

Engendering universal health coverage

Working towards a gender
transformative UHC
agenda for people most
affected by HIV



PITCH Partnership to Inspire, Transform
and Connect the HIV response



aidsfonds

**FRONTLINE
AIDS** 



Ministry of Foreign Affairs

1. Introduction

The PITCH programme¹ has supported many partners to advocate for universal health coverage (UHC) as critical for affirming the inclusion of key populations and adolescent girls and young women². For advocacy on UHC to be successful it must address the root causes of exclusion and discrimination, not only in the change we are seeking but also in the process of advocating for that change. A gender transformative approach means working to challenge and subvert the norms that have caused the marginalisation of women and girls in all their diversity and people with diverse sexual orientation, gender identity/ expression or sex characteristics (SOGIESC) who are most affected by HIV. It also means working to ensure the change can be longer-term and more sustainable.

This brief is intended to support ongoing work towards gender transformation in UHC advocacy by HIV activists and advocates at the national and sub-national level. It also highlights some examples of promising practice and recommendations for the development and strengthening of this important work. This is to ensure that national governments commit to addressing gender inequality as a root cause of the disproportionate burden of HIV, and denial of sexual and reproductive health and rights (SRHR) for adolescent girls and young women, sex workers, men who have sex with men, and trans*³ women, among others.

¹ The Partnership to Inspire, Transform and Connect the HIV Response (PITCH) is a strategic partnership between Aidsfonds, Frontline AIDS, and the Dutch Ministry of Foreign Affairs. It aims to build the capacity of community-led organisations representing people living with and most affected by HIV to advocate for HIV prevention, human rights and sexual and reproductive health and rights (SRHR). PITCH supports advocacy in Indonesia, Kenya, Mozambique, Myanmar, Nigeria, Uganda, Ukraine, Vietnam and Zimbabwe. For more information, visit www.aidsfonds.org/pitch and www.frontlineaids.org/pitch

² Key populations are defined under PITCH as sex workers of all genders; people who use drugs; lesbian, gay, bisexual and transgender (LGBT) individuals and communities.

³ We use the asterisk here to both represent trans as being an umbrella term for multiple gender-diverse identities, and for other identities which are not encompassed by the L, G, B, or T categories.

The brief is structured as follows:

1. Introduction
2. Definitions of a gender transformative approach and what this means within UHC advocacy
3. Case studies from four countries highlighting examples of working in a gender transformative way in UHC advocacy
4. Reflections for gender transformative UHC advocacy: key steps and critical issues
5. Recommendations for taking a gender transformative approach in all UHC advocacy work and programmes.

The approach to 'engendering UHC' is informed by feminist principles. Examples are given throughout the text of how these principles can be applied in practice. A full list of feminist principles can be found on page 19.

2. Definitions

What is universal health coverage (UHC)?⁴

UHC is a global goal that all member states of the United Nations have committed to achieve by 2030 as part of the Sustainable Development Goals (SDGs). According to the World Health Organization (WHO), universal health coverage will have been achieved when all people and communities receive the health services⁵ they need without financial hardship.

Three core dimensions of UHC

- Leave no one behind, with specific attention to the poor, vulnerable and marginalised
- Ensure progressive access to a wide range of high-quality services
- Eliminate financial hardship among users of healthcare services

It is important to acknowledge the many barriers to UHC facing people living with HIV, as well as the limitations of some government approaches to UHC. However, the 2019 political declaration on UHC states clearly that a 'gender mainstreaming perspective' should be implemented when 'designing, implementing and monitoring health policies, taking into account the specific needs of all women and girls' including their right to have control over and decide freely and responsibly on all matters related to their sexuality, including sexual and reproductive health, free of coercion, discrimination and violence.' In addition, there needs to be recognition of the 'fundamental importance of equity, social justice and social

protection mechanisms as well as the elimination of the root causes of discrimination and stigma in healthcare settings to ensure universal and equitable access to quality health services without financial hardship for all people'⁶. UHC provides an important 'entry point to leverage for the rights of people living with HIV'⁷.

"If universal health coverage is to be truly universal it must encompass everyone, especially those who have the most difficulty accessing health services, such as migrants, rural populations, people in prison, LGBT community, sex workers, drug users, poor people #Healthforall"

Dr Tedros Adhanom Ghebreyesus,
Director-General, WHO

What is the role of civil society in achieving UHC?

Civil society and communities have a critical role to play in UHC, especially in advocacy, research and service delivery. UHC advocacy for HIV activists and advocates takes many forms including (but not limited to) campaigning to challenge attitudes and beliefs; inspiring and mobilising those most affected by HIV in their diversity to

⁴ See Protect the gains, push for progress: How to advocate for effective inclusion and integration of HIV services in universal health coverage in the context of COVID-19. Available at: https://aidsfonds.org/assets/resource/file/PITCH%20UHC%20Advocacy%20Guide%202020_final.pdf

⁵ Defined as health promotion, prevention, treatment, cure, rehabilitation and palliative care services.

⁶ Political declaration of the High-Level Meeting on Universal Health Coverage: "Universal health coverage: moving together to build a healthier world", September 2019. <https://www.un.org/pga/73/wp-content/uploads/sites/53/2019/07/FINAL-draft-UHC-Political-Declaration.pdf>

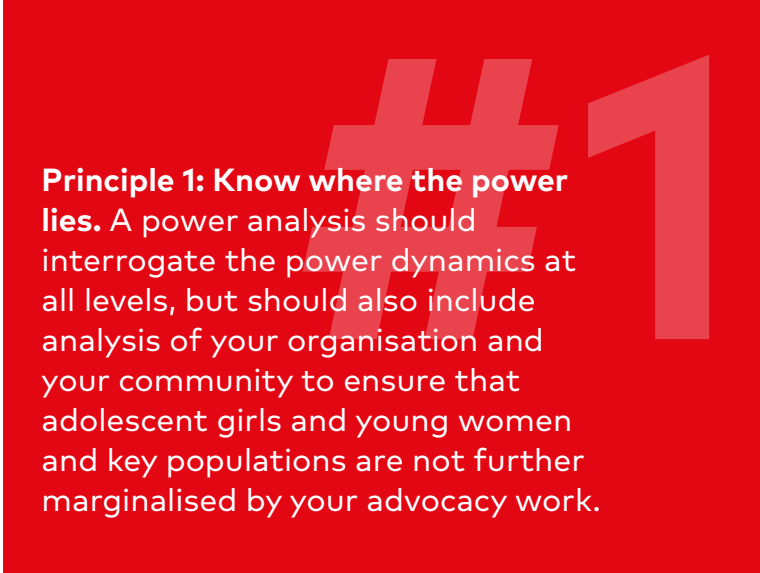
⁷ Protect the gains, push for progress: How to advocate for effective inclusion and integration of HIV services in Universal Health Coverage in the context of COVID-19: https://aidsfonds.org/assets/resource/file/PITCH%20UHC%20Advocacy%20Guide%202020_final.pdf

lobby for the inclusion of their priorities and needs in UHC; building evidence and knowledge about the situation for women and girls in all their diversity and people with diverse SOGIESC most affected by HIV; and lobbying for legal reform and developing policies that ensure their inclusion. It also includes direct lobbying of key policy makers and decision makers.

What is a gender transformative approach?⁸

Gender inequality is underpinned by patriarchal, gendered norms, expectations and stereotypes that are reinforced at all levels of society, including household, community, institutional and state. Norms are unwritten rules about what individuals should be and do - as well as what they should not be and not do. Societies and institutions expect individuals and groups to behave according to those rules, within a particular social group or culture. Gender norms are particularly harmful to women and girls, and key populations including sex workers, LGB+ (lesbian, gay and bisexual) and trans* individuals, and women who use drugs because norms are driven by unequal power relations and upheld by strict policing of those who transgress them through social coercion and violence. This hinders individuals' access to resources and limits their power within most societies and, ultimately, perpetuates a cycle of violence and control.

An **intersectional approach**, which works to understand the experiences that people have based on multiple factors, is also key to working in a gender transformative way and to ensure we **leave no one behind**. This includes understanding how gender norms interact with poverty, racial inequality, age discrimination, homophobia and transphobia (among others) to address structural barriers to UHC for women and girls in all their diversity and people with diverse SOGIESC most affected by HIV.



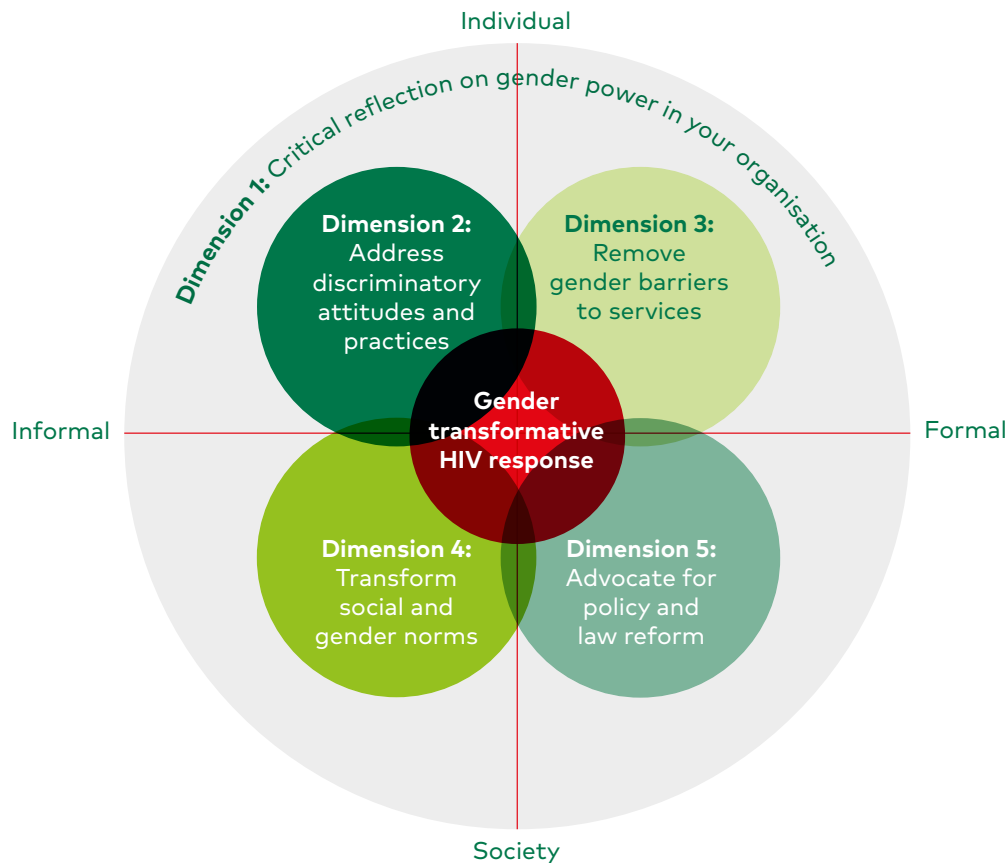
Principle 1: Know where the power lies. A power analysis should interrogate the power dynamics at all levels, but should also include analysis of your organisation and your community to ensure that adolescent girls and young women and key populations are not further marginalised by your advocacy work.

Gender transformative UHC advocacy should be guided by feminist principles. We have illustrated how these can be used throughout the brief. For additional examples of how these principles have been applied in PITCH, see page 19.

The PITCH partnership has articulated five dimensions through which, working with a gender transformative approach, it is both possible and necessary to challenge and change gender relationships of power. These are described in more depth in the brief [What does it take to achieve a gender transformative HIV response?](#)⁹

⁸ Kristy Evans (2005) A guide to feminist advocacy, Gender & Development, 13:3, 10-20

⁹ See <https://frontlineaids.org/wp-content/uploads/2020/10/Pitch-Gender-Guide-FINAL.pdf>



The following table explores the way gender inequality materialises in each of the five dimensions. It is not an exhaustive list but gives

examples of inequitable gender power and the consequences of that inequity in the context of HIV.

What does gender inequality look like in the different dimensions?	What does this mean in the context of HIV?
Dimension 1: Critically reflect on how gender norms, attitudes and beliefs are shaping interactions, workplaces and programme activities	
Structures of power within the workplace reflect and reproduce societal gender norms and power dynamics which discriminate against women in their diversity, LGBT+ and trans* populations.	Gender bias within organisations, processes and governance structures can further exclude and marginalise key populations and adolescent girls and young women from accessing decision making spaces, and thus their ability to influence strategy, priorities and agenda-setting. It also means that the lived realities of these communities – including their vulnerability to HIV – may not be taken into account in the work of the organisation.
Dimension 2: Address internalised harmful norms and discriminatory attitudes held by individuals and communities most affected by HIV	
The internalisation of harmful gender norms means that individuals may be unaware of their rights, especially sexual and reproductive health and rights, and lack agency to make informed choices.	In the context of HIV, we see that adolescent girls and young women are afraid to buy or carry condoms for fear of being stigmatised or labelled. Sex workers, women who use drugs, lesbian, bisexual and trans* women, and gay or other men who have sex with men may not report gender-based violence to the police for fear of not being believed or facing arrest and persecution themselves. Some forms of gender-based violence may be so 'normal' that they are not even recognised as such.

Dimension 3: Remove gender barriers to services

Discriminatory service provision particularly within healthcare, means individuals can be denied healthcare, mistreated or prevented from accessing critical healthcare services. In addition, gender inequality in socio-economic opportunities limits access to a number of services and other public and private resources, including credit.

In the context of HIV, we see that adolescent girls and young women, sex workers, LGB+ and trans* individuals, women who use drugs and women living with HIV experience exposure, negative attitudes from health workers, denial of services, or violence and coercion within health services. This results in both sub-standard service provision, and the possibility that individuals will avoid or postpone using available services.

Dimension 4: Transform social and gender norms in communities and societies

Rigid gender norms at household and community levels promote male dominance through aggression, coercion and violence, which is normalised and largely accepted. There is pressure on cis women and men¹⁰ to marry and have children to prove their value. A disproportionate burden of unpaid care work falls on women and girls in all their diversity.

Intimate partner violence, and other forms of gender-based violence (GBV), are both a cause and consequence of HIV, and a contributing factor in the disproportionate burden of HIV on adolescent girls and young women, sex workers, LGB+ and trans* communities, and women who use drugs. Moreover, GBV can be a barrier to accessing antiretroviral treatment (ART) or retention in care. The disproportionate care burden on women and girls places a strain on their own physical and mental health and stops them from participating in other activities (education, gainful employment, advocacy) that is beneficial to them. Gender norms may also be a barrier for men to enact health-seeking behaviour and access care, which has detrimental impacts on both their own, and their sexual partners' sexual and reproductive health and wellbeing.

Dimension 5: Advocate to change and reform laws, policies and resource allocation to achieve gender equality

Laws and policies can reinforce gender inequality, harmful gender norms, and the control of women's bodies. For example, the criminalisation of sex work, same sex practices, abortion, and HIV exposure/transmission; lack of policies that protect women, sex workers, and LGB+ and trans* persons from violence (e.g. laws that fail to recognise or address marital rape); and laws that inhibit personal agency such as age of consent to access services.

Laws that discriminate against women and girls - or criminalise individuals based on their sexual orientation or practice(s) or gender identity and/or expression - underpin, sanction and sustain stigma and discrimination, and normalise violence against these communities. As a result, gender-based violence and discrimination are often undocumented, or individuals are unable to pursue legal recourse or critical HIV or other medical services and support.

It is important to highlight that the drivers and consequences of gender inequality in the context of HIV can often be mutually reinforcing. For example, patriarchal social and gender norms at society and state levels are concretised in

national laws criminalising key populations. These laws then reinforce norms and become a driver of unequal or discriminatory treatment in service delivery.

¹⁰ The term cis women / men refers to people whose felt and expressed gender aligns with the sex they were assigned at birth: e.g. a woman who was assigned female at birth and identifies as a woman; or a man assigned male at birth, who identifies as a man. In contrast, a trans* or gender non-binary individual does not identify with the sex assigned at birth.

What does it mean to take a gender transformative approach in UHC advocacy?

Advocacy efforts concerned with empowerment, citizenship, and participation appear different than those that focus solely on policy reform [this] advocacy is not just about getting to the table with a new set of interests, it's about changing the size and configuration of the table to accommodate a whole new set of actors. Effective advocacy challenges imbalances of power and changes thinking. (VeneKlasen and Miller 2002 in Feminist Movement Builder's Dictionary)

Gender transformative advocacy is intimately connected to – and grounded in – the struggles and experiences of the individuals and communities affected,¹¹ and ensures its legitimacy through the leadership of the individuals and communities who are experiencing injustice and inequality. For gender transformative activists and advocates, the political commitment to realising the rights of women and girls in all their diversity and people with diverse SOGIESC most affected by HIV must be reflected in the means that are used to achieve the goals.

In other words, it's not just about WHAT we advocate for, but HOW we do it and the strategies and approach we use in that advocacy process and journey. The transformation of norms, attitudes and values should be central to the strategies as well as the goal of UHC advocacy. It is a long-term commitment because it entails a process of promoting shared power, control of resources, decision making, and affirmation of the rights of women and girls in all their diversity and people with diverse SOGIESC most affected by HIV.

¹¹ JASS (2013) Feminist Movement Builder's Dictionary Second Edition. JASS: <https://www.justassociates.org/sites/justassociates.org/files/feminist-movement-builders-dictionary-jass.pdf>

3. Case studies : What does gender transformative UHC advocacy look like in practice?

Education as a Vaccine (EVA) – Nigeria: Supporting adolescent girls and young women to be at the forefront of demanding the removal of gender barriers to services.

What was the problem?

Adolescent girls and young women in Nigeria face several barriers in accessing healthcare services particularly sexual and reproductive health information and services. The cost of services, stigma and discrimination, and negative attitudes of healthcare service providers hinder service access, especially for adolescent girls and young women living with HIV and unmarried young women. The age of consent to access services independently in the Nigerian constitution is 18. This contributes to younger girls being unable to access HIV services and other SRHR services. Universal health coverage implies that all individuals are able to access comprehensive, good quality health services without financial hardship. It targets health for all ages and all individuals. This reinforces our advocacy ask for the inclusion and prioritisation of adolescent girls and young women in health interventions.

What needs to change?


1. Lowering the age of consent to enable adolescent girls and young women to access health services, including SRHR information and services, without the need for consent from an older parent or guardian. This will improve access and protect service providers from any legal implications.

2. User fee exemption to ensure that adolescent girls and young women do not bear any extra cost implication at the point of accessing services. The Basic Health Care Provision Fund, which is Nigeria's vehicle for implementing UHC, makes provisions for specific people as vulnerable groups (pregnant women and children under five) to be exempted from user fees. EVA has advocated for adolescents and young people to be added to this category as most adolescent girls and young women do not have access to resources to finance their health needs.
3. Adolescent girls and young women still face discrimination and stigma when accessing SRHR services. The implementation of the HIV/AIDS Anti-Discrimination Act will create an enabling environment for them to thrive without fear and stigmatisation.

What is transformative about the process of lobbying for the inclusion of the adolescent girls and young women?

Centralising the voices and experiences of adolescent girls and young women:

EVA has been collecting stories and experiences that document the experiences of adolescent girls and young women, and highlight the importance of ensuring age-appropriate services. These stories provide qualitative data as well as being an important tool to ensure that adolescent girls and young women have a voice and space in advocacy work.



Principle 6: Mobilising for collective action. A key strategy for effective gender transformative UHC advocacy ensures that the individuals and communities affected by the issues take leadership of the work.

Mobilising to build solidarity and critical mass.

EVA is led by young women as well as creating spaces with and for young women. The organisation builds their capacity, not only to engage in external advocacy but also as a strategy for mobilising young people around the issue of UHC. EVA has provided training to ensure that young people are involved in the review of the guidelines for basic healthcare provision in order to 'build a mass of young people who understand the issue and can interact with decision makers'. A youth advocacy/advisory group was created to ensure that adolescent girls and young women led the advocacy process. Its members were also supported to hold group meetings with their peers (including young people living with and not living with HIV). The support group meetings were a safe space created by and for adolescent girls and young women to discuss their experiences as young women, especially when living with HIV, and to discuss issues they face with access to HIV and other SRHR services.

Creating space and access:

EVA works towards creating space and access for adolescent girls and young women in high-level meetings, consultations and engaging with policy makers. It equips young people with the language, information and knowledge about UHC to be able to meet with decision makers to push for better and more effective implementation for young people. EVA has ensured that young people have access to those in power – an opportunity often denied them.

"Opportunities ... exist for women – being strategic and smart about how we engage with decision makers to deepen their understanding of services to ensure the inclusion of young people [is key]."

Toyin Chukwudozie, Advocacy Officer at EVA

What have been the results?

EVA has been making progress in removing barriers to services for adolescent girls and young women, particularly with the lack of age-appropriate services. For example, the adolescent girls and young women who have been involved in the storytelling have had the opportunity to represent their issues in different spaces nationally and at the regional level as well. At the national level, they participated in the consultations for the recent round of country proposals for the Global Fund to Fight AIDS, Tuberculosis and Malaria's replenishment process. They also participated in adolescent health technical working group meetings and one youth advocate from the PITCH programme was recently made the co-chair of the adolescent health technical working group in Benue State. Increasingly, adolescent girls and young women are able to access critical information about sexual health, and are claiming agency in the UHC space.

Trans*Alliance Kenya: Advocating for the voice and agency of the trans* community in Kenya

What was the problem?

Trans*Alliance Kenya works to improve healthcare services and alleviate stigma and discrimination for transgender and gender non-conforming communities. A serious problem is the invisibility of the trans* community within healthcare provision in Kenya, and specifically in terms of HIV services. Trans*Alliance Kenya used the opportunity created by the government's declaration of UHC as a 'national priority'¹² as leverage for recognition and rights of the transgender community. Trans*Alliance Kenya collaborated with other trans* organisations all over Kenya to conduct research that would be critical in lobbying for inclusion of the trans* community in the government's commitment to UHC, amongst other trans* health programming issues.

What were the barriers?

Transgender Kenyans face entrenched prejudice in the medical sector. Despite requests for services such as hormone therapy and sex reassignment therapy, government officials and public hospitals continue to deny the transgender community medical services.

According to the research, the main barriers identified by the trans* community in health care provision are as follows:

- **Cost of care:** A vast majority of participants (68%) recorded that they postponed care because they could not afford it. Kisumu County had the highest proportion (79%) of the respondents who postponed seeking medical health care because they could not afford it.
- **Refusal of care:** 32% of survey respondents reported being refused medical care due to their transgender or gender non-conforming status, with a higher proportion (38%) among

Principle 2: Shift the power.

Once you have identified where the power lies you need to identify strategies during your advocacy work that specifically shifts this power imbalance.

participants in the major cities – Kisumu, Nairobi and Mombasa.

- **Discrimination in care:** nearly half (48%) of survey participants had postponed medical care because of discrimination and disrespect from providers. In Mombasa County, the proportion was even higher (68%).

What was transformative about the process of lobbying for the inclusion of the trans* community in UHC?

Ownership and leadership of research by the trans* community

Members of the trans* community were trained as research assistants and worked alongside consultants to collect qualitative data - conducting interviews, focus group discussions and questionnaires. A key component of the project was ensuring that the trans* community had ownership of the findings. This was an important step in shifting the power imbalances in research and data collection that often mean that gathering information can be extractive and exploitative.

Mobilising and movement building

The process of being trained and conducting the research was also a tool for mobilising and building solidarity across the trans* community in all parts of Kenya. There are eleven organisations in Kenya working on trans* rights, so solidarity and cooperation were important for the success of the research project.

¹² <https://www.health.go.ke/wp-content/uploads/2019/01/UHC-QI-Policy-Brief.pdf>

Strengthening alliances

In addition, the trans* community was supported by other broader LGB organisations. However, very importantly, these organisations did not take space away from the trans* organisations and acted as an ally. This was an important step in strengthening the relationships and creating more space for trans* and gender non-conforming voices to be heard.

What has been the change?

The research supported the development of the national transgender guidelines in Kenya giving visibility and government recognition to the trans* community. This process transformed the way research is conducted and the way in which the trans* community interacted with government.

According to Trans*Alliance Network's advocacy officer Dayo Atieno:

"developing these national standardised guidelines meant implementation of comprehensive health programmes for trans* people for health practitioners and policy makers to better protect the health and rights of transgender people. This means that the transgender population will have health programming specifically tailored to them, hence reinforcing the critical UHC message of leaving no one behind."

Principle 9: Accountability.

The organisations leading the advocacy work must be accountable to community members and create mechanisms for feedback, consultation and participation.

Indonesia Positive Women's Network (IPPI): Centralising the voice of women living with HIV in Indonesia

What was the problem?

In 2014, the Indonesian government developed new policies with the intention of ensuring UHC for the population. Unfortunately, these didn't take into account the needs of people living with HIV; the new policies actually created more barriers for women living with HIV. One example was insurance. The state introduced a new law that meant people had to re-register for insurance, creating an additional cost, particularly for those living with HIV who were either being supported by families or supporting families. As Baby Rivona Nasution, PITCH country focal person and national coordinator of the Indonesia Positive Women's Network (IPPI) explains: "we needed to show the government what UHC was really about and what it can mean for people living with HIV".

What were the barriers?

"When you are talking about criminalisation, about justice, about healthcare services, about UHC, they are cross-cutting. You cannot look at one in isolation without looking and thinking about the others."¹³

Baby Rivona Nasution, IPPI

The main barriers to people living with HIV being aware of or participating in UHC advocacy were identified as: (1) a narrow definition of UHC with an emphasis on health insurance among government and decision makers (2) lack of understanding of how the community of people living with HIV could use UHC as an entry point and a tool for advocacy (3) invisibility of people living with HIV in the advocacy on UHC.

¹³ <https://aidsfonds.org/story/how-to-bring-uhc-to-marginalised-groups-in-indonesia>

What was transformative about the process?

Learning the language

As the PITCH programme's country focal person, Baby started hosting policy dialogues led by women living with HIV. These started as a process to educate marginalised communities on what UHC could mean for them, but women living with HIV also started to transform the way they worked. The dialogues created space to include a wide representation of women living with HIV, women who use drugs and the trans* community.


As they started to understand the scope of UHC and how it could be used by HIV activists, women living with HIV then started collecting data to reflect the wide-ranging needs and demands of affected community members.

Opening doors

IPPI also started hosting policy dialogues with ministers. The government had developed a roadmap on UHC that had not been shared with HIV-affected communities. IPPI became the bridge, sharing information from the government with the wider HIV community as well as ensuring that the government had data and information from the community. To have women living with HIV in this position of leadership and playing a convening role is in itself transformative. However, change can be slow, and the political processes are volatile so it requires constant engagement and lobbying. It was critical in this process that the most marginalised communities were visible and empowered to lobby for UHC. HIV activists and advocates attended meetings with ministers, consulted on documents and participated in research to support their case for UHC advocacy.

What has been the change?

Through this process, women living with HIV were mobilised, and in turn mobilised other key populations including women who use drugs and the trans* community, to participate in further studies and research to support the inclusion of



Principle 7: Transparency. It is important that all processes during the advocacy work are transparent and that rightsholders are given equal opportunities to participate and lead at different stages so that we do not reaffirm the exclusion.

people living with HIV in UHC. Women living with HIV are now represented in a broader range of policy spaces. For example, they recently participated in USAID research to lobby the government not to remove HIV services from insurance; and women living with HIV representing IPPI now sit in the government's technical working group for health.

Legalife-Ukraine: Shifting restrictive gender norms and attitudes towards sex workers in Ukraine

What was the problem?

The criminalisation of sex work, and the restrictive gender norms and attitudes that underpin it, are a significant barrier to sex workers' right to health. According to Nataliia Isaieva, director of Legalife-Ukraine, decision makers "perceive sex work as a crime, and sex workers at best as victims and at worst as criminals". For sex workers, who are particularly vulnerable to HIV, there are limited HIV prevention services, and the law makes it very difficult to lobby for change. Legalife-Ukraine is concerned that the push for UHC will threaten the services for sex workers even further and its focus is therefore on legal reform and recognition of sex work as work. The work on decriminalisation and transforming norms, attitudes and values highlights critically important strategies to achieve the right to health.

What were some of the barriers?

Sex workers frequently experience stigma, discrimination and even violence by the police and other service providers. Legalife-Ukraine has been working at national and sub-national level to shift norms, attitudes and values towards sex workers of all genders. The work has focused on working with law enforcers and healthcare providers in different regions of the country. Since 2018, the organisation has conducted about 700 educational events for more than 6,000 police officers across Ukraine. The events tackle discrimination, rights violations and violence against sex workers by the police. The aim is to reduce the level of stigma and offences committed by the police and to improve sex workers' access to legal and medical services. During the events, an attitude assessment is conducted with police officers to assess the level of stigma and discrimination against sex workers. The findings indicate that many law enforcement officers hold very discriminatory attitudes towards female sex workers, often viewing them as criminals. Attitudes towards male sex workers are even more negative.

What was transformative about the process?


Creating space for dialogue

There were many cases when police officers showed a change in attitude towards sex workers during the training because, for example, sex workers participated as trainers, and personal communication between the two parties led to a shift in perceptions of sex workers and sex work in general. As a result, the training of police officers, as well as representatives of the prosecutor's office and courts, was continued in 2020.

Monitoring the change

In December 2019, Legalife-UKRAINE conducted a survey among 76 sex workers in seven regions of Ukraine and held a focus group with eight leaders of regional initiative groups within the framework of the PITCH and Bridging the Gaps¹⁴ monitoring and evaluation projects. The analysis

of the results showed the number of cases of violence by police officers halved compared to the previous year - in 2019, 5.3% of sex workers faced such abuse, whereas in 2018 such cases were reported by about 11% of sex workers.



Principle 8: Human rights-based approach. This is particularly important in transforming norms because it ensures that all rightsholders are treated equally and with dignity and affirmed for who they are in all their diversities.

What has been the change?

"As a group we have grown and now many sex workers are openly talking about their demands and the services they need... now sex work is being discussed openly at a higher level."

Nataliia Isaieva, Legalife-Ukraine

There are different factors that have contributed to this change, but a key one was the collective action and collaboration between sex workers, the LGBT community and the community of people who use drugs. Their combined efforts helped to kick start the conversations about sex work which, with the support of other organisations, has gained momentum, and is producing promising results.

¹⁴ An Aidsfonds-led partnership with the Dutch Ministry of Foreign Affairs under the Dialogue and Dissent programme. See <https://aidsfonds.org/work/bridging-the-gaps>

4. Reflections for gender transformative UHC advocacy: key steps and critical issues

As discussed in the case studies in section three, the process is just as important as the outcome for successful gender transformative UHC advocacy. This section reflects on critical issues that need to be considered in the process of designing and implementing UHC advocacy.

1. Identifying a UHC advocacy goal. Who is involved in the decision making process? Is the process diverse and inclusive, ensuring the most marginalised people participate and have a voice?

Using an intersectional lens is crucial to ensuring that a wide representation of communities impacted by gender inequality is involved in identifying the goal.

As Nataliia from Legalife emphasised, **“it is important to remember that sex workers might also be part of the LGBT community and might also be drug users, so we need to work together.”**

The advocacy goal should reflect the needs of the impacted community and be evidence-based. As all the case studies illustrate, the most effective

advocacy goal comes from the community, but is also an ongoing process beyond the goal. As the case in Kenya highlights, establishing the national transgender guidelines was just the first step. Now, their implementation has to be monitored and the government and service providers need to be continuously held to account.

2. Ensuring that UHC advocacy towards this goal addresses the exclusion of the community, as well as shifting power and ownership TO the community.

Movement building and mobilisation are critical approaches to transforming power imbalances. ‘Movement building and other empowerment approaches explicitly seek to engage and support primary beneficiaries in defining and driving the change that they themselves wish to see’¹⁵. Movement building does not need to be an indirect outcome but can also be a goal of successful UHC advocacy. However, governments and decision makers must be held to account to ensure that individuals are safe to participate in movements and coalitions without fear of persecution or violence.

Principle 3: Intersectional approach. Advocacy work needs to ensure that no one is left behind or further marginalised.

Principle 5: Wellness and wellbeing for staff and rightsholders. There is growing awareness of the importance of integrating wellness and wellbeing into all work including advocacy work. Wellness and wellbeing should be included in the advocacy budgets.

¹⁵ JASS (2013) Feminist Movement Building Dictionary Second Edition. JASS

3. Challenging norms, attitudes and values that underpin gender discrimination.

It is important to assess the impact that gender norms have on access to UHC for women and girls in all their diversity and people with diverse SOGIESC most affected by HIV. To develop UHC advocacy that transforms harmful gender norms,

and is HIV-responsive, we need to know and understand those norms and how they play out in individuals' lives. What is the impact of these gender norms on individuals' access to UHC? Which norms need to be challenged to transform UHC and ensure that it works for women and girls in all their diversity and people with diverse SOGIESC most affected by HIV. See figure below.¹⁶



¹⁶ Example adapted from Criminalising Condoms: How Policing Practices put sex workers and HIV services at risk in Kenya, Namibia, Russia, South Africa, the United States and Zimbabwe. Open Society Foundations (2013)

4. Embedding a theory of change. How and why will this process result in change for community-led organisations and the community more broadly?

As mentioned above, qualitative diagnosis of harmful gender norms is crucial for designing successful gender transformative programmes and advocacy. One of the challenges in working on transforming harmful gender norms is how to measure change. Approaches for measuring social norms do not need to be too complex¹⁷, however, it is important to consider how and when to do this in the planning and development of UHC advocacy work. Articulating a theory of change at the outset of the work can help identify incremental progress markers, which can be seen as pre-conditions for reaching outcomes at different levels. It can also help unpack the assumptions behind our beliefs about how change happens.

Principle 10: Learning and reflection.

In order to transform norms, attitudes and values we need to learn and reflect throughout our work and create space for adaptation, flexibility and innovation based on shifting needs and issues of community members affected by the advocacy issue.

¹⁷ See the following: https://www.researchgate.net/publication/323075181_Measuring_social_norms_A_learning_report

5. Recommendations

This section focuses on how to strengthen a gender transformative approach in UHC advocacy for HIV activists and advocates within the five dimensions of gendered power. It is important to

note that these recommendations reinforce each other so organisations should explore how they can work in all the dimensions, either as individual organisations or in collaboration.

Dimension One: Critical reflection on gender power within the organisation

- **Creating a learning and reflexive culture:** Create opportunities for knowledge and learning within safe spaces. Be open to learning from adolescent girls and young women and key populations about how to improve the work of organisations. This will transform the power relations between the community and organisations.
- Ensure the organisation has the **capacity, knowledge and networks** to gather and analyse data on social and gender norms.
- **Build alliances and networks** with key partners including those working on women's rights and with adolescent girls and young women; and LGB+, trans* and sex worker-led organisations to ensure that these organisations are central to the UHC advocacy process and campaigns.
- Organisations working with sex workers, LGB+ or trans* communities, or with adolescent girls and young women can explore how to **partner** with other like-minded and supportive organisations.
- Strengthen the intersectional approach by using a **power analysis** to analyse the context as well as the programme. Is inclusive gender language being used? Are certain ethnic minority groups excluded? Are key populations living with disabilities included in the UHC advocacy?

Dimension Two: Address discriminatory attitudes and practices

- Use **participatory learning approaches and methodologies** to explore and establish safe spaces for HIV-affected communities.
- **Ensure a gender transformative and rights-based approach in working with communities** to ensure the programmes advance the leadership and ownership of excluded and marginalised communities through democratic and transparent approaches.
- **Empower and support affected communities to collect qualitative data** about gender norms, attitudes and values through asking questions and analysing the answers across different HIV-affected communities.
- **Strengthen the economic empowerment and financial inclusion components** of the programmes to ensure that women and girls in all their diversity and people with diverse SOGIESC most affected by HIV can affirm their socio-economic rights.
- **Create linkages with other issues** as women, girls and other marginalised populations are further disenfranchised and disempowered by climate change, conflict, states of fragility, weak and autocratic governments, and pandemics such as COVID-19. Strengthen the knowledge and capacity of marginalised populations to participate in platforms that explore linkages to broader human rights and the link to UHC. This is also a key strategy for networking and alliance building.
- **Raise awareness on gender-based violence** including provision of resources with information about medical, psychosocial and legal services available.

Dimension three: Remove gender barriers to services

- **Strengthen the capacity of young women in their diversity - especially those living with HIV - and people with diverse SOGIESC most affected by HIV** to be able to train, sensitise and dialogue with the police and key healthcare service providers to advance UHC. If communities marginalised on the basis of gender are able to lead and own this work, then it will be transformative in terms of breaking down barriers and challenging norms and attitudes of service providers.
- **Build evidence** to make the case about the barriers and challenges that women and girls in their diversity, and people with diverse SOGIESC most affected by HIV face in accessing services and what this means for UHC.
- **Support service providers to set up mechanisms to monitor and evaluate** the services they are providing to ensure accountable and transparent service provision.
- **Document rights violations based on gender identity and expression** experienced by women and girls in their diversity, and people with diverse SOGIESC most affected by HIV to map trends or to use for lobbying – documentation can also include media monitoring.
- **Develop gender-based violence referral systems:** map key services for survivors of gender-based violence. Establish strong referral networks and systems with paralegal or legal aid services as well as medical and psycho-social care services. Ensure comprehensive and holistic responses to gender based violence - including access to justice - as part of transforming gender norms.

Dimension four: Transform social and gender norms in communities and societies

- **Identify the influencers and gatekeepers in the context** – who are holders of power and the individuals or groups reinforcing the harmful gender norms? This will probably include work on toxic masculinities to promote positive masculinities and work with media, faith leaders and traditional leaders – but the most important question is ‘who holds power’? What do these power dynamics mean for the realisation of UHC for all people most affected by HIV?
- **Develop networks** to work across all levels of society: individual, household, community, institutions (such as religious institutions) and state. It is not possible for organisations to work everywhere so develop strategic networks that seek to transform norms at all levels.
- **Engage for the long-term** because transforming harmful gender norms takes a long time, but is the most sustainable and effective approach to ensure change.
- **Conduct media campaigns** to challenge harmful gender norms that perpetuate gender inequality, violence and discrimination.

Dimension five: Advocate to change and reform laws, policies and resource allocations to achieve gender equality

- **Support adolescent girls and young women- and key population-led advocacy** for law reform. This is critical to gender transformative UHC advocacy because it can be transformative in itself for marginalised or discriminated populations to take ownership and leadership of issues that directly affect them.
- **Be prepared:** know the laws and policy frameworks and work in collaboration with technical experts to develop clear proposals and changes.
- **Lobby for communities to be involved in the whole process** rather than just lobbying for the change so as to transform attitudes during the process by engaging with key strategic government officials, ministries and decision makers.

Feminist principles to guide gender transformative UHC advocacy¹⁸

- 1. Know where the power lies:** a power analysis should interrogate the power dynamics at all levels but should also include analysis of your organisation and community to ensure that key populations are not further marginalised by the advocacy work.
- 2. Shift the power:** for example, REPSSI in Mozambique is creating space for the participation of government representatives and civil society organisation to discuss the challenges on accessing health services.
- 3. Intersectional approach:** the advocacy work needs to ensure that no one is left behind or further marginalised. For example, Associação LAMBDA in Mozambique recognised how neglected trans* women have been among key populations so the organisation worked in coalition to get a commitment from government for the inclusion of trans* women in the next five year national HIV strategy.
- 4. Safety and security:** The safety and security of all community members involved in the advocacy work is of the utmost importance. Staff should receive safety and security training and support to implement policies. It is very important that donors allocate resources for this.
- 5. Wellness and wellbeing for staff and rightsholders:** There is growing awareness of the importance of integrating wellness and wellbeing into all work including advocacy work. Wellness and wellbeing lines should be included in the advocacy budgets
- 6. Mobilising for collective action:** A key strategy for effective gender transformative UHC advocacy ensures that the individuals and communities affected by the issues take leadership of the work. For example, in Uganda, Reproductive Health Uganda is 'building a critical mass of civil society members to start engaging with the UHC process'.
- 7. Transparency:** It is important that all processes during the advocacy work are transparent and that community members are given equal opportunities to participate and lead at different stages so that we do not reaffirm the exclusion experienced by many women, girls and gender-diverse individuals.
- 8. Human-rights based approach:** A human-rights based approach is particularly important in transforming norms because it recognises different needs, but ensures that all community members are treated equally, with dignity and affirmed for who they are in all their diversities. For example, in Mozambique, Associação Comunitaria Ambiente da Mafalala highlighted how its advocacy 'helped to make it clear that the needs of women who use drugs for harm reduction are different from men who use drugs'.
- 9. Accountability:** The organisations leading the advocacy work must be accountable to community members and create mechanisms for feedback, consultation and participation.
- 10. Learning and reflection:** To transform norms, attitudes and values, we need to learn and reflect throughout our work and create space for adaptation, flexibility and innovation based on the shifting needs and issues of community members affected by the advocacy issue.

¹⁸ Please see the following for more inspiration: <https://www.justassociates.org/sites/justassociates.org/files/feminist-movement-builders-dictionary-jass.pdf> and <https://youngfeministfund.org/wp-content/uploads/2017/05/Global-State-of-Young-Feminist-Organizing.pdf> and <https://civilsocietyfutures.org/four-lessons-african-feminist-organising/>

Acknowledgements:

We would like to acknowledge the contributions from all PITCH partner organisations that completed the survey on gender transformation and UHC advocacy. Special thanks to Toyin Chukwudozie, Advocacy Officer, and Buky Williams, Executive Director at Education as Vaccine (EVA) Nigeria; Baby Rivona, National Coordinator of Indonesia Positive Women's Network (IPPI); Dayo Atieno, Advocacy Officer, Trans* Alliance Kenya; and Nataliia Isaieva, Executive Director, LEGALIFE-UKRAINE for providing the inspiring material for the case studies.

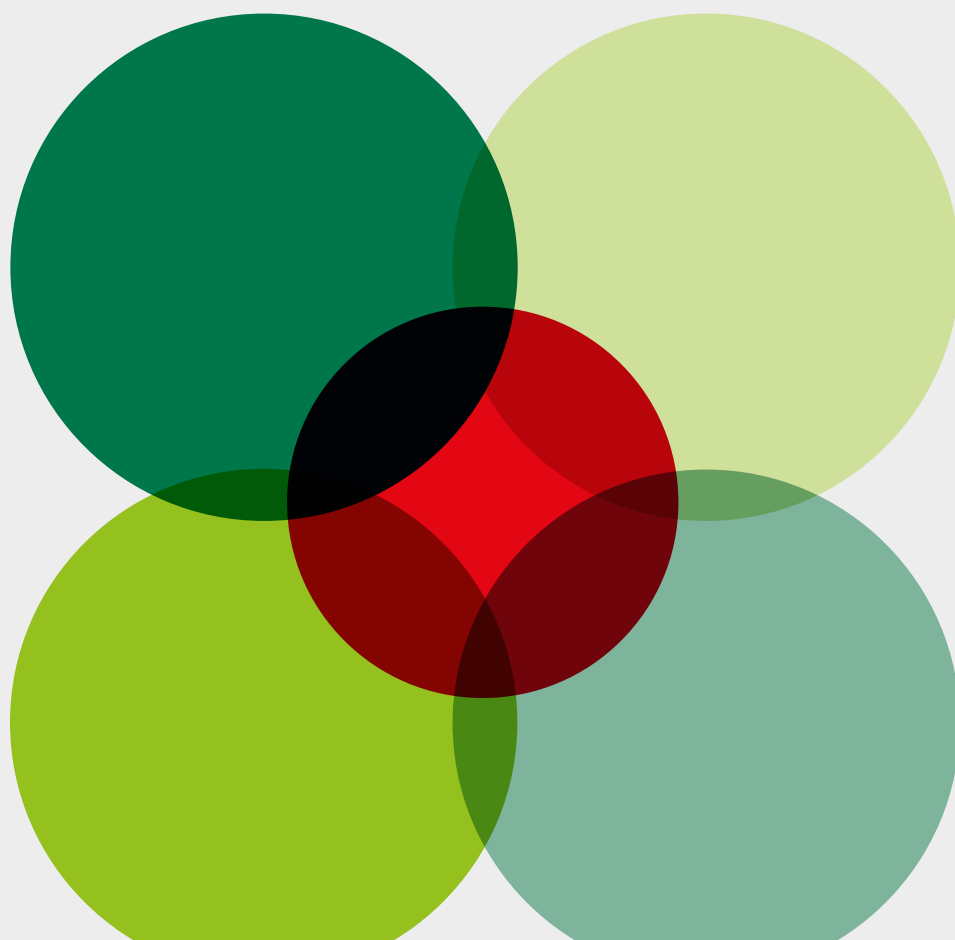
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Editor: Ann Noon

Design: Mariska Proost, Ziezo

December 2020





PITCH Partnership to Inspire, Transform
and Connect the HIV response

