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PEPFAR MALAWI GENDER ASSESSMENT REPORT (2015)

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PEPFAR Malawi Gender Assessment Report (2015)

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Executive Summary

The President's Emergency Plan for AIDS Relief (PEPFAR) in Malawi contributes to a robust national strategic agenda that seeks to integrate gender equality priorities more fully into national HIV and AIDS programs and planning, including in meeting Joint United Nations Programme on HIV/AIDS (UNAIDS) 90-90-90 targets. Gender-related social norms, violence, and power dynamics that limit decision-making and access to resources among women and girls, and that stigmatize and marginalize key populations such as sex workers and men who have sex with men (MSM), put these groups at greater risk of acquiring HIV. These factors affect how individuals access health and social services, including their decisions and ability to seek and adhere to HIV treatment. Men and boys also face gender-related risk factors and barriers to services, and need to be specifically targeted through comprehensive HIV and AIDS programming.

To support this national gender and HIV agenda in alignment with PEPFAR 3.0, PEPFAR Malawi commissioned a gender assessment to (1) review current national gender and HIV data, analyses, and programming and (2) develop recommendations for addressing gender barriers as a part of its COP16 (2016 Country Operational Plan) programming and beyond. The assessment, conducted in November and December, 2015, was designed to supplement recent national assessments and focus on PEPFAR Malawi stakeholder priorities. The Health Policy Plus (HP+) project team team used a desk review, key informant interviews, and a stakeholder consultation meeting (held on November 23, 2015) to gather information from donors, development partners, and community members working in gender and HIV.

Findings pointed to a range of recommendations at the policy, community, and clinical levels:

- At the national policy level, PEPFAR and implementing partners should identify and coordinate around advocacy opportunities to ensure the finalized *HIV and AIDS Prevention and Management Bill* enshrines principles of gender equality and nondiscrimination, and to ensure that these principles are carried forward into its enforcement.
- More support is needed, particularly at the subnational level, to move from national policy commitments to implementation. At the district level, this includes supporting implementing partners and national policymakers to develop and disseminate operational guidance and to strengthen capacity and leadership for gender programming. At the facility level, there is a need to increase provider awareness and standardize monitoring and reporting on gender-sensitive care and nondiscrimination, including through current supportive supervision programs and district and health facility ombudsmen.
- Community-based social and behavior change programming is an important area for ongoing investment to facilitate access, retention, and adherence to services, and to address damaging norms and practices that contribute to specific populations' vulnerabilities to early and unwanted sex, gender-based violence (GBV), and restricted access to services. These activities must explicitly include older and married men and adolescent girls among their target populations.
- Current community-based interventions to reach specific underserved populations require more locally-specific evaluation to understand their intended and unintended effects on all gender groups. Recommended interventions for evaluation include
  - An evaluation of how the use of community bylaws and penalties to incentivize men's access to HIV testing and counseling (HTC) affects men's and women's follow-up on treatment, and whether such measures create unintended barriers to access for women whose partners are unable or unwilling to comply; and

  - A formal assessment of how PEPFAR-supported youth-centered HIV prevention and adherence support programs are reaching teenage girls and boys differently, in order to reduce gender gaps in participation.

- National network partners such as the Coalition of Women Living with HIV/AIDS in Malawi (COWLHA), the Malawi Network of AIDS Service Organisations (MANASO), the Malawi Network of People Living with HIV/AIDS (MANET+), and the Centre for the Development of People (CEDEP) can play a pivotal role in coordination and advocacy, and should be leveraged to identify strong community-based organizations and local champions for gender programming and research.

- Malawi has been a pioneer in the implementation of Option B+, but more can be done to support women who are offered Option B+ in making safe, informed decisions about disclosure of HIV status to their partners and adherence to treatment. Research is currently underway with PEPFAR funding to understand what happens to women who are lost to follow-up. This research can be used to identify current, scalable practices that effectively address women's family and psychosocial needs. Practices that pose barriers to adherence should be explicitly documented and systematically eliminated from facility level interventions. PEPFAR may wish to support implementing partners to train district health officers and service providers based on these findings.

- Use the 2015 launch of a newly branded female condom as an opportunity to refocus programmatic investments to support community sensitization and more targeted distribution of female condoms, in alignment with efforts to improve overall female acceptance and agency regarding condom use.

- Many male involvement strategies that promote partner accompaniment risk disempowering or stigmatizing women. Non-coercive approaches to encouraging HTC for men and couples counseling need to be reinforced at both community and facility levels. Health facility structures and communications programming need to be designed to address the privacy and information needs of both male and female clients.

- Pre- and in-service training for providers must more systematically incorporate sensitization and clinical protocols for identifying and responding to cases of GBV, as well as ensuring medically appropriate, non-discriminatory services for key populations.

- Improved data collection is needed to inform policies and programming targeting specific key (or vulnerable) population groups that are frequently overlooked in programming, including not only MSM and sex workers, but also other lesbian, gay, bisexual, transgender, and intersex (LGBTI) persons, and prisoners. As PEPFAR supports further research in this area under LINKAGES, it is important that dialogue around new policies and programs is not limited to groups for which more evidence is available, as gaps in data are likely among groups such as transgender persons or adolescent sex workers.

- There is a need for improved sex- and age-disaggregated data on adolescents and youth. Gaps in data on young adolescents are particularly evident, and issues related to gender, stigma, and adherence must be better understood for individuals across the pediatric and adolescent HIV treatment cascade. An analysis of gaps and bottlenecks across the cascade, in combination with available research on how stigma and other family and social barriers affect uptake of YFHS, can further inform community- and school-based programming, as well as sensitization of service providers.

- Building upon the Gender and Sexual Diversity trainings conducted by the Health Policy Project for PEPFAR in 2015, there is a need to expand these trainings to reach implementing partners and strengthen not only awareness of the social and health needs of gender and sexual minorities, but also practical, programming capacity to systematically address those needs.

Abbreviations

AIDS	acquired immune deficiency syndrome
ART	antiretroviral therapy
ARV	antiretrovirals
CBO	community-based organization
CCM	Country Coordinating Mechanism
CDC	Centers for Disease Control and Prevention
CEDEP	Centre for the Development of People
COP	country operational plan
COWLHA	Coalition of Women Living with HIV/AIDS in Malawi
CSO	civil society organization
DFID	U.K. Department for International Development
DNHA	Department of Nutrition, HIV and AIDS
DREAMS	Determined, Resilient, Empowered, AIDS-free, Mentored, and Safe Women initiative
FPAM	Family Planning Association of Malawi
GBV	gender-based violence
GEWE	Gender Equality and Women Empowerment
Global Fund	Global Fund to Fight AIDS, Tuberculosis and Malaria
GNP+	Global Network of People Living with HIV/AIDS
HIV	human immunodeficiency virus
HP+	Health Policy Plus
HPP	Health Policy Project
HTC	HIV testing and counseling
LGBTI	lesbian, gay, bisexual, transgender and intersex
MANASO	Malawi Network of AIDS Service Organisations
MANET+	Malawi Network of People Living with HIV/AIDS
MDHS	Malawi Demographic and Health Survey

MOE	Ministry of Education
MOGCDSW	Ministry of Gender, Children, Disability and Social Welfare
MOH	Ministry of Health
MSF	Médecins Sans Frontières
MSM	men who have sex with men
NAC	National AIDS Commission
NGO	nongovernmental organization
NSP	National Strategic Plan for HIV and AIDS (2015–2020)
PEP	post-exposure prophylaxis
PEPFAR	The President's Emergency Plan for AIDS Relief
PLHIV	people living with HIV
PMTCT	prevention of mother-to-child transmission
PWID	people who inject drugs
SAT	Southern African AIDS Trust
STI	sexually transmitted infection
SRH	sexual and reproductive health
UNAIDS	Joint United Nations Programme on HIV/AIDS
UNFPA	United Nations Population Fund
UNHCR	United Nations High Commissioner for Refugees
UNICEF	United Nations Children's Fund
USAID	U.S. Agency for International Development
USG	U.S. Government
VACS	Violence against Children and Young Women in Malawi
VMMC	voluntary medical male circumcision
VSU	victim support unit
WHO	World Health Organization
WSW	women who have sex with women
YFHS	youth-friendly health services

Introduction

Background

Gender inequality is a key driver of the HIV epidemic in Malawi, with HIV disproportionately affecting women (NSO and ICF Macro, 2011). Gender-related social norms, violence, and power dynamics that limit decision-making and access to resources among women and girls, and that stigmatize and marginalize key populations such as sex workers and men who have sex with men (MSM), put these groups at greater risk of acquiring HIV. These factors also restrict these groups' access to health and social services, including their ability to seek and adhere to HIV treatment. Men and boys also face gender-related risk factors and barriers to services, and need to be specifically targeted through comprehensive HIV and AIDS programming.

The Government of Malawi has committed to promoting gender equality and reducing gender-based violence (GBV). The forthcoming National Gender and HIV and AIDS Implementation Plan and the Malawi concept note (July 2015–December 2017) for the Global Fund to Fight AIDS, Tuberculosis and Malaria (Global Fund) seek to integrate gender equality priorities more fully into national HIV programs and planning. PEPFAR Malawi coordinates within this robust national gender and HIV policy context, as well as within the context of PEPFAR 3.0 and the 90-90-90 treatment targets adopted by the Joint United Nations Programme on HIV/AIDS (UNAIDS). According to the *National Strategic Plan for HIV and AIDS (2015–2020) (NSP)* (NAC, 2014), by 2020, achieving the 90-90-90 targets will result in viral suppression among 73 percent of the projected 1.1 million people living with HIV (PLHIV) in Malawi, as well as a dramatic reduction in sexual and vertical HIV transmission. When scaling up health sector programs, a variety of challenges to addressing gender barriers are known to exist (Rottach et al., 2012). As Malawi strives to rapidly scale up HIV testing and treatment to meet 90-90-90 targets, there is a need to keep these challenges in mind, and to ensure that data collection and programming (1) specifically target different gender and age cohorts and key populations, and (2) do not inadvertently reinforce HIV risks or barriers to testing and treatment among these groups.

In November and December 2015, to inform its COP16 (Country Operational Plan, 2016) program planning efforts and adhere to the requirements set out in the Updated PEPFAR Gender Strategy (FY2014), PEPFAR Malawi worked with the Health Policy Plus project (HP+) to undertake a national, programmatic gender assessment. This assessment was designed to (1) review current national gender and HIV data, analyses, and programming and (2) develop recommendations for addressing gender barriers as part of PEPFAR's COP16 programming and beyond. This study was designed to supplement recent national assessments and focuses particularly on the priorities of PEPFAR Malawi stakeholders.

Methods

General Approach

The assessment methodology drew heavily on four key tools and guidelines:

1. *PEPFAR Gender Analysis: Key Principles and Minimum Standards* (PEPFAR Gender and Adolescent Girls Technical Working Group, 2015),
2. *UNAIDS Gender Assessment Tool: Towards a gender-transformative HIV response* (UNAIDS, 2014),
3. *A Practical Guide for Managing and Conducting Gender Assessments in the Health Sector* (Greene, 2013), and
4. *Updated PEPFAR Gender Strategy (FY2014)* (PEPFAR, 2013).

The desk review and key informant interviews aimed to address three main areas:

1. **Gender Analysis:** This area of the assessment was adapted from the sources previously mentioned to include information on the following:
   - HIV prevalence, incidence, treatment, and adherence, as well as other behavioral information (disaggregated by sex, age, and key population).
   - Social, cultural, and economic factors and norms that contribute to HIV risk, access to and utilization of services, and adherence to treatment for women and girls, men and boys, and key populations.
   - Legal and policy environment.
2. **Program Assessment:** This portion of the assessment examined the gender-responsiveness of planning, implementation, and monitoring of current programs in support of the national HIV response. It drew upon interviews with representatives of PEPFAR implementing partners and agencies, as well as COP15 and Malawi Determined, Resilient, Empowered, AIDS-free, Mentored, and Safe Women (DREAMS) initiative planning documents (PEPFAR, 2014a; 2014b; 2015; 2015a; n.d.). Areas of focus included:
   - Meaningful inclusion of women and girls, men and boys, and key populations in programs and planning;
   - Engagement with national, civil society, and other donor initiatives and coordination mechanisms to address gender equality, key populations, and GBV in the context of the national HIV response;
   - Collection and use of sex- and age-disaggregated data and gender-sensitive indicators to inform program initiatives; and
   - Documented capacity (or capacity strengthening initiatives) among the PEPFAR team and implementing partners to understand and address gender equality, key populations, and GBV in HIV programs and planning.
3. **Gap Analysis/Recommendations:** This piece sought to identify areas or programs for increased or new investments to address gender issues or constraints that may be influencing the HIV epidemic in Malawi.

Two recent/concurrent gender assessments significantly informed and complemented the PEPFAR gender assessment:

1. The UNAIDS and the Southern African AIDS Trust (SAT) conducted a comprehensive national HIV gender assessment in Malawi in 2014 (Kachika, 2014). This current PEPFAR assessment does not seek to duplicate the 2014 research or findings, but rather to supplement the UNAIDS/SAT assessment with recent research, updates on the national gender and HIV policy context, and more in-depth programmatic feedback from key PEPFAR stakeholders identified in consultation with the country PEPFAR team.
2. The U.S. Department of State Office of Global Women's Issues commissioned a Malawi national gender assessment to inform interagency implementation of the Let Girls Learn initiative and the U.S. Strategy to Prevent and Respond to Gender-based Violence Globally (Sieff et al., forthcoming). This assessment was conducted concurrently with the PEPFAR gender assessment, with research for both assessments taking place in November and December 2015.The two teams coordinated the research process to avoid duplicate interviews and shared preliminary findings and initial draft assessment reports to verify the consistency of their findings.

Key Concepts

Gender is a culturally-defined set of economic, social, and political roles, responsibilities, rights, entitlements, and obligations associated with being female and male, as well as the power relations between and among women and men, boys and girls, and people with other gender identities. (PEPFAR Gender and Adolescent Girls Technical Working Group, 2015)

Gender-based violence (GBV) is defined as any form of violence that is directed at an individual based on biological sex, gender identity (e.g., transgender persons), or behaviors that are not in line with social expectations of what it means to be a man or woman, boy or girl (e.g., MSM and female sex workers). It includes physical, sexual, and psychological abuse; threats; coercion; arbitrary deprivation of liberty; and economic deprivation, whether occurring in public or private life (Adapted from the US Strategy to Prevent and Respond to Gender-based Violence Globally, 2012).

Key populations are people who inject drugs, gay men and other men who have sex with men (MSM), transgender persons, and sex workers (Beyrer et al., n.d.). The PEPFAR Gender Strategy points to the need to identify specific "populations that are vulnerable due to the fact that their gender identity (e.g., transgender persons), sexual orientation (e.g., gay, lesbian), and/or sexual behavior (e.g., MSM, sex workers) does not conform to existing gender norms" (PEPFAR, 2013).

Process

The assessment began with a desk review of over 30 country-level gender analyses and strategic guidance documents produced by the Government of Malawi, USAID, and other donors and partners within the past five years. The desk review aimed to identify major themes, data points, and possible interviewees prior to key informant interviews and consultations. The assessment team identified additional sources through the initial desk review and key informant interviews, resulting in a total of 75 documents.

Following the desk review, the assessment team conducted semi-structured interviews with 31 stakeholders/stakeholder organizations. These interviews focused on identifying new information, updates in programmatic trends and research, gaps in data, and/or priority and scalable interventions/programs. Participants, identified in consultation with the PEPFAR Malawi team, included representatives of U.S. government (USG) implementing partners and agencies, national- and district-level officials, other international donors, nongovernmental organization (NGO) and civil society organization (CSO) representatives, and service providers. Interviews were held in Lilongwe, Zomba, and Mchinji—districts that were identified in consultation with the PEPFAR team and stakeholders. Many stakeholders and organizations interviewed in Lilongwe also led programs in a number of other districts (See Annexes A and B for list of interviewees and interview guide).

In addition to key informant interviews, the PEPFAR Malawi team hosted a stakeholder consultation in Lilongwe on November 23, 2015. Twenty-nine individuals participated, including representatives from PEPFAR, other donor agencies, development partners, and the Government of Malawi. At the meeting, the HP+ team presented initial findings from the assessment and sought stakeholder input on programmatic gaps and priority issues (See Annex C for meeting agenda and participants).

Limitations

As described above, this assessment built upon recent donor assessments and previously identified PEPFAR priorities. The assessment took place on a rapid timeline in November and December 2015. The in-country assessment and key informant interviews did not, therefore, provide a comprehensive review of individual districts that could capture community-specific issues and programming needs such as, for example, disparities between urban and rural areas. As testing and treatment are scaled up to meet 90-90-90 targets, variability in gender norms across different communities (such as matrilineal versus patrilineal systems, which influence sexual partnerships and family health decision-making differently) may mean that a program that is effective in one community could be ineffective or even damaging in another.

As the assessment design focused on identifying gaps and providing recommendations for future programming, comprehensive feasibility assessments were beyond the scope of this study. While the recommendations provided in this report do not contain feasibility analyses, they do address needs and priorities identified by stakeholders and are based on global best practices and proven approaches in the Malawian context. The assessment also points to existing gaps in HIV and GBV program evaluation data.

Another limitation the study team faced was the lack of standardized definitions of key population groups—either between PEPFAR and the Government of Malawi, or within the Government of Malawi itself. Moreover, there is a lack of comprehensive and current data on key populations in Malawi. PEPFAR, through the LINKAGES project, is currently working to address some of these gaps. However, this lack of data, in combination with sensitivities and stigma around discussing key population issues, is reflected in the literature and in stakeholder responsiveness around current programming, needs, and gaps with respect to key populations—an issue discussed in further detail below.

Lastly, the research team noted the heavy weight many stakeholders gave to anecdotal information and shared perceptions that the literature neither specifically supports nor contradicts. These trends stem, in part, from gaps in comprehensive program evaluation data. At times, stakeholder feedback was contradictory, but where observations were of particular note or consistently articulated by multiple stakeholders, they are captured in this assessment report, with clear attributions to the key informant interviews.

Findings

Findings from the assessment are organized around the following areas:

1. Malawi's national policy framework for gender equality in HIV programming and institutional roles in policy implementation.
2. Current social norms and power dynamics, their related implications for HIV risk, testing, and treatment, and how current programs and health services do and do not address resulting disparities for specific population groups: women, men, adolescents and youth, men who have sex with men, sex workers, transgender persons and other key populations.
3. GBV (including harmful cultural practices) as a cross-cutting issue.

National Policy Framework and Institutional Arrangements for Gender and HIV

Policy Framework

The Government of Malawi is undertaking significant national planning and policy updates to address the HIV epidemic, bringing greater attention to some of the underlying gender and social inequalities that influence risk, as well as access to and utilization of HIV testing and treatment services.

The *NSP* and the new *Global Fund Concept Note* (Global Fund, 2015) are viewed as rallying points for coordination around national HIV programming and investments. Two national policies that are poised to further shape the gender and HIV policy landscape are currently undergoing debate or review and finalization:

- The *National Gender and HIV Implementation Plan* (MOGCDSW, 2015) integrates priorities from the *National Gender Policy* into an operational plan for the *NSP,* the first such policy document to do so. In alignment with the *NSP,* this policy stresses the importance of addressing gender inequality, harmful cultural practices, discrimination, and other human rights violations in order to meet UNAIDS 90-90-90 treatment targets. It points not only to health services, but also to the need for substantial community and behavior-change interventions to meet these targets. The final draft of the plan was submitted for review in November 2015, costed in February 2016, and is poised for launch during the first or second quarter of 2016.

- The *HIV and AIDS Prevention and Management Bill* is still undergoing discussion due to lack of consensus and silence around key principles of gender equality and nondiscrimination. Gender and human rights activists and development partners are advocating for inclusion of important issues around which previous versions of the bill are silent, such as key populations and harmful cultural practices. Advocacy efforts are also seeking to ensure that provisions in the draft bill that would require mandatory testing of certain groups and, in some circumstances, allow service providers to disclose individuals' HIV status without their consent are removed before the bill is finalized.

Other key national guidance on gender equality, GBV, and harmful cultural practices include the *Marriage, Divorce, and Family Relations Act (2015); National Plan of Action to Combat Gender-Based Violence in Malawi 2014–2020 (2015); Gender Equality Act (2013); Child (Care, Protection and Justice) Act (2010); Prevention of Domestic Violence Act (2006);* and the *Deceased Estates (Wills, Inheritance and Protection) Act (2011).*

National gender equality priorities are not consistently reflected in operational policies and district-level enforcement. Despite these national gender equality policy guidelines, gender integration into health sector

guidelines—particularly operational guidance on HIV and sexual and reproductive health (SRH)—is at best inconsistent. An assessment of gender and reproductive health policies conducted by the Health Policy Project (HPP) in 2015 identified particular gaps in gender-responsiveness among community and clinical guidelines such as the 2014 *Clinical Management of HIV in Children and Adults* (Pendleton et al., 2015). Government stakeholders and development partners interviewed as part of the PEPFAR gender assessment pointed to gaps in gender-responsiveness and principles of nondiscrimination, not only in clinical and operational guidelines, but also in legal literacy and understanding of how to enforce these principles at the district level. Given their role in policy implementation and management, district health and human resource officers are poised to be key actors in promoting accountability for gender equality and nondiscrimination in programs and practice. To do so effectively, however, they will need additional technical guidance and increased policy awareness.

Principles of nondiscrimination are not consistently articulated or enforced. High-level principles of equal access and nondiscrimination are inconsistently articulated and enforced at the national level and absent in district- and facility-level operational policies. Same-sex sexual behavior is illegal in Malawi. Although sex work is not itself illegal, female sex workers are frequently arrested under "rogue and vagabond" laws. As discussed in the section below on key populations (see p.18), de facto criminalization of these groups contributes to increased stigma and discrimination against them, and poses a significant barrier to accessing services. Most government stakeholders and some development partners interviewed for this assessment spoke about "working within the legal framework" rather than challenging or changing it to ensure equal access to services for key populations. Proactive policies and strategic guidance to reach these groups are limited to the forthcoming *National Gender and HIV Implementation Plan* and the *Global Fund Concept Note*.

Institutional Arrangements, Capacity, and Coordination

National coordination for gender in the context of HIV policies is weak. At the national level, responsibility for coordination and implementation of gender and HIV policies rests with the Ministry of Gender, Children, Disability and Social Welfare (MOGCDSW); the National AIDS Commission (NAC); the Ministry of Health (MOH) HIV Unit; the Department of Nutrition, HIV and AIDS (DNHA); and various technical and sectoral working groups. Despite recent efforts to strengthen its planning and coordination role, some stakeholders suggested that the MOGCDSW's leadership in gender, and its coordination with health and other sectors, remain inconsistent, and that the ministry is severely under-resourced.

District-level officials and community leaders are positioned to play a key role in program implementation and changing social norms. At the subnational level, district health officers and committees play a direct role in policy implementation, monitoring, and human resources for health. Stakeholders pointed to gaps in capacity at this level in policy literacy and gender, as well as in overall management. Community and religious leaders also play a critical role in influencing social and cultural norms around gender, health, and HIV. They are the enforcers of customary law, and their role in establishing community bylaws—which provide formal incentives and penalties that can either reinforce or change community level norms and practices—was frequently cited by stakeholders as a successful entry point, for example, to (1) promote male partner accompaniment to clinics; (2) reduce GBV, early marriage, and other harmful practices; and (3) keep girls, including young mothers, in school. The positive and negative gender outcomes with respect to such interventions are discussed in more detail below. Regardless, it is imperative that, as "custodians of culture," these community leaders be sensitized around gender norms and HIV.

National NGO and CSO networks help strengthen and coordinate member organizations to engage in advocacy, local programs, and monitoring. National networks such as the Coalition of Women Living with HIV/AIDS in Malawi (COWLHA), the Malawi Network of AIDS Service Organisations (MANASO), the Malawi Network

of People Living with HIV/AIDS (MANET+), and the Centre for the Development of People (CEDEP), among others, play a critical role in linking national and community-based organizations (CBOs) to strengthen overall advocacy, coordination, and participation.

Recommendations:

- Support advocacy for a finalized *HIV and AIDS Prevention and Management Bill* that enshrines principles of gender equality and nondiscrimination.
- Support development and dissemination of district- and facility-level operational guidance that advances principles of nondiscrimination and gender equality.
- Strengthen capacity and policy literacy among district officers and community leaders in the areas of gender equality, key populations, and nondiscrimination in HIV and SRH programming.

Women

Gender Analysis

In Malawi, women are disproportionately affected by HIV. HIV prevalence among women ages 15–49 (13%) is more than 1.5 times the HIV prevalence rate among men of the same age (8%) (NSO and ICF Macro, 2011). GBV and harmful cultural practices (See "Gender-based Violence," pp.23-28) place women at increased risk even within stable partnerships. At the household level, women often lack economic independence and are expected to defer to their husbands' authority over sexual relations, which can inhibit women's acceptance and ability to negotiate condom use, or lead to unprotected anal sex or "dry sex" to please sex partners (Kachika, 2014; Stakeholder interviews). Stakeholders repeatedly indicated that women are more likely to seek health services than men, but that household norms, intimate partner violence, and other barriers to HIV testing and counseling (HTC) for men (discussed later in this paper) affect whether women adhere to treatment.

At the service delivery level, standards of respectful care, nondiscrimination, and the sexual and reproductive health and rights of women living with HIV are not fully protected. For example, one study found that 46.6 percent of HIV-positive women surveyed had been advised by a health professional not to have children since being diagnosed (GNP+ and MANET+, 2012). While some supportive supervision programs are in place, monitoring and data on quality of care and nondiscrimination from the client perspective are lacking. This gap in monitoring respectful care and gender sensitivity at the facility level affects not only women, but all populations.

Program Assessment

Option B+. Introduced in Malawi in 2011, Option B+ offers lifelong antiretroviral therapy (ART) to all pregnant or breastfeeding women diagnosed with HIV. The adoption of Option B+, together with the integration of HTC into antenatal care, has expanded opportunities for women to access HIV testing and treatment. However, while ART coverage has increased notably among pregnant women, these programs have not contributed to an increase in testing and treatment among other women (NAC, 2015). Furthermore, under Option B+ approximately 17 percent of women are lost to follow-up within six months of initiating ART under the new protocol (Tenthani et al., 2014; Rosenberg et al., 2015).

More comprehensive data is needed on when and why women default on treatment under Option B+. However, some literature and stakeholder interviews point to the influence of gender norms and family dynamics on women's adherence to treatment (Stakeholder interviews; Chinkonde et al., 2009). Stakeholders noted in particular that

the husbands or partners of women who have tested positive under these protocols may not know their own HIV status (See "Men" on pp.14-16) for further discussion of men's utilization of HTC). In such instances, women may be reluctant to disclose their HIV-positive status to their partners, or may need more time and support to prepare for disclosure, fearing that it may lead to violence or rejection. In some instances, women are immediately provided with antiretrovirals (ARVs) upon initiation of Option B+. In such instances women often do not have adequate time or psychosocial support to process their diagnosis, make informed decisions about committing to lifelong treatment, or consider how best to disclose their HIV status to their partners (Rebekah Webb Consulting et al., 2013). Anecdotal evidence suggests that some women hide their ARVs when they get home and may choose not to return for further treatment. Among couples with a higher risk of intimate partner violence, women may be blamed for "bringing HIV into the home," thus compounding the issue (Rebekah Webb Consulting et al., 2013; Stakeholder interview). Women who are told that they are receiving treatment "to save the baby" may also drop out of treatment postpartum (Croce-Galis et al., 2015). Women's groups and expert client programs provide community and social support to women on ART. However, apart from efforts to promote partner accompaniment and counseling in conjunction with antenatal and postnatal care (discussed in further detail below), the direct client encounter under Option B+ is not fully responsive to women's family and psychosocial support needs.

As programs are rapidly scaled up, it is important to identify current approaches that ensure women have sufficient time and social support to initiate and adhere to treatment. The Centers for Disease Control and Prevention (CDC) and PEPFAR are supporting a National Evaluation of Malawi's Prevention of Mother-to-Child Transmission Program (NEMAPP) under Dignitas International. The evaluation includes a qualitative sub-study to identify and understand psychosocial barriers to treatment under Option B+. Findings can inform future planning and interventions to address women's family and psychosocial needs more effectively during the counseling and treatment process.

Female condoms. Although female condoms offer one mechanism by which to empower women, including female sex workers (see pp.20-21), to negotiate safe sex practices, investment, distribution, and uptake of female condoms in Malawi has been low. At community level, uptake is complicated by widespread misconceptions about side effects, and perceptions of female condoms as promoting promiscuity among women (Kachika, 2014). The 2015 launch of a re-branded female condom by Population Services International has sought to mitigate some of these misconceptions and advance women's agency in the use of new reproductive health technologies, and may offer an opportunity to refocus program investments to support community sensitization and more targeted distribution of female condoms.

Community-level approaches. Stakeholders repeatedly cited the need for community-level outreach and behavior change approaches to reduce GBV and promote women's empowerment and utilization of HIV services. COWLHA, for example, has implemented the *Stepping Stones* program to reduce intimate partner violence and strengthen partner communication for women living with HIV (COWLHA, 2015). Network partners specifically emphasized the need to leverage local organizations and leaders who understand community-specific norms and practices. Specific interventions mentioned include community women's groups and mothers' clubs that provide support to HIV-positive women. In some of these groups, members take turns picking up ARVs for other members, which supports treatment adherence in situations where, for example, women are fearful of disclosing their HIV status to their partners. One stakeholder voiced concern, however, that under this system not all individuals receive regular, direct consultations with health providers. Another approach, adopted by PEPFAR in COP15 and employed by partners such as Dignitas, is the designation of HIV-positive "expert clients" who support and share their own experiences with other HIV- positive women either inside or outside of health facilities, to help them understand and navigate the health system and address other psychosocial factors that may inhibit adherence to treatment.

Recommendations:

- Identify, support, and scale up successful community-based social and behavior change programs, leveraging network partners to identify and strengthen established CBOs that understand and can explicitly address community-specific, harmful gender norms—including those at the family level that affect household decision-making—that inhibit access to and use of clinical services. Ensure that CBO engagement and behavior change interventions are not limited to prevention programming, but also support women's adherence to treatment.
- Support targeted marketing and sensitization around female condoms as a part of efforts to improve overall female acceptance and agency regarding condom use.
- Leverage NEMAPP study findings, as these become available, to ensure that rapid scale-up of testing and treatment under Option B+ is responsive to women's family and psychosocial concerns, including barriers to women's disclosure of HIV status to their partners.

Men

Gender Analysis

Men and boys are also affected by social expectations that may limit their use of health services, encourage risk-taking behavior, and narrowly define their roles as partners and family members. With a heavy emphasis on antenatal care and prevention of mother-to-child transmission (PMTCT) services, health facility design and staffing often does not accommodate the privacy and security needs of men. Men are typically viewed as primary "breadwinners" in the household and may view taking time to seek health services as burdensome or a sign of weakness. Such economic opportunity costs and norms around masculinity may delay or discourage use of health services among men (Croce-Gilis et al., 2015; Stakeholder interviews). These factors contribute to lower uptake of HTC, delayed ART initiation, and high treatment dropout rates among men (Taylor-Smith et al., 2010; Stakeholder interviews).

Masculinity norms that encourage multiple concurrent sexual partnerships also remain a driver of the epidemic. The 2010 Malawi Demographic and Health Survey (MDHS) (NSO and ICF Macro, 2011) found that 7 percent of all men and 10 percent of currently married men had multiple concurrent partners (USAID Malawi, 2014; NSO and ICF Macro, 2011). High levels of intergenerational sex between older men and young women, together with the fact that 67 percent of new HIV infections occur within stable, heterosexual relationships (NAC, UNAIDS, and Futures Institute, 2013), indicates that testing and treatment efforts must specifically and more effectively target adult men, including older men.

Program Assessment

Male involvement and couples counseling. While male involvement is increasingly articulated as a priority approach within national policy and strategic guidance on SRH and HIV, detailed operational guidance is lacking for district health officers and service providers (Pendleton et al., 2015). Evaluations of current male involvement strategies have been limited in scope (Nyondo et al., 2013), although some research suggests that couple-initiated or community-centered approaches may be more sustainable than facility-based initiatives (Kululanga et al., 2012). Community leaders and service providers have begun to incentivize partner accompaniment when women seek antenatal care or other maternal health services (Kululanga et al., 2012; Stakeholder interviews). These incentives include neutral outreach such as "love letters" that invite or encourage husbands to accompany their wives to the clinic, positive incentives such as facility prioritization of couples in waiting lines, as well as more punitive

approaches such as community bylaws that attempt to issue fines when men do not accompany their partners. Evidence suggests that some providers interpret couples counseling as mandatory for women to receive services, even requiring letters of explanation from women who are unaccompanied. In practice, such interventions tend to reinforce harmful gender norms and power dynamics by prioritizing men over women in accessing services, as well as by suggesting that men themselves are not independent users of health services. Women whose partners are unwilling or unable to accompany them are doubly stigmatized, and there is evidence of women paying taxi drivers to accompany them to clinics (Croce-Galis et al., 2015; Stakeholder interviews).

Facilities themselves need to be better designed to deliver couples counseling and services in a manner that respects the privacy and needs of both men and women (Kululanga et al., 2012). Bicycles are a significant mode of transportation in Malawi. Multiple stakeholders noted that men who ride their bikes to clinics do not have a secure space to leave their bikes, and are thus unwilling to come inside. Once inside, men may be mocked by women in the waiting room, or be subjected to health messages and songs that cause discomfort because they are designed for women.

Masculinities and behavior change communication. Limited strategic and program guidance exists to address norms around masculinity that contribute to low HIV service uptake among men and related HIV and GBV risks facing their partners and families. The *NSP* points to the importance of promoting HTC among men, but does not clarify how this is to be accomplished. While the *NSP* and National HIV Prevention Strategy aspire to reduce multiple and concurrent sexual partnerships and intergenerational sex, the documents do not target men for behavior change communication interventions to address these issues (Kachika, 2014; NAC, 2014). Under DREAMS (see Box 1), PEPFAR is supporting programming to target high-risk male sexual partners for HTC, linkage to ART, and voluntary medical male circumcision (VMMC), and to cultivate male champions to address harmful gender norms and GBV. Local networks and NGOs have found the Stepping Stones methodology to be effective in engaging men as champions and change agents to improve partner communication and challenge masculine gender norms that inhibit use of HIV services (Kachika, 2014; Stakeholder interviews).

Voluntary medical male circumcision (VMMC). Malawi has not been on track to meet VMMC targets due to late startup of the national program, funding challenges, and low uptake of VMMC among adult men. Perceptions and masculine norms inhibiting demand for VMMC include concern about surgical complications and sexual side effects and embarrassment at being seen accessing VMMC services by other men and boys (USAID Malawi, 2014; NAC, 2015). Another misperception affecting HIV risk and prevention is the belief that VMMC guarantees protection against HIV, which may lead to riskier behavior among some men who have undergone the procedure. Communications and outreach activities need to be responsive of these norms and misconceptions and target specific gender and age groups, including older men. Some donors and health providers interviewed also pointed to increasing efforts to include women in VMMC outreach. There is a need to engage women in VMMC demand creation for their partners and sons, as well as to disseminate accurate information and support positive male norms around VMMC (USAID Malawi, 2014).These stakeholders recommended using VMMC programs as another opportunity to promote couples counseling and testing and encourage VMMC during the period after the man's partner has given birth.

Recommendations:

- Identify and evaluate a representative sample of current facility- and community-based male involvement and couples counseling incentives to identify effective approaches that do not reinforce negative gender norms.
- Include information, education, and communication targeting adult men, including older and married men, in community-level social and behavior change programming to address:

- Social and economic factors influencing early marriage and sexual relationships with younger women/adolescents;
- Gender norms around masculinity that inhibit health-seeking behavior and use of HIV services, including VMMC; and
- Men's potential to act as role models and champions to reduce GBV and promote health-seeking behavior among men and boys at family and community levels.

- Ensure that facility/structural interventions take into consideration privacy for male clients, secure facilities for bike parking, and male-targeted health messaging.
- Work with development partners and policymakers charged with SRH leadership to (1) develop and disseminate operational guidance to implement national strategic priorities in constructive male involvement at the district, community, and facility levels, and (2) ensure that this guidance includes a specific lens on how boys and men currently access HIV services and programming.[1]

Adolescents and Youth

Gender Analysis

Approximately half of all new HIV infections in Malawi occur among individuals 15 to 24 years of age (Government of Malawi, 2010). HIV prevalence among young women in Malawi ages 15 to 24 is 9 percent, more than four times the prevalence among young men of a similar age (2%) (GNP+ and MANET+, 2012). While some gender-related HIV risks and barriers to services echo those described above for adult women and men, adolescents—particularly adolescent girls and young women—also face unique barriers to HIV prevention, testing, and treatment.

Risks to adolescent girls and young women are compounded by their increased vulnerability to GBV and harmful cultural practices (see p.23, "Gender-based Violence"), as well as the influence of social and economic norms that prioritize girls' family responsibilities over education and stigmatize young people's use of SRH services. A 2014 evaluation pointed to barriers adolescent girls and young women face in accessing SRH services, including low self-confidence and shyness; stigma, particularly around use of condoms; and fear of being labeled as sex workers (E2A, 2014). Some community leaders have begun enforcing the 2015 *Marriage, Divorce and Family Relations Act*, which establishes 18 years as the minimum legal age of marriage. Yet, early marriage and intergenerational sex continue to place young women at greater risk of HIV and other problems.

Early sexual initiation is a risk factor among both adolescent girls and boys, with 55.8 percent of females and 50.4 percent of males having had sex before age 18. More than one-third (37.7%) of those ages 18 to 24 who reported having sex prior to age 18, reported that the sex was unwanted (MOGCDSW et al., 2014), suggesting an inability to negotiate protected sex. National data on youth and adolescents are not consistently sex-disaggregated, nor are these data designed to track treatment of pediatric cases as children age, particularly between the ages of 10 and 15. National guidelines provide clear recommendations to service providers for a supportive pediatric HIV disclosure process. However, as children who have been on ART from a young age reach adolescence and begin

[1] Many existing tools and resources focus on supporting men's engagement in reproductive health more broadly. Nevertheless, resources that have been applied in other country contexts may be instructive or adaptable. See, for example, *From Adding to the Burden to Sharing the Load: Guidelines for Male Involvement in Reproductive Health in Cambodia* (POLICY Project, 2006). Available at http://www.policyproject.com/abstract.cfm/2605.

to ask more questions about their health, parents/guardians may struggle with the disclosure process (Stakeholder interview). Adolescents and youth are also more likely to default on treatment if they do not have a stable parent or guardian supporting them. In these instances, other community and social support mechanisms such as teen clubs and mentors are critical (Stakeholder interview).

Box 1. DREAMS

The PEPFAR DREAMS partnership in Malawi focuses on reducing HIV risk among vulnerable adolescent girls and young women, including young married women, in the Zomba and Machinga districts.

The two-year DREAMS program is a package of layered interventions within schools and at the community level that are designed to reduce HIV transmission by

- Strengthening skills and empowerment among adolescent girls and young women,
- Addressing harmful community and social norms,
- Promoting girls' education in safe school environments,
- Supporting linkages to Malawi's YFHS program, and
- Expanding access to HTC and ART among high-risk male partners.

Program Assessment

School-based interventions and sensitization. Under Malawi's current education policy, SRH services are not directly available in schools, but partners—including the Family Planning Association of Malawi (FPAM), the Save the Children Federation/ASPIRE, the U.K. Department for International Development (DFID)-funded Keeping Girls in School program, and the United Nations Children's Fund (UNICEF)—are working with the Ministry of Education (MOE) to integrate sexuality education into teacher training and other programs to complement the national Life Skills Education curriculum. In cooperation with Save the Children, the MOE also developed and conducted a teacher training on GBV, SRH, and child protection in six districts, which the ministry hopes to scale up. Both national programs and community incentives are in place to encourage girls, including young mothers, to stay in school (Stakeholder interviews; Sieff, et al., 2016). PEPFAR DREAMS programming includes specific in-school interventions tailored to address adolescent girls and young women ages 15 to 19, as well as school-wide interventions to reach orphans and vulnerable children ages 10 to 14. Interventions include support for Life Skills Education programming, code of conduct training for teachers, youth clubs, and linkages to community bursary programs and youth-friendly health services (YFHS). These interventions, specifically targeting adolescent girls and young women, can help ensure that youth-centered programming is not inadvertently biased toward boys' participation.

Youth-friendly Health Services (YFHS). Malawi's YFHS program is designed to enable young people to access SRH services, including HIV testing, contraceptives, and contraceptive counseling, more easily. However, uptake of these services is low (13%) (E2A, 2014; Chandra-Mouli et al., 2015; HPP, 2015a). In addition to barriers girls experience in accessing SRH services, described above, barriers affecting both girls and boys include distance to services; perceptions that SRH services, particularly contraceptives, are only for married persons; parental pressure and messages that contraception and SRH services are not appropriate for unmarried adolescents; and concerns about confidentiality (E2A, 2014). Among providers who have supported or complemented such services, FPAM supports Youth Life Centres designed to complement public YFHS through stigma-free recreational activities and SRH and HIV services, though girls remain less likely to use this program (Stakeholder interview; Pendleton et al., 2015).

Teen clubs and mentoring. Community-based teen clubs and mentoring programs, such as those implemented by Dignitas and the Baylor International Pediatric AIDS Initiative in Malawi, provide additional, scalable opportunities for health and social norms messaging, as well as direct mentoring and support to young people. Clubs for HIV-positive teens often include ARV distribution and expert client programming to support adherence to treatment. Stakeholder perspectives differed regarding gender differences in participation in teen clubs, indicating a need for further research and evaluation of community-specific programs from a gender perspective. In some contexts, girls are more likely to participate in teen clubs, particularly where programs focus on life skills. In other instances, girls' household responsibilities prevented them from participating. Particularly sensitive SRH discussion topics are not always appropriate for boys and girls together, and risk alienating one group when health messages are targeted primarily toward the other. No known teen clubs exist specifically serving teenage mothers, who by regulation must then participate in adult women's groups, which may not fully address their needs.

Recommendations:

- Systematize routine national monitoring mechanisms to capture sex- and age-disaggregated data more effectively for youth and adolescents, particularly those ages 10–15.
- Identify and address the gendered effects of stigma across the adolescent/youth HIV treatment cascade.
- Conduct community-specific gender analyses of the use of YFHS and teen club programming to ensure the needs of different sex and age groups are being met and effective interventions being scaled up.
- Identify opportunities to engage both male and female youth leaders—including a newly formed young PLHIV network—in planning and monitoring initiatives to ensure age- and gender-specific social and health service needs are being met.
- Assess the effectiveness of the DREAMS model of layered interventions to reach most-at-risk adolescent girls and young women and their male partners.

Key Populations

PEPFAR defines key populations as "people who inject drugs (PWID), gay men and other men who have sex with men (MSM), transgender persons and sex workers [who] are disproportionately infected with HIV compared to the general population" (Beyrer et al., n.d.). Based on PEPFAR priorities and stakeholder feedback, this assessment looks most closely at the gender dimensions of HIV risk, testing, and treatment among sex workers, MSM, and transgender persons. Several gender norms and issues cut across the populations addressed.

Stigma and discrimination. MSM, gay men, women who have sex with women (WSW), lesbians,[2] transgender persons, and intersex persons all face stigma and discrimination due to their perceived transgression of social, community, and religious norms around what it means to be male or female, masculine or feminine. Sex workers and PWID also face stigma and discrimination, as sex work and drug use fall outside the norms of acceptable behavior. Identification with key population groups is often associated with criminal behavior. Both the actual experience of stigma and the fear of stigma (anticipated stigma) are powerful. Global evidence shows that along the HIV care continuum, stigma prevents key populations from "(1) seeking and accessing HIV testing; (2) disclosing their HIV status; (3) accessing and practicing prevention; (4) accessing care; and (5) adhering to treatment" (Jain

[2] It is important to remember, especially for HIV programming, that the terms MSM and WSW refer to a person's sexual practices, while the terms gay and lesbian refer to a person's sexual orientation.

and Nyblade, 2012). Examples of the way stigma and discrimination manifest in healthcare settings can be found in Box 2. Interviewees and previous research describe instances in which healthcare workers refused to treat, or provided sub-optimal treatment to, members of key populations (Stakeholder interviews; Wirtz et al., 2014a).

Provider capacity and sensitization. Although some partners—such as CEDEP (under the USAID and PEPFAR-funded LINKAGES project) and, previously, the USAID/Malawi Evidence-Based, Targeted HIV Prevention (EBT Prev) project—have conducted ad hoc trainings on the specific clinical needs of different key populations, there is a need for health providers to receive more systematic pre- and in-service training. Without knowledge of the clinical needs of key populations, providers generally assume that patients are in heterosexual, monogamous partnerships, and therefore miss opportunities to ask specific questions about sexual practices or examine, for example, for sores on the anus or other indications of sexually transmitted infections (STIs). Intake forms play an important role in enabling providers to conduct a comprehensive initial consultation in an objective manner that helps identify key populations—who may not otherwise disclose their sexual orientation or gender identity—and offer appropriate counseling and treatment. LINKAGES is currently working with the MOH on a tool to enhance providers' ability to take medical histories of key population clients.

Box 2. Common Manifestations of Stigma and Discrimination Experienced by Key Populations in Healthcare Settings

- Denial of care
- Provision of substandard services
- Making care conditional (e.g., dependent on bringing in a partner, using family planning, etc.)
- Premature discharge
- HIV testing without consent
- Breaches of confidentiality
- Stigmatizing comments or behavior
- Use of excessive precautions against infection
- Referring clients unnecessarily to other providers
- Compulsory or forced treatment

(Source: Mbuya-Brown et al., 2015)

Principles of nondiscrimination not effectively monitored or enforced at the facility level. As noted above (see "National Policy Framework and Institutional Arrangements for Gender and HIV," p. 11), nondiscrimination policies are not effectively operationalized or evident in practice at the facility level. Some stakeholders noted that even where patients' rights charters are posted in facilities, formal recourse/reporting mechanisms are unclear or absent. The lack of clear, easily accessible recourse/reporting mechanisms is problematic for all clients, but is especially important for ensuring equitable access to and use of services among key populations, for whom specific, heightened forms of stigma and discrimination have been documented (as described above). One stakeholder pointed to the need for a consolidated national human rights reporting system, yet cautioned that the Malawi Human Rights commission—which would likely be charged with leading such an effort—currently lacks the capacity or political will to address violations against some key populations, such as MSM.

Inadequate data. Lack of data, not only on HIV prevalence, but also on treatment needs and adherence among different key populations in Malawi, is frequently cited as rationale for the lack of targeted programming for these groups (Stakeholder interviews). Among the limited national sources of data on key populations are CEDEP's yearly human rights violations reports (CEDEP, 2014), FPAM's 2011 study on sex workers (Chizimba and Maleria, 2011), and some smaller-scale research studies on MSM (Baral et al., 2009; Fay et al., 2010; Wirtz et al., 2014a, Wirtz et

al., 2014b). Reports and stakeholders expressed concern that these studies are of varying quality, with most limited to specific geographic areas (Stakeholder interviews; UNAIDS, 2014). Through projects such as LINKAGES, there are several studies planned or underway to map estimated presence and HIV/healthcare needs among MSM, sex workers, and transgender persons in Malawi. The Global Fund will also support expansion of mapping efforts using the LINKAGES approach. These studies will provide much-needed data that must be translated into better targeted policy and programming.

Limited participation in planning and advocacy. In light of the current legal environment and social stigma, only a few, primarily nascent, key population organizations exist in Malawi, and diverse key population groups are not uniformly included or represented in high-level planning and coordination bodies. Where key populations are represented, such as on the Country Coordinating Mechanism (CCM), the most well-organized and -funded groups are usually selected for the single available seat and other groups are left out. In the case of the CCM, this seat is held by the Malawi Sex Workers Alliance, a network formed in late 2012; a representative of MSM was excluded from the process. This limited effort to engage different key population groups fails to acknowledge that MSM, sex workers, PWID, and transgender persons have different HIV-related needs, as well as different programming and advocacy priorities.

Sex workers

Associated risks. Of the 670 female sex workers over the age of 18 tested for the 2014 Behavioural Surveillance Survey, 62.7 percent tested positive for HIV (NSO, 2014). Although sex work is not illegal in Malawi, sex workers are often picked up by police based on other laws, such as rogue and vagabond regulations. Stakeholders reported that sex workers are often subjected to sexual violence in exchange for their freedom. As a result of such abuse and stigma, sex workers rarely report GBV by any perpetrator, as they do not feel protected by the law (Chizimba and Maleria, 2011).

Condom use—including use of female condoms—is also known to be low among sex workers. Clients offer more money for unprotected sex, and the cost of condoms is a barrier to their use among sex workers (Chizimba and Maleria, 2011). Some stakeholders suggested that female condoms have the potential to be a popular prevention method among sex workers in Malawi, but that more sensitization is needed to ensure female condoms are being used properly.

Data availability. The 2011 FPAM study (Chizimba and Maleria, 2011) and the 2014 *Behavioural Surveillance Survey* (NSO, 2014) are two major sources of data on sex workers in Malawi. This research will be updated by the current research under LINKAGES and Global Fund mapping efforts. There is a significant gap in available data on female sex workers under the age of 18, as surveys typically count them as exploited children rather than as sex workers. Limited data—primarily anecdotal—are available on male sex workers (Chizimba and Maleria, 2011).

Utilization of health services. Sex workers tend to be a largely invisible group due to stigma and fear of arrest, and, as described above, they often do not seek health services (Chizimba and Maleria, 2011). When sex workers do seek HIV and other health services, they tend not to disclose their engagement in sex work (Stakeholder interview). FPAM's 2011 study (Chizimba and Maleria, 2011) reported that "Sex workers go for HIV testing if and when they start falling sick or if they are pregnant and required to undergo an HIV test as part of PMTCT. Fears for the outcome of the test and its consequences are some of the reasons why sex workers do not go for testing (p. 12)."

Médecins Sans Frontières (MSF) and FPAM have both implemented specific programming for sex workers in the past, including income generating activities, safe sex and condom promotion campaigns, distribution of free female condoms, STI treatment, and HTC (MSF, 2013). LINKAGES is currently providing comprehensive services

to sex workers through its partners FPAM and Pakachere. The services are provided via static, mobile, and drop-in centers that offer quarterly HTC, STI screening and treatment, post-GBV care, and ART initiation. Part of this approach includes use of the "moonlight clinic" model to better reach sex workers where they work, thereby avoiding the stigma they may face when seeking HIV services at health facilities. No comprehensive evaluation of these interventions was identified during this assessment, although FPAM has pointed to moonlight clinics—in addition to peer education and condom promotion among sex workers—as a "best practice" for reaching sex workers with prevention messages, HTC, and STI diagnostic services (Chizimba and Maleria, 2011).

Transactional sex. The 2014 study, *Violence against Children and Young Women in Malawi* (VACS) (MOGCDSW et al., 2014), found that, among girls and boys ages 19–24 who reported having sexual intercourse in the past 12 months, 1.6 percent of males and females reported engaging in transactional sex during those 12 months. Transactional sex increases risk of contracting HIV (Stakeholder interview; Carlson, 2005; UNHCR, 2005), and the trade of sex for goods is known to occur in contexts such as refugee camps and fishing communities, where resources are extremely limited (McPherson et al., 2012, Carlson, 2005; UNHCR, 2005). Transactional sex is also reported to occur in prisons (Kanguade, 2014).

Trafficking. Trafficking is another HIV risk factor of particular concern in certain contexts such as mining communities, where many men live apart from their wives and partners, and refugee camps, where women and girls face risk of trafficking (Stakeholder interview; Carlson, 2005; UNHCR, 2005). Limited community-based interventions were cited during interviews as targeting contexts that pose additional risk. Such interventions have sought to increase legal literacy around human trafficking and, in some instances, created village redress committees to talk about and address issues of human trafficking (Stakeholder interviews).

Men who have sex with men

Data on MSM and concurrent partnerships. HIV prevalence estimates for MSM in Malawi vary widely. A small-scale study of 202 MSM in Blantyre and Lilongwe found an HIV prevalence of 21.4 percent (Baral et al., 2009). Concurrent partnerships between MSM and women are also significant. In the same study, 21.9 percent of the men reported that their current primary relationship was with a regular female partner, and 25.5 percent reported being concurrently involved with both a regular male and female partner. Nearly two-thirds (63.4%) of respondents reported having both male and female partners within the last six months. This study has significant implications in a society where MSM behavior is criminalized and stigmatized. MSM with female partners may hide their sexual behavior with other men from their female partners, putting their female partners at risk of contracting HIV and other STIs.

Stigma and willingness to seek health services. Stigma and the legal environment affect MSM's willingness to seek health services. In the 2009 study, nearly one-in-five MSM (17.6%) reported they were afraid to seek health services because of their sexual practices (Baral et al., 2009).

Misconceptions and messaging around HIV transmission. Community and social norms and laws around key populations have resulted in current sensitization messages focusing almost entirely on sex between men and women (Wirtz et al., 2014a). In a 2008 study of MSM in Central and Southern Africa, only 17.5 percent of participants reported being exposed to HIV prevention messages targeted at MSM (Ntata et al., 2008). The Baral et al. 2009 study found that, while almost all (94.5%) of the men surveyed reported having ever received information on preventing HIV infection from women, only 56.5 percent reported having received information on preventing HIV infection from men. This gap in messaging also leads to a lack of knowledge on HIV risk for MSM

among healthcare providers and decisionmakers (Wirtz et al., 2014a). There is a misunderstanding among some Malawians that HIV can only be transmitted through vaginal sex, or that it can only be transmitted between a man and a woman (Wirtz et al. 2014a). This is significant because anal sex also occurs among heterosexual couples.

Prisoners. While not consistently identified as a "key population," prisoners are often categorized among other vulnerable or "most-at-risk" populations. Infrastructure constraints and overcrowding create an environment that exacerbates numerous HIV risk factors. However, stigma around MSM and GBV in prisons reduces attention to HIV risk in this environment (Kangaude, 2014). Review of the limited research conducted on GBV in these settings points to potentially high GBV prevalence rates (Mellish et al., 2015). Rape and transactional sex increase risk of HIV exposure, and stakeholders indicated that monitoring and reporting mechanisms to track this information within prisons are weak or nonexistent. Currently, three of the four major prisons in Malawi receive routine screening and HIV services through PEPFAR implementing partners such as Dignitas and Management Sciences for Health, as well as through other donor-supported programs (MSF). However, the current policy environment limits access to condoms and lubricants, despite universal acknowledgement that men are having sex with men in prison settings (Stakeholder interviews). Some stakeholders indicated that the Prison Act is currently under review, potentially providing a new opening for discourse and advocacy to support HIV prevention among prison populations.

Transgender persons

Need for sensitization around transgender populations. Transgender persons in Malawi are a largely invisible population, and were generally not referenced during interviews without prompting. Many interviewees did not understand the difference between MSM and transgender persons, and several partners expressed the belief that MSM-focused programming would automatically include and meet the needs of transgender persons. As stated in the World Health Organization's (WHO's) global guidance, *Prevention and Treatment of HIV and Other Sexually Transmitted Infections Among Men who Have Sex with Men and Transgender People*, "It is important to note that underlying correlates of HIV and STI risk as well as the specific sexual health needs of transgender people may be distinct from those of MSM. Although the same basic HIV and STI prevention interventions may be indicated for the two groups, public health professionals should avoid conflating the two groups and work towards a more nuanced understanding of each group's needs" (WHO, 2011, p.10).

Lack of data and exclusion from national programming. Global data, where available, point to high HIV prevalence rates among transgender women. LINKAGES is working on research on the transgender population in Malawi, but the current gap in national data on this group means they have not been targeted in key national policies and programming, including Malawi's draft *National Gender and HIV and AIDS Implementation Plan* (Baral et al., 2013; Stakeholder interviews).

Recommendations

- Strengthen capacity and increase awareness and sensitization on gender and sexual diversity and appropriate programming for key populations among implementing partners.
- Systematize pre- and in-service training for health facility personnel (both medical and support staff) to increase sensitivity and responsiveness to the health and psychosocial needs of key populations.
- Support and expand upon existing capacity building initiatives on coordination and advocacy for local key population-led groups and networks to ensure that the needs of different key population groups are fully addressed in policies and programs that impact them.

- Support efforts to establish a viable human rights violations reporting system that will enable key populations to report stigma, discrimination, and other rights violations experienced, including while attempting to access health services.
- Ensure programs understand and address concurrent MSM and female partnerships, educating not only MSM, but also men and women in heterosexual partnerships, on safer practices for all sex acts.
- Continue to expand upon national data on HIV prevalence and treatment for key populations, including transgender persons, and use this data to advocate for more targeted national programming. In the absence of Malawi-specific data for transgender persons or other gender and sexual minorities, it is nevertheless critical to ensure that policies and programs are inclusive of these populations.

Gender-Based Violence

Gender Analysis

GBV prevalence and risk factors. GBV is pervasive in Malawi, disproportionately affecting women and girls. GBV, as well as fear of violence, limits women and girls' ability to negotiate sex and/or safe sex practices to prevent HIV transmission (UNAIDS et al., 2004). Intimate partner violence can also influence women and girls' decisions about disclosing their HIV status to partners and their adherence to HIV treatment. Harmful traditional practices (or "harmful cultural practices"), including early marriage, are a form of GBV that can also increase HIV risk and influence adherence to treatment (see Box 3).

The 2010 *Malawi Demographic and Health Survey* (MDHS) found that more than one-quarter (25.3%) of female respondents reported having ever experienced sexual violence (NSO and ICF Macro, 2011). Rates of intimate partner violence were also high: Around one-quarter (25.2%) of female respondents reported having ever experienced emotional violence perpetrated by a partner, 21.7 percent reported having ever experienced physical violence at the hands of a partner, and 18.9 percent reported having ever experienced sexual violence by a partner. Around 15 percent (14.7%) of women reported that their first sexual experience was forced against their will. Among adolescent girls and young women, 68.4 percent of 18–24 year olds and 76.3 percent of 13–17 year olds reported experiencing multiple incidents of sexual abuse before the age of 18. Among 18–24 year olds who reported their first sexual intercourse was prior to age 18, 37.7 percent reported that the sex was unwanted. Among those who experienced any sexual abuse prior to 18 years of age, 28.7 percent first experienced abuse before age 14, 35.5 percent between ages 14 and 15, and 35.8 percent between ages 16 and 17 (MOGCDSW et al., 2014).

Boys and men also experience GBV, although at lower rates than girls and women. Recent data show that 14.8 percent of males ages 18–24 experienced sexual abuse before the age of 18; with nearly three-quarters (74.4%) having experienced multiple incidents of abuse (MOGCDSW et al., 2014). Among males ages 13–17, 12.7 percent reported having experienced sexual abuse, with 79.3 percent reporting multiple incidents of abuse. While GBV is underreported by girls and women, it is severely underreported by men and boys, and there is widespread silence on the subject of men and boys' experiences of such violence (Stakeholder interviews; Burton, 2005). Stakeholders expressed that boys and men face significant stigma, including from healthcare workers, when attempting to report or seek health services for sexual and gender-based violence. This stigma may cause men and boys to avoid reporting violence to the police or seeking health services following an incident of sexual abuse, including services such as post-exposure prophylaxis (PEP) that would reduce their likelihood of contracting HIV as a result of the abuse.

Certain industrial, workplace, and living contexts, including prisons and refugee camps, present increased risk factors for GBV. In Malawi, the limited studies conducted in prisons suggest that high rates of GBV occur in these settings (see p.22). Qualitative studies from a large refugee camp in Malawi showed that women and girl refugees experience GBV in the form of rape, forced marriage, and trafficking (Carlson, 2005; UNHCR, 2005). Previous studies show that female domestic workers in Malawi may be at increased risk for GBV. In a 2005 study interviewing 48 female domestic workers, 96 percent reported having experienced some form of abuse, whether verbal (48%), sexual (27%), and/or physical (23%), from their employers or other members of the households in which they worked (Mkandawire-Valhmu et al., 2009).

Women's education and economic empowerment are also linked to GBV risk. Lower levels of education and literacy can reduce women's employment opportunities and economic autonomy, and in turn prevent some women from leaving abusive relationships (UNAIDS et al., 2004). The experience of violence in school settings can negatively impact student performance and increase rates of attrition. Studies have shown that girls in Malawi experience GBV both on school grounds, perpetrated by fellow classmates and by teachers, and traveling to and from school (Mellish et al. 2015). One household study, which looked at the effects of GBV on girls' education, found that 60.9 percent of girls experiencing GBV reported that their experience had resulted in performance problems at school, and a small percentage of girls (3.3%) reported they had stopped going to school as a result (Bisika et al., 2009). Teachers are known perpetrators of GBV in school. In the same study, 3.8 percent of girls who reported being inappropriately touched reported the perpetrator was a teacher. In another study of three schools in Malawi (one urban, one rural, and one peri-urban), 38.7 percent of girls and 64.4 percent of boys reported that they knew of a teacher having sex with a girl student. Half of the girls reported that they knew of at least one girl who had been approached by a teacher for sex and more than one-quarter (25.5%) reported that they knew a girl who had accepted the proposition. These numbers are alarming given that male teachers are known high-risk partners, with a reported HIV prevalence rate of 13.3 percent (PEPFAR, 2015a).

Existing studies consistently find that, in Malawi, understanding of GBV is generally poor and acceptance of GBV is pervasive (Mellish, et al., 2015). The recent 2015 MDG Endline Survey reported that 13 percent of women believed wife beating was justified in at least some situations (NSO, 2015). Stakeholder interviews conducted for this assessment, as well as for the parallel assessment conducted on behalf of the Department of State, revealed that community-level understanding of what constitutes GBV is inconsistent, and at times extremely broad,[3] which may dilute community-level responses to GBV (Sieff et al., 2016).

GBV reporting and use of services. At the community level, social norms and extrajudicial processes lead many GBV cases to go unreported. As a result, accompanying health issues such as HIV may go untreated. Data from the 2010 MDHS show low levels of reporting of GBV: among women ages 15–49 who have ever experienced physical or sexual violence, nearly one-third (30.6%) of those who experienced physical violence and 60.1 percent of those who experienced sexual violence reported they never told anyone.

Recent data also point to a gap between reporting and treatment. According to the 2010 MDHS, 43.8 percent of women ages 12–49 who experienced physical violence, and 69.9 percent of those who experienced sexual violence, reported they never sought help. The VACS study (MOGCDSW et al., 2014) reports that only 9.6 percent of 18–24

[3] During both assessments, for example, some community-level interviewees said that men whose wives withhold sex are considered to be GBV survivors. In some contexts these men participate in or benefit from community-level response such as mediation and socioeconomic support mechanisms for survivors.

year olds and 7.7 percent of 13–17 year olds who reported that they had experienced sexual abuse in the last 12 months indicated they had sought help; with 9.0 percent and 3.1 percent of those who sought help, respectively, reporting that they had received help (MOGCDSW, 2014). The 2010 MDHS (NSO and ICF Macro, 2011) concluded that "Help-seeking behaviour is fairly constant in urban and rural areas and by region," and found no strong relationship between help-seeking and wealth (p.259).

Reported reasons for not seeking GBV services include embarrassment, inability to afford services or transportation, threats from the perpetrator, not wanting to get into trouble, not wanting the perpetrator to get into trouble, not understanding how to access services, or barriers created by relatives (MOGCDSW, 2014). According to the 2010 MDHS (NSO and ICF Macro, 2011), women surviving GBV who did seek help generally sought help either from their own family or from in-laws. Traditional and religious leaders also serve as gatekeepers, strongly influencing GBV survivors' access to health, legal, and other social services. In some communities, GBV survivors are expected to obtain guidance or permission from community leaders before seeking services, which can cause them to miss critical treatment and prevention windows. Often, community leaders encourage survivors to reconcile with partners rather than seeking criminal justice. Although mediation can place survivors in further danger, particularly if the process creates a sense of confrontation, some survivors also prefer to avoid the courts, for fear of losing financial support if their partners are imprisoned.

Stakeholders expressed mixed opinions about whether or not survivors of violence knew how to access the health, legal, and psychosocial services available to them. However, the VACS findings (MOGCDSW et al., 2014) and reports of low uptake of services, discussed below, suggest this likely gap merits more in-depth inquiry.

Program Assessment

GBV prevention work with traditional and religious leaders. Stakeholders highlighted interventions in this area being conducted by FPAM, UN Women, other development partners, and small CBOs. These efforts, which help bridge the gap between customary and statutory law, include working with traditional leaders to adopt bylaws imposing fines for GBV and early marriage and raising awareness among religious leaders on the provisions against early marriage in the 2015 *Marriage, Divorce, and Family Relations Act*. This work seeks to identify champions who will help enforce the law by refusing to preside over early child marriage ceremonies. As a result, in summer 2015 a senior chief in Dedza annulled over 300 child marriages and sent the youth back to school (Nyasa Times, 2015).

Community-level sensitization. Many stakeholders spoke of GBV awareness raising activities in the form of dramas, movies, or talks being conducted at the community level. The UN Women *HeForShe* campaign, launched in 2015, is active in Malawi and addresses social and community norms as well as GBV. The campaign encourages boys and men to stand up against GBV affecting girls and women and asks them to support girls in continuing their education. The campaign has achieved high-level commitments, including a formal statement of commitment from President Mutharika to end child marriage, increase women's access to credit, and implement the forthcoming *National Plan of Action to Combat GBV in Malawi*.[4]

School-centered programming and interventions. The PEPFAR DREAMS initiative includes in-school programming to reduce GBV, including activities such as conditional primary school block grants linked to safe and

[4] The plan outlines four priority areas: (1) Prevention of GBV and its relationship with HIV, SRH, and maternal and newborn health; (2) Support for survivors and rehabilitation of perpetrators of GBV; (3) Coordination, implementation, and sustainable financing of GBV programs; and (4) Research, monitoring, and evaluation (Mellish, et al., 2015).

healthy schools, as well as linkages and referral to YFHS—including GBV screening and treatment—through school health days. DREAMS, along with other projects such as Save the Children's Keeping Girls in Schools, are creating community and school structures—including establishing clearer roles and responsibilities among teachers—to improve awareness, prevention, and response to violence (PEPFAR, 2015a; Save the Children, unpublished).

Long distances between home and school, particularly in rural areas, are a barrier to girls remaining in school. As noted above, girls are vulnerable to GBV, including harassment, while traveling to and from school. Several stakeholders mentioned a desire to invest more in boarding schools or hostels for girls to address this issue, and the Government of Malawi has also recognized this need (Sieff et al., 2016). To the extent that the Government of Malawi or other partners pursue the construction of girls' hostels, in alignment with its safe schools initiatives, PEPFAR can help these projects to support or plan for (1) security measures within the boarding facilities to ensure that girls are not inadvertently subjected to different GBV risks (e.g., from teachers or other classmates), (2) health and social support services that are accessible to girls at or near boarding facilities, and (3) resource mobilization strategies that ensure high construction costs are not passed along to girls and their families in a manner that further deters school attendance.

Women's economic opportunity and empowerment. Some development partners have supported village savings and loans to strengthen women's economic opportunity and empowerment (Stakeholder interview). The DREAMS partnership plans to work to increase girls' economic resiliency through activities such as continuing village savings and loans programs, providing seed money to mothers' groups to support girls' education, and implementing cash transfer programs (PEPFAR, 2015a).

Health facilities and One-Stop Centres. UNICEF, in coordination with other donors, such as the U.K.'s Department for International Development (DFID), has supported One-Stop Centres—multisectoral facility models that offer multiple GBV services, including health, justice, and psychosocial support, in one stand-alone structure. However, utilization of these facilities is low (Stakeholder interviews). Low uptake has translated into inconsistent staffing at the centers, leading to longer wait times for those who do try to access services. HIV services, including HTC and PEP, are not currently offered at all centers, requiring survivors to obtain referrals to an outside health facility. In at least one center, government stockouts required survivors to obtain PEP from STI clinics. The process of traveling to another facility for additional care risks re-victimizing survivors, who may have to undergo additional examinations or describe their experience of violence to additional providers. Based on available national guidelines and monitoring frameworks, the provision of HTC and PEP within 72 hours of incidents of sexual violence does not appear to be routinely offered or reported across facilities (Kachika, 2014; Stakeholder interview).

Outside of specialized facilities such as One-Stop Centres (for which specific treatment guidelines are in place), stakeholders expressed concern that healthcare providers are poorly equipped to handle cases of GBV and that GBV is not included in pre-service training curricula (Stakeholder interviews). Malawi's recent child and social welfare pre-service training program may, however, prove a promising foundation or model for training new health providers on GBV case management and treatment. PEPFAR may look for opportunities to collaborate with other donor partners or directly support efforts to develop or adapt appropriate curricula, drawing upon such nascent pre-service training programs as well as current state of the art global resources.

Victim Support Units (VSUs). The police can be the first point of contact for survivors reporting GBV (Keesbury and Askew, 2010). A recent self-assessment study conducted by the Malawi Police Service suggests, however, that officers' understanding of gender and GBV is lacking, and that systematic training is needed (Malawi Police Service, 2014).

Victim support units (VSUs) are police-run centers affiliated with police stations throughout Malawi, in both urban and rural areas. Survivors come to the units to report cases of physical, sexual, and emotional violence. The units work with several local and international NGO groups to link survivors up to care, and some provide shelter or raise funds to provide survivors with clothing or food, if needed. VSUs provide medical referral forms, and, in some instances, depending on the distance between the police station and health facility, VSU staff will accompany survivors to a health facility. Hospitals refer clients to VSUs in a similar manner. Similar to the community norms and preferences for mediation and reconciliations described above, VSUs also typically encourage survivors to pursue mediation prior to taking formal legal action, asking (with the survivor's consent and support from community leaders) the survivor to confront the accused perpetrator. VSUs also conduct violence sensitization programs in nearby schools and during community events (Stakeholder interview). Research suggests that police training and outreach conducted through VSUs in Malawi has had an impact on coordination with the health sector, including high referral rates from police to health facilities (Keesbury and Askew, 2010).

Data and research. A comprehensive literature review on GBV published by HPP in 2015 (Mellish et al., 2015) points to numerous national data sources on GBV that can be used to inform policymaking and programming. Access to this data in a consolidated source should grow easier over time, with the recent creation of a national-level GBV Management Information System. This online system aims to automate and digitize information previously captured through district-level GBV reporting registers. It can be used to generate public reports that partners can access for programming purposes. Stakeholders cautioned that the system will require support to ensure that it is well-maintained and that data are readily available. A user manual for the system has been developed, and the United Nations Population Fund (UNFPA)-funded Gender Equality and Women Empowerment (GEWE) initiative is supporting

Box 3. Harmful Traditional Practices

Harmful traditional practices, including early marriage, are a form of GBV. Examples of traditional practices in Malawi that put women and girls at increased risk for HIV include

- **Wife inheritance:** a practice in which a widow is forced to marry one of her husband's relatives;
- **Polygamy:** the practice of having multiple wives;
- **HIV cleansing myths**: the belief that having sex with a widow or virgin can cure a person of HIV;
- **Fisi:** a practice in which elders arrange for older men to sleep with girls to remove their virginity; and
- **Mourning rituals:** rituals of which numerous types exist in Malawi, including a "death inheritance" practice that requires another man to have sex with a widow on the night of her husband's death.

Some efforts to modify harmful traditional practices at the community level seek to preserve a sense of tradition or culture while reducing related violence and HIV risks. One such modification of the death inheritance practice now allows a married couple from the village to have sex in a widow's house on the night of her husband's death, rather than forcing the widow to have sex with another man.

* Taken from the 2015 HPP GBV Literature review findings, as well as practices mentioned during stakeholder interviews.

training and rollout to 13 districts. Further technical and financial support is needed to continue district rollout after GEWE ends in May 2016, including training district officials on ethical standards and use of the system. Currently, few evaluations of GBV programs in Malawi exist or are publicly available.

Recommendations

- Engage in community-level outreach and legal literacy programming to enhance understanding of GBV, GBV services, and legal protections among district, community, traditional, and religious leaders—cultivating them as champions and advocates for more effective GBV prevention and response.
- Engage in community-level outreach and legal literacy programming to enhance understanding of GBV, GBV services, and legal protections among women, men, youth, and key populations as potential clients and as supportive family or community members.
- Systematize provider training on clinical and legal protocols to identify and respond to cases of GBV, including sexual violence experienced by men and boys, and GBV against key populations.
- Improve referral protocols and ensure survivors receive HTC and are able to access PEP within 72 hours of an incident.
- Build capacity for use and management of the recently created GBV information system, both centrally and to continue rollout at the district level. Following initial efforts under the GEWE initiative, observed needs include internet access to support the system, capacity to use the system, and improved understanding of ethical considerations in GBV reporting.
- Evaluate select GBV programs that have demonstrated success at the community level for scalability, and to identify trends in misinformation or unintended consequences.
- Improve reporting systems and data collection on GBV experienced by men and boys.

Overarching Recommendations

A number of opportunities exist for alignment of PEPFAR global gender priorities with Malawi's national gender and HIV programming. Identified needs and stakeholder recommendations cut across a range of policy, community, and clinical interventions. Many point to a need to improve data quality, availability, and use to evaluate and scale up the interventions that are most effective in both the national context and specific localities, and to reach specific populations. As evaluation and research are undertaken, a platform is needed to help share learning and translate that research into practice. Importantly, as interventions are scaled up, a principle of "do no harm" and attention to unintended or adverse consequences for different population groups must be actively applied and monitored in different communities and health facility settings.

- At the national policy level, PEPFAR and implementing partners should identify and coordinate around advocacy opportunities to ensure the finalized HIV and AIDS Prevention and Management Bill enshrines principles of gender equality and nondiscrimination, and to ensure that these principles are carried forward into its enforcement.
- More support is needed, particularly at the subnational level, to move from national policy commitments to implementation. At the district level, this includes supporting implementing partners and national policymakers to develop and disseminate operational guidance and to strengthen capacity and leadership for gender programming. At the facility level, there is a need to increase provider awareness and standardize monitoring and reporting on gender-sensitive care and nondiscrimination, including through current supportive supervision programs and district and health facility ombudsmen.
- Community-based social and behavior change programming is an important area for ongoing investment to facilitate access, retention, and adherence to services, and to address damaging norms and practices that contribute to specific populations' vulnerabilities to early and unwanted sex, GBV, and restricted access to services. These activities must explicitly include older and married men and adolescent girls among their target populations.
- Current community-based interventions to reach specific underserved populations require more locally-specific evaluation to understand their intended and unintended effects on all gender groups. Recommended interventions for evaluation include
  - An evaluation of how the use of community bylaws and penalties to incentivize men's access to HTC affects men's and women's follow-up on treatment, and whether such measures create unintended barriers to access for women whose partners are unable or unwilling to comply; and
  - A formal assessment of how PEPFAR-supported youth-centered HIV prevention and adherence support programs are reaching teenage girls and boys differently, in order to reduce gender gaps in participation.
- National network partners such as the Coalition of Women Living with HIV/AIDS in Malawi (COWLHA), the Malawi Network of AIDS Service Organisations (MANASO), the Malawi Network of People Living with HIV/AIDS (MANET+), and the Centre for the Development of People (CEDEP) can play a pivotal role in coordination and advocacy, and should be leveraged to identify strong CBOs and local champions for gender programming and research.
- Malawi has been a pioneer in the implementation of Option B+, but more can be done to support women who are offered Option B+ in making safe, informed decisions about disclosure of HIV status to their partners and

adherence to treatment. Research is currently underway with PEPFAR funding to understand what happens to women who are lost to follow-up This research can be used to identify current, scalable practices that effectively address women's family and psychosocial needs. Practices that pose barriers to adherence should be explicitly documented and systematically eliminated from facility level interventions. PEPFAR may wish to support implementing partners to train district health officers and service providers based on these findings.

- Use the 2015 launch of a newly branded female condom as an opportunity to refocus programmatic investments to support community sensitization and more targeted distribution of female condoms, in alignment with efforts to improve overall female acceptance and agency regarding condom use.
- Many male involvement strategies that promote partner accompaniment risk disempowering or stigmatizing women. Non-coercive approaches to encouraging HTC for men and couples counseling need to be reinforced at both community and facility levels. Health facility structures and communications programming need to be designed to address the privacy and information needs of both male and female clients.
- Pre- and in-service training for providers must more systematically incorporate sensitization and clinical protocols for identifying and responding to cases of GBV, as well as ensuring medically appropriate, non-discriminatory services for key populations.
- Improved data collection is needed to inform policies and programming targeting specific key (or vulnerable) population groups that are frequently overlooked in programming, including not only MSM and sex workers, but also other lesbian, gay, bisexual, transgender, and intersex (LGBTI) persons, and prisoners. As PEPFAR supports further research in this area under LINKAGES, it is important that dialogue around new policies and programs is not limited to groups for which more evidence is available, as gaps in data are likely among groups such as transgender persons or adolescent sex workers.
- There is a need for improved sex- and age-disaggregated data on adolescents and youth. Gaps in data on young adolescents are particularly evident, and issues related to gender, stigma, and adherence must be better understood for individuals across the pediatric and adolescent HIV treatment cascade. An analysis of gaps and bottlenecks across the cascade, in combination with available research on how stigma and other family and social barriers affect uptake of YFHS, can further inform community- and school-based programming, as well as sensitization of service providers.
- Building upon the Gender and Sexual Diversity trainings conducted by HPP for PEPFAR in 2015, there is a need to expand these trainings to reach implementing partners and strengthen not only awareness of the social and health needs of gender and sexual minorities, but also practical, programming capacity to systematically address those needs.

Annex A. Key Informant Interviews

Date	Organization	Met With
November 11, 2015	Ministry of Health, HIV and AIDS Department	National PMTCT Coordinator
November 11, 2015	Ministry of Education	Gender Officer
November 11, 2015	Center for Development Management	Lead Consultant, Bright Sabel
November 12, 2015	Centers for Disease Control and Prevention	PEPFAR team (group interview)
November 12, 2015	Lilongwe District Health Office	District Medical Officer
November 13, 2015	Peace Corps	Country Director
November 13, 2015	Ministry of Gender, Children, Disability and Social Welfare	Department of Gender Affairs (group interview)
November 13, 2015	Ministry of Gender, Children, Disability and Social Welfare	Child Protection Officer
November 13, 2015	Ministry of Health Reproductive Health Directorate	Director
November 13, 2015	Millennium Challenge Account	Social and Gender Assessment Director
November 13, 2015	Coalition of Women Living with HIV/AIDS (COWLHA)	Programs Manager
November 16, 2015	Zomba District Health Office	District Health Officer
November 16, 2015	Zomba One Stop Centre	One Stop Centre Coordinator
November 16, 2015	Dignitas	Chief of Party
November 17, 2015	Family Planning Association of Malawi (FPAM)	Executive Director
November 17, 2015	Independent consultant	Linley Kamtengeni
November 17, 2015	USAID	PEPFAR team (group interview)
November 18, 2015	Department of State	Self Help Fund Coordinator

November 18, 2015	Independent consultant	Bridget Chibwana
November 18, 2015	Malawi Network of AIDS Service Organisations (MANASO)	Programme Officer
November 18, 2015	NGO Gender Coordination Network	Network Coordinator
November 19, 2015	Malawi Network of People Living with HIV/ AIDS (MANET+)	Executive Director
November 19, 2015	Abt Associates, SSDI Communications	Chief of Party
November 20, 2015	UN Women	HIV Program Officer
November 20, 2015	FHI360, LINKAGES Project	LINKAGES Program Officer
November 20, 2015	Centre for the Development of People (CEDEP)	Executive Director
November 24, 2015	Lilongwe Victims Support Unit	Gender Empowerment Coordinator
November 24, 2015	UNAIDS	Gender Advisor
November 25, 2015	Pact, LINKAGES Project	SBCC Officer
November 26, 2015	Tadzuka Women's Group	Executive Director, Board Chairperson, and Accountant as well as the local village headman, and MoGCDSW Child Protection Officer (group interview)
December 2, 2015	ActionAid	Women's Rights Theme Manager

Annex B. Interview Guide

Interview Guide for Key Informants
Malawi PEPFAR Gender Assessment November 2015

Background:

[Introductions; request permission to record]

The US Embassy in Malawi is supporting two related gender assessments to inform USG development programming and coordination with the Government of Malawi and civil society. As a part of this process, HP+/ Palladium is working with the PEPFAR team to (1) conduct a gender analysis of the socio-cultural gender norms, inequities, and inequalities that put people at risk for acquiring or transmitting HIV, and their ability to access HIV testing, care, and treatment, including adherence and retention in care; and (2) assess how current programming responds to these issues.

For purposes of this conversation, gender is a culturally-defined set of economic, social, and political roles, responsibilities, rights, entitlements obligations, associated with being female and male, as well as the power relations between and among women and men, boys and girls. Key populations are "populations that are vulnerable due to the fact that their gender identity (e.g. transgender persons), sexual orientation (e.g. gay, lesbian), and/or sexual behavior (e.g. MSM, sex workers [SW]) does not conform to existing gender norms." Disabled populations should also be considered as they face heightened risk of violence, including sexual violence.[5]

We would like to speak briefly about some of the key gender norms and influencing factors in the context of HIV programs and services, but spend the majority of our time focused on specific program approaches, planning, and monitoring.

Gender and social norms and legal/political context

1. What are some of the key gender-related norms and disparities affecting HIV prevention, care, and treatment in Malawi? In your district?

   Prompts:

   - differences in how men, women, girls, boys, key populations, access HIV services (testing, care, treatment, support)
   - differences in power, access to and control over resources among these groups (sources of income for men and women, decisions around sexual and reproductive health, household decisionmaking, access to education/technology…)
   - attitudes toward same sex relationships and gender and sexual minorities
   - understanding, particularly among youth, of how to prevent transmission; what are major misconceptions around transmission

[5] PEPFAR Updated Gender Strategy FY2014

- GBV prevalence/harmful traditional practices (early marriage, FGM, others…)
- discriminatory practices in health care settings
- media portrayals of gender norms (or stereotypes); violence; HIV and FP; other issues noted above
- impact of stigma on access to HIV services and quality of care
- notable geographic differences in any of the above
- religious influences on gender and social norms

2. Legal/political context:

(a) What current (or forthcoming/anticipated) laws, regulations, or policies directly impact men, women, girls, boys, and key populations differently with respect to HIV?

Prompt: focus on recent changes and/or areas that interviewees point to as having specific relevance to / influence on their programs. Examples

- GBV prevention and response (both broadly, and more specifically with respect to sexual violence response / treatment and referral protocols; recognition, e.g., of marital rape…)
- Gender equality, other non-discrimination policies
- Child marriage, trafficking, other harmful cultural practices…
- Gender identity and/or sexual orientation (criminalization or protections in place)
- Land and property rights
- Other aspects of family code
- Formal rights with respect to health care access
- Drug use

(b) Implementation and advocacy:

- How are these laws disseminated to civil society, local implementers and implementing partners, service providers, and other health sector actors?
- Do these individuals/groups understand, adhere to, and monitor compliance?
- Who are proven champions in monitoring and/or advocating for equity/non-discrimination in these areas?

Prompt: key civil society actors, government officials, others who can be strong partners/advocates around gender equality, key populations, GBV, especially in the context of health/HIV planning and programs.

Program planning, implementation, and monitoring

1. Data and data use:

   (a) What data sources do you typically draw upon to identify relevant gender issues for your programming?

   (b) Have you / your organization conducted or consulted with available gender analyses in the areas of health or specifically HIV? If so when, what/whose analysis?

   (c) What gaps in data on gender and key populations have you identified in those sources with respect to participation in programs or access to services—across testing, care, treatment?

   (d) In your own program monitoring:

   - Are data gender- and age- disaggregated?
   - **For PEPFAR / implementing partners:** Are you familiar with and using PEPFAR gender indicators to monitor and report on your activities?
   - What populations are included or missing?
   - Are gender-sensitive indicators used? (Measuring reduction in gender disparities, increased participation/access, changes in legal rights/status, GBV or female empowerment)
   - How has your institution used this information?

2. Program planning and implementation:

   (a) [Build on response to previous question on use of data.] Are identified gender issues/disparities explicitly considered as a part of your current program planning cycle? [If interviewee has knowledge of the planning process.] Was a specific gender guideline or framework used to inform planning?

   (b) Please describe key programs or activities and how they address gender:

   For MOH and other donor/development partners:

   Describe the relevant program and how it is responsive. How do those programs reach women, girls, key populations?

   Prompt around both gender equality/gender norms programming, GBV programming, and programs designed to reduce disparities in service delivery for targeted populations.

For PEPFAR agencies and implementing partners:

Describe programs that reflect the following (probe around program details and which populations are targeted):

- Provision of gender-equitable HIV prevention, care, treatment, and support. This includes targeting programs and services to specific populations.
- GBV prevention and provision of services for post-GBV care
- Activities designed to change harmful gender norms and promote positive gender norms
- Promote gender-related policies and laws that increase legal protection / reduce discrimination
- Increase gender equitable access to income and productive services, including education

(c) **For non-USG PEPFAR agencies (Government of Malawi, implementing partners):** Which of these programs are specifically supported under PEPFAR; which are being implemented in cooperation with PEPFAR-funded programs (and if so, please specify); what other sources of funding / donor initiatives are being leveraged?

For PEPFAR agencies: Identify key partners and areas of donor collaboration.

For other donors/development partners: Which programs being implemented in cooperation with PEPFAR (please specify the relevant PEPFAR initiative)?

(d) [If interviewee is able to speak about budgeting process.] Do annual program budgets systematically/ adequately allocate resources and track expenditures for gender equality, GBV prevention and response, and/or other interventions to integrate gender into programs and activities.

(e) Are diverse networks and civil society actors representing women and girls, men and boys, youth, and key populations systematically engaged in program planning, implementation, and/or monitoring? Please elaborate.

(f) Are national/district level coordination mechanisms in gender, youth, key populations, GBV, reproductive health, and HIV involved in planning and/or program implementation?

3. **[For PEPFAR and implementing partners]** Please describe any training or capacity strengthening initiatives you have undertaken to understand and address gender equality, key populations, and GBV in HIV program planning, implementation, and monitoring. What else is needed?

4. Are you engaged in any other gender, key populations, and/or GBV related research or monitoring initiatives that we haven't already discussed?

5. Including or in addition to what we have already discussed, can you point to any specific programs or activities that provide especially strong examples and model good practices in addressing gender and GBV through HIV programming?

6. Based on your own observations and experience, what recommendations do you have for better addressing gaps / strengthening the gender-responsiveness of your own institution's HIV programs and activities, or at the broader national or district level context?

7. Is there anything else you would like to add?

Annex C. Stakeholder Consultation Agenda and Participants

PEPFAR Gender Assessment
Stakeholder Consultation

November 23, 2015
US Public Affairs Auditorium (Old Mutual Building)
Lilongwe, Malawi

1:30–1:45 P.M. Welcome and introductions
PEPFAR Coordinator

1:45–2:00 P.M. Gender assessment background and approach
Health Policy Plus

2:00–3:10 P.M. Preliminary findings and gap analysis – Part 1
Plenary presentation and small groups

- Social and community norms
- Gender-based violence and harmful practices
- Key populations
- Legal and policy context

3:10–3:20 P.M. Tea break

3:20–4:30 P.M. Preliminary findings and gap analysis – Part 2
Plenary presentation and small groups

- HIV/health facilities and services
- Data and data use
- Coordination and participation

4:30 –4:50 P.M. Recommendations
Small-group report out

4:50–5:00 P.M. Wrap-up
PEPFAR Coordinator

Participants

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