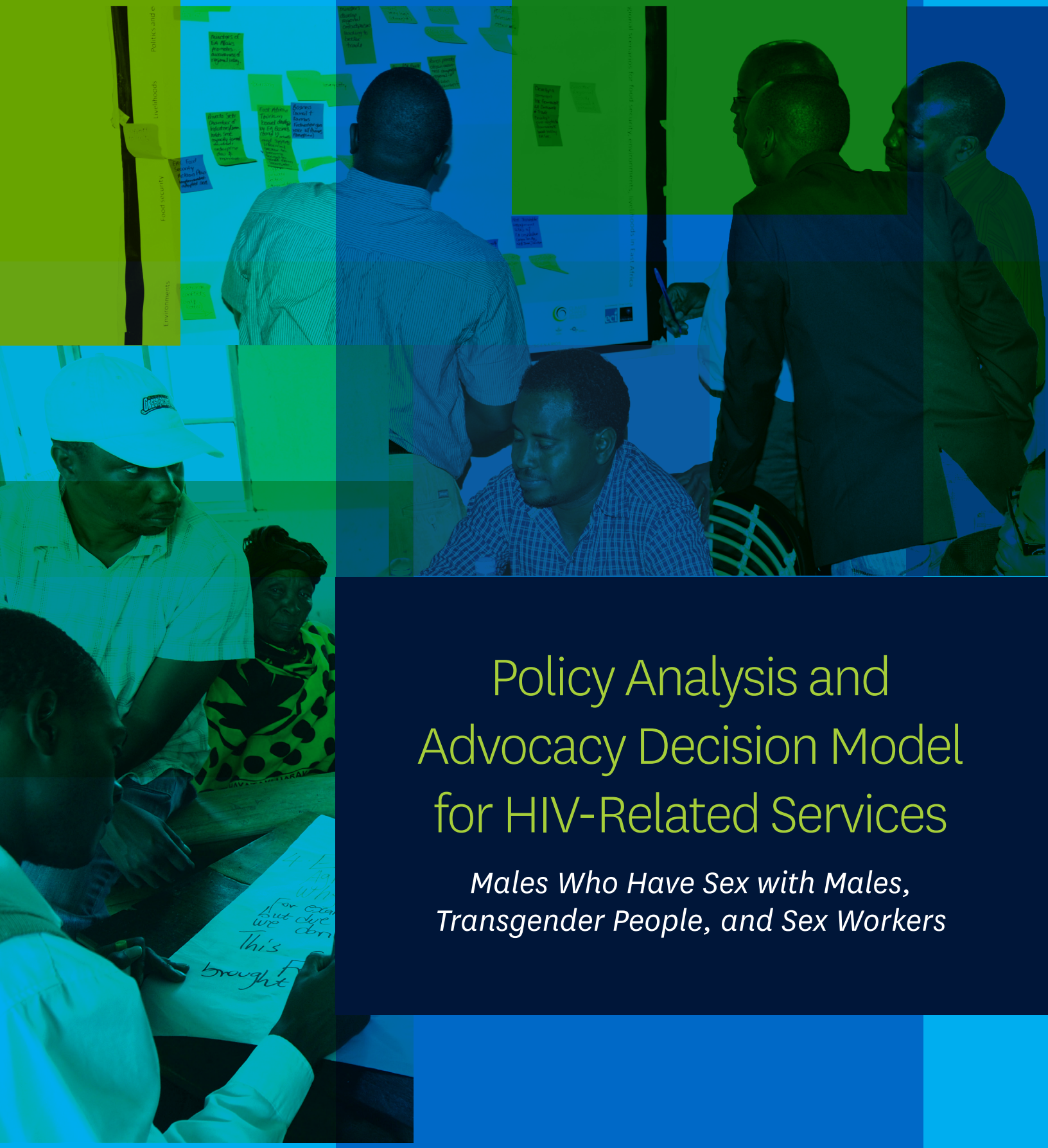

Policy Analysis and Advocacy Decision Model for HIV-Related Services

Males Who Have Sex with Males, Transgender People, and Sex Workers

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HEALTH POLICY PROJECT

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The African Men for Sexual Health and Rights (AMSHeR) is a regional coalition of MSM/LGBTI-led organizations in Africa that work to address the vulnerability of MSM to HIV. AMSHeR provides a platform for exchange, learning, and advocacy among grassroots MSM organizations, human rights organizations, national agencies, and other stakeholders working with and/or for MSM/LGBTI communities.

Policy Analysis and Advocacy Decision Model for HIV-Related Services: Males Who Have Sex with Males, Transgender People, and Sex Workers

SEPTEMBER 2013

Contents

Note that it is both a humbling and daunting effort to capture a policy environment as complex and dynamic as policies related to services for males who have sex with males, transgender people, and sex workers. While we have made every attempt to capture the situation as of the date of this publication, we recognize the need to keep updating and improving the Decision Model. Before using it, please visit www.healthpolicyproject.com to check for an updated version.

All comments for clarification, expansion, and improvement are welcome. Please send comments to PolicyInfo@futuresgroup.com.

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Executive Summary

Primary Goal and Content of Decision Model

The Decision Model provides country stakeholders—such as advocates, policymakers, and service providers—with tools to inventory, assess, and advocate for policies that affect access to and sustainability of key services for males who have sex with males (MSM), transgender (TG) people, and sex workers (SWs). The model maps service-specific policies to international human rights frameworks to identify needs and opportunities for policy advocacy that will help improve access to services, even while broader, long-term human rights initiatives are implemented.

The Decision Model addresses policies that specifically affect services related to MSM/TG/SW, including service coordination; data use and decisionmaking; participation in decisionmaking, service delivery, and evaluation; consent; personal data; stigma and discrimination; criminal sanctions; gender-based violence; human rights; procurement and supply management; funding; and service eligibility and delivery protocols. These policies are assessed for services delivered in community and prison settings.

The Decision Model can address the following fundamental questions related to developing and implementing an incremental advocacy strategy for MSM/TG/SW or integrating population-specific policies into prevention and treatment strategies for sexual and reproductive health and rights (SRHR), sexually transmitted infections (STIs), and HIV:

1. What is the legal basis for services to reduce the risk and address sexual transmission as a component of national SRHR, STI, and HIV strategies?
2. Do national policies conform to standards and guidelines developed by international, multilateral bodies and leading international, regional, and local organizations?
3. Are there national policies and guidance to support the establishment of and access to services for MSM/TG/SW?
4. Are policies disseminated and implemented at the local level?
5. What are the feasible policy targets for advocacy?
6. Who are the in-country advocates for service scale-up, and how can a scale-up strategy be developed?

Policy Barriers to MSM/TG/SW Services

The Decision Model specifically aims to address three types of policy barriers to services for MSM/TG/SW: restrictive, inadequate, and absent policies. The more easily detected of these are restrictive policies—policy document provisions that explicitly deny or rule out scientifically proven services (e.g., a policy that expressly outlaws the distribution of condoms in prison settings). Inadequate policies are those that are unclear or do not respond to current science, current accepted guidelines, or international best practices.

The final type of policy barrier reflects the absence of explicit policy provisions to provide, sustain, and/or expand access to services. Identifying absent policies is difficult, yet may be as important as, or even more important, than restrictive policies, requiring the thorough assessment of the policy

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environment against external standards such as the Decision Model. The absence of explicit policy provisions can hamper the implementation and sustainability of services through mechanisms such as the following:

1. *Provider reluctance to offer potentially controversial services unless there are explicit policy documents that permit or even direct them to do so.* While providers in some countries may feel free to offer services not explicitly banned or prohibited, the culture and practices of other countries often discourage this practice.

2. *Reliance on executive or administrative decrees rather than legislation to establish a legal framework for services.* While this may be sufficient to set up pilot programs, there is no substitute for legislation to mandate broad public policy and objectives. Policies established by the executive branch of government can be overturned more easily by subsequent administrations, while legislative provisions enacted by parliaments and legislatures establish a more sustainable public policy for services.

3. *Ineffective or non-existent policies to coordinate national strategies and operational plans.* National coordinating bodies or advisory committees have a key role in ensuring a country's effective, coordinated, and holistic HIV, STI, and SRHR services. Their composition and powers must be specified in national legislation.

The Decision Model identifies the existence of restrictive, inadequate, or absent enabling policies required for SRHR, STI, and HIV programs so they can provide sustained, accessible HIV counseling and testing (HCT); antiretroviral therapy (ART); STI screening, diagnosis, and treatment; sexual risk information and harm reduction; alcohol harm reduction; and SRHR services for MSM/TG/SW. These policies are mapped against established human rights guidelines in the areas of (1) framework; (2) community partnership; (3) legal environment; and (4) intervention design, access, and implementation.

Components of an Effective Policy Environment

Framework

The national framework for coordination of the SRHR, STI, and HIV response and across relevant ministries (e.g., health and justice) is particularly important for improving access to services for MSM/TG/SW. People who are at increased levels of risk from sexual transmission often require services to address multiple and interrelated health concerns, such as SRHR, STI, and HIV, in community and detention settings. Designing national programs to ensure an integrated continuum of care among these health concerns and between governmental and nongovernment providers increases entry points and retention in services that reduce harm to the individual and the community.

The national framework also sets the policy guidance for data use in decisionmaking. The decisionmaking process for MSM/TG/SW services can be influenced by myriad political, social, and environmental factors. To be most effective at addressing the health concerns of these populations, policy must also define the scientific evidence base for decisions on funding levels, types of services needed, and coverage targets.

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Community Partnership

Best practices recognize the value that community partnership brings to program planning and implementation; services will be more accessible and effective if they are designed, implemented, and evaluated with the input of individuals and organizations who have personal or professional experience with issues impacting sexual health. Moreover, partnership with some of the more under-served MSM/TG/SW, such as youth, MSM who do not identify themselves as gay, non-organized or occasional SW, clients and romantic partners of SW, and individuals with multiple and compounded risks (e.g., sexual and drug using risks), is crucial in designing programs to address the specific needs of these populations.

Legal Environment

Public health law empowers public health authorities to provide a comprehensive range of HIV-related services and establishes standards for informed consent, confidentiality, and program implementation. Public health law is also the mechanism that can be used to protect individual rights and dignity (e.g., protection from stigma and discrimination) (UNAIDS, 2006, pp. 26-29).

Even when legislation may not criminalize sex work, gender nonconformity, or same-sex sexual behavior, individuals who engage, or are perceived to engage, in these activities are often treated as criminals, even if they commit no crimes and inflict no harm to others. A pervasive environment of formal or informal stigmatization and discrimination leads to violations of human rights; facilitates abuse, violence, and extortion; and creates barriers to seeking services. Also, in spite of ethical guidelines to the contrary, (World Medical Association, 2006), (World Medical Association, 2011), a restrictive legal environment and underlying stigma and discrimination serve as barriers to healthcare providers fulfilling their obligation to provide services to all.

Intervention Design, Access, and Implementation

Policies that authorize, fund, and guide specific services for MSM/TG/SW are an essential piece of the policy environment. As has been documented in services for people who inject drugs (PWID), government officials and program managers may be reluctant to take political risks by authorizing or initiating programs and services that can be perceived as controversial and not directly required by the law (Reshevska, Foreit, Beardsley, & Porter, 2010). Policies that guide service implementation are also critical for establishing protocols to address the specific needs of MSM/TG/SW within larger service areas, such as SRHR and STI services.

Conclusion

It is clear that human rights violations; stigma and discrimination; and restrictive, inadequate, or absent policies create barriers to access and delivery of effective services for MSM/TG/SW. This Decision Model provides local stakeholders and advocates with a template to build a customized advocacy approach—specific to the needs and environment of each jurisdiction. The model provides valuable information as to which level of government to target advocacy efforts and whether to target actual policy language or implementation. This customizable, in-depth, and standardized approach will build the capacity to identify incremental, feasible, near-term opportunities to improve the legal environment and the resulting quality of and access to services for MSM/TG/SW while long-term human rights strategies are implemented.

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Abbreviations

AMSHeR	African Men for Sexual Health and Rights
ART	antiretroviral therapy
BCC	behavior change communication
CBO	community-based organization
CCM	Country Coordinating Mechanism
C/L	condoms and lubrication
CSO	civil society organization
DM	Decision Model
EHRN	Eurasian Harm Reduction Network
EPT	expedited partner therapy
FP	family planning
FSW	female sex worker
GBV	gender-based violence
GUM	genitourinary
HAV	hepatitis A virus
HBV	hepatitis B virus
HCT	HIV counseling and testing
HCV	hepatitis C virus
HIV	human immunodeficiency virus
IEC	information, education, communication
ILGA	International Lesbian, Gay, Bisexual, Trans and Intersex Association
IOM	International Organization on Migration
IRB	Institutional Review Board
LGBTI	lesbian, gay, bisexual, transgender, and intersex
MARP	most-at-risk population
MAT	medication-assisted therapy
MSM	males who have sex with males
NGO	nongovernmental organization
NSP	national strategic plan
PEP	post-exposure prophylaxis
PEPFAR	United States President's Emergency Plan for AIDS Relief
PHRplus	Partners for Health Reformplus
PLHIV	people living with HIV
PPT	periodic presumptive treatment
PSM	procurement and supply management
PWID	people who inject drugs
PWID DM	*Policy Analysis and Advocacy Decision Model for HIV-Related Services: People Who Inject Drugs*
SRHR	sexual and reproductive health and rights
STI	sexually transmitted infection
SW	sex workers
TB	tuberculosis
TG	transgender
UN	United Nations
UNAIDS	Joint United Nations Programme on HIV/AIDS
UNDP	United Nations Development Programme
UNGASS	United Nations General Assembly Special Session
UNODC	United Nations Office on Drugs and Crime

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USAID	U.S. Agency for International Development
WBL	water-based lubricant
WHO	World Health Organization

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Introduction

Background

Males who have sex with males (MSM), transgender (TG) people, and sex workers (SW) are at higher risk for HIV transmission than other individuals, even in generalized epidemics. While country and regional epidemics identify significant differences in the level of risk experienced by MSM, TG, and SW, global estimates of low- and middle-income countries indicate that MSM are 19.3 times more likely to be infected than the general population (Baral, Sifakis, Cleghorn, & Beyrer, 2007) and female SWs are 13.5 times more likely to be HIV infected than women of reproductive age in the general population (Baral, et al., 2012), with regional prevalence of HIV among SWs in sub-Saharan Africa approaching 40 percent (WHO, 2012). While drawing from more limited data for TG, the picture remains severe and consistent, with TG women almost 50 times more likely to be HIV positive than other adults of reproductive age and TG SWs four times more likely to be living with HIV than female SWs (Baral, Poteat, Strömdahl, Wirtz, Guadamuz, & Beyrer, 2013).

Detailed Technical Guidance

Sex Work

http://www.who.int/hiv/topics/sex_work/en/

http://www.nzpc.org.nz/page.php?page_name=Law

MSM and TG

http://www.who.int/hiv/topics/msm/en/index.html

Prisons

http://www.who.int/hiv/topics/prisons/en/index.html

HIV

http://www.who.int/hiv/en/

STI

http://www.who.int/topics/sexually_transmitted_infections/en/

Reproductive Health

http://www.who.int/topics/reproductive_health/en/

Family Planning

http://www.who.int/topics/family_planning/en/

Biological and behavioral factors that contribute to this increased risk include the heightened biological HIV transmission risk of anal intercourse; more frequent exposure to HIV through higher numbers of sexual partners; high HIV prevalence among sexual networks; concurrent bacterial or ulcerative STIs; and compounding risks of drug use, sexual violence, and interactions with detention and incarceration settings. Structural factors that limit individual and community agency to reduce these risks include funding limitations and access barriers for services, program protocols that fail to address the needs of these populations, actual or feared violence, and policies that drive detention and incarceration—increasing exposure to high-risk environments and/or reducing availability of prevention and treatment resources. Personal factors include the effects of social stigma, such as drug and alcohol use, internalized shame, secrecy, loneliness, and hyper-sexual expression of gender norms.

The focus of this methodology is on assessing and improving the structural and policy issues that create barriers for MSM/TG/SW in seeking services and adopting individual and community harm reduction strategies. These issues include outright criminalization of MSM in 78 countries (The International Lesbian, Gay, Bisexual, Trans and Intersex Association [ILGA], 2012); general policy barriers to services reported for populations most at risk in 63 percent of countries (UNAIDS, 2008a, p. 109); and critical underfunding (UNAIDS, 2008a, p. 180), deprioritization, and marginalization of funding for MSM services by national HIV programs (amfAR & JHU, 2012, p. 6). The link between policy and services is

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clear, with the reach of HIV prevention programs for key populations better in countries with non-discrimination laws (UNAIDS, 2008a, p. 84).

Additionally, marginalized and criminalized populations tend to experience, at disproportionate levels, specific environments that present higher risk of HIV transmission and HIV disease progression. For example, the correlation between sexual behavior and experience with incarceration can present through a number of circumstances, including conviction for criminalized behaviors before incarceration, sexual behaviors while incarcerated, conviction for activities related to sex work, nonpayment of fines, and use of illegally acquired funds to pay fines (Clark, 2006, p. 6). Once placed in a pre-trial detention center or incarcerated, the limited access to antiretroviral therapy (ART) and sharing/reusing injection equipment and drug solutions facilitates the risk of HIV transmission and disease progression. Also, despite rules that prohibit sexual activity, consensual, coerced, and exchange sex; rape; and sexual violence are well documented in prison settings for both men and women. One survey in the United States documented that men who identify or are perceived to be gay or bisexual experience sexual victimization at 10 times the level of heterosexual males and that, overall, sexual victimization accounts for a doubling of the risk of HIV infection (Beck & Johnson, 2012). Finally, prisoners and staff alternate between prison and community environments, making prison health inseparable from the health of the broader population, not only for HIV but also other communicable diseases, such as hepatitis and tuberculosis (TB) (UNODC, n.d., pp. 11–17) (WHO, 2007d, pp. 8–11).

Other high-risk environments experienced by marginalized and criminalized populations, especially children and youth, are living on the streets and in settings where minors are in state custody, such as orphanages, foster care, or juvenile detention. Whether the result of or conducive to HIV-risk behavior, children living on the streets have documented HIV prevalence rates of 40 percent, injection drug use prevalence of more than 50 percent, almost universal sexual activity, and high levels of transactional (16.5% boys, 56.7% girls) and non-consensual (11.2% boys, 52.2% girls) sex (UNICEF, 2010, pp. 31–37).

These environments are coupled with challenges in resource allocation and availability of harm reduction services and commodities. In 2008, SWs, who frequently have insufficient access to adequate services, such as condoms and lubricants, STI diagnosis and treatment, post-exposure prophylaxis, protection from violence and abuse work conditions, and social and legal support, received less than 1 percent of global funding for HIV prevention (UNAIDS, 2012, pp. 2, 5), and MSM programs are often deprioritized and defunded by national HIV programs (amfAR & JHU, 2012).

Resource allocation issues are present even with the Global Fund, the largest donor to programs for key populations. Worldwide, key affected populations constitute 1 percent of Country Coordinating Mechanism (CCM) membership, with participation barriers and power differentials exacerbated in countries that criminalize sex work and homosexuality, and by limited capacity of representatives to navigate complex bureaucracies. This lack of representation results in limited human rights and population-specific HIV interventions, especially from government principal recipients, who receive almost 70 percent of Global Fund grants and are accountable to the same bodies that institute and enforce criminalization statutes (De Lollo, 2012).

Against this backdrop of increased risk and inadequate resources lie fundamental challenges in the policy legal environment. In 2010, 46 percent of government responses and 62 percent of civil society responses to the National Composite Policy Index acknowledged the existence of laws, regulations, and policies that

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obstruct access to prevention, treatment, care, and support services for populations at higher risk. In addition, almost one-third of reporting countries do not have laws and regulations that protect people living with or vulnerable to HIV from discrimination. Also, while the percentage of countries with protective legislation has increased from 32 percent in 2004 to 62 percent in 2010, little evidence exists to determine whether these laws are effectively enforced or whether individuals have access to justice or can seek redress for wrongs experienced (UNAIDS, 2010, pp. 126–128).

The Decision Model

Purpose and Target Audiences

This Decision Model is designed to help country stakeholders build a public policy foundation that supports access to and implementation and scale-up of evidence-informed services for MSM/TG/SW. The model provides tools to help advocates, policymakers and decisionmakers, national committees and advisory boards, program developers, service providers, clients, nongovernmental organizations (NGOs), civil society organizations (CSOs), and other stakeholders identify and address the policy barriers to services. The services covered are HIV counseling and testing (HCT); ART; STI screening and treatment; condoms and lubrication; information, education, and communication (IEC); outreach; alcohol harm reduction; and SRHR. The Decision Model is designed for global application but also addresses specific policy concerns for Africa.

Detailed Technical Guidance Note

Services included in this document were those that had shown proven efficacy and established protocols at the time of its publication. Consideration of additional service areas may be warranted as new technologies and approaches are developed.

Microbicides

http://www.who.int/hiv/topics/microbicides/microbicides/en/

http://www.global-campaign.org/about.htm

Pre-exposure prophylaxis

http://apps.who.int/iris/bitstream/10665/75188/1/9789241503884_eng.pdf

Advocacy site that covers advancements in HIV prevention

http://www.avac.org/

The model can be used to

- Compare the current policy environment in a particular country with international best practices and identify the extent to which current laws and policies enable or restrict implementation of services for MSM/TG/SW (this could also serve as a baseline for the design of advocacy programs);
- Identify policy barriers and the strategies and opportunities that could mitigate these barriers (this could form the basis of designing a policy advocacy strategy);
- Provide summary best-practice guidance for programmers and decisionmakers working with MSM/TG/SW in determining the content of programs and planning interventions; and
- Monitor the impact of policy advocacy and implementation (change in the country's policy/program environment could be measured by reapplying selected modules at a later date and comparing findings with the baseline).

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The Decision Model is a companion document to the *Policy Analysis and Advocacy Decision Model for HIV-Related Services: People Who Inject Drugs* (PWID DM) (Beardsley & Latypov, 2012) and the culmination of an initiative conducted by the Health Policy Project and funded by the U.S. Agency for International Development (USAID) in collaboration with African Men for Sexual Health and Rights (AMSHeR).

Organization and Design

The model is organized into two chapters. The first chapter provides background information on the overall policy framework, the Decision Model's components, and additional advocacy strategies. The second chapter includes sets of tools that collect various quantitative (*inventory*) and qualitative (*interviews*) data on policy language and implementation, and provide basic steps to create an advocacy strategy and set priorities (*worksheets*). These tools are the following:

1. *Policy Inventory and Analysis.* Instruments and procedures to compile and analyze a reference library of country documents and an analytic framework to compare the collected documents against international best practices and assess the extent to which they enable or restrict implementation of hepatitis, TB, HIV, drug treatment, and harm reduction services.
2. *Policy Implementation Assessment Interviews.* Survey instruments to collect opinions and experiences of key informants, service providers, and clients regarding the implementation of policies.
3. *Policy Advocacy Planning Worksheets.* Guidance for advocates to identify and prioritize policy issues, engage stakeholders, and conduct advocacy campaigns.

In addition to the type of information collected, the Decision Model provides levels of detail appropriate to different kinds of stakeholders—from an inventory of detailed language that identifies specific clauses to change, to an assessment of policy implementation that identifies barriers to program access and implementation, to a high-level overview of policy documents that can identify gaps in the overall policy matrix (see Table 1).

Table 1. Levels of Detail Provided and Use

Tool/Instrument	Level of Detail	Uses
Policy Inventory and Analysis (Reference Library)	Highest	• Listing of citations to support policy arguments • Specification of policy clauses that should be changed
Policy Assessment Interviews	High	• Assessment of overall adequacy of policy environment • Identification of policy barriers, contradictory policies, and/or policy gaps

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Implementation

Considerations

- *Overlapping identities, complex contexts, and differentiated risks*. When assessing the policy barriers to HIV prevention, care, and treatment services for MSM/TG/SW, it is critical to be specific about the specific populations and contexts of primary interest. For example: policy barriers to services will be different for gay-identified MSM versus those MSM who do not identify themselves as gay; for male, female, and transgender SWs; dependent on the location in which sex work takes place, the place of solicitation, and whether or not sex work is a primary occupation; and impacted by urban and rural settings. While it may be impossible to uniquely address every possible combination of identities and contexts, engaging members of these populations in the design of the assessment will help to fine-tune these factors so that the assessment addresses the specific characteristics of primary interest.
- *It is not necessary to implement the entire model.* While a complete implementation of the Decision Model will provide the most comprehensive analysis of policies impacting the access to and sustainability of services for MSM/TG/SW, a full implementation of all of the points of policy analysis may not be feasible or necessary. Thus, the document is designed so that it can be implemented in a modular fashion. For example, stakeholders may be most interested in policies for a specific intervention or specific contexts, such as prison environments. When designing the policy analysis, simply identify the topics for consideration and complete the analysis for these policies.
- *As policy issues are being considered for inclusion, be sure to consult with implementers and MSM/TG/SW.* Policy analysis points that may not appear to be directly related to the interventions or contexts of interest may actually prove to be crucial policy barriers to services.
- *The policy inventory, analysis, and advocacy tools can be implemented at different levels of governmental jurisdiction.* Depending on the scope of the analysis, policies can be analyzed for national and subnational (e.g., regional, state, or local) governmental jurisdictions. If implementing at multiple levels of government, be sure to identify any policy contradictions among the different levels of government.
- *No country's analysis will achieve a perfect score.* The policy analysis standards used in this document are based on international standards that may or may not be relevant in a specific country. Advocates and stakeholders will need to consider the country context when incorporating assessment findings into advocacy strategies.
- *Just because a policy does not align with international standards, it does not mean that it is inappropriate for the country context.* Again, local stakeholders and advocates will need to consider the local country context when interpreting the assessment findings. The assessment is meant to be the beginning of a conversation, not a declarative statement of absolute fact.
- *References for the assessment standards for policy language and implementation cannot always be specific to the intervention.* As much as possible, we have identified specific international standards for assessing policies. However, when language specific to the intervention and context was not identified, we tried to apply and adapt the spirit and overarching concepts of related policies to specific policy analysis standards.

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Model Implementation Challenges

- There are often *no national repositories of all policy documents* related to SRHR, STI, and HIV. Time will be needed to identify and collect policy documents, and some information may be totally lacking or inaccessible (e.g., for local estimates of coverage targets, many countries rely on international sources).
- Application of the Decision Model will *probably require external assistance*—at least to train the data collectors and perhaps provide assistance with analysis. The inventory and analysis are best undertaken by individuals already familiar with policy documents.
- It is *unlikely that a single person will have the policy and content area expertise* to apply the entire model; thus, countries should assemble a team of knowledgeable individuals who collectively can cover the policy content areas.
- Written policy documents set the stage for program implementation but cannot guarantee program success by themselves. The *policy assessment is only the first step* of a longer planning and implementation process; stakeholders will need additional resources to disseminate findings, train advocates and develop advocacy plans, support needed policy reform, train service providers, fund expanded treatment programs, and monitor progress.

Limitations to Findings

- *No policy or law is universally translatable* to all countries, and international standards must be implemented in a country context. The standards identified in the Decision Model are based on the language and context of international documents and best practices and are not meant to be either restrictive or comprehensive. The inventory and analysis of country documents outlined in the model serves to identify policies that require additional attention, as well as country-specific solutions.
- This model is designed to provide a high-level overview of the MSM/TG/SW-specific policies that most directly affect sustainability, access, utilization, and design of a defined list of services (HCT, ART, STI, condoms and lubrication, IEC, outreach, alcohol harm reduction, and SRHR). It is *not designed to be a tool that measures implementation quality or effectiveness,* nor is it a detailed technical guide for these services. Stakeholders interested in a more in-depth analysis of the services are encouraged to consult service-specific documents—many of which are referred to in this document.

Technical/Administrative Capacity Requirements

Organizations implementing the Decision Model should have some level of expertise in the following areas—or partner with organizations that offer this expertise:

- *Project management.* Implementation will involve multiple collaborators, consultants, and potentially significant financial resources. Organizations should have administrative and organizational systems in place to facilitate financial management, project planning, and contracting.
- *Information analysis.* The model will generate a large volume of information that should be analyzed and presented in a manner that facilitates meaningful comment and feedback.

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Organizations should have experience in identifying overarching issues, key themes, and priority actions.

- *Information dissemination and presentation.* Any analysis of policy and subsequent advocacy efforts must be a collaborative and participatory process to be seen as valid. Results will need to be validated with key stakeholders, and the priorities identified will need broad consensus and buy-in.
- *Policy environments.* Many policies identified in the Decision Model will not be contained in documents specific to MSM/TG/SW. Implementing organizations should have general knowledge of policies related to sectors such as health, family law, human rights, law enforcement, justice and correctional systems, gender-based violence (GBV), and procurement and supply management.
- *Coalition building.* Policy issues that impact services for MSM/TG/SW also impact services for other populations. Implementing organizations need to be creative in thinking about potential coalitions to engage in the analysis and advocacy effort.

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Chapter 1: Policy Environment and Requirements

Policy Framework

Fundamental human rights and policies of almost any sector impact the HIV epidemic among MSM/TG/SW and the quality of services for these populations. Human rights guidelines and principles create a framework for a "more comprehensive understanding of the complex relationship between the public health rationale and the human rights rationale of HIV/AIDS" (UNAIDS, 2006, p. 9). Implementing interventions within a combined public health and human rights framework increases the effectiveness of the overall country strategy. To align the value of a human rights approach with the policy environment required for program implementation, this Decision Model maps implementation policy to existing human rights frameworks developed by UNAIDS and the Office of the United Nations High Commissioner for Human Rights (UNAIDS, 2006). By mapping the structure to this well-established human rights framework, intervention-specific policy components are layered onto the broad foundation of human rights. The identification of the specific policy areas in each section were informed by the content of overarching human rights principles, published and grey literature, and the experience of program implementers and participants.

Detailed Technical Guidance

International Guidelines on HIV/AIDS and Human Rights
http://www.ohchr.org/EN/Issues/HIV/Pages/InternationalGuidelines.aspx

Legal Aspects of HIV/AIDS: A Guide for Policy and Law Reform
http://siteresources.worldbank.org/INTHIVAIDS/Resources/375798-1103037153392/LegalAspectsOfHIVAIDS.pdf

Policy Components

Table 2 maps the structure of the Decision Model to the UNAIDS human rights framework. The policy areas included in this model are categorized into four components of an overall policy environment required for effective program implementation: (1) framework, (2) community partnership, (3) legal framework, and (4) intervention design, access, and implementation. These components will be found throughout country legislation, policies, regulations, guidelines, protocols, and operational plans.

Table 2. Mapping of UNAIDS Human Rights Framework to Decision Model Components

UNAIDS Human Rights Guidelines	Decision Model Component
Guideline 1: Framework Guideline 12: International Cooperation	**Framework** Multisectoral coordination and integration Data-informed planning and budgeting
Guideline 2: Community Partnerships	**Community Partnership** Community engagement and participation in policy design, program implementation, and evaluation Support for community organizations

Throughout this document, the term "policy" is inclusive of legislation, policies, legal decisions, judicial precedent, regulations, guidelines, and/or operational plans and protocols.

UNAIDS Human Rights Guidelines	Decision Model Component
Guideline 3: Public Health Legislation Guideline 4: Criminal Laws and Correction Systems Guideline 5: Anti-discrimination and Protective Laws Guideline 7: Legal Support Services Guideline 9: Challenging Discriminatory Attitudes through Education, Training, and the Media Guideline 11: State Monitoring and Enforcement of Human Rights	**Legal Environment** Public health legislation Authorization Consent Privacy and confidentiality Stigma and discrimination Criminal law Sanctions, aiding and abetting Gender-based violence Human and legal rights Legal Services Prison systems integrated throughout Decision Model
Guideline 6: Access to Prevention, Treatment, Care, and Support Guideline 10: Development of Public and Private Sector Standards and Mechanisms for Implementing these Standards	**Intervention Design, Access, and Implementation** Procurement and supply management Service-specific policy Authorization/legality Eligibility/access Service protocols Referral mechanisms
Guideline 8: Women, Children, and Other Vulnerable Groups	Integrated throughout Decision Model

Inclusion of Policies Impacting Detention and Prison Settings

It is important to assess and advocate for policies impacting services in all environments that increase risk of HIV transmission. Imprisonment increases a person's risk of being exposed to TB, HIV, hepatitis C virus (HCV), and other blood-borne infections, as the prevalence rates of HIV, HCV, and TB in prison populations by far exceed those among the general population (UNODC, 2006). In Africa and around the world, prisons—where socioeconomic barriers break down—offer new norms of dominance and power, particularly between male prisoners. Same-sex relations, including "marriages" between male prisoners, are common, although considered circumstantial. Gang rape and sexual abuse (e.g., exchange of men for favors among gangs and individual prisoners) take place frequently (UNODC, 2006b). In Kamfinsa prison, Zambia, 8.4 percent of men reported anal sex in a 1995 study (UNAIDS, 1997). Estimates of the percentage of prisoners who had at least one homosexual encounter while in detention in Zomba Central Prison in Malawi varied from 10 percent to as high as 60 percent. Out of these, about one-third is thought to have had habitual sex with other prisoners (Jolofani & DeGabriele, 1999).

Detailed Technical Guidance

WHO HIV/AIDS in Prison Settings Resource Page
http://www.who.int/hiv/topics/prisons/en/index.html

In countries that have high rates of HIV infection among prisoners, there is demonstrated evidence that there is also a higher rate of HIV in the wider population as a whole. In spite of this mounting evidence, national governments have yet to include comprehensive HIV prevention programs in prisons in their national strategic frameworks or achieve a standard of prison healthcare equivalent to the standard outside of prison, thereby jeopardizing the health of prisoners, prison staff, and the wider community. For example, key informants in Burkina Faso confirmed that both sex work and

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same-sex behavior occur in prison settings; however, prison officials have interpreted the penal code as prohibiting sexual relations in prisons and consequently restrict provision of family planning services, including condoms and lubricants (Duvall, Beardsley, Campaoré, Sanon, & Bassonon, 2012). States thus have an obligation to implement legislation, policies, and programs consistent with international human rights norms and ensure that prisoners are provided with a standard of healthcare equivalent to that available in the outside community (UNAIDS, WHO, 2006, p. 9).

In most cases, limited access to core services in prisons can be explained by national policy silence on the right of inmates to services for SRHR, STI, and HIV. As a rule, national legislation does not strip the inmates of the right to the highest attainable state of health, as this would be in direct contradiction to international treaties signed by the respective countries; however, they fail to explicitly authorize and mandate provision of evidence-based services such as condoms or secure funding for these services (UNODC & CHALN, 2010). In the absence of clear legislation requiring accessibility of services for inmates, high-level penitentiary officials remain reluctant to introduce services in prisons for various reasons. They may be unwilling to acknowledge the HIV-risk behavior in prisons where policies mandate zero tolerance of sexual behavior and drug use, may see harm reduction services as undermining measures to prevent prohibited behaviors, or may lack resources to support service provision (The Beckley Foundation Drug Policy Programme [BFDPP], 2007), (WHO, 2007a).

Inclusion of Law Enforcement Policies and Practice

Policing policies and practices play an integral role in increasing or decreasing exposure to HIV-risk environments and prevention, care, and treatment resources for populations that experience stigma and discrimination and whose identity and/or behaviors may be criminalized. A recent review of models of collaboration between law enforcement and HIV programs has identified the importance of both collaborative and individual leadership across government sectors and jurisdictions and the value of civil society in facilitating formal and informal communications to integrate harm- and risk-reduction philosophies that address structural drivers of HIV vulnerability into law enforcement practices. While there are limited examples of documented policing policy best practices, issues related to law enforcement are integrated throughout this document in the spirit of engaging the influence of and fostering interactions between police and MSM/TG/SW. In both the assessment and subsequent setting of an advocacy agenda, engagement of law enforcement will be a critical component in identifying opportunities to align and overlap public health and policing goals (Thomson & Tenni, 2012).

Detailed Technical Guidance

Law Enforcement and HIV Network
http://www.leahn.org/

Description of Policy Document Categories

Many kinds of policy documents guide and/or affect the overall public policy environment for effective HIV programs. The components identified above (framework; community partnership; legal environment; and intervention design, access, and implementation) must work together across a variety of policy documents to create and sustain an enabling policy environment. When assessing the policy environment, the following categories of policy documents should be analyzed: legislation, national strategic plans and policies, regulations, legal decisions and judicial precedent, guidelines and protocols, and operational plans.

Throughout this document, the term “policy” is inclusive of legislation, policies, legal decisions, judicial precedent, regulations, guidelines, and/or operational plans and protocols.

Legislation

Laws (civil, criminal) and other documents are enacted or originated by the legislative branch of government, such as a parliament or national assembly. It is important that the legislation designates a body or agency to be responsible for the intent of the legislation and clearly and unambiguously empowers that agency to issue orders or regulations to guide development of implementing procedures (see Regulations, below).

Detailed Technical Guidance

Taking Action against HIV, Handbook for Parliamentarians
http://data.unaids.org/pub/Manual/2007/20071128_ipu_handbook_en.pdf

Handbook for Legislators on HIV/AIDS, Law and Human Rights
http://www.ipu.org/PDF/publications/aids_en.pdf

A common problem with national legislation is that the various program components required for interventions are rarely contained in a single piece of legislation. Usually, references are scattered across different pieces of legislation and different government sectors, with little attention given to linking the goals of each sector to an overarching national strategy. Analysts and advocates need to have broad knowledge of legislation concerning topics such as authorization, criminal laws, medication and medical commodities procurement and supply chains, clinical practice and standards of care, and law enforcement, because relevant legislative provisions seldom have intervention-specific titles. Moreover, this lack of linkage among the different sectors that influence HIV-related services is often a major policy constraint at the national level. For this reason, advocates may decide to prioritize measures to establish or strengthen national coordinating bodies so that the legislative goals of different sectors are defined. Additional discussion of the components of legislation, using the example of medication-assisted therapy (MAT), is included in the Annex.

National Strategic Plans and Policies

High-level documents issued by the executive branch of government—such as the president, prime minister, and cabinet of ministers—include edicts, presidential or ministerial decrees, resolutions, national plans, and programs. National strategic plans and programs, established by the executive branch, are especially important for advocates to analyze. Strategic plans demonstrate the government's understanding of the overall picture of services for MSM/TG/SW (e.g., estimates of population size, where they are located, levels of current and optimal services, etc.) and lay out the government's vision underpinning risk reduction and other prevention and treatment efforts. In many countries, national advisory and coordinating bodies help governments formulate national strategic plans and policies. They are of special interest because they link policy development, program planning, and legislative enactments. Government authorities should collaborate with nongovernmental and civil society organizations in the establishment of a nationwide coordinating body to guide the development and maintenance of comprehensive services for MSM/TG/SW.

Regulations

Once legislation has been adopted, regulations are issued by line ministries and departments, specifying how laws, decrees, and other high-level policies should be put into practice. Implementation issues, such as the details of day-to-day operations of a treatment service, are also handled best by regulations rather

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than the primary legislation. Regulations are more flexible than legislation and can be altered more easily as circumstances change. Relevant regulations may be found in a variety of instruments, including ministerial orders, administrative rules, or departmental or board regulations. These instruments are generally drawn up and promulgated by the agency (e.g., line ministry, department) designated in the legislation.

Regulations flow from legislation in the following manner:

- Legislation authorizes the administrative agency through delegated authority.
- The delegated authority facilitates the ability of the administrative agency to carry out the legislative mandate.
- The administrative agency has the flexibility, within boundaries of delegated authority, to fulfill legislative goals in the face of changing public health, social, or workplace conditions.

In some legal systems, the drafts of regulations and other subsidiary instruments must be presented to a country's parliament or a parliamentary committee for approval or review, or must be approved by another public agency, such as its Ministry of Justice. In addition, regulations may be subject to a period of public comment prior to approval.

Legal Decisions and Judicial Precedent

As the primary state organ charged with interpretation of the law, decisions of the judiciary on implementation of statutes and policies are binding in the context of a given decision. In countries that apply the principle of judicial precedent, the decisions of the apex court become law and thus are binding on other courts within the judicial hierarchy. These interpretations are distinguished from "statutory law," which comprises the statutes and codes (laws) enacted by legislative bodies; and "regulatory law," which comprises regulations required by agencies based on statutes.

Guidelines and Protocols

These include published documents prepared by organizations such as the World Health Organization (WHO), the United Nations Office on Drugs and Crime (UNODC), and professional associations/ societies (e.g., medical, pharmacy, nursing, etc.) that specify the content of services and method of delivery. Guidelines and protocols can be prepared with the assistance of implementing agencies, such as the Ministry of Health or a specialized treatment unit. For example, the World Professional Association for Transgender Health (www.wpath.org) has established standards of care that provide clinical guidance for health professionals.

Operational Plans

Operational plans are prepared by departments and programs, usually on an annual or biennial basis; they specify the type and number of program activities to be conducted, such as training events, supervision schedules, and commodities purchases. Operational plans are needed to set out activities across the spectrum of program dimensions—such as activities to meet new requirements that may be imposed by ministerial orders or regulations, keep up with licensure and accreditation standards, and prepare plans for new advances in treatment and rehabilitation services.

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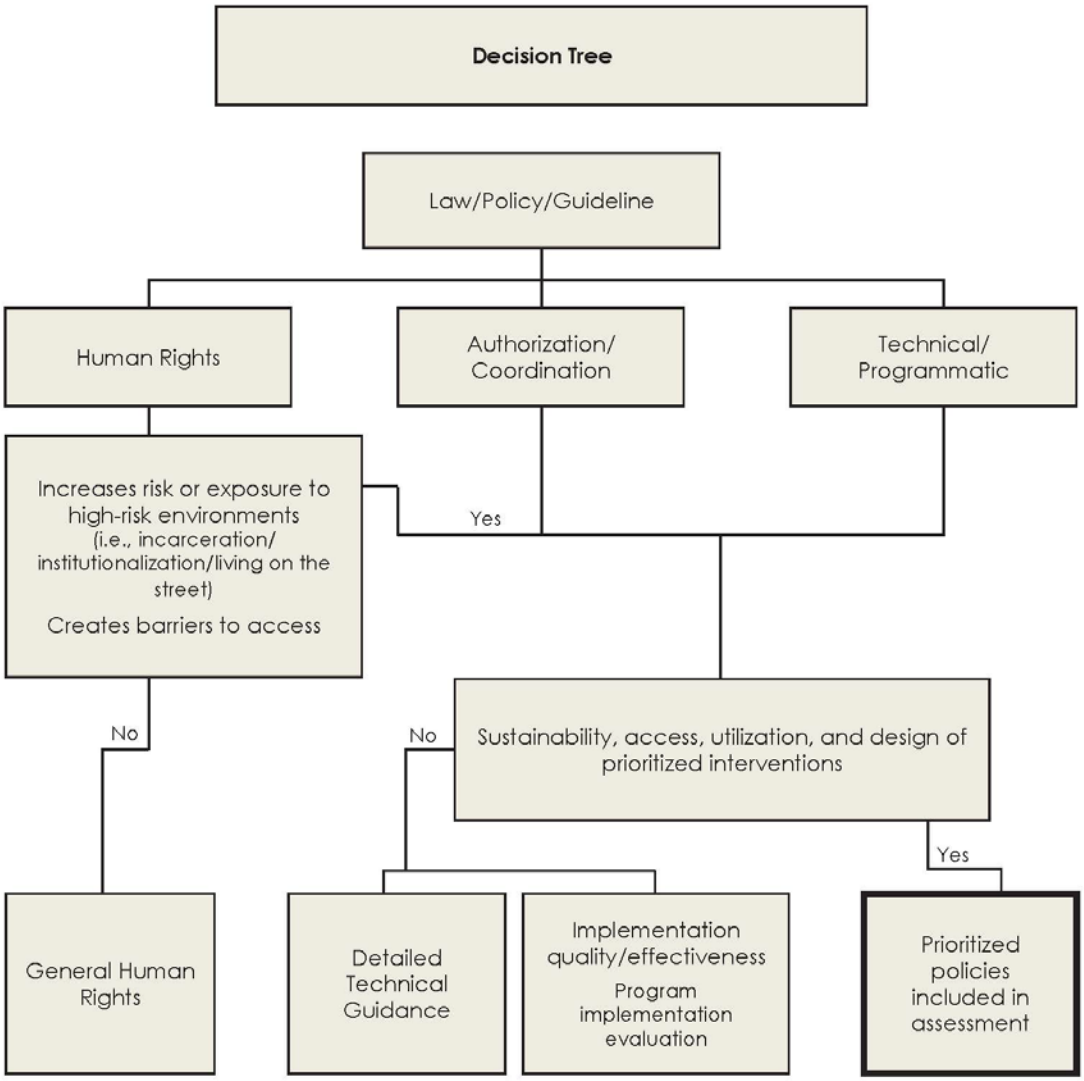
Policies that Directly Enable or Restrict Effective Access to MSM/TG/SW-related Services

As stated in the limitations section above, the purpose of this Decision Model is to provide an overview of the MSM/TG/SW-specific policies that most directly affect sustainability, access, utilization, and design of a defined list of services (HCT, ART, STI, condoms, IEC, outreach, alcohol harm reduction, and SRHR). To identify policy areas for inclusion in this analysis, the following decision tree was developed; it categorizes policies as related to (1) human rights, (2) authorization and coordination, and (3) technical and programmatic implementation.



Throughout this document, the term "policy" is inclusive of legislation, policies, legal decisions, judicial precedent, regulations, guidelines, and/or operational plans and protocols.

Human rights policy issues are assessed to the degree that they directly increase risk or exposure to high-risk environments, such as prisons, institutions, and living on the street, and the degree to which they create barriers to access. Human rights policies identified as directly affecting risk and access are then assessed—along with authorization, coordination, and technical and programmatic policy—for the degree to which they affect sustainability, access, utilization, and design of the interventions prioritized for this Decision Model.

Models for Policy Change

The earlier sections of this document describe the components of the policy framework for policies that enable or restrict access to services for MSM/TG/SW. This section addresses the process of policy change to expand services. It builds on the conceptual framework described in *The Policy Circle: A Framework for Analyzing the Components of Family Planning, Reproductive Health, Maternal Health, and HIV/AIDS Policies*, developed by the POLICY Project.

Policy Models

Many models have been developed to describe policy change. Some are linear (Lasswell, 1951), (Meier, 1991), others are iterative (Grindle & Thomas, 1991), and others describe change as policy streams (Kingdon, 1984). They all share the common recognition that policies emerge from perceived problems and stress the importance of a wide range of stakeholders—not only policymakers, but also others in nonofficial roles—in proposing policies and acting on policy options.

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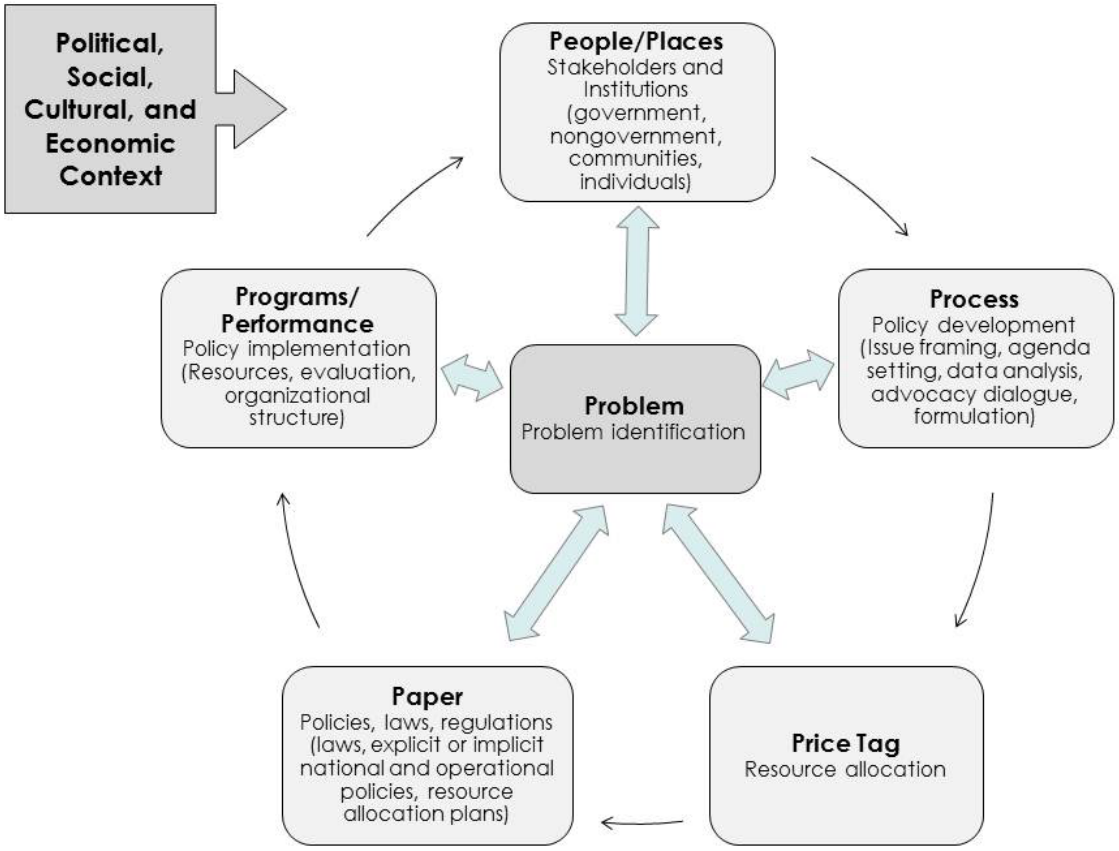
The Policy Circle Framework

The Policy Circle framework highlights six main components of policy, which play out against the backdrop of each country's unique political, cultural, social, and economic contexts: the *problems* that arise requiring policy attention, the *people* who participate in policy and the *places* (institutions) they represent, the *process* of policymaking, the *price tag* of the policy (the cost of policy options and how resources are allocated), the *paper* produced (actual laws and policies), the *programs* that result from implementing policies, and their *performance* in achieving policy goals and objectives. This section will emphasize the identification of problems, the people who participate in policy and the places they represent, and the process of policymaking.



The political, social, cultural, and economic context. Policymaking does not take place in a vacuum. Different countries have their own political systems, forms of government, social and cultural traditions, and economic systems and levels of development. It is important to ascertain whether the political situation is stable or whether the government is working in a crisis mode. In addition to these general contextual issues that affect any policy change, policy reform related to MSM/TG/SW faces specific political, social, and economic barriers, including stigma, political and cultural alliances, policies of dominant countries in the region, lack of access to up-to-date scientific information, uneven or hostile mass media coverage, and fledgling design and implementation of both advocacy efforts and programs for MSM/TG/SW.

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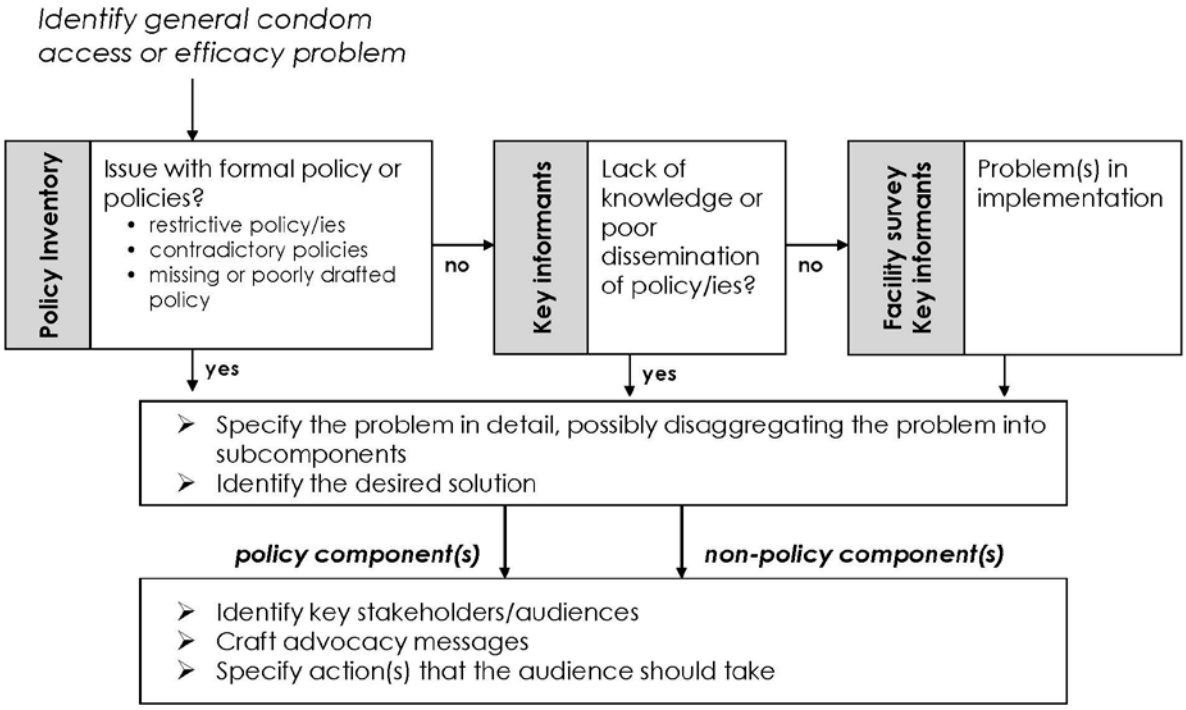

The problem. The Policy Circle begins with the problem that needs to be addressed through policy change (see figure above). The general problem addressed by this Decision Model is access to high-quality prevention and care services for MSM/TG/SW. To tackle such a broad issue, advocates must identify which specific problem or problems contributing to the overall lack of or access to services they wish to address first. Utilizing the policy inventory and assessment tools and methodologies presented here will provide analysis of the evidence that will underpin any effort to change policy; this evidence will help to measure the extent of the problem and suggest feasible and cost-effective policy responses.

People: individual stakeholders. Many people are affected by policies and programs related to MSM/TG/SW—legislators who enact laws, economists who design national budgets, law enforcement officials and the court systems responsible for maintaining public order, clinicians who set standards of care and provide services, people who need and use those services, and their families and the communities in which they live. Each has some interest or stake in services for MSM/TG/SW. These stakeholders (the people involved in and/or affected by policymaking) and the institutions (the places) they represent are central to policy change.

Individual stakeholders come from both within and outside of the government. Public sector stakeholders can include politicians (heads of state and legislators); government officials and technicians from various sectors (e.g., health, education, finance, local government); and staff who implement public programs. Stakeholders from outside of the government can include members of CSOs; support groups (e.g., groups of MSM/TG/SW or people living with HIV, women's health advocacy groups) or networks of these

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groups; and faith-based organizations. They also may include researchers and opinion leaders, such as media personalities. Individual beneficiaries of policy can also be involved in calling for policy change.

Places: stakeholder institutions. Individual stakeholders not only have their own ideas and opinions, they also exercise responsibilities within their institutions. Various parts of government play key roles in formal policymaking, including the executive branch (the head of state and the ministerial or departmental agencies of government); the legislative branch (parliament, congress, or equivalent); and the judicial branch. In some countries, local governments have their own policymaking structures. Program implementers also play important roles in policymaking—for example, the Ministry of Health or the Ministry of Justice. The strength of institutions involved in policymaking can have a direct impact on the success of the policies and programs.

Institutions outside of the government play a role in policymaking by acting as advocates for policy change; providing data for decisionmaking; and providing funding for policy research, dialogue, formulation, and implementation. Finally, international organizations also play a role in supporting and influencing policymaking.

- *The expanded role of nongovernmental and civil society stakeholders in policy*: In the past, policymaking was concentrated in the hands of policymakers and a few influential people and organizations outside of the government. Over the past decade, policymaking increasingly has included the participation of a wider range of stakeholders outside of the government.

  It is not enough that nongovernmental and civil society stakeholders are kept informed as policies are developed. To be effective advocates, they should be included as contributing members of government bodies, consulted and engaged in policy dialogue with policymakers, and included as participants in multisectoral coordination mechanisms (UNFPA, 1999). For example, excluding representatives of MSM/TG/SW from policy formulation runs the risk of developing an unresponsive or unsupported policy (both politically and socially). Advocates may find it useful to adapt the principles of Greater Involvement of People Living with HIV/AIDS to policymaking and program implementation for MSM/TG/SW. This would include application of the continuum of participation and involvement in decisionmaking and policymaking to participation of MSM/TG/SW, as this continuum identifies the value of including individuals, advocates, and family and friends (UNAIDS, 1999), (UNAIDS, 1999a).

  International organizations and donors are also important stakeholders in policy development and implementation. Donor funds often drive policy and program agendas. For example, the Global Fund included a reserve fund for most-at-risk populations (MARPs) in Round 10, which generated proposals for SW, TG, MSM, and PWID, and has included a strategic action to ensure appropriate and systematic inclusion of MARPs in the 2012–2016 strategy (The Global Fund, 2012, p. 9).

References

Global Fund Gender Equality Strategy
http://www.theglobalfund.org/documents/core/strategies/Core_GenderEquality_Strategy_en/

The Global Fund Strategy in Relation to Sexual Orientation and Gender Identities
http://www.theglobalfund.org/en/civilsociety/reports/

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- *The importance of policy champions:* High-level support within government is crucial for policy change to occur. While many stakeholders can and should be involved in advocacy, it is especially important to identify and support policy champions. A policy champion can be anyone committed to an enabling policy environment for MSM/TG/SW-related services who will use his/her convictions to motivate others to act on or participate in policy development and reform. Being an effective policy champion requires not only positive personality characteristics to engage and communicate with others, but also a solid understanding of the scientific and human rights arguments for services. Policy champions can come from any stakeholder group; what is important is that they have access to key decisionmakers. Generally, the higher the level of the policy champion, the more likely he or she will have a positive influence on the policy issue.
- *Analysis of people/places:* Stakeholder analysis is a useful tool for understanding the people and places (institutions) that can facilitate or block the desired policy reform. In its simplest form, a stakeholder matrix will list relevant individuals and organizations or groups; the reasons for their interest in MSM/TG/SW-related services; knowledge about sexual risk reduction; resources they can bring to bear on behalf of or in opposition to services (including access to information, human and financial resources, legal or moral authority, etc.); their capacity to mobilize resources; and their position on services for MSM/TG/SW. This tool is best used when stakeholders from different sectors are brought together to conduct a comprehensive analysis that includes government, the political sector, nongovernmental and civil society organizations, the commercial sector (including private medical practice), other civil society groups, and possibly international donors (POLICY Project, n.d.).

The process: policy development. Once the specific problem requiring a policy solution has been identified, the process of policy development includes framing the problem (by various stakeholders), getting it onto the policymaking agenda, and formulating the policy document. Moving the process along requires advocacy and policy dialogue by stakeholders, as well as data analysis at each step; documenting this process facilitates sharing of best practices and success in dealing with other issues, sectors, and jurisdictions.

- *Issue framing:* The way a problem is stated or an issue is framed influences the types of solutions proposed. Often, policy stakeholders take different sides regarding sex work and same-sex sexual orientation and behavior, with some advocating a law enforcement philosophy and others a human rights or public health philosophy. Issue framing—that is, describing the problem and its proposed solutions—sets the terms for policy debate and may influence the eventual outcome. Knowing likely arguments against services for MSM/TG/SW will help advocates frame the issue in the best possible way from the outset.
- *Agenda setting:* Stakeholders outside of the government can advocate for policy reform related to MSM/TG/SW services, but government policymakers must be engaged in the process for the needed policy change to happen. Government policymaking bodies follow fixed calendars and terms of office. Health and welfare in general, and services for MSM/TG/SW in particular, are only a few of the myriad issues simultaneously clamoring for policymakers' attention. Clear issue framing, strong evidence to substantiate the problem, and effective policy champions are all needed to place services for MSM/TG/SW on the policy agenda.

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- *Policy formulation:* Policy formulation is the part of a process in which proposed actions are articulated, debated, and drafted into language for a law or policy.
- *Advocacy and policy dialogue:* Both advocacy and policy dialogue are important for policy development. In advocacy, stakeholders promote issues and their positions on the issues. Advocacy is more likely to succeed if networks of organizations and individuals join forces (POLICY Project, 1999). The media also can play an influential role by highlighting issues that need to be addressed and stimulating public discourse—even deciding which issues will receive public attention and which will not.

  Policy dialogue involves discussions among stakeholders to raise issues, share perspectives, find common ground and, if possible, reach agreement or consensus on policy solutions. Policy dialogue takes place among policymakers, advocates, other nongovernmental and civil society stakeholders, other politicians, and beneficiaries.
- *Data analysis:* Lack of information is a common barrier to MSM/TG/SW-related policy reform. Policymakers weigh their decisions on various criteria, including the technical merits of the issue; potential effects of the policy on political relationships within the bureaucracy and among groups in government and their beneficiaries; potential impact of the policy change on the regime's stability and support; perceived severity of the problem and whether the government is in crisis; and pressure, support, or opposition from international aid agencies (Thomas & Grindle, 1994). Data analysis expands from the technical aspects of MSM/TG/SW-related services to the political costs and benefits of policy reform.

The price tag. Price refers to the financial, physical, and human resources needed to implement policies, plans, and programs. It is crucial when developing or analyzing a policy to consider the level of resources necessary for proper implementation, whether those resources already are available and allocated or need to be added, and any potential unintended consequences that funding decisions may have on program outcomes.

The paper: policies, laws, and regulations. Policy formulation culminates in the promulgation of formal policy documents that provide a broad framework for MSM/TG/SW services. These include legislation, policies, regulations, guidelines and protocols, and operational plans.

The programs and performance: policy implementation. Policies require strategic plans, operational policies and, ultimately, programs to ensure that the policy is carried out as intended. Programs require organizational structure (including the lead implementing agency or body), resources, activities, and monitoring and evaluation of performance to assess the achievement of policy and implementation goals.

Policy implementation is political as well as technical and requires some of the same steps as policy development. The process of policy implementation is often left to technicians, including upper- and mid-level managers. They may not be knowledgeable about services for MSM/TG/SW, or even about established routines of the government, such as annual budget cycles.

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Scaling up programs (i.e., moving beyond pilot programs to broad access to treatment) faces several implementation challenges (USAID, 2001), including the following:

- Generating and maintaining the support of community and government leaders
- Ensuring sufficient present and future budgets and human resources
- Adjusting the objectives, procedures, systems, and structures of agencies responsible for MSM/TG/SW-related service implementation
- Developing or reforming operational policies
- Monitoring progress and alerting decisionmakers and program managers to snags and intended and unintended consequences

Summary

The *Policy Circle* presents a simple framework with easy-to-remember components. This simplicity is not intended to imply that formulating policy is simple—indeed, each component is complex and requires significant work. There will be many challenges. For example, perhaps the problem has not been well articulated through adequate policy analysis. Perhaps there is strong opposition or differences of opinion on how to address the problem. There may have been insufficient efforts to consult those who will be affected by the policy change. Perhaps the policy document is vague or lacks an implementation strategy. Resources for implementation may be inadequate. Using the *Policy Circle* and related tools can help identify what aspects of policy or the policy process need to be addressed to solve an identified problem.

There is no rule as to how much time each component will take because it depends on the context and the issue to be addressed. Small or lower-level policy changes may be resolved more quickly than more comprehensive changes. Finally, MSM/TG/SW-related service problems may need to be addressed by more than one policy. What is considered first to be an adequate policy solution may not succeed, and the problem may need to be addressed through further policy reform—going back to the *problem* and beginning the cycle again.

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Additional Advocacy and Policy Reform Tools

The following tools listed may be also helpful in implementing advocacy and policy reform.

Tool Name	Description
Advocacy Tools and Guidelines: Promoting Policy Change Manual	This training guide familiarizes program managers with key advocacy concepts and techniques. It suggests a framework for identifying policy goals, creating a plan of action, and effectively building a case for change. http://www.care.org/getinvolved/advocacy/tools.asp
Networking for Policy Change: An Advocacy Training Manual	The Advocacy Training Manual describes the building blocks of advocacy and includes background notes, learning objectives, and handouts. It can easily be adapted to MSM/TG/SW advocacy efforts. http://www.policyproject.com/pubs/AdvocacyManual.cfm
Guidelines for Conducting a Stakeholder Analysis	The guidelines were developed by the Partners for Health Reformplus (PHRplus) Project to provide users with a framework for assessing key actors and their interests, knowledge, positions, alliances, resources, power, and importance. http://www.phrplus.org/Pubs/hts3.pdf
HIV/AIDS Toolkit: Building Political Commitment for Effective HIV/AIDS Policies and Programs	The POLICY Project HIV/AIDS Toolkit contains five modules to assist activists interested in increasing political commitment for effective HIV/AIDS policies and programs. http://www.policyproject.com/pubs/toolkit.cfm
Policy Characteristics Checklist	The Policy Characteristics Checklist assesses the various aspects of policy. It poses questions such as these: Where did the impetus for policy change come from? What is the nature of the costs and benefits, and who bears them? How complex are the changes? http://www.policyproject.com/policycircle/content.cfm?a0=6c
Policy Stakeholder Analysis Matrix	The Policy Stakeholder Analysis Matrix is used to analyze the stakeholders related to a specific issue. It assesses the group or organization and their potential vested interest in the policy reform, level of knowledge about the issue, available resources, capacity for resource mobilization, and position on the issue. http://www.policyproject.com/policycircle/content.cfm?a0=3a
Political Mapping	PolicyMaker is a rapid assessment method for analyzing and managing the politics of public policy. PolicyMaker software is available at www.polimap.com.
Summary of Regulations and Policy Issues	The Summary of Regulations and Policy Issues provides a framework for assessing the population policy environment, including its legal, political, economic, demographic, ecological, cultural, and technological elements. The framework helps users identify the influences of obstacles and facilitators in each environmental element. It also provides a matrix to assess various issues and their impact and propose strategies for change. http://www.policyproject.com/policycircle/content.cfm?a0=6b

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Chapter 2: Tools

Policy Inventory and Analysis

Background on Inventory of Documents Pertaining to Services for MSM/TG/SW

Addressing HIV among MSM/TG/SW requires a spectrum of concurrent, synergistic services that are implemented at a sufficient level of coverage, uptake, intensity, and duration. These services include condoms and lubrication, HCT, ART, screening and treatment of STIs, and alcohol and drug use harm reduction services—all delivered in a manner that engages and empowers individuals individually and collectively to address structural constraints, leverage human rights, and create social norms around behavior and accessing health services (WHO, 2012).

Written policy documents set the stage for program implementation but alone cannot guarantee program success. In other words, documents are necessary but not sufficient for effective policy and program implementation. The inventory is meant to be the first step in a comprehensive review that can help guide advocacy efforts to ultimately ensure widely accessible and high-quality MSM/TG/SW-related programs. Effective access to services depends not only on a positive policy environment that enables programs to provide services but also on the absence of negative policies and practices that might keep otherwise motivated people from accessing prevention and treatment services—such as the fear of being arrested or losing their job if seen at a clinic or prevention program and identified as an MSM/TG/SW. The inventory thus covers key documents that may not directly affect the availability of services and medications but could affect whether people in need of these services seek them out.

The inventory considers five types of documents: legislation, policies, legal decisions/judicial precedent, regulations, guidelines/protocols, and operational plans.

Legislation: Laws and other documents enacted or originated by the *legislative branch* of government, such as a parliament or national assembly. Is broadly inclusive of legal codes in many sectors.

Policies: High-level documents issued by the *executive branch* of government, such as the president, prime minister, and other cabinet ministers. Includes edicts, presidential or ministerial decrees, national strategies, and programs.

Legal decisions/Judicial precedent: The history of *court decisions and legal rationale* that guide interpretation and implementation of legislation.

Regulations: Documents issued by *line ministries and departments* that specify how laws, decrees, and other high-level policies should be put into practice. Includes orders, resolutions, and rulings.

Guidelines, protocols: Published documents prepared by *professional associations* (e.g., medical, pharmacy, nursing, and dispensers) that specify the content and delivery of services.

Operational plans: Published documents prepared by *departments and programs* (e.g., a national HIV treatment program), usually on an annual or biennial basis, that specify the type and number of program activities to be conducted, such as training events, supervision schedules, commodities, and/or purchases.

Operational protocols: Specific guidance on day-to-day operations and standards.

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After the country's policies have been collected, summary information can be put into a matrix that provides a snapshot of existing policies. The inventory and analysis of country policies can be used, either as part of the model or independently, to identify areas of strength and weakness in the country's policy/program environment and measure change in the environment over time. This allows users of the model to conduct a diagnosis, establish a baseline, advocate for specific changes, and evaluate the impact of advocacy efforts.

The purpose of the inventory is to compile and analyze a reference library of policy documents addressing specific policy areas that impact service implementation. As such, it does not assess the adequacy of the documents' provisions or the extent to which they have been put into practice (see example sidebar). Information on these aspects will be collected following the inventory, using the interview tools. While there is no single set of standards that encompasses all "best practices" for every situation and circumstance, the inventory identifies best practices based on the content and context of the source references cited for each policy standard.

For example, for all services, data collection would ascertain whether policies allocate government funding for that service. If there is a budget-related document or authorization with a line item for the service, the data collector should check "yes," denoting that a line-item budget has been mandated, and should attach the relevant policy document(s), noting the section or clause.

The data collector should not attempt to judge whether the amount of budget is sufficient to respond to the need or whether the allotted resources were spent effectively. These analyses will fall under the realm of a more in-depth implementation and effectiveness methodology.

Profile of Team to Complete the Inventory Tools

The contents of the inventory are wide ranging—from administrative coordination and decision-making, to public health and criminal law statutes, to service-specific guidelines and, finally, to legal decisions and judicial precedents in legal systems where these are integral parts of the legal code. The policy documents to be collected range from national legislation (and in some cases, the national constitution itself) to clinical guidelines and operational plans. Because it is unlikely that a single person will have the policy and content area expertise to complete the entire inventory, a country should assemble a team of knowledgeable individuals who collectively cover the content areas.

In addition, given the overlapping identities and complex contexts discussed in the implementation considerations presented in the Introduction, engaging members of these the MSM/TG/SW populations in the design of the assessment will help to fine-tune the assessment so that it addresses the specific characteristics of primary interest.

Instructions for Filling Out the Inventory Tools

1. Engage stakeholders in deciding the scope and scale of the inventory. Identify the policy sections most relevant to the country context. Note that, even if some policy areas are not analyzed, keep the numbering system the same, as it is designed to align with policy assessments in other countries and policy assessments done with the Policy Analysis and Advocacy Decision Model for HIV-Related Services: People Who Inject Drugs (PWID DM). (See http://www.healthpolicyproject.com/index.cfm?id=HIVPolicyModels).

Throughout this document, the term "policy" is inclusive of legislation, policies, legal decisions, judicial precedent, regulations, guidelines, and/or operational plans and protocols.

2. For each item in the inventory (1, 2, 3, 4, etc.), determine whether the country has enacted or issued pertinent policies.
3. For every policy identified, decide whether it is a law, policy, regulation, guideline, and/or operational plan and identify those components that address the best practices identified under each number (a, b, c, d, etc.).
4. Document the policy citation related to each best practice (name of policy and page/article/paragraph) and the responsible agency in a separate document.
5. For every identified policy citation, assess whether it meets the criteria identified in the best practice language (a, b, c, d, etc.).
6. Note that you may find multiple citations from different sources that may conflict. Cite, assess, and document each policy individually.

Hints

Before starting to score, skim every policy document from the beginning to end. You may find a lot of useful information for multiple items.

Re-read each assessment question and the background information twice before you start to make sure you understand the context of what is being asked.

Do not forget to record the page number and section title of each source along with its citation.

Collect an electronic copy of all policy documents. If documents are not available electronically, collect paper copies.

Collect a copy (in English and electronically, if possible) of the relevant document(s). Many documents may pertain to more than one item in the inventory. Each discrete document should be attached only once. If it is not possible to locate a physical copy of the policy document, describe it in detail—for example, the exact name of the document, date of publication, registry number, etc. Use the description in lieu of the actual document only as a last resort.

Note that, more often than not, the documents pertaining to the various subjects in the inventory will not be in a law, regulation, or policy that uses the term "HIV" in its title. Rather, many of the relevant documents will be trade, procurement, or customs documents or may be part of a criminal or family law that uses a different title (see "Profile of team to complete the inventory tools" above).

Definition of Terms

Different countries may use different terms to describe substance use and related services, and even different documents from the same country may use different terms to refer to the same concept. The data collector should be mindful of these variations and not restrict the search to a single, precise term.

Gender identity: Gender identity is understood to refer to each person's deeply felt internal and individual experience of gender—which may or may not correspond with the sex assigned at birth—including the personal sense of the body (which may involve, if freely chosen, modification of bodily appearance or function by medical, surgical, or other means) and other expressions of gender, including dress, speech, and mannerisms (The Global Fund, n.d.).

Sex and gender: Sex refers to the biological (genetic and anatomical) characteristics that define humans as female, male, or transsexual or intersex. Gender refers to the array of socially constructed roles and

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relationships, personality traits, attitudes, behaviors, values, relative power, and influence ascribed by society. Whereas biological sex is determined by genetic and anatomical characteristics, gender is an acquired identity (e.g., male, female, transgender people) that is relational, learned, changes over time, and varies widely within and across cultures, religions, class, and ethnicity (The Global Fund, n.d.).

Sexual orientation: Sexual orientation is understood to refer to each person's capacity for profound emotional, affectional, and sexual attraction to, and intimate and sexual relations with, individuals of a different gender (e.g., heterosexual), the same gender (e.g., homosexual), or more than one gender (e.g., bisexual) (The Global Fund, n.d.).

Mention: The purpose of the inventory is to collect all documents that expressly allow or prohibit specific practices as described in each item. The term "mention" includes both permission and prohibition. Pay attention to the entire phrase. For example, a document that states "public facilities may provide treatment" mentions governmental but not nongovernmental facilities; however, if the document states "only government facilities may provide treatment," it explicitly mentions public facilities and implicitly notes that nongovernmental facilities would be prohibited because *only* public facilities are permitted.

Active participation: New policies, guidelines, and other procedures are usually developed by a group of people working together, rather than by a single individual. Often a governmental office decides who should participate in that group and ensures that the group meets and accomplishes the task. Other organizations or individuals may be invited to observe the meetings, comment on draft documents before they are officially approved, or receive the final documents before they are formally circulated. An organization is considered to be an *active* participant if it contributes directly to discussions, votes on the outcomes, or has another way of making its positions known and considered. An organization invited to observe the process would not be considered an active participant unless there was an additional mechanism to ensure that its opinions were considered in the debate; similarly, an organization receiving a pre-publication copy of an approved document would not be an active participant.

Prison: In its use throughout this document, the term prison is inclusive of all pre- and post-trial detention settings for both adults and youth. Because of the extended time that individuals can spend in pre-trial detention, the common practice of commingling both accused and convicted individuals, and examples of different levels of resources and services for pre- and post-trial detainees, assessments inclusive of prison and detention settings will need to document the differences in the policy environment for these settings.

Sex Worker: "Includes female, male, and transgender adults and young people (18 years of age and above) who receive money or goods in exchange for sexual services, either regularly or occasionally" (WHO, 2012).

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1. Framework—Coordination and Integration

The right to health, like all human rights, imposes three types or levels of obligations on States parties: the obligations to ***respect, protect and fulfill***. In turn, the obligation to fulfill contains obligations to facilitate, provide and promote. The obligation to **respect** requires States to refrain from interfering directly or indirectly with the enjoyment of the right to health. The obligation to **protect** requires States to take measures that prevent third parties from interfering with article 12 guarantees. Finally, the obligation to **fulfill** requires States to adopt appropriate legislative, administrative, budgetary, judicial, promotional and other measures towards the full realization of the right to health (OHCHR , 2006, p. 11).

International guidelines identify the importance of a coordinated, participatory, transparent, and accountable approach that integrates program responsibilities across all branches of government, aligns with international standards, supports international initiatives, and shares knowledge and information (UNAIDS, 2006, p. 63). This section focuses on policies that impact the coordination of HIV services, including the following:

- Multisectoral coordination
- Integration with the broader development agenda
- Access equity between prison and community settings
- Roles and responsibilities of government and community programs

An effective coordination framework identifies the value of (1) multisectoral coordination, roles, and responsibilities; (2) coordination among related health programs; (3) the importance of services within the prison system in achieving national goals; and (4) evidence-based decisionmaking in setting program priorities, budgets, and approaches for services for MSM/TG/SW.

In serving MSM/TG/SW populations, a primary example of an opportunity for coordination is understanding the connection between gender, race, citizenship, religion, and socioeconomic status with sexual risk and resilience, including the role that violence plays in initiation into and the risk of acquiring HIV while engaged in sex work (UNDP, ICRW and The Global Coaltion on Women and AIDS, 2009), (WHO, 2000).

Detailed Technical Guidance

UNAIDS Gender Inequality Resource Page
http://www.unaids.org/en/targetsandcommitments/eliminatinggenderinequalities/

USAID – Gender-based Violence Resource Page
http://www.usaid.gov/what-we-do/gender-equality-and-womens-empowerment/gender-based-violence

For example, gender experts positioned within ministries and organizations such as those pertaining to labor, commerce, transportation, education, immigration, prisons, or armed forces, can serve as strong voices for gender equality and have a significant impact on ensuring gender equality in policy and programs, including the potential to support programs for MSM/TG/SW. Where this has happened, gender experts have had active roles in shaping national HIV policies and strategies. However, when gender-related work is assigned to government officials who have little interest or training in this area, leveraging this sector becomes more difficult and may require advocacy to help them become aware of the

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significant role that sexuality and gender play in addressing key populations (AIDSTAR-One, 2009, p. 13).

An evaluation of El Salvador's National Strategic Plan for the Prevention, Attention and Control of HIV/AIDS and STIs (2005–2010) found that the plan lacks a strategy specifically for transgender people, gender equality, and sexual diversity. It discovered that the government invests most of its funds in the provision of HCT and prevention in the general population, while few resources are directed towards key populations. In 2006 and 2007, for example, the government, donors, and NGOs spent just $30,000 on HIV prevention programs for transgender people out of a total budget of more than $16 million (AIDSTAR-One, 2011, p. 2).

Integrating MSM, TG, and SW issues into a broader set of issues and the workplans of the respective government agencies is more likely to capitalize on a broader set of alliances, along with reducing the likely negative reaction of policymakers and the population at large (Lwabaayi, Anyamele, Binswanger, & Nguyen, 2005, p. 26). While countries like Brazil have included MSM as a priority group in their national HIV-prevention campaigns, most national HIV programs in other parts of the world, specifically many countries in Africa, have been slow to acknowledge and address key populations in official policy (Geibel, Tun, Tapsoba, & Kellerman, 2010, p. 322). Also, when countries have acknowledged a role for MSM/TG/SW, language has been sparse or weak, and their inclusion has not occurred throughout all relevant policy documents across sectors (Duvall, Beardsley, Campaoré, Sanon, & Bassonon, 2012).

Sample policy documents to consider include the following (not an exhaustive list):

- Constitution;
- National public health law, policy, strategy, and guidelines;
- National health law, policy, strategy, and guidelines;
- National AIDS law, policy, strategy, and guidelines;
- National STI law, policy, strategy, and guidelines;
- National reproductive health and family planning law, policy, strategy, and guidelines;
- National law enforcement and prison law, policy, strategy, and guidelines;
- National gender policy;
- Sectoral strategies, ministry action plans, operational plans and reports on HIV, STIs, and reproductive health and family planning; and
- National development plans and poverty reduction strategies.

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Inventory and Analysis of Country Documents

Country: _____ Date completed: _____

Name of data collector: _____

Position: _____

Contact information for data collector:

Email address: _____

Telephone/fax: _____

Instructions to data collector:

Please fill out this page and indicate the best way to contact you (email, telephone, fax, etc.) should we need further information.

Refer to the instructions page for directions on how to fill out the inventory. Please provide information only on the areas with which you are familiar or have been assigned to research, and leave the others blank. Within these areas, please be sure to answer "yes" or "no" to each item. All data collectors should address the open-ended question at the end of the areas on which they are working.

If you find a policy document that addresses areas on which you are not working, send the document or citation to the team leader. He or she will share this information with the individual primarily responsible for that section.

When you have completed the inventory, please send all the pages and all the documents you have referenced to [*team leader should fill this in before distributing to team members*].

Throughout this document, the term "policy" is inclusive of legislation, policies, legal decisions, judicial precedent, regulations, guidelines, and/or operational plans and protocols.

I. Framework – Coordination and integration									
A. Collect all policy documents that describe gender, social protection, education, labor, commerce, transportation, immigration, and military/uniformed services programs									
	Gender	Social Protection	Education	Labor	Commerce	Transportation	Immigration / Migration	Prisons	Military / Uniformed Services
• Program mentions environments or circumstances where **sex work** may take place (Y) • Program does not mention environments or circumstances where sex work may take place (N)	1.	2.	3.	4.	5.	6.	7.	8.	9.
• Program mentions environments or circumstances where **male-to-male sexual activity** may take place (Y) • Program does not mention environments or circumstances where male-to-male sexual activity may take place (N)	10.	11.	12.	13.	14.	15.	16.	17.	18.
For each affirmative citation (Y), make an additional assessment (#) on the level of coordination and alignment. Report on a scale of 1–5 (1 [one] representing limited coordination, contradictory program goals and approaches, etc.; 5 [five] representing complete alignment of program goals and approaches).									
• Program mentions **HIV prevention, care, and treatment** services or identifies coordination mechanisms with HIV Programs (Y, #) • Program does not mention HIV prevention, care, and treatment services or identify coordination mechanisms with HIV Programs (N)	19.	20.	21.	22.	23.	24.	25.	26.	27.
• Program mentions **STI diagnosis and treatment services** or identifies coordination mechanisms with STI Programs (Y, #) • Program does not mention STI diagnosis and treatment services or identify coordination mechanisms with STI Programs (N)	28.	29.	30.	31.	32.	33.	34.	35.	36.
• Program mentions **reproductive health and family planning services** or identifies coordination mechanisms with SRHR Programs (Y, #) • Program does not mention reproductive health and family planning services or identify coordination mechanisms with SRHR Programs (N)	37.	38.	39.	40.	41.	42.	43.	44.	45.

B. Collect all policy documents that describe general development plans (UNAIDS, 2009c, p. 95)			
	SW	TG	MSM
• The **National Development Plan** specifically identifies initiatives that address specific needs of population (Y) • The National Development Plan does not specifically identify initiatives that address the needs of population (N)	1.	2.	3.
• The **Common Country Assessment/UN Development Assistance Framework** specifically identifies initiatives that address specific needs of population (Y) • The Common Country Assessment/UN Development Assistance Framework does not specifically identify initiatives that address the needs of population (N)	4.	5.	6.
• The **Poverty Reduction Strategy** specifically identifies initiatives that address specific needs of population (Y) • The Poverty Reduction Strategy does not specifically identify initiatives that address the needs of population (N)	7.	8.	9.
Answer the same question re: addressing the needs of populations for other development and donor strategies			
•	10.	11.	12.
•	13.	14.	15.
•	16.	17.	18.
•	19.	20.	21.
•	22.	23.	24.
C. Collect all policy documents that describe HIV, STI, and SRHR programs in **community settings**			
For #1–33, with each affirmative citation (Y), make an additional assessment (#) on the level of coordination and alignment. Report on a scale of 1–5, one [1] representing limited coordination, contradictory program goals and approaches, etc.; five [5] representing complete alignment of program goals and approaches.	SRHR	STI	HIV
• Program guiding documents mention coordination with **SRHR** Program (Y, #) • Program does not mention coordination with SRHR Program (N)		1.	2.
• Program guiding documents mention coordination with **STI Program** (Y, #) • Program does not mention coordination with STI Program (N)	3.		4.
• Program guiding documents mention coordination with **HIV Program** (Y, #) • Program does not mention coordination with HIV Program (N)	5.	6.	
• Program guiding documents mention coordination with **gender** programs (Y, #) • Program does not mention coordination with gender programs (N)	7.	8.	9.
• Program guiding documents mention coordination with **social protection** programs (Y, #) • Program does not mention coordination with social protection programs (N)	10.	11.	12.

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• Program guiding documents mention coordination with **education** programs (Y, #) • Program does not mention coordination with education programs (N)	13.	14.	15.
• Program guiding documents mention coordination with **labor** programs (Y, #) • Program does not mention coordination with labor programs (N)	16.	17.	18.
• Program guiding documents mention coordination with **commerce** programs (Y, #) • Program does not mention coordination with commerce programs (N)	19.	20.	21.
• Program guiding documents mention coordination with **transportation** programs (Y, #) • Program does not mention coordination with transportation programs (N)	22.	23.	24.
• Program guiding documents mention coordination with **immigration/migration** programs (Y, #) • Program does not mention coordination with immigration/migration programs (N)	25.	26.	27.
• Program guiding documents mention coordination with **prison** programs (Y, #) • Program does not mention coordination with prison programs (N)	28.	29.	30.
• Program guiding documents mention coordination with **military/uniformed services** programs (Y, #) • Program does not mention coordination with military/uniformed services programs (N)	31.	32.	33.
Numerical coordination assessment not required for #34–42			
• Program guiding documents **address the human rights of SWs** (Y) • Program does not address the human rights of SWs (N)	34.	35.	36.
• Program guiding documents **address the human rights of TG** (Y) • Program does not address the human rights of TG (N)	37.	38.	39.
• Program guiding documents **address the human rights of MSM** (Y) • Program does not address the human rights of MSM (N)	40.	41.	42.
D. Intentionally blank to align with PWID DM			
E. Collect all policy documents that describe HIV, STI, and SRHR programs in **prison settings**			
For #1–30 for each affirmative citation (Y), make an additional assessment (#) on the level of coordination and alignment. Report on a scale of 1–5, 1 [one] representing limited coordination, contradictory program goals and approaches, etc.; 5 [five] representing complete alignment of program goals and approaches.	SRHR	STI	HIV
• Program guiding documents mention coordination with **SRHR Program** (Y, #) • Program does not mention coordination with SRHR Program (N)		1.	2.
• Program guiding documents mention coordination with **STI Program** (Y, #) • Program does not mention coordination with STI Program (N)	3.		4.
• Program guiding documents mention coordination with **HIV Program** (Y, #) • Program does not mention coordination with HIV Program (N)	5.	6.	

Throughout this document, the term "policy" is inclusive of legislation, policies, legal decisions, judicial precedent, regulations, guidelines, and/or operational plans and protocols.

• Program guiding documents mention coordination with **gender** programs (Y, #) • Program does not mention coordination with gender programs (N)	7.	8.	9.
• Program guiding documents mention coordination with **social protection** programs (Y, #) • Program does not mention coordination with social protection programs (N)	10.	11.	12.
• Program guiding documents mention coordination with **education** programs (Y, #) • Program does not mention coordination with education programs (N)	13.	14.	15.
• Program guiding documents mention coordination with **labor** programs (Y, #) • Program does not mention coordination with labor programs (N)	16.	17.	18.
• Program guiding documents mention coordination with **commerce** programs (Y, #) • Program does not mention coordination with commerce programs (N)	19.	20.	21.
• Program guiding documents mention coordination with **transportation** programs (Y, #) • Program does not mention coordination with transportation programs (N)	22.	23.	24.
• Program guiding documents mention coordination with **immigration/migration** programs (Y, #) • Program does not mention coordination with immigration/migration programs (N)	25.	26.	27.
• Program guiding documents mention coordination with **military/uniformed services** programs (Y, #) • Program does not mention coordination with military/uniformed services programs (N)	28.	29.	30.
Numerical coordination assessment not required for #31-39			
• Program guiding documents **address the human rights of SWs** (Y) • Program does not address the human rights of SWs (N)	31.	32.	33.
• Program guiding documents **address the human rights of TG** (Y) • Program does not address the human rights of TG (N)	34.	35.	36.
• Program guiding documents **address the human rights of MSM** (Y) • Program does not address the human rights of MSM (N)	37.	38.	39.
F. Intentionally blank to align with PWID DM			
G. Collect all policy documents that describe HIV, STI, and SRHR programs in community or prison settings (WHO, 1993, pp. 1-8), (UNODC, 2006, pp. 17, 22-26), (WHO, 2007a, pp. 6, 11), (UNAIDS, 1999, p. 61) , (UNODC, 2008a, p. 18), (UNODC, 2009, pp. 42, 43), (UNODC, 2010, pp. 39, 41)			
	SRHR	STI	HIV
• Policy defines or promotes **equitable levels** of access and resources between **community and prison settings** (Y) • Policy is silent on equitability or describes different or conflicting levels of access and resources for community and prison settings (N)	1.	2.	3.

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H. Collect all policy documents that describe HIV, STI, and SRHR programs in community or prison settings		
• Policy defines **roles and responsibilities** between government agencies and **nongovernmental organizations** for administration and provision of services (Y) • Policy makes no mention of roles and responsibilities between government agencies and nongovernmental organizations (N)	(Y/N)	
	Community	Prison
HIV Program	1.	2.
STI Program	3.	4.
SRHR Program	5.	6.
• Policy defines **roles and responsibilities** between government agencies and **civil society organizations** for administration and provision of services (Y) • Policy makes no mention of roles and responsibilities between government agencies and civil society organizations (N)	(Y/N)	
	Community	Prison
HIV Program	7.	8.
STI Program	9.	10.
SRHR Program	11.	12.
Please include any additional remarks or observations about related policy areas not included in the items listed above. If analysis is being done at different levels of government, be sure to identify whether national, regional, and/or local policies differ or contradict each other.		

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2. Framework—Data-informed Planning and Budgeting

States must ensure that strategic frameworks for HIV include programs for key populations that

Have a clearly defined budget;

- Have explicit provisions for allocating the funds necessary to implement the proposed programs and actions;
- Ensure compliance of priorities and targets with available scientific evidence;
- Provide specific coverage or scale-up targets for services;
- Specifically ensure access of key populations, including those in prisons, to core interventions;
- Enlist full commitment from all designated authorities across various sectors; and
- Identify clear implementation mechanisms (UNODC & CHALN, 2010).

An evidence-based process for setting priorities among target populations should be based on the epidemiologic profile and the community services assessment (CDC, 2008).

International guidelines require States to ensure that HIV service frameworks have clearly defined budgets and that program design and implementation are informed by scientific evidence. This section focuses on policies that relate to the use of data/evidence to inform decisionmaking in relation to HIV service, including the following:

- Coverage targets, funding, and scale up
- Disaggregated data reporting
- Size estimation
- United Nations General Assembly Special Session (UNGASS) indicator reporting
- Data on sexual violence in prisons
- HIV surveillance reporting

Detailed Technical Guidance

Estimating the Size of Populations at Risk for HIV – Issues and Methods

http://data.unaids.org/publications/external-documents/estimatingpopsizes_en.pdf

Understanding the size of the population is the foundation upon which to identify the burden of disease and service capacity needs. This information provides a critical foundation for advocacy, resource and program planning, measurement of coverage, and monitoring and evaluation of programs. While many countries may have national population prevalence estimates, advocacy and programming for MSM/TG/SW require data specific to these populations. Also, because MSM/TG/SW may not be distributed uniformly across a country, local or regional data are important for program planning and resource allocation (UNAIDS/WHO, 2003).

Epidemiological surveillance of MSM in countries around the world is woefully inadequate for determining the true burden of HIV among MSM. This lack of data is used to justify the absence of effective MSM programming, and not using community-generated data creates a logical paradox for government and civil society advocacy for increased resources. The UNGASS process provides limited

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accountability for marginalized or vulnerable groups and, in its current manifestation, does little to resolve this problem (amfAR & John Hopkins Bloomberg School of Public Health, 2012, p. 6). Studies point out that relevant data related to MSM are least available in settings where stigma is the most intense and manifested in the form of criminalization of sexual practices, lack of prevention services, and exclusion from national surveillance systems (amfAR & John Hopkins Bloomberg School of Public Health, 2012, pp. 10-11).

In Mozambique and Nigeria, MSM remain uncounted, unrepresented, and under-served in the HIV epidemic. Limited government buy-in makes these programs very urban centric and out of reach of most MSM in the country (amfAR & John Hopkins Bloomberg School of Public Health, 2012, p. 6). Similarly, due to the criminalized status of MSM in Ethiopia, the government openly refuses to recognize, track, or provide services to MSM; the few organizations that work with MSM remain silent for fear of official persecution; and many MSM forego seeking medical care because of discrimination (amfAR & John Hopkins Bloomberg School of Public Health, 2012, p. 5).

As described in the examples above, it is also important that local advocates and stakeholders understand data collection and use in the context of the political environment. Careful attention should be paid to how data are summarized and disseminated, with an awareness of how they may be misconstrued and/or used to support discriminatory policy dialogue—either because the numbers are too small to merit attention, or because the numbers are so big that restrictive policies must be enacted. The quality of data and their subsequent interpretation is also context dependent, as individuals may not feel safe enough to be honest in providing risk-behavior information (e.g., an MSM who identifies heterosexual risk as his primary risk for HIV).

Sample policy documents to consider (not an exhaustive list) include the following:

- Estimations of Resource Flows and Expenditures
- UNGASS Country Progress Reports
- Health Statistics Yearbooks
- Behavioral Surveillance Surveys
- National laws on statistical activities
- National public health law, policy, strategy, and guidelines
- National health law, policy, strategy, and guidelines
- National AIDS law, policy, strategy, and guidelines
- National STI law, policy, strategy, and guidelines
- National reproductive health and family planning law, policy, strategy, and guidelines
- National law enforcement and prison law, policy, strategy, and guidelines

Throughout this document, the term “policy” is inclusive of legislation, policies, legal decisions, judicial precedent, regulations, guidelines, and/or operational plans and protocols.

Inventory and Analysis of Country Documents

Country: _____ Date completed: _____

Name of data collector:_____

Position: _____

Contact information for data collector:

Email address: _____

Telephone/fax: _____

Instructions to data collector:

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If you find a policy document that addresses areas upon which you are not working, send the document or citation to the team leader. He or she will share this information with the individual primarily responsible for that section.

When you have completed the inventory, please send all the pages and all the documents you have referenced to [*team leader should fill this in before distributing to team members*].

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II. Framework – Data-informed planning and budgeting

A. Collect all policy documents that describe SRHR, STI, and HIV programs in community and prison settings (CESCR, 2000, p. 13), (UNAIDS, 2006, p. 23), (CESCR, 2000, p. 7), (WHO, 1993, p. 8), (UNODC, 2006, p. 28), (CHALN, 2006e, p. 34), (De Lollo, 2012, p. 19)

Policy:	SRHR		STI		HIV	
	Community	Prison	Community	Prison	Community	Prison
• Identifies **services for SWs** (Y) • Does not identify services for SWs (N)	1.	2.	3.	4.	5.	6.
• Requires **internationally recognized scientific basis for determining services** for SWs (Y) • Does not state that services will be determined by scientific evidence, identifies another evidence base, or identifies services that do not fall within internationally recognized standards (N)	7.	8.	9.	10.	11.	12.
• Identifies **coverage targets for SWs** (Y) • Does not mention coverage targets for SWs (N)	13.	14.	15.	16.	17.	18.
• Coverage targets for SWs **reference international coverage recommendations** (Y) • Coverage targets are made without reference or comparison to international coverage recommendations (N)	19.	20.	21.	22.	23.	24.
• Requires **evidence basis for funding decisions** for SWs (Y) • Policy for making funding decisions for SW services is not clear or not based on scientific and epidemiological data (N)	25.	26.	27.	28.	29.	30.
• Identifies **achievement of coverage targets for SWs** as a goal for funding allocations (Y) • Does not tie funding decisions to achievement of coverage targets (N)	31.	32.	33.	34.	35.	36.
• Identifies **government commitment to scale** up services for SWs (Y) • Does not identify government commitment to scaling up services for SWs (N)	37.	38.	39.	40.	41.	42.
• Identifies **data reporting requirements that disaggregate SWs from other participants** (Y) • Does not identify data reporting requirements specific to SWs (N)	43.	44.	45.	46.	47.	48.

• Policy describes mechanisms for identifying and monitoring and evaluation of **program outcomes for SWs** (Y) • Policy makes no mention of SW-specific outcomes (N)	49.	50.	51.	52.	53.	54.
• Identifies **services for clients of SWs** (Y) • Does not identify services for clients of SWs (N)	55.	56.	57.	58.	59.	60.
• Requires **internationally recognized scientific basis for determining services** for clients of SWs (Y) • Does not state that services will be determined by scientific evidence, identifies another evidence base, or identifies services that do not fall within internationally recognized standards (N)	61.	62.	63.	64.	65.	66.
• Identifies **coverage targets for clients of SWs** (Y) • Does not mention coverage targets for clients of SWs (N)	67.	68.	69.	70.	71.	72.
• Coverage targets for clients of SWs **reference international coverage recommendations** (Y) • Coverage targets are made without reference or comparison to international coverage recommendations (N)	73.	74.	75.	76.	77.	78.
• Requires **evidence basis for funding decisions** for clients of SWs (Y) • Policy for making funding decisions for clients of SW services is not clear or not based on scientific and epidemiological data (N)	79.	80.	81.	82.	83.	84.
• Identifies **achievement of coverage targets for clients of SWs** as a goal for funding allocations (Y) • Does not tie funding decisions to achievement of coverage targets (N)	85.	86.	87.	88.	89.	90.
• Identifies **government commitment to scale** up services for clients of SWs (Y) • Does not identify government commitment to scaling up services for clients of SWs (N)	91.	92.	93.	94.	95.	96.
• Identifies **data reporting requirements that disaggregate clients of SWs from other participants** (Y) • Does not identify data reporting requirements specific to clients of SWs (N)	97.	98.	99.	100.	101.	102.

A. Collect all policy documents that describe SRHR, STI, and HIV programs in community and prison settings (CESCR, 2000, p. 13), (UNAIDS, 2006, p. 23), (CESCR, 2000, p. 7), (WHO, 1993, p. 8), (UNODC, 2006, p. 28), (CHALN, 2006e, p. 34), (De Lollo, 2012, p. 19)						
• Policy describes mechanisms for identifying and monitoring and evaluation of **program outcomes for clients of SWs** (Y) • Policy makes no mention of outcomes specific to clients of SWs (N)	103.	104.	105.	106.	107.	108.
• Identifies **services for TG** (Y) • Does not identify services for TG (N)	109.	110.	111.	112.	113.	114.
• Requires **internationally recognized scientific basis for determining services** for TG (Y) • Does not state that services will be determined by scientific evidence, identifies another evidence base, or identifies services that do not fall within internationally recognized standards (N)	115.	116.	117.	118.	119.	120.
• Identifies **coverage targets for TG** (Y) • Does not mention coverage targets for TG (N)	121.	122.	123.	124.	125.	126.
• Coverage targets for TG **reference international coverage recommendations** (Y) • Coverage targets are made without reference or comparison to international coverage recommendations (N)	127.	128.	129.	130.	131.	132.
• Requires **evidence basis for funding decisions** for TG (Y) • Policy for making funding decisions for TG services is not clear or not based on scientific and epidemiological data (N)	133.	134.	135.	136.	137.	138.
• Identifies **achievement of coverage targets for TG** as a goal for funding allocations (Y) • Does not tie funding decisions to achievement of coverage targets (N)	139.	140.	141.	142.	143.	144.
• Identifies **government commitment to scale** up services for TG (Y) • Does not identify government commitment to scaling up services for TG (N)	145.	146.	147.	148.	149.	150.

• Identifies **data reporting requirements that disaggregate TG from other participants** (Y) • Does not identify data reporting requirements specific to TG (N)	151.	152.	153.	154.	155.	156.
• Policy describes mechanisms for identifying and monitoring and evaluation of **program outcomes for TG** (Y) • Policy makes no mention of TG-specific outcomes (N)	157.	158.	159.	160.	161.	162.
• Identifies **services for MSM** (Y) • Does not identify services for MSM (N)	163.	164.	165.	166.	167.	168.
• Identifies **coverage targets for MSM** (Y) • Does not mention coverage targets for MSM (N)	169.	170.	171.	172.	173.	174.
• Coverage targets for MSM **reference international coverage recommendations** (Y) • Coverage targets are made without reference or comparison to international coverage recommendations (N)	175.	176.	177.	178.	179.	180.
• Requires **evidence basis for funding decisions** for MSM (Y) • Policy for making funding decisions for MSM services is not clear or not based on scientific and epidemiological data (N)	181.	182.	183.	184.	185.	186.
• Identifies **achievement of coverage targets for MSM** as a goal for funding allocations (Y) • Does not tie funding decisions to achievement of coverage targets (N)	187.	188.	189.	190.	191.	192.
• Identifies **government commitment to scale** up services for MSM (Y) • Does not identify government commitment to scaling up services for MSM (N)	193.	194.	195.	196.	197.	198.
• Identifies **data reporting requirements that disaggregate MSM from other participants** (Y) • Does not identify data reporting requirements specific to MSM (N)	199.	200.	201.	202.	203.	204.
• Policy describes mechanisms for identifying and monitoring and evaluation of **program outcomes for MSM** (Y) • Policy makes no mention of MSM-specific outcomes (N)	205.	206.	207.	208.	209.	210.
Collect any available reports for these programs and analyze actual reporting against reporting requirements.						

B. Collect all policy documents that describe population **size estimation methodologies** used for SWs, TG, clients of SWs, and MSM—see citation for explanation of methods (UNAIDS/WHO, 2003, pp. 29-37)			
	Census/ capture-recapture	Multiplier	Population Behavioral Surveys
• Policy identifies data and methodologies for **SW** population size estimation (Y) • Policy does not mention data and methodologies for SW population size estimation (N)	1.	2.	3.
• Policy identifies data and methodologies for **SW client** population size estimation (Y) • Policy does not mention data and methodologies for SW client population size estimation (N)	4.	5.	6.
• Policy identifies data and methodologies for **TG** population size estimation (Y) • Policy does not mention data and methodologies for TG population size estimation (N)	7.	8.	9.
• Policy identifies data and methodologies for **MSM** population size estimation (Y) • Policy does not mention data and methodologies for MSM population size estimation (N)	10.	11.	12.
• Policy identifies opportunities to **engage SWs in validating population size estimates** (Y) • Policy does not identify opportunities to engage SWs in validating population size estimates (N)			13.
• Policy identifies opportunities to **engage TG in validating population size estimates** (Y) • Policy does not identify opportunities to engage TG in validating population size estimates (N)			14.
• Policy identifies opportunities to **engage MSM in validating population size estimates** (Y) • Policy does not identify opportunities to engage MSM in validating population size estimates (N)			15.
Please note if a policy requires other size estimation methodologies for any of these populations. Collect the most recent size estimation reports, if available.			

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C. Collect the most recent UNGASS Indicator Report (UNAIDS, 2009c)	
• Country reports on **Indicator #8** (percentage of most-at-risk populations that have received an HIV test in the last 12 months and who know the results) AND country data are no more than 2 years old (Y) • Country does not report on Indicator #8 or uses data that are more than 2 years old (N)	1.
• Country reports on **Indicator #9** (percentage of most-at-risk populations reached with HIV prevention programs) AND country data are no more than 2 years old (Y) • Country does not report on Indicator #9 or uses data that are more than 2 years old (N)	2.
• Country reports on **Indicator #14** (percentage of most-at-risk populations who both correctly identify ways of preventing the sexual transmission of HIV and reject major misconceptions about HIV transmission) AND country data are no more than 2 years old (Y) • Country does not report on Indicator #14 or uses data that are more than 2 years old (N)	3.
• Country reports on **Indicator #18** (percentage of female and male sex workers reporting the use of a condom with their most recent client) AND country data are no more than 2 years old (Y) • Country does not report on Indicator #18 or uses data that are more than 2 years old (N)	4.
• Country reports on **Indicator #19** (percentage of men reporting the use of a condom the last time they had anal sex with a male partner) AND country data are no more than 2 years old (Y) • Country does not report on Indicator #19 or uses data that are more than 2 years old (N)	5.
• Country reports on **Indicator #23** (percentage of most-at-risk populations who are HIV infected) AND country data are no more than 1 year old (Y) • Country does not report on Indicator #23 or uses data that are more than 1 year old (N)	6.
D. Collect all policy documents that describe regular data collection requirements for **sexual violence in prison** (NPREC, 2009)	
• Policy identifies **data collection requirements** of the incidence and context of sexual violence in prison (Y) • Policy does not identify data collection requirements or include data specific to sexual violence in prison (N)	1.
If a policy requires collection of data on sexual violence, obtain a copy of the last report with this information and analyze actual reporting against reporting requirements.	
E. Intentionally blank to align with PWID DM	
F. Intentionally blank to align with PWID DM	
G. Collect all policy documents that describe data collection requirements for HIV surveillance	

	MSM	TG	SW
• HIV surveillance systems collect information specific to MSM/TG/SW (Y) • HIV surveillance systems do not disaggregate data on MSM/TG/SW (N)	1.	2.	3.

Please include any additional remarks or observations about related policy areas not included in the items listed above. If analysis is being done at different levels of government, be sure to identify whether national, regional, and/or local policies differ or contradict each other.

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3. Community Engagement and Participation

> "Programs or policies that are developed without the involvement and support of the people they are attempting to assist or serve are less likely to succeed" (WHO, 2005a, p. 47).
>
> "States should ensure, through political and financial support, that community consultation occurs in all phases of HIV/AIDS policy design and program implementation and evaluation and that community organizations are enabled to carry out their activities, including in the fields of ethics, law, and human rights, effectively. Community representation should comprise people living with HIV, community-based organizations, AIDS-service organizations, human rights NGOs, and representatives of vulnerable groups. Formal and regular mechanisms should be established to facilitate ongoing dialogue with and input from such community representatives into HIV-related government policies and programs" (UNAIDS, 1999, pp. 199-120).

The value of including target populations in the design, implementation, and evaluation of programs and policies is well documented in both human rights and intervention-specific guidelines. This component of the Decision Model identifies policy factors that affect partnerships of government and community organizations in the design, implementation, and monitoring of policy and services, including the following:

- CCM membership
- Membership of multisectoral HIV/AIDS coordination bodies
- The role of nongovernmental and civil society organizations in service delivery
- State support for the establishment and funding of NGOs and CSOs

Despite the recommendations of leading international technical agencies on meaningful involvement of representatives of key populations (e.g., MSM/TG/SW) in HIV policymaking processes, vulnerable communities are often either excluded from decisionmaking or do not have the capacity to exercise sufficient influence in the process. Efforts to create strong partnerships between government and community at national, local, and community levels help to identify and remove barriers that key populations face in relation to accessing services and reinforce the implementation of policies and programs targeting key populations. These partnerships also support monitoring and evaluation mechanisms that document and hold officials accountable for implementation of policies that impact these communities. They also encourage community members to be engaged in the governing processes and reinforce the implementation of supportive policies and laws developed at the national level (UNAIDS, 2009b, pp. 15, 16). These partnerships also facilitate the creation and support of NGOs and CSOs working directly with and on behalf of MSM, TG, and SWs.

The National Strategic Plan (NSP) of most countries describes the overarching design of the HIV interventions in a country. It determines the emphasis, scale, and budget of the components of the response to the HIV epidemic. Thus, it becomes critical that marginalized groups such as SWs, MSM, and TG are part of the team that designs the NSP and overall responses. Many countries have written guidelines on the composition of committees and procedures for consultation that involve most marginalized and key affected populations. Understanding these procedures is not only critical to the involvement of most marginalized populations, but also to beginning dialogues with other stakeholders that may be critical in the overall response. Many countries (like Ethiopia) ignore participation of key

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populations on board or policy making bodies such as the National AIDS Council (Federal HIV/AIDS Prevention and Control Office, Ethiopia, 2010, p. 19).

In addition to engaging the involvement of individuals or representatives of key populations, programs and policies are unlikely to be successful without the simultaneous involvement of those individuals who influence these populations' vulnerability to HIV, including sex industry gatekeepers, sexual partners, police, local authorities, and influential individuals who directly affect the success of interventions (WHO & SEARO, 2008, p. 33).

The development and implementation of policies and initiatives to address HIV/AIDS in prisons should also involve input and support from relevant international bodies and organizations; all levels of national government, including those with related responsibilities; CSOs; prison staff and their representative organizations; researchers; and relevant professional organizations. It must also recognize the important role and expertise of prisoners and former prisoners, the families of prisoners, and people living with HIV/AIDS, and provide mechanisms for their meaningful participation throughout the process of developing and implementing legislation, policies, and programs (UNAIDS, WHO, 2006, p. 13).

Engagement of target populations is also achieved through the establishment of nongovernmental and civil society organizations. Several studies show that vulnerability to HIV and exploitation is lower among SWs who have family and community support and access to organizations such as clubs, banks, schools, and religious institutions. Organizing to improve conditions in the sex industry can help to promote safe sex and sustain safer working conditions. This usually results in increased SW control over their working environment. Some SW organizations have evolved into powerful self-advocacy forces. They actively challenge SW bosses and clients, as well as politicians, police, and others they view as contributing to SWs' vulnerability (Global Network of Sex Work Projects, 2011, p. 7).

While there may be no policy against establishment of NGOs or CSOs serving MSM/TG/SW, the process of achieving formal registration status can be put under indefinite review—effectively blocking the establishment and funding of these organizations (Duvall, Beardsley, Campaoré, Sanon, & Bassonon, 2012). Restrictive legal authorization may also take the form of policies denying or withdrawing registration from CSOs providing services to MSM/TG/SW groups. Due to the existence of sodomy laws and pervasive societal intolerance, those who work on these issues do so as secretly and anonymously as possible (Kisia & Wahu, 2010). Organizations working on MSM/TG/SW issues are often denied registration on the grounds of contravening "public order" or "public morals." For instance, in Botswana, the Registrar of Societies, in denying registration to LeGaBiBo, an organization working to promote sexual health among lesbian, gay, bisexual, transgender, and intersex people (LGBTIs), wrote 'We have considered your application, however we wish to advise you that the country (Botswana) constitution does not recognize homosexuals. Plus the societal act Section 7 (2) (a) which says that: The Registrar shall refuse to register and shall not exempt from registration a local society where it appears to him that any of the objects of the society is, or is likely to be used for any unlawful purpose or any purpose prejudicial to or incompatible with peace, welfare or good order in Botswana' (Changing Attitude).

Policy silence regarding the full involvement of MSM/TG/SW in the decisionmaking misses an important opportunity for the community to voice concerns and needs to government officials; advocate for availability, increased coverage, and better quality of services; and ensure that national responses address the specific needs of populations. Finally, this situation hinders dialogue between the government and

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vulnerable communities and undermines efforts to remove criminalizing and stigmatizing approaches from national policies.

Sample policy documents to consider (not an exhaustive list) include the following:

- Global Fund proposals
- Donor partnership agreements
- Decrees concerning the creation, attribution, organization, and functioning of national councils for AIDS, STIs, and reproductive health and family planning
- National public health law, policy, strategy, and guidelines
- National health law, policy, strategy, and guidelines
- National AIDS law, policy, strategy, and guidelines
- National STI law, policy, strategy, and guidelines
- National reproductive health and family planning law, policy, strategy, and guidelines
- National law enforcement and prison law, policy, strategy, and guidelines

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Inventory and Analysis of Country Documents

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If you find a policy document that addresses areas upon which you are not working, send the document or citation to the team leader. He or she will share this information with the individual primarily responsible for that section.

When you have completed the inventory, please send all the pages and all the documents you have referenced to [*team leader should fill this in before distributing to team members*].

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III. Community engagement and participation

A. Collect all policy documents that identify **decisionmaking processes** for government policies and programs for SRHR, STI, and HIV programs (UNAIDS, 1999, pp. 119-120), (UNAIDS, 2006, pp. 24-26), (UNDP, 2009b, pp. 10, 11)

	SRHR	STI	HIV
• Policy identifies **formal and regular mechanisms for active participation in decisionmaking or policy design** from individual and organizational representatives of **SWs** (Y) • Policy does not provide specific mechanisms ensuring active participation or explicitly excludes participation by SWs (N)	1.	2.	3.
• Policy identifies formal and regular mechanisms for active participation in **evaluation of policy implementation** from individual and organizational representatives of **SWs** (Y) • Policy does not provide specific mechanisms ensuring active participation or explicitly excludes participation by SWs (N)	4.	5.	6.
• Policy identifies **formal and regular mechanisms for active participation in decisionmaking or policy design** from individual and organizational representatives of **TG** (Y) • Policy does not provide specific mechanisms ensuring active participation or explicitly excludes participation by TG (N)	7.	8.	9.
• Policy identifies formal and regular mechanisms for active participation in **evaluation of policy implementation** from individual and organizational representatives of **TG** (Y) • Policy does not provide specific mechanisms ensuring active participation or explicitly excludes participation by TG (N)	10.	11.	12.
• Policy identifies **formal and regular mechanisms for active participation in decisionmaking or policy design** from individual and organizational representatives of **MSM** (Y) • Policy does not provide specific mechanisms ensuring active participation or explicitly excludes participation by MSM (N)	13.	14.	15.
• Policy identifies formal and regular mechanisms for active participation in **evaluation of policy implementation** from individual and organizational representatives of **MSM** (Y) • Policy does not provide specific mechanisms ensuring active participation or explicitly excludes participation by MSM (N)	16.	17.	18.

B. Collect all policy documents that describe **the Country Coordinating Mechanism** (De Lollo, 2012, p. 13)

	MSM	TG	SW
• Documents require membership of MSM/TG/SW or organizations serving MSM/TG/SW (Y) • Documents fail to require membership of population or organizations serving them (N)	1.	2.	3.

Collect membership list of CCM and compare to representation requirements.

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C. Collect all policy documents that describe/identify **national multisectoral HIV/AIDS coordination bodies** (National AIDS Council or equivalent)			
	MSM	TG	SW
• Documents require membership of MSM/TG/SW or organizations serving MSM/TG/SW (Y) • Documents fail to require membership of population or organizations serving them (N)	1.	2.	3.
Collect membership list of coordination body and compare to representation requirements.			

D. Collect all policy documents that identify the **role of nongovernment organizations** in SRHR, STI, and HIV programs (UNAIDS, 1999, p. 130) (UNAIDS, 2008, pp. 215-217), (UNDP, 2009b, pp. 10, 11)						
Policy:	SRHR		STI		HIV	
	Community	Prison	Community	Prison	Community	Prison
• Policy **supports the registration of nongovernment organizations** inclusive of those comprising **SWs** (Y) • Policy **does not mention** nongovernment organizations or **explicitly restricts** registration of nongovernment organizations comprising SWs (N)	1.	2.	3.	4.	5.	6.
• Policy **supports the registration of nongovernment organizations** inclusive of those comprising **TG** (Y) • Policy **does not mention** nongovernment organizations or **explicitly restricts** registration of nongovernment organizations comprising TG (N)	7.	8.	9.	10.	11.	12.
• Policy **supports the registration of nongovernment organizations** inclusive of those comprising **MSM** (Y) • Policy **does not mention** nongovernment organizations or **explicitly restricts** registration of nongovernment organizations comprising MSM (N)	13.	14.	15.	16.	17.	18.
• Policy **identifies mechanisms for government funding** of nongovernment organizations (Y) • Policy does not identify funding mechanisms for nongovernment organizations (N)	19.	20.	21.	22.	23.	24.

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E. Collect information on other guiding **donor partnership agreement documents** for SRHR, HIV, and STI programs			
• Agreement was created with the **collaboration and engagement** of MSM/TG/SW (Y) • Agreement was not created with the collaboration and engagement of MSM/TG/SW (N) • It is either unclear or information is not available on the engagement of MSM/TG/SW in the development of this document (DK)	MSM	TG	SW
• Document name	1.	2.	3.
• Document name	4.	5.	6.
• Document name	7.	8.	9.
• Document name	10.	11.	12.
• Agreement mentions **addressing the needs of MSM/TG/SW** (Y) • Agreement does not mention addressing the needs of MSM/TG/SW (N)			
• Document name	13.	14.	15.
• Document name	16.	17.	18.
• Document name	19.	20.	21.
• Document name	22.	23.	24.
Please include any additional remarks or observations about related policy areas not included in the items listed above. If analysis is being done at different levels of government, be sure to identify whether national, regional, and/or local policies differ or contradict each other.			

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4. Legal Environment—Authorization

The way that the policy and regulatory environment describes authorization to provide services is important because it gives "permission" to provide services, it can formalize funding of these services, and it identifies the oversight mechanisms that may drive the philosophy of service provision. This section focuses on policies that relate authorization to provide HIV service, including the following:

- Definitions of authorized services
- Roles of public health and law enforcement
- Oversight and coordination of health and harm reduction programs
- Oversight and management of prison health
- Authorization of services

Detailed Technical Guidance

HIV Standards and Resources
http://www.who.int/hiv/en/

STIs Standards and Resources
http://www.who.int/topics/sexually_transmitted_infections/en/

SRHR Standards and Resources
http://www.who.int/reproductivehealth/en/

World Professional Association for Transgender Health
http://www.wpath.org/index.cfm

University of California, San Francisco Center of Excellence for Transgender Health
http://www.transhealth.ucsf.edu/trans?page=home-00-00

Legal silence on evidence-based services is probably one of the major reasons why, from the policy formulation point of view, HIV strategies and programs are unspecific, non-binding, and neglect scientific evidence. Since access to specific services is not required by the law, policymakers are reluctant to indicate specific actions and indicators in lower-level policies and resort to broad or unclear statements. As a result, executive bodies are not held accountable for ensuring the availability and quality of services, and advocates cannot refer to national strategies and programs to demand access to core interventions.

Programs may often be declarative in nature, amounting simply to statements of the government's policy intentions or desired outcomes, without identifying specific implementation mechanisms (Duvall, Beardsley, Campaoré, Sanon, & Bassonon, 2012). For example, a program may recognize MSM/TG/SW and inmates as priority groups but not guarantee specific access to evidence-based interventions, such as condoms, HCT, and STI services, or set service coverage targets specific to these populations. The program may call for ensuring access of MARPs to a comprehensive package of services; however, it does not clearly define who the MARPs are, or so broadly defines "most-at-risk" as to negate the purpose of identifying priority populations. Also, descriptions of the package of services to be delivered may make no direct reference to UNODC/WHO/UNAIDS core interventions.

Agency Authorized to Provide Services

Who is authorized to deliver services is also important. For example, entrusting law enforcement with oversight, coordination, provision, and monitoring of prevention, treatment, and care services is the manifestation of an overall repressive approach to issues related to populations who are marginalized because they are incarcerated or because of "moral issues" related to gender norms and sexual behavior. A model of that kind gives control and enforcement agencies greater weight in making decisions on these issues compared with public health specialists and human rights activists, thus making the policy

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environment less favorable for core HIV and public health interventions. An example of the impact of authorization can be found in Ouagadougou, Burkina Faso, where public health authorities, rather than law enforcement, carried out a public health campaign to improve conditions in brothels (Duvall, Beardsley, Campaoré, Sanon, & Bassonon, 2012).

A related issue is the authorization of the agency responsible for health in prison settings. A barrier to services may be posed by entrusting healthcare of inmates, including HIV prevention and treatment, to non-public health ministries, such as the Ministries of Justice or Internal Affairs. Addressing this issue requires collaboration between prison authorities and public health agencies, such as the Ministry of Health—including vesting responsibility for prison health with the Ministry of Health (UNODC, 2008a).

Sample policy documents to consider (not an exhaustive list) include the following:

- National public health law, policy, strategy, and guidelines
- National health law, policy, strategy, and guidelines
- National AIDS law, policy, strategy, and guidelines
- National STI law, policy, strategy, and guidelines
- National reproductive health and family planning law, policy, strategy, and guidelines
- National law enforcement and prison law, policy, strategy, and guidelines

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IV. Authorization of SRHR, STI, and HIV programs			
A. Collect all policy documents that describe **authority to provide** SRHR, STI, and HIV services (UNAIDS, 2006, pp. 26, 27)			
• Policy empowers public health **authorities to provide a comprehensive range of prevention and treatment services** for the following programs (Y) • Policy **fails to authorize** or **limits authority or services provided** for the following programs (N)		Community	Prison
1) SRHR – see citations in narrative (contraception, disease screening, vaccinations, sexual functioning, fertility evaluation, etc.)		1.	2.
If No – what service(s) are missing?			
2) STI – see citations in narrative (screening, diagnosis, syndromic management, contact tracing, etc.)		3.	4.
If No – what service(s) are missing?			
3) HIV – see citations in narrative (outreach, behavior change communication, testing, treatment, etc.)		5.	6.
If No – what service(s) are missing?			
B. Collect all policy documents that identify the **government sector with the authority to coordinate health promotion and risk reduction programs**			
	MSM	TG	SW
• Policy authorizes **public health agencies** with oversight and coordination authority for health promotion and risk reduction for population (Y) • Policy authorizes **law enforcement and/or judicial agencies** with oversight and coordination authority for health promotion and risk reduction services for population (N)	1.	2.	3.
Note: if both statements are true – indicate (Y/N) and comment.			
C. Collect all policy documents that mention responsibility for the **management and provision of pre-trial detention and prison health services** (UNODC, 2006, pp. 18, 22)			
• Policy assigns responsibility for **prison health services** to the same ministries, departments, and agencies providing **health services** to the general population (Y) • Policy does not explicitly mention responsibility for health services or assigns prison health to **law enforcement, prison, or detention authorities** (N)		1.	
Note: if both statements are true – indicate (Y/N) and comment.			
• Policy provides for independent **health provider decisions in prison settings** (Y) • Policy places health provider treatment decisions under authority of law enforcement, prison, or detention authorities (N)		2.	
Please include any additional remarks or observations about related policy areas not included in the items listed above. If analysis is being done at different levels of government, be sure to identify whether national, regional, and/or local policies differ or contradict each other.			

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5. Legal Environment—Consent for Testing and Treatment

"The vague and unelaborated language of laws and ministerial instructions regulating HIV testing and especially those related to testing of vulnerable groups opens the door for discrimination and other human rights violations" (UNODC, CHALN, 2010).

Policies may provide for certain services for which consent is required but fail to specify requirements of consent for all populations, environments, and interventions, and the procedures for informed consent. This section focuses on policies that relate to requirements for informed consent for HIV, STI, and SRHR services, including the following:

- Consent for medical testing and treatment
- Access to information for children
- Access to services for adolescents
- Mandatory or compulsory testing and treatment

Informed Consent

The declaration on the promotion of patients' rights in Europe, adopted by the European Meeting on Patient Rights, Amsterdam (WHO, 1994, p. 11), states that the informed consent of patients is a prerequisite of any medical intervention. The right to informed consent may be abused if policies do not set requirements or specify components and procedures for informed consent (e.g., the nature of testing or treatment, risks and benefits, the right to refuse intervention at any stage without punishment, etc.). For instance, laws may state that citizens and their legal representatives have the right to refuse testing and treatment at any stage, and refusal should be provided in written form. However, if the law lacks provisions requiring healthcare providers to obtain informed consent from patients, it may be interpreted to mean that the absence of written refusal from a patient counts as informed consent. Similarly, HIV legislation and policies stating the voluntary nature of testing for HIV often fail to specify the procedures for informed consent.

A review of Burkina Faso's consent policy found that it fails to identify the right to refuse or withdraw from testing or treatment at any time and provides no specific guidelines to determine when HIV testing can or should be included in a battery of tests. The impact of this policy status is that consent for HIV testing is not always obtained, particularly in the case of prenatal examinations (Duvall, Beardsley, Campaoré, Sanon, & Bassonon, 2012).

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Age Restrictions

"States' parties need to introduce legislation or regulations to ensure that children have access to confidential medical counseling and advice without parental consent, irrespective of the child's age, where this is needed for the child's safety or well-being. Children may need such access, for example, where they are experiencing violence or abuse at home, or in need of reproductive health education or services, or in case of conflicts between parents and the child over access to health services. The right to counseling and advice is distinct from the right to give medical consent and should not be subject to any age limit" (UN, 2009, p. 23).

"States must ensure that adolescents have access to appropriate health information and services regardless of parental consent, particularly those concerning sexual and reproductive health. Given sufficient maturity, adolescents may request confidential health services and information" (UNGA, 2009, p. 14).

Considering that in 2009, young people ages 15–24—a majority throughout Africa—accounted for 41 percent of new HIV infections, reducing this level of incidence requires a continuum of HIV prevention that provides information, support, and services to adolescents (UNICEF, 2011, p. 1). Findings from studies of young MSM in urban settings in sub-Saharan Africa demonstrate the urgent need to remove barriers to prevention programming and improve access to services. By the time a young MSM turns 24 in the suburbs of Cape Town, South Africa or Lilongwe, Malawi, he has a 15 to 17 percent higher risk of becoming infected with HIV compared to his heterosexual peers (UNICEF, 2011, p. 6).

However, young people in many countries are reported to have limited access to core health services due to age limitations posed by policy or healthcare providers. A positive example of enabling policy is South Africa's Children's Act, passed in 2005,which lowered the age of consent for testing and contraceptives to age 12, effectively opening up access to full sexual and reproductive healthcare for adolescents in a country of young women who become sexually active before the age of 15 (UNICEF, 2011, p. 3).

Mandatory/Compulsory Testing and Treatment

"UNAIDS/WHO supports mandatory screening for HIV and other bloodborne viruses of all blood that is destined for transfusion or for manufacture of blood products. Mandatory screening of donors is required prior to all procedures involving transfer of bodily fluids or body parts, such as artificial insemination, corneal grafts and organ transplant. UNAIDS/WHO do not support mandatory testing of individuals on public health grounds" (WHO, 2005, p. 8).

"Mandatory or compulsory testing continues being a reality, particularly for members of most-at-risk and vulnerable populations. Sometimes it is done without the knowledge of the person being tested. The purpose of such testing is not to provide access to HIV prevention, treatment, care and support, but most often to exclude people with HIV from access to certain services, or otherwise impose restrictions on them. Such mandatory or compulsory forms of testing violate ethical principles and basic rights of consent, privacy and bodily integrity; they cannot be justified on public health grounds" (WHO, 2010c, p. 12).

Despite WHO and UNODC recommendations, legislation in some countries requires mandatory HIV testing for reasons other than transplantation or blood transfusion procedures. Legislation may require mandatory HIV testing for drug users, pregnant women, persons diagnosed with STIs, and persons suspected by public health or law enforcement agencies to be HIV positive, which results in police raids targeting drug users and SWs and in compulsory HIV testing (EHRN, 2011c). In other countries, the problem lies in legislation that fails to explicitly prohibit broad application of mandatory HIV testing or

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requiring informed consent. In such cases, ministerial orders and guidelines tend to expand categories of people who should be tested based on "epidemiological indications." However even in sub-Saharan Africa, which accounts for more than two-thirds of the world's HIV infected, mandatory testing is unlikely to provide a significant contribution to HIV prevention (De Cock, Mbori-Ngacha, & Marum, 2002).

While there is no argument that HIV and STI testing and treatment must be available to SWs, these services need to follow the basic tenets of self-determination, privacy, informed consent, and protection. Mandatory or coercive testing of SWs is never appropriate and opens up individuals to police abuse, extortion, and invasion of privacy (WHO, 2012).

Legal silence on the right to informed consent and related procedures may lead to vague policies that lack details on service providers' responsibilities. For example, policies may indicate that voluntary testing for HIV is done with a person's informed consent; however, no specifics are given on how this consent should be obtained (oral or written), or what kind of information should be provided to the client. In this case, service providers may assume that consent has been obtained if no objections are made by the patient, effectively violating the requirement for informed consent (UNODC & CHALN, 2010).

Sample policy documents to consider (not an exhaustive list) include the following:

- Charters for health services users/patient rights and responsibilities
- Regulations for healthcare professionals
- National public health law, policy, strategy, and guidelines
- National health law, policy, strategy, and guidelines
- National AIDS law, policy, strategy, and guidelines
- National STI law, policy, strategy, and guidelines
- National reproductive health and family planning law, policy, strategy, and guidelines
- National law enforcement and prison law, policy, strategy, and guidelines

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Inventory and Analysis of Country Documents

Country: _____ Date completed: _____

Name of data collector:_____

Position: _____

Contact information for data collector:

Email address: _____

Telephone/fax: _____

Instructions to data collector:

Please fill out this page and indicate the best way to contact you (email, telephone, fax, etc.) should we need further information.

Refer to the instructions page for directions on how to fill out the inventory. Please provide information only on the areas with which you are familiar or have been assigned to research and leave the others blank. Within these areas, please be sure to answer "yes" or "no" to each item. All data collectors should address the open-ended question at the end of the areas upon which they are working.

If you find a policy document that addresses areas upon which you are not working, send the document or citation to the team leader. He or she will share this information with the individual primarily responsible for that section.

When you have completed the inventory, please send all the pages and all the documents you have referenced to [*team leader should fill this in before distributing to team members*].

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V. Consent

A. Collect all policy documents that mention **consent for medical testing and treatment** for SRHR, STI, and HIV in prison and community settings, including protocols for research trials (WHO, 2007e, pp. 36, 37), (UNGA, 2009), (UNODC, 2006, p. 25), (WHO, 2007a, p. 7), (WHO, 2007c, p. 6), (UNODC, 2009, p. 39), (WHO, 1993, p. 7)

	SRHR		STI		HIV	
	Community	Prison	Community	Prison	Community	Prison
• Policy **requires consent for medical testing** (Y) • Policy does not explicitly require consent for medical testing (N)	1.	2.	3.	4.	5.	6.
• Policy **requires consent for medical treatment** (Y) • Policy does not explicitly require consent for medical treatment (N)	7.	8.	9.	10.	11.	12.
• Policy **requires consent for research** (Y) • Policy does not explicitly require consent for research (N)	13.	14.	15.	16.	17.	18.
• Policy identifies the **right to refuse or withdraw from medical testing** at any time (Y) • Policy does not explicitly give the right to refuse or withdraw from medical testing at any time (N)	19.	20.	21.	22.	23.	24.
• Policy identifies the **right to refuse or withdraw from medical treatment** at any time (Y) • Policy does not explicitly give the right to refuse or withdraw from medical treatment at any time (N)	25.	26.	27.	28.	29.	30.
• Policy identifies the **right to refuse or withdraw from research** at any time (Y) • Policy does not explicitly give the right to refuse or withdraw from research at any time (N)	31.	32.	33.	34.	35.	36.
• Policy identifies ALL of the following **elements required** for consent to **medical testing** (Y) o The consent must relate specifically to the treatment administered; o The consent must be fully informed; o The consent must be given voluntarily; o The consent is given individually, in private, in the presence of a healthcare provider o The consent may be verbal or written; and o The consent must not be obtained through misrepresentation, coercion, or fraud • Policy does not explicitly identify ALL of the consent components listed above (N)	37.	38.	39.	40.	41.	42.

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A. Collect all policy documents that mention **consent for medical testing and treatment** for SRHR, STI, and HIV in prison and community settings, including protocols for research trials (WHO, 2007e, pp. 36, 37), (UNGA, 2009), (UNODC, 2006, p. 25), (WHO, 2007a, p. 7), (WHO, 2007c, p. 6), (UNODC, 2009, p. 39), (WHO, 1993, p. 7)						
• Policy identifies ALL of the following **elements required** for consent to **medical treatment** (Y) o The consent must relate specifically to the treatment administered; o The consent must be fully informed; o The consent must be given voluntarily; o The consent is given individually, in private, in the presence of a healthcare provider o The consent may be verbal or written; and o The consent must not be obtained through misrepresentation, coercion, or fraud • Policy does not explicitly identify ALL of the consent components listed above (N)	43.	44.	45.	46.	47.	48.
• Policy identifies ALL of the following **elements required** for consent to **research** (Y) o The consent must relate specifically to the treatment administered; o The consent must be fully informed; o The consent must be given voluntarily; o The consent is given individually, in private, in the presence of a healthcare provider o The consent may be verbal or written; and o The consent must not be obtained through misrepresentation, coercion, or fraud • Policy does not explicitly identify ALL of the consent components listed above (N)	49.	50.	51.	52.	53.	54.

B. Collect all policy documents mentioning access by **children**, in and out of State custody, to confidential medical counseling and advice about SRHR, STI, and HIV (UNGA, 2009, pp. 5, 14), (HRC, 2011, p. 19)			
	SRHR	STI	HIV
• Policy guarantees children **access to information** regardless of parental/caregiver consent, irrespective of the child's age (Y) • Policy does not explicitly guarantee children access to information, or describes parental consent requirements or age restrictions (N)	1.	2.	3.
• Policy guarantees children **access to counseling** on medical services regardless of parental/caregiver consent, irrespective of the child's age (Y) • Policy does not explicitly guarantee children access to counseling, or describes parental consent requirements or age restrictions (N)	4.	5.	6.
C. Collect all policy documents mentioning access by **adolescents**, in and out of State custody, to information and medical services for SRHR, STI, and HIV (UNGA, 2009, pp. 5, 14)			
	SRHR	STI	HIV
• Policy guarantees adolescents **access to information on medical services** regardless of parental consent (Y) • Policy does not explicitly guarantee adolescents access, or describes parental consent requirements or age restrictions higher than adolescence (N)	1.	2.	3.
• Policy guarantees adolescents **access to medical services** regardless of parental consent (Y) • Policy does not explicitly guarantee adolescents access, or describes parental consent requirements or age restrictions higher than adolescence (N)	4.	5.	6.

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D. Left blank to align with PWID DM

E. Policy that mentions **mandatory or compulsory testing or treatment** (WHO, 1993, p. 5), (UNODC, 2006, p. 18), (WHO, 2007a, p. 7), (UNODC, 2009, p. 35), (UNODC, 2010, p. 38), (UNAIDS, 1999, pp. 124, 128) , (UNAIDS, 2006, p. 37), (UNGA, 2009, pp. 8, 23, 24), (WHO, 2002, p. 9) , (Inter-Parliamentary Unit [IPU], 2007, p. 79), (YP, 2007, p. 23)

	SRHR		STI		HIV	
	Community	Prison	Community	Prison	Community	Prison
• **Policy prohibits mandatory or compulsory medical testing** except for screening of donated blood prior to transfusion, occupational exposure, and before all procedures involving transfer of bodily fluids or body parts, such as artificial insemination, corneal grafts, and organ transplant (Y) • Policy does not prohibit mandatory or compulsory medical testing (N) *If answer to this assessment point is (Y), skip to # 28 below; if answer is (N), continue with assessment #s 7–27.*	1.	2.	3.	4.	5.	6.
• Policy specifically allows or identifies mandatory medical testing of MSM (exception above notwithstanding) (N)	7.	8.	9.	10.	11.	12.
• Policy specifically allows or identifies mandatory medical testing of TG (exception above notwithstanding) (N)	13.	14.	15.	16.	17.	18.
• Policy specifically allows or identifies mandatory medical testing of SWs (exception above notwithstanding) (N)	19.	20.	21.	22.	23.	24.
• Policy specifically allows or identifies mandatory medical testing of prisoners (exception above notwithstanding) (N)		25.		26.		27.

E. Policy that mentions **mandatory or compulsory testing or treatment** (WHO, 1993, p. 5), (UNODC, 2006, p. 18), (WHO, 2007a, p. 7), (UNODC, 2009, p. 35), (UNODC, 2010, p. 38), (UNAIDS, 1999, pp. 124, 128) , (UNAIDS, 2006, p. 37), (UNGA, 2009, pp. 8, 23, 24), (WHO, 2002, p. 9) , (Inter-Parliamentary Unit [IPU], 2007, p. 79), (YP, 2007, p. 23)

	SRHR		STI		HIV	
	Community	Prison	Community	Prison	Community	Prison
• **Policy prohibits mandatory or compulsory medical treatment** (Y) • Policy does not prohibit mandatory or compulsory medical treatment (N) *If answer to this assessment point is (Y), skip to # 55 below; if answer is (N), continue with assessment #s 34–54.*	28.	29.	30.	31.	32.	33.
• Policy specifically allows or identifies mandatory medical treatment of MSM (N)	34.	35.	36.	37.	38.	39.
• Policy specifically allows or identifies mandatory medical treatment of TG (N)	40.	41.	42.	43.	44.	45.
• Policy specifically allows or identifies mandatory medical treatment of SWs (N)	46.	47.	48.	49.	50.	51.
• Policy specifically allows or identifies mandatory medical treatment of prisoners (N)		52.		53.		54.
• Prohibits mandatory or compulsory medical or psychological treatment, procedures, testing, or confinement to a medical facility based on **sexual orientation** (Y) • Fails to prohibit or allows mandatory or compulsory medical or psychological treatment, procedures, testing, or confinement to a medical facility based on sexual orientation (N)						55.
• Prohibits mandatory or compulsory medical or psychological treatment, procedures, testing, or confinement to a medical facility based on **gender identity** (Y) • Fails to prohibit or allows mandatory or compulsory medical or psychological treatment, procedures, testing, or confinement to a medical facility based on gender identity (N)						56.

F. Collect all policy documents mentioning services or interventions for MSM/TG/SW (CHALN, 2007, p. 8)	
• Policy requires that **prevention interventions for MSM be provided only with consent** of participants (Y) • Policy does not specifically require consent for prevention interventions for MSM (N)	1.
• Policy requires that **prevention interventions for TG be provided only with consent** of participants (Y) • Policy does not specifically require consent for prevention interventions for TG (N)	2.
• Policy requires that **prevention interventions for SWs be provided only with consent** of participants—including "100% condom use" and "raid and rescue" interventions (Y) • Policy does not specifically require consent for prevention interventions for SWs (N)	3.
• Policy requires that **medical interventions for MSM be provided only with informed consent**, as described above (Y) • Policy does not specifically require informed consent for medical interventions for MSM (N)	4.
• Policy requires that **medical interventions for TG be provided only with informed consent**, as described above (Y) • Policy does not specifically require informed consent for medical interventions for TG (N)	5.
• Policy requires that **medical interventions for SWs be provided only with informed consent**, as described above (including presumptive STI treatment) (Y) • Policy does not specifically require informed consent for medical interventions for SWs (N)	6.
Please include any additional remarks or observations about related policy areas not included in the items listed above. If analysis is being done at different levels of government, be sure to identify whether national, regional, and/or local policies differ or contradict each other.	

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6. Legal Environment—Privacy and Confidentiality

"Public health legislation should ensure that HIV and AIDS cases reported to public health authorities for epidemiological purposes are subject to strict rules of data protection and confidentiality.

"Public health legislation should ensure that information related to the HIV status of an individual is protected from unauthorized collection, use or disclosure in the healthcare and other settings, and that the use of HIV-related information requires informed consent" (UNAIDS, 1999, p. 122).

To protect their rights to privacy and confidentiality, international clinical practice guidelines require the protection of medical records that could identify patients. Policy and practice regarding confidentiality will have an impact on the willingness of MSM/TG/SW to access services and provide the important information necessary for quality care. This section focuses on policies that impact privacy and confidentiality in relation to HIV services, including the following:

- Protection of individual-level data
- Disclosure of individual-level data
- Parental/guardian notification
- Access to personal medical records
- Discovery and admissibility of medical and mental health records for legal proceedings
- Partner notification

The disclosure of information regarding HIV status and MSM/TG/SW identity by health service providers to law enforcement agencies happens in numerous countries around the world. In most of these countries, healthcare legislation proclaims the confidentiality of patients' information but is contradicted by other provisions in health- or law enforcement-related policies that grant access to health records by prosecutors, police, and other agencies without court authorization. Laws may allow disclosure of personal health information without the consent of a patient or his/her legal representative or without court authorization for the purpose of initiating a criminal investigation or prosecution.

Countries that have laws providing anonymity for patients visiting sexual health and genitourinary (GUM) medical clinics generally improve the confidence of MSM/SW/TG persons in accessing vital sexual health services. In the United Kingdom, for instance, sexual health and GUM clinics may assign unique identification numbers to attendees that are entirely separated from their general medical records and National Health Service numbers. Studies suggest that this may be responsible for increased uptake of HIV testing among MSM (Dougan, et al., 2007).

In Burkina Faso, healthcare providers are required to disclose HIV test results to the parent/guardian of anyone who is under age 21, and key informant interviews identified cases of healthcare workers breaching the confidentiality of adult patients with family members (Duvall, Beardsley, Campaoré, Sanon, & Bassonon, 2012). The actual or perceived risk of breaches of confidentiality can pose significant danger to the health and well-being of those individuals whose parents or family members are unaware of stigmatized behaviors and identities.

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Sample policy documents to consider (not an exhaustive list) include the following:

- Regulations on statistical activities
- Guidelines for national health information systems
- Codes of ethics and regulations for healthcare professionals
- Laws concerning the protection of personal data
- Charters for health services users/patient rights and responsibilities
- National public health law, policy, strategy, and guidelines
- National health law, policy, strategy, and guidelines
- National AIDS law, policy, strategy, and guidelines
- National STI law, policy, strategy, and guidelines
- National reproductive health and family planning law, policy, strategy, and guidelines
- National law enforcement and prison law, policy, strategy, and guidelines

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Inventory and Analysis of Country Documents

Country: _____ Date completed: _____

Name of data collector:_____

Position: _____

Contact information for data collector:

Email address: _____

Telephone/fax: _____

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If you find a policy document that addresses areas upon which you are not working, send the document or citation to the team leader. He or she will share this information with the individual primarily responsible for that section.

When you have completed the inventory, please send all the pages and all the documents you have referenced to [*team leader should fill this in before distributing to team members*].

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VI. Privacy and confidentiality of personal medical and drug treatment/services utilization data

A. Collect all policy documents mentioning personalized **individual-level data on** SRHR, STI, and HIV (UNAIDS, 1999, pp. 122, 124, 125), (UNAIDS, 2006, p. 28), (ABAROLI, 2011, p. 64), (CHALN, 2006e, pp. 19, 20)

	SRHR		STI		HIV	
	Community	Prison	Community	Prison	Community	Prison
• Policy explicitly includes individual-level data within **definitions of personal/medical data subject to protection** that prohibits data collection, use, disclosure, and/or publication without the individual's consent (Y) • Policy fails to explicitly describe protections of individual-level data or identifies mechanisms for data collection, use, disclosure, and/or publication without the individual's consent (N)	1.	2.	3.	4.	5.	6.
• Policy explicitly includes individual-level **data collected or shared by participants in research trials** within definitions of personal/medical data subject to protection that prohibits data collection, use, disclosure, and/or publication without the individual's consent (Y) • Policy fails to explicitly describe protections of individual-level research data or identifies mechanisms for its collection, use, disclosure, and/or publication without the individual's consent (N)	7.	8.	9.	10.	11.	12.

B. Collect all policy documents mentioning **disclosure of individual-level data on medical and psychological service utilization** (WHO, 1993, p. 7), (UNODC, 2006, p. 18)

	SRHR		STI		HIV	
	Community	Prison	Community	Prison	Community	Prison
• Policy explicitly **prohibits routine disclosure** of individual-level data on **medical service** utilization without the individual's consent (for example, to administrative and security personnel and law enforcement authorities) (Y) • Policy fails to explicitly prohibit disclosure of individual-level data on medical service utilization beyond direct service providers or identifies mechanisms for routine data disclosure without the individual's consent (for example, to administrative and security personnel and law enforcement authorities) (N)	1.	2.	3.	4.	5.	6.

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• Policy explicitly **prohibits routine disclosure** of individual-level data on **psychological service** utilization without the individual's consent (for example, to administrative and security personnel and law enforcement authorities) (Y) • Policy fails to explicitly prohibit disclosure of individual-level data on psychological service utilization beyond direct service providers or identifies mechanisms for routine data disclosure without the individual's consent (for example, to administrative and security personnel and law enforcement authorities) (N)	7.	8.	9.	10.	11.	12.

C. Collect all policy documents defining **parental/guardian notification** requirements (WHO, 1993, p. 8)

	SRHR	STI	HIV
• Policy requiring notifying parents or guardians of their children's medical status requires due regard for the principle that the **best interests of the child or adolescent are paramount** (Y) • Policy requiring notification of parents of a child's medical status has no leeway or exceptions for the best interests of the child or adolescent (N)	1.	2.	3.

D. Collect all policy documents mentioning **individual access to personal medical records** (ABAROLI, 2011, p. 64)

	SRHR	STI	HIV
• Policy gives individuals **access to their own personal medical records** and the ability to request amendments to ensure that information is accurate, relevant, complete, and up to date (Y) • Policy fails to explicitly allow individuals access to their own personal medical records and the ability to request amendments to ensure that information is accurate, relevant, complete, and up to date, or restricts such access (N)	1.	2.	3.

E. Collect all policy documents that identify **recourse for release of confidential information** (UNAIDS, 2006, p. 33), (Inter-Parliamentary Unit [IPU], 2007, p. 94), (ABAROLI, 2011, p. 64), (UNODC, 2006, p. 18), (UNODC, 2009, p. 35)

• Policy establishes an **independent agency to address breaches of confidentiality and related sanctions** for the unauthorized release of confidential information (Y) • Policy fails to identify mechanisms for recourse regarding release of confidential information (N)	1.

F. Collect all policy documents mentioning **mandatory medical testing for SWs**

	SRHR	STI	HIV
• If mandatory testing exists for SWs, policy states that **confirmation of testing is provided to the relevant authorities, but that the test results are not disclosed** without the consent of the individual (Y) • If mandatory testing exists for SWs, policy allows for disclosure of test results to relevant authorities (N)	1.	2.	3.

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G. Collect all policy documents mentioning **discovery and admissibility of medical and mental health records** (CHALN, 2006c, p. 16)	Y/N
• Policy explicitly states that **medical and mental health records are not discoverable or admissible** during legal proceedings for the purposes of proving MSM/TG/SW identities or behaviors (Y) • Policy fails to explicitly protect medical and mental health records from legal proceedings (N)	1.
• Policy explicitly states that **medical and mental health records may not be used to initiate or substantiate any criminal charges** against a person who uses program services, or act as grounds for conducting any investigation of a person who uses program services (Y) • Policy identifies medical and mental health records as admissible evidence to initiate or substantiate criminal charges or conduct investigations (N)	2.
• Policy explicitly states that **medical and mental health program staff cannot be compelled to provide evidence** concerning the information that they received in that capacity (Y) • Policy explicitly states that medical and mental health program staff can be compelled to provide evidence concerning the information that they received in that capacity (N)	3.

H. Collect all policy documents mentioning **partner notification** for cases of exposure to communicable disease		
	STI	HIV
• Policy specifically mentions protocols to **protect the identity of the individual with the communicable disease** (Y) Policy makes no mention of protections or specifically authorizes the disclosure of the identity of the individual with a communicable disease (N)	1.	2.

Please include any additional remarks or observations about related policy areas not included in the items listed above. If analysis is being done at different levels of government, be sure to identify whether national, regional, and/or local policies differ or contradict each other.

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7. Legal Environment—Registries

Policies regulating data collection and management have implications for protection of privacy and confidentiality, and consequently on access to services. When data collection and management systems are known to insufficiently protect individual-level data or are responsible for discriminatory actions, individuals with criminalized identities or behaviors, such as MSM/TG/SW, have an incentive to avoid the health services collecting these data. This section focuses on policies that regulate data collected by/for medical and non-medical registries and how they affect access to HIV services, including the following:

- Epidemiological registries
- Registries of providers and clients
- Non-medical registries, such as sex offender registries

Medical/Epidemiological Registries

Registries are used in public health for epidemiological purposes and, at the health clinic or provider level, to record patient information. Whenever data are linked to personally identifying information, such as name, address, date of birth, etc., it is essential to adhere to regulations that protect data and confidentiality.

Non-medical Registries

In some countries, government officials compile records of individuals involved in and/or accused of illegal sexual activities. In countries where sex work and same-sex relations are illegal, jurisdictions may include MSM and SWs in a database of sex offenders that is publicly accessible, especially to employers in the educational and care-giving sectors. An example is the additional sanction of registering SWs soliciting oral and anal sex in the state of Louisiana in the United States as sex offenders, in addition to being charged with prostitution. In jurisdictions such as the state of California in the United States, where it is a crime to purchase sexual services, the client of the SW may be forced to register as a sex offender upon conviction. Registration as a sex offender serves as a significant barrier to employment and such basic services as housing, homeless shelters, and residential substance abuse treatment (Sukthankar, 2011).

An even more challenging policy issue may be the existence of informal and unregulated "lists" that may be kept by such agencies as law enforcement. Because of their informal status, these registries would be hard to identify and monitor (Duvall, Beardsley, Campaoré, Sanon, & Bassonon, 2012).

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Sample policy documents to consider (not an exhaustive list) include the following:

- Regulations on statistical activities
- Guidelines for national health information systems
- Laws concerning the protection of personal data
- National public health law, policy, strategy, and guidelines
- National health law, policy, strategy, and guidelines
- National AIDS law, policy, strategy, and guidelines
- National STI law, policy, strategy, and guidelines
- National reproductive health and family planning law, policy, strategy, and guidelines
- National law enforcement and prison law, policy, strategy, and guidelines

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Inventory and Analysis of Country Documents

Country: _____ Date completed: _____

Name of data collector:_____

Position: _____

Contact information for data collector:

Email address: _____

Telephone/fax: _____

Instructions to data collector:

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When you have completed the inventory, please send all the pages and all the documents you have referenced to [*team leader should fill this in before distributing to team members).*

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VII. Registries			
A. Collect all policy documents that authorize reporting individual-level data to public health authorities for **epidemiological purposes** (UNAIDS, 2006, p. 27), (ABAROLI, 2011, p. 65)			
	SRHR	STI	HIV
• Policy subjects individual-level data to **strict rules of data protection and confidentiality** (Y) • Policy fails to mention confidentiality protections, or provides for regular disclosure of these data to non-health agencies (N)	1.	2.	3.
B. Collect all policy documents that authorize **registries of providers and clients** for SRHR, STI, and HIV services (WHO, 2004b, p. 28), (CHALN, 2006b, p. 32)			
If Registries are authorized, assess the following **If Registries are NOT authorized or used**, respond with a "N/R" in the appropriate box	SRHR	STI	HIV
• Policy focuses implementation of registry on **ensuring the quality of services** (Y) • Policy provides no mention of mechanisms for quality assurance (N)	1.	2.	3.
• Policy guarantees **client and provider confidentiality** (Y) • Policy makes no mention of patient or provider confidentiality, or provides for regular disclosure of data (N)	4.	5.	6.
• Policy **protects program registries from disclosure and monitoring** by non-health authorities (e.g., law enforcement) (Y) • Policy authorizes disclosure or monitoring of the program registry by non-health authorities (e.g., law enforcement) (N)	7.	8.	9.

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C. Collect all policy documents that mention **non-medical registries** (i.e., sexual offender registries, informal law enforcement lists, etc.)

	MSM	TG	SW	Individuals accused of exposing others to HIV	Individuals accused of HIV non-disclosure
• If policy **does not register individuals in non-medical registries** (Y), mark the rest of the column for this population N/A • If policy requires registration on non-medical registries (N), continue analysis	1.	2.	3.	4.	5.
• Policy **prohibits discriminatory actions** such as o Loss of child custody o Denial of state services, such as education, housing, and financial assistance o Denial of eligibility for employment or driver's license solely on the basis of being registered in a non-medical registry (Y) • Policy fails to prohibit discrimination or authorizes actions such as any of those listed above solely on the basis of an individual being registered in a non-medical registry (N) If (N), describe discriminatory action	6.	7.	8.	9.	10.
• Policy identifies clear and easy processes and timeline for **removal of a person's name** from the registry (Y) • Policy provides no clear mechanism or timeline for removal of a person's name from the registry (N)	11.	12.	13.	14.	15.
• Policy requires **individual consent or court authorization** to disclose individual information (Y) • Policy grants access to records to prosecutors, police, other agencies, or the public without court authorization (N)	16.	17.	18.	19.	20.
Please include any additional remarks or observations about related policy areas not included in the items listed above. If analysis is being done at different levels of government, be sure to identify whether national, regional, and/or local policies differ or contradict each other.					

8. Legal Environment—Stigma and Discrimination

"States should enact or strengthen anti-discrimination and other protective laws that protect vulnerable groups, people living with HIV and people with disabilities from discrimination in both the public and private sectors" (UNAIDS, 2006, pp. 17-18).

In 2006, heads of State and government representatives committed to enact "legislation, regulations and other measures to eliminate all forms of discrimination against, and to ensure the full enjoyment of all human rights and fundamental freedoms, by people living with HIV and members of vulnerable groups" (UNGA, 2006, p. 4). Yet stigma and discrimination on the grounds of sex work, sexual orientation, and gender identity remain common throughout the world. This section focuses on policies that impact the barriers that stigma and discrimination pose to HIV services, including the following:

- Addressing stigma and discrimination in national programs
- National non/anti-discrimination policy
- Mechanisms for addressing discrimination
- Anti-incitement policies

Stigma and Discrimination on the Grounds of Sex Work

SWs are stigmatized for their occupation and because they are perceived as at high risk for HIV. Even in Senegal, where SWs can register with the government, they report stigmatization, rape, abuse from healthcare clinic staff, police corruption that includes extortion and bribery, and discrimination by potential landlords and schools for their children (OSI, 2006c, p. 49). For SWs living with HIV, there is a double stigma, leading to poor treatment by health officials and pressure to stop working. Stigma and discrimination lead SWs to avoid HIV testing and treatment, and to self-medicate or hide their occupation from healthcare providers, often resulting in inadequate diagnosis and treatment (NSWP, 2010, p. 15).

Stigma and Discrimination on the Grounds of Sexual Orientation/Behavior and Gender Identity

Although male-to-male sex is common, regardless of sexual orientation (World Bank, 2005), social perceptions that sexual relations between men are a violation of religious and natural laws and non-heteronormative sexual practices are contraband has resulted in many MSM being viewed as social deviants. Destructive consequences include rejection of MSM by their families, exclusion by religious and traditional leaders from their communities, punitive rape, extortion, and societal surveillance and policing. Double stigma may result for MSM who disclose an HIV-positive status (Lay, 2011).

Other stigma-related risks include loss of employment or livelihood, adolescents being thrown out of their homes, and eviction from housing by neighbors and landlords. These risks increase social isolation and jeopardize social safety nets, and can lead to such negative social and economic outcomes as prostitution, violence, STIs, and HIV (Lwabaayi, Anyamele, Binswanger, & Nguyen, 2005, p. 9). Stigma thus remains a critical obstacle to effective HIV response, as many MSM avoid accessing testing and treatment sites or disguise themselves as heterosexual to receive services (Lay, 2011).

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Research in Burkina Faso has revealed that MSM experience stigma, discrimination, and violence, including being beaten and publicly humiliated by family members (Niang, Moreau, Bop, Compaore, & Diagne, 2004, p. 11). Stigma and discrimination cause many MSM to hide their behavior, making them afraid to access HIV treatment and making it difficult for prevention, care, and treatment efforts to reach them. Stigma and discrimination also result in heterosexual marriage as a social cover among MSM in the region (World Bank, 2008, p. 105), which in turn can further increase the spread of HIV among the general population. Stigmatization is even greater for MSM living with HIV, who are stigmatized for their behavior, sexual identity, and HIV status.

Stigmatization of TG can even be expressed in the design of some HIV programs, in which the services for TG are combined with those for MSM and/or SW populations, ignoring the spectrum and differing sexual and reproductive health (RH) needs of transgender men and women. Stigmatization, denial, and invisibility also lead to the exclusion of TG from research and as fundamental data points (Scheibe, Brown, Duby, & Bekker, October 2011).

Many countries do try to address stigma and discrimination in various ways. Some countries (like South Africa) have explicit laws proactively addressing discrimination experienced by MSM and TG. The protection of LGBT rights in South Africa is based on section 9 of the Constitution, which forbids discrimination on the basis of sex, gender, or sexual orientation, and applies both to the government and the private sector. Its Constitutional Court has stated that the section must also be interpreted as prohibiting discrimination on the basis of transsexuality. These constitutional protections have been reinforced by the jurisprudence of the Constitutional Court and various statutes enacted by Parliament (LGBT Rights in South Africa, 2011). These statutes may pertain to marriage, civil unions, protecting people with a sexual orientation other than heterosexual, stigma and discrimination in the workplace, access to livelihoods, access to appropriate health services, change of gender on identity documents, and guidelines and access to health services addressing the needs of MSM and TG, including HIV prevention, diagnosis, and treatment.

Detailed Technical Guidance

UNAIDS Stigma and Discrimination Resource Page
http://www.unaids.org/en/targetsandcommitments/eliminatingstigmaanddiscrimination/

Stigma Action Network
http://www.stigmaactionnetwork.org/web/guest/home

Stigma and discrimination directed at MSM and SWs contribute to migration, as individuals will move from city to city or country to country to avoid being "known" in their home towns; as a result, they make themselves even more invisible and thus more difficult to reach with services (Duvall, Beardsley, Campaoré, Sanon, & Bassonon, 2012). This adds to the issues of discrimination described below and can contribute to discontinuation of HIV treatment.

Discrimination Based on Nationality, Place of Residence, and Migration

In many countries, policies discriminating against foreign nationals pose barriers to key healthcare and harm reduction services for individuals. Migrants, and particularly migrant SWs, often lack health insurance in the host country and thus can only attend private clinics and personally pay for services received, placing medical service out of financial reach for them (UNODC & CHALN, 2010) (Central and Eastern European Harm Reduction Network [CEEHN], 2005).

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Some countries still have legal provisions requiring deportation of foreigners living with HIV, TB, and STIs. Foreign citizens face mandatory testing for conditions such as HIV, TB, syphilis, and drug dependency, and face imminent cancellation of residency permits and deportation (UNODC & CHALN, 2010). In Egypt, foreigners seeking employment must present the Directorate of Manpower and Immigration with a certificate proving that they are not living with HIV, and those living with HIV are denied employment solely on the basis of their HIV status (EIPR & FIDH, 2007). Such requirements drive migrant communities underground and prevent them from seeking HIV services. The threat of deportation may cause migrants, including SWs, to avoid testing and treatment for HIV, TB, and STIs in the host country (International Organization on Migration [IOM], 2010).

Another barrier can be the requirement for local residency registration documents. In some countries, state-guaranteed care may be provided only by facilities covering the patients' registered residence area, thus creating access barriers for people from other regions, homeless people, and people without passports. This provision particularly discriminates against drug users and sex workers, many of whom lack identification or residence registration (UNODC & CHALN, 2010), (Spicer, Bogdan, Brugha, Marmer, Murzalieva, & Semigina, 2011).

"The removal of passports as a result of imprisonment and the absence of a registered residency address

Denial of services based on nationality or residence registration, which is an example of restrictive policies, is unjustified in terms of promoting public health, as it limits access to services to those most in need of them—including SWs or those who live with hepatitis, HIV, or TB—and makes them hard to reach by service providers. Furthermore, policies restricting provision of services based on residency documents conflict with the right of citizens to mobility and free choice of place of residence, as well as the right to health, as stated by their countries' constitutions.

Sample policy documents to consider (not an exhaustive list) include the following:

- Constitution
- Norms and guidelines for working with people living with HIV (PLHIV), MSM, TG, or SWs
- Codes of ethics and regulations for healthcare professionals
- Charters for health services users/patient rights and responsibilities
- National public health law, policy, strategy, and guidelines
- National health law, policy, strategy, and guidelines
- National AIDS law, policy, strategy, and guidelines
- National STI law, policy, strategy, and guidelines
- National reproductive health and family planning law, policy, strategy, and guidelines
- National law enforcement and prison law, policy, strategy, and guidelines

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Inventory and Analysis of Country Documents

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VIII. Stigma and discrimination

A. Collect all policy documents describing national-level SRHR, STI, and HIV programs (ABAROLI, 2011, p. 47), (UNAIDS, UNAIDS Reducing HIV stigma and discrimination: a critical part of national AIDS programs. A resource for national stakeholder in the HIV response, 2007, pp. 11-16), (Inter-Parliamentary Unit [IPU], 2007, p. 92), (UNDP, 2009b, pp. 10, 11), (Mahon, 2009, p. 244), (WHO, 2011, p. 30)

	SRHR			STI			HIV		
	MSM	TG	SW	MSM	TG	SW	MSM	TG	SW
• Document describes the **root causes of stigma** against population (Y) • Does not identify root causes of stigma and discrimination against population (N)	1.	2.	3.	4.	5.	6.	7.	8.	9.
• Document describes the **root causes of discrimination** against population (Y) • Does not identify root causes of stigma and discrimination against population (N)	10.	11.	12.	13.	14.	15.	16.	17.	18.
• Document identifies **mechanisms to measure stigma** against population (Y) • Does not identify mechanism to measure stigma against population (N)	19.	20.	21.	22.	23.	24.	25.	26.	27.
• Document identifies **mechanisms to measure discrimination** against population (Y) • Does not identify mechanism to measure discrimination against population (N)	28.	29.	30.	31.	32.	33.	34.	35.	36.
• Implements and monitors a multifaceted national **approach to reduce stigma** impacting population (Y) • Does not implement and monitor activities to address stigma impacting population (N)	37.	38.	39.	40.	41.	42.	43.	44.	45.
• Implements and monitors a multifaceted national **approach to reduce discrimination** impacting population (Y) • Does not implement and monitor activities to address discrimination impacting population (N)	46.	47.	48.	49.	50.	51.	52.	53.	54.

B. Collect all policy documents that describe the **general country-wide anti-discrimination policy** (e.g., prohibiting discrimination based on individual characteristics, such as gender, race, etc.) (UNAIDS, 2006, p. 31), (UNAIDS, 1999, p. 127), (Inter-Parliamentary Unit [IPU], 2007, p. 93), (WHO, 2011, p. 12), (WHO, 2011, p. 30)	
• Policy mentions **prisoners** as individuals protected from discrimination (Y) • Policy does not mention prisoners (N)	1.
• Policy mentions **relatives or associates of prisoners** as individuals protected from discrimination (Y) • Policy does not mention relatives or associates of prisoners (N)	2.
• Policy mentions **individuals with actual or perceived health conditions** (including hepatitis, TB, or HIV) as individuals protected from discrimination (Y) • Policy does not mention actual or perceived health conditions (N)	3.
• Policy mentions **actual or perceived source of income** as a characteristic protected from discrimination (Y) • Policy does not mention actual or perceived source of income (N)	4.
• Policy mentions **actual or perceived sexual orientation** as a characteristic protected from discrimination (Y) • Policy does not mention actual or perceived sexual orientation (N)	5.
• Policy mentions **actual or perceived gender identity** as a characteristic protected from discrimination (Y) • Policy does not mention actual or perceived gender identity (N)	6.
• Policy identifies **protections against harassment and victimization** for individuals who file a discrimination complaint (Y) • Policy does not provide protections against harassment and victimization (N)	7.
If traditional and **customary laws, teachings, or practices** affect the status and treatment of SWs, TG, or MSM (UNAIDS, 2006, p. 32), (WHO, 2011, p. 30) (if there is no such effect, respond with N/A) • Policy provides for **legal remedies** if such laws or practices are used against SWs, TG, or MSM (Y) • Policy does not provide for legal remedies (N)	8.
• Policy authorizes and supports **information, education, or community mobilization** campaigns to change these customary laws and the attitudes associated with them (Y) • Policy does not support activities to change laws and attitudes (N)	9.

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C. Collect all policy documents that describe the **processes for filing discrimination complaints**

• Policy contains defined **processes for filing discrimination complaints** (Y) • Policy does not identify processes for filing discrimination complaints (N)	1.
• Policy identifies **protections against harassment and victimization for filing a discrimination complaint** (Y) • Policy contains no protections for individuals filing discrimination complaints (N)	2.

D. Collect all policy documents that describe an **anti-discrimination policy for the following categories** (WHO, 2006, p. 6), , (UNAIDS, 2008, p. 187)

	Education	Housing	Employment	Healthcare
• Policy **prohibits discrimination based on source of income** (Y) • Policy fails to prohibit discrimination based on source of income (N)	1.	2.	3.	4.
• Policy **prohibits discrimination based on gender identity** (Y) • Policy fails to prohibit discrimination based on gender identity (N)	5.	6.	7.	8.
• Policy **prohibits discrimination based on sexual orientation** (Y) • Policy fails to prohibit discrimination based on sexual orientation (N)	9.	10.	11.	12.
• Policy **prohibits discrimination based on HIV status** (Y) • Policy fails to prohibit discrimination based on HIV status (N)	13.	14.	15.	16.
• Policy **prohibits discrimination based on residency/citizenship** (Y) • Policy fails to prohibit discrimination based on residency/citizenship (N)	17.	18.	19.	20.

E. Collect all policy documents that mention **incitement of hatred, contempt, or ridicule** (CHALN, 2006g, pp. 15, 16), (UNAIDS, 2006, p. 36), (UNAIDS, 2009)

	SW	TG	MSM	PLHIV
• Policy states that it is **unlawful to incite hatred towards, serious contempt for, or severe ridicule** of a person or group of persons on the grounds that they are, or are perceived to be (1) SWs, (2) TG, (3) MSM, (4) PLHIV (Y) • Policy does not mention incitement of hatred, contempt, or ridicule of people, or promotes such actions (N)	1.	2.	3.	4.

Please include any additional remarks or observations about related policy areas not included in the items listed above. If analysis is being done at different levels of government, be sure to identify whether national, regional, and/or local policies differ or contradict each other.

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10. Legal Environment—Criminalization

> International guidelines on HIV/AIDS and human rights recommend the review of laws that prohibit sex between consenting adults [including sodomy] in private 'with the aim of repeal'… there is growing international consensus that the decriminalization of homosexuality is an essential part of a comprehensive public health response to the elevated risk of HIV acquisition and transmission among men who have sex with men (Global Commission on HIV and the Law, 2012, p. 48).

Criminal and penal codes establish definitions and parameters of behavior that reflect a criminal justice perspective and identify options for enforcement and remedy. The Decision Model identifies criminal laws that affect access to services, including those that increase HIV risk or exposure to high-risk and low-service environments, such as prisons. This section focuses on laws that criminalize or regulate consensual sexual activities and HIV transmission, with a resultant impact on access to HIV services. These laws include the following:

- The legal status and punishment for sex work, sexual orientation, gender nonconformity, and same-sex activity
- Age of consent
- Regulations of extramarital sexual conduct
- Criminalization of HIV transmission
- Policies on promotion, facilitation, and aiding and abetting

Criminalization of Sexual Orientation and Behavior

Homosexuality remains criminalized in more than 80 UN member states, with punishments ranging from jail time to the death penalty. Criminalization of same-sex behavior has profound implications across the spectrum of policies, issues, and programs relating to MSM (Beyrer & Baral, 2011). Repressive legal contexts and pervasive social stigma can limit access to appropriate services for STIs and HIV for these men, including prevention and treatment, and can even be life threatening (Beyrer, Wirtz, Walker, Johns, Sifakis, & Baral, 2011, p. 314). For example, in Ethiopia, MSM are punished with "simple imprisonment." In Guyana, the prison sentence for same-sex sexual practices ranges from two years to life. In Nigeria same-sex sexual practices are illegal under federal law; in those parts of the country under sharia law, sentences include death by stoning (amfAR & John Hopkins Bloomberg School of Public Health, 2012, p. 13).

Legal sanctions have a profound effect on MSM, who may become hidden and hence less accessible to prevention, treatment, and care interventions in their area. The Center for Public Health and Human Rights at Johns Hopkins University has recently conducted an investigation into health-seeking behavior of MSM in Senegal; preliminary data suggest that use of services has declined dramatically among MSM in Senegal after a police crackdown (Beyrer, Wirtz, Walker, Johns, Sifakis, & Baral, 2011, p. 314). Also, a recent review suggests that HIV prevalence among MSM is higher in settings with criminalization of same-sex behavior than those where it is legal (MSMGF 2010). In addition, the very existence of some of these laws is considered suspect from a human rights standpoint.

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Criminalization of same-sex behavior may result in different interpretations and impacts. For example, distributing condoms or lubricants to gay men may constitute a crime in some countries, while in Namibia, laws related to loitering often are used to target gay men.

MSM are often targeted for prosecution or harassment through laws enacted on the grounds of protecting the morality and decency of society. These statutes may take the form of laws against "anti-social behavior," "immoral behavior," "causing a public scandal," or "loitering," among other categories. Police may use these laws to arrest people known to be or suspected of being MSM. Agents of NGOs and CSOs that try to help MSM can be targeted through the same statutes or may be charged for abetting a criminal offense. Laws that prohibit "promotion of homosexuality" have been used to prevent distribution of materials dealing with safer sex and public health issues faced by MSM (Gable, Gamharter, Gostin, Hodge Jr., & Van Puymbroeck, 2007, p. 148).

Police also indirectly discriminate and oppress MSM by harassing and obstructing community outreach workers providing services to them. These activities on the part of the police pose substantial obstacles to outreach workers and directly obstruct their ability to implement HIV prevention activities in the field (Chakrapani, Newman, Shunmugam, McLuckie, & Melwin, 2007).

In most places, violence against MSM and TG goes unreported due either to shame or criminalization of the behavior itself. In countries like South Africa, as the law applies equally and the behavior itself is not criminalized, reporting of crimes of violence against MSM and TG is higher than many countries. South Africa also has established specialized sexual offenses courts that aim to reduce the trauma experienced by sexual assault complainants during the investigations and prosecution processes; to improve coordination among criminal justice agencies; and to increase the reporting, prosecution, and conviction rate for sexual offenses (Gable, Gamharter, Gostin, Hodge Jr., & Van Puymbroeck, 2007, p. 145).

Criminalization of Sex Work

Laws that aim to prevent or regulate sex work can deeply impact the human rights of SWs. A myriad of regulations, civil and administrative laws, and criminal laws are aimed at stopping public disorder, prostitution, human trafficking, and immorality. These shape where and how SWs live and work. Laws may affect male and transgender SWs differently—for example, laws against sodomy, cross-dressing and public order offenses (Global Network of Sex Work Projects, 2011, p. 76).

Criminalization of voluntary sex work, including laws prohibiting commercial sex work, soliciting, pimping, brothel keeping, and human trafficking can adversely affect SW access to HIV prevention, treatment, and care. In some places, condoms are used as evidence against SWs and their clients. In addition to criminalization of sex work, other laws or articles, such as those that criminalize loitering or public indecency, often are used to stop, harass, and regulate MSM, TG, or SWs in public settings. SWs are often displaced from commercial development areas, further interfering with their access to services.

Criminalization and police harassment can deter SWs from carrying condoms, prevent them from reporting abuse, discourage them from accessing HIV services, and put them in unsafe and exploitive working conditions that make condom negotiation more difficult. Moreover, they legitimize generalized social stigma and discrimination against SWs.

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The legal definition of sex work differs from jurisdiction to jurisdiction and affects the ability of SWs to access healthcare services. For instance, definitions that conflate sex work and human trafficking, such as India's *Immoral Traffic [Prevention] Act*, which defines prostitution as 'sexual exploitation or abuse of persons for commercial purposes,' make it unclear whether the SW may be treated as a criminal or a victim (Sukthankar, 2011). The legislation governing sex work, brothels, and STIs in Turkey defines an SW as 'a woman who acquires an artisanship of giving satisfaction to others' sexual needs in return for profit and who engages in sexual relationship with different men' (Taşcıoğlu, 2011). The gendered definition of SWs excludes male and transgender SWs.

The lack of clear distinction between human trafficking and consensual sex work can have a negative impact on both SWs and those individuals being trafficked. Consensual sex workers may be harassed through programs and policies aimed at targeting human trafficking (UNAIDS Advisory Group 2011), and individuals who have been trafficked may be subjected to prosecution for sex work.

Criminalization of Transmission of Communicable Diseases (Including HIV)

Laws that criminalize negligent or willful exposure "seek to deter individuals whose actions lead to exposure of others to HIV and potential transmission" (Gable, Gamharter et al. 2007). In this context, intent and actual occurrence of transmission may be relevant legally, though difficult to prove. Article 36 of the N'djamena-type model law found in parts of West Africa refers to "willful transmission," defined as "transmission of HIV through any means by a person with full knowledge of his/her HIV/AIDS status to another person" (Pearshouse 2007). This leaves the law open to interpretation, with the potential to include cases in which condoms were used but failed, even in instances where water-based lubricants (WBL) were not available. Many countries that adopted N'djamena-type model laws have acted to criminalize transmission of HIV but may not have appropriately defined the conditions under which this is considered willful or negligent.

These laws are problematic in the context of SWs, who may not have sufficient agency to negotiate safe sex even if they are aware of their HIV status and wish to do so, and for MSM, who may not have access to WBL. WHO guidance on this matter determined that criminalization of HIV transmission should be a "last resort," seen as a failure of prevention efforts, and only undertaken in a manner consistent with human rights (WHO 2006). The guidance also raised the issue of such criminalization potentially being linked to greater stigma and discrimination for PLHIV. Key populations may avoid HIV testing or public health settings if such prosecutions are likely in the context of unsafe sex or injecting drug use.

Referral to Services Rather than Prosecution

Prosecution of MSM, TG, and SWs can be a major barrier to prevention efforts, adoption of safer sex behaviors, and access to support and care services. These populations may avoid HIV testing and services for fear of prosecution and are often forced to hide, making it harder for them to access services and for outreach efforts to find them. Service referral in lieu of prosecution is a mechanism to engage law enforcement in ensuring that key populations get the services they need. Furthermore, if convicted, non-custodial sanctions reduce the potential increased HIV risk and limited prevention and treatment resources associated with incarceration.

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Aiding and Abetting and Propaganda Legislation

The World Medical Association has cited the duty of medical providers to serve patients regardless of personal attributes, including sexual orientation, social standing, and "any other factor" that intervenes between the provider and patient (World Medical Association, 2006) and has stated that "no doctor or other health care professional be arrested, accused or tried for treating patients, regardless of the origins of the patient's injury or illness" (World Medical Association, 2011).

Those provisions of the Uganda Anti-Homosexuality Bill defining and criminalizing 'aiding and abetting homosexuality' would punish landlords, healthcare providers, lawyers, and even friends for failure to disclose alleged homosexuality. "This is an assault on community structures, preventing the development of social capital among MSM, including that focused on 'institutions, relationships, attitudes, and values that govern interactions among people and contribute to economic and social development'" (Segumoma, Beyrer, & Baral, 2012).

"Educational material which may necessarily involve detailed information about transmission risks and

Laws criminalizing incitement of other persons to sexual activity and prohibiting "propaganda" and "promotion and advertisement" of homosexuality may put harm reduction programs at risk of prosecution (Lawyers Collective). In places where "homosexual propaganda" is banned, MSM do not seek medical care and treatment, as this may lead to persecution, denial of services, detention, blackmail, or violence, according to the Eurasian Coalition on Male Health (European AIDS Treatment Group).

Sample policy documents to consider (not an exhaustive list) include the following:

- Constitution
- National penal code
- National family law
- National public health law, policy, strategy, and guidelines
- National health law, policy, strategy, and guidelines
- National AIDS law, policy, strategy, and guidelines
- National STI law, policy, strategy, and guidelines
- National reproductive health and family planning law, policy, strategy, and guidelines
- National law enforcement and prison law, policy, strategy, and guidelines

Inventory and Analysis of Country Documents

Country: _____ Date completed: _____

Name of data collector: _____

Position: _____

Contact information for data collector:

Email address: _____

Telephone/fax: _____

Instructions to data collector:

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Refer to the instructions page for directions on how to fill out the inventory. Please provide information only on the areas with which you are familiar or have been assigned to research and leave the others blank. Within these areas, please be sure to answer "yes" or "no" to each item. All data collectors should address the open-ended question at the end of the areas upon which they are working.

If you find a policy document that addresses areas upon which you are not working, send the document or citation to the team leader. He or she will share this information with the individual primarily responsible for that section.

When you have completed the inventory, please send all the pages and all the documents you have referenced to [*team leader should fill this in before distributing to team members*].

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IX.	Criminal/Administrative law – criminalization and punishment	
A.	Intentionally left blank to align with PWID DM	
B.	Intentionally left blank to align with PWID DM	
C.	Intentionally left blank to align with PWID DM	
D.	Collect all policy documents that describe or define **human trafficking**	
	• Policy defines human trafficking as the **acquisition of people by improper means**, such as force, fraud, or deception, with the aim of exploiting them (Y) • Policy makes no distinction between human trafficking and consensual sex work (N)	1.
E.	Collect all policy documents that mention sex work, prostitution, or solicitation (UNAIDS, 2006)	
	• Policy does not mention **selling sexual services** or, if it is mentioned, identifies it as legal (Y) • Policy states that selling sexual services is illegal (N)	1.
	• Policy does not mention **purchasing sexual services** or, if it is mentioned, identifies it as legal (Y) • Policy states that purchasing sexual services is illegal (N)	2.
	• Policy does not mention **solicitation for sex work** or, if it is mentioned, identifies it as legal (Y) • Policy states that solicitation for sex work is illegal (N)	3.
	• Policy does not mention **proceeds from sex work** or, if it is mentioned, identifies it as legal income (Y) • Policy criminalizes living off the earnings of sex work (N)	4.
	• Policy does not mention **operating places of prostitution** or, if it is mentioned, identifies it as legal (Y) • Policy states that operating places of prostitution is illegal (N)	5.
	• Policy does not identify **imprisonment as a punishment** for sex work, prostitution, or solicitation (Y) • Policy identifies sanctions for sex work, prostitution, or solicitation that include imprisonment (N)	6.
	• Policy identifies **alternatives to prison** and non-custodial diversions for people convicted of offenses related to sex work, prostitution, or solicitation (Y) • Policy does not identify alternatives to prison or requires prison sentences for offenses related to sex work, prostitution, or solicitation (N)	7.
	• Policy does **not identify escalating penalties for repeated** convictions for sex work, prostitution, or solicitation (Y) • Policy identifies escalating penalties for repeated convictions for sex work, prostitution, or solicitation (N)	8.
	• Policy states that individuals who have been **trafficked or otherwise coerced into transactional sex are not prosecuted for participating in the sex industry** (Y) • Policy fails to protect individuals who have been trafficked or coerced into transactional sex from prosecution (N)	9.

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F. Collect all policy documents that mention **homosexuality or sexual orientation or identity** (YP, 2007, pp. 11-12, 23)**,** (HRC, 2011, p. 7)	
• Policy does not mention homosexual identity or, if it is mentioned, identifies it as **legal** (Y) • Policy classifies homosexual identity as illegal (N)	1.
• Policy does not punish homosexual identity **by death** (Y) • Policy punishes homosexual identity by death (N)	2.
• Policy does not punish homosexual identity **by imprisonment** (Y) • Policy punishes homosexual identity by imprisonment (N)	3.
• Regulations ensure that **medical or psychological treatment** or counseling does not, explicitly or implicitly, treat sexual orientation as a medical condition to be treated, cured, or suppressed (Y) • Regulations allow for "curative" therapies for sexual orientation (N)	4.
G. Collect all policy documents that mention **gender identity or gender nonconformity** (YP, 2007, pp. 11-12)**,** (HRC, 2010, p. 6)	
• Policy does not mention gender identity or, if it is mentioned, gender identity is defined as an individual's **deeply felt internal and individual experience of gender**, which may or may not correspond with the sex assigned at birth, including the personal sense of the body and other expressions of gender (Y) • Gender nonconformity is defined as deviant, criminal, an illness, or otherwise socially unacceptable (N)	1.
• Policy does not mention transgender identity or gender nonconformity or, if it is mentioned, identifies it as **legal** (Y) • Policy classifies transgender identity or gender nonconformity as illegal (N)	2.
• Policy does not punish transgender identity or gender nonconformity **by death** (Y) • Policy punishes transgender identity or gender nonconformity by death (N)	3.
• Policy does not punish transgender identity or gender nonconformity **by imprisonment** (Y) • Policy punishes transgender identity or gender nonconformity by imprisonment (N)	4.
• Regulations ensure that **medical or psychological treatment** or counseling does not, explicitly or implicitly, treat gender identity as a medical condition to be treated, cured, or suppressed • Regulations allow for "curative" therapies for gender identity	5.

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H. Collect all policy documents that mention **consensual same-sex sexual activity, sodomy, debauchery, indecency, crimes against nature, or buggery** (YP, 2007, pp. 11-12), (UNAIDS, 1999, p. 127), (HRC, 2010, p. 5), (UNODC, 2006, p. 19), (UNAIDS, 2009), (HRC, 2011, p. 15)	
• Policy does not mention **consensual same-sex sexual activity** among persons who are over the age of consent or, if it is mentioned, identifies it as legal (Y) • Consensual same-sex sexual activity among persons who are over the age of consent is illegal (N)	1.
• Policy does not define the **age of consent for homosexual relationships** or, if it is defined, defines it as the same for both heterosexual and homosexual relationships (Y) • Policy includes an age of consent that is different for heterosexual and homosexual relationships (N)	2.
• Policy does not regulate **extramarital sexual conduct** through criminal or financial sanctions (Y) • Policy regulates extramarital sexual conduct through criminal or financial sanctions (N)	3.
• Policy does not mention **consensual sexual activity in prisons** or, if it is mentioned, ensures that consensual sexual activity is not penalized (Y) • Policy penalizes consensual sexual activity in prisons (N)	4.
• Consensual same-sex sexual activity among persons who are over the age of consent is **not punishable by death** (Y) • Consensual same-sex sexual activity among persons who are over the age of consent is punishable by death (N)	5.
• Consensual same-sex sexual activity among persons who are over the age of consent is **not punishable by imprisonment** (Y) • Consensual same-sex sexual activity among persons who are over the age of consent is punishable by imprisonment (N)	6.
• Policy identifies **alternatives to prison** and non-custodial diversions for people convicted of offenses related to consensual same-sex sexual activity among persons who are over the age of consent (Y) • Policy does not identify alternatives to prison or requires prison sentences for offenses related to consensual same-sex sexual activity among persons who are over the age of consent (N)	7.
• Policy does **not identify escalating penalties for repeated** convictions of consensual same-sex sexual activity among persons who are over the age of consent (Y) • Policy identifies escalating penalties for repeated convictions of consensual same-sex sexual activity among persons who are over the age of consent (N)	8.
I. Collect all policy documents that describe **restrictions on loitering, movement, and association** (includes terms such as hooligan, rogue, vagabond, etc.) (UNAIDS, 2006)	
• Policy provides for **no restrictions** on movement, association, and assembly (Y) • Policy provides for restrictions on movement, association, and assembly (N)	1.
• If loitering policies exist, they **do not specifically mention prostitution or solicitation** (Y) • Loitering policies specifically mention prostitution or solicitation (N)	2.

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J. Collect all policy documents that mention **protection of public morality, indecent behavior, and public scandal** (Bradley, n.d.)**,** (UNAIDS, 2009)	
• Policy relates to **activities in public** (Y) • Policy fails to limit protection of public morality to public activities or authorizes authority over private activities (N)	1.
• Policy focuses on **protection of consent of unsuspecting individuals to engage in behaviors** (Y) • Policy fails to limit protection of public morality to the protection of consent or authorizes authority that undermines individual consent (N)	2.
K. Collect all policy documents that mention **transmission of communicable diseases (including HIV)** (UNAIDS, 1999, p. 123), (UNAIDS, 2006, p. 29), (UNDP, 2008, p. 1), (ABAROLI, 2011, pp. 91, 92), (HRC, 2010, p. 17)	
• Criminal and/or public health legislation **does not include specific offenses pertaining to the deliberate and intentional transmission of HIV** (Y) • Policy contains specific HIV transmission criminalization codes (N)	1.
• Policy **applies general criminal offenses** in instances of deliberate, intentional, malicious transmission of HIV (Y) • Policy contains specific HIV transmission criminalization codes (N)	2.
• Policy does not identify **HIV exposure without transmission** as a criminal offense (Y) • Criminal liability exists for HIV exposure (N)	3.
• Policy does not identify **non-disclosure of HIV status** as a criminal offense (Y) • Criminal liability exists for non-disclosure of HIV status (N)	4.
• Criminal law is **not to be applied where there is no significant risk of transmission or the person** falls into ANY of these categories: (Y) o Did not know that he/she was HIV positive o Did not understand how HIV is transmitted o Disclosed his/her HIV-positive status to the person at risk (or honestly believed the other person was aware of his/her status through some other means) o Did not disclose his/her HIV-positive status because of fear of violence or other serious negative consequences o Took reasonable measures to reduce risk of transmission, such as practicing safer sex through use of a condom or other precautions to avoid higher-risk acts o Previously agreed on a level of mutually acceptable risk with the other person • Criminal law is applied in any of these circumstances (N)	5.

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L. Collect all policy documents that define **admissible evidence of criminalized behaviors** for the purposes of determining criminal or administrative offenses (CHALN, 2006e, p. 25) , (UNAIDS, 2009), (WHO, 2012, p. 23)		
	Community	Prison
• Policy states that the **presence of disease or the mode of transmission** is not admissible as evidence of criminalized behavior (Y) • Policy does not exclude this information from admissibility in criminal or administrative proceedings (N)		
• Sex work	1.	2.
• Gender nonconformity	3.	4.
• Same-sex sexual behavior	5.	6.
• Homosexual orientation	7.	8.
• Policy states that **condoms and other safer sex materials are not admissible as evidence of criminalized behavior** for the purposes of determining any criminal or administrative offense (Y) • Policy does not exclude this information from admissibility to criminal or administrative proceedings (N)		
• Sex work	9.	10.
• Gender nonconformity	11.	12.
• Same-sex sexual behavior	13.	14.
• Homosexual orientation	15.	16.
• Policy states that **information provided in the process of reporting violence** is not admissible for the purposes of any criminal or administrative offense (Y) • Policy does not exclude this information from evidence in criminal or administrative proceedings (N)		
• Sex work	17.	18.
• Gender nonconformity	19.	20.
• Same-sex sexual behavior	21.	22.
• Homosexual orientation	23.	24.
• Policy states that **information provided in the process of reporting blackmail** is not admissible for the purposes of any criminal or administrative offense (Y) • Policy does not exclude this information from evidence in criminal or administrative proceedings (N)		
• Sex work	25.	26.
• Gender nonconformity	27.	28.
• Same-sex sexual behavior	29.	30.
• Homosexual orientation	31.	32.
• Policy states that **information provided in the process of filing a discrimination complaint** is not admissible for the purposes of any criminal or administrative offense related to criminalized identity or behavior (Y) • Policy does not exclude this information from evidence in criminal or administrative proceedings (N)		

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• Sex work	33.	34.
• Gender nonconformity	35.	36.
• Same-sex sexual behavior	37.	38.
• Homosexual orientation	39.	40.
M. Collect all policy documents that mention **promotion, facilitation, or aiding and abetting** of criminal offenses (UNAIDS, 2006, p. 97), (UNAIDS, 2008, p. 203)		
• Policy states that serving those with criminalized identities or individuals engaged in criminalized behavior **does not incur criminal liability** for promotion, facilitation, or aiding and abetting these criminal offenses (Y) • Policy does not provide protection from criminal liability for providing services to those with criminalized identities or individuals engaged in criminalized behavior (N)		1.
• Policy states that **educational materials** that include detailed information about disease transmission risks and may target groups engaged in illegal behavior, such as sex work or same- sex sexual behavior, are not subject to laws making those imparting the information liable for criminal offenses such as aiding and abetting (Y) • Policy does not provide protection from criminal liability for distribution of HIV prevention information (N)		2.
• Policy states that **beneficiaries** of HIV prevention activities are provided immunity from prosecution for offenses such as aiding and abetting (Y) • Policy does not provide protection from criminal liability for beneficiaries of HIV prevention activities (N)		3.
• Policy states that **healthcare providers** of HIV prevention and related medical care activities are provided immunity from prosecution for offenses such as aiding and abetting (Y) • Policy does not provide protection from criminal liability for healthcare providers of HIV prevention and related medical care (N)		4.
• Policy states that **non-medical service providers** of HIV prevention, care, and treatment support activities are provided immunity from prosecution for offenses such as aiding and abetting (Y) • Policy does not provide protection from criminal liability for non-medical service providers of HIV prevention, care, and treatment support (N)		5.
N. Collect all policy documents that mention delivery of drug use-related information about hepatitis and HIV through **mass media** (UNAIDS, 1999, p. 128)		
• Policy enables widespread provision of information on how HIV is spread and ensures that this information is **not inappropriately subject to censorship** or other broadcasting standards (Y) • Policy does not explicitly mention protection of HIV information from censorship or identifies inappropriate censorship barriers to its delivery (N)		1.
O. Collect all policy documents that mention **cross-dressing**		
• Policy provides **no restriction of the style of clothing worn** (Y) • Policy restricts the style of clothing to that of an individual's physiological sex at birth (N)		1.
Please include any additional remarks or observations about related policy areas not included in the items listed above. If analysis is being done at different levels of government, be sure to identify whether national, regional, and/or local policies differ or contradict each other.		

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11. Legal Environment—Gender-based Violence

This section focuses on policies related to gender-based violence and access to HIV services for survivors of GBV, including the following:

- Definition of GBV offenses
- Domestic violence
- Access to medical services, including post-exposure prophylaxis (PEP)
- GBV in prison facilities

Detailed Technical Guidance

UNAIDS Gender Inequality Resource Page

http://www.unaids.org/en/targetsandcommitments/eliminatinggenderinequalities/

U.S. Government – Gender-based Violence Resource Page

http://www.usaid.gov/what-we-do/gender-equality-and-womens-empowerment/gender-based-violence

Gender-based violence refers to violence that targets individuals or groups on the basis of their gender. This includes acts that inflict physical, mental, or sexual harm or suffering, the threat of such acts, coercion, and other deprivations of liberty (UNGA, 1993). Not all victims of GBV are female; there are circumstances in which men are victims of sexual violence, including by being harassed, beaten, or killed because they do not conform to the dominant views of masculinity accepted by the society (IRIN).

Reporting and prosecution of acts of sexual and gender-based violence are affected by the legal definition of such acts as crimes in the penal code. A gendered definition invariably means that certain categories of victims or perpetrators may not be captured by the penal provisions. Such acts of sexual and gender-based violence cover rape, including marital rape; child sexual abuse; defilement and incest; forced sodomy or anal rape; sexual abuse; sexual exploitation; sexual harassment; and forced prostitution.

Although laws in many countries are being broadened to cover any gender of victim and attacker, laws typically consider victims as female and perpetrators as male. In countries where physical resistance is required, instances in which the victim is incapable of giving consent due to the influence of drugs, alcohol, or because of age may not be covered by the law. Laws may limit insertion and penetration to specific body parts (e.g., penis and vagina) or recognize other forms of rape. Understanding of gender and sexuality-based violence often is limited to violence against women in domestic situations and organized workplaces. Rape laws often are written from the perspective of women, overlooking issues of male rape and rape of TG. Rape of men often has been reported across Africa during situations of conflict, both in war situations and during riots (Gettleman, 2009). Prevalence of male rape, even in non-conflict situations, is reported to be 20 percent in Peru, 3.6 percent in Namibia, 13.4 percent in the United Republic of Tanzania (Stemple, 2009, p. 607), and 20.8 percent in the Democratic Republic of the Congo (Johnson, et al., 2010). However, there may be countries that are moving to make rape laws gender neutral or pass separate laws to cover male rape. Countries like South Africa also have domestic violence laws that cover same-sex couples that live in relationships (Domestic Violence Act, 1998).

Sexual violence against SWs is common and comes from many sources, including clients, pimps, members of the community, and police. In a study in Burkina Faso, 68 percent of female sex workers

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(FSWs) interviewed reported being victims of recurrent theft and rape (Drabo, et al. 2010). Sexual violence against SWs reduces their ability to negotiate condom use and access adequate healthcare and increases risk of HIV transmission. In places where sex work is illegal, SWs are unlikely to report cases of sexual violence or press charges out of fear of being prosecuted themselves.

It is important to understand how law enforcement agencies view issues of rape and domestic violence and react to complaints registered pertaining to such issues, including rape of SWs, men, and TG. Policies around provision of PEP for victims of sexual assault are often not clearly spelled out, healthcare providers not trained, availability of such services often not known, and protocols to administer them not clear. Due to stigma, victims of rape often do not approach police and healthcare providers within the timeframe required for PEP. However, countries like South Africa do have clear-cut policy on administering PEP for victims of rape and sexual abuse (SANAC, 2012, p. 19).

As a group, populations with criminalized behaviors, such as MSM, SWs, and TG, have more experience with the harms associated with detention and prison settings. This exposure to harm comes as a consequence of both arrest and conviction, but also because gender nonconforming attributes can make individuals more vulnerable to sexual abuse while detained in hyper-masculine and aggressive prison environments, where often it is assumed that individuals perceived as homosexuals or SWs have consented to sexual activity (NPREC, 2009).

A key concern regarding any harm reduction program for these populations will be to address sexual violence in detention and prison settings, as this violence provides another mechanism for both human rights violations and disease transmission.

Sample policy documents to consider (not an exhaustive list) include the following:

- National penal code
- National family law
- National public health law, policy, strategy, and guidelines
- National health law, policy, strategy, and guidelines
- National AIDS law, policy, strategy, and guidelines
- National STI law, policy, strategy, and guidelines
- National reproductive health and family planning law, policy, strategy, and guidelines
- National law enforcement and prison law, policy, strategy, and guidelines

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Inventory and Analysis of Country Documents

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X. Domestic, sexual, and gender-based violence	
A. Collect all policy documents that describe or **define rape and its punishment** (UNHCHR & McDougal, 1998), (UNGA, 2001)	Y/N
The definition of rape	
• Identifies any **penetration without consent** or under conditions of force, coercion, or duress (Y) • Requires proof of non-consent (e.g., physical resistance, physical bruises, internal examination, etc.) (N)	1.
• Includes **non-payment for a commercial sexual service** in the definition of rape (Y) • Does not identify non-payment for a commercial sexual service as rape (N)	2.
• Includes insertion of **any body part or object** (Y) • Is limited to the insertion of a penis (N)	3.
• Includes **penetration of the mouth, anus, and vagina** (Y) • Penetration in rape is limited to the vagina (N)	4.
• Identifies **non-gender-specific descriptions of the victim and perpetrator** (Y) • Victims are limited to females and/or perpetrators are limited to males (N)	5.
Punishment for rape	6.
• Policy identifies **equal punishment for rape of a man or a woman** (Y) • Policy identifies lesser or no punishment for rape of a man (N)	7.
• Policy identifies **equal punishment for rape of a TG** or a non-TG (Y) • Policy identifies lesser or no punishment for rape of a transgender individual (N)	8.
• Policy identifies **equal punishment for marital rape** or non-marital rape (Y) • Policy identifies lesser or no punishment for marital rape (N)	9.
B. Collect all policy documents that mention **honor killings** or **corrective rape** (UNAIDS, 2009, p. 15)	Y/N
• Policy identifies **full prosecution and punishment for honor killings** of individuals based on actual or perceived sexual orientation (Y) • Policy identifies sexual orientation as mitigating factor in the prosecution or punishment for honor killings (N)	1.
• Policy identifies **full prosecution and punishment for honor killings** of individuals based on actual or perceived gender identity or gender-nonconforming behaviors (Y) • Policy identifies gender identity or nonconforming behaviors as mitigating factors in the prosecution or punishment of honor killings (N)	2.
• Policy identifies **full prosecution and punishment for corrective rape** of individuals based on actual or perceived sexual orientation (Y) • Policy identifies sexual orientation as mitigating factor in the prosecution or punishment for corrective rape (N)	3.
• Policy identifies **full prosecution and punishment for corrective rape** of individuals based on actual or perceived gender identity or nonconforming behaviors (Y) • Policy identifies gender identity or nonconforming behaviors as mitigating factors in the prosecution or punishment for corrective rape (N)	4.

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C. Collect all policy documents that mention **sexual violence or abuse** (Pivot Legal Society, 2006, pp. 145-148, 190)	
• Policy states that SWs have **full access to a complaint process in cases where they are subject to sexual harassment or abuse by their employers and clients** (Y) • Policy excludes SWs from resolution processes for sexual harassment or abuse (N)	1.
• Policy states that, despite any terms of a contract (formal or informal) for the provision of commercial sexual services**, a person may, at any time, refuse to provide, or to continue to provide, a commercial sexual service to any other person** (Y) • Policy fails to protect individual consent for sexual services, or identifies a contract as carte blanche consent (N)	2.

D. Collect all policy documents that mention **services for individuals who experience sexual violence or abuse** (UNDP, 2009b, pp. 10, 11)	SW	TG	MSM	Prisoners
• Policy guarantees **access to a female law enforcement official** (Y) • Policy does not guarantee access to a female law enforcement official (N)	1.	2.	3.	4.
• Policy provides for **access to medical assistance** for people who experience sexual abuse (Y) • Policy fails to provide for access to medical assistance (N)	5.	6.	7.	8.
• Policy provides for **psychosocial support** for people who experience sexual abuse (Y) • Policy fails to provide for access to psychosocial support (N)	9.	10.	11.	12.
• Policy authorizes PEP for individuals who experience sexual abuse (Y) • Policy fails to authorize PEP for individuals who experience sexual abuse (N)	13.	14.	15.	16.
• Policy stipulates that criminalized status, occupation, or behavior **does NOT preclude an individual from legal recourse** for sexual abuse (Y) • Policy precludes individuals or circumstances that involve criminalized status, occupation, or behavior from legal recourse for sexual abuse (N)	17.	18.	19.	20.

E. Collect all policy documents that mention **domestic, sexual, or gender-based violence reporting requirements**	Y/N
• Policy **does not require universal reporting of domestic violence incidents to police**, as this may discourage SWs, TG, or MSM from seeking medical attention (Y) • Policy provides no leeway or judgment in domestic violence reporting requirements (N)	1.
• Policy identifies specific mechanisms to integrate data on domestic, sexual, or gender-based violence into programs and interventions (Y) • Policy identifies no mechanism for use of data (N)	2.

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F. Collect all policy documents that mention **access eligibility for domestic violence shelters**	Y/N
• Policy **does not restrict access of SWs** to domestic violence shelters (Y) • Policy restricts access of SWs to domestic violence shelters (N)	1.
• Policy **does not restrict access of TG** to domestic violence shelters (Y) • Policy restricts access of TG to domestic violence shelters (N)	2.
• Policy **does not restrict access of MSM** to domestic violence shelters (Y) • Policy restricts access of MSM to domestic violence shelters (N)	3.
G. Collect all policy documents that mention **housing of detainees** (WHO, 2009c, p. 11)	Y/N
• Policy directs that **female detainees are housed separately from male detainees** (Y) • Policy does not provide for separate housing for female and male detainees (N)	1.
• Policy directs that **TG detainees are given the option to choose to be housed with female detainees** (Y) • Policy does not house TG detainees with female detainees (N)	2.
H. Collect all policy documents that mention **non-consensual sex in prison** (WHO, 1993, pp. 5, 6) , (UNODC, 2006, p. 19), (UNODC, 2010, p. 38), (UNAIDS, 1999, p. 124), (UNAIDS, 2006, pp. 30, 31), (CHALN, 2006e, p. 34), (NPREC, 2009)	Y/N
• Policy **prohibits non-consensual sex, coerced sex, bullying, and rape** (Y) • Policy does not mention or prohibit non-consensual sex (N)	1.
• Policy outlines **structures and processes to punish** and/or segregate inmates who are sexual predators (Y) • Policy does not identify structures and processes to punish inmates who are sexual predators (N)	2.
• Policy outlines **structures and processes to punish** employees who are sexual predators (Y) • Policy does not identify structures and processes to punish employees who are sexual predators (N)	3.
• Policy provides for comprehensive and compassionate **care and counseling** for survivors of sexual violence (Y) • Policy does not provide for care and counseling for survivors of sexual violence (N)	4.
• Policy requires **education of prisoners** on their right to be safe and mechanisms to seek remedy for sexual violence (Y) • Policy does not require education of prisoners on their right to be safe and mechanisms to seek remedy for sexual violence (N)	5.
• Policy requires **education of employees** on their right to be safe and mechanisms to seek remedy for sexual violence (Y) • Policy does not require education of employees on their right to be safe and mechanisms to seek remedy for sexual violence (N)	6.
• Policy identifies **independent and external mechanisms to monitor and review** cases of sexual violence in prisons (Y) • Policy does not identify independent and external mechanisms to monitor and review cases of sexual violence in prisons (N)	7.
Please include any additional remarks or observations about related policy areas not included in the items listed above. If analysis is being done at different levels of government, be sure to identify whether national, regional, and/or local policies differ or contradict each other.	

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12. Legal Environment—Torture, Cruel, Inhuman, or Degrading Treatment or Punishment

> "No one shall be subjected to torture or to cruel, inhuman or degrading treatment or punishment. In particular, no one shall be subjected without his free consent to medical or scientific experimentation" Article 7, International Covenant on Civil and Political Rights.

MSM/TG/SW are disproportionately subjected to violence of a sexual nature or corporal punishment that can amount to cruel, inhuman, or degrading punishment, or even torture, directly targeting the transgression of gender roles. Prohibitions in international human rights law forbidding torture and other cruel, inhuman, or degrading treatment or punishment apply to conditions of confinement, including in medical and other institutions. This section focuses on policies that impact torture and other cruel, inhuman, and degrading treatment and punishment, especially in relation to HIV services, including the following:

- Prohibition and punishment of torture or cruel, inhuman, or degrading treatment or punishment
- Accountability for torture by law enforcement agents
- Medical or legal processes qualifying as cruel, inhuman, and degrading treatment
- Social rehabilitation center

It has been reported that transgender women have been beaten intentionally on areas that contain silicone implants, which causes the implants to leak toxic substances into their bodies. The actual or perceived threat of this treatment can be used against a whole population by discouraging MSM/TG/SW from meeting in certain places or initiating "social cleansing" campaigns. Furthermore, because of criminalized status and/or stigma and discrimination, victims of this abuse often have limited access to medical or legal resources, which may prove to exacerbate or continue, rather than mitigate, the abuse (UNGA, 2001).

Law Enforcement

In Egypt, the systematic abuse imposed on suspected MSM by police officials includes forcible anal examination conducted by forensic physicians. These examinations, which involve anal molestation and penetration, are used to establish whether an individual has violated the moral code against sodomy and debauchery (HRW, 2004).

Medical Treatment

In jurisdictions where SWs are required to register under national or municipal laws and undergo periodic medical checks and blood tests for STIs, the circumstances of these medical checks may constitute degrading treatment (Center for Reproductive Rights, 2011). Healthcare systems designed to provide service for SWs may inadvertently result in human rights abuses and violations, thereby making these systems inaccessible to the intended beneficiaries.

TG also face a particular form of ill-treatment in health settings, stemming from arbitrary requirements that they undergo psychiatric evaluation, genital surgery, or even sterilization to change their gender officially. Such requirements are inherently a form of coerced medical treatment that may violate the right to be free from torture and ill-treatment (OSF, n.d.).

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Confinement and Reparative Therapies

Confinement of MSM, TG, and other LGBTI persons to state medical institutions, where they are subjected to forced treatment on the grounds of their sexual orientation or gender identity—including electric shock therapy and other aversion therapy—constitutes cruel, inhuman, and degrading treatment. In a number of countries, persons suspected of homosexuality have been subjected to compulsory, intrusive, and degrading medical examinations of the anus and penis to determine whether penetration had taken place, including within the context of enlistment for military service (UNGA, 2001).

Social rehabilitation programs for women suspected of transgressing moral codes have been documented as including virginity examinations by healthcare personnel in Libya. State-sponsored forcible anal examinations for the prosecution of suspected homosexual activities and invasive virginity examinations by healthcare providers, hormone therapy, and genital-normalizing surgeries also are conducted under the guise of so called “reparative therapies” (UNGA, 2013).

Conversion/reparative therapy and other services that aim to "cure" people with a non-heterosexual sexual orientation lack medical justification and represent a serious threat to the health and well-being of affected people (PAHO, 2012).

Prison Settings

Strip searches and other forms of invasive body searches conducted by prison officials on persons with ambiguous genitalia or differing gender identity in a manner that exposes them to ridicule and contempt constitutes cruel, inhuman, and degrading treatment (Kenya High Court, 2010).

Sometimes well-intentioned actions can result in cruel, inhuman, and degrading treatment or punishment. One example is the practice of putting MSM/TG inmates into segregation or isolation to protect them from physical and sexual violence. While this may be a short-term, immediate solution, these categories of detention are usually imposed to punish prisoners and, as such, greatly reduce privileges, limit contact with other prisoners, and result in reduced or no educational programs. Given the negative impact on the health of the prisoner, segregated or isolated custody should be only short term, while other protective measures are identified (NPREC, 2009).

Sample policy documents to consider (not an exhaustive list) include the following:

- Constitution
- National penal code
- Charters for health services users/patient rights and responsibilities
- National public health law, policy, strategy, and guidelines
- National health law, policy, strategy, and guidelines
- National AIDS law, policy, strategy, and guidelines
- National STI law, policy, strategy, and guidelines
- National reproductive health and family planning law, policy, strategy, and guidelines
- National law enforcement and prison law, policy, strategy, and guidelines

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Inventory and Analysis of Country Documents

Country: _____ Date completed: _____

Name of data collector: _____

Position: _____

Contact information for data collector:

Email address: _____

Telephone/fax: _____

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If you find a policy document that addresses areas upon which you are not working, send the document or citation to the team leader. He or she will share this information with the individual primarily responsible for that section.

When you have completed the inventory, please send all the pages and all the documents you have referenced to [*team leader should fill this in before distributing to team members*].

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XI.	Torture or cruel, inhuman, or degrading treatment or punishment		
A.	Collect all policy documents that mention **torture or cruel, inhuman, or degrading treatment or punishment** (HRC, 2011, p. 6)		
		Community Settings	Prison Settings
	• Policy defines torture or cruel, inhuman, or degrading treatment or punishment as **illegal** (Y) • Policy does not define torture or cruel, inhuman, or degrading treatment or punishment as illegal (N)	1.	2.
	• Policy defines torture or cruel, inhuman, or degrading treatment as **liable for punishment** (Y) • Policy does not define torture or cruel, inhuman, or degrading treatment as liable for punishment (N)	3.	4.
	• Policy forbids torture or cruel, inhuman, or degrading treatment or punishment by state agents **for the procurement of evidence of a crime** (Y) • Policy allows torture or cruel, inhuman, or degrading treatment or punishment by state agents for the procurement of evidence of a crime (N)	5.	6.
	• Policy evaluates **extrajudicial punishments** against the restrictions on torture or cruel, inhuman, or degrading treatment or punishment (Y) • Policy does not consider or address extrajudicial punishments (N)	7.	8.
	• Policy guarantees **freedom from torture and other cruel, inhuman, or degrading treatment or punishment** (Y) • Policy does not protect from torture and other cruel, inhuman, or degrading treatment (N)	9.	10.
	• Policy **specifically mentions sexual orientation** as protected from torture and ill-treatment (Y) • Policy does not mention sexual orientation as protected from torture and ill-treatment (N)	11.	12.
	• Policy **specifically mentions gender identity** as protected from torture and ill-treatment (Y) • Policy does not mention gender identity as protected from torture and ill-treatment (N)	13.	14.
	• Policy identifies mechanisms of **redress for victims of torture and ill-treatment** (Y) • Policy does not identify mechanisms of redress for victims of torture and ill-treatment (N)	15.	16.
	• Policy specifically identifies protections from torture and ill-treatment in **contexts of State custody or control** (Y) • Policy does not mention protections from torture and ill-treatment in contexts of State custody or control (N)		17.

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B. Collect all policy documents that mention **isolation, detention, or quarantine** (ABAROLI, 2011, p. 108)			
	SWs	TG	MSM
• Policy **prohibits detention centers for "social rehabilitation"** that impose arbitrary confinement and other human rights abuses (e.g., forced labor) on SWs, TG, or MSM (Y) • Policy does not prohibit detention centers that impose arbitrary confinement (N)	1.	2.	3.
Please include any additional remarks or observations about related policy areas not included in the items listed above. If analysis is being done at different levels of government, be sure to identify whether national, regional, and/or local policies differ or contradict each other.			

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13. Legal Environment—Monitoring and Enforcement of Human and Legal Rights

"States should ensure monitoring and enforcement mechanisms to guarantee the protection of HIV-related human rights, including those of people living with HIV, their families and communities" (UNAIDS, 2006, p. 19).

This section focuses on policies that provide for the monitoring and enforcement of human rights and their impact on access to HIV services, including the following:

- Categories of rights recognized, including health, work, sexual orientation, property, etc.
- Constitutional bodies with human rights enforcement mandate
- Rights in migration, asylum, and during detention
- Prohibition of corruption
- Public officers' codes of conducts
- Inclusion of MSM/TG/SW in human rights programs

National Bodies with Human Rights Enforcement Mandates

In compliance with the 1993 Paris Principles on the Promotion and Protection of Human Rights many countries have established national human rights institutions that monitor human rights internally. These national human rights institutions may be grouped into two categories—human rights commissions and ombudsmen set up to deal with specific issues, such as discrimination, although some bodies have a very broad mandate and responsibilities, which may include quasi-judicial functions. Since the mandate of these bodies often is circumscribed by a national Bill of Rights and the legislation of their respective countries, national legal systems that do not recognize key populations invariably offer limited or no protection within the mandate of national human rights institutions.

Directory of National Human Rights Institutions

http://nhri.ohchr.org/EN/Contact/NHRIs/Pages/default.aspx

When dealing with the HIV epidemic, quantification of the impact of structural interventions is important, but action is also mandated to decrease human rights abuses against MSM on social justice and human dignity grounds alone (Beyrer, Wirtz, Walker, Johns, Sifakis, & Baral, 2011, p. 313). Many HIV policies, such as those of Kenya, do mention human rights issues as a major obstacle to delivery of HIV services; however, when costing human rights interventions, no or little money is allocated for them (Kenya National AIDS Control Council, 2009, p. 12). The presence of positive laws and policies in itself does not ensure compliance. It is also critical to understand how these rights are monitored and actively promoted.

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Conduct of Public Officials and Law Enforcement

Police violence, illegal detention and arrests, and police bribes in the form of sex or fines are common among SWs (NSWP, 2010). Even in Senegal, where FSWs can register with the government, they report police corruption that includes extortion and bribery (OSI, 2006c). MSM in Burkina Faso report frequent police raids (Niang, Moreau, Bop, Compaore, & Diagne, 2004). This type of police abuse legitimizes generalized social stigma and may make it difficult for SWs and MSM to form networks that could assist in HIV prevention efforts.

However, it should be noted that repressive policing policies are not the only cause of police abuse of SWs and MSM; in many developing countries, the problem is exacerbated by broader structural factors, such as a weak judicial system, corruption and lack of accountability of law enforcement, and stigma and intolerance among the general population. If these broader issues are not addressed, police may continue to harass SWs and MSM and prevent them from accessing services, even when sex work or homosexuality is decriminalized.

Detailed Technical Guidance

The Global Programme against Corruption

http://www.unodc.org/unodc/en/corruption/index.html

In contrast, policies that ensure protection of human rights and put an end to police abuse, enlist police support to protect key populations from abuse and violence, and provide legal aid to abused SWs, TG, and MSM can help ensure that HIV prevention, care, and treatment efforts can reach these key populations. One example is using performance indicators that provide incentives to respond to reports of violence against SWs, TG, and MSM.

Access to Education Curricula

Educational content related to sexual behavior and HIV prevention practices (including condoms) depends on the existence of a supportive policy. Age-appropriate sexuality education can increase knowledge and contribute to more responsible sexual behavior. A review of such programs in 2006 indicated that approximately 50 percent of program participants showed a decrease in sexual risk-taking, illustrating that a sexuality education program does not lead adolescents to start engaging in sexual activity at a younger age (UNICEF, 2011, p. 10).

Access to Legal Aid

The right to equality before the courts and tribunals and a fair trial is a key element of human rights protection and serves as a procedural means to safeguard the rule of law. The availability or absence of legal assistance often determines whether or not a person can access the relevant proceedings or participate in them in a meaningful way. States are encouraged to provide free legal aid for individuals who do not have sufficient means to pay for it (UNHRC, 2007).

Legal aid schemes provide assistance to people who ordinarily are unable to access legal representation and the judicial system. A number of legal aid models exist, including duty lawyers, community legal clinics, and the payment of lawyers to deal with cases of individuals entitled to legal aid. In many jurisdictions, legal aid still is offered *pro bono* by law associations or a state-run agency. Societal prejudices against MSM, SWs, and TG may result in lawyers refusing to offer legal aid to these populations for fear of secondary stigmatization.

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Sample policy documents to consider (not an exhaustive list) include the following:

- Constitution
- Laws and regulations applicable to public servants
- Codes of ethics and regulations for healthcare professionals
- Treaties/conventions ratified
- National penal code
- National public health law, policy, strategy, and guidelines
- National health law, policy, strategy, and guidelines
- National AIDS law, policy, strategy, and guidelines
- National STI law, policy, strategy, and guidelines
- National reproductive health and family planning law, policy, strategy, and guidelines
- National law enforcement and prison law, policy, strategy, and guidelines

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XII.	Monitoring and enforcement of human and legal rights	
A.	Collect all policy documents that mention the **right to health** (HRC, 2011, p. 17)	
•	Policy describes the right to the **highest attainable standard of physical and mental health** (Y) • Policy does not guarantee the right to the highest attainable standard of physical and mental health (N)	1.
B.	Collect all policy documents that mention **protocols for biomedical research trials**	
•	Policy ensures that trial participant will be **provided ART and related services** in the event of testing HIV+ as part of the trial process* (Y) • Policy does not ensure access to ART and related services (N) *This is particularly relevant in cases of HIV vaccine trials, where efficacy of vaccines is being tested on individuals involved in high-risk behavior.	1.
C.	Collect all policy documents that mention **same-sex relationships** (UNAIDS, 2006, p. 36), (HRC, 2010, p. 6), (HRC, 2011, p. 22)	
•	If there are no policy documents that mention issues related to same-sex relationships, mark #1 as "X" and proceed to assessment point "D" below. • If policy documents exist, then continue with the policy assessment points of "D" that follow	1.
•	Policy does not mention **same-sex relationships** or, if they are mentioned, provides legal recognition of such relationships (Y) • Policy excludes same-sex relationships from legal recognition (N)	2.
•	Policy does not mention same-sex relationships or, if they are mentioned, governs same-sex relationships with the **same property, divorce, and inheritance** provisions as heterosexual relationships (Y) • Policy excludes same-sex relationships from provisions for property, divorce, and inheritance (N)	3.
D.	Collect all policy documents that **describe benefits or protections given to people with disabilities** (UNAIDS, 2006, p. 31), (CHALN, 2006g, p. 12), (CHALN, 2006g, p. 14)	
•	Disability policy includes the **loss of physical or mental function/ability to earn a living** based on HIV infection (Y) • Disability policy does not include HIV infection as a condition in the definition of disability (N)	1.
E.	Collect all policy documents that mention eligibility for **social assistance/protection programs**	
•	Policy states that a person's entitlement to **social assistance** may not be canceled or affected in any other way by his or her work as an SW (Y) • Work as an SW disqualifies an individual from social assistance (N)	1.
F.	Collect all policy documents that mention **corruption** (UNODC, 2006c, p. 19)	
•	Policy authorizes an **independent anti-corruption body or bodies** in charge of preventive measures and policies (Y) • Policy fails to mention or authorize an independent anti-corruption body (N)	1.
•	Policy directs the **participation of civil society**, nongovernmental, and community-based organizations in anti-corruption activities (Y) • Policy fails to mention or restricts nongovernmental, civil society, and public participation in anti-corruption activities (N)	2.

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• Policy identifies **activities to increase public awareness** of the threats, causes, and consequences of corruption (Y) • Policy does not explicitly mention anti-corruption measures (N)			3.
G. Collect all policy documents that mention or define **public servant codes of conduct** (UNODC, 2004b, p. 123), (UNODC, 2006c, p. 80), (UNODC, 2004b, p. 15)			
• Policy states that **bribery by a public official is illegal** (Y) • Policy does not mention bribery by public officials or endorses such behavior (N)			1.
• Policy states that **coercion by a public official is illegal** (Y) • Policy does not mention coercion by public officials or endorses such behavior (N)			2.
• Policy states that **extortion by a public official is illegal** (Y) • Policy does not mention extortion by public officials or endorses such behavior (N)			3.
	Available to public	Monitored	Enforced
• Policy identifies a **code of conduct for public servants** that is (4) available to the public, (5) monitored through a public complaints system, and (6) enforced through disciplinary boards (Y) • Policy does not identify a **code of conduct for public servants** that is available to the public, monitored through a public complaints system, and enforced through disciplinary boards (N)	4.	5.	6.
H. Collect all policy documents that guide **compensation of civil servants and political leaders** (UNODC, 2004b, p. 125)			
• Policy identifies the **goal of commensurate compensation** between civil servants or political leaders and those in positions of similar responsibility in the private sector (Y) • Policy makes no mention of commensurate compensation levels between private and public sectors (N)			1.
I. Collect all policy documents that identify **performance indicators for law enforcement officials** (EHRN, 2011)			
• Policy provides **financial and professional incentives for law enforcement to respond to violence** against the populations listed below (Y) • Policy provides no incentive or allows law enforcement to charge those who report violence with a crime (N)			
• SWs			1.
• TG			2.
• MSM			3.
• Policy provides financial and professional incentives for law enforcement to **refer individuals to health resources** (Y) • Policy provides no incentive for referral (N)			
• SWs			4.
• TG			5.
• MSM			6.

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J. Collect all policy documents that describe **rights to education** (UNICEF, 2011b, pp. 12, 27), (HRC, 2011, p. 19)	
• Policy prohibits **discrimination in accessing education on the basis of sexual orientation or gender identity** (Y) • Policy fails to prohibit or specifically endorses discrimination in education on the basis of sexual orientation or gender identity (N)	1.
• Policy prohibits **bullying and other forms of discrimination and violence** on the basis of sexual orientation and gender identity (Y) • Policy fails to prohibit or endorses bullying or other forms of discrimination and violence on the basis of sexual orientation and gender identity (N)	2.
• Policy specifically authorizes age-appropriate **school health curricula** inclusive of all sexual orientations and gender identities (Y) • Policy fails to authorize or prohibits school health curricula inclusive of all sexual orientations and gender identities (N)	3.
K. Collect all policy documents that identify **processes to obtain identity papers** and other official documentation (UNDP, 2009a, p. 10), (UNICEF, 2011b, p. 12), (UNAIDS, 2009, p. 15), (HRC, 2011, p. 22)	
• Policy identifies clear and accessible process to obtain **residency papers** required for accessing services (Y) • Policy is unclear or creates unreasonable barriers to obtaining residency papers (N)	1.
• Policy guarantees the ability of TG to obtain **gender-aligned identity papers** and other official documentation that they need to access services (Y) • Policy restricts or fails to address changing gender on official identity papers or requires divorce, sterilization, genital surgery, and/or psychiatric diagnosis of "sexual or gender dysphoria" (N)	2.
L. Collect all policy documents that mention **access to legal advice and representation** (UNAIDS, 2006, p. 48), (ABAROLI, 2011, p. 128), (Pivot Legal Society, 2006, p. 220), (NPREC, 2009, pp. 171-173)	

	SW	TG	MSM	Prisoners
• Policy identifies **state funding to educate regarding legal rights** (Y) • Policy fails to provide funding for education on legal rights (N)	1.	2.	3.	4.
• Policy **provides funding to overcome basic costs** associated with the legal system and access to free legal aid/consultation (Y) • Policy fails to provide access to free legal aid/consultation (N)	5.	6.	7.	8.
• Policy identifies **external bodies that prisoners can access** at any time for redress of human rights violations and sexual violence (Y) • Policy fails to identify external bodies for redress of human rights violations and sexual violence (N) • Policy limits redress to internal prison systems (N)	[redacted]			9.

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M. Collect all policy documents that mention **international law** (ABAROLI, 2011, p. 124), (HRC, 2011)	Y/N
Country has ratified the following **international conventions/treaties** (Y) / (N)	
1) Universal Declaration of Human Rights	1.
2) International Covenant on Civil and Political Rights	2.
3) Optional Protocol to the International Covenant on Civil and Political Rights	3.
4) Second Optional Protocol to the International Covenant on Civil and Political Rights, aimed at abolition of the death penalty	4.
5) The International Covenant on Economic, Social and Cultural Rights (ICESCR)	5.
6) The Convention against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment (CAT)	6.
7) The Convention on the Elimination of All Forms of Discrimination against Women (CEDAW)	7.
8) Convention Relating to the Status of Refugees	8.
9) Convention on Rights of the Child (CRC)	9.
Identify **regional conventions/treaties** that impact SWs or MSM and indicate whether or not there is country ratification (Y) / (N)	
10)	10.
11)	11.
12)	12.
13)	13.
• Policy recognizes the **supremacy of adopted international law** vis-a-vis national legislation (Y) • Policy fails to mention supremacy of adopted international law (N)	14.
• Policy recognizes the **competence of international human rights bodies** to receive complaints or communications from individuals who claim that their rights have been violated (Y) • Policy fails to mention international human rights bodies or explicitly denies their jurisdiction (N)	15.

N. Collect all documents describing **human rights enforcement or promotion programs** (De Lollo, 2012, p. 21)								
For all points below, answer (N) if country does not have relevant human rights enforcement or promotion programs or resources: G = government, D = donor	SWs		TG		MSM		Prisoners	
	G	D	G	D	G	D	G	D
• Programs contain population-specific monitoring and evaluation **outcome indicators** (Y) • Programs fail to contain population-specific monitoring and evaluation outcome indicators (N)	1.	2.	3.	4.	5.	6.	7.	8.
• Programs contain population-**specific coverage and/or service delivery goals** (Y) • Programs fail to contain population-specific coverage and/or service delivery goals (N)	9.	10.	11.	12.	13.	14.	15.	16.

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• Programs **collect population-specific data on human rights violations** (Y) • Programs fail to collect population-specific data on human rights violations (N)	17.	18.	19.	20.	21.	22.	23.	24.
• Programs **report population-specific data on human rights violations** (Y) • Programs fail to report population-specific data on human rights violations (N)	25.	26.	27.	28.	29.	30.	31.	32.
O. Collect all policy documents that address population **mobility and migration**								
• Policy identifies persecution on the basis of **sexual orientation as a justification for granting asylum** (Y) • Policy makes no mention of persecution on the basis of sexual orientation as a justification for granting asylum (N)	1.							
• Policy identifies persecution on the basis of **gender identity as a justification for granting asylum** (Y) • Policy makes no mention of persecution on the basis of gender identity as a justification for granting asylum (N)	2.							
• Policy does not restrict issuance of **work permits based on the occupation or history of sex work** (Y) • Policy restricts work permits for individuals with occupation or history of sex work (N)	3.							
• Policy does not restrict issuance of **visas based on the occupation or history of sex work** (Y) • Policy restricts visas for individuals with occupation or history of sex work (N)	4.							
Please include any additional remarks or observations about related policy areas not included in the items listed above. If analysis is being done at different levels of government, be sure to identify whether national, regional, and/or local policies differ or contradict each other.								

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14. Intervention Design, Access, and Implementation—Procurement and Supply Management

Supply of appropriate drugs and commodities is critical to fighting the HIV epidemic. With "Treatment as Prevention" becoming one of the key strategies in the fight against the epidemic, and biomedical prevention methods such as vaginal microbicides on the horizon, the issue of proper procurement and supply chain management is gaining ground, especially for MSM/TG/SW populations. This section focuses on policies that regulate procurement and supply management of HIV services, including the following:

- Procurement and supply management (PSM) oversight
- Quality standards
- Essential medicines list
- Involvement of MSM/TG/SW in selection of commodities
- Quantification and forecasting of supplies
- Budgeting

Detailed Technical Guidance

Operational Principles for Good Pharmaceutical Procurement
http://apps.who.int/medicinedocs/en/d/Jwhozip49e/7.html

USAID/Deliver
http://deliver.jsi.com/dhome/

UNITAID
http://www.unitaid.eu/

WHO Model List of Essential Medicines
http://www.who.int/medicines/publications/essentialmedicines/en/

Engagement of Target Populations in PSM Oversight

It is important to understand how community-led groups are key to choosing such products as condoms and lubricants. For example, SW groups have often advocated for appropriate female condoms and vaginal lubricants, pressure from groups of PLHIV has been known to assist governments in predicting stockouts, and advocates have been critical in drawing attention to the importance of both condoms and lubricants for anal and vaginal sex.

The Kenyan strategic plan on HIV and AIDS acknowledges this point and states "the plan will ensure that: stockouts are minimized, and where possible eliminated; commodities are equitably and efficiently distributed; commodities are used appropriately; various procurement and supply chain management systems are harmonized; quality control and pharmaco-vigilance is ensured; appropriate staffing mix is available countrywide; parallel information systems are made more efficient and eventually integrated; and, public oversight, guidance and monitoring processes and structures (including citizen participation) are in place" (Kenya National AIDS Control Council, 2009, p. 43).

All of this information makes it imperative to understand the current policies regarding involvement of community groups in product selection and supply chain management.

Essential and Approved Drugs

A key element of the success of the services identified in this Decision Model is a functioning system for the PSM of medicines and medical commodities. Central to PSM is the concept of "Approved Drugs and Essential Drugs."

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There are several documents a national government may use to control or specify which drugs and other medical commodities may be used in its country. The Decision Model inventory includes two of these: the *Approved Drug List* and the *Essential Drug (or Medicine) List*. In addition, a government may specify which drugs are approved for local manufacture and which for importation. Alternatively, the government may explicitly indicate by law or regulation the use of controlled medications.

Approved Drug List

The Approved Drug List is the largest, most extensive listing of medical pharmaceuticals permitted for use in a country. It typically is maintained by the equivalent of the relevant national agency responsible for food and drug regulations. The Approved Drug List usually includes generic formulations as well as brand-name drugs; it also covers drugs that are sold or distributed "over the counter" (i.e., without a physician's prescription) and those that require a physician's prescription. The list typically does not include drugs still being tested for safety and efficacy or those permitted only for research purposes.

If the consultant has difficulty in locating a country's Approved Drug List, he/she might contact the local office of one of the large transnational pharmaceutical companies. Bayer-Schering, GlaxoSmithKline, and other companies often have local offices to ensure that their products can be imported, distributed, and sold. They would know who to contact for the Approved Drug List.

Essential Drug List

Many countries also maintain an Essential Drug List. Most are adapted from the *WHO Model Lists of Essential Medicines*, which is updated every two years. The WHO model list includes a *core list* of minimum medicines through which a basic healthcare system can address public health concerns, and a *complementary list* of essential medicines for priority diseases, for which specialized diagnostic or monitoring facilities, specialist medical care, and/or specialist training are needed.

The Essential Drug List is usually smaller than the Approved Drug List—in other words, all of the drugs on the Essential Drug List should also be found on the Approved Drug List, but the reverse is not necessarily the case—not all drugs on the Approved Drug List will be found on the Essential Drug List.

Countries may use their Essential Drug List in different ways. Some may require that government health programs purchase only drugs included on the Essential Drug List; on the other hand, private sector organizations may purchase any drugs on the Approved Drug List, whether or not they are on the Essential List. Other countries may require that government programs stock *all* of the drugs on the Essential Drug List. Some countries may not specify their own Essential Drug List, but instead direct their government health programs to use the WHO model lists as references. Finally, some countries may also have additional lists, such as the "List of drugs that are allowed to be purchased through state, municipal, or regional budget funding" that exists in Ukraine.

Local Manufacture and Importation

The drugs distributed and used in a country may include both locally manufactured and imported products. The decision to manufacture locally versus import is based on many considerations, including the costs and type of laboratory installations required to manufacture the product. Government approvals to manufacture a drug locally (sometimes with imported raw materials) and/or import the finished product may be found in different policy documents. In some cases, the approvals are indicated in the Approved

Throughout this document, the term "policy" is inclusive of legislation, policies, legal decisions, judicial precedent, regulations, guidelines, and/or operational plans and protocols.

Drug List and/or Essential Drug List. In other cases, approvals may be issued as special documents. Since methadone and buprenorphine are controlled substances, special approvals for their manufacture and/or importation are required to conform to international conventions.

Registration and Procurement of ART Medications

A complicated, lengthy, costly, and non-transparent process of drug registration undermines competition in the ART market, resulting in high cost and a limited range of available ART medications. Countries also lack smooth and coherent management information systems for the forecasting, procurement, and stock management of ART medications. Often, all data collection and decisions are made by one specialist, which makes the system susceptible to serious errors (UNAIDS, 1999). Problems with the procurement and supply of ART medications may result in stockouts, depriving patients of this life-saving treatment.

In some countries, the cost of ART drugs is unreasonably high because governments either failed to register the generic versions of ART drugs (HRW, 2007a) to exempt them from taxes (Belyaeva & Aftandilyants, 2010) or failed to establish effective monitoring of the procurement process.

Procurement Mechanisms

Another issue is the lack of flexibility of centralized procurement and supply mechanisms and the resulting inability to address timely changes in the type of commodities needed or an increase in the number of clients participating in the programs. A survey of the PSM systems in 24 West and Central African countries identified a number of recurrent PSM constraints common to almost all the countries: (1) recurrent stockouts in health facilities, mainly due to inadequate forecasting and inadequate information flow between stakeholders; (2) the large number of stakeholders involved working within complex and rigid scenarios; (3) inadequate consultation between donors and medical stores; (4) fractioning of the supply cycle; and (5) the multiplicity and lack of flexibility in supply procedures (UNICEF, 2008). The manner in which these constraints are dealt with in policy and practice have implications for access to services for MSM/SW/TG persons.

Sample policy documents to consider (not an exhaustive list) include the following:

- National pharmaceutical procurement policy and guides for the public health sector
- National List of Essential Drugs
- National pharmaceutical strategic plans and regulations
- Codes of ethics and regulations for public officials
- National public health law, policy, strategy, and guidelines
- National health law, policy, strategy, and guidelines
- National AIDS law, policy, strategy, and guidelines
- National STI law, policy, strategy, and guidelines
- National reproductive health and family planning law, policy, strategy, and guidelines
- National law enforcement and prison law, policy, strategy, and guidelines

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Inventory and Analysis of Country Documents

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Name of data collector: _____

Position: _____

Contact information for data collector:

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Telephone/fax: _____

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If you find a policy document that addresses areas upon which you are not working, send the document or citation to the team leader. He or she will share this information with the individual primarily responsible for that section.

When you have completed the inventory, please send all the pages and all the documents you have referenced to [*team leader should fill this in before distributing to team members*].

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XIII. Procurement and supply management of medicine and medical commodities

A. Collect all policy documents that identify bodies with **PSM oversight** responsibility (JSI/Deliver, 2005a, p. 29)

	Oversee, coordinate, and track resources	Identify gaps in funding	Identify technical assistance needs	Oversee tendering
• Policy states that **oversight bodies** have the responsibility to1) oversee, coordinate, and track resources that have been promised and allocated; 2) identify gaps in funding, medicines, and medical commodity inventories; 3) identify technical assistance needs; and 4) oversee tendering (Y) • Policy contains no mention of PSM oversight body or responsibility (N)	1.	2.	3.	4.
• Policy identifies **representation of nongovernment organizations** on oversight bodies (Y) • Policy does not identify requirement for or restricts representation of nongovernment organizations (N)				5.

	SW	TG	MSM
• Policy allows for **participation of individuals or nongovernmental or civil society organizations** in forecasting (Y) • Policy fails to support or restricts involvement of individuals or nongovernmental or civil society organizations in forecasting (N)	6.	7.	8.
• Policy allows for **participation of individuals or nongovernmental or civil society organizations** in quality monitoring (Y) • Policy fails to support or restricts involvement of individuals or nongovernmental or civil society organizations in quality monitoring (N)	9.	10.	11.
• Policy allows for **participation of individuals or nongovernmental or civil society organizations** in monitoring and reporting stockouts (Y) • Policy fails to support or restricts involvement of individuals or nongovernmental or civil society organizations in monitoring and reporting stockouts (N)	12.	13.	14.

• Policy guarantees that **procurement records are open to the public** (Y) • Policy restricts access to procurement records (N)	
• Policy identifies mechanisms to identify and **manage conflict of interest** of decisionmakers involved with procurement of medicine and medical commodities (Y) • Policy does not mention or encourages conflicts of interest (N)	16.
• Policy identifies mechanisms to **limit ability of companies to incentivize particular diagnostic and treatment decisions** (Y) • Policy is silent on corporate incentives or encourages their use (N)	17.

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B. Collect all policy documents that mention quality standards for medicines and medical commodities	
• Procurement policy prioritizes utilization of **WHO Prequalified Drugs List** (Y) • Policy does not mention use of WHO Prequalified Drugs List (N)	1.
• Policy identifies **quality assurance standards** for medicines and medical commodities (Y) • Policy does not mention quality assurance standards (N)	2.
• Policy identifies **post-procurement quality control** medicines and medical commodities (Y) • Policy does not mention post-procurement quality assurance standards (N)	3.
• Policy identifies mechanisms for engagement of key populations in **adoption and implementation of new medical technologies** (e.g., home test kits) (Y) • Policy does not identify mechanisms for engagement (N)	4.
C. Collect all policy documents that mention the Country **essential medicines** list (UNAIDS, 2008, p. 200), (WHO, 2003, p. 4)	
• The country essential medicines list **includes all medications identified in the WHO Model List of Essential Medicines** for STIs and HIV (Y) • The essential medicines list excludes some of the medications identified by WHO (N)	1.
• Drugs that can **procured through government funding** include medications for STIs and HIV • Government funding is restricted for any medications for STIs and HIV	2.
• Policy explicitly **allows importation or local manufacture for clinical use** of all medications identified in the WHO Model List of Essential Medicines for STIs and HIV (Y) • Policy fails to explicitly allow importation or local manufacture of WHO medicines for clinical use (N)	3.
• Policy **removes or reduces taxes and tariffs** on essential medicines, controls distribution margins, and sets pricing parameters (Y) • Policy fails to mention reduction in taxes or tariffs, distribution margins, or pricing parameters (N)	4.
D. Intentionally left blank to align with PWID DM	
E. Collect all policy documents that identify the process for **quantification and forecasting** of medicine and commodity need (WHO, 1999, pp. 12, 13), (JSI/Deliver, 2003, pp. 2, 8)	

	Reliable estimate of need	Review and update every six months	Monthly reporting cycle
1) Policy identifies mechanisms to calculate order quantities based on **reliable estimate of need**, including all those who are eligible for prevention, diagnostics, and treatment, based on internationally accepted guidelines (Y) 2) Policy requires **review and updating of forecasting** and quantification of medicines and medical commodities at least every six months (Y) 3) Policy requires implementation of a **monthly reporting** cycle (Y) • Policy fails to mention mechanisms for calculation or uses mechanisms that fail to consider current forecasts of need (N)	1.	2.	3.

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• Policy identifies guidelines that include **cost-effectiveness measures** for forecasting and procurement of appropriate quantities of initial and advanced categories of medicines and commodities (Y) Policy makes no mention of cost-effectiveness or encourages procurement of advanced categories of medicines and commodities (N)	4.

F. Collect all policy documents that establish **budgets** for medicines and medical commodities (JSI/Deliver, 2005a, p. 26), (WHO, 2007b, pp. 50-57)

	Budget for storage	Budget for distribution	Budget for logistics
• Budgets for medicines and medical commodities include a specific mechanism to finance: **1) storage, 2) distribution, and 3) logistics** (Y) • Budgets fail to fund storage, distribution, and logistics (N)	1.	2.	3.
• Policy allows for flexibility for **decentralized procurement** (Y) • Policy prohibits decentralized procurement (N)		4.	
• Policy allows for **international tendering** (Y) • Policy prohibits international tendering (N)		5.	

G. Collect all policy documents that mention **medicine and medical commodity distribution** (JSI/Deliver, 2005b, p. 9)

• Policy identifies systems **to redistribute medicines and medical commodities** to prevent stockouts, overstocks, and expiration (Y) • Policy fails to identify systems or prohibits redistribution (N)	1.

Please include any additional remarks or observations about related policy areas not included in the items listed above. If analysis is being done at different levels of government, be sure to identify whether national, regional, and/or local policies differ or contradict each other.

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15. Intervention Design, Access, and Implementation—Overarching Services Design

Policies that promote integration and referral can improve access to health services for MSM/TG/SW by increasing entry points into healthcare and related services. This section focuses on policies that provide for integration of HIV and other services, including the following:

- Integration of SRHR, STI, HIV
- Referral systems
- Continuity of care
- Training requirements

Integration of Services

Detailed Technical Guidance

WHO HIV service delivery
http://www.who.int/hiv/topics/capacity/en/index.html

Obstacles to access to interventions and services for key populations can be mitigated by using best practices in intervention design and ensuring human rights. Integrating STI, HIV, and SRHR services and other health services can increase access to services, including STI and HIV screening. A lack of such service integration and referral mechanisms can lead to lost opportunities for reaching MSM/TG/SW and discourage these populations from seeking services. One of the benefits of integration is delivering services to all individuals who are at risk—regardless of whether or not they personally identify as a member of these populations (e.g., MSM not identifying as gay, male and transgender SWs, and individuals who engage in occasional sex work and/or provide sex in exchange for non-monetary reasons, such as shelter and protection). Finally, if services are not convenient and accessible to clients, or if clients fear gaps in confidentiality or stigma and discrimination from healthcare providers and law enforcement, key populations will not be reached.

A range of integrated HIV services have been found to be cost-effective compared with 'do-nothing' alternatives, including HIV services integrated into sexual and reproductive health services, integrated tuberculosis/HIV services, and HIV services integrated into primary healthcare. The cost of integrated HIV counseling and testing is likely to be lower than that of stand-alone counseling and testing provision; however, evidence is limited on the comparative costs of other services, particularly HIV care and treatment. Also, little is known about the most efficient model of integration, the efficiency gain from integration beyond the service level, and any economic benefit to HIV service users (Dehne, Greener, Maier, Obure, Sweeney, & Vassall, 2009).

A critical component of integration is the cross-sectoral training of prison, law enforcement, and healthcare providers in the needs of MSM/TG/SW and ethics and human rights areas, such as informed consent, confidentiality, and avoiding stigma and discrimination. With proper policies, training, and supervision, a broad spectrum of public officials and services can be engaged in the health and well-being of MSM/TG/SW.

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Sample policy documents to consider (not an exhaustive list) include the following:

- National Penal Code
- Behavioral surveillance surveys
- National quality assurance guidelines for health
- Norms and guidelines for working with PLHIV, MSM, TG, or SWs
- National pharmaceutical procurement policy and guides for the public health sector
- National public health law, policy, strategy, and guidelines
- National health law, policy, strategy, and guidelines
- National AIDS law, policy, strategy, and guidelines
- National STI law, policy, strategy, and guidelines
- National reproductive health and family planning law, policy, strategy, and guidelines
- National law enforcement and prison law, policy, strategy, and guidelines

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XIV. Overarching SRHR, STI, and HIV services design

A. Collect all policy documents that guide **implementation** of SRHR, STI, and HIV services (UNODC, 2009, p. 43), (WHO, 1993, pp. 6, 8), (UNODC, 2010, pp. 39, 41), (WHO, 2007c, p. 6), (UNODC, 2006, pp. 23, 26), (CHALN, 2006e, pp. 30, 31), (UNAIDS, 1999, p. 123), (UNAIDS, 2008, p. 187), (UNDP, 2009b, pp. 10-11), (UNAIDS, 2009c, pp. 122, 123), (UNAIDS, 2006, pp. 29, 30), (WHO, 2012, p. 18)

Policy:	SRHR		STI		HIV		Alcohol Harm Reduction		Substance Abuse Harm Reduction	
	C	P	C	P	C	P	C	P	C	P
• Policy directs all services to have protocols to **assess need for SRHR** (Y) • Policy does not identify SRHR need assessment protocols (N)			1.	2.	3.	4.	5.	6.	7.	8.
• Policy directs all services to have protocols to **assess risk for STIs** (Y) • Policy does not to identify STI risk assessment protocols (N)	9.	10.			11.	12.	13.	14.	15.	16.
• Policy directs all services to have protocols to **assess risk for HIV** (Y) • Policy does not identify HIV risk assessment protocols (N)	17.	18.	19.	20.			21.	22.	23.	24.
• Policy directs all services to have protocols to **assess risk for alcohol abuse** (Y) • Policy does not identify alcohol abuse assessment protocols (N)	25.	26.	27.	28.	29.	30.			31.	32.
• Policy directs all services to have protocols to **assess risk for substance abuse** (Y) • Policy does not identify substance abuse assessment protocols (N)	33.	34.	35.	36.	37.	38.	39.	40.		
• Policy directs all services to have protocols to **assess risk for sexual and domestic violence** (Y) • Policy does not identify domestic and sexual violence risk assessment protocols (N)	41.	42.	43.	44.	45.	46.	47.	48.	49.	50.
• Policy directs all services to have protocols to **assess mental health and risk of depression** (Y) • Policy does not identify mental health and depression assessment protocols	51.	52.	53.	54.	55.	56.	57.	58.	59.	60.

Policy:	SRHR		STI		HIV		Alcohol Harm Reduction		Substance Abuse Harm Reduction	
	C	P	C	P	C	P	C	P	C	P
• Policy identifies **mechanisms of referral** to other services (Y) • Policy does not identify mechanisms of referral (N)	61.	62.	63.	64.	65.	66.	67.	68.	69.	70.
• Policy ensures **equal access for women and men** (Y) • Policy does not ensure equal access for women and men (N)	71.	72.	73.	74.	75.	76.	77.	78.	79.	80.
• Policy ensures **equal access for SWs** (Y) • Policy does not ensure equal access for SWs (N)	81.	82.	83.	84.	85.	86.	87.	88.	89.	90.
• Policy ensures **equal access for TG** (Y) • Policy does not ensure equal access for TG (N)	91.	92.	93.	94.	95.	96.	97.	98.	99.	100.
• Policy ensures **equal access for MSM** (Y) • Policy does not ensure equal access for MSM (N)	101.	102.	103.	104.	105.	106.	107.	108.	109.	110.
• Policy identifies mechanisms for **SWs to be involved in the development of program protocols** (Y) • Policy does not mention SW involvement in program design (N)	111.	112.	113.	114.	115.	116.	117.	118.	119.	120.
• Policy identifies mechanisms for **TG to be involved in the development of program protocols** (Y) • Policy does not mention TG involvement in program design (N)	121.	122.	123.	124.	125.	126.	127.	128.	129.	130.
• Policy identifies mechanisms for **MSM to be involved in the development of program protocols** (Y) • Policy does not mention MSM involvement in program design (N)	131.	132.	133.	134.	135.	136.	137.	138.	139.	140.
• Policy identifies **mechanisms to monitor program outcomes for SWs** (Y) • Policy does not mention monitoring and evaluation of programs for SW-specific outcomes (N)	141.	142.	143.	144.	145.	146.	147.	148.	149.	150.

Policy:	SRHR		STI		HIV		Alcohol Harm Reduction		Substance Abuse Harm Reduction	
	C	P	C	P	C	P	C	P	C	P
• Policy identifies **mechanisms to monitor program outcomes for TG** (Y) • Policy does not mention monitoring and evaluation of programs for TG-specific outcomes (N)	151.	152.	153.	154.	155.	156.	157.	158.	159.	160.
• Policy identifies **mechanisms to monitor program outcomes for MSM** (Y) • Policy does not mention monitoring and evaluation of programs for MSM-specific outcomes (N)	161.	162.	163.	164.	165.	166.	167.	168.	169.	170.
• Policy identifies **mechanisms for SWs to be involved in the monitoring and evaluation** of programs (Y) • Policy does not mention SW involvement in program monitoring (N)	171.	172.	173.	174.	175.	176.	177.	178.	179.	180.
• Policy identifies **mechanisms for TG to be involved in the monitoring and evaluation** of programs (Y) • Policy does not mention TG involvement in program monitoring (N)	181.	182.	183.	184.	185.	186.	187.	188.	189.	190.
• Policy identifies **mechanisms for MSM to be involved in the monitoring and evaluation** of programs (Y) • Policy does not mention MSM involvement in program monitoring (N)	191.	192.	193.	194.	195.	196.	197.	198.	199.	200.
• Policy states that **criminalized orientation or identity does not restrict** access to services (Y) • Policy does not specifically guarantee access to services for populations with criminalized orientation or identity, or identifies them as excluded from programs (N)	201.	202.	203.	204.	205.	206.	207.	208.	209.	210.
• Policy states that individuals with **criminalized behaviors** are not restricted from accessing programs (Y) • Policy does not specifically guarantee access to services for individuals with criminalized behaviors, or identifies them as excluded or ineligible for programs (N)	211.	212.	213.	214.	215.	216.	217.	218.	219.	220.

Policy:	SRHR		STI		HIV		Alcohol Harm Reduction		Substance Abuse Harm Reduction	
	C	P	C	P	C	P	C	P	C	P
• Identifies mechanisms to ensure **continuity of care between and within community and detention/prison/custodial settings** (Y) • Does not mention continuity of care between and within detention/prison/custodial settings and community services (N)	221.	222.	223.	224.	225.	226.	227.	228.	229.	230.
• **Prohibits mandatory use of family planning** as a condition for receiving services (Y) • Does not prohibit or requires use of family planning to receive services (N)	231.	232.	233.	234.	235.	236.	237.	238.	239.	240.
• **Prohibits mandatory sterilization** as a condition for receiving services (Y) • Does not prohibit or requires sterilization to receive services (N)	241.	242.	243.	244.	245.	246.	247.	248.	249.	250.
• Policy prohibits eligibility criteria that requires **leaving sex work** (Y) • Policy requires that eligibility for services is dependent on leaving sex work (N)	251.	252.	253.	254.	255.	256.	257.	258.	259.	260.
• Policy guarantees **access for females who are pregnant or have children** (Y) • Policy does not mention or denies access to females who are pregnant or have children (N)	261.	262.	263.	264.	265.	266.	267.	268.	269.	270.
• Policy directs that services be **available at times convenient to clients** (e.g., before/after working hours/weekends) (Y) • Policy does not direct that services be available at times convenient to clients, or identifies restricted service hours (N)	271.	272.	273.	274.	275.	276.	277.	278.	279.	280.
• Policy identifies **regulations for traditional and/or homeopathic practices** (Y) • Policy does not identify regulations for traditional and/or homeopathic practices (N)	281.	282.	283.	284.	285.	286.	287.	288.	289.	290.

Policy:	SRHR		STI		HIV		Alcohol Harm Reduction		Substance Abuse Harm Reduction	
	C	P	C	P	C	P	C	P	C	P
• Policy identifies the value of **engaging owners of sex work establishments or pimps** as partners in program implementation (Y) • Policy does not identify engaging owners of sex work establishments or pimps as partners (N)	291.		292.		293.		294.		295.	
• Policy identifies the value of **engaging owners of alcohol-serving venues** as partners in program implementation (Y) • Policy does not identify engaging owners of alcohol-serving venues (N)	296.		297.		298.		299.		300.	
• Policy identifies the value of **engaging police as partners** in program implementation (Y) • Policy does not identify engaging police as partners (N)	301.		302.		303.		304.		305.	
• Policy identifies the value of **engaging religious institutions as partners** in program implementation (Y) • Policy does not identify engaging religious institutions as partners (N)	306.	307.	308.	309.	310.	311.	312.	313.	314.	315.
• Policy identifies the value of **engaging cultural institutions as partners** (Y) • Policy does not identify engaging cultural institutions as partners (N)	316.	317.	318.	319.	320.	321.	322.	323.	324.	325.
B. Intentionally left blank to align with PWID DM										

C. Collect all policy documents that define training requirements for prison, law enforcement, and healthcare providers (UNAIDS, 1999, p. 122), (UNAIDS, 2006, p. 29), (UNODC, 2009, pp. 33, 34, 41), (WHO, 2011, p. 31), (UNAIDS, 2009c, p. 124)

• Policy requires the following staff to undergo regular training (Y) • Policy fails to mention training requirement (N)	Ethics and human rights, including consent and confidentiality	Avoiding stigma and discrimination	Domestic and sexual violence	Human sexuality	Specific needs of SWs, TG, and MSM	Referrals between law enforcement, medical, and harm reduction services	Training on hepatitis, TB, and HIV
Law enforcement staff	1.	2.	3.	4.	5.	6.	7.
Judges/court staff	8.	9.	10.	11.	12.	13.	14.
Detention/prison workers	15.	16.	17.	18.	19.	20.	21.
Teachers	22.	23.	24.	25.	26.	27.	28.
Healthcare workers	29.	30.	31.	32.	33.	34.	35.
Social workers	36.	37.	38.	39.	40.	41.	42.
Mental health/psychologists	43.	44.	45.	46.	47.	48.	49.

Please include any additional remarks or observations about related policy areas not included in the items listed above. If analysis is being done at different levels of government, be sure to identify whether national, regional, and/or local policies differ or contradict each other.

16. Intervention Design, Access, and Implementation—HCT

"HIV testing must always be done with informed consent, adequate pre-test information or counseling, post-test counseling, protection of confidentiality, and referral to services" (WHO, 2010c, p. 10).

This section focuses on policies that regulate HIV counseling and testing (HCT) services, including the following:

- Funding and access for HCT
- Confidentiality and anonymous services
- Voluntary testing for SWs
- Provider-initiated testing

Detailed Technical Guidance

WHO HIV testing and counseling
http://www.who.int/hiv/topics/vct/en/

Effective HCT for MSM/TG/SW

HCT services are critical links in the continuum of care. It is important that HCT services are accessible and available to most marginalized and key affected populations. Many countries ensure uptake of HCT services by SWs, MSM, and TG by adopting different strategies, often including training of staff on risk assessment and the counseling of MSM and TG, involving MSM and TG in counseling clients, and ensuring that HCT services are close to MSM and TG communities and accessible to them regarding timing and geographical location.

Effective HIV counseling and testing requires non-judgmental support and high-quality services specifically designed to address the needs of MSM, TG, and SWs (AVAC, 2011, p. 11). Best practice is to define the role of MSM, TG, and SWs in policy development, service delivery, and service quality monitoring. While general policies can ensure that HCT services are available and accessible at the desired quality level, they must also ensure the training and competencies of HCT providers in serving MSM/TG/SW.

Countries such as Nigeria do commit to making HCT accessible to MARPs, including FSWs, drug users, and MSM (National Agency for the Control of AIDS (NACA), 2009, p. 19). However, it is not clear what attempts they make in the operational stages to achieve this accessibility, especially in the environment of criminalization.

Role of NGOs and CSOs in HCT

The role of local nongovernmental and civil society organizations in providing HIV services cannot be overstated. There are comparative advantages to engaging local groups. These advantages include cultural competency and capacity for innovation, the way local organizations reflect the needs of the community by adopting a range of services to suit the needs of the many different people they serve, and close proximity to beneficiaries that enables them to use their connections in the community to mobilize it to engage in an effective response. Those links and connections also make the local NGOs and CSOs more cost-effective (PACT, 2005).

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Centralized HIV Testing and Confirmatory Testing

In many countries, testing of blood for HIV and post-test counseling is mostly performed in AIDS centers. Even if pre-test counseling and blood specimen drawing are done outside of AIDS centers, clients with positive or uncertain results are often referred to AIDS centers for confirmatory tests.

HIV testing is commonly done in two stages—if the first test demonstrates a positive or uncertain result, a confirmatory test is administered. In these cases, local HIV/AIDS authorities in some countries send blood samples to a central province or national laboratory for immunoassay analysis. Receiving final results thus may take up to a month, placing the clients in suspense and causing them to endure significant psychological stress; some clients may also fail to return and receive the confirmatory test results (Bobrova, Sarang, Stuikyte, & Lezhentsev, 2007), (Ibragimov, Latypov, Jamolov, & Khasanova, 2011). This issue can be addressed, at least in some countries, by using rapid HIV tests for confirmation, as recommended by WHO for resource-limited settings (WHO, 2004d).

Sample policy documents to consider (not an exhaustive list) include the following:

- Reports on resource estimates and expenditures
- National quality assurance guidelines for health
- Codes of ethics and regulations for healthcare professionals
- HCT guidelines
- Norms and guidelines for the medical care of PLHIV
- Norms and guidelines for working with PLHIV, MSM, TG, or SWs
- National public health law, policy, strategy, and guidelines
- National health law, policy, strategy, and guidelines
- National AIDS law, policy, strategy, and guidelines
- National STI law, policy, strategy, and guidelines
- National reproductive health and family planning law, policy, strategy, and guidelines

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XV. HIV counseling and testing (HCT)		
A. Collect all policy documents **authorizing HCT services** (WHO, 2010a, p. 10), (UNAIDS, 2006, pp. 26, 27), (WHO, 2004d), (WHO, 2011, p. 39)		
Policy:	Community Settings	Prison Settings
• Policy **guarantees state funding** for HCT services (Y) • Policy does not mention access or funding for HCT (N)	1.	2.
• Policy guarantees access to **free HCT for SWs** (Y) • Policy does not identify free services for SWs or identifies fees for HCT testing or HIV-status certification (N)	3.	4.
• Policy guarantees access to **free HCT for TG** (Y) • Policy does not identify free services for TG or identifies fees for HCT testing or HIV-status certification (N)	5.	6.
• Policy guarantees access to **free HCT for MSM** (Y) • Policy does not identify free services for MSM or identifies fees for HCT testing or HIV-status certification (N)	7.	8.
• Policy authorizes an **integrated service model** (Y) • Policy identifies HCT as an isolated service (N)	9.	10.
• Policy requires **linkage of individuals with an HIV-positive result to case management resources** • Policy does not require linkage to case management resources	11.	12.
• Policy allows use of **saliva-based rapid testing** (Y) • Policy does not authorize or prohibits saliva-based rapid testing (N)	13.	14.
• Policy allows use of **rapid-testing algorithms to diagnose HIV infection** (Y) • Policy does not identify or prohibits diagnosis by rapid-testing technologies (N)	15.	16.
• Policy guarantees that HCT services, including receipt of test results, are available on a **confidential basis** (Y) • Policy allows for the release of HCT results without the consent of the individual (N)	17.	18.
• Policy guarantees that HCT services, including receipt of test results, are available on an **anonymous basis** (Y) • Policy requires that names be provided for provision of HCT (N)	19.	20.
• Policy authorizes **nongovernment providers** to deliver HCT results (Y) • Policy does not specifically authorize nongovernment providers or restricts delivery of HCT to government bodies (N)		21.
• Policy authorizes **nongovernment providers** to provide HIV test results (Y) • Policy does not specifically authorize nongovernment providers or restricts delivery of test results to government bodies (N)		22.
• Policy does not put any **restrictions on the frequency of free HIV testing** (Y) • Policy restricts the frequency of free HIV testing (N)		23.

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B. Collect all policy documents defining **protocols for HCT** (UNAIDS, 2006, p. 27), (CHALN, 2006e, p. 18), (Inter-Parliamentary Unit [IPU], 2007, p. 82), (UNODC, 2006, pp. 18, 25), (WHO, 2009c, p. 10), (UNODC, 2010, p. 38), (WHO, 2007a, p. 7), (WHO, 2007c, p. 6), (UNODC, 2009, p. 43), (OSI, UNAIDS & WHO, 2010b, pp. 9, 16, 17), (WHO, 2007e, p. 25), (WHO, 2011, p. 39), (Parry, 2011), (WHO, 2012, pp. 29-31)		
	Community Settings	Prison Settings
• Policy requires **pre-test counseling** for all HIV testing (Y) • Policy does not require pre-test counseling for all HIV testing (N)	1.	2.
• Policy requires **informed consent** for all HIV testing (Y) • Does not require informed consent for all HIV testing (N)	3.	4.
• Policy requires that HCT be **voluntary** • Policy does not ensure voluntary HCT or makes HCT a requirement for SW licensing	5.	6.
• Policy requires **post-test counseling** for all HIV testing (Y) • Policy does not require post-test counseling for all HIV testing (N)	7.	8.
• Policy requires **referral** to medical and prevention services for all HIV testing (Y) • Policy does not require referral to medical and prevention services for all HIV testing (N)	9.	10.
• Policy calls for screening and referral for **alcohol abuse** (Y) • Policy does not call for screening and referral for alcohol abuse (N)	11.	12.
• Policy calls for screening and referral for **substance abuse** (Y) • Policy does not call for screening and referral for substance abuse (N)	13.	14.
• Policy calls for screening and referral for **mental health concerns and depression** (Y) • Policy does not call for screening and referral for mental health concerns and depression (N)	15.	16.
C. Collect all policy documents mentioning **access to HCT for prisoners** (WHO, 1993, p. 5), (UNODC, 2006, p. 25) (WHO, 2007a), (WHO, 2007c, p. 6), (UNODC, 2009, pp. 36, 37, 39), (UNODC, 2010, p. 38), (WHO, 2006, p. 10), (CHALN, 2006e, p. 18)		
• Policy requires that prisoners are made aware of and offered or recommended for voluntary, confidential HIV testing with counseling **upon entry and during imprisonment**—especially if a prisoner has signs, symptoms, or medical conditions that could indicate HIV infection (Y) • Policy does not mention HCT access for prisoners (N)		1.
A. Collect all policy documents mentioning provision of **HCT in the healthcare setting** (WHO, 2007e, p. 5), (UNGA, 2009, p. 10)		
• Policy identifies an **opt-in approach to provider-initiated HCT for SWs** (Y) • Policy identifies an opt-out approach to provider-initiated HCT for SWs (N)		1.
• Policy identifies an **opt-in approach to provider-initiated HCT for TG** (Y) • Policy identifies an opt-out approach to provider-initiated HCT for TG (N)		2.
• Policy identifies an **opt-in approach to provider-initiated HCT for MSM** (Y) • Policy identifies an opt-out approach to provider-initiated HCT for MSM (N)		3.

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D. Collect all policy documents that mention **HCT services**	
• Policy requires that accessing HCT services be **voluntary for SWs** (Y) • Policy does not ensure voluntary nature of HCT access or makes HCT a requirement for SW licensing (N)	1.
• Policy **focuses on prevention, diagnosis, and treatment of HIV** among SWs (Y) • Policy takes a punitive approach to HCT among SWs (e.g., removal of work license or deportation if diagnosed with HIV) (N)	2.
Please include any additional remarks or observations about related policy areas not included in the items listed above. If analysis is being done at different levels of government, be sure to identify whether national, regional, and/or local policies differ or contradict each other.	

17. Intervention Design, Access, and Implementation—ART

This section focuses on policies dealing with the design and implementation of antiretroviral therapy (ART), including the following:

- Access for MSM/TG/SW
- Eligibility
- ART protocols

ART services are critical in halting the spread of the virus, prolonging life, and improving the quality of life of PLHIV. Governments must ensure that their ART delivery policies are adequately defined and resourced. Protocols for initiating and maintaining ART are critical in its delivery. An effective ART delivery mechanism must include ensuring compliance with ART. ART delivery is a complex service that must take into account other issues, such as the interface with hormonal therapies for TG and issues of nutrition. There should be adequate resource allocation to deliver ART services to all.

Detailed Technical Guidance

WHO Antiretroviral therapy

http://www.who.int/hiv/topics/treatment/en/index.html

Although in many developing countries ART medications are provided for free (sponsored by international donors), fees for laboratory monitoring may pose a significant barrier for patients (WHO, 2010b), (Wolfe, Carrieri, & Shepard, 2010), (Belyaeva & Aftandilyants, 2010).

ART eligibility criteria may require specific testing that may be unavailable to certain segments of the population, thus impacting access to it. Access can also be affected by policies that do not ensure the application of national guidelines in detention or prison settings. Requiring documentation for HIV treatment can preclude access by SWs, who often are immigrants, as in West Africa (Ghys, Diallo, & et al., 2002), (Adu-Oppong, Grimes, & et al., 2007), (Kahn, Patnaik, & et al., 2008), or who have their documentation confiscated by pimps or brothel owners, as reported in Burkina Faso (Drabo & Ouedraogo, 2010).

Finally, it is important to address the specific needs and contexts of MSM/TG/SW in the decision to initiate ART and support ongoing adherence to it. Social structures may not be present at the same level for these populations, and barriers to services may require specific solutions to ensure optimal treatment outcomes.

Sample policy documents to consider (not an exhaustive list) include the following:

- Reports on resource estimates and expenditures
- National quality assurance guidelines for health
- National pharmaceutical procurement policy and guides for the public health sector
- Codes of ethics and regulations for healthcare professionals
- ART guidelines
- Norms and guidelines for working with PLHIV, MSM, TG, or SWs

Throughout this document, the term “policy” is inclusive of legislation, policies, legal decisions, judicial precedent, regulations, guidelines, and/or operational plans and protocols.

- National public health law, policy, strategy, and guidelines
- National health law, policy, strategy, and guidelines
- National AIDS law, policy, strategy, and guidelines
- National STI law, policy, strategy, and guidelines
- National reproductive health and family planning law, policy, strategy, and guidelines

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If you find a policy document that addresses areas upon which you are not working, send the document or citation to the team leader. He or she will share this information with the individual primarily responsible for that section.

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XVI. Antiretroviral Therapy (ART)		
A. Collect all policy documents **authorizing ART services**		
Policy:	Community Settings	Prison Settings
• Policy **guarantees state funding** for ART services (Y) • Policy does not mention access or funding for ART (N)	1.	2.
• Policy states that any **related or required services are provided free** of charge (Y) • Policy does not expressly prohibit fees or identifies fees for related services (N)	3.	4.
• Policy guarantees access to **free ART for SWs** (Y) • Policy does not identify free services for SWs or identifies fees for ART or related or required services (N)	5.	6.
• Policy guarantees access to **free ART for TG** (Y) • Policy does not identify free services for TG or identifies fees for ART or related or required services (N)	7.	8.
• Policy guarantees access to **free ART for MSM** (Y) • Policy does not identify free services for MSM or identifies fees for ART or related or required services (N)	9.	10.
• Policy requires **ART initiation and adherence counseling** that specifically addresses the needs of SWs (Y) • Policy does not require SW-specific counseling	11.	12.
• Policy requires ART initiation and adherence counseling that specifically addresses the needs of TG (Y) • Policy does not require TG-specific counseling	13.	14.
• Policy requires ART initiation and adherence counseling that specifically addresses the needs of MSM (Y) • Policy does not require MSM-specific counseling	15.	16.
B. Collect all policy documents defining **ART eligibility** (WHO, 2006, p. 20), (WHO, 2009a, pp. 20, 21), (WHO, 2008a, p. 7), (WHO, 2010e, p. 20), (WHO, 2010e, p. 64), (WHO, 2010e, p. 21), (WHO, 2010e, p. 67), (WHO, 2008a, p. 7), (UNODC, 2010, p. 39), (Parry, 2011)		
Policy:	Community Settings	Prison Settings
• Policy explicitly states that eligibility for ART includes those with **past or present drug use** and does not require detoxification as a prerequisite to access and initiate HIV treatment and care (Y) • Policy does not mention eligibility for ART for individuals with past or present drug use, or cites detoxification or "stability" requirements as a prerequisite to initiating HIV treatment and care (N)	1.	2.
• Policy explicitly states that **alcohol dependence is not a reason to withhold treatment** (Y) • Policy does not mention alcohol-dependent individuals as eligible for ART, or cites detoxification or "stability" requirements as a prerequisite to initiating HIV treatment and care (N)	3.	4.

Throughout this document, the term "policy" is inclusive of legislation, policies, legal decisions, judicial precedent, regulations, guidelines, and/or operational plans and protocols.

• Policy explicitly states that **mental health problems are not reasons to withhold treatment** (Y) • Policy does not mention those with mental health problems as eligible for ART, or cites "stability" requirements as a prerequisite to initiating HIV treatment and care (N)	5.	6.
C. Collect all policy documents defining **protocols for ART**		
• Policy specifically states that **national guidelines** on care and treatment of HIV **apply to detention/prison/residential settings** (Y) • Policy is silent on inmate/resident eligibility for ART or identifies more restrictive eligibility guidelines for detention/prison/residential settings (N)	1.	
• Policy identifies specific protocols for **treatment of HIV/Hepatitis B co-infection** (Y) • Policy does not identify specific protocols for treatment of HIV/Hepatitis B co-infection (N)	2.	
• Policy identifies specific protocols for **treatment of HIV/Hepatitis C co-infection** (Y) • Policy does not identify specific protocols for treatment of HIV/Hepatitis C co-infection (N)	3.	
Please include any additional remarks or observations about related policy areas not included in the items listed above. If analysis is being done at different levels of government, be sure to identify whether national, regional, and/or local policies differ or contradict each other.		

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18–21. Intentionally left blank to align with PWID DM

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22. Intervention Design, Access, and Implementation—Condoms and Lubrication

This section focuses on policies that regulate provision of condoms and lubricants within HIV services, including the following:

- Authorization, funding, and access
- Provision of lubricants
- SW condom programs

Detailed Technical Guidance

WHO Condoms

http://www.who.int/topics/condoms/en/index.html

Consistent and correct use of condoms and water-based lubricants (WBL) is strongly associated with reducing the risk of HIV transmission, and community-based evidence suggests that making free condoms available in a variety of settings is preferable to making them available in stores. Sufficient and appropriate (water- or silicone-based) lubricants must be available to reduce condom failure; however, barriers to lubricant access and utilization include cost, availability, and a lack of knowledge (Beyrer, Wirtz, Walker, Johns, Sifakis, & Baral, 2011).

Appropriate condoms and lubricants are often not available or are inadequately distributed to populations most at risk, such as SWs, MSM, and TG. Non-availability or inadequate availability often leads to the most vulnerable populations opting for unsafe sex. Governments must have a strategy and policy for condom and lubricant procurement and distribution. Community groups play an important role in the distribution of condoms, including social marketing of condoms when possible. Harassment and arresting of individuals carrying and using condoms often is used as evidence by the police to show the person's intent to solicit sex work (UNAIDS, 2011, p. 15).

Governments often view lubricants as a means of pleasure enhancement, not as tools that enhance the proper use of condoms. Such misconceptions are reflected in policies that lack an emphasis on procurement and use of lubricants. It is important that community groups be involved in the development of strategies for the procurement, distribution, and social marketing of lubricants and condoms.

For SWs, successful programs that focus on empowering them to negotiate condom use and on increasing client acceptance of condoms have increased condom use in many communities. A 2007–2008 randomized controlled trial of 98 female sex workers in Armenia found that a two-hour intervention with a three-month follow-up increased consistent condom use and their application to clients. The two-hour, face-to-face intervention by a health educator emphasized gender empowerment, self-efficacy in persuading clients to use condoms, condom application skills, and eroticizing safe sex (Markosyan, et al., 2010). Empowering and educating SWs is preferable to 100 percent condom use programs that put condom use in the hands of law enforcement.

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Sample policy documents to consider (not an exhaustive list) include the following:

- Reports on resource estimates and expenditures
- National quality assurance guidelines for health
- National pharmaceutical procurement policy and guides for the public health sector
- Codes of ethics and regulations for healthcare professionals
- Norms and guidelines for working with PLHIV, MSM, TG, or SWs
- National public health law, policy, strategy, and guidelines
- National health law, policy, strategy, and guidelines
- National AIDS law, policy, strategy, and guidelines
- National STI law, policy, strategy, and guidelines
- National reproductive health and family planning law, policy, strategy, and guidelines

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XXII. Condoms and lubrication (C/L)		
A. Collect all policy documents **authorizing provision of C/L**		
Policy:	Community Settings	Prison Settings
• Policy **guarantees state funding** for C/L (Y) • Policy does not mention access or funding guarantees for C/L (N)	1.	2.
• Policy guarantees access to **C/L for SWs regardless of the ability to pay** (Y) • Policy does not identify free services for SWs (N)	3.	4.
• Policy guarantees access to **C/L for TG regardless of the ability to pay** (Y) • Policy does not identify free services for TG (N)	5.	6.
• Policy guarantees access to **C/L for MSM regardless of the ability to pay** (Y) • Policy does not identify free services for MSM (N)	7.	8.
• Policy identifies **data collection requirements for distribution of condoms in prison** settings (Y) • Policy does not identify data collection requirements for condom distribution in prisons (N)		9.
B. Collect all policy documents that describe **C/L program protocols** (CHALN, 2007, pp. 11-13), (Parry, 2011), (WHO, 2012, p. 23)		
• Policy directs that condom programs provide both **male and female condoms** (Y) • Policy does not direct or restricts provision of both male and female condoms (N)	1.	
• Policy directs that condom programs support **awareness of both male and female condoms** (Y) • Policy does not direct or restricts awareness activities for both male and female condoms (N)	2.	
• Policy directs that condom programs also supply **water- and/or silicone-based lubricants** (Y) • Policy does not direct or restricts provision of water- or silicone-based lubricants (N)	3.	
• Policy directs that condom **programs for SWs provide support and guidance but allows SWs to retain control over their decisions regarding condom use** (Y) • Policy directs that condom programs mandate 100 percent utilization of condoms for sex with clients (N)	4.	
• Policy directs that **monitoring of uptake and effectiveness of condom programs is undertaken by public health authorities** (Y) • Policy directs that monitoring of uptake and effectiveness of condom programs is undertaken by law enforcement (N)	5.	
• Policy directs that condom programs address **condom use with both casual and regular partners** (Y) • Policy does not address all sexual partners (N)	6.	
• Policy directs that condom programs address the **impact of alcohol use on condom use** (Y) • Policy does not address impact of alcohol use on condom use (N)	7.	

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• Policy directs that condom programs address the **impact of substance use on condom use** (Y) • Policy does not address impact of substance use on condom use (N)	8.
• Policy directs that condom programs address the **impact of mental health and depression on condom use** (Y) • Policy does not address impact of mental health and depression on condom use (N)	9.
• Policy emphasizes the **importance of condom use** alone or in addition to other family planning methods (Y) • Policy fails to mention the importance of condom use (N)	10.
C. Collect all policy documents that describe **procurement processes for condoms and lubrication** (WHO, 2010f), (WHO, 2011, p. 33)	
• Condom procurement policies **reference WHO/UNFPA specifications** (Y) • Condom procurement policies fail to reference WHO/UNFPA specifications (N)	1.
• Policy identifies mechanisms for **SWs to be involved in the product selection** of condoms and lubricants (including brand and type) (Y) • Policy does not mention or excludes SWs from product selection process (N)	2.
• Policy identifies mechanisms for **TG to be involved in the product selection** of condoms and lubricants (including brand and type) (Y) • Policy does not mention or excludes TG from product selection process (N)	3.
• Policy identifies mechanisms for **MSM to be involved in the product selection** of condoms and lubricants (including brand and type) (Y) • Policy does not mention or excludes MSM from product selection process (N)	4.
Please include any additional remarks or observations about related policy areas not included in the items listed above. If analysis is being done at different levels of government, be sure to identify whether national, regional, and/or local policies differ or contradict each other.	

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23. Intervention Design, Access, and Implementation—Sexually Transmitted Infection (STI) Services

This section focuses on policies dealing with the provision of sexually transmitted infection (STI) services, including the following:

- Authorization for STI services
- Access and eligibility
- STI diagnosis and treatment protocols

In addition to being a valid human right and health concern in its own right, treatment of sexually transmitted infections (STIs) is critical in halting the spread of HIV infection. The review of policies shows that little is being done to take into account oral and anal STIs, and such co-infections as Hepatitis B and C. SWs, MSM, and TG may not feel comfortable in coming to general STI clinics and hence may require specialized services. In many countries, the criminalized status of these populations makes doctors culpable of abetting a crime if they do not inform law enforcement agencies, as policy does not explicitly exempt these populations from seeking STI treatment without the threat of criminal charges. Such policies also lead to governments not developing and medical providers not implementing oral and anal STI treatment protocols and training.

Detailed Technical Guidance

WHO Sexually transmitted infections
http://www.who.int/topics/sexually_transmitted_infections/en/

WHO Hepatitis
http://www.who.int/topics/hepatitis/en/

At the policy and decision-making levels, the following factors operate:

- Policymakers and planners give low priority to control of STIs. This situation is potentially aggravated by the stigmatization and prejudice associated with the infections and ignorance of the importance of their impact on health and economic development.
- Donors increasingly are using sector-wide approaches to allocate aid to the whole health sector rather than to specific projects, such as STI control. Although this allows health ministries to determine national priorities, it also means that countries traditionally according little importance to these infections in their health budgets because of stigmatization can continue to do so.
- There is a failure to provide suitable education and services to populations identified as being particularly vulnerable to STIs, such as young people and adolescents, SWs (both male and female) and their clients, MSM, TG, substance users, prisoners, populations that are mobile for work or recreation, children and young people on the street, and people affected by conflict and civil unrest (WHO, 2007f, p. 13).
- Even where sex work is legal and licensed, the diagnosis of an STI may cause SWs to lose their license and thus the means of supporting themselves. As a result, SWs may avoid healthcare facilities and go underground to escape rules and restrictions that threaten their welfare (UNFPA, n.d.).

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Sample policy documents to consider (not an exhaustive list) include the following:

- Reports on resource estimates and expenditures
- National quality assurance guidelines for health
- National pharmaceutical procurement policy and guides for the public health sector
- Codes of ethics and regulations for healthcare professionals
- Norms and guidelines for working with PLHIV, MSM, TG, or SWs
- National public health law, policy, strategy, and guidelines
- National health law, policy, strategy, and guidelines
- National AIDS law, policy, strategy, and guidelines
- National STI law, policy, strategy, and guidelines
- National reproductive health and family planning law, policy, strategy, and guidelines

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XXIII. Sexually Transmitted Infection (STI) Services		
A. Collect all policy documents **authorizing STI services** (WHO, 2002b)		
Policy:	Community Settings	Prison Settings
• Policy **guarantees state funding** for STI services (Y) • Policy does not mention access or funding for STI services (N)	1.	2.
• Policy guarantees access to **STI services for SWs regardless of the ability to pay** (Y) • Policy does not identify free services for SWs or identifies fees for testing, treatment, or status certification (N)	3.	4.
• Policy guarantees access to **STI services for TG regardless of the ability to pay** (Y) • Policy does not identify free services for TG or identifies fees for testing, treatment, or status certification (N)	5.	6.
• Policy guarantees access to **STI services for MSM regardless of the ability to pay** (Y) • Policy does not identify free services for MSM or identifies fees for testing, treatment, or status certification (N)	7.	8.
• Policy provides for **specialized STI services** to address the needs of SWs (Y) • Policy does not provide for the specific needs of SWs (N)	9.	10.
• Policy provides for **specialized STI services** to address the needs of TG (Y) • Policy does not provide for the specific needs of TG (N)	11.	12.
• Policy provides for **specialized STI services** to address the needs of MSM (Y) • Policy does not provide for the specific needs of MSM (N)	13.	14.
• Policy provides for **specialized STI services** to address the needs of PLHIV (Y) • Policy does not provide for the specific needs of PLHIV (N)	15.	16.
B. Collect all policy documents that describe STI diagnosis and treatment **protocols** (WHO, 2008c), (WHO, 2007f, p. 26), (CDC, 2006), (CDC, 2011), (WHO, 2006c), (Kroeger, Bock, & Patel, 2009), (Parry, 2011), (WHO, 2012, pp. 24-29)		
	Community	Prison
• Policy guarantees access to **free hepatitis A (HAV) and hepatitis B (HBV) vaccination** for all SWs (Y) • Policy does not guarantee free access or identifies fees for HAV and HBV vaccination for SWs (N)	1.	2.
• Policy guarantees access to **free HAV and HBV vaccination** for all TG (Y) • Policy does not guarantee free access or identifies fees for HAV and HBV vaccination for TG (N)	3.	4.
• Policy guarantees access to **free HAV and HBV vaccination** for all MSM (Y) • Policy does not guarantee free access or identifies fees for HAV and HBV vaccination for MSM (N)	5.	6.
• Policy guarantees access to **free hepatitis C (HCV) screening** for all SWs (Y) • Policy does not guarantee free access or identifies fees for HCV screening for SWs (N)	7.	8.

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• Policy guarantees access to **free HCV screening** for all TG (Y) • Policy does not guarantee free access or identifies fees for HCV screening for TG (N)	9.	10.
• Policy guarantees access to **free HCV screening** for all MSM (Y) • Policy does not guarantee free access or identifies fees for HCV screening for MSM (N)	11.	12.
• Policy authorizes **HCT** services in STI clinics (Y) • Policy does not provide for HCT services in STI clinics (N)	13.	14.
• Policy authorizes **periodic voluntary screening for asymptomatic STIs** • Policy does not authorize periodic voluntary screening for asymptomatic STIs	15.	16.
• Policy authorizes **syndromic STI management** services (Y) • Policy does not provide for syndromic STI management services (N)	17.	18.
• Policy authorizes **voluntary Periodic Presumptive Treatment** (PPT) with combination therapy/single-dose regimes (Y) • Policy does not provide for or allow PPT or calls for monotherapy and/or multiple dose regimes (N)	19.	20.
• Policy authorizes **Expedited Partner Therapy** (EPT) for cases of gonorrhea and chlamydial infection (Y) • Policy does not authorize or restricts EPT for gonorrhea and chlamydial infection (N)	21.	22.
• Policy identifies **antibiotic resistance monitoring** as part of STI operational protocols (Y) • Policy does not identify antibiotic resistance monitoring as part of STI operational protocols (N)	23.	24.
• Policy **protects providers from liability** for use of syndromic STI management, PPT, and EPT except in cases of willful or wanton misconduct (Y) • Policy provides no protection from liability for providers (N)	25.	26.
• Policy ensures that the most **effective medicines** are available at all levels of the medical system (Y) • Policy restricts most effective medicines from some levels of the medical system (N)	27.	28.
• Policy calls for **oral, vaginal, and rectal STI screening** (Y) • Policy does not call for comprehensive STI screening or restricts screening (N)	29.	30.
• Policy identifies **training requirements** for oral and rectal STI screening (Y) • Policy does not identify training requirements for oral and rectal STI screening (N)	31.	32.
C. Collect all policy documents that mention **STI services** (UNFPA, n.d.), (WHO, 2002b)		
• Policy requires that accessing STI services be **voluntary for SWs** (Y) • Policy does not ensure voluntary nature of STI access or makes STI diagnosis or treatment a requirement for SW licensing (N)		1.
• Policy **focuses on prevention, diagnosis, and treatment of STIs** among SWs (Y) • Policy takes a punitive approach to STIs among SWs (e.g., removal of work license or deportation if diagnosed with an STI) (N)		2.

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C. Collect all policy documents that mention **STI services** (UNFPA, n.d.), (WHO, 2002b)	
• Policy authorizes **pharmacists and other providers of informal healthcare to deliver STI syndromic management** (Y) • Policy does not authorize or restricts provision of syndromic management services in the informal sector (N)	1.
• Policy authorizes pharmacists and other providers of informal healthcare to deliver STI **PPT** (Y) • Policy does not authorize or restricts provision of PPT in the informal sector (N)	2.
Please include any additional remarks or observations about related policy areas not included in the items listed above. If analysis is being done at different levels of government, be sure to identify whether national, regional, and/or local policies differ or contradict each other.	

24. Intervention Design, Access, and Implementation—Information, Education, Communication (IEC)

This section focuses on policies dealing with the design and dissemination of information, education, and communication (IEC) materials on HIV services, including the following:

- Authorization, including funding for IEC programs
- Eligibility
- Protocols for delivery of IEC services
- Restriction on IEC content

IEC material plays a key role in raising awareness about various aspects of the HIV and AIDS epidemic, including providing information about HIV and AIDS, methods of prevention, behavior change, treatment, and other similar issues. Well-conceived IEC strategies and methods are important for achieving desired levels of behavior change and increasing uptake of condom use, HCT, and treatment. Involving community members in designing and delivering IEC material is considered critical, as identities and risk behaviors can be extremely heterogeneous across MSM, TG, and SWs.

For example, the behavior change communication (BCC) strategy under the Nigerian HIV and AIDS program does include SWs, MSM, and PWID as target groups. Moreover, these groups were not engaged in any consultation for developing the BCC strategy (National Agency for the Control of AIDS (NACA), 2008, pp. 11, 24). This defeats the whole purpose of developing a target-specific and sensitive BCC strategy for HIV and AIDS. Similarly, in Namibia, even though a focus on MSM is part of the prevention strategy, virtually no public health campaigns acknowledge HIV risk through homosexual behavior (Lorway, 2006), (HIVOS, 2011). Botswana has a similar story—its government led the push for HIV messaging, its BCC does not target TG or MSM, and BCC activities supported by NGOs are not supported by the government (HIVOS, 2011).

National strategic plans (NSPs) should have clear guidelines on the development of target-appropriate IEC material. For example, the Kenyan strategic plan on HIV and AIDS clearly states that the health sector will promote human rights standards in programs, especially for MARPs and vulnerable groups. The plan specifies that training be offered to health professionals to make them better able to provide services to MARPs and vulnerable groups. Specific intervention packages are to be designed to reach MARPs, such as SWs and their clients, MSM, PWID, and prisoners (Kenya National AIDS Control Council, 2009, p. 86).

In many countries, IEC material often does not focus on marginalized groups. In countries where some sexual acts are criminalized, the NSP or other relevant policy may restrict the content of or access to these materials. It also may not provide any immunity or exemption to people who develop and/or distribute these materials. These policies should ensure that the materials are sufficiently detailed and cover all relevant issues, such as partner reduction, condom use, and biomedical interventions. Also, they should ensure that production of IEC material is based on evidence and is not biased toward any particular sexual orientation. It is not clear whether all country strategies actually have such detailed and explicit policies. In the absence of detailed policies, it also is not clear how—or if—IEC materials are developed with participation of relevant communities.

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Sample policy documents to consider (not an exhaustive list) include the following:

- Reports on resource estimates and expenditures
- National quality assurance guidelines for health
- Norms and guidelines for working with PLHIV, MSM, TG, or SWs
- National public health law, policy, strategy, and guidelines
- National health law, policy, strategy, and guidelines
- National AIDS law, policy, strategy, and guidelines
- National STI law, policy, strategy, and guidelines
- National reproductive health and family planning law, policy, strategy, and guidelines

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If you find a policy document that addresses areas upon which you are not working, send the document or citation to the team leader. He or she will share this information with the individual primarily responsible for that section.

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XXIV. Information, Education, Communication (IEC)		
A. Collect all policy documents **authorizing HIV IEC programs**		
Policy:	Community Settings	Prison Settings
• Policy **guarantees state funding** for HIV IEC programs (Y) • Policy fails to mention access or funding for HIV IEC (N)	1.	2.
• Policy identifies **HIV IEC strategies and information specific to SWs** (Y) • Policy fails to identify HIV IEC strategies or restricts information for SWs (N)	3.	4.
• Policy identifies **HIV IEC strategies and information specific to TG** (Y) • Policy fails to identify HIV IEC strategies or restricts information for TG (N)	5.	6.
• Policy identifies **HIV IEC strategies and information specific to MSM** (Y) • Policy fails to identify HIV IEC strategies or restricts information for MSM (N)	7.	8.
B. Collect all policy documents that describe **protocols** for the delivery of HIV IEC services (WHO, 2011, p. 36), (Parry, 2011), (Beyrer, Wirtz, Walker, Johns, Sifakis, & Baral, 2011, p. 42)		
• Policy identifies **information on HIV transmission** in the following content areas to be included in HIV IEC materials (Y) • Policy fails to require this content in HIV IEC materials (N)	Community	Prison
• Risks and benefits of sexual abstinence	1.	2.
• Relative risks of insertive and receptive sexual activities	3.	4.
• Risks and benefits of non-penetrative sexual activities	5.	6.
• Relative risks of oral, anal, and vaginal sexual activities	7.	8.
• Risks and benefits of reducing the number of sexual partners	9.	10.
• Risks and benefits of condom use	11.	12.
• Risks and benefits of sero-sorting and sero-positioning	13.	14.
• Risks and benefits of suppressive HIV therapy	15.	16.
• Impact of alcohol use on sexual risk behavior	17.	18.
• Impact of alcohol use on gender-based violence	19.	20.
• Impact of substance use on sexual risk behavior	21.	22.
• Impact of substance use on gender-based violence	23.	24.
• Impact of mental health on sexual risk behavior	25.	26.
• Impact of mental health on gender-based violence	27.	28.
• Promotion of and information on where to access HIV services	29.	30.
• Promotion of and information on where to access STI services	31.	32.
• Promotion of and information on where to access SRHR services	33.	34.
• Promotion of and information on where to access alcohol harm reduction services	35.	36.

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• Promotion of and information on where to access substance abuse harm reduction services	37.	38.
• Promotion of and information on where to access mental health services	39.	40.
C. Collect all policy documents that describe **public decency or public morality** (HRC, 2011, p. 21)		
• Policy **places no restriction on HIV IEC content related to sexual orientation** (Y) • Policy places restrictions on HIV IEC content related to sexual orientation (N)		1.
• Policy **places no restriction on HIV IEC content related to gender identity** (Y) • Policy places restrictions on HIV IEC content related to gender identity (N)		2.
• Policy place no restriction on HIV IEC **content related to criminalized behaviors** (Y) • Policy restricts HIV IEC information related to criminalized behaviors (N)		3.
Please include any additional remarks or observations about related policy areas not included in the items listed above. If analysis is being done at different levels of government, be sure to identify whether national, regional, and/or local policies differ or contradict each other.		

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25. Intervention Design, Access, and Implementation—Outreach

This section focuses on policies dealing with outreach programs for HIV services, including the following:

- Authorization, including funding for outreach programs
- Eligibility

Outreach activities increase the access, utilization, and impact of community- and facility-based programs. Outreach through networks, communities, and peer educators is often the best or even the only way to reach populations that may be forced to hide their behavior and afraid to access services.

Participation of marginalized communities is key to their mobilization for HIV and AIDS prevention, care, and treatment (UNDP, 2009) (UNAIDS, 2011). As most of these populations are invisible to the mainstream or hidden, it is very difficult to reach out to them for services. Stigma and discrimination may be barriers to accessing services. Community outreach thus forms a critical part of HIV and AIDS program intervention strategies. Policy and guidelines should clearly state the role played by community outreach in HV and AIDS interventions. Such strategies should be adequately resourced.

Appropriate policies should be in place to protect outreach by community-based organizations (CBOs) to reach out to SWs, MSM, and TG (Naz Foundation International, 2005). The CBOs and their teams should be both capacitated and resourced adequately, especially to compensate peer educators and outreach workers. Ideally, national strategic plans should clearly mention these needs and ensure that governments demonstrate clear commitment to support community outreach on a sustainable basis.

Due to their legal environments, many countries do not initiate any community-based outreach. If they do, it is often not managed by the communities themselves. Legal reasons are often cited as a reason not to resource CBO workers adequately with proper materials, such as penis models, condoms, and lubricants. Peer educators, who are the mainstays of the interventions, are often not given proper incentives, yet the delivery of the key program components, such as IEC, condoms, and lubricants, depends on them. In many countries, governments are dependent on donors to support community outreach, thus making such activities unsustainable in the long term. However, it must be noted that the decriminalization of homosexuality in India, for example, was supported by the National AIDS Control Organization on the grounds that the criminal statute was a barrier to HIV prevention services—it allowed police to harass MSM and TG outreach workers with impunity for promoting “illegal acts” and so limited condom distribution at venues for MSM (parks and other “beats”) in India (Beyrer, Wirtz, Walker, Johns, Sifakis, & Baral, 2011, p. 311).

Health promotion also calls for strengthening community action by drawing on existing human resources and focusing on the development of community-based resources to enhance self-help and social support. The initial collective response to the HIV epidemic was led by PLHIV, their caregivers, and communities at risk. Strengthening community systems remains a core component of HIV prevention strategies and should be given further resources. As an example, building social capital has functioned in the development and dissemination of education for MSM in Ghana (Beyrer, Wirtz, Walker, Johns, Sifakis, & Baral, 2011, pp. 188-190).

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Sample policy documents to consider (not an exhaustive list) include the following:

- Reports on resource estimates and expenditures
- National quality assurance guidelines for health
- Norms and guidelines for working with PLHIV, MSM, TG, or SWs
- National public health law, policy, strategy, and guidelines
- National health law, policy, strategy, and guidelines
- National AIDS law, policy, strategy, and guidelines
- National STI law, policy, strategy, and guidelines
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XXV. Outreach

A. Collect all policy documents **authorizing outreach programs**

Policy:	Community Settings	Prison Settings
• Policy **guarantees state funding** for outreach programs (Y) • Policy fails to mention access or funding for outreach (N)	1.	2.
• Policy identifies **outreach approaches specific to SWs** (Y) • Policy fails to identify outreach approaches or restricts outreach for SWs (N)	3.	4.
• Policy identifies **outreach approaches specific to TG** (Y) • Policy fails to identify outreach approaches or restricts outreach for TG (N)	5.	6.
• Policy identifies **outreach approaches specific to MSM** (Y) • Policy fails to identify outreach approaches or restricts outreach for MSM (N)	7.	8.

B. Collect all policy documents that describe **protocols** for outreach services (CHALN, 2007, p. 16) (Parry, 2011)

• Policy identifies **roles and goals of government outreach programs** (Y) • Policy does not identify roles and goals of government outreach programs (N)	1.
• Policy identifies **roles and goals of civil society outreach programs** (Y) • Policy does not identify roles and goals of civil society outreach programs (N)	2.
• Policy directs that **peer leaders and outreach workers be compensated** for their work (Y) • Policy restricts peer leaders and outreach workers to unpaid volunteer status (N)	3.
• Policy directs that **peer leaders and outreach workers be issued official identification** for their work (Y) • Policy does not provide official identification to peer leaders and outreach workers (N)	4.
• Policy **authorizes outreach in prisons** (Y) • Policy fails to authorize outreach in prison (N)	5.
• Policy establishes protocols for peer leaders and outreach workers to **facilitate referrals and linkages** into services, such as those dealing with HIV, STI, SRHR, and alcohol and substance abuse harm reduction (Y) • Policy does not allow peer leaders and outreach workers to facilitate referrals and linkages into services (N)	6.
• Outreach **workers are allowed to carry condoms, lubricants, education materials, and training accessories** (Y) • Outreach workers are restricted from carrying condoms, lubricants, education materials, and training accessories (N)	7.
• Outreach **workers are provided with informational materials that include information on drug abuse use harm reduction and available services** (Y) • Outreach workers are not allowed to carry such informational materials (N)	8.
• Outreach **workers are provided with informational materials that include information on alcohol harm reduction and available services** (Y) • Outreach workers are not allowed to carry such informational materials (N)	9.

Please include any additional remarks or observations about related policy areas not included in the items listed above. If analysis is being done at different levels of government, be sure to identify whether national, regional, and/or local policies differ or contradict each other.

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26. Intervention Design, Access, and Implementation—Alcohol and Substance Abuse Harm Reduction

Given the linkage between alcohol and substance abuse and high-risk behaviors, policies dealing with alcohol and substance abuse will invariably have an impact on HIV services to MSM/TG/SW. This section focuses on policies dealing with alcohol and substance abuse harm reduction programs in relation to HIV services, including the following:

- Inclusive protocols for MSM/TG/SW
- Regulation of alcohol
- Integration of HIV education content into alcohol harm reduction programs

Detailed Technical Guidance

WHO Substance Abuse
http://www.who.int/topics/substance_abuse/en/

WHO Alcohol
http://www.who.int/topics/alcohol_drinking/en/

While the connection between alcohol abuse and risky behavior is not unique to HIV or any region or population, the HIV-related consequences of this connection are most significant in the context of high HIV prevalence. Reviews of the association between alcohol consumption and HIV risk indicate that alcohol drinkers in Africa are nearly twice as likely to be HIV positive as non-drinkers. Studies show that the primary association is with episodes of hazardous or binge drinking, the HIV risk for both men and women is driven by male behavior, and the social dynamics of environments where alcohol is consumed is important. In addition, alcohol has been identified as a risk factor for partner violence leading to coerced sex and rape (Simbayi & Phil, 2011). In addition, consumption of alcohol has been found to have a negative impact on HIV disease progression, impacting ART adherence and weakening the immune system (Parry, 2011).

Focus group discussions among male SWs in Burkina Faso reveal that stigma, discrimination, and poor work conditions have an influence on alcohol and drug abuse (Soulama, Draft Report 2011). Also, alcohol use has been found to be a predictor for unprotected anal sex among male SWs in Kenya (Geibel, Luchters, King'ola, Esu-Williams, Rinyiru, & Tun, 2008) and MSM in South African township communities (Lane, Shade, McIntyre, & Morin, 2008). Among all populations, alcohol use hampers condom negotiation skills and negatively affects sexual decisionmaking and judgment (WHO, 2011).

Policy and program implementation barriers affecting MSM/TG/SW ability to access effective alcohol and substance abuse harm reduction programs include a lack of support and confidentiality in individual and group counseling sessions, and protocols that fail to address the social and legal contexts of MSM/TG/SW.

Policy interventions can impact general problem alcohol use. An assessment of the implementation of the Alcoholic Drinks Control Act in Kenya has found that it reduced overall alcohol consumption and risky sexual behaviors, delayed youths' debut into alcohol use, and increased the public's awareness on the danger of alcohol use (Mwangi, 2011).

For a comprehensive policy assessment for PWID, see the Policy Analysis and Advocacy Decision Model for HIV-Related Services: People Who Inject Drugs at http://www.healthpolicyproject.com/index.cfm?ID=HIVPolicyModels.

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Sample policy documents to consider (not an exhaustive list) include the following:

- Reports on resource estimates and expenditures
- National alcohol regulations
- National quality assurance guidelines for health
- Norms and guidelines for working with PLHIV, MSM, TG, or SWs
- National public health law, policy, strategy, and guidelines
- National health law, policy, strategy, and guidelines
- National AIDS law, policy, strategy, and guidelines
- National STI law, policy, strategy, and guidelines
- National reproductive health and family planning law, policy, strategy, and guidelines

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XXVI. Alcohol and Substance Abuse Harm Reduction		
A. Collect all policy documents **authorizing alcohol harm reduction programs**		
Policy:	Community Settings	Prison Settings
• Policy **guarantees state funding** for alcohol harm reduction programs (Y) • Policy does not mention access or funding for alcohol harm reduction programs (N)	1.	2.
• Policy identifies **alcohol harm reduction approaches specific to SWs** (Y) • Policy does not identify specific approaches or restricts services for SWs (N)	3.	4.
• Policy identifies **alcohol harm reduction approaches specific to TG** (Y) • Policy does not identify specific approaches or restricts services for TG (N)	5.	6.
• Policy identifies **alcohol harm reduction approaches specific to MSM** (Y) • Policy does not identify specific approaches or restricts services for MSM (N)	7.	8.
B. Collect all policy documents **authorizing substance abuse harm reduction programs**		
Policy:	Community Settings	Prison Settings
• Policy **guarantees state funding** for substance abuse harm reduction programs (Y) • Policy does not mention access or funding for substance abuse harm reduction programs (N)	1.	2.
• Policy identifies **substance abuse harm reduction approaches specific to SWs** (Y) • Policy does not identify specific approaches or restricts services for SWs (N)	3.	4.
• Policy identifies **substance abuse harm reduction approaches specific to TG** (Y) • Policy does not identify specific approaches or restricts services for TG (N)	5.	6.
• Policy identifies **substance abuse harm reduction approaches specific to MSM** (Y) • Policy does not identify specific approaches or restricts services for MSM (N)	7.	8.
C. Collect all policy documents **regulating alcohol** (Parry, 2011), (Mwangi, 2011)		
Identify which of the following **regulatory approaches** are used		
• Reducing # of alcohol outlets (Y/N)	1.	
• Reducing hours/days of alcohol sales (Y/N)	2.	
• High and/or increasing tax on alcohol (Y/N)	3.	
• Restricting hours of alcohol advertising (Y/N)	4.	
• Restricting venues of alcohol advertising (billboards, etc.) (Y/N)	5.	
• Restricting sales and access to alcohol by age (Y/N)	6.	
• Restricting sports sponsorships (Y/N)	7.	
• Required health warning labeling (Y/N)	8.	

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• Other:	9.
• Other:	10.
D. Collect operational guidelines or standards for **alcohol treatment programs** (Parry, 2011)	
• Standards identify **screening for alcohol-related HIV risk** (Y) • Standards do not identify screening for alcohol-related HIV risk (N)	1.
• Standards identify **screening for alcohol-related exacerbation of HIV disease progression** (Y) • Standards do not identify screening for alcohol-related exacerbation of HIV disease progression (N)	2.
• Standards identify **provision of HCT and/or referral guidelines for HCT** for alcohol treatment patients (Y) • Standards do not identify provision and/or referral for HCT for alcohol treatment patients (N)	3.
E. Collect operational guidelines or standards for **substance abuse treatment programs**	
• Standards identify **screening for substance abuse-related HIV risk** (Y) • Standards do not identify screening for substance abuse-related HIV risk (N)	1.
• Standards identify **screening for substance abuse-related exacerbation of HIV disease progression** (Y) • Standards do not identify screening for substance abuse-related exacerbation of HIV disease progression (N)	2.
• Standards identify **provision of HCT and/or referral guidelines for HCT** for substance abuse treatment patients (Y) • Standards do not identify provision and/or referral for HCT for substance abuse treatment patients (N)	3.
F. Collect authorizing policy related to **alcohol research and awareness programs** (Mwangi, 2011)	
• Policy authorizes the government to undertake **research, documentation, and dissemination of relevant information on alcoholic drinks** (Y) • Policy fails to authorize government research or information dissemination (N)	1.
• Policy requires government to provide **public awareness on health consequences of alcoholic drink consumption** (Y) • Policy fails to require government to provide public awareness on health consequences of alcoholic drink consumption (N)	2.
Please include any additional remarks or observations about related policy areas not included in the items listed above. If analysis is being done at different levels of government, be sure to identify whether national, regional, and/or local policies differ or contradict each other.	

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27. Intervention Design, Access, and Implementation—Sexual and Reproductive Health and Rights (SRHR)

This section focuses on policies dealing with sexual and reproductive health and rights (SRHR) programs, including the following:

- Authorization
- Condom use
- STI services
- HCT
- Emergency contraception
- Legal options for termination of pregnancy

Assuring complementary legal and policy frameworks that support linkages between HIV and SRHR services improves access to and uptake of key HIV and SRHR services and helps to address stigma and discrimination, including for underserved, vulnerable, and key populations. Synergies between and integration of services can include everything from coordinated information and referral to provision of comprehensive, on-site services (Interagency Working Group on SRH & HIV Linkages).

Restrictive laws and policies in several countries pose major barriers for key populations to accessing high-quality contraceptive services and realizing their reproductive rights. For example, in India, women under the age of 18 are restricted from receiving family planning (FP) services. In Bangladesh, despite recent improvements in the policies for married women, unmarried women are officially prohibited from receiving popular and effective contraceptive methods, such as injectables or implants. These types of policies present real challenges for women such as FSWs, who are often young or unmarried (Petruney, Noriega Minichiello, McDowell, & Wilcher, 2012).

In societies where social status, pre-marital sex, and sex work pose challenges to accessing FP and RH services, including contraception, programs that permit some degree of anonymity, especially with regard to marital status, social status, and occupation, may improve uptake. For many, accessing contraceptives, particularly by going to a clinic, constitutes a public admission of having had sex, and is linked to being promiscuous or a prostitute (Williamson, Parkes, Wight, Petticrew, & Hart, 2009).

Many countries have well-established FP and RH programs aimed at reducing fertility rates and decreasing maternal and infant mortality. These programs can often be a good entry point for HIV and AIDS programming as well as outreach to SWs, MSM, female partners of MSM, and TG. In many countries, all of these services are located in different units. For example, in South Africa, STI treatment, testing for HIV, treatment for HIV and AIDS, family planning, and reproductive health services are often located in separate clinics (HIVOS, 2011).

National strategic plans, FP/RH policies, and HIV plans need to have explicit strategies to address RH and FP needs of SWs, women living with HIV, and female partners of MSM and TG. It is not clear how many countries have plans to integrate HIV and FP/RH services.

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Sample policy documents to consider (not an exhaustive list) include the following:

- Reports on resource estimates and expenditures
- National quality assurance guidelines for health
- Norms and guidelines for working with PLHIV, MSM, TG, or SWs
- National public health law, policy, strategy, and guidelines
- National health law, policy, strategy, and guidelines
- National AIDS law, policy, strategy, and guidelines
- National STI law, policy, strategy, and guidelines
- National reproductive health and family planning law, policy, strategy, and guidelines

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Inventory and Analysis of Country Documents

Country: _____ Date completed: _____

Name of data collector: _____

Position: _____

Contact information for data collector:

Email address: _____

Telephone/fax: _____

Instructions to data collector:

Please fill out this page and indicate the best way to contact you (email, telephone, fax, etc.) should we need further information.

Refer to the instructions page for directions on how to fill out the inventory. Please provide information only on the areas with which you are familiar or have been assigned to research and leave the others blank. Within these areas, please be sure to answer "yes" or "no" to each item. All data collectors should address the open-ended question at the end of the areas upon which they are working.

If you find a policy document that addresses areas upon which you are not working, send the document or citation to the team leader. He or she will share this information with the individual primarily responsible for that section.

When you have completed the inventory, please send all the pages and all the documents you have referenced to [*team leader should fill this in before distributing to team members*].

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XXVII. Sexual and Reproductive Health and Rights (SRHR)		
A. Collect all policy documents **authorizing SRHR programs**		
Policy:	Community Settings	Prison Settings
• Policy **guarantees state funding** for SRHR programs (Y) • Policy does not mention access or funding for SRHR programs (N)	1.	2.
• Policy identifies **SRHR approaches specific to SWs** (Y) • Policy does not identify specific approaches or restricts services for SWs (N)	3.	4.
• Policy identifies **SRHR approaches specific to TG** (Y) • Policy does not identify specific approaches or restricts services for TG (N)	5.	6.
• Policy identifies **SRHR approaches specific to MSM** (Y) • Policy does not identify specific approaches or restricts services for MSM (N)	7.	8.
B. Collect all policy documents that describe **protocols** for SRHR services (WHO, 2006c)**,** (Brahmi & Kapp, 2010)		
	Community	Prison
• Policy emphasizes the **importance of condom use**, alone or in addition to other family planning methods (Y) • Policy does not mention the importance of condom use (N)	1.	2.
• Policy **authorizes STI services in all reproductive health/family planning settings** (Y) • Policy restricts or does not allow STI services in reproductive health/family planning settings (N)	3.	4.
• Policy **authorizes HCT in all reproductive health/family planning settings** (Y) • Policy restricts or does not allow HCT in reproductive health/family planning settings (N)	5.	6.
• Policy **authorizes provision of emergency contraception** (Y) • Policy does not authorize emergency contraception (N)	7.	8.
• Policy authorizes **counseling on legal options to terminate pregnancy** (Y) • Policy does not authorize or restricts counseling on legal options for pregnancy termination (N)	9.	10.
• Policy **ensures that the decision to terminate pregnancy lies solely with the woman** (Y) • Policy does not specifically identify that pregnancy termination is the sole decision of the woman or provides for involuntary termination of pregnancy (N)	11.	12.
Please include any additional remarks or observations about related policy areas not included in the items listed above. If analysis is being done at different levels of government, be sure to identify whether national, regional, and/or local policies differ or contradict each other.		

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Policy Implementation Assessment Interviews

The purpose of conducting key informant interviews is to collect information on the perceptions and implementation of policies. This information will help advocates understand whether to direct advocacy efforts at changing policy language or policy dissemination/implementation.

A combination of client and provider interviews generally yields good overall information within the shortest timeframe and at the lowest cost.

This section provides samples of standard interview questions, which are numbered to correspond with the policy assessment tables. It will be important for the assessment team to make sure that these questions cover the issues that have been identified as most important for the assessment, including questions that may have come up during the assessment of policy documents. Finally, as the questions are finalized, it is important to prioritize them so that the interviews last no more than 20–30 minutes.

Instructions

Key Informant Interviews

The key informant interviews can be used to understand the opinions of the wide range of stakeholders involved in policies and programs for MSM/TG/SW. Respondents should come from within and outside of the government. Public sector stakeholders can include legislators and other policymakers; government officials and technicians from various sectors; local government, law enforcement, and court personnel; and program staff. Respondents outside of the government should include members of civil society organizations; support groups or networks (e.g., MSM/TG/SW, people living with HIV, women's health advocates); and faith-based organizations. Researchers and opinion leaders also may be included. Representatives of international organizations and donors are also important stakeholders in health and human rights-related policy and programs.

The team should form an advisory group to identify potential respondents and make introductions. A minimum of 15 to a maximum of 25 respondents can be managed easily and should include a range of stakeholders, including those resistant to services for MSM/TG/SW.

If possible, a single interviewer should conduct all of the interviews. He/she should have enough status to interview high-level officials and yet be sensitive to marginalized groups, such as MSM/TG/SW. It is important that the interviewer not be seen as identifying with or advocating for a particular point of view.

The sample will be too small and too varied for statistical analysis. Analyses should look for areas of agreement and disagreement among respondents and seek to compare respondents' opinions and perceptions against objective measures, such as actual policy documents or clinic/program norms. The key informant questionnaire is designed to be administered as a standardized interview; if respondents are agreeable and provide written or recorded permission, it may be useful to audio-record the interviews and transcribe responses to open-ended questions later.

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Preparing for the Facility-based Survey

If doing interviews in partnership with a clinic or program, simple preparations are essential to ensure that the right people are interviewed under proper conditions that safeguard privacy and do not impede patient flow or functioning of the facility. Clients should be interviewed immediately upon finishing their visit; providers should be interviewed after operating hours. To avoid interviewing the same client more than once, all client interviews should be completed during the same day, if possible.

The survey supervisor should visit the facility in advance of the fieldwork to meet with facility staff and explain the purpose of the survey and answer their questions. A normal workday should be chosen for the client interviews; it may be preferable to avoid the last day before the weekend or a major holiday and the first day after the weekend or holiday. Provider interviews should be conducted after all client interviews have been completed and may be scheduled over several days.

Criteria for selecting facilities to survey will depend on the policy issues of interest. If the purpose is to understand the typical facility and client experience, facilities would be selected proportional to size. If the purpose is to understand the range of facilities and client experience, purposive sampling would be more appropriate. In that case, it might be useful to compare facilities in the capital city to those in other locations, facilities that have been operating a longer time to those that opened more recently, public sector facilities to private sector facilities, or larger facilities to smaller ones.

Ethics Review

Client interviews likely will require approval by an Institutional Review Board (IRB) or comparable ethics review committee in the country where the survey will be conducted. If the survey is funded by U.S. government funds, IRB approval also will be required in the United States. An ethics review is required for any biomedical or behavioral research involving humans—particularly when vulnerable groups such as MSM/TG/SW are involved in the research—with the aim of protecting the rights and welfare of research participants.

Client Interviews

To gain a spectrum of experiences and opinions, it is important to design clinic or program client interviews to reach the different types of clients served by that program in a proportional manner. Different kinds of clients may have different experiences—for example, women vs. men, ethnic minorities, or even clients who come in the early morning vs. those arriving later in the day. Assigning interview quotas in proportion to the clients served will help to balance out the groups and ensure that enough interviews for each type of participant are conducted. It will also be helpful to establish a minimum number of interviews for each client type to ensure capturing diverse experiences and not exclude those from a group with small numbers.

Interviewers should be instructed to approach the first client who passes their station and continue interviewing until they complete their assigned quota. Care should be taken to avoid interviewer selection bias (for example, not approaching clients who look to be in a hurry, are poorly dressed, etc.).

Provider Interviews

It is important to interview the full range of facility staff who provide client services and/or supervise or manage those providing services. In many facilities, there may be only one or two of each kind of service provider, and some providers may fill multiple roles (e.g., an attending physician also supervises non-clinicians). If there are three or fewer of any kind of service provider (e.g., physicians, nurses, peer counselors), all should be interviewed. If there is a large number (e.g., volunteers), a sample can be chosen, taking care to represent different subgroups (e.g., men and women).

Data Entry and Analysis

Most assessments will probably include a limited number of interviews from which common and/or conflicting experiences can be identified manually. If a large number of interviews are conducted, any standard computer package can be used for data entry (Excel, SPSS, STATA, etc.). Double data entry verification is recommended, along with range checks for accuracy. The survey is designed for analysis with simple descriptive statistics, such as frequencies and cross-tabulations by facility and/or client characteristics. Responses to the last question, which asks for additional open-ended comments, should be transcribed into a separate text file. There probably will be too few interviews for meaningful statistical analysis. Provider responses should be compared to client responses.

Preliminary findings should be shared with staff and clients for feedback and discussion before the final report is prepared. Care should be taken to ensure that responses cannot be traced back to specific respondents—for example, attributing a comment to the Social Worker at Clinic X will identify that staff person to anyone familiar with the system, even if names are not given. Note: The interview questions are numbered to align with the policy analysis tables above.

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Key Informant Interview

Informed consent instructions

Good morning/afternoon/evening. My name is _____ and I work with _____. We are interviewing knowledgeable people such as you to learn about the availability of services for males who have sex with males/transgender people/sex workers in [country], the policies around services for these populations and the groups that participated in developing the policies, and attitudes toward MSM/TG/SW. The purpose of our work is to make recommendations to expand access to HIV prevention and treatment services and improve the quality of services provided in [country]. This work is funded by the U.S. Agency for International Development (USAID) [or other donor]. We invite you to take part in a survey about these topics.

- *All information will be kept confidential.* We will not ask for your name or for any other information that could identify you. We will not share your answers with anyone outside of the project. Our report will combine all of the interviews we collect and not single out any individual.
- *Taking part in this activity is entirely voluntary.* The interview should take no more than 30 minutes of your time. You are free to decline to answer any question or terminate the interview at any time.
- *We anticipate no risk to you as a result of your participation in this survey*, other than the inconvenience of taking the time to complete the questionnaire.
- Do you consent to participate in the survey?

  [ ] Consent to participate
  [ ] Decline to participate (Thank client and terminate interview.)

Identification number_____

City/Country: _____

Personal/professional affiliation(s) (Check at least one and all that apply)

[ ] National policymaker
[ ] Local policymaker
[ ] Service provider
[ ] Organization of people living with HIV
[ ] Organization of MSM/TG/SW (Circle population(s))
[ ] Organization of lawyers
[ ] Other advocacy group (specify): _____
[ ] Professional organization (specify): _____
[ ] Other (specify) _____

Primary area of oversight, authority, or expertise (check all that apply):
□ HIV □ STI □ SRHR/Family Planning and Reproductive Health □ Human Rights
□ Law Enforcement □ Courts/Justice
□ Other_____

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I. Framework			
A. **How would you describe the coordination of the following services with other services in the continuum of health services for MSM/TG/SW (HIV, drug and alcohol treatment and harm reduction, STI, reproductive health/family planning)?**			
	Aligned regulations and outcome targets	No coordination	Contradictory regulations and outcome targets
1. HIV coordination with the continuum of services	(circle letter corresponding to respondent's opinion - #a-c left blank to align with PWID DM)		
For MSM	(d)	(e)	(f)
For TG	(g)	(h)	(i)
For SWs	(j)	(k)	(l)
1.2 STI coordination with the continuum of services			
For MSM	(d)	(e)	(f)
For TG	(g)	(h)	(i)
For SWs	(j)	(k)	(l)
1.3 Reproductive health/family planning coordination with the continuum of services			
For MSM	(d)	(e)	(f)
For TG	(g)	(h)	(i)
For SWs	(j)	(k)	(l)
#2–5 left blank to align with PWID DM			
6. Please cite one example of good coordination			
7. Please cite one example of poor coordination			

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8. Left blank to align with PWID DM

9. Notes:

B. **How would you describe the coordination between health services for MSM/TG/SW and law enforcement programs?**

	Aligned regulations and outcome targets	No coordination	Contradictory regulations and outcome targets
1. At the national level	(circle letter corresponding to respondent's opinion - #a-c left blank to align with PWID DM)		
For MSM	(d)	(e)	(f)
For TG	(g)	(h)	(i)
For SWs	(j)	(k)	(l)
2. At regional/state levels			
For MSM	(d)	(e)	(f)
For TG	(g)	(h)	(i)
For SWs	(j)	(k)	(l)
3. At the local level			
For MSM	(d)	(e)	(f)
For TG	(g)	(h)	(i)
For SWs	(j)	(k)	(l)

4. Please cite one example of good coordination

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5. Please cite one example of poor coordination
6. Notes:

C. **What would you describe as your understanding of the differences between community and prison services for hepatitis, TB, HIV, drug and alcohol treatment and harm reduction, STI, and reproductive health/family planning programs?**		
1. National program guidelines and protocols apply equally between community settings and pre-trial detention and prison settings (letters left blank to align with PWID DM)	Pre-trial detention vs community	Prison vs community
HIV (Y/N)	(g)	(h)
Drug treatment (Y/N)	(m)	(n)
Drug harm reduction (Y/N)	(p)	(q)
Alcohol treatment (Y/N)	(r)	(s)
Alcohol harm reduction (Y/N)	(t)	(u)
STI	(v)	(w)
Reproductive health/family planning	(x)	(y)
2. Identify any services that are available in the community that aren't available in the following settings		
a) Pre-trial detention		
b) Prison		

3. Identify any levels of financial resources that are different between community settings and the following settings
a) Pre-trial detention
b) Prison
4. Left blank to align with PWID DM
5. Notes:

II. Data used in the decisionmaking processes
A. **Describe your perception of how the government sets funding-level and service-delivery targets or performance targets** (select all that apply)
1. □ Historic funding levels/support for existing physical infrastructure and staffing levels
2. □ Data on utilization or need
3. □ Community-level epidemiological or census data
4. □ Don't know
5. □ Other, please describe:
6. Notes (especially if more than one of the above is selected):

B. **If applicable, describe how you use the following data in programming and funding decisions** (circle letter corresponding to respondent's opinion)			
	Use data regularly	Would like to use data but not available	Don't need this level of data
1–4 left blank to align with PWID DM			
5. Data specific to MSM	(a)	(b)	(c)
6. Data specific to TG	(a)	(b)	(c)
7. Data specific to SWs	(a)	(b)	(c)
8. Data specific to clients of SWs	(a)	(b)	(c)
9. Notes:			

III. Government/community partnerships and engagement of key populations in decisionmaking

A. Please list any advisory bodies/processes for services for MSM/TG/SW and indicate (Y/N) if they include membership of individual MSM/TG/SW or organizations that serve MSM/TG/SW

	MSM		TG		SWs	
	Ind	Org	Ind	Org	Ind	Org
#1–4 left blank to align with PWID DM						
HIV						
5.	(a)	(b)	(c)	(d)	(e)	(f)
6.	(a)	(b)	(c)	(d)	(e)	(f)
Drug Treatment						
7.	(a)	(b)	(c)	(d)	(e)	(f)
8.	(a)	(b)	(c)	(d)	(e)	(f)

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Drug Harm Reduction						
9.	(a)	(b)	(c)	(d)	(e)	(f)
10.	(a)	(b)	(c)	(d)	(e)	(f)
11-12. left blank to align with PWID DM						
Alcohol Treatment						
13.	(a)	(b)	(c)	(d)	(e)	(f)
14.	(a)	(b)	(c)	(d)	(e)	(f)
Alcohol Harm Reduction						
15.	(a)	(b)	(c)	(d)	(e)	(f)
16.	(a)	(b)	(c)	(d)	(e)	(f)
STI						
17.	(a)	(b)	(c)	(d)	(e)	(f)
18.	(a)	(b)	(c)	(d)	(e)	(f)
Reproductive Health/Family Planning						
19.	(a)	(b)	(c)	(d)	(e)	(f)
20.	(a)	(b)	(c)	(d)	(e)	(f)
21. For areas above that have no participation from individuals or organizations, please describe barriers to engaging MSM/TG/SW in the decisionmaking process						
22. Notes:						

VI. Privacy and confidentiality of personal medical and drug treatment/services utilization data

A. Describe your understanding of the protections given to individual-level medical data

1. **Collection** of personal medical data is prohibited without the individual's consent Don't know (DK)

Community			Pre-trial Detention			Prison		
a) □ Yes	b) □ No	c) □ DK	d) □ Yes	e) □ No	f) □ DK	g) □ Yes	h) □ No	i) □ DK

2. **Disclosure** of personal medical data is prohibited without the individual's consent Don't know (DK)

Community			Pre-trial Detention			Prison		
a) □ Yes	b) □ No	c) □ DK	d) □ Yes	e) □ No	f) □ DK	g) □ Yes	h) □ No	i) □ DK

3. **Publication** of personal medical data is prohibited without the individual's consent Don't know (DK)

Community			Pre-trial Detention			Prison		
a) □ Yes	b) □ No	c) □ DK	d) □ Yes	e) □ No	f) □ DK	g) □ Yes	h) □ No	i) □ DK

4-5 left blank to align with PWID DM

7. Identify any exceptions to the general answers you gave above:

B. Left blank to align with PWID DM

C. Are there any circumstances in which personal medical data indicating criminalized behaviors (e.g., MSM/SW) or testing/disease status are used for the initiation or documentation of criminal charges or investigations?

1. □ Don't know
2. □ No
3. □ Yes (please describe)

4. Notes:

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VIII. HIV and drug-use stigma and discrimination

A.-B. **Left blank to align with PWID DM**

C. **Describe the mechanisms that the government uses to measure stigma and discrimination against MSM/TG/SW**

D. **Describe any government-supported activities that are being undertaken to reduce stigma and discrimination against MSM/TG/SW**

X. Criminal/administrative law

A. **Left blank to align with PWID DM**

B. **How would you describe sex work?**

Check all that apply

1. □ Sex work is a legitimate occupation
2. □ Sex work is a criminal activity
3. □ Sex work is socially unacceptable

4. □ Other_____

C. **How would you describe homosexuality?**

Check all that apply

1. □ Consensual same-sex behavior is a naturally occurring, normal expression of sexual behavior
2. □ Consensual same-sex behavior is deviant or criminal
3. □ Consensual same-sex behavior is an illness

4. □ Other_____

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D. **How would you describe individuals who don't conform to gender norms?**

Check all that apply

1. □ The expression of gender is based on an individual's internal experience and may not correspond with the sex assigned at birth
2. □ Gender nonconformity is deviant or criminal
3. □ Gender nonconformity is an illness
4. □ Other_____

5. Notes (especially if more than one of the above is selected):

XIII. Human and legal rights

A. **Please describe the steps that the government is taking to address corruption**

(check as many as apply)

1. □ We have independent anti-corruption bodies in charge of preventive measures and policies
2. □ Anti-corruption activities include the participation of civil society
3. □ We undertake public information campaigns on the threats, causes, and consequences of corruption
4. □ We undertake public information campaigns on the mechanisms for reporting corruption
5. □ Other_____

B. **Please describe your perception of compensation of civil servants and political leaders compared with similar positions in the private sector**

1. □ Compensation levels are about the same
2. □ Compensation levels are lower, but individuals are allowed to supplement their income through formal or informal supplemental fees collected from members of the public
3. □ Compensation levels are lower and individuals are forbidden to supplement their income through formal or informal supplemental fees collected from members of the public
4. □ Other_____

C. **Please describe the role that adopted international conventions/treaties play in the legislative process**

1. □ Don't know
2. □ Adopted international conventions/treaties have overall supremacy over country legislation
3. □ Country legislation attempts to align with adopted international conventions/treaties
4. □ I'm not aware of any international conventions/treaties that we have adopted
5. □ There is no role for international conventions/treaties in country legislation

6. □ Other_____

Those are all the questions I have. Before we finish, is there anything you would like to tell me about the services here, such as what could be done to make services better?

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Facility/Organization-based Service Provider Interview

Informed consent instructions

Good morning/afternoon/evening. My name is _____ and I work with _____. We are visiting facilities and organizations like this one to learn about their practices from both clients and staff. The purpose of our work is to make recommendations to expand access to services for MSM/TG/SW throughout [country]. This work is funded by [name of funder—for example, the U.S. Agency for International Development (USAID)]. We would like to interview you about the services provided here.

- *All information will be kept confidential.* We will not ask for your name. We will not share your answers with other staff working at this facility or any other authorities. Our report will combine all of the interviews we collect.
- *Taking part in this activity is entirely voluntary.* The interview should take no more than 30 minutes of your time. You are free to decline to answer any question or terminate the interview at any time.
- *We anticipate no risk to you as a result of your participation in this survey*, other than the inconvenience of taking the time to complete the questionnaire.
- Do you consent to participate in the survey?

[ ] Consent to participate

[ ] Decline to participate (Thank client and terminate interview.)

_____

Identification number_____

Facility/organization information

City/Country_____

Source of facility/organization funding (check all that apply):

□ Government □ Nongovernmental/donor sector □ Private

□ Other_____

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Facility/organization type (check all that apply):

□ Clinic/Health Facility □ Health Promotion/Disease Prevention □ Pre-trial Detention

□ Prison □ Other_____

Identify services provided at this facility (check all that apply):

□ HIV □ Drug or Alcohol Harm Reduction □ Drug or Alcohol Treatment □ STI

□ Reproductive Health/Family Planning □ Human Rights Advocacy

□ Other_____

Respondent position at facility

□ Attending physician

□ Drug treatment counselor

□ Facility manager

□ Nurse

□ Outreach worker/educator

□ Lawyer

□ Volunteer

□ Other (specify): _____

Length of time working at this facility

□ Less than 6 months

□ 7–12 months

□ 1–2 years

□ More than 2 years

I. Framework

A. **How would you describe the coordination of the following services with others in the continuum of health services for MSM/TG/SW (HIV, drug and alcohol treatment and harm reduction, STI, reproductive health/family planning)?**

	Aligned regulations and outcome targets	No coordination	Contradictory regulations and outcome targets
1. HIV coordination with the continuum of services	(circle letter corresponding to respondent's opinion - #a-c left blank to align with PWID DM)		
For MSM	(d)	(e)	(f)
For TG	(g)	(h)	(i)
For SWs	(j)	(k)	(l)
1.2 STI coordination with the continuum of services			
For MSM	(d)	(e)	(f)
For TG	(g)	(h)	(i)
For SWs	(j)	(k)	(l)
1.3 Reproductive health/family planning coordination with the continuum of services			
For MSM	(d)	(e)	(f)
For TG	(g)	(h)	(i)
For SWs	(j)	(k)	(l)
#2–5 left blank to align with PWID DM			
6. Please cite one example of good coordination			
7. Please cite one example of poor coordination			

Throughout this document, the term "policy" is inclusive of legislation, policies, legal precedent, judicial findings, regulations, guidelines, and/or operational plans and protocols.

8. Left blank to align with PWID DM			
9. Notes			
B. **How would you describe the coordination between health services for MSM/TG/SW and law enforcement programs?**			
	Aligned regulations and outcome targets	No coordination	Contradictory regulations and outcome targets
1. At the national level	(circle letter corresponding to respondent's opinion - #a-c left blank to align with PWID DM)		
For MSM	(d)	(e)	(f)
For TG	(g)	(h)	(i)
For SWs	(j)	(k)	(l)
2. At regional/state levels			
For MSM	(d)	(e)	(f)
For TG	(g)	(h)	(i)
For SWs	(j)	(k)	(l)
3. At the local level			
For MSM	(d)	(e)	(f)
For TG	(g)	(h)	(i)
For SWs	(j)	(k)	(l)
4. Please cite one example of good coordination			

5. Please cite one example of poor coordination		
6. Notes:		
C. **What would you describe as your understanding of the differences between community and prison services for hepatitis, TB, HIV, drug and alcohol treatment and harm reduction, STI, and reproductive health/family planning programs?**		
1. National program guidelines and protocols apply equally between community settings and pre-trial detention and prison settings	Pre-trial detention vs community	Prison vs community
HIV (Y/N)	(g)	(h)
Drug treatment (Y/N)	(m)	(n)
Drug harm reduction (Y/N)	(p)	(q)
Alcohol treatment (Y/N)	(r)	(s)
Alcohol harm reduction (Y/N)	(t)	(u)
STI	(v)	(w)
Reproductive health/family planning	(x)	(y)
2. Identify any services that are available in the community that aren't available in the following settings		
c) Pre-trial detention		
d) Prison		

3. Identify any levels of financial resources that are different between community settings and the following settings
c) Pre-trial detention
d) Prison
4. Notes:

II. Data used in the decisionmaking processes
A. **Describe your perception of how the government sets funding-level and service-delivery targets or performance targets** (select all that apply)
1. □ Historic funding levels/support for existing physical infrastructure and staffing levels
2. □ Data on utilization or need
3. □ Community-level epidemiological or census data
4. □ Don't know
5. □ Other, please describe:
6. Notes (especially if more than one of the above is selected):

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B. **Left blank to align with PWID DM**

C. **If applicable, describe how you use the following data in programming and funding decisions** (circle letter corresponding to respondent's opinion)

	Use data regularly	Would like to use data but not available	Don't need this level of data
1. Data specific to MSM	(a)	(b)	(c)
2. Data specific to TG	(a)	(b)	(c)
3. Data specific to SWs	(a)	(b)	(c)
4. Data specific to clients of SWs	(a)	(b)	(c)

5. Notes:

III. Government/community partnerships and engagement of key populations in decisionmaking

A. **Left blank to align with PWID DM**

B. **Have you or a representative of your facility ever been a part of discussions with government agencies about government policies and programs related to services for MSM/TG/SW?**

1. If yes, please describe:

2. If no, please describe barriers to participation:

3. Notes:

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V. Consent for testing and treatment

A. **Describe the elements of consent for services at your facility**

(interviewer—check off each as it is mentioned and obtain any written protocols for consent, if available)

1. □ the consent must relate specifically to the treatment administered
2. □ the consent must be fully informed
3. □ the consent must be given voluntarily
4. □ the consent is given individually, in private, in the presence of a healthcare provider
5. □ the consent may be verbal or written
6. □ the consent must not be obtained through misrepresentation, coercion, or fraud
7. □ other:

B. **Are there any restrictions on the ability of children or adolescents to access information or services without parental consent?**

1. □ No
2. □ Yes (please describe)

C. **Left blank to align with PWID DM**

D. **If a prison setting—are there any HIV, STI, or reproductive health/family planning services for which a prisoner cannot refuse testing or treatment?**

1. □ There are no cases where a prisoner is required to accept medical testing or treatment
2. □ Yes (please describe)

VI.	**Privacy and confidentiality of personal medical and drug treatment/services utilization data**
A-C	**left blank to align with PWID DM**
D.	**Does this facility routinely share personal medical data indicating criminalized behaviors (e.g., MSM/SW) or testing/disease status beyond the providers directly involved in the care of the client without the consent of the client?**
1.	□ No, information is not shared
	If yes, with whom is this information shared? (mark all that apply)
2.	□ Government health agencies or personnel
3.	□ Government administrative agencies or personnel
4.	□ Law enforcement or security agencies or personnel
5.	□ Employers
6.	□ Family
7.	□ Other
E.	**Has this facility ever been forced to share HIV data indicating criminalized behaviors (e.g., MSM/SW) or testing/disease status for the initiation or documentation of criminal charges or investigations?**
1.	□ No
2.	□ Yes (please describe)
F.	**Do the professional bodies that represent your staff (e.g., healthcare workers) have codes of conduct and use them to discipline breaches of confidentiality and unreasonable invasion of privacy as professional misconduct?**
1.	□ No
2.	□ Yes (please describe)

VIII. Stigma and discrimination in provision of services			
A-C. **Left blank to align with PWID DM**			
D. **Please describe the availability in your facility of the following services to people who you know or suspect of being an MSM/TG/SW**			
(cross off service if it is not provided at this facility)	Service provided to population	Service provided at facility but not available to population	Service not provided at facility
1. HCT	(circle letter corresponding to respondent's opinion)		
For MSM	(a)	(b)	(c)
For TG	(d)	(e)	(f)
For SWs	(g)	(h)	(i)
2. ART			
For MSM	(a)	(b)	(c)
For TG	(d)	(e)	(f)
For SWs	(g)	(h)	(i)
3. Hepatitis services			
For MSM	(a)	(b)	(c)
For TG	(d)	(e)	(f)
For SWs	(g)	(h)	(i)
4. Condoms/Lubricant distribution			
For MSM	(a)	(b)	(c)
For TG	(d)	(e)	(f)
For SWs	(g)	(h)	(i)
5. STI diagnosis and treatment			
For MSM	(a)	(b)	(c)
For TG	(d)	(e)	(f)
For SWs	(g)	(h)	(i)
6. HIV prevention information and education			

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For MSM	(a)	(b)	(c)
For TG	(d)	(e)	(f)
For SWs	(g)	(h)	(i)
7. Outreach			
For MSM	(a)	(b)	(c)
For TG	(d)	(e)	(f)
For SWs	(g)	(h)	(i)
8. Alcohol harm reduction			
For MSM	(a)	(b)	(c)
For TG	(d)	(e)	(f)
For SWs	(g)	(h)	(i)
9. Reproductive health and family planning			
For MSM	(a)	(b)	(c)
For TG	(d)	(e)	(f)
For SWs	(g)	(h)	(i)

E. **Please describe the availability in your facility of the following services to people of a different or undocumented residency or citizenship** (circle letter corresponding to respondent's opinion)

(cross off service if it is not provided at this facility)	Service provided regardless of residency/citizenship	Service provided at facility but not available to people without documentation of local residency/citizenship	Service not provided at facility
1. HCT	(a)	(b)	(c)
2. ART	(a)	(b)	(c)
3. Hepatitis services	(a)	(b)	(c)
4. Condoms/ Lubricant distribution	(a)	(b)	(c)
5. STI diagnosis and treatment	(a)	(b)	(c)

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6. HIV prevention information and education	(a)	(b)	(c)
7. Outreach	(a)	(b)	(c)
8. Alcohol harm reduction	(a)	(b)	(c)
9. Reproductive health and family planning	(a)	(b)	(c)

F. **Are any of the following services provided at a LOWER level in detention or prison facilities than in the community (e.g., more limited access, limited service components, etc.)?**
1. □ HCT—if indicated, please describe
2. □ ART—if indicated, please describe
3. □ Hepatitis services —if indicated, please describe
4. □ Condoms/Lubricant distribution—if indicated, please describe
5. □ STI diagnosis and treatment—if indicated, please describe
6. □ HIV prevention information and education—if indicated, please describe
7. □ Outreach—if indicated, please describe
8. □ Alcohol harm reduction—if indicated, please describe
9. □ Reproductive health and family planning—if indicated, please describe

X. Criminal law

A-B**. Left blank to align with PWID DM**

C. **Has this facility ever had the information it provides on HIV, STI, or reproductive health / family planning services censored?**

1. □ No
2. □ Yes (please describe)

D. **Has this facility or staff ever been accused formally or informally of promotion, facilitation, or aiding and abetting of criminal offenses?**

1. □ No
2. □ Yes (please describe)

E. **How would you describe sex work?**

Check all that apply

1. □ Sex work is a legitimate occupation
2. □ Sex work is a criminal activity
3. □ Sex work is socially unacceptable
4. □ other_____

F. **How would you describe homosexuality?**

Check all that apply

1. □ Consensual same-sex behavior is a naturally occurring, normal expression of sexual behavior
2. □ Consensual same-sex behavior is deviant or criminal
3. □ Consensual same-sex behavior is an illness
4. □ other_____

G. **How would you describe individuals who don't conform to gender norms?**

Check all that apply

1. □ The expression of gender is based in an individual's internal experience and may not correspond with the sex assigned at birth
2. □ Gender nonconformity is deviant or criminal
3. □ Gender nonconformity is an illness
4. □ other_____

G. **How would you describe individuals who don't conform to gender norms?**
5. Notes (especially if more than one of the above is selected):

XIII.	Monitoring and enforcement of human and legal rights
A.	**Does any of your staff or your organization receive incentive payments from the private sector for using particular products or procedures?**
1. □ No 2. □ Yes (please describe)	

XIV.	Medicine and medical commodity procurement and supply management
A.	**Does your facility have access to all of the medicines or medical commodities required for the services you provide?**
1. □ No (to what do you not have access?) 2. □ Yes (do they come from the government or another donor?)	

B. **In the last six months, have you run out of medicines or medical commodities?**

1. □ No
2. □ Yes

Please describe circumstances

Please describe how you managed your clients—e.g., changed medications, restricted new clients, reduced medication dose, artificially increased forecast for future need, etc.

C. **Mechanisms used to forecast and distribute medicines or medical commodities**

Forecasting

1. □ Is based on historical use
2. □ Is based on forecasted need
3. How often are forecasts reviewed and revised? Every _____ months
4. How often do you report on utilization? Every _____ months

Is there a system to redistribute inventory between facilities?

1. □ No
2. □ Yes (please describe)

XV. Overall intervention design

A. **Please describe where MSM/TG/SW can access the following services (circle all that apply)**

	Provided at this location	Coordinate clinical treatment plans and monitoring with another location	Referrals made to other locations	Client seeks independently at other locations	Unknown
1. HIV risk assessment/ screening	(a)	(b)	(c)	(d)	(e)
2. Client-initiated HCT	(a)	(b)	(c)	(d)	(e)
3. Provider-initiated HCT	(a)	(b)	(c)	(d)	(e)
4. ART	(a)	(b)	(c)	(d)	(e)
5. CD4/viral load testing	(a)	(b)	(c)	(d)	(e)
6. Testing for hepatitis A	(a)	(b)	(c)	(d)	(e)
7. Vaccination for hepatitis A	(a)	(b)	(c)	(d)	(e)
8. Treatment for hepatitis A infection	(a)	(b)	(c)	(d)	(e)
9. Testing for hepatitis B	(a)	(b)	(c)	(d)	(e)
10. Vaccination for hepatitis B	(a)	(b)	(c)	(d)	(e)
11. Treatment for hepatitis B infection	(a)	(b)	(c)	(d)	(e)
12. Testing for hepatitis C	(a)	(b)	(c)	(d)	(e)
13. Treatment for hepatitis C infection	(a)	(b)	(c)	(d)	(e)
#14–22. left blank to align with PWID DM					
23. Condom distribution	(a)	(b)	(c)	(d)	(e)
24. Lubricant distribution	(a)	(b)	(c)	(d)	(e)
25. STI screening	(a)	(b)	(c)	(d)	(e)
26. STI treatment	(a)	(b)	(c)	(d)	(e)

27. Information on HIV prevention	(a)	(b)	(c)	(d)	(e)
28. Alcohol harm reduction services	(a)	(b)	(c)	(d)	(e)
29. Substance abuse harm reduction services	(a)	(b)	(c)	(d)	(e)
30. Family planning/ reproductive health services	(a)	(b)	(c)	(d)	(e)

B. **Do you coordinate your services between community and prison settings?**

1. □ No (please describe barriers to coordination)

2. □ Yes (please describe)

C. **For the services you provide, please indicate if the following are reasons for denying, delaying, or interrupting the service**

(Assessment for c–f left blank to align with PWID DM)	HCT	ART	Condoms and lubricants	STI	Alcohol harm reduction	Family planning / reproductive health	Not provided at this facility
1. Age less than 18 years	(a)	(b)	(h)	(i)	(j)	(k)	(g)
2. Current, active alcohol or drug use	(a)	(b)	(h)	(i)	(j)	(k)	(g)
3. Active TB	(a)	(b)	(h)	(i)	(j)	(k)	(g)
4. Current treatment for hepatitis B	(a)	(b)	(h)	(i)	(j)	(k)	(g)
5. Hepatitis infection	(a)	(b)	(h)	(i)	(j)	(k)	(g)
6. Pregnant and/or breastfeeding	(a)	(b)	(h)	(i)	(j)	(k)	(g)
7. Non-use of contraception	(a)	(b)	(h)	(i)	(j)	(k)	(g)
8. HIV infection		(b)	(h)	(i)	(j)	(k)	(g)
9. Non-compliance with treatment	(a)	(b)	(h)	(i)	(j)	(k)	(g)
10. Inability to pay	(a)	(b)	(h)	(i)	(j)	(k)	(g)

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D. **When was the last time that your staff received training in the following areas?**				
	Within the last 6 months	6–12 months	More than 12 months	Never
1. Ethics and human rights	(a)	(b)	(c)	(d)
2. Domestic or sexual violence	(a)	(b)	(c)	(d)
3. Consent	(a)	(b)	(c)	(d)
4. Confidentiality of personal data	(a)	(b)	(c)	(d)
5. Stigma and discrimination	(a)	(b)	(c)	(d)
6. (Blank to align with PWID DM)				
7. Referrals between law enforcement, medical, and harm reduction services	(a)	(b)	(c)	(d)
8. Drug dependency	(a)	(b)	(c)	(d)
9. (Blank to align with PWID DM)				
10. Information on hepatitis, TB, or HIV	(a)	(b)	(c)	(d)
11. Specific needs of MSM	(a)	(b)	(c)	(d)
12. Specific needs of TG	(a)	(b)	(c)	(d)
13. Specific needs of SWs	(a)	(b)	(c)	(d)
14. Human sexuality	(a)	(b)	(c)	(d)

E. **Please describe if you engage other entities as partners in provision of services for these populations?**			
	MSM	TG	SWs
1. We engage owners of sex work establishments or pimps (Y/N)	(a)	(b)	(c)
2. We engage alcohol-serving venues (Y/N)	(a)	(b)	(c)
3. We engage police (Y/N)	(a)	(b)	(c)
4. We engage religious institutions (Y/N)	(a)	(b)	(c)
5. We engage cultural institutions (Y/N)	(a)	(b)	(c)
6. Other (Y/N)	(a)	(b)	(c)
7. Other (Y/N)	(a)	(b)	(c)

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8. Please describe barriers to engagement of partners in the provision of services
9. Please describe one example of successful engagement

XVI. HIV counseling and testing (for facilities providing this service)

A. **Left blank to align with PWID DM**

B. **When HIV testing is offered to an MSM/TG/SW, please describe how it is presented**

1. □ A healthcare worker presents it, along with a list of other medical tests, and the client can ask to not have the HIV test
2. □ A healthcare worker recommends that HIV testing be done, but the test is not done unless the client asks for it
3. □ We offer HIV testing only when the client asks us to
4. □ Other:

XVII. ART (for facilities providing this service)

A. **Left blank to align with PWID DM**

B. **Does your facility provide adherence support measures for your ART patients?**

1. □ No
2. □ Yes (please describe how you identify and address the adherence barriers specific to MSM/TG/SW)

XXII. Condoms and Lubricants (for facilities providing this service)

A. Mechanisms to include MSM/TG/SW in the selection of condoms and lubricants

Is there a mechanism to include MSM/TG/SW (or representative organizations) in the selection of condoms and lubricants?

1. □ No
2. □ Yes (please describe)

B. Does your facility have access to condoms and lubricants to distribute to MSM/TG/SW?

1. □ No (to what do you not have access?)

2. □ Yes (do they come from the government or another donor?)

C. In the last six months, have you run out of condoms or lubricants?

1. □ No
2. □ Yes (please describe)

XXIII. STI (for facilities providing this service)

A. **Please describe the screenings and procedures that you do for sexually transmitted infections for each population**

	Men	Women	TG
1. We ask about sexual partners of all sexes (Y/N)	(a)	(b)	(c)
2. We ask about use of alcohol (Y/N)	(a)	(b)	(c)
3. We ask about use of drugs (Y/N)	(a)	(b)	(c)
4. We ask about the experience of physical and emotional violence (Y/N)	(a)	(b)	(c)
5. We perform examination and laboratory screening of the penis/vagina (Y/N)	(a)	(b)	(c)
6. We perform examination and laboratory screening of the mouth and throat (Y/N)	(a)	(b)	(c)
7. We perform examination and laboratory screening of the anus (Y/N)	(a)	(b)	(c)
8. We provide hepatitis A vaccination (Y/N)	(a)	(b)	(c)
9. We provide hepatitis B vaccination (Y/N)	(a)	(b)	(c)
10. We perform HCV screening (Y/N)	(a)	(b)	(c)
11. Other (Y/N)	(a)	(b)	(c)

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12. Other (Y/N)	(a)	(b)	(c)
13. Please describe reasons for those screenings and procedures identified above that are not provided at this facility			

XXIV. IEC (for organizations/facilities providing this service)			
A. **Please describe the information that you provide to reduce risk of HIV transmission**			
	Men	Women	TG
1. Risks and benefits of sexual abstinence (Y/N)	(a)	(b)	(c)
2. Relative risks of insertive and receptive sexual activities (Y/N)	(a)	(b)	(c)
3. Risks and benefits of non-penetrative sexual activities (Y/N)	(a)	(b)	(c)
4. Relative risks of oral, anal, and vaginal sexual activities (Y/N)	(a)	(b)	(c)
5. Risks and benefits of reducing the number of sexual partners (Y/N)	(a)	(b)	(c)
6. Risks and benefits of condom use (Y/N)	(a)	(b)	(c)
7. Risks and benefits of sero-sorting and sero-positioning (Y/N)	(a)	(b)	(c)
8. Risks and benefits of suppressive HIV therapy (Y/N)	(a)	(b)	(c)
9. Impact of alcohol use on sexual risk behavior (Y/N)	(a)	(b)	(c)
10. Impact of alcohol use on gender-based violence (Y/N)	(a)	(b)	(c)
11. Impact of substance use on gender-based violence (Y/N)	(a)	(b)	(c)
12. Impact of mental health on sexual risk behavior (Y/N)	(a)	(b)	(c)
13. Impact of mental health on gender-based violence (Y/N)	(a)	(b)	(c)
14. Promotion of and information on where to access HIV services (Y/N)	(a)	(b)	(c)
15. Promotion of and information on where to access STI services (Y/N)	(a)	(b)	(c)
16. Promotion of and information on where to access SRHR services (Y/N)	(a)	(b)	(c)
17. Promotion of and information on where to access alcohol harm reduction services (Y/N)	(a)	(b)	(c)
18. Promotion of and information on where to access substance abuse harm reduction services (Y/N)	(a)	(b)	(c)

19. Promotion of and information on where to access mental health services (Y/N)	(a)	(b)	(c)
20. Other (Y/N)	(a)	(b)	(c)
21. Please describe the reasons why the information identified above is not provided at this organization/facility			

XXV. Outreach—for ALL organizations/facilities

A. **Please describe how you reach out to provide services to individuals who may not come to your facility/organization**

	MSM	SW	TG
1. We identify where these individuals gather and socialize (Y/N)	(a)	(b)	(c)
2. We do regular estimation of the size of this population to understand what proportion we are serving (Y/N)	(a)	(b)	(c)
3. We gather information from this population on what motivates health-seeking behavior (Y/N)	(a)	(b)	(c)
4. We implement non-facility-based services (e.g., drop-in centers, mobile services, etc.) (Y/N)	(a)	(b)	(c)
5. We compensate our peer outreach workers (Y/N)	(a)	(b)	(c)
6. We issue official identification to peer leaders and outreach workers (Y/N)	(a)	(b)	(c)
7. Outreach workers are allowed to carry condoms, lubricants, education materials, and training accessories (Y/N)	(a)	(b)	(c)
8. Outreach workers are provided with informational materials that include information on drug abuse use harm reduction and available services (Y/N)	(a)	(b)	(c)
9. Outreach workers are provided with informational materials that include information on alcohol harm reduction and available services (Y/N)	(a)	(b)	(c)
10. Other (Y/N)	(a)	(b)	(c)
11. Other (Y/N)	(a)	(b)	(c)

12. Please describe the reasons why the outreach efforts identified above are not provided at this organization/facility

XXVI. Alcohol and Substance Use Harm Reduction (for organizations/facilities providing this service)			
A. **Please describe the services that you provide to individuals seeking treatment or harm reduction for alcohol use**			
	Men	Women	TG
1. We include screening for alcohol-related HIV risk behavior (Y/N)	(a)	(b)	(c)
2. We include screening for substance use-related HIV risk behavior (Y/N)	(a)	(b)	(c)
3. For HIV-positive individuals, we screen for alcohol-related exacerbation of HIV disease progression (Y/N)	(a)	(b)	(c)
4. For HIV-positive individuals, we screen for substance use-related exacerbation of HIV disease progression (Y/N)	(a)	(b)	(c)
5. We provide or refer individuals to HCT services (Y/N)	(a)	(b)	(c)
6. Other (Y/N)	(a)	(b)	(c)
7. Other (Y/N)	(a)	(b)	(c)
8. Please describe the reasons why the services identified above are not provided at this organization/facility			

XXVII. Family planning/reproductive health services (for organizations/facilities providing this service) (circle Y or N for any column that applies)			
A. **Please describe the services that you provide to individuals seeking family planning/reproductive health services**			
	MSM	SWs	TG
1. Information on the importance of condom use, along with or in addition to other family planning methods (Y/N)	(a)	(b)	(c)

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2. Comprehensive information on a full range of FP methods (Y/N)	(a)	(b)	(c)
3. STI screening (Y/N)	(a)	(b)	(c)
4. HCT (Y/N)	(a)	(b)	(c)
5. Emergency contraception (Y/N)	(a)	(b)	(c)
6. Counseling on legal options to terminate pregnancy (Y/N)	(a)	(b)	(c)
7. Other (Y/N)	(a)	(b)	(c)
8. Other (Y/N)	(a)	(b)	(c)
9. Other (Y/N)	(a)	(b)	(c)
10. Please describe the reasons why the services identified above are not provided at this organization/facility			

Those are all the questions I have. Before we finish, is there anything you would like to tell me about the services here, such as what could be done to make services better?

Facility/Organization-based Client Intercept

Informed consent instructions

Good morning/afternoon/evening. My name is _____ and I work with _____. We are visiting facilities/organizations like this one to learn about their practices. The purpose of our work is to make recommendations to expand services for MSM/TG/SW throughout [country]. This work is funded by [name of funder—for example, the U.S. Agency for International Development (USAID)]. Information from clients such as you is critical to the work. We invite you to take part in a short survey to answer a few questions about yourself and the services you receive here.

- *All information will be kept confidential.* We will not ask for your name or for any other information that could identify you. We will not share your answers with the staff working at this facility or any other authorities. Our report will combine all of the interviews we collect.
- *Taking part in this activity is entirely voluntary.* The interview should take no more than 15 minutes of your time. You are free to decline to answer any question or terminate the interview at any time.
- *We anticipate no risk to you as a result of your participation in this survey* other than the inconvenience of taking the time to complete the questionnaire.
- Do you consent to participate in the survey? [If signed consent is required by local IRB: By signing/initialing this form, you indicate that you have been fully informed about the project and that you understand it, and you are voluntarily choosing to take part in this survey.]

  [ ] Consent to participate

  [ ] Decline to participate (Thank client and terminate interview.)

Identification number: _____

City: _____ Country: _____

Date (year/month/day): 20 __ __/ __ __/ __ __ Time interview started: __ __ : __ __

Gender: □ Male □ Female □ Transgender How old are you? __ __ years

In the last 6 months, have you exchanged sex for money, shelter, or protection? □ Yes □ No

Do you have sex with □ Men, □ Women, or □ Both?

How long have you been coming to this facility/organization for services?

□ Less than one month (including first visit) □ 1–6 months

□ 7–12 months □ More than one year

III.	Government/community partnerships and engagement of key populations in decisionmaking
A.	**Left blank to align with PWID DM**
B.	**Have you ever been a part of discussions with government agencies about government policies and programs related to services for MSM/TG/SW?**
1.	□ No (please describe barriers to participation)
2.	□ Yes (please describe)

V.	Consent for testing and treatment
A.	**Describe the information that was given to you about the services at this facility and the choice you made regarding accessing those services** (check all that apply)
1.	□ I felt fully informed about the risks and benefits of the services
	a. This information was given □ verbally, □ in writing
2.	□ I was given the ability to decide to accept or decline the services voluntarily
3.	□ I was informed that I had the ability to refuse or withdraw from treatment at any time
4.	□ I didn't understand or receive information about the services at this facility
5.	□ I felt forced to accept or decline the services at this facility
6.	Notes:

VIII.	Stigma and discrimination
A-C.	**Left blank to align with PWID DM**
D.	**Have you ever been denied any of the following services because someone assumed or knew that you were an MSM/TG/SW?**
1.	□ HIV counseling and testing (if indicated, please describe)
2.	□ Medications to treat HIV (antiretroviral therapy) (if indicated, please describe)
3.	□ Hepatitis testing or treatment services (if indicated, please describe)

4. □ Condoms and lubricant (if indicated, please describe)
5. □ STI testing or treatment services (if indicated, please describe)
6. □ HIV prevention information (if indicated, please describe)
7. □ Alcohol treatment services (if indicated, please describe)
8. □ Reproductive health/family planning (if indicated, please describe)
E. **Have you ever been denied any of the following services because you did not have the correct residency documentation?**
1. □ HIV counseling and testing (if indicated, please describe)
2. □ Medications to treat HIV (antiretroviral therapy) (if indicated, please describe)
3. □ Hepatitis testing or treatment services (if indicated, please describe)
4. □ STI testing or treatment services (if indicated, please describe)
5. □ Alcohol treatment services (if indicated, please describe)
6. □ Reproductive health / family planning (if indicated, please describe)
F. **Are there traditional teachings or policies (religious/cultural) about human sexuality or gender that create a barrier for you when seeking services?**
1. □ No 2. □ Yes (please describe)

X. Criminal/administrative law

A. **Left blank to align with PWID DM**

B. **How would you describe sex work?**

Check all that apply

1. □ Sex work is a legitimate occupation
2. □ Sex work is a criminal activity
3. □ Sex work is socially unacceptable

4. □ other_____

C. **How would you describe homosexuality?**

Check all that apply

1. □ Consensual same-sex behavior is a naturally occurring, normal expression of sexual behavior
2. □ Consensual same-sex behavior is deviant or criminal
3. □ Consensual same-sex behavior is an illness

4. □ Other_____

D. **How would you describe individuals who don't conform to gender norms, such as individuals who dress or assume the sexual or cultural role of a member of the opposite sex?**

Check all that apply

1. □ The expression of gender is based on an individual's internal experience and may not correspond with the sex assigned at birth
2. □ Gender nonconformity is deviant or criminal
3. □ Gender nonconformity is an illness

4. □ Other_____

5. Notes (especially if more than one of the above is selected):

XII.	Cruel, inhuman, or degrading treatment or punishment
A.	**Do you feel that you have ever been treated in a way that was cruel, inhuman, or degrading in the healthcare sector?**
1.	□ No
2.	□ Yes (please describe)
B.	**Do you feel that you have ever been treated in a way that was cruel, inhuman, or degrading by the police or criminal justice system?**
1.	□ No
2.	□ Yes (please describe)

XIII.	Monitoring and enforcement of human and legal rights
A.	Has anyone ever talked with you about your legal rights?
1.	□ No
2.	□ Yes (please describe)
B.	**Has anyone ever talked with you about your legal rights?**
3.	□ No
4.	□ Yes (please describe)
C.	**Do you know where to go if you feel that your rights have been violated?**
1.	□ No
2.	□ Yes (please describe)

D.	**What might be the biggest barrier for you in filing a complaint if you feel your rights have been violated?**
1.	(Please describe)
E.	**Have you ever been asked or required to pay a police officer to keep from being arrested or receive more favorable treatment?**
1.	□ No
2.	□ Yes (please describe)

XIV. Medicine and medical commodity procurement and supply management

A.	**Have you ever been turned away from services because the facility had run out of medicine or supplies?**
1.	□ No
2.	□ Yes (please describe – include how recent/how often)
B.	**Have you ever had your medication changed or reduced because the facility had run out of medicine or supplies?**
1.	□ No
2.	□ Yes (please describe–include how recent/how often)

XV. Overall HIV, hepatitis, TB, drug treatment, and harm reduction intervention design

A. **Please indicate where you access the following services (circle all that apply)**

	Provided at this location	I got information from staff at this facility about where this service is provided	I had to find this service on my own	I have never accessed this service
1. HIV risk assessment/ screening	(a)	(b)	(c)	(d)
2. HIV testing that I requested	(a)	(b)	(c)	(d)
3. HIV testing that my doctor suggested	(a)	(b)	(c)	(d)

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4. ART	(a)	(b)	(c)	(d)
5. CD4/viral load testing	(a)	(b)	(c)	(d)
6. Testing for hepatitis A	(a)	(b)	(c)	(d)
7. Vaccination for hepatitis A	(a)	(b)	(c)	(d)
8. Treatment for hepatitis A infection	(a)	(b)	(c)	(d)
9. Testing for hepatitis B	(a)	(b)	(c)	(d)
10. Vaccination for hepatitis B	(a)	(b)	(c)	(d)
11. Treatment for hepatitis B infection	(a)	(b)	(c)	(d)
12. Testing for hepatitis C	(a)	(b)	(c)	(d)
13. Treatment for hepatitis C infection	(a)	(b)	(c)	(d)
14–20 Left blank to align with PWID DM				
21. Condom distribution	(a)	(b)	(c)	(d)
22. Lubricant distribution	(a)	(b)	(c)	(d)
23. STI screening	(a)	(b)	(c)	(d)
24. STI treatment	(a)	(b)	(c)	(d)
25. Information on HIV prevention	(a)	(b)	(c)	(d)
26. Alcohol harm reduction services	(a)	(b)	(c)	(d)
27. Family planning/ reproductive health services	(a)	(b)	(c)	(d)

B – G **left blank to align with PWID DM**
H. **Have you ever been told that you would not be able to access HIV, STI, or reproductive health/family planning services because you were or perceived to be an MSM/TG/SW?**
1. □ No 2. □ Yes (please describe)
I. **Are there any other reasons that you have been denied HIV, STI, or reproductive health/family planning services?**
1. □ No 2. □ Yes (please describe)
J. **Have you ever had to pay for medications or laboratory tests?**
1. □ No 2. □ Yes (please describe)
K. **FOR WOMEN—have you ever been denied HIV, STI, or reproductive health/family planning services because you were pregnant or breastfeeding?**
1. □ No 2. □ Yes (please describe)
L. **FOR WOMEN—have you ever been required to use contraception or family planning to receive HIV, STI, or reproductive health/family planning services?**
1. □ No 2. □ Yes (please describe)

XVI. HIV counseling and testing

A. **The last time you received an HIV test, which of the following do you remember the healthcare provider doing?** (check all that apply)

1. □ Talked to me about my potential risk for HIV
2. □ Explained what the HIV test was
3. □ Asked me if I wanted to have an HIV test
4. □ After the test results—explained to me what they meant
5. □ Gave me information about services that might be helpful to me
6. □ The healthcare provider didn't ask, he/she just did the test
7. □ I don't remember or I have not had an HIV test

XVII. ART

A. **Do you know of systems in the community to support individuals in taking their HIV medications on a regular basis?**

1. □ No
2. □ Yes (please describe)

XXII. Condoms and lubricant

A. **Do you believe that the condoms provided by the government are of good quality?**

1. □ Yes
2. □ No (please describe)

B. **Do you believe that the condoms provided from NGOs are of good quality?**

1. □ Yes
2. □ No (please describe)

C. **Have you ever not been able to get condoms and lubricant?**
1. □ Yes (please describe)
2. □ No

XXIII. STI	
A. **Please describe if you have ever discussed the following issues with a medical provider or had the medical screening suggested to you**	
1. The number of sexual partners of both sexes (Y/N/DK)	1.
2. The impact of alcohol on decisions I make about sex (Y/N/DK)	2.
3. The impact of other drugs on decisions I make about sex (Y/N/DK)	3.
4. The experience of physical and emotional violence (Y/N/DK)	4.
5. Examination and laboratory screening of the penis/vagina(Y/N/DK)	5.
6. Examination and laboratory screening of the mouth and throat (Y/N/DK)	6.
7. Examination and laboratory screening of the anus (Y/N/DK)	7.
8. Hepatitis A vaccination (Y/N/DK)	8.
9. Hepatitis B vaccination (Y/N/DK)	9.
10. Hepatitis C testing (Y/N/DK)	10.
11. Other (Y/N/DK)	11.
12. Other (Y/N/DK)	12.
13. Have ever requested, but been denied, any of these services? If yes, please describe and give your perception of the reason you were not able to access this/these services	

XXIV. IEC	
A. **Please indicate if you have ever received the following information**	
1. Risks and benefits of sexual abstinence (Y/N)	1.
2. Relative risks of insertive and receptive sexual activities (Y/N)	2.
3. Risks and benefits of non-penetrative sexual activities (Y/N)	3.
4. Relative risks of oral, anal, and vaginal sexual activities (Y/N)	4.
5. Risks and benefits of reducing the number of sexual partners (Y/N)	5.
6. Risks and benefits of condom use (Y/N)	6.
7. Risks and benefits of sero-sorting and sero-positioning (Y/N)	7.
8. Risks and benefits of suppressive HIV therapy (Y/N)	8.
9. Impact of alcohol use on sexual risk behavior (Y/N)	9.
10. Impact of alcohol use on gender-based violence (Y/N)	10.
11. Impact of substance use on gender-based violence (Y/N)	11.
12. Impact of mental health on sexual risk behavior (Y/N)	12.
13. Impact of mental health on gender-based violence (Y/N)	13.
14. Information on where to access HIV services (Y/N)	14.
15. Information on where to access STI services (Y/N)	15.
16. Information on where to access SRHR services (Y/N)	16.
17. Information on where to access alcohol harm reduction services (Y/N)	17.
18. Information on where to access substance abuse harm reduction services (Y/N)	18.
19. Information on where to access mental health services (Y/N)	19.
20. Other	20.
21. Other	21.
22. Other	22.
23. Have ever requested, but been denied, any of this information? If yes, please describe and give your perception of the reason you were not able to access this information	

XXV. Outreach	
A. **Has anyone ever given you information about HIV, STI, or family planning in the following venues?**	
1. Places where I socialize (Y/N)	1.
2. In places like drop-in centers or mobile clinics (Y/N)	2.
3. Other	3.
4. Other	4.
5. Other	5.
B. **Have any of the following individuals ever given you information about HIV, STI, or family planning/reproductive health?**	
1. Someone that I recognize as a member of my community (Y/N)	1.
2. Owners of the establishments that I frequent (Y/N)	2.
3. Police officers (Y/N)	3.
4. Other	4.
5. Other	5.
6. Other	6.
7. Are there venues or individuals that you trust that you feel would be effective in giving you information about HIV, STI, or family planning/reproductive health? If so, please describe.	

XXVI. Alcohol and Substance Use Harm Reduction	
A. **Have you ever received any of the following information?**	
1. Information about how alcohol can impact decisions I make about the behaviors that may put me at risk for HIV (Y/N)	1.
2. Information about how alcohol may impact the health of someone who is HIV positive (Y/N)	2.
3. Information about how substance use can impact decisions I make about the behaviors that may put me at risk for HIV (Y/N)	3.
4. Information about how substance use may impact the health of someone who is HIV positive (Y/N)	4.
5. Other	5.
6. Other	6.
7. Is there information about alcohol use that you would like to receive that you have not been able to access? If yes, please describe.	

XXVII. Family planning/reproductive health services (for organizations/facilities providing this service)	
A. **Have you ever received any of the following information?**	
1. Information on the importance of condom use along with or in addition to other family planning methods (Y/N)	1.
2. Information on the use of emergency contraception (Y/N)	2.
3. Counseling on legal options to terminate pregnancy (Y/N)	3.
4. Other	4.
5. Other	5.
6. Other	6.

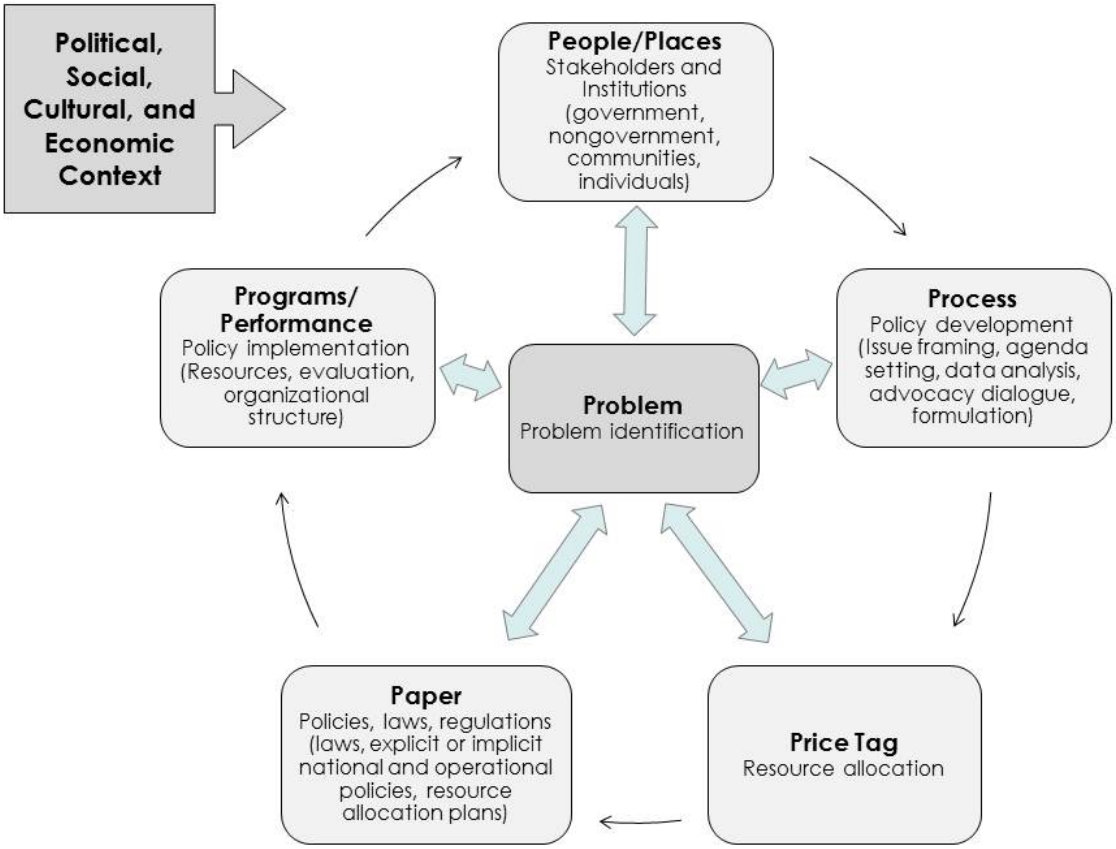
7. Is there information about family planning/reproductive health that you would like to receive that you have not been able to access? If yes, please describe.

Those are all the questions I have. Before we finish, is there anything you would like to tell me about the services here, such as what could be done to make the services better or what you especially like about your treatment here?

Policy Advocacy Planning Worksheets

Lessons learned from the field of policy advocacy have identified the importance of developing a coordinated, strategic, evidence-based advocacy strategy. This should be a strategy that has clear goals and objectives, addresses the needs of stakeholders, and is informed by a country's social, political, and economic contexts.

The following collection of worksheets is presented as a simple tool to help develop an advocacy strategy within the Policy Circle framework to incrementally increase access to services for MSM/TG/SW.



These worksheets are a highly summarized outline for developing an advocacy strategy. More in-depth information can be found in the following source documents.

Leading Voices in Securing Reproductive Health Supplies: An Advocacy Guide and Toolkit.
www.rhsupplies.org/fileadmin/user_upload/toolkit/Advocacy_Guide_and_Toolkit.pdf

Networking for Policy Change: An Advocacy Training Manual.
www.policyproject.com/pubs/advocacymanual.cfm

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People/Places: Stakeholder Engagement

Advocacy Steering Committee/Initiative Group of Stakeholders

The first step in policy advocacy will be to form or identify an advocacy committee or initiative group. Strategic engagement of stakeholders is critical to informing the design of an advocacy strategy. Look for individuals or organizations that have experience in policy development, advocacy, monitoring, and implementation; understand the contexts of those individuals marginalized because of criminalized identity, orientation, or behavior; and are providers and clients of services for MSM/TG/SW.

Composition of this committee/initiative group must strike a balance between a broad inclusion of stakeholders, including those resistant to some services, and establishment of a functional advisory body. While it is important to incorporate a range of expertise and opinion, try to include individuals who can work together constructively. Consider the different skills of individuals who design and implement policies; advocate for policy reform; and come from government agencies, nongovernmental groups, civil society, and international donors. Also consider the point at which law enforcement will be involved.

A decision also needs to be made on the role of the advocacy committee. Will the committee be convened simply to help develop an advocacy strategy or will it be involved more in implementation?

A decision will also need to be made on how—and if—other planning processes and groups are informed of the activities related to the policy advocacy agenda. For example, will it be beneficial to keep the CCM/National AIDS Committee informed, or would such a body try to block advocacy activities?

Keep this group at a reasonable size (12–15 maximum) and make sure that individuals who agree to participate have a clear understanding of the expectations for their roles and the time and resources that participation may require.

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MSM/TG/SW Services Advocacy Committee Composition Worksheet

This worksheet is used to analyze the composition of the advocacy committee. It is helpful to get a picture of the range of experience and perspective of the committee. The goal is to have the participation of representatives with a broad range of experience and perspectives on policy analysis and advocacy. (POLICY Project, 1999; Brinkerhoff & Crosby, 2002)

Expand the tool as necessary.

Name of individual and the organization/group they represent	Identify reason or nature of group's/ individual's interest in services for MSM/TG/SW	Indicate the level of knowledge about services for MSM/TG/SW *(Enter low, medium, or high)*	Identify specific resources that the individual or group brings to advocacy efforts *(Resources include staff and volunteers, financial, technology, information, legal skills, religious/moral influence, etc.)*	Estimate how easily the individual or group can mobilize advocates *(Enter low, medium, or high)*	**Position on services for MSM/TG/SW** (Enter one rating only. If you do not know, enter DK for "Don't Know.")		
					Support *+3 Very strong support* *+2 Moderate support* *+1 Weak support*	**Neutral** *Enter 0*	**Oppose** *-3 Very strong opposition* *-2 Moderate opposition* *-1 Weak opposition*
Government Sector							
Political Sector							

Name of individual and the organization/group they represent	Identify reason or nature of group's/ individual's interest in services for MSM/TG/SW	Indicate the level of knowledge about services for MSM/TG/SW *(Enter low, medium, or high)*	Identify specific resources that the individual or group brings to advocacy efforts *(Resources include staff and volunteers, financial, technology, information, legal skills, religious/moral influence, etc.)*	Estimate how easily the individual or group can mobilize advocates *(Enter low, medium, or high)*	**Position on services for MSM/TG/SW** (Enter one rating only. If you do not know, enter DK for "Don't Know.")		
					Support *+3 Very strong support* *+2 Moderate support* *+1 Weak support*	**Neutral** *Enter 0*	**Oppose** *-3 Very strong opposition* *-2 Moderate opposition* *-1 Weak opposition*
Commercial/Private Sector							
Nongovernment Sector (NGOs, CSOs, etc.)							
International Donors							

Political, Social, Cultural, and Economic Contexts

It will be important for the steering committee to agree on a common understanding of the general context and issues affecting the provision of services for MSM/TG/SW and the specific context for the problems identified. Given the dynamic nature of policy related to these populations, this information should be assessed against current realities and will come from sources such as existing assessments, key informants, and official documents. In addition to the laws, policies, and regulations identified from the policy inventory, summarize the following:

- Epidemiological data specific to HIV among MSM/TG/SW;
- Demand for services (official estimates, information from advocates, clients, providers); determine whether there is a difference in these estimates and, if so, why;
- Current state of services (primary providers, methods, coverage, quality, barriers to access); and
- Donor and government financing of programs for MSM/TG/SW.

Much of this information may seem obvious to local advocates, but documenting a common understanding will help in identifying positive and negative factors affecting access, assessing strategic alternatives, and crafting advocacy strategies to address barriers to access.

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Political, Social, Cultural, and Economic Contexts Worksheet

Country/Jurisdiction:

Epidemiological data on HIV (e.g., estimate number of MSM/TG/SW, estimate HIV prevalence among MSM/TG/SW, types of HIV-risk behaviors):

Demand for services for MSM/TG/SW:

Current state of services for MSM/TG/SW (providers, methods, coverage, quality, barriers to access):

Donor and government financing of MSM/TG/SW services:

Policymaking Process

A critical element in the success of any advocacy effort is a thorough understanding of the policy process. In-depth knowledge of the policy environment can help advocates identify and recognize advocacy opportunities and critical points of entry, so as to both influence the policy process and guide the selection of advocacy issues.

In many countries, government and political leaders remain skeptical, if not fearful, of NGOs and other representatives of civil society participating in the policy arena. There is a common perception among policymakers that civil society lacks the experience, skills, and knowledge required for policy analysis and formulation. This perception can lead to a reluctance or refusal to listen to or collaborate with networks in their advocacy efforts. Consequently, it is vital that advocates demonstrate a clear and accurate understanding of the process followed and the players involved in making policy decisions.

In addition, advocates should monitor the political, economic, sociocultural, and technological environment to keep abreast of emerging issues and the positions of government. Opportunities to influence policy and policymakers can arise or disappear at any time.

The advocacy committee should answer the following questions:

Issue Framing

1. How can we frame our problem/solution so it becomes a priority for policymakers to address?

2. How can the problem be framed to guide the terms of the policy debate in the direction that we want?

Agenda Setting

1. How are ideas or issues generated for new or revised policies?

2. How is a proposed issue introduced into the formal decisionmaking process?

3. Can the problem/solution be introduced at different levels of policymaking to increase pressure to address the issue?

Policy Formulation

1. What is the process for discussing, debating, and perhaps altering the proposal? Who are the players involved?

2. How is the proposal approved or rejected?

3. If approved, what are the steps needed to move the proposal to the next level of decisionmaking?

4. Once the proposal is finalized, what are the implementation steps? Who are the players involved?

5. What is the process for identifying and addressing barriers or challenges to implementation?

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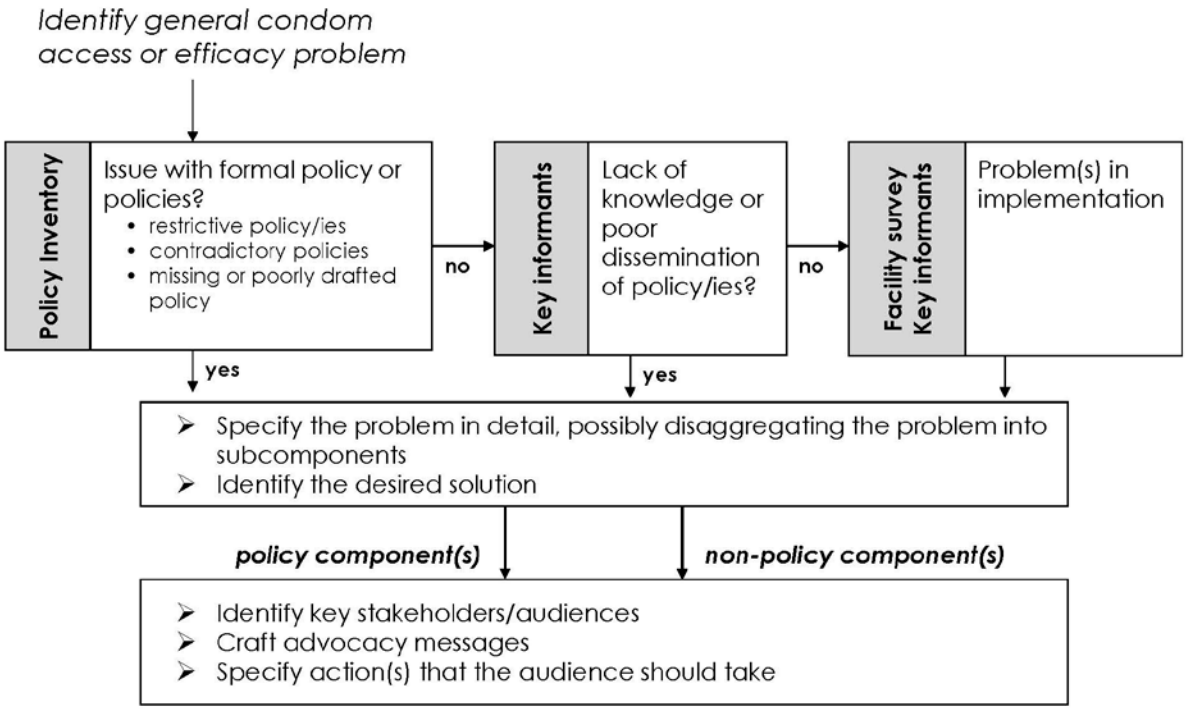
Advocacy Prioritization

There is no right or wrong way to prioritize advocacy efforts. Of real importance is keeping in mind the ultimate goal of increasing access to high-quality services and coming to an agreement on an incremental strategy to achieve that goal.

The Policy/Advocacy Prioritization Worksheet provides an example format to identify each advocacy need, consolidate information that has been gathered about the context, and undertake a process to weigh and prioritize advocacy activities.

Through a participatory process, the advocacy steering committee/initiative group should summarize and agree on a common list of the policy issues under problem identification.



Using the information gathered from policy inventories; policy assessment indexes; the political, social, and economic contexts; and relevant information from the policy process, members of the steering committee can assign numeric values to columns A through E of the worksheet and total their scores in column F.

By definition, the scoring will be subjective, which is why a membership of broad and diverse experience on the steering committee will be valuable. Scores can then be collected and averaged for the group to determine a final prioritization; the issues with the highest scores in column F will be the top priority issues to address.

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Once the worksheet has been completed, it is important to assess whether it makes sense.

Consider the following:

- Which advocacy issues rank highest (column F)? Does it make sense to address these issues first? Is there a logical sequencing of advocacy that either confirms this ranking or requires prioritizing issues with a lower score?

- For advocacy issues that rank lower but are really important, consider breaking the issues into smaller incremental steps and score each step. Finally, revisit the issue priority-setting process regularly, especially if there is a significant change in political climate or resources available to implement policy advocacy.

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Problem Identification/Advocacy Prioritization Worksheet

Specific issue	What need to be changed?	A	B	C	D	E	F
List all barriers to MSM/TG/SW services	• Policy—good, bad, contradictory, nonexistent • Implementation of existing policy • Other	Potential that addressing this issue would improve access for MSM/TG/SW Scale of 10–1 *(strong–weak)*	Time needed to change Scale of 10–1 *(short–long)*	Financial and human resources required for change Scale of 10–1 *(low–high)*	Strength of opposition Scale of 10–1 (weak–strong)	Opportunities for engaging diverse coalitions Scale of 10–1 *(many/strong–few/weak)*	Priority ranking *(Add values of columns A, B, C, D, E and enter total)*

Use of International Law/Human Rights-Based Advocacy

In many cases, countries will have ratified international and/or regional human rights covenants or declarations. Depending on the status the individual country gives to these documents, advocates can use their language as a mechanism for advocacy (see analysis from question 13.m, p. 118 in the policy inventory). For example, consider the following:

Document	Relevance to Services for MSM/TG/SW
International Covenant on Civil and Political Rights (ICCPR)	Examples of violations: arbitrary detention, due process violations, discrimination, forced labor, breaches of privacy, and other civil and political rights.
International Covenant on Economic, Social and Cultural Rights (ICESCR)	Examples of violations: denial of antiretroviral drugs or refusal to provide substitution therapy could fall under this committee's mandate. This is a major resource for advocates because of the attention this committee has devoted to the right to the highest attainable standard of health.
Convention Against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment (CAT)	Source for content related to torture, cruel, inhuman, or degrading treatment or punishment.
Convention on the Elimination of All Forms of Racial Discrimination (CERD) Convention on the Elimination of All Forms of Discrimination Against Women (CEDAW) Convention on the Rights of the Child (CRC)	All three conventions are relevant if a policy has a discriminatory effect or disproportionate impact on women, children, or particular racial groups.
Source: *A Brief Guide to the United Nations Human Rights System*, Harm Reduction International http://www.ihra.net/files/2011/03/29/A_brief_guide_to_the_UN_human_rights_system.pdf	

Target Audience Identification

For each prioritized advocacy issue, there will be essential audiences to target with advocacy messages. Target audiences include decisionmakers and individuals or mechanisms that influence decisionmakers. Consider identifying political leaders, legislators, officials of national and/or local government agencies, donors, national/local media, religious and traditional leaders, civic and nonprofit organizations, and groups representing current and potential users of services for MSM/TG/SW.

As they are identified, document important information about each audience. This information will help to inform advocacy messages and strategies.

- *Level of knowledge of services for MSM/TG/SW.* Is the audience well informed or does it lack accurate information? What are the sources of information the audience uses for learning about MSM/TG/SW services?

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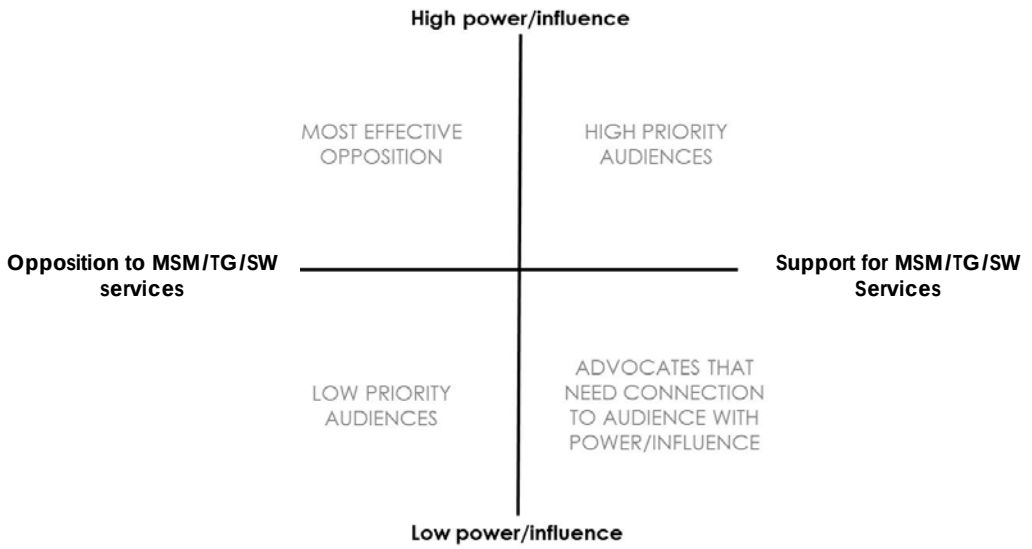
- *Level of demonstrated support for services for MSM/TG/SW.* Has the audience actively and/or publicly supported MSM/TG/SW services? Describe examples.
- *Level of demonstrated opposition toward services for MSM/TG/SW.* Has the audience actively and/or publicly opposed MSM/TG/SW services? Describe the reasons given for such opposition.
- *Undecided or unknown.* Has the audience failed to declare its position on services for MSM/TG/SW? What are the issues that remain unanswered?
- *Potential benefits to the audience.* How might the audience benefit on a personal, professional, or political level from supporting access to services for MSM/TG/SW?
- *Potential threats to the audience.* How might the audience's personal, professional, or political position be threatened?
- *Find shared values.* Is there a "we" message possible? Might there be a way to frame the issue, drawing on the values important to both the audience and advocates for MSM/TG/SW?

As an exhaustive list of audiences is compiled, time and resources may require identifying priority audiences. Which ones are most critical to accomplishing the advocacy outcome identified? Consider the following:

- Audiences' influence on decisionmaking
- The relative "distance" they need to be moved to become advocates
- The strength of the benefit and shared value between MSM/TG/SW advocates and the audience
- The cost and time required to gain their support

It can be helpful to place audiences on a chart and draw lines between audiences linked with each other.



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Target Audience Identification Worksheet

Prioritized advocacy issue:

Final outcome desired:

Audience: **Role:** (direct decisionmaker or influencer of decisionmaker—*if influencer*, identify decisionmaker and relationship between decisionmaker and audience)			
Level of knowledge/ source of information on services for MSM/TG/SW	Support/opposition/ unknown	Benefit/danger to audience for supporting services for MSM/TG/SW	Shared value between MSM/TG/SW advocates and audience

Audience: **Role:** (direct decisionmaker or influencer of decisionmaker—*if influencer*, identify decisionmaker and relationship between decisionmaker and audience)			
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Audience: **Role:** (direct decisionmaker or influencer of decisionmaker—*if influencer*, identify decisionmaker and relationship between decisionmaker and audience)			
Level of knowledge/ source of information on services for MSM/TG/SW	Support/opposition/ unknown	Benefit/danger to audience for supporting services for MSM/TG/SW	Shared value between MSM/TG/SW advocates and audience

Add additional audience assessments as necessary.
Repeat for each priority advocacy issue.

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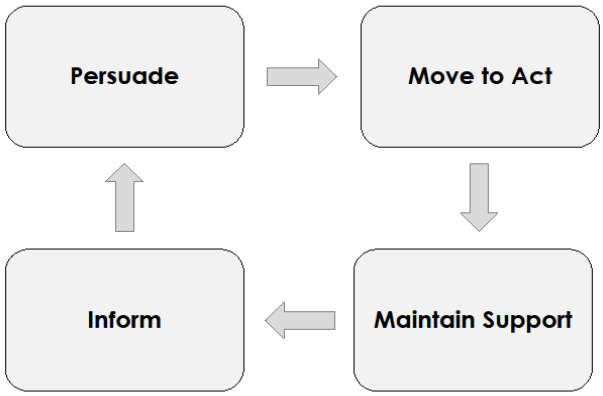
Stakeholder Mapping

As audiences are identified, carefully match the audience with stakeholder(s) that have credibility with that particular audience and message(s) that resonate with the audience's concerns.

To move an audience to action, stakeholders need information to develop a thorough understanding of the issue, the position of the audience, and the desired advocacy action. Once an audience is informed, the advocacy strategy seeks to persuade the audience to feel strongly about the issue, adopt the desired position, and move to action.



Successful Messages

Each message must inform the audience, persuade the audience to feel strongly about the issue, persuade it to adopt the desired position, and, finally, persuade it to move to action. For each message developed, ask if it is tailored to the specific audience to accomplish these tasks (inform, persuade, move, maintain). Consider the following:

1. Have all of the key audiences been covered by a credible stakeholder and advocacy message? Have contextual issues been addressed or incorporated?

2. Are advocacy goals clear and attainable?

3. What is the timeline for achieving each advocacy goal? Are there specific events or processes that need to be taken into consideration when considering timelines (elections, parliamentary processes, holidays, opposition advocacy campaigns, etc.)?

4. How will achieving the listed advocacy goals move the group to its final advocacy outcome? (Clarify or describe the outcome.)

5. After these goals are achieved, what are the next steps?

Now that you have a basic advocacy strategy in place, make sure that individuals know their responsibilities and timelines; create a process for feedback, reporting, and adjusting the process based on successes or challenges; keep track of each incremental step; and keep planning for future advocacy.

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Annex: Components of Functioning Legislation

Note: The following content was provided by Lane Porter (Reshevska, Foreit, Beardsley, & Porter, 2010), and is based on WHO guidelines for assessing legislation for services for PWID (WHO, 1987), (WHO, 1999a).

Orientation

Legislation for MSM/TG/SW services should include the following components (some of which have been consolidated in this example):

1. Statement of purpose—what the law is to accomplish;
2. Designation of agency—responsibility for program;
3. Coverage and client eligibility—who is eligible for services;
4. Budget—how the program is funded;
5. Operations—an adequate structure for operation of programs;
6. Accountability and evaluation—proper system of accountability and evaluation;
7. Delegation of regulatory powers—identification of agency or agencies to carry out day-to-day operations;
8. Human rights—fulfillment of civil, economic, social, and cultural rights protects the individual and advances achievement of program goals; and
9. Reconciliation of legislative provisions—new or revised legislation provides for amendments, revision, or repeal of provisions necessary to reconcile them to new law provisions.

These components are needed whether the legislation is broad reaching or addresses a narrower, specialized aspect of SRHR, HIV, or STI. Obviously, the text will vary according to the purpose of the legislation and the country context.

Legislative Components

Component 1: Statement of Purpose

A statement of purpose in legislation should include the following: (a) an indication of the problems that the legislation seeks to remedy and (b) the main purposes of the legislation. It forms the basis of efforts to win support from interested groups and thus ensures that the proposed legislation becomes law.

It should immediately be clear what the law is supposed to accomplish—improve health by means of a human rights-based approach, focusing on the provision of high-quality services designed to improve physical and mental health. The words “availability” and “accessibility,” in addition to their common-sense usage, carry special legal significance: they are terms used in the International Covenant on Economic, Social and Cultural Rights. One of the fundamental obligations included in this Covenant is

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the "right to health." Using "availability" and "accessibility" in the statement of purpose of the new law creates several advantages for advocates and stakeholders. The government of a country can point to this provision in its required periodic reports to the Committee on Economic, Social and Cultural Rights to demonstrate the country's progress in fulfilling its obligations under the treaty. Advocates can point to these provisions when holding to account those obligated to achieve the legislative purpose.

Component 2: Designation of Agency Responsible for Treatment Program

It is essential that the legislation designate the agency or agencies responsible for carrying out the program. The country will select the agency most appropriate to oversee the program, such as the Ministry of Health. The designated agency should be identified in the legislation itself. The agency should be directed in the legislation to coordinate the comprehensive program of treatment, rehabilitation, community and patient education, and epidemiological and other scientific research outlined in the preamble or statement of purpose. Whatever agency is selected, the aim should be to centralize the leadership of the program and ensure effective coordination of treatment services.

Legislation in a number of countries establishes national coordinating bodies or boards responsible for advice or policymaking in connection with HIV, STI, or SHRH. These entities can be effective in bringing together the different stakeholder sectors to find common ground and mutual benefit. The legislation establishing these bodies serves to establish the duties and powers, both of which should be spelled out clearly.

Legislation that fails to assign responsibility clearly to a particular agency creates a barrier to effective programs. Effective programs require services from different sectors, including social services, data collection and reporting, and education and training. The legislation should direct the designated authority to coordinate all of the services activities, consistent with the protection of rights set out in the statement of purpose.

Component 3: Coverage and Client Eligibility

Coverage means that services are permitted and funded under the legislation. Client eligibility refers to minimum requirements necessary to receive services.

Component 4: Budget

The legislation should set out a budgetary policy and provision of continuing fiscal support for the mandate.

One of the identified barriers for HIV, STI, and SRHR is a failure of the legislation (and other policy documents) to provide sufficient funds from government sources on a sustained basis. Financing provided by the Global Fund or other international donors does not provide the financial stability for the range of services needed for successful programs. Provisions that specify that "statutory funds" shall be used for prevention, treatment, and harm reduction activities suggest that public funds will be made available. However, advocates need to understand how health funds are raised and allocated in a country to be sure that appropriate financing is designated for services, which may mean examining other legislation or policies that direct allocation and disbursement of funds.

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Component 5: Operations

Legislation should set out a structure for program operations that administrators can follow and implement. Operational details should not be specified in the primary legislation but rather in regulations or other subsidiary legislation (see delegation of regulatory powers below).

Other operational aspects of programs should be covered in legislation, including the following:

- *Research, training, and education.* Legislation should provide for central planning (and financing to the extent determined) for research on HIV, STI, and SRHR and for the education and training of qualified personnel.

- *Minimum standards for staffing and resources.* Provision should be made for the establishment of a policy that sets out minimum standards (in such detail as may be deemed necessary and desirable) for program staffing and resources, including regulation of professional competence and adequacy of facilities.

- *Regulation of methods and procedures.* Provision should be made for the establishment of a policy for regulating the methods and procedures used in the program, including clear legislative definitions of persons eligible.

Legislation and national policies often are out of date and lag well behind health and technical scientific advances and guidance developed by researchers, investigators, and others working on HIV, STI, and SRHR. Community advocates seeking to strengthen legislation, national policies/strategies, regulations, guidelines, protocols, and operational programs should ensure that they take into consideration the latest science-based guidance.

Through its Technical Report Series, WHO makes available the findings of various international groups of experts that provide the latest scientific and technical advice on a broad range of medical and public health subjects.

Component 6: Accountability and Evaluation

The legislation should include a proper system of accountability and evaluation, which should be established in the basic law or implementing regulations.

Component 7: Delegation of Regulatory Powers

Legislation alone cannot make things happen. To implement legislative policy; apply technical detail to the program; and adjust operations to respond to changing conditions, scientific advances, and other inevitable trends, there also must be administrative regulations, decrees, or other legal instruments. The legislation must delegate specific authority to a specific administrative agency to adopt regulations in the area under consideration at that time.

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Component 8: Human Rights: The Fulfillment of Civil, Economic, Social, and Cultural Rights Protects the Individual and Advances Achievement of Treatment Goals

MSM/TG/SW have equal rights with other people and should not face discrimination. Legislation should make provision for equitable, non-discriminatory access to services. Protection of these rights is found, variously, in State constitutions and international and regional human rights treaties, such as the International Covenant on Economic, Social and Cultural Rights.

Component 9: Amending, Aligning of Laws

When planning for legislative changes to HIV, STI, and SRHR services, it essential to assess the potential impact on all sectors of such changes to existing laws and policies. A critical role in conducting an inventory is to identify other laws or policies that will need to be amended or deleted to ensure that new laws do not conflict with other laws. Refer to the policy inventory in this document to identify the full range of sectors.

Conclusion

Examination of existing legislation, gaps, and conflicts is an essential task for policy advocates. Advocates should seek out lawyers in local communities willing to give advice on laws already in the statute books. Attention to the legal basis for services should be given early priority in the design of HIV, STI, and SRHR services—and not relegated to a peripheral or optional concern.

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