Addressing gender issues in HIV programmes

Qualitative analysis of access to and experience of HIV services in Jordan and Yemen

World Health Organization

Regional Office for the Eastern Mediterranean

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WHO Library Cataloguing in Publication Data

World Health Organization. Regional Office for the Eastern Mediterranean

Addressing gender issues in HIV programmes: qualitative analysis of access to and experience of HIV services in Jordan and Yemen / World Health Organization. Regional Office for the Eastern Mediterranean

p.

ISBN: 978-92-9021-846-3

ISBN: 978-92-9021-845-6 (online)

1. HIV Infections - Jordan - Yemen 2. Acquired Immunodeficiency Syndrome 3. Gender Identity 4. National Health Programs 5. Sexually Transmitted Diseases I. Title II. Regional Office for the Eastern Mediterranean

(NLM Classification: WC 503.7)

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Design and layout by WHO Regional Office for the Eastern Mediterranean, Cairo
Printed by Al Marwa Press, Cairo

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Acknowledgements

This publication is the product of contributions by many individuals. The publication was written by Joanna Vogel, Regional Adviser, Gender in Health and Development, WHO Regional Office for the Eastern Mediterranean and Maria Anguera de Sojo, Consultant, Gender in Health and Development, in close collaboration with the Programme of AIDS and Sexually Transmitted Diseases, WHO Regional Office for the Eastern Mediterranean.

The publication was reviewed by Sana Naffa, WHO country office, Jordan, Nasreen Sayani Abdul-Hussain, Moses Mutebi and Mona Al-Mudhwahi, WHO country office, Yemen, Gabriele Riedner, Regional Adviser, AIDS and Sexually Transmitted Diseases, WHO Regional Office for the Eastern Mediterranean and Joumana Hermez, Technical Officer, AIDS and Sexually Transmitted Diseases, WHO Regional Office for the Eastern Mediterranean.

This assessment would not have been possible without the generosity of all the respondents: people living with HIV, doctors, nongovernmental organizations, people affected by HIV, sex workers, students, National AIDS Programme managers, spouses of injecting drug users, outreach workers, drug addicts, staff members of the Joint United Nations Programme on HIV/AIDS (UNAIDS) and the United Nations Entity for Gender Equality and the Empowerment of Women (UNWOMEN), formerly the United Nations Development Fund for Women (UNIFEM), men that have sex with men, battered women, HIV volunteers, lawyers and gatekeepers. Very special gratitude goes to those who had to overcome fear of stigma, losing anonymity, shame or consequences to participate in the interviews.

Without the translators it would not have been possible to communicate with a great many of the respondents. In this regard Nedhal Ali and Rula Jeldah in Jordan, Hani Abdlo, Alawi Bahmed and Ibrahim Nasher in Yemen, as well as others, provided valuable support.

National AIDS Programmes facilitated the contact into the countries, in particular, Assad Rahhal and Bassam Qasem Hijjawi in Jordan and Abdul Hamid Nagi Al Suhaiby and Areej Taher in Yemen.

Staff of UNAIDS, especially Wessam Elbeih and Hamidreza Setayesh in Egypt and Fouzia Gharamah in Yemen provided insights, contacts and ideas.

WHO gratefully acknowledges the financial contribution of Gesellschaft für international Zusammenarbeit (GIZ) to the gender analysis of women's access to and quality of experience of HIV/AIDS programmes and services, Jordan and Yemen, as well as to publication of the report.

Executive summary

A gender analysis of women's access to and quality of experience of HIV/AIDS programmes and services was conducted in Jordan and Yemen to identify gender issues that may increase women's vulnerability to acquire HIV, and/or have an impact on their access to and quality of experience of HIV/AIDS programmes and services. This information can be used to inform the gender components of proposals to the Global Fund to Fight AIDS, Tuberculosis and Malaria for those countries as well as others in the WHO Eastern Mediterranean Region with similar social dimensions. Interviews were conducted with beneficiaries of HIV services and programmes as well as HIV service providers. Snowballing proved an effective approach to identify beneficiaries, especially those most at risk, for interviews. Government and nongovernmental organizations working in fields related to HIV, men and women living with HIV, survivors of gender-based violence, male and female sex workers, men who have sex with men, male and female drug users, as well as male and female youths were included among the respondents interviewed. Transcripts were grouped into thematic areas pertaining to gender-related vulnerability to HIV infection and barriers in access to and quality of experience of HIV/AIDS programmes and services.

The gender analysis yielded the following thematic areas. The gender roles of marriage and motherhood for women in society and gender norms of virginity as a precondition for marriage in women were found to have a strong influence on the behaviour of both women and men in Jordan and Yemen, some of which had a negative impact on their access to information on HIV and their capacity to protect themselves against HIV. The reputation of virginity was closely guarded by women and respondents mentioned that visits to an obstetrician/gynaecologist before marriage can imply that the woman is sexually active, making women reluctant to consult them. In addition, many of the female respondents in Jordan and Yemen expressed a lack of trust in doctors with respect to breaching confidentiality, especially with regard to the status of their virginity. Unmarried women may be underutilizing health services as a result and not accessing the information and services they need to properly protect themselves against HIV.

Respondents often implied that when a woman speaks about sexuality, or sex-related issues such as HIV, she may be presumed to be sexually active and this would damage her reputation. This barrier to discussion is an impediment in spreading awareness about HIV among women and as a result women may be less knowledgeable about HIV and how to protect themselves against it. Awareness of oral and anal sex as methods of transmission of HIV and sexually transmitted diseases by female youth was cited as low, and corresponding condom use was also cited as low. Alternative unprotected sexual practices to preserve virginity may increase vulnerability to infection in female youth.

Respondents across both countries stated that female survivors of sexual violence rarely, if ever, disclosed incidents of rape, including disclosure to health providers. HIV has been shown to be transmitted with greater frequency in cases of sexual violence. There is a substantial risk that survivors of sexual violence are not accessing needed HIV prophylaxis or coming forward for testing. Many of the respondents mentioned the existence of domestic violence. Women who are survivors of domestic violence may be at increased vulnerability to infection and lack of awareness about HIV due to greater mobility restrictions and weaker negotiating power.

Wives of clients of sex workers and of men who have sex with men were found to be vulnerable in terms of lack of awareness of HIV and ability to protect themselves. It was noted by several

respondents that clients of sex workers vary in their condom use and that sex workers have limited negotiating power with their clients for use of condoms. Wives of men who have sex with men and/or wives of clients of sex workers may be a group that requires greater targeting by HIV-awareness campaigns.

Young newly recruited female sex workers may be underexposed to HIV campaigns and have less awareness of HIV than older, more experienced, sex workers. Several respondents noted that young female sex workers' access to information was deliberately prevented by their pimps or co-workers so that they would not be scared off from their work.

Female drug users, not necessarily injecting drug users, stood out as a vulnerable group. Transactional sex for drugs and incidents of sexual violence were cited as common among female drug users and respondents indicated little or no condom use, increasing their vulnerability to acquire HIV.

The stigma that people living with HIV/AIDS face is connected to the same gender norms outlined above and respondents expressed that they had transgressed social norms to contract the virus. The assumption expressed was that men living with HIV have sex with men and that women living with HIV are sex workers. However, this association of transmission was not expressed by all respondents. In Yemen, a few respondents had a slightly more lenient image of people living with HIV.

In some cases, norms formed protection for women, as cited by respondents in Yemen who said that women had greater anonymity going to voluntary counselling and testing as they were not recognizable because of their abaya and face veil. People living with HIV, especially women, expressed distrust about seeing doctors for fear of being turned away for treatment if their HIV status was known. There did not appear to be a difference between males and females living with HIV in this regard, except that finding reproductive health care presented a specific additional challenge for women.

Some inconsistency was noted about classification or criteria for the designation of "men who have sex with men". Several respondents, among them nongovernmental organizations providing services to people living with HIV, classified men who have sex with men as those who perform the "female" or receiving role in sexual encounters or classified them only as male sex workers. Married men who have sex with men, or men who perform the so-called "male" role in sexual encounters, did not appear to be classified as men who have sex with men by respondents in Yemen. Differences in classification may lead to underrepresentation of all men who have sex with men in HIV-related bio-behavioural surveillance.

Positive practices and experiences with HIV services and programmes were also noted among respondents. For example, the National AIDS Programme and voluntary counselling and testing were praised by respondents in Yemen and programmes targeting sex workers were cited as increasing awareness and protective measures among male and female sex workers. Positive feedback was also noted regarding a hotline for survivors of gender-based violence in Jordan.

Introduction

Vulnerability to, and the repercussions from, HIV differ for men and women due to a complex combination of physical and gender issues. Gender refers to the societal beliefs, norms, customs and practices that define what is considered acceptable behaviour for women and men in different settings. For example, gendered norms may compel men to appear all-knowing and experienced in sexual matters and therefore they may not seek out health information and services. Conversely, female social norms may prohibit women from asking questions about sex and contraception for fear they will be labelled promiscuous. These barriers are even greater for female adolescents specifically and young people in general.

The vulnerability of women and girls to HIV infection and the impact of the illness on them are exacerbated in contexts where they are afforded lower status and have restricted access to, and control over, resources. For example, women may be constrained in their ability to practice safe sex, both because of limited decision-making power and because of limited access to information on HIV/AIDS due to social norms that equate that knowledge with sexual experience. Not enough information is known about the repercussions for women living with HIV and their access to, and experience with, HIV/AIDS services, especially in the WHO Eastern Mediterranean Region. This information is essential to enable HIV/AIDS policy-makers, programme managers and health-care providers to address gender inequalities adequately in the design and delivery of age- and gender-friendly programmes and services.

Literature reviews have provided some direction in identifying potential gender and HIV issues of relevance in the Region. Issues of concern are: lack of awareness among women and girls about HIV; inability to negotiate condom use; gender-based violence; early marriage; and vulnerability of female commercial sex workers and female injecting drug users, areas reflective of gender inequality and lack of human rights.

Age-sex distributions of HIV in the Region indicate that women are infected at a younger age than men. (*1*) Biologically, the risk of vaginal and anal tearing is higher in not yet fully developed bodies and early marriage practices in some countries of the Region can mean early initiation into sexual activity for girls with husbands who are likely to have had previous sexual experience and therefore possible infection with HIV. (*2*) A total of 20.2% of female squatter residents interviewed in Egypt mentioned that they knew their husbands were practising sex before marriage, and 15.5% mentioned their husbands still had extramarital sex. None of the men in the same study who reported premarital sex had ever used a condom. (*3*) Younger women tend to be less exposed to information on HIV and would face difficulty in negotiating condom use.

There has been an increase in female HIV infections in the Region from transmission by male injecting drug users and/or clients of commercial sex workers to wives and girlfriends. (*4*) At a private clinic in Tehran, Islamic Republic of Iran, it was found that women's main vulnerability to contracting HIV was sexual intercourse with their HIV-positive husbands. (*4*) In Morocco, a study found that one third of HIV-positive women were married. (*4*) Lack of decision-making power for women in negotiating safe sex with HIV-infected husbands or partners and lack of awareness about HIV is an area of concern.

Lack of awareness about HIV is more common among women in the Region than among men. A study in Afghanistan found that only 23.3% of participants had ever heard of HIV/AIDS and that the most significant factor in whether or not participants had heard of HIV was if they were male, followed by urban residence,

travel outside Afghanistan, previous diagnosis with hepatitis, marijuana use, or previous incarceration. (5) This could be in part because male high-risk groups are most frequently targeted with HIV-prevention messages. In Iraq, among a sample of 23 000 women, only 49.9% had heard about HIV/AIDS and most held misconceptions, for instance that HIV could be transmitted via mosquitoes but not via breast milk. (6) Among this same sample, married women were 18% less likely to have adequate HIV knowledge. Similarly, 90% of survey respondents in Saudi Arabia had never discussed HIV/AIDS with their families, a similar number had never discussed it with health staff, and more than 80% had rarely, or never, discussed HIV/AIDS with friends. (7)

Lack of education also contributes to lower levels of knowledge regarding HIV and lower literacy levels diminish the ability to access and understand health information. Women in Iraq who have a formal education are 51% more likely to possess adequate HIV knowledge compared with those who have had no formal education. (6) A correlation between education level and HIV knowledge was found in Egypt, with more than half of illiterate respondents possessing "poor HIV knowledge" compared with only 10% of those with a university education. (3)

Female commercial sex workers represent a vulnerable group to HIV in the Region and some research indicates increasing numbers of women injecting drugs. Often the two practices intersect. One in 10 Syrian commercial sex workers reported injecting drugs. (4) A study in Morocco found that many of the female drug users interviewed married very young and their husband either used drugs or was a drug dealer and that is how they began using (Burns K, unpublished, 2007). The Joint United Nations Programme on HIV/AIDS (UNAIDS) reports that between 2% and 3% of commercial sex workers in Morocco are HIV positive and that 70% of female injecting drug users sampled reported multiple sexual partners, but with only 1 in 5 consistently using condoms.

Gender-based violence is an additional vulnerability to HIV because of vaginal injuries and inability to negotiate condom use. (*8*,*9*) Increased HIV incidence has been found in women who report more than one episode of physical or sexual violence. (*10*) Globally, prevalence of physical or sexual violence has been found to range between 15% and 71%. (*11*) In Jordan, 31.2% of a sample of married women reported experiencing physical violence and 18.8% reported sexual violence. (*12*) Another study in Jordan showed prevalence among sampled pregnant women of 10.4% experiencing physical spousal abuse and 5.7% experiencing sexual violence. (*13*) Data are lacking on prevalence of physical and sexual violence in Yemen.

More information is needed in the Region on:

- behaviour patterns in seeking voluntary counselling and testing for HIV among different female population groups;
- the intersect of violence against women and HIV;
- the experience of HIV-positive women in receiving treatment;
- barriers and the impact of disclosure to partners by HIV-positive women;
- repercussions and life quality impacts of HIV-positive status among women.

This information is necessary in order to ensure that HIV health information and HIV services, including prevention, harm reduction, testing and treatment are being tailored to women's needs and realities as well as to men's. This report details a gender analysis of access to and quality of experience of HIV/AIDS programmes and services in Jordan and Yemen in order to inform the gender components of proposals to the Global Fund to Fight AIDS, Tuberculosis

and Malaria and enhance gender-responsive HIV prevention and treatment programming.

Objectives

The long-term objective was the enhancement of HIV prevention and service programmes to meet the differential needs, vulnerabilities and contexts of women and girls in Jordan and Yemen.

The short-term objective was to identify areas in which gender norms may contribute to vulnerability to acquire HIV and have a negative impact on access to and quality of experience of HIV/AIDS programmes and services in Jordan and Yemen for inclusion in Global Fund proposals.

Methodology

Tool development

A literature review was conducted to identify potential gender issues that may contribute to women's and girls' vulnerability to acquire HIV and negatively impact their access to and quality of experience of HIV/AIDS programmes and services in the Region. Further, consultations were held with staff from the WHO Regional Office for the Eastern Mediterranean programme of AIDS and Sexually Transmitted Diseases and staff from UNAIDS to establish regional overviews on HIV. This information was collated and used to develop a semi-structured interview guide to be used with informants. Three distinct groups of respondents were identified:

- beneficiaries (including people living with HIV and populations at risk);
- service providers (including nongovernmental organizations);
- HIV-related government and United Nations agencies.

Questionnaires were tailored for each of the three groups, proposing questions around similar themes but taking into consideration the different experiences of each group. The themes identified as relevant, based on the background reviews, were:

- levels of HIV awareness;
- exposure and experience with HIV services and programmes;
- exploration of cultural norms that could impact access to services and information.

The semi-structured questionnaires were kept flexible to enable adding or omitting questions relevant to certain groups, such as sex workers. The semi-structured interview guides were circulated throughout their development for input from the WHO regional and country office HIV staff, regional and country office UNAIDS staff, and National AIDS Programme representatives in Jordan and Yemen.

While the questionnaires were being developed, key informants or respondents for the interviews were identified in Jordan and Yemen through nongovernmental organizations and consultations with regional and country office staff from WHO and UNAIDS as well as snowballing from respondents once the consultant was on location.

In-country data collection

Jordan

A total of 25 respondents were interviewed in Jordan. Snowballing enabled interviews with harder-to-reach population groups, such as sex workers and wives of injecting drug users. The HIV Country Coordinating Mechanism representative was instrumental in facilitating interviews with people living with HIV as well as introducing a gatekeeper to the sex worker communities. All respondents were briefed on the assessment objectives and informed of their rights to not answer questions or halt the interviews at any time. All respondents indicated their understanding of the assessment and their rights, and signed informed consents.

The interviews differed in formality, depending on the respondents. Interviews were less structured with beneficiaries than they were with governmental and United Nations agencies. Translation was used with interviews with nongovernmental organizations and many of the beneficiary respondents.

Comprehensive notes were taken during the interviews and transcribed in full within 24 hours.

Yemen

A total of 26 interviews took place in Yemen, some of them with multiple respondents. Interviews were held in Aden and Sana'a. The interviews in Yemen were primarily with beneficiaries and nongovernmental organizations. Translation was used mainly with beneficiaries and less with nongovernmental organizations. All respondents were briefed on the assessment objectives and informed of their rights to not answer questions or halt the interviews at any time. All respondents indicated their understanding of the assessment and their rights, and signed informed consents.

The respondents seemed comfortable with most of the questions, although some required additional explanation if they were culturally incongruous; for example "rape within marriage". Issues with terminology were encountered regarding men who have sex with men. In Yemen, "men who have sex with men" appeared to refer to male sex workers specifically, and not to men who have sex with men in general. For example, married men who have sex with men were often not classified as "men who have sex with men" in Yemen.

The men who have sex with men and the sex workers interviewed requested monetary compensation for their time. A fee coherent with the fees provided by the National AIDS Programme was given to these respondents. As some of the respondents expressed discomfort with the tape recorder, its use was inconsistent throughout the mission.

Comprehensive notes were taken during the interviews and then transcribed in full within 24 hours.

Data analysis

The transcript contents were first coded into categories pertaining to the assessment objectives; for example stigma, awareness and health-care access. Following coding, the views expressed in the categories were analysed and grouped into recurring themes. The analysts grouped the categories independently and then compared, discussed and adjusted any inconsistencies or different interpretations. For the most part, there were few inconsistencies and no major differences in interpretation among the authors. Recurring themes were identified in relation to women's vulnerability to acquire HIV, and their access to and quality of experience of HIV/AIDS programmes and services. Whenever possible, the identified themes were matched to relevance with different groups of women, such as unmarried women, female drug users and sex workers. The themes identified included: awareness of HIV; impact of gender norms and roles in marriage for women; gender-based violence; issues specific to sex workers; and risky behaviours and/or vulnerable groups. Finally, each of the subgroups was studied to identify how, and specifically which, gender norms influenced women's and institutional behaviour with regards to quality access to and exposure to HIV services and information or to their vulnerability.

Limitations

As a qualitative assessment of the intersections of gender and HIV, the findings are not statistically representative of the population groups questioned; however, they do serve to highlight perspectives from beneficiaries of

HIV programmes and to flag issues for HIV programme consideration and future research.

New issues surfaced over the course of the interviews that would have been useful to go back and discuss with prior respondents for triangulation but this was not possible due to time constraints.

Additional numbers and diversity of respondents, especially the beneficiaries, would have strengthened the emerging issues analysed from the data collected. Populations notably absent from this report include military men, street children, adolescents/young women and men (13–23 years), rural women, especially in Yemen, and wives of fishermen, specifically in Yemen.

The language barrier presented some limitations in communication; however, it also had an unexpected advantage. Several respondents expressed trust and ease in communication with the consultant because she was a foreigner and therefore was operating under different cultural norms, which were perceived as less stigmatizing.

The respondents' conceptions of the term "men who have sex with men" were not assessed during the interviews and different conceptions may have influenced the breadth of information for the men who have sex with men targeted questions.

Findings

Several issues were identified in Jordan and Yemen that increase women's vulnerability to acquire HIV and negatively impact their access to and quality of experience of HIV/AIDS programmes and services. Women's vulnerability to HIV infection and their access to and quality of experience of HIV/AIDS programmes and services can be negatively impacted in contexts where gender norms strongly regulate behaviours, determine social status and restrict access to resources.

In Jordan and Yemen, respondents indicated gender roles in marriage and motherhood as the main functions of women in society and gender norms of virginity as a precondition for marriage in women. The status of the family is closely linked to the woman's adherence to these gender norms. If they are transgressed, repercussions include social exclusion and, in extreme cases, death through honour killings. These norms have a strong influence on the behaviour of both women and men, some of which negatively impact their access to information on HIV and capacity to protect themselves against HIV.

> *She will never be able to marry [if she is not a virgin]. "She can get killed by her family.*
>
> (Woman living with HIV/AIDS, Jordan)

> *If one member of the family has something wrong, like HIV or men who have sex with men, or if she sleeps around or is seen with men, it will affect the entire family; her sister will not be able to marry because we check up the entire family.*
>
> (Young male, Yemen)

Protection of reputation of virgin status in unmarried women may reduce access to health-care services and exposure to information about HIV

The reputation of virginity is closely guarded by women and respondents mentioned that visits to an obstetrician/gynaecologist before marriage can imply the woman is sexually active, making women reluctant to consult them. In addition, many of the female respondents in Jordan and Yemen expressed lack of trust in doctors with respect to breaching confidentiality, especially with regard to the status of their virginity. While some nongovernmental organizations in Jordan and Yemen mention that doctors are not supposed to disclose the status of virginity and/or pregnancy of female patients,

they are uncertain whether doctors observe this confidentiality requirement. Unmarried women may be underutilizing health services as a result and not accessing the information and services they need to properly protect themselves against HIV.

Do unmarried women go to the obstetrician/gynaecologist?

> *In a few cases, and only if there are serious problems like excessive bleeding. And she will not tell anyone that she went to the obstetrician/gynaecologist. She would go to a far-away doctor and give a fake name.*
>
> (Future Guardians, Jordan)

Social barriers to discussion about sexuality and HIV may reduce awareness about HIV in women

Respondents often implied that when a woman speaks about sexuality or sexually related issues such as HIV, then she may be presumed to be sexually active and this would damage her reputation. Even in marriage, female respondents were reluctant to discuss issues pertaining to sexuality. Respondents also indicated fear of incurring social labelling of being at risk for, or infected with, HIV/AIDS if they publicly sought out HIV/AIDS information. This barrier to discussion and seeking information on HIV is an impediment in spreading awareness among women on HIV and as a result women may be less knowledgeable about HIV and less capable of protecting themselves against it.

> *There is ignorance about these things in the community because women are not to talk about sex things.*
>
> (Nongovernmental organization, Khawla Bint Al Azaw, Jordan)

> *Women in general do not speak about sex.*
>
> (Commercial sex worker, Al-Islah, Yemen)

Alternative unprotected sexual practices may increase vulnerability to infection in female youths

Several respondents mentioned that young females and unmarried women engage in oral and anal sex as a way of preserving their virginity and thereby retaining their social value and options for marriage. Awareness of oral and anal sex as methods of transmission of HIV and sexually transmitted diseases by females and youths was cited as low, and corresponding condom use was also cited as low. When questioned about if and how youths are engaging in premarital sex:

> *Yes it happens. Anal and oral sex. We can only address it in indirect ways since those who do it, do it in hiding.*
>
> (Commercial sex worker, Al-Islah, Yemen)

Women who are survivors of sexual violence are untreated/underdiagnosed for sexually transmitted diseases and HIV

Respondents in both countries stated that female survivors of sexual violence rarely, if ever, disclose incidents of rape, including disclosure to health providers. Many of the respondents expressed the existence of sexual violence in their communities and especially among sex workers. Shame of damaging the reputation of the family as well as fear for their safety prevents women from coming forward in cases of sexual violence. HIV has been shown to be transmitted with greater frequency in cases of sexual violence. There is substantial risk that survivors of sexual violence are not accessing required HIV prophylaxis or coming forward for testing.

> *Sex workers get raped too, but because their work is illegal they cannot go to the police or any services.*
>
> (Bushra Centre for Studies and Research, Jordan)

Women who are survivors of domestic violence may be at increased vulnerability to infection and lack of awareness about HIV

Many of the respondents mentioned the existence of domestic violence. Women who are subject to violence from their husbands may face greater mobility restrictions and may therefore be less able to access information on HIV. They are also in a weaker position to negotiate safe sex and may be more exposed to violent sexual intercourse, which increases their vulnerability to contracting HIV. Institutional options for women to protect themselves against violence were cited by respondents as weak in the two countries. The weak institutional capacities are further compounded by women's reluctance to disclose violence for fear of transgressing the social norms around family honour.

> *When you are at the police complaining about your husband, that makes you a bad woman and the police themselves will not like you very much because you have no respect for your husband.*
>
> (Three female survivors of gender-based violence, Jordan)

Wives of clients of sex workers and of men who have sex with men are vulnerable in terms of lack of awareness of HIV and ability to protect themselves

Wives of clients of sex workers and of men who have sex with men are vulnerable in terms of lack of awareness of HIV and ability to protect themselves. Several respondents mentioned cases where women were not aware their husbands had sex with men. In addition, husbands are unlikely to disclose to their wives that they are using sex worker services. It was noted by several respondents that clients of sex workers vary in their condom use and that sex workers have limited negotiating power with their clients over use of condoms. Respondents in Yemen, particularly in Aden, reported better negotiating power by sex workers over condom use. Several respondents indicated married men as common clients of both female and male sex workers. Women may not have the power to negotiate condom use with their partners and it is important that risk reduction counselling includes provision of skills for women in negotiating safer sex. Wives of men who have sex with men and/or wives of clients of sex workers may be a group that needs greater concentration with targeted HIV-awareness campaigns.

Does information on HIV reach wives of men who have sex with men?

> *Women never know that their husbands have sex with men. They hide this because they would be afraid of scaring their wives.*
>
> (Man who has sex with men, Yemen)

Who are your main clients?

> *Mostly married men. They want to try something new, experience something different. They might be bored of their wives.*
>
> (Female sex worker, Yemen)

Young newly recruited female sex workers may be underserved by HIV campaigns and have lack of awareness about HIV

Young female sex workers stood out in the analysis as a vulnerable group whose access to information on HIV and sexually transmitted diseases appeared deliberately limited. Several respondents noted that young female sex workers' access to information on HIV was prevented by their pimps or co-workers so that they would not become scared of contracting HIV and stop working as a result.

Do young girls (sex workers) know about HIV?

> *No, young girls don't know normally.*
>
> (Female sex worker, Yemen)

Female drug users may be at increased risk of HIV through unprotected transactional sex and exposure to sexual violence

Female drug users stood out as a vulnerable group. Respondents indicated very strong stigma against female drug users that render them largely invisible in society for fear of being discovered by their families or communities. This stigma implies underutilization of health services and less than optimal exposure to HIV outreach and awareness campaigns. The use of injecting drugs increases vulnerability to HIV via contaminated needles and the use of drugs without injection can facilitate risky sexual behaviours, including contractual sex and exposure to sexual violence. Transactional sex for drugs and sexual violence were cited as common among female drug users, and respondents indicated little or no condom use, meaning increased vulnerability to acquire HIV.

> *Families hide women that are using drugs, they don't help them recover but rather make them disappear. They will try to help a son get recovery but not women. A woman, even if she recovers, will not marry or will be divorced. The family will not accept her.*
>
> (Future Guardians, Jordan).

Sufficient and quality access to reproductive health-care services for women living with HIV presents a challenge

The stigma that people living with HIV face is connected to the same gender norms outlined above and it is assumed they have transgressed social norms to contract the virus. The assumption expressed is that men living with HIV have sex with men and that women living with HIV are sex workers. But this association of transmission was not expressed by all respondents. In Yemen, a few had a slightly more lenient image. Some respondents mentioned that a man living with HIV, while stigmatized, still has the option of living alone and establishing some sort of life, but that is not an option for women living with HIV because it is generally socially unacceptable for unmarried women to live alone.

For women living with HIV in Yemen, confidence and trust was expressed in voluntary counselling and testing but some concern was expressed that someone they know might see them there and disclose their status to the community. In some cases, norms formed protection for the women, for example respondents in Yemen cited the greater anonymity that women have going to voluntary counselling and testing because of the abaya and face veil.

People living with HIV, especially women, expressed distrust about seeing doctors for fear of being turned away for treatment if their HIV status is known. Medical practitioners were cited as refusing medical treatment for people with HIV, either because of lack of capacity to treat or from not having prophylaxis supplies. There did not appear to be a difference between males and females living with HIV in this regard, except that for women, finding reproductive health care presents a specific additional challenge and women living with HIV often have more pervasive and frequent gynaecological health problems than women who do not have HIV. This also has negative implications for reducing mother-to-child transmission of HIV.

> *Doctors don't tell you 'I am not going to see you because you are HIV positive'. They say things like: 'we cannot address your problem, we are not the right clinic for you', 'we are not prophylactic enough', 'we don't have the right technology'.*
>
> (Woman living with HIV, Jordan)

Inconsistent classification of men who have sex with men by national HIV programmes and nongovernmental organizations may limit the access and exposure to HIV campaigns of all men who have sex with men

Respondents, particularly in Yemen, appeared to classify men who have sex with men as those who perform the "female" or receiving role in sexual encounters. The designation of men who have sex with men also seemed constricted to male sex workers. For example, married men who have sex with men, or men who perform the so-called "male" role in sexual encounters, were not classified as men who have sex with men among respondents in Yemen. This is in alignment with gender norms that depict women as the passive recipient and men as the active provider. Inconsistent classification may limit outreach and exposure of HIV prevention and services to all men who have sex with men.

Positive practices

Programmes targeting sex workers

Female sex workers in Jordan and Yemen reported having been successfully educated by nongovernmental organizations regarding condom use and reported positive adjustments in health-care seeking as well as increased use of condoms as a result of such programmes. However, sex workers noted that there are still communities of female sex workers that have not been accessed by such programmes, especially young and newly recruited female sex workers. Pimps and clients should also continue to be targeted and educated on the importance of preventative health care for commercial sex workers.

Programmes targeting drug users

Drug users in recovery are educated about HIV, needle sharing and condom use and are trained in harm reduction methods in case of relapse in rehabilitation centres in Jordan. Encouraging access of female drug users to these programmes continues to present a challenge.

Programmes targeting gender-based violence

Respondents in Jordan expressed positive experiences with family protection units and a hot line for survivors of gender-based violence was reported to be receiving increasing calls each month. The Office of the United Nations High Commissioner for refugees (UNHCR) in Yemen has a programme in place for cases of gender-based violence in the refugee community and they reported a change over time in the community's perceptions of gender-based violence and their increasing comfort and actions in asking for the support of authorities in cases of gender-based violence.

Programmes targeting people living with HIV

In Yemen, it was reported that the National AIDS Programme and support groups for people living with HIV are facilitating marriages among HIV widowers and/or divorcees. Even though this initiative separates people living with HIV further from non-infected people and underlines their differences, in the perception of the people living with HIV, in particular in the Middle East and North Africa region, this was reported as an effective initiative in improving the quality of lives of people living with HIV.

Conclusions

Gender norms, or expectations of what constitutes socially acceptable men and women, have an influence on the behaviour of men, women, boys and girls. Stepping outside the boundaries of gender norms can result in negative consequences for both men and women, ranging in repercussions from social disapproval, to more severe repercussions of social exclusion and, in the most severe outcome, to death due to honour killings. In Jordan and Yemen, gender norms promote women's primary roles as wives and mothers and promote an absence of sexual experience as a prerequisite for entering into marriage and

fulfilling those roles. Gender norms for men promote their roles as head of households and as economic providers for the family. Family honour in Jordan and Yemen is upheld through adherence to primary gender roles of its female and male members; however, the larger weight for adherence falls on the female members.

Women go to great lengths to adhere to the norms, to ensure their reputation of adherence remains intact, and to protect themselves if the norms have been transgressed. These behaviours can negatively impact their access to and quality of experience of HIV/AIDS programmes and services and, in some cases, can increase their vulnerability to contract HIV. For example, avoidance of incurring suspicion about their reputation as sexually inexperienced may inhibit unmarried women's access to health-care services, especially reproductive health services, and thereby reduce their exposure to information about HIV and their subsequent ability to take protective measures. In addition, it was found among respondents that women avoid discussion about sexuality and HIV because it may damage their reputation, and as a result they may have less awareness about HIV, including knowledge about how to protect themselves. Women who transgress these gender norms will try to hide their activities from their families and the community and also from health providers. Respondents cited mistrust of doctors keeping their virginity status confidential. Cases were cited of female youths practicing alternative sexual practices of anal and oral sex in order to ensure their hymens remained intact for marriage. Unfortunately, it was also cited that in many cases female youths engaging in these sexual activities were not aware of all the methods of transmission of HIV and were primarily concerned with protecting their virginity and, as a result, did not use condoms.

According to respondents, married women are also strongly influenced by gender norms. Respondents cited examples of women not having the power to negotiate condom use, even if they were aware of their husband being at risk for having HIV, and of avoiding asking for information about HIV and sexually transmitted diseases for fear it might implicate them as sexually active. This is particularly worrisome for wives of clients of sex workers and for wives of men who have sex with men because they can be both insufficiently aware of HIV and unable to convince their husbands to use condoms, even if they are aware.

Gender-based violence in marriage was another issue that was raised frequently by respondents. Women who are subject to violence from their husbands are often in a weaker position to negotiate safe sex and may be more exposed to violent sexual intercourse, which increases their vulnerability to contracting HIV. They may also face greater mobility restrictions and therefore be less able to access HIV information and services.

Women and girls who transgress gender norms by force are not subject to leniency in the eyes of society. Respondents across both countries cited social stigmatization for rape survivors, reduced or no options for marriage, and even a risk of honour killings. As a result, respondents indicated that women rarely, if ever, disclose cases of rape and therefore are unlikely to have access to HIV prophylaxis and protection against unwanted pregnancy.

Sex workers and men who have sex with men transgress gender norms and respondents consistently mentioned their lack of access to institutional services and social protection as a result, preventing them from exercising their human rights to health and increasing their vulnerability to HIV. The illegal nature of sex work, together with law enforcement that heavily criminalizes the supply side, while silently condoning the demand side, places these women in a very vulnerable position.

Respondents did say that targeting HIV programmes and services at these groups has successfully reduced their vulnerability; however, some of the most vulnerable groups, such as newly recruited young female sex workers, may not yet be sufficiently targeted.

Drug use was reported by respondents as a growing issue in Jordan. Respondents in Yemen also reported some use of drugs other than khat and an increasing use of khat by women. Stigma based on the same gender norms characterizes these women as being sexually promiscuous during and after drug use and society does not "forgive" or forget their addiction. This results in female drug users going to great lengths to hide their addictions and as a result may limit their access or exposure to HIV programmes and services.

Sexuality between males is highly stigmatized and it was reported to often start in the school setting. Male bisexuality was also reported and outreach to their female partners was considered a significant challenge in both countries. Findings suggest that there is a population of single men who have sex with male sex workers whose clients are often married men. Married men having sex with male sex workers were in several cases not labelled by nongovernment organizations as men who have sex with men.

Women living with HIV overall reported good relationships with their HIV specialist doctors but expressed difficulties in finding doctors to attend to their reproductive health needs. Women living with HIV are more at risk of vaginal fungal infections, genital warts, pelvic inflammatory disease, menstrual irregularities and cervical cancer than HIV-negative women. In general, respondents mentioned that people living with HIV have to keep their status secret from family, friends or community for fear of rejection and ruining the reputation of their families.

Nevertheless, whenever and wherever efforts and resources have been invested, results are being achieved. The two countries have some effective programmes that are reaching out to hidden populations such as sex workers, female injecting drug users and men who have sex with men. Women's organizations are also making strides to change laws that discriminate against women. Particularly effective are those efforts that involve outreach and that use men who have sex with men to reach out to other men who have sex with men, and former sex workers to reach out to sex workers.

Recommended actions

Issue: Fear of harm to social reputation of unmarried women and girls may inhibit their access to health-care services and reduce necessary exposure to information about HIV and subsequent protective and preventive measures

Responsive actions

- Assessment of disclosure policies and practices by health-care providers, particularly with regard to female patients.
- Disclosure protocol that protects female patients in place and practised by all health-care providers.
- Awareness campaigns for women and girls on their rights to privacy in health consultations.

Issue: Social barriers to discussion about sexuality and HIV may reduce awareness about HIV in women and young people

Responsive actions

- Establishment of forums where women and young people can openly discuss issues of sexuality, HIV and sexually transmitted diseases without negative social repercussions.
- Targeted awareness campaigns for women and young people on HIV and sexually transmitted diseases that can be accessed

privately (i.e. simple brochures/posters in locations that only women and young people frequent).

- Establishing help lines where women and young people can call anonymously to seek counselling and information on HIV, and referral if needed.
- Increased HIV prevention and service outreach programmes targeting vulnerable women, i.e. young women, street children, women living in poverty and women in communities with high levels of work-related migration (e.g. wives of fishermen, truck drivers and seasonal workers).

Issue: Alternative unprotected sexual practices may increase vulnerability to infection in female youth

Responsive actions

- Targeted awareness campaigns for male and female youths on HIV and sexually transmitted diseases that emphasize all methods of virus transmission.
- Anonymous access to condoms for female youths (mechanisms to be established in consultation with female youths). While condoms are available in many pharmacies, women are inhibited from purchasing them publicly and therefore are dependent on their partner for their availability and use.

Issue: Women and girls who are survivors of sexual violence are untreated/ underdiagnosed for sexually transmitted diseases and HIV

Responsive actions

- Assessment of capacities and response of health-care providers, at all levels, to sexual violence, including availability of postexposure prophylaxis, counselling, care and confidentiality/disclosure practices.
- Establishment of national protocols for the management of rape and sexual abuse (adapted from WHO medico-legal guidelines) at all levels of health care, including the provision of postexposure prophylaxis where appropriate as well as emergency contraception, and disclosure practices that protect women.
- Training and support to health-care providers at all levels for the management of rape and sexual abuse.
- Monitoring of implementation of protocols for the management of rape and sexual abuse at all levels of health care.
- Awareness campaigns targeting women that inform them of health-sector responsibilities to protect their rights as survivors of sexual violence, emphasizing their rights to privacy and confidentiality. Note: this can only be done if it has been established that doctors are implementing protocol for response to sexual violence.

Issue: Women who are survivors of domestic violence may be at increased vulnerability to infection and have lack of awareness about HIV

Responsive actions

- Assessment on capacities and response of health-care providers, at all levels, to identify, treat and document gender-based violence, including provision of information on HIV and sexually transmitted diseases.
- Establishment of national health-sector protocols on health-care response, at all levels, to gender-based violence, including provision of information on HIV and sexually transmitted diseases.
- Training and support to health-care providers, at all levels, on health-sector protocol for response to gender-based violence.

- Monitoring and evaluation of implementation of health-sector protocol on gender-based violence.
- Awareness campaigns targeting women that inform them of health-sector responsibilities to protect their rights as survivors of gender-based violence, emphasizing their rights to privacy and confidentiality. Note: this can only be done if it has been established that doctors are implementing protocol for response to gender-based violence.

Issue: Wives of clients of sex workers and of men who have sex with men are vulnerable to HIV infection in terms of lack of awareness of HIV and insufficient negotiating skills and power to protect themselves

Responsive actions

- Enhanced targeting/outreach to wives of clients of sex workers and of men who have sex with men in HIV programmes.

Issue: Young newly recruited female sex workers and home-based sex workers may be underserved by HIV campaigns and have lack of awareness about HIV

Responsive actions

- Enhanced measures in bio-behavioural surveillance to identify and locate home-based sex workers and young newly recruited female sex workers.
- Outreach to managers/pimps of female sex workers and older female sex workers to encourage peer education of newly recruited female sex workers.
- Targeted HIV campaigns to home-based female sex workers and newly recruited female sex workers.
- Establishment of a health-provider network willing, supported and trained to treat, educate and protect confidentiality of both female and male sex workers.
- Female sex workers educated on the benefits of preventative care and informed about the locations of doctors (health-provider network sensitized and trained to treat sex workers) sensitive to their needs.

Issue: Female drug users may be at increased risk to HIV through unprotected transactional sex and exposure to sexual violence

Responsive actions

- Enhanced measures in bio-behavioural surveillance to identify female injecting drug users and female drug users.
- Assessment of differential practices and vulnerability to HIV infection of female injecting drug users and female drug users.
- Targeted HIV campaigns to female injecting drug users and female drug users, including use of peer education to contact harder-to-reach female drug users.
- Assessment of gender and age responsiveness of existing drug treatment centres, especially in consideration of substantial stigma female drug users face in becoming public.
- Establishment of health-provider network willing, supported and trained to treat, educate and protect confidentiality of both female drug users, including provision of referrals to gender-responsive drug treatment centres.

Issue: Sufficient and quality access to reproductive health-care services for women living with HIV presents a challenge

Responsive actions

- Assessment of health-provider capacities, perceptions, attitudes and practices to provide reproductive health services to women living with HIV.
- Strengthen the health-sector response in different settings to be receptive and

friendly and provide quality reproductive health-care services and referral, if need be, to women and girls living with HIV.

- Establishment of a health-provider network willing, supported and trained to provide reproductive health services and protect confidentiality of women living with HIV and their partners.
- Information campaigns about HIV and services available for women and designed to meet their needs.
- Awareness campaigns to women living with HIV of health-sector responsibilities to provide them with quality and confidential reproductive health services.
- Development and dissemination to women living with HIV of an updated directory of all available resources and services in the community to which women living with HIV can be referred.

Issue: Limited understanding of the sexual networks of men who have sex with men and distinction between different types of men who have sex with men may limit the access and exposure to HIV campaigns of all men who have sex with men

Responsive actions

- Assessment on classification criteria of men who have sex with men in bio-behavioural surveillance and among national and nongovernmental organization-based HIV programmes.
- Consensus on, and implementation of, a unified classification of men who have sex with men that encompasses all types of men who have sex with men.
- Assess health-provider capacities, knowledge, perceptions, attitudes and practices to provide health services to men who have sex with men.
- Establish a health-provider network willing, supported and trained to provide health services and protect the confidentiality of men who have sex with men.

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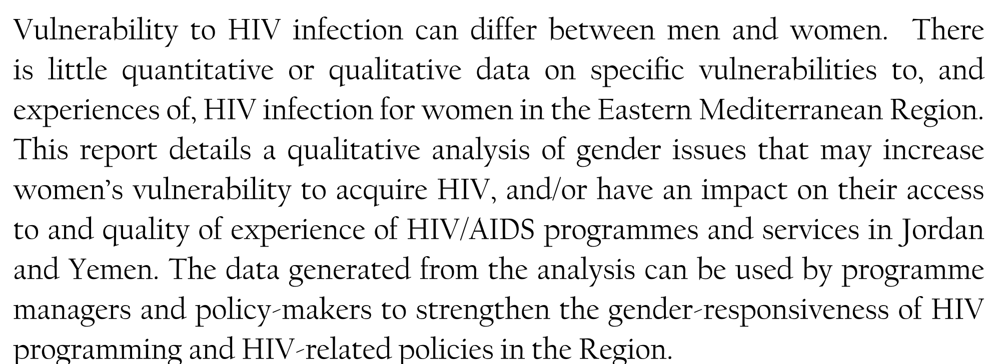
Annex 1. Respondents

Jordan

Organization/Most at-risk population	Date	Site
WHO	23/5/2010	WHO
WHO	23/5/2010	WHO
United Nations Development Fund for Women (UNIFEM)	23/5/2010	UNIFEM
Jordan Red Crescent and people living with HIV	23/5/2010	Amman
People living with HIV (Country Coordinating Mechanisms of the Global Fund)	23/5/2010	Hotel
People living with HIV – Al Amal (two women with HIV)	23/5/2010	Hotel
Key person	23/5/2010	D. Town
Sex worker	24/5/2010	Camp
National AIDS Programme	24/5/2010	Ministry of Health
Future Guardians Society	24/5/2010	Amman
Family and Children Protection Society	24/5/2010	Ministry of Health
Foreign recovering alcoholic	24/5/2010	D. Town
Abused woman	24/5/2010	Hotel
Two sex workers	25/5/2010	Camp
Two vulnerable women	25/5/2010	
Wife of injecting drug user	25/5/2010	Amman
Medical adviser for people living with HIV	25/5/2010	Hotel
Legal adviser for people living with HIV	25/5/2010	Hotel
Jordanian National Commission for Women (JNCW)	26/5/2010	JNCW
Narcotic police	26/5/2010	Police station
Khawla Bent Al-Azwar Society	26/5/2010	Zarka
Bushra Centre for Women Studies	26/5/2010	Zarka
MSM volunteer	26/5/2010	Hotel
WHO Representative	27/5/2010	WHO
WHO (Mental Health)	27/5/2010	WHO
Family protection	27/5/2010	Police station
Recovering drug user	27/5/2010	Recovery centre
Antinarcotic treatment centre	27/5/2010	Centre
Wife of recovering injecting drug user	27/5/2010	Her home
Young woman	27/5/2010	Restaurant
WHO	27/5/2010	WHO

Yemen

Organization/Most at-risk population	Date	Site
Sana'a		
Young male (23 years)	11/6/2010	Sana'a
WHO	12/6/2010	WHO
National AIDS Programme (no interview)	12/6/2010	National AIDS Programme
Two males living with HIV/AIDS	12/6/2010	National AIDS Programme
National AIDS Programme manager	12/6/2010	National AIDS Programme
WHO most at-risk population mapping	12/6/2010	National AIDS Programme
Two men who have sex with men	12/6/2010	Hotel
SOUL (nongovernmental organization)	13/6/2010	Nongovernmental organization site
Al-Islah	13/6/2010	Nongovernmental organization site
Yemeni Women's Union	13/6/2010	Nongovernmental organization site
Two sex workers	13/6/2010	City
Aden		
WHO	14/6/2010	WHO, Aden
Progressio	14/6/2010	Progressio
The Office of the United Nations High Commissioner for Refugees (UNHCR) Gender Focal Point	14/6/2010	UNCHR
Yemen Network Against AIDSYNAA	14/6/2010	Hotel
LIA (people living with HIV association)	14/6/2010	Hotel
Three sex workers	14/6/2010	Hotel
Three men who have sex with men	14/6/2010	Hotel
Sex worker club observation	14/6/2010	Club
Woman living with HIV/AIDS	15/6/2010	Hotel
Discordant wife of person living with HIV	15/6/2010	Hotel
Two women living with HIV/AIDS	15/6/2010	Hotel
Two female prisoners (1)	16/6/2010	Prison
Two female prisoners (2)	16/6/2010	Prison
Prison officials	16/6/2010	Prison
Joint United Nations Programme on HIV/AIDS (UNAIDS)	16/6/2010	UNAIDS



Vulnerability to HIV infection can differ between men and women. There is little quantitative or qualitative data on specific vulnerabilities to, and experiences of, HIV infection for women in the Eastern Mediterranean Region. This report details a qualitative analysis of gender issues that may increase women's vulnerability to acquire HIV, and/or have an impact on their access to and quality of experience of HIV/AIDS programmes and services in Jordan and Yemen. The data generated from the analysis can be used by programme managers and policy-makers to strengthen the gender-responsiveness of HIV programming and HIV-related policies in the Region.