



IGWG Gender, Sexuality and HIV Training Module



Suggested Activities and Objectives

Total Time: 11 hrs 30 min, plus introductory (+45 min), concluding sessions (+ 30 min) and breaks

2.0 days training in total

Overall Module Objectives:

1. Build a more comprehensive understanding of gender and sexuality;
2. Increase ability to identify how gender and sexuality drive the HIV epidemic and the effectiveness of HIV program responses; and
3. Become familiar with three practical tools (six circles of sexuality and related questions, the gender continuum, and a framework of gender analysis) that programmers can apply to enhance HIV responses across prevention, treatment, care and support.

Sub-Module 1: Gender, Sexuality and HIV (a focus on gender)

1. Vote with your Feet [30 min]
Recognize how personal and programmatic values shape gender, sexuality and HIV responses
2. Gender terms and definitions [45 min]
Define gender and concepts related to gender and sexuality
3. Act Like a Man/Act Like a woman [75 min]
Identify social expectations (gender and sexual norms) for women and men and articulate the impact of these norms on gender equality and SRH/HIV
4. ADS and PEPFAR Guidelines [45 min]
Know the USAID and PEPFAR requirements for addressing gender

Sub-module 2: Sexuality, Gender and HIV (a focus on sexuality)

5. What is sexuality? (Circles Activity & short PPT) [90 mins]
Become familiar with a comprehensive framework for sexuality, and recognize how such a framework can enhance HIV prevention, treatment, care, and support responses
6. Shaping our Sexualities: Gender and Sexual Norms (step in, short PPT & exercise) [1hr 45 mins]
Identify how gender and sexual norms shape sexuality and power for different groups



IGWG Gender, Sexuality and HIV Training Module



Understand how gender and sexual norms related to sexuality shape the HIV epidemic

Identify opportunities to address gender and sexual norms related to sexuality, and how these interventions can enhance HIV programming

7. Sexual Orientation and Gender Identity (SOGI) Definitions & Myths [45 mins for myths]
Define key terms and concepts related to sexual orientation and gender identity

Recognize and refute common misperceptions about sexual orientation, gender identity and HIV

8. Action Planning for HIV Programming (Facilitated Discussion & short PPT) [45 min]
Specify actions to strengthen how participants' HIV programming integrates sexuality

Sub-module 3: Carrying out Gender Analysis and Integration within HIV Programming

9. Gender continuum with HIV/gender and sexuality examples [60 min]
Understand the IGWG Gender Integration Continuum as a lens for assessing project approaches

10. Gender Analysis Domains [60 min]
Understand a framework for gender analysis that can be applied to HIV programming

11. Gender Integration Case Studies [90 min]
Apply a framework for gender analysis to real-world HIV program examples



Vote with Your Feet



Vote with Your Feet

45 minutes

1. Ask the group to stand in the center of the room. Explain that you are going to call out a statement. (A complete list of suggested statements is available on the next page.) Tell the participants to step to the right if they agree with the statement, or step to the left if they disagree. **Note:** You may want to acknowledge that, although some of the statements may be sensitive, it is important to recognize that reproductive and sexual health link with culturally sensitive issues and topics.
2. Call out the first statement. Repeat it to ensure that everyone heard it. After everyone indicates whether they agree or not, ask two or three participants from each side to explain why they voted the way they did.
3. Facilitate a brief discussion about their reasons. Read up to five statements, starting with statements that are less controversial and move to those that may be more provocative.
4. Debrief the activity by explaining the following:
 - Even though we may be familiar with gender and the importance of gender-sensitive programming, some questions are still difficult for us to work with.
 - Our own experience with and beliefs on gender can have an impact on how we view and understand our projects/programs.
 - We need to keep this in mind as we ask staff and project beneficiaries to address gender issues.

Statements on HIV/AIDS

- An HIV-positive woman should avoid getting pregnant if at all possible.
- Gender equitable relationships should be the goal of an HIV/AIDS program.
- HIV behavior change efforts would have greater success if they addressed sexual pleasure.
- MSM are more vulnerable to HIV because, in most countries, they cannot marry.
- A more “sex-positive” sociocultural environment—meaning an environment that promotes greater acceptance of sexuality and sexual desires—would decrease HIV risk and vulnerability.
- In a generalized epidemic, it is not important for HIV programs to focus on transgender people because they tend to be a small proportion of the



Vote with Your Feet



population.

Statements on Sexuality

- Men are more concerned about sexual performance than women.
- Sexual pleasure is more important to men than to women.
- These days, it's ok for a girl/woman to initiate sex.
- Oral sex is more intimate than intercourse.
- People who have multiple sexual partners concurrently are irresponsible.
- It is empowering for a woman to use her sexuality as a bargaining tool (e.g., by offering or withholding sex with her partner or another person).
- A sex worker is a victim.
- People in same-sex relationships have equal rights in my community.
- The ability to express one's sexuality and sexual diversity freely is key to contributing fully to society.



Defining Gender and Related Terms



45 minutes

Objective: Define gender and concepts related to gender and sexuality.

Materials

Printed flipcharts: Gender Definitions and Terms
Handout: Gender Definitions and Terms

1. Divide the group into pairs. Assign each group one of the following terms (additional terms may be added to address the specific topic area of the workshop):

- sex
- gender
- gender equity
- gender equality
- homophobia
- sexual orientation
- transgender
- gender integration
- gender mainstreaming
- women's empowerment
- constructive men's engagement
- heteronormativity
- gender identity

Tell the pairs to take 5 minutes and define the term. When they are done, ask them to write the definition on a flipchart and tape it up on the wall.

2. Have the group assemble around each term, have the pairs read the definition, and ask the larger group for their thoughts on how it was defined. Clear up any incorrect information if necessary.

Display the newsprint with the IGWG's definition of each gender term (see next page). Explain to the group that gender is defined in many ways, as displayed by their words, but for our purposes today, we are going to use the IGWG definitions. Continue through each IGWG definition.

Facilitation Alternative: If desired, the facilitator can use slides 2–8 and the accompanying speaker's notes from the "Gender 101 Master Presentation." These PowerPoint slides present the definitions of the standard 10 terms included in this exercise.



Defining Gender and Related Terms



Continued:

Sex refers to the biological differences between males and females. Sex differences are concerned with male and female physiology.

Gender refers to the economic, social, political, and cultural attributes and constraints and opportunities associated with being a woman or a man. The social definitions of what it means to be a woman or a man vary among cultures and change over time. Gender is a sociocultural expression of particular characteristics and roles that are associated with certain groups of people with reference to their sex and sexuality.

Gender Equity is the process of being fair to women and men. To ensure fairness, measures must be taken to compensate for historical and social disadvantages that prevent women and men from operating on a level playing field.

Gender Equality is the state or condition that affords women and men equal enjoyment of human rights, socially valued goods, opportunities, and resources.

Gender Integration refers to strategies applied in program assessment, design, implementation, and evaluation to take gender norms into account and to compensate for gender-based inequalities.

Gender Mainstreaming is the process of incorporating a gender perspective into policies, strategies, programs, project activities, and administrative functions, *as well as into the institutional culture of an organization.*

Women's Empowerment means improving the status of women to enhance their decisionmaking capacity at all levels, especially as it relates to their sexuality and reproductive health.

Constructive Men's Engagement involves men in actively promoting gender equity with regard to reproductive health; increases men's support for women's reproductive health and children's well-being; and advances the reproductive health of both men and women.

Homophobia is the fear of, aversion to, or discrimination against homosexuals or homosexual behavior or cultures. Homophobia also refers to self-loathing by homosexuals, as well as the fear of men who do not live up to society's standards of what it is to be a "true man."

Heteronormativity is the assumption that heterosexuality and heterosexual norms are universal and normal, and that these norms are the standard for legitimate social and sexual relations.



Defining Gender and Related Terms



Continued:

Sexual Orientation is the organization of a person's eroticism and emotional attachment with reference to the sex and gender of their desired partner; whether a person's primary attraction is to the opposite sex (**heterosexuality**), the same sex (**homosexuality**), or both sexes (**bisexuality**).

Gender Identity refers to a person's internal, deeply felt sense of being a man or woman, or something other or in between, which may or may not correspond with the sex assigned at birth. Because gender identity is internal and personally defined, it is not visible to others.

Adapted from Currah, Paisley and Shannon Minter. 2000. *Transgender Equality: A Handbook for Activists and Policymakers*. San Francisco: National Center for Lesbian Rights and The Policy Institute of the National Gay and Lesbian Task Force.

Transgender refers collectively to people who challenge strict gender norms by behaving as effeminate men or masculine women, adapting "third gender" roles, or embarking on hormonal and surgical treatment to adjust their bodies to the form of the desired sex. Transgender persons often find that the sex assigned to them at birth does not correspond with the innate sense of gender identity that they experience in life. Transgender may include **transsexuals** (people whose physical sex and gender identity as a man or a woman conflict); **transvestites** (people who cross-dress for sexual gratification but do not wish to be a person of the other sex); and **intersex persons** (people whose sexual anatomy is neither exclusively male nor exclusively female).

(Adapted from UNDP, 2010)

3. Be sure to acknowledge that not all people conform to the gender norms associated with their biological sex. People respond to the expectations of their sex in a multitude of ways. While many people comfortably conform to gender norms, most people behave in at least some ways that are contrary to gender-normative behaviors. Others challenge gender norms further—by identifying with gender norms of the opposite sex or by forging new identities that confound normative, binary constructions of gender. Non-conforming gender behaviors and identities are increasingly visible in mainstream society in many parts of the world. The fact that there are so many deviations from rigid roles and norms further supports the notion that gender is a social construction. This module understands gender analysis and integration to apply to the diversity of gender norms and sexual orientations.
4. Ask participants if they have any further questions and/or comments.



Handout: Gender and Related Terms



Sex refers to the biological differences between males and females. Sex differences are concerned with male and female physiology.

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Sexual Orientation and Gender Identity Definitions and Myths



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(Adapted from UNDP, 2010)



Act Like a Man, Act Like a Woman



Act Like A Man, Act Like A Woman

75 minutes

Activity Objective:

- Examine how cultural messages about gender can affect human behavior in women and men

Materials

Flipcharts, markers, and tape

1. Ask the participants if they have ever been told to “act like a man” or “act like a woman” based on their gender. Ask them to share some experiences in which someone has said this or something similar to them. Why did the individual say this? How did it make the participant feel?
2. Tell the participants that we are going to look more closely at these two phrases. Explain that by looking at them, we can begin to see how society can make it very difficult to be either male or female.
3. In large letters, print on a piece of flipchart paper the phrase “Act Like a Man.” Ask the participants to share their ideas about what this means. These are society’s expectations of who men should be, how men should act, and what men should feel and say. Draw a box on the paper, and write the meanings of “act like a man” inside this box. Some responses might include the following:
 - Be tough.
 - Do not cry.
 - Yell at people.
 - Show no emotions.
 - Take care of other people.
 - Do not back down
4. Once you have brainstormed your list, initiate a discussion by asking the following questions
 - Can it be limiting for a man to be expected to behave in this manner? Why?
 - Which emotions are men not allowed to express?
 - How can “acting like a man” affect a man’s relationship with his partner and children? How can social norms and expectations to “act like a man” have a negative impact on a man’s sexual and reproductive health?
 - Can men actually live outside the box? Is it possible for men to challenge and change existing gender roles?
 - What are the consequences of acting outside the box?
 - Is it different for men and women in rural vs. urban areas?
 - When is it OK for a man to live outside the box?
5. Now in large letters, print on a piece of flipchart paper the phrase “Act Like a Woman.” Ask the participants to share their ideas about what this means. These are society’s expectations of who women should be, how women should act, and what women should feel and say. Draw a box on



Act Like a Man, Act Like a Woman



the piece of paper, and write the meanings of “act like a woman” inside this box. Some responses may include the following:

- Be passive.
- Be the caretaker.
- Act sexy, but not too sexy.
- Be smart, but not too smart.
- Be quiet.
- Listen to others.
- Be the homemaker.

6. Once you have brainstormed your list, initiate a discussion by asking the following questions:

- Can it be limiting for a woman to be expected to behave in this manner? Why?
- What emotions are women not allowed to express?
- How can “acting like a woman” affect a woman’s relationship with her partner and children?
- How can social norms and expectations to “act like a woman” have a negative impact on a woman’s sexual and reproductive health?
- Can women actually live outside the box? Is it possible for women to challenge and change existing gender roles?
- What are the consequences of acting outside the box?
- Is it different for men and women in rural vs. urban areas?
- When is it OK for a woman to live outside the box?

7. Close the activity by summarizing some of the discussion and sharing any final thoughts. A final comment and question could be as follows:

The roles of men and women are changing in our society. It has slowly become less difficult to step outside of the box. Still, it is hard for men and women to live outside of these boxes. What would make it easier for men and women to live outside of the boxes?



Gender in USAID's Automated Directives System (ADS)



Gender in USAID's Automated Directives System (ADS)

45 minutes

Activity Objective:

- Understand USAID and PEPFAR requirements for addressing gender.

Materials

PowerPoint Slides 9–30 from the “Gender 101 Master Presentation”

1. Tell the group that USAID has collected mounting evidence illustrating that by addressing gender, we can achieve more sustainable program objectives. The USAID policy guidance (directives) also tell us that that we must do a better job addressing gender in all of our projects. It's rather like a “carrot and stick” approach: we need to follow the ADS guidance (stick), but doing so will make our work more sustainable (carrot). Similarly, there are laws (e.g., the PEPFAR legislation) and regulations that govern other USG programs and apply both to USG personnel and to contractors.

2. Deliver the PowerPoint presentation, using the talking points provided in the speaker's notes. The presentation should be interactive in nature, where possible. Stop periodically and ask if there are any questions, especially when presenting complex or challenging concepts.

Facilitator Note: It is **essential** that you familiarize yourself with the ADS and PEPFAR legislation before presenting this piece. This section usually generates many questions, and the facilitator needs to be able to answer them in order for the participants to understand how important this topic is. Any of the IGWG core training team members can provide assistance.

3. Ask if there are any final questions or need for clarification.

Facilitation Alternative: If you are doing a shorter version of this module for an audience that requires less in-depth coverage of the USAID ADS, you can skip the following slides and adjust your comments and timing accordingly: slides 10-12, 25-30.



What Is Sexuality?



What Is Sexuality?

90 minutes

Objective: Become familiar with a comprehensive framework for sexuality and recognize how such a framework can enhance HIV prevention, treatment, care, and support responses.

Materials: Flipcharts and markers

Flipchart printed with the Circles of Sexuality diagram for each small group

PPT: Gender, Sexuality, and HIV: So What? Part I

Facilitator's Resource: List of Illustrative Program Examples

Handout of the (6) circles with definitions

Part A. Brainstorming 'Sexuality'

15 minutes

1. Ask the group to brainstorm all the words they can think of that are associated with sexuality. Have 2 people write down the words on large sheets of paper as the facilitator probes for more words. This should be done quickly.
2. Probe for missing words: Any positive associations? What part of sexuality does society not like to talk about openly? Try to pull out the hidden aspects of sexuality. What are some negative actions related to sexuality?



What Is Sexuality?



Kissing	Rape	STIs	Self-esteem
Massage	Hugging	Ovaries	Orgasm
Caring	Sexual harassment	FGM	Sexual attraction
Infertility	Loving/liking	Contraception	Withdrawal method
HIV	Abortion	Vasectomy	Getting pregnant
Touching	Date aggression	Need to be touched	Lesbian, gay
Fantasy	Masturbation	Pornography	Body image
Sharing	Passion	Sperm	Petting
Child spacing	Impotence	Bisexual	Anal sex
Communication	Emotional vulnerability	Flirtation	Incest
Unwanted pregnancy			

3. Once a list is brainstormed (a sample list is provided, above), solicit a couple of responses to the following questions:

- What strikes you about this list?
- Any surprises?



What Is Sexuality?



Part B. Circles of Sexuality

75 minutes

1. Using the PPT, show participants the Circles of Sexuality diagram, which represents one definition of sexuality. Most aspects of human sexuality can fit in one or more of these circles. Explain the definition of each circle and ask for examples of sexuality concepts, thoughts, or behaviors that would fit in each circle.

Definitions

Sensuality

Awareness and feeling with one's own body and other people's bodies, especially the body of a sexual partner. Sensuality enables us to feel good about how our bodies look and feel and what they can do. Sensuality also allows us to enjoy the pleasure our bodies can give ourselves and others.

Intimacy

The ability and need to be close to another human being and accept closeness in return. Aspects of intimacy can include sharing, caring, emotional risk-taking, and vulnerability.

Sexual orientation and gender identity

A person's understanding of who he or she is sexually, including

- *Gender identity*: a person's internal sense of being a man or a woman, which may or may not correspond with the sex assigned at birth.
- *Gender expression*: how one's characteristics and behaviors conform to or transgress gender norms and roles of femininity and masculinity.

Sexual orientation: whether a person's primary attraction is to the opposite sex (heterosexuality), the same sex (homosexuality), or both sexes (bisexuality).

Sexual health and reproduction

One's capacity to reproduce, and the behaviors and attitudes that support sexual health and enjoyment. This includes factual information about sexual anatomy, sexual intercourse and different sex acts, reproduction, contraception, STI prevention, and self-care, among others.

Sexual behaviors and practices

Who does what with which body parts, items, and/or partners.



What Is Sexuality?



Definitions Continued:

Sexual power and agency

Power within sexual relations. This includes

1. Power *within*, derived from a sense of self-worth and understanding of one's preferences and values, which enables a person to realize sexual well-being and health.
2. Power *to* influence, consent, and/or decline.
3. Power *with* others to negotiate and decide.
4. Power *over* others; using sex to manipulate, control, or harm other people.

2. Using the PPT, explain the activity instructions. How do the words from the brainstorm fit into the circles? Are there any that don't seem to fit? Ask the small groups to put each word into the one circle where it best fits. Participants will have 15 minutes to complete this task.
3. Divide the group into smaller groups of 4–5 people each. Distribute flipchart pages prepared ahead of time with the circles of sexuality and a handout with the definitions of each word. Each group will need pens or markers and one of these flipchart pages.
4. When the groups are finished, facilitate a discussion with the larger group, asking
 - How was this exercise? Easy or hard?
 - Which circle had the most words associated with it? Why?
 - Did any other associated words need to be added?
 - Is there any part of these five circles that you never before thought of as sexual? Please explain.
 - Which of the five sexuality circles feels most familiar? Least familiar? Why do you think that is so?
 - Which ones do you think carry the heaviest silence and are hardest to talk about? Why is that?
Probe: For women? For men? For people in same-sex relationships? For HIV programming?
 - Which circle(s) present the most compelling learning opportunities for a community's men and women? On which circles do HIV programs focus? Are these the same or different? Why or why not?
 - Are some circles more important than others to address in the context of HIV programming? Why or why not?
5. Using the PPT, share final concluding points (slides 12–14).



What Is Sexuality?



This activity is adapted from:

Advocates for Youth. "Circles of Sexuality." Retrieved July 24, 2010, from http://www.advocatesforyouth.org/index.php?option=com_content&task=view&id=198&Itemid=129.

CARE and ICRW. "Inner Spaces, Outer Faces Initiative Toolkit: Tools for Learning and Action on Gender and Sexuality." Atlanta, GA and Washington, DC: Care and ICRW. Retrieved from <http://www.careacademy.org/health/isofi/welcome.html>.

Gender, **Sexuality** and HIV: So What?

Part I: What Is Sexuality?



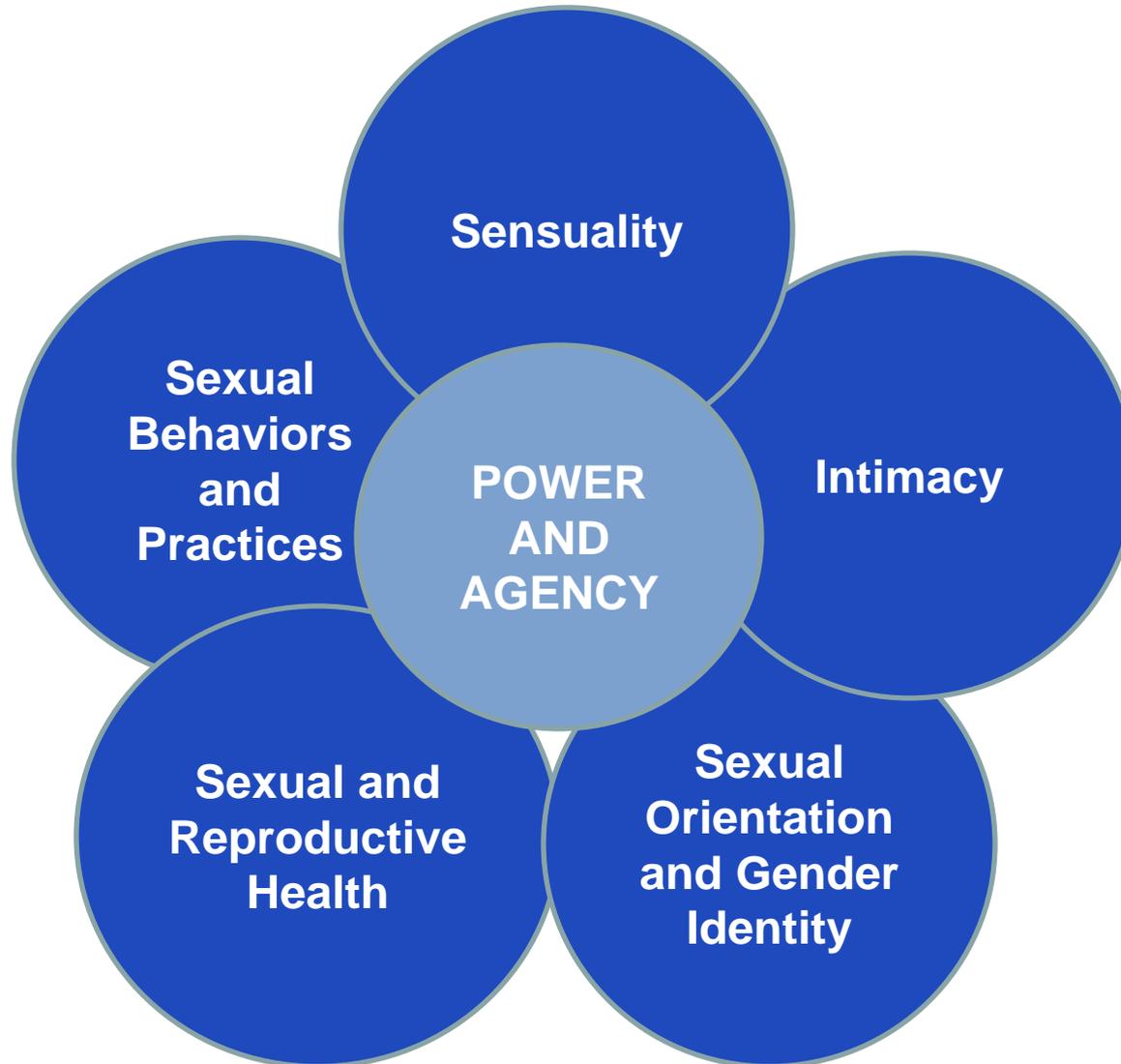
The dominant discourse [on HIV/AIDS] now reflects an increased acknowledgment of the role that gender plays in fueling the epidemic. Unfortunately, aside from a few exceptions, such public discourse on sex and sexuality is still invisible.

- Geeta Rao Gupta, 2000

Durban International AIDS Conference



What Is Sexuality?





Dimensions of Sexuality



- **Sexual behaviors and practices:** Who does what with which body parts, items, and/or partners.



Dimensions of Sexuality

- **Sensuality:** Awareness and feeling with one's own body and other people's bodies, especially the body of a sexual partner. Sensuality enables us to feel good about how our bodies look and feel and what they can do. Sensuality also allows us to enjoy the pleasure our bodies can give ourselves and others.



Dimensions of Sexuality



- **Intimacy:** The ability and need to be close to another human being and accept closeness in return. Aspects of sensuality can include sharing, caring, emotional risk-taking, and vulnerability.



Dimensions of Sexuality

- **Sexual orientation and gender identity (SOGI):** A person's understanding of who he or she is sexually, including
 - *Gender identity:* a person's internal sense of being a man or a woman, which may or may not correspond with the sex assigned at birth.
 - *Gender expression:* how one's characteristics and behaviors conform to or transgress gender norms and roles of femininity and masculinity.
 - *Sexual orientation:* whether a person's primary attraction is to the opposite sex (heterosexuality), the same sex (homosexuality), or both sexes (bisexuality).



- **Sexual and reproductive health (SRH):**
One's capacity to reproduce, and the behaviors and attitudes that support sexual health and enjoyment. This includes factual information about sexual anatomy, sexual intercourse and different sex acts, reproduction, contraception, STI prevention, and self-care, among others.



- **Sexual power and agency:** Power within sexual relations. This includes
 - 1. Power *within*, derived from a sense of self-worth and understanding of one's preferences and values, which enable a person to realize sexual well-being and health.
 - 2. Power *to* influence, consent, and/or decline.
 - 3. Power *with* others to negotiate and decide.
 - 4. Power *over* others; using sex to manipulate, control, or harm other people.

In your small group

- Review the brainstormed list of terms related to sexuality
- Place each term in the one circle where it best fits on your flipchart
- Note any debated terms

Take 15 minutes for this activity.



Sexuality is a central aspect of being human throughout life and encompasses sex, gender identities and roles, sexual orientation, eroticism, pleasure, intimacy and reproduction. Sexuality is experienced and expressed in thoughts, fantasies, desires, beliefs, attitudes, values, behaviors, practices, roles and relationships. While sexuality can include all of these dimensions, not all of them are always experienced or expressed. Sexuality is influenced by the interaction of biological, psychological, social, economic, political, cultural, ethical, legal, historical and religious and spiritual factors.

World Health Organization Working Definition, 2006



Sexuality is



1. Multidimensional
2. Socially constructed
3. Shaped by gender and sexual norms and inequalities



One dimension does not necessarily determine another

- Sexual practices are not determined by sexual orientation and gender identity
 - MSM describes the sex of partners
 - ‘Gay’ is an identity
 - Sexual practices within same- and opposite-sex relations are diverse
- Motivations for sexual activity may not be related to sexuality



A Comprehensive Framework of Sexuality



Enables HIV responses to

- Avoid common mis-assumptions
- Identify critical opportunities across prevention, treatment, care, and support



Shaping Our Sexualities (SOS): Gender and Sexual Norms¹



1 hour and 45 minutes

Objectives:

- Identify how gender and sexual norms shape sexuality and power for different groups.
- Understand how gender and sexual norms related to sexuality shape the HIV epidemic.
- Identify opportunities to address gender and sexual norms related to sexuality, and how these interventions can enhance HIV programming.

Materials

- Cards with identity of each character
- PPT presentation “Gender, Sexuality, and HIV: So What?” Part II “Shaping Our Sexualities (SOS): Gender and Sexual Norms”

Part I: Step In/Step Out

Time: 40 minutes

1. In Part II of the PPT, show PowerPoint slide “Gender and Sexual Norms.” Tell participants that we are going to explore in more depth how sexual and gender norms shape sexuality.
2. Create six small groups. Ask participants to number off from 1–6 until everyone knows which group she or he is in. *Note:* Choose the characters that are most relevant to participants’ programming contexts. If there are fewer than 12 participants, use only 5 groups and remove the character or situation that is least relevant. The exclusively heterosexual male must remain.
3. Show the activity instructions on the PowerPoint slide. Ask the participants to stand together in their small groups. Together, ask participants to form a larger circle, so that all of the groups are facing each other. Once the participants have broken into their small groups, announce that each group will represent a different person; give them their corresponding character cards as follows:

¹ Activity adapted from Naz Foundation. 2001. “Race Course Game.” Pp. 46-47 in *Training Manual: An Introduction to Promoting Sexual Health for Men Who Have Sex with Men and Gay Men*. New Delhi: Naz Foundation.



Shaping Our Sexualities (SOS): Gender and Sexual Norms¹



Characters:

A married woman who grows vegetables and sells them in the market. Her husband spends time away from home for seasonal work. He can be violent upon return, accusing her of having earned extra money from relationships from other men while at the market.

Non-married, exclusively heterosexual man who owns a small business. He most often pays for sex, especially when traveling outside of his town.

A young man who has sex with both men and women and lives with his extended family, who assume that he is heterosexual. He is attracted to and looks for validation from older men who assume the more dominant role.

Female sex worker with a boyfriend. While they used condoms at the start of their relationship, they have not recently as they have been together now for six months and their relationship is getting more serious.

A non-married, female high school student who is living away from home for the first time. She has her material needs met. She is attracted to a boy a year ahead of her at high school. When in town, some young men at the university have also started to notice her.

A young, recently married man who has had one daughter with his wife. He and his wife have agreed to wait until they have more children. His extended family and neighbors tease that he is almost like a girl (and make jokes about his virility), because he spends time with his wife and daughter—and has no immediate plans to try to produce a son.

A middle-aged, out, self-identified gay man who has lived through the HIV epidemic in his country and feels comfortable spending time at established social clubs and restaurants that make a point of welcoming gay, bi, trans, and other MSM.

4. Discuss briefly as a large group what each behavior/identity means. Make any clarifications needed.

Note: This exercise can also be done as a "board game" using flipchart paper. Make six columns on the flipchart, one for each group, and then add rows according to the number of questions being asked (choose 10–12 questions).

5. Each group assumes the assigned behavior or identity. Tell the group that we are going



Shaping Our Sexualities (SOS): Gender and Sexual Norms¹



to see how much room each person has to move, related to their sexuality. Explain that the facilitator will ask a series of questions. Each group should briefly discuss how they think their person would respond to the question. For each question it is possible to answer only YES or NO. If the answer to a question is YES, then the group takes one step forward into the circle. If the answer is NO then the group stays where it is. *The groups will be asked to explain their responses to the rest of the participants. Any of the groups may comment on or question another group's response.* After participants have responded to each question, they all go back to the edge of the circle (prior to responding to the next question).

6. All questions are related to the levels of empowerment and marginalization of the characters, related to sexuality. The questions link to the different areas of sexuality examined in the Circles of Sexuality exercise. To help the participants understand the exercise, you may use the first question as an example and help the teams to work out their responses. If their response is YES, make sure that they take a step forward into the circle.

Sensuality

Do you nearly always experience pleasure during sex?

Do you know what is most pleasurable to you sexually?

Do you know what is most pleasurable to your partner?

Practices

Is it acceptable for you to masturbate?

Would your sexual practices be respected and seen as legitimate by the broader community?

Health and Reproduction

Would it be easy for you to find relevant information (brochures, posters, etc.) about your sexual health?

Can you openly discuss your sexual practices and concerns with a provider?

If you are HIV positive, are you treated with respect, empathy, and care in public health facilities?

Intimacy

Could you have a long-term relationship with the partner of your choice?

Do you feel comfortable sharing intimate feelings, thoughts, or gestures with your partner?

Sexual orientation and gender identity

Would most people you meet be correct in their assumption about your sexual orientation?



Shaping Our Sexualities (SOS): Gender and Sexual Norms¹



Can you openly express your sexual orientation and gender identity without fear of violence?

Power

Can you ask for sex when you want it?

Can you refuse sex when you want to?

Is it easy for you to insist that a condom be used during sex?

Can you carry out your sexual practices without fear of being arrested, fined, or otherwise criminalized?

7. Upon completion of the game, ask participants to come back to the larger group. How did the different groups feel about the position of the individual they were representing? Did they feel happy, unhappy, frustrated, discriminated against, etc.? Were participants surprised by the outcomes—who was able to move, and who was not?
8. Facilitate a discussion regarding the various factors that allowed them to move (to step into the circle) or kept them from being able to move.
 - What patterns, similarities, and differences, did you see in
 - Who was able to move? Who could not?
 - What questions (dimensions) of sexuality had more movement? Less?
 - How did expectations of proper ‘masculine’ or ‘feminine’ behavior (gender norms) affect who was able to move? For which questions (and dimensions) of sexuality?
 - How did expectations of what’s proper ‘sexual’ behavior (sexual norms) affect who was able to move? Which sexual behaviors are privileged (accorded more power and ability to move)? How do these affect who was able to move—and in relation to what questions?
 - How did norms work (enable or constrain movement) *within* relationships or sub-cultures, versus within broader community and institutional expectations?
 - What does this tell us about
 - What is most valued in society? What is/isn’t acceptable?
 - Who has more power? When?



Shaping Our Sexualities (SOS): Gender and Sexual Norms¹



- What does this imply for HIV programming?
9. Summarize the discussion, highlighting the following points:
- Gender and sexual norms shape who has power in sexual relations.
 - Gender norms—expectations of what is proper feminine or masculine behavior related to sexuality—affect men, women, and trans people in relations with same and opposite sex partners. For example: men in a traditional masculine role decide when and how to have sex; women and those in a feminine role are expected to comply and face threat of violence if they do not. In the broader community, same-sex relations are often stigmatized for violating gender norms (that proper norms of masculinity include sex with and dominance over women). For women, sexual behaviors and relations that fall outside of norms are often met with threats or acts of violence, stigma and discrimination.
 - Sexual norms—expectations of what's acceptable sexual behavior—also affect men, women, and trans people in relations both with same and opposite sex partners. 'Acceptable' sex is penile-vaginal intercourse. Other forms of sexual behavior are often stigmatized and silenced. Sex is supposed to occur within the institution of marriage or within stable partnerships; multiple sexual partners or paying for sex is stigmatized (and in many instances criminalized). Talking about sexuality openly is still often taboo; most providers do not feel comfortable talking about sexual practices.
 - Gender and sexual norms related to sexuality also shape power in other areas of one's life—such as how the community or institutions respect, protect, and uphold your rights, or enact stigma and discrimination.
 - Other sources of inequality also contribute to a person's relative status and power related to sexuality (e.g., age, race, ethnicity, etc.).
 - Gender and sexual norms reinforce each other. Together, gender and social norms enforce dominant power inequalities. What is valued/privileged/assumed/correct in society is masculine, heterosexual, white (or the dominant ethnic/racial group), and financially secure. This reinforces a hierarchy of relations (men over women, more 'masculine' men over 'less masculine' men, and adult men over younger men).
 - Individuals and groups may have the agency to act outside of these norms. The degree to which individuals and groups are able to successfully act outside them and reshape sexual power relations to be more equitable depends on many contextual factors (including a person's own social position, social capital, community norms, laws, etc). It is important to identify where these opportunities exist, while also recognizing the



Shaping Our Sexualities (SOS): Gender and Sexual Norms¹



larger inequalities that constrain these factors.

- These gender and sexual norms—and the related inequalities or opportunities to reshape them—carry over into which sexual practices are valued or stigmatized and punished, who has the power to make decisions about sex, whose sexual pleasure and well-being is most important, and whose experiences and what perceived opportunities inform the development and delivery of HIV programming and services.

Part II: Lecturette with PowerPoint

Time: 20 minutes

1. Transition by saying that we now want to focus in more detail on the HIV implications of gender and sexual norms related to sexuality.
2. Deliver the PowerPoint slides on sexual and gender norms and inequalities, making connections with the activity and discussion.
3. After the presentation, debrief by asking the following questions:
 - Was there anything in the presentation that surprised you?
 - Do you agree with the main points of the presentation? Why or why not?
 - What further points or examples would you add?
 - Can some of the key points made in the presentation apply to the work that you do? Why or why not?

Part III: Identifying Intervention Opportunities

Time: 45 minutes

1. Explain that we will return to each of the characters. We want to consider what specific programming interventions might help to address the power imbalances each character faces with regard to sexuality, and to enhance HIV program outcomes.
2. Ask each group to return to their character, and take 20 minutes to answer the following



Shaping Our Sexualities (SOS): Gender and Sexual Norms¹



questions:

- In what areas (dimensions of sexuality) did your character experience constraints on their power and agency? Opportunities?
 - What key gender or sexual norms contributed to these constraints or opportunities?
 - What 2–3 options can you identify to address these gender and sexual norms?
 - How would these proposed interventions reduce HIV vulnerability and/or enhance access to prevention, treatment, and support?
3. Ask each group to report. When all groups have finished, facilitate a discussion addressing the following:
- How was this exercise? Easy or hard?
 - What struck you about people’s responses?
 - What new intervention ideas do you have?
4. Close the activity by recapping the central role that gender and sexual norms play in shaping sexuality—and in the relative power and well-being with which people are able to enjoy their sexual relations. Emphasize that being able to identify and respond to gender and sexual norms that shape sexuality is critical to effective HIV responses.

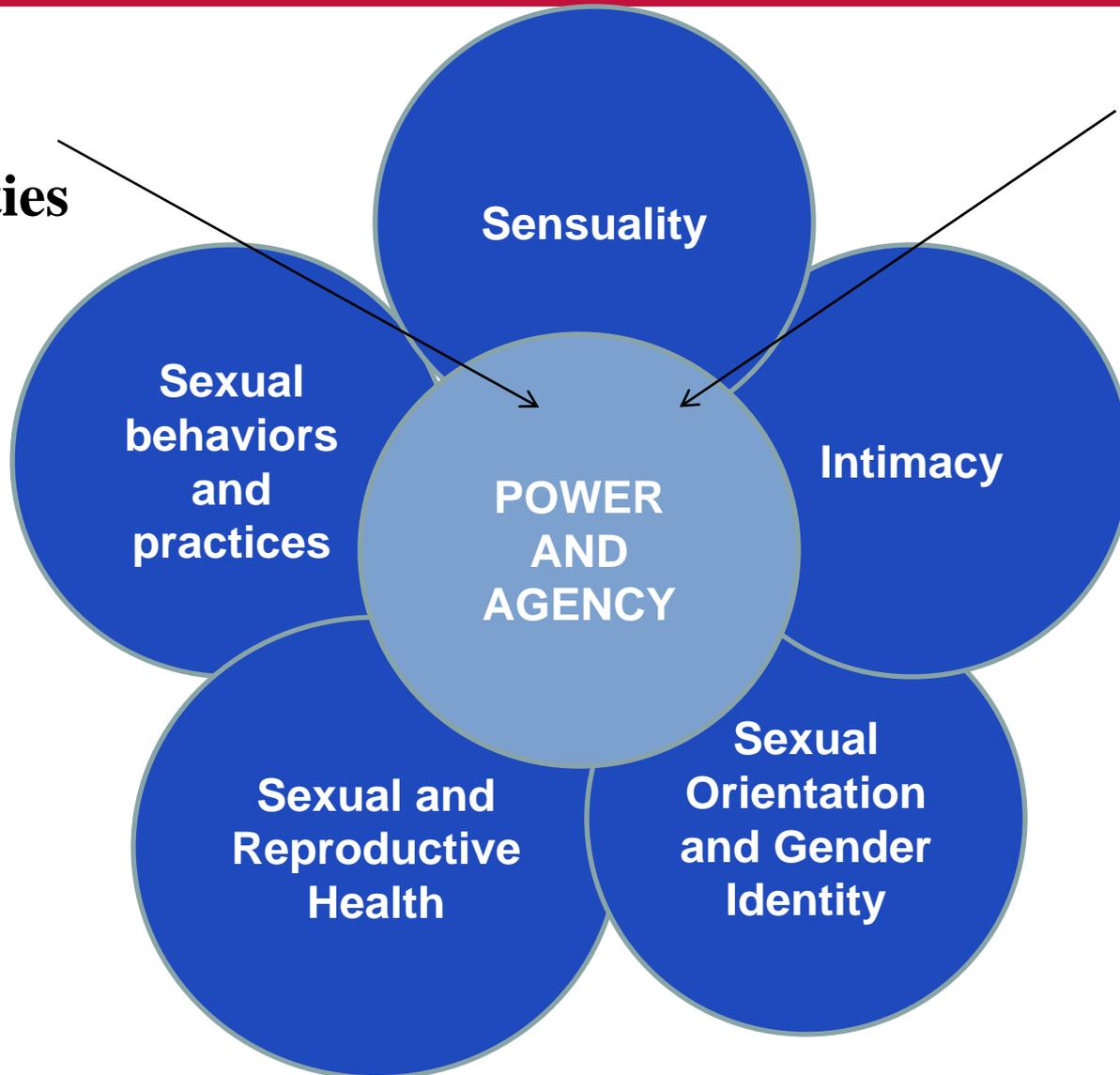
Part II: Shaping Our Sexualities (SOS): Gender and Sexual Norms



Gender & Sexual Norms

Gender norms/ inequalities

Sexual norms/ inequalities





Instructions: Step In/Step Out

- Stand together in your groups around a large circle.
- Each group will assume an assigned behavior or identity.
- The facilitator will ask a series of questions. Each group should briefly discuss how they think their person would respond to the question.
- If the answer to a question is YES, then the group takes one step forward into the circle. If the answer is NO, the group stays where it is.
- After each question, we will discuss who was able to move, and why.



Gender norms

- Expectations of proper ‘femininities’ and ‘masculinities’

Sexual norms

- Expectations of what is ‘proper’ sexual activity

Power

- Men and ‘the masculine’ often have more power than women and ‘the feminine’ (patriarchy)
- Those who appear to be, or are, in opposite-sex relations have more power (heterosexism)



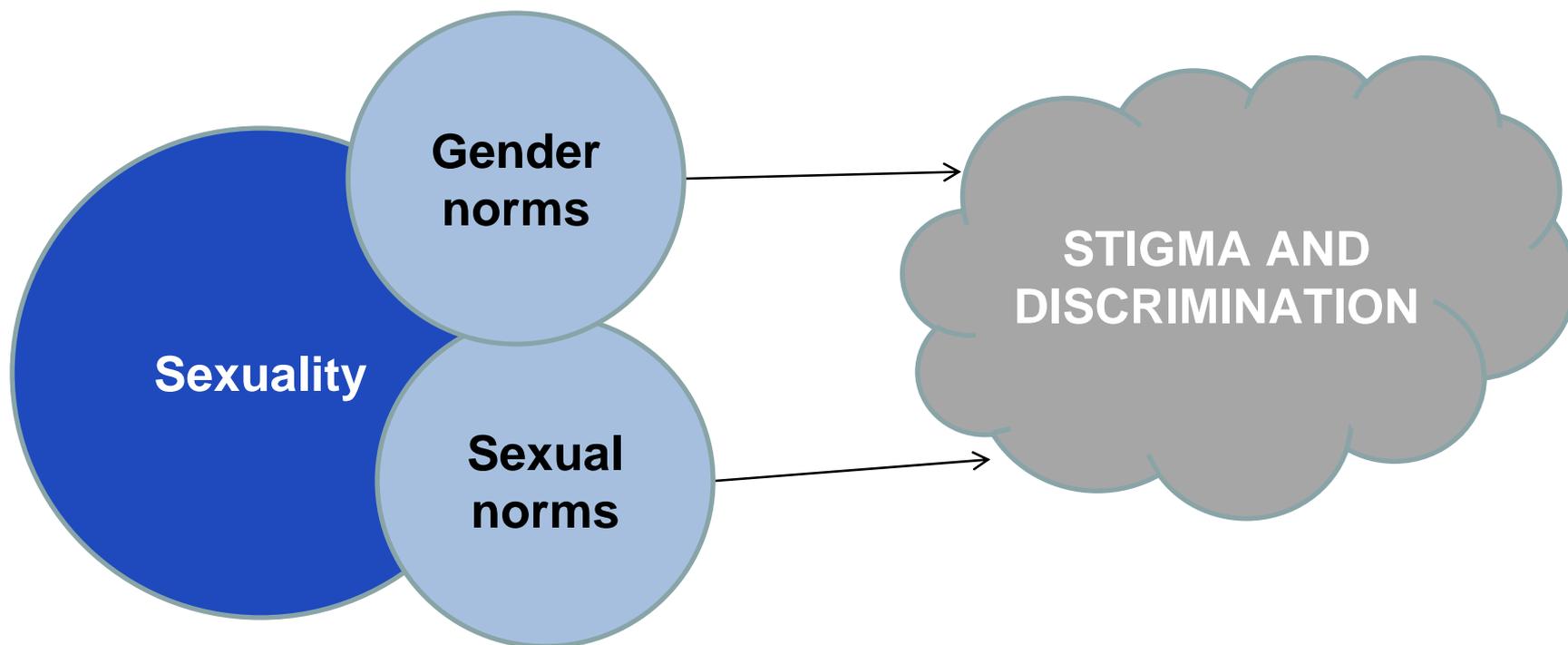
A Hierarchy of Power

... not only ... male-female hierarchies, but also hierarchies between men based on their gender status, that is the degree to which they conform to prevailing norms of masculinity and heterosexuality. Violence maintains the hierarchy by keeping men 'who are not men enough' in their place.

- Greig, 2008



A Root Cause of Stigma, Discrimination, & Violence





HIV Consequences

Of *transgressing gender and sexual norms of sexuality* include

- Stigma
- Discrimination
- Violence

A woman leaving home unaccompanied by her male family members may risk her own life or safety, simply because her reputation as a sexually pure woman is questioned.

Program staff, India

“It is when we show visible feminine traits that we are most at risk [for violence]. Man who has sex with men,
Mexico



HIV Consequences

Of staying within gender and sexual norms related to sexuality

- for women:
 - promotes passivity & ignorance, stigmatizes pleasure and autonomy, contributes to lack of power in sexual relations and society
- for men:
 - encourages multiple partners, inhibits sharing intimacy and sharing power, promotes use of violence to maintain hierarchies



Of staying within gender and sexual norms related to sexuality (continued)

- within same-sex relations
 - Gender norms and inequalities often reproduced
 - Passive and more feminized roles can have less power and more vulnerability
 - Dominant and more 'masculine' roles linked to expectations that can increase risk and decrease acceptability of seeking help or services



Agency, power, and norms vary with context

- Some individuals and groups exercise agency and act outside of dominant norms
- Where alternative sexual and gender norms exist, these can offer important entry points

HIV responses can identify, support, and build upon successful efforts



Multi-level Interventions

Social and legal norms and economic structures based on sexuality have a huge impact on people's physical security, bodily integrity, health, education, mobility and economic status. In turn, these factors impact on their opportunities to live out happier, healthier sexualities.

-Institute of Development Studies,
2006



Applying a Comprehensive Framework of Sexuality



Includes careful analysis of sexual and gender norms and enables HIV responses to

- Avoid common mis-assumptions
- *Hone understanding of key dynamics driving the epidemic*
- Act upon critical opportunities across prevention, treatment, care, and support



Instructions: Intervention Opportunities



For your character, please answer the following:

1. In what areas (dimensions of sexuality) did your character experience constraints on their power and agency? Opportunities?
2. What key gender or sexual norms contributed to these constraints or opportunities?
3. What 2–3 options can you identify to address these gender and sexual norms?
4. How would these proposed interventions reduce HIV vulnerability and/or enhance access to prevention, treatment, and support?

Part I: Definitions

15 minutes

Objective: Define key terms and concepts related to sexual orientation and gender identity.

Materials:

Handout: Sexual Orientation and Gender Identity Terms and Concepts

1. Read through the definitions aloud. Ask participants if they have any questions about the terms and definitions.
2. Note that if you would like to spend more time on these definitions—especially any terms related to local terms and definitions—you may wish to adapt an exercise from Naz Foundation, 2001 or Pact and ICRW, 2010.

Sexuality is a central aspect of being human throughout life and encompasses sex, gender identities and roles, sexual orientation, eroticism, pleasure, intimacy, and reproduction. Sexuality is experienced and expressed in thoughts, fantasies, desires, beliefs, attitudes, values, behaviors, practices, roles, and relationships. While sexuality can include all of these dimensions, not all of them are always experienced or expressed. Sexuality is influenced by the interaction of biological, psychological, social, economic, political, cultural, ethical, legal, historical, and religious and spiritual factors. (World Health Organization Working Definition, 2006)

Gender Identity refers to a person's internal, deeply felt sense of being a man or woman, or something other or in between, which may or may not correspond with the sex assigned at birth. Because gender identity is internal and personally defined, it is not visible to others. Adapted from Currah, Paisley and Shannon Minter. 2000. *Transgender Equality: A Handbook for Activists and Policymakers*. San Francisco: National Center for Lesbian Rights and The Policy Institute of the National Gay and Lesbian Task Force.

Gender Expression refers to all of the external characteristics and behaviors that are socially defined as either masculine or feminine, such as dress, mannerisms, speech patterns, and social interactions. A person's gender expression may or may not match his/her gender identity or his/her biological sex. Adapted from Currah and Minter, 2000

Sexual Orientation is the organization of a person's eroticism and emotional attachment with reference to the sex and gender of their desired partner, whether a person's primary attraction is to the opposite sex (**heterosexuality**), the same-sex (**homosexuality**), or both sexes (**bisexuality**).

Gay is a term used in many parts of the English-speaking world to refer to the people, practices, and cultures of homosexuality. It was adopted as an identity in the West by people attracted to members of the same sex. Gay can refer to women or men, but is sometimes used to specify men who identify as gay, as opposed to women who identify as gay (**lesbians**). The abbreviation LGBT/GLBT is often used to refer to communities of lesbian, gay, bisexual, and transgendered people.



Sexual Orientation and Gender Identity Definitions and Myths



(Adapted from UNDP and UNAIDS. Forthcoming, 2010. *Universal Access: From Vulnerability to Resilience: Strategic Framework for Strengthening National Responses to HIV for Gay Men, Other MSM, and Trans People in Latin America and the Caribbean*. UNDP and UNAIDS.)

Men who have sex with men (MSM) is an epidemiological category that refers to behavior rather than identity. It is thus inclusive of all adult males who engage in consensual male-to-male sex, including those self-identifying as gay, bisexual, or heterosexual in their sexual orientation; and including people who are biologically male regardless of gender identity.
(UNDP and UNAIDS, forthcoming 2010)¹

Transgender refers collectively to people who challenge strict gender norms by behaving as effeminate men or masculine women, adapting “third gender” roles, or embarking on hormonal and surgical treatment to adjust their bodies to the form of the desired sex. Transgender persons often find that the sex assigned to them at birth does not correspond with the innate sense of gender identity that they experience in life. Transgender may include **transsexuals** (people whose physical sex and gender identity as a man or a woman conflict); **transvestites** (people who cross-dress for sexual gratification but do not wish to be a person of the other sex); and **intersex persons** (people whose sexual anatomy is neither exclusively male nor exclusively female).
(Adapted from UNDP and UNAIDS, forthcoming 2010)

Homophobia is the fear of, aversion to, or discrimination against homosexuals or homosexual behavior or cultures. Homophobia also refers to self-loathing by homosexuals, as well as the fear of people who live outside of society’s standards of what it is to be a “true man” or “true woman.”

Heterosexism is the presumption that everyone is heterosexual and/or the belief that heterosexual people are naturally superior to homosexual and bisexual people.

Heteronormativity is the assumption that heterosexuality and heterosexual norms are universal and normal, and that these norms are the standard for legitimate social and sexual relations.

¹ The acronym should be used with an understanding of its limitations; namely, terms aimed at describing objective biological or behavioral facts may not capture socially constructed or individually constructed identities of sexuality and gender; people frequently transition in and out of behaviors and identities, and may not self-identify by their behaviors; behavior-based terms can obscure many other issues related to both health and rights, such as youth, poverty, sex work, drug use, social inequality, homelessness, violence, and incarceration; and internationally generalized terms frequently obscure diversities in people’s needs, ambitions, and vulnerabilities.

Please see resources such as the following to amend these terms to reflect the local context, including local terms for women who have sex with women:

Naz Foundation. 2001. “MSM and Gay Men’s Sexual Behaviors/Identities.” P. 43 in *Training Manual: An Introduction to Promoting Sexual Health for Men Who Have Sex with Men and Gay Men*. New Delhi: Naz Foundation.

Pact, Inc. and International Center for Research on Women (ICRW). 2010. “Sex, Gender Identity, Gender Expression and Sexual Orientation.” P. 150 in *Understanding and Challenging Stigma Toward Men who have Sex with Men: Toolkit for Action (Adapted version for use in Cambodia)*. Washington, DC: Pact, Inc and ICRW.

Part II: Myths and Realities: Sexual Orientation and Gender Identity

30 minutes

Objective: Recognize and refute common misperceptions about sexual orientation, gender identity, and HIV.

Materials: Flipcharts printed with SOGI myths

1. Point participants to five flipcharts hanging on the walls throughout the room, each with a statement about sexual orientation and gender identity (in italics below). Ask the participants to stand and join you by the first flipchart. Read the statement aloud, and ask whether it's true or false. Have participants raise their hand for the response they choose. Go to the next flipchart and do the same, facilitating a brief discussion around participants' responses.
2. As the discussions around each response develop, clarify the misperceptions and beliefs about each myth with the facts detailed after each myth below.
 1. *Sex between two men is, by definition, risky.*
False. Variance in gender identities, sexual behaviors, and sexual orientations is not inherently harmful. Sexual orientation does not itself determine risk. People's sexual exposure to HIV varies according to patterns of sexual behavior, condom use, other sexual risk-reduction practices, and overall HIV prevalence among sexual partners. People's ability to negotiate safer sex, safer drug use, and access to HIV treatment and care can be influenced by poverty, social and gender inequality, drug use, and other social or structural factors.²
 2. *Sex between two men is, by definition, coercive.* (Optional)
False. Consensual sex between adults takes many forms, including sex with people of the same and other sexes/genders. So too, does sexual coercion. Coercion is characterized by a lack of consent, regardless of the sex/gender of those involved.
 3. *Sex between two men is motivated by love, sexual pleasure, and economic exchange.*³
True. The same things that motivate sex between a man and a woman motivate men to have sex with other men. The reasons may include love and companionship, sexual pleasure, and as a way of earning money in exchange for sex.
 4. *Lesbians have little need for HIV prevention, treatment, or care.*
False. RH programs and providers have traditionally excluded lesbians because they may not have contraceptive needs and because sexual transmission of HIV between lesbians is relatively low; however, providers

should not make assumptions about HIV vulnerability based on sexual orientation alone. While the risk of sexual transmission of HIV between two women is very low, women who are lesbians nevertheless face risks for HIV as women and as lesbians. Research shows that many lesbians also have male partners. As women in society, lesbians may be vulnerable to HIV through rape (especially in contexts where sexual violence is used as a “punishment” or “cure” for homosexuality). Finally, just like people of any other sexual orientation lesbians could be vulnerable to HIV transmission through injecting drug use.⁴ Lesbians should have full access to the same range of reproductive healthcare as any women, including information about sexual and reproductive health, STI and HIV counseling and testing, pap tests, breast exams, and fertility services.

5. *Bisexual people are just sex addicts who will have sex with anyone.*

False. Bisexual is the term for people who have affection and sexual attraction to people of either sex. This does not imply that bisexuals are more likely than anyone else to have multiple partners or to be less “choosy” about sexual partners.

6. *You can spot a homosexual by the way they look or act. “Feminine” men or “masculine” women are usually gay.*

False. Gender identity and gender expression do not determine sexual orientation or vice versa. Ideas that link the two are rooted in *stereotypes* meant to preserve very rigid distinctions between men and women; that is, by accusing those who diverge from gender norms of being homosexual. Remember: though GLBT communities sometimes accept or promote gender deviance more than “mainstream” society, almost everyone acts or looks in some way different from the expectations of their sex. Likewise, there is a range of sexual orientation, and many people experience sexual orientation as fluid, or changing over the life course.

7. *MSM engage in the same sexual practices as other couples.*⁵

True. MSM use many of the same sexual practices as heterosexual couples, including: kissing, masturbation, touching, anal sex, and oral sex. These activities are not restricted to sex between a man and woman or MSM but are commonly practiced by both groups. Some of us, for example, assume that all MSM practice anal sex, but in fact, many do not and there are many heterosexual couples who practice anal sex.

8. *Homosexuality is a new phenomenon brought to my region by Westerners.*

False. Despite the fact that homosexuality is more visible in some contexts than others, same-sex intimate behavior is relatively common, having been found in almost every known culture of the world. Further, historians have documented that colonization in many areas altered pre-existing attitudes toward homosexuality, introducing extreme *homophobia* (rather than

homosexuality) by naming, categorizing, and even criminalizing same-sex practices and intimacies.⁶ Others argue that the invention of the term MSM by the development field similarly collapsed diverse experiences into a singular category of “other”—especially separating MSM in the global South from gay (white) men in the North.⁷ Around the world, visibility and acceptance of homosexuality is slowly growing.

3. Explain that all of these statements are actually myths that use judgment and fear to maintain rigid ideas about men, women, and proper sexual desire and behavior:
 - Justifications for homophobia are frequently based on gender norms, and these often unintentionally influence programming assumptions.
 - An important dimension of the stigma, discrimination, and/or violence that GLBT people experience is related to the fact that they deviate from *gender norms*—especially in their sexual behavior, but also in other ways.
 - Myths reinforce the perception that same-sex intimacy is rare, exceptional, and/or harmful
 - Myths are thus used as justifications for stigma, discrimination, and violence, all of which increase HIV vulnerability among GLBT or people thought to be GLBT.
 - Misguided associations between violence and same-sex intimacy may serve to justify and excuse such violence when it happens.
 - Stigma can lead to invisibility or exclusion of and discrimination against GLBT people in HIV testing, counseling, treatment, and care programs.
4. Conclude the exercise by encouraging participants to be alert to identifying myths and to be prepared to engage with the misperceptions that lie behind these myths.

²Adapted from UNDP and UNAIDS. Forthcoming 2010. Universal Access: From Vulnerability to Resilience; Strategic Framework for Strengthening National Responses for HIV for Gay Men, Other MSM and Trans People in Latin America and the Caribbean.

³ From Pact, Inc and International Center for Research on Women (ICRW). 2010. “Sex, Gender Identity, Gender Expression and Sexual Orientation.” *Understanding and Challenging Stigma Toward Men who have Sex with Men: Toolkit for Action (Adapted version for use in Cambodia)*. Washington, DC: Pact, Inc and ICRW. p. 170.

⁴Adapted from Gay, J., K. Hardee, M. Croce-Galis, S. Kowalski, C. Gutari, C. Wingfield, K. Rovin, and K. Berzins. 2010. *What Works for Women and Girls: Evidence for HIV/AIDS Interventions*. New York: Open Society Institute. www.whatworksforwomen.org

⁵From Pact, Inc and International Center for Research on Women (ICRW). 2010. “Sex, Gender Identity, Gender Expression and Sexual Orientation.” *Understanding and Challenging Stigma Toward Men who have Sex with Men: Toolkit for Action (Adapted version for use in Cambodia)*. Washington, DC: Pact, Inc and ICRW. p. 171.



Sexual Orientation and Gender Identity Definitions and Myths



⁶Alexander, M. Jacqui. 2005. *Pedagogies of Crossing: Meditations on Feminism, Sexual Politics, Memory and the Sacred*. New York:Durham.

⁷Gosine, Andil. 2006. "'Race', Culture, Power, Sex, Desire, Love: Writing in 'Men who have Sex with Men.'" *IDS Bulletin* 37(5).

Part III: Action Planning for Your HIV Programming



Discussion Questions: HIV Programming Opportunities



Based on activities and discussion today

1. What areas of sexuality do you want to pay more attention to?
2. What new ideas do you have for HIV programming?
3. What barriers might you face?
4. What supports can help you?

▪



Illustrative Program Responses



- Addressing neglected dimensions of sexuality
 - Sexual pleasure in marriage via FBOs (Mozambique)
 - Number One Plus lubrication packaging (Cambodia)
 - Men Against Violence including intimacy (Nicaragua)
- Challenging underlying homophobia to help promote gender equality, and vice versa
 - Proyecto D (Diversidad) in Brazil
 - Strategic alliances between women's equality and MSM advocates in Mexico
- Investing in analysis and capacity building
 - Inner Spaces Outer Faces (ISOFI) in India



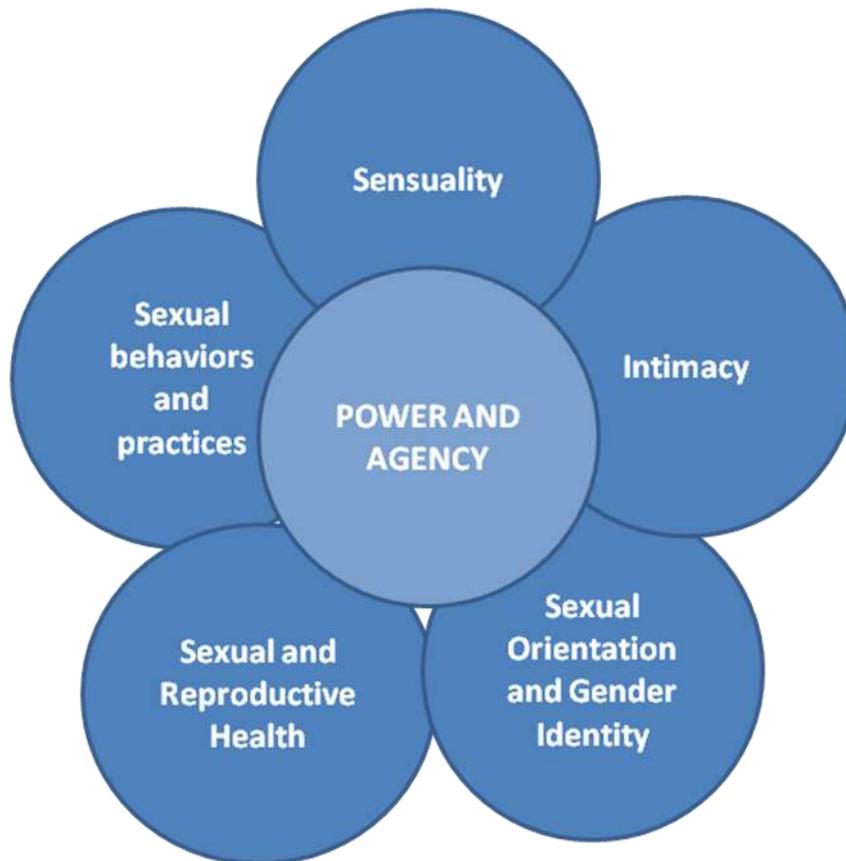
Effectively addressing sexuality offers opportunities to enhance effective HIV programming. To do so, programming needs to

- Be grounded in specific social context;
- Consider all dimensions of sexuality;
- Identify and respond to existing gendered sexual norms and inequalities; and
- Invest in research and capacity building on gender, sexuality, and stigma and discrimination.



More complex understandings of sexuality in AIDS work hold the potential to enable more sophisticated and effective HIV prevention strategies.

- Boyce, P. et al., 2007. “Putting Sexuality (back) Into HIV/AIDS: Issues, Theory and Practice.” *Global Public Health* 2(1):1–34.



Sensuality

Awareness and feeling with one's own body and other people's bodies, especially the body of a sexual partner. Sensuality enables us to feel good about how our bodies look and feel and what they can do. Sensuality also allows us to enjoy the pleasure our bodies can give ourselves and others.

Intimacy

The ability and need to be close to another human being and accept closeness in return. Aspects of sensuality can include sharing, caring, emotional risk-taking, and vulnerability.

Sexual orientation and gender identity

A person's understanding of who he or she is sexually, including

- *Gender identity*: a person's internal sense of being a man or a woman, which may or may not correspond with the sex assigned at birth.



Handout: Circles of sexuality and definitions



- *Gender expression*: how one's characteristics and behaviors conform to or transgress gender norms and roles of femininity and masculinity.
- *Sexual orientation*: whether a person's primary attraction is to the opposite sex (heterosexuality), the same-sex (homosexuality), or both sexes (bisexuality).

Sexual health and reproduction

One's capacity to reproduce and the behaviors and attitudes that support sexual health and enjoyment. This includes factual information about sexual anatomy, sexual intercourse and different sex acts, reproduction, contraception, STI prevention, and self-care, among others.

Sexual behaviors and practices

Who does what with which body parts, items, and/or partners.

Sexual power and agency

Power within sexual relations. This includes

1. Power *within*, derived from a sense of self-worth and understanding of one's preferences and values, which enable a person to realize sexual well-being and health.
2. Power *to* influence, consent, and/or decline.
3. Power *with* others to negotiate and decide.
4. Power *over* others; using sex to manipulate, control, or harm other people.



Handout: Sexual Orientation and Gender Identity related Terms and Concepts



Note: Within most cultures, there are specific terms and usages that should be identified and included on this definition sheet. See references at the end of this handout for suggested sources.

Sexuality is a central aspect of being human throughout life and encompasses sex, gender identities and roles, sexual orientation, eroticism, pleasure, intimacy, and reproduction. Sexuality is experienced and expressed in thoughts, fantasies, desires, beliefs, attitudes, values, behaviors, practices, roles, and relationships. While sexuality can include all of these dimensions, not all of them are always experienced or expressed. Sexuality is influenced by the interaction of biological, psychological, social, economic, political, cultural, ethical, legal, historical, and religious and spiritual factors.

(World Health Organization Working Definition, 2006)

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(Adapted from UNDP and UNAIDS. Forthcoming, 2010. *Universal Access: From Vulnerability to Resilience: Strategic Framework for Strengthening National Responses to HIV for Gay Men, Other MSM, and Trans People in Latin America and the Caribbean*. UNDP and UNAIDS.)



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Women who have sex with women (WSW) is an epidemiological category that refers to behavior rather than identity. It is thus inclusive of all adult females who engage in consensual female-to-female sex, including those self-identifying as **lesbian**, bisexual, or heterosexual in their sexual orientation.

Transgender refers collectively to people who challenge strict gender norms by behaving as effeminate men or masculine women, adapting “third gender” roles, or embarking on hormonal and surgical treatment to adjust their bodies to the form of the desired sex. Transgender persons often find that the sex assigned to them at birth does not correspond with the innate sense of gender identity they experience in life. Transgender may include **transsexuals** (people whose physical sex and gender identity as a man or a woman conflict); **transvestites** (people who cross-dress for sexual gratification but do not wish to be a person of the other sex); and **intersex persons** (people whose sexual anatomy is neither exclusively male nor exclusively female). (Adapted from UNDP and UNAIDS, forthcoming 2010)

Homophobia is the fear of, aversion to, or discrimination against homosexuals or homosexual behavior or cultures. Homophobia also refers to self-loathing by homosexuals, as well as the fear of people who live outside of society’s standards of what it is to be a “true man” or “true woman.”

Heterosexism is the presumption that everyone is heterosexual and/or the belief that heterosexual people are naturally superior to homosexual and bisexual people.

Heteronormativity is the assumption that heterosexuality and heterosexual norms are universal and normal, and that these norms are the standard for legitimate social and sexual relations.

¹ The acronym MSM should be used with an understanding of its limitations; namely, terms aimed at describing objective biological or behavioral facts may not capture socially or individually constructed identities of sexuality and gender; people frequently transition in and out of behaviors and identities, and may not self-identify by their behaviors; behavior-based terms can obscure many other issues related to both health and rights, such as youth, poverty, sex work, drug use, social inequality, homelessness, violence, and incarceration; and internationally generalized terms frequently obscure diversities in people’s needs, ambitions, and vulnerabilities.

Please see resources such as the following to amend these terms to reflect the local



Handout: Sexual Orientation and Gender Identity related Terms and Concepts



context, including local terms for women who have sex with women:

Naz Foundation. 2001. "MSM and Gay Men's Sexual Behaviors/Identities." P. 43 in *Training Manual: An Introduction to Promoting Sexual Health for Men Who Have Sex with Men and Gay Men*. New Delhi: Naz Foundation.

Pact, Inc and International Center for Research on Women (ICRW). 2010. "Sex, Gender Identity, Gender Expression and Sexual Orientation." P. 150 in *Understanding and Challenging Stigma toward Men Who Have Sex with Men: Toolkit for Action (Adapted version for use in Cambodia)*. Washington, DC: Pact, Inc and ICRW.



Action Planning for Your HIV Programming



30–45 minutes

Objective: Specify actions to strengthen how participants' HIV programming integrates sexuality.

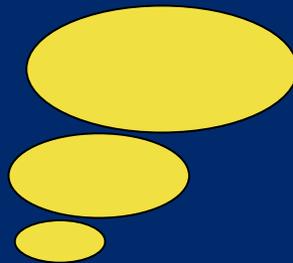
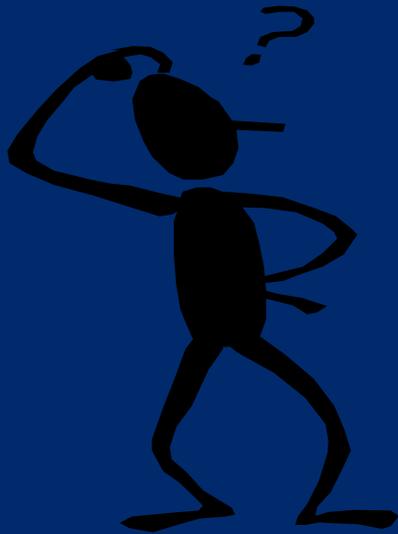
Materials

PPT presentation *Gender, Sexuality, and HIV: So What? Part III: Action Planning for Your HIV Programming*

1. Show PowerPoint slide “Action Planning for Your HIV Programming.” Explain that we want to conclude by giving participants an opportunity to think about the implications of today’s activities, frameworks for understanding sexuality, and intervention opportunities in the context of participants’ own HIV programming.
2. Tell participants that they will brainstorm their responses to the questions on the PowerPoint slide “Discussion Questions: HIV Programming Opportunities.”
3. Once participants have shared their ideas, facilitate a larger group discussion asking the following:
 - What common themes emerged?
 - What are some of the first steps you will need to take to put your ideas into action?
 - What other advice or support can the group offer to help put your plans into action?
4. Transition to the final PowerPoint slides to share other emerging practices for integrating sexuality, with a focus on gender and sexual norms, into HIV programming.



Gender Analysis & Integration for HIV and Sexuality





Gender Analysis



'Know Your Epidemic' & Steps of Gender Analysis



Identify patterns for who is most infected and affected, geographic areas, modes of transmission, equity of access – **“the what”**

Analyze norms and inequalities in different domains (norms, practices, access to resources, decisionmaking) *behind* the epidemic’s patterns – **“the why”**

Determine how these norms and inequalities constrain or support

- *Risk and vulnerability*
- *Living with HIV and those affected by HIV*
- *Programmatic responses (prevention, treatment, care and support)* – **“the so what”**

Adapted from Jerome, J. and van den Oever P. 1994. *Sex and Gender – What’s the Difference?: A Tool for Examining the Sociocultural Context of Sex Difference*, in Genesys, the Futures Group with Management Systems International and Development Alternatives Inc, *Gender Analysis Tool Kit*. Office of Women in Development, USAID.



What is Gender Analysis?

Gender analysis draws on social science methods to **examine relational differences** in women's and men's and girls' and boys'

- roles and identities
- needs and interests
- access to and exercise of power

and the **impact of these differences** in their lives and health.



How does Gender Analysis help us design and manage better health programs?

Through data collection and analysis, it identifies and interprets ...

- consequences of gender differences and relations for achieving health objectives, and
- implications of health interventions for changing relations of power between women and men.



Different approaches, but two fundamental questions

- How will gender relations **affect the achievement** of sustainable results?
- How will proposed results **affect the relative status of men and women**? (i.e., will it exacerbate inequalities or accommodate or transform gender relations?)



To understand gender relations ...

Examine different domains of gender relations

POWER

- Practices, Roles, and Participation
- Knowledge, Beliefs, and Perceptions
- Access to Resources
- Rights and Status

POWER



Different Contexts

Gender constraints and opportunities need to be investigated in specific contexts, as they vary over time and across ...

Social Relationships

- Partnerships
- Households
- Communities
- Civil society and governmental organizations/institutions

Sociocultural Contexts

- Ethnicity
- Class
- Race
- Residence
- Age

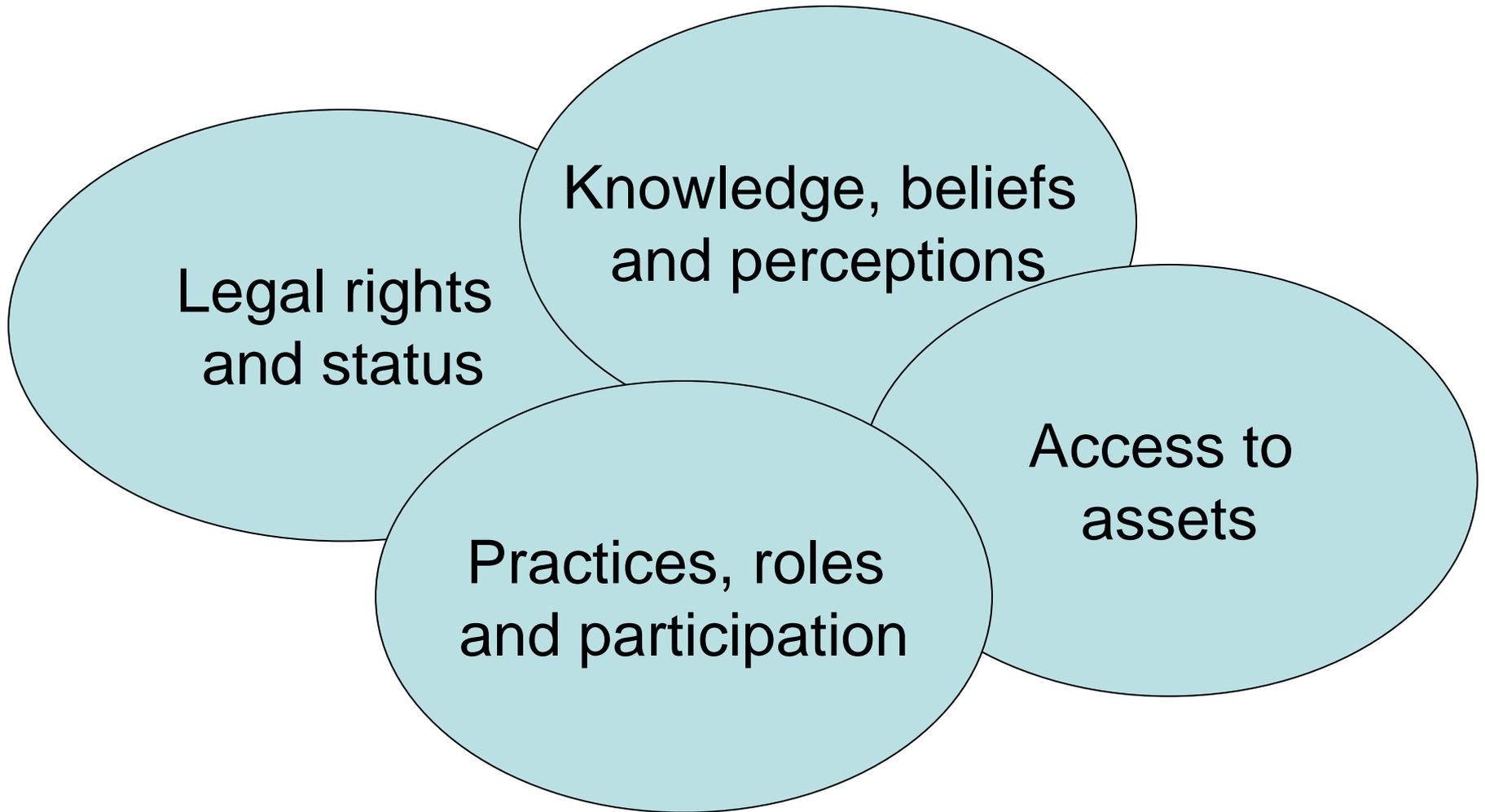


What different constraints and opportunities do women and men face?

- How do gender relations **(in different domains of activity)** affect the achievement of sustainable results?
- How will proposed results affect the relative status of men and women **(in different domains of activity)**?

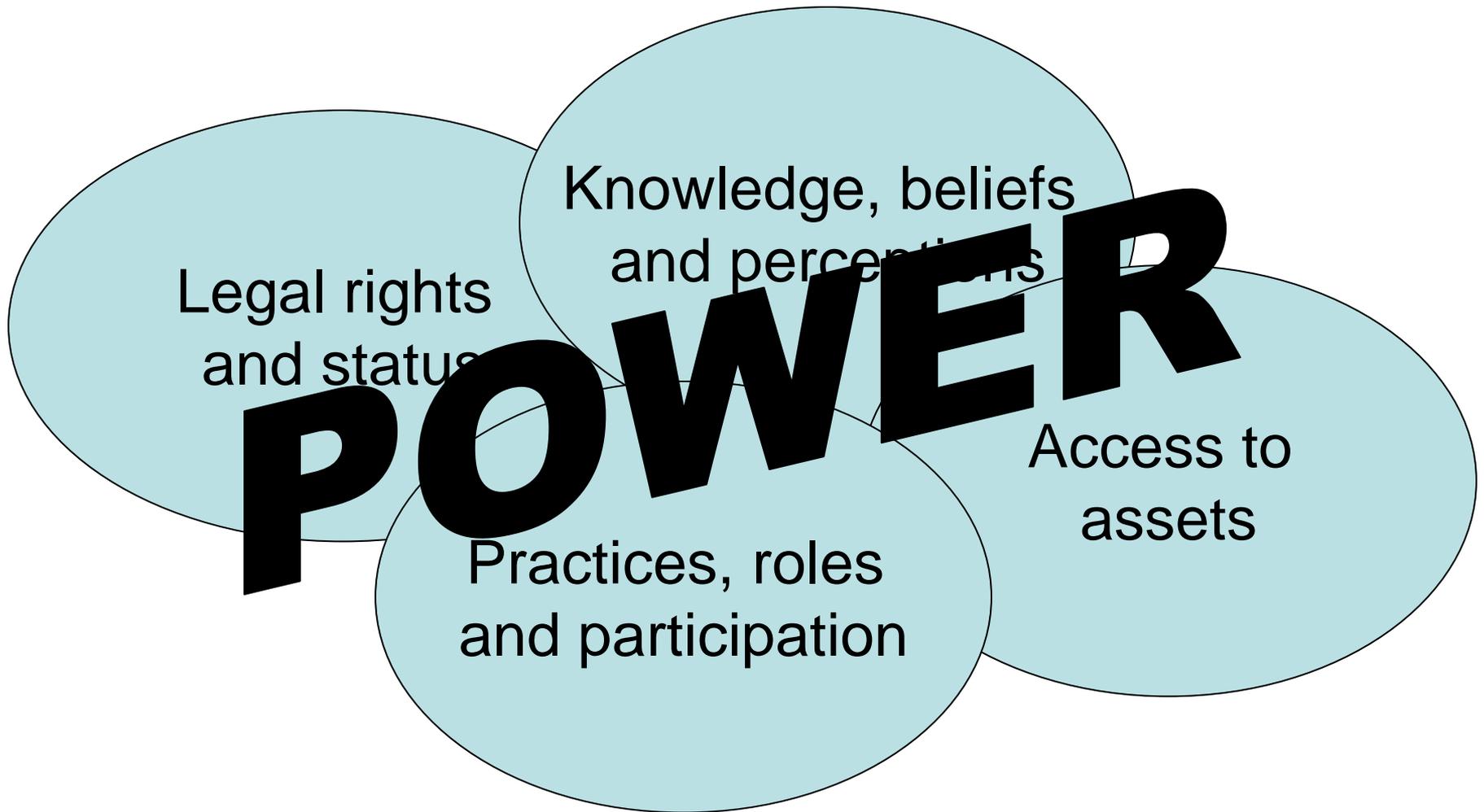


Different Domains of Gender Analysis



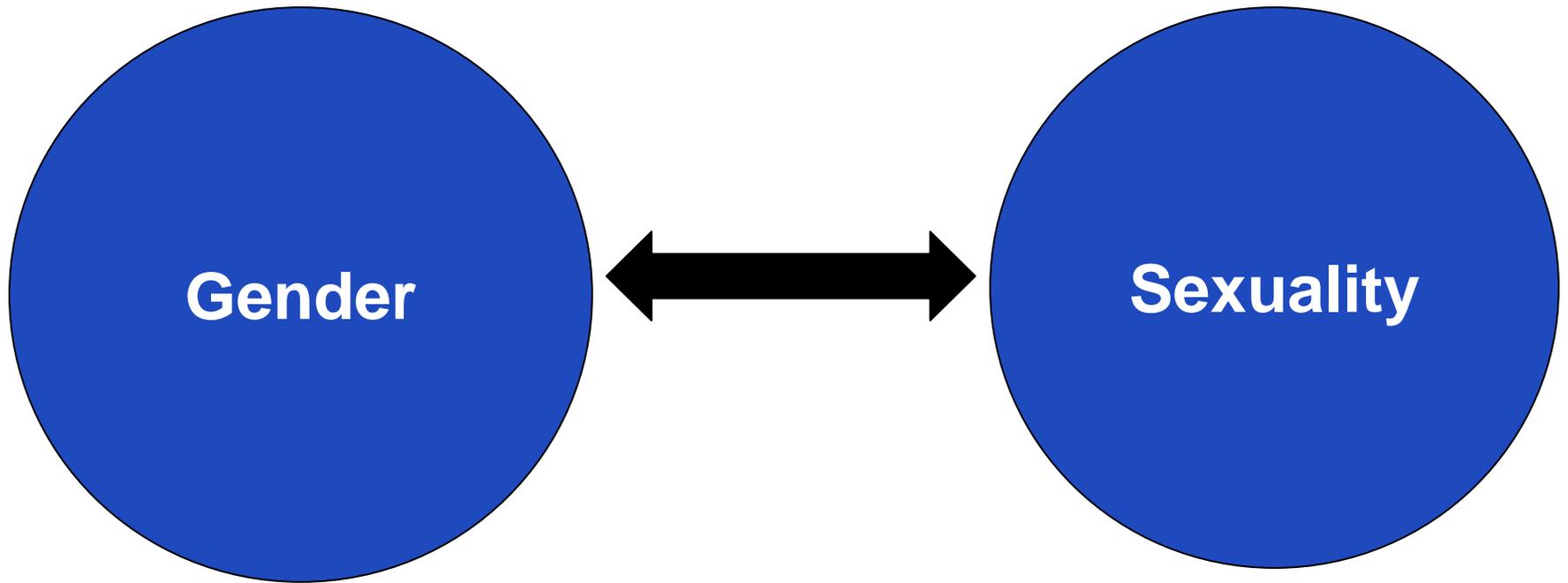


Different Domains of Gender Analysis





Gender and Sexuality Influence One Another





Practices, Roles, and Participation

Gender structures peoples' behaviors and actions —what they do (Practices), the way they carry out what they do (Roles), and how and where they spend their time (Participation).

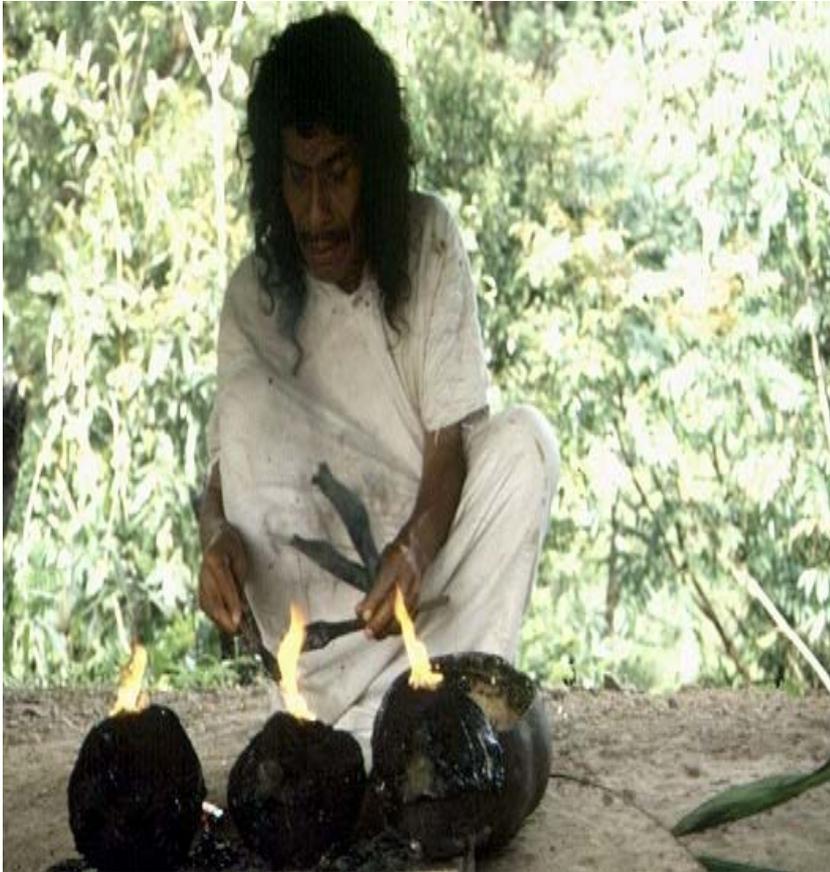
Participation

- Activities
- Meetings
- Political processes
- Services
- Training courses





Knowledge, Beliefs, and Perceptions



- **Knowledge** that men and women are privy to —*who knows what*
- **Beliefs** (ideology) about how men and women and boys and girls should conduct their daily lives
- **Perceptions** that guide how people interpret aspects of their lives differently depending on their gender identity



Access to Assets

The capacity to access resources necessary to be a **fully active and productive participant in society** (socially, economically, and politically).



Assets

- Natural and productive resources
- Information
- Education
- Social capital
- Income
- Services
- Employment
- Benefits



Legal Rights and Status

Refers to how gender affects the way people are regarded and treated by both **customary law** and the **formal legal code** and **judicial system**.



Rights

- Inheritance
- Legal documents
- Identity cards
- Property titles
- Voter registration
- Reproductive choice
- Representation
- Due process



Power

Gender relations influence **people's ability** to freely decide, influence, control, enforce, and engage in collective actions.



2005 Kevin McNulty, Courtesy of Photoshare

Decisions about ...

- One's body
- Children
- Affairs of household, community, municipality, and state
- Use of individual economic resources and income
- Choice of employment
- Voting, running for office, and legislating
- Entering into legal contracts
- Moving about and associating with others



In short, Gender Analysis reveals ...

Gender-based Opportunities

= gender relations (in different domains) that **facilitate** men's or women's access to resources or opportunities of any type.

Gender-based Constraints

= gender relations (in different domains) that **inhibit** men's or women's access to resources or opportunities of any type.

Moving from Analysis to Action: Lessons Learned

- Gender analysis needs to investigate gender relations across multiple domains and levels
- Sexuality across all of its dimensions needs to be explicitly included in gender analysis
- Prioritizing is key to the focus and depth needed to tackle underlying gender relations
- Successful gender-based interventions target at least two levels (are multi-level)



Example

- In Kenya, HIV programming for young women in slums
 - Increased attention to economic constraints
 - But neglect of sex and sexuality per se
- *“HIV is still being spread under the programming surface”*

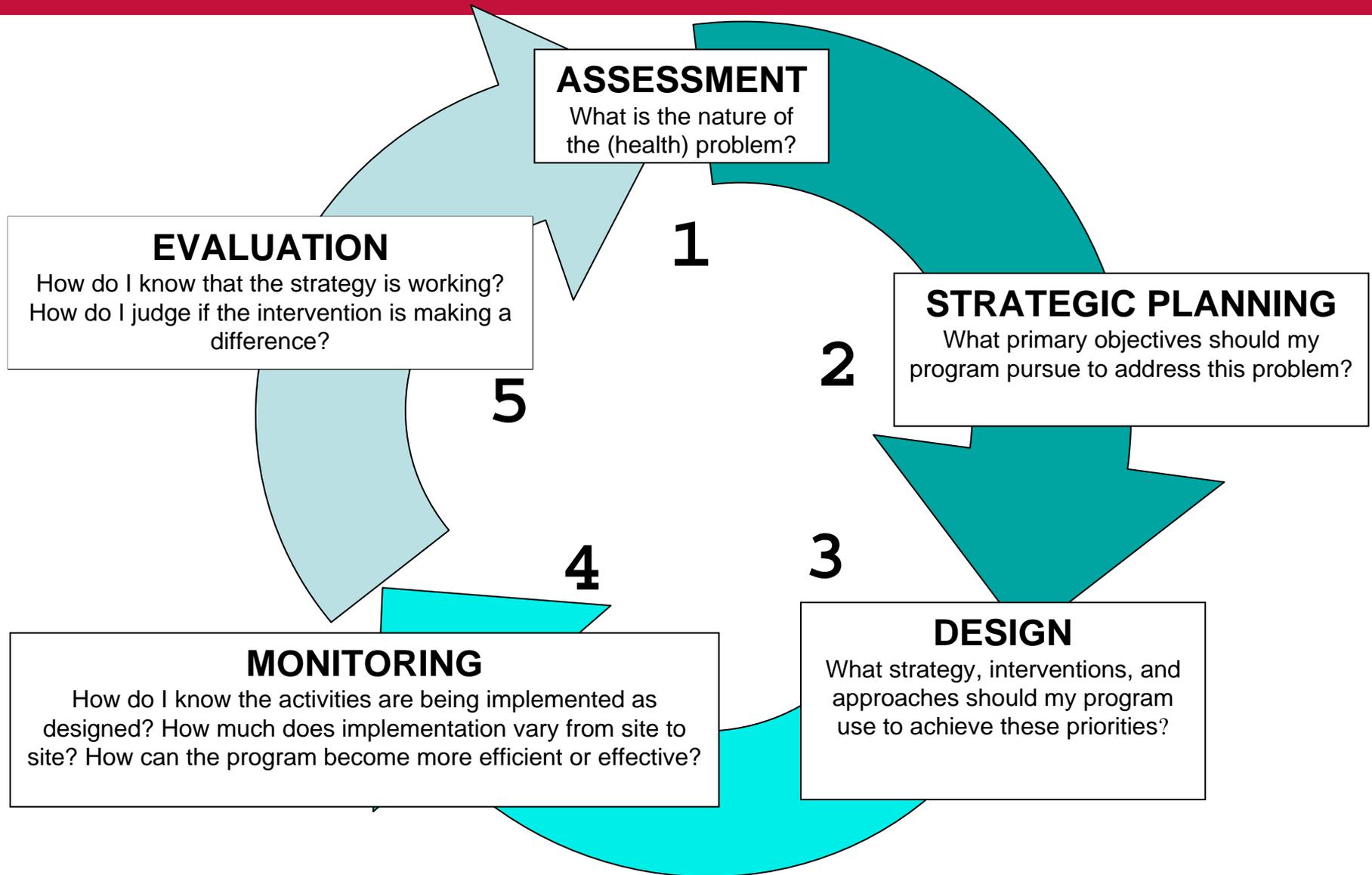
-Mohammed 2004



Integrating Gender into the Program Cycle



Strategic Information and Program Life Cycle



Moving from Analysis to Action: Practical Steps

Based on the analysis of gender constraints and opportunities . . .

1. Specify sub-objectives and activities
2. Tie indicators to change in specific gender constraints and opportunities



Integrating Gender Into Programming (Table 1)

Program goal and/or overall health objective: _____

Step 1: Conduct a gender analysis of your program by answering the following questions for your program goal or objective.

A. What are the key <u>gender relations</u> inherent in <u>each domain</u> (the domains are listed below) that affect women and girls and men and boys?	B. What other potential information is missing but needed about gender relations?	C. What are the <u>gender-based constraints</u> to reaching program objectives?	D. What are the <u>gender-based opportunities</u> to reaching program objectives?
<p>Be sure to consider these relations in different contexts—individual, partners, family and communities, healthcare and other institutions, policies</p> <p>Be sure to consider these gender relations as they affect different dimensions (circles) of sexuality.</p>			
<p>Practices, roles, and participation</p> <p>Knowledge, beliefs, perceptions (some of which are norms):</p> <p>Access to assets:</p> <p>Legal rights and status:</p> <p>Power and decision making:</p>			



Integrating Gender into Programming (Table 2)

Steps 2-5: Using the information you entered in Table 1, answer the following questions for your program goal/objective.

Step 2. What gender-integrated <u>objectives</u> can you include in your strategic planning to address gender-based opportunities or constraints?	Step 3. What proposed <u>activities</u> can you design to address gender-based opportunities or constraints?	Steps 4 & 5. What <u>indicators</u> for monitoring and evaluation will show if (1) the gender-based opportunity has been taken advantage of or (2) the gender-based constraint has been removed?



Small Group Work

Instructions for Exercise

- **Read your assigned case study, considering your group's focus**
 - **See flipchart for your group's details**
- **Complete Table 1, identifying gender-based opportunities, constraints, and missing information**
- **Complete Table 2, identifying gender sub-objectives, activities, and indicators**
- **Record highlights of your responses on flipchart paper**



Getting Started: Available Resources

- USAID Interagency Gender Working Group <http://www.igwg.org>
- USAID Global Health
http://www.usaid.gov/our_work/global_health/
- USAID Women in Development Office
http://www.usaid.gov/our_work/cross-cutting_programs/wid/
- PEPFAR Gender Technical Working Group



2006 Elizabeth Neason

Thank You!



Gender Continuum Examples: HIV and Sexuality



Human Rights and Sexuality Education for Women in Turkey

In Turkey, women's sexuality is considered taboo. Patriarchal norms about women's sexuality—including norms around virginity until marriage and the underlying cultural belief that women's bodies and sexuality belong to men, their families, or society—continue to legitimize human rights violations in the domain of female sexuality and sexual health. A women's health and human rights organization in Turkey runs a four-month human rights training for women, which concludes with modules on women's sexual and reproductive health, sexual rights, and pleasure. Sessions on sexual rights and pleasure are presented separately, following sessions on sexual and reproductive health and sexual violence, so as to dissociate sexuality from coercion and oppression and challenge the notion that women's sexuality and sexual health are limited to reproduction. One participant noted that, "Until I participated in this training, I didn't know that girls or women can feel sexual pleasure. Now I say, when women don't want to, they can say no. You want it, I don't and right now I'm not available. Men have to respect that. When it is forced, it is like rape."

Sexual Enrichment for Married Couples in Mozambique

An HIV prevention project in Mozambique sought to promote safer sex among married couples by tackling one of the reasons that husbands were having sex outside of their marriages—because they were bored with their sex lives at home. Preliminary research showed that men justified extra-marital sex by complaining that their wives would not agree to sexual experimentation, especially with regard to sex positions. Women, on the other hand, reported that, "I am never asked what I like in sex, if I like sex, and if I even want sex, so why should I do anything that gives him pleasure?" The project successfully advocated with local churches (including Catholic churches) by explaining to church-affiliated participants the importance of talking more openly about sex and helping them understand that open dialogue among married couples about sex and pleasure is not a threat to culture, religion, or people's sensibilities. Religious leaders supported the project, teaching couples about better sex by getting women and men to talk openly about what they like and do not like about sex in group and couple settings.

HIV-positive Mothers as Community Educators in Uganda

A group of HIV-positive mothers of small children came together to become advocates for prevention of mother-to-child transmission (PMTCT) and for positive mothers. The group encourages women to attend antenatal clinics, where they can access PMTCT services if they are positive. The group also educates positive mothers in their communities in life skills, PMTCT, infant care, and human rights. They use song, dance, and drama, as well as making appearances on television and radio, where they share their experiences as positive mothers and call for a reduction in stigma and discrimination. The peer educators also increase women's access to income by training positive mothers to look after their finances and generate income by tailoring, farming, and selling handicrafts. Finally, the group partners with HIV-positive men's networks to encourage men to value fatherhood and become involved in PMTCT.



Gender Continuum Examples: HIV and Sexuality



Gender-based Violence, Microfinance, and HIV Prevention in South Africa

A community-based intervention in South Africa combined a microfinance program with a gender and HIV curriculum. Its goals were to reduce HIV vulnerability and gender-based violence (GBV), promote women's empowerment, improve family well-being, and raise awareness about HIV. In the project, groups of five women guaranteed each other's loans, meeting every two weeks to discuss business plans, repay loans, and apply for additional credit. In addition, the groups took part in a participatory learning and action program with sessions on relationships, communication, cultural beliefs, gender-based violence, HIV prevention, critical thinking, and leadership. The microfinance groups elected leaders to participate in additional training on community mobilization. These leaders went on to organize dozens of community events to raise awareness on GBV and HIV.

Integrating HIV into Reproductive and Child Health Work in South India

The Government of India began integrating HIV into the National Rural Health Mission in April 2008. The government issued a circular to district Reproductive and Child Health (RCH) officers asking whether they were willing to work on HIV and report cases of HIV-positive women who came for antenatal care (ANC). One intervention developed subsequently aims to work to improve quality of antenatal care for HIV-positive women by addressing gender and quality of care issues. For example, special spousal counseling exists for women in ANC who test positive for HIV. The husband is encouraged to come in for a variety of tests, and the program divulges his status to him first. The program also puts HIV-positive women in contact with a lawyers' network and NGOs in the area that are working with people living with HIV. The program also introduces the woman and the healthcare worker to the specific obstetrician who will attend her labor and birth. This doctor gives the woman her fourth and extra ANC checkup in the third trimester and registers her name on the books to receive Nevirapine prophylaxis when she goes into labor.

Working with MSM in India

In India, men who have sex with men (MSM) face such severe stigma and discrimination in health settings, they find it difficult to access sexual health services, including STI and HIV counseling, testing, and treatment. An organization working on HIV prevention and mitigation established a pilot program to work with MSM. The group focused on *kothis*—biological males who adopt feminine behaviors and attributes, including normatively feminine sexual roles. The project established a place where they could come to meet and support one another, providing information on healthcare and other resources, training local healthcare providers on how to provide services to *kothis* in a sensitive manner, and organizing medical visits at the meeting space itself. The approach reflected the National AIDS Control Program's focus on high-risk groups including sex workers, truck drivers and



Gender Continuum Examples: HIV and Sexuality



MSM. In focusing on *kothis*, staff decided not to work with penetrators, whose numbers are much larger and who do not publically acknowledge having sex with men. They also made the decision to focus only on commercial sex workers and sexual activity occurring in public spaces.

Improving Maternal Health in Urban Slums in Delhi

A multi-pronged program to improve maternal and child health in several Delhi slums works on diarrheal case management, increasing institutional births, and increasing immunization, among other things. It conducts community outreach through the formation of women's groups focused on health and also has provided some limited access to credit. While women of reproductive age and children are the target of the program, it also reaches out to men as decisionmakers. The program runs local TV ads for services, encouraging men to support their partners in taking children for prevention and treatment, and also runs prevention messages directed at both men and women. The program reaches out to religious leaders and men at mosques on the subject of the need to take their wives for services.



Applying Gender Analysis to Health Programs



90 minutes

Objective: Apply a framework for gender analysis to real-world HIV program examples.

Materials

PowerPoint Slides 49–51 from the “Gender 101 Master Presentation”

Handouts: Tables 1 and 2, Integrating Gender into the Program Cycle

Handouts: Case Studies

1. Explain that to give participants a chance to practice integrating gender and sexuality into health programs, we have developed two worksheets to help guide this process. Hand out copies of Tables 1 and 2.

First, walk participants through Table 1, identifying the various components. Be sure to note that we will be paying special attention to sexuality in this exercise:

The gender analysis framework applies to all groups across different sexual orientations and gender identities.

We are talking about sexuality as a concept and framework that is broader than sexual orientations and gender identities. Thus, we are looking at how gender affects dimensions of sexuality that fit within each of the domains.

Certain gender domains link more strongly to different dimensions of sexuality, but the two frameworks do not match up perfectly. For example, legal rights and status may link most with SOGI, power and agency, and sexual and reproductive health; while access to assets is more closely linked with sexual behaviors and practices, and sexual and reproductive health. However, it is useful to keep both frameworks in mind to help identify opportunities and barriers for meeting your program objectives.

2. Ask participants to consider a concrete example (a case study that the facilitator has prepared in advance, a scenario from the movie, or their own project context).
3. Supply the participants with a sample overall program goal or health objective, written on a prepared flipchart).

For example, in the case of a safe motherhood (SM) program, a sample program objective could be —To ensure timely access to high-quality emergency obstetric care for all pregnant women. For this example, ask the participants to identify the following items, as per the columns in Table 1:

1st column—Key *gender* relations in each of the four domains plus power that can be identified from the case study or other specific context being considered. Probe to be sure that women and



Applying Gender Analysis to Health Programs



men are considered and that different levels are considered. (Record key highlights on a flipchart that looks like column A.)

2nd column—Having identified key information from the case study, ask participants to identify any additional/missing information that might help the program understand the gender barriers or constraints to safe motherhood. (Record highlights of missing information on a flipchart that looks like column B.)

3rd column—Gender-based constraints . . . for the women, for the men. Based on the gender relations identified, ask participants to identify which are *key gender constraints for the SM program (or the specific project being considered)*. Ensure that participants look across different domains and consider a few different levels. (Record several constraints on a flipchart that looks like column C.)

4th column—Gender-based opportunities for the woman, her spouse. Based on the gender relations identified, ask participants to identify any that could *be key gender opportunities for the SM program (or the specific project being considered)*. Ensure that participants look across different domains and consider a few different levels. (Record a couple on a flipchart that looks like column D.)

4. Direct participants to Table 2, explaining that, based on the gender analysis in Table 1, we can now consider specific sub-objectives, activities, and indicators. Walk participants through the use of Table 2, identifying the various components (and noting their ties to steps 2, 3, 4, and 5 of the program cycle).
5. Then ask participants to continue with the program example they have been using. Ask participants to choose one *priority gender-based constraint to the SM program (or other program being considered)* identified in Table 1. Related to this constraint, ask participants to identify the following:

1st column—A specific sub-objective related to a change they would like to see in this gender constraint. (Record on a flipchart that looks like the 1st column, Table 2.)

2nd column—One to two sample activities that could help achieve this objective. (Record on a flipchart that looks like the 2nd column, Table 2.)

3rd column—A sample indicator that would indicate a decrease in, or removal of, this gender barrier. (Record several indicators on a flipchart that looks like the 3rd column, Table 2.)

Question—Finally, ask the group to consider where on the IGWG Gender Integration Continuum they would place their brainstormed activities.

6. Ask participants if they have any questions or comments about Table 2 or the overall suggested process of using Tables 1 and 2.



Applying Gender Analysis to Health Programs



7. Review the instructions for the exercise (Slide 51 of the presentation and on the next page of this guide). Explain that groups will have 1 hour to complete both Tables 1 and 2 and that each group should complete both tables for its case study. (However, each group only needs to prepare flipcharts and present on one of the two tables, as assigned per the instructions on the presentation slide.)

Instructions for Exercise

Read your assigned case study

Groups 1A and 1B—Case study 1 (fill in)

Groups 2A and 2B—Case study 2 (fill in)

Complete Table 1, identifying gender-based opportunities, constraints, and missing information

Complete Table 2, identifying gender sub-objectives, activities, and indicators

Record highlights of your responses on flipchart paper

Groups 1A and 2A—Table 1

Groups 1B and 2B—Table 2

What did you think of this framework and exercise?

How will/can you apply this framework to your current project work?

Ask for final questions.

Facilitation Alternative: Depending on the workshop's objective(s), the facilitator may prefer to structure this exercise so that groups work directly on their own real project examples rather than sample objectives from other sources. In this case, the facilitator should determine ahead of time three to four relevant project examples with clear objectives and assign one to each group.

Table 1: Data Collection and Analysis

Program goal and/or overall health objective: _____

Step 1: Conduct a gender analysis of your program by answering the following questions for your program goal or objective.

A. What are the key <u>gender relations</u> inherent in each <u>domain</u> (the domains are listed below) that affect women and girls and men and boys?	B. What other potential information is missing but needed about gender relations?	C. What are the <u>gender-based constraints</u> to reaching program objectives?	D. What are the <u>gender-based opportunities</u> to reaching program objectives?
<p>Be sure to consider these relations in different contexts—individual, partners, family and communities, healthcare and other institutions, policies. Be sure to consider these gender relations as they affect different dimensions (circles) of sexuality.</p>			
<p>Practices, roles, and participation:</p> <p>Knowledge, beliefs, perceptions (some of which are norms):</p> <p>Access to assets:</p> <p>Legal rights and status:</p> <p>Power and decisionmaking:</p>			



Facilitator Resource: List of Illustrative Program Examples Related to Gender, Sexuality, and HIV



The facilitator can use these examples to amplify speaker notes for the PPT “Gender, Sexuality, and HIV: So What?” and also the sexuality examples referenced in the Gender Analysis and Integration section of the master “Gender 101 PPT” presentation. The speaker notes refer to these examples where they might be most appropriate to include, but further details for many of these examples are found below.

Neglected dimensions of sexual pleasure, practices, and intimacy (and programming opportunities):

- **Example 1: Sexual pleasure within marriage in Mozambique.** An HIV prevention project in Mozambique sought to promote safer sex among married couples by tackling one of the reasons that husbands were having sex outside of their marriages—because they were bored with their sex lives at home. Preliminary research showed that men justified extra-marital sex by complaining that their wives would not agree to sexual experimentation, especially with regard to sex positions. Women, on the other hand, reported that, “I am never asked what I like in sex, if I like sex, and if I even want sex, so why should I do anything that gives him pleasure?” The project successfully advocated with local churches (including Catholic churches) by explaining to church-affiliated participants the importance of talking more openly about sex and helping them understand that open dialogue among married couples about sex and pleasure is not a threat to culture, religion, or people’s sensibilities. Religious leaders supported the project, teaching couples about better sex by getting women and men to talk openly about what they like and do not like about sex in group and couple settings. (Philpott et al., 2006, p. 26)
- **Example 2: Research with sex workers in Cambodia** discovered that sex workers did not use condoms because there would not be enough lubrication during repeated sexual intercourse unless semen was present—and that lack of lubrication was also a reason MSM were not using condoms. Research findings resulted in new packaging of condoms with lubricants and attention to the lubricants being high quality and pleasing to use (with a nice smell and consistency, in addition to being water-based). (Philpott et al., 2006, pp. 26–28)
- **Example 3: Work with Nicaragua’s Men Against Violence network** included not only tackling violence perpetuated by men and others, but “encourages men to discover the pleasures of tenderness, intimacy, and equality in both sexual and nonsexual relations.” (Correa and Jolly, 2008, p. 38)
- **Example 4: People living with HIV** may experience difficulties related to libido and sexual arousal due to a combination of factors, including depression and side-effects of medication. Fear that treatment may produce (further) challenges with sexual performance may be a factor in non-adherence. Some evidence suggests that sexual difficulties may increase unprotected anal sex for MSM (Mao et al., 2009). The opportunity and importance of sexual pleasure to the well-being of PLHIV and their partners, or to specific program areas like treatment adherence, is often explored only within circumscribed settings (such as positive living courses) and not linked to broader programming efforts and priorities.



Facilitator Resource: List of Illustrative Program Examples Related to Gender, Sexuality, and HIV



Social construction of sexuality (and mis-assumptions in programming):

- **Example 5: Meaning of monogamy.** Research in the 1990s showed that for many young people ‘monogamy’ meant serial monogamy (Boyce et al., 2007, p. 17).
- **Example 6: Practices to maintain abstinence.** Campaigns designed to encourage ‘abstinence’ have not considered how sex is defined; young women and men may engage in anal intercourse, considering it a means to ‘preserve virginity’ as well as to protect against pregnancy (Gupta, 2002).
- *See also Example 1 above* (for mis-assumptions—about lack of condom use in sex work).

Linking challenges to underlying homophobia and gender inequality:

- **Example 7: Proyecto D (Diversidad) in Brazil** is a forthcoming addition to the prior resources from Instituto Promundo. The other resources are Proyecto H—their well-known and evaluated resources for programming for men and boys (hombres); and Proyecto M—programming for women and girls (mujeres). Proyecto D focuses on developing tolerance for sexual diversity, building on the recognition of the foundational role that homophobia plays in the construction of masculinities and gender inequalities. A currently available companion video, *Afraid of What?* is available through the Instituto Promundo website, available at <http://www.promundo.org.br/en/for-youngers/>.
- **Example 8: Strategic Alliance between MSM and HIV-positive Women in Mexico.** The POLICY project helped to foster policy dialogue and recognition of the links between sexism and homophobia, which resulted in an explicit strategy articulated within Mexico’s national HIV strategy to pursue a linked approach of working with both positive women and MSM communities (HPI, 2010). The Health Policy Initiative has also fostered policy dialogue and planning to foster linkages between health services’ responses to gender-based violence faced by women and by MSM/trans (Betron, 2009).

Investing in analysis and capacity building:

- **Example 9: Participatory Learning and Action with Truck Drivers in India.** The program example of CARE & ICRW’s work through ISOFI in India combined ongoing staff reflections and capacity building related to sexuality and gender; the program also used participatory learning and action activities to unpack sexuality and gender in the lives of community members. This work with mobile men (working in the long-distance trucking industry), for instance, enabled exploration of male sexual pleasure and power . . . and eventually led to an understanding of different forms of sexual practices, including ‘cab sex’ with junior, male truck conductors. Building on the space created for understanding these relations, the project then was able to design HIV prevention interventions that addressed these specific practices (CARE, 2007, pp. 48–49).



Facilitator Resource: List of Illustrative Program Examples Related to Gender, Sexuality, and HIV



Citations:

Betron, M. 2009. *Screening for Violence against MSM and Transgenders: Report on a Pilot Project in Mexico and Thailand*. Washington, DC: Futures Group, USAID | Health Policy Initiative, Task Order 1.

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Case Study: Considering Gender based Violence in Training for Voluntary Counseling and Testing in India



Project Objectives:

- 1) Increase VCT providers' understanding of links between GBV and VCT.
- 2) Increase providers' ability to screen for GBV pre- and post-testing.

Context

Voluntary Counseling and Testing (VCT): In India, as in other regions, women primarily access HIV counseling and testing in the context of antenatal care. Because of women's contact with the health system through antenatal care, they are disproportionately tested for HIV: one study from India of 800 adult men and 800 recently pregnant women found that, even though women were more than 80 percent less likely than men to be aware of HIV testing facilities or the existence of HIV testing and counseling, women were more than twice as likely to have had an HIV test (Khale et al., 2008 in Gay et al., 2010). Though this means many women have access to testing, it may also imply that non-pregnant women may have insufficient access to VCT. Further, there is some evidence that testing may be less than voluntary—a review of literature from 1980 to 2008 on health services in rural India found that “men sought testing out of personal concern, whereas women utilized testing on the recommendation of, and in some cases reported mandatory testing by, their antenatal provider” (Sinha et al., 2009 in Gay et al., 2010).

The disproportionate testing of women also means that women often bear the burden of status disclosure to men, which carries the risk of stigma, abandonment, and violence (Greig et al., 2008 in WHO, 2006). Not only does opt-out testing in the context of antenatal care place undue burden on women for disclosure, it may also keep some women from accessing antenatal care if they fear being tested or fear confidentiality violations if tested positive. This may be especially true for HIV-positive women, as these women are more likely to choose to opt out of testing (Aziz, 2010).

Gender-based Violence (GBV) and VCT: Gender-based violence (GBV) is prevalent in India. As of 2006, more than 37 percent of ever-married women had experienced physical or sexual abuse by a spouse at some point during their lives (IIPS and Macro International, 2007). GBV is also a critical barrier to VCT. Fear of violence may prevent women from seeking or consenting to testing, returning for test results, disclosing a positive result to their partners, or seeking treatment if they are found HIV positive.

Women who do disclose a positive HIV status risk stigma, abandonment, and GBV, especially as they may be accused of infidelity or blamed for bringing the infection into the relationship. Data from other regions suggests that serodiscordance in long-term couples can also result in violence and abandonment of women. Further, a study from South Africa found that intimate partner violence and low relationship power greatly increase women's HIV risk (Jewkes et al., 2010), which suggests that women who test positive may already be more likely to experience violence. Disclosure of a positive HIV status thus carries the potential for



Case Study: Considering Gender based Violence in Training for Voluntary Counseling and Testing in India



a number of negative consequences, including violence.

While data on violence following disclosure do not exist specifically for India, data do suggest that women in India fear the consequences of HIV testing: a comparative study in four Asian countries (India, Indonesia, the Philippines, and Thailand) found that men were more likely to be tested if they had HIV-related symptoms, whereas women were more likely to be tested if their partner tested positive first. Additionally, women who tested HIV positive were more likely than men to be excluded from social interactions and events, forced to change residences, or be physically assaulted (Paxton et al., 2005 in Gay et al., 2010).

Project Description

A university-affiliated nongovernmental organization (NGO) has been providing HIV-related capacity building to government and private healthcare providers for the last five years in South and Southeast Asia. Workshops range from two weeks to two months and are tailored to meet the needs of specific organizations and established programs. The organization has provided capacity building on issues such as stigma and discrimination, HIV counseling, care and support, and research.

Since 2001, the organization has initiated an annual 10-week advanced certificate program for service providers in India on HIV counseling and psychosocial interventions. This has been a core training activity for the organization. The entire certificate program is structured into seven modules of 30 hours each.

The organization would like to integrate a focus on gender and GBV in the context of VCT, including training providers to screen for violence in pre- and post-test counseling and to counsel patients on options for disclosure. The training also aims to teach skills in setting up support and self-help groups for HIV-positive people and their partners.

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Integrated Gender Strategies to Address HIV Vulnerability of Adolescent Girls in Urban Low income and Slum Areas:¹ Ethiopia



Overall project goal

- Reduce the vulnerability of adolescent and young women (ages 10–19) living in urban low-income and slum areas to adverse social and reproductive health outcomes, including HIV.

Project objectives

- Improve adolescent girls' livelihood options.
- Provide education and services to adolescent girls experiencing violence and coercion.
- Increase knowledge and access to adolescent and reproductive health services, including STI/HIV testing and use of contraception and condoms.
- Increase social cohesion and capital among marginalized young women.

Context

The HIV epidemic in Ethiopia is concentrated in urban areas, with prevalence in urban settings estimated at 7.7 percent. Differential infection rates are particularly great among younger age groups, though prevalence rates are low. For example, among youth ages 15–19, for every one HIV-positive male there are seven HIV-positive females.

Many adolescent girls residing in urban city slums experience a number of vulnerabilities to their reproductive health and well-being. Recent survey results² identify the most vulnerable girls in urban areas to be those who are out of school and migrants. The survey results indicate that 43 percent of girls in slums areas were migrants from rural areas, compared to 29 percent of boys. Most adolescent girls residing in the slums migrated as a result of having left rural communities to seek better economic opportunities; some migrated to avoid (or escape) forced early marriages. Twenty-nine percent of adolescent girls surveyed who were living in urban slum areas reported coerced first sex; of these, 76.4 percent were migrants.

Social networks among recent migrants, although not strong, often link adolescent girls to work in households as domestic help. In a recent survey, of the 69 percent of recent female migrants who had worked for pay, most (72%) were in domestic work. A few adolescent women (0.7%) report that they engage in sex work. Sex workers appeared to have more income (US\$51.50) and greater control of their income compared to girls in other professions. Sex workers, as well as girls working in bars and restaurants, were more likely to report being harassed at work and feeling that their work could harm their health. On the other hand, domestic workers reported less harassment but worked for much less pay than girls in other professions (US\$7.50 per month); there is some question about under-reporting of harassment and sexual exploitation, especially among younger girls in domestic work. Girls report transactional sex, especially feeling obligated to provide sex in exchange for gifts provided by boyfriends. An additional vulnerability is young women's legal status. Because of their distance from home, it can be difficult for young women to acquire government ID cards.

Respondents were knowledgeable about basic information related to HIV/AIDS; 91 percent knew that a healthy looking person can still be infected, and 87 percent knew that there is no



Integrated Gender Strategies to Address HIV Vulnerability of Adolescent Girls in Urban Low Income and Slum Areas¹



cure for HIV/AIDS. Yet, exposure to HIV prevention messages was relatively low. Peer education had reached only 8 percent of respondents, and only 6 percent had visited a youth center—both potential mechanisms for receiving information about HIV. More than half (56%) reported having no friends. Only 12 percent of girls reported having a safe place to go in their community to meet their female friends. Participation in social events was low, although more than half (56%) reported attending a coffee ceremony in the past week.

A programmatic scan shows that most existing adolescent HIV prevention efforts educate about reducing risky premarital sexual behavior and encourage participants with the “just say no to sex” slogan. Yet, these efforts overlook the context of sexual behavior. Staff highlight the economic needs that promote young women’s unprotected activity, often in coerced situations. Project staff from current adolescent reproductive health programs also suggest additional reasons that some young women enter into sexual relations. In particular, some staff express dismay that young women may be encouraged to exchange sex for money and gifts, not only to meet everyday needs, but also for companionship, for the pleasures that can be involved,³ and for access to luxuries, such as current fashionable clothing.

Project description

The program is considering an intervention model using savings, group-based credit, and adult mentors to reach young women with livelihood and social support.

The program will use a model of group savings that, once a minimum balance has been met, can then be used for small loans. The program will also pilot new models of focusing on the savings-only group for groups with younger girls. (Earlier programmatic experience showed that, especially for the most vulnerable and younger women, lack of flexibility in access to loans during emergencies may have contributed to drop-out and, in some cases, potentially increased their vulnerability).⁴

To reach young women with reproductive health information, mentors will also periodically organize large seminars with invited guest speakers on topics such as HIV and AIDS, prevention of mother-to-child transmission (PMTCT), voluntary HIV counseling and testing, the role of nutrition in HIV management, drug and substance abuse, relationships, child rights, violence against women, and business management.

¹ This is a composite case study. While set in Ethiopia, it draws upon integrated gender programming examples from the Biruh Tesfa project in Ethiopia and TAP and Reposition Youth (TRY) and Binti Panoji projects in Kenya, as cited in International Center for Research on Women [ICRW] (May 2009), *Integrating Multiple Gender Strategies to Improve HIV and AIDS Interventions: A Compendium of Programs in Africa*, Washington, DC. Supplementary information related to livelihoods and adolescent girls was also provided by Caro, D. 2009. *Livelihood Options for Girls: A Guide for Program Managers*. Washington, DC: USAID/Health Policy Initiative, Task Order 1.

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Integrated Gender Strategies to Address HIV Vulnerability of Adolescent Girls in Urban Low income and Slum Areas¹



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⁴ See the description of lessons learned from the TAP and Reposition Youth (TRY) intervention description in Kenya in ICRW (May 2009), *Integrating Multiple Gender Strategies to Improve HIV and AIDS Interventions: A Compendium of Programs in Africa*. Washington, DC, pp. 69–74.



Screening for Gender based Violence against MARPs in HIV Clinics: Thailand



Men who have sex with men (MSM) and transgender people (TG) have very high HIV prevalence rates. Gender-based violence (GBV) may be a key factor in these groups' vulnerability to HIV, especially in the context of sex work. To date, few interventions have addressed this vulnerability factor, especially in the context of healthcare services. A nongovernmental organization (NGO) wants to pilot test a tool and protocol in Thailand for screening MSM and transgender people, including male and transgender sex workers, for GBV in the context of HIV services.

Objective

Develop and pilot an intervention to integrate screening for GBV against MSM and transgender people into the context of existing HIV services.

Context

Violence experienced by MSM and TG is considered GBV because it is a manifestation of stigma and discrimination against these groups primarily due to the fact that they do not fit into traditional gender categories. For example, a study of male and transgender sex workers in Bangladesh found that, of those who had been raped, 87 percent said they were raped because they were effeminate. GBV against MSM and transgender people may take numerous different forms, including violence from community and family members, intimate partner violence, rape and sexual coercion, and police abuse, among others.

Limited information exists on violence against transgender people and MSM in Thailand, but global data suggest that GBV is a frequent experience of these groups. Studies from the United States and Latin America, for instance, found that rates of intimate partner violence among MSM and transgender people are similar to the rates in heterosexual couples.

Sexual coercion is another prevalent form of GBV against MSM and TG—in a study of 2,000 MSM in Thailand, 18 percent reported that they had been coerced to have sex; 67 percent of those were coerced more than once.

Abuse of MSM and transgender sex workers also is alarmingly high. A study of 475 sex workers in five countries, including Thailand, found that 63 percent had experienced sexual abuse. Reports from around the world indicate that police may abuse or extort money from sex workers (female, male, and transgender). This is especially pertinent in contexts where sex work is criminalized, as sex workers have little recourse against police abuse because sex work is an illegal behavior.

Just as GBV increases women's HIV vulnerability, so does GBV put MSM and TG at greater HIV risk. Forced or coerced sex poses a risk of HIV, especially as it may produce greater tearing, which increases the likelihood of HIV transmission. Further, studies from around the world suggest that MSM and trans who experience GBV are less likely to use condoms. Stigma, discrimination, and related loneliness may also push MSM and TG to avoid HIV prevention strategies.

Further, GBV decreases health seeking behavior, as feelings of shame and self-blame may prevent MSM and TG from seeking help or reporting the violence to a health provider. Stigma and discrimination from providers—based on gender, gender identity, and sexual orientation—may decrease access of MSM and transgender people's to HIV counseling, testing, and treatment.

Project Description: An NGO wants to pilot a screening tool to identify GBV among MSM and trans, and identify opportunities to improve access and quality of HIV services for these vulnerable



Screening for Gender based Violence against MARPs in HIV Clinics: Thailand



groups. The project chose four sites to pilot the tool: 1) an urban hospital; 2) a peri-urban STI clinic; and 3&4) two urban drop-in VCT centers supported by MSM and TG activist groups: one for MSM and one for transgender people. In the first two sites, providers have little knowledge and offer few services that specifically address the needs of MSM and transgender people, while the two VCT centers tailor their services specifically to the needs of MSM and transgender people, and maintain good relationships with social and activist groups of MSM and TG.

Preliminary qualitative research found that health facilities in general are not traditionally seen as safe spaces for MSM, TG, or sex workers. However, providers in all facilities responded with interest in treating these groups better and learning more about their needs.

The project intends to hold workshops for clinicians to teach them links between GBV and HIV as relevant to MSM and transgender people and train them to implement a screening tool (which was adapted from tools intended to screen women for GBV). The project also wants to hold referral planning sessions among clinicians, community groups, and other service providers but is unsure of whether to include the police in the referral network planning sessions, given that they can be key perpetrators of violence against MSM and transgender people.

After the workshops are conducted, providers will screen approximately 600 MSM and transgender clients in 10 weeks. Screening will be integrated into routine clinical care services and VCT programs in each service setting.

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Case Study: PMTCT Programming in Country Zed¹



As in many countries, Country Zed's PMTCT programs continue to find it difficult to facilitate women's access to prevention of mother-to-child transmission (PMTCT) services.

Program Goal: Expand access to and benefit from a full range of PMTCT interventions to

- Reduce the number of babies born with HIV
- Improve the health of pregnant and new mothers living with HIV, as well as their babies' health
- Fight the stigma associated with HIV, and encourage and support disclosure

Proposed Objective and Strategy: The program has decided to pursue two strategies to increase women's willingness to test, seek results and, if positive, follow through on prophylaxis, infant feeding recommendations, and their healthcare needs. These strategies are to (1) train peer counselors to provide education and psychosocial support to HIV-positive pregnant women, as well as follow up with women after delivery; and (2) involve men in couples counseling.

Available Background Information

The most recent Demographic and Health Survey reported high utilization (90%) of antenatal care by pregnant women, but only 47 percent deliver at a health facility. Most women have at least some primary schooling. Only 40 percent have access to piped water or electricity. More than half report no independent income. More than half of the women report having a partner or husband.

Country data from the WHO Multi-Country Study on Domestic Violence and the Domestic Violence Report in country Zed show the following: 41–56 percent of ever partnered women ages 15–49 had experienced physical or sexual violence from an intimate partner; 17–25 percent had experienced severe physical violence; and of these instances of severe physical violence, one-third to one-half had occurred during the past year.

In the context of pregnancy, it is becoming increasingly clear that this is a time of risk for acquiring sexually transmitted infections (STIs). Data suggest that it is not uncommon for male partners to have a sexual network with non-regular partners during the postnatal period; in addition, condom use with non-regular partners is low and with regular partner is even lower. There have been some recent poster campaigns with slogans like “test for the health of the next generation,” showing pictures of a pregnant woman holding a newborn baby. Yet, although antenatal care (ANC) use is high, a recent focus group shows that women have limited understanding of specific PMTCT interventions during pregnancy and after birth, and of their availability at the local health clinic.

When asked about their reactions to information about the importance and availability of specific medicines and recommended exclusive infant feeding practices, women expressed uncertainty about the effect of these recommendations on their pregnancy and the health of the infant. A number of women expressed feeling that women who are HIV positive should



Case Study: PMTCT Programming in Country Zed¹



not have any more children. Regarding testing for HIV, women responded with more interest about knowing their status in the context of benefits for how to protect themselves from infection (in case the result was negative) or the possibility of seeking care in case they were already infected. It is significant that when asked about primary reasons to find out their status, their concerns about a child being infected during pregnancy constituted only 11 percent of responses.

A woman is expected to seek permission from her partner before testing. Women believe that testing without his permission will increase conflict. Men feel free to make their own decisions about whether to test or not without their partner's permission and rarely disclose their status to their partners.

Men are reluctant to use testing sites close to their own communities for fear of lack of confidentiality. They also consider pregnancy to be too late for testing for themselves and their partners. They argue that a woman who is positive should not have any more children. If positive himself, however, he is unlikely to disclose, and will still desire more children. Men say that access to antiretrovirals (ARVs) would be a great incentive for them to agree to testing for themselves and their partners, even if the ARVs were provided only to their babies or their partners.

In the community, many people believe that if one parent is HIV+ both parents will be HIV+, and that children born will be HIV+ as well. HIV-related stigma in the community remains high—and directed at the person who first tests and discloses their status. More women than men know their HIV status, with most women tested during pregnancy. For women who reveal their HIV-status, it has not been uncommon to be abandoned and many have feared abuse by their male partners.

Both men and women in the community report that a family's health information is supposed to be brought in to the family by the man. Women's are not regarded as reliable sources of information. Men are also supposed to be the decision-makers in the family. Men see male community leaders and also health care providers as legitimate sources of information. Yet, men generally do not accompany their partners to family planning, antenatal or postnatal care services and would not be expected to attend the labor or birth of their child. Birth, delivery and care of infants are seen as exclusive purview of women, although men are increasing their involvement in sharing childrearing responsibilities as fathers with children once they become toddlers and above.

Women do discuss and health and relationship issues with other women in the community – and find other women and important source of social support, and practical information for women especially related to women's and children's health. However, this communication and use of information occurs separately among women, and is not directly brought in to the household.



Case Study: PMTCT Programming in Country Zed¹



Health care providers in the public sector have limited time to be able to provide much information and counseling to their clients. Overburdened by continued migration of health care staff as well as absences due to their own and family illnesses, midwives and nurses are stretched too thin to provide just the minimum standard of clinical care.

¹ This case study is a composite of data drawn from Baek et al. 2007 *Key Findings From an Evaluation of the Mothers2 Mothers Program in Kwazulu-Natal, South Africa*. Washington, DC: Population Council and Horizons Trust, Burke et al. n.d., *Male Participation in PMTCT Programs in Tanzania*, PPT Presentation, and additional findings from other country experiences. Thus, this case study and its data should not be taken as representative of any particular country or PMTCT intervention.