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Gendered Empowerment and HIV Prevention: Policy and Programmatic Pathways to Success in the MENA Region

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Abstract

Although HIV in the Middle East and North Africa is currently characterized as a low seroprevalence epidemic, there are numerous factors that are present in the region that could prevent—or exacerbate—the epidemic. The time to invest substantially in prevention—and gender-specific prevention in particular—is now. Given that most policy makers do not make gender-specific plans as epidemics progress, our research team—which draws upon expertise from both within and outside the region—worked together to make programmatic and policy suggestions in the Middle East and North Africa region in 5 key areas: (1) gender-specific and gender transformative HIV prevention interventions; (2) access to quality education and improvements in life skills and sex education; (3) economic empowerment; (4) property rights; and (5) antiviolence. In short, this work builds upon many ongoing efforts in the region and elucidates some of the links between gendered empowerment and health outcomes around the world, particularly HIV and AIDS.

According to recent reports in the Middle East and North Africa (MENA) region, 60% of infections among women occur before the age of 20 and over one half of new infections are in the 15–24 age group.[1] Of the nearly 500,000 individuals who are HIV positive in the region, about half are women. Although injection drug use transmission predominates overall, sexual contact is increasing.[1] Young people and married women are among some of the most vulnerable to HIV infection due to the fact that these groups experience high degrees of structural and social disenfranchisement and do not see themselves at risk of HIV.[2-4]

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Some erroneous assumptions are made about MENA society and the risks of the population mentioned above. Young people are assumed not to be sexually active until they are married, and husbands are assumed to be faithful to their wives. Although there may be strong societal prescriptions for norms against extramarital sex (which can be protective), the prevalence of sexually transmitted infections is fairly high in some studies in the region and this indicates much unprotected extramarital sex.[5] There are also some cultural practices such as widow inheritance, forced marriage, early marriage, the resurgence of temporary marriages, and in certain circumstances, polygamy which can increase women's and girls HIV risks.[5,6] Additionally, many young people in the region are remaining unmarried for longer periods of time at present (and therefore have the potential to be sexually active for longer before marriage) compared with the past given current economic constraints which have resulted in delayed marriages.[7] For those who do marry, young women often marry older men who are sexually more experienced and who may have been exposed to sexually transmitted infections (in the region, it is not uncommon for women to marry someone 10 years older than they are[5]).

Given that most policy makers do not make gender-specific plans for prevention policy as epidemics progress,[1] our research team—which draws upon expertise from both within and outside the region—worked together to make such suggestions in the MENA region in 6 key areas. Gender-specific and gender-transformative HIV prevention interventions; (2) access to quality education and improvements in life skills and sex education; (3) economic empowerment; (4) property rights, and (5) antiviolence work.

GENDER-SPECIFIC HIV PREVENTION INTERVENTIONS

Prevention interventions around the globe have emphasized that women cannot easily choose or enact condom use given that condoms are largely used by men and gendered power relations affect safer sex negotiations.[9] Interventions have sought to improve women's safer sex negotiation skills and increase awareness that one's own monogamy does not confirm the monogamy of partners.[9,10] Research has also emphasized the relationship between "traditional gender roles" and risk, examining how men are socialized to initiate and expect sex, whereas women are socialized to be responsive to men's request and to focus on partners' wants and needs.[11,12] Using this contextual information, prevention programs have successfully intervened at the level of couples and small groups.[9,10,13]

Gender-specific prevention also presses beyond the male condom to focus on female-initiated methods such as female condoms, and, where appropriate, outercourse and/or sexual refusal skills. Several evidence-based gender-specific prevention interventions have been successful and were reviewed elsewhere.[14-16] Interventions also have focused on the competing needs around HIV/sexually transmitted disease prevention and the desire to have children, especially because female and male condoms do not tend to these needs known as "dual protection."[14] Finally, gender-specific prevention interventions also examine how masculinity contributes to risk by focusing on the "costs of masculinity" to both men and women, seeking to create more gender equitable norms, reducing violence against women, and improving the health of both women and men.[17,18]

Example

Project FIO (the Future Is Ours), developed at the HIV Center for Clinical and Behavioral Studies (Columbia University & New York State Psychiatric Institute) in the United States, was a randomized controlled clinical trial conducted with heterosexually active women in a high seroprevalence area of New York City.[19] The trial tested the efficacy of a comprehensive gender-specific intervention that emphasized the contextual realities of women's daily lives (eg. struggles with housing, health care, work, child care) and their

relationships with men. The intervention involved an examination of traditional sexual scripts including challenging gender stereotypes; introduction of a sexual bill of rights which stressed the rights of women to have control over their bodies, their sexuality, and their entitlement to respectful noncoercive treatment from partners; direct techniques for negotiating and refusing unsafe sex and more indirect strategies of avoiding unsafe sex; and the eroticization of safer sex and exploration of alternatives to male condoms, including the female condom.

Women were randomly assigned to an 8-session, 4 -session, or control condition and at both 1 and 12-month follow-up, women assigned to the 8-session intervention arm had about twice the odds of reporting decreased or no unprotected vaginal and anal intercourse compared with controls.[9] Women assigned to the 8-session condition also had greater odds of using any of a range of alternative protective strategies.

Program and Policy Suggestions

1. Support the development of evidence-based gender-specific prevention interventions. These should be developed within the region and/or adapted from the existing evidence base, paying careful attention to the economic, social, religious, and relationship contexts of the region.
2. Policy support is critical. National-level HIV prevention policy responses should not be gender neutral, and guidance is available on how to ensure that policies are gender specific, gender sensitive, and gender empowering.[20,21]
3. Female condoms are effective and protect women against HIV. These initiatives are needed at the national, local, and agency level. Provider training is also needed, as providers frequently harbor negative attitudes about the female condom.[22] Engaging men in the use, acceptance, and promotion of female-initiated methods is also needed.
4. Continue and bolster positive momentum in the region on reaching high-risk populations (men who have sex with men, sex work, injection drug use) with HIV prevention. The interaction between drug use and sexual transmission will be vital in halting the progression of the epidemic. Although there are regional differences to be sure, one study in Iran has suggested that one half of injecting drug users (often male) in the country are married and that one third have extramarital sex.[23] Additionally, in some areas of the region, high levels of HIV infection have been found among drug users who may pass HIV to their partners.[1] Thus, destigmatization of and attention to the needs of bridge populations and their partners should now be a priority.
5. Multisectoral interventions that are gender specific are enormously helpful in minimizing HIV risks due to the fact that HIV/AIDS is not a single sector issue. Creative integrative or parallel services to reduce HIV/AIDS risks are needed across sectors that may not regularly work together (public and private sector, nongovernmental organizations, universities).

EDUCATION

The World Bank has drawn attention to “the window of hope” underscoring that although more than half of all new HIV infections are among 15- to 24-year olds, prevalence rates are lowest among those in the 5–14 age group, suggesting that if effective prevention measures could be extended to these young people—of school going age—the epidemic could be substantially impacted.[24-26]

In a recent review of relevant literature[27] to examine the relationship between young women's vulnerability to HIV and the impact of education, it was noted that HIV prevention campaigns often fail to address the increased vulnerability of young women because "they fail to deal with the simple fact that many women lack the power to determine who to have sex with or when and how to have sex." It was concluded that one of the best possible ways in which to empower young women to assert their sexual and reproductive rights is by increasing access to education, particularly secondary education. The review pointed to formal education (particularly secondary education) as influencing vulnerability to HIV in 3 significant different ways, namely:

- By proving an opportunity to be exposed to HIV/AIDS education in school-based programs
- By helping young women to act on HIV prevention messages—such as negotiating the use of condoms
- By providing better economic prospects, and hence potentially preventing HIV by providing greater protection from young women from being vulnerable to engaging in transactional sexual relations or staying in abusive or violent relationships

There is no "magic bullet" to address getting girls into school and keeping them there; however, research over the past decade does show that if the costs of education can be kept low, and if the quality of education is reasonable, most parents will educate girls—at least to a basic level (Bangladesh, Brazil, China, Egypt, India, Indonesia, Malawi, Mexico, Oman, Pakistan, Sri Lanka, and Uganda all introduced reforms that have shown much promise). To achieve this, most evidence suggests that what is needed is a package of policies and programs in 4 areas:

1. *Make school more affordable*, most effectively by eliminating direct fees (tuition and examination fees) and offering targeted scholarships to the most disadvantaged, although also paying attention to reducing or eliminating hidden indirect fees (such as supplementing teacher salaries and charging for educational materials); indirect costs (such as transport, uniforms, and meals); and opportunity costs (finding some way of contributing toward—through family stipends paid for attending school—or mitigating in some way—ensuring that schools are not open during harvesting times when family labor is most needed—the lost contribution to family income or maintenance by child who might have been working attending school).
2. *Provide schools nearby* (as a partial strategy to address transport, cost, and safety issues) that encourage community support (including contributions in kind for building, but which actively seek support for girls', and boys', educational opportunity); parental involvement (both formally through encouraging the establishment of parent–teacher associations addressing the management and financing of schools and more informally through school/community activities such as sport and 'mothers' clubs' which provide income-generating activities to mothers to help pay school fees), and which have flexible schedules (which take into account broader community time demands such as planting and harvesting).
3. *Make schools more girl friendly*—paying particular attention to protecting privacy and safety (such as separate private latrines for girls and which take into account the needs of sexual maturing girls, such as menstruation); which meet cultural requirements (such as having female teachers for adolescent girls, having separate schools or classes for girls); and addressing gender stereotypes in educational materials (such as reviewing and changing curriculums that portray women as passive or only in domestic situations) and teaching approaches and attitudes (such as believing girls are less able than boys, particularly in mathematics and science).

4. *Provide quality education*, with enough educated and trained teachers, and learning materials. Expanding access to education without investing in additional resources can result in a massive decline in quality and lead to very high drop outs, and/or an exodus by those that can afford it to private schools—both of which defeat the purpose of the goal. In addition, school needs to be relevant, with the main aim being to equip girls to cope in a way that parents and girls believe will be useful when they leave school, and justify their investment in the process.[24]

5. *Ensuring that a quality HIV prevention program that is embedded in a broader life skills and sexuality education framework is introduced and implemented effectively within both primary and secondary schools curriculums*. Evidence does suggest that a "quality program" is best done when embedded in a broader life skills and sexuality education framework. Such programs can help prevent HIV infection as they can particularly tackle the underlying issues which prevent girls and young women from being able to assert their sexual and reproductive rights—most fundamentally determining who to have sex with, and when and how.[28,29]

It should not be underestimated how challenging the introduction of such a program can be, and even with effective introduction, research demonstrates that teachers frequently do not teach this aspect of the curriculum. Much of this has to do with the deeply polarized debate around the provision of sexuality education to young people, particularly in schools. The worth of these efforts cannot be underestimated, however. Although there has been progress in the MENA region on the issue of education for girls (enrollment ratio is 85% for primary education in the region)—this progress remains slower than that of other countries at similar levels of economic development.[30,31] Additionally, the divide between education and employment has not been bridged well; even for those girls who are educated, employment too often remains well out of reach.[31]

ECONOMIC EMPOWERMENT

Despite the gains that the MENA region has made in health and education over the past several decades, these gains have not occurred as widely in the area of employment for women. That is, although the rate of participation of women in the labor force has increased during the last 3 decades, it still ranks among the lowest in the world. All of the MENA countries suffer from a high rate of unemployment, and this is disproportionately the case for young people and women.

Additionally, the countries of the region have had very high population growth, and about 70% of the population is below the age of 30. Unemployment is affecting young people much more than any other region and at a higher rate within the region than was the case previously. The number of first-time job seekers is very large and will require the creation of nearly 100 million new jobs over the next 2 decades. Already half the region's young people find themselves without work, with youth making up a large proportion of the total unemployed.

At the same time that women overall are more educated and capable than previous generations, MENA women are behind in labor force and political participation, and the overall poverty rate there has not improved much since 1990.[30] Although overall female labor force participation has risen from 28% in 2000 to 32% in 2006, it is also the case that male labor force participation has remained at 79% across the same period.[3] Some argue that women's financial dependence on men, coupled with lesser education, makes it difficult to request condom use.[6] An emphasis on the links between economic empowerment, control over assets, and sexual negotiation is therefore needed in the region.

Specific research findings from various regions of the world indicate that economically dependent women and girls are more likely to be constrained into sexually risky situations: less able to negotiate safer sex with partners, less likely to be able to leave an abusive or violent relationship (also associated with HIV risks), and much more likely to exchange sex for food, goods, or assets.[32-34] Additionally, some research has found that women who do sex work are first inducted into and have a difficult time getting out of sex work for economic reasons.[35,36] Research now also shows that economic independence for women is a factor that is strongly related to negotiating safer sex.[37] Thus, the combination of HIV/AIDS prevention and economic initiates could produce important synergies that extend beyond the economic realm to "empower women" and provide more enduring protection from HIV/AIDS risks than HIV/AIDS prevention can do alone.

Examples

Only 1 randomized controlled trial tested the effect of an integrated microfinance, gender equity, and HIV/AIDS prevention intervention on violence and HIV outcomes. The Intervention for Microfinance and Gender Equity (IMAGE) Program was based in Limpopo, South Africa, and innovatively merged a curriculum of gender equity, anti-violence work, and HIV/AIDS education with a microfinance program.[38,39]

The IMAGE project resulted in a 55% reduction in domestic violence at 1-year follow-up for program participants compared with controls.[33] More recent published results from the same project underscore that this integrated initiative changed numerous indicators of "women's empowerment" in positive directions.[38] HIV incidence as an outcome was not affected, however. Continuing to invest in integrated economic and HIV models so as to find the best models that meet the needs of the population—particularly young women—are highly worthwhile endeavors.

Policy Suggestions

1. Women in the region experience the lowest levels of employment found anywhere. Although economic initiatives such as microenterprise or microfinance are promising, the MENA region needs to continue to strengthen its efforts to create jobs for its citizens and enhance diver-sification in economic activities so as to ensure that women are not ghettoized into low-paying occupations.[41]
2. HIV/AIDS policies need to link to the goals for women of the region, including calls to "improve the regulatory and legislative frameworks relating to women regarding issues such as property rights, inheritance, mobility, the freedom to be entrepreneurial, and the right to have a national identity card."[40]
3. Support further research that examines the question of whether economic independence or increased access to and control over assets helps women to reduce HIV/AIDS risks in the region. Deepen an understanding of the mechanisms through which economic empowerment shapes reductions in HIV/AIDS risks.[41]
4. At the program level, strengthen the ability of organizations that carry out economic initiatives to integrate these with HIV education and HIV prevention. At the same time, strengthen the ability of organizations that carry out health programming to integrate with HIV prevention and economic programming.
5. At the policy level, bolster the integration of poverty reduction and health efforts, including HIV prevention, treatment, and care. Within the region, the Ain El Sira project is piloting a conditional cash transfer program which grants low-income families cash transfers conditional on families enrolling children in schools and attending regular health checkups, among other conditions. This collaboration is

multisectoral and includes the American University at Cairo Social Research Center and the Egyptian government (Ministry of Social Solidarity). Another country in the region, Turkey, has already experimented with such a design, and both programs are based off of the success of conditional cash transfer programs in Latin America. If successful, support for future, larger programs will be needed.

6. Continue to support not just access to economic initiatives for program participants but increased control over those assets. This can be accomplished through program or policy rules laid out in economic initiatives—or legal frameworks in the case of property rights.

7. Economic programs are often viewed as a place to largely mitigate the effects of the epidemic. Economic programs should also be viewed as a place to do prevention with HIV-positive and HIV-negative populations. Economic initiatives also need to be tested for their impact on adherence outcomes.

HIV and Property Rights

Among salient policy issues that should be addressed in a gendered national AIDS response, securing women's property and inheritance rights is paramount in reducing the vulnerability of women and girls to risk of HIV infection. Land and property rights ensure basic human rights to shelter and livelihood and has been recognized as a source of wealth, social status, and power.[42] The HIV epidemic amplifies the importance of property and asset ownership for women as it can profoundly compromise a woman's financial, social, and physical well being.

The intersection of HIV, gender and property rights has emerged in the literature primarily around the issue of 'property grabbing' or denying property access or rights of property ownership to women widowed because of HIV.[43,44] Women's property ownership and access in sub-Saharan Africa, as in the MENA, is mostly determined through partner, family and kinship relationships.[45,46] Results from a qualitative study in Kenya reveal not only that negotiation of relationships to be critical to women's access and ownership of property but that these relationships are mediated by many factors in the structural and social environment.[47]

The pathway between women's secure property rights and decreased vulnerability to HIVoperates through economic and, more broadly, social processes. Economic processes by which secure property rights decrease the HIV vulnerability of women include: providing women with a secure place to live; serving as a site for economic activity and means of livelihood; reducing economic dependence on men and extended (marital) family; and serving as collateral for credit.

At the same time, property ownership serves to empower women and reduce their vulnerability by giving them greater bargaining power at the household, individual, and community level; expanded social status in communities; and increased agency.

Women in the MENA region are typically able to access land and property only through a male relative or husband. Inheritance rights in countries of this region are governed by a mixture of civil laws and Islam-inspired laws, or Shari'a, with the exceptions of Turkey and Israel. Under the Qur'an, women and girls are allowed to inherit land and property in at least half of the proportion granted to men. In practice, however, the application of inheritance law is modified by cultural practices and traditions, which are often discriminatory against women. Strong social norms against women's property ownership deter women from claiming their inheritance, and women who have inherited property have experienced social ostracism and physical violence.[47] In the extreme cases, women have been murdered at the

hands of their father or brother in “honor killings” so that male relatives may claim the inheritance.[49] The experience of “honor killing” is documented in the MENA region, particularly in Jordan and Turkey.[48]

A recent report of women’s inheritance rights in 8 countries in the MENA region reveals the complexity of legal frameworks operating across the region governing women’s access to property.[49] Survey data indicate that women generally are not aware of their rights to inheritance, and unequal application of inheritance laws has become, among some women, culturally acceptable. Family pressure on women to give up their inheritance to preserve the “gender pact” or to maintain harmony with male relatives was also often mentioned in the countries surveyed. Given women’s limited access to resources, personal status laws governing marriage and divorce further disadvantage women. In Egypt, for example, women are allowed to divorce their husbands but, in so doing, must forfeit alimony and repay the dowry. Divorced women are generally stigmatized and, unless they can return to live with their parents, are often forced to live in poor marginalized areas for lack of access to housing and employment.

Policy and Program Suggestions

1. Development of legislative frameworks and community programs are vital in promoting and protecting women’s property rights. Continued exploration of gaps in legal structures and harmonization of legal systems is paramount. Building in an equality provision into laws that govern women’s realization of their rights including land titling, marital laws, to ensure that these various laws function together to serve women. Assessments of legal frameworks using a set of legislative indicators is step one in that process.
2. Women often lack legal knowledge, have limited resources and documentation to fully claim their right to property, and there is no standardization of interpretation of customary and religious laws. Efforts that engage whole communities in a process of reflection and mobilization should be supported to deal with these barriers comprehensively and holistically. Very promising efforts include the formation of community land and property ‘watch dog groups’ in Kenya where women in the community guard against property stripping for HIV positive widows and orphans. One organization that supports these activities is GROOTS–a network of women’s self-help and community mobilization groups with a membership of thousands of women across Kenya.
3. A network of stakeholders should be engaged in a variety of practical solutions to strengthen women’s property rights. Some of the practical needs include will-writing templates and engaging the legal system with the aid of community-based paralegals.
4. More research is needed to understand the intersections of gender, property, and HIV within the contexts of rapidly shifting social change. Studies that carefully explore the meaning of property, women’s access to property and the relationships that determine property access (not only ownership), particularly with intimate partners, are needed. The role of property rights in securing livelihoods or in some cases, food security in either prevention or mitigation of HIV should be further explored.

Understanding the legal structures behind property and inheritance rights in the MENA region is fundamental to realizing how to strengthen these rights for women; however, it should be noted that in matters of gender and property, women in the MENA region experience very similar outcomes to women in regions of sub-Saharan Africa. Great

sensitivity is needed to explore these issues from the perspective of those who are affected by the laws and practices governing issues of property and gender in this region.

GENDER-BASED VIOLENCE AND HIV

Of the various forms of violence such as sex trafficking and harmful cultural practices that are specific to particular geographic areas,[50] intimate partner violence (IPV) is the most pervasive. Research from around the world shows that between 15% and 71% of women have suffered physical and sexual violence by an intimate male partner at some point in their lives.[51] Violence and the fear of violence are increasingly being recognized as important risk factors contributing to the vulnerability to HIV infection for women. Violence and fear of abandonment act as significant barriers for women, who have to negotiate use of condoms, discuss fidelity with their partners, or leave relationships that they perceive as risky.[52-54] Increasing evidence also indicates a link between sexual violence and adult risk behavior; individuals who have been sexually abused are more likely to engage in unprotected sex, have multiple partners, report nonuse of condoms, and involvement in transactional sex such as trading sex for money or drugs.[53,56-58]

IPV is being increasingly recognized as a growing problem in many countries of the MENA.[59] Despite a paucity of systematic research on IPV, available studies show a high prevalence. In the West Bank and Gaza Strip, 48% of currently partnered women experienced assault by an intimate partner in the past 12 months.[60] The Egyptian Demographic and Health Survey provides the only nationally representative data on IPV from an Arab country in this region. The survey indicates that around 1 of 3 (34%) ever-married women aged 15–49 has been beaten by their spouse; 86% of ever-married women believes that husbands are sometimes justified in beating their wives, with the highest specified reason (70%) being the refusal of sexual intercourse.[61] According to the first Israeli national survey on domestic violence held in 2000–2001, 18% of women accepted the use of violence if a woman was sexually unfaithful to a man.[59]

As is true for all HIV prevention programs, but particularly so for policies and programs seeking to reduce gender-based violence, it is crucial to change socially constructed norms relating to male and female roles and behavior and to create an enabling environment to catalyze contextually relevant responses for violence reduction. Instrumental in a national response is the development of local and national leadership, and support for community-led action, ranging from grassroots educational campaigns to reducing structural barriers to advocating for changes in national laws and policies.

Examples

One example of a successful program to change social norms and reduce gender-based violence is the Men as Partners program created by EngenderHealth and implemented in South Africa to combat the synergistic epidemics of gender-based violence and AIDS. Men as Partners is designed to mobilize men to question the deep-seated attitudes and beliefs that put the health of men, women, and children at risk. Its implementation requires the involvement of men and women in male-only and mixed-gender groups. A recently conducted longitudinal evaluation of this program which included preintervention and postintervention interviews showed that after the intervention: 71% of participants believed that women and men should have the same rights, as compared with 25% of the control group; 82% of participants believed that it was wrong to rape a sex worker as compared with 33% of nonparticipants; and 82% of participants believed it was not right to beat their wives as compared with 38% of men in the control group.[62] In addition, the evaluation found that adolescent males, more than older men, were willing to accept alternative views that challenged the prevailing norms of masculinity.

Policy Suggestions

1. Given the dearth of credible statistics on gender-based violence (GBV) in the MENA region, it would be useful to commission research to collect empirical data to establish prevalence in each individual country.
2. In addition, qualitative research should be conducted to describe the range of attitudes of men and women to GBV, the origins and manifestations of those attitudes, and potential entry points for change.
3. It would be useful to conduct as part of a national assessment of the AIDS response an audit of national laws and policies concerning gender-based violence. Findings from the gender audit would substantiate advocacy with governments for revision or adoption of national legislation on domestic violence, along with ensuring that governance systems and resources are adequate for the laws' effective implementation.
4. Equally important is systematic and sustained sensitization of law enforcement agencies and a mandate from elected leaders to hold law enforcement agencies accountable.
5. To supplement epidemiological and anthropological data in national advocacy efforts, it is strategic to estimate the social and economic cost of the twin burdens of HIV and gender-based violence to households, communities, and the national economy.
6. On the program front, it is strategic to build gender capacity within civil society organizations working on HIV to be able to recognize the links between gender-based violence and HIV so that these organizations can then engage with families and communities in transformative processes to shift gender norms. Participatory methodologies on HIV stigma and violence reduction[63,64] that generate dialogue with populations at risk of HIVand other community stakeholder groups are needed (health care providers, police and outreach workers promoting adoption of safe sex practices).
7. No program on domestic violence has worked if men have been left out. Young men who perpetrate partner violence engage in significantly higher levels of HIV risk behavior than nonperpetrators, and more severe violence is associated with higher levels of risky behavior. HIV prevention interventions must explicitly address the links between the perpetration of IPV and HIV risk behavior among men and the underlying gender and power dynamics that contribute to both.[65]
8. Take the principles behind small, dispersed, successful interventions and replicate them on a large scale.

Although HIV in the MENA is currently characterized as a low seroprevalance epidemic, there are numerous risk factors that are present in the region and could lead to an exacerbation of the epidemic.[66] Many of the countries in the region have produced national plans to fight HIV/AIDS, but some argue that prevention is not receiving adequate investments.[67] As Fathalla and Rashad[68] have recently underscored within the MENA region: "*we have a window of opportunity to prevent what will otherwise be an epidemic, when the disease spreads beyond high risk groups. The costs of ignoring this window of opportunity will be high*." (2008, p. 817). In the current work, we've built upon many of the ongoing efforts in the region and have elucidated some of the links between gendered empowerment and health outcomes, particularly for HIV and AIDS. The time to invest substantially in prevention—and gender-specific prevention in particular—is now.

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