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GENDER IDENTITY AND VIOLENCE IN MSM AND TRANSGENDERS:

Policy Implications for HIV Services

JULY 2009

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ABBREVIATIONS

AIDS	acquired immune deficiency syndrome
CBO	community-based organization
CDC	Centers for Disease Control and Prevention
GBV	gender-based violence
HIV	human immunodeficiency virus
IPV	intimate partner violence
LGB	lesbian, gay, and bisexual
PLWHIV	people living with HIV
MSM	men who have sex with men
S&D	stigma and discrimination
STI	sexually transmitted infection
SW	sex worker
TG	transgender/transgender persons
UNAIDS	Joint United Nations Program on HIV/AIDS
US	United States
VCT	voluntary counseling and testing
WHO	World Health Organization

EXECUTIVE SUMMARY

Background

After 26 years of grappling with the HIV/AIDS epidemic, providers, researchers, and policymakers understand that social discrimination is connected to HIV risk, vulnerability, and access to care and prevention. Unfortunately, around the world, men who have sex with men (MSM) and transgender persons (TG) often face stigma, discrimination, poverty, violation of human rights, homophobia, and heterosexism. Negative attitudes and violence toward gay men, MSM, and TG commonly are condoned by the State and society in many countries. In such environments, MSM often face arrest if they overtly state their sexual orientation, and expressions of same-sex behavior can be punished by imprisonment. Law enforcement and healthcare providers often perpetrate widespread corruption, intimidation, and harassment against gay men, MSM, and TG, thus hindering them from accessing services. Similarly, the rates of violence among MSM and TG, particularly those engaging in sex work, are alarming.

This violence and stigma and discrimination (S&D) faced by MSM and TG often find their roots in homophobia, or fear of homosexuality, as well as a general fear of those whose gender identity does not adhere to traditional gender norms. Violence against MSM and TG often is a manifestation of stigma and discrimination due, at least in part, to the fact that they do not fit into traditional gender categories. Those who enact violence against MSM and TG may feel a sense of entitlement to greater power and control based on perceptions that his/her gender is of a higher social status than that of the victim. Moreover, evidence points to the fact that intimate partner violence (IPV) faced by MSM and TG mirrors intimate partner violence that women experience—the perpetrator uses violence as a way to maintain power and control over the victim, and often the victim takes on the more effeminate role in the relationships. In these ways, violence against MSM and TG can be considered a form of gender-based violence (GBV).

According to the literature, violence against MSM and TG increases their vulnerability to HIV and AIDS. The most direct documented link is the high level of sexual coercion—often without condoms—that MSM and TG suffer. Evidence also shows a correlation between IPV and having sex without condoms. Likewise, violence against MSM and TG may also further degrade their self-esteem, leading to other high-risk behavior, including substance abuse, transactional sex, or forcing sex themselves. More overtly, violence or fear of violence by health professionals prevents MSM, TG, and sex workers—those with and without HIV—from accessing critical health services, and sex workers often are harassed if they are found carrying condoms, which denotes being a sex worker (SW) in many cultures.

Despite the fact that MSM and TG face numerous vulnerabilities related to violence, stigma, and discrimination based on their gender identity, health-related services are limited to a handful of pilot programs that only touch upon the problem of violence as it emerges as a key issue for MSM and TG. On the whole, however, MSM and TG are so marginalized that they do not access health services, whether due to poverty, discrimination, or a general lack of knowledge.

There are no established guidelines for determining whether a particular health service setting is ready to work with MSM and TG to address issues of violence and S&D. Given the special considerations and sensitivities in working with MSM and TG, however, the most ethically sound approach requiring the fewest reforms would be constructing a pilot intervention to assess for violence in specialized STI clinics and/or community-based organizations (CBOs) accustomed to providing HIV/AIDS services for these groups. Even in these cases, if not already part of an organization's package of services, strong linkages should be made with CBOs that provide support services for MSM and TG, such as drop-in centers that offer social services and counseling or human rights organizations that may be able to empower MSM and TG to recognize their human rights.

It is important to recognize that, for many societies, gender-based stigma and discrimination may be so pervasive that interventions aimed at tackling the underlying attitudes and norms will need to be prioritized before attempting health service reforms, if not carried out in tandem. On the other hand, the health sector plays an integral role in changes to structural and societal norms. Where there is institutional support and laws that protect the human rights of MSM and TG, HIV services have a responsibility to respond to cases of violence against these groups and/or actively address violence and S&D against them in a manner that is nonjudgmental, confidential, and ensures access to counseling and/or social support. They may also help to link those experiencing violence with other specialized services so they can work together to ultimately reduce the vulnerability of MSM and TG to both violence and HIV.

Recommendations

Research

As this review has identified, there is still much to be learned about how gender-based violence affects the lives of MSM and TG, including HIV vulnerability. Through evaluation of the above interventions and additional studies, the following information should be collected:

- Different types of violence and abuse by subcategory of MSM and TG;
- Perceptions of MSM as to whether IPV is violence and to what extent they think it is gender based;
- The full complexity of the links between violence against MSM/TG and HIV, especially as revealed through qualitative research;
- The help-seeking behavior of MSM and TG to identify whom they are most likely to approach when in need of emotional or physical health services;
- Attitudes of health professionals toward MSM and TG to understand how open they are toward those individuals;
- Discovery of whether screening for violence in HIV or other health services is an effective entry point to address violence against MSM and TG; and
- Ways that HIV and/or other health interventions can address violence within their programs.

Advocacy

Numerous studies and reports discussed in this review indicate that MSM and TG are highly marginalized and face a wide range of social vulnerabilities to HIV beyond high-risk sexual behavior. Findings from this research as well as the research and interventions discussed above should be used to advocate for improved policies and increased attention to such social vulnerabilities through programming, including

- Laws that protect the dignity and rights of MSM and TG as human beings;
- Increased funding and support to identify appropriate interventions to respond to violence against MSM and TG; and
- HIV policies and strategic plans that include specific strategies to address violence, stigma, and discrimination against MSM and TG in related programs.

Action

Because MSM and TG are so marginalized and stigmatized by greater society, it is not clear how effective formal health services would be to reach them. Based on the formative research discussed above, pilot interventions should be designed, implemented, and rigorously evaluated to determine most effective programs to address violence against MSM and TG. Interventions should address the range of dimensions that influence, support, and potentially mitigate violence and effects of violence against MSM in TG. Such interventions may include

- Programs that eliminate related norms, attitudes, and behaviors of the general community;

- Health or HIV services that identify violence and incorporate violence-specific counseling into HIV counseling and testing and other health services;
- Sensitization and training of police on the human rights of MSM and TG and their roles in protecting those human rights, particularly where laws are supportive and well defined.
- Social services such as shelters and livelihood programs for MSM or TG who have been rejected from their home, work, or other livelihood; and
- More informal community-based peer support systems.

Through evaluation, it will be particularly important to identify the feasibility of the interventions and who and what types of interventions are best positioned to both reach MSM and TG and address violence and resulting impact on HIV vulnerability

INTRODUCTION

Purpose of the Review

There are two primary goals of this review. First, it aims to synthesize the literature on violence and related forms of stigma and discrimination among MSM and TG, particularly those engaging in sex work,¹ through a gender perspective. In doing so, it analyzes ways in which violence and S&D among MSM and TG are gender based. Second, the review looks at how violence and related S&D against MSM and TG affects vulnerability to HIV.

Rationale

This review began with the premise that violence against MSM and TG can lead to sex work, a lessening of economic options for survival, high-risk sexual behavior, poor health-seeking behavior, isolation, and low self-esteem—all vulnerabilities that anchor HIV as an epidemic. Although accurate prevalence statistics of HIV among MSM and TG, including those who engage in sex work, are difficult to gather because of the marginalization of those groups, studies reported by UNAIDS (2008) found rates of HIV among MSM to range from 6.2 percent in Egypt to 43 percent in the port of Mombasa in Kenya. For the general TG population and males or TG who engage in sex work, few data are available, but one study from Vietnam reported 33 percent HIV prevalence in male sex workers (UNAIDS, 2008).

The wide and overlapping prevalence of all of these epidemics—stigma and discrimination, GBV, and HIV—among MSM and TG raises questions about their linkages. While research is minimal among MSM and TG, in recent years, researchers have revealed that GBV is strongly linked to HIV in women. Several factors account for this correlation. First, coercive sexual intercourse may directly increase the risk for HIV through physiological trauma. Second, violence and threats of violence may limit the ability to negotiate safer sexual behaviors. Likewise, experiencing violence, particularly sexual violence, has been found to increase HIV-risk behavior, such as multiple sex partnerships and use of illicit drugs. Finally, international research shows that the fear of violence prevents women from accessing HIV information; being tested; disclosing HIV status; accessing services for the prevention of HIV transmission to infants; and receiving treatment, care, and support (Campbell, 2008).

Given this knowledge, and the anecdotal and media reports, it is plausible to conclude that the intersections between violence against MSM/TG and HIV are highly significant. Without a solid body of empirical research to support such a statement, however, it remains nothing more than a hypothesis. Diverse pieces of research explore this intersection and have been highlighted by MSM initiatives among HIV programs and in the more marginalized SW movement. To the best of the authors' knowledge, however, there has been no recent global synthesis of these findings.

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 former has the objective of using violence as a way to maintain power and control over the victim (Pan-American Health Organization, 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.

¹ It is important to note here how each of these categories—MSM, TG, and SWs—are defined in this paper. The complexity of the behaviors and characteristics of individuals within each group means that there is no perfect definition for each. In fact, the terms “men who have sex with men,” “transgender,” and “sex worker” actually do not refer to groups per se; rather, they group together individuals who engage in certain behaviors.

While, the term “gender-based violence” is often used interchangeably with the term “violence against women,”² this review includes violence against MSM and TG in its definition of GBV. To avoid confusion, however, this review uses “violence against MSM and TG” throughout most of the document.

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 a labeling of 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 same 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.

Although the literature rarely refers to violence experienced by MSM and TG as gender based, findings from this literature review reveal that for MSM and TG, gender identity is an important underlying cause of such violence. This paper examines the immensity of GBV against MSM and TG without detracting from the problem of violence against women and girls. Indeed, female victims do suffer greater physical damage than male victims (WHO, 2005) and their subordinate status (both economic and social) “contributes to an environment that accepts, excuses, and even expects violence against women” (Heise et al., 1999). Still, as this paper will point out, violence experienced by MSM and TG has similarities to violence against women in that it usually occurs because MSM and TG do not ascribe to traditional gender roles or because they are viewed as effeminate, and so, subordinate to others.

In the case of intimate partner violence among MSM and TG, including those who engage in sex work, violence appears to be a way to subordinate them to inferior feminine roles, similar to women who experience violence within heterosexual relationships. Some researchers assert that this imposed subservience makes it more difficult for men, including gay and bisexual men, to acknowledge being in violent relationships. In one of the earlier studies exploring GBV, Letellier (1994) identified the difficulty of accurately estimating violence because men may not necessarily view themselves as victims or because this would be inconsistent with their identity as “males” (cited in Burke and Follingstad, 1999).

Moreover, while women may experience violence at the hands of their husbands or partners for defying traditional gender roles, such as taking care of the household or being an obedient wife, gender-based reasons for violence toward MSM and TG lie in homophobia³ (irrational fear of, aversion to, or discrimination against homosexuals or homosexual behavior or cultures) and heterosexism (the belief that heterosexual people are naturally superior to homosexual and bisexual people). Homophobia and heterosexism drive violence perpetrated against MSM and TG by the wider community, as well as family and friends.

As Scott and colleagues point out, the etiology of violence cannot be reduced to simple causal factors, and certainly not just one. That is, a single variable such as gender cannot be emphasized while ignoring others (Scott et al., 2005); this is not the intention here. Contexts in which violence occur vary. Indeed, much violence in societies can be attributed to an overall culture of violence, alcohol, and drugs, as well as poverty—the same factors linked to youth violence, gang violence, and child abuse. Yet, evidence

² The United Nations General Assembly defines violence against women as, “Any act of gender-based violence that results in, or is likely to result in, physical, sexual, or psychological harm or suffering for women, including threats of such acts, coercion, or arbitrary deprivations of liberty, whether occurring in public or private life” (United Nations General Assembly, 1993).

³ Psychologists (Weinberg and Ramos Padilla) assert that homophobia also refers to the self-loathing by homosexuals, as well as the fear of men who do not live up to society’s standards of what it is to be a “true man.”

from studies identified by this review indicate that MSM and TG, including sex workers, most commonly experience violence as a result of homophobia and heterosexism.

This review will focus its discussion on these groups broadly but will also look at MSM and TG who engage in sex work—groups that have heightened risk for violence and HIV. A note here is warranted about how each of these categories—men who have sex with men, transgender, and sex workers—are defined in this paper. The terms “men who have sex with men,” “transgender,” and “sex worker” really do not refer to groups per se; rather, they group together individuals who engage in certain behaviors.

First, **MSM** are defined by the U.S. Centers for Disease Control and Prevention (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 or faceless sexual encounters between males; and male SWs with clients. In their assessment of the knowledge about the sexual networks and behaviors of men who have sex with men in Asia, Dowsett, Grierson, and McNally observe,

"The literature reveals that there are no socially or self-defined groups of men that fit into an overarching category of MSM. What the review shows is that there are just men!! Fishermen, students, factory workers, military recruits, truck drivers, and men who sell sex, and so on: all these categories of men are to be found in the studies and programmes reviewed" (Dowsett et al., 2006).

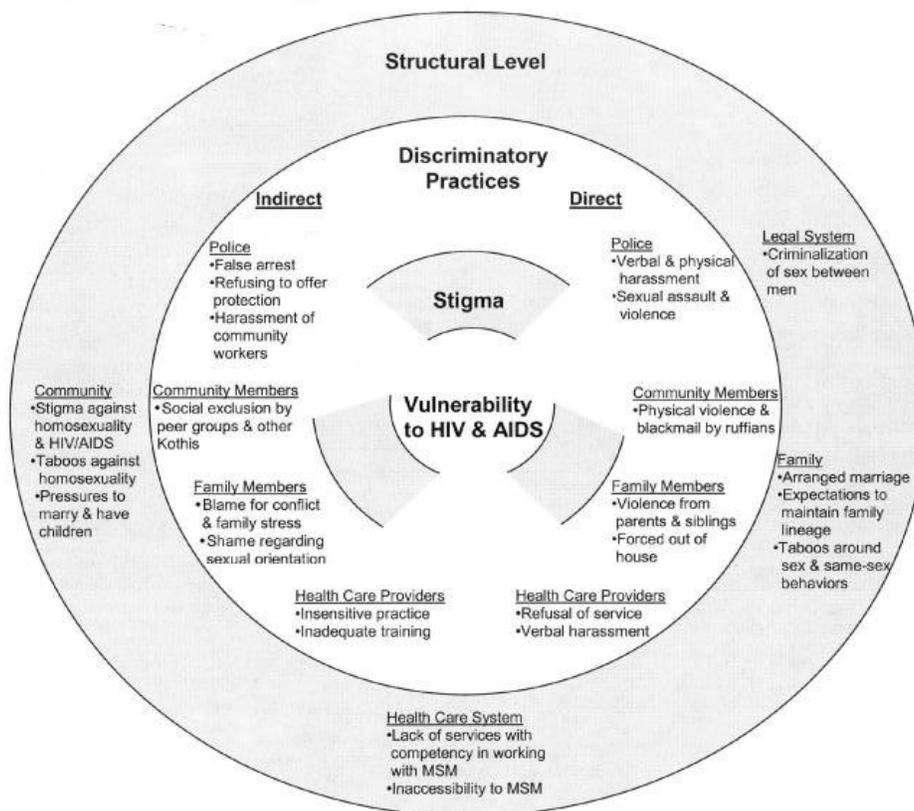
Unlike MSM, TG are not unambiguously of one sex. Instead, **transgenderers** are “people who were assigned a gender, usually at birth, based on their genitals, but who feel that this is a false or incomplete description of themselves” (T-VOX, 2009). Similar to MSM, however, transgender does not imply 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 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 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. Likewise, in developing countries, some young men maintain sexual relationships with an older male tourist in exchange for gifts, a chance to learn English, or the possibility of a better life abroad (Clatts et al., 2007). This review did not seek to exclude these forms of transactional sex; however, the search parameters (discussed in “Methods” below) were limited to articles referring to “sex work” and MSM or TG.

Theoretical Frameworks among Gay Men, MSM, and TG

Several researchers have explored the experience of violence, harassment, and discrimination. They have found that structural violence—stigma, discrimination, and violence endemic throughout society and its institutions—makes specific communities particularly vulnerable to HIV infection. For example, Chakrapani et al. (2007) conducted a qualitative study consisting of in-depth interviews in Chennai, India among MSM who identify as *kothis*⁴ (N=18). Results showed that *kothis* face violence from family and friends, and that violence was especially exacerbated in the healthcare and legal systems. *Kothis* who were HIV positive expressed greater levels of victimization and assault. The authors propose a conceptual model of structural violence and vulnerability that intersects direct and indirect discriminatory practices (see Figure 1). This is among the few models that categorize the types of discriminatory practices incorporating direct versus indirect forms of assault. For example, the legal system *directly* perpetuates violence by criminalizing sex between men, thereby facilitating the environment in which police feel justified in perpetrating harassment and violence against *kothis*. The community may *indirectly* perpetuate violence upon *kothis* (and non-identified *kothis*) by exerting pressure to marry and have children; if they choose not to do so, they feel ostracized and suffer the stigma of being labeled a *kothi*. The model makes various connections between HIV vulnerability and discriminatory practices, including violence, exerted upon MSM who identify as *kothis* in Chennai, India.

Figure 1. Structural violence model proposed by Chakrapani et al., 2007, p. 359



While analyses of structural models are not commonly found in the literature, analyses of the effects of social and structural discrimination are becoming more available. In these models, mental health, gender

⁴ Term used to describe transgender in India.

identity, and stress are studied among gay and bisexual men. Researchers' recent findings increasingly demonstrate that discriminatory practices lead to poor health outcomes. For example, based on a literature review, Meyer (2007) proposes the Minority Stress model. The model explores and summarizes various factors and their effects on mental health outcomes of gays and minorities: circumstances in the environment; minority identity (i.e., gay, lesbian, bisexual); minority status (i.e., sexual orientation, race/ethnicity, gender); general stressors; prejudice events; internalized homophobia; expectations of rejection; concealment; coping and social support; and characteristics of minority identity (i.e., prominence, valence, and integration).

Meyer illustrates that having to conceal sexual orientation may be a source of stress among the lesbian, gay, and bisexual (LGB) community. This concealment is a familiar coping mechanism that some men use to effectively exercise their day-to-day activities in contexts swamped with prejudiced views against MSM and TG. This notion is supported by research that Padilla et al. (2008) conducted on stigma, social inequality, and HIV risk among Dominican male SWs (N = 72). Gay and bisexual men described stories of their *need* to undertake sex work and hold dual identities by having girlfriends, wives, and children to sustain their livelihoods and defuse the effects of stigma and social inequality. It is "safer" to do this than to admit to being in sex work or to being gay, bisexual, or TG.

Many studies have found that people in LGB communities experience higher levels of prejudice than heterosexual adults. Being terminated from one's place of work, robbed, and sexually assaulted are among the denigrating and violent occurrences experienced by LGB due to their sexual orientation. Diaz and colleagues (2001) explored these issues in face-to-face interviews with 912 self-identified gay and bisexual Latino men in three major U.S. cities. They found that gay and bisexual Latino men who considered themselves to be effeminate had higher levels of mental distress and more frequently reported various negative experiences, compared with gay and bisexual Latino men who did not consider themselves effeminate. This type of stigma reinforces the need to conceal sexual orientation to avoid discrimination and prejudice. In the same study, the authors tested proxies for homophobia, such as feelings of shame due to family responses and attitudes to their gender identity, experiences of harassment by law enforcement, and social isolation. The authors make a strong connection between historical and current social discrimination and financial hardship as contextual factors contributing to the risk of social vulnerability. These risk situations, as further supported in the literature summarized below, make MSM and TG more vulnerable to contracting HIV.

Methods

The authors aimed to explore the various links, issues, and lessons in programming for violence, GBV, S&D, and HIV/AIDS among MSM and TG. With this goal in mind, the authors reviewed articles that considered the questions aligned with the purpose of the study outlined above:

- (1) What is the prevalence/extent and nature of violence and S&D faced by MSM and TG, including the subset of sex workers? To what extent is that violence and S&D gender based?
- (2) How do GBV and related S&D affect HIV vulnerability?

The review was performed using sources identified on POPLINE,⁵ MEDLINE,⁶ the Cochrane Database, and Ingentaconnect;⁷ a review of bibliographies of relevant literature reviews; and a search of more than 20 organizational websites for relevant documents. Database searches were limited to articles published in English from 1997 to May 2009. In searching these databases, the following terms were used: *gender-based violence, intimate partner violence, domestic violence, violence, HIV, sex worker, prostitute, gay,*

⁵ <http://db.jhuccp.org/popinform/basic.html>.

⁶ <http://www.ncbi.nlm.nih.gov/entrez/query.fcgi>.

⁷ www.ingentaconnect.com.

men who have sex with men, transgender, transsexual, transvestite, androgyny, and cross-dresser. Literature searches on Medline were limited to documents published within the last 10 years; those in English; and documents categorized as clinical trials, meta-analyses, guidelines, reviews, or randomized clinical trials. In addition, bibliographies of individual articles were referenced.

Finally, the authors also used documents recommended by colleagues in CBOs around the world who work in the fields of gender-based violence, human rights, advocacy, and information exchange, and HIV. A 25-member global network was approached via email⁸ to introduce the goals of the review.⁹ Informal inquiries also were made directly to CBOs¹⁰ (N=10) in various locations (i.e., Nicaragua, Colombia, India) that provide services to individuals at risk for HIV. The aim was to enrich the sources of information about violence against MSM, TG, and SWs by exploring studies with empirical and quasi-empirical designs, and those that are still in formative and descriptive phases..

Using all the above methods, more than 200 relevant articles were identified. Nonetheless, due to the variety of disciplinary backgrounds of researchers and practitioners working on GBV and HIV, it is certainly possible that some relevant articles have not been included in this review.

Limitations

There are several limitations in the data found in the literature on MSM and TG and, in particular, SWs among these groups. First, it is challenging to identify population-based samples of marginalized or hidden groups. Thus, most studies found in the literature surveyed small non-probability samples. Most commonly, researchers used convenience sampling—for example, recruiting study participants in gay bars or other venues where MSM and TG are commonly found. Moreover, many of the studies identified, particularly statistical surveys, were conducted in the United States. Perhaps because TG are an even more hidden population than MSM, there are few surveys of these groups. Instead, the literature provides much anecdotal evidence of violence and S&D experienced by TG. Still, even the anecdotal evidence does not provide a rich exploration of the nature of violence against MSM, TG, or SWs.

⁸ Responses were collected over a span of four weeks from March – April 2008, inclusive.

⁹ The network of organizations requested not to be identified in this document.

¹⁰ The community-based organizations requested not to be identified in this document.

PREVALENCE AND NATURE OF VIOLENCE AGAINST MSM AND TG: A REVIEW OF THE LITERATURE

Violence Against MSM

The statistical studies identified by this review indicate that levels of IPV experienced by MSM range from at least 22 percent for physical violence alone (Greenwood et al., 2002) to as high as 57 percent, measuring both physical and sexual IPV (Battles et al., 2003) (see Table 1). There are several limitations to these studies and their measures—namely the paucity of probability-based samples,¹¹ their concentration in North America, the variation in definitions of violence, and the variation in recall periods.¹² Still, these prevalence rates demonstrate that IPV among MSM is comparable to rates of violence in heterosexual relationships. In fact, like heterosexual relationships, there is said to be much under-reporting of IPV, not only because it is seen as a private matter but, particularly for MSM, fear of coming out and incurring more discrimination directed against the gay community causes reluctance to report violence (Kulkin, et al., 2008.)

While most studies reviewed do not delve into whether IPV in same-sex relations is gender based, four studies are telling. One study of MSM in Thailand, which included TG and male SWs, found that those identifying as female or gay and those who took on the anal receptive sex role in their relationships were significantly and independently associated (CI=95%) with experiencing coerced sex (Guadamuz et al., 2006). In the United States, a study by Nieves-Rosa and colleagues (2000) found that one-third of 273 Latino MSM in the New York metropolitan area experienced some form of abuse, and only half of them considered themselves victims of partner violence. Nieves-Rosa and colleagues point out that the levels of the abuse they identified are slightly higher than those found in non-minority same-sex and heterosexual couples. Thus, they argue that the *machismo* culture of Latinos may cause these people to deny their victimization in the interest of maintaining their “masculinity.” Another survey of 33 men and 33 women in same-sex relationships in the United States found that intimate partner assault may be more prevalent against gay men than heterosexual men, but there was no significant difference between lesbians and heterosexual females (Owen and Burke, 2004). Finally, Bartholomew and colleagues found correlates of IPV in male same-sex relations to be similar to those in heterosexual relationships—education, income, family violence, and substance abuse—but perpetration of abuse was uniquely associated with internalized homophobia (Bartholomew, et. al., 2008). Of note, MSM themselves may exercise violence in their intimate relationships as an act of hatred against homosexuality, which is commonly perpetrated against MSM by wider society, as further described in this section. While additional research needs to be conducted, the role of gender appears to play an important role in IPV among MSM.

Violence experienced by MSM outside of intimate partner relations is characterized by acute homophobia and is accompanied by various forms of discrimination that pervade other aspects of their community as well, including denial of schooling, work opportunities, or shelter; extortion; and arbitrary arrests (Human Rights Watch, 2003, 2004a, and 2004b; Chakrapani et al., 2007). Two-thirds of African countries have laws banning homosexual sex or 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). In Mexico, more than 26 percent of MSM surveyed (N=111) had experienced some sort of mistreatment, verbal abuse, or physical violence due to their sexual orientation (Gayet et al., 2007). Another study in Mexico (N=318) found that bisexual and gay males who challenged gender stereotypes were more frequently attacked than those who did not; men were identified as aggressors more frequently than women (Ortiz-Hernandez and Granados-Cosme, 2006). In a survey of 500 MSM in Kenya, one-third of

¹¹ Most studies used convenience or snowball sampling to reach MSM, and therefore study subjects may not be representative of all MSM, particularly those who do not openly identify as gay.

¹² Lifetime rates of abuse typically will be much higher than abuse within the past year or other shorter recall periods.

respondents reported experiencing some form of stigma or discrimination in the past 12 months, such as public humiliation (Onyango-Ouma, et al., 2006).

Smaller surveys and qualitative studies indicate that violence experienced by MSM and TG worldwide is most commonly perpetrated by the police and is done in an extreme and at times barbaric manner. For example, Human Rights Watch has uncovered horrific cases of violence against MSM in countries as diverse as Egypt, Jamaica, and Bangladesh. In Egypt, men suspected of having sex with men are routinely beaten, whipped, electro-shocked, and otherwise tortured to extract confessions (Human Rights Watch, 2004a). In Jamaica, where sodomy is illegal, Human Rights Watch researchers found that violence against MSM ranges from verbal abuse to armed attacks and murder (Human Rights Watch, 2004b). In Bangladesh, in addition to similar types of abuse by police, MSM face gang rape (Human Rights Watch, 2003).

Discrimination comes from family members as well. In India, MSM encounter derogatory comments, criticism and ridicule, abandonment, isolation, and expulsion from the family or marital home (Samuels et al., 2006; Chakaprani et al., 2007). In countries around the world, outright physical violence against MSM and TG by family members, particularly fathers, is also common. One study in the United States, for example, found that gay males suffered more abuse during adolescence than heterosexual males (Harry, 1989).

Table 1. Selected Surveys of Violence against MSM

Source/year	Country	Sample size/characteristics	Sampling methods	Definition & type of violence	Perpetrator of violence	Recall period	Rates of violence
Braitstein et al., 2006	Canada	N=498 MSM ages 18–30 years and who self-identify as gay or bisexual	Convenience sampling at gay community events, community health clinics, local physicians, and gay and mainstream media	<i>Sexual violence</i> : ‘Any type of sexual activity that you were forced or coerced into against your will (including child sexual abuse, molestation, rape, and sexual assault)’	Anyone	Lifetime	28%
Gayet et al., 2007	Mexico	N=1,111 men who had sexual relations (oral or anal) with other men in the last six months in bars, clubs, public baths, movie theaters, etc.	Time- , location- , and respondent-driven sampling	‘Received any rejection, mistreatment, or verbal or physical abuse in school due to sexual preference’	Teachers, director, classmates, administrative personnel, relatives, government staff, other	Lifetime	26.6%
Greenwood et al., 2002	USA	N=2,881 MSM in Chicago, Los Angeles, New York City, San Francisco	Probability sample of the four cities	<i>Psychological violence</i> : experiencing at least 1 of the following: ‘being verbally threatened, demeaned in front of others, ridiculed for his appearance, forced to get high or drunk, stalked, having property destroyed or damaged.’ <i>Physical violence</i> : ‘being hit with fists or an open hand, hit with an object, pushed or shoved, kicked, having something thrown at him.’ <i>Sexual violence</i> : ‘being forced to have sex’	Partner/s	5 years	Psychological: 34% Physical: 22% Sexual: 5.1%
Guadamuz et al., 2006	Thailand	N=2,049 MSM (had sex with a man in the past 6 months), including male SWs (N=754) and TG (474), ages 15 years or over	Convenience sampling of public venues	<i>Coerced sex</i> : ‘Ever being forced to have sex against one’s will’	Anyone	Lifetime	18.4%

Koblin et al., 2006	USA	N=539 MSM ages 15–22 years in New York City	Convenience sample from public venues	<i>Physical violence</i> : ‘ever been hit/kicked/punched or otherwise physically hurt by (a parent, guardian, or family member) (an exchange partner, non-steady partner, or steady partner)’	Partner/s and/or family	Lifetime	By partner: 23.4 % By family: 45%
Onyango-Ouma, et al., 2006	Kenya	N=500 men ages 18 years or older who have had sexual intercourse with one or more male partners	Snowball sampling	Verbal, physical, or sexual violence, or other (Definitions not provided)	Anyone	Previous 12 months	Verbal: 14% Physical: 12% Sexual: 5% Other: 4%
Rodriguez and Toro-Alfonso, 2005	USA (including Puerto Rico)	N=302 Puerto Rican MSM, 81% gay identified (199 living in Puerto Rico and 103 in New York)	Snowball sampling through social service organizations targeting gay men	Emotional, physical, and sexual violence by intimate partners and in childhood household (Definitions not provided)	Partner/s and family	Lifetime	By partners: Emotional–48% Physical–26% Sexual–25% In childhood: Emotional–48% Physical–40% Sexual–13%

Violence Against Transgenders

The violence experienced by TG, including physical and verbal abuse, appears even more severe. It is set apart by the fact that it is most often fueled by S&D against TG for crossing gender roles and is also perpetrated by others in the community, family, and even friends. Reports from around the world indicate harrowing forms of violence, including sexual assault and violence by police in Nepal in the name of “moral cleansing”; beatings by family members in Bangladesh, sometimes as a way to force marriage with a woman; and hate crimes, such as outright murder of TG, as reported in Guatemala (Human Rights Watch, 2006b; Khan, 1997; Human Rights Watch, 2006a).

“They threaten me that they will hit me if I don’t give them money...My friend was hit on his head by a gun for not giving them the money. Sometimes they curse us like we are dogs.” –Thai TG (cited in Jenkins, 2005, p. 16)

Although probability-based prevalence studies of violence among TG are lacking in the literature, evidence points to the fact that it is common, reaching levels even greater than violence against women in some contexts. For example, of 124 *kothis* surveyed in Bangladesh, 65 percent reported sexual assault or rape by gangsters and 48 percent by the police (Naz Foundation, 2003). These TG reasoned that they were the targets for such violence because they are seen as available for sex. In the United States, a small survey of TG determined that 54 percent (N=78) were forced to have sex and 51 percent (N=80) said that they were physically abused (Kenagy, 2005). Among these, male-to-female TG were said to have experienced significantly ($p < .001$) more physical and sexual violence than other TG.

TG may also face violence from “masculine” partners, and gender plays an undeniable role. As cited above, TG or female-identified MSM in Thailand are significantly more likely (CI=95%) to have been forced to have sex (Guadamuz et al., 2006). The Naz Foundation, which has been conducting research on TG and HIV for more than a decade, argues that there is a belief that those who are effeminate can be exploited and abused and that being feminine somehow weakens the person. As Shiv Khan, director of the Naz Foundation, states, “Accepted notions around effeminacy are therefore one of the major factors that lead to disempowerment and opens *zenanas/kothis/meti* [TG] to abuse and assault and to a refusal of service provision” (Khan, 2004, p. 3).

“When my parik beats me, I feel as helpless as a woman. Since I want to be a woman, it actually makes me feel good.” –TG in Bangladesh (cited in Khan, 2005a, p.1)

*“If the employer, like the three sons of my earlier employer, [is] to forcibly have sex with me anyway because I am a kothi, I might as well do sex work and get money for having sex.”
—TG sex worker in Bangladesh (cited in Naz Foundation, 2003, p. 9)*

The related discrimination that TG encounter is so cruel that it may also be considered a form of violence. In the United States, for example, TG in particular are denied jobs and shelter, including safe homeless shelters (Amnesty International, 2006). In India and Bangladesh, organizations working with TG report that transgenders face

harassment not only from law enforcement, but also from those whom they have called friends in school and those in positions of trust, such as relatives, neighborhood elders, and teachers (Khan, 2004). This violation of rights and marginalization leads to social isolation, often resulting in degradation of mental health, other illness, homelessness, and poverty. For some, as research in India and Thailand noted, being female or a male-to-female TG deprives them of economic means or exposes them to sexual slavery or coercion, which leads them to sex work (Naz Foundation, 2003; Jayasree, 2004; Jenkins, 2005). Ironically, sex work brings with it a host of other risks and vulnerability to violence and discrimination, as discussed in the next section.

Violence Against Sex Workers: A Focus on MSM and TG

The incidence and extent of violence encountered by sex workers—female, male, and TG—is so great that many sex workers consider it to be “part of the job” (Amin, 2005). While prevalence data of violence among SWs vary substantially, depending on the type of sex worker surveyed—whether street- or brothel-based—several studies indicate that some type of violence is experienced by more than 50 percent of those surveyed. In some populations, violence was experienced by as much as three-quarters of this population. A survey of female, male, and TG SWs (N=475) in South Africa, Thailand, Turkey, the United States, and Zambia, for example, found that 73 percent experienced physical abuse and 62 percent experienced rape (Farley et al., 1998). Likewise, in Cambodia, rates of rape and physical violence perpetrated against freelance¹³ TG sex workers (N=70) by the police reached 29 percent and 58 percent, respectively (Jenkins, 2006). Similarly, male SWs in Vietnam who do not necessarily identify as gay were significantly more likely ($p < 0.001$) than non-sex workers to have been forced into sex against their will (Clatts et al., 2007) (see Table 2).

Sex workers, regardless of sexual orientation, are targets of violence in many forms and from varying sources, largely because they are perceived as second-class citizens. They are subject to abuse by clients, pimps or managers, gangsters, and the police. Various studies, such as those in Argentina, Cambodia, India, Mexico, Papua New Guinea, and Vietnam, report arbitrary arrest, beatings, torture, and extortion, including extortion of free sexual services (Scott et al., 2005; Jenkins, 2006; Jayasree, 2004; Gayet et al., 2007; Jenkins, 2000; Clatts et al., 2007). In Cambodia, for example, SWs are raped and beaten if they refuse free sex to gangsters and police (Jenkins, 2006). In fact, the police are usually the leading perpetrators of violence against sex workers, so SWs have little recourse for dealing with such violence through the justice system. Criminalization of sex work helps create an environment in which violence against SWs is tolerated (Amin, 2005). If SWs do try to report violence or rape by clients or others, their claims are most often dismissed or they may face even more violence by the police (Scott et al., 2005).

Gender, stigma, and discrimination also underpin the violence and related abuse that SWs face. Female or feminized individuals, i.e., TG or those who take on the feminine “receptive” role in sexual relationships, may face the double discrimination of being an SW and being feminine, as revealed by studies in Bangladesh and Thailand (Naz Foundation, 2003; Guadamuz, et al., 2006). In Jamaica, adolescent gay males who engage in transactional sex say they want to identify as female, but they do not want to look female for fear of experiencing abuse, including sex against their will (Hanish, 2006). Although the research is not clear, the source of discrimination and violence may go beyond being feminine; rather, for TG SWs, the source may also be related to the defiance of traditional gender roles. In the Serbian study, for example, acts of physical and sexual assault were perpetrated on transvestite SWs in particular and were seen as a form of moral punishment linked to a broader social discrimination against their kind (Rhodes et al., 2008).

I am srey sraos (transgender). I am single and live with my family. I do this work for 3–4 years because my family discriminates against me. My family members don't like me to be half man and half woman like this. I do this work in the park, road, and in the nightclub. I have been abused by policemen working in the park and by male clients, such as hitting and rape without condom and without pay.

—TG sex worker in Cambodia (cited in Jenkins, 2006, p.15).

On the other hand, MSM who are not outwardly effeminate and males who engage in sex work may also suffer discrimination similar to female and TG SWs. Scott et al. (2005) put it well in their discourse on “the new context of the male sex work industry”:

¹³ Not contracted by an agency.

Both male and female SWs are subject to various forms of interpersonal violence, yet the way in which violence is acted and legitimated varies. Whereas violence toward female SWs might be understood as having a misogynistic basis, violence toward male SWs workers is best understood as having a homophobic or heterosexist basis. Female SWs are stigmatized because they are women, yet male SWs are stigmatized because they are homosexual or are assumed as such by their attackers. (p. 327)

In support of this claim, Scott and colleagues found that male SWs in Argentina were twice as likely to experience violence from clients perceived to be heterosexual than gay or bisexual clients (Scott et al., 2005).

Table 2. Selected Surveys of Gender-based Violence Experienced by MSM and TG Sex Workers

Source/Year	Country	Sample size/characteristics	Sampling methods	Definition & type of abuse	Perpetrator of abuse	Recall period	Rates of abuse
Clatts et al., 2007	Vietnam	79 male SWs ages 16–29 who self-reported heroin use	Convenience sampling	Forced to have sex against will	Any	30 days	11.4%
Farley et al., 1998	South Africa, Thailand, Turkey, United States, and Zambia	475 female, male, and TG SWs	Convenience sampling	Physically assaulted in prostitution; raped in prostitution		Since entering prostitution	Physical: 73% Sexual: 62%
Gayet et al., 2007	Mexico	386 male SWs (any male that exchanges money for sexual favors)	Convenience sampling	Rape, physical abuse, verbal abuse, extortion, robbery or assault, or other	Police, client, intimate partner, or other	Last 12 months	17%
Jenkins, 2006	Cambodia	70 freelance TG SWs	Respondent-driven sampling	Beaten, raped, or gang-raped	Police, client, or gangster	Past year	Beaten: By police–29.9% By gangster–57.6% By client–38.3% Raped: By police–23.9% By gangster–51.5% By client–48.5% Gang-raped: By police–18.2% By gangster–52.3% By client–37.5%

Violence Against MSM and TG and the Spread of HIV

Much can be learned from studies on the intersections between violence against women and HIV; these studies are somewhat more common than those on violence against MSM/TG and the connection with HIV. Research has found that the overlap in the prevalence of HIV and violence against women is great. For instance, a recent study in Dar es Salaam, Tanzania found that HIV-positive women were 2.68 times more likely than HIV-negative women to have experienced a violent episode by a current partner (Maman et al., 2001). Reasons for the overlap may vary and are still being uncovered. First, coercive sexual intercourse may directly increase women's risk for HIV through physiological trauma (Choi et al., 1998; He et al., 1998; Van der Straten et al., 1995; Zierler et al., 1996). Second, violence and threats of violence may limit women's ability to negotiate safe sexual behaviors (Gupta and Weiss, 1993; Karim et al., 1995; Van der Straten et al., 1998; Worth, 1989). Third, women who have been sexually abused in childhood may participate in more risk-taking behavior as adolescents or adults, including injection drug use, thereby increasing their risk for HIV infection (Jinich et al., 1998; Zierler et al., 1991; Gilbert et al., 2002). Finally, the literature from the United States and sub-Saharan Africa suggests that women who disclose their serostatus to partners may be at increased risk for violence and that the threat of violence may play a key role in deterring women from disclosing (Gielen et al., 2000).

According to the literature, most, if not all, links between gender-based violence and HIV/AIDS for the general female population hold true for SWs, MSM, and TG. The most obvious connection is the high level of sexual coercion that these groups suffer, as previously discussed. This sexual coercion often occurs without the use of a condom, which exposes MSM and TG to HIV. For instance, a survey of SWs in Cambodia indicates that 90 percent were raped in the last year; of these, two-thirds of female freelance SWs and 52 percent of TG sex workers were raped without a condom (Jenkins, 2006). Similarly, qualitative research among female and transvestite SWs in Serbia identified that coerced sex was provided to the police routinely and was linked to unprotected sex and the reduced capacity for avoiding sexual risk (Rhodes et al., 2008). As mentioned above, a recent CDC study shows that the prevalence of sexual coercion in MSM and TG in Thailand was more than 18 percent (Guadamuz et al., 2006). In the United States, in a sample of 273 Latino men, 12 percent were forced to have receptive anal sex without a condom (Nieves-Rosa et al., 2000).

Just as sexual coercion may often prevent condom use, violence or fear of violence may also prevent or inhibit MSM and TG from negotiating safe sex. In the United States, 41 percent of a group of 58 MSM reported being forced to have sex, and 28 percent said that they felt it unsafe to ask an abusive partner to use protection (Heintz and Mendez, 2006). In Kenya, researchers found a correlation between MSM experiencing violence and the non-use of condoms. The study found that MSM who were victims of verbal, physical, or other forms of violence in the past 12 months were significantly more likely to have not used a condom at their last receptive anal sex ($p < 0.01$, CI=95%), to have had unprotected sex at their last insertive anal sex ($p < 0.05$, CI=95%), and to have "never use[d]" condoms ($p < 0.05$, CI=95%) (Onyango-Ouma et al., 2006).

The literature also shows that the experience of sexual violence is associated with high-risk sexual behavior among MSM and TG. For example, in Brazil, a survey of more than 1,000 MSM found that participants who reported sexual violence in the past have a relative risk for unprotected intercourse that is twice as high as MSM who did not experience violence (Camargo et al., 2002). Similarly, in a study of 817 MSM in the Chicago area (United States), men reporting recent unprotected anal sex were also 1.6 times more likely to report abuse ($p < .05$, CI=1.18-2.21). Studies conducted in Brazil, Colombia, India, Kenya, the Philippines, and Thailand found that forced sex among young men—particularly those living on the street—has been associated with their perpetrating forced sex or becoming involved in transactional sex with older men and women (Best, 2005). In the United States, research among male, female, and TG SWs determined that sexual violence is significantly associated with having a sexually

transmitted infection ($p < .05$), an indicator of HIV risk and high-risk behavior (Cohan et al., 2004). These data are not unlike the data on violence against women and its links to HIV.

However, MSM and TG face special forms of S&D by the wider community, which cause them to devalue themselves so that they are more willing to engage in high-risk behavior; as a result of social isolation, they may also be so eager for intimacy that they compromise their own health. In India, researchers argue that disempowerment of TG (male-to-female) resulting from violence and stigma “creates significant levels of suicidal impulses and self-damage, an expression of self-hatred and despair,” all of which impede the successful implementation of risk-reduction strategies (Khan, 2004). As described earlier by Chakrapani et al. (2007), structural violence in India—stigma, discrimination, and violence endemic throughout society and its institutions—makes MSM and TG communities particularly vulnerable to HIV infection.

Beyond disempowerment, violence against MSM and TG and the related S&D also prohibits safer sex in more direct ways. Evidence has been found that violence or fear of violence and discrimination by health professionals hinders MSM, TG, and SWs, both those infected and not infected with HIV, from accessing HIV, sexual, or other health services. For instance, Human Rights Watch discovered that MSM in Jamaica experienced discrimination by health workers who forced them to wait for extended periods of time to be seen, treated them in an abusive and degrading manner, or denied treatment altogether. The *kothis* of India suffer oppression by health providers in the form of insults, breaches of confidentiality, and refusal of services (Chakrapani et al., 2007). In the Philippines and India, the police target SWs for harassment if they are found carrying condoms, which is seen as a sign of being a sex worker (Amnesty International, 2004; Jayasree, 2004). While these citations pertain to female SWs, anecdotal evidence points to the fact that the same discrimination holds for TG sex workers in other parts of the world. In Peru, for example, despite the existence of a Human Rights Manual among law enforcement personnel, a TG health advocate doing outreach to sex workers was violently assassinated in the presence of police officers, who offered no assistance (advocacy alert received from Taller-Arte Cambio Social, April 25, 2008).

MSM also suffer much abuse in relation to being HIV positive. As a report by the Panos Institute on MSM and HIV writes, “. . .men who have sex with men, especially the most visible categories—transvestites and transsexuals, male prostitutes, and male street children who sell sex—[are] blamed for the introduction and spread of AIDS” (McKenna, 1996 p. 48). This blame has resulted in a range of abuses. In Jamaica, for example, some MSM keep their HIV status a secret for fear that disclosure would subject them to violence (Human Rights Watch, 2004b). In South America, the Colombia Human Rights Network reported AIDS as a justification for social cleansing of gay men, writing:

“They are the target of ‘social clean-up’ death squads that operate under cover of darkness in the major cities of Brazil, Colombia, Ecuador and Peru....The presumed justification for these crimes has been the assumption that these homosexuals were the carriers of the AIDS virus and that their street activities drive tourists away” (Colombia Human Rights Network in McKenna, 1996, p. 49)

On the whole, however, studies linking GBV and other manifestations of S&D as risk factors for HIV among MSM and TG are limited. Much of the evidence is anecdotal, and surveys are cross-sectional, eliminating the possibility of proving a causal link between the two public health problems. The full effects of S&D on the HIV epidemic have yet to be explored. However, using a specific case as an illustration, such as the one outlined in the box below, may lead to a better understanding of the impact of GBV against MSM and TG and the link to HIV/AIDS.

Box 1. GBV and HIV as Experienced by a TG Woman

Noel, a TG woman, has a live-in boyfriend who is controlling and violent but she depends on him to sustain a livelihood. Prior to meeting him, she worked as an SW, which was one of the few ways for her to make a living. Because of her history as a sex worker, Noel knew that she was at high risk for HIV. There were times when her boyfriend threatened or simply forced her to have sex without a condom. Noel loves her boyfriend, despite his flaws, and wants to protect him from any disease that she might have. However, when she suggested using condoms, he became angry and suspicious that Noel was engaging in sex work again, or possibly cheating on him.

Noel wondered if she should get tested for HIV, but the last time she went to the hospital for other non-STI-related services, she was practically ignored and almost did not receive services. She was cursed as a “damn transgender.” When she noticed genital warts and discharge, however, she knew that she must get treated but was afraid of being subject to the same shame and discrimination at the hospital. Her fear of her boyfriend noticing the warts finally pushed her to go to the hospital. Noel was examined and, because of her symptoms, offered an HIV test. Although very fearful of the results, she decided to take the test and acknowledged that there was a good possibility that she had the disease. When she received the result that she was HIV positive, the voluntary counseling and testing (VCT) nurse lectured her about “not having so much sex” and using condoms. Noel went home with trepidation and anxiety about telling her boyfriend that she was HIV positive.

CONCLUDING REMARKS AND RECOMMENDATIONS FOR FUTURE INTERVENTIONS

Conclusions

This literature review has found evidence that violence against MSM and TG is a major problem, not only as a violation of human rights but also for the health implications and risk of HIV exposure of those groups. Much of the violence experienced by MSM and TG, particularly IPV and sexual coercion, is similar to that experienced by women. In both types, perpetrators use violence to exercise or express their sense of entitlement to greater power and control based on the perception of his/her gender possessing a higher social status than that of the victim. In other words, violence against MSM and TG is most often a form of gender-based violence. Moreover, there is often a wider range of violence to which MSM and TG are exposed, such as violence by police, which appears to be the principal form experienced by TG, particularly those engaging in sex work. MSM and TG also experience violence at the hands of their families, friends, fellow students, teachers, health professionals, and the wider community. This violence occurs in the context of extreme forms of S&D, which can be equated with emotional and psychological abuse. It aggravates the risk for and spread of HIV in various ways. It prevents safe sex because sexual coercion usually occurs without condoms and victims of abuse are afraid to negotiate condom use. Also, carrying a condom can identify individuals as SWs, who are often targeted for abuse. Thus, individuals avoid carrying condoms. Such abuse also causes internal stigma and decreases a sense of self-worth, thereby increasing risky behavior, such as multiple sex partnerships or transactional sex. Stigma from health providers also drives MSM and TG away from health services.

Recommendations

Research

As this review has established, there is still much to be learned about how gender-based violence affects the lives of MSM and TG, including HIV vulnerability. Much of this can be learned through evaluation of the above interventions, as well as additional studies. The following should be identified:

- Different types of abuse by subcategory of MSM and TG;
- Perceptions of MSM as to whether IPV is violence and to what extent they think it is gender based;
- The full complexity of the links of between violence against MSM and TG and HIV, especially through qualitative research;
- The help-seeking behavior of MSM and TG to identify whom they are most likely to approach when in need of emotional or physical health services;
- Attitudes of health professionals toward MSM and TG to understand their openness toward those individuals;
- Discovery of whether screening for violence in HIV or other health services is an effective entry point to address violence against MSM and TG; and
- How HIV and/or other health interventions can address violence within their programs.

Advocacy

As this review has identified through numerous studies and reports, MSM and TG are highly marginalized and face a wide range of social vulnerabilities to HIV beyond high-risk sexual behavior. Findings from this research and interventions should be used to advocate for improved policies and increased attention to such social vulnerabilities through programming, including the following:

- Laws that protect the dignity and rights of MSM and TG as human beings;
- Increased funding and support to identify appropriate interventions to respond to violence against MSM and TG; and
- HIV policies and strategic plans that include specific strategies to address violence and S&D against MSM and TG in related programs.

Action

Because MSM and TG are so marginalized and stigmatized by greater society, it is not clear how effective formal health services would be to reaching them. Based on the formative research recommended above, pilot interventions should be designed, implemented, and rigorously evaluated to determine most effective programs to address violence against MSM and TG. Interventions should address the range of dimensions that influence, support, and potentially mitigate violence and effects of violence against MSM in TG. Such interventions may include

- Programs that eliminate related norms, attitudes, and behaviors of the general community;
- Health or HIV services that identify violence and incorporate violence-specific counseling into HIV counseling and testing and other health services;
- Sensitization and training of police on the human rights of MSM and TG and their roles in protecting those human rights, particularly where laws are supportive and well defined.
- Social services such as shelters and livelihood programs for MSM or TG who have been rejected from their home, work, or other livelihood; and
- More informal community-based peer support systems.

Through evaluation, it will be particularly important to identify the feasibility of the interventions and who and what types of interventions are best positioned to both reach MSM and TG and address violence and its resulting impact on HIV vulnerability.

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