

Gender Analysis Toolkit for Key Population HIV Prevention, Care, and Treatment Programs

2017

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LINKAGES, a five-year cooperative agreement funded by the U.S. President's Emergency Plan for AIDS Relief (PEPFAR) and the U.S. Agency for International Development (USAID), is the largest global project dedicated to key populations. The project is led by FHI 360 in partnership with IntraHealth International, Pact, and the University of North Carolina at Chapel Hill. The contents of this toolkit do not necessarily reflect the views of PEPFAR, USAID, or the United States Government.

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Acronyms and abbreviations

ADS	Automated directive system
FSW	Female sex worker
GBV	Gender-based violence
HIV	Human Immunodeficiency virus
HR	Human resources
IGWG	Interagency Gender Working Group
KP	Key population
LGBTI	Lesbian, gay, bisexual, transgender, and intersex
MSM	Men who have sex with men
PEP	Postexposure prophylaxis
PEPFAR	President's Emergency Plan for AIDS Relief
PLHIV	People living with HIV
PrEP	Pre-exposure prophylaxis
PWID	People who inject drugs
STI	Sexually transmitted infection
SW	Sex worker
Trans	Transgender
USAID	United States Agency for International Development



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Executive summary

Efforts to reduce HIV transmission among key populations most affected by HIV – gay men and other men who have sex with men (MSM), people who inject drugs (PWID), sex workers (SWs), and transgender (trans) people – and to extend life for those who are living with HIV will fall short if they do not meaningfully address the gender norms and inequalities that shape key populations' risk of HIV and their ability to access prevention, care, and treatment services. Harmful gender norms – such as the belief that women should be sexually submissive and men sexually dominant – have long been recognized as drivers of HIV transmission among the general population. Many members of key populations face additional risks due to stigma, violence, and discrimination from family members, health care providers, police, and society because they are perceived as nonconforming to gender norms. For some key populations, gender inequalities and discrimination experienced throughout their lifetimes also result in differential access to education, economic opportunity, and control over financial resources. Collectively, these experiences limit the ability of key populations to engage in HIV preventive behaviors and create barriers to obtaining health care.

“Understanding the unique needs and vulnerabilities of men and women, boys and girls, and people with other gender identities helps identify target populations, tailor response and dedicate resources where they are most needed. Responding to these unique needs may improve health outcomes and enhance program sustainability.”

– [PEPFAR Gender Strategy 2013](#)¹

A gender analysis can be used to increase the effectiveness of HIV prevention, care, and treatment activities for key populations by identifying the specific gender issues in a given context, describing how they could affect a program's goals, and identifying ways to work around or transform gender-related barriers and leverage gender-related opportunities. For USAID-funded projects, USAID requires that a gender analysis be conducted during the project design phase to inform a project's design and implementation; it is the first step in the gender integration process.²

Due to the fundamental importance of gender integration in development and health programming generally, gender analysis guidance exists for other populations.³⁻⁷ However, as gender analyses have not been traditionally conducted with key populations, this toolkit is the first of its kind to provide practical guidance for a gender analysis with the four key populations that the LINKAGES project serves: MSM, PWID, SWs, and transgender people. This gender analysis toolkit:

- Outlines key considerations and steps for conducting a gender analysis for HIV programming with key populations;
- Explores how to engage with stakeholders, including key population members, in a meaningful partnership;
- Shares lessons learned from a comprehensive gender analysis in Kenya⁸ and an abridged gender analysis in Cameroon;⁹ and
- Provides tools and resources for conducting your own gender analysis with key populations.

The toolkit contains all the information needed to conduct a comprehensive gender analysis. However, in recognition that programs may want to conduct a more streamlined analysis, key steps can be found on pages 7-16. Each step can be streamlined based on time, resources, and information available for a gender analysis.

Content Key



must read pages



information on community engagement



additional guidance to conduct a gender analysis

Background

LINKAGES PROJECT

LINKAGES across the Continuum of HIV Services for Key Populations Affected by HIV (LINKAGES), a five-year cooperative agreement funded by the U.S. President's Emergency Plan for AIDS Relief (PEPFAR) and U.S. Agency for International Development (USAID), is the largest global project dedicated to key populations most affected by HIV: MSM, PWID, SWs, and transgender people. Led by FHI 360 in partnership with Pact, IntraHealth International, and the University of North Carolina at Chapel Hill, LINKAGES operates across central and eastern Asia, Africa, and Latin America and the Caribbean.

LINKAGES' goal is to accelerate the ability of governments, key population organizations, and private sector providers to plan, deliver, and optimize services that reduce HIV transmission among key populations and extend life for those who are HIV-positive. The project has three intermediate result areas:

- Increased availability of comprehensive prevention, care, and treatment services, including reliable coverage across the continuum of care for key populations,
- Enhanced and sustained demand for comprehensive prevention, care, and treatment services among key populations enhanced and sustained, and
- Strengthened systems for planning, monitoring, evaluating, and assuring the quality of programs for key populations.

All activities under LINKAGES should address the LINKAGES crosscutting areas: gender integration, human rights, and capacity development of local organizations, particularly those led by key populations.

Box 1. LINKAGES Gender Strategy

The LINKAGES Gender Strategy¹⁰ notes that a gender analysis with key populations is recommended in all countries where LINKAGES works. If it is not possible to conduct a gender analysis, it will be useful to look at findings from key-population-specific gender analyses from other countries as well as country-specific documents that are available (noting that past gender analyses undertaken are unlikely to include key populations explicitly). It may also be possible to incorporate key questions from the gender analysis into other data collection activities like the key population HIV cascade assessments that LINKAGES often undertakes (see **Box 11**).

THE ROLE OF GENDER INTEGRATION IN HIV PROGRAMMING FOR KEY POPULATIONS

HIV program managers working with the general population are accustomed to thinking about gender norms and inequalities as negatively affecting women and girls in particular (see **Box 2** for definitions). Appropriately, HIV programs respond to these realities through gender integration strategies that recognize the critical role played by gender norms and inequalities in the HIV epidemic. Gender integration has been shown to improve and sustain HIV programming outcomes.¹¹⁻¹³

Box 2. Definitions

Gender analysis: A subset of socioeconomic analysis. It is a social science tool used to identify, understand, and explain gaps between genders that exist in households, communities, and countries. It is also used to identify the relevance of gender norms and power relations in a specific context (e.g., country, geographic, cultural, institutional, economic) [[USAID Automated Directive System \(ADS\) 205.3.1](#)].²

Gender integration: Strategies applied in programmatic design, implementation, monitoring, and evaluation to take gender considerations into account and compensate for gender-based inequalities [Adapted from [Interagency Gender Working Group \(IGWG\) training materials](#)].¹⁴

Gender norms: The expectations of what it means to be a man or woman, including social and political roles, responsibilities, rights, entitlements and obligations, and the power relations between men and women [Adapted from [Health Policy Project Gender & Sexual Diversity Training](#)].¹⁵

Gender-based violence (GBV): Any form of violence that is directed at an individual based on biological sex, gender identity (e.g., transgender), or behaviors that are not in line with social expectations of what it means to be a man or woman, or a boy or girl (e.g., men who have sex with men, female sex workers). It includes physical, sexual, and psychological abuse; threats; coercion; arbitrary deprivation of liberty; and economic deprivation, whether occurring in public or private life [[PEPFAR Gender Strategy](#)].¹

Gender-accommodating programs: Programs that acknowledge, but work around, gender differences and inequalities to achieve project objectives [Adapted from [IGWG training materials](#)].¹⁴

Gender-transformative programs: Programs that aim to promote gender equality and achieve program objectives by (1) fostering critical examination of inequalities and gender roles, norms, and dynamics; (2) recognizing and strengthening positive gender-related beliefs that support equality and an enabling environment; and (3) promoting the relative position of marginalized groups and transforming the underlying social structures, policies, and broadly held social norms that perpetuate gender inequalities [Adapted from [IGWG training materials](#)].¹⁴

See [Appendix 1](#) for additional core gender concepts.

Systematic gender integration has not been widely employed in programming for key populations.¹⁶ However, this approach is vital because the negative impacts of gender norms and inequalities are amplified for members of key populations. They experience negative outcomes both when they and those around them conform to gender norms (e.g., trans women who have difficulty negotiating condom use due to societal expectations of women's submissive role in sex) and when they are perceived to be nonconforming (e.g., stigma and discrimination against female sex workers [FSWs] and MSM based on societal expectations regarding the sexual behaviors of women and men).

By taking a gender perspective in programming for key populations, programs can:

- 1. Ensure that all members of a specific key population, disaggregated by gender, have access to the services and information they need.**

Inaccurate assumptions about gender – such as “only women engage in sex work,” “individuals who inject drugs are men,” or “providing services for MSM is also sufficient to reach transgender women” – keep key population programs from reaching everyone who needs services. A gender analysis can help identify gaps in service provision, particularly as they pertain to under-served groups such as: male sex workers (MSWs), trans SWs, transgender people generally, and women who inject drugs (WWID). A gender analysis can also identify opportunities to make services more convenient and attractive to groups that have not been traditionally served. For example, in Kenya, WWID requested personal hygiene services, family planning, support for condom negotiation, and services for children in addition to traditional harm reduction and HIV/STI services.

Additionally, a gender analysis can help identify the needs of specific subpopulations. For example, the gender analysis in Kenya found that service needs varied in some cases based on gender expression. MSM with a more masculine gender expression were reportedly more likely to desire access to MSM-friendly services at a clinic that is not specifically designated for

MSM to avoid the need to “out” themselves to receive care. MSM with a more feminine gender expression were reportedly more likely to desire economic strengthening activities as part of an HIV program, as stigma and discrimination based on gender expression can make it more difficult to gain employment. Community members also noted the importance of talking about stigma within a key population community (in this case, stigma against MSM with a more feminine gender expression) to promote cohesion and limit discrimination.

2. Identify the gender-related beliefs that lie at the root of high HIV risk; low service uptake; and increased stigma, discrimination, and violence that key populations face and work around or transform those beliefs to achieve maximum impact.

Asking explicitly about beliefs affecting key populations' HIV risk, service uptake, and experiences of stigma, discrimination, and violence allows program managers to either work around (gender accommodating) or directly counter (gender transformative) those beliefs among members of key populations, service providers, power holders such as police, and the broader community. This is particularly important for reaching all individuals as these beliefs may be a reason that some do not wish to be identified as a member of a key population and will therefore avoid accessing services designed for key populations.

Specifically, a gender analysis can determine the ways in which gender-based violence (GBV), as well as other forms of violence, impact HIV risk and service uptake. While violence prevention and response are part of a comprehensive package of HIV services for key populations, the issue of violence is not always given adequate attention. A gender analysis, particularly if it includes the voices of key population community members, can help direct attention to the incidence of violence, the types of violence most often experienced by key populations, the perpetrators of that violence, and the gender norms and beliefs that justify or encourage that violence. Findings related to violence can inform adequate violence prevention and response in HIV programming.

Box 3. The connection between GBV and HIV

Global evidence demonstrates that HIV and violence — including physical, sexual, emotional, and economic violence — are linked in multiple ways. Violence:

- Violates the fundamental human right to live free from violence,^{17,18}
- Increases HIV risk,¹⁹⁻²²
- Decreases HIV testing uptake and disclosure,²³⁻²⁷ and
- Decreases enrollment and adherence to ART^{24,25,28} and pre-exposure prophylaxis (PrEP).²⁹

Addressing GBV in HIV programming is key for effective prevention, care, and treatment as seen in **Box 3**.

3. Connect key populations and the issues they face to those of the broader population and create opportunities for combined efforts.

Many of the gender norms and beliefs that negatively affect key populations also harm all women and girls. By identifying and highlighting these underlying issues a gender analysis can create opportunities for combined efforts to challenge harmful gender norms and beliefs and promote gender equality for all.

In Kenya, key informants identified the harmful belief that MSM and transgender women “degrade themselves when they act like women.” MSM and trans women were also reportedly more likely to experience violence if they “took on a woman's role” as violence against women is seen as acceptable. These beliefs demonstrate the clear link between homophobia, transphobia, and misogyny and highlight an opportunity for coalition building between activists working toward women's equality and those focused on ending stigma and discrimination against MSM and transgender women.

Key considerations before conducting a gender analysis

Several important questions can help you determine how and when to conduct a gender analysis. The most important questions to consider are listed here.

WHICH GENDER ANALYSIS FRAMEWORK SHOULD BE USED?

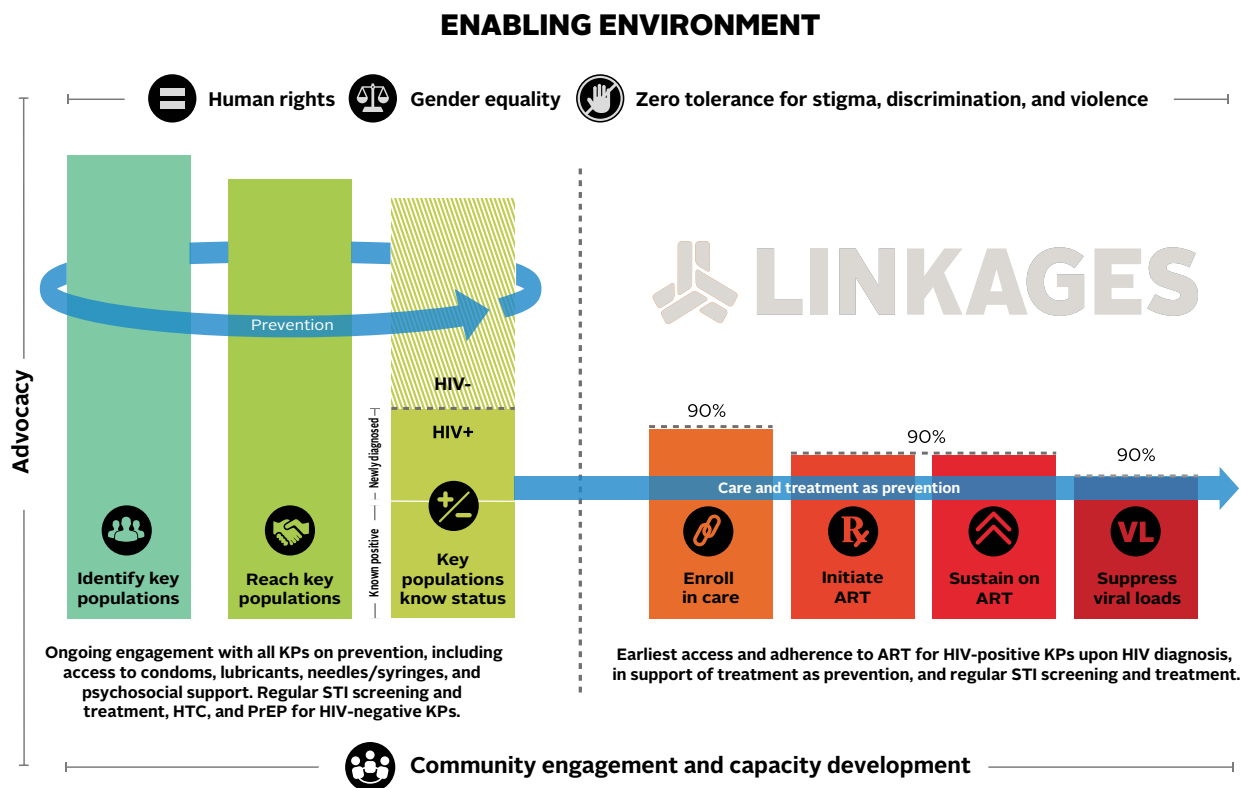
Which gender analysis framework should be used? A gender analysis framework provides a structure for systematically identifying important information about gender roles and relations. It also helps the user organize information regarding gender differences

across domains and examine how these differences affect individuals' lives and health.

There are a large number of frameworks for conducting a gender analysis.^{2,3,7} Each framework has a different focus, involves different tools, and is best suited to specific contexts.

We recommend using the LINKAGES continuum of prevention, care, and treatment cascade of HIV services for key populations (see Figure 1) as a framework for gender analysis for

FIGURE 1: LINKAGES continuum of prevention, care, and treatment cascade of HIV services for key populations



HIV programming with key populations. Using this framework in conjunction with USAID's domains (see **Box 4**) will allow programs to target specific gender-related barriers and opportunities in each step of the cascade and in the crosscutting domain of enabling environment.

WHEN SHOULD A GENDER ANALYSIS BE CONDUCTED?

Ideally, a gender analysis should be conducted as part of the program design process to inform the development of key population programming. However, a gender analysis can also be conducted during other phases of the program cycle. For example, a gender analysis conducted as part of a mid-term evaluation or special study can examine program impact by gender and determine whether ongoing programs could be adapted to achieve greater impact.

Throughout implementation, programs should disaggregate data by gender and monitor increases and decreases in gender inequalities.

WHO SHOULD CONDUCT A GENDER ANALYSIS?

A gender analysis can be conducted by those participating in program or policy design and monitoring and evaluation, including government officials (e.g., AIDS authorities, Ministry of Health, Ministry of Gender); funders supporting key populations; civil society representatives, including key population members and people living with HIV (PLHIV); and subject matter experts on gender, HIV, policies, and services. To obtain the highest quality information and greatest impact, it is preferable that these groups work together to identify a gender analysis coordinator and team, conduct the analysis, provide input or other support during the process, and promote the use of the findings.

Key population members should be at the center of the team tasked with the gender analysis, and should participate in the conception, implementation, interpretation, and dissemination of the findings

Box 4. USAID's domains for gender analysis

USAID recommends five domains for a gender analysis ([ADS 205.3.1](#))²:

1. Laws, policies, regulations, and institutional practices
2. Cultural norms and beliefs
3. Gender roles, responsibilities, and time used during paid work, unpaid work (including in the home), and community service
4. Access to and control over assets and resources
5. Patterns of power and decision making

While we primarily used the LINKAGES cascade (see **Figure 1**) to structure the gender analysis, these five domains are all addressed in our analysis as crosscutting areas.

and recommendations (see **Box 5**). Key population engagement and leadership are vital throughout the gender analysis process and specific opportunities will be identified throughout this toolkit.

WHAT INFORMATION SOURCES SHOULD BE USED IN A GENDER ANALYSIS?

A gender analysis can take different forms – small and targeted or large and comprehensive – depending on the time, resources, and information available to the program. A gender analysis should draw on as many different types of high-quality information sources as possible, including:

- **Secondary data:** Desk review of published and unpublished research, population-level indicators, and policy and program documents.
- **Primary data:** Interviews and/or focus group discussions with key informants (e.g., key population members, representatives from key population-led organizations, government officials, program managers and funders, health care workers).

Sources of information used will depend on the resources and time available for data collection and analysis. At minimum, a gender analysis should include a desk review of relevant literature and policies (secondary data) and small-scale data collection to identify gender norms that are likely to influence violence, HIV risk, and service uptake among key populations (primary data).

Box 5. “Nothing About Us, Without Us”

Key population programming must be informed by and built in partnership with members of key populations. International guidance documents (MSMIT,³⁰ SWIT,³¹ TRANSIT³²) all place community empowerment and leadership at the center of effective programming. The meaningful participation of key populations is essential to building trust, establishing relationships and partnerships that have integrity and are sustainable, and ultimately implementing successful research or programs. The same is true for a gender analysis.

Meaningful participation means that key populations:³⁰⁻³²

- Choose how they are represented, and by whom
- Choose how they are engaged in the process
- Choose whether to participate
- Have an equal voice in how partnerships are managed

Gender analysis steps

After determining your gender analysis framework, when the analysis will be conducted, who will be part of the gender analysis team, and your sources of information, you are ready to begin.

The following steps should be considered when conducting either a small-scale or more comprehensive gender analyses.

- Step 1:** Plan for a gender analysis.
- Step 2:** Conduct a desk review (secondary data).
- Step 3:** Conduct in-depth interviews and/or focus group discussions (primary data).
- Step 4:** Analyze data and synthesize findings.
- Step 5:** Review and prioritize gender analysis findings and recommendations with stakeholders.
- Step 6:** Package and disseminate findings and recommendations.

STEP 1: PLAN FOR A GENDER ANALYSIS

1.1 Develop a draft concept note

Prepare a brief one- or two-page concept note on the specific knowledge gaps that a gender analysis will fill and how the analysis will enhance HIV programming for key populations (e.g., improve reach and service quality). Components of a concept note should include the gender analysis' proposed objectives, process, timeline, roles and responsibilities of team members, dissemination plan, and budget as relevant.

1.2 Engage with stakeholders, including key population members, to share proposal and seek input

Dedicated steps need to be taken to guarantee key population leadership and ownership of the gender analysis and ensure high-level government commitment. Ideally, members of key populations and government are part of designing the concept note. However, if relationships have not yet been established with all those who should be involved, the steps below can aid in this process.

Sample gender analysis objectives

1. Assess how gender norms, including those reflected in laws, policies, and institutional practices, affect the behaviors of key populations — in particular their uptake of HIV-related prevention, care, and treatment services.
2. Inform strategies that the project and partners can employ to overcome the effects of harmful gender norms and inequities and enhance the accessibility and acceptability of HIV programs for key populations.
3. Identify activities to transform gender norms that have the greatest potential to increase key populations' use of services and reduce gender-related stigma and violence.

To initiate engagement with stakeholders:

1. Map out stakeholders, including key government decision makers and key population-led organizations. Work with existing key population networks, such as a key population technical working group, to identify stakeholders from each key population.
2. Share concept note with stakeholders.
3. Conduct a consultation meeting with interested stakeholders to discuss the gender analysis' overall objectives and process, and identify desired outcomes.
4. Circulate a revised concept note that includes recommended changes and explains any recommended changes that could not be incorporated (based on funding restrictions, for example).

See **Box 6** for recommendations on convening and engaging with a task force of government decision makers and key population-led organizations to drive the implementation of the gender analysis. For additional information on how LINKAGES engaged with key populations in Kenya, see **Appendix 2**.

TABLE 1: Sample gender analysis timeline

ACTIVITY	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec
1. Plan for a gender analysis												
1.1 Develop a concept note												
1.2 Engage with stakeholders to share proposal and seek input												
2. Conduct a desk review												
2.1 Gather relevant documents												
2.2 Analyze and synthesize relevant documents												
2.3 Share desk review findings with stakeholders												
3. Conduct in-depth interviews and/or focus group discussions												
3.1 Develop primary data collection tools												
3.2 Recruit participants												
3.3. Conduct interviews and/or focus group discussions												
4. Analyze data and synthesize findings												
4.1 Analyze data												
4.2 Synthesize findings												
5. Review and prioritize findings and recommendations with stakeholders (e.g., interpretation meeting)												
6. Package and disseminate findings and recommendations												
6.1 Package findings and recommendations												
6.2 Disseminate findings and recommendations												

Box 6. Engaging with the task force in Step 1

Meaningful engagement with stakeholders, particularly key population members, goes beyond consultation meetings. In line with principles of meaningful participation (see **Box 5**), we recommend convening a gender analysis task force of government decision makers and key population-led organizations during the planning step and agreeing upon the task force’s structure and function. In the planning step, specific roles may include:

- Identifying key population co-investigators and task force members
- Refining the gender analysis concept note

STEP 2: CONDUCT A DESK REVIEW (SECONDARY DATA)

Once the gender analysis concept note is refined with stakeholders, the next steps are to gather and analyze existing data through a desk review of relevant research, policy, and program documents.

2.1 Gather relevant documents

For country-specific data, review your country’s Demographic and Health Survey, Integrated Biological and Behavioral Surveillance survey, Polling Booth Surveys, and other nationwide surveys as available.



For published peer-reviewed research, conduct a literature search using databases such as PubMed and Google Scholar. See **Box 7** for illustrative search terms by population and topic.

For national, regional, and local laws or policies, work with stakeholders to identify and share relevant documents. Relevant laws or policies can include HIV prevention, care, and treatment strategies or frameworks; gender policies; GBV policies or guidelines; key population program guidelines; and criminal penal codes.

For HIV, key population, and gender programming, work with stakeholders to identify and share relevant documents such as project reports and other grey literature. It will also be useful to look at findings

Box 7. Illustrative search terms

Population:

- Key populations, KPs
- Sex work, sex workers, SW, female sex workers, FSW, male sex workers, MSW, transgender sex workers
- Gay men, men who have sex with men, MSM
- Trans, transgender, transsexual
- People who inject drugs, PWID, injection drug user, IDU, women who inject drugs, WWID, men who inject drugs, MWID
- Male
- Female

Topic:

- Gender, gender norms, gender roles, gender integration, gender inequality, gender justice
- Violence, gender-based violence, GBV, anti-LGBTI violence, intimate partner violence, police abuse, human rights violations
- Sexual orientation, gender identity, LGBTI
- Stigma, discrimination
- Masculinity, femininity
- HIV, HIV service uptake, antiretroviral therapy (ART)/ARV adherence, postexposure prophylaxis/PEP
- Condom negotiation
- Partners

Box 8. Engaging with the task force in Step 2

In Step 2, specific task force roles may include:

- Identifying and sharing secondary data sources for the desk review (e.g., published and unpublished literature, laws and policies, project reports and other grey literature)
- Reviewing and validating desk review findings
- Identifying knowledge gaps and prioritizing questions to be asked during primary data collection

from past gender analyses (noting that past gender analyses are unlikely to include key populations explicitly). For example, in Kenya, PEPFAR conducted a Gender Scan in 2012 and surveys on Gender and the HIV Response in 2016.

Compile and share the list of documents with stakeholders to ensure that it is complete and appropriate.

2.2 Analyze and synthesize relevant documents

Once the relevant documents have been gathered, it is important to analyze and synthesize them to identify questions that still need to be answered, contradictory findings that require further investigation, and key issues to address in the future HIV programs for key populations. This synthesis can also be incorporated in the final products of your program's gender analysis.

2.3 Share desk review findings with stakeholders

After existing data is synthesized, share the desk review findings with stakeholders and prioritize gender analysis questions to be asked during primary data collection.

STEP 3: CONDUCT IN-DEPTH INTERVIEWS AND/OR FOCUS GROUP DISCUSSIONS (PRIMARY DATA)

3.1 Develop primary data collection tools

Based on the gender analysis questions prioritized in Step 2, identify the most useful sources for primary data collection. Then, develop primary data collection tools (e.g., in-depth interview guides, focus group discussion guides) that address the prioritized questions.

We recommend organizing the data collection tools around the LINKAGES cascade (see **Figure 1**) using the following key categories:

- **Enabling environment:** Gender norms and gender-related beliefs that are harmful to key populations
- **Cascade:** Identify and reach key populations
- **Cascade:** Test key populations, diagnose PLHIV, and treat PLHIV
- **Enabling environment:** Violence
- **Enabling environment:** Laws and policies

See **Appendices 4, 5, and 6** for sample interview guides with SWs, PWID, and transgender people and **Appendix 7** for a sample focus group guide with MSM. The gender analysis questions in these data collection tools are organized by the key categories.

For gender analyses that require a limited number of questions, key gender analysis questions can be found in **Box 11**. Use these appendices and key questions to guide the development of your data collection tools. Other toolkits on developing gender analysis questions exist and can be adapted to your program and local context (see **Appendix 11**).

3.2 Recruit participants

Identify participants in collaboration with stakeholders and through recommendations from data collectors and existing informants. For a gender analysis, we recommend including:

- Representatives from key population-led organizations
- Policymakers, including government officials, who work with key populations
- Program managers and funders who are familiar with programs for key populations
- Health care workers who serve key populations
- Key population members

Box 9. Institutional Review Board (IRB)/Ethics Committee

Gender analyses, while they involve data collection, are typically exempt from ethics committee review because they are intended to contribute directly to programmatic improvements.⁴ However, ethics committee review may be required depending on the scope of the gender analysis. Check with your organizational and/or local ethics committee to determine whether your gender analysis will require an ethics committee review and informed consent forms. See **Appendix 3** for a sample informed consent form.

Box 10. Engaging with the task force in Step 3

In Step 3, specific task force roles may include:

- Supporting the development of the primary data collection tools
- Identifying, recruiting, and interviewing key population candidates as data collectors (as time and resources allow)
- Identifying and recruiting participants for in-depth interviews and/or focus group guides

Box 11. Key gender analysis questions

1. Key populations have a range of needs beyond HIV services. What non-HIV services should an HIV-focused program offer to attract key populations?
2. How do you ensure that your services are welcoming to key populations of all genders (e.g., SW programs that are tailored for female, male, and trans SWs; programs for trans women distinct from those for MSM)?
3. Is anyone in the program (e.g., peer educator, health care worker) talking to key population members about violence? [If yes] In what context? What information or services are provided?
4. How do experiences of violence affect whether key population members access HIV-related services? What would make HIV-related services more attractive and convenient to key population victims of violence?

Consider the geographic area of your gender analysis and reach out to both urban and rural key informants as relevant.

Data collectors and/or the gender analysis coordinator can reach out to potential interview or focus group discussion participants via email, phone, or through in-person meetings. Data collectors and/or the gender analysis coordinator should introduce the purpose and objectives of the gender analysis to each potential participant in private and determine their eligibility and interest. Eligible participants should be informed that their participation is optional and confidential, that they may terminate their participation at any time, and can refuse to answer any items. Eligible potential participants should then be scheduled by data collectors for in-depth interviews or focus group discussions.

When scheduling interviews or focus group discussions be sure to allow sufficient time to fit interviews into people's schedules. As both data collectors and gender analysis participants may have other full-time employment, it will important to build time into the data collection schedule in case interviews or focus group discussions start later than planned or need to be rescheduled. Data collector reimbursement for travel should not depend only on completed interviews and should accommodate key informants that cancel or require rescheduled appointments at the last moment.

Note that it is important to recruit and interview individuals who work with all subgroups of a specific key population. For example, it will likely be necessary to make special efforts to recruit program managers or others who work with MSWs and trans SWs or WWID to have an accurate understanding of the experiences of all members in a specific key population. We also found that it was necessary to define terms, especially the term transgender, with some key informants who spoke about key population programming broadly and were more familiar with MSM, SWs, and PWID.

3.3 Conduct interviews and/or focus group discussions

Depending on time and resources, there should be two data collectors working together in each interview, with one conducting the interview and the other taking notes on the main points elicited by each interview/focus

group question (see **Appendix 2** for lessons learned about working with key population data collectors in Kenya). Ideally, the note-taker should audio-record the interview/focus group discussion with participant consent (see **Appendix 3** for a sample informed consent form) so they can write detailed notes later. The detailed notes do not have to be captured verbatim; however, the notes should include key quotations.

While acting in accordance with the resources available, try to conduct enough interviews to capture diverse perspectives and begin to hear similar responses in the interviews (in research, this is often referred to as “reaching saturation”).

Ensure that all information collected is managed and stored properly (see **Box 12**).

Box 12. Data management and storage

To ensure the confidentiality of the interview or focus group data, all paper data and recordings should be brought to the organization's office and all electronic copies of computer files should be sent to the gender analysis coordinator within one week of data collection. All data should be kept confidential in either password-protected files for electronic data or locked cabinets for paper data. Only approved gender analysis team members should have access to the data. Data collection materials (guides) and field notes should only be labeled with ID numbers and should be kept in a locked file cabinet that is accessible only to the gender analysis team.

STEP 4: ANALYZE DATA AND SYNTHESIZE FINDINGS

4.1 Analyze data

Analyze data on an ongoing basis as it is collected. There are many tools to organize and analyze data from interviews and focus group discussions, including word processor and spreadsheet programs, such as Microsoft Word, Microsoft Excel, Google Docs, and Google Spreadsheets.

When you begin data analysis, we recommend analyzing the data separately according to key population served. For each key population served (e.g., PWID), read through the notes of each interview or focus group discussion to briefly summarize what each informant said about the following key categories, focusing on opportunities and barriers in each category:

- **Enabling environment:** Gender norms and gender-related beliefs that are harmful to key populations
- **Cascade:** Identify and reach key populations
- **Cascade:** Test key populations, diagnose PLHIV, and treat PLHIV
- **Enabling environment:** Violence
- **Enabling environment:** Laws and policies

Then review the summaries to identify recurring themes for each category and highlight places where key informants agreed or disagreed. If more than one person

is summarizing interviews/focus group discussions and identifying recurring themes and points of agreement and disagreement, it is important to ensure consistency between (or among) them. This can be achieved by having them all review the same interview/focus group discussion and compare their summaries to ensure they are highlighting similar information and providing the same level of detail. The data analysis spreadsheet found in **Appendix 8** and pictured in **Figure 2** is one tool you can use to analyze gender analysis data.

Appendix 8 also includes instructions on how to fill in the spreadsheet and a sample of a completed spreadsheet from the gender analysis in Kenya.

4.2 Synthesize findings

The next step is to synthesize information collected from different sources (e.g., desk review, interviews, focus group discussions). As a first step, look at all your information sources and create a draft summary of the gender analysis findings (such as a write-up or a handout) for each key population. The summary documents should highlight gender-related barriers and opportunities and identify recommendations about potential ways to address these barriers and opportunities in HIV programming for key populations. See **Appendix 9** for a handout template and sample that summarizes gender analysis findings and recommendations. Consider alternative ways to synthesize data, including conceptual models and case studies (see **Box 13**).

FIGURE 2: Data analysis spreadsheet

Category	Content	Theme	Justification and Quotes
DOMAIN			
Enabling Environment: Gender-related Beliefs			
Most common beliefs			
Common harms from beliefs			
How to address these beliefs			
Observations			
Cascade: Identify & Reach			
Barriers			
Opportunities			
Recommendations from key informants			
Observations			

Box 13. Prezi case studies

In Kenya, data collectors felt that stories would best illustrate the gender analysis findings. They presented Prezi (a free story-telling software) case studies that showcased how barriers and opportunities affect key population members across the cascade. Links to the Prezi case studies can be found below:

[MSM Martin](#)

[Transwoman Joan](#)

[WWID Hope](#)

[SW Olive](#)

STEP 5: REVIEW AND PRIORITIZE GENDER ANALYSIS FINDINGS AND RECOMMENDATIONS WITH STAKEHOLDERS

Once you develop a draft summary of the gender analysis findings per key population (e.g., write-up, handout, Prezi), it is critical to collaborate with stakeholders to:

- Make sure the findings were interpreted correctly,
- Identify priority findings and recommendations for gender integration in programming, policies, and research, and
- Provide guidance on the best ways to package and disseminate results.

One efficient and collaborative way to accomplish the above objectives is to bring together key stakeholders for an interpretation meeting.

Any stakeholder who was actively involved in the gender analysis process (e.g., task force member, data collector, participant) is a potential invitee to the interpretation meeting. While all participants do not need to be invited, several people from each key population and informant group should be represented. It is also important to invite people with influence and decision-making power regarding the country's HIV and key population agenda; they may offer ideas on how to maximize the utility of findings and may champion their use. Consider cohosting the interpretation meeting with the Ministry of Health

or influential key population groups to foster their commitment to advocating for and addressing gender in future HIV programs for key populations.

A one- to two-day meeting is ideal to present and discuss findings and implications. Keeping the meeting brief also increases full participation. A sample meeting agenda from the interpretation meeting in Kenya can be found in **Table 2**. The presentation of findings by key population underscores the importance of talking about the distinct issues faced by each group.

Box 14. Engaging with the task force in Step 5

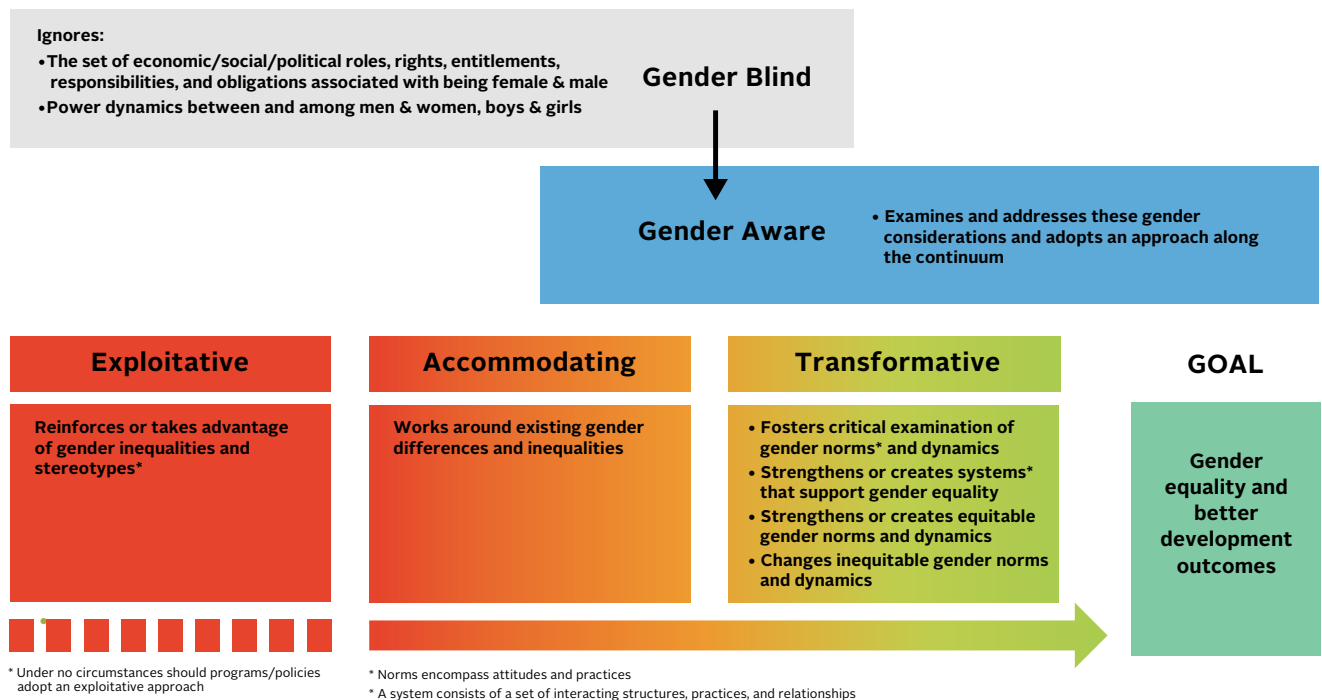
In Step 5, specific task force roles may include:

- Leading the review of analyzed data to help validate findings
- Identifying priority findings and recommendations
- Providing guidance on packaging and disseminating results

TABLE 2: Sample interpretation meeting agenda from Kenya gender analysis

TIME	SESSION TITLE	Presenter
8:30-9:00am	Arrival and Registration/TEA	
9:00-9:30am	Welcome and Introductions	
9:30-10:00am	Overview of the Gender Analysis Study	
10:00-10:45am	MSM – Findings, Recommendations, and Discussion	
10:45-11:00am	TEA BREAK	
11:00am-11:45am	Transgender People – Findings, Recommendations, and Discussion	
11:45am-12:30pm	PWID – Findings, Recommendations, and Discussion	
12:30–1:45pm	LUNCH	
1:45-2:30pm	SWs – Findings, Recommendations, and Discussion	
2:30-2:45pm	Overarching Findings and Recommendations	
2:45-3:15pm	Group Discussion on Packaging, Disseminating, and Implementing Findings	
3:15-3:35pm	Group Reports	
3:35-4:00pm	Way Forward and Closing Remarks	
4:00pm	TEA/END OF MEETING	

FIGURE 3: IGWG gender equality continuum tool



Box 15. Linking findings to gender and developing recommendations for gender integration

During the interpretation meetings, it is important to make clear the link between the findings, gender-related beliefs, and the gender norms that underlie these beliefs.

The IGWG Gender Equality Continuum Tool (see **Figure 3**) provides a way to think about different approaches to gender-integrated programs. A program should always strive to be “gender aware” and either “accommodating” or “transformative.” Conversely, programs should never deliberately be exploitative of harmful gender norms. As defined in the IGWG Gender Equality Continuum Tool, gender-accommodating programs acknowledge, but work around, gender differences and inequalities to achieve project objectives. Gender-transformative programs aim to promote gender equality and achieve program objectives by (1) fostering critical examination of inequalities and gender roles, norms, and dynamics; (2) recognizing and strengthening positive gender-related beliefs that support equality and an enabling environment; and (3) promoting the relative position of marginalized groups and transforming the underlying social structures, policies, and broadly held social norms that perpetuate gender inequalities.

During the interpretation meeting, you should prioritize recommendations for both gender-accommodating and gender-transformative programs. See **Appendix 10** for illustrative recommendations for gender-integrated programs serving transgender people in Kenya.

STEP 6: PACKAGE AND DISSEMINATE FINDINGS AND RECOMMENDATIONS**6.1. Package findings and recommendations**

Once the findings are finalized, write them up according to the recommendations of the stakeholders and within the scope of the gender analysis budget. Findings can be packaged in different ways for different audiences who are most likely to use them (e.g., journal articles, policy briefs, fact sheets, detailed programmatic recommendations, advocacy tools).

In Kenya, stakeholders who participated in the interpretation meetings indicated they did not want

a lengthy written report detailing the gender analysis process and findings for their country. Instead, stakeholders recommended we package the findings into easy-to-understand briefs for use by various audiences to encourage and inform gender-integrated HIV prevention, care, and treatment programming for key populations in Kenya. Thus, the main deliverable from the gender analysis in Kenya is a four-part series that highlights the key findings and recommendations by key population. See **Appendix 10** for an excerpt of the *Nexus of Gender and HIV among Transgender People in Kenya*.⁸ For the full briefs, please visit the [LINKAGES country briefs and reports page](#) or click on **Figure 4**.

Box 16. Engaging with the task force in Step 6

In Step 6, specific task force roles may include:

- Co-writing final gender analysis deliverables
- Reviewing final gender analysis deliverables
- Disseminating findings and recommendations

6.2 Disseminate findings and recommendations

Once the findings are packaged, develop and execute a dissemination strategy according to the recommendations of the stakeholders to reach as many potential users of the findings as possible. Both global and in-country dissemination can take many forms, such as:

- Informal presentations at relevant task force or working group meetings
- One-on-one meetings with influential decision makers or potential “champions” of the work
- Workshops with implementing partners who could apply the findings in existing programs
- Sharing of findings and deliverables via relevant local electronic channels (e.g., listservs, discussion forums, webinars, and websites)
- Formal presentations at relevant conferences

The findings should not just be disseminated passively. You should also follow up with stakeholders and other potential users of the findings to support their use.

FIGURE 4: The nexus of gender and HIV among key populations series



CONCLUSION

Programming for key populations is unique. It is uniquely challenging in the face of the stigma, discrimination, violence, and criminalization that many members of key populations face. And it is uniquely worthwhile; as USAID and others have noted, “There is no way toward an AIDS-free future without targeting approaches toward these highly marginalized and often hard to reach populations.”

By applying systematic gender integration in key population programming, programs can:

- Ensure that all members of a specific key population, disaggregated by gender, have access to the services and information they need.

- Identify the gender-related beliefs that lie at the root of the high HIV risk; low service uptake; and increased stigma, discrimination, and violence that key populations face and work around or transform those beliefs to achieve maximum impact.
- Connect key populations and the issues they face to those of the broader population and create opportunities for combined efforts.

A gender analysis is the first step in this gender integration process. The practical guidance and lessons learned in this toolkit can be used to implement gender analyses and increase the chance that their findings will be used—ultimately leading to programs that accelerate progress toward both better health outcomes and greater gender equality.



Appendices

- APPENDIX 1:** Core gender concepts
- APPENDIX 2:** Case study: Engaging with key populations in Kenya
- APPENDIX 3:** Sample informed consent form
- APPENDIX 4:** Sample interview guide for key informants working with sex workers
- APPENDIX 5:** Sample interview guide for key informants working with transgender people
- APPENDIX 6:** Sample interview guide for key informants working with people who inject drugs
- APPENDIX 7:** Sample focus group guide for gay men and other men who have sex with men
- APPENDIX 8:** Data analysis matrix template and sample
- APPENDIX 9:** Handout template and sample
- APPENDIX 10:** Nexus of gender and HIV among transgender people excerpt
- APPENDIX 11:** Additional resources

APPENDIX 1

Core gender concepts

GENDER-ACCOMMODATING PROGRAMS: Programs that acknowledge, but work around, gender differences and inequalities to achieve project objectives [Adapted from *IGWG training materials*].¹⁴

GENDER AFFIRMATION: The process by which individuals are affirmed in their gender identity. Gender affirmation typically involves three dimensions: social (being called by a name and pronouns that are aligned with a person's gender identity); medical (cross-sex hormone therapy, surgical procedures); and legal (changing a person's legal name or sex designation, if possible) [*AIDSTAR-Two Technical Report on the Global Health Needs of Transgender Populations*].³³

GENDER ANALYSIS: A subset of socioeconomic analysis. It is a social science tool used to identify, understand, and explain gaps between males and females that exist in households, communities, and countries. It is also used to identify the relevance of gender norms and power relations in a specific context (e.g., country, geographic, cultural, institutional, economic, etc.) [*USAID, Automated Directive System 205.3.1*].²

GENDER EXPRESSION: The external display of one's gender, through a combination of appearance, disposition, social behavior, and other factors, generally measured on a scale of masculinity and femininity [*Health Policy Project Gender and Sexual Diversity Training*].¹⁵

GENDER IDENTITY: A person's deeply felt internal and individual experience of gender, which may or may not correspond with the sex assigned at birth [*Health Policy Project Gender and Sexual Diversity Training*].¹⁵

GENDER INTEGRATION: Strategies applied in programmatic design, implementation, monitoring, and evaluation to take gender considerations into account and compensate for gender-based inequalities. [Adapted from *IGWG training materials*].¹⁴

GENDER NORMS: The expectations of what it means to be a man or woman, including social and political roles, responsibilities, rights, entitlements and obligations, and the power relations between men and women [Adapted from *Health Policy Project Gender and Sexual Diversity Training*].¹⁵

GENDER-TRANSFORMATIVE PROGRAMS: Programs that aim to promote gender equality and achieve program objectives by (1) fostering critical examination of inequalities and gender roles, norms, and dynamics; (2) recognizing and strengthening positive gender-related beliefs that support equality and an enabling environment; and (3) promoting the relative position of marginalized groups, and (4) transforming the underlying social structures, policies, and broadly held social norms that perpetuate gender inequalities [Adapted from *IGWG training materials*].¹⁴

GENDER-BASED VIOLENCE: Any form of violence that is directed at an individual based on biological sex, gender identity (e.g., transgender), or behaviors that are not in line with social expectations of what it means to be a man or woman, boy or girl (e.g., men who have sex with men and female sex workers). It includes physical, sexual, and psychological abuse; threats; coercion; arbitrary deprivation of liberty; and economic deprivation, whether occurring in public or private life [*PEPFAR Gender Strategy*].¹

HETEROSEXISM: The imposition of heterosexuality as the only normal and acceptable expression of sexuality, resulting in prejudice or discrimination against people who are not heterosexual or who are perceived not to be heterosexual [*MSMIT*].³⁰

HOMOPHOBIA: The irrational hatred, fear, or intolerance of homosexuality or gay men and other MSM. Homophobia is often the result of misunderstanding and prejudice and helps fuel the myths, stereotypes, stigma, and discrimination

that can lead to violence against gay men and other MSM. Gay men and other MSM who are gender nonconforming are more likely to experience homophobia [[Global Forum on MSM and HIV and Johns Hopkins University training curriculum for providers](#)].³⁴

SEX: A medical term used to refer to the chromosomal, hormonal, and anatomical characteristics that are used to classify an individual as female or male or intersex [[Health Policy Project Gender and Sexual Diversity Training](#)].¹⁵

SEXUAL ORIENTATION: An enduring emotional, romantic, or sexual attraction primarily or exclusively to people of a particular gender [[Health Policy Project Gender and Sexual Diversity Training](#)].¹⁵

TRANSGENDER: An adjective to describe people whose gender identity is different from the sex they were assigned at birth. Transgender is an umbrella term that describes a wide variety of cross-gender behaviors and identities [[TRANSIT](#)].³² **Transgender women** were assigned male at birth and identify as female. **Transgender men** were assigned female at birth and identify as male. **Gender nonconforming people**, in the context of this toolkit, refers to individuals who do not identify as male or female.

TRANSPHOBIA: Prejudice directed at trans people because of their actual or perceived gender identity or expression. Transphobia can be structural, i.e., manifested in policies, laws, and socioeconomic arrangements that discriminate against trans people. It can be societal when trans people are rejected or mistreated by others. Transphobia can also be internalized, when trans people accept and reflect such prejudicial attitudes about themselves or other trans people [[TRANSIT](#)].³²



APPENDIX 2

Case study: Engaging with key populations in Kenya

In line with principles of meaningful participation (see **Box 1**), we recommend convening a gender analysis task force of key population-led organizations and government decision makers to guarantee key population leadership and ownership of the gender analysis and ensure high-level government commitment.

Below you will find a case study of how LINKAGES engaged with a gender analysis task force and key population data collectors in Kenya in each step of the gender analysis process.

Step 1: Plan for a gender analysis

In Step 1, LINKAGES presented the gender analysis concept note at a Key Population Technical Working Group meeting convened by the National AIDS & STI Control Programme (NASCOP). The working group then formed a gender analysis task force, including representatives from:

- NASCOP Technical Support Unit (NASCOP TSU)
- National AIDS Control Council (NACC)
- Gay and Lesbian Coalition of Kenya (GALCK)
- Jinsiangu
- Kenya Sex Workers Alliance (KESWA)
- LVCT Health
- Minority Persons Empowerment Group (MPEG)
- Sex Workers Outreach Programme (SWOP)
- Support for Addictions Prevention and Treatment in Africa (SAPTA)

The task force highlighted the abundance of existing literature on key populations in Kenya and refined the gender analysis concept note to focus on gaps in the literature.

Step 2: Conduct a desk review (secondary data)

In Step 2, the task force recommended completing a desk review prior to primary data collection as substantial research on key populations had been conducted in Kenya. The task force also shared a list of references to review. The desk review findings informed the interview guide questions in Step 3.

Box 1. “Nothing About Us, Without Us”

Key population programming must be informed by and built in partnership with members of key populations. International guidance documents (MSMIT,³⁰ SWIT,³¹ TRANSIT³²) all place community empowerment and leadership at the center of effective programming. The meaningful participation of key populations is essential to building trust, establishing relationships and partnerships that have integrity and are sustainable, and ultimately implementing successful research or programs. The same is true for a gender analysis.

Meaningful participation means that key populations:³⁰⁻³²

- Choose how they are represented, and by whom
- Choose how they are engaged in the process
- Choose whether to participate
- Have an equal voice in how partnerships are managed

Step 3: Conduct in-depth interviews and/or focus group discussions (primary data)

In Step 3, the task force recommended working with data collectors from key population groups as participants would be more likely to talk to them (see **Box 2** for lessons learned on working with data collectors).

Based on this recommendation, members of key populations were formally employed as data collectors for the Kenya gender analysis. In Step 3, key population data collectors:

- Completed data collector training,
- Helped design the interview guides,
- Helped recruit participants,
- Scheduled and conducted the interviews, and
- Wrote detailed field notes.

Box 2. Engaging with data collectors

In the case of a well-resourced gender analysis that formally employs data collectors, consider the following:

- Hiring data collectors:** If possible, hire data collectors from key populations who have a background in gender, HIV, and/or key population programming. Due to limited opportunities (often resulting from stigma and discrimination), members of key populations may not have experience as professional data collectors. However, their expertise and insights into the issues facing key populations and the comfort that many key informants will have with other members of key populations must be considered. Work with your Human Resources (HR) department to ensure that HR processes do not put key population candidates at a disadvantage or cause undue barriers in the hiring process. For example, appropriate data collector qualifications can place more weight on experience working with key populations and less on degrees obtained, as some members of key populations may have fewer formal educational opportunities. HR team members should also work to ensure that key population candidates are treated with dignity and respect when they come to your organization (e.g., ensuring that security staff do not question a candidate whose government ID does not match their gender identity). Depending on your country laws and policies, you may have to use a government ID for national tax documents even if the government ID does not reflect the gender identity and chosen name of an individual. Make sure to discuss this issue and possible solutions with candidates when they are offered a position. Once hired, provide key population data collectors with photo ID cards that reflect their chosen names and official role on the gender analysis team.
- Training data collectors:** Data collectors should receive training on how to conduct interviews for the gender analysis. This training should cover gender concepts and qualitative data collection (e.g., techniques and practice interviewing, probing, and note-taking). During the training, data collectors should pilot test and revise the interview guides to prioritize the most useful questions and ensure they are appropriate to the local context.
- Supporting data collectors:** Hiring individuals with less formal data collection experience may mean that additional support is needed. The gender analysis coordinator should provide oversight, technical assistance, and feedback to data collectors throughout data collection. For example, the coordinator can review interview audio files and field notes and provide feedback to data collectors on how to probe in a qualitative interview or take more detailed notes. Also consider that key population members may be more likely to live or work in environments with limited options for safe storage of gender analysis materials (such as monetary incentives for participants). Thus, it may be necessary to arrange to drop off and pick up these materials at an interview or focus group site.

Step 4: Analyze data and synthesize findings

In Step 4, LINKAGES staff analyzed the gender analysis data and synthesized findings in summary documents with support from the key population data collectors.

Step 5: Review and prioritize gender analysis findings and recommendations with stakeholders

In Step 5, key population data collectors reviewed summary documents and determined priority findings and recommendations for presentation at a gender

analysis interpretation meeting cohosted by NASCOP and LINKAGES. Meeting participants included government representatives, community-based organization representatives, task force members, key population data collectors, and other stakeholders.

Key population data collectors presented findings per key population, highlighting:

- Gender-related beliefs affecting key population's access to services;
- Experiences of gender-based violence;
- Different needs by subpopulations;
- Barriers and opportunities at each step in the cascade;
- Policies and laws that affect key populations; and
- Recommendations on what can be done to improve service uptake among each key population.

LINKAGES staff presented key recommendations across and within each key population.

Step 6: Package and disseminate findings and recommendations

In Step 6, a task force member cowrote the briefs in the [*Nexus of Gender and HIV among Key Populations*](#)⁸ series. In addition, task force members and data collectors representing each key population group reviewed and approved the briefs.



APPENDIX 3

Sample informed consent form

KEY INFORMANT INTERVIEW INFORMED CONSENT FORM

TITLE: Gender Analysis: Access to HIV Prevention, Care, and Treatment Services by Key Populations

SPONSOR: FHI 360 and the U.S. Agency for International Development (USAID)

GENDER ANALYSIS COORDINATOR:

Introduction

You are invited to be part of a gender analysis about key populations' access to HIV-related services in [Country]. For the purposes of this gender analysis, key populations are gay men and other men who have sex with men, people who inject drugs, sex workers, and transgender people. The gender analysis looks at how gender norms and inequalities affect these groups' access to HIV-related services. We will use the findings to improve key populations' access to services. It is important that you understand the purpose of this gender analysis and your responsibilities before you decide to participate. Please ask me to explain anything that you may not understand.

Information about the Gender Analysis

If you agree to participate in this gender analysis, we will ask you questions about key populations' experiences, what programs currently serve key populations, how policies affect key populations, and how you think programs and policies can be improved. This is an opportunity for you to provide your thoughts and opinions. There are no right or wrong answers.

We will talk to you in a private place where no one can hear what we are saying. The interview will last about one hour. We will take notes during the interview; at no time will your name appear in the notes. If you agree, we will also audio record the interview to make sure our notes are accurate. Once we make sure the notes are accurate by listening to the audio tape, the recording will be destroyed.

Possible Risks

The risks of participating are minimal. The major risk is that other people may find out that you participated in this gender analysis. We are protecting what you tell us, but there is always a chance someone may find out what you told us. If you decide to participate now, you can still decide to leave the gender analysis at any time. You do not have to answer all the questions. The interviewer will not ask you to talk about your own behaviors.

Possible Benefits

You may improve your understanding of how gender norms and inequalities affect key populations' access to and use of HIV-related services.

If You Decide Not to Be in the Gender Analysis

Agreeing to be in this gender analysis is not a part of your work requirement or the work you do to support any groups. It is fine to decide not to participate; there will be no penalties.

Confidentiality

We will protect information about you and your participation in this gender analysis to the best of our ability. We will not use your name in any reports. We will not tell others about your participation. We may be asked to share data with our sponsor, USAID. If data is shared with USAID, no participant's name or other identifiers will be shared.

Compensation

You will be provided with [amount] as a token of appreciation for your time and travel.

Leaving the Gender Analysis

You may end your participation at any time.

If You Have Questions about the Gender Analysis

If you have any questions about the gender analysis, contact [gender analysis coordinator name] at [email address] or [phone number].

You can have a copy of this form, if you would like one.

Do you agree to be in this gender analysis? YES NO

Do you agree to let us audio record what you say? YES NO

PARTICIPANT AGREEMENT

I certify that the nature and purpose, the potential benefits, and possible risks associated with participating in this gender analysis have been explained to the participant and that he or she has agreed to participate.

Signature of Person Who Obtained Consent: _____

Date: ____ / ____ / ____



APPENDIX 4

Sample interview guide [Sex workers]

GENDER ANALYSIS OF KEY POPULATIONS' ACCESS TO HIV PROGRAMS AND SERVICES

Interview Guide for Key Informants Working with Sex Workers (SWs)

Archival number: _____	Location: _____
Date of interview: _____	Interviewer: _____
Start time: _____	Note-taker: _____
End time: _____	

[Interviewer please read] Thank you for your time. I am going to ask you some questions about gender-related barriers that sex workers (SWs) face to living healthy and violence-free lives. I am going to focus on SWs' access to and use of HIV-related services. Your answers will be used to improve programs and services for SWs.

You have been selected to participate in this gender analysis because of your work with SWs in [Country]. Since this questionnaire is used with different types of stakeholders, you may not know the answer to each question. If you do not know an answer, please simply say "I don't know," and I will move to the next question.

When answering the questions, please recall that some SWs are quite empowered while others may struggle with many gender-related barriers. We are interested in improving programs and services for all SWs.

To which stakeholder group or groups do you belong? *[Interviewer please circle the group or groups that this informant represents.]*

- Representative from a SW-led organization (REP)
- Health care worker who serves SWs (HCW)
- Program manager or funder who is familiar with programs for SWs (PROG)
- Government stakeholder or policy maker who works with SWs (GOV)

[Interviewer, if time is limited, prioritize relevant questions for informants based on each stakeholder group. If informants do not know or want to answer a question, they can skip it. Please write SKIP after any question that the participant chooses not to answer.]

Background

1. Who do you or your organization work with: female sex workers (FSWs), male sex workers (MSWs), and/or transgender sex workers (TSWs)?

[Interviewer please circle the group or groups that the informant works with and then use this answer to determine which of the questions in this questionnaire are appropriate to ask. If a question does not begin with a specific SW group, then it is appropriate to ask of all interviewees.]

FSWs

MSWs

TSWs

Enabling Environment: Gender-related Beliefs

2. Evidence shows that gender-related beliefs for how men and women should behave can harm SWs' well-being and keep them from accessing HIV-related services. Gender-related beliefs are not factual statements, but rather common beliefs held in a specific culture. I will now read some of the beliefs that were found in the literature. Please comment on whether you think each of these beliefs is widely held in [Country]. You can also say "I don't know" or change the statement to be more accurate.

- a. [FSWs] A woman's sexual behavior reflects her morals
 - b. [FSWs] FSWs are bad mothers
 - c. [FSWs] Women who engage in sex work deserve to experience violence
 - d. [FSWs] It is okay for women to be beaten once in a while by their partners
 - e. [FSWs] A woman should take care of those around her (husband, children) even if it means forgoing care for herself
 - f. [MSWs] Men degrade themselves when they behave in a feminine way
 - g. [MSWs] It's OK for violence to occur against gay men and other men who have sex with men
 - a. [TSWs] Transgender is the same as homosexual/gay.
 - b. [TSWs] Transgender is a Western invention and is not [African]
 - c. [TSWs] Transgender people are confused or mentally ill, and they need to be fixed or grow out of it
 - d. [TSW] Transgender people are cursed or possessed
 - e. [TSW] Violence toward transgender people is deserved; transgender people bring this violence onto themselves
 - f. [TSW] Trans women have degraded themselves by becoming women instead of remaining men
 - g. [TSW] A trans woman must do whatever her sexual partner asks because she, as a woman, should be sexually submissive
3. *[Interviewer, after each norm that the participant thinks is common in Country, please ask]*
How does this belief harm SWs?
4. Of all the gender-related beliefs we have discussed, which one is the most important to change to benefit FSWs in [Country]? Why?
- a. What could be done to change this belief?
 - b. Which gender-related belief is the most important to change to benefit MSWs? Why?
 - c. What could be done to change this belief?
 - d. Which gender-related belief is the most important to change to benefit TSWs? Why?
 - e. What could be done to change this belief?

[Interviewer read] As I mentioned at the start, the purpose of this interview is to learn more about how gender-related beliefs and inequalities are affecting access to HIV-related services for SWs in [Country]. The rest of the questions in this interview are to learn more about this issue.

Cascade: Identification and Reach

[Interviewer read] Are you aware of programs for SWs? *[If YES continue with this section, if NO, continue with the Testing, Diagnosis, and Treatment section]*

- 5. Please describe an existing HIV-focused program that is attractive and convenient for SWs.
 - a. How, if at all, does it make services welcoming to SWs of all genders (FSWs, MSWs, and TSWs)?
 - b. How, if at all, does it make services welcoming to young SWs?
 - c. How, if at all, does it deal with any financial barriers SWs may face?
- 6. How can HIV-focused programs be made more attractive and convenient for SWs?
 - a. How would this be different for FSWs, MSWs, and TSWs? Why?
 - b. How would this be different for young SWs? Why?
- 7. What are the best ways to share information about HIV with SWs? Why?
 - a. How is this different for FSWs, MSWs, and TSWs? Why?
 - b. How is this different for young SWs? Why?
- 8. SWs have a range of needs beyond HIV services. What non-HIV services should an HIV-focused program offer to attract SWs?
 - a. How should the services offered be different for FSWs, MSWs, and TSWs?
 - b. Would these services also attract young SWs? Why or why not?
- 9. *[If informant works with FSWs ask]*
Some programs, such as those designed to prevent domestic violence or prevent mother-to-child transmission of HIV (PMTCT), are supposed to benefit all women. Yet, FSWs are often excluded. How could these programs also serve FSWs?

Cascade: Testing, Diagnosis, and Treatment

[Interviewer read] This section focuses on HIV testing and treatment. You may not know the answer to each question. Please feel free to skip any question you cannot answer.

10. Is knowing one's HIV status a priority for SWs? Why or why not?
 - a. Who or what is likely to encourage SWs to get tested? Why?
 - b. Who or what is likely to discourage SWs from getting tested? Why?
 - c. How is this different for FSWs, MSWs, and TSWs? Why?
 - d. Are there formal or informal rules at hot spots that would either encourage or discourage SWs from getting tested?
 - e. [If YES] What are they?
11. In your experience, how do health care workers treat people who they think are SWs when they access HIV-related services?
 - a. How is this different than the way they treat other people?
 - b. How is this experience different for FSWs, MSWs, and TSWs? Why?
12. In your experience, when a SW tests positive, what information does a health care worker give on how to disclose their status to others (e.g., to a primary partner, clients, brothel owner/pimp/madam, friends, family, or other SWs)?
 - a. Is that person given any information on how to handle a violent response when disclosing?
 - b. How is the information given to FSWs, MSWs, and TSWs different? Why?
13. In your experience, for SWs living with HIV, who and what motivates them to seek treatment? Why?
 - a. Who or what discourages SWs from seeking treatment? Why?
 - b. How is this different for FSWs, MSWs, and TSWs? Why?
14. Do health care workers offering HIV-related services to SWs ask them if they have experienced violence? Why or why not?

- a. [If YES] How?
- b. What services or organizations do they refer SWs to?
- c. How is this different for FSWs, MSWs, and TSWs? Why?

Enabling Environment: Violence

[Interviewer read] This section focuses on violence. You may not know the answer to each question. Please feel free to skip any question you cannot answer.

15. SWs in [Country] experience high rates of emotional, physical, and sexual violence. How is the violence experienced by FSWs and TSWs different than that experienced by MSWs? Why?
 - a. How is this experience different for SWs living with HIV?
 - b. How is this experience different for SWs who are pregnant?
 - c. How is this experience different for young SWs?
16. How do SWs view the violence perpetrated against them? Why?
 - a. How is this different for FSWs, MSWs, and TSWs? Why?
 - b. How is violence against SWs perceived by the general public? Why?
 - c. How is this different for FSWs, MSWs, and TSWs? Why?
17. In your opinion, which group of perpetrators is most important to work with to decrease violence against SWs (e.g., police, intimate partner, family, or community)? Why?
 - a. How is this different for FSWs, MSWs, and TSWs? Why?
18. Where do SWs seek support if they experience violence (e.g., police, clinic, shelter, community-based organization)?
 - a. What are the differences in support seeking behavior between FSWs, MSWs, and TSWs? Why?
 - b. What information or services do these sources of support provide to SWs who have experienced violence?

- c. How is this different for FSWs, MSWs, and TSWs? Why?
 - d. What additional knowledge or resources do these sources of support need to be able to help SWs of all genders (FSWs, MSWs, and TSWs) who have experienced violence?
19. How do experiences of violence affect whether SWs access HIV-related services?
 - a. How is this different for FSWs, MSWs, and TSWs? Why?
 20. What would make HIV-related services more attractive and convenient to SWs who are victims of violence? Why?
 - a. How is this different for FSWs, MSWs, and TSWs? Why?
 21. How does criminalization of sex work affect SWs' access to HIV-related services?
 - a. What other laws or policies have a negative impact on SWs access to services?
 - b. [If laws or policies identified] How have they impacted SWs' access to services?
 - c. How is this different for FSWs, MSWs, and TSWs? Why?
 22. What laws or policies have a positive impact on SWs' access to services?
 - a. How have they impacted SWs' access to services?
 - b. How is this different for FSWs, MSWs, and TSWs? Why?
 23. Despite the illegality of sex work in [Country], how has the government successfully partnered with SW communities?
 - a. Do SWs participate in national policy or other discussions?
 - b. [If YES] How are SWs treated in those discussions?
 - c. How is this experience different for FSWs, MSWs, and TSWs? Why?
 - d. Are SWs involved in the Global Fund Country Coordinating Mechanism?
 - e. [If YES] How?

Enabling Environment: Laws and Policies

[Interviewer read] Are you aware of policies that affect SWs? [If YES continue with this section, if NO, continue with the Conclusion section]

21. How does criminalization of sex work affect SWs' access to HIV-related services?
 - a. What other laws or policies have a negative impact on SWs access to services?
 - b. [If laws or policies identified] How have they impacted SWs' access to services?
 - c. How is this different for FSWs, MSWs, and TSWs? Why?

Conclusion

24. Are there any other gender issues related to SWs' use of HIV-related services that you think are important to discuss?
25. Do you have any questions or comments for me?

[Interviewer please read] Thank you for your time. Your answers will help to inform programs and services for SWs in [Country].



APPENDIX 5

Sample interview guide [Transgender people]

GENDER ANALYSIS OF KEY POPULATIONS' ACCESS TO HIV PROGRAMS AND SERVICES

Interview Guide for Key Informants working with Transgender People

Archival number: _____	Location: _____
Date of interview: _____	Interviewer: _____
Start time: _____	Note-taker: _____
End time: _____	

[Interviewer please read] Thank you for your time. I am going to ask you some questions about gender-related barriers that transgender people face to living healthy and violence-free lives. I am going to focus on transgender people's access to and use of HIV-related services. Your answers will be used to improve programs and services for transgender people.

Transgender is a general term used to describe people whose gender identity differs from the sex they were assigned at birth. Gender identity is a person's inner sense of being male or female. Cisgender is the opposite of transgender, meaning someone whose gender identity is the same as the sex they were assigned at birth.

You have been selected to participate in this gender analysis because of your work with transgender people in [Country]. Since this questionnaire is used with different types of stakeholders, you may not know the answer to each question. If you do not know an answer, please simply say "I don't know," and I will move to the next question.

When answering the questions, please recall that some transgender people are quite empowered while others may struggle with many gender-related barriers. We are interested in improving programs and services for all transgender people.

To which stakeholder group or groups do you belong? *[Interviewer please circle the group or groups that this informant represents.]*

- Representative from an organization led by transgender people (REP)
- Health care worker who serves SWs (HCW)
- Program manager or funder who is familiar with programs for SWs (PROG)
- Government stakeholder or policy maker who works with SWs (GOV)

[Interviewer, if time is limited, prioritize relevant questions for informants based on each stakeholder group. If informants do not know or want to answer a question, they can skip it. Please write SKIP after any question that the participant chooses not to answer.]

Background

1. Who do you or your organization work with: transgender women and/or transgender men?

[Interviewer please circle the group or groups that the informant works with and then use this answer to determine which of the questions in this questionnaire are appropriate to ask. If a question does not begin with a specific trans group, then it is appropriate to ask of all interviewees.]

Transgender woman *[This is an umbrella term that refers to a person who was assigned male at birth, but identifies as female.]*

Transgender man *[This is an umbrella term that refers to a person who was assigned female at birth, but identifies as male.]*

Enabling Environment: Gender-related Beliefs

2. Evidence shows that gender-related beliefs for how men and women should behave can harm trans peoples' well-being and keep them from accessing HIV-related services. Gender-related beliefs are not factual statements, but rather common beliefs held in a specific culture. I will now read some of the beliefs that were found in the literature. Please comment on whether you think each of these beliefs is widely held in [Country]. You can also say "I don't know" or change the statement to be more accurate.
 - a. Transgender is the same as homosexual/gay
 - b. Transgender is a Western invention and is not [African]
 - c. Transgender people are confused or mentally ill, and they need to be fixed or grow out of it
 - d. Transgender people are cursed or possessed
 - e. Violence toward transgender people is deserved; transgender people bring this violence onto themselves
 - f. Trans women have degraded themselves by becoming women instead of remaining men
 - g. A trans woman must do whatever her sexual partner asks because she, as a woman, should be sexually submissive
 - h. The most important thing about a trans woman is how she looks
 - i. Trans men should prove their masculinity by being aggressive and violent

3. *[Interviewer, after each norm that the informant thinks is common in Country, please ask]*
How does this belief harm transgender people?
4. Are you aware of any other harmful gender-related beliefs? If so, what are they?
5. Of all the gender-related beliefs we have discussed, which one is the most important to change to benefit trans women in [Country]? Why?
 - a. What could be done to change this belief?
 - b. Which gender-related belief is the most important to change to benefit trans men? Why?
 - c. What could be done to change this belief?

[Interviewer read] As I mentioned at the start, the purpose of this interview is to learn more about how gender-related beliefs and inequalities are affecting access to HIV-related services for transgender people in [Country]. The rest of the questions in this interview are to learn more about this issue.

Cascade: Identification and Reach

[Interviewer read] Are you aware of programs for transgender people? *[If YES continue with this section, if NO, continue with the Testing, Diagnosis, and Treatment section]*

6. Feeling connected to a community is important for all people. How do transgender people find other trans community members in [Country]?
 - a. How is this different for trans women and trans men? Why?
7. In your experience, how do transgender people learn about HIV-related services, including testing (e.g., peer education, support materials, or provider outreach)?
 - a. What could be done to more effectively reach transgender people with information about HIV-related services?
 - b. How is this different for trans women and trans men? Why?
 - c. How is this different for trans women who engage in sex work? Why?

8. Transgender people have a range of needs beyond HIV services. What non-HIV services should an HIV-focused program offer to attract transgender people? Why?
 - a. How should the services offered be different for trans women and trans men? Why?
 - b. Would these services also attract young transgender people? Why or why not?
9. Gender-affirming treatments and information (e.g., access to hormones, gender reaffirming surgery, and psychosocial support for transition) are an important service for transgender people. How do transgender people in [Country] currently gain access to such treatments and information?
 - a. How is this different for trans men and trans women? Why?
 - b. In some settings, gender affirming services and information are offered to encourage transgender people to access HIV-related services. Would this work in [Country]? Why or why not?
10. Often, programs serving men who have sex with men (MSM) also serve trans women. What issues, if any, do you see with this approach in the [Country] context?
 - a. How should services for trans women differ from those for MSM? Why?
 - b. What, if any, services designed for MSM can meet trans women's needs? Why?
11. Many global HIV programs for trans women focus on appearance, with events like beauty pageants, or on promoting skills in traditionally feminine jobs, such as working in a salon. Are there any programs of this type in [Country]?
 - a. [If yes] Please describe these programs and how they are received by trans women in [Country].
 - b. [If no] Would such programming be of interest to trans women in [Country]? Why or why not?
 - c. Would programming that does not focus on traditionally feminine topics (such as beauty) be of as much interest to trans women in [Country]? Why or why not?
12. When a program is designed to serve trans women who engage in sex work, what specific additional needs should it address? Why?

Cascade: Testing, Diagnosis, and Treatment

[Interviewer read] This section focuses on HIV testing and treatment. You may not know the answer to each question. Please feel free to skip any question you cannot answer.

13. Is knowing one's HIV status a priority for transgender people? Why or why not?
 - a. Who or what is likely to encourage a transgender person to get tested? Why?
 - b. Who or what is likely to discourage a transgender person from getting tested? Why?
 - c. How is this different for trans women and trans men? Why?
 - d. How is this different for trans women who engage in sex work? Why?
14. How would you design an HIV testing and treatment clinic to accommodate transgender people's holistic needs?
 - a. How would the clinic affirm a transgender person's gender identity (e.g., using preferred pronouns, giving space on clinic paperwork to distinguish between sex assigned at birth and gender)?
 - b. How would the clinic address psychological concerns, including depression and suicidal thoughts?
 - c. How would the clinic address issues of official identification – that is, transgender people whose legal documents do not reflect their gender identity?
 - d. How would the clinic limit financial barriers for transgender people?
 - e. How would the clinic support transgender people who engage in sex work?
 - f. How would the clinic support transgender people who use drugs?
 - g. How would the clinic meet the needs of young transgender people (such as experiences of abuse from family)?

15. In your experience, how are transgender people treated if they are known or assumed to be transgender and present for HIV testing?
 - a. How is this different than the way that cisgender (someone whose gender identity is the same as the sex they were assigned at birth) people are treated?
 - b. How is this different than the way that other key populations (such as sex workers and MSM) are treated?
 - c. How is this experience different for trans women and trans men? Why?
16. In your experience, when a person known or assumed to be transgender tests positive for HIV, what information does a health care worker give on how to disclose their status to others (e.g., to a primary partner, clients, friends, family)?
 - a. Is that person given any information on how to handle a violent response when disclosing?
 - b. How is the information given to trans women and trans men different? Why?
 - c. How is the information given to trans women who engage in sex work different? Why?
17. In your experience, how is a transgender person treated if their community finds out that they are living with HIV (e.g., by other community members, by their partner)? Why?
 - a. How is this experience different for trans women and trans men? Why?
 - b. How is this experience different for trans women who engage in sex work? Why?
18. Transgender people experience high rates of emotional, physical, and sexual violence. How is the violence experienced different for trans women and trans men? Why?
 - a. How is this experience different for trans women who engage in sex work? Why?
19. How do transgender people view the violence perpetrated against them? Why?
 - a. How is this different for trans women and trans men? Why?
 - b. How is this different for trans women who engage in sex work? Why?
20. In your opinion, which group of perpetrators is most important to work with to decrease violence against transgender people (e.g., police, intimate partner, family, or community)? Why?
 - a. How is this different for trans women and trans men? Why?
21. Where do transgender people seek support if they experience violence (e.g., police, clinic, shelter, community-based organization)?
 - a. What are the differences in support seeking behavior between trans women and trans men? Why?
 - b. What about trans women who engage in sex work? Why?
 - c. Which of these sources of support is currently best able to support victims of violence?
 - d. What about this source makes it best?
 - e. How could people and organizations that provide support to trans victims of violence encourage them to seek HIV testing or HIV prophylaxis?
22. How do experiences of violence affect whether transgender people access HIV-related services?
 - a. How is this different for trans women and trans men? Why?
 - b. How is this different for trans women who engage in sex work? Why?
23. What would make HIV-related services more attractive and convenient to trans victims of violence? Why?
 - a. How is this different for trans women and trans men? Why?
 - b. How is this different for trans women who engage in sex work? Why?

Enabling Environment: Violence

[Interviewer read] This section focuses on violence. You may not know the answer to each question. Please feel free to skip any question you cannot answer.

18. Transgender people experience high rates of emotional, physical, and sexual violence. How is the violence experienced different for trans women and trans men? Why?
 - a. How is this experience different for trans women who engage in sex work? Why?



Enabling Environment: Laws and Policies

[Interviewer read] Are you aware of policies that affect transgender people? [If YES continue with this section, if NO, continue with the Conclusion section]

24. What laws or policies have been successfully used in courts to advocate for the rights of trans people in [Country]?
 - a. In what ways?
 - b. Why have these efforts been successful?

25. When advocating for support from the Government of [Country] for HIV-related key population programming, is it more difficult to get support for transgender people than more traditionally served key populations, such as sex workers or MSM? Why or why not?

Conclusion

26. Are there any other gender issues related to transgender people's use of HIV-related services that you think are important to discuss?

27. Do you have any questions or comments for me?

[Interviewer please read] Thank you for your time. Your answers will help to inform programs and services for transgender people in [Country].



APPENDIX 6

Sample interview guide [People who inject drugs]

GENDER ANALYSIS OF KEY POPULATIONS' ACCESS TO HIV PROGRAMS AND SERVICES

Interview Guide for Key Informants working with People who Inject Drugs

Archival number: _____	Location: _____
Date of interview: _____	Interviewer: _____
Start time: _____	Note-taker: _____
End time: _____	

[Interviewer please read] Thank you for your time. I am going to ask you some questions about gender-related barriers that people who inject drugs (PWID) face to living healthy and violence-free lives. I am going to focus on PWID's access to and use of HIV-related services. Your answers will be used to improve programs and services for PWID.

You have been selected to participate in this gender analysis because of your work with PWID in [Country]. Since this questionnaire is used with different types of stakeholders, you may not know the answer to each question. If you do not know an answer, please simply say "I don't know," and I will move to the next question.

When answering the questions, please recall that some PWID are quite empowered while others may struggle with many gender-related barriers. We are interested in improving programs and services for all PWID.

To which stakeholder group or groups do you belong? *[Interviewer please circle the group or groups that this informant represents.]*

- Representative from a PWID-led organization (REP)
- Health care worker who serves PWID (HCW)
- Program manager or funder who is familiar with programs for SWs (PROG)
- Government stakeholder or policy maker who works with SWs (GOV)

[Interviewer, if time is limited, prioritize relevant questions for informants based on each stakeholder group. If informants do not know or want to answer a question, they can skip it. Please write SKIP after any question that the participant chooses not to answer.]

Background

1. Who do you or your organization work with: women who inject drugs (WWID), men who inject drugs (MWID), and/or transgender people who inject drugs (TPWID)?

[Interviewer please circle the group or groups that the informant works with and then use this answer to determine which of the questions in this questionnaire are appropriate to ask. If a question does not begin with a specific PWID group, then it is appropriate to ask of all interviewees.]

WWID

MWID

TPWID

2. [For those working with MWID only] Why does your organization or program serve only MWID?

Enabling Environment: Gender-related Beliefs

3. Evidence shows that gender-related beliefs for how men and women should behave can harm PWID's well-being, particularly WWID, and keep them from accessing HIV-related services. Gender-related beliefs are not factual statements, but rather common beliefs held in a specific culture. I will now read some of the beliefs that were found in the literature. Please comment on whether you think each of these beliefs is widely held in [Country]. You can also say "I don't know" or change the statement to be more accurate.
 - a. [ALL] It is more acceptable for men to use drugs or be high than it is for women
 - b. [WWID] Women should take care of others (their partners and children) before they care for themselves
 - c. [WWID] WWID are not good mothers
 - d. [WWID] WWID should not be allowed to have children
 - e. [WWID] Women should not seek health care without permission from their partners
 - f. [WWID] A woman should inject drugs if her partner asks her to
 - g. [MWID] "Real men" don't seek health care services
 - h. [MWID] Only men inject drugs
 - i. [MWID] MWID are weak for giving in to addiction
4. [Interviewer, after each norm that the participant thinks is common in Country, please ask] How does this belief harm PWID?
5. Are you aware of any other harmful gender-related beliefs? If so, what are they?
6. Of all the gender-related beliefs we have discussed, which one is the most important to change to benefit WWID in [Country]? Why?
 - a. What could be done to change this belief?
 - b. Which gender-related belief is the most important to change to benefit MWID? Why?

[Interviewer read] As I mentioned at the start, the purpose of this interview is to learn more about how gender-related beliefs and inequalities are affecting access to HIV-related services for PWID in [Country]. The rest of the questions in this interview are to learn more about this issue.

Cascade: Identification and Reach

[Interviewer read] Are you aware of programs for PWID? *[If YES continue with this section, if NO, continue with the Testing, Diagnosis, and Treatment section]*

7. What do you think are the best ways to share information about HIV with PWID? Why?
 - a. How is this different for WWID and MWID? Why?
8. PWID have a range of needs beyond HIV services. What non-HIV services should an HIV-focused program offer to attract PWID? Why?
 - a. How should the services offered be different for WWID and MWID? Why?
 - b. Would these services also attract young PWID? Why or why not?
9. There are relatively few programs that focus on WWID in [Country]. In your opinion, what are the biggest gaps in programs for WWID?
 - a. How can these gaps be filled?
10. There are national campaigns to end violence against women. Do you think these campaigns are also preventing violence against WWID? Why or why not?

Cascade: Testing, Diagnosis, and Treatment

[Interviewer read] This section focuses on HIV testing and treatment. You may not know the answer to each question. Please feel free to skip any question you cannot answer.

11. Is knowing one's HIV status a priority for PWID? Why or why not?
 - a. Who or what is likely to encourage PWID to get tested? Why?
 - b. Who or what is likely to discourage PWID from getting tested? Why?

- c. Many PWID feel that they do not care. How could this misconception be addressed to improve service uptake?
 - d. How is this different for WWID and MWID? Why?
12. PWID often experience unique barriers to services. How would you design an HIV testing and treatment clinic to accommodate PWID's holistic needs?
 - a. How would it meet the holistic needs of all WWID?
 - b. How would it meet the holistic needs of young WWID?
 - c. How would it work around barriers that many women face, such as responsibilities at home?
 - d. How would it serve WWID who are mothers?
 - e. How would the clinic address WWID's fear of arrest?
 - f. How would it support WWID who engage in sex work?
 13. In your experience, how are PWID treated when they present for HIV testing?
 - a. How is this different than the way that people who do not inject drugs are treated?
 - b. How is this experience different for WWID and MWID? Why?
 14. Some PWID engage in sex work in order to pay for drugs. Are PWID routinely provided with counseling on how to limit HIV risk when engaging in sex work?
 - a. How is this different for WWID who engage in sex work and MWID who engage in sex work? Why?
 15. Some WWID learn their HIV status through antenatal testing. How do health care workers at antenatal clinics treat WWID that test positive for HIV?
 - a. What could be done to improve WWID's access to respectful maternity care?
 16. In your experience, when a PWID tests positive, what information does a health care worker give on how to disclose their status to others (e.g., to a primary partner, clients, friends, family)?
 - a. Is that person given any information on how to handle a violent response when disclosing?
 - b. How is the information given to WWID and MWID different? Why?
 17. In your experience, how is a PWID treated if their community finds out that they are living with HIV (e.g., by other community members, by their partner)? Why?
 - a. How is this experience different between WWID and MWID? Why?
 18. In your experience, for PWID living with HIV, who and what motivates them to seek treatment? Why?
 - a. Who and what discourages them? Why?
 - b. How is this different for WWID and MWID? Why?
 19. Do health care workers offering HIV-related services to PWID ask them if they have experienced violence? Why or why not?
 - a. [If YES] How?
 - b. What services or organizations do they refer PWID to?
 - c. How is this different for WWID and MWID? Why?

Enabling Environment: Violence

[Interviewer read] This section focuses on violence. You may not know the answer to each question. Please feel free to skip any question you cannot answer.

20. PWID experience high rates of emotional, physical, and sexual violence. How is the violence experienced by WWID different than that experienced by MWID? Why?
 - a. How is this experience different for PWID living with HIV? Why?
21. How do PWID view the violence perpetrated against them? Why?
 - a. How is this different for WWID and MWID? Why?

22. In your opinion, which group of perpetrators is most important to work with to decrease violence against PWID (e.g., police, intimate partner, family, or community)? Why?
 - a. How is this different for WWID and MWID? Why?
23. Where do PWID seek support if they experience violence (e.g., police, clinic, shelter, community-based organization)?
 - a. What are the differences in support seeking behavior between WWID and MWID? Why?
 - b. Which of these sources of support is currently best able to support victims of violence?
 - c. What about this source makes it best?
 - d. How could people and organizations that support PWID victims of violence encourage them to seek HIV testing or HIV prophylaxis?
 - e. How is this different between WWID and MWID? Why?
24. How do experiences of violence affect whether PWID access HIV-related services?
 - a. How is this different for WWID and MWID? Why?
25. What would make HIV-related services more attractive and convenient to PWID who are victims of violence? Why?
 - a. How is this different for WWID and MWID? Why?
28. Please share any laws or policies that are supportive of PWID.
 - a. How are they implemented?
29. Are there alternative measures, other than incarceration, when PWID are arrested for illegal possession?
 - a. How are these alternative measures different for WWID and MWID?
30. In what ways does the government's response to HIV reflect the importance of the health and rights of PWID?
 - a. Do PWID participate in national policy or other discussions?
 - b. [If YES] How are they treated at those meetings?
 - c. [If YES] Are PWID involved in the Global Fund Country Coordinating Mechanism? If so, how?
 - d. How is this different for WWID and MWID? Why?
31. When advocating for support from the Government of [Country] for key population programming, is it more difficult to get support for programming for WWID than for MWID? Why or why not?

Conclusion

Enabling Environment: Laws and Policies

[Interviewer read] Are you aware of policies that affect PWID people? [If YES continue with this section, if NO, continue with the Conclusion section]

26. Possessing or using narcotic drugs is illegal in [Country]. How is enforcement of this law different for WWID and MWID? Why?
 - a. Are there advocacy attempts to change this law? What are they?
27. What is the impact of the criminalization of injecting drugs on HIV service uptake?
 - a. How is this different for WWID and MWID? Why?
32. We focused on WWID and MWID throughout this questionnaire. Are there any issues you think it is important to discuss regarding transgender people who inject drugs?
33. Are there any other gender issues related to PWID's use of HIV-related services that you think are important to discuss?
34. Do you have any questions or comments for me?

[Interviewer please read] Thank you for your time. Your answers will help to inform programs and services for PWID in [Country].

APPENDIX 7

Sample focus group guide [Gay men and other men who have sex with men]

GENDER ANALYSIS OF KEY POPULATIONS' ACCESS TO HIV PROGRAMS AND SERVICES

Focus Group Discussion Guide for Gay Men and Other Men who Have Sex with Men (MSM)

Archival number: _____	Location: _____
Date of focus group: _____	Moderator: _____
Start time: _____	Note-taker: _____
End time: _____	Number of participants: _____

[Moderator please read] Thank you for your time. My name is _____, and this is my colleague _____. We're both part of the LINKAGES project. Today, I am going to ask you some questions about gender-related barriers that gay men and other men who have sex with men (MSM) face to living healthy and violence-free lives. I am going to focus on MSM's access to and use of HIV-related services. Your answers will be used to improve programs and services for MSM.

By gender I mean the economic, social, and political roles, responsibilities, and rights associated with being female, male, or transgender as well as the power relations between and among genders in a given culture. An example of a gender-related barrier to HIV services for MSM could be a clinician that does not treat him respectfully because he has same-sex sexual relationships.

We are not asking for your specific stories; please do not use any names. We are asking about things that you have heard of or know to be happening. If you feel uncomfortable at any time you can leave.

Participation in the focus group is completely voluntary, and you do not have to answer any questions that you do not want to answer. We have nothing to offer other than listening; there will be no other direct benefits related to this time we spend together today.

We do not want your names and will not be writing your names down. We will not present any other potentially identifying information in anything that we produce based on this discussion. We will treat everything that you say today with respect, and we will only share the answers you give as general answers combined with those from all the people who speak to us. We ask that you keep everything confidential, too. Please do not tell others what was said today.

We will be audio recording this focus group, and _____ will be taking notes to make sure that we accurately capture the discussion. We really want to hear what you have to say, and I want you to answer my questions however you want. There is no wrong answer to any question.

I expect our discussion to last for a maximum time of _____.

Do you have any questions before we begin?

May I have your permission to turn on the tape recorder and begin the focus group?

[Moderator turn on the tape recorder if permission granted.]

Group agreement about participant conduct

[Moderator ask the group to suggest some ground rules for participant conduct. After they brainstorm some, make sure the following are on the list.]

1. Respect and value that everyone is different and will think differently about things.
2. Listen to each other.
3. Do not interrupt each other.
4. Information provided in the discussion must be kept confidential.
5. You do not have to share any personal information about yourself.
6. Turn off cell phones.

Warm-up Questions

[Moderator skip warm-up if time is limited]

[Moderator read] First I would like to ask you a general question about MSM living in [Country].

1. How do MSM spend their time in [Country]?

Enabling Environment: Gender-related Beliefs

[Moderator read] As I mentioned at the start, the purpose of this focus group is to learn more about how gender-related beliefs and inequalities are affecting access to HIV-related services for MSM in [Country]. The rest of the questions in this focus group are to learn more about this issue.

2. Evidence shows that gender-related beliefs for how men and women should behave can harm MSM's well-being and keep them from accessing HIV-related services. Gender-related beliefs are not factual statements, but rather common beliefs held in a specific culture. I will now read some of the beliefs that were found in the literature. Please comment on whether you think each of these beliefs is widely held in [Country]. You can also say "I don't know" or change the statement to be more accurate.
 - a. A man should have children to carry on his legacy
 - b. "Real men" do not seek help including from health care workers unless they are very ill
 - c. Men degrade themselves when they behave in a feminine way

- d. Men prove their masculinity by having many sexual partners
- e. A man who is the bottom in anal sex is less manly than the partner who is the top
- f. Violence against MSM can "cure" them
- g. Only women can experience violence from their partners

3. *[Moderator, after each norm that participants think is common in Country, please ask]* How does this belief harm MSM?
 - a. Why?
 - b. What could be done to change this belief?
4. Of all the gender-related beliefs we have discussed, in your opinion, which one is the most important to change to benefit MSM in [Country]?
 - a. Why?
 - b. What could be done to change this belief?

Cascade: Identification and Reach

[Moderator read] Now I would like to ask you questions about programs for MSM in [Country].

5. What are existing HIV-focused programs that are attractive and convenient for MSM?
 - a. How, if at all, do they make services welcoming to MSM who are not "out"?
 - b. How, if at all, do they make services welcoming to young MSM?
 - c. How, if at all, do they deal with any financial barriers MSM may face?
6. How can HIV-focused programs be made more attractive and convenient for MSM?
 - a. How can they be made more attractive and convenient for MSM who are not "out"?
 - b. How can they be made more attractive and convenient for young MSM?
7. What do you think are the best ways to share information about HIV with MSM?
 - a. Why?
 - b. Are these the best ways to share information with MSM who are not "out"? Why or why not?
 - c. Are these the best ways to share information with young MSM? Why or why not?

8. MSM have a range of needs beyond HIV services. What non-HIV services should an HIV-focused program offer to attract MSM?
 - a. Why?
 - b. Would these additional services also attract MSM who are not “out”? Why or why not?
 - c. Would these additional services also attract young MSM? Why or why not?

Cascade: Testing, Diagnosis, and Treatment

[Moderator read] Now I would like to ask you questions about HIV testing, diagnosis, and treatment among MSM in [Country].

9. Thinking about the MSM you know, is knowing one’s HIV status a priority for MSM?
 - a. Why or why not?
 - b. Who or what is likely to encourage MSM to get tested? Why?
 - c. Who or what is likely to discourage MSM from getting tested? Why?
10. Thinking about the MSM you know, are they able to access HIV-related services that meet their needs?
 - a. Why or why not?
11. Without mentioning any names or indicating anyone specific, how do health care workers treat men who they think are MSM when they access HIV-related services?
 - a. How is this different than the way they treat other men?
 - b. Are MSM who are bottoms treated differently than MSM who are tops? Why or why not?
 - c. Are MSM who have a more feminine gender expression treated differently than MSM who have a more masculine gender expression? Why or why not?
12. Thinking about MSM you know, if an MSM tests positive, what information does a health care worker give him on how to disclose his status to others (e.g., to his primary partner, friends, family, or other MSM)?
 - a. What information would be useful to him?
 - b. Is he given information on how to handle a violent response when disclosing?

13. Thinking about MSM you know, who or what motivates MSM living with HIV to seek treatment?
 - a. Why?
 - b. Who or what discourages MSM from seeking treatment? Why?
14. Without mentioning any names or indicating anyone specific, how is an MSM treated by other MSM if he is believed to be living with HIV? Why?

Enabling Environment: Violence

[Moderator read] Now I would like to ask you a few questions about violence that MSM experience in [Country]. Everything that you say will be kept private, and you may skip any questions you do not want to answer. May I continue?

15. MSM in [Country] experience high rates of emotional, physical, and sexual violence. How is the violence experienced different for sub-populations of MSM (e.g., young vs. old, out vs. not out, feminine vs. masculine gender expression)?
 - a. How do MSM view the violence perpetrated against them? Why?
 - b. How is violence against MSM perceived by the general public? Why?
16. Without mentioning any names or indicating anyone specific, in your opinion, which group of perpetrators is most important to work with to decrease violence against MSM in [Country] (e.g., police, intimate partner, family, or community)?
 - a. Why this group?
17. Thinking about MSM you know, how does living with HIV affect MSM’s risk of violence?
18. Many MSM do not seek support after experiencing violence. Without mentioning any names or indicating anyone specific, where do MSM who do seek support go after experiencing violence?
 - a. What information or services are provided to SWs who seek support after experiencing violence?
 - b. What additional knowledge or resources do these sources of support need to be able to help MSM who have experienced violence?

19. Thinking about MSM you know, how do experiences of violence affect whether MSM access HIV-related services?
20. What would make HIV-related services more attractive and convenient to MSM victims of violence?
 - a. How can they be made more attractive and convenient for MSM who are not “out”?
 - b. How can they be made more attractive and convenient for young MSM?

Enabling Environment: Laws and Policies

[Moderator read] Now I would like to ask you questions about laws and policies that affect MSM in [Country].

21. How does criminalization of same-sex sexual relations affect MSM's access to HIV-related services?
 - a. What other laws or policies have a negative impact on MSM's access to services?
 - b. [If laws or policies identified] How have they impacted MSM's access to services?
22. What laws or policies have a positive impact on MSM's access to services?
 - a. How have they impacted MSM's access to services?

23. Despite the illegality of same-sex sexual relations in [Country], how has the government successfully partnered with MSM communities?
 - a. Do MSM participate in national policy or other discussions?
 - b. [If YES] How are MSM treated in those discussions?
 - c. Are MSM involved in the Global Fund Country Coordinating Mechanism?
 - d. [If YES] How?

Conclusion

24. Are there any other gender issues related to MSM's use of HIV-related services that you think are important to discuss?
25. Do you have any questions or comments for me?

[Moderator please read] Thank you for your time. Our discussion today will help to inform programs and services for MSM in [Country]. Please remember that you agreed to keep this discussion to yourself. If anyone would like to speak to _____ or me in private, we are happy to talk to you.

APPENDIX 8

Data analysis matrix template and sample

INSTRUCTIONS:

If you are using an Excel workbook, we recommend using one workbook for one key population with each spreadsheet in the workbook representing a key informant type. For example, a workbook on people who inject drugs (PWID) could include spreadsheets summarizing data from all program managers and funders in one spreadsheet and all health care workers in another spreadsheet. In addition, you can summarize data from all informants in an “ALL” spreadsheet. This will allow you to look at the similarities and differences within and between key informant types.

You can briefly summarize what each informant said in the “Content” column and capture additional detail and supporting quotations in the “Justification and Quotes” column.

Based on the summaries in the “Content” and “Justification and Quotes” columns, you can identify and define recurring themes and capture them in the “Theme” column.



Key populations served (SWs, MSM, Trans, PWID):

Key informant group (CBO, HCW, PROG, GOV):

Category	Content	Theme	Justification and Quotes
DOMAIN			
Enabling Environment: Gender-related Beliefs			
Most common beliefs			
Common harms from beliefs			
How to address these beliefs			
Observations			
Cascade: Identify & Reach			
Barriers			
Opportunities			
Recommendations from key informants			
Observations			
Cascade: Test & Diagnose			
Barriers			
Opportunities			
Recommendations from key informants			
Observations			
Cascade: Treat			
Barriers			
Opportunities			
Recommendations from key informants			
Observations			
Enabling Environment: Violence			
Barriers			
Opportunities			
Connections between violence and HIV service uptake			
Recommendations from key informants			
Observations			
Enabling Environment: Laws and Policies			
Barriers			
Opportunities			
Recommendations from key informants			
Observations			
Overall reflections			

SAMPLE DATA ANALYSIS MATRIX: FEMALE, MALE, AND TRANSGENDER SEX WORKERS

Key populations served (SWs, MSM, Trans, PWID): SWs

Key informant group (CBO, HCW, PROG, GOV): ALL

Category	Content	Theme	Justification and Quotes
DOMAIN			
Enabling Environment: Gender-related Beliefs			
Most common beliefs	Belief I. Men degrade themselves when they behave in a feminine way.	Differences in value (fem/masc)	5/5 REP, 3/3 PROG, 5/5 REP and 8/8 GOV answered gender norm questions. Mentioned by all 4 categories of key informants: 4/4 REP, 2/2 PROG, 4/4 HCW, 8/8 GOV [Total: 18/18] Identified as the most harmful belief to MSW by 4 categories of key informants: 3/4 REP, 2/2 PROG, 4/4 HCW, 2/8 GOV [Total: 11]
	Belief G. Men should have control over their partners' behavior, including who she has sex with and how (for example, whether a condom is used).	HIV risks, Access to assets	Mentioned by all 4 categories of key informants: 4/4 REP, 3/3 PROG, 4/5 HCW, 8/8 GOV [Total: 19/20] Identified as the most harmful belief to FSW by 3 categories of key informants: 1/3 PROG, 1/5 HCW, 1/8 GOV [Total: 3]
	Belief C. A woman's sexual behavior reflects her morals.	Lack of understanding	Mentioned by all 4 categories of key informants: 3/4 REP, 3/3 PROG, 4/5 HCW, 8/8 GOV [Total: 18/20] Identified as the most harmful belief to FSW by 1 category of key informants: 1/3 PROG [Total: 1]
	Belief F. Female sex workers are bad mothers.	Lack of understanding	Mentioned by all 4 categories of key informants: 3/4 REP, 3/3 PROG, 4/5 HCW, 7/8 GOV [Total: 17/20] No category of key informants identified this as the most harmful belief to FSW.
	Belief D. "Women who sell sex deserve to experience violence because they are acting immorally" was identified as one of the most harmful beliefs. However, it was not listed among the most common.	Beliefs and attitudes among KPs that impact health seeking behavior, Violence	Mentioned by all 4 categories of key informants: 4/4 REP, 1/3 PROG, 4/5 HCW, 7/8 GOV [Total: 16/20] Identified as the most harmful belief to FSW by 3 categories of key informants: 2/5 REP, 2/5 HCW, 4/8 GOV [Total: 8] Identified as the most harmful belief to MSW by 1 category of key informants: 1/8 GOV [Total: 1]
	Belief J. "It is OK for violence to occur against men who are bottoms" was identified as one of the most harmful beliefs. However, it was not listed among the most common.	Differences in value (fem/masc), Violence	Mentioned by all 4 categories of key informants: 4/4 REP, 1/2 PROG, 2/4 HCW, 7/8 GOV [Total: 14/18] Identified as the most harmful belief to MSW by 1 category of key informants: 5/8 GOV [Total: 5]
	Belief H. "A woman should take care of those around her (husband, children), even if it means forgoing care for herself" was identified as one of the most harmful beliefs. However, it was not listed among the most common.	Beliefs and attitudes among KPs that impact health seeking behavior	Mentioned by all 4 categories of key informants: 4/4 REP, 2/3 PROG, 2/5 HCW, 8/8 GOV [Total 16/20] Identified as the most harmful belief to FSW by 1 category of key informants: 3/8 GOV [Total: 3]
	Belief A. "Sex workers are cursed" was identified as one of the most harmful beliefs. However, it was not listed among the most common.	Lack of understanding	Mentioned by all 4 categories of key informants: 4/5 REP, 3/3 PROG, 3/3 HCW, 4/8 GOV [Total: 14/19] Identified as the most harmful belief to FSW by 1 category of key informants: 1/3 PROG [Total: 1] Identified as the most harmful belief to MSW by 1 category of key informants: 1/8 GOV [Total: 1]
	Belief E. "It is OK for women to be beaten once in a while by their partners" was identified as one of the most harmful beliefs. However, it was not listed among the most common.	Violence	Mentioned by all 4 categories of key informants: 2/4 REP, 3/3 PROG, 5/5 HCW, 6/8 GOV [Total: 16/20] Identified as the most harmful belief to FSW by 1 category of key informants: 1/5 HCW [Total: 1]

Common harms from beliefs	SWs do not access health services due to fear (of outing of HIV-positive status), lack of ability to do so, and lack of adequate services.	Access to services, Beliefs and attitudes among KPs that impact health seeking behavior	Mentioned by 3 categories of key informants: 3/5 REP, 2/3 PROG, 3/4 HCW, and 4/8 GOV "I have seen some, not all sex workers refuse to be tested because they already expect to be positive" GOV_1
	Women engage in risky behavior such as sex work and unprotected/unsafe sex (e.g., being unable to negotiate safer sex, accepting higher payment for unprotected sex).	HIV risks	Mentioned by 2 categories of key informants: 4/4 REP and 2/3 PROG (lack of condom negotiation skills) "This also happens practically, men insist on unsafe sex and they give women a hard time when they are negotiating for safe sex." REP_SW_04 "I have to care for my children, if the client is willing to pay more I accept to do without protection." REP_SW_05
	SWs experience physical, sexual and verbal violence, including being called names, harassed, arrested, beaten up, raped and killed.	Violence, Discrimination	Mentioned by all 4 categories of key informants: 2/4 REP, 2/3 PROG, 5/5 HCW, and 3/8 GOV "It actually happens, they are beaten up and raped." REP_SW_04 "It is not just a belief. MSWs suffer violence." (no key informant identified)
	Beliefs about SWs affects their work.	Access to assets, Violence	Mentioned by 1 category of key informants: 2/5 REP
	SWs hide their identity (including from HCW who need their true information to provide proper service provision).	Being untrue to oneself to fit in, Beliefs and attitudes among KPs that impact health seeking behavior	Mentioned by 3 categories of key informants: 3/3 PROG, 3/4 HCW, and 4/8 GOV "Essentially for proper service provision the HCW needs to have the entire true information of whom the patient is because that will inform on the best approach to use in giving services." PROG_SW_02
	SWs suffer self-stigma and low self-esteem.	Depression and self-stigma	Mentioned by 2 categories of key informants: 2/5 HCW and 4/8
	Judgment of and discrimination against SWs. SWs are labeled as immoral, are excluded, and are disowned.	Discrimination, Rejection and isolation	Mentioned by 2 categories of key informants: 2/3 PROG and 4/8 GOV
How to address these beliefs	Sensitization targeted at the community and HCWs	Lack of understanding	Mentioned by all 4 categories of key informants: 2/4 REP, 2/3 PROG, 3/5 HCW, and 1/8 GOV
	Provide health education for SWs, including condom negotiation skills	Lack of understanding, HIV risks	Mentioned by 2 categories of key informants: 2/4 REP and 1/3 PROG
	Provide legal support to SWs, including advocacy for legal reform and with law makers	Laws and policies, Non-HIV service needs	Mentioned by 2 categories of key informants: 1/4 REP and 2/4 GOV
	Empower FSWs to protect themselves	Lack of understanding	Mentioned by 1 category of key informants: 2/5 HCW
	Empower SWs to stand up for their rights	Lack of understanding, Access to assets	Mentioned by 1 category of key informants: 1/4 GOV
	Connect SW movements with other human rights movements	Channels to connect and share information	Mentioned by 1 category of key informants: 1/3 PROG
	Economic empowerment	Non-HIV service needs	Mentioned by 2 categories of key informants: 1/3 PROG and 1/8 GOV (financial independence)
	Socialization process	Lack of understanding	Mentioned by 1 category of key informants: 1/3 PROG "What can be done to change this is by a socialization process, men in our society bear the burden of suffering if they are weak." PROG_SW_02

Observations	Beliefs lower SW's dignity in society. Further, there are different categories of SWs whose dignity/morality is viewed differently. For example, FSWs who are also housewives may be viewed as more dignified/moral.	Rejection and isolation	Mentioned by 1 category of key informants: 2/4 REP Belief C - a women's sexual behavior reflects her morals - "is not widely held but it depends on the category of SW, we have housewives that are SWs." REP_SW_03
	FSW have to work even when they are unwell due to the belief that a woman should take care of those around her, even if it means forgoing care for herself.	Beliefs and attitudes among KPs that impact health seeking behavior	Mentioned by 1 category of key informants: 2/3 PROG
	SWs accept violence and suffer silently.	Violence	Mentioned by 1 category of key informants: 5/5 HCW
	Several harmful effects of gender norms were mentioned including but not limited to not taking SWs seriously, stress leading to substance abuse, inability of SWs to take control of their lives or even express their needs, lack of use of condoms and neglect of self for others	Discrimination, Depression and self-stigma, HIV risk	Mentioned by 1 category of key informants: 1/8 GOV





ILLUSTRATIVE THEME GLOSSARY

THEME	Definition
Access to assets	Factors impacting one's ability to provide for themselves. Examples include access to jobs, including selecting higher risk employment because of a lack of other opportunities.
Access to services	Factors impacting key populations' ability to access health and nonhealth services.
Beliefs and attitudes among KP that impact health seeking behavior	Personal beliefs and attitudes of key populations that impact their health seeking behaviors.
Channels to connect and share information	The best ways to share information about HIV with key populations and to connect key populations to one another. Examples include peer-to-peer methods and social media.
Depression and self-stigma	Feelings of sadness, depression, or suicidality among key populations based on how they are treated by society.
Differences in value (fem/masc)	The ways in which people perceived as more feminine or more masculine are valued more or less than one another. This can include different values assigned to primarily receptive and primarily insertive partners.
Discrimination	Any form of arbitrary distinction, exclusion or restriction affecting a person, usually (but not only) because of an inherent personal characteristic or perceived membership of a particular group. Examples include failure to provide services or programs, intentional provision of low-quality services, unkind treatment, not hiring someone or befriending someone because they are seen as different (includes discrimination due to discomfort with a population).
HIV risks	Factors affecting key population's risk of HIV, including behaviors (such as multiple partners) and violence when it is explicitly linked to HIV risk.
KP engagement	Working with key population-led organizations and key population peers.
KP-friendly care	Care from medical providers and at clinics that includes appropriate language, is welcoming, and inclusive of key populations.
Lack of understanding	Poor understanding of a specific key population's needs and/or anything about that key population (in the case of transgender people). This can include the conflation of MSM and trans communities.
Non-HIV service needs	Examples of non-HIV services that an HIV-focused program should offer to attract KP. Examples include mental health care.
Violence	Examples include physical and sexual, harassment in public spaces, fear of violence, and perceptions of violence.

APPENDIX 9

Handout template and sample

Below is a handout template to highlight gender analysis findings and recommendations. A sample of a completed handout focused on female, male, and transgender sex workers from the Kenya gender analysis can be found on the following pages.



Findings			Recommendations
Harmful Gender-related Beliefs			Overarching Recommendations
Violence			
Sub-populations			
HIV Prevention, Care, and Treatment Cascade Findings			HIV Prevention, Care, and Treatment Cascade Recommendations
Identify & Reach 	Barriers	Opportunities	
Test & Diagnose 			
Treat 			
Law and Policy Findings			Law and Policy Recommendations
	Barriers	Opportunities	



SAMPLE FINDINGS AND RECOMMENDATIONS: FEMALE, MALE, AND TRANSGENDER SEX WORKERS

Findings	Recommendations
<p>Harmful Gender-related Beliefs</p>	<p>Overarching Recommendations</p>
<ul style="list-style-type: none"> • A woman's sexual behavior reflects her morals. • A woman should take care of those around her. • Female sex workers are bad mothers. • Men should have control over their partners' behavior. • Men degrade themselves when they behave in a feminine way. 	<ol style="list-style-type: none"> 1. Address gender-related beliefs directly by promoting discussions among sex workers on the ways that gender norms increase HIV risk and limit service seeking and by explicitly countering these beliefs in program messaging.
<p>Violence (which is associated with increased HIV risk and decreased service seeking and adherence)</p>	<ol style="list-style-type: none"> 2. Address violence at each stage of the HIV prevention, care, and treatment cascade.
<ul style="list-style-type: none"> • New sex workers (who are often young) experience more violence because they do not know their rights, do not have money to bribe police, do not know how to deal with clients, and lack knowledge about the sex work industry. • Sex workers living with HIV also have an increased risk of violence because they are perceived to spread HIV knowingly and are blamed by clients who contract HIV. • Reporting violence to police is rare, and compared to female sex workers, male sex workers are even less likely to report violence to police. • There is a lack of counseling, screening, and violence response services at HIV testing and counseling clinics (e.g., no information is provided on how to handle violence when a sex worker discloses their HIV status to a partner/client). • The most important perpetrators to work with to decrease violence against sex workers are the police because they are the main perpetrators, are easier to reach than clients, and are seen as potential allies in violence response/prevention. 	<ol style="list-style-type: none"> 3. Address the needs of the different populations of sex workers, including young sex workers, female sex workers, male sex workers, sex workers living with HIV, and people who sell sex but don't identify as sex workers. 4. Promote greater understanding, acceptance, and tolerance of sex workers in Kenya by broader society. 5. Be strategic. Female sex workers in particular are well organized and are at the forefront of effective key population programming. Continue to support efforts aimed at female sex workers while intentionally extending services to sex workers who may not be as well served, including male sex workers, transgender sex workers, sex workers who do not identify as sex workers, and individuals who are young or new to sex work.
<p>Segmentation (gender, age, identity)</p>	
<p>Although some sex workers feel empowered to advocate for their rights and are proud to be sex workers, those who do not identify as sex workers are not as likely as those who identify as sex workers to benefit from programs and services.</p> <ul style="list-style-type: none"> • Young sex workers and people who don't identify as sex workers are rarely reached by sex worker programs and lack information about programs and services. • Organizations providing services to sex workers fear being accused of promoting sex work among young people and may exclude young sex workers from programming. • There is limited knowledge about male sex workers, resulting in male sex worker programming that is not well planned, researched, or publicized. 	

HIV Prevention, Care, and Treatment Cascade Findings		HIV Prevention, Care, and Treatment Cascade Recommendations	
Identify & Reach 	Barriers <ul style="list-style-type: none"> Programs serving “women” in the general population are not serving female sex workers, which creates a missed opportunity and further marginalizes them. Sex worker programs targeting male sex workers are limited (male sex workers are often believed to be served by programming for men who have sex with men). When sex workers do not identify as such, including due to fear of arrest or internalized stigma, they are harder to reach. Even when sex workers identify as sex workers, they may avoid sex worker programs due to fear of others finding out they are sex workers. The same sex workers who are least connected to others (such as new and young sex workers) and most difficult to find are those who most need information and services. 	Opportunities <ul style="list-style-type: none"> The available programs for sex workers take a holistic approach (e.g., legal services, violence response services). Peer educators are effective messengers and peers are a source of encouragement to test. Rights education has been effective; female sex workers who have attended feel empowered to demand their rights. Sex worker programs are led by the community. 	<ol style="list-style-type: none"> Conduct more research on male sex workers in particular (with leadership/involvement from the sex worker community) to better understand the specific needs of male sex workers and how those needs are best addressed. Explicitly include female sex workers in initiatives for women – such as maternal and child health services or violence prevention in order to reach those who don’t identify as female sex workers. Build on existing successful programs and provide centralized safe spaces for sex workers to receive integrated services, including rights education and violence response services (e.g., psychosocial support, post-exposure prophylaxis, emergency contraception, and medical referrals and accompaniment). Foster peer education and peer-led support groups to promote discussion of the ways that gender norms increase HIV risk and limit service seeking and testing and provide support to individuals who have experienced violence. Link those at the margins of sex work (new and young sex workers) to older and more experienced sex workers that they can learn from. Work with the police and other stakeholders in the justice system to promote understanding of the human rights of sex workers, reduce violence, and increase protections and access to justice among sex workers.
	Test & Diagnose 	<ul style="list-style-type: none"> Inadequate strategies at hotspots to encourage HIV testing. Some female sex workers prioritize children’s and partner’s care over their own, limiting the time they spend accessing health care. Health care workers in most nonsex worker specific clinics do not understand sex worker issues (particularly male sex worker issues). Health care workers stigmatize and discriminate against sex workers, and sex workers do not share their risk factors with health care workers due to fear of judgement, identification, and arrest. Some sex workers miss clinic appointments in order to work, especially when hours of clinic operation are limited. There is limited counseling for sex workers on how to disclose their HIV status to partners/clients. 	<ul style="list-style-type: none"> It is a priority for both female and male sex workers to know their HIV status. Sex workers living with HIV are advised to bring their partners to the clinic for testing. Sex worker-friendly clinics offer holistic services (family planning counseling services, cervical cancer screening, and voluntary medical male circumcision). Programs are encouraged to have a violence prevention and response mechanism which allows for timely response and reporting of cases of violence (e.g., screening). NASCOP developed data collection and reporting tools.

HIV Prevention, Care, and Treatment Cascade Findings		HIV Prevention, Care, and Treatment Cascade Recommendations
Treat 	Barriers <ul style="list-style-type: none"> Sex workers living with HIV face an increased risk of violence or may lose clients, which can cause individuals to hide their status (and drugs) affecting adherence. 	Opportunities <ul style="list-style-type: none"> Female sex workers may be encouraged to adhere due to a desire to be healthy for their children. Sex workers may be encouraged to adhere because being healthy allows someone to earn more.
	Law and Policy Findings	Law and Policy Recommendations
	Barriers <ul style="list-style-type: none"> The Penal Code, the Sexual Offenses Act, and Nairobi City bylaws criminalize sex work and same-sex relationships; this criminalization legitimizes stigma, discrimination, and violence. 	Opportunities <ul style="list-style-type: none"> The Constitution of Kenya accords everyone basic human rights, including: the right to human dignity, the right to privacy, freedom and security of person, freedom of expression, and freedom of association.
		<ul style="list-style-type: none"> 18. Develop messages that encourage adherence that take motivations (regarding children and earning potential) into account. 19. Offer support groups for sex workers living with HIV to strategize with one another on how to handle violence and share experiences and use this as an opportunity to share resources on other violence response services. 20. Directly address stigma against sex workers living with HIV through messages targeted at other sex workers and delivered by peer educators.
		<ul style="list-style-type: none"> 21. Advocate for legal reforms that best support sex workers' health and rights, including a comprehensive strategy to address and monitor violence, discrimination, and exploitation of sex workers by police. 22. Offer rights education to sex workers to improve their knowledge of their legal and human rights and improve their access to services and justice to the fullest extent; connect sex worker organizations with human rights organizations.

APPENDIX 10

The nexus of gender and HIV brief excerpt

The four-part *Nexus of Gender and HIV among Key Populations*⁸ series (see **Figure 1**) highlights the key findings and recommendations from the Kenya gender analysis. It was developed to encourage and inform gender-integrated HIV prevention, care, and treatment programming for gay men and other men who have sex with men, people who inject drugs, sex workers, and transgender people in Kenya. For the full briefs, please visit the [LINKAGES country briefs and reports page](#) or click on **Figure 1**.

FIGURE 1: The nexus of gender and HIV among key populations series



An excerpt of the harmful gender-related beliefs most relevant to transgender people, the gender norms they stem from, and recommendations for gender accommodating and gender transformative research, policy, and programming can be found on the next page.

HARMFUL GENDER-RELATED BELIEFS MOST RELEVANT TO TRANSGENDER PEOPLE

- Transgender is the same as homosexual/gay.
- Transgender is a Western invention and not African.
- Transgender people are confused or mentally ill, and they need to be fixed or grow out of it.
- Transgender people are cursed or possessed.
- Trans women have degraded themselves by becoming women instead of remaining men.
- Violence toward transgender people is deserved; transgender people bring violence onto themselves.
- The most important thing about a trans woman is how she looks.

GENDER NORMS MOST RELEVANT TO THE GENDER-RELATED BELIEFS AFFECTING TRANSGENDER PEOPLE:

- Sex assigned at birth dictates gender identity and gender expression (i.e., transgender people either do not exist or are simply confused).
- Men are superior to women/masculinity is superior to femininity.
- Sexual orientation and gender identity/ expression are the same thing.
- A woman's value comes from her appearance.
- Violence against women is acceptable.

RECOMMENDATIONS FOR GENDER-ACCOMMODATING AND GENDER-TRANSFORMATIVE PROGRAMMING:

The IGWG Gender Equality Continuum Tool (see Figure 3) provides a way to think about different approaches to gender-integrated programs. A program should always strive to be “gender aware” and either “accommodating” or “transformative.” Conversely, programs should never deliberately be exploitative of harmful gender norms. The next page provides some examples of gender-accommodating and transformative recommendations for research, policy, and programs:

Gender accommodating

- **Train clinic staff to provide trans-competent care at strategically selected sites offering HIV services.** Advocate to the Ministry of Health for both in-service and pre-service training for clinicians so that they become familiar with who transgender people are. Have trained clinicians at locations that will not immediately “out” someone as transgender when they visit (e.g., if a transgender woman attends an MSM clinic, it will be clear that she is transgender). Clinical services could be offered at specific times to ensure trans-friendly providers are available. See LINKAGES Health Worker Training and the [TRANSIT](#).³²

FIGURE 2: The impact of gender norms on transgender people's vulnerability to violence, HIV risk, and service uptake

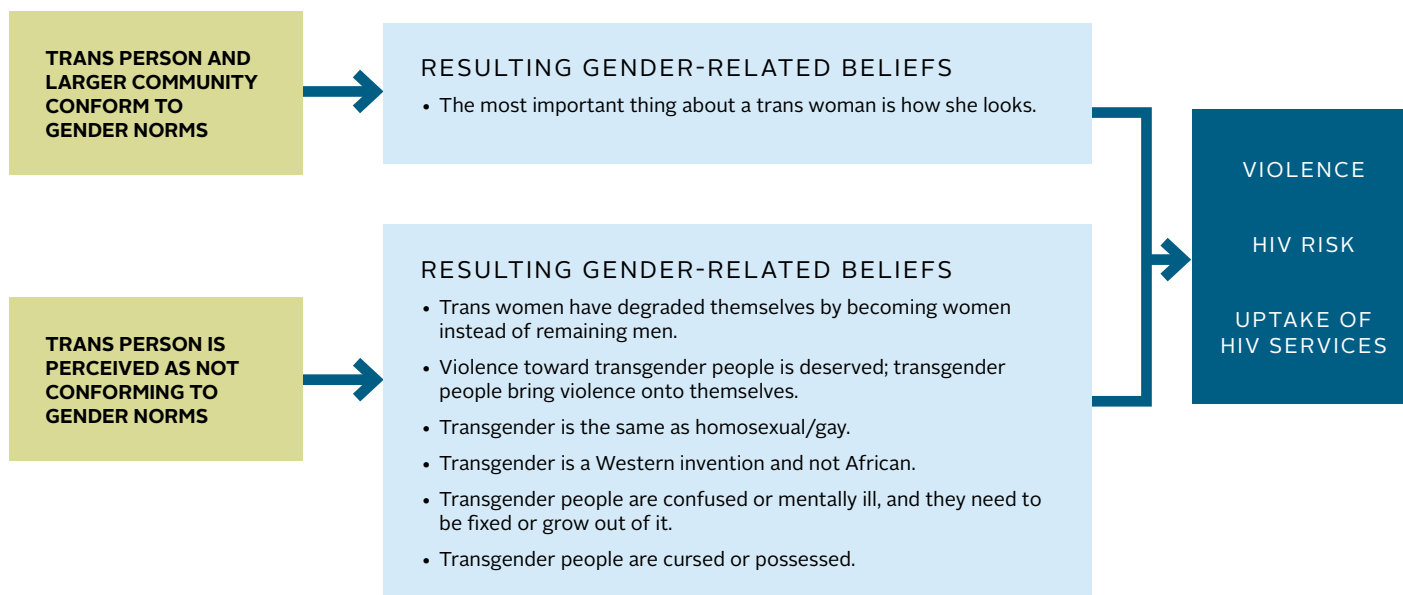
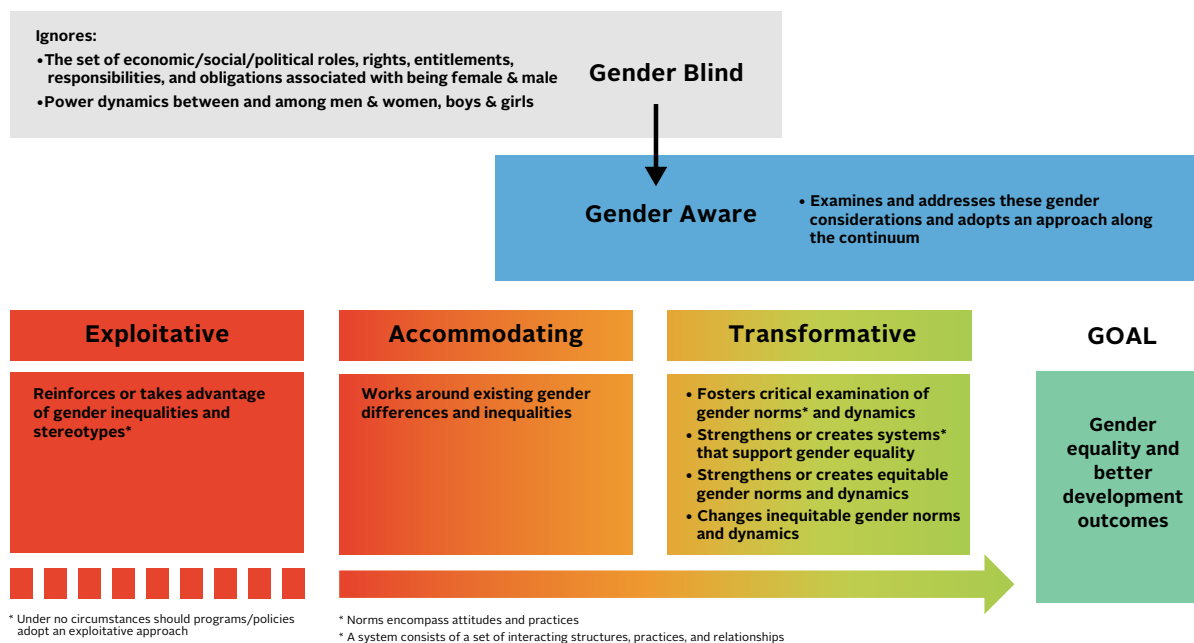


FIGURE 3: IGWG gender equality continuum tool

- **Provide support so that community-based organizations and health care facilities that transgender people already know and trust can offer HIV-related information and services.** Work with trans leaders and health care workers (including mental health workers) who support the transgender community to raise awareness about HIV as a concern. Provide access to trans-competent presenters who can come to these organizations and facilities and provide information and training on HIV prevention, care, and treatment. At the same time, HIV-focused program managers and providers should attend events put on or supported by trans-led community-based organizations to learn more about the community and learn from health care workers that transgender people already trust.
- **Integrate violence response services into HIV-related services for transgender people.** Train all those working with transgender people to provide first-line violence response and develop a network of referral services to meet the needs of transgender people who have experienced violence. Ensure that all referral points in the network, especially those that may be a first point of contact (e.g., the police), can share time-sensitive information on HIV services such as postexposure prophylaxis.

Document incidences of violence experienced by transgender people — including documenting them by gender (i.e., trans men and trans women) — and actions taken to address them. See *LINKAGES Violence Identification and Response Guidance and Training*.¹

- **Employ monitoring and evaluation that disaggregates key population programming data in a way that correctly identifies transgender people.** See [Recommendations for Inclusive Data Collection of Trans People in HIV Prevention, Care & Services](#)³⁵ for a two-step question that can collect accurate information and not discriminate against people whose sex assigned at birth is different from their gender identity.

Gender transformative

- **Include transgender people as a key population in the Kenya AIDS Strategic Framework** to promote their visibility and ensure that research and programming efforts with the transgender community are sufficiently funded.
- **Increase the provision of holistic care, including the provision of gender-affirming services (see Box 1), in clinical settings that offer HIV**

¹ The *LINKAGES Violence Identification and Response Guidance and Training* can be requested by writing to Giuliana Morales at gmorales@fhi360.org.

services. Services include contraception, mental health, and services addressing the specific needs of trans sex workers (e.g., pre-exposure prophylaxis), young trans people (e.g., economic strengthening), and transgender people living with HIV (e.g., addressing concerns about combining antiretroviral therapy with hormone therapy). Holistic service provision could be facilitated by developing memoranda of understanding with individual clinics that commit to providing trans-competent care. See the [TRANSIT](#).³²

Box 1. Gender-affirming services

- Information on transitioning (e.g., where hormones can be accessed, how to determine the required dosage, and the procedures that must be followed to transition in Kenya)
 - Information on how hormones interact with antiretroviral drugs
 - Provision of hormones or referrals to organizations that provide hormones
 - Referrals to organizations that provide legal services to transgender people (particularly around changing official identification)
- **Work directly with perpetrators of violence, such as the police, to prevent violence.** Training for the police should include information on ways that gender-related beliefs specifically condone or encourage violence and, ultimately, should counter the belief that transgender people deserve violence. See *Responsive Law Enforcement for HIV Prevention: A Manual for Training Trainers to Sensitize Police on Their Role in a Rights-based Approach to HIV Prevention among Key Populations*³⁶ for a Kenya-specific training resource.
 - **Explicitly discuss and challenge the gender-related beliefs that put transgender people at risk for HIV and violence as well as limit their uptake of services.** Use peer education to talk about where these beliefs come from, how gender-related beliefs affect individual and collective behavior, and how we can challenge harmful gender norms in our daily lives. At the same time, develop messages that reframe harmful gender-related beliefs to make them positive and conducive to service uptake. For example, use “Being true to yourself takes bravery” instead of “Transgender women have degraded themselves by becoming women instead of remaining men.”
 - **Invest in empowerment for transgender individuals and organizations.** Ensure that transgender people have a seat at the table when decisions about key populations are made and invest in capacity building for transgender-led organizations to ensure their full participation (see the [TRANSIT](#)³²). Build solidarity and encourage collective action by developing support groups for transgender people with common experiences (e.g., individuals living with HIV) and offering spaces where transgender community members can safely come together.
 - **Invest in community education and awareness, both inside the transgender community and with the broader community,** to promote greater understanding and acceptance of transgender people. In the process, directly counter the misinformation described under gender-related beliefs. Share these messages through outlets that transgender people already use, such as social media.
 - **Conduct further research, in collaboration with the transgender community, to estimate population size and inform programming for transgender people.** Use this information for advocacy, including data-driven decision making regarding the creation of a clinic that is exclusively for transgender people.

APPENDIX 11

Additional resources

GENDER ANALYSIS RESOURCES

TITLE	YEAR	AUTHOR
Toward gender equality in Europe and Eurasia: A toolkit for analysis	2012	Elizabeth Duban/JBS International
Gender assessment: Access to HIV services by key populations in Kyrgyzstan	2013	Lyn Messner & Tatiana Kazantseva/AIDSTAR-One Task Order 1
PEPFAR gender strategy	2013	PEPFAR
USAID ADS chapter 205: Integrating gender equality and female empowerment in USAID's program cycle	2013	USAID
PEPFAR Gender Analysis Technical Considerations ⁱ	ND	PEPFAR
A practical guide for managing and conducting gender assessments in the health sector	2013	Margaret Greene/Population Reference Bureau
UNAIDS gender assessment tool: toward a gender-transformative HIV response	2014	UNAIDS
Manual for conducting a gender analysis for microbicide introduction	2014	Michele Lanham, Elizabeth Doggett, Rose Wilcher, & Robyn Dayton/FHI 360
Compendium of gender equality and HIV indicators	2014	Shelah S. Bloom & Svetlana Negroustoueva/MEASURE Evaluation
Jhpiego gender analysis toolkit for health systems	2016	Jhpiego
Gender integration in Democracy, Human Rights, and Governance (DRG): programming toolkit	2016	Alyson Kozma/USAID

KEY POPULATION IMPLEMENTATION RESOURCES

TITLE	YEAR	AUTHOR	POPULATION
Implementing comprehensive HIV/STI programmes with sex workers: practical approaches from collaborative interventions (SWIT)	2013	WHO, UNFPA, UNAIDS, NSWP, World Bank	Sex workers
Implementing comprehensive HIV and STI programmes with men who have sex with men (MSMIT)	2015	UNFPA, MSMGF, UNDP, WHO, USAID, World Bank	Men who have sex with men
Implementing comprehensive HIV and STI programmes with transgender people: Practical guidance for collaborative interventions (TRANSIT)	2016	UNDP, IRGT, UNFPA, UCSF Center for Excellence for Transgender Health, JHSPH, WHO, UNAIDS, USAID	Trans people
Implementing comprehensive HIV and STI programmes with Injection Drug Users (IDUIT)	Forthcoming		People who inject drugs
Community Action and Leadership Collaborative (CLAC) resource library	Multiple	Multiple	Key populations

ⁱ The *PEPFAR Gender Analysis Technical Considerations* can be requested by writing to Giuliana Morales at gmorales@fhi360.org.

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