Gender power analysis report for the project, “Stop TB and AIDS through RRTTR” (STAR 2)

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Disclaimer

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TABLE OF CONTENT

Contents

ABBREVIATIONS 4

EXECUTIVE SUMMARY 5

BACKGROUND 9

RESEARCH FRAMEWORK 9

METHODOLOGY 11

- Research methods 11
- Sites of data collection 11
- Recruitment strategy 12
- Research team 13
- Ethical principles 14
- Research limitations 14

FINDINGS 15

- Area of inquiry 1: Sexual/gendered division of labour 15
- Area of inquiry 2: Decision-making in intimate relationships 16
- Area of inquiry 3: Perceptions toward gender-based violence (GBV), gender and sexual identity 17
- Area of inquiry 4: Control over one's body 18
- Area of inquiry 5: Violence and restorative justice 19
- Area of inquiry 6: Access to public spaces and services 22
- Area of inquiry 7: Aspirations for oneself 22

RECOMMENDATIONS 23

- Overall recommendations about program approaches 23
- Recommendations at individual agency level 23
- Recommendations at relational level 25
- Recommendations at structural level 26

ANNEX 1: RESEARCH METHODOLOGY MATRIX 28

ANNEX 2: FIELD GUIDE FOR THE GENDER POWER ANALYSIS 30

REFERENCES 53

ABBREVIATIONS

Design, Monitoring, Evaluation & Learning	DMEL
Focus group discussion	FGD
Gender-based violence	GBV
Gender power analysis	GPA
In-depth-interview	IDI
Men who have sex with men	MSM
Migrant workers	MW
Pre-exposure prophylaxis	PrPE
Prevention from sexual harassment, exploitation and abuse	PSHEA
Retain, Recruit, Test, Treat, Retain	RRTTR
Transgender people	TG
Tuberculosis	TB

EXECUTIVE SUMMARY

Raks Thai, as Principal Recipient of the Global Fund for the STAR-2 program (2018-2020), conducted a gender power analysis (GPA) with the purpose of gaining a deeper understanding about gender barriers, including those surrounding GBV that may prevent key populations (e.g. men who have sex with men (MSM), transgender women (TG) and migrant workers (MW)) from accessing HIV/TB services. Specific objectives of the GPA are to:

1. understand how gender inequalities affect key populations to access services
2. understand how key populations have negotiated social norms, power and identity with key stakeholders when accessing services
3. provide data to inform the development of a gender action plan which will strengthen gender equality results of existing interventions and inform the design of the new funding allocation cycle.

The research framework and questions were designed based on the CARE International Good Practices Framework on Gender Analysis. The GPA collected and analysed both secondary and primary data. Primary data was collected using qualitative methods in seven provinces: Phitsanulok, Chiang Mai, Rayong, Chonburi, Samut Sakhon, Nakorn Si Thammarat and Song Kla. In total, the research reached 101 participants (44 male and 57 female) who were key populations, service providers and NGO staff including some with diverse genders or sexual identities.

This research followed standard ethical principles including voluntary participation, informed consent, confidentiality, privacy, the right to skip questions or to stop at any time during the research and to refuse to participate in this research without bearing any consequences.

KEY FINDINGS AND RECOMMENDATIONS

Overall recommendations about program approaches

Recommendation 1: For the current and future program interventions, Raks Thai and its local partners are recommended to apply social norm change approaches and tools such as Social Analysis and Action (SAA) and Social Norm Analysis Plot (SNAP) Framework.

Recommendation 2: To strengthen community health systems, the Community Score Card (CSC) approach, a two-way and ongoing participatory tool for feedback, planning, and improving services could be introduced in the next phase of the STAR program.

Recommendation 3: Raks Thai could consider strengthening alliance with LGBT groups to advocate for better recognition, implementation and protection of human rights including LGBT rights by formal institutions in health care and law enforcement institutions.

Findings and recommendations at individual agency level

Key findings: Key populations such as male and female migrant workers and transgender women have upheld gendered social norms with regard to gender sexual roles and values in intimate relationships. Consequently, women have little time to take care of themselves and refrain from talking about sexual pleasure, safe sex and condom use. They were expected to accept violence, including meeting the sexual demands of their partners even when they did not want sex.

- Recommendation 4 and 5: Program interventions could facilitate discussions among key populations to challenge gendered social norms: 1) the perception of femininity and beauty among transgender women; 2) the perception of migrant men about women's role and values in intimate relationship; 3) the perception about masculinity and GBV among MSM.

Key findings: The vulnerability to GBV among MSMs was due to a power imbalance between age groups and also lack of power to negotiate with employers who, in some cases, were perpetrators as well. Some MSM experienced violence due to multiple identity and structural inequalities such as social norms and expectations about men and masculinity.

- Recommendation 6: Facilitate reflection among MSM to explore the social construction of masculinity from perspectives of intersectionality and fluidity of gender and sexuality. Discussions can include the following topics: the differences between sexual orientation, identity and behaviours, why some sexual orientations and identities are stigmatised by the binary heterosexual lens of masculinity and femininity.

Key findings: The perception of masculinity among MSM has found to be influential on the level of responding to GBV incidence and the decision to seek support. In this research, a MSM student denied the fact that he faced violence because of the social belief that men could not be raped. If he reported this incident, he might not be considered a man.

- Recommendation 7: Facilitate reflection among MSM to challenge perceptions of masculinity with regard to GBV which will help MSM to recognise that not all men are in positions of power. Men with multiple risk behaviours and identities can be vulnerable to GBV. When MSM deny the fact that they can be vulnerable to violence, they will feel reluctant to report violence experience or delay seeking support services.

Key findings: A small number of migrant men and women shared that they were aware about safe and consent sex and wanted to wear condoms for HIV/STI infection. Yet, both men and women did not feel comfortable to talk about sensitive topics.

- Recommendation 8: Migrant men and women need support to strengthen their communication skills so they will feel more comfortable to talk about sexual desire and expectations during their sexual relationship. It will help them find it easier to negotiate whether or not and when they want to have sex and use condoms.

Key findings: Most migrant workers and employers were not aware of which organisations provided GBV services. Neither did they know about the referral system and relevant policies on GBV prevention and response.

- Recommendation 9: Migrant workers need to access more information about their rights, the right to live free from violence, the right to receive information about GBV services, the right to access health and support services. Migrant workers, particularly women, need to access more information about HIV/TB prevention and treatment services.

Key findings: Transgender women experienced various forms of violence, both from family members and people in the public. Violence and discrimination were contributing factors to low access to HIV/TB information, treatment and support services.

- Recommendation 10: Provide a safe space for transgender women to learn more about GBV and how to access information about GBV services and to create supportive networks and opportunities to support each other to heal.

Key findings: Health service providers in public hospitals had experience in providing HIV/TB services but still held biases and were judgemental towards people with diverse gender and sexual identities. For example, many heath staff perceived MSM and transgender as those who were easy to sex.

- Recommendation 11: Health service providers need training on gender and sexuality, particularly about diverse gender and sexual identity, the difference between sexual orientation and behaviours. They need to gain skills about how to provide quality HIV/TB services in response to specific needs of each individual, not according to the gender of clients, based on their appearance.

Key findings: Health service providers and staff working in NGO drop-in centres had a limited understanding of GBV and lack of skills in assessing GBV incident among clients. Most of them had not received appropriate training in providing quality GBV services.

- Recommendation 12: Build the GBV capacity of staff of Raks Thai, its local partners and health service providers to understand: forms of GBV; vulnerability of key populations to GBV; and underlying causes

of GBV. Staff need to strengthen their skills in providing GBV services according to internationally recognised standard operating procedures for gender-based violence prevention and response. [1]

Findings and recommendations at relational level

Key findings: Due to the privilege of being men in a patriarchal society and having legal identification documents to work in Thailand, men had more power than women in making decisions for family issues, including accessing to HIV/TB and GBV services.

- Recommendation 13: Facilitate discussions between migrant couples exploring gender sexual norms and each other's expectations, how they can build respectful relationships and a shared vision for a happy family or happy relationship, how they can develop and review action plans to share productive and reproductive responsibilities.
- Recommendation 14: Support migrant women access income generation opportunities so they can become economically independent and have more power to negotiate with husbands (or partners) about household work, condom usage or access to services.

Key findings: Employers of migrant workers must be accountable for ensuring the right to access to HIV/TB and GBV information and services of their employees. However, there is little engagement of this important stakeholder in this research as well as in current interventions of the STAR 2 program.

- Recommendation 15: Where possible, advocate to employers to provide information on HIV/TB services and GBV prevention to employees using the evidence that is available about the benefit of having a healthy and respectful workplace which will reduce the number of waste hours, increase productivity and the loyalty of employees.

Key findings: Transgender women and MSM experienced various forms of violence and discrimination, both from family members and by public people.

- Recommendation 16: Reduce stigma and discrimination within families and set up a network of family members of LGBT community. Family members can share their experience of accepting and providing support to sexual minority groups which could either be online (e.g. social networks) or off-line (clubs).

Key findings: Dormitory owners, mamas of entertainment establishments and law enforcement staff are powerful stakeholders. In some cases, they can be the ones who offer help to key populations. In other cases, they can use their power to be perpetrators against key populations who have almost no power to negotiate. Yet, their engagement in current interventions was limited.

- Recommendation 17: Engage dormitory supervisors in HIV interventions and continue strengthening the relationship with mamas from existing interventions.
- Recommendation 18: Engage law enforcement staff for more effective HIV prevention and response. There are many levels of engagement. Raks Thai and its partners can consider building relationships with police personnel, organising sensitisation workshops about gender, sexuality and GBV, or advocacy for LGBT rights by engaging police personnel who are openly gay.

Key findings: Migrant workers, particularly illegal migrants rely heavily on support from local NGOs. It is possible that some development workers might take the advantage of their power position to abuse migrant workers.

- Recommendation 19: All NGO staff, outreach and community workers should receive training on child protection (CP) and prevention of sexual harassment, exploitation and abuse (PSHEA). In order to continue the learning process, Raks Thai can consider organising quarterly or biannual events where project participants could share their experience in applying PSHEA policy from "do no harm" perspective and learning from changing gendered social norms when working with key populations.
- Recommendation 20: CARE International has just introduced guidance for creating and managing effective feedback and accountability mechanisms.[i] The guidance provides tools and practical

[1] For example, global GBV standard operating procedures for health sector to respond to GBV, access at https://www.humanitarianresponse.info/sites/www.humanitarianresponse.info/files/documents/files/SOP%20Final.pdf

examples that Raks Thai teams and partners can use and adapt to their specific context as they develop, implement and manage an effective feedback and accountability mechanisms.

Findings and recommendations at structural level

Key findings: Restrictive gendered social norms about masculinity and femininity are the underlying causes of social inequalities, discrimination and violence towards key populations. At the same time, men and women with diverse gender and sexual identities have upheld such norms as a way to feel 'safe' in intimate relationships or to live with their own circumstances (e.g. in the case of a young MSM person abused by a dormitory owner). Behaviour change will not be sustainable if program interventions will only focus on social norm change at individual level.

- Recommendation 21: Program to implement social norm change interventions and communication campaigns among target groups and the wider public to change social expectations with regarding to GBV, women's roles and values, women's beauty and sexuality. Social norm change will create an enabling environment where men and women of diverse gender and sexual identity will feel comfortable to talk about their body, sexual pleasure and consensual sex.

Key findings: The STAR 2 program and its future interventions aim to address gender equality and GBV among key populations to better achieve transformative change. In order to design, implement, monitor and evaluate transformative programs, we need to build a gender transformative organisation at the same time. This requires supportive leadership and adequate resources to ensure that policies and strategies are in place to promote and implement gender transformative changes.

- Recommendation 22: Improve institutional capacity of service sites of Raks Thai and its local partners to better prevent and respond to GBV:
    - developing and implementing institutional policies which support staff delivering GBV services, for example providing training on GBV, allocate budget and time for staff to participate in training and provide opportunities for staff to practice new skills and knowledge
    - review human resource policies and standards to include GBV skills and knowledge as minimum competencies to use in recruitment and annual performance reviews
    - map GBV referral services and set up a feedback mechanism to regularly update the quality of GBV services provided by institutions in the referral list
    - amend recording systems of Raks Thai and its local partners to be inclusive of people of diverse gender and sexual identity. For example, when a man partner of a TG comes for a service, they will have their own right to self-identify as MSM, gay, heterosexual or bisexual.

Key findings: The main barriers for migrant workers to access HIV/TB and GBV prevention and support services in public institutions included language and legal identification documents.

- Recommendation 23: Raks Thai and its local partners to advocate to the government to allocate more budget for interpretation services and for providing language training to migrant workers.

Key findings: There have not been official guidelines for health sector to provide GBV prevention and response services. The lack of official guidance can pose a structural challenge for Raks Thai, its local partners and similar institutions to provide or advocate for quality and ethical services across sectors.

- Recommendation 24: The Ministry of Public Health include GBV response within the minimum standards for community-based HIV services. Raks Thai and its partners can take this opportunity to advocate for including guidelines on GBV services based on internationally recognised standard operating procedures.

BACKGROUND

The STAR 2 program (Stop TB and AIDS through Retain, Recruit, Test, Treat, Retain - RRTTR) is funded by the Global Fund to fight AIDS, Tuberculosis and Malaria. It aims to accelerate and sustain an end to AIDS and Tuberculosis (TB) in Thailand by leveraging public-sector and civil-society partnerships to improve early and sustained access to diagnosis and treatment among key populations, e.g. men who have sex with men (MSM), transgender people (TG) [2] and migrant workers (MW).

Raks Thai, as Principal Recipient of the Global Fund for the STAR-2 program (2018-2020), implements activities targeting several key affected populations, and builds on the success of the previous STAR-1 (2015-2017) phase. Intervention strategies emphasize prevention and transmission of HIV among key populations by sustaining intensive behaviour change activities, appropriate use of prophylaxis and strategic use of anti-retroviral drugs. The key populations are particularly vulnerable to gender-based violence (GBV) and discrimination based on their immigration status and sexual and gender identities. Raks Thai has committed to undertake a gender power analysis (GPA) with the primary purpose of gaining a deeper understanding on gender barriers, including those surrounding GBV that may prevent key populations from accessing services. [3]

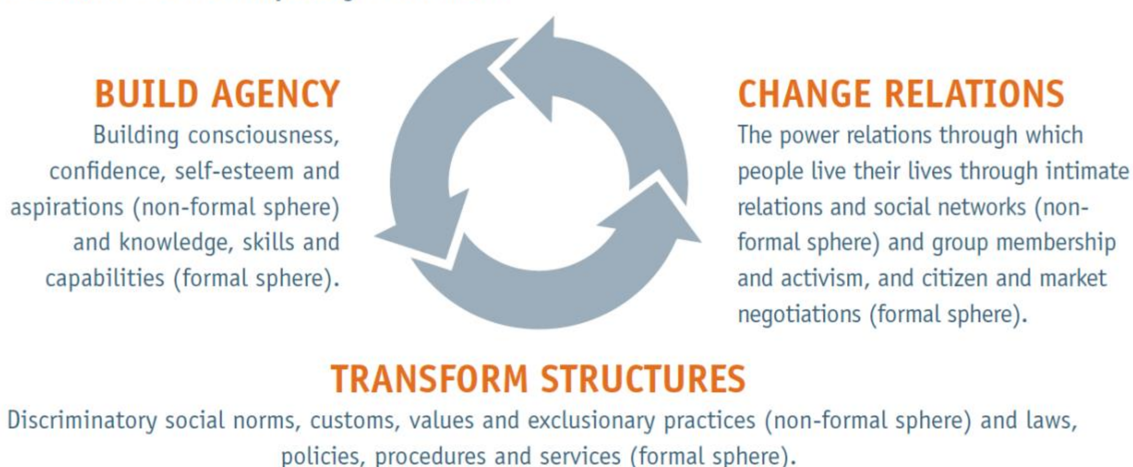
Specific objectives of the GPA are to:

1. understand how gender inequalities affect key populations to access services
2. understand how key populations have negotiated social norms, power and identity with key stakeholders when accessing services
3. provide data to inform the development of a gender action plan which will strengthen gender equality results of existing interventions and inform the design of the new funding allocation cycle.

RESEARCH FRAMEWORK

CARE's approach to gender transformative change recognises the importance of addressing power dynamics and structures that reinforce gendered inequalities. A gender-transformative approach to development goes beyond working on the symptoms of gender inequality to address the social norms, attitudes, behaviours, and social systems that underlie them. CARE's theory of change for achieving gender equality articulates three domains for action – agency, relations and structure. [ii]

Figure 1: CARE's Gender Equality Framework



[2] This research only targeted transgender women as they are more vulnerable to HIV/TB infection than transgender men

[3] Following the RRTTR approach, services in this GPA include behaviour change services, use of prophylaxis, ARV drugs, early and accurate diagnosis of HIV and TB disease.

Based on the CARE International Good Practices Framework on Gender Analysis[iii] and the research objectives, this gender power analysis will focus on the following areas of inquiry:

1. Sexual/gendered division of labour
2. Decision-making in intimate relationships
3. Perceptions toward gender-based violence (GBV), gender and sexual identities
4. Control over one's body
5. Violence and restorative justice
6. Access to public spaces and services
7. Aspirations for oneself.

Table 1: Main research questions

Areas of inquiry	Main research questions
1. Sexual/ gendered division of labour	• How do key populations (MSM, TG, female and male migrant workers) perceive their gender roles and value regarding household work and caring responsibilities?
	• How do social gender norms and roles (e.g. household work and caring responsibilities) affect key populations' access to services?
2. Decision-making in intimate relationships	• What are the differences in decision making power of key populations on day-to-day activities and access to services?
	• Which gender/sexual identity is likely to suffer violence resulting from conflicts in decision-making? Why?
	• How disagreement in decision making has affected key populations to access services?
3. Perceptions toward GBV, gender and sexual identities	• What are the perceptions of sex, love, beauty and trust among key populations?
	• What are the perceptions of GBV among key populations?
	• How have these perceptions affected key populations adopt safe behaviours and access to services? What else also affect their behaviours and access to services?
4. Control over one's body	• How do key populations negotiate safe and consensual sex? In which context and with whom?
	• What attitudes, information and skills do they need to negotiate safe and consensual sex?
5. Violence and restorative justice	• What have key populations done to prevent and respond to violence? What are their main strategies?
	• What attitudes, information, knowledge and skills will key populations need to prevent or address violence?
	• Which factors have also have an influence on GBV experienced by key populations? (e.g. gender sexual norms, family relationships, health and economic situation, power dynamics etc.)
	• How have relevant laws and institutions prevented and responded to GBV among key populations and their partners? (main institutions: social, justice and health services, NGOs and workplace)
6. Access to public spaces and services	• How do key populations access services? What are factors affecting their access to services (e.g. social perception about HIV/TB, sexual and gender identity, GBV experience, power relations with key actors such as police and employers)?

Areas of inquiry	Main research questions
	• Who (agencies or individuals) have most influence on this access, why (e.g. peers, partners, healthcare professionals, NGO staff, employers, law enforcement staff etc.)?
7. Aspirations for oneself	• What are aspirations that key populations articulate for themselves?
	• How do the aspirations for themselves reflect or contrast social gender norms?
	• How would key populations envision their relationships evolving (within the household level, in intimate relationships, within their community)?

METHODOLOGY

Research methods

The GPA uses both secondary and primary data. Secondary data is from existing project reports and research and includes:

- Gender analysis for key populations under STAR program (2017)
- Gender audit of the PHAMIT project
- Technical brief on HIV, Human rights and gender equality (The Global Fund 2017)
- Funding request application form – Full review (The Global Fund 2017)
- RRTTR Package of Service Guidelines for MSM, TG and migrant populations.

Primary data was collected using qualitative methods including focus group discussions (FGD), interviews and observation. Based on research questions and available data from relevant documents such as the gender analysis report in 2017 and the proposal of STAR 2, the lead researcher identified data gaps and designed tools to collect such data.

The research team met key populations (e.g. MSM, TG and migrant workers) and service providers who worked for public hospitals, community health centres, drop-in centres and mobile clinics of Raks Thai and its partners. Below is a summary of how each research method was used with each group of research participants during the field trip:

- Focus group discussions (FGDs) with MSM, TG women, female and male migrant workers.
- In-depth interviews with the following key informants:
  - Service providers and health service providers in public hospitals and community organisations
  - Community workers, outreach workers, staff and managers from local NGOs implementing the STAR 2 program
  - Key populations from diverse gender and sexual identity.
- Observation of service sites was conducted in two settings: 1) hospitals which have sexual health or HIV clinics and collaborate with the STAR-2 program in the research sites, and 2) the drop-in centres which are part of the network of the STAR-2 program.

Sites of data collection

The STAR 2 project team recognised the importance of providing more support to migrant workers who faced many barriers in accessing HIV/TB services while they already had extensive experience working with MSM and TG. Within the limited time and resources for this GPA, the project team decided to select three provinces to collect data about MSM and TG and four provinces to collect data about migrant workers from different nationalities. Each province has a large number of one key population, has its own local culture and way of life.

Table 2: List of research locations and institutions

Provinces	Raks Thai and local partners
1. Phitsanulok (Northern Central)	A local NGO which runs a drop-in centre and does outreach work to MSM.
	A public hospital which provides a range of services including HIV counselling and testing at the above drop in centre.
2. Chiang Mai (North)	A foundation working with migrant workers who are Thai Yai or Shan, an ethnic minority group of Myanmar.
3. Rayong (East)	A foundation which runs a drop-in centre, outreach and mobile clinic, targeting TG women.
	A public hospital provides a range of services including HIV counselling at the above foundation.
4. Chonburi (East)	Raks Thai office in Chonburi which runs a drop-in centre, outreach and mobile clinic, targeting Cambodian migrant workers.
5. Samut Sakhon (Central)	Raks Thai office in Samut Sakorn which runs a drop-in centre, outreach and mobile clinic, targeting migrant workers from Myanmar.
6. Nakorn Si Thammarat (South)	Raks Thai office in Nakorn Si Thammarat providing outreach work in schools and universities, targeting MSM and TG.
7. Song Kla (South)	A local NGO which runs a drop-in centre, outreach and mobile clinic, targeting migrant workers from Myanmar.

Recruitment strategy

In each province, prior to data collection, Raks Thai's DMEL team organised a consultation workshop with the team leader of enumerators and provincial managers. Raks Thai staff introduced research objectives, methods and ethical considerations so provincial managers and staff of Raks Thai and local partners could provide effective support in recruitment. Main criteria for selecting research participants were:

- Key populations who already used services. To avoid potential harmful impact, the research team only met one person from a family or one person from a relationship so other members (or partner) would not know about research questions or topics.
- Those who seemed to have multiple risk behaviours to provide a deeper insight about multiple dimensions of vulnerability.
- Service providers and staff who worked for the STAR program for at least one year.
- All research participants needed to be above 18 years so they could give full consent.
- Diversity of key populations and staff:
    - The research team recruited key populations from diverse gender and sexual identities, age groups, nationalities (e.g. Cambodian, Burmese, Thai Yai[4]) and occupations. However, only participants from a homogenous group were invited to group discussions. For example, MSM who were college students and working people, discussed in their own groups. MSM participants who had a masculine body were in one group while MSM who looked effeminate and were friends with transgender women were placed in another group.
    - Staff were at different levels of experience in providing HIV/TB and GBV services, and were from diverse gender sexual identity.

In total, the research recruited 101 participants (57 women and 44 men) who were from the key populations, service providers and NGO staff and who had diverse gender and sexual identities. Table 3 provides detailed information on research participants' location and institution.

[4] Thai Yai or Shan is an ethnic minority of Myanmar

Table 3: List of research participants

Research participants	Phitsanu lok		Chiang Mai		Rayong		Chon Buri		Samut Sakhon		Nakorn Si Thammarat		Songkla		Total	
	M	W	M	W	M	W	M	W	M	W	M	W	M	W	M	W
MSM (FGDs + IDIs)					9						2				**11**	
TG women (FGDs + IDIs)		8														**8**
Migrant workers (FGDs + IDIs)			7	9			7	7	6	7			5	6	**25**	**29**
Community health centres			1	1											**1**	**1**
Drop-in centres/Mobile clinics								1		1			1		**1**	**2**
Public hospitals	1	1				1						1			**1**	**3**
Managers of health centres/clinics		1	1			1		1	1			1		1	**2**	**5**
NGO staff, outreach and community workers		1		2		1		2	1	1	2			2	**3**	**9**
Total	**1**	**11**	**9**	**12**	**9**	**3**	**7**	**11**	**8**	**9**	**4**	**2**	**6**	**9**	**44**	**57**

Research team

The Design, Monitoring, Evaluation & Learning (DMEL) Team of Raks Thai took charge in organising and conducting this GPA. Nisanee Chaiprakobwiriya, Research and M&E Officer of the DMEL team, was the coordinator and main focal point for communication with other DMEL team members and external key stakeholders including data collectors and researchers. During the field trip, a MSM-TG Program Assistant and DMEL team members of Raks Thai travelled with enumerators to provide support and supervision of the whole process. This team also reviewed transcripts and field reports for quality control purposes. At the end of data collection in each province, the MSM-TG Program Assistant and DMEL team members conducted After-Action Review to help the whole team reflect on their experience in order to improve data quality.

The lead researcher who is a Gender Advisor from CARE Australia, designed the research framework, methods, tools and wrote the GPA report. The lead researcher also developed training materials and guidance for data collection and analysis which was undertaken by a group of external consultants who worked as enumerators with external consultants.

Enumerators were recruited according to the key selection criteria below:

- Advanced degree in gender studies, development studies, or public health
- In-depth understanding of the concept of gender norms, agency, gender relations, and structures
- At least 5 years' experience in qualitative research on health and gender related issues in Thailand (knowledge of GBV desirable)
- Knowledge of ethical considerations for GBV research or research on marginalized groups
- Experience working with key populations (men who have sex with men and transgender people)
- Advanced verbal and written in English and Thai language skills
- Ability to write a research report in English and present findings in Thai and English to various stakeholders.

Before the field work, all enumerators received a 2-day training to understand the purpose of the GPA, to practise using research tools, share research experience in collecting quality data and dealing with difficult situations. Enumerators also discussed key concepts such as sex, gender, gender and sexual identity. Finally, they received an introduction on research ethics, child protection, and prevention of sexual harassment, exploitation and abuse to ensure that they followed the code of conduct of CARE International.

During the field work, enumerators worked in pairs. One person played the role of lead data collector and the other person was the assistant. The lead data collector wrote the field report and submitted it to Raks

Thai staff. All interviews and FGDs with MSM and TG were conducted in Thai. When working with migrant workers who could not communicate in Thai, the research team used interpreters who had relevant knowledge and experience in HIV/TB from working with key populations at a hospital and a local NGO.

Following instructions from the lead researcher, enumerators used their note taking and memos which were completed at the end of each FGD or interview for data analysis. An interpretative and inductive approach to content analysis was used, focusing on the extraction of meanings and themes. Where possible, similarities and differences between key populations, geographical areas and age groups were documented.

Ethical principles

This research followed standard ethical principles; including voluntary participation, informed consent, confidentiality, privacy, the right to skip questions or stop at any time during the research or to refuse participating in this research without bearing any consequences.

Informed consent was obtained from research participants before conducting FGDs and IDIs. Also before commencing FGDs and IDIs, participants were fully briefed on their rights, the purpose of the research, data collection procedures, as well as the potential risks and benefits of participation. For migrant workers, the consent process was explained with the help of an interpreter. Participants then signed or left their fingerprint on the consent form [5] and gave permission for audio recording. Interpreters also signed a form acknowledging that they would translate honestly all conversations and keep them confidential. All signed consent forms were kept by Raks Thai M&E staff for documentation purposes.

To ensure privacy, FGDs and interviews with MSM and TG were conducted in a meeting room with closed doors, at a drop-in centre. FGDs and interviews with most migrant workers also took place in a meeting room of provincial offices. In some cases, when migrants lived far away from the provincial office, researchers travelled to their home for interviews. Husband and family members were not around the house during the interview. FGDs with construction migrant workers were conducted in the construction camp, their temporary living place.

To ensure confidentiality, participants were informed that they could use to use pseudo names during FGDs or interviews. The data then was de-identified during analysis and report writing to protect the identity of informants.

Research participants were paid a small allowance to compensate for transport costs expended. Any research participant who disclosed traumatic experiences or expressed the need for emotional or psychological support, would be referred to support services. During the field trip, researchers were informed of an incident of violence that occurred with young people under the age of 18. To avoid potential harmful impacts, they decided not to talk directly with these young people about the violence experience. Instead, they confidentially passed this information to Raks Thai staff who discussed with a local NGO to provide further support to survivors.

Research limitations

The research framework, methodology and tools were designed by the lead research who was not based in Thailand. Enumerators did not have a chance to contribute to tool development. They only received training about this research and some of them might have been using the research tools for the first time. The training for enumerators was provided by Raks Thai staff, not the lead researcher. Thus, it was not clear the extent to which the enumerators were able to use tools properly for the defined purpose of data collection. Below was an example from the field report.

This research aimed to collect data for seven areas of inquiry. However, the research team working with MSM and TG decided to drop three areas of inquiry 'sexual gendered division of labour', 'decision making

[5] The consent form was designed by Raks Thai M&E and legal officer

in intimate relationship' and 'aspiration for oneself'. Field managers and enumerators argued that most MSM TG participants did not have a permanent partner so it would not be relevant to talk about household decision making. MSM is a diverse group who can engage in different forms of sexual relationships. They can include heterosexual and bisexual men who are single or in a relationship. They can include hidden gay men, men who use drugs, and male sex workers. The decision to drop the first area of inquiry was not well justified. For the other areas of inquiry, enumerators said it was due to time constraints and that research participants did not share much information. As the lead researcher was not part of the data collection process, it was hard to understand how enumerators used research tools and whether tools or interview skills should be adjusted to enable participants share more information.

The research aimed to explore multiple dimensions of vulnerability due to intersectionality of multiple identities. It required researchers to use an intersectional lens to unpack unequal experience from various angles. It was not about asking key populations about how many identities they had. According to field reports, enumerators found it difficult to recruit participants with intersectional experience. It seemed that enumerators expected participants to self-identity themselves which was not the purpose of this research.

Nakorn Si Thammarat was the most difficult place to collect data due to the complexity of local social and cultural contexts. In this province, sexual diversity was considered a taboo. Local people were not open to talk about gender diversity and equality. Due to these reasons, the research team was not able to conduct FGDs but only individual interviews.

While the project team recognised the importance of working with employers of migrant workers and law enforcement institutions such as police, it was not possible to recruit them for this GPA as the project had not yet a strong relationship with them. Due to this challenge, there was limited data to answer some research questions. To answer the sub-research question 'how relevant public institutions prevented and responded to GBV among key populations and which actors played an important role to their access to HIV/TB services' the research was only able to obtain data from health service providers and service users. There was no information from those working in law enforcement institutions nor from employers.

FINDINGS

Area of inquiry 1: Sexual/gendered division of labour

Perception on gender roles and value regarding household work and caring responsibilities

The sexual/gendered vision of labour among migrant workers was based on perceptions of masculinity and femininity in a patriarchal society. Most migrant women were mainly in charge of household chores such as cooking, washing clothes, cleaning house, dish washing, taking care of children and buying foods. Migrant men were responsible for doing heavy work such as lifting, repairing and maintenance of their houses. More extreme inequalities often happened in families where the husbands were fishermen or construction workers. All men in these occupations said that because their jobs were very hard, they did not do anything to help their wives. The research found that if migrant women did not want to comply with traditional gender roles, they would bear the consequences including violence. A sex worker migrant from Shan ethnic minority in Chiang Mai, indicated that she would be hit if she refused to do the housework. Similarly, Cambodian men would not consider his wife a woman, if she also refused to do reproductive labour.

Due to being busy with household tasks and compounded by the lack of legal identification documents, women had little opportunity to earn money while most migrant men worked outside the home. Most working men did not share caring responsibilities. Instead, after working hours, they spent time socialising with friends or resting. When women worked outside the home, they still had to prepare meals for their husband and children in the early morning and in the evening. Consequently, women had less time to rest and take care of themselves.

The influence of social/ gender norms and their role on the access to HIV/TB services

The requirement to have legal identification documents in order to obtain work was considered a significant barrier for women migrants to earn money as well as to seek HIV/TB information and treatment. Among migrant workers, men were the ones who had legal working documents and therefore most of them had a job. When migrant women had to live on men's incomes, their power in decision making and negotiation for many family issues tended to become weaker. Women became more vulnerable when they experienced health issues such as HIV/TB infection because they could not stop doing household labour. Some women migrants worked in a factory without having legal identification documents. It was not possible for the research team to get the exact number of how many women were working illegally, yet we could assume that these women would be more likely to experience harassment and exploitation in the workplace in addition to the burden of household work and caring responsibilities.

When women became sick, men took women to the doctor, paid treatment fee and did some household tasks. If the illness was not severe, women still had to do household tasks as usual. There were few cases when men demonstrated positive deviant behaviours in caring for his wife. For example, in Samut Sakhon, a female migrant worker with HIV said that she did not do anything due to her poor health status because her husband wanted her to live as long as possible.

From the 2017 gender analysis, [iv] it seemed that transgender women tried to prove that they were truly women and good women by upholding traditional gender values. The set of beliefs on 'woman value' could include how women respond to their male partner's needs in terms of household duties, economic needs and sexual desire. This 'woman value' belief could also discourage them from participating in HIV-related activities as HIV was viewed as something a 'good woman' did not associate herself with.

The research team working with MSM and TG decided not to collect data about the perceptions of MSM on gender roles and values regarding household work and caring responsibilities and how these perceptions could affect to their access to HIV/TB services.

Area of inquiry 2: Decision-making in intimate relationships

Decision making power of key populations with regard to family activities and access to services

Due to the privilege of being men in a patriarchal society and having legal identification documents to work in Thailand, men had more power in decision making in the household than women. Most migrant men had the final say for important issues such as big household expenditure, investment, legal matters, and medical treatment. Even though migrant women kept money for the whole family, they only could make decisions for small household expenditure, childcare, saving and medical treatment.

Vulnerability to violence resulting from conflicts in decision-making

Migrant women were vulnerable to violence when there were disagreements in decision-making between husband and wife; for example husbands would spend money on drinking with his friends, even when his wife did not agree. Many migrant women reported that due to conflicts in decision making, their husbands became unfaithful, beat or cursed them or broke the relationship. At times migrant women would decide to make their own decisions, without waiting for their husbands' opinion particularly if the matter was urgent. As a consequence, they would often be subject to conflict and violence. When living in a patriarchal society where men already held more power and women are more economically dependent on men, many migrant women chose to be quiet and let men make decisions.

The effect of disagreement in decision making to the access to HIV/TB services

Field data showed that migrant men wanted to prove their power within the household by creating a boundary of their territory. Men expected their women to follow traditional gender roles and their decisions, and not share family issues with outsiders. It could implicate women in their access to health

services including HIV/TB services. Women may feel reluctant to share personal information with service providers and may not seek HIV/TB testing and treatment on timely basis.

Migrant workers who do not have legal identification documents, dare not to seek health services. As most female migrants were without legal documentation and therefore not in paid productive work, and were responsible for reproductive work, they were most disadvantaged in accessing services.

There is no data about decision making in intimate relationships of MSM and TG as enumerators decided to drop this area of inquiry from data collection.

Area of inquiry 3: Perceptions toward gender-based violence (GBV), gender and sexual identity

Perceptions of sex, love, beauty and trust and their effects to the practice of safe sex and access to services

Migrant workers perceived that having sex was considered a way to strengthen relationships, to show trust and honesty to each other. According to migrant men, (Thai Yai, Cambodian and Burmese) condom usage meant dishonesty and distrust. Most men used this argument for not using condoms when having sex with their wives. Yet the 2017 gender analysis reported that migrant men regularly used sex worker services. According to the Preliminary Research of AIDS Prevention Project in Migrant Workers in Thailand (PHAMIT-2) Year 2010, migrant workers from Laos, Cambodia and Myanmar reported having sex from a young age. They also were reported the incidence of them having sex with people who were not their partners within the past year as high as 15.9%, 10.2% and 5.2%, respectively.

A small number of Burmese migrant men and women reported that they were aware about safe and consensual sex and wanted to wear condoms for HIV/STI infection. According to Burmese migrant women, however if there was no agreement or request or insistence from women to wear a condom, then men would not use one. This indicated that both men and women would need support to learn how to communicate with each other about their desire and expectations during their sexual relationship.

Transgender women often faced many challenges in finding a long-term partner or staying in a relationship. Some of them said that their partners could neglect them or leave them without any reason. Many trans-women tried to be a “good girl” and provide good service in bed in order to keep their men. They relied on trust and felt uncomfortable to talk about condom use with their boyfriend. Their efforts to conform to traditional gender norms only reduced their negotiating power for safe and consensual sex. When trans-women were not able to stay in a long-term relationship, they underwent detrimental emotional impact which could affect to their decision to access services.

According to the 2017 gender analysis, sexual cruising was prevalent among MSM but many MSM believed that they should not wear condoms when they had sex with their boyfriends. Compared to other key populations, MSM seemed to enjoy privileged roles while they were quite invisible (for example MSM who did not come out, who used drugs, who were well-educated and from middle class backgrounds). When bisexual men came for HIV services, they might not be classified as MSM. Male sex workers used condoms with their customers, however outside of their work, they could have multiple partners without using condoms. In general, many MSM rarely used condoms in intimate relationships, either with male or female partners.

Perceptions of GBV and their effects on the practice of safe sex and access to services

Migrant workers had a fair knowledge of gender-based physical violence. The cited the main types of violence to be beating and slapping to the head, pulling hair, hitting, and cursing. Violence could happen as a consequence of disagreement in decision making, lack of respect and lack of communication about condom use, safe sex and sexual pleasure. In most cases, men were perpetrators and committed the physical violence. Women were expected to accept violence, and not report it to police to keep harmony in the family. Sometimes women could be violent to men when they experienced oppression and wanted to take revenge on men. Women often used cursing and insulted men with strong language.

When migrant men and women discussed decision making within the household, they mentioned that sometimes men controlled women's decisions because of her economic dependency. It is possible that migrant women accepted the fact that they could not do much to change their economic dependence and had little power to negotiate men's controlling behaviour. Economic control was therefore not mentioned as type of violence in the field report about migrant workers.

Experience of sexual violence was reported by migrant workers who were living with HIV/TB, or who were sex workers. Sexual violence however was not listed as a form of GBV by migrant workers in the focus group discussion. It could be that migrant workers, both men and women normalised violence. They perceived that as a wife, women's responsibility was to be ready to meet sexual demands from her husband all the time, even when she did not want it. It also might be hard for many migrant workers to talk openly about sexual violence. This indicates a need for health service providers and community workers to spend more time with migrant workers, especially women when providing GBV prevention and support services.

Transgender women, also known as Kathoey, experienced various forms of violence and discrimination, both from family members and the general public. Most family members and relatives did not accept that they were Kathoey. This has resulted in the transgender women feeling negatively about themselves; not wanting to join social activities where they could be looked down upon; rejected and subjected to abusive comments resulting in severe effects on them.

In public spaces or events, transgender were often verbally harassed such as teasing their feminine appearance or cursing them (e.g. calling Kathoey "yellow lines" – Thai slang referring to anal sex). In Pattaya, there were many cases where Kathoey were not allowed to enter to bars. A transgender woman reported being put down in front of her beloved one. She went to see a concert with her boyfriend in Ramkhamhaeng where the entrance was divided into male-female track. The organiser asked audience to present ID cards with tickets. Even though this transgender woman looked like a woman, an inspector told her to go into the other track for men. It turned the concert into a bad experience for her.

All discriminative comments and treatment by family and the public made transgender people live in fear of rejection and with loss of hope and self-confidence. They would tend to limit themselves in a small circle of friends who were in the same circumstances. Limiting socialisation may result in lack of access to HIV/TB information, treatment and support services. In addition, when transgender people have not seen a chance to claim justice, they could lose motivation to practice safe sex for a better future.

Area of inquiry 4: Control over one's body

Negotiation for safe and consent sex

Migrant men believed that women should not express sexual desire. Migrant women, particularly Burmese women said that they dare not to talk about sexual desires to their partners because it did not make them look like a good woman. The 2017 gender analysis also found that talking about sex brought bad luck and '*talking about sex is a disgrace act towards sacred spirit. Men can do anything to women who are easy*' (page 30). Consequently, migrant women refrain themselves from talking about sexual pleasure, safe sex and condom use. However, women were expected to be ready to meet the sexual demands of her partner even when she did not want it. For them, sex was mainly for procreation and keeping men in the relationship. Sometimes women accepted having sex as a way to avoid violence. Burmese migrant women in Songkhla said that when their husband came back from work at sea, wives should look after their husband and indulge him including in sexual matters. Otherwise, her husband could go out for sex workers.

Among MSM, their 'sub-culture' of talking before having sex is an opportunity to negotiate for safe and consensual sex. In this kind of conversation, MSM often asked if their partner was safe (e.g. living with HIV) or not, and if he had any condoms. If this partner had ever been bare backing, he would had a high risk to HIV infection. MSM used this information to estimate the level of risk and then negotiate for sex safe.

Transgender women shared that they were emotionally abused or hit by an intimate partner when they refused to have sex or asked for condom usage. Transgender women were the group who had least power to negotiate for safe sex with partners.

Attitudes, information and skills to negotiate safe and consensual sex

As mentioned above, migrant women were expected to be naïve about sex and not express sexual desire. Migrant women had little power to negotiate safe and consensual sex because they were expected to respond to men's sexual desire which could make them more vulnerable to HIV/STI infection. If migrant women illegally stayed in Thailand, they might not be able to access HIV testing and treatment on a timely basis.

Some migrant women said they were able to negotiate not having sex during their period or when they were not well due to working in the factory or due or had contracted an illness. Women's fatigue due to work appears to be an acceptable excuse to their husbands for not having sex. When migrant women only stayed home, however, they could not use their health status to excuse them from having sex. Men had total power to decide whether or not and when they wanted sex and the extent to which men could accept women's refusal, depending on their feelings.

Area of inquiry 5: Violence and restorative justice

Main strategies to prevent and respond to GBV

Migrant workers reported that they used strategies to avoid violence such as silence, non-confrontation, or trying get out of bad situation. When they needed help, they often approached landlords, dormitory owners, employers, head of villages and neighbours. It was mainly for small issues because migrant workers were afraid that they might be fired or asked to get out of rental houses if they were in big trouble. Burmese female migrant workers said that they would only report to police if there were severe cases. In some places, police officers were not responsive to requests from migrant workers. Some of them even took advantage of their power position to exploit vulnerable people.

NGOs staff played a critical role in reaching migrant workers and supporting them access GBV services. Most migrant workers and employers were not aware which organisations provided GBV services. Neither did they know about referral systems and relevant policies on GBV prevention and response. The main barriers for accessing GBV prevention and support services in public institutions included language and legal identification documents.

Transgender women and MSM were the two groups who experienced a high level of violence, both in private and public places. Sometimes, transgender and MSM ignored negative comments or even made fun of themselves in order to keep a positive social atmosphere. Sometimes, they found that negative comments crossed the boundary of acceptability and they fought back. In many cases, transgender women and MSM were unable to prevent themselves from using violence to respond to violence. It indicated a feeling of helplessness experienced by key populations, compounded by the failure of public institutions to address violence towards diverse gender and sexual identity.

Transgender women, particularly Kathoey experienced much more violence than MSM. When they sold sex, they were forced into group sex, were forced to watch porn or use sex toys. Other violence included squeezing their breasts and pulling hair which were considered the most common forms of violence. Transgender women reported that they were often touched without consent by customers in a bar or by strangers and were forced to have sex when they went to the public toilet or attended local festivals. When they experienced violence, transgender women usually talked with friends to seek support and sympathy but they also have reported their complaint to the village chief[6] as the formal process of reporting to police was often slow or helpless. Sometimes bribery was suggested in order to proceed at the police station.

[6] In some areas, where the attitude to MSM and TG was acceptable, the chief of village would be willing to help by asking perpetrators to pay fine.

MSM could provide support each other from being sexually harassed in the public when they went out as a group. For example, when MSM went to a bar, they observed customers who were regularly touching dancers' bodies (e.g. MSM working as a dancer) and shared this information among themselves. They warned each other not to go further or not have a chat with these customers who were called 'squid' (e.g. having multiple hands).

There was a rare case, when a strong transgender woman knew her rights, she fought back to the law enforcement staff.

> *Police investigated our car, let the women sit in the car, the men went out of the car. I got out, so the police said "are you a man or a woman?" I argued with the police "what if I am a man? and what if I am a woman then? I was not happy with what he said. I'm trans then why do I have to keep siting? We have rights. The Government officer used bad words, cursing me in front of many people, made me lose face in front of my boyfriend and his group. I became a black hole. Made me upset.*

There was another case when a transgender woman was judged as not 'feminine' enough. At the beginning, she was not allow to dress up in female uniform in an undergraduate ceremony. This trans student sought justice by submitting a supporting document from a psychiatrist to her university. Despite of the certificate from the psychiatrist, the officer in charge did not approve her request. This student lodged a complaint to the office of the university president and finally got approval to dress up in a female uniform. It was a symbol of accepting her gender identity.

These two examples showed that transgender women were able to claim justice because of their strong agency. There was no rule or policy which protected equal rights of people from diverse gender sexual identity. Nor was official institutions, platforms or social networks which provided support to these transgender women during these processes. Strengthening advocacy on TG rights could be an issue for the STAR program to consider in their design for the next phase.

Attitudes, knowledge and skills to prevent and respond to violence

Migrant workers said that they had never accessed information about violence, either in their country of origin or from their employers in Thailand. Migrant workers expressed the need to receive training on communication skills so they could share their opinions, feelings and decisions in a respectful manner.

According to the field report, some trans women said that they could say no to an intimate partner when he turned violent. Yet the field data did not provide detailed information about the status of her relationship and the context where this trans woman could refuse sex when she did not want it. A trans sex worker shared that she always talked about condom usage with her clients at the beginning of their appointment. Another trans sex worker said that she was openly talked with her clients about the risk of her job and successfully convinced them to use condoms. While it would be important to provide trans sex workers with skills to negotiate for condom use, it was not clear from the field work data in which context they were able to apply these skills with clients and who could support them applying these skills.

This GPA did not collect data about attitudes and knowledge of the public with regard to diverse gender and sexual identity. From the perspective of MSM and TG in this research, the public often viewed them as easy going and only wanting to have fun. The public did not show respect to MSM and TG, not simply because they lacked understanding about diverse gender sexual identity but also because they felt that they could do anything with MSM and TG who had little power to protect their rights. For future interventions, it would be important to provide key populations with information and skills to prevent and respond to violence. Yet interventions would not be sustainable if public perceptions about gender sexual identity is not challenged.

Factors that have influenced on GBV experience

Many structural inequalities have made migrant workers, particularly women become vulnerable to violence. Structural inequalities include the imbalance of power in decision making at the household level and restrictive sexual and gender norms about women's roles and value in intimate relationships. Only few NGOs provide limited social and GBV support services to migrant workers who could not

communicate in Thai. Some of migrant workers even didn't have legal identification documents. There was no engagement from employers who are accountable for providing migrant workers with information about their rights, GBV services and HIV/TB prevention and treatment.

For MSM and TG, their vulnerability to experiencing GBV was due to power imbalance between age groups and the lack of power to negotiate with employers who were perpetrators in some cases. For example, some young MSM and TG worked in arts and entertainment establishments such as beauty salons, wedding studios and dancing groups. They were forced to have sex without condom with a mama - an 'effeminate male' who was older and the organiser of popular cultural shows, e.g. he had the power to choose which dancers he wanted to give shows. These young MSM and TG had to accept this abusive relationship so they could keep their jobs. Later, they were found to get HIV infection from this mama.

MSM reported violence experience due to their multiple identity and structural inequalities such as social norms and expectations about men and masculinity. The research team was informed of a case when a MSM student in a boarding school was harassed by a 'black-bean' dormitory owner. It was not only him but other young students were forced having penetration or asked to perform oral sex by this 'black-bean' owner. The power imbalance between age groups made this MSM student feel it was not possible to prevent the senior from penetration and he did not seek help. This MSM student also denied the fact that he faced violence because of the social belief that men could not be raped; if he reported the incident, he might not be considered a man.

GBV prevention and response among key populations and their partners by laws and institutions

The current health and social support system had not been designed to provide effective GBV services. The One Stop Crisis Centre was designed to mainly support women and children, not MSM and TG. Even when staff did a lot of work for MSM and TG, their work was not counted because the centre did not consider violence among MSM couples as domestic violence. The concept of 'family' did not include same sex relationship or LGBT couples.

In the project sites of the STAR 2 program, public hospitals collaborated with drop-in centres of local NGOs to provide HIV/TB services. In a public hospital, the social medicine section was in charge of reaching key populations, working with the public health authority at the district level or community health units. Even though staff working in the social medicine section had strong experience in HIV/TB, they also were judgemental of different sexual behaviours and identities. A nurse at a public hospital said that she would not just give PrEP to any person who came and asked for PrEP. She said she would only give PrEP in cases where the condom was broken. By making judgements about to whom and when would be appropriate to give PrEP, she could be a gatekeeper and send key populations away from accessing essential measures for safe sex. A social worker shared her observation that many health staff perceived MSM and transgender as those who were easy to have sex.

Health staff had poor understanding about GBV as well as skills in assessing GBV incidents among clients. A counselling nurse at a public hospital thought that negotiation for condom usage or a partner's refusal to use a condom could not relate to GBV. In her perception, violence would only happen when people were drunk and consequently could become sexually violent. This nurse said that there could be GBV cases, but '*the clients didn't tell us*'. Another nurse also admitted that her young colleagues were not confident and afraid to ask questions about the gender identity of a client's partner. Consequently, clients did not feel comfortable to talk about their sexual life and were not open to seek support.

Similar to health staff working in public institutions, staff working in NGO drop-in centres and clinics also had a limited understanding of GBV and low skills in addressing GBV vulnerability of key populations in every step of their work. Managers and staff from two local organisations said that they had not received any training on confidentiality. Health staff repeatedly mentioned that '*clients don't tell us*'. It could be that staff were lacking in knowledge of, and skills to talk about, GBV. It seemed that most of them were not aware of nor were trained in the standard operating procedures (SOPs) for GBV services. SOPs usually include principles in working with victims, procedures to provide clinical examination and treatment,

psychological counselling, referrals, ethical and safety considerations. The application of SOPs across institutions will ensure the consistency of quality and ethical GBV services.

Area of inquiry 6: Access to public spaces and services

The level of access to public space and services by key population and factors affecting their access

For most migrant workers in this research, regardless of nationality and gender, language was the main barrier for accessing public spaces and services. Migrant workers with legal identification documents could access Thai public hospitals and public institutions for health and social services, yet many of them could not communicate in Thai language. Illegal migrants would have to rely on support and services provided by Raks Thai and its partners in the STAR 2 program due to language barriers and their illegal immigration status.

As migrant workers could not communicate in Thai, they did not know where they could seek support if they were infected by HIV/TB or had experienced GBV. Most of them did not seek information about HIV and TB prevention because they did not know about the importance of having early and accurate diagnosis of HIV and TB and how to use prophylaxis until they came to work in Thailand. They thought that they could not be infected easily; they only realised this when NGO staff provided that information and support. When supporting illegal migrant workers, it was a big challenge to ensure the continuity of service use including HIV/TB treatment. Illegal migrant workers may leave a rental house unexpectedly due to the fear of being arrested.

Health service providers in some areas said that transgender people had little or no access to health and HIV prevention service but the field report did not provide sufficient information about the reasons. It seemed that health service providers needed more training and experience in working with key populations in order to establish a relationship with them.

Influential actors to the access to public spaces and services

Within the scope of STAR 2 program, key actors in providing HIV/TB and GBV services include Department of Health, Department of Justice and Department of Welfare Services at provincial, district and community level; employers; community-based organisations; Raks Thai and its local partners. In the current program, Raks Thai and its local partners were the main actors supporting migrant workers, particularly those without legal documents to access services through direct service provision or supporting access through public institutions. This research was not able to collect data from law enforcement staff, welfare service providers and employers who actually play a critical role in enabling key populations' access and utilisation of services. They are also the ones who must be accountable for ensuring human rights related to health care and protection of key populations. Strategies to engage and build capacity of these stakeholders in providing GBV services could be a part of the gender strategy and future interventions.

Area of inquiry 7: Aspirations for oneself

Most migrants shared the same aspirations for themselves, at an individual and a collective level. They wished to have a better life and have enough money to support their family. Men and women also expressed a desire to have a happy and harmonious family, without fighting. Both men and women wanted more open and honest communication to increase understanding and reduce violence.

When a couple decided to move to a new country to work, the new life could bring positive or detrimental effects to migrant workers. Both men and women had to accept hardship, stress, and violence with the hope to have a better life one day. In most cases, migrant women experienced more negative effects of this move. Without family support, lack of legal identification documents and Thai language skills, migrant women often had to stay home to do housework and look after kids. They often had to accept violence so the family could stay intact. A Burmese woman in Samut Sakhon said that she tried to forgive her unfaithful husband, but could not it bear anymore and decided to break up the relationship. As a single mother, she had to work harder for the future of her child.

For migrant workers, language and legal identification documents are the two main barriers to achieve equality in accessing health care and their aspirations. Most migrant workers were unable to read and write in their own language. They faced many challenges in communication and negotiation with Thai employers. They found it hard to access legal support and health services. For those who worked illegally in Thailand, it was not possible to exercise health and work related rights.

There is no data about aspiration of MSM and TG as this area of inquiry was dropped from data collection.

RECOMMENDATIONS

Overall recommendations about program approaches

Recommendation 1: Findings from this GPA indicated the importance of applying social norm change approaches such as Social Analysis and Action (SAA) [v] to challenge harmful norms in current and future programming. SAA and the Social Norm Analysis Plot (SNAP) Framework[vi]could be used to map current norms as part of a baseline for the next phase of the Global Fund as well as a monitoring and evaluation tool for identifying changes in norms. Baseline data can be used to inform the design of social norm changes activities at individual level (e.g. among key populations, service providers and NGO staff), institutional level (e.g. Raks Thai, local partners, drop-in centres) and for the wider public.

Recommendation 2: Community Score Cards (CSC), a two-way and ongoing participatory tool for feedback, planning, and improving services can be introduced in the next phase of the STAR program. [vii] It brings together the 'demand side' (service users) and the 'supply side' (service providers), to jointly find ways of addressing service delivery problems. CSC has been proved to be effective in empowering communities to know and claim their rights and holding service providers accountable for their responsibilities. Its principles in promoting participation, transparency, accountability, responsibility and informed decision making are well aligned with the strategic objectives to strengthen community system of Global Fund.

Recommendation 3: Raks Thai has made strong commitment to support gender equality and GBV prevention in the current program. In order to create more systemic changes, Raks Thai can consider strengthening alliance with LGBT groups and put more efforts on advocacy for social norm changes with regard to diverse gender sexual identity and sexual pleasure. A dual focus on social norm change and HIV/TB prevention from a rights-based approach will enable better recognition, implementation and fulfillment of human rights including LGBT rights by formal institutions in health care and law enforcement institutions.

Recommendations at individual agency level

Gendered social norms

Key findings: Key populations such as male and female migrant workers and transgender women have upheld gendered social norms with regard to gender sexual roles and values in intimate relationships. Consequently, women have little time to take care of themselves and refrain from talking about sexual pleasure, safe sex and condom use. They were expected to accept violence, including meeting the sexual demands of their partners even when they did not want sex.

- Recommendation 4: Program interventions can facilitate discussions to explore and challenge the perception of femininity and beauty among transgender women. Transgender women need to be aware that complying with traditional gender roles and values does not help them maintain a long-term sexual relationship. It actually can affect to their power to negotiate consensual sex, to avoid violent relationships and to access services. Social norm change interventions can encourage transgender women to appreciate other values such feeling confident about themselves, the diversity of beauty, especially the inner beauty, the ability to love their body as it is and building aspiration for future.

- Recommendation 5: Challenge the perception of migrant men about women's role and value in intimate relationships so migrant women will have more time to take care of themselves, to look for income generation opportunities and feel comfortable to negotiate for safe and consensual sex.

Key findings: Some MSM share that they feel inferior when they only have same sex relationships (e.g. when they are in the 'receptive' position). If a man who has sex with both men and women (e.g. when they are in the 'penetrative' position) they feel more powerful. Such perceptions about 'power', 'macho' and 'attractiveness' are constructed by heteronormativity which only creates a line between genders. Instead of recognising the fluidity of sexuality and gender, heteronormativity views gender as binary and static. It asserts that each gender will have to comply with certain roles, values and expectations. It only results in unequal treatment to people whose gender and sexual identities are not accepted by dominant groups in society. The lack of self-reflection in MSM about their own bias on gender and sexual norms will only reinforce social inequalities which they already have experienced.

- Recommendation 6: Facilitate reflection among MSM to explore the social construction of masculinity from perspectives of intersectionality and fluidity of gender and sexuality. Discussions can include the following topics: the differences between sexual orientation, identity and behaviours, why some sexual orientations and identities are stigmatised by the binary heterosexual lens of masculinity and femininity.

Key findings: The perception of masculinity among MSM has found to be influential on the level of responding to GBV incidence and the decision to seek support. In this research, a MSM student denied the fact that he faced violence because of the social belief that men could not be raped. If he reported this incident, he might not be considered a man.

- Recommendation 7: Facilitate reflection among MSM to challenge perceptions of masculinity with regard to GBV which will help MSM to recognise that not all men are in positions of power. Men with multiple risk behaviours and identities can be vulnerable to GBV. Their admission of experiencing violence does not mean that they are not a "real" man. When MSM deny the fact that they can be vulnerable to violence, they will feel reluctant to report violence experience or delay seeking support services.

Knowledge, attitudes and skills of key populations

Key findings: A small number of migrant men and women shared that they were aware about safe and consent sex and wanted to wear condoms for HIV/STI infection. Yet, both men and women did not feel comfortable to talk about sensitive topics.

- Recommendation 8: Migrant men and women need support to strengthen their communication skills so they will feel more comfortable to talk about sexual desire and expectations during their sexual relationship. It will help them find it easier to negotiate whether or not and when they want to have sex and use condoms. This kind of conversation is not necessary limited to HIV/STI prevention but could be raised in broader topics of contraception, pregnancy, sexual and reproductive health care, sexual pleasure and respectful relationships.

Key findings: Most migrant workers and employers were not aware of which organisations provided GBV services. Neither did they know about the referral system and relevant policies on GBV prevention and response.

- Recommendation 9: Migrant workers need to access more information about their rights, the right to live free from violence, the right to receive information about GBV services, the right to access health and support services. Migrant workers, particularly women, need to access more information about HIV/TB prevention (e.g. risky behaviours, the importance of having early test, forms of GBV and how they can increase the likelihood of HIV infection) and treatment services. Information can be disseminated through landlords, employers and community leaders.

Key findings: Transgender women experienced various forms of violence, both from family members and people in the public. Violence and discrimination were contributing factors to low access to HIV/TB information, treatment and support services.

- Recommendation 10: Provide a safe space for transgender women to learn more about GBV and how to access information about GBV services and to create supportive networks and opportunities to support each other to heal.

Knowledge, attitudes and skills of service providers

Key findings: Health service providers in public hospitals had experience in providing HIV/TB services but still held biases and were judgemental towards people with diverse gender and sexual identities. For example, many heath staff perceived MSM and transgender as those who were easy to sex.

- Recommendation 11: Health service providers need training on gender and sexuality, particularly about diverse gender and sexual identity, the difference between sexual orientation and behaviours. Some transgender women have not gone through lower part operation and can take active roles in bed. Health service providers need to gain skills about how they can provide quality HIV/TB services in response to specific needs of each individual, not according to the gender of clients, based on their appearance.

Key findings: Health service providers and staff working in NGO drop-in centres had a limited understanding of GBV and lack of skills in assessing GBV incident among clients. Most of them had not received appropriate training in providing quality GBV services.

- Recommendation 12: Build the GBV capacity of staff of Raks Thai, its local partners and health service providers to understand: forms of GBV; vulnerability of key populations to GBV; and underlying causes of GBV including unequal power relations, lack of recognition of human rights and restrictive social norms for people of diverse gender and sexual identities. NGO staff and health service providers need to become more sensitive and have better skills in asking questions to assess GBV risks among key populations, know where they can send GBV survivors to seek support services and provide on-going support. They should be trained about what different roles and functions can do to manage violence cases in a sensitive and non-discriminative manner.

Recommendations at relational level

Key findings: Due to the privilege of being men in a patriarchal society and having legal identification documents to work in Thailand, men had more power than women in making decisions for family issues, including accessing to HIV/TB and GBV services.

- Recommendation 13: Facilitate discussions among migrant couples to explore gendered sexual norms and expectations of each other, build respectful relationships, create shared vision about a happy family or relationship, develop action plans to share productive and reproductive responsibilities and review these action plans periodically.
- Recommendation 14: Support migrant women access income generation opportunities so they can become economically independent and have more power to negotiate with husbands (or partners) about household work, condom usage or access to services. Before implementing income generation activities, project staff should provide migrant women and men with information about available violence referral services and awareness on rights to ensure that we minimize potential harmful effects.

Key findings: Employers of migrant workers must be accountable for ensuring the right to access to HIV/TB and GBV information and services of their employees. However, there is little engagement of this important stakeholder in this research as well as in current interventions of the STAR 2 program.

- Recommendation 15: Where possible, advocate to employers to provide information on HIV/TB services and GBV prevention to employees. Raks Thai can provide evidence about how employee health checks can contribute to a healthy and respectful workplace which can result in a reduction of

waste hours and increase in productivity and loyalty of employees. CARE Australia's regional project 'Enhancing women's voice to stop sexual harassment – STOP' [viii] has successfully used such kind of evidence to work with employers on building a workplace free from violence.

Key findings: Transgender women and MSM experienced various forms of violence and discrimination, both from family members and by public people.

- Recommendation 16: Reduce stigma and discrimination within families and set up a network of family members of LGBT community. Family members can share their experience of accepting and providing support to sexual minority groups which could either be online (e.g. social networks or forums) or off-line (clubs). This model has proved to be successful in many countries like Vietnam.

Key findings: Dormitory owners, mamas of entertainment establishments and law enforcement staff are powerful stakeholders. In some cases, they can be the ones who offer help to key populations. In other cases, they can use their power to be perpetrators against key populations who have almost no power to negotiate. Yet, their engagement in current interventions was limited.

- Recommendation 17: Engage dormitory supervisors in HIV interventions and continue strengthening the relationship with mamas from existing interventions.
- Recommendation 18: Engage law enforcement staff for more effective HIV prevention and response. There are many levels of engagement. Raks Thai and its partners can consider building relationships with police personnel, organising sensitisation workshops about gender, sexuality and GBV, or advocacy for LGBT rights by engaging police personnel who are openly gay.

Key findings: Migrant workers, particularly illegal migrants rely heavily on support from local NGOs. It is possible that some development workers might take the advantage of their power position to abuse migrant workers.

- Recommendation 19: All NGO staff, outreach and community workers should receive training on child protection (CP) and prevention of sexual harassment, exploitation and abuse (PSHEA). In order to continue the learning process, Raks Thai can consider organising quarterly or biannual events where project participants could share their experience in applying PSHEA policy from "do no harm" perspective and learning from changing gendered social norms when working with key populations.
- Recommendation 20: CARE International has just introduced guidance for creating and managing effective feedback and accountability mechanisms.[ix] The guidance provides tools and practical examples that Raks Thai teams and partners can use and adapt to their specific context as they develop, implement and manage an effective feedback and accountability mechanisms. Raks Thai can be a pioneer member in using this guidance both at the organisational and project level.

Recommendations at structural level

Key findings: Restrictive gendered social norms about masculinity and femininity are the underlying causes of social inequalities, discrimination and violence towards key populations. At the same time, men and women with diverse gender and sexual identities have upheld such norms as a way to feel 'safe' in intimate relationships or to live with their own circumstances (e.g. in the case of a young MSM person abused by a dormitory owner). Behaviour change will not be sustainable if program interventions will only focus on social norm change at individual level.

- Recommendation 21: Implement social norm change interventions and communication campaigns among wider public to change social expectations regarding women's roles and value, women's beauty and sexuality. Changing social norms on women's roles and values will help migrant women and transgender women better negotiate for safe sex. Changing social expectations about women's beauty and sexuality will create an enabling environment where men and women from diverse gender and sexual identity will feel comfortable to talk about their body, sexual pleasure and consensual sex. Based on research findings, the following norms should be challenged:
  - Women should be mainly responsible for household and child care work

- Woman should not talk about sexual pleasure with her partner
- Women should not talk about condom usage with her partner
- A woman should have sex with her husband even when she does not feel like it
- MSM and TG are easy going and like having fun.
- Being beautiful can keep a partner stay long in the relationship.

Key findings: The STAR 2 program and its future interventions aim to address gender equality and GBV among key populations to better achieve transformative change. In order to design, implement, monitor and evaluate transformative programs, we need to build a gender transformative organisation at the same time. This requires supportive leadership and adequate resources to ensure that policies and strategies are in place to promote and implement gender transformative changes. It also requires strong gender capacity of national staff who take a leading role throughout the transformational process, at individual, program and organisational level (see recommendation 11, 12 and 19 above).

➢ Recommendation 22: Improve institutional capacity of service sites of Raks Thai and its local partners to better prevent and respond to GBV:

   - Develop and implement institutional policies which supports staff delivering GBV services, for example providing training on GBV, allocate enough budget and time for staff to take training, provide opportunities for staff to practice new skills and knowledge.
   - Review human resource policies and standards: include GBV skills and knowledge as part of competency assessment system which will be used for recruitment and annual performance review.
   - Map referral GBV services and set up a feedback mechanism to regularly update the quality of GBV services provided by institutions in the referral list.
   - Amend recording systems of Raks Thai and its local partners to be inclusive of people of diverse gender and sexual identity. For example, when a man partner of a TG comes for a service, they will have their own right to self-identify as MSM, gay, heterosexual or bisexual. [7]

Key findings: The main barriers for migrant workers to access HIV/TB and GBV prevention and support services in public institutions included language and legal identification documents.

➢ Recommendation 23: Raks Thai and its local partners to advocate to the government to allocate more budget for interpretation services and for providing language training to migrant workers.

Key findings: There have not been official guidelines for health sector to provide GBV prevention and response services. The lack of official guidance can pose a structural challenge for Raks Thai, its local partners and similar institutions to provide or advocate for quality and ethical services across sectors.

➢ Recommendation 24: The Ministry of Public Health include GBV response within the minimum standards for community-based HIV services. Raks Thai and its partners can take this opportunity to advocate for including guidelines on GBV services based on internationally recognised standard operating procedures.

[7] The gender analysis in 2017 found that a staff records him as MSM, it can affect the participation of this man if he defines himself differently ('This service is not for me. I am not an MSM.' or 'I don't want to associate myself with this centre. It is a gay centre.')

ANNEX 1: RESEARCH METHODOLOGY MATRIX

Research areas	Key questions	Information source	Research tools
1. Sexual/ gendered division of labour	1.1. How do key populations (MSM, TG, male and female migrant workers) perceive their gender roles and values regarding household work and caring responsibilities?	TG and female MW: Gender analysis report 2017 MSM: from this GPA	• FGD (Pile sorting) with MSM • Literature review (for all domains or research areas)
	1.2. How do social gender norms and roles (e.g. household work and caring responsibilities) affect key populations access to services?	TG, MSM: from this GPA Male and female MW: Gender analysis report 2017	• FGD (Pile sorting) with MSM and TG
2. Decision-making in intimate relationship	2.1. What are the differences in decision making power of key populations on living activities and access to services?	TG, MSM: from this GPA Male and female MW: Gender analysis report 2017	• FGD (Pile sorting) with MSM and TG
	2.2. Which gender sexual identity is likely to suffer violence resulting from conflicts in decision-making? Why?	TG, MSM: from this GPA Male and female MW: Gender analysis report 2017	• FGD (Pile sorting) with TG and MSM
	2.3. How disagreement in decision making has affected key populations to access services?	TG, MSM, Male and female MW: from this GPA	• FGD (Pile sorting) with TG and MSM
3. Perceptions toward gender-based violence (GBV), gender and sexual identities	3.1. What are the perceptions of sex, love, beauty and trust among key populations?	TG, MSM, male and female MW: Gender analysis report 2017	
	3.2. What are the perceptions of GBV among key populations?	TG, MSM, male and female MW: from this GPA	• FGD (Body mapping) with MSM, TG, male and female MW • Interview with MSM, TG, male and female MW who are from diverse social backgrounds, gender and sexual identities
	3.3. How have these perceptions affected key populations adopt safe behaviours and access to services? What else also affect their behaviours and access to services?	TG, MSM, male and female MW: Gender analysis report 2017	
4. Control over one's body	4.1. How do key populations negotiate safe and consensual sex? In which context and with whom?	TG: from this GPA MSM, female MW: Gender analysis report 2017	• FGD (Body mapping) with MSM, TG, male and female MW
	4.2. What attitudes, information and skills do they need to negotiate safe and consensual sex?	TG: from this GPA MSM, female MW: Gender analysis report 2017	• Body mapping and FGD with TG, MSM, male and female MW • Interview with MSM, TG, male and female MW
5. Violence and restorative justice	5.1. What have key populations done to prevent and respond to violence? What are their main strategies?	TG, MSM, male and female MW: from this GPA	• Body mapping and FGD with TG, MSM, male and female MW • Interview with MSM, TG, male and female MW • Interview with community workers, outreach workers/ peer educators, legal aid staff and NGO staff (local partners and Rak Thai staff – those who have provided GBV services or haven't done yet).

Research areas	Key questions	Information source	Research tools
	5.2. What attitudes, information, knowledge and skills will key populations need to prevent or address violence?	TG, MSM, male and female MW: from this GPA	● Body mapping and FGD with TG, MSM, male and female MW ● Interview with MSM, TG, male and female MW ● Interview with service providers, community workers, outreach workers/ peer educators, legal aid staff and NGO staff (those who have provided GBV interventions or haven't done yet).
	5.3. Which factors also have influenced on GBV experienced by key populations (e.g. gender sexual norms, family relationships, health and economic situation, power dynamics etc.)	TG, MSM, male and female MW: Gender analysis report 2017 and from this GPA	● Body mapping and FGD with TG, MSM, male and female MW ● Interview with MSM, TG, male and female MW ● Interview with service providers, community workers, outreach workers/ peer educators, legal aid staff and NGO staff (those who have provided GBV interventions or haven't done yet), managers of service sites and NGOs. ● Observation of service sites.
	5.4. How have relevant laws and institutions prevented and responded to GBV among key populations and their partners? (main institutions: social, justice and health services, NGOs and workplace)	TG, MSM, male and female MW: Gender analysis report 2017 and from this GPA	● Interview with service providers, community workers, outreach workers/ peer educators, legal aid staff and NGO staff (those who have provided GBV interventions or haven't done yet), managers of service sites and NGOs. ● Observation of service sites.
6. Access to public spaces and services	6.1. How do key populations access to services? What are factors affecting their access to services (e.g. social perception about HIV/TB and SOGI, GBV experience, power relations with key actors such as police and employers)?	TG, MSM, male and female MW: Gender analysis report 2017, STAR-2 funding request	● Interview with MSM, TG, male and female MW ● Interview with service providers, community workers, outreach workers/ peer educators, legal aid staff and NGO staff (those who have provided GBV interventions or haven't done yet), managers of service sites and NGOs. ● Observation of service sites.
	6.2. Who (agencies or individuals) have most influence on this access, why (e.g. peers, partners, healthcare professionals, NGO staff, employers, law enforcement staff etc.)?	TG, MSM, male and female MW: Gender analysis report 2017 and from this GPA	
7. Aspirations for oneself	7.1. What are aspirations that key populations articulate for themselves?	From this GPA	● FGD (Visioning exercise) with MSM, TG, male and female MW
	7.2. How do the aspirations for themselves reflect or contrast social gender norms?		
	7.3. How would key populations envision their relationships evolving (within the household level, in intimate relationship, within their community)?		

ANNEX 2: FIELD GUIDE FOR THE GENDER POWER ANALYSIS

WHO SHOULD BE INVOLVED?

The focus group should involve a minimum of 6 and maximum of 10 participants. The focus group discussion will take around 2-3 hours.

Focus group discussion roles: The facilitator makes sure everyone has a chance to speak and that the discussion stays focused

PREPARATION NOTES:

- Record the key information of participants[8] such as age, gender and location
- What are majority ethnicity this FGD (for the FGD with migrant workers)? Who can able to speak and write English? Who cannot? Average age of all members?

Use clear language with probes for discussion; repeat the question if needed for making sure everyone have common understanding about subject; promoting each participant have opportunity to talk and share idea; no judgment (no right or wrong answers; non threatening or embracing; arrange translator in case participants wish to use their own language).

INTRODUCTION
Each member of the team introduces him/herself and **clearly explain the purpose of the visit:** Rak Thai Foundation is currently doing a research to understand gender issues including harmful gender norms that affect vulnerability to the HIV/TB and access to services by migrant workers, men who have sex with men, and transgender. The research will try to learn more about your life, the way you communicate with peers, family members, partners and service providers to make decision regarding access to diagnosis and treatment. The information that you share with us is valuable – we will use it to help us design a project that better responds to your needs. The discussions will take about 2 hours. We realise how busy you all are, and we are very grateful to you for taking the time to speak with us.   **Ask participants if they have any questions.**

[8] In registering to participate in the FGD, it is recommended to ask participants individually in advance if they have any difficulty seeing, hearing, walking, remembering/concentrating, or communicating (understanding and being understood) in the group discussion. It can be due to their health status, medication or disability status. If this is not possible, I would **not** ask this in front of the whole group as it may be stigmatizing.

INFORMED CONSENT

Before starting the discussion **explain the following** to participants:

- All of the information that you share will be **confidential.** Our notes will be kept secure and we will not share personal details or personal views with anyone else. Is that okay?
- Because you will be sharing your thoughts and experiences together in a group, other people in the discussion will know what each person has said. So that other people do not find out about what people in this group said, lease do not talk about the details of this discussion once the discussion has finished. In this group you should feel comfortable to speak openly. Is that clear?
- Some of the information you give me may be included in a **report** that will be used by Rak Thai Foundation to make improvements to our project. It will not be possible from this report to identify you as individuals. Is that okay?
- Participation in the group discussion is **voluntary**. If you want to leave the discussion at any time you can. After the discussion, you can tell us if you do not want us to use what you have said. You do not have to give a reason why. If you decide not to participate, we will not use any of the information you have given us unless you tell us you want us to. If there is anything you tell us that you do not want us to mention in the report, tell us and we will keep this confidential. Do you understand? Is this OK?
- If you have any **complaints** about the discussion you can tell us. If you don't feel comfortable sharing your concerns with us, you or someone representing you can make contact with XXX (Add a name and a title here), phone number: XXX. Is this clear?
- We will be taking a lot of photos of the activities today. We will include these photos in the report that we write. Is this ok? **If so, please sign the consent form.**
- Do you understand what we have told you? Can we start the discussion now?
- Could you please introduce yourself, including your name, age and any personal details you want to share? (You can choose a pseudo name if you wish)

Focus Group Discussion – Pile sorting

Objective: To collect data for:

Domain 1: Gendered/sexual division of labour (**30**')
Domain 2: Decision making in intimate relationship (**30**')

This tool will be used with **homogenous** groups: MSM only and TG only groups. If necessary, we can divide MSM according to age group or according to self-identified gender (TG women).

According to the methodology matrix, it's not necessary to use this tool with migrant workers. If we want to use this tool with them, male and female migrant workers should be in their own gender group. They should also be grouped according to their nationality/ethnicity.

Steps:

1. Demonstrate tool with the whole group and emphasise that participants should participate from *their own perspective* for self reflection (5')

2. Instructions for group discussion on **gendered/sexual division of labour** (25'):

- Distribute cards to participants (see the preparation instruction on the following page). Each card is about one task of household or caring work.
- Group members discuss and put cards under 3 columns (5'):
  - 'Men', 'Women', and 'Both' (for migrant workers)
  - 'Men', 'Partner' and 'Both' (for MSM)
  - 'Women', 'Partner' and 'Both' (for TG women)
- Ask participants to add more tasks if they want. Write each task in one card
- In the big group (20'):
  - Ask why participants put cards under each column
  - Which tasks are usually done by men (decision will be made on the basis of who will do this task in most cases)? Why? The purpose is to explore their gender norms and values
  - Which tasks are usually done by women or by their partner (in the group discussion with MSM and TG)? Why?
  - Are there ways that men and/or women are limited by the division of labour, e.g. can't go some places, can't interact with some people, can't do some work they might want to do regarding:
    - Behaviour change communication and information
    - Use of prophylaxis, ARV drugs
    - Have early and accurate diagnosis of HIV and TB disease

3. Instructions for group discussion on **decision making in intimate relationship** (30')

- Distribute cards to participants (see the preparation instruction on the next page). Each card is about one issue in the family or regarding access to services (e.g. Safe sex behaviours; Seeking HIV/TB information; Use of prophylaxis, ARV drugs; Have early and accurate diagnosis of HIV and TB disease).
- Ask participants discuss which decisions do men and women (or partner) usually make (**who usually make decision for this issue in most cases and if there is disagreement who has the final say**?). After that they will put corresponding cards under (10):
  - 'Men', 'Women', and 'Both' (for migrant workers)
  - 'Men', 'Partner' and 'Both' (for MSM)
  - 'Women', 'Partner' and 'Both' (for TG women)

- Ask participants to add more tasks if they want. Write each task in one card.
- In the big group (20'):
  - How do men and women (or their partner) make these decisions? Can they make their own decision? Are there any barriers? Why? Is this way of decision making similar to other couples they know? Why?
  - In which situation or for which issues men and women are likely to disagree in decision making?
  - How do you solve disagreement? What are the strategies and techniques they use to solve disagreement, whether or not women and/or TG are able to solve disagreement and example when they are successful in solving disagreement.
  - Who are most likely to experience violence resulting from disagreement in decision making?
  - How has life of male, female migrants, MSM/TG been affected due to disagreement, in terms of?
    - Practise safe sex behaviours
    - Seeking HIV/TB information
    - Use of prophylaxis, ARV drugs
    - Have early and accurate diagnosis of HIV and TB disease

Preparation instruction for facilitators of pile-sorting tool:

- Household tasks: shopping foods and groceries, cooking, washing dishes, washing clothes, hanging clothes, cleaning house etc.
- Caring work: feeding children, elderly, sick family members, taking kids to school, helping kids to do homework etc.
- Please see the attached document for reference. Each household or caring task will be printed in one card. Please search for photos which look relevant to the context of Thailand. If it's too difficult to get these photos, we can take photos by ourselves.
- Issues for decision making: contribute money for daily expenses, spending money on health care, spending money for personal consumption, consistent use of condom, use of contraceptives, seeking information on HIV and/or TB prevention, use of prophylaxis, use of ARV drug, having early HIV and/or TB test, having sex with another person etc. Pictures to present each issue will be printed in one card. Please search for photos which look relevant to the context of Thailand. If it's too difficult to get these photos, we can draw on colour papers and then take pictures.
- **The rule is that there shouldn't be any image of men and women in these pictures**.

Focus group discussion – Body mapping

Objectives: To collect data for:
Domain 3 – Perception on GBV
Domain 4 – Control over one's body
Domain 5 - Violence and restorative justice

This tool will be used with male and male migrant workers, MSM and TG.

Note: Male and female migrant workers can do this exercise together if logistics allows. Similarly, MSM and TG can do this exercise together.

Total time: 70'

Steps:

1. Ask participants to work in small groups. Each group draws a body map for their assigned person (5'):

- One group of male migrant workers will draw a body of men.
- One group of female migrant workers and one group of TG women will draw a body of a woman (each group will draw a body of woman in their own group).
- A group of MSM will draw a body of male sex workers (if in the group of MSM there are not many male sex workers, you can ask this group to draw man's body).

2. On the body map, participants are going to mark points on the body that experience sexual pleasure, pain and violence in blue, dark and red colour (violence can include physical, emotional, mental, etc.) (10')

3. Then, reflecting on their body map, each group should discuss their respective questions (10'):

   Men's body group:
   - Why do men want sex? When do men feel aggressive towards their partners? How would a man feel if he was abused?
   - Is sex used as a tool to achieve certain goals? If so, what are these things? How do men use sex to achieve things? How do women use sex?
   - Why should we talk about sex?

   Women's body group:
   - Why do women want sex? When do women feel aggressive towards their partners? How would a woman feel if she was abused?
   - Is sex used as a tool to achieve certain goals? If so, what are these things? How do men use sex to achieve things? How do women use sex?
   - Why should we talk about sex?

   Male sex workers' group:
   - Why do male sex workers want sex? When do male sex workers feel aggressive towards their partners? How would a male sex worker feel if he was abused?
   - Is sex used as a tool to achieve certain goals? If so, what are these things? How do men use sex to achieve things? How do women use sex?
   - Why should we talk about sex?

Note to numerators: During group work, each numerator will sit with one group to facilitate discussion and document answers which will be used in data analysis. If not, information will be varied among groups.

4. All groups share their body mapping work in the big group (20'). If two groups have the same task, for example draw a body of a woman, the facilitator will invite one group to present their work and another group to add more information to save time.

   Participants often don't adequately mention about pain and violence in different body parts such as eyes (being forced to see porno movies, observe violence acts), ears (hearing abusive words, shouting or screaming by a partner), mouth (being forced to have oral sex), head/brain (pull hairs, mental distress due to violence or being control, being manipulated by a partner), anus (being forced to have anal sex, partner using toys to insert into anus etc.). In this case, facilitators/numerators will have to probe questions to encourage them provide more information.

5. Big group discussion (25'):
   - Do men, women and male sex workers enjoy safe and consensual sex differently? Why?
   - How have men, women and male sex workers negotiated safe and consensual sex? In which context and with whom they are able to negotiate safe and consensual sex? Why?
   - How do perceptions on GBV impact on the ability to negotiate safe and consensual sex by men, women and male sex workers?
   - What else have also affected their ability to negotiate safe and consensual sex?
   - What attitudes, information and skills do they need to negotiate safe and consensual sex?
   - What attitudes, information and skills do they need to reduce the risk of GBV?

   Note to numerators/facilitators: It's important to ask the question 'What else have also affected the ability to negotiate safe sex and access to services'. If necessary, you will have to give probing questions such as how about police attitude to harm reduction and GBV, how about employment opportunities for TG, how about gender norms about women's role and value in intimate relationship etc. We cannot assume that changing perceptions on GBV of key populations, improving their attitude and skills are enough to practice safe and consensual sex.

Guiding questions for the group discussions

Objective: To collect data for Domain 6 - Access to public spaces and services

This tool will be used with male and male migrant workers, MSM and TG.

Total time: 40’

For the following questions, I want you to think of your own communities in a general sense. Do not refer to specific examples (though you can think of them if they help you think of the answer) but give your impression of how community member think. Is that clear?

1. When there is violence either in a relationship, workplace, health setting or in the public who do people usually think is responsible for that violence (for example if a man slaps his wife/partner, who is responsible)?

2. In your experience, what do most migrant women/men/MSM/TG who experience violence usually do? Why?

3. If you have any questions about GBV or seek support on GBV prevention, which service providers/actors/institutions will you go for? Why? (Probe: community workers, outreach workers/peer educators, NGO staff, health service provider, legal aid staff, policemen etc.)

4. How does the fact you all are __ (a woman/man/MSM/TG) impact on what you chose to do about violence? Are you more or less likely to seek help for violence? Why or why not? When?

5. What would community members think of a migrant woman/men/MSM/TG who officially reported violence (for example went to the police)? How would they treat her/him?

6. Where can a migrant woman/man/MSM/TG who experiences violence in your community go for support? What kind of support would community people/groups give to her/him?

7. What would you suggest to make services for violence more accessible and responsive to MSM, TG, male and female migrant workers? (Probe questions not only about social and health services, but also legal aid, access to justice, report to police, privacy and confidentiality protection etc.)

8. Which attitudes, information and skills do migrant women/men/MSM/TG need to reduce the risks of violence?

Group discussion: Visioning Exercise

Objective: To collect data for domain 7 - Aspirations for oneself

This tool will be used with male and male migrant workers, MSM and TG.

Note: Male and female migrant workers can do this exercise together if logistics allows. Similarly, MSM and TG can do this exercise together.

Total time: 45’

Steps:

1. Introduce visioning exercise, envisioning what we hope change looks like for the lives of male and female migrant workers/MSM/TG (Note: facilitator will have to select the relevant identity, depending on group participants). This is anchored by our understanding of the current context laid out by the gender norms and gender-based violence. This helps to explore strategies toward reaching the vision (5’).

2. Ask participants to close their eyes and imagine that they have gone to sleep and when they awake, 10 years have passed and we have really achieved social change. What does empowerment look like for male and female migrant workers/MSM/TG in this new world? Ask participants to keep in mind all that empowerment entails: **change across agency, structures and relations**. Ask them to be focused on the achievements of fully access to HIV and TB testing and treatment without any constraints, financial and emotional burden.

   Split the participants into groups of MSM, TG women, male migrant workers and female migrant workers.

3. Small group work (20’):

- Ask participants to develop a poster with pictures and words to communicate their vision of empowerment.
- Questions for group discussion
  - What are the aspirations of male and female migrant workers/MSM/TG that are articulated for yourselves?
  - What are collective aspirations of male and female migrant workers/MSM/TG that are articulated for yourselves as a group?
  - What limitations do you place on your dreams in terms of who you want to be, what you can achieve and what you can change?
  - How social and gender norms do affects your aspirations?
  - How do you see the world around you changing within these aspirations or priorities?
  - How would you envision your relationships evolving (e.g. relationships with partners, family members, peers, employers, health workers etc.)?
  - How are these envisioned shifts different from the current relationships you have?

4. Bring women and men together to share their vision. Questions for plenary discussion (20’):

- Looking across these visions, what are commonalities and differences?

- What are the key relationships that have influence on achieving a world where everybody will have full access to HIV and TB testing and treatment without any constraints, financial and emotional burden?
- What are key changes that are required to reach the vision of living in a world where all male and female migrant workers/MSM/TG will have full access to HIV and TB testing and treatment without any constraints, financial and emotional burden?

5. Wrap up (5'):

- Remind participants of the purpose of the discussion and explain how we are going to use the information – what the next steps are.
- Check if participants have any questions
- Thank participants for their time
- Collect up materials

Introduction for In-Depth Interview

To be read aloud by the interviewer at the start of the interview.

My name is ______________ and I work for Rak Thai Foundation. I am here to interview you a research to understand gender issues including harmful gender norms that affect vulnerability to the HIV/TB and access to services by migrant workers, men who have sex with men, and transgender. I would like to ask you questions about your experience and your suggestions for improvement. I expect that it will take up to 60 minutes. We realise how busy you all are, and we are very grateful to you for taking the time to speak with us.

The information you share is anonymous and all data collected will be kept confidential in a secure place here and will not be disclosed.

If you do not want to answer any of the questions I ask, please let me know. We can skip those questions. We can also end the interview at any time that you wish. I will not ask you why you do not want to participate.

If you have any **complaints** about the discussion you can tell us. If you don't feel comfortable sharing your concerns with us, you or someone representing you can make contact with XXX (Add a name and title here), phone number: XXX. Do any of you have any questions for me?

If any participant has questions, record questions and your response here:

____

____

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Interview guide with key populations

Objectives: To collect data about how the intersectionality of sexual gender identities and sexual behaviours has affected each key population's likelihood to experience violence and access to GBV experience.

Domain 3 – Perception on GBV
Domain 4 – Control over one's body
Domain 5 - Violence and restorative justice
Domain 6 - Access to public spaces and services

This tool will be used with:
- MSM
- TG women
- Male migrant workers
- Female migrant workers

Total time: 60-90'

Guiding questions:

1. Can you please introduce yourself (actual name or a pseudo name, age, how you would like us to call you, your work, if you are married or cohabitate with a partner)?

2. How long have you participated in our project activities? What have motivated you to join our activities?

Now I will ask you few questions about your personal life. Please let us know if the questions are unclear or if you don't want to answer. We will respect your decision and we can stop at any time you wish. If you need more information or support, please don't hesitate to let us know. We will try to respond to your questions as much as we can. Is this clear?

3. Have someone ever:
    - hit or slap you, throw things at you?
    - created pressure or forced you to have sex?
    - threatened, intimidated, cursed at you?
    - used financial resources to control you?
    - trafficked you?

If the respondent answers yes to one of the above questions, facilitators will have to probe: who is this person, when and how this happened?

If the respondent answer no, facilitators will ask if they know someone has experienced violence (can be their friends or family members) and then probe: who is this person, when and how this happened. If they still say no, refer to the interview questions in the next page.

1. Did you speak to anyone about your violence experience? Probe: a family member, friend, colleague, NGO staff, a service provider or a policemen? If you didn't speak with anybody, why?

2. Did you seek support from a service site (e.g. community health centre, public hospitals, private hospitals)? why did you choose to go to that service? How did you hear about it? What did you expect them to do?

3. For the service site(s) which the interview accessed to seek support: How did you feel about this service site? Did staff give you information and support which you were looking for? Were they welcoming and believe in your story?

4. For the service site(s) which the interviewee didn't access: why you did not go to those services? What is your impression of those services? How accessible are they?

5. Did they ask you which sex you would prefer to see (female or male provider)?

   Was (were) the providers that you saw respectful of you? Or do you think that you are treated differently because of your appearance or identity?

6. Did they refer you to outside services for further support? What is the name of that service? If the respondent cannot remember the name, ask which type of services was referred? Ask the respondent to provide any other info which they can recall.

7. Which types of information did you get about the referral service (location, working hours, type of services, cost, availability etc.)?

8. Is this easy to access to the referral service? What do you think about the referral service?

9. If you experience violence again, will you still go to these providers (can be the first service site which they accessed or the referral service)? Why or why not?

10. Are there any consequences to the perpetrator as a result to your seeking services? If so, what?

11. Which services should be provided to better prevent and respond to GBV among MSM/TG/male and female migrant workers? Why? (Probe questions not only about social and health services, but also legal aid, access to justice, report to police, privacy and confidentiality protection etc.)

12. What would you suggest to make services for violence more accessible and responsive to MSM, TG, male and female migrant workers? (Probe questions not only about social and health services, but also legal aid, access to justice, report to police, privacy and confidentiality protection etc.)

For those who haven't experienced any violence:

1. When there is violence either in a relationship, workplace, health setting or in the public who do people usually think is responsible for that violence (for example if a man slaps his wife/partner, who is responsible)?

2. In your experience, what do most migrant women/men/MSM/TG who experience violence usually do? Why? (Numerators probe questions to get information regarding knowledge and skills of key populations in dealing with GBV incidence).

3. If you have any questions about GBV or seek support on GBV prevention, which service providers/actors/institutions will you go for? Why and why not? (Probe: community workers, outreach workers/peer educators, NGO staff, health service provider, legal aid staff or police

officers etc.)

4. How does the fact that you are __ (a woman/man/MSM/TG) impacts on what you chose to do about violence? Do you often keep silence? Why? Are you more or less likely to seek help for violence? Why?

5. What would community members think of a migrant woman/men/MSM/TG who officially reported violence (for example went to the police)? How would they treat her/him?

6. Where can a migrant woman/man/MSM/TG who experiences violence in your community go for support? What kind of support would community people/groups give to her/him? Do GBV survivors know where they can seek help?

7. What would you suggest to make services for violence more accessible and responsive to MSM, TG, male and female migrant workers? (Probe questions not only about social and health services, but also legal aid, access to justice, report to police, privacy and confidentiality protection etc.)

8. Which attitudes, information and skills do migrant women/men/MSM/TG need to reduce the risks of violence?

Interview guide on GBV

Objectives: To collect data for:
Domain 5 - Violence and restorative justice
Domain 6 - Access to public spaces and services

This tool will be used with:
- Health/GBV service providers working in community health centres and public hospitals
- Drop-in clinic staff and/or mobile service providers

Total time: 60'

Guiding questions:

I. Overall introduction about the service site (10')

1. What is the name of the service you work for?

2. Please describe your duties at the service site:

3. How long have you worked here? How long have you provided services to migrant workers, MSM and TG?

4. What does the service site provide to survivors of violence? (List the different types of services and ask for details about each – who provides them, what benefit they think it brings to the survivors etc.)

II. The provision of GBV services (20')

5. What are the most common types of violence experienced by key MSM, TG, male and female migrant workers?
    - Someone hit or slapped them, throw things at them?
    - Someone created pressure or forced them to have sex?
    - Someone threatened, intimidated, cursed at them?
    - Someone used financial resources to control them?
    - Being trafficked?

   Ask interview participants to provide more examples if they know
   Note to numerators:
    - Go through all forms of violence, not only physical and sexual violence, but also economic control, control of mobility, threat, verbal abuse.
    - Probe questions about different spaces where violence might occur, not only in family setting.
    - Probe question for each group, don't use 'key populations' in general

6. If you have to guess, what is the percentage or number of GBV survivors who are male migrant workers? What is the percentage of survivors who are female migrant workers? MSM? TG? (We understand these are just estimates).

7. Which GBV services have migrant workers, MSM and TG mostly sought when they come to this clinic/centre? Why?

8. Do you know if there are any GBV services available to MSM, TG and migrant workers in this area (e.g. in this district or province, numerator will have to choose the relevant word)? Who are they (e.g. CBOs, public service or private service, names and type of services etc.)?

9. Have you ever referred GBV survivors to outside services? Do you feel confident to refer GBV survivors to these services?

No ☐ Why not? ____

____

Yes ☐ Why yes? ____

____

10. How does the whole referral system ensure confidentiality of GBV survivors?

11. What do you usually do after you refer GBV survivors to other services or after you complete providing services? Do you follow up with them after that?

12. What are the challenges for male and female migrant workers, MSM and TG in accessing services?

13. How do you (and your organization) keep track of survivors? Do you have files on people who access your services? How are those files kept? (Are they locked? Who has access to the files?)

14. Who are your team members in this clinic/centre? How do you communicate and share responsibilities with each other?

III. Skills and attitudes of service providers about key populations, gender and GBV (30')

15. Why do you believe migrant workers, MSM and TG who experience GBV come to services?

16. What challenges have you experienced in providing services to male and female migrant workers, MSM and TG? Which questions do you find most difficult to answer?

17. Do you feel that you were sufficiently prepared to provide services to survivors of violence?

No ☐ Why not? ____

____

What would help you become more prepared?

____

____

Yes ☐ Why yes? ____

____

18. Did you receive any training to work effectively with migrant workers, MSM and TG? Did you receive any training on gender and gender-based violence? Which skills and knowledge you will need to strengthen in order to provide better support to them?

19. What else do you need to better provide GBV services to male and female migrant workers, MSM and TG?

20. How have your perspectives on GBV been changed, if at all, since you have involved in this project?

21. Anything else you would like to mention on this subject? Any questions for us?

Interview guide on GBV

Objectives: To collect data for:
Domain 5 - Violence and restorative justice
Domain 6 - Access to public spaces and services

This tool will be used with NGO **staff** who have provided GBV interventions and support including legal aid, outreach workers/peer educators, community workers

Total time: 60'

Guiding questions:

I. Overall introduction (10')

1. What is your position at __ and how long have you worked with them?

2. Do you feel comfortable speaking for this organization? Let them know you think we should interview other staff or others could be called into this meeting (IF others join please record the names and positions and when they joined.)

3. Please describe the service team. How many providers are there? How many of them are female and male? How many of them are from MSM, TG and migrant communities?

II. The provision of GBV services (20')

4. What are the most common types of violence experienced by key MSM, TG, male and female migrant workers?
   - Someone hit or slapped them, throw things at them?
   - Someone created pressure or forced them to have sex?
   - Someone threatened, intimidated, cursed at them?
   - Someone used financial resources to control them?
   - Being trafficked?

   Ask interview participants to provide more examples if they know
   Note to numerators:
   - Go through all forms of violence, not only physical and sexual violence, but also economic control, control of mobility, threat, verbal abuse.
   - Probe questions about different spaces where violence might occur, not only in family setting.
   - Probe question for each group, don't use 'key populations' in general

5. Does your organization implement activities to address GBV among MSM, TG and migrant workers in this area (e.g. in this district or province, numerator will have to choose the relevant word)? What are the key GBV prevention efforts? What types of resources and service are available to MSM, TG and migrant workers?

6. What is your impression of the overall quality of GBV services/interventions by your organisation? What are the major challenges?

7. Do staff have a list of referral services? To which services do providers refer clients?

8. How is the referral process (e.g. easy to access and communicate with, quickly and smoothly run)? How does the whole referral system ensure confidentiality of GBV survivors?

9. If MSM, TG and migrant workers bring a case to trial, how successful are they? How does the state “prove” GBV in the courts? Is there forensic evidence? Do service providers provide testimony?

10. How do state actors ensure the survivors safety during and after prosecution? How can the state protect MSM, TG and migrant workers if the perpetrator threatens them? Are there “orders of protection” in Thailand (laws that can be used to prohibit a partner from being in contact with the survivor)?

11. What are the key needs in GBV programming?

III. Skills and attitudes of service providers about key populations, gender and GBV (30’)

12. What are the major reasons for GBV among MSM, TG and migrant workers?

13. What challenges have you experienced in providing support for male and female migrant workers, MSM and TG?

14. Did you receive any training on gender and gender-based violence? Which skills and knowledge you will need to strengthen in order to provide better support to them?

15. What else do you need to better provide GBV services to male and female migrant workers, MSM and TG?

16. What are your priorities in advocacy for more support to GBV prevention and respond?

17. Anything else you would like to mention on this subject? Any questions for us?

Interview guide on GBV

Objectives: To collect data for:
Domain 5 - Violence and restorative justice
Domain 6 - Access to public spaces and services

This tool will be used with **staff** working for NGOs who haven't worked on GBV

Total time: 50'

Guiding questions:

I. Overall introduction (10')

1. What is your position at __ and how long have you worked with them?

2. Do you feel comfortable speaking for this organization? Let them know you think we should interview other staff or others could be called into this meeting (IF others join please record the names and positions and when they joined.)

3. Please describe the service team. How many providers are there? How many of them are female and male? How many of them are from MSM, TG and migrant communities?

II. Skills, knowledge and attitudes of service providers about key populations, gender and GBV (30')

4. What are the most common types of violence experienced by key MSM, TG, male and female migrant workers?
    - Someone hit or slapped them, throw things at them?
    - Someone created pressure or forced them to have sex?
    - Someone threatened, intimidated, cursed at them?
    - Someone used financial resources to control them?
    - Being trafficked?

    Ask interview participants to provide more examples if they know
    Note to numerators:
    - Go through all forms of violence, not only physical and sexual violence, but also economic control, control of mobility, threat, verbal abuse.
    - Probe questions about different spaces where violence might occur, not only in family setting.
    - Probe question for each group, don't use 'key populations' in general

5. What are the major reasons for GBV among MSM, TG and migrant workers?

6. How likely is a survivor from migrant, MSM, TG community to seek GBV services? Why? What services would they mostly use? Why?

7. Do you know if there are any GBV services available to MSM, TG and migrant workers in this area (e.g. in this district or province, numerator will have to choose the relevant word)?

8. What is your impression of the overall quality of these GBV services? What are the major challenges?

9. If MSM, TG and migrant workers bring a case to trial, how successful are they? How does the state "prove" GBV in the courts? Is there forensic evidence? Do service providers provide testimony?

10. How do state actors ensure the survivors safety during and after prosecution? How can the state protect MSM, TG and migrant workers if the perpetrator threatens them? Are there "orders of protection" in Thailand (laws that can be used to prohibit a partner from being in contact with the survivor)?

III. Plan to provide GBV interventions and support (10')

11. Does your organization have a plan to include activities to address GBV among MSM, TG and migrant workers in this area (e.g. in this district or province, numerator will have to choose the relevant word)? Is your organisation ready to support GBV survivors from migrant, MSM, TG community?

12. What can be key interventions for GBV prevention among MSM, TG and migrant workers? What knowledge, skills and support do service providers need to address for GBV prevention among MSM, TG and migrant workers?

13. Do you have plan to advocate for more support to GBV prevention and respond? What are your advocacy priorities?

14. Anything else you would like to mention on this subject? Any questions for us?

Interview guide on GBV

Objectives: To collect data for:
Domain 5 - Violence and restorative justice
Domain 6 - Access to public spaces and services

This tool will be used with **managers** of community health centres, drop-in clinics, mobile clinics and NGOs (local partners of Raks Thai Foundation)

Total time: 40'

Guiding questions:

I. Introduction of the service site (20')

1. Name of the service site and its location

2. What kinds of services does this site provide to GBV survivors?

3. How many staff provide GBV services? What are their roles and responsibilities?

4. How is staff training?
   - How many staff received training? How many of them are female and male? How many of them are from MSM, TG and migrant communities?
   - When were staff trained?
   - How long was the training?
   - Who did the training?
   - What did the training cover in general?

5. Does the training of staff (if it happens) go over:
   - Gender equality, gender and sexual identity
   - Causes and consequences of GBV
   - How to respond to GBV?
   - Issues regarding people with MSM, TG and migrant workers?
   - Maintaining survivors' confidentiality
   - Safety planning

6. Which staff have access to GBV files?

7. Have all staff trained on client confidentiality (e.g. finance, HR, admin and other support staff)?

II. The provision of GBV services (20')

8. How do clients find out about your services?

9. Which groups do you see most in your service site (e.g. PLHIV, PWID, Sex workers, MSM, TG, male and female migrant workers, from which nationality)?

10. Do providers have a list of referral services? To which services do providers refer clients? How is the referral process?

11. What is your impression of the overall quality of GBV services by your organization/centre? What are the major challenges?

12. Are there specific issues in providing services to these groups compared to other populations?

13. What are your priorities in advocacy for more support to GBV prevention and respond?

14. Anything else you would like to mention on this subject? Any questions for us?

Observation Checklist for GBV Service Sites

Community Name:

Name of specific service site:

Services provided:

Hours of operation:

Free or Fee: __ If clients have to pay fee, please note the average cost here: ___

Date:

Name of the person writing observations:

**Take a picture of the location or building after receiving consent*

1. Is the building or location easily accessible? Describe any features e.g. ramps, steps, paths
2. Does the site provide other services besides GBV services? If yes, what services?
3. If this site provides only GBV services, how is it identified? *(* Take photo of the front*)
4. If yes, do GBV survivors share the same waiting are with other clients? Would others in the waiting area know they are there for GBV services?
5. Are there interview/counselling room(s) where a provider gives services: ** Take picture*
6. If there is more than one room, ask if one of the rooms is reserved for female survivors.
7. If it is not a room, please ask where the counselling area is and if there is a reserved area for female survivors.
8. Where are client files kept? Is the location:
   - Dedicated only to GBV survivor's files?
   - Locked under key?
   - Who has access to these files?
   - Describe the location: _______________
9. Do they have a list of referral services with updated contacts? Which services do they often refer clients?
10. Do they have an interview guide or service provision guide for providing GBV services?
11. If it is a health service centre, check whether they have the following supplies:
    - Post Exposure Prophylaxis __
    - HIV test kit
    - Emergency Contraception
    - Rape Kit or other kit for gathering evidence

REFERENCES

[i] CARE International (2020) *Guidance for creating and managing effective feedback and accountability mechanisms, access at*: https://www.careemergencytoolkit.org/wp-content/uploads/2020/01/FAM-guidance-2020-01.pdf

[ii] CARE International (2018). *Gender Equality and Women's Voice Guidance Note,* access at: https://insights.careinternational.org.uk/images/in-practice/GEWV/GEWV_guidance-note_english_2018.pdf

[iii] CARE International Gender Network (2012) *Good Practices Framework – Gender*, access at: https://www.care.org.au/wp-content/uploads/2015/02/Good-Practices-Brief.pdf

[iv] Raks Thai Foundation (2017) *Gender Analysis for key populations under STAR program*

[v] CARE International (2017) *Social Analysis and Action Global Implementation Manual*, access at: https://care.org/sites/default/files/saatoolkit_final_rights_reserved.pdf

[vi] Stefanik, L. and Hwang, T. (2017). *Applying theory to practice: CARE's journey piloting social norms measures for gender programming*. CARE USA. Available at: http://www.care.org/sites/default/files/applying_social_norms_theory_to_practice_cares_journey.pdf

[vii] CARE International (2013) *The Community Score Card (CSC): A generic guide for implementing CARE's CSC process to improve quality of services*, access at: https://www.care.org/sites/default/files/documents/FP-2013-CARE_CommunityScoreCardToolkit.pdf

[viii] CARE International (2017). 'I know I cannot quit.' The Prevalence and Productivity Cost of Sexual Harassment to the Cambodian Garment Industry. Canberra: CARE Australia. Access at: https://www.care.org.au/wp-content/uploads/2017/04/SHCS_Full_Technical_Report_March_2017.pdf

[ix] CARE International (2020) *Guidance for creating and managing effective feedback and accountability mechanisms, access at*: https://www.careemergencytoolkit.org/wp-content/uploads/2020/01/FAM-guidance-2020-01.pdf