium_africa

[15] Rao Gupta G, Ogden J, Parkhurst J, Appleton P, Mahal A. Understanding and addressing structural factors in HIV prevention. *The Lancet*, August 2008, Vol. 372 No. 9640: 764-775.

[16] Caro D, *A Manual for Integrating Gender Into Reproductive Health and HIV Programs: From Commitment to Action (2nd Edition).* Washington, DC*:* Interagency Gender Working Group. November 2009. Available online at http://www.prb.org/igwg_media/manualintegrgendr09_eng.pdf

		R-ii. Involve relevant community leaders and opinion makers as appropriate (e.g., involve faith community leaders as violence prevention partners). **R-iii.** While maintaining sensitivity to local cultural norms, these groups need to challenge harmful traditional practices and messages. They should, for example, encourage women and girls to explore safe ways of using woman-initiated HIV prevention tools even in the cultural context of male dominance during sexual interactions. They also need to communicate that GBV is a crime and a civil rights violation, not a normative act.
Criminal Justice	One reference to HIV prevention for prisoners in the NHAS Implementation Plan concerns "access to HIV, STD, viral hepatitis screening to prisoners on entry" and "risk reduction interventions for healthy reintegration of ex-prisoners back into community settings." (*see page 15*)	**S.** The Plan does not mention prisoners' other HIV prevention service needs. BOP should revise its guidance regarding medical services that must be provided as a condition of Federal funding to require that all incarcerated people have access to comprehensive HIV-related health care and prevention services, including sexual health education, screening and treatment for HIV and other STDs (periodically during incarceration as well as at entry), and access to prevention tools including condoms (male and female) and dental dams. BOP should promote adoption of this guidance by non-Federal systems, as well **T.** BOP should require federally funded correctional facilities to submit the institutional measurement tools they use to assess health care delivery for review and evaluation by federally assembled panels with expertise on gender and corrections. These panels are needed to assess the adequacy of these tools with regard to measuring delivery of the HIV-related services specified above. **U.** BOP should direct contracted providers to provide access to gender-responsive mental health and substance abuse screening and treatment services to all incarcerated women and girls, since these factors directly affect their HIV risk. **V.** BOP should make Federal funding to correctional facilities conditional on human rights and civil rights compliance, as well as the delivery of evidence-based programs to meet the correctional health care needs articulated in this document. BOP should also work with DOJ to create and implement mechanisms for effectively monitoring this compliance and service delivery.

Microbicides	The NHAS states that "effective vaccines and microbicides are not yet available and investments in research to produce safe and effective vaccines and microbicides must continue." (*see page 15*). The Implementation Plan, however, makes no mention of microbicides.	**W.** Continued Federal investment in microbicide research and development. Discovery of the first safe, effective microbicide underscores the urgency of the need for products effective enough for use by women in the United States and globally.
Anonymous HIV Testing	The NHAS acknowledges that "[p]eople at high risk for HIV cannot be expected to, nor will they seek testing or treatment services if they fear that it would result in adverse consequences or discrimination." (*see page 36*). Research shows that the option of anonymous HIV testing is essential to encourage testing and risk reduction among people who are not yet ready to be tested confidentially.[17,18,19,20] While the Implementation Plan emphasizes the need to scale up HIV testing, the specific need for anonymous HIV testing services is not mentioned either in the NHAS or its Implementation Plan.	**X.** Require all States and territories to fund and provide broad access to anonymous HIV testing services. Where such services are not currently available (as is the case in eleven states and in Native communities), they should be established in consultation with the local organizations advocating on behalf of the populations at highest risk of HIV.
HIV Prevention Targeted to Sex Workers	Neither the NHAS nor its Implementation Plan makes any mention of sex workers or prostitution.	**Y.** DHHS needs to re-assess its May 13, 2010, guidance regarding implementation of the "Anti-Prostitution Pledge" language in the Leadership Act (legislation authorizing PEPFAR). This guidance is not evidence-based and its burdensome "Organizational Integrity" rule hampers grantees' ability to carry out the intent of the Leadership Act efficiently and effectively.[21,22,23] Thus, it wastes scarce HIV prevention dollars and (pending litigation) may soon restrict the ability of U.S.-based NGOs to use proven methods and best practices to deliver HIV prevention services to sex workers.

[17] Fehrs LJ, Fleming D, Foster LR, et al. Trial of anonymous versus confidential human immunodeficiency virus testing. *Lancet.* 1988 Aug 13;2(8607):379-82.
[18] Hirano D, Gellert GA, Fleming K, Boyd D, Englender SJ, Hawks H. Anonymous HIV testing: the impact of availability on demand in Arizona. *Am J Public Health.* 1994;84:2008-10. [PMID: 7998649]
[19] CDC. Revised Guidelines for HIV Counseling, Testing, and Referral. November 9, 2001: 50(RR19);1–58. Available online at http://www.cdc.gov/mmwr/preview/mmwrhtml/rr5019a1.htm.
[20] Bindman AB, Osmond D, Hecht FM, Lehman JS, Vranizan K, Keane D, et al. *MMWR.* Multistate evaluation of anonymous HIV testing and access to medical care. Multistate Evaluation of Surveillance of HIV (MESH) Study Group. *JAMA.* 1998;280:1416-20. [PMID: 9801001]
[21] Open Society Institute, Pathfinder International. "New Federal Regulations on HIV/AIDS Funds Restrict Free Speech Statement by the Open Society Institute and Pathfinder International". 13 May 2010. Available online at file:///Users/admin/Documents/Sex%20work/Prostitution%20Pledge/DHHS%20regs%2005%2013%2010.webarchive.
[22] American Civil Liberties Union. "Comments on Office of Global Health Affairs–Regulation on the Organizational Integrity of Entities Implementing Leadership Act Programs and Activities—Notice of Proposed Rulemaking, 74 Fed Reg. 61,096, 23 November, 2009. Available online at http://www.aclu.org/hiv-aids-womens-rights/aclu-comments-submitted-secretary-health-and-human-services-regarding-obama-a
[23] Bliss K. "Sex Workers' Rights are Human Rights." 23 July 2010. Center for Strategic & International Studies. Available online at http://www.smartglobalhealth.org/blog/entry/sex-workers-rights-are-human-rights/

Chapter 2: Increasing Access to Care and Improving Health Outcomes for People Living with HIV

1.1 Facilitate linkages to care	**NHAS states** that "CDC, HRSA and SAMHSA and other relevant HHS agencies will work with States, tribal governments, localities and CBOs to promote co-location of providers of HIV screening and care services as a means of facilitating linkages to care and treatment, and to enhance current referral systems within CBOs."	**A.** Expand the range of HIV service provision sites (including prevention, voluntary counseling and testing, and treatment) to include integration of these services (by direct provision or referral) at: • federally qualified health centers • federally funded community health centers • Indian Health Service centers • GBV service provider sites • Mental health care provider sites • SRH provider sites **A-i.** Fund community-based programs and ongoing peer-to-peer support services that empower, educate and assist women and girls living with HIV in communicating fully with their health care providers.
1.2 Promoting collaboration among providers	**NHAS states** that "HUD and other relevant federal agencies will develop joint strategies to encourage the co-location of, and enhance availability of, HIV-related services at housing and other non-traditional HIV care sites."	**B.** Develop and sustain substance abuse and HIV prevention programs in public housing developments and other venues heavily impacted by poverty, illegal drug trade, and commercial sex. **B-i.** Require local service providers implementing these programs to incorporate into them community-based outreach and education components on women's and girls' human and civil rights. This should include distribution of low-literacy information regarding local sources of accessible legal assistance for those whose rights have been violated. **B-ii.** Identify local public and community legal service organizations with demonstrable expertise in HIV, GBV, and gender rights violations. List these as local sources of assistance in the program outreach materials described above. Scale up funding to these legal service providers to meet the increased need for their services generated by this outreach and referral system.
	NHAS directs "CDC, SAMHSA, DOJ and HUD to identify and develop potential programs where there can be joint grant awards."	**C.** Issue RFAs for joint grants to fund demonstration projects in the area of SRH/HIV/GBV integration. Fund and implement pilot projects particularly in epidemiological "hotspots" (areas with high numbers of new HIV infections). *(this recommendation also applies to section 2.3 in Chapter 3 below)*

1.3 Maintain people living with HIV in care

NHAS states that "BOP will conduct a review of current policies and procedures and issue guidance to encourage all prisons to provide discharge planning to link HIV-positive persons to appropriate services upon release from incarceration in order to reduce interruptions in HIV treatment. This will include considering ways to promote broader adoption by nonfederal systems of BOP's standards of providing a 30-day supply of HIV medications upon release."

D. Given that family reunification programs help to both reduce recidivism[24,25,26] and assure continuity of care for HIV positive inmates upon release[27,28], provide DOJ/DHHS funding to support family reunification programs in correctional facilities housing HIV-positive people. Make the provision of these programs a condition of such facilities' eligibility for DOJ block grant funding.

E. Given that sustaining family and community relationships during and following incarceration can reduce HIV risk-taking behaviors among incarcerated people and help assure continuity of care for HIV- positive individuals upon their release (*see references above*), DOJ should:

- Study and document the impact of peer-based support programs (both during incarceration and after release) on preventing recidivism and reducing HIV risk
- Require correctional facilities to fund tele-video services for use by inmates in dependency court appearances[29] and general visiting with family members
- Research programs that allow babies to stay with their mothers in correctional facilities[30,31,32,33] to determine their impact on
    - Retention of HIV positive mothers in care following their release,
    - family reunification after the incarcerated women's release, and
    - acquisition of effective parenting skills by HIV positive mothers.

[24] Williams BD. "Testimony on Recidivism Reduction Strategies for Application during Incarceration For Presentation to the State of Illinois Prison Management Reform Committee of the Illinois House of Representatives." Springfield, IL. 4 May 2001.
[25] Nugent WR, Carpenter D, Parks J. A statewide evaluation of family preservation and family reunification services. *Research on Social Work Practice* January 1993 3: 40-65, doi:10.1177/104973159300300103
[26] McLean RL, Robarge J, Sherman SS. Release from jail: Moment of crisis or window of opportunity for female detainees? *Urban Health.* 2006 May; 83(3): 382–393. Published online 2006 May 4. doi: 10.1007/s11524-006-9048-3.
[27] Spaulding AC, Jacob Arriola KR, Ramos KL et al. Enhancing linkages to HIV primary care in jail settings: Report on a consultants' meeting. *J Correct Health Care* April 2007 13: 93-128, available in line at http://enhancelink.org/sites/hivjailstudy/Emory_Jail.pdf
[28] Jacobs R. "Re-entry Issues for Offenders Living with HIV." Prepared for the New Jersey Reentry Roundtable, Session Two: Reentry & Public Health. January 24, 2003. New Jersey Institute for Social Justice, Newark, NJ. available online at http://www.njisj.org/document/jacobs_report.pdf
[29] Courts may, but are not required to, allow parents to participate in dependency hearings by telephone rather than in person. Failure to appear in person (or to participate by telephone, if permitted) often weighs against a person in the court's judgment (see "Willie G and Bonnie H v. Arizona Department of Economic Security and Nykole G, 2005" available online at http://www.apltwo.ct.state.az.us/Decisions/CV20040065_66_Opinion.pdf). Tele-video services enable inmates to participate in such hearings in a way that courts may find more acceptable than telephone participation. They also spare the State the expense of transporting prisoners to hearings when a personal appearance is not required.
[30] Smalley S, "Bringing Up Baby in the Big House." *Newsweek* 14 May 2009. Available online at http://www.newsweek.com/2009/05/13/bringing-up-baby-in-the-big-house.html
[31] Carlson, JR. Evaluating the effectiveness of a live-in nursery within a women's prison. 1998. *Journal of Offender Rehabilitation*, 27(1/2):73-85.
[32] Carlson, JR. 2001. Prison nursery 2000: A five year review of the prison nursery at the Nebraska Correctional Center for Women. *Journal of Offender Rehabilitation*, 33(3):75-97.
[33] Goshin LS, Byrne MW. Converging Streams of Opportunity for Prison Nursery Programs in the United States. 2009. *J Offender Rehabil.*,48(4): 271–295.

2.1 Increase the number of available providers of HIV care	**NHAS directs** HRSA, NIH and OMH to "develop a proposal to fund training programs to increase interest, representation and competence of health professionals, researchers, and racial/ethnic minority students in research, public health and HIV/AIDS care."	**F.** Require cultural competency qualification (with training and re-assessment for existing staff who fail to qualify) for all publicly funded health care providers and program staff to assure that these employees can accurately assess and respond to the needs of the populations they serve. **F-i.** Diversify the staff within provider facilities to better reflect the communities they serve.
2.2 Strengthen the current provider workforce to improve the quality of HIV care and health outcomes for people living with HIV.	**NHAS states** that the AIDS Educational and Training Centers (AETCs) will "expand training for HIV clinicians and provider organizations to address provider-associated factors (e.g. cultural competency, provider continuity) that affect treatment adherence."	**G.** Substantially strengthen the AETCs'capacity to build cultural competency among primary health care providers, thus improving providers' capacity for cross-cultural communication that correctly identifies and responds to their patients' interrelated sexual health care, HIV, and violence prevention needs. **G-i** Increase the AETCs' use of instructors with specific expertise in culturally and linguistically appropriate communication around sensitive issues such as medical treatment adherence and the factors that may affect it (such as gender-based roles, stigma and violence). **G-ii.** Highest priority for expanding this aspect of AETC trainings should be given to training providers in underserved and/or high HIV incidence areas.
	NHAS directs HRSA to "increase the number of clinical providers who are engaged in innovative rural HIV/AIDS health care delivery systems (e.g. home health care, telehealth)."	**H.** In addition to providing training to assure the cultural competency of these providers *(see recommendation G above*), invest in targeted and culturally competent outreach to promote uptake of innovative rural HIV/AIDS health care delivery systems (e.g., home health care, telehealth), particularly among underserved people in rural areas, Puerto Rico, and the U.S. Virgin Islands, as well as in Native communities. **H-i.** With the same level of attention to cultural competence as required in work with the rural and underserved communities mentioned above, extend targeted outreach to older-citizen communities, using age-appropriate models that make discussion of sexual health issues acceptable and de-stigmatize discussion of HIV risk, testing, and services.

3.1 Enhance client assessment tools and measurement of health outcomes	**NHAS states that** Federal agencies "in coordination with HHS OS, will work with States, localities, and CBOs to encourage the adoption of nationally accepted clinical performance measures to monitor the quality of HIV care."	**I.** Develop uniform gender-responsive standards of care and quality measures for the delivery of SRH and HIV care. Standards must assure equity in the levels and quality of care provided to women, men, and transgender individuals.
3.2 Address policies to promote access to housing and supportive services to people living with HIV	**NHAS directs** Federal agencies to "collaborate and increase access to nonmedical supportive services (e.g. housing, food/nutrition services, transportation) as critical elements of an effective HIV care system."	**J.** Expand resources and programmatic support available to informal (unpaid) caregivers who are providing primary, day-to-day care to people living with HIV in their family and/or community networks. Most unpaid care givers are women and girls, and the provision of supportive services such as day care, transportation, food resources, etc. is essential to their ability to sustain this role effectively.
3.4 Strengthen enforcement of civil rights laws	**NHAS notes** that the "Department of Justice and other Federal agencies must enhance cooperation to facilitate enforcement of Federal antidiscrimination laws."	**K.** Issue a joint DOJ/DHHS statement against discriminatory practices affecting people living with HIV in the criminal justice system. Such a statement should specify the penalties and funding repercussions that will attach to such practices.

Chapter 3: Reducing HIV-Related Health Disparities

2.1 Establish pilot programs that utilize community models	**NHAS states** that DHHS agencies will collaborate "to engage in policy research and evaluation activities to identify effective prevention approaches to reduce disease burden in high prevalence communities."	**A.** Support community-based participatory research (CBPR) to identify barriers to HIV testing and treatment in areas of high HIV prevalence and incidence in the United States. CBPR should also be funded to develop effective tools for SRH promotion and HIV prevention programming, as well as optimal methods of program integration, particularly in these regions.
	NHAS directs "relevant HHS agencies to consider ways to enhance the effectiveness of prevention and care services provided for high risk communities, including services provided through the Minority AIDS Initiative."	**B.** Create a funded Congressional Initiative on Women and HIV that is directly analogous to the Minority AIDS Initiative.
2.3 Promote a more holistic approach to health	**NHAS directs** "HRSA/CDC, SAMHSA" DOJ and HUD to "include language in grant announcements requiring the integration of prevention and care services, including referrals to clinical services."	**C.** Issue RFAs for joint grant awards to fund demonstration projects in SRH/HIV/GBV integration. Pilot such collaborations in epidemiological "hotspots" (areas with high numbers of new HIV infections) in the United States. *(this recommendation also applies to section 1.2.4 in Chapter 1 above)*

	NHAD directs the HHS OS to "mine existing databases to explore associations between HIV infection and social determinants of health."	**D.** Feed this information into the process described above *(see recommendation A of Chapter 1)* in the development of mechanisms with which states and localities can collect, record, and use social and structural determinants data relevant in their assessments of HIV service needs. Data should be disaggregated by sex (male, female, MTF, FTM) wherever possible.
3.1 Engage communities to affirm support for people living with HIV.	**NHAS directs** Federal agencies to "develop a joint initiative to consider ways to help individuals living with HIV access income supports, including job skills and employment."	**E.** Fund and support HIV service providers to train and engage qualified HIV-positive women as peer health educators, primary and secondary prevention promoters, and service advocates for people living with HIV (PLWH). Assure that they are provided with regular, professional supervision and appropriate compensation.
3.2 Promote public leadership of people living with HIV	**NHAP states** that Federal agencies will "develop recommendations for strengthening the parity, inclusion and meaningful representation of people living with HIV in planning and priority-setting bodies."	**F.** The CDC/HRSA HIV/AIDS Advisory Committee, jointly with the DOJ, should establish a Community Advisory Board that includes formerly incarcerated women (both HIV positive and HIV negative) among its members to review the potential effectiveness and impact of all HIV and gender-related initiatives implemented in correctional facilities.
3.3 Promote public health approaches to HIV prevention and care	**NHAS states** that the "CDC/HRSA HIV/AIDS Advisory Committee will solicit public input and make recommendations for normalizing and promoting individuals' safe, voluntary disclosure of their HIV status."	**G.** Support school-based, community outreach, and social marketing campaigns that normalize HIV testing and care as a part of primary health care. This should be a part of comprehensive sexual health education *(see recommendation I in Chapter 1 above).*
	NHAS states that DOJ and DHHS will "identify a departmental point of contact and provide technical assistance resources to States considering changes to HIV criminal statutes in order to align laws and policies with public health principles."	**H.** Invest in research to assess the impact that laws criminalizing HIV exposure and transmission are having on various populations' willingness to get tested for HIV and access HIV care and services.

Important issues not included in the NHAS that relate to health disparities

SRH and GBV integration issues	The Implementation Plan does not address the integration of SRH and GBV services into HIV-related service provision as a way of more effectively and holistically meeting the needs in underserved communities, especially women and girls at high risk of HIV.	**I.** During reauthorization of the Ryan White CARE Act, add SRH provision and GBV reduction language that requires grantees to indicate how these services will be linked with, and/or integrated into, the services provided by CARE Act grantees.

		I-i. Ensure that the Affordable Care Act (ACA) guidance language, as it is developed, includes integration of SRH/HIV/GBV screening and treatment services by primary health care providers and provides incentives for such integration of services at the local level. **I-ii** The scope of the need for integrated services in diverse locations including rural communities, high-risk urban settings, and Native communities should be taken firmly into account during development of ACA guidelines and delivery systems.
Criminal justice	The value of peer health education is widely acknowledged and supported throughout the rest of the NHAS but this significant barrier to its provision in correctional institutions is not addressed.	**J.** BOP guidance should include direction to revise "clearance procedures" that prohibit people with criminal histories from entering correctional facilities to deliver peer health education, since the provision of such information by formerly incarcerated peers has been shown to be highly effective.[34,35]
Puerto Rico and the U.S. Virgin Islands	The NHAS mentions that "Puerto Rico and the U.S. Virgin Islands are disproportionately impacted by HIV" (*see page 2*) but steps assess the scope of this impact are not included in the Implementation Plan.	**K.** Invest in more research to analyse the scope of the epidemic in the U.S. Virgin Islands and Puerto Rico, specifically with regard to incidence, structural risk factors, transmission rates, etc. Determine the impact of human trafficking (as distinct from the sale of adult, consensual sex) on HIV transmission in the U.S. Virgin Islands

[34] The Foundation for AIDS Research. HIV in correctional settings: implications for prevention and treatment policy. Issue Brief No 5, March 2008.
[35] Richard R (Ed.). "Forging A Future: The HIV-Positive Ex-Offender." July 2007. HRSA CAREAction Report. Washington, DC: Health Resources and Services Administration (HRSA), HIV/AIDS Bureau, available online at http://hab.hrsa.gov/publications/july2007/default.htm.
This article notes: "Peer educators can be inmates incarcerated alongside the inmates they are teaching, or they can be former inmates who have "been there, done that" and have the valuable experience of life both inside and outside prison walls—and the experience of successfully remaining outside prison walls."

Chapter 4: Achieving a More Coordinated National Response to the HIV Epidemic in the United States

1.1 Ensure coordinated program administration	**NHAS states** that "OGAC will take specific action to facilitate the exchange of best practices and lessons learned between domestic and international HIV/AIDS programs funded by the U.S. government. "	**A.** All Federal funding agencies should be required to systematically document and disseminate information on "best practices" emerging from the programs they fund. A technical assistance database containing this information should be created and updated regularly to assure that it is readily available to grantees, service consumers, advocates and others. Program evaluation data contained in this database should be disaggregated by sex wherever possible. **A-i.** Identify the interventions, techniques, opportunities, and evaluation strategies that have successfully met the needs of women and girls in PEPFAR-funded programming abroad and assess their possible applicability in specific U.S. regions and populations. **A-ii.** Similarly, identify gender-responsive strategies in the United States that have been effectively incorporated into the prevention and management of other diseases such as diabetes, cancer, hypertension, etc. Use the "best practices" database to make documented descriptions of these available for incorporation into HIV/SRH/GBV program, policy, and research as appropriate. **A-iii.** Set aside resources to evaluate how such gender-responsive strategies, once adapted and incorporated into existing programs, have functioned and whether further adaptation and adoption of them is warranted.
	NHAS states that "CDC, HRSA and SAMHSA will collaborate to examine the use of the same unique identifier across federal reporting to allow better coordination at the local, state and federal levels."	**B.** Through the Office of National Coordination of Health Information Technology (ONCHIT), develop systems to ensure that electronic health records can be accessed regardless of health care provision site. Ensure appropriate transfer of electronic records when referrals for care and/or preventions services occur.

Glossary

ACA	Affordable Care Act (recently passed legislation also known as "health care reform" or "health insurance reform")
AETC	AIDS Education and Training Centers, federally mandated programs that train clinical staff on HIV/AIDS, funded through the Ryan White Care Act
BOP	Bureau of Prisons, Department of Justice
CDC	Centers for Disease Control and Prevention
DHHS	Department of Health & Human Services
DOJ	Department of Justice
GBV	Gender-based violence
HRSA	Health Resources and Services Administration (part of DHHS)
HUD	Department of Housing and Urban Development
IHS	Indian Health Service
NGO	Nongovernmental organization (private, nonprofit)
NHAS	National HIV/AIDS Strategy
OGAC	Office of the Global AIDS Coordinator, Department of State
OMH	Office of Mental Health
ONCHIT	Office of National Coordinator for Health Information Technology
PEPFAR	President's Emergency Plan for AIDS Relief, U.S. funding on global AIDS response
RFA	Request for Applications
SAMHSA	Substance Abuse and Mental Health Services Administration
SRH	Sexual and Reproductive Health
STI	Sexually Transmitted Infections
USAID	U.S. Agency for International Development

AGENDA

Meeting Purpose
The purpose of the OWH Gender Forum is to promote increased leadership in gender-responsive programming for women and girls. Participants at the forum will discuss how to develop, integrate, and modify existing interventions and strategies to assist with preventing sexually transmitted diseases (STDs) and HIV/AIDS in women and girls. Forum participants also will identify and address the various roles and behavior of women and girls that increases their risk for contracting and/or transmitting STDs and HIV/AIDS.

Thursday, June 10, 2010

8:30 a.m. – 9:00 a.m. **Registration**

9:00 a.m. – 10:30 a.m. **Welcome, Opening Remarks, and Introductions**

Christopher Bates
Executive Director, Presidential Advisory Council on HIV/AIDS (PACHA)
U.S. Department of Health & Human Services

Howard Koh, M.D., M.P.H.
Assistant Secretary for Health
U.S. Department of Health & Human Services

John D. Hassell
Director
UNAIDS–Washington, DC

Jeffrey Crowley, M.P.H.
Director, Office of National AIDS Policy, and Senior Advisor on Disability Policy
The White House

Vivian Pinn, M.D.
Director, Office of Research on Women's Health
National Institutes of Health

10:30 a.m. – 11:30 a.m. **Opening Plenary—Gender Impact on U.S. Women and Girls**
Moderator: **Mary Bowers, M.S.W.**

Cynthia Gomez, Ph.D.
Director, Health Equity Initiative
Institute for Research, Practice & Policy
San Francisco State University

Jantine Jacobi, M.D.
Head of Gender and AIDS Team, UNAIDS Secretariat
UNAIDS

11:30 a.m. – 12:00 noon **Open Discussion**

12:00 noon – 12:20 p.m. **Positive Perspectives**
Moderator: **Beri Hull**

Naina Khanna
Coordinator
U.S. Positive Women's Network

12:20 p.m. – 1:20 p.m. **Lunch—Plenary**
Moderators: **Jennifer Augustine, M.P.H., CHES;** and **Linda J. Koenig**, **Ph.D., M.S.**

Nancy Mahon
Executive Director, MAC AIDS Fund
U.S. Initiative for Women and Girls

Miguelina Leon, **Ph.D.**
Consultant, Previewing the *HIV Prevention Gender Toolkit for U.S. Women and Girls* by the Office on Women's Health

1:20 p.m. – 2:35 p.m. **Panel—Prevention Challenges from U.S. Experts on Gender**
Moderators: **Diane Adger-Johnson** and **Vera Yakovchenko, M.P.H.**

Roberta Black, Ph.D.
Chief, Microbicides Research Branch, Division of AIDS
National Institute of Allergy and Infectious Diseases
National Institutes of Health

Dazon Dixon Diallo, **M.P.H.**
Founder and President
SisterLove, Inc.

Gail E. Wyatt, M.D.
Associate Director
UCLA AIDS Institute

Susan Rodriquez
President/Founding Director
Sisterhood Mobilized for AIDS/HIV Research & Treatment, Inc. (SMART)

2:35 p.m. – 2:50 p.m. **Break**

2:50 p.m. – 4:05 p.m. **Panel—The Global Experience: Application from International Experts on Gender**
Moderators: **Serra Sippel** and **Jacqui Patterson**

Carmen Barroso, M.D.
Regional Director
International Planned Parenthood Federation–Western Hemisphere Region

Robin A. Smalley
Co-Founder and International Director
mothers2mothers International

Lillian Mworeko
International Community of Women (ICW) Living With HIV/AIDS–Eastern Africa, Uganda

Rolake Odetoyinbo
Executive Director
Positive Action for Treatment Access (PATA), Nigeria

4:05 p.m. – 5:20 p.m. **Panel—Operationalizing Gender-Responsive Strategies in the United States From International and U.S. Experts on Gender**
Moderators: **Pauline Muchina, Ph.D.;** and **Katie Kramer, M.S.W., M.P.H.**

Terry McGovern, J.D.
Program Officer
The Ford Foundation

Beri Hull
Global Advocacy Officer
International Community of Women Living With HIV/AIDS

Purnima Mane
Deputy Director, United Nations Population Fund (UNFPA)

Carol Nawina Nyirenda
Board Member, Communities Delegation; and National Coordinator
Community Initiative for TB, HIV/AIDS & Malaria (CITAM+)

5:20 p.m. – 6:00 p.m. **Overview/Discussion**
Moderators: **Jacqui Patterson, M.P.H.;** and **Aleisha Langhorne, M.P.H., M.H.S.A.**

Friday, June 11, 2010

8:30 a.m. – 9:00 a.m. **Opening/Introductions**
Moderators: **CAPT Sylvia Trent-Adams, Ph.D., M.S., RN;** and **Anissa Brown, Ph.D.**

9:00 a.m. – 10:00 a.m. **Plenary—Federal Perspectives: Gender-Responsive Programming**

Irene Hall, Ph.D., FACE
Acting Associate Director for Health Equity
National Center for HIV/AIDS, Viral Hepatitis, STD, and TB Prevention
Centers for Disease Control and Prevention

Deborah Parham Hopson, Ph.D., RN, FAAN
Associate Administrator, HIV/AIDS Bureau

Health Resources and Services Administration

Beverly Watts Davis
Senior Advisor to the Administrator
Substance Abuse and Mental Health Services Administration

Gina Brown, M.D.
Office of AIDS Research
National Institutes of Health

10:00 a.m. – 12:00 noon **Breakout Sessions**

Prevention/Risk Reduction (Room: New York)
Moderator: **Dazon Dixon Diallo, M.P.H.**

Lakshmi Goparaju, **Ph.D.,** Assistant Professor and Project Director, Women's Interagency HIV Study (WIHS), Department of Medicine, Georgetown University

Yasmin Halima, Executive Director, Global Campaign for Microbicides

Stephanie Laster, SisterLove, Inc.

Care/Treatment (Room: Massachusetts)
Moderator: **CAPT Sylvia Trent-Adams, Ph.D., M.S., RN**

Lisa Hirschhorn, **M.D., M.P.H.**, Senior Clinical Consultant HIV/AIDS, JSI Research and Training

CAPT Magda Barini-Garcia, M.D., M.P.H., U.S. Public Health Service, and Senior Medical Advisor, Office of Health Equity, Office of Special Health Affairs, Health Resources and Services Administration

Violence (Room: Pennsylvania)
Moderators: **Aleisha Langhorne, M.P.H., M.H.S.A.;** and **Linda J. Koenig, Ph.D., M.S.**

Gail E. Wyatt, M.D., Associate Director, UCLA AIDS Institute

Pauline Muchina, Ph.D., UNAIDS–Washington, DC

Reproductive & Sexual Health (Room: Rhode Island)
Moderators: **Kimberly Whipkey,** and **Vera Yakovchenko, M.P.H.**

Ebony Johnson

Hadiyah Charles, Community Organizer, Center for Women's HIVAdvocacy, HIV Law

Jomo Osborne, M.D., Senior Program Officer for HIV/AIDS/STI, International Planned Parenthood Federation (IPPF)

Soraya Galeas, Director of Community Education, Planned Parenthood of Metropolitan Washington, DC

Human Rights (Room: Georgia)

Moderators and Experts: **Susana T. Fried, Ph.D.,** and **Jacqui Patterson**

Terry McGovern, Program Officer, Ford Foundation
Vanessa Johnson, J.D., Positive Women's Network and NAPWA
Lillian Mworeko, ICW–Eastern Africa, Uganda
Kelli Dorsey, Different Avenues

Criminal Justice (Room: Virginia)
Moderator and Expert: **Katie Kramer, M.S.W., M.P.H.**

Cathy Olufs, Education Services Director, Center for Health Justice
Megan McLemore, Researcher, Human Rights Watch
Kim Hunter, Corrections Manager, Hyacinth AIDS Foundation

Territorial Perspectives (Room: South Carolina)
Moderator and Expert: **Juan C. Espinosa Charriez, M.S.W., LCSW**

Sarinda Mirabal Roberts, **M.Ed.,** Education & Prevention Director, Office of Women's Affairs/Oficina de la Procuradora de la Mujer, Government of Puerto Rico
ChenziRa D. Kahina, Ph.D., Managing Director, PerAnkh, Inc.

12:00 noon – 1:00 p.m. **Networking Lunch**

1:00 p.m. – 3:00 p.m. **Breakout Sessions (continued)**

- *Prevention/Risk Reduction*
- *Care/Treatment*
- *Violence*
- *Reproductive/Sexual Health*
- *Human Rights*
- *Criminal Justice*
- *Territorial Perspectives*

3:00 p.m. – 3:10 p.m. **Break**

3:10 p.m. – 4:00 p.m. **Breakout Sessions (continued)**

4:00 p.m. – 5:30 p.m. **Recommendations From Breakout Sessions**
Moderators: **Angela Bates, Monique Claggett-Davis, Juan C. Espinosa Charriez,** and **Vera Yakovchenko**

5:30 p.m. **Closing Remarks and Acknowledgements**
Mary L. Bowers, M.S.W., and **Pauline Muchina**, **Ph.D.**