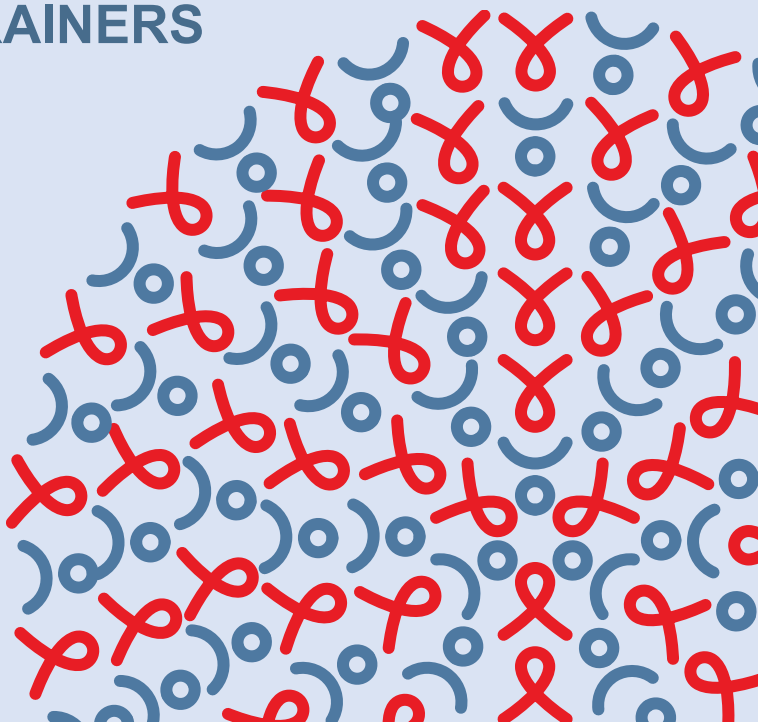
MEETING TARGETS AND MAINTAINING EPIDEMIC CONTROL (EPIC) PROJECT

COOPERATIVE AGREEMENT NO.
7200AA19CA00002

Identifying, preventing, and responding to violence in HIV programs serving key populations: Building health care workers' capacity to offer safe and ethical index testing

FACILITATOR'S HANDBOOK FOR A VIRTUAL TRAINING OF TRAINERS



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EpiC Meeting Targets and Maintaining Epidemic Control

Acknowledgments

This training was developed by Robyn Dayton (Senior Technical Advisor, FHI 360) and includes adapted activities from the *LINKAGES Health Care Worker Training: Preventing and Responding to Violence against Key Populations.*[1] Its various iterations have been conducted with FHI 360 staff and partner organizations around the world, including in Cambodia, Cote d'Ivoire, Central Asia, Eswatini, Indonesia, Laos, Lesotho, Liberia, Kenya, Papua New Guinea, Malawi, Mali, Nepal, Nigeria, Tanzania, Vietnam, and Zambia.

Many thanks to the staff and partners who were patient with technology glitches and sometimes awkward adaptations of activities originally designed to be delivered face to face. Their experiences attending the training and rolling it out to others, and their feedback and insights on what works virtually and during a global pandemic, helped shape this final content.

It was reviewed by Chris Akolo and Rose Wilcher (FHI 360) and Amelia Peltz (USAID). It was edited by Stevie Daniels with design assistance from Lucy Harber.

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

[1]Dayton R, Morales GJ, Dixon KS. LINKAGES health care worker training: preventing and responding to violence against key populations. Durham (INC): FHI 360; 2019. Available from: https://www.fhi360.org/sites/default/files/media/documents/resource-linkages-hcw-training-manual.pdf.

Contents

Acronyms and abbreviations

COVID-19 – Coronavirus disease of 2019

FAQ – Frequently asked question

GBV – Gender-based violence

HCW – Health care worker

HIV – Human immunodeficiency virus

IPV – Intimate partner violence

KP – Key population

LIVES – Listen, inquire, validate, enhance safety, support

MOH – Ministry of Health

PEPFAR – U.S. President's Emergency Plan for AIDS Relief

REDCap – Research Electronic Data Capture

SIMS – Site Improvement Monitoring System (PEPFAR)

SOP – Standard operating procedure

STI – Sexually transmitted infection

TOT – Training of trainers

USAID – United States Agency for International Development

WHO – World Health Organization

Snapshot of the training

Audience and purpose

This training package is for use by HIV programs working with key populations (KPs)—gay men and other men who have sex with men, people who inject drugs, sex workers, and transgender people—whose services include index testing. It will help these programs comply with U.S. President's Emergency Plan for AIDS Relief (PEPFAR) guidance for safe and ethical index testing and address gaps that were identified in the U.S. Agency for International Development (USAID) Research Electronic Data Capture (REDCap) Survey.

Although the focus is on the unique experiences of key populations, the training is also relevant for HIV programs working with the general population. As a training of trainers (TOT), it will enable HIV program staff in a specific context to understand and master the requirements for safe and ethical index testing and effectively convey the requirements—along with their own programmatic tools to meet these requirements, such as standard operating procedures (SOPs)—to health care workers in their programs. It can be conducted virtually or in person, or as a hybrid of the two. After the TOT, participants who demonstrate mastery of the learning objectives may adapt these resources and use them to train staff in their programs.

Contents

The training package contains:

1. Facilitator's handbook, with training agenda, pre- and post-test, pre- and post-test key, guidance on effective training implementation, detailed activity instructions, and links to SOPs that can be adapted for use in local programs
2. Training slides, with clear guidance on where facilitators should add or substitute content, and detailed speaker's notes (including language to use when presenting, citations for references given on the slides, and information on when to advance the slide to use animations).

Learning objectives for participants

HIV programmers trained will:

- Describe the reasons to identify violence in an HIV program.
- Name and act according to the principles of violence prevention and response.
- Identify and make plans to meet the PEPFAR requirements for asking about and responding to violence and monitoring adverse events, including within index testing (REDCap Survey).
- Demonstrate practical skills for asking about and responding to violence ethically (LIVES—listen, inquire, validate, enhance safety, support).
- Document and investigate adverse events related to index testing.
- Brainstorm adaptations necessary for their program.
- Be prepared to roll out the training to health care workers in their program (virtually or in person).

Time and preparation requirements

The training, when delivered virtually, is designed to be given over three two-hour periods, with participants completing homework between each session and submitting a video that demonstrates skill mastery at the end. To allow for completion of homework between sessions, it should be implemented ideally on nonconsecutive days. It should be co-facilitated by two people: at least one person who has demonstrated expertise in first-line support (LIVES)[2] and one person familiar with the participants, who can track their progress toward achieving a certificate to train others.

An agenda for hosting the training virtually is provided below. The hour added to the end of Day 2 can either be done immediately following the training or, according to participants' availability, between the second and third days of training. Most people who host the training in person do so over 1.5 days. See Annex A for an example. This gives more time for participants to practice and digest skills, including covering what would have been homework assignments during the training itself.

Virtual agenda

DAY 1	Time
Participant introductions and workshop expectations/objectives	20
Pre-test	5
Background	45
Fundamental principles of violence prevention and response	45
Homework assignment	5
DAY 2	
Recap Day 1 (Mentimeter) and homework review	20
Asking about and responding to violence	90
Assign homework	10
Additional one hour for small-group practice (homework)	60
DAY 3	
Recap Day 2 (Mentimeter) and homework review	25
Practical questions	35
Adverse events related to index testing	20
Monitoring and documentation	10
Reflections on what we have learned and how to integrate it into our work	10
Closing: Post-test and evaluation of the workshop (Mentimeter)	10

[2]First-line support is also known as psychological first aid. It is described in extensive detail in World Health Organization (WHO). Health care for women subjected to intimate partner violence or sexual violence. A clinical handbook. Geneva: WHO: 2014. Available: here. WHO has also created a five-day, in-person training on caring for women subjected to violence; available here.

Using the facilitator's handbook

This facilitator's handbook offers tips to help you conduct the training in a way that engages participants, particularly those joining virtually. It also provides additional information on topics covered. Please read the full handbook before organizing and implementing a training. The Detailed Session Instructions combined with the speaker's notes in the PowerPoint presentation provide implementation guidance.

Connectivity

When conducting this training virtually, please ensure that you have a plan in place for the following:

- **What platform(s) will you use to conduct this training?** We have used Microsoft Teams and Mentimeter for presentation when rolling out this training across the EpiC project. Mentimeter is an online survey/quiz platform through which you can ask questions of the participants who enter their answers on a computer or smartphone. Their answers are visible to the facilitator—and to the participants if the facilitator shares their screen—as they are received. This creates an opportunity for the facilitator to check how well participants have understood the content and provide clarification as needed (see Figures 1 and 2 for images from Mentimeter). We used Google Forms for pre- and post-tests and evaluations. Whatever platform(s) you choose, make sure all participants have access and can use all features, such as chat and unmuting to speak. As necessary, build in extra time before the first session to test each participant's ability to use the platform(s) successfully to avoid frustration and low participation later.

Figure 1. Question without answers

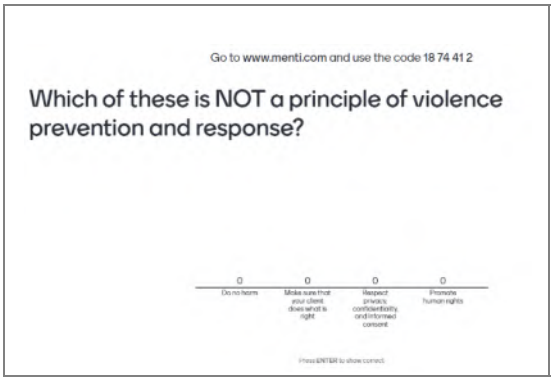
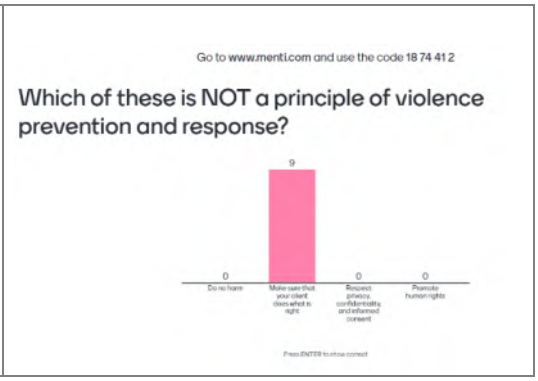


Figure 2. Question with answers



- **How will you address inevitable issues of disconnection in virtual training?** When conducting a virtual training, connectivity issues almost always cause someone to be unable to attend at least part of a session. Plan a workaround, such as recording your trainings and making them available to participants afterwards. If you would like to record, ask participants if they have any concerns before beginning to record. If there are concerns, you can either avoid recording or advise those who do not wish to be recorded speaking or chatting to contribute in other ways. For example, they may wish to send their thoughts via email after the

training. Also consider how participant requirements may be adjusted for those who try to engage but have connectivity issues. For example, those who miss a live session could send the facilitator their questions and observations by email after watching the recording.

Resources for conducting the training in a low-connectivity setting are listed below.

- **Camp Coordination and Camp Planning (CCCM) Cluster** hosted a webinar on adaptations to capacity building, mentoring, and coaching approaches for humanitarian workers in the time of COVID-19. Although directed at camp coordination and management professionals, there are helpful pointers from guest speakers and participants on strengthening operational capacity when connectivity and access are limited. A YouTube recording is available here.
- **UNESCO (United Nations Educational, Scientific and Cultural Organization)** compiled a list of distance learning solutions by category, including systems with strong off-line functionality.
- Outside the development and health sectors, **TalentLMS** put together a guide for facilitators on adjusting e-learning opportunities for users with poor connectivity. **EdTech** provides tips on using off-line access in remote learning.

Language

This training material is currently available in English, French and Arabic. However, all slides can be edited and translated into other languages as needed. We recommend that you translate the slides into the language that local trainers will use before conducting the TOT whenever possible.

When translating or adapting to a local context, please also change the names used in the scenarios to be more locally relevant. This can avoid confusion for participants unfamiliar with the types of names currently used in the slides. Try to avoid using names of training participants in the scenarios.

Number of participants

Invite no more than 25 participants to each training, even if it is delivered virtually. This way, you can engage everyone who attends.

Participant accountability and mastery of skills

Share expectations with all participants. Ensure they understand what is expected of them from the beginning, which includes their full participation during each training session. The recommended expectations are below. If a participant cannot commit to meeting these requirements, they will not be allowed to go on and train others. Training others to address the violence in clients' lives requires an emphasis on "do no harm." Only well-trained participants can hope to do no harm when they go on to train others.

We recommend that all TOT attendees who will go on to train others must meet each of these expectations:

- Participate in all sessions for the entirety of each session
- Contribute verbally (substantively) at least twice per session
- Contribute via chat at least five times during each session
- Complete homework assignments after sessions 1 and 2
    - Reflections on Thandi's story
    - First-line support (LIVES) practice in groups of three, with feedback
- Score 90% on the post-test
- Submit a video of themselves using LIVES skills for facilitator review or demonstrate LIVES skills via role-play during a phone call with the facilitator

Accessing additional resources

The content of this virtual training is significantly pared down from the original training from which it was adapted. If you have time for a longer training, especially one that is delivered in person, please consider adding activities from the *LINKAGES Health Care Worker Training: Preventing and Responding to Violence against Key Populations,* available here: https://www.fhi360.org/resource/linkages-violence-prevention-and-response-series. Pulling content from a longer curriculum is especially important if you are training a group that has not worked with key populations in the past as it explores gender, sexual orientation, gender identity, and human rights in much greater detail.

For additional content on offering LIVES to women in the general population, forensic examination, mental health care for survivors, or self-care for providers experiencing stress or vicarious trauma, refer to *Caring for Women Subjected to Violence: A WHO Curriculum for Training Health-Care Providers*, found here: https://www.who.int/reproductivehealth/training-health-care-providers-help-women-survivors-of-violence/en/.

Addressing intimate partner violence and adverse events is an important component of community-led monitoring that is complemented by the addition of community score cards, routinely collected patient feedback, and implementer security. For more on the full EpiC community-led monitoring package, please visit: https://www.fhi360.org/resource/community-led-monitoring-resources

This training package and its related standard operating procedures, links to which can be found as part of Activity Z, are part of the EpiC index testing training package. The full *Index Testing and Risk Network Referral: Program Implementation Orientation and Training Package* can be found here: https://www.fhi360.org/resource/index-testing-and-risk-network-referral-program-implementation-orientation-and-training

Making the content engaging

Keeping participants engaged during virtual trainings can be particularly difficult. This training is designed to foster participation in a virtual setting. However, keeping participants engaged will also be up to the facilitators, whose role it is to continually call on participants and engage them via chat to make sure everyone is learning the skills presented.

If you will be presenting virtually, depending on COVID-19 restrictions, consider having some small groups come together (for example, in a training of 15 people, they could be at three different locations in groups of five). See Table 1 for more ideas on making different types of activities more engaging for in-person or virtual training.

Table 1. Ways to engage participants in virtual or in-person training sessions

Activity	In person	Virtual
Question that needs the entire groups' response	Note cards; dot voting	Mentimeter; type in chat (short answer only)
Pre-test/post-test	On paper or online	Online using Google Forms
Daily evaluation	Dot voting to indicate favorite activity; open brainstorm on what went well and what can be improved; post-it notes for anonymous response for what went well and what can be improved	Google Forms or Mentimeter
Small group activities	Divide into groups and give each group space and time to formulate a response	Assign small group work outside of sessions and designate someone in each group to ensure that the group meets; have participants call one another on cell phones for short conversations during the training; use breakout room features in Zoom or Teams
Make presentation more engaging	If you have the opportunity to extend the time needed for presentation, consider having presentation-heavy sessions such as "Fundamental Principles of Violence Prevention and Response" taught by small groups who are assigned slides in advance	As much as possible, have participants use the chat to talk to each other about what is being presented and raise questions for the presenter

Preparation for training

The steps below are useful for preparing either a virtual or in-person training unless otherwise indicated.

Step 1. Review the slides and read this complete handbook. You will note that many of the slides contain green text. Green text in the slides should be removed or replaced either before you give the TOT or by those who will be giving the training to the health care workers (HCWs) after they received the TOT. If the text will remain in the slides during the TOT, make clear to participants what green text indicates.

If you plan to revise activities to increase interaction among participants or to make the training in person, make these changes after doing a complete review of this handbook and the slides.

Step 2 (required if virtual, optional if in person). Prepare interactive polls using Mentimeter.com (or another platform of your choice) and a pre- and post-test and evaluation using Google Forms (or another platform of your choice). Sessions that require the use of these platforms are indicated below. This is also noted in the slide presentation by highlighted text that must be replaced before conducting the TOT.

Step 3. Review all instructions for participatory components of the training. While most slides include a script to guide what the facilitator says, the activities marked with stars are interactive and require understanding and/or advance planning by the facilitators.

Step 4 (if virtual). Create a tracker for virtual participation. It should include the following:

Participant number	Participant organization	Participant name	Session 1 contributions		Session 2 contributions		Session 3 contributions		Home-work #1	Home-work #2	Post-test score
			# Chat	# Verbal	# Chat	# Verbal	# Chat	# Verbal			

This will allow you to document the participation of each person and determine who has met minimum requirements to go on and train others. See participant accountability and mastery of skills to learn more.

Step 5. Send out invitations with dates of the training, expectations for all participants, learning objectives, agenda, and information on how the training will be conducted (for example, it may include a link to Zoom if that is the method). If participants have not used these platforms before, schedule time in advance for practice. Do not use the time meant for training to trouble-shoot technological issues. You can also look for instructional videos on how to use the technologies you will employ. For example, by searching on YouTube for a “how to” video in the language of your participants. These links can then be shared in advance to support participants’ technology use.

If resources allow, consider inviting a mental health professional (such as a social worker or psychologist) to attend the training. This individual can help answer technical questions

about providing support to survivors and they can also provide psychological support as needed to participants. This can be particularly helpful in such a training, as sometimes discussions of GBV can cause distress for individuals who have experienced or who are experiencing violence. If a mental health professional is available to participants, make them known to all attendees and provide their contact information and instructions on how to connect (particularly if the training is virtual).

Step 6. At the end of each day of training, share the slides covered and a recording of those slides (if recorded).

Detailed session instructions

Day 1

Activity	Time
Participant introductions and workshop expectations/objectives	20
Pre-test	5
Background	45
Fundamental principles of violence prevention and response	45
Homework assignment	5

Required online preparation for Day 1

- A pre-test (example in Annex B) should be created on Google Forms. The link should be added to **slide 9**. When you score the pre-test, use Annex C.
- An evaluation (example in Annex D) of the day should be created on Google Forms. The link should be added to **slide 47**.

Instructions for activities on Day 1

Use the slide presentation to direct the flow of the training—the slides and speaker notes either summarize key messages or provide instructions for activities. All activity-based slides are denoted with a star. This notation means the facilitator should not simply present the information on the slide, but instead should engage participants to generate the answers. Each activity slide is described further below.

A. **Participant introductions –** In this activity, have participants introduce themselves using the prompts on **slide 4**. As participants share their feedback, keep track of hopes shared. If hopes are mentioned that will not be covered in the training (for example, a wish to gain clinical skills for post-exposure prophylaxis provision), note that you will capture and share this information with the relevant people in leadership to inform future trainings. Alternatively, you can help link people to existing resources.

B. **Pre-test –** Ensure you have a working pre-test link on **slide 9**. Give participants 5 minutes to complete the pre-test. When conducting the training, share the link in the chat.

C. **How difficult is it? –** In the activity on **slide 12,** participants try to empathize with a client considering what to tell their doctor. The facilitator reveals statements one by one and calls on participants to share how difficult, or easy, it would be to share this information and justify their answer. When information is difficult to express, the participant should also explain what a provider or clinic could do to make it easier for the client.

D. **Brainstorm examples of gender-based violence –** The activity on **slide 15** gives participants an opportunity to mention the types of violence that commonly occur in

their setting. If you need ideas for types of violence, see the list below. The point is not to be in perfect agreement about whether a specific form of violence is economic or emotional, but to be aware that violence extends well beyond physical and sexual assault. In addition, below is a complete definition of gender-based violence, for your reference. This completes the definition shared on **slide 14**.

The United States Strategy to Prevent and Respond to Gender-Based Violence Globally[3] defines "gender-based violence" as violence that is directed at an individual based on his or her biological sex, gender identity, or perceived adherence to socially defined norms of masculinity and femininity. It includes physical, sexual, and psychological abuse; threats; coercion; arbitrary deprivation of liberty; and economic deprivation, whether occurring in public or private life. Gender-based violence can include female infanticide; child sexual abuse; sex trafficking and forced labor; sexual coercion and abuse; neglect; domestic violence; elder abuse; and harmful traditional practices such as early and forced marriage, "honor" killings, and female genital mutilation/cutting.

Women and girls are the most at risk and most affected by gender-based violence. Consequently, the terms "violence against women" and "gender-based violence" are often used interchangeably. However, boys and men can also experience gender-based violence, as can sexual and gender minorities. Regardless of the target, gender-based violence is rooted in structural inequalities between men and women and is characterized by the use and abuse of physical, emotional, or financial power and control. Gender-based violence can include female infanticide; child sexual abuse; sex trafficking and forced labor; sexual coercion and abuse; neglect; domestic violence; elder abuse; and harmful traditional practices such as early and forced marriage, "honor" killings, and female genital mutilation/cutting.

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

Psychological/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;

[3] USAID. Strategy to Prevent and Respond to Gender-Based Violence Globally Factsheet. https://www.usaid.gov/sites/default/files/documents/2155/GBV_Factsheet.pdf

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 or punish 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)

Other human rights violations
Denied or refused food or other necessities; arbitrarily stopped, detained, or incarcerated in jails, detention centers, and rehabilitation centers without due process; 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 sexually transmitted infection (STI) and HIV testing, drug-dependence treatment, reparative therapy (to change someone's sexual orientation), sterilization, or abortion

E. **Quizzes 1 and 2 –** Multiple-choice questions on **slides 21–24** are designed to make it clear that many types of violence impact HIV transmission and access to care.
    - For each, read the scenario to the participants. Note that the color of the act matches the type of violence being perpetrated. For example, emotional violence is red in Quiz 1.
    - Ask participants to put their answers in the chat window. Emphasize that they can choose multiple letters. As answers are coming in, call on individuals who gave various responses to explain their thinking. Once all have explained, advance the slide to reveal the correct answer and explain the rationale.

F. **Quizzes 1 through 5 –** Multiple-choice questions on **slides 34, 36, 38, 41, and 43** are designed to help participants think about the real-world application of each principle. After reading the scenario, ask everyone to type their responses in the chat. Then, as additional answers are coming in, ask a few people to explain their answers. After the majority have responded, advance the slide to show the correct answer. Then, refer to the speakers' notes to explain why this answer is correct if participants have not already covered these topics.

G. **Case study: Thandi –** The activity on **slide 44** tells the story of a promising young woman who experiences intimate partner violence. Because the story is so long, it is included here and not in the slide notes. In preparation for this activity, change the green text to the name of a local city. After reading the text of the slide to participants, read each of the bullets below. Advance the slide where noted to show the animation of Thandi's diminished autonomy, self-esteem, and opportunities.

- After a few weeks, Thandi is getting ready for work and putting on makeup. John tells her, “Why do you dress like that now? I don’t want other men looking at you the way I looked at you before we were married. Take that off.” Thandi doesn’t want to upset John and she feels embarrassed that he has such a low opinion of her. She takes off her makeup. *[Advance slide.]* A little bit of her autonomy and self-esteem are gone.
- A few more weeks pass and Thandi is looking for something to wear while she is out with John. She chooses a skirt. He immediately looks at her with disgust. “What are you wearing? I don’t want people thinking my wife is some kind of trash. Don’t you respect yourself? Put on something longer.” Again, Thandi does what John says. *[Advance slide.]* A little bit of her autonomy and self-esteem are shaved away.
- After about three months, they decide to have a baby. They get pregnant quickly. Thandi continues to go to work as normal and to see her friends from work some evenings. One night when she gets home, John tells her that he doesn’t want her out without him. He tells her that he and the baby should be what is important to her. Thandi stops seeing her friends from work. *[Advance slide.]* A little bit more of her autonomy and self-esteem are gone.
- When the baby comes, Thandi loves her time off with him but is ready to go back to work after six months. She shares a list of nannies with John to see which one he likes. He looks shocked and replies, “You’re going to let a stranger raise our children? I can’t believe I married such a heartless woman.” Thandi doesn’t go back to work. *[Advance slide.]* A little bit more of her autonomy and self-esteem are gone.
- When she is with the baby, she often goes to see her sister. One day her sister asks why she hasn’t gone back to work. Thandi tells her. The sister encourages her to stand up for herself. When she does, John tells Thandi not to see her sister anymore. He says she is a bad influence. *[Advance slide.]* A little bit of her autonomy and self-esteem are gone.
- Thandi also speaks to her mother often. One day the baby is teething, and she asks her mother for advice. Thandi shares her mother’s advice with John. He replies, “Is your mother in charge of our child, or are you? I can’t believe the ways she meddles in our relationship. I don’t want you all speaking so often.” So Thandi stops calling her mother. *[Advance slide.]* A little bit of her autonomy and self-esteem are gone.
- Soon after, the baby gets sick. Thandi spends all day at the clinic with him. She gets home just a little after John. John asks where dinner is. Thandi explains the situation. John says, “My mother had nine children and dinner was never late once. What kind of a woman are you?” *[Advance slide.]* A little bit of her autonomy and self-esteem are gone.
- The next day, the baby is even sicker. Thandi doesn’t want to leave home and make John mad, but the baby’s fever keeps climbing. She finally takes

him back to the clinic. After his exam, she rushes home. John arrives just before her. She apologizes for being late. John slaps her across the face. *[Advance slide.]*

Case study: Thandi (debrief) – After sharing the emotional story of Thandi, ask the group to debrief by answering the questions on **slide 45** about what happened and how it compares to experiences they have heard about.

- Show the first question and ask: Are stories like Thandi's common in your context? Allow time for responses. If no one mentions that this story is quite usual, mention that in much of the world people have experiences similar to this one.
- Show the second question and ask: How do you think Thandi feels at this point? Allow time for responses. If no one mentions the following points, bring them up.
  - Thandi is likely feeling isolated, ashamed, scared, unsure of what to do. Especially because all her connections to others have been cut, she is likely to feel unsure of how to get help. She may not even believe she deserves help because of the emotional abuse she has been experiencing.
- Show the third question and ask: Sometimes people hear about others' experiences of intimate partner violence and say, "I would leave the first time someone was violent toward me." Allow time for responses to both sub-questions. If no one mentions the following points, bring them up.
  - John's first acts designed to humiliate and control—telling Thandi that she was dressed inappropriately and bringing shame on herself—were violence. However, we see that John's violence was gradual and Thandi did not see it as violence in the beginning.
  - Intimate partner violence is very complex. It is incredibly difficult to leave. As we said before, it can also be very dangerous to leave. By the time Thandi experiences physical abuse, she is cut off from work, friends, and family and is trying to take care of a small child. She also has limited self-esteem and perhaps energy. She may not feel capable of making a big change at this point.

H. **Homework #1 –** Ask the group to answer questions 1 and 2 individually and send their answers, via email, to the person indicated at the bottom of **slide 46**. In advance of the training, replace the highlighted text with the correct person's name and email address if necessary.

I. **Evaluation: Day 1 –** Using the instructions on **slide 47** as a prompt, ask all participants to complete the evaluation of Day 1 within 24 hours of the completion of this day of the session (less if the next session will occur the next day). This will help you continue to improve subsequent sessions.

Day 2

Activity	Time
Recap Day 1 (Menti) and homework review	20
Asking about and responding to violence	90
Assign homework	10
Additional one hour for small-group practice (homework)	60

Required online preparation for Day 2

1) Two quiz questions should be created on Mentimeter and the link to the quiz placed on **slide 49**. When you get to **slide 49**, click the link to display the Mentimeter quiz question screen. Below is the text of the questions and responses. Responses ending in *** are correct; the "***" should not be included in the text of the quiz.

   Quiz question 1 – Which of these is NOT a principle of violence prevention and response?

   A. Do no harm

   B. Providers should make choices for their clients***

   C. Self-determination and access to all services

   Quiz question 2 – Which of these makes it difficult for clients to disclose violence? (Select all that apply)

   A. They don't think of health care facilities as a place to talk about violence.***

   B. They fear that the provider will not keep what is said confidential.***

   C. They are ashamed that they are experiencing violence.***

2) Use the same evaluation (example in Annex D) that you've already created in Google Forms. The link for this evaluation should be added to **slide 89**.

Instructions for activities on Day 2

All activity-based slides have a star. This means the facilitator should not simply present the information, but instead should engage participants to generate the answers. Each activity slide is described further below.

J. **Mentimeter questions from Day 1 –** Per instructions above, use prepared **slide 49** to review previous content by asking questions to check understanding and memory of what was covered.

K. **Discussion of homework #1 –** Use **slide 50** (question 1) to show the first homework question. Call upon a few of those who submitted homework #1 to share their responses. Reveal answers after volunteers have answered the first question. Use **slide 51** (question 2) to repeat the process for the second question. If homework assignments submitted contained incorrect information, take a moment to clarify why those answers were incorrect (without calling attention to the individual people whose answers were wrong).

L. **Skills of a good listener –** The activity on **slide 62** is designed to help participants think about what they themselves want from a listener so that they can understand what the survivor of violence might want. The facilitator reads the scenario and then asks participants to share, via the chat, who they would speak to and why. The facilitator should then call upon some of those who have shared in the chat to elaborate on their answers.

M. **Inquire about needs and concerns (1–3) –** This activity helps participants feel comfortable asking survivors about their needs and concerns. On each of **slides 66, 67, and 68,** read the client statement and ask what a provider could do to employ a specific technique, such as encouraging the survivor to talk. Once you have solicited answers in the chat, advance the slide and show the correct answer. You can then provide the explanation as to why this is the best response for that technique per the notes in the slides.

N. **Practice responding –** The activity on **slide 71** gives participants the chance to try out validating statements and decide which feel comfortable. Read a survivor statement and ask someone to “unmute” and share a validating statement that seems relevant in this scenario. After they share the statement, ask if they feel it works in this situation. There are no right or wrong answers. The point is to help the participants find statements that work for them and let them know that there are many options which may feel better, depending on the scenario. It’s also important to recognize that each statement is not meant to be a solution to the survivor’s situation; it’s the start of a conversation.

O. **Safety strategies during COVID-19 –** The activity on **slide 78** asks participants to consider what might work in their context. The facilitator should review all the strategies and ask participants to type numbers into the chat to indicate which of these strategies could work in their context. There are no right or wrong answers. The point is to see there are options and each program, and each survivor, can tailor questions to touch on issues that may be most relevant.

P. **Meeting survivor’s needs –** The activity on **slide 80** helps providers find places to refer survivors. If this training is being done in person and there is additional time, you can divide into small groups (organized by geographic location) during the session. If you, as the trainer, have this information, it is advisable to fill out this table before the training is implemented. Then, you can use this activity to ask participants if anything is missing.

Q. **What would you need? –** The activity on **slide 81** helps put training participants in the shoes of someone getting a referral. The participants brainstorm in the chat what they would want to know about an organization to which they are being referred.

- If you already have the type of information needed to successfully refer, please add that information on **slide 82**.

R. **Seeing it all together –** The activity on **slide 86** is the most important one in the training. The facilitator will model how to use all the skills in LIVES. Anyone giving this training should have practice using these skills. If you need a refresher, please review this video:

- https://youtu.be/Hu06nVCzih0?t=520 (from 8:40 until 20:36)

In advance of this activity, designate one co-facilitator (or a strong participant) to be the survivor in the activity. Make sure this person agrees to participate and understands the role in advance. The person role-playing the survivor can make up answers to the questions asked by the facilitator/provider as long as the answers align with the scenario described on the slide.

- After the role-play, the facilitator asks the person who role-played the survivor how they felt during the role-play. In particular, did they feel supported? Why or why not?
- Then, the facilitator self-evaluates their own performance. Would they do anything differently? Why or why not? Ideally, they will find at least one thing to change to demonstrate a willingness to receive feedback and to emphasize that everyone can improve.
- Now, the facilitator opens the floor to the participants. Ask about the participants' perception of the support provided to the survivor generally and then whether the provider successfully used each of the skills in the checklist.
- If the person playing the provider did not use each of the acts in the observer checklist, the feedback will be helpful to them for use in the future. The facilitator should model gracefully and humbly receiving feedback, as opposed to becoming defensive about anything they may not have done.

S. **Homework #2 –** This assignment gives all participants the opportunity to practice LIVES' skills. As described on the slide, they will work in groups of three. The facilitator should create these groups in advance and share them via slides (as shown on **slide 87**) or divide people into groups during the training. In these small groups, each person will take turns being the health care worker (who asks about and receives the disclosure of violence), the survivor (who pretends to have experienced violence as described in their scenario), and the observer (who fills out the checklist during the interaction between the HCW and survivor. Similar to the previous activity, after each role-play, the HCW, survivor, and observer share feedback on the performance.

- If this is assigned as homework, make sure there is a mechanism for the group members to connect and complete this practice before the next session. Insert email address of facilitator on **slide 88**.
- If this activity is conducted during a live training, give groups one hour to get through all three rounds of role-plays.
- Scenarios should be shared with participants after they are divided into groups. It is fine if all of the group members see one another's scenarios.

Scenario 1: A 28-year-old mother of three children says that her husband beats her whenever he has been drinking.

Scenario 2: A 22-year-old gay man says that his boyfriend will not let him visit his parents or friends and controls who he can speak to on the phone. When the client asks his boyfriend to wear a condom, the boyfriend becomes verbally abusive and calls the client harmful names.

Scenario 3: An 18-year-old transgender woman is living with an older man. Recently, he has begun to force her to have sex with his friends, who pay the older man. The older man tells her that it is to pay her living costs.

T. **Evaluation: Day 2 –** Ask all participants to complete the evaluation of Day 2 (insert link to evaluation on **slide 89**) within 24 hours of the completion of this day of the session (less if the next session will occur the next day). This will help you continue to improve subsequent sessions.

Day 3

Activity	Time
Recap Day 2 (Menti) and homework review	25
Practical questions	35
Adverse events related to index testing	20
Monitoring and documentation	10
Reflections on what we have learned and how to integrate it into our work	10
Closing: Post-test and evaluation of the workshop (Menti)	10

Required online preparation for Day 3

All activity-based slides have a star. This means the facilitator should not simply present the information, but instead should engage participants to generate the answers. Each activity slide is described further below.

1) Create two quiz questions on Mentimeter and insert the link to the quiz on **slide 91**. When you get to **slide 91**, click the link to display the Mentimeter quiz question screen. Below is the text of the questions and responses. Responses ending in *** are correct; the "***" should not be included in the text of the quiz.

   Quiz question 1 – Which of these is part of validating the survivor? (Select all that apply)

   A. We let them know that we are safe to talk to***

   B. We let them know that they do not deserve violence***

   C. We let them know that we will protect them from further harm

   D. We let them know that we will support their decisions***

   Quiz question 2 – What do we need to know about a service before we refer someone to that service? (Select all that apply)

   A. When is this service available (hours)***

   B. To whom is this service offered (populations)***

   C. How can this service be accessed (point of contact/phone number)***

2) Use the same evaluation (example in Annex D) that you've already created in Google Forms. Add the link for this evaluation to **slide 135**.
3) Use the same post-test (example in Annex B) that you used for the pre-test. Provide the link to the post-test on slide **135**. When you score the pre-test, use Annex C.
4) Provide name of person to send video of role-play to on slide **129**.

Instructions for activities on Day 3

U. **Mentimeter questions from Day 2**

Debrief Mentimeter quiz:

- When discussing the answer to the first quiz question on validating the survivor, remind participants we are not able to promise that we can protect someone from further harm. We can only promise to support them as they move forward. Provide link to quiz on **slide 91**.
- When discussing the answer to the second quiz question on offering services, reiterate that we never want to send someone to a service we ourselves do not understand well and trust.

V. **Discussion of homework #2**

- Each group shares their reflections on the use of LIVES by following the instructions on **slide 92**.
- The facilitator should note any challenges during the feedback. If those challenges are not covered in the next session, address them here or let the participants know that you will look for answers and come back to them with ideas.

W. **Frequently asked questions (FAQs) –** Questions shown on **slide 95** are those that have come up most often during training. Depending on the number of participants, assign one or two questions to each small group. If you have limited time, ask the group to vote on the five (or fewer) questions most relevant to them. Then, only assign those questions to the groups. Add contact information for local child protection services to slide **101**.

- Show each frequently asked question using **slides 96–104** and ask the relevant group to present their answer. Then, advance the slide to show the correct answer.
- Sometimes the group's answer will not align exactly with the "correct answer." Highlight similarities and ask the group that presented if they have any concerns about differences between their answers and the answers presented. In some cases, the group may have come up with something different but still correct. For example, question 9 asked about time management – a problem that could have other solutions. If you are not sure whether the answer a group provided is acceptable, let them know that the answers in this training have been tested and are suggested, and that you will check with others to determine whether their suggestion may also be feasible.
- If your time is limited and groups reflect on only some of the FAQs, please present on the suggested answers to the remaining unselected FAQs yourself.

X. **What might a provider think of each of these clients? –** This activity demonstrates how a training on violence builds HCWs' empathy toward key populations.

- Ask a volunteer to share what a provider—who has not been trained to understand violence in the lives of key population members—might think in each scenario (**slide 105**, Part 1).
- Emphasize answers that judge the client negatively or place blame on the client for their behaviors.
- Advance to **slide 106** (Part 2), and reveal, one by one, the red text in each bullet. After revealing all the revised bullets, ask whether having this information might change an untrained provider's opinion.
- While this activity stresses the importance of training providers on identifying and responding to violence, it also points to the need to train them on key populations, generally. This is because key population members can be blamed for violence against themselves if the provider does not understand how marginalization and stigmatization lead to violence. For example, gender norms that condone using violence to force a man to "act/dress like a man" are the root cause of violence against a man whose gender expression is feminine. The violence is not caused by an individual man's decision to wear clothing that does not align with gendered expectations; it is caused by the norms that encourage violence against someone who is not in line with gendered expectations.

Y. **Which of these are already in place?** – This activity gives trainees the opportunity to take stock of what is already in their facilities. The facilitator asks them to look at each of the seven requirements, **slide 110**, and then type the letters of all those that they already have in place into the chat.

It's important to note that participants may struggle to admit that very little is in place, so make sure to reassure them that many people are still working to meet these requirements and that this training is a strong starting point. They may also raise questions about what to put if some of their facilities have the requirements in place but others do not. Ask them to do their best to estimate. You can also give participants the opportunity to explain their thinking by unmuting and commenting during the activity.

The purpose of this assessment is not to get perfectly accurate numbers. Instead, you are asking them to self-assess and type a number into the chat so that they realize how far they have to go and how much they could learn from one another. You, as the facilitator, will also know which requirements to spend the most time on: those in place in the fewest facilities.

Z. Planning to roll out this training

- The activity on **slide 133** gives participants the chance to reflect on how they are going to extend this training to others and to hear and gain from others' insights.
- Ask several participants to share concerns or strategies they plan to use when rolling out the training.
- The standard operating procedures (SOPs) referenced on this slide are hyperlinked here in Word and PDF formats.
  i. SOP for Adverse Event Monitoring, Investigation, and Response in the Context of Index Testing (Word)
  ii. SOP for Adverse Event Monitoring, Investigation, and Response in the Context of Index Testing (PDF)
  iii. SOP for Identifying and Responding to Intimate Partner Violence in the Context of Index Testing (Word)
  iv. SOP for Identifying and Responding to Intimate Partner Violence in the Context of Index Testing (PDF)
- If there is time, have small groups develop action plans that describe: (1) next steps for rollout of the training, (2) timeline, (3) person responsible, (4) resources needed (funding, materials), and (5) technical assistance needed (e.g., support to develop SOPs). An action planning template is below.

Step	Date	Person responsible	Resources needed	Technical assistance needed
1.				
2.				
3.				

AA. Closing

The activity on **slide 135** gives participants the opportunity to think about what they, as individuals, are taking away from this training. Ask each participant to "unmute" themselves or type into the chat to share how what they learned in the training will impact their actions going forward. Encourage them to make their reflection just one sentence.

Annex A: In-person agenda

DAY 1	Time
Participant introductions and workshop expectations/objectives	8:00 AM
Pre-test	8:30 AM
Background	8:45 AM
Break	9:45 AM
Fundamental principles of violence prevention and response	10:15 AM
Lunch	12:00 PM
Asking about and responding to violence	1:00 PM
Small group practice responding to violence	2:30 PM
Reflections and closing	3:45 PM
DAY 2	
Recap Day 1	8:00 AM
Practical questions	8:30 AM
Break	9:30 AM
Adverse events related to index testing	10:00 AM
Monitoring and documentation	10:45 AM
Reflections on what we have learned and how to integrate it into our work	11:15 AM
Closing: Post-test and evaluation of the workshop	12:00 PM
Lunch	12:30 PM

Annex B: Pre- and post-test

This test can be entered into Google forms to collect answers electronically. For more information on using Google forms, click here: https://support.google.com/docs/answer/6281888?co=GENIE.Platform%3DDesktop&hl=en.

We recommend making each question required. This can be done by selecting the "required" button on Google forms.

Pre- and post-test: Identifying, preventing, and responding to violence in HIV programs serving key populations: Building health care workers' capacity to offer safe and ethical index testing

1. Please write your first and last name.
2. What country or countries do you primarily work in?
3. Why is it important for health care workers (HCWs) to ask their clients about intimate partner violence (IPV) during index testing? (Select all that apply)
   A. The HCW will know whether partner notification may put the client in danger.
   B. The HCW can connect clients to violence-response services, as relevant and desired by the client.
   C. If IPV is occurring, the HCW can offer tailored counseling to support HIV service use.
   D. The HCW can notify the police about the violence without the client's knowledge.
   E. By asking about IPV, the HCW is demonstrating that they can be a resource for anyone experiencing violence.
4. What should an HCW do if they learn about violence during index testing? (Select all that apply)
   A. Listen empathetically
   B. Ask about the client's needs related to violence
   C. Confront the perpetrator of the violence
   D. Tell all other health facility staff that this client may be in danger
   E. Respect the client's wishes
5. Are these statements true or false? (Indicate with a "T" for true and "F" for false)
   - During index testing, providers should ask clients if they are experiencing or afraid of IPV from all named partners. When a provider asks about violence, they must use standard questions.
   - Providers must be trained to ask about and respond to violence BEFORE they are allowed to conduct index testing.
   - Providers should force clients to admit they are experiencing violence.

- It is best to offer accompaniment when referring a client to a violence-response service.
- Providers must document disclosures of IPV that occur within index testing in an index testing register.
- Providers should tell clients who have experienced violence what to do.
- Each facility must have a way to document and investigate adverse events.
- Forcing a client to disclose their sexual partners' names is acceptable if it achieves PEPFAR targets.

6. When an adverse event occurs, which of the following must be done by health facility staff? (Select all that apply)
   A. If it was a case of IPV, ensure that all the initial steps were taken (screening for IPV, providing LIVES support).
   B. If it was not a case of IPV, investigate why the event occurred.
   C. Document what was done to support the client who experienced the adverse event.
   D. If applicable, make changes to prevent a similar event from happening in the future.

Annex C: Pre- and post-test answer key

There are no correct or incorrect answers to questions 1 and 2. They are designed to collect participant information.

3. Correct answers = **A, B, C, E**
4. Correct answers = **A, B, E**
5. Are these statements true or false?? Correct answers indicated in bold.
   - During index testing, providers must ask about IPV committed by all named partners. **TRUE**
   - When a provider asks about violence, they must use standard questions. **TRUE**
   - Providers must be trained to ask about and respond to violence BEFORE they are allowed to conduct index testing. **TRUE**
   - Providers should force clients to admit they are experiencing violence. **FALSE**
   - It is best to offer accompaniment when referring a client to a violence-response service. **TRUE**
   - Providers must document disclosures of IPV that occur within index testing in an index testing register. **TRUE**
   - Providers should tell clients who have experienced violence what to do. **FALSE**
   - Each facility must have a way to document and investigate adverse events. **TRUE**
   - Forcing a client to disclose their sexual partners' names is acceptable if it achieves PEPFAR targets. **FALSE**
6. Correct answers = **A, B, C, D**

Annex D: Example evaluation

1. **The content of this training is interesting.**

   strongly disagree — strongly agree

   1 2 3 4 5

2. **The content of this training will help me to do my job.**

   strongly disagree — strongly agree

   1 2 3 4 5

3. **I can share what I learned today with others.**

   strongly disagree — strongly agree

   1 2 3 4 5

4. **I would recommend this training to others.**

   strongly disagree — strongly agree

   1 2 3 4 5

5. **The facilitator's speed is:**

   a. Too slow b. About right c. Too fast

6. **I could successfully use the technology (e.g., Zoom, Teams, Mentimeter, Google Forms) employed in this training.**

   strongly disagree — strongly agree

   1 2 3 4 5

7. **Please indicate any concerns you have about sharing this training with others.**

8. **Please share anything else you think is important for the facilitators to know.**