LINKAGES

A GUIDE *to* COMPREHENSIVE VIOLENCE PREVENTION *and* RESPONSE

IN KEY POPULATION PROGRAMS

USAID FROM THE AMERICAN PEOPLE
PEPFAR
INPUD International Network of People who Use Drugs
IRGT A GLOBAL NETWORK OF TRANS WOMEN AND HIV
M•PACT FORMERLY KNOWN AS MSMGF
nswp
LINKAGES Across the Continuum of HIV Services for Key Populations

ACKNOWLEDGMENTS
Robyn Dayton (LINKAGES Gender Advisor, FHI 360), Giuliana Morales (Senior Technical Officer, FHI 360), and Kim Dixon (LINKAGES gender-based violence consultant) developed this publication. As part of the process, Kim Dixon also conducted a comprehensive desk review to identify global best practices for addressing violence against the general population and key populations.

Special thanks to Parinita Bhattacharjee from the University of Manitoba for her contributions and feedback to this document and Program Area 3: Structural Interventions in the *Key Population Program Implementation Guide*. This document is informed by and responsive to the implementation guide's contents and elaborates on the implementation of the violence prevention and response activities it recommends. Thanks also to Judy Chen, Amelia Peltz, Tisha Wheeler, and the team of technical advisors at USAID; Judy Chang (INPUD), JoAnne Keatley (IRGT), George Ayala (MPact Global Action for Gay Men's Health and Rights), Katherine Koster and Neil McCulloch (NSWP), Avni Amin (WHO), and Meg DiCarlo and Hally Mahler (FHI 360) for their technical review; Stevie Daniels (FHI 360) for copy editing; and Design Lab 360 for design.

Finally, we thank the many key-population-led and key-population-serving community-based organizations that are integrating the activities described in this guide into their HIV prevention, care, and treatment programs. Their experiences using earlier iterations of this document helped shape its content, and we hope that the guidance included here is useful to their incredibly important work.

SUGGESTED CITATION:
Dayton R, Morales GJ, Dixon KS. LINKAGES: a guide to comprehensive violence prevention and response in key population programs. Durham (NC): FHI 360, 2019.

LINKAGES

Linkages across the Continuum of HIV Services for Key Populations Affected by HIV (LINKAGES) Project

A GUIDE *to* COMPREHENSIVE VIOLENCE PREVENTION *and* RESPONSE

IN KEY POPULATION PROGRAMS

2019

This guide is made possible by the generous support of the American people through the U.S. Agency for International Development (USAID) and the U.S. President's Emergency Plan for AIDS Relief (PEPFAR) through the terms of cooperative agreement #AID-OAA-A-14-00045. The contents are the responsibility of the LINKAGES project and do not necessarily reflect the views of USAID, PEPFAR, or the United States Government.

LINKAGES, funded by PEPFAR and USAID, is the largest global project dedicated to key populations—sex workers, men who have sex with men, people who inject drugs, and transgender people. The project is led by FHI 360 in partnership with IntraHealth International, Pact, and the University of North Carolina at Chapel Hill.

ACRONYMS AND ABBREVIATIONS

AIDS	Acquired immunodeficiency syndrome
ART	Antiretroviral therapy
ARVs	Antiretroviral medicines
DIC	Drop-in center
GBV	Gender-based violence
EPOA	Enhanced peer outreach approach
HCW	Health care worker
HIV	Human immunodeficiency virus
HTC	HIV testing and counseling
IEC	Information, education, and communication
IPC	Interpersonal communication
IPV	Intimate partner violence
IRGT	A Global Network of Trans Women and HIV
KP	Key population
LGBT	Lesbian, gay, bisexual, and transgender
M&E	Monitoring and evaluation
NSWP	Global Network of Sex Work Projects
ORW	Outreach worker
PE	Peer educator
PEP	Post-exposure prophylaxis
PEPFAR	U.S. President's Emergency Plan for AIDS Relief
PN	Peer navigator
PrEP	Pre-exposure prophylaxis
SIMS	Site improvement through monitoring system
SOP	Standard operating procedure
STI	Sexually transmitted infection
Trans	Transgender
UNAIDS	Joint United Nations Programme on HIV/AIDS
UNDP	United Nations Development Programme
UNFPA	United Nations Population Fund
UNODC	United Nations Office on Drugs and Crime
USAID	U.S. Agency for International Development
VPR	Violence prevention and response
WHO	World Health Organization

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SECTION 1

Introduction

Section 1.1
Overview of Guide Contents

This guide was designed to support the integration of violence prevention and response (VPR) activities into HIV prevention, care, and treatment service delivery programs for members of key populations (KPs)—gay men and other men who have sex with men, people who inject drugs, sex workers, and transgender (trans) people.

SECTION 1 describes the rationale for integrating VPR and HIV services, source documents that shaped this guide, and other LINKAGES documents that can be used in a complementary way. It also describes the LINKAGES vision for comprehensive VPR and how VPR fits in with the LINKAGES HIV prevention, care, and treatment cascade.

SECTION 2 provides background information about key concepts including an extensive definition and examples of violence, the importance of asking about violence, and how to enhance the safety of implementers.

SECTION 3 includes principles for designing, implementing, and monitoring VPR activities that form the foundation for VPR programming. These principles promote the protection, dignity, rights, and health of KP members and aim to help ensure their right to self-determination, particularly for individuals who have experienced violence.

SECTION 4 provides a detailed overview of the implementation of each VPR program element and the rationale for its inclusion.

SECTION 5 is a glossary of key terms used throughout the guide.

SECTION 6 is a set of annexes with additional information and examples to help implement the program elements.

SECTION 7 is a list of works referenced.

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."[1] This guide addresses violence across five major domains:[2, 3] physical, emotional, sexual, and economic violence, and other human rights violations. See SECTION 2.1 for more information.

Section 1.2

LINKAGES Vision for Violence Prevention and Response within HIV Programs for Members of Key Populations

The Linkages across the Continuum of HIV Services for Key Populations Affected by HIV LINKAGES (Project), a cooperative agreement supported by the U.S. President's Emergency Plan for AIDS Relief (PEPFAR) and the U.S. Agency for International Development (USAID), delivers HIV prevention, care, and treatment services to members of KPs to prevent HIV transmission and extend the lives of those living with HIV. Led by FHI 360—in partnership with Pact, IntraHealth International, and the University of North Carolina at Chapel Hill—and with guidance from the LINKAGES Advisory Board, LINKAGES operates across Asia, Africa, and Latin America and the Caribbean.

The LINKAGES project is committed to protecting and promoting the human rights of key populations. Violence against any person violates numerous articles of the Universal Declaration of Human Rights, including the fundamental human right to live free from violence.[4, 5] When violence—such as that committed by health care workers (HCWs)—limits access to health care, this prevents enjoyment of the highest attainable standard of health, also a fundamental human right.

MEMBERS OF KPS ARE ENTITLED TO FULL PROTECTION OF THEIR HUMAN RIGHTS, as specified in international human rights instruments, including the right to nondiscrimination; security; recognition, equality, and access to justice and due process under the law; the highest attainable standard of health; freedom from arbitrary arrest/detention and cruel and inhumane treatment; and protection from violence.[6]

In addition to violating human rights, violence, including gender-based violence (GBV), increases HIV vulnerability and makes accessing HIV services more difficult. Living with HIV also increases vulnerability to violence, and key populations living with HIV experience layered stigma based on both key population status and HIV status in health care and other settings.[7, 8] To respond to the dual epidemics of violence and HIV, we envision activities resourced and implemented across the HIV prevention, care, and treatment cascade (FIGURE 1) to ensure KP members:

- Know their rights.
- Have a safe space to disclose violence, including in a crisis, to trained individuals who can offer empathetic and nonjudgmental first-line support.[i]
- Are given access to the full range of health, social, and justice/legal services recommended for people who experience violence.

Furthermore, we envision VPR programs that include:

- HCWs, peer educators (PEs), peer navigators (PNs), and outreach workers (ORWs)—many of whom are members of KPs—who understand the ways in which violence interacts with HIV and are committed to addressing both issues simultaneously.
- Activities with or targeting law enforcement and other power holders to prevent violence and decrease impunity for perpetrators.

i **First-line support** refers to the minimum level of (primarily psychological) support and validation of experience that all people who disclose violence to a provider should receive.

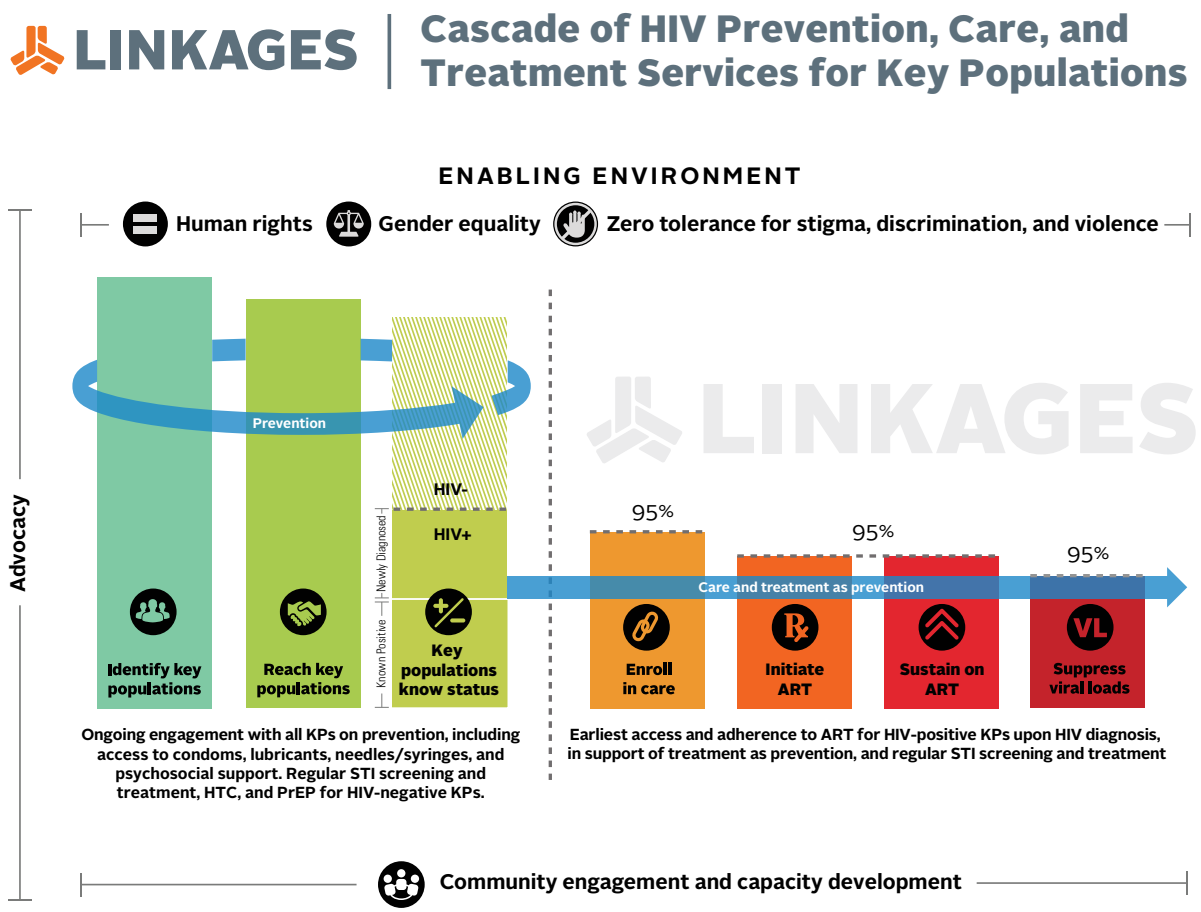

FIGURE 1. LINKAGES cascade of HIV prevention, care, and treatment services for members of KPs

- Strengthened referral systems between public, private, and multilateral institutions and civil society organizations that can provide long-term and sustainable support beyond the life of a given project.
- Documentation of violence that can be used to support advocacy to change factors that lie at the heart of violence against KP members.
- Continual reflection and program improvement through performance review.
- Sufficient funding to integrate these elements into HIV prevention, care, and treatment services.

Section 1.3

Rationale for Integrating Violence Prevention and Response and HIV Prevention, Care, and Treatment Services for Key Populations

The links between violence and HIV are well established, and KP members experience a disproportionate burden of both violence and HIV (see SECTION 2.1). Both HIV status and experiences of violence can affect almost every aspect of health and well-being, including access to health services and education and full enjoyment of legal and human rights. KP members' vulnerability to violence and HIV is rooted in structural inequalities, including unequal power relationships based on biological sex, gender identity, gender expression, and sexual orientation. These structural inequalities are entrenched in cultural beliefs and societal norms and are reinforced by legal, political, and economic systems.[9, 10]

Violence against key populations increases vulnerability to HIV infection and poses significant barriers to accessing HIV services and other health services, while making a range of health outcomes worse and decreasing quality of life (FIGURE 2).[2, 3, 11-14] Violence directly increases vulnerability to HIV by limiting one's ability to use safe injecting practices[15] or negotiate safe sex,[9] and the efficiency of HIV transmission may increase during sexual violence in which force causes oral, vaginal, or anal/rectal abrasions or lacerations.[9, 16] More distally, a history of violence is associated with increased engagement in sexual activities that increase one's risk of HIV acquisition, such as sex without a condom and difficulty refusing unwanted sexual advances among both women and men who have sex with men.[9, 17] A history of violence can also make it more difficult to test for HIV or to disclose one's HIV status.[9] The fear of violence, including abandonment by individuals' families and communities, also decreases the uptake of HIV services.[2] Experiences of violence are also associated with never having initiated HIV care and the interruption of antiretroviral therapy (ART).[18-21]

Due to the disproportionate burden of violence KP members face, the effectiveness of HIV prevention, care, and treatment services can be compromised when VPR interventions are not implemented concurrently.[2] Addressing violence may also help achieve HIV-related goals. Modeling estimates in two different epidemic contexts (Kenya and Ukraine) suggest that a reduction in HIV infections of approximately 25 percent among sex workers could be achieved by reducing physical and sexual violence.[22] Research and programmatic experiences also demonstrate that addressing violence can contribute to increased condom use[23] and safer injecting practices[24] and may increase individuals' access to HIV testing and improve adherence to treatment.[25] This evidence—in addition to the recommendations in each key population implementation tool that violence be addressed as part of KP programming[2, 3, 11, 12]—supports the integration of VPR and HIV prevention, care, and treatment services whenever working with members of KPs.[26]

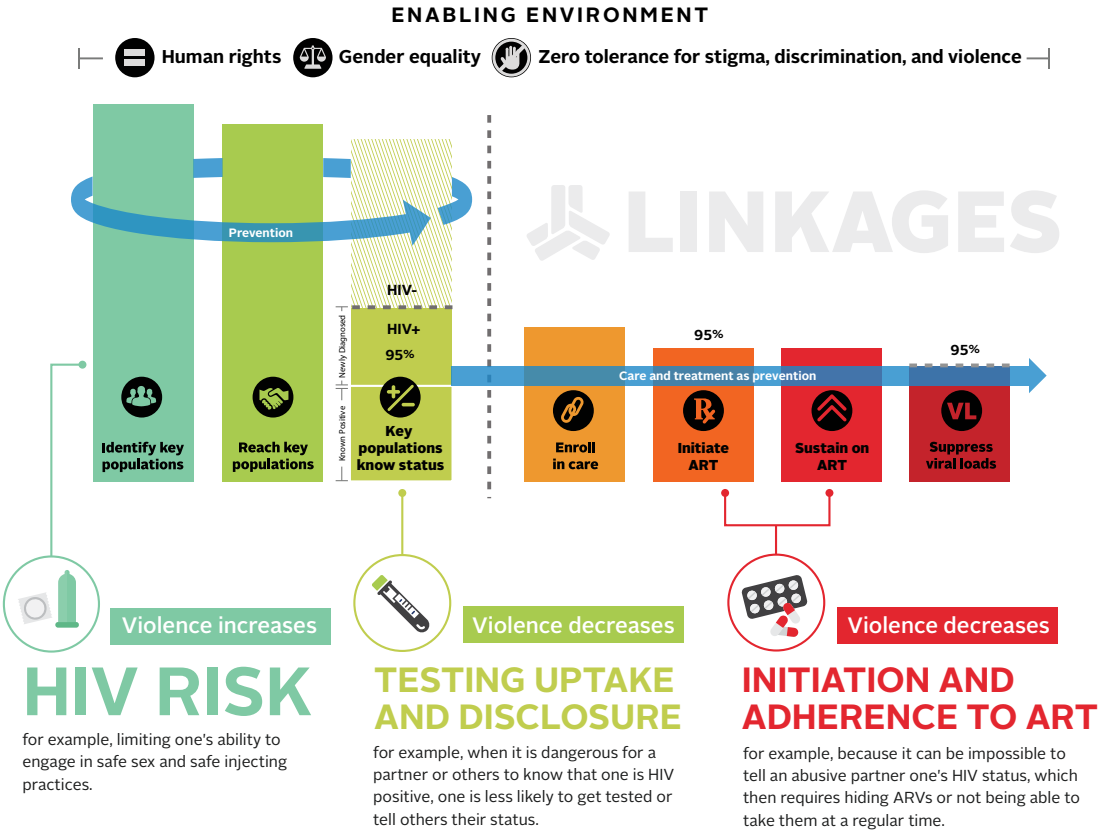

FIGURE 2. Impact of violence on members of KPs across the cascade of HIV prevention, care, and treatment services

Section 1.4
What Informed this Guide

The approach to VPR described in this document aligns with normative guidance on KP programming. It is also informed by and refers to guidance on identifying and supporting victims of violence. Where this guidance is specific to women in the general population, to the health sector, or to intimate partner violence (IPV), adaptations are noted to increase applicability to key populations experiencing many forms of violence and served by a broader range of direct service providers (including peers). Finally, it is informed by USAID and PEPFAR guidance on integrating HIV and VPR programming and best practices for designing and implementing VPR interventions in low resources settings, including with KP members. Key source documents include:

GUIDANCE ON THE IMPLEMENTATION AND MONITORING OF KP PROGRAMS

- LINKAGES, 2017. *Key Population Program Implementation Guide*[27]
- PEPFAR, 2018. *PEPFAR Monitoring, Evaluation, and Reporting (MER 2.0) Indicator Reference Guide (version 2.3)*[28]
- United Nations Population Fund (UNFPA), Global Forum on MSM & HIV, United Nations Development Programme (UNDP), WHO, USAID, World Bank, 2015. *Implementing Comprehensive HIV and STI Programmes with Men Who Have Sex with Men: Practical Guidance for Collaborative Interventions (the "MSMIT")*[3]
  - » Chapter 2: Addressing Violence against Men Who Have Sex with Men
- UNDP, IRGT: A Global Network of Trans Women and HIV, UNFPA, UCSF Center of Excellence for Transgender Health, Johns Hopkins Bloomberg School of Public Health, WHO, et al., 2016. *Implementing Comprehensive HIV and STI Programmes with Transgender People: Practical Guidance for Collaborative Interventions (the "TRANSIT")*[11]
  - » Chapter 2: Stigma, Discrimination, Violence & Human Rights
- United Nations Office on Drugs and Crime (UNODC), International Network of People Who Use Drugs, Joint United Nations Programme on HIV/AIDS (UNAIDS), UNDP, UNFPA, WHO, et al., 2017. *Implementing Comprehensive HIV and HCV Programmes with People Who Inject Drugs: Practical Guidance for Collaborative Interventions (the "IDUIT")*[12]
  - » Chapter 2: Legal Reform, Human Rights, Stigma and Discrimination
- WHO, UNFPA, UNAIDS, Global Network of Sex Work Projects (NSWP), World Bank, 2013. *Implementing Comprehensive HIV/STI Programmes with Sex Workers: Practical Approaches from Collaborative Interventions (the "SWIT")*[2]
  - » Chapter 2: Addressing Violence against Sex Workers
- WHO, 2016. *Consolidated Guidelines on HIV Prevention, Diagnosis, Treatment and Care for Key Populations—2016 Update*[13]

GUIDANCE ON THE IMPLEMENTATION OF VIOLENCE RESPONSE SERVICES

- Bill & Melinda Gates Foundation, 2013. *Community Led Crisis Response Systems: A Handbook*[29]
- Keesbury, Askew, 2010. *Comprehensive Responses to Gender Based Violence in Low-Resource Settings: Lessons Learned from Implementation*[30]
- Khan, 2011. *Gender-Based Violence and HIV: A Program Guide for Integrating Gender-Based Violence Prevention and Response in PEPFAR Programs*[10]
- PEPFAR, 2013. *FY 2014: Updated Gender Strategy*[31]

- USAID, 2016. *United States Strategy to Prevent and Respond to Gender-Based Violence Globally: 2016 Update*[32]
- WHO, 2003. *Guidelines for Medico-Legal Care of Victims of Sexual Violence*[33]
- WHO, 2013. *Responding to Intimate Partner Violence and Sexual Violence against Women: WHO Clinical and Policy Guidelines*[34]
- WHO, 2014. *Health Care for Women Subjected to Intimate Partner Violence or Sexual Violence: A Clinical Handbook*[35]
- WHO, 2017. *Strengthening Health Systems to Respond to Women Subjected to Intimate Partner Violence or Sexual Violence: A Manual for Health Managers*[36]

To ensure flexibility and feasibility, particularly for programs with limited resources to address structural interventions, the program elements recommended in this guide were identified in collaboration with implementers operating VPR activities within KP programs. LINKAGES convened program staff and implementing partners from Haiti, India, Kenya, Malawi, and South Sudan, along with technical experts from FHI 360 and USAID, at a consultation in Washington, DC, August 31–September 1, 2016. The program elements described in this guide were identified during the consultation and captured succinctly in *Key Population Program Implementation Guide.*[27] Over time, refinements to the activities under each element were made, in accordance with lessons learned from implementation across LINKAGES countries, to create the final content presented here.

Section 1.5
Who Should Use this Guide

This guide—designed to support the operationalization of the VPR content included in the *Key Population Program Implementation Guide*[27]—provides the information needed for KP program planners, managers, and evaluators to accelerate their efforts in designing, implementing, and evaluating comprehensive VPR activities as part of an HIV program.

Individuals who design, manage, and evaluate KP programs should use this document to ensure that these programs are adequately addressing violence within the context of HIV prevention, care, and treatment services and that good practices are used in all VPR programming.

Sharing the information presented in this guide with those who deliver services—such as PEs, PNs, ORWs, and partnering HCWs, counselors, psychosocial support providers, law enforcement officers, and allied lawyers—can be facilitated through the many trainings, job aids, and other resources referred to throughout this document.

This guidance can be used by KP-led organizations as well as those that are KP-competent. It has been effectively utilized by both in the context of the LINKAGES project.

DIRECT SERVICE PROVIDERS are contractors, employees, or volunteers who provide outreach; counseling; psychological, medical, and justice/legal services; and other types of support services directly to members of KPs. In many cases, direct service providers are members of KPs and/or work for KP-led organizations.

Section 1.6
Objectives

This guide can be used to accomplish two main objectives:

OBJECTIVE 1

To advocate for the inclusion of fully funded VPR activities within HIV prevention, care, and treatment programming for key populations by showing that they are both feasible and important.

OBJECTIVE 2

To support KP programs as VPR program principles and elements are incorporated into their design, implementation, and evaluation.

Section 1.7
Adapting this Guide to the Local Context

This document draws from global guidance and good practice standards, including recent guidance from WHO and PEPFAR on both violence response services and specific services for KP members (see SECTION 1.4). When KP programs use this guide to develop their own standard operating procedures (SOPs), they will need to align with the policies, laws, and services available in their location. For example, country programs should refer to their national protocols for country-specific guidance on the clinical protocols for responding to victims of sexual violence (e.g., post-rape protocol) and ensure that these national protocols are informed by WHO guidance.

Position titles used in this document may differ from those used in a given program. In this document, we use the following terms:

- **PEED EDUCATOR:** A peer who does outreach and links an individual to testing
- **PEER NAVIGATOR:** A peer who works with individuals who have been diagnosed with HIV to facilitate their access to care and treatment
- **OUTREACH WORKER:** Someone who supervises peer outreach; may also be a peer (sometimes called a peer supervisor)

The program principles should be used wherever VPR is implemented. Ideally, all the program elements will be implemented, but how and whether each is implemented will depend on resource availability and the structure of the relevant HIV program. The nature of activities with law enforcement will be highly dependent on the local context, and all activities should be implemented with guidance from and in collaboration with members of KPs. When this guide is used in a context in which additional resources are available, implementers may wish to include elements beyond those that are described in detail here.

Section 1.8
Using this Guide with Complementary Materials

This guide draws from, complements, and informs many other LINKAGES guidance and training documents. They are summarized below.

TITLE	PURPOSE	TARGET AUDIENCE
Key Population Program Implementation Guide[27]	Provide information on the essential elements of KP programs and help standardize LINKAGES country programs based on proven, high-quality interventions	Program implementers
Gender Strategy[37]	Explain the rationale and process for implementing the LINKAGES Gender Strategy, including activities to prevent and respond to GBV	Program designers, managers, and evaluators
Health4All: Training Health Workers for the Provision of Quality, Stigma-Free HIV Services for Key Populations[38]	Raise the consciousness of staff in health care settings about the effects of stigma and discrimination and train HCWs on how to provide stigma-free, appropriate services to KP members	Staff in health care settings
Health Care Worker Training: Preventing and Responding to Violence against Key Populations[39]	Build the knowledge and skills of HCWs to ask KP members about violence and respond to individuals who disclose violence	HCWs (clinical and nonclinical)
Peer Educator and Outreach Worker Training: Preventing and Responding to Violence against Key Populations[40]	Build the knowledge and skills of PEs, PNs, and ORWs to ask KP members about violence and provide first-line support to individuals who disclose violence during outreach activities	PEs, PNs, and ORWs
Enhanced Peer Outreach Approach (EPOA): Implementation Guide[41]	Describe EPOA and its potential benefits, the essential components of EPOA, and the steps involved in implementation, including potential challenges	PEs
Peer Navigation for Key Populations: Implementation Guide[42]	Provide guidance for programs implementing peer navigation as part of a core package of HIV-related interventions for KP members	PNs
Law Enforcement Training: Preventing and Responding to Violence against Key Populations to Increase Access to Justice and Strengthen the HIV Response[43]	Reduce violence against KP members that is perpetrated by law enforcement officers and ensure that law enforcement can provide appropriate services to victims of violence who are members of KPs	Law enforcement officers
Safety and Security Toolkit: Strengthening the Implementation of Programs for and with Key Populations[44]	Help KP program implementers identify and address safety and security challenges	Program implementers

SECTION 2

Key Concepts

Section 2.1
Defining and Exploring Patterns of Violence against Key Populations

Violence is defined by 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."[1] In this guide, we look at violence across five major areas:[2, 3] physical, emotional, sexual, and economic violence, and other human rights violations.

Physical: Being hit, pushed, kicked, choked, spit on, pinched, punched, poked, slapped, bit, or shaken; having hair pulled; having objects thrown at you; being dragged, beaten up, or deliberately burned; having a weapon used against you; being kidnapped, held against your will, or physically restrained; being deprived of sleep by force; being forced to consume drugs or alcohol; being subjected to invasive body searches/forced to strip by law enforcement officers; being poisoned; being killed

Sexual: Being raped or gang raped; being physically forced, coerced, psychologically intimidated, or socially or economically pressured to engage in any sexual activity against your will (undesired touching, oral, anal, or vaginal penetration with penis, fingers, or with an object); being forced to have sex without a condom

Emotional: Experiencing psychological and verbal abuse, humiliation, threats of physical or sexual violence or any other harm, including threats to take custody of an individual's children or to "out them" by sharing that they are a member of a KP; coercion, controlling behaviors, name calling, or verbal insults; being confined to or isolated from friends/family; repeated shouting, intimidating words/gestures, bullying, blaming; the destruction of emotionally meaningful possessions

Economic: Using money or resources to control an individual; blackmail; being refused the right to work or forced to give up earnings; being refused pay for money that is earned/due (including clients who refuse to pay); having someone withhold resources as punishment

Other human rights violations: There are also system-level abuses and other human rights violations against members of KPs that interfere with their ability to seek and access important services, including various forms of harassment, extortion, and exploitation. Some human rights violations include being: [2, 3, 12, 45]

- Denied or refused food or other necessities
- Arrested or threatened with arrest for carrying condoms or clean injecting equipment; condoms or clean injecting equipment taken away
- Refused or denied health care or other services
- Subjected to coercive health procedures or treatments such as forced STI and HIV testing, drug-dependence treatment, reparative therapy (to change someone's sexual orientation), sterilization, or abortion
- Arbitrarily stopped, detained, or incarcerated in jails, detention centers, and rehabilitation centers without due process (many transgender people, after being deprived of liberty, also experience abuse from other people who are incarcerated because they are put in cells based on their sex assigned at birth and not their gender identity)

Violence against KP members occurs all over the world (FIGURE 3). While the forms, prevalence, and perpetrators of violence differ by key population and location, studies at the global and regional level can help describe overall trends.

A global review of the literature on violence against gender and sexual minorities, including men who have sex with men and trans people, found that the prevalence of physical violence against men who have sex with men, motivated by perceived sexual orientation or gender identity, was between 9 and 35 percent and sexual violence motivated by the same was between 4 and 17 percent.[46] IPV, which studies have shown is common among men who have sex with men,[47] was not included. Men who have sex with men often experience emotional violence including verbal abuse by law enforcement and HCWs, rejection by one's family, and economic violence such as blackmail and extortion.[48-50]

In the global review of gender and sexual minorities, violence against transgender people—motivated by perceived sexual orientation or gender identity—was reported by between 12 and 68 percent of respondents, and sexual violence motivated by the same was reported by between 7 and 49 percent.[46] IPV is also common among trans and gender nonconforming individuals and has been reported at higher levels than IPV against cisgender women in the general population.[51] Emotional violence, often in the form of verbal abuse, occurs from a range of perpetrators including law enforcement, government officials, HCWs, and family members,[8, 50, 52] and economic violence—particularly among transgender sex workers who have to pay money to law enforcement to avoid arrest and may not be paid by their clients—is widespread.[50, 52-54]

A systematic review of violence against sex workers[ii] found that 19 to 44 percent have experienced physical violence and 15 to 31 percent have experienced sexual violence at the workplace—which includes violence committed by law enforcement, clients, and third-parties that facilitate sex work—in the past year. Violence from intimate or nonpaying partners was also common; studies demonstrated that in the past year between 15 and 61 percent experienced physical violence and between 8 and 19 percent experienced sexual violence.[61] Exposure to violence differed based on the legal context, with the criminalization of sex work creating an environment in which violence against sex workers, including by law enforcement, can often occur with impunity, increasing the burden of abuse (see box to the right for more on legal context). Most of the research on violence against sex workers focuses on cisgender women, but a recent briefing paper developed by NSWP and MPact Global Action for Gay Men's Health and Rights describes the experiences of homophobia and transphobia experienced by LGBT (lesbian, gay, bisexual, and transgender) sex workers. While many transgender people employ sex work as a resilience strategy, in response to exclusion from mainstream employment opportunities and family rejection, they are also often more vulnerable to violence than male or female sex workers. Furthermore, male sex workers affected by violence described a silent epidemic, where the dominant narrative—which includes the presumption that violence occurs in the context of heterosexuality—

While each key population is described largely separately in this document, there are important overlaps between populations—such as sex workers who use drugs—that must be considered in programming. Such overlaps are particularly important in the context of VPR as they can increase an individual's risk of violence.

Emotional violence, apart from that which is commonly captured in studies of stigma and discrimination, against members of KPs is rarely the focus of research[46] or programs,[55] and sexual violence receives much of the attention because of its direct contributions to HIV vulnerability. However, the psychological impacts of emotional violence, such as depression, are a predictor of HIV vulnerability[56, 57] and decreased adherence to treatment for people living with HIV.[58] Verbal abuse, a form of emotional abuse, is also independently linked to attempted suicide.[59] All forms of violence are important to address.

LEGAL CONTEXT

Laws beyond those that criminalize sex workers affect the prevalence of violence against them. Research demonstrates that in criminalized settings sex workers can use online spaces to find and screen clients to reduce the burden of violence.[60] Laws that prohibit such risk-reduction strategies and make websites that facilitate sex work illegal are likely to increase violence.

ii The review included 41 studies, three of which included trans women sex workers, 37 were female sex workers only, and one was trans women sex workers only. No male sex workers were included.

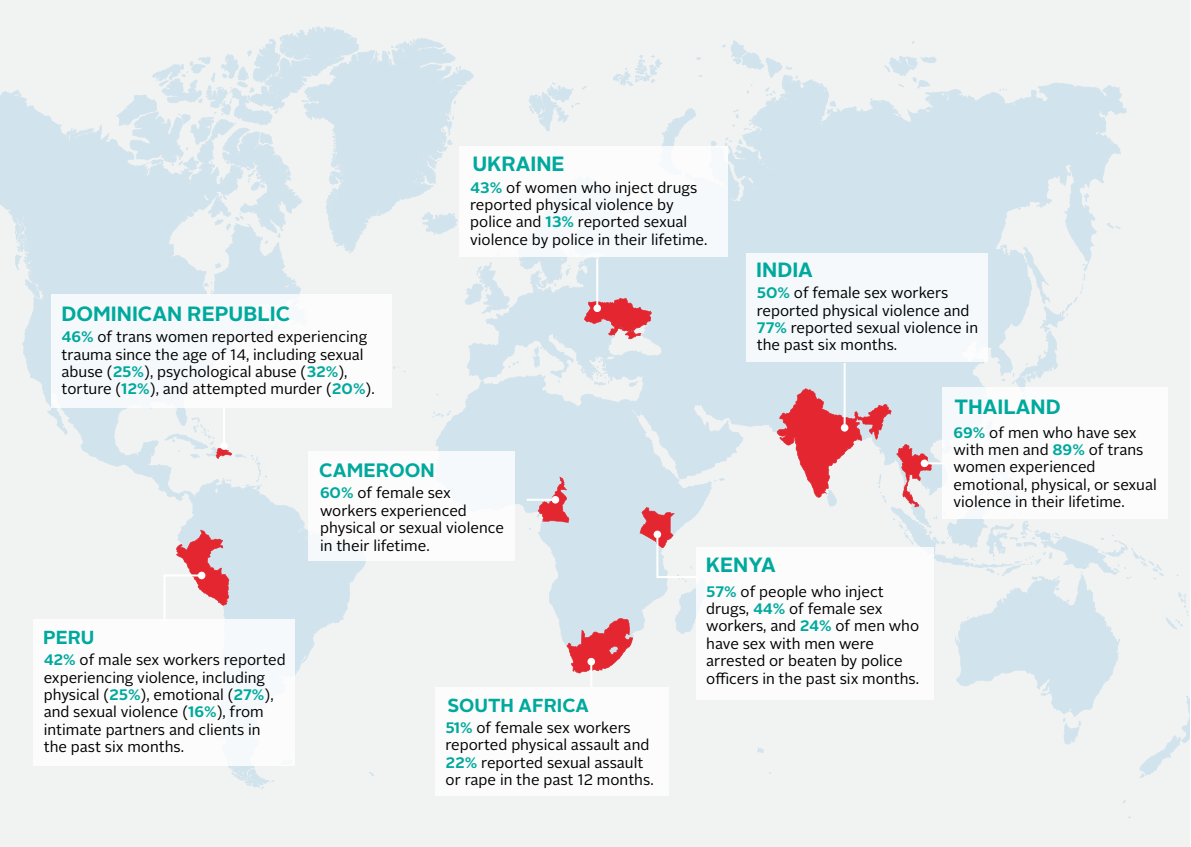

FIGURE 3. Map of selected studies documenting violence against members of KPs

leaves them concerned that their experiences as victims of violence will be not acknowledged or that they will be seen as abnormal.[62]

Both men and women who inject drugs are subjected to confiscation or destruction of harm reduction equipment (e.g., sterile needles and syringes) by law enforcement. During interrogation and detention, they also face forced or coerced drug-dependence treatment, extortion of money or confessions through forced withdrawal without medical assistance, and beatings or even death.[12,63] Violence from sexual partners is normalized[64] and women who inject drugs also experience high levels of IPV. In Georgia, for example, 81 percent of women who inject drugs reported IPV.[63] In a study in the U.S., a history of injecting among service users at an emergency department increased risk of physical IPV by 5 to 6 times and sexual IPV by 7 to 9 times.[65]

It is important to note that not all forms of violence are against the law, and laws may actually explicitly call for violence (such as laws that allow men who have sex with men and trans women to be invasively examined to determine whether they have had anal sex, a practice condemned by the United Nations as amounting to torture).[66] Even laws ostensibly designed to protect KP members—such as "end demand" laws that criminalize clients and third-parties who facilitate sex work—result in increased violence against sex workers, decreased condom use, increased difficulty to negotiate safe-sex practices, and decreased use of HIV services.[67-69]

Finally, human trafficking—a form of violence often inaccurately conflated with sex work—requires specific intervention that is not the focus of this guide. For more on responding to human trafficking, see ANNEX 2.

OTHER USEFUL/RELATED TERMINOLOGY

While we use the term "violence" in this document, it is important to note that some implementers or members of KPs may use different terminology. For example, many of the acts described here as "violence" are referred to by others as "stigma and discrimination." Stigma, defined as "the co-occurrence of labeling, stereotyping, separation, status loss, and discrimination in a context in which power is exercised,"[72] is a cause of violence and manifests as acts of violence.[73] As the *Implementing Comprehensive HIV and STI Programmes with Men Who Have Sex with Men* guidance states, "Although stigma and discrimination cause violence, in their most aggressive forms they may also themselves be acts of violence."[3] As a result, actions such as blackmail and physical and sexual harassment are measured as manifestations of stigma in tools such as the People Living with HIV Stigma Index 2.0 but are also relevant to surveys collecting information specifically about violence.[8] While stigma and violence are not synonymous, approaches to VPR put forward in this document complement and help achieve the goals of stigma reduction activities because of the strong connection between the two.

Others may use the term "gender-based violence" to describe some of the violence experienced by key populations. According to PEPFAR, GBV refers to "any form of violence that is directed at an individual based on his or her biological sex, gender identity or expression, or his or her perceived adherence to socially-defined expectations of what it means to be a man or woman, boy or girl. It includes physical, sexual, and psychological abuse; threats; coercion; arbitrary deprivation of liberty; and economic deprivation, whether occurring in public or private life. GBV is rooted in gender-related power differences, including social, economic and political inequalities."[55] The United Nations also acknowledges transphobic and homophobic violence to be forms of GBV, writing that these attacks are "driven by a desire to punish individuals whose appearance or behaviour appears to challenge gender stereotypes."[74] While use of the term GBV is relevant more broadly, it is important to note that some people understand GBV to apply only to women and girls (see box on the next page). Therefore, if the term GBV is used in the context of a KP program, a specific effort should be made to explicitly describe the groups of people who could be victims of such violence.

INTIMATE PARTNER VIOLENCE

Intimate partner violence, defined as ongoing or past violence by an intimate partner or ex-partner, affects the lives and HIV vulnerability of many members of KPs.[47, 51, 65, 71] A history of IPV among men who have sex with men is associated with recent condomless sex for both individuals who have been victims and perpetrators; for sex workers, IPV can be as important to HIV vulnerability as violence from clients.[71] IPV, while important to address, can be more difficult for KP members to disclose than violence perpetrated by actors such as paying partners or strangers because, just as for victims of IPV in the general population, there are a range of emotions, dependencies, and shared children or property that connect KP members to their intimate partners. In many KP communities, victims of IPV are also stigmatized in a way that victims of perpetrators such as law enforcement officers are not, making disclosure more difficult. In addition, leaving a violent partner is often difficult for members of KPs who may experience violence from actors such as law enforcement or the judiciary system when they seek support, or who may not be included in laws or services designed to protect victims of IPV—e.g., men in relationships with other men who live in countries where domestic violence is defined exclusively as violence against women.

While this guidance document does not include direct work with intimate partners as a program element, this omission is a product of the need to work in resource-constrained environments and not a commentary on the importance of addressing IPV. In addition, IPV can and should be addressed via effective responses from law enforcement, HCWs, PEs, PNs, and ORWs. Training for these direct service providers should include knowledge and skill-building that address the unique needs of KP victims of IPV, a topic covered in each LINKAGES training curriculum, so that when IPV occurs KP members are able to access appropriate support.

Violence against key population members also stems from a range of other motivations. Politicians often incite or seek to exacerbate violence against key populations and other marginalized groups, such as immigrants, for political gain.[75] Moralistic frameworks that make addiction or drug use a sin, or position individuals who use drugs as a danger to society, are used to justify and promote violence against people who inject drugs.[76] HIV-related stigma is also a source of violence.[8]

When working to address violence against members of KPs, the terminology used is less important than a shared understanding of both its breadth (i.e., violence is not only physical and sexual) and the understanding that both structures, such as laws and social norms, and power differentials between individuals contribute to violence. This understanding rejects the normalization of violence (including stigma), repudiates the belief that KP members are responsible for the violence against them, and points to the need for broader societal and legal change.

At the individual level, what is most important is respecting the terminology that each person who has experienced violence is comfortable with. Everyone has the right to define their own experience. When direct service providers talk with KP members, they should use the language used by the individual they are working with as much as possible.

"Many definitions of gender-based violence focus on women as victims of such violence; for example, the Committee on the Elimination of Discrimination Against Women (CEDAW) states that gender-based violence is 'violence that is directed against a woman because she is a woman or that affects women disproportionately.' Definitions of gender-based violence are also pertinent to all forms of violence that are related to social expectations and social positions based on gender, or to not conforming to a socially accepted gender role or expression."

Regional Director Asia
International Center for Research on Women[48]

VICTIM OR SURVIVOR

The terms *victim* and *survivor* are often used when referring to an individual who has experienced violence. Some people who have experienced violence choose to describe themselves as victims—someone who was attacked or abused—that is, someone who was victimized. Other people prefer to identify as survivors because the term implies strength and resilience. Some people feel that they were victims when the violence occurred but then became survivors by choosing each day to continue to live their lives.

As others have done, particularly when addressing the issue of violence in both the health and legal sectors, we use only the word victim for the sake of simplicity.[70] However, this is not intended to imply any lack of agency or empowerment.[33]

All those engaging with an individual who has experienced violence should use the language the individual employs or a more inclusive term such as *service users or people who experience(d) violence.*

Section 2.2
Defining Violence Prevention and Response

Most program elements in this guide focus primarily on responding to the needs of victims of violence. However, violence prevention and response are overlapping, and responding to violence also serves to prevent it. As the U.S. Centers for Disease Control and Prevention note in their guidance on violence prevention, "While the major purpose of interventions that take place after violence has occurred is to reduce or ameliorate the negative effects of the violence, some of these approaches may have the advantageous effect of preventing a reoccurrence of violence."[77] One example of this advantageous effect was demonstrated in India where an intervention that sensitized and trained law enforcement and educated sex workers on their legal rights decreased police violence as well as violence by any perpetrator.[78] Furthermore, the individuals for whom training is recommended so that they can be included in violence response, such as HCWs, may also be perpetrators of violence. In a recent study of trans women in Latin America and the Caribbean, 83 percent of those sampled reported experiencing emotional, physical, sexual, or economic violence in health care settings.[52] This included being made to wait until last, being refused services, and actual and threatened physical violence. Training HCWs to recognize such behaviors as abusive in the context of improving their response to KP members who are victims of violence can also help stop such abuses more generally. See box to the right for more information on the overlap between violence prevention and response.

PRIMARY, SECONDARY, AND TERTIARY VIOLENCE PREVENTION[77]

In a public health approach to addressing violence, prevention of violence is conceived of in three ways (see below). This framing informs our understanding of opportunities for prevention that arise within response. For clarity, within this document we separate response and prevention, but as these examples—taken from within the program elements—demonstrate, this is often a false dichotomy.

PRIMARY PREVENTION. Approaches that prevent initial perpetration (e.g., training law enforcement officers to stop their perpetration of violence, changing the acceptability of violence at a broader societal level by decreasing the normalization of violence among both potential victims and perpetrators).

SECONDARY PREVENTION. Immediate responses after violence has occurred to deal with the short-term consequences (e.g., providing first-line support and linking a victim to services so that they can leave a violent situation or have an offender held accountable legally or otherwise to prevent future violence and reduce the sense of impunity among other potential perpetrators).

TERTIARY PREVENTION. Long-term responses after violence has occurred to deal with lasting consequences and work with offenders of violence (e.g., support groups and long-term counseling to help victims rebuild self-esteem and improve mental health to facilitate changes, such as believing one has value and does not deserve to experience violence, that can prevent exposure to future abuse).

Section 2.3
Addressing Violence Proactively

As stated, violence against KP members is common, occurs across their lives, and is perpetrated by a range of actors. To address violence and its impacts on individuals' HIV vulnerability, HIV treatment uptake, and overall well-being, preventing violence and ensuring access to support for those who experience violence is important. Linking victims of violence to support requires that KP members have opportunities to, comfort with, and an incentive to disclose violence.

The health-related benefits of creating an opportunity for disclosure and providing support to individuals who disclose violence, both for victims and the direct service providers working with them (e.g., PEs, PNs, ORWs, HCWs),[35] include the following.

BENEFITS TO SERVICE USER'S OVERALL WELL-BEING

- Realization that violence is associated with health problems
- Decreasing sense of isolation
- Feeling that the direct service provider cares about them
- Increased ability to access HIV and other health services
- Increased access to services, such as psychosocial support, that may help them deal with trauma

BENEFITS RELATED TO CLINICAL OUTCOMES

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

Collecting information on violence from service users is also important at an aggregate level, where information on prevalence and perpetrators of violence can help identify and monitor abuses.

REMEMBER: ASKING ABOUT VIOLENCE IS NOT ABOUT CHECKING A BOX; IT SHOULD BE DONE TO MEET THE NEEDS OF THE SERVICE USER. Direct service providers should not ask about violence if they do not have the capacity to respond appropriately. Responding appropriately is more than just referring. Many victims do not complete referrals and may not wish to access other services immediately or at any point. Direct service providers who ask about violence must, therefore, be trained in first-line support.

To provide opportunities for KP members to report violence, a range of direct service providers should create environments conducive to disclosure. In such an environment, KP members understand their legal rights, perceive violence as unacceptable, believe that disclosure will benefit them, and are given the opportunity to talk about any violence in their lives. Outside of a clinical setting, questions about violence are often included in risk assessments, for example, in microplanning when peers ask about HIV vulnerabilities.[79] In a clinical setting, HCWs can ask about violence in order to link individuals to care, prevent harm, and improve the health services that they provide. Both approaches are discussed in more detail in SECTION 4, ELEMENT 4. Spontaneous disclosure of violence, while not the focus of this section, also increases when violence services are available and KP members can observe others receiving appropriate support when reporting abuse.[80]

In every instance, before being asked about violence, individuals should first be asked whether they are willing to answer questions about experiences of violence. In addition, they must understand who, if anyone, else will have access to the information that they share (an important aspect of informed consent). Finally, individuals should only be asked about violence if the minimum standards below can be met:[36]

- A protocol or SOP is in place that describes the provision of violence response services.
- Direct service providers are trained on how to ask about violence and respond to disclosures of violence in a way that respects service users' rights, dignity, and choice.
- A private setting is available as well as mechanisms are in place to ensure service users' confidentiality during and after disclosure.
- A system is in place for referral across health and other sectors (e.g., a service directory).
- A standard set of questions is in place to ask about violence and document responses in a way that protects victim's confidentiality.

More standards, specific to health care settings, can be found in *Strengthening Health Systems to Respond to Women Subjected to Intimate Partner Violence or Sexual Violence: A Manual for Health Managers* within Job Aid 3.2 Assessing Service Readiness (page 31).[36]

QUESTIONS ABOUT VIOLENCE

When asking about experiences of violence, the questions must be clear to the service user. If a KP program is providing education on the forms of violence that KP members experience (see SECTION 2.1) it may be possible for a direct service provider to use a question such as, "Have you ever experienced violence?" Absent an explanation of violence, a mutual understanding of what "violence" entails should never be assumed; and failing to be explicit may mean that violence is dramatically underreported. In many contexts, individuals asked about their experiences of violence may imagine that only severe physical abuse or rape can be considered violence. A series of questions that include examples—such as "Has anyone ever humiliated you in front of others, attempted to control your activities, or intentionally made you feel afraid?" and "Has anyone slapped you, punched you, hit you, or caused you any other type of physical harm?"—can help ensure that the service user understands what they are being asked. Depending on the service user's understanding, it may also be important to explicitly state who is meant by "anyone." For example, a set of questions used to ask transgender people and men who have sex with men in Mexico and Thailand about experiences of violence included this statement after each question: "Anyone includes: your partner, a client, someone in your family, a friend, neighbor, police, or other persons."[81]

The period included in the question (e.g., violence during the past three months, past 12 months) can be determined by the program. Violence in the past, including childhood violence, is correlated with current experiences of violence.[82, 83] Past experiences of violence are also correlated with present-day increased vulnerability to HIV acquisition.[17, 84] Therefore, when questions about violence are part of determining HIV vulnerability as well as linking individuals to services, asking about lifetime experiences of violence can be appropriate. Questions to determine specific risks to a service user, for example, in the context of partner notification (also called voluntary partner referral or index testing), may simply ask about an individual without a time frame (e.g., "Are you afraid of your partner?"). (For more questions on IPV specifically, see Job Aid 11 Asking about Violence in *Health Care for Women Subjected to Intimate Partner Violence or Sexual Violence: A Clinical Handbook.*[35]) Where resources are limited, and it is not possible to provide support to all victims of violence, KP programs have triaged using time limitations such as violence in the past three or 12 months. However, those who wish to disclose violence that occurred outside a given time frame should not be prevented from doing so or from being supported if they disclose.

Finally, any questions should be developed in collaboration with members of KPs to ensure relevance locally.

Section 2.4
Addressing Violence Safely

While safety of victims within the context of "do no harm" is explored in more practical detail throughout this guide, it is also important to consider the safety of program implementers. LINKAGES, in collaboration with the International HIV/AIDS Alliance, developed a *Safety and Security Toolkit: Strengthening the Implementation of Programs for and with Key Populations.*[44] This toolkit can help implementers identify security gaps and plan to fill those gaps using existing tools and case studies.

Implementer safety should be prioritized in efforts to address violence to both protect the human rights of those who implement programs and to ensure that HIV programs can be implemented effectively. Following the guidance in this document, such as focusing outreach efforts on communities where the most violence occurs, may require that added resources—for example, funds for PEs or PNs to use taxis instead of public transport—be provided to ensure safety. The mental health and well-being of direct service providers, especially those who are KP members, is explored in ELEMENT #4E.

SECTION 3

Principles for Violence Prevention and Response Programs

These program principles are rules of conduct that guide how VPR activities are designed, implemented, and monitored. In line with recommendations by WHO, PEPFAR, and UNAIDS, this guide embraces program principles that prioritize the protection, dignity, rights, and health of KP members who experience violence and those at risk of violence.[2, 10, 85] These principles should be incorporated into all VPR programming for key populations.

Principle #1
Do No Harm

Adherence to ethical codes of conduct is particularly relevant when working with victims of violence, including the duty or obligation to:

- Act in accordance with the wishes and choices of victims of violence
- Avoid harming KP members or causing further harm to individuals who have experienced violence
- Consider the safety of victims of violence
- Provide services without judgment and that respect the confidentiality of victims (including that they are members of a key population)
- Get informed consent from victims before providing services and/or making referrals

"Do no harm" also means proactively avoiding harm. While many actions to avoid harm will occur at the individual direct service provider level, these actions should be reinforced through:

- Organizational policies to address violence and sexual harassment
- Codes of conduct
- Sensitization of staff and direct service providers on issues of power and control, including in intimate partner relationships
- Ongoing training and support for direct service providers (e.g., on supporting victims of violence and working with members of KPs)
- Safety planning for people who disclose violence

WHAT COULD CAUSE HARM?

Even well-intentioned efforts to support KP victims of violence can cause harm. For example, direct service providers may believe that a victim can only effectively avoid future violence by reporting to law enforcement. As a result, the direct service provider may try to force the victim to report. This can cause the victim harm in several ways. It is often unsafe for KP members to report to law enforcement, especially in the context of criminalization, and reporting to them may cause further harm to the victim. Furthermore, if a victim does not feel comfortable taking an action that is strongly suggested by a direct service provider, the victim may avoid seeking help from the direct service provider in the future, effectively limiting his/her support network. All direct service providers should instead ensure that a victim fully understands the range of available options, including the consequences of electing or not electing to access each one, and then support the victim to access the option(s) that best meets his/her needs.

DO NO HARM TO AVOID REVICTIMIZATION

"A victim is often in a heightened state of awareness and very emotional after an assault due to circulating stress hormones; events may be recalled in dramatic detail. Many survivors of sexual assault have described the kindness of the treating personnel as being beneficial to their recovery. Conversely, many describe comments made by police, doctors, counsellors and other persons with whom they have had contact as a result of the assault that have haunted them for years. For this reason, health workers must choose their words with great care when dealing with sexual assault patients and take care not to contribute in any way to revictimization of the patient."[33]

Principle #2

Promote the Full Protection of Key Populations' Human Rights and Reject Any Intervention Based on the Notion of Rescue and Rehabilitation

A human rights perspective should be part of all VPR planning, implementation, and evaluation. This means embracing the beliefs that people have a right to live free of violence and the right to information, respect, dignity, and the highest attainable standard of health. Specifically, these rights include nondiscrimination; security of person and privacy; recognition and equality before the law; due process of law; employment and fair conditions of employment; peaceful assembly and association; freedom from arbitrary arrest and detention, and from cruel and inhumane treatment; and protection from violence.

It is important that any VPR activities, including sensitization and training, do not imply that being a sex worker, man who has sex with men, trans person, or person who injects drugs is an inherently violent experience. Instead, exploring root causes of violence should help make clear that violence against KP members occurs within a context of stigma, marginalization, and criminalization. Any conflation of violence and sex work, including through conflating sex work and trafficking, should be explicitly rejected.

Interventions based on the notion of rescue and rehabilitation should be rejected. Empowering and supporting KP members to make their own choices and gain a sense of power and control over their lives is a central tenet of KP programs. Raids and other interventions that claim to "rescue and rehabilitate" KP members deprive them of their agency (the choice, control, and power to act for themselves), are counterproductive, and actually increase the likelihood that they will experience violence.[2] "Reparative therapy," which seeks to change someone's sexual orientation, has been shown to cause emotional and psychological trauma.[3]

Principle #3

Respect Key Population Members' Rights to Make Informed Choices (Self-Determination) and to Access the Full Range of Services Recommended for Victims of Violence (Provided Free of Stigma and Discrimination)

KP members have the right to make informed choices about their lives, which may involve *not* reporting or seeking justice/legal services for violence, not seeking health services, or deciding to stay in an abusive relationship. There is no "one-size-fits-all" way to deal with violence, and each person experiencing violence is best placed to decide what is right in their situation.

Thus, direct service providers should use a victim-centered approach to give power and control back to KP members and respect their rights, needs, and wishes while offering information about the range of available options to allow them to make informed decisions. It should always be the decision of KP members—not the direct service provider—to report violence and/or to pursue legal action against a perpetrator. A direct service provider's role is to offer information about KPs' rights and available services so that people can weigh this information against the possible risks of retaliation by a perpetrator, further stigmatization and abuse, and/or loss of basic needs (e.g., shelter, food, financial support).

KP members have the right to access and receive services without being subjected to stigma, discrimination, or violence. KP members often face stigma, discrimination, and violence by the same professionals who are charged with protecting and providing services to them (e.g., law enforcement officers, HCWs). Thus, KP programs should:

- Conduct ongoing training with all staff and direct service providers involved in the continuum of care on the rights and unique needs of KP members.
- Work to increase accountability within institutions that should serve KP members, for example, by seeking input on direct service provider behavior via continuous monitoring.
- Address barriers that KP members face to accessing health care services, including access to post-exposure prophylaxis (PEP) and other violence response services.

Principle #4

Promote Gender Equality and Challenge Harmful Gender and Other Societal Norms that Contribute to Violence

All VPR training curricula should include content that promotes and supports gender equality and challenges harmful gender and other societal norms. The content should build participants' knowledge about issues that are relevant to KPs, including concepts of power relations, inequality, gender norms, and discrimination on the basis of gender identity and sexual orientation. These trainings should also highlight how power imbalances beyond those related to gender (see box to the right) make people more vulnerable to stigma, discrimination, and violence.

In addition to addressing harmful gender norms during structured trainings, **implementers should be mindful of unequal gender roles, social norms, and distribution and control of resources and power within their own organizations and programs and identify solutions to address any disparities.** Disparities that need to be addressed may include failing to offer programming specifically for individuals who don't fit gendered stereotypes about who KP members are, for example, male and trans sex workers or women who inject drugs. Finally, since violence against KP members is rooted in structural inequalities and unequal power relationships, all VPR interventions and strategies should aim to create more equitable power relationships between KP members and power holders in the larger community.[2]

CONSIDER EQUALITY ACROSS DIMENSIONS

This principle focuses on gender equality, including for individuals who face discrimination and violence because of their biological sex, gender identity, gender expression, or sexual orientation. However, other dimensions of equality and access should also be considered.

Age, race, ethnicity, nationality, disability, religion, educational attainment, and socioeconomic class can all affect vulnerability to violence. The more that marginalized and criminalized identities, behaviors, or characteristics converge at the individual or community level, the greater the risk of violence. For example, an immigrant sex worker who does not speak the local language, has limited financial resources, and is afraid of deportation will be more vulnerable to abuse by law enforcement than a sex worker who is a citizen and has the connections and financial resources to find and hire a lawyer if violence should occur.

Intersectionality—which "focuses on relationships and interactions between factors, and across multiple levels of society, to determine how health is shaped across population groups and geographical contexts"—is not yet part of mainstream global health but is increasingly seen as an important approach to addressing unequal access to health and well-being.[86] Intersecting vulnerabilities should be considered in program design, implementation, and evaluation, and efforts should be made to both (1) focus resources on those whose intersecting identities and experiences place them at greatest risk of violence, and (2) ensure that VPR trainings create spaces to discuss the ways in which people with different identities or experiences are served (or not served) by institutions and programs in order to challenge inequalities in access.

Principle #5

Be Responsive to Local Patterns of Violence and Barriers to Accessing Services

To develop VPR programs that are relevant to specific KP communities in any geographic location, implementers should use a **variety of mechanisms (e.g., assessment, focus groups, stakeholder interviews, microplanning, hot spot mapping, training) to understand the local patterns of violence against KP members and barriers to accessing services** in their communities; how KP members are currently coping with violence; the services available and accessible to individuals who experience violence; and the attitudes of direct service providers who provide health, social, and justice/legal services to KP members. (See ELEMENT #2). If research about violence is conducted, it should adhere to standards of ethics and safety outlined in *Ethical and Safety Recommendations for Intervention Research on Violence against Women.*[87]

When violence becomes more extreme, such as during political unrest, violence against members of KPs can intensify disproportionately. In these cases, it is also important to think about opportunities to engage a broader network of actors, including those outside the country. This is explored in more detail in *When Situations Go From Bad to Worse: Guidance for International and Regional Actors Responding to Acute Violence against Key Populations.*[88]

Principle #6

Place Key Population Members at the Center of Design, Implementation, and Evaluation of Violence Prevention and Response Activities and Identify/Build on Existing Key Population Community-Led Efforts to Prevent and Respond to Stigma, Discrimination, and Violence

Use participatory methods to ensure that KP members are involved in design, implementation, and evaluation activities. KP members have detailed knowledge about the legal, social, cultural, and institutional constraints that block their access to services and deny them their rights. One way to promote the protection of KP members' human rights is to establish meaningful ways to include KP members, 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.

Programs should draw on KP members' knowledge and experiences and tailor VPR services to the local context by:

- Providing training and ongoing support to empower KP members to participate in organizational and community processes
- Creating opportunities for participation, such as training KP members as PEs, PNs, paralegals, advocates, health promoters, and program staff
- Involving KP members in the sensitization and training of staff and direct service providers
- Establishing ways to obtain ongoing input and feedback from KP members

Meaningful participation means that KP members:[2, 3, 11, 12]

- Choose how they are represented and by whom
- Choose how they are engaged in the process
- Choose whether to participate
- Have an equal voice in how partnerships are managed

Meaningfully engaging KP members will help improve their acceptance of, access to, and use of important health and other services.

Identify and build on existing KP community-led efforts to prevent and respond to violence. Often, KP communities have developed their own strategies for preventing and responding to violence. KP programs should build on the resourcefulness and resilience of KP members and identify ways they can support and strengthen existing systems and strategies. For example, if a group of sex workers has a system in place to communicate with one another in case of emergency (e.g., phone tree, WhatsApp group), the KP program should work with the sex workers to identify ways to support and strengthen the existing system (e.g., providing mobile phones, airtime, transportation reimbursement, printed materials, training) and the resources needed.

Principle #7

Build the Capacity of Key Population Communities and Partners to Understand and Address the Links between Violence and HIV

All direct service providers involved in the continuum of care should be sensitized to issues that are relevant to KP members and trained to be able to respond effectively to KP members who experience violence. They should understand this training is not separate from their work to control the HIV epidemic but is a vital part. They should also work to ensure that KP members are aware of the links between violence and HIV; their human and legal rights, including what to do if arrested and correct law enforcement procedures; what they can do if they experience violence; and how they can access health, social, and justice/legal services. (See ELEMENT #4C and ELEMENT #4D for more information about sensitization and training activities.)

Principle #8

Integrate Violence Prevention and Response into HIV Prevention, Care, and Treatment Programming

VPR services should be integrated into existing programming and viewed as key components of HIV prevention, care, and treatment programs. They are not a separate intervention.

Principle #9

Ensure Privacy, Confidentiality, and Informed Consent When Interacting with Victims of Violence

Privacy and confidentiality are essential for KP members' safety in any setting. Direct service providers can put people's safety at risk if they share sensitive information with partners, family members, or friends without the KP members' consent. This includes sharing KP members' information with other direct service providers within one's own organization or within the referral network without the explicit consent from the KP member. A breach of confidentiality about pregnancy, violence, contraception, HIV status, sexual orientation, sex assigned at birth, gender identity, involvement in sex work, drug use, or a history of sexual abuse can put KP members at risk for additional violence.

To protect individuals' confidentiality and privacy, the following procedures should be put in place:

- Designate a private space where conversations about violence can occur
- When asking about violence and responding to disclosures, direct service providers must speak with individuals alone (with the exception of children under age 2)
- Establish a privacy and confidentiality policy that specifies:[36]
  - » Who will be responsible for collecting and recording information
  - » Where and how information will be collected and recorded
  - » How information will be stored
  - » Who will have access to the information, including what information will be shared within a facility or with third parties (such as providers within a referral network)
  - » The need to obtain the victim's consent before sharing any information and the need to inform victims about the limits of confidentiality before a disclosure occurs (for example, in the case of mandatory reporting)
  - » If victims are given records to take home with them, information about the experience of violence should not be mentioned
- Provide ongoing training for implementers on protecting KP members' privacy and confidentiality, including obtaining informed consent and sharing information on options and rights.

Consultations with members of KPs have shown that having to provide identifying information—such as government-issued identification or biometric data—limits the uptake of services. Providing services without requiring such identifying information can protect individuals' confidentiality while increasing service access.

MANDATORY REPORTING

In some contexts, HCWs may be mandatory reporters. The following is taken from *Health Care for Women Subjected to Intimate Partner Violence or Sexual Violence: A Clinical Handbook.*[35]

"HOW CAN I PROMISE CONFIDENTIALITY IF THE LAW SAYS I HAVE TO REPORT TO THE POLICE?"
If your law requires you to report violence to the police, you must tell the victim this. You can say, for example, "What you tell me is confidential, that means I won't tell anyone else about what you share with me. The only exception to this is....."

As a HCW, learn about the specifics of the law and conditions in which you are required to report (e.g., the law may require reporting rape or child abuse). Assure the victim that, outside of this required reporting, you will not tell anyone else without their permission.

Principle #10

Monitor and Evaluate Programs to Identify Any Unintended Harmful Impacts and Develop Strategies to Improve Violence Prevention and Response Programming

Data collection tools and tracking mechanisms should be used to inform and improve programming and track unintended harmful consequences. Data collection forms and tracking mechanisms allow PEs, PNs, ORWs, and other direct service providers to document disclosures of violence, services provided, referrals made, dates for follow-up services (e.g., clinical follow-up dates related to PEP), and whether victims followed through with referrals and scheduled follow-up visits. Documentation of this information is necessary for programs to be able to analyze what types of violence KP members are experiencing, who is committing the violence, what services were offered, and what services KP members received. This information will help the program track trends, identify gaps, and make improvements. When possible, report into national systems such as Health Management Information Systems or systems managed by the Ministry of Women or a national Human Rights Commission.

Backlash and reprisals should also be tracked and addressed. For example, in some programs there have been reports of increased violence against sex workers once they begin to assert their rights with law enforcement officers. Tracking such issues can help ensure that there are resources to address them, such as additional law enforcement training to ensure a shared understanding of the legal context.

SECTION 4

Program Elements

1 Build core knowledge among implementers and key population communities

2 Build an understanding about violence against key populations and existing efforts to address it

3 Create networks to ensure key populations' access to health, psychosocial support, and legal services

4 Create systems to provide opportunities for disclosure and respond to violence, including crisis response

5 Promote accountability to prevent violence

6 Document and monitor

FIGURE 4. Violence prevention and response program elements

This section outlines the six program elements (FIGURE 4) and provides a rationale and implementation guidance for each.

The program elements are based on the content of Program Area 3: Structural Interventions in the *Key Population Program Implementation Guide.*[27] Activities to address structural issues are only one component of the implementation guide (FIGURE 5) and do not occur in isolation in KP programs. Other components, such as engaging and empowering KP members, while also a part of VPR activities, are explored in more comprehensive detail within the relevant section of the *Key Population Program Implementation Guide.*[27]

If appropriate, implementers should work to ensure that all VPR program elements are in place. However, (1) in some contexts, various program elements will already be implemented and additional efforts may not be an effective use of resources (e.g., an effective law enforcement training on the rights of KP members already underway should not be duplicated, but could be expanded), (2) the inclusion or exclusion of program elements or activities within those elements will be dependent on resources available and what can be integrated into HIV-focused activities being implemented in a given context (e.g., whether a program is only offering prevention and testing or working across the cascade will dictate whether PNs are available for engagement), and (3) the extent to and way each element is implemented must depend on the priorities and direction of the KP communities for whom the program is designed.

When it is not possible to implement all elements or all activities under each element, the action planning workshop (described in ELEMENT #1A) can be used to select priorities. At the end of the workshop, attendees come together to note the elements/activities already in place and prioritize those that best address the violence occurring through integration with existing programming and according to available resources.

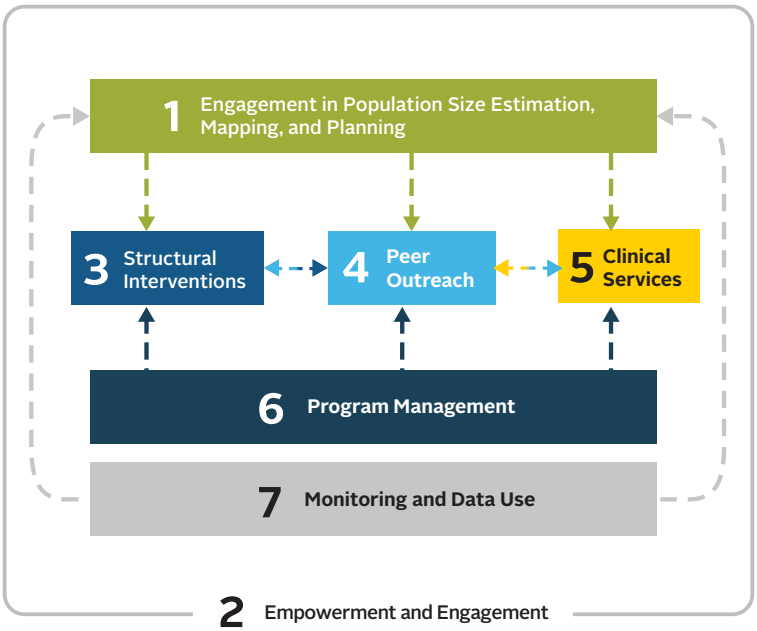

FIGURE 5. Seven program areas in the *Key Population Program Implementation Guide*[27]

For implementers who have dedicated resources to address violence and can be more expansive than what is suggested here, we recommend starting with this recommended set of elements and building onto it as resources allow. For example, more activities around primary prevention could be an important addition—such as working directly with the intimate partners of KP members to stop the perpetration of IPV—as could activities that change the overarching legal environment, such as efforts to decriminalize same-sex sexual relations.

COLLABORATING WITH OTHER KP PROGRAMS

In some contexts, multiple programs providing HIV prevention, care, and treatment for KP members will be in operation. When this occurs, as much as possible, work together and take responsibility for different VPR program elements (or their implementation in different locations) to ensure that resources go to filling gaps and not re-creation or duplication of the same activities.

The program elements do not need to be implemented sequentially—for example, it is possible to begin training law enforcement (under ELEMENT #5) before creating a referral network (ELEMENT #3)—nor does one element need to be completed before the next is begun. Implementers are likely to work on several simultaneously. When deciding what order to pursue activities, consider the importance of setting up systems to respond effectively to the needs of victims before creating demand for those services.

Element #1

Core Knowledge among Implementers and Key Population Communities

ELEMENT #1A

A trained core team of staff, partners, and direct service providers (e.g., staff, drop-in center [DIC] managers, allied lawyers, and selected HCWs, PEs, PNs, and ORWs) is able to lead the design and implementation of a tailored comprehensive VPR program for KP members.

MATERIALS/RESOURCES

Guide for Developing and Implementing Comprehensive Violence Prevention and Response Programs for Key Populations (this document)

OVERVIEW/RATIONALE

To create leadership and buy-in, it is important to train a core team who can lead the design, implementation, and evaluation of all VPR activities. This team should be organized and trained as part of planning VPR activities.

GUIDANCE FOR IMPLEMENTATION

A. Determine the role of the core team and select members. Invite those that are passionate and will continue to engage. The members of this group will serve as the leadership team and be involved in the design, implementation, and evaluation of all VPR activities. Members should be familiar with how the HIV service delivery aspects of the program operate in the case of an existing program, and the team should include staff in charge of both technical and M&E functions as well as leadership from KP-led and other partner organizations, DIC managers; and select HCWs, PEs, PNs, and ORWs. An allied lawyer or HCW passionate about human rights and VPR could also be included. Once trained, the members of this core team can be mobilized and supported to train others involved in the continuum of care (e.g., HCWs, PEs, crisis response team members).

B. Organize an action planning workshop for the core team. The content of the training should align with this guide, which reflects the VPR content of the *Key Population Program Implementation Guide*.[27] The goal of this workshop is to equip the core team with the knowledge and skills needed to design, implement, and evaluate a set of activities to help prevent and respond to violence against KP members. The outcome of the workshop is an action plan of existing activities that correspond to Program Elements and activities that the core team believes should be prioritized for future implementation/expansion. An action planning template can be found in ANNEX 3.

C. Who trains the core team? Typically, this training is conducted by program staff and/or consultants, a local human rights lawyer, and select KP members. Depending on existing relationships with health and law enforcement officials, it may also be appropriate to include them as trainers for relevant sections.

ELEMENT #1B

Activities to build KP communities' understanding of violence through the lens of gender, power, and human rights. These activities will also strengthen community cohesion and agency among KP members (e.g., discussions of power; gender norms and inequalities at the root of stigma, discrimination, and violence against KP members; rights education; and so on).

MATERIALS/RESOURCES

- Information, education, and communication (IEC) materials and interpersonal communication (IPC) tools (developed by country programs)

OVERVIEW/RATIONALE

Effective HIV programs are ones in which KP members are empowered to make their own choices and act for themselves, including on issues of violence. KP programs should design and implement activities that allow KP members to come together to support each other, share information, and strengthen their ability to effect change as individuals and as a group at risk for experiencing violence.

MEMBERS OF KP COMMUNITIES MUST KNOW THEIR LEGAL RIGHTS AND THE SERVICES AVAILABLE TO THEM

KP members may not have a full understanding of their legal rights. Once they become aware of their rights, they may raise new or recurring legal issues they face. In addition to receiving information about their legal rights from PEs and other direct service providers during individual interactions, KP members can benefit from legal literacy workshops that provide more information and increase access to lawyers. Lawyers who are part of the crisis response team or the core team can be mobilized to conduct these workshops.[29]

In addition, KP members must know the services that are available to them if they experience violence. Efforts to share information on rights can and should also contain information on services beyond legal support that are available when violence occurs. Information on time-bound services, such as PEP and emergency contraception, should be emphasized.

GUIDANCE FOR IMPLEMENTATION

A. Types of activities. The following are examples of activities that can be conducted by PEs, PNs, and ORWs through DIC meetings or during KP community outreach. (IEC materials would be a helpful component of these activities.)

- Support groups and discussion groups
- Health education sessions (individual and group), which can include an emphasis on the health services that are time limited (PEP and emergency contraception)
- Recreational activities
- Dissemination of safety tips
- Rights education/legal literacy workshops
- Social activities at safe spaces
- Dissemination of printed and electronic materials that inform KP members about their rights and how to access available services

B. What should these activities accomplish? KP programs should prioritize activities that support KP communities to:

- Understand that violence is not acceptable, and they deserve to live free of violence
- Recognize that many people experience violence and that they are not alone
- Understand that they are never to blame for violence that happens to them
- Understand ways to reduce one's vulnerability to violence and tips for staying safe
- In the case of IPV, understand that violence is not inevitable or about love, but about the perpetrator(s) exerting power and control over the victim
- Develop ways to support each other
- Strengthen individual self-esteem and group cohesiveness
- Advocate for themselves within the larger community
- Understand their legal rights, including the local laws most relevant to KP members, and how to access the support and services they need (see box titled, "Members of KP communities must know their legal rights and the services available to them")
- Understand law enforcement procedures and what to do if arrested
- Know where and how to access violence response care services, both clinical and nonclinical (for example, psychosocial support) and which services must be accessed immediately (PEP, emergency contraception)

Rights education can help change norms around the acceptability of violence and generate demand for services.

C. When should these activities occur? Sharing information on rights and services available is important throughout the implementation of VPR activities.

Element #2

An Understanding among Program Implementers of Violence against Key Populations and Existing Efforts to Address Violence

ELEMENT #2A

Mechanisms in place (e.g., assessment, focus groups, stakeholder interviews, microplanning, mapping, training) to increase understanding of violence experienced by key populations, including types of violence, common perpetrators, key hot spots, needs of KP members when they experience violence, and barriers to accessing violence response services.

MATERIALS/RESOURCES

- ANNEX 4: Sample Focus Group Guide for Female Sex Workers
- ANNEX 5: Sample In-Depth Interview Guide for Key Stakeholders/Facilities
- Completed mapping exercises to identify KP hot spots and other locations where individuals may experience violence
- *Ethical and Safety Recommendations for Intervention Research on Violence against Women*[87]
- *Mapping and Population Size Estimates of Sex Workers: PROCEED WITH EXTREME CAUTION*[89]

OVERVIEW/RATIONALE

To design effective VPR programs that meet the unique needs of KP members, program implementers need to understand what KP members are experiencing, how they are coping, what violence response services are available and accessible to them, and what barriers they face to seeking and receiving violence response services and support.

GUIDANCE FOR IMPLEMENTATION

A. What information should be collected? Program staff should collect the following information for the development of VPR programs:

- Types of violence experienced by KP members
- Types of perpetrators who commit violence against KP members
- Community attitudes toward KP members
- Existing health, social, and justice/legal services available to KP members who experience violence
- Existing programs, services, or initiatives to prevent violence (i.e., primary prevention interventions) focused on both the general population and key populations
- Barriers for KP members in accessing health, social, and justice/legal services
- Needs of KP members who experience violence, and common coping mechanisms

» Barriers for direct service providers in asking about and responding to violence among KP members
» Opportunities for training to strengthen direct service providers' skills in asking about and responding to violence among KP members

B. How should this information be collected? Use already available information as much as possible as any new information needed can be collected through one of the options below.

» Focus groups with KP members
» Focus groups with direct service providers
» Interviews with other key stakeholders and power holders
» Microplanning
» Hot spot mapping
» Discussion with KP members during meetings, training, and other events
» Individual risk assessments with KP members during outreach activities
» Gender analyses (see box below)

C. Ethical and safety considerations for data collection and storage

» Refer to *Ethical and Safety Recommendations for Intervention Research on Violence against Women*[87] before beginning to collect information. This resource provides important insights on how to ensure that the process is ethical and does not endanger those collecting the information or those reporting violence.
» Hot spot mapping in some contexts has been linked to harms, such as increased policing and breaches in confidentiality. Before conducting hot spot mapping, refer to the NSWP policy brief *Mapping and Population Size Estimates of Sex Workers: PROCEED WITH EXTREME CAUTION.*[89]

GENDER ANALYSIS FOR KP PROGRAMS

A gender analysis is a specific type of assessment that can be used to determine the ways in which GBV affects HIV risk and service uptake. A gender analysis, particularly if it includes the voices of KP members, can provide information on incidence of GBV, the most common types of GBV, the perpetrators of GBV, and the gender norms that justify or encourage violence against KP members. Findings related to violence can inform adequate VPR in HIV programming. LINKAGES developed a *Gender Analysis Toolkit for Key Population Programs*[90] to aid others to undertake a gender analysis with key populations.

LINKAGES also created the *Nexus of Gender and HIV series* in Kenya to highlight key findings and recommendations from a gender analysis with men who have sex with men, people who inject drugs, sex workers, and trans people.[91-94]

The Nexus of Gender and HIV among Men Who Have Sex with Men in Kenya

The Nexus of Gender and HIV among People Who Inject Drugs in Kenya

The Nexus of Gender and HIV among Transgender People in Kenya

The Nexus of Gender and HIV among Sex Workers in Kenya

D. How should this information be used? Ongoing efforts to understand how violence is affecting KP members and their ability/inability to access services can be used to:

- Identify geographic areas where KP members are experiencing a disproportionate burden of violence so PEs, PNs, and ORWs can provide additional support to those areas and violence prevention efforts can be focused there
- Identify harmful attitudes among stakeholders and direct service providers and include these individuals in sensitization and training activities
- Provide continuous quality improvement for violence response services and refine primary prevention interventions
- Identify barriers to accessing violence response services and collaborate with stakeholders to eliminate these barriers
- Tailor VPR activities to meet the specific needs of KP members
- Understand how KP communities are currently coping with violence and what systems are currently in place to respond to violence; identify ways that KP programs can strengthen and support those systems

ELEMENT #2B

A map that illustrates key stakeholders and established relationships with them, including Ministry of Health, senior-level law enforcement officers, allied lawyers, and health and mental health service providers frequently used and/or preferred by KP members. This resource map should reflect the health, social, and justice/legal needs of KP members who experience violence and should include all existing systems/activities/tools to address stigma, discrimination, and violence.

MATERIALS/RESOURCES

- Information from focus groups, interviews, and discussions with KP members and other stakeholders
- Information gathered from key stakeholders during a mapping workshop/meeting or action planning workshop

OVERVIEW/RATIONALE

To understand existing efforts to address violence, both within the KP community and within the larger community, it is important to map out those efforts, including informal and formal support systems. This map will be useful in developing an effective referral network, which is described in ELEMENT #3 of this document.

GUIDANCE FOR IMPLEMENTATION

A. Create a map of key stakeholders. The core team should convene a working group or workshop, including staff, representatives of KP-led and -serving organizations, KP members who have experienced violence (they do not have to disclose that they are victims of violence in order to participate), and known health, social, and justice/legal service providers, to create a map of existing services and support and to identify gaps. Be sure to include organizations that may have come up in either the action planning workshop (ELEMENT #1A) or efforts to understand ways that KP members currently experience and address violence (ELEMENT #2A). In mapping stakeholders, programs should consider the following support structures and resources:

- KP members and KP-led organizations and networks
- Health, social, and justice/legal service providers
- Local activists
- Government leaders
- Law enforcement officers
- GBV centers/organizations
- Public lawyers
- Judges/magistrates
- Mobile/emergency medical support
- Women's rights groups and/or the Ministry of Women
- Safe houses
- Human rights groups and lawyers
- Bar and venue owners
- Human Rights Commission
- Other power holders (e.g., religious leaders, tribal leaders)

Element #3

Networks to Ensure Key Populations' Access to Health, Social, and Justice/ Legal Services

ELEMENT #3A

A referral network and directory of direct service providers. The network should include health, social, and justice/legal services, including safe spaces like DICs and emergency shelters.

MATERIALS/ RESOURCES

- Completed map of key stakeholders (from ELEMENT #2B)
- ANNEX 6: Sample Printed Referral Network
- WHO, 2017. *Strengthening Health Systems to Respond to Women Subjected to Intimate Partner Violence or Sexual Violence: A Manual for Health Managers*[36]
  - » **Chapter 3.4:** Establish Coordination and Referrals within the Health System, list of potential entry points to enter the health system (page 34)
  - » **Job Aid 4.1:** Assigning Roles and Responsibilities to Different Cadres of Health-Care Providers (pages 38-39)
  - » **Chapter 8.1:** Strengthen Engagement of the Health Sector in Multisectoral Coordination Mechanisms, portion on law enforcement engagement (page 86)
  - » **Annex 7:** Developing a Memorandum of Understanding (page 143)

WHAT SERVICES SHOULD BE AVAILABLE TO INDIVIDUALS WHO HAVE EXPERIENCED VIOLENCE?

Each victim of violence will have unique needs based on the type of violence experienced (for example, some services will be relevant only in the case of sexual violence) and the victim's characteristics and preferences. The following should be accessible to ensure comprehensive support is available to all victims.

Health services: treatment of injuries, HIV testing, PEP, emergency contraception, STI testing and treatment, rape kits/forensic exam, tetanus vaccine, and hepatitis B screening and treatment. Mental health screening and treatment for depression and post-traumatic stress disorder should also be available. National protocols on clinical care for sexual assault victims will determine the availability of some of these services.

Social services: psychosocial support including crisis counseling and support groups, securing/replacing identity documents, transportation assistance, child care, interpreters, financial aid (such as vocational training), food assistance, and connections to community-based organizations that can provide information and facilitate access to services, including through accompaniment.

Programs for perpetrators, safe accommodation, and links to child protection services are also recommended but may not be available or able to meet the needs of KP members and may require resources beyond what the KP program can provide. They should be offered if the program has sufficient resources to ensure these services can safely and appropriately serve members of KPs.

Justice/legal services: information on the rights of KP members, information on law enforcement procedures, legal counsel (including in cases of arrest), ability to give a statement or otherwise document the case. When law enforcement can be safely engaged, they can be part of providing these services as well as additional violence response support, such as forensic/medico-legal examination.

OVERVIEW/RATIONALE

Programs should establish a referral network of direct service providers who can provide stigma-free services to KP members who have experienced violence. Many of the services that KP members need access to will require referrals to other institutions or individuals beyond those direct service providers supported by the KP program. The way that these services are connected to one another should be outlined in VPR SOPs, and all referral points should be familiar with referral processes.

Services that meet a victim's mental health needs may be available from multiple sources, including community-based organizations. However, some conditions, such as post-traumatic stress disorder, require access to a professional with more training. Part 4 of the *Health Care for Women Subjected to Intimate Partner Violence or Sexual Violence: A Clinical Handbook* provides information on the mental health services that can benefit victims of violence and who may be equipped to offer each.[35]

It is generally not realistic for a program to provide all the services needed by victims of violence, nor is it sustainable. Referral networks broaden available services and can help strengthen those services' ability to serve members of KPs.

WHO CAN PROVIDE LEGAL INFORMATION AND SERVICES?

Direct service providers should be knowledgeable about the basic legal rights of KPs and be able to share this information with service users who disclose violence to help them understand their options. KP members who disclose violence should also be referred as needed to individuals with more legal knowledge. They may include:

- **Paralegals.** Paralegals can provide legal information and support to KPs. In addition to informing KP members about their legal rights, PEs and PNs who are trained as paralegals can provide additional support by being available to accompany a peer to file a report with law enforcement officers, give a statement, access a lawyer, and accompany a peer to any court proceedings.
- **Allied lawyers that have agreed to provide legal services to KPs,** particularly when KPs are arbitrarily arrested and detained. These lawyers can provide services pro bono or funds can be budgeted to provide stipends to lawyers.

GUIDANCE FOR IMPLEMENTATION

A. Use the map of key stakeholders (from ELEMENT #2B) to identify individuals and organizations that should be included in the referral network. Program staff should assess and strengthen their relationships with those individuals and organizations to establish a strong network of direct service providers.

B. Build on any existing referral pathways/networks for victims of violence. In many settings, there is an existing referral network for victims of violence (or GBV specifically). KP program implementers should become familiar with and build on any existing referral networks, if appropriate. These existing referral sites may already have some capacity to provide services to people who have experienced violence but may need to be sensitized and trained to provide services to KP members.

C. Contact the local law enforcement chief (or other head of local uniformed forces) to explain the KP program, build rapport, and solicit support for VPR. (See ELEMENT #5A for more information on working with law enforcement officers.) For information on coordinating forensic evidence collection and storage, review the portion on law enforcement engagement in Chapter 8.1 of *Strengthening Health Systems to Respond to Women Subjected to Intimate Partner Violence or Sexual Violence: A Manual for Health Managers (page 86).*[36]

D. Establish links with legal aid organizations and identify allied lawyers (e.g., lawyers willing to work pro bono or to offer legal-rights training to the staff and KP members). Identify lawyers who understand the local laws that affect KP members and the human rights protections that exist in local/national-level policy documents, including a country's constitution. Ideally, they will be available to provide legal support to KP members who experience violence, including being detained, arrested, or otherwise harassed by law enforcement or other uniformed officers.

E. Develop links with any additional social service and health facilities that may be called upon to provide services to KP members who are victims of violence. This should include community-based organizations working specifically with KP members who may not be part of the existing referral pathway/network for victims of violence initially identified (under B above). *Strengthening Health Systems to Respond to Women Subjected to Intimate Partner Violence or Sexual Violence: A Manual for Health Managers*[36] has tools to help develop coordination and referral networks within the health system (page 34), a job aid that can help in assigning responsibilities within the health sector (pages 38-39), and resources to help ensure strong connections across sectors, including Annex 7 (page 143).

F. Develop a printed or online referral network and update it regularly. The list should include each referral site, the name and contact information for focal points, and hours of operation. When including focal points on a printed referral network, consider their safety and that of others offering services and also the issue of secondary stigma (stigma against those working with a stigmatized group). Ask the focal points to think about whether they can be safely included in the referral network directory, particularly if it will be distributed. Alternatively, you may decide not to share the printed referral network broadly in order to protect those listed. (See ANNEX 6 of this guide for a sample template for a printed referral network.)

REFERRAL NETWORK MEMBERS' ABILITY TO SUPPORT MEN AND TRANSGENDER PEOPLE

Recent recommendations on meeting the needs of KP members in both Asia and Latin America and the Caribbean, call upon traditional GBV service providers to expand their services to include trans people and men who have sex with men among others.[48, 50] Building a referral network that can meet the comprehensive needs of KP victims of violence, including traditional GBV service providers, can help create broader coalitions that work together to strengthen violence response services and advocate for GBV prevention with a united voice.[95] However, building such networks will require energy and understanding of one another's mandates and resources. Most existing GBV services are designed for cisgender women and may already be overstretched. In addition, some of the institutions offering GBV services to women only, such as Ministries of Women, may have strict mandates on who their resources can go to support. When referral network focal points are trained it is important to build their skills and understanding of violence against and the unique needs of all KP members, including cisgender men and trans people, so that regardless of which service users come to them for support, at a minimum they can make an appropriate referral. Service directories should also make clear whether a given organization serves all KPs or a specific subset of KP members.

RIGHTS, NOT RESCUE

Some organizations that work with victims of violence view sex work as violence against women and/or conflate trafficking and sex work. Any organization that does not agree to the principles of VPR including Principle #2 Promote the Full Protection of KP Members' Human Rights and Reject any Intervention Based on the Notion of Rescue and Rehabilitation will be unable to offer appropriate services to KP victims.

Psychological and emotional harm are some of the most common responses to violence against KP members.[50] Ensure that the referral network developed can appropriately meet the mental health needs of KP members. Mental health is important both to the individual's overall well-being, as well as their vulnerability to HIV and their uptake of and success in HIV services.[96-98]

G. Maintain an effective referral network. In addition to the steps outlined above, the following will help programs maintain an effective referral network.

- Sensitize and train focal points together to ensure a shared understanding of the local issues affecting KP members and how to use the referral network.
- Accompany service users to referral sites or arrange for accompaniment (this is often the role of PEs or PNs).
- Notify focal points in advance that a service user is being referred.
- Convene regular meetings with focal points to discuss problems with referral mechanisms, address issues with stigma and discrimination at referral sites, and identify ways to strengthen the referral network.
- Monitor referral mechanisms and routinely assess procedures to ensure they are effective and focal points are sensitized and able to appropriately serve KP members.

ELEMENT #3B

Sensitized and trained referral points with whom the program has formal relationships.

MATERIALS/RESOURCES

- *Health Care Worker Training: Preventing and Responding to Violence against Key Populations*[39]
- *Law Enforcement Training: Preventing and Responding to Violence against Key Populations to Increase Access to Justice and Strengthen the HIV Response*[43]
- *Peer Educator and Outreach Worker Training: Preventing and Responding to Violence against Key Populations*[40]

OVERVIEW/RATIONALE

Establishing a referral network (ELEMENT #3A) is of fundamental importance in ensuring that KP members have access to all the services they need if they are victims of violence. It is also important to identify and train focal points at each referral site so (1) KP members can be directly referred to this focal point, and (2) program implementers can contact the focal point to facilitate referrals and address any issues that KP members may experience in accessing or receiving services at those sites.

GUIDANCE FOR IMPLEMENTATION

A. Identify, assess, and train focal points. Identify focal points at each organization involved in the referral network, including through seeking input from KP members who have interacted with these organizations. If the KP program is engaged in efforts to monitor direct service provider or site-level stigma and discrimination, consider those results when selecting direct service providers and facilities to participate in the referral network. Once direct service providers have been identified and selected to participate in the referral network, focal points should participate in sensitization and training activities to help ensure that they deliver stigma-free services to KP members. Sensitization and training of focal points can be part of broader efforts to train HCWs (ELEMENT #4D) or law enforcement (ELEMENT #5A), if such trainings will occur.

B. Bring focal points together regularly. All focal points should come together, through a working group or other mechanism, at regular intervals to discuss and strengthen inter-organizational referral and ensure that members of the referral network have an up-to-date understanding of the services that each institution is offering. This helps ensure that referrals are made only for services currently available and may create opportunities for collaboration between institutions on new initiatives. If a working group already exists to facilitate effective referral between violence response services, consider joining and requesting that members be added as needed (for example, it will be important to add KP-led and -serving organizations if they are not already members). Resources that would have been required to initiate such a working group may instead be most useful in training the existing group on KP-friendly service provision.

ELEMENT #3C

Efforts to build acceptance for violence prevention and response, including engaging with civil society and government, that can increase access to violence response services for KP members.

MATERIALS/RESOURCES

Strategy/action plan that includes key messages to deliver to stakeholders; names of people who will be contacted at media outlets, civil society, and government agencies; a determination of which members of the core team will contact each stakeholder; and a timeline for contacting each stakeholder.

OVERVIEW/RATIONALE

Because KP members are stigmatized, it is important to build awareness and acceptance of VPR efforts within the larger community, disseminate accurate information about issues that KP members face, and create an enabling environment that rejects violence against KP members and protects them from discrimination, violence, and other human rights violations.

One way to increase the acceptability of and buy-in for VPR programs for KP members is to demonstrate their benefit to the general population as well. For example, setting up a functional violence response referral network (ELEMENT #3A) and/or training individuals from the public sector (ELEMENT #4D and #5A) to provide improved services to victims of violence not only improves the violence response services available to KP members but strengthens the services for victims overall.

GUIDANCE FOR IMPLEMENTATION

A. Create a strategy for increasing awareness and acceptance of VPR programs for KP members among media outlets, civil society, and government agencies. Convene the core team to create a strategy that includes:

- A list of organizations and agencies to engage
- A list of which members of the core team or other allies will contact these agencies, along with a timeline for engagement
- Key information to share with stakeholders to increase awareness and acceptability of VPR programs for KP members, such as HIV prevalence in the country; levels of violence against KP members; how violence impacts HIV; and the KP program's efforts to increase KP members' access to HIV testing, care, and treatment, including addressing violence and other barriers
- Printed materials that include key information, messages, and talking points

Element #4

Systems to Provide Opportunities for Disclosure and Respond to Violence, including Crisis Response

ELEMENT #4A

Standard operating procedures on creating opportunities for disclosure and providing first-line support and violence response services.

MATERIALS/RESOURCES

WHO, 2017. *Strengthening Health Systems to Respond to Women Subjected to Intimate Partner Violence or Sexual Violence: A Manual for Health Managers*[36]

- Job Aid 3.1: Topics to Include in a Protocol/SOP to Address Violence against Women (page 26)
- Annex 2: Pathways of Care for Sexual Assault and Intimate Partner Violence (page 129)

OVERVIEW/RATIONALE

Having written SOPs in place ensures that all direct service providers are knowledgeable of program procedures and increases the likelihood of consistent implementation of programs and activities.

GUIDANCE FOR IMPLEMENTATION

A. Develop draft SOPs. The core team should develop a draft set of SOPs for review by the broader group that will be tasked with implementing them. The draft should include:

Background

- The principles for VPR programming (SECTION 3)
- Information on the legal context including: KP members' rights to violence response services, what acts of violence are criminalized under the law (e.g., whether domestic violence laws are inclusive of men and transgender people), and laws that may have implications for the services provided by HCWs (for example, regarding forensic examination, abortion, and mandatory reporting)

Any approaches that include asking about and responding to violence should be explicitly included in the SOPs. Both partner notification (also called voluntary partner referral or index testing) and partner-delivered self-testing require assessing the risk of partner violence. In both cases, any violence disclosed should be considered as the health care worker and service user decide whether partner notification or partner-delivered self-testing are safe options. The service user should be the person to make the ultimate decision about whether to engage in partner notification or partner-delivered self-testing.

Whenever a program asks about violence it must be able to respond appropriately to a disclosure of violence. Therefore, if there is no ability to respond to violence it is not possible to implement partner notification or partner-delivered self-testing. For more information on asking about violence in the process of partner notification or partner-delivered self-testing, please refer to WHO's *Guidelines on HIV Self-Testing and Partner Notification.*[100]

VPR activities by PEs/PNs/ORWs

» The training that PEs/PNs/ORWs should receive before beginning to undertake VPR activities (ELEMENT #4C)

» How PEs/PNs/ORWs will create opportunities for disclosure (ELEMENT #4C)

- Materials or activities that will be used to share relevant information on rights, identifying violence, and services available (ELEMENT #4B)
- Questions that will be asked about violence (SECTION 2.3)

» How PEs/PNs/ORWs will respond if violence is disclosed (ELEMENT #4C)

- Provision of first-line support (ANNEX 7 of this guide)
- A simple pictorial flow diagram describing the actions of PEs/PNs/ORWs (an example relevant to HCWs can be found in Annex 2 of *Strengthening Health Systems to Respond to Women Subjected to Intimate Partner Violence or Sexual Violence: A Manual for Health Managers*[36])

» How PEs/PNs/ORWs will receive supportive supervision, including support for self-care (ELEMENT #4E)

VPR activities by HCWs

» The training that HCWs should receive before beginning to undertake VPR activities (ELEMENT #4D)

» How HCWs will create opportunities for KP members to disclose violence

- Materials or activities that will be used to share relevant information on rights, identifying violence, and services available (ELEMENT #4B)
- Questions to ask about violence (SECTION 2.3)

» Additional SOP guidance specific to service provision by HCWs can be found in Job Aid 3.1 in *Strengthening Health Systems to Respond to Women Subjected to Intimate Partner Violence or Sexual Violence: A Manual for Health Managers*[36]

Coordination

» The violence response services each organization will provide (should include as many of the services listed in ELEMENT #3A as possible), which key populations can access these services, focal points for each organization

» A flow chart that describes how victims should move between these services (including how to access accompaniment)

» The ways in which other VPR activities, such as a crisis response system, will connect victims to the full range of services available (ELEMENT #4F)

Documentation, including data collection and management

» Specify where and how information about violence is recorded and what information will be shared with whom (ELEMENT #6A)

» Specify how confidentiality of records will be maintained, including who across the program will have access to these records (ELEMENT #6A)

» Specify what information the program will compile, report, and how frequently for purposes of monitoring and improving quality of care (ELEMENT #6A)

B. Use a collaborative process to finalize VPR SOPs. Even though each organization (e.g., one-stop center, legal aid group) involved in violence response should have SOPs that govern internal service provision, the VPR SOPs developed by the KP program managers/administrators should guide VPR activities in a given location (e.g., city or province) *across* organizations. The inclusion of PE/PN/ORWs' responsibilities in the SOPs will allow their roles to be better understood by all others providing services. Providing an opportunity for the draft, developed in A above, to be reviewed and refined by all those involved creates a space for dialogue about how to ensure quality services and completed referrals between organizations.[99]

If the health care facilities involved in the referral network do not already have SOPs to guide their service provision for victims of violence, refer them to Job Aid 3.1 in *Strengthening Health Systems to Respond to Women Subjected to Intimate Partner Violence or Sexual Violence: A Manual for Health Managers*[36]

ELEMENT #4B

Information, education, and communication materials and interpersonal communication tools developed and disseminated. These materials should be designed for service users and direct service providers.

MATERIALS/RESOURCES

- ANNEX 8: Sample Information, Education, and Communication Materials and Interpersonal Communication Tools
- WHO, 2017. *Strengthening Health Systems to Respond to Women Subjected to Intimate Partner Violence or Sexual Violence: A Manual for Health Managers*[36]
  - » Job Aid 8.2: What Should Communities Know about the Health Response to Violence against Women? (page 95)

OVERVIEW/RATIONALE

IEC materials (e.g., posters, pamphlets) and IPC tools (e.g., discussion guides, story boards) have been used extensively by health programs to deliver health-related messages, promote healthy decision-making and healthy behaviors, and provide important information about where service users can receive support and services. IEC materials and IPC tools should be used to deliver and reinforce VPR messages that:

- Increase awareness about the different types of violence (particularly beyond sexual and physical violence)
- Increase knowledge of the negative health consequences of violence, including the link between violence and HIV
- Inform KP members that everyone has a basic human right to live free of violence
- Inform KP members about their legal rights
- Encourage KP members to talk to trusted direct service providers about their experiences with violence and seek services in a timely manner (especially for PEP and emergency contraception)
- Inform KP members about available services, including how to access them
- Help members of KPs experiencing violence recognize that they are not alone

All key populations for whom services are intended should be represented on IEC and IPC materials and programs should ensure that images used to portray each population are representative of the diversity of genders, races, ethnicities, etc. among that group. Depending on unique needs of subpopulations (such as male, trans, and female sex workers) and the laws that affect them differently, it may also be more appropriate to have different IEC materials for each.

Examples of IEC and IPC materials include:

- **Posters that incorporate VPR messages** to post throughout facilities and private spaces (e.g., wash rooms, counseling rooms).[34]
- **Pamphlets** that include information about KP members' legal and human rights and how to access health, social, and justice/legal services.
- **Provider badges/buttons** that encourage KP members to talk to a direct service provider about their experiences with violence.
- **A large health education wall chart** with VPR messages that direct service providers can refer to during health education groups with KP members.
- **Discussion guides/story boards** for PEs, PNs, ORWs, and other direct service providers to use in discussions/activities about violence.

GUIDANCE FOR IMPLEMENTATION

A. Collaborate with key stakeholders to develop IEC materials and IPC tools. Members of the core team, including KP members, should convene a working group to identify (1) the types of IEC materials and IPC tools that will be developed and (2) the messages that will be included in the materials and tools. Please see Job Aid 8.2 (page 95) in *Strengthening Health Systems to Respond to Women Subjected to Intimate Partner Violence or Sexual Violence: A Manual for Health Managers*[36] for additional messages to include in IEC materials. KP members and other key stakeholders (e.g., direct service providers) should be involved in the working group to ensure that the materials and strategies for dissemination will be effective.

When IEC materials on VPR are disseminated, create opportunities that make it possible to privately access them. If materials are distributed directly, the person distributing them should provide adequate opportunity for the individuals receiving the materials to reflect on whether they can safely leave with the information (e.g., is there a place the material can be stored where it is unlikely that a perpetrator will find it).

B. Finalize and share the IEC materials and IPC tools. Once the IEC materials and IPC tools have been drafted, the core team should convene to review, edit, and finalize them. IEC materials and IPC tools should be appropriate for a range of literacy levels. The tools can then be printed or prepared for digital dissemination.

C. Determine how to document and track the dissemination of IEC materials. The core team should create a dissemination and tracking plan that includes:

- A list of stakeholders who will receive each type of material
- The number of materials that will be disseminated to each stakeholder
- Procedures for (1) determining who will disseminate materials to which stakeholders, (2) tracking dissemination of materials to direct service providers/organizations, (3) tracking dissemination from direct service providers to the public, and (4) assessing the effectiveness of the materials

ELEMENT #4C

Sensitized and trained peer educators, peer navigators, and outreach workers raise awareness about violence; provide opportunities to disclose violence; offer first-line support to victims of violence; and accompany victims of violence to seek additional services.

MATERIALS/RESOURCES

- *Peer Educator and Outreach Worker Training: Preventing and Responding to Violence against Key Populations*[40]
- ANNEX 7: Additional Guidance for Providing First-Line Support: Focus on Safety
- WHO, 2014. *Health Care for Women Subjected to Intimate Partner Violence or Sexual Violence: A Clinical Handbook*[35]
  - Part 2: First-line Support for Sexual Assault and Intimate Partner Violence (pages 13-38)

OVERVIEW/RATIONALE

PEs, PNs, and ORWs are vital "entry points" for KP members into a range of services. They are often best placed to share information on rights and violence response services available, and to raise awareness about the types of violence affecting their communities. They are also often the first people to learn about violence in the lives of those they live and work with, either through spontaneous disclosure or when they ask about violence to determine HIV vulnerability in activities such as risk assessments. It is therefore important that they are sensitized and trained to ask about and respond to violence in a standardized way, including providing immediate first-line support, and linking/accompanying individuals to time-sensitive violence response services (e.g., PEP, emergency contraception).

GUIDANCE FOR IMPLEMENTATION

A. Identify PEs, PN, and ORWs to engage in VPR activities. Consider individuals' skill sets and interest in VPR, in addition to their well-being (see box).

B. Identify and adapt a training curriculum. LINKAGES developed the *Peer Educator and Outreach Worker Training: Preventing and Responding to Violence against Key Populations*,[40] which can be adapted to fit the cultural context of a country program. Topics included in this curriculum are listed in the table below.

WELL-BEING OF PES, PNS, AND ORWS

PEs, PNs, and ORWs are responsible for many of the day-to-day activities fundamental to a successful KP program. Adding VPR to their tasks should be discussed with existing workers and the process for integrating new responsibilities should be a collaborative one. For example, when identifying PEs, PNs, and ORWs to create opportunities for disclosure and respond to violence, talk to each one about whether they have concerns about the impact of such responsibilities on their personal mental health. Individuals who are experiencing violence in their own lives may not feel well-positioned to support others. In a new program, if addressing violence will be part of all PE/PN/ORW activities, this expectation should be clearly conveyed during the hiring process and written into job descriptions.

In addition, addressing violence and reaching out to individuals who are in hot spots with elevated levels of violence can bring added risks. Think through how these risks can be mitigated, for example, by hiring a taxi instead of depending on public transport for outreach, and ensure that plans for risk mitigation are reflected in program budgets.

LINKAGES VPR TRAINING TOPICS FOR PEs, PNs, AND ORWs

The HIV epidemic in [country]	Discussing safety, rights, and available services during outreach
Sex, gender, gender identity, gender expression, sexual orientation: understanding ourselves and each other	Asking about and responding to violence in key population members' lives
Understanding violence against key populations (characteristics, perpetrators, causes, consequences)	Referring effectively: overview of recommended health, social, and justice/legal services and improving access to each one
Focus on intimate partner violence	Putting it all together
Legal and policy obligations, opportunities, and barriers in the local context	Data collection and sharing
Panel discussion with key population members	Recap: minimum requirements to ask about violence
Fundamental principles of violence prevention and response	Taking care of ourselves: identifying and confronting secondary stigma and stress
Barriers to disclosing violence	Reflections on what we have learned and how to integrate it into our work
The importance of peer educators, peer navigators, and outreach workers in violence prevention and response	

C. Train PEs, PNs, and ORWs. Ensure extensive periods are provided during the training where new skills, particularly in first-line support, can be practiced. Time for feedback and the opportunity to play both the role of victim and direct service provider in role-plays is invaluable. If possible, invite a program-affiliated psychologist or other trained mental health care provider to participate. If this person will be part of the referral network, their participation can increase comfort with making referrals. In addition, it allows anyone who experiences a strong emotional response during the training to seek immediate support.

This training should be facilitated by one or more experienced trainers who have demonstrated knowledge on issues related to gender, gender norms, violence, stigma, discrimination, and human rights violations experienced by key populations; knowledge of the links between violence and HIV; and experience providing instruction on compassionate and nonjudgmental first-line support for individuals during disclosures. Members of KPs should play facilitation roles whenever possible.

Sometimes outreach settings are not conducive to the disclosure of violence, especially when it is difficult to find a location for a private conversation. In other instances, service users may prefer not to talk to a peer about the violence they are experiencing. To ensure service users have opportunities to disclose in private and in a way with which they feel comfortable, some programs use outreach activities to provide education on violence and then invite individuals who indicate they would like to talk about violence or access other services back to a DIC, clinic, or other facility. There, the service user can decide whether to speak to someone other than the peer who first told them about the violence services available, for example, to an ORW or psychologist.

D. Integrate VPR activities into outreach

- **Provide information on KP members' rights, how to identify violence, the link between violence and HIV, and the violence response services available and how to access them.** Ensure that KP members understand how the program can help meet their needs if they have experienced violence and where to go for support if desired.
- **Prioritize hot spots and other locations with a disproportionate burden of violence.** Hot spot mapping, microplanning, and risk assessments may include information that helps identify specific locations or groups that experience a higher burden of violence (e.g., young female sex workers may report more violence than their older counterparts). Logs of raids by law enforcement can also be useful in identifying locations where violence is likely to occur. For more on data for decision-making see ELEMENT #6A.
- **Provide opportunities to disclose violence.** If possible (e.g., standards for privacy, confidentiality, and training are met), during outreach activities, KP members should be given the opportunity to talk about their experiences of violence. Some individuals will not want to share their experiences and that decision should be respected. The "end goal" is not disclosure, but the creation of an environment in which KP members feel comfortable and safe talking about their experiences if they choose to.
- **Offer first-line support to KP members who disclose violence.** When individuals have the courage to share their experiences, PEs, PNs, and ORWs must respond in a compassionate and nonjudgmental way. This may be the first time a KP member has shared their experience with anyone, or they might have been blamed for violence in the past. When individuals feel disrespected or judged, they are less likely to share their experiences or to engage in important follow-up services, including health care. Anyone who discloses violence should be offered immediate, compassionate first-line support. Training on offering first-line support to key populations is in all LINKAGES trainings on violence prevention and response. First-line support includes listening, inquiring about needs and concerns, validating the victim, enhancing the victim's safety, and supporting the victim to access information or services. Recommendations for first-line support for victims of IPV and sexual assault can be found in Part 2 of *Health Care for Women Subjected to Intimate Partner Violence or Sexual Violence: A Clinical Handbook.*[35] While the focus of the handbook is cisgender women experiencing IPV, the steps—which are informed by psychological first-aid—are largely appropriate for all members of KPs. Safety strategies specific to key populations are further explored in ANNEX 7. In many cases, PEs and PNs will not complete all the steps of first-line support. Instead, if violence is disclosed they will

listen and validate and then accompany victims of violence to another member of their team, such as a supervisor or ORW. However, in the case that the person disclosing violence does not wish to speak to anyone else, it is important for PEs and PNs to have a basic knowledge of safety planning and the services available so that they can provide information on all of the victim's options and help the person stay safe.

ELEMENT #4D

Sensitized and trained health care workers ask about violence among service users and provide first-line support and clinical services to victims of violence.

MATERIALS/RESOURCES

- ANNEX 7: Additional Guidance for Providing First-Line Support: Focus on Safety
- *Health Care Worker Training: Preventing and Responding to Violence against Key Populations*[39]
- WHO, 2003. *Guidelines for Medico-Legal Care of Victims of Sexual Violence*[33]
  - » Body Charts (pages 126-132)
- WHO, 2014. *Health Care for Women Subjected to Intimate Partner Violence or Sexual Violence: A Clinical Handbook*[35]
  - » Part 2: First-line Support for Sexual Assault and Intimate Partner Violence (pages 13-38)
  - » Job Aid: Physical Exam Checklist (page 47)
  - » Job Aid: STI Treatment (page 53)
  - » Job Aid: Follow-up after Sexual Assault (page 59)
  - » Job Aid: Testing Schedule (page 64)
  - » Job Aid: Sample History and Examination Form (pages 89-98)
- WHO, 2017. *Strengthening Health Systems to Respond to Women Subjected to Intimate Partner Violence or Sexual Violence: A Manual for Health Managers*[36]
  - » Job Aid 3.2: Assessing Service Readiness (pages 31-32)
  - » Job Aid 5.1: Infrastructure Considerations, Barriers, and Suggestions to Overcome Them (pages 53-54)
  - » Job Aid 5.2: Checklist of Equipment, Medicines, and Other Supplies for Examination and Care of Women Subjected to Violence (page 56)
  - » Job Aid 6.1: Checklist to Assess Your Legal Frameworks (pages 61-62)
  - » Annex 3: Sample Training Agenda (pages 131-136)
- WHO, forthcoming. *Health Care for Women Subjected to Intimate Partner Violence or Sexual Violence: In-service Training Curriculum for Doctors, Nurses, and Midwives*[101]

OVERVIEW/RATIONALE

When service users disclose an experience of violence, HCWs can better understand their health needs, support their risk-reduction strategies, and act as an entry point to violence response services. Many KP members report a desire for HCWs to ask them about violence in their lives (with the caveat that HCWs must first be trained to respond appropriately).[50]

There are several sources of normative guidance relevant to whether and how HCWs should ask about violence. Normative guidance on HIV testing, *HIV Testing Services Consolidated Guidelines*,[102] notes that providers should "assess the risk of intimate partner violence and discuss possible steps to ensure the physical safety of clients, particularly women, who are diagnosed HIV-positive." Furthermore, according to a supplement to the consolidated testing guidelines, *Guidelines on HIV Self-Testing and Partner Notification*,[100] assessing risk of IPV is a mandatory step in partner notification (also called voluntary partner referral or index testing)—a widely used strategy. Normative guidance on addressing IPV among women in the general population, *Responding to Intimate Partner Violence and Sexual Violence against Women: WHO Clinical and Policy Guidelines*,[34] recommends that HCWs employ clinical enquiry in the context of IPV. Clinical enquiry refers to "the identification of women experiencing violence who present to health-care settings, through use of questions based on the presenting conditions, the history, and where appropriate, examination of the patient." The guidance includes depression, anxiety, alcohol and substance use, adverse reproductive outcomes, and repeat sexually transmitted infections (STIs) as presenting conditions associated with violence. While *Responding to Intimate Partner Violence and Sexual Violence against Women* recommends against universal screening for violence or "large-scale assessment of whole population groups," it states that "Intimate partner violence may affect disclosure of HIV status or jeopardize the safety of women who disclose, as well as their ability to implement risk-reduction strategies. Asking women about intimate partner violence could therefore be considered in the context of HIV testing and counseling, although further research to evaluate this is needed." Finally, normative guidance on KP programming, *Consolidated Guidelines on HIV Prevention, Diagnosis, Treatment, and Care for Key Populations—2016 Update*, states that "All violence against people from key populations should be monitored and reported."[13] Implementation tools designed to operationalize the consolidated guidelines state that it is important for health care workers to "ask about the history of violence."[2,3]

It is important for HCW trainings to stress that KP members have the right to receive medical care and treatment, regardless of their decisions about whether to file a report with law enforcement. Providers should emphasize to KP members that they do not have to agree to file a report to receive medical care and treatment. As stated in *Strengthening Health Systems to Respond to Women Subjected to Intimate Partner Violence or Sexual Violence: A Manual for Health Managers*: "WHO does not recommend laws that require health-care providers to report cases of partner violence and sexual violence to the police without the woman's consent. They do recommend, however, that HCWs inform individuals of their legal rights and offer to report to the police, should the individual want this."[36]

Given that IPV risk should be assessed among all those diagnosed HIV positive,[102] the high prevalence of presenting conditions associated with violence in KP communities (substance use, mental health issues, etc.),[98] the acknowledgement that violence affects risk-reduction strategies among those who are HIV negative,[34] and recommendations specific to key populations that encourage asking about violence,[3, 13] we extrapolate from these guidance documents to recommend that HCWs provide all KP members, not only those who are cisgender women, with the opportunity to disclose by asking about violence. Furthermore, questions should be inclusive of a broad range of violence, not only IPV.

Asking about violence should never be done to simply check a box, and HCWs should not ask about violence without adequate preparation. All HCWs who will be asking about violence must receive training specific to violence detection and response, including an introduction to the LIVES model for first-line support.[35] HCWs speaking to KP members about violence must also have the opportunity to reflect critically on their attitudes, beliefs, and knowledge. Many HCWs will need additional information on the issues faced by KP members; gendered and other power dynamics of violence; the relationship between violence and HIV; and

the barriers, including HCW stigma, that interfere with KP members' access to health services when they experience violence. Training HCWs can be an opportunity to address these topics and introduce approaches such as cultural humility[103] to improve their ability to meet KP members' needs.

Additional minimum requirements—such as a private space in which disclosure can occur—must also be in place before HCWs can ask about violence. A checklist of the requirements can be found in Job Aid 3.2 of *Strengthening Health Systems to Respond to Women Subjected to Intimate Partner Violence or Sexual Violence: A Manual for Health Managers.*[36] Finally, before HCWs ask about violence they must tell service users about any limits regarding confidentiality (such as mandatory reporting).

GUIDANCE FOR IMPLEMENTATION

A. Identify HCWs who will ask about and respond appropriately to violence. Use information collected while establishing the referral network and the list of HCWs affiliated with the program to identify participants for training activities. PEs and PNs who are part of a program can also be called upon to complement HCWs' efforts (training for PEs and PNs is discussed in ELEMENT #4C), including by providing accompaniment to individuals who disclose violence. If PEs and PNs will be working with HCWs, having them attend part of the training can increase comfort with a collaborative approach.

B. Identify and adapt training curricula. When seeking appropriate training materials, consider what is already used locally to prepare HCWs to address violence. In most cases, existing trainings will focus on IPV and/or sexual violence against women in the general population. For example, organizations such as the International Rescue Committee[104] may have already trained HCWs on the clinical management of rape. A nationally approved training to address IPV and sexual assault more broadly may also be in use. This is the case in Cambodia, where the Ministry of Health has developed guidelines to operationalize *Health Care for Women Subjected to Intimate Partner Violence or Sexual Violence: A Clinical Handbook.*[35] At the global level, WHO is developing a training that aligns with the suggested content of Annex 3 in *Strengthening Health Systems to Respond to Women Subjected to Intimate Partner Violence or Sexual Violence: A Manual for Health Managers.*[36] The title is *Health Care for Women Subjected to Intimate Partner Violence or Sexual Violence: In-service Training Curriculum for Doctors, Nurses, and Midwives.*[101] While trainings already in use may not focus on key populations, they offer the foundational skills providers need to respond to violence. For example, *Health Care for Women Subjected to Intimate Partner Violence or Sexual Violence: In-service Training Curriculum for Doctors, Nurses, and Midwives*[101] builds skills in asking about violence, offering first-line support, safety planning, connecting victims to services, and offering clinical care for sexual assault victims. It also covers additional care for mental health, principles for forensic examination in sexual assault cases, HIV status disclosure in the context of a violent relationship, and family planning.

USING MATERIALS FOCUSED ON THE GENERAL POPULATION

Health Care for Women Subjected to Intimate Partner Violence or Sexual Violence: In-service Training Curriculum for Doctors, Nurses, and Midwives[101] and other trainings like it build foundational skills that are applicable to all populations affected by IPV and sexual violence. However, these trainings are designed to serve women in the general population. If they are used to train HCWs to support KP members, content should be added that addresses KP-specific concerns. For example, IPV against KP members may manifest differently than in the general population. Trans people's partners may try to control their gender identity disclosure and transition or prohibit them from interacting with other trans people. Partners of men who have sex with men may expose or threaten to expose same-sex sexual behavior. For female sex workers and women who inject drugs, IPV may manifest as coerced sex work or drug use or threats to report criminalized behaviors to law enforcement to influence child custody disputes. The best way to ensure that training materials are responsive to the realities of KP members' lives is to know local patterns of violence, identify the specific additional barriers KP members face when seeking violence response services (such as stigma, exclusionary legal frameworks that don't provide them with protection, difficulty interacting safely with law enforcement or courts) and provide opportunities for KP members to speak directly to participants during the training in order to raise awareness of the issues that affect them.

To avoid duplication and confusion, if a training that adequately covers clinical skills—including taking a history and medical examination, providing treatment and follow-up, mental health care, and forensic examination in sexual assault cases[101]—is being rolled out, KP program managers should collaborate with training planners and facilitators to include principles, case studies, and skill building that meets the specific needs of key populations. Sessions that provide time for HCWs to examine their own attitudes and beliefs about KP members will also need to be added to a general population-focused training to ensure that HCWs can offer stigma-free care to KP victims of violence. KP-specific content can be taken from *Health Care Worker Training: Preventing and Responding to Violence against Key Populations*.[39] If the training designed to meet the needs of women in the general population has already been implemented, additional case studies and sessions focused on violence faced by KP members may be offered. In this case, program managers may also wish to use the supplemental training to refresh skills that HCWs gained previously.

The *Health Care Worker Training: Preventing and Responding to Violence against Key Populations*[39] can be used in conjunction with the *Health4All training*,[38] but dual use is not required. The two trainings are synergistic but neither is a prerequisite for the other. HCWs who have attended the Health4All training before the VPR training will have the opportunity to expand and deepen their ability to ask about and respond to the disclosure of violence. HCWs who first attend the VPR training and then attend the Health4All training will gain broader clinical skills that help them meet the many health needs of KP members. Regardless of order, attending both trainings will provide HCWs with a refresher on the roots of stigma against KP members and opportunities for self-reflection and action around attitudes and behaviors that may cause KP members harm.

JOB AIDS FOR CLINICAL CARE

Specific job aids from both *Health Care for Women Subjected to Intimate Partner Violence or Sexual Violence: A Clinical Handbook*[35] and *Guidelines for Medico-Legal Care of Victims of Sexual Violence*[33] will be useful to HCWs providing clinical services, especially following sexual assault. These include physical exam checklist (page 47), STI treatment (page 53), follow-up after sexual assault (page 59), testing schedule (page 64), and a sample history and examination form (pages 89-98) in the clinical handbook and body charts (pages 126-132) from the guidelines for medico-legal care.

Health Care Worker Training: Preventing and Responding to Violence against Key Populations[39] can also be used as a stand-alone training if clinical skills have already been taught or HCWs associated with the KP program will be able to refer to others with those skills. The LINKAGES training builds core knowledge on issues affecting KP members; facilitates creating an environment in which disclosure can safely occur; builds skills for asking about violence and providing first-line support (in line with Part 2 of *Health Care for Women Subjected to Intimate Partner Violence or Sexual Violence: A Clinical Handbook*[35] and supplemented with **ANNEX 7** of this guide); provides an overview of the range of health, social, and justice/legal services KP victims may need; and discusses best practices for safe data collection and management. It does not provide instruction on clinical skills. Topics covered in *Health Care Worker Training: Preventing and Responding to Violence against Key Populations*[39] are listed in the table below.

Any training to strengthen HCWs' ability to address violence in the lives of KP service users should be adapted to reflect local laws, policies governing health services, and the most common forms of violence experienced by KP members locally. Job Aid 6.1 in *Strengthening Health Systems to Respond to Women Subjected to Intimate Partner Violence or Sexual Violence: A Manual for Health Managers*[36] can support training adaptation. As designed, it analyzes the local legal framework to determine how it applies to cisgender women who are victims of violence. KP program managers should adapt the questions in the job aid to include key populations to determine whether/how the legal framework addresses their needs.

LINKAGES VPR TRAINING TOPICS FOR HCWs[5, 34, 105, 106]

The HIV epidemic in [country]	The importance of health care workers in violence prevention and response
Sex, gender, gender identity, gender expression, sexual orientation: understanding ourselves and each other	Asking about and responding to violence in key population members' lives
Understanding violence against key populations (characteristics, perpetrators, causes, consequences)	Referring effectively: overview of recommended health, social, and justice/legal services and improving access to each one
Focus on intimate partner violence	Putting it all together
Legal and policy obligations, opportunities, and barriers in the local context	Data collection and sharing
Panel discussion with key population members	Recap: minimum requirements to ask about violence
Fundamental principles of violence prevention and response	Taking care of ourselves: identifying and confronting secondary stigma and stress
Barriers to disclosing violence	Reflections on what we have learned and how to integrate it into our work

C. Conduct the training. The sessions from the LINKAGES training should be facilitated by an experienced trainer who has demonstrated knowledge on issues related to gender, violence, stigma, discrimination, and human rights violations experienced by key populations; knowledge of the links between violence and HIV; and experience training HCWs on asking about violence and providing compassionate and nonjudgmental first-line support. Members of KPs should play facilitation roles whenever possible. If the HCW training will include clinical skills, all clinical sessions should be led by an experienced clinician.

D. Consider the infrastructure needs of health facilities. Before HCWs begin asking about violence, the physical space in which they work should be reviewed to ensure it is appropriate. Please see Job Aid 5.1 in *Strengthening Health Systems to Respond to Women Subjected to Intimate Partner Violence or Sexual Violence: A Manual for Health Managers*[36] to assist in the review process. Job Aid 5.2 in the same document describes supplies that will be needed.

E. Follow best practices in managing programmatic data to ensure safety and confidentiality. See more in ELEMENT 6.

ELEMENT #4E

Mechanisms are available 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 direct service providers).

MATERIALS/RESOURCES

- *Safety and Security Toolkit: Strengthening the Implementation of HIV Programs for and with Key Populations*[44]
- WHO, 2014. *Health Care for Women Subjected to Intimate Partner Violence or Sexual Violence: A Clinical Handbook*[35]
  - » Job Aid: Exercises to Help Reduce Stress (pages 70-71)
- WHO, 2017. *Strengthening Health Systems to Respond to Women Subjected to Intimate Partner Violence or Sexual Violence: A Manual for Health Managers*[36]
  - » Job Aid 4.4: Checklist for Supportive Supervision (pages 48-50)

When direct service providers are also members of a key population, they may be experiencing much of the same violence that they are trying to help service users navigate. Sufficient opportunities for check-in and self-care are imperative.

OVERVIEW/RATIONALE

Working with individuals who have experienced violence can be rewarding, but it can also be difficult. Working with victims can take a lot of energy, and direct service providers may feel drained, upset, frustrated, or fearful. This may be especially true during times of increased workloads or heightened personal stress. It is important for direct service providers to maintain a balance between their professional and personal lives and take good care of themselves. If direct service providers do not take care of themselves, they will be less effective in helping others.

GUIDANCE FOR IMPLEMENTATION

A. Three guiding principles for self-care for direct service providers. Direct service providers should:

- **Be aware** of their own emotional reactions and distress when confronting others' traumatic experiences, and know what traumatic material may trigger them
- **Connect** with others by talking about their reactions with trusted colleagues or others who will listen (e.g., organizations may offer regular debriefing for their staff to discuss cases that are particularly difficult) but should take care not to violate confidentiality
- **Maintain a balance** between their professional and personal lives, with a focus on self-care (e.g., relaxation, exercise, stress management) to prevent or lessen the effects of workplace stress

B. Supervision for direct service providers. Direct service providers should receive ongoing supportive supervision, which can be offered in individual or group sessions. This supervision gives direct service providers an opportunity to discuss ways to cope with and manage their own feelings about working with victims of violence. Supervision should be offered as needed but also available on a regular basis, such as during monthly meetings. A checklist on supportive supervision for HCWs can be found in *Strengthening Health Systems to Respond to Women Subjected to Intimate Partner Violence or Sexual Violence: A Manual for Health Managers*.[36]

C. Teach skills for stress relief. Activities that promote mindfulness and relaxation can help with stress management. The job aid Exercises to Help Reduce Stress in *Health Care for Women Subjected to Intimate Partner Violence or Sexual Violence: A Clinical Handbook*[35] provides examples of such activities. Stress reduction activities can be offered on-site, as can informal conversations where direct service providers have opportunities to share their strategies for coping and resilience with one another.

D. Consider the safety of direct service providers. Safety measures can help decrease risk and should be shared with program staff and direct service providers, including peers. LINKAGES supported the development of *Safety and Security Toolkit: Strengthening the Implementation of HIV Programs for and with Key Populations*[44] to help implementers of KP programs identify safety and security gaps and then easily find strategies and tools (e.g., training, case studies, and IEC materials) to help fill those gaps. See more under SECTION 2.4 in this guide.

ELEMENT #4F

An operational crisis response system (e.g., hotline, WhatsApp group) is in place, including (1) an identified and trained crisis management team responsible for handling incoming calls/texts and (2) the resources to support implementation of the crisis response system.

MATERIALS/RESOURCES

Bill & Melinda Gates Foundation, 2013. *Community Led Crisis Response Systems: A Handbook*[29]

OVERVIEW/RATIONALE

KP community-led crisis response is a method for responding to violence experienced by KP members. Crisis response must be led by KP communities to be effective and sustainable so, throughout the process, KP members must shape the effort. While program staff may play an important role in developing and refining the crisis response system initially, it is important that KP members participate in its leadership from the beginning and gain the skills needed to take over its management.[29]

A. What is a crisis response system? It is a system through which KP members who experience violence can seek and receive rapid, on-the-spot support either by calling or messaging a phone number that is managed by a crisis response team. The crisis response team, which includes KP members, is responsible for:

- Assessing the nature and urgency of the crisis
- Responding to crisis, addressing immediate danger, and providing first-line support, including accompaniment in the case of referral
- Assisting KP members in resolving crises and taking steps to prevent future violence
- Following up with KP members who access the crisis response system
- Working with stakeholders and people in positions of power (e.g., law enforcement) to advocate on KP members' behalf

B. Who is involved in a crisis response team?

- A dedicated team that could include a mix of program staff and/or PEs, PNs, and ORWs—including members of KPs—who are trained as members of the crisis response team; they can be selected from hot spots/venues/stations where violence is high
- Crisis response team members can work in teams of two to four on a rotating basis (e.g., weekly rotation)
- PEs, PNs, and ORWs who can raise awareness about the crisis response system among KP members during outreach and other activities
- Lawyers on call—on a full-time or retainer basis—who can provide legal support to KP members who are detained and/or arrested
- Local human rights activists who can assist/advise the crisis response team on a regular or as-needed basis

C. Why is a crisis response system important? A crisis response system:

- Provides immediate and rapid support for KP members who experience crisis
- Builds connection and cohesiveness among KP members
- Improves self-esteem and ability to negotiate safe sex
- Empowers KP members to challenge perpetrators and report/reach out for help
- Reduces impunity of those in positions of power (e.g., holds law enforcement officers who perpetrate violence against KP members accountable)

GUIDANCE FOR IMPLEMENTATION

For information on implementation, please see *Community Led Crisis Response Systems: A Handbook.*[29] Smaller scale crisis response systems—such as crisis response teams based at specific hot spots and including law enforcement, a peer outreach worker, bar or brothel owners, and someone from a local health facility—can also be created when resources do not allow for larger systems. These hot spot-based teams can respond to the issues occurring at that specific location as well as other issues affecting KP members who frequent that hot spot, even if the issue occurs elsewhere (e.g., violence in the home). All crisis response teams should have the opportunity to come together to discuss and clearly define individual roles so that they are prepared when a crisis occurs.

Element #5
Accountability to Prevent Violence

ELEMENT #5A

Sensitized and trained law enforcement officers and other uniformed officers (if possible) commit to serving KP members who experience violence and to not perpetrating violence against members of KPs.

MATERIALS/RESOURCES

- *Law Enforcement Training: Preventing and Responding to Violence against Key Populations to Increase Access to Justice and Strengthen the HIV Response*[43] (to be adapted by country programs)
- Women's Legal Centre, 2014, *Police Sensitization Training Manual: A Guide for South African Police Service (SAPS) Officers to the Rights of Sex Workers and the LGBTI Community*[107]

OVERVIEW/RATIONALE

Law enforcement officers can both directly and indirectly hinder the ability of HIV programs to curb the epidemic among KP members.[108-110] In many countries, sex work, injecting drug use, and same-sex sexual behaviors and relationships are criminalized, and their enforcement/regulatory control are in the hands of law enforcement officers. When law enforcement officers arrest people who inject drugs as they try to enter harm reduction services, use condoms as evidence against sex workers, or harass and arbitrarily detain men who have sex with men or trans women working as PEs, they force KP members to take their lives underground, limit their access to services, and create circumstances of decreased safety—such as being forced to have sex without a condom or inject quickly without clean equipment.[111, 112] Among female sex workers, arrest, confiscation of drug paraphernalia, workplace raids, and having to pay a bribe to law enforcement are associated with experiencing violence from clients.[113-116] Furthermore, the environment of fear and anxiety that is created by violent policing practices has been associated with increased vulnerability to HIV.[117] Law enforcement officers can also directly increase HIV risk, for example, by sexually assaulting sex workers and exposing them to HIV.[45] Arrest is also strongly associated with HIV incidence.[118] In addition, law enforcement officers—who should be among first-responders when violence occurs—can rarely be called upon to support KP victims of violence because they are often unwilling to serve KP members, are perpetrators of violence, or both.[108, 109, 119-122]

Ongoing sensitization and advocacy work with law enforcement officers can significantly improve their attitudes toward members of KPs. For example, working directly with law enforcement officers has been a key element of efforts to reduce violence against men who have sex with men, people who inject drugs, and/or sex workers in some settings.[2, 80] Law enforcement officers are also essential direct service providers in the continuum of care. Engaging with law enforcement officers is a recognized way to effectively address the HIV epidemic. UNAIDS identified sensitizing law enforcement officers as a key component of the HIV response in 2012.[123] The Global Fund did the same in 2014.[124]

GUIDANCE FOR IMPLEMENTATION

A. Connect with law enforcement. There are myriad ways to connect to and strengthen relationships with law enforcement, both at the national and local levels. They range from informing law enforcement of activities supported by the Ministry of Health and carried out by a KP program to training and actively including law enforcement officers in a range of program activities. All activities to engage law enforcement need to acknowledge the hierarchy within the organization(s) so that permission can be sought at the appropriate level, which will often be from a senior official locally or nationally. However, in some contexts it is important to go through lower level officials or specific officials who are tasked with HIV prevention within the law enforcement hierarchy to reach senior level officials initially.

It is important to note that the level of collaboration possible with law enforcement will vary greatly among KP communities and contexts. Programs should be flexible and cognizant of existing relationships between KP members and law enforcement and ensure, through conversation and joint planning, that any potential collaboration with law enforcement is seen as safe and beneficial by the KP members the program is serving.

ENGAGING WITH LAW ENFORCEMENT WHILE RESPECTING COMMUNITY EXPERIENCES

Many members of KPs have had negative experiences with law enforcement officials. When a program engages with law enforcement—for example, inviting an officer to a peer educator meeting—this activity should be planned with KP leadership and must be communicated in advance to KP members who can then decide whether to attend.

At national/state level

- Advocate with senior leadership within law enforcement
- Share the National HIV/AIDS Strategic Plan, or other similar document, with law enforcement and organize meetings between law enforcement and the Ministry of Health to ensure law enforcement officials recognize the government buy-in for services to members of KPs
- Get an official letter of support for HIV and VPR programs from senior leadership
- Include senior-level and field-level law enforcement officers in coordinating groups and technical working groups
- Advocate to integrate HIV and VPR training curriculum into pre-service and in-service law enforcement training curricula
- Explore larger initiatives with law enforcement (e.g., campaigns to improve law enforcement officers' professionalization/compensation or HIV testing and treatment initiatives specifically for law enforcement)
- Support the development of HIV and VPR policies for law enforcement, including opportunities to better connect to services such as PEP, which may even be possible for law enforcement to offer (e.g., in a Victim Support Unit)
- Collaborate with law enforcement leadership to clarify misinterpreted laws and publicly share interpretations of laws and policies that mitigate harm to KP members (e.g., warning instead of arresting whenever possible)
- Advocate for a system or position to be created that allows victims of law enforcement abuse to report their experiences without negative repercussions
- Support the development of reporting forms that accurately capture KP members' experiences of violence; for example, forms that acknowledge that gender identity may be different than sex assigned at birth or that recognize men may also be victims of IPV

At the local/district/county level

- Recognize law enforcement officers who are supportive through formal ceremonies and events

- Invite law enforcement officers to events such as PE supervision meetings (with permission of all those attending); this can provide an opportunity for law enforcement officers to respond directly to community concerns and share information
- Hold monthly meetings between KP members and the officers for ongoing discussion and resolution of grievances; ideally, a designated officer should deal with identified issues on a routine basis
- Involve law enforcement officers in local/district/county-level coordinating and technical working groups
- Co-brand materials on rights with law enforcement agencies to demonstrate their buy-in and acceptance of the messages shared
- Have PEs' identification cards endorsed by the law enforcement agencies with a signature from the highest-ranking officer possible; PEs can show their cards to officers on the street to prevent harassment and allow uninterrupted outreach work
- Build mechanisms for accountability, including programmatic documentation of abuses that can be reported back to higher-ranking officials either in an aggregated way or, with permission of individual victims, on a case-by-case basis. (While internal accountability within law enforcement agencies is vital, a separate mechanism, such as programmatic documentation of abuses, will likely be necessary to build community trust.)

TRAINING SECURITY FORCES WITH U.S. GOVERNMENT FOREIGN ASSISTANCE

If training security forces, such as law enforcement, to improve the impact of HIV programs with funds from the U.S. government, each U.S. embassy will need to determine whether vetting, also referred to as Leahy vetting, is required for the officers nominated to be trained. According to the U.S. Department of State, "Leahy vetting is a process through which the U.S. government vets foreign security forces nominated to receive assistance with funds appropriated in the Foreign Assistance Act, Arms Export and Control Act, or the National Defense Authorization Act to ensure they have not committed a gross violation of human rights."[125] More can be found in the *Leahy fact sheet*.[126]

The vetting process requires detailed personal information from both the potential trainees and the units that the potential trainees come from. Anyone deemed, through the vetting process, to have committed gross human rights violations is not eligible to be trained.

B. Sensitize and train law enforcement officers. One of the most important ways to engage with law enforcement officer is training. Before beginning this process, get permission from senior-level law enforcement officials to conduct sensitization and training with officers on violence and HIV prevention and response.

- **Form a training team.** Law enforcement training should be jointly led by KP members, law enforcement officers (who are allies and have been trained as trainers), a lawyer, and KP program implementers.[2]
- **Find and adapt a training curriculum such as the** *Law Enforcement Training: Preventing and Responding to Violence against Key Populations to Increase Access to Justice and Strengthen the HIV Response*[43] or another curriculum already developed locally. Trainings for law enforcement officers should aim to sensitize them about issues that are relevant to KP members, including concepts of gender, gender norms, the relationship between stigma, discrimination, violence, and HIV; types of violence experienced by KP members; and the harmful effects that violence has on members of KPs, including the health and mental health consequences. Trainings should also aim to strengthen law enforcement officers' knowledge of the human rights protections in national-level policies that protect KPs and local laws that affect KPs, including the misapplication and correct application of these laws. Additionally, trainings for law enforcement officers should strengthen their skills for responding to KP

members who experience violence, including linking victims to health, social, and justice/legal services.

- **Pilot the training.** Use the adapted training with officers who can give feedback on additional changes needed.
- **Conduct trainings with law enforcement officers.** Once the pilot is adapted and finalized, KP programs should roll out trainings to local law enforcement officers as widely as possible. These trainings should be ongoing, and refresher training should be offered as needed. If possible, work to include the material in pre-service as well as in-service trainings.
- **Arrange for continued interaction to reinforce messages and promote accountability.** Organize opportunities for law enforcement officers, including senior officials, to have continued contact with the program. In some settings, Ministry of Health officials convene ongoing meetings of law enforcement and program leadership to review progress, including changes in law enforcement behavior toward KP members, and to address any challenges that arise.

LINKAGES VPR TRAINING TOPICS FOR LAW ENFORCEMENT:

Preventing and Responding to Violence against Key Populations to Increase Access to Justice and Strengthen the HIV Response

What is possible? Examples of law enforcement practices in other countries	Fundamental principles of violence prevention and response
Basics of HIV: epidemiology, prevention, available services (including an optional section: harm reduction at work)	Needs of key population members who experience violence
Sex, gender, gender identity, gender expression, sexual orientation: understanding ourselves and each other	Barriers to disclosing violence
Understanding violence against key populations (characteristics, perpetrators, causes, consequences)	Victim-centered support
Human rights and local legal context	Responding to and documenting cases of violence
Recognizing and challenging violence in law enforcement/key population member interactions	Trauma-informed approach to law enforcement (optional)
Focus on intimate partner violence	Taking care of ourselves: identifying and confronting secondary stigma and stress
Panel discussion with key population members	Reflections on what we have learned and how to integrate it into our work

ELEMENT #5B

Other sensitized power holders (e.g., religious leaders, tribal leaders, third parties in the sex industry such as managers and bar and lodge owners) commit to connecting victims of violence to available services and condemning violence against KP members.

MATERIALS/RESOURCES

The information is this section draws from three key documents. Programs should refer directly to these documents for more detailed guidance on how to advocate with power holders to promote the protection and rights of KP members:

- Beardsley, 2013. *Policy Analysis and Advocacy Decision Model for HIV-Related Services: Males Who Have Sex with Males, Transgender People, and Sex Workers*[127]
- UNDP, IRGT: A Global Network of Trans Women and HIV, UNFPA, Center of Excellence for Transgender Health, Johns Hopkins Bloomberg School of Public Health, WHO, et al., 2016. *Implementing Comprehensive HIV and STI Programmes with Transgender People: Practical Guidance for Collaborative Interventions (the "TRANSIT")*[11]
- WHO, UNFPA, UNAIDS, NSWP, World Bank, 2013. *Implementing Comprehensive HIV/STI Programmes with Sex Workers: Practical Approaches from Collaborative Interventions (the "SWIT")*[2]

OVERVIEW/RATIONALE

Engaging and sensitizing institutions and individuals who hold power in the larger community helps address stigma and discrimination against KP members at the macrolevel, resulting in changes in policies and procedures that promote the rights of KP members and protect them from violence. These power holders often set the tone for the rest of the community and engaging them as allies is key to effective HIV and VPR programs.

GUIDANCE FOR IMPLEMENTATION

A. Identify power holders that need to be engaged for advocacy and sensitization: Advocacy and sensitization efforts need to strike a balance between targeting frontline workers in different sectors (e.g., HCWs, law enforcement officers) and decision-makers (e.g., government ministers, administrators, and managers), as frontline workers may respond to pressure from these leaders and decision-makers. Map out the power holders (those who have positive impact/benefit and those who have negative impact/harm) at country/state/district/facility levels.

Power holders to engage for advocacy and sensitization may include:

- Third parties such as lodge/bar owners
- Criminal gangs (especially in locations where law enforcement are not active or present)
- Local and national government officials responsible for law enforcement: justice, military, and security personnel (e.g., minister of justice, attorney general)
- Media (e.g., print, television, radio, social)
- Religious and tribal leaders (e.g., village chiefs, imams, priests, church leaders)
- Local, municipal, district, and provincial governments (e.g., mayors, local councils, Ministry of Health, Ministry of Gender, Ministry of Social Welfare)

- School teachers (particularly for young trans people and men who have sex with men and the children of sex workers)
- Directors of community-based organizations that work on human rights
- Women's organizations
- HCWs and health care professional organizations
- United Nations organizations
- International nonprofit organizations

B. Who should engage power holders? Programs should explore existing allies within the community and pull together a team of advocates who can join the core team in engaging power holders for individual or group meetings. Advocates could include:

- KP members
- Program staff, including PNs, PEs, and ORWs
- Directors of community-based organizations that support KP members
- Lawyers and other advocates from the Human Rights Commission
- Allied HCWs, law enforcement officers, and local lawyers
- Allied religious and tribal leaders
- Allied leaders from civil society and government agencies

C. What should engagement of power holders include? The most effective campaigns will be those designed for the local context and led by members of KPs. They may include one or more of the activities below.

- Public campaigns to highlight the rights of KP members
- Sensitization workshops
- Meeting individually to discuss the violence faced by KP members and the importance of specific power holders to mitigating this violence
- Highlighting the issue of violence against KP members to raise awareness on specific international and national days and in campaigns relevant to HIV, KP members' rights, and GBV within the general population
- Disseminating print and other multimedia materials about violence against KP members
- Working with journalists and other members of the media to promote positive stories and language relevant to KP members
- Building partnerships and networks with organizations that work on human rights and HIV, for joint advocacy efforts
- Supporting collective action by KP members to demand redress for violence faced by their community members building other institutions' understanding of laws affecting KP members' rights

D. Develop a plan to engage power holders: The core VPR team should create a strategy for engaging power holders including which ones to engage, messages to deliver, plan for engagement (e.g., who will engage power holder and how will they do it), and the expected outcome (e.g., what does the KP program want from this power holder and what would success look like?)

Element #6
Documentation and Monitoring

ELEMENT #6A

Aggregated information on cases of violence is used to identify trends in both characteristics of violence (What are the most common forms of violence? Who are common perpetrators? Where does violence occur?) and responses to violence (Are most people who report violence getting violence response services? Is reporting changing overtime?) to inform programming and support advocacy.

MATERIALS/RESOURCES

- *Monitoring Guide and Toolkit for Key Population HIV Prevention, Care, and Treatment Programs*[128]
- *Performance Indicator Reference Sheet for Key Populations*[129]
- WHO, 2017. *Strengthening Health Systems to Respond to Women Subjected to Intimate Partner Violence or Sexual Violence: A Manual for Health Managers*[36]
  - » Job Aid 2.4: Framework for the Logic Model of a Plan to Strengthen the Health System Response to Violence Against Women (page 20)
  - » Chapter 9, Section 1: Conduct an Evaluation (page 108-110)
  - » Annex 9: Sample Intake/Record Form for Clients Subjected to Intimate Partner Violence or Sexual Assault (pages 147-151)
  - » Annex 11: Privacy and Confidentiality in Documentation (pages 155-156)

OVERVIEW/RATIONALE

At the individual service user level, direct service providers document reports of violence and the services each person received to provide coordinated and responsive care. This effort requires protocols to ensure service user confidentiality, privacy, and safety (see box) and standard tools for data collection.

PRIVACY, CONFIDENTIALITY, AND SAFETY IN DATA COLLECTION, SHARING, AND REPORTING

Privacy, confidentiality, and safety are key principles to consider in developing health information and surveillance systems for documenting cases of violence and for program monitoring. Implementing these principles is important for protecting the service user from further harm in the form of stigma, discrimination, or retaliation by the perpetrator. Establish a privacy and confidentiality policy that specifies:

- Who will be responsible for collecting and recording information
- Where and how information will be collected and recorded how information will be stored
- Who will have access to the information, including what information will be shared within the health facility or with third parties (e.g., other service providers within a referral network)
- The need to obtain the victims' consent before sharing any information and informing them about limits to confidentiality where applicable (e.g., in case of mandatory reporting)

At the programmatic level it's important to establish an M&E framework—including a logic model, indicators, and tools and procedures for data collection, management, and reporting—to guide implementation and allow information collected from victims of violence to be aggregated. Job Aid 2.4 in Strengthening Health *Systems to Respond to Women Subjected to Intimate Partner Violence or Sexual Violence: A Manual for Health Managers*[36] may be of use during logic model development. Page 21 in the same document provides more information on developing an M&E plan.

Aggregating data collected when providing services to victims of violence serves many purposes. A program can determine whether efforts to create environments in which disclosure can occur have been effective, the percentage of reporting victims who received services, and the impact of specific interventions to prevent violence.[10] This information is important for programmatic improvement. Aggregating also provides an opportunity to describe the levels of reported violence against KP members, including the perpetrators and characteristics of violence—information useful for programming and advocacy.

GUIDANCE FOR IMPLEMENTATION

A. Use appropriate data collection tools to document individual reports of violence. Country programs should train PEs, PNs, ORWs, and other direct service providers to use Tool 12 in the *Monitoring Guide and Toolkit for Key Population HIV Prevention, Care, and Treatment Programs*[128] or adapt their own tools according to the information that the monitoring guide collects. Where possible, integrating data collection into national systems is ideal. See Annex 9 in *Strengthening Health Systems to Respond to Women Subjected to Intimate Partner Violence or Sexual Violence: A Manual for Health Managers*[36] for a sample intake/record form for clients subjected to intimate partner violence or sexual assault, which provides an example designed for the general population that could be adapted to more explicitly include KP members—for example, by asking about both sex assigned at birth and gender identity and a wider range of forms of violence. In the context of PEPFAR, refer to PEPFAR's most up-to-date GEND_GBV indicator[28] and *LINKAGES' custom GBV_REPORT_COMM indicator*[129] to ensure that the necessary information is collected. These tools will be used to record incidents of reported violence and the services provided to each victim.

A NOTE ABOUT REPORTED VIOLENCE

Observing increases in reported violence can indicate how well a program is supporting KP members to recognize violence when it occurs, know their rights, and have confidence in the violence response support mechanism. An increase in reports of violence often occurs when sensitization begins and does not mean that violence is increasing.[80]

B. Develop M&E systems that allow records to be maintained in a way that is confidential and does not put service users at risk.[34] Country programs should use the most up-to-date PEPFAR monitoring, evaluation, and reporting document[28] and SIMS tools to inform the development of their M&E plans. Please also refer to Annex 11 in *Strengthening Health Systems to Respond to Women Subjected to Intimate Partner Violence or Sexual Violence: A Manual for Health Managers*[36] to ensure privacy and confidentiality in documentation within health facilities.

C. Use aggregated data to identify and track trends to monitor and improve programming. For example:

- Disaggregating data on reported violence by the victim's age, gender, key population, hot spot, or other characteristics can help determine who is at most risk for violence and where additional rights education, safety tips, or violence response activities are needed. The same can be done with data on types of perpetrators to determine where primary prevention efforts should be focused. Information should never be disaggregated to the point that individuals who have reported violence can be identified.
- Data on reports of violence and services received can be discussed at monthly outreach meetings to monitor whether efforts to encourage reporting have been effective and whether all those who report violence receive adequate follow-up.
- For more on conducting an evaluation using programmatic data, see Chapter 9 in *Strengthening Health Systems to Respond to Women Subjected to Intimate Partner Violence or Sexual Violence: A Manual for Health Managers.*[36]

D. Package aggregated data for advocacy. KP members and/or program implementers may be able to use reports of violence to advocate with power holders to invest in violence prevention activities. See ELEMENT #5B. It may also be useful in trainings, such as those with law enforcement (ELEMENT #5A) and HCWs (ELEMENT #4D) to help demonstrate the urgency of the issue.

ELEMENT #6B

Systems in use to monitor the quality of violence prevention and response programs including opportunities for feedback from victims who use violence response services and efforts to identify unintended consequences.

OVERVIEW/RATIONALE

As VPR programs are developed, quality improvement and assurance mechanisms are essential for ensuring that interventions are technically sound; implemented correctly; and meet the needs of KP members, key stakeholders, and the community. They should include mechanisms to solicit the opinions of victims of violence who have used the services provided and to monitor for unintended consequences of any work to address violence.

A. Establish systems for quality assurance. VPR programs should be implemented according to the principles in this document. Developing tools that align with these principles and then continually reviewing these tools to ensure adherence can help ensure quality. Such tools include:

- Guidelines
- Protocols
- SOPs
- An M&E framework

B. Collect user feedback. Programs should monitor the perception of their VPR services, particularly the feedback of those using violence response services. This can be done through:

- Reviewing referral completion rates that may indicate which organizations are seen as KP-friendly (e.g., those with almost no completed referrals may be perceived as offering poor services)
- Interviewing those who did and did not complete referrals
- Providing opportunities for anonymous feedback
- Site visits, to observe waiting rooms or speak directly with individuals who wish to share their experiences, may also be important. No M&E activity should ever compromise any service user's confidentiality.

COLLECTING INFORMATION ON VIOLENCE FOR IMMEDIATE USE BY KP MEMBERS

Information on violence can be used by KP members in many ways. Aggregated, it can be a powerful advocacy tool, especially in contexts where violence is committed by state actors such as law enforcement officers. For example, information on the number of violent incidents perpetrated by law enforcement could be presented back to local authorities to show the extent to which violence occurs and encourage buy-in to train officers. Communities may also use information on common perpetrators to help avoid dangerous individuals. For example, sex workers in many places have compiled lists of violent clients, sometimes called "bad dates" or "ugly mugs." These lists include physical descriptions of the perpetrators along with information such as type of car driven and can be shared at physical locations, such as DICs, or by email, short message service, or printed document.[2] Please note that local laws should be consulted prior to developing and determining the distribution for such a list to avoid lawsuits.

C. **Monitor for unintended consequences.** Working on issues of violence may cause unintended negative or positive consequences. Those that are negative are important to identify so that they can be addressed. Those that are positive may help build buy-in for VPR. Some unintended consequences that have been recorded include:

- Law enforcement becoming more violent when sex workers began to assert their rights
- Staff of small community-based organizations becoming the targets of angry individuals when their intimate partners sought services to address IPV
- Increased use of justice/legal services by individuals in the general population as a result of efforts to increase use by KP members
- More efficient PEP distribution to individuals who have been exposed to HIV in workplace accidents as a result of training to improve PEP provision for KP members who may have been exposed through sexual violence

SECTION 5

Glossary

Direct service providers are individuals, contractors, employees, or volunteers who provide outreach, counseling, social services, medical, legal, or other types of support services to KP members.

First-line support refers to the minimum level of (primarily psychological) support and validation of experience that all people who disclose violence to a provider should receive. It shares many of the elements of "psychological first aid" in the context of emergency situations involving traumatic experiences.[36]

Forensic specimens help prove or exclude a physical connection between individuals and objects or places. They include: semen, hair, blood, DNA, skin, saliva, fibers, and drugs (for example, found in the blood).[70]

Gender is a culturally defined set of economic, social, and political roles, responsibilities, rights, entitlements, and obligations associated with being female and male. It is also reflected in the power relations between and among women and men, and boys and girls. The definition and expectations of what it means to be a woman or girl and a man or boy, and sanctions for not adhering to those expectations, vary across cultures and over time, and often intersect with other factors such as race, class, age, and sexual orientation.[130]

Gender-based violence (GBV) is defined as any form of violence that is directed at an individual based on their biological sex, gender identity or expression, or their perceived adherence to socially defined expectations of what it means to be a man or woman, boy or girl. It includes physical, sexual, and psychological abuse; threats; coercion; arbitrary deprivation of liberty; and economic deprivation, whether occurring in public or private life. GBV is rooted in gender-related power differences, including social, economic and political inequalities. It is characterized by the use and abuse of physical, emotional, or financial power and control. GBV takes on many forms and can occur across childhood, adolescence, reproductive years, and old age. It can affect women and girls, men and boys, and people with other gender identities. Women, girls, men who have sex with men, and trans persons are often at increased risk for GBV.[55]

Gender expression refers to the external display of one's gender through a combination of appearance, disposition, social behavior, and other factors, generally measured on a scale of masculinity and femininity.[131, 132] A person's gender expression may or may not be consistent with socially prescribed gender roles.[133]

Gender identity refers to a person's deeply felt internal and individual experience of gender, which may or may not correspond with the sex they were assigned at birth.[131, 134]

Gender norms refers to a set of rules and expectations created by society and culture that dictate how boys/men and girls/women should look and act in both public and private spaces.

Health care workers are individuals engaged in actions whose primary intent is to enhance health.[39] This group may include physicians, nurses, pharmacists, and those who do not deliver services directly but are essential to the functioning of health systems, such as receptionists, managers, and data entry clerks.

Homophobia refers to "an irrational fear of, aversion to, or discrimination against persons known or assumed to be homosexual, or against homosexual behavior or cultures."[3]

Intersex is a general term used for a variety of conditions in which a person is born with a reproductive or sexual anatomy that does not seem to fit the typical definition of female or male. Because of this, sex is not always either male or female. Sex may exist on a continuum.

Intimate partner violence is ongoing or past violence by an intimate partner or ex-partner.

Law enforcement refers to the organized and legitimate effort to produce or reproduce social order—evident in rules and norms—to enhance the safety and security of society.[43] Law enforcement agencies are generally government agencies that enforce laws, investigate crimes, and make arrests.

Men who have sex with men describes males who have sex with males, regardless of whether or not they also have sex with women or self-identify as gay or bisexual.[135]

Nonbinary refers to someone who identifies as neither male nor female.[134]

An **outreach worker** is someone who supervises peer outreach; may also be a peer.

A **peer educator** is a peer who does outreach and links people to testing.

A **peer navigator** is a peer who works with people who have been diagnosed with HIV to keep them in care.

People who inject drugs refers to people who inject psychotropic (or psychoactive) substances for nonmedical purposes.[13] These drugs include opioids, amphetamine-type stimulants, cocaine, hypnosedatives, and hallucinogens. Injection may be intravenous, intramuscular, subcutaneous, or other injectable routes.

A **protocol** is an official set of rules or regulations that guides procedures or services. It describes what needs to be done and under what conditions it needs to be done. This is distinct from standard operating procedures (see definition for standard operating procedures).

Sensitization, in this document, means helping an individual or institution understand who KP members are and the issues that they face.

Sex is a medical term used to refer to the chromosomal, hormonal, and anatomical characteristics (e.g., internal reproductive organs, external genitalia) used to classify an individual as female, male, or intersex.[131, 133]

Sex workers include consenting female, male, and trans adults—age 18 and over—who regularly or occasionally receive money or goods in exchange for sexual services.[135]

Sexual orientation is an enduring emotional, romantic, or sexual attraction to another person of a different sex or gender, the same sex or gender, or to both sexes and more than one gender.[136] It is not related to gender identity.[134]

Standard operating procedures (SOPs) are detailed instructions or steps that describe *how* to implement protocols. SOPs include a fixed, step-by-step sequence of activities or course of actions that must be followed to perform a task.

Stigma is the co-occurrence of labeling, stereotyping, separation, status loss, and discrimination in a context in which power is exercised.[72]

Training aims to improve specific knowledge and skills

Transgender is an umbrella term referring to an individual whose gender identity is different from their sex assigned at birth.[131]

- Trans woman: Someone who was assigned male at birth and identifies as female.
- Trans man: Someone who was assigned female at birth and identifies as male.

Transphobia refers to "prejudice directed at trans people because of their actual or perceived gender identity or expression."[11]

Violence is 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.[1]

SECTION 6

Annexes

ANNEXES

ANNEX 1	Checklist for Developing and Implementing Comprehensive Violence Prevention and Response Programs for Key Populations: Principles and Elements
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Annex 1

Checklist for Developing and Implementing Comprehensive Violence Prevention and Response Programs for Key Populations: Principles and Elements

PROGRAM PRINCIPLES

1. Do no harm.
2. Promote the full protection of key populations (KPs) members' human rights and reject any intervention based on the notion of rescue and rehabilitation.
3. Respect KP members' rights to make informed choices (self-determination) and to access the full range of services recommended for victims of violence (provided free of stigma and discrimination).
4. Promote gender equality and challenge harmful gender norms that contribute to violence.
5. Be responsive to local patterns of violence and barriers to accessing services.
6. Place KP members at the center of design, implementation, and evaluation of violence prevention and response (VPR) activities and identify/build on existing KP community-led efforts to prevent and respond to stigma, discrimination, and violence.
7. Build the capacity of KP communities and partners to understand and address the links between violence and HIV.
8. Integrate VPR into HIV prevention, care, and treatment programming.
9. Ensure privacy, confidentiality, and informed consent whenever interacting with victims of violence.
10. Monitor and evaluate programs to identify any unintended harmful impacts and develop strategies to improve VPR programming.

PROGRAM ELEMENTS

ELEMENT 1

CORE KNOWLEDGE AMONG IMPLEMENTERS AND KP COMMUNITIES

- ☐ 1A **A trained core team of staff, partners, and direct service providers** (e.g., staff, drop-in center [DIC] managers, allied lawyers, and selected health care workers [HCWs], peer educators [PEs], peer navigators [PNs], and outreach workers [ORWs]) is able to lead the design and implementation of a tailored comprehensive VPR program for KP members.
- ☐ 1B **Activities to build KP communities' understanding of violence** through the lens of gender, power, and human rights. These activities will also strengthen community cohesion and agency among KP members (e.g., discussions of power; gender norms and inequalities at the root of stigma, discrimination, and violence against KP members; rights education; and so on).

ELEMENT 2

AN UNDERSTANDING AMONG PROGRAM IMPLEMENTERS OF VIOLENCE AGAINST KP MEMBERS AND EXISTING EFFORTS TO ADDRESS VIOLENCE

- ☐ 2A **Mechanisms in place (e.g., assessment, focus groups, stakeholder interviews, microplanning, mapping, training) to increase understanding of violence experienced by KP members**, including types of violence, common perpetrators, key hot spots, needs of KP members when they experience violence, and barriers to accessing violence response services.
- ☐ 2B **A map that illustrates key stakeholders and established relationships with them**, including Ministry of Health, senior-level law enforcement officers, allied lawyers, and health and mental health service providers frequently used and/or preferred by KP members. This resource map should reflect the health, social, and safety/security needs of KP members who experience violence and should include all existing systems/activities/tools to address stigma, discrimination, and violence.

ELEMENT 3

NETWORKS TO ENSURE KP MEMBERS' ACCESS TO HEALTH, SOCIAL, AND JUSTICE/LEGAL

- ☐ 3A **A referral network and directory of direct service providers.** The network should include health,[iii] social,[iv] and justice/legal services,[v] including safe spaces like DICs and emergency shelters.
- ☐ 3B **Sensitized and trained referral points** with whom the program has formal relationships.
- ☐ 3C **Efforts to build acceptance for VPR**, including engaging with civil society and government, that can increase access to violence response services for KP members.

ELEMENT 4

SYSTEMS TO PROVIDE OPPORTUNITIES FOR DISCLOSURE AND RESPOND TO VIOLENCE, INCLUDING CRISIS RESPONSE

- ☐ 4A **Standard operating procedures** on creating opportunities for disclosure and providing first-line support and violence response services.
- ☐ 4B **Information, education, and communication (IEC) materials and interpersonal communication (IPC) tools developed and disseminated.** These materials should be designed for service users and direct service providers.
- ☐ 4C **Sensitized and trained PEs, PNs, and ORWs** raise awareness about violence; provide opportunities to disclose violence; offer first-line support[vi] to victims of violence; and accompany victims of violence to seek additional services.
- ☐ 4D **Sensitized and trained HCWs** ask about violence among service users and provide first-line support and clinical services to victims of violence.

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iii Health services: treatment of injuries, HIV testing, PEP, emergency contraception, STI testing and treatment, rape kits/forensic exam, tetanus vaccine, and hepatitis B screening and treatment. Mental health screening and treatment for depression and post-traumatic stress disorder should also be available.

iv Social services: psychosocial support including crisis counseling and support groups, securing/replacing identity documents, transportation assistance, child care, interpreters, financial aid (such as vocational training), food assistance, and connections to community-based organizations that can provide information and facilitate access to services, including through accompaniment.

v Justice/legal services: information on the rights of KP members, information on law enforcement procedures, legal counsel (including in cases of arrest), ability to give a statement or otherwise document the case.

vi First-line support: the minimum level of (primarily psychological) support and validation of experience that all people who disclose violence to a provider should receive.

- ☐ 4E **Mechanisms are available to support/supervise individuals engaged in VPR and promote self-care and personal safety** (e.g., peer education supervision, support groups for direct service providers).
- ☐ 4F **An operational crisis response system** (e.g., hotline, WhatsApp group) is in place, including (1) an identified and trained crisis management team responsible for handling incoming calls/texts and (2) the resources to support implementation of the crisis response system.

ELEMENT 5

ACCOUNTABILITY TO PREVENT VIOLENCE

- ☐ 5A **Sensitized and trained law enforcement officers** and other uniformed officers (if possible) commit to serving KP members who experience violence and to not perpetrating violence against KP members.
- ☐ 5B **Other sensitized power holders** (e.g., religious leaders, tribal leaders, third parties in the sex industry such as managers and bar and lodge owners) commit to connecting victims of violence to available services and condemning violence against KP members.

ELEMENT 6

DOCUMENTATION AND MONITORING

- ☐ 6A **Aggregated information on cases of violence** is used to identify trends in both characteristics of violence (What are the most common forms of violence? Who are common perpetrators? Where does violence occur?) and responses to violence (Are most people who report violence getting violence response services? Is reporting changing overtime?) to inform programming and support advocacy.
- ☐ 6B **Systems in use to monitor the quality of violence prevention and response programs,** including opportunities for feedback from victims who use violence response services and efforts to identify unintended consequences.

Annex 2

Sample Internal Guidance on Suspected Cases of Human Trafficking

This internal guideline is an example from the LINKAGES project that can be adapted to support implementers' responses to a suspected case of human trafficking.

WHAT IS HUMAN TRAFFICKING?

USAID's Counter-Trafficking in Persons Policy (2012)[138] incorporates the principles set forth in the *U.S. Trafficking Victims Protection Act of 2000* (Pub. L. 106-386, Div. A) and follows the standards set forth in the *United Nations Protocol to Prevent, Suppress and Punish Trafficking in Persons, Especially Women and Children*[139] ("the Palermo Protocol"). According to the Palermo Protocol, human trafficking is:

> The recruitment, transportation, transfer, harbouring or receipt of persons, by means of the threat or use of force or other forms of coercion, of abduction, of fraud, of deception, of the abuse of power or of a position of vulnerability or of the giving or receiving of payments or benefits to achieve the consent of a person having control over another person, for the purpose of exploitation. Exploitation shall include, at a minimum, the exploitation of the prostitution of others or other forms of sexual exploitation, forced labour or services, slavery or practices similar to slavery, servitude or the removal of organs.[139]

As *USAID's Counter-Trafficking in Persons Policy* states:

> The [Palermo] Protocol also clarifies that the recruitment, transportation, transfer, harboring, or receipt [for example, by a human smuggler] of an individual under the age of 18 for the purpose of exploitation is considered trafficking in persons, even if none of the means listed above (force, coercion, abduction, etc.) are involved. Therefore, according to the Protocol, minors in prostitution are considered trafficking victims; by definition they cannot have consented to being prostitutes.[138]

Regardless of international and legal classifications, it is important to note that many individuals under 18 will not identify as "trafficking victims" and programs must recognize this and be aware of the specific needs of minors who sell sex (see WHO *Technical Brief: HIV and Young People Who Sell Sex*[140] for more).

THE CONFLATION OF SEX WORK AND TRAFFICKING

Sex work and trafficking have been inaccurately conflated in a way that has caused harm to sex workers for decades. In the ***Briefing Paper #3 Sex Work Is Not Trafficking***, the NSWP writes, "[NSWP] members share a common belief and experience that sex work is work and should be recognized as such. They are united in their conviction that no person should be trafficked or forced to do work that they have not chosen. The conflation of trafficking and migration with sex work, in law, policies and practice, presents serious challenges [...] as it negatively impacts on sex workers' work and lives."[137]

CARE FOR VICTIMS

LINKAGES staff and implementers need to be ready to respond in the case that the project encounters a suspected victim of human trafficking. Should they be required, there are many tools to facilitate the identification of trafficking victims. Tool 6.7 from the *UNODC Toolkit to Combat Trafficking in Persons*[141] can be used as needed.

If a trafficked person is identified to the LINKAGES program, no matter their age, they should be supported according to international guidance. In *Caring for Trafficked Persons: Guidance for Health Providers*[142] the authors share the following good practice principles for all professionals involved with persons who have been trafficked:

1. **Adhere to existing recommendations** in *WHO Ethical and Safety Recommendations for Interviewing Trafficked Women.*[143]
2. **Treat all contact with trafficked persons as a potential step toward improving their health.** Each encounter with a trafficked person can have positive or negative effects on their health and well-being.[vii]
3. **Prioritize the safety of trafficked persons, self, and staff** by assessing risks and making consultative and well-informed decisions. Be aware of the safety concerns of trafficked persons and potential dangers to them or their family members.
4. **Provide respectful, equitable care that does not discriminate** based on gender, age, social class, religion, race, or ethnicity. Health care should respect the rights and dignity of those who are vulnerable, particularly women, children, the poor, and minorities.
5. **Be prepared with referral information and contact details for trusted support persons** for a range of assistance, including shelter, social services, counseling, legal advocacy, and law enforcement. If providing information to persons who are suspected or known victims who may still be in contact with traffickers, this must be done discretely, e.g., with small pieces of paper that can be hidden.
6. **Collaborate with other support services** to implement prevention activities and response strategies that are cooperative and appropriate to the differing needs of trafficked persons.
7. **Ensure the confidentiality and privacy of trafficked persons and their families.** Put measures into place to make sure all communications with and about trafficked persons are dealt with confidentially and that each trafficked person is assured that their privacy will be respected.
8. **Provide information in a way that each trafficked person can understand.** Communicate care plans, purposes, and procedures with linguistically and age-appropriate descriptions, taking the time necessary to be sure that each individual understands what is being said and has the opportunity to ask questions. This is an essential step prior to requesting informed consent.
9. **Obtain voluntary, informed consent.** Before sharing or transferring information about patients, and before beginning procedures to diagnose, treat, or make referrals, it is necessary to obtain the patient's voluntary informed consent. If an individual agrees that information about them or others may be shared, provide only that which is necessary to assist the individual (e.g., when making a referral to another service) or to assist others (e.g., other trafficked persons).
10. **Respect the rights, choices, and dignity of each individual by:**
    - Conducting interviews in private settings.
    - Offering the patient the option of interacting with male or female staff or interpreters.

vii When relevant, consider guidance specific to STI and reproductive tract infections for trafficked women, such as *Recommendations for Reproductive and Sexual Health Care on Trafficked Women in Ukraine: Focus on STI/RTI Care.*

For interviews and clinical examinations of trafficked women and girls, it is of particular importance to make certain female staff and interpreters are available.

While LINKAGES will not be able to provide for all the needs of a trafficked person, **a LINKAGES staff person in each LINKAGES country office should be named as the *counter-trafficking point of contact.* This staff person will maintain a directory of the available resources so that referrals can be made as appropriate.**

In some countries there may already be a functional referral system for victims of trafficking.[viii] When this is not the case, it is important that LINKAGES staff seek out all the services that are available. The United Nations High Commissioner for Human Rights states that all the following should be made available to trafficking victims:[144]

- Safe and adequate shelter (not immigration detention centers)
- Primary health care and counseling[ix]
- Information on their rights to access diplomatic and consular services from their state or nation
- Protection from harm, threats, or intimidation by traffickers or associated persons (this includes not publicly sharing the name of the trafficking victim) as well as information on the limitations of the protection that can be provided, particularly as it relates to protecting one's identity if a case goes to trial
- Legal and other assistance in relation to any criminal, civil, or other actions against traffickers/exploiters (legal information should be provided in a language understood by the victim)
- Safe and, where possible, voluntary return to their home country; or exploration of residency in the country of destination or a third-country resettlement (particularly to prevent reprisals or re-trafficking). If the person returns to their home country, support to ensure their well-being and facilitate their social integration and prevent re-trafficking.

When selecting agencies to refer to, consider this further guidance from the authors of *Caring for Trafficked Persons: Guidance for Health Providers.*[142] They state:

> Referral options should be reputable and well-established. It is beneficial to patients and to the referring organization to know whether the staff and key individuals at the referral organization provide non-discriminatory, supportive care to such marginalized groups as migrants, sex workers and minority populations. It can also be helpful to know which service providers have multi-lingual staff.

RESPONSIBILITIES OF THE LINKAGES COUNTER-TRAFFICKING POINT OF CONTACT IN EACH COUNTRY

- Be familiar with the good practice principles above.
- Know local mandatory reporting laws regarding trafficked persons, particularly exploited children.
- Develop and maintain a list of organizations—including hours of operation, location, contact information, languages spoken—that can meet the needs of trafficking victims and assess their ability to provide stigma-free and appropriate services to members of key populations and young people, including minors.
- Provide your name and contact information to all LINKAGES-affiliated program implementers and direct service providers so that they can contact you in the case that they interact with someone who is a suspected victim of trafficking.

viii To better understand available resources for victims of trafficking, including exploited children, LINKAGES country office staff should contact the local USAID Mission. Under USAID's *Counter-Trafficking in Persons Policy*, each USAID Mission has an obligation to address trafficking, including equipping "USAID personnel with the knowledge and tools necessary to recognize, report, and address human trafficking offices," and designating "a Counter-Trafficking in Persons Coordinator at all USAID Missions to serve as the primary point of contact for this issue. The Coordinator will disseminate information, respond to inquiries, and liaise with appropriate staff in developing anti-human trafficking strategies."

ix Note that HCWs collaborating with LINKAGES may benefit from guidance on how to support trafficking victims by referring to documents such as *Caring for Trafficked Persons: Guidance for Health Providers* to better understand the specific needs.

Additionally, it is important to know whether a referral option could cause disruption to HIV service access. HIV services providers have an obligation to ensure that HIV services are not denied to anyone. This means that any referrals made should not, for example, result in a situation in which an individual living with HIV is denied access to ARVs. Ensure that you are aware of each referral option's policies on accessing HIV services and their ability to support access.

The LINKAGES counter-trafficking point of contact should be ready to provide detailed relevant referral information whenever called upon. The counter-trafficking point of contact should also be familiar with the 10 principles described above and able to act in a way that acknowledges the unique risks and needs of trafficking victims as well as those working with them.

REPORTING

The name and contact information of the country office counter-trafficking point of contact should be provided to all LINKAGES staff, implementing partners, clinic staff, and outreach teams. In the event that anyone associated with the LINKAGES project interacts with a trafficked person, the LINKAGES-affiliated individual should reach out to the counter-trafficking point of contact for guidance. Only if the victim of trafficking has agreed to share their information with LINKAGES staff should their name be provided to the LINKAGES counter-trafficking point of contact. Mandatory reporting requirements, including in the case of minors, are dependent on local law and should be known by the counter-trafficking point of contact. Beyond reaching out to local agencies according to national mandatory reporting requirements, the counter-trafficking point of contact will inform the country manager who will reach out to the U.S.-based programmatic backstop and LINKAGES leadership.

Note that mandatory reporting to USAID is triggered if FHI 360, a subawardee, or contractor, at any tier, or their employees, labor recruiters, brokers, or other agents are engaged in trafficking. If any individual hired by LINKAGES believes they have witnessed others employed by the project engaging in human trafficking, they should report the issue to the relevant LINKAGES country manager immediately.[145] The country manager will contact LINKAGES leadership at the global level, and LINKAGES global leadership will notify the Mission and USAID/Washington.

In addition, if any employee of LINKAGES wishes to report a case of trafficking by an individual hired by the LINKAGES project, they can do so without fear of retaliation by reporting to the Global Human Trafficking Hotline at 1-844-888-FREE and its email address at *help@befree.org*. FHI 360 also has a counter-trafficking in persons policy that can be referred to as needed.[146]

Annex 3
Action Planning Template

Element 1.
Core Knowledge among Implementers and Key Population (KP) Communities

ELEMENT 1A: A trained core team of staff, partners, and direct service providers (e.g., staff, drop-in center [DIC] managers, allied lawyers, and selected health care workers [HCWs], peer educators [PEs], peer navigators [PNs], and outreach workers [ORWs]) is able to lead the design and implementation of a tailored comprehensive violence prevention and response (VPR) program for members of KPs.

What existing tools or activities are part of this element?

Specific Steps/Activities	Person(s)/Agencies Responsible	Timeline

ELEMENT 1B: Activities to build KP communities' understanding of violence through the lens of gender, power, and human rights. These activities will also strengthen community cohesion and agency among KP members (e.g., discussions of power; gender norms and inequalities at the root of stigma, discrimination, and violence against KP members; rights education; and so on).

What existing tools or activities are part of this element?

Specific Steps/Activities	Person(s)/Agencies Responsible	Timeline

Element 2.
An Understanding among Program Implementors of Violence against KPs and Existing Efforts to Address Violence

ELEMENT 2A: Mechanisms in place (e.g., assessment, focus groups, stakeholder interviews, microplanning, mapping, training) to increase understanding of violence experienced by KP members, including types of violence, common perpetrators, key hot spots, needs of KP members when they experience violence, and barriers to accessing violence response services.

What existing tools or activities are part of this element?

Specific Steps/Activities	Person(s)/Agencies Responsible	Timeline

ELEMENT 2B: A map that illustrates key stakeholders and established relationships with them, including Ministry of Health, senior-level law enforcement officers, allied lawyers, and health and mental health service providers frequently used and/or preferred by KP members. This resource map should reflect the health, social, and justice/legal needs of KP members who experience violence and should include all existing systems/activities/tools to address stigma, discrimination, and violence.

What existing tools or activities are part of this element?

Specific Steps/Activities	Person(s)/Agencies Responsible	Timeline

Element 3.
Networks to Ensure KP Members' Access to Health, Social, and Justice/Legal

ELEMENT 3A: A referral network and directory of service providers. The network should include health,[x] social,[xi] and justice/legal services,[xii] including safe spaces like DICs and emergency shelters.

What existing tools or activities are part of this element?

Specific Steps/Activities	Person(s)/Agencies Responsible	Timeline

ELEMENT 3B: Sensitized and trained referral points with whom the program has formal relationships.

What existing tools or activities are part of this element?

Specific Steps/Activities	Person(s)/Agencies Responsible	Timeline

ELEMENT 3C: Efforts to build acceptance for VPR, including engaging with civil society and government, that can increase access to violence response services for members of KPs.

What existing tools or activities are part of this element?

Specific Steps/Activities	Person(s)/Agencies Responsible	Timeline

x **Health services:** treatment of injuries, HIV testing, PEP, emergency contraception, STI testing and treatment, rape kits/forensic exam, tetanus vaccine, and hepatitis B screening and treatment. Mental health screening and treatment for depression and post-traumatic stress disorder should also be available.

xi **Social services:** psychosocial support including crisis counseling and support groups, securing/replacing identity documents, transportation assistance, child care, interpreters, financial aid (such as vocational training), food assistance, and connections to community-based organizations that can provide information and facilitate access to services, including through accompaniment.

xii **Justice/legal services:** information on the rights of KP members, information on law enforcement procedures, legal counsel (including in cases of arrest), ability to give a statement or otherwise document the case.

Element 4.
Systems to Provide Opportunities for Disclosure and Respond to Violence, including Crisis Response

ELEMENT 4A: Standard operating procedures on creating opportunities for disclosure and providing first-line support and violence response services.

What existing tools or activities are part of this element?

Specific Steps/Act/Activities	Person(s)/Agencies Responsible	Timeline

ELEMENT 4B: Information, education, and communication (IEC) materials and interpersonal communication (IPC) tools developed and disseminated. These materials should be designed for service users and direct service providers.

What existing tools or activities are part of this element?

Specific /Activities	Person(s)/Agencies Responsible	Timeline

ELEMENT 4C: Sensitized and trained PEs, PNs, and ORWs raise awareness about violence; provide opportunities to disclose violence; offer first-line support[xiii] to victims of violence; and accompany victims of violence to seek additional services.

What existing tools or activities are part of this element?

Specific /Activities	Person(s)/Agencies Responsible	Timeline

xiii **First-line support:** the minimum level of (primarily psychological) support and validation of experience that all people who disclose violence to a provider should receive.

Element 4.
Systems to Provide Opportunities for Disclosure and Respond to Violence, including Crisis Response

ELEMENT 4D: Sensitized and trained HCWs ask about violence among service users and provide first-line support and clinical services to victims of violence.

What existing tools or activities are part of this element?

Specific Steps/Act/Activities	Person(s)/Agencies Responsible	Timeline

ELEMENT 4E: Mechanisms are available to support/supervise individuals engaged in VPR and promote self-care and personal safety (e.g., peer education supervision, support groups for direct service providers).

What existing tools or activities are part of this element?

Specific /Activities	Person(s)/Agencies Responsible	Timeline

ELEMENT 4F: An operational crisis response system (e.g., hotline, WhatsApp group) is in place, including (1) an identified and trained crisis management team responsible for handling incoming calls/texts and (2) the resources to support implementation of the crisis response system.

What existing tools or activities are part of this element?

Specific /Activities	Person(s)/Agencies Responsible	Timeline

Element 5.
Accountability to Prevent Violence

ELEMENT 5A: Sensitized and trained law enforcement officers and other uniformed officers (if possible) commit to serving KP members who experience violence and to not perpetrating violence against KP members.

What existing tools or activities are part of this element?

Specific Steps/Activities	Person(s)/Agencies Responsible	Timeline

ELEMENT 5B: Other sensitized power holders (e.g., religious leaders, tribal leaders, third parties in the sex industry such as managers and bar and lodge owners) commit to connecting victims of violence to available services and condemning violence against KP members.

What existing tools or activities are part of this element?

Specific Steps/Activities	Person(s)/Agencies Responsible	Timeline

Element 6.
Documentation and Monitoring

ELEMENT 6A: Aggregated information on cases of violence is used to identify trends in both characteristics of violence (What are the most common forms of violence? Who are common perpetrators? Where does violence occur?) and responses to violence (Are most people who report violence getting violence response services? Is reporting changing overtime?) to inform programming and support advocacy.

What existing tools or activities are part of this element?

Specific Steps/Activities	Person(s)/Agencies Responsible	Timeline

ELEMENT 6B: Systems in use to monitor the quality of violence prevention and response programs, including opportunities for feedback from victims who use violence response services and efforts to identify unintended consequences.

What existing tools or activities are part of this element?

Specific Steps/Activities	Person(s)/Agencies Responsible	Timeline

Annex 4

Sample Focus Group Guide for Female Sex Workers[xiv]

Date of Group: _____ **Site:**_____

Start Time: _____ **End Time:** _____

Name(s) of Facilitator(s): _____

Name of Note-Taker: _____

# of Female Sex Workers Participating in Focus Group: _____

INTRODUCTION:

INTRODUCE THE PURPOSE OF THE GROUP: Let's go ahead and get started. My name is _____ and this is my colleague _____. We work with LINKAGES, which is a global project that focuses on increasing access to HIV prevention, care, and treatment services for sex workers and other groups that are particularly vulnerable to HIV. The reason we're having this discussion group is because we are interested in learning about some of the concerns and needs of female sex workers who live here in this community. In particular, we know that violence and other human rights abuses can create barriers for female sex workers in accessing important services and support, so we are interested in talking to you all about how violence and other types of abuse are affecting female sex workers in this community and what services might be available and accessible to you and your peers.

CONFIDENTIALITY AND HOW THIS INFORMATION WILL BE USED: We're interested in knowing about things you know or have heard to be happening, including things you have experienced yourself, but if you share something you know about someone else, please don't use the person's name. You can also share things that have happened to you in a general way, instead of directly describing your own experience.

We will only share the information we learn today in a general way among members of the LINKAGES team and in a way that does not reveal the identity of anyone in the group. We will only use the information we learn today to help us improve our programs. It's important that the information shared in this group does not leave this group, so we ask everyone to not share who was here or what was said in the group with others outside the group when you leave here.

If it's okay with you, I (or a colleague) will take notes during our interview. I will not be writing down your name or any other identifying information on these notes. No identifying information will be linked to anyone's remarks. Is it OK for me (or a colleague) to take notes?

Your participation is completely voluntary. If at any point, you would like to stop participating in the discussion group, that is fine. You do not have to answer any questions that you do not want to. Do you have any questions before we get started?

xivThis is an illustrative focus group guide that focuses on female sex workers. It will need to be adapted to meet the needs of a specific project, which could include changing the focus population.

SECTION 1: COMMUNITY ATTITUDES TOWARD FEMALE SEX WORKERS

SAY: *I'd like to start by asking about general attitudes toward female sex workers in the larger community.*

1. *In general, what do people in the larger community think and say about female sex workers? (What are some commonly held beliefs about female sex workers?)*

   PROBE for negative attitudes and beliefs toward female sex workers.

2. *More specifically, what are some of the community attitudes toward female sex workers who experience violence or other types of abuse? (What do people in the larger community say or do when female sex workers experience violence?)*

   PROBE for stigma and victim-blaming attitudes.

3. *What do you think contributes to these community attitudes and beliefs?*

SECTION 2. PERCEPTIONS OF VIOLENCE/EXPERIENCES WITH VIOLENCE

SAY: *We'd like to learn more about how violence and abuse is affecting the lives of female sex workers here in [country].*

4. *When you hear the term "violence and abuse," what does that include? (What are the different types of violence and abuse? Besides physical violence, are there other forms of violence and abuse?)*

   PROBE for participants' understanding of what violence and abuse is (e.g., physical abuse, sexual abuse, emotional abuse, economic abuse). Don't introduce the different types of abuse here; rather, probe for their understanding of what violence and abuse is.

   SAY: *Sometimes it is difficult for us to tell people about violence and abuse that we have experienced, because we might feel embarrassed or are afraid that it is not safe to talk about our experiences. Sometimes we are blamed for violence that happens to us—when in fact, it is never our fault. We know that female sex workers can be particularly vulnerable to violence and abuse, and it would be very helpful for us to learn more about your personal experiences or experiences of other female sex workers you know about. Remember your name will not be attached to this information. Before we move on, we want to make sure everyone understands what we mean when we ask about "violence" and the different ways violence and abuse can happen. We just talked about some of these different types of violence and abuse.*

When we talk about PHYSICAL ABUSE, this can include things like punching; slapping; pushing; pinching; choking; slamming you against something; spitting at you; pulling your hair; burning you; twisting your fingers, arms, or other body parts; using a weapon on you; or kidnapping you or holding you against your will.

SEXUAL ABUSE can include things like attempted or completed rape or sexual assault, including forced or coerced oral, vaginal, or anal sex or any other sexual activity that you did not want to do. It includes forcing you to have sex without a condom.

Other types of abuse can include emotional or psychological abuse, including verbal abuse—such as calling you names, yelling at you, putting you down—or economic abuse—such as fining you for having condoms, taking your money or limiting your access to money for food and other basic needs, or refusing to pay for your services. Abuse can also include limiting or denying your access to health care or other needed services.

5. *What types of violence and abuse do female sex workers experience in this community?*

   PROBE for physical, sexual, emotional, and economic abuse, as well as other human rights violations.

6. *Without mentioning names, who is committing violence against female sex workers?*

   PROBE: intimate partners, clients, law enforcement officers, family members, brothel/bar/lodge owners, direct service providers

ASK ABOUT LAW ENFORCEMENT OFFICERS: *How about law enforcement officers? Are female sex workers experiencing violence and abuse by law enforcement officers? What types of violence and abuse do law enforcement officers commit against female sex workers? Does this happen while they are clients—or mostly in their role as law enforcement officers—or both? Are there any law enforcement officers who have been supportive or helpful to female sex workers? How so?*

7. *Where does violence against female sex workers usually occur?*

   PROBE: hot spots—bars, lodges, brothels—where you work—or somewhere else?

8. *When are female sex workers experiencing violence—mostly during the week or weekends— or particular times of the day or evening?*

SECTION 3: NEEDS/AVAILABLE SERVICES FOR FEMALE SEX WORKERS WHO EXPERIENCE VIOLENCE

SAY: *People have different needs when they experience violence. Also, people do many different things to help themselves be safe, like talking to a trusted friend or family member, seeking help from organizations, going to the hospital, or reporting it to law enforcement officers. Or, they may do nothing at all.*

9. *When female sex workers experience violence in [country], what types of services and support do they need?*

   PROBE for specific health, social, or justice/legal needs.

   ASK: *How do female sex workers in your community cope when they experience violence? How are they getting their needs met?*

10. *In your community, where do female sex workers go for help when they experience violence?*

    ASK: *What services do they seek? Who do they talk to? Are there "informal" systems in place among the sex worker community that support female sex workers when they experience violence—such as a phone tree or calling/texting system? Are there things that female sex workers definitely would not do? Places they definitely would not go if they experienced violence and abuse?*

11. *What are the barriers to female sex workers in accessing services and support?*

PROBE for barriers such as direct service provider attitudes, direct service provider abuse toward female sex workers, lack of trust in direct service providers, previous bad experiences, etc.

ASK: *In particular, what are some of the attitudes of health care workers and other direct service providers toward female sex workers?*

ASK: *What have female sex workers experienced when they reached out for health care services after experiencing violence? How about reaching out to law enforcement officers/making a report to law enforcement officers?*

12. *Are there safe spaces where female sex workers can go when they experience violence?*

SECTION 4: CLOSING QUESTIONS

13. *In your opinion, what should be done to end violence against female sex workers in [country].*

PROBE: *How can a key population program support female sex workers to address violence against their communities?*

PROBE: *Is there anything else you'd like to share, or you think is important for us to know?*

CLOSE THE FOCUS GROUP DISCUSSION

Thank you all for your time and ideas. This has been extremely helpful. The information you shared will help us understand ways we can support female sex workers who experience violence and ways we can work with the larger community to address some of the problems faced by female sex workers—particularly in being able to access services and receive stigma-free and friendly services when they do reach out for help.

Please remember that you agreed to keep this discussion confidential. Please do not share with others the details of what was said here. Does anyone have questions before we finish?

If anyone would like to speak with me in private, I'm available to speak to you after the group ends.

Annex 5

Sample In-Depth Interview Guide for Key Stakeholders/Facilities[xv]

Interview Date: _____ **Start Time:** _____ **End Time:** _____

Location of Interview: _____

Facility/Program Name: _____

Type of Facility/Program:
☐ **HCW** ☐ **Law Enforcement** ☐ **Official** ☐ **Other:** _____

INTRODUCTION:

Interviewer introduces herself/himself:

My name is _____ and I am _____ for the LINKAGES project. As part of the LINKAGES project's efforts to strengthen violence prevention and response services for men who have sex with men in [country] I am talking to Ministry officials, health care workers, and law enforcement officers to learn more about (1) the perceptions of men who have sex with men and victims of violence; (2) the health, social, and justice/legal services that are currently available for victims of violence and abuse, including men who have sex with men; and (3) what support would help your organization serve men who have sex with men and victims of violence. I'm here today to learn more from you about your experiences living and working in this community and your experiences providing various services. I appreciate you taking time to talk with me.

If it's okay with you, I will take notes during our interview. I will not be writing down your name or any other identifying information on these notes. Your participation in this interview will not affect your employment, and it is not part of a performance review. The information I learn during our interview will only be used to help the LINKAGES project plan for violence prevention and response activities. The information I collect will be aggregated and shared with LINKAGES and _____. No identifying information will be linked to anyone's remarks.

This interview is completely voluntary. If at any point, you would like to stop the interview, just let me know and we will stop. You do not have to answer any questions that you do not want to. The interview will take about 30-45 minutes. Do you have any questions before we get started?

xv This is an illustrative in-depth interview guide that focuses on men who have sex with men. It will need to be adapted to KP members who are the focus of a specific project.

SECTION 1: GENERAL

SAY: *I'd like to start by learning more about your role at [name of facility/program/organization].*

1. *What is your position with this [facility/program/organization]?*

   PROBE: *What is your title?*

2. *What are your main responsibilities?*

SECTION 2: COMMUNITY ATTITUDES TOWARD KEY POPULATIONS

SAY: *Communities often have specific attitudes and beliefs about people who work with or provide services to men who have sex with men. I'd like to ask your opinion about attitudes in your community.*

3. *In general, what do people in your community think and say about people who work with or provide services to men who have sex with men?*

   PROBE: *What do you think contributes to these attitudes?*

SECTION 3: INTERACTIONS WITH KEY POPULATIONS

4. *In the course of your work with [facility/program], do you have direct interactions with men who have sex with men seeking services?*

   ☐ *1. Yes* ☐ *2. No* ☐ *3. I don't know*

5. *In general, how do/would you feel about providing services to men who have sex with men?*

   PROBE FOR STIGMA, SHAME, PRIDE, SATISFACTION, SAFETY CONCERNS

SECTION 4: COMMUNITY ATTITUDES ABOUT VIOLENCE

6. *All over the world, men who have sex with men experience high levels of violence. What is said about violence against men who have sex with men in [country]? Is it considered to be common? How would you describe the types of violence that men who have sex with men most commonly experience?*

   What is the perception of men who have sex with men who experience violence?

   PROBE: *What contributes to these perceptions*

   PROBE: *What causes violence against men who have sex with men in [country]?*

SECTION 5: WHERE VICTIMS OF VIOLENCE GO FOR HELP

SAY: *Experiencing violence and abuse is difficult, and people do many different things to help themselves be safe, like talking to a trusted friend or family member, seeking help from organizations, going to the hospital, or reporting it to law enforcement officers. Or, they may do nothing at all.*

7. *How about men who have sex with men who have experienced violence and abuse? What do they do and where do they go for help?*

PROBE: *Are there things that men who have sex with men definitely would not do? Places they definitely would not go if they experienced violence and abuse?*

PROBE: *What keeps men who have sex with men from seeking support when they experience violence?*

SECTION 6: SERVICE USERS/AVAILABLE SERVICES

SAY: *I'd like to learn more about your interactions with service users and available services.*

8. *What services [do you provide/are provided at this facility or program] for victims of violence?*

PROBE: *Have you or your staff received special training to work with victims of violence?*

PROBE: *Do you/they use what was learned in these trainings? How?*

9. *Have you received special training to work with men who have sex with men?*

PROBE: *Do you/they use what was learned in these trainings? How?*

SECTION 7: ASKING ABOUT VIOLENCE

10. *How does your [facility/program] find out about cases of violence? For example, do service users come to your [facility/program] and report? Do you have a hotline? Do service users come for another reason and then report violence?*

PROBE: *In health care settings, are service users asked about violence? If so, in what circumstances?*

11. *Is there a specific protocol your [facility/program] or you as an individual must follow when a service user reports abuse? If so, please describe it. Please identify any official documents that dictate your response.*

PROBE: *Are there any areas where clarity is lacking? For example, when dealing with minors? With men who have sex with men? With certain types of violence?*

SECTION 9: REFERRAL PATHWAYS

12. *Are there mechanisms in place at your [facility/program] to refer individuals who disclose violence or abuse to resources outside of your [facility/program]? If so, what are those mechanisms?*

PROBE: *Have referral pathways been developed for victims of violence? What organizations are involved in the referral pathways? Which agencies work specifically with men who have sex with men?*

ASK: *Does staff here have a list of these organizations in order to make referrals?*

13. *Is there a mechanism in place to find out what happens with individuals who disclose violence or abuse after [you work with them/they leave facility/program]? If so, how does that follow-up happen?*

IF YES, ASK: *Does the follow-up happen with men who have sex with men?*

SECTION 10: INFORMATION, EDUCATION, AND COMMUNICATIONS MATERIALS

14. *Are there printed materials (brochures/pamphlets/posters) available/displayed at your [facility/program] that inform service users about the legal and human rights of specific groups, such as men who have sex with men? If yes, do these materials provide information about where they can go to receive legal advocacy and support?*

PROBE: Are there printed materials (brochures/pamphlets/posters) available/displayed at your organization with information about violence and abuse? If yes, what information is included?

SECTION 11: OPINIONS

15. *For your [facility/program] to do its job well, does it need to be able to talk about violence with service users? Why or why not?*

16. *If your [facility/program] needed to talk to your service users about violence, what kind of support would you need to do this effectively? For example, trainings, tools, supervision, staff.*

[Law Enforcement]

17. *What support do you need to appropriately serve victims of violence, including men who have sex with men? For example, trainings, tools, supervision, staff.*

CLOSE THE INTERVIEW

Thank you for your time and ideas. This has been extremely helpful. The information you shared will help us understand the ways we can support men who have sex with men who experience violence and ways we can work with the larger community to address some of the problems faced by men who have sex with men—particularly in being able to access services and receive stigma-free and friendly services when they do reach out for help.

Do you have any questions before we finish?

Annex 6
Sample Printed Referral Network

Use the following template to fill in details of the referral network for your geographic area. All organizations and individuals must be able to provide stigma-free services to key population members.

INDIVIDUAL DISCLOSES VIOLENCE

Direct service provider provides immediate support (first-line support)

The direct service provider ensures privacy and confidentiality and uses the LIVES model to respond to the disclosure. Whenever possible the direct service provider should offer to accompany the service user to any referral site or arrange for the service user to be accompanied to any referral site that the service user chooses.

HEALTH SERVICES *(such as treatment of injuries, HIV testing, PEP, emergency contraception, STI screening and treatment, and mental health screening)*	SOCIAL SERVICES *(such as crisis counseling and support groups, financial aid, community-based organizations that may provide accompaniment)*	JUSTICE/LEGAL SERVICES *(such as legal information, assistance with arrest/detention, and contact information of trained law enforcement officers when they can be safely engaged)*
[Name of Organization/Facility] Hours: Location: Focal Point: Phone: Email: Services available:	**[Name of Organization/Facility]** Hours: Location: Focal Point: Phone: Email: Services available:	**[Name of Organization/Facility]** Hours: Location: Focal Point: Phone: Email: Services available:
[Name of Organization/Facility] Hours: Location: Focal Point: Phone: Email: Services available:	**[Name of Organization/Facility]** Hours: Location: Focal Point: Phone: Email: Services available:	**[Name of Organization/Facility]** Hours: Location: Focal Point: Phone: Email: Services available:
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Annex 7

Additional Guidance for Providing First-Line Support: Focus on Safety

The LIVES model, as presented in *Health Care for Women Subjected to Intimate Partner Violence or Sexual Violence: A Clinical Handbook*,[35] is an adaptation of psychological first aid that focuses on intimate partner violence and sexual assault. As key population (KP) members may be dealing with other forms of violence and may encounter additional barriers to seeking safety, this annex provides supplemental ideas to support productive safety conversations.

Explore safety strategies. Safety strategies depend on the individual's situation, personal strengths, resources, and social networks, but could include:

- Identifying shelters that may be willing or able to meet the needs of KP members (for example, determining whether the shelter is welcoming to trans women)
- Carrying emergency phone numbers of peers, crisis response teams, or violence response service providers, including lawyers who may be able to provide support in case of arrest
- Contacting international funds that may be able to help with relocation or other costs. See below for a resource list that can be used to support emergency response

For sex workers, additional safety strategies could include:

- Negotiating payment up front
- 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

See tools such as *Keeping Safe* by the UK Network of Sex Work Projects for more tips on safe sex work [147]

Bringing up safety strategies: It is important that direct service providers do not tell KP members how to stay safe. Safety planning is a conversation in which the direct service provider asks questions to help KP members 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 up front, 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 up front?"* It is also the case that safety strategies should be presented in other settings, not just after violence occurs. Discussing safety strategies is a recommended action under ELEMENT #1B.

RESOURCE LIST | EMERGENCY RESPONSE

Support for responding to human rights violations and security threats

This resource list explains international support available for human rights defenders and organizations that work with LGBTI people and men who have sex with men, sex workers, or people who inject drugs in the case of human rights violations or security threats. It is meant for digital use. PLEASE DO NOT PRINT.

DIGNITY FOR ALL

What do they do? Dignity for All is a consortium of organizations focused on safety and security for LGBTI communities. Dignity can provide:

(1) **Emergency financial assistance** to LGBTI human rights defenders (HRDs) or organizations who are threatened because of their work. Support can address urgent needs such as temporary relocation, security, medical expenses, legal representation, and dependent support.

(2) **Security, opportunity, and advocacy rapid response (SOAR) grants** for short term interventions to help civil society organizations (CSOs) counteract urgent threats or take advantage of unexpected opportunities to protect or advance LGBTI human rights.

(3) **Preventative security workshops** that help CSOs and HRDs increase their security awareness, develop security plans, and gain skills to keep themselves and their communities safer.

Where do they provide support? Global (anywhere)

Who can apply? HRDs or CSOs with a proven history of LGBTI activism. CSOs do not need to be officially registered.

To find out more or apply—*click here*.
Or email *info@dignitylgbti.org*

FRONTLINE AIDS

What do they do? The Rapid Response Fund, managed by Frontline AIDS, issues grants for interventions that respond to new or worsening situations that impact HIV services for LGBTI individuals and MSM. They issue:

(1) **Emergency Response Grants**, to respond to immediate threats to MSM and the LGBT community, and the HIV services that they need, and where action must happen very quickly to be effective. For example, supporting the relocation of individuals forced out of their homes, who need help to find and access friendly HIV services in their new location.

(2) **Challenge Response Grants** to respond to urgent situations that require an intervention that may take place over several months (typically up to 6 months) and will contribute to the removal of barriers to accessing HIV services. For example, engaging with local government in response to sudden policy developments affecting access to HIV services for MSM and LGBT people.

Where do they provide support? 29 countries in sub-Saharan Africa, Latin America and the Caribbean. *See list*.

Who can apply? Grants can be provided to CSOs led by or working closely with LGBTI people or MSM.

To find out more or apply—*click here*.

FRONT LINE DEFENDERS

What do they do? Front Line Defenders provides support in the form of: advocacy, emergency support for those in immediate danger, grants to pay for the practical security needs of human rights defenders, trainings and resource materials on security and protection, opportunities for human rights defenders dealing with extreme stress, and an emergency 24-hour phone line. They aim to approve emergency grants within 48 hours.

Where do they provide support? Global (anywhere)

Who can apply? Human rights defenders and their organizations

To find out more or apply—*click link*.

URGENT ACTION FUND FOR WOMEN'S HUMAN RIGHTS

What do they do? Urgent Action Fund for Women's Human Rights provides grants to women and transgender human rights defenders at critical moments. They intervene quickly when activists are poised to make great gains or face serious threats to their lives and work. A list of their grants to date can be found *here*. They respond to requests within 72 hours and have funds on the ground within 1-7 days.

Where do they provide support? Asia, the Middle East, Central and Eastern Europe, and North America

Who can apply? Women and transgender human rights defender

To find out more or apply—*click here*.

Annex 8

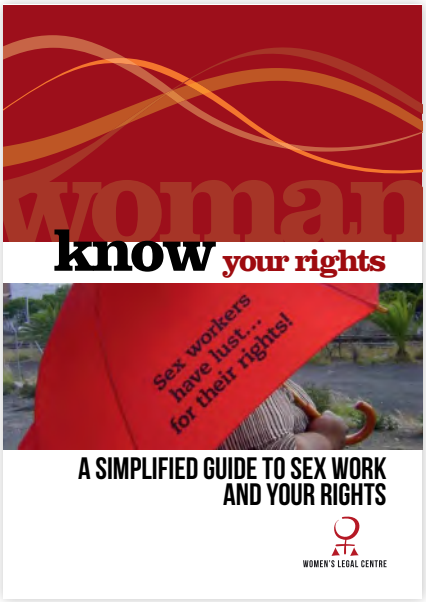
Sample Information, Education, and Communication Materials and Interpersonal Communication Tools[xvi]

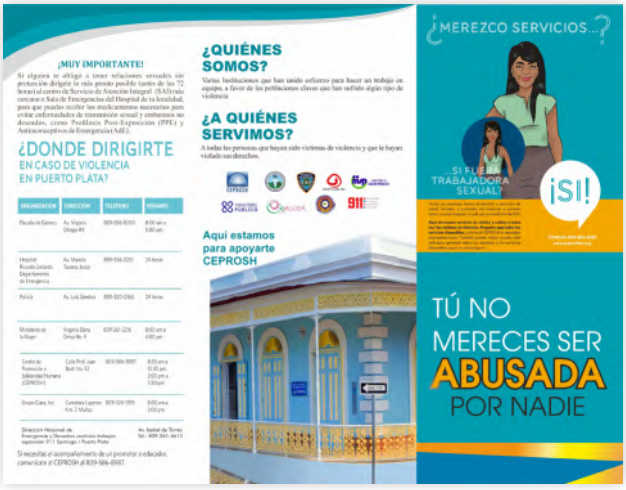
Create posters that incorporate selected violence prevention and response messages and post throughout facilities and offices of organizations involved in the continuum of care

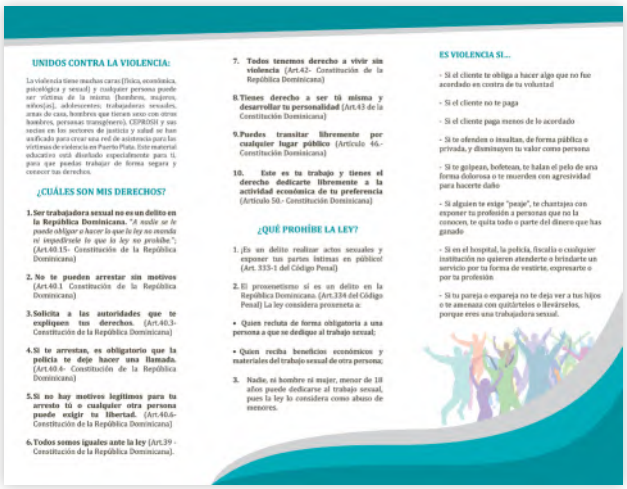
Create provider badges that encourage service users to talk to a direct service provider about violence.

xvi The sample materials and tools in this annex were published by the University of North Carolina at Chapel Hill, the Women's Legal Centre, FHI 360, and Together for Girls.[148-152]

Create brochures/ booklets that inform key population members about their legal and human rights and provide information about violence, rights, and how to access services.







Create pocket cards that key population members can use to remind law enforcement officers of their rights if they are arrested.

Dear Police Officer

Please tell me if I am under arrest. If I am not under arrest, you must let me go.

If I am under arrest, you must tell me why, give me a *Notice of Rights* and explain my rights until I fully understand.

If you don't intend to charge me, you must release me immediately.

I have a right not to speak and I do not have to answer questions until you show me your police badge. Once I see your badge, I only need to tell you my name and address.

I have a right to contact and speak to my legal adviser before I say anything to you. I need to use a phone to do this and have the right to call a mobile phone if necessary. Do not ask me questions until I speak to them.

I do not give you permission to search me.

I have a right to be free from violence and be treated with respect from you and all other officers.

I have a right to a clean cell and blankets, meals and medication. [Police Standing Orders G341, 349 (2), 361].

I wish to be released without delay. I have a right to apply for police bail and wish to use that right.

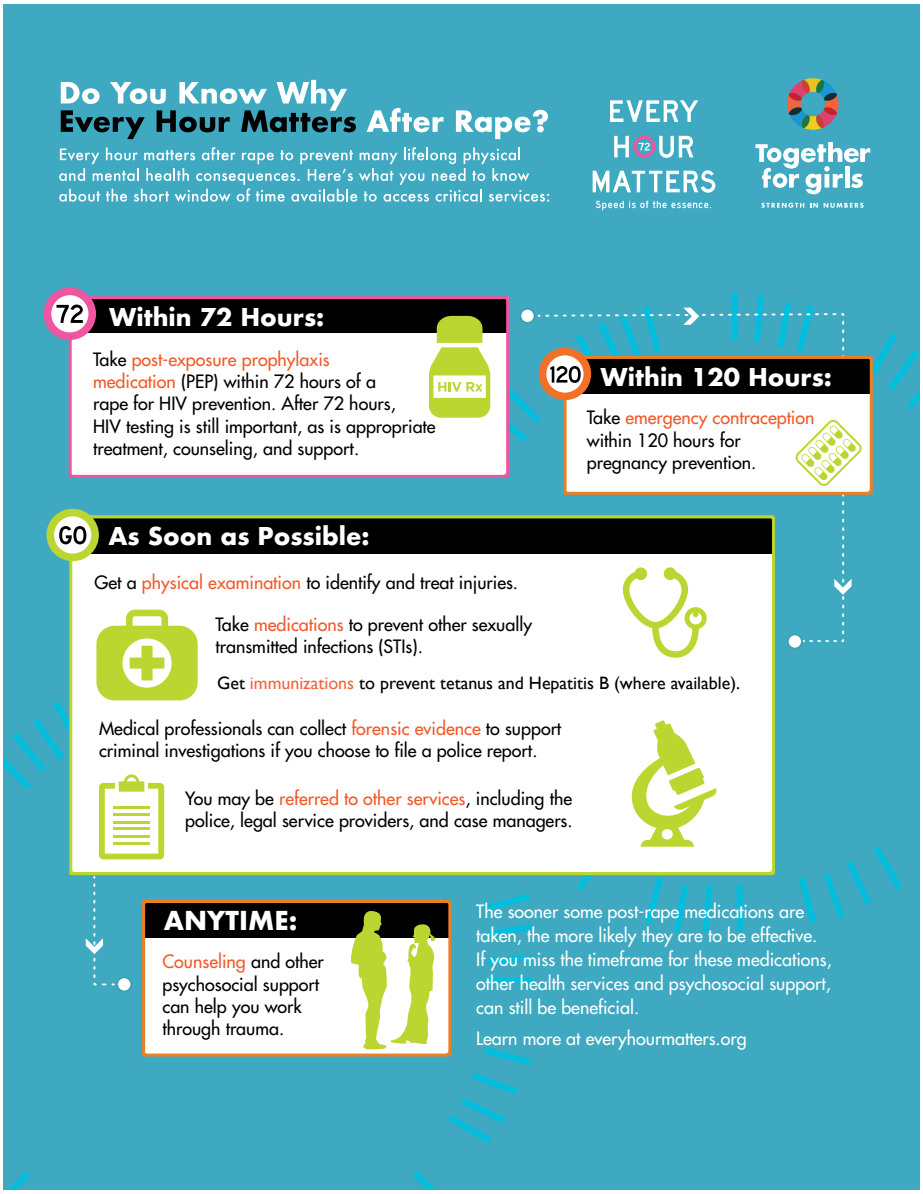
Thank you for respecting my rights. If you need more information, please contact the Human Rights Defence Team (SWEAT, Sisonke and Women's Legal Centre) at

076 3112 543

sweat Sisonke WOMEN'S LEGAL CENTRE

Create health education wall charts that inform service users about the types of violence; effects of violence, including HIV; violence as a violation of human rights; and where to go for help. Direct service providers can use these wall charts during discussions with service users.

Use existing resources that help explain the importance of seeking care immediately after rape (available in English, French, Spanish, and Swahili at *https://www.togetherforgirls.org/every-hour-matters/*)[xvii]



xvii Together for Girls has created a suite of resources you can use to break the cycle of violence and spread the word about post-rape care in your region. If you are planning to replicate any resources for your own purposes, please reach out to *info@togetherforgirls.org*.

SECTION 7

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