USAID | HEALTH POLICY INITIATIVE
FROM THE AMERICAN PEOPLE

SCREENING FOR VIOLENCE AGAINST MSM AND TRANSGENDERS: REPORT ON A PILOT PROJECT IN MEXICO AND THAILAND

OCTOBER 2009
This publication was produced for review by the U.S. Agency for International Development (USAID). It was prepared by Myra Betron of the USAID | Health Policy Initiative, Task Order 1.

Suggested citation: Betron, M. 2009. *Screening for Violence against MSM and Transgenders: Report on a Pilot Project in Mexico and Thailand*. Washington, DC: Futures Group, USAID | Health Policy Initiative, Task Order 1.

The USAID | Health Policy Initiative, Task Order 1, is funded by the U.S. Agency for International Development under Contract No. GPO-I-01-05-00040-00, beginning September 30, 2005. The project's HIV activities are supported by the U.S. President's Emergency Plan for AIDS Relief (PEPFAR). Task Order 1 is implemented by Futures Group, in collaboration with the Centre for Development and Population Activities (CEDPA), White Ribbon Alliance for Safe Motherhood (WRA), and Futures Institute.

SCREENING FOR VIOLENCE AGAINST MSM AND TRANSGENDERS: REPORT ON A PILOT PROJECT IN MEXICO AND THAILAND

OCTOBER 2009

TABLE OF CONTENTS

ACKNOWLEDGMENTS

This publication was based on final project reports written by Phongsak Sakhunthaksin of the Policy Research Institute Foundation in Thailand and Guillermo Egremy of the USAID | Health Policy Initiative, Task Order 1 in Mexico. Without their documentation and collaboration, this report would not have been possible. Additional inputs by Anne Eckman, consultant, and Ken Morrison, HIV Technical Advisor for the Health Policy Initiative, were also invaluable to this report. The project itself would not have been possible without the leadership and support of Dr. Wiput Phoolcharoen, Nonthathorn Chaiphet, Dr. Somchai Sriplienchan, and Dr. Werasit Sittitrai, advisors to the Policy Research Institute Foundation, as well as Clif Cortez, Nithya Mani, Patchara Rumakorn, and Cameron Wolfe of the USAID regional mission in Bangkok, Thailand. Likewise, we are grateful to Dr. Beatriz Ramirez, Chief of the HIV/AIDS Program in Mexico State and Dr. Marcela Ruiz, director of the CAPASITS of Puerto Vallarta, as well as Nancy Alvey of USAID Mexico and Mirka Negroni and Anuar Luna of USAID | Health Policy Initiative Mexico for their leadership and support of the project. Finally, many thanks go to all of the project participants, including the health providers and staff at Banglamung Hospital, Pattaya Rak Center, SISTERS and SWING in Thailand, and the CAPASITS in Puerto Vallarta and Mexico State and Vallarta Engrente al SIDA, for their contributions and efforts in designing and implementing the screening tool and the project overall.

ABBREVIATIONS

AIDS	acquired immune deficiency syndrome
CAPASITS	HIV & STD Ambulatory Care and Prevention Clinics
CBO	community-based organization
CDC	Centers for Disease Control and Prevention
GBV	gender-based violence
HIV	human immunodeficiency virus
IDU	injection drug user
IPV	intimate partner violence
MARP	most–at-risk population
MSM	men who have sex with men
MSW	male sex worker
NGO	nongovernmental organization
OSCC	one-stop crisis center
PRI	Policy Research and Development Institute Foundation
S&D	stigma and discrimination
STI	sexually transmitted infection
SW	sex worker
TG	transgender(s)
U.S.	United States
VCT	voluntary counseling and testing

EXECUTIVE SUMMARY

Recent studies and anecdotal evidence have shown that gender-based violence perpetrated against men who have sex with men (MSM) and transgenders (TG) can increase their HIV vulnerability, especially in the context of sex work and concurrent partnerships. Few interventions directly address this vulnerability, however. The project described in this document piloted the integration of screening for violence against MSM and TG into HIV health services. The pilot hypothesized that health providers would be an effective entry point to (1) identify violence faced by MSM and TG, (2) facilitate access to appropriate GBV services for MSM and TG, and (3) improve community organization and health service collaboration. The project was implemented in Mexico and Thailand, countries with concentrated HIV epidemics but differing services for MSM/TG.

Based on a desk review and field research, a screening tool and protocol were designed and piloted to detect violence among MSM and TG, especially those engaging in sex work, often one of the few livelihoods open to these populations.[1] Important features of the tool include request for consent to screen, questions for identifying violence related to stigma and discrimination, recommendations on when to apply the tool, indications on referral to specialized support services, and simplicity. Screening was piloted in HIV clinical services, including VCT and treatment programs, in Pattaya City, Thailand, and in Puerto Vallarta, Mexico and the state of Mexico. In Thailand, screening also was integrated into community drop-in services, which included VCT and outreach for MSM and TG. Evaluation assessed the acceptability of the tool from provider perspectives and in Thailand, client perspectives.[2]Barriers to screening and referral in the different contexts were also evaluated.

Although not a population-based study, data from six weeks of implementation at 11 sites (n= 279) in both countries identified high levels of violence among those MSM and TG screened. Results showed that at least half of MSM and TG experienced violence in the year prior to being screened (Mexico: 50% among MSM, n=142 and 65% among TG, n=51; Thailand: 69% among MSM, n=59 and 89% among TG, n=27), with TG experiencing greater levels. All forms of violence were high in both countries. Emotional violence was most common in Thailand (63% among MSM; 78% among TG); sexual violence was most common in Mexico (47% among MSM; 65% among TG). Higher levels of sexual as opposed to physical violence were identified in almost all groups (except for MSM in Thailand, where levels of the two kinds of violence were comparable).

Consultation with providers identified general acceptability of the tool. In Mexico, where the first draft of the tool was developed, providers found the tool to be easy to use and comprehensible. In Thailand, some providers found the language academic and difficult to understand. Providers in both countries found screening to be appropriate for the HIV/STI clinic setting but challenging in a hospital setting, due to larger caseloads, which limited providers' time to apply the screening tool.

The tool helped providers to improve communication and trust with patients, as well as identify and better understand the range of social vulnerabilities MSM and TG face. Providers requested additional training on sexual diversity and how to counsel victims of violence. They also indicated the importance of having in place referral services that cover all needs of MSM and TG, such as legal services and shelters. Overall, providers saw the tool as beneficial to their work and agreed that screening should continue, provided there is institutional support, training, and adequate time and space.

[1] The pilot screening process took place in sites where there are large populations of sex workers. However, for purposes of confidentiality and safety, the screening tool itself did not record whether clients were sex workers.

[2] In Thailand, clients interviewed were those who had close relationships with the personnel of screening sites, which included drop-in/support services for MSM and TG. In Mexico, follow-up of clients would have been necessary, which was beyond the scope of the design and ethical review board approval for the project.

Given the high levels of HIV and violence against MSM and TG, services for them must address the causes and consequences of this violence. In settings with favorable policies and a legal environment that protect MSM and TG, where confidentiality can be ensured, and where an understanding of addressing health issues of HIV includes respect for human rights, HIV programs should sensitize and build the capacity of providers to screen for violence against these populations. Providers also should promote efforts in the community to strengthen multisectoral support services for MSM and TG before screening. In this way, the screening tool can provide an impetus to initiate community-health system collaboration to better respond to violence against these populations in the context of HIV/STI services. The pilot project identified the following key criteria to establish before screening:

- Screen only where there are assurances of no increased harm to MSM and TG or where their human rights are recognized.
- Conduct screening in a space that is private and confidential.
- At a minimum, ensure that psychologists and self-support groups within the clinic are available to counsel victims after screening for violence.
- Continually sensitize and train providers on gender, sexual diversity, violence, and stigma discrimination.
- Before developing screening services, assess, consult with, and engage external referral services to ensure that they can adequately address the needs of MSM and TG.
- Develop clear protocols of who, when, where, and how to screen; make providers aware of the protocols by training these personnel, posting the protocols in visible places, and including them with screening documents.

Screening is hardly enough and certainly not the only or even most appropriate response to violence against MSM and TG. A multisectoral approach, including collaboration with community-based organizations, is essential in responding to the needs of MSM and TG who face gender-based violence. Given that these groups are extremely marginalized and may not readily access health services, there is a special need to develop and support services such as drop-in centers and peer support activities. These may act as the first-line response to MSM and TG who have undergone violence. Likewise, national and community policies and norms must ensure that no increased harm will come to MSM and TG accessing these services. In some cases, this might require parallel advocacy and awareness-raising efforts. The screening and referral process should be complementary to behavior change efforts and activities in these communities.

BACKGROUND

Gender-based Violence and HIV Vulnerability in Most-at-Risk Populations

Men who have sex with men (MSM) and transgenders (TG)—some of the most-at-risk populations (MARPs) for HIV—often face stigma, discrimination, poverty, violation of human rights in the form of homophobia, and heterosexism. Negative attitudes can foster environments that support violence against MSM and TG. Findings from a global literature review on violence, stigma, and discrimination faced by MARPs indicates that worldwide, MARPs face violence from their families, friends, fellow students, and teachers, and in the wider community. Law enforcement and healthcare providers often are guilty of widespread corruption, intimidation, and harassment directed at gay men, other MSM, and TG (Medina et al., 2006; Chakaprani et al., 2002; Khan and Bondyopadhyay, 2005). These acts frequently are cited in India, Latin America, and the Caribbean. Laws also are misused to target and harass MSM and TG in the Middle East, China, and Egypt. In Africa, two-thirds of its countries have laws banning homosexual sex, or at least male-to-male sex. Punishments range from imprisonment (five years in Cameroon, Senegal, and Ghana; life in Uganda) to death (Mauritania, Sudan, and parts of Nigeria) (Betron and Gonzalez-Figueroa, 2009.)

The rates of violence against MSM and TG, particularly those engaging in sex work, are alarming. For example, in Cambodia, rates of rape and physical violence perpetrated against freelance[3] TG sex workers by the police reached 29 percent and 58 percent, respectively (Jenkins, 2006). In a survey of more than 2,000 MSM in Thailand, which included TG, 18.4 percent reported being coerced into sex and, of those, 67.3 percent were coerced more than once (Guadamuz et al., 2006).

This violence is a manifestation of stigma and discrimination (S&D) against MSM and TG, primarily because they do not fit into traditional gender categories. In other words, violence experienced by MSM and TG often is a form of gender-based violence (GBV). The same study in Thailand, for example, found that identifying as female or visibly gay or taking a receptive sexual role, are significantly and independently associated with coerced sex (Guadamuz et al., 2006).

Stigma, discrimination, and violence foster isolation, depression, low self-esteem, and behaviors that put one at high risk for HIV, such as drug and alcohol use and sex work. For MSM and TG populations, stigma, discrimination, violence, and sex work are vulnerabilities that anchor HIV as an epidemic. Although accurate prevalence statistics of HIV among MSM and TG—including those engaged in sex work—are difficult to determine because of the marginalization of those groups, studies reported by UNAIDS (2008) found that rates of HIV among MSM range from 6.2 percent in Egypt to 43 percent in the port of Mombasa, Kenya. For the general TG population and male or TG sex workers, few data are available, but one study from Vietnam reported 33 percent HIV prevalence among male sex workers (UNAIDS, 2008).

Researchers have only recently begun to explore the intersection between violence and HIV vulnerability in MARPs. Nonetheless, strong evidence points to the importance of these linkages. For example, in Kenya, researchers found that MSM who were victims of verbal, physical, or other forms of violence in the past 12 months were significantly less likely to have used a condom at their last receptive anal sex, were more likely to have had unprotected sex at their last insertive anal sex, and were more likely to "never use" condoms (Onyango-Ouma et al., 2006). Moreover, evidence has been found that violence or fear of violence prevents MSM, transgendered people, and sex workers, regardless of HIV serostatus, from accessing HIV and other health services. For example, a study of MSM in the United States showed

[3] Not contracted by an agency.

that participants reporting intimate partner violence (IPV) were significantly less likely to get tested for HIV in the past year or on a regular basis (Leung et al., 2005). Finally, sexual coercion puts MARPs at risk for HIV. In Cambodia, a survey of 1,000 sex workers found that 90 percent had been raped, with more than half of the TG sex workers raped without a condom (Jenkins, 2006).

Just as the research on violence against MARPs is scarce, programs and services that address violence and related health issues are rare or nonexistent (Betron and Gonzalez-Figueroa, 2009). Health-related violence services are limited to a handful of HIV programs that acknowledge the problem of violence, usually through awareness raising, as it emerges as a key issue for MARPs. On the whole, MARPs are so marginalized that they often do not access health services because of poverty, fear of discrimination or social consequences, or general lack of knowledge (Betron and Gonzalez-Figueroa, 2009).

Screening for violence, particularly IPV, against women in the healthcare setting has been recommended by many experts as an opportunity to reach out to victims of violence. Benefits include the potential to counsel victims, to consider violence as a factor in HIV prevention and/or risk reduction and adherence counseling, and to raise the awareness of clients on their rights to live free from violence (Betron and Gonzalez-Figueroa, unpublished). There may also be potential benefits from screening for violence with MSM and TG in the areas of outreach, prevention, and community building.

Violence against MSM and TG: Definitions and Overview

Gender-based violence is "any harmful act that is perpetrated against a person's will and that is based on socially-ascribed (gender) differences between males and females" (IASC, 2005). The perpetrator has the objective of using violence as a way to maintain power and control over the victim (PAHO, 2002). The perpetrator's sense of entitlement to greater power and control is based on the perception that his/her gender holds a higher social status than that of the victim.

Stigma is "an undesirable or discrediting attribute that an individual possesses, thus reducing that individual's status in the eyes of society" (Goffman, 1963). It is labeling an individual or group as different or deviant. *Discrimination* moves into acts and behavior—a differential treatment based on those negative attitudes (Morrison, 2006). Violence against MSM and TG is related to and often can be equated with gender-based stigma and discrimination (S&D). When S&D is enacted against MSM and TG through verbal insults, threats, blackmail, or differential treatment, it becomes—along with physical and sexual violence—part of the spectrum of gender-related abuse that sexual minorities typically face. (Throughout the document, when referring to the range of gender-based S&D and violence perpetrated against MSM and TG, the term *abuse* is used.)

MSM are defined by the U.S. Centers for Disease Control and Prevention (CDC, 2007) as "all men who have sex with other men, regardless of how they identify themselves (gay, bisexual, or heterosexual)." Thus, MSM comprise a broad range of individuals, including, but not limited to, sexually active gay males who identify as such, bisexuals who are sexually active with other males, "closeted" homosexuals having sex with other men, anonymous sexual encounters between males, and male sex workers with clients.

Unlike MSM, TG are not unambiguously of one sex. Instead, **transgenders** are "people who were assigned a gender, usually at birth, based on their genitals but who feel that this is a false or incomplete description of themselves" (T-VOX, 2009). Similar to MSM, however, transgender does not imply any specific form of sexual orientation or identity. In fact, transgender people may identify as heterosexual, homosexual, bisexual, pansexual, polysexual, or asexual. Beyond sexuality, transgender identities include many categories that may overlap, including transvestite or cross-dresser; androgynies (those who are non-gendered or between genders); people who live cross-gender; drag kings and drag queens (those who cross-dress for special occasions); and, frequently, transsexuals (those who undergo sex reassignment therapy to physically change their bodies so as to live and be accepted as a member of the sex opposite to that assigned at birth). The definition of transgender is still in flux and is often hotly contested. Recognizing these ambiguities in terminology and the absence of clear distinctions between transgender subcategories in the existing literature, this review tries to be as inclusive as possible. Nonetheless, most literature reviewed did not necessarily differentiate among the aforementioned subgroups of TG. Therefore, this review will use TG to refer to all of the subgroups described above.

Finally, there are definitional challenges about what constitutes a sex worker (SW), particularly a male and transgender SW. According to UNAIDS, a basic definition of **sex work** is "the exchange of money or goods for sexual services, either regularly or occasionally, involving female, male, and TG adults, young people and children, where the sex worker may or may not consciously define such activity as income-generating" (UNAIDS, 2005). In other words, sex work occurs in very diverse contexts besides the traditional prostitute selling sex on the street or in a bar or brothel. For example, there is the boy who sells sex to the office worker in the park, the drug addict who occasionally sells sex to finance his next high, or the young man who has a "sugar daddy" to pay the rent.

Excerpted and adapted from: Betron and Gonzalez-Figueroa, 2009.

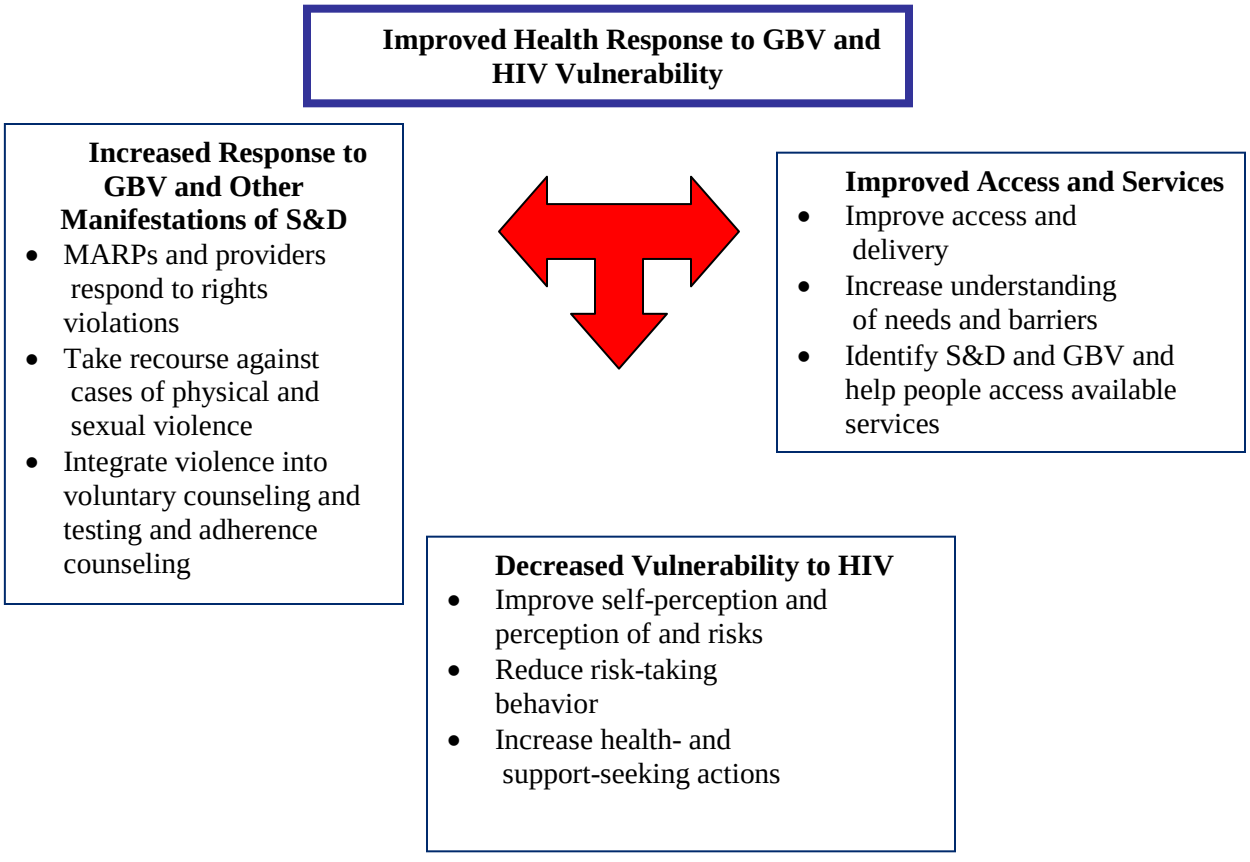
PROJECT OBJECTIVES

Given these important opportunities and benefits in screening for violence, the USAID | Health Policy Initiative, Task Order 1 assessed the feasibility of HIV clinic-based screening for gender-based violence and other forms of S&D in select sites in Mexico State and Puerto Vallarta, Mexico and Pattaya, Thailand. The objectives of the project were the following:

- To *pilot a screening tool* for GBV and S&D against MSM and TG to be applied by health service providers for increasing their recognition of and responses to these issues when providing HIV counseling;
- To *increase understanding of links* between GBV, S&D, and sexual risk taking and access to health services; and
- To foster collaboration of community organizations and health services *to respond to cases of GBV* and S&D that affect HIV risk.

Through these objectives, the project ultimately sought to test a model of care and response to violence against MARPs that would reduce vulnerability to HIV. The project objectives are elaborated in the conceptual model below.

Diagram 1. Conceptual Framework



Overview of Project Components

The first phase of the project consisted of an assessment to identify relevant issues and factors that affected the design of the project, including the following:

(1) A *literature review* to identify and understand (a) the impact of stigma, discrimination, and violence against MSM and TG on their vulnerability and risk behavior related to HIV; (b) promising interventions among programs and policies worldwide that are responding to S&D and violence against MSM and TG; and (c) best practices in screening for violence in the healthcare setting.

(2) A *participatory assessment* comprising in-depth interviews with service providers and focus group discussions with select subpopulations of MARPs to determine the following: (a) types and dynamics of S&D and GBV in the pilot areas; (b) how they affect risk behavior and access to services; and (c) characteristics of HIV clinics selected as pilot sites that would affect the design and success of the GBV screening intervention, such as how clinics organized their services and services providers' openness to addressing GBV.

The second phase of the project, the implementation phase, consisted of the following:

(1) *Design of a screening tool and training module* for healthcare providers to better respond to violence against MSM and TG. The project team incorporated information gathered from the literature review and field research into the design of a tool for service providers to use in HIV health services to screen for violence against MSM and TG. Likewise, the team designed a module to train service providers on the use of the screening tool and on appropriate referral and follow-up.

(2) *Sensitization and training* of health providers and administrators at the pilot sites on (a) gender, S&D, and violence against MSM and TG; (b) the linkages between violence and HIV vulnerability in MARPs; and (c) application of the screening tool, including best practices in screening for violence, particularly intimate partner violence (IPV).

(3) *Set-up of referral systems*, including identifying and establishing linkages with organizations that provide services for victims of violence and for MSM and TG, such as counseling programs, human rights and legal services, and other social support programs.

(4) *Piloting of the screening tool* for approximately six to eight weeks in seven HIV clinics in Mexico, as well as one HIV clinic, one hospital, and two community drop-in-centers in Pattaya, Thailand.

(5) *Evaluation of the screening tool,* including interviews with service providers and, in Thailand, select clients at drop-in-centers who had familiar relationships with screening personnel[4]. Evaluation determined the ease of applying the tool; its appropriateness and components; the perceived improvement in identifying services, access, and delivery for MARPs; and overall, possible improvements to the tool and process for future use. Based on evaluation findings, the project team adapted the tool. (See Annex II for the final version of the screening tool.)

Context of Pilot Sites

Mexico and Thailand both have high levels of discrimination against MSM and TG. Studies have identified and elaborated on the levels and forms of stigma and discrimination—often manifested as physical and sexual violence—perpetrated against MSM and TG in these countries (e.g., Gayet et al.,

[4]In Thailand, clients interviewed were those who had close relationships with the personnel of screening sites, which included drop-in/support services for MSM and TG. In Mexico, follow-up of clients would have been necessary, which was beyond the scope of the design and ethical review board approval for the project.

2007; Jenkins, 2006). It is estimated that two people a week are killed in Mexico because of their sexuality (UNAIDS, 2009). Newspapers in Thailand commonly report on denial of services to TG. Nonetheless, both Mexico and Thailand have developed more progressive laws and policies seeking to eliminate discrimination against MSM and TG. In 2001, Mexican legislators amended the Constitution to prohibit discrimination based on (among other factors) sexual orientation, and in 2003 the Parliament passed the "Federal Law to Prevent and Eliminate Discrimination," which includes a ban on discrimination based on one's sexual preferences (International Gay and Lesbian Human Rights Commission, 2003). Sodomy was decriminalized in Thailand in 1956 and important gains have been made more recently for the equal status of MSM and TG, including the removal of homosexuality from the Department of Mental Health's list of mental disorders (2002) and the creation of "transsexual" as a third category in the military (Armbrecht, 2008).

The project carried out pilots in Mexico State and Puerto Vallarta, Mexico and Pattaya City, Thailand, where there are high concentrations of MSM and transgender populations and high rates of HIV among these populations. Accurate data on the prevalence of HIV among MSM and TG are limited. However, a recent study in select cities with large MSM and TG populations in Mexico found HIV to be approximately 10 percent among MSM (Acapulco, Monterrey, Tampico) and 10–15 percent among TG (Acapulco, Monterrey) (Gayet et al., 2007). Mexico City, its surrounding metropolitan area, and Puerto Vallarta generally are known to have relatively higher numbers of MSM and TG—many are sex workers—although precise numbers are undocumented. Pattaya is a major tourist city and sex work destination in Thailand, with an estimated 4,500 male sex workers (MSW) and 1,200 transgender sex workers (Sakhunthaksin, unpublished). These populations have reported HIV rates as high as 30 percent (CDC TUC et al., 2005).

Due to the high rates of HIV among MARPs in Mexico and Thailand, their governments have implemented HIV and STI services for these groups. Among Thailand's government-run clinics and hospitals that offer specialized HIV and STI services for MARPs, there is one hospital (Bangrak Hospital) within the Bangkok Metropolitan Authority (BMA) health system,[5] one clinic in Phuket,[6] and one clinic in Pattaya (Pattaya Rak).[7,8] These clinics typically are staffed with one or two doctors, one or two nurses, and a social worker.

Similarly, in Mexico, between 2006 and 2008, the Secretary of State put into place 55 public clinics, or CAPASITS (Centros Ambulatorios para la Prevención y Atención del SIDA e Infecciones de Transmisión Sexual), which provide specialized services for people living with HIV and so predominantly serve MSM, TG, SWs, and injection drug users (IDUs) (La Jornada, 2006.) A CAPASITS normally is staffed by a range of health professionals, including two medical doctors, two nurses, a psychologist, a social worker, a lab technician, a dentist, and an infectious disease specialist (Egremy, unpublished). The CAPASITS and the clinics in Thailand provide HIV treatment, testing, care, and support, as well as some prevention and outreach activities.

In both Mexico and Thailand, models of screening for IPV against women have been implemented in select sites with some degree of success. The Thai government has implemented screening in 20 hospitals throughout the country, using the "One-Stop Crisis Center" (OSCC). Women identified as IPV victims are referred to counseling and psychosocial support services incorporated on site within the hospital

[5]Interview with Director of the BMA Health Clinic #9, February 21, 2007.
[6]Interview with Dr. Kimberly Fox, CDC Thailand, January 31, 2007.
[7]Interview with a nurse at Pattaya Rak clinic, May 3, 2007.
[8] There are also a number of private clinics that offer services to MSM and TG based on special arrangements made with SISTERS and SWING, community-based organizations that conduct HIV/AIDS education and outreach.

(Grisurapong, 2002). Mexico has a multisectoral Integrated Model for the Prevention and Care for Family and Sexual Violence; the health sector's role is to provide quality care for women experiencing violence. The Secretary of Health also has a policy of universal screening for violence against women. However, health providers interviewed in the initial participatory assessment indicated that the screening tool is not used consistently either in their clinics or others because some clinic staff perceive the questionnaire to be too long or unnecessary.

In both Mexico and Thailand, high levels of HIV among MSM and TG, a legal and political environment relatively accepting of these populations, and the existence of clinics with experience and interest in serving MARPs all provided appropriate settings to pilot screening for violence against MSM and TG. Although attitudes and practices are far from equitable and non-discriminatory in these countries, there is heightened awareness, especially in HIV settings, for the need to address social vulnerabilities faced by MSM and TG. Moreover, many stakeholders recognize that HIV services in the health sector have an important role to play in addressing those vulnerabilities.

Project Partnerships

In Thailand, the Health Policy Initiative partnered with the Policy Research and Development Institute Foundation (PRI), a Thai policy and research organization working in the area of sexual and reproductive health, to lead the project at the local level. In turn, PRI worked closely with the following four implementing partners: SISTERS, SWING, Banglamung Hospital, and Pattaya Rak Centre. (See Box 1 for a full list and description of project partners in Thailand.) SISTERS and SWING, two NGOs run by transgenders and MSM, respectively, played key roles in the project by training service providers, serving as screening sites, and providing referral services. Both SISTERS and SWING have drop-in centers in Pattaya and conduct prevention outreach for transgenders and MSW, respectively. The clinical pilot screening sites were Banglamung Hospital, the main government hospital in Pattaya City and Pattaya Rak Centre, a government-run STI clinic for male and female sex workers and TG. All partners provided input to the project and screening tool design. The municipal government in Pattaya and the government-run domestic violence shelter in the province of Chonburi also provided input for the project design and collaborated in its implementation by participating in referral networks for follow-up support to victims of violence.

Box 1. Project Partners in Thailand

Policy Research and Development Institute Foundation: NGO conducting research and analysis of policies at the community, civil society, local, national, and international levels to promote fair, equal, and inclusive public policy.

SWING: NGO providing STI- and HIV-related education, outreach activities, and counseling services targeting male and female sex workers in Pattaya.

SISTERS: NGO providing STI- and HIV-related education, outreach activities, and counseling services targeting transgendered sex workers in Pattaya.

Banglamung Hospital: District-level government hospital providing general medical services for the general population.

Pattaya Rak Centre: Governmental clinic providing STI-related screening, treatment, and counseling services, targeting male and female sex workers and transgendered populations.

Pattaya Municipal Government: The district-level entity responsible for social security and welfare for the Pattaya population.

Nhongprue Municipal Government: The subdistrict entity in charge of social security and welfare for the Nhongprue subdistrict population.

Children and Family Housing: Chonburi province: The government shelter in Chonburi Province providing temporary accommodation and counseling for women and children facing domestic violence and other family problems.

Source: Sakhunthaksin, Unpublished.

In Mexico, local project staff also worked with key partners, in particular the HIV/AIDS Program of the state of Mexico and the CAPASITS of Puerto Vallarta. The directors of these programs were instrumental in providing an enabling environment to implement the project activities. In both Puerto Vallarta and the state of Mexico, NGOs were involved, but to a lesser extent than in Thailand. It is worth noting that at the time of the pilot there were no NGOs in Mexico specifically organized to undertake outreach to MSW or TG. Instead, project staff worked with organizations such as Vallarta Enfrenta el SIDA and APROASE that offer services to MSM and female sex workers.

Findings from the Participatory Assessment

A participatory assessment in both countries informed the development and design of the pilot implementation of the screening tool. The assessment consisted of in-depth interviews and group discussions using participatory learning and assessment methodologies, such as free-listing, community mapping, open-ended stories, and problem trees. Discussions with health providers identified their attitudes and behavior, as well as perceived barriers to and opportunities for integrating screening for violence against MARPs within their services. In discussions with MSM and TG, the project team sought to identify types of violence, including S&D, that these populations face and how those experiences may limit access to, or could be addressed by, health services.

In Thailand, PRI staff conducted in-depth interviews with key stakeholders, including 11 health providers at Banglamung Hospital (the main hospital in Pattaya City), 3 providers at Pattaya Rak (the STI clinic specializing in services for MSM and TG), and 8 representatives from government and SISTERS and

SWING. Staff also facilitated focus group discussions with two MSM groups recruited by SWING and two TG groups recruited by SISTERS, each group consisting of 10–11 individuals.

In Puerto Vallarta, Mexico, the project research team conducted in-depth interviews with 12 health providers and a focus group with 5 providers, all of whom CAPASITS identified as having worked with HIV patients who have experienced violence. The project team also conducted a focus group with TG in Mexico City (n=5) and in-depth interviews with 5 TG in Puerto Vallarta and 8 MSW in Puerto Vallarta, Jalisco, and Mexico City. The NGOs Vallarta Enfrenta el SIDA in Puerto Vallarta and APROASE and the Network of People Living with HIV in Mexico City identified the focus group participants. Because there were no NGOs that reached out to TG and MSW in Mexico, project staff found recruitment to be more difficult and interviewed fewer respondents than initially planned.

The assessment identified common themes regarding violence, S&D, and HIV vulnerability in both Mexico in Thailand. In both, violence was widespread. In Mexico, MSM and TG experience the range of forms of violence identified in the literature review—physical, sexual, and emotional/psychological, including S&D. When asked with whom they felt most unsafe, Mexican TG cited gangs, police, drug addicts, priests, neighbors, and co-workers.

- "*There are more unsafe than safe spaces*."—TG in Mexico
- "*He tied him up, with a bat he hit him in the ribs, he burned his hair, and he penetrated him without a condom*." MSM sex worker in Mexico, referring to a fellow MSM
- "*There are many who deny violence [in MSM and TG], but it is perhaps as high 60 percent*."—Health provider in Mexico
- "*The police have gone as far as to rape and beat me and my friends…*"—TG in Mexico
- "*Anyone that is passing by yells profanities, throws objects, or hits us*."—TG in Mexico

In Thailand, assessment results also indicate that violence—particularly as an expression of S&D—is pervasive and is perpetrated by various members and institutions throughout the community, such as businesses, employers, and hospitals.

- "*Some hotels did not allow us to stay in their premises. Some treat us very bad like we were just animals. Some asked for the identity card and when they knew that we were not women, but TG, they did not permit us to stay as well. Some asked for additional charge*." —TG sex worker in Thailand
- "*Some people hate TG. When we were passing by, they splashed water on us*."—TG in Thailand
- "*When [I] go shopping, some shopkeepers were staring at me as if I were a disgusting monster*."—MSM in Thailand

Health providers, MSM, and TG alike acknowledged that the police are recurring perpetrators of violence in both Mexico and Thailand. This was particularly true for TG in Thailand. Violence by police consists of verbal harassment as well as physical abuse and extortion of money or sex to avoid arrest.

- "*Any place can be unsafe for us, but particularly in the street, above all with the police*."—TG in Mexico
- "*Occasionally, I did not have money, so I had to do oral sex for a police as reciprocity of a fine*."—TG in Thailand
- "*Police were extremely rude to us and treat us like animals. Sometimes we did not have enough money for a fine; then they seize our properties and belongings*." —TG in Thailand

In both Mexico and Thailand, evidence from the focus group discussions with MSM and TG also point to the fact that violence is gender-based. Respondents in Mexico perceived "feminized" MSM and TG to be

at greater risk for violence. In Thailand, TG respondents cited their distinctive appearance as a key factor in the violence and related S&D they experienced.

"*It is when we show visible feminine traits that we are most at risk [for violence]*."—MSM in Mexico

Finally, it was enlightening to find that the violence described above has gone largely unacknowledged and indeed is seen as the norm; MSM and TG who experienced violence did not necessarily recognize it as such. Because they were so accustomed to ridicule, discrimination, and other forms of abuse, many MSM and TG in Thailand had never realized or considered that they were living an experience of violence. In Mexico, some respondents seemed resigned to the abuse they faced, saying

"*We have always suffered this rejection, and it will always be that way.*"—TG in Mexico

Health providers generally did not make the connection between violence against MSM/TG and HIV vulnerability. In Thailand, they did not seem to recognize violence as a public health problem at all. For example, health providers interviewed in Thailand did not see violence as something that could undermine the confidence of MSM or TG to access health services, nor did they perceive their own attitudes toward these populations as a potential barrier. In Mexico, on the other hand, providers recognized that violence isolates MSM and TG, preventing them from accessing care and causing them to abandon treatment:

"*The violence has effects in that [*MSM and TG*] do not attend consultations and they isolate themselves a lot*."—Health provider in Mexico

Still, providers had not made the explicit link between violence against MSM/TG and HIV:

- *"No, I have never thought about that* [the link between violence against these populations and HIV]*."***—**Health provider in Mexico
- "*Before I had not thought about the link between HIV and violence*."—Health provider in Thailand
- "*In the past, I thought about violence as only physical and sexual harm. I had not thought about emotional abuse as a form of violence*."—Health provider in Thailand

Despite having little experience in addressing issues of violence, most providers interviewed in Mexico welcomed the idea of screening for violence against MSM and TG. Providers in Mexico recognized that they were not prepared to respond to violence against these populations but could do so if provided with the proper training.

- *"We are not prepared, but we have to help."* —Health provider in Puerto Vallarta, Mexico
- "*It seems like a very good idea. What we need in this is trained personnel; there is no training*."—Health provider in Puerto Vallarta, Mexico

Although providers in Thailand also were open to testing the screening tool, they reported that, in the past, they had not seen the importance of their role in responding to violence against MSM and TG. Some felt that MSM and TG in Pattaya are widely accepted and so do not need special attention related to violence and S&D. Others initially saw the police or friends as the first line of response for MSM and TG experiencing violence. In fact, as described above, the police often are the worst perpetrators of this violence.

- "*When this population* [is] *faced with violence, they coped with it by themselves without their request [for] help and support from others. They could go to report their experience to the police. They always asked for help from their peers, but never asked from us*." —Health provider in Thailand

On the other hand, those MSM and TG interviewed said that they were open to a GBV screening intervention and, in Mexico, identified health clinics or CAPASITS as the most appropriate sites for implementing the screening (Egremy, unpublished; Sakhunthaksin, unpublished). They also recommended training for health providers to ensure that MSM and TG are treated with respect throughout the process. On the whole, in both Mexico and Thailand, MSM and TG who were interviewed sought comprehensive, non-discriminatory, quality health services.

- "*They could have talks for the abused and abuser for men, the same as for women and men.*"—MSM in Mexico
- "*There has to be training, to treat everyone with respect.*"—MSM and TG in Mexico
- "*The hospital staff just performed their duties but in reality they did not like us.*"—MSM in Thailand

PROJECT IMPLEMENTATION PHASE

Country-Specific Project Adaptations

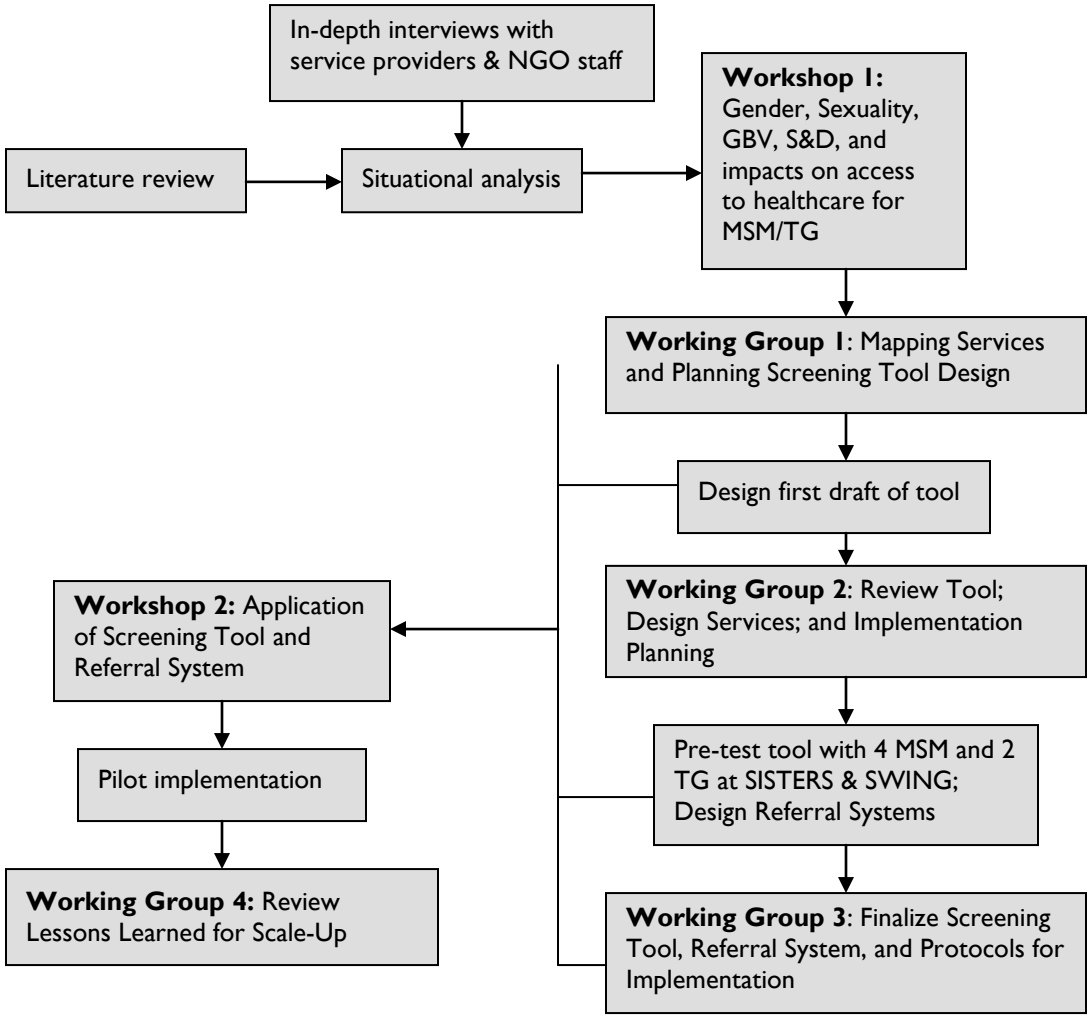
As a project that focuses on improving the health policy environment and overcoming policy barriers in sexual and reproductive health, the Health Policy Initiative works closely with—or often through—existing government programs and services This project was no exception. In cooperation with the state and municipal governments of the pilot sites, the project team adapted an implementation approach that fit local needs, resources, timelines, and other constraints and opportunities.

Thailand

Following the participatory assessment to determine the types and dynamics of violence against MSM and TG, as well as the qualities of participating clinics (as described in the next section), these government and civil society stakeholders came together in a series of workshops and meetings (see diagram below) to collectively

- Design the screening project;
- Participate in training on issues of gender, sexuality, S&D, and GBV, as well as applying the screening tool;
- Determine the flow of patient services from health to other services that could provide some type of support for MSM and TG who experience GBV (i.e., the referral system); and
- Discuss the project findings, outcomes, and implications for future services and programs.

Diagram 2: Overview of Project Implementation Process in Thailand



Mexico

Once the participatory assessment phase was complete, the HPI Mexico team developed a training package to sensitize health providers on gender, sexuality, gender-based violence and HIV/AIDS, and best practices in screening for violence. Participating health providers in Mexico were trained more extensively than the Thai collaborators on the minimum requirements needed before screening (as described in Box 2) and implementing referral systems. Unlike the Thai team, however, the providers also led the set-up of referral systems and protocols for screening. HPI Mexico assisted by holding meetings with participating clinic staff to discuss devising possible safety plans for clients and arranging for referral organizations; both of these elements are considered critical minimum support for victims.

Box 2. Elements to Address before Screening

- Be aware of the legal environment, including laws on homosexuality, homophobia, and sexual and domestic violence
- Provide ongoing in-service training sessions on gender, sexual diversity, and GBV for *all* staff.
- Establish norms, policies, and protocols for screening.
- Ensure infrastructure to allow for private consultations.
- Ensure the supply of STI/HIV prophylaxis.
- Identify counseling, legal aid, and support groups as referral services for MSM and TG; consider providing services where none exist.
- Identify elements of a safety plan or specific to MSM and TG
- Maintain adequate records/information systems.

Adapted from: Heise et al., 1999.

As in Thailand, HPI Mexico also conducted mid-term site visits to check on the progress of the screening and encourage the clinic staff to apply the tool. Finally, the project team facilitated a meeting of stakeholders, including providers who applied the screening tool, the coordinators of the CAPASITS of Puerto Vallarta, the Chief of the HIV/AIDS Program of the state of Mexico, the director of the National Center for the Prevention and Control of AIDS (CENSIDA), and the Program Officer for the Program for Transgender People at CENSIDA to share findings from the pilot intervention, discuss possible scale-up, and recommend policy-related actions.

SCREENING TOOL DESIGN

Based on the literature on screening for IPV against women, screening tools for violence are most effective when they are designed with language that is simple, direct, and non-judgmental. Best practices in IPV screening also indicate that questions may best be asked in person, in a confidential setting, and in a way that allows victims to choose whether they will report their case to the authorities or seek follow-up care (Betron, unpublished). A verbal screen also is important for allowing the provider to collect contextual information related to the incidence of violence; provide valuable advice to the client, such as safety planning for those in immediate danger for heightened abuse, murder, or suicide; and refer patients to specialized support services for violence, such as psychosocial care or legal services (Betron, unpublished).

Box 3. Screening Tool Questions to Identify Experience of Violence

(1) In the past year, has anyone insulted you, threatened you, made you feel inadequate, or yelled at you?

YES ( ) NO ( ) NO RESPONSE ( )

(2) In the past year, has anyone made you feel threatened, fearful, or in danger?

YES ( ) NO ( ) NO RESPONSE ( )

(3) In the past year, has anyone slapped you, punched you, hit you, or caused you any other type of physical harm?

YES ( ) NO ( ) NO RESPONSE ( )

(4) In the past year, has anyone forced or coerced you to have sexual relations against your will?

YES ( ) NO ( ) NO RESPONSE ( )

Based on these and other important findings from the literature, the project designed a questionnaire to do the following:

- Ask for a client's consent to inquire about his/her experience of violence.
- Identify whether a patient has experienced emotional, physical, or sexual violence at the hands of a partner or other individual among family, friends, or community (see Box 3).
- Determine the context of violence, including the perpetrator's identity and potential effects of that violence.
- Assess the risk that the client will experience ongoing or life-threatening violence.
- Refer the victim to a counselor, human rights ombudsman, or other social service, such as a drop-in center.

During workshops in Mexico and Thailand, the project team asked health providers and NGO representatives to help vet and adapt the initial set of questions to be used in the screening tool. This process sensitized providers on issues related to GBV and S&D and oriented them on the use of the screening tool and follow-up care (as described in the next section). In Thailand, MSM and TG participated in the workshops and gave input on the tool's design. The resulting screening tools applied in each country were very similar. (Annexes I and II show the English translation of screening tools applied in each country.)

Nonetheless, a few variations emerged from the country vetting processes. One key difference was that the questions applied in Thailand aimed at identifying gender identity (male, female, MSM, TG) by asking clients to indicate their sex as well as the sex of their partner/s. In Mexico, however, the screening

tool assumed that providers would rely on being an integral part of the client history intake, which provided this information.

Training Providers to Screen for Violence against MSM and TG

Box 4. Topics on which Providers were Trained

- Sexuality, sexual diversity, and gender
- Violence and S&D against MARPs
- Violence, S&D, links to HIV
- Health sector role in responding to violence against MSM and TG
- Best practices in screening for violence: lessons from IPV screening
- Hands-on practice in applying screening tool
- Referral system and follow-up support

Previous studies on GBV screening, particularly intimate partner violence against women, have identified sensitization and training of health providers on issues related to GBV care for victims as critical for encouraging providers both to screen and to do so appropriately. Recognizing this important best practice, the project team developed training modules covering a range of topics, from sexual diversity and gender, to lessons learned in IPV screening, as described in Box 4. The project team adapted training sessions on IPV patterns and screening from lessons and programs for women to fit the contexts of MSM and TG, including those in sex work.

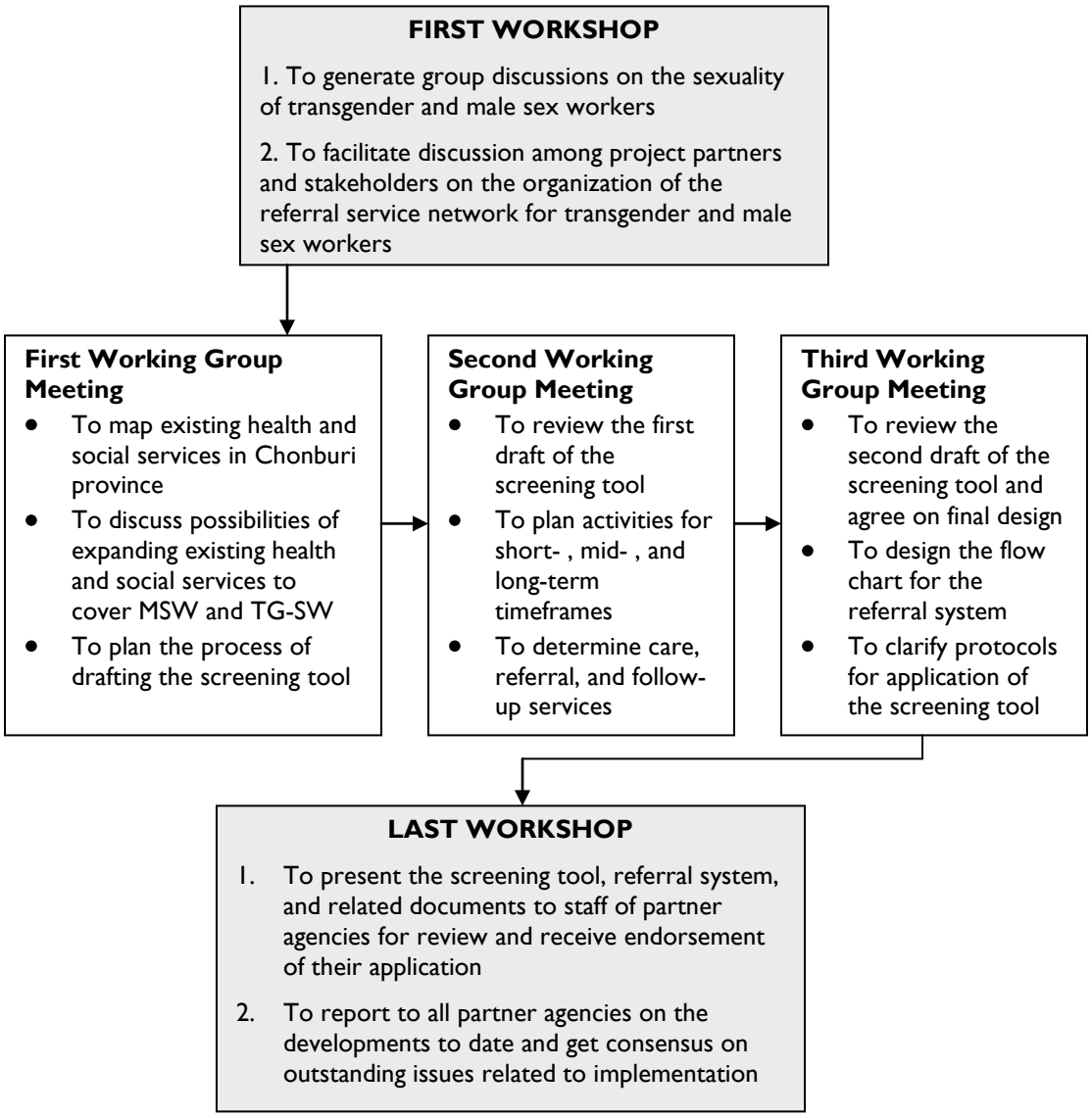
During the application of the training modules, the project team identified sessions that worked well and those that needed further adaptation, in addition to gathering new ideas and feedback from the participants. In Thailand, due to time limitations for some participants, the team used an abbreviated version of the training, with less focus on experiences of screening for IPV in women. (The training workshops in Mexico and Thailand had specific training objectives of their own.)

In Mexico, the project team applied the training modules during two workshops of approximately 28 hours each, with 42 participants from five CAPASITS (Ecatepec, Naucalpan, Netzahualcóyotl, Tlalnepantla, and Toluca) and two hospitals in the state of Mexico (General Hospital of Cuautitlán and Atizapan); and another 14 participants from the CAPASITS in Puerto Vallarta. Participants included doctors, nurses, psychologists, dentists, and social workers in both the state of Mexico and Puerto Vallarta, some of whom piloted the screening tool in their clinics. Other participants in Puerto Vallarta included representatives from the NGO Vallarta Enfrente el SIDA (VES) and local and state governments (the Municipal Committee against AIDS (COMUSIDA/Vallarta), the Institute of Social Security and Services for State Employees (ISSTE), Mental Health and Prevention, the Secretary of State Health, and the State AIDS Program (COESIDA/Jalisco).

This participation by NGO and government representatives was important in developing referral systems and establishing cooperation among NGOs, health providers, and other government services that could form a network of support services for MSM and TG experiencing violence. In follow-up sessions of approximately two to four hours, the project team worked with individual clinics in the state of Mexico to identify referral services. The team presented the concepts of referral directories and safety planning for those at risk of immediate grave or life-threatening violence. However, establishing referral systems was left to the individual clinic to pursue. This variation ultimately resulted in weaker referral systems in Mexico, as described later.

The training model in Thailand differed in that there were only 10 hours of traditional training—5 hours on gender, sexuality, S&D, and GBV and 5 on how to use the screening tool and referral system. The project team trained a limited number of clinic/organization directors (21–24 participants per session). However, between the two workshops, the team in Thailand also conducted three working group meetings; the groups were composed of key stakeholders and decisionmakers from participating health services, SISTERS, SWING, and local government (13–16 per meeting). The goal was to develop adaptations to the screening tool and referral system. Participating in these working groups helped to further sensitize and train service providers on the use of the tool and referral system. The entire training process, which took place over three months (February–April 2008), is described in Diagram 3.

Diagram 3. Objectives of Training in Thailand



Adapted from: Sakhunthaksin, unpublished.

In addition to the workshops and meetings facilitated by PRI described above, the director of Banglamung Hospital arranged a half-day of in-service training for 10 more members of the hospital staff. Training covered application of the tool, as in the second workshop shown in the diagram above. Although these individuals did not administer the tool, they did refer clients who fit the target profile to other staff who had participated in the PRI-led trainings. In turn, those staff administered the screening tool to the referred clients.

PILOT SCREENING PHASE

Thailand

The screening tool was tested in the following six pilot settings: Pattaya Rak Center, an STI clinic for male and female sex workers and TG; SISTERS drop-in centers; SWING drop-in centers; and three departments in Banglamung Hospital, the city's main government hospital. Outpatient services (OPD), Emergency, and Sanitation were selected, based on interest from staff in these departments who volunteered to participate in the project. Providers at the hospital sometimes had difficulty in identifying whether a client was an MSM or TG, or felt awkward asking. As a result, these providers screened only clients they perceived to be MSM or TG; the exceptions were VCT counselors, who felt comfortable openly discussing sexuality with clients. Pattaya Rak Center, SISTERS, and SWING have a small enough number of clients that they were able to apply the screening tool more broadly throughout their services. Screening began one month after the last training session and lasted six weeks (between May and July 2008). (See Table 1 for further details on the screening sites and timeframes.)

Table 1. Sites of Screening in Thailand

Site	Total Days of Pilot Test	Types of Clients	Interviewer / Persons Responsible	Number of Tools Applied, % of Target Clients Screened
1. Outpatient Department, Banglamung Hospital	40 Days	- VCT clients - All clients presenting any types of violence - General clients perceived as MSM/TG	1. Nurse 2. Nurse	9, 0.05%
2. Emergency Department, Banglamung Hospital	40 Days	- All clients perceived as MSM/TG	1. Nurse 2. Nurse	7, 0.07%
3. Department of Sanitation, Banglamung Hospital	39 Days	- VCT clients	1. Other health provider 2. Other health provider	13, 1.21%
4. Pattaya Rak Center	41 Days	- Clients for STI checkup	1. Nurse	42, 26.09%
5. SWING	45 Days	Clients for: - Counseling - Emergency service - Drop-in center	1. Outreach worker	10, 28.5%
6. SISTERS	45 Days	Clients for: - Counseling - Health service - Drop-in center - Outreach to target individuals	1. Outreach worker 2. Outreach worker 3. Other health provider	6, 1.55%

Following best practices in screening for IPV against women, providers also were instructed to refer MSM and TG clients to other specialized services if they were experiencing abuse. The referral network

devised by the working groups was included as an annex to the screening tool. Due to the variation in services they offered, Banglamung Hospital, Pattaya Rak, SISTERS, and SWING referred clients experiencing violence to each other for specialized areas of care. For example, Pattaya Rak could refer clients to SISTERS and SWING for peer support services and SISTERS or SWING might refer clients to Banglamung or Pattaya Rak for VCT services. In addition, other referral agencies included local shelters for women and children or those living with HIV, municipal social welfare offices, child legal services, and occupational training centers. Also included with the screening tool was a form to register referrals made to other organizations and a list of referral organizations for clients identified as victims of violence (see Annex V). Another registration form recorded information about clients referred from other institutions participating in the referral network (see Annex VI). This form recorded which institution referred the patients and what follow-up service they may need. (See Annex III for English translations of the referral network, Annex IV for the list of referral agencies, and Annexes V and VI for the referral registration forms.)

Mexico

In Mexico, five of the trained health sites piloted the screening tool, including the CAPASITS of Ecatepec, Naucalpan, and Tlalnepantla, the General Hospital of Cuautitlán in the state of Mexico (which will be converted to a CAPASITS in the near future), and the CAPASITS in Puerto Vallarta. These sites were selected based on their interest and experience in working with MARPs and MARPs' involvement in facilitating self-support groups and promoting services in the community. Screening was conducted in two departments per CAPASITS and, in most cases, the psychologist and/or social worker conducted the screening with one other provider. The CAPASITS screened clients seeking testing and treatment for HIV. In Cuautitlán General Hospital, clients seeking HIV treatment were screened. In four out of five sites—those in Mexico State—screening took place over a period of six weeks; in Puerto Vallarta, screening was conducted for just four weeks, as further detailed in Table 2.

Table 2. Sites of Screening in Mexico

Site	Weeks of Testing	Types of Clients	Interviewer / Persons Responsible	Number of Tools Applied
Puerto Vallarta	4	VCT and HIV-related or AIDS-related treatment	Administrator, Doctor, Psychologist, Social Worker	17
Ecatepec	6	VCT and HIV/AIDS treatment	Doctor, Social Worker	39
Tlalnepantla	6	VCT and HIV/AIDS treatment	Social Worker, Psychologist	61
Cuautitlán	6	HIV/AIDS treatment	2 Doctors, Nurse	18
Naucalpan	6	VCT and HIV/AIDS treatment	Social Worker, Pharmacist	58
TOTAL				193

The referral systems varied for each site in Mexico but overall, clinics had trouble identifying formal services that could respond adequately to the needs of MSM and TG experiencing violence. Most sites depended largely on services internal to their health center, such as psychosocial services. In other cases, providers reported that they referred clients to family or friends. Just one site, the CAPASITS of Tlalnepantla, developed a list of services to which clients who had experienced violence could be referred. These services included NGOs that provide HIV/AIDS services for MSM/TG; the State family

social services institution; the government-run family violence care and prevention units in Mexico City; an NGO that offers health, legal, and psychological services to rape survivors; the human rights ombudsman for the government of Mexico; the public prosecutor's office; and a juvenile rehabilitation center that attends to family conflicts.[9] One of the key aims of the project was to link health to specialized community services outside of the health system. Thus, for the purposes of this analysis, referrals to family, friends, and psychological services internal to the clinic were excluded in data analysis.

[9] Desarrollo Integral de la Familia, Unidades de Atención y Prevención de la Violencia Familiar del Gobierno del Distrito Federal (UAPVIF), Asociación para el Desarrollo Integral de Personas Violadas, A.C. (ADIVAC), Consejo Nacional para Prevenir la Discriminación (CONAPRED), Ministerio Público. Centro de Integración Juvenil.

SCREENING RESULTS

To collect and analyze screening data while still maintaining confidentiality, a form attached to the end of each screening tool provided a summary of key data identified from each screening. Such data included the sexual orientation of the client (MSM or TG); whether the client experienced violence; which type of violence (emotional, if the client answered "yes" to questions 1 or 2 in Box 3; physical, if "yes" to question 3; or sexual, if "yes" to question 4); whether the provider referred the client to other services; and whether the client accepted the referral.[10] In Mexico, the form also asked the provider to report whether he/she helped the client to create a safety plan. The project team (PRI in Thailand and Health Policy Initiative in Mexico) collected these forms, coded the data, and aggregated data using Excel.[11]

Levels of Violence Detected

First and foremost, it is important to note that this was a screening, not a survey, and so was not intended to produce results that could be generalized to all MSM and TG. Instead, the results of this pilot project are indicative of the high levels of violence found in groups at risk for HIV and accessing HIV services. Indeed, the screening tool found that half or more than half of MSM and TG in both Mexico and Thailand experienced violence. A full 50 percent of MSM in Mexico and 69 percent in Thailand had experienced some form of violence. A much smaller number of TG was screened in both countries, but the screening still identified high levels of violence in this population. In Thailand, 89 percent of TG reported having experienced violence. In Mexico, 58 percent of TG were officially registered as experiencing violence, and another 15 of 20 individuals indicated on the forms as both MSM and TG had experienced violence. The researchers coded these individuals as TG, as they were likely male-to-female TG who might not always be visually identifiable as female or had undergone sex reassignment therapy or surgery.[12] (As discussed in more detail in the section on findings for screening tool use, providers seemed to be confused about how to classify clients according to the categories provided in the screening tool.) If the clients registered as both MSM and TG are considered in the TG category, levels of violence reached 65 percent for this group.

Emotional violence was most common in Thailand, with one out of three MSM and four out of five TG experiencing this type of violence. In Mexico, sexual violence was the most common type, with nearly half of MSM and three out of five TG experiencing this. Both physical and sexual violence levels were high, but higher levels of sexual violence (compared to physical violence) were identified in almost all groups in both countries except for MSM in Thailand, where levels of these types of violence were comparable (20% vs. 24%). Based on the literature, MSM and TG who are sex workers—as many in this sample are—often face extortion, blackmail, and threats by police. This may explain the higher levels of sexual violence.

[10] In Thailand, separate referral forms were used to track whether referrals were accepted. In Mexico, referrals were not tracked. Providers only judged whether clients showed interest in pursuing the referral service. This was a major limitation of the study.
[11] Due to the small sample sizes for all groups in each setting, statistical significance could not be established.
[12] As discussed in the background section, definitions of MSM and TG can be fluid, overlapping, and open to debate, which also can lead to confusion.

Table 3. Levels of Violence Detected

Persons Screened	Number Screened	Violence Experienced within Past Year, #, %			Type of Violence, #, % of those screened				If Experienced Violence, previously sought help? #, %
		Yes	No	No answer	Emotional	Physical	Sexual	All Types	Yes
Mexico–MSM	142	71 50%	67 47%	4 3%	42 30%	22 16%	67 47%	16 23%	29 41%
Mexico–TG	51	33 65%	16 31%	2	29 57%	28 55%	33 65%	26 51%	10 20%
Thailand–MSM	59	41 69%	18 31%	0	37 63%	14 24%	12 20%	4 6.8%	4 10%
Thailand–TG	27	24 89%	3 11%	0	21 78%	9 33%	16 59%	5 18.5%	4 17%

Help Seeking and Referrals

The majority of those who experienced violence had not sought help from anyone; this confirmed what the project had learned from the literature review and participatory assessment. Only two out of five (41%) MSM in Mexico sought help for violence, yet this was the group that had the highest reported levels of help seeking. In Thailand, help seeking was very low for both MSM and TG, with 1 in 10 and 1 in 5, respectively, seeking help.

In both Mexico and Thailand, few screened clients indicated the need for specialized referral services. According to providers, most positive screens accounted for cases of violence that took place in the distant past rather than recent incidents. Thus, most providers did not find that clients needed referral services beyond basic counseling available on-site. In Mexico, because of the limitation of specialized services for MSM and TG in the community, most participating clinics generally referred only those positive screens who demonstrated need for further care and support to the on-site psychologist (in cases where the psychologist did not conduct the screening). Tlalnepantla, the clinic at which staff developed and distributed referral lists, was the exception in that its providers referred positive screens by distributing copies of the referral list. Providers reported that 59 out of 104 positive screens were referred, but 15 of these were referred to family, friends, or psychologists internal to the organization.[11] For purposes of project analysis, providers in Mexico referred 42 percent (44 out of 104) of those who experienced violence. (More than half of these—27—comprised Tlalnepantla clients.) Of those referred, 38 percent seemed to accept the referrals, according to providers. The project did not conduct tracking and follow-up in Mexico to determine whether clients actually accessed the referral services, however.

Table 4. Referral Made and Accepted

Persons Screened	Experienced Violence #	Referred by Provider, #, % of those who experienced violence	Referral Accepted, #, % of those referred
Mexico–MSM and TG	104	44[13] 43%	23 38%
Thailand–MSM and TG	65	7 11%	5 71%

In Thailand, staff recorded referrals only for clients who demonstrated immediate need for specialized services. All clients screened received a list of referral agencies that could provide related services, however. There were a total of seven clients who were referred: SWING and SISTERS referred three clients to Pattaya Rak for STI screening and treatment, and Pattaya Rak referred four clients to SWING for peer counseling. The success in tracking these referrals indicates the functionality of the tracking forms used and the partnerships formed among service providers in the referral network.

It is important to note that, of the referrals made for immediate services needed, a high proportion—five out of seven—resulted in clients accessing the services to which they were referred. (Two clients referred by Pattaya Rak did not seek services.) However, given the small number of referrals recorded, little scientific analysis can be made as to the types of services needed by clients. Most clients screened indicated that they did not need further help with respect to the violence they experienced. Instead, they preferred to seek support from friends, indicating that strong peer support networks may be a possible complementary service that should be developed.

[13] Providers actually reported referring 59 clients, but 15 of these were referred only to family, friends, or psychologists internal to the organization. For the purposes of this research, we have included referrals only to formal institutions outside of the screening service setting.

EVALUATION FINDINGS

In addition to analyzing screening data, project teams in each country interviewed providers who had implemented the screening tool. In Mexico, all providers who applied the tool—a total of 13—were interviewed, and in Thailand, 10 out of 11 providers were interviewed. (See Annex VII for a list of providers interviewed.) These interviews verified the adequacy and appropriateness of the language used in the tool; ease of use; any barriers to screening for violence against MARPs; perceived benefits or drawbacks to screening; additional capacity building needed to apply the screening tool; and recommendations for scaling up the screening intervention. The team in Thailand also interviewed 16 clients after the screening process, which was approved by a local ethical review board. In Mexico, follow-up with clients was beyond the scope of the evaluation design.

Evaluation of the Screening Tool Design

Providers in both countries found the tool useful and comprehensive. Those in Thailand said that the tool helped them better understand the violence and related struggles that MSM and TG face. In Mexico, providers found the screening tool useful not only in helping them understand violence against these populations but also in raising awareness among clients, who began to realize that what they have experienced constitutes violence.

> *"Using the screening tool was a great opportunity for me to know their way of lives that I had never known before. Further, I could understand more about the concept of violence, which was not limited only to physical and sexual violence, but also includes emotional violence, which could [be] severely affect[ted to] their lives. In addition, due to the real experiences I faced [in applying the screening tool], this resulted in my good and positive attitudes towards them."* —Provider in Thailand

> "*Yes … it surprised me that the people's answers were positive, but when you talk of violence and its different types, they catch on that they are living it*."—Provider in Mexico

The language of the tool proved to be more acceptable to providers in Mexico than those in Thailand. In Mexico, providers generally found the language to be appropriate and easy to understand.

> *"[It's] simple, clear, concrete*."—Provider in Mexico

> "*All the patients answered me. It was not difficult for them, they respond quickly*."—Provider in Mexico

Perhaps reflecting the fact that a first draft of the screening tool was developed with the team in Mexico and then translated to English and then to Thai, a few (2 out of 10) providers in Thailand found the language of the tool to be academic, technical, and difficult to understand early in the pilot process. They became confused and had difficulty when applying the tool at the start of the pilot. Clients, in turn, became confused and did not understand questions asked by providers. As a result, in some cases, the screening process collected some information not intended, such as details regarding the past help that patients obtained related to experiences of violence (Sakhunthaksin, unpublished). Challenges due to the language dissipated, however, as providers became more familiar with the tool.

> "*For the first case, I was very confused how to use it, but after a few cases, it was easier later."*—Provider in Thailand

"*Sometimes I could understand what the staff said, but sometimes it was so confusing. I heard that even the staff did not understand when they had to read the long questions*."—Client in Thailand

In analyzing screening forms and interviews with providers in both countries, the following two items in the tool stand out as requiring further clarification: how to identify whether a client is MSM or TG, and when and how to carry out safety planning. First, as explained above, Mexico's screening forms did not have questions asking clients to identify their sex/gender identity, while the Thai forms did. Providers in Mexico were expected to identify whether a client was MSM or TG based on clinical history notes and then check a box indicating one or the other on screening forms. However, this proved to be problematic in that several providers checked both MSM and TG boxes. While male-to-female TG may in fact be considered a subset of MSM by some, many TG themselves consider that they have distinct identities, neither male nor female or, in some cases, both.[14] Moreover, for the purpose of this project, experiences and screening of TG were to be analyzed separately from MSM more broadly. The Thai screening forms explicitly asked clients what they considered their sex/gender to be—male, female, TG—as well as the sex/gender of his/her sexual partner, minimizing confusion about whether a client screened was MSM or TG. However, service providers in clinical services said that they were uncomfortable proposing the screening service to clients who appeared "masculine."

"*Sometimes I dared not to ask whether a client was gay, because he looked very masculine. If I asked him and he was not gay, I became very embarrassed and felt shame*."—Provider in Thailand

To address these issues, the final screening tool (see below and Annex X) includes the original Thai questions that identify sex/gender of the client and his/her partner. However, it excludes the introductory statement, "Our hospital is currently providing special services for men who have sex with men and transgenders," which eliminates the indication that the interviewer may be presuming that a client is an MSM or TG. Moreover, it is recommended that the screening tool be applied in HIV services catering to clients that include MSM and TG and where, ideally, questions to identify sex/gender of clients would be integrated into existing clinical forms in place of the standard "male" or "female" check boxes. Questions regarding the sex/gender of the client in the form would thus be commonplace and asked of all clients.

[14]For a definition of MSM and TG, see the box "Violence against MSM and TG: Definitions and Overview" in the Background section of this report.

Box 5. Screening Form Questions that Identify Gender Identity of Client

1.1 We would like to first ask information regarding your sex and sexual identity? We ensure that this information will be kept confidential and will be used only as a basis for providing you services that will best respond to your needs. So, if you don't mind, could you please indicate whether you are:

☐ Male ☐Female ☐ TG (Multiple answers allowed)

1.2 Please indicate the sex of your sexual partner:
☐ Male ☐ Female ☐ TG ☐ Do not have sexual partner (Multiple answers allowed)

In order to determine whether one is MSM or transgender, it is important to consider 1) sexual identity: or the sex with which the person considers him/herself to be or has adopted; 2) sexual orientation: as defined by the sex or sexes of the person's sexual partner/s; and 3) gender expression: the preferences and behavior that communicates one's sex/gender, for example, clothing, hair styles, mannerisms, way of speaking, roles we take in interactions, as defined by traditional social and gender norms. Questions 1.1 and 1.2 pertain to sexual identity and sexual orientation. Based on this information, is the client:

☐ MSM ☐ TG ☐ Other, specify:_____
(Please choose one.)

Safety planning is another concept that providers did not adequately understand. Although most providers reported that the positive screens they detected consisted of cases of violence that occurred long ago and did not pose an immediate threat to the patient, when interviewed, providers in Mexico and Thailand did not differentiate between referrals and safety planning. Although safety planning was discussed with providers, they had difficulty in grasping the concept of a safety plan and identifying options for safety planning beyond referral to specialized services. Additional guidelines on safety planning attached to the screening tool could have helped to remind providers that this step is important, beyond simply referring the client to other services. Such guidelines, now incorporated into the final tool, should indicate when to conduct safety planning, the objectives of such planning, and possible elements of a safety plan. Overall, clear protocols are an essential component for any efforts to screen for violence, as discussed in the next section.

Strengths of the Screening Process

On the whole, providers found the screening process beneficial to their work. Providers in both Mexico in Thailand noted that the screening process helped them to better understand the social situations that MSM and TG face and, in turn, their increased vulnerability to HIV. Likewise, providers in both countries indicated that asking the questions via the screening tool improved communication and trust between themselves and the client, despite the fact that several initially were hesitant to ask what they perceived to be very private questions.

> "*I heard the violence issues in some interviews in the past, but there was no direction to focus in this issue. When applying this tool, it was easier for me to interview on the violence issues.*"—Health Provider in Thailand before pilot screening began

> "*After using the screening tool, it was a great opportunity for me to know their way of lives that I had never known before. Further, I could understand more about the concept of violence, which was not limited only to physical and sexual violence, but also included emotional violence, which*

could severely affect their lives. In addition, due to the real experiences I faced, this resulted in my good and positive attitudes towards them."—Provider in Thailand

"*Yes, it has given us tools, better knowledge to investigate what we can do; we know more about the legalities; it allows us to identify [violence] as a factor of importance for prevention of STIs and HIV, not just a primary [factor] but also a secondary one*."—Provider in Mexico

"*Obviously, asking these questions and contributing knowledge with respect to them, has given me more trust with them; touching on this rather intimate point has given me the opening to address other issues*." —Provider in Mexico

For many clients, the screening process allowed them to realize for the first time that the abusive experiences they have faced are forms of violence. The simple act of asking clients about the mistreatment that they have experienced reinforced that those experiences consisted of violence and a violation of human rights; this seemed to have improved some clients' self-esteem.

"[In the past] I met the staff almost everyday…The issue of violence used to be our topic of conversation, but it was never taken seriously, since I had never known before that what I faced with is the violence."—Client in Thailand

"*I feel that it surprised them; one is accustomed to all violence and when one emphasizes that [what they experienced was violence], it makes them feel important and that they do not deserve the violence. I felt that it bolstered their self-esteem*."—Provider in Mexico

Providers and clients in both countries also found the referrals to other specialized services to be beneficial. In Thailand, where MSM and TG organizations and social support services were identified and included as partners in the pilot intervention, the system of referrals proved to be a key positive outcome and resulted in strengthened collaboration among health, MSM/TG, and social support services. In Mexico, where the participating HIV clinics and project team identified few referral services, providers emphasized the need for such services and expressed their feeling of helplessness due to this lack. They noted the potential value of having peer organizations as partners in dealing with violence.

More specifically, in Thailand, providers reported that, prior to the screening intervention, they did not refer patients who shared experiences of violence to other services. Providers believed that clients preferred to cope with such problems themselves and/or that there was no recourse for such clients. Also, some providers did not trust or know of services that could offer an adequate specialized response to MSM and TG experiencing violence. For that reason, if they did refer clients to other services, some providers used their own personal network of services (Sakhunthaksin, unpublished).

"*Most of clients did not want help for the violent circumstances, because such violence was common to them, and they did not see a solution for them. They tried to cope with it and did not want any help*."—Provider in Thailand

"*If we had to refer a client, we were not sure that the receiving agency could provide the best services responding to such client as we did. So we were afraid that if we refer him to other services, he might be in a worse situation*."—Provider in Thailand

"I have never seen any list of organizations providing help and support. Mostly, I knew such organizations by personal connections. So the list is very helpful to me."—Provider in Thailand

As a result of the screening intervention, however, providers at health sites and SISTERS and SWING developed more formal linkages with each other. Moreover, clients at SWING and SISTERS who were screened (and agreed to be interviewed afterward) indicated that the referrals were useful in letting them know where they could access help and prevented them from feeling abandoned or ignored by the attending clinic/provider.

> "*I could feel that nurses paid more attention to me. In the past, they rarely talked to me. Now I was very glad that they tried to talk to me more. So in the future if I am faced with such violence, I know where I can go for help*."—MSM at SWING

The length of time needed to conduct the screening itself generally was not perceived as burdensome by providers in Mexico. (This differs from Thailand, as described in the Challenges section.) Screening took a mean average of just under 12 minutes (13 minutes for those who had experienced violence and 10 minutes for those who had not) and a mode average of 10 minutes to complete, based on general estimates recorded by providers.[15] Most providers did not see time as a barrier. (See Annex VIII for a complete analysis of the average time to complete screening forms by clinic.)

> "*I do it at the same time as the identification forms, so it does not take much time from them*." — Provider in Mexico

> "*It's adequate, quick; no problem*."—Provider in Mexico

Challenges Associated with the Screening Process

Providers and clients in Thailand, on the other hand, found the screening process to be time-consuming. On average, providers in Thailand reported that they needed 15–20 minutes to apply the screening tool (based on general estimates recorded by providers at the end of each screening session.) The minimum was 8 minutes at Pattaya Rak Center. The maximum was 30 minutes at the Department of Sanitation at Banglamung Hospital, which included VCT counseling sessions into which the tool was incorporated. This problem was evident in the very low percentages of individuals screened, especially at the hospital (as seen in Table 1). Where there was a much lower volume of clients, such as at Pattaya Rak or SWING, higher numbers of clients were screened.

> "*I could not [always] use the screening tool. That was because there were so many clients and if I used it, other clients would wait for me for a long time. For this reason, I used it only when there were not so many clients*."—Health provider in Thailand

> "*When I went to there, I did not have much time for an interview, because I had to go for my appointment. The staff could only ask me a few questions, and I had to go out*."—Client in Thailand

Other challenges with the screening tool confirm best practices in IPV screening with women. As described in Box 2, these include identifying counseling, legal aid, and support groups as referral services for victims, or providing services where none exist; ensuring infrastructure to allow for private consultations; and providing ongoing in-service training sessions on GBV for *all* staff.

[15] It is important to note that there was a wide range in the length of time to complete the screening for both positive and negative screens, as reported by providers. For those who were screened positive, the range was 5 to 35 minutes; for those who were screened negative, the range was 5 to 20 minutes. In two of the CAPASITS, Puerto Vallarta and Ecatepec, there was a significant difference in the average time to complete positive screens—approximately +4 and +9 minutes, respectively. In the other three sites, the HIV/AIDS clinic at the hospital of Cuautitlan and the CAPASITS of Tlalnepantla and Naucalpan, the difference between average time for positive and negative screens was little to none, at 0, -.76 and +2.34, respectively. For full details, see Annex VIII.

In Mexico, most providers found a dearth of referral services. Instead, providers referred clients who had experienced violence to psychosocial services within their own clinics and found these to be good sources of support. Still, providers emphasized a lack of legal services, shelters, and self-support groups for MSM and TG. One provider also noted the need for post-exposure prophylactics for the violence victims they identified. Overall, lack of referral services was a major impediment and was identified by providers as the principal barrier to and reason for not continuing to use the screening tool. When asked about the negative aspects of the screening, the following were some of the responses:

> "*Outside the CAPASITS, we did not identify more support. In the majority of the cases, they go to self-support groups organized by our psychological services…they are a great support to us, since there are people [there] with the same characteristics. We also sent them to human rights office for work-related cases*."—Provider in Mexico

> "*I felt very limited…if there were other options to channel them to, it would be more comprehensive…that they choose the services*."—Provider in Mexico

> "*That we do not have a structured referral network. I don't see a positive aspect; the patient will think that he can ask for help, but where? If no, [and] the institution doesn't exist, [then] how?*"—Provider in Mexico

Where referral services were available and providers made appropriate referrals, clients sometimes found them inadequate. However, providers noted that the act of referring clients and drawing their attention to the possibility of taking action to deal with their experiences gave clients information.

> "*I had difficulty in where to refer them; I feel that it should not be like this…[thinking of] the time and the needs of the [client]. The slow services, the phones that were not answered…also, the hours…what about the weekends, the holidays, after 4 p.m., [for] for PEP*?" —Provider in Mexico

> "*The patient knew that he was experiencing violence but was not aware that he needed help; upon telling him about the services at UAPVIF,*[16] *[he had a moment of enlightenment], that he could do something about it*."—Provider in Mexico

The dearth of referral services posed a problem for providers in Mexico in particular. Yet, interviews with providers in both Mexico and Thailand indicate that adequate emotional support through peer support groups proved to be a great help to clients.

> "*Outside the CAPASITS, we did not identify more help. In the majority of cases, they go to the self-help groups more than our psychological support services. The self-help groups helped us a lot; they are a great support, since there are people there with the same characteristics*."—Provider in Mexico

Likewise, providers in Thailand reported that clients preferred counseling services over other referral services, especially legal recourse. Clients generally opposed the idea of being referred to OSCCs (as explained earlier in the Background section), where women who experience violence get support, because police typically are part of service teams there. In Mexico, when asked what clients seemed to need most, providers stated that simply being listened to when they share their experiences of violence was the main need demonstrated by clients.

[16] In Mexico City, the Family Violence Attention Units (UAPVIF) provide legal assistance and psychological counseling to victims of domestic violence.

"*To feel actively listened to, to reflect on what happens to them, their pain, their limitations. That we pay attention to them.*"—Provider in Mexico

"*To be listened to, above all in the case of trans[gender], that have said that people that [around] them made them feel that they are crazy, they do not believe them.*" —Provider in Mexico

The ability to provide emotional support or counseling services varied at each clinic setting, however. As indicated above, self-support groups were a great resource at SISTERS and SWING, where such services are available. However, at hospital and clinic settings, providers felt that they had inadequate skills for consoling victims. Accordingly, several providers requested further training in counseling and psychotherapy.

Lack of time was a barrier in the hospital settings in each country because providers attended to a much higher number of clients[17] than in the specialized HIV/STI clinics/services. Participating providers interviewed at Banglamung Hospital in Thailand expressed a concern that application of the screening tool would further prolong other clients' waiting time. In Mexico, providers at the hospital of Cuatitlan noted competing activities that prevented them from using the screening tool.

"*[Sometimes] I could not use the screening tool. That was because there were so many clients and if I used it, other clients would wait for me for a long time. For this reason, I used it only when there were not so many clients.*"—Provider at hospital in Thailand

"*If there were space and time [screening should continue]…one should give the consultation [medical] and then pass the client on to the social worker or other department to carry it [the screening] out.*"—Provider at hospital in Mexico

Privacy and confidentiality are a must when conducting screening for gender-based violence. In the interest of identifying and serving victims under challenging conditions, this principle may be overlooked at times. During the pilot intervention, providers sometimes conducted screening in the hallway or in a room that did not ensure privacy and confidentiality. As a result, providers were compelled to whisper questions, which could have interfered with comprehension (a challenge described above). The lack of privacy also inhibited responses by some clients.

"*…[screening] has been done little, and it would be done more if there were adequate space.*"—Provider in Thailand

"*Sometimes the interview room was not vacant, so I had to interview a client in the hall. However, I talked to him very softly so that no one could listen to us.*"—Provider at hospital in Thailand

"*When I was interviewed in a hall, it was so crowded and noisy. I felt uncomfortable to be interviewed among other clients surrounding me. I was afraid that they could hear what we talked and they may gossip about me with their peers.*"—Client in Thailand

Finally, providers also expressed their need for greater capacity and skills to respond to the emotional needs of patients who experienced violence. In both Mexico and Thailand, when asked what recommendations they had for further application of the screening tool, providers called for more training on psychosocial support and counseling for victims of violence.

[17] In Thailand, for example, the outpatient department attended to 8,804 patients in the month of June 2008, while Pattaya Rak attended to 73, and SWING and SISTERS attended to 16 and 188 clients, respectively.

Policy Outcomes

Leadership

Leaders of local governmental institutions have demonstrated strong interest and participation in the project activities. In Mexico, although the project was to be piloted in just two clinics in the state of Mexico, the director of the state's CAPASITS requested that all clinics participate in workshops to sensitize and train providers on screening for violence against MSM and TG. Likewise, four clinics in the state of Mexico ultimately piloted the screening intervention instead of two. In Thailand, representatives of local government institutions participated in the project throughout its lifecycle, from working group meetings for designing the intervention and training workshops to a final meeting on identifying the intervention's strengths and weaknesses. Participating offices included the following: Nongprue Municipality, Camillian Social Center of Rayong Province, the Center for Child Welfare Protection and Development, and the Shelter for Children and Families of Chonburi Province.

Replication

During the course of the project and in the months after the completion of the intervention and evaluation, other health clinics expressed interest in *replicating portions of the project*. The director of the CAPASITS in Tampico, Mexico requested that health providers working in five clinics throughout the state of Tamaulipas also be trained on issues relating to violence and S&D against MSM and TG, as well as on how to respond to the problem within health services. For this reason, an additional 74 health providers in the area of Tampico were trained by the project team in Mexico.

Additionally, most participating services supported continuing the use of the screening tool. In Thailand, SISTERS, SWING, and Pattaya Rak all reported that they will continue screening for violence among MSM and TG clients. Banglamung Hospital's outpatient department and VCT division will continue this screening for TG and MSW. Due to their limitations in clearly identifying MSM (for fear of offending other males who do not have sex with men), staff at the hospital have chosen not to screen MSM. In Mexico, although they struggled with the lack of referral services, the majority of providers still appreciated the value of screening as a way to help them understand the comprehensive needs of their clients. Various providers (4 out of 10 in Thailand and 2 out of 13 in Mexico) interviewed after the intervention said that the screening tool should be incorporated into the standard procedures for serving clients. The lack of overwhelming consensus may indicate that providers still felt that they had inadequate capacity to conduct screening, as previously discussed. Overall, many recognized the need to understand how violence affects HIV vulnerability and the provision of comprehensive care:

> "*To me, it is an important tool since it forms part of comprehensive care, and we can suggest this care to identify violence. And if we do it, we would have more benefits…I think it can remain within my services permanently*."—Provider in Mexico

> "*Yes, [the tool] should [be maintained] because it helps us to understand a little more the emotional situation of the patient*." —Provider in Mexico

> "*The doctor and nurse took time to talk to me about violence. I feel more self-confident to respond to violence in my life*."—MSM in Thailand

> "*It is a good thing that the health provider asks me about violence, but I am not sure she really understands what this means in my life*."—TG in Thailand

In the hospital setting of Cuatitlan, Mexico, where lack of time was an issue due to large caseloads, providers recognized the need to incorporate the screening intervention into their services. However, they emphasized the need for additional staff to be designated to attend to violence victims.

"*Yes, it is necessary…just that one has to consider that an MSM that has been assaulted is not likely to ask for help because of the discrimination [he fears]...maybe someone that is available during the consultation and helps in the consultations or another space [and] gives appointments for these services*." —Provider in Mexico hospital

Collaboration

In Thailand, *improved collaboration* between participating health services and NGOs was also a key outcome of the project. Through the design of the project itself, the main public health services for MSM and TG in Pattaya—Banglamung Hospital and Pattaya Rak Center—and the MSM and TG drop-in-centers and HIV community outreach programs—SISTERS and SWING—collaborated in the design of the intervention, jointly participated in trainings, and ultimately referred clients to each other. By participating in the project, particularly the screening intervention, and consequently seeing first hand the violence and related social vulnerabilities that MSM and TG face, nurses at Banglamung Hospital have demonstrated strong willingness to collaborate with SISTERS and SWING to support MSM and TG. Most notably, the nurses have agreed to facilitate the process of offering quality services to clients who present a letter stating that they have been referred by SISTERS OR SWING.

Policy Changes

A number of noteworthy *institution-level policy changes* also occurred as a result of the project. In Thailand, the OSCC at Chonburi Hospital (the provincial hospital in Pattaya), which traditionally has served women, agreed, along with the members of the project's multisectoral working group, that their clinic could be a place where MSM and TG could access services related to gender-based violence. Since OSCCs also offer services for youth, and many of the MSM or TG identified were younger people, the OSCC is seen as a safe place for victims to seek services. To be sure, work still needs to be done to ensure that these services meet the special needs of MSM and TG. For example, once clients are referred to OSCCs, typically the police and courts get involved, but most screened MSM and TG did not want to be referred to OSCCs because they did not want to deal with the police. As the literature reflects, police often harass and commit violence against MSM and TG (Betron and Gonzalez-Figueroa, 2009). Therefore, stronger emphasis may need to be placed on counseling, which clients prioritized as a need, or on linking clients with human rights and empowerment groups that can raise awareness of clients' rights. Still, OSCC administrators' willingness to open their doors to MSM and TG demonstrates that the screening intervention has raised awareness and improved attitudes of some health systems personnel regarding the needs of MSM and TG.

In Mexico, when the project team shared the results in a meeting of key stakeholders, representatives from national and state-level AIDS organizations, sexual diversity and violence programs, and CAPASITS coordinators, key policy recommendations were made as follows:

- The director of the national AIDS program's Prevention and Social Participation division requested that the sensitization and training program on stigma, discrimination, and violence against MSM and TG be included in the training and certification programs for health providers working in the CAPASITS.
- Participants in the stakeholders' meeting also recommended that TG with the appropriate skills participate in the sensitization of providers and work with them in serving MSM and TG at CAPASITS.
- Participants also agreed that TG identified as experiencing violence should be referred to services for women who experience violence.

In Thailand, policy recommendations and initiatives were put forth by leaders of local government entities that had been involved in the intervention's design, implementation, and evaluation. The recommendations were as follows:

- The project's (multisectoral) working groups identified the need to include legal services and the human rights committee in the referral networks.
- The Pattaya municipal government is working with the advisor of the project at PRI to integrate screening for violence against MSM and TG into a long-term plan for health services.
- The project team is designing strategies to conduct advocacy to reduce violence, stigma, and discrimination against MSM and TG, including disseminating the project results to six other regions.

CONCLUSIONS AND RECOMMENDATIONS

This pilot project hypothesized that health providers would be an effective entry point to (1) screen for violence faced by MSM and TG, and (2) facilitate access to appropriate GBV services for these populations. To that end, the project developed a screening tool to identify violence against MSM and TG for use in the HIV service setting. The tool included (1) an introduction and informed consent, (2) questions about the history of violence experienced by the respondent, (3) an assessment of the client's current safety, and (4) indications of interest in referrals to other specialized services. The tool was piloted in Mexico and Thailand, both of which have concentrated HIV epidemics, as well as laws that are progressively seeking to provide equal rights to MSM and TG.

The screening tool, which was widely accepted by providers, identified high levels of physical, sexual, and emotional violence. In most cases, identified levels of violence for MSM or TG in both countries were greater than 50 percent. The tool also helped providers to improve communication and trust with patients and identify the range of social vulnerabilities MSM and TG face. Importantly, providers came to recognize the link between violence against MSM/TG and HIV vulnerability.

Providers identified additional factors that would enable them to support the screening process, however. These included additional training on counseling for victims of violence and on sexual diversity and a need for referral services that cover all needs of MSM and TG, particularly legal services and shelters. In the hospital setting, providers saw lack of time and competing workloads as a challenge and thus recommended that a specialist dedicated to issues of GBV be responsible for handling GBV cases for MSM and TG. Overall, providers saw the tool as beneficial to their work and agreed that screening should continue, provided there is institutional support, training, and adequate time and space.

Given the high levels of HIV and violence against MSM and TG, services for them must address the causes and consequences of this violence. Where the legal environment is favorable, HIV programs should build capacity of providers to understand sexual diversity and screen for violence against MSM and TG. Likewise, they should promote efforts in the community to strengthen multisectoral services for socially vulnerable MSM and TG before screening. In this way, the screening tool can provide an impetus to initiate community-health system collaboration to better respond to violence against MSM and TG and its relationship to HIV. The following key criteria should be put in place before screening.

Screen only where laws do not criminalize MSM and TG and/or that recognize the human rights of MSM and TG. Laws protecting equal rights for MSM and TG do not necessarily translate into equitable policies, norms, and actions, however. Likewise, there may be instances where services have been set up to cater to MSM, TG, and other MARPs despite their actions being illegal, or where service providers recognize and try to meet the needs of MSM and TG as human beings. Asking questions about one's sexual identity, however, (as is done in this screening tool) can be highly contentious and dangerous for clients where laws criminalize homosexuality or same-sex sexual activity. Thus, at a minimum, screening should take place only where laws protect individuals as MSM and TG.

Conduct screening in a space that is private and confidential. Several providers in Thailand and some in Mexico reported that they conducted the screening in hallways or rooms that lacked privacy due to lack of space. As one client in Thailand pointed out, this may cause the client to hesitate about responding due to shame and fear that others are listening. Although unwarranted, there is usually a great deal of stigma associated with being a victim of GBV, particularly sexual violence. For MSM and TG, there may be the added concern of revealing information about his/her sex or sexuality that he/she may want to keep private.

At a minimum, it is important to *ensure that psychologists and/or peer support groups within the clinic are available to counsel victims after screening for violence.* Providers in Mexico indicated that they felt helpless once they identified that a patient had experienced violence because there were no services to which they could refer them. However, providers also indicated that in-house psychologists and peer support groups were an important resource for these clients and that those identified as victims of violence needed above all to be heard. This supports the findings from the situation assessment prior to the screening intervention in which MSM indicated the need for psychological services. In Thailand, victims of GBV were most accepting of emotional support, as opposed to legal recourse. Moreover, evidence from the literature on screening for violence against women also has shown that victims of violence simply need someone with whom they can discuss their difficult experiences (Betron and Gonzalez-Figueroa, 2009). Development of peer support organizations would be a complementary element to the screening process and a vital component of a functional referral service.

Continually sensitize and train providers on gender, sexual diversity, violence, and stigma discrimination. As noted above, providers requested further training on sexual diversity. While the piloted violence screening intervention helped providers to understand and empathize with their clients more, some providers in Thailand expressed that they were embarrassed to ask clients about their sexuality if the clients appeared "masculine"; providers in Mexico acknowledged that they needed more training on sexual diversity, as many were confused about who would be considered MSM or TG.

Before screening, assess, consult with, and engage external referral services to ensure that they can address the needs of MSM and TG adequately. In Thailand, the project team invited women's shelter services to project design and preparation meetings; through that process, the women's shelter agreed to offer space for MSM and TG violence victims who might need shelter. In Mexico, this type of engagement was limited. In some cases, no such services were available in the immediate area of the clinic. In others, providers either simply did not know of violence-related services to which they could send MSM and TG or the referral services were inappropriate because they considered their programs to be for women only or could not adequately address the needs of MSM and TG. Programs for women who have experienced violence teach that engaging services in other sectors and in the community is important for ensuring a coordinated response to GBV. It is critical that this multisectoral engagement happens at the start of screening or even before it begins.

Akin to referral services, *strategies for safety planning that meet the specific needs of MSM and TG should be explored and tested in future operations research.* The experience of the pilot efforts described here did not identify situations that required safety planning. However, it was clear in the evaluation findings that most providers saw little differentiation between safety planning and referrals. This likely could have been because the concept of safety planning, derived originally from the field of intimate partner violence perpetrated against women, does not yet have clear practical strategies that apply for the dangerously violent situations in which MSM and TG might find themselves. Further research is required to identify practical strategies that MSM or TG typically use or could use to protect themselves from extreme forms of violence.

Develop clear protocols for who, when, where, and how to screen. Help make providers aware of the protocols by training them, posting protocols in visible spaces, and including these protocols with screening documents. As experiences from screening for GBV against women have shown, clearly stating protocols for violence screening is a fundamental strategy to reinforce the key steps for conducting screening and providing proper care for victims (Skye et al., 2001). In this project, for example, protocols would have been particularly helpful in reminding providers to conduct safety planning when necessary.

In conclusion, responding to violence against MSM and TG in the health setting is not enough. As this project highlights, the need for a multisectoral approach, including collaboration with community-based

organizations, is essential in responding to the needs of MSM and TG who face GBV. Given that MSM and TG are extremely marginalized and may not readily access health services, there is a special need to develop and support drop-in centers and group support activities, such as those offered by SISTERS and SWING in Thailand, which can act as the first-line response to MSM and TG who are suffering violence. Indeed, such support may have to be conducted through informal or non-traditional channels, such as in bars, clubs, or other areas where MSM and TG meet. Likewise, limiting action to improving health providers' attitudes and treatment of MSM and TG would be a short-sighted vision. National and community laws, policies, and norms must be changed to put into practice the human rights of MSM and TG, which will require strong advocacy, awareness raising, and behavior change efforts across society.

GLOSSARY

Gender-based violence – any harmful act perpetrated against a person's will, and based on socially-ascribed (gender) differences between males and females (IASC, 2005). The fundamental differences between gender-based violence and other manifestations of interpersonal violence are that (1) the former has the objective of using violence as a way to maintain power and control over the victim, and (2) the perpetrator's sense of entitlement to greater power and control is based on the perception that his/her gender holds a higher social status than that of the victim.

Gender expression – gender identity is commonly communicated to others through gender expression—clothing, hairstyle, gestures.

Gender identity – refers to a person's internal, deeply felt sense of being either male or female, or something else in between. Because gender identity is internal and personally defined, it is not visible to others.

Men who have sex with men – all men who have sex with other men, regardless of how they identify themselves (gay, bisexual, or heterosexual) (U.S. CDC, 2007).

Safety plan – A safety plan is a combination of suggestions, plans, and responses created to help victims reduce their risk of harm. To address situations in which someone is in imminent danger of harm from an abuser, survivors of gender-based violence can develop a safety plan. A safety plan can involve thinking about the best way to leave a home quickly in case violence begins to escalate. It can involve alerting trusted neighbors or friends about the situation and enlisting their help or perhaps planning ways to leave an abusive spouse/partner to prevent the type of violence that is common at the time of separation. (Adapted from Bott et al., 2004)

Sexual identity – the overall sexual self-identity—male, female, masculine, feminine, or some combination, and the individual's sexual orientation. It is the internal framework, constructed over time, which allows an individual to organize a self-concept based upon sex, gender, and sexual orientation and to perform socially in regard to perceived capabilities based on sex and sexuality.

Sexual orientation – the organization of an individual's eroticism and emotional attachment with reference to the sex and gender of the sexual partner.

Transgender – gender identity or expression differs from conventional expectations regarding biological sex, including the following:

Transsexuals – people who feel they were born with the wrong biological sex. They may be in a time of pre-operation, post-operation, or not having an operation.

Transvestites or cross-dressers – use clothing of the other gender with to better express their inner identity.

Intersexual – A general term used for a variety of conditions in which a person is born with a reproductive or sexual anatomy different from the standard definitions of female or male in terms of his/her internal or external body features. For example, a person might be born appearing to be female on the outside but have mostly male-typical anatomy on the inside; or a person may be born with genitals that seem to be a combination of the usual male and female types (International Planned Parenthood Federation, 2008).

ANNEX I. SCREENING TOOL PILOTED IN MEXICO

Screening Tool to Identify Violence against Men Who Have Sex with Men and Transgenders

Introduction

Why screen?

Gender-based violence (GBV) can increase a patient's (client's) vulnerability to HIV and other STIs. Evidence suggests that GBV is associated with increased chances of acquiring HIV. GBV may also affect a person's ability to access and adhere to care, treatment and support, as well as their overall health status and ability to live positively.

By identifying clients who have experienced GBV, providers may be able to better identify a client's healthcare needs and factors affecting their health; help break the silence and stigma a client may experience related to GBV; and to connect clients with other sources of support.

This screening tool is a pilot project designed to develop a simple, effective method for providers to identify GBV among their clients. The pilot is being carried out in collaboration between _____ (insert name of partner organizations) and the Health Policy Initiative of Constella Futures in Mexico and Thailand. The results of your experience piloting this tool will be used to improve this tool and contribute to an intervention designed to help reduce HIV vulnerability. Many thanks for your important collaboration in this effort.

Who and when to screen?

The tool is for use with men who have sex with men and transgenders, including male sex workers within both groups. The screening should be carried out with all new patients; it should also be carried out with existing patients (initially as part of introducing the new screening tool and then on a regular basis, to be determined with the staff [suggested time: every year]).

The following questions are designed to be integrated into already existing, routine interview and counseling processes within the clinic. The specific place to insert these questions into these existing, routine processes will be determined in each clinic in consultation with staff. These questions about violence will most likely follow questions already asked about sexual history.

Based on discussions in your clinic, these questions will be inserted into:
Clinical history
[Form:_____ ; Place in format:_____]
Mental health history
[Form:_____; Place in format:_____]
Counseling for VCT
[Form:_____; Place in format: _____]
For existing clients, these questions are best asked:
[Insert response based on consultation with clinic staff]

Step 1 (Ask all patients)

Because of the fact that mistreatment and violence are often common and can have an effect on people's health, we have begun to ask patients about it. The information will be kept confidential. If you do not mind, I would like to ask you questions about any mistreatment or violence you may have or currently experience. (*If patient indicates it is ok, proceed with the following questions.)*

1. In the past year, has anyone forced or coerced you to have sexual relations against your will? Anyone includes: your partner, a client, someone in your family, a friend, neighbor, police, or other persons.

   YES ( ) NO ( ) NO RESPONSE ( )

2. In the past year, has anyone slapped you, punched you, hit you, or caused you any other type of fiscal harm? Anyone includes: your partner, a client, someone in your family, a friend, neighbor, police, or other persons.

   YES ( ) NO ( ) NO RESPONSE ( )

3. In the past year, has anyone insulted you, threatened you, made you feel inadequate or yelled at you? Anyone includes: your partner, a client, someone in your family, a friend, neighbor, police, or other persons.

   YES ( ) NO ( ) NO RESPONSE ( )

4. In the past year, has anyone made you feel threatened, fearful, or in danger? Anyone includes: your partner, a client, someone in your family, a friend, neighbor, police, or other persons.

   YES ( ) NO ( ) NO RESPONSE ( )

Step 2 (If patient responds yes to any of the above)
If the patient responds positively to any of the above, it is important to express that violence is never deserved. Suggested phrase to express this:

"Mistreatment and abuse are often more common than thought. Yet, no one deserves to be abused. I am now going to ask you a few questions so that we can evaluate possible effects on your health and outline some alternatives if necessary."

1. **Can you tell me about the experiences of violence you have had in the past year?** (Please note that this is an open question. You do not need to ask each of these questions. Let the client recount their experiences – and use the following questions as follow-up probes if the client does not directly state these details in their account. Afterwards, fill in the chart according to the details obtained for each act of violence).

   For each act of violence the patient has experienced in the past year, please fill out columns A, B, and C.

A. Who?	**B1. When?**	**B2. Where?**	**B3. How?**	**C1.* What were the physical consequences?**	**C2.* What were the emotional consequences?**	**C3.* Other consequences?**
Romantic/sexual partner( )						
Pimp ( )						
Client/friend ( )						
Family member ( )						

Friend ( )						
Neighbor ( )						
Unknown people ( )						
Police ( )						
Health Worker ( ) Type:						
Others ( ) Specify:						

(*C1) Bruises, scratches, wound, superficial or serious injuries, injuries from a type of weapon, being disfigured, being incapacitated in some way, loss of consciousness, acquiring an STI or HIV.
(*C2) Depression, loss of confidence, loss of self-esteem, feeling dirty, feeling guilty or fear, anxiety.
(*C3) Loss of authority, loss of respect, loss of material godos, loss of family, loss of supportive relations, etc,

2. Did you seek any support or services when you experienced this violence?

Yes ( ) No ( ) No Response ( )

If the answer is yes, ask: **Can you tell me about what help or services you sought?** Please remember that this is an open question. Let the client tell his or her experience, and afterwards mark the information obtained for help or services sought. For each, then ask 'how much . . . .' Note: The information obtained may help to decide what types of references to make in Step 3.

Type of help	**How much did the support or services help you?**
Support from a family member ( )	Much Some Little None
Support from friends ( )	Much Some Little None
Psychologist ( )	Much Some Little None
Monk or priest or faith leader ( )	Much Some Little None
NGO offering services for violence ( )	Much Some Little None
Human rights commission ( )	Much Some Little None
Public Hospital ( )	Much Some Little None
Specific medical service ( )	Much Some Little None
Red Cross ( )	Much Some Little None
Other ( ) _____	Much Some Little None

3. Are you still in contact with the person(s) who committed this violence?
Yes ( ) No ( ) No Response ( )

4. At this time do you feel safe, without threats, in returning to your daily life and routine?
Yes ( ) No ( ) No Response ( )

5. At this time, have you thought of hurting yourself due to the violence that has happened to you?
Yes ( ) No ( ) No response ( )

Step 3: Referrals

From the information obtained, as a health provider you need to decide: do you consider that this person could be in immediate danger?

YES ( ) NO ( )

There are groups and institutions that could offer you help. I would like to mention some of the groups and institutions, so that you know about them and can decide if they might be able to offer help that is useful to you.

1A. NO, the person is not in immediate danger:
Make the appropriate reference. (See the directory of referrals).

Type of Referral?	**Referral Made? (Mark with an X if you made the reference)**
List options once directory is developed	

1B. Did the client accept the referrals?

YES ( ) NO ( )

1C. If the person is in immediate danger, and there are specialized services for MSM, trans, or sex workers, call or consult with the available service to identify the best action to assure the immediate safety of the person. Elaborate a security plan when:

1. No specialized services exist
2. Existing services are not available.
3. Services exist and are available, but the person does not accept a referral

(See sheet X "Security Planning")

Summary of Results:

Complete the summary with the information obtained from the patient.

Date: ___/____/____

Has the client experienced violence?:

Physical? Yes ☐ No ☐
Sexual? Yes ☐ No ☐
Emotional? Yes ☐ No ☐
_____ Yes ☐ No ☐

If the client has experienced violence, what type of help did they seek before?
_____

If you referred the patient, to what service or support: _____

Did the client accept the referral? Yes ☐☐No ☐

If you made a security plan with the client, explain it briefly here
_____

Estimated time for using the screening tool:_____

ANNEX II. SCREENING TOOL PILOTED IN THAILAND

No._____

Screening Tool for MSM and Transgenders Experiencing Gender-Based Violence

Date.....Time..... Place.....

Instruction: Fill the information in the blanks and put ✓ in the box ☐ in front of the answer

General Information

Nickname.....Age.....Years old

Mode of access to service
- ☐ By self
- ☐ Referred by (name of person or organization).....
- ☐ Recommended by (name of person or organization).....

This form is utilized together with another form identified as .....

Have you been asked by another organization in the last 2 months questions about your experiences related to gender-based violence?

☐ Yes (End of interview) ☐ No

Step 1. Informed consent, questioning, and identifying of sex

The following questions relate to your personal characteristics. In case you are uncomfortable with or not willing to answer any questions, you may choose to refuse to answer those questions. Your refusal will not affect the service you are receiving.

1.1 Our hospital/clinic/organization is currently providing special services for men who have sex with men and trangenders. The service is providing support for such individuals who have been affected by violence. Are you interested in such special services?

☐ Yes ☐ No (End of interview)

1.2 We would like to first ask information about your sex. We ensure that this information will be kept confidential and will be used only as a basis to determine services that respond to your needs. So, if you don't mind, could you please indicate if you are: (Multiple answers allowed)

☐ Male ☐Female ☐ TG

1.3 Can you please describe the sex of your sexual partner/s? That is, are they (Multiple answers allowed)

☐ Male ☐ Female ☐ TG ☐ Do not have sexual partner

1.4 Now we would like to request your consent to ask you information about any experiences of violence that may have affected your physical or psychological well-being. This includes physical

harm, being insulted, offended, teased, etc. All that you are going to share with us will be kept confidential. So, would you agree to talk with us about these matters?

☐ Agree ☐ Not agree (End the interview)

Step 2. History of violent experiences

During the past year, have you ever faced any of the following by any person, including your boy/girlfriend, sexual partner, client, colleague, supervisor, unknown people, policemen, soldier, government officer, friends, father, mother, brother, sister, uncle, aunty, or else?

Violence incidences	Answer		
2.1 Anyone insulted, humiliated, yelled at, said bad things about, teased, and made you feel uncomfortable.	☐ Yes	☐ No	☐ No answer
2.2 Anyone violated your rights, or made you feel threatened, fearful, or in danger.	☐ Yes	☐ No	☐ No answer
2.3 Anyone did any physical harm to you, including slapped, punched, hit, or something else.	☐ Yes	☐ No	☐ No answer
2.4 Anyone unreasonably discriminated against you when you have sought health services.	☐ Yes	☐ No	☐ No answer
2.5 Anyone forced or coerced you to have sexual relation against your will.	☐ Yes	☐ No	☐ No answer

**End the interview. In the case that the patient never experienced any of the above violence, provide the patient with the list of supporting organizations to which they can refer if they or their peers suffer from violence or abuse in the future.

2.6 If the patient responds positively to any of the above, it is important to express that violence is never deserved. Suggested phrase to express this: "Mistreatment and abuse are often more common than thought. Yet, no one deserves to be abused."

According to your experiences of violence you mentioned earlier, do you want or are you ready to tell me more detail about the incidences?

☐ Yes, I would like to talk provide more details about my experience. (Instruction: Continue with question 2.7, and allow the patient to describe all the incidences mentioned or select only the event which s/he feel it most severe.)

☐ No, I would not like to talk about this. But I can come back to this conversation again on (Date) at (Time), (Place). (Skip to Question 4.1)

☐ No, I would not like to talk about this right now, but I need you to refer me to support services. (Skip to Question 4.1)

☐ I totally don't want to talk about this. (End of interview and provide the patients the list of supporting organization.)

2.7 Description of the violence incidences mentioned in 2.1-2.5 (Please fill in the below table only the most severe incidences)

Incidences of Violence	**No. of times/ frequencies**	**Actors/Offenders (boy/girlfriend, sexual partner, client, colleague, supervisor, unknown people, policemen, soldier, government officer, friends, father, mother, brother, sister, uncle, aunty, or** someone **else)**	**When**	**Where**	**How (What offender said or did with you?)**	**Do you think this happened to you only because you are MSM or TG?**

2.8 May we talk about your experiences **during your childhood**? When you stayed with your family, had you ever been abused or assaulted **physically**, e.g. being beaten, slapped, kicked, punched, hurt, etc., and/or **emotionally**, e.g. insulted, affronted, yelled at, condemned, teased, or felt uncomfortable, etc., and/or **psychologically**, e.g. threatened, feared, felt in danger, etc., and/or **sexually**, e.g. touched, forced to have sex or raped, etc.?

☐ Yes. Could you please describe the events? Who was the offender?
_____
_____
_____

Do you think that the violence incidence happened to you mainly because you are men having sex with men or transgendered?
☐ Yes ☐ No ☐ Not Sure

☐ No

☐ Cannot remember

Step 3: Help or assistance ever received

3.1 After the events you mentioned in 2.7, have you ever received or asked for help or support from any organization?

☐ Yes, I got help.

Who or What organization provided help or support for you?
_____

What type of help or support did you receive?
_____

☐ Yes, I asked for help.

From whom or what organization did you asked for help or support?
_____

What type of help or support did you ask for?
_____

Have you ever been refused by any person or organization you asked for help?

☐ No ☐ Yes. Do you know why you didn't get the help or support?
_____

☐No, I never received any help.

☐ No, I never asked or sought any help.

Step 4: Assessing the need for and deciding on appropriate referral and help

From all information you had talked about today, do you think you are now in a safe or unsafe situation due they violence you have or are facing?

☐ I'm feeling unsafe. I'm still feeling fearful, and afraid of being attacked again. And/or I have thought of hurting myself due to the violence I have faced. Please specify reason for feeling unsafe: _____

What kind of help/support do you think you are in need? (Multiple answers allowed)

- ☐ Medical care
- ☐ Psychological counseling support
- ☐ Living place/sheltering
- ☐ Legal help
- ☐ Other (specify).....
- ☐ No need for other help or support (End of interview and provide the patients the list of supporting organization.)

☐ I'm feeling safe, confident, and have nothing to fear anymore.

For the interviewer: Make the decision to identify the suitable help/support to be arranged within the setting, or to refer the case to another organization, in response to the need of the case.

☐ Arrange help/support at the setting, specify.....(End of the interview)

☐ Arrange help/support at the setting, specify.....

And arrange the referral to external services

☐ Arrange the referral to external services. A list of support services is available.

List of organization	Help/support in response to needs
☐ Banglamung Hospital	☐ General Medical care ☐ VCT ☐ Psychological support groups ☐ Other specify_____
☐ Pattaya Rak Centre	☐ STI treatment ☐ VCT ☐ Other specify_____
☐ Service Workers In Group (SWING)	☐ Psychological counseling support groups ☐ Drop in centre ☐ Peer Education ☐ Other specify_____
☐ SISTERs	☐ Psychological counseling support groups ☐ Drop in centre ☐ Peer Education ☐ Other specify_____
☐ Social welfare centre of Pattaya government	☐ Social work support ☐ Other specify_____
☐ Social welfare centre of Nhongprue municipal government	☐ Social work support ☐ Other specify_____
☐ Children and family housing, Chonburi	☐ Living place/sheltering ☐ Psychological counseling support groups ☐ Other specify_____
☐ The Fountain of Life Women's Center, Pattaya	☐ Psychological counseling support ☐ Living place/sheltering ☐ Peer Education ☐ Other specify_____
☐ Centre for welfare and children development	☐ Psychological counseling support ☐ Living place/sheltering ☐ Legal helps ☐ Other specify_____
☐ Pattaya Primary Health Care	☐ General Medical care ☐ Other specify_____
☐ Camillian Social Centre, Rayong	☐ Psychological counseling support ☐ Living place/sheltering ☐ Peer Education ☐ Other specify_____
☐ Chonburi Hospital	☐ General Medical care ☐ VCT ☐ Psychological support groups ☐ Other specify_____
☐ Other……	☐ Medical care ☐ Psychological counseling support ☐ Living place/sheltering ☐ Legal help ☐ Other specify_____
☐ Other.....	☐ Medical care ☐ Psychological counseling support ☐ Living place/sheltering ☐ Legal help ☐ Other specify_____
☐ Other.....	☐ Medical care ☐ Psychological counseling support ☐ Living place/sheltering ☐ Legal help ☐ Other specify_____
☐ Other.....	☐ Medical care ☐ Psychological counseling support ☐ Living place/sheltering ☐ Legal help ☐ Other specify_____
☐ Other.....	☐ Medical care ☐ Psychological counseling support ☐ Living place/sheltering ☐ Legal help ☐ Other specify_____

For the interviewer: Describe means of help/support offered in case of the unavailability of MSM/TG organizations or organization working on violence issues, lack of service in the community that the patient needs, or in case that the patient refuses the referral.

Summary Sheet (To be filled in by the interviewer)

Date of interview _____

Sexual identity of the client ☐ Heterosexual man ☐ Heterosexual woman ☐ Gay/MSM ☐ TG ☐ Do not have sexual partner

Informed consent ☐ Yes ☐ No

Client over 18? ☐ Yes ☐ No

Has this patient ever experienced violence?

Physically	☐ Yes	☐ No	☐ No answer
Sexually	☐ Yes	☐ No	☐ No answer
Psychologically/emotionally	☐ Yes	☐ No	☐ No answer
Physically, psychologically/emotionally, or sexually during childhood	☐ Yes	☐ No	☐ No answer
Other (specify) _____	☐ Yes	☐ No	☐ Not answer

After the most severe event, did the patient receive or ask for any help or support from anybody or any organization? And, what were help or support s/he received or asked for?

_____

Self-assessment for his/her own safety: ☐ Feeling safe ☐ Feeling unsafe

What is/are the internal service(s) provided for the patient _____

If a referral was made, what organization was the patient referred to?

_____

What are the services the patient will receive?

_____

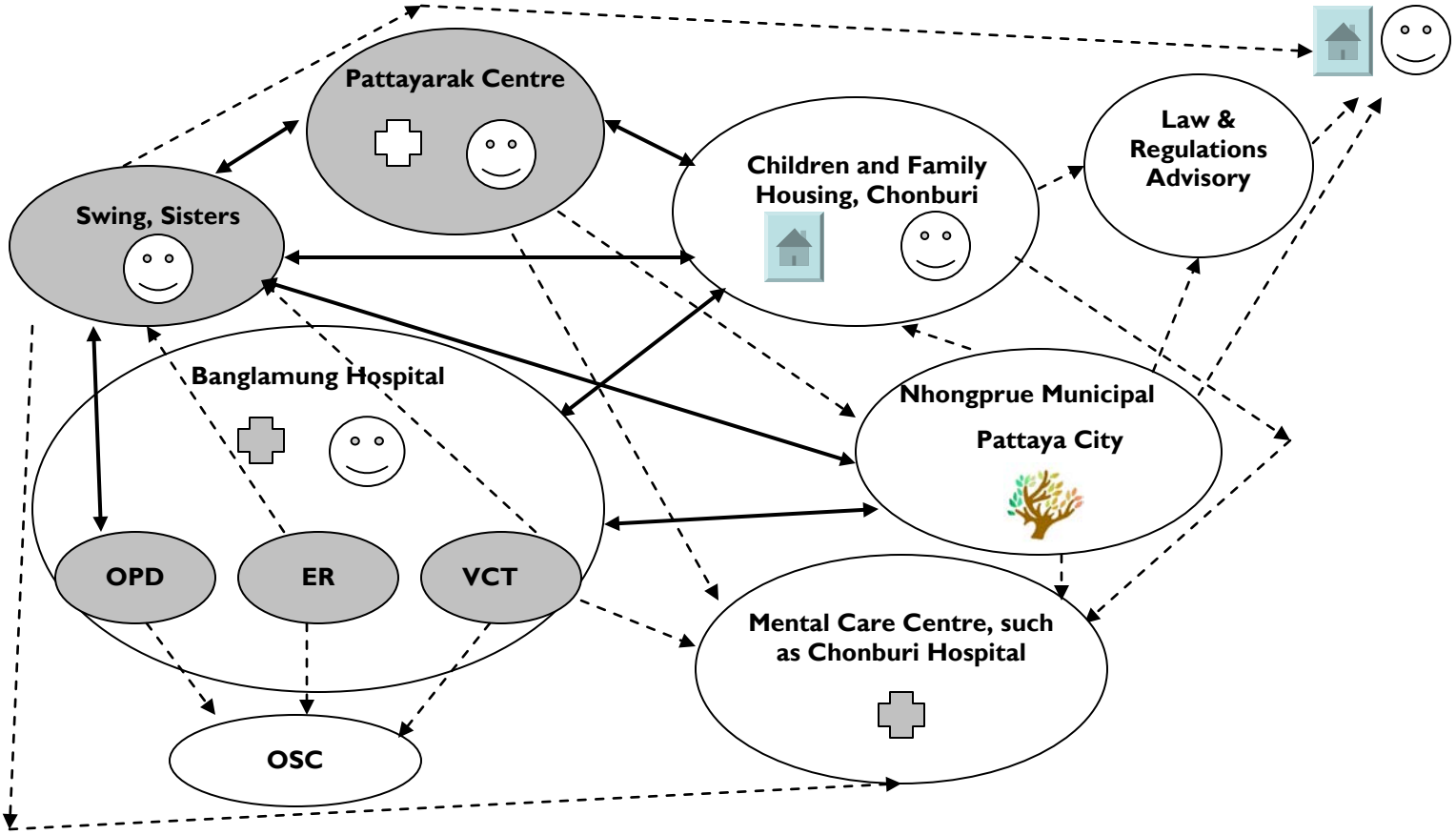
If you have identified other help or support for the patient, please give a brief description._____

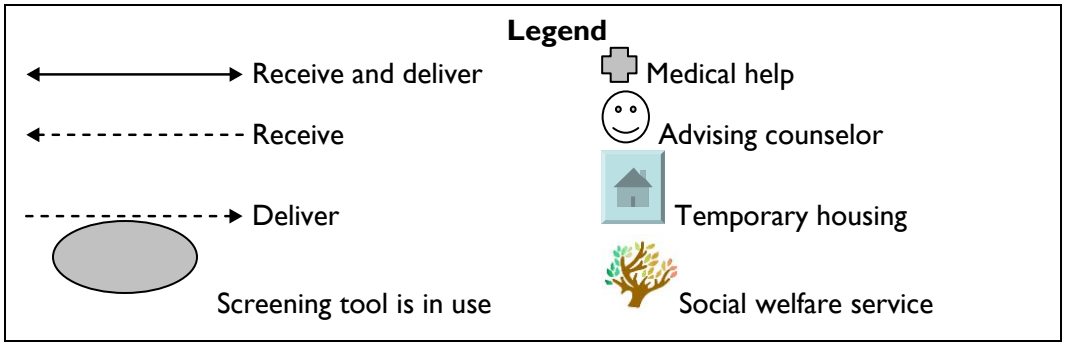
Estimated time spent with this screening tool _____ (Minutes/Hours)

Organization/division/type of service employing this screening tool:

☐ Sanitary at Banglamung Hospital
☐ ER at Banglamung Hospital
☐ OPD at Banglamung Hospital
☐ Pattaya Rak Centre
☐ Service Workers in Group (SWING)
☐ SISTERS

ANNEX III. FLOW CHART OF HEALTH AND SOCIAL SERVICES FOR MSM AND TRANSGENDERS





ANNEX IV. THAILAND REFERRAL LIST: Agencies Providing Medical Care, Legal Services, and Temporary Shelter that Form Projects

Institute	Service offered	Contact details
Banglamung Hospital	- Medical treatment and advisory - Service Hours ER : Mon-Sun 24 hours OPD Mon-Fri 08.00 – 20.00 Hrs Sat-Sun 08.00 – 16.00 Hrs Sanitation : Mon-Fri 08.00 – 16.00 Hrs	Tel : 038-411551-2 ER : extension109 Sanitation : ext 212, 228 OPD : ext. 416 Sanitation: Kh Pitak 080 – 5510223 OPD: Kh Tuchsaranporn 081-6418099 ER : Kh Prayong 089 - 5443241
Pattaya Rak Centre	- Sexual Contagious Disease - Service hours Mon-Fri 08.30 – 16.00 Hrs	Tel : 038-221708 Fax : 038-221707 Kh Supharp : 081 – 2943032 Kh Anong : 081-9883801
SWING (Friend of Male Sex Workers)	- Information and Advisory Centre for AIDS/Sexual Contagious Disease - Service hours Mon-Fri 10.30 – 20.00 Hrs	Tel : 038-713055 Fax : 038–713432 Hot line : 087-6076730 Kh Preecha : 085-3966518 Khun Manop : 086-8966463 (BKK) Kh Jamrong : 081-0392583 (BKK)
SISTERS (Advisory Centre for Transgender)	- Advisory and Health Centre for AIDS/Sexual Contagious Disease - Service hours Mon-Fri 11.00 – 20.00 Hrs	Tel : 038-423382 Fax : 038-420513 Kh Nachanon : 081 – 6026025 Kh Thanawat : 081-2775701
Social Service Division Nhongprue Municipal	- Social and Welfare Service - Service hours Mon-Fri 08.00 – 16.00 Hrs	Tel : 038-249820 ต่อ 118, 119 Fax : 038-249820 ต่อ 115 Kh Puongpech : 081-8614240 Kh Pattaya : 086-8244974
Social Service Division Pattaya City Municipal	- Social and Welfare Service - Service hours Mon-Fri 08.00 – 16.00 Hrs	Tel : 038-253261 Fax : 038-253257 Kh Aroonrasamee : 081-7158285 Kh Pailin : 083-2258243
Children and Family Housing	- Temporary Housing and Advisory on Family problems - Service hours Mon-Sun 24 hrs	Tel : 038-240220 , 038-240135 Kh Kanokwan : 080-5663881
Child Security Centre	- Assist in Lawsuits involved with influential person - Service hours Mon-Sun 24 hrs	Tel : 038-422749 Fax : 038-374475 Kh Supakorn : 081 – 9499349 Kh Narongsak : 084-8737661
The Fountain of Life Women's Centre	- Occupation Training Centre / AIDS Info Centre - Service hours Mon-Sun 24 hrs	Tel : 038-361720 Kh Khemtiyatam : 0895219907
Camilian Social Centre, Rayong	- Basic Housing Assistance and Advisory for HIV	Tel : 038-685480

Institute	Service offered	Contact details
	patients - Service hours Mon-Sun 24 hrs	Fax : 038-687480 Kh Saowanee : 089-9360080 Kh Supaporn : 081-5885430
Pattaya Public Health Service, Soi Buakhao	- Medical Help - Service hours Mon-Fri 08.00 – 16.00 น.	Tel : 038-420562 Fax : 038-420526 Kh Naaunya : 089-2514028

Agencies Providing Other Social Welfare Services

Institute	Service offered	Contact details
Children and Women Security by Provincial Police District 2		Tel : 038-223815
Chonburi Hospital	Medical assistance for general and mental patient	Tel : 038-931040
Women Foundation	Rights protection for women in domestic violence crisis	Tel : 02-5131001 02-5132708
Father Ray's Foundation	Homeless children's rights protection	Tel : 038-716628 Kh Suthichart 089-7480557 Kh Chanokkorn 086-3555380
Life improvement for Homeless Children, Pattaya City (Supnimitr Foundation)		Tel : 038-374521
Community Development and Human Security, Chonburi	Social and welfare general services	Tel : 038-282586 038-277877 Fax : 038-285208
Occupation Centre under Patronage of HRN Princess Chakri Sirindhorn	Occupation Centre	Tel : 038-241072 038-241766
Foster Home for Children, Banglamung	Children Support for children living in poverty	Tel : 038-241373 038-241-492
Foster Home for Elderly, Banglamung	Home support for abandoned and elderly	Tel : 038-241121 038-241759
KAROONWEST Social and Welfare Disable	Services for female adolescents over 18 years old	Tel : 038-241741-2

ANNEX V. THAILAND REFERRAL REGISTRATION FORM

Health and Social Services for Homosexuals, Male Sex Workers, and Male Transgenders Affected by Violence, Stigma, and Discrimination

Name of institute.....

Network registration number	Delivery date	By	Deliver to which institute	Service needed

ANNEX VI. RECEIVING REGISTRATION FORM

Health and Social Services for Homosexuals, Male Sex Workers, and Male-to-Female Transgenders Affected by Sexual Violence, Stigma, and Discrimination

Name of institute.....

Network registration number	Received date	By	Receive from which institute	Service needed

ANNEX VII. PROVIDERS INTERVIEWED IN THAILAND

SWING Foundation (1)
Sisters (2)
Department of Sanitation, Banglamung Hospital (2)
Outpatient Department, Banglamung Hospital (2)
Emergency Department, Banglamung Hospital (2)
Pattaya Rak Center (1)

ANNEX VIII. AVERAGE MINUTES TO APPLY SCREENING TOOL AT MEXICAN SITES

Site	Mean			Mode		
	Overall	**Yes (Violence)**	**No (Violence)**	**Overall**	**Yes (Violence)**	**No (Violence)**
Puerto Vallarta	8.29	9.36	5	5	5	5
Ecatepec	19.49	22.22	13.33	30	30	10
Cuautitlan	15	15	15	15	15	15
Tlalnepantla	9.30	9.90	9.86	10	10	10
Nuacalpan	9.47	11.43	9.09	10	10	10
All sites	11.93	13.40	10.30	10	10	10

ANNEX IX. MEXICO STAKEHOLDERS' MEETING TO DISCUSS NEXT STEPS AND SCALE-UP OF SCREENING FOR VIOLENCE AGAINST MSM AND TRANSGENDERS

December 11, 2008

Participant List

Dr. Jorge A. Saavedra Lopez
Director General del Centro Nacional para la prevención y el control de SIDA (CENSIDA)

Dr. Javier Cabral
Director de Prevención y Participación Social
CENSIDA

Hazel Davenport
Encargada del Programa de Personas Transgéneros
CENSIDA

Nancy Alvey
USAID/México

Dra. Marcela Ruiz
Coordinadora del CAPASITS
Vallarta, Jalisco

Dra. Beatriz Ramírez Amador
Jefa del Programa de VIH/SIDA
Estando de México

Mariana Perez
CAPASITS Toluca

Dra. Aurora de Rio
Directora General Adjunta
Dirección General Adjunta de Equidad de Genero
Centro Nacional de Equidad de Género y Salud Reproductiva

Georgina Aquino
Dirección General Adjunta de Equidad de Genero
Centro Nacional de Equidad de Género y Salud Reproductiva

Lic. Carmen Miranda
Dirección General de Igualdad y Diversidad Social
Coordinadora del Sistema de Atención de Violencia Familiar
Gobierno del Distrito Federal

Norma Angelica Lopez Mendez
Dirección General de Igualdad y Diversidad Social
Coordinadora Programa de Diversidad Sexual

Dra. Juana Arredondo Fuentes
Coordinadora
CAPASITS Naucalpan

T.S. Sara Jiménez González
CAPASITS Naucalpan

Enc. Farm. Brenda Tablas Gutiérrez
CAPASITS Naucalpan

Dr. Jose Luis Centeno Pedroza
Coordinador
CAPASITS Ecatepec

T.S. Rocio Loza Bonilla
CAPASITS Ecatepec

Dra. Margarita Rosas Dossetti
Coordinadora
Sai Cuautitlan

Enf. Rufina Costa Martinez
Sai Cuautitlan

Cynthia Navarrete
APROASE, A.C.

ANNEX X. FINAL SCREENING TOOL

Screening Tool to Identify Violence against Men Who Have Sex with Men and Transgenders

Instructions to Health Providers

Why screen?

Gender-based violence—violence "based on socially ascribed differences between males and females"—that is perpetrated against men who have sex with men (MSM) and transgenders (TG), can increase their vulnerability to HIV and other STIs. Evidence suggests that violence against MSM and TG and related stigma and discrimination (S&D) is associated with increased risk of acquiring HIV. Violence against MSM and TG may also affect their ability to access and adhere to care, treatment, and support, as well as affecting their overall health status and ability to live positively.

By identifying patients who have experienced GBV, providers may be able to better identify a patient's healthcare needs and factors affecting their health, help break the silence and stigma a patient may experience related to GBV, and connect patients with other sources of support.

Who and when to screen?

The tool was developed for use with MSM and transgenders—including male sex workers within both groups—in HIV service settings that specialize in services for these populations. Ideally, one will determine whether the patient belongs to one of these populations through demographic information collected in the patient in-take form (for new patients) or the clinical history for returning patients.

This tool was designed with MSM and TG patients in mind but could be adapted to be used with persons from other vulnerable communities, provided that your clinic has instituted proper training and sensitization for staff and has implemented referral systems.

What is gender-based violence? Gender-based violence is "any harmful act that is perpetrated against a person's will and that is based on socially-ascribed (gender) differences between males and females" (IASC, 2005). The former has the objective of using violence as a way to maintain power and control over the victim (PAHO, 2002). The perpetrator's sense of entitlement to greater power and control is based on the perception that his/her gender holds a higher social status than that of the victim.

Who is considered MSM (men who have sex with men)? Any man who has sexual relations with other men. Some, but not all MSM identify as gay. MSM can include a broad range of individuals, including but not limited to sexually-active gay males who identify as such, bisexuals who are sexually active with other males, men who are married to or have sex with a woman but also with men, "closeted" homosexuals having sex with other men, anonymous or faceless sexual encounters between males, and male sex workers with patients (CDC, 2007).

Who is considered transgender? Transgendered persons (also referred to simply as trans) are people who were assigned a gender, usually at birth, based on their genitals, but who feel that this is a false or incomplete description of themselves. Transgender people may identify as heterosexual, homosexual, bisexual, pansexual, polysexual or asexual. Beyond sexuality, transgender identities also include many categories that may overlap, including transvestite or cross-dresser; androgynies (those who are non-gendered or between genders); people who live cross-gender; drag kings and drag queens (those who cross-dress for special occasions); and, frequently, transsexuals (those who undergo sex reassignment therapy to physically change their bodies to live and be accepted as a member of the sex opposite to that assigned at birth).

It is recommended that you as the health provider screen all new and existing patients, initially, as part of introducing the new screening tool and then on a regular basis. (The times should be determined by the health service providers—the suggested time is once a year.) Both the administration and staff of your clinic should develop and agree on these protocols.

Key Steps to Take Before Screening

Develop institutional values and commitment regarding care for victims of gender-based violence

The values, mission, and overall commitment of an institution can have an enormous influence on the professional culture of frontline providers in any organization. Heise (1999) and others have argued that the most effective way for health services to respond to gender-based violence is for the whole institution to make a commitment to the issue (a systems approach), rather than simply letting the responsibility fall on the shoulders of individual providers. Ideally, senior managers should be aware of gender-based violence as a public health problem and human rights violation and should voice their support for efforts to improve the health service response to violence.

Ensure privacy and confidentiality

Privacy and confidentiality are essential for a victim's safety in any healthcare setting, given that providers can put the patient at risk if they share sensitive information with partners, family members, or friends without consent. Moreover, those who have experienced gender-based violence need privacy to be able to disclose those experiences to providers without fear of retaliation from a perpetrator. To protect confidentiality and privacy, health programs need adequate infrastructure and patient flow, as well as clear policies outlining when and where providers are allowed to discuss sensitive information.

Provide ongoing sensitization and training for providers

Providers' attitudes, knowledge, and skills regarding gender-based violence can have a major impact on quality of care. Even without routine screening, patients may disclose experiences of physical or sexual violence, and providers who respond poorly can inflict emotional harm of different magnitudes. Moreover, providers who fail to consider the possibility of violence while counseling victims about STIs and HIV prevention or other health issues may be ineffective. Ignorance about links between health and violence may lead health workers to misdiagnose certain conditions and overlook the risks that some people face, such as internal stigma, isolation, and self-harm. Each institution must decide how much sensitization and training it can afford to provide. At a minimum, staff should be aware of the epidemiological evidence about violence, a human rights framework for understanding violence, and a basic understanding of local legislation. They should be able to respond to victims in a compassionate way.

Set up alliances and referral networks

Before encouraging staff to discuss violence with patients, health programs have an obligation to investigate what referral services exist in the local community and to compile this information into a format that healthcare providers can use. Networks and alliances with other organizations are important for other reasons as well. For example, they allow the health sector to play a role in the broader policy debate by raising awareness of gender-based violence as a public health problem. Informal or formal referral protocols should be developed with key partners.

Understand local and national legislation

Educating providers about laws related to gender-based violence and stigma and discrimination can prepare them to inform victims about their rights and can alleviate their concerns about getting involved in legal proceedings when a patient discloses violence. Both managers and service providers need to be familiar with local and national laws about gender-based violence, discrimination, and sexuality, including what constitutes a crime, how to preserve forensic evidence, what rights patients have with regard to bringing charges against a perpetrator and protecting themselves from future violence, and what steps people need to take to separate from a violent spouse. Healthcare providers also need to understand their obligations under the law, including legal reporting requirements (for example, in cases of child sexual abuse), as well as regulations governing who has access to medical records (for example, whether parents have the right to access the medical records of adolescents).

Set up medical records and information systems

Information systems play an important role in the response to violence in several ways. For example, health organizations have an obligation to ensure that providers know how to record sensitive information about cases of gender-based violence. Documenting information about violence in medical records may be important for completing a patient's medical record and in some cases, may provide evidence for future legal proceedings and advocacy. To protect clients' safety and well-being, medical records need to be stored securely. Information systems are also important for monitoring a health organizations' work in the area of gender-based violence. For example, healthcare organizations can gather service statistics on the number of patients identified as victims of violence, information that can help them determine the level of demand for other services.

Adapted from: Bott et al., 2004, pp. 40–41.

The following questions are designed to be integrated into already existing, routine interview and counseling processes within the clinic. These questions about violence ideally should follow questions you already ask about sexual history. The specific place to insert these questions into these existing processes and how often to screen should be determined in each clinic in consultation with staff.

Based on discussions in your clinic, insert these GBV-related questions into one of the following:

- New patient in-take
  - [Form:_____ ; Place in format:_____]
- Mental health history
  - [Form:_____; Place in format:_____]
- Counseling for VCT
  - [Form:_____; Place in format: _____]
- For existing patients, these questions are best asked during
  - Clinical history
  - [Insert response based on consultation with clinic staff]

Step 1: Informed Consent and Sexual Identity (ASK ALL PATIENTS)

1.1 We would like to first ask information regarding your sex and sexual identity. The clinic ensures that this information will be kept confidential and will be used only as a basis for providing you services that will best respond to your needs. So, if you don't mind, could you please indicate whether you are

☐ Male ☐Female ☐ TG (Multiple answers allowed)

1.2 Please indicate the sex of your sexual partner:

☐ Male ☐ Female ☐ TG ☐ Do not have sexual partner (Multiple answers allowed)

Note for the Healthcare Provider
To determine whether one is MSM or transgender, it is important to consider 1) sexual identity—the sex the person considers him/herself to be or has adopted; 2) sexual orientation—as defined by the sex or sexes of the person's sexual partner/s; and 3) gender expression—the preferences and behavior that communicates one's sex/gender; for example, clothing, hair styles, mannerisms, way of speaking, roles in interactions, as defined by traditional social and gender norms. Questions 1.1 and 1.2 pertain to sexual identity and sexual orientation. Based on this information, is the patient

☐ MSM ☐ TG ☐ Other, specify: _____

Introduction of Tool to Patients
Because mistreatment and violence are common and can have an effect on people's health, health providers have begun to ask patients about them. In particular, our clinic seeks to address the needs of different vulnerable communities such as MSM and transgenders who may be experiencing violence. The information will be kept confidential. If you do not mind, I would like to ask you questions about any mistreatment or violence you may have experienced in the past or currently.

Understand that if you are uncomfortable or not willing to answer any questions, you can refuse to answer. Your refusal will not affect the service you are receiving. (*If the patient indicates that it is okay, proceed with the following questions.)*

☐ Agree ☐ Not agree (**End the interview**)

Step 2: History of Violent Experiences

2.1 In the past year, has anyone forced or coerced you to have sexual relations against your will? This includes your partner, a patient, supervisor, colleague, someone in your family, a friend, neighbor, police, or other persons.

YES ( ) NO ( ) NO RESPONSE ( )

2.2 In the past year, has anyone slapped you, punched you, hit you, or caused you any other type of physical harm? This includes your partner, a patient, supervisor, colleague, someone in your family, a friend, neighbor, police, or other persons.

YES ( ) NO ( ) NO RESPONSE ( )

2.3 In the past year, has anyone insulted you, humiliated you, made you feel inadequate, or yelled at you? This includes your partner, a patient, supervisor, colleague, someone in your family, a friend, neighbor, police, or other persons.

YES ( ) NO ( ) NO RESPONSE ( )

2.4 In the past year, has anyone made you feel threatened, fearful, or in danger? This includes your partner, a patient, supervisor, colleague, someone in your family, a friend, neighbor, police, or other persons.

YES ( ) NO ( ) NO RESPONSE ( )

IF PATIENT RESPONDS 'NO' TO QUESTIONS 2.1 –2.4

*If the patient has never experienced any of the above violence, **end the interview**, and provide the patient with a list of organizations that provide specialized services from which he/she can seek support if experiencing violence or abuse in the future.*

IF PATIENT RESPONDS 'YES' TO ANY OF THE ABOVE

If the patient responds positively to any of the above, it is important to tell them that violence is never deserved. The following is a suggested way to phrase this thought:

"Mistreatment and abuse are often more common than thought. Yet, no one deserves to be abused. I am now going to ask you a few questions so that the clinic can evaluate possible effects on your health and outline some alternatives, if necessary."

2.5 Do you want or are you ready to tell me more detail about the incidences of violence you mentioned earlier?

- ☐ Yes, I would like to talk about the detail. (Instruction: Continue with question and allow the patient to describe all of the incidences mentioned or select only the event s/he feel was most severe.)
- ☐ No, I would not like to talk about this. But I can come back to this conversation again on _____(Date) at _____(Time)_____ (Place). (Skip to Question 3.1)
- ☐ No, I would not like to talk about this right now, but I would like more information on possible support services. (Skip to Question 3.1)
- ☐ I totally don't want to talk about this. (**End the interview** and provide the patient the list of referral organizations.)

Tell me about the last time you experienced violence. *Note to providers: this is an open question. You do not need to ask each of these questions. Let the patient recount their experiences—and use the following questions as follow-up probes if the patient does not directly state these details in their account. Afterward, fill in the chart according to the details obtained for each act of violence.*

For each act of violence the patient has experienced in the past year, please fill out columns A, B, and C.

A. Who?	**B1. When?**	**B2. Where?**	**B3. How?**	**Do you think this happened to you because you are MSM/TG? Explain.**	**C1.* What were the physical consequences?**	**C2.* What were the emotional consequences?**	**C3.* Other consequences?**
Romantic/ sexual partner( )							
Pimp ( )							
Patient/ sexual friend ( )							
Family member ( )							
Friend ( )							
Neighbor ( )							
Stranger ( )							
Police ( )							
Health							

Worker ( ) Specify:							
Others ( ) Specify:							

(*C1) Bruises, scratches, superficial or serious wounds, injuries from a type of weapon, disfiguration, disability, loss of consciousness, acquiring an STI or HIV.

(*C2) Depression, loss of trust, loss of self-esteem, feeling dirty, feeling guilty, fear, anxiety.

(*C3) Loss of the following: work, authority, respect (from others or self-respect), material goods, family, supportive relationships, etc.

2.6 Did you seek any support or services when you experienced this violence?
Yes ( ) No ( ) No Response ( )

2.7 *If the answer to 2.6 is 'yes,' providers should ask:* **Can you tell me about what help or services you sought? Note**: *Please remember that this is an open question. Let the patient tell his or her experience, and afterward fill in the appropriate information below. For each type of help the patient mentions, follow up with "how much?" Also note that this information may help you decide what types of references to make in Step 3.*

Type of help	How much did the support or services help you?			
Support from a family member ( )	Much	Some	Little	None
Support from friends ( )	Much	Some	Little	None
Psychologist ( )	Much	Some	Little	None
Monk, priest, or faith leader ( )	Much	Some	Little	None
NGO offering services for violence ( )	Much	Some	Little	None
Human rights commission ( )	Much	Some	Little	None
Public hospital ( )	Much	Some	Little	None
Specific medical service ( )	Much	Some	Little	None
Red Cross ( )	Much	Some	Little	None
Other ( ) _____	Much	Some	Little	None

Step 3: Assessment of patient's safety

3.1 Are you still in contact with the person(s) who committed this violence?

Yes ( ) No ( ) No Response ( )

3.2 At present do you feel safe and without threats, and able to return safely to your daily life and routine?

Yes ( ) No ( ) Specify reason for feeling unsafe: _____

No Response ( )

3.3 At this time, have you thought of hurting yourself or committing suicide due to the violence that has happened to you?

Yes ( ) No ( ) No response ( )

From the information obtained, as a health provider you need to decide: do you consider that this person could be in immediate danger?

Yes ( ) No ( )

Step 4: Referrals

4.1.A. NO, the person is not in immediate danger. Make the appropriate reference:

What kind of help/support do you think you need? (Multiple answers allowed)

☐ Medical care ☐ Psychological counseling support ☐ Living place/sheltering ☐ Legal help ☐ Other (specify)_____

☐ No need for other help or support (**End interview** and provide the patients the list of referral organizations.)

There are groups and institutions that could offer you help. I would like to mention some of these so that you know about them and can decide if they might be able to offer help that would be useful to you.

Name of Organization	**Type of Referral**	**Referral Made?** (Mark with an X if referral made.)
List service organization	☐ General Medical care ☐ VCT ☐ Psychological support groups ☐ Shelter ☐ Social Service ☐ Drop-in center ☐ Other specify_____	
	☐ General Medical care ☐ VCT ☐ Psychological support groups ☐ Shelter ☐ Social Service ☐ Drop-in center ☐ Other specify_____	
	☐ General Medical care ☐ VCT ☐ Psychological support groups ☐ Shelter ☐ Social Service ☐ Drop-in center ☐ Other specify_____	
	☐ General Medical care ☐ VCT ☐ Psychological support groups ☐ Shelter ☐ Social Service ☐ Drop-in center ☐ Other specify_____	
	☐ General Medical care ☐ VCT ☐ Psychological support groups ☐ Shelter ☐ Social Service ☐ Drop-in center ☐ Other specify_____	

4.1.B. Did the patient accept the referral?
Yes ( ) No ( )

4.1.C. If the person is in immediate danger, and there are specialized services for MSM, transgenders, or sex workers, consult with the available service to identify the best action for ensuring the immediate safety of the person. Elaborate a safety plan (such as described below) when 1) no specialized services exist; 2) existing services are not available; or 3) services exist and are available, but the person does not accept a referral.

For the interviewer: Describe the help/support you can offer when there are no special services for MSM/TG or adequate services addressing violence issues.

Developing a Safety Plan

A safety plan is a combination of suggestions, plans, and responses created to help victims reduce their risk of harm. To address situations in which someone is in imminent danger of harm from an abuser, survivors of gender-based violence can develop a safety plan. A safety plan can involve thinking about the best way to leave a home quickly in case violence begins to escalate. It can involve alerting trusted neighbors or friends about the situation and enlisting their help or perhaps planning ways to leave an abusive spouse/partner to prevent the type of violence that is common at the time of separation. (Adapted from Bott et al., 2004)

One of the most important actions that a health provider can take when a patient discloses that s/he is living with a violent partner or otherwise regularly in contact with his/her perpetrator, is to work with the patient to assess her risk and help him/her develop a safety plan. A healthcare provider can facilitate this planning process by helping the patient identify the measures she can take when needing to make quick decisions that could save her life. During this process, it is important that the provider help his/her patient identify the real risk in which she finds herself. Safety planning can include a wide range of details, but at the very minimum, providers should help their patients think through the following points:

- Identify possible escape routes (from common places where violence occurs) and a place to go (e.g., the home of a family member or friend) if s/he needs to leave her home;
- Know phone number(s) for organizations that provide help, including drop-in centers or rape hotlines;
- Notify one or more trusted friends to watch for signs of violence;
- Decide what s/he needs to have ready if she needs to leave her home in a hurry (e.g. clothes, money, documents, keys);
- Pack a bag with these items and store it somewhere in her home or with a friend or relative; and
- If an argument or confrontation cannot be avoided, try to deal with it in a room or location with an easy exit. Stay away from any room where weapons might be available.

Adapted from: Skye et al., 2001, p. 9.

Citations from Final Screening Tool

Bott, S., A. Guedes, M.C. Claramunt, and A. Guezmes. 2004. *Improving the Health Sector Response to Gender-based Violence: A Resource Manual for Health Care Professionals in Developing Countries*. New York, New York: International Planned Parenthood Federation [IPPF], Western Hemisphere Region [WHR].

Centers for Disease Control and Prevention. June 28, 2007. *HIV/AIDS and Men Who Have Sex with Men*. Retrieved May 15, 2009 from http://www.cdc.gov/hiv/topics/msm/.

Heise, Lori, Mary Ellsberg, and Megan Gottemoeller. 1999. "Ending Violence against Women." *Population Reports* XXVII, Number 4, Series L, Number 11.

Inter-Agency Steering Committee (IASC). 2005. *Guidelines for Gender-based Violence Interventions in Humanitarian Settings: Focusing on Prevention and Response to Sexual Violence in Emergencies. (Field Test Version)*. Geneva, Switzerland: IASC.

Pan-American Health Organization (PAHO). 2002 Programa Mujer, Salud y Desarrollo. Serie Género y Salud Pública.-Violencia Sexual Basada en Género. San José, Costa Rica.

Skye, Donald, Alessandra Guedes, and Zhenja La Rosa, eds. Winter 2001. *Incorporating Personal Experiences and Perceptions into GBV Sensitization and Training*. New York: IPPF/WHR.

REFERENCES

Armbrecht, Jason. 2008. *"Transsexuals and Thai Law."* Thailand Law Forum. Retrieved March 27, 2009, from http://www.thailawforum.com/Transsexuals-and-Thai-Law.html.

Betron, M., E. Gonzalez, A. Eckman, and K. Morrison. 2008. "Screening for Gender-based Violence and Other Forms of Stigma and Discrimination among MSM and Transgendered Persons: A Synthesis and Review of Relevant Literature." Paper presented at the International AIDS Conference, Mexico City, Mexico.

Betron, Myra, and Evelyn Gonzalez-Figueroa. 2009. *Gender Identity and Violence in MSM and Transgenders: Policy Implication for HIV Services*. Washington, DC: USAID | Health Policy Initiative, Task Order 1.

Bott, S., A. Guedes, M.C. Claramunt, and A. Guezmes. 2004. *Improving the Health Sector Response to Gender-based Violence: A Resource Manual for Health Care Professionals in Developing Countries*. New York: International Planned Parenthood Federation, Western Hemisphere Region.

Centers for Disease Control and Prevention (CDC). 2007. "HIV/AIDS and Men Who Have Sex with Men (MSM)." Last accessed: September 9, 2009, from http://www.cdc.gov/hiv/topics/msm/index.htm. Atlanta: CDC.

CDC TUC, Thailand Ministry of Public Health, Thai Red Cross Society, and The Rainbow Sky Association of Thailand. 2005. "The Prevalence of HIV and Associated Risks among Men Who Have Sex with Men (MSM) in Bangkok, Chieng Mai and Phuket." Presentation at the Meeting at USAID Bangkok 21 October 2005.

Chakrapani, Venkatesan, Peter A. Newman, Murali Shunmugam, Alan McLuckie, and Fredrick Melwin. 2007. "Structural Violence against Kothi-identified Men Who Have Sex with Men in Chennai, India: A Qualitative Investigation." *AIDS Education and Prevention* 19(4): 346–364.

Egremy, G., M. Betron, and A. Eckman. 2009. *Identifying Violence against Most-at-Risk Populations: A Focus on MSM and Transgenders. Training Manual for Health Providers.* Washington, DC: Futures Group, USAID | Health Policy Initiative, Task Order 1.

Eckman, A., K. Morrison, M. Betron, G. Egremy, A. Luna, W. Phoolcharoen, S. Sriplienchan, and P. Sakhunthaksin. 2008. "HIV-service-based Screening for Violence (GBV and Discrimination) in Marginalized Vulnerable Populations (MSM/TG)." Paper presented at the International AIDS Conference, Mexico City, Mexico.

Egremy Mendivi, G.A., A. Eckman, K. Morrison, and A. Luna. 2008. "Building the Capacity of HIV Providers in Health and Community Settings to Respond to GBV among MSM/TG." Paper presented at the International AIDS Conference, Mexico City, Mexico.

Egremy, Guillermo. Unpublished report. *Entendiendo las manifestaciones de Estigma y Discriminación, incluyendo a la Violencia Basada en Género, en Poblaciones con Mayor Prácticas de Riesgo (MARP): Estudio en México y Tailandia: Informe del Diagnóstico Situacional sobre Violencia Basada en Género en HSH/TS y TG con Personal de Salud y Poblaciones MARPs.* USAID | Health Policy Initiative, Task Order 1.

Gayet, C., C. Magis, D. Sacknoff, and L. Guli. 2007. *Prácticas Sexuales de las Poblaciones Vulnerables a la Epidemia de VIH/SIDA en México.* Mexico: CENSIDA, Facultad Latinoamerica de Ciencias Sociales, Sede México.

Goffman, Erving. 1963. *Stigma: Notes on the Management of Spoiled Identity*. New York: Touchstone.

Grisurapong, S. 2002. "Establishing a One-stop Crisis Center for Women Suffering Violence in Khonkaen Hospital, Thailand." *International Journal of Gynecology and Obstetrics* 78 Suppl. 1 (2002) S27–S38.

Guadamuz, T.E., S. Naorat, A. Varangrat, P. Phanuphak, R. Jommaroeng, P.A. Mock, J.W. Tappero, F. van Griensven, and T. Siraprapasiri. 2006. "Thailand MSM Study Group. Correlations of Sexual Coercion among Populations of Men who have sex with Men in Thailand." Paper presented at the International Conference on AIDS, Toronto, Canada.

Heise, Lori, Mary Ellsberg, and Megan Gottemoeller. 1999. "Ending Violence against Women." *Population Reports* XXVII, Number 4, Series L, Number 11.

Inter-Agency Steering Committee (IASC). 2005. *Guidelines for Gender-based Violence Interventions in Humanitarian Settings: Focusing on Prevention and Response to Sexual Violence in Emergencies. (Field Test Version).* Geneva, Switzerland: IASC.

International Gay and Lesbian Human Rights Commission, 2003. "Mexico Protects Its Gay and Lesbian Citizens with New Law." Retrieved March 27, 2009, from http://www.thefreelibrary.com/Mexico+protects+its+gay+and+lesbian+citizens+with+new+law.-a0108149079.

International Planned Parenthood Federation/Western Hemisphere Region. 2008. *Sexual Diversity Toolkit.* New York.

Jenkins, Carol. 2006. *Violence and Exposure to HIV among Sex Workers in Phnom Penh, Cambodia*. Washington, DC: USAID Policy Project.

Joint United Nations Programme on HIV/AIDS (UNAIDS). 2005. *Fact Sheet: HIV/AIDS, Gender and Sex Work*. Retrieved June 8, 2008, from http://www.genderandaids.org/downloads/events/Fact%20Sheets.pdf .

Khan, S., A. Bondyopadhyay, and K. Mulji. 2005. From the Front Line: The Impact of Social, Legal and Judicial Impediments to Sexual Health Promotion, and HIV and AIDS Related Care and Support for Males Who Have Sex with Males in Bangladesh and India. Naz Foundation International.

La Jornada. April 6, 2006. "Letra: Salud, Sexualidad, SIDA." Number 117. Mexico City.

Leung, S.J., J.M. Tesoriero, S.J. Klein, K.K. Heavner, H.B. Battles, C. Nemeth, and G.S. Birkhead. 2005. "Intimate Partner Violence and HIV Testing History among High Risk Individuals." Presented at the National HIV Prevention Conference.

Medina, E.J., J. Toro-Alfonso, and Baños. 2006. "No Más en el Tintero: Hombres Gay: Nuestras Vidas y el VIH en Centro America y el Caribe." Los Angeles: Coalición de Organizaciones Gay en Centro América.

Morrison, Ken. 2006. *Breaking the Cycle: Stigma, Discrimination, Internal Stigma and HIV*. Washington, DC: Futures Group, POLICY Project.

Onyango-Ouma, W., Harriet Birungi, and Scott Geibel. 2006. *Understanding the HIV/STI Prevention Needs of Men Who Have Sex with Men in Kenya*. Washington, DC: Population Council, Horizons Program.

Pan-American Health Organization (PAHO). 2002. *Programa Mujer, Salud y Desarrollo. Serie Género y Salud Pública. Violencia Sexual Basada en Género.* San José, Costa Rica.

Sakhunthaksin, Phongsak. Unpublished report. *Understanding and Developing and Assessment Tool for Manifestations of Stigma and Discrimination and Gender-based Violence in Men who Have Sex with Men and Transgenders in Pattaya, Thailand*. Final report. Bangkok: Population Research Institute Foundation.

Sakhunthaksin, Phongsak. Unpublished report. *Understanding and Developing and Assessment Tool for Manifestations of Stigma and Discrimination and Gender-Based Violence in Men who Have Sex with Men and Transgenders in Pattaya, Thailand*. Situation Assessment Report. Bangkok: Population Research Institute Foundation.

Sakhunthaksin, P., N. Chaiphet, W. Phoolcharoen, S. Sriplienchan, A. Eckman, K. Morrison, and M. Betron. 2008. "NGOs and Health Service Provider Collaboration to Tackle Stigma and Discrimination (S&D), Including Gender-based violence (GBV) among Transgender Sex Workers and Male Sex Workers in Pattaya, Chonburi, Thailand." Paper presented at the International AIDS Conference, Mexico City, Mexico.

Skye, Donald, Alessandra Guedes, and Zhenja La Rosa (eds). Winter 2001. *Incorporating Personal Experiences and Perceptions into GBV Sensitization and Training*. New York: IPPF/WHR.

T-VOX. Retrieved June 12, 2009 from http://www.t-vox.org/index.php?title=Transgender.

UNAIDS. 2009. "HIV Prevention Hampered by Homophobia." Retrieved March 27, 2009 from http://www.unaids.org/en/KnowledgeCentre/Resources/FeatureStories/archive/2009/20090113_MSMLATAM.asp.

UNAIDS. 2008. *Report on the Global AIDS Epidemic*. Geneva: UNAIDS.

Health Policy Initiative, Task Order 1
Futures Group
One Thomas Circle, NW, Suite 200
Washington, DC 20005 USA
Tel: (202) 775-9680
Fax: (202) 775-9694
Email: policyinfo@futuresgroup.com
http://ghiqc.usaid.gov
http://www.healthpolicyinitiative.com