For many years, approaches to HIV prevention, care, and treatment focused on changing individual behaviors, such as reducing risk, getting tested regularly, and adhering to treatment. However, more recently, those involved in the response to HIV have argued that behavior change can only occur when the economic, social, and legal conditions under which people live enable them to change. This issue of The LINK focuses on how changes in laws and policies can contribute to an enabling environment—so critical to key populations’ engagement in the HIV cascade of services—by helping to secure and advance the human rights of key populations; reduce stigma, discrimination, and violence; and ensure gender equality.

How laws and policies affect key populations and HIV services

As of June 2016, approximately 73 countries criminalize people on the basis of sexual orientation or gender identity (13 states include death penalties). More than 100 countries criminalize some aspect of sex work. Additionally, according to UNAIDS, “people who inject drugs are almost universally criminalized, either for their drug-use activity or through the lifestyle adopted in order to maintain their drug use.” Several of these laws and policies have also been used to prohibit key populations from organizing, which limits the ability of communities affected by HIV to support the HIV response, reduce stigma and discrimination, and empower themselves. Punitive laws and policies have real effects on the HIV response for members of key populations, like this entertainment worker in Cambodia, as well as for their partners and families. Although the bill became law for several months, a Ugandan court has since struck it down on the basis that it was passed without a proper quorum. A similar bill in Nigeria, called the Same-Sex Marriage Prohibition Act, was signed into law in 2014. One study surveyed men who have sex with men before and after the bill was signed. It found that the percentage of men who have sex with men who reported a “fear of seeking health care” increased from 25 percent (before the bill became law) to 38 percent after it was.

CONTINUED ON PAGE 2
passed. That study also found increases in loss to follow-up, avoidance of health care, and increases in verbal abuse and blackmail experienced by men who have sex with men after the law took effect. For people who inject drugs, one study found that 56 to 90 percent will be incarcerated at some stage during their life, where they have limited access to HIV prevention services and are more likely to be exposed to HIV. Modeling data indicate that, “decriminalization of sex work would have the greatest effect on the course of HIV epidemics across all settings, averting 33 to 46 percent of HIV infections in the next decade.”

The Health Policy Plus Project (see page 8) is contributing to an improved policy environment by training staff of the U.S. President’s Plan for Emergency AIDS Relief (PEPFAR) in nearly 40 countries on issues pertaining to the health and rights of gender and sexual minorities. Part of the training reviews U.S. government policies related to gender and sexual diversity, discusses how these policies apply to the workplace and PEPFAR programming, and helps participants develop a broader knowledge base with which to support effective policies and robust policy advocacy efforts by civil society organizations and other key stakeholders.

Even in the absence of criminalization, environmental factors such as social stigma and discrimination can have an alarming effect on key populations’ engagement in and retention in the HIV cascade of services. For example, on page 3 of this issue of The LINK, Leigh Ann van der Merwe, founder of The Social, Health, and Empowerment Feminist Collective of Transgender Women of Africa (S.H.E.), describes how a health care system’s lack of respect for gender identity can have dire impacts.

Where and how progress is being made

In recent years, a notable shift toward more inclusive and less punitive policies for key populations has occurred in some countries. From 2015 to 2016, for example, Belize, Nauru, Seychelles, Benin, Botswana, Tunisia, and Mozambique legalized consensual sexual activity between individuals of the same sex. Improvements in the enabling environment for the delivery of HIV services have also emerged elsewhere. An article on page 5 describes a large-scale policy review process the United Nations Development Programme (UNDP) undertook in Asia and the Pacific and gives examples of important policy reforms related to key populations.

These efforts, among many others, show that effective responses to HIV must recognize the importance of, and program for, an enabling environment. Since September 2016, LINKAGES has worked toward this goal by supporting the establishment of a technical advisory group (TAG) on violence, stigma, and discrimination against key populations. The TAG includes major global partners in HIV prevention, treatment, and care. The group convenes to advocate for the inclusion of structural issues in HIV responses, support coordination of activities, and share best practices. In coordination with this TAG, LINKAGES in 2017 will be working with communities to monitor levels of stigma and prevent, detect, and respond to incidents of violence. At the country level, LINKAGES field teams also plan and implement activities to address the structural environment. In Cambodia, for example, LINKAGES is helping to develop a more standardized and streamlined case reporting and documentation mechanism to decrease unlawful arrest or detention and other forms of abuse inflicted on key populations, particularly by sex workers’ clients (see page 7). Ultimately these monitoring efforts will help make an even more powerful case for shifting from punitive policies and laws, and their enforcement, to harm-reduction and rights-based principles that create a better enabling environment for entrance into and retention in the HIV cascade of services.

Understanding and addressing the structural barriers to HIV services for key populations will greatly contribute to global success in meeting UNAIDS’ 90-90-90 goals ending AIDS. Doing this will entail continued research and advocacy; strengthened financial support for HIV programs that recognize and program for an enabling environment; and engagement by key population communities in each stage of the response.

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“Where the legal and social environments punish, stigmatize and discriminate against [key populations, they] are less likely to have sufficient awareness of HIV risks, to access HIV prevention services ... They are also less likely to organize and participate meaningfully in the design of programmes to provide HIV services, peer outreach or other community-level initiatives, thus limiting the public health outcomes for the country.”

– UNAIDS Gap Report 2014

The Social, Health, and Empowerment Feminist Collective of Transgender Women of Africa (S.H.E.) was founded by Leigh Ann van der Merwe in 2010. S.H.E. is based in the Cape Province of South Africa and addresses the concerns and issues of transgender women through feminist analysis.

LINKAGES interviewed Leigh Ann to learn more about S.H.E.’s mission and activities.

What made you decide to form S.H.E.?
In this region, the discussion about transgender issues had been dominated by trans men, with trans women in the background. Human rights abuses were so glaring for trans women, yet we were quiet, relegated to support roles and not really participants at the table. We realized that we needed to increase the visibility of transgender women in feminist circles; explore the barriers that trans women face in their communities; and research health issues that affect trans women and advocate for safe and acceptable health care standards.

How did feminism become the framework for S.H.E.?
The hate of transgender women has its roots in patriarchy. All the inequalities that women and sexual and gender minorities experience are very deeply rooted in patriarchy—health inequalities, social marginalization, gender-based violence, employment discrimination, and resulting issues around sex work. Feminism is the lens through which we can understand and address this. Feminism gives us a foundation and philosophy—a way of articulating, analyzing, and understanding things. As a result, S.H.E. joined the Amanitare Coalition, which formed around women’s sexual and reproductive health rights in East London, South Africa, in November 2010.

Has there been any pushback from traditional feminist groups?
Of course. One feminist organization excluded transgender women from a feminist political education training. They limited participation to those who had been born as a woman and socialized as a woman. We wrote them an open letter (https://transfeminists.wordpress.com/tag/one-in-nine-campaign-south-africa/) expressing why we thought they were wrong. Nothing was resolved, but we opened the conversation...not just with this particular organization but more broadly.

What did you hear from Free Talk participants?
We heard about so many human rights violations. We live in harsh conditions where it’s not safe to express our gender identity. Sex work came up often: many had or were doing sex work, and there was a great deal of discussion about how sex work affected their lives and health, especially HIV. And related to HIV, we know that people are not going to be retained in care if they are not addressed by the name they choose, if preferred names gender pronouns aren’t used, and if their very identity isn’t respected. Just last month we had two trans women die...that’s indicative of the lack of care. One was our colleague; one was a sex worker. The system failed them.

What kinds of activities does S.H.E. implement?
At the provincial level, and a little at the country level, we advocate for greater inclusion of transgender women and their issues in the African women’s (and feminist) movement. Research and documentation of issues related to trans women is also an important part of our...
mission. Right now, we’re working on a report called “It Costs to be a Woman,” which looks at violence against trans women in South Africa and at the social, psychological, economic, and physical costs of gender-based violence.

With the [Commission for Gender Equality], we approached the local hospital to provide gender-affirming services. We advocated with the local health department about the fact that trans people aren’t asking for anything extraordinary or special. Health care is a right spelled out in our constitution. We got support from the local government, and now the hospital provides gender-affirming services in the form of psychological support.

We also have an outreach program with peer educators in the field who provide HIV testing. Depending on test results, we’ll refer clients to health services almost immediately. This is a one-of-a-kind service in eastern Cape Province since it is targeting the LGBT community with HIV intervention. Trans women used to seek care at MSM organizations, but now we don’t. Though we are a trans women organization, we render services (HIV services) to everyone on the queer spectrum.

We almost ended up in court over referrals to the local hospital for psychological support in order to receive gender-affirming therapies. We approached hospital officials and asked, “How do we meet the needs of trans people?” We had to remind them that we weren’t asking for special services; we were asking them as citizens of the country. We partnered with the Commission for Gender Equality. The legal advisor for the commission is fantastic; she was one of the first people to recognize that transgender is a gender issue and falls within their mandate. That gender isn’t just a woman’s issue. So, she took the case on. With the commission, we approached the local hospital to provide gender-affirming services. We advocated with the local health department about the fact that trans people aren’t asking for anything extraordinary or special. Health care is a right spelled out in our constitution. We got support from the local government, and now the hospital provides gender-affirming services in the form of psychological support.

We’re also working with a pro bono legal group to train paralegals to facilitate legal gender recognition. It’s a long and complicated process. The Alteration of Sex Description and Status Act of 2003 was never issued with any directive; there is no guidance for implementation. Processes can differ from site to site, wherever you apply. It took me two years. Imagine not having an identity for two years, or having the incorrect identity for two years.

What’s next?

It has clearly been a long and personal struggle to get trans women recognized as a key population. For the longest time we were subsumed in MSM and sex work. We were invisible, but now we’re not. One of the next big steps will be to ensure that the research agenda is driven by trans women themselves. For a key population at high risk of HIV, trans women critically need a PrEP study tailored to them.
Laws and policies that prevent members of key populations from accessing HIV services—or worse, criminalize HIV transmission—not only further stigmatize and discriminate against people at risk for HIV but are detrimental to their health and well-being.

More than 75 countries have laws that criminalize lesbian, gay, bisexual, and transgender (LGBT) people. These countries also have housing, employment, and other policies that discriminate against people living with HIV (PLHIV). However, efforts to reverse this negative environment are under way in Asia and the Pacific, where national reviews were conducted between 2012 and 2016 to examine laws and policies related to access to HIV services.

The work has been jointly led by United Nations Development Programme (UNDP), the Joint United Nations Programme on HIV/AIDS (UNAIDS), and the United Nations Economic and Social Commission for Asia and the Pacific (ESCAP). At least 25 countries conducted reviews. Most were informed by extensive, participatory consultations engaging governments, civil society stakeholders (including PLHIV and key populations), the United Nations, and development partners.

“Over the past decade we have seen some 25 countries and territories across Asia Pacific introduce a range of protective laws and ordinances, rule on supportive court judgments, and pioneer constitutional reforms to promote the inclusion of sexual and gender minorities,” said Edmund Settle, a Bangkok-based policy advisor for UNDP.

“We have seen that as the enabling environment improves, critical steps can be taken to remove barriers—such as discrimination—to HIV and health services for key populations,” he added.

Changes in policies, laws, and law enforcement practices have resulted in expanded availability of HIV prevention and treatment options, including antiretroviral therapy (ART), condoms, needles and syringes, and opioid substitution therapy (OST). Several countries have also introduced or strengthened legal protections for PLHIV in the areas of discrimination, breach of confidentiality, and right to informed consent.

Removing these barriers has had a broader impact on advancing human rights by reducing social inequalities, promoting gender equality, fulfilling rights in employment and education, and improving access to justice.

In many countries, the reviews also have led to the increased availability of data on legal and policy barriers to HIV responses, and the mobilization and engagement of stakeholders to address barriers through partnerships and collaboration.

CONTINUED ON PAGE 6
FROM TOXIC TO ENABLING  CONTINUED FROM PAGE 5

Some examples of progress include:

Cambodia: A community legal service provides free legal advice to sex workers in Phnom Penh, and a legal advice hotline provides advice on violence protection and other legal issues using interactive voice software. Community networks have received training on documenting human rights and legal rights violations. A toolkit on scaling up legal services for PLHIV and key populations was published.

“**We have seen that as the enabling environment improves, critical steps can be taken to remove barriers—such as discrimination—to HIV and health services for key populations.”**

Indonesia: Nongovernmental organizations have made progress in piloting legal aid services for sex workers through OPSI (Indonesian Sex Workers Network) and LBH Masyarakat (Community Legal Aid Institute). Legal aid services for people who use drugs were expanded by the use of paralegals through PKNI (Indonesian Network of People Who Use Drugs) and LBH Masyarakat.

Nepal: The new 2015 constitution prohibits discrimination on the grounds of health status and recognizes citizenship based on gender identity and the rights of sexual minorities to employment in state structures on the basis of the principle of inclusion. Also, government authorities, in coordination with national and international partners, developed standard operating procedures on HIV prevention, treatment, and care services in prisons. Finalized in 2015, the procedures outline a comprehensive package of interventions including OST, NSPs, and condoms.

Palau: After various stakeholders raised concerns about criminalization of same sex practices, the State of Palau accepted recommendations to decriminalize sexual relations between consenting adults of the same sex, and the offense of sodomy was removed from the Penal Code in 2014.

Thailand: No national HIV law exists, but protections are provided under human rights laws. In 2015, the Gender Equality Act was passed that prohibits discrimination on the grounds of gender expression, thereby protecting transgender people. Sexual orientation, gender identity, HIV status, and drug use issues were included in the 3rd National Human Rights Plan 2014–2018. In 2013, the National Human Rights Commission declared that a negative HIV test result cannot be required as a precondition of employment.

Vietnam: As a result of the introduction of the Law on Handling Administrative Violations, compulsory detention centers for sex workers were phased out in 2013. Sex work remains an administrative offense, but the government now sanctions only a minimal fine instead of detention, which reduces barriers to accessing HIV care.

Improving the legal and policy environment depends on:

- Integration of outcomes of reviews into existing planning processes
- Multisectoral and participatory approaches to implementation that also engage key populations
- High-level government engagement
- Prioritization of specific laws or policies to change given political realities
- Attention to subnational contexts such as a province or district highly affected by HIV or that has locally specific legal or policy obstacles

“Support of community-led advocacy efforts can produce change,” said Manisha Dhakal, executive director of the Blue Diamond Society, an organization for lesbian, gay, bisexual, and transgender people. “Recognized as full citizens by the Constitution of Nepal, transgender people now have rights to HIV and health services without fear of violence or the threat of being denied care.”

Success will also depend on focusing resources on high-impact programs in the geographical areas and among populations in greatest need. It also means addressing laws and policies specific to the localities and populations most affected, such as municipal laws and policies in the large cities where key populations are concentrated. And, finally, legal and human rights issues need to be integrated into national and regional planning, budgeting, programming, monitoring, and evaluation.

Editor’s note: This article is adapted from UNDP, UNAIDS, ESCAP, Review of country progress in addressing legal and policy barriers to universal access to HIV services in Asia and the Pacific: Report for the UN Regional Interagency Team on AIDS. Bangkok, Thailand: United Nations Development Programme; 2016. The full report is available from: http://www.asiapacific.undp.org/content/rbap/en/home/library/democratic_governance/hiv_aids/review-of-country-progress-in-addressing-legal-and-policy-barrie.html.


By: Stevie O. Daniels  
Assistant Editor, FHI 360
FILLING THE VOID: A DATA-DRIVEN RESPONSE TO GBV AGAINST KPS IN CAMBODIA

As other articles in this issue of The LINK have demonstrated, efforts are under way in countries around the world to examine legal and policy environments and to make them more conducive to supporting the delivery of HIV services for key populations (KPs).

One major barrier to services is the gender-based violence (GBV) and other forms of abuse perpetrated against KPs by family, sexual partners, clients of entertainment workers,1 and society at large. Fear and lived experiences of violence—physical, sexual, psychological, and even economic—discourage KPs from seeking health services (even if they are not actively denied them) and have had a negative impact on accessing HIV testing and counseling, adhering to antiretroviral therapy,2 and seeking other health services.

In Cambodia, as in many countries, detailed reporting and official documentation of violence perpetrated against KPs have been deficient, despite continued efforts by the country’s Khmer HIV/AIDS NGO Alliance (KHANA), UNAIDS, and HIV/AIDS Coordinating Committee (HACC). Facing this challenge, LINKAGES has made the recording and reporting of violence a high priority. Specifically, LINKAGES Cambodia was tasked with building on progress made so far to develop a more standardized and streamlined case reporting and documentation (CRD) mechanism. The aim of this initiative is to help decrease (1) unlawful arrest or detention of key populations and (2) other forms of abuse inflicted on them, particularly by entertainment workers’ clients.

This initiative will support another important component of the LINKAGES project, the provision of legal services for KPs. Legal AIDS Cambodia (LAC, a LINKAGES partner), intervenes when contacted by KP-led networks in response to reports of abuse or mistreatment by law enforcement officials or others. The new CRD mechanism will be used not only to report and document these cases, but also to allow LAC’s lawyer to track the progress of cases through the justice system. Moreover, data gathered through this mechanism will allow for quick review and analysis of trends, resulting in data that could be used for future advocacy and policy change.

Recently, LINKAGES—with extensive involvement of the National AIDS Authority (NAA), HACC, UNAIDS, and KHANA—trained nearly 50 people from 13 agencies to use the new CRD mechanism, run on an application called Martus,3 which is simple, flexible, and reliable, and also provides a high level of confidentiality.

Training participants—including several high-level government officials—learned about the concepts and principles of CRD, the critical need for accurate CRD, the use of Martus to accurately and consistently record and document cases, and how the success of the CRD mechanism relies on partnerships among government and nongovernmental organizations, community-based organizations, and KP outreach workers.

With hard data in hand, KP organizations and their allies will be able to make an even more powerful case for shifting from current policies and laws, and their enforcement, to harm-reduction and rights-based principles that create a better enabling environment for KPs’ entrance into and retention in the HIV cascade of services.

By: Tea Phauly, LINKAGES Representative, Cambodia

1. Sex workers.
3. Developed by Benetech and widely used as human rights tool for documenting incidents.
BEYOND THE GENDER BINARY: GENDER AND SEXUAL DIVERSITY TRAINING ON HIV

Gender and sexual minorities (GSM) are treated unfairly in almost every society. Violence, stigma, and discrimination directly affect their health and interfere with access to health services, including HIV-related prevention, care, and treatment.

In 2014, the Health Policy Project (HPP), in coordination with a U.S. government interagency team, developed a training aimed at sensitizing staff of the President’s Emergency Plan for AIDS Relief (PEPFAR) and their implementing partners in 38 countries to issues pertaining to the health and rights of GSM.

GSM are a significant percentage of key populations at risk of acquiring HIV and, given the evolving climate around these issues, PEPFAR leadership believed that sensitizing their staff would help the agency reach its 90-90-90 goals. In response, the HPP team developed four modules to be delivered over the course of a working day. The training is provided from a rights-based perspective, but with humility, because we realize that there are myths, misconceptions, prejudices, and outright discrimination and violence facing GSM in all countries around the world, including our own.

The first module explores U.S. government policies related to gender and sexual diversity (GSD), as well as the instrumental part that gender roles play in driving actions and perceptions. The second module takes a deeper look at GSD concepts and terminology, especially as they apply to the workplace and PEPFAR programming. The third and most powerful module introduces participants to local GSM advocates and legal experts within their community, giving them the chance to explore GSD concepts in their own context. The final module then asks participants to apply their recently acquired knowledge to their PEPFAR work and to commit to proactively and meaningfully improving the impact they make in the lives of GSM.

A core pillar of the training is to expand beyond traditional, binary expectations of women and men in PEPFAR programming. As Sam Killerman explains in The Social Justice Advocate’s Handbook A Guide to Gender—on which much of the GSD training is based—“gender binary” is a rigid model of gender that classifies all people into one of two distinct gender archetypes. To illustrate how limiting a gender binary worldview is, the training draws upon participant experiences using four key concepts placed on a continuum—biological sex, gender expression, gender identity, and sexual orientation—because all people have these qualities, not just GSM.

By expanding the worldview of PEPFAR staff and implementing partners beyond a binary construction of gender, the training helps participants (1) move beyond the traditional ways gender has been applied to programmatic responses addressing the HIV epidemic for key populations and (2) build better programmatic solutions that address the health and rights of all people. The training also helps participants develop a broader knowledge base with which to support effective policies and robust policy advocacy efforts by civil society organizations and other key stakeholders.

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We delivered this training to a diverse range of PEPFAR staff and their implementing partners across language barriers, cultures, and other distinct variables. The power of the training has resonated with many people around the world. “The training helped clarify my role as USAID staff to make a change in the inclusion of GSM in programs. I gained knowledge of what to transfer to USAID implementers vis-à-vis that community,” said a participant from Mozambique. Research conducted on the training concluded that it produced sustained changes in attitudes about GSM and had an impact on both PEPFAR programming and conduct in the workplace.

As the GSD trainings move forward under the Health Policy Plus (HP+) project, we will adapt the training in two significant ways. More PEPFAR staff will now be able to receive the training via a blended learning approach that combines an online component with in-person training. HP+ is also adapting the training to two different country contexts in Jamaica and Kenya using specific data points, anecdotes, and examples from those regions, ensuring that stakeholders in these countries are even more sensitized to GSD issues faced by minorities in their own country.

As a result, we can see the potential outcomes of this work. GSM, especially those represented within key populations, will be more thoughtfully targeted in PEPFAR's HIV response, and we expect to see this lead to better health outcomes and contribute to the ultimate goal of ending the HIV epidemic. The training also helps deepen the understanding of how existing policies harm GSM and must be changed to create a policy landscape that affirms the health and rights of all people. This not only includes addressing laws criminalizing same-sex sexualities and gender nonconforming people, but also the numerous peripheral policies that determine access to health services, education, housing, and labor.

We can also see how expanding the conception of gender beyond traditional binary thinking can affect programmatic responses, whether working with key populations, women and girls, men and boys, or a combination of them all through gender synchronist approaches. These impacts can and will range from the enabling environments that govern programs to the very clinics where direct prevention, care, and treatment services are provided. This means that in some cases GSM will have unique interventions to fit their specific needs, and in other cases, programs that target broader populations will account for the diverse range of individuals they serve.

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It's been a privilege to deliver the gender and sexual diversity trainings to a wide variety of professionals around the world. After each session, I'm struck with how participants challenged their basic assumptions and their approaches to the PEPFAR programs they support and the policy environments in which they work. In the most recent training I cofacilitated at the headquarters of USAID’s Office of HIV and AIDS, one participant remarked, “I’ll work to remember that gender is not binary. We need to work to make sure that people of all gender identities, sexual orientations, and sexes are equally able to access our services.”

What this training ultimately demonstrates is that when we re-examine some of our most basic assumptions, powerful ways to reimagine meaningful responses to the HIV epidemic are not only possible, but found all around us.

By: Ryan Ubuntu Olson, Senior Associate, Palladium, Health Policy Plus (HP+)


What excites you most about your work with LINKAGES?

We have great bench strength among the SI team members in the home and country offices. I’m delighted to work with such an enthusiastic group of professionals. It’s also exciting to work with such a diverse range of countries, each with their unique contextual issues and challenges.

What do you wish for key populations?

I hope that we can create the conditions in which key populations can access prevention and treatment services free of stigma and discrimination.

By: Michael Szpir, PhD, FHI 360

THE PEOPLE @ LINKAGES: NAVINDRA PERSUAD

Navindra Persaud joined FHI 360 in July as the Deputy Director of Strategic Information for LINKAGES. Navindra brings a great depth of experience to the role, having worked on HIV and AIDS in different parts of the world since the early 1990s. In Guyana, he served as the National AIDS Program Manager and the National Epidemiologist. And he worked for FHI nearly a decade ago as Director of Strategic Information and Prevention for the Guyana HIV/AIDS Reduction and Prevention (GHARP) project. His return to FHI 360 is a welcome addition to the LINKAGES team.

What are your duties as Deputy Director of Strategic Information?

As leader of the strategic information (SI) team, I coordinate the policies and guidelines that we establish for SI and for monitoring and evaluation (M&E) at the global and country level. I’m responsible for several tasks associated with the collection, collation, analysis, and use of data in the LINKAGES project. This includes developing and strengthening the SI systems, building the capacity for SI and M&E among staff members, and supporting the analysis and use of data to improve LINKAGES programs.

What attracted you to the LINKAGES project?

I have a long-standing interest in the prevention and treatment of HIV in developing countries. I started my career many years ago in Guyana, managing patients with sexually transmitted infections (STIs). With the advent of the AIDS epidemic, an increasing number of people were directed to the STI clinic. This included key populations who have been at high risk of HIV from the outset of the epidemic. Many lives were lost because antiretroviral drugs were not available, and the majority of people came to the clinic very late in their illness after they became symptomatic. Moreover, many providers were reluctant to provide care to them.

Despite the high risk of HIV for these men and women, they have been heavily stigmatized and largely ignored by health care systems. LINKAGES is the largest global project that specifically targets these individuals for the prevention and treatment of HIV. In that respect, LINKAGES is vitally important from a humanitarian and public health perspective.

What progress has been made by the strategic information team?

We recently completed LINKAGES’s global database, called INFOLINK, and finalized an SI package of guidelines to standardize the SI systems in all the country projects. INFOLINK captures data from all the key population service delivery points that are supported by LINKAGES in civil society organizations and the health sector. INFOLINK will contain all the data gathered since the start of the project.

We also conducted a quarterly review of the data from each project site to assess the achievements and identify areas to improve the program. There are varying start-up rates across the projects and so technical assistance will need to be tailored to suit the unique requirements of each.

What challenges have you encountered?

It’s a challenge to keep abreast of the SI needs of the 28 country projects in diverse settings. We must ensure that they all produce high-quality data that are collected in a standardized way.

LIFE FACTS

Expertise: HIV/AIDS/STIs, strategic planning, monitoring and evaluation, research, health systems strengthening, capacity building

Roles: leader, coach, teacher, mentor, manager, researcher

Global experience: Africa, Asia, Caribbean

Languages: English, basic Spanish

Family: I have a wonderful family — my wife and two daughters (23 and 21 years old)

Leisure Activities: cooking, gardening, nature

Philosophy: family comes first

What excites you most about your work with LINKAGES?

We have great bench strength among the SI team members in the home and country offices. I’m delighted to work with such an enthusiastic group of professionals. It’s also exciting to work with such a diverse range of countries, each with their unique contextual issues and challenges.

What do you wish for key populations?

I hope that we can create the conditions in which key populations can access prevention and treatment services free of stigma and discrimination.

By: Michael Szpir, PhD, FHI 360
PACTE-VIH REPLICATION TOOLKIT: STRATEGIES AND RESOURCES FOR IMPLEMENTING HIV PREVENTION, CARE, AND TREATMENT PROGRAMMING WITH KEY POPULATIONS IN WEST AFRICA


To address critical gaps in key population programming in West Africa, USAID paired with FHI 360 to develop PACTE-VIH, a five-year project. This new toolkit brings together lessons learned over the past four years, resources, and implementation steps. Now in its fourth year, PACTE-VIH provides HIV programming for sex workers and men who have sex with men in Burkina Faso and Togo.

ALL WOMEN, ALL RIGHTS, SEX WORKERS INCLUDED: U.S. FOREIGN ASSISTANCE AND THE SEXUAL AND REPRODUCTIVE HEALTH AND RIGHTS OF FEMALE SEX WORKERS

http://www.genderhealth.org/files/uploads/All_Women_All_Rights_Sex_Workers_Included_Report.pdf

The Center for Health and Gender Equity (CHANGE) provides an overview of best practices related to the sexual and reproductive health and rights of female sex workers, and assesses how U.S. foreign assistance can better conform. Based on a review of peer-reviewed articles; collaborative recommendations; and interviews with U.S. officials, implementers, researchers, sex workers, sex worker advocates, and service providers, the report lists specific steps the U.S. government can take.

COUNTING TRANS PEOPLE IN: ADVANCING GLOBAL DATA COLLECTION ON TRANSGENDER COMMUNITIES AND HIV


This new brief, published by IRGT: A Global Network of Transgender Women and HIV, reviews the current state of quantitative data collection on trans people and HIV globally, assesses data collection methods, and recommends improvements. It is based on a review of existing publicly available data and interviews with stakeholders involved in collecting, analyzing, and using data on trans people and HIV.
THE CONNECT EFFECT: TOOLS FOR INTEGRATION OF HIV AND SEXUAL AND REPRODUCTIVE HEALTH WITH KEY POPULATIONS

http://www.connect-effect.com/

Populations that face the highest risk of HIV infection have interconnected health needs and priorities. The Connect Effect, a new microsite developed by the UNFPA’s Asia Pacific office and APMGlobal Health, features workshop materials used in seven countries in Asia and the Pacific and guidance on making adaptations for different country contexts.

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