International HIV/AIDS Alliance

Together to end AIDS

Gender-transformative HIV programming

Identifying and meeting the needs of women and girls in all their diversity

About the International HIV/AIDS Alliance

We are an innovative alliance of nationally based, independent, civil society organisations united by our vision of a world without AIDS.

We are committed to joint action, working with communities through local, national and global action on HIV, health and human rights.

Our actions are guided by our values: the lives of all human beings are of equal value, and everyone has the right to access the HIV information and services they need for a healthy life.

Cover photos: Top: Margaret Gakii – a sex worker who uses drugs – hugs her counsellor from a harm reduction programme in Watamu, Kenya. © Alliance

Middle: Transgender sex workers get ready to welcome clients at a *hammam* in Bangalore. © Gitika Saksena for the Alliance

Bottom: Gladys Mosquera and family at home in Esmeraldas, Ecuador. Gladys is an outreach worker for Association 21 de Septiembre – an association promoting the rights of sex workers. © Alliance

Design and illustration: Jane Shepherd

Alliance good practice standards for gender-transformative HIV programming

This good practice guide contains information, strategies and resources to help meet the Alliance good practice standards for gender-transformative HIV programming for women and girls in all their diversity. Implementing these standards is one of the ways that the Alliance secretariat, Linking Organisations (LOs) and other organisations we work with can define and promote a unified, quality-driven approach to HIV programming.

The Alliance HIV programming standards can be used at any time in the programme cycle to assess and share good practice; to help develop proposals and monitoring and evaluation (M&E) frameworks; design and refine interventions; and for community-led advocacy.

Key resources

For more information about the Alliance's accreditation system go to: www.aidsalliance.org/resources/336-alliance-accreditation-system

Alliance good practice standards for gender-transformative HIV programming

Good practice standard 1	Our organisation is committed to a gender-responsive approach and to advancing gender equality.
Good practice standard 2	Our organisation promotes the human rights of children, young people and adults of all gender identities and sexual orientations.
Good practice standard 3	Our organisation's programmes and advocacy are based on a comprehensive gender analysis that recognises and takes into account the intersectional nature of gender issues and the experiences of women and girls in all their diversity.
Good practice standard 4	Our organisation is committed to the meaningful involvement of women and girls living with and most affected by HIV at all stages of programme design and implementation, including planning, monitoring and evaluation.
Good practice standard 5	Our programmes and advocacy promote the active participation, empowerment and leadership of women and girls in all their diversity in all decision-making that affects their lives.
Good practice standard 6	Our organisation's programme activities are designed to prevent and address gender-based violence (GBV) in all its forms in the context of and the response to HIV, and are designed and implemented in such a way that recognises and minimises the risk of GBV within HIV programming. Our organisation promotes and/or provides access to competent services for people who have experienced GBV in the context of HIV, and advocates for the integration of GBV and HIV programmes and services.
Good practice standard 7	Our organisation's programming is designed to promote and contribute to the full realisation of the sexual and reproductive health and rights (SRHR) of women and girls in all their diversity, including those living with and most affected by HIV.
Good practice standard 8	Our organisation's programmes address harmful gender norms and practices that make some people vulnerable to HIV and sexual and reproductive health (SRH) problems, or that limit access to services.
Good practice standard 9	Our organisation is working to ensure that national laws and policies do not criminalise or stigmatise people because of their gender identity or sexual orientation.

Abbreviations and acronyms

ART	antiretroviral therapy
GBV	gender-based violence
HIV	human immunodeficiency virus
HRI	Harm Reduction International
IPV	intimate partner violence
LGBTI	lesbian, gay, bisexual, transgender and intersex
LO	Linking Organisation
M&E	monitoring and evaluation
PEP	post-exposure prophylaxis
PrEP	pre-exposure prophylaxis
SRH	sexual and reproductive health
SRHR	sexual and reproductive health and rights
STI	sexually transmitted infection
TB	tuberculosis
UNAIDS	Joint United Nations Programme on HIV/AIDS
VAW	violence against women
VAWG	violence against women and girls
VMMC	voluntary medical male circumcision
WHO	World Health Organization

Contents

Introduction

Overview and aims

This Good Practice Guide provides the rationale for gender-transformative programming, as well as tools to help civil society and community-based organisations, including Alliance Linking Organisations (LOs) and implementing partners, to integrate a gender perspective into their HIV programmes. It aims to strengthen HIV programming with, by and for women and girls in all their diversity, and to sharpen the Alliance's focus on gender in its work with key populations. It draws upon – and refers to – other resources on women, girls and gender equality in the context of and response to HIV.

Section 1 describes how gender analysis can strengthen programming by looking at three overlapping and mutually reinforcing areas:

- using available data and filling in the gaps
- promoting gender equality and addressing harmful gender norms
- removing gender-related barriers to access to services and information.

Section 2 provides practical guidance and tools for integrating gender considerations into HIV programmes, particularly for women and girls most impacted by HIV. The section comprises:

- a **template for conducting a participatory gender analysis**, including key questions that LOs and community stakeholders may like to consider to help design rights-based, gender-transformative programmes
- a series of fictional **scenarios** taken from true-to-life experiences that highlight some of the intersecting challenges and barriers women and girls in all their diversity face when accessing HIV prevention, treatment and care
- **intervention strategies**, including 'what works' and case studies highlighting examples of **promising practices**
- **evidence** from around the world to deepen understanding of the relationship between gender and HIV.

By strengthening the integration of gender into the HIV response, LOs will increase the effectiveness and sustainability of their programmes and advance community efforts to address poverty, inequality and vulnerability.

Language matters: A few words about 'women' and 'gender'

The language we use matters. This is particularly true in the context of HIV. The impact of HIV is strongly influenced by a wide range of identity factors (including practices and behaviours) that make individuals and communities more or less vulnerable because of the stigma and discrimination attached to them. This guide provides a lens through which to identify and analyse these identities – and the stigma and discrimination that is often attached to them – in order to better understand and serve communities.

Icons used in this guide

 Key resource

 Advocacy opportunity

 Gender analysis

 Scenario

 Example of promising practice

 Global evidence

Key resource

Read about the Alliance's gender-responsive and gender-transformative approach to our HIV and SRHR programming here: www.aidsalliance.org/our-priorities/955-gender

We use the phrase **'women in all their diversity'** to highlight that there are many distinctions among women, with differences associated with age, race, gender identity or expression, sexual orientation, ethnicity, language, marital status or partnership status, health status, (im)migrant status, job status, educational level, literacy level, developmental differences (i.e. physical or learning challenges), living in a conflict or post-conflict setting, surviving violence or other human rights violations etc. In other words, there is no one generic 'woman'. Being a *woman* (or man or transgender person) encompasses all these factors and experiences among others too numerous to name. In sum, it is all the things that make an individual the person they are.

Gender refers to the array of socially-constructed roles and relationships, personality traits, attitudes, behaviours, values, relative power and influence that society ascribes to individuals, usually on the basis of their perceived biological sex. Societies typically promote the idea that there are only two genders and only two sexes. Sex is understood as determined by biology, whereas gender is an 'acquired' identity that is learned, changes over time, and varies widely within and across cultures. The Alliance recognises that there is a range of genders, gender identities, sexual orientations and gender expressions. In this sense, gender refers not only to women or men, but also to the relationship and power dynamics between and among people because of how they are defined by their communities and how they themselves identify and understand their gender.

The phrase 'women in all their diversity' is intended to capture ideas of power and of **intersectionality,** i.e. the idea that an individual stands at an intersection of multiple social experiences, often of discrimination or marginalisation. For example, a Rohingya woman in Myanmar may experience intersecting and intertwined forms of discrimination and violence because she is a woman; because she is Rohingya; because she is Muslim; and because of Myanmar's internal political situation. Sometimes this is referred to as 'multiple and overlapping forms of discrimination' or 'compound discrimination'.

In the context of HIV, we often talk about 'women and girls' as one key population, and about 'people living with HIV', 'sex workers', 'people who use drugs ', 'lesbian, gay, bisexual, transgender and intersex (LGBTI) communities' and 'adolescents' as others – as if they are separate populations that don't overlap. In reality all these groups overlap and intersect. For example, a woman who sells sex may also be a mother, a wife, a rural woman, a woman of a particular faith (or none), a lesbian, bisexual or transgender woman, a woman or young woman living with HIV, and a person who experiences intimate partner violence (IPV), and so on. By not considering the intersectional nature of all our identities, we risk siloing programming or creating unrealistic divisions between different groups of women. At best, our programming will lack effectiveness – at worst we may risk entrenching stereotypes and doing harm.

> I experience multiple layers of stigma as a woman who sells sex, a lesbian, and a person living with HIV.
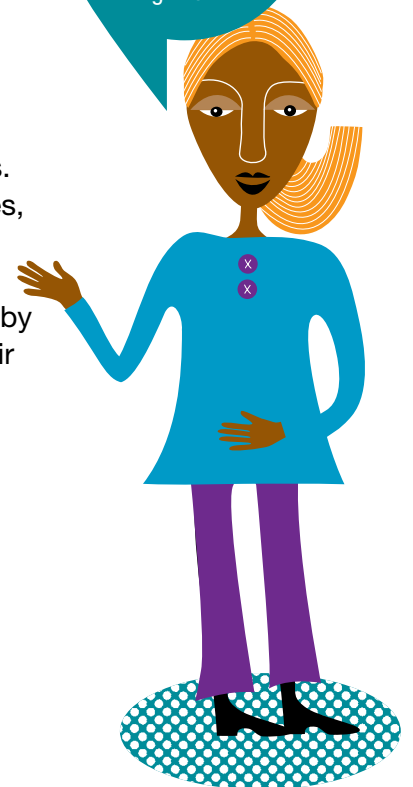
Key resource

UNAIDS (2017), 'When women lead, change happens'.
www.unaids.org/en/resources/documents/2017/when-women-lead-change-happens

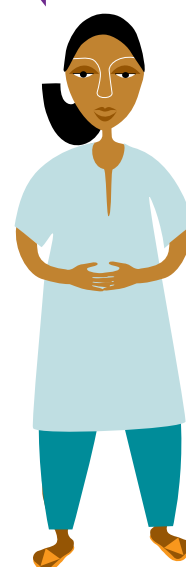## Understanding the relationship between HIV and gender inequality

Evidence gathered over the course of the epidemic shows that HIV flourishes in conditions of inequality and lack of accountability. In many countries, HIV prevalence continues to rise among women, especially adolescent girls, young women and women from key populations. In sub-Saharan Africa, three out of four people aged 15-19 newly acquiring HIV are girls.[1] Women and girls are at increased risk of contracting HIV, due to biological, social and behavioural factors. They often have less control over their sexual choices and bodily autonomy than men. Even if women aren't living with HIV, the virus has a significant impact on their lives, as women and girls are usually responsible for taking care of family and community members who are living with HIV.

The relationship between gender and HIV is constantly evolving. Many variables, such as education, income, age, ethnicity, race, disability, migrant status, health, location, and sexual orientation influence the links between HIV and gender. It is therefore important to consider the many ways in which gender and HIV interact. The relationship between gender and HIV is two-fold: while gender affects susceptibility to HIV and the impact of HIV, HIV also influences gender inequality and human rights more generally. Key contextual factors include:

- **the legal and policy environment** (such as laws that discriminate against women and girls; prohibit same-sex relations; or penalise gender identities that do not conform to gender norms and stereotypes)
- **the individual context** (such as drug use, sex work, coerced sex, experience or fear of GBV and the inability to negotiate sex and safer sex practices, or living with disability/ies)
- **the social context** (such as relationships between older men and younger women/girls, early or forced marriage, accessibility, acceptability, affordability and quality of health services and information available to different communities affected by or living with HIV, as well as access to economic resources and education).

Worldwide, women and adolescent girls face alarming levels of violence.[2] There is a well-documented relationship between gender inequality, IPV and HIV.[3] Gender-based violence – including IPV and sexual abuse – increases the risk of acquiring HIV. Women living with HIV are particularly likely to experience violations of their right to safety and bodily integrity. They are often discouraged from having children or, in some cases, face forced or coerced sterilisation and abortion.[4] As a result of accessing more routine sexual and reproductive health (SRH) care – for example in

In sub-Saharan Africa, three out of four people aged 15-19 newly acquiring HIV are girls.

Key resource

UNAIDS (2014), 'Women living with HIV speak out against violence: A collection of essays and reflections of women living with and affected by HIV'.

www.unaids.org/en/re-sources/documents/2014/womenlivingwithhivspeak-out

1. UNAIDS (2016), 'HIV prevention among adolescent girls and young women'. Available at: www.unaids.org/en/resources/documents/2016/20160715_Prevention_girls

2. UNAIDS (2014), 'Women living with HIV speak out against violence: A collection of essays and reflections of women living with and affected by HIV'. Available at: www.unaids.org/en/resources/documents/2014/womenlivingwithhivspeakout

3. Jewkes R., Sen P. and Garcia-Moreno C. (2002), 'Sexual violence'. In Krug E.G. et al., eds., 'World report on violence and health'. Geneva: World Health Organization, pp. 149-181. Available at: www.who.int/violence_injury_prevention/violence/world_report/en/summary_en.pdf

4. Center for Reproductive Rights and Federation of Women Lawyers – Kenya (2008), 'At risk: rights violations of HIV-positive women in Kenyan health facilities'. Available at: www.reproductiverights.org/document/at-risk-rights-violations-of-hiv-positive-women-in-kenyan-health-facilities

the context of antenatal care – women are more likely to find out their HIV status than their male partners. Disclosure may expose them, not only to stigma and discrimination from their communities and even health-care providers, but potentially also to IPV or abandonment.[5]

Transgender women also face extremely high levels of violence, and often, nearly insurmountable barriers to SRH services and care.

Gender affects the health outcomes of people living with HIV. More women are accessing antiretroviral therapy (ART) than men.[6] Compared to men, however, women living with HIV often experience delayed access to treatment as well as poorer quality of care. In some cases, they are also more likely to have treatment interruptions and worse treatment outcomes.[7]

A global review of women's access to HIV treatment and care[8] (undertaken by UN Women and partners) revealed that there are also major gaps in the data around treatment and care for women living with HIV in all their diversity, and that while more women than men initiate ART, many women do not remain on treatment, and may even have lower rates of long-term retention in care than men. Findings revealed that major challenges to women's access to treatment and retention in care include:

- stigma, discrimination and violence against women living with HIV
- gender roles and responsibilities (including caregiving responsibilities)
- violations of the right to privacy, confidentiality and bodily integrity within health settings
- punitive laws, including criminalisation of women from key populations.

Fundamental values

The Alliance's work to promote gender equality is underpinned by a range of fundamental values, for example:

- Right to informed choice, belief and free speech
- Freedom of movement, expression and self-determination
- Freedom from violence, abuse and slavery
- Right to meet and organise to further common interests or beliefs
- Non-discrimination, whether by race, religion, nationality, age, gender identity or sexual orientation
- Valuing diversity and non-judgmental cross-cultural understanding
- Protection of children and upholding the rights of girls
- Protection of, and assistance to, the poor and marginalised

Key resources

The Alliance's person-centered approach is described in 'Putting people at the heart of the HIV response' (2017) www.aidsalliance.org/resources/987-putting-people-at-the-heart-of-the-hiv-response

For more information on the Alliance theory of change go to: www.aidsalliance.org/resources/324-briefing-our-theory-of-change

5. UNAIDS (2014), 'Women living with HIV speak out against violence.'

6. UNAIDS (2017), 'When women lead, change happens: Women advancing the end of AIDS'. Available at: www.unaids.org/en/resources/documents/2017/when-women-lead-change-happens

7. Patterson S. E. et al. (2015), 'The impact of criminalization of HIV non-disclosure on the healthcare engagement of women living with HIV in Canada: a comprehensive review of the evidence'. *Journal of the International AIDS Society*, Vol 18(1), 20572. http://doi.org/10.7448/IAS.18.1.20572

8. ATHENA Network, AVAC, Salamander Trust, UN Women (2016), 'Key barriers to women's access to HIV treatment: making 'Fast-Track' a reality'. Available at: http://salamandertrust.net/wp-content/uploads/2015/07/UNWomenetal_Web_Treatment_access_4pp2016_Final.pdf

The benefits of incorporating gender into HIV programming

The Alliance's work with key populations is greatly enhanced by integrating a gender analysis and commitment to gender-responsive programming. Conducting a gender analysis – with the help of this guide – will ensure that particular attention is paid to the factors that increase the vulnerability and risks faced by women and girls in all their diversity. This guide is rooted in a rights-based approach towards women from key populations. It does not rely on a narrow approach created by 'modes of HIV transmission', nor does it assume that behavioural identities (i.e. women who have sex with women or sex workers) equate with risk.

There is a pressing need for civil society organisations and community-based organisations to fully understand how to integrate a gender perspective into HIV programmes. This means addressing gender inequality as well as challenging the underlying factors that fuel HIV. There is a critical need to better understand how gender shapes experiences of stigma and discrimination, health-seeking behaviour, and the uptake of HIV prevention, care and treatment services. It is important to take these layered realities into consideration at every level of the policy and programming cycle.

To do this, the Alliance advances **gender-responsive** and **gender-transformative approaches**. This entails working to change gender roles and by promoting relationships that are fair and just in the distribution of benefits and responsibilities, as well as advocating for laws and policies that promote and protect gender equality, human rights and public health.

In the best-case scenario, responses to HIV can change harmful social norms and practices, and transform gender relations based on principles of equity and equality.[9] Efforts to integrate a gender perspective into HIV programmes will not only empower women and girls in all their diversity – unlocking their potential – but will also result in more equitable relations between all genders, and more effective HIV programming. Ensuring the meaningful engagement and leadership of women and girls in their diversity in all aspects of HIV programming is key to a sustainable response. In fact, the resilience of many women and girls is a resource that can strengthen and fortify HIV responses. This requires that they be recognised and included in decision-making.

Table 1 shows how approaches to integrating gender equality and human rights-based interventions occur along a continuum: from gender-blind to gender-responsive and gender-transformative programmes. It is essential that awareness of the gender context be integrated from the outset. This may require carrying out an initial gender analysis as part of the programme planning and design phase. Adopting a gender-responsive approach means recognising that various forms of discrimination and marginalisation build upon and reinforce each other. These complex intersections require gender-transformative interventions that confront all forms of discrimination and marginalisation.

Advocacy opportunity

Advocate for laws and policies that promote and protect gender equality, human rights and public health.

The resilience of many women and girls is a resource that can strengthen and fortify HIV responses.

9. UNDP (2012), 'On course: mainstreaming gender into national HIV strategies and plans: a roadmap'. Available at: www.undp.org/content/undp/en/home/librarypage/hiv-aids/roadmap-on-mainstreaming-gender-into-national-hiv-strategies-and.html

Table 1. Continuum of interventions on gender inequality

|	Gender-blind	Gender-responsive	Gender-transformative
Impact	Fails to acknowledge the different needs or realities of women and men, girls and boys and transgender people. This can either be exploitative or accommodating. **Exploitative** interventions aggravate or reinforce existing gender inequalities and norms. **Accommodating** interventions work around existing gender differences and inequalities.	Recognises the distinct roles and contributions of different people based on their gender and takes these differences into account. Attempts to ensure that women or girls will benefit equitably from the intervention.	Explicitly seeks to redefine and transform gender norms and relationships to redress existing inequalities.
Example	**The 'ABC' approach (Abstain, Be faithful and/or use a Condom)** This approach fails to recognise the gendered power dynamics between couples (which are supported by social and cultural norms around gender and sexuality that make certain behaviours acceptable or unacceptable). For example, in many societies men are encouraged to have multiple sexual partners, and women are discouraged from challenging them about this. Doing so may lead to arguments or even violence. An individual alone cannot be responsible for the fidelity of both partners in a couple. Questions of abstinence, faithfulness and use of condoms all rest on the individual having the power to assert control over these behaviours, and as they are behaviours that are negotiated between couples (not just under the control of one individual) the more powerful partner is likely to control what happens. Often women lack power in relationships because they have less access to economic resources and sometimes they are dependent on male partners for their own and their children's survival.	**Promotion of female condoms and voluntary medical male circumcision** These prevention approaches recognise different biological and socio-structural vulnerabilities to HIV and suggest gender-specific interventions to address them. Female condoms are the only women-controlled barrier method of prevention, recognising that it's not always easy or possible for women, including young women, to ask for or to initiate condom use. While female condoms don't alleviate these gender dynamics, they give women the power to at least initiate condom use. Peer-led female condom education can include gender-transformative elements, for example by encouraging women to become familiar with their own bodies, opening a space for talking about sexual preferences and pleasure, and addressing challenging issues like IPV, forced and coerced sex. Voluntary medical male circumcision (VMMC) is a sex-specific bio-medical intervention, recognising biologically different vulnerabilities and protection. VMMC interventions can be gender neutral, but they can also open a space for talking about SRHR, HIV, sexuality, etc. with men and boys – which could also include 'transformative' elements as above.	**Stepping Stones approach**[10] This is a community-wide approach that encourages better communication between different members of the community. This approach recognises and challenges gender- and age-related power relations by creating space for conversation within *and between* gender and age groups (older men, older women, younger men and younger women). It is based on participatory learning techniques where the participants drive the content of topic-focused sessions (thereby also challenging the power dynamic between – often external – facilitator and participants, and enhancing the notion that communities are best placed to uncover their own solutions). Sessions begin with creating safe spaces, addressing issues around communication and conflict resolution more generally, and build on these to include topics that are often taboo like gender, power, sexuality, HIV and IPV. After discussing issues in separate 'safe' groups, participants share their agreed conclusions with other groups to bring about better understanding of each others' points of view and break traditional silences, mores, and beliefs. 10. http://steppingstonesfeedback.org/

1 Looking through a gender lens

Overview

Gender analysis is a useful tool that can help integrate a commitment to gender equality into HIV interventions. It offers strategies to increase understanding of the impact that policies and programming have on women and girls in all their diversity, compared to men and boys, and transgender people. Particular attention is paid to women and girls from key populations, as well as on trans people. The view through a 'gender lens' reveals different roles and needs, discrimination and marginalisation that may otherwise be overlooked. More specifically, a gender analysis makes it easier to see gender inequality and harmful gender norms, as well as gender-related barriers to access to services by highlighting:

- laws, policies and practices that reinforce (or counteract) power imbalances between and among women and men, and the particular marginalisation of trans women
- advantages and disadvantages experienced by people of different genders in a given context
- links between gender and other identity factors such as race, age, disability, ethnicity, income, sexual orientation, geographic location and health.

A gender analysis can identify gaps in service provision, especially for key populations, as well as reveal opportunities to make services more accessible to underserved groups. It can also identify beliefs, practices and assumptions related to gender that lie at the root of high HIV acquisition, low service uptake, and increased discrimination and violence.[11] As such, a gender analysis can make HIV prevention, care and treatment interventions more effective.

In practice, addressing the range of challenges faced by women and girls in all their diversity and across their life cycle requires a range of interventions tailored to different contexts and experiences. A gender analysis produces a better understanding of the strengths and weaknesses of any given intervention with respect to particular individuals and groups. It can lead to focused programming that addresses women and girls more broadly, a specific marginalised group of women and girls, or key populations. You can find examples of strategies and promising practices in Section 2.
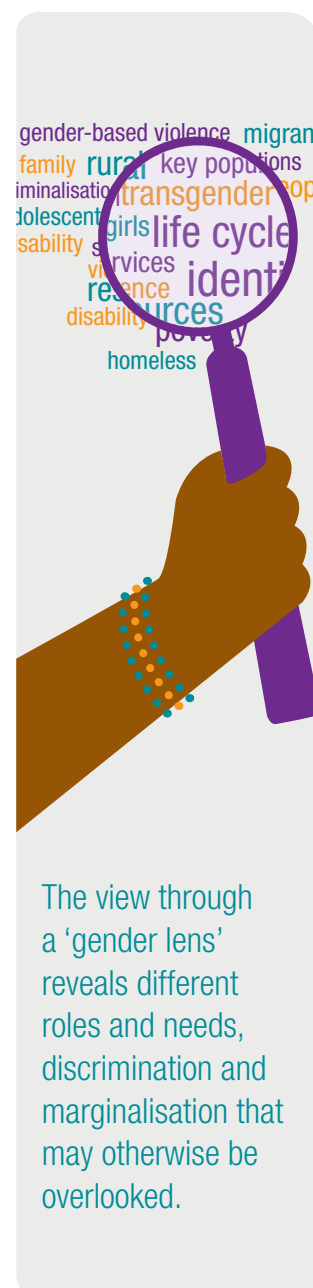
The view through a 'gender lens' reveals different roles and needs, discrimination and marginalisation that may otherwise be overlooked.

11. FHI 360 (2017), 'Gender analysis toolkit for key population HIV prevention, care and treatment programs'. Available at: www.fhi360.org/resource/gender-analysis-toolkit-key-population-hiv-prevention-care-and-treatment-programs

The gender analysis in Section 2 explores these three overlapping and mutually reinforcing areas.

1. Using available data and filling in the gaps

2. Promoting gender equality and addressing harmful gender norms

3. Removing gender-related barriers to access to services and information

1. Using available data and filling in the gaps

The first step in a gender analysis is to determine what data are available, and whether or not those data are at the very least disaggregated by sex and age (see also the box 'Transgender data'.) Data-informed interventions are better positioned to address multiple facets of women's diversity, and are also able to better demonstrate impact over time.

Sex-disaggregated data present information separately for men and women, girls and boys. If collected consistently over time, sex-disaggregated data can be used to measure change and impact in the lives of men, women, girls and boys. It can highlight weaknesses or strengths in resource allocation, and provide clearer insights that can help guide interventions and make them more impactful. Without sex-disaggregated data, interventions risk leaving out the most vulnerable groups, making the work at best ineffective.[12] Age disaggregation is also important. Classifying data by five-year age cohorts can capture another dimension of vulnerability or resilience that can prove crucial when planning an intervention that hopes to address underserved communities. An additional layer of data collection is required in order to capture and distinguish information about trans people.

The importance of age-differentiated data

Globally, age is an important factor in understanding vulnerability to and risk of HIV. For example, in Southern Africa, adolescent girls and young women aged 15-24 are among those most at risk of HIV. Without data that is disaggregated by age and sex, it would not be possible to identify this group of people as highly vulnerable. Young key populations also face risks that are specific to their gender and age.

For more information, see the UNAIDS Gap report (2014) at: www.unaids. org/en/resources/documents/2014/20140716_UNAIDS_gap_report

More visibility means more understanding

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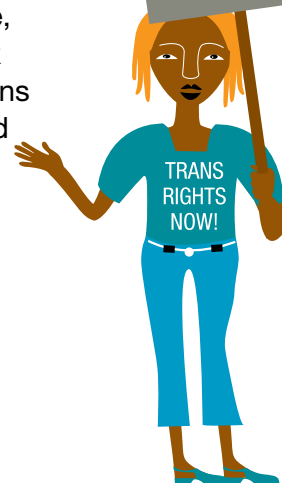
Transgender data

While sex-disaggregated data can reflect gender roles, responsibilities and lived realities for men and women, to date few countries also capture information about transgender people. There is also almost no information (or data) about HIV and SRHR for transgender men.

12. UNDP (2012), 'On course: mainstreaming gender into national HIV strategies and plans: a roadmap'. Available at: www.unaids.org.cn/pics/20130916134356.pdf

Monitoring and evaluation

It is important to consider ways of gathering and measuring gender (and age) inequalities and other related forms of discrimination from the beginning of a programme cycle, in order to track progress towards the expected outcomes; and to understand why outcomes may have been achieved (or not). Monitoring and evaluation should involve all individuals affected by the programme, in particular capturing the voices of women and girls in all their diversity. This information can prove critical for developing promising practices that can be shared with other organisations for adaptation to different contexts.

Data-informed advocacy

As well as shaping programmes, quantitative and qualitative evidence documenting the harmful effects of gender inequality and other human rights violations on HIV responses, can be a vital advocacy tool. Community engagement and awareness also directs attention and action to harmful gender norms, including GBV; discrimination against men who have sex with men; laws that criminalise sex work; and stigma against people living with HIV, among others. By focusing on the root causes of HIV – such as poverty, gender inequality, unsafe migration or overpopulated prisons – advocacy groups can help create an enabling environment for increased access to HIV services and the exercise of human rights.[13]

2. Promoting gender equality and addressing harmful gender norms

While the focus on treatment, including pre-exposure prophylaxis (PrEP) and post-exposure prophylaxis (PEP), is clearly essential to HIV responses, medical approaches alone will not lead to sustainable reductions in HIV. For gender-responsive HIV interventions to be successful in the long-term, we have to look at factors beyond the medical sector. These factors, also known as social and political determinants of health[14] – the distribution of power, money, goods and services – often have gender components.

Gender norms – specifically traditional views of 'masculinity' and 'femininity' – play a key a role in influencing sexual choices and health-seeking activities that can heighten HIV vulnerability and risk. Gender norms related to masculinity may encourage men and boys to have multiple partners, thereby increasing their risk of contracting and/or transmitting HIV. Traditional norms of masculinity may also discourage men and boys from seeking information or services for fear of seeming ignorant. Traditional norms of femininity that constrain women's independent decision-making power may increase women's risk during sexual activity. Discrimination and stigma towards homosexuality puts men who have sex with men and their male *and* female sexual partners at risk of HIV, as they may fear exposure or ill treatment by health-care workers and others.

Key resource

For guidance on successful advocacy, especially for key populations, see the Alliance Empowerment for Advocacy (EMPAD) Framework, available at: www.aidsalliance.org/resources/307-advocacy-toolkit-for-key-populations

Key resource

ATHENA Network and the Global Coalition on Women and AIDS (2014), Community Innovation: achieving an end to gender-based violence through the HIV response. www.athenanetwork.org/assets/files/Community%20Innovation/CommunityInnovationHIVGBV.pdf

13. Global Fund to Fight AIDS, Tuberculosis and Malaria (2016), B35/15, GF/, Community, Rights and Gender Report 2016, 35th Board Meeting. Available at: www.theglobalfund.org/media/4239/bm35_15-communityrightsgender_report_en.pdf

14. WHO Commission on Social Determinants of Health (2008), 'Closing the gap in a generation: health equity through action on the social determinants of health. Final report of the Commission on Social Determinants of Health'. Available at: www.who.int/social_determinants/final_report/csdh_finalreport_2008.pdf

Interventions that focus on the rich diversity of women across their life span can:

- increase the impact of programming, policy and advocacy
- promote human rights and gender equality
- reduce stigma and discrimination
- strengthen communities.

A number of initiatives can help, such as challenging gender norms – including stigma, discrimination and violence – that prevent women and other marginalised groups from accessing services. Increasing access to and uptake of quality services for women, men and transgender people in all their diversity can be strengthened by creating safe spaces for dialogue, rights literacy and awareness-raising in their communities. Empowering communities is most effective if empowerment reaches all members of the community, with a focus on engaging those who are the most marginalised.

Gender-transformative responses also entail reforming punitive and discriminatory policies, and advancing a legal and policy environment that promotes and protects public health, human rights and gender equality.[15] Punitive laws and policies, such as the criminalisation of sex work and homosexuality, or laws that fail to protect children's and women's rights to inheritance, perpetuate gender and other forms of inequality. Even when countries state a commitment to gender equality, or laws are in place, there is often a significant gap between rhetoric and action. It's imperative that most-affected populations *know* about these laws, and that law enforcers are trained to enact them.

3. Removing gender-related barriers to access to services and information

Gender influences levels of HIV risk, access to prevention, treatment, care and support, and the ability to deal with the consequences of HIV.[16] Gender norms and inequalities indirectly increase HIV risk by limiting access to health services as well as formal and informal educational opportunities that can reduce the likelihood of acquiring HIV. Spousal permission may be required to use services, or women may not be able to access services, particularly SRH services, if the local service provider is male. Many women living with HIV fear abuse, rejection, abandonment and violence by health-care practitioners, as well as people in their families and communities.[17]

Using a gender lens to analyse service availability, access, acceptability, affordability and quality for people living with HIV and from key populations reveals unequal access to treatment, care and support, depending on age, gender, sexual orientation and gender identity. As a result, interventions must consider and plan for the different needs of men, women and

Advocacy opportunity

Ensure the most-affected populations know about any laws and committments in their country that uphold gender equality. Law enforcers also need to be trained to enact them.

Analysing our services using a gender lens showed that our harm reduction services needed to be more women-friendly.

15. UNDP (2012), 'On course: mainstreaming gender into national HIV strategies and plans: a roadmap'. New York: UNDP. Available at: www.unaids.org.cn/pics/20130916134356.pdf

16. For more information on gender inequalities and HIV see UNAIDS (2014), 'Guidance note on gender-responsive HIV programming for women and girls'. Available at: www.unaids.org/sites/default/files/media_asset/genderresponsiveHIVprogramming_en.pdf

17. People Living with HIV Stigma Index, www.stigmaindex.org

transgender people in all their diversity, such as ensuring 'women-friendly', 'key population-friendly' and 'adolescent-friendly' services in harm reduction and SRHR programmes. This also means ensuring treatment access in hard-to-reach communities, such as HIV and TB diagnosis and treatment services in female prisons, or HIV outreach in transgender communities, including provision of male and female condoms.[18]

Despite ample evidence of the benefits of integrated approaches, services still tend to operate in isolation, for example:

■ Key populations may face specific barriers, particularly if their identities or practices are criminalised, or if discriminatory laws hinder their access to services and information.

■ Adolescent girls and young women living with HIV may not receive HIV-related support beyond infancy or childhood.

■ Although women living with HIV are at high risk of developing cervical cancer, the majority are never screened for it.[19]

■ Women living with HIV must often visit multiple service providers to secure a full complement of HIV treatment, care and support, as well as SRH services.

■ Those who are not considered high risk, such as women who have sex with women, often find themselves ignored, resulting in a failure to deliver information and SRH and HIV services.

■ While inadequate linkages between SRH and HIV services pose a challenge to all people living HIV, lack of family planning and the risk of unwanted pregnancies most negatively impacts women living with HIV.

■ Women living with HIV are also often responsible for caring for ill family members, regardless of their own health.

Some laws explicitly discriminate against women, for example those requiring male consent to access health-care. Where HIV transmission or exposure is considered a crime, pregnant women are at significant risk of being charged, reinforcing cycles of vulnerability and violence against women and girls (VAWG).[20]

Decriminalise sex work!

Advocacy opportunities

 Gender equality won't be achieved without advocacy to change the legal and policy environment. This might include:

■ influencing national policies to establish zero tolerance for violence against key populations

■ increasing access to justice for key populations

■ outlawing discrimination against women, key populations and people living with HIV

■ sensitising health workers and law enforcement personnel to the rights, needs and priorities of key populations from the perspective of gender

■ influencing policies to expand use of mobile services in order to reach underserved groups, such as migrant workers, sex workers, transgender people, and men who have sex with men.

18. Global Fund to Fight AIDS, Tuberculosis and Malaria (2016), B35/15, GF/, Community, Right and Gender Report 2016, 35th Board Meeting. Available at: www.theglobalfund.org/media/4239/bm35_15-communityrightsgender_report_en.pdf

19. UNAIDS (2016), 'HPV, HIV and cervical cancer: leveraging synergies to save women's lives'. Available at: www.unaids.org/en/resources/documents/2016/HPV-HIV-cervical-cancer

20. UNDP (2012), 'On course: mainstreaming gender into national HIV strategies and plans: a roadmap'. Available at: www.unaids.org.cn/pics/20130916134356.pdf

Gender-based violence

Homophobia

Transphobia

Stigma

Discrimination

Criminalisation

Poverty

Patriarchy

Occupation

Income

Social status

HIV status

Disability

Geography location

Sexuality

Housing

Ethnicity

Immigration status

Family status

Religion

Race

Education

Age

Gender identity

Women in all their diversity have multiple identities and stand at the intersection of multiple social experiences.

How to conduct a gender analysis

How can you use a gender lens to focus on groups and issues that would otherwise go unseen? The goal of this section is to help you do precisely that, and to build a deeper understanding of what it means to bring a gender analysis to your work.

The questions in the template on pages 17 and 18 are intended to help generate discussion, and to allow you to identify and understand the different needs, priorities, experiences and roles of women, men and transgender people in their diversity. You can use and adapt these questions to better understand how to apply a gender approach to your local situation, based on community realities and needs.

When conducting a gender analysis of this kind in your own community, it is vital that all stakeholders are meaningfully involved in these discussions. This includes key populations, people living with HIV, women, men and transgender people in all their diversity, as well as implementing partners. You may also want to involve service providers, community leaders and other decision-makers in the discussion.

The six fictionalised scenarios are based on real-life experiences. These scenarios have been designed to illustrate that people are complex, and to identify gender-related assumptions and beliefs as well as intersecting layers of marginalisation that are often overlooked. Read through the scenarios and use them to help you answer the questions in the tool with your own context in mind. This will help you develop the skills needed to perform a comprehensive gender analysis in your own community/context.

Your analysis can be supplemented with examples of good and promising practice.

Examples of additional relevant evidence from different parts of the world are also provided with each of the scenarios.

Your contextualised gender analysis, good practice examples and additional evidence comprise the toolkit you will need to design and implement gender-transformative interventions that address gender inequalities, stigma and discrimination, and barriers to access to services and information – ultimately leading to a more effective HIV response.

Gender analysis template for women and girls in all their diversity

Work through this template using the scenarios on pages 19-35, or adapt it to carry out a gender analysis with other groups of marginalised women in your community.

Context

Thinking about the woman in the scenario you have just read:

- What are three to five unique aspects of this woman's situation and identity?

- Do any of these aspects make her particularly likely to acquire HIV in the context of your community?

- What other health or human rights issues may she have experienced or be exposed to?

1. Using available data and filling in the gaps

- How does HIV impact groups of people in your community that share these identities?
  What is the best estimation of HIV prevalence for this group?

- How many people living with HIV are on treatment in your community?
  What percentage of these are women? Young women?
  What proportion of women from this particular population of women and girls who have started on treatment are retained in care after 12 months?

- If you do not have this information, how might you gather it?
  Do you work with organisations that address the factors you identified that heighten vulnerability? Would they have better data or population size estimates for your community? Do they have information about HIV prevalence for people who experience compound discrimination, for example, men who have sex with men and women, women who use drugs and sell sex, or transgender people who sell sex?

2. Promoting gender equality and addressing harmful gender norms

- Are any of the women in the scenario criminalised (for instance, women sex workers or women who use drugs, or adolescents and young women seeking SRH)? What is the law?
  If these practices aren't criminalised, are they regulated, and how?

- Is stigma attached to any of these practices?
  What are the cultural views in the community about these practices?

- Is police harassment common in your community? What kind of harassment?
  Do you think women from this population are likely to be exposed to police harassment?

- Are there any cultural, traditional or religious beliefs or practices that make women more likely to get HIV than men, such as child marriage or widow inheritance?

Which women and girls are most likely to be affected by these practices?

- Is violence against women accepted in your community?
Are women able to say 'no' to sex if their husband or partner demands it?
Are they able to ask for a condom to be used?
Will women who sell sex be taken seriously if they report being raped by a client?
Will lesbian women feel confident to report a sexual assault to the police?

- Is rights-based comprehensive sexuality education provided to adolescent girls and boys?

- Is peer outreach, support or education available for this population?

3. Removing gender-related barriers to access to services and information

- What kind of HIV services and information are available for women in all their diversity, and where? Who uses them?
What problems might women and girls from this key population face with accessing services and information?

- Do laws in your country require that women obtain permission from their husbands or male family members in order to access HIV and SRHR services?
Do you have information on how many women are able to access these services by themselves?

- Do laws prohibit providers from serving young people under the age of 18 without parental consent?

- Which SRH services and information are available?
Are integrated HIV and SRH services available in the same location?
What about young women and adolescents – are adolescent-friendly HIV and SRH services available?

- Are services available for survivors of violence in your community?
Are comprehensive post-rape services available, such as PEP, psychosocial care, emergency contraception and safe abortion?
What barriers might women and girls in similar situations encounter when they need to access these services?

- Where can women and girls from this key population group access HIV treatment and care?
Is it in the community? Are the opening hours convenient?

- What kinds of community health services are available for these women and girls?

- What do people who share these vulnerabilities say about the accessibility, acceptability, availability, affordability and quality of these services?
What do they say about service providers' attitudes towards them?

- Are legal services available and accessible to women and girls in similar situations?

Scenario 1: Empowering women who sell sex and use drugs to be their own advocates

Lili's story

Lili is 29. She has sold sex since her early teens as a way to help support her family. When she was 18 she began injecting opioids. She knows that some of her friends sell sex to support their drug dependence. While Lili uses some of her income to purchase drugs, it is not her sole motivation for engaging in sex work.

Lili and many of her friends have experienced violence from their clients. They know their work is illegal and do not trust the police to intervene on their behalf. Clients are not required to use condoms, and Lili sometimes negotiates extra money by agreeing to unprotected sex. Despite having friends who have contracted HIV, she doesn't seek help or find out her HIV status because she is worried about the stigma she will suffer if people in her community find out about her drug use and her work.

Are there women like me in your community? If not, how is your community different?

Please refer to the questions in the template on pages 17 and 18 to conduct a gender analysis on **sex workers who also use drugs**.

Intervention strategies and promising practices

Adopting a comprehensive harm reduction approach

Harm Reduction International (HRI) recommends the following components of effective programming for people who sell sex and use drugs:[21]

- Join forces with other organisations that work with sex workers and people who use drugs. Collaboration and sharing resources and knowledge ensures that interventions are appropriate to these target groups. Where possible, HRI recommends hiring members of the populations being served.

- Training peer educators has shown promise in educating hard-to-reach populations.

- Focus interventions on harm reduction services, including needle exchanges, condom distribution and non-judgemental counselling.

- Create safe spaces for these groups, particularly in countries and communities with pronounced discrimination and punitive laws, where police abuse is a particular risk.

- Focus on empowering these groups to be their own human rights advocates, and giving them the information they need to reduce the risk of HIV transmission.

In addition, increased income and better control over the money they earn will help sex workers say no to high risk sex or dangerous clients. Increasing skills for managing money, referring sex workers to alternative income generating options and planning for the future are some strategies that may help.

21. Harm Reduction International (2013), 'When sex work and drug use overlap: considerations for advocacy and practice'. http://www.harm-reduction.org/sites/default/files/pdf/Download%20%5BEnglish%5D_26.pdf

Adopting a comprehensive harm reduction approach

In Eastern Europe, an estimated 20-50% of women who inject drugs also sell sex, which requires responses that address the entire scope of their concerns, needs and rights. The Eurasian Harm Reduction Network's campaign, 'Women Against Violence', reaches out to *all* women who use drugs inclusive of sex workers, in a broad multi-country advocacy initiative. The three-year campaign focuses on combating police violence across 16 cities in Eastern Europe and Central Asia by reporting police violence against women who use drugs; fostering dialogue between women who use drugs and community decision-makers; and monitoring the implementation of government commitments to address the violence.

www.harm-reduction.org/actions/women-against-violence

Alliance for Public Health (APH), the Alliance LO in Ukraine, focuses on a harm reduction package of services for people who inject drugs, which includes needle and condom distribution, as well as counselling and testing for HIV and other sexually transmitted infections (STIs). To access hard-to-reach populations, APH also uses mobile clinics, peers, referrals, job training and employment opportunities. It has adopted gender-sensitive approaches, including short-term childcare; woman-focused peer outreach, counselling, and training; peer support groups for women who inject drugs; and, gender-sensitive harm reduction (including providing smaller needles for women who inject drugs). APH has focused on women who inject drugs who are also engaged in sex work, and has successfully reduced new HIV infections.[22]

http://aph.org.ua/en/home/

> Few interventions address the multiple vulnerabilities to HIV for women who inject drugs and sex workers.

Background information: the evidence

According to the Joint United Nations Programme on HIV/AIDS (UNAIDS), approximately 12.7 million people inject drugs, of whom 12% are living with HIV.[23] Female sex workers account for as much as 7.4% of the population, depending on the region. A 2012 study found that on average, HIV prevalence among female sex workers is 12%.[24] Yet although both groups are considered key populations most affected by HIV, few interventions address the multiple vulnerabilities to HIV for women who inject drugs and sex workers of all genders, or the other risks they face – particularly violence by police or clients, inadequate legal services, or education for themselves or their children.

22. Deshko T. (2015), 'HIV Reduction Among Women Who Inject Drugs Can Be Achieved Through Women-Specific Programs and Global Targets: A Model From Ukraine, *Journal of Acquired Immune Deficiency Syndromes*. Vol 69: S98-S99. Available at: http://journals.lww.com/jaids/Fulltext/2015/06011/HIV_Reduction_Among_Women_Who_Inject_Drugs_Can_Be.4.aspx.

23. UNAIDS (2014), 'Women living with HIV speak out against violence: A collection of essays and reflections of women living with and affected by HIV. Available at: www.unaids.org/sites/default/files/media_asset/womenlivingwithhivspeakout_en.pdf

24. Baral S., et al. (2012), 'Burden of HIV among female sex workers in low-income and middle-income countries: a systematic review and meta-analysis'. *The Lancet Infectious Disease*, Vol 12 (7): 538-549.

A 2013 review of studies found that over half of female sex workers in Latvia and Portugal also injected drugs.[25] This illustrates that female sex workers who inject drugs face a heightened risk of contracting HIV. A study in China found that 35.5% of female sex workers who also injected drugs were living with HIV.[26] Similarly, research in India concluded that HIV rates among female sex workers who inject drugs were 9.4 times higher than female sex workers who did not inject drugs.[27]

Research also shows that women who use drugs experience different risks to men. In South Africa, a study found that men exercise more control over drug and sexual transactions than women, with female sex workers who use drugs being controlled to a great extent by male managers, who threaten women with loss of shelter or violence if they do not make enough money. Drugs are used to increase stamina for sex work, enhance sexual pleasure or cope with the stress of sex work. Female sex workers who inject drugs may decide not to use condoms in order to earn more money, or may get drugs directly in exchange for their services.[28]

Very little is known about young people who inject drugs and also sell sex. Being under 18 makes a person more vulnerable – not only because of their age – but also due to legal structures, social, economic, and environmental factors.

Scenario 2: Increasing public awareness and including women who have sex with women when we talk about HIV

Are there women like me in your community? If not, how is your community different?

Patience's story

Patience was walking home from a local bar known to be open to the LGBTI community when three men stopped her and pushed her into an alleyway. They told her they were going to make her remember that she was a woman, and raped her. Afterwards she was afraid, but went to the police to report the crime anyway. The police officer she spoke to dismissed her report, asking what she did to encourage her attackers. Six months later, Patience tested positive for HIV at the local health centre. On receiving the results she didn't know what to do. The doctor told her to inform all her sexual partners – meaning her male partners. No one said anything about how this could affect her girlfriend, and she was afraid of how her girlfriend would react to the news. She assumed, based on the information available that since the virus couldn't be transmitted through lesbian sex, she didn't need to disclose either the rape or her HIV status to her girlfriend.

25. Platt L., Jolley E., Rhodes T., et al. (2013), 'Factors mediating HIV risk among female sex workers in Europe: a systematic review and ecological analysis'. *BMJ Open* 2013,Vol 3, e002836. doi: 10.1136/bmjopen-2013- 002836

26. Jia et al. (2010), 'The HIV Epidemic in Yunnan Province, China, 1989–2007'. *Journal of Acquired Immune Deficiency Syndrome.* Vol 53, Suppl 1, February 2010: S34-40. doi: 10.1097/QAI.0b013e3181c7d6ff

27. UNAIDS, (2014), 'Women living with HIV speak out against violence.'

28. Needle et al. (2008), 'Sex, drugs, and HIV: Rapid assessment of HIV risk behaviors among street-based drug using sex workers in Durban, South Africa'. *Social Science & Medicine*, Vol 67(9), November 2008: 1447-1455. https://doi.org/10.1016/j.socscimed.2008.06.031.

Please refer to the questions in the template on pages 17 and 18 to conduct a gender analysis on **women who have sex with women**.

Intervention strategies and promising practices

Ensuring women who have sex with women have access to accurate, non-judgemental information about HIV risk

The limited information about HIV among women who have sex with women may lead to some lesbians and other women who have sex with women engaging in behaviour that places them at risk of HIV transmission. Some women who have sex with women inject drugs and may share needles; others are sex workers, have sex with HIV-positive men and/or people who inject drugs. Services for men who have sex with men or heterosexual women often do not feel safe or appropriate for lesbians and other women who have sex with women. This is compounded by gender inequality and stigma and discrimination against lesbians and other women who have sex with women, including sexual and gender-based violence, which is reportedly very prevalent among this community. Service providers therefore need to disseminate some basic information:

- Sex between women is low risk for HIV, but not no risk
- The use of sex toys or fingers without a condom increases HIV risk between sexual partners where one partner is HIV-positive and the other HIV-negative
- Oral sex without a barrier especially when one sexual partner is menstruating increases risk of HIV transmission.[29]

There are multiple factors that put us at risk of HIV, and yet we are often left out of service planning.
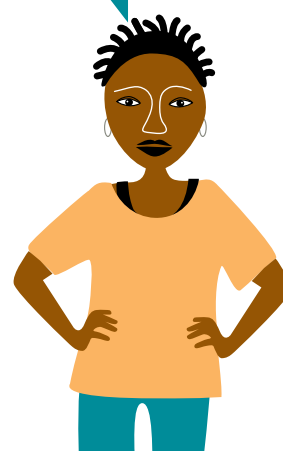
Preventing and addressing violence against women in the context of HIV

The World Health Organization (WHO) and UNAIDS have identified four critical pathways that create causal linkages between violence against women (VAW) and HIV. A review of interventions showing positive results in either preventing or addressing VAW and/or HIV has shown that successful programming falls into four strategic areas:

- Economic empowerment of women and girls
- Addressing gender and social norms (including by working with men and boys)
- Integrating VAW and HIV services
- Creating an enabling legal environment[30]

Raising awareness and creating safe spaces for people from the LGBTI community

The non-profit Triangle Project is a human rights organisation that has worked in Cape Town and other parts of the Western Cape in South Africa for over 20 years. Its holistic approach takes into account the multiple factors that put people at risk of HIV. The project offers health services and counselling, public education and research, and leads government advocacy efforts. The Triangle Project also helps members of the LGBTI community to create activist hubs for them, their partners and families. These hubs are called safe spaces, and there are currently 14 in operation.[31]

https://triangle.org.za/

29. Women's Institute at Gay Men's Health Crisis (2009). Available at: http://www.gmhc.org/files/editor/file/GMHC_lap_whitepaper_0609.pdf

30. WHO (2013), '16 Ideas for addressing violence against women in the context of HIV epidemic: a programming tool'. Available at: www.who.int/reproductivehealth/publications/violence/vaw_hiv_epidemic/en/

31. Lynch I. and Clayton M. (2014), '"I never thought lesbians can be infected": Women who have sex with women and HIV risk'. Available at: http://triangle.org.za/wp-content/uploads/2015/04/wsw-hiv-triangle-project-research-brief-2.pdf

There is a lack of strong research documenting HIV prevalence among women who have sex with women due to the misconceived perception that they are not at risk – yet that is often not the case. One 2013 study in four Southern African countries found that 9.6% of women who have sex with women were living with HIV.[32]

Women who have sex with women are often left out of HIV conversations. Women who have sex with women, including those who identify as lesbian and bisexual, may be at risk of HIV due to several factors including: sexual relations with partners of the opposite sex, blood transfusions, sex work, injecting drug use, artificial insemination and occupational exposure.[33] One in five women who have sex with women in Kyrgyzstan reported having sex with a man during the previous six months, with only half using condoms.[34]

Women who identify as lesbian and engage in sex work may participate in riskier sexual practices with male partners.[35] A study of 72 HIV-positive women who have sex with women found that 21 were currently married to men and 47 reported having children.[36] In South Africa, gang rape by men who target women who have sex with women because of their sexual preferences is also a significant risk factor.[37]

At least 76 countries criminalise consensual same-sex contact. These discriminatory legal frameworks make it very difficult to reach women who have sex with women, likewise men who have sex with men and transgender people. It is partly because of this marginalisation that significant gaps remain in both services and research in this area. There is a lack of training for health care workers specifically designed to address the needs of women who have sex with women. This has led to the refusal of treatment, or withholding of personal information, such as sexual orientation from the healthcare provider in order to avoid discrimination.[38]

32. Sandfort T. et al. (2013), 'Forced sexual experiences as risk factor for self-reported HIV infection among southern African lesbian and bisexual women'. *PLoS One*. 2013, Vol 8(1): e53552. Epub 2013 Jan 9. doi: 10.1371/journal.pone.0053552.

33. Mora and Monteiro (2010), 'Vulnerability to STIs/HIV: sociability and the life trajectories of young women who have sex with women in Rio de Janeiro". *Cult Health Sex*. 2010 Jan;12(1):115-24. doi: 10.1080/13691050903180471.

34. Alisheva D et al. (2007), 'Access to Health Care for LGBT People in Kyrgyzstan'. Sexual Health and Rights Project (SHARP) Soros Foundation–Kyrgyzstan.

35. Roberts A. et al. (2010), 'Women who inject drugs: A review of their risks, experiences and needs'. Available at: www.unodc.org/documents/hiv-aids/Women_who_inject_drugs.pdf

36. Cloete A. et al. (2011), 'Are HIV positive women who have sex with women (WSW) an unrecognized and neglected HIV risk group in South Africa?'. *Journal of AIDS and HIV Research.* Vol. 3(1), pp. 1-5 January 201. www.academicjournals.org/jahr

37. Henderson J. et al. (2011), "We women are women with a different manner": sexual health of WSW in four Western Cape communities. Triangle Project. Available at: www.hsrc.ac.za/en/research-outputs/view/5749

38. Ndirangu, E., Evans, C. (2009), 'Experiences of African immigrant women living with HIV in the U.K.: implications for health professionals'. *Journal of Immigrant and Minority Health*. 11(2), 108-114. Available at: http://ecommons.aku.edu/eastafrica_fhs_sonam/43

Scenario 3: Reaching out to migrant women and eliminating gender-based violence

Dina's story

Originally from Kyrgyzstan, Dina spends four months of the year in Moscow working in a sewing factory. She works 12 hours a day and lives with 40 other migrants in an apartment that is constantly raided by police who demand payoffs in return for their silence. Her friend, Gulmira, also lives there with her husband, Osh. He is very jealous and Dina can often hear him beating her friend in the kitchen because she has come home from the factory later than he wanted. When immigration officers come to inspect the factory she hides with the other Kyrgz women, as her papers are illegal. Whenever anyone is late for work, the boss beats them and docks their wages. Once, when Dina was late, her manager brought her into his office and sexually assaulted her. She could not complain because she was afraid he would call the police or refuse to pay her.

Please refer to the questions in the template on pages 17 and 18 to conduct a gender analysis on **migrant women and other women who experience GBV.**

Intervention strategies and promising practices

Ensuring safety for migrant women within health services

In spite of significant research gaps, several studies among migrant women living in Europe stress the importance of non-judgmental, personalised and respectful treatment by health-care providers. These studies show that ensuring health-care workers maintain respectful attitudes toward their clients can have a significant impact on whether clients continue to use health services.[39]

For example, Migrante Seguro + runs a medical clinic for poor migrants living with HIV in Tijuana, Mexico.[40] The clinic provides integrated physical and mental health care to some of the border region's most vulnerable people, including migrants, deportees, people who use drugs and sex workers. Services include HIV care, preventive screening and pre/post-test counselling for HIV, STIs, tuberculosis (TB); as well as referrals to social services, basic prescription medications, minor medical procedures, mental health assessments and counselling services. Because of their temporary or undocumented status, migrants are less likely to access health services without targeted efforts. Among the outreach efforts, peer-to-peer support is a way to increase migrants' engagement in HIV care across the continuum of care, including for mental health and treatment for opioid addiction. Trained peer 'navigators/educators' reach out to others in their community. A new clinic for male, female, and transgender sex workers, created in collaboration with Tijuana's General Hospital, offers comprehensive HIV prevention services, including PrEP. The hospital also provides services to survivors of IPV and sexual violence.

39. Ndirangu, E. and Evans, C. (2009), 'Experiences of African immigrant women living with HIV in the UK: implications for health professionals'. *Journal of Immigrant and Minority Health*, Vol 11(2): 108-114. Available at: http://ecommons.aku.edu/eastafrica_fhs_sonam/43

40. The Elton John AIDS Foundation, http://newyork.ejaf.org/2016-grants

Changing power relations and harmful gender norms to prevent IPV

A study of a community-based violence prevention intervention – SASA! – in Uganda, found that the intervention led to significantly lower social acceptance of IPV among women and men; greater acceptance by women and men that women can refuse sex; and lower levels of sexual and physical IPV in the past year. Women experiencing violence were more likely to receive support from the community. SASA! promotes a new, bold analysis of power and demonstrates how we all have the power to create change. It provides organisations with a sound conceptual framework for discussing the links between VAW and HIV, and the structure in which to implement creative and comprehensive programmes. SASA! is designed to reach a broad spectrum of stakeholders and is for organisations that traditionally address VAW as well as HIV agencies.

http://raisingvoices.org/sasa

Since 1995, the Ugandan training programme, Stepping Stones, has provided a curriculum that focuses on building communication and relationship skills in the context of HIV, with the express goal of reducing VAW. This rights-based approach has been used in over 60 countries worldwide. In 2016, an updated curriculum was released – Stepping Stones Plus – that covers GBV, SRHR, and treatment and adherence issues. The lessons are designed to be tailored to a range of contexts and communities and across genders, faiths and generations. It is underpinned by the belief that entire communities are affected by HIV and that it will therefore take collective community support to respond. The workshops use non-formal learning and participatory approaches to encourage participants to share their life experiences and explore alternative outcomes to challenging situations.

http://steppingstonesfeedback.org

> Migrants living with HIV in Europe often contract HIV in their destination country, not their country of origin.

Background information: the evidence

Worldwide, a third of all women have experienced IPV and/or non-partner sexual violence in their lifetime. One recent study among women (15-49) in Uganda found that those who had experienced IPV were 55% more likely to be living with HIV compared to women who had never experienced IPV.[41] Violence in a relationship places women at additional risk from HIV. A study in Chile found that women who had suffered IPV were highly likely to have sexual relations with a partner whose HIV status was unknown, as well as having sex without condoms.[42]

A study of migrants living with HIV in Europe found that most of the migrants contracted HIV in the destination country, not their country of origin.[43] A review of women migrants from Asia who travel to Arab States, including female returnees living with HIV, found that these women have poor access to even basic information about HIV.[44] Discrimination in health-care centres and elsewhere makes female migrant workers even more vulnerable. A survey of women migrant workers in Hong Kong found that 77% of the respondents reported that they have felt discriminated against in Hong Kong, of whom 42% felt discriminated against in hospitals.[45]

41. Kouyoumdjian F. et al. (2013), 'A Systematic Review of the Relationships between Intimate Partner Violence and HIV/AIDS', *Plos One*, Nov 25, 2013. https://doi.org/10.1371/journal.pone.0081044

42. Miner et al. (2011), 'Intimate partner violence and HIV risk behaviors among socially disadvantaged Chilean women'. *Violence Against Women*, Apr, Vol 17(4): 517-31. Epub 2011 Apr 11. doi: 10.1177/1077801211404189

43. See Aidsmap, www.aidsmap.com/The-majority-of-migrants-living-with-HIV-in-Europe-may-have-acquired-HIV-in-their-new-country/page/3008928/

44. UNDP (2008), 'HIV Vulnerabilities Faced by Women Migrants: from Asia to the Arab States'.

45. Bandyopadhyay M. and Thomas J. (2002), 'Women migrant workers' vulnerability to HIV infection in Hong Kong'. *AIDS Care*, 2002, Aug, Vol 14(4): 509-21. Available at: www.ncbi.nlm.nih.gov/pubmed/12204153

Scenario 4: Increasing support and services for transgender people including those selling sex

Nurul's story

Nurul came out to her family as transgender when she was 17. Her family threw her out and she started selling sex to support herself. Constant police harassment and abuse by clients left Nurul depressed and frightened. She tried to find another job – this time at a local restaurant – but was turned away because all her legal documents were for a man with a different name. It is illegal in her country for a man to pose publically as a woman, and last year one of her friends was arrested in a government raid. A month ago, Nurul was raped and beaten by a client who tried to kill her when he discovered that she was transgender. She couldn't go to the police because she was afraid of being arrested. Scared that she had been exposed to HIV, she went to the health clinic to get tested, but the health worker mocked her, refusing to call her by her female name. She ended up leaving without the PEP she was hoping to receive.

Please refer to the questions in the template on pages 17 and 18 to conduct a gender analysis on **transgender people who sell sex.**

Intervention strategies and promising practices

Ensuring access to non-judgemental services for trans people

Stigma and discrimination against trans women and transgender sex workers is widespread. Trans women and sex workers are frequent targets of violence and harassment by the police and members of their communities. As a result, service providers need to reach out to this population and assure them that they will receive tailored, non-judgmental, skilled, personalised and respectful treatment by health-care providers. It is vital that providers are knowledgeable about the impact of hormonal treatments and/or medical procedures that are undertaken by many trans people. In addition, given the levels of harassment and violence faced by trans women and sex workers, health providers need to ensure confidentiality for their trans and sex worker clients.

Creating safe dialogue spaces for trans people to share experiences and knowledge

Transgender people are often considered a hard-to-reach group, in part because of the typically insular nature of their social circles. To address this issue, the TBLz Sexperts project in Thailand created an online platform for transgender people to talk about topics of interest, ranging from fashion to sex to socialising. Advice is provided on safer sex practices, particularly HIV prevention. The messages come from within the community, allowing transgender people to share video clips and other content, while also validating safer sex messages to other members of the community. The platform allows for peer counselling and discussion of human rights issues facing transgender people in Thailand.[46]

www.facebook.com/TLBzSexperts/

46. To read more about TBLz Sexperts! project, see: www.digitalcultureandeducation.com/uncategorized/chaiyajiy_html/

The India HIV/AIDS Alliance's Pehchan programme aims to strengthen the capacities of men who have sex with men, and the transgender and *hijra* communities. The programme's '207 against 377' campaign unites 207 organisations to protest Section 377 of the Indian Penal Code, which criminalises homosexuality. Section 377 was upheld in 2013 by the Supreme Court. In response, the campaign organised teams at the local level to monitor and report on human rights-related barriers to HIV and health services. In 2015, the campaign also successfully contributed to the passing of the Transgender Persons Rights Bill in the upper house of the Indian Parliament.

www.allianceindia.org/our-work/pehchan/

🌐 Background information: the evidence

Transgender people often do not feel safe and secure in their own homes. In Latin America, for example, between 44 and 70% of transgender women were either thrown out, or felt the need to leave their homes.[47] They are also more likely to be victims of violence. According to Transgender Europe's Trans Murder Monitoring report, 2,016 trans and gender diverse people were killed between 2008 and 2015. This number is likely to be underreported. More than 1,500 of these killings were reported in Central and South America and 65% of all those murdered were sex workers.

Transgender people are disproportionally affected by HIV. In Malaysia, for example, of the approximately 20,000 transgender people, 9.7% are living with HIV, compared to just 0.05% of the national adult population. A study in Peru found that out of 450 trans women, 30% were living with HIV, suggesting that trans women are the group most vulnerable to HIV in Peru.[48]

There is a notable lack of data on transgender populations, especially transgender women. In many cases, where HIV statistics are compiled, transgender women are included in the same category as men who have sex with men. This not only denies their gender identity, but also fails to recognise their specific needs and vulnerabilities. One of the few studies available noted that transgender women were more likely to report selling sex in the last 12 months than men who have sex with men, and to have sexual relations that put them at high risk of HIV.[49]

There is a lack of data on transgender women. We are often included in the same category as men who have sex with men.

47. UNAIDS (2014), The Gap Report. Available at: http://files.unaids.org/en/media/unaids/contentassets/documents/unaidspublication/2014/UNAIDS_Gap_report_en.pdf

48. Silva-Santisteban A. et al. (2012), 'Understanding the HIV/AIDS epidemic in transgender women of Lima, Peru: results from a sero-epidemiologic study using respondent driven sampling'. *AIDS and Behavior*, 2012 May, Vol 16(4): 872-81. doi: 10.1007/s10461-011-0053-5.

49. Stahlman S. et a., (2016), 'Characterizing the HIV risks and potential pathways to HIV infection among transgender women in Côte d'Ivoire, Togo and Burkina Faso'. *Journal of the International AIDS Society*. 2016, Vol 19, Suppl 2: 20774. Published online 2016 Jul 17. doi: 10.7448/IAS.19.3.20774.

Scenario 5: Supporting adolescents and young people living with HIV and increasing access to SRH education

Maria's story

Maria suspected that she was different. Ever since she could remember, she and her parents took their medicine together every day, but her sister didn't. Maria felt like she was always getting sick, but didn't know why. When she got meningitis at the age of 12, she lost a lot of weight and took a long time to recover. Then, when she was 16, her mother finally told her the truth: that Maria and her parents were all living with HIV. She's not sure who she can talk to about her status aside from her parents, and is afraid what her friends will say once they find out. Sometimes she gets sick of taking her medicine, and wishes she could just be like her sister and other 'normal' kids.

At school, her teacher told them about sex, and how important it is to abstain from sex before marriage – but that left her with more questions than answers. Her mum told her that it was better to stay away from boys altogether. But that doesn't help Maria deal with her new feelings. Some of her friends are having sex with their boyfriends, and their boyfriends buy them presents and help pay for books and school supplies. Yesterday, Maria's friend Rosario told her that she has started having sex with her boyfriend. She proudly explained to Maria how they went to the health centre to get tested for STIs together, shared their results, and then went to buy condoms in preparation. Maria worried that she would never be able to do that. Maria wants to get married and have a family someday, but feels like that is impossible.

> Are there young women like me in your community? If not, how is your community different?
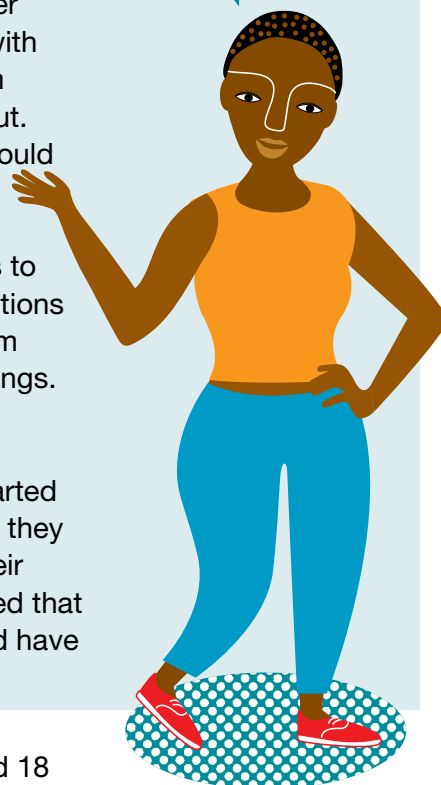
Please refer to the questions in the template on pages 17 and 18 to conduct a gender analysis on **adolescents living with HIV.**

Intervention strategies and promising practices

Ensuring adolescent/youth-friendly SRHR services for adolescents

HIV and SRHR services need to be responsive to the needs of adolescents and young people to make them attractive to use, accessible and acceptable. This means addressing stigmatising attitudes of all health facility staff (not just service providers, but also receptionists and auxiliary staff); providing quality information in attractive ways that is accessible and relevant to young people; and addressing barriers posed by distance, cost, transport, limited autonomy/independence, and legal age of consent for accessing services, as well as young people's educational and social needs. Evidence suggests that:

- adolescent-friendly and gender-responsive HIV treatment support sessions can increase adherence among adolescents
- providing clinic services that are gender-responsive and youth-friendly, conveniently located, affordable, confidential and non-judgmental can expand use of clinic reproductive health services, including HIV testing and counselling and treatment services

Key resources

The Alliance's work with, by and for adolescents and young people is guided by our Good Practice Guide on Adolescent and HIV Programming: READY – Here we come! Available at: www.aidsalliance. org/resources/922- good-practice-guide- adolescent-hiv- programming

- youth-friendly condom distribution can help young people feel more comfortable accessing condoms
- integrating HIV testing and counselling into existing SRH services for young people may lead to increased uptake of HIV testing and counselling for youth aged 15 to 24.[50]
- age-of-consent requirements and mandatory parental consent requirements limit adolescents' decisions to access HIV testing, and inhibit adolescent girls' use of sexual health services.[51]

Promoting women and girls' leadership and challenging gender norms and stereotypes

Taking the specific HIV needs and vulnerabilities of girls and young women into consideration will increase the effectiveness of interventions. This includes girl-specific preventions strategies, fostering girls' leadership and increasing boys' responsibility for ensuring health and safety, among others.

Peer-led integrated HIV and SRHR programming for adolescents and young people

In Uganda, the Alliance's Link Up programme empowered young people to take control of their sexual and reproductive health and rights. By working through a consortium of local, regional and international organisations, Link Up focused on fostering youth leadership by building their skills and providing them with the opportunity to make a difference in their own communities – through mentorship and peer educator programmes. They were also able to reach more than 296,000 young people through integrated SRHR/HIV services including family planning services and voluntary counselling and testing. These efforts were further strengthened through technical capacity building with local health care providers and health extension workers.[52]

www.aidsalliance.org/our-impact/link-up

Background information: the evidence

According to UNAIDS, adolescents are the only group to experience an increase in AIDS-related deaths in the past seven years. Of the 2.1 million adolescents living with HIV, 1.7 million live in sub-Saharan Africa.[53]

Young girls are disproportionately affected by HIV. In high prevalence countries, they can be two to three times more likely to be infected than boys.[54] In sub-Saharan Africa, only 10% of young men and 15% of young women (aged 15–24) are aware of their HIV status. Two out of three people below the age of 14 lack access to HIV treatment worldwide.[55]

Key resources

IPPF (2012), 'Healthy, happy and hot: a young people's guide to their rights, sexuality and living with HIV'. Available at: www.ippf.org/resource/healthy-happy-and-hot-young-peoples-guide-rights

Key resources

For key resources and to read more about the Alliance's approach to adolescents and young people, see: www.aidsalliance.org/our-priorities/164-adolescents-and-young-people

50. What works for women & girls. www.whatworksforwomen.org/chapters/9-Prevention-and-Services-for-Adolescents-and-Young-People/sections/25-Increasing-Access-to-Services/evidence#s-757

51. UNAIDS (2014), The Gap Report. Available at: http://files.unaids.org/en/media/unaids/contentassets/documents/unaidspublication/2014/UNAIDS_Gap_report_en.pdf

52. To read more about the International HIV/AIDS Alliance's approach to adolescents and young people, see: www.aidsalliance.org/our-priorities/164-adolescents-and-young-people

53. See: UNICEF https://data.unicef.org/topic/hivaids/adolescents-young-people/#

54. UNICEF (2016), 'United Nations Children's Fund, For Every Child, End AIDS – Seventh Stocktaking Report'. New York: UNICEF. Available at: https://data.unicef.org/wp-content/uploads/2016/12/HIV-and-AIDS-2016-Seventh-Stocktaking-Report.pdf

55. UNAIDS (2014), The Gap Report.

What's so different about adolescents?

Adolescents are unique in their development, their health and their social needs; therefore, their service requirements are different. The developmental changes experienced during adolescence make it one of the most rapidly changing stages of life. These changes impact on adolescents' health, not only during adolescence but also across their lifetime.

Learning from the Link Up project is encapsulated in a range of tools, case studies, issue briefs and workshop guides, which support programming, service delivery and advocacy with and for early adolescents and young adults.
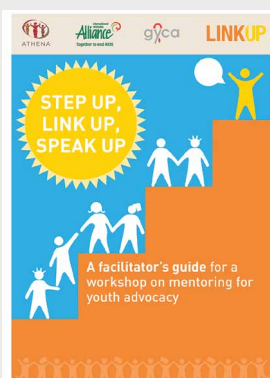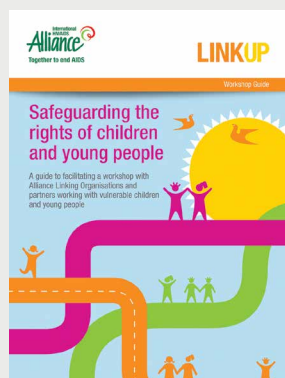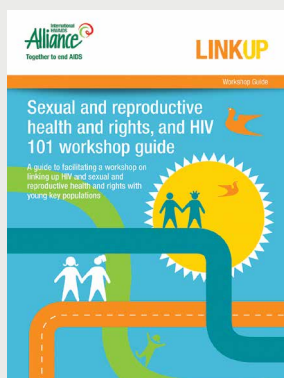
The Alliance's adolescent programme – READY: Resilient and Empowered ADolescents & Young people – builds on the work of Link Up and is the Alliance's current focus of work with adolescents and young people living with and most affected by HIV.

READY+ is a four-year programme in southern Africa that will reach 30,000 adolescents and young people living with HIV in Mozambique, Swaziland, Tanzania, and Zimbabwe. It provides HIV and SRHR education, peer support and high quality integrated HIV/SRHR and mental health services. It also supports young people to participate in local, national, and global SRH/HIV advocacy activities to address structural barriers to accessing SRH services and realising their sexual and reproductive rights.

READY Teens focuses on 10-19 year olds living with and most affected by HIV in Burundi, Ethiopia and Uganda. The project particularly recognises the vulnerabilities and marginalisation experienced by adolescents from key populations, including adolescents living with HIV, selling sex, using drugs and those from sexual minorities.

READY to LEAD is building adolescent girls' and young women's leadership in Zimbabwe, in response to the continuing lack of space for women and girls in decision-making that affects their lives. It will build a cadre of 100 young women, who in turn will mentor 1,000 others to build their personal knowledge and agency to make healthier choices.

Access to comprehensive sexuality education is often lacking in and out of school, leading to dangerous misconceptions about sex and sexuality. A 2011 study in Nigeria found that boys worried that delaying sex would affect their ability to engage in sex later in life; while girls felt that early sex would ensure their physiological sexual development.[56] Another study found that girls in Uganda begin receiving pressure for sex as soon as their breasts began to develop.[57]

A number of countries have been experimenting with different ways of responding. For instance, South Africa provides health services within schools as a way to reach adolescents.[58] In 2012, 3,242 consenting students from five randomly selected public sector high schools in rural South Africa were tested for HIV. This effort demonstrates the feasibility of providing HIV testing and counselling from schools linked to HIV testing and counselling services within primary care clinics.[59] HIV testing in schools may enable adolescent girls to access HIV testing prior to their first pregnancy, whereas the current approach of HIV testing during antenatal care misses that window.[60]

Research in Uganda undertaken by the Population Council as part of the Link Up Project (see page 30), showed that young people aged 10-24 hold gender inequitable views and norms; however, among younger adolescents (aged 10-14) these views were more inequitable than among the older age group. The findings point to the need for HIV and SRHR information and programmes that address and challenge inequitable norms, and are tailored to the younger age group. There is an important window of opportunity to influence these norms at a time when adolescent socialisation processes are underway, and before these views manifest in negative health outcomes.[61]

We need information and programmes tailored to different age groups.
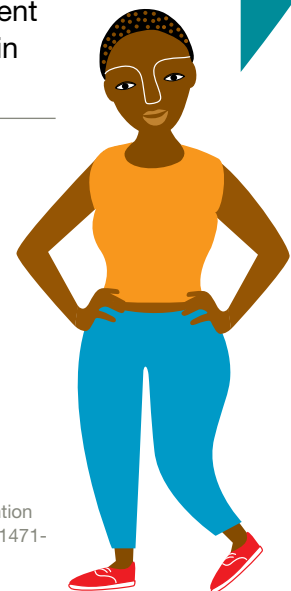
56. Oladepo O. and Fayemi M.M. (2011), 'Perceptions about sexual abstinence and knowledge of HIV/AIDS prevention among in-school adolescents in a western Nigerian city'. *BMC Public Health*. 201111:304. https://doi.org/10.1186/1471-2458-11-304

57. Nobelius et al. (2010), 'Delaying sexual debut amongst out-of-school youth in rural southwest Uganda'. *Culture, health & sexuality*, 2010 Aug: Vol 12(6): 663-76. doi: 10.1080/13691051003768132

58. UNFPA (2014), 'Operational Guidance for Comprehensive Sexuality Education: A focus on Human rights and Gender'. Available at: www.unfpa.org/publications/unfpa-operational-guidance-comprehensive-sexuality-education

59. Kharsany A.B. et al. (2014), 'HIV infection in high school students in rural South Africa: role of transmissions among students'. AIDS Research and Human Retroviruses, 2014 Oct, Vol 30(10): 956-65. epub 2014 Sep 4. doi: 10.1089/AID.2014.0110.

60. Kurth A. et al. (2015), 'HIV testing and linkage to services for youth'. *Journal of the International AIDS Society*, Vol 18, 19433. doi:10.7448/IAS.18.2.19433

61. Vu L.et al. (2016), 'Inequitable gender norms from early adolescence to young adulthood in Uganda: Tool Validation and Differences Across Age Groups'. *Journal of Adolescent Health*, 2017, Vol 60: S15-S21. Available at: www.jahonline.org/article/S1054-139X(16)30376-7/pdf. See also: www.popcouncil.org/uploads/pdfs/2016HIV_LinkUp_UgandaKAP-Brief.pdf

Scenario 6: Reaching the female partners of men who have sex with men, with HIV prevention, treatment and care for themselves and their children

Marjorie's story

Marjorie did not know why her babies kept dying. Plenty of other women in her family and community had had babies at home and they almost never had any problems. Her husband said he didn't have the money to send her to the clinic, and she couldn't afford to pay for transport on her own. After their second child died, Marjorie's husband also fell ill. The family spent what meagre resources they had to take him to the community's traditional healer. What Marjorie didn't know was that her husband sometimes engaged in sexual activity with other men – something he felt he had to keep hidden from his wife, family and community. Four months after falling ill, her husband was dead. Marjorie, pregnant for a third time, was starting to show signs of the same illness. She worried she did not have the money to seek medical treatment for herself, and was concerned about the well-being of her baby.

Please refer to the questions in the template on pages 17 and 18 to conduct a gender analysis on **women whose male partners also have sex with other men.**

Intervention strategies and promising practices

Preventing vertical transmission and keeping mothers healthy

To prevent new HIV infections among children and reduce HIV-related maternal mortality, women must be able to access integrated HIV and SRH services. This encompasses counselling and testing for HIV, rights-based family planning (including condoms for dual protection against HIV and unintended pregnancy), maternal health services, prevention and management of gender-based violence and STIs, and ART.

Addressing the potential for abandonment, abuse and violence by intimate partners after HIV testing – and/or fear of these – can lead to greater disclosure and treatment.

It is important to promote male participation through couples counselling or peer support groups, ensuring the consent and safety of female partners as well as that women who choose not to involve a male partner are not adversely impacted by such promotion.

Programming with and for men who have sex with men

UNFPA has developed guidelines for effective programme approaches, comparing programmes carried out *for* men who have sex with men, and those *with* men who have sex with men.[62] Programming that is for men who have sex with men is often considered prescriptive, paternalistic and tokenistic. These kinds of approaches typically only monitor the number of goods and services delivered. In contrast, programmes that work *with* men who have sex with men are collaborative and participatory. They emphasise leveraging the knowledge and skills within the community, and work with men who have sex with men as equal partners to determine what to do and how to do it. Their approach to monitoring and evaluation focuses more on the quality, safety, accessibility, and acceptability of services instead of just looking at the number of goods provided. It is an approach that succeeds because it forges relationships within communities of men who have sex with men, while also building support networks between these communities and other organisations and service providers.

Challenging social norms around same sex sexuality

Reducing homophobia, may also reduce the number of men who have sex with men while also having female partners. Research has shown that stigmatisation of homosexuality puts pressure on men to enter into heterosexual marriages as a way of conforming to social pressure and traditional gender norms.[63] Homophobia and fear of disclosing one's sexual identity has also been shown to be a significant barrier to providing SRH services to female partners of men who have sex with men.[64]

Improving service access for men who have sex with men

Sundown Clinics' Klinika Bernardo in Quezon City, Metro Manila, has set its hours to maximise its accessibility to men who have sex with men.[65] Their clients are mainly gay men, other men who have sex with men and transgender people. By the end of 2014, Klinika Bernardo had conducted more than 2,500 tests, with just over 200 clients diagnosed with HIV. The clinic's peer outreach network brings mobile rapid testing services to Quezon City's gay nightlife hotspots. It also raises awareness with other community members, such as church groups, religious leaders and officials from local police and government, in order to help them understand the importance of social acceptance to achieving the city's public health goals. Klinika Bernardo has proven so successful that a second clinic opened in 2015.

Key resources

For key insights from the Alliance's work with the Men's Sexual Health and Rights Programme (SHARP) in Kenya, Tanzania, Uganda and Zimbabwe, visit: www.aidsalliance. org/our-impact/the-sharp-programme/ key-insights

Homophobia makes it hard for us to talk openly with our families, especially our wives.

62. UNFPA (2015), 'Implementing comprehensive HIV and STI programmes with men who have sex with men: practical guidance for collaborative interventions'. Available at: www.unfpa.org/publications/implementing-comprehensive-hiv-and-sti-programmes-men-who-have-sex-men#sthash.u4U8R7Rs.dpuf

63. Beyrer, C. et al. (2010). 'Bisexual Concurrency, Bisexual Partnerships and HIV among Southern African Men Who Had Sex with Men'. *Sexually Transmitted Infections*, Vol 86(4): 323-327. Available at: https://jhu.pure.elsevier.com/en/publications/bisexual-concurrency-bisexual-partnerships-and-hiv-among-southern-3

64. UNDP India, (2012), 'A report on: Addressing the SRH needs of MSM and their female partners using existing SRH facilities and/or working in collaboration with existing organizations'.

65. To read more about Klinica Bernardo, see: UNAIDS (2015), 'On the fast-track to end AIDS by 2030: focus on location and population', pp 87-88. Available at: www.unaids.org/en/resources/documents/2015/FocusLocationPopulation

MenCare+, a community-based intervention in Brazil, Indonesia, Rwanda and South Africa, engages young men aged 15-35 to encourage them to be positive and active participants in their own health and the health of their partners and children.[66] They conduct group education sessions with youth, couples, and fathers in group sessions on gender equality, SRHR, maternal and child health, fatherhood and care, and use reflection groups with men who have used violence with their partners.

https://men-care.org/

🌐 Background information: the evidence

Criminalisation and stigma of same-sex conduct places men who have sex with men and their female partners at increased risk, resulting in fear and discrimination when receiving health services. In a 2011 review of studies on the issue, men who have sex with men in Malawi, Namibia, and Botswana were found to be nearly four times more likely to experience fear and 46 times more likely to report discrimination when receiving antiretroviral treatment.[67] This fear of discrimination and lack of trust in service providers prevents key populations from getting the services they need.

The question of how male partners should be engaged in maternal health must be approached through a gender lens, yet this is not always reflected in programming. A review of gender inequality through male involvement in maternal health noted 13 studies which discussed the leading perception of men as gatekeepers for women's health who could then be used to instigate change in their female partners.[68]

While it seems clear that there is a need to help build women's ability to influence family decision-making about sex and health, not enough is known about interpersonal relationships in the context of HIV. Very little is also known about how to improve communication within couples about sensitive topics, including risk, sex and transmission.[69]

A 2011 study with 426 pregnant women in Tanzania found that 78.6% of women felt they needed their partners' permission to get an HIV test. Pregnant wives were socially pressured to refrain from using condoms, which appeared to be rooted in the belief that the husband should be responsible for decision-making.[70]

66. Beyrer C. et al. (2011), Expanding the space: inclusion of most-at-risk populations in HIV prevention, treatment, and care services. *BaJ Acquir Immune Defic Syndr*, 2011, Aug, Vol 57 Suppl 2: S96-9. doi: 10.1097/QAI.0b013e31821db944

67. Comrie-Thomson L. et al. (2015), 'Challenging gender inequity through male involvement in maternal and newborn health: critical assessment of an emerging evidence base'. *Culture, Health and Sexuality,* 2015, Vol 17 Suppl 2: S177-89. Epub 2015 Jul 10. doi: 10.1080/13691058.2015.1053412.

68. Ramirez-Ferrero E. and Lusti-Narasimhan M. (2012), 'The role of men as partners and fathers in the prevention of mother-to-child transmission of HIV and in the promotion of sexual and reproductive health'. *Reproductive Health Matters*, 2012 Dec, Vol 20 Suppl 39: 103-9. doi: 10.1016/S0968-8080(12)39642-0.

69. Falnes E.F. et al. (2011), '"It is her responsibility": partner involvement in prevention of mother to child transmission of HIV programmes, northern Tanzania'. *Journal of the International AIDS Society*, 2011 Apr 26, Vol 14(21). doi: 10.1186/1758-2652-14-21.

70. Shamu S. et al. (2014), 'Intimate Partner Violence after Disclosure of HIV Test Results among Pregnant Women in Harare, Zimbabwe'. *Plos One*. Available at: http://journals.plos.org/plosone/article?id=10.1371/journal.pone.0109447

A 2014 recent study of 1,951 pregnant women in Zimbabwe who disclosed their HIV status found that male control of women's sexual decision-making was associated with interpersonal violence during pregnancy.[71]

It is also clear that stigma and homophobia make female partners of men who have sex with men a particularly vulnerable and often overlooked group. Stereotypes about gender and sexuality make it difficult to recognise that often men may identify as heterosexual while still engaging in same-sex conduct. For example, in a 2009 study of men who have sex with men in the Islamic Republic of Iran, 51.8% of participants reported having been married and 87.7% reported being sexually intimate with a woman within the past six months.[72]

71. Shamu S. et al. (2014), 'Intimate Partner Violence after Disclosure of HIV Test Results among Pregnant Women in Harare, Zimbabwe'. *Plos One*. Available at: http://journals.plos.org/plosone/article?id=10.1371/journal.pone.0109447

72. Eftekhar M. et al, (2008), High risk behavior and HIV/AIDS prevalence among men having sex with men: the first report from Iran. AIDS 2008-XVII International AIDS Conference. Mexico City, Mexico.

Annex 1: Glossary

The following definitions are adapted from the *Alliance Approach to Gender Equality*.

Gender: The array of socially constructed roles and relationships, personality traits, attitudes, behaviours, values, relative power and influence that society ascribes to two sexes on a different basis. Whereas sex is understood as determined by biology, gender is an acquired identity that is learned, changes over time, and varies widely within and across cultures. Gender refers not only to women or men, but to the relationship and power dynamics between and among them. It is inclusive of all genders, with an understanding of gender as a spectrum or circle.

Women and girls in all their diversity: Refers to all women and girls, recognising the differences, and often overlapping and intersecting identities among them. In the context of the Alliance, it has a specific focus on women living with HIV, young women, women who do sex work, women in same-sex relationships, transgender people, women who use drugs, and women who are sexual partners of men who have sex with men, men living with HIV, men who use drugs and trans people.

Sexuality: A central aspect of being human throughout life. It encompasses sex, gender identities and roles, sexual orientation, eroticism, pleasure, intimacy and reproduction. Sexuality is experienced and expressed in thoughts, fantasies, desires, beliefs, attitudes, values, behaviours, practices, roles and relationships.

Sexual orientation: Refers to each person's capacity for profound emotional and sexual attraction to, and intimate and sexual relations with, individuals of a different gender, the same gender or more than one gender.

LGBTI: An acronym for lesbian, gay, bisexual, transgender, and intersex. LGBTI can refer to individual people or a community of people.

Transgender: An umbrella term for people whose gender identity and/or expression is different from cultural expectations based on the sex they were assigned at birth. Being transgender does not imply any specific sexual orientation: transgender people may identify as straight, gay, lesbian, bisexual etc.

Gender-based violence (GBV): Violence that is directed at an individual based on that person's social expectations of masculinity and femininity. It includes physical, sexual and psychological abuse; threats; coercion; deprivation of liberty; and economic deprivation, whether occurring in public or private life. Women and girls are the most at risk and most affected by GBV. Consequently, the terms 'violence against women' and 'gender-based violence' are often used interchangeably. Boys and men can also experience GBV, however, as can sexual and gender minorities. Trans people are frequent targets of GBV, often of the most extreme kind.

Gender equality: Refers to the ability of all human beings – regardless of sex or gender – to reach their potential and make choices without limitations set by stereotypes, rigidly ascribed gender roles, norms or prejudices. Gender equality is a recognised human right. It means that the different behaviours, aspirations and needs of women and girls in particular are valued equally. It also means that there is no discrimination on the grounds of a person's gender in the allocation of resources or benefits, or in access to services. Gender equality may be measured in terms of whether there is equal opportunity or results.

Gender discrimination: The systematic, unfavourable treatment of some individuals on the basis of their (real or perceived) gender, which denies them rights, opportunities or resources.

Gender-responsive: Gender-responsive policies, programmes or training modules recognise and attempt to undo or redress the ways in which gender differences have often been translated into discrimination and disadvantages.

Gender-transformative: A gender-transformative HIV response not only seeks to address the gender-specific aspects of HIV, but also to change existing structures, institutions and gender relations to ones based on gender equality. Gender-transformative programmes recognise and address gender differences. They go a step further by creating the conditions whereby people of all genders can examine the damaging aspects of gender norms, especially towards women and girls. These programmes also experiment with new behaviours to create more equitable roles and relationships.

Gender analysis: A form of social, economic, cultural and political analysis used to identify, understand and describe gender differences and the relevance of gender roles and power dynamics on defined aspects of life. Gender analysis typically involves examining the different impact of development policies and programmes on women, men and transgender people in a specific context.

Gender analysis frameworks: Step-by-step tools for carrying out gender analysis, which help to pose questions, analyse information and develop strategies to increase women's, men's and trans people's participation in and benefits from programmes. It is a systematic way of exploring the roles and responsibilities of people of all genders and their access to and control over resources and benefits within a particular setting, with a focus on the historical disadvantage faced by women and girls in all their diversity.

Gender integration: A strategy for recognising various concerns and experiences as a result of gender inequality and taking these into account in developing all aspects of programming through gender analysis. The goal is to ensure that development, health and human rights responses are grounded in revoking gender-based disadvantages as an integral part of the design, implementation, monitoring and evaluation of policies and programmes.

Sexual and reproductive rights: According to Amnesty International, sexual and reproductive rights rest on the assumption that all people have the right to a healthy, safe, consensual and enjoyable sex life; to control their bodies and have sufficient accurate information to use in making decisions and seeking healthy behaviours; and to have affordable, accessible services that keep them healthy, including – but not limited to – before, during and after pregnancy.

Good Practice Guide series

This guide is one in a series of good practice guides produced by the International HIV/AIDS Alliance in collaboration with partner organisations. This series brings together expertise from our global community-level HIV programming to define and guide good practice in a range of technical areas, including:

- Adolescent HIV programming
- HIV and human rights
- Family-centred HIV programming for children
- Greater involvement of people living with HIV (GIPA)
- HIV and drug use
- Employing people who use drugs
- Integration of HIV and sexual and reproductive health and rights
- Community-based TB and HIV integration

Alliance Good Practice Guides:
- are user-friendly 'how to' guides
- target HIV programmers working in community settings in developing and transitional countries
- help to define what is good practice for community-level HIV programmes.

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