June 2017

Ministry of Health

IDENTIFYING AND RESPONDING TO VIOLENCE:

Training Curriculum for Key Population Health Care Workers in Kenya

NASCOP

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National AIDS and STI Control Programme,
Ministry of Health

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CONTENTS

ACRONYMS/ABBREVIATIONS

CMR	Clinical management of rape
FSW	Female Sex Worker
GBV	Gender-Based Violence
HIV	Human Immunodeficiency Virus
HTC	HIV Testing and Counseling
IEC	Information, Education, and Communications
IPV	Intimate Partner Violence
M&E	Monitoring and Evaluation
MSM	Men who have Sex with Men
NASCOP	National AIDS and STI Control Project
PEP	Post-Exposure Prophylaxis
PEPFAR	President's Emergency Plan for AIDS Relief
PTSD	Post-Traumatic Stress Disorder
PWID	People Who Inject Drugs
SOP	Standard Operating Procedure
STI	Sexually Transmitted Infection
Trans	Transgender
TSU	Technical Support Unit
USAID	U.S. Agency for International Development
WHO	World Health Organization

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BACKGROUND

The Kenya AIDS Strategic Framework 2014/15- 2018-19 has identified KPs as a priority population who disproportionately contribute high number of new infections in the country and recommends the need to prioritize this population in interventions to reduce new HIV infection. The KASF also recommends adaptation and scaling up of effective evidence based combination HIV prevention intervention which includes structural interventions. The strategic direction 3 of the KASF recommends use of a human rights based approach to facilitate access to services. By 2019, it is expected that violence and social exclusion among KPs, PLHIV and other priority populations will reduce by 50%. The **national guidelines for HIV and STI programming for key population (2014)** details out the violence prevention and response system that needs to be established in all programmes working with KPs. The recently launched **policy for the prevention of HIV infections among KPs in Kenya (June 2016)** clearly states its policy objectives of increasing access to scaled up and comprehensive services for KPs. Within this objective, one of the policy directions is to develop violence prevention and response system in programmes to address violence and discrimination against KPs.

KPs are entitled to the full protection of their human rights, as specified in numerous international human rights instruments. These rights include the right to non-discrimination; security; recognition and equality under the law; access to justice and due process under the law; the highest attainable standard of health; freedom from arbitrary arrest and detention, and from cruel and inhumane treatment; and protection from violence. (WHO, UNFPA, UNAIDS, NSWP, 2012)

Additionally, the links between violence and HIV are well-established. Both HIV and GBV have implications for almost every aspect of health, including access to health services and education, and full enjoyment of legal and human rights. KPs' vulnerability to HIV and violence are rooted in structural inequalities, including unequal power relationships based on biological sex, gender identity, and sexual orientation; these structural inequalities are well-entrenched in cultural beliefs and societal norms and are reinforced by political and economic systems. (Dunkle & Decker, 2013; Khan, 2011)

The criminalization of sex work, same-sex relationships, drug use, stigma, discrimination, and violence pose significant barriers for KPs in seeking and receiving HIV services. (WHO, 2014) More specifically, violence fosters the spread of HIV by limiting one's ability to negotiate safe sexual practices, disclose HIV status, and access health care and other critical services due to fear of reprisal, discrimination, and denial of services. (Dunkle and Dunkle, 2013) The inability to seek HIV testing and access HIV treatment due to fear of violence and abandonment by their families and communities are also contributing factors to the spread of HIV. (WHO, 2013)

Linking violence and HIV service efforts is necessary for eliminating the structural drivers of each and achieving lasting results in the fight against HIV. Both require well-coordinated, multi- sectoral efforts that address the many ways in which violence and HIV infection can affect peoples' lives, including their health, education, social interactions, economic opportunities, safety, legal protections, and human rights. Both must be addressed on a continuous basis throughout the lifecycle to ensure lasting results. (Khan, 2011)

Evidence shows the effectiveness of violence prevention and response strategies to mitigate HIV and supports recent mandates to integrate violence and HIV prevention, care, and treatment services. (Kerrigan et al., 2013). These integrated strategies can protect the health and human rights of KPs and achieve long-lasting results in the fight against HIV. (Kerrigan et al., 2013; Spratt, 2011) Specifically, addressing violence can increase individuals' access to HIV testing and improve adherence to treatment. Modeling estimates in two different epidemic contexts (Kenya and Ukraine) show that a reduction of approximately 25% in HIV infections among sex workers may be achieved when physical and sexual violence are reduced. (Decker, et al 2013)

Despite the compelling information about the high rates of violence experienced by KPs, the ratification of international legal instruments that address violence, and the prohibition of violence in legislation, violence prevention and response interventions continue to be limited or inaccessible for KPs in many countries. KPs continue to experience stigma and discrimination, denial of medical care and treatment, and harassment, exploitation, and severe forms of violence.

To address these barriers and gaps, and in line with recommendations from the Kenya AIDS Strategic Framework, national guidelines for key population programming and the national policy on HIV prevention among KPs, the national programme prioritizes the integration of violence screening and response services and HIV prevention, care, and treatment services.

Terminology: Violence vs. Gender-Based Violence (GBV)

The term "gender-based violence" is frequently used interchangeably with the terms "violence and abuse" or "violence." GBV is an inclusive term for any harm that is perpetrated against a person's will and that results from power inequalities that are based on gender roles and expectations of a person's role in society or culture (UNGA, 1993; UN Women, 2013).

The term gender-based violence refers to "any form of violence that is directed at an individual based on biological sex, gender identity (e.g., transgender), or behaviors that are [perceived as] not in line with social expectations of what it means to be a man or woman, boy or girl [e.g., men who have sex with men -MSM and FSWs]. 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).

KPs may face violence because of the stigma associated with sex work or homosexuality, which in many settings are criminalized, or due to discrimination based on gender, HIV status, drug use or other factors (WHO, 2013). For example, most violence against female sex workers is a result of gender inequality and discrimination directed at women or because their behaviors are perceived as deviating from traditional gender norms for women. Additionally, violence is often directed at men and transgender individuals who are perceived as not conforming to gender and heterosexual norms, either because of their appearance or the way they express their sexuality (WHO, 2013).
Because the definition of GBV highlights the gender dimensions of violence and acknowledges the relationship between the subordinate status of marginalized populations in society and their increased vulnerability to violence, it is relevant to use the term GBV in work that involves KPs. Understanding the role of gender norms and inequalities in how they affect KPs can also help direct service providers and others understand the underlying reasons for violence and respond more appropriately to KPs who experience violence.

On the other hand, some prefer not to use the term "GBV" in work with KPs and prefer to use "violence" to describe the physical, sexual, emotional/psychological, and economic abuse, as well as discrimination, harassment, and exploitation committed against KPs. "Violence" is defined by the World Health Organization (WHO) as the intentional use of physical force or power, threatened or actual, against oneself, another person, or against a group or community that results or has a high likelihood of resulting in injury, death, sexual or psychological harm, maldevelopment or deprivation of liberty.

Using both "GBV" and "violence" to describe our work is appropriate, but using the terms "GBV" or "gender-based violence" in outreach and other activities with KPs is not necessary. It is important that each person is allowed to define their own experience. People may be more familiar with terms such as "violence," "abuse," or "stigma and discrimination." They may also choose to define a specific experience using terms such as "rape," "harassment," or "blackmail." When providers talk with KPs, using the language used by the KP member or a more generic or commonly-used term such as "violence and abuse" is recommended.

Finally, because the term GBV does not resonate with all individuals who experience violence, we use the term "violence" in this document to include all forms of GBV—including physical, sexual, psychological, emotional, and economic abuse. Additionally, because other human rights violations (e.g., harassment and discrimination because of KPs' occupation, gender identity, sexual orientation, or other behaviors that are perceived as deviating from social and gender norms) can interfere with KPs ability to seek and access important services, these human rights violations are also important to address in the context of VPR programming.

Addressing Violence during Prevention, Care and Treatment of KPs

The most recent WHO (2013) and PEPFAR (2013) guidance related to identifying and responding to GBV recommends screening for GBV when **assessing conditions that may be caused or complicated by GBV** (e.g., HIV) **in order to improve diagnosis and subsequent care and treatment** –in this case, people at high risk for or living with HIV. This means all clients coming to KP clinics could be screened for violence. However, certain services must be available to clients if screening is to occur. PEPFAR and WHO recommend screening for violence only when providers are able to provide first-line support. **Due to the direct links between violence and HIV –with violence as both a direct cause of HIV (e.g., inability to negotiate the use of condoms; sexual assault) and as a consequence of HIV (e.g., violence against an individual who discloses HIV status) –screening for violence and providing first-line support are essential parts of violence response services.** Additionally, experiencing violence is associated with poorer adherence to treatment – making it important for service providers to know the factors that may shape a client's ability to adhere. Being pro-active about identifying Violence among KPs (e.g. routinely screening clients for violence) and providing a compassionate and supportive first-line response to clients who disclose violence are ways for providers to assist clients in addressing barriers to adhering to treatment.

There are a number of benefits to screening for violence and providing support to clients who have experienced violence, both for clients and direct service providers, including (WHO, 2014):

Benefits to Clients' Overall Well-Being

- Realization that violence is associated with health problems
- Decreasing sense of isolation

- Feeling that the provider cares about them
- Increased ability to access HIV and other health services
- Increased access to services, such as mental health services, that may help them deal with trauma

Benefits related to Clinical Outcomes

- Improvement in quality of care
- Greater efficiency (can detect and treat health problems caused by violence)
- Increased likelihood that clients will adhere to HIV care and treatment

Identifying and responding to violence are not one-time activities. Since some clients may not be willing to disclose violence initially but will as they feel more comfortable with a provider or clinic and because clients' situations change over time, direct service providers involved in KP clinics should screen for and respond to violence throughout the HIV prevention, care, and treatment cascade, during the initial contact and subsequent visits. This will ensure that clients have the opportunity to share information about previous and new incidents of violence, allowing providers to give support and reduce any barriers that interfere with clients' uptake and retention of HIV services.

Role of Direct Service Providers in Identifying and Responding to Violence

Direct service providers, including health care workers, who are reaching KPs for HIV testing, care, and treatment are well-positioned to address violence among their clients, ultimately decreasing KPs' risk of HIV infection and increasing their access to HIV care and treatment. Because of the relationship between HIV and violence --including the negative impact of violence on uptake and retention in the HIV cascade, the significant physical and mental health consequences of violence, and the human and legal rights violations experienced by many KPs - - direct service providers who are providing health services have an obligation to be proactive in identifying violence (via screening) and responding to violence among clients with whom they have contact.

OVERVIEW OF TRAINING CURRICULUM

What is the purpose of this training curriculum?

NASCOP adapted this three-day training curriculum for training of direct service providers of Key Population Clinics. This was adapted from the original manual developed by LINKAGES implemented by FHI 360. This training covers the key elements of the national guidelines, including the information and skills needed to identify and respond to violence in a supportive way that protects the autonomy and rights of KPs. It is NASCOP's vision that every client who is reached will receive stigma-free services, be provided with a safe and compassionate environment where disclosures of violence can happen, and receive emotional support, quality health care, and access to legal information and services. This training provides the knowledge and skills necessary to make that happen.

Who is the target audience for this training curriculum?

This training curriculum was designed for clinical and non-clinical direct service providers who are involved in providing services to KPs, including KP project staff, peer educators, HTC outreach workers, as well as partnering health care workers. Although screening for violence is typically conducted by health care workers, peer educators are often the first entry-point for KPs who disclose violence and could also be included in the training.

What is included in this training curriculum?

The training covers core sensitization and training topics, including understanding the rationale for integrating violence prevention and response (VPR) and HIV services; concepts related to sex and gender; rigid gender norms and how they affect KPs; links between rigid gender norms, stigma, discrimination, and violence; violence as a public health and human rights issue; links between violence and HIV; types of violence and other human rights violations commonly experienced by KPs; and exploring our own values and beliefs that might impact our work with KPs. Participants will also hear from KPs during a panel discussion to learn how stigma, discrimination, and violence have affected their lives and the kinds of support they need. This training also provides information about VPR programming structure, including an introduction to a set of VPR principles and program components that are relevant for health care workers and other direct service providers, including a "minimum package of VPR services." Providers will learn how to use a standardized tool to screen KPs for violence, provide first-line support to KPs who disclose violence, and link KPs to important services. This curriculum also provides an *overview* of the recommended clinical post-violence services (e.g. rapid HIV testing, HIV PEP, emergency contraception, screening and treatment for sexually-transmitted infections (STI) and Hepatitis B, tetanus booster/vaccination).

This training does not include specific instructions for medico-legal examinations and the collection of forensic specimens. Clinical protocols are available in country for such procedures. KP programmes should refer to the national protocols for specific guidance on the clinical protocols for responding to violence (e.g. post-rape protocol).

Additionally, this curriculum does not include training on developing and implementing a comprehensive response to violence against KPs. While it covers many important services that KPs need following an incident of violence, it is important to note that this training does not address the system-level advocacy needed to address the legal and human rights violations against KPs – a necessary complement to violence screening and response. It does not include content for how to set-up a peer-led crisis response system (e.g. hotline, training crisis response teams). It also does not cover the full range of activities that could be delivered to prevent violence against KPs.

How is this training curriculum structured?

This training curriculum has five modules. Each module has a set of sessions which includes a mix of presentations, activities, exercises, and small and large group discussions. Each session includes step-by-step instructions for facilitators, including key points to emphasize throughout the training. There are a number of participant handouts for various activities, which are referenced throughout the curriculum and annexed to this document. Also annexed are a sample agenda, pre/post-tests, training evaluation (to be administered at the end of the last training day), and exercises/cards. Below is a list of the training modules and sessions.

Training Modules

Module One: Setting the Stage (1 hour and 45 minutes)

Session 1.1	Welcome and Introductions
Session 1.2	Pre-Test
Session 1.3	Review Agenda, Learning Objectives, and Participant Training Packets
Session 1.4	Group Norms and Confidentiality
Session 1.5	Key Population Programme and Rationale for Integrating VPR and HIV Services
Session 1.6	Terminology used in VPR Programming: What in a name?

Module One: Building Core Knowledge (6.5 hours)

Session 2.1	Sex, Gender, Gender Identity, Gender Expression, Sexual Orientation
Session 2.2	Gender Norms/Stigma/Discrimination/Violence
Session 2.3	Understanding Violence and Links with HIV
Session 2.4	Panel Discussion with Key Population Members
Session 2.5	Human Rights Protections and Laws that are incorrectly used against KPs
Session 2.6	Exploring our own values and how they impact our work

TRAINING MODULES

OPENING ACTIVITIES AND ENERGIZERS

1. Think about ourselves in a positive way:

Ask participants to break into pairs with someone at their table. Each person will take a turn sharing their two most positive characteristics. Have participants introduce each other, including their positive characteristics, to the larger group and record on flipchart titled, "We are FABULOUS!" Emphasize that we all have a lot to offer and we do this work because we care about people.

2. Two lies and a truth:

Everyone writes down three statements on a piece of paper, two that are true and one that is false. People then read each other's statements then try to determine which is false.

3. Four Cs:

This is a good ice-breaker to emphasize that we all are unique, yet we still have some things in common. Each person gets a note card or index card and draws lines to make four squares on it. In the squares, they write: their favorite cuisine, the favorite place to visit on vacation (it can be one they have never been to), their favorite color, and a dream that they have. They then mingle around and find people with whom they have something in common. When they find a commonality, they latch on with that person and form a unit. They then go find more people with commonalities. The idea is that everyone in the room will become attached because we all have something in common.

4. Guess who?

This is a good ice-breaker for team building and helping people to get to know one another. It is also often very funny. Split participants into groups of five or so. Give each participant an index card (everyone in the group gets the same color card.) Ask them to write one interesting thing about themselves on the card. They shuffle the cards (within their group) and then re-draw so that each person gets someone else's card (they don't know whose it is.) They then try to guess whose card it is.

5. Write your name:

Have participants stand and put room in between themselves and the next person. As a way to get the blood flowing in different parts of the body, have participants imagine they have a huge pencil in their dominant hand. Instruct them to write their name in the air with that pencil as big as they can. Then instruct them to place that imaginary pencil in their non-dominant hand and write their name in the air. Then have them put the pencil in between their toes on their right foot and write their name. The toes on their left foot; their mouth and lastly their belly buttons. Participants have a lot of fun watching others since everyone looks funny spelling their name in the air.

6. Word and deed:

Stand in a circle, trainer starts by doing one action and describing another. The person to her right acts out what she is saying and does something else. Continue around the circle until everyone has a chance to “multitask”

7. ABCs:

a. Get participants to form a circle.
b. Pick a category like animals, countries, or foods. Choose a category that will be easy for those participants. Even the easiest category is hard in this game!
c. Tell participants to go around the circle and each person will name something within that category. The first person will name an animal starting with “A” (e.g. aardvark). The next person in the circle will name an animal starting with “B” (e.g. bear). The third person in the circle will name an animal starting with “C” (e.g. cat), and so on.

MODULE 1

SETTING THE STAGE

Time: 1 hour and 45 minutes

Introduction:

This module sets the stage for the rest of the training, including introductions; administering a pre-test; reviewing the agenda, learning objectives, and participant training packets; establishing group norms; describing the types of training methods used throughout the training; and brief background information about the KPs programme and the rationale for integrating VPR and HIV services. This module sets the tone for the rest of the training.

This module includes the following sessions:

Session 1.1 Welcome and Introductions
Session 1.2 Pre-Test
Session 1.3 Review Agenda, Learning Objectives, and Participant Training Packets
Session 1.4 Group Norms and Confidentiality
Session 1.5 Background on KP Programme/Rationale for Integrating VPR and HIV Services
Session 1.6 Terminology used in VPR Programming: What's in a name?

Session 1.1: Welcome and Introductions

Time: 15 minutes

Preparation/Materials:

- Name tags for participants and/or name tents
- Markers

STEP 1:

- Welcome everyone.
- **Ask:** Is everyone in the right place/training? Here for the violence training?
- Trainers introduce themselves
- Opening remarks from NASCOP or organizing team

STEP 2: Announcements and logistics (e.g., restrooms, sign-in sheet)

- **Explain:** See organizing team for any questions about logistics related to your travel or accommodations.
- Thank staff who handled logistics and helped set up for the training.

STEP 3: Participant Introductions

- **Explain:** Let's get to know each other a little bit.
- **Ask everyone to introduce themselves -** including their name, role/organization, and what district/area they work in and one thing they hope to get out of this training.
- **Note to Facilitator:** Take notes about expectations. After everyone has introduced themselves, summarize the participants' expectations that will and will not be covered in the training.
- Thank everyone for coming to the training.

Session 1.2: Administer Pre-Training Evaluation

Time: 15 minutes

Preparation/Materials: Printed pre-test for each participant

STEP 1: Purpose of pre- and post-tests

- **Explain:** In order for us to learn how well we are doing with trainings, we ask participants to complete a training evaluation at the beginning and again at the end of the training.
- The information you provide on these evaluations is confidential and will not be shared with anyone outside the organizing team and NASCOP.
- You don't need to write your name on the pre- or post-training evaluations.
- However, please write your mother's date of birth at the top. This will allow us to link your pre- and post-training evaluation, without providing your name.
- We only use this information to help us understand the training needs of participants and to learn if we are accomplishing what we hope to accomplish.
- It is okay if you are not sure how to answer any of the questions.
- If we all knew the answers to these questions, we wouldn't be in this training!
- Please do not refer to your participant handouts/packets or discuss with your neighbor as you complete the evaluation.

STEP 2: Distribute the pre-test

- Give everyone about 15 minutes to complete them.
- Collect the completed pre-training evaluations and immediately put them in a large envelope. Do not read the completed pre-tests as you collect them. Wait until after the training to review them.

Session 1.3: Review Agenda and Participant Training Packets

Time: 15 minutes

Preparation/Materials: Printed agendas and participant training packets/handouts

INTRODUCTION:

- **Explain:** We will be spending three days together, and we have a lot to cover.
- This is an interactive training, and we will be doing a lot of activities, including small group exercises, large group discussions, and other activities that involve participants talking and interacting with each other.
- Although we may use some PPT slides to complement and facilitate our discussions, much of our work and learning together will be through interaction and discussion.
- People have different learning styles and preferences, but the reason we try to use interactive training methods as much as possible is because the research tells us that we remember:
  - 20% of what we hear,
  - 40% of what we see, and
  - **80% of what we discover by themselves.**
- Having said this, there are certain topics where it will be more about the presentation of information.
- These parts may feel more didactic, but then we will spend some time building our skills for screening for violence, and providing first-line support, including linking clients to services.
- My/our role as facilitator(s) is to provide information, facilitate activities that allow everyone to learn new information, and create a positive learning environment where everyone feels supported and energized.
- **If trainer is not speaking in first language of training participants, explain:**
  - Ideally, trainers would be speaking in the language of the training participants.
  - But as you know, we often work in situations that are not always ideal.
  - So, I hope we can all commit to being patient with each other and being patient with a slower pace of conversation to allow for the interpreter to translate for us.
  - If something needs to be repeated or clarified, speak up and don't hesitate to ask.
- Review agenda/training topics.
- Refer to participant training packets. Ask participants to refer to the handouts in the training packets and explain that we will refer to these handouts throughout the training.

Session 1.4: Group Norms and Confidentiality

Time: 30 minutes

Preparation/Materials:

- Prepare flipchart titled, "Group Norms"
- Prepare flipchart titled, "Parking Area"
- Stack of blank paper (printer paper) at each table (one page per participant)

STEP 1: Refer to the flipchart titled "Group Norms"

- **Explain:** Setting some ground rules or group norms at the beginning of a training is always a good idea to make sure we're all on the same page, maintaining common values throughout the training, and to ensure a positive learning environment.
- As a group, let's come up with some group norms that we think are important for us.
- **Ask:** What are some good ground rules you think we should have for this training?
- Write ground rules on flipchart.
- **Suggested ground rules**
  - We will value differences (of opinion and experience).
  - We will keep everything shared in this training **confidential**.
  - We will arrive on time to show respect to other people in the group.
  - We will seek to practice active listening.
  - We will switch off mobile phones and laptops during sessions.

STEP 2: If confidentiality is mentioned and written as one of the ground rules, draw a circle around it. If not, write "Confidentiality" in large letters on the flipchart.

- **Explain:** It's important that participants feel comfortable to share their thoughts.
- Some of us may have own experiences with GBV or know people who have.
- Some of us may be sex workers, men who have sex with men, or transgender.
- Some may decide to share personal experiences.
- A commitment to confidentiality within the training group will help everyone feel more comfortable sharing their thoughts.
- We will keep these group norms posted so they are easily visible and we can refer to them if needed throughout the training.
- **Facilitator note:** If "valuing/respecting different opinions" is not listed as a group norm, request to add it.

STEP 3: OPTIONAL Large Group Activity: "Same Instructions, Different Perceptions"

- **Explain:** One of our group norms is valuing each other's differences and respecting different opinions.
- This is especially important when we're talking about sensitive topics.
- We're all different; we see things differently and we hear things differently.
- How we communicate with each other during this training (and also with the clients who seek our services) is very important.
- **Explain:** Let's do a short exercise.

- **Ask** each participant to hold a sheet of paper (from the stack on their table) and tell them to close their eyes and hold the paper in front of them.
- **Explain:** I am going to give you some instructions about what to do with the piece of paper with your eyes closed.
- During the exercise, you cannot ask me any questions.
- Just listen to the instruction and do the best you can with what I tell you. Okay. Fold the paper in half and tear off a top corner.
- Fold it in half again and tear off the top corner
- Fold it in half again and tear off the left corner.
- Rotate the paper to the right three times and tear off the bottom corner.
- This last one might be hard, but fold it in half again and tear off the middle piece.
- Open your eyes and hold your paper high so everyone can see them.
- **Ask:** What do we notice about everyone's papers? (many look different)
- **Ask:** What are we trying to demonstrate with this exercise? (communications are sometimes unclear or vague; we hear instructions differently; how we are different and alike.)
- **Emphasize:** Our perceptions and understanding of the same instructions might be different.
- **Ask:** Why is it that even though everyone received the same instructions, not everyone had the same outcome?
- **Ask:** What would have changed if you could have asked questions?
- **Ask:** Have you ever told someone one thing only to have the person hear and do something different?
- **Ask:** How does this affect our group? (We all process information differently and have different opinions.
- We need to do our best in communicating clearly and also be open to feedback and hearing different ideas.
- If we are not clear on what someone says, we can ask for clarification so we can better understand their point or opinion.

STEP 4: Refer to the flipchart titled, "Parking Area."

- **Explain:** Sometimes participants bring up important points during training that don't relate to the current topic.
- We use the "Parking Area" to write down good ideas/questions that don't directly relate to the current discussion, but we want to make sure we come back to it later.

Session 1.5: Key Population Programme In Kenya

Time: 15 minutes

Preparation/Materials: Handout and/or PPT slide(s)

INTRODUCTION:

- **Explain:** Some of you are familiar with NASCOP, so we won't spend a lot of time reviewing the background of NASCOP, but we do want to spend a few minutes getting us grounded in why many countries are prioritizing KPs in their HIV prevention, care and treatment strategies.
- This will set the stage for us in exploring why and how violence prevention and response services are being integrated into HIV programming.

STEP 1: Large Group Discussion: KPs

- **Ask:** What do we mean by KPs? What makes a group considered a "key population?" (Elicit responses and then click slide again to post definition.)

Slide:

What do we mean by "key populations?"

Defined groups who, due to specific higher – risk behaviours, are at increased risk of HIV. Also, they often have legal and social issues related to their behaviours that increase their vulnerability to HIV.

- **Ask:** What makes KPs at high risk of contracting HIV? (common response is high risk behaviors)
- **Explain:** In addition to higher-risk behaviors, there are other factors that make KPs more vulnerable to HIV, which we'll talk about in a minute.
- **Explain:** NASCOP focuses on three KPs.

- **Post slide and ask:** Who are they? (Elicit responses; click slide again to post answer.)

Slide:

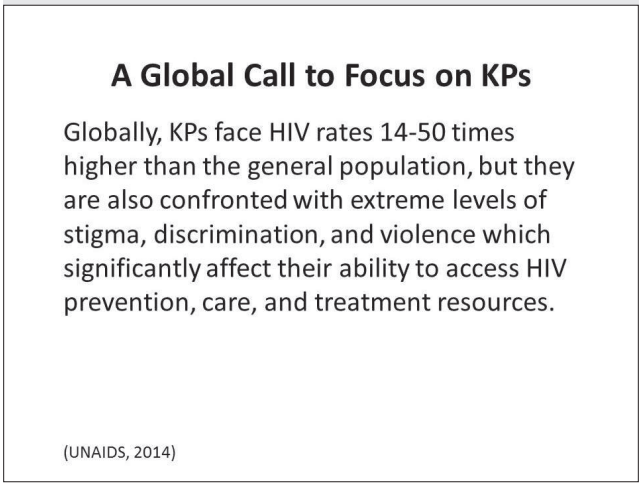
NASCOP KPs: Who are they?

- Sex workers (SWs)
- Men who have sex with men (MSM)
- People who inject drugs (PWIDs)

- **Ask:** Why is there a global call to focus on KPs? (Elicit responses and click slide again to post answer.)
  - **Emphasize:** KPs are at greater risk of HIV infections than other groups.
  - Many governments now recognize that it is impossible to reduce or eliminate HIV without focusing on the entire population, including KPs.
  - Many national HIV prevention, care and treatment strategies now include specific strategies for reaching KPs and improving their access to HIV services.
  - Many of these national strategies also highlight the need to focus on reducing stigma, discrimination, and violence against KPs if we hope to reach our goal of eliminating HIV.

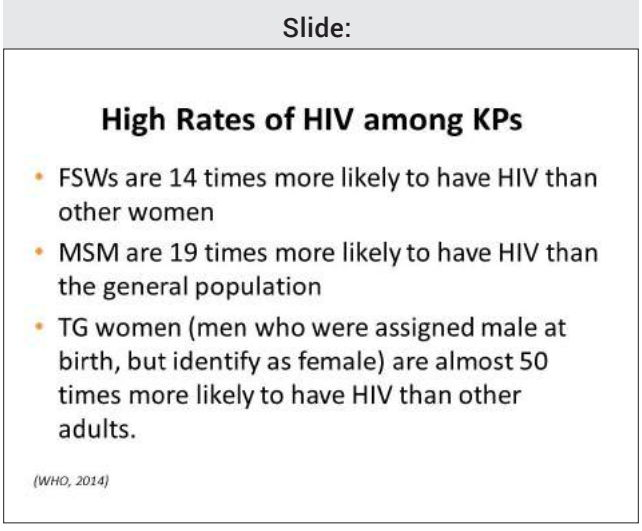
- **Present and/or post PPT slide and explain:** According to UNAIDs, we know that...

Slide:



- **Present and/or post PPT slide and explain:** More specifically, according to the World Health Organization, we know that...

Slide:



- **Post slide and ask:** Why do you think these rates are so high among KPs?
  - **Explain:** We already mentioned one reason is due to high risks behaviors...
  - But there are other reasons.
  - **Ask:** What are other reasons? (Elicit responses; click slide again for answers)

Slide:

Why do you think these rates are so high among KPs?

- High-risk behaviors...but what else?
- Structural barriers (denial of services)
- Stigma, discrimination, violence
- Poverty
- Criminalization of their occupation (e.g. sex work) or who they choose as partners (e.g. MSM)

  - **Emphasize:** structural barriers, stigma, discrimination, violence and abuse, poverty, criminalization of their occupation (e.g. sex work) or who they choose as partners (e.g. MSM)
  - All of these things prevent KPs from accessing care and treatment services – contributing to these high prevalence rates among KPs.

- **Post 3 PPT slides and explain:** In Kenya, NASCOP focuses on FSW, PWID, MSM.
- There is also a focus and commitment at the national level.

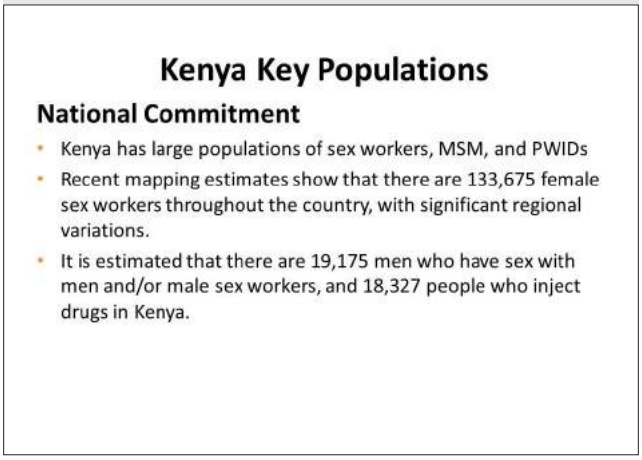
Slide:

Kenya Key Populations

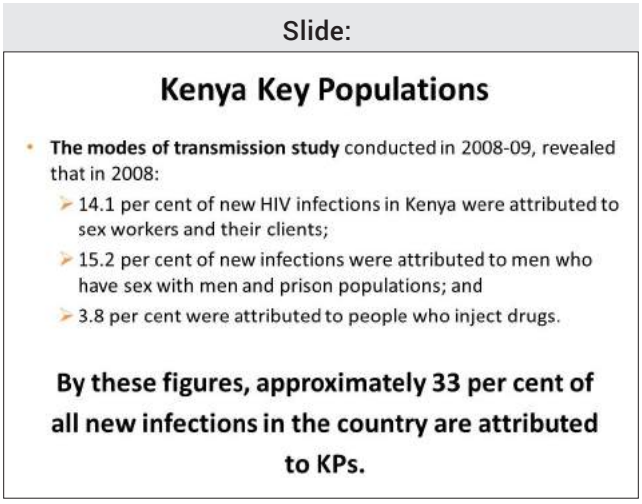
Focus on 3 key populations

- The Kenya AIDS Strategic Framework(KASF) 2014/15–2018/19 (KASF) identifies these KPs as female sex workers (FSWs), men who have sex with men (MSM), and people who inject drugs (PWID).
- The KASF specifically takes cognizance of violence against KPs because of its contribution to HIV vulnerability. The significance of violence as a risk factor is evident from epidemiological modeling which has suggested that "elimination of sexual violence alone could avert 17 per cent of HIV infections in Kenya . . . through its immediate and sustained effect on non-condom use among FSWs and their clients in the next decade.

Slide:



Slide:



- **Explain:** So, we have the global commitment, but also commitment at the national level to focus on KPs and developing interventions that reduce stigma, discrimination, and violence, and abuse.

- **OPTIONAL:** Post PPT slide and show video presentation of the 2016 AIDS conference in Durban that highlights the importance of prioritizing KPs. https://www.youtube.com/watch?v=qirlH4S3qwg&sns=em

Slide:

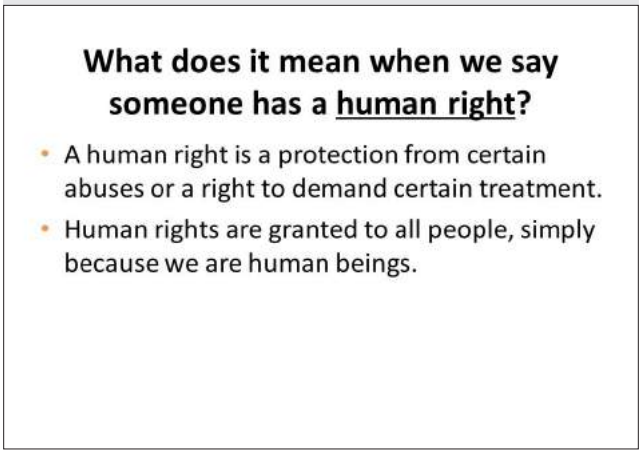
- **Debrief video and ask:** What is something from this video that struck you or had an impact on you? (Elicit responses.)

STEP 2: Large Group Discussion: Addressing Violence in HIV programmes for KPs

- **Ask:** So, why are we addressing violence in the context of HIV services? (Elicit responses)
- **Explain:** The links between violence and HIV are well established.
- We know that violence interferes with one's ability to seek and access HIV testing, care and treatment services.
- Also, a positive HIV status can also trigger acts of violence and abuse from family members, intimate partners, community members, and other others.
- In addition to HIV, there are also many other health issues related to violence, which we'll talk more about later.
- **Explain:** One of the fundamental principles of NASCOP is ensuring access to services for KPs and since violence has been recognized as one of the most pervasive human rights violations in the world that acts as a barrier to access to services, NASCOP is prioritizing response to violence in its HIV programs.

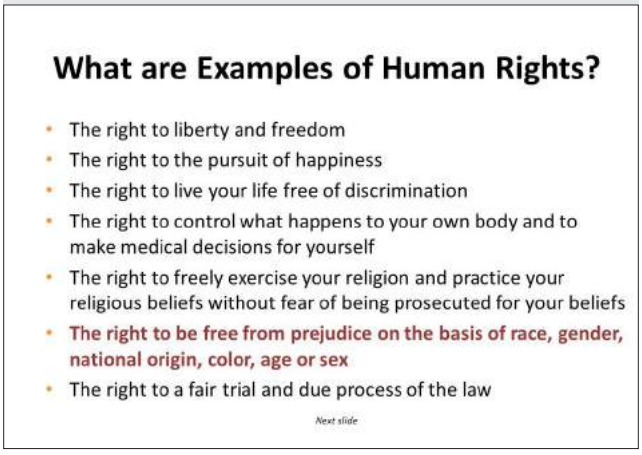
- **Post slide and ask:** What does it mean when we say someone has a human right? (Elicit responses and then click slide again to post answer.)

Slide:



- Later, we're going to talk more about the human rights protections in Kenya, but for now, let's quickly brainstorm some examples of human rights.
- **Post slide and ask:** What are some examples of human rights? (Record on flipchart and after this is done, click slide again to post examples on next two slides.)

Slide:



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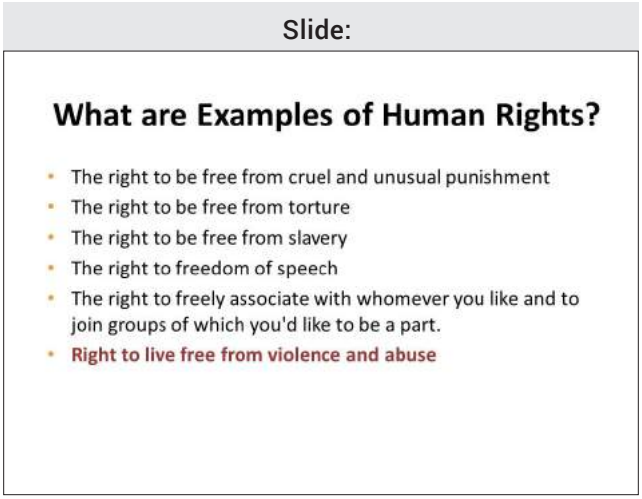


- **Emphasize:** Human rights include the right of all persons to be free from coercion, discrimination, and violence, and include the right to...
  - The highest attainable standard of sexual health, including access to sexual and reproductive health care services
  - Seek, receive and impart information related to sexuality
  - Sexuality education
  - Respect for bodily integrity
  - Choose their partner
  - Decide to be sexually active or not
  - Consensual sexual relations (in and out of marriage)
  - Consensual marriage;
  - Decide whether or not, and when, to have children
  - Pursue a satisfying, safe, and pleasurable sexual life
- **Explain:** Globally, KPs report experiencing high rates of violence, which violates their right to live free from violence and abuse.
- It's important to acknowledge that...
  - despite being a human rights violation,
  - despite the compelling information about the high rates of violence experienced by KPs,
  - despite commitments at the global and national levels to address violence...
- VPR services continue to be limited or inaccessible for KPs in many countries.

- **Post slide and explain:** To address these barriers and gaps, NASCOP is prioritizing the integration of violence screening and response services in KP programmes
- **Emphasize:** Violence screening and response services can be integrated throughout different programme activities like:
  - Outreach in hotspots
  - Reach and test KPs;
  - Diagnose and enroll clients in care;
  - Initiate and sustain clients on anti-retroviral therapy (ART)
- Violence screening and response is not a one-time activity. We'll talk more about screening later.
- For now, the important take away message is that addressing violence in the context of HIV services is a priority for NASCOP, which is why we are having this training.

Session 1.6: Violence Prevention and Response Terminology: What's in a name?

Time: 15 minutes

Preparation/Materials: PPT slides

INTRODUCTION:

- **Explain:** In this session, we're going to briefly talk about a few terms that are commonly used in VPR programs –and some things to think about when using these terms.

STEP 1: Large Group Discussion: GBV vs. Violence

- **Explain:** The terms "gender-based violence" or "GBV" are frequently used interchangeably with the terms "violence and abuse" or "violence."
- We are accustomed to thinking about GBV as affecting women and girls.
- It is important to acknowledge that when violence is directed at MSM, trans people, or female sex workers because others perceive that they do not conform to gender norms, this is a form of gender-based violence.
- We're going to talk more about gender norms later.
- There are many working definitions for GBV.
- Let's look at the definition used by PEPFAR.
- **Post PPT slide and review definition.**

Slide:

GBV Definition

(PEPFAR FY 2014 UPDATED GENDER STRATEGY)

The term gender-based violence refers to:

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

- **Post next PPT slide and explain content:**

Slide:

GBV Definition

(PEPFAR FY 2014 UPDATED GENDER STRATEGY)

- GBV is rooted in power differences, including social, economic and political inequalities.
- GBV can occur across childhood, adolescence, reproductive years, and old age.
- It can affect all individuals, but women and girls, MSM, trans people, and female sex workers are often at increased risk.

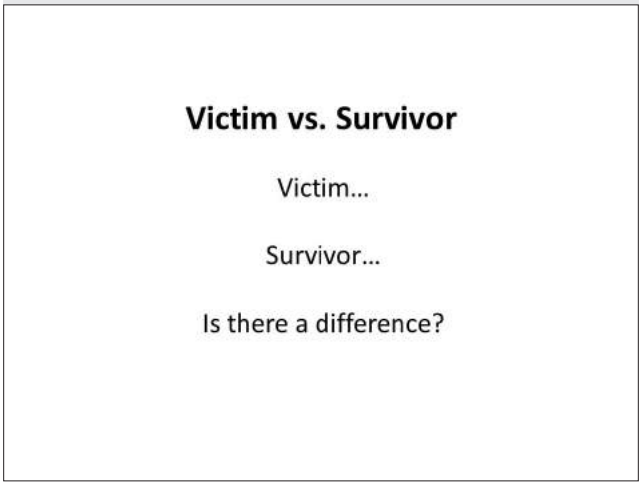
- **Emphasize:** Because of the gender dynamics involved in GBV, it's relevant to use this term in our work with KPs.
- Both terms are okay to use, but especially when we are talking directly with clients, it's often better to use the term "violence and abuse."
- Often, clients understand the term "violence and abuse" more than the term GBV.
- Just know that it is okay to use both, but use whatever terms works well in your context.
- You will notice that we mostly use the term "violence" in this training.
- We use the term "violence" to refer to all forms of GBV against KPs;

STEP 2: Large Group Discussion: Victim vs. Survivor

- **Explain:** People use different terms to refer to someone who has experienced violence.
- For example, some people use the term "victim" when referring to someone who has experienced violence.
- **Ask:** Are there other terms commonly used to refer to someone who has experienced violence? (Allow participants to brainstorm.)

- **Post PPT slide and explain:** The terms "victim" and "survivor" are the most commonly used terms when referring to an individual who has experienced violence.

Slide:

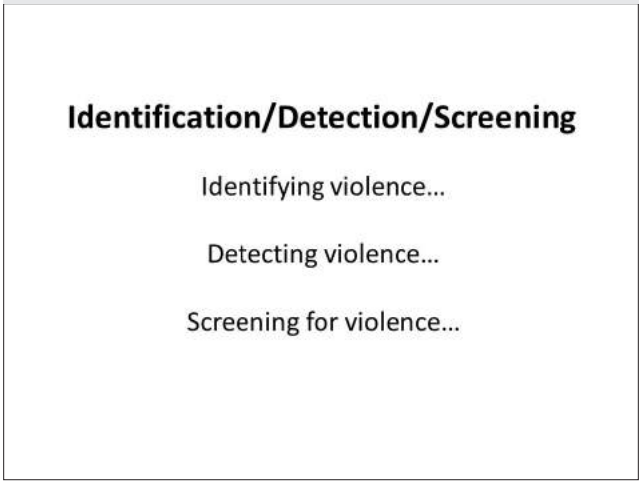


- **Emphasize:** As program implementers, we sometimes use these terms interchangeably.
- Ultimately, it should be up to the individual who experienced violence to determine how to identify themselves.
- **Ask:** Is there a difference in these two terms? (Elicit input from participants.)
- Some people who have experienced violence and abuse choose to describe themselves as victims –someone who was attacked or abused –someone who was victimized.
- They feel they are victims of a crime or other human rights violation.
- Other people prefer to identify as survivors.
- They feel this is an empowering term that implies strength and resilience.
- Program implementers should use the KP member's language or use more inclusive terms such as "clients" or "people who experience(d) violence and abuse."
- Although we use these terms interchangeably, we use the term "victim" throughout this training to refer to KPs who have experienced violence.
- This is not intended to imply any lack of agency or empowerment for those who prefer to use the term "survivor."

STEP 3: Large Group Discussion: Identification/Detection vs. Screening

- **Post PPT slide and explain:** The terms "identifying violence," "detecting violence," and "screening for violence" are also used interchangeably by program implementers when referring to activities or interventions that aim to identify clients who have or are experiencing violence.

Slide:



- **Emphasize:** All of these terms are used in various settings to refer to activities that aim to "discover" or "become knowledgeable" that someone has or is experiencing violence.
- The term "screening" refers to asking clients a question or series of questions to determine if they have experienced violence or are at risk of experiencing violence.
- Screening for violence is an important intervention to implement with populations who are at high risk of HIV (e.g. KPs) since violence is a barrier for people in seeking and accessing HIV prevention, care, and treatment services.
- For purposes of this training, we use "screening" to mean –asking KPs about their experiences with violence.
- Screening is a way of identifying or detecting violence among KPs.
- We'll talk more about screening later in the training.

MODULE 2

BUILDING CORE KNOWLEDGE

Time: 6.5 hours

Introduction:

This module focuses on core sensitization topics to increase participants' understanding of and sensitivity to key issues faced by KPs. It aims to increase participants' understanding of issues related to sex and gender; how rigid gender norms affect KPs, including how these norms lead to stigma, discrimination, and violence; the types of violence commonly experienced by KPs; the effects of violence, including the links between violence and HIV; and the needs of KPs who experience violence. Participants will learn from a panel of KPs about how stigma, discrimination, and violence have affected their lives and the types of support they need. Participants will also hear about local human rights protections, as well as local laws that are incorrectly used against KPs. This module also provides participants an opportunity to explore their own values and beliefs that might impact their work with KPs.

This module includes the following sessions:

Session 2.1 Sex, Gender, Gender Identity, Gender Expression, Sexual Orientation
Session 2.2 Gender Norms/Stigma/Discrimination/Violence
Session 2.3 Understanding Violence and Links with HIV
Session 2.4 Panel Discussion with KP members
Session 2.5 Human Rights Protections and Laws that are incorrectly used against KPs
Session 2.6 Exploring our own values and how they impact our work

Session 2.1: Sex, Gender, Gender Identity/Expression, Sexual Orientation

Time: 60 minutes

Learning Objectives:

At the end of the session, participants will be able to:
- Understand the difference between sex and gender
- Understand the difference between gender identity and sexual orientation
- Understand that sex, gender identity, gender expression, and sexual orientation all exist on a continuum

Preparation/Materials:

- Flip charts/or PPT slides with the definitions of sex, intersex, gender, gender identify, gender expression, and sexual orientation
- Blank flip chart paper and markers for small group exercise

INTRODUCTION:

- **Explain:** In this session, we will think through concepts of sex, gender, gender identity, gender expression, and sexual orientation –and what these concepts mean for KPs.
- In the following sessions, we will also talk more the links between violence and HIV and the types of violence commonly experienced by KPs.

STEP 1: Small group exercise: Sex and Gender: What's the difference?

- **Explain:** In this first activity, we'll think through the concepts of sex and gender, two commonly confused words that have important meanings for each of us.

Slide:

Small Group Activity
Sex and Gender: What's the difference?

- Divide into groups (about 6-7 per group)
- Each group select an artist.
- The artist, taking directions from the group, will draw either a woman or a man, as assigned by facilitator.
- Add details that distinguish the figure as a woman or man, using body shape, clothing, and anything else they can think of.
- Work in your groups for 10 minutes

- Ask each group to explain their drawings. Then, ask everyone to return to their seats.
- **Explain:** We'll come back to your drawings in a few minutes.

STEP 2: Large group discussion: Defining key terms

- **Explain:** Let's look at some definitions related to sex and gender.
- **Post PPT slide and ask:** What do we mean by sex? (Elicit responses and click slide again to post definition.)

Slide:

Sex is...

Is a medical term used to refer to the chromosomal, hormonal, and anatomical characteristics that are used to classify an individual as female or male or intersex.

Sex refers to the biological aspects of a person.

The following slides related to sex and gender concepts are adapted from HPP Training- https://www.healthpolicyproject.com/pubs/398_GSDGuide.pdf

- **Emphasize:** We often focus on the anatomical because that is what is easiest to observe. (i.e., When we talk about anatomical, we're talking about physical characteristics that we can see, such as genitalia.)
- However, there are chromosomal and hormonal characteristics that are also used to classify an individual as female, male, or intersex.

- **Post PPT slide and ask:** What do we mean by intersex? (Elicit responses and click slide again to post definition and then again to post continuum.)

Slide:

Intersex...

refers to a person born with reproductive or sexual anatomy that doesn't seem to fit the typical definitions of female or male.

Sex is not always either male or female. Sex can exist on a continuum.

- **Post PPT slide and ask:** If sex refers to the biological aspects of a person, what do we mean by gender? (Elicit responses and click slide again to post definition.)

Slide:

Gender is...

a culturally-defined set of economic, social, and political roles, responsibilities, rights, entitlements obligations, associated with being female and male.

- **Post PPT slide with the definition of gender identity, and read:**

Slide:

Gender identity refers to "one's sense of self as male, female, or transgender."

When one's gender identity does not correspond with the biological sex they were assigned at birth, one may identify as:

- **Transgender**: gender identity is different from sex assigned at birth
- **Trans woman**: Assigned male at birth and identifies as female
- **Trans man:** Assigned female at birth and identifies as male

- **Post PPT slide and explain:** Beyond a person's biological sex, we can see by the drawings from our activity--that there are common ways that women and men express their gender. (Review content of slide.)

Slide:

Gender expression is the external display of gender through:

- Appearance
- Disposition
- Social behavior

A person's gender expression may or may not be consistent with socially prescribed gender roles.

- **Ask:** Do gender and expressions of gender vary between cultures? (Elicit examples.)
- **Provide an example of varied gender expression:** In some places, it is masculine to have long hair, in other places long hair is considered feminine.
- **Emphasize:** Like sex, gender and expressions of gender exist on a continuum, as well.
- Refer back to the groups' drawings.
- Ask the group to identify which things on each drawing represent the person's sex (first) and then which things represent their gender.
- Use one marker color for sex and one for gender --write an "S" by the items for "sex" and a "G" by the items for "gender."

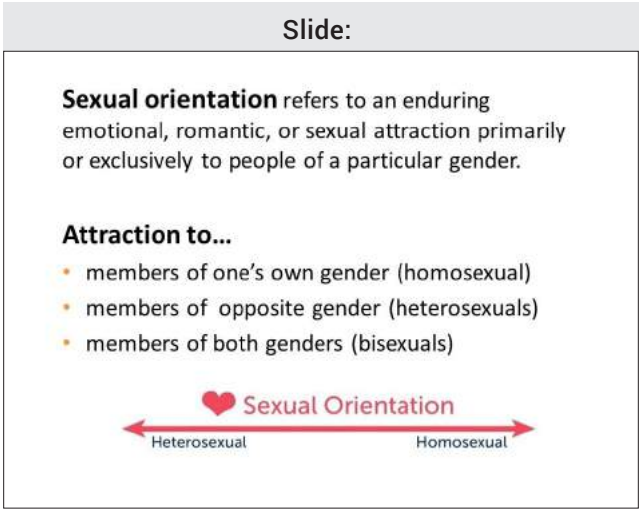
  For a woman, earrings, a skirt, long hair, long nails, high heels, a purse, a specific stance (for example, one hip out) would all be expressions of gender. Breasts, vagina, wider hips would all be signs of her biological sex.

  For a man, a specific stance (for example, arms crossed), short hair, short nails, type of clothing and shoes could all be expressions of gender. Tall height, strong arms, a penis and testicles, and facial hair would be signs of biological sex.

- **Summarize:** We've talked about the difference between sex and gender, what we mean by gender identity, and the different ways in which people can express their gender.

- **Post PPT slide and ask:** What do we mean by sexual orientation? (Elicit responses and then click slide again and review content of slide.)

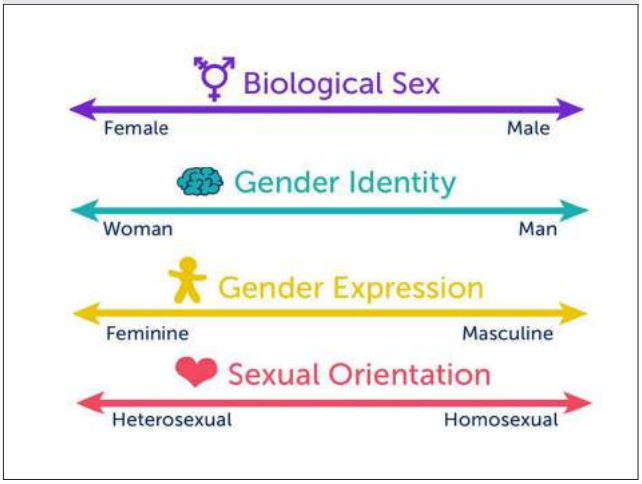
Slide:



- **Emphasize:** While these categories continue to be widely used, sexual orientation does not always fit in such definable categories and also exists on a continuum.
- **Summarize:** We said sex refers to biological aspects, gender identity is one's sense of self as being male, female or transgender-- gender expression is how one chooses to express their sense of being male or female, and sexual orientation is the romantic, emotional or sexual attractions.
- **Emphasize:** Since each of these exist on their own continuum, these aspects can vary widely in each person.

- **Post PPT slide with all four continuu and allow participants to think about it.**

Slide:



- **Emphasize:** it's important to understand and respect each person as an individual who can be anywhere on these continua.

Session 2.2: Understanding Gender Norms/Stigma/GBV

Time: 120 minutes (2 hours)

Learning Objectives:

At the end of the session, participants will be able to:
- Explain how cultural and societal expectations establish gender norms
- Describe how gender norms can negatively affect people who conform to them
- Explain how rigid gender norms are particularly harmful to KPs
- Explain the relationship between rigid gender norms, stigma, and GBV

Preparation/Materials:

- Prepare flipchart titled "Social/Cultural Expectations." Add two columns underneath (men/boys and women/girls). Put aside. (Flipchart should look like Handout #1 worksheet)
- Handout #1: Social/Cultural Expectations Worksheet
- Handout #2: How do Gender Norms Affect us?
- Handout #3: Case Scenario: David
- Handout #4: Case Scenario: Diana

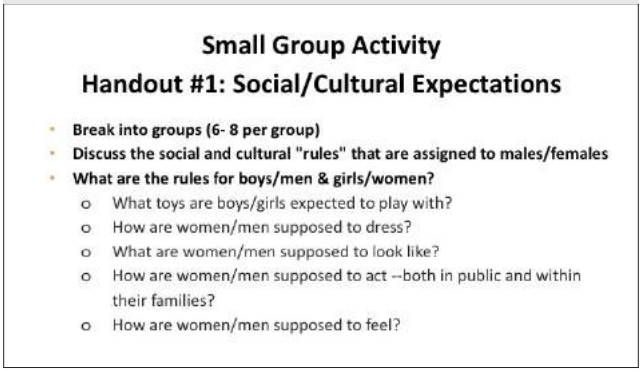
INTRODUCTION:

- **Explain:** Let's do a small group exercise that will help us further think through the concepts of sex and gender and how they affect our lives.

STEP 1: Small Group Exercise: Understanding Gender Norms

- **Post PPT slide** and assign participants to small groups (6-8 per group) and refer to
- Handout #1 in their training packets, titled "Social/Cultural Expectation Worksheet."
- **Explain:** In your groups, discuss the social and cultural "rules" that are assigned to males/females, beginning from the time they are born and throughout adulthood.
- **Ask yourselves:** What kinds of toys are boys and girls expected to play with? How are women and men supposed to dress? What are women and men supposed to look like? How are women and men supposed to act --both in public and within their families? Think about your own culture.
- Have one person in your group record your thoughts on Handout #1. Only one person needs to record the group's answers. Then, we'll come back and discuss as a group.
- Give participants about 15 minutes to discuss in their groups.

Slide:



- Debrief the exercise and post the flipchart "Social/Cultural Expectations."
- Alternate between groups and ask them to share one expectation at a time, until all ideas have been shared.
- Record expectations on flip chart.

Some example expectations are: (these will vary depending on the context)

Norms for boys/men	Norms for girls/women
Stay in control	Be soft/gentle/kind
Take risks	Be emotional or sensitive
Be brave and courageous	Be silent
Have sex when you want it	Please your partner
Have many sexual partners	Be faithful
Don't ask for help	Rely on others
Resolve conflicts with violence	Take care of others
Earn money	Be a homemaker
Ignore pain	Endure pain and don't complain
Be in command	Obey husband or father
Be self-reliant	Have children
Be intelligent	Be submissive

- **After all expectations are listed, review each expectation that the group created and ask:** Is this expectation based on sex or gender?
- Discuss as a group whether each expectation is based on a person's sex or gender.
- Refer back to the definitions of sex and gender as needed.
- **Summarize:** We can see that most of the expectations listed are based on gender.
- These are called gender norms...a set of expectations or rules assigned by our society and culture that tell us how act, look, and feel as men/boys and women/girls.
- **Ask:** How do we learn these gender norms?
- **Emphasize:** We are all socialized to adopt certain gender norms from an early age.
- They are deeply entrenched in our society, culture, and deeply entrenched in us.
- These gender norms shape our beliefs about how males and females should act, what they should look like, how they should feel, and how they should live their lives.
- For example: Boys and girls start out seeing their peer group in an affectionate way, but boys may begin to be less affectionate with other boys as they move out of childhood and into adolescence...
- And they begin to reject the emotional and affectionate attachment to other boys – because the gender expectation is that boys should be strong and not emotional....
- And expressions of love and affection should be directed towards girls, not boys.
- So, if boys continue to display affection (not sexual) towards other boys, it's socially unacceptable and they could be shamed for it –and maybe stigmatized as being gay.
- **Transition to next activity:** In life, many of us think, if we follow the rules –if we conform-- things will be okay.
- However, this is not always the case when we're talking about gender norms.

- Living according to these norms often causes harms and inequalities.
- For example, if women are expected and encouraged to rely on others, they will not have opportunities to be independent if they wanted or needed to (e.g., a male partner is abusive).
- For example, if men are supposed to be strong and not ask for help, they might not reach out for critical help when they need it.
- Let's look more closely at how rigid gender norms can be harmful to people who conform to them and those who are perceived as not conforming to them.

STEP 3: Small Group Exercise: How do Gender Norms Affect Us?

- **Post PPT slide and ask participants to break into pairs to discuss the questions on Handout #2 and record their ideas on the handout:** How do gender norms affect us?
- **Explain:** Think about the list of gender norms we created in the previous activity when answering the questions.

Slide:

Small Group Activity
Handout #2: How do gender norms affect us?

- **Break into pairs**
- **Think about the list of gender norms from previous activity and answer these questions:**

1. How could conforming for gender norms cause problems for both men and women?
2. What happens when someone is perceived as non-conforming to "rules" about gender?
3. How could gender norms increase both men's and women's risk for HIV?

- Give participants about 10 minutes to complete the activity.
- Ask the pairs to report back to the larger group and share their thoughts.

1. **How could conforming for gender norms cause problems for both men and women?** ***Example answers include:***
   - *men may be kept from being caring parents because it is seen as a woman's role*
   - *men may not ask for help when it's needed (including with their health) and suffer the consequences*
   - *men may get into fights and be hurt or hurt others to prove their masculinity*
   - *women have few options for occupations outside the home, limiting productivity*
   - *boys instead of girls get to go to school because parents prioritize son's education*
   - *women are not allowed to speak up and contribute their good ideas*

2. **What happens when someone is perceived as non-conforming to or they reject the "rules" about gender?** ***Example answers include:***
   - *they can be made fun of*
   - *they can be rejected*
   - *they can be denied health services o they can be arrested*
   - *they can develop low self-esteem o they can suffer violence*
   - *they can harm themselves or commit suicide*
   - *they can be killed*

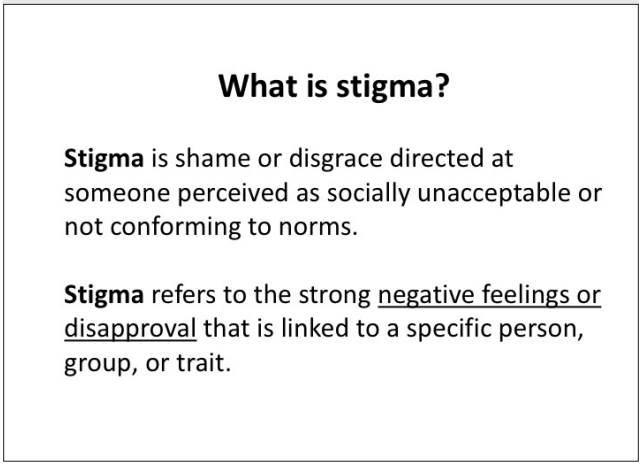
3. **How could conforming gender norms increase both men's and women's risk for HIV?** ***Example answers include:***
   - *When men are supposed to be sexually aggressive and have many partners, this increases their risk of HIV exposure*
   - *When women are supposed to be sexually submissive, including not asking partners to use condoms, this increases HIV risk*
   - *When early marriage for young girls is acceptable –young girls won't ask or insist that older men wear condoms*

- **Emphasize:**
  - *Within any culture, some gender norms can be harmful...*
  - *And conforming to these norms and not conforming to them can cause poor health and other harmful outcomes (refer to examples in question #3 above).*

STEP 4: Large Group Discussion: What do rigid gender norms mean for KPs?

- **Explain:** As we just discussed, there can be negative consequences for individuals who are perceived as both conforming and not conforming to gender norms.
- These negative consequences are often exacerbated for KPs whose behaviors may be perceived as deviating far from gender expectations.
- **Emphasize:** These negative consequences can include social exclusion or isolation, stigma, discrimination, and violence.
- Let's talk about stigma.
- **Post PPT slide and ask:** What do we mean by stigma? What is it? (Elicit responses and then click slide again to post definition.)

Slide:



- **Explain:** Let's talk about a few examples where someone might get stigmatized because their behaviors are perceived as non-conforming.

- **Example:** Think about a woman who negotiates for condom use in a context where this is not considered acceptable feminine behavior.
- **Ask:** What might people in her family or community think about her? (she's sleeps around with many men; she's being too bold or aggressive; she's acting like a man)

- **Example:** Think about a man who has sex with men in a context where this is perceived as unacceptable or non-conforming to traditional gender or social norms.
- **Ask:** What might people in his family or community think about him? (he's "deviant"; he's a "sinner")

- **Ask:** What are some other ways KPs are stigmatized? How are female sex workers stigmatized? What are the ways in which FSWs are shamed or blamed? (they are the cause of the HIV epidemic; they are immoral; they are lazy and don't want to work)

- **Ask:** What do we mean by internalized stigma? How do people feel about themselves when they are experiencing stigma from others? (e.g. They start to believe these outside beliefs; they can also experience multiple levels of stigma -such as, a female sex worker could be stigmatized for being female, but also stigmatized for being perceived as not conforming to rigid gender norms because she's a sex worker –not being a good mom, not having only one partner, etc)

- **Emphasize:** Many KPs are perceived as not conforming to gender norms, including around sexual behavior and gender expression.
  - They are often stigmatized for their behaviors and choices.
  - When KPs are stigmatized –that is, they are shamed or disgraced because of their behavior –it's easy to see them as "less than" others and not valued as human beings that deserve respect.
  - Many people have been taught to stigmatize others – to judge or devalue others because they are different or exhibit behaviors that are different than what the community expects and sees as normal.
  - Many people use gender or social norms to decide what is "normal" and then feel comfortable judging those who fall outside of these categories or norms.
  - When we do this, we are stigmatizing others.
  - And, when people are stigmatized by others, it makes them more vulnerable to discrimination, human rights violations, and violence and abuse.
  - We're going to talk more about that now.

STEP 5: Large group: How rigid gender norms and stigma lead to discrimination and violence

- **Explain:** Let's talk about the direct link between rigid gender norms, stigma, discrimination, and violence.
- We just talked about what we mean by stigma.
- Let's look at a definition for discrimination.
- **Post PPT slide** and review definition of discrimination.

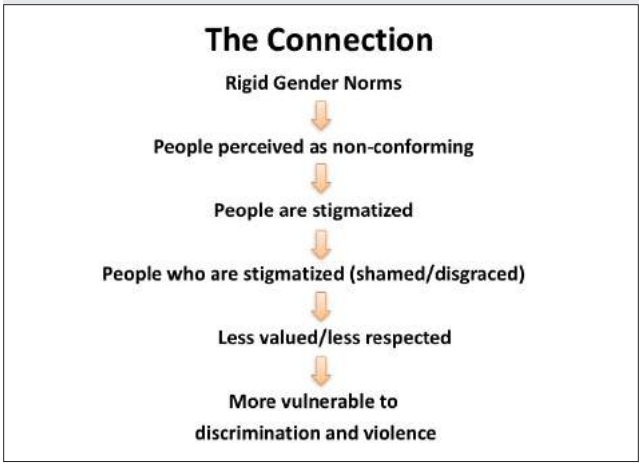
Slide:

What is discrimination?

When a person or group of individuals are treated unjustly or unfairly because of a specific trait they possess.

- **Explain:** We can think about stigma as being the *negative feelings or beliefs* towards a person or a group and...
- Discrimination as the *actions or behaviors* that are taken as a result of stigma.
- **Explain:** Here is how rigid gender norms and stigma can lead to discrimination and Violence.

Slide:



- **Emphasize:** We can see how stigma can quickly result in discrimination and violence, particularly when KPs are seen as "less than" others and not human beings that merit respect.
- **Ask:** How might this play out for KPs in real life? Can you think of an example or scenario? (Allow participants to think of/share scenarios.)

Here is one scenario:

- I am a health care provider who believes men should only have sex with women.
- A client comes to my clinic with anal warts and discloses he has a male partner.
- Because of my belief in the rigid gender norm that men should only have sex with women...
- I believe my client is not conforming to societal rules –I believe his behavior is beyond what I think is "normal."
- Because of this, I feel he is shameful and disgraceful.
- Because I think he is disgraceful, I see him as less valuable as a human being.
- I don't respect him.
- Because I don't value him and because I don't' respect him...
- This could affect my behavior.
- I tell him that there are limited resources at the clinic and there are more deserving patients.
- I tell him I will not give him the medication he needs to treat his STI –and that if he wants treatment, he will have to go to a private pharmacy/clinic and buy the medications himself.

- **Summarize:** In this example, I am part of the problem. I have interfered with a client's ability to access important medical services because of my personal beliefs.

STEP 6: Small Group Exercise: Case Scenario - Davide

- **Post PPT slide and explain:** Let's look at another scenario. Refer to Handout #3.

Slide:

Small Group Exercise
Handout #3: Case Scenario-David

- Break into groups (4-6 per group)
- Read case scenario: David
- Discuss questions at the end handout.
- Record your answers to share with the large group.

- Give participants 15 minutes to work.
- **Post PPT slide** with questions and discuss as a large group:

Slide:

Debrief Small Group Exercise
Handout #3: Case Scenario: David

- What gender norms are David perceived as not conforming to?
- How did the community respond when they perceived him as not conforming to traditional gender norms?
- How did the HCW's response affect David?
- How could the provider have responded in a way that could have improved David's health?

1. **What gender norms are David perceived as not conforming to?**
   - *David has sex with men instead of women.*
   - *Breaking with norms around who men should have sex with.*
   - *David has been the receptive partner when having sex with men (anal warts) - a role that is seen as feminine - which may also be seen as "less than" masculine.*

2. **How did the community respond to David when they perceived him as not conforming to traditional (rigid) gender norms?**
   - *David's co-workers ostracized him when they began to think he was gay.*
   - *His health care provider shamed him instead of helped him.*

3. **How did the community's response affect David's health?**
   - *David became depressed and put himself at greater risk for STIs and HIV through the coping mechanisms he used to deal with his depression.*

4. **How did the HCW's response affect David?**
   - *The HCW's shaming him may affect David's willingness to reach out for health care services in the future for fear of being shamed or humiliated again.*

5. **How could the provider have responded in a way that could have improved David's health?**
   - *If the health care provider had talked to David about the behavior that put him at risk, he could have recognized that his risky behavior was linked to depression.*
   - *By treating David's depression, he may have been able to help limit his risk behaviors.*

- **Emphasize:** In this scenario, the provider is part of the problem.
- Because of his own values around how men should act and behave, he shamed David – he stigmatized him.
- This provider is creating barriers for this client in reaching out for important health care services in the future...
- Which is the opposite of what providers need to be doing if we are going to reach of our goal of reducing and eventually eliminating HIV among the entire population.

- **STEP 7: OPTIONAL Small Group Exercise: Handout #4: Case Scenario: Diana**

- **Post PPT slide and explain:** Let's break up into different groups and look at another case study. Refer to Handout #4.

Slide:

Small Group Exercise
Handout #4: Case Scenario-Diana

- Break into groups (4-6 per group)
- Read case scenario: Diana
- Discuss questions at the end handout.
- Record your answers to share with the large group.

- Give groups about 10-15 minutes to work.
- Post PPT slide with questions and discuss as a large group.

Slide:

Debrief Small Group Exercise
Handout #4 Case Scenario: Diana

- What parts of her experience are common to many women, including those who do not sell sex?
- What gender norms do you think the provider felt Diana was not conforming to?
- What did the health care provider do that could negatively affect Diana's health?
- What could the provider do to improve Diana's health?

1. **What parts of her experience are common to many women, including those who do not sell sex?**
   - *Family prioritized boy's education over hers; she had to quit school.*
   - *Diana experiences partner violence –like many other women*
   - *Lack of ways to earn a decent income*
   - *Expectation that she will be responsible for her child --in line with what is expected of most women*

2. **What gender norms do you think the provider felt Diana was not conforming to?**
   - *Women should be married –only have one partner*
   - *Women should have not work*
   - *Women should have babies*
   - *Women should not have sex outside of marriage*

3. **What did the health care provider do that could negatively affect Diana's health?**
   - *Diana might attempt self-abortion, which is dangerous*
   - *Diana might be forced to have a child that she cannot afford to take care of*
   - *She may feel so ashamed that she will now hesitate to reach out for help in the future –including getting tested for HIV or other STIs –for fear of being further shamed and humiliated*
   - *Emotional/mental health –depression, anxiety, could feel suicidal because she feels like she doesn't have other options*

4. **What could the provider do to improve Diana's health?**
   - *Pulled her aside in private*
   - *Tell her she did the right thing by coming to the pharmacy*
   - *Provided the emergency contraception*
   - *Give her information about places she can go for additional health services, including testing for HIV and other STIs*

STEP 8: Summarize Session

- **Explain:** In this session, we've talked a lot about gender norms.
- As we just discussed, we can see how KPs are particularly vulnerable to violence and abuse due to the extreme levels of stigma they experience, which can interfere their ability to access important services - including health care services.
- We also discussed how one's beliefs can lead to stigma and discrimination, which could interfere with a client's right to receive quality health care.
- This is why there is a global call and a national call to address stigma, discrimination, and violence towards KPs - at all levels - because we know that these prevent KPs from reaching out for and receiving services, including HIV testing, care, and treatment services.

Session 2.3: Understanding Violence and links with HIV

Time: 90 minutes (1.5 hours)

Learning Objectives:

At the end of the session, participants will be able to:
- Understand how power inequalities and other factors contribute to violence
- Understand the types of violence experienced by KPs
- Understand how violence increases one's risk of HIV infection
- Understand how one's positive HIV status increases their risk of violence

Preparation/Materials:

- Flip charts and markers
- Handout #5: Case Study: Nicole
- Handout #6: Case Study: Sylvia

INTRODUCTION:

- **Explain:** In this session, we'll talk about how power inequalities between and among individuals and groups contribute to violence and other human rights violations.
- We will also explore the different types of violence commonly experienced by KPs...as well as
- Other human rights violations often reported by KPs.
- We'll finish up the session by exploring the specific links between violence and HIV.

STEP 1: Large Group Exercise: Understanding Power and Factors that Contribute to Violence

- Write the word "power" in the middle of a large square of flipchart paper.
- Ask participants to take turns contributing words and expressions that mean "power."
- **Ask:** What is the first word that comes to mind when you hear the word "power?"
- Write all contributions on the flipchart, around the word "power." Keep this process at the pace of a fast brainstorm. (Contributions could include: strength, ability, authority, violence, force, prestige, control, money, energy, etc.)—be sure the brainstorm includes the idea that having power means having control and access to decision-making processes and/or resources.
- **Ask:** Do you consider power as positive or negative? Why?
- **Emphasize:**
  - There are many types of power; it can be used positively or negatively.
  - We all have power within us, even if at times we don't realize it.
  - Using our power over someone else is an abuse of that person's rights.
  - Sometimes, we join our power with others to give support.
  - We all have power to do something, to act.
  - Those who have less power in relationships are always more vulnerable to abuse.
  - Violence is about the abuse of power over someone who has less power.
  - It's important to recognize that those who have less power are vulnerable to a range of human rights violations, including violence

- **Ask:** Besides rigid gender norms, stigma, and power inequalities, what other factors contribute to violence and abuse KPs:
  - Criminalization of behavior (sex work, homosexuality)
  - Discriminatory laws
  - Impunity (exemption from punishment for unjust behaviors)
  - Lack of training for providers and key stakeholders
  - Religious beliefs

STEP 2: Large Group Exercise: Power Walk

- Find a large open space where participants can stand in a straight line, and there is space for them to take steps forward and backwards.
- Ask participants to stand in a line in the middle of the space and ask everyone to face the trainer. Make sure there is a lot of space behind and in front of the line of participants so they can take many steps forward and backward during the exercise.

  Note to Trainer: If you do not have at least three women and three men, ask for volunteers to take on the identity of a woman or man. In case there are members of KPs in the group, to protect participants' privacy, this exercise does not single out the inequalities of KPs by asking specific questions about the experiences of KPs; rather, this exercise will highlight the inequalities between men and women, which the facilitator can then use as a springboard during the debrief to highlight that these inequalities are even greater KPs and other groups that hold less power.

- **Explain:** I'm going to read some questions to the group.
- After I read each question, take one step forward or backward, based on your life experiences and the instruction that is given.
- When I read a question, take a moment to think about it before moving. I'll repeat the question to make sure it is clear, and then you can take your step forward or backward.
- The definition of "partner" is someone with whom you are in an intimate relationship (spouse or dating partner).

  Note to Facilitator: If someone is in a wheelchair, instead of taking a step, they can move/roll the equivalent.

- Read each question below, and after each question, wait for participants to take their steps based on the instruction given at the end of each statement. Speak loudly when reading the questions to ensure participants can hear the questions and instructions. Allow enough time in between questions for participants to think about the question and make their decisions to move forward or backward.

Some example expectations are: (these will vary depending on the context)

Norms for boys/men	Instructions
Are most court judges in your country the same gender as you?	If yes, take one step forward. If no, take one step back.
Have you ever been harassed or disrespected by a police officer because of your gender?	If yes, take one step forward. If no, take one step back.
Is it acceptable in your culture for people of your gender to physically punish their partner for cheating/adultery?	If yes, take one step forward. If no, take one step back.
Are most military officers the same gender as you?	If yes, take one step forward. If no, take one step back.
Do you ever fear being sexually assaulted when you walk alone at night?	If yes, take one step forward. If no, take one step back.
Has someone you know who is the same gender as you ever been denied a job or promotion because of their gender?	If yes, take one step forward. If no, take one step back.
Is your gender sometimes considered as the "weaker gender?"	If yes, take one step forward. If no, take one step back.
Are most political leaders in your country the same gender as you?	If yes, take one step forward. If no, take one step back.
Are people of your gender responsible for most of the childrearing responsibilities?	If yes, take one step forward. If no, take one step back.
Is it acceptable in your culture for people of your gender to have multiple sexual partners?	If yes, take one step forward. If no, take one step back.
Are most religious leaders in your country the same gender as you?	If yes, take one step forward. If no, take one step back.
When married, can your family name be given to your children?	If yes, take one step forward. If no, take one step back.

- After all statements are read, pause. Ask the participants to remain where they are.
- Ask the participants to look around to see where they are standing and where others around them are standing.
- Ask them to take a moment to reflect on their own position and the position of others.
- **Ask:** If I ask everyone to run towards (pick a spot that is some distance in front of the participants), who would get there first? Raise your hand if you think you would get there first.
- **Emphasize:** The people standing in the front have an unfair advantage over the people behind them.
- There may be some women who have more equality and advantages in their lives, and these women may be standing ahead of other women, including women who experience additional disadvantages or additional inequities due to their occupation (e.g. sex work, being viewed as deviating substantially from what is acceptable for women). If this is the situation, explain that women and men also experience difference levels of equality in their lives and some women and men may have more advantages than other women and men.

- Debrief Power Walk exercise and ask participants to return to their seats.
- Facilitate a large group discussion. Make sure everyone is contributing their thoughts and everyone feels safe and respected during the discussion.
- **Ask:**
  - How did you feel doing this exercise?"
  - How did you feel at the beginning when you were all in the straight line?
  - How did it feel to move forward? To move back?
  - What does this exercise tell us?
  - What did it tell you about your own power? The power of those around you?"
- **Emphasize:** The power imbalances among us put some people at a disadvantage and make them more vulnerable to violence.
- There are also power imbalances within a specific gender. For example, some women in our society have more power and advantages than other women (e.g. women who are not sex workers may have more advantages than female sex workers; for example, female sex workers may have less access to important health care than women who are not sex workers.)
- Another example, female sex workers may be more vulnerable to harassment and other forms of violence by police than other women who are not sex workers.
- Also, MSM and Trans people might be even more stigmatized than other groups, which makes it more difficult for them to access resources, etc.
- These power imbalances can and do violate the basic human rights of individuals, particularly among vulnerable groups, such as KPs, to enjoy the same types of freedom and access to resources as those with more power and status.
- **Emphasize:** The difference in status and the power imbalances between individuals or between groups of people are the root cause of violence.
- Power imbalances are what allows violence to happen.
- Poverty, alcohol, unemployment (and other such factors) may be the context of violence (co-occurring factors) but the difference in status and power (gender inequality) are the root cause of violence.
- **Ask:** What do we mean when we say other factors - like alcohol, poverty, etc. - can be co-occurring factors, but not the cause of violence? (Example: Many people drink alcohol and don't abuse other people. Many people are poor, but don't abuse other people.)
- **Emphasize:** Again, because of the extreme levels of stigma, discrimination, and criminalization of behavior, KPs often have less power than other groups, which makes them vulnerable to discrimination and violence.

STEP 3: Small Group Exercise: Types of violence experienced by KPs

- Hang the 4 flipcharts, titled, physical, emotional, sexual, economic.
- **Explain:** There are many forms of violence. They are usually categorized into 4 types: physical, emotional, sexual, and economic, but some types of abuse don't fit neatly into these categories, so we should consider these as well.
- There are also system-level abuses, or structural abuses, that are often experienced by KPs.
- We're going to break up into 4 groups –one for each category.
- In your groups, think about specific examples of violence and abuse for your assigned category.
- Keep in mind that some forms of violence will cross over into one or more categories.
- That's okay. Focus on your category and think of specific behaviors and examples that fit into your category.
- Break into 4 small groups and assign each group to one of the 4 flipcharts.
- Give participants about 10/15 minutes.

- **Debrief as a large group:** Ask for a volunteer from each group to present their group's responses from the small group exercise (types of violence).
- After each category is presented, ask the group if there are any examples missing.
- The facilitator should then add any examples that are missing from the category.
- Make sure the flipcharts include the examples listed below.
- **Physical:** Hitting; pushing; kicking; choking; spitting; pinching; punching; poking, slapping; biting; being shaken; pulling hair; throwing objects; being dragged; beaten up; deliberately burned; use of weapon or threat of weapon; kidnapping; holding against will; physically restraining; poisoning; killing
- **Sexual:** Rape; gang rape; sexual harassment; being physically forced, coerced, or psychologically intimidated to engage in any sexual activity against one's will (undesired touching, oral, anal, or vaginal penetration with penis or with an object); emotionally, socially, or economically pressured into sexual activity; refusal to wear a condom; genital cutting/mutilation (e.g., FGM); early or forced marriage; forced abortion
- **Emotional:** Psychological and verbal abuse; humiliation; threats; coercion; controlling behaviors; calling names; verbal insults; blackmail; threatened with loss of custody of children; being confined to or isolated from friends/family; threatening to harm someone you care about; repeated shouting; intimidating words/gestures; destroying possessions; blaming; isolating; bullying
- **Economic:** Use of money or resources to control an individual; refusing right to work; taking earnings; withholding resources as punishment; clients refusing to pay
- **Other human rights violations** have been cited by KPs and should be considered in the context on violence. Some of these human rights violations include:
  - having money extorted
  - being denied or refused food or other basic necessities
  - being refused or cheated of salary, payment or money that is due to the person
  - being forced to consume drugs or alcohol
  - being arbitrarily stopped/subjected to invasive body searches/detained by police
  - being arbitrarily detained or incarcerated in police stations, detention centers and rehabilitation centers without due process
  - being arrested or threatened with arrest for carrying condoms
  - being refused or denied health-care services
  - being subjected to coercive health procedures such as forced STI and HIV testing, sterilization, abortions

- being publicly shamed or degraded (stripped, chained, spat upon, put behind bars)
- being deprived of sleep by force

STEP 4: Large Group Discussion: Who are the perpetrators?

- **Ask:** Who is perpetrating violence against KPs?
- **Emphasize:** spouses, intimate partners, family members, community members, teachers, clergy members, strangers, health care workers, other service providers. Other perpetrators may include--police, military, hotel owners --and for female sex workers, perpetrators could also include clients, pimps, brothel owners, hotel owners.

STEP 5: Small Group Exercise: Effects of Violence and Links to HIV

- **Explain:** In this next exercise, we will explore the effects that violence has on KPs.
- We'll work together in 4 small groups.
- I will give your group a case study to read together and then discuss the questions at the end of your case study sheet.
- In your groups, think about the physical health and mental health consequences that violence has or could have for the person in your case study.
- Give half of the group Handout #5 (Nicole) and the other half of the groups Handout #6 (Sylvia).
- Give participants about 10/15 minutes to work in small groups.

Small Group Exercise
Handout #5: Case Study - Nicole

Nicole is a 22-year-old transgender woman. She was born male but realized at a very early age that she felt much comfortable as a girl than as a boy. Nicole hid this from her parents and spent much of her childhood feeling lonely and sad. As soon as she left home she began to dress as a woman, grew her hair long, started to take hormones and felt much more like herself. Nicole tried to get several jobs but her identification said "male" and did not match her gender expression or her current name and no one was willing to hire her. She began to sell sex in order to pay for food and housing. One night, a police officer saw Nicole when she was selling sex. He begins to harass her and forced her to have sex with him or to be arrested. After having sex with her, he beat her and said that she deserved to be treated this way. Nicole needed several stiches and went to a clinic the next day. The receptionist asked Nicole for her ID and used her previous name when calling her to see the doctor. Nicole was embarrassed but decided to get treatment. The doctor referred to Nicole as "he" and used her previous name even when she corrected him. The doctor told Nicole to stop complaining that others can't understand her "unnatural lifestyle."

Small Group Exercise
Handout #6: Case Study - Sylvia

Sylvia lived with her husband, Armand. When they got married, Armand paid dowry/bride price to her family and, from the beginning, expected Sylvia to work hard to make up for it. He would often tell her that he had paid a good price for her so she better work and be a good wife, or else he would send her back and demand the money back from her family. Sylvia worked from early in the morning until late in the evening selling vegetables in the market. When she got home, she would be tired, but she had to cook dinner, fetch water, wash clothes, and look after her young children as well. She was having difficulty managing all of her work.

Armand would often take the money that Sylvia earned at the market and go out in the evening. He would not come home until late, and often, he would beat her in front of the children. Sometimes he would make her sleep outside to punish her if the food was cold or not cooked to his liking and to show the neighbors that he was the boss in his house. Because Armand took all the family income, there was not enough money to feed her children. She began to sell sex to earn enough money to provide for her family. She did this without her husband's knowledge. Sometimes, her clients would force her to have sex without a condom, even though she always insisted. She thought about going to a clinic to get tested for HIV, but decided not to go because she was afraid of the results and what her husband might do if the results were positive.

- Debrief Small Group Exercise
- Ask a volunteer from one of the two groups who worked on the "Nicole" case study to read the case study out loud to the large group.
- Post flipchart with a heading "Consequences of Violence," with two columns underneath for "Physical" and "Mental/Emotional"
- Ask "Nicole" (two groups) to describe the physical health consequences for Nicole and record on flipchart.
- Then, ask them to share the mental health consequences for Nicole.
- Ask a volunteer from one of the two groups who worked on the "Sylvia" case study to read the case study out loud to the large group.
- Ask "Sylvia" (two groups) to describe the physical health consequences for Sylvia and record on flipchart.
- Then, ask them to share the mental health consequences for Sylvia.

- **Emphasize:** (Some examples of consequences)

Physical	Emotional/Mental
Unintended pregnancies	Hopelessness
Attempted self-abortions	Sadness
Miscarriage	Low self-esteem
Isolation	Stress
Physical Injuries/short- and long-term	Depression
Gynecological disorders	Anxiety
Chronic pain (headaches, chest, abdomen, pelvic, back)	Post-traumatic stress disorder (PTSD)
Insomnia	Guilt
Drug/alcohol abuse	Distrust in people
HIV infection	Fear of people
Faster on-set of AIDS	
Self-harm/suicide	
Death	

- **Summarize:** Violence is both a cause and consequence of HIV

Violence is a direct cause of HIV (leads to higher risk of HIV)

- Violence increases HIV transmission risk (injury)
- Violence, including threats and extortion, limit one's ability to negotiate safe sex
- Violence impedes one's access to HIV testing and treatment
  Ask: How? (May not have freedom/permission to get tested)
- Violence is associated with decreased compliance with treatment
  Ask: What happens when a person living with HIV is non-compliant with treatment? (increased viral load/increase risk of infecting others)

Violence is a consequence of HIV (occurs as a result of HIV status)

- Positive HIV status increases risk of violence
- Disclosure of status to partner and/or family
- Accusations of infidelity by partner

Session 2.4: Panel Discussion with Key Populations

Time: 30 minutes

Learning Objectives:

At the end of the session, participants will be able to:
- Understand violence from KPs' perspectives

Preparation/Materials:

- Table at the front where two or three KPs can sit
- PPT slide with questions for each KP member to discuss

**This session should be organized prior to the training. KPs should be identified by training organizers and could include a female sex worker, gay man or MSM, and a transgender person. KPs will be asked to participate in a panel discussion. Panel members should receive the questions ahead of time so they can think about what they would like to share during the training.*

INTRODUCTION:

- **Explain:** One of the most important ways we can develop our understanding about violence against KPs is to hear from members of KP communities.
- In this session, KP members have agreed to share their experiences with us.
- We will ask each person to answer a set of questions to help us understand more about KP communities from their perspective.
- Then, at the end, we'll have some time for participants to ask questions.

STEP 1: Panel Discussion with KPs

- Ask panel members to sit at a table at the front of the room or if they are more comfortable sitting at their own table, that is fine, as well.
- **Explain:** We are fortunate to have some key population members here today who are willing to share their experiences with us.
- **Explain to panel members:** We are eager to listen to whatever you'd like to share with us, and although we have a few specific topics we'd like to hear your thoughts on, please feel free to share whatever you'd like with the group.
- In addition, if you are not comfortable sharing something with the group, that is okay, and we respect your privacy.
- Just a reminder to the group, everything we hear in the training is confidential and we should not share what we hear with others outside of the training.

- **Post PPT slide** with questions and ask each panel to share whatever they feel comfortable sharing.

Slide:

- **If a panel member needs some help or prompts, ask:**
  - How has stigma, discrimination, and violence affected your life and the lives of your peers? What has been hard for you?
  - Have you had any positive experiences within the larger community or within your peer community that has had a positive impact on you?
  - What are some ways that the community can support you?
  - What do you think is important for this group to know about you?

- After panel members have finished sharing their experiences, ask participants if they have any questions for the panelists.
- **Emphasize** that questions that ask people about genitals or details about a sexual assault (e.g. do you have a penis? How did he rape you?) are inappropriate and should not be asked.

Session 2.5: Human Rights Protections and Laws that are incorrectly used against KPs

Time: 60 minutes

Learning Objectives:

At the end of the session, participants will be able to:
- Understand violence against KPs from a human rights perspective.
- Understand how local laws negatively affect KPs
- Understand strategies that KPs can use to counter the misapplication of these laws

Preparation/Materials: Presenters' PPT slides and handouts

Part A

**This 30-minute presentation should be organized prior to the training. It should be facilitated by a human rights lawyer or staff person from the Human Rights Commission who is familiar with the human rights protections included in national-level policy documents that pertain to all people, including KPs.*

INTRODUCTION:

- **Explain:** In this session, we will cover the human rights protections highlighted in [country's] constitution and other national-level policy documents.

General Points to Emphasize: (from REAact)

A. What are human rights?
- Human rights are basic universal entitlements that all people have because they are human.
- They are based on the idea that every person is equal and entitled to be treated with dignity and respect, regardless of their race, sex, gender, age, disability or any other characteristic.
- Human rights apply to all people throughout the world at all times.
- Human rights give people the freedom to choose how they live, how they express themselves, and what kind of government they want to support, among many other things.
- They also guarantee people their basic needs, such as food, housing and education. By guaranteeing life, liberty and security, human rights protect people against abuse by those who are more powerful.
- State institutions and representatives, including government officials, policemen and women, army personnel, prison officers, civil servants, the judiciary, political authorities, and medical or education personnel in state-run facilities, have the obligation to fulfil the rights of all their citizens without discrimination.
- In order to do so, states have the responsibility to:
  - respect the human rights of all people, and to prevent, investigate and sanction violations committed by their officers
  - protect the human rights of all citizens by taking all necessary measures to avoid the deprivation of their rights
  - promote the respect of the human rights of all citizens without distinction.

B. What are human rights violations?

- Generally, a human rights violation can only be committed by a state.
- This includes state institutions and representatives, such as government officials, policemen and women, army personnel, prison officers, civil servants, the judiciary, political authorities, and medical or education personnel in state-run facilities.
- Human rights violations can occur through:
  - **Failing to respect human rights:** This is an act committed directly by the state that is contrary to its human rights obligations (e.g. arbitrarily depriving someone of their freedom or torturing them).
  - **Failing to protect human rights:** This is an indirect violation committed by the state by omission (i.e. by not providing protection against systematic abuse committed by one group against another, or by not promoting the rights of all citizens). Omission is negligence in performing the requirements of national or international law relating to the protection of human rights. In the case of omission:
    - The actual hurt can be committed by common citizens.
    - The state has a responsibility to act to stop these incidents and provide protection to the victims.
    - If the authorities don't do so, they are violating the rights of the victims by their omission.
  - **Failing to promote human rights:** It is the state's duty to ensure that laws that protect everyone without discrimination are enforced.
    - The state must also promote these rights to ensure that all its citizens are aware of them and how they can claim them effectively.
    - The state and its representatives must ensure that the mechanisms for denunciation and redress are in place for all citizens to access.
    - Failure to do all these (e.g. by failing to undertake campaigns against social discrimination against a particular ethnic group or sexual minority) constitutes a violation of the state's responsibility to promote the human rights of all its citizens.

Part B

**This 30-minute session should be organized prior to the training. It should be facilitated by an allied lawyer who has experience working with KPs in [country] and is knowledgeable about how police implement local laws that target or have a negative impact on KPs. This presenter should also present strategies that KPs can use to counter the misapplication of these laws.*

INTRODUCTION:

- **Explain:** In this session, our presenter will help us understand more about local laws that negatively affect KPs, the misapplication of these laws by police, and strategies KPs can use to protect themselves and counter the misapplication of these laws.

Session 2.6: Understanding our Own Values and Beliefs

Time: 30 minutes

Learning Objectives:

At the end of the session, participants will be able to:

- To identify and examine the role of external influences, such as family and social norms, religious beliefs, and life experiences on the formation of personal values about KPs and violence.
- To explain ways personal values can change over time, in response to new knowledge and experiences.
- To identify any conflicts between the social norms with which one is raised and their current values.

Preparation/Materials: Handout #7: Where do we stand?

INTRODUCTION:

- **Explain:** We all bring our personal values and beliefs to our work, and these personal values and beliefs influence how we work with our clients.
- As direct service providers, it's important to think about how our personal values and beliefs affect our work.
- The first part of this next exercise is to first silently reflect on our own beliefs.
- We'll then have a discussion as a group about the things that affect our personal values, and people can share their own experiences and beliefs if they want, but it is not necessary.
- The main and most important point of this exercise is for each of us to reflect on your own beliefs and values, whether we end up sharing them with each other or not.

STEP 1: Individual/Silent Exercise: Introduction

- **Post PPT slide** and ask participants to refer to Annex #7,

Slide:

Handout #7: Where do we stand?

- Individual/silent exercise
- Answer the questions and record your thoughts
- This worksheet is for you.
- We will not collect it.
- 10/15 minutes to complete exercise.

- **Explain:** In about 10 or 15 minutes, we will have a large group discussion, but you do not have to share anything personal that you don't feel comfortable sharing.

Questions on Handout #7:

- Did the family who raised you discuss specific beliefs about KPs, including sex workers, MSM, trans people, or people who inject drugs? Describe.
- Did you experience any personal or family events that changed your beliefs or values about KPs? Describe.
- Are there any differences or similarities between your family's values and your personal values and beliefs related to KPs? Describe.
- Which social group has had the greatest influence on your current values related to KPs? Racial/Ethnic group? Family who raised you? Friends? Religious leaders? Activist community?
- How similar or different are your current spiritual or religious beliefs compared to those of your family?
- How do your religious or spiritual beliefs influence your decisions?
- Have you faced a situation where your personal beliefs and values conflict with the values and beliefs of your religion? If yes, how do you resolve these internal conflicts?

- Facilitate a group discussion.
- Remind participants that they do not have to share personal experiences from their silent reflection if they don't want to.
- Tell participants that it's important that we be respectful if someone decides to share a personal belief or value –even if there are differences among us –and that the point of this exercise is not to change others' personal beliefs or values
- **Post PPT slide** and ask the following questions (do not record on flipchart):

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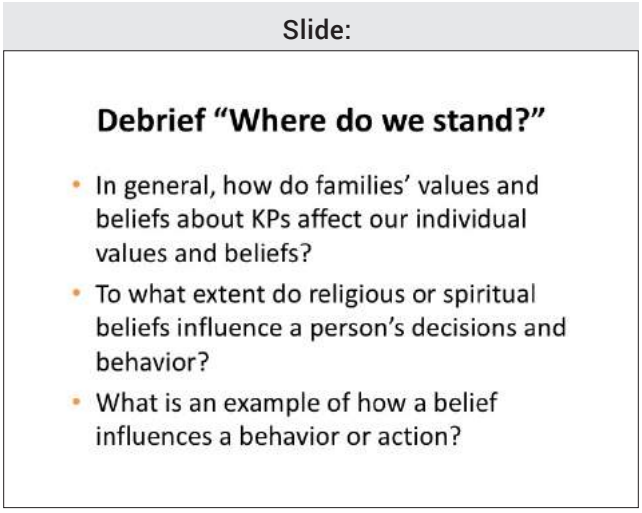

- Provide an example: A person believes sex workers are immoral and don't deserve the same rights as others; when this person engages a sex worker for services and she refuses to have sex without a condom, he forces her to have sex.)
  - **Ask:** What are some of the beliefs he holds that drive his behavior? (His behavior to force her to have sex is influenced by his belief that she is obligated to have sex with him and she doesn't have the right to say, "No.")
  - **Another example:** Let's say I was raised to believe that women should dress in a way that does not show bare legs. My neighbor wears dresses that come above her knees. When she is raped by a co-worker and comes to me for support, I tell her that if she dressed more appropriately, he would not have raped her.
  - This is an example of how my personal beliefs and values affect my behavior –in this case –my behavior is what I said to her and what I did to her –which was blame her.

- **Summarize Activity:** The purpose of this activity was to get us all thinking about our personal values and beliefs and to recognize that these values influence the way we work with KPs.
- We all have personal values and it's important to recognize that our personal values do not need to match those of others, including those of the people we are trying to help.
- Our family, friends, religious and spiritual beliefs can impact our personal values and beliefs.
- With age comes increased knowledge and experiences that shape our beliefs and values.
- Sometimes, our beliefs change over time as we get older.
- Our beliefs guide our behaviors and how we treat others.
- There is a popular saying, "Check your values at the door."
- **Ask:** What does this saying mean?
- **Explain:** It means that as direct service providers, we need to set aside any personal values and beliefs that may interfere with our ability to be supportive of the people we are trying to help.
- **Example:** If I'm a provider and you're a client who tells me that you were raped, and I believe that you are not dressed properly, does this mean that you deserve to be treated differently by me because I think you should dress a certain way? Do I have the right to make judgments about you as a person and the decisions you make?
- We need to always be thoughtful about how our personal values and beliefs may be affecting or influencing our work, and if we think they are interfering with our ability to be completely supportive or may be causing further harm or pain to the person we are trying to help, we need to stop working with that person and seek support from our supervisor or other supportive colleague.

MODULE 3

VPR PROTOCOL FOR HEALTH CARE WORKERS AND OTHER DIRECT SERVICE PROVIDERS

Time: 2 hours and 45 minutes

Introduction:

This module is designed for participants who have completed module 2 (Building Core Knowledge). It introduces a set of VPR program principles, program components (supportive structures), and a minimum package of VPR services. This module lays the foundation for Module Four, which focuses on building providers' skills for implementing the minimum package of VPR services.

This module includes the following sessions:

Session 3.1 VPR Program Principles for HCWs/Direct Service Providers
Session 3.2 VPR Program Components for HCWs/Direct Service Providers
Session 3.3 Minimum Package of VPR Services

Session 3.1: VPR Program Principles for HCWs/Direct Service Providers

Time: 60 minutes

Learning Objectives:

At the end of the session, participants will be able to:
- Describe the five VPR principles for health care workers and direct service providers
- Describe the difference between consent and informed consent

Preparation/Materials:

- PPT slides
- Handout #8: Overview of VPR Programming for HCWs/Direct Service Providers
- Handout #9: VPR Program Principles (detailed descriptions)
- Handout #10: Case Study (Grace)

INTRODUCTION:

- **Explain:** During this module, we will introduce the VPR program principles and program components, as well as the minimum package of VPR services for health care workers (HCWs) and other direct service providers.
- **Post PPT slide and explain:** Refer to Handout #8 for an overview of the VPR programming that we will talk about in detail in this module.
- You can use this handout as a reference tool for later use, and since we are going to cover all of the information on this handout during this training module, we will not review it now.

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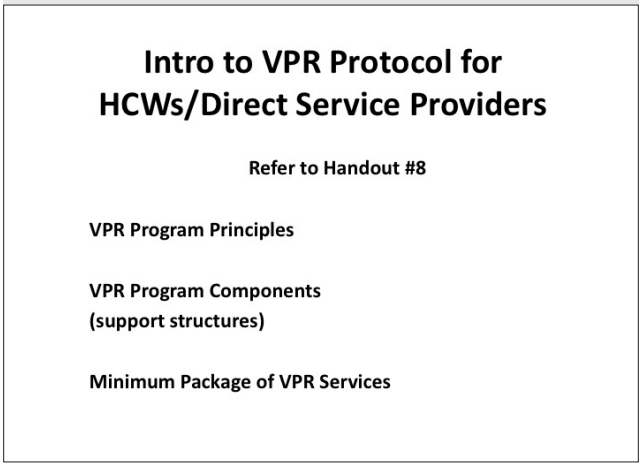

STEP 1: Large Group Discussion: VPR Program Principles for HCWs/Direct Service Providers

- **Post PPT slide and explain:** When designing and implementing new programs, we often talk about the principles that inform our program.
- **Ask:** What do we mean by "program principles?" (Allow participants to brainstorm and then click slide again to post definition of program principles. Review content of slide.)

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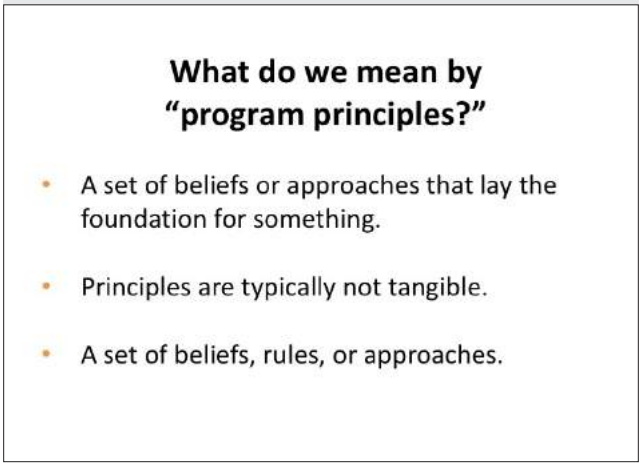

STEP 2: Large Group Discussion: Overview of VPR Program Principles for HCWs/Direct Service Providers

- **Post PPT slide and explain:** These five VPR program principles lay the foundation for all VPR programming with KPs by health care and other direct service providers.

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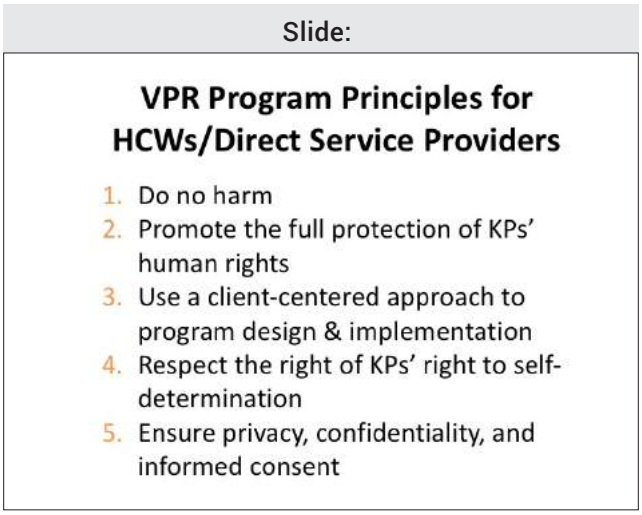

- **Emphasize:** These principles draw from global standards, guidance, and recommendations from WHO, PEPFAR, USAID, UNFPA, UNAIDS, UN Women, and IPPF (International Planned Parenthood Federation).
- These five principles inform the rest of VPR programming for KPs in health care and other direct service settings.
- They promote the protection of KPs and to ensure their right to self-determination.
- **Refer participants to Handout #9:** VPR Program Principles for HCWs/Direct Service Providers.
- **Explain:** This handout includes a description for each of these principles.
- You don't have to read through it now.

- We're going to talk about a few key points related to these five principles and then we'll do a small group exercise to help us think through how we these principles can be applied (or not applied) in practice –using a case study.
- You can use this handout as a reference tool for later.

STEP 3: Large Group Discussion: Principle #2: Promote the full protection of KPs' human rights

- **Post PPT slide and explain:** One way we can ensure the protection of KPs' human rights is to promote meaningful engagement of KPs who have experienced violence.
- This means it's important to involve KPs in all aspects of the VPR programming.
- **Ask:** What are some ways we can involve KPs in the work we do? (Allow participants to brainstorm ideas.)

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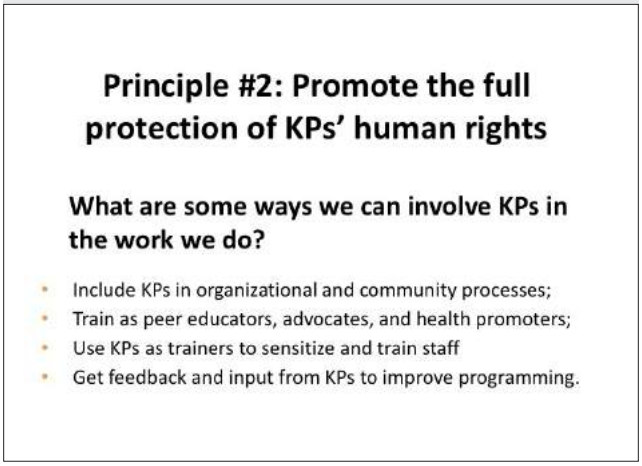

- **Emphasize:** KPs should be involved in program planning, implementation, and evaluation – including direct services, community mobilization, and system-level advocacy.
- Hearing from KPs about the barriers for them accessing services and adhering to treatment can help us develop strategies for better access to and uptake of services, including important time-sensitive health services –such as PEP and emergency contraception.
- We can learn from KPs about how stigma and discrimination is affecting them so we can develop system-level and program-level strategies to address these issues.

STEP 4: Large Group Exercise: Principle #5: Ensure privacy, confidentiality, informed consent

- **Explain:** All of these principles are equally important, but maintaining confidentiality is one that comes up often for direct service providers, so we want to spend a few minutes on this up front.
- Give your handbag, wallet, or cell phone to the person sitting to your left.
- It's okay --your item will be okay!
- Once everyone is holding their neighbor's person item:
- Hold your neighbor's person item in your lap.
- **Ask:** How does it feel to have your personal item in the control of someone else? (Possible observation: "Some of you seem more interested in what the person next to you is doing with your personal item than the item you have in your own lap."
- **Ask:** How would you feel if I asked your neighbor to open (or look inside) your bag or start looking into your phone? (Possible observation: For most participants, this would make them feel uncomfortable.)

- **Ask participants to return the items to their neighbor.**
- **Possible Observation:** "I noticed that while bags were with someone else, people were very alert, sitting up very straight, and their attention was on their bag more than anything else. After their bags were returned to them, there were many smiles, people relaxed more and their level of alertness dropped."
- **Ask:** So, what does this have to do with confidentiality? (rhetorical)
- Things that are personal to us, even when they are very ordinary, generate very strong feelings, and we are very careful about who can see them, who can 'hold' them, and we have strong feelings when they seem to be out of our control.
- For people who have experienced violence and abuse, especially for KPs, personal things can also be humiliating, demeaning and upsetting.
- So, the feelings about who knows and what they do with that information, are even more intense.
- We keep information confidential in order to keep clients safe and to ensure that clients have control over what happens to their information, who has it, and where it goes.

STEP 5: Large Group Exercise: Ensure privacy, confidentiality, informed consent (continued)

- **Explain:** Earlier, we talked about keeping things we hear in this training confidential.
- **Post PPT slide and ask:** What does that really mean --to keep something confidential? (Allow participants to brainstorm and then click the slide again to post definition.)

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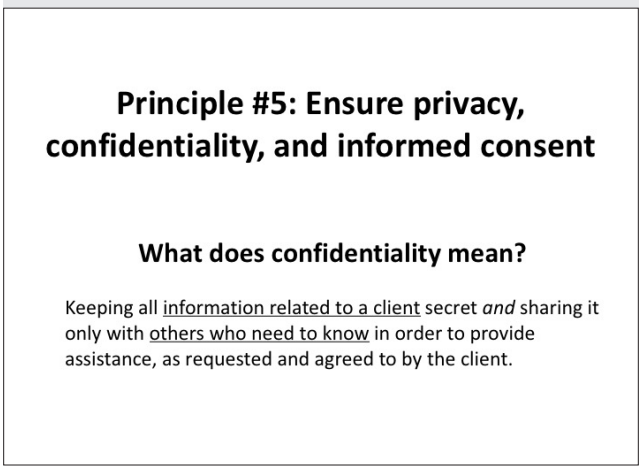

- **Ask:** What do we mean by "information related to a client?" (Allow participants for brainstorm.)
- **Emphasize:** Information related to the client includes name, date of birth, age, address, family information, the name of the perpetrator, location of the incident and any other information that might identify the client, the family of the client, the perpetrator and the family of the perpetrator.
- It means any identifying information.
- **Ask:** When we say... sharing the client's information only with others who need to know in order to provide assistance, as requested and agreed to by the client...What do we mean by "others who need to know"? (Allow participants to brainstorm.)
- **Emphasize:** Those who might "need to know" about the incident, the client and/or the perpetrator include the program manager and any other actors who might assist the client, such as a police officer, a legal adviser, a doctor, a health worker, etc.
- The level depends on the service they are able to provide and whether the client has given consent for you to share information.

- Even within our own organization or clinic, it is not okay to share client information with other staff and providers, unless they are directly involved in the client's care and the client knows and gives consent for this information to be shared.
- Outside agencies, including police, health clinic, etc. who "need to know" (in your mind)still need consent of client before you share information with them, or ask information of them.

STEP 6: Small Group Exercise: Ensure privacy, confidentiality, informed consent (continued)

- **Post PPT slide** and ask participants to break into pairs and discus the kinds of things that can happen if confidentiality is broken.

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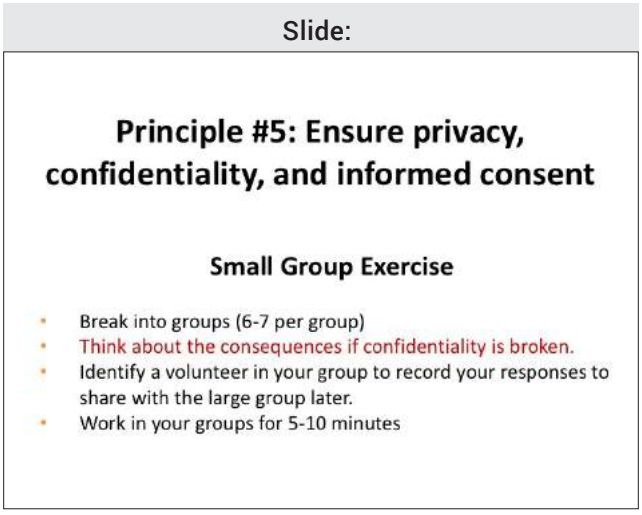

- Facilitate large group discussion about the consequences of breaking confidentiality.
- **Emphasize:**
  - It could bring serious consequences for the client, including: being killed or physically hurt, particularly if adequate protection is not in place.
  - A client may end up feeling re-traumatized or being socially stigmatized.
  - It may discourage other clients from coming forward.
  - It can also ruin the reputation of the staff that broke confidentiality, as others will think they are unethical.

STEP 7: Large Group Exercise: Ensure privacy, confidentiality, informed consent (continued)

- Tell participants that you will present a few short scenarios and you would like them to reflect on the specific situation and share what they think.
- **Ask:** Without a signed consent from the client, will confidentiality be breached if you share information with...
  - a journalist wants to speak with a client so the client can explain their side of the story since the journalist has already spoken with the perpetrator? (Answer=yes)
  - your supervisor in order to get additional help? (Answer=yes)
  - a government representative/donor who insists on seeing case files? (Answer=yes)
  - a police offer who arrives at the clinic and says they are trying to find the woman who reported an assault last night so they can arrest the perpetrator? (Answer=yes)
  - a doctor who calls to find out the correct spelling of a patient who came into his clinic this morning --and the doctor thinks the client may also be a client of your clinic. (Answer=yes))
  - a journalist who wants statistics about the violence incidents in the region? (Answer=no)

STEP 8: Large Group Exercise: Ensure privacy, confidentiality, informed consent (continued)

- **Post PPT slide** and ask: What does it mean to give consent? (Allow participants to share words and phrases to describe consent and then click slide again to post answer.)

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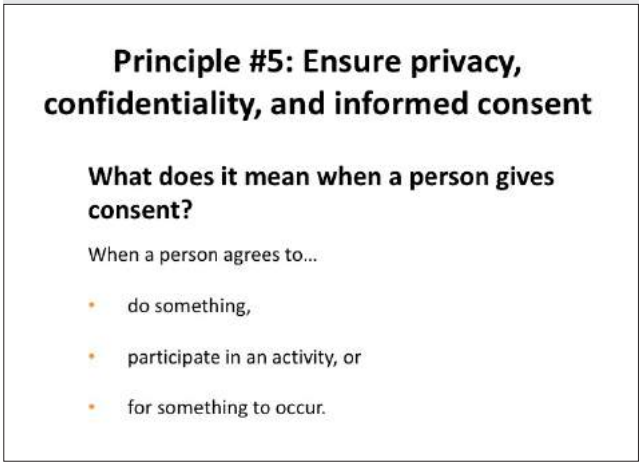

- **Post PPT slide** and explain:

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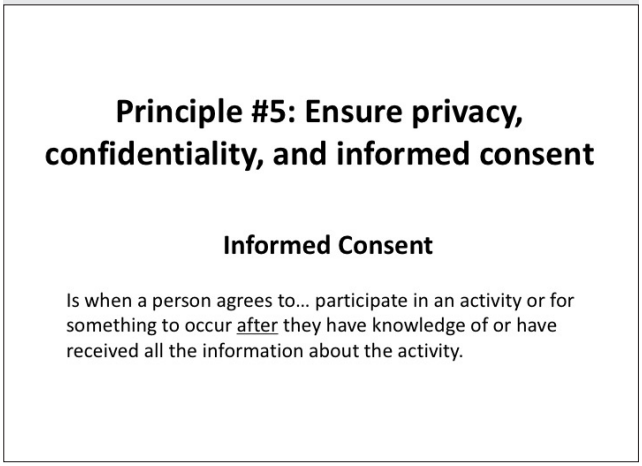

- **Emphasize:** In order to give *informed* consent, a person must:
  - Have all the information
  - Be over the legal age required to give consent.
  - Be mentally sound enough to understand the agreement and the consequences.
  - Have equal power in the relationship.
- **Explain:** Here is an example of the difference between consent and informed consent.
  - If the doctor says 'we're going to give you this pill to make you better' and you say 'OK' --that's consent.
  - If the doctor says 'we're going to give you this pill to make you better, but it might cause you to feel sick and get stomach cramps, and you say 'OK' --that's informed consent.
- **Explain:** There is no consent when agreement is obtained through:
  - the use of threats, force or other forms of coercion, abduction, fraud, manipulation, deception, or misrepresentation;
  - the use of a threat to withhold a benefit to which the person is already entitled to
  - a promise is made to the person to provide a benefit.

- **Explain:** Let's go through an example of how power imbalances impact one's ability to give consent and informed consent:
  - A female sex worker has a rule that she always uses condoms. One of her clients, who is a police officer, tells her that if she doesn't agree to have sex with him without a condom, he will arrest her. She agrees to have sex with him. Is this consent? Why or why not?
- **Emphasize:**
  - Consent cannot be given if there is coercion involved.
  - **Ask:** What does coercion mean?
  - Coercion means persuading an unwilling person to do something by force, threats, or trickery.
  - In the example just discussed, the officer coerced her to have sex with him.
  - He also threatened to arrest her if she did not comply.
  - Any coerced sex is abuse.
  - One reason we talk about this in this training is to get us thinking about power imbalances and how these power imbalances affect one's ability to give consent.
- **Summarize:**
  - As direct service providers, we need to get informed consent from clients to talk to or share relevant information about the client with other service providers.
  - We do this sometimes to coordinate care.
  - We need to make sure that we provide detailed information to the client about what information will be shared, with whom it will be shared, and obtain written authorization from the clients to share this information.
  - We call this getting "informed consent" from the clients.

STEP 9: Small Group Exercise: Five VPR Program Principles (Case Study: Grace)

- **Post PPT slide and explain:** Refer to Handout #10: Case Study: Grace.
- Ask a volunteer to read it out loud.

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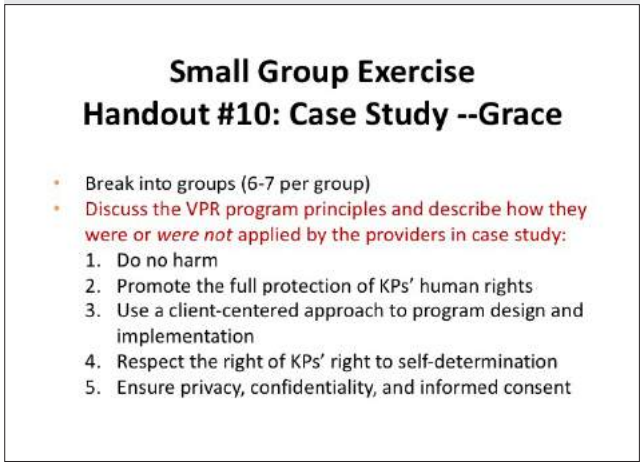

- **Explain:** Work together in your group for about 15 minutes to discuss the five principles and how they were or were not applied in the case study.
- You can refer to Handout #9 for reminders about each of the five principles, if needed.
- Debrief the exercise and allow participants to share their outputs

Police Officer:

- Used threats and coercion to force her to have sex, violating her right to be free from cruel and inhumane treatment and from violence (coerced/forced sex)
- Performed body search without cause, violating her right to privacy and security.
- Used the fact that she had condoms on her to threaten to arrest her for sex work.
- Punched her in the face, violating her right to live free from violence.
- Used his power and authority over her.

Receptionist:

- Discriminated against her by making her wait for other clients to be seen by the doctor.
- Disrespected her right to respect and dignity –disrespected her by not accepting her wish to speak with the doctor about the purpose of her visit and by rolling her eyes.
- Asked her about her bruised eye in front of others.

Nurse:

- Blamed her for the violence. Shamed her for her lifestyle.
- Called the other office to the clinic without her permission.
- Coerced into providing details about the incident to the police officer (did not use a client-centered approach)

Session 3.2: VPR Program Components (Supportive Structures)

Time: 90 minutes

Learning Objectives:

At the end of the session, participants will be able to:

- Describe the VPR program components that must be in place before rolling out violence screening and response services

Preparation/Materials:

- PPT slides
- Handout #11: Sample Printed Referral Network
- Handout #12 : VPR messages

INTRODUCTION:

- **Explain:** So, we have our five fundamental principles that set the foundation and guide our VPR services.
- We also have what we call "VPR program components for HCWs and direct service providers" that need to be in place in order to begin providing violence screening and response services.

STEP 1: Large Group Discussion: Introduction to the Six program components

- **Post PPT slide and explain:** Let's talk about each one of these briefly.

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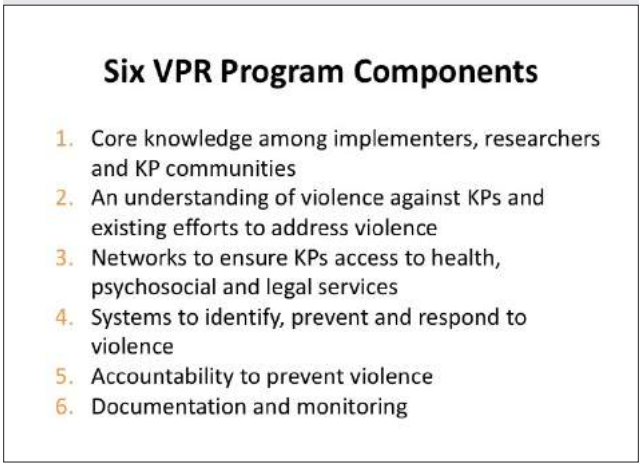

- The first program component is to build core knowledge among implementers and KPs
- **Ask:** Why is it important to give train staff to give core knowledge?
- **Explain:** Like many members of the community, direct service providers often have deeply-rooted beliefs about gender, violence, and the rights of KPs.
- Sometimes, as providers, we have a limited understanding of issues faced by KPs, the dynamics of violence, the relationship between violence and HIV, and the barriers that interfere with KPs' access to HIV testing, care, and treatment.

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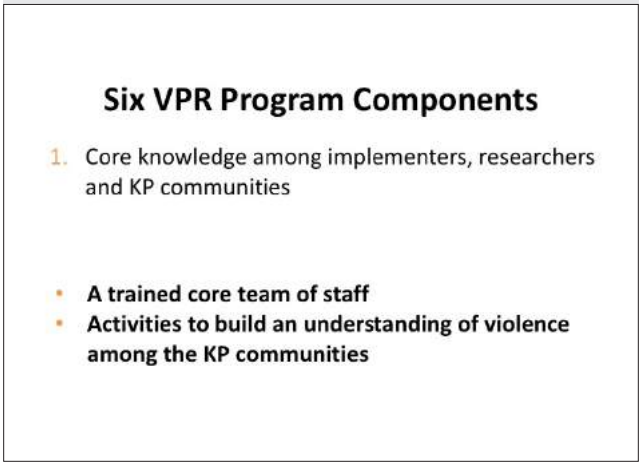
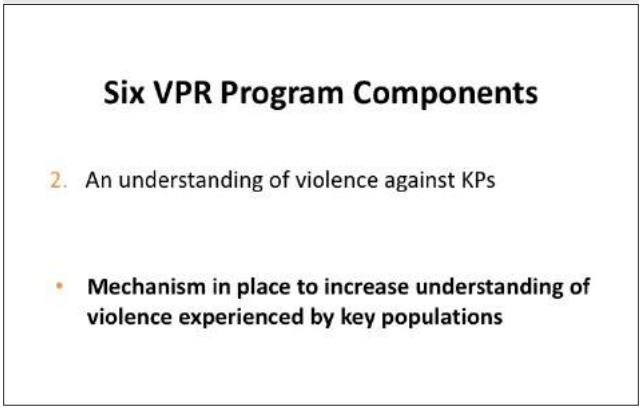


- In the national programme, we prioritize the training of staff and service providers so they can understand the key issues faced by KPs, and to ensure our attitudes, beliefs, knowledge, and practices are in line with a human rights approach and are supportive of the needs of KPs.
- We also want to ensure that providers have the necessary skills to screen for and respond to violence.
- **Emphasize:** The need for a trained core team of staff at national, county and implementation level. Several national training curriculum exists in Kenya to train the core team of staff SOPs need to be maintained because procedures change.

STEP 2: **Present Second Program Component:** To develop an understanding of Violence against KPs and existing efforts to address violence

- **Post PPT slide and explain:** The second program component is to develop an understanding of Violence against KPs and existing efforts to address violence

Slide:



- **Emphasize:** Mechanisms in place (e.g., assessment, focus groups, stakeholder interviews, micro planning, mapping, training) to increase understanding of violence experienced by key populations, including types of violence; common perpetrators, key hotspots, needs of key populations when they experience violence, and barriers to accessing violence response services. It is also important to understand the coping mechanisms that key populations adopt in response to violence and safety tips that they adopt to prevent violence

STEP 3: Present third program component: Utilize a referral network

- **Post PPT slide and explain:** The third program component to utilize a referral network

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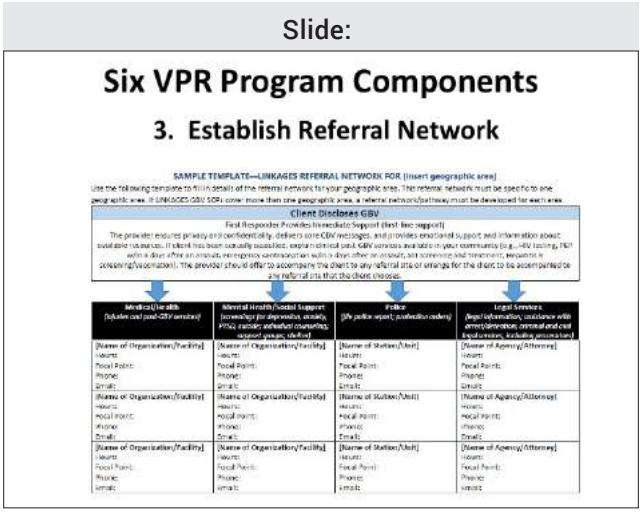
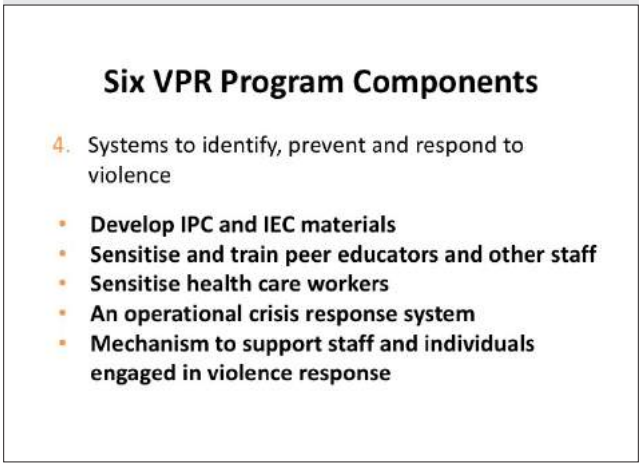


- **Ask:** Is there a formal (printed) referral pathway for KPs in your community?
- Sometimes referral networks are more informal.
- It's important to identify who/what organizations need to be involved in the continuum of care...
- Many referral networks include heath care services, mental health services, legal services, police/law enforcement, social services, advocacy groups (e.g. human rights commission; association for sex workers)
- It's important that all referral sites are friendly to KPs.
- **Refer to Handout #12:** This is a sample of what a printed referral network could look like.
- It's important for your organization/facility be familiar with any existing referral networks for KPs and utilize them during the course of your work with KPs.

STEP 4: Systems to Identify and Respond to Violence

Slide:



- Explain that the fourth step is to build systems to identify and respond to violence. This includes various sub steps:
  - Develop SOPs for how to identify and respond to violence among KPs
  - Develop and disseminate Information, education, and communication (IEC) and interpersonal

communication (IPC) materials. These materials should target key populations and other stakeholders (e.g., HCWs) and include information on what violence is; violence as a human rights violation that affects many people; and available violence response resources. NASCOP has developed prototype of these IPC materials
  - Sensitize and train peer educators and outreach workers raise awareness about violence; detect violence among community members; provide first-line support to victims of violence; and accompany victims of violence to seek additional services.
  - Sensitize and train health care providers identify/ screen violence among clients and provide first-line support and clinical services to victims of violence.
  - Develop mechanisms to support/supervise individuals engaged in violence prevention and response and promote self-care and personal safety (e.g., peer education supervision, support groups for providers).
  - Implement a crisis response system (e.g., hotline, WhatsApp group), including an identified and trained crisis management team that is responsible for handling incoming calls/texts and the resources to support implementation of the crisis response system.

- **Emphasize:** Incorporating a set of core messages throughout all VPR programming ensures that clients understand that they:
  1. have a basic human right to live a life free from violence;
  2. are not to blame for any violence or abuse committed against them;
  3. are not alone; and
  4. can access available resources. NASCOP has developed IPC materials with these core VPR messages.

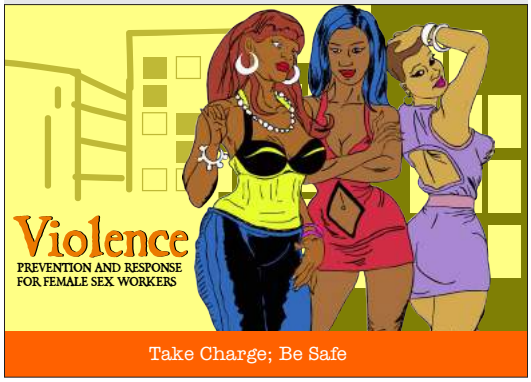
- **Refer participants to Handout #12 and explain:** There are seven core VPR messages that should be delivered to all KPs during the delivery of services.
- This set of core messages is not meant to be an all-inclusive set of messages about violence; rather it is set of messages that guides our work.
- Read the messages out loud and the rationale for each one.

CORE VPR MESSAGES	CRITERIA: WHY IS THIS MESSAGE IMPORTANT?
"Everyone has the right to a life free from threats, humiliation, and violence. These are basic human rights."	The national programme uses a human rights framework to view violence because everyone has a basic human right to live free from threats, humiliation, and violence and abuse.
"When we talk about violence, we include physical, emotional, sexual, and economic abuse, extortion, and exploitation committed by any person."	The national programme has a comprehensive view of violence because all of these types of violence are linked to negative health consequences for KPs, including HIV.
"Violence has negative health consequences, and can increase the risk of HIV infection and individuals' ability to seek and receive important HIV care and treatment."	The national programme wants to increase clients' awareness of the harmful effects of violence on health, especially the effects related to HIV.

CORE VPR MESSAGES	CRITERIA: WHY IS THIS MESSAGE IMPORTANT?
"Many people experience violence. You are not alone."	Clients who experience violence often become isolated and experience extreme forms of stigma and discrimination by community and family members. The national programme wants to decrease isolation and stigma among clients.
"People are often blamed for the violence and abuse committed against this, but it is never their fault."	Clients who experience violence are often blamed for it. The national programme wants to increase clients' understanding that they are never to blame for violence and to decrease stigma surrounding violence.
If client is 18+ years old: *"What someone shares about their experiences with violence is confidential. We want clients to feel comfortable and to trust that they can talk to us about any abuse they may be experiencing or experienced in the past. We will respect their privacy and keep what they tell us confidential."*	The national programme wants to protect clients' privacy and safety, and reassure clients that their information will be kept confidential. This will encourage clients to share their experiences with violence with a direct service provider.
"We are here to support clients and let them know about available resources."	The national programme wants to let clients know it's okay to talk about their experiences with violence. If there are community resources available, we want to increase clients' knowledge of those resources.

- **Ask:** What are some ways we can get these messages out?
- **Emphasize:** Core VPR Messages should be delivered and reinforced through:
  - IEC/IPC materials (posters, pamphlets, provider badges) posted at facilities and disseminated to clients during in-person contacts.
  - Direct service providers during violence screening and first-line support.
  - Health care workers (nurse, clinical officers and community health workers) during the provision of clinical post-GBV services.
  - Counselors Peer educators during outreach activities.

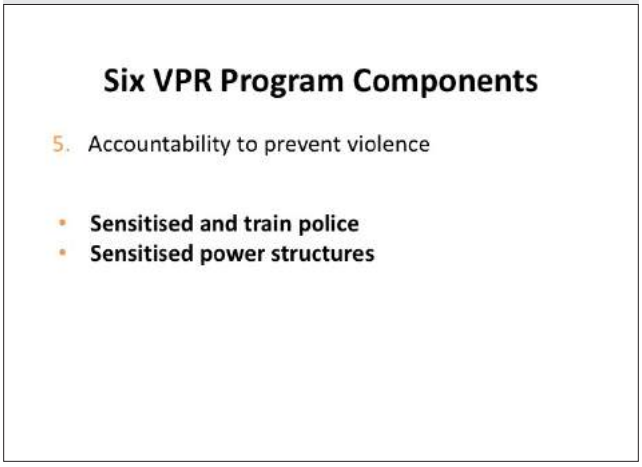
Slide:



STEP 5: Present Fifth Program Component: Accountability to prevent violence

- **Post PPT slide and explain:** As with any programming, it is important to establish an accountability mechanism works towards preventing violence.

Slide:

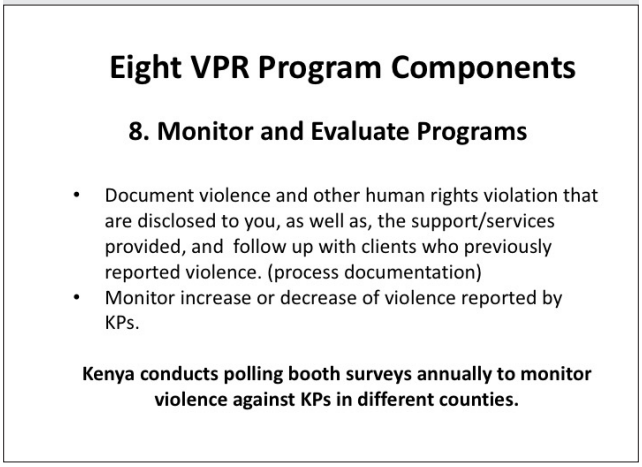


- Sensitized and trained police and other uniformed officers (if possible) commit to serving KPs who experience violence and to not perpetrating violence against KPs.
- Sensitized power structures (e.g., religious leaders, tribal leaders, bar and lodge owners, pimps) commit to connecting victims of violence to available services and condemning violence against KPs.

STEP 6: Present Eighth Program Component: Monitor and evaluate programs

- **Post PPT slide and explain:** As with any programming, it is important to establish a monitoring and evaluation (M&E) framework and plan to track the prevalence of violence. (Review content of slide.)

Slide:



Session 3.3: Overview of Minimum Package of VPR Services for KPs

Time: 15 minutes

Learning Objectives:

At the end of the session, participants will be able to:
- Describe the minimum package of VPR services for KPs

Preparation/Materials: PPT slides

INTRODUCTION:

- **Explain:** There are six services included in the minimum package of VPR services for KPs.
- **Post PPT slide** and review the minimum package of VPR Services.

Slide:

Minimum Package of VPR Services

Service #1: Screen KPs for Violence

Service #2: Provide First-Line Support

Service #3: Provide/Refer to Clinical Post-Violence Services

Service #4: Provide/Refer to Psychosocial and MH Services

Service #5: Provide Legal Information/Refer to Legal Services

Service #6: Follow-up with Clients who disclosed violence

- **Explain:** In Module 4 (next module), we will begin to build our skills in screening KPs for violence, providing first-line support to KPs who disclose violence, and linking KPs to important services.
- We will begin with talking about barriers for KPs in disclosing violence and how we communicate with clients.

4

MODULE

IDENTIFYING AND RESPONDING TO VIOLENCE: BUILDING OUR SKILLS

Time: 9 hours

Introduction:

This module aims to increase participants' knowledge of the barriers that interfere with KPs ability to disclose violence, the role of direct service providers in identifying and responding to violence, and the various ways we communicate with clients. This module focuses on the implementation of the minimum package of VPR services, including helping direct service providers build their skills in screening for violence and providing compassionate and first-line support. This training module also provides an overview of the clinical post-violence services included in the minimum package; how to link clients with community-based services, including psychosocial support/mental health and legal services; and providing clinical follow-up services.

This module includes the following sessions:

Session 4.1 Barriers for KPs in Disclosing Violence
Session 4.2 Role of Direct Service Providers in Screening for and Responding to Violence
Session 4.3 How we Communicate with Clients
Session 4.4 Minimum Package of VPR Services (in practice/building skills)
- 4.4.1 Service #1: Identify Violence (via screening) among KPs
- 4.4.2 Service #2: Provide First-Line Support
- 4.4.3 Service #3: Provide/Refer to Clinical Post-Violence Services
- 4.4.4 Service #4: Provide/Refer to Psychosocial Support/Mental Health Services
- 4.4.5 Service #5: Provide Legal Information/Refer to Legal, Safety, & Security Services
- 4.4.6 Service #6: Follow-up with KPs who disclosed Violence

Session 4.1: Barriers for KPs in Disclosing Violence

Time: 60 minutes

Learning Objectives:

At the end of the session, participants will be able to:
- Describe the barriers for clients in disclosing GBV

Preparation/Materials: Exercise cards: Standing in her Shoes

INTRODUCTION:

- **Explain:** As direct service providers, it's important for us to think about the barriers that prevent KPs from disclosing violence.
- If we understand the reasons KPs may not disclose, we can try to eliminate those barriers –so clients feel comfortable enough to share their experiences and get the help they need.

STEP 1: Large Group Exercise: How easy is it?

- **Facilitator Note:** This activity should highlight how we all find it difficult to talk about the sensitive subjects of sex, gender identity, sexual orientation, and violence and abuse, especially sexual violence.
- Place a piece of paper on one side of the room with word "easy," and on other side of the room, the word "hard"
- Ask participants to stand in the center of the room.
- **Explain:** Imagine that there is a virtual line on the floor/ground from easy to hard.

Easy ⟷ **Hard**

- **Explain:** For this exercise, I am going to ask a series of questions.
- As you feel comfortable, when I ask a question, stand on the line at a location you feel best reflects your answer.
  - How easy or hard is it for people in your community to talk about sexual concerns, such as sexually transmitted diseases/infections?
  - How easy or hard is it for teens to talk to their parents about sex?
  - How easy or hard is it for people in your community to decide to get tested for HIV?
  - How easy or hard is it for people in your community to talk about sexual violence occurring in the community?
  - How easy or hard is it for people in your community to talk about homosexuality?
  - How easy or hard is it for gay men and other men who have sex with men to be open about their identity in your community?
  - How easy or hard is it for sex workers to be open about their profession in your community?
  - How easy or hard is it for trans people to be open about their identify in your community?
  - How easy or hard is it for MSM to share their identify with their immediate family?

- **Facilitator Note:** Do not have a plenary discussion after each question; rather, after asking 3-4 questions, and seeing a pattern where people are mostly at the "hard" end of the line, acknowledge to the group that these are not easy issues to talk about.
- Ask everyone to return to their seats.
- **Explain:** Think for a moment about when you felt comfortable talking to someone about a difficult topic...something that was sensitive or maybe felt embarrassing.
- **Ask:** What is it that makes it easier to talk about a difficult topic? (Record on flipchart.)
- After participants' answers have been recorded on flipchart, write the word Safety across the top of the page.
- **Emphasize:** What makes it easy to talk about a difficult topic can depend on...
  - The person we're talking to
  - The relationship we have with them
  - The location
  - The way they talk or listen?
  - But in general, we talk to people about difficult topics when we feel like it is safe to do so and we trust the person we are talking to.
- **Emphasize:** We can see that it is often difficult for all people to talk about some of these sensitive topics –and it is especially difficult for KPs.
- Let's remind ourselves of some of those reasons.
- **Ask:** Why is it especially hard for KPs to talk about issues of sex, gender identify, and violence that has been committed against them? (Allow participants to brainstorm.)
- **Emphasize:**
  - Lack of trust in provider.
  - Lack of confidence in that her information will be kept confidential.
  - Feelings of shame or guilt.
  - Fear of being blamed for the abuse by the provider.
  - Fear of being lectured and told to do things that are unrealistic for them.
  - Fear of being arrested.
  - Fear of being shamed or humiliated.

STEP 2: Large Group Exercise: Standing in Her Shoes

- **Explain:** We've talked about some of reasons it might be difficult for clients to share their experiences with violence and abuse.
- It's important for us to put ourselves in their shoes to understand the isolation they often feel.
- **Instructions for exercise:**
  - Ask for 8 volunteers to stand up and form a circle in the room, facing towards the middle of the circle
  - One for 1 volunteer to stand in the center of the circle.
  - Give the participant standing in the center of the circle the "Sex Worker" card.
  - Distribute one of the remaining 8 exercise cards to each of participant in the circle.
  - Ask the person in the center of the circle to walk up to each person in the circle, one at a time, and read their card to each person on the outer rim of the circle, and ask the participants in the circle to read the card in their hand in response and follow the instruction at the end of the card.
  - After the person in the center has approached each person in the circle and all cards have been read, debrief the exercise.

- **Ask:** What do you think it felt like for [name of person who played the role of a sex worker to approach people and tell them what happened?
- Ask the person who played the role of a sex worker: What were you feeling as you went around the circle and told people what happened to you?
- **Emphasize:** Victims are often blamed for the violence against them.
- **Ask:** How do we sometimes blame victims by the things we say or questions we ask? (Allow participants to brainstorm.)
- **Emphasize:**
  - Why were you alone? Why were you walking in that neighborhood?
  - Why were you wearing such revealing clothes?
  - What did you do to make him angry?
  - If you were really afraid, why didn't you run or scream?
  - Why do you choose to put yourself in risky situations?
- **Emphasize:** Sometimes we don't intend to blame victims but we end up putting the focus on them instead of the abuser by the questions we ask.
- When we talk to victims who have experienced violence, the focus should be on validating and supporting them.
- For KPs, they are doubly blamed –blamed for who they are and their lifestyle –and blamed for any violence or abuse that happens to them.
- This blaming creates barriers for clients in disclosing violence.
- How we communicate with clients is important. We're going to talk about that in a bit.

Session 4.2: Role of Service Providers in VPR

Time: 45 minutes

Learning Objectives:

At the end of the session, participants will be able to:
- Describe what service providers should be involved in the referral network
- Describe ways that direct service providers can cause harm to clients
- Describe ways that direct service providers can support clients

Preparation/Materials:

- PPT slides (optional)
- Flip charts and markers
- Handout #13: Provider Power and Control Wheel
- Handout #14: Provider Protection and Support Wheel

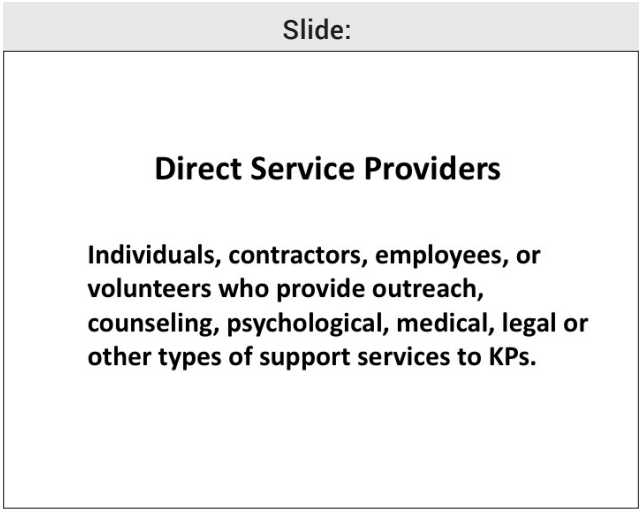
INTRODUCTION:

- Let's talk about your roles as direct service providers.

STEP 1: Large Group Discussion: Role of Direct Service Providers

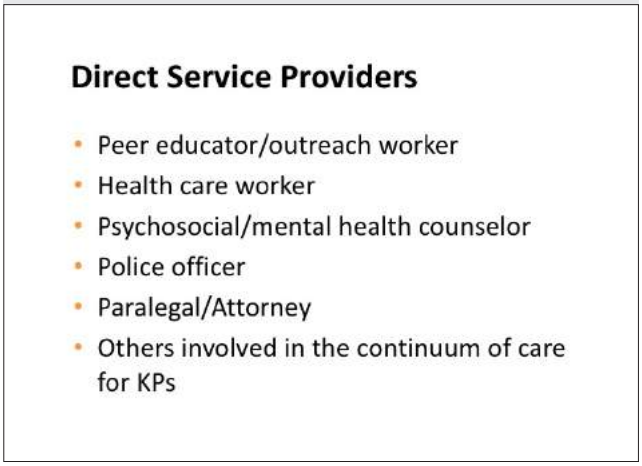
- **Post slide and explain:** We've been using the term "direct service providers."
- **Ask:** Who is a direct service provider? (Elicit response; click slide again to post definition.)

Slide:



- **Post slide and explain:** A direct service provider could be:

Slide:

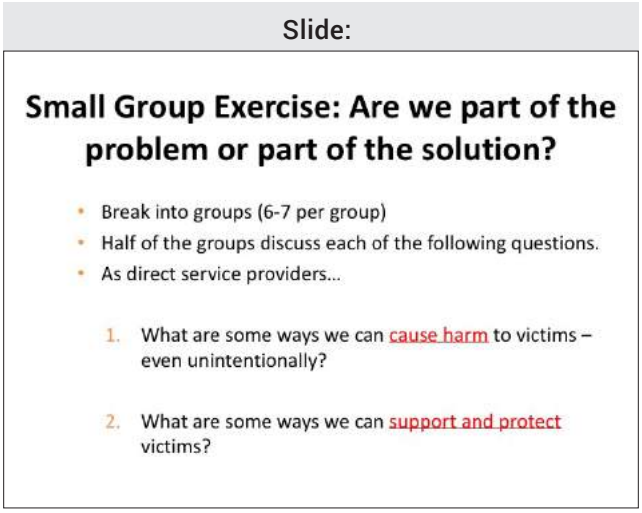


- **Emphasize:** We are used to using the term direct service provider for health care workers, but for KP programme, our definition is much broader.
- All direct service providers should be trained to provide first-line support if a client discloses violence.
- The direct service providers are typically tasked with screening for violence include:
  - Peer educators;
  - HTC counsellors;
  - Health care workers, including nurses; and
  - Clinical officers
- **Emphasize:** KP programme settings may be different and each programme will have to identify their direct service providers to screen clients for violence (e.g., health care workers and peer educators)
- It depends on the context, structure, and capacity of the program and stakeholders.
- For now, we want to make sure we have a shared understanding of what we mean when we use the term "direct service provider."

STEP 2: Small Group Exercise: Are we part of the problem or part of the solution?

- **Explain:** KPs may have difficulty in trusting direct service providers.
- **Ask:** Why do you think this may be the case? (e.g., previous bad experiences, afraid of being arrested, shamed, or humiliated)
- **Explain:** Although direct service providers often have good intentions, they sometimes do things that can cause harm to clients or jeopardize their privacy and safety.
- **Post PPT slide and explain:** As direct service providers, let's think about ways we that we might cause harm to KPs who have experienced violence—even unintentionally and ways we can support them.

Slide:



- Give participants 10 minutes to work in small groups.
- Debrief exercise ask participants to present their outputs about ways we can cause harm.
- Record on flipchart and ask other participants if they have anything to add.
- Refer participants to Handout #13 (Provider Power and Control Wheel).
- **Explain:** We've talked about some of these.
- This handout shows us ways that, as providers, we can cause harm clients, making it difficult for them to disclose their experiences with violence with us. Including:

Violating Confidentiality

- Screening client or asking about violence in a public area where others can overhear.
- Screening or asking client about violence in front of partner, family members, pimp/brothel owner.
- Sharing information client shares with you with others without client's consent.
- Calling the police without client's consent.

Trivializing & Minimizing Violence

- Not taking client's fears seriously.
- Blaming clients for violence
- Assuming that, if client has endured abuse for years, it can't be too bad.
- Not recognizing the impact that emotional/psychological abuse and threats/intimidation have on clients.
- Denying services to clients based on own beliefs and assumptions about who is "worthy" of services.

Disrespecting Client's Autonomy

- Forced/coerced HIV testing and other services.
- "Prescribing" divorce or leaving a relationship or occupation (e.g. sex work).
- Punishing or shaming a client for not taking your advice.
- Not asking client questions about what they want or how they feel.

Blaming Clients

- Asking what client did to provoke abuse.
- Focusing on client as the problem:
  - "Why do you put yourself in danger?"

- » "Why do you let him do that to you?"
- Placing the unrealistic expectation on the client that there is something they can do to stop the abuse.

Ignoring Client's Need for Safety

- Failing to recognize client's sense of danger.
- Failing to conduct safety planning with client, or not asking:
  - » "Are you afraid to go home?"
  - » "Do you have a safe place to go?

Normalizing Victimization

- Not recognizing that violence is a violation of human rights for all clients, including KPs.
- Failing to respond to client's disclosure of violence.
- Accepting intimidation as normal in the context of clients' lifestyles.
- Belief that violence is natural outcome when a person disobeys their partners/clients/pimps, etc.

- **Explain:** Providers are in a unique position to influence if, how, and when clients disclose violence.
- Ask participants to present their outputs about ways we can protect and support our clients.
- Record on flipchart and ask other participants if they have anything to add.
- Refer participants to Handout #14 (Provider Protection and Support Wheel)
- **Explain:** We've talked about some of these.
- This handout shows us ways that we can support and protect clients, making them feel safe and comfortable to disclose their experiences with violence.
- These are things we can do to help clients feel like they have control over their lives.

Ask about Violence and Respond in Private

- Do not screen or ask client about violence in a public area.
- Do not screen or ask client about violence in front of partner, family members, sex workers' clients, pimps, brothel owners, or police/military, or others.
- If it's not possible to talk to a client alone, do not ask client about violence.

Establish an Effective Relationship

- Validate the client's experience.
- Ask clients how they feel about their situation.
- Share information without "telling" client what to do.
- Remember: Clients have a lot of wisdom about their own lives.
- For clients who are 18+ yrs. old, protect client's privacy and safety by keeping their information confidential, and tell client information will be kept confidential.

Provide Education and Information

- Inform clients of their legal rights.
- Deliver key educational messages, including:
  - » Thank you for sharing this with me. I'm sorry this happened to you.
  - » Many people experience violence and abuse and even though they may be blamed for what happened, it is never their fault.

- Everyone has the right to live free from violence and abuse.
- I am here to support you and explain your options.

Offer Services and Refer Client to Resources

- Tell client that seeking support is the first step to healing.
- Inform client of available resources.
- For sexual assault, offer or link to post-violence services.
- Inform client of community-based resources (if available).
- Encourage client to continue to share their experiences with you and to seek support from other appropriate resources.

Summarize/Emphasize: At a minimum, as providers, we should...

- Ask clients about violence (as long as there are services to refer them to).
- Tell clients that violence is a violation of their basic human rights.
- Tell clients they are not to blame for violence.
- Give clients autonomy to make their own decisions.
- Refer clients to health care, psychosocial/mental health, and legal services.

Session 4.3: How we Communicate with our Clients

Time: 90 minutes

Learning Objectives:

At the end of the session, participants will be able to:
- Understand the different ways we communicate with our clients
- Describe the qualities of a good communicator/listener

Preparation/Materials: Flip charts and markers

INTRODUCTION:

- **Explain:** As service providers, our goal is to acknowledge the barriers for our clients and to develop trusting with.
- We need to create a safe and comfortable space for them to be, and let them know that we are there to support them.
- If we take the time to establish these things from the beginning, it may allow a client to open-up to us and let us know if they experience violence.
- How we communicate with clients is key in developing rapport and trust.

STEP 1: Small Group Exercise: The Ways we Communicate

- **Post slide and explain:** For this next exercise, let's work in small groups at our tables.

Slide:

Small Group Exercise:
The ways we communicate

- Break into small groups (6-7 per group)
- Identify volunteer who had a busy weekend
- **Volunteer explains to group what they did without using words or writing it down, only using gestures to describe their activities.**
- Group guesses out loud what the volunteer did, and once they guess correctly, the volunteer acknowledges the correct answer and moves on to describe their next activity.

- **Tip:** Ask the volunteer to include many things about their weekend --including small details --to give the group more opportunities to guess.
- **Emphasize:** Do this for a few minutes --and try to guess all the things the volunteer did this weekend.
- Give participants 5/10 minutes for the exercise.
- Debrief small group exercise and explain: This exercise showed us how we can communicate using body language.

- **Post PPT slide and ask:** What are some other ways we communicate? (Allow participants to brainstorm and click slide again to post answers.)
- **Emphasize:** There are many ways to communicate --or exchange thoughts, using verbal and non-verbal methods (e.g. speech, tone, visuals, signals, writing, or behavior/body language)

Slide:

Debrief Small Group Exercise:

- This exercise showed us how we can communicate using body language.
- **What are some other ways we communicate?**

Verbal and non-verbal methods
speech, tone, visuals, signals, writing, or behavior/body language

- **Post PPT slide and explain:** Communication means that one person gives information and another receives the information.
- Communication can be intentional or unintentional.

Slide:

Debrief Small Group Exercise:
The ways we communicate

Most communication happens through body language.

- Verbal communication is a small part of the messages we give
  - Words account for 7%
  - Tone of voice accounts for 38%
  - Body Language accounts for 55%

Research that Albert Mehrabian undertook in 1971

- **Explain:** I'm going to give an example and say this statement in two ways, using the exact same words, but different tone and body language.
- **Example:** "So tell me more. What is it that you're afraid of?"
- Thinking about our tone of voice and body language are important for us to think about because our clients are "sizing us up" from the moment they meet us.
- **Ask:** What do I mean by "sizing us up?" (clients are assessing us –trying to decide how they feel about us –wondering if they can trust us, how much they should share with us)
- The goal of communication between a service provider and a client is to establish a trusting, safe and supportive helping relationship.
- Once this is established, clients are more likely to share their experiences with violence with you.

STEP 2: Large Group Discussion: Who do I talk to?

- **Post PPT slide and read question to the group:** (Allow participants to brainstorm and record on flipchart)

Slide:

Large Group Discussion:
Who do I talk to?

When you have something hard
in your life and you want
someone to talk to about it,
what qualities do you look for?

- Some example qualities are:
  - Someone who respects me
  - Someone who cares about me
  - Someone who does not judge me or lecture me
  - Someone who is compassionate
  - Someone who is patient and listens to me
- **Emphasize:** Our clients are looking for these same qualities in us.
- If we get it wrong during our initial interaction with clients, we may miss an opportunity to learn about what's going in their life and connect them to important health and other services.

STEP 3: Large Group Exercise: What is my body language telling you?

- **Facilitator Note:** For this exercise, the facilitator will sit in a chair in the front of the room so everyone can see.
- **Post PPT slide and explain:** I'm going to use my body language to communicate with you, and I want you all to tell me what I'm saying.

Slide:

Large Group Exercise:
Guess what I'm saying

Facilitator Role Plays

In these examples, what is my body language is telling you?

- The facilitator demonstrates each of the examples below and allows participants to brainstorm about what the body language is saying to them. (Example answers are included after each example.)
  - Folded arms: Can be defensive/cautious. Can be just cold, or protecting the body.
  - Limited or No Eye Contact: Lying, uninterested, uncomfortable, distracted.
  - Leaning forward: indicates they are interested.
  - Direct eye contact, looking at you: indicates interested, likes you.
  - Chin on hand: Critical, cynical and negative towards the other person.
  - Looking up and to the right: not paying attention, but looking up to the right can indicate the person is accessing their memory. It could be she is trying to think about how what she is hearing relates to something else.
  - Fidgeting with paper / pen: Bored or has something to say
- **Debrief exercise and emphasize:** Culture and context can make a difference in how body language is used.
- For example, what is a sign of respect in one culture can be considered rude in another.
- **Ask:** What is an example of body language that might be viewed as respectful in one culture, but disrespectful in another culture? (having eye contact)
- As we think about the different ways we communicate, especially with body language, it's important to think about what is appropriate in the culture/context in which participants are operating.
- Later, when we talk about providing first-line support to clients during and after the violence screening process, we will build our active listening skills and learn specific strategies for communicating with clients in a supportive way.
- For now, we just want to think about the different ways we communicate, which will help us in delivering VPR services to clients.

Session 4.4: Minimum Package of VPR Services

Time: 15 minutes

Learning Objectives:

At the end of the session, participants will be able to:

- Describe the six services included in the Minimum Package of VPR Services

Preparation/Materials:

- PPT slide
- Handout #15: Flowchart: VPR Minimum Package of VPR Service

INTRODUCTION:

- **Post PPT slide and explain:** Remember we said there are six services included in minimum package of VPR services.

Slide:

Minimum Package of VPR Services

Service #1: Identify Violence (via screening) among Kps

Service #2: Provide First-Line Support

Service #3: Provide/Refer to Clinical Post-Violence Services

Service #4: Provide/Refer to Psychosocial and MH Services

Service #5: Provide Legal Information/Refer to Legal Services

Service #6: Follow-up with Clients who disclosed violence

STEP 1: Present Screening and Response FLOWCHART

- **Post PPT slide and explain:** Refer to Handout #15: Minimum Package of VPR Services Flowchart.
- **Explain:** These are the six services organized on a flowchart.
- As I explained, we are going to talk about each of these steps separately, so it will make more sense later, but I wanted to show you a visual aid of the entire service package.
- Facilitator should review the content of the handout.

Slide:

Handout #15: FLOWCHART
Minimum Package of VPR Services

Session 4.4.1: Service #1: Identify Violence (via screening) among KPs

Time: 60 minutes

Learning Objectives:

At the end of the session, participants will be able to:
- Describe the rationale for screening KPs for violence.
- Demonstrate skills in using a standardized tool to screen clients for violence.

Preparation/Materials: Handout #16: Violence Screening Tool

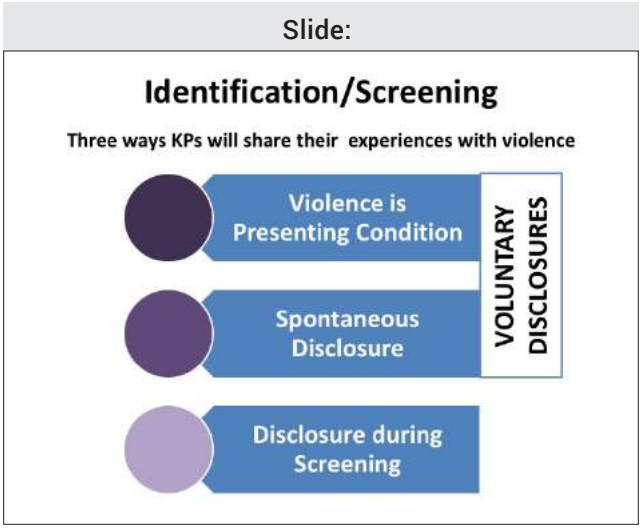
INTRODUCTION:

- **Explain:** In this session, we're going to cover the first service and build our skills for screening for violence.
- Since violence can have immediate and long-lasting effects on a person's health, it is important for direct service providers to understand clients' experiences with violence.
- Having said this, screening and getting clients to disclose is not the "end goal."
- Some clients do not want to share their experiences, and that decision should be respected.
- The most important goal is to create an environment where clients feel comfortable and safe so if they choose to share their experiences, they will feel supported.
- Clients are more likely to share their experiences with violence when they feel safe to do so.

STEP 1: Large Group Discussion: Ways KPs typically Disclose Violence

- **Post PPT slide and explain:** There are three ways KPs typically disclose violence:

Slide:

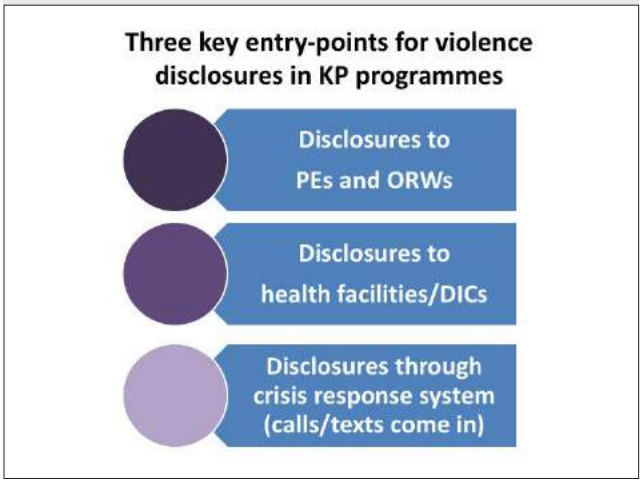


- **Emphasize:**
  - KPs may visit a facility or reach out for help when violence is the presenting condition or the reason they are seeking assistance;
  - KPs may spontaneously disclose experiences with violence when they are seeking or receiving other services (e.g. HIV services); or
  - KPs may disclose violence in response to violence screening.

STEP 2: Large Group Discussion: Violence Disclosures in KP programmes

- **Post PPT slide and explain:** In KP programmes, violence disclosures are likely to happen at three entry points. (Review information on slide)
- **Emphasize:** KPs will disclose violence to
  1. peer educators (PEs) or outreach workers (ORWs);
  2. health facilities, including drop-in-centers (DICs)—either voluntarily or through screening; and
  3. crisis response systems (e.g. hotlines).

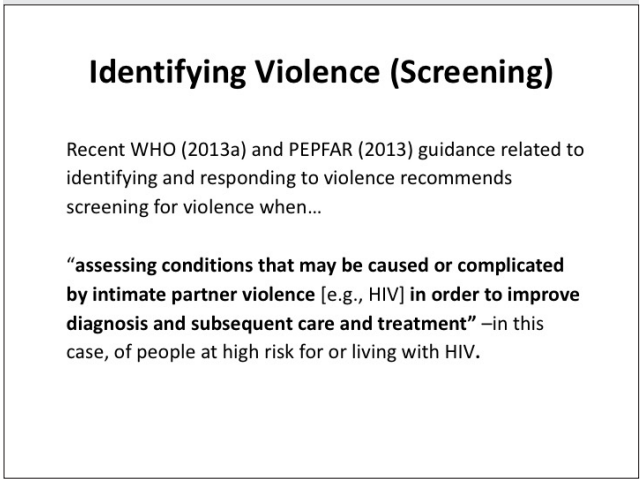
Slide:



STEP 3: Large Group Discussion: Rationale for Screening KPs for Violence

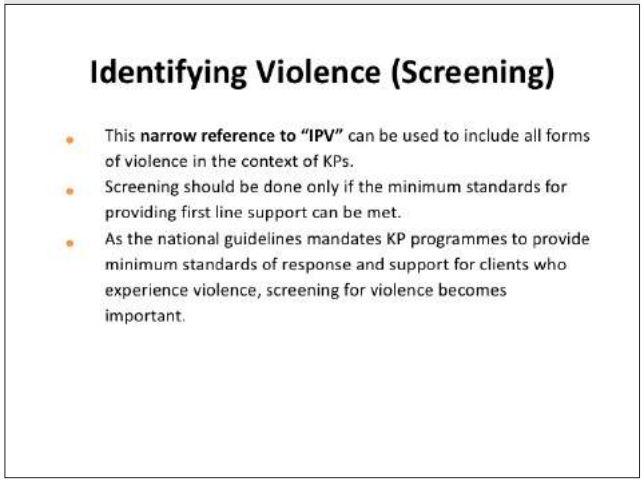
- **Explain:** *Screening* refers to asking a client a series of questions to determine if the client has or is experiencing violence.
- **Post PPT slide and review content:**

Slide:



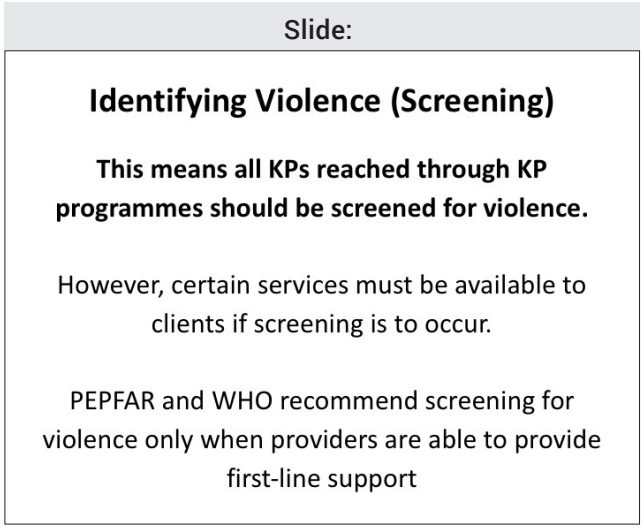
- **Post PPT slide and explain how we can expand the narrow reference to IPV:**

Slide:



- **Post PPT slide and explain:**

Slide:

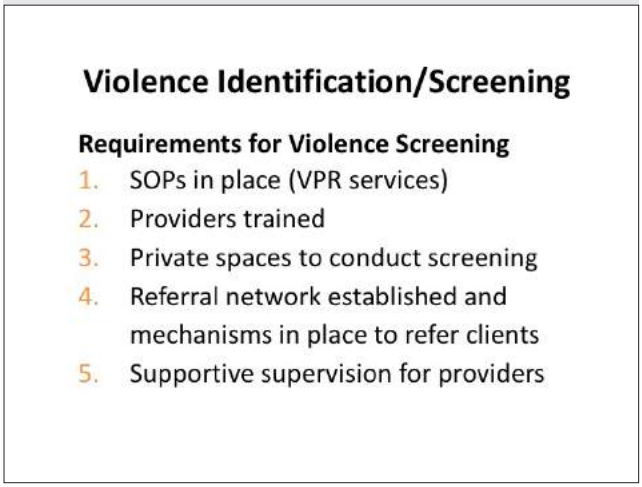


- **Explain:** We will talk more about how to provide first-line support in the next session.
- **Emphasize:** So, we have the rationale for why it's important to be proactive and screen KPs for violence.
- Using a more passive approach to identifying violence among clients requires victims to seek out services on their own and report their experiences with violence to health care providers, without being promoted or asked.
- This passive approach requires the victim to:
  1. have knowledge of available services and the rights of victims, and
  2. trust in the confidentiality, privacy, and compassion of the person providing the service.
- These are challenging expectations, particularly for KPs –for reasons we have already talked about.
- Also, if providers do not initiate discussions about violence, clients may not feel empowered to initiate the discussion themselves.
- As a result, violence continues to be underreported, existing services underutilized, and KPs will continue to experience barriers in accessing HIV services.
- In KP programmes, we use a more proactive approach –in that we routinely ask all KPs about their experiences with violence –that is, we screen them for violence.

STEP 4: Large Group Discussion: Requirements for Violence Screening

- **Explain:** In line with WHO guidelines, a set of requirements have been developed that must be met before violence screening and response services are implemented.
- **Post PPT slide and explain points below:**

Slide:



- **Emphasize:** You'll notice that these requirements for screening are a subset of the list of program components (or support structures) that we talked about earlier in the training.
  - SOPs for violence screening and response should be established and in use.
  - Direct service providers are trained on how to ask about and provide first-line support in a way that respects clients' rights, dignity, and choice;
  - Violence screening occurs in a private setting with mechanisms in place to ensure the client's confidentiality during and after the client's visit;
  - A system is in place for referrals to in-house or community resources; and
  - Direct service providers receive supportive supervision.

STEP 5: Large Group Discussion: Create a welcoming environment for clients

- **Explain:** We can do a good job of getting providers trained and ready to screen for and respond to violence, but if we don't have a welcoming environment for clients, they may be less willing to share their experiences with us.
- **Post PPT slide and ask:** How can we create a welcoming environment? What are the specific aspects of what makes a space welcoming? (Allow participants to brainstorm and then click slide again to post examples.)

Slide:

Create a Welcoming Environment

How do we create a welcoming environment that increases KPs' comfort in sharing their experiences with violence?

- Good first interaction at reception
- Tone and delivery
- IEC materials
- What else?

- **Emphasize:**
  - Good interaction with first point of contact (e.g. receptionist)
  - Providers' tone and "delivery" while screening for violence is a key factor in whether clients feel comfortable enough to disclose violence.
  - IEC materials should be visible at facilities and distributed to clients to help them feel safe and encourage them to disclose their experiences with violence during screening.
  - This is an important part of creating an environment that is conducive to screening. When clients are exposed to visual aids and other printed information, it lets them know that the providers in "this space" are willing and ready to hear their experiences with violence and link them to support.

STEP 6: Large Group Discussion: Using a standardized tool to screen for violence

- **Explain:** As previously mentioned, the national programme recommends screening all KPs for violence as long as the requirements we just discussed have been met.
- **Post PPT slide and explain:** Refer to Handout #16 for a job aid for screening KPs for violence.

Slide:

Tool for Screening for Violence

Handout #16: Job Aid

- **Explain:** I want to spend a few minutes orienting everyone to this job aid and making some key points about its content and use.

- This job aid incorporates basic first-line support responses directly in the tool.
- There are prompts throughout the tool that direct service providers can use to deliver core messages when clients respond a certain way to the questions throughout the screening process.
- Provide an orientation to the job aid and review in detail.
- After reviewing the job aid, discuss the importance of conducting a full screening for each client the first time they are seen –and then conducting a "shortened" version of screening for subsequent visits.
- For example, during subsequent visits a provider might say, "Remember during our first visit, I asked you some detailed questions about whether you had experienced any type of violence and abuse. We ask these questions because of the significant health consequences for people who experience violence and abuse–so I just want to check-in with you to see if anything has changed for you since I last saw you. Has anyone threatened or hurt you in any way?"

STEP 7: Large Group Discussion: Supportive Statements

- **Explain:** In a minute, we're going to talk about what is involved in providing first-line support during and after the screening process.
- Then, we'll break into groups of three to practice screening and providing first-line support.
- **Post PPT slide and explain:** There are prompts listed in the screening tool to deliver core messages and support, but here are some of the core supportive statements EVERYONE should say to clients who disclose violence.

Slide:

Screening for Violence

Supportive Statements

- I believe you.
- It's not your fault.
- I'm sorry that happened to you.
- You can ask me anything you want.
- Other people have also gone through this.
- You are not alone.
- You are brave to talk me about it.

- **Ask:** Can you think of other supportive statements?

STEP 8: Large Group Discussion: Violence as presenting condition or spontaneous disclosure

- **Explain:** Remember we said there are typically three ways clients disclose violence?
- We just talked about screening for violence with the provider initiating the topic of violence.
- But, sometimes clients might come in with violence as the presenting issue or condition or they spontaneously disclose violence before you've had a chance to introduce the topic and ask the screening questions.
- In these cases, providers can say, "I'm sorry this happened to you and I'm really glad you shared this with me." –and then use the job aid as a guide for responding.
- For example, if a sex worker comes to you and tells she was raped by a client last night, you would say, "I'm sorry this happened to you and I'm glad you told me." [Refer to prompts on job aid for "sexual violence," and say...
  - I'd like to share some information with you, but before I do that...
  - Do you have injuries that need immediate attention?
  - [refer to job aid and follow prompts/instructions]

STEP 9: OPTIONAL: Large Group Discussion: Provider Barriers to Screening

- **Ask:** What are some things that prevent providers from screening for violence? (Elicit responses and then provide examples below.)
- **Provider Barriers:** (Here is what we've heard from some providers...)
  - *It isn't my job.*
  - *I don't know how to ask.*
  - *It makes me uncomfortable to ask.*
  - *I fear I will offend my client.*
  - *I don't know what to say if the client says "yes" or tells me about their experiences*
  - *Clients might get upset if I ask personal questions about their experiences.*
  - *Since I'm a male, they won't want to talk to me about GBV.*
  - *I don't have the time.*
  - *It isn't my business. I don't want to probe.*
  - *The provider has GBV in their own history. It's too difficult to ask others.*
  - *The provider buys into myths.*
- **Emphasize:** Even though some providers might feel that screening for GBV is intrusive, many clients report that they are actually glad when their providers ask them about it.
- Remember we said before that GBV is a major health issue.
- It's important to view asking about GBV –the same we view asking about other health issues.

Session 4.4.2: Service #2: First-Line Support

Time: 120 minutes

Learning Objectives:

At the end of the session, participants will be able to:
- Provide a compassionate and non-judgmental response to KPs who disclose violence
- Demonstrate active listening skills
- Demonstrate how to assess safety and explore safety strategies with clients
- Demonstrate how to explore next steps with KPs who experience violence and link them to them to services

Preparation/Materials:

- Handout #17: Overview of First-Line Response (Support)
- Handout #18: Active Listening Skills Worksheet

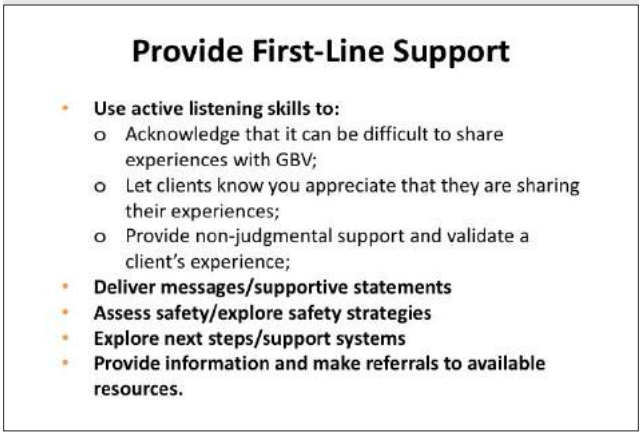
INTRODUCTION:

- **Explain:** When clients have the courage to share their experience with direct service providers, it may be the first time the client has shared their experience with anyone.
- If clients feel disrespected or judged, they are less likely to share their experiences and less likely to engage in follow-up services, including health care services.
- In this session, we'll focus on building our skills for providing first-line support to clients.

STEP 1: Large Group Discussion: What is first-line support?

- **Explain:** In alignment with the WHO guidance, clients who disclose violence should be offered immediate compassionate first-line support by direct service providers.
- **Post PPT slide and ask:** What do we mean by first-line support?

Slide:



- **Emphasize:** First-line support is ongoing throughout service delivery.
- **Refer participants to Handout #17:** Overview of First-Line Response/Support and explain: This is an overview of what is included in first-line support.
- In this session, we will go over and practice these steps in providing first-line support.

STEP 2: Large Group Discussion: Introduction to the Concept of Active Listening

- **Explain:** Many times, when someone is in pain, the message they hear from others in their life is: "Feel better! Stop feeling what you are feeling! Cheer up!"
- Often, these things are said by people who are trying to help, or because they are uncomfortable with pain.
- Our job is to create a space where it's okay for a client to feel whatever they are feeling.
- Clients can be honest with us if they feel terrible or sad that day.
- Sadness and fear are NORMAL reactions to violence and abuse.
- We want to let clients know that what they are feeling is normal and give them the opportunity to talk about their feelings –whatever they may be.
- **Explain:** Active listening is an essential component of providing first-line support, so we're going to spend some time learning about and practicing 4 active listening skills.
- Active listening techniques include expressing your interest and concern using your body language, as well as your words.

STEP 3: Large Group Discussion: Introduction to Four Active Listening Skills

- **Post PPT slide and explain:** There are four main skills in practicing good active listening.
- We're going to talk about each of these as a group and then practice using these skills – both as a large group and then in small groups/role plays.

Slide:

First-Line Support

4 Active Listening Skills

- Attentive listening
- Reflecting
- Validating
- Inquiring/clarifying

STEP 4: Large Group Exercise: Skill #1: Attentive Listening

- **Explain:** The most important thing to do is be a good listener.
- Much of being a good listener is demonstrated through body language, being comfortable with silence, and not rushing the person.
- **Ask:** What are some ways we show people we are being a good listener?
- Elicit responses and record on flip chart. Some examples include:
  - Lean forward
  - Maintain good eye contact
  - Nod your head to let the person know you hear them
  - Be comfortable with silence and pauses

STEP 5: Small Group Exercise: Practice being a good listener

- **Explain:** Let's practice being a good listener. Break participants into pairs.
- Person A talks about what they like about their current job for two minutes.
- Person B actively listens and does not speak at all.
- Then, switch. Person B talks for two minutes, while person A listens and does not speak.
- **Debrief activity and ask:** When you were the talker, what was it like to talk for several minutes with no response from your listener? When you were the listener, what was it like to just sit there and not verbally respond to the person talking?
- **Emphasize:** Some people find it strange—because we are used to having people talk back and forth.
- However, this is the beginning of developing good listening skills—learning to just listen.
- It can feel awkward to just sit and listen and not respond verbally to the person who is talking to you, but it's an important skill to learn.
- **Ask:** What things get in the way of being a good listener? (Elicit responses)
- **Emphasize:** The average person thinks 4 times faster than the average person talks.
- During this time, when a person is talking to you, you have the choice of what to do with the extra time:
  - Thinking of what you have to do tonight
  - Silently thinking that you have been through worse
  - Silent arguing
  - Predicting what the person is going to say next
  - Planning what you will say next
  - Noise --environmental—like construction, a busy office next door
  - Physical—sleepy, have to go to bathroom
  - Psychological—defensiveness, fear, anxiety, anger, judgment, analyzing, projecting own feelings and values
- **Explain:** Try not to do any of these things and minimize external distractions.
- Use the time to really focus on what the person is expressing, both with their words and without words—through body language, what they are not saying.
- When the person is done speaking, acknowledge what they have just said and then let there be a moment of silence if nothing comes to you to say.

STEP 6: Large Group Exercise: Skill #2: Reflecting

- **Explain:** Active listening means more than just listening.
- In addition to attentive listening, there are also things we can say that show we are being good listeners.
- **Explain:** The second active listening skill is "reflecting."
- **Ask:** What do you think we mean by "reflecting?" (Elicit responses)
- **Emphasize:** Reflecting means using statements that reflect back what the person is saying to you.
- This lets the person know you're listening. It also gives them an opportunity to clarify how they are feeling.
- We do this all the time when we talk to each other –our co-workers, friends, and family.
- **Reflecting statements** begin with phrases such as:
  - *So, it sounds like...*
  - *What I hear you saying... o I get the sense that...*
  - *You appear to be feeling...*

- **Explain:** Avoid statements such as:
  - *"I know" or "I understand"*
  - *Labeling an experience: "You were raped."*
- **Here's an example:** When someone says: "*I do not want to even be around men or talk with them. I think something bad might happen again and I want to hide from them when they come my way."*
- **Ask:** What do you think this person is feeling? (scared)
- You can reflect this person's feeling by saying:
  - *"It sounds like you are feeling scared" or "I can hear that you feel really scared."*
- You have just reflected her feelings, said it back to her to make sure you understood her correctly, and let her know that you are paying attention and that you understand what she is saying.

STEP 7: Large Group Exercise: Skill #3: Validating

- **Explain:** Validating just means that we are letting the person know that what they are feeling or experiencing is okay or normal.
- Some example validating statements include:
  - *"It makes sense that you feel that way."*
  - *"It's understandable that you feel that way after what happened."*
  - *"Many people feel this way after experiencing this."*
- When validating feelings of clients, try not to make it personal from your end.
- For example, instead of saying, *"It sounds like you are really angry at your partner. I would be upset with my partner too!"* –You could say, *"It sounds like you are really angry with your partner. That's understandable."*

STEP 8: Large Group Exercise: Practice reflecting and validating as a large group

- **Explain:** Let's practice reflecting and validating as a large group.
- I'll share something with you, and you can reflect my feeling and then validate my feeling.

Client statement #1:

Ever since they raped me I don't want to eat or talk to anybody. I just want to sleep and stay in bed.

- **Ask:** What am I feeling? Reflect it back to me.
  - *"It sounds like you're in a lot of emotional pain. (reflecting)*
- **Ask:** What can you say to me to validate my feeling?
  - *"That is understandable after what you've been through." (validating)*

Client statement #2:

I still see the man who did this to me at the market. He saw me passing the other day and I thought he was going to come after me. It was like I was back there again-- in the worst day of my life.

- **Ask:** What am I feeling? Reflect it back to me.
  - *"It sounds like you're feeling really scared." (reflecting)*
- **Ask:** What can you say to me to validate my feeling?
  - *"It makes sense that you feel that way after what happened." (validating)*

Client statement #3:

My partner threatens to beat me at any little thing lately. I try to do things the way he likes them, but he only gets angrier. I don't know what he will do next.

- **Ask:** What am I feeling? Reflect it back to me.
  - *"It sounds like you're worried about your safety." (reflecting)*
- **Ask:** What can you say to me to validate my feeling?
  - *"It's understandable that you feel that way." (validating)*

STEP 9: Small Group Exercise: Active Listening Worksheet

- **Explain:** Refer to Handout #18: Active Listening Skills Worksheet
- Work in pairs to read each scenario, and provide a reflecting and validating statement for each client statement.
- Give participants 5/10 minutes.
- Debrief as large group.

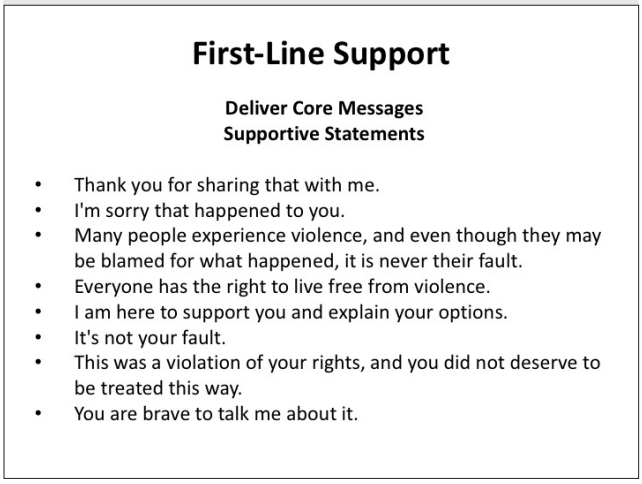
STEP 10: Large Group Exercise: Skills #4: Inquiring/Clarifying

- **Explain:** We can use open-ended questions/statements to clarify information or obtain more information.
- **Ask:** What is a closed ended question? An open-ended question? What is the difference? Explain:
  - Closed-ended questions have a yes or no answer—or one-word/ brief answer. Can someone give an example?
  - Open-ended questions invite people to talk more—usually use "how" or "what."
- For example, "What would that be like?" "How are you feeling about that?"
- **Explain:** We want our clients to feel comfortable talking and get clarification when needed, so we try to use open-ended questions as much as possible, such as:
  - *What would you like to share?*
  - *Tell me a little about how you've been feeling.*
  - *Tell me how I can help you.*
  - *I'm not sure if I fully understand what you mean. Could you tell me a little more?*
- **Ask:** What about "why" questions? Even though they can be open-ended, they often sound like they are judging.
- For example: "Why does that scare you?"
- **Ask:** How else could you say this question? ("What about that scares you?")
- **Explain:** Let's practice changing some "why" questions.
- **Ask** participants to listen to each question and think of a different way to ask it.
  - "Why are you feeling frustrated?"
    Better: What is it that is making you feel frustrated?
  - "Why don't you want to do that?"
    Better: What are your reasons for not wanting to do that?
  - "Why are you here?"
    Better: What brought you here today?
  - "Why don't you want to go to the hospital?"
    Better: What are your reasons for not wanting to go the hospital?

STEP 11: Large Group Exercise: Deliver core messages and supportive statements

- **Post PPT slide and explain:** In addition to using active listening skills during first-line response, it's important to deliver core messages and supportive statements that convey:
  - That you appreciate them sharing their experiences with you.
  - That you believe them.
  - That what happened wasn't their fault.
  - That their experience has happened to other people and they are not alone.
  - That their feelings are normal.
  - That they have the right to live without threats, violence, and abuse.
  - That it's safe for them to talk to you about her experience.
  - That you will support them and the choices they make.
- Review core messages/supportive statements on slide.

Slide:



- Refer participants back to Handout #17 for additional supportive statements:

Feeling	Some ways to respond
Hopelessness	*"Many people manage to improve their situation. Over time, most people feel hopeful again."*
Despair	Focus on the person's strengths and how they have been able to handle a past dangerous or difficult situation.
Powerlessness, loss of control	*"You have some choices and options today in how to proceed."*
Flashbacks	Explain that these are common and often become less frequent or disappear over time.
Denial	*"I'm taking what you have told me seriously. I will be here if you need help in the future."*
Guilt/self-blame	*"You are not to blame for what happened to you. You are not responsible for this behavior."*
Shame	*"There is no loss of honor in what happened. You are a valuable person."*

Feeling	Some ways to respond
Fear	Emphasize, *"You are in a safe place now. We can talk about how to keep you safe."*
Numbness	*"This is a common reaction to difficult events. You will feel again. For most people, this changes over time."*
Mood swings	Explain that these can be common and should ease with the healing process.
Anger with the perpetrator	Acknowledge that this is a valid feeling.
Anxiety	*"This is common, but we can discuss ways to help you feel less anxious."*
Helplessness	*"I am here to support you."*

- **Ask:** What are some things we should avoid saying to clients who disclose violence? (Elicit responses and record on flip chart.)

- **Emphasize: DO NOT...**
  - **Blame the client**
  - *"You put yourself at risk."*

  - **Say anything that judges what the client has done or will do**
  - *"You should feel lucky that you weren't more injured."*
  - *"You shouldn't feel this way."*

  - **Question the client's story (doubting the client) or interrogate the client**
  - *"What I don't understand is why he would have attacked you?"*

  - **Say anything that minimizes how the client feels**
  - *"Everyone has bad days. You'll get over it."*

  - **Lecture, command, or advise**
  - *"What you need to do is...." "You have to stop thinking about what happened." "You need to make a plan to avoid this happening again."*

  - **Ever recommend that they change their profession, sexual orientation, or gender identity to avoid violence**
  - *"You need to leave sex work. It's just a violent profession."*
  - *"If you stopped being so open about who you are, you would be safer."*

STEP 12: Large Group Discussion: Ask about safety and explore safety strategies

- **Post PPT slide and explain:** After delivering core messages, assess for safety.

Slide:

First-Line Support

Assess Safety
Do you have any concerns about your safety?

- Is there anywhere that you feel safe?
- Is there someone you feel safe with?
- Are there others in your community that you can talk to about how to stay safe?
- What strategies have you used in the past to stay safe?

- **Explain:** Ask questions to assess safety and identify opportunities to increase safety.

"I want to check with you about your safety. Do you have concerns about your safety?"

- If the client does not feel safe, explore safety strategies by asking:
  - *"Is there anywhere that you feel safe?" "Is there someone you feel safe with?"*
  - *"Are there people you could talk to about how they stay safe (other sex workers)?"*
  - *"What strategies have you used in the past to stay safe? Could they be used again?"*

- **Post next PPT slide:** Explore safety strategies with clients. Safety strategies depend on the individual's situation, but could include:

Slide:

First-Line Support

Assess Safety (cont.)

Explore safety strategies:

- exploring safe ways to disclose HIV status
- exploring emergency shelter/stay with friend
- Walking/working in pairs or groups
- trusting instincts about others
- avoiding secluded locations
- carrying emergency phone numbers.

What are other safety tips for FSWs?

- **For sex workers, additional safety strategies could include:**
  - negotiating payment upfront
  - screening clients and work locations
  - working in own space or well-known locations
  - avoiding drunk clients
  - writing down client's car registration number, color and make
  - avoiding getting into cars with more than one person in them

- **Emphasize:** It is important not tell clients how to stay safe.
- Safety planning is a conversation where the direct service provider asks questions to help clients determine what is best for them.
- If specific safety strategies are mentioned, they should be brought up as questions.
- For example, "Some sex workers report that when they negotiate payment upfront, this helps reduce their risk of violence. Do you think this could work in your situation? If so, what would help you begin to negotiate payment upfront?"

STEP 13: Large Group Discussion: Explore next steps with clients

- **Post PPT slide and explain:** When we explore next steps with clients, we want to help them think about their existing strengths.

Slide:

First-Line Support

Explore Next Steps

Help KPs identify and use their existing strengths:
"What helped you cope with hard times in the past?"
"What activities help you when you're feeling anxious?"
"How could what has helped in the past be helpful now?"

Help KPs explore existing support networks:
"When you're not feeling well, who do you like to be with?"
"Who helped you in the past? Could they be helpful now?"
"Are there people you trust that you can talk ?

ASK: ***Can I follow-up with you tomorrow or soon to check to see how you are doing? How can I reach you?***

- **Explain:** You can use your questions to help KPs recognize their strengths and existing coping mechanisms. For example:
  - *What has helped you cope with difficult situations in the past?*
  - *What kinds of activities help you when you're feeling anxious or tense?*
  - *How could what has worked in the past be helpful now?*
- **Explain:** Help the person explore existing support networks:
  (Even if the client does not wish to share their experience with others, spending time with people they trust and enjoy is important.)
  - *When you're not feeling well, who do you like to be with?*
  - *Who has helped you in the past? Could they be helpful now?*
  - *Are there people who you trust that you could talk to about this?*
- Arrange for a time to follow-up with the client. Ask when and how you can reach them, and then put it on your calendar (if you are a PE) or some other tracking sheet.
- Following up provides an opportunity for you to identify barriers for the client in accessing referrals and assist the client in following through with referrals.

- **Post PPT slide and explain:** WHO recommends the following times for follow-up for clinical services. (Review information on slide.)

Slide:

Follow-Up with Victims

WHO Recommendations

Clients who received HIV PEP	Clients who did not receive HIV PEP
One-week follow-up	Two-week follow-up
Six-week follow-up	Three-month follow-up
Three-month follow-up	

STEP 14: Large Group Discussion: Provide information and make referrals

- **Post PPT slide and explain:** Talk to client about their options.

Slide:

First-Line Support

Provide Information and Refer to Resources

- Clinical post-violence services
- Psychosocial support/counseling
- Legal information/services
- Other services in referral network

- **Emphasize:** It's important to provide printed materials with information about resources, with caution about taking printed materials home if the person lives with an abuser.
- Be familiar with the referral network for your community.
- Offer to go with the client (or send someone with the client) to referral site.
- Do not pressure anyone to seek additional services.
- Offer yourself as a resource.
- Track referrals to ensure completion, satisfaction.

STEP 15: Role Plays: Practice using Job Aid for Screening and Providing First-Line Support

- The facilitator should do a brief role play to demonstrate using the job aid.
- Then, ask participants to break into groups of three and take turns practicing using the job aid.
- **Explain:** One person will play the provider, one person will play the KP member, and the other person will be the observer.
- **Explain:** Don't worry if it feels mechanical to you right now.
- With practice, it will feel and come across as less mechanical.
- The goal is to make screening feel more like a conversation, but for now, because the tool is new to you, it may feel mechanical.
- Focus on getting oriented with the job aid, and practice asking the questions and providing the first-line support statements that are provided throughout the job aid.
- **Note about giving feedback to each other:**
  - Start with something positive
  - Share something that might need improvement
  - End with something positive

    For example: I thought you did a great job. I noticed that you asked a few why questions, but then you quickly re-phrased them. That was quick thinking. I thought you did a good job of using all of the 4 skills.
- After the first role play and observations are shared within your small group, switch roles, until all three of you have had a chance to practice the skills.
- We will spend about 20 to 30 minutes practicing, so use your time well!
- Facilitators should circulate, observe, provide guidance, answer questions, etc.
- After 20 to 30 minutes, find two participants to volunteer to do role play in front of large group.
- Provide guidance, as needed throughout role play, and then debrief the role play.

Session 4.4.3: Service #3: Provide/Refer to Clinical Post-Violence Services

Time: 15 minutes

Learning Objectives:

At the end of the session, participants will be able to:
- Describe the recommended clinical post-GBV services

Preparation/Materials:

- PPT slides
- Handout #19: Clinical Post-Violence Services

INTRODUCTION:

- **Explain:** As we've talked about throughout this training, we know that people who experience violence are at increased risk of negative health outcomes, including...
  - Unintended pregnancies, HIV and other STIs, complications from incomplete or unsafe abortions, and range of other health problems.
- Early and appropriate care for victims of violence by trained service providers can mitigate these negative effects, including reducing the risk of HIV, eliminating barriers to HIV care and treatment, and linking clients to important support services (e.g., psychosocial support and mental health services) to improve their emotional and overall well-being.
- In this session, we're going to review the recommended clinical post-violence services, which draw from a number of global guidance documents, mainly WHO.
- This session is only an overview of recommended clinical services –it is not meant to provide detailed information or develop providers' clinical skills.

STEP 1: Large Group Discussion: Developing a country-specific clinical post-violence protocol

- **Ask:** Does Kenya have a national protocol for providing clinical post-violence services? – Introduce the participants to the National Guidelines on Management of Sexual Violence in Kenya, 2014

STEP 2: Large Group Discussion: Developing a country-specific clinical post-violence protocol

- **Explain:** Clinicians who will provide post-violence services should be trained on all the topics included in this three-day training...
- And on the clinical management of rape (CMR)
- CMR is a training that builds clinician's clinical skills.
- **Ask:** Has anyone here attended a training on CMR?
- **Emphasize** that post violence care for sexual violence should be provided by only those who are trained in CMR.
- **Ask** the participants to identify the nearest GBV centre and ensure that the client who has experienced sexual violence is accompanied by a peer educator to the GBV centre.

STEP 3: Invite a service provider from the GBV centre to talk about the clinical post sexual violence services and the role KP service provider will play.

Session 4.4.4: Service #4: Provide/Refer to Psychosocial Support and Mental Health Services

Time: 15 minutes

Learning Objectives:

At the end of the session, participants will be able to:
- Understand the importance of linking clients to psychosocial support and mental health services
- Describe common reactions to experiencing violence

Preparation/Materials: None

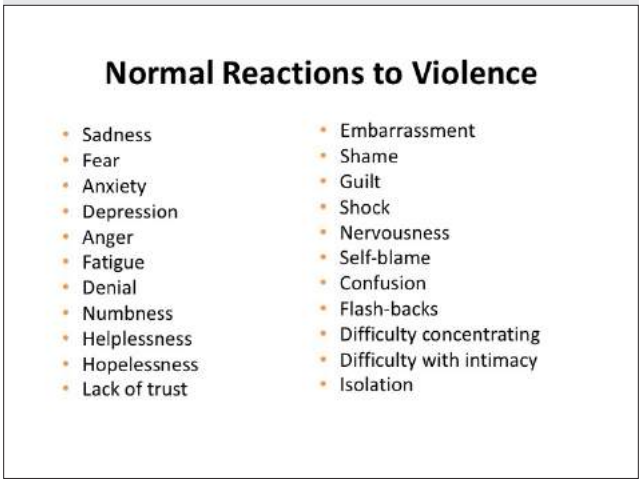
INTRODUCTION:

- **Explain:** The short- and long-term psycho-social effects of violence are well documented.
- In this session, we will briefly talk about some normal reactions to violence and the types of psychosocial support and mental health services that should be available to victims.

STEP 1: Large Group Discussion

- **Explain:** It's normal for people to feel sad, anxious, and/or angry after experiencing violence.
- **Post PPT slide and ask:** What are some other normal reactions that one might experience after experiencing violence? (Allow participants to brainstorm and then click slide again to post examples.)

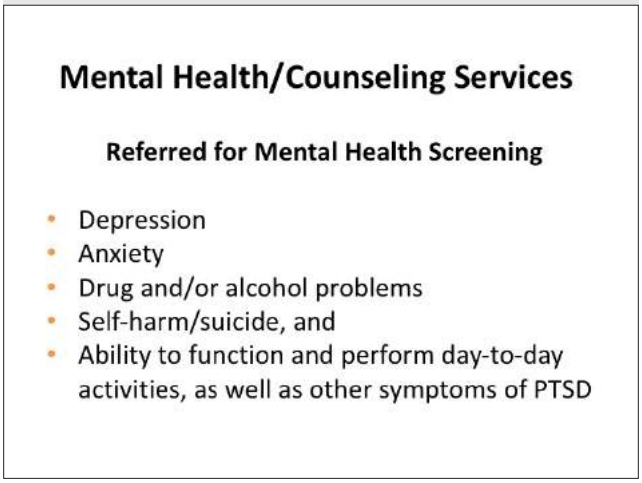
Slide:



- **Emphasize:** After a traumatic experience (e.g., sexual assault), it is normal for people to experience stress and anxiety.
- These conditions are often referred to as "acute stress," (WHO, 2013) and...
- With the support of trained counselors and mental health providers acute stress can often lessen over time. (Clarify that "acute" means severe, intense)

- **If the traumatic event happened within the past month, and the client is experiencing...**
  - Insomnia
  - Re-experiencing symptoms
  - Avoidance symptoms (like avoiding certain places, people)
  - Symptoms related to a sense of heightened current threat
  - Any disturbing emotions or thoughts
  - Changes in behavior that trouble the person or others around them (e.g. aggressiveness, social isolation/withdrawal, risk-taking behavior)
  - Medically unexplained physical complaints including hyperventilation and dissociative disorders of movement and sensation (e.g. paralysis, inability to speak or see).
  - Problems with day-to-day functioning...
- Then the client is likely experiencing acute stress. (WHO, 2013)
- Often, these symptoms will get better with time...
- But it's important for a trained mental health provider to see the client to do an initial assessment and follow-up assessment to check for longer-term, ongoing issues.
- **Who can provide psychosocial support?** Basic emotional and psychosocial support can be provided by PEs, ORWs, and other providers, such as HCWs, who have been trained to provide first-line support.
- Another type of basic psychosocial support is peer support groups, which are typically semi-structured groups that are led by a person (sometimes a mental health counselor, a trained peer educator, or lay counselor) who introduces topics for discussion and uses group facilitation skills to facilitate discussion among group members around various topics.
- Victim support groups can help decrease the isolation that victims often experience, encourage them to share their experiences, and provide safe spaces for victims to receive emotional support from their peers.
- Support groups can provide the social support the victims often need to begin to heal from violence and abuse.
- But, since some victims develop long-term issues that develop over-time and that go beyond what first-line responders can help with...
- All KPs who disclose violence should be provided or referred to psychosocial support and mental health services, as available in your setting.
- **Post PPT slide and explain:** As I just mentioned, sometimes, KPs who have experienced violence have needs that go beyond what can be provided during first-line support (e.g., KPs who are experiencing PTSD, substance abuse, depression, thoughts of suicide).

Slide:



- **Emphasize:** In these cases, KPs should be referred to mental health providers who have the expertise and experience to screen for and treat a variety of mental health issues, including but not limited to: depression, anxiety, substance abuse, self-harm and suicidal ideation, and PTSD.
- **Emphasize:** Who can provide mental health services and any required certifications or licensing varies among countries.
- Programs should refer to national mental health protocols to determine who in their community is able to provide these services.
- Assessing for these conditions requires specialized training.
- If first-level responders (people who receive the disclosure) are not trained to assess for these conditions, clients should be referred to a trained professional within the referral network who can conduct mental health screenings and provide the necessary support to clients.
- **Emphasize:** WHO provide specific guidance, as well as resources for mental health providers for assessing for and providing support for common symptoms.
- Since most of us are not mental health providers, we will not cover this detailed guidance in this training.
- But, we want to make sure we are all aware of the basic level of psychosocial support and longer-term mental health services that should be available to victims and work towards making sure this type of support is available in our community.

Session 4.4.5: Service #5: Provide Legal Information/Refer to Legal Services

Time: 15 minutes

Learning Objectives:

At the end of the session, participants will be able to:

- Describe common interventions used in country programs to improve clients' access to legal information and justice.

Preparation/Materials: None

STEP 1: Large Group Discussion

- **Post PPT slide and explain:** Here are some examples of what's being done in KP programmes:

Slide:

Legal Information/Legal Services

Examples from KP Programs

- Train direct service providers to provide legal information about KPs' rights
- Train peer educators as paralegals
- Third-party reporting system to report violence/human rights violations
- Identify/train allied attorneys
- Workshops with police

1. Ensure that direct service providers involved in the KP continuum of care are knowledgeable of the country's human rights protections and laws that protect KPs.

2. Train peer educators as paralegals to provide legal information and support KPs.
   - In addition to informing KPs about their legal rights, peer educators who are trained as paralegals can provide additional support by being available to accompany a peer to file a police report, give a statement, access a lawyer, and accompany a peer to any court proceedings

3. Establish a third-party reporting system for KPs to report violence and other human rights violations.
   - Alternative reporting options beyond going to the police, which will encourage reporting of violence, discrimination and exploitation, and other human rights violations, should be established. (WHO, 2014)
   - An organization should be identified to receive reports from KPs and mechanisms put in place to accompany KPs to the police station to file a report if this is what the client chooses.
   - The organization who receives third-party report will develop mechanism to receive and compile reports from KPs.

4. Identify and train a pool of allied attorney to provide legal services to KPs

- Particularly when KPs are unlawfully arrested and detained.
- These attorneys can provide services pro-bono or funds can be budgeted to provide stipends to attorneys who provide services to KPs.

5. Training/workshops with police

- Working directly with the police has been a key element of efforts to reduce violence against KPs in some settings.
- These workshops with police officers also build relationships between KPs and the police in order to minimize police harassment, exploitation and violence.
- In some settings, these types of workshops have been jointly led by KPs, police (who are allies) and other community-based organizations. (WHO, UNFPA, UNAIDS, 2013)
- Depending on your context here in [country], whatever strategy is used, it's important that KPs are safe –and that we are not putting them at risk when we involve them in our activities.

- **Emphasize:** IEC/IPC materials that include information about clients' legal rights and how to access support and information about legal services should be visible to clients who visit health facilities and distributed to clients during the provisions of health care services, including outreach services. (developed by country programs)
- **Ask:** Are there any existing materials that inform clients of their legal rights?

Session 4.4.6: Service #6: Follow-Up with Clients

Time: 15 minutes

Learning Objectives:

At the end of the session, participants will be able to:

- Describe the clinical follow-up schedule clients who receive HIV PEP and those who don't

Preparation/Materials: Handout #23: Clinical Post-GBV Follow-up

INTRODUCTION:

- **Explain:** For clients who have experienced violence, the WHO recommendations for follow-up visits vary slightly for clients who are receiving HIV PEP and those who are not.

STEP 1: Large Group Discussion: WHO recommendations

- **Explain:** It's normal for people to feel sad, anxious, and/or angry after experiencing violence.
- **Post PPT slide**, refer to Handout #23, and review follow-up recommendations.

CLIENTS WHO RECEIVED HIV PEP	CLIENTS WHO DID NOT RECEIVE HIV PEP
One-week follow-up visit: • Evaluate post-exposure prophylaxis (side-effects/adherence). • If not supplied at the first visit, provide additional three-week supply of PEP medication. • Check that client has taken full course of any STI medication. • Evaluate for STI, treat as appropriate, and provide advice on voluntary counselling and testing for HIV. • Evaluate mental/emotional status; refer or treat as needed	**Two-week follow-up visit:** • Evaluate for pregnancy and provide counselling. • Check that client has taken full course of any STI medication. • If prophylactic antibiotics were not given, evaluate for STIs, treat as appropriate, provide advice on voluntary HIV counselling/testing. • Evaluate mental/emotional status; refer or treat as needed
Six-week follow-up visit: • Evaluate for pregnancy and provide counselling. • If prophylactic antibiotics were not given, evaluate for STIs, treat as appropriate; provide advice on voluntary counselling and testing for HIV. • Evaluate mental/emotional status; refer or treat as needed.	**Three-month follow-up visit:** • Evaluate for STIs, and treat as appropriate. • Assess pregnancy status, if indicated. • Test for syphilis if prophylaxis was not given. • Provide advice on voluntary counselling and testing for HIV. • Evaluate mental/emotional status; refer or treat as needed
Three-month follow-up visit: • Evaluate for STIs, and treat as appropriate. • Assess pregnancy status, if indicated. • Test for syphilis if prophylaxis was not given. • Provide advice on follow-up voluntary HIV counselling/testing for those who had negative test during first week. • Offer voluntary HIV counselling/testing to clients not tested before. • Evaluate mental/emotional status; refer or treat as needed.	

MODULE 5

RE-CAP AND CLOSING

Time: 20 minutes

This module includes the following sessions:

Session 5.1 Recap/What did we learn?
Session 5.2 Next Steps
Session 5.3 Post-Evaluation Training

Sessions 5.1, 5.2, 5.3: Re-Cap, Next Steps, Post-Training Evaluation

Time: 20 minutes

Preparation/Materials: Printed Post-Training Evaluations

- **RE-CAP:** Use the pre/post training evaluation to guide a large group “ask and answer” session to re-cap key points from the training.
- **Next Steps:** Develop action plans for each of the programmes
- **Post-Test:** Thank everyone for attending the training and administer post-training evaluation.

SOURCES

Many documents were referred to during the development of this training curriculum, including the use and adaptation of various training activities and exercises. The following are the sources used to develop the content of this training curriculum:

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ANNEXES

ANNEX #1: Identifying and Responding to Violence: Training for HCWs/ Direct Service Providers

AGENDA

DAY ONE

MODULE 1: Setting the Stage

Welcome and Introductions	08:00 – 08:15
Pre-Test	08:15 – 08:30
Review Agenda and Training Materials	08:30– 08:45
Group Norms (with activity)	08:45 – 9:15
Brief Background on KP Programme/Rationale for VPR and HIV Integration	09:15 – 09:30
Terminology used in VPR Programming: What's in a name?	09:30 – 09:45

MODULE 2: Building Core Knowledge

Sex, Gender, Gender Identify & Expression, Sexual Orientation	09:45 – 10:45
Break	10:45 – 11:00
Gender Norms, Stigma, Discrimination, and Violence	11:00 – 12:30
Lunch	012:30 – 01:30
Understanding Violence and Links with HIV	01:30 – 03:00
Panel Discussion with KPs	03:00 – 03:30
Human Rights Protections and Laws that are incorrectly used against KPs	03:30 – 4:30
Exploring our own Values	04:30 – 05:00

Wrap-up Day One

DAY TWO

Opening Activity	08:30 – 09:00

MODULE 3: VPR Programming for HCWs/Service Providers

VPR Program Principles for HCWs/Direct Service Providers	09:00 – 10:00
VPR Program Components (supportive structures)	10:00 – 10:30
Break	10:30 – 10:45

DAY TWO contd.

VPR Program Components (continued)	10:45 – 11:45
Minimum Package of VPR Services	11:45 – 12:00

MODULE 4: Identifying and Responding to Violence

Barriers for KPs in Disclosing Violence	09:00 – 10:00
Lunch	10:00 – 10:30
Barriers for KPs in Disclosing Violence (continued)	10:30 – 10:45
Role of HCWs/Direct Service Providers in VPR	10:45 – 11:45
How we Communicate with Clients	11:45 – 12:00

Wrap-up Day Two

DAY THREE

MODULE 4: Identifying and Responding to Violence (continued)

Opening Activity	08:30 – 09:00
Minimum Package of VPR Services	09:00 – 09:15
Service #1: Screen KPs for Violence	09:15 – 10:45
Break	10:45 – 11:00
Service #2: Provide First-Line Support	11:00 – 12:30
Lunch	12:30 – 01:30
Service #2: Provide First-Line Response (continued)	01:30 – 02:00
Service #3: Provide/Refer to Clinical Post-Violence Services	02:00 – 02:30
Service #4: Provide/Refer to Psychosocial Support/Mental Health Services	02:30 – 03:00
Service #5: Provide Legal Information/Refer to Legal Services	03:00 – 03:30
Service #6: Follow-Up with KPs who Disclosed Violence	03:30 – 03:45

MODULE 5: Re-Cap and Closing

Re-Cap: What did we learn?	03:45 – 04:00
Next Steps	04:00 – 04:15
Post-Test and Training Evaluation	04:15 – 04:45

ANNEX #2: Pre-Test

Date: ..... Mother's Date of Birth: .....

Please indicate how strongly you agree or disagree with the following statements:
(Check the box that fits your answer.)

Statement	Strongly Agree	Agree	Disagree	Strongly Disagree
1. I understand the difference between sex and gender.				
2. I can describe how stigma makes people more vulnerable to gender-based violence.				
3. If sex workers are assaulted while engaging in sex work, they are at least somewhat to blame.				
4. People who put themselves in dangerous situations should not complain if they are assaulted.				
5. I am confident in my ability to ask clients about their experiences with violence.				
6. I am confident in my ability to respond to clients who disclose violence.				

7. Briefly describe the difference between sex and gender:

8. How does stigma towards KPs make them more vulnerable to violence?

9. Describe one way violence increases a person's risk of HIV.

10. Describe one way that a person living with HIV is at increased risk of violence.

11. What are two things we can do or say to cause harm to KPs who have experienced violence?

    1.

    2.

12. What are two things we can do or say to support KPs who have experienced violence?

    1.

    2.

13. Scenario: A sex worker tells you that she has been very nervous about walking around her neighborhood. She tells you that she keeps thinking about the attack she experienced a few months ago. She tells you that she doesn't trust anyone to help her. **Provide a statement that reflects and validates her feelings:**

    Reflecting:

    Validating:

14. List the 4 techniques used in Active Listening:

    1.

    2.

    3.

    4.

15. List three of the eight VPR program components (supportive structures) that must be in place before violence screening and response services can be implemented?

    1.

    2.

    3.

ANNEX #3: Post-Test

Date: ..... Mother's Date of Birth: .....

Please indicate how strongly you agree or disagree with the following statements:
(Check the box that fits your answer.)

Statement	Strongly Agree	Agree	Disagree	Strongly Disagree
1. I understand the difference between sex and gender.				
2. I can describe how stigma makespeoplemorevulnerable to gender-based violence.				
3. If sex workers are assaulted while engaging in sex work, they are at least somewhat to blame.				
4. People who put themselves in dangerous situations should not complain if they are assaulted.				
5. I am confident in my ability to ask clients about their experiences with violence.				
6. I am confident in my ability to respond to clients who disclose violence.				

7. Briefly describe the difference between sex and gender:

8. How does stigma towards KPs make them more vulnerable to violence?

9. Describe one way violence increases a person's risk of HIV.

10. Describe one way that a person living with HIV is at increased risk of violence.

11. What are two things we can do or say to cause harm to KPs who have experienced violence?

    1.

    2.

12. What are two things we can do or say to support KPs who have experienced violence?

    1.

    2.

13. Scenario: A sex worker tells you that she has been very nervous about walking around her neighborhood. She tells you that she keeps thinking about the attack she experienced a few months ago. She tells you that she doesn't trust anyone to help her. **Provide a statement that reflects and validates her feelings:**

    Reflecting:

    Validating:

14. List the 4 techniques used in Active Listening:

    1.

    2.

    3.

    4.

15. List three of the eight VPR program components (supportive structures) that must be in place before violence screening and response services can be implemented?

    1.

    2.

    3.

ANNEX #4: Evaluation of Training: KP VPR Training for HCWS/ Direct Service Providers

Date: .....

1. **The content of the training was interesting for me.**
   - ☐ Strongly Agree
   - ☐ Agree
   - ☐ Disagree
   - ☐ Strongly Disagree

2. **The content of the training was comprehensive.**
   - ☐ Strongly Agree
   - ☐ Agree
   - ☐ Disagree
   - ☐ Strongly Disagree

3. **The training was well structured.**
   - ☐ Strongly Agree
   - ☐ Agree
   - ☐ Disagree
   - ☐ Strongly Disagree

4. **The content of the training was useful for my professional career.**
   - ☐ Strongly Agree
   - ☐ Agree
   - ☐ Disagree
   - ☐ Strongly Disagree

5. **The use of lectures and practical exercises were well balanced.**
   - ☐ Strongly Agree
   - ☐ Agree
   - ☐ Disagree
   - ☐ Strongly Disagree

6. **The applied methods of teaching (e.g. small group work, lectures, role plays, practical exercises, group discussion) were suitable for me.**
   - ☐ Strongly Agree
   - ☐ Agree
   - ☐ Disagree
   - ☐ Strongly Disagree

7. **Please provide any other comments or suggestions:**

PARTICIPANT HANDOUTS

HANDOUT #1: Social/Cultural Expectations

WORKSHEET

Social/Cultural Expectations	
Men / Boys	**Women / Girls**

HANDOUT #2: How do gender norms affect us?

Instructions: Break into pairs and discuss the following questions. Write your answers on this handout.

1. How could conforming for gender norms cause problems for both men and women?

2. What happens when someone is perceived as non-conforming to "rules" about gender?

3. How could conforming to gender norms increase both men's and women's risk for HIV?

HANDOUT #3: Case Scenario "David"

Instructions: Read the case scenario and then discuss the questions below.

David is 27 years old. He enjoys his job and is happy with his partner of two years, Jonathan. They have sex only with one another and have both been tested for HIV and other STIs. At work, David does not tell anyone about Jonathan. Often his colleagues ask why he isn't married and try to introduce him to women they know. He always politely declines, but a new co-worker begins to suggest openly that David is gay. Soon David is ostracized at work and becomes depressed. He begins to drink more alcohol and stay out several nights each week. On nights when he has been drinking, he sometimes has sex with men from the bar without using a condom. After a few months, he notices painful anal warts and goes to a health care provider. David tells the provider about his sexual history and the provider yells at David, saying that he doesn't understand what would make David want to be a woman instead of a man.

1. What gender norms is David perceived as not conforming to?

2. How did the community respond to David when they perceived him as not conforming to traditional (rigid) gender norms?

3. How did the community's response affect David's health?

4. How did the health care worker's response affect David?

5. How could the provider responded in a way that could have improved David's health?

HANDOUT #4: Case Scenario "Diana"

Instructions: Read the case scenario and discuss the questions below. Write your answers on this handout.

Diana is 23-year old woman and university student. She was not able to attend university when she was younger because her parents could only afford to support one child and paid her brother's fees instead. Diana had a baby at age 20 and worked for a time in various shops. The pay was poor and she could not afford to care for her daughter and pay her own school fees. A friend told her that she could earn more money selling sex. Diana began to sell sex and was able to start attending school. She used condoms whenever she could, but sometimes clients threatened violence if she insisted on condom use. After an experience where she was forced to have sex without a condom she sought emergency contraception. Diana wanted to go to a clinic that she knew was sex worker-friendly but she did not have anyone who could watch her daughter for the full afternoon it would take to get there and back. Instead she went to a pharmacy close to her home. There she was recognized as a sex worker and the pharmacist scolded her in front of the other customers. He refused to give her emergency contraception.

1. What parts of her experience are common to many women, including those who do not sell sex?

2. What gender norms did the health care provider feel Diana was not conforming to?

3. What did the provider do that could negatively affect Diana's health?

4. What could the provider do to improve Diana's health?

HANDOUT #5: Small Group Exercise Case Study: Nicole

Instructions: Read the case study below and then answer the questions that follow

Nicole is a 22-year-old transgender woman. She was born male but realized at a very early age that she felt much comfortable as a girl than as a boy. Nicole hid this from her parents and spent much of her childhood feeling lonely and sad. As soon as she left home she began to dress as a woman, grew her hair long, started to take hormones and felt much more like herself. Nicole tried to get several jobs but her identification said "male" and did not match her gender expression or her current name and no one was willing to hire her. She began to sell sex in order to pay for food and housing. One night, a police officer saw Nicole when she was selling sex. He begins to harass her and forced her to have sex with him or to be arrested. After having sex with her, he beat her and said that she deserved to be treated this way. Nicole needed several stiches and went to a clinic the next day. The receptionist asked Nicole for her ID and used her previous name when calling her to see the doctor. Nicole was embarrassed but decided to get treatment. The doctor referred to Nicole as "he" and used her previous name even when she corrected him. The doctor told Nicole to stop complaining that others can't understand her "unnatural lifestyle."

1. What are some of physical health consequences that violence has or could have for Nicole?

2. What are some of the emotional/mental health consequences that violence has or could have for Nicole?

3. What are some other potential consequences?

HANDOUT #6: Small Group Exercise Case Study: Sylvia

Instructions: Read the case study below and then answer the questions that follow

Sylvia lives with her husband, Peter. When they got married, Peter paid dowry/bride price to her family and, from the beginning, expected Sylvia to work hard to make up for it. He would often tell her that he had paid a good price for her so she better work and be a good wife, or else he would send her back and demand the money back from her family. Sylvia worked from early in the morning until late in the evening selling vegetables in the market. When she got home, she would be tired, but she had to cook dinner, fetch water, wash clothes, and look after her young children as well. She was having difficulty managing all of her work.

Peter would often take the money that Sylvia earned at the market and go out in the evening. He would not come home until late, and often, he would beat her in front of the children. Sometimes he would make her sleep outside to punish her if the food was cold or not cooked to his liking and to show the neighbors that he was the boss in his house. Because Peter took all the family income, there was not enough money to feed her children. She began to sell sex to earn enough money to provide for her family. She did this without her husband's knowledge. Sometimes, her clients would force her to have sex without a condom, even though she always insisted. She thought about going to a clinic to get tested for HIV, but decided not to go because she was afraid of the results and what her husband might do if the results were positive.

1. What are some of physical health consequences that violence has or could have for Sylvia?

2. What are some of the emotional/mental health consequences that violence has or could have for Sylvia?

3. What are some other potential consequences?

HANDOUT #7: "Where do we stand?"

1. Did the family who raised you discuss specific beliefs about KPs, including sex workers, MSM, trans people, or people who inject drugs? Describe.

2. Did you experience any personal or family events that changed your beliefs or values about KPs? Describe.

3. Are there any differences or similarities between your family's values and your personal values and beliefs related to KPs? Describe.

4. Which social group has had the greatest influence on your current values related to KPs? Racial/ Ethnic group? Family who raised you? Friends? Religious leaders? Activist community?

5. How similar or different are your current spiritual or religious beliefs compared to those of your family?

6. How do your religious or spiritual beliefs influence your decisions?

7. Have you faced a situation where your personal beliefs and values conflict with the values and beliefs of your religion? If yes, how do you resolve these internal conflicts?

HANDOUT #8: VPR Programming for Health Care Workers/Direct Service Providers

Program Principles

1. Do no harm
2. Promote the full protection of KPs' (KPs) human rights
3. Use a client-centered approach to program design & implementation
4. Respect the right of KPs' right to self-determination
5. Ensure privacy, confidentiality, and informed consent

Program Components (support structures)

1. Written SOPs
2. Set of core VPR messages
3. Referral network established and utilized
4. Sensitizes & trained staff/providers
5. IEC materials developed and disseminated
6. Safe and secure spaces
7. Mechanisms in place to ensure provider self-care, support, personal safety
8. Systems for monitoring and evaluating programs

Minimum Package of VPR Services

1. Identify violence (via screening) among KPs
2. Provide first-line support[1]
3. Provide/refer to clinical post-violence services[2]
4. Provide/refer to psychosocial support/mental health services[3]
5. Provide legal information/refer to legal services[4]
6. Follow-up with KPs who disclosed violence

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[1] **First line support includes:** Active listening, the provision of key messages and information on rights, safety planning, and referrals to other services.

[2] **Health services** that should be accessible via either referral or within KP Programmes are: treatment of injuries, HIV testing, PEP, emergency contraception, STI testing and treatment, rape kits/forensic exam, Hepatitis B screening and treatment if needed.

[3] **Psychosocial support** that should be accessible via either referral or within KP Programmes are: support groups, mental health assessment, and other psychosocial support (short and long-term).

[4] **Legal services** that should be accessible via either referral or within KP programmes are: documentation of an incident of violence and support to interact with the justice system (i.e., access to a lawyer or paralegal)

HANDOUT #9: Five Fundamental Principles VPR Programming (for HCWs/direct service providers)

Principle #1:

Do no harm

Adherence to ethical codes of conduct is particularly relevant when working with client who have experienced violence, including:

- The right of clients to make decisions on their own behalf.
- All steps taken in providing services are based on the informed consent of the client.
- The duty or obligation to act in the best interests of the client.
- The duty or obligation to avoid harm to the client.
- Providing universal access to services without judgment or negative repercussions for the client.

Since key population often face stigma, discrimination, and violence and abuse by the same professionals who are charged with protecting and providing services to them (e.g. police officers, health care workers), stigma and discrimination against KPs must be proactively addressed in HIV prevention, care, and treatment programs so that these populations can access these important services. Programs should:

- Conduct ongoing training with all staff and direct service providers on the rights and unique needs of KPs;
- Do more than train. Challenge stakeholders on issues of stigma and discrimination; and
- Address barriers for KPs in accessing health care services, including post-exposure prophylaxis for HIV.

Principle #2:

Promote the full protection of KPs' human rights

This means embracing the belief that people have a right to live free of violence and the right to information, respect and dignity. This includes the right to:

- Non-discrimination;
- Security of person and privacy;
- Recognition and equality before the law;
- Due process of law and the highest attainable standard of health;
- Freedom from arbitrary arrest and detention, and from cruel and inhumane treatment;
- Protection from violence.

KPs have a right to have their voices heard. Using a human rights-based approach also means establishing meaningful way to include KPs, particularly those who have experienced violence, in all aspects of program planning, implementation, and evaluation –including direct services, community mobilization and outreach, and system-level advocacy. Engaging KPs in a participatory process can facilitate access to and acceptance and uptake of important health and other services. Their involvement can help confront stigma and discrimination. It allows programs to build on the experiences of KPs and tailor their services to the local context.

Programs should:

- Provide training and ongoing support to empower KPs to participate in organizational and community processes
- Create opportunities for participation, such as being trained as peer educators, advocates, and health promoters
- Involve KPs in the sensitization and training of staff and providers
- Establish ways to obtain ongoing input and feedback from KPs

Principle #3:

Use a client-centered approach to program design and implementation

The fundamental premise of a client-centered approach is to give power and control back to clients. A client-centered approach encompasses respect for clients' rights, needs, and wishes. This principle is fundamental to VPR services, especially given the stigma and risk of future violence associated with disclosures of violence for KPs. To avoid doing further harm, program managers, direct service providers, and staff involved in the continuum of care need to ensure clients have access to information about their rights and options and respect clients' rights to choose their own course of action in dealing with the violence in their lives. Direct service providers can apply a client-centered approach by recognizing that:

- Each person is unique
- Each person reacts differently to violence and will have different needs as a result
- Each person has different strengths, resources, and coping mechanisms
- Each person has the right to decide who should know about what has happened to them and what should happen next.

Principle #4:

Respect the right of KPs' right to self-determination

In line with a client-centered approach, clients have the right to make informed choices about their lives, which may involve not reporting or seeking legal services for violence, not seeking support services, or deciding to stay in an abusive relationship. It should always be the decision of the client—not the provider—to report violence and/or to pursue legal action against a perpetrator. A provider's role is to offer information about clients' rights and available services so clients can weigh this information
against the possible risks of retaliation by the abuser, further stigmatization and abuse, and/or loss of basic needs (e.g., shelter, food, financial support).

Principle #5:

Ensure privacy, confidentiality, and informed consent

Privacy and confidentiality are essential for victims' safety in any health care setting. Providers can put the client's safety at risk if they share sensitive information with partners, family members, or friends without the client's consent. This includes sharing client information with other service providers, even in one's own organization/facility, who are not involved in the client's care without the client's consent. A breach of confidentiality about pregnancy, rape, contraception, HIV status, or a history of sexual abuse can put clients at risk of additional emotional, physical, or sexual violence. In addition, clients need privacy in order to disclose their experiences with violence to providers without fear of retaliation from an abuser.

To protect confidentiality and privacy, direct service providers need adequate infrastructure, including private and safe spaces for clients, as well as clear policies outlining when and where providers are allowed to screen for and respond to violence and discuss other sensitive topics. Direct service providers and other staff must not speak with clients about violence unless the client is alone and there is a private space for the client and provider to talk. Providers must not report violence to law enforcement or anyone else without the client's informed and voluntary consent. The minimum procedures that should be put in place to protect clients' privacy and confidentiality include:

- Designate a private consultation space.
- When screening for violence and responding to disclosures, providers must speak with clients alone, with the exception of infants, so that no one can overhear, including anyone accompanying the client or people in nearby areas.
- Programs must obtain written informed consent from the client to share information with other providers in the process of making a referral or otherwise.
- Programs must implement secure measures to keep client records and information confidential, and develop policies for sharing information.
- Provide ongoing training for staff on protecting clients' privacy and confidentiality, including obtaining informed consent, ensuring that victims are informed of their options and their rights.

HANDOUT #10: Small Group Exercise Case Study: Grace

Instructions: Read the case study below. Refer to Handout #9, as needed, and answer the questions on the following page.

Background Information: Grace is a 23-year-old trans woman who was born male. Grace began to realize at as a teen that she felt more comfortable as a girl than a boy. She began to express herself in more feminine ways, even though she was teased and harassed by classmates, teachers, family, and community members. When Grace finished school, she tried to find a job, but she was discriminated against because of her gender identity and no one would hire her. She began to sell sex in order to pay for food and housing.

Current Situation: One night, she was harassed by a police officer who performed a body search on her. When the officer found condoms in Grace's bag, he threatened to arrest her for being a sex worker unless she paid him money or had sex with him. Grace was afraid of what might happen to her at the police station and she didn't have money to pay the officer. She agreed to have sex with the officer and although she insisted he wear a condom, he refused. When Grace refused to have sex without a condom, he punched her in the face and forced her to have sex without a condom.

The next day, Grace decided to go to a clinic because she was worried about HIV and other STIs. The receptionist greeted her and asked her why she came to the clinic. Grace was embarrassed to answer because others were standing at the reception desk. Grace told the receptionist she wanted to see a doctor. The receptionist told Grace she needed to know the reason for her visit before she could see the doctor. She asked Grace what happened to her face and why she had a bruised eye. Grace was embarrassed and told her she got into a fight with her sister. When she showed the receptionist her identification card, which listed her as "male," the receptionist rolled her eyes and told Grace that there were people there with more serious issues than her, and she would have to wait until the others were seen by the doctor.

A few hours later, a nurse took Grace to an examination room. When asked why she came to the clinic, Grace told the nurse what happened with the police officer. The nurse told Grace, "The officer should not have done that to you, but you put yourself in a risky situation. Plus, your lifestyle is illegal. You are lucky you are not in jail right now." The nurse told Grace they would test her for HIV and other STIs, but she should consider changing her lifestyle to avoid being assaulted in the future. The nurse left the room. When she returned, she was accompanied by a police officer. The nurse told Grace that she brought the police officer in so she could report to him what happened. Grace told the officer she did not want to press charges and that she just wanted to get tested. After being pressured by the nurse and the officer, she provided them with details about the assault and the perpetrating officer.

Discuss the five principles for VPR programming and describe how they were applied or not applied by the direct service providers in this case study: *(Refer to Handout #9, as needed, for detailed information about each principle)*

1. **Principle #1: Principle #4: Do no harm**

2. **Principle #2: Promote the full protection of KPs' human rights**

3. **Principle #3: Use a client-centered approach to program design and implementation**

4. **Principle #4: Respect the right of KPs' right to self-determination**

5. **Principle #5: Ensure privacy, confidentiality, and informed consent**

HANDOUT #11: Sample Template: VPR Referral Network For (insert geographic area)

Use the following template to fill in details of the referral network for your geographic area. This referral netwrok must be specific to one geographic area. If VPR SOPs cover more than one geographic area, a referral netwrok/pathway must be developed for each area.

CLIENT DISCLOSES VIOLENCE

First Responder Provides Immediate Support (first-line support)
The provider ensures privacy and confidentiality, delivers core messages, and provides emotional support and information about available resources. If KP has been sexually assaulted, explain clinical post-violence services available in your community (e.g., HIV testing, PEP withing 3 days after an assault, emergency contraception within 5 days after an assault, STI screening and treatment, Hepatitis B screening/vaccination). The provider should offer to accompany the victim to any referral site or arrange for the victim to be accompanied to any referral site that the victim chooses.

↓ ↓ ↓ ↓

Medical/Health *(injuries and post-violence services)*	**Mental Health/Social Support** *(screenings for depression, anxiety, PTSD, self-harm/suicide; individual counseling; support groups; shelter)*	**Police** *(file police report; protection orders)*	**Legal Services** *(legal information; assistance with arrest/detention; criminal and civil legal services, including prosecutors)*
[Name of Organization/ Facility] Hours: Focal Point: Phone: Email:	**[Name of Organization/ Facility]** Hours: Focal Point: Phone: Email:	**[Name of Station/Unit]** Hours: Focal Point: Phone: Email:	**[Name of Agency/ Attorney]** Hours: Focal Point: Phone: Email:
[Name of Organization/ Facility] Hours: Focal Point: Phone: Email:	**[Name of Organization/ Facility]** Hours: Focal Point: Phone: Email:	**[Name of Station/Unit]** Hours: Focal Point: Phone: Email:	**[Name of Agency/ Attorney]** Hours: Focal Point: Phone: Email:
[Name of Organization/ Facility] Hours: Focal Point: Phone: Email:	**[Name of Organization/ Facility]** Hours: Focal Point: Phone: Email:	**[Name of Station/Unit]** Hours: Focal Point: Phone: Email:	**[Name of Agency/ Attorney]** Hours: Focal Point: Phone: Email:
[Name of Organization/ Facility] Hours: Focal Point: Phone: Email:	**[Name of Organization/ Facility]** Hours: Focal Point: Phone: Email:	**[Name of Station/Unit]** Hours: Focal Point: Phone: Email:	**[Name of Agency/ Attorney]** Hours: Focal Point: Phone: Email:

HANDOUT #12: Core VPR Messages

CORE VPR MESSAGES	CRITERIA: Why is this Message Important?
Everyone has the right to a life free from violence and abuse. These are basic human rights.	The national programme uses a human rights framework to view violence because everyone has a basic human right to live free violence and abuse.
When we talk about violence, we include physical, emotional, sexual, and economic abuse, extortion, and exploitation committed by any person.	The national programme has a comprehensive view of violence because all of these types of violence are linked to negative health consequences for KPs, including HIV.
Violence and abuse have negative health consequences, and can increase the risk of HIV infection and individuals' ability to seek and receive important HIV care and treatment.	The national programme wants to increase clients' and others' awareness of the harmful effects of violence on health, especially the effects related to HIV to let clients know why we are talking to them about an issue they may not see as health- related.
Many people experience violence and abuse.	Victims of violence often become isolated and experience extreme forms of stigma and discrimination by community and family members. The national programme wants to decrease isolation and stigma among clients.
People are often blamed for the violence and abuse committed against them, but it is never their fault.	Victims are often blamed for violence. The national programme wants to increase clients' understanding that they are never to blame for violence and to decrease stigma surrounding violence.
<u>If client is 18+ years old:</u> ***What someone shares about their experiences with violence and abuse is confidential. We want clients to feel comfortable and to trust that they can talk to us about any abuse they may be experiencing or experienced in the past. We will respect their privacy and keep what they tell us confidential.***	The national programme wants to protect clients' privacy and safety, and reassure clients that their information will be kept confidential. This will encourage clients to share their experiences with violence with a direct service provider.
We are here to support any clients who have experienced violence and abuse and let them know about available resources.	The national programme wants to let clients know it's okay to talk about their experiences with violence. If there are community resources available, we want to increase clients' knowledge of those resources.

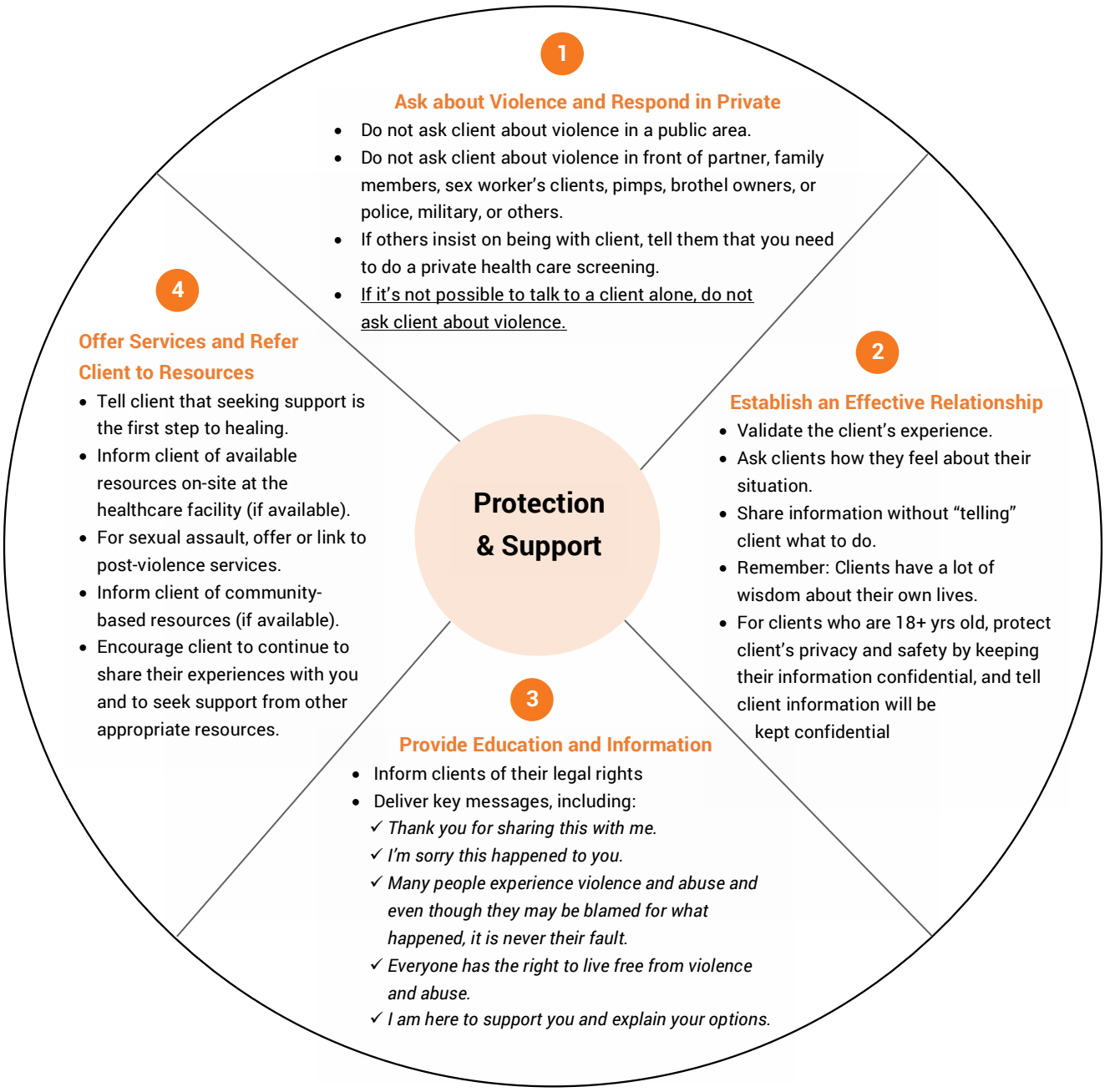
HANDOUT #13: Provider Power and Control Wheel

Responding to Violence Among Key Populations: Are we part of the problem?

Adapted from the Domestic Abuse Intervention Project, Duluth, Minnesota, USA

HANDOUT #14: Provider Protection and Support Wheel

Responding to Violence Among Key Populations: Are we part of the solution?



Adapted from the Domestic Abuse Intervention Project, Duluth, Minnesota, USA

HANDOUT #15: Screening for Violence by DICs, Program Sites/Health Facilities

Client voluntarily discloses violence
(Violence is either the reason the client reaches out for help or the client discloses violence before the being screened)

...or...

Client seeks HIV/other services
(Peer reaches out for other services/Violence is not the presenting issue)

Step 1: Screen Client for Violence

- *Many people tell me they have been emotionally, physically, or sexually harmed, including forced to have sex without a condom.*
- *Some have been threatened, robbed, denied salary, made to pay money to avoid arrest, or denied services.*
- *Since violence and abuse can cause health problems, I'd like to ask you about your experiences.*
- ***IN THE PAST 3 MONTHS HAVE YOU EXPERIENCED ANY OF THESE TYPES OF VIOLENCE OR ABUSE?*** **If yes, ask:**
  - ***What types of violence/abuse?***
  - ***When was the most recent time this happened?***
  - ***Who did this to you?***

YES

Step 2: Provide First-Line Support and Deliver Core Messages

- *Thank you for sharing this with me.*
- *I'm sorry this happened to you.*
- *Many people experience violence and abuse and even though they may be blamed for what happened, it is never their fault.*
- *Everyone has the right to live free from violence and abuse.*
- *I am here to support you and explain your options.*

Step 3: Treat injuries/accompany client to health facility for Tx

Step 4: Provide/Refer to Clinical Post-Violence Services

- Medical history/examination
- Rapid HIV testing
- HIV PEP (w/in 3 days)
- Emergency contraception (w/in 5 days)
- Screening/Tx for other STIs
- Tetanus booster/vaccination
- Hepatitis B testing & vaccination

Step 5: Safety Planning (See Box "A")

Step 6: Explore strengths, support systems, next steps
(Arrange time to follow-up with client)

Step 7: Provide Information and Resources (See Box "B")
Arrange for Accompaniment to Referral Sites
I'd like to share additional information with you about available services. Is that okay? (Share resources from referral network, including information about making a police report and medical, legal, and mental health services -- and provide or arrange for accompaniment to resources. If client lives with the abuser or taking printed materials might put client at risk, offer caution about taking printed materials home.)

Step 8: Follow-Up with Client

Follow-up with client about referrals made, including psychosocial and other services. Follow clinical follow-up schedule below:

Clients who received HIV PEP	Clients who did not receive HIV PEP
One-week follow-up	Two-week follow-up
Six-week follow-up	Three-month follow-up
Three-month follow-up	

**Refer to WHO guidance and national clinical protocol.*

NO

Deliver core messages and share resources

- *If you experience violence or any type of abuse in the future, I am here to support you.*
- *Many people have these experiences and even though they may be blamed for what happened, it is never their fault.*
- *Everyone has the right to live free from violence and abuse.*
- *If sexual violence occurs, it is important to seek help quickly. There are medical options that can be used within 3 days after the assault that can reduce risk of HIV infection and pregnancy.*
- *Because of the health problems caused by violence and abuse, I'd like to share some resources with you in case you ever need them or know someone who does. Is that okay?"*

Box "B" -- Provide Resources/Referral Network

- Psychosocial Support
- Legal Services/Lawyers
- Health/Medical Services/DIC
- Police
- Peer Educators/Navigators
- Advocacy Groups

Box "A" –Safety Planning/Safety Strategies

Safety strategies depend on the individual's situation, but could include: disclosing HIV status to partner or family members; arranging emergency shelter; staying with a friend; walking in pairs or groups; trusting instincts about others; avoiding secluded locations; carrying emergency phone numbers. For sex workers, additional safety tips could include negotiating payment upfront; screening clients and work locations; working in own space or well-known locations; avoiding drunk clients; writing down client's car registration number, color and make; avoiding getting into cars with more than one person in them;

HANDOUT #16: JOB AID: Identifying and Responding to Violence (Long Form)

I.D./UIC: ..... Age: ..... Sex: .....

KP: ☐ SW ☐ MSM ☐ TG ☐ PWID

Provider Name/ID: ..... Date: .....

INITIAL CONTACT (first time meeting a client)

- *Many people tell me they have been emotionally, physically, or sexually harmed, including forced to have sex without a condom.*
- *Some have been threatened, robbed, denied money that is due to them, made to pay money to avoid arrest, or denied services.*
- *Since violence and abuse can cause health problems, I'd like to ask you about your experiences.*
- ***In the past three months have you experienced any of these types of violence or abuse?***

FOLLOW-UP CONTACTS

- *Last time, I asked you if you had experienced violence or other abuse.*
- ***Have you experienced violence or abuse since we met?***

YES = EXPERIENCED VIOLENCE/ABUSE
[Prompt: *What types of violence and abuse have you experienced in the last 3 months?*]

Check all that Apply	When was the most recent time this happened?	Who did this to you?
☐ **EMOTIONAL** (threatened, verbally abused, humiliated, made to feel afraid)	☐ Past 24 hours ☐ Past week ☐ Past month ☐ Past 3 months	☐ Non-paying partner/ ex-partner ☐ Paying client ☐ Police ☐ Military ☐ Other:
☐ **ECONOMIC** (not being paid money due to you, being robbed, blackmailed, or forced to pay money to avoid arrest)	☐ Past 24 hours ☐ Past week ☐ Past month ☐ Past 3 months	☐ Non-paying partner/ ex-partner ☐ Paying client ☐ Police ☐ Military ☐ Other:

YES = EXPERIENCED VIOLENCE/ABUSE
[Prompt: *What types of violence and abuse have you experienced in the last 3 months?*]

Check all that Apply	When was the most recent time this happened?	Who did this to you?
☐ **PHYSICAL** (hit, punched, kicked, slapped, choked, cut, or otherwise physically hurt)	☐ Past 24 hours ☐ Past week ☐ Past month ☐ Past 3 months **Do you have injuries from this assault?** ☐ No ☐ Yes [**Injuries:** Connect to treatment (Tx) of injuries. Go to "Guidance" to deliver first-line support. Ask about sexual violence/other rights violations when appropriate.]	☐ Non-paying partner/ ex-partner ☐ Paying client ☐ Police ☐ Military ☐ Other:
☐ **SEXUAL** (forced to have sex or do something sexual you didn't want to do such as have sex without a condom)	☐ **Past 24 hours** ☐ **Past 3 days** ☐ **Past 5 days** ☐ Past month ☐ Past 3 months **Do you have injuries from this assault?** ☐ No ☐ Yes [**Injuries:** Offer link to Tx of injuries. Share medical options below and then go to GUIDANCE to deliver first-line support. Ask about other rights violations as appropriate.]	☐ Non-paying partner/ ex-partner ☐ Paying client ☐ Police ☐ Military ☐ Other:

FOR ALL CLIENTS WHO HAVE EXPERIENCED SEXUAL VIOLENCE:
I'd like to share information with you about medical options after sexual violence. Some services are important only for oral, vaginal, or anal penetration. A health provider can help you decide what options are best for you.

- Rapid HIV testing (regardless of when assault happened)
- **HIV PEP (w/in 3 days of assault and if HIV test is negative)**
- **Emergency contraception (EC) (w/in 5 days)**
- Screening/Tx for other STIs (any time after assault)
- Hepatitis B testing/vaccination & Tetanus vaccination (if appropriate based on national guidelines)

YES = EXPERIENCED VIOLENCE/ABUSE
[Prompt: *What types of violence and abuse have you experienced in the last 3 months?*]

Check all that Apply	When was the most recent time this happened?	Who did this to you?
☐ **OTHER RIGHTS VIOLATIONS** (denied services, arrested, detained, condoms taken away)	☐ Past 24 hours ☐ Past week ☐ Past month ☐ Past 3 months ☐ Arrested during sex work ☐ Denied health care ☐ Condoms taken away	☐ Non-paying partner/ ex-partner ☐ Paying client ☐ Police ☐ Military ☐ Other:

NO VIOLENCE/ABUSE

- *If you experience violence or abuse in the future or recall an incident, I am here to support you.*
- *Many people have these experiences and even though they may be blamed for what happened, it is never their fault.*
- *Everyone has the right to live free from violence.*
- *If sexual violence occurs, there are medical options to consider within 3 days after the assault that can reduce risk of HIV infection and pregnancy.*
- *I'd like to share resources in case you ever need them or know someone who does. Is that okay?* ***[SHARE INFO ABOUT HEALTH, PSYCHOSOCIAL, AND LEGAL SERVICES]***

GUIDANCE FOR FIRST-LINE SUPPORT

DELIVER MESSAGES:

1. *Thank you for sharing this with me. I'm sorry this happened to you.*
2. *Many people experience violence and abuse and even though they may be blamed for what happened, it is never their fault.*
3. *Everyone has the right to live free from violence and abuse.*
4. *I am here to support you and explain your options.. Is that okay?*

SAFETY PLANNING: *I want to check with you about your safety. Do you have concerns about your safety?* [If client does not feel safe, ask:]

- *Is there anywhere that you feel safe? Is there someone that you feel safe with? Are there others that you can talk to about how to stay safe?*
- *What strategies have you used in the past to stay safe?I am here to support you and explain your options.. Is that okay?*

Explore safety strategies:
Note: Safety strategies depend on the individual's situation, personal strengths, resources, and social networks, but could include: exploring safe ways to disclose HIV status to partner/

GUIDANCE FOR FIRST-LINE SUPPORT

family members; identifying an emergency shelter; staying with a friend; walking in pairs or groups; avoiding secluded locations; carrying emergency phone numbers.

For sex workers, strategies include: negotiating payment upfront; screening clients/work locations; working in own space or familiar locations; avoiding drunk clients; writing down client's car registration number, color and make; avoiding getting into cars with more than one person in them.

EXPLORE NEXT STEPS: *Sometimes it's helpful to think about what support systems we have in place to help us when we have difficult times. I am also here to support you.* [Explore next steps, existing strengths and support networks. Example questions to ask are listed below:]

- *"What has helped you cope with difficult situations in the past?"*
- *"What kinds of activities help you when you're feeling anxious or tense?" "How could what has worked in the past be helpful now?"*
- *"When you're not feeling well, who do you like to be with?" "Who has helped you in the past? Could they be helpful now?"*
- *"Are there people who you trust that you could talk to about this or other difficult things in your life?"*

ASK: Is it okay if I follow up with you tomorrow or some other time soon to see how you're doing? How can I get in touch with you?

SHARE RESOURCES AND MAKE REFERRALS: [Share information on legal rights and available services; make referrals and offer to accompany the person to seek services. If person lives with the abuser or taking printed materials might put person at risk, caution about taking printed materials home.]

SERVICES DELIVERED/REFERRALS MADE

SERVICES DELIVERED BY PERSON COMPLETING THIS FORM:

First-line support: ☐ Delivered core messages ☐ Discussed safety ☐ Explored next steps ☐ Arranged for follow-up ☐ Shared resources on rights and services

Clinical post-violence services: ☐ Physical exam ☐ Forensic exam ☐ Treated injuries ☐ PEP ☐ EC ☐ STI screen/Tx ☐ Hep B Vac ☐ Tetanus ☐ HIV Test

Psychosocial support: ☐ Mental health screening (depression, anxiety, suicide) ☐ Counseling ☐ Other: .....

Accompanied person to: .....

REFERRALS MADE BY PERSON COMPLETING THIS FORM:

Clinical post-violence services at: ..... for

☐ Tx/injuries ☐ PEP ☐ EC ☐ STI screen/Tx ☐ Hep B Vac ☐ Tetanus ☐ HIV Test ☐ HIV Care

☐ Child protection services for child(ren) of client at: .....

☐ Psychosocial support at: .....

☐ Legal services (attorney/legal advocate) at: .....

☐ Police (specify location): .....

☐ Other Referrals: .....

COMMENTS:

HANDOUT #17: First-Line Support

I. Use Active Listening Skills
II. Deliver Core Messages (Supportive Statements)
III. Ask about Safety and Explore Safety Strategies
IV. Explore Next Steps with Client
V. Provide Information and Make Referrals to Available Resources
VI. Follow-up with Client

I. Use Active Listening Skills (4 skills)

1. **Attentive Listening:** The most important thing to do is be a good listener. Much of being a good listener is demonstrated through body language, being comfortable with silence, and not rushing the person.
   - Lean forward
   - Maintain good eye contact
   - Nod your head to let the person know you hear them
   - Be comfortable with silence and pauses

There are also things we can ***say*** that show we are being good listeners (Skills 2 through 5):

2. **Reflecting:** Use statements that reflect back what the person is saying to you. This lets the person know you're listening. It also gives them an opportunity to clarify how they feel:
   - *So, it sounds like...*
   - *What I hear you saying...*
   - *I get the sense that...*
   - *You appear to be feeling...*

Avoid statements such as:
- *"I know" or "I understand"*
- Labeling an experience: *"You were raped."*

3. **Validating:** Use statements that let the person know that what they are feeling or experiencing is okay or normal.
   - *"It makes sense that you feel that way."*
   - *"It's understandable that you feel that way after what happened."*
   - *"Many people feel this way after experiencing this."*

4. **Inquiring/Clarifying:** Use open-ended questions/statements to clarify information or obtain more information.
   - *"What would you like to share?"*
   - *"Tell me a little about how you've been feeling."*
   - *"I'm not sure if I fully understand what you mean. Could you tell me a little more?"*

II. Deliver Core Messages (Supportive Statements)

1. **Deliver core messages and supportive statements that convey:**
   - That you appreciate them sharing their experiences with you.
   - That you believe them.
   - That what happened wasn't their fault.
   - That their experience has happened to other people and they are not alone.
   - That their feelings are normal.
   - That they have the right to live without threats, violence, and abuse.
   - That it's safe for them to talk to you about her experience.
   - That you will support them and the choices they make.

Supportive Statements to Help Clients Cope with Specific Feelings (WHO, 2014b)

Feeling	Some ways to respond
Hopelessness	*"Many people manage to improve their situation. Over time, most people feel hopeful again."*
Despair	Focus on the person's strengths and how they have been able to handle a past dangerous or difficult situation. For example: *"You showed a lot of courage by..."* *"By the way you handled that situation, you showed determination and strength."* *"With all the obstacles you have right now, it's impressive that you've been able to stay strong."*
Powerlessness	*"You have some choices and options today in how to proceed."*
Flashbacks	*"These are common and often become less frequent or disappear over time."*
Denial	*"I'm taking what you have told me seriously. I will be here if you need help in the future."*
Guilt/self-blame	*"You are not to blame for what happened to you. You are not responsible for the abuser's behavior."*
Shame	*"There is no loss of honor in what happened. You are a valuable person."*
Fear	Emphasize, *"You are in a safe place now. We can talk about how to keep you safe."*
Numbness	*"This is a common reaction to difficult events. You will feel again. For most people, this changes over time."*
Mood swings	*"Mood swings are common and should ease with the healing process."*
Anger at abuser	*"It makes sense that you are angry at this person after what they did to you."*
Anxiety	*"This is common, but we can discuss ways to help you feel less anxious."*
Helplessness	*"I am here to support you."*

2. **DO NOT...**
   - **Blame the client**
   - *"You put yourself at risk."*
   - **Say anything that judges what the client has done or will do**
   - *"You should feel lucky that you weren't more injured."*
   - *"You shouldn't feel this way."*
   - **Question the client's story (doubting the client) or interrogate the client**
   - *"What I don't understand is why he would have attacked you?"*
   - **Say anything that minimizes how the client feels**
   - *"Everyone has bad days. You'll get over it."*
   - **Lecture, command, or advise**
   - *"What you need to do is...."*
   - *"You have to stop thinking about what happened."*
   - *"You need to make a plan to avoid this happening again."*
   - **Ever recommend that they change their profession, sexual orientation, or gender identity to avoid violence**
   - *"You need to leave sex work. It's just a violent profession."*
   - *"If you stopped being so open about who you are, you would be safer."*

III. Ask about Safety and Explore Safety Strategies

1. **Your questions can help assess current safety and identify opportunities to increase safety.** ***Do you have concerns about your safety?*** If client does not feel safe, ask:
   - Is there anywhere that you feel safe?
   - Is there someone that you feel safe with?
   - Are there others in your community that you can talk to about how to stay safe?
   - What strategies have you used in the past to stay safe?

IV. Explore Next Steps

1. **Help the person identify and use their existing strengths:** Use your questions to help clients recognize their strengths and existing coping mechanisms:
   - *"What has helped you cope with difficult situations in the past?"*
   - *"What kinds of activities help you when you're feeling anxious or tense?"*
   - *"How could what has worked in the past be helpful now?"*

2. **Help the person explore existing support networks:** Use our questions to help clients recognize their existing support networks: *(Even if the client does not wish to share their experience with others, spending time with people they trust and enjoy is important.)*
   - *"When you're not feeling well, who do you like to be with?"*
   - *"Who has helped you in the past? Could they be helpful now?"*
   - *"Are there people who you trust that you could talk to about this?"*

Ask: Is it okay if I follow-up with you tomorrow or some other time soon to see how you're doing? How can I get in touch with you?

V. Provide Information and Make Referrals to Available Resources

- Provide printed information about rights and available services; provide caution about taking printed materials home if they live with an abuser.
- Some clients have needs that are beyond what can be provided during first-line response.
- Talk to the client about their options.
- Know specific information about referral points:
  - Name of focal point at referral sites
  - Hours of operation
  - Services available at the referral site
- Offer to go with the person (or send someone with the person) to referral site.
- Do not pressure anyone to seek additional services.
- Track referrals to ensure completion, satisfaction.

VI. Follow-up

It is important to follow-up with clients who previously disclosed violence. This is an opportunity for you to identify any barriers for the client in accessing any referrals that were made and assist the client in following through with referrals.

HANDOUT #18: Active Listening Skills Worksheet (reflecting and validating)

Instructions: Review the following client statements and write down one reflecting statement and one validating statement for each client statement:

Client Statement: *Ever since the assault, I don't want to go outside.*

Reflecting Statement:

Validating Statement:

Client Statement: *I've thought about going to the Doctor, but I don't want to go through that?*

Reflecting Statement:

Validating Statement:

HANDOUT #19: Clinical Post-Violence Services

Although clinical protocols will vary among country programs, the clinical services listed in the table below are recommended by the WHO, as well as other international global health organizations. (PEPFAR, 2013; WHO, 2013; WHO, 2014; WHO, 2013) To adequately capture the provision of these services, logs and monitoring forms will need to be used wherever the services are offered. These forms will need to track both the outcome of the initial assessment and the provision of referrals or services.

	Clinical Post-Violence Services	Sexual Violence (Post-Rape)	Violence (Non-Sexual)
1.	Evaluation and treatment of injuries. (History taking and forensic exam)	✓	✓
2.	Rapid HIV testing with referral to HIV care and treatment if test is positive	✓	✓
3.	HIV post-exposure prophylaxis (PEP) if HIV test is negative (within 72 hours of assault)	✓	
4.	STI screening/testing and treatment, including chlamydia, gonorrhea, trichomonas, as well as syphilis depending on prevalence. Tetanus booster/ vaccination for clients with injuries.	✓	✓
5.	Hepatitis B testing and vaccination if person is not immune	✓	
6.	Emergency contraception (within 5 days of assault) Note: *Kenya administers EC within 3 days only*	✓	
7.	Referrals for mental health screening, counseling and mental health services, and legal services	✓	✓

HANDOUT #20: Checklist of Supplies

1. Protocol	Available
• Written medical protocol in language of provider	
2. Personnel	**Available**
• Trained (local) health care professionals (on call 24 hours a day)	
• A "same language" female health worker or companion in the room during examination	
3. Furniture/Setting	**Available**
• Room (private, quiet, accessible, with access to a toilet or latrine	
• Examination table	
• Light, preferably fixed (a torch may be threatening for children)	
• Access to an autoclave to sterilize equipment	
4. Supplies	**Available**
• "Rape Kit" for collection of forensic evidence, including:	
◦ Speculum	
◦ Set of replacement clothes	
◦ Tape measure for measuring the size of bruises, lacerations, etc.	
• Supplies for universal precautions	
• Resuscitation equipment for anaphylactic reactions	
• Sterile medical instruments (kit) for repair of tears, and suture material	
• Needles, syringes	
• Gown, cloth, or sheet to cover the survivor during the examination	
• Sanitary supplies (pads or local cloths)	

5. Drugs	Available
• For treatment of STIs as per country protocol	
• Emergency contraceptive pills and/or IUD	
• For pain relief (e.g. paracetamol)	
• Local anaesthetic for suturing	
• Antibiotics for wound care	
6. Administrative Supplies	**Available**
• Medical chart with pictograms	
• Consent forms	
• Information pamphlets for post-rape care (for survivor)	
• Safe, locked filing space to keep confidential records	

HANDOUT #21: Sample Consent Form

Name of facility: .....

Note to the health worker:
After providing the relevant information to the patient as explained on page 40 (notes on completing the consent form), read the entire form to the patient (or his/her parent/guardian), explaining that she can choose to refuse any (or none) of the items listed. Obtain a signature, or a thumb print with a signature of a witness.

I, ... (print name of survivor) authorize the above-named health facility to perform the following (tick the appropriate boxes):

	Yes	No
Conduct a medical examination	☐	☐
Conduct pelvic examination	☐	☐
Collect evidence, such as body fluid samples, collection of clothing, hair combings, scrapings or cuttings of fingernails, blood sample, and photographs	☐	☐
Provide evidence and medical information to the police and/or courts concerning my case; this information will be limited to the results of this examination and any relevant follow-up care provided.	☐	☐

I understand that I can refuse any aspect of the examination I don't wish to undergo.

Signature: .....

Date: .....

Witness: .....

HANDOUT #22: Medical History and Examination Form - Sexual Violence

CONFIDENTIAL Code: .....

1. GENERAL INFORMATION

First Name		Last Name
Address		
Sex	Date of birth	Age
Date/Time of examination /		In the presence of

In case of a child include: name of school, name of parents or guardian

2. THE INCIDENT

Date of incident:	**Time of incident:**
Description of incident (survivor's description)	

Physical violence	Yes	No	Describe type and location on body
Type (beating, biting, pulling hair, etc.)			
Use of restraints			
Use of weapon(s)			
Drugs/alcohol involved			

Physical violence	Yes	No	Not sure	Describe (oral, vaginal, anal, type of object)
Penis				
Finger				
Other (describe)				

	Yes	No	Not sure	Location (oral, vaginal, anal, other)
Ejaculation				
Condom used				

3. MEDICAL HISTORY

After the incident, did the survivor	Yes	No		Yes	No
Vomit?			Rinse mouth?		
Urinate?			Change clothing?		
Defecate?			Wash or bathe		
Brush teeth?			Use tampon or pad		

Contraception use					
Pill		IUD		Sterilisation	
Infectable		Condom		Other	

Menstrual/obstetric history	
Last menstrual period	Menstruation at time of event Yes ☐ No ☐
Evidence of pregnancy Yes ☐ No ☐	Number of weeks pregnant ..... weeks
Obstetric history	

History of consenting intercourse (only if samples have been taken for DNA analysis)		
Last consenting intercourse within a week prior to the assault	Date:	Name of individual:

Existing health problems

History of female genital mutilation, type

Allergies

Current medication				
Vaccination Status	Vaccinated	Not Vaccinated	Unknown	Comments
Tetanus				
Hepatitis B				
HIV/AIDS status	Know		Unknown	

4. MEDICAL EXAMINATION

Appearance (clothing, hair, obvious physical or mental disability)		
Mental state (calm, crying, anxious, cooperative, depressed, other)		
Weight:	Height:	Pubertal stage (pre-pubertal, pubertal, mature):
Pulse rate:	Blood pressure:	Respiratory rate: Temperature:

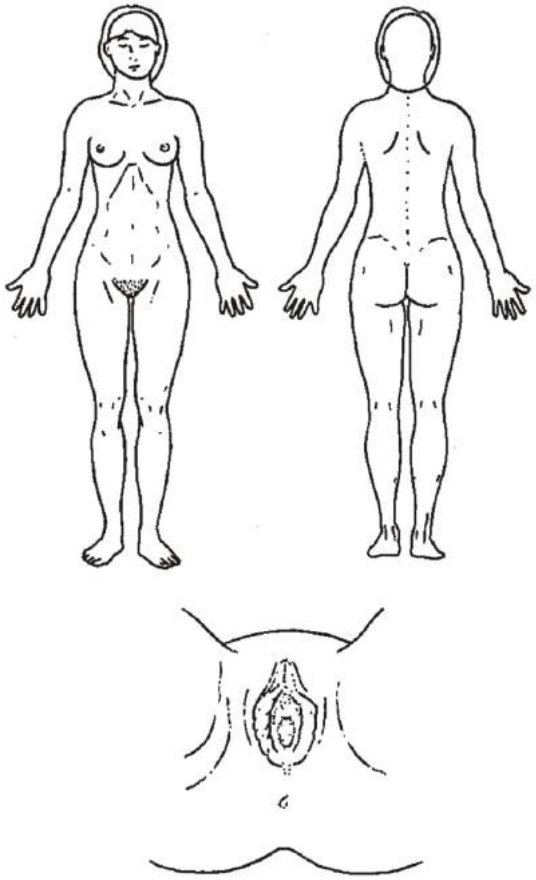
Physical findings
Describe systematically, and draw on the attached body pictograms, the exact location of all wounds, bruises, petechiae, marks, etc. Document type, size, colour, form and other particulars. Be descriptive, do not interpret the findings.

Head and face	*Mouth and nose*
Eyes and ears	*Neck*
Chest	*Back*
Abdomen	*Buttocks*
Arms and hands	*Legs and feet*

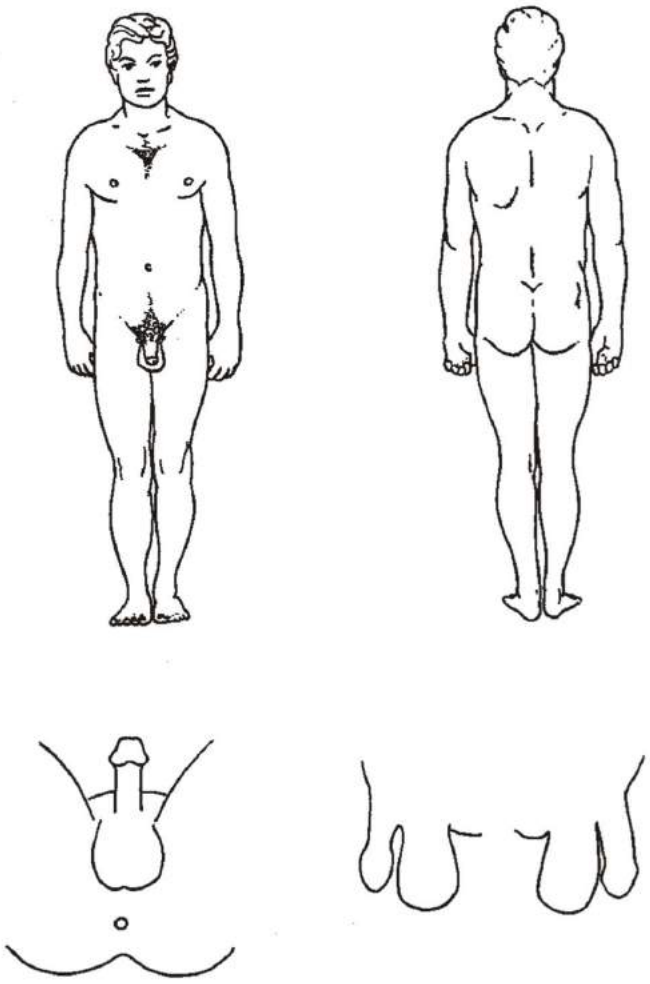
5. GENITAL AND ANAL EXAMINATION

Vulva/scrotum	*Introitus and hymen*	*Anus*
Vagina/penis	*Cervix*	*Bimanual/rectovaginal examination*
Position of patient (supine, prone, knee-chest, lateral, mother's lap)		
For genital examination:	For anal examination:	

BODY FIGURE PICTOGRAMS



WHO. (2004) Clinical management of rape survivors: developing protocols for use with refugees and internally displaced persons -- Revised ed



WHO. (2004) Clinical management of rape survivors: developing protocols for use with refugees and internally displaced persons -- Revised ed

HANDOUT #23: Clinical Post-Violence Follow-Up Services

For clients who have been raped, the WHO recommendations for follow-up visits vary slightly for clients who are receiving HIV PEP and those who are not:

CLIENTS WHO RECEIVED HIV PEP	CLIENTS WHO DID NOT RECEIVE HIV PEP
One-week follow-up visit: • Evaluate post-exposure prophylaxis (side-effects/adherence). • If not supplied at the first visit, provide additional three-week supply of PEP medication. • Check that client has taken full course of any STI medication. • Evaluate for STI, treat as appropriate, and provide advice on voluntary counselling and testing for HIV. • Evaluate mental/emotional status; refer or treat as needed	**Two-week follow-up visit:** • Evaluate for pregnancy and provide counselling. • Check that client has taken full course of any STI medication. • If prophylactic antibiotics were not given, evaluate for STIs, treat as appropriate, provide advice on voluntary HIV counselling/testing. • Evaluate mental/emotional status; refer or treat as needed
Six-week follow-up visit: • Evaluate for pregnancy and provide counselling. • If prophylactic antibiotics were not given, evaluate for STIs, treat as appropriate; provide advice on voluntary counselling and testing for HIV. • Evaluate mental/emotional status; refer or treat as needed.	**Three-month follow-up visit:** • Evaluate for STIs, and treat as appropriate. • Assess pregnancy status, if indicated. • Test for syphilis if prophylaxis was not given. • Provide advice on voluntary counselling and testing for HIV. • Evaluate mental/emotional status; refer or treat as needed
Three-month follow-up visit: • Evaluate for STIs, and treat as appropriate. • Assess pregnancy status, if indicated. • Test for syphilis if prophylaxis was not given. • Provide advice on follow-up voluntary HIV counselling/testing for those who had negative test during first week. • Offer voluntary HIV counselling/testing to clients not tested before. • Evaluate mental/emotional status; refer or treat as needed.	

EXERCISE CARDS
Standing in Her Shoes

Stand in the middle of the circle. Walk up to each person in the circle and say:

“I am a Sex Worker.”

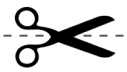
“I was raped by a client last night who lives in my neighborhood, and I’m afraid.”

Say:

“I am your sister.”

“You chose this life. It’s partly your fault”

Turn your back to the victim after you read the statement.



Say:

“I am your brother.”

“You bring shame to our family. You deserve what happened to you.”

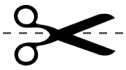
Turn your back to the victim after you read the statement.

Say:

“I am a Police Officer.”

“What you are doing is illegal. Your client paid for a service. It’s his right. You are lucky I don’t’ arrest you.”

Turn your back to the victim after you read the statement.

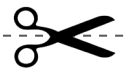


Say:

“I am your Neighbor.”

“He is always so nice to everyone in the neighborhood. It’s hard to believe he would do that. Plus, it’s your job, isn’t it?”

Turn your back to the victim after you read the statement.

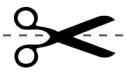


Say:

“I am your Friend.”

“You should not cause trouble. You are a sex worker and no one will believe you.”

Turn your back to the victim after you read the statement.

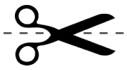


Say:

“I am your Religious leader.”

“Your lifestyle is a sin. You should not complain. You live a shameful life, and you deserve what happened to you.”

Turn your back to the victim after you read the statement.

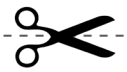


Say:

“I am your Mother”:

“What did you do to make him do that to you?”

Turn your back to the victim after you read the statement.



Say:

“I am your health care provider.”

“If you put yourself in risky situations, what do you expect will happen to you?”

Turn your back to the victim after you read the statement.

Ministry of Health

NASCOP

National AIDS/STI Control Programme

Box: 19361-(00202) Kenyatta National Hospital (KNH) Grounds