DISCUSSION PAPER

GETTING GENDER IN TO HIV PROGRAMMING IN ASIA

2009

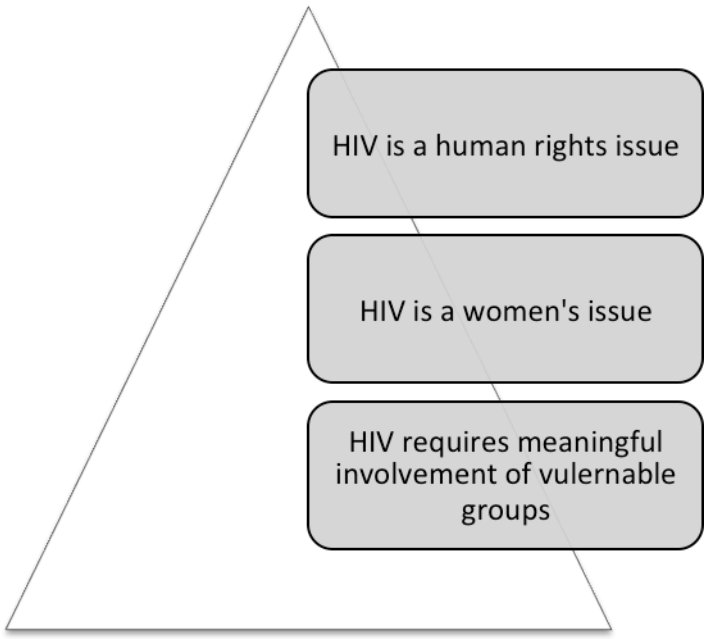
Authors: Scott Berry, Dave Burrows, Lou McCallum and Ruth Birgin

The HIV Foundation Asia and *APMGlobal Health* developed this *Asian Cities and HIV Concept Note.* We welcome reproduction and modification by other organizations that wish to utilize this resource. Please acknowledge the authors of this manual and our organisations.

After more than twenty years of programming to prevent and treat HIV there is consensus that the most effective approach involves a focus on key populations for HIV – sex workers and their clients, people who inject drugs (PWID) and their partners, men who have sex with men (MSM) and transgender people (TG). Gender and gender inequity is a major concern for HIV vulnerability but the evidence is scant on how gender and gender inequity impacts on the HIV vulnerability of particular key populations. This article attempts to explore gender and gender inequity in most at risk populations for HIV including issues for women PWID and sex workers, MSM and TG and female partners of MSM and men who buy sex. It presents two innovative interventions that are attempting to address gender relate issues in key populations in the Asia Pacific.

1. OVERVIEW

HIV prevalence among key populations in some major Asian cities is said to have outstripped the capacity to prevent it[i]. As well as the behaviors that place them at high risk for HIV transmission, key populations face high-levels of social and structural stigma and discrimination that makes them more vulnerable to HIV infection including major human rights violations[ii]. They are more likely to find themselves in situations where they are unable to get the information or resources they need to prevent HIV and more likely to be unable to, or fearful of accessing health care.



Responding effectively to HIV among key populations requires a complex analysis of the drivers of HIV transmission and acquisition and of access to health care for people affected by HIV. An analysis of the drivers of HIV transmission makes three things clear: (a) HIV is a human rights issue – vulnerability to HIV increases where human rights are being eroded or violated; (b) HIV is a women's issue – women who are sex workers, who inject drugs or are partners of men who buy sex or MSM are especially vulnerable and are not currently well served in the HIV service system; and, (c) HIV requires meaningful involvement of key populations – key populations aim to stay hidden and they do not come forward for service unless there are clear indicators of sensitivity and protection of privacy and confidentiality in the service system[iii].

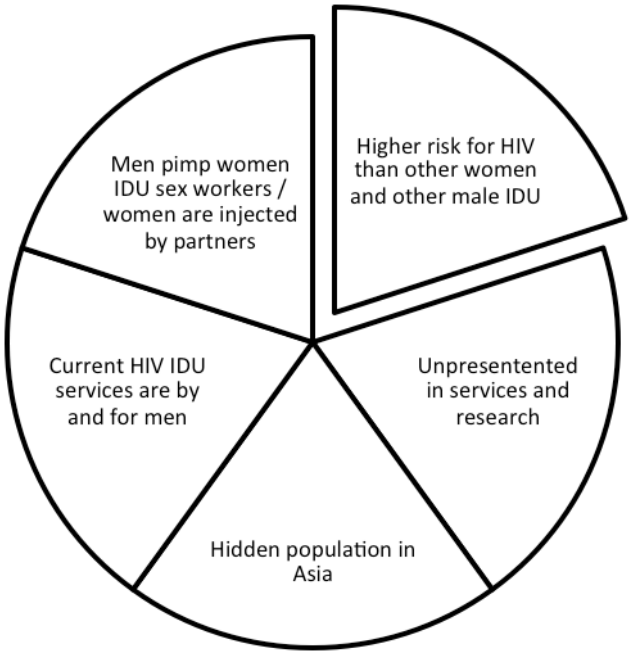
The simplistic approaches that have dominated many HIV programs to date have assumed these sub-populations are homogeneous and that their risk behaviors are distinct from each other. Sex workers should use condoms, MSM should use condoms and PWID should use clean needles. The reality is more complex - these are heterogeneous populations but with a high degree of overlap between them and overlap in the behaviors which put them at risk for HIV (an apparent

contradiction). HIV risk and vulnerability is not evenly spread within each sub-population. More important for HIV programming is to understand that some MSM work as sex workers and use drugs while female sex workers may also inject drugs and may be more at risk of HIV transmission from their regular male partner than from their clients[iv].

The little we know about gender and key populations is compelling. Women PWID and sex workers are more at risk for HIV than other women. They are more at risk than their male PWID counterparts. Female partners of sex work clients and of MSM (where MSM have female partners) are more at risk of HIV infection than other women. Yet many key populations programs and services have yet to extend their reach in to services targeted to women[v]. In many settings transgender people are at higher risk of HIV than MSM, but programs and services focus more on MSM as they are often thought to be easier to identify and work with[vi]. Women, TGs, and MSM are punished for their transgression of socially constructed gender norms and expectations. They may stay hidden, avoiding disclosure of their risk behavior for fear of social persecution and exclusion. This in turn adds to the cycle of risk and vulnerability for all involved. Given this level of hostility in the environment, a key element of effective programming is the meaningful involvement of these groups in programming and decision making. Let's explore what is known about women who inject drugs, gay men and other MSM and transgender people.

2. SUB-POPULATIONS WITHIN KEY POPULATIONS

WOMEN WHO INJECT DRUGS



Women who inject drugs are at likely higher risk of acquiring HIV than other women (from the very limited evidence available) and are at higher risk of acquiring HIV than their male PWID counterparts. The increased social/cultural shame and punishment of women PWID compared to men means they are unrepresented in PWID services and in research on PWID and HIV. services are often geared towards single client management and find the complex management of women and their children more challenging – not to say that all female PWID issues revolve around their role as mothers – but that services and programs have been particularly challenged by this. Services of all types related to drugs and HIV are often established by and for men. This is in spite of women representing perhaps 25%-35% of PWID in some Asian countries and in Eastern Europe women are thought to make up half of all PWID in some jurisdictions. Women sell sex to buy drugs, may be pimped by their male partners for drugs and are often injected by their male partners. This means they can be less powerful and less able to negotiate safe sex and injecting. Programmatic issues

related to gender are rarely discussed in the literature. Evaluations of programs designed specifically to address the needs of women PWID appear to be non-existent[vii]. However, a Ukraine AIDS Alliance PWID program has increased its access to women PWID by 20% by creating a web of social networks to target women and encourage women's involvement in their program. That success offers lessons to other programs and a report is soon to be published.

GAY MEN AND OTHER MSM AND TRANSGENDER PEOPLE

Understanding the gender dynamics of sex between men and the behavioral, identity issues and concerns of TG are important factors for delivering effective HIV policy and service to them. In Asia and the Pacific, particular gender-based categories, definitions and behaviors operate in between MSM and TG but are often more complex than the definitions suggest. For example, insertive for anal sex may mean an MSM is referred to as a 'man' while receptive for anal sex can mean an MSM is referred to as a 'woman' or 'lady'. But it would be a mistake to think that these behaviors and descriptions define the social relationships, power and gender dynamics between MSM or between TG and their partners. TGs and MSM can move fluidly between these sexual and social behaviors and categories. Let's explore issues for transgender people and their risk of HIV through gender.

TRANSGENDER PEOPLE

Biological men who dress and live as women or as a third gender face criminal sanctions (as MSM or as sex workers). They face violence, rape and ridicule and social isolation, with restricted access to education, work and community life. TG who live openly as TG or as 'women' are often restricted to low paying retail and service jobs. Those who decide on gender reassignment surgery cannot raise the money required. They often have to engage in sex work to raise the cash for surgery. TG may be forced out of families and into sex work to make a living. Poverty and lack of education play a key role in poor health outcomes for transgender people. HIV and public health programs have often lumped TG into MSM populations together to make it easier for them to design and implement programs. This has not always been a successful approach and is often criticized by TG themselves, who do not see themselves as men and certainly not 'men who have sex with men'. They argue that they face a different set of challenges to MSM. They also argue that most of their sex partners are actually 'heterosexual' men who do not see themselves as having sex with another man when having sex with a TG. Many TG populations are at higher risk of acquiring HIV than MSM in Asia and the Pacific, as they are more cut off from programs and services, more likely to be discriminated against in education, employment and health services and more likely in many cases to be selling sex in environments where insisting on condom use is either not possible or financially impractical[viii].

GAY MEN AND OTHER MEN WHO HAVE SEX WITH MEN

The very idea of anal sex between men - of a man being penetrated by another man – often triggers great hatred toward them. The neglect of emerging HIV incidence in Asia among MSM is now well documented as is the alarming rate of HIV prevalence that may have outstripped the capacity to prevent HIV among MSM and TG in a number of regions. Societies simply prefer not to deal with it.

Gay men and MSM have the power to 'transmute' or 'camouflage' their sexuality – that is, to hide their sexual orientation and to appear, act and sound heterosexual. While this strategy works well to prevent the many forms of stigma and discrimination that can affect them, it means they give up power (and importantly, their health agency) through self-censorship. They may not come forward

for HIV or STI related service and, where they do, they may not disclose their sex with men to a health service provider. Loss to follow up is a serious concern across the Asia Pacific region in relation to gay men and other MSM.

Anecdotal evidence suggests that effeminate boys and young men may be targets for forced sex and a recent study by the Population Council found that one-third of boys and young men in an African study reported their first sexual encounter as a forced encounter[ix].

FEMALE PARTNERS

Important in terms of gender dynamics is the sub-population of MSM who are married or have regular sex with women. The gender inequity and health risk for women partners of these men is obvious and concerning and mirrors the concern the sector shares for women partners of men who buy sex from sex workers. Female partners who don't know their male partners are having sex outside their relationship and/or with other men are simply powerless to protect themselves or their unborn children. The men involved are exercising a power that their female partners do not have. Protecting those women from HIV infection is a key concern. However, the most effective programs in relation to MSM who have female partners have been those with seek to educate these men about the risk of infection while making no judgments about their behavior. Other programs seek to educate the MSM and transgender people having sex with these men so they can, in turn, educate their male sex partners about HIV risk and how to avoid it. In Africa, Australia and the UK there is evidence that where MSM with female partners have the right information about HIV prevention, they *do* take steps to prevent HIV transmission to their partners. This includes modifying the kinds of sex they have with men and transgender partners to avoid high risk activity for HIV[x]. But these are not gender transformative approaches to HIV prevention. They may prevent HIV but the power dynamics which keep these women uninformed remain unresolved.

3. INNOVATIVE GENDER-BASED KEY POPULATIONS INTERVENTIONS IN ASIA

Two interventions are presented here for their innovative incorporation or targeting of gender in key population-based interventions. The first is an experimental program by Kios Atma Jaya in West Java Indonesia. Kios established a program of service targeting women PWID who sold sex to maintain their drug habit. The second is The Poz Home Center in Bangkok which incorporates gender-based assessment in to its intake and case management approach to MSM and TG with HIV.

KIOS ATMA JAYA

Kios Atma Jaya is a program of the Atma Jaya Catholic University providing PWID outreach education in West Java Indonesia. It began in 2002 and they service a highly marginalized population, many of whom resist going to clinics even when seriously ill – for example, in a recently published report they describe a small but significant percentage of referrals to clinic services die before getting service or while receiving clinical service.

In response to the small numbers of women PWID sex workers accessing services in West Java generally and the overrepresentation of that small number in the most complex of client

presentations, they developed a program to deliver night outreach to female PWID sex workers[xi] .One key element of success in this program was the active involvement of both male and female outreach workers, some of whom were ex-PWID and some of whom were previously or presently part of the target group. The numbers of female PWID sex workers reached were small (n=341) but numbers of female PWID (who were not sex workers) was higher (n=2,471). Nevertheless, this approach has been applauded as one of the few examples of targeted women PWID service provision in the Global South and is certainly innovative for Indonesia.

The range of program activities included an outreach needle and syringe distribution program, voluntary testing and counseling for HIV, STI referral, case management, basic health services, reproductive health referral and advice, HIV and drug dependence counseling, peer education/support, advocacy, referral to peer support groups and referral to vocational training. The particular outreach activities engaged for this project included:

- Promoting of reproductive health services
- Condom negotiation techniques
- Referral to STI clinics
- Safety procedures related police raids, aggressive and abusive clients – including self defensive training

Kios Atma Jaya noted that best time to reach this group of women is at night time – they work at night and sleep during the day (another reason why they are not and do not access mainstream health services). They note that in the BCC intervention there is limited time to make a strong connection, communicate effectively and provide relevant information education. The work occurs on the street, in the middle of the crowded areas, the education is often hectic, interrupted by police raids or drunk patrons. Kios has twelve outreach workers who carry the main responsibility for reaching PWID and PWID sexual partner generally. To meet the need to target women PWID sex workers seven out of twelve outreach workers were diverted to this project.

STRATEGIES

The strategies used to make this work most effective included:

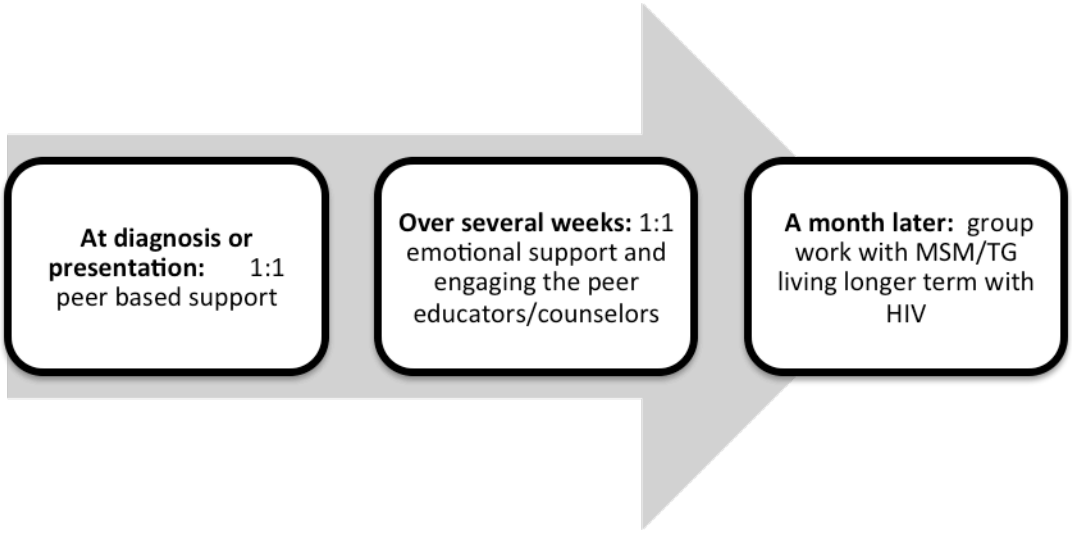
- Involving women in the outreach team
- Rearranging schedules for the outreach team to do late night and early morning outreach – they describe the best time to reach this group of women was before 'peak hour' (around 2-3 am)
- Because of the control their male partners exerted over them, the team often had to approach female PWID sex workers through their partner and/or pimp and ensure that the partner/pimp was not threatened by their engagement
- Involving local people associated with female sex work activity like venue owners, other women PWID sex workers to deliver prevention material and promote health services was a particularly successful element of this program.

PRINCIPLES APPLIED

✓ Maintaining flexibility - this program worked to provide service late at night when women PWID are engaged in sex work. They provided services on the street, often in difficult circumstances and found ways to do so that made a connection and communicated needed information to their female clients.
✓ Addressing the context of women PWID's lives – they didn't just respond to HIV risk, the team also provided strategies for getting away from the police, getting legal representation and dealing with aggressive and abusive clients to ensure safety. They provided referrals and support in relation to reproductive health and wellbeing for female clients.
✓ Promote meaningful participation – the team involved male and female outreach workers, often PWID or ex-PWID themselves to signal safety and the meaningful involvement of PWID. In a conversation with one of the team after their ICAAP 9 presentation, she described how women PWID know if you know the language, they know if you know how to inject and the difficulties of injecting in public places as well as the difficulties with their clients and partners/pimps. Her key advice to others was "You have to speak their language".

THE POZ HOME CENTER, BANGKOK THAILAND

The Poz Home Center is a drop-in, peer-based service for HIV positive gay men & other MSM, transgender people and these individuals engaged in sex work. The center uses a 3-stage peer counseling model that is an example of one of the only programs to incorporate gender analysis in to intake and assessment and case management for gay men, MSM and TG in this region. The 3-stage model provides 1-2-1 support at diagnosis or first presentation. It is at this stage that gender-related questions and concerns are considered and dictate how the rest of the service delivery is managed. The second stage involves matching clients to peer-based buddies for ongoing 1-2-1 support and the third stage involves connecting clients to groups and networks of peers.



At intake and assessment the presenting issues of the client are filtered through the 'lens' of gender to identify particular challenges in the client's life. Then, in case planning, these issues are raised with a view to setting goals to resolve them. The Poz Home Center identifies a set of gender-based presentations that are particularly common:

- Transgender people working toward gender-reassignment and diagnosed with HIV need to consider the impact of HIV on surgery and the preparedness of hospitals to complete reassignment after their diagnosis with HIV
- Transgender people are often engaged in sex work to pay for gender reassignment as this is one of the few ways available to them to save the money for surgery
- Kathoey (the Thai word for transgender) experience violence, intimidation, sexual violence and may be unable to negotiate safe sex in their relationships
- MSM experiencing difficulties and rejection at home because of their sexuality or gender transgressions (especially young people). Young People may be particularly vulnerable to HIV infection because they have limited experience at negotiating sex and may be negotiating with adults. They are also more likely to not understanding how to manage HIV once diagnosed
- MSM experience violence, intimidation, sexual violence and can be unable to negotiate safe sex in their relationships

The Poz Home Center, as one element of its service program, provides peer counselors to newly presenting clients. These peer educators/counselors are chosen because they have similar experiences to the client and have overcome similar difficulties. So a young transgender person may be matched to another, a young MSM with another and older MSM to each other.

PRINCIPLES APPLIED

✓ Uses a non-judgmental approach – Poz Home works with these clients 'where they are' in their lives.
✓ Fulfills rights and respect choices – a key principle is respecting the choices of each individual and supporting them.
✓ Protects confidentiality and privacy – Poz Home is trusted because it has a reputation for protecting and preserving the anonymity of its clients.
✓ Maintains flexibility – Poz Home provides weekend and evening services as well as weekday services.
✓ Promotes meaningful participation – Poz Home uses peers, and often people who have been through their program as clients, as buddies and as staff.
✓ Assists with all aspects of the client's life, not just HIV.

4. RESPONDING EFFECTIVELY TO THE GENDER NEEDS OF KEY POPULATIONS

Responding practically to the gender needs of key populations means understanding both the service-level needs and the national-level needs of key populations. Services need to establish proper, long term service goals that aim for 'life long' contact with key populations where possible. Legal and cultural impediments are getting in the way of that goal right now. Services need to consider how to effectively attract and retain key populations in their service programs. Involving key populations as volunteers, staff and key populations-based groups and organizations in promoting services is a key element for success. Getting key populations services to 'scale' remains a challenge. The gap between 'supply' and 'demand' can be wide; loss to follow up is a problem. The role of key populations community-based groups, networks and organizations cannot be over-emphasized in the challenge to reach scale and attract and retain key populations. Approaches relying on peer workers have been found to have a greater effect than other approaches to HIV prevention to key populations)[xii]. Key population community-based organizations need to emphasize

the role of women in service provision and leadership and provide specialized promotion and programming for women.

Given the formidable social hostility and marginalization of key populations, people from these groups find it difficult to engage in leadership, policy and advocacy or meaningful involvement in service design and delivery. A recent review of Global Fund Country Coordinating Mechanisms by Fried and Dowalski-Morton found that out of 65 CCMs they reviewed, just 5 had representatives easily identifiable as LGBT organizations or members. Another study commissioned by the Global Fund on the proposal development and review process in seven countries in Africa, Asia, Latin American and the Caribbean, found that "marginalized groups were seldom discussed as an issue per se of particular relevance" by CCMs[xiii]. This means that governments are determining their country priorities without key populations. There is insufficient strategic information about the prevalence and impact of HIV among key populations in many countries where this should be driving programs. This means that there is little attention to what, anecdotally, is believed to be high levels of HIV transmission and burden in key populations. Governments and national public health partners are not using Global Fund resources to deliver high intensity, targeted programs that can disrupt HIV transmission where it's needed or to improve health outcomes for key populations living with HIV.

Fried and Dowalski found that key populations groups often operate 'below the radar'. They stay informal because they fear the consequences of a more public presence. Their capacity to engage can be limited, especially where government programs and other formal instruments are involved. We still don't know the answers to this but what would best national government practice look like for involving and engaging key populations in these contexts?

HIV in key populations is a gender issue but gender activists have yet to fully grapple with the implications of gender and at-risk-behavior in women or to embrace and advocate for the gender-related issues of MSM and transgender people. Equally, key population-based analysis would benefit from a more sophisticated consideration of gender and incorporation of best thinking on gender and HIV vulnerability.

REFERENCES

[i] Van Griensven, F. (2007) The epidemiology of HIV and STI among MSM and Transgender in Asia. Presentation. 8th International Congress on AIDS in Asia and the Pacific. Colombo, Sri Lanka.

[ii] Watchirs, Helen. AIDS Audit = HIV and Human Rights: An Australian Pilot. In Law and Policy, Vol 25, No 3, July 2003 p247.

[iii] Kirby, Michael. Speech at the UNDP Symposium: Overcoming Legal Impediments to HIV services for MSM and TG. 9th International Congress on AIDS in Asia and the Pacific. Bali, Indonesia.

[iv] Amin, Avni and Burrows, Dave. Where sex work, drug injecting and HIV overlap. Practical issues for reducing vulnerability, risk and harm. WHO. Feb 2007 (unpublished).

[v] Burrows, Dave. Summary: women PWID, harm reduction and HIV/AIDS. Unpublished.

[vi] Van Griensven, F. (2009) The epidemiology of HIV and STI among MSM and Transgender in Asia. Presentation. The 200 Forum. APCOM Pre-Conference Meeting at the 9th International Congress on AIDS in Asia and the Pacific. Bali, Indonesia.

[vii] This summary taken from Burrows, Dave (unpublished) ibid.

[viii] Van Griensven, F. (2009) ibid.

[ix] Barker, Gary. Engaging Adolescent Boys and Young Men in promoting reproductive and sexual health: lessons, research and programmatic challenges. Chapter 6. Population Council Resource on Men and Boys. 2004; p114.

[x] Research by STIGMA (UK), UNSW (Australia) and reference from Africa not available.

[xi] Kios Atma Jaya team: Oral Presentation: Night Outreach: Addressing Female PWID Sex Worker needs in West Java, Indonesia. Presentation. 9th International Congress on AIDS in Asia and the Pacific. Bali, Indonesia

[xii] Hangzo, C et al. reaching out beyond the hills: HIV prevention among injecting drug users in Manipur, India. Addiction 92 (7), pp. 813-20.

[xiii] The Global Fund to Fight AIDS, TB and Malaria. 15th Board Meeting Decision Points. Available at http://www.theglobalfund.org/en/ September 11, 2007.