Issue 7

THE LINK

News About HIV Prevention, Care, and Treatment for Key Populations

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VIOLENCE PREVENTION AND RESPONSE: AN ESSENTIAL COMPONENT OF PROGRAMS FOR KEY POPULATIONS

Violence against key populations (KPs) is epidemic. Although consolidated global data are lacking, statistics at the country and regional levels provide some idea of the staggering scale. According to data compiled by AIDSTAR Two,[1] in Bangladesh, 94% of sex workers (SWs) have experienced violence from clients, gatekeepers, police, intimate partners, or neighbors.[2] In Latin America, 826 transgender people were murdered in a four-year period.[3] In Ukraine, 55% of women who inject drugs reported psychological violence by their partners, while 49% reported physical violence and 41% economic violence.[4] And, according to the 2014 *Global Gay Men's Health and Rights Survey,* 69% of respondents reported experiencing physical assault because they are gay or men who have sex with men (MSM).[5]

Sex workers, MSM, transgender people, and people who inject drugs (PWID) are deeply vulnerable to violence. Laws that criminalize same-sex relationships, "gender impersonation," drug use, and sex work create an environment in which violence against KPs by police, clients of sex workers, and others is tacitly accepted or even considered justified. As well, people whose sexual behaviors or gender expression fails to comply with rigid gender norms are subjected to abuse and violence by family, community members, and strangers alike.

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Key populations, like these Hijras in India, are subject to high levels of violence, which is a clear abuse of human rights and a detriment to accessing health care services.

While there is some discussion about the vocabulary we use related to violence against KPs (see "Language Matters" sidebar), there is no debate that the issue must be addressed to offer effective KP programming. The first two steps of the HIV cascade of services are to identify KPs and to reach them. 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). Conversely, addressing violence in KP programming creates new opportunities to engage with members of KPs in a way that addresses their most pressing needs and can help expand reach. Violence is also known to limit adherence to ARV therapy among people living with HIV,[6] which provides yet more evidence that violence prevention and response are important tools for meeting ambitious 90-90-90 goals.

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This issue of The LINK focuses on the way violence contributes to HIV among key populations. An article on page 3 by Michele Decker, an expert in gender-based violence (GBV) and its effects on sexual and reproductive health, sums up the critical importance of addressing GBV among KPs. She discusses the disproportionate rates of GBV among KPs, the numerous factors that contribute to KPs' vulnerability, and the impact of GBV on HIV.

This issue also highlights efforts around the world to prevent and respond to violence. For example, an article on page 4 illustrates how comprehensive response to violence involves a long and complex series of actions and the dedication of many. Parinita Bhattacharjee, with the Key Population Technical Support Unit, University of Manitoba, and Helgar Musyoki, from the Kenya Ministry of Health's National AIDS and STI Control Project, describe how Kenya's strong commitment to key populations evolved and how violence prevention and response became a national priority in the fight against HIV and AIDS. To help inform future work in the country, LINKAGES and partners conducted a gender analysis; a story on page 8 describes the GBV-related outcomes of this work.

The previous issue of *The LINK* focused on the effectiveness and promise of peer-led and peer-assisted KP interventions. Peer mentoring and other dedicated support from community members and caregivers proved particularly effective in encouraging uptake of services in a World Bank-led evaluation of community responses to HIV in 12 countries.[7] Community-based organizations (CBOs), many led by KPs, are also playing a critical role in responding to GBV. On page 6, Kim Dixon and Vanessa Mosenge look at how CBOs in Cameroon and Malawi, with funding and technical support from LINKAGES and others, are screening and treating KPs for GBV, raising awareness among police and health care workers about violence and stigma as human rights violations, and training KP peer educators to be first-line responders to violence among their peers.

The KP community has shown great resilience in the face of violence, from the routine to the horrific. All cases of violence are violations of human rights, and all hinder our efforts to reach bold treatment targets to help end the AIDS epidemic. We must continue to wage a strong, united response against violence in all its forms.

1. Middleton LS. Technical Paper: Review of training and programming resources on gender-based violence against key populations. USAID's AIDS Support and Technical Assistance Resources, AID-STAR-Two, Task Order 2 and the International HIV/AIDS Alliance. Arlington, VA: 2013.
2. World Health Organization (WHO) and United Nations Program on AIDS (UNAIDS). Addressing violence against women and HIV/AIDS: what works? Geneva, Switzerland: WHO, 2010.
3. REDLACTRANS, International HIV/AIDS Alliance, What's Preventing Prevention. The night is another country. Impunity and violence against transgender women human rights defenders in Latin America. Buenos Aires, Argentina: REDLACTRANS, 2012. (Period addressed: 1 Jan 2008 to 31 Dec 2011.)
4. International HIV/AIDS Alliance in Ukraine. Evaluation of gender sensitive approaches to HIV prevention and harm reduction interventions among IDU. Ukraine: International HIV/AIDS Alliance, 2009.
5. Beck J, Jason Peretz JJ, and Ayala G. Services under siege: the impact of anti-LGBT violence on HIV programs. Oakland, CA: Global Forum on MSM & HIV, 2015.
6. Mugavero M, Ostermann J, Whetten K, et al. Barriers to antiretroviral adherence: the importance of depression, abuse, and other traumatic events. N AIDS Patient Care STDS. 2006 Jun;20(6):418–28.
7. Rodriguez-Garcia R, Wilson D, York N, Low C, N'jie N, Bonnel R. Evaluation of the community response to HIV and AIDS: learning from a portfolio approach. AIDS Care 2013;25:(suppl 1):S7-S19.

LANGUAGE MATTERS

Among KP communities and those who work alongside them, there is respectful debate about the language we use when we talk about violence. Language matters, as the 2015 UNAIDS Terminology Guidelines remind us: "language shapes beliefs and may influence behaviours." In this issue of The LINK, contributing authors used the terms that resonate with them. In general, they discuss "gender-based violence," though we recognize that many prefer "anti-LGBT violence" when discussing violence against MSM and transgender people. Others prefer to speak broadly about human rights violations or to use terms more easily understood in the field, like "violence and abuse."

There are some technical and strategic reasons to use the term GBV. Although many are accustomed to thinking of GBV only in relation to women and girls, when the definition is expanded to include MSM and transgender people—as both UNAIDS and PEPFAR do—the root cause of much of the violence against key populations is revealed. Review of Training and Programming Resources on GBV against KPs explains that "homophobia, transphobia, and narrow norms about how a 'male' or 'female' is expected to identify and behave…reflect entrenched prejudice and poor acceptance of 'difference' (such as in sexual practices or gender identity)" and result in a heightened risk of GBV.

Also, the term GBV is already widely used around the world. Many accept GBV as a wrong that must be addressed, and many countries have policies against it. If we can expand people's understanding that GBV affects KPs, we will create opportunities to tap into existing GBV response systems, to build coalitions with women's rights groups with decades of experience in GBV work, and to more explicitly include the LGBT community in anti-GBV policies.

The use of "GBV" does have drawbacks. For one, GBV can be understood as only violence against women, making the term feel too narrow for KP programming. Also, GBV may call to mind acts by individuals and not by the state. When violence occurs because it is state-sanctioned (such as in the case of criminalization) or when politicians use anti-LGBT sentiment to motivate a voting base, the term GBV may not go far enough. And, finally, not all violence against KPs is gender-based—particularly in the case of men who inject drugs—and the root cause of the violence should not be used to determine whether we have an obligation to address the issue.

Ultimately, what matters most is our shared commitment, whatever our terminology, to preventing and responding to all forms of violence against KPs.

By Robyn Dayton, MPH, FHI 360/LINKAGES

1. 2015 UNAIDS Terminology Guidelines. http://www.unaids.org/sites/default/files/media_asset/2015_terminology_guidelines_en.pdf
2. Middleton LS. Technical paper: review of training and programming resources on gender-based violence against key populations. USAID's AIDS Support and Technical Assistance Resources, AIDSTAR-Two, Task Order 2 and the International HIV/AIDS Alliance. Arlington, VA; 2013.

GBV: HUMAN RIGHTS VIOLATION AND IMPEDIMENT TO HIV SERVICES

Gender-based violence (GBV) has been recognized as a public health and human rights issue since the early 1990s. Globally, an estimated one in three women is affected by physical or sexual violence, with significant consequences for physical, sexual, and mental health, as well as mortality. Defined as violence perpetrated based on sex, gender identity, or perceived lack of adherence to socially defined gender norms,[1] GBV is increasingly recognized as pervasive in key populations (KPs) in the global HIV epidemic.

Many people think that HIV is the most immediate concern for KPs, who include men who have sex with men (MSM), sex workers (SWs), people who inject drugs (PWID), and transgender people. Yet the profound and disproportionate risk these populations face of physical and sexual GBV is increasingly coming to light. For example, for sex workers, the homicide rate is approximately 17 times higher than that of women in the general population. Perpetrators of GBV include intimate partners, but also police, community members, and a host of other members of KPs' social and sexual networks.

GBV represents an outgrowth of the stigma and marginalization that profoundly affect KPs globally. As in general populations, GBV against KPs is shaped by underlying social, political, and economic forces, particularly those that perpetuate gender-based and gender-identity-based disparities. Despite their distinctions, MSM, SWs, PWID, and trans people share harms that include criminalization and marginalization of their occupation, sexual identity, and practices. A confluence of social, legal, and policy factors enables GBV against KPs, often with impunity. Dehumanization of KPs in policy and public discourse, and related stigma and discrimination afford tacit approval of physical and sexual violence. Where individuals remain isolated to avoid detection, they are vulnerable to violence that can occur and persist undetected. Even more alarming, KPs remain underserved by traditional GBV prevention and support programs, which are often targeted primarily to the general population of women and girls. Inclusion of KPs within these efforts is critical to meet their needs, yet in practice lags behind.

Photo Credit: © Ismail Ferdous

A confluence of social, legal, and policy factors enables gender-based violence against key populations, often with impunity.

Access to social support, medical care, and justice—cornerstones of a comprehensive GBV response system—are effectively unattainable in the face of marginalization and criminalization.

The HIV implications of GBV are far-reaching. GBV is considered a critical structural driver of HIV risk, that is, one that extends beyond individual behavior and is embedded within the broader social, economic, and policy climate. GBV enables HIV transmission directly through sexual violence perpetrated by individuals living with HIV or by prompting HIV risk behavior; examples include having unprotected intercourse out of fear that requesting condom use could lead to violence, or substance use as a coping mechanism for trauma. GBV can also impede successful treatment for those living with HIV; evidence from general populations illustrates that trauma, violence, and other life stressors can undermine treatment uptake and adherence.

Left unaddressed, GBV against KPs impedes our ability to respond effectively to the global HIV epidemic. By contrast, effective GBV prevention and response systems for KPs hold the promise of synergistically mitigating the HIV epidemic. For example, our epidemiologic modeling demonstrated significant infections averted among FSWs by reducing GBV against them in both generalized and concentrated epidemics.[2] Translating these results to a reality that supports GBV prevention and response and access to justice for KPs will take political courage and commitment. Without it, our global efforts to mitigate the HIV epidemic will fall short, and the health, safety, and security of KPs will continue to suffer.

By Michele R. Decker, ScD MPH, Johns Hopkins Bloomberg School of Public Health

1. USAID, US Department of State. United States Strategy to Prevent and Respond to Gender-Based Violence Globally. USAID and Department of State, Government of the United States of America;2012.
2. Decker MR, Wirtz AL, Pretorius C, et al. Estimating the impact of reducing violence against female sex workers on HIV epidemics in Kenya and Ukraine. American journal of reproductive immunology. Feb 2013;69 Suppl 1:122-132.

IN FOCUS: A CASE STUDY IN RESPONSE

In most contexts, the word *response* implies a relatively straightforward remark or answer. However, a country's response to a public health crisis or to human rights abuses usually involves a complex series of actions: research into causes and solutions; years of coalition-building, advocacy, policy change, and strategy development; training and capacity-building for those who will implement the strategy; and, finally carrying out the strategy through a variety of interventions. Kenya's response to violence against key populations (KPs)—based on the work of Avahan, the India AIDS Initiative of the Bill & Melinda Gates Foundation—could serve as a case study for this process.

Laying the foundation

The catalyst for Kenya's commitment to KPs was a 2008–2009 study on modes of HIV transmission, which revealed that 33% of all new HIV infections in the country occurred among female sex workers (FSWs), men who have sex with men (MSM), and people who inject drugs (PWID). A flurry of important policy guidelines and strategic plans followed. These include the *Kenya National AIDS Strategic Plan III* in 2009, which set the tone for the country's commitment to KPs; the *Kenya AIDS Strategic Framework (2014–2018),* in which programming for KPs was highlighted as a prominent approach for HIV prevention; and national guidelines for KP programming, developed in 2010 by the National AIDS and STI Control Project (NASCOP) and revised in 2014 to prioritize violence prevention and response as a key approach to preventing HIV among KPs.

To operationalize the guidelines, a NASCOP-led team developed a strategy with three key objectives. These were to (1) train KPs and staff working with KPs to recognize different forms of violence and to understand the link between violence and HIV; (2) develop a community-led system to respond to violence against KPs within 24 hours and (3) sensitize law enforcement (national police and city councils) to help reduce violence by the state against KPs.

Evidence-gathering and advocacy played important roles in meeting these objectives: evidence to convince stakeholders of the critical need to reduce violence toward KPs, advocacy for funding to implement activities, and engagement with senior police officials to garner their support for sensitization at the highest levels.

Strengthening capacity to increase success

With this foundation of high-level support, favorable policy, approved guidelines, and funding, a number of local organizations began conducting GBV prevention and response activities in Kenya in 2013. They were trained and supported by NASCOP, the National AIDS Control Council, and the Technical Support Unit implemented by the University of Manitoba and funded by Bill and Melinda Gates Foundation. In 2016, the LINKAGES project began providing technical and funding assistance to 10 of these local organizations to help them continue their important work and expand on their successes by further strengthening their violence response and prevention systems.

One of these organizations, Keeping Alive Societies Hope (KASH), conducts joint workshops on a regular basis in Nyanza Province for police and sex workers. Workshop participants learn about HIV/AIDS and Kenyan laws on sex work, and sex workers share their experiences of violence and explain how their fear of police affects them. KASH also trained a core group of sex

Photo Credit: © Nell Freeman for the Alliance

A couple, "George" and "Michael," who are members of the gay rights organization PEMA Kenya. LINKAGES recently examined key populations' experiences of gender-based violence in Kenya and the services available to survivors.

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workers and police officers to sensitize and train other police officers. This group collected evidence on emerging patterns of abuse and conducted meetings to determine how to address them. The provincial and county police administrations have made the program an integral part of all police training programs in Kisumu by supporting KASH to conduct pre-service and in-service trainings for police. Since 2013, KASH has trained 692 police personnel (518 male and 174 female) to make them aware of and sensitive to violence and HIV among KPs.

In Mombasa, the International Centre for Reproductive Health—a NASCOP learning site and another LINKAGES partner—runs two crisis lines for FSWs and MSM who experience violence and want immediate help. The 24-hour crisis lines are managed by community mobilizers who supervise a trained outreach team. The team is comprised mostly of KP peers selected from hot spots where violence is prevalent. When mobilizers receive a call from a KP member who has experienced violence, they quickly organize a team to meet the caller within 30 minutes. The team provides immediate support and also links the person to medical, legal, and psychosocial support services, or escalates the issue to supervisors. People who choose to resolve their case through the legal system are also supported by the outreach team. Since September 2013, the learning site has received reports of 447 cases of violence against FSWs and 269 cases of violence against MSM. Ninety-eight percent of the cases have been addressed by the response team.

Tracking results

Experience of violence and response is monitored by NASCOP quarterly through routine monitoring and annually through polling booth surveys. Between March 2014 and March 2016, violence response increased from 36% to 77% among FSWs, 39% to 82% among MSM, and 24% to 81% among PWID. Also, two rounds of survey results (2014 and 2015) show a significant decline in forced sex across KP groups. However, much work remains to be done: with the exception of PWID, the results show an increase in police violence. Despite this, the reaction of one police officer trained recently offers hope for positive change.

"The training was very good and timely, especially now with rampant violence against KPs," said. Joseph Lemarleni, of the Kenya Police Service in Nakuru. "What I liked most was when KPs shared stories of their life experiences with law enforcement officers. Before, I had a negative attitude towards these people because I thought they spread HIV through their lifestyle but now I have learnt that as the law enforcement agency, we contribute to the spread HIV among KPs by creating fear and harassing them whenever we carry out raids. We must sensitize our law enforcement officers that KPs have rights and the penal code is not against them."

By:

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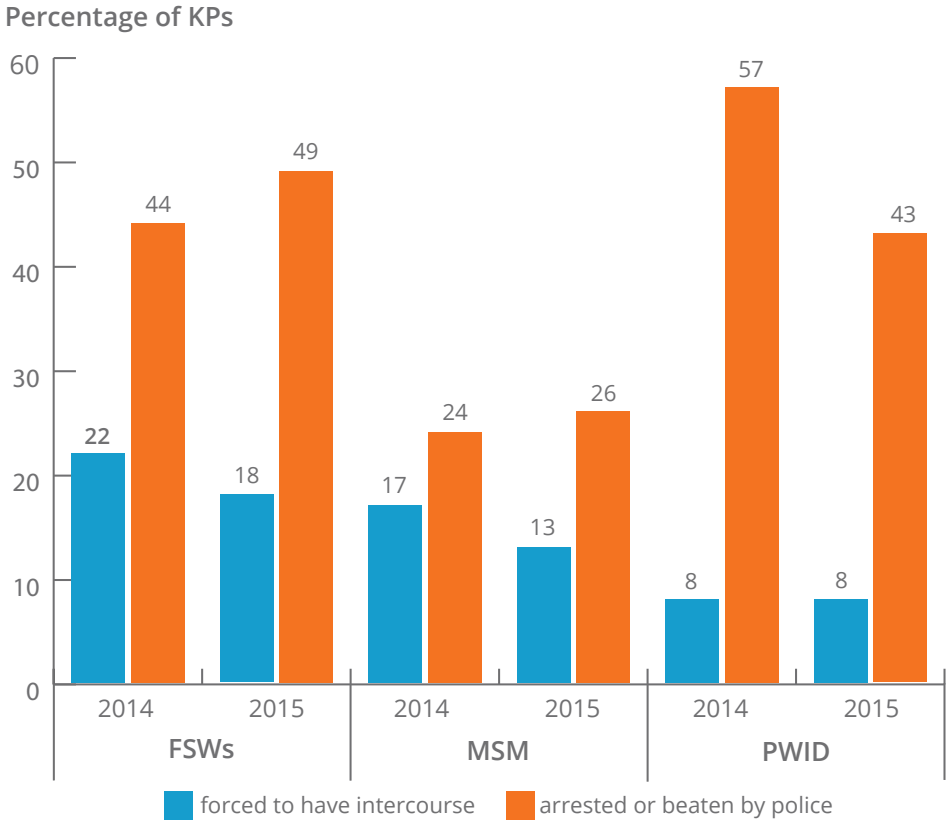
Helgar Musyoki, Key Population Programme Manager, National AIDS and STI Control Project, Ministry of Health, Kenya

Experience of violence by type and year



SUPPORT FOR GBV RESPONSE SERVICES IN CAMEROON AND MALAWI

The links between gender-based violence (GBV) and HIV are well-established.[1,2] Because of extreme levels of stigma and discrimination, criminalization (of drug use, sex work, and homosexuality, for example), and other structural factors, key populations (KPs) are particularly vulnerable to both. GBV fosters the spread of HIV by limiting one's ability to negotiate safe sexual practices; to disclose HIV status and the presence of other STIs; and to access health care and other critical services due to fear of reprisal, discrimination, and denial of services.[3] These barriers also interfere with KPs' ability to disclose their experiences with violence and abuse to direct service providers, such as health care workers, peer educators, counselors, and police officers. The result is missed opportunities to receive time-sensitive post-GBV services like post-exposure prophylaxis and emergency contraception.

Cameroon and Malawi are two of the countries in which LINKAGES is working with government partners, community-based organizations (CBOs), and international nongovernmental organizations to raise awareness about GBV, reduce its incidence, and increase KPs' access to services.

Cameroon

In 2015, a Johns Hopkins University (JHU) study among female sex workers (FSWs) identified violence across various perpetrator groups, including police, clients, and non-paying partners, and showed prevalence of physical or sexual violence at 60 percent.[1] Another JHU study conducted among men who have sex with men (MSM) showed that one in four reported a history of sexual violence and more than one in 10 reported physical abuse.[2] The studies showed that for both FSWs and MSM, violence is associated with fear of seeking health services, mistreatment at health centers, denial of services in the health sector, and feelings that police fail to protect them.[1,2]

The USAID-funded CHAMP project in Cameroon works to create an enabling environment for HIV and AIDS programming for KPs. LINKAGES is assisting CHAMP and government counterparts to reduce and respond to GBV against KPs by providing technical assistance to CBOs and through advocacy at regional and national levels.

LINKAGES led a PEPFAR gender analysis that identified a number of structural barriers to HIV service uptake rooted in gender-based stigma, discrimination, and violence. Recommendations from the analysis are being used to inform effective HIV programming for KPs.[4]

LINKAGES also supported CHAMP by helping to define a minimum package of services (MPS) for GBV response through a process that involved seven CBO implementing partners, the government, and nongovernmental agencies. At the conclusion of the process, the seven CBOs in five program sites agreed to offer the MPS for GBV response. The MPS consists of:

- Clinical services: evaluation and treatment of injuries; rapid HIV testing with referral to care and treatment as appropriate; post-exposure prophylaxis; STI screening, testing, and treatment (including prophylaxis); emergency contraception; mental health screening; mental health services from a psychologist; and forensic (medico-legal) examination
- Psychosocial services: counseling and support groups
- Legal services: statement-taking/documentation and legal counsel
- Information, education, and communication on GBV prevention and response

To ensure that all direct service providers have the skills they need to provide the MPS, LINKAGES and CHAMP developed standard operating procedures based on global standards. The two projects have conducted capacity-building activities for peer educators, psychosocial counselors, social workers, and other service providers. These activities have focused on providing comprehensive first-line response skills to increase access to and quality of health services for GBV survivors. Training has also been provided on management procedures related to GBV services, including screening interventions to make timely and appropriate referrals.

For FSW peer educators, training is helping them become more aware of services for survivors and of their role in providing first-line response. Speaking on behalf of her peers, one FSW stated, "Violence is prevalent; people don't respect us; our clients and police do violate us. With this training, we know what to say to our peers; we tell our peers to talk about violence because it is very important to our health."

CHAMP: CONTINUUM FOR PREVENTION, CARE, AND TREATMENT OF HIV/AIDS AMONG KEY POPULATIONS

The CHAMP project aims to improve the technical capacity of CBO partners to implement evidence-based programs that provide prevention, care, and treatment services for KPs, notably MSM and FSWs. CHAMP is a five-year program funded by the U.S. Agency for International Development and implemented by CARE Cameroon, Johns Hopkins University, Global Viral, the National AIDS Control Committee, and CBOs.

The notion of breaking the silence is echoed by health center staff. "Training on GBV response helps us address stigma in relation to violence in the sense that we can help survivors know that violence is not their fault, and to speak up," one staff member said. "We can also assure survivors of confidentiality and help them feel safe to disclose violence."

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Malawi

In Malawi, because of the level of stigma against KPs and lack of training of direct service providers on KP-related issues, KPs are often unable to access important post-GBV services. One-stop centers set up in several public hospitals serve as central locations where all victims of GBV can receive post-GBV services, including health, counseling, and legal services. In addition to the one-stop centers, district health offices are located throughout the country to provide health care services and link victims to the one-stop centers for post-GBV services that cannot be provided at the district health offices (such as treatment of serious injuries, legal services). LINKAGES' drop-in centers (DICs) are safe spaces for KPs, and DIC staff are working closely with the one-stop centers and district health offices to ensure that KPs are linked to important and time-sensitive post-GBV services.

In March 2016, the LINKAGES Malawi team began sensitizing and training direct service providers from the one-stop centers, district health offices, and DICs to screen KPs for GBV using a standardized tool. Providers also learned about offering compassionate and nonjudgmental assistance, including delivering key messages about human and legal rights, assessing safety, and exploring safety strategies and existing support systems. Finally, the training also reviewed procedures for linking KPs to health, mental health, and legal services. LINKAGES is providing technical assistance to the one-stop centers and implementing partners to strengthen coordination among all three kinds of facilities and to address any barriers KPs face in accessing stigma-free services.

So far, approximately 25 direct service providers—health care workers and allied police officers—have been trained in GBV screening and response, and more will be trained as the LINKAGES project continues. A smaller group of these direct service providers were trained as trainers. Since peer educators are often the first people who have contact with KPs, the newly trained trainers will, in turn, train approximately 238 peer educators to screen their peers—female sex workers, men who have sex with men, and transgender people—for violence and abuse and connect them with post-GBV services.

Progress and next steps

In Cameroon, CHAMP is working with CBOs and relevant government ministries to establish a functional referral network through which survivors can receive timely and appropriate services and can report incidents of violence. Both MSM and FSWs are eager to see GBV response services expanded. When KP members and KP-friendly service providers were asked about their priorities for CHAMP's scale-up of the GBV component, they listed:

- Advocacy efforts related to safe police reporting and protection
- Strengthened referral system for GBV crisis response
- Targeted educational outreach and advocacy activities that can help reduce the stigma related to discussing GBV in local communities and beyond
- Integration of KPs' needs within existing national forums and strategic plans that address GBV and other human rights

In Malawi, as a result of efforts to proactively identify KPs who experience GBV (via screening), the Malawi LINKAGES team expects to see an increase in the number of KPs who disclose their experiences with violence and abuse to health care workers and peer educators. Thus, more people will receive violence response services and HIV prevention, care, and treatment.

GBV is a human rights violation and seriously affects the health and well-being of KPs in both the direct harm it causes and the ripple effects that fear, stigmatization, and discrimination have on their access to health services. The continued concerted efforts of KPs and their allies are making a difference in the lives of those most vulnerable to GBV.

By:

Vanessa Mosenge, GBV Consultant, LINKAGES Cameroon

Glenn de Swardt, BA (MW), Anova Health Institute

Andrew Tucker, BA MPhil, PhD, Anova Health Institute

Kim Dixon, MSW, GBV Advisor, LINKAGES Malawi

Photo Credit: © Vanessa Mosenge

Peer educators and health care staff reviewing the principles of responding to gender-based violence (GBV) during CHAMP/LINKAGES GBV screening and response training.

1. Decker MR, Lyons C, Billong SC, et al. Physical and sexual violence among female sex workers in Cameroon: correlates with HIV risk, and access to health services and justice. Presented at the Sexual Violence Research Initiative Forum, Stellenbosch; South Africa; 2015a Sept.
2. Decker MR, Lyons C, Billong SC, et al. Physical and sexual violence among men who have sex with men in Cameroon: HIV, access to health, and justice. Presented at the Sexual Violence Research Initiative Forum, Stellenbosch, South Africa; 2015b Sept.
3. Dunkle KL, Decker MR. Gender-based violence and HIV: Reviewing the evidence for links and causal pathways in the general population and high-risk groups. American Journal of Reproductive Immunology, 2013;69(s1): 20-6. doi: 10.1111/aji.12039
4. PEPFAR Gender analysis in Cameroon: summary of findings and recommendations for key populations. March 2016.

RESULTS AND RECOMMENDATIONS FROM A GENDER ANALYSIS IN KENYA

As part of a larger gender analysis among key populations (KPs) in Nairobi, Kenya, LINKAGES recently examined KPs' experiences of gender-based violence (GBV) and the services available to survivors of GBV. The analysis consisted of a desk review of relevant literature, policies, and programs for four KPs: sex workers, men who have sex with men, people who inject drugs, and transgender people. It also included 57 qualitative interviews with representatives from KP organizations, government officials, program managers and funders, and health care workers in Nairobi.

> *Even men get violence but it's only that they do not speak out [because] a man is supposed to be strong and not speak out when assaulted and it's bad for gay men because they can't talk about it for fear of stigma and ridicule by society."*
>
> *– Gender analysis respondent*

A task force of KP representatives and government officials provided guidance on the study design, and research assistants from all four KPs implemented the study. Respondents were asked about gender norms that affect KPs, concerns related to violence against KPs, and recommendations for programming to prevent and respond to violence.

Findings

Respondents described widespread GBV against all four KPs. Individuals living with HIV, younger individuals, and those who have overlapping risks — such as transgender women who sell sex — were especially vulnerable to experiencing violence. Although reporting of violence has increased among sex workers, men who have sex with men, and people who inject drugs as a result of rights education and awareness raising, respondents noted that many continue to be unlikely to report violence or seek help. Transgender people, who are often not reached with programming for KPs, have not even been educated about their right to report violence and are unlikely to have access to appropriate services if they experience violence.

Gender norms give rise to beliefs that respondents believe contribute to the GBV that KPs experience, an acceptance of GBV, a decreased likelihood that incidents of GBV will be reported, and stigmatizing attitudes from providers toward KP survivors. Some of the harmful beliefs are that "it is ok for women to be beaten once in a while by their partners," that "women who sell sex deserve to experience violence," and that "'real men' do not seek health care unless they are very ill." Criminalization, the belief that violence is not a health issue, and the lack of acknowledgment of some forms of GBV that KPs experience (such as intimate partner violence among men who have sex with men) were also seen as barriers to care seeking and appropriate service provision.

Recommendations

The KP national guidelines in Kenya outline a comprehensive violence response. Ongoing work includes sensitization of police and a violence response system with access to legal services. Yet more remains to be done on a wider scale, particularly with transgender people and in health care settings.

Health care settings present an important new opportunity for responding to GBV, as health care workers can be trained to routinely screen for and provide counseling on violence, including when discussing strategies for disclosing one's HIV status. Respondents also noted a desire for community-based organizations and nongovernmental organizations to be more involved in responding to violence, in particular by offering safe spaces and providing counseling for survivors in these settings. To facilitate sustained change, more work should also be done with both KPs and the larger community — including perpetrators and those whose job it is to respond to violence (such as police) — to transform the harmful gender norms that cause and justify violence.

By:

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Jeffery Walimbwa, GALCK

Antony Gikari, SAPTA

James Ngugi and Lucas Nthei, HOYMAS

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Helgar Musyoki, NASCOP

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THE PEOPLE @ LINKAGES: HALLY MAHLER

Hally Mahler joined FHI 360 in June as the new project director of LINKAGES. Hally worked at FHI and AED many years before the two groups merged to form FHI 360 in 2011. Her return to the unified organization coincides with her return to the United States after 10 years in Tanzania. Her familiarity with FHI 360 has allowed Hally to hit the ground running, and this interview was conducted in the brief moments she had before dashing off to another meeting.

What circumstances brought you to the LINKAGES project?

The HIV epidemic has hit my friends and family, and this has made me very passionate about the topic. I have been working with key populations since the beginning of my career, when I started with FHI in 1993. I remember my first visits to Haiti . . . I was working on behavior-change communication at that time. It was dynamic work, and I was fascinated by it.

I have worked in a number of HIV-related areas since then, including HIV testing and counseling for key populations and the use of voluntary medical male circumcision for HIV prevention. About two years ago I became chief of party for Jhpiego's key population program in Tanzania. It was very exciting work at the country level.

When the opportunity arose to join LINKAGES, it was difficult to pass up. I had been overseas for nearly a decade, and it was time to come home. I can see the U.S. Capitol rotunda from my office window, and it makes me proud that the American people are helping people in other parts of the world to avert new HIV infections. This is exactly the right job to come home to.

What are some of LINKAGES greatest challenges at this time?

The program is halfway through its term, and it has grown much bigger than it was at the start. The funding ceiling just increased from $73 million to $225 million. This reflects a change of focus at the Office of the U.S. Global AIDS Coordinator. Until recently, HIV programs often attempted to reach everyone in the general population, but there is now a greater focus on reaching key populations. That's because it's now evident that the epidemic cannot be stopped without engaging key populations.

So the nature of the program has changed, and with that we have a greater number of buy-ins, not just for technical assistance but also for more comprehensive programs. All of this means that we must re-think how LINKAGES is supported at headquarters, and how it operates in the field. It will be a challenge to make sure that the global technical leadership is aligned with country needs.

It will also be difficult to implement these changes in certain countries because of the stigma linked with key populations. We will need to work closely with community leaders and policymakers so they understand that their country's HIV epidemic cannot be addressed without reaching key populations. That will mean changing perceptions so that more people understand key populations and their needs.

What are you most looking forward to about leading the LINKAGES project?

I am looking forward to working with all the smart, innovative people associated with the LINKAGES project. I am in awe of how much work LINKAGES is doing on three continents

One of our biggest strengths is the LINKAGES Advisory Board. The key population members on the board and others have kept LINKAGES focused and moving in the direction where the beneficiaries want us to be.

I'll be working with some of the most dedicated USAID people I've ever encountered. They are our biggest allies and biggest advocates. I hope to make a meaningful contribution alongside all these people who are so devoted to LINKAGES's mission.

What do you hope the project's biggest impact or legacy will be?

At the end of the day, it's not about LINKAGES, it's about the individuals and the groups — people who are members of key populations, the home-grown civil society organizations, and the ministries of health. Our job is to support them so they can successfully address the problems that affect them.

When LINKAGES ends, I hope we will see that key population members and groups are more empowered to take action for HIV, human rights, and their own health. I hope we can show that more people are HIV negative, that those who are HIV positive are virally suppressed because of our programs, and that LINKAGES has made a difference in people's lives.

What is your greatest hope for key populations?

My hope is that they achieve their greatest hopes — to be active, contributing members in a society without stigma or shame. And that the societies they live in accept them as full equal members.

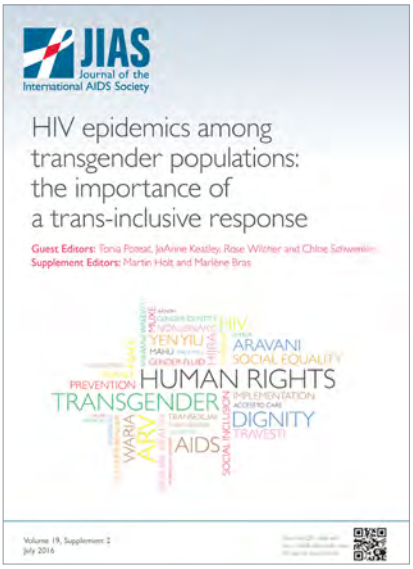
By Michael Szpir, PhD, FHI 360

NEW RESOURCES: RESEARCH AND REPORTS

BIG DATA REAL PEOPLE, 2016 AVAC REPORT

http://www.avac.org/sites/default/files/u3/AVAC_Report2016.pdf

This year's AVAC Report addresses gaps in the type and quality of data collected on prevention for HIV-negative people. Globally, the number of new HIV infections is not declining. Even where gains have been made, continued progress is not guaranteed. Fixing problems with how prevention data are collected and reported is key to slowing the rate of new cases of HIV.



HIV EPIDEMICS AMONG TRANSGENDER POPULATIONS: THE IMPORTANCE OF A TRANS-INCLUSIVE RESPONSE

http://jiasociety.org/index.php/jias/issue/view/1480

This special supplement of the Journal of the International AIDS Society cover a wide range of topics focusing on the unique concerns of transgender communities. The 11 papers in this supplement, selected from among 80 abstracts submitted, expand the evidence base on the HIV epidemic in transgender communities, and offer practical recommendations for reducing the burden of HIV among transgender people and promoting their broader health and human rights.

(EVEN) GREATER THAN THE SUM OF ITS PARTS: A CASE STUDY ON WORKING TOGETHER AS THE CONSORTIUM OF MSM AND TRANSGENDER NETWORKS

http://msmgf.org/wp-content/uploads/2016/01/MSMGF_Final_Screen.pdf

In 2013, The Consortium of MSM and Transgender Networks was founded. This publication documents the lessons learned when 10 global and regional networks that are by and for men who have sex with men (MSM) and transgender communities work together as a united force.

FIRST DO NO HARM: DISCRIMINATION IN HEALTH CARE SETTINGS AGAINST PEOPLE LIVING WITH HIV IN CAMBODIA, CHINA, MYANMAR, AND VIETNAM

http://www.nswp.org/sites/nswp.org/files/First%20Do%20No%20Harm%2C%20Asia%20Catalyst%20-%202016.pdf

Asia Catalyst embarked on an 18-month community-led research project to document the types of discrimination in health care settings experienced by members of key populations living with or affected by HIV. The study focused on China, Cambodia, Myanmar and Vietnam, which represent some of the Asia Pacific countries with the highest HIV burden and highest numbers of new infections in the region. This report is based on 202 interviews with people living with HIV conducted between May – July 2015.

LINKAGES, a five-year cooperative agreement funded by the U.S. President's Emergency Plan for AIDS Relief (PEPFAR) and the U.S. Agency for International Development (USAID), is the largest global project dedicated to key populations. The project is led by FHI 360 in partnership with IntraHealth International, Pact, and the University of North Carolina at Chapel Hill.

The contents of The LINK do not necessarily reflect the views of PEPFAR, USAID, or the United States Government.

Send feedback to LINKAGES@fhi360.org

Thank you to the following for submitting photos for the LINKAGES banner: FHI 360's Asia-Pacific Regional Office (Ian Taylor and Mr. Naysokhim); Global Forum on MSM & HIV; Global Network of Sex Work Projects; and the International Network of People who Use Drugs.

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