LINKAGES

PEER AND OUTREACH WORKER TRAINING

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

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LINKAGES
Across the Continuum of HIV Services for Key Populations

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

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

2022

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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
CSO	Civil society organization
DIC	Drop-in center
EPOA	Enhanced peer outreach approach
GBV	Gender-based violence
HIV	Human immunodeficiency virus
IEC	Information, education, and communication
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
USAID	U.S. Agency for International Development
UNAIDS	Joint United Nations Programme on HIV/AIDS
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, including members of key populations (KPs) and KP-led organizations, who wish to equip peer educators, navigators, or outreach workers with the knowledge and skills they need to understand, assess, prevent, 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. The materials presented here can be used to train peer educators, navigators, and outreach workers at any level, and adaptable case studies make it relevant to those with a range of mandates.

Participant learning objectives:

Participants trained will:

- Explore the underlying causes of stigma, discrimination, and violence against KP members and the connection with HIV
- Identify interaction with peer educators, navigators, and outreach workers as a key entry point into violence response services
- Learn to create an environment in which disclosure of violence can safely occur
- Identify and make plans to meet the PEPFAR requirements for asking about and responding to violence and monitoring adverse events, including within index testing
- Build skills for asking about violence and providing first-line support
- Understand the range of health, social, and justice/legal services KP survivors 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 days, depending on time available and program and participant needs. Implementing the training successfully will require the following steps, some of which may not necessitate advance preparation depending on program implementers' existing knowledge and relationships:

(1) Understand KP members' experiences with violence in the local context, including the most common forms of violence
(2) Review local laws, policies, and guidelines to determine the obligations of the health system to care for survivors and to understand any situations in which mandatory reporting of violence is required
(3) Adapt the training for the local context, reflecting societal norms, local laws, and existing project and facility-specific standard operating procedures, particularly those related to supporting survivors of violence and monitoring and responding to adverse events related to index testing
(4) Understand KP service users' current experiences with peer educators, navigators, and outreach workers
(5) Form relationships with peer educators, navigators, and outreach 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 survivors, developing a list of organizations that peer educators, navigators, and outreach workers can refer to for violence response services, and considering the type of site (such as hot spot, drop-in-center, public clinic, private facility, etc.)

(6) Determine those who should be trained
(7) Pilot the adapted training, making further revisions as needed
(8) Identify and train effective facilitators (when possible, working with a lead trainer who has successfully implemented similar trainings previously), including KP service users, peer educators, navigators, or outreach workers as appropriate
(9) 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 is especially important if the training is implemented by HIV programmers who are not part of a KP-led organization. This includes ensuring that the programs in which participants operate are ready to handle disclosures of violence (minimum requirements for which are shared in Session 3.4).

Notes:

This training has been updated to incorporate PEPFAR guidance on safe and ethical index testing services. More guidance on safe and ethical index testing can be found here. A training on the implementation of index testing can be found here.

BACKGROUND

The Importance of Integrating HIV and Violence Prevention and Response Services

Peer educators, navigators, and outreach 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]

Peer educators, navigators, and outreach workers

HIV programs use different position titles to describe those involved in outreach and connecting KP members to services. Many of these positions are staffed by members of the key populations served by the HIV program (generally referred to as "peers"). These could include:

- A trained peer who provides education and/or needed prevention commodities and who may link individuals to HIV testing or other services (sometimes called a peer educator)
- A trained peer who works with people who have been diagnosed as HIV positive to link them to a clinic and support their ART initiation and/or adherence (sometimes called a peer navigator)
- Someone who oversees outreach, which may include supervising peer educators and/or navigators; may also be a peer (sometimes called an outreach worker)

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 practices[9] 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] Due, in part, to the disproportionate burden of violence faced by key populations , HIV services themselves can increase the risk of violence if not implemented appropriately. Partner notification, in particular, requires careful consideration and implementation to ensure that index clients (individuals who are HIV positive) are able to safely name their sexual partners (referred to as "index cases") who may benefit from HIV testing and

that neither those who share names nor those who are contacted experience adverse events related to index testing.[i]

Integrating HIV and violence response services increases the ability of peer educators, navigators, and outreach workers to meet the needs of KP members in their care. When service users disclose an experience of violence, peer educators and others can better understand their health needs, support their risk-reduction strategies, and act as an entry point to violence response services. Learning about violence in KP members' lives also allows peer educators and others to avoid causing inadvertent harm when offering services such as index testing.

[i] **An adverse event* associated with index testing** is an incident that results in **harm** to the client or others as a result of their participation in index testing services or because they were offered index testing services and declined to accept them. **Harm** includes any intended or unintended physical, economic, emotional, or psychosocial injury or hurt caused by one person to another, a person to themselves, or an institution to a person, occurring before, during, or after index testing services.

Categories of adverse events:*

Severe

1. Threats of physical, sexual, or emotional harm to the index client, their partner(s), or family members, or to the index testing provider
2. Occurrences of physical, sexual, or emotional harm to the index client, their sexual or drug-injecting partner(s), or family members, or the index testing provider
3. Threats or occurrences of economic harm (e.g., loss of employment or income) to the index client, their partner(s), or family members
4. Withholding HIV treatment or other services from the person offered index testing, their partners, or family members
5. Forced or unauthorized disclosure of client's or contact's name or personal information
6. Abandonment or forced removal of children < 19 years old from the home

Serious

1. Contacting partners without obtaining consent for participation in index testing and/or for notifying partners
2. Stigma perpetrated by health site staff (e.g., intentionally prolonging clients' wait times, discriminatory behavior) or criminalization (e.g., sharing personal information with the criminal justice system about a KP member and/or person living with HIV who is seeking care)

**The definition of adverse event and categories of adverse events are adapted from U.S. President's Emergency Fund for AIDS Relief (PEPFAR). PEPFAR guidance on implementing safe and ethical index testing services. Washington: PEPFAR; 2020.*

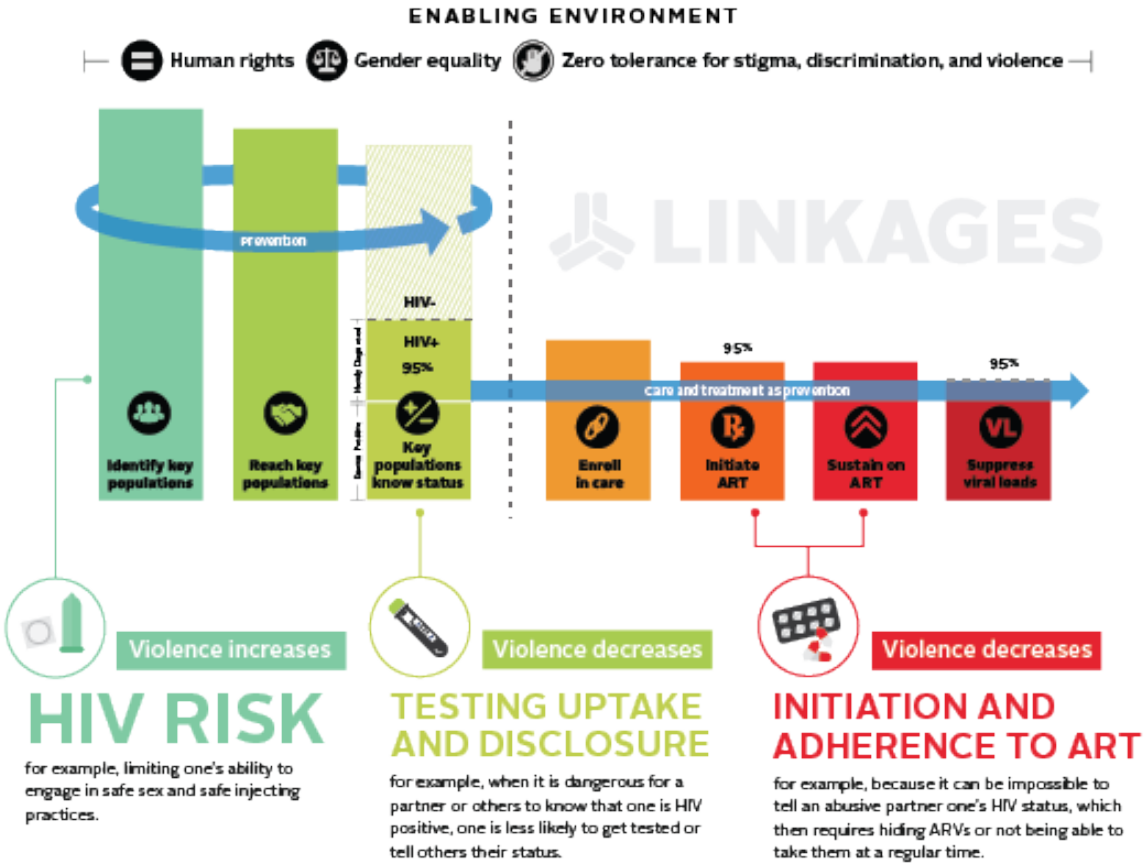


Figure 1. Impact of violence on members of KPs across the cascade of HIV prevention, care, and treatment services

Conceptualizing Violence Prevention and Response

Much of what participants 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 (preventing initial violence). 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 survivors and perpetrators).
- Secondary prevention (preventing further violence right away). Immediate responses after violence has occurred to deal with the short-term consequences (e.g., providing first-line support and linking a survivor 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 (preventing further violence longer-term). Continued responses after violence has occurred to deal with lasting consequences (e.g., support groups and long-term counseling to help survivors 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) and work with offenders of violence to prevent recidivism.

This training supports primary prevention by raising awareness about violence and the right to live free of violence; secondary prevention by improving peer educators', navigators', and outreach workers' skills in immediate response including safety planning; and tertiary prevention by supporting them to link survivors to long-term counseling or other services.

LINKAGES Guidance and Additional Materials Related to Integrating HIV and Violence Prevention and Response Services in Key Population Programs

Minimum requirements

Training those responsible for asking about and responding to violence 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 survivors 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*.[17]

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*[16] 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. All LINKAGES materials on integrating violence and HIV services, including adverse event prevention, monitoring, investigation, and response in index testing, can be found in Annex 1.

The Importance of Peer Educators, Navigators, and Outreach Workers in Integrating HIV and Violence Prevention and Response Services in Key Population Programs

Peer educators, navigators, and outreach workers are vital "entry points" for KP members into a range of services. They are often best placed to share information on legal and human rights and violence response services available, and to raise awareness about the types of violence affecting their communities—activities that can prevent violence and encourage those who experience violence to seek help. They also are often the first people to learn about violence in the lives of those they live and work with, either through spontaneous disclosure or when they ask about violence to determine HIV vulnerability in activities such as risk assessments. It is therefore vital that they are sensitized and trained to ask about and respond to violence in a standardized way, including providing immediate first-line support and linking/accompanying individuals to time-sensitive violence response services (e.g., post-exposure prophylaxis [PEP], emergency contraception). Through training, they learn not only what needs to be done to educate, ask about, and respond to violence, but also why. Training also provides peer educators, navigators, and outreach workers who will be addressing violence in KP service users' lives with the opportunity to reflect critically on their attitudes, beliefs, and knowledge. This is important because many participants may need additional information on gendered and other power dynamics of violence; the relationship between violence and HIV; and the barriers, including stigma against both KP members and survivors of violence, that interfere with KP members' access to health, social, and justice/legal services when they experience violence.

OVERVIEW OF TRAINING CURRICULUM

Purpose

This training document is for use by HIV programmers, including members of KPs and KP-led organizations, who wish to equip peer educators, navigators, and outreach 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 seven main learning objectives. Additional, session-specific objectives are in the agenda. Participants trained will:

- Explore the underlying causes of stigma, discrimination, and violence against KP members and the connection with HIV
- Identify interaction with peer educators, navigators, and outreach workers as a key entry point into violence response services
- Identify and make plans to meet the PEPFAR requirements for asking about and responding to violence and monitoring adverse events, including within index testing
- 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 survivors 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, 18-20] 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.[21] Additionally, this training was designed in partnership with members of KPs to ensure that it responds to the experiences and local contexts of the people it is meant to benefit. 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.*[16]

Intended Training Audience

This training curriculum was designed for people, primarily peers, involved in outreach and connecting KP members to services within HIV programs. This may include peer educators, navigators, and outreach workers.

Violence prevention and response trainings to support law enforcement officers and health care workers are also available and can complement the peer and outreach 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 health care workers can also attend Session 3.5 in this training, which explores linkages to multi-sectoral violence response services. Introducing all those engaged in violence response 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 intimate partner violence (IPV). Participants also strengthen their knowledge of local laws and the constitution, particularly as they relate to violence response for key populations, including the legal obligation of health care workers, law enforcement officers, and others to care for all survivors 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 survivors, and provides the opportunity for participants to learn more about the range of local organizations working to meet survivors' needs. Effective referral is also discussed. Finally, asking about and responding to violence and documenting adverse events in the context of index testing are discussed.

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 and worker security.

Below is a complete list of sessions in the training.

Peer and Outreach 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 (IPV)
Session 2.5: Human rights and the local legal context

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 peer educators, navigators, and outreach workers in violence prevention and response
Session 3.4: Asking about and responding to violence
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: Focus on index testing
Session 3.8: Data collection and sharing

Module 4: Using what we have learned
Session 4.1: Taking care of ourselves
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 training 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 program staff—or those to whom the responsibility has been delegated—to adapt the training. Recall that if you, the facilitator(s), are not a member of a KP-led organization, KP members should also be intimately involved in adaptation. As you adapt, consider the following elements of meaningful collaboration between peer educators, navigators, and outreach workers and KP service users:

- Appeal to the interests of the peer educators, navigators, and outreach workers. For example, talk to senior program staff about how this training can clearly benefit peer educators, navigators, and outreach workers and not be perceived as a burden on top of an existing heavy workload.
- Provide opportunities to showcase senior program staff support. When developing the agenda, build in time for a senior program official to give opening remarks. As appropriate, encourage the opening speaker to include content that clearly states their commitment to an HIV program that meets the needs of survivors of violence.
- Incorporate local context by determining the participants' understanding of violence, most common forms of violence, and societal norms that impact that understanding.

Other considerations for adaptation are:

Other trainings currently or previously in use locally. Consider whether the participants to be trained have attended other relevant trainings and/or if a nationally recognized training on violence is offered.

To avoid duplication and confusion, if the participants to be trained have already attended a training on violence or a training that addressed violence prevention and response as part of a specific approach in HIV programming (for example, an EPOA training), consider working with senior program staff to identify the portions of this training that either do not need to be covered in detail or that can be supplemented with a refresher on the earlier training. For example, if participants have already learned and practiced first-line support skills in a training focused on violence against women, they do not need to relearn them. Instead, they can practice these skills with service users who are KP members, focusing on adaptations that meet their unique needs.

In some countries, there are nationally recognized violence prevention and response trainings, particularly for health care workers. While content from such a training may require adaptation to be appropriate for peer educators, navigators, and outreach workers, it is likely to provide important content on the local context, including information on laws, policies, and referral protocols.

In addition to the materials described in Annex 1, LINKAGES developed two broader trainings for peer educators, navigators, and outreach workers: the *Enhanced Peer Outreach Approach (EPOA): Training Curriculum for Peer Outreach Workers*[22] and the *Peer Navigation Training Core Modules*.[23] The *EPOA training* includes an overview of what participants should do if violence is disclosed during outreach and how to prevent/respond to coercion related to incentives, and the *Peer Navigation training* includes violence response referrals. The resources available within the *Index Testing and Risk Network Referral: Program Orientation and Training Package* are also relevant to peer educators, navigators, and outreach workers engaged in index testing or risk network referral. The training that is part of this package includes a session to build their skills to ask about violence and provide first-line support to those who disclose abuse by an intimate partner.

This VPR training can be used before or after EPOA, peer navigation, or index testing trainings. Participants who have attended any or all of these trainings before the VPR training will have the opportunity to expand and deepen their ability to ask about and respond to the disclosure of violence. Participants who first attend the VPR training and then attend one or more of the other trainings will gain broader outreach skills that will help them meet the many health needs of KP members.

Key populations that will be the focus of the training. Those 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. 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 participants can be away from their duties. While the training is designed to be delivered in two days, in some contexts, less time will be available. If you implement the training in less than two days, it is better to remove activities and devote sufficient time to fewer than to rush through all of them. In this situation, prioritize maintaining sessions that cover practical skills such as asking about and responding to violence (Session 3.4) but recognize that participants may not understand the importance and value of the skills they are learning if the additional content is not covered.

If you have more than two days for the training, you may also consider adding materials. Videos are often helpful, especially those that provide an opportunity for KP members to describe the ways violence affects their HIV vulnerability or how support after violence impacted their lives.

As you design the agenda for your specific time constraints, see Annex 2 for energizers, Annex 3 for activities to recap information (especially useful at the start of each new day of training), and Annex 4 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 cognitive and emotional motivation to make a change in participants' 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 peer educators, navigators, outreach workers, and KP service users 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. Facilitators should incorporate local laws, policies, and guidelines to determine the obligations of the health system to care for survivors and to understand any situations in which mandatory reporting of violence is required. Slides that require country-specific information are noted in green text. The most extensive adaptation to the local context occurs in *Session 2.5: Human Rights and the Local Legal Context.* Preparation of this information is best done by an allied lawyer.

Who will be trained and their responsibilities within the program. Peer educators, navigators, and outreach workers have different opportunities for interaction with KP members who have experienced violence, and HIV programs differ in their approach to addressing violence during outreach. For example, in some HIV programs, peer educators ask about violence during risk assessments and provide first-line support to those who disclose violence. Whereas, in other programs, peer educators do not ask about violence directly but do provide education on violence and offer first-line support if a KP member spontaneously discloses. To ensure that their peer educators, navigators, and outreach workers have the skills to carry out their specific responsibilities, senior program staff can select relevant sessions from Module 3.

When deciding who to train, KP service users, senior program staff, and peer educators, navigators, and outreach workers themselves should have an opportunity to give input. This helps ensure that those who are most likely to interact with a survivor will be sensitized appropriately and those peer educators, navigators, and outreach workers who take on violence prevention and response responsibilities feel comfortable doing so, particularly if their job descriptions change after they receive the training. For example, if they will be newly expected to support survivors of violence, the process for deciding if and how an individual will take on these responsibilities should be a collaborative one. Program staff should talk to each worker about whether they have concerns about the impact of such responsibilities on their personal mental health or safety. As violence against KP members is widespread, it is important to consider that some, and especially peers, being asked to support others may also be experiencing violence themselves.

As much as possible, the training should include case studies and discussions relevant to the participants. Basing new case studies on real-life experiences of KP service users will be helpful (although the identity of a specific KP member should never be discernable).

Types of both HIV and violence response service delivery models: Where participants operate, whether they ask about violence or simply receive spontaneous disclosures, and how participants link survivors to violence response services will influence how they implement what they learn during the training. The HIV service delivery model itself—for example, does the program have drop-in centers (DICs) or focus more on mobile clinics—will also impact how violence response services are integrated into existing activities. During the training, time should be provided for all attendees to discuss how they will operationalize what they have learned within their service delivery model. Examples of violence response models in three different countries are described below.

Dominican Republic: Peer educators conduct education sessions on violence and then accompany survivors to a psychologist who manages referrals to public facilities

In the Dominican Republic, peer educators deliver education on violence and rights at hotspots and community gatherings that focus specifically on how to identify abuse and seek help if it occurs. In situations where education is done one-on-one, peer educators will ask the service user about their experiences of violence, deliver first-line support, document the case, and accompany the survivor to a psychologist at the civil society organization (CSO) implementing the HIV program. If no private place is available to speak or violence is discussed in a group, peer educators do not ask further questions in order to maintain confidentiality. Instead, they let individuals know that they can be accompanied to the local CSO to speak to a psychologist. Often, if education events occur far from the CSO, the peer educator will accompany several people back to the CSO at the same time, but each speaks to a psychologist alone.

In both cases, the psychologist then manages all further documentation and referrals, with the peer offering accompaniment if the survivor wishes to receive PEP, legal help, or other services from public facilities. Peer educators also continue to follow-up with survivors via WhatsApp.

Malawi: Peer educators who learn about violence during regular outreach refer cases back to the DIC or outreach worker

In Malawi, peer educators ask about experiences of violence, including during risk assessment, and provide supportive messages to anyone who discloses violence. When violence is disclosed, the peer educators connect the survivor to an outreach worker or DIC manager who takes over documentation, service provision (including PEP and emergency contraception at the DIC), and further referral according to an established algorithm that guides the services that should be offered based on the type of violence reported. Peer educators then provide follow-up with survivors during later outreach sessions.

In cases where the survivor does not wish to disclose to anyone other than the peer educator, the peer educator uses their basic knowledge of the violence response services available and safety planning questions to help the survivor think through immediate next steps and understand their future options.

Kenya: Hotlines and peer outreach connect survivors to crisis response teams

In Kenya, violence response services are centralized at the CSOs implementing HIV programs for key populations. Crisis response teams at each CSO can be accessed using the hotline (which can operate via WhatsApp) or through direct contact during peer educator outreach. Crisis response teams are operated by peers, outreach workers, and other CSO staff. They provide first-line support and link service users to violence response care at the CSO or elsewhere. Some crisis response teams include connections to local transport operators to ensure survivors can quickly receive medical and other needed services when violence occurs. Paralegals on the crisis response teams document violence response services accessed (internally and externally); they also support survivors who wish to pursue legal action. At some CSOs, crisis response teams facilitate alternative dispute resolution.

Outreach goes online

Increasingly, HIV programs are using online tools and platforms to conduct outreach, often employing peers who may have previously done more traditional forms of outreach. While this training focuses on traditional outreach and not virtual interactions, this is not because peers working online do not need to cultivate these skills. In many contexts, peers reaching out to offer HIV services receive spontaneous disclosures of violence or programs designed to assess risk include questions on violence and then peers follow-up to link to referral. As a result, many of the approaches encouraged here, such as offering first-line support and making referrals, could also be of use in online spaces but would likely need to be adapted to the medium employed. Furthermore, questions such as digital security would need to be addressed.

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 a maximum of 25 participants at one time.

Literacy levels. The training slides and activities should be adapted for the literacy level of the training participants. Reviewing the slides with local facilitators—especially peer educators, navigators, and outreach workers—is an important

opportunity to rephrase or simplify language. Many activities that require reading can be done in large or small groups so that those with higher literacy levels can assist others. For individual activities, such as the pre and post-test, each question can be read out loud. As desired, for longer readings like Amanda's Story (Exercise Card 2), 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 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 peer educators, navigators, or outreach 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.).[24]

As you identify trainers, strongly consider peer educators, navigators, and outreach workers with facilitation capacity (if they are not KP members then KP members should also be included as trainers). All those implementing the training, should be trained in facilitation (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 Peer Educators, Navigators, and Outreach 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 peer educators, navigators, and outreach workers receive training, which is especially important in areas with high staff turnover.

Beyond offering the training repeatedly to achieve broad coverage among peer educators, navigators, and outreach workers, you may also consider mini-refresher trainings (10–15 minutes long) during existing events—such as staff meetings—to continually engage with peer educators, navigators, and outreach workers post training and introduce them 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. Participants 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 [peer educators, navigators, outreach 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

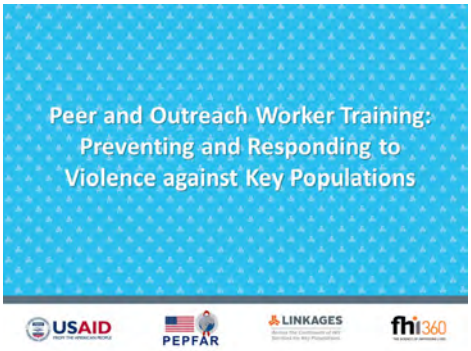
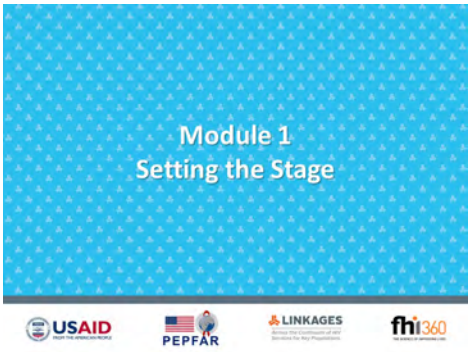
Time: 30 minutes

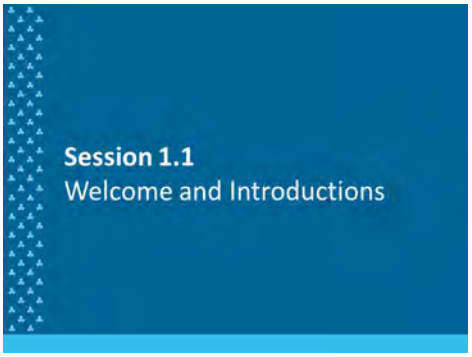
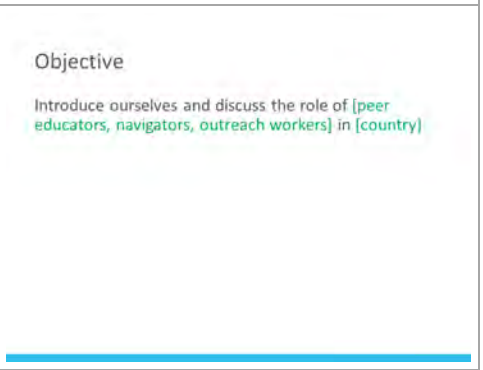
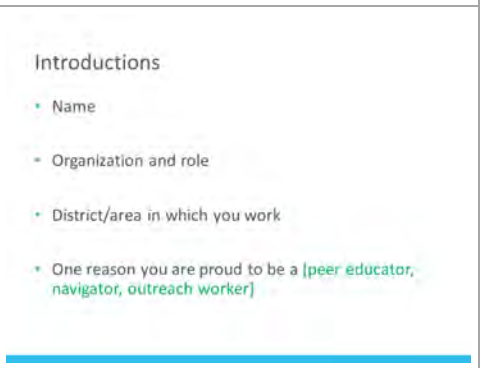
Materials

- Slide presentation
- Opening remarks by senior program official
- Name tags for participants and/or name tents
- Flip chart and markers
- Flip chart titled "Why I'm proud to be a [peer educator, navigator, outreach worker]"

Planning Ahead

HIV programs use different position titles—such as peer educator, navigator, and outreach worker—to describe those involved in outreach and linking KP members to services. When the terms "peer educator, navigator, and outreach worker" are noted in green text, the facilitator should replace the green text with the position title(s) specific to their HIV program.

• Welcome everyone to the training and thank them for being there. If an 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 participants 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).	
• Thank the official for their commitment and support. • Show slide and explain: We will start with *Module 1: Setting the Stage*.	

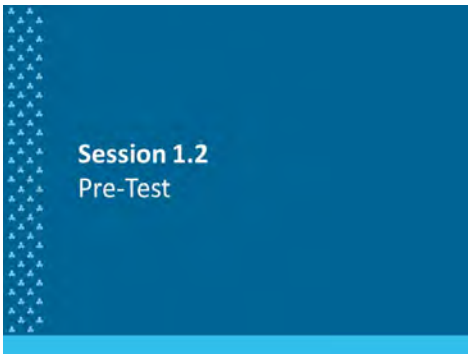
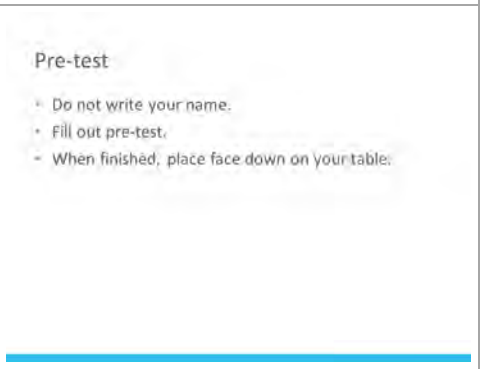
Launch training • Show slide and have facilitators introduce themselves. **Share announcements and logistics (e.g., restrooms, sign-in sheet)** • Describe the location of restrooms; if possible, determine in advance if there are gender-neutral bathrooms that can be used by trans participants or others 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.	
• Explain that each session has one or more objectives. • Read aloud the objective for this session. *[Note to the facilitator: Green text on the slide should be replaced in preparation for the training.]*	
• 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 [peer educator, navigator, outreach 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 they 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 [peer educators, navigators, outreach workers] contribute to society?" *[Note to the facilitator: If you are working with a specific organization you may wish to make this question more specific. For example, you might ask: "What do [peer educators, navigators, outreach workers] in [organization represented in the training] contribute to society?"]*	

Session 1.2: Pre-Test

Time: 10 minutes

Materials

- Slide presentation
- Handout 1: Pre-Test

• Show slide and explain: It is now time for the pre-test.	
• Show slide and explain: We will use this test to understand participants' current knowledge and attitudes toward several topics.	
• Show slide and explain: 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. • 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. *[Note to the facilitator: As this pre-test asks about participant opinions, there are no correct answers.*	

However, the desired direction of participant opinions is noted in the following key.]	

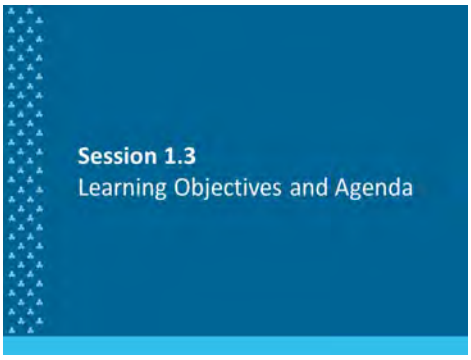
Desired Response Key				
Statement	**Strongly agree**	**Agree**	**Disagree**	**Strongly disagree**
1. Gender norms, or the expectations we have for men and women, can cause harm.	X			
2. Transgender people are responsible for the violence they experience.				X
3. If sex workers are assaulted while engaging in sex work, they are at least somewhat to blame.				X
4. Men who are openly gay should not complain if they are assaulted.				X
5. People who inject drugs must stop using drugs if they do not wish to be abused.				X
6. It is important that I am able to talk about violence with those I provide services to.	X			
7. It harms survivors of violence when they are blamed for the abuse they experienced.	X			
8. Health care workers have a duty to support key population members who experience violence.	X			
9. Law enforcement officers have a duty to support key population members who experience violence.	X			
10. Key population members have the right to live free of violence.	X			
11. Intimate partner violence often causes serious harm.	X			

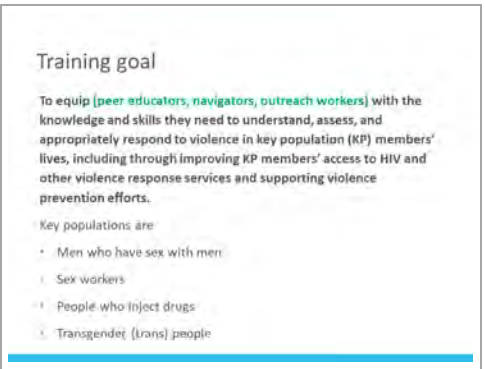
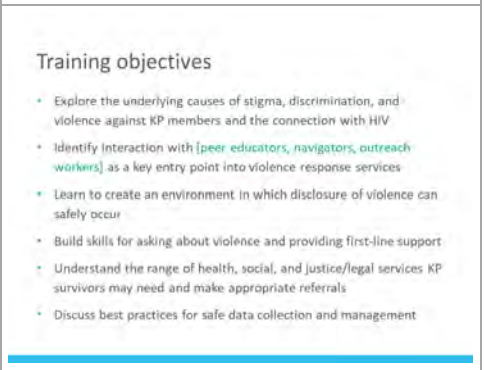
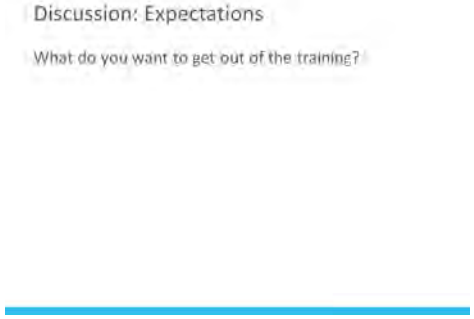
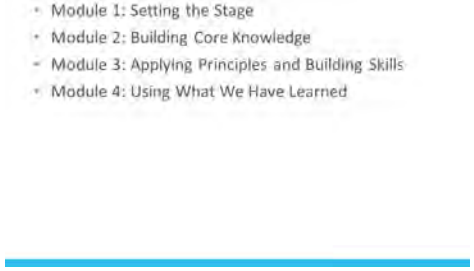
Session 1.3: Learning Objectives and Agenda

Time: 15 minutes

Materials

- Slide presentation
- Flip chart and markers
- Flip chart titled "Expectations"
- Handout 2: Participant Agenda

• Show slide and explain: We will spend two 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 knowledge and skills, 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.	
• 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.	

• 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.	
• 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.	
• Show slide and 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.	
• 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 program staff so they recognize it as a need that should be addressed elsewhere.]*	

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"

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- Show slide and explain: Now we move to establishing group norms that will help us work effectively together.

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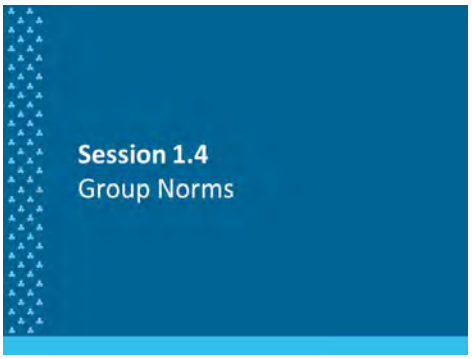
<td> 
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- Show slide and read objective.
- Refer to the flip chart titled "Group Norms."
- Explain: Setting some ground rules or group norms at the beginning of a training is always a good idea to make sure we are all on the same page, maintain common 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:
  - 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, write "Confidentiality" in large letters on the flip chart.

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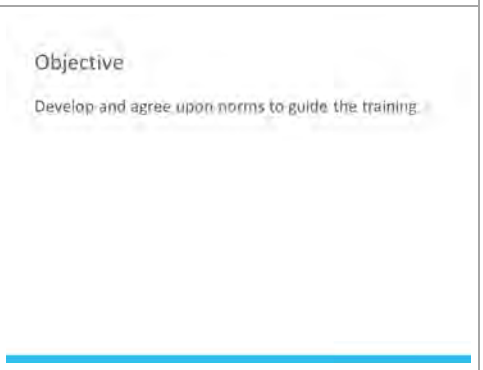
<td> 
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• Explain: It's important that participants feel comfortable sharing their thoughts. Some of us may have had experiences with violence or know people who have. Some may decide to share personal experiences. A commitment to confidentiality within 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. 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 HIV outreach programs 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 survivors of violence.

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 (IPV)

- Recognize the ways in which IPV can evolve over time
- Discuss the importance of responding to all survivors 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 Human Rights and the Local Legal Context

- Identify local laws and constitutional provisions that outline the rights of all people
- Recognize the laws and policies that most affect KP members and discuss common applications and misapplications
- Become familiar with strategies that KP members can use to counter the misapplication of these laws, including redress mechanisms
- Recognize the role of [peer educators, navigators, outreach workers] in providing basic information about KP members' legal and human rights, the links between violence and HIV, and how to access services

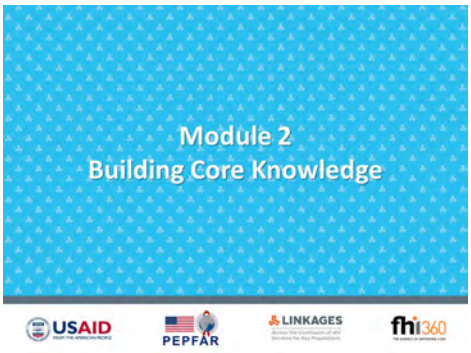
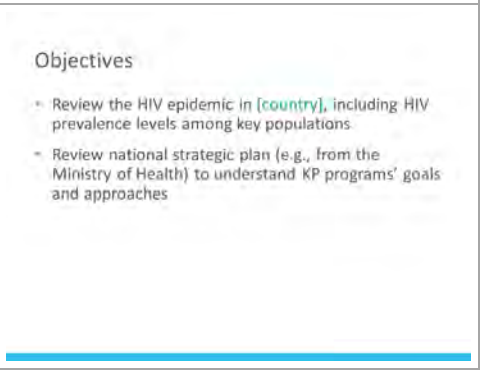
Session 2.1: The HIV Epidemic in [Country]

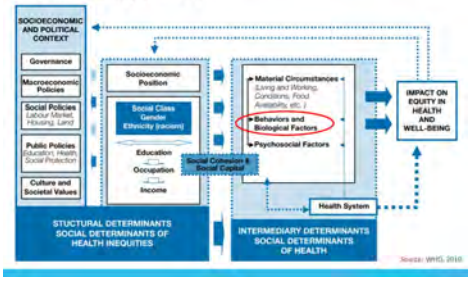
Time: 30 minutes

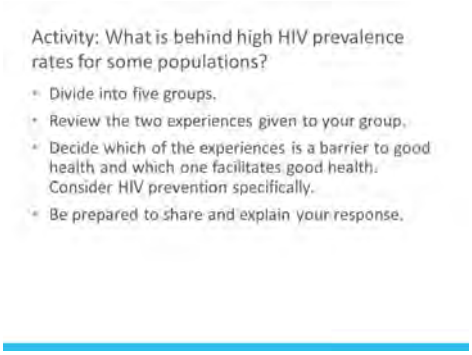
Materials

- 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.

• Show slide and explain: We will now move on to building our knowledge on this important topic.	
• 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].	
• Show slide and ask a participant to read each objective out loud.	

• Show slide and explain: Let's talk about HIV in [country]. • Show country-specific slide(s) and review the content. *[Note to the facilitator: Add one or more slides explaining the HIV epidemic among the general population in the country.]*	HIV epidemic in [country] [Country team to add data on the HIV epidemic in their country. Key-population-specific data should be included on a later slide.]
• 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. *[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.]*	Key populations and HIV globally • 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.[1]
• 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. *[Note to the facilitator: Add one or more slides explaining the HIV epidemic among key populations in the country.]*	HIV among key populations in [country] 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]. Insert country-specific information/statistics about HIV among these KP groups in [country]. You may also wish to include size estimation data. 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.
• Show slide and 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	What influences people's health, including their vulnerability to HIV? 

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.[25] It shows us that an individual's behavior is just one small part of what determines if they will be healthy. • 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. *[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.* *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.]*	
• Show slide and 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.

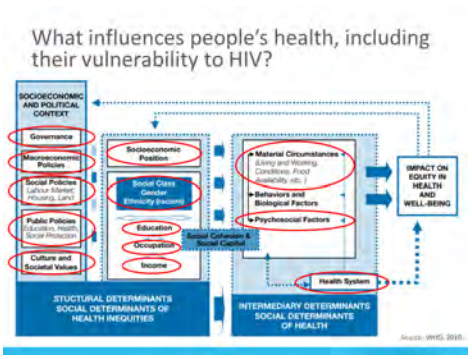
- Give five minutes for discussion in small groups and then have each group share their answers.

[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 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 survivors 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-raking.[26] 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 survivors 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.[27]
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.[28]
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.[29]
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.[30] Sexual violence and higher risk sexual behaviors are common among individuals who are homeless.[31, 32] Sex workers who are homeless experience more violence than those who are housed.[33] Violence, as we will see throughout this training, both directly and indirectly increases HIV vulnerability.

• Show the 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.	
• 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 participants 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

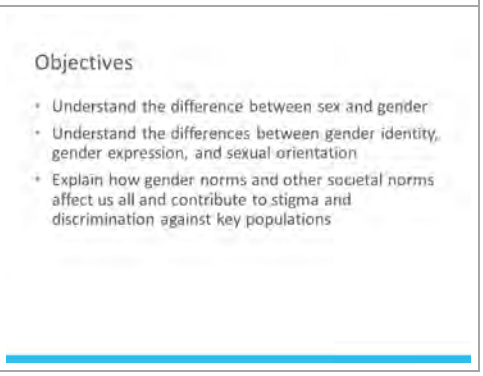
Time: 90 minutes

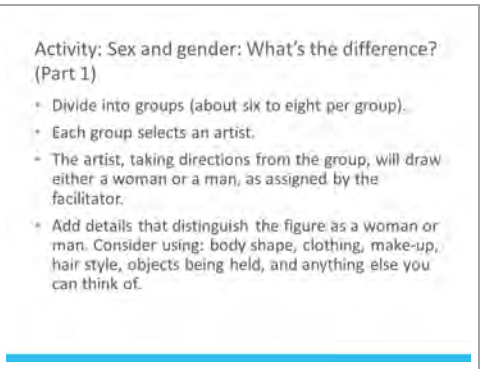
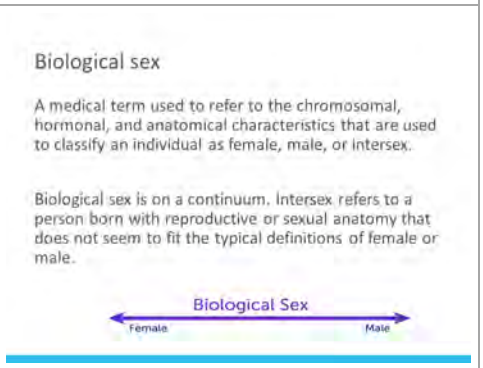
Materials

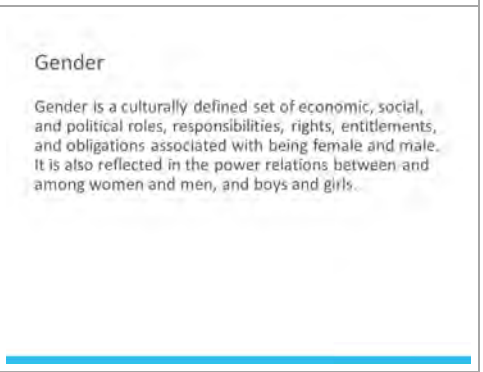
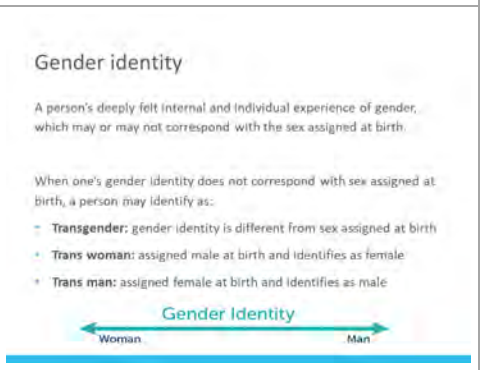
- Slide presentation
- Flip chart and markers

Planning Ahead

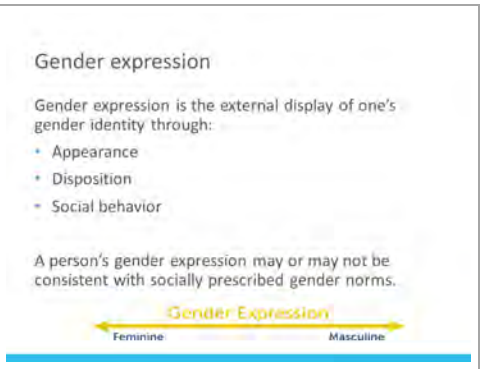
Because gender norms vary by culture, it's important to do some thinking in advance about the gender norms in your setting. Many of the examples here come from a western context (e.g., long hair is considered feminine, short hair is considered masculine) and might not resonate with the training participants. 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 participants 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.

• Show slide and 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.	

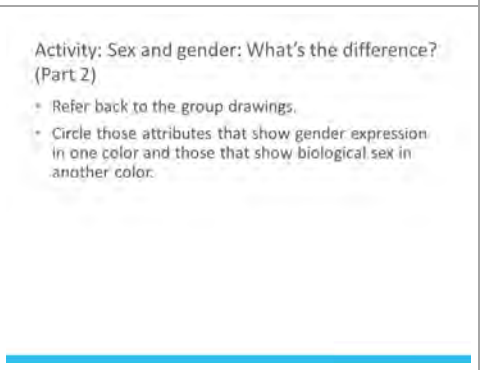
• Show slide and explain: In this activity, we'll think through the concepts of sex and gender, two commonly confused words that have important and different meanings. • Divide participants into two or more groups (about six to eight per group). • Explain: Each group should select an artist. That person, 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.	
• 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	

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. *[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?".[34]* *"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%)."]*	
• 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.	
• 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, 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, sometimes referred to as nonbinary. 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 likely to have good mental health than those who are not accepted by their parents.[35]	

- 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.



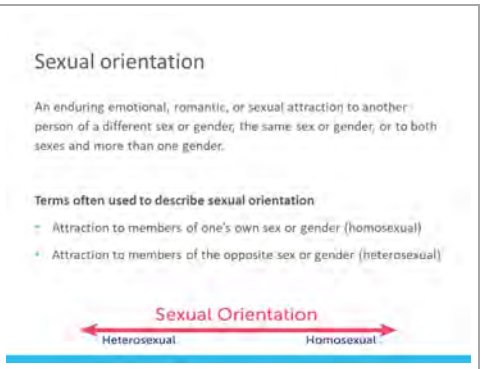
- Show slide and refer back to the groups' drawings.
- Instruct the groups to classify some aspects of each drawing as sex and others as gender expression.
- Summarize: We've talked about the difference between sex and gender, what we mean by gender identity, and the different ways in which people express their gender.

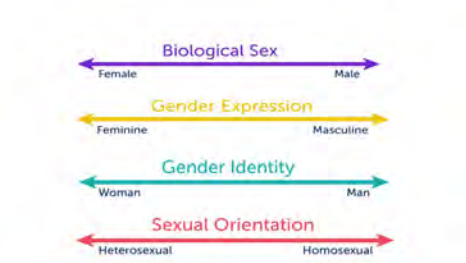


Examples of Gender Expression and Sex (these will vary depending on the context)

	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

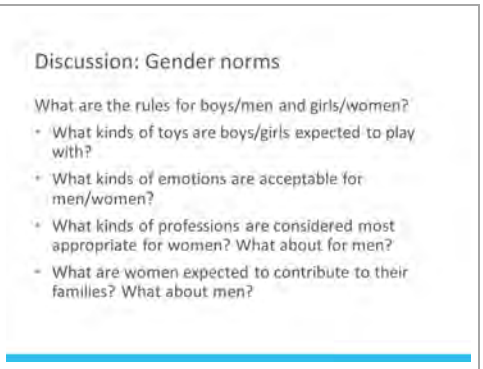
- Show slide and explain: Now let's talk about who we are attracted to, not how we think of or present ourselves.
- Ask: What do we mean by sexual orientation? Elicit responses.
- Click slide again to show and review the definition as well as the terms used to describe sexual orientation.
- Emphasize: 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



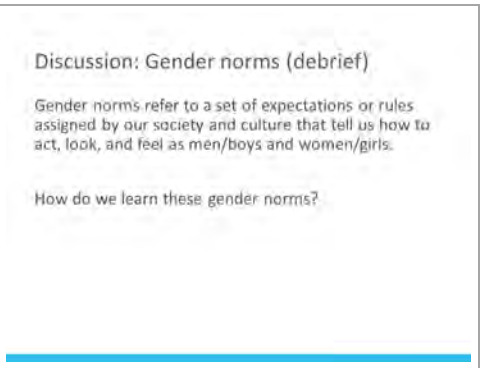
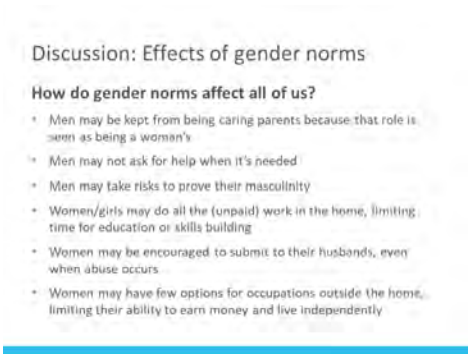
not effective. Furthermore, the way someone is raised does not determine who they will be attracted to. While a parent's acceptance of their children could make their children more likely to be open about their sexual orientation and therefore less likely to experience depression or commit self-harm, 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. • It's important to understand and respect each person as an individual who can be anywhere on these continua.	

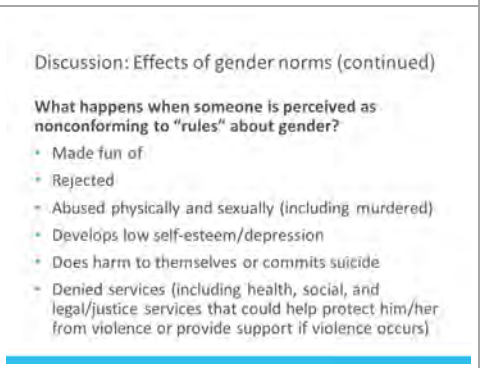
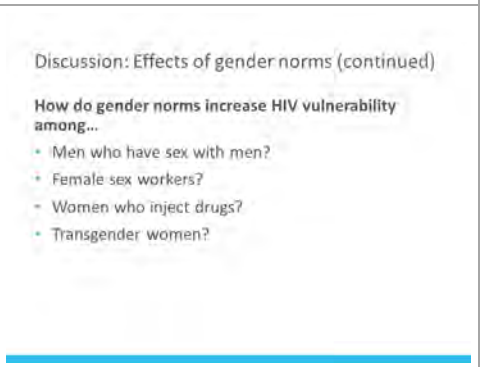
- Show slide and explain: Now let's think again about gender, and not just as it relates to how we dress or look. Turn to the person next to you and answer each of the questions on the slide.
- Give participants about 5–10 minutes to discuss in pairs. If you are running short on time, you can assign 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 not a certain other way).

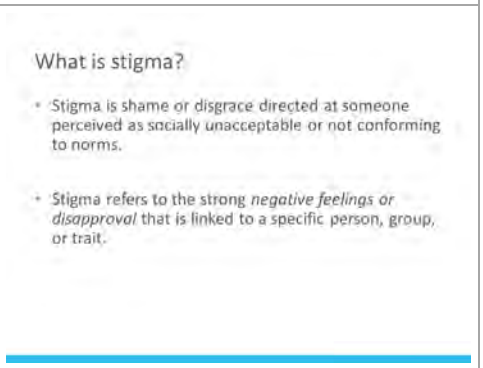
[Note to the facilitator: Gender norms differ by country. In some countries, women have been encouraged to take on roles or professions that were traditionally masculine because those roles are often considered superior (e.g., leader, strong, brave) and are better compensated (e.g., lawyer/doctor versus 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.]

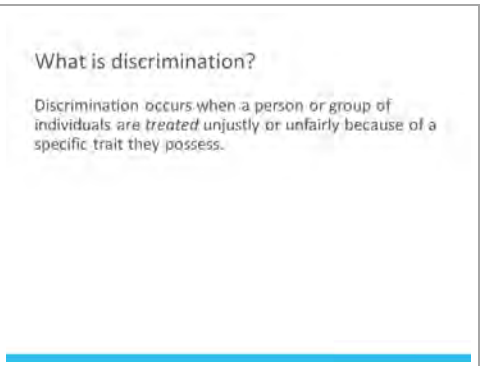
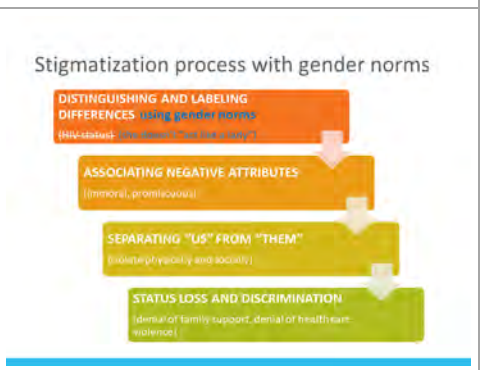


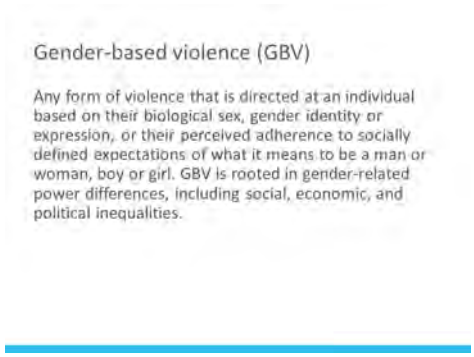
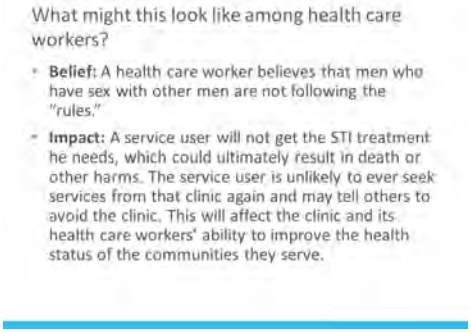
Examples of "rules" for men/boys versus women/girls (these will vary depending on the context)		
	Men/Boys	**Women/Girls**
Toys	Blocks, trucks, balls, guns, sticks	Dolls, babies, kitchen toys
Emotions	Calm, stoic, angry when needed	Happy, sad, scared, more emotive ("hysterical")
Professions	Professors, 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, housework, cooking, shopping

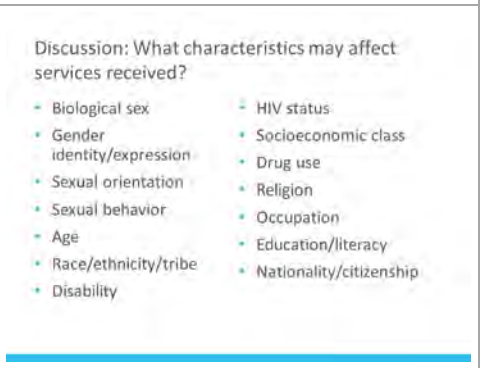
• Show slide and explain: What you just described are called gender norms. They are expectations based on gender that tell us how to act, look, and feel as men/boys and women/girls. These are cultural messages. Not everyone abides by them, but we know they are there. • Ask: How do we learn these gender 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.	
• 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.	

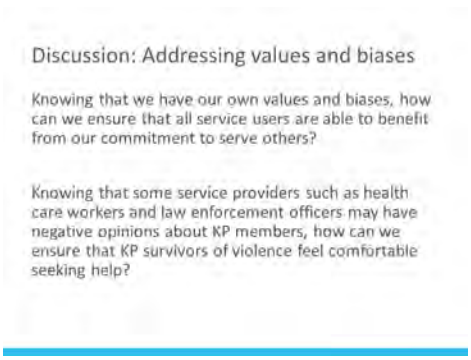
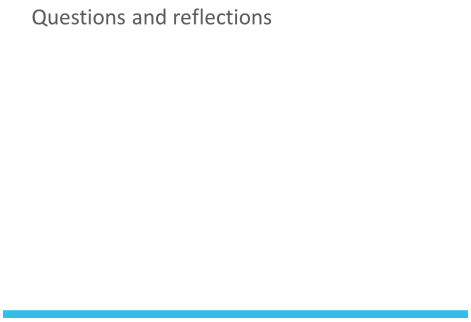
• Ask: Let's think about it more broadly. How do the rules that we're all asked to follow harm both men and women? • Solicit responses from the group. • Click slide again to show and review examples. When reviewing the example about men not seeking help, make the point that this also affects HIV testing 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].	
• 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. • Click slide again and review examples. Say: - 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 survivor 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.	
• 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): - 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	

behavior to them. This means they cannot receive appropriate counseling and information to protect themselves from HIV. - 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. • 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.	
• 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.	

• Show slide and explain: We just talked about what we mean by stigma. Let's look at a definition for discrimination. • 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.	
• 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.	
• 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.	

• 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 survivor 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.	
• Show slide and ask: How might the effects of stigma be felt for KP members looking for help from health care workers? • Here is one example: - 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.	

• 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, but 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 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.]*	
• Show slide and explain: 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 health, social, or justice/legal services after experiencing violence? • Ask the group to come up with a list of characteristics that might affect how individuals are treated. • Then click to show the list on the slide. • Explain: Society's views of different groups or individual characteristics are likely to affect the services that [peer educators, navigators, outreach workers] provide and make it difficult to ensure that all people have access to health, social, and justice/legal services. Access to services 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 service providers, such as health care workers and law enforcement officers, treat someone are also increasing that person's risk of violence, we see how important it is to be prepared to provide services to those who are most vulnerable.	

[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.]	
• Show slide and ask participants to recall why they are proud to be [peer educators, navigators, outreach workers]. Summarize the responses from the earlier flip chart titled "Why I'm proud to be a [peer educator, navigator, outreach worker]." Click slide and ask: 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? Emphasize the responses that show a commitment to meet the needs of their community and/or to help people who are the most vulnerable. • Click slide again and ask: Knowing that some service providers such as health care workers and law enforcement officers may hold negative opinions about KP members, how can we ensure that KP survivors of violence feel comfortable seeking help? Probe for: offer to accompany a KP member to the violence response services they wish to seek	
• Show slide and explain: 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 service providers' opinions and actions determine who has access to health, social, and justice/legal services. • 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.	

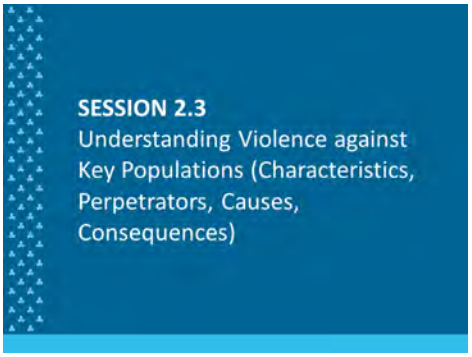
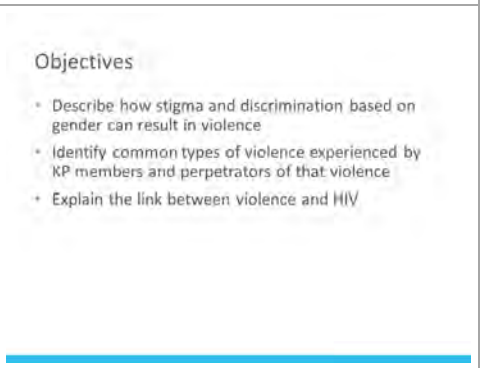
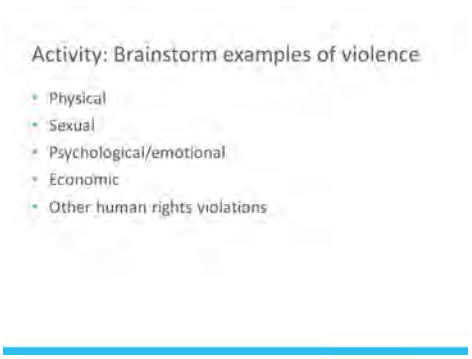
Session 2.3: Understanding Violence against Key Populations (Characteristics, Perpetrators, Causes, Consequences)

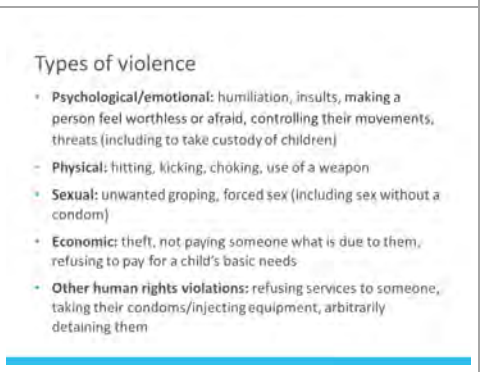
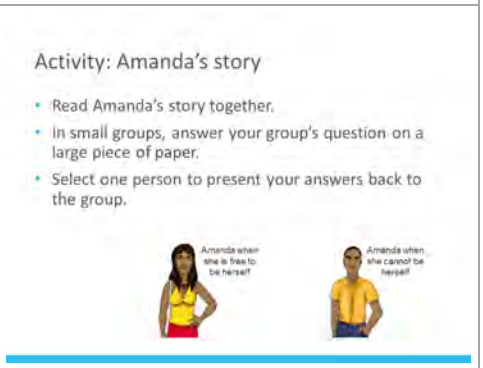
Time: 60 minutes

Materials

- Slide presentation
- Flip chart and markers
- Exercise Card 2: 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.

• Show slide and 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.	
• Show slide and ask a participant to read each objective out loud.	
• Show slide and explain: As [peer educators, navigators, outreach 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. • Click to advance the slide. 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.	
• Say: Many people only understand violence to be physical and sexual, but emotional/psychological violence has huge ramifications for people's well-being and some survivors of multiple forms of violence report that emotional violence was even more harmful to them than other forms that left physical marks. Then 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.	
• Show slide and explain: We 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 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 2: Amanda's Story. Click the slide to review each step of the instructions. Explain you are going to read the story either (1) aloud as a large group, paragraph by paragraph, if literacy levels are low, or (2) each small group is going to read it once they come together. • Break participants into small groups (of no more than five to six) and assign one question to each (see next slide and/or exercise card). If there are 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. • 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.	

- 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.

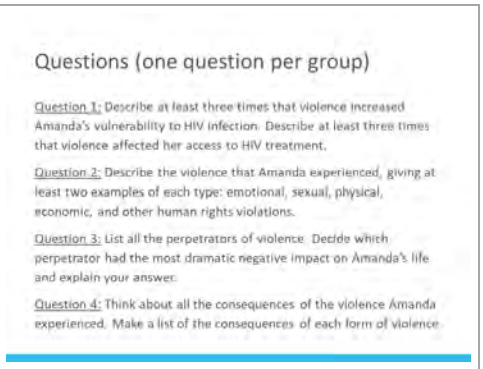
  Example answers to **question 1** include:
  Amanda's HIV vulnerability increased when:
  - Her parents kicked her out; she had to engage in transactional sex to have a place to live.
  - Edward refused to wear a condom; she was at risk for HIV infection.
  - She was raped by the other inmates at the prison.

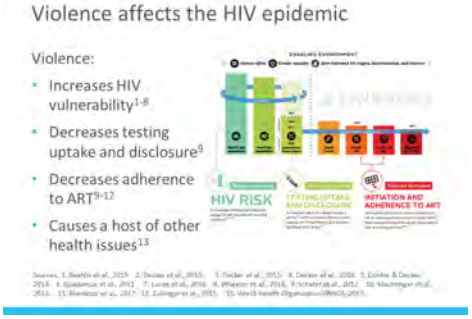
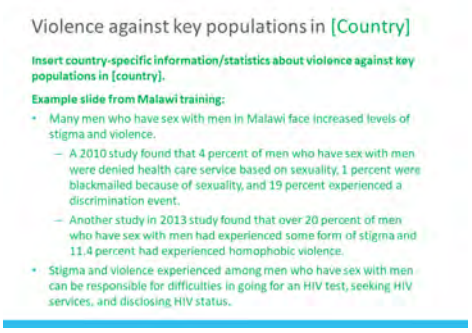
  Amanda's HIV treatment was affected when:
  - She could not get tested due to fear of Edward.
  - She had to hide her medication.
  - The nurse made her feel that she was irresponsible.

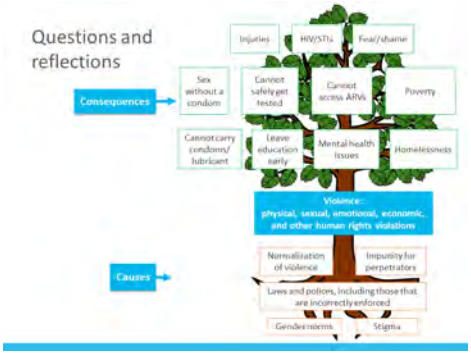
  Example answers to **question 2** include:
  - **Emotional**: parents said they would rather have a dead son than a gay son; Edward is constantly berating and threatening Amanda; nurse berates her
  - **Sexual**: rape; forced to have sex without a condom
  - **Physical**: beaten by Edward; students threw 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

  Example answers to **question 3** include:
  - Parents and family
  - Edward
  - Other inmates
  - Police
  - Daniel
  - Men who come to Daniel's house
  - Nurse

  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. Example answers to **question 4** include: - **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 *[Note to the facilitator: Set aside the flip chart created by group 4 for use in Session 3.5.]*	
• 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 each aloud before advancing to the next.	
• 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.	
• 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]. • 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. Citations are especially useful if those being trained will be asked to or wish to use the information for advocacy or to educate others. 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 service providers' actions could increase violence. • You also have a better sense of how the HIV epidemic is affected by violence and why you, as	

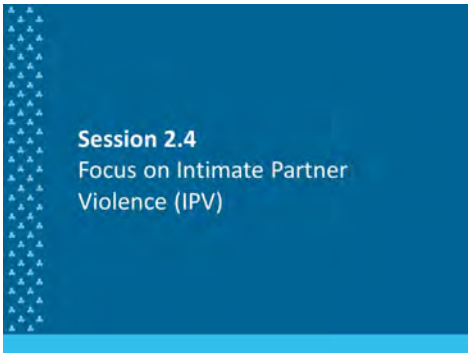
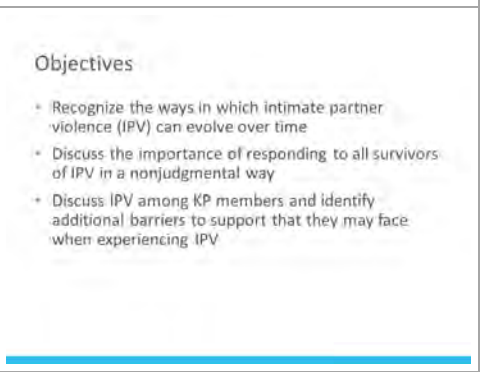
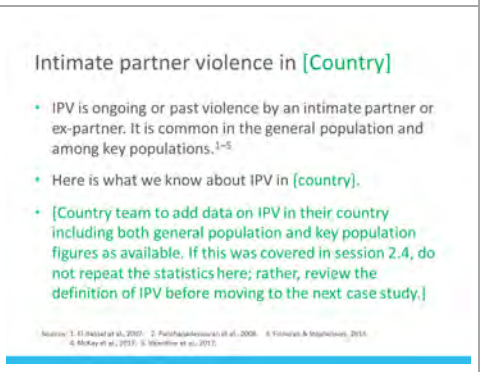
[peer educators, navigators, outreach workers], are such an important part of an effective HIV response. If we can't stop violence and can't get support to those who experience it, we won't have an effective response to the HIV epidemic. • Finally, you now have a sense of the consequences of violence, so we can think about the services survivors 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.]*	

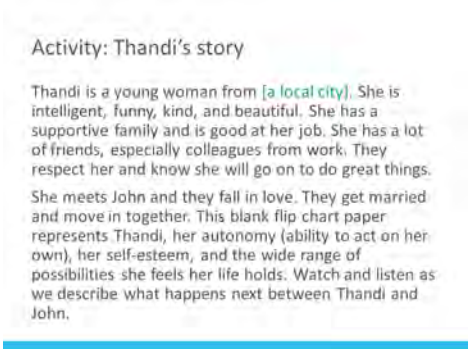
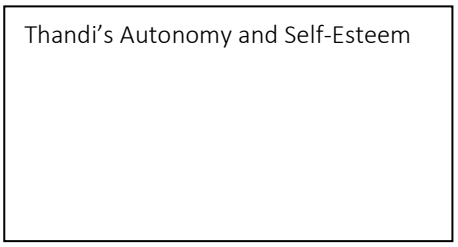
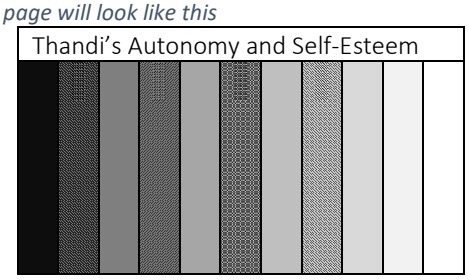
Session 2.4: Focus on Intimate Partner Violence (IPV)

Time: 30 minutes

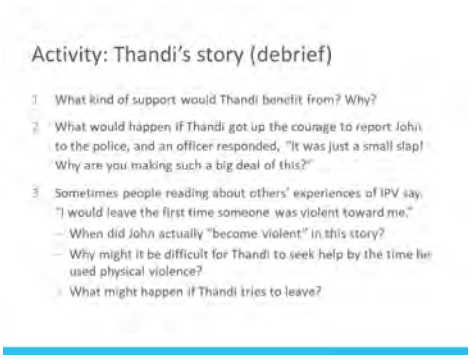
Materials

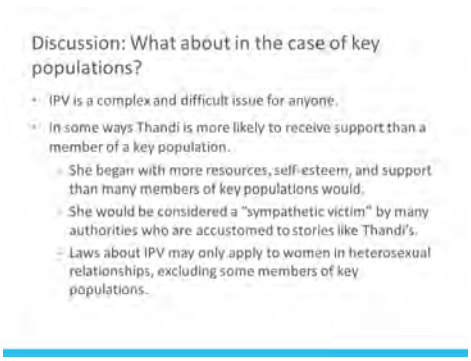
- Slide presentation
- Flip chart and markers
- Exercise Card 3: Thandi's Story

• 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).	
• Ask a participant to read each objective out loud.	
• 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 survivors 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 [peer educators, navigators, outreach workers] are such important responders to incidents of IPV, we want to spend some time talking about IPV specifically. While understanding the needs of survivors of IPV and linking them to care has always been important, the demand for addressing IPV against people living with HIV is greater than ever.	

[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.]	
• 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: 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 survivor of violence may experience. Then we'll transition to think about what this would look like in KP members' lives. • Use Exercise Card 3 to read Thandi's story to the participants.	 *Figure 1. At the start of the activity, the page will be blank like this*  *Figure 2. When the activity is completed, the page will look like this* 

- 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:
  - 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?
    - 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 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.
  - It is important for Thandi to know what kind of help is available. Why?
    - 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?
    - Thandi may feel embarrassed about 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 survivors 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 survivor of violence may not recognize controlling behavior or other emotional abuse as violence. Also mention the stigma against survivors of violence and how this stigma makes it difficult for someone to disclose that they are experiencing violence. Finally, explain that survivors 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.	
• Show slide and explain: IPV is incredibly common and can happen to anyone. 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. Service providers 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 survivor'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 survivors 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. • As a reminder, cisgender describes a person whose gender identity is the same as their sex assigned at birth. In this example, we are talking about a	

person who assigned female at birth and identifies as a woman. *[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].*[16]	
• Close the session by reiterating 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 [peer educators, navigators, outreach 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 should take time to care for themselves].*	Questions and reflections

Session 2.5: Human Rights and the Local Legal Context

Time: 60 minutes

Materials

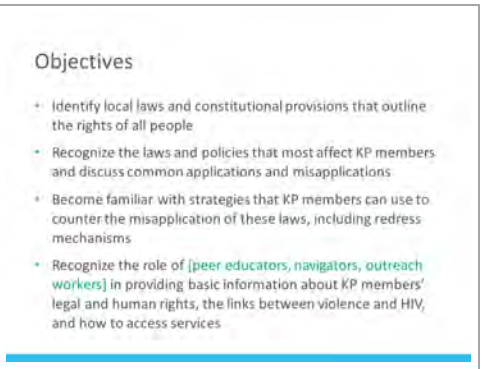
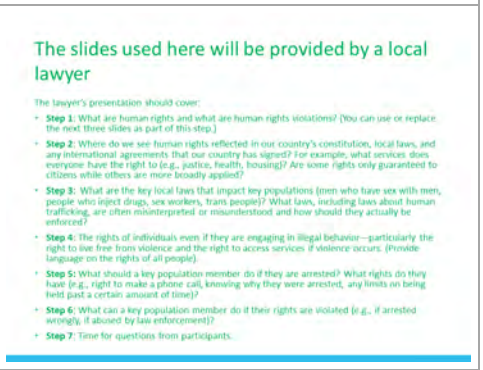
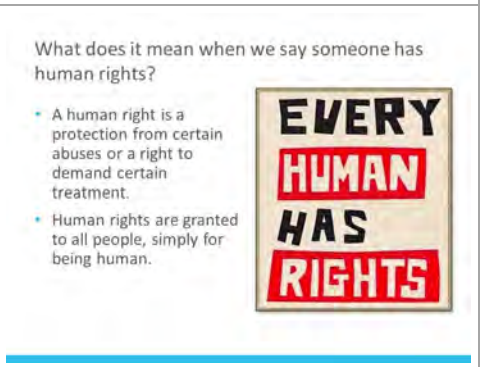
- Slide presentation
- Flip chart and markers
- Annex 5: Sample "Know Your Rights" Information, Education, and Communication (IEC) Materials
- Locally used IEC materials to inform KP members about their rights and empower them to access services (if available)

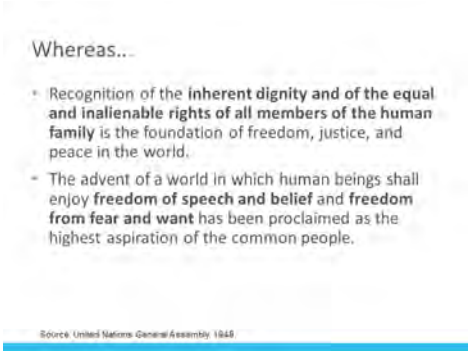
Planning Ahead

This session should be organized prior to the training. It should be facilitated by a human rights lawyer and/or allied lawyer who is familiar with the human rights protections included in national-level policy documents that pertain to all people, including KP members. The person must also be knowledgeable about how local laws are implemented in a way that targets or affects KP members. This presenter should also share strategies that KP members can use to counter the misapplication of these laws and highlight laws and national policies that protect key populations. See the green text in the slide presentation to consider the specific information the lawyer should be able to speak to. If the local lawyer needs ideas on how to present information about the human rights of KP members, check out the *"Sex Worker Rights Are Human Rights"* training developed by the Kenya Sex Worker Association and the Leitner Center for International Law and Justice.[37]

If the HIV program implementing this training has "know your rights" activities or IEC materials that aim to educate and empower KP members, present the activities and print the IEC materials so participants can use them during outreach to inform KP members about their legal and human rights, the link between violence and HIV, and how to access health, social, and justice/legal services.

- Show slide and explain: As we saw in our earlier activities, laws can also affect violence experienced by KP members and whether KP members feel safe seeking help.
- In this session, we will cover the human rights protections highlighted in [country's] constitution and other national-level policy documents.
- We will also talk about local laws and how those laws are implemented.
- We have a local lawyer here who can help all of us understand some of the ways that laws can either harm or protect members of KPs and how to work within the local legal context.

• Show slide and ask a participant to read each objective out loud.	
[Note to the facilitator: The slide in green was designed to help you identify a human rights lawyer to conduct this session. You will not use this slide in the final presentation; replace it with slides needed for the session.]	
[Note to the facilitator: This slide is for use by the local human rights lawyer to address Step 1 if they choose to use it. If useful for you or the lawyer, some general points that can be emphasized are below (from the REAct User Guide).[38]] • Show slide and ask: What are human rights? • Elicit responses, advance the slide, and explain: - Human rights are basic universal entitlements that all people have because they are human. - They are based on the idea that every person is equal and entitled to be treated with dignity and respect, regardless of their race, sex, gender, sexual orientation, age, disability, or any other characteristic. - Human rights apply to all people throughout the world at all times. - Human rights give people the freedom to choose how they live, how they express themselves, and what kind of government they want to support, among many other things. - They also guarantee people basic needs such as health, food, housing, and education. By guaranteeing life, liberty, and security, human rights protect people against abuse by those who are more powerful. - State institutions and representatives including government officials, law enforcement officers,	

army personnel, prison officers, civil servants, the judiciary, political authorities, and medical or education personnel in state-run facilities have the obligation to fulfill the rights of all citizens without discrimination. • Ask: What are human rights violations? Elicit responses and explain as needed: Human rights violations can occur through: - Failing to respect human rights: an act that does not respect an individual's human rights (e.g., arbitrarily depriving someone of their freedom or torturing them, such as a law enforcement officer putting a transgender woman in a men's cell and encouraging the other inmates to sexually assault her). - Failing to protect human rights: an indirect violation by omission (i.e., by not providing protection against systematic abuse committed by one group against another or by not promoting the rights of all citizens). Omission is negligence in performing the requirements of national or international law relating to the protection of human rights. In the case of omission: ▪ The actual hurt can be committed by common citizens. ▪ The state has a responsibility to act to stop these incidents and provide protection to the survivors. ▪ If the authorities don't do so, they are violating the rights of the survivors by their omission. ▪ An example of this would be a sex worker who is raped and robbed by a client goes to the police for help and they refuse to document the case or search for the perpetrator.	
[Note to the facilitator: This slide is for use by the local human rights lawyer to address Step 1 if they choose to use it.] • Show slide and explain: The preamble of the Declaration of Human Rights provides information on who human rights apply to (everyone) and why they are important.	

[Note to the facilitator: This slide is for use by the local human rights lawyer. If they choose to use this activity, it will help them begin a conversation about step 2. There are no sample slides for Steps 3-6.]

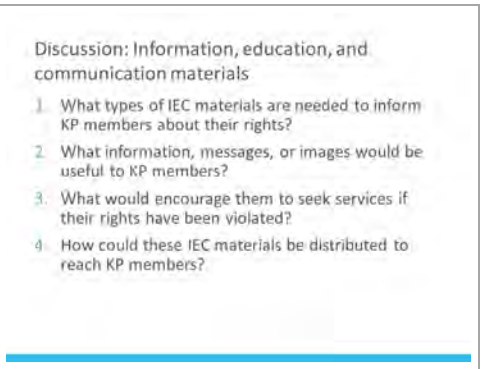
- Show slide and explain: The Declaration of Human Rights includes 28 rights; a few are listed on the slide. Many country governments have committed to protect these rights and created their own human rights agreements, which are often reflected in their constitution and local laws. Yet, in many contexts, KP members are not aware of laws that could protect them as people living in [country].
- Ask participants to form small groups (3-4 participants) and explain: You will work in small groups to make a list of the rights, according to local laws or the constitution, that you believe key populations have as people living in [country]. You can use the list on the slide to come up with ideas. Put a star next to those rights that you think are included in the law but are not respected by law enforcement or others.
- Allow about 10 minutes for participants to discuss.
- The human rights lawyer should now come to the front of the room and ask a representative from one group to share one right that KP members have according to the local law. The human rights lawyer should note whether the right was described accurately and then write down the correct protection on a new large piece of paper.
- Each additional group will then contribute one of the rights they wrote down (making sure to list one that is different from those already stated) until all the examples that groups came up with have been discussed. For each one, the human rights lawyer will note whether this is correct and include accurate information on the new sheet of paper.
- After all groups contribute what they have written, the human rights lawyer should add any rights under the law that were not mentioned, including those that describe the services that all survivors of violence have the right to receive (e.g., justice, health, etc.).

[Note to the facilitator: This slide is for use by the facilitator.]

- Show slide and explain: KP members may not have a full understanding of their legal and human rights. Knowing their rights enables them to claim them and stand up for them. For example, once they become aware of their rights, they may raise new or recurring legal issues they face.
- Ask: How can [peer educators, navigators, outreach workers] support KP service users to learn about their rights? Elicit responses.
- Explain: [Peer educators, navigators, outreach workers] should be knowledgeable about the basic legal and human rights of KP members and be able to share this information with service users who disclose violence to help them understand their options. During outreach, [peer educators, navigators, outreach workers] often use IEC materials such as posters, pamphlets, or pocket cards to provide KP service users with rights information.
- In addition to informing KP members about their legal and human rights, these materials can be used to:
  - Inform KP members that everyone has a basic human right to live free of violence
  - Increase knowledge of the negative health consequences of violence, including the link between violence and HIV
  - Inform KP members about available health, social, and justice/legal services, including how to access them

[Note to the facilitator: Rights education activities may already be planned that [peer educators, navigators, outreach workers] will be asked to participate in. If this is the case, the facilitator can present those here instead of posing this as a question].

Discussion: How can we support KP service users to learn about their rights?

[Note to the facilitator: This slide is for use by the facilitator. *If the HIV program leading this training has already developed IEC materials on KP members' legal and human rights, share the printed materials with participants at this point instead of facilitating this discussion.* *If the materials do not include the following components—information about legal and human rights, links between violence and HIV, and how to access services—the HIV program may decide to invest in generating these materials. Examples can be found in Annex 5.]* • Show slide and explain: Now that you've learned how IEC materials can inform KP members about their rights, let's brainstorm what IEC materials would be most useful for the KP members we interact with during outreach. • Discuss the questions on the slide one by one (each click will cause the next question to appear on the screen). Note that you will be recording participant responses to share with program management in order to inform future IEC materials created.	
[Note to the facilitator: This slide is for use by the facilitator.] • Show slide and explain: Working to bring attention to the human rights of KP members can result in a backlash. For example, an organization that promotes the human rights of men who have sex with men may be targeted with homophobic violence by its neighbors or local religious leaders. Backlash against individual KP members can also occur. Sex workers who know their rights and stand up for themselves to law enforcement officers may be targeted for their perceived non-compliance. • At the organizational level, each HIV implementing partner should review tools such as the Safety and Security Toolkit you see on the slide to ensure that they have mechanisms in place to assess and mitigate any security risks they may face, including during activities focused on human rights.	

• Advance the slide and explain: At the individual level, peer educators, navigators, and outreach workers can encourage KP members who are learning about their rights to think about the safest ways to articulate those rights to power holders. For example, IEC materials, such as "know your rights" cards can include the contact information of a lawyer or CSO, demonstrating that the individual with the card is supported by others. On the screen we see an example from South Africa that can be handed directly to a law enforcement officer.	
[Note to the facilitator: The presentation should end with time to ask questions of the lawyer and any other presenters.]	Questions and reflections

MODULE 3:

Applying Principles and Building Skills

MODULE 3: APPLYING PRINCIPLES AND BUILDING SKILLS

Introduction

This module improves peer educators', navigators', and outreach workers' ability to handle the disclosure of violence and to create environments that foster disclosure. It also describes how service providers can revictimize someone though an inadequate or hostile response to the disclosure of violence. Finally, participants 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 survivor safety. Participants will also become familiar with referral options to meet the many needs of survivors 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 service provision and explain their importance, particularly when working with KP members
- Recognize when other service providers such as health care workers and law enforcement officers uphold or neglect the fundamental principles

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 the well-being of the survivor

Session 3.3 The Importance of Peer Educators, Navigators, and Outreach Workers in Violence Prevention and Response

- Explain why it is important for [peer educators, navigators, outreach 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 survivors 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 Focus on Index Testing

- Explain the process of index testing and PEPFAR guidance on safe and ethical index testing as it relates to IPV and "adverse events."

Session 3.8 Data Collection and Sharing

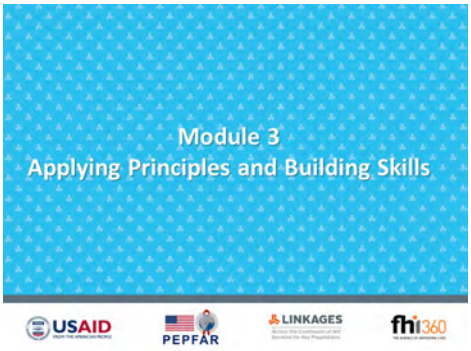
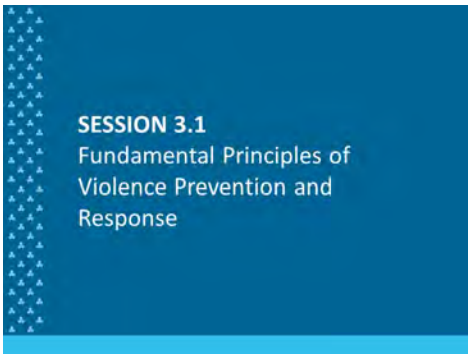
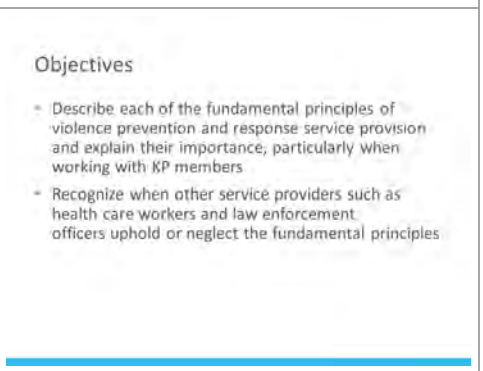
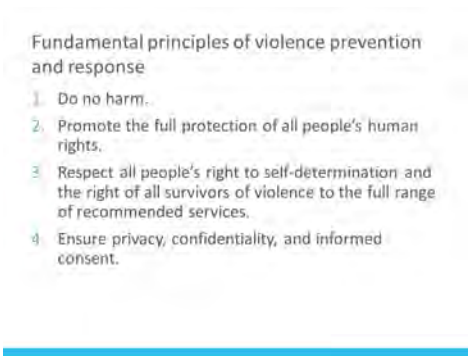
- Discuss the importance of documenting violence against KP members
- Identify practices for safe data collection and management in cases of violence

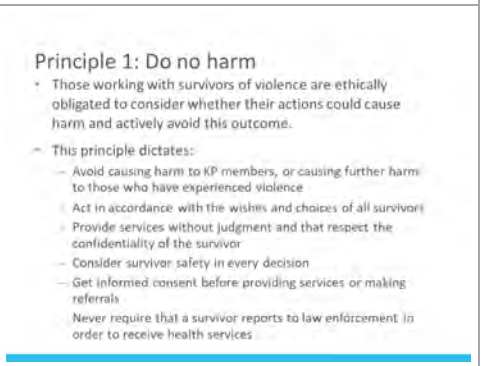
Session 3.1: Fundamental Principles of Violence Prevention and Response

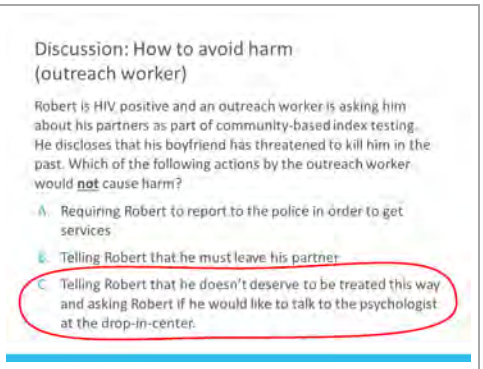
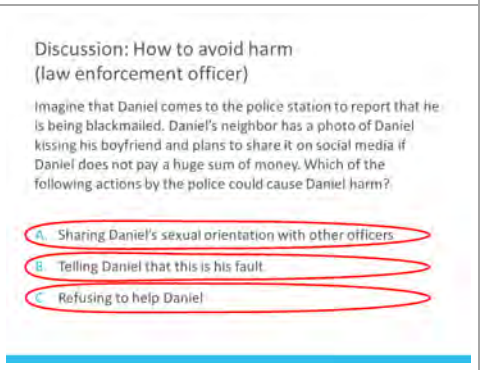
Time: 30 minutes

Materials

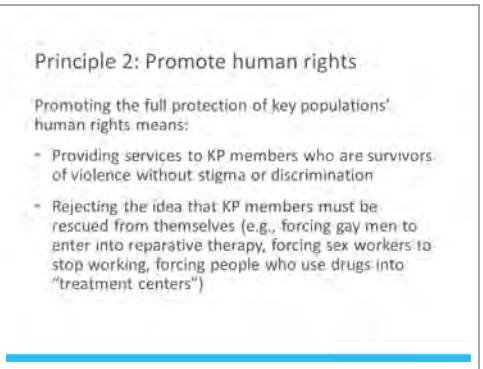
- Slide presentation
- Flip chart and markers
- Handout 3: Fundamental Principles for Violence Prevention and Response Service Provision

• 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.	
[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.] • Show slide and 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.	
• Show slide and ask a participant to read the objectives out loud.	
• Distribute *Handout 3: Fundamental Principles for Violence Prevention and Response Service Provision*. • Show slide and explain: This training contains four fundamental principles of violence prevention and response which are described in the handout. They provide the foundation for preventing violence against KP members and responding to KP members who are survivors of violence. These are	

the same principles that service providers, including health care workers and law enforcement officers, should uphold. As a project, we are working with [types of service providers] in [geographic area] and can provide a referral list of those who have been trained. • 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 service providers, including peer educators, navigators, outreach workers, health care workers, and law enforcement officers, 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. *[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.*[16]*]*	
• Show slide and explain: First, we have to "do no harm." It is most relevant when we're thinking about survivors of violence, who are already highly vulnerable. • Ask: What do we mean by "do no harm?" • Elicit responses; advance the slide; and 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.	

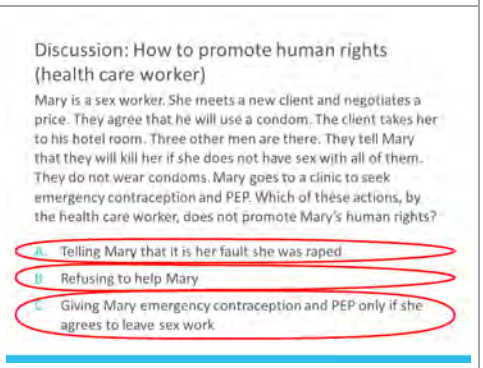
• Explain that you will be checking their understanding of "do no harm" with an example from an outreach worker. • Ask for a volunteer to read the scenario. • Then ask for people to raise their hands if they think that A, B, and/or C would avoid harm. After each one, ask a participant who raised their hand to explain why this would not cause harm. • Click slide again to show the red circle. Explain that A and B could cause harm and should be avoided. C lets Robert know that his well-being is important to the outreach worker and that support is available if he chooses to access it.	
• Explain that you will be checking their understanding of "do no harm" with an example from a law enforcement officer. This will help them further their understanding of how the human rights they learned earlier should be applied. • 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 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. An officer should provide support to Daniel as he would any other survivor of violence, helping Daniel to understand his legal options and decide what is best for his situation. *[Note to the facilitator: Depending on whether law enforcement officers are known to be KP friendly, this session can either (1) help peers feel safe supporting others' access to services from law enforcement or (2) help peers identify circumstances in which law enforcement officers violate survivors' rights. In the second situation, anonymized complaints can be collected by the project and used to advocate for change.]*	

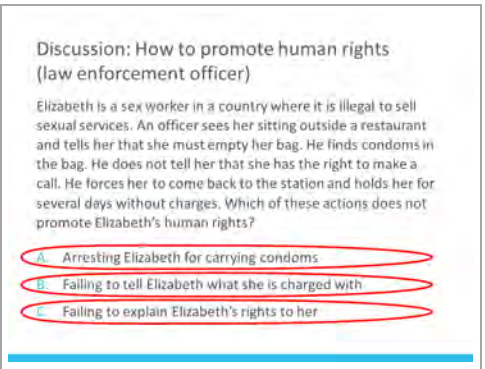
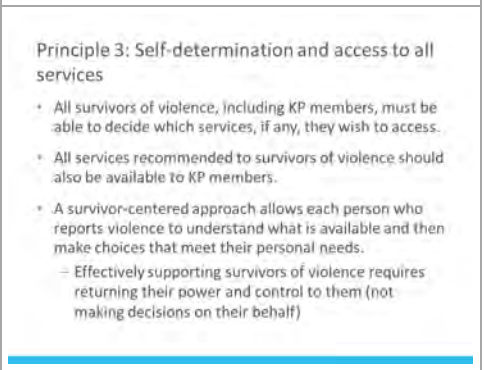
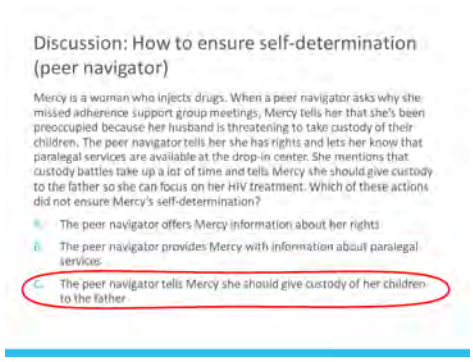
- Show slide and explain: The second principle is the promotion of human rights. This means embracing the belief that people have a right to live free of violence and the right to information, respect, and dignity. This principle is relevant whenever you interact with KP members, including if someone has been arrested.
- This principle means that you:
  - Provide services to KP survivors 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. Treatment centers for people who inject drugs are often places of torture and forced labor—not rehabilitation.

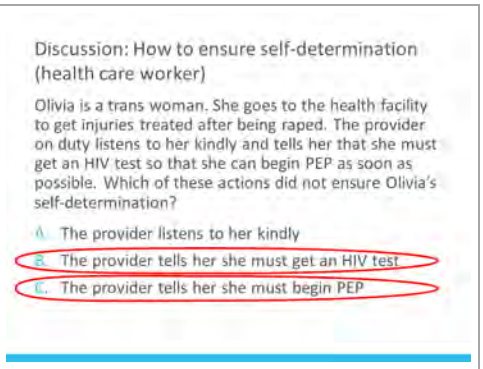
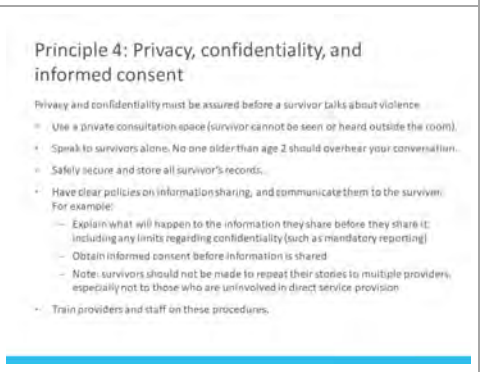


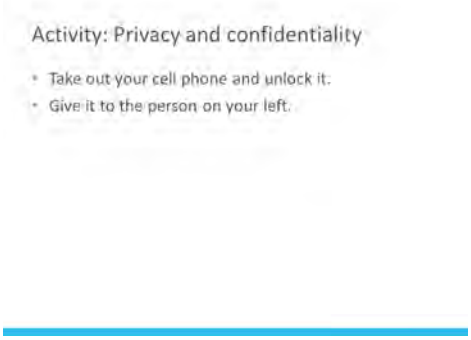
- Show slide and explain that you will be checking their understanding of "promote human rights" with an example from a health care worker.
- Ask for a volunteer to read the scenario.
- Then ask for people to raise their hands if they think that A, B, and/or C would not promote Mary's human rights. After 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.

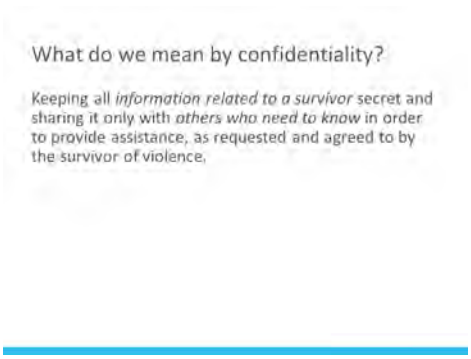
[Note to the facilitator: Depending on whether health care workers are known to be KP friendly, this session can either (1) help peers feel safe facilitating others' access to services from violence response health care workers or (2) help peers identify circumstances in which health care workers violate survivor's rights. In the second situation, anonymized complaints can be collected by the project and used to advocate for change.]

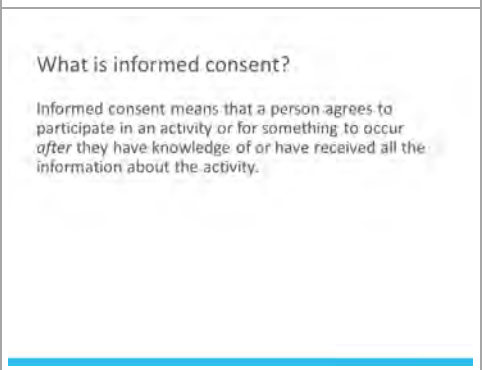
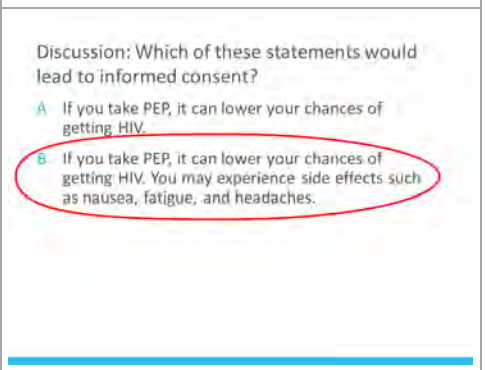


• Show slide and explain that you will be checking their understanding of "promote human rights" with an example from a law enforcement officer. • Ask for a volunteer to read the scenario. • Then ask for people to raise their hands if they think that A, B, and/or C would not promote Elizabeth's human rights. After each one, ask a participant who raised their hand to explain why this would not promote Elizabeth's human rights. • Click slide again to show the red circles. Explain that all of these violate Elizabeth's human rights.	
• Show slide and explain: This third principle is about giving survivors of violence back their power and control. Whenever we are dealing with survivors 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 survivors of violence available to KP members, so they can choose what to access. • This is also referred to as a survivor-centered approach, which helps us to remember that each person is different and best equipped to understand and act upon their needs.	
• Explain that you will be checking their understanding of "ensure self-determination" with an example of a peer navigator. • 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 C forces Mercy to do something instead of asking her what she would like to do and then supporting this decision. For this reason, it does not ensure self-determination.	

• Explain that you will be checking their understanding of "ensure self-determination" with an example from a health care worker. • 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.	
• 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 survivor's safety at risk if we share sensitive information with partners, family members, or friends without the survivor's consent. • This includes not sharing service user information with other peer educators, navigators, or outreach workers within one's own organization or within the referral network without the survivor'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 survivors at risk of additional emotional, physical, and sexual violence. • The minimum procedures that should be put in place to protect survivors' privacy and confidentiality include: - Designate and use a private consultation space. The survivor should not be able to be seen or heard outside the room. - When asking about violence and responding to disclosures, [peer educators, navigators, outreach workers] must speak with survivors alone, with the exception of infants, so that no one can overhear. - [Peer educators, navigators, outreach workers] must implement secure measures to keep	

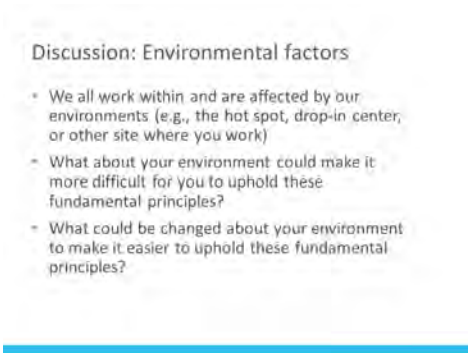
survivor's records and information confidential and develop policies for sharing information. • Provide ongoing training for staff on protecting survivors' privacy and confidentiality, including obtaining informed consent, and ensuring that service users are informed of their options and their rights. *[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.]*	
• Show slide and explain: 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 item? Possible observation: For most participants, this would make them feel uncomfortable. • Ask participants to return the items to their neighbor. • Say: 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: 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. • For people who have experienced violence and abuse, sharing personal experiences can be humiliating, demeaning, and upsetting. • 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.	
• Show slide and explain: Earlier, we talked about keeping things we hear in this training confidential. • Ask: What does that really mean—to keep something confidential? Elicit responses. • Click slide again to show definition. Ask a participant to read the definition out loud. • Ask: What do we mean by "information related to a survivor"? Elicit responses. • Emphasize: Information related to the survivor 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 survivor, the family of the survivor, the perpetrator, and the family of the perpetrator. It means any identifying information. • Ask: When we say…sharing the survivor's information only with others who need to know in order to provide assistance, as requested and agreed to by the survivor...What do we mean by "others who need to know"? Elicit responses. • Emphasize: Those who might need to know about the incident, the survivor, and/or the perpetrator include any actors who might assist the survivor, such as an outreach worker, a 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 survivor has given consent for you to share information.	

• Show slide and ask: What does it mean to give consent? Elicit responses. • Click slide again to show and review definition.	
• 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: - 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	
• 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: - 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	

- Say: To uphold these principles, service providers 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 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 survivor 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 [peer educators, navigators, outreach 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 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 program staff—what could be done to change the environment to facilitate upholding these principles. If you will be sharing participants' reflections with senior program staff or others, be sure to note this before the discussion begins. At the same time, share that the feedback will be aggregated and no individuals who give feedback will be named.]



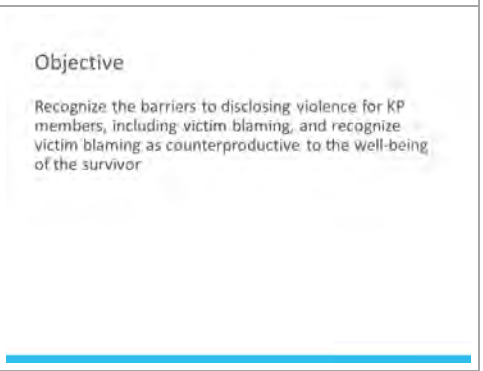
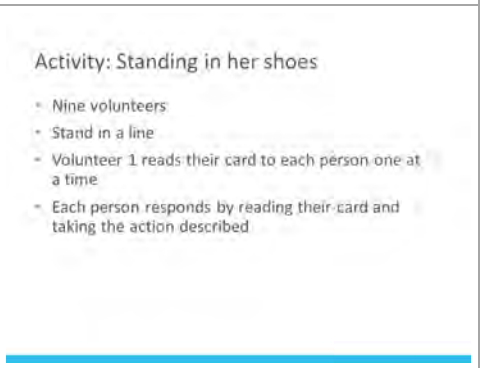
• Summarize: When we are working to prevent and respond to violence, it's helpful to have a set of values or principles to work from. These are helpful in our work broadly, but particularly when we work with survivors of violence and/or KP members. We can all make decisions each day to follow these principles 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

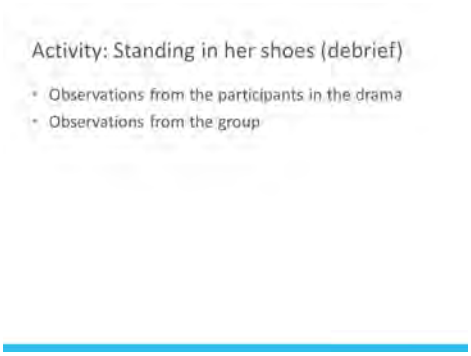
Session 3.2: Barriers to Disclosing Violence

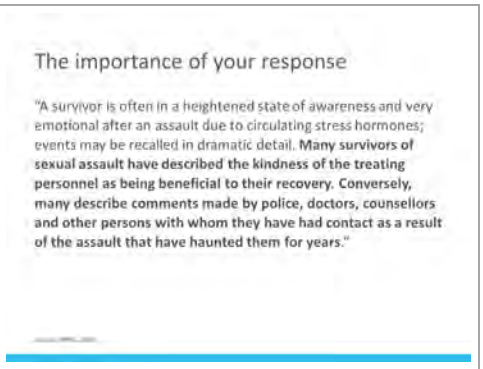
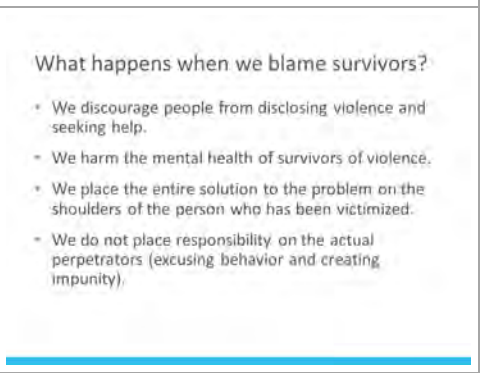
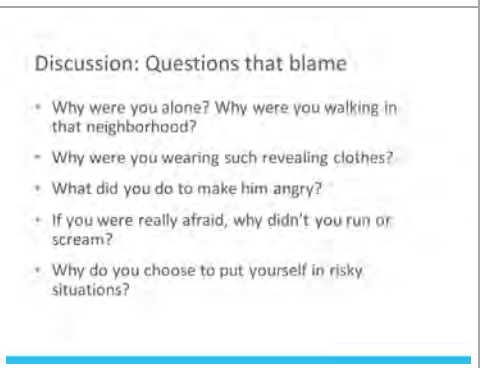
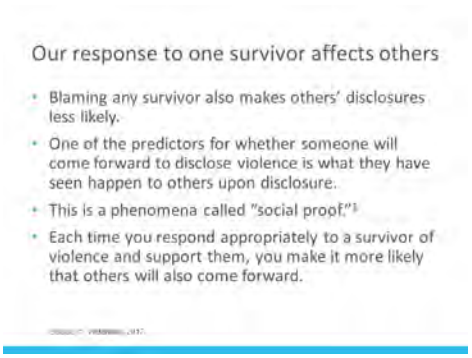
Time: 30 minutes

Materials

- Slide presentation
- Flip chart and markers
- Exercise Card 4: Standing in Her Shoes

• 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 referral and accompaniment to time-sensitive clinical violence response services such as PEP and emergency contraception.	
• Show slide and ask a participant to read the objective out loud.	
Step 1: Standing in Her Shoes (Blaming Survivors) • 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 4: Standing in Her Shoes. Give the volunteer standing at the start of the line the "Sex Worker" portion of the exercise card. • 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 ("I am a sex worker. I was raped by a client last night. He lives in my neighborhood, and I am afraid.") • 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 survivor after responding to what the survivor 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.	
Step 2: Debrief Standing in Her Shoes • Show slide and ask the person who played the role of a sex worker: What were you feeling as you went around 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 survivors 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.	

• 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.	
• Show slide and ask: Having seen the activity and heard the quote from WHO, what happens when we blame survivors? • Elicit responses; then advance the slide. • Review the content on the slide.	
• 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 survivor feel that you believe they are at fault for what happened? • Example responses are: they make it seem that the survivor 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 survivor 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.	
• Show slide and explain: It's not only important to the one person we're interacting with. If we blame one survivor, this negatively affects the likelihood that others will 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	

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 get violence response services because they've had such good experiences.	
• Show slide and explain: Knowing how common it is to blame survivors, let's talk for a minute about why. This may also help us to avoid blaming survivors, 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 to reveal each bullet and review any that weren't brought up. - 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 survivors, we distance ourselves from what happened to them. We do this with all kinds of survivors, not just survivors of violence. We want to believe that we would never do what the survivor 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 survivor. - 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.	

We've seen this play out in research, for instance in a study by Lerner and colleagues.[39] 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 survivor already worries that it was their fault, and we will only be feeding this belief.	
• 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 survivor, this impulse must be overcome so that we can meet the survivor'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 survivors 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 survivors, including one that does not blame. • Ask if there are any final reflections or questions before you move on.	Questions and reflections

Session 3.3: The Importance of Peer Educators, Navigators, and Outreach Workers in Violence Prevention and Response

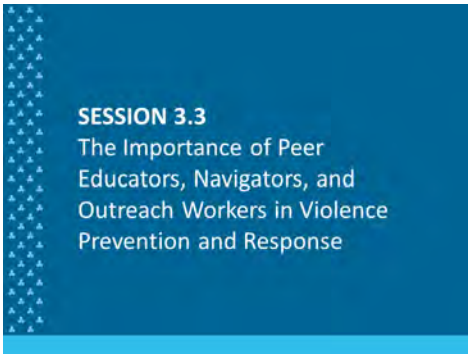
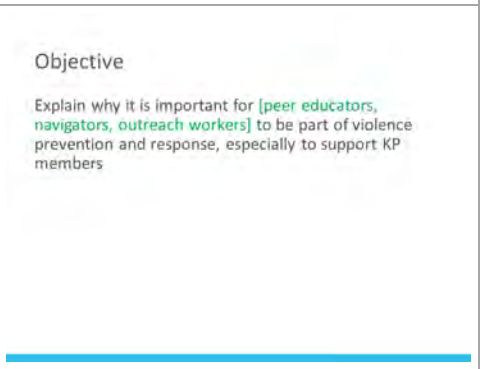
Time: 15 minutes

Materials

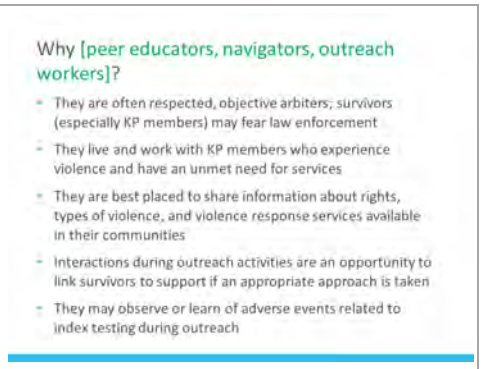
- Slide presentation
- Flip chart and markers

Planning Ahead

HIV programs have different violence prevention and response responsibilities for peer educators, navigators, and outreach workers. For example, in some HIV programs, peer educators ask about violence during risk assessments and provide first-line support to those who disclose violence. Whereas in other programs, peer educators do not ask about violence directly but do provide education on violence and offer first-line support if a KP member spontaneously discloses violence. This session requires adding program-specific information about the violence prevention and response responsibilities expected of [peer educators, navigators, and outreach workers]. To ensure that [peer educators, navigators, outreach workers] have the skills to carry out their responsibilities, senior program staff should replace the green text with the expected responsibilities and select the relevant content from this module.

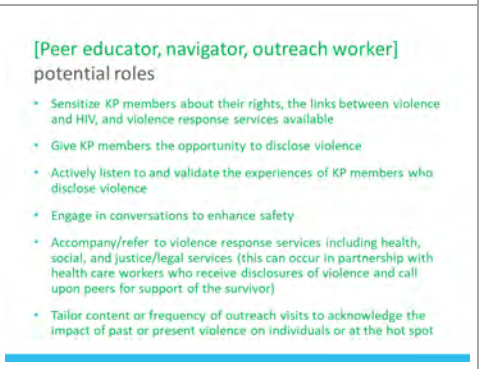
• Show slide and explain: In this session, we'll talk about our role as [peer educators, navigators, outreach workers] in addressing violence.	
• Show slide and ask a participant to read the objective out loud.	

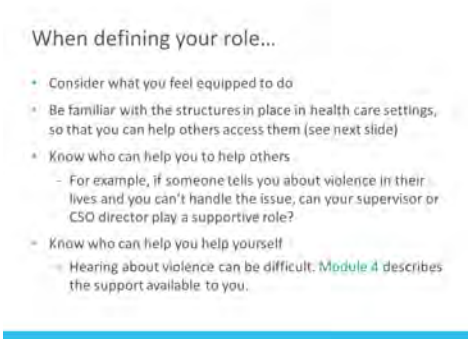
- Show slide and explain: Some people believe that violence is simply a legal issue and wonder why those working on the issue of HIV need to learn to address violence. But, as we've seen, violence also has HIV-related outcomes and [peer educators, navigators, outreach workers] are a vital part of violence response. In fact, [peer educators, navigators, outreach workers] are in a unique position to influence if, how, and when KP members and others disclose violence.
- [Peer educators, navigators, outreach workers]—who are often trusted and respected—may be the best opportunity for a survivor to disclose.
- They are also often the first people to learn about violence in the lives of those they live and work with.
- They are often best placed to share information on rights and violence response services available, and to raise awareness about the types of violence affecting their communities.
- When service users disclose an experience of violence during outreach, [peer educators, navigators, outreach workers] can be an entry point to violence response services.
- In addition, [peer educators, navigators, outreach workers] may learn about adverse events related to index testing.



[Note to the facilitator: The roles should be revised as needed in advance of the presentation.]

- Show slide and explain: There are many roles that peers can play related to violence.
- You can use what you've learned in this training to sensitize other KP members about their rights, the links between violence and HIV and the services available to them.
- You can give KP members the chance to disclose the violence they have experienced, including through asking them about violence.
- You can actively listen and validate those who share violence with you, something we'll go over in much more detail.
- You can help survivors think about their safety and make plans to mitigate danger.
- You can also accompany or refer survivors to services. This may be something you do when you



receive a disclosure or something you are called to do when a survivor disclosed at the facility • Finally, when you know about violence at the personal or hotspot level, you can use this information to tailor what you share and how often you visit. • In this module, we will build our skills to fulfill these roles to address violence. *[Note to the facilitator: As relevant, explain how individuals in those roles should work together on violence prevention and response.]*	
• Show slide and explain: The role of peer educators, navigators and outreach workers can look different depending on the project. This training will help you to understand the roles that you can play and who you can go to for help if a problem is beyond your capacity. For example, you should consider what you feel equipped to do. If, following this training, you are not sure if you are ready to provide all the steps in LIVES—for example, you're not sure if you can talk about safety—find out which local health care settings also have violence services and plan to link survivors to their support. It is very important that you know who can help you to help others, as sometimes issues will come up that require additional support. • Finally, hearing about violence, especially if it's something that you too have experienced, can be difficult. In Module 4 we will talk about caring for yourself and share resources available if you find yourself struggling with your mental/emotional health due to taking on this important work.	
• Show slide and explain: All PEPFAR-supported projects that offer index testing, pre-exposure prophylaxis (PrEP), or secondary distribution of self-testing kits must ask about intimate partner violence. Before they can ask about IPV, the facility must meet the following minimum requirements: - A written protocol that describes the violence response services available and how they can be accessed - A standard set of questions that are asked of individuals about IPV.	

[Note to facilitator: The questions about violence used in this presentation can be modified to reflect the questions asked in the facility] - Trained providers who know how to ask about and respond to violence - Providers who are regularly providing LIVES when necessary - A private setting in which to talk about violence - A referral system for survivors • If the PEPFAR program being supported offers any of the services above, the health care facilities should have these requirements in place and the work of peers should leverage what is available in health care facilities. *[Note to the facilitator, if your project does not have the required SOPs in place, consider adapting those at the link on the slide and then presenting the project SOPs to the peers during this session.]*	
• 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 to 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 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.	Questions and reflections

Session 3.4: Asking about and Responding to Violence

Time: 90 minutes

Materials

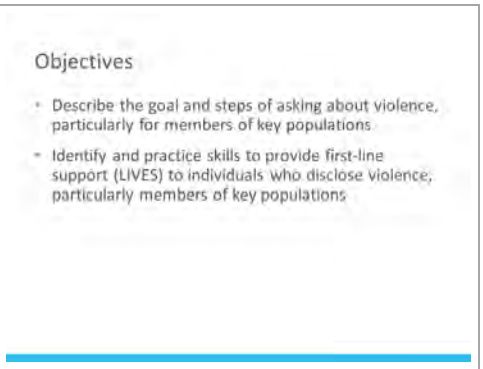
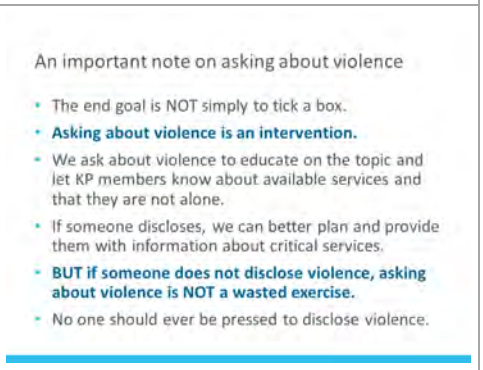
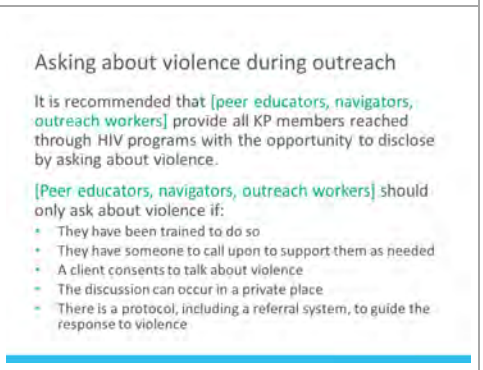
- Slide presentation
- Flip chart and markers
- Handout 4: Overview of First-Line Support
- Handout 5: Sample Tool to Ask about and Respond to Violence, or locally used tool serving a similar function
- Exercise Card 4: Standing in Her Shoes

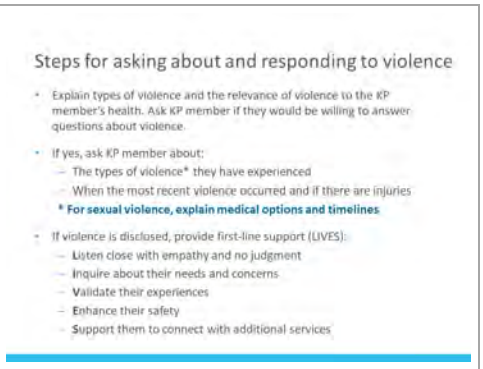
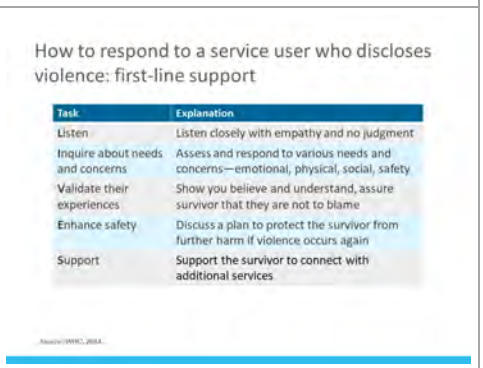
Planning Ahead

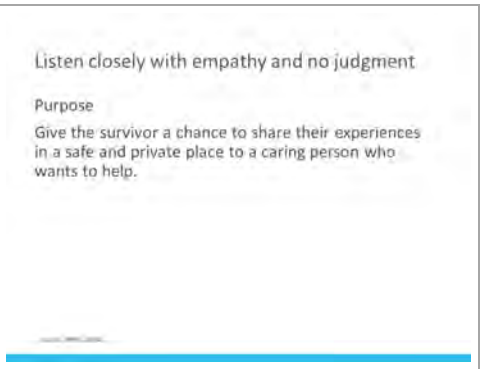
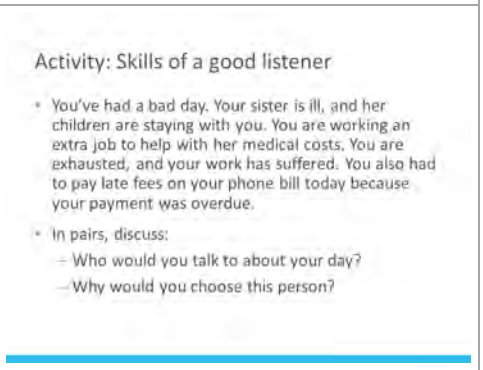
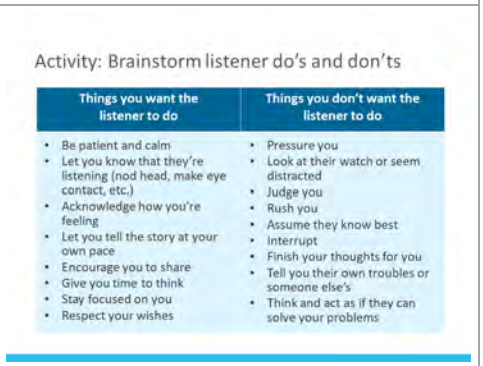
This session should be organized prior to the training to ensure that the content aligns with the first-line support responsibilities (Listen, Inquire about needs and concerns, Validate, Enhance safety, and Support) that [peer educators, navigators, outreach workers] will be expected to complete. For example, in many HIV programs, peer educators and navigators will not complete all the steps in first-line support. Instead, if violence is disclosed, they will listen and validate and then accompany survivors of violence to another member of their team, such as a supervisor or an outreach worker. However, even in this scenario, in some cases the person disclosing violence will not wish to speak to anyone else. Therefore, it is important for peer educators and navigators to have a basic knowledge of safety planning (Enhance safety) and the services available so they can understand needs (Inquire) and provide information on all the survivor's options and help the person stay safe (Support).

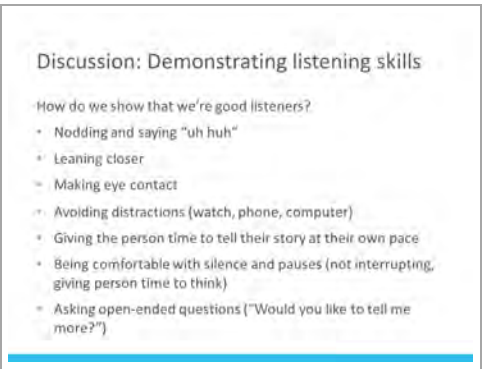
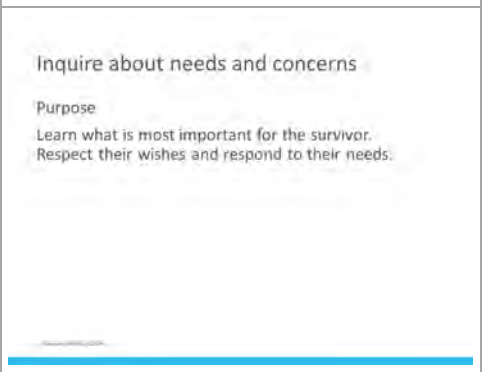
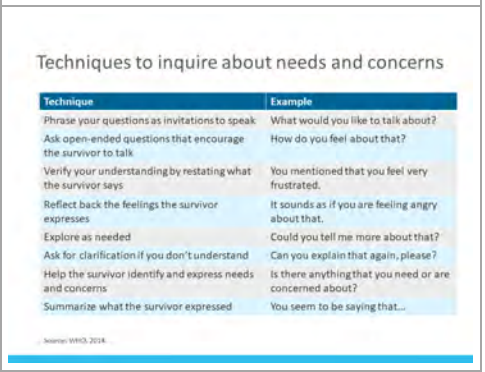
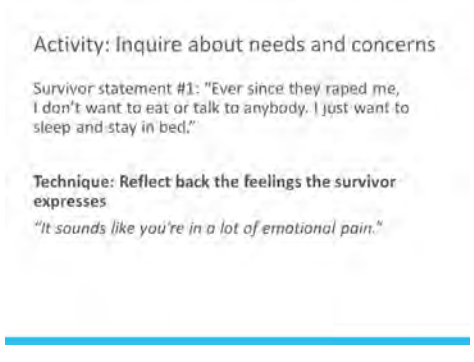
Facilitators should ask [peer educators, navigators, outreach workers] to bring copies of tools used to ask about and respond to cases of violence, such as risk assessment forms or crisis response forms, during outreach. If they do not have such tools, Handout 5 can be used.

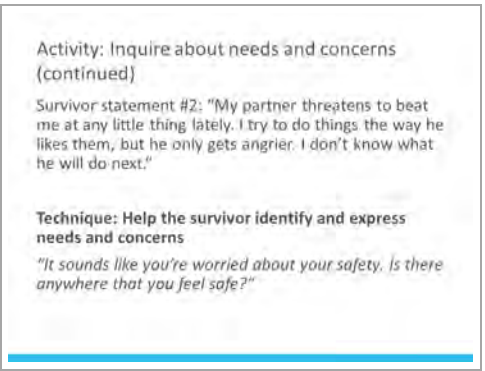
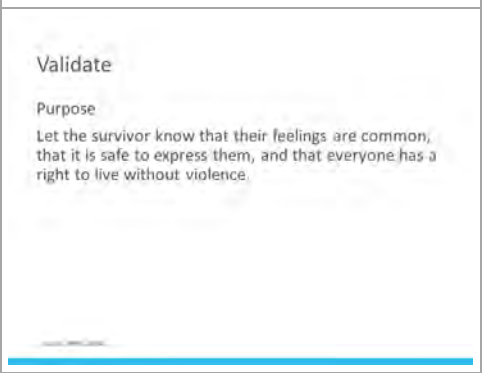
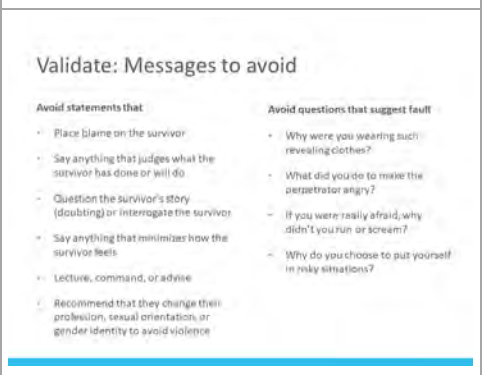
• Show slide and explain: Beyond creating an environment in which disclosure is possible, we can also ask a service user a series of questions to determine if they are experiencing violence. In this session, we're going to build our skills for asking about violence and for responding to violence if disclosure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

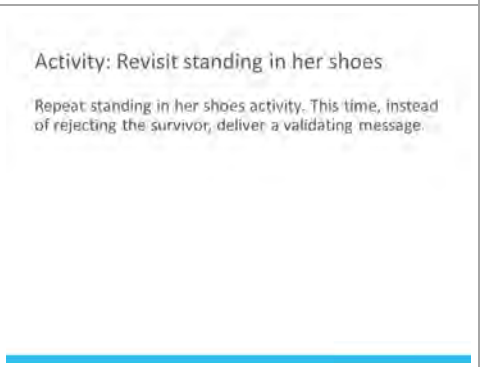
• Show slide and ask a participant to read the objectives out loud.	
• Show slide and explain: Before we start, it's important to make sure that we all have the same goal. Getting KP members to disclose violence is not the "end goal." Some KP members do not want to share their experiences, and that decision 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.	
• Show slide and explain: As we have said, when peer educators or others ask about violence during outreach activities, they can learn important information and link clients to services. However, this should only occur if the following are in place: - The peer has been trained, using materials such as those we are using today. - The peer has someone to call upon, such as a supervisor, who can support them, including to support the survivor, as needed. - The client consents to talk about violence, meaning they say it is okay to ask them questions about violence in their lives. - The discussion occurs in a place where no one can overhear what is being discussed. - There is a protocol or other guidance document that describes what the peer should do if violence is disclosed; it should include the referral options available to support the survivor.	

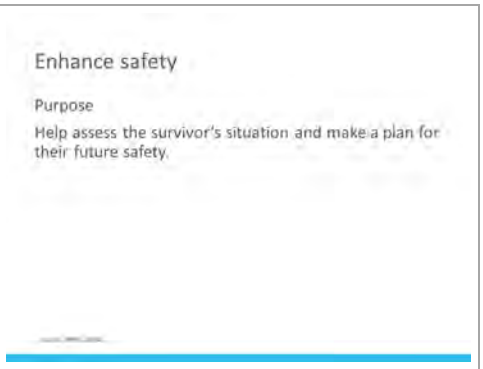
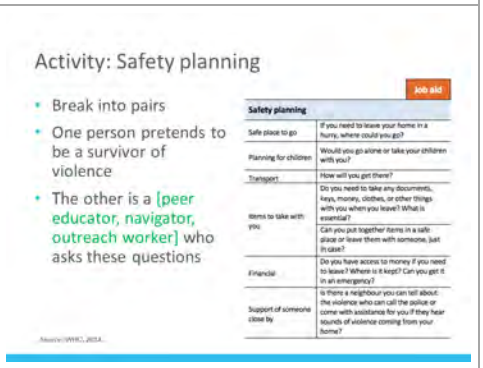
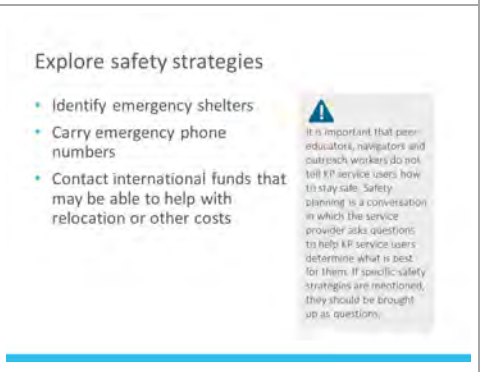
• Show slide and explain: Here are the basic steps for asking about and responding to violence. • Review the content on the slide.	
• Show slide and explain: Let's talk briefly about what asking about violence may look like. • Review the content on the slide and explain: This is how you can introduce 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.	
• Say: Before we practice asking about violence, we'll learn how to respond 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 [peer educators, navigators, outreach workers] during outreach 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 should receive. It involves five simple tasks: listening, inquiring about needs and concerns, validating the survivor's experiences, enhancing the survivor's safety, and supporting the survivor 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.	

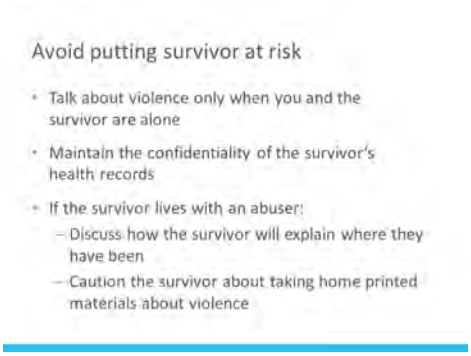
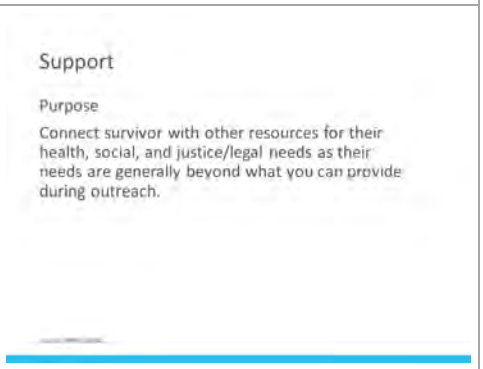
• Show slide and explain: You see that the first task is listening. Listening is the most important part of good communication and the basis of first-line support. • Review the purpose of listening on the slide.	
• Show slide and explain: We all know what good listeners are like, because they are often 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.	
• 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. Review any that were not discussed. • Click again to show what should be avoided. Review 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 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 survivors 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 survivor tries to leave an abusive relationship so telling someone to leave may actually cause harm.*[40] *Furthermore, if they give advice and the survivor chooses not to take it, the survivor may decide not to come back to them because they fear disappointing them by being non-compliant. Everyone must be trusted to know what is right for themselves; the [peer educators, navigators, outreach workers] are there to be supportive and explain the options.]*	

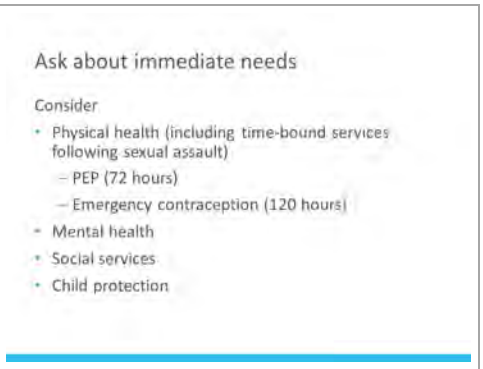
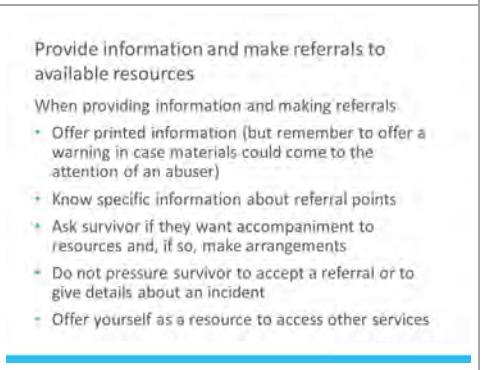
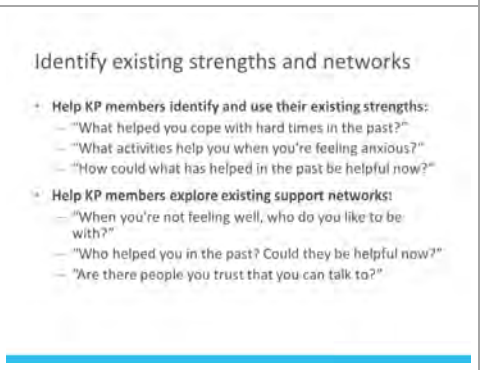
• Show slide and emphasize: As we saw from the brainstorm, you know who good listeners are. But that doesn't mean we always use good listener skills. Since listening is an essential component of providing first-line support, we're going to spend some time learning about and practicing listening skills. • 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. • Click slide again to show examples.	
• Show slide and explain: When survivors disclose violence, they may have various needs and concerns, including: - Immediate mental health needs - Immediate physical health needs - Ongoing social needs - Ongoing safety needs Inquiring about a survivor's needs and concerns can help a survivor express their wishes and ensures that you understand and respond to their needs.	
• Show slide and explain: As you listen to a survivor's story, pay particular attention to what the survivor says about their needs and concerns—and what the survivor implies with words or body language. You can use the techniques on the slide to help a survivor express what they need and check your understanding. • Review the content on the slide.	
• Show slide and explain: Let's practice these techniques as a large group. • I'll read the survivor's statement on the slide, and you can use a technique to assess my needs and concerns. • Read survivor statement #1 on the slide. Allow participants to practice providing statements using the following technique: reflect back (paraphrase) the feelings the survivor expresses. • Click slide again to show an example statement.	

• Read survivor statement #2 on the slide. Allow participants to practice providing statements using the following technique: help the survivor identify and express needs and concerns. • Click slide again to show an example statement.	
• Show slide and explain: In addition to the listening and inquiring tasks of first-line support, it's important to validate the survivor's experiences. Validating means we are letting the survivor know that their feelings are okay or common, and it is safe to express them.	
• Show slide and explain: Validating messages convey that: - 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. • Review validating messages on the slide.	
• Show slide and ask: What are some things we should avoid saying to survivors who disclose violence? Elicit responses. • Click slide again to show examples. • Emphasize: DO NOT… - Place blame on the survivor ▪ "You put yourself at risk." - Say anything that judges what the survivor 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." - Question the survivor's story (doubting) or interrogate the survivor ▪ "What I don't understand is why he would have attacked you?" - Say anything that minimizes how the survivor feels ▪ "Everyone has bad days. You'll get over it." - Lecture, command, or advise ▪ "What you need to do is…." ▪ "You have to stop thinking about what happened." - Recommend that they change their profession, sexual orientation, or gender identity to avoid violence ▪ "You need to leave sex work. It's just a violent profession." ▪ "If you stopped being so open about who you are, you would be safer." • Emphasize: Avoid asking questions that suggest fault. Review questions on the slide.	
• Show slide and 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 4: Standing in Her Shoes. • Explain that the survivor will go up to each person individually and tell them what happened to her. • When the survivor 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.	

• 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.	
• Show slide and explain: You can assess a survivor'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 survivor does not feel safe, it is important to take the survivor seriously and help them create a safety plan.	
• Show slide and explain: Having a safety plan will help a survivor 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 survivors 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 survivor and the other taking the role of the [peer educator, navigator, outreach worker]. • Explain: The person playing the role of the [peer educator, navigator, outreach worker] will use the job aid on the slide to ask questions. The person playing the role of a survivor will respond to the questions. Together, they will create a safety plan. • Give participants 10 minutes to work together.	
• 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	
• 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. • Remind participants that pushing sex workers to stop engaging in sex work to stay safe is counterproductive and not in line with the principles reviewed earlier.	
• Show slide and explain: In addition to exploring safety strategies with survivors of violence, [peer educators, navigators, outreach workers] should also ensure they are not putting the survivor at risk. • Review the content on the slide.	
• Show slide and explain: Individuals who are experiencing violence may have a range of needs beyond what you can address during outreach. Yet, they may face multiple barriers to reaching out for help. Your voice is important in encouraging a survivor to seek support. • In line with the principle of survivor-centered care, your role is to discuss a survivor's needs with them, make sure the survivor 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.	

• Show slide and explain: To provide support to a survivor 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.	
• Show slide and explain: It is important to talk to a survivor about their options, including referrals to available resources. • Explain: Effectively linking someone to other services is easier when you: - Are familiar with the referral network for their community - Explain what types of clinical/medical services are available and refer to them - Refer to mental health providers/counselors - Provide legal information and refer to legal services - Offer to go with the survivor (or send someone with the survivor) to the referral site - Do not pressure anyone to seek additional services - Offer yourself as a resource • Explain that if they provide printed materials with information about resources to the survivor, 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.	
• Show slide and explain: You can also help support survivors 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.	

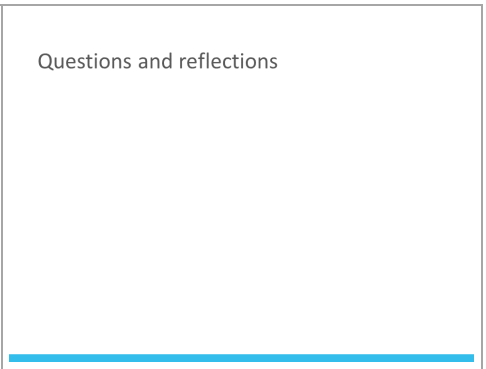
- Show slide and explain: Even if a service user does not disclose violence, it is important to deliver messages, provide information, and share resources related to violence in case they are experiencing violence but are not comfortable disclosing or if they experience violence in the future.
- Review the content on the slide.

How to respond when a service user says they have NOT experienced violence

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?"

- 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 designed to be used by peer educators, navigators, and outreach workers to ask about and document violence, 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.
- 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 3.1, 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.

Review tool to ask about and respond to violence

• Show slide and summarize: When KP members have the courage to disclose their experiences to [peer educators, navigators, outreach 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 survivors 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 [peer educators, navigators, outreach workers] know how to provide first-line support they can handle the disclosure of violence appropriately and may change the lives of survivors of violence, including KP members. • Ask participants whether they have any final questions or reflections on what has been shared.	

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

Time: 45 min

Materials

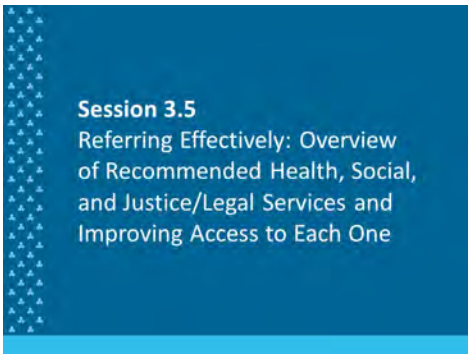
- Slide presentation
- Flip chart and markers
- Handout 6: Sample Printed Referral Network, or local violence response service directory

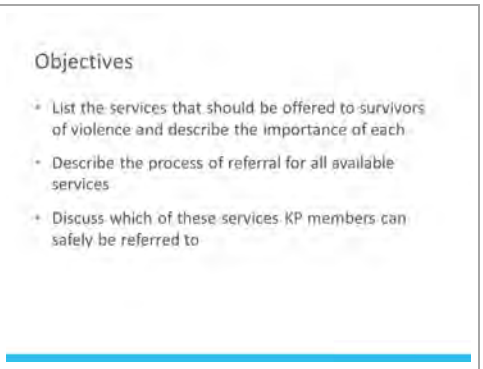
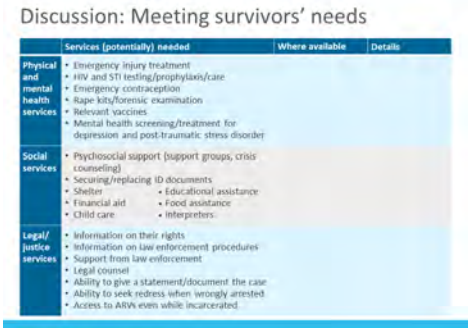
Planning Ahead

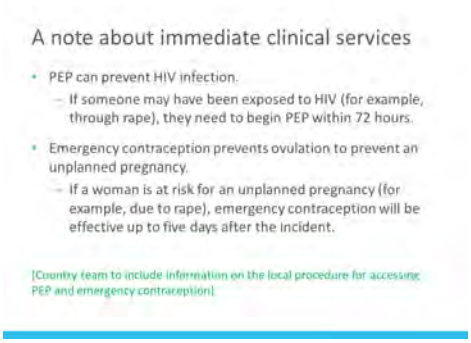
Review existing referral mechanisms, including those already in use by peer educators, navigators, and outreach workers, before this session. If possible, make copies of a local violence response service directory that describes existing organizations engaged in violence response and provides information 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 survivors of violence, describe the referral order and process during this session.

Having one or more law enforcement officer, health care worker, or other violence response service provider come to the 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 program official if they are knowledgeable about the topic.

• Show slide and explain: Each survivor 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 survivor's characteristics and preferences. Health, social, and justice/legal services, including through referral, should be accessible to ensure comprehensive support is available to all survivors. [Peer educators, navigators, outreach workers] are an important part of this referral network.	

• Show slide and ask a participant to read the objectives out loud.	
• Show slide and explain: As you saw in the objectives, in this session we are going to think about all the services that survivors 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 (Session 2.3). 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 readily available, it should be re-presented at this time. • Ask the larger group: What kinds of services would Amanda 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 survivor, 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—for example, do these organizations or specific service providers within these organization uphold the fundamental principles of violence prevention and response service provision. 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.	

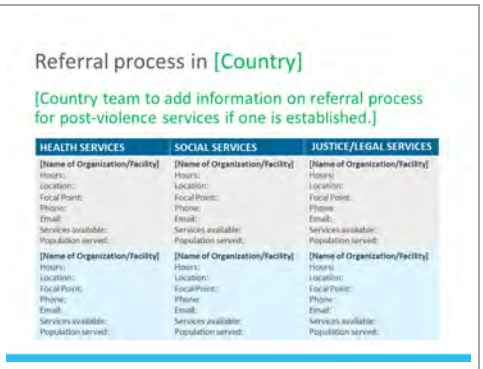
For each place that the service is available, provide details about the service in the "details" column; e.g., when it is open, where it is located, a contact number to call. • Break participants into groups by region or other geographical unit and ask each group to fill in the last two columns for their 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. *[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 participants as part of sharing the list of available services.* *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.]*	
• Show slide and explain: When referring, 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. *[Note to the facilitator: Ideally this slide will be presented by a medical professional who is part of the referral network for survivors 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.* *Having a medical professional come to the training can also help strengthen connections between referral points.]*	

- 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 survivor of violence to a service that is either no longer offered or does not treat the survivor with respect.
- In addition, if you learn that a provider on the referral list is not treating survivors with respect or is violating principles, such as not maintaining confidentiality, share this information with program staff so that the referral list can be updated to remove those who do not provide quality services and/or the person can be further trained.

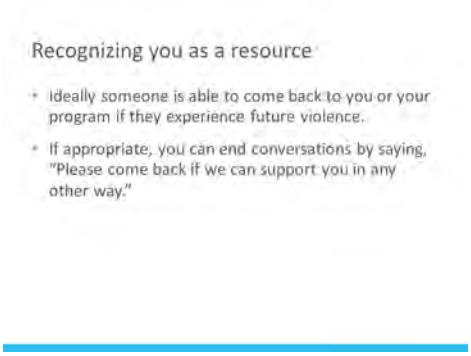
[Note to the facilitator: Adapt this slide to describe how participants can make sure someone can get quickly to services they need urgently. Add referral information (e.g., services offered, location, hours, contact information) to the image on the slide. If the HIV program can offer accompaniment for survivors 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 program you work with, can help those organizations that offer services to survivors of violence coordinate their services so that referral between agencies is smoother, this can improve access to all services and make survivor'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.



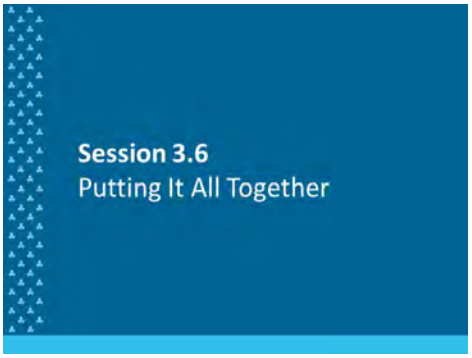
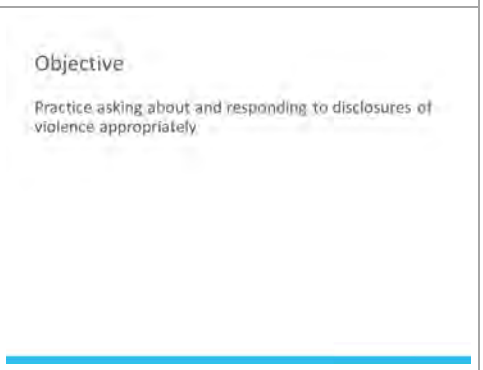
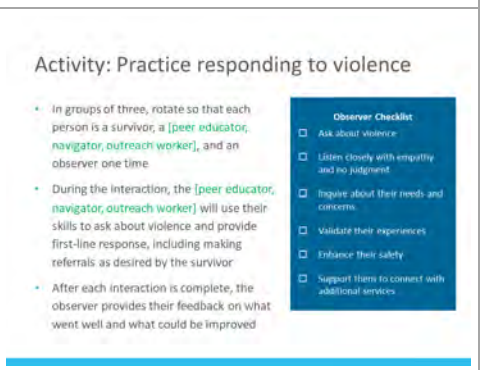
• Summarize: With time, you will feel more comfortable performing these functions. The most important thing is to make sure that people feel like they can look to you for support. • Ask participants whether they have any final questions or reflections on what has been shared.	Questions and reflections

Session 3.6: Putting It All Together

Time: 50 min

Materials

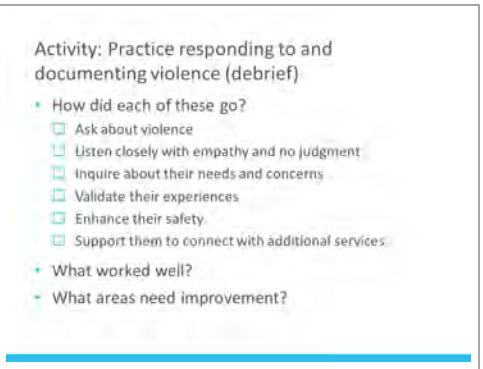
- Slide presentation
- Flip chart and markers
- Handout 5: Sample Tool to Ask about and Respond to Violence, or locally used tool serving a similar function
- Exercise Card 5: Survivor Roles for First-Line Support Practice

• Show slide and 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.	
• Show slide and ask a participant to read the objective out loud.	
• Show slide and ask participants to break into groups of three, taking turns in the roles of survivor, [peer educator, navigator, outreach worker], and observer. • Distribute Exercise Card 5: Survivor Roles for First-Line Support Practice. In each group of three, give one participant the Survivor 1 story, give the second participant the Survivor 2 story, and give the third participant the Survivor 3 story. • Explain: The person playing the role of the [peer educator, navigator, outreach 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 [peer educator, navigator, or outreach worker] of the steps of first-line support.	

• The person playing the role of a survivor will base their responses on the story from Exercise Card 5: Survivor 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 survivors that don't want services or who want specific services and need referrals that the person playing the role of [peer educator, navigator, outreach 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.	

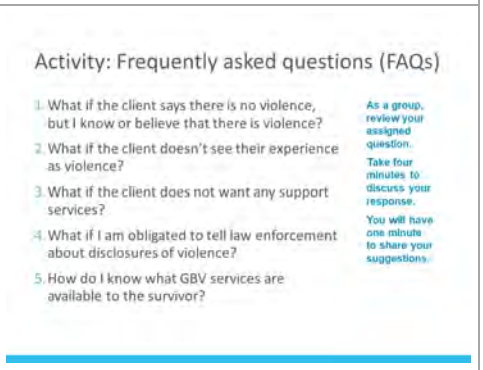
- Depending on the time you have available, either after each round or after everyone has had a turn in each role, show the slide and debrief with the large group. Ask questions such as:
  - Were some of the items in this checklist more difficult to do than others? (If any of the checklist items were 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 survivor feel we think they are at fault?
  - What worked well?
  - What areas need improvement?
  - Was it hard to meet the survivor's needs with available referrals?
  - Was anything surprising?

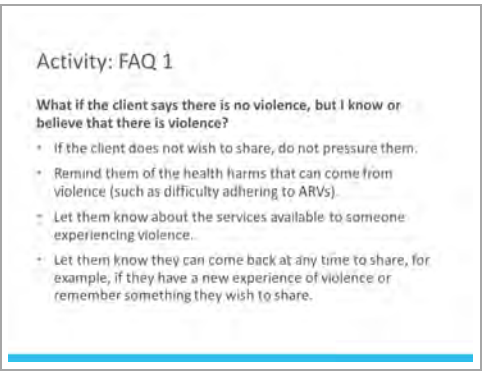
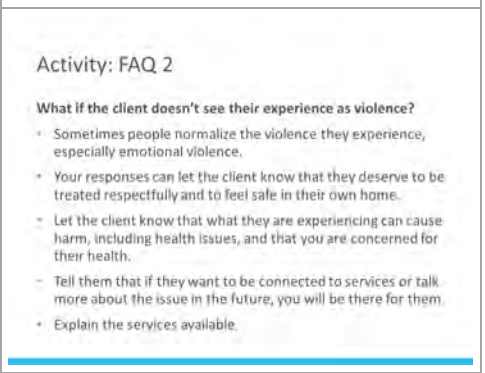
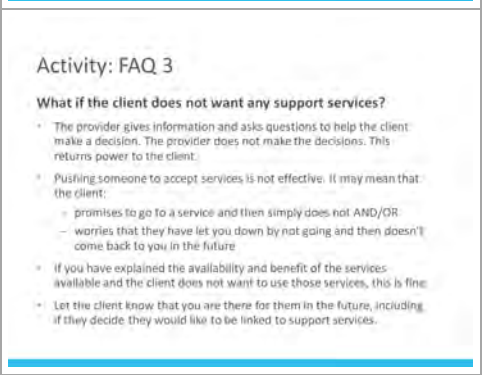
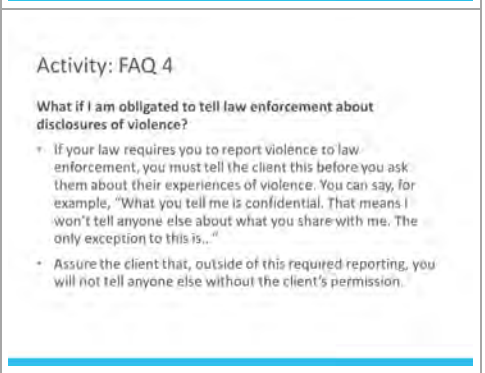
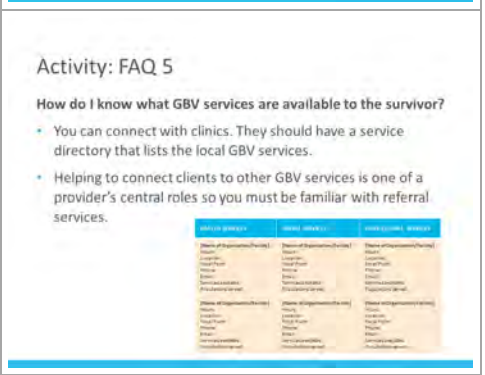
[Note to the facilitator: If you have time to extend this activity, consider doing another three rounds to allow each person to be the survivor, [peer educator, navigator, outreach worker], and observer a second time. Either have the participants generate their own scenarios or add additional scenarios in advance.]



[Note to the facilitator: Decide in advance how you will assign participants to small groups; group size will depend on the number of participants. If the number of participants is small, groups may be assigned more than one question.]

- Show the slide and explain: Here are some questions that others have had. We will answer them together to help each of us be fully prepared to understand LIVES.
- Advance the slide to reveal the instructions, say: You will now work in small groups to answer an assigned question. Please work with your group in a breakout room to discuss for four minutes. We will then reconvene and one of your group members will have one minute to share the group's response.



• Ask the first group to present their answer. After they have shared, advance the slide, and show the answers. • Note any commonalities and differences between what the group proposed and what is suggested on the slide. If there are differences, ask whether the group has any concerns about what is presented on the slide. Discuss as needed.	
• Ask the next group to present their answer. After they have shared, advance the slide, and show the answers. • Note any commonalities and differences between what the group proposed and what is suggested on the slide. If there are differences, ask whether the group has any concerns about what is presented on the slide. Discuss as needed.	
• Ask the next group to present their answer. After they have shared, advance the slide, and show the answers. • Note any commonalities and differences between what the group proposed and what is suggested on the slide. If there are differences, ask whether the group has any concerns about what is presented on the slide. Discuss as needed.	
• Ask the next group to present their answer. After they have shared, advance the slide, and show the answers. • Note any commonalities and differences between what the group proposed and what is suggested on the slide. If there are differences, ask whether the group has any concerns about what is presented on the slide. Discuss as needed.	
• Ask the next group to present their answer. After they have shared, advance the slide, and show the answers. • Note any commonalities and differences between what the group proposed and what is suggested on the slide. If there are differences, ask whether the group has any concerns about what is presented on the slide. Discuss as needed.	

• Ask participants whether they have any final questions or reflections on what has been shared.	Questions and reflections

Session 3.7: Focus on Index Testing

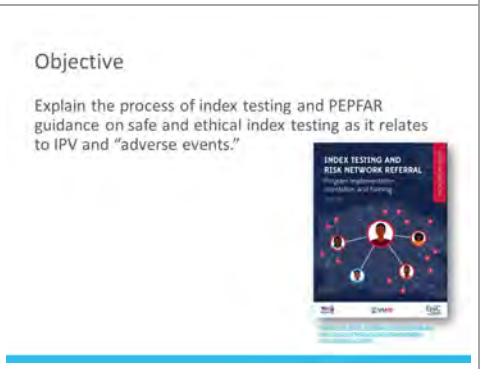
Time: 20 minutes

Materials

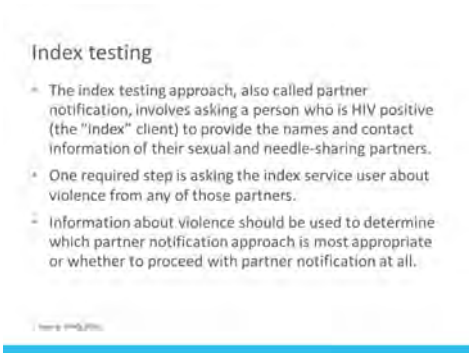
- Slide presentation
- Flip chart and markers

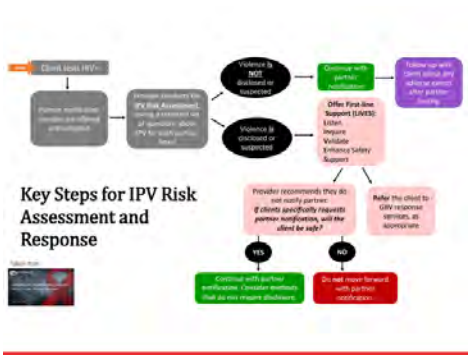
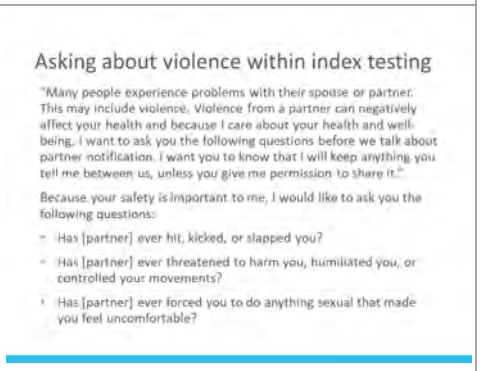
Planning Ahead

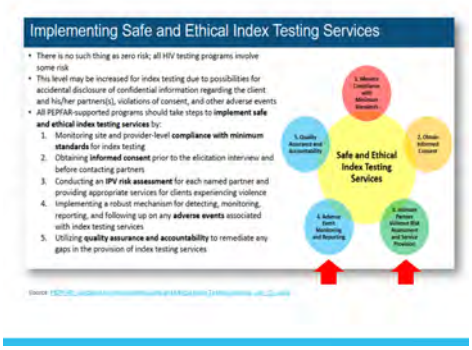
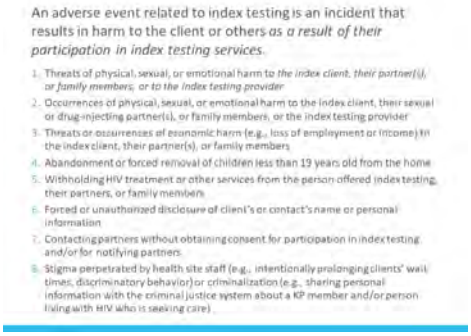
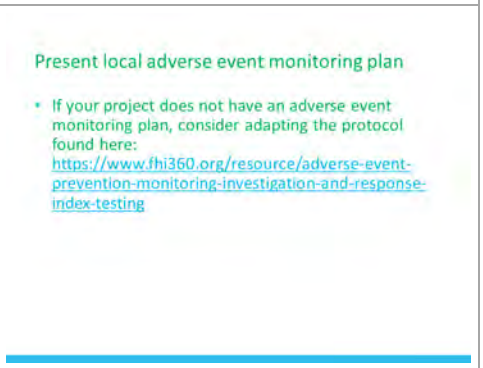
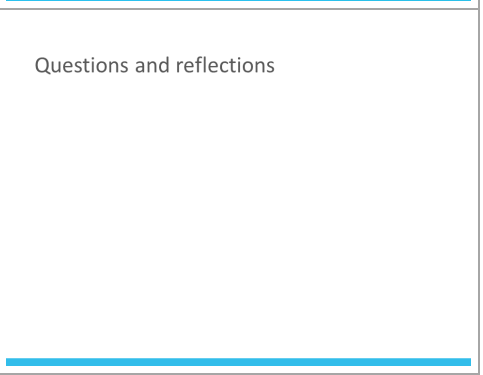
HIV programs are now expected to make stronger links between the HIV prevention, care, and treatment cascade and GBV prevention and clinical post-violence response services. HIV programs have different violence prevention and response responsibilities for peer educators, navigators, and outreach workers. Index testing has minimum requirements for asking about and reporting violence and although [peer educators, navigators, outreach workers] do not conduct index testing, [peer educators, navigators, outreach workers] are a vital part of violence response and can help recipients understand their rights and advocate for them. This session requires adding program-specific information about the violence prevention and response responsibilities expected of [peer educators, navigators, and outreach workers] as it pertains to Index Testing. To ensure that [peer educators, navigators, outreach workers] have the skills to carry out their responsibilities, senior program staff should replace the green text with the expected responsibilities and select the relevant content from this module.

• Show slide and explain: In this session, we'll discuss the adverse events that can result from index testing and the requirements to help safeguard recipients.	
• Show slide and explain: We are going to focus, during this short session, on index testing. This training alone is not enough to prepare you to conduct index testing, but it covers the elements of safe and ethical index testing related to violence and adverse events. • Since peers are such an integral part of HIV programs, even if you will not be directly participating in index testing, it is important that you understand the process and requirements. *[Note to the facilitator: For a complete index testing training, download the manual shown on the slide.]*	

- Show slide and explain: Demand for [peer educators, navigators, outreach workers] who know how to address violence is growing because more HIV programs are implementing partner notification (also called index testing and voluntary partner referral) at the facility and community levels. It is 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.[36] 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 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 [peer educator, navigator, outreach worker] can explain the options and note any safety concerns, but the decision ultimately rests with the service user. A health care worker may also be engaged in this discussion if this is useful to the service user. Remember to prioritize doing no harm, one of the principles that we discussed in an earlier session.
- Importantly, remember that just asking about violence alone does not guarantee the safety of index service users. As such, standards for tracking the safety of an index service user and documenting adverse events are urgently needed.[36]



• Show slide and explain: While the basics of asking about and responding to violence are all the same, we want to spend a moment talking about index testing because there are some important nuances. In index testing, individuals who are HIV positive (index clients) must be asked whether each of their sexual partners has committed violence against the index client before those partners can be considered for partner notification. This is an important safeguard against harm to the client. You can see here that an IPV risk assessment (which consists of the questions you saw in the last session about violence) is required before partner notification can occur. • Review the steps in the diagram.	
• Show slide and explain: As we discussed in the session on *Asking about and Responding to Violence,* when you are ready to begin the conversation on violence, it's important to give some introductory remarks so that the client knows why you're asking the questions. • This slide shows another example of language that can be used/adapted before asking questions about violence. Review the slide. • Say: As we discussed earlier, the questions include specific examples of violence. Why is it important to use these detailed questions instead of simply asking "Are you experiencing violence?" • If no one replies, remind participants: It's important because otherwise the service user may not see themselves as experiencing violence. Think about Thandi. Would she have said she was experiencing violence when John was only preventing her from seeing her friends or sister? By asking these more detailed questions, including one on emotional violence, we're more likely to get an accurate response. Asking multiple questions can also give us a better idea of what the person is experiencing.	

• Show slide and explain: These are the requirements under PEPFAR related to asking about IPV and about adverse event monitoring. We have gone over IPV in detail, so let's talk specifically about adverse events.	
• Show slide and explain: Here is PEPFAR's list of adverse events related to index testing. It is not exhaustive. As a reminder, an adverse event in this context refers to "an incident that results in harm to the client or others as a result of their participation in index testing services." • Review the examples on the slide.	
• The project should take this time to share the local or facility-specific adverse event monitoring plan. It should clearly outline how peers and other outreach team members should share their observations related to adverse events.	
• Ask participants whether they have any final questions or reflections on what has been shared.	

Session 3.8: Data Collection and Sharing

Time: 45 minutes

Materials

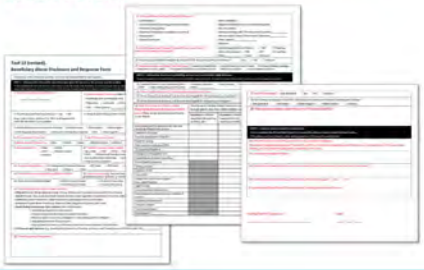
- Slide presentation
- Flip chart and markers
- Locally used intake/record forms to document cases of violence
- Annex 6: Privacy and Confidentiality in Documentation Checklist

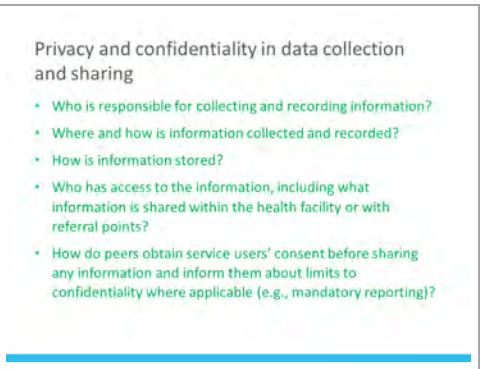
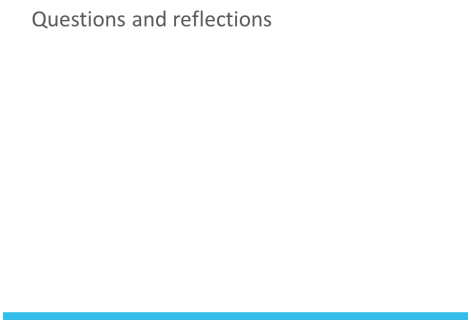
Planning Ahead

This session should be organized prior to the training. Facilitators should ask senior program staff to provide any forms routinely used to document cases of violence. If senior program staff report that forms vary for different service providers, 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 program staff wish to strengthen their existing forms, review Tool 12: Crisis Management Register from *Monitoring Guide and Toolkit for Key Population HIV Prevention, Care, and Treatment Programs*.[41]

The slide on privacy and confidentiality in data collection and sharing should be reviewed and revised by a senior program official in advance. See the green text on the slide presentation and the checklist on Annex 6 to consider the specific information the senior program official should be able to address.

• Show slide and explain: Just like other interactions with KP service users, you will be asked to document the disclosure of violence and the services provided.	
• Show slide and ask a participant to read the objectives out loud.	

• Ask: Why do we document violence? • Give time for a few answers and then click again. • Explain: - Documenting cases of violence captures information on what the survivor experienced, including the characteristics of violence. This can keep the survivor from having to share their story repeatedly with others. It's also important to record services given and referrals made. - If you will continue to support the survivor, having documentation of what occurred can help you follow up effectively. - At the hot spot level, capturing cases of violence can help determine which hot spots may expose individuals to greater HIV risk. - Having documentation of the violence occurring against a community can also be an effective advocacy tool.	Discussion: Why do [peer educators, navigators, outreach workers] document cases of violence? • To capture information about the violence experienced (type, perpetrator, injuries) • So that the survivor doesn't have to repeat their story to others if they decide to seek additional services • To record the services provided to the survivor and any referrals made • To manage the survivor's care immediately and longer term • To advocate for violence prevention and response services
• If your project has a specific tool to capture information on violence and/or adverse events, present those here. If you would like to use the EpiC tool to document both experiences of violence and adverse events, find it here: https://www.fhi360.org/sites/default/files/media/documents/resource-epic-sop-for-adverse-event-monitoring-investigation-response-context-index-testing-english.pdf (beginning on page 21).	Data collection tools can cover violence and adverse events 
• Show slide and explain: Although documenting violence is necessary to provide appropriate care for survivors, we can put the survivor'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 survivor's consent or not recording and storing their information safely. • Ask: What could happen if [peer educators, navigators, outreach 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 survivors at risk of additional emotional, physical, and sexual violence.	Discussion: What could happen if [peer educators, navigators, outreach workers] don't protect service users' data? • Stigma and discrimination • Retaliation by the perpetrator • Theft of service users' files

• Show slide and explain: As previously discussed, 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. *[Note to the facilitator: The slide in green was designed to help a senior program 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.[17] Additional questions that senior program officials should prepare responses to are included in Annex 6: Privacy and Confidentiality in Documentation Checklist. You will not use this slide in the final presentation; replace it with slides needed to describe the roles and procedures specific to your situation.]*	
• Summarize: Documenting violence helps us to track performance and improve service delivery for survivors of violence, and we must ensure privacy and confidentiality when documenting violence to protect survivors from further harm. • Ask participants whether they have any final questions or reflections on what has been shared.	

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 and includes an opportunity to reflect on what you have learned and how you will apply it.

This module includes the following sessions and learning objectives:

Session 4.1 Taking Care of Ourselves

- Identify ways to counter the impacts of work-related stress
- Discuss the security of [peer educators, navigators, outreach workers] who are implementing violence response services

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

- Identify and discuss specific "asks" of [peer educators, navigators, outreach 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

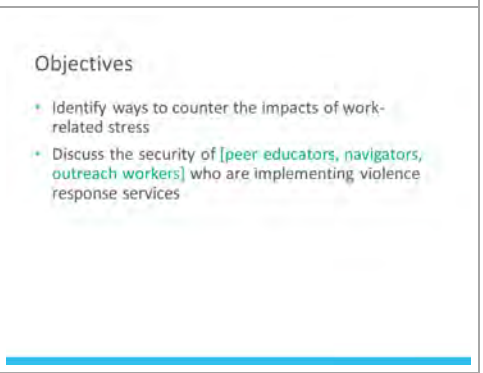
- Acknowledge participant effort and commitment

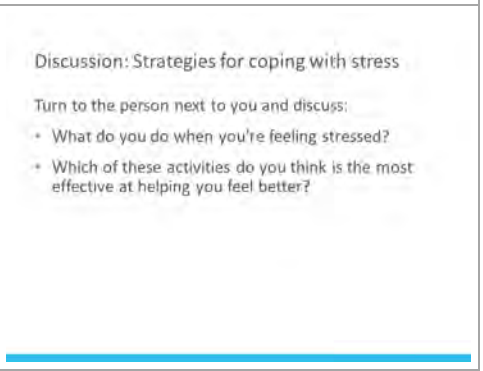
Session 4.1: Taking Care of Ourselves

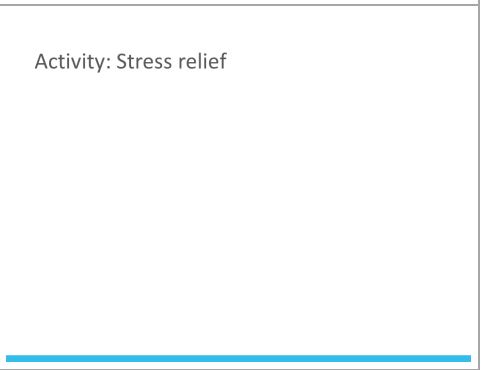
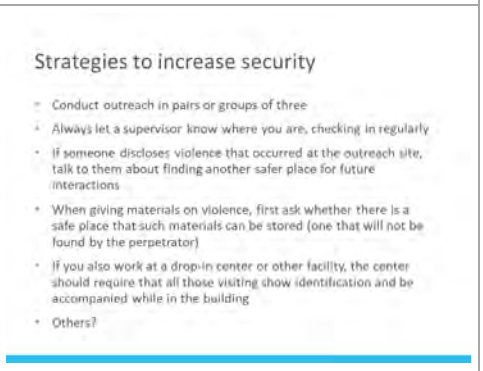
Time: 60 minutes

Materials

- Slide presentation
- Flip chart and markers
- Candy (as prizes)
- Exercise Card 6: Stress Reduction Activities

• Say: We are now in our final module of the training.	
• Show slide and 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 HIV programs—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.	
• Show slide and ask a participant to read each objective out loud.	
• Say: Now let's think about self-care broadly. • Show slide and review the content.	

• Show slide and explain: 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. • Ask for volunteers to read aloud the contents of the slide.	
• Show slide and explain: Let's look at some recommendations for self-care that can help us avoid stress or cope with it. • 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 survivors. • 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 impression can be discussed, but without disclosing any information that would identify a given survivor. • Maintain a balance so that 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.	
• Show slide and review the content. • After four to five minutes, ask participants to share anything that was particularly helpful or something their partner said that they had never thought of doing before or had never tried.	

• Show slide and say: These are some examples that others have found helpful to relieve stress and take care of themselves. *[Note to the facilitator: Review these examples in advance to ensure they are appropriate in your setting. Add or revise as needed.]*	
[Note to the facilitator: Consider doing one of the activities included in Exercise Card 6 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.[24]]	
• Show slide and say: It's also important to think about personal security when working on the issue of violence. Some individuals who work with survivors of violence report begin targeted by the perpetrator, especially in cases of intimate partner violence, with verbal abuse or other violence. These are some of the strategies that can be used to increase your security. • Ask: Are there any other strategies that you have used or think you could use? • Take three to five answers and summarize what was said. *[Note to the facilitator: As needed, consider suggesting a separate training or meeting to discuss security measures more broadly as they are outlined in the Safety and Security Toolkit: Strengthening the Implementation of HIV Programs for and with Key Populations.[48]]*	
• Adapt this slide to share resources that the project makes available to peers who are struggling with secondary trauma, burnout, or stress. Ideally, this will include some options within the project (e.g., speaking to a supervisor who can help manage workload or provide support for a specific case) and some that can be used confidentially outside of the project (e.g., a free therapist that is not on project staff).	

• Ask if there are any questions or reflections from participants about self-care.	Questions and reflections

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

Time: 60 minutes

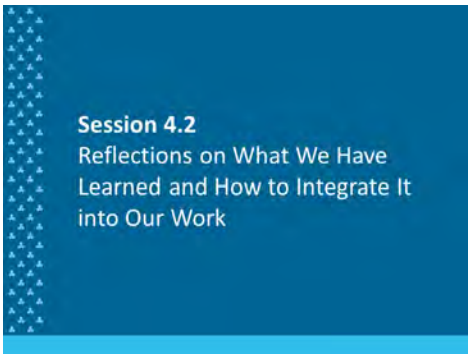
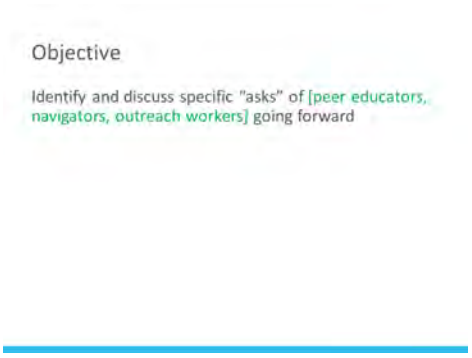
Materials

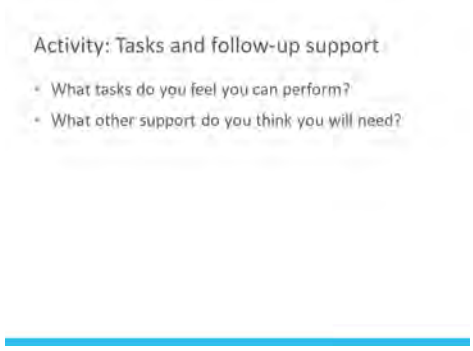
- Slide presentation
- Flip chart and markers
- Printed slides titled "What we are asking of each of you" and "How we will support you" (after they have been reviewed and revised by senior program staff)
- Handout 7: Asks and Follow-Up Support

Planning Ahead

This session makes a series of "asks" of participants. These asks should be reviewed and revised by senior program staff before they are shared during the training. In addition, a slide describes the ongoing support participants will receive as they use what they've learned during the training. This slide should also be reviewed and revised by senior program staff. It should also be modified to reflect any follow-up support offered by the HIV program implementing the training. After they are reviewed and revised, the slides titled "What we are asking of each of you" and "How we will support you" should be printed and shared with participants in this session.

Finally, any issues that came up throughout the training—especially the environmental factors discussed in Session 3.1—can be responded to by senior program staff during this session if they 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 the objective out loud.	

• 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. *[Note to the facilitator: Review this list of "asks" in advance with senior program staff to ensure that nothing here contradicts other instructions. Modify it as needed. Ideally, a senior program official is able to present this slide to show their support for these "asks" and answer questions about them.]*	
• 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 3.3. *[Note to the facilitator: Review and revise the contents of this slide in advance with senior program staff to ensure that this is an accurate representation of the support to be provided going forward. Ideally, a senior program 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 program 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.]* *[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 program staff, this time is a good opportunity for them to share their responses.]*	
• Show slide and distribute the printed slides titled "What we are asking of each of you" and "How we will support you." • Explain: Now that you better understand what it would mean to work on violence prevention and response, we would like to hear whether you feel that you can take on the responsibilities that have been outlined for you. We also want to know what kind of support you think you will need. • Distribute Handout 7: Asks and Follow-Up Support to participants and ask them to write their names	

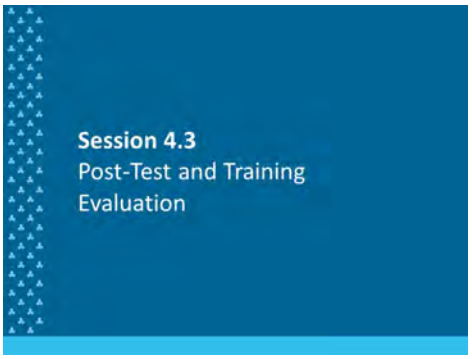
and responses on the handout. Explain that the completed handouts will be reviewed by their supervisors. Note that there are no correct answers. The purpose of the exercise is to understand what participants feel comfortable doing and what kind of support they need to do that work.	

Session 4.3: Post-Test and Training Evaluation

Time: 15 minutes

Materials

- Slide presentation
- Flip chart and markers
- Handout 1: Post-Test
- Handout 8: Training Evaluation

• Show slide and explain: We're now wrapping up the training by listening to your feedback so that we can continue to improve.	
• 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 8). • Give 10–15 minutes to complete both. *[Note to the facilitator: As this post-test asks about participant opinions, there are no correct answers. However, the desired direction of participant opinions is noted in the following key.]*	

Desired Response Key					
	Statement	**Strongly agree**	**Agree**	**Disagree**	**Strongly disagree**
1.	Gender norms, or the expectations we have for men and women, can cause harm.	X			
2.	Transgender people are responsible for the violence they experience.				X
3.	If sex workers are assaulted while engaging in sex work, they are at least somewhat to blame.				X
4.	Men who are openly gay should not complain if they are assaulted.				X
5.	People who inject drugs must stop using drugs if they do not wish to be abused.				X
6.	It is important that I am able to talk about violence with those I provide services to.	X			
7.	It harms survivors of violence when they are blamed for the abuse they experienced.	X			

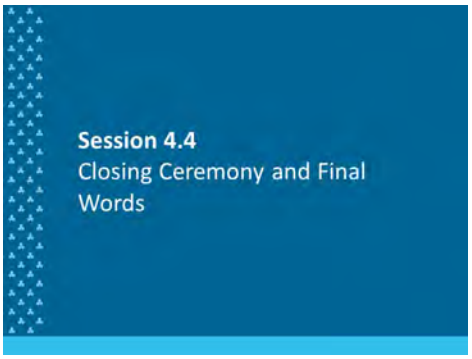
8.	Health care workers have a duty to support key population members who experience violence.	X
9.	Law enforcement officers have a duty to support key population members who experience violence.	X
10.	Key population members have the right to live free of violence.	X
11.	Intimate partner violence often causes serious harm.	X

Session 4.4: Closing Ceremony and Final Words

Time: 15 minutes

Materials

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

• 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.	
• 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 an HIV program senior official who can officially close the training. *[Note to the facilitator: If it is important to provide certificates of completion/attendance, do so at this time.]*	

ANNEXES

Annex 1: Additional LINKAGES Violence Prevention and Response Tools

Title	Purpose	Target Audience
Key Population Program Implementation Guide[42]	Provide information on the essential elements of KP programs and help standardize LINKAGES country programs based on proven, high-quality interventions	Program implementers
A Guide to Comprehensive Violence Prevention and Response in Key Population Programs[16]	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
Gender Strategy[21]	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
Health4All: Training Health Workers for the Provision of Quality, Stigma-Free HIV Services for Key Populations[43]	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
Law Enforcement Training: Preventing and Responding to Violence against Key Populations to Increase Access to Justice and Strengthen the HIV Response[44]	Reduce violence against KP members that is perpetrated by law enforcement officers and ensure that law enforcement can provide appropriate services to survivors of violence who are members of KPs	Law enforcement officers
Health Care Worker Training: Preventing and Responding to Violence against Key Populations[45]	Build the knowledge and skills of health care workers to ask KP members about violence and respond to individuals who disclose violence	Health care workers (clinical and nonclinical)
Enhanced Peer Outreach Approach (EPOA): Implementation Guide[46]	Describe EPOA and its potential benefits, the essential components of EPOA, and the steps involved in implementation, including potential challenges	Peer educators
Peer Navigation for Key Populations: Implementation Guide[47]	Provide guidance for programs implementing peer navigation as part of a core package of HIV-related interventions for KP members	Peer navigators
Safety and Security Toolkit: Strengthening the Implementation of Programs for and with Key Populations[48]	Help KP program implementers identify and address safety and security concerns	Program implementers
Adverse Event Prevention, Monitoring, Investigation and Response in Index Testing	Help HIV programs train their staff and health care providers on PEPFAR requirements for adverse events, as well as develop procedures and monitoring and evaluation tools to meet those requirements	Program implementers, health care workers (clinical and nonclinical)

Annex 2: 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 3: 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 survivors 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:

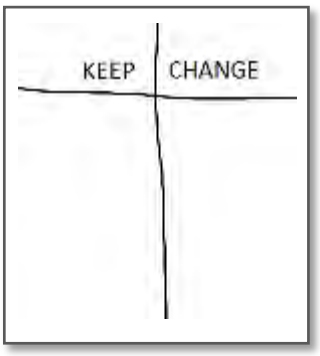
- Put up the word "true" on one side of the room and "false" on the other.
- Have everyone stand in between the two words.
- Read out statements that are either true or false. Statements should be facts and not opinions about what was learned the day before (e.g., "Violence against gay men may occur because people think that gay men aren't living according to 'rules' that dictate men's behavior." [true] or "Survivors 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 4: 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 5: Sample "Know Your Rights" Information, Education, and Communication Materials

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

Dear Police Officer

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

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

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

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

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

I do not give you permission to search me.

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

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

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

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

076 3112 543

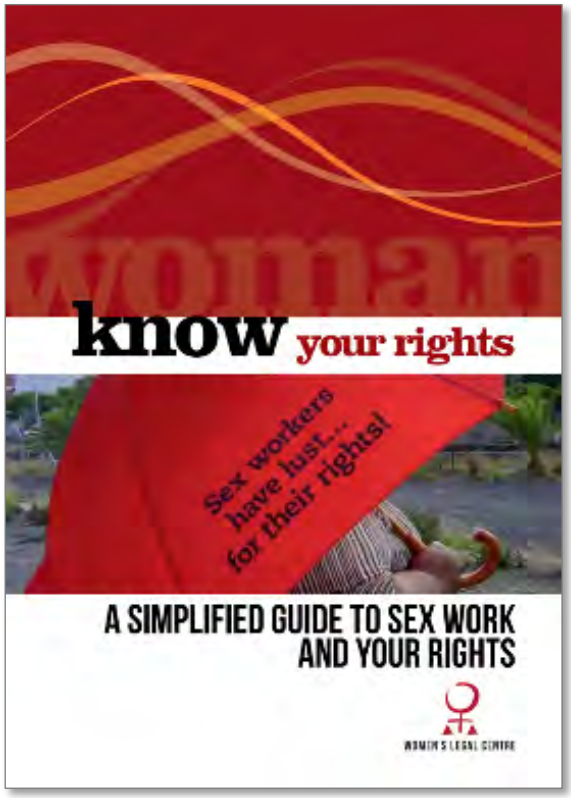
sweat

Sisonke

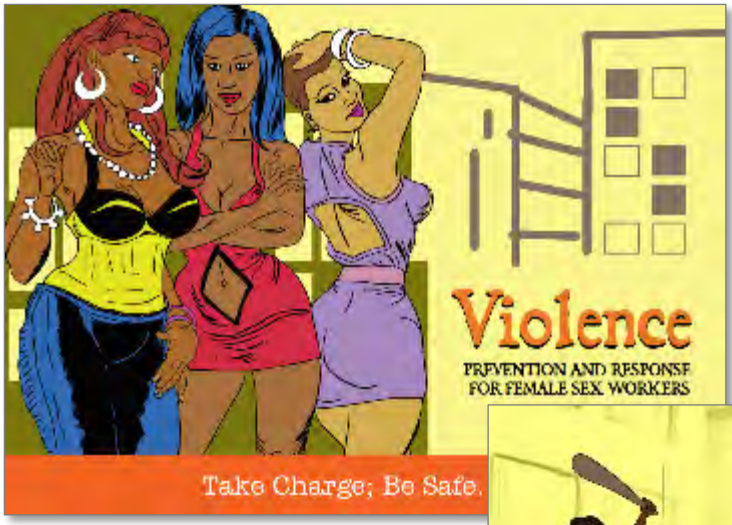
WOMEN'S LEGAL CENTRE

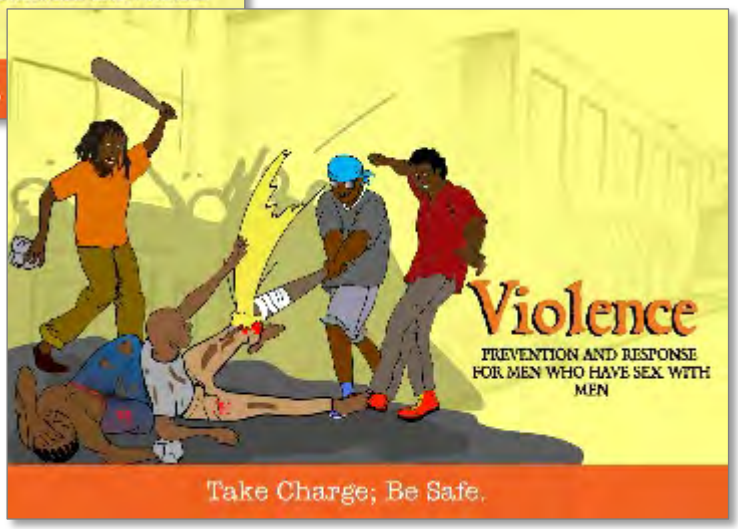
Source: Sex Workers Education & Advocacy Taskforce, Sisonke, Women's Legal Centre[49]

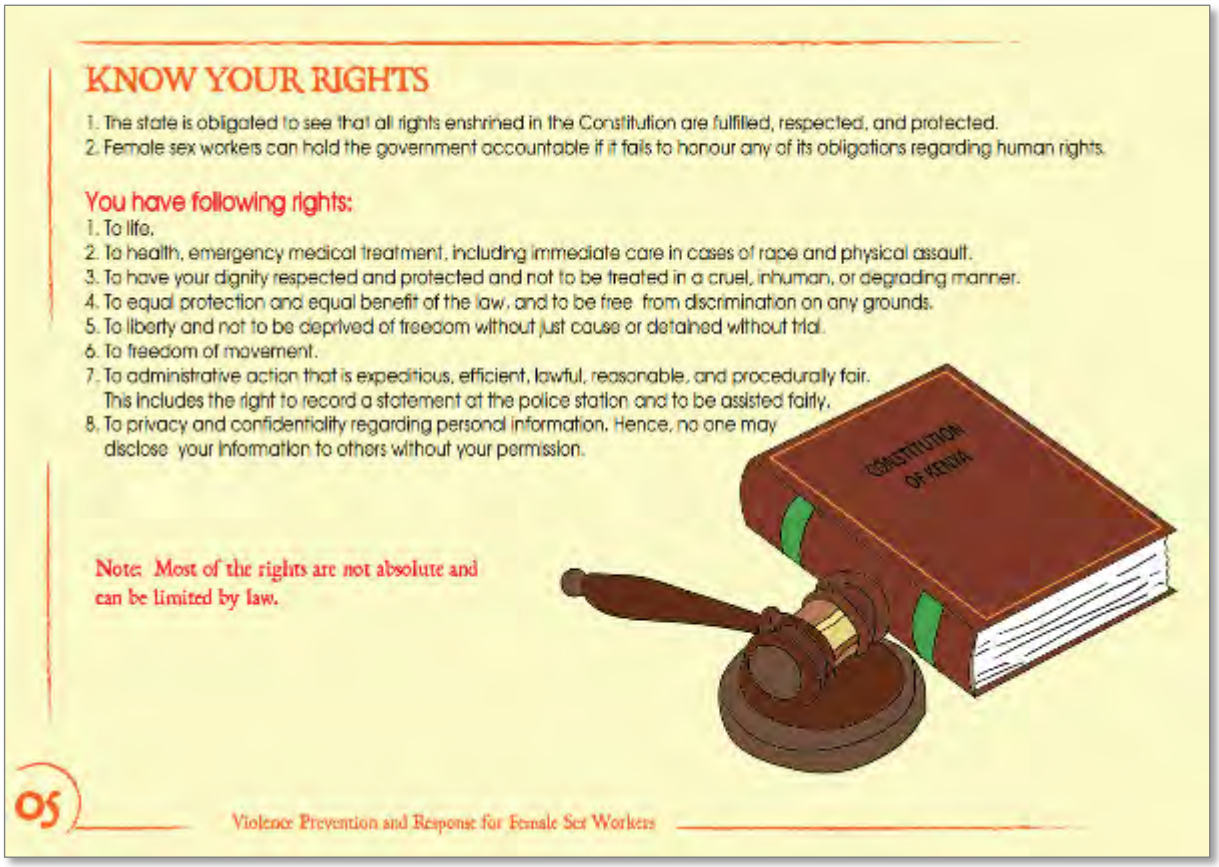
Sample brochures/booklets that inform key population members about their legal and human rights and provide information about violence, rights, and how to access services.



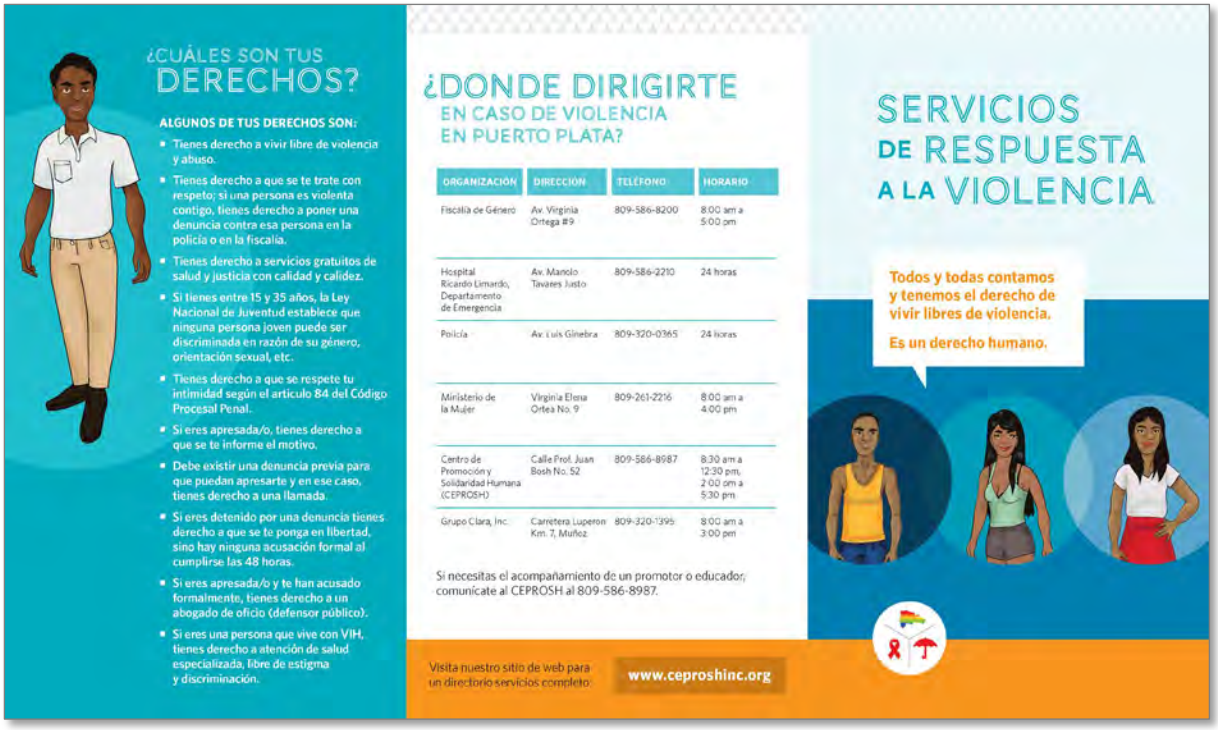
Source: Women's Legal Centre[50]



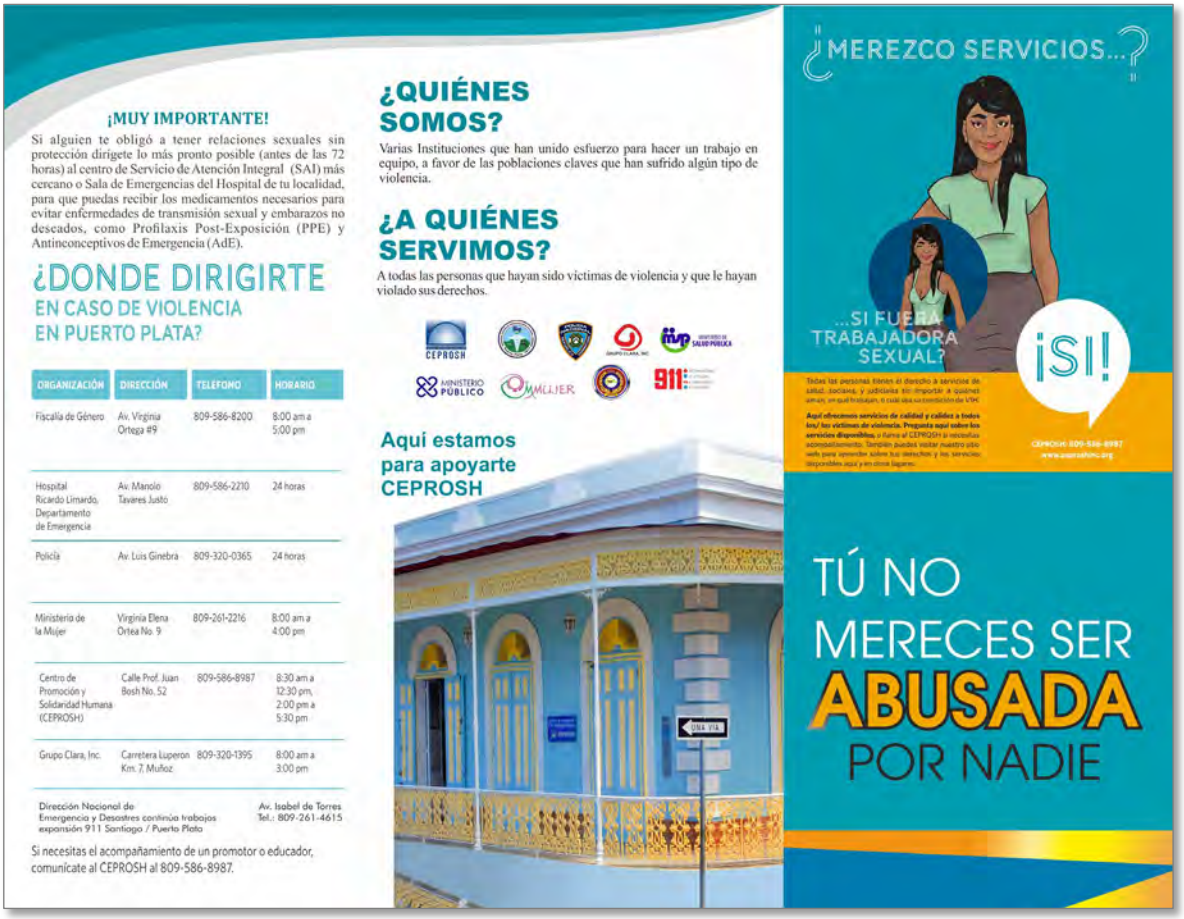




Source: National AIDS & STI Control Programme[51, 52]


¿CUÁLES SON TUS DERECHOS?
ALGUNOS DE TUS DERECHOS SON:
Tienes derecho a vivir libre de violencia y abuso.
Tienes derecho a que se te trate con respeto; si una persona es violenta contigo, tienes derecho a poner una denuncia contra esa persona en la policía o en la fiscalía.
Tienes derecho a servicios gratuitos de salud y justicia con calidad y calidez.
Si tienes entre 15 y 35 años, la Ley Nacional de Juventud establece que ninguna persona joven puede ser discriminada en razón de su género, orientación sexual, etc.
Tienes derecho a que se respete tu intimidad según el artículo 84 del Código Procesal Penal.
Si eres apresada/o, tienes derecho a que se te informe el motivo.
Debe existir una denuncia previa para que puedan apresarte y en ese caso, tienes derecho a una llamada.
Si eres detenido por una denuncia tienes derecho a que se te ponga en libertad, sino hay ninguna acusación formal al cumplirse las 48 horas.
Si eres apresada/o y te han acusado formalmente, tienes derecho a un abogado de oficio (defensor público).
Si eres una persona que vive con VIH, tienes derecho a atención de salud especializada, libre de estigma y discriminación.
¿DONDE DIRIGIRTE EN CASO DE VIOLENCIA EN PUERTO PLATA?
ORGANIZACIÓN
DIRECCIÓN
TELÉFONO
HORARIO
Fiscalía de Género
Av. Virginia Ortega #9
809-586-8200
8:00 am a 5:00 pm
Hospital Ricardo Limardo, Departamento de Emergencia
Av. Manolo Tavares Justo
809-586-2210
24 horas
Policía
Av. Luis Ginebra
809-320-0365
24 horas
Ministerio de la Mujer
Virginia Elena Ortea No. 9
809-261-2216
8:00 am a 4:00 pm
Centro de Promoción y Solidaridad Humana (CEPROSH)
Calle Prof. Juan Bosh No. 52
809-586-8987
8:30 am a 12:30 pm, 2:00 pm a 5:30 pm
Grupo Clara, Inc.
Carretera Luperon Km. 7, Muñoz
809-320-1395
8:00 am a 3:00 pm
Si necesitas el acompañamiento de un promotor o educador, comunícate al CEPROSH al 809-586-8987.
Visita nuestro sitio de web para un directorio servicios completo:
www.ceproshinc.org
SERVICIOS DE RESPUESTA A LA VIOLENCIA
Todos y todas contamos y tenemos el derecho de vivir libres de violencia.
Es un derecho humano.


¿QUIÉNES SOMOS?
Nosotros brindamos servicios a las personas que han sufrido violencia y les informamos acerca de los recursos disponibles.
CEPROSH
GRUPO CLARA, INC.
MINISTERIO PÚBLICO
MMUJER
¿A QUIÉNES SERVIMOS?
Los servicios de respuesta a la violencia son para todos y todas. Nosotros nos enfocamos en las poblaciones clave, que incluyen:
Hombres gay y otros hombres que tienen sexo con hombres
Mujeres transgénero
Personas que viven con VIH
Trabajadoras sexuales
¿QUÉ ES LA VIOLENCIA?
La violencia es un fenómeno social, económico y/o cultural que cada vez se arraiga más en la vida humana. La violencia puede pasarle a cualquiera y puede ser cometida por cualquiera, inclusive una pareja sentimental, un cliente, un oficial de la policía, un miembro de la familia, entre otros. Hay muchos tipos de violencia. Algunos ejemplos son:
VIOLENCIA
EJEMPLOS
Física
Golpes, mordidas, empujones, patadas, asfixia, uso de armas
Sexual
Violación, acoso sexual, relación sexual forzada o bajo amenaza
Emocional
Maltrato psicológica y verbal, humillación, amenazas, coerción
Económica
Uso del dinero o recursos para controlar un individuo, chantaje, no pagar dinero adeudado
La violencia puede tener consecuencias negativas para la salud, y puede aumentar el riesgo de VIH y el acceso y la búsqueda de atención del VIH.
Muchas personas experimentan violencia, y aunque puedan ser culpado/as por lo que pasó, nunca es la culpa de ellos/as.
TODOS Y TODAS TIENEN EL DERECHO DE VIVIR LIBRES DE VIOLENCIA.
¿HAS EXPERIMENTADO VIOLENCIA O ABUSO?
No estás solo/a, te podemos apoyar. Nosotros respetamos tu privacidad y mantenemos la confidencialidad.
¿QUE SERVICIOS ESTÁN DISPONSIBLES?
Servicios clínicos:
Prueba de VIH,
Profilaxis post exposición,
Anticonceptivos de emergencia,
Examen forense,
Y más
Servicios legales
Apoyo emocional y psicológico
Educación sobre los derechos de poblaciones clave



¡MUY IMPORTANTE!

Si alguien te obligó a tener relaciones sexuales sin protección dirígete lo más pronto posible (antes de las 72 horas) al centro de Servicio de Atención Integral (SAI) más cercano o Sala de Emergencias del Hospital de tu localidad, para que puedas recibir los medicamentos necesarios para evitar enfermedades de transmisión sexual y embarazos no deseados, como Profilaxis Post-Exposición (PPE) y Anticonceptivos de Emergencia (AdE).

¿DONDE DIRIGIRTE EN CASO DE VIOLENCIA EN PUERTO PLATA?

ORGANIZACIÓN	DIRECCIÓN	TELÉFONO	HORARIO
Fiscalía de Género	Av. Virginia Ortega #9	809-586-8200	8:00 am a 5:00 pm
Hospital Ricardo Limardo, Departamento de Emergencia	Av. Manolo Tavares Justo	809-586-2210	24 horas
Policía	Av. Luis Ginebra	809-320-0365	24 horas
Ministerio de la Mujer	Virginia Elena Ortea No. 9	809-261-2216	8:00 am a 4:00 pm
Centro de Promoción y Solidaridad Humana (CEPROSH)	Calle Prof. Juan Bosh No. 52	809-586-8987	8:30 am a 12:30 pm, 2:00 pm a 5:30 pm
Grupo Clara, Inc.	Carretera Luperon Km. 7, Muñoz	809-320-1395	8:00 am a 3:00 pm
Dirección Nacional de Emergencia y Desastres continúa trabajos expansión 911 Santiago / Puerto Plata		Av. Isabel de Torres Tel.: 809-261-4615	

Si necesitas el acompañamiento de un promotor o educador, comunícate al CEPROSH al 809-586-8987.

¿QUIÉNES SOMOS?

Varias Instituciones que han unido esfuerzo para hacer un trabajo en equipo, a favor de las poblaciones claves que han sufrido algún tipo de violencia.

¿A QUIÉNES SERVIMOS?

A todas las personas que hayan sido víctimas de violencia y que le hayan violado sus derechos.

Aquí estamos para apoyarte CEPROSH

¿MEREZCO SERVICIOS...?

...SI FUERA TRABAJADORA SEXUAL?

¡SI!

Todas las personas tienen el derecho a servicios de salud, sociales, y sobretodo sin importar a quienes aman, en qué trabajan, o cual sea su condición de VIH.

Aquí ofrecemos servicios de calidad y calidez a todos los/ las víctimas de violencia. Pregunta aquí sobre los servicios disponibles, o llama al CEPROSH si necesitas acompañamiento. También puedes visitar nuestro sitio web para aprender sobre tus derechos y los servicios disponibles aquí y en otros lugares.

CEPROSH: 809-586-8987
www.ceprosh.org

TÚ NO MERECES SER ABUSADA POR NADIE

UNIDOS CONTRA LA VIOLENCIA:

La violencia tiene muchas caras (física, económica, psicológica y sexual) y cualquier persona puede ser víctima de la misma (hombres, mujeres, niños(as), adolescentes; trabajadoras sexuales, amas de casa, hombres que tienen sexo con otros hombres, personas transgénero). CEPROSH y sus socios en los sectores de justicia y salud se han unificado para crear una red de asistencia para las víctimas de violencia en Puerto Plata. Este material educativo está diseñado especialmente para ti, para que puedas trabajar de forma segura y conocer tus derechos.

¿CUÁLES SON MIS DERECHOS?

1. **Ser trabajadora sexual no es un delito en la República Dominicana.** *"A nadie se le puede obligar a hacer lo que la ley no manda ni impedírsele lo que la ley no prohíbe."*; (Art.40.15- Constitución de la República Dominicana)
2. **No te pueden arrestar sin motivos** (Art.40.1 Constitución de la República Dominicana)
3. **Solicita a las autoridades que te expliquen tus derechos.** (Art.40.3- Constitución de la República Dominicana)
4. **Si te arrestan, es obligatorio que la policía te deje hacer una llamada.** (Art.40.4- Constitución de la República Dominicana)
5. **Si no hay motivos legítimos para tu arresto tú o cualquier otra persona puede exigir tu libertad.** (Art.40.6- Constitución de la República Dominicana)
6. **Todos somos iguales ante la ley** (Art.39 - Constitución de la República Dominicana).
7. **Todos tenemos derecho a vivir sin violencia** (Art.42- Constitución de la República Dominicana)
8. **Tienes derecho a ser tú misma y desarrollar tu personalidad** (Art.43 de la Constitución Dominicana)
9. **Puedes transitar libremente por cualquier lugar público** (Artículo 46.- Constitución Dominicana)
10. **Este es tu trabajo y tienes el derecho dedicarte libremente a la actividad económica de tu preferencia** (Artículo 50.- Constitución Dominicana)

¿QUÉ PROHÍBE LA LEY?

1. ¡Es un delito realizar actos sexuales y exponer tus partes íntimas en público! (Art. 333-1 del Código Penal)
2. El proxenetismo sí es un delito en la República Dominicana. (Art.334 del Código Penal) La ley considera proxeneta a:

• Quien recluta de forma obligatoria a una persona a que se dedique al trabajo sexual;

• Quien reciba beneficios económicos y materiales del trabajo sexual de otra persona;

3. Nadie, ni hombre ni mujer, menor de 18 años puede dedicarse al trabajo sexual, pues la ley lo considera como abuso de menores.

ES VIOLENCIA SI...

- Si el cliente te obliga a hacer algo que no fue acordado en contra de tu voluntad
- Si el cliente no te paga
- Si el cliente paga menos de lo acordado
- Si te ofenden o insultan, de forma pública o privada, y disminuyen tu valor como persona
- Si te golpean, bofetean, te halan el pelo de una forma dolorosa o te muerden con agresividad para hacerte daño
- Si alguien te exige "peaje", te chantajea con exponer tu profesión a personas que no la conocen, te quita todo o parte del dinero que has ganado
- Si en el hospital, la policía, fiscalía o cualquier institución no quieren atenderte o brindarte un servicio por tu forma de vestirte, expresarte o por tu profesión
- Si tu pareja o expareja no te deja ver a tus hijos o te amenaza con quitártelos o llevárselos, porque eres una trabajadora sexual.

Source: LINKAGES project[53]

Annex 6: Privacy and Confidentiality in Documentation Checklist

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.*[17]

Annex 7: Glossary

Cisgender describes a person whose gender identity is the same as their sex assigned at birth.

Discrimination occurs when a person or group of individuals are *treated* unjustly or unfairly because of a specific trait they possess.

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.[17]

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).[54]

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.[55]

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.[56]

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.[57, 58] A person's gender expression may or may not be consistent with socially prescribed gender roles.[59]

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.[57, 60]

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.[61] 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]

Informed consent means that a person agrees to participate in an activity or for something to occur *after* they have knowledge of or have received all the information about the activity.

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.[62] 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.[63]

Nonbinary refers to someone who identifies as neither male nor female.[60]

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

A peer educator is a peer who conducts 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, hypnosedatives, 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.[57, 59]

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.[63]

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.[64] It is not related to gender identity.[60]

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.[65]

Transgender is an umbrella term referring to an individual whose gender identity is different from their sex assigned at birth.[57]

- 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.[66]

HANDOUTS

Handout 1: Pre-Test/Post-Test

Handout 2: Participant Agenda

Handout 3: Fundamental Principles for Violence Prevention and Response Service Provision

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: Asks and Follow-Up Support

Handout 8: 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. Gender norms, or the expectations we have for men and women, can cause harm.				
2. Transgender people are responsible for the violence they experience.				
3. If sex workers are assaulted while engaging in sex work, they are at least somewhat to blame.				
4. Men who are openly gay should not complain if they are assaulted.				
5. People who inject drugs must stop using drugs if they do not wish to be abused.				
6. It is important that I am able to talk about violence with those I provide services to.				
7. It harms survivors of violence when they are blamed for the abuse they experienced.				
8. Health care workers have a duty to support key population members who experience violence.				
9. Law enforcement officers have a duty to support key population members who experience violence.				
10. Key population members have the right to live free of violence.				
11. Intimate partner violence often causes serious harm.				

Handout 2: Participant Agenda

Goal: To equip [peer educators, navigators, outreach 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 [peer educators, navigators, outreach 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 survivors 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, Perpetrators, Causes, Consequences)	60 min
Focus on Intimate Partner Violence (IPV)	30 min
Human Rights and the Local Legal Context	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 Peer Educators, Navigators, and Outreach 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	50 min
Focus on Index Testing	20 min
Data Collection and Sharing	45 min
Module 4: Using What We Have Learned	**Time**
Taking Care of Ourselves	60 min
Reflections on What We Have Learned and How to Integrate It into Our Work	60 min
Post-Test and Training Evaluation	15 min
Closing Ceremony and Final Words	15 min

Handout 3: Fundamental Principles for Violence Prevention and Response Service Provision

Principle 1: Do No Harm

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

- Avoid harming KP members or causing further harm to individuals who have experienced violence
- Act in accordance with the wishes and choices of survivors of violence
- Provide services without judgment and that respect the confidentiality of survivors (including that they are members of a key population)
- Consider the safety of survivors of violence
- Get informed consent from survivors before providing services and/or making referrals
- Never require that a survivor reports to law enforcement in order to receive health services

Do no harm to avoid revictimization

"A survivor 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."[31]

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

- Organizational policies to address violence and sexual harassment
- Codes of conduct
- Sensitization of service providers on issues of power and control, including in intimate partner relationships
- Ongoing training and support for service providers (e.g., on supporting survivors 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 survivors 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 Survivors 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, service providers should use a survivor-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 service provider—to report violence and/or to pursue legal action against a perpetrator. Their role is to offer KP members information about their rights and available services so that survivors 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, without being subjected to stigma, discrimination, or violence.

Mutually reinforcing principles: do no harm and self-determination

Even well-intentioned efforts to support KP survivors of violence can cause harm. For example, a service provider may believe that a survivor can only effectively avoid future violence by reporting a perpetrator to law enforcement and taking them to court. As a result, they may try to force the survivor to confront their abuser in this way. This can cause the survivor harm in several ways, particularly if the perpetrator is also providing for the survivor economically or otherwise. Furthermore, if a survivor does not feel comfortable taking an action that is strongly suggested by a service provider, the survivor may avoid seeking help from them in the future, effectively limiting their support network. All those working with survivors of violence should instead ensure that the survivor fully understands the range of available options, including the consequences of electing or not electing to access each one, and then support the survivor 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. Service providers 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 service providers within one's own organization or within the referral network without the explicit consent from the KP member. A breach of confidentiality about pregnancy, violence, contraception, HIV status, sexual orientation, 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, service providers 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 survivor's consent before sharing any information and the need to inform survivors about the limits of confidentiality before a disclosure occurs
- 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*.[24] 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 survivor that they are not to blame
Enhance safety	Discuss a plan to protect the survivor from further harm if violence occurs again
Support	Support the survivor to connect with additional services

In many cases, peer educators and navigators will not complete all the steps of first-line support. Instead, if violence is disclosed, they will listen and validate and then accompany survivors of violence to another member of their team, such as a supervisor or an outreach worker. However, in the case that the person disclosing violence does not wish to speak to anyone else, it is important for peer educators and navigators to have a basic knowledge of safety planning (Enhance safety) and the services available so that they can provide information on all of the survivor's options and help the person stay safe (Support).

Techniques for each task in LIVES 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.

Active Listening Dos and Don'ts *(continued)*	
Dos	**Don'ts**
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 survivor to talk	How do you feel about that?
Verify your understanding by restating what the survivor says	You mentioned that you feel very frustrated.
Reflect back (paraphrase) the feelings the survivor 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 survivor 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.

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 survivor.
  - "You put yourself at risk."
- Saying anything that judges what the survivor 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 survivor's story (doubting) or interrogating the survivor.
  - "What I don't understand is why he would have attacked you?"
- Saying anything that minimizes how the survivor 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 survivor 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 Survivors 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 survivor'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 survivor does not feel safe, it is important to take the survivor seriously and help them create a safety plan.

Safety Planning	
Concern	**Some ways to respond**
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 with 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 survivor lives with an abuser
- Know specific information about referral points and share this information when making the referral:
    - Name of referral facility and focal point at referral site
    - Hours of operation
    - Services available
    - Populations served
    - Contact information (location, phone number, email)
- Ask survivors if they want accompaniment to resources and, if so, make arrangements
- Do not pressure survivor 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 survivors 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 survivors 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 next page 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 peer educators, navigators, and outreach workers do not tell KP members how to stay safe. Safety planning is a conversation in which the peer educator, navigator, or outreach 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.[67]

RESOURCE LIST | EMERGENCY RESPONSE

Support for responding to human rights violations and security threats

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

DIGNITY FOR ALL	FRONTLINE AIDS
What do they do? Dignity for All is a consortium of organizations focused on safety and security for LGBTI communities. Dignity can provide: (1) **Emergency financial assistance** to LGBTI human rights defenders (HRDs) or organizations who are threatened because of their work. Support can address urgent needs such as temporary relocation, security, medical expenses, legal representation, and dependent support. (2) **Security, opportunity, and advocacy rapid response (SOAR) grants** for short term interventions to help civil society organizations (CSOs) counteract urgent threats or take advantage of unexpected opportunities to protect or advance LGBTI human rights. (3) **Preventative security workshops** that help CSOs and HRDs increase their security awareness, develop security plans, and gain skills to keep themselves and their communities safer. **Where do they provide support?** Global (anywhere) **Who can apply?** HRDs or CSOs with a proven history of LGBTI activism. CSOs do not need to be officially registered. To find out more or apply—*click here*. Or email *info@dignitylgbti.org*	**What do they do?** The Rapid Response Fund, managed by Frontline AIDS, issues grants for interventions that respond to new or worsening situations that impact HIV services for LGBTI individuals and MSM. They issue: (1) **Emergency Response Grants**, to respond to immediate threats to MSM and the LGBT community, and the HIV services that they need, and where action must happen very quickly to be effective. For example, supporting the relocation of individuals forced out of their homes, who need help to find and access friendly HIV services in their new location. (2) **Challenge Response Grants** to respond to urgent situations that require an intervention that may take place over several months (typically up to 6 months) and will contribute to the removal of barriers to accessing HIV services. For example, engaging with local government in response to sudden policy developments affecting access to HIV services for MSM and LGBT people. **Where do they provide support?** 29 countries in sub-Saharan Africa, Latin America and the Caribbean. *See list*. **Who can apply?** Grants can be provided to CSOs led by or working closely with LGBTI people or MSM. To find out more or apply—*click here*.
FRONT LINE DEFENDERS	**URGENT ACTION FUND FOR WOMEN'S HUMAN RIGHTS**
What do they do? Front Line Defenders provides support in the form of: advocacy, emergency support for those in immediate danger, grants to pay for the practical security needs of human rights defenders, trainings and resource materials on security and protection, opportunities for human rights defenders dealing with extreme stress, and an emergency 24-hour phone line. They aim to approve emergency grants within 48 hours. **Where do they provide support?** Global (anywhere) **Who can apply?** Human rights defenders and their organizations To find out more or apply—*click link*.	**What do they do?** Urgent Action Fund for Women's Human Rights provides grants to women and transgender human rights defenders at critical moments. They intervene quickly when activists are poised to make great gains or face serious threats to their lives and work. A list of their grants to date can be found *here*. They respond to requests within 72 hours and have funds on the ground within 1-7 days. **Where do they provide support?** Asia, the Middle East, Central and Eastern Europe, and North America **Who can apply?** Women and transgender human rights defender To find out more or apply—*click here*.

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

Handout 7: Asks and Follow-Up Support

Name: _____

What tasks do you feel you can perform?

What other support do you think you will need?

Handout 8: 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 trainer answered my questions.
   - ☐Strongly Agree
   - ☐Agree
   - ☐Disagree
   - ☐Strongly Disagree

5. The trainer made me feel comfortable and welcomed.
   - ☐Strongly Agree
   - ☐Agree
   - ☐Disagree
   - ☐Strongly Disagree

6. The trainer seemed knowledgeable about the content.
   - ☐Strongly Agree
   - ☐Agree
   - ☐Disagree
   - ☐Strongly Disagree

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

8. The use of lectures and practical exercises was well balanced.
   - ☐Strongly Agree
   - ☐Agree
   - ☐Disagree
   - ☐Strongly Disagree

9. 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

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

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

12. What feedback would you like to provide to the trainer?

EXERCISE CARDS

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

Print one copy of each 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: Amanda's Story

Print enough so that each group of participants can have at least 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 3: 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 apologies 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 4: 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 survivor 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 survivor 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 survivor 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 survivor 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 survivor 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 survivor after you read the statement.

……cut……

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

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

……cut……

Exercise Card 5: Survivor 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.....

Survivor 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. You call a crisis response line to ask about emergency contraception.

.....cut.....

Survivor 2—Nicole

You are a 22-year-old transgender woman. A group of young men know where you live and often damage your fence or write slurs on your car. If they see you, they throw stones and bottles at you; recently you were injured and had to get several stiches. You begin to feel depressed and stop taking your antiretroviral medication. When you don't pick up your ARVs, a peer navigator comes to your house to see how you are doing. You tell them what is happening.

.....cut.....

Survivor 3—James

You are a 19-year-old gay man. You live with your boyfriend at his house. Every time you want to go out, you have to tell him where you're going and who you're going with. He then tells you whether you can go, threatening that if you leave without his permission, you can never come back. He looks through your phone to see who you've called and messaged. If you try to refuse, he says he pays for the phone so he can do whatever he wants with it. You feel like you can't speak to anyone, you can't see anyone, you can't even breathe without his permission. You think that if you leave your boyfriend, you won't have anywhere else to go. You attend a community dialogue, and the peer educator mentions examples of intimate partner violence. You decide to talk to the peer educator privately once the community dialogue ends.

.....cut.....

Exercise Card 6: Stress Reduction Activities

Print one copy for the facilitator.

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