

# **INTEGRATION OF GENDER AND HUMAN RIGHTS IN HIV AND SEXUAL AND REPRODUCTIVE HEALTH SERVICES**

Training for Health Care Providers  
Facilitators' Manual





---

# **Integration of Gender and Human Rights in HIV and Sexual and Reproductive Health Services**

---

Training for Health Care Providers  
Facilitators' Manual

---

## PAHO HQ Library Cataloguing-in-Publication Data

---

Pan American Health Organization.

Integration of Gender and Human Rights in HIV and Sexual and Reproductive Health. Training for Health Care Providers: Facilitators' Manual. Washington, DC : PAHO, 2013.

1. HIV. 2. Sexual and Reproductive Health. 3. Gender. 4. Human Rights. 5. Health Services. I. Title.

ISBN 978-92-75-11740-8

(NLM Classification: WA 530 DA1)

The Pan American Health Organization welcomes requests for permission to reproduce or translate its publications, in part or in full. Applications and inquiries should be addressed to Editorial Services, Entity of Knowledge Management and Communications (KMC), Pan American Health Organization, Washington, D.C., U.S.A. ([pubrights@paho.org](mailto:pubrights@paho.org)). The Area of Family and Community Health/Prevention, Treatment and Care of HIV and STI Project will be glad to provide the latest information on any changes made to the text, plans for new editions, and reprints and translations already available.

© Pan American Health Organization, 2013. All rights reserved.

Publications of the Pan American Health Organization enjoy copyright protection in accordance with the provisions of Protocol 2 of the Universal Copyright Convention. All rights are reserved.

The designations employed and the presentation of the material in this publication do not imply the expression of any opinion whatsoever on the part of the Secretariat of the Pan American Health Organization concerning the status of any country, territory, city or area or of its authorities, or concerning the delimitation of its frontiers or boundaries.

The mention of specific companies or of certain manufacturers' products does not imply that they are endorsed or recommended by the Pan American Health Organization in preference to others of a similar nature that are not mentioned. Errors and omissions excepted, the names of proprietary products are distinguished by initial capital letters.

All reasonable precautions have been taken by the Pan American Health Organization to verify the information contained in this publication. However, the published material is being distributed without warranty of any kind, either expressed or implied. The responsibility for the interpretation and use of the material lies with the reader. In no event shall the Pan American Health Organization be liable for damages arising from its use.

## Table of Contents

Page iv PREFACE

Page v ACKNOWLEDGMENTS

Page vi ACRONYMS

Page 1 INTRODUCTION

Page 7 Definition of Key Concepts

Page 9 **Module 1** Gender Dimensions of HIV and SRH

Page 25 **Module 2** HIV, SRH, and Human Rights

Page 37 **Module 3** Transforming HIV and SRH Programs and Services

Page 49 **Module 4** Addressing Gender-Based Violence

Page 61 Module Evaluation Form

Page 62 End-of-Training Evaluation Form

Page 63 References



## Preface

Since the beginning of the HIV epidemic, Latin America and the Caribbean (LAC) have made significant progress in the reduction of new infections and expansion of HIV treatment and care services. At the same time the annual estimated number of women, in particular young women, infected with HIV is growing, and key populations such as sex workers, men who have sex with men, and transgender persons, remain disproportionately affected by HIV. In order to achieve the global targets of universal access, zero new infections and zero HIV-related deaths, sustained and targeted efforts will be required, focusing on the most vulnerable groups.

Gender inequity, stigma and discrimination serve as barriers to an effective HIV response. Gender norms, values, power relations, and stereotypes related to masculinity and femininity help shape the sexuality and sexual expressions of individuals and groups, and influence the level of control over one's own sexuality and sexual behavior, and access to resources. Traditional

gender norms and stereotypes also contribute to stigma and discrimination against gay, bisexual, and transgender persons, because of their non-conformity with prevailing gender norms.

PAHO and UN Women developed this training package as a resource for national stakeholders, to build capacity among service providers, including physicians, nurses, midwives, patient care assistants, health educators, community health workers and volunteers, to provide gender-responsive and human rights-based HIV and sexual and reproductive health services.

The aim of this resource is to improve availability, acceptability, accessibility and quality of HIV and sexual and reproductive health (SRH) services for women, men, girls, and boys, regardless of gender identity or sexual orientation, with the ultimate goal to improve HIV and SRH related health outcomes, including prevention of HIV infection and mortality, and reduction of other sexually transmitted infections, unwanted and unplanned pregnancy, and intimate partner violence.

**Gina Tambini**

Manager

Family and Community Health

Pan American Health Organization



## Acknowledgments

Writing, editing, and coordination:

- Roberta Clarke (UN Women)
- Sonja Caffè (PAHO)

PAHO and UN Women recognize the contributions of the following persons to this training resource:

- Alessandra Guedes (PAHO)
- Catharine Cuéllar (PAHO)
- Cherise Adjodha (UN Women)
- Floriza Gennari (PAHO)
- Javier Vásquez (PAHO)
- Marcy Hersh (Independent consultant to PAHO)
- Matilde Maddaleno (PAHO)
- Sandra Jones (PAHO)
- Sara Both (Independent consultant to PAHO)

*Funding for the development of this tool was provided by PAHO, UN Women, DFID, and the Royal Norwegian Embassy in Guatemala.*

## Acronyms

<b>AIDS</b>	Acquired immunodeficiency syndrome
<b>ANC</b>	Antenatal care
<b>ART</b>	Antiretroviral therapy
<b>ARV</b>	Antiretroviral
<b>CEDAW</b>	Convention on Elimination of all Forms of Discrimination against Women
<b>DFID</b>	Department for International Development
<b>eMTCT</b>	Elimination of mother-to-child transmission
<b>GBV</b>	Gender-based violence
<b>HIV</b>	Human immunodeficiency virus
<b>HTC</b>	HIV testing and counseling
<b>LAC</b>	Latin America and the Caribbean
<b>LGBT</b>	Lesbian, gay, bisexual, transsexual
<b>MSM</b>	Men who have sex with men
<b>NGO</b>	Nongovernmental organization
<b>NHRPS</b>	National Human Rights Protection System
<b>OAS</b>	Organization of American States
<b>PAHO</b>	Pan American Health Organization
<b>PEP</b>	Post-exposure prophylaxis
<b>PrEP</b>	Pre-exposure prophylaxis
<b>SRH</b>	Sexual and reproductive health
<b>STI</b>	Sexually transmitted infection
<b>UDHR</b>	Universal Declaration of Human Rights
<b>UN</b>	United Nations
<b>UNAIDS</b>	United Nations Joint Program on HIV/AIDS
<b>UNGASS</b>	United Nations General Assembly Special Session (on HIV/AIDS)
<b>WHO</b>	World Health Organization





# Introduction

## Introduction

This tool is intended to enhance the capacity of health workers, in particular in the primary health care setting, to deliver high quality and nondiscriminatory HIV and sexual and reproductive health (SRH) services to all clients, regardless of sex, gender identity and sexual orientation, through integration of a gender-responsive and human rights-based approach.

HIV services aim to prevent new infections, identify HIV positive persons, and provide treatment and care to enhance the quality of life and prevent premature death. Sexual and reproductive health services are services that promote and facilitate a positive and respectful approach to sexuality and sexual relationships, the possibility of having pleasurable and safe sexual experiences, support individuals and couples to make informed decisions on if, when and how often they want to reproduce, and facilitate the widest possible range of safe and effective family planning methods, including barrier methods, as well as prevention and management of reproductive tract infections, including sexually transmitted infections and other essential care such as preventive screening.

While in many countries HIV and SRH services remain vertical, this training resource positions HIV and SRH services as complementary and overlapping services that can best be delivered in an integrated approach, aligned with other services such as maternal and child health, adolescent health and men's health services.

Gender norms, values and power relations help shape the sexual and reproductive health behaviors of individuals and groups. They tend to prescribe what it means to be a man or woman. Gender norms for femininity in many communities value sexual innocence, passivity, virginity, and motherhood. In such societies, women and girls are not supposed to be knowledgeable about sex and may have limited access to relevant information and services. Unequal power relationships may also compromise their ability to negotiate safer sexual behavior and fertility issues with their male partners (1, 2).

Gender norms for masculinity often dictate that men and boys should be knowledgeable, experienced, and capable of taking the lead in sexual relationships. Many societies condone, if not encourage, multiple partners among men, as well as sexual risk-taking and early initiation of sexual activity. These gender expectations may contribute to increased risk for HIV infection among men and boys (1, 2).

Traditional gender norms of masculinity and femininity also contribute to homophobia, violence, stigma, and discrimination by society and health care workers against lesbian, gay, bisexual, and transgender (LGBT) persons, and contribute to reduced access to essential services, including information, condoms, and HIV testing, treatment and care.

The enjoyment of the highest attainable standard of health is a fundamental right of every human being without distinction of sex, race, religion, political belief, gender identity, gender expression or sexual orientation. Health care providers have a critical role in the provision of equitable, inclusive, and quality services that will contribute to protection of sexual and reproductive rights, promotion of sexual and reproductive health and prevention of HIV infections, morbidity and mortality. International and regional legal instruments require that health workers act in a nondiscriminatory manner toward all who seek care, including HIV and SRH services.

Gender-responsive and human rights-based health services improve the availability, acceptability, accessibility and quality of health services for women, men, girls, and boys by addressing gender-based barriers, homophobia, stigma, and discrimination, thus improving health-seeking behavior and health outcomes.

This training tool builds on the public health values of equity, social justice, solidarity, community participation, and respect for diversity and self-determination. The training aims to build or strengthen the following competencies in health care workers:

- Demonstrate an understanding of basic gender concepts including gender power relations, gender roles, access to and control over resources, gender equity and equality, and gender as a social determinant of health.
- Ability to explain the effects of gender-based societal and cultural roles and beliefs on health and health care, in particular related to HIV and SRH.
- Ability to explain the importance of considering the needs of women, men, boys and girls in the provision of HIV and SRH services.
- Ability to explain the importance of considering sexual diversity and the needs of sexually diverse persons in the provision of HIV and SRH services.
- Ability to recognize personal values, beliefs, attitudes and prejudices related to sexuality, reproduction, HIV, sexual diversity and gender, and understand their potential impact on service delivery.
- Ability to critically assess services and programs through a gender and human rights lens and identify gender biases and human rights violations, and modify practices in line with an equity and human rights perspective.
- Ability to provide HIV and SRH services in a way that respects and protects every client's rights and dignity.
- Ability to identify the occurrence and risk of gender-based violence, and work collaboratively with other actors to prevent and reduce gender-based violence (GBV), and assist persons who experience GBV.

These competencies are aligned with the essential attributes of integrated health service delivery networks that place the person, family and community at the center, are responsive to people's health needs, promote and apply intersectoral action that addresses wider determinants of health. While the emphasis is on HIV services and programs, the training positions these services in a comprehensive continuum of integrated sexual and reproductive health services.

### **Who Can Benefit from this Training?**

This training can benefit all health care providers but particularly targets primary health care workers, as the first level of care serves as a gateway to the health care system with a central role in coordination of the continuum of care. The training can be applied in the context of pre- or in-service training for physicians, nurses, midwives, nursing assistants, patient care assistants, psychosocial service providers, health educators, sexual and reproductive health workers, and can also benefit community health workers and volunteers.

### **Organization of the Training**

This facilitators' manual is part of a training package consisting of PowerPoint slides, participant handouts, group work templates, and background information for facilitators. The training adopts a modular, practical adult learning approach that incorporates diverse learning activities, including presentations, brainstorming, group discussions, role play, and games. The training is comprised of four modules:

- **Module 1:** Gender Dimensions of HIV and SRH
- **Module 2:** HIV, SRH, and Human Rights
- **Module 3:** Transforming HIV and SRH Health Services
- **Module 4:** Addressing Gender-Based violence

The training is intended to be adaptable across different contexts; therefore, facilitators are encouraged to adapt the content to reflect the specific context and needs of participants. These adaptations could include adaptation of PowerPoint presentations, changing names of case study characters or developing alternative exercises or activities.

The training can be presented during four consecutive days or spread out in one-day or two-day blocks, depending on the context and the availability of participants and facilitators. An approximate time is specified for each session. However, the actual length of time needed for each session will depend on contextual factors, including the prior familiarity of participants with the subjects of gender and human rights.

<b>Module 1</b> Gender Dimensions of HIV and SRH (6 hours)	45 minutes	<b>Session 1.1:</b> Workshop overview and introduction of participants
	45 minutes	<b>Session 1.2:</b> Gender-Bbased overview of the status of SRH and the HIV epidemic (in the region or country where the training is taking place)
	1.5 hours	<b>Session 1.3:</b> Gender, sexuality , and HIV risk and vulnerability
	1 hour	<b>Session 1.4:</b> The rationale for gender mainstreaming
	1.5 hours	<b>Session 1.5:</b> Gender-responsive HIV and SRH programs and services
	30 minutes	Closing of Module 1
<b>Module 2</b> HIV, SRH, and Human Rights (6 hours)	30 minutes	Learning log and morning warm-up activity
	1.5 hours	<b>Session 2.1:</b> Defining the application of human rights instruments in HIV and SRH services
	1.5 hours	<b>Session 2.2:</b> Stigma and discrimination as drivers of the HIV epidemic
	2 hours	<b>Session 2.3:</b> Human rights dimensions of HIV and SRH
	30 minutes	Closing of Module 2
<b>Module 3</b> Transforming HIV and SRH Programs and Services (6 hours)	30 minutes	Learning log and morning warm-up activity
	1.5 hours	<b>Session 3.1:</b> Transforming health services to provide gender-responsive and human rights-based health services
	1 hour, 15 minutes	<b>Session 3.2:</b> Gender, human rights, HIV prevention and promotion of sexual health
	1.5 hours	<b>Session 3.3:</b> Gender and human rights dimensions of HIV testing, treatment, and care
	45 minutes	<b>Session 3.4:</b> Gender and human rights dimensions in the elimination of mother-to-child transmission of HIV and congenital syphilis
	30 minutes	Closing of Module 3
<b>Module 4</b> Addressing Gender-Based Violence (5 hours, 15 minutes)	30 minutes	Learning log and morning warm-up activity
	1 hour, 45 minutes	<b>Session 4.1:</b> Gender-based violence as a public health problem
	45 minutes	<b>Session 4.2:</b> Gender-based violence and HIV/SRH
	1 hour, 45 minutes	<b>Session 4.3:</b> Addressing GBV in health services
	30 minutes	Closing of Module 4



Each module follows a standardized format with the following components:

---

1. Title of Module

---

2. Introduction

---

3. Learning Objectives

---

4. Main Messages

---

5. Overview of Module

---

6. Additional Resources

---

7. Sessions

---

a. Objective

b. Activities

c. Preparations required

d. Handouts and other materials

---

8. Facilitator Notes

---

### Facilitation of Training Modules

It is recommended that a team of facilitators deliver the training. Combined expertise and competencies in the following areas should be available within the team:

- Sexual and Reproductive Health (SRH)
- Gender analysis
- Human rights
- HIV prevention, treatment and care
- Health systems
- Adult learning

One lead facilitator should be appointed for each training workshop. The lead facilitator coordinates the adaptation of the training program and materials to the local context and supervises the implementation of the training. Ideally, the lead facilitator should be an experienced trainer with a sound understanding of the core principles of gender equality and gender relations, human rights, and HIV, including the epidemic and key aspects of the HIV response.

The other facilitators could be assigned responsibilities for specific modules, sessions, or activities. The role of each facilitator should be agreed upon in advance of the workshop, and all members of the facilitating team should have the necessary skills and experience in participatory training and the thematic sessions they will facilitate.

It is recommended that facilitators review the entire training package, including handouts and PowerPoint presentations, to be fully aware of the scope and organization of the training content and to easily transition between the different modules.

Session facilitators have multiple tasks, including presenting content, assessing the mood of the group, dealing with learning aids, providing guidance for group work, and so forth. Alternating facilitators during and between sessions will allow one facilitator to “rejuvenate” and be more effective for the next session, and the different styles of facilitators can contribute

to a more dynamic learning environment. Co-facilitators should work as a team and avoid situations of conflict, which may undermine the learning process.

The facilitators must be able to help create an enabling response by encouraging every participant to contribute to the learning process and helping the group to maintain focus. They should also encourage participants to explore different beliefs, values, and positions without fear of judgment; establish mutual trust and respect for opposing opinions to enable consensus building; and summarize key learning moments before guiding the group to the next issue.

Facilitators should try to avoid the following pitfalls: allowing group exchanges to stray from the central theme, lecturing rather than promoting an interactive exchange among the participants, allowing an individual to dominate the dialogue in the workshop, and not allowing adequate time to enable the participants to get to know each other.

Additional tips for facilitators:

- Make sure that the electrical equipment you intend to use is in good working condition and set up in advance.
- Arrange the room in a way that promotes interaction (i.e., participants facing each other).
- Prepare relevant handouts prior to each session. Ensure that there are adequate supplies of all necessary materials (flip charts, markers, notepaper, etc.).
- Engage the participants in the establishment and maintenance of a positive workshop environment through joint formulation of ground rules (i.e., cell phones off or on silent, timely returns after breaks, listening to and respecting each other, etc.).
- Participatory training is most effective when the facilitator does a minimum of talking and relies on the participants to share and develop their views through group work and discussion. Create spaces for participants to share their experiences and thoughts.
- Start each module with a review of the previous module (learning log) and a warm-up activity to break the ice and set the stage for a productive day.
- Using the learning log, ask participants the following questions:
  - What did you learn during the previous module that was useful to you?
  - What was difficult to understand?
  - What didn't you like about the previous sessions? What did you like about the previous sessions?
  - What can you suggest to make the process more meaningful?
- During afternoon sessions and sessions where participants have been sitting for a long while, "energizers" (quick physical exercises) will help to revitalize the group. Have some energizers in mind; participants could also be invited to suggest energizers. Some of the sessions provide examples of energizers that the facilitators can use or replace with other energizers of their choice.
- Allow time in the agenda for administrative and housekeeping matters as needed.
- Inclusion of evaluations at the end of each module and/or at the end of the training program will facilitate structured feedback from the participants for ongoing improvement of the program. Evaluation forms are included in this training package.

## Definition of Key Concepts

**DISCRIMINATION** refers to any form of arbitrary distinction, exclusion, or restriction affecting a person, usually but not only by virtue of an inherent personal characteristic or perceived belonging to a particular group (3).

**DUTY-BEARERS** are those actors who have a particular responsibility to respect, promote, and realize human rights and to abstain from human rights violations. The term is most commonly used to refer to state actors, but non-state actors can also be considered duty-bearers (1, 4).

**FEMININITY** refers to the qualities, characteristics, and behaviors considered appropriate for women and girls (1).

**GENDER** refers to socially constructed roles, relationships, responsibilities, values, attitudes and forms of power assigned to women, men, boys and girls (2, 3).

**GENDER** relations refer to the rules, norms, customs, and expectations of society about the appropriate roles, duties, rights, responsibilities, accepted behaviors, opportunities, and status of women and men in relation to one another (2, 5).

**GENDER IDENTITY** refers to a person's deeply felt internal and individual experience of gender, which may or may not correspond with the sex assigned at birth. Gender identity can be different from biological sex, for instance in transgender persons (3).

**GENDER EQUALITY** refers to the equal treatment of women and men in laws and policies and equal access to resources and services within families, communities, and society at large (2, 6).

**GENDER EQUITY:** While equality carries a notion of sameness, equity carries a notion of fairness. Gender equality refers to the fact that men and women should be treated in the same way, while gender equity refers to specific actions taken to reduce unfair and unnecessary inequalities with consideration of the differential needs of men and women (2, 6).

**GENDER EXPRESSION** can be defined as a visible source of identification that is displayed through characteristics such as personal deportment, mode of dress, mannerisms, speech patterns, socioeconomic behaviors and interaction, and other external features that may subvert traditional expectations of male and female norms (7).

**GENDER-RESPONSIVE** programming refers to programs where gender norms, roles, and inequalities have been considered and measures have been taken to actively address gender inequalities (2).

**GENDER MAINSTREAMING** is the process of assessing the implications for women and men of any planned action, including legislation, policies, or programs in any area and at all levels. It refers to strategies for making women's as well as men's concerns and experiences an integral dimension in the design, implementation, monitoring, and evaluation of policies and programs in all political, economic, and social spheres such that inequality between men and women is not perpetuated (2, 6).

**HUMAN RIGHTS** are the rights regarded as fundamentally belonging to all persons, regardless of nationality, place of residence, sex, national or ethnic origin, color, religion, language, or any other status. All individuals are equally entitled to human rights without discrimination. These rights are all interrelated, interdependent and indivisible (8).

**A HUMAN RIGHTS-BASED APPROACH** contributes to the realization of human rights as reflected in the Universal Declaration of Human Rights and other international human rights instruments, adheres to international human rights standards and principles, and supports the development of the capacities of duty bearers to meet their obligations, and of rights-holders to claim their rights (1).

**RIGHTS-HOLDERS** are individuals and social groups that have particular entitlements. In general terms, all human beings are rights-holders under the Universal Declaration of Human Rights (1).

**RISK (HIV-related)** is defined as the risk of exposure to HIV or the likelihood of a person becoming infected with HIV. Certain behaviors create, increase, and perpetuate that risk (1, 9).

**SEX** is usually defined as the sum of biological characteristics that define the spectrum of humans as females and males (e.g., reproductive organs, hormones, chromosomes) (1, 2). However, the Committee on Economic, Social and Cultural Rights (CESCR) commented that the concept of "sex" has evolved to cover not only physiological characteristics, but also the social construction of gender stereotypes, prejudices and expected roles, which have created obstacles to the equal fulfillment of economic, social and cultural rights (7).

**SEXUAL ORIENTATION** refers to a person's capacity for profound emotional and sexual attraction to, and intimate and sexual relations with, individuals of a different, the same, or more than one gender (3).

**STIGMA:** the origin of the word "stigma" is Greek, and historically referred to the physical marks made by fire or knives on individuals considered outsiders or inferiors. Today the term refers to a mark of social disgrace applied by society based on one or more attributes such as age, class, skin color, ethnicity, religious beliefs, sex, sexual orientation, acts such as adultery or criminal behavior, or a disease or health condition such as mental illness or HIV (3).

**VULNERABILITY** refers to unequal opportunities, social exclusion, and other social, cultural, political, and economic factors that make a person more susceptible to HIV infection and to develop AIDS. The factors underlying vulnerability may reduce the ability of individuals and communities to avoid HIV risk and may be outside the control of individuals (3).





# **Module 1**

**Gender Dimensions of HIV and SRH**

# Module 1

## Introduction

In this module, participants will explore the dimensions of sexual and reproductive health, the prevalence and trends of HIV in their country (or region) and the gendered dimensions of the trends and patterns in the epidemic. Participants will review core concepts related to gender mainstreaming and the rationale and approaches for gender mainstreaming in HIV and SRH health services and programs.

## Learning Objectives

- At the end of this module, participants will be able to:
- Describe the current status of sexual and reproductive health in their country (or region);
  - Describe what is known about the current status of the HIV epidemic in their country (or region), the most affected groups, and the patterns among men and women;
  - Recognize the importance of disaggregation of HIV and SRH data by sex, age group, ethnicity, and other relevant variables;
  - Define key gender concepts, including gender, sex, masculinity, femininity, gender identity, and gender socialization;
  - Describe key gender-related factors that influence sexual and reproductive health and HIV risk and vulnerability among women, men, boys, and girls;
  - Articulate the importance of gender mainstreaming in HIV and SRH programs and services; and
  - Describe key elements of gender mainstreaming in HIV and SRH programs and services.

## Main Messages

- The generation and analysis of data disaggregated by sex, age group, and ethnicity enhances understanding of how HIV impacts women, men, girls, and boys at different stages in their lives and in different cultural settings.
- Gender norms, roles, power relationships and stereotypes influence:
  - Sexual behavior and reproductive decisions.
  - Access to HIV and SRH services, programs and commodities.
  - Vulnerability and risk for HIV infection.
  - The consequences of HIV infection for women, men, girls, and boys.
  - The roles of women and men related to caring for persons infected with and affected by HIV.
- Gender stereotypes are usually negative and often limit the opportunities of women and girls to access necessary information, make decisions about their sexual behavior and fertility, protect themselves against HIV infection, and fulfill their development and health potential.
- The same gender norms, roles, and stereotypes that are harmful to women and girls might also contribute to increased risk and vulnerability among men and boys, and prevent them from realizing their full potential. Sound understanding of male vulnerability and risk is essential for the development of appropriate HIV and SRH services.
- Empowerment of adolescent girls is a critical entry point to start reshaping societal attitudes related to gender, sexuality and reproduction, to break the cycle of poverty and low productivity and early pregnancy, and to reduce the rates of fertility, STI and HIV.



- Gender stereotypes commonly assume heterosexuality as the norm and stigmatize sexual diversity, often resulting in discrimination of sexually diverse individuals. This is of particular relevance in the context of the HIV epidemic, where sexual minorities, including men who have sex with men and transgender persons have been identified as groups with higher risk and vulnerability for HIV infection. Stigma and discrimination serve as barriers for optimal access to and utilization of HIV health services by sexually diverse persons.
- Gender-responsive programs must take into account how gender norms, roles, and stereotypes affect risk, vulnerability, and access to and utilization of services among gay, bisexual, and transgender persons.
- HIV prevention, treatment, and care strategies that take gender dynamics into account and proactively address gender inequalities are in line with international mandates for gender equality and human rights, and will be more effective in preventing new infections and addressing the needs of women, men, girls, and boys infected with or affected by HIV.
- Gender mainstreaming refers to the process of assessing the implications of any planned action for women and men and making women's as well as men's concerns and experiences an integral dimension in the design, implementation, monitoring, and evaluation of policies and programs, such that inequality between men and women is not perpetuated.

### Additional Resources

- Pan American Health Organization (PAHO). Gender Equality Policy. Washington, D.C., PAHO, 2005. <http://www.paho.org/english/ad/ge/PAHOGenderEqualityPolicy2005.pdf> .
- Pan American Health Organization (PAHO). Plan of Action for Implementing the Gender Equality Policy of the Pan American Health Organization 2009–2014. Washington D.C., PAHO, 2010, [http://new.paho.org/hq/dmdocuments/2010/Plan\\_of\\_ActionEN\\_gender.pdf](http://new.paho.org/hq/dmdocuments/2010/Plan_of_ActionEN_gender.pdf) .
- Pan American Health Organization. Gender mainstreaming in health: a practical guide. Washington D.C., PAHO, 2010. <http://www2.paho.org/hq/dmdocuments/2010/manualENweb.pdf> .
- Pan American Health Organization. Empowerment of adolescent girls. A key process for achieving the Millennium Development Goals. Washington, D.C., PAHO, 2010. [http://new.paho.org/hq/dmdocuments/2010/empowerment\\_final\\_lr.pdf](http://new.paho.org/hq/dmdocuments/2010/empowerment_final_lr.pdf) .
- United Nations General Assembly. Report of the Special Rapporteur on the Rights of Everyone to the Enjoyment of the Highest Attainable Standard of Physical and Mental Health. United Nations, 2010. <http://www2.ohchr.org/english/bodies/hrcouncil/docs/14session/A.HRC.14.20.pdf> .
- International Commission of Jurists. Sexual Orientation and Gender Identity in International Law: References to Jurisprudence and Doctrine of the United Nations Human Rights System (3rd updated edition). United Nations, 2007. [http://www.icj.org/IMG/UN\\_References.pdf](http://www.icj.org/IMG/UN_References.pdf) .
- UNIFEM. The Role of Gender Equality/Relations in Halting and Reversing HIV in the Caribbean: A Training Manual. Barbados, UNIFEM, 2008.

**Overview of Module 1**

**Session 1.1:** Workshop overview and introduction of participants

**Session 1.2:** Gender-based overview of the status of SRH and the HIV epidemic

**Session 1.3:** Gender, sexuality, and HIV risk and vulnerability

**Session 1.4:** The rationale for gender mainstreaming

**Session 1.5:** Gender-responsive HIV and SRH programs and services

Module 1	Activity	Duration	Format
<b>Session 1.1</b>			
(45 minutes)	Welcome and training overview	15 minutes	Plenary
	Interactive activities to introduce participants and establish ground rules	30 minutes	Plenary
<b>Session 1.2</b>			
(45 minutes)	Gender-based overview of the status of SRH and the HIV epidemic (in the region or country where the training is taking place)	45 minutes	PowerPoint presentation and plenary discussion
<b>Session 1.3</b>			
(1.5 hours)	Power Walk	40 minutes	Group activity
	Facilitator presentation: Gender, sexuality and HIV vulnerability and risk	30 minutes	PowerPoint presentation and plenary discussion
	Plenary discussion	20 minutes	Plenary
<b>Session 1.4</b>			
(1 hour)	True or false? Exploring gender norms and expectations related to sexual behaviors, reproduction, and HIV	30 minutes	Small group activity and plenary report-back
	Facilitator presentation: The rationale for gender mainstreaming	30 minutes	PowerPoint presentation and plenary discussion
<b>Session 1.5</b>			
(1.5 hours)	“Circle of Truth” group reflection exercise	20 minutes	Group activity
	Facilitator presentation: Gender-responsive HIV and SRH programs and services	40 minutes	PowerPoint presentation and plenary discussion
	Plenary discussion	30 minutes	Plenary
<b>Closing</b>			
(30 minutes)	Closing of Module 1	30 minutes	Plenary

## Session 1.1

### Workshop Overview and Introduction of Participants

**Objective:** The goal of this session is to set the stage for a successful training experience.

#### Activities

- Welcome and training overview: The main purpose of this activity is to set the stage for successful training through motivational welcoming words from strategic managers who will emphasize the relevance of the workshop for the local context, the critical role the training participants have in the national response, and what will be expected of participants after completion of the training. Speakers could include representatives from the Ministry of Health, civil society representatives, persons living with HIV, and training facilitators. The lead facilitator could close with a brief overview of the training objectives and the four modules.
- Introduction of participants, establishment of ground rules, and discussion of expectations: During the training program, participants will be exploring personal values, norms, and experiences, and how these factors have shaped their professional values and conduct. It is therefore imperative that the training provides a safe space where participants feel free to share and explore. The introduction strategy should encourage optimal interaction between participants to start building rapport in the group. Similarly, the joint formulation of ground rules should contribute to establishment of this common safe space and to orderly and fluid proceedings during training. Discussion of expectations is a useful way of providing an outline of the issues that will be covered during training and what the facilitators expect participants to learn. If there are expectations that cannot be covered in the training sessions, the facilitators may suggest ways in which these could be met.

#### Introduction exercises:

- **What was your name again?** Participants pair up with someone they do not know. They share the following information about each other and then each introduces the other to the group:
  - Name
  - Organization and position (main responsibilities)
  - What makes the participant “tick”
  - What expertise the participant is bringing to the workshop
- **Alliteration game:** Participants choose an adjective describing them that begins with the letter that is also the first letter in their name (for example, Kind Katherine, Friendly Frank). Go around the room and have each participant say his/her name and adjective as well as recall and say the names and adjectives of all of the other participants.

#### Expectations exercises:

- Participants write their expectations anonymously on a piece of notepaper. The papers are collected and the facilitator goes through the expectations together with participants, reading them out or writing them on flipcharts. The facilitator discusses which expectations can possibly be covered and cannot be covered during the training.
- Have participants work in pairs and write up one expectation in terms of the training content and one in terms of the group dynamics, followed by a plenary discussion.

#### Preparations Required

- Identification and invitation of suitable official(s) to participate in the opening ceremony.
- Identification and preparation of introduction and expectations exercises.

#### Handouts and Other Materials

- Materials for introduction and expectations exercises.

## Session 1.2

### Gender-Based Overview of the Status of SRH and the HIV Epidemic

**Objective:** At the end of this session, participants will be able to explain the trends and gender dimensions of SRH and the local HIV epidemic.

#### Activities

- PowerPoint presentation on the status of SRH and the HIV epidemic in the country or the region where the training is taking place: The presentation should include information on key SRH indicators such as total fertility rate, teen pregnancy rate, contraceptive prevalence and unmet contraceptive need, HIV prevalence rates and mortality data disaggregated by sex, age group, ethnicity, and other variables relevant for the context (e.g., migrants), and sexual behaviors, including age of sexual initiation, numbers of sexual partners, and condom use. The presentation should also outline the most common modes of HIV transmission, service delivery and coverage, and gaps. Where these data are not available, the facilitator should emphasize how this lack of information limits sound understanding of the trends and dynamics in the epidemic.

#### Preparations Required

- Review and updating of the PowerPoint presentation (PPT) provided in this training tool and addition of local information.

#### Handouts and Other Materials

- None.

## Session 1.3

### Gender, Sexuality and HIV Risk and Vulnerability

**Objective:** Participants will gain a better understanding of how gender norms and expectations differentially influence SRH behaviors, outcomes and HIV risk and vulnerability among women, men, girls, and boys.

#### Activities

- **Power Walk:** This exercise is a simulation of gender inequity and other social disparities in action. The role play provides the participant with a real sense of the person behind the inequity. The debriefing following the exercise allows participants to reflect on the types of disparities that exist and how they influence the life experiences of individuals.

#### Instructions for Power Walk

This activity is preferably carried out in an open and fairly wide space to allow for movement.

**Step 1:** Make cards for each character using the roles provided below, or by making up diverse characters using the local context.

**Step 2:** Write cards with questions for observers: What did they notice as people took steps forward or remained still? After disclosure of characters, where were the male characters and where were the female characters? Why do they think is empowered and why?

**Step 3:** Identify two or three observers, provide them with their questions, and place them in strategic places where they have a good overview of the participants. They will be asked to share their observations at the end of the activity.

**Step 4:** Instruct all other participants to start off in a straight line as if they are about to begin a race, reflecting the Universal Declaration of Human Rights, which states that "All are born free and equal in dignity and rights."

**Step 5:** Randomly pass cards with the characters to the participants.

**Step 6:** Read out the statements provided below. With each statement, the participants who feel that the statement responds to their character take one step forward. Participants who feel that the statement partially responds to their character take a small step forward. Participants who feel that the statement does not respond to their character remain in the same place.

**Step 7:** After the last statement has been read, participants remain in their position and reveal their character.

**Step 8:** Lead a discussion on the outcomes of the Power Walk:

Select a couple of characters from the front section to describe their experience, and what it felt like to be in those positions. These are the high-level persons and decision-makers in the community.

- Select a couple of characters from the middle section to share their experience. Usually these are community organizers and professionals, including health professionals. When it comes to health services, we would like these persons to be able to say yes more often to the Power Walk statements. Ask participants what strategies they think could help to do this.
- Select a couple of characters from the back section to share their experience, and what it felt like to be in those positions. Ask how they felt as they watched others moving forward. If no one else points it out, mention that the people at the back are usually the direct beneficiaries of the programs and policies we are involved in, and usually the most difficult to reach. These are the women and men whose health we are supposed to promote and protect—why are they at the back?
- Ask what the Power Walk tells us about the way in which we should develop health programs and policies, and what the different people need in order to participate effectively. How can the front group better respond to the different situations to improve health programming and policies?
- Conclude by highlighting the following key points:
  - Sex, age, ethnicity, sexual orientation, and place of residence are all important determinants of health. When they interact with gender norms, they often reduce the ability of characters (both women and men) to take a step forward in the Power Walk—or to safeguard their own health.
  - It is not only the existence of health services that ensures proper and effective access and use. Who you are and the conditions of your life make a difference in how you interact with the health system and how the health system treats you.
  - Furthermore, certain conditions of your life may mean that you have less social support for coping with disease and illness or less power to control decisions over your own body. These are all aspects that are uncovered when we pay attention to gender.

*(Modified from: Gender Mainstreaming in Health: A Practical Guide. PAHO, Washington, D.C.)*

### Roles/Characters for Power Walk

Orphan girl (10 years old)	Poor rural grandmother looking after 4 grandchildren
Orphan boy (10 years old)	Poor rural indigenous woman (18–24 years old)
Male sex worker	Poor rural indigenous man (24–44 years old)
Female sex worker	Illiterate woman (50 years old)
Minister of Health	Illiterate man (50 years old)
Director of health	Professional man with 1 child
Female community health worker	Professional woman with 1 child
Male community health worker	Teenage boy (14–16 years old)
Female journalist for a local newspaper	Teenage girl (14–16 years old)
Male journalist for a local newspaper	Man suffering from a mental health disorder
Primary school teacher	Nurse
20-year-old female survivor of rape	Pharmacist
20-year-old male survivor of rape	15-year-old rural girl, married to a man 45 years old
Professional gay man (24–44 years old)	HIV-positive woman
Divorced woman with children	Visually impaired young woman
Divorced man with children	Visually impaired young man
Professional lesbian woman (24–44 years old)	Transgender woman
Professional gay man living with HIV	Transgender man
25-year-old man addicted to cocaine	14-year-old pregnant girl
25-year-old woman addicted to cocaine	16-year-old boy with symptoms of an STI

**Statements for Power Walk**

1	I know where to find the nearest health facility.
2	I feel respected by local health care workers.
3	I have a say in the way health services are organized and delivered in my community.
4	I can consult health services when and if I need to.
5	I have access to family resources if I need to pay for health care.
6	I can talk openly to local health care workers about my health problems.
7	I can talk openly to my family about my health problems.
8	Health programs in my area understand what my life is about.
9	I understand how to take medication given to me by my doctor.
10	I am allowed to be treated by a health care worker of the opposite sex.
11	I get to meet government officials.
12	I can read and understand the health information posters at the health facility.
13	If I get sick, I know I will be able to find the medicines I need.
14	I have access to micro-credit or other forms of borrowing money.
15	My opinion is important within my own ethnic or tribal group.
16	I have access to clean and safe drinking water.
17	I eat at least two full meals a day.
18	I can buy condoms.
19	I can negotiate condom use with my sexual partner(s).
20	I can refuse sex with my partner or spouse if I want.
21	I went to secondary school or I expect to go to secondary school.
22	I can pay for treatment in a private hospital if necessary.
23	My opinion is respected/is considered important by municipal or district health officials where I live.
24	I am not in danger of being sexually harassed or abused.
25	I do not feel judged by health care workers.

- Facilitator presentation on key concepts of gender, vulnerability, and risk (including gender, sex, gender equality and equity, gender socialization, gender stereotypes, gender identity, sexuality, vulnerability, and risk): This presentation summarizes and clarifies these core concepts and places them in the context of HIV prevention, treatment, care, and support. The presentation lays the foundation for sound understanding and application of the core concepts during the rest of the training.
- Plenary discussion to allow training participants to ask questions and engage in dialogue to ensure that they fully understand the core concepts: The plenary discussion can be open-ended or can be guided by questions from the facilitator.

**Preparations Required**

- Review, updating, and adaptation of the PowerPoint presentation to the local context.
- Identification of suitable location for the Power Walk exercise.
- Preparation of flash cards with Power Walk characters and observer questions.

**Handouts and Other Materials**

- Power Walk flash cards.
- **Handout 1.1:** Social Determinants of Health.



## Session 1.4

### The Rationale for Gender Mainstreaming

**Objective:** This session's goal is to consolidate the understanding of participants regarding the international, regional, and national mandates for gender mainstreaming and the key aspects of gender mainstreaming in health.

### Activities

- **Small group activity—“True or false? Exploring gender norms and expectations”:** Through discussion of statements on gender norms, expectations, and behaviors in small groups, participants will explore dimensions of gender stereotypes. The purpose is not to arrive at a consensus on whether the statement is true or not, as most of these statements will be true for some people and true in certain situations. The main purpose of the exercise is to make participants aware of the various gender norms and expectations that are explicitly or implicitly embedded in the social narrative and script. Give each small group a statement and instruct the groups to discuss whether their statement is mostly true or untrue in their experience and their community. Ask the group to list reasons why the statement might be mostly true or untrue. Also, ask the group to summarize opposing points of view for sharing during the plenary discussion. Close this part of the exercise with presentation of the key conclusions of each group in a plenary discussion. Continue the plenary follow-up with a brainstorm on how traditional feminine and masculine roles are defined in key words related to general gender roles and behaviors and to sexuality. Share the handout on gender stereotypes with the participants after the brainstorm and close the session with a brief review of the key words, allowing for participants' reactions to the lists.
- **Facilitator presentation on the rationale for gender mainstreaming:** This presentation outlines what gender mainstreaming is and the international, regional, and national mandates for gender mainstreaming in health, including the PAHO/WHO Gender Equality Policy. The presentation also illustrates the link between gender and human rights (Module 2) through clarification that the full enjoyment of human rights, including the right to health, cannot be achieved without gender equality. Finally, the presentation summarizes the key aspects of gender mainstreaming.

### Preparations Required

- Preparation of flash cards with the statements.
- Review and adaptation of the PowerPoint presentation.

### Handouts and Other Materials

- **Handout 1.2:** Gender Stereotypes.
- **Handout 1.3:** Gender Mainstreaming Continuum.

### True or False?

#### Exploring Gender Norms and Expectations

STATEMENT 1	
Male on male sex is not accepted in the community. Men who have sex with men have to keep it hidden, to avoid problems.	TRUE or FALSE?
STATEMENT 2	
Women and girls are expected to wait for men to take the initiative when it comes to sex. If a woman is too free or open about her desires, she can be seen as immoral.	TRUE or FALSE?
STATEMENT 3	
Men and boys are expected to know all about sex and to have early sexual relations. If a man is not openly sexually active, people might think that he is a homosexual.	TRUE or FALSE?
STATEMENT 4	
Men are less likely to seek health care than women since they are socialized to believe that real men do not get sick.	TRUE or FALSE?
STATEMENT 5	
“Age mixing,” or older men engaging in sexual relationships with young girls, is happening a lot in our community. People don't see it as a problem.	TRUE or FALSE?
STATEMENT 6	
Intimate partner violence happens frequently in our community. In most cases both partners are to blame when it happens.	TRUE or FALSE?

## Session 1.5

### Gender-responsive HIV and SRH Programs and Services

**Objective:** At the end of this session, participants will be able to articulate how to mainstream gender into their HIV-related service delivery.

#### Activities

- **“Circle of Truth” group exercise:** This is a small exercise meant to illustrate the intuitive associations health workers have when it comes to HIV. In general, these associations tend to be negative and based on fear, misinformation, and stereotypes regarding who becomes infected and why. Confronting these misconceptions will contribute to the process of change aimed for in this training.

#### Instructions for Circle of Truth

**Step 1.** Ask the group to stand in a circle.

**Step 2.** Explain that when a person catches the ball (or beanbag or similar item), she/he must shout out the first HIV-related word that comes into her/his head.

**Step 3.** Throw the ball at somebody and after he/she has said a word, ask him/her to continue throwing the ball around the circle to random people.

**Step 4.** Ensure that everybody has several turns at throwing and catching the ball.

**Step 5.** When ideas seem to be running out, ask the group to sit down where they are.

**Step 6.** Prompt discussion by asking the following questions:

- Which words came up most often?
- Did these words reflect the reality of HIV?
- Why do these stereotypes exist?
- How can these stereotypes be overcome?

- **Facilitator presentation on gender-responsive HIV and SRH programs and services:** Building on the previous presentation on the definition, rationale, and key aspects of gender mainstreaming in health, this presentation will highlight key aspects of gender mainstreaming in HIV and SRH service delivery. The presentation will be further elaborated upon in Module 3, when details on gender and human rights in the various programmatic aspects of SRH and HIV will be explored.

#### Preparations Required

- Bring a ball or beanbag for the group exercise.
- Review and adaptation of the PowerPoint presentation.

#### Handouts and Other Materials

- None.

## Closing of Module 1

It is recommended that facilitators dedicate 30–60 minutes at the end of the day to wrap up the module. The main purpose of the closing session is to summarize and reinforce the key messages and provide final clarifications if needed. The PowerPoint presentation contains some slides with key messages of the module. The facilitators can adapt these slides to summarize the key conclusions or use alternative strategies, such as inviting participants to articulate what they have learned and what they consider the key messages of the day.

## Facilitator Notes

### **Gender Dimensions of SRH and HIV Vulnerability and Risk**

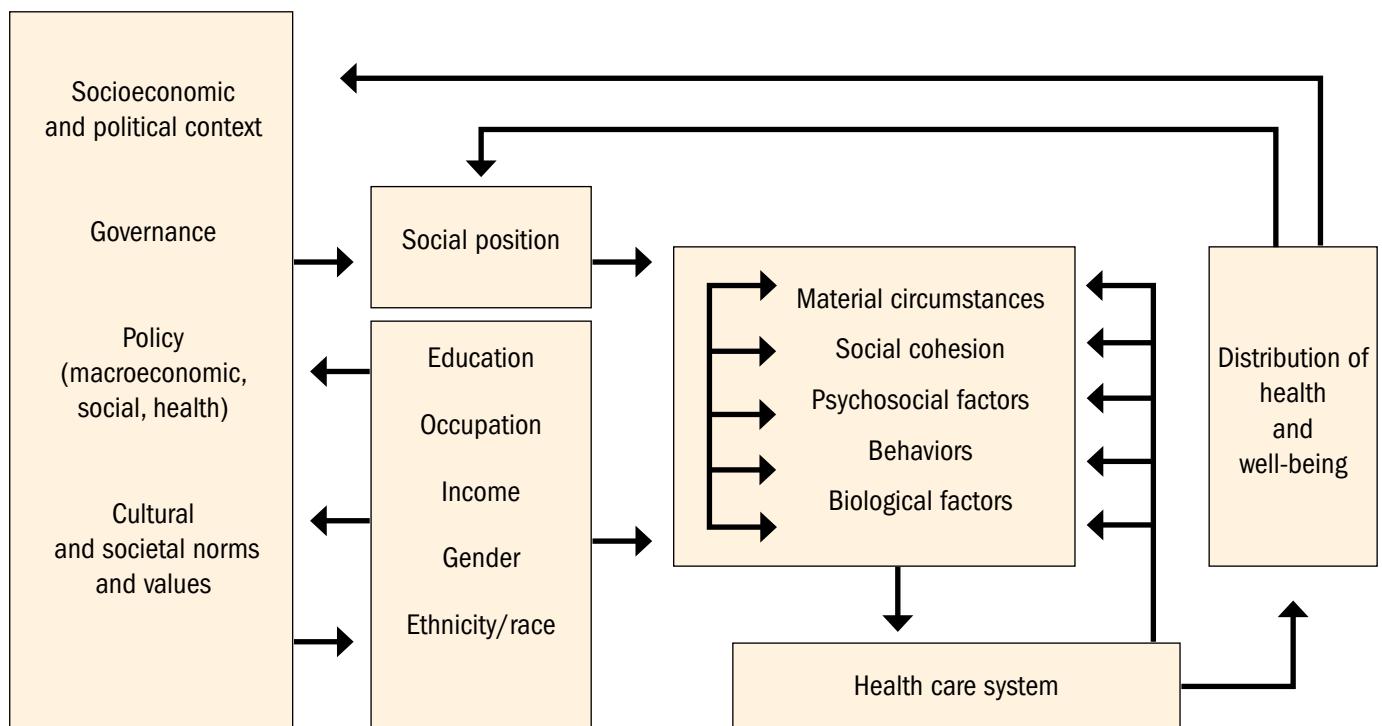
- Pregnancy and abortion are among the leading causes of death for adolescent girls in the region. Adolescents in general, but in particular adolescents girls are more prone to risky sexual behavior, are more likely to have forced or unprotected sex, and tend to have less bargaining power to negotiate safer sex and make autonomous and informed decisions about their sexual and reproductive life (10).
- Globally, and in the Region of the Americas, available data indicate a rising trend in the number of women, in particular young women, infected with HIV. In the Caribbean, in particular, the reported numbers of HIV infections among young women is increasing (11, 12).
- Seroprevalence studies indicate that men who have sex with men (MSM), sex workers, and transgender persons continue to be disproportionately affected by the HIV epidemic globally and in Latin America and the Caribbean (LAC) (13).
- Injecting drug users have also traditionally been recognized as a high-burden group, especially in Brazil, Argentina, Paraguay, Uruguay, and the Mexico-U.S. border region. Non-injecting drug use (such as crack cocaine) in Latin America and the Caribbean is recognized as an important risk factor for HIV transmission (13).
- Migrant and mobile populations may be at higher risk of HIV infection because of social exclusion, violence, and limited access to health services. Other vulnerable and key populations with regards to HIV are specific ethnic groups such as the Garifuna population in Honduras and prison inmates in Brazil, Belize, and Guyana (13).
- Countries will better understand the specific risks and vulnerabilities of women, men, girls, and boys if HIV-related data are collected and analyzed disaggregated by sex, age group ethnic group, and other relevant characteristics (5, 6).
- Dominant norms of masculinity demand of men that they be strong, in control of women, and sexually aggressive. Traditional views of femininity value sexual innocence and submissiveness, impeding women's ability to demand or negotiate safe sex practices (1, 2).
- Societal norms and popular culture may encourage men into early sexual initiation and multiple intimate partnerships as signs of heterosexual virility. Additionally, condom use may be rejected as limiting sexual pleasure. Having unprotected sex with multiple partners increases the risk of HIV infection (1, 2).

- Unequal power relationships between men and women, including economic dependency and transgenerational relationships reduce the capacity of women, especially young women, to negotiate safer sexual practices (1, 2) .
- Traditional gender norms of masculinity and femininity contribute to homophobia and related silence, denial, stigma, and discrimination against key populations at higher risk, such as MSM and transgender persons. These norms affect access to accurate prevention information, power to negotiate consistent and correct condom use, and, among those living with HIV, access to treatment, care, and support. In particular, limited access to accurate, non-stigmatizing prevention information increases vulnerability to HIV infection among MSM, WSW, and transgender individuals and their sex partners. Sanctions against same-sex sexual intimacy contribute to stigma and discrimination and can deter utilization of prevention, treatment and care services (1, 2).
- Stigma and discrimination are at the heart of the HIV pandemic. Fear, shame, and ignorance regarding HIV keep people from practicing prevention and seeking treatment and care. Gender norms and standards in many societies may create double stigma for women, as they might be judged if they insist on safer sexual practices. Women living with HIV who have not disclosed their status and who choose not to have children or not to breastfeed their infants might face further stigma associated with cultural norms related to childbearing and breastfeeding. Members of the LGBT community also face stigma and discrimination within health care settings, negatively affecting their ability to access prevention, treatment and care services (14, 15).

### **Gender Mainstreaming**

- The four global conferences on women, starting in 1975 in Mexico and resulting in the Agreement on the Beijing Platform of Action in 1995, established the lines of action to ensure women's rights, equality, and participation. The commitment to gender equality and women's health was formalized in the Convention on the Elimination of All Forms of Discrimination against Women (CEDAW), which holds these states accountable for reporting on advances every four years (5, 16).
- The Latin American and Caribbean (LAC) region was the first to define a regional and legal framework for preventing and addressing gender-based violence in 1994 through the Inter-American Convention on Prevention, Punishment and Eradication of Violence against Women (Convention of Belem do Para) (17).
- In September 2005 the PAHO Directing Council adopted the Gender Equality Policy, which forms the basis for the efforts of PAHO and Member Countries to mainstream gender in health service delivery. The goal of the Gender Equality Policy is to "contribute to the achievement of gender equality in health status and health development through research, policies, and programs which give due attention to gender differences in health and its determinants and actively promote equality and equity between women and men" (6).
- The 2001, 2006, and 2011 United Nations General Assembly Declarations of Commitment on HIV/AIDS reinforced the critical importance of gender mainstreaming and ensuring promotion and protection of the health, dignity, human rights, and security of women and girls (18, 19, 20).
- The objective of gender equality is to ensure that opportunities and chances are the same for both sexes. Achieving gender equality requires specific measures designed to reduce existing inequalities. In some instances, this can mean that more emphasis has to be placed on women. Gender equity refers to fairness in distribution of goods and resources in order to rectify the imbalance between the sexes. In other words, gender equity strategies are used to attain gender equality (1, 5, 6).
- A gender equity approach implies that all policies and interventions need to be scrutinized for their impact on gender relations. It requires a rethinking of policies and programs to take account of men's and women's different realities and needs (1, 5, 6).

- The Gender Mainstreaming Continuum categorizes interventions by how they consider or address gender norms and inequalities in program design, implementation, and evaluation (1, 2, 5, 6):
    - The term *gender blind* refers to interventions with the absence of any proactive consideration of the larger gender environment and specific gender roles affecting beneficiaries. Programs that are gender blind fail to consider the relationships between gender norms, unequal power relations, and programs.
    - *Gender-aware* programs purposefully examine and address the anticipated gender-related outcomes during all phases of the program cycle. Gender awareness is an important prerequisite for all gender-responsive interventions.
    - *Gender-exploitative* approaches, on the left side of the continuum, take advantage of discriminatory gender norms and imbalances in power to achieve program objectives. While using a gender-exploitative approach may seem expeditious in the short run, it is unlikely to be sustainable and can, in the long run, result in harmful consequences and undermine a program's intended objective. This is an unacceptable approach.
    - *Gender-accommodating* approaches, in the middle of the continuum, acknowledge the role of gender norms and inequities and seek to develop actions that adjust to and often compensate for them. While such projects do not actively seek to change norms and inequities, they strive to limit any harmful impact on gender relations. A gender-accommodating approach does not deliberately contribute to increased gender equity, nor does it address the underlying structures and norms that perpetuate gender inequities.
    - *Gender-transformative* approaches, at the right end of the continuum, actively strive to examine, question, and change harmful gender norms and power imbalances as a means of reaching health as well as gender equality objectives. Gender-transformative approaches encourage critical awareness of gender roles and norms, promote the empowerment of women and challenge the distribution of resources, roles and power between men and women in general, and between intimate partners (heterosexual and same-sex partners).
  - In addition to the international, regional, and national mandates for gender mainstreaming in health, health workers have a professional ethical responsibility to do no harm, to do good, and to uphold justice (1, 2, 5, 6, 21). Recognizing that gender inequality reduces the capacity or opportunity to protect and advance the health of individuals and groups, health workers must take gender dynamics into account in the design and provision of programs and services.
- Gender-responsive HIV Programs and Services**
- Reducing gender inequalities and transforming gender stereotypes and gender relations are essential to reduce vulnerability to HIV infection and ensure optimal access to treatment, care, and support (1, 2, 5, 6, 21).
  - The World Health Organization (WHO) recommends six basic strategies to mainstream gender in HIV and other health programs (5):
    - Integrate gender analysis in the design of programs.
    - Strengthen the capacity of providers to address gender inequality.
    - Reduce gender-based barriers to HIV health services.
    - Promote the participation of women, girls, and sexual minorities.
    - Integrate a gender perspective in the monitoring and evaluation of programs.
    - Advocate for gender-responsive public health policy.

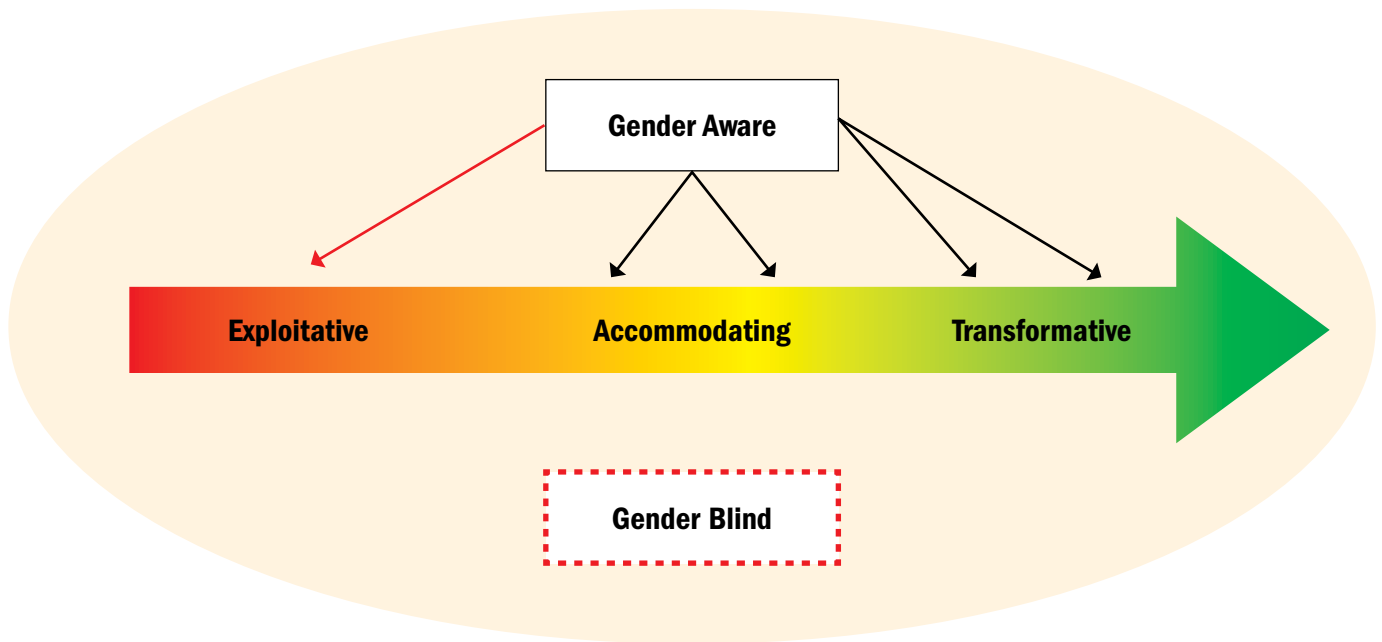
**Handout 1.1**  
**Social Determinants of Health**


**Source:** World Health Organization. A Conceptual Framework for Action on the Social Determinants of Health. 2010.  
[http://www.who.int/sdhconference/resources/ConceptualframeworkforactiononSDH\\_eng.pdf](http://www.who.int/sdhconference/resources/ConceptualframeworkforactiononSDH_eng.pdf) . Last accessed on 21 February, 2013.

**Handout 1.2**  
**Gender Stereotypes**

Traditional woman	Traditional man
Weak Dependent Submissive Passive Accommodating Emotional Nurturing Tender Domestic Talkative Careful	Strong Independent Dominant Active Assertive Rational Aggressive Firm Breadwinner Silent Risk taker
Sexuality	
Heterosexual Low sex drive Duty Accommodates One meaningful partner Experience = "slut" (bad) Sex object Passive Please partner	Heterosexual High sex drive (biological need) Pleasure and need Initiates Experiments (gains experience) Multiple partners Experience = "stud" (good) Sexual predator Orgasm

**Handout 1.3**  
**The Gender Mainstreaming Continuum**



Gender Blind \_\_\_\_\_  
\_\_\_\_\_

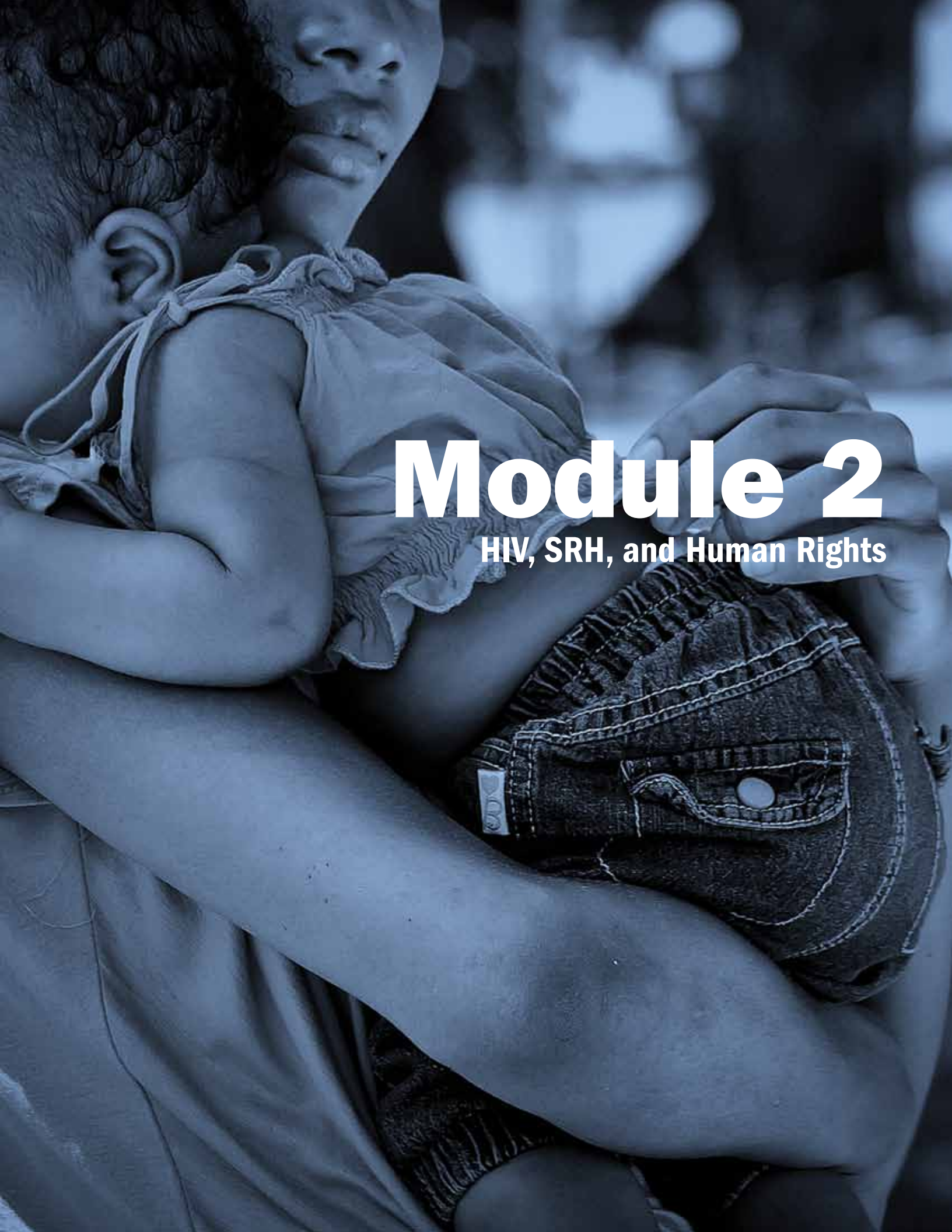
Gender Aware \_\_\_\_\_  
\_\_\_\_\_

Gender Exploitative \_\_\_\_\_  
\_\_\_\_\_

Gender Accommodating \_\_\_\_\_  
\_\_\_\_\_

Gender Transformative \_\_\_\_\_  
\_\_\_\_\_





# Module 2

HIV, SRH, and Human Rights

# Module 2

## Introduction

In this module, participants will learn about the intersection of human rights with HIV and SRH, and the treaties, conventions, and laws that must inform their work. Participants will examine their own values related to stigma and discrimination and learn about their legal obligations as health service providers.

## Learning Objectives

At the end of this module, participants will be able to:

- Understand the intersection between health worker obligations and human rights;
- Explain the key human rights instruments, including conventions and protocols that inform health worker obligations;
- Understand stigma and discrimination as they relate to HIV service delivery; and
- Understand the meanings of informed consent, confidentiality, and partner notification and how to apply these concepts to HIV and SRH service delivery.

## Main Messages

- Enjoyment of the highest attainable standard of health is one of the fundamental rights of every human being without distinction of race, religion, political belief, or economic or social condition (Preamble to the Constitution of the World Health Organization).
- The right to sexual and reproductive health implies that people are able to enjoy a mutually satisfying and safe relationship, free from coercion or violence and without fear of infection or pregnancy, and that they are able to regulate their fertility without adverse or dangerous consequences.
- The United Nations and the Inter-American System have in place a significant body of legal instruments for the protection of human rights that can be used to protect the rights and liberties of persons living with HIV.

- The protections embodied in the UN and Inter-American Human Rights System lie at the heart of any effort designed to increase the protection of persons living with HIV in the Americas.
- Health care workers should familiarize themselves with the rights of persons living with HIV and ensure that those rights are being upheld at all times. If they witness any violations, they must act to stop them and bring them to the attention of responsible officials.
- Human rights and public health share a principal objective: to promote and protect the well-being of people. Health care workers have a legal obligation to respect, protect, and fulfill human rights.
- HIV-related stigma and discrimination have a negative effect on all aspects of the HIV response. Legal and ethical obligations require that health workers act in a nondiscriminatory manner toward all who seek services for HIV prevention, testing, treatment, and care.
- Health care providers must understand and respect issues of confidentiality, partner notification, disclosure, and informed consent.

## Additional Resources

- United Nations. The Universal Declaration of Human Rights. United Nations, 1948. <http://www.un.org/en/documents/udhr/> .
- Office of the United Nations High Commissioner for Human Rights. International Covenant on Economic, Social and Cultural Rights. United Nations, 1966. <http://www2.ohchr.org/english/law/cescr.htm> .
- Office of the United Nations High Commissioner for Human Rights. International Covenant on Civil and Political Rights. United Nations, 1966. <http://www2.ohchr.org/english/law/ccpr.htm> .

**Overview of Module 2**

**Session 2.1:** Defining the application of human rights instruments in HIV and SRH services

**Session 2.2:** Stigma and discrimination as drivers of the HIV epidemic

**Session 2.3:** Human rights dimensions of HIV and SRH

Module 2	Activity	Duration	Format
<b>Opening Session</b>			
(30 minutes)	Learning log and morning warm-up activity	30 minutes	Plenary
<b>Session 2.1</b>			
(1.5 hours)	The “Sinking Ship” group reflection exercise	30 minutes	Group activity
	Facilitator presentation: What are human rights?	45 minutes	PowerPoint presentation
	Plenary Q&A and discussion	15 minutes	Plenary
<b>Session 2.2</b>			
(1.5 hours)	Personal reflection on values related to HIV and provision of HIV prevention, treatment, and care services	45 minutes (15 minutes individual, 15 minutes in pairs, 15 minutes plenary)	Individual activity followed by reflection in pairs
	Facilitator presentation: Stigma and discrimination as drivers of the epidemic	45 minutes	Interactive PowerPoint presentation
<b>Session 2.3</b>			
(2 hours)	Cases studies and role plays	45 minutes	Small group and plenary
	Facilitator presentation: Human rights dimensions of HIV and SRH	45 minutes	Interactive PowerPoint presentation
	Group discussion	30 minutes	Plenary
<b>Closing</b>			
(30 minutes)	Closing of Module 2	30 minutes	Plenary

- Office of the United Nations High Commissioner for Human Rights. Convention on the Elimination of All Forms of Discrimination against Women (CEDAW). United Nations, 1976. <http://www2.ohchr.org/english/law/cedaw.htm> .
- Office of the United Nations High Commissioner for Human Rights. Convention on the Rights of the Child (CRC). United Nations, 1989. <http://www2.ohchr.org/english/law/crc.htm> .
- American Convention on Human Rights (Pact of San Jose). OAS, 1968. [http://www.oas.org/dil/treaties\\_B-32\\_American\\_Convention\\_on\\_Human\\_Rights.htm](http://www.oas.org/dil/treaties_B-32_American_Convention_on_Human_Rights.htm) .
- Additional Protocol to the American Convention on Human Rights (Protocol of San Salvador). OAS, 1988. <http://www.oas.org/juridico/english/treaties/a-52.html> .
- Inter-American Convention on the Prevention, Punishment and Eradication of Violence against Women (“Convention of Belem Do Para”). OAS, 1994. <http://www.oas.org/cim/english/convention%20violence%20against%20women.htm> .
- UNAIDS. (2006). International Guidelines on HIV/AIDS and Human Rights. 2006 Consolidated Version. Geneva, UNAIDS, 2006. [http://data.unaids.org/Publications/IRC-pub07/jc1252-internguidelines\\_en.pdf](http://data.unaids.org/Publications/IRC-pub07/jc1252-internguidelines_en.pdf) .

## Opening Session

### Learning Log and Morning Warm-up Activity

#### Learning log

Ask the participants:

- What did you learn during the previous module that was useful to you?
- What was difficult to understand?
- What didn't you like about the previous sessions? What did you like about the previous sessions?
- What can you suggest to make the process more meaningful?

## Session 2.1

### Defining the Application of Human Rights Instruments in HIV and SRH Services

**Objective:** At the end of this session, participants will be able to:

- Name relevant international and regional legal instruments for the protection of human rights that can be used to protect the rights and liberties of persons living with HIV;
- Understand the linkages between these legal instruments and their work; and
- Articulate their own values related to the provision of HIV prevention, treatment, and care services and how these values influence their work.

#### Activities

- **The Sinking Ship:** This is a values clarification exercise to explore participants' values when dealing with other individuals and groups.

#### Instructions for the Sinking Ship group activity

1. Assign each participant a character or role. Characters can be similar to those used in the Power Walk exercise (Module 1) or alternatives designed based on the local context. Ask participants to announce their character to the group.
2. Ask participants to imagine that they are on a ship that is sinking, and the lifeboat is in danger of being overcrowded.
3. Depending on the number of participants, determine what the threshold of the lifeboat can be. Ensure that it is at least 5 persons less than the number of participants.
4. Ask the participants to decide who should be allowed in the lifeboat and who should be left on the sinking ship. The ship will sink in 10 minutes, so participants have only 10 minutes to determine who gets into the lifeboat and who does not.
5. Keep reminding the participants of the number of minutes left before the ship sinks, to keep up the pressure.
6. Once a decision has been made about a person not allowed in the lifeboat, this person should step away from the group.



## Session 2.2

- **Facilitator presentation on the international and regional legal instruments for the protection of human rights that can be used to protect the rights and liberties of persons living with HIV:** This presentation will elaborate on the body of legal instruments from the UN and the Inter-American System that can be used to protect the rights and liberties of persons living with HIV.
- **Plenary Q&A and discussion:** Since the human rights material might be new to many participants, this Q&A session should encourage participants to ask all questions they have regarding terminology and concepts, to ensure full understanding of the content and main messages of the session. If there are no questions, the facilitator can ask the group questions or use the time to illustrate the key messages with some examples.

### Preparations Required

- Prepare flash cards with characters for the Sinking Ship exercise.
- Review PowerPoint presentation and add local content as appropriate.

### Handouts and Other Materials

- **Handout 2.1:** Key International Human Rights Instruments.
- **Handout 2.2:** International Guidelines on HIV and Human Rights.

### Stigma and Discrimination as Drivers of the HIV Epidemic

**Objective:** At the end of this session, participants will have reflected on and recognized their values related to persons living with HIV and the provision of HIV-related prevention, treatment, and care services.

### Activities

- **Personal reflection on values related to HIV and provision of HIV and SRH services:** The point of departure for this exercise is that health workers are human beings with their own personal values, norms, and expectations related to sexuality, sexual identity and sexual behavior. Some of these values and norms might contribute to difficulties for these health workers in dealing with the issue of HIV and persons living with HIV. While on a cognitive level health workers might agree with the principles of human rights, on an emotional level they might still have difficulties. Furthermore, they might never have voiced their hidden fears and biases and are struggling secretly with these issues. The main purpose of this activity is for the participants to confront their own feelings through honestly completing the self-assessment form (Handout 2.3). The form is strictly for personal use, and will not be shared with others. Following the individual reflection, participants will be paired and asked to share some of their fears and issues with their partner, followed by some joint reflection on how they might address these fears and issues. A critical aspect of this session is for the facilitators to emphasize the confidential nature of what is shared. Facilitators might wish to have some professional counselors available for persons who want or need further assistance.
- **Facilitator presentation on stigma and discrimination as drivers of the epidemic:** This presentation will provide definitions of core concepts and will link stigma and discrimination to the human rights instruments and the ethical codes and principles associated with health service delivery.

### Preparations Required

- Identify counselors to be on standby in case a participant needs further assistance following the personal reflection activity.
- Review PowerPoint presentation.

### Handouts and Other Materials

- **Handout 2.3:** Personal Reflection Form.

## Session 2.3

### Human Rights Dimensions of HIV and SRH

**Objective:** At the end of this session, participants will be able to explain the key elements and implications of core human rights aspects of SRH and HIV health service delivery, including informed consent, confidentiality, partner notification, and disclosure.

#### Activities

- **Case studies and role play:** The main purpose of this activity is to provide a platform for participants to explore real-life situations with human rights and ethical implications. It is strongly recommended that external persons be invited to take on the client roles to support this activity, as this will add to the authenticity of the experience. Form small groups and ask one participant to volunteer for the role of health worker. The remaining group members will be observers and provide feedback after the role play.

#### Case 1: The young girl

**Roles:** 1) health worker; 2) young girl (12–14 years old)

A young girl comes to the clinic without her parents to ask for an HIV test.

**Q:** What do you do as a health worker? Do you perform the test? How can you help this girl?

#### Case 2: The serodiscordant couple

**Roles:** 1) health worker; 2) couple

A couple comes to the clinic because they desire to have a baby. The man tested HIV positive about one year ago.

**Q:** What would be your advice to the couple? Why?

#### Case 3: The married MSM

**Roles:** 1) health worker; 2) married man who also has sex with other men

A married man comes in for HIV testing. He tests positive and discloses that he also has a sexual relationship with another man.

**Q:** How do you approach this case? How do you deal with his female and male partner?

#### Case 4: The sex worker

**Roles:** 1) health worker; 2) female sex worker

A female sex worker comes to the clinic to ask for an HIV test and ARV because she has been raped by a client.

**Q:** How can you help this client? What do you recommend to her?

#### Case 5: The married woman

**Roles:** 1) health worker; 2) married middle-aged woman

A married middle-aged woman comes to the clinic because she has symptoms of an STI (vaginal discharge, burning itch). She is concerned about the fidelity of her husband and about contracting HIV.

**Q:** What can you do for this client? What is your advice to her?

#### Case 6: The male sex worker

A male sex worker comes in and requests PEP. You recognize him from a previous request for PEP two months ago.

**Q:** How can you help this client? What will influence your decision to provide the PEP or not (provided PEP is available in your setting)?

**Alternative activity:** panel discussion with a panel consisting of a person living with HIV, a young person, a sex worker, and a homosexual man. The panel can make short presentations on their experiences with health care providers related to sexual/reproductive health and/or HIV and other STIs, followed by discussion with the group.

- **Facilitator presentation on HIV-related human rights issues:** This presentation will elaborate on some key human rights issues such as access to health services and health information, informed consent, confidentiality, partner notification, and disclosure. The facilitator can make use of the case studies and the experiences during the role plays to illustrate how these key concepts can be interpreted and applied in a variety of circumstances.
- **Group discussion:** Following the PowerPoint presentation, the session can close with a guided or open group discussion for final synthesis of the content.

#### Preparations Required

- Identify and invite persons to participate in the role play or panel discussion.

#### Handouts and Other Materials

- Copies of the role scenarios for all participants.

## Closing of Module 2

It is recommended that facilitators dedicate 30–60 minutes at the end of the day to wrap up the module. The main purpose of the closing session is to summarize and reinforce the key messages and provide some last-minute clarifications if needed. The PowerPoint presentation contains some slides with key messages of the module. The facilitators can adapt these slides to summarize the key conclusions or use alternative strategies, such as inviting participants to articulate what they have learned and what they consider the key messages of the day.

## Facilitator Notes

### Human Rights, SRH, and HIV

- The international and regional communities have formulated a variety of mandates to safeguard human rights. Some of these mandates are specifically related to HIV, while others are more general in scope (1, 21, 22).
- Human rights are universal legal guarantees protecting individuals and groups against actions that interfere with fundamental freedoms and human dignity. Some of the most important characteristics of human rights are that they are guaranteed by international standards, are legally protected, focus on the dignity of the human being, oblige states and state actors, cannot be waived or taken away, are interdependent and interrelated, and are universal (1, 21, 22).
- Because human rights instruments established by international law protect all persons without distinction of any kind, including race, color, sex, language, religion, political or other opinion, national or social origin, property, birth, or other status, they are considered to also protect the rights and freedoms of all persons living with HIV (1, 21).
- Some human rights instruments (conventions or treaties) are legally binding for states that have ratified them. Others—international human rights declarations or “standards”—although not legally binding, are considered to be authoritative interpretations of international convention requirements. In most cases, they are issued by the UN General Assembly, Human Rights Council, or High Commissioner’s Office and by the OAS Inter-American Commission on Human Rights, or they originate through the work of other specialized UN and Inter-American System agencies. They may be used to guide the formulation or review of policies, plans, or programs; the enactment of pertinent legislation; and/or the restructuring of health services as part of a more effective response to HIV (22).
- The relationship between HIV and human rights highlights the ways in which people vulnerable to human rights violations and neglect are more vulnerable to HIV infection, and how persons living with HIV might be more vulnerable to denial of these rights, including access to appropriate care and treatment (1, 21).
- At the heart of the human rights framework is the measure of state accountability. States have a three-pronged obligation: to respect rights, to protect rights, and to fulfill rights (1, 21, 22).
  - To respect a right means that a government cannot violate human rights directly in laws, policies, programs, or practices.
  - To protect a right means that governments must prevent violations by others and provide affordable and accessible redress. For example, states should ensure that private employers do not discriminate against employees living with HIV and should provide avenues for redress if they are fired because of their HIV status.
  - To fulfill a right means that governments must take measures (legislative, administrative, programmatic) that move towards the realization of these rights. For example, a state may adopt a policy to provide antiretroviral treatment to all individuals in need, yet, due to resource constraints, may be able to cover only a small percentage of the population. In this case it would be incumbent on the government to take measures to progressively extend coverage by soliciting support from donors and/or reassessing budget priorities.
- National human rights protection systems (NHRPSs) consist mainly of legal frameworks, institutions, policies, procedures, and actors designed to ensure that international human rights norms and standards are promoted, respected, protected, and fulfilled and included in these systems (22, 23).
- The objective of an NHRPS is to ensure sustainable and effective respect for human rights in a country. Particular consideration should be given to ensuring that all aspects of any NHRPS are responsive to the human rights of women and other groups in situations of vulnerability. Special attention should always be given to groups subjected to discrimination and suffering from disadvantage, including racial and ethnic minorities, children, the disabled, women, the poor, and groups with gender identity and sexual orientation considerations (for example, LGBT groups) (1, 21, 22, 23).

### Health Worker Obligations

- Human rights and public health share a principal objective: to promote and protect the well-being of people. In human rights terms this means promoting and protecting the dignity of all, with an emphasis on the most vulnerable. In public health terms this means promoting health for all, with an emphasis on the most vulnerable (1, 21, 22, 23).
- Health workers are state actors and, as such, must respect and act in a manner consistent with national and international laws and treaties. These legal obligations ensure that health workers act in a nondiscriminatory manner toward all who seek testing, care, and treatment for HIV (1, 21, 22, 23).
- Health workers are obligated to ensure (1, 21, 22, 23):
  - The right to a system of health protection providing equality of opportunity so that everyone can enjoy the highest attainable level of health.
  - The right to prevention, treatment, and control of diseases.
  - Access to essential medicines.
  - Maternal, child, and reproductive health.
  - Equal and timely access to basic health services.
  - The provision of health-related education and information.
- HIV-related discrimination is not only a human rights violation; it is also a barrier for effective action to achieve public health goals and overcome the epidemic. Responses to HIV can be placed along a continuum of prevention, treatment, and care, and stigma and discrimination negatively affect each of these aspects of the response.

### HIV and SRH-related Human Rights Issues

- Every autonomous individual has the right to make informed decisions about his/her health and treatment. Informed consent means giving competent and voluntary permission for a medical procedure, test, or medication. This consent is given based on an understanding of the nature, risks, and alternatives of the procedure or test (5, 21).
- Confidentiality means ensuring that information is accessible only to those authorized to have access. All medical professional codes have provisions related to client confidentiality, defining what type of client information should not be shared and what can or should be shared and under which conditions.
- A breach of confidentiality (5, 21):
  - Violates ethical professional standards
  - Deters testing and care seeking
  - Results in mistrust/avoidance of health care facilities
  - Creates humiliation and shame when the client's personal information becomes public
  - Creates potentially dangerous situations for the client
- Health care workers have the duty to ensure confidentiality, including (5, 21):
  - Coworker vigilance
  - Constant reiteration of this duty
  - Swift response to breaches
  - Support systems for maintaining confidentiality (supervision and debriefing)
- Disclosure is the sharing of confidential information. Sometimes service providers are obliged to share confidential information with others: Health workers share this information on a need to know basis, always bearing the client's interests in mind. Sharing client information is needed and assumed between members of a care provider team to facilitate appropriate provision of care. All cases of disclosure by service providers must be guided by legislation and policy and must ensure that access to client information is limited to those who need to know (5, 21).
- Partner notification means informing known partners, including spouses, of confidential medical information, for instance of the HIV status of a client. From a public health perspective, a primary benefit of notifying partners of a client's HIV status is to help ensure that partners are aware of their possible exposure to the infection while protecting patient confidentiality. Health care providers can provide coaching and assistance with this process and provide support and linkages to appropriate medical and prevention services (5, 21).
- According to UNAIDS partner notification can take place only if (5, 21):
  - The HIV-positive person in question has been thoroughly counseled;
  - Counseling of the HIV-positive person has failed to achieve appropriate behavioral changes;
  - The HIV-positive person has refused to notify, or consent to the notification of, his/her partner(s);
  - A real risk of HIV transmission to the partner(s) exists;
  - The HIV-positive person is given reasonable advance notice;
  - The identity of the HIV-positive person is concealed from the partner(s), if this is possible in practice; and
  - Follow-up is provided to ensure support to those involved, as necessary.



## Handout 2.1 Key International Human Rights Instruments

Universal Declaration of Human Rights	Sets out basic rights and freedoms that all persons should enjoy. Some of the rights included are the right to life, liberty, and security; the right to not be subject to inhuman or degrading treatment or punishment; the right to freedom of movement; the right to own property; the right to work; the right to a standard of living adequate for health and well-being; the right to social security and services; the right to education; and the right to marriage and family. These are both civil and political rights requiring state non-interference and social and economic rights requiring positive state action to ensure an adequate standard of living.
International Covenant on Economic, Social and Cultural Rights	Article 12 recognizes the universal right to the “enjoyment of the highest attainable standard of physical and mental health” and requires state parties to take steps for the prevention, treatment, and control of disease and to create the necessary conditions “which would assure to all medical service and medical attention in the event of sickness.” Article 6 recognizes the universal right to work, and Article 13 states that education should be equally available and accessible to all.
International Covenant on Civil and Political Rights (1966)	Article 2 requires states to protect the rights and freedoms of all persons regardless of race, color, sex, language, religion, political or other opinion, national or social origin, economic status, birth, or any other social condition. Other articles relevant to those living with HIV are as follows: 6 (the right to life), 7 (the right to humane treatment), 9 (the right to liberty and personal security), 12 (the right to liberty of movement and freedom to choose residence), 14 (equality before the courts and tribunals), 16 (the right to recognition everywhere as a person before the law), 17 (the right to privacy and protection of the law against arbitrary or unlawful attacks on personal honor and reputation), 18 and 19 (the right to freedom of thought and expression, including the freedom to seek, receive, and impart information), 23 (the right to form a family), 24 (the right of children to protective measures by the state based on their status as minors), 26 (equality before the law and the right to equal protection), and 27 (the rights of ethnic, religious, or linguistic minorities).
Convention on the Elimination of All Forms of Discrimination against Women	Promotes the elimination of all forms of discrimination against women to encourage gender equality.
Convention on the Rights of the Child	Sets out civil, political, economic, social, and cultural rights of children.
Convention against Torture and Other Cruel, Inhuman, or Degrading Treatment or Punishment (1984)	This instrument may be applied in cases where individuals have been subjected specifically to cruel, inhuman, or degrading treatment or punishment based on their HIV status, whether in a health care facility, prison, or other public institution. Article 10 specifies that the training of law enforcement, medical, civil, and military personnel and other public officials must include the prohibition of torture during the custody, interrogation, or treatment of any individual subjected to arrest, detention, or imprisonment. Article 13 ensures that any person alleging that he/she has been subjected to torture has the right to complain to, and have his/her case promptly and impartially reviewed by, the competent authorities. Article 14 calls on legal systems of state parties to provide redress to victims, who have an “enforceable right to fair and adequate compensation, including the means for as full rehabilitation as possible.”
National Constitutions	Sections on fundamental rights and freedoms include nondiscrimination, equal protection and equality before the law, privacy, and liberty of movement and belief, among other guarantees.
International Labour Organization Code on HIV (nonbinding)	Contains principles for policy development and practical guidelines for effective responses at enterprise, community, and national levels in the following key areas: <ul style="list-style-type: none"> <li>• Prevention and management of HIV and mitigation of the impact of HIV on the world of work.</li> <li>• Care and support of workers infected with or affected by HIV.</li> <li>• Elimination of stigma and discrimination on the basis of real or perceived HIV status.</li> </ul>
Beijing Platform for Action (nonbinding)	Calls on governments, the international community, and civil society, including NGOs and the private sector, to take action in 12 critical areas of concern, including: <ul style="list-style-type: none"> <li>• The persistent and increasing burden of poverty on women.</li> <li>• Inequalities and inadequacies in and unequal access to health care and related services.</li> <li>• Violence against women.</li> <li>• Inequality between men and women in the sharing of power and decision-making at all levels.</li> <li>• Lack of respect for and inadequate promotion and protection of the human rights of women.</li> <li>• Persistent discrimination against and violation of the rights of young girls.</li> </ul>
United Nations General Assembly Special Session on HIV (nonbinding)	Recognizing HIV as a global problem leads to a commitment to various measures, including: <ul style="list-style-type: none"> <li>• Empowerment of women.</li> <li>• Alleviating social and economic impact.</li> <li>• Respecting human rights of persons with HIV.</li> </ul>

General Comment No. 14, International Covenant on Economic, Social, and Cultural Rights (2000) (nonbinding)	The Commission on Human Rights' Committee on Economic, Social, and Cultural Rights, which monitors the Covenant, made clear in its Twenty-second Session that the right to the highest attainable standard of physical and mental health (known as the "right to health") included inter alia access to treatment and HIV-related education. Paragraph 10 notes that "formerly unknown diseases, such as...HIV... have created new obstacles for the realization of the right to health...." Paragraph 12 specifies that health facilities, goods, and services must be within safe physical reach for all persons living with HIV; paragraph 18 calls for nondiscrimination and equal treatment in access to health care regardless of health status, "including HIV"; and paragraph 28 prohibits state parties from restricting the movement of, and incarceration of, those living with HIV based solely on their condition. Paragraph 36 establishes that states must provide "information campaigns...with respect to HIV." Paragraph 33 states that "the right to health, like all human rights, imposes three types or levels of obligations on State parties: the obligations to respect, protect, and fulfill."
Declaration of Commitment on HIV (2001) (nonbinding)	All UN member countries pledged to scale up their response to HIV within a human rights framework. The Declaration sets concrete targets with dates for the introduction of national legislation and related measures to ensure the respect of human rights in the areas of education, inheritance, employment, health care and other social services, prevention, support, treatment, information, and legal protection. Even though the Declaration is not legally binding, an annual review by the UN General Assembly of governments' progress in meeting commitments and the monitoring instruments developed to measure compliance provides powerful incentives to encourage sustainable actions.
Declaration on the TRIPS Agreement and Public Health (nonbinding)	Following the global outcry against the high cost of antiretroviral drugs, the 2001 Ministerial Conference of the World Trade Organization (WTO) agreed that the TRIPS (Trade-Related Aspects of Intellectual Property Rights) Agreement should be interpreted to support public health and to promote universal access to life-sustaining medicines, thus allowing for patents to be overridden if required to respond to public health emergencies such as the AIDS epidemic. This international statement followed the decision of the Brazilian government to permit the local generic manufacture of foreign patented medicines for AIDS treatment unless prices for imported drugs were drastically reduced or the international companies began producing them in Brazil. In 2003, the TRIPS Council granted a waiver providing flexibility to countries unable to produce pharmaceuticals domestically to import patented drugs under compulsory licensing. The Declaration extends exemptions on pharmaceutical patent protection for the least-developed countries until 2016.
International Guidelines on HIV and Human Rights (nonbinding)	Provides policy guidance on the development and implementation of effective national strategies for combating HIV.
1995 Commonwealth Plan of Action on Gender and Development (nonbinding)	Seeks to realize a world in which women and men have equal rights and opportunities at all stages of their lives to express their creativity in all fields of human endeavor, and in which women are respected and valued as equal and able partners in establishing values of social justice, equity, democracy, and respect for human rights.
Commonwealth Plan of Action 2005-2015 (nonbinding)	Recommits to advancing gender equality, building on past achievements and seeking to close persistent gaps in four critical areas, one of which is HIV.
1994 International Conference on Population and Development (ICPD) (nonbinding)	Commits to gender equality, empowerment, and reproductive and sexual health and rights.
<b>Regional</b>	
American Convention on Human Rights	According to its preamble, the purpose of the Convention is "to consolidate in this hemisphere, within the framework of democratic institutions, a system of personal liberty and social justice based on respect for the essential rights of man." Chapter I establishes the general obligation of state parties to uphold the rights set forth in the Convention to all persons under their jurisdiction, and to adapt their domestic laws to bring them into line with the Convention. The 23 articles of Chapter II outline a list of individual civil and political rights due to all persons, including the right to life "in general, from the moment of conception," as well as the right to humane treatment, to a fair trial, to privacy, to freedom of conscience, to freedom of assembly, to freedom of movement, and so forth. The single article in Chapter III deals with economic, social, and cultural rights.
Additional Protocol to the American Convention on Human Rights	The protocol's provisions cover such areas as the right to work, the right to health, the right to food, and the right to education. It came into effect on 16 November 1999 and has been ratified by Argentina, Bolivia, Brazil, Colombia, Costa Rica, Ecuador, El Salvador, Guatemala, Mexico, Panama, Paraguay, Peru, Suriname, and Uruguay.
Inter-American Convention on the Prevention, Punishment and Eradication of Violence against Women ("Belem Do Para")	The Convention recognizes the American Declaration of the Rights and Duties of Man and the Universal Declaration of Human Rights, and affirms that violence against women is a violation of the human rights of women. Article 8 of the Convention of Belem Do Para outlines the kind of infrastructure that should be present in OAS member states attempting to eradicate violence against women. Member states should implement progressive measures such as programs to educate and make the public aware of the right of women to be free of violence.
Nassau Declaration of Health (2001) (nonbinding)	Emphasizes the critical role of health in the economic development of the Caribbean and identifies the HIV epidemic as a health problem that may impede the development of human capital.
Pan-Caribbean Partnership (PANCAP) (2001) (nonbinding)	Acknowledges that the HIV epidemic can halt the socioeconomic survival of the region and commits to eradicating the problems of intolerance, homophobia, and discrimination against people with HIV as well as poverty, ignorance, gender inequities, and lack of skills, which it recognizes as contributing to the spread of HIV.

## Handout 2.2

### International Guidelines on HIV and Human Rights

The following 12 guidelines were adopted at the Second International Consultation on HIV and Human Rights at the UN in Geneva in September 1996 and updated at the Third International Consultation in July 2002 (2).

**GUIDELINE 1:** States should establish an effective national framework for their response to HIV which ensures a coordinated, participatory, transparent, and accountable approach, integrating HIV policy and program responsibilities across all branches of government.

**GUIDELINE 2:** States should ensure, through political and financial support, that community consultation occurs in all phases of HIV policy design, program implementation, and evaluation and that community organizations are enabled to carry out their activities, including in the field of ethics, law, and human rights, effectively.

**GUIDELINE 3:** States should review and reform public health laws to ensure that they adequately address public health issues raised by HIV, that their provisions applicable to casually transmitted diseases are not inappropriately applied to HIV, and that they are consistent with international human rights obligations.

**GUIDELINE 4:** States should review and reform criminal laws and correctional systems to ensure that they are consistent with international human rights obligations and are not misused in the context of HIV or targeted against vulnerable groups.

**GUIDELINE 5:** States should enact or strengthen anti-discrimination and other protective laws that protect vulnerable groups, people living with HIV, and people with disabilities from discrimination in both the public and private sectors, ensure privacy and confidentiality and ethics in research involving human subjects, emphasize education and conciliation, and provide for speedy and effective administrative and civil remedies.

**GUIDELINE 6** (as revised in 2002): States should enact legislation to provide for the regulation of HIV-related goods, services, and information, so as to ensure widespread availability of quality prevention measures and services, adequate HIV prevention and care information, and safe and effective medication at an affordable price. States should also take measures necessary to ensure for all persons, on a sustained

and equal basis, the availability and accessibility of quality goods, services, and information for HIV prevention, treatment, care, and support, including antiretroviral and other safe and effective medicines, diagnostics, and related technologies for preventive, curative, and palliative care of HIV and related opportunistic infections and conditions. States should take such measures at both the domestic and international levels, with particular attention to vulnerable individuals and populations.

**GUIDELINE 7:** States should implement and support legal support services that will educate people affected by HIV about their rights, provide free legal services to enforce those rights, develop expertise on HIV-related legal issues, and utilize means of protection in addition to the courts, such as offices of ministries of justice, ombudspersons, health complaint units, and human rights commissions.

**GUIDELINE 8:** States, in collaboration with and through the community, should promote a supportive and enabling environment for women, children, and other vulnerable groups by addressing underlying prejudices and inequalities through community dialogue, specially designed social and health services, and support to community groups.

**GUIDELINE 9:** States should promote the wide and ongoing distribution of creative education, training, and media programs explicitly designed to change attitudes of discrimination and stigmatization associated with HIV to understanding and acceptance.

**GUIDELINE 10:** States should ensure that the government and the private sector develop codes of conduct regarding HIV issues that translate human rights principles into codes of professional responsibility and practice, with accompanying mechanisms to implement and enforce these codes.

**GUIDELINE 11:** States should ensure monitoring and enforcement mechanisms to guarantee the protection of HIV-related human rights, including those of people living with HIV, their families, and communities.

**GUIDELINE 12:** States should cooperate through all relevant programs and agencies of the United Nations system, including UNAIDS, to share knowledge and experience concerning HIV-related human rights issues and should ensure effective mechanisms to protect human rights in the context of HIV at the international level.

**Handout 2.3  
Personal Reflection Form**

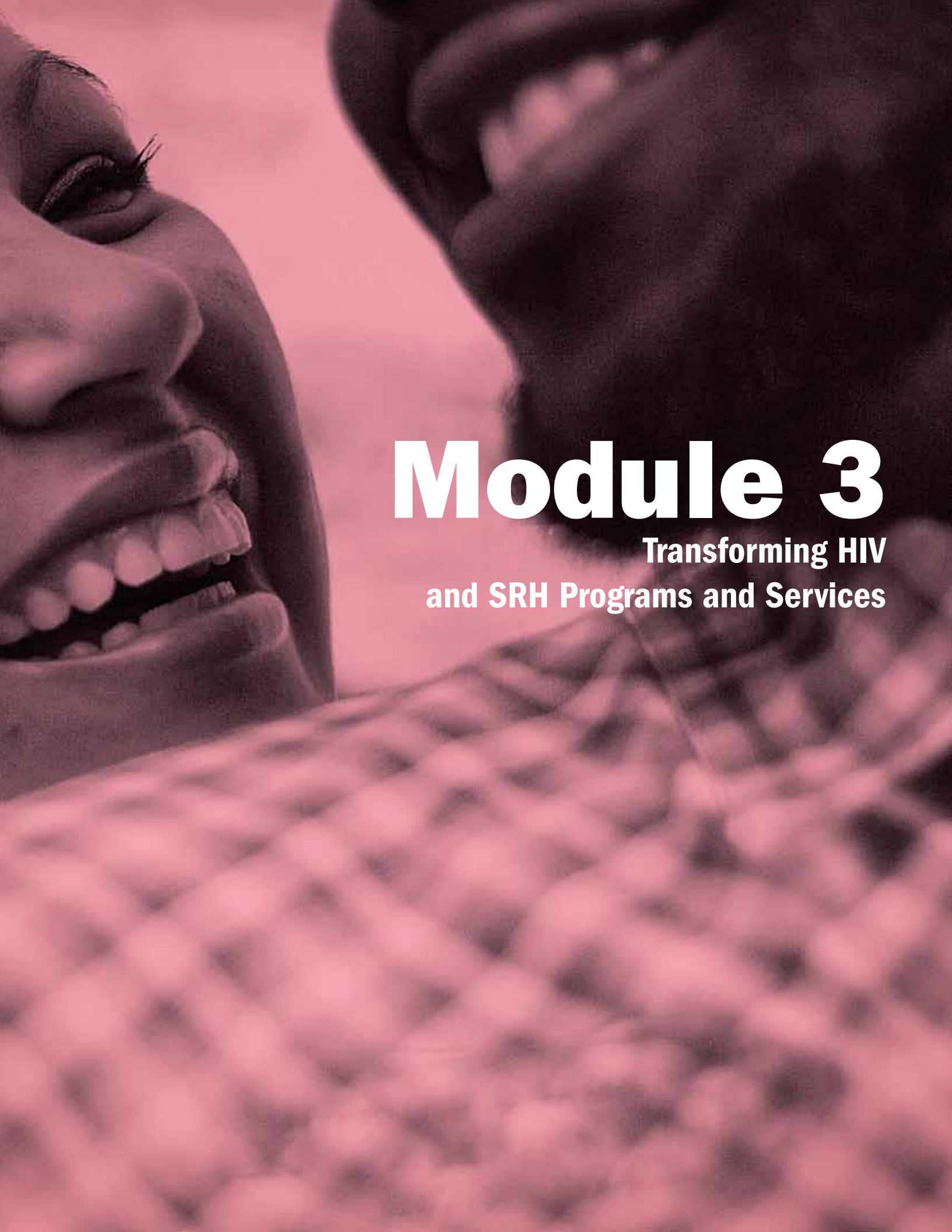
This personal reflection exercise is for you only. You will not share it with the facilitators or other participants. We encourage you to be completely honest with yourself about your fears and feelings, as it is sometimes good for us to express what

we really feel. Following this personal reflection, you have the opportunity to share with one other person. It is your decision what you want to share. Please let one of the facilitators know if you would like to speak with a counselor about these issues.

Statement	Yes	No	Not sure
1. I would prefer if I did not have to provide health care to persons with HIV because of the possible risk of infection.			
2. As a health worker I think I have the right to know if a client I am caring for is HIV positive, even if the consultation is not related to HIV.			
3. I think that it is irresponsible of an HIV-positive woman to get pregnant deliberately.			
4. I would be afraid to have my child play with an HIV-positive child.			
5. If a person becomes infected with HIV through sex, it is mostly their own fault.			
6. I would not drink from the same glass with an HIV-positive person.			
7. I don't think that there is justification for a person to become a sex worker.			
8. I have difficulty understanding homosexuality.			
9. I think homosexual persons should not flaunt it through public displays of affection with their partners.			
10. I have difficulty accepting that young people are sexually active.			
11. I would have difficulty providing young girls with condoms and contraceptives.			
12. I would rather not get involved if one of my clients is experiencing domestic violence.			

**The five things I am most afraid of or have the most problems with when it comes to providing HIV services**

1	
2	
3	
4	
5	



# Module 3

Transforming HIV  
and SRH Programs and Services



# Module 3

## Introduction

Persisting gender inequalities and human rights violations compromise the rights and opportunities of individuals to pursue optimal health for themselves, their families, and their communities.

Gender inequalities and human rights violations contribute to avoidance of or delay in seeking needed services, which contributes to further spread of HIV and avoidable morbidity and mortality.

In this module, participants will further explore gender and human rights dynamics related to SRH and HIV services. The focus will be on practical application of learned concepts to enhance the skills to provide equitable, inclusive, and quality services through mainstreaming of gender and human rights in program development and service delivery.

## Learning Objectives

- At the end of this module, participants will be able to:
- Describe key gender and human rights issues related to HIV and SRH programs and services.
  - Identify key actions that can be taken to integrate gender and human rights in HIV and SRH service delivery.
  - Apply gender-responsive and gender-transformative skills in their service delivery.

## Main Messages

- The differential health care needs of men, women, boys, girls, and sexually diverse persons require that service providers are aware of these differences and are trained to address the specific needs of these groups.
- A gender-transformative approach to HIV and SRH services considers the inequalities generated by gender norms and stereotypes and incorporates measures to address these inequalities and empower the most vulnerable persons and groups.
- Incorporation of human rights instruments in HIV and SRH services will contribute to improved quality of services and protection of clients, in particular the most vulnerable.

## Additional Resources

- Gay, J., Hardee, K., Croce-Galis, M., Kowalski, S., Gutari, C., Wingfield, C., Rovin, K., Berzins, K. What Works for Women and Girls: Evidence for HIV Interventions. New York, Open Society Institute, 2010. <http://www.soros.org/sites/default/files/what-works-summary-20100811.pdf> .
- Gay, J., Croce-Galis, M., Hardee, K. What Works for Women and Girls: Evidence for HIV/AIDS Interventions. 2nd edition. Washington, DC: Futures Group, Health Policy Project, 2012. [www.whatworksforwomen.org](http://www.whatworksforwomen.org) .

### Overview of Module 3

**Session 3.1:** Transforming health services to provide gender-responsive and human rights-based services

**Session 3.2:** Gender, human rights, HIV prevention and promotion of sexual health

**Session 3.3:** Gender and human rights dimensions of HIV testing, treatment, and care

**Session 3.4:** Gender and human rights dimensions in the elimination of mother-to-child transmission of HIV and congenital syphilis

Module 3	Activity	Duration	Format
<b>Opening Session</b>			
(30 minutes)	Learning log and morning warm-up activity	30 minutes	Plenary
<b>Session 3.1</b>			
(1.5 hours)	Group activity: Checklist on Gender and Human Rights in Programs and Services	45 minutes	Small group followed by plenary
	Facilitator presentation: Transforming health services to provide gender-responsive and human rights-based health services	45 minutes	Plenary
<b>Session 3.2</b>			
(1 hour, 15 minutes)	Facilitator presentation: Gender, human rights, HIV prevention and promotion of sexual health	30 minutes	Plenary
	Group activity: Transforming HIV prevention messages	45 minutes	Small group followed by plenary
<b>Session 3.3</b>			
(1.5 hours)	Facilitator presentation: Gender and human rights dimensions of HIV testing, treatment, and care	45 minutes	Plenary
	Role play: HIV testing and counseling	45 minutes	Small group followed by plenary
<b>Session 3.4</b>			
(45 minutes)	Facilitator presentation: Gender and human rights dimensions in the elimination of mother-to-child transmission of HIV and congenital syphilis	45 minutes	Plenary
<b>Closing</b>			
(30 minutes)	Closing of Module 3	30 minutes	Plenary

- World Health Organization (WHO). Integrating Gender into HIV Programmes in the Health Sector: Tool to Improve Responsiveness to Women's Needs. Geneva, WHO, 2009. [http://www.who.int/gender/documents/gender\\_hiv\\_guidelines\\_en.pdf](http://www.who.int/gender/documents/gender_hiv_guidelines_en.pdf) .
- World Health Organization (WHO). Guidelines on HIV Disclosure Counseling for Children Up to 12 Years of Age. Geneva, WHO, 2011. [http://www.who.int/hiv/pub/hiv\\_disclosure/en/index.html](http://www.who.int/hiv/pub/hiv_disclosure/en/index.html) .
- World Health Organization (WHO). Guidance on Couples HIV Testing and Counseling, Including Antiretroviral Therapy for Treatment and Prevention in Serodiscordant Couples: Recommendations for a Public Health Approach. Geneva, WHO, 2012. <http://www.who.int/hiv/pub/guidelines/9789241501972/en/> .
- World Health Organization (WHO). Service Delivery Approaches to HIV Testing and Counseling (HTC): A Strategic HTC Programme Framework. Geneva, WHO, 2012. [http://apps.who.int/iris/bitstream/10665/75206/1/9789241593877\\_eng.pdf](http://apps.who.int/iris/bitstream/10665/75206/1/9789241593877_eng.pdf) .

## Opening Session

### Learning Log and Morning Warm-up Activity

#### Learning log

Ask the participants:

- What did you learn during the previous module that was useful to you?
- What was difficult to understand?
- What didn't you like about the previous sessions? What did you like about the previous sessions?
- What can you suggest to make the process more meaningful?

## Session 3.1

### Transforming Health Services to Provide Gender-responsive and Human Rights–based Health Services

**Objective:** At the end of this session, participants will be able to list the key actions for integrating gender and human rights into HIV programs and services.

#### Activities

- **Group activity on gender and human rights in HIV health services:** During this exercise, participants will complete a checklist reviewing the current status of gender and human rights in their place of work.

**Group activity:** Checklist on Gender and Human Rights in Programs and Services

1. Distribute Handout 3.1.
2. Give participants 10 minutes to complete the checklist.
3. Divide the group into small groups.
4. Give the group 20 minutes to discuss their responses.
5. Use the last 15 minutes for a plenary guided discussion on the current gender and human rights dimensions of the programs and services represented in the room.

- **Facilitator presentation on the transformation of health services to provide gender-responsive and human rights–based HIV health services:** This presentation will elaborate on the 15 basic steps in gender-responsive programming recommended by the World Health Organization (3).

#### Preparations Required

- Review, updating, and adaptation of PowerPoint presentation.

#### Handouts and Other Materials

- **Handout 3.1:** Checklist on Gender and Human Rights in Programs and Services.



## Session 3.2

### Gender, Human Rights, HIV Prevention and Promotion of Sexual Health

**Objective:** At the end of this session, participants will be able to:

- Identify gender-stereotypical HIV prevention messages.
- Formulate gender-transformative HIV prevention messages.

#### Activities

- **Facilitator presentation on gender, human rights, and HIV prevention:** This presentation will elaborate on the continuing need to focus on HIV prevention, considering that 30-plus years into the epidemic, the annual number of new infections still outpaces the number of persons enrolled in treatment. The PowerPoint presentation will summarize the key elements of combination prevention (which consists of biomedical, behavioral, and structural interventions) and the core gender and human rights assumptions and implications of HIV prevention strategies and messages. Facilitators are recommended to start the presentation with an overview of the trends in new HIV infections in the country or region where the training is taking place.
- **Group exercise on formulation of gender-transformative HIV prevention messages and strategies:** In this exercise, participants will review existing HIV prevention materials, including posters, folders, video clips, and program documents, through the lens of the Gender Mainstreaming Continuum to determine the level of gender responsiveness, followed by formulation of suggestions to make these materials more gender responsive.

#### Preparations Required

- Review and adaptation of PowerPoint presentation.
- Collection and preparation of materials for the group to review—include local and international materials and burn video materials on compact discs (CDs).
- Secure laptops for each group to watch the video materials.

#### Handouts and Other Materials

- Extra copies of the Gender Mainstreaming Continuum (distributed in Module 1).
- Prevention materials (posters, folders, etc.).

## Session 3.3

### Gender and Human Rights Dimensions of HIV Testing, Treatment, and Care

**Objective:** At the end of this session, participants will be able to describe the key steps in gender-responsive and human rights-based HIV testing, treatment, and care services.

#### Activities

- **Facilitator presentation on gender and human rights dimensions of HIV testing, treatment, and care:** This presentation will elaborate on the gender and human rights dimensions of HIV testing, treatment, and care services, including equitable access, quality of services, safe disclosure of HIV status, adherence to treatment, and support systems for women, men, girls, and boys living with HIV. It is recommended that facilitators start the presentation with an overview of HIV testing and treatment services, numbers of persons being tested annually, and numbers of persons on treatment, disaggregated by sex, age group, and other relevant parameters.
- **Role play: HIV testing and counseling:** Participants will have the opportunity, through role play, to explore the interactions between service providers and clients in the context of HIV testing and counseling, as well as some of the underlying assumptions implicitly and explicitly embedded in the HIV testing and counseling dialogue. For this role play, it is recommended that facilitators bring in some volunteers from outside the group. This will add to the authenticity of the exercise.

#### Scenarios for HIV testing and counseling role play

<b>Pre-test</b>	You are working at a clinic that provides walk-in HIV test services. One day a couple comes in for testing. You provide individual pre-test information to the man, followed by the woman. In her individual session, the woman shares with you that she does not really want to get tested, but her partner forced her to come. <b>Q:</b> How do you proceed?
	You are a service provider at a primary care clinic. One day a boy and girl visit the clinic. He is 16 years old, and she is 14 years old. They share with you that they have been dating for one year, and are now ready to take their relationship to the next level of intimacy—to have sex. They ask for condoms, an HIV test, and contraceptive pills. <b>Q:</b> How do you proceed?

## Session 3.4

<b>Pre-test</b>	<p>You are working at a government clinic. One of your female clients came in at least twice with bruises. When asked, she says that she tripped and fell. You suspect that she is a victim of abuse. She comes in today requesting pregnancy and HIV tests.</p> <p><b>Q:</b> How do you proceed?</p>
<b>Post-test</b>	<p>Your 24-year-old female client who came in for a pregnancy test and also consented to do an HIV test has just tested HIV positive. She is married and has a two-year-old child. You recommend that her husband and child be tested as well. When she comes back for her next antenatal visit four weeks later, she comes without her family.</p> <p><b>Q:</b> What could be the reasons that she did not bring her family in for testing? What will be your next steps as her care provider?</p> <p>Your client is a sex worker who just tested positive for HIV.</p> <p><b>Q:</b> How do you proceed with the posttest counseling?</p> <p>Your client is a married man who just tested positive for HIV. His wife recently gave birth, and her tests during the pregnancy were negative.</p> <p><b>Q:</b> How do you proceed with the posttest counseling?</p>

### Preparations Required

- Review and adaptation of PowerPoint presentation.
- Identification and invitation of volunteers for the role play session.

### Handouts and Other Materials

- Copies of the role play scenarios for players and observers
- Handout 3.2 and 3.3.

### Gender and Human Rights Dimensions in the Elimination of Mother-to-Child Transmission of HIV and Congenital Syphilis

**Objective:** At the end of this session, participants will be able to describe the key steps in gender-responsive and human rights-based services for elimination of mother-to-child transmission of HIV and congenital syphilis.

### Activities

- Facilitator presentation on gender and human rights dimensions in the elimination of mother-to-child transmission of HIV and congenital syphilis: This presentation will elaborate on the guiding principles and lines of action of the regional elimination initiative and will highlight specific human rights and gender dimensions, including the implications of increased testing of women in the context of the elimination of mother-to-child transmission (eMTCT), reproductive choices and rights of women living with HIV, and male involvement. It is recommended that facilitators include data on the current status of eMTCT in their country or region.

### Preparations Required

- Review and adaptation of PowerPoint presentation to local context.

### Handouts and Other Materials

- None.

## Closing of Module 3

It is recommended that facilitators dedicate 30–60 minutes at the end of the day to wrap up the module. The main purpose of the closing session is to summarize and reinforce the key messages and provide some last-minute clarifications if needed. The PowerPoint presentation contains some slides with key messages of the module. The facilitators can adapt these slides to summarize the key conclusions or use alternative strategies, such as inviting participants to articulate what they have learned and what they consider the key messages of the day.

## Facilitator Notes

### Transforming HIV Health Services

- WHO identifies six broad program components for the integration of gender and human rights into HIV programming (5):
  - Integration of gender analysis into program design.
  - Building capacity of care providers to address gender inequalities.
  - Reduction of barriers in access to HIV health services.
  - Promoting the participation of women and sexual minorities in the development and implementation of programs and services.
  - Development of gender-sensitive monitoring and evaluation measures.
  - Advocacy for human rights-based and gender-responsive health policies.
- The transformation of health programs and services requires attention with respect to provider, health system, and client aspects, as all three influence access, utilization, and quality of services (5, 24) .
  - Provider-related issues:
    - » Knowledge and expertise
    - » Attitude towards disease and client
  - Health system-related issues:
    - » Financial accessibility
    - » Physical/practical accessibility
    - » Types and quality of care providers and services
  - Client-related issues:
    - » Perception of health care and care providers
    - » Socioeconomic status
    - » Knowledge
    - » Self-efficacy
    - » Perception of value and condition of health status and specific health issues

### HIV Prevention and Promotion of Sexual Health

- On a global level and in the Region of the Americas, significant progress has been made in the reduction of new HIV infections. The estimated annual number of new infections has been decreasing in the Caribbean and has stabilized in Latin America. However, the annual number of new infections continues to outpace the number of persons placed on treatment (12, 15).

- Recent years have brought some new and promising approaches, including evidence that antiretroviral treatment has a significant prevention benefit for HIV and tuberculosis. Treatment as prevention (TasP) is a term used to describe the use of ART by HIV-positive persons, independent of CD4 cell count, to decrease the chances of onward HIV transmission (25).
- Pre-exposure prophylaxis (PrEP) refers to the HIV prevention method where persons who do not have HIV use ARV (daily pill) to reduce their risk of becoming infected. Evidence exists for the application of PrEP in men and transgender women who are having sex with men as well as serodiscordant couples (26).
- In spite of these very promising new tools, there is also recognition that a sustained prevention effort consisting of an appropriate mix of HIV prevention interventions, including biomedical, behavioral, and structural interventions (combination prevention), will be needed to revert the trend of new infections. It is also recognized that the new biomedical interventions have behavioral components, which must be addressed to maximize their benefits (15, 26).
- A gender-responsive approach towards HIV prevention requires careful consideration of how each element of the prevention strategy affects men, women, boys, and girls, as well as proactive measures to ensure equal access and elimination of gender-based barriers and threats (1, 2, 5, 14).
- Gender-transformative prevention approaches portray men as positive role models with responsible sexual behaviors and respect for women. Gender-transformative prevention approaches portray women as empowered, with equal participation in sexual and reproductive decisions, and proactive to protect themselves (1, 2, 5, 14).
- Countries should select a combination of delivery modes that are most suitable for their context. The design of the strategy should take into account factors such as the nature of the epidemic; the cost-effectiveness of approaches, measured by a comparison of the number of infections newly identified with the number of tests performed; equity of access, ensuring optimal access for those most in need; and available resources, including trained workers and infrastructure (28).
- The design and implementation of HTC strategies and services must take into account the differences between men and women when it comes to issues such as the decision to get tested, disclosure of the test results to one's intimate partner, implementation of risk reduction strategies, and the ability to access treatment in case of a positive test result (5, 27, 28).
- The right to privacy outlined in the International Covenant on Civil and Political Rights entails the responsibility of state parties to safeguard informed consent, confidentiality, and nondisclosure of personal information. This obligation has particular relevance in the context of HIV, in view of the stigma and discrimination attached to the loss of privacy and confidentiality if HIV status is disclosed. A decision to consider bypassing this right must be weighed carefully (for instance, in the context of partner notification, this decision might be considered if the HIV-positive person, by concealing his/her status, constitutes a real risk for harm to his/her partner's health, welfare, and safety) (5, 21, 27, 28).
- A critical issue to take into consideration is the intersection of HIV testing with intimate partner violence. For instance, fear of violence can serve as a barrier to women accessing HIV testing, and disclosure of HIV test results can trigger intimate partner violence (5, 27, 28, 29).
- HIV care providers must take into account that the decision to do an HIV test has important gender aspects related to power dynamics in relationships. Care providers must provide a safe and confidential space for clients to express themselves about issues such as forced testing, violence, and abuse (5, 27, 28, 29).
- Violence or the fear of violence can be a barrier to disclosure of HIV test results. HIV test services should include support for women to safely disclose their test results to their partners. Therefore HIV test services must include measures to detect violence or the threat of violence and provision of appropriate referral to protective and support services (5, 27, 28, 29).

### **HIV Testing and Counseling**

- HIV testing and counseling (HTC) serves as a gateway for HIV prevention, treatment, and care. Delays in diagnosis of HIV infection mean that people may start antiretroviral therapy (ART) when they are already significantly immunocompromised, resulting in poor health outcomes and ongoing transmission (27, 28).
- According to the WHO, there are many approaches towards HTC, including the traditional voluntary counseling and testing usually provided in stand-alone facilities, the provider-initiated testing and counseling provided in health care facilities such as ANC clinics, rapid point-of-care testing with same-day results, and couples HTC (28).

- Service providers might be reluctant to engage with domestic violence, or lack the skills and/or time to address violence. The lack of adequate referral services also constitutes a barrier to addressing GBV in service delivery. A comprehensive approach to addressing GBV in HIV testing should therefore include capacity building of service providers, reorganization of services where necessary, and establishment of referral networks and services (5, 29).

### HIV Treatment and Care

- The availability of affordable antiretroviral (ARV) medicines changed the face of the HIV epidemic, creating the potential for longer and healthier lives for persons infected with HIV. In efforts to achieve universal access to HIV treatment, it is critical to recognize that gender roles and responsibilities influence men's and women's access to and use of health services, including HIV-related services (5, 14, 29, 30).
- Barriers to treatment access include:
  - Economic constraints such as lack of money to pay for services or transportation, child care, and other expenses associated with accessing care (5, 14, 29, 30).
  - Social factors: Stigma and discrimination, both in general and on the part of health workers, form substantial barriers to scaling up of HIV treatment. In many societies, HIV-positive women experience more stigma and discrimination than HIV-positive men. Gender stereotypes can also negatively influence male utilization of services if norms suggest male invulnerability, risk-taking, and not caring for one's body (5, 14, 29, 30).
  - In most communities women bear the heaviest burden of caring for the sick and the young, often to the detriment of their own needs. In the case of HIV-positive women, the disproportionate burden in the care economy can negatively influence adherence to their own treatment regimen (5, 14, 30).
  - Adequate adherence to medication regimes is essential to achieve optimal results of ARV treatment. Poor adherence contributes to treatment failure and the development of drug resistance. Gender-based differences between men and women must be taken into account in the design of adherence measures (5, 14, 30).
  - The WHO/UNAIDS policy statement "Ensuring Equitable Access to Antiretroviral Treatment for Women" (30) recommends the following actions to adequately address gender issues in the scale-up of ART:
    - Development of a supportive policy environment through:
      - » Advocating for gender equality
      - » Ensuring equity within the health system
      - » Expanding eligibility criteria for treatment
      - » Promoting the active participation of people living with HIV
    - Strengthening of health systems to make them more responsive to the specific needs of women and men through:
      - » Integration of HIV and SRH services with other relevant services, including maternal and child health (MCH), men's health and adolescent health services
      - » Financing ART programs
      - » Strengthening home- and community-based programs
      - » Building capacity of health workers and other caregivers
    - Promotion of programs that overcome obstacles to access through:
      - » Addressing gender-related barriers to access
      - » Targeted efforts to reach marginalized groups
      - » Ensuring that women and men have access to reliable HIV/AIDS information
      - » Addressing gender issues in HIV testing and counseling
      - » Creating multiple entry points for ART
      - » Providing gender-sensitive adherence support
      - » Offering reproductive health services for women and girls on ART
    - Development of benchmarks and indicators to measure progress through:
      - » Setting targets disaggregated by age for women and men
      - » Monitoring and evaluation
      - » Examining the impact of ART financing on women, MSM, sex workers and other vulnerable groups
      - » Conducting operational research on gender equity in access to ART
      - » Sharing promising practices



### Elimination of Mother-to-Child Transmission of HIV and Congenital Syphilis

- The human immunodeficiency virus (HIV) is transmitted from person to person via contact with bodily fluids, including blood, semen, vaginal fluid, and breast milk. HIV can cross the placenta during pregnancy, infect the baby during the birth process, and infect the baby after delivery through breastfeeding. HIV infection of infants creates a chronic condition that potentially shortens life expectancy and contributes to substantial human, social, and economic costs (31).
- Without preventive interventions, an estimated 15% to 45% of infants delivered by HIV-positive women will become infected with HIV during pregnancy, during delivery, or through breastfeeding. In the absence of breastfeeding, the risk of transmission ranges from 15% to 30%, and it rises to 20% to 45% when HIV-positive mothers breastfeed their children. The use of antiretroviral prophylaxis by HIV-positive women during pregnancy and childbirth and the young infant during the first weeks of life, along with application of safer obstetric practices and avoidance of breastfeeding, can reduce the risk of HIV transmission from mother to infant to 2% or less. Maternal use of triple therapy during breastfeeding also reduces the risk of HIV transmission to the infant (31).
- As noted by the WHO, recently a third option to provide lifelong ART to all HIV-infected pregnant women (Option B+) has emerged. Important advantages of option B+ include: further simplification of regimen and service delivery and harmonization with ART programs including unification of the lifelong treatment message, protection against mother-to-child transmission in future pregnancies, prevention benefit against sexual transmission to serodiscordant partners, and avoiding stopping and starting of ARV drugs (32).
- Syphilis is an infectious disease caused by the bacterium *Treponema Pallidum*. It is generally transmitted sexually and across the placenta. If the disease is not treated during the acute phase, it becomes a chronic condition with potentially serious manifestations, in some cases even leading to death. Syphilis can cross the placenta and infect the baby while it is in utero. Without treatment, an estimated 50% to 80% of pregnant women with syphilis infection experience adverse events, including abortion, fetal death, stillbirth, neonatal mortality, premature delivery, low birth weight, and infants with congenital syphilis. Treatment of the infected pregnant woman with an appropriate dose of penicillin can prevent vertical transmission (31).
- Efficacious and affordable interventions are available to prevent mother-to-child transmission of both infections. Prevention of mother-to-child transmission of HIV and congenital syphilis will contribute to reductions in maternal and neonatal morbidity and mortality, improvements in the sexual and reproductive health of women and men, improvements in infant and child health, and achievement of national, regional, and global targets, including the UN-GASS targets and Millennium Development Goals related to reduction of child mortality (MDG 4), improvement of maternal health (MDG 5), and combating HIV/AIDS, malaria and other diseases (MDG 6) (31).
- In 2010, the PAHO Member Countries adopted the Strategy and Plan of Action for the Elimination of Mother-to-Child Transmission of HIV and Congenital Syphilis by the year 2015 (31).
- The regional eMTCT strategy includes prevention of HIV and syphilis among women of reproductive age, prevention of unintended pregnancies among women living with HIV, HIV and syphilis screening for all pregnant women and their male partners, and appropriate treatment for women who test positive for HIV and syphilis as well as their male partners and infants (31).
- The increased testing of women in the context of eMTCT contributes to increased detection of women living with HIV. As a result, women might end up bearing the burden of being the first to take home an HIV-positive result. Consequently, women may be blamed for bringing HIV into their families and passing it on to their children (5, 31).
- Socialization of men may result in lack of interest or participation in eMTCT services, as child-bearing and child-rearing are often perceived as the woman's domain. According to the WHO, gender-transformative eMTCT services encourage men's involvement in the antenatal care process, including HIV testing, protecting their female partner against HIV infection during the pregnancy, and supporting their partner in treatment and care in case of a positive HIV test result (5).
- According to the WHO, women living with HIV, as well as HIV-positive and HIV-discordant couples, must be provided with appropriate sexual and reproductive health (SRH) services to facilitate informed decision-making related to safer sexual practices and child-bearing (5, 27).



**Handout 3.1**  
**Checklist on Gender and Human Rights in Programs and Services**

Item	Yes	No	Not sure
We have policies and guidelines that promote gender equality and human rights			
There are mechanisms in place to promote active participation of women, men, girls, and boys in the development of our services			
We have services tailored to the specific needs of women and girls			
We have services tailored to the specific needs of men and boys			
We have services tailored to the specific needs of sexually diverse persons			
Our services contribute to the empowerment of women and girls			
In our clinic men are encouraged to be involved in HIV service delivery, in particular services usually considered for females (i.e., ANC, eMTCT, SRH)			
Our protocols address gender-based violence			
I would feel confident in addressing gender-based violence if it came up			
Service delivery data are recorded and analyzed disaggregated by sex, age, ethnic group, educational level, place of residence, and sexual orientation			
I know which groups of men and women (age groups, ethnic groups, sexual orientation, and behaviors) in my catchment area are most affected by HIV			
I have participated in gender and/or human rights training provided by my employer at least once in the past 3 years			
There are mechanisms in place for reporting if I observe a violation of human rights by a coworker			
I would report to supervisors if I observed a violation of human rights by a coworker			
I feel that there are equal employment and advancement opportunities for males and females in our organization			

List 3–5 more things in your work environment that in your opinion contribute to gender-responsive and human rights–based service delivery in your place of work:

1. \_\_\_\_\_
2. \_\_\_\_\_
3. \_\_\_\_\_
4. \_\_\_\_\_
5. \_\_\_\_\_

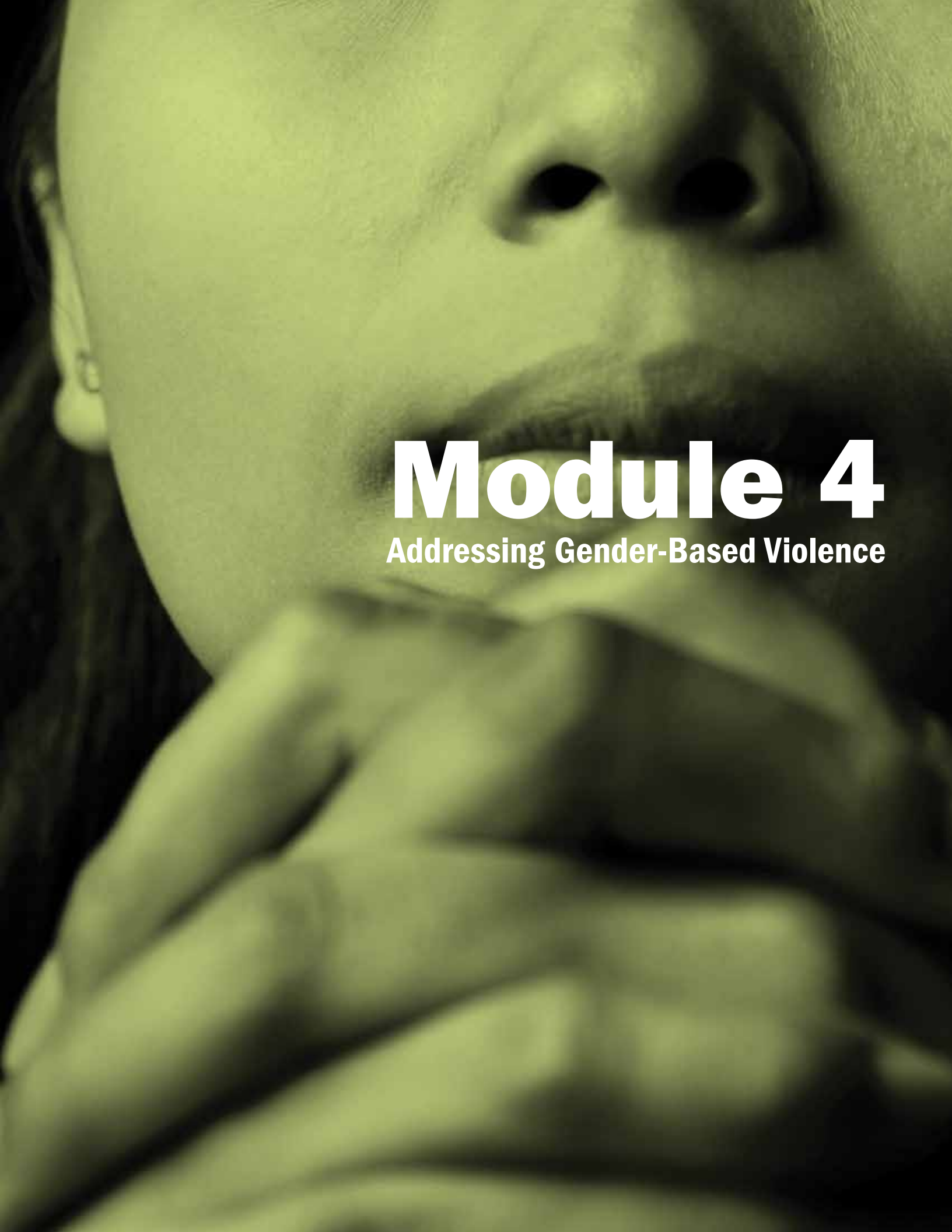
### Handout 3.2 Addressing Violence in HIV Testing and Counseling

Addressing violence as a barrier to accessing HIV testing and counseling services	<ul style="list-style-type: none"> <li>· Raise awareness of the link between HIV and violence among program managers, counselors, and clients.</li> <li>· Ensure confidential services.</li> </ul>
Addressing violence as a barrier to and/or outcome of disclosure	<ul style="list-style-type: none"> <li>· Train counselors to identify and counsel women who fear violence and other negative outcomes following HIV status disclosure.</li> <li>· Offer alternative modes for HIV disclosure, including mediated disclosure with the help of counselors.</li> </ul>
Addressing violence as a barrier to implementing risk reduction strategies	<ul style="list-style-type: none"> <li>· Assist women in developing strategies to protect themselves when negotiating safer sexual relationships.</li> </ul>
Addressing post-test support needs of women in violent relationships	<ul style="list-style-type: none"> <li>· Refer women to peer or other groups for ongoing psychosocial support.</li> <li>· Develop referral agreements with organizations that offer services for women living with violence.</li> <li>· Build support systems for women, including peer support models, where these services do not exist.</li> </ul>

**Source:** World Health Organization. Addressing Violence against Women in HIV Testing and Counseling. [http://www.who.int/gender/documents/VCT\\_addressing\\_violence.pdf](http://www.who.int/gender/documents/VCT_addressing_violence.pdf) . Last accessed 22 February, 2013.

### Handout 3.3 Recommended Questions and Issues to Include in HIV Testing and Counseling

Pre-test questions	<ul style="list-style-type: none"> <li>-Is your partner aware that you will be tested for HIV?</li> <li>-Would you feel safe discussing HIV testing with your partner?</li> <li>-Has your partner ever pushed, grabbed, slapped, choked, or kicked you? Threatened to hurt you, your children, or someone close to you? Stalked, followed, or monitored your movements?</li> <li>-Are you intending to share the test results with your partner?</li> <li>-What response would you anticipate from your partner if your results come back positive?</li> </ul>
Pre-test information	<ul style="list-style-type: none"> <li>-If partner notification is part of the protocol, it is important to inform the client of the partner notification procedures.</li> <li>-Inform the client about referral services if available.</li> <li>-Inform the client of options for mediated disclosure options if available.</li> </ul>
Post-test issues	<ul style="list-style-type: none"> <li>-Make arrangements for facilitated disclosure if needed.</li> <li>-Discuss and practice scenarios to negotiate condom use and other risk reduction measures.</li> </ul>



# **Module 4**

**Addressing Gender-Based Violence**

# Module 4

## Introduction

In this module, participants will review the prevalence, risks, and consequences of gender-based violence (GBV) as a public health problem, and will explore their own values and beliefs regarding GBV. The intersection between GBV and HIV will be analyzed, and participants will acquire basic skills to start addressing GBV in their service delivery. It is recommended that facilitators invite one or more persons with experience in provision of care to survivors of domestic violence to be present during this module, as these persons can share experiences and lessons learned. This also provides an opportunity for health workers to build alliances with this sector. Keep in mind that training participants might themselves be victims or perpetrators of gender-based violence. Be prepared to deal with personal issues raised by participants and to provide referrals as needed. The presence of persons with experience in this field will be an asset in dealing with these issues.

## Learning Objectives

At the end of this module, participants will be able to:

- Demonstrate understanding of the prevalence and public health consequences of gender-based violence;
- Demonstrate understanding of the intersection between HIV/SRH and gender-based violence;
- Recognize the need to address gender-based violence in health service delivery; and
- Articulate key actions that frontline health workers can take to address GBV in HIV/SRH services and programs.

## Main Messages

- Gender-based violence occurs more frequently than commonly estimated, and has been declared a major public health problem by the World Health Assembly (1996) and other international platforms.
- Gender-based violence violates human rights, has a major impact on health, and causes great suffering. Physical and sexual abuse of women is illegal in most settings; emotional abuse is another form of gender-based violence with serious negative consequences for mental and physical health; it robs people of their basic rights to dignity and wellbeing.
- Gender-based violence has significant public health consequences, including homicide, suicide, maternal mortality, physical trauma, unwanted pregnancies, unsafe abortions, and psychological problems such as depression and anxiety.
- Health professionals have an important role to play in addressing gender-based violence. Integrating attention to gender-based violence in health care settings will improve the quality and outcomes of health services. By not responding to GBV, health care workers may inadvertently put clients at risk.
- Gender-based violence may increase the risk for HIV and other STIs, as it reduces the capacity of individuals to choose their sexual partners, refuse sex, or negotiate condom use. Sexual violence can also lead to tears in mucosal tissue, increasing the risk of infection.
- HIV testing can put persons living in situations of gender-based violence in danger, for example, if women test without their partner's consent, if they disclose their test results, or if they try to convince their partner to get tested.
- Gender-based violence can negatively impact access to, utilization of, and adherence to prevention behaviors as well as HIV treatment and care services, because fear of violence is a major barrier to disclosure and lack of disclosure is a major barrier to prevention, treatment and care.

**Overview of Module 4**

**Session 4.1:** Gender-based violence as a public health problem

**Session 4.2:** Gender-based violence and HIV

**Session 4.3:** Addressing GBV in HIV/SRH health services

Module 4	Activity	Duration	Format
<b>Opening Session</b>			
(30 minutes)	Learning log and morning warm-up activity	30 minutes	Plenary
<b>Session 4.1</b>			
(1 hour, 45 minutes)	Exploring myths and facts about gender-based violence	1 hour	Small group (20 minutes) followed by plenary (40 minutes)
	Facilitator presentation: Gender-based violence as a public health problem	45 minutes	Plenary
<b>Session 4.2</b>			
(45 minutes)	Facilitator presentation: Gender-based violence and HIV/SRH	45 minutes	Plenary
<b>Session 4.3</b>			
(1 hour, 45 minutes)	Facilitator presentation: Addressing GBV in HIV/SRH health services	45 minutes	Small group followed by plenary
	Role play: Addressing GBV in health services	1 hour	Plenary
<b>Closing</b>			
(1.5 hours)	Closing of Module 4	30 minutes	Plenary
	Closing of the training program	1 hour	

- Health care workers have an ethical and human rights mandate to address gender-based violence in their service delivery.
- Service providers can address gender-based violence through various actions, including:
  - **Primary prevention:** working with the Ministry of Health and the community to reduce tolerance for violence against women and girls in the community, aimed at preventing domestic violence before it occurs. In addition, service providers can prevent violence and discrimination against women who test positive for HIV by providing post-test counseling that integrates attention to GBV, including for example, danger assessment, the offer of facilitated disclosure, referral to support groups and services, and careful attention to confidentiality.
  - **Secondary prevention:** routinely asking clients about GBV; providing appropriate care, including psychosocial counseling, referral, support for development of a safety plan; and, in case of sexual violence, ensuring counseling and psychological services, emergency contraception, PEP, STI prophylaxis, preservation of forensic evidence, and referral.
  - **Tertiary prevention:** provision of or referral to more specialized services that focus on long-term care for survivors.
- Institutional commitment, policies and protocols, training of health workers, and alliances with specialized services will strengthen providers' capacity to address GBV in health services.
- Engaging men and boys as partners and agents of change in the prevention of GBV is essential. Strategies could include systematic inclusion of messages on gender equality and zero tolerance for violence against women in service delivery, public education campaigns, and involving male advocates against GBV in programs and campaigns.

### Additional Resources

- Bott, S., Guedes, A., Claramunt, M., Guezmes, A. Improving the Health Sector Response to Gender Based Violence. New York, International Planned Parenthood Federation, Western Hemisphere Region, 2010. <http://www.ippfwhr.org/en/node/288>
- Campbell JC, Baty ML, Ghandour RM, Stockman JK, Francisco L, Wagman J. The intersection of intimate partner violence against women and HIV/AIDS: a review. *Int J Inj Contr Saf Promot.* 2008,15(4):221-31.
- Gay, J., Hardee, K., Croce-Galis, M., Kowalski, S., Gutari, C., Wingfield, C., Rovin, K., Berzins, K. What Works for Women and Girls: Evidence for HIV Interventions. New York, Open Society Institute, 2010. <http://www.soros.org/sites/default/files/what-works-summary-20100811.pdf> .
- Maman S, King E, Amin A, Garcia-Moreno C, Higgins D, Okero A. Addressing violence against women in HIV testing and counseling: a meeting report. Geneva, WHO, 2006.
- Medley A, Garcia-Moreno C, McGill S, Maman S. Rates, barriers and outcomes of HIV serostatus disclosure among women in developing countries: implications for prevention of mother-to-child transmission programmes. *Bull World Health Organ.* 2004,82(4):299-307.
- SASA Preventing violence against women and HIV. VCT Counselor Interview Guide. Uganda, Raising Voices, 2008.
- World Health Organization (WHO). Integrating Gender into HIV Programmes in the Health Sector: Tool to Improve Responsiveness to Women's Needs. Geneva, WHO, 2009.
- World Health Organization, Regional Office for the Western Pacific. Integrating Poverty and Gender into Health Programmes: A Sourcebook for Health Professionals. Module on Gender-Based Violence. WPRO, 2005. [www.wpro.who.int](http://www.wpro.who.int) .
- World Health Organization. Addressing violence against women and HIV/AIDS. What works? Report of a consultation. Geneva: WHO and UNAIDS, 2010.

## Opening Session

### Learning Log and Morning Warm-up Activity

#### Learning Log

Ask the participants:

- What did you learn during the previous module that was useful to you?
- What was difficult to understand?
- What didn't you like about the previous sessions? What did you like about the previous sessions?
- What can you suggest to make the process more meaningful?

#### TEAMWORK PUZZLE

**Purpose:** collaboration of small groups and larger group to solve the puzzle.

**Preparation:**

- Gather 8 different colors of poster board, about 8x11 inches each.
- Draw one large letter from the word "TEAMWORK" on each board. Put some marks on the back of each letter to distinguish the front from the back.
- Cut each letter into puzzle pieces, at least 6 pieces per letter. Put the pieces of each letter into a separate envelope.

**Exercise:**

- Divide the participants in groups of 3-5, depending on the size of the group. Make sure to end up with 8 groups.
- Give each group an envelope, and tell them they have a puzzle to put together.
- Walk around to give encouragement and support as needed.
- As groups figure out that they have a letter, encourage them to announce what letter they have. This will encourage and help other groups that might be struggling with their puzzle.
- After all groups have finished their letter, announce that the whole group now has to form a word with the letters.
- After the group completes the word TEAMWORK, invite them to share what it was like to do the puzzle.

**Note:** This exercise is also useful to emphasize that teamwork within the health care setting (small group) as well as with external partners (larger group) will be necessary to adequately address GBV.



## Session 4.1

### Gender-Based Violence as a Public Health Problem

**Objective:** At the end of this session, participants will be able to:

- Recognize common and harmful myths about gender-based violence; and
- Identify public health aspects of gender-based violence.

### Activities

- **Exploring myths and facts about gender-based violence:** Many myths about the prevalence of, patterns in, and factors contributing to gender-based violence contribute to ignoring or even denouncing the significance of this public health problem. This activity will facilitate a discussion among participants of some of these myths.

#### Small-group activity: Exploring myths and facts about gender-based violence

##### 1. Small group exercise (20 minutes)

- Divide the group into small groups of 5–7 persons
- Instruct the small groups to identify a moderator and a note-taker
- Distribute the list of myths and facts about GBV
- Instruct the group to review the list as follows:
  - i. The moderator reads each statement out loud.
  - ii. Group members indicate whether they agree or disagree with the statement.
  - iii. Note-taker notes how many group members agree or disagree (if possible, tallying could disaggregate male/female and age groups).
  - iv. Group members provide one or a maximum of two key reasons why they agree or disagree with the statement.
  - v. Note-taker notes key reasons for agreement or disagreement with the statement.
  - vi. The moderator recommends that groups not spend too much time on discussion, as this exercise aims to capture “instinctive” rather than intellectual responses to these statements.

##### 2. Plenary discussion (40 minutes)

- Call the groups back to plenary
- Project the myths and facts as a PowerPoint slide
- Ask each group to briefly indicate their agreement/disagreement and reasons for each statement
- Provide facilitator’s perspective on the myths and facts and possible reasons for general agreement or disagreement
- Take sufficient time for discussions on each statement, as this is an important step in building the case to address GBV

#### Myths and facts about gender-based violence:

- Gender-based violence does not happen frequently.
- Gender-based violence mostly happens in poor, uneducated families.
- Sometimes it is the behavior of women that causes their male partner to become violent.
- Alcohol abuse causes gender-based violence.
- When there is violence in the family, all members need to change to stop the violence.
- Persons who are subject to gender-based violence and stay in the relationship are also to blame for the continuation of the violence. They would leave if they wanted it to stop.
- Domestic violence is a family problem. It is not the role of the health worker to interfere in this problem.
- Hitting your partner now and then is not a crime.
- Women are just as violent as men in relationships.

#### Comments on Myths and Facts About Gender-Based Violence

##### 1. Gender-based violence does not happen frequently

**Comments:** *documenting the prevalence of gender-based violence is challenging since many events go unreported. The differences in methodology between the available studies also make it difficult to compare or conduct meta-analysis. As a result, understanding of the scope of the problem is limited. The 2005 WHO Multi-country study on women’s health and domestic violence against women conducted in 10 countries included Peru and Brazil from the LAC region. The study, found that between 6% and 59% of women reported experiencing sexual violence by an intimate partner in their lifetime. De-*

mographic and reproductive health surveys conducted in thirteen Latin America and the Caribbean between 2003 and 2009 noted that between 5 and 18 percent of ever-partnered women in the age group 15-49 years reported forced sex by an intimate male partner ever. Eight of the thirteen had percentages higher than 10 percent (32). A comparative analysis of national, population-based studies conducted in 12 countries in Latin America and the Caribbean between 2003 and 2009 (33) found the following:

- The percentage of women ever married or in union reported ever experiencing physical or sexual violence by an intimate partner ranged from 17% to 53.3%. Between 7.7% and 25.5% reported recent (i.e. past 12 months) partner violence.
- The proportion of women ever married or in union who reported emotional abuse by a partner ever ranged from 17.0% to 47.8%. Recent emotional abuse ranged from 13.7% to 32.3%.
- A majority of women who experienced physical violence in the past 12 months also reported emotional abuse, ranging from 61.1% to 92.6%.
- Women from all socioeconomic backgrounds reported having experienced physical or sexual violence by an intimate partner, but the prevalence of physical or sexual intimate partner violence ever or in the past 12 months was significantly higher among urban compared with rural women, among divorced or separated women compared with married women, among women who were currently or recently employed compared with those who were not, and among women in the lowest wealth or education categories compared with those in the highest.
- The percentage of women listing a partner's drunkenness or drug use as a "trigger" in intimate partner violence ranged from 29.8% to 53.4%.
- The proportion of women who sought help for intimate partner violence by telling someone close to them ranged from 29.3% to 65.5%; the percentage who sought institutional help ranged from 8.2% to 36.0%.

## **2. Gender-based violence mostly happens in poor, uneducated families**

**Comments:** Studies of domestic violence consistently find that abuse occurs among all types of families along all levels of income, educational level, profession, and ethnicity. Some studies have found an association between low levels of education and the perpetration and experience of intimate partner violence and that women living in poverty are disproportionately affected by intimate partner violence, but this is not a universal finding (29, 33).

## **3. Sometimes it is the behavior of women that causes their male partners to become violent**

**Comments:** In some settings, wife-beating and other forms of physical violence may be considered justified as a form of discipline. However, the global and regional human rights frameworks are clear that women have a fundamental right to live free of violence under all circumstances, regardless of such traditional norms. The right of a husband to use physical violence to 'discipline' his wife for any reason has been rejected by the UN Declaration on the Elimination of Violence against Women and the Inter-American Convention on the Prevention, Punishment and Eradication of violence against Women (Convention of Belem Do Para) (34). Module II elaborates on these human rights instruments.

## **4. Alcohol abuse causes gender-based violence**

**Comments:** There has been a lot of controversy over whether or not alcohol causes violence against women. It has been argued that it should not be seen as a cause, though there is general agreement that it is a risk factor. Studies noted associations between alcohol use, particularly binge drinking, and battering (35, 36).

## **5. When there is violence in the family, all members need to change to stop the violence.**

**Comments:** GBV is often interpreted as a relationship problem. However, GBV is a behavioral choice of the abuser. Many battered partners make efforts to change their behavior in the hope that this will stop the abuse, only to be abused again. Changes in family members' behavior will not necessarily cause the batterer to stop.

**6. Persons who are subject to intimate partner violence and stay in the relationship are also to blame for the continuation of the violence. They would leave if they wanted it to stop.**

**Comments:** *physical abuse is often combined with emotional abuse and other issues such as financial dependency and children to consider, leaving the person feeling powerless and without options. Leaving the battering partner is usually a very difficult decision. Battered partners may make repeated attempts to leave the violent relationship, but fail due to lack of options and fear for escalation of the violence. Shame and lack of support from the social environment, the police and support agencies further compromises the capacity to end a violent relationship (5, 14, 29).*

**7. Domestic violence is a family problem. It is not the role of health workers to interfere in this family problem.**

**Comments:** *Gender-based violence is a public health problem that requires a public health approach. The health consequences of gender-based violence include fatal outcomes such as homicide, suicide, maternal mortality, physical consequences including injuries, disability, chronic pain syndromes, mental health issues including depression, anxiety, post traumatic stress disorder, negative behaviors including smoking, alcohol & drug use, and reproductive health consequences including unwanted pregnancies, unsafe abortions, miscarriage, and HIV/STI. Health workers have the ethical and professional responsibility to address issues affecting the health and well-being of clients. The therapeutic process provides an opportunity to detect and address GBV in their interaction with clients. If health workers do not ask about violence, they may misdiagnose victims, offer inappropriate care, or even put clients inadvertently at risk through breach of confidentiality, or failure to recognize that a client is in danger of suicide or homicide (5, 14, 29).*

**8. Hitting your partner now and then is not a crime**

**Comments:** *violence is in any context, including intimate relationships, is a violation of the human rights of the individual. All persons, women, men, boys and girls have the right to live their lives free of violence (34). In recent decades, countries around the world have strengthened laws that make physical violence against women and girls a criminal offense. There are some countries in which wife-beating has not yet been criminalized, but most countries have legislation making it a crime to hit a partner – even occasionally.*

**9. Women are just as violent as men in relationships.**

**Comments:** *Studies documented that women can also use violence in relationships. However, research indicates that the most severe forms of domestic violence—those characterized by high levels of fear, control and injury—are almost always perpetrated by men against women. Apart from the greater physical strength of men that puts them at an advantage, gender norms and expectations in many communities support male superiority, domination and control over women as the norm, creating fertile conditions for gender-based violence. Due to gender discrimination, women often have fewer options and resources at their disposal to avoid or escape abusive situations. In addition, the consequences of intimate partner violence are generally more severe for women in terms of levels of injury and reproductive consequences, including forced and unwanted pregnancies, unsafe abortions, and higher risk of HIV and other STIs (5, 14, 29).*

- Facilitator presentation on GBV as a public health problem: The PowerPoint presentation will elaborate on the definition and dimensions of GBV and the individual, relationship, community, and structural factors contributing to violence.

**Preparations Required**

- Review and modification of the list of myths and facts about GBV (keep the number of statement to around 10).
- Copies of the list of myths and facts about GBV.
- Review and adaptation of PowerPoint presentation through addition of local data and relevant information.

**Handouts and Other Materials**

- **Handout 4.1:** List of Myths and Facts about GBV.

## Session 4.2

### Gender-Based Violence and HIV/SRH

**Objective:** At the end of this session, participants will be able to explain the linkages between gender-based violence and HIV.

#### Activities

- Interactive facilitator presentation on the linkages between HIV and GBV: The PowerPoint presentation will elaborate on the growing body of evidence that indicates that GBV increases the risk of acquiring HIV and that HIV-positive status increases the likelihood of experiencing intimate partner violence.

#### Preparations Required

- Review and adaptation of PowerPoint presentation.

#### Handouts and Other Materials

- None.

## Session 4.3

### Addressing GBV in Health Services

**Objective:** At the end of this session, participants will be able to apply simple strategies to incorporate GBV in their service delivery.

#### Activities

- **Facilitator presentation on addressing GBV in health services:** The PowerPoint presentation summarizes lessons learned globally and in the region from other initiatives and provides an overview of options and tools that health workers can apply in their service delivery to address GBV.
- **Role play: Addressing GBV in health services:** During this role play participants will be able to practice with key elements of the proposed strategy, including addressing GBV in HIV testing and counseling, asking about GBV, validating experiences, facilitating safety plans, and providing referrals. If possible, invite external persons to serve as clients in the role play.

#### Preparations Required

- Review of PowerPoint presentation.
- Invitation to external persons to participate in the role play.

#### Handouts and Other Materials

- Copies of role play scenarios.
- **Handout 4.2:** Safety Planning with Women at Risk for Violence.

## Closing Session

On the final day of the training, the closing session will consist of two parts. The first part will summarize and reinforce the key messages related to Module 4, and the second part will reinforce the key messages of the training program as a whole. It is recommended that facilitators encourage optimal participant input into this final session, for instance by inviting participants to articulate what they have learned, what they consider the key messages of the training, and how they will apply the new insights in their work.

## Facilitator Notes

### Defining Gender-Based Violence

- Various terms are used to capture different dimensions of violence taking place in the context of family and other close relationships, including “family violence”, “domestic violence”, “intimate partner violence” and “gender-based violence”. Family violence and domestic violence refer to violent acts of one family member against another. Intimate partner violence refers to violence or abuse by one partner against another in an intimate relationship (14, 29).
- The United Nations Declaration on the Elimination of Violence Against women referred to violence against women as ‘gender-based’ to highlight the need to understand the violence against women within the context of women’s and girls’ subordinate status in society (35).
- The World Health Organization defines intimate partner violence as behavior within an intimate relationship that causes physical, sexual or psychological harm, including acts of physical aggression, sexual coercion, and psychological abuse (29).
- The violence can be physical, sexual, or psychological/emotional (29).
  - **Physical:** actual or threatened infliction of physical injury which is intentional. Physical violence can include a range of threatened or actual behaviors from slapping, hitting, burning, pulling of hair, to the use of weapons.
  - **Sexual:** any sexual act, attempt to obtain a sexual act, unwanted sexual comments or advances directed against a person’s sexuality using coercion, by any person regardless of their relationship to the victim, in any setting including but not limited to home and work. Sexual violence includes physical force to have sexual intercourse, or to engage in acts the person finds degrading or humiliating.
  - **Psychological/emotional:** can include intimidation, threats, humiliation, embarrassment, destroying the persons’ property, threats to harm the person or someone she cares about, isolating the person from family and friends, etc.
- Gender power relationships are at the root of gender-based violence. Studies have found that men and women’s attitudes towards violence are strongly correlated with intimate partner violence, both in terms of victimization and perpetration. In some settings, women’s acceptance of violence is also positively associated with the experience of intimate partner violence (29). Dominant patriarchal values, restrictive gender roles, ideologies of male sexual entitlement, poverty, past

history of victimization or perpetration of violence, including exposure to childhood maltreatment, harmful use of alcohol, antisocial personality, low education, multiple partners, and weak community sanctions against intimate partner violence have all been found to be correlated to intimate partner violence in studies (29).

- Limited research has been conducted on the occurrence of LGBT intimate partner violence. A systematic review of 17 studies conducted between 1995 and 2006 found that the rates of same sex intimate partner violence were comparable to rates of heterosexual domestic violence (38).
- Abuse thrives in silence and isolation. Due to the secrecy many LGBT people experience about their sexual orientation and relationships, LGBT intimate partner violence is often hidden, and sometimes referred to as the second closet or the closet within the closet (36, 37, 38, 39).
- Regardless of sexual orientation, many persons living with GBV face barriers of ignorance and prejudice in the health care setting.
- Intimate partner violence profoundly affects the physical, sexual, reproductive, emotional, mental and social well-being of individuals and families. The health consequences include death, suicide, depression and other mental health problems, physical injury, unwanted pregnancy, abortion, miscarriage and other gynecological complications, HIV and other STIs (29, 36, 37, 38, 39).
- A comparative analysis of national, population-based studies conducted in 12 countries in Latin America and the Caribbean between 2003 and 2009 (34) found the following:
  - The percentage of women ever married or in union who reported ever experiencing physical or sexual violence by an intimate partner ranged from 17% to 53.3%. Between 7.7% and 25.5% reported recent (i.e. past 12 months) partner violence.
  - The proportion of women ever married or in union who reported emotional abuse by a partner ever ranged from 17.0% to 47.8%. Recent emotional abuse ranged from 13.7% to 32.3%.
  - A majority of women who experienced physical violence in the past 12 months also reported emotional abuse, ranging from 61.1% to 92.6%.
  - Women from all socioeconomic backgrounds reported having experienced physical or sexual violence by an intimate partner, but in many countries, the prevalence of physical or sexual intimate partner violence ever or in the past 12 months was significantly higher among urban compared with rural women, among divorced or separated women compared with married women, among women who were currently or recently employed compared with those who were not, and among women in the lowest wealth or education categories compared with those in the highest.
  - The percentage of women listing a partner's drunkenness or drug use as a "trigger" of intimate partner violence ranged from 29.8% to 53.4%.
  - The proportion of women who sought help for intimate partner violence by telling someone close to them ranged from 29.3% to 65.5%; the percentage who sought institutional help ranged from 8.2% to 36.0%.

### **The Prevalence of Gender-Based Violence**

- Documenting the prevalence of gender-based violence is challenging due to reluctance or fear to disclose experiences of violence to researchers. Differences in methodology between the available studies also make it difficult to compare prevalence rates across different settings. As a result, understanding of the scope of the problem is limited.
- The 2005 WHO Multi-country study on women's health and domestic violence against women conducted in 10 countries included Peru and Brazil from the LAC region. The study found that between 6% and 59% of women reported experiencing sexual violence by an intimate partner in their lifetime. Demographic and reproductive health surveys conducted in thirteen countries in Latin America and the Caribbean between 2003 and 2009 found that between 5 and 18 percent of ever-partnered women aged 15-49 reported forced sex by an intimate male partner ever. Eight of the thirteen had percentages higher than 10 percent (29).



### The Intersection between HIV and Gender-Based Violence

- Gender-based violence is both a cause and a consequence of HIV infection. HIV transmission risk increases during forced sex, as abrasions caused by forced penetration facilitate entry of the virus. In addition, persons living in a situation of physical or psychological abuse, or financial dependency are less likely to negotiate safer sexual practices, including condom use (5, 14, 15, 29).
- Fear of violence can deter HIV testing due to fear of a positive result and the potential consequences of disclosing a positive test result to the partner, including violence or termination of the relationship. Women may also be afraid to test without their partner's consent, even if they expect a negative test result (5, 27, 29).
- Due to the expansion in programs for prevention of mother-to-child transmission of HIV, women in many countries have greater access to HIV testing compared to their male partners. As a result, many women might be the first to get tested in a relationship, and if tested positive, might be blamed for bringing HIV into the home (5, 29).
- Fear of violence and other forms of HIV stigma and discrimination can also cause women to decide not to disclose their HIV positive status - which has been shown to undermine prevention and care seeking behavior (5, 14, 29).

### Addressing Gender-Based Violence in Health Services

- Addressing GBV in health care setting starts with recognition among health care providers that GBV is an important public health problem in general, and has direct impact on the HIV response (5, 14, 15, 29).
  - Health care institutions have an ethical mandate to address GBV, and the institutional policies and protocols can either facilitate or hinder a structural approach towards addressing GBV. In addition, capacity building of service providers is critical, and learning opportunities must be provided to staff (5, 14, 29).
- What health care institutions can do (5, 29):
    - Raise awareness among program staff, clients and communities regarding the links between gender-based violence and HIV.
    - Provide training on gender-based violence for staff.
    - Maintain a list of available referral services and work with NGOs, women's groups, peer support groups and shelters to establish a functional network.
    - Develop and implement protocols for the management of rape and sexual abuse, including the provision of post-exposure prophylaxis (PEP) and emergency contraception.
    - Develop mechanisms for staff to address violence in their own lives.
    - Offer couples HIV testing and counseling: in this approach counselors can provide a safe environment and can help couples talk through difficult issues. The counselor can also help ease tension, and diffuse blame in case of a positive test result. The partners hear their test results together, and decisions regarding prevention, treatment, care, and family planning can be made together.
  - Even if there is no institutional framework, health workers can incorporate strategies in their dealing with clients to break the silence on GBV, and serve as catalyst in their organization to advocate for an institutional response to GBV (5, 29).
  - What health workers can do (5, 29):
    - Respect women's right to consent or decline the HIV test.
    - Understand that some women may decide not to disclose their HIV test or status to their partner for fear of violence.
    - Respect medical confidentiality.
    - Assess the danger of violence during post-test counseling.
    - Provide support to women who test positive.

**Handout 4.1**

#	Myths and facts about gender-based violence	Fact	Myth
1	Gender-based violence does not happen frequently.		
2	Gender-based violence mostly happens in poor, uneducated families.		
3	Sometimes it is the behavior of women that causes their male partner to become violent.		
4	In most cases gender-based violence is a one time, isolated event.		
5	When there is violence in the family, all members need to change to stop the violence.		
6	Persons who are subject to gender-based violence and stay in the relationship are also to blame for the continuation of the violence. They would leave if they wanted it to stop.		
7	Domestic violence a family problem. It is not the role of the health worker to interfere in this family problem.		
8	Hitting your partner now and then is not a crime.		
9	Women are just as violent as men in relationships.		

**Handout 4.2**
**Safety Planning with Women at Risk for Violence**

- Ask about violent and controlling behaviors.
  - Show a sympathetic attitude; do not blame or judge women.
  - Inform women of their rights and the services available to them.
  - Help women to make their own choices about their relationships, and discuss the implications of violence against women with regard to the risk of HIV and living with HIV.
  - In the event a woman decides to stay with a violent partner, assist her in planning what to do if the violence increases.
  - In the event a woman decides to leave her partner, assist her in planning what to do. This involves answering the following questions:
    - Where could she go?
    - How would she get there?
    - Is money needed? Does she need her identification documents?
    - Would she need emergency clothes, etc.?
    - Can she always keep a bag packed?
    - Would it help to agree on a signal to neighbors in order to get their help?
  - Provide options for support, including police, social workers, and community-based organizations.
  - Discuss informal options for support, including neighbors, friends, and relatives.
    - Key guidance about disclosure of a positive HIV test among women affected by violence:
  - Decide on the best time and place to have the conversation.
  - Choose a time when you expect that you will both be comfortable, rested, and as relaxed as possible.
  - Think about how your partner may react to stressful situations.
  - If there is a history of violence in your relationship, consider your safety first, and plan the situation with a support person (e.g., counselor).
  - Prepare for the conversation. Imagine several ways in which your partner might react to the news. Write down what he might say, and think about what you might say in response.
- Source:** World Health Organization (WHO). (2009). Integrating Gender into HIV Programmes in the Health Sector: Tool to Improve Responsiveness to Women's Needs. Geneva: WHO.

## Module Evaluation Form

**1.** Please rate the usefulness of the content presented to you in module (add module #) (Circle the number corresponding to the appropriate answer)

- (1) not so useful                      (3) useful  
(2) rather useful                      (4) very useful

**2.** What training methods did you find most useful? (Please list)

---

---

**3.** Which activities did you find most useful? (Please list)

---

---

**4.** Which activities did you not find very useful? (Please list)

---

---

**5.** What content would you like to have further clarified before the end of the training?

---

---

**6.** What additional content would you like to be covered before the end of the training?

---

---

**7.** Any comments or suggestions to make about the training?

---

---

## End-of-Training Evaluation Form

Please complete the form below to help us evaluate this training.

1. How well did the training meet your expectations?

Did not meet ( ) Partly met ( ) Fully met ( )

2. Explain which of your expectations were not met.

---



---



---

3. Please evaluate the course on the following aspects

	Very poor	Poor	Fair	Good	Very good
They kept to the daily schedule					
Organization and contents of the group work					
Quality of the plenary sessions					
Facilitators' knowledge and expertise					
Facilitators' skills and behavior					
Group activities					

What other specific comments do you have about the training?

---



---



---



---

## References

1. UNAIDS Interagency Task Team on Gender and HIV/AIDS. Operational guide on gender & HIV/AIDS. A rights-based approach. Geneva, UNAIDS, 2005.
2. Pan American Health Organization. Gender mainstreaming in health: a practical guide. <http://www2.paho.org/hq/dmdocuments/2010/manualENweb.pdf> . Last accessed on 25 February, 2013.
3. UNAIDS. UNAIDS Terminology Guidelines. Revised version. Geneva, UNAIDS, 2011.
4. UNFPA. FAQs on human Rights. [http://www.unfpa.org/derechos/preguntas\\_eng.htm](http://www.unfpa.org/derechos/preguntas_eng.htm). Accessed on October 10, 2012. Last accessed on 25 February, 2013.
5. World Health Organization (WHO). Integrating Gender into HIV Programmes in the Health Sector: Tool to Improve Responsiveness to Women's Needs. Geneva, WHO, 2009. [http://www.who.int/gender/documents/gender\\_hiv\\_guidelines\\_en.pdf](http://www.who.int/gender/documents/gender_hiv_guidelines_en.pdf). Last accessed on 25 February, 2013.
6. Pan American Health Organization (PAHO). Gender Equality Policy. Washington D.C., 2005. <http://www.paho.org/english/ad/ge/PAHOGenderEqualityPolicy2005.pdf>. Last accessed on 25 February, 2013.
7. Pan American Health Organization. The right of young people to health and gender identities. Findings, trends and targets for public health action. Washington, D.C., PAHO, 2011.
8. United Nations Office of the High Commissioner for Human Rights. What are human rights? <http://www.ohchr.org/en/issues/Pages/WhatareHumanRights.aspx>. Last accessed on 25 February, 2013.
9. UNAIDS. Expanding the Global Response to HIV/AIDS through Focused Action: Reducing Risk and Vulnerability; Definitions, Rationale and Pathways. Geneva, UNAIDS, 1998. [http://data.unaids.org/Publications/IRC-pub01/jc171-expglobresp\\_en.pdf](http://data.unaids.org/Publications/IRC-pub01/jc171-expglobresp_en.pdf). Last accessed on 25 February, 2013.
10. Pan American Health Organization. Empowerment of adolescent girls. A key process for achieving the Millennium Development Goals. Washington, D.C., PAHO, 2010. [http://new.paho.org/hq/dmdocuments/2010/empowerment\\_final\\_lr.pdf](http://new.paho.org/hq/dmdocuments/2010/empowerment_final_lr.pdf). Last accessed on 25 February, 2013.
11. UNAIDS. Keeping Score III. The Voice of the Caribbean People. Trinidad & Tobago, UNAIDS, 2011. <http://www.unaidscaribbean.org/sites/default/files/field/upload/keeping-scoreIII.pdf>. Last accessed on 25 February, 2013.
12. World Health Organization. Global HIV/AIDS Response. Epidemic update and health sector progress towards Universal Access. Progress report 2011. Geneva, WHO, 2011 [http://whqlibdoc.who.int/publications/2011/9789241502986\\_eng.pdf](http://whqlibdoc.who.int/publications/2011/9789241502986_eng.pdf). Last accessed on 25 February, 2013.
13. Pan American Health Organization. Challenges posed by the HIV epidemic in Latin America and the Caribbean. Washington, D.C., PAHO, 2009. <http://www2.paho.org/hq/dmdocuments/2010/CHALLENGES-hiv-epidemic-INGLES-2010.pdf>. Last accessed on 25 February, 2013.
14. UNAIDS. UNAIDS Action Framework: Addressing Women, Girls, Gender equality and HIV. Geneva, UNAIDS, 2009. [http://www.unfpa.org/webdav/site/global/shared/documents/publications/2010/un aids\\_action\\_framework.pdf](http://www.unfpa.org/webdav/site/global/shared/documents/publications/2010/un aids_action_framework.pdf). Last accessed on 25 February, 2013.
15. UNAIDS. Getting to Zero. 2011-2015 Strategy. Geneva, UNAIDS, 2010. [http://www.unaids.org/en/media/un aids/contentassets/documents/un aidspublication/2010/jc2034\\_un aids\\_strategy\\_en.pdf](http://www.unaids.org/en/media/un aids/contentassets/documents/un aidspublication/2010/jc2034_un aids_strategy_en.pdf). Last accessed on 25 February, 2013.
16. United Nations General Assembly. The Convention on the Elimination of all forms of Discrimination against Women. United Nations, 1979. <http://www.un.org/womenwatch/daw/cedaw/> . Last accessed on 25 February, 2013.

17. Organization of American States (OAS). Inter-American Convention on Prevention, Punishment and Eradication of Violence against Women (Convention of Belem do Para). OAS, 1994. <http://www.oas.org/juridico/english/sigs/a-61.html>. Last accessed on 25 February, 2013.
18. United Nations General Assembly. Declaration of Commitment on HIV/AIDS. United Nations, 2001. [http://data.unaids.org/publications/irc-pub03/aidsdeclaration\\_en.pdf](http://data.unaids.org/publications/irc-pub03/aidsdeclaration_en.pdf). Last accessed on 25 February, 2013.
19. United Nations General Assembly. Political Declaration on HIV/AIDS. United Nations, 2006. [http://data.unaids.org/pub/Report/2006/20060615\\_HLM\\_PoliticalDeclaration\\_ARES60262\\_en.pdf](http://data.unaids.org/pub/Report/2006/20060615_HLM_PoliticalDeclaration_ARES60262_en.pdf). Last accessed on 25 February, 2013.
20. United Nations General Assembly. Political Declaration on HIV/AIDS. United Nations, 2011. <http://www.un.org/en/ga/aidsmeeting2011/>. Last accessed on 25 February, 2013.
21. UNAIDS. International Guidelines on HIV/AIDS and Human Rights. 2006 consolidated version, Geneva, UNAIDS, 2006. [http://data.unaids.org/Publications/IRC-pub07/jc1252-interguidelines\\_en.pdf](http://data.unaids.org/Publications/IRC-pub07/jc1252-interguidelines_en.pdf). Last accessed on 25 February, 2013.
22. Pan American Health Organization. Human Rights & Health. Older Persons. Washington DC, PAHO, 2008. [http://www.paho.org/english/dd/pub/10069\\_OlderPersons.pdf](http://www.paho.org/english/dd/pub/10069_OlderPersons.pdf). Last accessed on 25 February, 2013.
23. Pan American Health Organization. Resolution CD50/12. Health and Human Rights. Washington D.C., PAHO, 2010. [http://www.un.org/disabilities/documents/paho\\_mh\\_concept\\_paper.pdf](http://www.un.org/disabilities/documents/paho_mh_concept_paper.pdf). Last accessed on 25 February, 2013.
24. Pan American Health Organization. Series Renewing Primary Health Care in the Americas. No.4: Integrated Health Service Delivery Networks. Concepts, Policy Options and a Road Map for Implementation in the Americas. Washington D.C., PAHO, 2001. [http://new.paho.org/hq/dmdocuments/2011/PHC\\_IHSD-2011Serie4.pdf](http://new.paho.org/hq/dmdocuments/2011/PHC_IHSD-2011Serie4.pdf). Last accessed on 25 February, 2013.
25. World Health Organization. Programmatic update. Antiretroviral treatment as Prevention (TaSP) of HIV and TB. Geneva, WHO, 2012. [http://www.who.int/entity/hiv/pub/mctct/programmatic\\_update\\_tasp/en/index.html](http://www.who.int/entity/hiv/pub/mctct/programmatic_update_tasp/en/index.html). Last accessed on 25 February, 2013.
26. World Health Organization (WHO). Guidance on pre-exposure oral prophylaxis (PrEP) for serodiscordant couples, men and transgender women who have sex with men at high risk of HIV. Geneva, WHO, 2012. [http://apps.who.int/iris/bitstream/10665/75188/1/9789241503884\\_eng.pdf](http://apps.who.int/iris/bitstream/10665/75188/1/9789241503884_eng.pdf). Last accessed on 25 February, 2013.
27. World Health Organization (WHO). Guidance on Couples HIV Testing and Counseling, Including Antiretroviral Therapy for Treatment and Prevention in Serodiscordant Couples: Recommendations for a Public Health Approach. Geneva, WHO, 2012. <http://www.who.int/hiv/pub/guidelines/9789241501972/en/>. Last accessed on 25 February, 2013.
28. World Health Organization (WHO). Service Delivery Approaches to HIV Testing and Counseling (HTC): A Strategic HTC Programme Framework. Geneva, WHO, 2012. [http://apps.who.int/iris/bitstream/10665/75206/1/9789241593877\\_eng.pdf](http://apps.who.int/iris/bitstream/10665/75206/1/9789241593877_eng.pdf). Last accessed on 25 February, 2013.



29. World Health Organization. Preventing intimate partner and sexual violence against women. Taking action and generating evidence. Geneva, WHO, 2010. [http://www.who.int/violence\\_injury\\_prevention/publications/violence/9789241564007\\_eng.pdf](http://www.who.int/violence_injury_prevention/publications/violence/9789241564007_eng.pdf). Last accessed on 25 February, 2013.
30. World Health Organization. Ensuring equitable access to antiretroviral treatment for women; WHO/UNAIDS Policy Statement. Geneva, WHO, 2004. <http://whqlibdoc.who.int/unaid/2004/a85588.pdf>. Last accessed on 25 February, 2013.
31. Pan American Health Organization. Regional Initiative for Elimination of mother-to-child transmission of HIV and Congenital Syphilis in Latin America and the Caribbean. Concept Document for the Caribbean. Trinidad & Tobago, PAHO, 2010.
32. World Health Organization (WHO). Use of antiretroviral drugs for treating pregnant women and preventing HIV infection in infants. Programmatic Update. Geneva, WHO, 2012. [http://www.who.int/hiv/PMTCT\\_update.pdf](http://www.who.int/hiv/PMTCT_update.pdf). Last accessed on 25 February, 2013.
33. Sexual Violence Research Initiative. Sexual violence in Latin America and the Caribbean: a desk review. 2010. <http://www.svri.org/SexualViolenceLACaribbean.pdf>. Last accessed on 25 February, 2013.
34. Bott, S., Guedes, A., Goodwin, M., Mendoza, J. Violence against Women in Latin America and the Caribbean: A Comparative analysis of population-based data from 12 countries. PAHO & CDC, 2012. (Publication pending).
35. United Nations General Assembly. Declaration on the Elimination of Violence against Women. A/RES/48/104. 85th Plenary Meeting 20 December 1993. <http://www.un.org/documents/ga/res/48/a48r104.htm>. Last accessed on 25 February, 2013.
36. Carvalho, A., Lewis, R., Derlega, V., Winstead, B., Viggiano, C. Internalized Sexual Minority Stressors and Same-Sex Intimate Partner Violence. *J Fam Viol*, 2011, 26:501-509.
37. Stanley, J., Bartholomew, K., Taylor, K., Oram, D., Landolt, M. Intimate Violence in Male Same-Sex Relationships. *J Fam Viol*, 2006,21(1): 31-41.
38. Murray, C., Mobley, A. K. Empirical Research about Same-Sex Intimate Partner Violence: A Methodological Review. *Journal of Homosexuality* 2009, 56 (3), pp 361-389.
39. Ball, M., Hayes, S. . Same-sex intimate partner violence: exploring the parameters. In Scherer, Burkhard (ed.) *Queering Paradigms*. Peter Lang AG, Bern, 2009,pp 161-177.







**INTEGRATION OF GENDER AND HUMAN RIGHTS  
IN HIV AND SEXUAL AND REPRODUCTIVE HEALTH SERVICES**  
Training for Health Care Providers  
Facilitators' Manual

