MEETING TARGETS AND MAINTAINING EPIDEMIC CONTROL (EPIC) PROJECT

COOPERATIVE AGREEMENT NO.
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EpiC Gender Strategy

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EpiC
Meeting Targets and Maintaining Epidemic Control

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EpiC is a global cooperative agreement dedicated to achieving and maintaining HIV epidemic control. It is led by FHI 360 with core partners Right to Care, Palladium International, Population Services International (PSI), and Gobee Group. For more information about EpiC, including the areas in which we offer technical assistance, click here.

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Acknowledgments

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Abbreviations

AGYW	Adolescent girls and young women
CSO	Civil society organization
EpiC	Meeting Targets and Maintaining Epidemic Control
GBV	Gender-based violence
KP	Key population
LINKAGES	Linkages across the Continuum of HIV Services for Key Populations Affected by HIV
PEP	Post-exposure prophylaxis
PEPFAR	U.S. President's Emergency Fund for AIDS Relief
PLHIV	People living with HIV
PrEP	Pre-exposure prophylaxis
SDART	Same-day antiretroviral therapy
UNAIDS	Joint United Nations Programme on HIV/AIDS
USAID	U.S. Agency for International Development
Trans	Transgender

Vision and Overview

The Meeting Targets and Maintaining Epidemic Control (EpiC) project envisions a world in which all people living with and at risk of acquiring HIV—including adult men and women, members of key populations (KPs) (gay men and other men who have sex with men, people who inject drugs, sex workers, and transgender people), and adolescent girls and young women (AGYW)—are able to freely access HIV prevention, care, and treatment services that meet their needs, as well as engage in protective behaviors that allow them to live healthy and productive lives. Realizing this vision requires that gender norms and inequalities which create barriers to service uptake and increase vulnerabilities to HIV be identified and systematically addressed through equitable, rights-based HIV programming that places beneficiaries at the center and treats them as holistic beings. The *EpiC Gender Strategy* describes the project's commitment to and operational plans for making this vision a reality. Further, it explains the rationale for gender-integrated HIV programming; provides illustrative examples of how EpiC will integrate gender considerations into specific priority technical areas across the HIV prevention, care, and treatment cascade; and discusses how the project will monitor and evaluate its gender integration efforts to track progress and guide program improvements.

Project Commitment to Gender Integration for Optimized Outcomes across the Cascade

The EpiC project's plan for gender integration aligns with guidance from the U.S. President's Emergency Plan for AIDS Relief (PEPFAR) and the U.S. Agency for International Development (USAID) and recognizes that meaningfully addressing gender-based stigma and inequalities, including gender-based violence (GBV), is critical to optimizing project performance. As such, the EpiC team is committed to the following:

Global level: A headquarters-based project gender advisor, with a minimum of 20 percent dedicated time, will oversee and coordinate the project's gender integration efforts (see Box 1 for definitions of key concepts and terms) and work closely with country-based gender focal points to ensure effective implementation, monitoring, and evaluation of those efforts. The gender advisor will contribute to developing and implementing global EpiC work plans. In addition, the gender advisor will provide technical assistance to country programs in a manner that is responsive to field priorities and budgets to support their efforts to identify and mitigate or transform harmful gender norms that may hinder the impact of programming. Technical assistance will involve the use of existing tools for gender integration, be adapted to the needs of each country, and be aligned with evidence-based best practices. At the global level, the project will also identify opportunities to document EpiC's gender integration practices and lessons learned to benefit the broader HIV field and encourage knowledge sharing with a range of HIV and gender stakeholders, implementers, and decision makers.

Knowledge products may include success stories; presentations during conferences, technical meetings, and webinars; and articles published in peer-reviewed journals.

Global analyses of routinely collected data will help identify specific populations or programming areas that require gender-related technical assistance, as well as identify opportunities for inter-country learning. For example, the gender advisor may facilitate exchanges whereby countries with strong transgender programming, including those offering gender-affirming services, share this expertise with countries that are only beginning to reach transgender communities.

Country level: EpiC project teams at the country level will designate a staff member to be the gender focal point for local programming (see Box 2). This person will be trained on the EpiC gender strategy and oriented on the importance of gender integration to effective HIV programs. As part of their responsibilities, gender focal points will seek opportunities to understand and challenge the harmful gender norms and inequalities that increase vulnerability to HIV and inhibit service uptake, for example, those manifested in rights violations such as GBV.

Box 1. Definitions of Relevant Gender-Related Terms

Gender integration: Strategies applied in programmatic design, implementation, monitoring, and evaluation to take into account gender considerations and compensate for gender-based inequalities (adapted from Interagency Gender Working Group, 2014).

- Gender-accommodating programs acknowledge, but work around, gender differences and inequalities to achieve project objectives.
- *Gender-transformative programs* aim to promote gender equality and achieve program objectives by (1) fostering critical examination of inequalities and gender roles, norms, and dynamics; (2) recognizing and strengthening positive gender-related beliefs that support equality and an enabling environment; and (3) promoting the relative position of marginalized groups and transforming the underlying social structures, policies, and broadly held social norms that perpetuate gender inequalities.

Gender-based violence (GBV): Any form of violence that is directed at an individual based on their biological sex, gender identity (e.g., transgender), or behaviors that are not in line with social expectations of what it means to be a man, woman, boy, or girl (e.g., men who have sex with men, female sex workers). It includes physical, sexual, and psychological abuse; threats; coercion; arbitrary deprivation of liberty; and economic deprivation, whether occurring in public or private life (PEPFAR, 2013).

Transgender: An adjective to describe people whose gender identity is different than the sex they were assigned at birth. Transgender is an umbrella term that describes a wide variety of cross-gender behaviors and identities (United Nations Development Programme et al., 2016).

Project level: All gender-integration activities undertaken within EpiC will occur as part of achieving outcomes across the HIV prevention, care, and treatment cascade to achieve epidemic control. A hallmark of our gender-integration activities will be the meaningful engagement of women, men, AGYW, and transgender people to ensure that the project is being implemented in a way that meets their needs, is responsive to their experiences, and builds on their expertise.

Box 2. Gender Focal Points in EpiC

Qualifications: Each EpiC gender focal point should be a member of the country technical team who has knowledge/training on sex and gender, sexual orientation, gender identity, GBV (including against young women and KP members, depending on the scope of the project), and the ways gender norms and inequalities contribute to the HIV epidemic.

Responsibilities: EpiC gender focal point responsibilities will include contributing to/reviewing work plans and advocating for dedicated funding for gender-integration activities as needed; attending relevant local technical working groups (e.g., a GBV technical working group); providing sensitization and/or training to create stigma-free and accessible programs for all; identifying relevant local funding opportunities to strengthen gender-related programming; reviewing data disaggregated by gender and specific to GBV to identify programming gaps and social harms resulting from program strategies; supporting the documentation of gender-integration activities in case studies, blogs, or other knowledge products; and liaising with other gender focal points and the global gender advisor to receive updates, share approaches, and request support, as needed.

Training: EpiC gender focal points will attend a brief internal webinar to become familiar with the EpiC gender strategy and gender focal point responsibilities.

Not only how we program, but with whom, will be informed by a desire to shift power dynamics to decrease inequality. When we work to identify capable local partners and leaders, we will seek to collaborate with organizations led by or serving key populations, priority populations, and women. EpiC will also look for opportunities to address GBV and other gender issues using approaches that engage a broader coalition of stakeholders in HIV-related efforts—for example, those who have traditionally worked only on GBV—bringing new resources to the table and making HIV programming more holistic to benefit service users.

Recognizing that this vision is contingent upon adequate resources, both global project leadership and country-based EpiC representatives will advocate for dedicated project funding to address restrictive gender norms and inequalities, in particular to prevent and respond to GBV, and will seek opportunities for collaboration with other projects and donors.

Project Background

EpiC is a five-year global project funded by PEPFAR and USAID dedicated to achieving and maintaining HIV epidemic control. The project provides strategic technical assistance and direct service delivery to break through the barriers to achieving the 95-95-95 goals, as well as to promote self-reliant management of national HIV programs by improving HIV case finding, prevention, treatment programming, and viral load suppression. EpiC is led by FHI 360 with core partners Right to Care, Palladium International, Population Services International (PSI), and Gobee Group. The project also draws upon regional resource partners (Africa Capacity Alliance, Enda Santé, Thai Red Cross AIDS Research Center, University of the West Indies, and VHS-YRG Care) to provide technical assistance, as well as global resource partners who bring unique capacities (Aurum Institute; Dimagi; Johns Hopkins University Key Populations Program; JSI Research and Training Institute, Inc.; MTV; and World Vision International).

EpiC is one of the central PEPFAR awards of USAID's Office of HIV/AIDS and is designed to accept funding from USAID missions interested in expanding or initiating programs that address their epidemic control needs. The EpiC consortium works in partnership with governments, civil society organizations (CSOs), other PEPFAR implementing partners, and the private sector to strengthen their capacity, introduce innovations, and expand evidence-based HIV services to unprecedented levels of scale, coverage, quality, effectiveness, and efficiency.

The project has four areas, each of which will require specific gender-integration strategies.

Area 1: Attain and maintain HIV epidemic control among at-risk adult men, women, and priority populations

Area 2: Attain and maintain HIV epidemic control among key populations

Area 3: Improve program management, health information systems, human resources for health, and HIV financing solutions to attain and maintain epidemic control

Area 4: Support the transition of direct funding and implementation to capable local partners in order to meet PEPFAR's goal of providing 70 percent of its funding to local partners by 2020

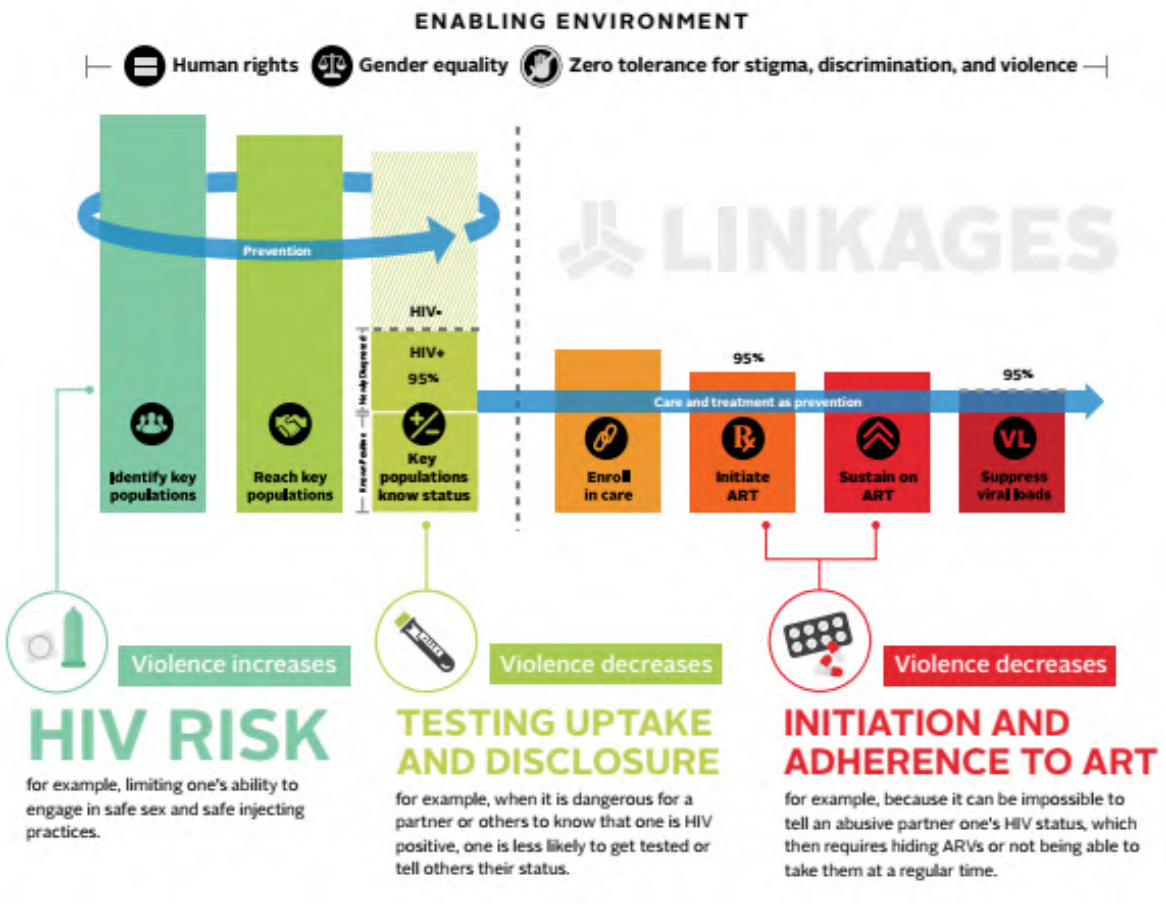
Role of Gender Integration in HIV Programming

Effects of Gender Inequalities and Restrictive Norms on HIV-related Outcomes

Gender is a social system that affects all people across their lifespans, and gender inequality and restrictive gender norms are determinants of health and well-being. Individuals who are born male or female are met with different expectations, rights, and responsibilities that affect their health, particularly their vulnerability to HIV and their access to HIV services. Around the world, gender inequalities and rigid gender norms harm the health and human rights of girls and women and promote the marginalization of anyone who challenges restrictive gender norms, including boys, men, and transgender people (Heise et al., 2019). This is perhaps most clearly illustrated in patterns of GBV, where women, girls, and KP members experience a disproportionate burden of abuse which has immediate and long-term effects on their vulnerability to HIV and their access to HIV services (see Figure 1 for the effects of violence across the HIV cascade).

In most cultures, gender norms support a hierarchy wherein masculine/male is perceived to be superior to feminine/female in a way that undermines women's rights and narrows and limits opportunities for gender and sexual minorities to safely live their lives. While the burden of gender inequality—historic and current—falls mainly on women and gender and sexual minorities, restrictive gender norms harm everyone. The level of harm caused to individuals is dependent on intersecting factors, such as socioeconomic status, race, ethnicity, disability, citizenship, and education. As noted in guidance from the Linkages across the Continuum of HIV Services for Key Populations Affected by HIV (LINKAGES) project on addressing GBV against KP members, "The more that marginalized and criminalized identities, behaviors, or characteristics converge at the individual or community level, the greater the risk of violence. For example, an immigrant sex worker who does not speak the local language, has limited financial resources, and is afraid of deportation will be more vulnerable to abuse by law enforcement than a sex worker who is a citizen and has the connections and financial resources to find and hire a lawyer if violence should occur." For this reason, an intersectional approach is often more able to address the complex and nuanced issues faced by individuals.

Figure 1. The effects of violence across the HIV prevention, care, and treatment cascade



Gender Integration for Optimized and Sustained Impact

While gender norms and inequalities are pervasive, they are not stagnant. Changes occur with social pressure, macro-level policy and economic changes, and individuals' efforts to think critically about and challenge the norm. Gender integration strategies applied in HIV programs that take gender considerations into account, challenge harmful gender norms, and compensate for gender-based inequalities have been shown to improve and sustain HIV programming outcomes (Boender et al., 2004; Barker et al., 2007; Rottach et al., 2009; Interagency Gender Working Group, 2014).

Modeling suggests that this may be particularly true of effective GBV prevention efforts. Estimates in Kenya and Ukraine—two different epidemic contexts—indicate that a reduction in HIV infections of approximately 25 percent among sex workers could be achieved by reducing physical and sexual violence (Decker et al., 2013). See Box 3 for gender considerations by population in EpiC programming.

Box 3. Gender Considerations by Population for EpiC Programming

Adult Men and Women and Priority Populations

Gender inequality, GBV, and norms for both feminine and masculine sexual, social, and health-seeking behaviors facilitate HIV transmission and trap men and women in gender roles that perpetuate the epidemic. Women may not have the ability to access services or use HIV prevention products without their male partners' implicit or explicit support, health care providers' biases may negatively affect their interactions with women seeking HIV services, men may take risks or fail to prioritize health-seeking behaviors until they are extremely ill due to norms around masculinity, and approaches such as index testing that offer promising opportunities to identify new HIV cases may increase the danger of intimate partner violence (IPV) in unequal relationships. In addition, responding to GBV in service users' lives, and particularly instances of IPV, can place those implementing HIV programs at risk, as perpetrators may become violent toward individuals and organizations supporting survivors of violence.

Key Populations

Members of KPs can experience negative effects when conforming to gender norms (e.g., transgender women experiencing GBV within their intimate partnerships as part of taking on the female role), as well as when they are perceived to deviate from restrictive norms (e.g., a man marginalized for having sex with other men or a female sex worker stigmatized for having multiple sex partners). Gender-based stigma, discrimination, and violence make it more difficult to reach KP members with services and harder for KP members to engage in protective behaviors, such as using pre-exposure prophylaxis (PrEP), that would reduce their vulnerability to HIV. Structural violence can also play a role; in contexts in which sex work is criminalized and subject to violent policing practices, the resulting environment of fear and anxiety has been associated with increased vulnerability to HIV.

Implementers working with key populations in restrictive or hostile environments, where their programs may be seen as encouraging behaviors that deviate from accepted gender norms, also often face violence and abuse.

Adolescent Girls and Young Women

The health challenges faced by adolescent girls and young women are exacerbated by their relative lack of power, opportunity, and resources and their increased risk for violence, even when compared to their older female counterparts. In addition, their physiology puts them at higher risk of complications in childbirth and increases their vulnerability to HIV infection. Improving AGYW's access to comprehensive sexual and reproductive health education and youth-friendly services, while working to address the structural issues that increase their vulnerability and keep them from seeking services, are important for meeting the needs of the most vulnerable.

USAID and PEPFAR Guidance

EpiC's approach to gender integration is aligned with and informed by PEPFAR 3.0's focus on gender equality as an aspect of the PEPFAR 3.0 human rights agenda (PEPFAR, 2015) as well as the *PEPFAR Gender Strategy* (PEPFAR, 2013) (Box 4). It is also in line with the *USAID Gender Equality and Female Empowerment Policy* (Box 5) and the *United States Strategy to Prevent and Respond to Gender-based Violence Globally*, both of which put forward principles such as "do no harm" that shape the EpiC approach to addressing GBV (State Department and USAID, 2016).

Box 4. PEPFAR Guidance

PEPFAR 3.0 Human Rights Action Agenda

Success in our Human Rights Action Agenda is defined as: (1) expanded access to nondiscriminatory HIV prevention, treatment, and care for all people, including LGBT [lesbian, gay, bisexual, and transgender] people; (2) increased civil society capacity to advocate for and create enabling environments; and (3) increased gender equality in HIV services and decreased GBV.

PEPFAR Gender Strategy, Recommended Activities

1. Provide gender-equitable HIV prevention, care, treatment, and support.
2. Implement GBV prevention services and provide services for post-GBV care.
3. Implement activities to change harmful gender norms and promote positive gender norms.
4. Promote gender-related policies and laws that increase legal protection.
5. Increase gender-equitable access to income and productive resources, including education.

Box 5. Objectives of USAID's Gender Equality and Female Empowerment Policy

- Reduce gender disparities in access to, control over, and benefits from resources, wealth, opportunities, and services—economic, social, political, and cultural;
- Reduce gender-based violence and mitigate its harmful effects on individuals and communities.
- Increase the capability of women and girls to realize their rights, determine their life outcomes, and influence decision making in households, communities, and societies.

EpiC Gender Integration Activities

EpiC programming will be tailored to meet the needs of each country where it operates. Activities for gender integration will differ based on the technical strategies implemented. EpiC will conduct a gender analysis in the countries that buy in to EpiC, as needed and requested by USAID missions and in accordance with Automated Directive Systems (ADS) 205 (USAID, 2017) to guide the gender-integrated programming the project will undertake. For KPs, gender-analysis tools will be based on guidance developed under LINKAGES (LINKAGES, 2017). Other relevant tools, such as the gender-analysis tools for PrEP introduction developed by FHI 360 under the OPTIONS project, will be used as needed.

To address the twin epidemics of GBV and HIV within EpiC, efforts to prevent and respond to GBV will be of paramount importance. Not only will IPV be addressed as part of index testing and PrEP (Table 1), efforts will also be made to educate communities at risk of GBV on what violence is, the link between violence and HIV, their rights, and the GBV response services available. HIV program implementers working in communities and at health facilities will be equipped to provide first-line support when disclosures of violence occur; first-line support is also referred to as psychological first aid and includes listening to survivors, inquiring about their needs, validating them, enhancing their safety, and supporting them through connections to other services and social support. In addition, networks of GBV response services will be strengthened and documented so that they can be shared with HIV program beneficiaries. Finally, under EpiC, program implementers will reach out to dedicated GBV sites, such as one-stop centers, to ensure linkages between HIV and GBV programs. (See Annex A for tools on GBV and HIV integration across the HIV prevention, care, and treatment cascade.)

Table 1 outlines illustrative, non-exhaustive gender-integration activities in technical areas to be addressed under EpiC.

Table 1. Illustrative gender-integration activities to optimize interventions and performance across EpiC technical areas

TECHNICAL AREA	ILLUSTRATIVE GENDER INTEGRATION ACTIVITIES
PREVENTION	
Pre-exposure prophylaxis (PrEP) PrEP scale-up is critical to interrupt transmission in networks with individuals who are not yet virally suppressed.	▪ Engage target populations such as AGYW and KPs to understand their knowledge of PrEP, preferences, past experiences with providers, and risk and protective factors in order to develop policies, guidelines, and implementation plans responsive to each community's unique needs (FHI 360, 2016).

TECHNICAL AREA	ILLUSTRATIVE GENDER INTEGRATION ACTIVITIES
	▪ Make PrEP available to all women, not only those considered to be at highest risk, to avoid stigmatizing the product. ▪ Include couple counseling to help promote partner communication about HIV risk and disclosure of HIV status. ▪ Offer PrEP at service delivery outlets already used by target populations for other health services (e.g., family planning) to reduce obstacles to access. ▪ Train providers, including on identifying their own discriminatory behaviors and attitudes toward AGYW and KP members who may want PrEP. ▪ Build the capacity of AGYW to talk with their partners and parents about PrEP. ▪ Integrate IPV screening and first-line support into PrEP services for women, AGYW, and KP members during both PrEP initiation and follow-up visits.
Voluntary medical male circumcision Voluntary medical male circumcision is a highly effective and cost-effective HIV prevention intervention recommended in countries with high HIV prevalence and low levels of male circumcision.	▪ Consider engaging female partners to build buy-in for the procedure and improve couple communication. ▪ Address masculinity norms connected to circumcision, such as changes in sexual performance and ability to satisfy one's sexual partners post-circumcision (Fleming et al., 2017).
Condom supply and demand In spite of substantial past donor investments, condoms remain underused, and many markets fall short of meeting the needs of priority and key populations.	▪ Ensure the provision of both female and male condoms. ▪ Develop the capacity of peer educators/outreach workers to provide support to female clients and members of KPs on how to negotiate condom use with partners.

TECHNICAL AREA	ILLUSTRATIVE GENDER INTEGRATION ACTIVITIES
CASE DETECTION	
HIV index and network testing The impact and efficiency of HIV testing services can be accelerated by targeted testing among networks of people living with HIV who are not yet virally suppressed.	▪ Ensure that routine inquiry about IPV is part of any index-testing program. Ask about IPV when speaking to gender and sexual monitories—not only women—and adapt screening questions to reflect unique experiences, such as partners threatening to out men who have sex with men and transgender people. (See Annex B for the requirements that must be in place before using routine inquiry.) ▪ Train providers and outreach workers to ask about IPV in a way that encourages disclosure, and to respond using first-line support. Ensure that questions on violence ask about economic and psychological violence, in addition to physical and sexual abuse. ▪ Improve clinical GBV response services at HIV care and treatment sites and strengthen links to community, justice/legal, psychosocial, and other health services needed by GBV survivors. ▪ Support individuals to communicate with their partners about their HIV status, including through support for couple communication or couple testing, as desired. ▪ Support providers to understand KP members' unique barriers to sharing partner names, including concerns in contexts of criminalization, and to put mechanisms in place so that such sharing can be done safely.
HIV self-testing HIV self-testing expands access to HIV testing services, particularly for people at high risk who may not otherwise get tested.	▪ When providing self-tests for distribution by service users, discuss the potential for GBV when encouraging one's partner to self-test. ▪ Use gender-disaggregated data to determine whether gender integration strategies could support greater uptake of HIV self-testing among specific populations, or greater linkage to care following a reactive test.

TECHNICAL AREA	ILLUSTRATIVE GENDER INTEGRATION ACTIVITIES
CARE AND TREATMENT	
Antiretroviral therapy (ART) optimization Dolutegravir is the preferred first-line ART regimen in the 2018 World Health Organization (WHO) Interim Guidelines because of its superior efficacy, improved tolerability, and higher threshold for resistance as compared to efavirenz-containing regimens.	▪ Ensure that standard operating procedures state that women, including women of childbearing age, should be offered dolutegravir. ▪ Build the capacity of providers to respect women's autonomy in decision making and provide information and options that enable them to make an informed decision about which ART regimen to use.
Same-day ART (SDART) SDART reduces the time to treatment initiation and viral suppression, thereby maximizing the health and prevention benefits of treatment.	▪ Disaggregate data, including by sex, age, and KP, to determine whether specific populations are less likely to initiate SDART. ▪ Address specific gender-based barriers to SDART by offering testing and ART services in locations where primary care services are also provided and at KP-friendly drop-in centers.
Viral load Access to patients' viral load is essential to optimize care and maximize the prevention benefits of treatment.	▪ Enhance couple communication around viral load and provide point-of-care viral load testing in settings friendly to KPs, women, and adolescent girls. ▪ Promote U=U messaging to mitigate gender-based stigma that may prevent viral load testing or even initial HIV testing (UNAIDS, 2018).
Tuberculosis (TB) preventive therapy TB is the leading cause of death for people living with HIV (PLHIV). TB preventive therapy is an essential and cost-effective component of HIV care for PLHIV, but it remains widely underutilized.	▪ Understand and respond to gendered delays in diagnosis that occur among men (Rajeswari et. al, 2002; Kaur et al., 2013) in some settings and women in others (Yimer et al., 2005; Storla et al., 2008; Li et al., 2013). ▪ Collect evidence on TB among women to fill a gap in the research (Perumal et al., 2018).

TECHNICAL AREA	ILLUSTRATIVE GENDER INTEGRATION ACTIVITIES
CROSSCUTTING	
Differentiated service delivery Differentiation is critical to increase options for patients, simplify their care, and free up resources to address individuals with greater needs.	▪ Consider ways in which gender norms create opportunities or barriers to differentiated care. For example, in some settings, groups of women may have stronger connections to one another, which could allow approaches such as community dispensing to function more effectively. ▪ Take into account gender and population when developing service delivery models, for example, by providing mobile outreach to sex workers who struggle to come to facilities during their regular business hours or making treatment more accessible to men who have sex with men y enabling ART dispensing at KP-friendly drop-in centers. Differentiated service delivery can also occur across individuals' lives. For example, studies have shown that adherence rates among women who initiate ART during pregnancy are particularly low, suggesting that health-care-worker-managed models may be most appropriate immediately after childbirth, while other, less intensive models are more appropriate later (Grimsrud et al., 2017).
Key-population-specific program approaches Addressing the differentiated preferences and needs of those most at risk and most underserved, including young and hidden KP members, transgender women, and older men who have sex with men, is critical to achieving epidemic control.	▪ Implement approaches such as gender-affirming care for trans people to increase the uptake of services among those who are most vulnerable. (See Annex C for more "quick steps" to improve trans programming.) ▪ Address gender-based stigma and discrimination against KPs by training health care workers and monitoring provider behavior, including through technologies such as LINK (LINKAGES, 2019b). ▪ Integrate violence detection and response into both community and facility-based services tailored for KPs, including strong crisis response systems and community-led rights education and first-line support. ▪ Work to prevent violence against KP members, including by engaging law enforcement.

TECHNICAL AREA	ILLUSTRATIVE GENDER INTEGRATION ACTIVITIES
	▪ Ensure that KPs and KP CSOs know their rights and have access to services or support (including international crisis response) when those rights are violated, as well as options to document violations
"Smart" care and prevention cascades Increasing achievement along the prevention, care, and treatment cascade requires weighing the value of improvements (in terms of reducing leaks in the cascade and improving adherence/ follow-up) vs. the increased cost of these additional interventions.	▪ When developing cascades, disaggregate by population, including separate cascades for transgender people that clearly indicate whether the program is serving transgender women or transgender men. ▪ When determining the root causes of leaks in the cascade, explore barriers to service uptake that may have a gendered root cause, such as GBV, lack of ability to control resources, and duties at home that interfere with adherence.
Sustainable financing Sustained epidemic control for a national HIV program requires mobilizing additional domestic resources for HIV, improving the efficiency of the HIV response, integrating HIV into broader health financing mechanisms and health sector reforms, and leveraging the private sector.	▪ Encourage the inclusion of line items for GBV in national HIV budgets and for money allocated to specific populations who bear a disproportionate burden of HIV due, in part, to gender inequalities—particularly girls, women, and KPs.
"Going online" Online platforms can accelerate progress toward epidemic control by engaging previously unreached individuals according to their preferences and by leveraging technology-related efficiencies.	▪ Reach populations experiencing high levels of gender-related stigma through approaches that tap into online networks (LINKAGES, 2019a). ▪ Use online risk assessments for HIV to raise awareness on the link between GBV and HIV, linking survivors to GBV response services, including HIV testing (and post-exposure prophylaxis [PEP], when relevant). ▪ Take gender and population into account when developing outreach models. (See Annex D for graphic of differentiated service delivery.)

TECHNICAL AREA	ILLUSTRATIVE GENDER INTEGRATION ACTIVITIES
Undetectable = Untransmittable Promotion of U=U can provide a pivotal platform to overcome barriers to HIV testing, adherence, viral load testing, and participation in index testing, while mitigating stigma and discrimination.	▪ Disaggregate adherence and viral load data by gender and population to determine the groups that may benefit most from U=U messaging. ▪ Ensure that advocates for U=U come from all target populations and that all populations have the opportunity to contribute to the development of materials so that messages resonate in their communities.
Stigma and discrimination Stigma and discrimination are among the greatest barriers to health-seeking behaviors for priority and key populations.	▪ Use technology-facilitated feedback systems such as LINK to monitor and address stigma and discrimination in health facilities (LINKAGES, 2019b). ▪ Build support networks to help mitigate self-stigma among PLHIV and KP members. ▪ Train health care workers to ensure that services are friendly to youth and KP members. ▪ Support KP, women-led, and AGYW organizations to claim their place at the table in national discussions, including by improving their HIV advocacy skills and by linking them to national/ international resources and networks.
Violence prevention and response Integrating HIV and violence prevention and response services is key to improving service access, as well as to protecting health and human rights.	▪ Strengthen referral systems that meet survivors' comprehensive GBV response needs—including physical and mental health services, social services, and legal/justice services—and ensure that services are welcoming to those who will be referred (in particular, AGYW and KP members) before making a referral. ▪ Use accompaniment or active referral to support survivors' access to referral services. ▪ Train providers to use routine inquiry, as appropriate, and to provide first-line response. (See Annex B for the requirements that must be in place before conducting routine inquiry.)

TECHNICAL AREA	ILLUSTRATIVE GENDER INTEGRATION ACTIVITIES
	▪ Strengthen and build upon systems already developed by communities and use information on violence to better understand and respond to the risks faced by program beneficiaries (including those disclosed in risk assessments of KP members). ▪ When possible, build coalitions to address violence that can simultaneously address GBV against all priority and key populations. ▪ Work toward policy changes that improve access, such as making PEP available in cases of sexual assault rather than only after occupational exposure (especially in countries reporting on GEND_GBV), and remove barriers to comprehensive GBV response services for all survivors (e.g., changing policies that explicitly define victims of IPV as women).
Safety and security of implementers Threats to the safety of HIV program implementers—often due to stigma, discrimination, and violence against PLHIV and KP members—negatively affect all aspects of the HIV program cycle and limit opportunities for epidemic control.	▪ Identify ways in which supporting GBV survivors may affect implementer security and mitigate any risks identified through the development and implementation of a security plan. ▪ In contexts where serving KP members entails risks to implementer safety, especially due to gender-related stigma and discrimination within the local culture and/or laws, have implementing partners complete security checklists in the Safety and Security Toolkit (International HIV/AIDS Alliance and LINKAGES, 2018) and provide tailored support to enhance the security mechanisms they have in place. This is particularly important when local implementers are members of key populations who may be targeted for their work, identities, or behaviors.

TECHNICAL AREA	ILLUSTRATIVE GENDER INTEGRATION ACTIVITIES
Human-centered design thinking Persistent gaps in access reflect limited capacity to address the differentiated preferences and needs of priority and key populations. Human-centered design thinking can accelerate solutions to close these gaps.	▪ Conduct rapid, small-scale gender analyses using human-centered design to find solutions to gender disparities in how men and women access or benefit from innovations such as PrEP and HIV self-testing. ▪ Use human-centered design to address gender barriers to men's uptake of services and to create messages that transform norms responsible for a delay in or lack of service-seeking behavior among men. ▪ Consider individuals' holistic sexual and reproductive health needs and respond to them through HIV programs; for example, provide family planning information and services at HIV clinics for both women and men. ▪ Acknowledge structural barriers that disproportionately affect women and include programs such as economic empowerment and financial literacy to improve outcomes in the prevention of mother-to-child transmission or HIV prevention for female sex workers.

Tracking Gender-Integrated Programming under EpiC

PEPFAR Monitoring, Evaluation and Reporting (MER) and Custom Indicators

A robust monitoring and evaluation system, including a MER indicator used in the context of targets (GEND_GBV) and a project-wide custom indicator (GEND_REPORT_COMM), is in place for EpiC (Box 5). The data from these indicators will be used to inform program planning, improvement, and policy advocacy.

Additional custom disaggregates focused on GBV will be optional, depending on their relevance to programs. Indicator reference sheets for custom disaggregates can be found in Annex E. They describe the number of PREP_NEW, HTS_INDEX, HTS_TST_POS, and TX_NEW clients (sex- and age-disaggregated) screened for GBV, identified as having experienced GBV, and referred to or provided with clinical and non-clinical GBV services.

Box 6. Gender-Based Violence Indicators

GEND_GBV tracks the number of people receiving post-GBV clinical care based on the minimum package. The minimum package includes treatment of injuries, rapid HIV testing, sexually transmitted infection testing and treatment, counseling (first-line support), referrals to other services as necessary, and PEP and emergency contraception (in cases of sexual violence and if within time limits). The full reference sheet can be found in the MER guidance (PEPFAR, 2019).

GEND_REPORT_COMM measures reported experience of all forms of violence among individuals served by PEPFAR community-based programs and services. It captures both disclosure of violence (the denominator) and coverage of post-violence services for those who have experienced violence (the numerator). The full reference sheet for GEND_REPORT_COMM can be found in Annex F.

Data Disaggregation

EpiC country teams will be expected to disaggregate data by gender, key population, and priority population (e.g., AGYW, clients of sex workers). These data will be used for in-depth analyses of the people EpiC approaches are reaching, who is benefiting from the approaches, and with whom more targeted efforts should be made. The *PEPFAR Monitoring, Evaluation, and Reporting Indicator Reference Guide. MER 2.0 (Version 2.4)* includes guidance on KP disaggregation, including separating men who have sex with men and transgender people, for a subset of indicators (PEPFAR, 2019). To collect the information needed for this level of disaggregation, the project will use PEPFAR's two-step question method (Table 2).

TABLE 2. Two-step question recommended to correctly identify transgender people in service use statistics

Health Care Provider script to Client: "I will be asking you about some sexual and drug using risk behaviors. Your responses will help me/us provide you with better care. Your answers to these questions will be kept in your confidential clinic record. Answering these questions is voluntary and you can refuse to answer any question and still receive the service you've come here for today."	
1. Do you consider yourself: male, female, transgender or other? □ MALE □ FEMALE □ TRANSGENDER (male to) FEMALE □ TRANSGENDER (female to) MALE □ _____OTHER □ REFUSE TO ANSWER	*If TRANSGENDER (male to) FEMALE: client was born a boy, but identifies as a woman* *If TRANSGENDER (female to) MALE: client was born a girl, but identifies as a man*
2. What was your sex at birth: male or female? □ MALE □ FEMALE □ _____OTHER □ REFUSE TO ANSWER	

Source: Appendix A in PEPFAR, 2019

Process Indicators

Additional indicators will be developed to capture efforts to enhance gender equality within EpiC processes. For example, EpiC will track the number of CSOs owned or led by KP members that are receiving subawards or transition awards. Such indicators will continue to evolve over the life of the project and will be reported to USAID in semi-annual reports.

Filling Evidence Gaps

While studies clearly demonstrate that gender inequality and particularly GBV increase vulnerability to HIV and make service seeking more difficult (see Figure 1), more robust evidence that HIV programs are able to achieve better outcomes by addressing violence in the lives of beneficiaries is still needed. For this reason, EpiC will seek opportunities, including through collaboration with other institutions and funders that leverage the EpiC service delivery platform, to generate these data. Internally, EpiC will review routinely collected data in individual e-cascades to determine whether receiving GBV response services supports PrEP continuation and antiretroviral use and whether investing in violence prevention and response overall changes program-level cascades. Tool 12 of the *EpiC Monitoring Guide and Toolkit for Key Population HIV Prevention, Care, and Treatment Programs* (EpiC, forthcoming) will be used to collect information on instances of violence and the services provided to survivors.

EpiC will also track unintended consequences associated with index testing such as social harms. This information will be used to inform strategies to enhance the safety of survivors of violence and the safety of program implementers. It will be tracked in two places. First, when the harm occurs to an index client, it will be recorded as such in Tool 12, which has a specific option to note that the violence occurred in the context of index testing. Second, country

security focal points will use implementer security incident logs to document incidents that affect an organization or individual delivering services; for example, if a health care worker experiences violence from an individual whose contact information was shared by an index client (see Annex G for an example of a security logbook).

Data Safety

Data safety is of paramount importance for any HIV program. Adding data on occurrences of IPV, as is required when implementing index testing or offering PrEP, increases the harm that could come to beneficiaries if data are breached. EpiC will follow strong data-protection procedures first established under LINKAGES and elaborated in *Ensuring Compliance with the LINKAGES Data Safety and Security Checklist* (LINKAGES, 2020). (See Annex H for a description of the specific protections for the data of individuals who report violence.)

Reports

Regular reports to USAID will contain content highlighting approaches to address gender-related barriers, including any activities to identify and respond to physical, sexual, emotional, and economic violence against program beneficiaries.

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Annex A: Gender-Based Violence Prevention and Response Tools

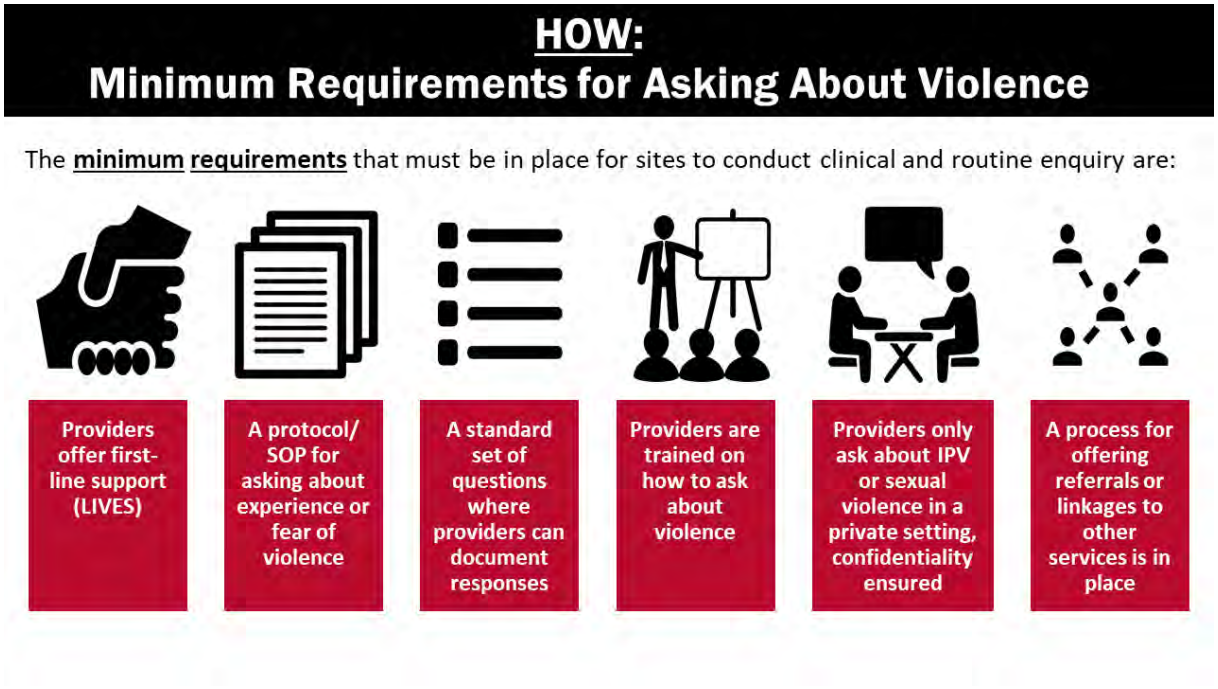
LINKAGES Tool	Purpose	Target Audience
LINKAGES Gender Strategy (LINKAGES, 2017b)	Explains the rationale and process for implementing the *LINKAGES Gender Strategy*, including activities to prevent and respond to GBV	Program designers, managers, and evaluators
LINKAGES Health4All: Health Workers' Training Guide for the Provision of Quality, Stigma-Free HIV Services for Key Populations (LINKAGES, 2018)	Raises the consciousness of staff in health care settings about the effects of stigma and discrimination and trains health care workers on how to provide stigma-free, appropriate services to KP members	Staff in health care settings
LINKAGES Violence Prevention and Response Training Curriculum for Health Care Workers (Dayton et al., 2019a)	Builds the knowledge and skills of health care workers to ask KP members about violence and respond to individuals who disclose violence	Health care workers (clinical and non-clinical)
LINKAGES Violence Prevention and Response Training Curriculum for Peers and Outreach Workers (Dayton et al., 2019b)	Builds the knowledge and skills of peer educators, peer navigators, and outreach workers to ask KP members about violence and provide first-line support to individuals who disclose violence during outreach activities	Peer educators, peer navigators, and outreach workers
LINKAGES Law Enforcement Training: Preventing and Responding to Violence against Key Populations to Increase Access to Justice and Strengthen the HIV Response (Dayton, 2019)	Reduces violence against KP members that is perpetrated by law enforcement officers and ensures that law enforcement can provide appropriate services to victims of violence who are members of KPs	Law enforcement officers
Safety and Security Toolkit: Strengthening the Implementation of Programs for and with Key Populations (International HIV/AIDS Alliance and LINKAGES, 2018)	Helps KP program implementers identify and address safety and security challenges	Program implementers

Additional tools for use in GBV programming include:

- Jhpiego. n.d. Gender-Based Violence Quality Assurance Tool: Standards for the Provision of High Quality Post-Violence Care in Health Facilities. Available at: http://resources.jhpiego.org/resources/GBV-QA-tool.
- Jhpiego. n.d. *Gender Service Delivery Standards: Quality Assurance Tool.* Available at: http://resources.jhpiego.org/system/files/resources/Gender%20Service%20Delivery%20Standards-%20web.pdf.

Annex B: Minimum Requirements before Conducting Routine Inquiry

This graphic was developed by the Office of HIV and AIDS Gender and Sexual Diversity Team based on WHO guidance (WHO, 2013).



Annex C: Quick Steps for Improving Transgender Programming

Quick Steps for Improving Transgender Programming

The following are steps that can be taken relatively quickly to improve the ability of key population programs to (1) understand and meet the needs of transgender (trans) people, (2) offer services that are attractive and appropriate to the trans community, and (3) more accurately capture services being provided to trans people. **Box 1** contains relevant definitions. This document focuses on programs supported by the United States President's Emergency Plan for AIDS Relief (PEPFAR) to reach key populations, but can be applied more widely.

Photo credit: Cynthia Matonhodze for International HIV/AIDS Alliance

Crosscutting considerations

- Help ensure that trans people are counted. Use the PEPFAR-recommended two-step question found in **Box 2** each time you do a formal intake for someone who attends any key population programming (i.e., do not ask these questions only of individuals whom the program staff believe may be trans). The two-step question will allow you to accurately

Box 1. Definitions
(all taken from the TRANSIT[2] unless otherwise noted)

Transgender - An adjective to describe a diverse group of individuals whose gender identity differs to varying degrees from the sex they were assigned at birth. In this document, we will use transgender and the shortened form "trans" as umbrella terms to refer to people whose gender identity and/or gender expression does not correspond with the social norms and expectations traditionally associated with their sex assigned at birth. A t**rans woman** is a person who was assigned male sex at birth and identifies as female, while a **trans man** is a person who was assigned female sex at birth and identifies as male.

Gender identity – A person's internal, deeply felt sense of being a man or woman, or something other, or in between, which may or may not correspond with the sex assigned at birth.

Gender expression - A person's ways of communicating masculinity and/or femininity externally through their physical appearance (including clothing, hair style, and cosmetics), mannerisms, ways of speaking, and behavioral patterns.

Gender affirmation – The process by which individuals are affirmed in their gender identity. Gender affirmation typically involves three dimensions: social (being called by a name and pronouns that are aligned with a person's gender identity); medical (hormone therapy, surgical procedures); and legal (changing a person's legal name or sex designation).[3]

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determine whether individuals you serve are transgender. This is of fundamental importance to estimating the size of the trans population, making key population programs feel more inclusive for trans people, avoiding conflation of men who have sex with men (MSM) and trans women, documenting whether services are provided to trans men or women, and supporting global advocacy efforts for better trans community programming. When asking the two-step question:

Box 2. Two-step question[1]

1. Do you consider yourself: male, female, transgender, or other?
   - Male
   - Female
   - Transgender (male to) female
   - Transgender (female to) male
   - _____ other
   - Refused to answer

2. What was your sex at birth?
   - Male
   - Female
   - _____ others
   - Refused to answer

  - Pilot the questions before they are rolled out locally to ensure that they are both culturally acceptable and that they identify trans women and men appropriately. The intention of these questions is to allow key population program staff to correctly identify trans people, regardless of their ability to express their gender identity. Use of the two-step question also helps avoid misidentifying as trans women any MSM who take on a feminine role or who are the receptive partner in their sexual relationship with another man, a misidentification that has occurred in some contexts.
  - Keep in mind that there are many reasons why trans people may not feel comfortable disclosing their gender identity, and do not press anyone to answer in a certain way. Anyone who wishes not to answer any question, including regarding gender identity or sex assigned at birth, always has the right to do so.
  - Ensure that those who are asking the questions are coached to explain the importance of the two-step question (i.e., accurate risk assessment and monitoring and evaluation). It is also imperative that whenever the two-step question is asked, the person asking it explains that these questions are asked of all people. Explaining that the two-step question is standard procedure helps avoid any client discomfort that may come from an impression that they are being singled out for such questions.
  - Ask the questions in private, as opposed to during broad outreach activities, to protect confidentiality and increase accurate response rates.
  - Consider asking about sexual orientation immediately following questions about gender identity and sex assigned at birth, as this will give program staff the opportunity to talk about the difference between gender identity and sexual orientation and to further assess risks.
- Hire trans staff, peer educators, peer navigators, and outreach workers, and support trans-led community-based organizations (CBOs). This will benefit the targeted outreach and mobilization to these key populations members, and because trans people are often underemployed, hiring them provides an important example to other organizations, as well as an opportunity for programming to reflect and increase engagement with the trans community.

Know the needs and size of the transgender community

- Conduct focus group discussions (FGDs) with trans stakeholders to: understand their priorities, particularly those related to HIV; learn terminology that is most appropriate in the specific country context, including locally relevant terms such as hijra, which is used in India, or waria, used in Indonesia; identify any existing local organizations that support transgender people; and find out where trans people gather. See **Annex 1** for example questions you might consider including in the FGD.
- In cases where there is no formal population size estimate, you can multiply the size of the country's adult population by 0.6% to create a rough estimate.[4] This calculation will not take the place of a local population size estimate, but it does provide some sense of the size of the population for whom their sex assigned at birth differs from their current gender identity. It should be noted that the 0.6% estimate of the transgender population size comes from recent studies in the United States and that self-identification as transgender in this sample was greater among younger people who are more comfortable and aware of the concept of transgender gender identities.
  - In African contexts, recent literature shows that roughly 20% of individuals recruited as MSM identify as transgender or female. In Togo, Burkina Faso, and Côte d'Ivoire, researchers found that 18% of participants in studies that sought to recruit cisgender MSM (i.e., MSM whose gender identify and sex assigned at birth are both male) actually identified as female or transgender.[5] In studies targeting MSM in Burkina Faso, Côte d'Ivoire, the Gambia, Lesotho, Senegal, Togo, Malawi, and Swaziland, 937 (20%) of the 4,586 individuals enrolled identified as transgender or female.[6]
- Know the laws that may affect trans people in your country and the risks trans people may face based on these laws. Use this information to engage in conversations about safety and security with members of the trans community, and have a plan for how your program will support members of the trans community if a safety and security concern does arise.

Make the program more welcoming to trans people

- Post pictures and language that are inclusive and trans-affirming in physical and virtual spaces (as appropriate from a safety perspective); this will go a long way toward making trans people feel more welcome. It also shows that you see the differences between MSM and trans people, even though the physical space for programming may be shared.
  - If the local project is on social media, recognize and commemorate days such as the Trans Day of Remembrance (November 20) or the International Day of Trans Visibility (March 31).[7]
- Inquire about the person's preferred pronoun, and then use it whenever referring to that person.
  - For example, a trans woman conducting outreach could say the following to a new client, "We want to be sure that we are respecting everyone's gender identity. What pronoun do you use to refer to yourself? I use she/her."

  - Male and female pronouns are one way society denotes gender, and public use of the wrong gender pronoun for a given person can cause harm and limit that person's trust in a provider or program.
- If possible, provide single-stall, nongendered restrooms. If only multi-stall restrooms are available, consider posting signs that clearly indicate that all are welcome to use the restroom where they feel most comfortable.
- Do not conflate trans women and MSM, and do not speak about the two groups as one community. Provide education to lesbian, gay, bisexual, and transgender (LGBT) CBOs, as needed, that clarifies the distinction between gender identity and sexual orientation.
- Conduct sensitization with country staff and health care workers associated with the project on appropriate language and terminology, and review health needs and HIV epidemiology specific to the trans community.

Offer the services and spaces that trans people prioritize and which will improve acceptance for HIV services

- HIV services may be more attractive to the trans community when they are linked to clinical services that help affirm trans people's gender.[8] At a minimum, make sure that there are medical staff who are familiar with cross-sex hormone therapy and its interactions with HIV antiretrovirals (ARVs). For more on offering gender-affirming care, see Chapters 3 and 4 of the TRANSIT.[2]
  - PEPFAR does not currently pay for gender-affirming hormones. However, in some key population programs, other donors have covered the cost of hormones that are provided at PEPFAR-supported clinics, or the program has been able to facilitate access to hormones provided elsewhere.
- Provide physical space for trans people to come together and network with each other.
- Provide psychological support to help trans people as they consider or undergo transitioning.[9]
- Address violence, stigma, and discrimination in trans people's lives. As resources allow:
  - Provide human rights education/legal literacy to help trans people, especially in contexts where police harassment is common.
  - Support trans people when they are victims of violence by offering first-line response and more extended psychosocial support, and by creating a network of trained service providers who can meet the full range of victims' needs.
  - Intervene with common perpetrators, such as police or family members.
  - Provide economic strengthening services.
  - Offer activities and support groups to build self-esteem.
  - Connect to or offer programs to support individuals dealing with drug and alcohol abuse.

Advocate with the Ministry of Health, USAID, and other funders to support appropriate programs for transgender people

- Use the Rights in Action advocacy brief to explain the importance of addressing trans people's programming needs to decision makers.[10]
- Consider a harm-reduction angle[11] to advocate for training medical staff on how to prescribe and monitor cross-sex hormone therapy.
- Advocate for trans people's explicit inclusion in national strategic plans for addressing HIV.
- If there are no program trans targets, or if the targets seem too low, advocate with USAID for improved size estimation and other related efforts.
- Encourage the representation of trans people on Global Fund Country Coordinating Mechanisms (CCMs).

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Annex 1: Sample Focus Group Discussion Guide

Begin the focus group discussion (FGD) by thanking participants for coming and by describing the relevant project. Let participants know that you are asking them these questions to better understand the health needs — and specifically, the HIV-related needs — of the trans community in order to inform programming. Then set the ground rules, as you would in any FGD, and begin by having everyone introduce themselves with whatever name and pronoun they choose.

1. Please start by telling us a little bit about the transgender community in X country. How would you describe this community?
    a. Probe on where transgender people come together.
    b. Probe on whether there are groups of people or organizations that are working to support transgender people or to create safe spaces where transgender people can spend time.
    c. Ask what is important for health care providers and other programmers to understand about transgender people in X country.

2. What are the current risks that transgender people face, especially those that may increase their exposure to HIV?
    a. Probe on sex without condoms, sexual violence, and engagement in sex work.
    b. Probe on alcohol and drug use, self-harm, other forms of violence, and depression.

3. Think about the health care needs of transgender people. What services are most important to you?
    a. Probe on locally available HIV-related services such as condoms and lubricant, HIV testing and self-testing, post-exposure prophylaxis (PEP), pre-exposure prophylaxis (PrEP), and ARVs.
    b. Probe on hormone therapy or other gender-affirming services (e.g., hair removal, breast augmentation).

4. Of all the services you mentioned [name some of the priorities they mentioned earlier], which do you currently lack access to?

5. Where do you currently go for health information? If you go to specific organizations or websites, please share those names.
    a. Probe on whether these resources are helpful and what other health information is needed.

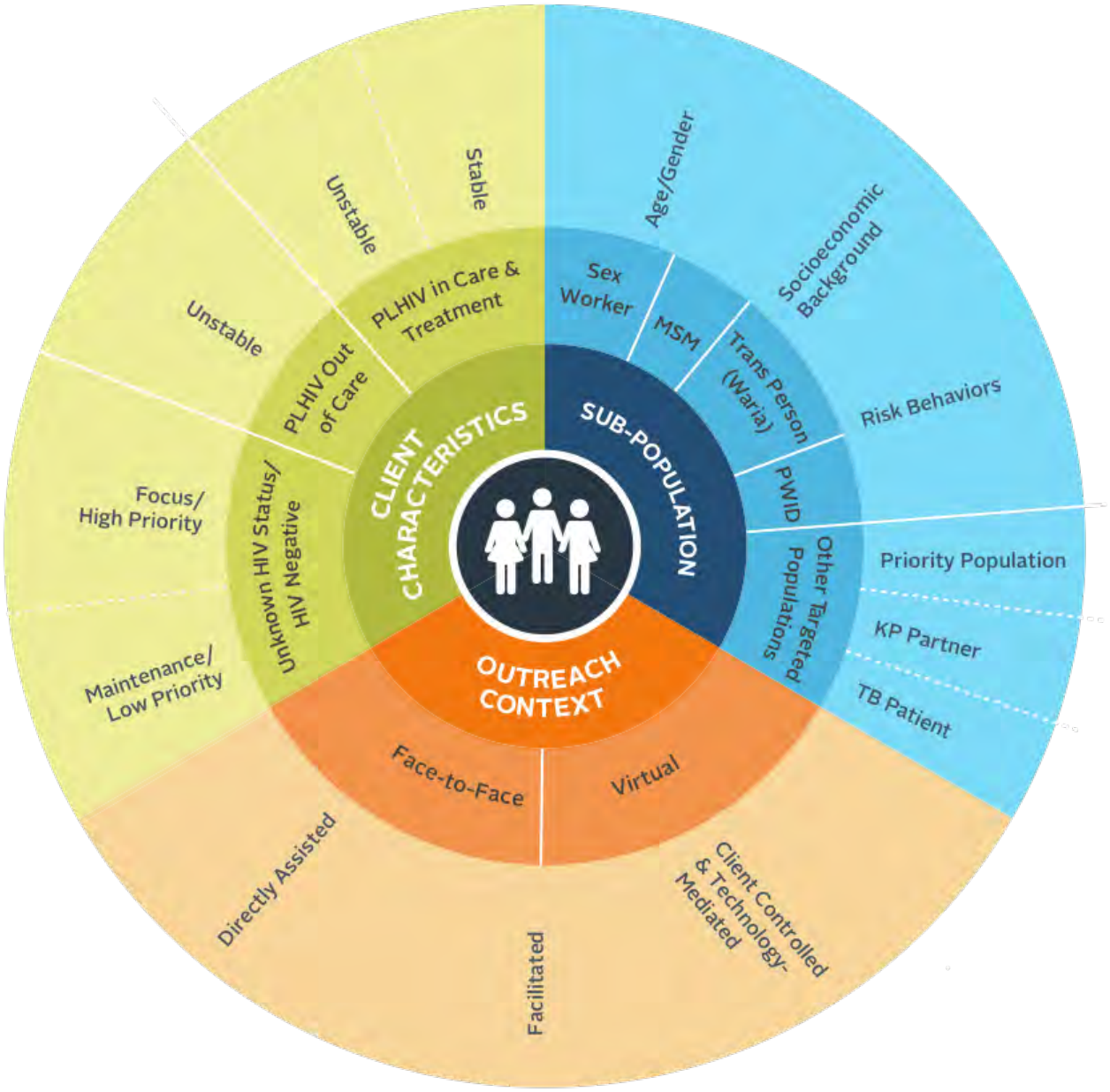
6. Imagine that you are designing HIV services for your community—what would they be like?
    a. Probe on who would deliver these services, where would they be located, what their hours would be, and what the space would look like on the inside (e.g., art, posters, seating).

7. Some HIV programs also address violence or mental health concerns in the lives of their clients. What role(s) would you like your health care provider or peers hired by an HIV program to play in helping victims of violence or helping trans people who are dealing with depression, addiction, etc.?

8. What else do you think is important for us to know as we work to make sure our program meets the needs of transgender people?

June 2018

Annex D: Differentiated Outreach Service Delivery



Annex E. Custom GBV Disaggregate Reference Sheets

HTS_INDEX_GBV		
Description:	Number of individuals who were identified and tested using index testing services, and received their results	
Numerator:	Number of individuals who were identified and tested using index testing services, and received their results	This indicator aims to monitor the scale and fidelity of implementation of HIV index testing-related services.
Denominator:	N/A	There is no official denominator. However, this indicator represents a cascade, and the collected disaggregations serve as both numerators and denominators when analyzing the index testing cascade.
Reporting level:	See PEPFAR MER Indicator Reference Guide (Version 2.4 FY20)	
How to use:	See PEPFAR MER Indicator Reference Guide (Version 2.4 FY20)	
How to collect:	See PEPFAR MER Indicator Reference Guide (Version 2.4 FY20)	
How to review for data quality:	[Screened for GBV=YES] + [Screened for GBV=NO] = HTS_INDEX [Identified as having experienced GBV=YES] + [Identified as experiencing GBV=NO] = [Screened for GBV=YES] [Referred to and/or provided GBV services=YES] + [Referred to and/or provided GBV services=NO] = [Identified as having experienced GBV=YES] For those reporting GEND_GBV: [Referred to and/or provided GBV services =YES] >=GEND_GBV The following percentages can be calculated from the disaggregations: Percentage of HTS_INDEX that were screened for GBV: [Screened for GBV=YES]/HTS_INDEX x 100 Percentage of HTS_INDEX who were identified as experiencing GBV among those screened: [Identified as having experienced GBV=YES]/[Screened for GBV=YES] x 100 Percentage of HTS_INDEX who were identified as having experienced GBV and who were referred to and/or provided GBV services: [Referred to and/or provided GBV services=YES]/[Identified as having experienced GBV=YES] * 100 See PEPFAR MER Indicator Reference Guide (Version 2.4 FY20)	

Supplemental Disaggregation:	**Supplemental numerator disaggregation for gender-based violence (GBV)**	
	Disaggregate group	**Disaggregates**
	Screened for GBV	Yes/No Definition: Screened for GBV (disaggregated by sex/age per HTS_INDEX groups)
	Identified as having experienced GBV	Yes/No Definition: Identified as having experienced GBV—among those screened for GBV (disaggregated by sex/age per HTS_INDEX groups)
	Referred to and/or provided GBV services	Yes/No Definition: Referred to and/or provided clinical and/or nonclinical GBV services—among those screened and identified as having experienced GBV (disaggregated by sex/age per HTS_INDEX groups)

Disaggregate descriptions & definitions:	U.S. Agency for International Development (USAID) HIV testing partners conducting index testing and partner notification services are expected to **identify survivors of violence** through routine or clinical enquiry (if capacity exists to conduct clinical enquiry) and **provide or refer for appropriate post-violence clinical care** as defined by the GEND_GBV MER indicator. Per the PEPFAR MER Indicator Reference Guide (Version 2.4 FY20) for HTS_INDEX, all index clients should be screened for intimate partner violence (IPV) per World Health Organization (WHO) guidelines at the time of index testing. Providers are required to identify all index testing clients (index client and contacts of the index client who are tested for HIV) experiencing or at risk of experiencing violence through routine enquiry (i.e., providers ask clients about experience or fear of violence in settings where clinical enquiry cannot be conducted, but where violence is a known risk factor for HIV). The **minimum requirements** that must be in place for sites to conduct routine (and clinical) enquiry are as follows: • Providers offer first-line support: **L**isten, **I**nquire, **V**alidate, **E**nhance Safety, and **S**upport (**LIVES**); • Protocol/standard operating procedure (SOP) for conducting routine enquiry; • Standard set of questions where providers can document responses; • Providers are trained on how to ask about IPV or sexual violence; • Providers only ask about IPV or sexual violence in a private setting, confidentiality ensured; • Process for offering referrals or linkages to other services is in place. For those screened and for whom violence is identified or disclosed, the provider will offer the client first-line support (**LIVES**), refer to (or directly provide) post-violence clinical care, and refer to nonclinical and community support services. The provider will follow child protection and mandatory reporting guidelines according to the principle of the best interests of the child. Of note: For clients screened and for whom violence is suspected but not acknowledged or disclosed, the provider will offer information on available GBV services, follow child protection and mandatory reporting guidelines according to the principle of the best interests of the child, and offer a follow-up visit. Data sources are standard program monitoring tools, such as forms, logbooks, spreadsheets, and databases that national programs and /or partners develop or already use. Data should be collected continuously at the point of index testing service delivery and aggregated in time for U.S. President's Emergency Plan for AIDS Relief (PEPFAR) reporting cycles.
Special considerations:	As outlined in the Program Guide for Integrating GBV Prevention and Response in PEPFAR Programs, all programs seeking to address GBV must first and foremost protect the dignity, rights, and well-being of those at risk for, and survivors of, GBV. There are four fundamental principles for integrating a GBV response into existing programs and specific actions for putting these principles into practice. These principles are as follows: • Do no harm; • Privacy and confidentiality; and informed consent (for research); • Meaningful engagement of people living with HIV (PLHIV) and GBV survivors; • Accountability and monitoring and evaluation (M&E).

PrEP_NEW_GBV

Description:	Number of individuals newly enrolled on oral antiretroviral pre-exposure prophylaxis (PrEP) to prevent HIV infection in the reporting period	
Numerator:	Number of individuals who were newly enrolled on oral antiretroviral pre-exposure prophylaxis (PrEP) to prevent HIV infection in the reporting period	The numerator is generated by counting the number of people newly enrolled on oral PrEP (including WHO specified regimens "tenofovir-containing PrEP" which could be TDF alone, TDF/FTC, or TDF/3TC) during the reporting period, in accordance with the demonstration project guidance or the nationally approved protocol (or WHO/UNAIDS standards).
Denominator:	N/A	
Reporting level:	See PEPFAR MER Indicator Reference Guide (Version 2.4 FY20)	
How to use:	See PEPFAR MER Indicator Reference Guide (Version 2.4 FY20)	
How to collect:	See PEPFAR MER Indicator Reference Guide (Version 2.4 FY20)	
How to review for data quality:	[Screened for GBV = YES] + [Screened for GBV = NO] = PrEP_NEW [Identified as having experienced GBV = YES] + [Identified as experiencing GBV = NO] = [Screened for GBV = YES] [Referred to and/or provided GBV services = YES] + [Referred to and/or provided GBV services = NO] = [Identified as having experienced GBV = YES] For those reporting GEND_GBV: [Referred to and/or provided GBV services = YES] >= GEND_GBV The following percentages can be calculated from the disaggregations: Percentage of PREP_NEW screened for GBV: [Screened for GBV = YES]/PREP_NEW x 100 Percentage of PREP_NEW identified as experiencing GBV among those screened: [Identified as having experienced GBV = YES]/[Screened for GBV = YES] x 100 Percentage of PREP_NEW identified as having experienced GBV and who were referred to and/or provided GBV services: [Referred to and/or provided GBV services = YES]/[Identified as having experienced GBV = YES] x 100 See PEPFAR MER Indicator Reference Guide (Version 2.4 FY20)	

Supplemental disaggregation:	**Supplemental numerator disaggregation for gender-based violence (GBV)**	
	Disaggregate group	**Disaggregates**
	Screened for GBV	Yes/No Definition: Screened for GBV (disaggregated by sex/age per PrEP_NEW groups)
	Identified as having experienced GBV	Yes/No Definition: Identified as having experienced GBV—among those screened for GBV (disaggregated by sex/age per PrEP_NEW groups)
	Referred to and/or provided GBV services	Yes/No Definition: Referred to and/or provided clinical and/or nonclinical GBV services—among those screened for and identified as having experienced GBV (disaggregated by sex/age per PrEP_NEW groups)

Disaggregate descriptions and definitions:	USAID's PrEP partners are expected to **identify survivors of violence** through routine or clinical enquiry and **provide or refer for appropriate post-violence clinical care** as defined by the GEND_GBV MER indicator. At the time of initiation on PrEP, providers are required to identify individuals experiencing or at risk of experiencing violence through routine enquiry (i.e., providers ask clients about experience or fear of violence in settings where clinical enquiry cannot be conducted, but where violence is a known risk factor for HIV, including PrEP). The following are the **minimum requirements** that must be in place for sites to conduct routine (and clinical) enquiry: • Providers offer first-line support: **L**isten, **I**nquire, **V**alidate, **E**nhance Safety, and **S**upport (**LIVES**). • Protocol/standard operating procedure (SOP) exists for conducting routine enquiry. • Standard set of questions exists in which providers can document responses. • Providers are trained on how to ask about intimate partner violence (IPV) or sexual violence. • Providers ask about IPV or sexual violence only in a private setting, confidentiality ensured. • Process is in place for offering referrals or linkages to other services. For those screened and for whom violence is identified or disclosed, the provider will offer the client first-line support (**LIVES**), refer to (or directly provide) post-violence clinical care, and refer to nonclinical and community support services. The provider will follow child protection and mandatory reporting guidelines according to the principle of the best interests of the child. Of note: For clients screened and for whom violence is suspected but not acknowledged or disclosed, the provider will offer information on available GBV services, follow child protection and mandatory reporting guidelines according to the principle of the best interests of the child, and offer a follow-up visit. Data sources are standard program monitoring tools, such as forms, logbooks, spreadsheets, and databases that national programs and/or partners develop or already use. Data should be collected continuously at the point of PrEP service delivery and aggregated in time for PEPFAR reporting cycles.
Special considerations:	As outlined in the Program Guide for Integrating GBV Prevention and Response in PEPFAR Programs, all programs seeking to address GBV must first and foremost protect the dignity, rights, and well-being of those at risk for and survivors of GBV. There are four fundamental principles for integrating a GBV response into existing programs and specific actions for putting these principles into practice. These principles are as follows: • Do no harm • Privacy and confidentiality; and informed consent (for research) • Meaningful engagement of people living with HIV (PLHIV) and GBV survivors • Accountability and monitoring and evaluation

TX_CURR_GBV		
Description:	Number of adults and children currently receiving antiretroviral therapy (ART)	
Numerator:	Number of adults and children currently receiving antiretroviral therapy (ART)	Count the number of adults and children who are currently receiving ART.
Denominator:	N/A	
Reporting level:	See PEPFAR MER Indicator Reference Guide (Version 2.4 FY20)	
How to use:	See PEPFAR MER Indicator Reference Guide (Version 2.4 FY20)	
How to collect:	See PEPFAR MER Indicator Reference Guide (Version 2.4 FY20)	
How to review for data quality:	[Screened for GBV=YES] + [Screened for GBV=NO] = TX_CURR [Identified as having experienced GBV=YES] + [Identified as experiencing GBV=NO] = [Screened for GBV=YES] [Referred to and/or provided GBV services=YES] + [Referred to and/or provided GBV services=NO] = [Identified as having experienced GBV=YES] For those reporting GEND_GBV: [Referred to and/or provided GBV services =YES] >=GEND_GBV The following percentages can be calculated from the disaggregations: Percentage of TX_CURR that were screened for GBV: [Screened for GBV=YES]/TX_CURR x 100 Percentage of TX_CURR who were identified as experiencing GBV among those screened: [Identified as having experienced GBV=YES]/[Screened for GBV=YES] x 100 Percentage of TX_CURR who were identified as having experienced GBV and who were referred to and/or provided GBV services: [Referred to and/or provided GBV services=YES]/[Identified as having experienced GBV=YES] x 100 See PEPFAR MER Indicator Reference Guide (Version 2.4 FY20)	

Supplemental Disaggregation:	Supplemental numerator disaggregation for gender-based violence (GBV)	
	Disaggregate group	**Disaggregates**
	Screened for GBV	Yes/No Definition: Screened for GBV (disaggregated by sex/age per TX_CURR groups)
	Identified as having experienced GBV	Yes/No Definition: Identified as having experienced GBV—among those screened for GBV (disaggregated by sex/age per TX_CURR groups)
	Referred to and/or provided GBV services	Yes/No Definition: Referred to and/or provided clinical and/or nonclinical GBV services—among those screened and identified as having experienced GBV (disaggregated by sex/age per TX_CURR groups)

Disaggregate descriptions & definitions:	U.S. Agency for International Development (USAID) care and treatment partners are expected to **identify survivors of violence** through routine or clinical enquiry and **provide appropriate post-violence clinical care** as defined by the GEND_GBV MER indicator. During clinical care appointments, providers are required to identify clients experiencing or at risk of experiencing violence through clinical enquiry (i.e., healthcare providers identify signs/symptoms of violence) or routine enquiry (i.e., providers ask clients about experience or fear of violence in settings where clinical enquiry cannot be conducted, but where violence is a known risk factor for HIV). The **minimum requirements** that must be in place for sites to conduct routine and clinical enquiry are as follows: • Providers offer first-line support: Listen, Inquire, Validate, Enhance Safety, and Support (LIVES); • Protocol/standard operating procedure (SOP) for conducting routine and/or clinical enquiry; • Standard set of questions where providers can document responses; • Providers are trained on how to ask about intimate partner violence (IPV) or sexual violence; • Providers only ask about IPV or sexual violence in a private setting, confidentiality ensured; • Process for offering referrals or linkages to other GBV response services is in place. For those screened and for whom violence is identified or disclosed, the provider will offer the client first-line support (**LIVES**), refer to (or directly provide) post-violence clinical care, and refer to nonclinical and community support services. The provider will follow child protection and mandatory reporting guidelines according to the principle of the best interests of the child. Of note: For clients screened and for whom violence is suspected but not acknowledged or disclosed, the provider will offer information on available GBV services, follow child protection and mandatory reporting guidelines according to the principle of the best interests of the child, and offer a follow-up visit. Data sources are standard program monitoring tools, such as forms, logbooks, spreadsheets, and databases that national programs and /or partners develop or already use. Data should be collected continuously at the point of clinical care service delivery and aggregated in time for the U.S. President's Emergency Plan for AIDS Relief (PEPFAR) reporting cycles.
Special considerations:	As outlined in the Program Guide for Integrating GBV Prevention and Response in PEPFAR Programs, all programs seeking to address GBV must first and foremost protect the dignity, rights, and well-being of those at risk for, and survivors of, GBV. There are four fundamental principles for integrating a GBV response into existing programs and specific actions for putting these principles into practice. These principles are as follows: • Do no harm; • Privacy and confidentiality; and informed consent (for research); • Meaningful engagement of people living with HIV (PLHIV) and GBV survivors; • Accountability and monitoring and evaluation (M&E).

TX_NEW_GBV

Description:	Number of adults and children newly enrolled on antiretroviral therapy (ART)	
Numerator:	Number of adults and children newly enrolled on antiretroviral therapy (ART)	The indicator measures the ongoing scale-up and uptake of ART programs.
Denominator:	N/A	
Reporting level:	See PEPFAR MER Indicator Reference Guide (Version 2.4 FY20)	
How to use:	See PEPFAR MER Indicator Reference Guide (Version 2.4 FY20)	
How to collect:	See PEPFAR MER Indicator Reference Guide (Version 2.4 FY20)	
How to review for data quality:	[Screened for GBV=YES] + [Screened for GBV=NO] = TX_NEW [Identified as having experienced GBV=YES] + [Identified as experiencing GBV=NO] = [Screened for GBV=YES] [Referred to and/or provided GBV services=YES] + [Referred to and/or provided GBV services=NO] = [Identified as having experienced GBV=YES] For those reporting GEND_GBV: [Referred to and/or provided GBV services =YES] >=GEND_GBV The following percentages can be calculated from the disaggregations: Percentage of TX_NEW that were screened for GBV: [Screened for GBV=YES]/TX_NEW x 100 Percentage of TX_NEW who were identified as experiencing GBV among those screened: [Identified as having experienced GBV=YES]/[Screened for GBV=YES] x 100 Percentage of TX_NEW who were identified as having experienced GBV and who were referred to and/or provided GBV services: [Referred to and/or provided GBV services=YES]/[Identified as having experienced GBV=YES] x 100 See PEPFAR MER Indicator Reference Guide (Version 2.4 FY20)	

Supplemental Disaggregation:	**Supplemental numerator disaggregation for gender-based violence (GBV)**	
	Disaggregate group	**Disaggregates**
	Screened for GBV	Yes/No Definition: Screened for GBV (disaggregated by sex/age per TX_NEW groups)
	Identified as having experienced GBV	Yes/No Definition: Identified as having experienced GBV—among those screened for GBV (disaggregated by sex/age per TX_NEW groups)
	Referred to and/or provided GBV services	Yes/No Definition: Referred to and/or provided clinical and/or non-clinical GBV services—among those screened and identified as having experienced GBV (disaggregated by sex/age per TX_NEW groups)

Disaggregate descriptions & definitions:	U.S. Agency for International Development (USAID) care and treatment partners are expected to **identify survivors of violence** through routine or clinical enquiry and **provide appropriate post-violence clinical care** as defined by the GEND_GBV MER indicator. During enrollment of a client on ART, providers are required to identify clients experiencing or at risk of experiencing violence through clinical enquiry (i.e., healthcare providers identify signs/symptoms of violence) or routine enquiry (i.e., providers ask clients about experience or fear of violence in settings where clinical enquiry cannot be conducted, but where violence is a known risk factor for HIV). The **minimum requirements** that must be in place for sites to conduct routine and clinical enquiry are as follows: • Providers offer first-line support: **L**isten, **I**nquire, **V**alidate, **E**nhance Safety, and **S**upport (**LIVES**); • Protocol/standard operating procedure (SOP) for conducting routine and/or clinical enquiry; • Standard set of questions where providers can document responses; • Providers are trained on how to ask about intimate partner violence (IPV) or sexual violence; • Providers only ask about IPV or sexual violence in a private setting, confidentiality ensured; • Process for offering referrals or linkages to other GBV response services is in place. For those screened and for whom violence is identified or disclosed, the provider will offer the client first-line support (**LIVES**), refer to (or directly provide) post-violence clinical care, and refer to nonclinical and community support services. The provider will follow child protection and mandatory reporting guidelines according to the principle of the best interests of the child. Of note: For clients screened and for whom violence is suspected but not acknowledged or disclosed, the provider will offer information on available GBV services, follow child protection and mandatory reporting guidelines according to the principle of the best interests of the child, and offer a follow-up visit. Data sources are standard program monitoring tools, such as forms, logbooks, spreadsheets, and databases that national programs and /or partners develop or already use. Data should be collected continuously at the point of clinical care service delivery and aggregated in time for PEPFAR reporting cycles.
Special considerations:	As outlined in the Program Guide for Integrating GBV Prevention and Response in PEPFAR Programs, all programs seeking to address GBV must first and foremost protect the dignity, rights, and well-being of those at risk for, and survivors of, GBV. There are four fundamental principles for integrating a GBV response into existing programs and specific actions for putting these principles into practice. These principles are as follows: • Do no harm; • Privacy and confidentiality; and informed consent (for research); • Meaningful engagement of people living with HIV (PLHIV) and GBV survivors; • Accountability and monitoring and evaluation (M&E).

Annex F: GBV_REPORT_COMM Reference Sheet

GBV_REPORT_COMM	
Description:	Percentage of individuals who were provided with or referred to post-violence services among those who disclosed experience of violence within community settings
Numerator:	Number of individuals who disclosed to program staff or outreach workers outside of clinical facilities that they experienced violence within the past three months from any type of perpetrator and were provided with post-violence services or referrals
Denominator:	Number of individuals who disclosed to program staff or outreach workers outside of clinical facilities that they experienced violence within the past three months from any type of perpetrator
Reporting level:	Community
Purpose/how to use:	This indicator measures reported experience of all forms of violence among individuals served by community-based programs and services supported by the U.S. President's Emergency Plan for AIDS Relief (PEPFAR). It captures both disclosure of violence (the denominator) and coverage of post-violence services for those who have experienced violence. It is intended to measure the extent of experiences of violence and program response, focusing on outreach or other nonclinical settings where disclosures of violence occur, as well as opportunities to respond. This indicator will enable PEPFAR headquarters (HQ), country teams, governments, implementing partners, and other in-country counterparts to do the following: • Determine the number of individuals who disclose experience of violence among those being served by PEPFAR community programs and services, thus signaling groups at greater risk of lost to follow-up (LTFU), poor antiretrovirus therapy (ART) adherence, or poorer viral suppression • Enable program partners to target and tailor services to mitigate vulnerability to HIV/AIDS and provide post-violence care • Track program performance in delivery of post-violence services and identify program gaps and strengths • Track trends in reports of violence at the community level and design structural and other interventions to reduce violence

How to collect:	The denominator is generated by counting the number of persons who disclose to community program staff or outreach workers that they have experienced violence within the past three months (either unprompted or through enquiry) . If multiple occurrences are reported, only the most recent occurrence should be counted. Sex/gender, age, and type of violence (sexual, physical, and other), and, as relevant, type of key population (KP) should be recorded (see below for disaggregation information). Post-violence care services or referrals must be included as part of the program or service through which violence was disclosed and recorded. The numerator is generated by counting the number of persons who disclose violence and are provided with post-violence services and/or referrals to post-violence services. This count includes those who disclose violence, after which program staff/outreach workers respond by doing all of the following: (1) offer first-line support: Listen, Inquire, Validate, Enhance Safety, and Support (LIVES); (2) provide and/or refer to nonclinical and community support services; and (3) refer to post-violence clinical care (as relevant). Of note: For clients for whom violence is suspected but not disclosed, the provider should offer information on available post-violence services and offer follow-up services. Program staff will follow child protection and mandatory reporting guidelines according to the principle of the best interests of the child. **Definitions:** Sexual violence is defined as “any sexual act, attempt to obtain a sexual act, unwanted sexual comments or advances, or acts to traffic, or otherwise directed, against a person’s sexuality using coercion, by any person regardless of their relationship to the victim, in any setting, including but not limited to home and work. Coercion can cover a whole spectrum of degrees of force. Apart from physical force, it may involve psychological intimidation, blackmail or other threats—for instance, the threat of physical harm, of being dismissed from a job or of not obtaining a job that is sought. It may also occur when the person aggressed is unable to give consent—for instance, while drunk, drugged, asleep or mentally incapable of understanding the situation.” WHO, https://apps.who.int/iris/bitstream/handle/10665/77434/who_rhr_12.37_eng.pdf9;jsessionid=4688854E0C6C306AF3AC61276D8583E3?sequence=1. Physical violence is defined as "the intentional use of physical force or power, threatened or actual, against oneself, another person, or against a group or community, that either results in or has a high likelihood of resulting in injury, death, psychological harm, maldevelopment, or deprivation." WHO, https://www.who.int/violence_injury_prevention/violence/world_report/en/summary_en.pdf Data sources are standard program monitoring or assessment tools, such as forms, logbooks, spreadsheets, and databases that national programs and/or partners develop or already use—for example, LINKAGES Tool 12. Data on provision and completion of referrals should also be captured and reported. Data should be collected continuously at the point of community programs and services and aggregated over time quarterly or for PEPFAR reporting cycles. Special considerations: As outlined in the Program Guide for Integrating GBV Prevention and Response in PEPFAR Programs, all programs seeking to address gender-based violence (GBV) and other forms of violence must first and foremost protect the dignity, rights, and well-being of those at risk for and survivors of violence. There are four fundamental principles for integrating a violence response into existing programs and specific actions for putting these principles into practice. These principles are as follows: (1) do no harm; (2) privacy and confidentiality, and informed consent (for research); (3) meaningful engagement of people living with HIV (PLHIV) and violence survivors; and (4) accountability and monitoring and evaluation.

<table>
<tr><td>How to review for data quality:</td><td colspan="2">Numerator should be <= the denominator.

Numerator and denominator subtotals for the disagggregations should sum to the aggregates—for example, number of people reporting experience of violence should be equal to the sum of all violence type, sex, age group, and population type disaggregates.</td></tr>
<tr><td rowspan="11">Disaggregations:</td><td colspan="2">Numerator disaggregations</td></tr>
<tr><td>Disaggregate groups</td><td>Disaggregates</td></tr>
<tr><td>Violence type</td><td>• Sexual violence
• Physical violence
• All other forms of violence
If individuals disclose experience of both sexual and physical or another form of violence, they should be counted only under sexual violence to prevent duplicate counting.</td></tr>
<tr><td>Perpetrator type</td><td>Intimate partner, client, relative/family member, police, other, not disclosed/unknown

Perpetrator type can fall under only one category; if multiple types are described, select only one to prevent duplicate counting.</td></tr>
<tr><td>Sex/gender</td><td>Female, male, other</td></tr>
<tr><td>Age group</td><td>10–14, 15–19, 20–24, 25–29, 30–34, 35–39, 40–44, 45–49, 50+, unknown age</td></tr>
<tr><td>Key population type</td><td>Men who have sex with men (MSM): Sex worker/not sex worker
Transgender: Sex worker/not sex worker
Female sex worker
People who inject drugs (PWID): Male/female
People in prisons and other closed settings</td></tr>
<tr><td>Service or referral type</td><td>Referral only, service provision only, referral and service provision</td></tr>
<tr><td colspan="2">Denominator disaggregations</td></tr>
<tr><td>Disaggregate groups</td><td>Disaggregates</td></tr>
<tr><td>Same as numerator</td><td>Same as numerator</td></tr>
</table>

Annex G: Security Incident Log

Security Incident Log			
	Question	**How to Answer**	**Response**
1	Security incident number	Begin with number 1 and continue; the numbering allows security incidents to be linked to one another (see question #14)	
2	Date of incident	Type as YEAR-MONTH-DAY (e.g., 2019-02-17 for February 17, 2019) in order to organize this security event log by date	
3	Time of incident	Specific time of day (if known), or more general (morning, afternoon, evening, night)	
4	Perpetrator	If known and safe to list, or use a more general term such as “law enforcement officer”	
5	Affected organization	Name of HIV program implementing partner (i.e., community-based organization’s name)	
6	Target	Specific person or type of staff, physical space (e.g., name of a specific hot spot), website, database, etc. Do not name individuals here unless you have their permission to do so.	
7	Where incident occurred	Physical address, online, by phone, etc.	
8	Believed motivation of aggressor (if known)	For example: intimidation, to stop programming, to deflect attention from other local issues	
9	Description of security incident	For example: Facebook posts on project page said “paste specific message here;” or peer educators were arrested without charge when distributing condoms to a group of MSM during a mobile HIV testing event	
10	Programmatic consequences of security incident	For example: implementing partner will conduct only online outreach until physical outreach is considered safe to conduct	
11	Description of actions taken to respond to security incident	For example: on YEAR-MONTH-DAY implementing partner targeted in Facebook post decided that it is not safe to conduct outreach activities for a two-week period and implementing partner filed a complaint with the police. On YEAR-MONTH-DAY local Ministry of Health officials held a meeting with power holders and local law enforcement; they discussed threats to the implementing partner and created a WhatsApp group that can be used to notify and activate allies immediately as needed. Please include dates of actions taken (and continue to update this row as actions are taken).	

12	Was the security incident related to index testing?	Select one: Yes or No	
13	Was the security incident related to COVID-19?	Select one: Yes or No	
14	Which other security incidents is this related to? (if any)	Note whether this incident was related to other security incidents by listing other security incident numbers here.	
15	Incident resolution (if any)	For example: on YEAR-MONTH-DAY peer educators were released from state custody and provided with mental health support.	

Annex H: Data Safety for GBV Survivors

Taken from Strengthening Health Systems to Respond to Women Subjected to Intimate Partner Violence or Sexual Violence: A Health Manager's Manual

Confidential documentation and record keeping are vital to the safety of patients experiencing intimate partner or sexual violence. Records may take the form of paper, external computer hard drives or CDs, or they may be network-based. Regardless of format, all types of files must be secured. This checklist will help you make sure that records are secure.

How can we create secure records in practice?

- All staff members understand the importance of confidentiality and secure record-keeping, and staff members who routinely care for women subjected to violence have been trained to keep records secure.
- Identifying information about a woman, including her name and contact information, is not visible or accessible to those not caring for this patient.
- Staff members do not leave documents where a patient (unless requested), those accompanying the patient or anyone else might see them. Staff members do not carry charts open or lay them on shared desks or counters.
- When documenting information from women about their experience of violence, staff members avoid asking for or writing this information on records in a public place.
- Staff members do not write a notation indicating intimate partner violence or sexual violence on the first page of a record, which is more likely to be seen if flipped open.
- Staff members use a code, such as an abbreviation or symbol, to indicate cases of intimate partner violence or sexual violence on charts (recommended option). They do not write "DOMESTIC VIOLENCE SUSPECTED" or "RAPE" or other explicit wording in large print across the chart. Some countries (such as Malaysia) use a colour coding system on medical records that is known only to the relevant health staff.
- Any sensitive information that needs to be destroyed is shredded by an authorized staff member.

How can we create secure records in storage?

- We have a secure site to store files.
- Documents are locked up at all times.
- Only a limited number of designated staff members have access to patient records.
- Staff members who need access to records have received training on record confidentiality and storage practices.
- Staff members authorized to access stored files have a means of access that is not available to others. (As the setting allows, this may be a key to a room, an electronic password or a security code to enter a room, or another method of obtaining access to a restricted area.)