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INTEGRATING GENDER INTO PROGRAMS WITH MOST-AT-RISK POPULATIONS

TECHNICAL BRIEF

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INTRODUCTION

Gender inequity¹ is a fundamental driver in the HIV epidemic, and integrating strategies to address gender inequity and change harmful gender norms is an increasingly important component of U.S. Government-supported HIV programs in countries with generalized epidemics. Much less prevalent are efforts to integrate gender strategies into programs targeting most-at-risk populations (MARPs), which include men who have sex with men (MSM), transgender (TG) people, injecting drug users (IDUs), and male, female, and TG sex workers, in both mixed or concentrated epidemic countries.² The purpose of this technical brief is to provide program managers and planners with an overview of the recent research literature on gender-related constraints affecting MARPs, promising program practices, future program approaches, and gender-related challenges that should be considered in programs to reduce HIV risk among MARPs.

While subpopulations of MARPs have unique HIV risk behaviors and vulnerabilities, there is growing evidence of overlapping risk behaviors. For example, some MSM and sex workers may inject drugs, some MSM and IDUs may be sex workers, and some MSM may buy sex from male or female sex workers (Berry et al. 2009). With this caveat in mind, this technical brief is organized by individual MARP subpopulations, because that is how most programs focus their work.

In many countries, the behaviors that increase HIV transmission risk among these populations are highly stigmatized, illegal, or both. Sixty-nine percent of countries with low-level or concentrated epidemics

report having laws, regulations, or policies that pose barriers to use of HIV services for MARPs (World Health Organization [WHO]/Joint U.N. Programme on HIV/AIDS [UNAIDS] 2008). As a result, the size of MARPs is underestimated, as is the prevalence of HIV within different subpopulations (American Foundation for AIDS Research [amfAR] 2006). Despite stereotypes to the contrary, many MARPs are involved in long-term intimate relationships with partners who are overlooked by programs targeting MARPs. For example, a recent UNAIDS (2009) report about Asia showed that HIV transmission to women from their long-term male partners who inject drugs, who have sex with other men or with casual female partners, or who are clients of sex workers account for an increasing proportion of heterosexual transmission of HIV among women in the region.

Government responses to addressing the HIV epidemic among MARPs have been disturbingly slow and remain weak. In many countries, overall HIV prevention spending for MARPs is a small proportion of all prevention spending (WHO/UNAIDS 2008). Countries like Thailand, Cambodia, and Senegal, which successfully curbed rising HIV prevalence in the general population and among female sex workers, have only recently included IDUs, MSM, and male and TG sex workers in national epidemiological surveillance protocols (Beyrer 2007). Only slightly more than half of the countries with rising prevalence among MARPs have developed budgets that estimate the cost of antiretroviral therapy (ART) for those needing treatment (UNAIDS 2008). With rare exceptions, leadership for community-based programs targeting MARPs comes from civil society, not governments. Populations most at risk for HIV infection continue to remain invisible to, or ignored by, most policymakers, planners, and program implementers (Sawires et al. 2009).³

¹ *Gender equity* refers to the principle that, where the needs of men and women are different, resources and programmatic attention should be in proportion to those needs; equal opportunities should be ensured; and, if necessary, differential treatment and attention should be provided to guarantee equality of results and outcomes and redress historical and social disadvantages experienced by women or men. See <http://www.unfpa.org/gender/index.htm>.

² In a mixed epidemic, HIV infections occur at almost equal rates among MARPs and the general population (Wilson 2006). In a concentrated epidemic, HIV prevalence is consistently over five percent in at least one defined MARP, but below one percent in pregnant women in urban areas (World Health Organization [WHO]/Joint U.N. Programme on HIV/AIDS [UNAIDS] 2009).

³ Countries with generalized epidemics may also have a concentrated subepidemic among defined subpopulations. Programs for MARPs in generalized epidemics are rare, so for the purpose of this technical brief, only countries with concentrated epidemics will be described in detail. However, evidence suggests that MARPs living in countries with generalized epidemics, such as Tanzania and South Africa, experience similar stigma, discrimination, and human rights violations as do MARPs living in countries with concentrated epidemics.

PROGRAMS WITH MOST-AT-RISK POPULATIONS

Injecting Drug Users

UNAIDS (2008) estimates that 3 to 4 million IDUs are living with HIV. Globally, 10 percent of all HIV cases are related to injecting drug use, which drives the HIV epidemics in Eastern Europe, Southeast Asia, and the southern cone of Latin America, with prevalence among IDUs of more than 20 percent in some countries in these regions. Evidence suggests that injecting drug use occurs in Africa and the Middle East, but as in most countries in the world, few reliable data are available describing the size of these IDU populations. More extensive and rigorous monitoring must be undertaken to enable appropriate and effective responses to HIV among IDUs (Aceijas et al. 2004; Inchaurreaga 2003; WHO 2008).

IDUs experience a wide variety of health issues, including high prevalence of hepatitis B and C, sexually transmitted infections (STIs), a variety of chronic and acute physical health concerns, and a lifetime prevalence of depressive symptoms more than twice that of the general population, which may translate into high-risk sexual behavior (Williams and Latkin 2005). Although sharing contaminated drug equipment is the primary mode of HIV transmission among IDUs, studies in the United States and elsewhere suggest that sexual transmission is also high in drug-using groups. Sex work is much more common among female IDUs, which increases their vulnerability to HIV infection significantly (Australian Agency for International Development [AusAID] 2008; Cleland et al. 2007; Kumar et al. 2008). Reducing the risky sexual behaviors of IDUs has proven to be more challenging than adopting safer needle practices (Semaan, Des Jarlais, and Malow 2006; Williams and Latkin 2005). Despite the growing evidence of the sexual transmission of HIV among IDUs and their regular same-sex or opposite-sex partners, there are few programs reaching out to sexual partners, who may also be injecting drugs or having unprotected sex, or both, with their IDU partners.

Gender Differences in HIV Risk between Male and Female Injecting Drug Users

Most data on gender differences in IDU risk behaviors come from studies conducted in the United States and Europe, and understanding of how well these differences generalize to low-resourced countries is limited (Cleland et al. 2007). What is clear from the available data is that addressing the different vulnerabilities is a critical concern (United Nations Office on Drugs and Crime [UNODC] 2004).

Studies suggest that women's initiation into drug use intersects with wider social factors, including drug use in the family, peer group influence, and sexual relationships with male IDUs (Stocker 1998; Sarin and Selhore 2008). Studies from a number of countries indicate that in many instances, women are likely to have been initiated to drug use by their drug-using spouses or sexual partners, are more likely to share prefilled syringes and other equipment (Cleland et al. 2007), and are strongly influenced in their drug use behaviors by the sharing norms within women's social networks and sexual relationships (Cleland et al. 2007; Rieham et al. 2004). Programs focused on increasing female IDUs' access to HIV programs need to also empower female IDUs to negotiate equipment sharing norms and safer injection behaviors with their sexual partners and within their social networks.

Most female IDUs fulfill the cultural and gender roles of mother, sister, partner, and daughter (Andrade and Estrada 2003). Frequently, the financial and caring burden for male IDU partners, whether living with HIV or not, falls disproportionately on women and girls (AusAID 2008). Male drug users often prefer non-drug-using female partners, and women with drug-using partners often maintain traditional gender role expectations, acting as "caretakers" to their partner's drug use by attempting to limit drug use for both parties or by increasing their use to "match" that of their partner (UNODC 2004).

Gender norms influence men's injecting behavior and sexual risk behaviors as well. Studies in the United

States have shown that male norms of dominance may inhibit men's willingness to insist on protected sex or safe injecting (Knight et al. 2002). Men are more likely than women to engage in injecting drug use with friends or with strangers in places like shooting galleries (Cruz et al. 2007; Davey-Rothwell and Latkin 2007). Among men, needle sharing often occurs during activities with other men, reinforcing masculine norms and making unsafe injecting a more accepted behavior. The willingness to share needles, despite the awareness of its potential risk of HIV transmission, can be perceived as fearlessness, generosity, loyalty, and solidarity toward peers (Choi, Cheung, and Chen 2006). Because gender norms vary in different contexts, in some settings men may inject first because women are expected to defer to men; in other settings, men inject after their partners because men are expected to take a greater risk (Jackson et al. 2003). In the United States, Eastern Europe, and Asia, men are more likely to have spent time in prison, where sharing of injection equipment is prevalent, and are much less likely to use health care services (Population Services International [PSI] and Salud CENSIDA 2008).

Lack of social support is a major barrier in the long-term rehabilitation of male and female IDUs; the provision of mental health services within treatment centers is an urgent need. A particular challenge for women users is the shortage of long-term residential services with sufficient space for women to keep their children with them; otherwise, women leave to return to their communities and families to care for their children. There is also a need for nonresidential day treatment programs to provide day care services for children of women in treatment. Services need to diversify from inpatient services only to include community-based detoxification services and female-only drop-in centers (Hankins 2007; UNODC 2004).

Programming Experience

Few countries in Eastern Europe, Latin America, and Asia are reaching significant numbers of IDUs with any community-based HIV prevention or care programs

(Needle et al. 2005). Peer outreach and drop-in-center-based services have been successful—for male IDUs (Des Jarlais and Semaan 2005). Evidence from more than 40 published studies shows that when IDUs are reached by community-based outreach and provided with access to risk-reduction services, they report reducing HIV risk behaviors (Needle et al. 2005). Despite this evidence, the gap between the number of IDUs who want or could benefit from outreach services and the number of IDUs who actually receive them remains large. This is especially true for female IDUs. There is a need to raise levels of understanding among service providers, government agencies, and donor agencies in order to set priorities and strategize interventions for the growing number of IDUs who are women (Hankins 2007; Tran et al. 2005; UNODC 2004). Pregnant IDUs, who could be also infected with HIV, form an additional subgroup of female IDUs with specific unmet needs (UNODC 2004). Pregnant women who use drugs may face criminal charges for causing harm to their unborn children and thus avoid prevention and treatment programs.

Lessons learned from two programs in India highlight some of the specific kinds of support needed by female IDUs in almost all countries. The Sahara Centre for Residential Care & Rehabilitation (Sahara) and its sister organization, the Society for Service to Urban Poverty (SHARAN), based in New Delhi, India, work in drug rehabilitation with female drug users, including IDUs. Since 1995, SHARAN and Sahara have provided multilevel services to 3,700 women. More than 1,000 women have availed of its residential services, which include detoxification, medical care, literacy classes, vocational training, and job placement. Another 2,400 women have been offered drop-in center facilities, free lunches, referrals to medical and mental health care, legal aid, and shelter homes. While the program for women has not been evaluated separately, a 2005 evaluation of the effectiveness of SHARAN's program from 1999 to 2002 showed that, in addition to unconditional acceptance of the drug users by the service providers, substantial reduction in risk behavior

and noticeable improvement in quality of life was reported by program users (Priya et al. 2005).

Within a harm reduction framework and the recognition that women need and want safe spaces of their own, Ladies' Night, a U.S.-based program in San Francisco, California, is being implemented for highly marginalized homeless IDUs and TG women who experience violence and other physical and sexual trauma. This program is offered at the Mission Neighborhood Resource Center, a community space for homeless and marginally housed men and women. Ladies' Night, offered one evening a week, provides a safe space for women to escape violence, chaotic drug use, discrimination, family, and health concerns. Women can participate in diverse activities that respond to their needs: art activities, games, health education discussions on topics ranging from safer sex to overdose prevention, health services, and HIV testing. Women are not required to abstain from substance use, attend a support group, or meet with a case manager in order to gain access to services. By feeling valued in an environment that offers safety, social support, and empowerment, women report feeling less stigma and establishing trusting and respectful relationships between participants and providers. For women in the program who have experienced significant trauma, a sense of safety is essential to healing and engaging in change (Magee and Hurliaux 2008).

In 2008, the International Harm Reduction Development Program of the Open Society Institute, with the support of the Canadian International Development Agency, funded six gender-sensitive IDU programs in different regions of Ukraine, including Kyiv, Dnipropetrovsk, Poltava, Nikopol, and Mykolayiv. These programs have provided more than 4,500 women drug users, the majority of them mothers, with services that included a needle and syringe exchange program (NSP), access to substitution treatment, sexual and reproductive health care, assistance during pregnancy, and legal aid. The program takes a holistic

EXPLORING GENDER NEEDS IN INDONESIA: THE STIGMA FOUNDATION

The STIGMA Foundation (SF), a nongovernmental organization (NGO) run by and for IDUs in Jakarta, Indonesia, has been proactive in its strategy to reach female IDUs. In 2009, after five years of implementing a peer outreach program and an NSP, SF had reached 3,000 IDUs, of which only 200 were women, not all of whom were accessing services. SF staff knew from their own experience that cultural norms restrict women more to the household and expect women to focus on the domestic roles of wife and mother. SF realized that there is a dearth of research in Indonesia on women IDUs. For example, there is little data about the constraints that affect women's access to NSP, methadone maintenance treatment, or drug rehabilitation services. Furthermore, there is no information in the national language, Bahasa Indonesia, for female IDUs on the effect of antiretroviral therapy (ART) on sexual and physical changes associated with treatment, or on the ability of female IDUs to pay the cost of ancillary ART services. SF has started a newsletter called "Angels" that is dedicated to issues of women IDUs. In addition, SF produces short leaflets on specific topics such as the impact of ART on women, arrest procedures, and "tips" for women facing gender-based violence (GBV).

approach, working with women as individuals and with their families, as well as at the structural level, to strengthen connections and coordination among the many medical and social services needed to reduce the barriers the women and their families face as they attempted to negotiate the social services system. Health care providers working for the programs or at referral clinics and hospitals receive training on the needs of women who use drugs, human rights, violence and discrimination against women, and substitution treatment in order to reduce stigma and discrimination (S&D) against women drug users and build their capacity to provide sensitive and appropriate care. Programs include a community sensitization component as well as to foster tolerance and understanding about drug abuse in the general public (Pinkham and Shapoval 2010).

Men Who Have Sex with Men

MSM⁴ are embedded within social and cultural contexts that equate masculinity with risk taking, dominance, and sexual conquest, behaviors that negatively influence risk reduction and health-seeking behaviors (Peacock et al. 2009). In a 2009 study of HIV risk behavior by Latino MSM in New York City, researchers note the perception that condom use with sexual partners outside of a primary relationship is a sign of weakness and suggest that machismo may be influencing both unprotected insertive anal sex and excessive consumption of alcohol at bars and clubs (Flores et al. 2009; Peralta and Ross 2009). While the authors do not suggest interventions that would change male norms among MSM, addressing harmful gender norms in the design of HIV prevention, treatment, or care and support programs targeting MSM is an important but underutilized strategy.

New HIV infections among MSM remain a key driver of the HIV epidemic in many countries. In low- and middle-income countries, data on MSM and HIV are sparse and of poor quality (Pan American Health Organization [PAHO] 2008; WHO 2008). In many African countries experiencing generalized epidemics, most MSM remain hidden due to the harassment and stigma driven by cultural, religious, and political unwillingness to acknowledge that same-sex behavior occurs within African societies (Smith et al. 2009), which makes outreach to this population difficult. Globally, MSM are 19 times more likely to be infected with HIV than the general population (amfAR 2008). UNAIDS estimates that fewer than 1 in 20 MSM had access to appropriate HIV infection prevention and care services in 2005 (Beyrer et al. 2005; WHO/Europe 2008). Individual-level risks for HIV infection among MSM—such as unprotected anal intercourse; a high number of sexual partners; use of alcohol, injection-, and non-injection drugs that reduce inhibition; and having STIs—are similar in high- and low-income

⁴The term *men who have sex with men* refers to men who have sex only with men, men who have sex with men and women, and male sex workers who have sex with male clients.

countries (Beyrer 2007; Ramachandran 2008). Factors that may interact to increase HIV risk—such as substance use and abuse, violence, and mental health problems experienced by many MSM—are rarely addressed in programs targeting MSM.

Terms like *homosexual* and *heterosexual* do not adequately categorize the dynamic nature of sexual expression over time or within cultures (Duch et al. 2009; Silenzio 2003). In India, for example, male-to-male sex is practiced without any admission or recognition of identity, which is based on caste, class, and religious affiliation (International Center for Research on Women [ICRW] 2002). A study in Russia and Hungary found that 97 percent of the men in the sample reported same-sex activity in the past year: 75 percent of Hungarian participants, but only 34 percent of the Russian sample identified themselves as exclusively homosexual (Amirkhanian et al. 2009). In a study of urban Mexican men, 42 percent who identified as MSM reported having sex with women (Strathdee and Magis-Rodriguez 2008). In Vietnam, like other countries in the region, there are many subgroups of MSM: self-identified gay, bisexual, TG, or heterosexual. In countries as diverse as Thailand and Guatemala, homosexual behavior does not necessarily lead to an “MSM identity” or a transgression of gender norms (International HIV/AIDS Alliance [IHAA] 2007a). Social stigma attached to homosexual activity may prevent some men from disclosing their sexual orientation, leading them to deny their own risk or to assume that their risk for HIV is significantly lower than heterosexually identified men who have sex with women (Saewyc et al. 2006). Male sex workers and their male clients are another group of individuals who are missed by HIV prevention programs that target MSM (amfAR 2006); male sex workers who are also IDUs are missed by programs targeting MSM and IDUs.

Gender-based Violence

The focus of research and programs to reduce GBV has, with rare exception, been on women and girls. Yet GBV against MSM is widespread and may begin early in

life as child sexual abuse (CSA) or be experienced later in life as punishment for deviating from gender sexual norms (ICRW 2002). As noted by Peralta and Ross (2009, p. 95):

There are more studies on specific groups of women than there are about men...Defining women as victims of IPV [intimate partner violence] and men as perpetrators obscures the variability in violence and contributes to the perpetuation of stereotypes and myths... Generating data founded on gender and sexual diversity allows for richer understanding of IPV both within and between social groups.

Many studies have documented the high levels of CSA experienced by MSM and the association between CSA and risky sexual behavior (Brennan et al. 2007; Jay et al. 2001). A growing literature is exploring the syndemic of GBV directed against MSM and negative health outcomes, including HIV infection, poorer mental health, barriers to medical care, and substance abuse (Human Rights Watch 2004; PAHO 2008; Rodríguez-Madera and Toro-Alfonso 2005; Stall 2007; Stall et al. 2003). Recent studies report that 68 percent of young MSM reported ever experiencing threats or violence from either family or partners, and 25 percent reported threats or violence by both family and partners. Recent unprotected anal sex and drug use were significantly associated with a history of threats or violence by both family and partners, or with a history of sexual victimization (amfAR 2006; Bennet and Messeri 2007; Koblin et al. 2006; Saewyc et al. 2006). Although most of these studies were conducted in the United States, given the violence experienced by MSM in higher-resourced countries (Bingswanger 2005), the association between violence, HIV risk behavior, and poor health outcomes among MSM may also be applicable in lower-resourced settings (Bingswanger 2005; PAHO 2008).

The relationship between GBV and access to HIV programs by MSM is largely unexplored. The literature

on S&D, of which GBV is an extreme manifestation, focuses mostly on MSM (and other most-at-risk groups) who are already living with HIV. Yet it also provides some evidence that S&D has been a barrier to the uptake of HIV testing and counseling services by MSM, as well as to the effectiveness of prevention and care services (Genberg et al. 2009).

Transgenders

Male-to-female TGs constitute a unique subpopulation underserved by HIV programs and are often subject to pervasive S&D not only from the heterosexual majority but from other MARPs as well. TGs have multiple HIV risk behaviors: unprotected anal sex, sex work (in which many but not all TGs engage), and female-identity gender norms. Many TGs may have difficulty negotiating condom use with their intimate partners or, if they are sex workers, with their clients. Because TGs reproduce traditional gender roles (which construct women as subservient to male partners) to strengthen their gender identity, they may feel constrained about initiating discussions about condom use or safer sex practices with clients or about condom use and HIV testing with intimate partners (Rodríguez-Madera and Toro-Alfonso 2005). Understanding how TGs construct gender must be addressed in all programs for TGs. As Rodríguez-Madera and Toro-Alfonso (2005, p. 12) note:

[TG] participants in this study reported that they protect themselves more with “tricks” and casual partners than they do with their primary partner, as a result of their “feminine” gender socialization. Women often base their partnership on the values of truth, love, and trust. According to these values, many “biological women” adhere to the philosophy that if you trust your partner, you do not have to protect yourself. The same may be true for TG[s] and this issue is of vital importance in developing HIV prevention programs for TG[s].

Some data suggest that men who have sexual relationships with TGs are more likely to identify as

a TG's partner rather than view themselves as MSM. In contrast, TGs are more likely to see themselves as part of a cohesive community and therefore might be more easily targeted in prevention programs (Bocking et al. 2005). HIV prevention programs targeting TGs should focus on developing the same self-respect and condom negotiation skills training provided to non-TG sex workers and women who do not identify as sex workers but who are involved in relationships that include transactional sex. Although the evidence for promising programmatic approaches using couples-based HIV prevention and sexual health education is still weak, these strategies may offer promising approaches for reducing risk for transmission among TGs and their sexual partners. However, further research is necessary to understand how existing approaches to HIV counseling for couples must be adapted to incorporate gender and relationship dynamics between male partners of TGs (El-Bassel et al. 2003; Farquhar et al. 2004).

Programming Experience

There are far too few programs targeting MSM or TGs. Programs addressing how gender norms increase HIV risk and providing life skills training for MSM and TGs to address GBV, HIV prevention information, and violence are virtually non-existent.

SISTERS, PATTAYA, THAILAND

Sisters was founded in 2005 "by TG, for TG" to provide solidarity, support, and HIV prevention and care services to TG women. Sisters conducts outreach and peer education with TG sex workers in Pattaya, a major sex-tourism resort town. Sisters has established a drop-in center, carries out peer education on the beach and at go-go bars, does behavior change communication, distributes condoms and lubricants, and provides on-site counseling for HIV testing. Sisters provides referrals to STI and ART services. Sisters also has a home-based care program that sends Sisters staff or volunteers to visit TGs with HIV to provide adherence and psychosocial support.

HIV prevention programs have overwhelmingly focused on reducing sexual risk behavior. In the multisystemic context of structural violence, S&D, and social exclusion, HIV prevention programs that address individual-level factors would be more effective if they included strategies to influence the social, economic, political, legal, and health system factors that drive risk behavior (Stall 2007).

An example of one effort to generate data on GBV against MSM is the U.S. Agency for International Development's Health Policy Initiative Project, which collaborated with NGOs in Thailand and Mexico to pilot test a screening tool for health care providers to assess the experience of GBV among MSM. Experience from this pilot demonstrated that addressing GBV among MSM in a health services setting requires addressing the capacity of health systems to integrate gender equity and reduce S&D (Egremy, Betron, and Eckman 2009). The tool was piloted at three sites in Mexico in 2009, and a training manual is available for health care providers.

A growing amount of literature shows that the most promising practices for reducing S&D—a combination of the empowerment of MARPs and participatory education at the community level, which encourages people to reflect on their own attitudes and actions—seems especially effective for catalyzing individual change around stigma (Kidd and Clay 2003). Several programs and tools have been developed to reduce S&D among health care providers against people living with HIV, although these tools often fail to include sections on gender, working with MARPs in general, or with MSM and TGs in particular.

Examples of programs to reduce homophobia include mass media campaigns conducted between 2002 and 2005 in Colombia, Argentina, Mexico, and Brazil. The campaigns moved away from individual behavior messaging approaches and instead raised issues of how political, cultural, and socioeconomic factors increase vulnerability to the virus. The

campaigns promoted dialogue and debate on homophobia in the public arena, attempting to change social norms, public policy, and even culture. Process evaluation and impact evaluation, however, were extremely limited due to lack of standardized implementation strategies and of robust indicators to measure change in attitudes. One conclusion of the campaign implementers was that while mass media can be an important tool in reducing homophobia, “Real, sustainable change can only be achieved through a combination of prevention approaches. In that sense, it is best not to evaluate the impact of individual interventions, but rather the impact of a combination of interventions of which the campaigns...are only a component” (PAHO 2008, p. 39).

Sex Workers

During the first wave of the HIV epidemic, female sex workers were among the groups identified at high risk for HIV infection; almost three decades later, sex workers remain a highly vulnerable population. While countries such as Cambodia can report impressive decreases in HIV prevalence among brothel-based sex workers—43 percent in 1998 to 13 percent in 2006 (National Center for HIV/AIDS, Dermatology and STD [NCHADS] 2007a)—prevalence is still unacceptably high. Sex workers are a diverse population; one review conducted in India found at least nine categories of sex workers (Buzdugan, Halli, and Cowan 2009), but program interventions are not always diverse enough to reach all groups. Male sex workers have been relatively absent from the research, and HIV prevention or sexual health programs that target sex workers rarely include interventions for male or TG sex workers, a significant omission that urgently needs addressing.

The context of sex work introduces myriad harms, including forced unprotected sex, exploitation, infections and physical injury, suicide attempts, coercion, criminalization, and alcohol and drug abuse. A longitudinal study conducted in Vancouver, Canada,

found that over an 18-month follow-up period, 49 percent of sex workers experienced physical violence, 30 percent experienced client-perpetrated violence, and 25 percent had been raped. These forms of violence are all too common around the world, and researchers concluded that structural inequities of poverty, criminalization, and gender inequality drive both GBV and HIV infection risk (Shannon et al. 2008).

High rates of needle and syringe sharing and use of non-injecting drugs have been more recently identified as a risk behavior among sex workers. Drug and alcohol use is used as a coping strategy to reduce the physical and psychological stress of sex work, which in turn contributes to the vulnerability of sex workers by decreasing their ability to engage in safe sex (Panchanadeswaran et al. 2008; Shahmanesh et al. 2009). Entry into sex work may be motivated by the need to support drug abuse or addiction. The epidemics of methamphetamine use among sex workers and young women in Thailand, Cambodia, Mexico, and elsewhere suggest a growing association between sex work and drug use (Thomson et al. 2009).

Sex Worker Clients

Much more work needs to be done with clients of sex workers to understand how to influence male norms at the individual and group levels that drive paid sex. There is growing research literature on the influence of globalization and modernization on the sexual practices of wealthy urban businessmen and government officials in China (Uretsky 2008), and sex worker clients in Vietnam (Family Health International [FHI] 2006) and in Cambodia (PSI and FHI 2007). This literature highlights how group eating and drinking and group visits to sex workers is used to “strengthen social networks that are founded on culturally prescribed masculine customs of sharing” (Uretsky 2008, p. 809) or to demonstrate to friends or coworkers they are “real men” (FHI 2006; PSI and FHI 2007). Results from a recent qualitative study conducted among 48 urban men by PSI in

Cambodia suggest that many men viewed strong group pressure as a barrier to opt out of transactional sex (Dianna et al. 2008). By frequenting entertainment establishments, men demonstrate commitment to their social group and reap rewards in terms of self-esteem, belonging, and pleasure.

Programming Experience

The early response to the epidemic was to encourage condom use with every client, but the limited ability of some sex workers to negotiate condom use with clients led to new strategies that focused on knowledge of HIV and condom negotiation skills, and such structural determinants of condom use as the implementation of 100 percent condom use programs (CUPs), which shifted some of the onus for use of condoms to brothel owners. CUPs are credited with driving a significant decrease in HIV prevalence in such countries as Cambodia (NCHADS 2007b) and Thailand (Rojanapithayakorn and Hanenberg 1996), and with increasing consistent condom use among sex workers in the Dominican Republic (Kerrigan et al. 2003) and Guatemala (Sabido et al. 2009). In India, the Sonagachi program in Kolkata and the Sangram in Sangli define HIV as an occupational health problem and empower sex workers through multifaceted, multilevel interventions at the community level (reducing S&D, increasing access to government entitlements, and engaging in high-level advocacy with community stakeholders), group level (building trust between sex workers to change social relationships and collective action to protest exploitation or violence), and individual level (improving skills and competencies related to negotiating condom use). Project components such as empowerment, self-efficacy training, and peer outreach support appear to be replicable across settings within India and worldwide (Jana et al. 2004). However, most of these interventions were conducted with female sex workers in brothels. Far fewer success stories are available on reducing risk among “indirect” entertainment venues, street-based sex workers, or male or TG sex workers.

There are significant economic variations among sex workers, and while they are not always poor, they are one of the most socially marginalized groups. Given that economic problems and debts play a role for many in the initiation and continuation of sex work, microfinance/microcredit programs that offer sex workers alternative income options are an underutilized prevention strategy. Recognizing that sex workers are unlikely to be able to get conventional microcredit, the World Bank project in Bangladesh, Financial Services for the Poorest Project (2003–2007), finds models of sustainable interventions for the poorest groups through the use of microcredit and other financial services and included sex workers as a target group. A research project for sex workers in Chennai, India, that provided microenterprise training to produce and market canvas bags reduced the women’s sexual risk by reducing the number of clients they had and enhancing their economic well-being. The project has resulted in a sustainable foundation that markets sex workers’ products around the world (Sherman et al. 2010). Another project in Kenya, the Strengthening STD/AIDS Control Project, provided small loans (average of \$133) to program participants, which included sex workers. After one year, 17 percent of sex workers had left sex work, and for those who remained in sex work, the average number of clients declined by two-thirds, STI incidence fell by 50 percent, and average income from sex work decreased by 50 percent as it was supplemented by income from their microenterprises (Hanck, West, and Tsui 2007).

Sex workers have long been active agents in addressing the violence and stigma they face. A report by the IHAA (2007b), while not specifically reporting on gender strategies to reduce HIV risk, notes that sex workers and HIV projects have collaborated to develop strategies for reducing GBV. These campaigns have countered violence and stigma by:

- Challenging the blame for HIV directed toward sex workers. Sex workers have conducted many campaigns providing information or arranging discus-

sions with clients and community leaders, nationally, or even at the international level, as with the International Day of No Violence against Sex Workers.

- Promoting dialogue between sex workers and religious leaders in Mali to change perceptions of sex workers, which religious leaders then disseminate to the wider community.
- Helping sex workers in Kyrgyzstan and Madagascar develop relationships with and contribute to training for journalists to make reporting about sex work more balanced.
- Enabling sex worker organizations to participate in media events to challenge perceptions that sex workers accept violence as a condition of their work.

FUTURE PROGRAMMING DIRECTIONS

HIV programs working with MARPs should conduct gender analysis of their current prevention, treatment, and care and support programs to identify how and where gender strategies that reduce inequity—and HIV risk—can be integrated into all programs targeting MSM, TG, sex workers, and IDUs. Specific activities include the following.

Increasing gender equity in HIV programs and services:

- Recognizing that men's and women's needs differ is the first step to finding ways of tailoring responses to those needs. Engaging and involving MSM, TGs, female IDUs, and male and female sex workers in program design, implementation, and evaluation not only improves program outcomes but also enhances self-esteem and helps reduce stigma by demonstrating the value of the contribution of women's and TG's lived experience (Pinkham and Malinowska-Sempruch 2007).
- Implementation of gender-responsive services requires that all program staff undergo ongoing, not one-off, gender-sensitization training on the concerns and needs of each MARP.

- Services must become more gender responsive by scheduling flexible hours, implementing drop-in and mobile services and having services available in the evening and on weekends, setting minimal rules for use of services, providing child care, and creating women-, TG-, or men-only spaces or hours.
- Financial, procurement, and distribution barriers to wide distribution of female condoms and lubricant must be addressed to enable MSM and male, TG, and female sex workers to exercise more control over HIV prevention with partners unwilling to use a male condom.

Reducing violence and coercion:

- Programs should screen for a history of CSA and GBV and develop strategies and services to address the mental health needs of MARPs.
- Programs working with MARPs should incorporate violence reduction, mitigation, and social support into all their programs. Conflict resolution programs within the communities should also be developed to mitigate violence between individual IDUs, sex workers, TGs, and MSM.

Increasing MARPs' legal protections:

- Policy change and advocacy for more evidence-based approaches to prevention, care and support, and treatment programs for MARPs are urgently needed. Countries should enact legislation that decriminalizes same-sex consensual sexual relationships and possession of condoms and injecting equipment.
- Advocacy for policy changes that provide voluntary, evidence-based rehabilitation services rather than incarceration for sex workers and IDUs is urgently needed.
- Facilitating partnerships between police and national security agencies and HIV prevention initiatives for MARPs to reach agreement on mutually acceptable harm reduction strategies is critical for creating environments conducive to risk reduction (Rhodes et al. 2006).

Increasing MARPs' access to income and productive resources:

- Programs working with sex workers should link with and provide referrals for adult education programs.
- Programs working with sex workers should provide access to microfinance and income generation that link credit or incentive systems with skills building, literacy, and vocational training in work that provides a comparable or near comparable wage to sex work.

Addressing gender norms and behaviors:

- Prevention programs should highlight sexual relationships as a salient context for injection risk behavior and emphasize the avoidance of syringe sharing and other risk behaviors with intimate partners.
- Working with boyfriends and pimps and using a team approach to outreach may enable more women and TGs to do peer outreach work.
- Programs for intimate partners and families of MARPs should be conducted in tandem with interventions for MARPs.
- Much more work needs to be done with men to change norms about commercial and transactional sex.
- To target sex worker clients, mass media campaigns alone are not sufficient to change norms that are influenced by the group or structured within work or political contexts. Programs need to work along a continuum, from mass media to men in the communities, with male peer groups, and in workplaces where men are employed.

Gender norms and risk behaviors vary between and within cultures based on class, ethnic and minority affiliation, and economic status. What the literature makes clear is that far too little is known about the sexual dynamics, normative expectations, and gender scripts that influence risk behaviors among at-risk populations and their sexual partners (Andrade and Estrada 2003).

The good news is that studies conducted in resource-rich and resource-constrained settings have shown that MARPs are able to change their risk behaviors to avoid becoming infected with HIV or, if they are living with HIV, infecting their sexual partners (Colon et al. 2009; Des Jarlais and Semaan 2005). Because risk reduction behavior is influenced less by individual-level determinants than by social- and contextual-level factors—which are amenable to change over periods of years or decades—future programs for and with MARPs must engage government, the legal system, civil society organizations, and MARP advocacy organizations in a long-term, multipronged strategy to influence gendered social norms and societal barriers.

CHALLENGES

1. *The international community lacks the tools and resources to address the epidemics emerging in countries experiencing concentrated epidemics.* There is a particular need to recognize and address the specific characteristics of HIV transmission in intersecting sexual and needle sharing networks of IDUs, sex workers and their partners and clients, and MSM (AIDS Projects Management Group 2005).
2. *There is a lack of international and national leadership and advocacy on behalf of MARPs.* Donor and government support for long-term advocacy efforts remains weak, as does funding to build the capacity of local community-based organizations to lead advocacy efforts.
3. *Governments continue to respond insufficiently to the HIV epidemic among MARPs.* Few governments and donors have made a priority of prevention, care, and treatment programs for MARPs.
4. *There are few prevention programs designed to reach and work with female IDUs in safe and appropriate ways.* Engaging female IDUs to do peer outreach programs may be more difficult due to gender constraints: Visiting parks, shooting galleries, dark streets and corners, or going into a contact's home

may be dangerous for women. Women may be less able to engage as peer outreach workers because they have less autonomy, either due to domestic responsibilities, stigma, and fear of revealing their drug using status, or because of control by boyfriends or pimps (Birgin 2009).

5. *There is too little research on gender and HIV vulnerability in resource-constrained countries.* Because most of the research on gender, vulnerability, and HIV has been conducted in resource-rich settings, it is important to conduct research in different national and cultural settings to develop interventions appropriate to MARPs in low-resource countries.
6. *Female condoms (and lubricant) are missing from the mix of prevention interventions available to MARPs.* In 2009, PEPFAR distributed 25 billion male condoms and 2.5 million female condoms. Sex workers, MSM, and TGs do not have access to a proven prevention product whose use they can control.

RESOURCES

Bill & Melinda Gates Foundation AVAHAN Project: www.gatesfoundation.org/avahan/Pages/overview.aspx

Understanding and Challenging HIV/AIDS Stigma: A Toolkit for Action. Available at www.icrw.org/publications/understanding-and-challenging-hiv-stigma-toolkit-action

WHO, UNODC, and UNAIDS. 2009. *Technical Guide for Countries to Set Targets for Universal Access to HIV Prevention, Treatment, and Care for Injecting Drug Users*. Geneva: Switzerland. Available at www.unodc.org/documents/hiv-aids/WHO%20UNODC%20UNAIDS%20%20IDU%20Universal%20Access%20Target%20Setting%20Guide%20-%20FINAL%20-%20Feb%2009.pdf

The Global Forum on MSM & HIV: www.msmsgf.org
amfAR's MSM Initiative: www.amfar.org/msm/

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UNAIDS. Men who Have Sex With Men: Key Operational Guidelines of the UNAIDS Programme. Available at www.unaids.org/en/KnowledgeCentre/Resources/PolicyGuidance/OperationGuidelines/men_men_sex_operational_guidelines.asp

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IHAA's Frontiers Prevention Project. At the XVII International AIDS Conference, 2008, the Frontiers Prevention Project reported on a model program and successful HIV prevention campaign for sex workers and MSM in Andhra Pradesh, India. Available at www.aidsalliance.org/publicationsdetails.aspx?id=79

Naz Foundation International provides technical assistance and support to MSM groups and organizations in Asia. Available at www.nfi.net/index.htm

Women's Harm Reduction International Network (WHRIN). WHRIN is a global platform to reduce the harms associated with drug use by women and to develop an enabling environment for the implementation and expansion of harm reduction resources for women. Available at www.talkingdrugs.org/womens-harm-reduction-group

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