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Technical Paper: Review of Training and Programming Resources on Gender-Based Violence against Key Populations

Addressing Sex Workers, Men Who Have Sex with Men, Transgender People and People Who Inject Drugs

Submitted to USAID by Management Sciences for Health

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ACRONYMS

GBV	Gender-based violence
Gender Policy	Gender Equality and Female Empowerment Policy
GHI	Global Health Initiative
IPV	Intimate partner violence
LGBT	Lesbian, gay, bisexual and transgender
MSH	Management Sciences for Health
MSM	Men who have sex with men
PEPFAR	The President's Emergency Plan for AIDS Relief
PLHIV	People living with HIV
PWID	People who inject drugs
SMS	Short message services
SRH	Sexual and reproductive health
TWG	Technical Working Group
USAID	United States Agency for International Development
USG	United States Government
WGGE Principle	Women, Girls and Gender Equality Principle
WHO	World Health Organization

EXECUTIVE SUMMARY

This *Technical Paper* is part of the ***Review of Resources: Gender-Based Violence against Key Populations*** – an activity commissioned by the Gender Technical Working Group (TWG) of the President's Emergency Plan for AIDS Relief (PEPFAR).

The activity was implemented by AIDSTAR-Two, through the International HIV/AIDS Alliance and Project Partners (global key population networks/expert consultants[1]), in collaboration with Management Sciences for Health. The activity's aim was to contribute to the ability of PEPFAR and its partners to better understand and respond to gender-based violence (GBV) against four key populations - sex workers, men who have sex with men (MSM), transgender people and people who inject drugs (PWID) - and, in turn, to reduce HIV risk among such communities, their sexual partners, friends and family.

The *Review* used the broad **definition** of GBV provided by the United States Government (USG) Strategy to Prevent and Respond to GBV[2]. This indicates that GBV: takes different forms (physical, sexual, psychological, etc.); affects women, girls, men, boys and sexual and gender minorities; is related to socially defined norms; and occurs both *against* and *among* key populations. The activity also used the Strategy's framework for a **comprehensive response to GBV.** This has three key components focused on: 1. Prevention; 2. Protection (support and services for survivors); and 3. Accountability (legal and policy action).

The context to the *Review* was that it is already known that at least a third of all women are physically or sexually abused during their lifetime[3]. However, both female and male members of key populations face ***heightened* and *additional* risk factors related to GBV**. For example, in Bangladesh, 94% of sex workers have experienced violence from clients, gatekeepers, police, intimate partners or neighbors[4]. All violence against key populations matters. However, ***gendered* violence** remains particularly under-addressed. Gender and sexuality lie at the heart of many of the key issues that have shaped HIV epidemics. These include those – such as homophobia, transphobia and narrow norms about how a 'male' or 'female' is expected to behave – that reflect entrenched prejudice and poor acceptance of difference (such as in sexual practices or gender identity). The circumstances and behaviors associated with key populations' heightened risk factors for HIV – such as social stigma, power imbalances and lack of access to resources – are often the same as those that heighten their risk factors for GBV. As GBV and HIV are connected, so should be the actions that address them. There is an opportunity to improve and increase the response to *both*.

The content of the *Technical Paper* reflects the *Annotated Bibliography: Training and Programming Resources on Gender-Based Violence against Key Populations* - an earlier product of the *Review of Resources* that lists and describes the training and programming resources identified for each of the four key populations by the Project Partners. This *Paper* focuses on two areas of **cross-cutting findings**: the existing training and programming resources (their number, strengths, weaknesses and gaps); and the framing of responses to GBV against key populations (their principles, models and approaches). Annexes 1-4 provide a more detailed summary of the findings in relation to each of the populations.

Based on the findings and conclusions of the *Review of Resources*, this *Technical Paper* provides the following **recommendations** for PEPFAR and USAID:

Recommendation 1: Within PEPFAR and USAID's own program work and partnerships, use the findings of the *Review of Resources* to strengthen: the integration of attention to GBV into all existing HIV and sexual and reproductive health core program packages for sex workers, MSM, transgender people and PWID; a systems-wide approach to ensuring 'key population inclusive' GBV services, including those within mainstream health systems; and the development of enabling environments for successful responses to GBV against key populations, including through the removal of structural barriers.

Recommendation 2: Ensure that any response to GBV is based on the existing lessons learned, good practices and principles (see box) of programs by and for key populations.

Principles for responses

1. Use a rights-based approach
2. Base action on evidence
3. Meaningfully involve key populations and do 'nothing about us without us'
4. 'Do no harm'
5. Maximise both 'what works' and innovation
6. Be specific to the individual and the population
7. Address all forms of violence
8. Work with people associated with key populations, including those that carry out or facilitate GBV
9. Work in partnership
10. Document and learn

Recommendation 3: Ensure that, as a pre-requisite, any response to GBV against key populations is based on a thorough, nuanced understanding of the whole picture of an individual's life and context, including their real needs and their multiple risk factors, opportunities and entry points for action.

Recommendation 4: Ensure that any response to GBV against key populations is conceptualized, designed and implemented to be: ecological (multi-level); comprehensive (addressing all of 1. Prevention, 2. Protection and 3. Accountability); and cohesive (by both key population programs and mainstream GBV services). Responses should also: provide support to those – such as project staff and peer educators – that work on the frontline of GBV against key populations; and complement support to key populations by targeting people associated with such communities who may carry out or facilitate GBV or may, themselves, be survivors of GBV.

Recommendation 5: Consolidate the global evidence base on the scale of GBV against each key population and the nature/efficacy of responses – by funding a systematic review by a recognized international research institution, in order to inform advocacy and programming.

Recommendation 6: Champion the specific and heightened risk factors, needs and opportunities of key populations – including those who are gender and/or sexuality minorities - within national, regional and global policy forums on GBV and violence against women, while also facilitating the direct involvement of affected communities in such initiatives. Also advocate to other donors on both the 'human value' and 'investment case' for funding responses to GBV against key populations.

Recommendation 7: Invest strategically in action on GBV against key populations. Prioritize:

- Advocacy by and for key populations at all levels (national, regional and global) to address the structural barriers (such as oppressive laws) and socio-cultural barriers (such as stigma).
- Capacity building of organizations by and for key populations. Initially, this should focus on the development of a set of core tools to enable groups to 'get started' – by integrating at least a degree of action on GBV into *any and all* existing program packages for key populations and making the best use of the identified training and programming resources.
- Capacity building of mainstream stakeholders who can be key to the rights, safety and GBV services for key populations, such as the police, judiciary and rape crisis services.

SECTION 1: INTRODUCTION

This Section includes the rationale for the *Review of Resources,* as well as the aims, audiences, definitions and framework used in this *Technical Paper*. It also includes an outline of the contents of this Paper.

1.1. Rationale for Review of Resources

This *Technical Paper* is part of a ***Review of Resources: Gender-Based Violence against Key Populations*** commissioned by the **Gender Technical Working Group (TWG)** of the President's Emergency Plan for AIDS Relief (PEPFAR). The project has been implemented by AIDSTAR-Two, through the International HIV/AIDS Alliance (the Alliance) and Project Partners (global key population networks/expert consultants - see Acknowledgements), in collaboration with Management Sciences for Health (MSH).

The PEPFAR Gender Strategy calls for programs to identify and address the unique needs of women and men and to ensure equity in access to HIV programs and services. The Women, Girls and Gender Equality Principle (WGGE Principle) of the Global Health Initiative (GHI) of the United States Government (USG) reaffirms that commitment. It also explicitly calls for attention to marginalized populations that are most vulnerable to negative health outcomes, including HIV. Various USG Policies and Strategies - including the USG Strategy to Prevent and Respond to GBV Globally, USAID Gender Equality and Female Empowerment Policy, WGGE Principle and PEPFAR Gender Strategy - highlight the need to support programing to prevent and respond to gender-based violence (GBV), including among key populations.

The *Review of Resources* was developed to address and strengthen these priorities. It aimed to contribute to the ability of PEPFAR and its partners to better understand and respond to GBV against four key populations - **sex workers, men who have sex with men (MSM), transgender people and people who inject drugs (PWID)** - and, in turn, to reduce HIV risk among such community members, their sexual partners, friends and family. The PEPFAR Gender TWG was specifically interested in building the capacity of community and service-provider groups that support key populations to integrate gender into their work, with an emphasis on addressing GBV.

1.2. Aim and audiences of Technical Paper

The **aim** of this *Technical Paper* is to:

- Summarize the **findings and gaps** identified in the *Annotated Bibliography: Training and Programming Resources on Gender-Based Violence against Key Populations*[5]. (The Bibliography is a further product of the *Review of Resources* and is summarized in Box 7 in Section 3).
- Identify and analyze the **cross-cutting issues** (addressing all four key populations) highlighted by the *Annotated Bibliography*.
- Make **recommendations** to the PEPFAR Gender TWG and USAID on how to take this work forward.

The primary **audiences** for this Paper are: PEPFAR and USAID decision-makers and program managers, including the PEPFAR Gender TWG, Key Populations TWG and Country Teams; other partners involved in the project, notably the Alliance and global, regional and national key population networks; and relevant national, regional and global organizations and stakeholders.

1.3. Definitions and framework for Technical Paper

This *Technical Paper* uses recognized **definitions** of key populations – both as a whole[6] and as individual communities (see below).

Box 1: Definitions of key populations

Sex workers: *"Female, male and transgender adults and young people (18 years of age and above) who receive money or goods in exchange for sexual services, either regularly or occasionally ….. It is important to note that sex work is consensual sex between adults, which takes many forms and varies between and within countries and communities. Sex work may vary in the degree to which it is more or less 'formal' or organized."*[7]

Men who have sex with men: *"An inclusive public health construct used to define the sexual behaviors of males who have sex with other males, regardless of the motivation for engaging in sex or identification with any or no particular 'community'. The words 'man' and 'sex' are interpreted differently in diverse cultures and societies, as well as by the individuals involved. As a result, the term MSM covers a large variety of settings and contexts in which male-to-male sex takes place. Perhaps the most important distinction to make is one between men who share a non-heterosexual identity (i.e. gay, homosexual, bisexual or other culture-specific concepts that equate with attraction to other men) and men who view themselves as heterosexual but who engage in sex with other males for various reasons (e.g. isolation, economic compensation, sexual desire, gender scripts*[8]*)."*[9]

Transgender people: *"An umbrella term for persons whose gender identity and expression does not conform to the norms and expectations traditionally associated with the sex assigned to them at birth. Transgender people may self-identify as transgender, female, male, transwoman or transman, trans-sexual, hijra, kathoey, waria*[10] *or one of many other transgender identities and may express their genders in a variety of masculine, feminine and/or androgynous ways."*[11]

People who inject drugs*: *"People who inject drugs are a key constituency among people who use drugs because this group is often the most discriminated against, marginalized, criminalized and experiences some of the most serious health problems that can be associated with drug-taking under the regime of global prohibition."*[12]

*Of note, as requested in its terms of reference, the Project addressed people who *inject* drugs rather than the wider group of people who *use* drugs. However, it was acknowledged that such a differentiation can be unhelpful and that, in practice, a broad range and types of people who *use* drugs face heightened risk factors in relation to GBV. It should also be noted that, within the remit of attention to MSM and transgender people, the Project incorporated resources that address 'general' lesbian, gay, bisexual and transgender (LGBT) communities. In practice, however, the extent to which such materials *specifically* address the two populations varied significantly. This was especially the case for transgender people – whose specific needs are often under-acknowledged/addressed in wider LGBT resources.

The *Review* addressed adult (18 years and above) members of the four key populations. However, it was recognized that those below 18 years often face especially heightened risk factors related to GBV. This is an important area for further investigation.

This *Technical Paper* uses the broad definition of GBV provided by USG Strategy to Prevent and Respond to GBV Globally (see Box 2). Of note, within the context of key populations, this is understood to include attention to violence that can: affect women, girls, men, boys *and* sexual and gender minorities; be related to socially defined norms of gender and sexuality identity; and occur both *against* and *among* key populations, including through intimate partner violence (IPV).

Box 2: Definition of gender-based violence[13]

"Violence that is directed at an individual based on his or her biological sex, gender identity or perceived adherence to socially defined norms of masculinity and femininity. It includes physical, sexual and psychological abuse; threats; coercion; arbitrary deprivation of liberty; and economic deprivation, whether occurring in public or private life ... GBV takes on many forms and can occur throughout the life cycle. Types of gender-based violence can include: female infanticide; child sexual abuse; sex trafficking and forced labor; sexual coercion and abuse; neglect; domestic violence; elder abuse; and harmful traditional practices, such as early and forced marriage, 'honor' killings and female genital mutilation/cutting ... Women and girls are the most at risk and most affected by GBV. Consequently, the terms 'violence against women' and 'gender-based violence' are often used interchangeably. However, boys and men can also experience GBV, as can sexual and gender minorities. Regardless of the target, GBV is rooted in structural inequalities between men and women and is characterized by the use and abuse of physical, emotional, or financial power and control."

As a **framework**, this Paper uses the three core components of a comprehensive response to GBV as outlined by the USG Strategy:

Box 3: Core components of a comprehensive response to GBV[14]

1. **Prevention** of GBV from occurring in the first place and from recurring, by working with local grassroots organizations, civil society and key stakeholders in the community, including men and boys.
2. **Protection** from GBV by identifying and providing services to survivors once the violence occurs.
3. **Accountability** to ensure that perpetrators are prosecuted and to end impunity by strengthening legal and judicial systems.

1.4. Overview of Technical Paper

Following this Introduction, Section 2 of this *Technical Paper* provides a brief look at the scale and impact of GBV against key populations. Sections 3 and 4 summarize the cross-cutting findings of the *Annotated Bibliography* – the former focusing on the resources identified, the latter on the issues raised about how to respond to GBV. Section 5 suggests the 'top 10' conclusions that can be drawn from this activity, while Section 6 presents the key recommendations for action.

Annexes 1 – 4 summarize the findings of the *Annotated Bibliography* for each of the four key populations.

SECTION 2: GBV AGAINST KEY POPULATIONS – THE SCALE AND IMPACT

This Section provides the context to the *Technical Paper* through a brief look at the scale, impact and importance of GBV against key populations and the positioning of the issue within the policy environment.

2.1. Scale of GBV against key populations

GBV is a *"global health problem of epidemic proportions"*[15]. According to the World Health Organization (WHO), at least a third of all women are physically or sexually abused during their lifetime[16]. There is also growing evidence of GBV against men and boys, particularly within conflict settings[17].

GBV cuts across ethnicity, race, religion, class and education[18]. However, key populations are among those ***most* affected**. This reflects a range of causal factors – combining on-going inequalities for women and girls with prejudice and discrimination against those (such as sex workers, MSM and transgender people) who are perceived to transgress 'acceptable' gender and sexuality norms and identities. Depending on their circumstances, the risk factors, such as for sex workers, include: social stigma and isolation; lack of GBV prevention services; low self-esteem; and negative community attitudes to 'immorality'[19]. They also include practical issues related to behavior. For example, sex workers based indoors may be more isolated from their peers, making them more exposed to the risk of violence[20].

In many countries, key populations' social vulnerability to GBV and other formers of violence is fueled by oppressive **legal and policy frameworks** that criminalize their wider status and/or behavior. For example, laws deeming drug use or same sex relationships illegal are in place in the majority of the world's countries and are often used to 'ignore' – or even 'justify' - violence against such populations by the police and community members, within a culture of impunity[21]. Meanwhile, stigma and discrimination may mean that members of key populations have less access to services or are even denied support within mainstream GBV services[22].

The *Review of Resources* confirmed that the **scale of GBV** against each of the key populations is vast and often far greater than the already unacceptably high levels against the wider community. Box 4 provides just a few examples of available data on violence that is at least partially gender-based (based on the definition provided in Box 2). This comes from a range of resources – many of which use different definitions for terms, methodologies and frameworks. The *Review of Resources* was unable to find one, consolidated source of verified data – such as that provided by WHO and partners on violence against women[23]. This gap presents a significant challenge in terms of an agreed evidence base for programmatic and policy responses.

Box 4: Examples of data on levels of gender-based violence against key populations

In Bangladesh, 94% of **sex workers** have experienced violence from clients, gatekeepers, police, intimate partners or neighbors[24].

In the USA, 68% of young **MSM** report ever experiencing threats or violence from their family or partners[25].

In Latin America, 826 **transgender people** were murdered in a four year period[26].

In Ukraine, 55% of **women who inject drugs** report psychological violence by their partners, while 49% report physical violence and 41% economic violence[27].

2.2. Impact of GBV on key populations

Box 5: Experiences of GBV against key populations

"You can tell the client to stop… he says, 'Didn't I buy you with my money?' .... You don't appear to him like a human being."

Sex worker, Southern Africa[28]

"Violence and abuse is our fate. We are beaten by our spouses, brothers, children …"

Woman who injects drugs, Pakistan[29]

"About six months ago, I got in a car with a man who I know is a policeman. He hired me to provide my sexual services, but afterwards he didn't want to pay and he wouldn't let me get out of the car. He shouted at me, 'Today you really are going to die, hueco[30]!' I told him to kill me because I knew that sooner or later I'd end up dead because, for me, life is a bonus."

Transgender woman activist, Guatemala[31]

The **impacts** of GBV are vast and varied. For example, the research cited previously by WHO and partners identifies that the most common health impacts of IPV against women are: death and injury; depression; alcohol use problems; sexually transmitted infections; unwanted pregnancy and abortion; and low birth-weight babies[32]. More widely, examples of socio-economic impacts associated with GBV include: limited access to education; increased costs for medical and legal services; loss of household productivity; and reduced income.

Again, there are many indications that the impacts of GBV can be *heightened* and *additional* for key populations. As just one example, research by the Red Latinoamericana y del Caribe de Personas Trans (REDLACTRANS) documents how GBV against transgender women (who are perceived as 'non-conforming' to mainstream gender identities) has resulted in a shocking level of severe injuries and murders ('feminicidios')[33]. In most cases, the perpetrators have not been prosecuted. Within the 'machismo' culture found in some of the region's societies, transgender people – who are treated as 'indecisive' and, therefore, 'invisible' - often also face particularly grotesque forms of violence, such as mutilation of their genitalia[34].

2.3. Why GBV against key populations matters

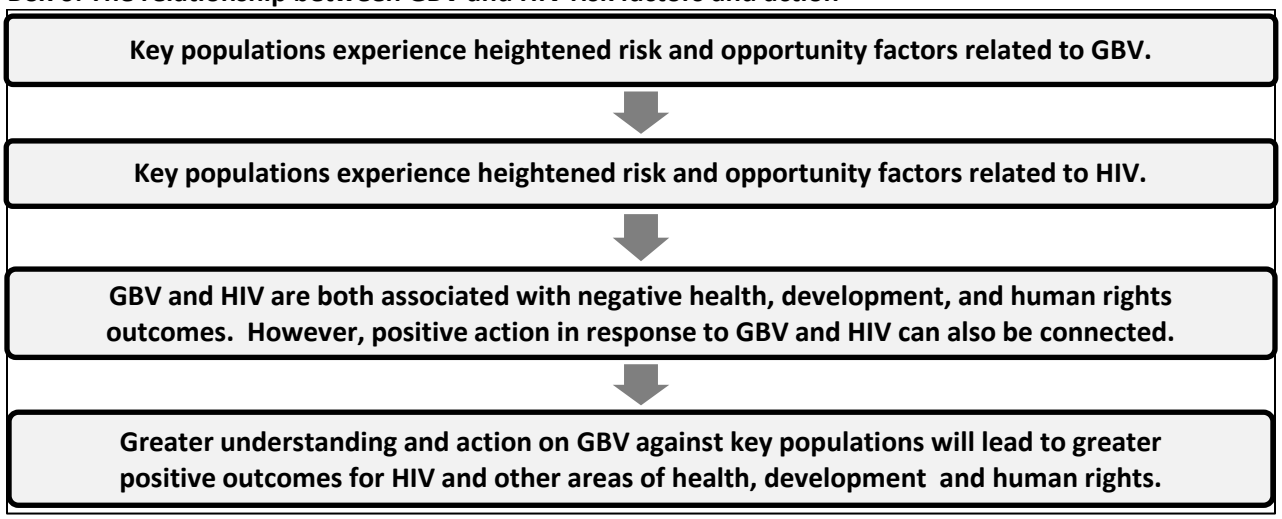
Every incident of GBV is an abuse and a **violation of human rights.** It is also a public health challenge and a barrier to civil, social, political and economic participation.

With key populations, heightened levels of GBV also risk limiting the positive outcomes of health, development and human rights interventions, including those related to HIV. Responses to HIV, particularly within concentrated epidemics, have increasingly used a 'know your epidemic' approach to focus on those with the highest risk factors. However, their results (in terms of universal access to HIV prevention, care, support and treatment for key populations) will remain limited while GBV continues. GBV is both a cause and effect of HIV transmission. For example, fear and experience of violence can undermine a sex worker's capacity to negotiate condom use with a client or a PWID's choices of harm-reducing injection practices. Due to on-going stigma and discrimination, living with or being associated with HIV can make people especially at-risk of violence.

All violence against key populations matters. However, *gendered* violence remains particularly under-addressed. Gender lies at the heart of many of the most significant issues that have shaped HIV epidemics. These include those – such as homophobia, transphobia and narrow norms about how a 'male' or 'female' is expected to identify and behave – that reflect entrenched prejudice and poor acceptance of 'difference' (such as in sexual practices or gender identity).

The circumstances and behaviors associated with key populations' heightened risk of HIV – such as social stigma, power imbalances and lack of access to resources – are the same and/or intimately connected to those that heighten their risk factors for GBV. This is summarized in Box 6. As a specific example, research by Johns Hopkins University in Kenya and Ukraine (which represent generalized and concentrated HIV epidemics respectively) indicates that, among sex workers, reducing physical or sexual violence would, in turn, reduce HIV incidence by 25%[35].

Box 6: The relationship between GBV and HIV risk factors and action



2.4. Positioning of GBV against key populations in the policy environment

In recent years, violence against women has received an overdue and sincerely welcome increase in profile and advocacy, both within global policy forums and country/community programs. However, many such initiatives have failed to recognize or address the specific and/or additional needs of key populations. Overall, while physical violence against sex workers has long been identified as a critical issue, wider definitions of GBV and the disproportionate experiences of key populations, have been neglected.

The *Review of Resources* activity and this *Technical Paper* represent a step towards filling that gap. By identifying the existing resources and the key issues involved in responses, they serve as an indication of the status of training and programming on GBV against key populations and provide recommendations as to how to take this critical work forwards, both programmatically and within policy forums.

SECTION 3: CROSS-CUTTING FINDINGS – EXISTING RESOURCES ON GBV AGAINST KEY POPULATIONS

This Section looks across the four key populations addressed by the *Review of Resources*. It explores the cross-cutting findings about the number, strengths, weaknesses and gaps in the resources identified in the *Annotated Bibliography*. It is supported by a synthesis of the specific findings for each of the four populations, provided in Annexes 1 – 4.

Box 7: Overview of Annotated Bibliography

This *Technical Paper* is informed by the *Annotated Bibliography of Training and Programming Resources on GBV against Key Populations,* an earlier product of the *Review of Resources*. The 80-page *Annotated Bibliography* describes the training and programming resources on GBV that were identified by the Alliance and its Project Partners. It has four Parts – one for each population. Each part provides:

- **Analysis of existing resources on GBV against (the key population)** – assessing the number, breadth, quality and gaps in resources.
- **Top priority existing resources on GBV against (the key population)** – listing and describing the approx. five resources identified as being the best quality and having the greatest potential for further use, adaptation and/or replication for training and programming.
- **List of other existing resources on GBV against (the key population).**

3.1. Number and sources of resources

The *Annotated Bibliography* identified a large **number** of resources of relevance to training and programming on GBV against key populations. These totaled 111 of relevance to sex workers, 40 for MSM, 41 for transgender people and 39 for PWID. The significantly higher number for sex workers seemed to reflect that (physical and sexual) violence against such community members is a more established subject for action, especially in contexts where sex workers have a history of collectivization. The number of resources for MSM and transgender people is lower without the inclusion of resources for 'general' LGBT communities. The modest number of resources for PWID could reflect the wider challenge that relatively little programming and resource development has taken place on integrating gender and women-focused services into harm reduction initiatives[36]. Also, definitions of 'harm' have tended to focus on bio-medical impact and excluded the types of psychological and social harm that are associated with stigma and discrimination and are included in the definition of GBV (see Box 2).

The Review also showed, however, that few of the existing resources are **'true' training and programming resources** - such as training guides, budgeting tools or monitoring and evaluation frameworks. Instead, the majority are materials - such as case studies and policy reports - that could be used to *inform* such resources. Similarly, many of the resources do not solely focus on GBV, but incorporate it – to different degrees – into wider areas, such as HIV programs or sexual and reproductive health (SRH) interventions. Overall, it is clear that there is no need to 'start from scratch' – as much important work has already been done and provides key ideas about 'what works'. It is also clear, however, that there are few ready-made training and programming packages that can be simply replicated or scaled-up. Furthermore, among the few that exist – and that show significant potential for further use – many are yet to be systematically evaluated.

The resources in the *Annotated Bibliography* came from a range of **sources**, predominantly civil society organizations, as well as multi-lateral agencies and donors. They were from the global South and North – reflecting that GBV against key populations is a challenge across economic, social and political contexts. Some of the most important resources were developed **by and/or for key populations** themselves. The *Review's* Project Partners (global key population networks/expert consultants) emphasized that such approaches bring significant added-value – as the resources are owned by the population in question and respond to their specific needs, local context and policy environment. Where such involvement is lacking, the relevance of resources may be limited. For example, concern was expressed that 'LGBT' resources are often developed without the specific involvement of transgender people. In turn, they risk neglecting crucial issues within GBV against that community (such as how legal processes related to gender recognition can exacerbate violence).

In some cases, the project found a large number of resources from a **particular country/region or organization**. Examples include the important resources on GBV against sex workers from India – reflecting the pioneering work of organizations such as Sampada Gramin Mahila Sanstha[37], programs such as Avahan[38] and networks such as the Asia Pacific Network of Sex Workers[39]. Similarly, many of the key resources on GBV against PWID, were produced by the Eurasian Harm Reduction Network which has been a leader in gender-sensitive and women-focused programming in the Eastern Europe and Central Asia region. While these examples reflect high quality initiatives, they also highlight some of the potential challenges in the transferability of resources. For example, it might be difficult to immediately adapt India's collectivization model – developed through years of work led by sex workers themselves - to contexts where sex work is more underground and/or the capacity of key people in the sex worker community is more limited. Similarly, the specific and highly oppressive policy environment faced by the PWID that the Eurasian Harm Reduction Network supports might make the organizations' resources difficult to adapt to other contexts.

In the process of compiling the *Annotated Bibliography*, the project made efforts to identify non-English training and programming resources, including through the involvement of Project Partners with members in relevant regions. However, in practice, it experienced limited success in this area and, as such, utilized few resources from important regions such as Latin America and Caribbean. Identifying and making maximum use of such resources remains an area for further attention.

It should be noted that the *Review of Resources* project did not explicitly explore general GBV training and program resources - such as those focused on women and girls and heteronormative communities - or assess their adaptability to key populations. However, it indicated that there is a significant gap in most of such resources, in terms of their lack of attention to, or sometimes even mention of, key populations.

3.2. Strengths and weaknesses of resources

Annexes 1-4 of this *Technical Paper* present a summary of the strengths, weaknesses and gaps in the training and programming resources for each of the four key populations, as well as the approximately five resources identified for each as top priorities (those that indicate the greatest potential for adaption, replication and/or scale-up). More detail, including descriptions of all of the resources and links to where they can be downloaded, are provided in the *Annotated Bibliography*.

The following summary looks *across* the four key populations to identify a number of common trends – as well as differences - in relation to the strengths and weaknesses of existing resources:

- **Use of a good practice approach:** Many of the top priority resources show a good practice approach in responding to GBV. For example, resources that explicitly demonstrate a **rights-based approach** include the *Blueprints* for comprehensive support to transgender people[40] and to gay men and other MSM[41] in Latin America and the Caribbean, developed by the Pan-American Health Organization, promotes the integration of action on GBV into a rights-based framework.

  There are indications that such an approach is particularly important for those working in highly oppressive environments and/or with key populations that are especially marginalized. This is illustrated by the *Lost in Transition* report by the Asia Pacific Transgender Network and United Nations Development Program[42] - which provides guidance on how to address stigma and promote the rights of transgender people, including in relation to GBV, within an intensely transphobic environment.

  Some of the top priority resources – such as the case studies of Sampada Gramin Mahila Sanstha's collectives for sex workers in India and the STIGMA Foundation's work with PWID in India[43] - reflect an **empowerment approach**. For example, in India, the *My Body Is Not Mine* report by Naz Foundation International and Centre for Media and Alternative Community documents participatory research that enabled the Kothi community[44] to speak for itself – including through writing and photography – about their experiences of GBV[45]. Similarly, *Understanding and Challenging Stigma toward Men who Have Sex with Men* - a toolkit by USAID, the International Centre for Research on Women and Pact – was developed with local groups and through participatory methods.

  Some of the resources demonstrate an understanding of USAID's wide definition of GBV. For example, the website and multiple tools of ACON's Anti-Violence Project in Australia specifically include attention to IPV against MSM and also addresses the psychological impact of surviving violence[46]. In contrast, some of the multiple resources for sex workers predominantly focus on physical and sexual violence by clients and the police, without, for example, addressing IPV or issues of mental health. Furthermore, some of the resources identified take a public health, rather than rights and empowerment, approach. Such resources tend to view GBV as a predictor for HIV and/or wider ill health, rather than a social and rights issue.

  Beyond those selected as priorities, many of the resources, while broadly referring to and being informed by good practice, do not give explicit guidance on how to operationalize such approaches within training and programming on GBV. Also, some specific concerns were raised about individual key populations. For example, with many of the resources for PWID, the Project Partner - the International Network of People who Use Drugs was concerned that there was little indication that they were based on a participatory assessment of people's needs and/or had been developed by PWID themselves. This goes against the principle of 'nothing about us without us'.

  Some of the resources, notably those identified as top priorities, show a thorough understanding of the many factors that affect GBV against key populations. However, some show less analysis of the wider issues that, for example: contribute to community members' vulnerability (such as poverty and class); and can lessen people's personal risk of violence (such as literacy and internet skills).

Many of the resources identified as top priorities integrate attention to GBV within wider program packages for key populations. Examples include a case study of Soins Infirmiers et Développement Communautaire, Lebanon, which addresses GBV within a broad program for MSM[47]. Such an approach is also seen in some of the guidance documents by normative agencies, such as PEPFAR[48], that provide frameworks within which GBV can be integrated into programs focused on HIV and/or key populations. Meanwhile, a few resources – notably the collections of good practice examples by the Global Network of Sex Work Projects[49] and Asia Pacific Network of Sex Workers[50] – focus on how to build on existing programs, by citing the necessary components of responses to GBV.

A concern is that the majority of the resources lack a systematic **evidence-base**, in terms of data that demonstrates the scale and nature of the need that is being addressed and the efficacy of the intervention. There appears to be a gap between the 'true' training and programming resources identified and the more research/academic-orientated publications. An example of an exception is the crisis response system for key populations developed by the Avahan program in India, supported by the Bill and Melinda Gates Foundation. This, through funding for operations research and data collection as well as program implementation, has benefited from systematically being piloted, implemented, evaluated and scaled-up, and includes the development of detailed guides that enable the program's approach to be replicated in other contexts and countries[51].

- **Address structural factors that affect GBV against the key population:** The majority of the resources identified focus on the first two components of a comprehensive response to GBV (1. Prevention and 2. Protection) and give little attention to the third (3. Accountability) (see Box 3). However, many resources do acknowledge the practical and political challenges of working within the often oppressive legal and policy environment for key populations. Some incorporate this acknowledgement into their contents, such as providing information about ways to reach and support groups that are forced to exist underground. However, overall, relatively few – even of the top priorities - provide clear strategies on how to advocate for change to the structural barriers that present persistent and significant barriers to action on GBV and/or support to key populations. Some exceptions include the case study of the Solidarity Association to Promote Human Development in El Salvador which combines outreach and drop-in services for transgender people with advocacy (to the government and health providers) and legal protection (such as accompanying members to the Human Rights Protection Office)[52].

  Some other resources describe efforts to address structural issues by working towards change, such as in social norms, at the local level. For example, Avahan's community-led crisis response approach is based on dialogue and action on GBV by a range of local stakeholders and decision-makers, alongside key populations themselves[53].

  Meanwhile, other resources target **key stakeholders** who are either directly or indirectly involved in influencing the environment in which key populations live and/or work. Examples are the: *Toolkit for Training Police Officers on Tackling LGBTI-Phobic Crime* developed by the International Lesbian and Gay Association (IGLA) Europe[54]; and *Open Minds Open Doors* developed by The Network in the USA to support mainstream service providers to be 'LGBT-inclusive'[55].

  The Project Partners emphasized that working with others is important for all of the key populations addressed by the project, but especially for those – such as sex workers – who often face daily abuse from the authorities, clients and community members.

- **Target the specific population:** Some of the priority resources – such as those by organizations that work with LGBT groups 'as a whole' - address a number of key populations. Overall, however, as highlighted previously, there is a preference – expressed especially strongly by the Project Partner focused on the transgender community – for resources to be tailored to the key population in question. Examples of this include the *Sexual Health for Transgender and Gender Non-Conforming People* guide by Gender Dynamix, South Africa[56], and *HIV and Gender-Based Violence Prevention for Transgender People* by the Southern Africa HIV/AIDS Information Dissemination Service[57]. Both of these respond to the specific and heightened risk of GBV of transgender people.

  Within the resources as a whole, attention to some sub-groups of key populations is missing. For example, few were identified that specifically address: transgender men; male sex workers; transgender sex workers; feminine-identifying MSM; members of all key populations who are young or elderly; and members of all key populations who have disabilities. Such nuanced attention is critical to ensuring that training and programming on GBV is as relevant as possible. For example, in some contexts, transgender men (especially those who are 'read' as female by other people) may feel uncomfortable accessing services for women, but also be unable to access services for men (due to their legal papers not identifying them as male). Yet, at the same time, they may face severe and high levels of violence, such as 'corrective' rape. Meanwhile, again in some contexts, transgender females – as well as MSM who identify or are 'read' as feminine – may face multiple, complex challenges, potentially combining homophobia, transphobia and misogyny.

- **Indicate potential for adaption, replication and/or scale-up in other contexts:** Some of the resources selected as top priorities are highly specific to the key population and/or context in question – indicating potential challenges for their replication or adaption to other contexts. Examples include the resources of organizations that target empowered LGBT communities and may be less transferable to, for example, MSM who do not identify as gay and/or are in a politically oppressive context. However, many other resources reflect approaches and/or contexts that are likely to be generic and strong *enough* to be transferred to other populations and/or countries. Examples include the GBV screening tool for MSM and transgender survivors of GBV developed for health providers by the Health Policy Initiative in Mexico and Thailand[58].

- **Have a user-friendly and/or innovative format:** Overall, although useful, many of the resources listed in the *Annotated Bibliography* are narrative documents (such as reports and case studies) rather than practical materials. As such, while vital for providing evidence for advocacy and *informing* training and programming, they are not highly user-friendly. There are, however, some exceptions. Examples of clear formats include the: training packages for PWID developed by the Eurasian Harm Reduction Network (which are presented in a clear format, such as PowerPoints, handouts and session guides)[59]; and easy-to-navigate website of ACON's Anti-Violence Project for LGBT communities in Australia[60].

  Examples of innovative formats include a: body mapping tool for transgender people in Bolivia (used by the Red Nacional de Personas que Viven con VIH y Sida en Bolivia and suitable for people with different levels of literacy)[61]; animated video for transgender sex workers (developed by MPlus in Thailand)[62]; and e-empowerment forum for indoors-based sex workers (by the Indoors Project in Europe)[63].

3.3. Gaps in resources

Again looking across the four key populations, the project also identified a number of common gaps or areas of under-development in training and programming resources on GBV. The extent of these varies according to the population. However, in terms of the **types of resources,** they include resources that:

- Support **practical and participatory capacity building** on GBV against key populations, such as facilitators' guides, session plans and group activities.
- Provide **step-by-step program tools** (such planning guides, indicators and budgeting tools) to develop and implement interventions to respond to GBV against key populations.
- Are demonstrably based on the **assessed needs** of key populations and have been developed by and for such community members.
- Facilitate connection of key population programs to **wider GBV services**, such as through referral systems or the training of GBV services to be 'key population-inclusive'.
- Target **people associated with key populations**, including those that carry out or facilitate GBV or that may, themselves, be survivors of GBV. For example, while many resources promote work with sex workers and the police, relatively few target clients, pimps, intimate partners or other family members, including children.
- Make maximum use of **new technologies** (such as mobile phone apps) that, in some contexts, are proving successful in other areas of programming with key populations.

Likewise, a number of **subject areas** also seem to be gaps or under-addressed in the identified resources. Once more, the extent varies according to the population. However, overall, they include resources that address:

- **The structural factors** (such as the legal and policy environment and socio-cultural norms) that limit action on GBV and/or support to key populations.
- **A broad understanding of GBV** that, in particular, includes: IPV (alongside GBV carried out by others, such as the police and sex work clients); and the non-physical dimensions of violence (such as the impact on mental health).
- **The intersection and overlap of different risk factors related to GBV,** such as in the case of an MSM who is young, sells sex and is living with HIV.
- **Male experiences of GBV and involvement in responses to GBV.**
- **How to respond to the 'gender dimensions' of GBV** – in terms of not only preventing and addressing incidents of violence, but taking action on the gender norms and practices that 'facilitate' GBV in the first place. Many resources – such as handbooks for sex workers – offer practical tips (such as how to work in safer locations), but do not address the underlying issues, such as power inequities between men and women or between mainstream communities and gender/sexual minorities.
- **GBV against specific types of key populations,** including those that are especially marginalized and/or at risk. Examples include: male sex workers; transgender sex workers; MSM from ethnic minorities; young transgender people; and women who inject drugs who are in closed settings, such as prisons and rehabilitation or 'reform' centers.
- **How to support workers and volunteers on the frontline of GBV-related services for key populations,** such as peer educators and counselors.

SECTION 4: CROSS-CUTTING FINDINGS – FRAMING RESPONSES TO GBV AGAINST KEY POPULATIONS

This Section builds on Section 3 – and the resources identified in the *Annotated Bibliography* - to explore the cross-cutting findings about how to frame and develop responses to GBV against the four key populations.

4.1. Principles for responses to GBV

The *Review of Resources* highlighted that responses to GBV against key populations are not only about *what* is done (the interventions), but *how* (the principles). Within the sensitive and complex subject of GBV, it is more important than ever that action is based on the established **good practice principles** of programming by and for key populations. Examples of such principles include: using a rights-based approach; being evidence-based; 'doing no harm'; and enacting 'nothing about us without us' (ensuring that key populations are – in a meaningful, not tokenistic way - central to all stages of responses to GBV, including the design, implementation and evaluation of programs).

Responses to GBV should also be based upon the extensive lessons about **'what works'** in programming for key populations, especially those learned through responses to HIV. Examples include empowerment, collectivization and peer-led approaches. They also include the use of innovative methods and new technologies, some of which – such as short message services (SMS) messaging – have been seen to be effective with groups such as young sex workers in Asia Pacific[64].

Of critical importance, responses to GBV must be **specific to the individual (and their personal circumstances) and population** in question, for example being tailor made to address the needs of transgender people, rather than treating MSM and transgender people as a combined group. A further example is understanding the different identities and needs of male sex workers who, for example, might – but also might not – identify as MSM. Action must also, where possible, respond to the **specific demographics** of different members *within* key populations. For example, this includes responding to the needs of *male* sex workers, *women* injecting drugs users, *feminine-identifying* MSM and transgender *men*.

Responses must not only target key populations themselves, but also the **people around them** – such as intimate partners, family members, friends, community members, the police and health providers – who may commit or facilitate GBV or, themselves, be survivors of violence. This is particularly important when there is a nexus between such people, such as when members of the police are both law enforcers and the clients of sex workers – a situation that risks those that carry out GBV experiencing impunity. Specifically, there is an opportunity to build on the work that has already been carried out by some research institutions and agencies to encourage **male involvement** in responses to violence against women[65]. For example, while the *Review of Resources* found multiple resources targeting sex workers and the police, few were found that address sex workers' clients or intimate partners.

4.2. Understanding multiple risk factors for GBV

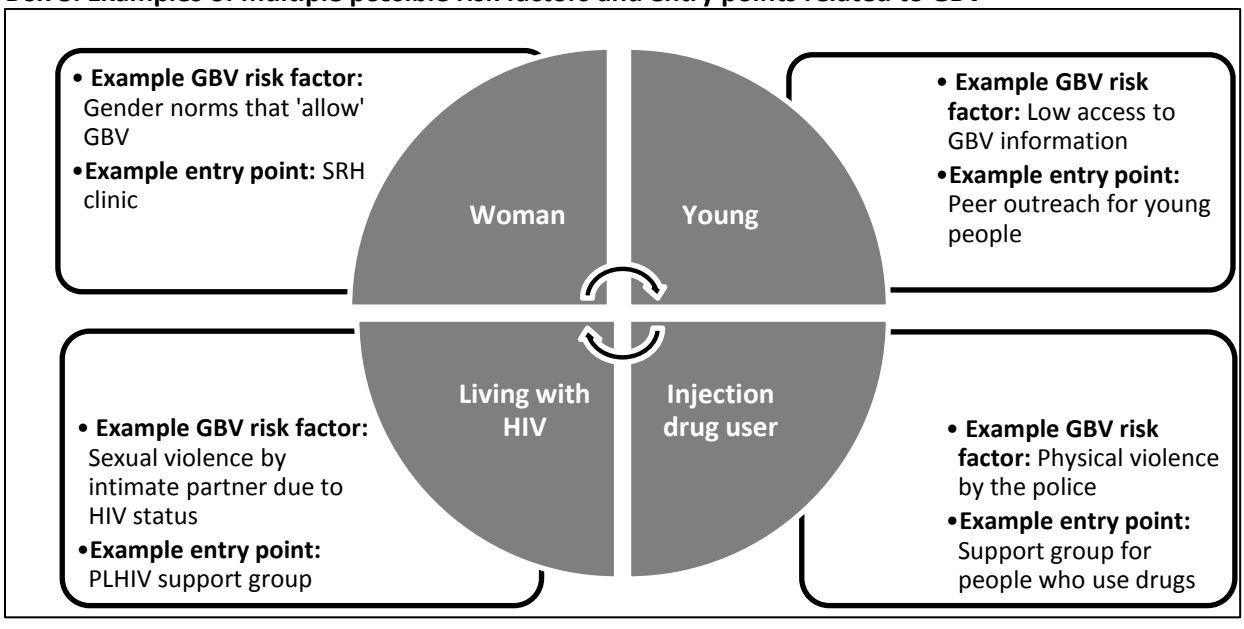
The *Review of Resources* confirmed that a focus on *gender*-based violence can be highly strategic – both programmatically and politically - in programs for and by key populations.

However, the Review also found that, in practice, it is often difficult to differentiate the (root) causes of incidents of violence against such communities. For example, if a woman who injects drugs is physically abused by the police, it is not necessarily clear the extent to which the incident is or is not related to gender. As such, while it is important to explore the 'gender factors' that influence violence – in particular in order to identify how best to respond – it is critical to address ***all* forms of violence** against key populations. Every incident is an abuse and a violation of human rights, whether it is fully or partially related to gender.

To develop a response, it is also vital to have a full and nuanced understanding of key populations' multiple – and often complex and overlapping – possible **risk factors related to GBV**. Box 8 illustrates a schematic example of someone who is: a woman; young; an injection drug user; and living with HIV. Each of these aspects of her life can bring different types and levels of risks in relation to GBV, as well as other health outcomes (such for SRH) and socio-economic status (such as related to poverty and education). However, as also illustrated, each aspect can also bring different types and levels of **entry points** - opportunities to reach, engage with and support her. For example, as an injection drug user, she might be part of a support group for people who use drugs that has trained peer educators who could provide support on GBV and mobilize against incidents of violence. Of note, the 'living with HIV' aspect of the life of the woman featured in Box 8 highlights specific cross-cutting risks and opportunities (as further described in Section 2.3). While this project did not focus on PLHIV as a key population, there is significant potential for collaboration and mutual learning with the work currently taking place on the connections between, and responses to, GBV and HIV, especially in relation to women living with HIV[66].

Box 8 is based on the types of community members and possible risk factors identified by the Project Partners and seen in some of the *Annotated Bibliography's* resources. It is vital to note that, in practice, a real person is less 'compartmentalized' than that depicted in the schematic example – with the young woman's life feeling very different to the 'labels' assigned to her. Also, her everyday life, including her experiences related to GBV, may actually be more affected by other factors (such as her economic situation) than the risks cited in the diagram.

Box 8: Examples of multiple possible risk factors and entry points related to GBV



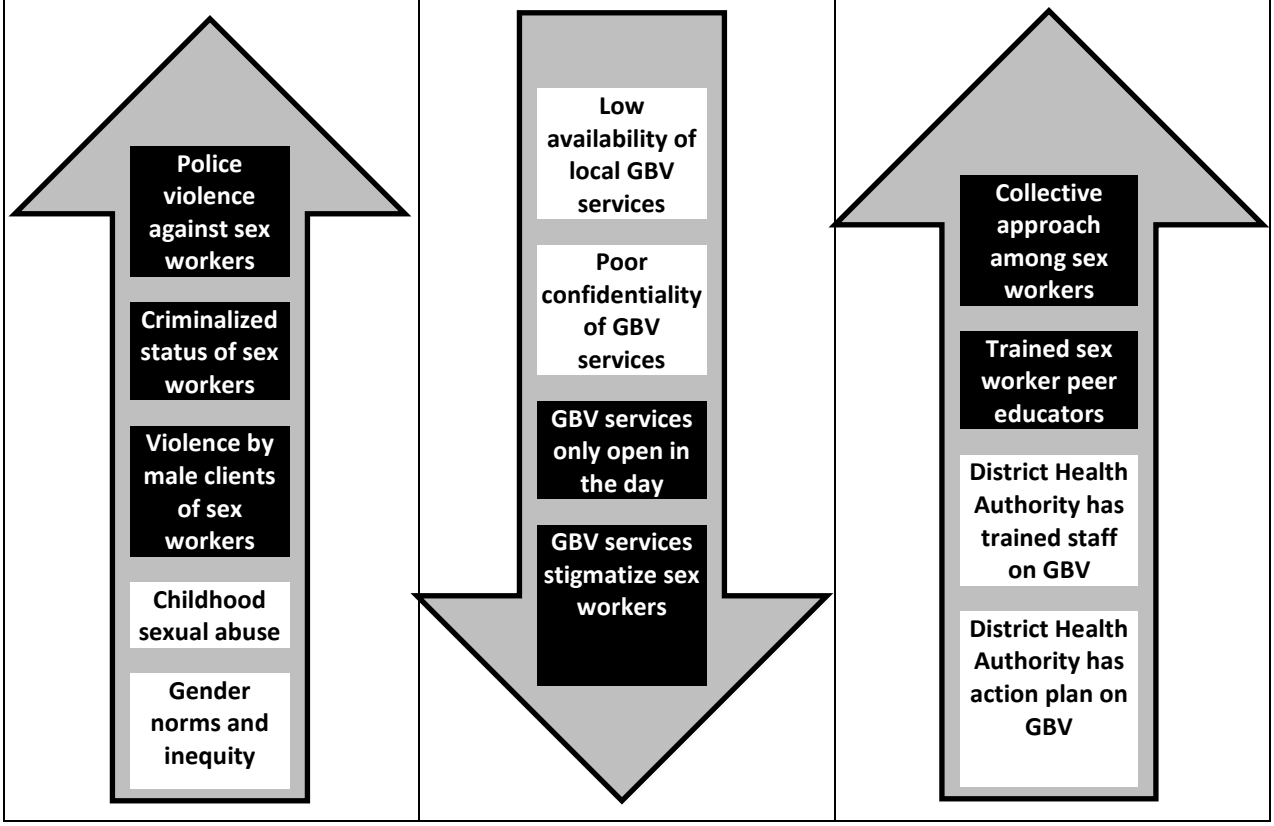
4.3. Understanding the impact of risk factors related to GBV

It is also vital to understand the (negative and positive) impacts of the different factors experienced by key populations and how these may differ from other community members. As shown in Box 9 – which uses the theoretical example of Sunita, a female sex worker in India - different impacts can be seen in relation to a person's: risk of GBV; access to GBV services; and potential to respond to GBV.

Box 9: Example of impacts of risk and opportunity factors for an individual

Sunita is a sex worker in India. As a female member of the local community, she experiences a range of factors that impact on her risk factors for GBV, access to GBV services and potential to respond to GBV. Examples of these are written in **black** in the arrows below. However, as a sex worker, Sunita experiences a range of *additional* factors that may increase or decrease her risk, access and potential to respond. Examples of these are written in **white**.

A. Risk factors for GBV	B. Access to GBV services	C. Potential to respond to GBV
As a woman, Sunita may experience factors - such as harmful gender norms - that, like any female in her community, put her at risk of GBV. However, as a sex worker, her risk may be *higher* because she also experiences violence by the police.	As a woman, Sunita may experience factors - such as the low availability of local GBV services – that reduce her access to GBV-related support. However, as a sex worker, her access may be *further* reduced because the GBV services that exist stigmatize her.	As woman, Sunita may benefit from her District Health Authority having an action plan to respond to GBV. In *addition*, as a sex worker, she may also benefit from being a member of a collective that takes a peer education and empowerment approach to action on GBV.

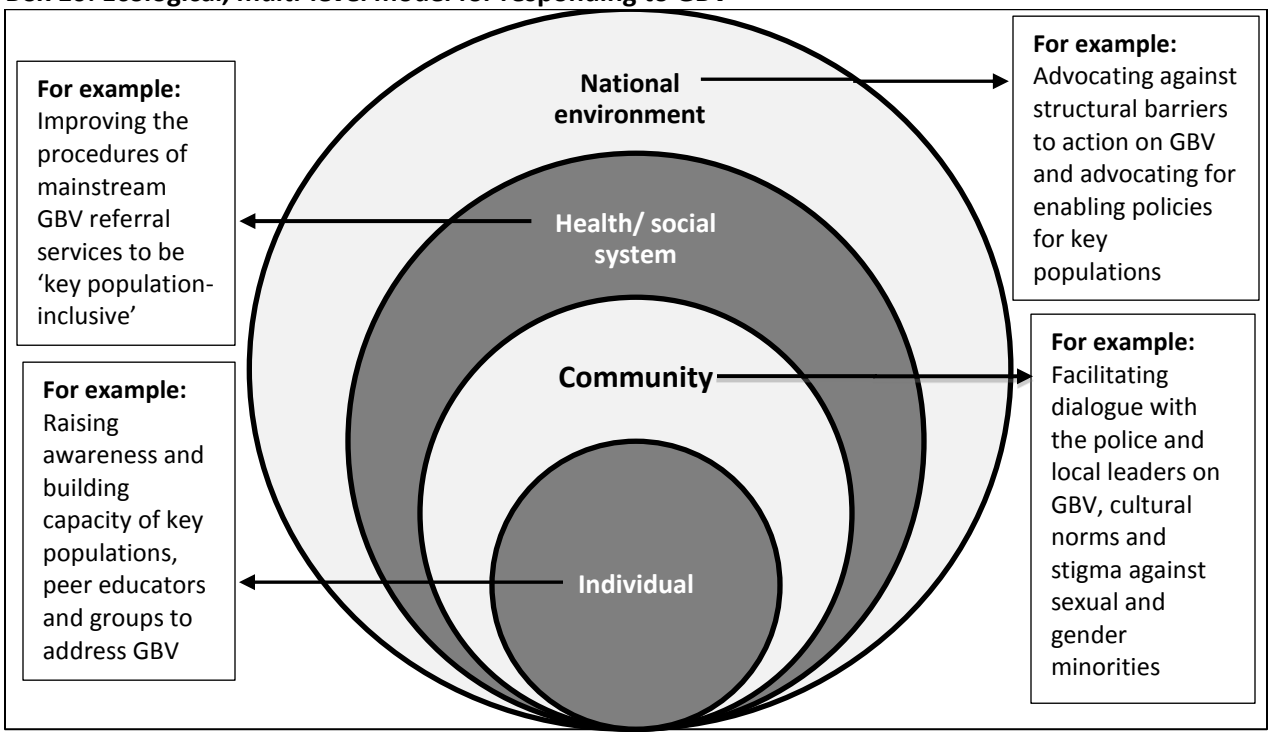


4.4. Framing responses

The *Review of Resources* confirmed that capacity building for and by key populations is critical to responses to GBV. In turn, appropriate and high quality training and programming resources play a vital role. The project also found, however, that, before the adaptation, replication or scale-up of such resources, there is a need to reflect on the most appropriate model of response to GBV.

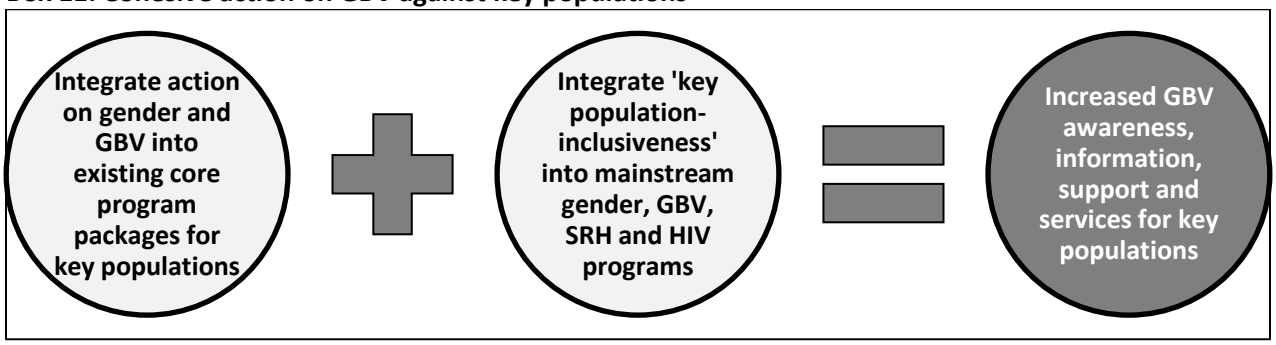
Many of the most useful resources identified in the *Annotated Bibliography* utilize an **ecological model** – one that, as seen in Box 10, conceptualizes a multi-level approach. Vitally, this model includes addressing the **structural barriers** to effective support for key populations, including in relation to GBV. This emerged as one of the strongest messages throughout the *Review of Resources*: that training and programming will only ever have a limited impact if critical barriers, such as oppressive legislation and discriminatory policies, continue to violate the rights of key populations. A clear example is drugs laws that, in many countries, pose a major barrier to the rights of and evidence-based programs for PWID. It is critical to look at how individual laws, such as against human trafficking, can have (sometimes unintentionally) negative impacts, such as forcing sex workers underground where they may be at greater risk of violence. It is also critical to address how different laws inter-sect with – or, sometimes, contradict - each other. For example, the benefits of positive legislation on violence against women may be counter-acted by negative legislation that criminalizes the behavior of women who inject drugs or fails to give legal recognition to transgender women.

Box 10: Ecological, multi-level model for responding to GBV



Within an ecological response to GBV against key populations, it is important that support is **cohesive.** As shown in Box 11, this involves a two-pronged approach of: integrating action on gender and GBV into existing program packages for key populations; and integrating 'key population-inclusiveness' into mainstream gender, GBV, SRH and HIV programs. The balance between the two prongs will depend on the local context, such as the legal status of key populations (and, hence, whether mainstream GBV services are even permitted to provide services to them). Combined, these approaches can add up to increased GBV awareness, information, support and services for key populations.

Box 11: Cohesive action on GBV against key populations



In terms of the first prong in the cohesive approach, the *Annotated Bibliography* clearly demonstrated that there is no need to 'start from scratch'. As shown by the **multiple 'snapshot' examples** provided in Box 12 (taken from resources listed and described in the *Bibliography*) many programs throughout the world are already integrating action – in different ways, to different extents and to different levels of success - on one or more of the key components of a comprehensive response to GBV (1. Prevention, 2. Protection, 3. Accountability – see Box 3).

It should be noted that many of the examples cited in Box 12 have not undergone systematic evaluation and, as such, do not necessarily represent proven good practice. Furthermore each needs to be considered within the specific local context as well as the factors affecting the lives of individual members of the key populations. However, the examples provide useful ideas of the types of responses that groups might consider.

In terms of the second prong in the cohesive approach, the *Annotated Bibliography* indicated that there are fewer resources to support work by mainstream services. However, some of the resources that exist provide good ideas and tools for how, for example, to support mainstream IPV services to become welcoming of, and provide appropriate services for, LGBT community members.

4.5. 'Getting started' on responses

The *Review of Resources* indicated that, despite understanding the critical importance of the subject, many organizations by and/or for key populations feel a sense of nervousness or lack of clarity about 'where to start'. This appears to be due to many different reasons, including the critical need to 'do no harm' and ensure that action does not make the lives of key populations *worse* rather than better.

However, the *Review* also showed that there is strong potential to support such organizations to **'get going'** on integrating at least a degree of action on GBV into their work. For example, the core packages for key populations promoted by normative agencies - such as USAID, UNAIDS and WHO - could be used as the basis of tools that give ideas for what action on GBV looks like in practice. Organizations could be supported to understand the options that are available to them and the different implications, such as in terms of time, skills and funding. Recommendation 6 in Section 6 provides an example of what such a tool could look like for programs for MSM. It gives options along a **'GBV transformative scale'**. This is based on the same approach used in 'gender transformative' programming – providing a range of options and activities, from ones that are 'GBV sensitive' (such as just acknowledging and raising awareness about GBV) to ones that 'GBV transformative' (such as that actually change social patterns and reduce risk factors related to GBV).

An important issue for organizations to consider is that different options bring not only different levels of opportunity, but **responsibility**. For example, it is vital that groups do not get in 'too deep, too quick' – raising issues and expectations related to GBV before they can provide adequate services, either themselves or through referrals. In particular, there is a need to ensure that organizations can support those who work on the front-line of GBV-related work, such as by providing counseling and mentoring for peer educators.

Developing these kind of tools – which serve as 'menus' of options – would be of enormous help to the key population groups struggling to identify 'what to do' in relation to GBV. They also present a practical opportunity to maximize the extensive experience and skills of PEPFAR, the Alliance and key population networks - in terms of building on what has already been learned in other fields (notably HIV) to strengthen the response to GBV.

Box 12: 'Snapshot' examples of practical responses to GBV against key populations

Core component 1: Prevention

Sex workers:

- In Canada, Chez Stella supports sex workers to be in control of their situation, including dealing with aggressive clients[67].
- In Cambodia, partner organizations have developed a Code of Conduct for beer promoters to protect the health and safety of 'beer girls'[68].
- In Nepal, SAATHI raises awareness among sex workers through street dance and drama about GBV[69].
- In the UK, Netherlands and USA, groups have developed 'Ugly Mug', 'Bad Date' and buddy schemes to protect sex workers from dangerous clients[70].
- In India, Sampada Grameen Mahila Sanstha addresses GBV through sex worker collectives and peer education in red light areas and on the streets[71].
- In Bangladesh, Durjoy Nari Sangha mobilizes sex workers, clients, police, religious leaders and male community members to address GBV[72].
- In India, Karnataka Health Promotion Trust uses Stepping Stones to support sex workers to talk openly about different types of violence[73].
- In Portugal, Medicin du Mundo developed a manual for sex workers with tips about self-defense and how to avoid violence[74].
- In Europe, the Indoor Project provides booklets and e-empowerment forums for indoor-based sex workers to support themselves to prevent GBV[75].
- In Canada, Community Initiative for Health and Safety has developed guides for sex workers' clients to prevent GBV[76].
- In Bangladesh, Protirodh runs community watchdog committees (with shop owners, guards, etc.) who alert sex workers and raise public awareness[77].
- In Hong Kong, JJJ Association and Zi Teng encourage sex workers to support each other, install security cameras and develop panic alarm systems[78].
- In New Zealand, the Scarlet Alliance and partners raise awareness among the employers of sex workers as to their responsibility to prevent GBV[79].
- In South Africa, the Sex Worker Education and Advocacy Task Force developed a handbook for sex workers on how to get out of dangerous situations[80].
- The UK Network of Sex Worker Projects provides sex workers with advice on preventing GBV in work contexts, such as home, hotels and online[81].

MSM:

- In Australia, ACON provides MSM with information on remaining safe, including how to avoid IPV[82].
- In Russia, New Life provides MSM with safe spaces to access information, services and counseling without fear of violence[83].
- In Jamaica, Communication for Change integrates GBV into peer programs for MSM, using tools such as 'Mapping a Day in the Life' to identify risks[84].
- In the US, the Anti-Violence Project operates a Safe Nights and Safe Bar program to protect LGBT people from violence in urban areas[85].
- In the US, the GLBTQ Domestic Violence Project provides safety planning tips, leadership development and safety festivals for LGBT communities[86].
- In Cambodia, local organizations do training and discussions for MSM to address stigma as an entry point to preventing GBV[87].

Transgender people:

- In Peru, Asociación de Trabajadoras Sexuales Miluska Vida y Dignidad provides GBV peer education and training by and for transgender people[88].
- In El Salvador, Solidarity Association to Promote Human Development includes GBV prevention in outreach/a drop-in centre for transgender people[89].
- In the US, the Urban Coalition for HIV/AIDS Prevention Services includes training on IPV in its HIV prevention programs for transgender people[90].
- The Southern Africa HIV/AIDS Information Dissemination Service gives information to transgender people about identifying IPV and preventing abuse[91].
- The Asia Pacific Network of Sex Workers provides a handbook to support transgender women, including tips for safe sex work[92].

PWID:

- In Indonesia, the STIGMA Foundation empowers PWID to live safer lives through organizing, advocacy and networking.[93]
- In Lebanon, Soins Infirmiers et Développement Communautaire has PWID peer workers who discuss violence and offer counseling on prevention.[94]
- In the US, Project Connect provides women who inject drugs with couple counseling, safety planning and skills to assess levels of danger[95].
- In India, Social Awareness Service Organization combines a drop-in center with community support for women who inject drugs to prevent GBV[96].

Core component 2: Protection

Sex workers:

- In India, Ashadya has a rapid response team for incidents of GBV against sex workers, with counseling, medical care and psycho-social support[97].
- In Eastern Europe and Central Asia, Women against Violence Europe offers advice on GBV referral system/monitoring mechanisms for sex workers[98].
- In India, AVAHAN developed a crisis response system, including emergency services and counseling, for the community to respond to incidents of GBV[99].
- In India, Sampada Gramin Mahila Sanstha provides safe spaces for survivors of GBV and has a social worker to offer support and counseling at hospitals[100].
- In Bangladesh, Durjoy Nari Sangha addresses the barriers to sex workers reporting violence and has a toolkit for case management of survivors[101].
- In South Africa, the Desmond Tutu AIDS Foundation does screening to identify survivors and supports health facilities to be 'sex worker-inclusive'[102].
- In New Zealand, the Scarlet Alliance and partners take sex workers through the procedure of how to make a complaint about an incident of GBV[103].
- In Lebanon, Soins Infirmiers et Développement Communautaire makes direct interventions and mediates in incidents of GBV against sex workers[104].
- In Scotland, Roam Outreach enables sex workers to do remote reporting of incidents of GBV through e-mail or the phone[105].
- In Hungary, a local group provides a handbook to support sex worker survivors of GBV through mental health and post-traumatic stress counseling[106].

MSM:

- In India, Avahan has set up community-based crisis response teams and documents incidents of GBV, including against MSM[107].
- In Australia, ACON has an LGBT guide on what to do if they experience IPV, how to recover, how to support friends and where to find services[108].
- In the UK, the National Health Service developed a booklet for MSM on identifying abuse and getting help[109].
- In Thailand, MPlus and ThaiLadyBoyz.net use social networking and messaging to address stigma and support survivors of GBV[110].
- In the US, the Anti-Violence Project developed an MSM survivors' handbook including a checklist of signs of abuse and a leaflet on IPV[111].
- In Mexico and Thailand, AIDSTAR-One worked with local groups to develop a kit for government health providers to screen for GBV against MSM[112].
- In the US, the GLBTQ Domestic Violence Project has a 24 hour helpline for survivors of GBV and provides advice, such as on filing restraining orders[113].
- In India, Solidarity and Action against the HIV Infection in India provides a phone and e-mail helpline for MSM survivors of GBV[114].

Transgender people:

- In Mexico and Thailand, groups developed tools for health providers to develop GBV referral systems and client safety plans for transgender people[115].
- In South Africa, Gender Dynamix provides a handbook for transgender people on GBV survivor best practice and tips for interacting with the police[116].
- In Thailand, MPlus provides transgender sex workers with information about their rights and what to do if they are assaulted[117].
- The Southern Africa HIV/AIDS Information Dissemination Service gives transgender people tips about reporting violence and a list of services[118].
- The Bolivian Network of People Living with HIV uses body mapping activities for transgender survivors of GBV to articulate their experiences[119].
- In the US, The Network/La Red supports mainstream IPV services to be 'LGBT-inclusive'[120].

PWID:

- In Indonesia, the STIGMA Foundation combines HIV prevention/needle exchange services with referral to GBV services and intervening in cases of harm[121].
- In Eastern Europe and Central Asia, the Eurasian Harm Reduction Network provides a tool for project workers to identify PWID survivors of GBV[122].
- In Lebanon, Soins Infirmiers et Développement Communautaire has a GBV referral system - with 52 other organizations - for PWID survivors of GBV[123].
- In India, Project ORCHID set up a community-led crisis response system, including counseling for PWID and conflict resolution for communities[124].
- In Russia, Humanitarian Action provides counseling and a shelter for women who inject drugs who are survivors of violence[125].
- In India, the Social Awareness Service Organization has a night shelter and short-stay home for women who inject drugs or are the partners of PWID[126].

Core component 3: Accountability
Sex workers: • In Thailand, Service Workers in Group provides sex workers with legal aid to take legal action on GBV and claim their rights[127]. • In Papua New Guinea, groups provide a comic book and train peer educators in the police to address structural issues on GBV against sex workers[128]. • In India, Sampada Gramin Mahila Sanstha carries out advocacy to local communities, leaders and health services to address GBV against sex workers[129]. • In Cambodia, groups held consultations between business stakeholders, government and unions to plan action on the risk factors of sex workers[130]. • In Bangladesh, Durjoy Nari Sangha works with the judiciary to increase its understanding of, and response to, GBV against sex workers[131]. • In Cambodia, PRASIT runs a SMARTgirl/MStyle program that addresses harmful gender norms that contribute to GBV against sex workers[132]. • In Fiji, Survival Advocacy Network provides sex workers with access to legal redress following incidents of GBV[133]. • In South Africa, the Sex Worker Education and Advocacy Task Force carries out 'know your rights' work with sex workers[134]. • In India, a program in Karnataka State advocates on structural issues related to GBV with the police, government, lawyers and the media[135]. • In Bangladesh, Protirodh supports sex workers to engage in advocacy on GBV at the district and national levels[136].
MSM: • In South Africa, OUT LGBT Well-Being developed minimum standards for GBV services, including on GBV, and supports MSM to take legal action on IPV[137]. • In India, Pehchan raises awareness on the types/breadth of GBV against MSM, transgender people and hijras[138] to inform advocacy with policy-makers[139]. • In the USA, Community United against Violence issues an annual report on hate crime and IPV against MSM, such as for use in advocacy work[140]. • In Nicaragua, Centro para la Prevencióny Educación del SIDA does medical/social media work to change perceptions about masculinity and sexuality[141]. • In Australia, ACON provides advice for the providers of mainstream health services to become 'LGBT-inclusive', including in relation to GBV[142].
Transgender people: • In Thailand, MPlus provides transgender sex workers with information about how to access free local legal counseling services[143]. • In India, Pechan uses a training module on GBV to raise awareness among local stakeholders and inform advocacy and policy work for transgender people[144]. • In Europe, the International Lesbian and Gay Association supports the training of police officers to address transphobic violence[145]. • In El Salvador, Solidarity Association to Promote Human Development advocates to the government and takes GBV survivors to the Human Rights Office[146]. • Solidarity and Action against the HIV Infection in India runs an advocacy coalition (including sexual minorities) to address violence and promote rights[147].
PWID: • In Indonesia, the STIGMA Foundation provides PWID with access to legal services, including in relation to incidents of GBV.[148] • In India, Avahan builds relations with the media and increases the public's positive perception of PWID and understanding about GBV[149]. • In Lebanon, Soins Infirmiers et Développement Communautaire does legal review and research to address GBV structural barriers and support PWID[150]. • In India, Project ORCHID trains PWID on their legal rights related to GBV and networks with lawyers to support PWID in negotiations with the authorities[151]. • In Russia, Humanitarian Action provides legal aid to PWID, including survivors of violence[152].

SECTION 5: CONCLUSIONS

This Section draws the 'top 10' conclusions from the findings of the *Review of Resources on Gender-Based Violence against Key Populations*.

1. Every incident of violence against key populations is an **abuse and a violation of human rights**. However, ***gendered* violence** affecting individuals in such communities remains particularly under-addressed. Gender lies at the heart of many of the most significant issues that have shaped HIV epidemics. These include those – such as homophobia, transphobia and narrow norms about how a 'male' or 'female' is expected to identify and behave – that reflect entrenched prejudice and poor acceptance of 'difference' (such as in sexual practices or gender identity). The circumstances and behaviors associated with key populations' heightened risk of HIV – such as social stigma, power imbalances and lack of access to resources – are often the same as those that heighten risk of GBV.

2. The impact of training and programming on GBV against key populations will only ever be limited while **structural barriers** – that restrict and oppress the daily lives of key populations and provide 'impunity' for those that commit violence against them – remain in place. Examples include: laws that criminalize sex work, drug use and same-sex relationships; policies that deny transgender people their gender identity (and, hence, make them 'invisible'); oppressive drug policies; and protocols that discriminate against key populations, such as in health services. Advocacy to remove such barriers is not an 'optional extra', but essential component, of responses to GBV.

3. With the training and programming resources on GBV against key populations available today, there is **no need to start from scratch**. Significant work has already been done, notably by groups by and/or for key populations 'on the ground'. There are many, useful existing resources, the characteristics of which include that:

    - By far the largest **number** of resources (111) are relevant to sex workers, while 40 relate to MSM, 41 to transgender people and 39 to PWID. The numbers for MSM and transgender people are lower without including resources for 'general' LGBT communities.
    - Common **strengths** include resources that: use a rights-based/empowerment approach; are developed by and for key populations; and integrate action on GBV into wider programs.
    - Common **weaknesses** include resources that: lack an evidence base; and are not user-friendly.
    - Common **gaps** include that resources do not: provide step-by-step guidance/tools for training and programming; address sub-groups of key populations (such as male sex workers and transgender men); address the intersection of key populations' risk factors; use a broad definition of GBV and address the 'gender factors' behind it (such as power inequalities); and address the 'how to' of challenging the inequality brought by discriminatory laws and policies.

4. While numerous, the majority of the existing resources on GBV against key populations (such as case studies and policy reports) are **not 'true' training and programming materials**. They can be used to *inform* such work. However, overall, there are few ready-made packages that could be immediately scaled-up or replicated, especially in diverse contexts that, for example, provide challenging legal environments for key populations.

5. There are many **cross-cutting issues** related to training and programming on GBV against key populations. Examples include the need for tools to support situational analyses and the integration of attention to GBV in the work of peer educators. In such areas, there is great potential for high quality resources to be shared and transferred across communities.

However, the sensitive and complex nature of GBV also requires **tailor-made approaches for individual key populations, based on a 'know your (HIV and GBV) epidemic' approach**. For example, specific programs are essential for transgender people (rather than combining them with MSM). Also, further specificity is needed *within* key populations, such as to support transgender people who are young, involved in sex work or in physical transition to their gender. In some cases, it is also necessary to achieve conceptual shifts in order to understand, and effectively respond to, GBV against specific key populations. For example, it is necessary to move from a perception of sex work as being 'inherently violent' to action that is focused on addressing the violence that sex workers are subjected to while doing their work.

6. **Practical GBV training and capacity building** by and for key populations are critical and represent an important investment. In practice, however, due to many different reasons, many groups are currently struggling with 'what to do' and 'how to get started'.

7. There is a need to reflect on the most appropriate **model of response** to GBV against key populations. This involves:

    - Understanding and addressing the often **multiple risk factors** related to GBV and other forms of violence experienced by members of key populations.
    - Using an **ecological model**, with action at multiple levels (from individual members of key populations to the national environment).
    - Being **comprehensive**, with action on all of the key components of a response to GBV (1. Prevention, 2. Protection, 3. Accountability).
    - Providing **cohesive support** – combining the integration of GBV into program packages for key populations with ensuring that mainstream GBV services are 'key population-inclusive'.
    - Supporting members of key populations, but also targeting **people associated with key populations** who may carry out or facilitate GBV or may, themselves, be survivors of GBV. Examples include: intimate partners; family members (including children); the police; community members; and clients (for sex workers).

8. Significantly greater action is needed on GBV against key populations. However, responses should not be stand-alone, but **integrated into existing program packages for key populations** - such as on gender and HIV – that are based on years of lessons learned and good practice, such as in the response to HIV. Within such packages, organizations can be offered a spectrum of options to pursue, from actions that are 'GBV sensitive' to ones that are 'GBV transformative'. Each option has different implications, such as for the required skills, funding, referrals and responsibility.

9. Responding to GBV against key populations is not just about *what* you do (the interventions), but *how* you do it (**the principles**). The latter is essential for effective responses and requires practices - such as rights-based, 'do no harm', 'nothing about us, without us', participatory and evidence-based approaches – that, once more, have been developed through years of programming by and for key populations, such as in relation to HIV.

10. GBV against key populations has received an unacceptably **low profile in global advocacy and policy forums**. However, the global momentum for action on violence against women presents an opportunity to recognize such communities' heightened risk factors and specific needs and to secure relevant commitments for action not only for women, but for key populations as well.

SECTION 6: RECOMMENDATIONS

This Section includes seven key recommendations based on the findings and conclusions of the *Review of Resources on Gender-Based Violence against Key Populations*. They are for action by PEPFAR and USAID and to inform the future work of other key stakeholders.

Based on the *Review of Resources*, a number of key recommendations can be made to PEPFAR and USAID. The recommendations can also be easily adapted to inform the programs and policies of other relevant agencies and organizations, such as the Alliance and key population networks and their partners, as well as donors and multi-lateral agencies.

Recommendation 1: Within PEPFAR and USAID's own program work and partnerships, use the findings of the *Review of Resources* to strengthen: the integration of attention to GBV into all existing HIV and SRH core program packages for sex workers, MSM, transgender people and PWID; a systems-wide approach to ensuring 'key population inclusive' GBV services, including those within mainstream health systems; and the development of enabling environments for successful responses to GBV against key populations, including through the removal of structural barriers.

The *Review of Resources* identified that there is significant potential for PEPFAR and USAID to play a leading role in developing, supporting and implementing high quality and effective responses to GBV against key populations. It is recommended that PEPFAR and USAID ensure:

- **The integration of attention to GBV into all existing HIV and SRH core program packages for sex workers, MSM, transgender people and PWID** – and, in turn, encourage and support program partners to identify and implement appropriate interventions.
- **A systems-wide approach to ensuring 'key population inclusive' GBV services, including those within mainstream health systems** – to ensure that the required attitudes, capacities and systems are in place to be inclusive of key populations and responsive to their needs.
- **The development of enabling environments for successful responses to GBV against key populations, including through the removal of structural barriers** – such as oppressive laws and policies – to the rights and needs of such communities.

Recommendation 2: Ensure that any response to GBV is based on the existing lessons learned, good practices and principles – such as human rights-based, 'do no harm' and 'nothing about us without us'/participation approaches - of programs by and for key populations.

The *Review of Resources* identified that responding to GBV against key populations is not just about *what* you do (the training and programming interventions), but *how* you do it. It is recommended that PEPFAR and USAID ensure that any response to GBV fulfils the good practices and principles that are widely promoted for programs by and for key populations, such as in response to HIV. Box 13 provides ten examples of such principles, based on the indications of good practice identified through the *Review* process.

Box 13: Examples of good practices and principles for responses to GBV against key populations

1. **Use a rights-based approach:** Recognizing that *any* incident of GBV is a violation of human rights and that *any* person has the right to health and a life free from violence.
2. **Base action on evidence:** Understanding and responding to the real risks, needs and opportunities of key populations in their specific context and maximizing proven examples of successful actions.

3. **Meaningfully involve key populations and do 'nothing about us without us':** Ensuring that key populations are – in a meaningful, not tokenistic way - central to all stages (including design, implementation and evaluation) of responses to GBV.
4. **'Do no harm':** Ensuring that action on GBV prioritizes the safety and well-being of key populations (and those that support them) and does not put them at *further* risk of stigma or violence.
5. **Maximize both 'what works' and innovation:** Using existing lessons and good practice from other fields - such as empowerment, collectivization and peer-led approaches – to address GBV against key populations. But also using innovative methods - such as SMS and social media - that are showing increasing potential among some key populations in some contexts.
6. **Be specific to the individual and the population:** Ensuring resources and programs are tailor made – addressing people's unique circumstances and, for example, the specific needs of: male sex workers; feminine-identifying MSM; and transgender people (rather than MSM/transgender people as a combined group).
7. **Address <u>all</u> forms of violence:** While better understanding and addressing the 'gender factors', ensuring action on *any* and *all* forms of violence against key populations.
8. **Work with people associated with key populations, including those that carry out or facilitate GBV:** Complementing support to key populations by also targeting those who are associated with them and that may carry out/facilitate GBV or, themselves, be survivors of GBV. Examples include: intimate partners; family members (including children); the police; community members; and clients (for sex workers).
9. **Work in partnership:** Identifying and building relationships with a range of 'allies' and organizations at all levels that can support responses to GBV against key populations.
10. **Document and learn:** Being open to learning from and improving responses to GBV through sharing lessons both within programs and among other stakeholders.

<u>Recommendation 3:</u> Ensure that, as a pre-requisite, any response to GBV against key populations is based on a thorough, nuanced understanding of the whole picture of an individual's life and context, including their real needs and their multiple risk factors, opportunities and entry points for action.

The *Review of Resources* identified that key populations often experience multiple types and levels of GBV-related risk factors that (as illustrated in Box 8 in Section 4) can be overlapping and, in combination, complex. For example, a sex worker might also be an MSM and/or injection drug user.

Key populations also, however, experience multiple opportunities, such as entry points through which they can engage and receive support in relation to GBV. It is recommended that - as a pre-requisite, rather than 'optional extra' - PEPFAR and USAID ensure that any response to GBV is informed by a thorough – and, vitally, participatory - assessment of the real risks, needs and opportunities of the specific key population in question. These should consider both the 'big picture' structural factors (such as laws and policies) that often affect key populations as a whole and also the everyday factors (such as social status, education and income level) that influence someone's daily life.

<u>Recommendation 4:</u> Ensure that any response to GBV against key populations is conceptualized, designed and implemented to be: ecological (multi-level); comprehensive (addressing all of 1. Prevention, 2. Protection and 3. Accountability); and cohesive (by both key population programs and mainstream GBV services). Responses should also: provide support to those – such as project staff and peer educators – that work on the frontline of GBV against key populations; and complement support to key populations by targeting people associated with such communities who may carry out or facilitate GBV or may, themselves, be survivors of GBV.

The *Review of Resources* identified the need for responses to GBV against key populations to be carefully and holistically conceptualized, designed and implemented. It is recommended that PEPFAR and USAID support action on GBV against key populations that:

- **Uses an ecological model** (see Box 10), with action at multiple levels (from individual members of key populations to the national environment).
- **Is comprehensive**, with action on all of the key components of a response to GBV: 1. Prevention, 2. Protection and 3. Accountability (see Box 3).
- **Provides cohesive support** (see Box 11), combining the integration of GBV into program packages for key populations with ensuring that mainstream GBV services are 'key population-inclusive'.
- Supports members of key populations, but also **targets** people associated with key populations who may: carry out or facilitate GBV; or, themselves, be survivors of GBV. Examples include: intimate partners; family members (including children); the police; community members; and clients (for sex workers).
- Provide **support (for example, counseling and mentoring)** to those, such as project staff and peer educators, on the frontline of addressing GBV against key populations.

<u>Recommendation 5:</u> Consolidate the global evidence base on the scale of GBV against each key population and the nature/efficacy of responses – by funding a systematic review by a recognized international research institution, in order to inform advocacy and programming.

The *Review of Resources* indicated a growing wealth of evidence about the scale and impact of GBV against key populations and the range of responses being implemented by organizations (see Box 12). However, this data results from a range of research methods and is of a mixed quality. This limits its use in advocacy and programming work. It is recommended that PEPFAR and USAID fund and support the implementation of a systematic review to both assess the existing data and identify any critical gaps in research. This should be carried out by a recognized international institution, such as Johns Hopkins University or the London School of Hygiene and Tropical Medicine, in collaboration with key population networks and experts. This should aim to ensure that, to the extent that is possible, the work is of comparable quality to the data currently available on violence against women[153].

This work should connect with existing research of direct relevance to this project. Examples include work on the: impacts of IPV on women (being implemented by the London School of Hygiene and Tropical Medicine, UK[154]); involvement of men in responses to GBV (by the Institute of Development Studies, UK[155]); GBV against women living with HIV (by the Salamander Trust, UK, and partners[156]); and violence-related safety and protection factors for sex workers (by the Asia Pacific Network of Sex Workers and partners[157]). Specific opportunities should be identified for exchange. For example, the evidence about action on GBV against key populations could be applied to other particularly challenging areas of work on GBV, such as support to male survivors of GBV. Equally, the evidence about how to address masculinity and engage men in responses to violence against women could be applied to work with, for example: men who inject drugs; men who assume 'masculine' identities or roles within MSM relationships; and transgender people living within cultures of 'machismo'.

<u>Recommendation 6:</u> Champion the specific and heightened risk factors, needs and opportunities of key populations – including those who are gender and/or sexuality minorities - within national, regional and global policy forums on GBV and violence against women, while also facilitating the direct involvement of affected communities in such initiatives. Also advocate to other donors on both the 'human value' and 'investment case' for funding responses to GBV against key populations.

The *Review of Resources* identified that, within the growing number of campaigns and initiatives on GBV and, in particular, violence against women, the specific and heightened issues of key populations are often neglected. It is recommended that PEPFAR and USAID build on their broad definition of GBV (see Box 2) to ensure explicit attention to GBV against gender and sexual minorities and women who are marginalized. This should involve championing the needs of and facilitating the direct involvement of key populations in relevant policy forums at national, regional and global level. In addition, the PEPFAR Gender TWG and USAID should use their position as global leaders to advocate to other donors on how responding to GBV is not only a critical component of any good practice program for key populations, but represents a sound investment of resources.

Recommendation 7: Invest strategically in action on GBV against key populations. Prioritize: advocacy by and for key populations to address structural barriers (such as oppressive laws and policies); capacity building of organizations by and for key populations; and capacity building of mainstream stakeholders who are key to the rights, safety and GBV services for key populations. Initially, the second priority should focus on the development of a set of core tools to enable groups to 'get started' – by integrating at least a degree of action on GBV into *any and all* existing program packages for key populations and making the best use of the identified training and programming resources.

The *Review of Resources* noted multiple areas related to GBV against key populations that would benefit from financial and technical investment. However, two areas were identified as priorities – recognizing the critical need to address structural barriers and to support organizations to 'get started'. It is recommended that, in particular, PEPFAR and USAID should invest in:

- **Advocacy by and for key populations at all levels** (national, regional and global) to address both the structural barriers (such as oppressive laws and policies) and socio-cultural barriers (such as stigma and power inequalities).
- **Capacity building of organizations by and for key populations**. Initially, this should focus on developing a set of core tools to support such groups to: 'get started' in responding to GBV (by identifying appropriate options and integrating at least a degree of action on GBV into *any and all* existing program packages for key populations); and make best use of the available training and programming resources. (See below for further details).
- **Capacity building of mainstream stakeholders**. Initially, this should focus on stakeholders who can be central to upholding the rights of key populations (such as the police and judiciary) and ensuring that mainstream GBV services (such as rape crisis centers) are inclusive.

The tools for capacity building of organizations by and for key populations should support such groups to: have conceptual clarity on GBV (such as what risks, discrimination and stigma different groups face, why and the implications); understand the entry points for action and the options available; make decisions about which entry points and options best suit their organization and context; understand the implications of their decisions (such as for skills, funding and responsibility); and access existing relevant resources to support their work. In turn, such tools should support organizations to include action on GBV in their strategic plans and funding proposals.

Box 14 presents an example of a tool to help organizations to 'get started'. The left hand column lists the six core components of an HIV prevention package for MSM, as recommended by PEPFAR[158]. Across each of the components, examples are given of actions on GBV that an organization could take along a **Gender Equality Continuum**[159]**.**

The Continuum is a PEPFAR tool that supports the development of programs to achieve gender equality and, in turn, better health and development outcomes. The continuum has three levels:

- **Exploitative gender programming:** Policies and programs that intentionally or unintentionally reinforce or take advantage of gender inequalities and stereotypes in pursuit of project outcome, or whose approach exacerbates inequalities. This approach is harmful and can undermine the objectives of the program in the long-run.
- **Accommodating gender programming:** Policies and programs that acknowledge, but work around, gender differences and inequalities to achieve project objectives. Although this approach may result in short-term benefits and realization of outcomes, it does not attempt to reduce gender inequality in the long-term or address the gender systems that contribute to the differences and inequalities.
- **Transformative gender programming:** Policies and programs that seek to transform gender relations in order to promote sustained equality and achieve program objectives. This approach attempts to promote gender equality by: 1. Fostering critical examination of inequalities and gender roles, norms and dynamics; 2. Recognizing and strengthening positive norms that support equality and an enabling environment; and 3. Promoting the relative position of women, girls and other marginalized groups (including gender and sexual minorities) and transforming the underlying social structures, policies and broadly-held social norms that perpetuate gender inequalities.

As seen in Box 14, the first level – exploitative gender programming - is not an appropriate option for responding to GBV against key populations. Meanwhile, the tool provides examples of accommodating and transformative gender programming actions. For each one, it gives examples of issues to consider and useful resources identified in the *Annotated Bibliography*. Organizations can select how many and what combination of activities they want to take and when – depending on their community, context and resources.

Box 14: Example of a tool to support organizations to 'get started' in responding to GBV against a key population

PEPFAR core HIV prevention package for MSM[160]	Options for programming on GBV - using the PEPFAR Gender Equality Continuum[161]		
	Exploitative gender programming	**Accommodating gender programming**	**Transformative gender programming**
1. Community-based outreach	**Not appropriate for responses to GBV against key populations – as they should fulfill the principle of 'do no harm'**	**Example action:** Use HIV prevention and anti-stigma outreach activities, including by peer educators, to raise GBV issues with MSM **Example issues to consider:** • Requires GBV training for outreach workers and peer educators • Needs supportive referral services to be available **Example of useful resource:** *Understanding and Challenging Stigma toward Men who have Sex with Men: A Toolkit for Action,* Phon Yut Sakara, Sam Eng, Phan Phorp Barmey, Margaret Reeves, Laura Nyblade, Amy Gregowski and Ross Kidd for USAID, ICRW and PACT Cambodia, 2010.	**Example action:** Set up a Community Action Team - involving MSM, the police and local leaders - to address stigma, cultivate violence prevention and take action on incidents of violence against MSM. **Example issues to consider:** • Requires sensitive coalition building and may raise local opposition • May need long-term financial and/or technical resources to sustain the Team **Example of useful resource:** *Community Led Crisis Response Systems: Detailed Guidelines: Best Practices Implementation Tools,* Avahan and Bill and Melinda Gates Foundation, India, 2013.
2. Distribution of condoms and condom-compatible lubricants		**Example action:** Include issues about GBV in discussions and workshops with MSM to identify the challenges to accessing and using condoms and lubricants. **Example issues to consider:** • Requires relevant staff to have training in GBV • May identify different GBV issues related to condom use with intimate partners, casual partners and sex work clients **Example of useful resource:** *HIV Communication for MSM, SWs and Peer Educators in Jamaica*, Communication for Change and USAID/PEPFAR, Jamaica, 2011.	**Example action:** Identify and address GBV factors within the development of safe and accessible condom services for MSM. **Example issues to consider:** • Requires relevant staff to have training in GBV • Risks deterring MSM from condom services if they are afraid of experiencing GBV **Example of useful resource:** *Developing a Comprehensive Package of Services to Reduce HIV among Men who have Sex with Men (MSM) and Transgender (TG) Populations in the Asia Pacific Region: Regional Consensus Meeting,* UNDP, ASEAN, WHO, USAID, UNAIDS, UNESCO and APCOM, 2009.
3. HIV counseling and testing		**Example action:** Use HIV counseling and testing activities as an opportunity to learn about the experiences and needs of MSM in relation to GBV. **Example issues to consider:** • Requires counseling and testing staff to be trained in GBV • Requires guidelines on what to do if MSM identify as GBV survivors **Example of useful resource:** *Follow the Voice of Life: HIV Prevention and Empowerment of Men who Have Sex With Men in Orenburg,* New Life, Russia, 2011.	**Example action:** Identify and address GBV factors within the development of safe and accessible HIV counseling and testing services for MSM, including couples. **Example issues to consider:** • Requires GBV training for relevant staff/referral organizations • Risks double stigma for MSM who are both living with HIV and survivors of GBV • Requires sensitivity to sero-discordant couples, as well as the complex range of romantic and sexual partnering practices of MSM **Example of useful resource:** *Developing a Comprehensive Package of Services to Reduce HIV among Men who have Sex with Men (MSM) and Transgender (TG) Populations in the Asia Pacific Region: Regional Consensus Meeting,* UNDP, ASEAN, WHO, USAID, UNAIDS, UNESCO and APCOM, 2009.

	Exploitative gender programming	Accommodating gender programming	Transformative gender programming
4. Active linkage to health care and antiretroviral treatment	**Not appropriate for responses to GBV against key populations – as they should fulfill the principle of 'do no harm'**	**Example action:** Identify local GBV services and include them in your organization's referral system for MSM. **Example issues to consider:** • May risk referring clients to non 'MSM-inclusive' services • May 'out' survivors of violence who already face stigma due to being MSM **Example of useful resource:** *More than Just HIV Prevention: Outreach to Most-at-Risk Populations through SIDC in Lebanon,* Soins Infirmiers et Développement Communautaire and AIDSTAR-One/USAID, Lebanon, 2011.	**Example action:** Build the capacity of GBV service providers to understand stigma and gender issues and develop minimum standards for 'MSM-inclusive' services. **Example issues to consider:** • May initially require strong advocacy to mainstream GBV services • May require follow-up to maintain quality and standards **Example of useful resource:** *Understanding the Challenges Facing Lesbian and Gay South Africans: Some Guidelines For Service Providers,* OUT LGBT Well-Being, South Africa.
5. Targeted information, education and communication (IEC)		**Example action:** Incorporate issues related to GBV (such as intimate partner violence) into existing HIV prevention materials for MSM. **Example issues to consider:** • May risk detracting from HIV messages if GBV issues are sensitive for MSM • Requires the organization to be prepared to offer further GBV support to clients **Example of useful resource:** Campaign posters and leaflets on intimate partner violence, *Anti-Violence Project*, ACON, Australia, 2013.	**Example action:** Carry out participatory research to understand the GBV risks and responses among MSM and use the evidence to re-design targeted IEC initiatives. **Example issues to consider:** • Requires a strongly ethical approach, especially in contexts where MSM are criminalized • May require the organization to have GBV research skills and expertise **Example of useful resource:** *My Body Is Not Mine: Stories of Violence and Tales of Hope: Voices from the Kothi Community in India,* Naz Foundation International and Centre for Media and Alternative Communication, India, 2007.
6. STI prevention, screening and treatment		**Example action:** Use STI and HIV services to provide a 'safe space' for MSM to discuss their experiences and needs in relation to GBV. **Example issues to consider:** • Requires STI staff (clinical and non-clinical) to have at least basic GBV training • Requires the organization to be prepared to offer further GBV support to clients **Example of useful resource:** *Follow the Voice of Life: HIV Prevention and Empowerment of Men who Have Sex With Men in Orenburg,* New Life, Russia, 2011.	**Example action:** Use STI/HIV services as an opportunity to 'screen' for MSM survivors of violence and ensure appropriate follow-up services for them. **Example issues to consider:** • Requires a strong, ethical screening process • May require significant investment in staff training and protocol development **Example of useful resource:** *Identifying Violence Against Most-At-Risk Populations: A Focus on MSM and Transgenders: Training Manual for Health Providers,* Health Policy Initiative and AIDSTAR-One/USAID, Mexico and Thailand, 2009.

ANNEX 1: SUMMARY OF FINDINGS - REVIEW OF RESOURCES ON GBV AGAINST SEX WORKERS

1. Introduction and definition

Part 1 of the A*nnotated Bibliography: Training and Programming Resources on GBV against Key Populations* focused on sex workers (defined below). The following pages summarize its findings. Further details of the resources cited can be found in the full report of the *Annotated Bibliography*[162].

Definition of sex workers[163]

"Female, male and transgender adults and young people (18 years of age and above) who receive money or goods in exchange for sexual services, either regularly or occasionally ... It is important to note that sex work is consensual sex between adults, which takes many forms and varies between and within countries and communities. Sex work may vary in the degree to which it is more or less 'formal' or organized."

2. Top priority resources on GBV against sex workers

In Part 1, based on criteria outlined in the *Annotated Bibliography*, the following were identified as the top priority resources – in terms of those with the greatest potential for adaptation, replication and/or scale-up for training and programming on GBV against sex workers:

Top priority resources on GBV against sex workers

1. ***SANGRAM's Collectives,*** **Sampada Gramin Mahila Sanstha (SANGRAM), VAMP, AIDSTAR-One/United States Agency for International Development (USAID), 2011.** http://www.aidstar-one.com/sites/default/files/AIDSTAR-One_CaseStudy_GenderMARPs_SANGRAM_India.pdf
Case study of SANGRAM's 10-step, rights-based approach to collectives to support sex workers to help one another and protect their rights to live in safety, avoid violence and increase access to services.
2. ***Documenting Good Practice by Sex Worker-Led Organizations: Addressing Violence against Sex Workers,*** **Global Network of Sex Worker Projects (NSWP), 2012.** http://www.nswp.org/sites/nswp.org/files/DGP%20Violence_0.pdf
Guide to the causal factors of GBV against sex workers. Cites characteristics of good practice responses – such as collectivization, rights-based programming and peer-led strategies – and illustrates them with case studies.
3. ***Teaching Transgender Victims of Sexual Violence how to Access Legal Rights in Chiang Mai Thailand,*** **MPLUS.** http://www.youtube.com/watch?v=LQ4rBIZo1qk&feature=channel
Animated video for transgender sex workers on what to do if you are sexually assaulted. Informs viewers of their legal and sexual rights and how to access local free legal counseling services.
4. ***The HIV and Sex Work Collection: Innovative Responses in Asia and the Pacific,*** **Asia Pacific Network of Sex Workers (APNSW), United Nations Population Fund (UNFPA) and United Nations Program on AIDS (UNAIDS), 2012.** http://www.unaids.org/en/media/unaids/contentassets/documents/unaidspublication/2012/20121212_HIV_SW.pdf
Collection of detailed case studies on key issues affecting sex workers (female, male, MSM and transgender). Addresses the benefits of responding to violence and lists the features of effective anti-violence programs. Includes multiple cases studies, including from Thailand, Bangladesh and Fiji.
5. ***Power of the Collective,*** **VAMP, 2012.** http://vimeo.com/40236081
Film from India on the benefits of collectivization among sex workers, including in terms of empowerment to report violence and violations of rights.

3. Number of resources on GBV against sex workers

The *Annotated Bibliography* identified a very large number of resources (111) related to GBV against sex workers. This was significantly more than for the other three key populations addressed by the project.

This perhaps reflects that (physical and sexual) violence against sex workers is more established as an important subject for action and that, in some contexts, sex workers have a strong history of collectivization ('working together'). Indeed, all of the initiatives represented in the top priority resources reflected the experiences and 'value added' of such groups and approaches.

4. Strengths and weaknesses of resources on GBV against sex workers

The following provides an overview of the strengths and weaknesses of the resources that were identified, with particular attention to those selected as top priorities. It uses the criteria outlined in the Introduction section of the *Annotated Bibliography*, in terms of the extent to which the resources:

- **Use a rights-based approach:** All of the resources identified as top priorities respond to the importance of human rights. A strong example is the case study on *SANGRAM's Collectives*[164]. This documents a rights-based approach to help sex workers help one another and live/work in safety. It focuses on the work of VAMP – a collective addressing human rights violations, including GBV.

- **Use an empowerment principle and promote collectivization:** All of the resources identified as top priorities promote an empowerment approach. As noted, the case study on *SANGRAM's Collectives* provides an example of a response to GBV that is by and for sex workers. Many of the resources also emphasize the use of participatory approaches, such as addressing GBV within processes of community dialogue on a range of gender, health and development issues. An example is *Stepping Stones: A Training Package on HIV/AIDS Communication and Relationship Skills* which was adapted specifically for sex workers in Karnataka, India[165]. A number of resources offer practical advice for peer educators and/or sex workers, including on how to stay safe and to know/use your rights. Examples include *Don't Become a Victim* by the International HIV/AIDS Alliance in the Ukraine[166].

- **Are based on evidence/assessed needs and were developed by/for the key population:** The top priority resources are all either developed by sex workers or benefitted from their active involvement. Some resources – notably those by the Global Network of Sex Work Projects[167] and Asia Pacific Network of Sex Work Projects[168] – provide high quality case studies of good practice and cite the components involved in such programs. While not training or programming materials per se, they provide invaluable examples of 'what works' (such as using multiple types of interventions, promoting a human rights-based approach and emphasizing empowerment). Many of the resources – notably those selected as top priorities – show understanding of the factors that contribute to violence against female sex workers. However, they show less analysis of the factors that: contribute to the risk of sex workers (such as poverty, class and gender inequality); and can lessen personal risk to violence (such as literacy skills and the ability to use the internet).

- **Address structural factors that affect GBV against the key population:** While recognizing the immense challenge of working within oppressive legal/policy environments, few of the identified resources provide clear strategies to address structural violence against sex workers. None of them provide any 'how to' for advocating for change in policy, law and the social environment.

- **Target the specific population:** The majority of the resources in Part 1 are specific to sex workers (as opposed to key populations in general). However, while those selected as top priorities address a range of community members, a large overall proportion of the resources are designed for female sex workers, as opposed to those that are male, MSM or transgender. Some of the resources address specific circumstances for sex work, including indoors (such as a resource by the Indoors

Project[169]) and brothels (such as a resource by the Synergy Project[170]). These often respond to the specific and different types and levels of GBV related to such situations.

- **Indicate potential for adaption, replication and/or scale-up in other contexts:** The resources in Part 1 reflect a range of needs and strategies to address GBV – by sex workers themselves, sex worker organizations, law enforcement officials and others. Some promote specific, violence-focused good practice, such as the Ugly Mugs projects in the UK[171] and Avahan's crisis response systems in India[172]. Some reflect the integration of GBV within wider, comprehensive programs for sex workers. Examples include the: case study of SANGRAM, India, and its rights-based program to build sex worker collectives[173]; *Stepping Stones* training package by the Karnataka Health Promotion Trust, India[174]; and manual for health care workers by the Desmond Tutu AIDS Foundation, South Africa[175].

  A notable number of resources and good practice responses for sex workers came from India – reflecting the quality of initiatives, but also, perhaps, the allocation of donor resources to document and learn from them. A key example is the Avahan project – which has developed a set of detailed program guides on how to design and implement a crisis response system for key populations, including sex workers[176]. The strategy pioneered in India – and the Asia Pacific region as a whole – of combining collectivization, rights and empowerment has significant potential to be replicated in other settings. However, it is often dependent on there being considerable capacity building of key people within the sex worker communities. Overall, the resources for Part 1 were identified from a range of different organizations (from sex worker groups to international donors), contexts (such as generalized and concentrated HIV epidemics) and countries (including in both the global North and South). However, only a modest number were 'true' training or programming materials, such as workshop guides, practical guidelines, budgeting tools or monitoring indicators. However, many of them have strong potential to *inform* such resources and to be adapted to different contexts. Some, however, might be challenging to use elsewhere, such as if they were developed within a relatively supportive environment (such as New Zealand[177] and Belgium[178]), as opposed to a more punitive context. Many of the identified resources are highly relevant to their contexts – having been developed through the involvement of sex workers. Examples include the sex worker handbooks developed by Chez Stella, Canada[179], and SCOT-PEP, Scotland[180].

- **Have a user-friendly and/or innovative format:** Some of the resources are highly accessible, using clear, user-friendly formats**.** Examples include: *9 Lives: Surviving Sexual Assault in the Sex Industry* – a guide for sex workers by the Sex Workers Outreach Project, Australia, with clear information and comic strips[181]; and the *Sex Work Toolkit* – an online resource for sex workers, clients, residents and local businesses by the Community Initiative for Health and Safety, Canada[182]. Some use innovative formats, such as an animated video for transgender sex workers by MPlus, Thailand[183] – which can be used for training sex workers or advocacy with the public, including among non-literate communities. Other examples of innovation include: an e-empowerment forum for sex workers by the Indoors Project, Europe[184]; and a violence body mapping activity by the Bolivian Network of People Living with HIV[185]. Such formats aim to be user-friendly, appealing to the sex workers in question and responding to specific challenges, such as low levels of literacy or the need to access support discretely. Of note, however, few of the resources provide a step-by-step guide for programs to respond to GBV against sex workers. Exceptions include: *Sex Work, Violence and HIV: A Guide for Programs with Sex Workers* by the International HIV/AIDS Alliance – which takes users through background information before focusing on the principles, strategies and services for addressing GBV against sex workers[186]; *Making Sex Work Safe* by the Global Network of Sex Work Projects[187]; the guide by the United Nations Population Fund and United Nations Joint Program on

AIDS which, based on experiences in Namibia, provides the steps to designing and implementing a needs assessment by and with sex workers, including attention to issues of violence[188].

5. Gaps in resources on GBV against sex workers

Based on Part 1 of the *Annotated Bibliography*, a number of **types of resources** for addressing GBV against sex workers seem to be absent or under-developed. Examples include resources that:

- Support **practical and participatory capacity building** on GBV against sex workers, such as facilitators' guides, session plans and group activities.
- Provide **practical, step-by-step program tools** (such planning tools, indicators and budgeting tools) to develop/implement interventions to respond to GBV against sex workers.
- Facilitate connection of sex worker projects to **wider GBV services**, such as through the development of referral systems or the training of GBV services to be 'sex worker-inclusive'.
- Target **people associated with sex workers**, including those that carry out or GBV or may, themselves, be survivors of violence. While many resources promote work with sex workers themselves and the police, few appear to target clients, pimps, intimate partners or other family members, such as children.
- Make use of **new technologies** (such as mobile phones and the internet), while also providing capacity building to sex workers in how to use them effectively.

In addition, a number of subject areas seem to be absent or **under-addressed** in many of the existing resources. Examples of these include:

- The **structural factors** (such as the legal and policy environment) that facilitate or prevent effective action on GBV against sex workers. There is a need to support capacity building for decision-makers in organizations, donors, peer educators and sex workers on using collective action, human rights and strategic lobbying in relation to GBV.
- How to engage **male and transgender sex workers** and build their advocacy and lobbying skills to secure safe places to work. Also facilitation guidelines for conducting focus group discussions with male or transgender sex workers on the topic of male risk of violence.
- **Intimate partner violence** – in addition to violence by clients and the police.
- **The non-physical dimensions of violence**, such as the emotional impact experienced as well as physical harm.
- **How to respond to the 'gender dimensions'** of GBV – in terms of not only preventing and addressing acts of violence, but taking action on the negative gender norms and practices that fuel GBV against sex workers.
- **GBV against specific types of sex workers**. Some resources address groups of sex workers that have heightened risk of GBV. However, overall, few address the specific needs of groups such as sex workers who are adolescents, transgender, living with HIV or PWID.

Many of the resources appear to lack a systematic **evidence-base**, such as in terms of data to demonstrate the scale/nature of the need being addressed and the efficacy of the approach taken. Overall, there appears to be a gap between the 'true' training and programming materials identified (and included in the priority resources) and the more research/academic-orientated materials (some of which are included in the 'other' resources). An example of an exception is the crisis response system developed by the Avahan project in India[189] which – through operations research and data collection – has benefited from being piloted, implemented, scaled-up and continuously improved.

ANNEX 2: SUMMARY OF FINDINGS - REVIEW OF RESOURCES ON GBV AGAINST MEN WHO HAVE SEX WITH MEN

1. Introduction and definition

Part 2 of the Ann*otated Bibliography: Training and Programming Resources on GBV against Key Populations* focused on MSM (see definition below). The following pages summarize its findings. Further details of all of the resources cited here can be found in the full report of the *Annotated Bibliography*[190].

Definition of MSM[191]

"An inclusive public health construct used to define the sexual behaviors of males who have sex with other males, regardless of the motivation for engaging in sex or identification with any or no particular 'community'. The words 'man' and 'sex' are interpreted differently in diverse cultures and societies, as well as by the individuals involved. As a result, the term MSM covers a large variety of settings and contexts in which male-to-male sex takes place. Perhaps the most important distinction to make is one between men who share a non-heterosexual identity (i.e., gay, homosexual, bisexual or other culture-specific concepts that equate with attraction to other men) and men who view themselves as heterosexual but who engage in sex with other males for various reasons (e.g. isolation, economic compensation, sexual desire, gender scripts)."

2. Top priority resources on GBV against MSM

In Part 2, based on criteria outlined in the *Annotated Bibliography*, the following were identified as the top priority resources – in terms of those with the greatest potential for adaptation, replication and/or scale-up for training and programming on GBV against MSM:

1. ***My Body Is Not Mine: Stories of Violence and Tales of Hope: Voices from the Kothi[192] Community in India,*** **Naz Foundation International (NFI) and Centre for Media and Alternative Communication (CMAC) in partnership with Department for International Development (DfID), 2007.** http://cmaconline.org/gender1/my-body-is-not-mine
Report from participatory research among Kothi in India, including a workshop on writing and photography with participants from across the country. Focuses on Kothis' gender/sexuality identity and experiences of violence.
2. ***Anti-Violence Project,*** **Acon.** http://www.acon.org.au/anti-violence/What-We-Do
Resources for an Anti-Violence Project in Australia to support LGBTI people who have experienced homophobic, transphobic, domestic or family violence. Also supports and trains other LGBTI organizations and mainstream services. Resources include websites, leaflets and reporting campaigns.
3. ***Domestic Violence: A Resource for Gay and Bisexual Men*****, Barking and Dagenham Primary Care Trust, National Health Service, 2008.** http://www.stonewall.org.uk/documents/domestic_violence_resource_for_gay_men_1_1.pdf
Booklet from a demonstration project in the UK, for use by MSM. Gives information to define intimate partner violence and support men to identify if they are being abused and get help. Addresses the specific nature of sexuality-based violence and how violence inter-relates with chronic illness. Lists local/national resources.
4. ***Toolkit for Training Police Officers on Tackling LGBTI-Phobic Crime,*** **International Lesbian and Gay Association (ILGA)-Europe, 2011.** http://www.ilga-europe.org/home/publications/reports_and_other_materials/training_toolkit_police_2011
Comprehensive guide for identifying needs and designing strategies to train the police in addressing LGBTI-phobic violence in Europe. Contains sections on designing, conducting and evaluating training.
5. ***Identifying Violence against Most-At-Risk Populations: A Focus on MSM and Transgenders: Training Manual for Health Providers,*** **Health Policy Initiative (HPI) and AIDSTAR-One/United States Agency for International Development (USAID), 2009.** http://www.aidstar-one.com/sites/default/files/1097_1_GBV_MARPs_Workshop_

Manual_FINAL_4_27_10_acc.pdf; http://www.healthpolicyinitiative.com/Publications/Documents/1100_1_GBV_MARP_Final_Project_Report_FINAL_4_27_10_acc.pdf
Report and step-by-step training manual from a pilot study in Mexico and Thailand to develop a screening tool to support health providers to: identify violence against MSM and transgender people, including those involved in sex work; facilitate their access to appropriate GBV services; and improve community organization and health service collaboration. Uses participatory methods and includes case studies, handouts, Powerpoints, etc.
6. ***Blueprint for the Provision of Comprehensive Care to Gay Men and Other Men who Have Sex with Men in Latin America and the Caribbean*, Pan American Health Organization (PAHO), 2009.** http://new.paho.org/hq/index.php?option=com_content&view=article&id=2449&Itemid=1993
Report for Latin America and the Caribbean that integrates attention to a range of GBV (against and among MSM) into a comprehensive approach to their health needs. Includes a section on the consequences of on-going and crisis violence. Emphasizes the importance of clinical screening and evaluations. Provides algorithms/ frameworks, such as for the interaction between clinic and community support in a human rights framework.
7. ***Understanding and Challenging Stigma toward Men who have Sex with Men: A Toolkit for Action,* United States Agency for International Development (USAID), International Centre for Research on Women (ICRW) and PACT USAID, ICRW and PACT, 2010.** http://www.icrw.org/publications/understanding-and-challenging-stigma-toward-men-who-have-sex-men-cambodia-edition
Toolkit developed in Cambodia that integrates attention to violence within a wider understanding of, and action on, stigma against MSM. Adapted and tested with local groups. Includes participatory, educational exercises that can be used with a wide range of individuals/groups to stop stigma. Includes a fact sheet on hate violence.

3. Number of resources on GBV against MSM

The *Annotated Bibliography* identified 38 resources related to GBV against MSM. The number was especially large when including generic resources related to lesbian, gay, bisexual and transgender (LGBT) communities, as opposed to solely MSM.

4. Strengths and weaknesses of resources on GBV against MSM

The following provides an overview of the strengths and weaknesses of the resources that were identified, with particular attention to those selected as top priorities. It uses the criteria outlined in the Introduction section of the *Annotated Bibliography*, in terms of the extent to which the resources:

a. **Use a rights-based approach:** Some of the key resources identified for Part 2 strongly promote a rights-based approach to addressing GBV against MSM. For example, ACON's anti-violence campaign website and resources equip users with principles and practical tools to understand their rights and to take practical action (as well as building the capacity of other service providers in the rights of LGBT communities)[193]. The *Blueprint for the Provision of Comprehensive Care to Gay Men and Other Men who Have Sex with Men (MSM) in Latin America and the Caribbean* by the Pan-American Health Organization promotes the integration of action on GBV within a rights-based framework for programs for MSM[194].

b. **Use an empowerment principle and promote collectivization:** Many of the identified resources target MSM, either directly or via groups that support them. For example, *Domestic Violence: A Resource for Gay and Bisexual Men* developed by the National Health Service in the UK can be used both by individuals and MSM peer educators[195]. Some of the resources target other stakeholders, such as: trainers – such as *Sexual Minorities, Human Rights and HIV* by Botswana Network on Ethics, Law and HIV/AIDS[196]; and mainstream GBV service providers – such as the *Open Minds Open Doors* guide on 'LGBTI inclusivity' developed by The Network in the USA[197].

c. **Are based on evidence/assessed needs and were developed by/for the key population:** Some of the resources aim to identify and respond to the specific needs of MSM communities. For example, *My Body Is Not Mine* by the Naz Foundation International and Centre for Media and Alternative Communication shares the results of participatory research among the Kothi community[198], with different methods used to support them to express their opportunities and challenges[199]. However (as discussed below), some of the resources appear to lack an evidence-base, especially in terms of systematic data, such as in the form of a baseline. Many of the identified resources reflect good practice in interventions for MSM. For example, the case study of the work of Soins Infirmiers et Développement Communautaire in Lebanon focuses on integrating attention to GBV within wider programs that address a range of issues and needs for MSM[200]. Similarly, the guidance documents by normative agencies, such as the President's Emergency Plan for AIDS Relief[201], provide frameworks within which GBV can be integrated into programs focused on HIV and/or MSM. Resources such as the *Blueprint for the Provision of Comprehensive Care to Gay Men and Other Men who Have Sex with Men (MSM) in Latin America and the Caribbean* by the Pan American Health Organization[202] demonstrate a comprehensive understanding of the wide definition of GBV. Some – such as the website and multiple tools of ACON's Anti-Violence Project in Australia[203] – specifically include attention to intimate partner violence within LGBT relationships.

d. **Address structural factors that affect GBV against the key population:** Many of the resources shared in Part 2 have clearly been developed within the context of challenging environments for MSM, such as social stigma and oppressive policy/legal frameworks. However, relatively few include practical guidance on 'what to do' – in terms of how, such as through advocacy, MSM can engage in relevant policy-making processes and change the nature of the environment.

e. **Target the specific population:** Some of the identified resources benefit from being tailor-made to their community. *My Body Is Not Mine* is an example – focusing on the specific experiences and needs of the Kothi community[204] in India[205]. However, some of the resources in Part 2 are for 'generic' LGBT communities. While many include useful ideas and tools, some give limited attention to the specific needs of MSM, especially those who do not identify as homosexual or gay.

f. **Indicate potential for adaption, replication and/or scale-up in other contexts:** The resources for Part 2 came from a range of organizations and contexts. While some are from the global South (such as India and Mexico), many are from the North (such as the USA and UK). While the latter often benefit from innovative designs and formats, they could, potentially, present challenges in terms of adaptation to other socio-political environments. Some of the resources provide high quality, detailed guidance on a specific component of training or programming. Examples include the GBV screening tool developed by the Health Policy Initiative in Mexico and Thailand[206]. A further important example is the materials developed by the Avahan project in India[207]. These include a detailed guide that takes users through designing and implementing a crisis response system for key populations, including MSM. Such resources demonstrate strong potential for scale-up and adaptation, particularly in similar contexts. Meanwhile, others – such as the websites of some LGBT-orientated organizations – might require extensive adaption for use in other political contexts, such as where MSM communities are less organized or have less political capital.

g. **Have a user-friendly and/or innovative format:** Some of the resources for Part 2 are text-heavy, being predominantly research or policy materials. However, others utilize more accessible and creative formats.

These vary from an easy-to-navigate website, such as that of ACON's Anti-Violence Project in Australia[208] to an on-line Prezi presentation featuring a short video scenario of domestic violence between MSM – as part of GLBTQ's Domestic Violence Project in the USA[209]. The *My Body Is Not Mine* process in India[210] used writing and photography to support Kothi participants[211] to express their experiences and opinions about gender/ sexuality identity and violence.

5. Gaps in resources on GBV against MSM

Based on those identified for Part 2 of the *Annotated Bibliography*, a number of **types of resources** for addressing GBV against MSM seem to be absent or under-developed. Examples include resources that:

- Provide **practical, step-by-step program tools** – such as frameworks, planning tools, indicators and budgeting tools – to develop, integrate and implement interventions to respond to GBV against MSM.
- Facilitate connection of MSM projects to: **wider GBV services**, such as through the development of referral systems or the training of GBV services to be 'MSM-inclusive; and **other key population initiatives** (such as for lesson-sharing and joint advocacy planning).
- Target **people associated with MSM,** including those that **carry out or facilitate GBV or may, themselves, be survivors of violence.** While many resources promote work with MSM themselves, few appear to target: male clients (for those who sell sex); female partners (such as in the case of MSM who have sex with both men and women); or family members.
- Make maximum use of **established methods** – such as peer support and collectivization – that have proven vital for initiatives with MSM.
- Make maximum use of **new technologies** (such as mobile phone apps) that, for example in some countries in Africa, are providing successful in other aspects of programming to support MSM.

In addition, a number of subject areas seem to be absent or **under-addressed** in many of the existing resources. Examples of these include:

- The **structural factors** (such as the legal and policy environment and health systems) that facilitate GBV against key populations or prevent effective responses.
- **The non-physical dimensions of GBV**, such as the emotional impact that may be experienced in addition to physical harm.
- **How to respond to the 'gender dimensions'** of GBV – in terms of not only preventing/ addressing acts of violence, but taking action on the negative gender norms and practices that fuel GBV against MSM.
- **GBV against specific types of MSM**. For example, few resources seem to address the heightened risk of GBV of MSM who are young, are from ethnic minorities, sell sex or are in prison.

Many of the resources appear to lack a systematic **evidence-base**, such as in terms of data to demonstrate the scale/nature of the need being addressed and the efficacy of the approach taken. Overall, there appears to be a gap between the 'true' training and programming materials identified (and included in the priority resources) and the more research/academic-orientated materials (some of which are included in the 'other' resources). An example of an exception is the crisis response system developed by the Avahan project in India[212] which – through operations research and data collection – has benefited from being piloted, implemented, scaled-up and continuously improved.

ANNEX 3: SUMMARY OF FINDINGS - REVIEW OF RESOURCES ON GBV AGAINST TRANSGENDER PEOPLE

1. Introduction and definition

Part 3 of the *Annotated Bibliography: Training and Programming Resources on GBV against Key Populations* focused on transgender people (defined below). The following pages summarize its findings. Further details of the resources cited can be found in the full report of the *Annotated Bibliography*[213].

Definition of transgender people[214]

"An umbrella term for persons whose gender identity and expression does not conform to the norms and expectations traditionally associated with the sex assigned to them at birth. Transgender people may self-identify as transgender, female, male, transwoman or transman, trans-sexual, hijra, kathoey, waria[215] *or one of many other transgender identities and may express their genders in a variety of masculine, feminine and/or androgynous ways."*

2. Top priority resources on GBV against transgender people

In Part 3, based on criteria outlined in the *Annotated Bibliography*, the following were identified as the top priority resources – in terms of those with the greatest potential for adaptation, replication and/or scale-up for training and programming on GBV against transgender people:

Top priority resources on GBV against transgender people

1. ***Giving Voice to Transgender Communities through ASPIDH in El Salvador,*** **Solidarity Association to Promote Human Development (ASPIDH) and AIDSTAR-One/United States Agency for International Development (USAID), 2011.** http://www.aidstar-one.com/focus_areas/gender/resources/case_study_series/aspidh_salvador
Case study of El Salvador's only legal transgender NGO that promotes human rights and access to services and safety. Program combines outreach and drop-in services with advocacy (to the government and health providers) and legal protection (such as accompanying members to the Human Rights Protection Office).
2. ***Sexual and Reproductive Health for Transgender and Gender Non-Conforming People*****, Dr. Alex Muller for Gender Dynamix, 2013.** http://www.genderdynamix.org.za/document-categories/for-trans-and-gender-nonconforming-persons/
Handbook for transgender and gender non-conforming people in Southern Africa, with specific information for transgender women and men. Includes sections on sexual and domestic violence and rape and sexual assault– both including attention to survivor best practice. Includes tips for interacting with the police.
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Report from the US on best practices to strengthen transgender HIV prevention. Includes recommendations on how to ensure inclusivity, address stigma and do training on intimate partner violence and hate crimes.
4. ***HIV and Gender-Based Violence Prevention for Transgender People,*** **Southern Africa HIV/AIDS Information Dissemination Service (SAFAIDS), 2011.** http://safaids.net/files/Transgender%20Booklet.pdf
Booklet to support male and female transgender people in Southern Africa to protect themselves from HIV and GBV. Includes pages on how to identify IPV, tips on how to avoid and report violence in public (and if doing sex work) and a list of LGBTI support services.
5. ***Lost in Transition: Transgender People, Rights and HIV Vulnerability in the Asia-Pacific Region*****, Asia Pacific Transgender Network (APTN) and United Nations Development Program (UNDP), 2012.** http://www.undp.org/content/dam/undp/library/hivaids/Lost%20in%20translation.pdf

Report on the impact of vulnerability on transgender people in Asia Pacific and how HIV is linked to laws, regulations, policies and practices related to stigma and prejudice. Includes a graphic of the 'stigma-sickness slope' and concludes that violence against transgender people is sometimes systematic and sustained. Cites the impact of violence on emotional health and wellbeing, sexual practices and access to services.
6. *Positive Women, Sex Workers and Transgender Women: Body Mapping Violence and HIV in Bolivia,* Gracia Violeta Ross for Red Nacional de Personas que Viven con VIH y Sida en Bolivia (REDBOL), 2012. http://pag.aids2012.org/EPosterHandler.axd?aid=9360
E-poster from Bolivia sharing research among transgender women, focusing on a body mapping tool, with participants mapping the marks of violence on drawings of their bodies and discussing feelings and identity.

3. Number of resources on GBV against transgender people

The *Annotated Bibliography* identified 41 resources related to GBV against transgender people. The number was especially large when including resources related to lesbian, gay, bisexual and transgender (LGBT) communities in general (as opposed to transgender people specifically).

4. Strengths and weaknesses of resources on GBV against transgender people

The following provides an overview of the strengths and weaknesses of the resources that were identified, with particular attention to those selected as top priorities. It uses the criteria outlined in the Introduction section of the *Annotated Bibliography*, in terms of the extent to which the resources:

a. **Use a rights-based approach:** Many of the identified resources recognize and respond to the need for a rights-based approach to GBV and support to transgender people in general. In some cases, this is explicitly reflected in their content, such as the case study of Solidarity Association to Promote Human Development in El Salvador[216] – which takes a rights-based approach within an intensely transphobic environment.

b. **Use an empowerment principle and promote collectivization:** Overall, the identified resources target a range of stakeholders, including: transgender community members/peer educators, such as *HIV and Gender-Based Violence Prevention for Transgender People* by the Southern Africa HIV/AIDS Information Dissemination Service[217]; trainers, such as *Sexual Minorities, Human Rights and HIV* by Botswana Network on Ethics, Law and HIV/AIDS [218]; and mainstream GBV service providers, such as the *Open Minds Open Doors* guide on 'LGBTI inclusivity' developed by The Network in the USA[219].

c. **Are based on evidence/assessed needs and were developed by/for the key population:** Many of the identified resources reflect good practice. A strong example is provided by the case study of the work of Solidarity Association to Promote Human Development in El Salvador[220] which focuses on integrating attention to GBV within wider programs for transgender people. Similarly, the guidance documents by normative agencies such as the President's Emergency Plan for AIDS Relief[221] provide frameworks within which GBV can be integrated into programs focused on HIV and/or transgender people. Some resources – such as the website and multiple tools of ACON's Anti-Violence Project in Australia[222] – demonstrate a broad understanding of GBV and specifically include attention to intimate partner violence within LBGT relationships.

d. **Address structural factors that affect GBV against the key population:** Many of the identified resources are clearly based on the reality of working within a challenging policy and legal environment for transgender people. However, few give specific attention to 'what can be done' – such as through advocacy – to address such challenges and influence change.

e. **Target the specific population:** Some of the resources provide generic guidance in relation to LGBT communities. Others, however – such as *Sexual Health for Transgender and Gender Non-Conforming People* by Gender Dynamix, South Africa[223] – provide highly tailored guidance that responds to the heightened risk of GBV of transgender people.

f. **Indicate potential for adaption, replication and/or scale-up in other contexts:** Many of the identified materials – while important and useful – are not 'true' training or programming resources. For example, they are case studies or policy reports that could be used to inform such resources, but are not practical materials such as workshop guides, guidelines, budgeting tools or monitoring indicators. The resources for Part 3 were identified from a range of organizations, contexts and countries, including in the global North and South. While this represents a rich wealth of experience and lessons, it might, in some cases, make some of the resources challenging to adapt to other countries or contexts.

   Some of the resources provide high quality, detailed guidance on a specific component of training or programming. Examples include the GBV screening tool developed by the Health Policy Initiative in Mexico and Thailand[224]. A further important example is the materials developed by the Avahan project in India[225]. The latter include a detailed guide that takes users through designing and implementing a crisis response system for key populations, including transgender people. Such resources – by taking a systematic approach – demonstrate strong potential for scale-up and adaptation, particularly in similar contexts.

g. **Have a user-friendly and/or innovative format:** Many of the resources identified for Part 3 are narrative-based – being, for example, research or policy materials. However, some do use more accessible formats. Examples include the easy-to-navigate website of ACON's Anti-Violence Project in Australia[226] and the highly participatory body mapping tool used in Bolivia (that could be used by people with different levels of literacy)[227].

5. Gaps in resources on GBV against transgender people

Based on those identified for the *Annotated Bibliography*, a number of **types of resources** for addressing GBV against transgender people seem to be absent or under-developed. Examples include resources that:

- Provide **practical, step-by-step program tools** – such as planning tools, indicators and budgeting tools – to develop, integrate and implement interventions to respond to GBV against transgender people.
- Facilitate connection of transgender projects to **wider GBV services**, such as through the development of referral systems or the training of GBV services to be 'transgender-inclusive'.
- Target **people associated with transgender people**, including those that **carry out or facilitate GBV or may, themselves, be survivors of violence,** such as their intimate partners, family members or clients (for those who sell sex).

In addition, a number of subject areas seem to be absent or **under-addressed** in many of the existing resources. Examples of these include:

- The **structural factors** (such as the legal and policy environment) that facilitate or prevent effective action on GBV against key populations.
- **The non-physical or sexual dimensions of GBV**, such as the emotional impact experienced.
- **How to respond to the 'gender dimensions'** of GBV – in terms of not only preventing/ addressing acts of violence, but taking action on the negative gender norms and practices that fuel GBV against transgender people.
- **GBV against specific types of transgender people**, such as those that are young or that sell sex.

Many of the resources appear to lack a systematic **evidence-base**, such as in terms of data to demonstrate the scale/nature of the need being addressed and the efficacy of the approach taken. Overall, there appears to be a gap between the 'true' training and programming materials identified (and included in the priority resources) and the more research/academic-orientated materials (some of which are included in the 'other' resources). An example of an exception is the crisis response system developed by the Avahan project in India[228] which – through operations research and data collection – has benefited from being piloted, implemented, scaled-up and continuously improved.

ANNEX 4: SUMMARY OF FINDINGS - REVIEW OF RESOURCES ON GBV AGAINST PEOPLE WHO INJECT DRUGS

1. Introduction and definition

Part 4 of the *Annotated Bibliography: Training and Programming Resources on GBV against Key Populations* focused on PWID (defined below). Of note, as requested in its terms of reference, the Project addressed 'people who inject drugs' rather than the wider group of 'people who use drugs'. However, it was acknowledged that, in reality, a broad range and types of people who use drugs face heightened risk factors related to GBV.

The following pages summarize its findings. Further details of the resources cited can be found in the full report of the *Annotated Bibliography*[229].

Definition of PWID[230]

"A key constituency among people who use drugs because this group is often the most discriminated against, marginalized, criminalized and experiences some of the most serious health problems that can be associated with drug-taking under the regime of global prohibition."

2. Top priority resources on GBV against PWID

In Part 4, based on criteria outlined in the *Annotated Bibliography*, the following were identified as the top priority resources – in terms of those with the greatest potential for adaptation, replication and/or scale-up for training and programming on GBV against PWID:

Top priority resources on GBV against PWID

1. ***Developing Services for Female Drug Users,*** **Eurasian Harm Reduction Network (EHRN).** http://www.harm-reduction.org/index.php/component/content/article/18-knowledge-hub/1746-developing-services-for-female-drug-users.html
Online training modules for Eastern Europe and Central Asia, with 47 files including presentations, session guides, case studies, trainer notes and handouts. Examples include: *Addressing Domestic Violence Among Women Who Use Drugs* – a training presentation; *Addressing Domestic Violence in Substance Abuse Treatment for Women* – a training hand out; and *Safety Tips For You And Your Family* – a training hand-out.
2. ***Developing Services for Women who Use Drugs,*** **Eurasian Harm Reduction Network (EHRN), 2010.** http://harm-reduction.org/services_women_idu/index_en.html
Online toolkit for Eastern Europe and Central Asia region to assess services for women who inject drugs. Examples referring to violence include assessment tools, such as on access to services, for different levels.
3. ***The Power to Tackle Violence: Avahan's Experience with Community-Led Crisis Response in India; Community Led Crisis Response Systems: A Guide to Implementation;*** **and** ***Community Led Crisis Response Systems: Detailed Guidelines: Best Practices Implementation Tools,*** **Avahan and Bill and Melinda Gates Foundation, 2009 and 2013.** http://docs.gatesfoundation.org/avahan/documents/avahan_powertotackleviolence.pdf; http://docs.gatesfoundation.org/avahan/documents/community-led-crisis-response-systems.pdf
Report, guide and guidelines on Avahan's work in India to integrate crisis response systems into broader programs, including with PWID. Systems aim to address incidents of violence, act as a deterrent and tackle longer-term issues. The resources provide a step-by-step guide to the system.

4. *Domestic Abuse and Other Gender-Based Violence,* Eurasian Harm Reduction Network (EHRN), 2012.
Comprehensive training package that defines GBV and helps workers to: understand what it means in human rights terms; recognize that it occurs; and teach survivors self-protective behaviors.
5. *STIGMA Foundation: Empowering Drug Users to Prevent HIV in Indonesia,* STIGMA Foundation and AIDSTAR-One/United States Agency for International Development (USAID), 2011. http://www.aidstar-one.com/sites/default/files/AIDSTAR_One_CaseStudy_Gender_STIGMA_Foundation_Indonesia.pdf
Case study of an NGO in Indonesia staffed by PLHIV and former PWID that empowers male and female PWID to live safer and healthier lives through community organizing, advocacy and networking in a context where GBV is illegal, but pervasive. Program combines HIV prevention, needle exchange and referrals for health care/GBV services. Also works with local police, health workers and government to ensure services/PWID involvement.

3. Number of resources on GBV against PWID

A modest number of materials related to GBV against PWID were identified – 39 top priority/other resources. The process indicated that comparatively little resource development has taken place in this area compared to, for example, violence against sex workers.

4. Strengths and weaknesses of resources on GBV against PWID

The following provides an overview of the strengths and weaknesses of the resources that were identified, with particular attention to those selected as top priorities. It uses the criteria outlined in the Introduction section of the *Annotated Bibliography*, in terms of the extent to which the resources:

a. **Use a rights-based approach:** An important number of the resources identified for Part 4 were developed by the Eurasian Harm Reduction Network[231] – which has played a critical role in promoting and developing gender-sensitive approaches to programs for PWID. These resources pay specific attention to issues of rights – as the basis for programming and action to respond to, in particular, the needs of women who inject drugs. Within some of the other resources identified, it is less evident the extent to which they take a rights-based approach.

b. **Use an empowerment principle and promote collectivization:** Some of the identified resources are clearly and explicitly based on an empowerment approach that promotes action by and for PWID themselves. An example of this is the case study of the work of STIGMA Foundation in Indonesia[232].

c. **Are based on evidence/assessed needs and were developed by/for the key population:** With many of the resources, there was little explicit indication that they were based on a participatory assessment of the needs of PWID and/or that they were developed by PWID themselves. However, many of the resources do refer to good practice, such as the integration of GBV within wider programs for PWID. Again, the case study of the STIGMA Foundation in Indonesia[233] is an example – with GBV integrated within a broad program of support for PWID.

d. **Address structural factors that affect GBV against the key population:** The significant challenge presented by structural factors (such as oppressive drug policies and legislation) was a consistent backdrop to many of the identified resources related to PWID. However, few of them appear to provide practical support on 'how to respond' – in terms of training and programming, such as in advocacy to influence a more enabling environment. Avahan's community-led crisis response approach[234] provides a useful example of a local-level response that involves local stakeholders and decision-makers, alongside PWID themselves.

e. **Target the specific population:** Some of the identified resources, such as those by the Eurasian Harm Reduction Network[235], are giving increasing attention to the specific needs of women who inject drugs and, in turn, are including action on GBV, especially intimate partner violence.

f. **Indicate potential for adaption, replication and/or scale-up in other contexts:** While important and useful, many of the identified materials are not 'true' training or programming resources. For example, they are case studies or policy reports that could be used to inform such resources, but are not practical materials such as workshop guides, guidelines, budgeting tools or monitoring indicators. As noted, many of the resources identified for Part 4 came from Eastern Europe and Central Asia – a region with a specific and highly oppressive policy environment in the context of drug use. Practically, the formats of these resources show great potential for replication or scale-up. However, politically, they might require significant adaptation to be useful and appropriate in different policy environments.

g. **Have a user-friendly and/or innovative format:** The majority of the resources identified for Part 4 are narrative documents (such as reports and case studies) rather than practical training or programming materials. As such, while vital for providing evidence for advocacy and informing training and programming, they are not highly user-friendly. However, some of the exceptions – such as the training packages developed by the Eurasian Harm Reduction Network[236] – are presented in a clear format, such as PowerPoints, handouts and session guides. Another exception is the program guide developed by the Avahan project – which takes users step-by-step through the process of designing and implementing a crisis response system for key populations, including PWID[237]. Meanwhile, some of the advocacy materials identified have used more creative formats, such as video testimonies about the 'real life' experiences of GBV against women who inject drugs[238].

5. Gaps in resources on GBV against PWID

Based on those identified for the *Annotated Bibliography*, a number of **types of resources** for addressing GBV against PWID seem to be absent or under-developed. Examples include resources that:

- Are demonstrably based on the **assessed needs** of PWID and have been **developed by and for** such community members.
- Provide **practical, step-by-step program tools** – such as planning tools, indicators and budgeting tools – to develop and implement interventions to respond to GBV against PWID.
- Facilitate connection of PWID projects to **wider GBV services**, such as through the development of referral systems or the training of GBV services to be 'PWID-inclusive'.
- Target those **associated with PWID**, such as those that carry out or facilitate GBV or may, themselves, be survivors of violence – such as intimate partners, the police, clients (for those who sell sex) or family members, including children.

In addition, a number of subject areas seem to be absent or **under-addressed** in many of the existing resources. Examples of these include:

- The **structural factors** (such as the legal and policy environment) that affect action on GBV against key populations and, more specifically, the need for drug law reform and decriminalization.

- **A broad understanding of GBV** – that includes IPV against women who inject drugs or the partners of PWID, but also addresses GBV carried out by the police, community members and (for those who sell sex) clients.
- **The intersection of different areas of risk factors related to GBV,** such as for women who inject drugs, sell sex and/or are living with HIV.
- **How to respond to the 'gender dimensions'** of GBV – in terms of not only preventing/ addressing acts of violence, but taking action on the negative gender norms and practices that fuel GBV against women in general and women who inject drugs in particular.
- **Male PWID experiences of GBV and involvement in responses to GBV.**
- **GBV against specific types of women in the context of drug use**, such as young women, women who sell sex or women who are in closed settings, such as prisons and rehabilitation or 'reform' centers.

Many of the resources appear to lack a systematic **evidence-base**, such as in terms of data to demonstrate the scale/nature of the need being addressed and the efficacy of the approach taken. Overall, there appears to be a gap between the 'true' training and programming materials identified (and included in the top priority resources) and the more research/academic-orientated materials (some of which are included in the 'other' resources). An example of an exception is the crisis response system developed by the Avahan project in India [top priority resource 3 which – through operations research and data collection – has benefited from being piloted, implemented, scaled-up and continuously improved.

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