Exploring gender-based violence among men who have sex with men, male sex worker and transgender communities

in Bangladesh and Papua New Guinea

RESULTS AND RECOMMENDATIONS

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Executive Summary

Gender-based violence (GBV) is commonly thought of as an issue affecting primarily women and girls; however, stigma, discrimination and violence are also expressed toward men who have sex with men (MSM), male sex workers (MSW) and transgender (TG) individuals. While there is an increasing body of research among sexual minorities identifying the association between GBV and physical and mental health issues, including increased risk of contracting HIV, programs for these populations tend to focus on raising HIV awareness to reduce sexual risks. A better understanding of GBV among MSM/MSW/TG populations is necessary in order to develop clear and targeted recommendations for future interventions targeting this issue.

Methods

FHI 360 conducted a qualitative descriptive study using focus group discussions and in-depth interviews with MSM/MSW/TG community representatives and other key informants. The goals of this study were to explore the GBV-related issues; identify current programs, policies and donor funding as well as existing gaps; to explore potential interventions; and to provide recommendations for intervention design.

Data collection took place in Dhaka, Bangladesh and Port Moresby, Papua New Guinea between April and May 2011. A total of 143 individuals (including 115 MSM/MSW/TG) were successfully recruited for the study. Participants were purposively sampled to select information rich cases able to provide the study with in-depth and relevant information on the research topic domains. These domains included descriptions of the MSM/TG communities; descriptions of gender; community perceptions of MSM/TG people; partner perceptions and treatment; MSM/TG community experiences with healthcare services; and ideas for improving quality of life and future intervention strategies to reduce GBV against MSM/TG communities.

Key Findings

Study participants reported that MSM, MSWs and TGs in Bangladesh and PNG face numerous types of GBV, ranging from being teased by people on the street to being raped and murdered. We grouped the types of GBV reported by study participants into four types - physical violence, sexual violence, verbal violence and other types of violence. In both research sites, “other types of violence” were the most commonly discussed, emphasizing that while direct, easily identifiable (physical, sexual and verbal) violence directed at MSM/MSW/TG individuals is common in these settings, of equal importance are other, less obvious, and less easily categorized or defined forms of violence.

In this study, rarely did our participants face only one single form of gender-based violence; many individuals face multiple forms of GBV from various sources, indicating that multi-faceted interventions may be needed.

Gender-based violence was perpetuated against sexual minorities from a wide variety of sources, including one’s own family members and sexual partners, transactional sex clients, and community members. Two key sources of GBV were police officers and healthcare providers. Thus, participants in this study faced barriers to accessing some of the most common sources of protection or assistance.

The chief reason identified by study participants for gender-based violence toward sexual minorities was because these individuals have identities or exhibit behaviors which violate existing societal norms - for example, displaying feminine behaviors. Participants also stressed that MSM and TG individuals are often seen as weak and powerless by the general community and are often taken advantage of, especially as male-to-male sex is criminalized in both countries and there are insufficient legal safeguards to protect sexual minorities.

Finally, engaging in sex work was noted by participants in both Bangladesh and Papua New Guinea as a major cause of GBV toward MSM/TG individuals. Some participants described a vicious circle wherein members of marginalized communities find difficulty securing regular employment, and therefore turn to transactional sex which further reinforces their marginalization and vulnerability.

Participants were able to name a variety of programs and service providers in their communities working to either reduce the incidence of gender-based violence or to assist GBV survivors. Available services included healthcare and counseling services, human rights advocacy, legal support and skills training. However, they also listed numerous obstacles to effective implementation of GBV interventions and services, including religious beliefs and on-going political and legal barriers.

Recommendations

Several recommendations for future intervention targeting both a reduction in the incidence of gender-based violence and improved services to ameliorate the harm caused to GBV survivors are proposed as a result of this work. While recommendations were specific to the different contexts in the two research sites (and are therefore discussed separately in this report) there are a number of key recommendations which were consistent between Bangladesh and PNG:

- Greater advocacy in support of legal reforms to discourage gender-based violence, which in addition to prohibiting violence should also focus on promotion of the dignity and human rights of MSM/TG individuals as human beings
- Efforts to ensure enforcement of existing laws on violence through (for instance) policy-level advocacy and training for police agencies and officers, emphasizing their role as protectors of human rights
- Strengthening community awareness and mobilization with a particular emphasis on reaching key community leaders and other influential figures
- Integration of information, messages and services around reduction of gender-based violence into existing community-level programs disseminating HIV/AIDS/STI information
- Provision of services (including health services, counseling and temporary shelter) specifically targeting MSM/TG survivors of gender-based violence patients

This report discusses the above-mentioned findings and recommendations in much greater detail, and disaggregated by country. It is hoped that this document will provide an evidence base and strategic directions for organizations planning to launch GBV interventions or to strengthen existing GBV programs and services among the affected communities.

An Introduction to Gender-based Violence

Gender-based violence (GBV) refers to "any harmful act that is perpetrated against a person's will and that is based on socially ascribed (gender) differences between males and females." [1] While GBV is commonly thought of as an issue which has affected primarily women and girls [2, 3], a recent USAID report [4] illustrates that stigma, discrimination and outright violence are also expressed toward men who have sex with men (MSM), male sex workers (MSW) and transgender (TG) individuals because they contradict traditional male gender roles. Such forms of violence are based out of unfounded fear of homosexuals (homophobia) and from the belief that men are superior to women (sexism). Thus, this manifestation of violence toward MSM and TG persons can also be considered a form of gender-based violence.

Gender-based violence may include (physical, sexual, psychological or economic) intimate partner violence, sexual coercion/rape, or stigma and discrimination. GBV may also include state-sponsored violence (e.g. persecution of sex workers, MSM) and structural discrimination, such as an MSM/TG person being forced out of their family home (direct) or being treated in an insensitive manner by healthcare providers (indirect). In the past decade, data on such violence and its relationship with mental health issues and HIV risk behaviors among MSW/MSW/TG populations have been limited. However, there is now an increasing body of research identifying the different forms of gender-based harassment or violence, including coerced sex, and their association with physical and mental health issues such as suicidal behaviors, depression and social isolation [5-11].

In addition to the primary ill-health effects of GBV, experiencing such violence can have additional adverse effects for the victims, including substance use and engaging in sexual activities that put them at higher risk of contracting HIV and other STIs, as well as experiencing forced sex or being more likely to force sex on others. High levels of stigma and discrimination also serve as disincentive to practice prevention behaviors; for example, because individuals carrying condoms are viewed as sex workers, so condom availability decreases as individuals seek to avoid becoming stigmatized. Additionally, MSM and TG persons do not seek health care for fear of being discriminated against by health care workers, or, as a report commissioned by the Swedish Ministry of Foreign Affairs notes, they may be entirely unaware of their rights to enjoy access to health care services [12]. Low rates of uptake of health care services exacerbate HIV proliferation in the MSM population in particular.

GBV in the Asia Pacific Region

In the Asia Pacific region, violence and harassment among MSM, MSW and TG populations is monitored in some surveys, mainly through national HIV surveillance systems such as those in Indonesia, Laos, Cambodia, Bangladesh, Papua New Guinea and Thailand. While data are limited, what information does exist illustrates the magnitude of gender-based violence among MSM and TG populations: in Bangladesh, 36% of MSM, 28% of TG individuals (*Hijras*), and 45% of MSWs reported having been raped or beaten in the previous year[13]; in Thailand, 18% of MSM/MSWs/TG individuals reported a history of forced sex [5]; and in Pattaya (Thailand) 89% and 69% of TG people and MSM, respectively, reported having experienced violence as a result of their sexual identity and/or behavior [14].

Despite the apparently widespread nature of violence against members of these populations, where MSM/MSW/TG programs exist, they tend to be behavioral interventions relying mainly on raising

awareness of HIV and other STIs in order to reduce sexual risks. Gender-based violence and its consequences for MSM/MSW/TG populations are rarely addressed; most gender-based violence efforts to date have been focused on women and girls [2, 3], resulting in limited expertise and a lack of clear and targeted recommendations for conducting GBV interventions with other populations. It is therefore essential to gain a better understanding of this issue in order to inform the development of future behavioral interventions.

Study Objectives

The main objective of this study was to conduct formative research to explore issues related to gender-based violence among MSM, MSW and TG communities in Bangladesh and Papua New Guinea in order to provide recommendations to inform the design of future GBV interventions.

Specific study objectives were as follows:

1. To explore the GBV-related issues that MSM/MSWs/TG individuals face.
2. To identify current programs, policies and donor funding that exist to address GBV among the target population and the gaps that exist.
3. To explore potential interventions, including possible barriers and facilitators of these interventions, among the MSM/MSW/TG communities.
4. To provide recommendations for the design of future intervention programs related to addressing MSM/MSW/TG-specific GBV issues and to suggest ways to incorporate GBV-related activities into existing programs.

Study Design

A qualitative descriptive study was conducted in 2011 using 1) focus group discussions (FGDs) among MSM, MSWs and TG individuals, as well as; 2) in-depth interviews (IDIs) with key informants (e.g. community stakeholders from MSM, MSW and TG populations; representatives from community-based organizations who work with these populations; law enforcement officers; health service providers; legal service providers; managers and owners of establishments (e.g. bars, discos); key local policy-makers, and donors).

Data collection for this study took place at two sites: 1) Dhaka, Bangladesh; and 2) Port Moresby, Papua New Guinea. These countries were selected because a literature review identified GBV as an issue among MSM/MSW/TG communities in these settings and because there have been limited interventions to prevent GBV in these communities. There is also an interest on the part of funding agencies to develop GBV intervention programs as part of MSM programming in these sites.

Sample

For the purposes of this study, MSM were defined as "all men who have sex with other men, regardless of how they identify themselves (gay, bisexual, or heterosexual) [15]." Transgender individuals were defined as "people who were assigned a gender, usually at birth, based on their genitals, but who feel that this is a false or incomplete description of themselves [16]." In this study, transgender participants also self-identified as male-to-female transgender individuals, regardless of whether they had received sexual reassignment surgery. Sex work among male and transgender sex workers was defined as "the exchange of money or goods for sexual services, either regularly or occasionally, involving female, male, and TG adults, young people and children where the sex worker may or may not consciously define such activity as income generating [17]."

Participant categories for the study were selected to represent multiple perspectives. A summary of the data collection activities as well as the sample size for each participant category is shown in Table 1. The proposed maximum sample size was 172 participants for this formative research. The sample size was calculated to ensure the final sample would represent a variety of perspectives not only from among members of the target populations (MSM/TG/MSW) but also from key informants who work and interact closely with these populations. Purposeful sampling was employed so that information rich cases were selected. Information rich cases are cases that will be able to provide the study with in-depth and relevant information on the research topic domains. For key informants participating in the in-depth interviews, a type of purposeful sampling called maximum variation sampling was used to purposefully select a wide variety of cases to get variation in the phenomenon of interest. The sample size allowed for flexibility in the data collection process according to the needs of each site and the emergent findings. The sample sizes for the in-depth interviews and focus group discussions were also based on substantiated numbers for data saturation in qualitative data in applied research studies [18].

Table 1: Summary of Data Collection Activities and Maximum Sample Size

Type of data collection	Participant Category	Site	Number of IDIs/FGDs	Maximum Number of Participants	Actual Number of Participants
Focus Group Discussions (FGDs)	**MSM, TG and MSW**	Dhaka	9 FGDs (5 FGDs with MSM; 4 FGDs with TGs)	72	72
		Port Moresby	9 FGDs (5 FGDs with MSM; 4 FGDs with TGs)	72	43
In-depth Interviews (IDIs)	**Key informants** (e.g. community stakeholders from MSM/MSW/TG communities; representatives from community based organizations who work with these populations; law enforcement officers; health service providers; legal service providers; managers and owners of establishments; key local policy makers and donors)	Dhaka	14 IDIs	14	14
		Port Moresby	14 IDIs	14	14
Total number of participants				**172**	**143**

Recruitment of study participants

All study participants were aged 18 years or older, and FGD participants reported having had sex with a man in the previous year. For select FGDs, participants also self-identified as transgender (male to female), regardless of whether they have received sexual reassignment surgery.

Purposeful sampling was employed to ensure selection of information-rich participants who were able to provide in-depth and relevant information on the research topic domains. For key informants participating in the IDIs, a type of purposeful sampling, maximum variation sampling, was used to purposefully select a wide variety of cases, in order to achieve variation in the phenomena of interest [19].

For the FGDs and IDIs, each FHI 360 country office worked with local partner organizations to identify and recruit study participants through MSM/TG/MSW project staff, project activities and networks of professional contacts.

Data Collection

Interviews and focus group discussions were conducted in English or the local language (Bangla in Bangladesh, Tok Pisin in Papua New Guinea) and were guided by semi-structured question guides with open-ended questions and suggested probes. Data collection was carried out by consultants from partner organizations who (1) worked with MSM/TG/MSW populations; (2) were familiar with qualitative research techniques; and (3) were fluent in both the local language to be used for the FGDs and IDIs as well as English. Consultants audio recorded all FGDs/IDIs and transcripts were produced. The FHI 360 country office focal point for each country monitored the activities of the consultants.

Focus group discussions were conducted among MSM, MSW and TG participants. Eighteen FGDs were conducted across the two sites, with a maximum of eight participants per FGD to allow for interactive discussions among group members. Each FGD lasted from 2 to 2.5 hours, and all participants gave consent for audio-recording so that discussions could be recorded accurately.

FGDs were conducted according to a focus group guide (Appendix A) that included research domains around descriptions of the MSM/TG communities; descriptions of gender; community perceptions of MSM/TG people; partner perceptions and treatment; MSM/TG community experiences with healthcare services; and ideas for improving quality of life and future intervention strategies to reduce GBV against MSM/TG communities.

In-depth interviews were conducted with key informants, a category of participants which included community stakeholders from MSM/MSW/TG communities; representatives from community based organizations who work with these populations; law enforcement officers; health service providers; legal service providers; managers and owners of establishments (e.g. bars, discos); key local policy makers and donors. Fourteen IDIs were conducted at each of the two sites for a maximum of 28 IDIs. Each interview lasted between 1 and 1.5 hours, and all interviews were audio-recorded with participant consent.

IDIs were conducted according to an interview guide (Appendix B) that included research topic domains around the participant's role in the community; the participant's perspective on the TG/MSM community; interactions with the TG/MSM community; current/past programs addressing violence toward MSM/TG people; and recommendations for future intervention strategies to prevent GBV directed at this community. While there were general questions for all IDI

participants, there were also additional questions on selected topics for some IDI participants depending on the background, experience and expertise of the participant.

Data Analysis

Data from the in-depth interviews and focus group discussions were analyzed by country using qualitative thematic analysis methods (Ulin, Robinson & Tolley, 2005) by two FHI 360 data analysts. The analysts reviewed transcripts in English to be familiar with the interviews and focus group discussions, correct errors, and identify recurrent themes. Transcripts were then coded using QSR NVIVO, a qualitative data software program, to organize and prepare the data for analysis. The codes were assigned thematically using a codebook which was developed based on the study objectives, interview topic domains, and emergent themes. Intercoder reliability was assessed throughout the coding process.

After the transcripts were coded, textual coding reports were developed, including key sub-themes that emerged, noting differences and similarities between types of respondents and separating qualitative and quantitative aspects. Data were summarized with key findings and relationships between key themes highlighted, and an organizational structure was developed to relate data back to the study objectives. Data were written up by county in order to provide country-level recommendations for future interventions.

Ethical Considerations

The protocol for this study was reviewed and approved by the Protection of Human Subjects Committee of FHI 360 as well as the Bangladesh Medical Research Council and the Family and Sexual Violence Ethics Committee in Papua New Guinea.

Basic demographic information such as age, education, and occupation were collected for all FGD participants in this study using a demographic questionnaire (Appendix C for Bangladesh and Appendix D for Papua New Guinea); however, no names were collected from FGD participants, who were instead issued a unique participant ID number.

The names and contact information of key informants were collected with their permission, to facilitate contacting them regarding further questions or to provide a copy of the final study report. Consenting to provide a name was not a requirement for participation in the study.

Oral informed consent was obtained from each study participant prior to the IDI or FGD. All IDIs and FGDs were conducted in a private place to make it difficult for other people to listen to what was being said during the interview. All FGD participants were briefed prior to the discussions that all discussions held should not be discussed with others once the FGD was completed so as to protect confidentiality.

Findings

As discussed above, data collected through this study have been analyzed at the country level – results below are similarly reported by country to facilitate the development of recommendations for interventions/services preventing and/or ameliorating gender-based violence targeting MSM/MSW/TG communities which are appropriate to the local context in each country.

Bangladesh

Context in Bangladesh

Available research indicates that MSM/MSW and TG persons are the victims of sexual abuse and violence in Bangladesh, often at the hands of police; in one study roughly a third of MSW and transgender sex workers reported being involved in group sex against their will [20]. Breaking with traditional gender roles is often cited as the primary reason for such abuse.

A report issued by the Bandhu Social Welfare Society [21], which facilitates sexual and reproductive health services for sexual minorities in Bangladesh, noted that 64% (n=124) of MSM in that country reported some type of persecution from police. Group rape by police or gangsters (so-called *mastaan*) was common for MSM and *kothis* (term for receptive MSM), and 87% of respondents said that they were sexually assaulted because they appeared feminine.

A separate study, conducted among MSM and *hijra* (transgender persons) in the first half of 2008, reported very few instances of violence, and only two participants reported forced sex, but many acts likely go unreported [22]. Once again, the chief perpetrators of GBV were reported to be gangsters and police, who claimed they were "allowed" to rape MSM and *hijra* persons because these individuals contradict traditionally masculine gender roles.

Hijra in particular face stigma and discrimination throughout all parts of their lives, including potential exclusion by family members, difficulties finding and maintaining romantic relationships, and difficulty securing employment. They also face forced sex at early ages, usually by men they know, and because doctors do not understand *hijra* people or fear being associated with them, *hijra* do not have adequate access to healthcare [24].

The emphasis on masculine gender roles, and the expectation of heterosexual marriage, in this context means that many Bangladeshi MSM also have female sexual partners as a means to be culturally masculine, and may feel shame for their homosexual feelings [24]. While this type of internalized stigma is not itself gender-based violence as typically defined, it can precipitate GBV as well as increased risk of HIV infection. For instance, low rates of consistent condom

Text Box 1: Organizations cited as addressing GBV against MSM/TB Communities in Bangladesh

Ain O Shalish Kendra – legal services
Asha Alo Society – clinical, legal services
Bandhu Social Welfare Society – legal and clinical services including intensive counseling
Bangladesh Women's Health Coalition – social mobilization, campaigning
BHS (Badhan) – advocacy and clinical support
CARE Bangladesh – clinical and legal services
Cinno Mul – clinical services
Concern Worldwide – sensitization and community empowerment, coordination of and referral to GBV services, training, clinical and psychosocial services
Dhaka Medical College & Hospital – One-Stop-Crisis Management, emergency support, legal services
ICDDR,B (RCC) – clinical and counseling services
Light House – clinical and counseling services, harassment documentation
Manusher Janno Foundation – promotion of human rights, child protection, legal and sociao-economic development services
Marie Stopes – legal and clinical services for women
Modhumita – clinical and counseling services
Salahuddin Hospital – clinical services
Shakti Foundation – credit program, clinical, legal referral network for underprivileged women
Sharwardy Hospital – clinical, counseling
Shurjer Hashi [SC: Smiling Sun clinic]
Shustha Jibon – clinical, counseling, advocacy
UNICEF – training on GBV, gender mainstreaming into programming, GBV data collection systems in hospitals and police stations, One-Stop Crisis Center, production of IEC materials

use among *hijra* persist even after intensive interventions, and are in part the result of "low self-esteem induced by stigma and social exclusion" [25].

Demographics of FGD Participants in Bangladesh

A total of 72 MSM/MSW/TG individuals participated in nine FGDs conducted in Bangladesh. The mean age of participants was 27.4 years (range 18-50 years) and the sample was fairly evenly divided between participants who self-identified as men (n=17,23.6%), *Badhai hijra*[1] (n=16, 22.2%), *Kandari hijra* (n=16, 22.2%) and *kothi* (n=22, 30.6%). One participant self-identified as a woman (1.4%).

Nearly three quarters of participants had some degree of formal schooling but less than a full secondary education (n=52, 72.2%), while 6 participants (8.3%) had some post-secondary/tertiary education. Fourteen participants (19.4%) had no education. More than half of participants (n=43, 59.7%) reported having ever exchanged sex for money of gifts. In terms of employment, nearly half of all participants reported that they were sex workers (n=33, 45.8%) while 17 participants (23.6%) mentioned they were *Badhai Hijras* who perform baby blessings, dance, sing and collect tolls from shops.

Finally, among MSM, 76.9% reported that they only had sex with men while 20.5% reported sex with both men and women and 2.6% reported sex with both men and transgender partners. Among TG participants, all reported that they had sex with men only.

Table 2: Demographic profile of FGD study participants in Bangladesh (n=72)

Mean age, years (range)	27.4 years (18-50)
Self-identified gender, N (%)	
Man	17 (23.6%)
Women	1 (1.4%)
Badhai hijra	16 (22.2%)
Sex worker *hijra*	16 (22.2%)
Kothi	22 (30.6%)
Level of education	
None	14 (19.4%)
Some primary	7 (9.7%)
Completed primary	15 (20.8%)
Some secondary	30 (41.7%)
Completed secondary	0 (0%)
Some post-secondary/tertiary education	6 (8.3%)
Ever exchanged sex for money or gifts	
Yes	43 (59.7%)
No	29 (40.3%)
Employment*	
Sex worker	33 (45.8%)
Badhai (baby blessing, dancing, singing etc)	17 (23.6%)
Business	8 (11.1%)
Unemployed	5 (6.9%)
Healthcare worker	4 (5.6%)
CBO/NGO worker	4 (5.6%)
Hotel employee/owner	2 (2.8%)
Garment worker	2 (2.8%)
Others	7 (9.8%)
Sex partners within last year	
MSM	
Men only	30 (76.9%)
Both men and women partners	8 (20.5%)
Both men and transgender partners	1 (2.6%)
TG	
Men only	33 (100%)
* More than one employment type allowed	

GBV among MSM/TG People in Bangladesh

Study participants from both FGDs and IDIs reported that MSM, MSWs and TG people in Bangladesh face several different types of GBV, ranging from being

[1] *Badhai hijra* who participate in ritual performance

teased by people on the street to being raped and murdered, from a large range of different groups of people, ranging from boys on the street to religious leaders, police, and sex partners. We grouped the types of GBV reported by study participants into four types - physical violence, sexual violence, verbal violence and other types of violence (Table 3).

Table 3: Types of gender-based violence mentioned in transcripts

Total N=23 transcripts (5 MSM FGDs, 4 TG FGDs, 14 IDIs)

	Physical	Sexual	Verbal	Other GBV
Total[2]	21/23 transcripts	19/23 transcripts	13/23 transcripts	22/23 transcripts

The most common type of GBV reported by MSM/MSW/TG participants and key informants in Bangladesh was what is being described as "other" gender-based violence - stigma, discrimination, exclusion, harassment, blackmail, clients refusing to pay after having sex, rejection or non-acceptance by family or community members, disrespect, police ignoring GBV complaints, healthcare staff refusing to provide care, and humiliation. Participants also reported instances of theft and blackmail linked to their sexual identity or behavior:

> *They do blackmail repeatedly and take away my mobile, money and we have to manage this by giving money.* (MSM FGD, Bangladesh)

Physical and sexual violence were also widely reported and discussed – participants in 21 (out of a total of 23) transcripts cited instances of physical violence (including beating, burning, throwing stones, slapping, physically assaulting, physical torture, and killing); and sexual violence (including rape, forced sex with no condom, gang rape) was discussed in 19 out of 23 transcripts.

> *When we walk in the street, they throw stones at me, and the police beat us to our hip.* (MSW FGD, Bangladesh)

> *One day my friend was kidnapped and raped. Twelve-thirteen people raped him continuously. Terrible bleeding occurred and my friend became sick for a long time. He faced lots of problems getting the treatment.* (MSW FGD, Bangladesh)

Participants also cited numerous instances of verbal abuse (13 out of 23 transcripts) which included name-calling, teasing, insulting and gossiping about individuals.

> *The society hates me, use bad language.* (MSW FGD, Bangladesh)

Among transgender communities specifically, study participants reported incidents of gender-based violence similar to MSM. Transgender individuals also experienced physical violence (9/18 transcripts), sexual violence (8/18 transcripts) and verbal violence (7/18 transcripts) as well as various types of direct and indirect structural violence often relating to difficulties accessing necessary services.

> *At night, people throw stone at us from trucks and one of our friends died in an incident.* (TG FGD, Bangladesh)

> *Once I was returning after collecting from the bazaar, two men stopped me and proposed me for sex. I refused them for being sick but they picked me to the bazaar and 40 to 45 persons raped me! They did not pay me and took all my money.* (TG FGD, Bangladesh)

[2] Refers to the count of each unique transcript that mentioned each type of GBV. Each transcript is only counted once, but it should be noted that one transcript could have mentioned each type of violence more than once.

> *We do not get advantage like other people in the society. One day I was very sick and went to the [name of hospital] in Dhaka city. But they did not admit me because I am a TG. But when I offered 50 takas bribery they admitted me. We get service only for exchange of money. They know that we are uneducated and cannot protest against them. Our life is meaningless because nobody shows respect to us.* (TG FGD, Bangladesh)

One lesson which can be drawn from this is that, while incidents of direct, easily identifiable (physical, sexual and verbal) violence directed at MSM/MSW/TG individuals are distressingly common in this setting, of equal importance are the other, less obvious, and less easily categorized or defined forms of violence such as the stigma and discrimination that (for instance) deny these individuals access to necessary services, or prevent them from enjoying the support and protection of their families and communities.

It is also important to remember that rarely do sexual minorities in Bangladesh face only one single form of gender-based violence; many individuals face multiple forms of GBV from various sources which will require multi-faceted interventions to address.

> *Some of us have been victims of rape and sexual assault and beatings - look at this scar on my forehead. The* mastaan [gangsters] *hit me with a rod and I had to take 12 stitches. I was bleeding and I went to a public hospital in Uttara, but the doctor refused to touch me, he said to go away from here, we do not treat people like you. Thankfully there were other* hijras *who threatened the doctor and then they treated her out of fear that the* Hijra Guru [leader] *accompanying the group was literally ready to beat him up.* (TG sex worker FGD, Bangladesh)

Perpetrators of GBV against MSM and TG people in Bangladesh

Participants in this study identified a wide range of perpetrators of gender-based violence, ranging from one's own family and intimate partners to local gangsters and community members to the police and political/community/religious leaders who are ostensibly charged with protecting vulnerable members of society.

> *The general community members do not like it as if I have come close to live with him. They dislike living close to them and exclude us from all kinds of community affairs, like to be elected or work in local government or private institutions.* (MSM FGD, Bangladesh)

> *February of 2011, I went to [name of police station] Police Station for registration purpose on violence against one male sex worker. But the police did not pay any attention to register the incident and they tried to make fun when they heard the details and blamed us.* (Key informant, Bangladesh)

> *Once I went to decorate a marriage program and some young people beat me without any reason. I ask for justice to the local leader but they also beat me. Nobody wants to hear what a* Kothi *has to say.* (MSW FGD, Bangladesh)

One key source of GBV, reported by numerous participants, was that from healthcare providers (doctors and nurses) when MSM/TG individuals seek medical care, often in emergency situations and in response to instances of physical violence perpetuated by other members of the general population. In some cases, MSM and TG participants also reported healthcare providers sexually abusing the MSM/TG patients under their care, which likely makes members of these communities even less likely to seek healthcare when they need it.

> *Once a friend of mine was raped by 3 to 4 clients and was bleeding and he went to [name of hospital] for treatment. The receptionist, ward boy and others just heard him but did not even give a ticket and they told him to go where he belongs.* (MSW FGD, Bangladesh)

Encouragingly, participants also shared instances of banding together in groups and successfully bringing social pressure to bear on healthcare facilities to provide services for MSM/TG patients in emergency situations.

Reasons for GBV toward MSM/TG Populations in Bangladesh

Similar to previous research cited above, the chief explanation given by participants in this study for gender-based violence toward MSM/MSW/TG populations in Bangladesh was the existence of sexual identities and feminine behaviors exhibited by members of these populations that go against societal norms. Participants explained that because they violate these norms, they are viewed as unacceptable by the "general community."

> *The life of a* Hijra *is pathetic. Parents want him to grow up as male, but he loves to mix with girls. Siblings want to hide him due to his different behavior. When family members attend social gatherings like marriage, they do not want to bring her. Even the family members give her punishment to stop behaving like a girl. She does not get the chance to study. She always faces discrimination from the society. When she sees another independent* Hijra*, she desires to go with her. She thinks she has no freedom and cannot talk to anybody in this society. One day she leaves her parent's house and join the* Hijra *community.* (Key informant, Bangladesh)

Engaging in sex work was also cited as a major source of GBV, both from their clients and from the community at large. Some participants described what could be seen as a vicious cycle wherein an individual's social marginalization makes it more difficult for them to secure regular employment, wherein they engage in sex work as their only viable source of livelihood, which only further reinforces their marginalization and vulnerability.

> *Male sex workers obviously earn money by selling sex due to low economic status. Not only that, because of their feminized attitudes, they do not get good jobs and therefore get involved in the sex profession very easily. I am the great example of this kind of issues. I completed graduation degree and tried to get government and private jobs through interviews. But I did not get any job opportunity. Perhaps my feminine attitude makes everything unfriendly.* (Key informant, Bangladesh)

Participants also stressed that MSM and TG individuals are often seen as weak and powerless by the general community and are often taken advantage of, especially as there are insufficient legal safeguards to protect members of these communities. They cited specifically Section 377 of the Penal Code of Bangladesh, which criminalizes voluntary "carnal intercourse against the order of nature" as punishable with fines and/or life imprisonment. A report by the Sexual Rights Initiative indicates that there has never been a case tried under Section 377, but that it is primarily used to "bully *Hijra*, *Kothi* and LGBT [lesbian, gay, bisexual, transsexual] - identified communities [26]." Some participants additionally pointed to abuse of Section 54 of the criminal code, which allows the police to detain citizens without formal charges, as a tool for harassment and suppression of marginalized voices.

> *Local goons in the area treat us badly and with less respect, they beat us and take away the money just because we are weak and are not able to raise a finger against them; just because they are strong and are often backed by local corrupt politicians.* (TG sex worker FGD, Bangladesh)

Addressing GBV in Bangladesh

Participants in this study identified a wide range of organizations in Bangladesh working either to prevent occurrences of GBV or to provide services for victims (see Text Box 1). The types of interventions cited in the study included provision of health services (STI treatment, distribution of condoms/lubricant) and education on GBV; human rights advocacy including workshops with police, religious leaders and local administrators; legal support for victims of rape and physical abuse; post-GBV support; skills training; and violence reporting to raise awareness on the scope of the problem.

Despite the presence of numerous organizations working to reduce or ameliorate the effects of gender-based violence in Bangladesh, there remain numerous challenges to the effective implementation of GBV interventions and services. Challenges cited by participants in this study included ongoing stigma and discrimination by society, which discourages MSM/TG clients from actively seeking services and also makes members of these populations more hidden and difficult to reach; police, political and legal barriers (for instance, the above-mentioned Article 377), religious beliefs, and a lack of funding for programs and activities which target GBV among MSM/TG populations specifically.

Recommendations for future programs/interventions

Given the on-going legal and policy barriers to working with and providing services for MSM and TG communities in Bangladesh, many of the key recommendations made by participants in this study centered around the reform of legal policies and frameworks. Specifically, participants recommended **advocacy in support of laws that prohibit gender-based violence** and protect the dignity and rights of MSM/TGs as human beings. Participants also said that this advocacy should be carried out via news media, street dramas, seminars, meetings, and posters, in order to build public support for such legal reform.

> *Decriminalize the Article 377 and if possible should be repealed. Article 54 should be corrected and up to date with the human rights.* (Key informant, Bangladesh)

Participants also recommended **additional measure to ensure the enforcement of existing laws** on violence, including building police support for the prevention of GBV through training on MSM/TG human rights and their roles in protecting those rights, particularly where laws are supportive and well defined.

Participants also recommended **strengthening community awareness, outreach and mobilization efforts** in order to raise awareness of MSM/TG culture and history, inform MSM/TG individuals of their rights and educate them on how to exercise those rights – including how to claim their rights through the judicial system. They recommended **continuing and strengthening existing programs to disseminate information on HIV and STI** transmission and prevention, and expanding existing programs to include **job training and create job opportunities**, including establishing vocational training centers serving MSM/TG communities.

Finally, participants in this study recommended improvements to service delivery, including the creation of **health services specifically for MSM/TG patients**. There was also strong feeling that, rather than focusing exclusively on sexual health services for HIV prevention, service delivery should be expanded to **include services for victims/survivors of GBV** (safety planning, crisis intervention, legal services, support groups, counseling, safe havens and advocacy services). Participants also recommended that greater attention be paid to ensuring appropriate service provision, by **providing training for health care providers, counselors, lawyers, courts** and

others on information, knowledge and sensitization on MSM/TGs and technical skills to implement a range of services and support related GBV.

Papua New Guinea

Context in Papua New Guinea

There is relatively little research on gender-based violence among sexual minorities (MSM/MSW/TG persons) in Papua New Guinea, though violence and abuse towards women and girls is well documented [27]. Qualitative research has documented the presence of MSM behavior in some areas of the country ([28] as cited in [29]), though because of strong social and religious stigma, as well as laws criminalizing homosexual behavior, these communities tend to be quite hidden and difficult to reach.

Text Box 2: Organizations cited as addressing GBV against MSM/TB Communities in Papua New Guinea

FHI 360 - clinical, legal, and trauma counseling services

International Development Law Organization (IDLO) – legal services, training and capacity building on legal literacy

World Vision (PNG) - awareness raising and training, referral to clinical services

A recent behavioral surveillance survey conducted by FHI 360 using respondent driven sampling (RDS) in the national capital of Port Moresby sheds some light on violence perpetuated against MSM/TG communities in this context. MSM in that survey (n= 302) reported frequent discrimination within the previous year, including physical assault (57%), sexual abuse (58%), blackmail (18%) and being refused medical treatment (13%). Sources of GBV included police, *raskols*[3], regular sexual partners and relatives [30].

These findings are similar to another recent mixed-methods study conducted using RDS among sex workers in Port Moresby [31], which included in its final sample, 96 male sex workers and 56 transgender sex workers. In that study 52% of MSWs and 64% of TG sex workers reported having been physically abused in the last 6 months, while 47% and 57% respectively reported having been raped in that same time period. TG sex workers in particular reported having been physically or sexually abused by police.

Most MSM in PNG have not revealed their sexual orientation and/or behavior to their family (76%) or community (77%) because of fears of social exclusion – in the FHI 360 behavioral surveillance survey (BSS), the majority (63%) of those who had revealed their orientation had been excluded by their families, and 26% had been excluded by their communities. Additionally, 5% of MSM reported avoiding healthcare services because of their sexual orientation [30] – it is not known what percentage, due to non-disclosure of sexual behaviors, may have received inappropriate or inadequate care when they did seek a healthcare provider.

Papua New Guinea also has the highest reported HIV prevalence in the Pacific Islands region (approximately 0.8% of the adult population) and this relatively high prevalence has been linked to the persistence of GBV [27] though as of yet no link has been specifically made between HIV and GBV among TG persons and/or MSM in this setting, possibly due to the lack of research attention to this issue.

[3] Gangs of street youth

Demographics of FGD Participants in Papua New Guinea

A total of 43 participants were recruited for 9 focus group discussions, with a mean age of 26.1 years (range 18-34). The majority of participants self-identified as men (n=21, 49%) while 11 identified as women (25.5%) and 11 identified as male-to-female transgender individuals (25.5%). More than half of participants reported having at least some secondary or post-secondary education (n=26, 60%), while 11 participants (26%) had completed primary education, and the remaining six (14%) had some primary education. More than half of participants (n=28, 65.1%) reported having ever exchanged sex for money of gifts. Nearly half of all participants were unemployed (n=21, 48.8%), while the single largest category of employment was as an employee or volunteer of a community-based or nongovernmental organization (n=14, 32.6%).

Table 4: Demographic profile of FGD study participants in Papua New Guinea (n=43)

Mean age, years (range)	26.1 years (18-43)
Self-identified gender, N (%)	
Man	21 (49%)
Woman	11 (25.5%)
Transgender (male to female)	11 (25.5%)
Level of education	
Some primary	6 (14%)
Completed primary	11 (25.6%)
Some secondary	12 (27.9%)
Completed secondary	9 (20.9%)
Some post-secondary/tertiary education	5 (11.6%)
Ever exchanged sex for money or gifts	
Yes	28 (65.1%)
No	15 (34.9%)
Employment*	
Unemployed	21 (48.8%)
CBO/NGO employee	8 (18.6%)
NGO/outreach volunteer	6 (14%)
Business/office worker	2 (4.7%)
Student	2 (4.7%)
Sex worker	1 (2.3%)
Other	4 (9.3%)
Sex partners within last year	
MSM	
Men only	5 (20.8%)
Both men and women partners	19 (79.2%)
TG	
Men only	17 (89.5%)
Both men and women partners	2 (10.5%)
* More than one employment type allowed	

Finally, among MSM, 20.8% reported that they only had sex with men while 79.2% reported sex with both men and women. Among TGs, the majority (89.5%) reported sex with men only while only 10.5% reported sex with both men and women.

GBV among MSM/TG People in Papua New Guinea

Study participants from both FGDs and IDIs reported that MSM, MSWs and TGs in Papua New Guinea face several different types of GBV, ranging from being teased by people on the street to being raped, by a large range of different groups of people, ranging from boys on the street to police, and sex partners. We grouped the types of GBV reported by study participants into four types - physical violence, sexual violence, verbal violence and other types of violence (Table 5).

Table 5: Types of gender-based violence mentioned in transcripts

Total N=23 transcripts (5 MSM FGDs, 4 TG FGDs, 14 IDIs)

	Physical	Sexual	Verbal	Other GBV
MSM (n=19)	10/19	5/19	7/19	15/19
TG[4] (n=21)	12/21	10/21	11/21	18/21
Unclear (n=14)	2/14	1/14	2/14	8/14
Total[5] (n=23)	19/23	15/23	20/23	23/23

The type of gender-based violence against MSM and TG persons most commonly reported by participants in this study was what has been categorized as "other types of GBV," including stigma, discrimination, stealing from MSM/TG people, social exclusion, police refusing to file cases for MSM/TG people, clinic staff refusing services, and familial rejection. These types of GBV were reported in all transcripts (14 in-depth interviews and 9 focus group discussions) and included vague statements such as "MSM experience abuse", where it was not clear to what specific type of abuse participants were referring.

> *Sometimes the security guards at the health facility may know and identify a person to be MSM through their approach and then discriminate against them and inform the other health workers not to assist the MSM.* (MSM FGD, Papua New Guinea)

The next most commonly reported type of violence was verbal abuse (20 transcripts) which included name calling, swearing, degrading language, and insulting; this was followed closely by physical abuse (19 transcripts) which included beating, hitting, torturing, throwing stones, and punching.

> *Physical abuse such as beatings, torture and rape. Straight men tend to lure MSMs and have sex with them and then beat them and torture them and leave them in critical condition. Sometimes the beatings and torture can be fatal.* (MSM FGD, Papua New Guinea)

> *Some real women like to verbally abuse MSM persons and look for arguments with them, in which they like to call them names such as* kai kai kok *(cock sucker) or* lukim em arse kan *(look at yourself your anus is a vagina).* (MSM FGD, Papua New Guinea)

Finally, 15 transcripts mentioned that MSM or TG people face sexual violence including rape, forced sex with no condom, and gang rape.

> *A group of elderly men were drinking with an MSM. They later tricked and took the MSM to a community school and raped him.* (MSM FGD, Papua New Guinea)

It should be noted that, in most cases, FGDs conducted with MSM participants discussed gender-based violence toward both the MSM and TG communities; however, discussion in the TG FGDs focused exclusively on GBV toward their own community and the issue of violence toward MSM was not raised.

> *[Physical violence] happens when our steady partners get jealous, for example if a TG is in the night club and meets a man that he works with and says hello to this person then the steady*

[4] Although they were not specifically asked about TG communities, participants in three separate MSM FGDs mentioned violence against TGs

[5] Refers to the count of each unique transcript that mentioned each type of GBV. Each transcript is only counted once, but it should be noted that one transcript could have mentioned each type of violence more than once.

partner beats her up because he is jealous. It's just like a husband beating up his wife, the same for TG and her partner. (TG FGD, Papua New Guinea)

Most small children know who are TGs and they call out gay type *or* gay mahn *(homosexual). These children's ages range from four to seven years old, they can tell who is a TG, through the actions that the TG is doing.* (TG FGD, Papua New Guinea)

As can be seen in Table 5, the different categories of gender-based violence were raised as a topic of discussion more commonly among TG persons than among MSM. For example, ten transcripts mentioned that TG face sexual violence, whereas 5 transcripts mentioned that MSM face sexual violence. This should not, however, be understood as a measure of relative frequency of GBV within these respective communities; nor does this count reflect the degree to which GBV was discussed by the members of any specific FGD group once it was initially raised as a topic. Finally, it should be noted that key informants also discussed GBV against MSM and TG persons, but as it was sometimes unclear whether their comments related to MSM, TG individuals, or both, these comments in some cases were recorded under the "Unclear" category.

Perpetrators of GBV against MSM and TG people in Papua New Guinea

Overall, the most commonly reported perpetrators of GBV towards MSM and TG persons were community members (Table 5). This category included, for the most part, men, youth, groups of boys, or intoxicated men, but also included wives of the lovers of MSM, children, and university students. All 23 transcripts mentioned some kind of GBV towards MSM or TG people by community members.

I think the straight men, most of the straight men in the community, they verbally and physically hurt the TG. (TG FGD, Papua New Guinea)

Police were the next most commonly reported perpetrators of GBV (16 transcripts), and a common theme of focus group discussions was the unwillingness of many MSM and TG persons to seek police protection or legal redress in the case of physical violence or other violations of their rights, because the police would at best disregard their claims and at worst assault or blackmail them.

Most cases been reported at police stations have been unsuccessful because police persons see MSM person as different kind of human beings. Hence, when abuse is done upon to MSM persons most persons do not wish report because he/she knows that it would be down the drain. (MSM FGD, Papua New Guinea)

The police vehicle …blackmailed my sisters [TG people in drag] for sex in order to both release them and transport them to their homes. My sisters gave in and had sex with the policemen and later they were dropped off at their homes in [name of village] village. (TG FGD, Papua New Guinea)

Other perpetrators of gender-based violence mentioned by participants included sex partners (13 transcripts), health clinic staff (11 transcripts), and family members (10 transcripts).

Sometimes, a sex partner can harm an MSM when there is lack of sexual pleasure or activity. In addition, violence and harm may occur when an act or favor agreed upon is not fulfilled or carried out. (MSM FGD, Papua New Guinea)

Sometimes the security guards at the health facility may know and identify a person to be MSM through their approach and then discriminate against them and inform the other health workers not to assist the MSM. (MSM FGD, Papua New Guinea)

His own family (his cousins) threw kerosene on him; they were going to kill him. (Key informant, Papua New Guinea)

Reasons for GBV toward MSM/TG Populations in Papua New Guinea

The chief reason identified by study participants for gender-based violence toward sexual minorities in Papua New Guinea was because of their identities that go against societal norms - for example, having an alternative sexual identity that falls outside of traditionally accepted norms and, displaying feminine behaviors. Participants explained that members of the "mainstream" community either do not understand or do not accept them, commonly because of their sexual identity or sexual practices (11 transcripts), feminine behavior, or going outside of gender norms (11 transcripts), and because they engage in sex work (nine transcripts).

For an example, in the Highlands Region, most TG/MSM persons are in hiding due to their cultural background. In some cases, community members tend to gossip a lot about the sexual practices of MSM which eventually leads to trouble for the MSM being beaten or ridiculed by other community members. (MSM FGD, Papua New Guinea)

Violence experienced amongst MSM is real. It happens when the other person does not understand the other person's way of doing things like dressing up, way of socializing and also as a result of the other person's way of thinking. He/She thinks that he/she is smarter than the other and eventually becomes violent or abusive. (Key informant, Papua New Guinea)

It should be noted that explanations for GBV focusing on a lack of understanding or acceptance and/or because of feminine behaviors were more common among TG participants than among MSM. While these are not quantitative data, this discrepancy may in part be attributable to a greater visibility among members of TG communities and greater tendency to be openly nonconforming with regard to traditional gender roles.

Another common reason participants reported for GBV toward MSM/TG communities was a lack of legal rights for members of these communities, especially related to anal sex and sex work.

MSM persons are most vulnerable to blackmail and all sorts of abuse, because of less manpower or over powered by his/her partner who's dominant. Hence, whatever the dominant partner says the MSW will do it like sex without money or no condom use because the MSW person cannot retaliate to report the case. (MSM FGD, Papua New Guinea)

Other explanations for GBV included: that people think TG/MSM are weak, vulnerable, powerless (five transcripts), when TG/MSM refuse to have sex or refuse to do certain sex acts (five transcripts), and sex partners and sex work clients abuse them because they want to be dominant over MSM/TG (three transcripts).

Sex Work in MSM/TG Communities

The phenomenon of sex work within MSM and TG communities in PNG deserves special attention, both because of the widespread nature of this work and because it is frequently cited as a driver of gender-based violence toward MSM and TG individuals. In this study, sex work was the most commonly referenced source of livelihood for MSM and TG people, mentioned in 15 transcripts as opposed to informal employment (12 transcripts), formal employment (10 transcripts), and unemployment (three transcripts). MSM and TG reported engaging in sex work for three main reasons: for livelihood (to earn money or gain material goods), because they are marginalized and are not able to get other types of jobs, and for sexual pleasure.

> *The ones in city, they sell sex to make a living because they find it hard to apply for jobs because of their sexual identity. So the easiest way is to sell sex to earn a living.* (TG FGD, Papua New Guinea)

Participants noted that MSM/TG individuals face GBV from the mainstream population based on the perception (and often, reality) that they engage in sex work; however, this study also highlighted another important source of gender-based violence. Clients of sex workers were mentioned numerous times as perpetrators of GBV toward MSM and TG sex workers; as discussed above, this may in part be due to the lack of recourse to legal or police protection for MSM/TG sex workers.

"The clients who they meet along roads for one night stands or in the nightclubs, force themselves on TGs to have sex without the use of condoms." (TG FGD, Papua New Guinea)

"Some TGs get rape[d] after having sex with a partner (low-class men and unemployed youths). Because the TG asks for payment for having sex, after the partner having his way with the TG, these instances occur when there is no negotiation for payment is done prior to having sex." – (TG FGD, Papua New Guinea)

Addressing GBV in Papua New Guinea

Participants in this study were able to name a number of organizations working in PNG either to reduce the incidence of GBV or to assist victims of violence (see Text Box 2). The types of services discussed by participants included medical care (including HIV counseling and testing and management of sexually transmitted infections), liaison with police, sensitization work to reduce stigma and discrimination, and legal advocacy. Participants also made specific mention of policy advocacy around the decriminalization of homosexuality and sex work and, despite the identification of police in this study as key perpetrators of GBV, they were also noted by some participants as a resource with a duty and obligation to protect human rights.

It is worth noting that the majority of organizations specifically named were either international non-governmental organizations or locally branded projects administered by those organizations. This may in part be because the majority of participants were themselves representatives of these organizations, but it could also point to a dearth of locally funded and owned resources for addressing this issue.

Recommendations for future programs/interventions

There was considerable discussion among participants about the role of community education in preventing and responding to GBV, with some participants particularly stressing that this **education should focus on not only awareness but also advocacy for the human rights of MSM and TG individuals**. In addition to education among members of the community at large, some participants felt that programs should also attempt to **build relationships with key figures** including community gatekeepers and police liaison officers. Participants also felt that community leaders had a key role to play in this process, along with the government and NGOs, in showing people that GBV is a violation of human rights and should be stopped.

> *The government and other NGO's should host public forums to discuss issues on GBV experienced by MSM/TG/MSW and advocacy should be carried out by community members to make people aware about these issues.* (MSM FGD, Papua New Guinea)

Have a meeting together and have gate keepers, that are a technique you can use, build friends; these can include taxi drivers, security, and these people become the 'gate keepers.' When violence happens, these people can help. (TG FGD, Papua New Guinea)

Participants also discussed the need for MSM and TG individuals to be more "self-reliant" and suggested activities such as sporting competitions or other programs which could **bring MSM and TG communities together**. On the one hand, these comments can be seen as recognition of the importance of community solidarity and personal empowerment; on the other hand, several comments raised the specter of victim blaming as participants suggested that MSM and TG individuals bring violence upon themselves through their "unacceptable" behavior.

Educate the MSM persons to be self-reliant so as to avoid gender-based violence. In this way they keep themselves busy and stay out of trouble. (MSM FGD, Papua New Guinea)

A TG person must pay attention to the way they dress and carry themselves in public as this may trigger negative attention resulting in gender-based violence against them. 'If they respect themselves the community will respect them as well. (TG FGD, Papua New Guinea)

Sex work as a source of gender-based violence was also again raised, and in two FGDs there was discussion about **communication and negotiation skills for sex workers** as a way to prevent GBV. At least one participant also noted the role of alcohol in precipitating incidents of violence, though participants did not discuss strategies to limit or otherwise manage the effects of widespread alcohol use.

GBV occurs mainly when parties are under the influence of alcohol and do not listen to instructions. Communication and negotiation of sex acts between partners bring about more understanding. (TG FGD, Papua New Guinea)

Both community participants and key informants also stressed the need for **MSM/TG-specific clinical services** to be provided to them , whether through sensitized service providers or through dedicated service centers located in churches, NGOs or drop-in centers. This is so as to reduce stigma and discrimination and to have healthcare providers be trained to provide MSM/TG friendly services.

If we have this national organization, we would have our own clinic, our own counselors so the TG and the MSM they would feel more free to access these services. At the moment we have public[referring to public healthcare services] *and especially TG they get stigmatized if they want to access public services.* (Key informant, Papua New Guinea)

There are existing resources for female victims of gender-based violence in PNG, such as *Meri Seif Ples* or *Haus Ruth* shelters, and all focus group participants expressed a need for a similar service for MSM/TG communities. Some key informants, however, questioned the efficacy of this approach, and asked whether such centers are effective even for the women they are currently serving.

It is my opinion that the Meri Seif Ples concept at present still needs a lot of attention and work. (Key informant, Papua New Guinea)

Maybe all they need is a telephone hotline not such places, since all of us has phones. We need to ask them first and foremost what are their immediate needs. Best safe place is their community if the community understands. It is less costly than to throw someone in a house. (Key informant, Papua New Guinea)

In group discussions regarding future intervention strategies, MSM/TG participants tended to focus more on education and on individual-level service provision; a key theme of discussion with key informants, however, was the need for **legal reform to both remove laws criminalizing sexual behavior and to build a protective legal framework for sexual minorities**. Key informants also recognized a key role for police to play in protecting the person and rights of all Papua New Guinea citizens equally, rather than discriminating against or otherwise targeting vulnerable members of society.

> *Before any [new] laws should come in play; the Government should rescind the current law about MSM activities been illegal. It's a 19th Century law that was inherited from Queensland and it has rescinded it whereas PNG is still practicing it, which is old-fashioned and ridiculous.* (Key informant, Papua New Guinea)

> *The PNG Constitution provides for the rights and freedoms of all its citizens. However, there are no laws to protect TG and MSM persons; there are only laws protecting straight men and women or heterosexuals.* (Key informant, Papua New Guinea)

Finally, participants also noted a number of on-going challenges which they said limit the potential for reductions in gender-based violence in Papua New Guinea. For instance, key informants noted the difficulty in creating safe spaces and empowering individuals in a society that is overwhelmingly male dominated and where existing laws criminalize MSM and TGs. They also noted limited resources both to provide dedicated, sensitized services for MSM/TGs and to transport individuals to those services even if they existed - they said that many of the existing services for MSM and TG populations are focused on issues dealing with HIV, sexual behavior and alcohol and it is difficult to redirect them toward other issues. And finally, a key challenge was the widespread interpretation of Christian religious beliefs which condemn MSM and TG populations and thus could fuel discrimination and physical violence toward these individuals. It should be noted that, while this was mentioned as a key barrier to effective reduction of GBV, there was very little discussion among participants about ways to work effectively with religious communities or leaders, which may be a key question moving forward with intervention planning and implementation.

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Appendix A: TG/MSM/MSW Focus Group Discussion Guide

Introduction (to be read to the respondent)

Thank you for being able to meet with me today. As part of our research, we would like to understand more about transgender (TG), male sex workers(MSW) and men who have sex with men (MSM) (use appropriate local terms) persons in this community and the violence and abuse they face because of their identity. We will refer to this as gender based violence. We have chosen to speak with you all here because you have information about TG/MSM persons.

Please know that we are not asking you to share personal experiences, but you are welcome to share personal experiences if you are comfortable doing so in this setting. Some of the questions that I will be asking may be difficult for you to talk about. If there are questions that you do not feel comfortable talking about, please feel free to skip them. You may also leave the group discussion at any time. We ask that everyone here keeps what everyone says confidential.

[Instructions to the moderator: The questions in this guide have been written in general for TG/MSM/MSW persons. Depending on the composition of the FGD participants (i.e. TG or MSM or a combination), you will need to tailor the questions in reference to the participants in the group. For example, if there are only TG persons in the group, please ask questions by referring only to TG persons; it is not necessary to ask about MSM persons (e.g. the first question below should ask: "Let's begin by talking about the TG community."]

1. **Description of the TG/MSM community**
   Let's begin by talking about the TG/MSM community.

   1.1. How would you describe people who are TG/MSM? For example, if you were to pass by a TG/MSM person on the street, how would you know this person is TG/MSM?

   1.1.1. What do TG/MSM persons refer to themselves as?

   1.1.2. How would any other community member identify them as TG/MSM?

   1.1.3. What is life like for them? (probe about their general age, do they live in rural or urban areas, are they educated or uneducated)

   1.1.4. What do they do to earn a living?

   1.1.5. How do they live? (alone, with other TG/MSM, with family, etc)

   1.1.6. Tell me about what parts of the city where you would find TG/MSM. (probe for parts of the city that they can be found)

   1.1.6.1. Why are they found in those parts of the city?

   1.1.6.2. Are there places where they are not found? Where? Why?

   1.1.7. What else should I know about TG/MSM people?

2. Description of gender

The word "gender" can have various meanings. In this section, I would like to know what you think about this term.

2.1. How would you describe the meaning of the word "gender"?

2.1.1. What does it mean to be a "man"?

2.1.2. What does it mean to be a "woman"?

2.2. In the TG/MSM community, how do they describe their gender?

3. Community perceptions of TG/MSM people

Now I would like to hear your thoughts about how community members treat TG/MSM persons. Let me explain a few things first. By "community members," I mean people who live in this community that are not TG/MSM. And when talking about how community members "treat" TG/MSM persons, I will be using the term "gender-based violence." This means that a person has been violent or abusive toward a TG/MSM person because he/she is seen as TG/MSM. In other words, the person would not have experienced gender-based violence if the person was not perceived to be TG/MSM. What I mean by violence or abuse is physical harm such as beatings, sexual harm such as rape, psychological abuse such as blackmail, and emotional harm such as name-calling or bullying.

3.1. First, do you have any questions about what I mean by gender-based violence? (The interviewer should address all questions for clarification.)

3.2. How do community members who are not TG/MSM generally treat people who are TG/MSM? (are they liked or disliked) (probe for specific examples)

3.2.1. Many different kinds of people live in the same community as TG/MSM, such as family members, coworkers, schoolmates, police, religious leaders [use local terms], just to name a few. Who in the community treats TG/MSM people respectfully?

3.2.1.1. What do they do to show respect? (Be sure to clarify the type of community member being referred to.)

3.2.1.2. Why do they act respectfully (Or: What makes them act positively or respectfully toward TG/MSM persons)?

3.2.2. Thinking about the different kinds of people that I mentioned before, who in the community is responsible for gender-based violence toward TG/MSM persons? In other words, who harms or abuses TG/MSM persons in this community?

3.2.2.1. What do they do to harm TG/MSM people? (probe about: beating, blackmail, verbal abuse, rape, etc)

3.2.2.2. Without taking names, can you share stories about how a TG/MSM person experienced gender-based violence? (Probe about what happened, why did they do that and what happened after the harmful situation)

3.2.2.3. What do you think are the reasons that some people cause harm to TG/MSM people?

3.2.2.4. What would a TG/MSM person do after experiencing gender-based violence?

3.2.2.5. Where would a TG/MSM person go to seek help after experiencing gender-based violence? (clinic, friend's house, family house, etc)

3.2.2.6. Out of 10 TG/MSM persons, how many do you think have ever experienced physical harm like being beaten or raped because of gender based violence?

3.2.2.6.1. Why do you think this many people experienced gender-based violence?

3.2.3. Now I would like to ask about TG and MSM persons who exchange sex for money or gifts. Do these persons experience gender based violence?

3.2.3.1. Are their experiences of violence the same or different from what you have already described? Please explain why it is different or similar.

3.2.4. Are there organizations or healthcare centers that help TG/MSM persons when they experience gender-based violence? (If yes, probe for names of the organizations/centers; and services they provide for TG/MSM person in terms of assisting with victims of violence)

3.2.5. Do you know of any organization(s) working to stop gender-based violence against TG/MSM persons? (if yes, probe for what types of programs these are and who they target – communities, leaders, youth, parliamentarians, etc)

4. Partner perceptions and treatment

TG/MSM persons can have different kinds of sexual relationships, and I would now like to ask you questions about those relationships.

4.1. What are the different kinds of sexual relationships TG/MSM persons have? (probe about sexual relationships such as steady partners, casual partners, one-time partners and also probe in general about whether they have sexual relationships with TGs, MSM, heterosexual men, bisexual men etc.)

4.1.1. Do TG/MSM persons ever exchange sex for money or gifts? Tell me more about sex work done by TG/MSM persons.

4.1.1.1. What are the reasons that they exchange sex for money or gifts?

4.2. Of the sex partners that you mentioned, which ones show TG/MSM persons respect?

4.3. From which sex partners does a TG/MSM person experience gender-based violence?

4.3.1. What kind of gender based violence do they experience? (probe about beating, blackmail, verbal abuse, rape etc)

4.3.2. What are the reasons that a sex partner would harm a TG/MSM person?

4.4. In your opinion, what should be the ideal healthy, positive relationship for a TG/MSM person?

4.4.1. Would the TG/MSM person face gender-based violence in this healthy relationship? Why or why not?

5. TG /MSM community experiences with health services

Now, I would like to change the subject to discuss health care.

5.1. What reasons would a TG/MSM person seek health care in general? (probe about going for general health checkups, whenever they are sick, when they think they have an STD, HIV testing, never at all, etc)

5.2. What reasons would a TG/MSM person not go to a clinic/hospital when they need medical help? (probe about stigma and discrimination)

5.3. Many different kinds of people work at a health facility, such as guards, receptionists, nurses, counselors and doctors.

5.3.1. Do TG/MSM persons ever encounter problems with any of these persons? Please explain.

5.3.2. Do TG/MSM persons ever receive support from any of these persons? Please explain.

5.4. If a TG/MSM person experienced gender-based violence by a sex partner and needed care, how would he or she feel about going to see a doctor?

5.4.1. How would he or she feel about going to talk to someone or get counseling?

5.5. If a TG/MSM person has been raped and requires urgent medical help, what would he or she do?

5.6. If a TG/MSM person thought he or she had a sexually transmitted infection, what would he or she do?

5.6.1. How would he or she feel about seeking healthcare?

5.7. What can healthcare providers do to improve the quality of care for TG/MSM persons? (probe about what people in the supply chain could do – guards, reception, nurses, counselors, doctors)

6. Recommendations for future interventions

I have already heard about TG/MSM experiences in the community and with seeking health care. Now, let us talk about programs and different ways that could reduce or prevent gender-based violence.

6.1. What actions can TG/MSM persons do for him/herself to prevent gender based violence done by community members? And by community members, I mean people who live in the community and are not TG/MSM.

6.2. What is the main way that TG/MSM persons themselves can prevent gender-based violence done by sex partners?

6.3. What strategies or programs can you think of that organizations should develop to help prevent gender based violence against TG/MSM persons?

[***Interviewer instructions****: please only read the examples below if participants do not seem to understand the question, or are having difficulties with coming up with strategies/programs. These are the examples to read aloud:* "Let me give you three examples of how organizations in other countries have helped prevent gender-based violence toward TG/MSM persons. One organization taught health care providers about harm against TG/MSM persons that is committed by community members or sex partners, trained them to identify it in their clinics, and told them how to help the TG/MSM person. In southern India, one organization worked with local leaders to create a "Transgender Day," which was made to educate the public about who transgender persons are in order to reduce community stigma and abuse. And finally, another group worked with peers of TG/MSM persons to educate other TG/MSM about sexually transmitted diseases, provide them with condoms, and connect them with clinics. They even had a phone number people could call in case they experienced violence and needed help. These are examples. What strategies or programs can you think of that would work in your community?"]

6.4. What services or programs should be implemented to assist TG/MSM persons after they have experienced gender based violence?

6.5. What are the organizations in this community that should help prevent gender-based violence toward TG/MSM persons or assist them after they have experienced gender-based violence?

6.6. *[**Interviewer instructions: This question for Papua New Guinea only***] This is my last question. Meri Seif Ples is a program in Papua New Guinea for women who are victims of domestic violence and offers a designated zone to allow victims to take temporary refuge so that they can assess the situation, call for police help if needed, take the victim to hospital for medical help or refer them to professional safe houses like Haus Ruth or allow the woman to sit there while the man cools off. This program can be adopted by businesses or government organizations. Do you think that such a program might work for MSM/TG persons?

6.6.1. [**If yes ask**:] If you think this program could work for MSM/TG persons, how can we modify it to work for MSM/TG persons?

6.6.1.1. Haus Ruth has been mentioned as a safe house for female victims of domestic violence. Which safe houses could MSM/TG persons go to?

6.6.2. [**If no ask:**] If you don't think it is a good idea, why would it not work?

6.7. I appreciate your time spent here today. We are at the end of the interview. If you have anything to add to this interview, you are free to do so now.

6.8. [*Interviewer instructions: If participants have revealed gender based violence during the group discussion read the following:*] From what you have told me today, I can tell that you have had some very difficult times in your life. No one has the right to abuse and harm someone else in that way. However, from what you have told me, I can also see that you are strong and have survived through some difficult circumstances. Again, thank you for participating in this group discussion today. Are there any questions for me?

***[Interviewer instructions**: Please offer the list of referral organizations to all study participants. Also provide referral to study participants who show distress during the focus group.]*

Appendix B: Key Informant In-Depth Interview

Introduction (to be read to the respondent)

Thank you for being able to meet with me today. As part of our research, we would like to understand more about transgender (TG), male sex workers (MSW) and men who have sex with men (MSM) (use appropriate local terms) persons in this community and the violence and abuse they face because of their identity. We will refer to this as gender based violence. We have chosen to speak with you because you have worked with TG/MSM/MSW persons.

Also, if there are questions you do not feel comfortable talking about, please feel free to skip them. You may end the interview any time.

1. **Information about their role in community**

   1.1. What is your role in the community?

   1.2. How long have you been in this role?

   1.3. Does your organization offer services/programs, or interact with MSM or TG persons in any way? Tell me more about what your organization offers.

      1.3.1. (If informant is not part of any organization, like a community leader, or pastor, then ask the following) How have you been involved in working with/for TG or MSM persons?

2. **Perspectives of the TG/MSM community**

   I have some questions about TG and MSM persons in your community. Let us begin with questions about TG persons.

   2.1. How would you describe people who are TG? For example, if you were to pass by a TG person on the street, how would you know this person is TG?

      2.1.1. What is life like for them?

      2.1.2. Where do they live? (alone, with other TG, with family, etc)

      2.1.3. What do they do to earn a living?

      2.1.4. What else should I know about TG people?

   2.2. What is your opinion of TG persons in general?

      2.2.1. Where does your opinion come from? (or: Why do you have this opinion?)

2.3. How would you describe people who are MSM? For example, if you were to pass by an MSM person on the street, how would you know this person is MSM?

2.3.1. What is life like for them?

2.3.2. Where do they live? (alone, with other MSM, with family, etc)

2.3.3. What do they do to earn a living?

2.3.4. What else should I know about MSM people?

2.4. What is your opinion of MSM persons in general?

2.4.1. Where does your opinion come from? (or: Why do you have this opinion?)

3. [This section is for police officers, healthcare providers, legal service providers and representatives of community organizations only.]

Interaction with TG/MSM community

3.1. Without stating any names, do you know someone who is TG or MSM (like a friend or family member)?

3.2. Have you ever been in contact with a TG or an MSM person as a (police officer, health care provider, etc.)?

3.2.1. [If yes] Please tell me about an experience where you were in contact with a TG or MSM person.

3.2.2. How did you feel while interacting with the TG or MSM person? (Were you comfortable or uncomfortable? What made you feel comfortable/uncomfortable?)

3.3. Now I would like to ask you questions about TG/MSM persons experiencing "gender-based violence." This means that a person has been violent or abusive toward a TG/MSM person because he/she is seen as TG/MSM. In other words, the person would not have experienced gender-based violence if the person was not perceived to be TG/MSM. What I mean by violence or abuse is physical harm such as beatings, sexual harm such as rape, psychological abuse such as blackmail, and emotional harm such as name-calling or bullying.

3.3.1. First, do you have any questions about what I mean by gender-based violence? (The interviewer should address all questions for clarification.)

3.4. Are you aware of any TG or MSM experiencing gender-based violence because they are TG or MSM? For example, a TG or MSM person might have been beaten or raped?

3.4.1. [If yes] What were the reasons the person was abused?

3.4.1.1. [If yes] How did you learn about this? (probe: Did you witness the abuse or hear about it afterward?)

3.4.1.2. [If yes] What was your reaction to learning about the TG or MSM person being abused?

3.4.1.3. [If yes] Who were the perpetrators? [do not ask for names, but rather what role they play in the community: police, family members, religious leaders, etc]

3.4.1.4. [If yes] Did you ever register or report this case to the police? Why or why not?

3.4.2. [If no] Do you think this happens or does not happen? Why do you think this way?

3.5. If a TG or MSM person came to you as a (police officer, health provider, etc.) to report that they have been sexually assaulted or raped, what would you do?

3.5.1. Why would you respond this way?

3.5.2. What do you think other (police officers, health providers, etc.) would do?

3.5.3. How might other (police officers, health providers, etc.) handle this situation differently than you?

3.5.4. Would your response differ if the person was a woman, and not TG/MSM? Please explain.

3.6. What is your opinion regarding TG/MSM persons being abused, sexually assaulted or raped? (or ask: Would you say it is acceptable or unacceptable for persons to abuse, sexually assault or rape a TG/MSM person?)

3.7. [For police officers only] Have you ever taken any disciplinary action against a TG/MSM person?

3.7.1. [For police officers only] Can you tell me about the situation?

4. [This section is for owners/managers of establishments (e.g. bars/discos) only.]

Their interaction with TG/MSM population – harm against TG/MSM

4.1. Now I would like to ask you questions about TG/MSM persons experiencing "gender-based violence." This means that a person has been violent or abusive toward a TG/MSM person because he/she is seen as TG/MSM. In other words, the person would not have experienced gender-based violence if the person was not perceived to be TG/MSM. What I mean by violence or abuse is physical harm such as beatings, sexual harm such as rape, psychological abuse such as blackmail, and emotional harm such as name-calling or bullying.

4.1.1. First, do you have any questions about what I mean by gender-based violence? (The interviewer should address all questions for clarification.)

4.2. Are you aware of any TG/MSM person experiencing gender-based violence because they are TG/MSM? For example, a TG/MSM person might have been beaten or raped?

4.2.1. [If yes] What were the reasons the person was abused?

4.2.1.1. [If yes] How did you learn about this? (probe: Did you witness the abuse or hear about it afterward?)

4.2.1.2. [If yes] What was your reaction to learning about the TG/MSM person being abused?

[If yes] Who were the perpetrators? [do not ask for names, but rather what role they play in the community: police, family members, pastor, etc)

5. Police as perpetrators of violence [For <u>all</u> respondents]

5.1. In other studies, TG/MSM people say that police officers sexually harass and rape them. Are you aware of TG/MSM persons being treated this way by police officers?

5.1.1. What do you think about these claims of violence? (probe: Are TG/MSM telling the truth, lying, etc?)

6. Addressing violence toward TG/MSM [For <u>all</u> respondents]

6.1. Out of 10 TG persons, how many do you think have ever experienced physical harm like being beaten or raped because of gender based violence?

6.1.1. Why do you think this many people experienced gender-based violence?

6.1.2. What about out of 10 MSM persons, how many of them do you think have ever experienced gender-based violence?

6.2. Do the police currently have a role in preventing and addressing violence that TG/MSM persons experience?

6.2.1. What role do they play?

6.3. Do you think the police should have a role in preventing and addressing violence that TG/MSM persons experience? Tell me more about why you think this way.

6.4. [**For police officers only**] What do you think you can do as a police officer to prevent TG/MSM persons from experiencing violence in this community?

6.5. What actions can TG/MSM persons do for him/herself to prevent gender based violence done by community members? And by community members, I mean people who live in the community and are not TG/MSM.

6.6. What is the main way that TG/MSM persons themselves can prevent harm done by sex partners?

7. Current/past programs/services for addressing GBV [For all respondents]

Let us now talk about current or past policies, programs, and services for preventing and addressing violence among TG and MSM persons. I am asking these questions so that we can understand what types of programs and services are currently in place or were being implemented in the past so that this can help us with finding out what gaps exists and what future interventions can be developed.

7.1. Are you aware of any laws to prevent and address violence among TG and MSM persons?

7.1.1. [If yes] What are these laws? (probe about details of the policies)

7.1.2. [If no] What laws or policies should be implemented to address violence among TG and MSM persons? (probe about details of the policies)

7.2. Does your organization support any program or service to prevent and address violence against TG and MSM persons? By support I mean whether your organization has developed, implemented or hosted any program or service to address violence against TG and MSM persons.

7.2.1. [If yes] Please tell me about these programs and/or services. (Probe about <u>each</u> program and/or service mentioned using the probes below)

7.2.1.1. Who does the program/service target?

7.2.1.2. What are the components of the programs/services

7.2.1.3. Where is it being implemented?

7.2.1.4. Who provided funding for this service/program? (probe for names of organization or government ministry)

7.2.1.5. What has been the feedback from TG/MSM persons and staff about the program/service?

7.2.1.6. What are the successes of the program/service?

7.2.1.7. What challenges were encountered?

7.2.1.8. What strategies were used to overcome these challenges?

7.2.1.9. What changes to the service/programs would you like to see in the future?

7.3. Have you heard about any program or service that other organizations have implemented to prevent and address violence among TG/MSM persons? [If yes, probe using the above probes]

8. Recommendations for Interventions [For all respondents]

In this next section, we'll talk about other services/programs that you would like to see implemented in the future to prevent and address violence among TG, MSW and MSM persons.

8.1. What recommendations for future services or programs can you think of to prevent violence among TG, MSW and MSM persons? (probe for details of each suggestion – including the target population of the services/programs, how the service/program can be implemented)

8.1.1. What challenges do you foresee?

8.1.2. What organizations in this community <u>should</u> help prevent gender-based violence toward TG/MSM persons or assist them after they have experienced harm?

8.1.3. Where can funding for these services/programs come from?

8.2. What recommendations for future services can you think of to assist TG/MSM persons after they have experienced gender based violence? (probe for details of each suggestion)

8.2.1. What challenges do you foresee?

8.2.2. What organizations in this community <u>should</u> provide services to assist TG/MSM persons who have experienced gender based violence?

8.2.3. Where can funding for these services come from?

8.3. [***Interviewer instructions: This question for Papua New Guinea only***] Meri Seif Ples is a program in Papua New Guinea for women who are victims of domestic violence and offers a designated zone to allow victims to take temporary refuge so that they can assess the situation, call for police help if needed, take the victim to hospital for medical help or refer them to professional safe houses like Haus Ruth or allow the woman to sit there while the man cools off. This program can be adopted by businesses or government organizations. Do you think that such a program might work for MSM/TG persons?

8.3.1. [**If yes ask**:] If you think this program could work for MSM/TG persons, how can we modify it to work for MSM/TG persons?

8.3.1.1. Haus Ruth has been mentioned as a safe house for female victims of domestic violence. Which safe houses could MSM/TG persons go to?

8.3.2. [**If no ask:**] If you don't think it is a good idea, why would it not work?

9. We are at the end of the interview. If you have anything to add to this interview, you are free to do so now.

10. Thank you for participating in this interview. Do you have any questions for me?

[Interviewer instructions: *Please offer the list of referral organizations to all study participants. Also provide referral to study participants who show distress during the interview.]*

APPENDIX C
DEMOGRAPHIC QUESTIONNAIRE – FOR FOCUS GROUP DISCUSSION PARTICIPANTS
BANGLADESH ONLY

SECTION A: COMPLETE INTRODUCTORY QUESTIONS

A1. Date of interview: |__|__| / |__|__| / |__|__|__|__| (DD/MM/YYYY)

A2. Interviewer Number: |__| __|

A3. Participant/Archival ID#: |__|__| __|__|__|__|__|__|-|__|

SECTION B: CONFIRM ELIGIBILITY CRITERIA

B1. How old are you? **[Interviewer: Write response in C1 below.]**

☐ 18 years old or older → go to question B2 (1)

☐ Under 18 years old → stop, do not continue [explain eligibility and thank person] (2)

B2. In the past one year, have you had sex with a man?

☐ Yes → go to question C1 (1)

☐ No → stop, do not continue [explain eligibility and thank person] (2)

SECTION C: ASK DEMOGRAPHIC QUESTIONS

Interviewer script: I would like to begin by asking questions about you.

#	Question	Response categories
C1	Age of participant	
		|__|__|__| __|age in years *(note: write year of birth if age is unknown; write 999 if either is unknown)*

#	Question	Response categories
C2	What is your religion?	☐ Muslim (1) ☐ Hindu (2) ☐ Christian (3) ☐ Buddhist (4) ☐ Others *(please specify below)* (5) _____
C3	How do you identify your gender? Would you say you are a man, a woman, or would you use another term?	☐ Man (1) ☐ Woman (2) ☐ Other (please specify below) (3) _____ [If participant is a Hijra, please write on the line above under "others" if she is a 1) Badhai Hijra; or 2) sex worker Hijra]
C4	What is the highest standard/grade in school that you completed?	☐ None (1) ☐ Some primary school (2) ☐ Completed primary school (3) ☐ Some secondary school (4) ☐ Completed secondary school (5) ☐ Some post-secondary school/Tertiary education (6)

#	Question	Response categories
C5	What is your occupation? [Interviewer instruction: If participant has multiple occupations, please list all occupations]	☐ Unemployed (1) ☐ Student (2) ☐ Street/Market vendor/Shop employee (3) ☐ Bar, disco, entertainment establishment owner or employee (4) ☐ Hotel owner/employee (5) ☐ Security guard, cleaner (6) ☐ Hairdresser, barber (7) ☐ Community based organization/non-governmental organization staff (8) ☐ Government employee (9) ☐ Health care worker (10) ☐ Business/office work (11) ☐ Transport worker/Rickshaw puller (12) ☐ Garment/Factory worker (13) ☐ Badhai (Perform baby blessings, dancing, singing and collecting tolls from shops) (14) ☐ Other (please specify below) (15) _____
C6	In the past year, who were your sex partners? (Interviewer instructions: Please check all that apply)	☐ Men only (1) ☐ Both men and women (2) ☐ No response (3) ☐ Transgender (4)
C7	Have you <u>ever</u> exchanged sex for money or gifts?	☐ Yes (1) ☐ No (2) ☐ No response (4)

APPENDIX D
DEMOGRAPHIC QUESTIONNAIRE – FOR FOCUS GROUP DISCUSSION PARTICIPANTS
PAPUA NEW GUINEA ONLY

SECTION A: COMPLETE INTRODUCTORY QUESTIONS

A1. Date of interview: |__|__| / |__|__| / |__|__|__|__| (DD/MM/YYYY)

A2. Interviewer Number: |__| __|

A3. Participant ID#/Archival number: |__|__| __|__|__|__|__|__|-|__|

SECTION B: CONFIRM ELIGIBILITY CRITERIA

B1. How old are you? **[Interviewer: Write response in C1 below.]**

☐ 18 years old or older (1) → go to question B2

☐ Under 18 years old (2) → stop, do not continue [explain eligibility and thank person]

B2. In the past one year, have you had sex with a man?

☐ Yes (1) → go to question C1

☐ No (2) → stop, do not continue [explain eligibility and thank person]

SECTION C: ASK DEMOGRAPHIC QUESTIONS

Interviewer script: I would like to begin by asking questions about you.

#	Question	Response categories
C1	Age of participant	|__|__|__| __|age in years *(note: write year of birth if age is unknown; write 999 if either is unknown)*
C2	Which province are you from?	_____

#	Question	Response categories
C3	How do you identify your gender? Would you say you are a man, a woman, or would you use another term?	☐ Man (1) ☐ Woman (2) ☐ Other (please specify below) (3) _____
C4	What is the highest standard/grade in school that you completed?	☐ None (1) ☐ Some primary school (2) ☐ Completed primary school (3) ☐ Some secondary school (4) ☐ Completed secondary school (5) ☐ Some post-secondary school/Tertiary educatio(6)
C5	What is your occupation? [Interviewer instruction: If participant has multiple occupations, please list all occupations]	☐ Unemployed (1) ☐ Student (2) ☐ Street/Market vendor/Shop employee (3) ☐ Bar, disco, entertainment establishment owner /employee (4) ☐ Hotel owner/employee (5) ☐ Security guard, cleaner (6) ☐ Hairdresser, barber (7) ☐ Community based organization/non-governmental organization staff (8) ☐ Government employee (9) ☐ Health care worker (10) ☐ Business/office work (11) ☐ Other (please specify below) (12) _____
C6	In the past year, who were your sex partners?	☐ Men only (1) ☐ Both men and women (2) ☐ No response (3)
C7	Have you ever exchanged sex for money or gifts?	☐ Yes (1) ☐ No (2) ☐ Not sure (3) ☐ No response (4)

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Exploring gender based violence among men who have sex with men (MSM), male sex worker (MSW) and transgender (TG) communities in Bangladesh and Papua New Guinea

RESULTS AND RECOMMENDATIONS

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