

The Nexus of Gender and HIV among People Who Inject Drugs in Kenya

SUMMARY PAGE

Gender norms and inequalities increase the experiences of violence and HIV risk for people who inject drugs (PWID) while limiting their service uptake. Specific gender-related beliefs (however untrue) are one cause of stigma and discrimination against PWID and a reason that HIV programs do not reach all PWID. Acknowledging and working to transform the gender norms most harmful to the PWID community can further strengthen HIV-focused programs for and by PWID.

Harmful gender-related beliefs most relevant to people who inject drugs

- It is more acceptable for men to use drugs or to be high than it is for women.
- Only men use drugs.
- Men should take risks.
- Women should not seek health care services without permission from their partners.
- Women should take care of others (their partners and children) before they care for themselves.
- Women who inject drugs (WWID) are not good mothers.
- WWID should not be allowed to have children.

Recommendations

- Sensitize clinical teams working with PWID on how gender norms are at the root of stigma, discrimination, and violence against PWID to help them understand and question their own and others' negative attitudes.
- Make holistic services currently offered in limited sites more convenient for and friendly to WWID.
- Reach out to WWID and young PWID with specific, individualized information and skills.
- Fully integrate violence response services within HIV services for PWID.
- Continue to work with the police on the prevention of violence against PWID and to document incidences of violence experienced by PWID.
- Explicitly discuss and challenge the gender-related beliefs that put PWID at risk for HIV and violence as well as limit their uptake of services.
- Continue to engage WWID as leaders in identifying their needs and designing PWID-friendly programming.
- Ensure that campaigns directed at PWID do not inadvertently use messages that suggest that only men inject drugs or that exploit harmful gender norms.
- Use principles of constructive male engagement to engage men who inject drugs (MWID) as partners.
- Partner with other women-focused initiatives.

This brief was developed to encourage and inform gender-integrated HIV prevention, care, and treatment programming for people who inject drugs in Kenya. It can be used by individuals and organizations that deliver services to people who inject drugs; those participating in program design and monitoring and evaluation; and decision makers and funders supporting the programs. It is one in a series of briefs on the **Nexus of Gender and HIV** among key populations most affected by HIV: men who have sex with men, sex workers, transgender people, and people who inject drugs. Information relevant to individuals who are members of multiple key populations (such as sex workers who inject drugs) can be found across the series.

- Ensure that programmatic monitoring and evaluation is used to inform decision making but not to justify exclusion of groups not currently seeking services.

DEFINITIONS

GENDER NORMS:

The expectations of what it means to be a man or woman, including social and political roles, responsibilities, rights, entitlements and obligations, and the power relations between men and women [Adapted from *HPP Gender & Sexual Diversity Training*].³

GENDER IDENTITY:

A person's deeply felt internal and individual experience of gender, which may or may not correspond with the sex assigned at birth [*HPP Gender & Sexual Diversity Training*].³

GENDER EXPRESSION:

The external display of one's gender, through a combination of appearance, disposition, social behavior, and other factors, generally measured on a scale of masculinity and femininity [*HPP Gender & Sexual Diversity Training*].³

GENDER INTEGRATION:

Strategies applied in programmatic design, implementation, monitoring, and evaluation to take gender considerations into account and compensate for gender-based inequalities [Adapted from *IGWG training materials*].⁴

GENDER-BASED VIOLENCE:

Any form of violence that is directed at an individual based on biological sex, gender identity (e.g., transgender), or behaviors that are not in line with social expectations of what it means to be a man or woman, or a boy or girl (e.g., men who have sex with men, 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 [*PEPFAR Gender Strategy*].⁵

TRANSGENDER:

An adjective to describe people whose gender identity (see definition above) is different from the sex they were assigned at birth. Transgender is an umbrella term that describes a wide variety of cross-gender behaviors and identities [*TRANSIT*].⁶

BACKGROUND

In Kenya, 3.8 percent of new HIV infections are among PWID.¹ In Nairobi, 19 percent of PWID are living with HIV.² HIV prevalences disaggregated by gender — for transgender people who inject drugs (TWID), WWID, and MWID — in Kenya are not known. To inform HIV programming for PWID of all genders, the USAID- and PEPFAR-supported LINKAGES project conducted a gender analysis to examine how gender norms and inequalities affect PWID's HIV risk and uptake of services across the HIV prevention, care, and treatment cascade.

Why focus on gender in HIV programs for transgender people?

HIV programmers working with the general population are accustomed to thinking about gender norms and inequalities as negatively affecting women and girls in particular (see definitions to the left). For example, they have long understood that women, who have less access to education and employment and are expected to be submissive to their male partners, experience difficulty negotiating condom use. Appropriately, HIV programs respond to these realities through gender integration. Gender integration has been shown to improve and sustain HIV programming outcomes.^{4, 7, 8}

Systematic gender integration has not been widely employed in programming for key populations (KPs).⁹ However, this approach is vital because gender norms and inequalities negatively affect KPs, and their effects are often amplified because they occur not only when KPs and those around them conform to gender norms but also when KPs are perceived to be non-conforming. A gender analysis is the first step in the process of gender integration and an important tool for achieving ambitious 90-90-90 targets.

In Kenya, programming for PWID, particularly MWID, is established and steadily improving, and research with PWID is emerging.

In this context, a gender analysis can build on existing research and explore the gender norms and inequalities that underlie these issues. It can also be used to identify new ways to approach these long-standing problems through addressing gender-related root causes. Finally, a gender analysis can ensure that the needs of PWID of all genders are understood and met in HIV programming.

METHODS

The gender analysis with PWID was part of a larger gender analysis conducted in Nairobi with the four KPs that are the focus of the LINKAGES project. The PWID portion of the analysis consisted of a desk review of relevant literature and policies, a scan of PWID programming in Nairobi, and 23 qualitative interviews with representatives from PWID-led organizations (REP_PWID), government officials (GOV), program managers and funders (PROG_PWID), and health care workers (HCW_PWID) in Nairobi. Of the 23 respondents, 21 reported working with both WWID and MWID, and 10 respondents reported working with TWID. A task force of KP representatives and government officials provided guidance and helped identify relevant programs and literature. Furthermore, research assistants who identified as former PWID or worked with PWID helped design the questionnaires, conducted the interviews, and assisted with the interpretation of the findings. The desk and program reviews and interview guides were designed to cover the five gender analysis domains proposed by USAID: laws, policies, and institutional practices; cultural norms and beliefs; gender roles, responsibilities, and time used; access to and control over resources; and patterns of power and decision making.¹⁰

Interview guides included a list of gender-related beliefs potentially relevant to the PWID community in Kenya (see **Box 1** for the interview prompt about gender-related beliefs). Respondents identified the most common gender-related beliefs and described each belief's impacts on PWID's HIV risk and HIV service uptake; violence was also discussed in detail because of its impact on each of these outcomes (see **Box 2**). Additionally, respondents recommended activities to counter harmful beliefs and ideas for tailoring programs to meet the needs of PWID of all genders.

One weakness of our approach is that, for purposes of easy replicability and in line with most gender analyses' methodology, we did not interview individual PWID about their personal experiences.^{11, 12} Thus, we were dependent on informants' ability to speak to the realities of PWID with multiple risks, such as PWID and TWID who engage in sex work. We asked specific questions about the needs and experiences of these groups and present

those findings here. Additional information on the needs of sex workers and transgender people can be found in *The Nexus of Gender and HIV among Sex Workers in Kenya* and *The Nexus of Gender and HIV among Transgender People in Kenya*.

FINDINGS

Gender norms and inequalities are at the root of much of the increased vulnerability to violence and HIV risk experienced by PWID, as well as the root of many of the barriers they face to HIV service uptake. As shown in **Figure 1**, gender norms influence PWID through two primary pathways:

- Pathway 1: PWID are affected by those gender norms to which they and those around them conform.
- Pathway 2: PWID experience stigma and discrimination or are not understood/ believed to be irrelevant when they are perceived as not conforming to gender norms.

The specific gender-related beliefs that reflect either conforming or being perceived as non-conforming are presented in **Figure 1**. These beliefs were identified by respondents as both common and harmful to PWID in Kenya. Detailed findings below describe how various beliefs affect experiences of violence, HIV risk, and uptake of services for MWID, WWID, and TWID.

Violence

The incidence of gender-based violence and other forms of violence against PWID in Kenya is high.² Violence is a human rights violation that increases HIV risk and decreases the uptake of services (see **Box 2**). Violence is often perpetrated against PWID because they are suspected of stealing. However, as respondent PROG_PWID_02 explained, violence against PWID also has a gendered element: *“Yes, almost all PWIDs have experienced some degree of physical violence, maybe from mob justice, because they have stolen something or they were caught in the hands of police using drugs. Women have suffered sexual abuse both from their partners and other men and possibly from the police or the city council askaris [security officers].”* Respondents noted that increased violence against WWID comes from traditional inequitable norms about the value of men and women. *“The violence that WWIDs face may not be specifically due to drug injection, it may be due to other social factors like men feeling more superior to women”* (PROG_PWID_05). Violence not only impacts HIV risk for PWID (e.g., unprotected sex and riskier behaviors) but also impacts their self-esteem, which in turn reduces the probability they will seek health services.

Respondents further reported different types of violence based on gender. WWID are believed to be sex workers and subjected to emotional and sexual violence while MWID are

BOX 1. INTERVIEW PROMPT ABOUT GENDER-RELATED BELIEFS

“Evidence shows that **gender-related beliefs** for how men and women should behave can harm PWID’s well-being and keep them from accessing HIV services. Gender-related beliefs are not factual statements, but rather common opinions in a specific culture. Which of the following beliefs is common in Kenya?”

perceived as criminals or thieves and reported to experience more physical violence. As respondent REP_PWID_04 stated, *“Men experience high physical violence since they hustle, they steal, and they are beaten up.”* The literature supported these findings.^{2,13} Very few respondents commented on the types of violence experienced by TWID; however, respondent PROG_PWID_02 noted, *“People are more likely to view them [TWID] negatively because they don’t understand them at all. We do know many families have beaten up their family members because they are lesbians, sex workers, and other groups like this, especially if they are [transgender] females.”*

Violence against PWID, including women, is perceived as unimportant and even inevitable.

FIGURE 1. The Impact of Gender Norms on PWID’s Vulnerability to Violence, HIV Risk, and Service Uptake



“PWIDs get beaten up, sexually abused and no one cares” (GOV_O3). As a result, PWID fear reporting violence and also tolerate violence against themselves. As respondent PROG_PWID_O2 stated “It’s a combination of both terror, fear, and resignation. They also feel that they choose this life and what else should they expect to happen?” WWID, who are seen as violating gender norms, reflected in the beliefs that **only men inject drugs and it is more acceptable for men to use drugs or to be high than it is for women** are blamed when they are victims of violence, including

BOX 2. CONNECTION BETWEEN HIV AND VIOLENCE

Global evidence demonstrates that HIV and violence are linked in multiple ways.

- Violence increases the risk of HIV, and living with HIV increases the risk of violence.¹⁴⁻¹⁷
- Experiences of violence limit HIV testing.¹⁸⁻²²
- Experiences of violence decrease disclosure and adherence.¹⁸⁻²²

Evidence also shows that criminalization of drug use increases both violence against PWID²³ and their HIV incidence.

International guidance states that HIV programs for PWID should address the issue of violence.²⁴ Respondents reported a preference to report violence to and receive violence response services from non-governmental organizations (NGOs) and clinics that specifically serve PWID because they do not feel judged. However, the link between violence and HIV services is not as strong as respondents believe it should be. Respondents recommended that offering a broader range of services at drop-in centers (e.g., hygiene-related services) would attract WWID and ultimately help them feel safe disclosing violence: “In the [drop-in] centers there should be group interventions that are focused on the women that make it much easier [to seek support for violence] such as hairdressing services and other services that are prioritized by the women” (PROG_PWID_O5).

sexual violence. This affects their willingness to seek services: “A lady who injects drugs is raped while a non-drug user is also raped, they are not treated in the same way. She will not open up because using drugs is a crime and she will be told that it’s her fault that she was raped when she decides to report” (REP_PWID_O4). It also affects whether a woman would be provided with services if she did report them. As expressed by respondent REP_PWID_O3, “When a woman goes to the police to report for violence she will be even chased away and be told that it’s because you used drugs that’s why you were raped.” WWID are also excluded from broader campaigns to prevent violence against women — a further sign that violence against them is perceived differently than violence against other women. As one respondent noted, “WWIDs are a forgotten population. They are degraded” (REP_PWID_O1).

Overall, respondents felt that WWID and PWID who are also living with HIV are most at risk of violence because they are seen as a source of HIV transmission in their communities: “Living with HIV increases the risk of violence if the community members know that he/she is the source of infection” (PROG_PWID_O5). Several different perpetrators of violence were named, including police, vigilante groups, and the general community. Intimate partner violence was also noted as common for WWID. Further, police were identified as one of the most important groups of perpetrators to work with to decrease violence against PWID: “We need to find ways in advocating with the police and making sure that the users are not the primary target. The police should address the efforts to address the demand and supply pattern of the drug. The police should ensure that these people are taken to rehabilitation centers” (PROG_PWID_O5).

HIV Risk

According to respondents, in conforming with gender norms, the beliefs that **only men use drugs, it is more acceptable for a man to use drugs or to be high than it is for women, and men should take risks** cause WWID to feel entitled — and sometimes encouraged — to use drugs, because “It’s like it’s his right to do so” (REP_PWID_O3).

Not conforming to beliefs about who should or even does use drugs also affects HIV risk for WWID. They experience rejection and internalized stigma, which lead to riskier drug use practices.²⁵ As REP_PWID_O3 noted, “The girl felt like she can consume more drugs to cover up the disappointment.” Furthermore, WWID who feel “abnormal” often hide their drug use, sometimes increasing the riskiness

of their injection practices and making them difficult to reach with risk reduction programs. “Some of them inject on the groin rather than on the hands so that the general public doesn’t realize that they are injecting drugs” (REP_PWID_O2). Finally, respondents repeatedly noted that programs for PWID focus more on men because women are not seen as an important demographic to reach — likely because there are fewer women than men who report (as drug users) for services. This causes a critical missed opportunity to provide education on prevention or harm reduction services to women.

Respondents knew little about TWID. Overall, TWID are not seen as an important target for PWID programming, as confirmed by one PROG respondent: “Transgender people are hidden people and they have their own programs or interventions so there is no need of discussing about them right now” (PROG_PWID_O1). Thus, individual TWID are unlikely to be reached with the information they need to understand and reduce their HIV risks as they relate to drug use.

Service Uptake

PWID have many other immediate needs and obligations that can affect whether they access HIV services. Respondents noted that “getting the next dose” can take priority over almost anything else, as suggested by respondent PROG_PWID_O5: “Because of their behavioral pattern among the PWIDs they don’t prioritize care since their primary need is a drug.” When an individual wants to seek HIV services, women in particular often have other obligations that must be taken into account. Respondents stated that the belief that **a woman should take care of those around her even if it means forgoing care for herself** causes some WWID to prioritize care for their partners or children over themselves, including when it comes to seeking HIV care and treatment. According to respondent REP_PWID_O3, the phenomenon can be explained this way: “Even if her partner is sick she will take care of him more than she is supposed to do for herself.” Women’s obligation to care for their children, often in drug dens and away from more public locations, also reduces the opportunities for outreach workers to connect with WWID.

The service seeking behavior of WWID is also affected by beliefs about women as partners and as mothers. The belief that **women should not seek health care services without permission from their partners** was perceived as a barrier for many WWID, particularly if their partners also inject drugs. As respondent REP_PWID_O3 noted, “I experienced a case

where a partner was HIV positive and when the woman wanted to visit a clinic which dealt with HIV positive clients, the man felt like it's like his status will be exposed. She was waiting for her husband's permission to seek services. The woman was only going to check her status." Pregnant WWID or those with children refrain from seeking services for PWID because they fear providers believe that **WWID are not good mothers** and that **WWID should not be allowed to have children**.²⁵ These beliefs also prevent WWID from disclosing their drug use to providers when they seek other health services, such as antenatal care, which causes a missed opportunity for appropriate referral. Respondent PROG_PWID_05 summarized this predicament: "The health service providers view the WWIDs as people who do not take responsibility. This affects the health seeking behavior of the mothers."

Respondents also reported that the available services for PWID cater more to men: "The world of PWID operates on its own; very little is done for WWID" (PROG_PWID_06). The programmatic focus on MWID is attributable to the understanding that **only men use drugs** and to program data that suggest there are very few WWID because women do not come to PWID programming as a result of either the issues described above or the belief that PWID programs are not meant for them. This creates a cycle of chronic underfunding for programming that serves WWID. "At the intervention level if the population target is mostly composed of men, the donor will always focus on the large numbers and leave the less number out. The program data affect the policy too since they will report low data on women but they are there. It's only that they were not reached because of this misconception [that only men inject drugs]." (PROG_PWID_05).

The needs of WWID that reportedly require additional attention within PWID programming are pregnancy and prevention of mother-to-child transmission, family planning, sexually transmitted infection (STI) and HIV screening, psychosocial support, child welfare, post-exposure prophylaxis, possible involvement in sex work, homelessness, and subordinate positions in their relationships with men (such as condom negotiation).²⁵ Respondents also noted that what is available should be more convenient for WWID specifically. Recommendations to increase convenience called for mobile clinics, extended hours of operation, and childcare during appointments.

The literature supported these findings and the need for a better understanding of and more advocacy around the needs of WWID.²⁵ None of the health care workers interviewed about PWID services worked with TWID, and services for TWID specifically are not available.

Service seeking is also delayed by MWID who adhere to the belief that **real men don't seek health services**. Respondents stated that this belief prevents men from going to a provider or getting tested until they are very sick, for fear of appearing weak. As respondent PROG_PWID_02 stated, "This harms the PWID in that their morbidity progresses more rapidly and this makes them not to get proper time to seek the medical care they need."

OPPORTUNITIES

Respondents identified a variety of supportive laws and policies including Kenya's constitution, which promotes the right to health care and discourages discrimination, and the *Standard Operating Procedure For Medically Assisted Therapy (MAT) For People Who Use Drugs*.²⁷ MAT standard operating procedures also indicate that MAT sites are not to be used to arrest or harass people who are seeking services or engaged in treatment.²⁸ The National Campaign Against Drug Abuse has a progressive non-discriminatory policy: treatment facilities seek to ensure that no discrimination occurs in the quality of care and type of service offered.²⁸ Respondents also reported legal opportunities such as advocacy efforts to change the Narcotic Drugs and Psychotropic Substances (Control) Act to focus on offering alternatives to incarceration for PWID, including rehabilitation, MAT, drop-in centers, custodial sentences, and community service. Many programs are reportedly youth-friendly.

The Ministry of Health, Government of Kenya, through the National AIDS and STI Control Programme (NAS COP) and the National AIDS Control Council (NACC) have shown strong leadership in setting policy and programs for HIV prevention and service provision for PWID. The country has several policy documents such as *The Prevention Revolution Roadmap*,²⁹ the *National AIDS Strategic Framework*,¹ and *National Guidelines for STI and HIV Programming with Key Populations*³⁰ that guide the response. The national guidelines commit a combination prevention approach with a focus on biomedical, behavioral, and structural interventions with PWID. Funding for PWID programs in Kenya is available specifically from

BOX 3. MULTIPLE VULNERABILITIES

In addition to the violence, stigma, and discrimination stemming from the gender norms that exist in society, vulnerabilities related to age, HIV status, and criminalization of behaviors were also raised by respondents.

PWID living with HIV are one of the most vulnerable groups of PWID. Not only are they at an increased risk of violence, but they are also less likely to seek services for fear of double stigma and discrimination.

Young PWID were identified as a population at high risk for HIV and violence, and as an extremely difficult population to reach, particularly because of laws related to drug use and families who reject them: "That is to simply say that 'good girls don't do this and good boys don't do this,' so they are looked as bad boys and girls so whatever happens to them it's their own fault and that's why their families abandon them" (PROG_PWID_02).

Homeless WWID and WWID who are sex workers were reported as particularly vulnerable to both violence and HIV acquisition, and programs reportedly do not provide services that meet their unique needs, including night outreach and offering food and shelter: "The biggest gap is limited services. For example, WWID who have families and babies are mostly homeless. This is not being catered for by the programs" (REP_PWID_01).

Respondents reported that the **criminalization** of possessing or using narcotic drugs in Kenya acts as a major barrier to HIV service uptake. PWID do not seek services because they fear health centers will see them as criminals and reveal their identity to law enforcement. They fear arrest under the Narcotic Drugs and Psychotropic Substances (Control) Act, which is punitive against drug users. Criminalization also interferes with HIV programming, including needle and syringe programs and peer education and outreach. Many respondents noted that focusing on rehabilitation and treatment instead of incarceration would increase PWID's willingness to seek help for addiction and receive HIV services.

¹No age ranges were specified by gender analysis respondents regarding "young" and "old." The LINKAGES project uses the UNAIDS definition of sex worker: "Sex workers include consenting female, male, and transgender adults — as well as young people over the age of 18 years — who regularly or occasionally receive money or goods in exchange for sexual services. As sex work is defined as the consensual sale of sex between adults, children (people under 18 years) cannot be involved in sex work."²⁶

PEPFAR, the Global Fund, and others. The government also supports PWID programming as seen in the inclusion of PWID in national working groups and forums such as the Global Fund; development of policy to guide PWID programming; establishment of rehabilitation and counseling; and roll-out of needle and syringe programs and methadone programs. Further, NASCOP is conducting a study on the prevalence of HIV among PWID in Kenya. NASCOP, with support from other development partners, has also recently scaled up MAT for PWID, and has prioritized providing these services to WWID.

Of vital importance, a growing network of PWID organizations is involved in advocacy efforts. According to gender analysis respondents, PWID — including a limited number of WWID — are involved in shaping policy and programs including in the County Coordinating Mechanism of the Global Fund and the NASCOP Key Population Technical Working Group.

Many efforts have been made by the Government of Kenya and partner organizations to improve programming for PWID, including WWID. In Nairobi, there are programs that provide community outreach services, including to WWID. Efforts are also ongoing to ensure that clinics for PWID provide the complete package of services as recommended by the

Ministry of Health, including integrated sexual and reproductive health services especially for WWID. In addition, respondents mentioned one program in Nairobi with an established network of women who use drugs. However, as demonstrated in the responses of gender analysis respondents, more needs to be done to make WWID feel that PWID programming is designed for and welcoming to them. This would increase their uptake of services, which would in turn provide programmatic data that proves that services for WWID merit additional funding. Respondents recommended increased peer-to-peer contact by female peer educators to connect with those who are hardest to reach and may not be currently counted. *“You can hold talks with the ladies, talk on issues on sex work mostly on ladies. Since they are mothers/ pregnant ladies. Men have their own issues which they can discuss on their own.”* (REP_PWID_O4). Additionally, Bomu Hospital and the Omari Project are working to help women “come out” from hiding by addressing harmful gender beliefs about WWID.

TWID are reportedly served through existing programs currently available to PWID. However, very little was known about their needs, and respondents felt that they were more likely to be served by programming for men who have sex with men or sex workers than services for PWID. The Ministry of Health

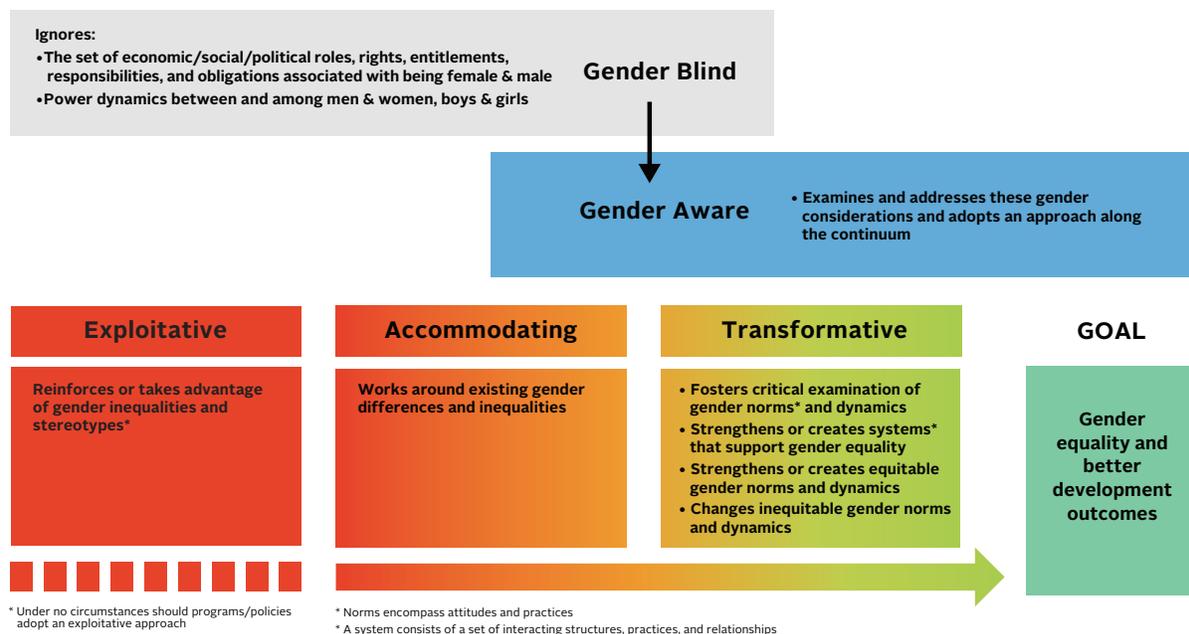
is engaging with the transgender community about how to address their needs through more targeted programming.

Violence, a clear issue for PWID, has also been prioritized within some interventions, particularly at PWID clinics and NGOs. To address violence, some existing PWID programs in Nairobi offer support to survivors of violence through support groups where PWID share real life experiences; NASCOP is also beginning to support additional training for health care workers to screen for and respond to violence experienced by PWID. Clinics and NGOs also provide treatment and make referrals for the necessary violence response services. Additionally, NASCOP and others are working with police to prevent violence against PWID and increase support from police if someone who injects drugs reports an incident of violence. There are also programs working to sensitize the broader community on PWID's rights.

NEXT STEPS FOR GENDER-INTEGRATED PROGRAMS FOR PEOPLE WHO INJECT DRUGS

Knowledge of the ways that gender norms and inequalities affect MWID's, WWID's, and TWID's vulnerability to violence, HIV risk, and HIV service uptake can inform current and

FIGURE 2: IGWG Gender Equality Continuum Tool



future gender accommodating or gender transformative programming for all PWID in Kenya. As defined in the USAID Interagency Gender Working Group's Gender Equality Continuum Tool (see **Figure 2**), **gender accommodating** programs acknowledge, but work around, gender differences and inequalities to achieve project objectives. Gender transformative programs aim to promote gender equality and achieve program objectives by 1) fostering critical examination of inequalities and gender roles, norms, and dynamics; 2) recognizing and strengthening positive gender-related beliefs that support equality and an enabling environment; and 3) promoting the relative position of marginalized groups and transforming the underlying social structures, policies, and broadly held social norms that perpetuate gender inequalities.

Looking at the gender-related beliefs that should be considered in such programming (presented in **Figure 1**), it is also possible to make connections back to the original gender norms that underlie these beliefs. The norms most relevant to the gender-related beliefs affecting PWID are:

- Men are superior to women.
- Men don't ask for help.
- Men should take risks and women should keep themselves and others safe.
- A woman's value comes from her role as a mother.
- Violence against women is acceptable and normal.
- Sex assigned at birth dictates gender identity (i.e., transgender people either do not exist or are simply confused).

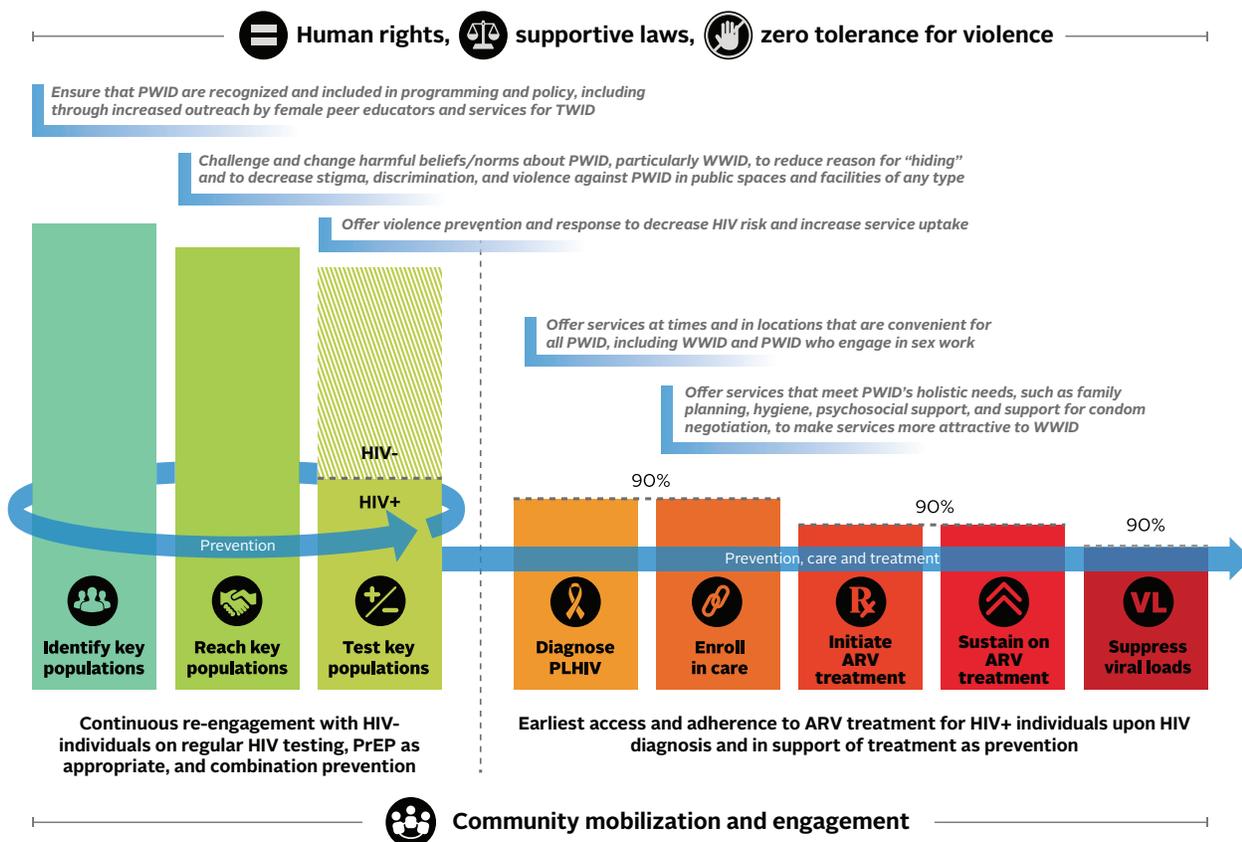
Gender transformative programming in particular should consider both how to challenge the specific harmful belief that is relevant to PWID (e.g., WWID are bad mothers) and the underlying norm (e.g., a woman's value comes from her role as a mother). The following are our recommendations for both gender accommodating and gender transformative programs serving PWID in Kenya. **Figure 3** demonstrates the relevance of the recommendations to achieving the 90-90-90 targets.

Recommendations

- **Sensitize clinical teams working with PWID on how gender norms are at the root of stigma, discrimination, and violence against PWID to help them understand and question their own and others' negative attitudes.** Ensure that health care workers are aware of the additional health care needs of and barriers to care that WWID may experience, including self-stigma, partner control, and assumptions that health care workers will think WWID are unfit mothers. See *LINKAGES Health Worker Training*.ⁱⁱ
- **Make holistic services currently offered in limited sites more convenient for and friendly to WWID** by offering longer evening hours, childcare, mobile clinics, and services that meet their stated needs all in one location: condom negotiation, prevention of mother-to-child transmission, family planning, HIV and STI testing and counseling, post-exposure prophylaxis, psychosocial support, and legal aid services for children. Ensure that these services are marketed specifically to WWID, including through outreach by female peer educators.

ⁱⁱ Unlinked resources can be requested by writing to LINKAGES@fhi360.org.

FIGURE 3: Application of Gender Analysis Recommendations to HIV Prevention, Care, and Treatment Cascade



- **Reach out to WWID and young PWID with specific, individualized information and skills** that address their unique needs, including condom negotiation, family planning, and psychological support. Include additional, individualized information and skills for WWID who engage in sex work, and recognize that MWID and TWID may also need this information. Employ peer educators who are truly peers of each target group, including young PWID.
- **Fully integrate violence response services within HIV services for PWID.** Train all those working with PWID to provide first-line response and referrals to provide first-line response and referrals to meet the holistic needs of PWID who have experienced violence. Ensure that all referral points, especially those that may be a first point of contact (e.g., the police), can share time-sensitive information on HIV services such as post-exposure prophylaxis. See *LINKAGES Violence Screening and Response Training*.³⁰
- **Continue to work with the police on the prevention of violence against PWID and to document incidences of violence experienced by PWID** (disaggregated by gender) and actions taken to address them. See *Responsive Law Enforcement for HIV Prevention: A Manual for Training Trainers to Sensitize Police on Their Role in a Rights-based Approach to HIV Prevention among Key Populations* for a Kenya-specific training resource.³¹
- **Explicitly discuss and challenge the gender-related beliefs that put PWID at risk for HIV and violence as well as limit their uptake of services** in programming with PWID community members. Use peer education (by MWID, WWID, and TWID) and existing rights education to talk about where these beliefs come from, how gender-related beliefs affect individual and collective behavior, and how to challenge harmful gender norms. Ensure that the norms affecting all genders are discussed explicitly. See *Stepping Stones for Women in Sex Work* for ideas on facilitating these conversations.³² At the same time, **develop messages that directly address the gender-related beliefs that prevent people from disclosing their drug use or seeking help.** For example, “Women should take care of others before they

³⁰ Unlinked resources can be requested by writing to LINKAGES@fhi360.org.

care for themselves” could be countered by “Women deserve to live healthy productive lives.” Ensure that in countering inaccuracies, such as “All WWID are sex workers,” other KPs are not stigmatized.

- **Continue to engage WWID as leaders in identifying their needs and designing PWID-friendly programming.** Build the capacity of WWID as needed to ensure that they are able to be involved meaningfully.
- **Ensure that campaigns directed at PWID do not inadvertently use messages that suggest only men inject drugs or that exploit harmful gender norms.** Program material should avoid imagery that is not inclusive of WWID (such as a silhouette of MWID on a campaign logo) and should never tap into harmful existing power dynamics to encourage women’s uptake of services – for example, by asking MWID to bring their female partners to seek services. Instead, MWID with female partners should be encouraged to tell their female partners about available services and let them make decisions regarding their own care. For more on how to engage men positively in their female partners’ lives see the next recommendation.
- **Use principles of constructive male engagement to engage MWID who are in heterosexual relationships as partners** in order to encourage their female partners’ service uptake in a way that respects their rights and autonomy, and to prevent intimate partner violence by MWID. See *MenEngage Africa Training Initiative*.³³
- **Partner with other women-focused initiatives** so that campaigns to promote women’s health and well-being, such as those on violence against women, explicitly include WWID.
- **Ensure that programmatic monitoring and evaluation is used to inform decision-making but not to justify exclusion of groups not currently seeking services.** Limited numbers of both WWID and TWID clients in PWID programming can be used to justify a lack of programs for these individuals, even when known barriers prevent service uptake. Use both appropriate program monitoring — including disaggregation of information on trans gender people (see *Policy Recommendations for Inclusive*

Data Collection of Trans People in HIV Prevention, Care & Services for accurate data collection practices) — and additional tools such as surveys to understand who PWID are.³⁴ Use this additional data to advocate for more inclusive PWID programming, more funding for underserved individuals, and stronger connections between services for PWID and transgender people.

CONCLUSION

Gender analyses have been conducted in projects working with women and girls for many years. However, conducting a gender analysis in the context of injection drug use and HIV is a relatively new area of work. Another unique feature of this research is the partnership it created within and across civil society, community groups, and the government, including between organizations that primarily serve transgender people and those working with WWID and MWID.

Our research adds to the body of knowledge that shows that harmful gender norms affect HIV-related outcomes. PWID’s HIV risk, vulnerability to violence, and service uptake are all affected by both conforming to gender norms and being seen as non-conforming. In the context of HIV in Kenya, this research provides evidence that addressing gender norms and the beliefs that stem from them in HIV prevention and care interventions is essential. Recommendations made here will assist both implementers and the government to use the research findings to enhance programs and policies for PWID.

Finally, gender transformative programming for PWID could have a much wider impact. Critically looking at and challenging norms that encourage men to take risks and delay care would benefit all men. In the same way, changing harmful gender norms affecting WWID would also benefit all women, whether or not they use drugs, by challenging biases that value and empower men over women or state that women who are perceived not to conform to gender norms “deserve” violence. For example, challenging the legitimacy of using beliefs such as “Only men should use drugs” as a justification of violence against women is of relevance to all women, as respondent GOV_1 stated, “*The fact that you inject drugs does not mean that you are not a woman.*”

Learn more about LINKAGES by visiting www.fhi360.org/LINKAGES or writing to LINKAGES@fhi360.org.

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