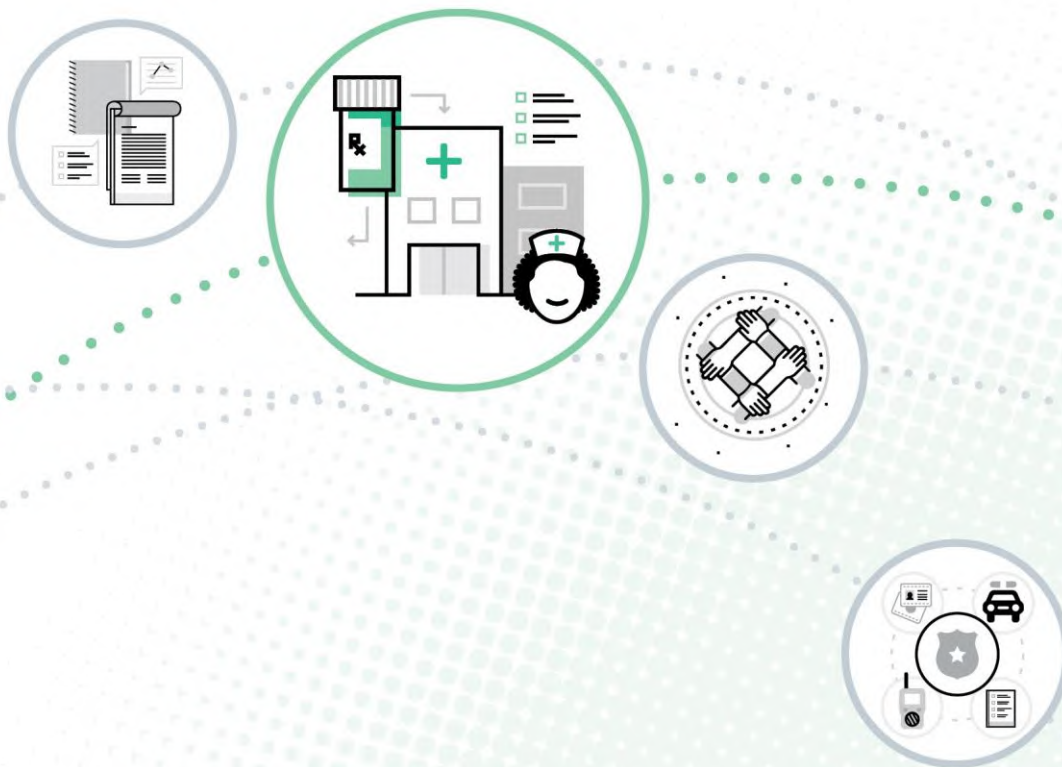


HEALTH CARE WORKER TRAINING

PREVENTING *and* RESPONDING *to* VIOLENCE
against KEY POPULATIONS



LINKAGES

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

HEALTH CARE WORKER TRAINING

PREVENTING *and* RESPONDING *to* VIOLENCE
against KEY POPULATIONS

2019

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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 immune deficiency syndrome
ART	Antiretroviral therapy
ARVs	Antiretroviral medicines
DIC	Drop-in center
GBV	Gender-based violence
HIV	Human immunodeficiency virus
IPV	Intimate partner violence
KP	Key population
PEP	Post-exposure prophylaxis
PEPFAR	U.S. President's Emergency Plan for AIDS Relief
PrEP	Pre-exposure prophylaxis
SOP	Standard operating procedure
STI	Sexually transmitted infection
Trans	Transgender
UNAIDS	Joint United Nations Programme on HIV/AIDS
USAID	U.S. Agency for International Development
VPR	Violence prevention and response
WHO	World Health Organization

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SNAPSHOT OF THE TRAINING

Audience and Purpose:

This training document is for use by HIV programmers and health facility staff who wish to equip health care workers with the knowledge and skills they need to understand, assess, and appropriately respond to violence in key population (KP) members' lives, including through improving KP members' access to HIV and other violence response services and supporting violence prevention efforts. The material presented here can be used to train clinical and nonclinical health care workers at any level, and adaptable case studies make it relevant to health care workers with a range of specialties and mandates.

.....

Participant learning objectives:

Health care workers trained will:

- Explore the underlying causes of stigma, discrimination, and violence against KP members and the connection with HIV
 - Identify interaction with health care workers as a key entry point into violence response services
 - Learn to create an environment in which disclosure of violence can safely occur
 - Build skills for asking about violence and providing first-line support
 - Understand the range of health, social, and justice/legal services KP victims may need and make appropriate referrals
 - Discuss best practices for safe data collection and management
-

Time and preparation requirements:

The training is designed to last for two-and-a-half days, depending on time available and program and participant needs. Implementing the training successfully will require advance preparation to:

- (1) Understand KP members' experiences with violence in your context, including the most common forms of violence
- (2) Understand KP members' current experiences with health care workers
- (3) Form relationships with health care workers and adapt the training to their needs and the local context—this may include expanding or removing portions of the training based on existing skill levels and previous training, identifying relevant laws and policies that will impact services available to victims, developing a list of organizations that health care workers can refer to for violence response services, and considering the type of site (such as drop-in-center, public clinic, private facility, etc.)
- (4) Determine those who should be trained
- (5) Pilot the adapted training, making further revisions as needed
- (6) Identify and train effective facilitators, including KP members and health care workers as appropriate
- (7) Identify and prepare a lawyer(s) who can participate in the training

All preparation and implementation should be continually guided by KP members' expertise and experiences and should prioritize KP member safety. This includes ensuring that the facilities in which health care workers operate are ready to handle disclosures of violence (minimum requirements for which are shared in Session 3.8).

BACKGROUND

The Importance of Integrating HIV and Violence Response Services

Health care workers are an important part of any HIV service delivery program, and they are vital to the successful integration of HIV and violence response services. The well-established links between HIV and violence make it important to address both simultaneously. 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. In the context of KP programming, integration is also important because KP members—gay, bisexual, and other men who have sex with men, people who inject drugs, sex workers, and transgender people—experience a disproportionate burden of both violence and HIV. 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.^{1, 2}

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 1).³⁻⁸ Violence directly increases vulnerability to HIV by limiting one's ability to use safe injecting practices⁹ or negotiate safe sex,¹ and the efficiency of HIV transmission may increase during sexual violence in which force causes oral, vaginal, or anal/rectal abrasions or lacerations.^{1, 10} 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.^{1, 11} A history of violence can also make it more difficult to test for HIV or to disclose one's HIV status.¹ The fear of violence, including abandonment by individuals' families and communities, also decreases the uptake of HIV services.⁶ Experiences of violence are also associated with never having initiated HIV care and the interruption of antiretroviral therapy (ART).¹²⁻¹⁵

Integrating HIV and violence response services increases health care workers' ability to meet the needs of KP members in their care. When service users disclose an experience of violence, health care workers 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 health care workers to ask them about violence in their lives.¹⁶

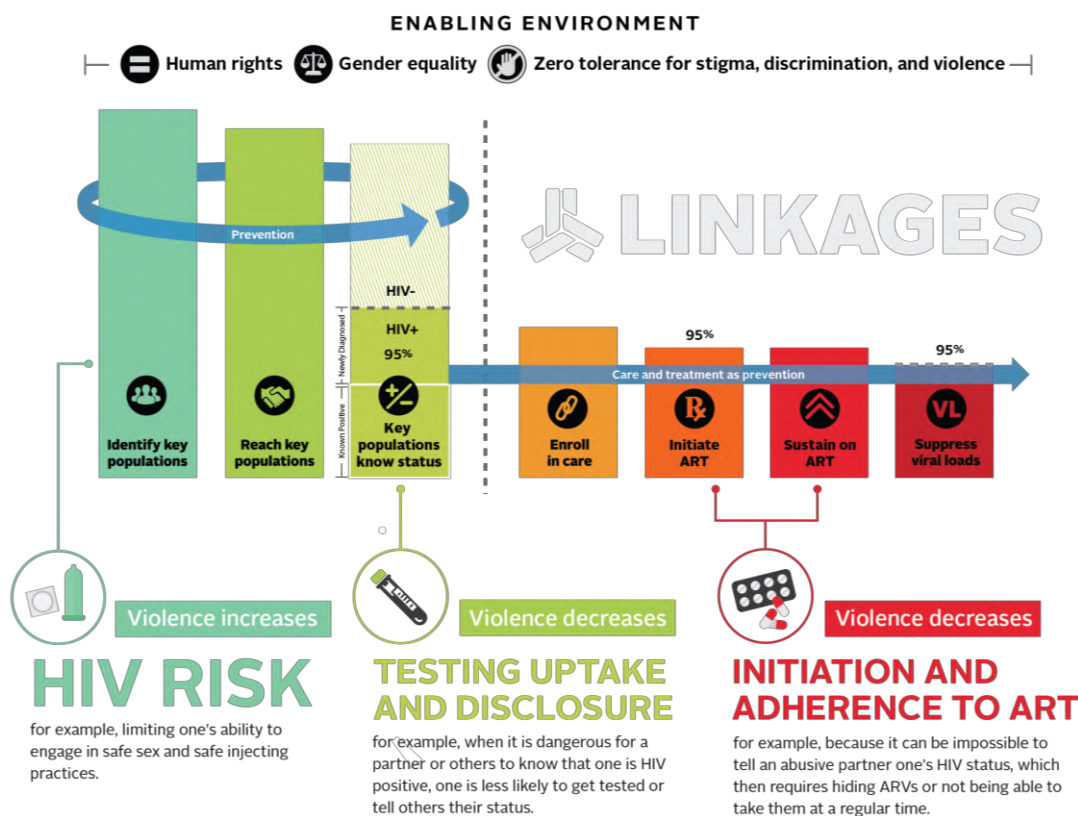


Figure 1. Impact of violence on members of KPs across the cascade of HIV prevention, care, and treatment services

Guidance Related to Integrating HIV and Violence Response Services in Key Population Programs

Linkages across the Continuum of HIV Services for Key Populations Affected by HIV (LINKAGES)—the largest global project dedicated to key populations, funded by the U.S. President’s Emergency Plan for AIDS Relief (PEPFAR) and the U.S. Agency for International Development (USAID)—developed *A Guide to Comprehensive Violence Prevention and Response in Key Population Programs*¹⁷ to inform the integration of HIV and violence response services in the context of KP programs. LINKAGES’ vision is that every KP member will have access to a safe and compassionate environment where disclosures of violence can occur and that all those who disclose violence will be able to access quality health, social, and justice/legal services. *A Guide to Comprehensive Violence Prevention and Response in Key Population Programs*¹⁷ is informed by and refers to several sources of guidance related to health care workers engaging in violence detection and response. The following paragraphs are taken from the guide. All LINKAGES materials on integrating violence and HIV services can be found in [Annex 1](#); a short description of *Health4All*, LINKAGES health care worker training that addresses stigma and discrimination as well as clinical skills, is on the next page.



The *LINKAGES Violence Prevention and Response Training Curriculum for Health Care Workers*¹⁸ can be used in conjunction with the *LINKAGES Health4All training*,¹⁹ but dual use is not required. The trainings are synergistic but neither is a prerequisite for the other. Health care workers 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. Health care workers who first attend the VPR training and then attend the Health4All training will gain broader clinical skills that will help them meet the many health needs of KP members. Regardless of order, attending both trainings will provide 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.

Guidance on HIV testing, *HIV Testing Services Consolidated Guidelines*,²⁰ 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*,²¹ assessing risk of intimate partner violence (IPV) is a mandatory step in partner notification—a widely used strategy. 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*,²² recommends that health care workers 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, 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.”⁷ Implementation tools designed to operationalize the consolidated guidelines state that it is important for health care workers to “ask about the history of violence.”^{5, 6} For a table summarizing this guidance, see [Annex 2](#).



Minimum requirements

Training health care workers is only one part of meeting minimum requirements—such as a private space in which disclosure can occur—that must be in place to meet the needs of victims of 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*.²³

Given that IPV risk should be assessed among all those diagnosed HIV positive,²⁰ the high prevalence of presenting conditions associated with violence in KP communities (substance use, mental health issues, etc.),²⁴ the acknowledgement that violence affects risk-reduction strategies among those who are HIV negative,²² and recommendations specific to key populations that encourage asking about violence,^{5, 7} we extrapolate from these guidance documents to recommend that health care workers provide all KP members, not only those who are cisgender women, with the opportunity to disclose by asking about violence. Furthermore, based on the range of violence in KP members' lives, questions should be inclusive of a broad range of violence, not only IPV.

The Importance of Health Care Worker Training in Integrating HIV and Violence Response Services in Key Population Programs

Training health care workers is vital to operationalizing these recommendations. Through training, they learn not only what needs to be done to ask about and respond to violence, but also why. Training also provides health care workers who will be addressing violence in KP members' lives with the opportunity to reflect critically on their attitudes, beliefs, and knowledge. This is important because many health care workers 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 health care worker stigma, that interfere with KP members' access to health services when they experience violence.

Conceptualizing Violence Prevention and Response

Much of what health care workers will learn through this training focuses on violence response. This does not mean that prevention is neglected. In a public health approach to addressing violence, prevention of violence is conceived of in three ways—including opportunities for prevention within response.

- 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).

This training supports primary prevention by addressing stigmatizing attitudes that health care workers may hold against KP members thus reducing discrimination or abuse in health facilities; secondary prevention by improving health care workers' skills in immediate response including safety planning; and tertiary prevention by supporting health care workers to link victims to long-term counseling or other services.

OVERVIEW OF TRAINING CURRICULUM

Purpose

This training document is for use by HIV programmers and health facility staff who wish to equip health care workers with the knowledge and skills they need to understand, assess, and appropriately respond to violence in KP members' lives, including through improving KP members' access to HIV and other violence response services and supporting violence prevention efforts.

Learning Objectives

The training achieves six main learning objectives. Additional, session-specific objectives are in the agenda. Health care workers trained will:

- Explore the underlying causes of stigma, discrimination, and violence against KP members and the connection with HIV
- Identify interaction with health care workers as a key entry point into violence response services
- Learn to create an environment in which disclosure of violence can safely occur
- Build skills for asking about violence and providing first-line support
- Understand the range of health, social, and justice/legal services KP victims may need and make appropriate referrals
- Discuss best practices for safe data collection and management

To support the achievement of these objectives and implement programming more likely to have a sustained impact, this curriculum is designed according to human-rights-based and gender-transformative approaches.^{3-6, 25-27} A human-rights-based approach, which is fundamental to KP programming, is nondiscriminatory, accountable to the populations it seeks to serve, upholds and respects individuals' autonomy and rights, and requires that the principles of fairness and equity are applied.⁷ A gender-transformative approach seeks to support participants as they identify, critically examine, and counter harmful gender norms to challenge unequal gender roles, social norms, and the distribution and control of resources and power.²⁸ For more on LINKAGES' approaches to violence prevention and response, including the rationale for the recommendations and activities in this training, please refer to *A Guide to Comprehensive Violence Prevention and Response in Key Population Programs*.¹⁷

Intended Training Audience

This training curriculum was designed for clinical and nonclinical health care workers. Health care workers are individuals engaged in actions whose primary intent is to enhance health. 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, HIV counselors, managers, and data entry clerks.

Violence prevention and response trainings to support law enforcement officers and peer educators, navigators, and outreach workers are also available and can complement the health care worker training in efforts to establish comprehensive violence prevention and response systems within KP programming (see more on these tools in [Annex 1](#)). Trained officers and peer educators, navigators, and outreach workers can also attend Session 3.5 in the health care worker training, which explores linkages to multi-sectoral violence response services. Introducing violence response service providers to one another during training can facilitate effective referral between organizations.

The training can be adapted based on the needs and responsibilities of the individuals being trained. See more under [Adapting this Training for the Local Context](#).

Training Curriculum Content and Structure

The training includes four modules. Each module contains session titles, session objectives, slides, speaker notes, and activity instructions. The curriculum begins with *Module 1: Setting the Stage*, which includes activities for participants to get to know one another and share what makes them proud of the role they play in society. *Module 2: Building Core Knowledge* provides a brief overview of the HIV epidemic in the country in which the training is held. The module explores who KP members are and why they are more vulnerable to both HIV and violence; concepts related to sex and gender; links between rigid gender norms, stigma, discrimination, and violence; links between violence and HIV; and types of violence and other human rights violations commonly experienced by key populations. Special attention is paid to the issue of IPV. Participants also strengthen their knowledge of local laws and the constitution, particularly as they relate to violence response for key populations, including the obligations of health care workers to care for all victims of violence.

After strengthening understanding of the issues, *Module 3: Applying Principles and Building Skills* introduces and gives time to practice skills to address violence appropriately, including asking about violence, offering first-line support, and engaging in safety planning. It also reviews the health, social, and justice/legal needs of victims, and provides the opportunity for participants to learn more about the range of local organizations working to meet victims' needs. Effective referral is also discussed. Finally, Module 3 explores the minimum



Stigma and discrimination

Throughout the training, participants have opportunities to explore their personal values and beliefs related to key populations and consider how these impact KP members' access to services.

Participants will also hear from KP members during a panel discussion to learn how stigma, discrimination, and violence have affected their lives and the kinds of support they need.

requirements that must be in place for health care workers to safely ask about and respond to violence.

Module 4: Using What We Have Learned is the final module and recaps what has been covered while making clear the expectations and support available going forward. It contains sessions on self-care for health care workers, including confronting secondary stigma, and ends with a commitment, made confidentially, where those trained can join a list of sensitized health care workers willing to support KP members.

Below is a complete list of sessions in the training.

Health Care Worker Training: Preventing and Responding to Violence against Key Populations	
Module 1: Setting the stage	
Session 1.1: Welcome and introductions	
Session 1.2: Pre-test	
Session 1.3: Learning objectives and agenda	
Session 1.4: Group norms	
Module 2: Building core knowledge	
Session 2.1: The HIV epidemic in [country]	
Session 2.2: Sex, gender, gender identity, gender expression, sexual orientation: understanding ourselves and each other	
Session 2.3: Understanding violence against key populations (characteristics, perpetrators, causes, consequences)	
Session 2.4: Focus on intimate partner violence	
Session 2.5: Legal and policy obligations, opportunities, and barriers in the local context	
Session 2.6: Panel discussion with key population members	
Module 3: Applying principles and building skills	
Session 3.1: Fundamental principles of violence prevention and response	
Session 3.2: Barriers to disclosing violence	
Session 3.3: The importance of health care workers in violence prevention and response	
Session 3.4: Asking about and responding to violence in key population members' lives	
Session 3.5: Referring effectively: overview of recommended health, social, and justice/legal services and improving access to each one	
Session 3.6: Putting it all together	
Session 3.7: Data collection and sharing	
Session 3.8: Recap: minimum requirements to ask about violence	
Module 4: Using what we have learned	
Session 4.1: Taking care of ourselves: identifying and confronting secondary stigma and stress	
Session 4.2: Reflections on what we have learned and how to integrate it into our work	
Session 4.3: Post-test and training evaluation	
Session 4.4: Closing ceremony and final words	

Each session begins with an estimated time and materials required. Actual times may vary according to the adaptations made to meet the needs of participants, and session times should be revised by the facilitator as needed. In addition, some sessions begin with a note on **planning**

ahead. This section describes steps for preparation that are specific to a session; these are generally in addition to preparation required for the workshop overall.

With each session guidance for facilitators appears on the left side of the page and corresponding PowerPoint slides on the right (the slides are also provided as a separate PowerPoint file). The guidance for facilitators includes:

- **Supporting information:** Highlights the key points for facilitators. Depending on time constraints, facilitators may choose to discuss all information included or only a selection of the notes. The choice is at the discretion of the facilitators. Facilitators should also add their own examples, anecdotes, clarifying points, and discussion questions that they determine are appropriate. **Text in orange** in the facilitator guidance is meant to be said (but can be paraphrased or otherwise amended to avoid the facilitator reading throughout the training). Sometimes “notes to the facilitator” are included in italics. These notes can be useful in contextualizing what is being shared; they also provide additional guidance on how information can be framed.
- **Activities:** Provides operational instructions for facilitators to engage participants in activities and discussion.

At the end of this document are annexes, handouts, and exercise cards. The **annexes** provide additional information to support the facilitator in preparation for the training and with any questions asked during the training. The **handouts** are documents to be provided to all participants during the training; the facilitator decides whether to provide all handouts at the start or share them at relevant points during the training. The **exercise cards** are materials the facilitator will need to print to help facilitate activities. Each exercise card includes information on how many copies are needed.

Adapting this Training for the Local Context

You can work collaboratively with senior health officials—or those to whom the responsibility has been delegated—and members of KPs to adapt the training. As you adapt, consider the following elements of meaningful collaboration between health care workers and KP members:

- **Appeal to health care worker interests.** For example, talk to senior leadership about what they would like to see included in the training for the benefit of their health care workers.
- **Provide opportunities to showcase senior health official support.** When developing the agenda, build in time for a senior health official to give opening remarks. As appropriate, encourage the opening speaker to include content that clearly states their commitment to a health facility, specialty, or position that serves all, including men who have sex with men, people who inject drugs, sex workers, and transgender people. As needed, provide the opening speaker with data on the HIV epidemic locally.
- **Develop regular and systematized health care worker trainings that involve members of key populations.** Any training for health care workers should provide opportunities for health care workers to meet KP members. Apart from leading and participating in training sessions, KP members should also have opportunities during lunch or breaks to talk to health care providers informally. In addition, consider from the start what

can be done to ensure the training will be used widely and that newly initiated health care workers will have the opportunity to be trained.

Other considerations for adaptation are:

Other health care worker trainings on violence prevention and response currently or previously in use locally. Consider whether the health care workers to be trained have attended other trainings focused on violence and/or if a nationally recognized training on violence is offered. In most cases, any previous or currently offered trainings will focus on IPV and/or sexual violence against women in the general population. For example, organizations such as the International Rescue Committee²⁹ may have already trained health care workers on the clinical management of rape. 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*³⁰ 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, and teaches clinical skills including taking a history and medical examination, providing treatment and follow-up, mental health care, and forensic examination in sexual assault cases.³⁰

To avoid duplication and confusion, if the health care workers to be trained have already attended a training on violence or a nationally recognized training is being rolled out, consider working with senior health officials to identify the portions of this training that either do not need to be covered in detail or that can be supplemented with the nationally recognized training. For example, if health care workers have already learned and practiced first-line support skills, they do not need to relearn them. Instead, they can practice using them with service users who are KP members. Elements of the nationally recognized training that could be used to supplement this training include clinical skills, which are not covered in detail here, and information on laws, policies, and referral protocols.

Key populations that will be the focus of the training. The program staff person charged with leading this training will need to make decisions about the content based on the populations involved in the KP program. This training includes information on men who have sex with men, people who inject drugs, sex workers, and transgender people. In most contexts, health care workers will have experience with all four of these populations. However, depending on your setting and priorities, you may decide to emphasize one more than the others, for example, by using case studies focused only on those populations with whom you work the most.

Time available for training. An important logistical consideration will be how long health care workers can be away from their duties. In some contexts, this training has been delivered in only two days. Two-and-a-half days is preferable if possible. If you implement the training in two days, it is better to remove activities and devote sufficient time to fewer than to rush through all of them. If you have more than two days, you may also consider adding material, especially videos.

As you design the agenda for your specific time constraints, see [Annex 3](#) for energizers, [Annex 4](#) for activities to recap information (especially useful at the start of each new day of training), and [Annex 5](#) for daily closing activities. Additionally, almost all sessions end with time for participant questions and reflections. Depending on the time allotted for the training, you may make these shorter or longer in duration.

We recommend that the training occur over consecutive days. The first two modules are designed to strengthen health care workers' cognitive and emotional motivation to make a change in their practices. The final two modules build skills that help them become part of the solution to the problems initially presented. Implementing all the modules close together can strengthen participants' commitment to building their own capacity, causing them to work more diligently during skills building and leave more inspired to make a change.

Locally appropriate examples and names. Work with local health care workers and KP members to review the examples used in the training and replace them, as needed, with more relevant ones. The character names used in all the case studies and stories that are part of the training can also be changed to ensure local relevance. Whatever is presented should resonate with the participants; the more local examples used, the more effective the training will be.

Local laws and policies. The training requires information highly specific to your country during different sessions. To ensure that content is locally relevant, facilitators should also prepare country-specific slides related to HIV, violence, and laws in their countries. Slides that require country-specific information are noted in **green text**. The most extensive adaptation to the local context occurs in *Session 2.5: Legal and Policy Obligations, Opportunities, and Barriers in the Local Context*. Preparation of this information is best done by an allied lawyer.

Who will be trained. Health care workers in a range of facilities, specialties, and positions (such as receptionist, security guard, health care provider) have different responsibilities and opportunities for interaction with KP members who have experienced violence. Both KP members and senior health officials should be given an opportunity to inform who will be trained to ensure that all those likely to interact with a victim will be sensitized appropriately. Because this training does not include clinical skills and the skills taught are also valuable in participants' lives more broadly, all sessions are appropriate for all attendees.

As much as possible, the training should include case studies and discussions relevant to those health care workers being trained. Basing new case studies on real-life experiences of KP members will be helpful (although the identity of a specific KP member should never be discernable). Panel members (in Session 2.6) may also focus on their communities' interactions with specific facilities, specialties, or positions during their remarks.

Type of facility: Where health care workers operate will influence how they implement what they learn during the training, particularly how often they receive disclosures of violence from KP members and how they link victims to other services. For example, in the Dominican Republic, a community-based organization shares their building with a clinic. In this case, individuals who disclose violence while receiving clinical care can be immediately met by a psychologist operating in the same building. Health care workers operating in a drop-in-

center for key populations may use a different model. For example, in Cameroon, a nurse or doctor visited drop-in-centers weekly and was therefore rarely the person to whom violence was disclosed; in addition, the doctor or nurse was often not immediately available if a victim required clinical services. The drop-in-centers therefore relied primarily on psychosocial counselors and social workers to offer first-line support if violence was disclosed. These individuals would provide accompanied referral to a doctor or nurse trained to work with KP victims of violence as needed.

The responsibilities of health care workers at public and private facilities may also differ, especially if public facilities are not perceived to be KP-friendly and primarily see only those KP members who require services provided at tertiary facilities (in some countries, this includes forensic examination and post-exposure prophylaxis [PEP]). During the training, there should be time provided for all attendees to discuss how they will operationalize what they have learned within their service delivery model.

Number of participants. The training is designed to be highly interactive, with opportunities for everyone to share their thoughts in pairs, small groups, or plenary sessions. The more participants, the longer the amount of time needed for many activities to ensure that everyone may fully engage. We recommend training between 25 to 40 people at a time.

Literacy levels. The training slides and activities should be adapted for the literacy level of the health care workers being trained. Reviewing the slides with local facilitators—especially health care workers who work with KP members—is an important opportunity to rephrase or simplify language. Many activities that require reading can be done in large or small groups so that health care workers with higher literacy levels can assist others. As desired, for longer readings like Amanda’s Story ([Exercise Card 3](#)), the facilitator could ask that someone come to the front and draw pictures of the story as it is read. In addition, whenever large group discussions occur, the questions can first be discussed in pairs. This gives those who may have less confidence in their contributions the opportunity to work through the issue together before sharing in a larger group.

Skilled facilitators will take the time needed to ensure that participants understand the content, including written portions. The adaptations needed may require that the training be extended past two-and-a-half days, which should be discussed and agreed upon during the planning process.

Piloting is key! An adapted version of the training should be pilot-tested with a representative group of participants who are given the opportunity to provide feedback and suggest revisions before the final version is developed and rolled out. This will help address all the issues above.

Selecting Facilitators

This 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 health care workers on asking about violence and providing

compassionate and nonjudgmental first-line support according to the LIVES model (Listen. Inquire about needs and concerns. Validate. Enhance Safety. Support.).³¹

As you identify trainers, strongly consider having workshops jointly led by both KP members and health care workers (who may also be KP members) who have been trained as trainers (or indicate a desire to be trained in facilitation skills). It may be possible to train trainers as part of the piloting process. When this is possible, the trainers' ability to influence the training—via suggested revisions during the pilot—can also increase their fidelity during training rollout. Those selected as facilitators should be comfortable with the content of the training and with supporting participants to share their opinions and questions in an environment that facilitates learning and exploration.

When to Train Health Care Workers

This curriculum can be used as part of in-service or pre-service training. No training prerequisites are required, and it can be used at any time. Ideally, the training content is integrated into pre-service training. This ensures that all health care workers receive training, which is especially important in areas with high staff turnover.

Beyond offering the training repeatedly to achieve broad coverage among health care workers, you may also consider mini-refresher trainings (10–15 minutes long) during existing health care worker events—such as staff meetings—to continually engage with health care workers post training and introduce new health care workers to the topic.

MODULE 1:

Setting the Stage

MODULE 1:

SETTING THE STAGE

Introduction

This module sets the stage for a successful and collaborative training. Health care workers get to know one another and share what makes them proud of the role they play in society. They also review the agenda and learning objectives, take a pre-test to determine their baseline knowledge and attitudes, and establish group norms for the training.

This module includes the following sessions and learning objectives:

Session 1.1 Welcome and Introductions

- Introduce ourselves and discuss the role of health care workers in [country]

Session 1.2 Pre-Test

- Determine baseline knowledge and attitudes

Session 1.3 Learning Objectives and Agenda

- Review training goal and objectives and discuss how modules will help us achieve all objectives

Session 1.4 Group Norms



- Develop and agree upon norms to guide the training

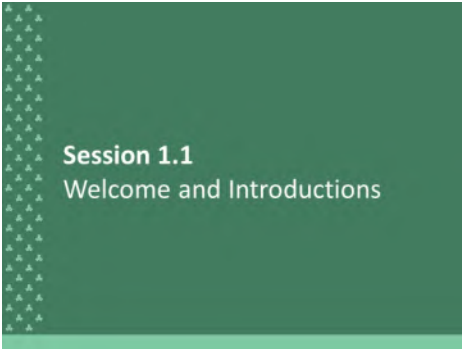
Session 1.1: Welcome and Introductions

Time: 30 minutes

Materials

- Slide presentation
- Opening remarks by senior health official
- Name tags for participants and/or name tents
- Flip chart and markers
- Flip chart titled “Why I’m proud to be a health care worker”

<ul style="list-style-type: none"> • Welcome everyone to the training and thank them for being there. If a high-level health official such as a member of the Ministry of Health or another ministry overseeing the HIV response, health facility administrator, or HIV program senior official is present, have them speak first to give words of welcome that stress the importance of the training’s content. • If possible, you may want to help the official prepare remarks in advance so they mention this training helps health care workers fulfill their mission (for example, if “improving health outcomes” is the mission, then the official could say this training makes sure that all individuals receive quality, stigma-free health care). • The official may also want to discuss the importance of collaboration between and among government institutions, including those working on public health (Ministry of Health, National AIDS Commission, etc.), social welfare (Ministry of Social Welfare), and public security (law enforcement). 	
<ul style="list-style-type: none"> • Thank the official for their commitment and support. • Show slide and explain: <i>We will start with Module 1: Setting the Stage.</i> 	

<p>Launch training</p> <ul style="list-style-type: none"> • Show slide and have facilitators introduce themselves. <p>Share announcements and logistics (e.g., restrooms, sign-in sheet)</p> <ul style="list-style-type: none"> • Describe the location of restrooms; if possible, determine in advance if there are gender-neutral bathrooms that can be used by trans participants or others if this is their preference. • Ask everyone to sign the sign-in sheet. • Thank staff members who handled logistics and helped set up for the training. • Ask if there are any questions. 	
<ul style="list-style-type: none"> • Explain that each session has an objective. • Read objective. <p><i>[Note to the facilitator: Green text on the slide should be replaced in preparation for the training.]</i></p>	<p>Objective</p> <p>Introduce ourselves and discuss the role of health care workers in [country]</p>
<ul style="list-style-type: none"> • Show slide and ask everyone to introduce themselves including their name, organization and role, and district/area where they work. Ask them to also include the reasons they are proud to be a health care worker. • Write each reason on flip chart paper and refer back to it throughout the training. They will likely say such things as: “I help people lead healthy lives,” “People come to me for help,” and/or “I have a challenging job that allows me to solve problems.” These are statements you can refer to during the training when talking about how important health care workers are to the health and well-being of KP members. • If you think participants may not feel comfortable talking about pride in their work—in some contexts, publicly sharing pride in oneself can be perceived as negative—you may choose to ask instead: “What do health care workers contribute to society?” <p><i>[Note to the facilitator: If you are working with a specific facility, specialty, or position you may wish to</i></p>	<p>Introductions</p> <ul style="list-style-type: none"> • Name • Organization and role • District/area in which you work • One reason you are proud to be a health care worker

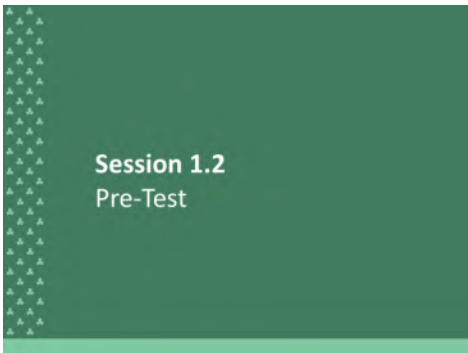
<p><i>make this question more specific. For example, you might ask: “What do health care workers in [specific facility, specialty, or position attending the training] contribute to society?”]</i></p>	
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Session 1.2: Pre-Test

Time: 10 minutes

Materials

- Slide presentation
- [Handout 1](#): Pre-Test


<ul style="list-style-type: none">• Explain: <i>It is now time for the pre-test.</i>	
<ul style="list-style-type: none">• Show slide and explain: <i>We will use this test to understand participants' current knowledge and attitudes toward several topics.</i>	<p>Objective</p> <p>Determine baseline knowledge and attitudes</p>
<ul style="list-style-type: none">• Show slide and explain: <i>To learn how well we are doing with trainings, we ask participants to complete a pre-test at the beginning and a post-test at the end.</i>• The information you provide on these is confidential and will not be shared with anyone outside the facilitation team.• We only use this information to help us understand the training needs of participants and to find out if we are accomplishing the learning objectives.• You don't need to write your name on the pre- or post-test.• Do you have any questions before we begin?• Distribute printed pre-tests (Handout 1).• Give everyone about 10 minutes to complete the pre-test.• Collect the completed pre-tests.	<p>Pre-test</p> <ul style="list-style-type: none">• Do not write your name.• Fill out pre-test.• When finished, place face down on your table.

Session 1.3: Learning Objectives and Agenda

Time: 15 minutes

Materials

- Slide presentation
- Flip chart and markers
- Flip chart titled “Expectations”
- [Handout 2](#): Participant Agenda

<ul style="list-style-type: none">• Explain: We will spend two-and-a-half days together, and we have a lot to cover.• This is an interactive training. We will be doing a lot of activities, including small group exercises, large group discussions, and other activities that involve participants talking and interacting with each other.• Although we may use slides to complement and facilitate our discussions, much of our work and learning together will be through interaction and discussion.• My/our role as facilitator(s) is to provide information, facilitate activities that allow everyone to learn new information, and create a positive learning environment where everyone feels supported and energized.• If facilitator is not speaking in the first language of training participants, explain that an interpreter will be used and participants should not hesitate to share questions they have or to ask for the material to be presented more slowly.	
<ul style="list-style-type: none">• Show slide and explain: During this session, our objective is to understand what we’re trying to achieve in this training and how the training will allow us to achieve it.• This is the objective of this specific session, but we will be describing the overall goal and objectives of the entire training.	<p>Objective</p> <p>Review training goal and objectives and discuss how modules will help us achieve all objectives</p>

<ul style="list-style-type: none"> • Show slide and explain that the goal on the slide is the overarching goal for the entire training. • Ask a participant to read the goal out loud. Then ask if anyone knows what you mean by “key populations.” • After giving time for people to guess, explain that you’re talking about key populations most affected by HIV. • Then click slide again and show the key populations list. Explain that you’ll be talking about specific HIV prevalence rates in [country] in Module 2. 	<p>Training goal</p> <p>To equip health care workers with the knowledge and skills they need to understand, assess, and appropriately respond to violence in key population (KP) members’ lives, including through improving KP members’ access to HIV and other violence response services and supporting violence prevention efforts.</p> <p>Key populations are</p> <ul style="list-style-type: none"> • Men who have sex with men • Sex workers • People who inject drugs • Transgender (trans) people
<ul style="list-style-type: none"> • Show slide and explain: These are the objectives that will help us achieve our goal. Each session will help us achieve one or more of these objectives. • Ask a participant to read each objective out loud. • Explain that this training does not provide instruction on clinical skills such as taking a history and conducting a medical examination, providing treatment and follow-up, providing or referring for mental health care, and completing a forensic examination as in sexual assault cases. <p><i>[Note to the facilitator: If the participants have been taught clinical skills, you may tell them that this training will build on their skills and address KP-specific concerns. If they have not been taught clinical skills, share that they will be able to refer to others with those skills or receive additional training so that they can provide all services needed.]</i></p>	<p>Training objectives</p> <ul style="list-style-type: none"> • Explore the underlying causes of stigma, discrimination, and violence against KP members and the connection with HIV • Identify interaction with health care workers as a key entry point into violence response services • Learn to create an environment in which disclosure of violence can safely occur • Build skills for asking about violence and providing first-line support • Understand the range of health, social, and justice/legal services KP victims may need and make appropriate referrals • Discuss best practices for safe data collection and management
<ul style="list-style-type: none"> • Explain: Now that you’ve seen the goal and objectives of the training, please tell me your personal goals for the training. • Write each goal on flip chart paper. After everyone has shared their goals, say: We’ll review the agenda and talk about how this training can address your goals, or how they might be addressed outside the training. 	<p>Discussion: Expectations</p> <p>What do you want to get out of the training?</p>

- Show slide and distribute [Handout 2](#): Participant Agenda. Go through the agenda to show individual sessions within modules.
- Refer to the participant goals as you review the agenda to help demonstrate your efforts to meet the group's needs and build buy-in for the content covered.
- Explain: We will begin by getting to know one another and our objectives—what we are doing now—then we will focus on building our knowledge of core topics. After this, we will develop and use new skills. And finally, we will talk about how to take what we learn here back to our work.

[Note to the facilitator: If any participant expectations will not be met during the training, share this stated need with senior health officials so they recognize it as a need that should be addressed elsewhere.]

Agenda review


- Module 1: Setting the Stage
- Module 2: Building Core Knowledge
- Module 3: Applying Principles and Building Skills
- Module 4: Using What We Have Learned and Closing

Session 1.4: Group Norms

Time: 10 minutes

Materials

- Slide presentation
- Flip chart and markers
- Flip chart titled “Group Norms”
- Flip chart titled “Parking Area” or “Garden of Ideas”

<ul style="list-style-type: none">• Explain: Now we move to establishing group norms that will help us work effectively together.	
<ul style="list-style-type: none">• Read objective.• Refer to the flip chart titled "Group Norms."• Explain: Setting some ground rules or group norms at the beginning of a training is always a good idea to make sure we are all on the same page, maintain common values throughout the training, and ensure a positive learning environment.• As a group, let's come up with group norms that we think are important for us.• Write group norms on flip chart.• If participants need prompting, consider asking, “What kind of training environment do we want for ourselves?” and “What kind of behaviors and attitudes do we want to encourage or discourage?”• Suggested group norms. We will:<ul style="list-style-type: none">– Keep everything shared in this training confidential– Arrive on time to show respect to other people in the group– Listen to different opinions– Seek to practice active listening– Switch off mobile phones and laptops during sessions– Take care of ourselves and one another• If confidentiality is mentioned and written as one of the group norms, draw a circle around it. If not,	<p>Objective</p> <p>Develop and agree upon norms to guide the training</p> <hr/>

write “Confidentiality” in large letters on the flip chart.

- Explain: It’s important that participants feel comfortable sharing their thoughts. Some of us may have had experiences with violence or know people who have. Some may decide to share personal experiences. A commitment to confidentiality within the training group will help everyone feel more comfortable sharing their thoughts. We will keep these group norms posted so they are easily visible, and we can refer to them, if needed, during the training.
- If “listening to different opinions” is not listed as a group norm, request to add it.
- If “taking care of ourselves and each other” is not added, request to add it and note: The topic of violence touches all of us, not just as health care workers but also as individuals. We encourage people to walk out or take space as needed.

[Note to the facilitator: Some programs have invited a psychologist to participate in the training to build stronger links to facilities, specialties, and positions, and ensure that participants have someone to speak to if they need to process intense emotions during the training.]

- Post the flip chart where it can be seen by all participants during the training.

MODULE 2:

Building Core Knowledge

MODULE 2:

BUILDING CORE KNOWLEDGE

Introduction

This module describes the HIV epidemic in the country in which the training is held. It then explores who KP members are and why they are at greater risk for both HIV and violence; concepts related to sex and gender; links between rigid gender norms, stigma, discrimination, and violence; links between violence and HIV; and types of violence and other human rights violations commonly experienced by KPs. Participants also strengthen their knowledge of local laws and the constitution—particularly as they affect KP victims of violence—and of policies and protocols guiding the health sector’s provision of violence response services.

Content in this module on IPV may help health care workers improve their support to both members of KPs and the general population who are experiencing IPV.

This module includes the following sessions and learning objectives:

Session 2.1 The HIV Epidemic in [Country]

- Review the epidemic in [country], including HIV prevalence levels among key populations
- Review national strategic plan (e.g., from the Ministry of Health) to understand KP programs’ goals and approaches

Session 2.2 Sex, Gender, Gender Identity, Gender Expression, Sexual Orientation: Understanding Ourselves and Each Other

- Understand the difference between sex and gender
- Understand the differences between gender identity, gender expression, and sexual orientation
- Explain how gender norms and other societal norms affect us all and contribute to stigma and discrimination against key populations

Session 2.3 Understanding Violence against Key Populations (Characteristics, Perpetrators, Causes, Consequences)

- Describe how stigma and discrimination based on gender can result in violence
- Identify common types of violence experienced by KP members and perpetrators of that violence
- Explain the link between violence and HIV

Session 2.4 Focus on Intimate Partner Violence

- Recognize the ways in which IPV can evolve over time
- Discuss the importance of responding to all victims of IPV in a nonjudgmental way
- Discuss IPV among KP members and identify additional barriers to support that they may face when experiencing IPV

Session 2.5 Legal and Policy Obligations, Opportunities, and Barriers in the Local Context

- Understand policies and protocols that describe the health sector's obligation to and processes for providing care to victims of violence, including members of key populations
- Identify the legal opportunities and barriers to support faced by KP members who are victims of violence

Session 2.6 Panel Discussion with Key Population Members

- Get to know the issues of violence affecting KP members
- Understand KP members' perspectives and hopes regarding their interactions with law enforcement

The panel discussion falls on the first day of the agenda. However, you may wish to have the panel discussion directly before lunch on the second day so that panel members can be introduced after a full day of the training, and they can stay for more informal conversations during lunch.

Session 2.1: The HIV Epidemic in [Country]

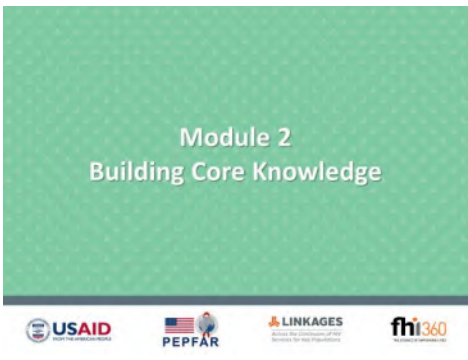

Time: 30 minutes

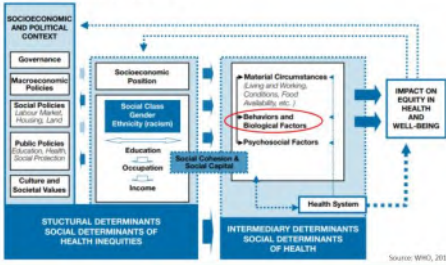
Materials

- Slide presentation
- [Exercise Card 1](#): What Is Behind High HIV Prevalence Rates for Some Populations?

Planning Ahead

This session requires that you add country-specific information on the HIV epidemic.

<ul style="list-style-type: none">• Explain: We will now move on to building our knowledge on this important topic.	 <p>Module 2 Building Core Knowledge</p> <p>USAID PEPFAR LINKAGES fhi360</p>
<ul style="list-style-type: none">• Show slide and explain: We'll be talking about some basics regarding HIV, including which groups are most likely to be living with HIV in [country].	 <p>SESSION 2.1 The HIV Epidemic in [Country]</p>
<ul style="list-style-type: none">• Show slide and ask a participant to read each objective out loud.	<p>Objectives</p> <ul style="list-style-type: none">• Review the HIV epidemic in [country], including HIV prevalence levels among key populations• Review national strategic plan (e.g., from the Ministry of Health) to understand KP programs' goals and approaches

<ul style="list-style-type: none"> • Show slide and explain: Let's talk about HIV in [country]. • Show country-specific slide(s) and review the content. <p><i>[Note to the facilitator: Add one or more slides explaining the HIV epidemic among the general population in the country.]</i></p>	<p>HIV epidemic in [country]</p> <p>[Country team to add data on the HIV epidemic in their country. Key population-specific data should be included on a later slide.]</p>
<ul style="list-style-type: none"> • Show slide and explain: Now let's look at how HIV is affecting key populations. The high burden of HIV among key populations is well documented at a global level. Many of the reasons for these high levels are related to violence, something that we'll be talking about throughout this training. • Review the content on the slide. <p><i>[Note to the facilitator: If you have national data for each KP group, you may skip this slide. Please be sure that the information on prevalence among KP members is presented in a way that does not blame KP members for the HIV epidemic in the country.]</i></p>	<p>Key populations and HIV globally</p> <ul style="list-style-type: none"> • HIV prevalence among sex workers is 10 times greater than among the general population.¹ • Men who have sex with men are 24 times more likely to be living with HIV than the general population.¹ • Trans women are 49 times more likely to be living with HIV than other adults of reproductive age.² • People who inject drugs are 28 times more likely to be living with HIV than the general population.³ <p><small>Sources: 1. Joint United Nations Programme on HIV/AIDS, 2016. 2. Baral et al., 2013. 3. United Nations Office on Drugs and Crime et al., 2017.</small></p>
<ul style="list-style-type: none"> • Show slide and explain: Earlier, we looked at the HIV epidemic among the general population in [country]. Now, let's look at what we know about HIV among key populations here in [country]. • Show country-specific slide(s) and review the content. <p><i>[Note to the facilitator: Add one or more slides explaining the HIV epidemic among key populations in the country.]</i></p>	<p>HIV among key populations in [country]</p> <p>Specify which KP groups—men who have sex with men, people who inject drugs, sex workers, trans people—are the focus of the national HIV/AIDS strategy in [country].</p> <p>Insert country-specific information/statistics about HIV among these KP groups in [country]. You may also wish to include size estimation data.</p> <p>Consider carefully whether data is safe to share; for example, it is likely inappropriate to share mapping data that names specific hot spots as this may result in increased chance of arrest.</p>
<ul style="list-style-type: none"> • Explain: Sometimes when HIV or any other health outcome—for example, diabetes, heart disease, or malaria—is discussed, we find ourselves asking what behaviors lead some groups to experience more disease. By this I mean, what are some groups doing that makes them more vulnerable to an illness while other groups don't have as much illness. • This question—what behaviors can lead to more illness—is not wrong, but it will give a very limited answer because it doesn't take into account the many factors beyond behavior that can influence health. The World Health Organization (WHO)—an 	<p>What influences people's health, including their vulnerability to HIV?</p>  <p><small>Source: WHO, 2010.</small></p>

<p>agency of the United Nations that focuses on international public health—wanted to know all the things that can influence health. They came up with this model on the social determinants of health.³² It shows us that an individual’s behavior is just one small part of what determines if they will be healthy.</p> <ul style="list-style-type: none"> • Click to show red circle around behavioral factors. • Instead of discussing the model, we are going to do an activity that helps us think about the many things that can affect how healthy a person or community is. <p><i>[Note to the facilitator: Some audiences may find this figure difficult to understand. That is OK. It is not important that they understand each element of the model presented. The figure is simply an opportunity to show that it is not only service user behavior that determines health, as participants will see when the same figure is shown again later with many more red circles.]</i></p> <p><i>If “vulnerability” to illness is not understood, you can also talk about how likely someone is to have an illness. For example, people who live in places without clean drinking water are more vulnerable to having diarrhea and other diseases that can occur from drinking contaminated water. This means they are more at risk of experiencing diarrhea than someone who has access to clean drinking water.]</i></p>	
<ul style="list-style-type: none"> • Explain: I’m going to divide you into five groups. Each group will receive two experiences that a person could have. The group members should choose which of these experiences is more likely to be a barrier to good health and which is more likely to support or facilitate good health. When I say health, I am including staying HIV negative. • You will then present your answers. You will also need to explain why one experience facilitates health and the other is a barrier. • Divide participants into five groups and distribute one set of experiences to each group (e.g., one group should have 4A and 4B, another will have 5A and 5B, etc.). A table with all the experiences is below. The versions to be printed and given to participants are in Exercise Card 1. 	<p>Activity: What is behind high HIV prevalence rates for some populations?</p> <ul style="list-style-type: none"> • Divide into five groups. • Review the two experiences given to your group. • Decide which of the experiences is a barrier to good health and which one facilitates good health. Consider HIV prevention specifically. • Be prepared to share and explain your response. <hr/>

- Give five minutes for discussion in small groups and then have each group share their answers.

[Note to the facilitator: If the groups are struggling to understand how to do the activity or how to explain why one experience would facilitate health and the other would be a barrier, begin by looking at 1A and 1B together and then have only four groups discuss the remaining experiences. This will require that the facilitator alter the previous slide to have only four groups. In addition, if “facilitators of good health” is difficult for participants to understand, consider using other terms such as “health aids” or “health promoters” as column titles.]

- As each group presents, put all the experiences that are barriers to good health in one column and all those that facilitate good health in the other column. It should look like the image at right.
- As groups share their explanations, you can refer to the table below for examples of why each experience would be a barrier or facilitator of HIV prevention specifically. If these reasons are not mentioned by participants; be sure to share them.
- Facilitators are all labeled with A and barriers are all labeled with B. If any group’s answer is not correct, take time to correct their answer, while explaining the correction.
- Now, encourage participants to look at the list of barriers and facilitators. Ask the group how many of the barriers to health are more common among KP members than members of the general population (i.e., individuals who are not members of key populations).
 - Many sex workers cannot seek help from law enforcement in case of rape, experience harassment from neighbors or family due to their profession, and experience stigma in health care settings. Many sex workers also experience homelessness.
 - Many men who have sex with men are forced to leave home as children or adolescents because their families reject them, increasing their risk of homelessness. It may be difficult for them to report rape because many law enforcement officers believe only women can

Facilitators of good health

1A
2A
3A
4A
5A

Barriers to good health

1B
2B
3B
4B
5B

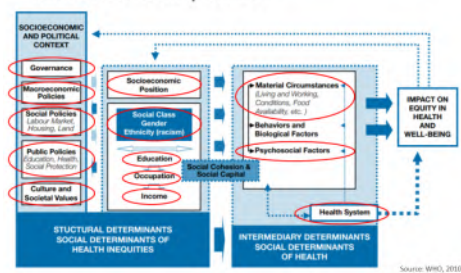
be raped or will end up arresting a man who they believe to be gay if he reports a crime against himself. Finally, many men who have sex with men report gossip or poor service from health care workers, limiting their desire to access services and ability to be honest with providers.

- Many people who inject drugs experience judgment or harassment from law enforcement officers or health care workers—making it difficult to look to them for help—and often experience violence and harassment from the public. Many people who inject drugs also experience homelessness.
- Transgender women experience high levels of homelessness beginning in childhood/ adolescence due to family rejection. Some law enforcement officers abuse transgender women, especially those engaged in sex work, making it difficult or impossible for them to seek support from law enforcement when they are victims of violence. Trans women are also often harassed in public places. Finally, many health care workers do not understand what transgender means and/or have negative attitudes toward transgender people. Trans women report that health care workers often call other staff to jeer at transgender people who present for services or refuse to serve them at all, making it difficult for transgender people to feel comfortable attending clinics.

Facilitators of health	Barriers to health	How does one of these experiences facilitate health while the other is a barrier to health, with a focus on HIV prevention?
1A. A person is accepted and supported by their family throughout childhood and adolescence	1B. A person is rejected by family and forced to leave home during their teenage years	Cultural and societal values , for example, related to the acceptability of homosexuality can lead parents to reject their children. Parents who reject children may influence that child's self-worth and self-esteem negatively leading to sexual risk-taking. ³³ Parents' continued support for education can allow for more years of schooling, which is also associated with less vulnerability to HIV. Education can also provide opportunities to better understand HIV risk. Having more education also often means access to higher-income occupations .
2A. A person can safely seek help from the police if they are raped	2B. A person cannot safely seek help from the police if they are raped	Local laws and governance that criminalize members of KPs and cultural and societal values that lead to negative behaviors from law enforcement can make it nearly impossible for some victims of crimes to safely seek police support. Not being able to seek support from the police limits access to services such as PEP that can prevent the acquisition of HIV. It also means that those who commit crimes, such as rape, know they can do so with impunity, increasing the risk that the violence will happen again. Sexual assault can lead to HIV infection. Public policies designed to protect men who have sex with men and sex workers are associated with reductions in HIV prevalence among men who sell sex. ³⁴
3A. A person can leave home without fear of verbal harassment	3B. A person feels afraid to leave home due to experiences of verbal harassment	Sometimes cultural and societal values lead to harassment and bullying of those who are considered outside of what is "normal." This is especially true if no public policy is in place to offer protection to marginalized groups. People who experience harassment are often unable to move freely due to fear of harassment, limiting their access to information or services that can help prevent HIV. Past experiences of harassment and verbal abuse—which could be the root of the current fear—are also linked to HIV risks such as sex without a condom. ³⁵
4A. A person feels comfortable talking about their sexual/drug use behaviors with a health care provider because they know the provider will listen nonjudgmentally	4B. A person feels uncomfortable talking about their sexual/drug use behaviors with a health care provider because they fear the provider will respond negatively	Public policies dictate the education that health care workers receive, affecting the health care available. Some health care workers are never taught to work with KP members and may also hold negative attitudes toward them due to cultural and societal values . When KP members cannot confide their sexual/drug use behaviors to their health care provider due to a fear that the provider will respond negatively, that provider will not be able to understand the needs of the service user and cannot give advice targeted to their needs. For example, if a health care worker does not know that someone is injecting drugs, they will not know to talk to this person about the importance of clean injecting equipment. In addition, fear of provider judgment keeps many KP members from seeking health services, such as HIV testing, at all. ³⁶
5A. A person has a home	5B. A person does not have a home	Class, socioeconomic position, and policies that do not prohibit housing discrimination may all influence whether someone has a home. Macroeconomic policies that affect how many jobs are available can also affect how many people experience homelessness. Homelessness is associated with HIV infection among people who inject drugs. ³⁷ Sexual violence and higher risk sexual behaviors are common among individuals who are homeless. ^{38, 39} Sex workers who are homeless experience more violence than those who are housed. ⁴⁰ Violence, as we will see throughout this training, both directly and indirectly increases HIV vulnerability.

- Show next slide and explain: The experiences we just discussed touched on every one of these other factors. Individual behaviors were not mentioned at all. This shows how important other factors can be.
- While not all KP members have these experiences, they are more common among this group. As a result, HIV prevalence rates in these communities are often higher than in the general population.
- In summary, sometimes we think about individual behaviors or biological risks to understand why someone would be more or less vulnerable to HIV acquisition. However, the laws and policies in a location, the cultural and societal values of that place, individuals' power and opportunities in society, access to services that do not stigmatize, and fulfillment of basic needs such as shelter, and other factors all play a role in HIV prevalence. In this training, we will talk about how we can address some of these factors in our service users' lives to help end the HIV epidemic and improve the lives of those we serve.
- Ask if there are any final questions.

What influences people's health, including their vulnerability to HIV?



- Show slide and explain: Because of the level of HIV in our country and the high burden of HIV among key populations, our Ministry of Health has developed a national strategic plan on HIV and AIDS that recommends specific programs to meet the needs of KP members.
- Show country-specific slide(s) and review the content.

[Note to the facilitator: This slide should be filled with relevant information about the country's national strategic plan on HIV and AIDS. Focus on what the plan says should be done for key populations. Make sure it's clear to participants what activities are sanctioned/supported by ministries.]

National strategic plan

Share information here about the national strategic plan to address KP members' needs. This is an opportunity to share information on what the program looks like on the ground so that health care workers at the training are aware of the activities that are sanctioned/supported by ministries (such as outreach and peer education/commodity delivery).

- Summarize: We've talked about the HIV epidemic in [country], including HIV prevalence levels among key populations and factors that play a role in HIV prevalence. Before we move to our next session, are there any final questions or reflections?

Questions and reflections

Session 2.2: Sex, Gender, Gender Identity, Gender Expression, Sexual Orientation: Understanding Ourselves and Each Other

Time: 90 minutes

Materials

- Slide presentation
- Flip chart and markers
- [Exercise Card 2](#): The Last Post-Exposure Prophylaxis

Planning Ahead

Because gender norms vary by culture, it's important to do some thinking in advance about the gender norms in your setting. Many of the examples here come from a western context (e.g., long hair is considered feminine, short hair is considered masculine) and might not resonate with the training participants. As you identify the gender norms in your culture, you may decide to include photos in the presentation to give concrete examples of these norms (e.g., photos of how boy versus girl babies are dressed by their parents). In addition to gender norms, this session touches briefly on other identities or characteristics that may affect how health care workers interact with service users. Think, in advance, about characteristics such as age, race/ethnicity, and religion that may be important to acknowledge when discussing inequitable access to justice.

- Explain: In this session, we will spend some time talking about core concepts related to sex and gender and what these concepts mean for members of KPs and all of us. Understanding these concepts is important because they will help us understand the violence that KP members experience. They can also help us understand ourselves.


- Show slide and ask a participant to read each objective out loud.


SESSION 2.2


Sex, Gender, Gender Identity,
Gender Expression, Sexual
Orientation: Understanding
Ourselves and Each Other

Objectives


- Understand the difference between sex and gender
- Understand the differences between gender identity, gender expression, and sexual orientation
- Explain how gender norms and other societal norms affect us all and contribute to stigma and discrimination against key populations

<ul style="list-style-type: none"> • Show slide and explain: In this activity, we'll think through the concepts of sex and gender, two commonly confused words that have important and different meanings. • Divide participants into two or more groups (about six to eight per group). • Explain: Each group should select an artist. That person, taking directions from the group about what to include, will draw either a woman or a man, as assigned by me. • Instruct the groups to make sure they add details that clearly distinguish the figure as a woman or a man using body shape, clothing, and anything else they can think of. • Assign the groups "woman" or "man" and give them 5–10 minutes to draw their woman or man. • This activity is usually a lot of fun, and participants might want to name their man or woman to make it easier to refer to them throughout the session. • Once all the groups have completed their drawings, have them return to their seats. One person from each group should present the man or woman drawing, describing what makes them clearly a man or clearly a woman. 	<p>Activity: Sex and gender: What's the difference? (Part 1)</p> <ul style="list-style-type: none"> • Divide into groups (about six to eight per group). • Each group selects an artist. • The artist, taking directions from the group, will draw either a woman or a man, as assigned by the facilitator. • Add details that distinguish the figure as a woman or man. Consider using: body shape, clothing, make-up, hair style, objects being held, and anything else you can think of.
<ul style="list-style-type: none"> • Show slide and explain: Before we talk further about these drawings, let's look at some definitions related to sex and gender. • Ask: What do we mean by sex? I don't mean the "act of sex." I am referring to the biological sex of an individual. What am I talking about? Elicit responses. • Click slide again to show and review the definition. • Emphasize: We often focus on the anatomical because that is what is easiest to observe. For example, when we talk about anatomical, we're referring to physical characteristics we can see, such as genitalia. However, chromosomal and hormonal characteristics are also used to classify an individual as female, male, or intersex. • Ask: Is anyone familiar with the term intersex? What does it mean? Click slide again and review the definition. • Explain: Many people are accustomed to thinking that everyone is either male or female, but this isn't backed up by science. When scientists consider all of the aspects that determine 	<p>Biological sex</p> <p>A medical term used to refer to the chromosomal, hormonal, and anatomical characteristics that are used to classify an individual as female, male, or intersex.</p> <p>Biological sex is on a continuum. Intersex refers to a person born with reproductive or sexual anatomy that does not seem to fit the typical definitions of female or male.</p> 

<p>biological sex, up to 2 percent of people are intersex. This is because chromosomal or hormonal patterns differ from the binary of male/female more often than just reproductive anatomy.</p> <p><i>[Note to the facilitator: In case there are questions from the group about intersex, you can refer to the article “How Sexually Dimorphic Are We?”.⁴¹</i></p> <p><i>“We surveyed the medical literature from 1955 to the present for studies of the frequency of deviation from the ideal male or female. We conclude that this frequency may be as high as 2% of live births. The frequency of individuals receiving ‘corrective’ genital surgery, however, probably runs between 1 and 2 per 1,000 live births (0.1–0.2%).”]</i></p>	
<ul style="list-style-type: none"> • Show slide and ask: If sex refers to the biological aspects of a person, what do we mean by gender? Elicit responses. • Click slide again to show and review the definition. • Emphasize: Sex is biologically defined while gender is culturally defined. 	<p>Gender</p> <p>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.</p>
<ul style="list-style-type: none"> • Show slide and review definition. • Explain: Gender identity is part of each of us, and it’s something that is deeply felt and personal. • Review the content on the slide. • Explain: Gender identity, just like biological sex and gender expression, exists on a continuum. Some people feel strongly that they are a man or a woman, and some feel that they are both or neither. When a person’s gender identity does not align with the sex they were assigned at birth, the person may identify as transgender. • Ask if there are any questions. • If there is a local celebrity or other known person who is openly transgender, you may consider mentioning this person, particularly if they are well regarded. • Explain: Being transgender is not a choice, each of us has a gender identity that we feel deeply about. Our gender identity is not determined by how our parents raised us. But the role that parents of trans children play is very important. Transgender children whose parents accept them are more 	<p>Gender identity</p> <p>A person’s deeply felt internal and individual experience of gender, which may or may not correspond with the sex assigned at birth.</p> <p>When one’s gender identity does not correspond with sex assigned at birth, a person may identify as:</p> <ul style="list-style-type: none"> • Transgender: gender identity is different from sex assigned at birth • Trans woman: assigned male at birth and identifies as female • Trans man: assigned female at birth and identifies as male 

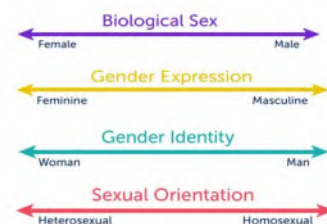
likely to have good mental health than those who are not accepted by their parents. ⁴²	
<ul style="list-style-type: none"> • Show slide and explain: Beyond a person's biological sex, we can see by the drawings from our activity that there are common ways women and men express their gender through appearance, behavior, and disposition. • Ask: Do gender and expressions of gender vary between cultures? Elicit responses. • Provide an example of varied gender expression: In some places it is masculine to have long hair; in other places long hair is considered feminine. This also changes over time. • Emphasize: Like sex, gender and expressions of gender exist on a continuum. Some people like to dress and act in a hyper masculine way; others hyper feminine. Most of us are somewhere in between. 	<p>Gender expression</p> <p>Gender expression is the external display of one's gender identity through:</p> <ul style="list-style-type: none"> • Appearance • Disposition • Social behavior <p>A person's gender expression may or may not be consistent with socially prescribed gender norms.</p> 
<ul style="list-style-type: none"> • Show slide and refer back to the groups' drawings. • Instruct the groups to classify some aspects of each drawing as sex and others as gender expression. • Summarize: We've talked about the difference between sex and gender, what we mean by gender identity, and the different ways in which people express their gender. 	<p>Activity: Sex and gender: What's the difference? (Part 2)</p> <ul style="list-style-type: none"> • Refer back to the group drawings. • Circle those attributes that show gender expression in one color and those that show biological sex in another color.

Examples of Gender Expression and Sex (these will vary depending on the context)		
	Man	Woman
Gender Expression	A specific stance (for example, arms crossed), short hair, short nails, type of clothing and shoes	Earrings, a skirt, long hair, long nails, high heels, a purse, a specific stance (for example, one hip out)
Sex	Tall height, strong arms, a penis and testicles, and facial hair	Breasts, vagina, wider hips

<ul style="list-style-type: none"> • Show slide and explain: Now let's talk about who we are attracted to, not how we think of or present ourselves. • Ask: What do we mean by sexual orientation? Elicit responses. • Click slide again to show and review the definition as well as the terms used to describe sexual orientation. 	<p>Sexual orientation</p> <p>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.</p> <p>Terms often used to describe sexual orientation</p> <ul style="list-style-type: none"> • Attraction to members of one's own sex or gender (homosexual) • Attraction to members of the opposite sex or gender (heterosexual) 
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- **Emphasize:** Who someone is attracted to is not a choice. Therapies to change gay children or adults to make them heterosexual have been shown to cause emotional and psychological trauma and are not effective. Furthermore, the way someone is raised does not determine who they will be attracted to. While a parent's acceptance of their children could make their children more likely to be open about their sexual orientation and therefore less likely to experience depression or commit self-harm, it will not change to whom they are attracted.
- Review the terms but note there are others, such as bisexual, that reflect the full spectrum of attractions.
- Remind the group: It's important for us to remember that sexual orientation will not always align with sexual behavior. A female sex worker may be attracted only to other women but have male clients. Or, a man may be attracted only to men but feel the need to marry a woman because of societal pressures. He may consider himself heterosexual but also have sex with other men from time to time. In addition, specific sex acts are not limited by sexual orientation. For example, both same sex and different sex couples may have anal sex.

- **Show slide and summarize:** We said:
 - Sex refers to biological aspects.
 - Gender expression is how one chooses to express their sense of being male, female, or nonbinary.
 - Gender identity is one's sense of self as being male, female, or nonbinary.
 - Sexual orientation is an enduring emotional, romantic, or sexual attraction to a person of another gender or sex, the same gender or sex, or both sexes and more than one gender.
- **Emphasize:** Since each of these characteristics exists on its own continuum, we cannot assume that one will predict another. For example, just because someone is born biologically female does not mean this person will identify as a woman or have a feminine gender expression.



<ul style="list-style-type: none"> It's important to understand and respect each person as an individual who can be anywhere on these continua. 	
<ul style="list-style-type: none"> Show slide and explain: Now let's think again about gender, and not just as it relates to how we dress or look. Turn to the person next to you and answer each of the questions on the slide. Give participants about 5–10 minutes to discuss in pairs. If you are running short on time, you can assign each pair just one of the questions. Then go question by question and ask for volunteers to share their responses. After sharing, ask what the group observed about the responses. If it doesn't come up, explain that we are taught what is expected of us from a young age and then we see those expectations play out when we are adults (e.g., little girls are given kitchen toys and dolls and are expected to grow up to take care of the house). Gender comes with rules for boys and girls and men and women, and these are often quite distinct (e.g., men and women should be different) and limiting (e.g., men should be a certain way, and <u>not</u> a certain other way). <p><i>[Note to the facilitator: Gender norms differ by country. In some countries, women have been encouraged to take on roles or professions that were traditionally masculine because those roles are often considered superior (e.g., leader, strong, brave) and are better compensated (e.g., lawyer/doctor versus teacher/nurse). In these situations, it may be harder for participants to see gender norms at work. One way to demonstrate the norms clearly in these more equitable settings is to focus on what would be unacceptable for men, as this is generally more rigid than what is unacceptable for women. For example, even in a setting where women are encouraged to work in high power jobs, men may still be looked down upon if they stay at home with children or if they handle all the household chores. A husband who earns less than his wife is also often considered to have given up part of his manhood. And even when girls are being encouraged to play with blocks and other more traditionally "boy" toys, boys who play with dolls are often still looked down upon.]</i></p>	<p>Discussion: Gender norms</p> <p>What are the rules for boys/men and girls/women?</p> <ul style="list-style-type: none"> What kinds of toys are boys/girls expected to play with? What kinds of emotions are acceptable for men/women? What kinds of professions are considered most appropriate for women? What about for men? What are women expected to contribute to their families? What about men? <hr/>

Examples of “rules” for men/boys versus women/girls (these will vary depending on the context)		
	Men/Boys	Women/Girls
Toys	Blocks, trucks, balls, guns, sticks	Dolls, babies, kitchen toys
Emotions	Calm, stoic, angry when needed	Happy, sad, scared, more emotive (“hysterical”)
Professions	Professors, doctors, lawyers, engineers, construction workers, drivers, plumbers, law enforcement officers	Grade school teachers, nurses, child care providers, maids, housewives, receptionists
Contributions to family	Earn money, discipline children	Take care of the children, provide children with affection, house work, cooking, shopping

- Show slide and explain: What you just described are called gender norms. They are expectations based on gender that tell us how to act, look, and feel as men/boys and women/girls. These are cultural messages. Not everyone abides by them, but we know they are there.
- Ask: How do we learn these gender norms? Elicit responses.
- Emphasize: We are all socialized to adopt certain gender norms from an early age. They are deeply entrenched in our society, culture, and in ourselves because we are part of the world. Gender norms shape our beliefs about how males and females should act, what they should look like, how they should feel, and how they should live.
 - For example, boys and girls start out interacting with their peer group in an affectionate way, but boys in many cultures begin to be less affectionate with other boys as they move out of childhood and into adolescence.
 - This happens because they get the message, from society, that boys should be independent and strong, and that expressions of love toward girls are acceptable but that an expression of love toward another young man would be a sign of weakness or possibly a sign of homosexuality.

Discussion: Gender norms (debrief)

Gender norms refer to a set of expectations or rules assigned by our society and culture that tell us how to act, look, and feel as men/boys and women/girls.

How do we learn these gender norms?

- Show slide and explain: So how does this affect us? What do these rules about our behavior mean for our lives? As you could hear in the example about young men ceasing to have affectionate relationships with other young men, following these rules for our behavior or conforming to gender norms can cause harm.

Discussion: Effects of gender norms

How do gender norms affect all of us?

- Men may be kept from being caring parents because that role is seen as being a woman's
- Men may not ask for help when it's needed
- Men may take risks to prove their masculinity
- Women/girls may do all the (unpaid) work in the home, limiting time for education or skills building
- Women may be encouraged to submit to their husbands, even when abuse occurs
- Women may have few options for occupations outside the home, limiting their ability to earn money and live independently

<ul style="list-style-type: none"> • Ask: Let's think about it more broadly. How do the rules that we're all asked to follow harm both men and women? • Solicit responses from the group. • Click slide again to show and review examples. When reviewing the example about men not seeking help, make the point that this also affects HIV testing or accessing other health services. • Ask whether examples that did not come up in the brainstorm but are listed on the slide happen in [country]. 	
<ul style="list-style-type: none"> • Show slide and ask: Now we've talked about what happens if someone does conform. What happens when someone is seen as nonconforming to "rules" about gender? Elicit responses. • Show slide again and review examples. Say: <ul style="list-style-type: none"> – They can be made fun of (e.g., to a man, "You cried in front of your friends! You're pathetic!") – They can be rejected (e.g., to a woman, "You're too assertive. You don't know your place and will not be a good member of our team.") – They can be abused physically and sexually (e.g., in some places homophobic rape is common, where perpetrators claim to be trying to "fix" the victim through sexual violence). – As a result, they can develop lower self-esteem and/or depression, which impacts their well-being and may also lead to self-harm, including suicide. – They can be denied services. This could include health, social, or justice/legal services that they need access to because they've experienced violence. 	<p>Discussion: Effects of gender norms (continued)</p> <p>What happens when someone is perceived as nonconforming to "rules" about gender?</p> <ul style="list-style-type: none"> • Made fun of • Rejected • Abused physically and sexually (including murdered) • Develops low self-esteem/depression • Does harm to themselves or commits suicide • Denied services (including health, social, and legal/justice services that could help protect him/her from violence or provide support if violence occurs) <hr/>
<ul style="list-style-type: none"> • Show slide and ask: How do gender norms increase HIV vulnerability among each key population? Elicit responses for men who have sex with men, female sex workers, women who inject drugs, and trans women. • Review some examples (there are many other correct answers in addition to the ones below): <ul style="list-style-type: none"> – Health care workers' assumption that all male service users have sex only with women and/or their negative attitudes toward men who have sex with men can make it difficult for men who have sex with men to disclose same-sex sexual 	<p>Discussion: Effects of gender norms (continued)</p> <p>How do gender norms increase HIV vulnerability among...</p> <ul style="list-style-type: none"> • Men who have sex with men? • Female sex workers? • Women who inject drugs? • Transgender women? <hr/>

<p>behavior to them. This means they cannot receive appropriate counseling and information to protect themselves from HIV.</p> <ul style="list-style-type: none"> – For female sex workers, gender norms that paint sex workers as immoral are used to justify violence against them, increasing HIV risk due to sexual assault. – For women who inject drugs, imbalances in power mean they often inject after men, making them more likely to be the receptive partner in sharing needles or syringes. – Trans women are often poorly understood by KP programs that conflate them with men who have sex with men or do not mention them at all; this can make it difficult for trans women to find HIV prevention programs that are welcoming and meet their needs, limiting their access to services and information. <ul style="list-style-type: none"> • Emphasize: Within any culture, some gender norms can cause harm when people conform to them and when people are punished or marginalized for not conforming. For key populations, we see that the negative impacts of gender norms can be quite severe and include an increased risk for HIV infection. 	
<ul style="list-style-type: none"> • Show slide and explain: When an individual or group is perceived to be acting in a way that doesn't conform to gender norms, they may experience stigma. Strong negative feelings about a person, group, or trait is called stigma. • When KP members, or others, are stigmatized, that is, they are shamed or disgraced because of their behavior, it's easy to see them as "less than" others and not valued as human beings that deserve respect. • Many people have been taught to stigmatize others; to judge or devalue others because they are seen as somehow outside of the norm. • Many people use gender norms to decide what is "normal" and then feel comfortable judging those who fall outside of these categories or norms. • When we do this, we are stigmatizing others. • And, when people are stigmatized by others, it makes them more vulnerable to discrimination and violence, as well as other human rights violations. 	<p>What is stigma?</p> <ul style="list-style-type: none"> • Stigma is shame or disgrace directed at someone perceived as socially unacceptable or not conforming to norms. • Stigma refers to the strong <i>negative feelings or disapproval</i> that is linked to a specific person, group, or trait. <hr/>

<ul style="list-style-type: none"> • Explain: Let's talk about the direct link between rigid gender norms, stigma, discrimination, and violence. • We just talked about what we mean by stigma. • Let's look at a definition for discrimination. • Show slide and review the definition. • Explain: We can think about stigma as being the negative feelings or beliefs toward a person or a group, and discrimination as the actions or behaviors taken as a result of stigma. 	<p>What is discrimination?</p> <p>Discrimination is when a person or group of individuals is <i>treated</i> unjustly or unfairly because of a specific trait they possess.</p>
<ul style="list-style-type: none"> • Show slide and explain: Let's look at how rigid gender norms lead to stigma, discrimination, and violence. • The stigmatization process starts with labeling differences—for example, HIV status. • Then attributes are associated with the status. (Someone with HIV is immoral; is promiscuous.) • We use those labels to separate ourselves. (I'm not like that. I'm a good person. He is not.) • And the person who is separated from the others now has lower status and is much more likely to experience discrimination. 	<p>Stigmatization process</p> <pre> graph TD A["DISTINGUISHING AND LABELING DIFFERENCES (HIV status)"] --> B["ASSOCIATING NEGATIVE ATTRIBUTES (immoral, promiscuous)"] B --> C["SEPARATING 'US' FROM 'THEM' (isolate physically and socially)"] C --> D["STATUS LOSS AND DISCRIMINATION (denial of family support, denial of health care, violence)"] </pre> <p>Source: Link & Phelan, 2001.</p>
<ul style="list-style-type: none"> • Show slide and explain: So how does this relate to gender norms? When we're talking about gender norms, we are talking about the use of gender norms to distinguish differences. "See that girl over there; she has sex with a lot of guys. She isn't acting the way a woman should." • What do you say about her? It's very likely we say the same things that are sometimes said about a person living with HIV. "She's immoral. She is promiscuous." • And we see how quickly stigma results in discrimination and violence, particularly when KP members are perceived as "less than" others and not human beings that merit respect. • And we also see how closely connected gender-related and HIV-related stigma can be. 	<p>Stigmatization process with gender norms</p> <pre> graph TD A["DISTINGUISHING AND LABELING DIFFERENCES using gender norms (HIV status - 'she doesn't 'act like a lady')"] --> B["ASSOCIATING NEGATIVE ATTRIBUTES (immoral, promiscuous)"] B --> C["SEPARATING 'US' FROM 'THEM' (isolate physically and socially)"] C --> D["STATUS LOSS AND DISCRIMINATION (denial of family support, denial of health care, violence)"] </pre>

<ul style="list-style-type: none"> • Show slide and explain: One way that stigma can manifest is violence. When violence is directed at someone because of biological sex, gender identity, or the idea that the victim doesn't conform to gender norms, we use the term "gender-based violence" or GBV. • There are many working definitions for GBV. Let's look at the definition used by the U.S. President's Emergency Plan for AIDS Relief (PEPFAR). • One of the most important things to note here is that GBV doesn't only affect women and girls. • The other important thing to note is that it is rooted in power differentials. When someone has less power—including because they are discriminated against and excluded—they are much more vulnerable to violence. • Review definition on slide. 	<p>Gender-based violence (GBV)</p> <p>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. GBV is rooted in gender-related power differences, including social, economic, and political inequalities.</p> <hr/>
<ul style="list-style-type: none"> • Ask: How might the effects of stigma be felt for KP members looking for help from health care workers? • Here is one example: <ul style="list-style-type: none"> – Imagine that I am a health care worker who believes men should only have sex with women. – A service user comes to my clinic with anal warts and discloses he has a male partner. – Because of my belief that men should only have sex with women (a gender norm), I believe he is not acting like a man should act. – Because of this, I feel he is shameful and disgraceful. – Because I think he is disgraceful, I see him as less valuable as a human being. – Because I don't value him, this guides my behavior. – I tell him the clinic has limited resources and there are more deserving service users. – Even though I know that he may be at risk for HIV, I do not offer a test or test for other STIs. Instead, I tell him to leave. • So, we see that negative opinions about gay men and other men who have sex with men, also called homophobia, are not just attitudes. When people with power, such as health care workers, have and act upon these attitudes, they can cause terrible harm. 	<p>What might this look like among health care workers?</p> <ul style="list-style-type: none"> • Belief: A health care worker believes that men who have sex with other men are not following the "rules." • Impact: A service user will not get the STI treatment he needs, which could ultimately result in death or other harms. The service user is unlikely to ever seek services from that clinic again and may tell others to avoid the clinic. This will affect the clinic and its health care workers' ability to improve the health status of the communities they serve. <hr/>

- Ask: **What is likely to happen once this man is turned away?**
- Give time to brainstorm; then click and review the impact. Note that the service user will not receive the services he needs, could go on to acquire and/or transmit HIV, and may also experience a poor mental health outcome due to the health care worker's abusive treatment. In addition, not only is he very unlikely to come back and seek services at that clinic, his poor treatment may also result in a larger community of individuals being unwilling to seek services at that clinic or any other if they believe all health care workers will engage in the same type of discriminatory behaviors. All of these results prevent health care workers from serving their purpose effectively.

[Note to the facilitator: Speak to health care workers and KP members during the training adaptation process to determine if this example is relevant in their setting. If not, replace this example with one that commonly occurs in their context.]

- **Gender norms are just one reason that stigma and discrimination may occur. What are some other characteristics such as disability, age, race that you have seen impact the way people might be treated if they seek services from health care workers?**
- Ask the group to come up with a list of characteristics that might affect how individuals are treated if they come in to report violence or any other crime.
- Then click to show the list on the slide.
- Note that: **Society's views of different groups or individual characteristics are likely to affect the services that health care workers provide and make it difficult to ensure that all people have access to health care. Access to health care can be especially difficult for an individual with many marginalized identities—for example, a sex worker who cannot read and is from a minority ethnic group. Recognizing that the same biases and stigmas that may negatively affect how health care workers treat someone are also increasing that person's risk of violence, we see how important it is for health care workers to be prepared to provide services to those who are most vulnerable.**

Discussion: What characteristics may affect services received?

- | | |
|------------------------------|---------------------------|
| • Biological sex | • HIV status |
| • Gender identity/expression | • Socioeconomic class |
| • Sexual orientation | • Drug use |
| • Sexual behavior | • Religion |
| • Age | • Occupation |
| • Race/ethnicity/tribe | • Education/literacy |
| • Disability | • Nationality/citizenship |

[Note to the facilitator: This is a superficial overview of many issues that could, by themselves, be the basis of much longer trainings. This training is not able to go into depth on these issues, and additional trainings should be arranged as needed.]

- Click to show the title of the slide.
- Finally, let's do an activity to help us think through our own beliefs a bit more. In this activity, you and a partner are going to have to make a difficult choice. Before I tell you about your task, we need to have a common understanding of a drug that can help prevent HIV infection. That drug is called post-exposure prophylaxis or PEP for short. Does anyone know what PEP is?
- After taking answers, click to show the first bullet. As needed, explain that PEP can prevent HIV infection. It is for emergency use. For example, if someone who is HIV negative is exposed to HIV because they are forced to have sex without a condom, that person could take PEP to help prevent HIV acquisition. PEP should be started as soon as possible, and always within 72 hours of exposure.
- Click to reveal the second bullet and say: **Imagine you are the health worker in charge at your health facility one night. Five people are there, and each is a candidate for PEP. You only have enough for one person and must decide who you will give it to. Read each person's story and, with your partner, decide who will be given PEP. One person in your group should be prepared to share your choice and explain your reasoning.**
- Instruct people to pair up with the person next to them. Give each pair [Exercise Card 2: The Last Post-Exposure Prophylaxis](#) and then allow 5–10 minutes for pairs to decide on an answer. Have each group share their response and rationale.
- After everyone has shared, click to reveal the last bullet and say: **There is no one right answer to this activity. But who we choose to help can help us recognize our own values and biases. Often, we subconsciously, or consciously, decide that we're going to help the person who seems most deserving according to our views of the world. This can prevent us from making the decision that is**

Activity: The last post-exposure prophylaxis (PEP)

- PEP is a drug that can prevent HIV infection. It must be initiated within 72 hours after the potential exposure.
- Imagine you are the health care worker in charge at your health facility. There are five service users who all entered at the same time. Read about each of them, and in your small group, decide which one will be given PEP. Be prepared to share and explain your response.
- There is no one right answer. But this activity can help you identify any biases that you may have. Ask yourself how you made your decision. Did you consider who was most likely to have been exposed to HIV or **something else**?

most logical and most helpful. Decisions about PEP are ideally based on the risk of HIV exposure. Thinking back to the prevalence rates we saw earlier [have available the data that you presented in Module 1 on HIV prevalence in the country], all of the perpetrators are not equally as likely to be living with HIV. In this situation, considering the likelihood of exposure based on HIV prevalence rates among different populations should be part of any decision made. Being aware of your own biases can help you know when they might be affecting your decisions.

[Note to the facilitator regarding PEP: In [country], national guidelines may dictate that PEP is only available to those exposed to HIV occupationally; for example, a health care worker who is stuck by a needle when taking a sample of blood. However, in some places, health care workers are part of delivering PEP to victims of sexual assault and it's beneficial for them to know of its multiple uses. PEP may also be confused with pre-exposure prophylaxis (PrEP). An easy distinction is that PrEP is taken in advance of a potential exposure; PEP is only administered after a potential exposure and is for use in emergencies. In some cases, participants may explain they selected a specific service user because they believed that person was most likely to complete PEP's 28-day course. You can let participants know you will be talking about PEP in more detail in Module 3 and it's useful to think about any personal biases that may lead them to believe only some of the service users would complete the full course of the drug.]

[Note to the facilitator regarding use of the word "rape" in the scenarios: Participants may notice that in some of the scenarios the word "rape" is used. In others, it is not. However, all the scenarios describe rape (non-consensual penetration of the vagina or anus). Misconceptions about who commits rape (e.g., only strangers) and about consent (e.g., that someone who is unconscious can consent to having sex), laws that define rape as limited to vaginal penetration, or even the erroneous belief that sex workers cannot be raped can affect our beliefs about who deserves services. If participants bring up this difference between scenarios and there is time to discuss this

<p><i>topic, discussions of language and the impact of language on our biases can be an important conversation.]</i></p>	
<ul style="list-style-type: none"> • Ask participants to reflect on why they are proud to be health care workers. Summarize the responses from the flip chart titled “Why I’m proud to be a health care worker.” Emphasize the answers that show a commitment to meet the needs of their community and/or to help people who are the most vulnerable. • Ask: <i>Knowing that we have our own values and biases, how can we ensure that all service users are able to benefit from our commitment to serve others?</i> 	<p>Activity: The last PEP (debrief)</p> <p>Knowing that we have our own values and biases, how can we ensure that all service users are able to benefit from our commitment to serve others?</p> <hr/>
<ul style="list-style-type: none"> • In summary, we form opinions about others in many ways, including whether someone is following “rules” about gender. These “rules” vary over time and across cultures and many of the foundations for these beliefs—such as that all people are born male or female—are not actually supported by science. • Our opinions of others—which can also be based on race, class, religion, etc.—can affect how we treat them, and health care workers’ opinions and actions determine who has access to health care. • We need to be aware of our biases and act in a way that allows all people to access our vital services. • Are there any questions or observations before we keep going? • End by saying that this session has focused on individuals interacting with other individuals, but that other factors—such as laws and policies—also have an important impact. These will be discussed in detail in later sessions. 	<p>Questions and reflections</p> <hr/>

Session 2.3: Understanding Violence against Key Populations (Characteristics, Perpetrators, Causes, Consequences)

Time: 60 minutes

Materials

- Slide presentation
- Flip chart and markers
- [Exercise Card 3](#): Amanda's Story

Planning Ahead

If you are able to give more than 60 minutes to this session, consider including one or more videos in which KP members describe their own experiences of violence. The video *Romeo: Sensitize health care workers to end stigma towards sex workers* (1:55 minutes) about the experience of a male sex worker at a health facility is one example. The video *Melissa: Engage police officers to end violence against sex workers* (2:15 minutes) about a sex worker's experience of violence from law enforcement is another example.

- Explain: In this session, we will deepen our understanding of violence experienced by KP members including common types, perpetrators, causes, and consequences—particularly direct links to HIV.

SESSION 2.3

Understanding Violence against Key Populations (Characteristics, Perpetrators, Causes, Consequences)

- Show slide and ask a participant to read each objective out loud.

Objectives

- Describe how stigma and discrimination based on gender can result in violence
- Identify common types of violence experienced by KP members and perpetrators of that violence
- Explain the link between violence and HIV

- Show slide and explain: As health care workers, you are all aware of violence that occurs locally. We want to start this session by hearing from you about common types of violence here, especially violence against members of key populations. Elicit responses.
- It's likely the case that most of the examples given are of physical and sexual violence. Depending on whether this is the case, you can say: Many of you gave examples of physical violence (kicking, hitting, biting, use of a gun) and sexual violence (rape and other sexual assault). These are the kinds of violence that we usually focus on. But these are not the only types that occur, and they are not always the most damaging, even if they are the most visible.
- Click slide again and review each type of violence.
- Explain: To think more about violence against key populations and its impact, we're going to read and discuss a story.

Types of violence

- **Emotional:** humiliation, threats, making someone feel worthless or afraid
- **Physical:** hitting, kicking, choking, use of a weapon
- **Sexual:** unwanted groping, forced sex (including sex without a condom)
- **Economic:** theft, not paying someone what is due to them, refusing to pay for a child's basic needs
- **Other human rights violations:** refusing services to someone, taking their condoms/injecting equipment, arbitrarily detaining them

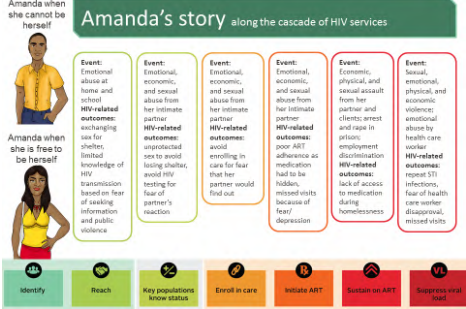
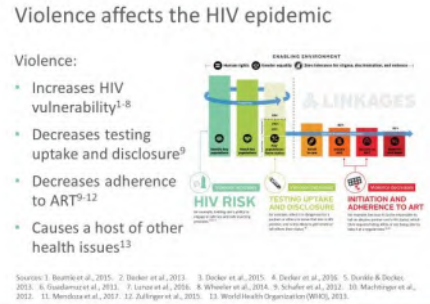
- Show slide and explain: In your groups, you are going to read a story of a trans woman named Amanda. As we discussed, a transgender woman is a person who was assigned male at birth—the doctor said, “it’s a boy”—and who identifies as a woman.
- Click slide again to show Amanda when she can be herself and when she cannot be herself.
- Explain: Here you can see an image of Amanda when she is free to be who she really is, as well as when she does not feel safe being who she really is.
- Distribute [Exercise Card 3: Amanda’s Story](#) and explain either (1) as a large group, you are going to read the story aloud, paragraph by paragraph, or (2) each small group is going to read it once they come together. If literacy levels are low, read the story as a large group.
- Once you have given instructions or read the story out loud as a group, break participants into small groups (of no more than five to six) and assign one question to each. If you have more than four groups, have multiple groups answer the same question (i.e., both group 1 and group 5 could answer question 1). Ask them to write their answer on a large piece of paper and select someone to present back to the large group.

Activity: Amanda’s story

- Read Amanda’s story together.
- In small groups, answer your group’s question on a large piece of paper.
- Select one person to present your answers back to the group.



<ul style="list-style-type: none"> • Give everyone 15–20 minutes to answer their question. If they will also be reading the story in their small groups, allow 30–35 minutes for the small group work. 	
<ul style="list-style-type: none"> • After everyone has time to answer their questions, have groups come up and present their answers. If more than one group answered question 1, have both groups present their answers before going to question 2. • In case it is necessary for the facilitator to share examples or elaborate on answers, please refer to the examples below. <p>Example answers to question 1 include:</p> <p>Amanda’s HIV vulnerability increased when:</p> <ul style="list-style-type: none"> – Her parents kicked her out; she had to engage in transactional sex to have a place to live. – Edward refused to wear a condom; she was at risk for HIV infection. – She was raped by the other inmates at the prison. <p>Amanda’s HIV treatment was affected when:</p> <ul style="list-style-type: none"> – She could not get tested due to fear of Edward. – She had to hide her medication. – The nurse made her feel that she was irresponsible. <p>Example answers to question 2 include:</p> <ul style="list-style-type: none"> – Emotional: parents said they would rather have a dead son than a gay son; Edward is constantly berating and threatening Amanda; nurse berates her – Sexual: rape; forced to have sex without a condom – Physical: beaten by Edward; students threw objects at Amanda – Economic: kicked out of her home; cannot finish school because parents refuse to support her – Other human rights violations: police arrested her for having condoms and lubricant; police do not ensure her safety while she is detained <p>Example answers to question 3 include:</p> <ul style="list-style-type: none"> – Parents and family – Edward – Other inmates – Police – Daniel 	<p>Questions (one question per group)</p> <p><u>Question 1:</u> Describe at least three times that violence increased Amanda’s vulnerability to HIV infection. Describe at least three times that violence affected her access to HIV treatment.</p> <p><u>Question 2:</u> Describe the violence that Amanda experienced, giving at least two examples of each type: emotional, sexual, physical, economic, and other human rights violations.</p> <p><u>Question 3:</u> List all the perpetrators of violence. Decide which perpetrator had the most dramatic negative impact on Amanda’s life and explain your answer.</p> <p><u>Question 4:</u> Think about all the consequences of the violence Amanda experienced. Make a list of the consequences of each form of violence.</p> <hr/>

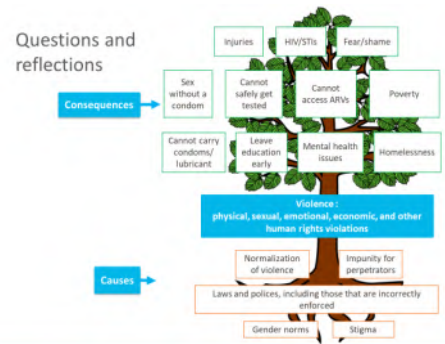
<ul style="list-style-type: none"> – Men who come to Daniel’s house – Nurse <p>There is no correct answer to who had the biggest negative impact on her life. However, it’s likely that some groups will choose parents and family, police, or nurse. These individuals are in the position to cause the most harm because they should be providing protection to the most vulnerable, like Amanda.</p> <p>Example answers to question 4 include:</p> <ul style="list-style-type: none"> – Emotional: fear, sleeplessness, anxiety, depression; is not able to take care of her health; suicidal – Sexual: HIV, STIs – Physical: concussion – Economic: homelessness, poverty – Other human rights violations: cannot protect herself in sex work (cannot carry condoms and lubricant), severe abuse in jail 	
<ul style="list-style-type: none"> • After everyone has presented, say: As this training looks at how violence and HIV are related, I want to take a moment to look at Amanda’s story using the HIV prevention, care, and treatment cascade. • Click slide repeatedly to show how different events affected each aspect of the HIV prevention, care, and treatment cascade. Read over each one before advancing to the next. 	 <p>Amanda's story along the cascade of HIV services</p> <p>Identify: Amanda when she cannot be herself. Event: Emotional, economic, and sexual abuse at home and school. HIV-related outcome: exchanging sex for shelter; limited knowledge of HIV transmission based on fear of seeking information and public violence.</p> <p>Reach: Amanda when she is free to be herself. Event: Emotional, economic, and sexual abuse from her intimate partner. HIV-related outcome: unprotected sex to avoid losing shelter; avoid HIV testing for fear of partner's reaction.</p> <p>Key populations know status: Event: Emotional, economic, and sexual abuse from her intimate partner. HIV-related outcome: avoid enrolling in care for fear that her partner would find out.</p> <p>Enroll in care: Event: Emotional, economic, and sexual abuse from her intimate partner. HIV-related outcome: poor ART adherence as medication had to be hidden; missed visits because of fear/depression.</p> <p>Initiate ART: Event: Emotional, economic, and sexual abuse from her intimate partner and clients' arrest and rape in prison; employment discrimination. HIV-related outcome: lack of access to medication during homelessness.</p> <p>Adhere to ART: Event: Emotional, economic, and sexual abuse from her intimate partner and clients' arrest and rape in prison; employment discrimination. HIV-related outcome: missed STI infections; fear of health care worker disapproval; missed visits.</p> <p>Suppress viral load:</p>
<ul style="list-style-type: none"> • Show slide and explain: The story of Amanda showed us how HIV vulnerability increased due to violence, testing and ART use went down, and adherence to ART was much more difficult due to violence. This doesn't only happen in stories. We see the same thing reported in many studies, which you can see cited here. 	 <p>Violence affects the HIV epidemic</p> <p>Violence:</p> <ul style="list-style-type: none"> • Increases HIV vulnerability¹⁻⁸ • Decreases testing uptake and disclosure⁹ • Decreases adherence to ART⁹⁻¹² • Causes a host of other health issues¹³ <p>LINKAGES</p> <p>TESTING UPTAKE AND DISCLOSURE</p> <p>INITIATION AND ADHERENCE TO ART</p> <p>SOURCES: 1. Boulianne et al., 2015. 2. Dierker et al., 2013. 3. Dierker et al., 2015. 4. Dierker et al., 2016. 5. Dierker & Dierker, 2013. 6. Gaudamur et al., 2013. 7. Lounsbury et al., 2016. 8. Whetten et al., 2014. 9. Schuler et al., 2012. 10. Machingira et al., 2012. 11. Mendez et al., 2017. 12. Julligan et al., 2015. 13. World Health Organization (WHO), 2015.</p>
<ul style="list-style-type: none"> • Show slide and explain: Amanda’s story didn’t take place in only [country]. It is a real story taken from the experiences of trans women in many different countries. But we know there are a lot of Amandas all over the world. Let’s look briefly at what we know about violence against KP members, not just trans women, in [country]. 	<p>Violence against key populations in [Country]</p> <p>Insert country-specific information/statistics about violence against key populations in [country].</p> <p>Example slide from Malawi training:</p> <ul style="list-style-type: none"> • Many men who have sex with men in Malawi face increased levels of stigma and violence. <ul style="list-style-type: none"> – A 2010 study found that 4 percent of men who have sex with men were denied health care service based on sexuality, 3 percent were blackmailed because of sexuality, and 19 percent experienced a discrimination event. – Another study in 2013 study found that over 20 percent of men who have sex with men had experienced some form of stigma and 11.4 percent had experienced homophobic violence. • Stigma and violence experienced among men who have sex with men can be responsible for difficulties in going for an HIV test, seeking HIV services, and disclosing HIV status.

- Show country-specific slide(s) and review content. Describe where the data come from and ask if there are any questions.

[Note to the facilitator: As much as possible, the data you present on violence should have citations. If you have data on violence committed by law enforcement, make sure you can describe how the information was collected and when. If questions come up from participants, offer to look into the sources further, but stress that one of the most important ways to change behavior is to acknowledge what is actually occurring.]

[Note to the facilitator: You may wish to draw this tree on a poster to hang on the wall so that it can be referred to and added to throughout the training.]

- Show slide and explain: We've covered a lot in this session, and sometimes it's helpful to have a visual representation to remember all we've learned. For this question and reflections, we're going to look at a problem tree that is a visual representation of Amanda's story. It shows the underlying causes of violence (the roots), the types of violence (the trunk), and the consequences of violence (the branches/leaves). You've described the branches and the trunk in the group answers, so I want to spend some time on the roots. Many of the roots of violence are revealed in Amanda's story; for example:
 - Gender norms/stigma based on gender norms: Amanda's parents' rigid gender norms lead them to kick her out of the house when they believe Amanda is gay.
 - Stigma against people living with HIV: Edward attacks Amanda because he finds her antiretroviral medicines (ARVs).
 - Laws: Like those that allowed Amanda to be arrested for carrying condoms and then held in a cell with male inmates.
 - Normalization of violence: Amanda's friends and Edward say his abuse is just a sign of love.
 - Impunity for perpetrators: Edward tells Amanda the police won't help someone who is transgender; Amanda is afraid to ask the police for help when she is being raped.



- In closing, you now have a sense of what violence looks like in the lives of KP members, including how health care workers' actions could increase violence. You'll have the opportunity to hear more from KP members during a panel that occurs [insert time], and you'll also have time to ask them questions.
- You also have a better sense of how the HIV epidemic is affected by violence and why you, as health care workers, are such an important part of an effective HIV response. If we can't stop violence and can't get support to those who experience it, we won't have an effective response to the HIV epidemic.
- Finally, you now have a sense of the consequences of violence, so we can think about the services victims need and how to link them to care. We'll continue to talk about this throughout the training so that you feel comfortable making referrals to other institutions since no one organization can do everything.
- Ask if there are any questions before closing the session.


[Note to the facilitator: Time permitting, you may consider showing a video or videos at this point. Introduce the video(s) by saying they are an opportunity for KP members to describe their experiences and needs in their own words. If you do show one or more videos, make sure to include time for participant reflection on the content.]

Session 2.4: Focus on Intimate Partner Violence

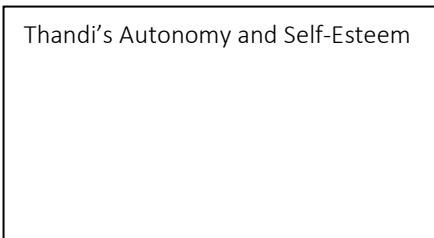
Time: 30 minutes

Materials

- Slide presentation
- Flip chart and markers
- [Exercise Card 4](#): Thandi's Story

<ul style="list-style-type: none"> • Show slide and explain: In the previous session, we talked about different perpetrators of violence. In many contexts, spouses/partners and ex-spouses/partners make up the majority of perpetrators of violence against KP members. In this session, we will focus on intimate partner violence (IPV). 	 <p>Session 2.4 Focus on Intimate Partner Violence</p>
<ul style="list-style-type: none"> • Ask a participant to read each objective out loud. 	<p>Objectives</p> <ul style="list-style-type: none"> • Recognize the ways in which intimate partner violence (IPV) can evolve over time • Discuss the importance of responding to all victims of IPV in a nonjudgmental way • Discuss IPV among KP members and identify additional barriers to support that they may face when experiencing IPV
<ul style="list-style-type: none"> • Show slide and explain: Intimate partner violence is a form of gender-based violence. Here is what we know about IPV among both the general population and key populations in [country]. • Common myths and misconceptions about IPV include the belief that men cannot be victims of violence, and violence does not occur in same-sex relationships. However, people who identify as lesbian, gay, or bisexual have an equal or higher prevalence of experiencing IPV as compared to heterosexuals in the U.S., and IPV against KP members is common globally. • Because health care workers are such important responders to incidents of IPV, we want to spend some time talking about IPV specifically. While understanding the needs of victims of IPV and linking them to care has always been important for health care workers, the demand for addressing 	<p>Intimate partner violence in [Country]</p> <ul style="list-style-type: none"> • IPV is ongoing or past violence by an intimate partner or ex-partner. It is common in the general population and among key populations.¹⁻⁵ • Here is what we know about IPV in [country]. • [Country team to add data on IPV in their country including both general population and key population figures as available. If this was covered in session 2.4, do not repeat the statistics here; rather, review the definition of IPV before moving to the next case study.] <p><small>Sources: 1. El-Bassoufi et al., 2007. 2. Panchanathan et al., 2008. 3. Freeman & Stephenson, 2013. 4. McKay et al., 2017. 5. Valleron et al., 2017.</small></p>

<p>IPV against people living with HIV is greater than ever.</p> <p><i>[Note to the facilitator: Please include information here on local statistics regarding IPV among the general population. If you have results specific to key populations, share those as well. Participants may question how one man could abuse another man when they have similar physical strength. If this question comes up, it's important to remind participants that IPV is about power, and power is not only physical. You can also use Thandi's story to help illustrate that violence takes many other forms that do not require physical strength.]</i></p>	
<ul style="list-style-type: none"> • Show slide and explain: Demand for health care workers who know how to address violence is growing because more facilities are implementing partner notification (also called index testing and voluntary partner referral)—an approach that asks a person who is HIV positive (the “index” service user) to provide the names and contact information of their sexual and needle-sharing partners. In the process of partner notification testing, one required step is asking the index service user about violence from any of those partners. • As part of the scale-up of partner notification, advocacy organizations recommend that referral to IPV services be reasonably available in all facilities where index testing occurs.⁴³ If IPV services are not reasonably available to the index service user, including services that don't cater to the service user (e.g., IPV services for men who have sex with men), index testing should not be implemented in that facility until IPV services are available. • If someone discloses violence, this information should help determine which partner notification service is most appropriate or whether to proceed with partner notification at all. The health care worker can explain the options and note any safety concerns, but the decision ultimately rests with the service user. Remember to prioritize doing no harm, a concept we will discuss further in a later session. • Importantly, remember that just asking about violence alone does not guarantee the safety of 	<p>Index testing</p> <ul style="list-style-type: none"> • The index testing approach, also called partner notification, involves asking a person who is HIV positive (the “index” service user) to provide the names and contact information of their sexual and needle-sharing partners. • One required step is asking the index service user about violence from any of those partners. • Information about violence should be used to determine which partner notification approach is most appropriate or whether to proceed with partner notification at all. <u>The ultimate decision lies with the service user.</u> <p><small>Source: WHO, 2016.</small></p>

<p>index service users. As such, standards for tracking the safety of an index test service user and documenting adverse events are urgently needed.⁴³</p>												
<ul style="list-style-type: none">• Hang a piece of flip chart paper turned horizontally and draw a large empty box. (It will look like Figure 1.)• In this activity, you will read a set of numbered statements. Each time you read one, draw a line inside the box. The lines represent a reduction in Thandi’s autonomy and self-esteem. At the end, you will have a drawing that looks like Figure 2.• Explain: <i>In this next activity, we will explore autonomy and self-esteem in intimate partnerships by looking at a case study. This case study is about intimate partner violence against someone who is not a KP member. We will talk about some of the barriers that any victim of violence may experience. Then we’ll transition to think about what this would look like in KP members’ lives.</i>• Use Exercise Card 4 to read Thandi’s story to the participants.	<p>Activity: Thandi’s story</p> <p>Thandi is a young woman from [a local city]. She is intelligent, funny, kind, and beautiful. She has a supportive family and is good at her job. She has a lot of friends, especially colleagues from work. They respect her and know she will go on to do great things.</p> <p>She meets John and they fall in love. They get married and move in together. This blank flip chart paper represents Thandi, her autonomy (ability to act on her own), her self-esteem, and the wide range of possibilities she feels her life holds. Watch and listen as we describe what happens next between Thandi and John.</p> <p>Figure 1. At the start of the activity, the page will be blank like this</p> <div><div>Thandi’s Autonomy and Self-Esteem</div></div> <p>Figure 2. When the activity is completed, the page will look like this</p> <div><div>Thandi’s Autonomy and Self-Esteem</div><table><tr><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td></tr></table></div>											
<ul style="list-style-type: none">• After finishing the story, show slide and discuss the following questions one by one (each click will cause the next question to come onto the screen).• For question 1, be sure to discuss:<ul style="list-style-type: none">– It could help Thandi to hear that she does not deserve to be treated the way John is treating her and that it is wrong for anyone to commit this type of abuse. Why?<ul style="list-style-type: none">▪ Her self-esteem is likely already decreased from the emotional abuse she has experienced. She may have begun to believe she deserves John’s abuse.▪ Thandi may feel that John’s abuse is a normal way for men to act toward women and that she should be able to live with this	<p>Activity: Thandi’s story (debrief)</p> <ol style="list-style-type: none">1. What kind of support would Thandi benefit from? Why?2. What would happen if Thandi got up the courage to report John to the police, and an officer responded, “It was just a small slap! Why are you making such a big deal of this?”3. Sometimes people reading about others experiences of IPV say, “I would leave the first time someone was violent toward me.”<ul style="list-style-type: none">– When did John actually “become violent” in this story?– Why might it be difficult for Thandi to seek help by the time he used physical violence?– What might happen if Thandi tries to leave?											

<p>kind of treatment. Knowing that such behavior is abuse can help Thandi understand why she feels so bad, instead of judging herself harshly for any anger or sadness she feels.</p> <ul style="list-style-type: none"> – It is important for Thandi to know what kind of help is available. Why? <ul style="list-style-type: none"> ▪ She may feel that she has no options, especially since she is no longer employed and her social network is greatly reduced. ▪ She may not realize that many people experience intimate partner abuse and that help exists. – It is important for Thandi to know that others care about her and will support her choices. Why? <ul style="list-style-type: none"> ▪ Thandi may feel embarrassed of the abuse or guilty about losing contact with her friends and family. ▪ Thandi will benefit from having control returned to her after John took so much of her independence and autonomy. • For question 2, explain that this would likely mean Thandi does not come forward again. She will have gotten the message that John’s behavior is acceptable, and it’s her response that is wrong. • For question 3, mention that emotional violence is often reported by victims as more damaging than physical or sexual violence. These forms of violence often occur together, yet we almost always talk about violence as simply physical or sexual, and a victim of violence may not recognize controlling behavior or other emotional abuse as violence. Also mention the stigma against victims of violence and how this stigma makes it difficult for someone to disclose that they are experiencing violence. Finally, explain that victims are most at risk of being killed by an abusive partner when they try to leave, so it’s likely that walking away from John will not be as simple as it may seem. 	
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- Show slide and explain: Anyone who experiences IPV and wishes to receive support should be able to access that support. And it may be very difficult for Thandi to get support, especially if IPV is considered normal where she lives.
- A KP member in Thandi's position may have even more difficulty accessing support because of the stigma we already spoke about. Health care workers and others may see a sex worker as deserving abuse from her partner or may not believe that violence between two men is possible or may not recognize the unique forms that it may take. For example, in a same-sex relationship psychological abuse may manifest as threats to "out" the victim's sexual orientation.
- But, as we understand, no one deserves violence, and everyone should be able to access support, regardless of their identity, their occupation, their drug use, or who they are attracted to.
- Thandi also began with more resources and support than many KP members might have because of stigma (think about Amanda in comparison).
- Finally, some KP members are not covered by IPV-related laws. For example, in some countries only cisgender women can legally be victims of domestic violence. In this case, men or trans women who have abusive partners may not have access to the full range of services (such as protective orders) that a cisgender woman would.

[Note to the facilitator: In some circumstances, there may be disbelief that IPV can occur between two men. Participants may believe that men have similar physical strength and, therefore, violence cannot occur between them. If IPV in same-sex couples is questioned, share the statistic that while IPV in same-sex couples and trans couples is rarely measured, when it is measured it is as common or more so than violence in heterosexual couples. You can also note that in Thandi's case, as in many cases of IPV, the abuse takes forms that are not dependent on physical strength. Almost all the abuse that Thandi experiences is psychological].¹⁷

Discussion: What about in the case of key populations?

- IPV is a complex and difficult issue for anyone.
- In some ways Thandi is more likely to receive support than a member of a key population.
 - She began with more resources, self-esteem, and support than many members of key populations would.
 - She would be considered a "sympathetic victim" by many authorities who are accustomed to stories like Thandi's.
 - Laws about IPV may only apply to women in heterosexual relationships, excluding some members of key populations.

- Close the session by saying that IPV is incredibly common and can happen to anyone. Whenever someone has the courage to come forward, they should be supported. Ask if there are any final reflections before moving to the next session.

[Note to the facilitator: Individual health care workers may also be experiencing violence from an intimate partner. Consider sharing information at this time, as well as later, about where help can be accessed. If it's possible to have a trained psychologist attend the training, remind participants that the psychologist is available to talk to as needed, and they can take the space they need to take care of themselves at any time].

Questions and reflections

Session 2.5: Legal and Policy Obligations, Opportunities, and Barriers in the Local Context

Time: 60 minutes

Materials

- Slide presentation
- Flip chart and markers

Planning Ahead

This session should be organized prior to the training. It should be facilitated by an allied lawyer who is familiar with national-level law and policy documents on violence, such as those that (1) govern the health system's support to victims of violence including in the case of sexual violence and (2) identify violence and victims and perpetrators of violence.

See the green text on the slide presentation to consider the specific information the lawyer should be able to speak to. If the lawyer is not able to answer any of the questions—particularly “What violence response services are specified in the essential package of health services?”—ask that a senior health official co-present this session to address these questions.

- Explain: In this session, we have a local lawyer here who can help all of us understand some of the ways that laws and policies can either support or impede KP members' access to violence response services.

SESSION 2.5 Legal and Policy Obligations, Opportunities, and Barriers in the Local Context

- Show slide and ask a participant to read each objective out loud.

Objectives

- Understand policies and protocols that describe the health sector's obligation to and processes for providing care to victims of violence, including members of key populations
- Identify the legal opportunities and barriers to support faced by KP members who are victims of violence

<p><i>[Note to the facilitator: The slide in green was designed to help you contact a lawyer who will give this session. The questions were informed by Job Aid 2.2 and 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.²³ You will not use this slide in the final presentation; replace it with slides needed for the session.]</i></p>	<p>The slides used here will be provided by a local lawyer</p> <p>Overall, the lawyer's presentation should cover:</p> <ol style="list-style-type: none"> 1. What forms of violence are criminalized in [Country]? 2. What are the obligations of the health system in addressing violence? 3. What are legal barriers to addressing violence in the health system? 4. What national or subnational policies and plans are there for a multisectoral or a health system specific response to violence? 5. What violence response services are specified in the essential package of health services?
<p><i>[Note to the facilitator: The slide in green was designed to help you contact a lawyer who will give this session. The questions were informed by Job Aid 2.2 and 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.²³ You will not use this slide in the final presentation; replace it with slides needed for the session.]</i></p>	<p>The slides used here will be provided by a local lawyer</p> <p>Laws and regulations</p> <ul style="list-style-type: none"> • Are there criminal law provisions related to violence against KP members (for example, in the penal code of the country)? • Are there laws protecting KP members from intimate partner or domestic or family violence? • Are there laws related to sexual violence including rape and child sexual abuse?
<p><i>[Note to the facilitator: The slide in green was designed to help you contact a lawyer who will give this session. The questions were informed by Job Aid 2.2 and 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.²³ You will not use this slide in the final presentation; replace it with slides needed for the session.]</i></p>	<p>The slides used here will be provided by a local lawyer</p> <p>Laws and regulations</p> <ul style="list-style-type: none"> • Are there court orders and regulations that protect women subjected to the violence from violent partners or stalkers? What about men? • Are there regulatory or policy barriers that limit access to emergency contraception for women subjected to sexual assault/rape? • Are there laws related to sexual violence and sexual harassment in the work place? Do they apply to men and women? Are there any special protections for KP members such as transgender people or men who have sex with men?
<p><i>[Note to the facilitator: The slide in green was designed to help you contact a lawyer who will give this session. The questions were informed by Job Aid 2.2 and 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.²³ You will not use this slide in the final presentation; replace it with slides needed for the session.]</i></p>	<p>The slides used here will be provided by a local lawyer</p> <p>Legal obligations of health care workers in relation to addressing violence</p> <ul style="list-style-type: none"> • Do laws specify provision of health care to survivors of IPV or sexual assault/rape? • Do laws or regulations mandate reporting individual cases of sexual assault/rape or IPV to the police? • Do laws mandate reporting data/statistics on violence to health or other authorities? • Which providers are authorized to perform forensic exams and provide testimony in court in cases of sexual assault/rape?
<p><i>[Note to the facilitator: If local laws require that health care workers report any form of violence to law enforcement, have the lawyer present this slide. The lawyer may choose to use the facilitator's notes below or speak on their own experiences but should use these two slides.]</i></p> <ul style="list-style-type: none"> • Explain: As I have mentioned, in some cases the law requires you to report what a service user tells 	<p>"How can I promise confidentiality if the law says I have to report to the police?"</p> <p><u>If your law requires you to report violence to the police, you must tell the victim this before they are asked to talk about their experiences of violence.</u> 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..."</p> <p>Assure the victim that, outside of this required reporting, you will not tell anyone else without their permission.</p>

<p>you to local authorities. Many health care workers correctly wonder what to do in this instance since sharing a service user's story without permission would break confidentiality and could cause harm to the victim. As a result, it is important that you tell someone any limits on confidentiality BEFORE you ask them about their experiences of violence.</p> <ul style="list-style-type: none"> At the same time, you should assure them that as long as you are not obligated legally to share something, you will not pass their information on to anyone else without permission. 	
<ul style="list-style-type: none"> Explain: It's important for us to stress that no one should be turned away from medical care because they do not wish to file a report. There are many reasons, including personal safety, that someone may not wish to report to the police or other local authorities. Please make sure to share this with service users so that they do not think they must report to receive your help. As stated in <i>Strengthening Health Systems to Respond to Women Subjected to Intimate Partner Violence or Sexual Violence: A Manual for Health Managers</i>: "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 health-care providers inform individuals of their legal rights and offer to report to the police, should the individual want this."³⁶ This is not only applicable to women but to any person who experiences IPV or sexual violence. 	<p>Remember</p> <ul style="list-style-type: none"> Everyone has the right to receive medical care and treatment, regardless of their decisions about whether to file a report with law enforcement. Health care workers should emphasize that service users do not have to agree to file a report to receive medical care and treatment. Health care workers should inform victims of their legal rights and offer to report to the police, should the victim want this support. <hr/>
<p><i>[Note to the facilitator: If you are working with a specific facility, specialty, or position you may ask a senior health official to share the health care worker code of conduct and/or service user's rights charter from [specific facility, specialty, or position].</i></p> <p><i>The presentation should end with time to ask questions of the lawyer and any other presenters.]</i></p>	<p>Questions and reflections</p> <hr/>

Session 2.6: Panel Discussion with Key Population Members

Time: 60 minutes

Materials

- Slide presentation
- Flip chart and markers
- Table at the front where two to three KP members or community outreach workers can sit


Planning Ahead

This session should be organized prior to the training. KP panel participants should be identified in collaboration with KP-led community-based organizations, HIV program staff, and/or implementing partners. The panel's makeup should correspond to the populations that are the emphasis of the training (this could include men who have sex with men, people who inject drugs, sex workers, and/or transgender people). Ideally, the panel members will be representative of the diversity among key populations (e.g., age, race/ethnicity, gender, etc.).

When asked to participate, potential panelists should be briefed on the purpose of the panel and who is attending the training. Panelists should also be asked whether they would like to be identified as members of KPs (alternatively, they could speak as individuals working and familiar with a specific population) and how they would like seating to be arranged for the panel (e.g., would they like to be in the front of the room, should all chairs be arranged in a circle, etc.). If potential panelists have other requests, do your best to accommodate them while being honest about what is not possible and accepting that this may mean someone is unable to participate.

You may choose to use the provided questions in the slides or develop other questions with KP members that allow for a meaningful exchange. All panelists should have the opportunity to review the main questions in advance and be told that training participants will have other questions after the initial presentation. Panelists should also be told that they do not have to answer any question that they do not wish to.

Although the panel falls on the first day of the training, you may choose to wait and have this session before lunch on the second day. Let training participants know that this panel will occur and invite them to come up with questions in advance. Request that participants only ask questions that they themselves would be willing to answer (e.g., no questions about specific sexual behaviors, anatomy, etc.).

<ul style="list-style-type: none"> • Explain: We are excited to have a time during this training where members of the communities we've been discussing will speak about their own experiences. <p><i>[Note to the facilitator—you or another person should act as the moderator of the panel, helping to ensure that each panelist has time to speak and calling upon participants during the time for questions and answers.]</i></p>	 <p>SESSION 2.6 Panel Discussion with Key Population Members</p>
<ul style="list-style-type: none"> • Show slide and ask a participant to read each objective out loud. 	<p>Objectives</p> <ul style="list-style-type: none"> • Get to know the issues of violence affecting KP members • Understand KP members' perspectives and hopes regarding their interactions with health care workers
<ul style="list-style-type: none"> • Show slide and explain: One of the most important ways we can develop our understanding about violence against KP members is to hear from them directly. • In this session, KP members have agreed to share their experiences and recommendations with us. • We will ask each person to answer a set of questions to help us understand more about KP communities from their perspective. • Then, at the end, we'll have some time for the training participants to ask questions. Please remember that you should only ask questions that you yourself would be willing to answer about your own life. • Just a reminder to everyone: everything we hear in the training is confidential, and we should not share what we hear with others outside of the training. • After panel members have finished sharing their experiences, ask participants if they have any questions for the panelists. Remind panelists that they can choose not to answer any question. 	<p>Panel discussion</p> <ul style="list-style-type: none"> • What do you think is important for health care workers to know about your community? • What are the common types of violence against KP members? Who perpetrates this violence? • What do you wish health care workers would do to help and support your community when you experience violence?

- Close the session by thanking panelists again for their reflections and the health care workers for their attention.

[Note to the facilitator: If it's possible for the panelists to stay for lunch or another unstructured time, ask if they would be willing to answer any follow-up questions that individuals may have for them.]

Thank you!

MODULE 3:

Applying Principles and Building Skills

MODULE 3:

APPLYING PRINCIPLES AND BUILDING SKILLS

Introduction

This module improves health care workers' ability to handle the disclosure of violence and to create environments that foster disclosure. It also describes how service providers, including health care workers, can revictimize someone through an inadequate or hostile response to the disclosure of violence. Finally, health care workers are introduced to the recommended violence response services, including those addressing physical health (e.g., treatment of injuries, rapid HIV testing, PEP, emergency contraception, screening and treatment for STIs, mental health, and victim safety). Participants will also become familiar with referral options to meet the many needs of victims of violence and how to refer effectively.

This module includes the following sessions and learning objectives:

Session 3.1 Fundamental Principles of Violence Prevention and Response

- Describe each of the fundamental principles of violence prevention and response for health care workers and explain their importance, particularly when working with KP members

Session 3.2 Barriers to Disclosing Violence

- Recognize the barriers to disclosing violence for KP members, including victim blaming, and recognize victim blaming as counterproductive to health care's mission

Session 3.3 The Importance of Health Care Workers in Violence Prevention and Response

- Explain why it is important for health care workers to be part of violence prevention and response, especially to support KP members

Session 3.4 Asking about and Responding to Violence

- Describe the goal and steps of asking about violence, particularly for members of key populations
- Identify and practice skills to provide first-line support (LIVES) to individuals who disclose violence, particularly members of key populations

Session 3.5 Referring Effectively: Overview of Recommended Health, Social, and Justice/Legal Services and Improving Access to Each One

- List the services that should be offered to victims of violence and describe the importance of each
- Describe the process of referral for all available services
- Discuss which of these services KP members can safely be referred to

Session 3.6 Putting It All Together

- Practice asking about and responding to disclosures of violence appropriately

Session 3.7 Data Collection and Sharing

- Discuss the importance of documenting violence against KP members
- Identify practices for safe data collection and management in cases of violence

Session 3.8 Recap: Minimum Requirements to Ask about Violence

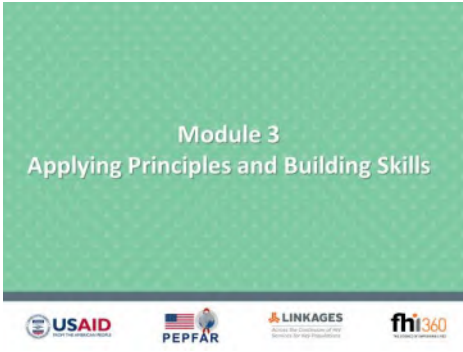

- Discuss the importance of the minimum requirements that must be in place before health care workers can ask about violence

Session 3.1: Fundamental Principles of Violence Prevention and Response

Time: 30 minutes

Materials

- Slide presentation
- Flip chart and markers
- [Handout 3](#): Fundamental Principles for Violence Prevention and Response Service Provision by Health Care Workers

<ul style="list-style-type: none"> • Show slide and explain: Now that we understand the issue, let's agree on some fundamental principles that help us to prevent violence and address it appropriately. 	 <p>Module 3 Applying Principles and Building Skills</p> <p>USAID PEPFAR LINKAGES fhi360</p>
<p><i>[Note to the facilitator: Before leading this session familiarize yourself with Handout 3: Fundamental Principles for Violence Prevention and Response Service Provision so that you can answer questions that may come up.]</i></p> <ul style="list-style-type: none"> • Explain: Let's talk about what to do when someone discloses violence. Before we get into the specifics, we have to think about the principles, or values, behind our actions. 	 <p>SESSION 3.1 Fundamental Principles of Violence Prevention and Response</p>
<ul style="list-style-type: none"> • Show slide and ask a participant to read the objective out loud. 	<p>Objective</p> <p>Describe each of the fundamental principles of violence prevention and response service provision and explain their importance, particularly when working with KP members</p>

<ul style="list-style-type: none"> • Show slide and explain: This training contains four fundamental principles of violence prevention and response. They provide the foundation for preventing violence against KP members and responding to KP members who are victims of violence. • Refer participants to Handout 3: Fundamental Principles for Violence Prevention and Response Service Provision and read the principles out loud. • Explain: These principles draw from global standards, guidance, and recommendations from WHO, PEPFAR, USAID, UNFPA, UNAIDS, UN Women, and International Planned Parenthood Federation. • These principles should be considered by health care workers to prevent abuse of KP members and ensure they have the support they need when violence occurs. • We’re going to talk about a few key points related to these principles. <p><i>[Note to the facilitator: If you would like to see the longer list of fundamental principles of violence prevention and response for KP programs, which includes those described in this training, refer to A Guide to Comprehensive Violence Prevention and Response in Key Population Programs.^{17]}</i></p>	<p>Fundamental principles of violence prevention and response</p> <ol style="list-style-type: none"> 1. Do no harm. 2. Promote the full protection of all people’s human rights. 3. Respect all people’s right to self-determination and the right of all victims of violence to the full range of recommended services. 4. Ensure privacy, confidentiality, and informed consent. <hr/>
<ul style="list-style-type: none"> • Show slide and explain: First, we have to “do no harm.” It is most relevant when we’re thinking about victims of violence, who are already highly vulnerable. • Ask: What do we mean by “do no harm?” • Explain: Do no harm means you consider whether any of your actions could harm the person that you are trying to help. • Review the slide’s contents. • Note that this principle shows up in a lot of the other principles as well. 	<p>Principle 1: Do no harm</p> <ul style="list-style-type: none"> • Those working with victims of violence are ethically obligated to consider whether their actions could cause harm and actively avoid this outcome • This principle dictates: <ul style="list-style-type: none"> – Avoid causing harm to KP members, or causing further harm to those who have experienced violence – Act in accordance with the wishes and choices of all victims – Provide services without judgment and that respect the confidentiality of the victim – Consider victim safety in every decision – Get informed consent before providing services or making referrals <hr/>

<ul style="list-style-type: none"> ● Explain that you will be testing their understanding of “do no harm.” ● Ask for a volunteer to read the scenario. ● Then ask for people to raise their hands if they think that A, B, C, and/or D would do harm. After each one, ask a participant who raised their hand to explain why this would cause harm. ● Click slide again to show the red circles. Explain that all of these could cause harm and should be avoided. 	<p>Discussion: How to avoid harm</p> <p>Robert is HIV positive and a health care worker is asking him about his partners as part of index testing. He discloses that his boyfriend has threatened to kill him in the past. Which of the following actions by the health care worker could cause Robert harm?</p> <ul style="list-style-type: none"> A. Requiring Robert to report to the police in order to get services B. Sharing Robert’s sexual orientation with other health care workers C. Telling Robert that this is his fault D. Calling Robert’s partner to inform him that one of his sexual partners is HIV positive
<ul style="list-style-type: none"> ● Show slide and explain: The second principle is the promotion of human rights. This means embracing the belief that people have a right to live free of violence and the right to information, respect, and dignity. This principle is relevant whenever you interact with KP members, including if someone has been arrested. ● This principle means you: <ul style="list-style-type: none"> — Provide services to KP victims without discrimination — Do not attempt to “save KP members from themselves,” by taking away their right to make choices about their own lives. This is not a human rights-based approach and it often causes harm. For example, reparative therapy—which seeks to change someone’s sexual orientation or gender identity—can cause mental health trauma and is not recommended by psychologists. Telling someone to leave sex work may mean they simply stop coming to you for health care, and treatment centers for people who inject drugs are often places of torture and forced labor—not rehabilitation. 	<p>Principle 2: Promote human rights</p> <p>Promoting the full protection of key populations’ human rights means:</p> <ul style="list-style-type: none"> • Providing services to KP members who are victims of violence without stigma or discrimination • Rejecting the idea that KP members must be rescued from themselves (e.g., forcing gay men to enter into reparative therapy, forcing sex workers to stop working, forcing people who use drugs into “treatment centers”)
<ul style="list-style-type: none"> ● Explain that you will be testing their understanding of “promote human rights.” ● Ask for a volunteer to read the scenario. ● Then ask for people to raise their hands if they think that A, B, and/or C would not promote Mary’s human rights. After each one, ask a participant who raised their hand to explain why this would not promote Mary’s human rights. ● Click slide again to show the red circles. Explain that all of these violate Mary’s human rights. 	<p>Discussion: How to promote human rights</p> <p>Mary is a sex worker. She meets a new client and negotiates a price. They agree that he will use a condom. The client takes her to his hotel room. Three other men are there. They tell Mary that they will kill her if she does not have sex with all of them. They do not wear condoms. Mary goes to a clinic to seek emergency contraception and PEP. Which of these actions, by the health care worker, does not promote Mary’s human rights?</p> <ul style="list-style-type: none"> A. Telling Mary that it is her fault she was raped B. Refusing to help Mary C. Giving Mary emergency contraception and PEP only if she agrees to leave sex work

<ul style="list-style-type: none"> • Show slide and explain: This third principle is about giving victims of violence back their power and control. Whenever we are dealing with victims of violence, the most important thing we can do is return control to them. Control is one of the things taken away by the attacker. This means letting them make decisions and respecting their needs, rights, and wishes. • It also means making the full range of services needed by victims of violence available to KP members, so they can choose what to access. • This is also referred to as a victim-centered approach, which helps us to remember that each person is different and best equipped to understand and act upon their needs. 	<p>Principle 3: Self-determination and access to all services</p> <ul style="list-style-type: none"> • All victims of violence, including KP members, must be able to decide which services, if any, they wish to access. • All services recommended to victims of violence should also be available to KP members. • A victim-centered approach allows each person who reports violence to understand what is available and then make choices that meet their personal needs. <ul style="list-style-type: none"> – Effectively supporting victims of violence requires returning their power and control to them (not making decisions on their behalf)
<ul style="list-style-type: none"> • Explain that you will be testing their understanding of “ensure self-determination.” • Ask for a volunteer to read the scenario. • Then ask for people to raise their hands if they think that A, B, and/or C would not ensure self-determination. After each one, ask a participant who raised their hand to explain why this would not ensure self-determination. • Click slide again to show the red circles. Explain that B and C force Olivia to do something instead of asking her what she would like to do and then supporting this decision. For this reason, they do not ensure self-determination. 	<p>Discussion: How to ensure self-determination</p> <p>Olivia is a trans woman. She goes to the health facility to get injuries treated after being raped. The provider on duty listens to her kindly and tells her that she must get an HIV test so that she can begin PEP as soon as possible. Which of these actions did not ensure Olivia's self-determination?</p> <p>A. The provider listens to her kindly</p> <p>B. The provider tells her she must get an HIV test</p> <p>C. The provider tells her she must begin PEP</p>
<ul style="list-style-type: none"> • Show slide and explain: Principle 4 is that we must constantly prioritize and be committed to privacy, confidentiality, and informed consent. These are all essential for service users' safety. We can put the victim's safety at risk if we share sensitive information with partners, family members, or friends without the victim's consent. • This includes not sharing service user information with other health care workers within one's own organization or within the referral network without the victim's explicit consent. As shown on the slide, clear policies must govern any information sharing. • A breach of confidentiality about rape, HIV status, sexual orientation, gender identity, sex work, drug use, or a history of sexual abuse can put victims at risk of additional emotional, physical, and sexual violence. 	<p>Principle 4: Privacy, confidentiality, and informed consent</p> <p>Privacy and confidentiality must be assured before a victim talks about violence</p> <ul style="list-style-type: none"> • Use a private consultation space (victim cannot be seen or heard outside the room). • Speak to victims alone. No one older than age 2 should overhear your conversation. • Safely secure and store all victim's records. • Have clear policies on information sharing communicated to the victim. For example: <ul style="list-style-type: none"> – Explain what will happen to the information they share before they share it, including any limits regarding confidentiality (such as mandatory reporting) – Obtain informed consent before information is shared – Note: victims should not be made to repeat their stories to multiple providers, especially not to those not directly involved • Train providers and staff on these procedures.

<ul style="list-style-type: none"> • The minimum procedures that should be put in place to protect victims' privacy and confidentiality include: <ul style="list-style-type: none"> – Designate and use a private consultation space. The victim should not be able to be seen or heard outside the room. – When asking about violence and responding to disclosures, health care workers must speak with victims alone, with the exception of infants, so that no one can overhear. – Health care workers must implement secure measures to keep victim's records and information confidential and develop policies for sharing information. • Provide ongoing training for staff on protecting victims' privacy and confidentiality, including obtaining informed consent, and ensuring that service users are informed of their options and their rights. <p><i>[Note to the facilitator: If participants ask how they can ensure that they see the service user alone without raising suspicion you may wish to ask other participants to share their tips. Sample tips include thinking of an excuse to be able to see the service user alone, sending the extra person to do an errand or fill out a form, and, if the service user has children with them, ask a colleague to look after them while you talk.]</i></p>	
<ul style="list-style-type: none"> • Show slide and explain: Instead of testing your understanding, let's do an activity to show how important privacy and confidentiality are. Everyone, please take out your wallet or your cell phone. If your cell phone has a lock, unlock it. • Click slide again and tell participants to pass the phone or wallet to the person on their left. Explain that no one should look into the wallet or phone, just hold it. • Ask participants: How does it feel to have your personal item in the control of someone else? (Possible observation: "Some of you seem more interested in what the person next to you is doing with your personal item than the item you have in your own lap.") • Ask participants: How would you feel if I asked your neighbor to open (or look inside) your personal 	<p>Activity: Privacy and confidentiality</p> <ul style="list-style-type: none"> • Take out your cell phone and unlock it • Give it to the person on your left <hr/>

<p>item? (Possible observation: For most participants, this would make them feel uncomfortable.)</p> <ul style="list-style-type: none"> • Ask participants to return the items to their neighbor. • Possible observation: “I noticed that while personal items were with someone else, people were very alert, sitting up very straight, and their attention was on their item more than anything else. After their items were returned to them, there were many smiles, people relaxed more, and their level of alertness dropped.” • Ask: <i>So, what does this have to do with confidentiality? Things that are personal to us, even when they are very ordinary, generate very strong feelings, and we are very careful about who can see them, who can hold them, and we have strong feelings when they seem to be out of our control.</i> • <i>For people who have experienced violence and abuse, sharing personal experiences can be humiliating, demeaning, and upsetting.</i> • <i>We keep information confidential to keep KP members safe and to ensure they have control over what happens to their information, who has it, and where it goes.</i> 	
<ul style="list-style-type: none"> • Show slide and explain: <i>Earlier, we talked about keeping things we hear in this training confidential.</i> • Ask: <i>What does that really mean—to keep something confidential? Elicit responses.</i> • Click slide again to show definition. Ask a participant to read the definition out loud. • Ask: <i>What do we mean by “information related to a victim”? Elicit responses.</i> • Emphasize: <i>Information related to the victim includes name, date of birth, age, address, family details, name of the perpetrator, location of the incident, and any other information that might identify the victim, the family of the victim, the perpetrator, and the family of the perpetrator.</i> • <i>It means any identifying information.</i> • Ask: <i>When we say...sharing the victim’s information only with others who need to know in order to provide assistance, as requested and agreed to by the victim...What do we mean by “others who need to know”? Elicit responses.</i> 	<p>What do we mean by confidentiality?</p> <p><i>Keeping all information related to a victim secret and sharing it only with others who need to know in order to provide assistance, as requested and agreed to by the victim of violence.</i></p> <hr/>

<ul style="list-style-type: none"> • Emphasize: Those who might need to know about the incident, the victim, and/or the perpetrator include any actors who might assist the victim, such as another law enforcement officer, a legal adviser, a doctor, a health worker, etc. • The level of information sharing depends on the service they provide and whether the victim has given consent for you to share information. 	
<ul style="list-style-type: none"> • Show slide and ask: Now, what does it mean to give consent? Elicit responses. • Click slide again to show and review definition. 	<p>What do we mean by consent?</p> <p>When a person agrees...</p> <ul style="list-style-type: none"> • To do something • To participate in an activity • For something to occur
<ul style="list-style-type: none"> • Show slide and ask: If consent means that a person agrees to something, what does informed consent mean? Elicit responses. • Click slide again to show and review definition. • Emphasize: To give informed consent, a person must: <ul style="list-style-type: none"> – Have all the information – Be over the legal age required to give consent – Be mentally sound enough to understand the agreement and the consequences – Have equal power in the relationship 	<p>What is informed consent?</p> <p>Informed consent means that a person agrees to participate in an activity or for something to occur <i>after</i> they have knowledge of or have received all the information about the activity.</p>
<ul style="list-style-type: none"> • Show slide and provide two examples. • Explain: One of these examples is consent and one is informed consent. • Ask the group to tell you which one allows the participant to make a decision that is informed (the answer is B because it explains what will actually happen when taking PEP). • Click slide again to show the red circle. • Explain: There is no consent when agreement is obtained through: <ul style="list-style-type: none"> – The use of threats, force or other forms of coercion, abduction, fraud, manipulation, deception, or misrepresentation – The use of a threat to withhold a benefit to which the person is already entitled – A promise made to the person to provide a benefit 	<p>Discussion: Which of these statements would lead to informed consent?</p> <p>A. If you take PEP, it can lower your chances of getting HIV.</p> <p>B. If you take PEP, it can lower your chances of getting HIV. You may experience side effects such as nausea, fatigue, and headaches.</p>

- Say: To uphold these principles, health care workers must reflect on their personal actions and make any changes needed. However, the environment in which you work can make upholding these principles easier or more difficult. For example, if there is not a place to securely store information that you collect, it will be very difficult to uphold Principle 4 on privacy and confidentiality.
- Think about what may make it harder to uphold each of these principles. What about things that could be done to make it easier for everyone you work with to uphold them?
- Ask participants for their responses.
- Participants may describe issues such as lacking infrastructure; for example, no private space for a victim to talk about what happened to them. Record these issues on flip chart paper.
- Close this discussion by saying: *These challenges are real, and we can and must work to address them. We will cover this in more detail when we talk about the requirements that must be in place before health care workers begin to ask about violence as some of these challenges will be explored then. It's important to remember that even when we face challenges, there is still much we can do as individuals and as a group of those being trained who are now committed to upholding these principles.*

[Note to the facilitator: Depending on who is in the room, participants may not wish to share what makes it harder to uphold these principles, especially if there are issues with health facility management. If there is discomfort with openly sharing, you could also ask everyone to share anonymous written reflections that you then compile. This can be an important opportunity for you to record—and share with senior health officials—what could be done to change the environment to facilitate upholding these principles. If you will be sharing reflections with senior officials or others, be sure to note this before the discussion begins.]

Discussion: Environmental factors

- We all work within and are affected by our environments (e.g., the health facility where you work)
- What about your environment could make it more difficult for you to uphold these fundamental principles?
- What could be changed about your environment to make it easier to uphold these fundamental principles?

- Summarize: When we are working to prevent and respond to violence, it's helpful to have a set of values or principles to work from. These are helpful in our work broadly, but particularly when we work with victims of violence and/or KP members. We can all make decisions each day to follow these principles and to shape the environment in which we work to help others follow them as well.
- Ask if participants have any final reflections or questions on the principles.

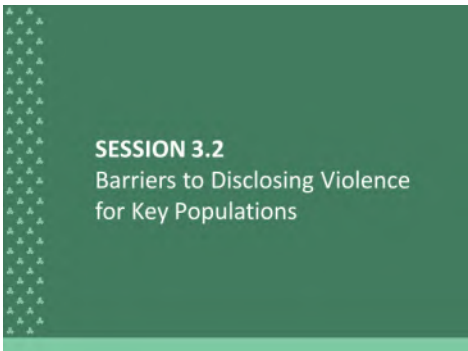
Questions and reflections

Session 3.2: Barriers to Disclosing Violence

Time: 30 minutes

Materials

- Slide presentation
- Flip chart and markers
- [Exercise Card 5](#): Standing in Her Shoes

<ul style="list-style-type: none">• Show slide and explain: People need many services after they experience violence but it's only possible for them to get the support they need if they tell someone about the violence they have experienced.• It's important to think about the barriers that prevent KP members from disclosing violence to us so we can work to break down those barriers, increasing their access to important services including time-sensitive clinical violence response services such as PEP and emergency contraception.	
<ul style="list-style-type: none">• Show slide and ask a participant to read the objective out loud.	<p>Objective</p> <p>Recognize the barriers to disclosing violence for KP members, including victim blaming, and recognize victim blaming as counterproductive to health care's mission</p>
<p>Step 1: Standing in Her Shoes (Blaming Victims)</p> <ul style="list-style-type: none">• Show slide and explain: We've talked about some of reasons it might be difficult for KP members to share their experiences with violence and abuse.• It's important for us to put ourselves in their shoes to understand the isolation they often feel.• Ask for eight volunteers to stand up and form a line in the front of the room, facing the other participants.• Ask for one volunteer to stand at the start of the line.• Distribute the pieces of Exercise Card 5: Standing in Her Shoes. Give the volunteer standing at the start of the line the "Sex Worker" portion of the exercise card.	<p>Activity: Standing in her shoes</p> <ul style="list-style-type: none">• Nine volunteers• Stand in a line• Volunteer 1 reads their card to each person one at a time, and each person responds by reading their card

<ul style="list-style-type: none"> • Distribute one of the remaining portions of the exercise card to each participant in the line. • Ask the “sex worker” to walk up to each person in the line, one at a time, and read their card. • Ask the volunteers in the line to read the card in their hand in response and follow the instructions at the end of their card (which tells them to turn their back to the victim after responding to what the victim says to them). • After the “sex worker” has approached each person in the line and all cards have been read, debrief the exercise using the next slide. 	
<p>Step 2: Debrief Standing in Her Shoes</p> <ul style="list-style-type: none"> • Show slide and ask the person who played the role of a sex worker: What were you feeling as you went around the circle and told people what happened to you? • Ask the people who rejected the sex worker: How did you feel having to say what you said? • Ask the full audience of participants: How did you feel watching this? Does this happen in your context? Elicit responses. • Explain: People who experience violence are often blamed for the violence against them. KP members who experience violence are often doubly blamed—blamed for the violence that happened to them, but also blamed for who they are or their behaviors. • Often, when victims reach out for help to various members of the community or people in their lives, they get blamed or rejected—they are victimized again when they reach out for help. • Emphasize: It’s unlikely that someone would go to so many people to disclose what happened to them. Even one person blaming her for what happened or not being sympathetic could stop her from disclosing again. • When we deal with disclosures, we should know people may be anticipating that we won’t be helpful because of their past experiences. It’s that much more important to deal with the disclosure appropriately. 	<p>Activity: Standing in her shoes (debrief)</p> <ul style="list-style-type: none"> ▪ Observations from the participants in the drama ▪ Observations from the group <hr/>

<ul style="list-style-type: none"> • Show slide and ask: Why is how we respond to disclosure so important for the person who is disclosing? • While the original violent act can stay with people for a long time, it's also true that the responses of those to whom they disclosed can continue to help or hurt them long after the response. • Ask a participant to read the quote from WHO to emphasize this point. 	<p>The importance of your response</p> <p>"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."</p> <p><small>Source: WHO, 2003.</small></p>
<ul style="list-style-type: none"> • Show slide and ask: Having seen the activity and heard the quote from WHO, what happens when we blame victims? • Review the content on the slide. 	<p>What happens when we blame victims?</p> <ul style="list-style-type: none"> • We discourage people from disclosing violence and seeking help. • We harm the mental health of victims of violence. • We place the entire solution to the problem on the shoulders of the person who has been victimized. • We do not place responsibility on the actual perpetrators (excusing behavior and creating impunity).
<ul style="list-style-type: none"> • Show slide and explain: Sometimes we blame unintentionally by asking questions. • Ask: What are some questions that might blame someone? Allow group to provide some answers. • Click on slide again to show results. Ask: Why might these questions make the victim feel that you believe they are at fault for what happened? • Example responses are: they make it seem that the victim caused the abuse to occur and/or liked or wanted the abuse. • Discuss commonalities across questions. All of them ask "why" which is asking the victim to justify something about their experience instead of simply validating what happened to them. • Explain: We want to avoid asking why, as this puts the onus on the person who experienced the violence. 	<p>Discussion: Questions that blame</p> <ul style="list-style-type: none"> • Why were you alone? Why were you walking in that neighborhood? • Why were you wearing such revealing clothes? • What did you do to make him angry? • If you were really afraid, why didn't you run or scream? • Why do you choose to put yourself in risky situations?
<ul style="list-style-type: none"> • Show slide and explain: It's not only important to the one person we're interacting with. If we blame one victim, this affects the likelihood that others will not come forward. • Social proof is a concept that psychologists refer to. It helps people determine how to act. When we see someone who had a similar experience to us being blamed, we are less likely to come forward. • But, by the same token, each time we respond positively, we create social proof that people will 	<p>Our response to one victim affects others</p> <ul style="list-style-type: none"> • Blaming any victim also makes others' disclosures less likely. • One of the predictors for whether someone will come forward to disclose violence is what they have seen happen to others upon disclosure. • This is a phenomena called "social proof."¹ • As a health care worker, each time you respond appropriately to a victim of violence and support them, you make it more likely that others will also come forward. <p><small>Source: 1. Velders, 2017.</small></p>

<p>be supported. So each time you respond appropriately you create a greater chance for more people to disclose to you. In some cases, we have even seen members of KPs become “ambassadors,” taking their friends to a health facility to get violence response services because they’ve had such good experiences there.</p>	
<ul style="list-style-type: none"> ● Show slide and explain: Knowing how common it is to blame victims, let’s talk for a minute about why. This may also help us to avoid blaming victims, which can easily occur based on how we’re socialized and on some very human desires to feel safe. ● Ask for some ideas on why we blame. Then click slide again and go over any that weren’t brought up. <ul style="list-style-type: none"> – Gender and societal norms: as we saw in our earlier session on gender, what we believe men and women should and shouldn’t do is part of victim blaming. Men are often thought to be unable to control themselves—although not accurate, it is commonly believed—which leaves all the responsibility on women. We hear this in comments that ask what she was wearing, why she was drunk, etc. We also see people blamed for being too far outside of gender norms—for example, a gay man, who is seen as deserving the violence because of being outside of societal expectations. – To feel safe ourselves: when we blame victims, we distance ourselves from what happened to them. We do this with all kinds of victims, not just victims of violence. We want to believe that we would never do what the victim did because then we can be convinced that it couldn’t happen to us. To go around thinking, this could happen to me at any time, is exhausting. So subconsciously, we tell ourselves that we’re not like the person it happened to in some way, which leaves the blame on the victim. – We also know that people want to believe that the world is a just place. If we believe that bad things happen to only bad people, it helps us feel better about the world. 	<p>Discussion: Why do we blame victims?</p> <ul style="list-style-type: none"> ▪ Gender and other societal norms and myths that make violence the fault of women and individuals who are seen as nonconforming to gender norms¹⁻³ ▪ To feel safe ourselves⁴ ▪ To feel that the world is just^{5,6} ▪ In an effort to be helpful <p><small>Sources: 1. Crotteau et al., 2018. 2. UNRIGES, 2016a. 3. UNRIGES, 2016b. 4. Jancoff-Bulman, 2010. 5. Lerner, 1980. 6. Lerner & Sternberg, 1969.</small></p>

<ul style="list-style-type: none"> – We’ve seen this play out in research, for instance in a study by Lerner and colleagues.⁴⁴ Research subjects were asked to watch someone being shocked. The person was an actor, so no one was really hurt. One group of research subjects could stop the shocks. The second group could not stop the shocks, so they simply had to watch a person being hurt. After this, both groups were asked to give their opinions of the person being shocked. The research participants who could stop the shocks said the person was a good person. The research participants who could not stop the shocks said the person being shocked was a bad person. – Finally, we often think that we’re being helpful and giving someone a way to avoid violence in the future. But often, especially with sexual and other forms of GBV, the victim already worries that it was their fault and we will only be feeding this belief. 	
<ul style="list-style-type: none"> • Summarize: When someone comes to us to disclose violence, we can help them on a path to healing or further traumatize them. While many of us may find that our gut reaction is to blame the victim, this impulse must be overcome so that health care workers can meet victim’s needs. • Avoiding victim blaming does not mean we do not talk about how to increase individuals’ safety. We will talk about safety planning in a few sessions so that victims who disclose violence to you can leave with ideas on how to increase their safety. • The next sessions will be about how to create an environment that welcomes victims, including one that does not blame. • Ask if there are any final reflections or questions before you move on. 	<p>Questions and reflections</p> <hr/>

Session 3.3: The Importance of Health Care Workers in Violence Prevention and Response

Time: 15 minutes

Materials

- Slide presentation
- Flip chart and markers

<ul style="list-style-type: none"> • Show slide and explain: In this session, we'll talk about our role as health care workers in addressing violence. 	 <p>SESSION 3.3 The Importance of Health Care Workers in Violence Prevention and Response</p>
<ul style="list-style-type: none"> • Show slide and ask a participant to read the objective out loud. 	<p>Objective</p> <p>Explain why it is important for health care workers to be part of violence prevention and response, especially to support KP members</p>
<ul style="list-style-type: none"> • Show slide and explain: Some people believe that violence is simply a legal issue and wonder why health care workers need to learn to address violence. But, as we've seen, violence also impacts health and health care workers are a vital part of violence response. In fact, health care workers are in a unique position to influence if, how, and when KP members and others disclose violence. • Many KP members, especially those in criminalized environments, do not feel safe seeking support from law enforcement. Health care workers—who are often trusted and respected—may be the best opportunity for a victim to disclose. • Health care workers serving KP members are supporting individuals who are more likely to experience violence and can help them address the needs that arise when violence occurs. 	<p>Why health care workers?</p> <ul style="list-style-type: none"> • Health care workers are often respected, objective arbiters, and victims (especially KP members) may fear law enforcement • Health care workers interact with KP members who experience violence and have an unmet need for services • KP victims of violence report a desire for health care workers to ask them about violence in their lives (with the caveat that they must first be trained to respond appropriately) • Health care interactions are an opportunity to link victims to support if an appropriate approach is taken

<ul style="list-style-type: none"> • When asked, many KP members say they want health care workers to ask them about violence as long as the health care workers are trained to respond appropriately. • When service users disclose an experience of violence, health care can be an entry point to violence response services. • Review the content on the slide. 	
<ul style="list-style-type: none"> • Show slide and explain: As health care workers, our role in addressing violence includes: <ul style="list-style-type: none"> – Asking service users about violence (as long as minimum requirements are met). – Assessing service users' safety and identifying opportunities to increase their safety. – Providing and/or referring service users to health, social, and justice/legal services to meet their needs. – Tailoring health services to acknowledge the impact of past or present violence. This may include tasks such as helping someone in a violent relationship decide if or how to disclose their HIV status or explaining the services available, such as emergency contraception, if violence occurs. • In this module, we will build our skills to fulfill these roles to address violence. 	<p>Health care worker roles</p> <ul style="list-style-type: none"> • Ask KP members about violence • Provide first-line support to KP members who disclose violence • Engage in conversations to enhance safety • Provide/refer to violence response services including health, social, and justice/legal services • Tailor health services to acknowledge the impact of past or present violence <hr/>
<ul style="list-style-type: none"> • Explain: When health care workers understand the violence in service users' lives it can also provide insight into their interactions with health personnel. To show you how this might happen, consider the following three scenarios. What might a new health care worker—or someone who has never been to a training like this one—think if they encountered these situations? • Show the first case and solicit responses. Answers may include: She doesn't care about her health, or she is irresponsible. • Click to show the second case and solicit responses. Answers may include: He is lying to the doctor, or he is trying to cover up for irresponsible behavior. • Click to show the third case and solicit responses. Answers may include: She is rude, she is trying to start a fight, or she is being disrespectful. 	<p>Activity: What would you think?</p> <ul style="list-style-type: none"> • A woman who injects drugs shows up late for appointments and regularly fails to pick up her ARVs. • A male sex worker tells his doctor that he always asks his clients to use condoms but he tests positive for chlamydia. • A trans woman screams at a nurse when the nurse tells her she will have to wait one hour. <hr/>

<ul style="list-style-type: none"> • Show slide to share each of the cases with additional information. Click slide to show each case. • Ask: How would the health care worker's interpretation of the woman who injects drugs change if they knew more about her history of violence? Probe for: she would understand the reason for the woman's tardiness and absence and not attribute these to a lack of concern for her health or irresponsible behavior. • Click slide again and ask: How would a new health care worker's interpretation of the male sex worker change if they knew more about his history of violence? Probe for: she would understand that he is not being dishonest and condom use is not always in his control. • Click slide again and ask: How would the health care worker's interpretation of the trans woman change if they knew about her history of violence? Probe for: she would understand that her reaction is due to exhaustion and not disrespect. • When we recognize that KP members' actions today may be affected by previous or current violence, it can help prevent judgmental attitudes that cause us to jump to false conclusions, improving our ability to provide services. 	<p>Activity: What would you think? (continued)</p> <ul style="list-style-type: none"> • A woman who injects drugs whose controlling partner does not allow her to go to the clinic shows up late for appointments and regularly fails to pick up her ARVs. • A male sex worker tells his doctor that he always asks his clients to use condoms but he tests positive for chlamydia because a violent client forced him to have sex without a condom. • A trans woman who was just kicked out of her home and has not slept for two nights screams at a nurse when the nurse tells her she will have to wait one hour. <hr/>
<ul style="list-style-type: none"> • Summarize the session by noting: Becoming a part of violence prevention and response allows us to better support service users, help people who need help get it, and may also help us better understand, instead of judge, those we serve. Because violence against KP members is so common, it's especially important for those health care workers who serve key populations to be able to appropriately ask about and address the violence in their lives. • Ask if there are any final reflections or questions before you move on. 	<p>Questions and reflections</p> <hr/>

Session 3.4: Asking about and Responding to Violence

Time: 90 minutes

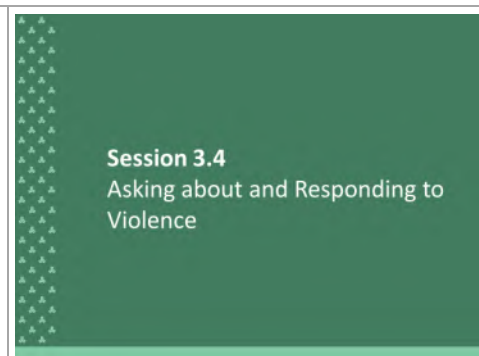
Materials

- Slide presentation
- Flip chart and markers
- [Annex 2](#): Guidance on Asking about Violence
- [Handout 4](#): Overview of First-Line Support
- [Handout 5](#): Sample Tool to Ask about and Respond to Violence, or locally used tool serving a similar function
- [Exercise Card 5](#): Standing in Her Shoes

Planning Ahead

This session should be organized prior to the training. Facilitators should ask health care workers to bring copies of tools used to ask about and respond to cases of violence in their facility, specialty, or position. If they do not have such tools, [Handout 5](#) can be used.


- Show slide and explain: **Beyond creating an environment in which disclosure is possible, we can also ask a service user a series of questions to determine if they are experiencing violence. In this session, we're going to build our skills for asking about violence and for responding to violence if disclosure occurs.**



- Show slide and ask a participant to read the objective out loud.

Objectives

- Describe the goal and steps of asking about violence, particularly for members of key populations
- Identify and practice skills to provide first-line support (LIVES) to individuals who disclose violence, particularly members of key populations

<ul style="list-style-type: none"> • Show slide and explain: Before we start, it's important to make sure that we all have the same goal. Getting KP members to disclose violence is not the “end goal.” Some KP members do not want to share their experiences, and that decision should be respected. • Our goal is to create an environment in which KP members feel comfortable and safe so if they choose to share their experiences, they will feel supported. • Review the content on the slide. 	<p>An important note on asking about violence</p> <ul style="list-style-type: none"> • The end goal is NOT simply to tick a box. • Asking about violence is an intervention. • We ask about violence to educate on the topic and let KP members know about available services and that they are not alone. • If someone discloses, we can better plan and provide them with information about critical services. • BUT if someone does not disclose violence, asking about violence is NOT a wasted exercise. • No one should ever be pressed to disclose violence.
<ul style="list-style-type: none"> • Show slide and explain: Extrapolating from guidance by WHO and global KP networks, it is recommended that health care workers provide all KP members reached through HIV programs with the opportunity to disclose by asking about violence. <p><i>[Note to the facilitator: If there are questions about guidance that informed this portion of the training, see Annex 2.]</i></p>	<p>Asking about violence in health care settings (continued)</p> <p>It is recommended that health care workers provide all KP members reached through HIV programs with the opportunity to disclose by asking about violence.</p> <p>Minimum requirements must be in place before health care workers can ask about violence.</p>
<ul style="list-style-type: none"> • Show slide and explain: In line with WHO and USAID guidelines, a set of minimum requirements must be met before health care workers can ask about violence. These include: <ul style="list-style-type: none"> – Written protocol/standard operating procedure (SOP) that describes how violence response services will be integrated into clinical practice including who asks about violence, how and when asking about violence takes place, how to respond to disclosures of violence, how to link service users to additional services, and how to document cases of violence is in place. – A standard set of questions are used to facilitate documentation, and safe storage mechanisms are in place. – Health care workers are trained on the appropriate way to ask about and respond to violence. – Health care workers offer immediate, first-line support to service users who disclose violence. – Health care workers only ask about violence in a private setting. They ensure confidentiality during and after the service user’s visit. 	<p>Minimum requirements to ask about violence</p>  <p><small>Source: Adapted from USAID, Office of MINARIS, Gender and Sexual Diversity Branch</small></p>

<ul style="list-style-type: none"> — A system for referrals to violence response services including health, social, and justice/legal services is in place. • If these requirements are met, health care workers can begin asking about violence. 	
<ul style="list-style-type: none"> • Show slide and explain: Here are the basic steps for asking about and responding to violence. • Review the content on the slide. 	<p>Steps for asking about and responding to violence</p> <ul style="list-style-type: none"> • Explain types of violence and the relevance of violence to service users' health. Ask service user if they would be willing to answer questions about violence. • If yes, ask service user about: <ul style="list-style-type: none"> — The types of violence they have experienced — The most recent time violence happened — Whether there are injuries related to the violence • * For sexual violence, explain medical options and timelines • If violence is disclosed, provide first-line support (LIVES): <ul style="list-style-type: none"> — Listen close with empathy and no judgment — Inquire about their needs and concerns — Validate their experiences — Enhance their safety — Support them to connect with additional services
<ul style="list-style-type: none"> • Show slide and explain: Let's talk briefly about what asking about violence may look like. • Review the content on the slide and explain: This is how you can introduce the topic of violence and explain why you are asking KP members about their experiences with violence. • Emphasize: Before launching into the questions, remember to first ask service users if it's okay to ask them about their experiences of violence. 	<p>What asking about violence can look like</p> <p>Initial Contact (first time meeting a service user)</p> <ul style="list-style-type: none"> • Many people tell me they have been emotionally, physically, or sexually harmed, including forced to have sex without a condom. Some have been threatened, robbed, denied money that is due to them, made to pay money to avoid arrest, or denied services. • Since violence and abuse can cause health problems, I'd like to ask you about your experiences. Is that okay? • In the past [number] months have you experienced any of these types of violence or abuse? <p>Follow-up Contacts: Last time, I asked you about violence and abuse. Has anything new happened since we met?</p>
<ul style="list-style-type: none"> • Show slide and explain: If a facility is implementing partner notification—also known as index testing or voluntary partner referral—a health care worker is required to ask the service user living with HIV about IPV as part of deciding whether it is safe and appropriate to reach out to an identified partner. If partner-delivered self-testing is being considered—the process by which a service user takes an HIV self-test to their partner—the service user should also first be asked about violence to assess safety. • Here are some simple and direct questions about intimate partner violence that you can ask the index service user. • Review the questions. • Disclosures of violence should be taken into account as the health care worker and service user decide whether partner notification or partner-delivered self-testing are safe options. As mentioned before, the service user should be the person to make the ultimate decision about whether these approaches will be used. 	<p>Direct questions on IPV</p> <ul style="list-style-type: none"> • Are you afraid of your partner? • Has your partner or someone else at home ever threatened to hurt you or physically harm you in some way? If so, when has it happened? • Does your partner bully or insult you? • Does your partner try to control you, for example, not letting you have money or go out of the house? • Has your partner forced you into sex or forced you to have any sexual contact you did not want? • Has your partner threatened to kill you? <p>Partner notification (also called voluntary partner referral or index testing) requires asking about IPV. When considering partner-delivered self-testing IPV must also be assessed. Disclosures of violence should be responded to with first-line support. Disclosures of violence should also help inform decision-making about the appropriateness of partner notification or partner-delivered self-testing; ultimate decisions rest with the service user.</p> <p>Source: WHO, 2016. Source: WHO, 2014.</p>

- Before practicing asking about violence, we'll practice responding to disclosures of violence using the LIVES model for first-line support. LIVES is an acronym that can help us remember the steps for responding to violence.
- Distribute [Handout 4: Overview of First-Line Support](#) and explain that it will be useful throughout the remainder of the training.
- People who disclose violence to health care workers should be offered immediate, compassionate first-line support.
- Ask: What do we mean by first-line support? Elicit responses.
- Explain: First-line support refers to the minimum level of (primarily psychological) support and validation of experience that all people who disclose violence to a health care worker should receive. It involves five simple tasks: listening, inquiring about needs and concerns, validating the victim's experiences, enhancing the victim's safety, and supporting the victim to access information or services. The letters in the word "LIVES" can remind you of these five tasks. In this session, we will build our skills to provide first-line support using these five tasks.

How a health care worker could respond to a service user who discloses violence: first-line support

Task	Explanation
Listen	Listen closely with empathy and no judgment
Inquire about needs and concerns	Assess and respond to various needs and concerns—emotional, physical, social, safety
Validate their experiences	Show you believe and understand, assure victim that they are not to blame
Enhance safety	Discuss a plan to protect the victim from further harm if violence occurs again
Support	Support the victim to connect with additional services

Source: WHO, 2014.

- Show slide and explain: You see that the first task is listening. Listening is the most important part of good communication and the basis of first-line support.
- Review the purpose of listening on the slide.

Listen closely with empathy and no judgment

Purpose

Give the victim a chance to share their experiences in a safe and private place to a caring person who wants to help.

Source: WHO, 2014.

- Show slide and explain: We all know what good listeners are like, because they are often the ones we choose to reach out to when we want to talk about our day. Let's do an activity to think about this further.
- Ask a participant to read the scenario on the slide and then have the group break into pairs to discuss who they would want to talk about their bad day and why. Give them five minutes to work together.

Activity: Skills of a good listener

- You've had a bad day. Your sister is ill, and her children are staying with you. You are working an extra job to help with her medical costs. You are exhausted, and your work has suffered. You also had to pay late fees on your phone bill today because your payment was overdue.
- In pairs, discuss:
 - Who would you talk to about your day?
 - Why would you choose this person?

- Show slide and facilitate large group discussion about things they would want a listener to do and not do when they are sharing details about their bad day.
- Click the slide again to show good listening skills. Go over any that were not discussed.
- Click again to show what should be avoided. Go over any that were not discussed.
- Explain that these good listening skills apply when someone discloses violence.
- Ask if there are any questions or comments.

[Note to the facilitator: Sometimes it's hard for health care workers to understand why it is wrong to tell individuals experiencing violence what to do. If participants express that it's important for them to give advice to victims of violence, remind the participants that, while they want to help, it can be harmful to tell someone who is experiencing violence what to do. For example, a partner can become more violent and may even commit murder when a victim tries to leave an abusive relationship so telling someone to leave may actually cause harm.⁴⁵ Furthermore, if the health care worker gives advice and the victim chooses not to take it, the victim may decide not to come back to the health care worker because they fear disappointing the health care worker by being non-compliant. Everyone must be trusted to know what is right for themselves; the health care worker is there to be supportive and explain the options.]

- Show slide and emphasize: As we saw from the brainstorm, you know who good listeners are. But that doesn't mean we always use good listener skills. Since listening is an essential component of providing first-line support, we're going to spend some time learning about and practicing listening skills.
- Listening techniques include expressing your interest and concern with your body language such as facial expressions, eye contact, and gestures, as well as your words.
- Much of being a good listener is demonstrated through body language, being comfortable with silence, and not rushing the person.
- Ask: What are some ways we show people we are being a good listener? Elicit responses.

Activity: Brainstorm listener do's and don'ts

Things you want the listener to do	Things you don't want the listener to do
<ul style="list-style-type: none"> • Be patient and calm • Let you know that they're listening (nod head, make eye contact, etc.) • Acknowledge how you're feeling • Let you tell the story at your own pace • Encourage you to share • Give you time to think • Stay focused on you • Respect your wishes 	<ul style="list-style-type: none"> • Pressure you • Look at their watch or seem distracted • Judge you • Rush you • Assume they know best • Interrupt • Finish your thoughts for you • Tell you their own troubles or someone else's • Think and act as if they can solve your problems

Discussion: Demonstrating listening skills

How do we show that we're good listeners?

- Nodding and saying "uh huh"
- Leaning closer
- Making eye contact
- Avoiding distractions (watch, phone, computer)
- Giving the person time to tell their story at their own pace
- Being comfortable with silence and pauses (not interrupting, giving person time to think)
- Asking open-ended questions ("Would you like to tell me more?")

<ul style="list-style-type: none"> Click slide again to show examples. 																			
<ul style="list-style-type: none"> Show slide and explain: When victims disclose violence, they may have various needs and concerns, including: <ul style="list-style-type: none"> Immediate mental health needs Immediate physical health needs Ongoing social needs Ongoing safety needs Inquiring about a victim's needs and concerns can help a victim express their wishes and ensures that you understand and respond to their needs. 	<p>Inquire about needs and concerns</p> <p>Purpose Learn what is most important for the victim. Respect their wishes and respond to their needs.</p> <p><small>Source: WHO, 2014.</small></p>																		
<ul style="list-style-type: none"> Show slide and explain: As you listen to a victim's story, pay particular attention to what the victim says about their needs and concerns—and what the victim implies with words or body language. You can use the techniques on the slide to help a victim express what they need and check your understanding. Review the content on the slide. 	<p>Techniques to inquire about needs and concerns</p> <table border="1"> <thead> <tr> <th>Technique</th><th>Example</th></tr> </thead> <tbody> <tr> <td>Phrase your questions as invitations to speak</td><td>What would you like to talk about?</td></tr> <tr> <td>Ask open-ended questions that encourage the victim to talk</td><td>How do you feel about that?</td></tr> <tr> <td>Verify your understanding by restating what the victim says</td><td>You mentioned that you feel very frustrated.</td></tr> <tr> <td>Reflect back the feelings the victim expresses</td><td>It sounds as if you are feeling angry about that.</td></tr> <tr> <td>Explore as needed</td><td>Could you tell me more about that?</td></tr> <tr> <td>Ask for clarification if you don't understand</td><td>Can you explain that again, please?</td></tr> <tr> <td>Help the victim identify and express needs and concerns</td><td>Is there anything that you need or are concerned about?</td></tr> <tr> <td>Summarize what the victim expressed</td><td>You seem to be saying that...</td></tr> </tbody> </table> <p><small>Source: WHO, 2014.</small></p>	Technique	Example	Phrase your questions as invitations to speak	What would you like to talk about?	Ask open-ended questions that encourage the victim to talk	How do you feel about that?	Verify your understanding by restating what the victim says	You mentioned that you feel very frustrated.	Reflect back the feelings the victim expresses	It sounds as if you are feeling angry about that.	Explore as needed	Could you tell me more about that?	Ask for clarification if you don't understand	Can you explain that again, please?	Help the victim identify and express needs and concerns	Is there anything that you need or are concerned about?	Summarize what the victim expressed	You seem to be saying that...
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<ul style="list-style-type: none"> Show slide and explain: Let's practice these techniques as a large group. I'll read the victim's statement on the slide, and you can use a technique to assess my needs and concerns. Read victim statement #1 on the slide. Allow participants to practice providing statements using the following technique: reflect back (paraphrase) the feelings the victim expresses. Click slide again to show an example statement. 	<p>Activity: Inquire about needs and concerns</p> <p>Victim statement #1: "Ever since they raped me I don't want to eat or talk to anybody. I just want to sleep and stay in bed."</p> <p>Technique: Reflect back the feelings the victim expresses <i>"It sounds like you're in a lot of emotional pain."</i></p>																		
<ul style="list-style-type: none"> Read victim statement #2 on the slide. Allow participants to practice providing statements using the following technique: help the victim identify and express needs and concerns. Click slide again to show an example statement. 	<p>Activity: Inquire about needs and concerns (continued)</p> <p>Victim statement #2: "My partner threatens to beat me at any little thing lately. I try to do things the way he likes them, but he only gets angrier. I don't know what he will do next."</p> <p>Principle: Help the victim identify and express needs and concerns <i>"It sounds like you're worried about your safety. Is there anywhere that you feel safe?"</i></p>																		

<ul style="list-style-type: none"> • Show slide and explain: In addition to the listening and inquiring tasks of first-line support, it's important to validate the victim's experiences. Validating means we are letting the victim know that their feelings are okay or common, and it is safe to express them. 	<p>Validate</p> <p>Purpose Let the victim know that their feelings are common, that it is safe to express them, and that everyone has a right to live without violence.</p> <p><small>Source: WHO, 2014.</small></p>		
<ul style="list-style-type: none"> • Show slide and explain: Validating messages convey that: <ul style="list-style-type: none"> — You appreciate them sharing their experiences with you. — You believe them without judgment or conditions. — What happened was not their fault. — Their experience has happened to other people, and they are not alone. — Their feelings are common. — They have the right to live without threats, violence, and abuse. — It's safe for them to talk to you about their experience. — You will support them and the choices they make, either through services offered by health care workers or referral. • Review validating messages on the slide. 	<p>Validate: Messages to use</p> <ul style="list-style-type: none"> • "Thank you for sharing that with me." • "I'm sorry that happened to you." • "Many people experience violence, and even though they may be blamed for what happened, it is never their fault." • "Everyone has the right to live free from violence." • "I am here to support you and explain your options." • "It's not your fault." • "This was a violation of your rights, and you did not deserve to be treated this way." • "You are brave to talk me about it." 		
<ul style="list-style-type: none"> • Show slide and ask: What are some things we should avoid saying to victims who disclose violence? Elicit responses. • Click slide again to show examples. • Emphasize: DO NOT... <ul style="list-style-type: none"> — Place blame on the victim <ul style="list-style-type: none"> ▪ "You put yourself at risk." — Say anything that judges what the victim has done or will do <ul style="list-style-type: none"> ▪ "You should feel lucky that you weren't more injured." ▪ "You shouldn't feel this way." ▪ "You should go to the police." — Question the victim's story (doubting) or interrogate the victim <ul style="list-style-type: none"> ▪ "What I don't understand is why he would have attacked you?" — Say anything that minimizes how the victim feels 	<p>Validate: Messages to avoid</p> <table border="0"> <tr> <td> <p>Avoid statements that</p> <ul style="list-style-type: none"> • Place blame on the victim • Say anything that judges what the victim has done or will do • Question the victim's story (doubting) or interrogate the victim • Say anything that minimizes how the victim feels • Lecture, command, or advise • Recommend that they change their profession, sexual orientation, or gender identity to avoid violence </td><td> <p>Avoid questions that suggest fault</p> <ul style="list-style-type: none"> • Why were you wearing such revealing clothes? • What did you do to make the perpetrator angry? • If you were really afraid, why didn't you run or scream? • Why do you choose to put yourself in risky situations? </td></tr> </table>	<p>Avoid statements that</p> <ul style="list-style-type: none"> • Place blame on the victim • Say anything that judges what the victim has done or will do • Question the victim's story (doubting) or interrogate the victim • Say anything that minimizes how the victim feels • Lecture, command, or advise • Recommend that they change their profession, sexual orientation, or gender identity to avoid violence 	<p>Avoid questions that suggest fault</p> <ul style="list-style-type: none"> • Why were you wearing such revealing clothes? • What did you do to make the perpetrator angry? • If you were really afraid, why didn't you run or scream? • Why do you choose to put yourself in risky situations?
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<ul style="list-style-type: none"> ▪ “Everyone has bad days. You’ll get over it.” – Lecture, command, or advise <ul style="list-style-type: none"> ▪ “What you need to do is...” ▪ “You have to stop thinking about what happened.” – Ever recommend that they change their profession, sexual orientation, or gender identity to avoid violence <ul style="list-style-type: none"> ▪ “You need to leave sex work. It’s just a violent profession.” ▪ “If you stopped being so open about who you are, you would be safer.” 	
<ul style="list-style-type: none"> • Explain: Let’s practice delivering validating messages right now. • Ask four of the original volunteers plus the person who played the sex worker in the Standing in Her Shoes activity to come to the front. • Give the same volunteer the “sex worker” card from Exercise Card 5: Standing in Her Shoes. • Explain that the victim will go up to each person individually and tell them what happened to her. • When the victim does this, the listener will deliver ONE validating message. • Don’t provide feedback as participants practice (unless they ask for help); rather, wait until the end to provide constructive feedback. • Acknowledge that this takes practice. 	<p>Activity: Revisit standing in her shoes</p> <p>Repeat standing in her shoes activity. This time, instead of rejecting the victim, deliver a validating message.</p> <hr/>
<ul style="list-style-type: none"> • Show slide and explain: The next task is to enhance safety. Many people who have been subjected to violence have legitimate fears about their safety. Other people may not think they need a safety plan because they do not expect that the violence will happen again. • Asking questions to assess safety and identify opportunities to increase safety is an ongoing process—it is not just a one-time conversation. 	<p>Enhance safety</p> <p>Purpose</p> <p>Help assess the victim’s situation and make a plan for their future safety.</p> <p><small>Source: WHO, 2014.</small></p> <hr/>
<ul style="list-style-type: none"> • Show slide and explain: You can assess a victim’s safety by asking: “I want to check with you about your safety. Do you have concerns about your safety or the safety of your children?” • If the victim does not feel safe, it is important to take the victim seriously and help them create a safety plan. 	<p>Ask about safety</p> <p>Do you have any concerns about your safety or the safety of your children (if relevant)?</p> <hr/>

- Show slide and explain: Having a safety plan will help a victim of violence deal with a situation if violence occurs again. The job aid on the slide includes the elements of a safety plan and questions you can ask victims to help them make a plan. This job aid is also in [Handout 4: Overview of First-Line Support](#).
- Ask participants to break into pairs with one person taking the role of a victim and the other taking the role of the health care worker.
- Explain: The person playing the role of the health care worker will use the job aid on the slide to ask questions. The person playing the role of a victim will respond to the questions. Together, they will create a safety plan.
- Give participants 10 minutes to work together.

Activity: Safety planning

- Break into pairs
- One person pretends to be a victim of violence
- The other is a health care worker who asks these questions

Job aid

Safety planning	
Safe place to go	If you need to leave your home in a hurry, where could you go?
Planning for children	Would you go alone or take your children with you?
Transport	How will you get there?
Items to take with you	Do you need to take any documents, keys, money, clothes, or other things with you when you leave? What is essential?
Financial	Can you just together items in a safe place or leave them with someone, just in case?
Support of someone close by	Do you have access to money if you need to leave? Where is it kept? Can you get it in an emergency?
	Is there a neighbour you can tell about the violence who can call the police or come with assistance for you if they hear sounds of violence coming from your home?

Source: WHO, 2014.

- Show slide and explain: KP members may be dealing with other forms of violence and may encounter additional barriers to seeking safety compared to members of the general population.
- Safety strategies depend on a KP member'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

Explore safety strategies

- Identify emergency shelters
- Carry emergency phone numbers
- Contact international funds that may be able to help with relocation or other costs

!

It is important that health care workers do not tell KP members how to stay safe. Safety planning is a conversation in which the 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.

- Show slide and ask: Some communities have already come up with safety tips that they share with one another. Sex workers in the United Kingdom created this guidance that includes the following suggestions. Review content of the slide.
- If you're supporting a sex worker who has experienced violence, you can let them know that other sex workers have found these tips valuable and encourage them to use whichever tips meet their needs.
- Remember that it's not your role to tell anyone what to do; you are simply presenting options.


What are safety tips for sex workers?

- 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



Source: UK Network of Sex Work Projects, 2018.

<ul style="list-style-type: none"> Remind health care workers that pushing sex workers to stop engaging in sex work to stay safe is counterproductive and not in line with the principles reviewed earlier. 	
<ul style="list-style-type: none"> Show slide and explain: In addition to exploring safety strategies with victims of violence, health care workers should also ensure they are not putting the victim at risk. Review the content on the slide. 	<p>Avoid putting victim at risk</p> <ul style="list-style-type: none"> Talk about violence only when you and the victim are alone Maintain the confidentiality of the victim's health records If the victim lives with an abuser: <ul style="list-style-type: none"> Discuss how the victim will explain where they have been Caution the victim about taking home printed materials about violence
<ul style="list-style-type: none"> Show slide and explain: Individuals who are experiencing violence may have a range of needs beyond what you, as a health care worker, can address. Yet, they may face multiple barriers to reaching out for help. Your voice is important in encouraging a victim to seek support. In line with the principle of victim-centered care, a health care worker's role is to discuss a victim's needs with them, make sure the victim knows their full range of options and has all the information, and then support them in obtaining services that meet their needs if they want it. This is the last task in first-line support. 	<p>Support</p> <p>Purpose</p> <p>Connect victim with other resources for their health, social, and justice/legal needs as their needs are generally beyond what you can provide in a health facility.</p> <p><small>Source: WHO, 2014.</small></p>
<ul style="list-style-type: none"> Show slide and explain: To provide support to a victim of violence, first ask them whether they have immediate needs that you can help them address, including through referral. For example, you could ask, "What would help the most if we could do it right away?" Review the content on the slide. 	<p>Ask about immediate needs</p> <p>Consider</p> <ul style="list-style-type: none"> Physical health (including time-bound services following sexual assault) <ul style="list-style-type: none"> PEP (72 hours) Emergency contraception (120 hours) Mental health Social services Child protection
<ul style="list-style-type: none"> Show slide and explain: It is important to talk to a victim about their options, including referrals to available resources. Explain that effectively linking someone to other services is easier when the health care workers: <ul style="list-style-type: none"> Are familiar with the referral network for their community Explain what types of clinical/medical services are available Refer to mental health providers/ counselors 	<p>Provide information and make referrals to available resources</p> <p>When providing information and making referrals</p> <ul style="list-style-type: none"> Offer printed information (but remember to offer a warning in case materials could come to the attention of an abuser) Know specific information about referral points Ask victim if they want accompaniment to resources, and if so, make arrangements Do not pressure victim to accept a referral or to give details about an incident Offer yourself as a resource to access other services

<ul style="list-style-type: none"> – Provide legal information and refer to legal services – Offer to go with the victim (or send someone with the victim) to the referral site – Do not pressure anyone to seek additional services – Offer themselves as a resource • Explain that if health care workers provide printed materials with information about resources to the victim, they should caution about taking printed materials home if the person lives with an abuser. • Explain: In the next session, we will discuss the referral network and process in [Country] in more detail. 									
<ul style="list-style-type: none"> • Show slide and explain: You can also help support victims of violence by discussing their existing strengths and support networks—particularly in settings where services and referral networks are limited. You can ask questions to help them recognize these strengths and support networks. • Review the content on the slide. 	<p>Identify existing strengths and networks</p> <ul style="list-style-type: none"> • Help KP members identify and use their existing strengths: <ul style="list-style-type: none"> – “What helped you cope with hard times in the past?” – “What activities help you when you’re feeling anxious?” – “How could what has helped in the past be helpful now?” • Help KP members explore existing support networks: <ul style="list-style-type: none"> – “When you’re not feeling well, who do you like to be with?” – “Who helped you in the past? Could they be helpful now?” – “Are there people you trust that you can talk?” 								
<ul style="list-style-type: none"> • Show slide and explain: Even if a service user does not disclose violence, it is important to deliver messages, provide information, and share resources related to violence in case they are experiencing violence but are not comfortable disclosing or if they experience violence in the future. • Review the content on the slide. 	<p>How a health care worker could respond when a service user says they have NOT experienced violence</p> <table border="1"> <thead> <tr> <th>Task</th><th>Message</th></tr> </thead> <tbody> <tr> <td>Deliver violence prevention and response messages</td><td>“If you experience violence or abuse in the future, I am here to support you. Many people have these experiences but everyone has the right to live free from violence and abuse.”</td></tr> <tr> <td>Provide information about medical options for sexual violence</td><td>“If sexual violence occurs, it is important to seek help quickly. There are medical options that can be used within three days after the assault that can reduce risk of HIV infection and within five days to reduce risk of pregnancy.”</td></tr> <tr> <td>Share resources</td><td>“I’d like to share resources in case you ever need them. Is that okay?”</td></tr> </tbody> </table>	Task	Message	Deliver violence prevention and response messages	“If you experience violence or abuse in the future, I am here to support you. Many people have these experiences but everyone has the right to live free from violence and abuse.”	Provide information about medical options for sexual violence	“If sexual violence occurs, it is important to seek help quickly. There are medical options that can be used within three days after the assault that can reduce risk of HIV infection and within five days to reduce risk of pregnancy.”	Share resources	“I’d like to share resources in case you ever need them. Is that okay?”
Task	Message								
Deliver violence prevention and response messages	“If you experience violence or abuse in the future, I am here to support you. Many people have these experiences but everyone has the right to live free from violence and abuse.”								
Provide information about medical options for sexual violence	“If sexual violence occurs, it is important to seek help quickly. There are medical options that can be used within three days after the assault that can reduce risk of HIV infection and within five days to reduce risk of pregnancy.”								
Share resources	“I’d like to share resources in case you ever need them. Is that okay?”								
<ul style="list-style-type: none"> • Show slide and explain: This is the process that we want to follow when asking about violence and responding to it. Tools can be used to help us remember all the steps in this process. • Ask participants to refer to existing tools used by their facility, specialty, or position, or to the sample tool (Handout 5: Sample Tool to Ask about and Respond to Violence). • Explain: I want to spend a few minutes orienting everyone to this tool and making some key points about its content and use before we practice using it. 	<p>Review tool to ask about and respond to violence</p> 								

<ul style="list-style-type: none"> • Provide an orientation to the tool and review in detail. This includes reading each section out loud or summarizing its contents. • Bring participants' attention to the information at the top that says, "Remember to discuss confidentiality and information sharing." This should always be done before questions are asked. • Explain: As we discussed in Session 2.5, in some cases the law requires you to report what a service user tells you to local authorities. As a result, it is important that you tell someone any limits on confidentiality BEFORE you ask them about their experiences of violence. • At the same time, you should assure them that as long as you are not obligated legally to share something, you will not pass their information on to anyone else without permission. 	
<ul style="list-style-type: none"> • Summarize: When KP members have the courage to disclose their experiences to health care workers, it may be the first time they have told anyone or, as we saw in the "in her shoes" exercise, it may be that they have already had several terrible experiences when disclosing. • If victims feel disrespected or judged, they are less likely to share their experiences and less likely to engage in follow-up services, including health care. • But when health care workers know how to provide first-line support they can handle the disclosure of violence appropriately and may change the lives of victims of violence, including KP members. • Ask participants whether they have any final questions or reflections on what has been shared. 	<p>Questions and reflections</p> <hr/>

Session 3.5: Referring Effectively: Overview of Recommended Health, Social, and Justice/Legal Services and Improving Access to Each One

Time: 45 min

Materials

- Slide presentation
- Flip chart and markers
- [Handout 6](#): Sample Printed Referral Network, or local violence response service directory

Planning Ahead

Review existing referral mechanisms, including those already in use by health care workers, before this session. If possible, make copies of a local violence response service directory that describes existing organizations engaged in violence response and provides information such as services offered, location, hours, and contact information for each one. If a local violence response directory is not available or if it does not provide the necessary information, you can use [Handout 6](#) to develop one. If a national or other protocol guides how services should be offered to victims of violence, describe the referral order and process during this session.

Having one or more law enforcement officer, peer educator, outreach worker, or other violence response service provider come to the health care worker training can also help strengthen connections between referral points in different sectors. Trusted referral points can be invited to explain the services available and how referral works.

Finally, the slide on PEP and emergency contraception is best presented by a medical professional. If the facilitator is not a medical professional, it is beneficial to find someone prior to this session who can present this information. This individual could be a senior health official or even one of the participants if they are knowledgeable about the topic.

- Show slide and explain: 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. Health, social, and justice/legal services, including through referral, should be accessible to ensure comprehensive support is available to all victims. Health care workers are an important part of this referral network.

Session 3.5

Referring Effectively: Overview of Recommended Health, Social, and Justice/Legal Services and Improving Access to Each One

- Show slide and ask a participant to read the objective out loud.

Objectives

- List the services that should be offered to victims of violence and describe the importance of each
- Describe the process of referral for all available services
- Discuss which of these services KP members can safely be referred to

- Show slide and explain: As you saw in the objectives, in this session we are going to think about all the services that victims of violence need and where those services are available.
- I would like us to start this conversation by looking back at Group 4's answers in response to Amanda's story. They were looking at the consequences of different forms of violence.
- Ask Group 4 to summarize some of the consequences they recorded. If the poster that Group 4 created is still easily available, it should be re-presented at this time.
- Now, ask the larger group what kinds of services Amanda would need to deal with those consequences. After a few examples of services are given, click slide again to show the table.
- Explain: You've just named many services that Amanda could have benefitted from. Depending on the kinds of violence experienced and the effects of that violence, as well as the wishes of the victim, a range of services may be helpful. You can see those services presented here. Now we're going to talk about where each of these services can be found in our area.
- Explain: We will break into regional groups. Each group will generate the names of all the organizations that offer each of the services in the table on the slide. Use a star to show whether you think it would be safe and appropriate to send a KP member to this organization. If some KP members could go there without a problem but others could not (e.g., the organization would serve female sex workers but not men who have sex with men), indicate this. For each place that the service is available, provide details about the service in the "details" column; e.g., when it is open, where it is located, a contact number to call.

Discussion: Meeting victims' needs

	Services (potentially) needed	Where available	Details
Physical and mental health services	<ul style="list-style-type: none"> • Emergency injury treatment • HIV and STI testing/prophylaxis/care • Emergency contraception • Rape kits/forensic examination • Relevant vaccines • Mental health screening/treatment for depression and post-traumatic stress disorder 		
Social services	<ul style="list-style-type: none"> • Psychosocial support (support groups, crisis counseling) • Securing/replacing ID documents • Shelter • Financial aid • Child care 		<ul style="list-style-type: none"> • Educational assistance • Food assistance • Interpreters
Legal/justice services	<ul style="list-style-type: none"> • Information on their rights • Information on law enforcement procedures • Support from law enforcement • Legal counsel • Ability to give a statement/document the case • Ability to seek redress when wrongly arrested • Access to ARVs even while incarcerated 		

<ul style="list-style-type: none"> • Break participants into groups by region or other geographical unit and ask each group to fill in the last two columns for their geographic area. • Give groups about 15–20 minutes to work together. • Facilitator should circulate and assist groups, as needed. • Debrief the exercise and ask a volunteer from each group to present their results. <p><i>[Note to the facilitator: If the HIV program leading this training has already developed a referral list of all KP-friendly agencies, this list can be shared at the beginning of the small group work and used as the basis of the list of services available. Note that each geographic region will still need to revise the list to be location specific. If possible, providers of the KP-friendly services can present on what they offer and meet newly trained health care workers as part of sharing the list of available services.]</i></p> <p><i>Allow time to review the referral list to see how it compares to the services brainstormed by participants and for the participants to ask any clarifying questions about how to access each service on the list.]</i></p>	
<ul style="list-style-type: none"> • Show slide and explain: Please remember that some services are time-bound. Post-exposure prophylaxis, or PEP, must be initiated within 72 hours of a potential exposure to HIV. Emergency contraception must be initiated within 120 hours, which is five days. However, for both, the sooner they are started, the better. <p><i>[Note to the facilitator: Ideally this slide will be presented by a medical professional who is part of the referral network for victims of violence. The medical professional should talk about the importance of PEP and emergency contraception, how PEP and emergency contraception work (including that emergency contraception does not cause abortion), and how to access both emergency contraception and PEP.]</i></p>	<p>A note about immediate clinical services</p> <ul style="list-style-type: none"> • PEP can prevent HIV infection. <ul style="list-style-type: none"> – If someone may have been exposed to HIV (for example, through rape), they need to begin PEP within 72 hours. • Emergency contraception prevents ovulation to prevent an unplanned pregnancy. <ul style="list-style-type: none"> – If a woman is at risk for an unplanned pregnancy (for example, due to rape), EC will be effective up to five days after the incident. <p><small>[Country team to include information on the local procedure for accessing PEP and emergency contraception]</small></p> <hr/>

- Show slide and explain: Now that we have a list of all the available services, it's important to follow existing referral processes.
- Before referring, it is important to call to ensure that each service is available and whether the service provider offers care that is friendly to KP members. We do not want to cause further harm by sending a victim of violence to a service that is either no longer offered or does not treat the victim with respect.

[Note to the facilitator: Use this slide to describe how health care workers can make sure someone can get quickly to services they need urgently. Add referral information (e.g., services offered, location, hours, contact information) to the image on the slide. If the HIV program can offer accompaniment for victims to other services, share this information with them here.]

Time permitting, ask whether participants have experience referring to any of the agencies that have been presented and what could have made those referral processes more effective.]

[Note to the facilitator: If you, or the project you work with, can help those organizations that offer services to victims of violence coordinate their services so that referral between agencies is smoother, this can improve access to all services and make victim's experiences seeking help less difficult.]

- Show slide and explain: Even if someone does not get all the services that you wish they would in this moment, know that they are learning to recognize you as a resource. Ideally, this will mean someone will come back to you if they have issues in the future.

Referral process in [Country]

[Country team to add information on referral process for post-violence services if one is established.]

HEALTH SERVICES	SOCIAL SERVICES	JUSTICE/LEGAL SERVICES
[Name of Organization/Facility]	[Name of Organization/Facility]	[Name of Organization/Facility]
Hours:	Hours:	Hours:
Location:	Location:	Location:
Focal Point:	Focal Point:	Focal Point:
Phone:	Phone:	Phone:
Email:	Email:	Email:
Services available:	Services available:	Services available:
[Name of Organization/Facility]	[Name of Organization/Facility]	[Name of Organization/Facility]
Hours:	Hours:	Hours:
Location:	Location:	Location:
Focal Point:	Focal Point:	Focal Point:
Phone:	Phone:	Phone:
Email:	Email:	Email:
Services available:	Services available:	Services available:

Recognizing you as a resource

- Ideally someone is able to come back to you or your facility if they experience future violence.
- If appropriate, you can end conversations by saying, "Please come back if we can support you in any other way."

- Summarize: With time, you will feel more comfortable performing these functions. The most important thing is to make sure that people feel like they can look to you for support.
- Ask participants whether they have any final questions or reflections on what has been shared.

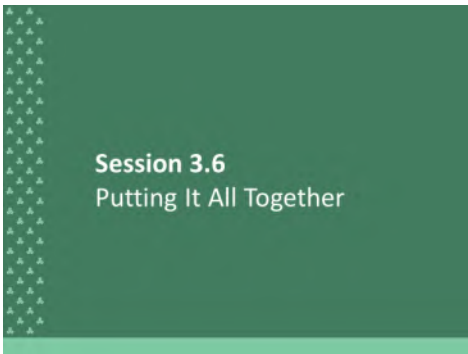
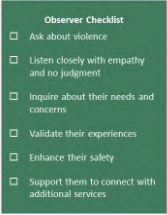
Questions and reflections

Session 3.6: Putting It All Together

Time: 40 min

Materials

- Slide presentation
- Flip chart and markers
- [Handout 5](#): Sample Tool to Ask about and Respond to Violence, or locally used tool serving a similar function
- [Exercise Card 6](#): Victim Roles for First-Line Support Practice

<ul style="list-style-type: none">• Explain: Now that we have covered how to ask about violence, provide first-line support, and refer to services, we're going to practice using all these skills at once.	 A green slide with white text that reads "Session 3.6 Putting It All Together". The left side of the slide has a decorative pattern of small white stars.
<ul style="list-style-type: none">• Show slide and ask a participant to read the objective out loud.	<p>Objective</p> <p>Practice asking about and responding to disclosures of violence appropriately</p>
<ul style="list-style-type: none">• Ask participants to break into groups of three, taking turns in the roles of victim, health care worker, and observer.• Distribute Exercise Card 6: Victim Roles for First-Line Support Practice. In each group of three, give one participant the Victim 1 story, give the second participant the Victim 2 story, and give the third participant the Victim 3 story.• Explain: The person playing the role of the health care worker will use their skills to ask about violence and provide first-line support.• Note that if you are using Handout 5 it includes the questions that can be asked and reminds the health care worker of the steps of first-line support.	<p>Activity: Practice responding to violence</p> <ul style="list-style-type: none">• In groups of three, rotate so that each person is a victim, a health care worker, and an observer one time• During the interaction, the health care worker will use their skills to ask about violence and provide first-line response, including making referrals as desired by the victim• Once each interaction is complete, the observer provides their feedback on what went well and what could be improved  A green box with white text titled "Observer Checklist". It contains a list of six items, each with a checkbox: "Ask about violence", "Listen closely with empathy and no judgment", "Inquire about their needs and concerns", "Validate their experiences", "Enhance their safety", and "Support them to connect with additional services".

- The person playing the role of a victim will use a story found in [Exercise Card 6: Victim Roles for First-Line Support Practice](#).
- The observer will use the observer checklist, shown on the slide, to note what they see. Each role-play will last seven minutes. After this time, I will let you know that you should stop and allow the observer to share feedback about what went well and areas that might need improvement.
- When you are the observer, please:
 - Share something that could be improved
 - End with something positive
 - For example: I noticed that you asked a few “why” questions, but then you quickly rephrased them. That was quick thinking. I thought you did a good job using all of the listening skills.
- After the first role-play and observations are shared within your small group, switch roles until all three of you have had a chance to practice the skills.
- We will spend about 30 minutes practicing, so use your time well!
- Don’t worry if it feels awkward to you right now. With practice, it will feel and come across as more natural.
- The goal is to make documenting cases of violence feel more like a conversation.
- Give participants about 10 minutes for each scenario, seven for the role-play and three for the feedback.
- Encourage people to make this as realistic as possible, including having victims that don’t want services or who want specific services and need referrals that the person playing the role of health care worker practices providing.
- Facilitators should circulate, observe, provide guidance, answer questions, etc. If you see a small group that is particularly skilled, consider having them come up to the front to demonstrate for the large group.

<ul style="list-style-type: none"> Depending on the time you have available, either after each round or after everyone has had a turn in each role, show slide and debrief with the large group. Ask questions such as: <ul style="list-style-type: none"> Were some of the items in this checklist more difficult to do than others? (If any of the checklist items were particularly difficult, ask all participants if anyone was in a group that had strategies that worked well to address that particular item. If so, have participants from that group share with everyone.) How can we get the information we need without making a victim feel we think they are at fault? What worked well? What areas need improvement? Was it hard to meet the victim's needs with available referrals? Was anything surprising? 	<p>Activity: Practice responding to and documenting violence (debrief)</p> <ul style="list-style-type: none"> How did each of these go? <ul style="list-style-type: none"> <input type="checkbox"/> Ask about violence <input type="checkbox"/> Listen closely with empathy and no judgment <input type="checkbox"/> Inquire about their needs and concerns <input type="checkbox"/> Validate their experiences <input type="checkbox"/> Enhance their safety <input type="checkbox"/> Support them to connect with additional services What worked well? What areas need improvement? <hr/>
<ul style="list-style-type: none"> Ask participants whether they have any final questions or reflections on what has been shared. <p><i>[Note to the facilitator: If you have time to extend this activity, consider doing another three rounds to allow each person to be the victim, health care worker, and observer a second time. Either have the participants generate their own scenarios or add additional scenarios in advance.]</i></p>	<p>Questions and reflections</p> <hr/>

Session 3.7: Data Collection and Sharing

Time: 45 minutes

Materials

- Slide presentation
- Flip chart and markers
- Locally used intake/record forms to document cases of violence
- [Exercise Card 7](#): Privacy and Confidentiality in Documentation Checklist

Planning Ahead

This session should be organized prior to the training. Facilitators should ask senior health officials to provide any forms routinely used to document cases of violence. If senior officials report that forms vary across facilities, participants should be asked to bring copies of the intake/record forms they use to document cases of violence. In case no intake/record forms to document cases of violence are used or if senior health officials wish to strengthen their existing forms, review Annex 9: Sample Intake/Record Form for Clients Subjected to Intimate Partner Violence or Sexual Assault from *Strengthening Health Systems to Respond to Women Subjected to Intimate Partner Violence or Sexual Violence: A Manual for Health Managers*²³ and Tool 12: Crisis Management Register from *Monitoring Guide and Toolkit for Key Population HIV Prevention, Care, and Treatment Programs*.⁴⁶

The slide on privacy and confidentiality in data collection and sharing should be reviewed by a senior health official in advance. See the green text on the slide presentation to consider the specific information the senior health official should be able to address.

- Show slide and explain: **As health care workers, you have a lot of experience using medical intake and other forms to document service user's health information and the services they receive.**
- You may already be using forms from the Ministry of Health or from your own facility, specialty, or position to document information about cases of violence.

- Show slide and ask a participant to read the objective out loud.

Session 3.7 Data Collection and Sharing

Objectives

- Discuss the importance of documenting violence against KP members
- Identify practices for safe data collection and management in cases of violence

<ul style="list-style-type: none"> ● Ask: Why do we document violence? ● Give time for a few answers and then click again. ● Explain: <ul style="list-style-type: none"> — Documenting cases of violence captures information on what the victim experienced, including the characteristics of violence. This can keep the victim from having to share their story repeatedly with others. It's also important to record services given and referrals made. — Ideally, it's also possible to record the referrals that have been completed. All of this can help manage immediate care but also provide information that may assist in longer-term health care provision. For example, if someone reports a violent partner at one visit, it is useful to ask whether this remains a concern at subsequent visits, especially if the health care worker will be engaging in activities such as partner notification (also called index testing and voluntary partner referral). — Documenting cases of violence can also help victims of violence if they decide to file a report in the legal system. 	<p>Discussion: Why do health care workers document cases of violence?</p> <ul style="list-style-type: none"> ▪ To capture information about the violence experienced (type, perpetrator, injuries) ▪ So that the victim doesn't have to repeat their story to others if they decide to seek additional health services ▪ To record the services provided to the victim and any referrals made ▪ To manage the victim's health care immediately and longer term <hr/>
<ul style="list-style-type: none"> ● Show slide and explain: Documenting violence not only helps our individual clients. It also allows us to aggregate information on cases of violence and identify trends. This aggregated data serves many purposes. ● We can determine whether efforts to create environments in which disclosure can occur have been effective and the percentage of reporting victims who received services. ● Aggregating also provides an opportunity to describe the levels of reported violence against KP members, including the perpetrators and types of violence. ● This data is important to track health system performance and make improvements in service delivery. ● These are examples of how we use data to strengthen service delivery at [specific facility, specialty, or position]. ● Show country-specific slide(s) and review the content. 	<p>Using data to strengthen service delivery</p> <p>[Country team to add how data on violence is used to strengthen service delivery at specific facility, specialty, or position. This could include:</p> <ul style="list-style-type: none"> ▪ Adjusting planning for existing services or informing plans for expanding services ▪ Providing feedback to staff on the findings and discussing ways to improve quality of service delivery ▪ Sharing or disseminating the findings in the community and discussing how to make quality improvements with community members, community leaders, and other service providers ▪ Refining protocols or SOPs ▪ Providing additional training to health care workers ▪ Improving the infrastructure for service delivery and strengthening referral pathways] <hr/>

[Note to the facilitator: If relevant, this slide should describe how data on violence is already used to strengthen delivery at [specific facility, specialty, or position]. If data are not currently used in this way or more ideas for data use are desired, the examples shown here can also be helpful to generate ideas.]

- Show slide and explain: For example, if we document and aggregate data on violence, we might compare the number of people who reported cases of violence to us versus the number of those same people who followed through with the full course of PEP.

- Ask: Think of the data on this graph: If we have 50 female sex workers who reported being raped—and only 10 of them followed through with the full course of PEP—what might that tell us?

Probe for: It might tell us that we need to focus our efforts on following up with female sex workers—or maybe we were able to see that the 10 female sex workers who followed through with PEP were accompanied to the health facility by a peer educator.

Discussion: Using data to strengthen service delivery



- Show slide and explain: Appropriate data collection tools are needed to document individual reports of violence.

- Ask participants to refer to the intake/record forms that their facility, specialty, or position uses to document cases of violence. If they do not have existing intake/record forms choose either Annex 9 of *Strengthening Health Systems to Respond to Women Subjected to Intimate Partner Violence or Sexual Violence: A Manual for Health Managers*²³ or Tool 12 of *Monitoring Guide and Toolkit for Key Population HIV Prevention, Care, and Treatment Programs*⁴⁶ and use it as an example.

- Explain: I want to spend a few minutes orienting everyone to this intake/record form and making some key points about its content.

- Provide an orientation to the form and review in detail.

[Note to the facilitator: It may be most appropriate for a senior health official to review the form, especially if they are aware of common errors in its use and want to remind those trained how to fill it out correctly.]

Data collection tools

Presenting symptoms/conditions	<input type="checkbox"/> Injuries	<input type="checkbox"/> Sexual/reproductive health conditions	<input type="checkbox"/> Mental/emotional problems	<input type="checkbox"/> Other (specify)
Type of violence	<input type="checkbox"/> Physical violence	<input type="checkbox"/> Sexual violence	<input type="checkbox"/> Psychological/emotional	<input type="checkbox"/> Other (specify)
	<input type="checkbox"/> Rape	<input type="checkbox"/> Rape – arrived within 72 hours		
Perpetrator	<input type="checkbox"/> Intimate partner	<input type="checkbox"/> Family member in household	<input type="checkbox"/> Family member/acquaintance living elsewhere	<input type="checkbox"/> Stranger
Assessments and clinical care for all survivors	<input type="checkbox"/> First-line support	<input type="checkbox"/> Safety assessment	<input type="checkbox"/> Injuries & wound care	<input type="checkbox"/> Tetanus prophylaxis
	<input type="checkbox"/> Other (specify)			

Source: WHO, 2017.

<ul style="list-style-type: none"> • Show slide and explain: Although documenting violence is necessary to provide appropriate care for victims, we can put the victim’s safety at risk if we do not protect the information we document. This could include sharing sensitive information with partners, family members, friends, or other health care workers without the victim’s consent or not recording and storing their information safely. • Ask: What could happen if health care workers don’t protect service users’ data? Elicit responses. • Click slide again and review content. • Summarize: A breach of confidentiality about rape, HIV status, sexual orientation, gender identity, sex work, drug use, or a history of sexual abuse can put victims at risk of additional emotional, physical, and sexual violence. 	<p>Discussion: What could happen if health care workers don’t protect service users’ data?</p> <ul style="list-style-type: none"> • Stigma and discrimination • Retaliation by the perpetrator • Theft of service users’ health files <hr/>
<ul style="list-style-type: none"> • Show slide and explain: As you saw in the previous discussion, privacy, confidentiality, and safety are key principles to consider when documenting cases of violence. Implementing these principles is important for protecting service users from further harm. • Show country-specific slide(s) and review the content. <p><i>[Note to the facilitator: The slide in green was designed to help a senior health official prepare responses to these questions in advance. The questions were informed by the “Privacy and confidentiality in data collection, sharing, and reporting” box in Strengthening Health Systems to Respond to Women Subjected to Intimate Partner Violence or Sexual Violence: A Manual for Health Managers.²³ You will not use this slide in the final presentation; replace it with slides needed for the session.]</i></p>	<p>Privacy and confidentiality in data collection and sharing</p> <ul style="list-style-type: none"> • Who is responsible for collecting and recording information? • Where and how is information collected and recorded? • How is information stored? • Who has access to the information, including what information is shared within the health facility or with referral points? • How do health care workers obtain service users’ consent before sharing any information and inform them about limits to confidentiality where applicable (e.g., mandatory reporting)? <hr/>
<ul style="list-style-type: none"> • Show slide and explain: Regardless of format—electronic or paper-based—all types of files must be secured. • We’ll review Exercise Card 7: Privacy and Confidentiality in Documentation Checklist in small groups to help us think through how we can ensure records are secure, including what practices are already in place and what support we need to address gaps. 	<p>Activity: How can we create secure records in practice and storage?</p> <ul style="list-style-type: none"> • Break into small groups • Respond to checklist questions <ul style="list-style-type: none"> – YES or NO – If NO, what support is needed to address this gap? <hr/>

<ul style="list-style-type: none"> • Break participants into groups by region or other geographical unit and ask each group to fill in the checklist for their geographic area. • Give groups about 15 minutes to work together. • Circulate and assist groups, as needed. • Ask a volunteer from each group to present their results. • Note that a senior health official will provide updates on how their facility, specialty, or position will support health care workers to ensure records are secure in Session 4.2. <p><i>[Note to the facilitator: Exercise Card 7 is adapted from Annex 11: Privacy and Confidentiality in Documentation in <i>Strengthening Health Systems to Respond to Women Subjected to Intimate Partner Violence or Sexual Violence: A Manual for Health Managers</i>.²³]</i></p> <p><i>[Note to the facilitator: Share a summary of the completed checklists with senior health officials so they can address the support that will be provided to health care workers in Session 4.2.]</i></p>	
<ul style="list-style-type: none"> • Summarize: Documenting violence helps us to track performance and improve service delivery for victims of violence, and we have to ensure privacy and confidentiality when documenting violence to protect victims from further harm. • Ask participants whether they have any final questions or reflections on what has been shared. 	<p>Questions and reflections</p> <hr/>

Session 3.8: Recap: Minimum Requirements to Ask about Violence

Time: 15 minutes

Materials

- Slide presentation
- Flip chart and markers
- [Handout 2](#): Participant Agenda

<ul style="list-style-type: none"> • Show slide and explain: Before we end this module, let's look back at the minimum requirements that must be in place before health care workers can ask about violence. 	
<ul style="list-style-type: none"> • Show slide and ask a participant to read the objective out loud. 	<p>Objective</p> <p>Discuss the importance of the minimum requirements that must be in place before health care workers can ask about violence</p>
<ul style="list-style-type: none"> • Explain: Let's remind ourselves why each minimum requirement is important. • Ask participants about the importance of the first requirement and allow them to provide some answers before going to the next requirement. Repeat until you've discussed the importance of all six requirements. <ul style="list-style-type: none"> – Example answers for “written protocol/SOP for the provision of violence response services is in place” include: <ul style="list-style-type: none"> ▪ To ensure health care workers are knowledgeable about how violence response services will be integrated into their clinical practice, including who asks about violence, how and when asking about violence takes place, how to respond to disclosures of violence, how to link service 	<p>Discussion: Why is it important to have the minimum requirements in place before asking about violence?</p>  <p>Source: Adapted from USAID, Office of HIV/AIDS, Gender and Sexual Diversity Branch</p>

<p>users to additional services, and how to document cases of violence</p> <ul style="list-style-type: none"> – Example answers for a “standard set of questions are used to facilitate documentation, and safe storage mechanisms are in place” include: <ul style="list-style-type: none"> ▪ To ensure that providers have support as they bring up the topic of violence, that they ask questions in a way that service users will understand, and that it is possible to document the types of violence reported ▪ To ensure that health records related to violence disclosures and violence response services are safely stored and kept confidential – Example answers for “providers are trained on how to ask about and respond to violence” include: <ul style="list-style-type: none"> ▪ To ensure that health care workers create an environment where service users feel safe and comfortable disclosing their experiences with violence ▪ To ensure that health care workers respond appropriately to disclosures of violence – Example answers for “providers offer first-line support (LIVES)” include: <ul style="list-style-type: none"> ▪ To support and validate the experiences of victims of violence – Example for “providers only ask about violence in a private setting, confidentiality ensured” include: <ul style="list-style-type: none"> ▪ To create an environment in which disclosure can safely occur – Example answers for a “system for referrals to violence response services is in place” include: <ul style="list-style-type: none"> ▪ To ensure that health care workers are aware and knowledgeable about health, social, and justice/legal services available to victims of violence ▪ To meet the health, social, and justice/legal needs of victims of violence ▪ To ensure that referral points are KP-friendly 	
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- Refer back to [Handout 2](#): Participant Agenda to help demonstrate how this training covered each of the minimum requirements.
- Note that a senior health official will provide updates on how their specific facility, specialty, or position is addressing each of the minimum requirements in Session 4.2.

Minimum requirements in this training



- Summarize: **If these requirements are met, health care workers can begin asking service users about violence.**
- Ask if there are any final reflections or questions before you move on.

Questions and reflections

MODULE 4:

Using What We Have Learned

MODULE 4:

USING WHAT WE HAVE LEARNED

Introduction

This is the final module of the training. It recaps what has been learned while making clear the expectations going forward. It contains sessions on self-care for health care workers including confronting secondary stigma and ends with an opportunity to confidentially commit to joining a list of sensitized health care workers willing to support KP members.

This module includes the following sessions and learning objectives:

Session 4.1 Taking Care of Ourselves: Identifying and Confronting Secondary Stigma and Stress

- Recognize and identify ways to counter the impacts of secondary stigma on health care workers who work with members of KPs
- Identify ways to counter the impacts of work-related stress

Session 4.2 Reflections on What We Have Learned and How to Integrate It into Our Work

- Identify and discuss specific “asks” of health care workers going forward

Session 4.3 Post-Test and Training Evaluation

- Assess newly acquired knowledge and attitudes
- Provide feedback on the training

Session 4.4 Closing Ceremony and Final Words


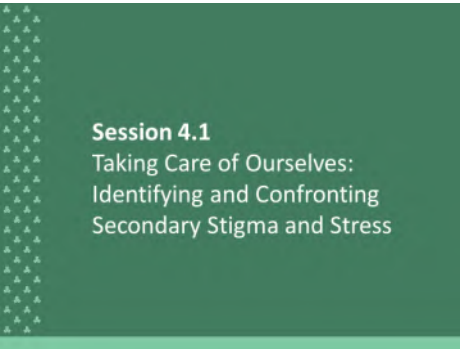
- Acknowledge participant effort and commitment

Session 4.1: Taking Care of Ourselves: Identifying and Confronting Secondary Stigma and Stress

Time: 60 minutes

Materials

- Slide presentation
- Flip chart and markers
- Candy (as prizes)
- [Exercise Card 8](#): Combatting Secondary Stigma
- [Exercise Card 9](#): Stress Reduction Activities

<ul style="list-style-type: none"> • Say: We are now in our final module of the training. 	 <p>Module 4 Using What We Have Learned</p> <p>Logos: USAID, PEPFAR, LINKAGES, fhi360</p>
<ul style="list-style-type: none"> • Explain: Our first session in this module is about taking care of ourselves. We have spent a lot of time improving our skills to support others, but when we work in health care—a high-stress profession—and when we serve those who are most vulnerable, we need to make sure we have appropriate mechanisms in place to support ourselves in this difficult work. 	 <p>Session 4.1 Taking Care of Ourselves: Identifying and Confronting Secondary Stigma and Stress</p>
<ul style="list-style-type: none"> • Show slide and ask a participant to read each objective out loud. 	<p>Objectives</p> <ul style="list-style-type: none"> ▪ Recognize and identify ways to counter the impacts of secondary stigma on health care workers who work with members of KPs ▪ Identify ways to counter the impacts of work-related stress

<ul style="list-style-type: none"> • Show slide and say: One of the big issues that comes up for health care workers as they implement what they have learned in this training is secondary stigma. As you can see here, secondary stigma is directed at those who are working with stigmatized groups. In this context, it would mean that a health care worker who is now helping sex workers, for example, may also be stigmatized for this association. • Ask: How could secondary stigma affect health care workers who recognize it is their job to serve all people and stop discriminating against men who have sex with men, people who inject drugs, sex workers, and transgender people? • Answers may include: It could cause health care workers to fear helping KP members, and it could lead to stress and anxiety for health care workers. • Say: We recognize this potential barrier to using what you've learned during this training and are going to play a game to learn how to overcome it. 	<p>Secondary stigma</p> <ul style="list-style-type: none"> • Stigma refers to the strong <i>negative feelings or disapproval</i> that is linked to a specific person, group, or trait. • Secondary stigma is directed toward those who support a stigmatized group. For example, health care workers who support people living with HIV can sometimes experience stigma from their family members. <hr/>
<ul style="list-style-type: none"> • Refer to Exercise Card 8: Combatting Secondary Stigma. • Remind health care workers of all the reasons they are proud to be health care workers, especially if helping the vulnerable is referenced. Then say that this can still be difficult, even when someone is brave and committed to their work. • Explain: We will play a game called “the best response game.” We are going to think together about what we can say/do when confronted with secondary stigma so that we can limit its impact on our actions. • In this game, we will begin with two contestants. (Alternatively, this can be done in teams.) They will hear an example of secondary stigma and give their ideas for how they could address this situation. The rest of the participants will decide by clapping for the answer they think is the best. • Have two people come up to the front of the room. Read the first scenario and let them respond. Then let the participants decide, by clapping loudly for their favorite answer, which answer was best. • The winner of the most applause stays in the front to compete again. The other person sits down. • You can give the winner of each scenario candy or wait until the end to award the candy prize. 	<p>Activity: Best response game</p> <ul style="list-style-type: none"> • Being willing to stand up for and with marginalized groups takes bravery. • Trained health care workers will also be helpful in supporting each other. • The best response game allows you to think through scenarios of secondary stigma that could occur and come up with a response. <hr/>

<ul style="list-style-type: none"> After each round, ask participants why the winning answer won and then invite a new competitor to come to the front. Continue until all the scenarios have been used (or you can ask participants to share some of their own experiences or scenarios they worry could occur). The winner of the last round gets the largest candy prize. 									
<ul style="list-style-type: none"> Say: <i>Now that we have thought about secondary stigma specifically, let's think about self-care more broadly.</i> Show slide and review the content. 	<p>Self-care</p> <p>Self-care is the <i>intentional</i> time taken by an individual to <i>nurture</i> themselves physically, mentally, spiritually, and emotionally on a <i>daily</i> basis.</p>								
<ul style="list-style-type: none"> Show slide and explain: <i>All these elements are part of the balance that allows us to care for ourselves. When we don't care for ourselves, we see consequences that affect our work and our personal well-being.</i> Ask for volunteers to read over the contents of the slide. 	<p>Consequences of poor self-care</p> <table border="1"> <tbody> <tr> <td>Mental health</td><td>Frustration, irritability, anxiety/fear, confusion, poor concentration, helplessness, hopelessness, depression, low morale, pessimism, compassion fatigue, guilt, etc.</td></tr> <tr> <td>Physical health</td><td>Stress-related illness (hypertension, ulcers, acid reflux/heartburn, skin rash, etc.); caregivers often experience headaches, back pain, insomnia, and arthritis</td></tr> <tr> <td>Relationships (personal and professional)</td><td>Conflict, tension, misunderstanding, anger, emotional or physical abuse</td></tr> <tr> <td>Organizational health</td><td>Increased absenteeism, diminished productivity, team conflict, turnover</td></tr> </tbody> </table>	Mental health	Frustration, irritability, anxiety/fear, confusion, poor concentration, helplessness, hopelessness, depression, low morale, pessimism, compassion fatigue, guilt, etc.	Physical health	Stress-related illness (hypertension, ulcers, acid reflux/heartburn, skin rash, etc.); caregivers often experience headaches, back pain, insomnia, and arthritis	Relationships (personal and professional)	Conflict, tension, misunderstanding, anger, emotional or physical abuse	Organizational health	Increased absenteeism, diminished productivity, team conflict, turnover
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Organizational health	Increased absenteeism, diminished productivity, team conflict, turnover								
<ul style="list-style-type: none"> Show slide and explain: <i>Let's look at some recommendations for self-care that can help us avoid stress or cope with it.</i> First, you need to be aware of what might trigger you. For example, some people find it difficult to support individuals who want to talk about experiences of violence from childhood because they themselves also had those experiences and have never discussed them. If you have specific triggers you're aware of, talk to your supervisor about how others might be able to be called in to support specific cases or victims. Connect with trusted colleagues you can talk to about your responses. Ideally some kind of monthly meeting is held during which staff mental health is discussed and prioritized. Cases that are the most difficult or have made a lasting 	<p>Recommendations for self-care</p> <ol style="list-style-type: none"> Be aware of our own emotional reactions and distress when confronting others' traumatic experiences (know what traumatic material may trigger us). Connect with trusted colleagues or other supportive people and talk about our reactions. Maintain a balance between our professional and personal lives, with a focus on self-care (e.g., relaxation, exercise, stress management) to prevent and lessen the effects of workplace stress. 								

<p>impression can be discussed, but without disclosing any information that would identify a given victim.</p> <ul style="list-style-type: none"> • Maintain a balance in which you are not working all the time and not constantly exposed to violence. This might mean limiting your exposure to news or even violent movies and books. When you do have time to yourself, see whether it's possible to fit in even five minutes of deep breathing to give yourself the chance to reset and calm down. 	
<ul style="list-style-type: none"> • Show slide and review the content. • After four to five minutes, have people share anything that was particularly helpful or something their partner said that they had never thought of doing before or had never tried. 	<p>Discussion: Strategies for coping with stress</p> <p>Turn to the person next to you and discuss:</p> <ul style="list-style-type: none"> • What do you do when you're feeling stressed? • Which of these activities do you think is the most effective at helping you feel better?
<ul style="list-style-type: none"> • Show slide and say: <i>These are some examples that others have found helpful to relieve stress and take care of themselves.</i> <p><i>[Note to the facilitator: Review these examples in advance to ensure they are appropriate in your setting. Feel free to add or revise as needed.]</i></p>	<p>Some examples of self care</p> <ul style="list-style-type: none"> • Quiet walks by yourself • Little meditative periods (waiting for something, a cancellation of a session, a brief illness) are opportunities for a quiet, reflective, peaceful time • Time and space for meditation • Reading (spiritual, fiction, biographies) • Some light exercise • Opportunities to laugh in the company of cheerful friends • A hobby • Listening to music you enjoy
<p><i>[Note to the facilitator: Consider doing one of the activities included in Exercise Card 9 if you think it would be well received. If not, you can simply remind participants that breathing deeply is often enough to help calm our minds and bodies when we are stressed. The exercises are taken from Health Care for Women Subjected to Intimate Partner Violence or Sexual Violence: A Clinical Handbook.^{31]}</i></p>	<p>Activity: Stress relief</p>
<ul style="list-style-type: none"> • Ask if there are any questions or reflections from participants about secondary stigma or self-care. 	<p>Questions and reflections</p>

Session 4.2: Reflections on What We Have Learned and How to Integrate It into Our Work

Time: 60 minutes

Materials

- Slide presentation
- Flip chart and markers

Planning Ahead

This session makes a series of “asks” of health care workers who have just been trained. These asks should be reviewed and revised by senior health officials such as a member of the Ministry of Health or another ministry overseeing the HIV response, health facility administrator, or HIV program senior official before they are shared during the training. In addition, a slide describes the ongoing support health care workers will receive as they use what they’ve learned during the training. This slide should also be reviewed and revised by senior health officials. It should also be modified to reflect any follow-up support offered by the HIV program implementing the training. Finally, any issues that came up throughout the training—especially the environmental factors discussed in Session 3.1—can be responded to by senior health officials during this session if the officials are prepared to comment.

- Say: Now that we understand the issue of violence against members of key populations and how it also affects health and well-being, what we can do about it, and how to take care of ourselves as we do this important work, let’s talk about what’s next.

- Show slide and ask a participant to read each objective out loud.

Session 4.2

Reflections on What We Have Learned and How to Integrate It into Our Work

Objective

Identify and discuss specific “asks” of health care workers going forward

<ul style="list-style-type: none"> • Show slide and say: One of the most important things to take away from this training is what we ask of you. • Ask participants to read each one aloud; answer any questions if a specific “ask” is unclear. <p><i>[Note to the facilitator: Review this list of “asks” in advance with senior health officials to ensure that nothing here contradicts with other instructions. Add to it as possible. Ideally, a senior health official is able to present this slide to show their support for these “asks” and answer questions about them.]</i></p>	<h3>What we are asking of each of you</h3> <p>Always</p> <ul style="list-style-type: none"> • Treat all people with respect. <p>When supporting clients living with HIV or members of key populations (especially in partner notification)</p> <ul style="list-style-type: none"> • Ask about violence in their lives (if minimum requirements are met). <p>When someone discloses violence</p> <ul style="list-style-type: none"> • Provide first-line support. • Engage in conversations to enhance safety. • Provide/refer to violence response services including health, social, and justice/legal services. • Tailor continued health services to acknowledge the impact of past or present violence.
<ul style="list-style-type: none"> • Show slide and say: This is how we will support you in your work going forward. • This support also ensures that we align with the minimum requirements covered in Session 3.8. • Ask: What other support do you need? <p><i>[Note to the facilitator: Review and revise the contents of this slide in advance with senior health officials to ensure that this is an accurate representation of the support to be provided going forward. Ideally, a senior official will present this slide to show their commitment to offering this support and answer questions about the support to be offered. If a senior official is not able to attend this session, capture any additional support needed and share this later. Ongoing support from the HIV program should also be captured in this slide.]</i></p> <p><i>[Note to the facilitator: If issues that came up in the training—such as environmental factors that make it more difficult to uphold the fundamental principles (discussed in Session 3.1)—were already shared with senior health officials, this time is a good opportunity for the officials to share their responses.]</i></p>	<h3>How we will support you</h3> <ul style="list-style-type: none"> • Updates to protocols/SOPs for the provision of violence response services • Updates to standardized questions to facilitate documentation and safe storage mechanisms • Updates to referral system for violence response services including health, social, and justice/legal services • Continued training or expanded training on preventing, asking about, and responding to violence for other health care workers • Ongoing supportive supervision for health care workers
<ul style="list-style-type: none"> • Show slide and explain: One thing each of you can do is add your name to a service directory. This will be used to identify health care workers who can be called upon if a KP member needs support in your district or has had trouble getting help from others. • Distribute small cards and have everyone write their name and contact information on the card. At the bottom of the card, each person should indicate whether they wish to be part of the service directory. 	<h3>Service directory</h3> <ul style="list-style-type: none"> • We invite everyone to add their name and contact information to a service directory that will be shared with members of key populations and those implementing HIV programs for key populations. • You do not have to add your name if you do not wish to.

- Collect all cards; do not disclose who did and did not choose to be part of the directory.


[Note to the facilitator: There may be those who indicate a willingness to be on the list who should not be included because they do not offer KP-friendly support. Ensure that the list is reviewed by KP-led or KP-serving organizations both before it is initially circulated and at regular times so that all health care workers included can be relied upon to provide support.]

Session 4.3: Post-Test and Training Evaluation

Time: 15 minutes

Materials

- Slide presentation
- Flip chart and markers
- [Handout 1](#): Post-Test
- [Handout 7](#): Training Evaluation

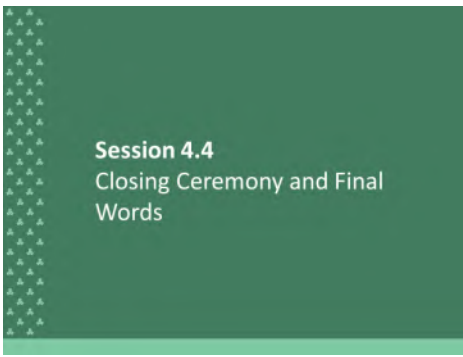
<ul style="list-style-type: none">• Explain: We're now wrapping up the training by hearing your feedback so that we can continue to improve.	
<ul style="list-style-type: none">• Show slide and ask a participant to read each objective out loud.• Distribute the post-test (the same as the pre-test, Handout 1).• Distribute the evaluation (Handout 7).• Give 10–15 minutes to complete both.	<p>Objectives</p> <ul style="list-style-type: none">▪ Assess newly acquired knowledge and attitudes▪ Provide feedback on the training

Session 4.4: Closing Ceremony and Final Words

Time: 15 minutes

Materials

- Slide presentation
- Closing remarks by senior health official
- Flip chart and markers
- Certificates of completion (optional; to be developed by the local program)

<ul style="list-style-type: none">• Show slide and explain: We are now in our final session of the training and will complete a closing activity.• Ask each person to say one way that the training will impact their personal or professional lives.	
<ul style="list-style-type: none">• Facilitators should provide final words and thank all those who came, especially senior level officials who supported the effort, and anyone who helped with logistics.• Depending on protocol, the final speaker may be a high-level official such as a member of the Ministry of Health or another ministry overseeing the HIV response, health facility administrator, or HIV program senior official who can officially close the training. <p><i>[Note to the facilitator: If it is important to provide certificates of completion/attendance, do so at this time.]</i></p>	<p>Objective</p> <p>Acknowledge participant effort and commitment</p>

ANNEXES

[Annex 1](#): Additional LINKAGES Violence Prevention and Response Tools

[Annex 2](#): Guidance on Asking about Violence

[Annex 3](#): Opening Activities and Energizers

[Annex 4](#): Ways to Recap Information

[Annex 5](#): Daily Closing Activities

[Annex 6](#): Glossary

Annex 1: Additional LINKAGES Violence Prevention and Response Tools

Title	Purpose	Target Audience
<i>Key Population Program Implementation Guide</i> ⁴⁷	Provide information on the essential elements of KP programs and help standardize LINKAGES country programs based on proven, high-quality interventions	Program implementers
<i>A Guide to Comprehensive Violence Prevention and Response in Key Population Programs</i> ¹⁷	Support the design, implementation, and evaluation of violence prevention and response activities within KP programs, including principles and step-by-step guidance for implementation	Program designers, managers, and evaluators
<i>Gender Strategy</i> ²⁸	Explain the rationale for and the process for implementing the LINKAGES gender strategy, including activities to prevent and respond to GBV	Program designers, managers, and evaluators
<i>Health4All: Training Health Workers for the Provision of Quality, Stigma-Free HIV Services for Key Populations</i> ¹⁹	Raise the consciousness of staff in health care settings about the effects of stigma and discrimination and train health care workers on how to provide stigma-free, appropriate services to KP members	Staff in health care settings
<i>Law Enforcement Training: Preventing and Responding to Violence against Key Populations to Increase Access to Justice and Strengthen the HIV Response</i> ¹⁸	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
<i>Peer Educator and Outreach Worker Training: Preventing and Responding to Violence against Key Populations</i> ⁴⁸	Build the knowledge and skills of peer educators, navigators, and outreach workers to ask KP members about violence and provide first-line support to individuals who disclose violence during outreach activities	Peer educators, peer navigators, and outreach workers
<i>Enhanced Peer Outreach Approach (EPOA): Implementation Guide</i> ⁴⁹	Describe EPOA and its potential benefits, the essential components of EPOA, and the steps involved in implementation, including potential challenges	Peer educators
<i>Peer Navigation for Key Populations: Implementation Guide</i> ⁵⁰	Provide guidance for programs implementing peer navigation as part of a core package of HIV-related interventions for KP members	Peer navigators
<i>Safety and Security Toolkit: Strengthening the Implementation of Programs for and with Key Populations</i> ⁵¹	Help KP program implementers identify and address safety and security concerns	Program implementers

Annex 2: Guidance on Asking about Violence

Guidance	Recommendation
<i>Consolidated Guidelines on HIV Testing Services (WHO)</i> ²⁰	Health care workers 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.”
<i>Guidelines on HIV Self-Testing and Partner Notification (WHO)</i> ²¹	“In consultation with the client, the risk of harm should be assessed by the provider to determine which partner notification service approach is most appropriate, including more supportive options such as dual referral or couples HTS, or whether not to proceed with partner notification at all.”
<i>Consolidated Guidelines on HIV Prevention, Diagnosis, Treatment, and Care for Key Populations—2016 Update (WHO)</i> ⁷	“All violence against people from key populations should be monitored and reported.”
<i>Implementing Comprehensive HIV and STI Programmes with Men Who Have Sex with Men (UNFPA et al.)</i> ⁵	“A clinical recommendation is to ask about the history of violence , listen carefully without pressuring the person to talk, facilitate access to social support, resources and services (e.g., legal if needed) and, in the case of intimate partner violence or the threat of aggression following discharge, help develop a safety plan.”
<i>Implementing Comprehensive HIV/STI Programmes with Sex Workers (WHO et al.)</i> ⁶	“Providers should ensure confidentiality, be non-judgmental, provide practical care, ask about the history of violence , listen carefully without pressuring the person to talk, facilitate access to social support, resources and services (e.g., legal if needed) and help develop a safety plan.”
<i>Responding to Intimate Partner Violence and Sexual Violence against Women: WHO Clinical and Policy Guidelines (WHO)</i> ²²	“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.”

Annex 3: Opening Activities and Energizers

Think about ourselves in a positive way: Ask participants to form pairs with someone at their table. Each person will take a turn sharing their two most positive characteristics. Have participants introduce each other, including their positive characteristics, to the larger group and record on flip chart titled “We are FABULOUS!” Emphasize that we all have a lot to offer, and we do this work because we care about people.

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

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

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

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

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

ABCs:

- Have participants form a circle.
- Pick a category such as animals, countries, or foods. Choose a category that will be easy for the participants. Even the easiest category is hard in this game!
- Tell participants to go around the circle with each naming something within that category. The first person will name an animal starting with “A” (e.g., aardvark). The

next person will name an animal starting with “B” (e.g., bear). The third person in the circle will name an animal starting with “C” (e.g., cat), and so on.

- Once you have gone around the circle once, you can stop there, go around again with the same category, or choose another category.

Annex 4: Ways to Recap Information

Each morning after the first day, it will be useful to recap what was learned the previous day. Here are some activities for this purpose.

Ball of questions:

- Write down questions about what the group learned the day before, one question per sheet of printing paper.
- Scrunch up the first question/paper into a small ball. Wrap the second question/paper around the first and so on until you have a ball that is many sheets of paper.
- Tell the group that they will throw the ball to one another. Each person that receives the “ball” should unwrap and try to answer the outermost question.
- Continue to throw the “ball” until all questions are answered.

Tweets and texts:

- Tell participants one of the things they will be doing after the training is explaining to others why the material from the training is important. This means they need to be able to share their ideas quickly and in an interesting way.
- Ask participants to work with a partner to create a tweet or text message about one thing they learned the previous day. Tweets/texts should have no more than 20 words. For example, “We must protect KPs from violence or we will never stop HIV.” Or “Working with law enforcement officers prevents violence and makes sure KP victims get the help they need.”
- Give partners five minutes and then have everyone share their tweet/text. As they are shared, write them on flip chart paper.
- After all are shared, have everyone vote for their favorite. Give the winning pair candy or another small prize.

True/false:

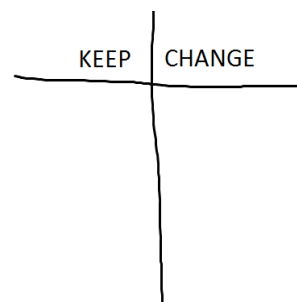
- Put up the word “true” on one side of the room and “false” on the other.
- Have everyone stand in between the two words.
- Read out statements that are either true or false. Statements should be facts and not opinions about what was learned the day before (e.g., “violence against gay men may occur because people think that gay men aren’t living according to ‘rules’ that dictate men’s behavior.” [true] or “Victims of violence only need legal support.” [false])
- Have people move to one side or the other based on whether they think each statement is true or false.
- After each, explain whether the statement was true or false and why.

Annex 5: Daily Closing Activities

These activities can give you a sense of what people learned, enjoyed, or want to see changed in the future. Make sure if you solicit feedback on possible changes, you are responsive to that feedback—either changing things the next day or explaining why certain changes are not possible.

Something I would keep; something I would change:

- Draw a “T-chart” on a piece of flip chart paper (it looks like a lower case “t”; see image at right).
- Write “keep” across the top left-hand side and “change” on the top right-hand side.
- Ask for volunteers to share both things they would keep the same and things they would change if they were to do that day of training over again.



Colorful feedback:

- Distribute sticky notes in three colors and explain that each color corresponds to a different bit of feedback (e.g., pink = something they like; blue = something they would change; green = a question they have about what was covered that day)
- Give time for participants to fill out the three sticky notes.
- Have participants place the sticky notes on the wall in a specific location (organized by color).
- Summarize the sticky notes during the evening and present a summary of the feedback in the morning, making sure to answer any questions raised.

Voting with stickers:

- Put up a large version of the agenda on flip chart paper (with the titles of each session).
- Give each participant three stickers.
 - Have participants come up and “vote,” using their stickers, for the activities they liked the most.
- Tell them they can distribute their stickers over multiple activities or put all on one activity.
- Review the results, letting people know their feedback is useful for the training now and in the future.

In just one word:

- Ask participants to stand in a circle.
- Ask them to describe how they are feeling about the day in just one word. Common words are: energized, interested, inspired, happy, curious.
- Go around the circle until everyone has shared a word.

Annex 6: Glossary

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.²³

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).⁵²

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.⁵³

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.⁵⁴

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.^{55, 56} A person’s gender expression may or may not be consistent with socially prescribed gender roles.⁵⁷

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.^{55, 58}

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.⁵⁹ 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.”⁵

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.⁶⁰ 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.⁶¹

Nonbinary refers to someone who identifies as neither male nor female.⁵⁸

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.⁷ These drugs include opioids, amphetamine-type stimulants, cocaine, hypnotics, and hallucinogens. Injection may be intravenous, intramuscular, subcutaneous, or other injectable routes.

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.^{55, 57}

Sex workers include consenting female, male, and trans adults—age 18 and older—who regularly or occasionally receive money or goods in exchange for sexual services.⁶¹

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 more than one sex or gender.⁶² It is not related to gender identity.⁵⁸

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.⁶³

Transgender is an umbrella term referring to an individual whose gender identity is different from their sex assigned at birth.⁵⁵

- **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.”³

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.⁶⁴

HANDOUTS

[Handout 1](#): Pre-Test/Post-Test

[Handout 2](#): Participant Agenda

[Handout 3](#): Fundamental Principles for Violence
Prevention and Response Service
Provision by Health Care Workers

[Handout 4](#): Overview of First-Line Support

[Handout 5](#): Sample Tool to Ask about and Respond to Violence

[Handout 6](#): Sample Printed Referral Network

[Handout 7](#): Training Evaluation

Handout 1: Pre-Test/Post-Test

Date: _____

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

Statement	Strongly agree	Agree	Disagree	Strongly disagree
1. Sex workers are to blame for the violence they experience.				
2. Gay men and other men who have sex with men are to blame for the violence they experience.				
3. People who inject drugs are to blame for the violence they experience.				
4. Transgender people are to blame for the violence they experience.				
5. Many women stay in abusive relationships because they like to be abused.				
6. Only women can be victims of intimate partner violence.				
7. To do my job well, I must understand how to support victims of violence.				
8. To do my job well, all people must feel that they can come to me for support.				
9. It is my duty to provide services to sex workers.				
10. It is my duty to provide services to people living with HIV.				
11. It is my duty to provide services to people who inject drugs.				
12. It is my duty to provide services to transgender people.				
13. It is my duty to provide services to gay men and other men who have sex with men.				
14. I worry that if I help gay men and other men who have sex with men, people who inject drugs, sex workers, or transgender people my friends or family will think less of me.				

15. What requirements must be in place before health care workers can ask service users about violence? (select all that apply)
- a. Providers are trained on how to ask about and respond to violence
 - b. Written protocol/standard operating procedure for the provision of violence response services
 - c. System for referrals to violence response services
 - d. Standard set of questions are used to facilitate documentation, and safe storage mechanisms are in place
 - e. Health care workers only ask about violence in a private setting, confidentiality ensured
 - f. Health care workers offer first-line support to service users who disclose violence
16. What first-line support should health care workers provide to service users who disclose violence? (select all that apply)
- a. Enhance their safety
 - b. Inquire about their needs and concerns
 - c. Listen closely with empathy, not judging
 - d. Validate their experiences, showing them you believe and understand
 - e. Support them to connect with additional services
 - f. Tell them what they should do

Handout 2: Participant Agenda

Goal: To equip health care workers with the knowledge and skills they need to understand, assess, and appropriately respond to violence in KP members' lives, including through improving KP members' access to HIV and other violence response services and supporting violence prevention efforts.

Training objectives:

- Explore the underlying causes of stigma, discrimination, and violence against KP members and the connection with HIV
- Identify interaction with health care workers as a key entry point into violence response services
- Learn to create an environment in which disclosure of violence can safely occur
- Build skills for asking about violence and providing first-line support
- Understand the range of health, social, and justice/legal services KP victims may need and make appropriate referrals
- Discuss best practices for safe data collection and management

Module 1: Setting the Stage	Time
Welcome and Introductions	30 min
Pre-Test	10 min
Learning Objectives and Agenda	15 min
Group Norms	10 min
Module 2: Building Core Knowledge	Time
The HIV Epidemic in [Country]	30 min
Sex, Gender, Gender Identify, Gender Expression, Sexual Orientation: Understanding Ourselves and Each Other	90 min
Understanding Violence against Key Populations (Characteristics, Perpetrator, Causes, Consequences)	60 min
Focus on Intimate Partner Violence	30 min
Legal and Policy Obligations, Opportunities, and Barriers in the Local Context	60 min
Panel Discussion with Key Population Members	60 min

Module 3: Applying Principles and Building Skills	Time
Fundamental Principles of Violence Prevention and Response	30 min
Barriers to Disclosing Violence	30 min
The Importance of Health Care Workers in Violence Prevention and Response	15 min
Asking about and Responding to Violence	90 min
Referring Effectively: Overview of Recommended Health, Social, and Justice/Legal Services and Improving Access to Each One	45 min
Putting It All Together	40 min
Data Collection and Sharing	45 min
Recap: Minimum Requirements to Ask about Violence	15 min
Module 4: Using What We Have Learned	Time
Taking Care of Ourselves: Identifying and Confronting Secondary Stigma and Stress	60 min
Reflections on What We Have Learned and How to Integrate It into Our Work	60 min
Post-Test and Evaluation	15 min
Closing Ceremony and Reflections	15 min

Handout 3: Fundamental Principles for Violence Prevention and Response Service Provision by Health Care Workers

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
- Never require that a victim reports to law enforcement in order to receive health services

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.”³¹

Do no harm also means proactively avoiding harm. While many actions to avoid harm will occur at the individual health care worker level, these actions should be reinforced through:

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

Principle 2: Promote the Full Protection of Key Populations’ Human Rights

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 inhuman treatment; and protection from violence.

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 and programs that support victims of violence. 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 increase the likelihood that they will experience violence. Reparative therapy, or therapy to change someone’s sexual orientation, has been shown to cause emotional and psychological trauma.

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 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, health care workers 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 health care worker—to report violence and/or to pursue legal action against a perpetrator. A health care worker’s role is to offer KP members information about their rights and available services so that victims of violence 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, including violence response services from health care workers, without being subjected to stigma, discrimination, or violence.

Mutually reinforcing principles: do no harm and self-determination

Even well-intentioned efforts to support KP victims of violence can cause harm. For example, a health care worker may believe that a victim can only effectively avoid future violence by reporting a perpetrator to law enforcement and taking them to court. As a result, the health care worker may try to force the victim to confront their abuser in this way. This can cause the victim harm in several ways, particularly if the perpetrator is also providing for the victim economically or otherwise. Furthermore, if a victim does not feel comfortable taking an action that is strongly suggested by a health care worker, the victim may avoid seeking help from health care workers in the future, effectively limiting their support network. All those working with victims of violence should instead ensure that the 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 their needs.

Principle 4: Ensure Privacy, Confidentiality, and Informed Consent

Privacy and confidentiality are essential for KP members’ safety in any setting. Health care workers can put people’s safety at risk if they share sensitive information with partners, family members, or friends without the KP member’s consent. This includes sharing KP members’ information with other health care workers 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,

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 a conversation about violence can occur.
- When asking about violence and responding to disclosures, health care workers must speak with individuals alone (with the exception of children under 2 years old).
- 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 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)
- Provide ongoing training for staff on protecting KP members' privacy and confidentiality, including obtaining informed consent and sharing information on options and rights.

Handout 4: Overview of First-Line Support

Anyone who discloses violence should be offered immediate, compassionate first-line support. The LIVES model for first-line support is described in detail in [*Health Care for Women Subjected to Intimate Partner Violence or Sexual Violence: A Clinical Handbook*](#).³¹

While the focus of the handbook is cisgender women experiencing intimate partner violence, the five tasks in the LIVES model—which are informed by psychological first aid—are largely appropriate for all members of KPs. The letters in the word “LIVES” can remind you of these five tasks:

First-Line Support (LIVES)	
Task	Explanation
Listen	Listen closely with empathy and no judgment
Inquire about needs and concerns	Assess and respond to various needs and concerns—emotional, physical, social, safety, and economic
Validate	Show you believe and understand, assure victim that they are not to blame
Enhance safety	Discuss a plan to protect the victim from further harm if violence occurs again
Support	Support the victim to connect with additional services

Techniques for each task are described in more detail below.

LISTEN

Active Listening Dos and Don'ts	
Dos	Don'ts
How you act	
Be patient and calm.	Don't pressure them to tell their story.
Let them know you are listening; for example, nod your head or say “hmm....”	Don't look at your watch or speak too rapidly. Don't answer the telephone, look at a computer, or write.
Your attitude	
Acknowledge how they are feeling.	Don't judge what they have or have not done, or how they are feeling. Don't say: “You shouldn't feel that way,” or “You should feel lucky you survived,” or “Poor you.”
Let them tell their story at their own pace.	Don't rush them.
What you say	
Give them the opportunity to say what they want to. Ask, “How can we help you?”	Don't assume you know what is best for them.
Encourage them to keep talking if they wish. Ask, “Would you like to tell me more?”	Don't interrupt. Wait until they have finished before asking questions.
Allow for silence. Give time to think.	Don't try to finish their thoughts for them.
Stay focused on their experience and on offering them support.	Don't tell them someone else's story or talk about your own troubles.
Acknowledge what they want.	Don't think and act as if you must solve their problems for them.

INQUIRE

Techniques to Inquire about Needs	
Technique	Example
Phrase your questions as invitations to speak	What would you like to talk about?
Ask open-ended questions that encourage the victim to talk	How do you feel about that?
Verify your understanding by restating what the victim says	You mentioned that you feel very frustrated.
Reflect back (paraphrase) the feelings the victim expresses	It sounds as if you are feeling angry about that.
Explore as needed	Could you tell me more about that?
Ask for clarification if you don't understand	Can you explain that again, please?
Help the victim identify and express needs and concerns	Is there anything that you need or are concerned about?

VALIDATE

Deliver validating messages that convey:

- You appreciate them sharing their experiences with you.
- You believe them without judgment or conditions.
- What happened wasn't their fault.
- Their experience has happened to other people, and they are not alone.
- Their feelings are common.
- They have the right to live without threats, violence, and abuse.
- It's safe for them to talk to you about their experience.
- You will support them and the choices they make, either through services offered by health care workers or referral.

For example:

- "Thank you for sharing that with me."
- "I'm sorry that happened to you."
- "Many people experience violence, and even though they may be blamed for what happened, it is never their fault."
- "Everyone has the right to live free from violence."
- "I am here to support you and explain your options."
- "It's not your fault."
- "This was a violation of your rights, and you did not deserve to be treated this way."
- "You are brave to talk to me about it."

Avoid (examples of what NOT to say appear in quotations):

- Placing blame on the victim.
 - "You put yourself at risk."
- Saying anything that judges what the victim has done or will do.
 - "You should feel lucky that you weren't more injured."
 - "You shouldn't feel this way."

- “You should go to the police.”
- Questioning the victim’s story (doubting) or interrogating the victim.
 - “What I don’t understand is why he would have attacked you?”
- Saying anything that minimizes how the victim feels.
 - “Everyone has bad days. You’ll get over it.”
- Lecturing, commanding, or advising.
 - “What you need to do is...”
 - “You have to stop thinking about what happened.”
- Recommending that the victim change their profession, sexual orientation, gender identity, or drug use to avoid violence.
 - “You need to leave sex work. It’s just a violent profession.”
 - “If you stopped being so open about being gay, you would be safer.”

Helping Victims Cope with Specific Feelings	
The feeling	Some ways to respond
Hopelessness	“Many people do manage to improve their situation. Over time you will likely see that there is hope.”
Despair	Focus on their strengths and how they have been able to handle a past dangerous or difficult situation.
Powerlessness, loss of control	“You have some choices and options today in how to proceed.”
Flashbacks	Explain that these are common and often become less common or disappear over time.
Denial	“I’m taking what you have told me seriously. I will be here if you need help in the future.”
Guilt and self-blame	“You are not to blame for what happened to you. You are not responsible for others’ behavior.”
Shame	“There is no loss of honor in what happened. You are of value.”
Unrealistic fear	Emphasize, “You are in a safe place now. We can talk about how to keep you safe.”
Numbness	“This is a common reaction to difficult events. You will feel again—all in good time.”
Mood swings	Explain that these can be common and should ease with the healing process.
Anger with perpetrator	Acknowledge that this is a valid feeling.
Anxiety	“This is common, but we can discuss ways to help you feel less anxious.”
Helplessness	“We are here to help you.”

ENHANCE SAFETY

You can assess a victim’s safety by asking: “I want to check with you about your safety. Do you have concerns about your safety or the safety of your children?”

If the victim does not feel safe, it is important to take the victim seriously and help them create a safety plan.

Safety Planning	
Safe place to go	If you need to leave an unsafe place in a hurry, where could you go?
Planning for children	Would you go alone or take your children with you?
Transport	How will you get there?
Items to take with you	Do you need to take any documents, keys, money, clothes, or other things with you when you leave? What is essential? Can you put together items in a safe place or leave them with someone, just in case?
Financial	Do you have access to money if you need to leave? Where is it kept? Can you get it in an emergency?
Support of someone close by	Is there a neighbor you can tell about the violence who can call for help or come with assistance if they hear sounds of violence?

SUPPORT

Individuals who are experiencing violence may have a range of needs. Ask whether the person has other immediate needs that you can help them address, including through referral.

Remember that some health needs must be addressed immediately. Post-exposure prophylaxis (PEP), to prevent HIV acquisition, can only be initiated within 72 hours of a sexual assault. Emergency contraception is only effective if initiated within 120 hours of a sexual assault. If someone reports sexual assault, it is important to share information regarding time-bound health services so they can make an informed decision. Consider asking: What would help the most if we could do it right away?

When providing information and making referrals:

- Offer printed information about rights and available services; provide caution about taking printed materials home if the victim lives with an abuser
- Know specific information about referral points and share this information when making the referral:
 - Name of focal point at referral sites
 - Hours of operation
 - Services available at the referral site
 - Location
- Ask victims if they want accompaniment to resources and, if so, make arrangements.
- Do not pressure victim to accept a referral or to give details about an incident
- Offer yourself as a resource in the future, even if the person does not wish to access any other services now

When identifying existing strengths and support networks:

- Help victims identify and use their existing strengths:
 - “What helped you cope with hard times in the past?”
 - “What activities help you when you’re feeling anxious?”
 - “How could what has helped in the past be helpful now?”
- Help victims explore existing support networks:

- “When you’re not feeling well, who do you like to be with?”
- “Who helped you in the past? Could they be helpful now?”
- “Are there people you trust that you can talk to?”

BEYOND LIVES: ADDITIONAL APPROACHES TO ENHANCE SAFETY

As KP members may be dealing with other forms of violence and may encounter additional barriers to seeking safety, below are 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

Bringing up safety strategies: It is important that health care workers do not tell KP members how to stay safe. Safety planning is a conversation in which the health care worker 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.



Safety resources

See tools such as *Keeping Safe* by the UK Network of Sex Work Projects for more tips on safe sex work.⁶⁵



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.

	
<p>What do they do? Dignity for All is a consortium of organizations focused on safety and security for LGBTI communities. Dignity can provide:</p> <p>(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.</p> <p>(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.</p> <p>(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.</p> <p>Where do they provide support? Global (anywhere)</p> <p>Who can apply? HRDs or CSOs with a proven history of LGBTI activism. CSOs do not need to be officially registered.</p> <p>To find out more or apply—click here. Or email info@dignitylgbti.org</p>	<p>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:</p> <p>(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.</p> <p>(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.</p> <p>Where do they provide support? 29 countries in sub-Saharan Africa, Latin America and the Caribbean. See list.</p> <p>Who can apply? Grants can be provided to CSOs led by or working closely with LGBTI people or MSM.</p> <p>To find out more or apply—click here.</p>
	
<p>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.</p> <p>Where do they provide support? Global (anywhere)</p> <p>Who can apply? Human rights defenders and their organizations</p> <p>To find out more or apply—click link.</p>	<p>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.</p> <p>Where do they provide support? Asia, the Middle East, Central and Eastern Europe, and North America</p> <p>Who can apply? Women and transgender human rights defender</p> <p>To find out more or apply—click here.</p>

Handout 5: Sample Tool to Ask about and Respond to Violence

INITIAL CONTACT *Remember to discuss confidentiality*

- Many people tell me they have been emotionally, physically, or sexually harmed, including forced to have sex without a condom.
- Some have been threatened, robbed, denied money that is due to them, made to pay money to avoid arrest, or denied services.
- Since violence and abuse can cause health problems, I'd like to ask you about your experiences. Is that okay?
- **IN THE PAST [NUMBER] MONTHS HAVE YOU EXPERIENCED ANY OF THESE TYPES OF VIOLENCE OR ABUSE?**

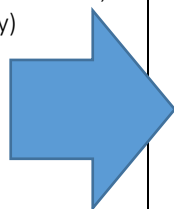
OR

FOLLOW-UP CONTACTS

- Last time, I asked you about violence and abuse.
- **HAS ANYTHING NEW HAPPENED SINCE WE MET?**

YES EXPERIENCED VIOLENCE/ABUSE

- ☐ EMOTIONAL
- ☐ ECONOMIC
- ☐ PHYSICAL
- ☐ SEXUAL
- ☐ OTHER RIGHTS VIOLATIONS
(e.g., arrested/detained arbitrarily, denied health care, condoms taken away)



- *When was the most recent time this happened?*
- *Do you have any injuries? [IF YES, offer link to treatment of injuries. Share medical options below and then provide first-line support as indicated in the bottom of the page.]*

SEXUAL VIOLENCE: ☐ Past three days ☐ Past five days

I'd like to share information with you about medical options after sexual violence. A health provider can help you decide what options are best for you depending on the nature of the assault.

- Rapid HIV testing (regardless of when assault happened)
- **HIV post-exposure prophylaxis (PEP) (within three days of assault and if HIV test is negative)**
- **Emergency contraception (within five days)**
- Screening/treatment for other sexually transmitted infections (STIs) (any time after assault)
- Hepatitis B testing/vaccination and tetanus vaccination (if appropriate based on national guidelines)

PROVIDE FIRST-LINE SUPPORT (LIVES)

Listen closely with empathy and no judgment.

Inquire about their needs and concerns. Assess and respond to their various needs and concerns—emotional, physical, social, safety, economic.

Validate their experiences. Show that you believe and understand them. Assure them that they are not to blame.

Enhance their safety. Discuss a plan to protect the victim from further harm if violence occurs again.

Support them to connect with additional services.

NO VIOLENCE/ABUSE

- If you experience violence or abuse in the future, I am here to support you.
 - Many people have these experiences, but everyone has the right to live free from violence and abuse.
 - If sexual violence occurs, it is important to seek help quickly. There are medical options that can be used within three days after the assault that can reduce risk of HIV and within five days to reduce risk of pregnancy.
 - I'd like to share resources in case you ever need them. Is that okay?
- [SHARE INFORMATION ABOUT HEALTH, SOCIAL, AND JUSTICE/LEGAL SERVICES]**

Handout 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.

HEALTH SERVICES <i>(such as treatment of injuries, HIV testing, PEP, emergency contraception, STI screening and treatment, and mental health screening)</i>	SOCIAL SERVICES <i>(such as crisis counseling and support groups, financial aid, community-based organizations that may provide accompaniment)</i>	JUSTICE/LEGAL SERVICES <i>(such as legal information, assistance with arrest/detention, and contact information of trained law enforcement officers when they can be safely engaged)</i>
[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:
[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:

Handout 7: Training Evaluation

Date: _____

1. The content of the training was interesting for me.

- ☐ Strongly Agree
- ☐ Agree
- ☐ Disagree
- ☐ Strongly Disagree

2. The content of the training gave me all the information I needed to know.

- ☐ Strongly Agree
- ☐ Agree
- ☐ Disagree
- ☐ Strongly Disagree

3. The training was well structured.

- ☐ Strongly Agree
- ☐ Agree
- ☐ Disagree
- ☐ Strongly Disagree

4. The content of the training was useful for my professional career.

- ☐ Strongly Agree
- ☐ Agree
- ☐ Disagree
- ☐ Strongly Disagree

5. The use of lectures and practical exercises was well balanced.

- ☐ Strongly Agree
- ☐ Agree
- ☐ Disagree
- ☐ Strongly Disagree

6. The applied methods of teaching (e.g., small group work, lectures, role-plays, practical exercises, group discussion) worked well for me.

- ☐ Strongly Agree
- ☐ Agree
- ☐ Disagree
- ☐ Strongly Disagree

7. What part of the training was most useful for you?

8. What part of the training was least useful for you?

EXERCISE CARDS

[Card 1:](#) What Is Behind High Prevalence Rates for Some Groups?

[Card 2:](#) The Last Post-Exposure Prophylaxis

[Card 3:](#) Amanda's Story

[Card 4:](#) Thandi's Story

[Card 5:](#) Standing in Her Shoes

[Card 6:](#) Victim Roles for First-Line Support
and Documentation Practice

[Card 7:](#) Privacy and Confidentiality in Documentation Checklist

[Card 8:](#) Combatting Secondary Stigma

[Card 9:](#) Stress Reduction Activities

Exercise Card 1: What Is Behind High Prevalence Rates for Some Populations?

Print one copy of this exercise card.

1A. A person is accepted and supported by their family throughout childhood and adolescence.

1B. A person is rejected by family and forced to leave home during their teenage years.

2A. A person can safely seek help from the police if they are raped.

2B. A person cannot safely seek help from the police if they are raped.

3A. A person can leave home without fear of verbal harassment.

3B. A person feels afraid to leave home due to experiences of verbal harassment.

4A. A person feels comfortable talking about their sexual/drug use behaviors with a health care provider because they know the provider will listen nonjudgmentally.

4B. A person feels uncomfortable talking about their sexual/drug use behaviors with a health care provider because they fear the provider will respond negatively.

5A. A person has a home.

5B. A person does not
have a home.

Exercise Card 2: The Last Post-Exposure Prophylaxis

Print enough so that each pair of participants can have one copy

If someone who is HIV negative may have been exposed to HIV—for example, through sexual assault—they can take post-exposure prophylaxis (PEP) to prevent HIV infection. To be effective, PEP must be initiated within 72 hours of the potential exposure. In some places, health care workers help distribute PEP to victims of sexual assault.

Imagine that your health facility distributes PEP. Your supply is running low, and you only have enough for one person. You are the health care worker in charge this evening, and there are five people at your health facility who are all candidates for PEP. **Who do you give it to? Why do you choose this person?**

Work with a partner to choose one of the people below. One person should be prepared to share the pair's answer and explain how you made your decision.

- A. A female student, age 19. She is walking alone to an evening class when a stranger rapes her. He does not use a condom.
- B. A mother who stays at home to take care of her two children, age 32. Her husband—who is often physically abusive to his wife and who has several other sexual partners—comes home drunk, physically assaults her, and forces her to have sex without a condom.
- C. A transgender waitress, age 21. She is walking to work very early in the morning when a customer who is always rude to her stops her. He forces her into his car and rapes her without a condom.
- D. A female sex worker, age 22, with one young child. She works outside a hotel and accepts a client who has been drinking. Normally she would avoid clients who were drunk but her son's school fees are due the next day and she does not want him to be expelled. She walks with the client to his room and finds two other men there. All three men force her to have sex with them; no one pays her. No one uses a condom.
- E. A male apprentice at a local mechanic, age 20. He goes to a party at a gay bar. Someone puts a drug in his drink. When he wakes up, he finds out that two men had sex with him while he was unconscious. He learns that no one used a condom.

Exercise Card 3: Amanda's Story

Print enough so that each group of participants can have two copies.

The following story was created using real histories taken from transgender women living in Latin America, the Caribbean, and Africa. Globally, transgender women have an HIV prevalence 49 times that of the general population. This story will help us understand why their burden of HIV is so high. It will also introduce us to five types of violence:

- Physical: punches, hits, kicks, use of a weapon
- Sexual: harassment, unwanted sexual contact, forced sex without a condom, rape
- Emotional/psychological: threats, humiliation, making someone feel afraid, isolating someone from family and friends
- Economic: theft, withholding money to care for basic needs of partner or children, blackmail
- Other human rights violations: state actors such as law enforcement officers or health care workers denying health or justice services; arbitrary detention

Question 1

Describe at least three times that violence increased Amanda's vulnerability to HIV infection. Describe at least three times that violence affected her access to HIV treatment.

Question 2

Describe the violence that Amanda experienced, giving at least two examples of each type: emotional, sexual, physical, economic, and other human rights violations.

Question 3

List all the perpetrators of violence. Decide which perpetrator had the most dramatic negative impact on Amanda's life and explain your answer.

Question 4

Think about all the consequences of the violence Amanda experienced. Make a list of the consequences of each form of violence.

Emotional:

Sexual:

Physical:

Economic:

Other human rights violations:

Marcus was an intelligent and kind child. In primary school, Marcus got good grades and went to church with his parents at least twice each week. He wanted to study hard and become a doctor to help others. When Marcus was 10, he began to feel that he was different from the other boys his age. He felt strongly that he was truly a girl and felt uncomfortable when he wore the pants and shirts his parents bought for him. He wore his sister's skirts and shoes when no one was home. He also started to call himself Amanda in private. Marcus hid all this from his parents, but they still thought that he spoke and behaved too much like a girl. By the time he was 13 they were constantly telling him to "act like a man." Marcus tried to change his behavior and thinking. He wanted to be someone his parents could be proud of and hated that he was disappointing them. But he could not change.

His parents, who had never heard of the term transgender, believed that Marcus was gay. When Marcus was 14, the bullying at school got very bad. Several students threw objects at Marcus and taunted him for being gay. They stole from him. When Marcus went to the teacher, she told him that he was asking for the abuse due to his "unnatural behavior." The teacher contacted Marcus's parents and said that Marcus was immoral and a bad example to the other students. Marcus's parents were furious. They told Marcus that they would rather have a dead son than a gay son.

Marcus's parents kicked him out of the house. They stopped paying his school fees. None of Marcus's extended family would help him. They felt that providing him a place to stay or helping him attend school would be promoting homosexuality. Marcus had nowhere to go and began to have sex with an older man, Edward, so he could stay at Edward's house. Marcus missed his family but was relieved to finally be able to live as Amanda. At times, Amanda still felt it necessary to dress and act as Marcus—for example, when out in public during the day—but, whenever possible, she was true to herself.

When Amanda went out in public as her true self—wearing make-up and dresses—she tried to avoid interacting with anyone other than her closest friends. She was afraid she might be attacked. Public attacks of transgender women happen often where Amanda lives. Due to fear, Amanda avoided the peer educators from a local HIV clinic for several months. Then a friend told her they were safe to talk to. When Amanda did speak with them, they gave her condoms and lubricant. They said that anal sex without a condom could lead to HIV infection. Amanda had not been using condoms because she didn't realize that she was at risk. Amanda had only heard that vaginal sex could lead to HIV infection.

Once she knew more about HIV, Amanda was worried that she was at risk. She tried to talk to Edward about using a condom, but he screamed at her. He told her to know her place as the woman in the relationship and promised to kick her out of the house if she brought up condoms again. Amanda didn't know what to do. The peer educators told her about HIV testing at a local clinic. She wanted to know her status but was afraid to go. What if someone saw her and told Edward?

Edward's abuse intensified. He forced Amanda to give him the passwords to her phone and social media accounts. He asked where she was constantly, saying it was proof of how much he cared for her. When Amanda told her friends about Edward's behavior, they told her that it was just a sign of how much he loved her. One night, Edward told Amanda that if she ever

had sex with someone else he would murder her. She was terrified and could not sleep or eat. She threatened to go to the police and Edward laughed at her, saying that the police wouldn't care if someone like her lived or died.

Several months later, while Edward was out of town, Amanda finally got tested at a clinic in another town. Amanda's HIV test result was positive. She was worried about her diagnosis but was more worried that Edward would find out. She avoided going back to the clinic for two months. She didn't want Edward to wonder where she was. When he left town again, she returned to the clinic and enrolled in care. She brought home antiretroviral medicines (ARVs) and hid her medication. She missed several clinic visits for refills because Edward watched her movements. She wondered whether her life was worth living at all and thought about suicide.

Edward often went through Amanda's things, looking for proof that she was sleeping with another man. He eventually found her ART, beat her, and locked her out of the house. Amanda suffered a concussion and was now homeless—without her medication or any money.

Amanda tried to find work. She went to stores dressed in a masculine way and applied as Marcus. But potential employers told her that she did not have enough education because she had not completed secondary school. She began to do sex work and tried to save enough to rent a small room. One night she was waiting for a client when a police officer made her open her purse. He saw condoms and lubricant and took her to jail. Once there, he placed her in a cell with all men. It was a weekend, and she spent two days in jail. She was raped by the other inmates. She did not have access to her ARVs. She was released because there was no proof of a crime. She stopped carrying more than a few condoms at a time to avoid another arrest. She often ran out.

After two months of being homeless, Amanda was incredibly grateful to meet Daniel. Daniel invited her to stay at his home. One afternoon, Amanda was the only one there. Two men came by and asked to see Daniel. Amanda let them in to wait. The men raped Amanda at knife point. Amanda told Daniel what happened. Daniel said that he knew the men. They had paid Daniel to have sex with Amanda. Daniel told Amanda that if she was going to continue to stay in the house, she had to help pay the bills by having sex with people who paid Daniel.

Amanda had nowhere to go and was afraid of being homeless again. She was terrified of the police after her experience being held in jail. More men came and forced her to have sex, often violently. Amanda asked the men to use condoms. Most of them refused to. Amanda contracted STIs several times. She sought treatment at the same clinic where she received her ARVs because she liked the nurses there. After her third treatment for gonorrhea in a two-month period, one of the nurses told Amanda that she was being irresponsible by having sex without condoms. The nurse told Amanda that she could be passing HIV to others and should be ashamed of herself. Amanda felt terrible. She believed that she was letting down one of the few people who had been kind to her. She stopped going to the clinic and stopped taking her ARVs.

Exercise Card 4: Thandi's Story

Print one copy for the facilitator only.

Thandi is a young woman from [a local city]. She is intelligent, funny, kind, and beautiful. She has a supportive family and is good at her job. She has a lot of friends, especially colleagues from work. They respect her and know she will go on to do great things.

She meets John and they fall in love. They get married and move in together. This blank flip chart paper represents Thandi, her autonomy (ability to act on her own), her self-esteem, and the wide range of possibilities she feels her life holds. Watch and listen as we describe what happens next between Thandi and John.

1. A few weeks into their marriage, John tells Thandi that he thinks it would be better if she dressed a little more conservatively. He sees her going out in the same short skirts she wore when they met. She doesn't need to find a husband anymore, so there is no need to keep wearing them. Thandi says OK as the request doesn't sound unreasonable and she knows John says it out of love. A little of Thandi's autonomy is gone.
2. A few more weeks pass and John asks Thandi to stop wearing so much make-up. He worries that people will "get the wrong idea about her" because she looks a little "cheap." He says he isn't trying to be mean; he is just looking out for her. Thandi is embarrassed and changes her look. Another piece of her self-esteem and autonomy are cut away.
3. A month passes and John asks Thandi to stop staying out after work to spend time with her friends. He wants to see more of her at home – "Doesn't she want to spend time with him? Isn't that why they got married?" Thandi's world becomes a little smaller as her social network shrinks, and she loses a bit more autonomy.
4. A few more months pass and Thandi and John decide to have a baby. They are thrilled when the baby is born. Thandi tells John that she has found a good nanny to care for the baby once she goes back to work. John says, "I can't imagine a woman leaving her baby to others to care for! Aren't you going to stay home and be a good mother? Why would you go back to work?" Thandi apologizes for neglecting her duties as a mother. Her autonomy, social network, and self-esteem are diminished.
5. Thandi is at home with the baby and has her sister and sister's kids over often. She enjoys spending time with them and they have fun taking the baby to park. When John finds out, he tells Thandi that he doesn't like her spending so much time with her sister. Her kids are not well-behaved, and he thinks they are bad examples for the baby. Thandi tells her sister about John's fears and Thandi's sister, offended, stops visiting. Thandi's social network and autonomy are further reduced.
6. Thandi often talks to her mother. Thandi gets ideas on food or toys that the baby might enjoy. When Thandi shares a recommendation that her mother made, John yells that he doesn't need some other person telling him how to parent. He asks Thandi not to speak

to her mother as all her mother does is try to undermine John's authority in his own home. Her mother continues to call but Thandi stops answering. Her autonomy and social support are further cut.

7. Thandi and the baby are home alone all day and Thandi is often eager to share news of the baby when John comes home. John tells Thandi that she can't expect this type of conversation to be interesting to him and that he is going to spend more evenings with his friends who are still interesting. Thandi's self-esteem is further reduced.
8. One day Thandi doesn't have dinner ready when John arrives from work. He asks her how she spends her time and why she has become so "worthless." "Can't you watch a child and care for a home?" His mother had five kids and never failed to meet her duties as a mother. Thandi apologizes and assures him it won't happen again. Her self-esteem is further reduced.
9. A week later the baby is sick and Thandi spends the afternoon at the pediatrician. She arrives back to the house just when John gets home from work. He questions where she was. When she tells him, he calls her a liar and asks who she was really seeing. She is cut down still further.
10. The next day the baby is still sick but Thandi stays home and takes care of him, afraid to take him back to the doctor in case John will become more jealous. Dinner is not ready when John arrives, and he slaps her when she explains what happened. He then apologizes and asks her not to "make him so mad" again in the future.

Exercise Card 5: Standing in Her Shoes

Print one copy and cut into nine separate pieces on the lines provided.

.....cut.....

Stand at the beginning of the line. Walk up to each person in the line and say:

“I am a sex worker. I was raped by a client last night. He lives in my neighborhood, and I am afraid.”

.....cut.....

Say: “I am your sister. You chose this life. It’s partly your fault.”

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

.....cut.....

Say: “I am your brother. You bring shame to our family. You deserve what happened to you.”

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

.....cut.....

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

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

.....cut.....

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

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

.....cut.....

Say: “I am your friend. You should not cause trouble. You are a sex worker and no one will believe you.”

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

.....cut.....

Say: “I am your religious leader. Your lifestyle is a sin. You should not complain. You live a shameful life, and you deserve what happened to you.”

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

.....cut.....

Say: “I am your mother. What did you do to provoke him?”

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

.....cut.....

Say: “I am your health care provider. If you put yourself in risky situations, what do you expect will happen to you?”

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

Exercise Card 6: Victim Roles for First-Line Support Practice

Print as many copies as there are groups of three participants. Cut each copy along the dotted lines so that each group receives all three sections.

.....cut.....

Victim 1—Julia

You are a 28-year-old female sex worker. The man who owns the bar where you find new clients has been sexually harassing you—grabbing your breasts and making sexual comments whenever he sees you. One night he asks you to help him in the back of the bar. There, he forces you to have sex with him and does not use a condom. You are worried about HIV and an unplanned pregnancy as you already have two small children. You go to a health care facility to access emergency contraception.

.....cut.....

Victim 2—Nicole

You are a 22-year-old transgender woman. Every day, a group of students taunt you and call out threats when they pass you on your way to work. One day, they throw stones and bottles at you, injuring your face and causing you to need several stitches. You decide to go to a health facility to treat your injuries, but you are afraid that the students will continue to harass and harm you.

.....cut.....

Victim 3—James

You are a 33-year-old gay man. Gangs on the street have chased and beaten you and your friends late at night. Today, the same gang of men chased you and beat you badly. You have a broken arm and several broken ribs. Law enforcement officers arrive at the scene but instead of helping you, they tell you that police don't help "indecent people." You find a friend to take you to the hospital the next day after spending the night in terrible pain.

Exercise Card 7: Privacy and Confidentiality in Documentation Checklist

Print enough so that each group of participants can have one copy.

How can we create secure records in practice?

Do we have the following in place?	Yes	No	If no, what support is needed to address this gap?
All staff members understand the importance of confidentiality and secure record-keeping, and staff members who routinely care for people who experience violence have been trained to keep records secure.			
Identifying information about a service user, including their name and contact information, is not visible or accessible to those not caring for this service user.			
Staff members do not leave documents where a service user (unless requested), those accompanying the service user, or anyone else might see them. Staff members do not carry charts open or lay them on shared desks or counters.			
When documenting information about a service user's experience of violence, staff members avoid asking for or writing this information on records in a public place.			
Staff members do not write a notation indicating violence on the first page of a record, which is more likely to be seen if flipped open.			
Staff members use a code, such as an abbreviation, symbol, or color, to indicate cases of intimate partner violence or sexual violence on charts (recommended option). They do not write "DOMESTIC VIOLENCE SUSPECTED" or "RAPE" or other explicit wording in large print across the chart.			
Any sensitive information that needs to be destroyed is shredded by an authorized staff member.			

How can we create secure records in storage?

Do we have the following in place?	Yes	No	If no, what support is needed to address this gap?
We have a secure site to store files.			
Documents are locked up at all times.			
Only a limited number of designated staff members have access to patient records.			
Staff members who need access to records have received training on record confidentiality and storage practices.			
Staff members authorized to access stored files have a means of access that is not available to others. (As the setting allows, this may be a key to a room, an electronic password, a security code to enter a room, or another method of obtaining access to a restricted area.)			

Source: This exercise card is adapted from Annex 11: Privacy and Confidentiality in *Documentation in Strengthening Health Systems to Respond to Women Subjected to Intimate Partner Violence or Sexual Violence: A Manual for Health Managers*.²³

Exercise Card 8: Combatting Secondary Stigma

Print one copy for the facilitator's use.

Scenario 1: A young man comes into your health facility. He reports that his partner, another man, beat him last night. You offer him first-line support and violence response services and give him the contact information of an organization that can provide him with further help. When the young man leaves, another health care worker asks why you would help someone who deserved to be beaten.

Scenario 2: Two days per week, you provide HIV services to transgender women at a drop-in center. One day, a transgender woman reports rape and asks for post-exposure prophylaxis (PEP). The drop-in center has a stock-out so you have to go to your main health facility for PEP. Your brother-in-law sees you accompanying the transgender woman to your health facility. After that, he stops attending gatherings at your house and doesn't let his children go either.

Scenario 3: You work at a health facility that primarily serves sex workers. Your work recently received media attention because you helped sex workers address violence perpetrated by police and now many in your church ostracize you.

Scenario 4: You work at a health facility that provides gender-based violence response services to women. You have a meeting with the health administrator to encourage her to incorporate content that addresses the specific concerns of female sex workers in training and sensitization activities for providers. She asks why you care more about immoral people than about innocent victims like women who suffer intimate partner violence.

Scenario 5: In your health facility, you hear a fellow health care worker refusing to treat a gay man who reported he was chased and beaten by a mob. She says, "I don't know why we should help them. They are going against our culture and should be punished." You tell her that it is your job to provide health care to everyone. Another health care worker says, "You used to be one of us but now you're on the side of the gays."

Scenario 6: You want to begin to offer the full range of clinical violence response services to women who inject drugs in the health facility you oversee. When you approach providers to help you, one says, "If we offer more services, we'll be inviting more of them here. Why should we help them when they can't help themselves? We should be getting them to leave our community, not making it more welcoming to them."

Exercise Card 9: Stress Reduction Activities

Print one copy.

Say: Sit with your feet flat on the floor. Put your hands in your lap. After you learn how to do the exercises, do them with your eyes closed. These exercises will help you to feel calm and relaxed. You can do them whenever you are stressed, anxious, or cannot sleep.

1. Slow breathing technique

- First, relax your body. Shake your arms and legs and let them go loose. Roll your shoulders back and move your head from side to side.
- Put your hands on your belly. Think about your breath.
- Slowly breathe out all the air through your mouth, and feel your belly flatten. Now breathe in slowly and deeply through your nose, and feel your belly fill up like a balloon.
- Breathe deeply and slowly. You can count 1–2–3 on each breath in and 1–2–3 on each breath out.
- Keep breathing like this for about two minutes. As you breathe, feel the tension leave your body.

2. Progressive muscle relaxation technique

- In this exercise you tighten and then relax muscles in your body. Begin with your toes.
- Curl your toes and hold the muscles tightly. This may hurt a little. Breathe deeply and count to three while holding your toe muscles tight. Then, relax your toes and let out your breath. Breathe normally and feel the relaxation in your toes.
- Do the same for each of these parts of your body in turn.
- Each time, breathe deeply in as you tighten the muscles, count to three, and then relax and breathe out slowly.
 - Hold your leg and thigh muscles tight...
 - Hold your belly tight...
 - Make fists with your hands...
 - Bend your arms at the elbows and hold your arms tight...
 - Squeeze your shoulder blades together...
 - Shrug your shoulders as high as you can...
 - Tighten all the muscles in your face....
- Now, drop your chin slowly toward your chest. As you breathe in, slowly and carefully move your head in a circle to the right, and then breathe out as you bring your head around to the left and back toward your chest. Do this three times. Now, go the other way...inhale to the left and back, exhale to the right and down. Do this three times.
- Now bring your head up to the center. Notice how calm you feel.

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LINKAGES

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