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IDENTIFYING VIOLENCE AGAINST MOST-AT-RISK POPULATIONS: A FOCUS ON MSM AND TRANSGENDERS

TRAINING MANUAL FOR HEALTH PROVIDERS

OCTOBER 2009
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ABBREVIATIONS

AIDS	acquired immune deficiency syndrome
GBV	gender-based violence
HIV	human immunodeficiency virus
MARP	most-at-risk population
MSM	men who have sex with men
NGO	nongovernmental organization
S&D	stigma and discrimination
STD	sexually transmitted disease
STI	sexually transmitted infection
SW	sex worker
TG	transgender(s)
VCT	voluntary counseling and testing

INTRODUCTION

Background

Men who have sex with men (MSM) and transgenders (TG) often face stigma, discrimination, poverty, violation of human rights, and homophobia. Negative attitudes and violence toward MSM and TG are common worldwide and, in fact, are condoned by many societies. Structural and institutional discrimination and violence against MSM and TG are supported by law enforcement and healthcare providers, who often perpetrate widespread corruption, intimidation, and harassment against gay men, MSM, and TG (Medina et al., 2006; Chakaprani et al., 2002; Khan et al., 2005). In this way, violence against MSM and TG is a form of gender-based violence (GBV).[1]

The rates of violence against MSM and TG, particularly those engaging in sex work, are alarming. For example, in a survey of more than 2,000 MSM in Thailand, which included TG, 18.4 percent reported being coerced into sex and, of those, 67.3 percent were coerced more than once (Guadamuz et al., 2006). In Mexico, 17 percent of male sex workers suffered rape, physical abuse, verbal abuse, extortion, robbery, or assault (Gayet et al., 2007). This violence is a manifestation of stigma and discrimination (S&D) against MSM and TG, primarily because they do not fit into traditional gender categories or have been subordinated due to their gender identity. In other words, although it is not commonly perceived as such, violence experienced by MSM and TG is most often gender-based (Betron and Gonzalez-Figueroa, 2009).

Researchers have only recently begun to explore the intersection between violence and HIV vulnerability in most-at-risk populations (MARPs). Nonetheless, strong evidence points to the importance of these linkages. First, coercive sexual intercourse may directly increase the risk for HIV. Second, violence and threats of violence may limit the ability to negotiate safer sexual behaviors. Likewise, experiencing violence, particularly sexual violence, has been found to increase HIV risk behavior, such as multiple sex partnerships and the use of illicit drugs. Moreover, evidence has been found that violence or fear of violence prevents MSM, transgendered people, and sex workers, regardless of HIV serostatus, from accessing HIV and other health services. Health professionals have the potential to play a key role in the promotion of sexual health, including the prevention of GBV associated with stigma and discrimination in most-at-risk populations for HIV. Equipping health workers with knowledge, skills, and tools greatly enhances their ability to address GBV with their clients and in their communities.

Screening for intimate partner violence against women in the healthcare setting, done in a sensitive and confidential manner, has been recommended by many experts as an opportunity to reach out to survivors of violence. Benefits identified include the potential to counsel survivors, consider violence as a factor in HIV prevention and/or risk reduction and adherence counseling, and raise the awareness of clients as to their rights to live free from violence (Betron and Gonzalez-Figueroa, 2009).

How Was This Manual Developed?

Given the important opportunities and benefits of screening for gender-based violence, the USAID | Health Policy Initiative, Task Order 1 piloted HIV clinic-based screening for violence and other forms of S&D against MSM and TG in select sites in Mexico State and Puerto Vallarta, Mexico and in Pattaya, Thailand. (See Box 1 for more information.) The objectives of the project were to

- **Develop a screening tool** for GBV and S&D against MSM and TG to be applied by health service providers to increase their recognition and response to these issues when providing HIV counseling;

[1] Gender-based violence is "any harmful act that is perpetrated against a person's will and that is based on *socially ascribed (gender) differences* between males and females." Inter-agency Steering Committee of the United Nations, 2006.

- **Increase understanding of links** among GBV, S&D, and sexual risk taking and access to health services; and
- **Foster collaboration** of community organizations and health services **to respond to cases of GBV and S&D** that affect HIV risk.

Prior to piloting the screening tool, Health Policy Initiative/Mexico and, in Thailand, Health Policy Initiative's local partner, Population Research Institute Foundation (PRI) trained health providers at participating sites on how to apply the tool but also importantly, sensitized providers on gender, sexuality, S&D, and violence faced by MARPs.

The Health Policy Initiative piloted and used the methodology compiled in this manual to train health providers at sites in Mexico and Thailand. In some instances, particularly where time was limited, a subset of sessions was conducted. Based on experiences with the pilot, adjustments have been made so that the sessions are presented here in the form in which the project recommends they be conducted. A full description of the pilot is described in the box below.

Box 1. Screening for violence against MSM and transgenders: A pilot project in Mexico and Thailand

From 2007–2008, the USAID | Health Policy Initiative, Task Order 1 (the project) implemented a pilot project that developed a screening tool for service providers in the HIV health clinic setting to identify violence experienced by MARPs. Screening was integrated into HIV clinical services, including voluntary counseling and testing (VCT) and treatment programs, in Pattaya City, Thailand and in Puerto Vallarta, Mexico and the state of Mexico. In Thailand, screening also was integrated into community drop-in services, which include VCT and outreach for MSM and TG.

Data from six weeks of implementation (N= 279) in both countries identified high levels of violence in MSM and TG screened. Results showed that at least half of MSM and TG experienced violence in the year prior to being screened (Mexico: 50% among MSM, n=142 and 65% among TG, n=51; Thailand: 69% among MSM, n=59 and 89% among TG, n=27), with TG experiencing greater levels. All forms of violence were high in each country. Emotional violence was most common in Thailand (63% among MSM; 78% among TG); sexual violence was most common in Mexico (47% among MSM; 65% among TG). Higher levels of sexual than physical violence were identified in almost all groups (except for MSM in Thailand, where levels of the two kinds of violence were comparable).

The screening tool helped providers improve communication and trust with clients and identify the range of social vulnerabilities MSM and TG face. Providers recommended training on counseling to use with survivors of violence and on sexual diversity, as well as referral services that cover all needs of MSM and TG, such as legal services and shelters. Overall, providers saw the tool as beneficial to their work and agreed that screening should continue, provided there is institutional support, training, and adequate time and space.

Given the high levels of HIV and violence against MSM and TG, services for them must address the causes and consequences of this violence. In settings with a favorable policy and legal environment that protects MSM and TG, HIV programs should sensitize and build capacity of providers to screen for violence against these populations and promote efforts in the community to strengthen multisectoral support services for MSM and TG before screening is implemented. In this way, the screening tool can provide an impetus to initiate community-health system collaboration to better respond to violence against MSM and TG, as well as HIV. The pilot project identified the following key criteria to establish before screening:

- Screen only where laws do not criminalize MSM and TG or where the human rights of MSM and TG are recognized.
- Conduct screening in a space that is private and confidential.
- At a minimum, ensure that psychologists and self-support groups within the clinic are available to counsel survivors after screening for violence.
- Continually sensitize and train providers on gender, sexual diversity, violence, and stigma discrimination.

- Before developing screening services, assess, consult with, and engage external referral services to ensure that they can adequately address the needs of MSM and TG.
- Develop clear protocols of who, when, where, and how to screen; make providers aware of the protocols by training these personnel, posting the protocols in visible places, and including them with screening documents.

Additional information on the project and its outcomes, as well as literature on GBV and its link to HIV vulnerability in MARPs can be accessed at: www.healthpolicyinitiative.com.

Adapted from: Betron, 2009.

How Do I Use This Manual?

This training manual is meant to be used by a skilled facilitator. The manual compiles the training methodology used to sensitize and train providers on how to screen for and respond to violence against MSM and TG in an HIV service setting. Modules I through V—Setting the Stage; Sexuality and Gender; Stigma and Discrimination and Gender-Based Violence; Gender-Based Violence; and Gender-Based Violence, Stigma and Discrimination, and HIV—can also be used to sensitize health providers on these issues. This manual is based on the following three key concepts: participatory learning, the social construction of gender, and evidence-based practices in healthcare. As a facilitator, it is important to understand and feel comfortable with these concepts.

A **participatory learning** approach to training, or a **learner-centered** approach, uses discussion and small group activities. Through careful facilitation, this approach allows open, constructive discussion on gender, sexuality, S&D, and violence against MSM and TG. Ultimately, the goal is for participants to identify how they can promote a change in attitudes and practices in their work and communities.

A **gendered** approach is also critical to the training methodology. Recognizing that gender is the social construction of what it means to be male or female and thus varies according to culture and over time, the exercises in the first part of the manual explore participants' perspectives on gender and sexuality. By virtue of the fact that the topics of gender and sexuality of MARPs are to a certain degree taboo, they need to be addressed at various levels. These include the influence of gender biases in all aspects of one's life, including beyond the professional arena; each health professional's position regarding his/her own sexuality and the sexuality of others; and how a health professional's understanding of gender and sexuality can impact service provision. Using the participatory learning approach, reflection on gender and sexuality allows for questioning of existing norms and proposing new, more effective, and equitable ways to provide services.

Evidence-based practice (EBP) refers to a decisionmaking process that integrates the best available research, clinician expertise, and client characteristics. EBP underpins the latter half of the methodology, in particular, where data on violence and S&D against MSM and TG and their link to HIV vulnerability are presented. Overall, the goal of this training, much like the goal of EBP, is to ensure the state-of-the art knowledge and skilled health providers needed to provide quality care to clients.

How Is the Manual Organized?

The training begins with exercises that explore participants' perceptions regarding gender and sexuality. Thus, as key foundations to providing adequate and non-discriminatory services to MSM and TG, the exercises on gender and sexuality occupy the first day and a half of the agenda. The manual then moves on to knowledge-based exercises regarding prevalence and data on violence against MSM and TG and its link to HIV vulnerability. On the last day, the methodology uses skills-based exercises to allow participants to practice using the screening tool. Final sessions include action planning to identify how to integrate the tool into existing services and how to form referral networks to help provide a

comprehensive response to clients facing gender-based violence. A sample agenda is provided based on a four-day workshop. Each session is organized by objective, materials needed for the activity, estimated time to carry out the activity, and step-by-step instructions. Facilitator resource sheets and handouts for participants are placed at the end of each session. PowerPoint presentations are available at www.healthpolicyinitiative.com.

Objectives of the Workshop

By the end of this workshop, participants will improve their

(1) Understanding of gender and sexuality and how perceptions regarding these concepts impact health or health-related behavior;
(2) Understanding of violence against MSM and TG and its effect on HIV risk;
(3) Understanding of the role of health providers in responding to violence against MSM and TG; and
(4) Knowledge of best practices in screening for GBV in the health setting.

Proposed Agenda

TIME	SESSIONS
	DAY 1
2 hours	**I. Setting the Stage**
1 hour 30–45 minutes 15 minutes	A. Common Expressions Regarding Gender and Sexuality B. Expectations, Challenges, Objectives, and Agenda of the Workshop C. Creation of a Favorable Environment: Basic Rules
5 hours	**II. Sexuality and Gender**
2 hours 1 hour 2 hours	A. Personal Beliefs B. Accommodating Roles C. Body Map
4.5 hours	**III. Stigma and Discrimination and Gender-based Violence**
1.5 hours 1 hour 30 minutes 1.5 hours	A. Personal Perceptions B. Introduction to the Theme of Stigma and Discrimination C. "Put Yourself in My Shoes" D. Obstacles Related to Stigma and Discrimination in Service Provision
2.5 hours	**IV. Gender-based Violence**
	DAY 3
2 hours	**V. Gender-based Violence, Stigma and Discrimination, and HIV**
2 hours	**VI. Responding to GBV in MSM and Transgenders: The Role of the Health Sector and Other Sectors**
2 hours	**VII. Best Practices in GBV Screening**
1 hour	**VIII. Presentation of the Tool**
	DAY 4
1 hour	**IX. Development of a Referral System**
1 hour	**X. Construction of the Safety Plan**
1 hour	**XI. Use of the Screening Tool**
1 hour	**XII. Follow-up and Next Steps**
30 minutes	**XIII. Closing**

I. SETTING THE STAGE

A. Common Expressions Regarding Sexuality and Gender

Objective

- To allow workshop participants to get to know one another through shared activities, common objectives, or specific interests.

Materials

- Resource Sheet: **Examples of Common Expressions**
- One index card per participant with half of a written phrase regarding sex and gender

Time: 1 hour

Instructions

To be prepared prior to the workshop, gather common phrases, approximately one for every two participants (for example, 15 phrases for a group of 30 participants). Write half of each phrase on one card and the other half on another card.

- Hand each participant a card on which half of a phrase is written.
- Instruct participants to find the person with the other half of the phrase, by means of reading his or her card out loud and repeating it as many times as necessary until finding the person whose card complements his/her own.
- After participants find their partners, ask that they spend five minutes introducing themselves to each other. Suggest that they share with each other any similar hobbies, common objectives in participating in the workshop, or interests. Also ask that they discuss the phrase that brought them together.
- Then, have each person present his or her partner from the exercise and summarize what they talked about, as well as their thoughts about their phrase.

Upon completing the exercise, proceed immediately to the next exercise.

Facilitator Note: Prepare a list of common phrases, expressions, or proverbs relevant to your cultural context regarding men, women, or homosexuality, based on gender stereotypes. Examples are provided below.

FACILITATOR RESOURCE SHEET: Examples of Common Expressions

(1) A woman is like a lemon; you squeeze her and throw her away.

(2) Seven women in their right senses are surpassed by a mad man.

(3) Women have long hair and short sense.

(4) A woman's tongue cracks bones.

B. Expectations, Challenges, Objectives, and Agenda of the Workshop

Objective

- To identify participants' professional and personal expectations and perceived challenges regarding the workshop objectives and agenda.

Materials

- Flipchart sheets or PowerPoint presentation of workshop objectives and agenda. (See page 4 for proposed agenda.)
- Markers

Time: 30 minutes

Instructions

- Divide the group into subgroups, approximately five per group. Indicate that they will have 15 minutes to identify up to three personal and professional expectations for the workshop and that they will present them to the general group later. Also ask participants to identify elements they are going to contribute so that their expectations and challenges will be fulfilled. Ask them to write these on flipchart sheets.
- Afterward, have a representative from each group present the group's expectations for the workshop, as well as contributions their group will make to fulfill the expectations.
- Next, present your prepared flipchart sheets or PowerPoint slide with the workshop's objectives, pointing out which objectives and agenda items coincide with participant expectations. Clarify and explain any differences between participant expectations and the objectives.

You may want to leave the sheets taped to the walls so that the group can revisit the objectives and expectations during the final evaluation of the workshop.

Facilitator Note: Participants should feel free to excuse themselves from an activity at any time if they feel uncomfortable. Inform them that they have the right to refrain from participating in activities when they feel uncomfortable and will not be judged or punished for doing so. Also add that if there is a personal matter that a participant would like to discuss with the facilitator, he or she may do so at any time.

C. Creation of a Favorable Environment: Basic Rules

Objective

- To create a favorable workshop environment.

Materials

- Flipchart paper and markers
- Resource sheet: **Creation of a Favorable Environment**

Time: 15 minutes

Instructions

- Request that the general group identify rules that will favor the creation of an environment conducive to successful interaction during the workshop.
- Refer to the resource sheet **Creation of a Favorable Environment: Basic Rules** to supplement or provide feedback on the rules selected.
- The sheet of Basic Rules should remain posted in the meeting room to act as a reminder, if necessary, of rules that should be respected during the course of the workshop.

Facilitator Note: Once the group establishes rules, it is important that, as facilitator, you ensure the rules are respected, which may require intermittent intervention.

FACILITATOR RESOURCE SHEET: Creation of a Favorable Environment: Basic Rules

As workshop activities get underway, it will become apparent that the workshop often involves discussion of personal or sensitive topics such as gender, sexuality, and cultural norms. The following are some rules or guidelines to create a favorable environment for reflection, discussion, and learning about such topics.

Confidentiality: What we share in this group remains in this group.

Frankness: It is important to be frank and honest, but problems related to the personal/ private lives of others shall not be divulged to family, neighbors, or friends.

Non-judgmental posture: It is okay to disagree with another person's point of view, but it is not okay to judge them or "point fingers at them."

"I" statements: It is preferable to share our feelings or values using declarations such as *I think* or *I feel*.

Right to pass: This workshop is designed to foster participation, but there will be occasions where it will be okay to say "I pass," "I prefer not to do this activity," or "I reserve my right of opinion."

Anonymity: A question may be made anonymously if necessary (a box should be available for questions), and all questions will be answered.

Acceptance: It is normal to feel uncomfortable. Even adults feel uncomfortable when talking about sensitive issues such as social values or sexuality.

There may be other basic rules that the group will want to adopt as well—for example, prohibiting the use of cellular phones in the meeting space. If possible, allow the rules to come from the group, perhaps after giving an example of a "basic rule." Add those rules from the above list if the participants do not suggest them. Participants will safeguard implementation of the rules if they feel the rules came from within the group.

II. SEXUALITY AND GENDER

A. Personal Beliefs

Objective

- To teach participants a comprehensive concept of human sexuality.

Participants will identify elements of sexuality from their own experiences and those of their fellow participants. They will understand that sexuality is a positive human dimension, defined individually. They also will understand how to talk about sexuality.

Materials

- Copies of Handout: **Personal Beliefs Questionnaire**
- Copies of Handout: **Definitions of Sexuality**
- PowerPoint presentation: **Sexuality: Definitions, Components, and Expressions**. (Available at: www.healthpolicyinitiative.com .)

Time: 2 hours

Instructions

- Tell the group that, in this session, they will learn about the concept of sexuality and how individuals in the group are similar in some aspects related to sexuality.
- Ask the group: "What is sexuality?" and allow them to express their ideas. Avoid correcting concepts at this time; the objective is to let the participants share their own concepts on sexuality.
- Give each participant a Personal Beliefs Questionnaire. Instruct them to *not* put their names on the questionnaires. Wait for the group to finish. Emphasize the questionnaire's anonymity and ask participants to be sincere in their responses.
- Explain to the group that this questionnaire relates to their own sexuality. When they submit their questionnaires, ask them which topic they would like to discuss more with the group.
- Read aloud four to five responses for each question.
- Continue to read as many responses to questions selected by the group as time allows. Continually reorder the questionnaires so that participants cannot detect who filled them out. To facilitate their identification, questions are ordered according to elements of sexuality: "A" Gender, "B" Bonds, "C" Eroticism, "D" Reproductivity, "E" Sexual orientation, "F" Sexual identity.
- When you have completed reading a broad selection of responses, ask the participants what they have learned about the sexuality of their group members. After hearing a few responses, thank them for their participation.
- Reiterate to the group that
    - Sexuality is a beautiful human quality and all persons have sexuality.
    - We can talk about sexuality with other persons, including men and women.
    - Your sexuality belongs to you, just as the sexuality of each and every participant belongs to him/her.
- To finalize, explain to participants the World Health Organization's concept of sexuality using the PowerPoint presentation.

HANDOUT: Personal Beliefs Questionnaire

A.

1. What I most like about my body is:

2. What I least like about my body is:

3. I think women in general are:

4. I think men in general are:

5. What I enjoy most about my sex (man / woman) is:

B.

6. For me, love is:

7. For me, friendship is:

8. As a friend, I am:

9. As a partner, I am:

10. In general, my relationships with the members of my family are:

C.

11. For me, sexual pleasure means:

HANDOUT: Personal Beliefs Questionnaire (continued)

12. My ideal sexual experience would be:

13. My opinion of self-eroticism is that:

D.

14. For me, being a mother/father means:

15. For me, my first menstruation (ejaculation) meant:

16. When I help a person, I feel:

17. When I see babies, I feel:

E.

18. The moment in my life in which I discovered my sexual orientation was when:

19. Seeing homosexual persons showing mutual affection or caressing each other makes me feel:

F.

20. In general, regarding my sexuality, I feel:

21. The values that I feel are most important in defining my sexuality are:

B. Accommodating Roles

Objective

- To reflect on stereotypes in gender roles.

Materials

- 2 flipchart sheets
- Markers
- Adhesive tape

Time: 1 hour

Instructions

- Write the headlines “men are” and “women are” on two separate flipchart sheets.
- Break into small groups of four to five participants. Request that participants write the adjectives they think correspond to each of the headlines.
- Once each group has written the adjectives on each of the flipchart sheets, ask people to present them in a plenary session.
- To conclude, facilitate a plenary discussion with the following questions:

  (1) Do these adjectives describe the roles and characteristics that all people consider “normal” or “natural”?

  (2) Do they describe what society has decided that persons of the male or female sex should or should not do?

  (3) Do men behave as if these stereotypes are true? Do women behave as if they are true?

  (4) What are some of the consequences of these stereotypes for women? For men?

  (5) What are some of the consequences for women when they act differently than the above mentioned (socially accepted(?)) norms? For men?

C. Body Map

Objective

- To identify values and attributes of the sexes and their influence on gender, stigma, and discrimination.

Materials

- Flipchart sheets
- Markers
- PowerPoint presentation: **Sexual Diversity** (Available at: www.healthpolicyinitiative.com.)
- Copies of Handout: **Sexual Diversity**

Time: 2 hours

Instructions

- Divide participants into groups of approximately five people.
- Ask half the teams to work on drawing the silhouette of an ideal man, and the other half to draw the silhouette of an ideal woman. Once participants finish drawing, ask them to write the physical attributes of each sex on the right side of the silhouettes and the values each sex should possess on the left side. Allow 15 minutes for this portion of the activity.
- Next, ask participants to take 20 minutes to discuss in their small groups what would happen if that ideal man or woman wanted to change his or her sex. Each small group should respond to the following questions:
    - What would the ideal man/woman have to modify about his/her body in order to be the other sex?
    - What mental changes, values, and roles would he or she have to modify to change sex?
    - What social consequences would the person need to confront with a sex change?
    - Once participants have responded to the questions, ask them to make a new drawing representing the new ideal man/woman.
- Ask each team to present its fictitious person and the responses to the questions. Allow about 10 minutes per group.
- After completing the presentations, facilitate a plenary discussion on how the values and attributes of each sex influence the way we perceive roles and how these in turn influence gender.
- Present the PowerPoint: **Sexual Diversity**, which explains the differences among the various categories of sexual orientation (men who have sex with men, transgender, transsexual, transvestite.) Distribute the accompanying handout with definitions of each category.

HANDOUT: Sexual Diversity: Terms and Definitions

Gender identity—refers to a person's internal, deeply felt sense of being either male or female, or something else in between. Because gender identity is internal and personally defined, it is not visible to others (Currah and Minter, 2000).

Gender expression[2]**—**refers to all of the external characteristics and behaviors that are socially defined as either masculine or feminine, such as dress, mannerisms, speech patterns, and social interactions (Currah and Minter, 2000).

MSM—which stands for *males who have sex with males,* describes a behavior rather than a specific group of people. It includes self-identified gay, bisexual, or heterosexual men, many of whom may not consider themselves gay or bisexual (UNAIDS).

Transgenders—refers collectively to individuals who challenge strict gender norms by behaving as effeminate men or masculine women, adapting "third gender" roles, or embarking on hormonal and surgical treatment to adjust their bodies to the form of the desired sex (IUSTI Asia Pacific Branch, 2009).

- **Transsexual—**a person who has a conflict between physical sex and gender identity as a man or a woman (Currah and Minter, 2000).
- **Transvestite—**heterosexual man who cross-dresses for sexual gratification but does not wish to be a woman (IUSTI Asia Pacific Branch, 2009).
- **Intersexual person—**a person who has a sexual anatomy that mixes male and female characteristics (Currah and Minter, 2000).

III. STIGMA AND DISCRIMINATION AND GENDER-BASED VIOLENCE

A. Personal Perceptions

Objective

- To reflect on one's own perceptions of most-at-risk populations.

Materials

- List of questions.

Time: 1.5 hours

Instructions

- Divide participants into two groups. Have each group form two separate circles with their chairs, one circle inside the other:
    - Ask the first group to form an inner circle with their chairs facing toward the outer circle.
    - Ask the second group to form an outer circle with their chairs facing in toward the inner circle.
- Explain that the exercise will consist of the facilitator formulating questions for each pair to discuss, sharing their points of view. Each question will have a two-minute response time. Explain that when you indicate that time is up, those occupying the inner circle should move one chair to their right. You will formulate a new question, and the same steps will be repeated. Give an example.
- Begin the exercise, using each of the following topics for the different rounds of discussion:
    - What is your opinion of homosexuality?
    - What is homophobia?
    - Would you be willing to live with a transgender?
    - What is your opinion of a man wanting to be a woman?
    - Do you think a transgender deserves to be hit or insulted on the street? Why or why not?
    - What is your opinion of transvestites?
    - Do you think the client of a sex worker has the right to physically abuse him or her simply because he or she is paying for a sexual service?
    - What do you think about the murder of homosexuals and transgenders?
    - Do transsexuals have the right to have their feminine identity recognized by the government?
    - Do you think insulting a transgendered person is violence against their person?
    - Is sex work a necessary evil?
    - Why do you think a man would want to be a sex worker?
    - Have you ever thought transgenders and sex workers should be exterminated?
    - Should transgenders, MSM, and sex workers have separate specialized health services?
- Ask participants to return to the plenary to conclude the activity.
- Ask participants: "How did you feel about the exercise?"; "What did you learn?"; "How easy or difficult was it for you to talk about the proposed topics with unfamiliar persons?"

B. Introduction to the Theme of Stigma and Discrimination

Objective

- To increase the understanding of underlying issues linked to the HIV epidemic: vulnerability, risk, stigma, discrimination, and gender.

Materials

- PowerPoint presentation: **Breaking the Cycle: Stigma, Discrimination, Internal Stigma, and HIV** (Available at: www.healthpolicyinitiative.com.)
- For speakers' notes, see Morrison, K. 2006. "Breaking the Cycle: Stigma, Discrimination, Internal Stigma, and HIV." Washington, DC: USAID Policy Project.

Time: 1 hour

Instructions

- Present the concepts as they are explained in the PowerPoint.
- Ask participants if they have any questions and facilitate a discussion on how S&D increase vulnerability to HIV, particularly for MSM and transgenders, as follows:
  - Stigma and discrimination may decrease self-esteem and self-value for MSM and transgenders, thereby causing them to engage in high-risk behavior, such as drug use, multiple sex partnerships, or sex without a condom.
  - Stigma and discrimination may isolate MSM and transgenders from others, including key sources of support and care for HIV.
  - Not respected by many people in the wider community, MSM and transgenders are often the target of sexual assault, which can increase the risk of or vulnerability to HIV.

C. "Put Yourself in My Shoes"

Objectives

- To understand that the first step in respecting differences is establishing empathy and considering the feelings of another person.
- To establish respect for differences and reflect on how to maintain one's own values and principles, while at the same time maintaining a respectful attitude toward others.

Materials

- A lot of enthusiasm

Time: 30 minutes

Instructions

- Introduce the topic by explaining that the exercise will allow participants to reflect on the differences among human beings.
- Ask the group to randomly place themselves in one of two separate circles. Instruct participants to implement the following instructions as rapidly as possible.
- Invite participants to remove one shoe and place it in a pile in the middle of their circle.

- The facilitator takes one shoe from each circle, leaving one less shoe than the number of participants in the circle.
- Ask each participant to take a shoe that does not belong to them. Whoever is left without a shoe loses the game. This individual will later help the facilitator identify the importance of appreciating and respecting differences.
- Ask participants to try to put on the shoe, which in some cases will not be possible. Ask people to try to walk and identify how it feels to wear someone else's shoe. After a brief moment, instruct participants to replace the incorrect shoes on the pile and recover their own shoe.
- Initiate collective reflection, posing questions such as the following:
  - "How did you feel when you took off your own shoe?"
  - "What did you experience when you put on someone else's shoe?"
  - "Were you afraid the other person might reject your shoe because it was old, big, small, ugly, or for other characteristics?"
  - "Is it easy or difficult to move about in someone else's shoe?"
- Remember to explore the difference in feelings among male and female participants, asking what happened in the cases in which the men put on women's shoes, and vice versa.
- Continue the exercise with analogies between the individual differences of the shoes and other differences (of sex, ethnicity, economic position, age) among the people, pointing out the diversity of shoes and feet.
- Conclude the exercise, asking the person who was left without a shoe—with his or her help and that of the group—to point out some ways in which respect for differences can be created.

Additional points of discussion for group facilitators:

- The phrase "put yourself in my shoes" may also prove useful in exploring the differences between men and women, MSM, gays and lesbians, and transgenders, and the need to understand the feelings of each sex and gender.
- It is important to point out that each person is unique and therefore different from everyone else, yet that diversity enriches us as human beings and should not be the source of inequalities.
- Remind the group that all the shoes are different but their individual value depends on their importance to each of us. The best shoe is the one that fits me best! At the same time, I should understand another person when "their shoe pinches."
- Sometimes, to understand the other person, we must "put ourselves in their shoes." We must respect his/her age, sex, personal circumstances, history, everything that makes him/her who he/she is, and in particular, that which makes him or her different from us.

D. Obstacles Related to Stigma and Discrimination in Service Provision

Objective

- To identify S&D in the provision of health services to transgenders and sex workers and to discuss related obstacles and barriers to service delivery.

Materials

- Flipchart sheets
- Markers
- Copies of Handout: case study on **Jenny** (following page)

Time: 1.5 hours

Instructions

- Divide participants into three small groups.
- Explain that each group will identify and discuss the stigma and discrimination faced by transgenders and sex workers when accessing health services and related obstacles and barriers to quality health service delivery. Encourage participants to think of situations they have experienced or witnessed, such as denial of services, mistreatment, or aggression. Allow 30 minutes for this portion of the activity.
    - Team 1 will work on personal obstacles faced by individuals, such as emotions, prejudices, or fears.
    - Team 2 will work on programmatic obstacles found in health services, such as guidelines, norms, procedures, or instructions.
    - Team 3 will work on policy-related obstacles, such as how laws or their absence hinder or limit quality of service.
- After 30 minutes, ask everyone to remain in their small groups and brainstorm ways to improve services in each of the three spheres addressed in the exercise. Allow another 30 minutes for this part of the activity.
- Ask each small group to present their work and open a discussion with the larger group on the results of the exercise.

HANDOUT: Case Study

Case study

Jenny is a transgender sex worker. She is visiting a health center in her neighborhood because the night before, while working in the street, a group of drunken young men threw a rock at her from a moving vehicle. Jenny and her companions ran after the car and were able to identify it. They called the police and a patrol car came. Jenny was badly injured and the police offered to take her to the hospital. On the way to the hospital, the police verbally assaulted Jenny and harassed her until they forced her to have sexual relations with them. After sexually assaulting her, they left her alongside the road unconscious.

Jenny is badly injured and emotionally very depressed from the encounters with the drunken men and the police. She has an injury over the right eyebrow, and during the rape the police introduced a bottle into her anus that left her with a serious anal injury. However, Jenny is most concerned that she may have acquired HIV or another sexually transmitted infection during the rape because the police did not use condoms.

At the health center, Jenny is received by a social worker. While the social worker is collecting Jenny's personal data before admitting her for emergency care, she expresses surprise at Jenny's feminine name. The social worker emphasizes that she needs to know her "real" name and not her professional name. Given her emotional state, Jenny does not have the energy to explain that Jenny is her name, considering that she chose it. Noticing how Jenny lowers her head and sensing that Jenny feels ashamed, the social worker tells her that what happened to her was the result of her bad life, and that if she didn't walk the street in women's clothing, such incidents would not happen.

The social worker tells Jenny that she doesn't believe that the police raped her and instead concludes that the incident occurred with a client.

Jenny feels continually worse, but she is finally able to see the doctor, who asks her to take off all of her clothes so he can examine her. He begins with the anal injuries. The site is still bleeding, but the doctor does not want to touch her to carry out a more thorough exploration that will verify whether there are more serious injuries. He tells Jenny to use her own hand to apply some cotton to the injury. Jenny asks whether he is going to check more thoroughly because she is concerned that it continues to bleed heavily. The doctor responds that it is not his obligation to be attending to "this type" of injuries and tells Jenny that she should request an appointment with his colleague, Dr. Pérez.

Jenny leaves and goes home crying. She decides to call a friend who will prepare a treatment with some plants that she knows will work to stop the bleeding.

IV. GENDER-BASED VIOLENCE (GBV)

Objective

- To define violence in general, gender-based and other types of violence, and the differences between them.

Materials

- Flipchart sheets and markers
- PowerPoint presentation: **Gender-based Violence** (Available at: www.healthpolicyinitiative.com.)
- PowerPoint presentation or flipchart with diagram depicting the **Cycle of Violence in Intimate Partner Relationships** and **A Conceptual Model of Structural Violence and Vulnerability to HIV and AIDS in MSM and Transgenders**
- Handouts: **Cycle of Violence** and **Conceptual Model of Structural Violence**, which follow this exercise

Time: 2.5 hours

Instructions

Part 1 (1.5 hours):

- Divide the group into 4 teams by counting off from 1 to 4.
- Ask each group to define the following concepts:
    - Team 1: What is violence?
    - Team 2: What is GBV?
    - Team 3: What are the differences between GBV and other types of violence?
    - Team 4: What are the types of GBV?

  Allow 15 minutes for this portion of the activity.
- After 15 minutes, tell participants that they will continue in their groups but they will now review and discuss specific case studies of an MSM or transgender person who has experienced violence. Give the Case Study of Person 1 to teams 1 and 2 and give the Case Study of Person 2 to teams 3 and 4.
- Then ask the teams to read their cases and discuss within their teams what types of GBV they represent. Allow another 15 minutes for this portion of the activity.
- Have them note the types of GBV on a flipchart sheet.
- After time is up, have each team share their findings with the larger group. Facilitate a discussion on how GBV against MSM and transgenders is similar to, yet not exactly the same as, GBV against women. Include the following points in the discussion:
    - How GBV in heterosexual intimate partner or couple relations is similar to GBV in homosexual intimate partner relations;
        - The same types and range of abuse typically occur, including: physical violence; sexual violence; isolation; economic abuse, such as ensuring that the survivor is dependent on the perpetrator; threats; and other emotional abuse.

        - Gender, masculine privilege, power, and control underpin GBV. While research and data on intimate partner violence in homosexual and transgender relationships is minimal, some evidence from the literature shows that the more "feminine" partner, or the one who takes on the anal receptive role, suffers from higher levels of this type of violence.

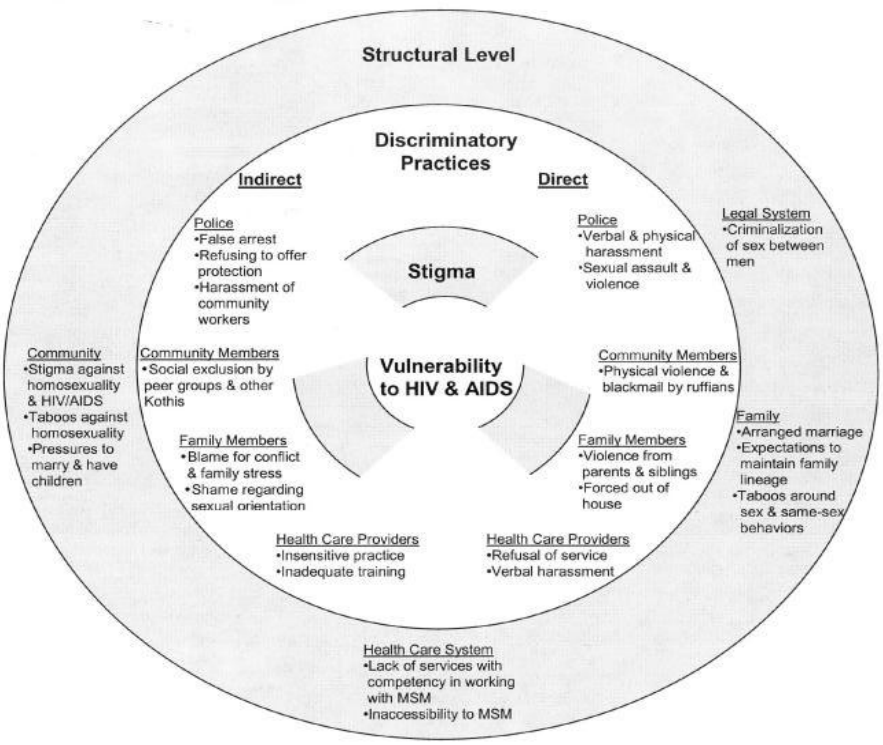
    - How rape of women is often similar to rape of MSM and TG
        - International research suggests that rape is predominantly an abuse of power.
        - Men may perceive a contradiction between expectations of being powerful stemming from societal ideals of manhood and a reality of lack of power due to other social forces.
        - Men may rape to have a transitory experience of power over women or those they perceive to be "feminine," i.e., MSM and TG.
    - Some forms of GBV against MSM and TG are extreme forms of stigma and discrimination for violating gender norms.

Close this section by explaining that these points and themes will be explored further in the next section, using data from international research.

Part 2 (1 hour):

- Present the PowerPoint presentation "Gender-based Violence." (Available at: www.healthpolicyinitiative.com.) Ask participants if they have any questions or need any clarifications.
- Briefly present the cycle of violence model from the handout **Cycle of Violence in Intimate Partner Relationships** on a flipchart or PowerPoint (prepared in advance). Ask the social workers in the group if they are familiar with the model and can share some experiences of clients who are living with this cycle of violence. Facilitate a discussion on how MSM and transgenders also may face similar dynamics of a cycle of violence in their intimate partnerships due to power imbalance or the subordinate status of feminized MSM or transgenders.
- Present the conceptual model for structural violence and vulnerability to HIV, as diagrammed below, on a flipchart (prepared in advance). Explain that the experiences and consequences related to stigma, discrimination, and violence against MSM and transgenders occur across all social and institutional contexts, including with the police, community members, family, and the healthcare system. Specific types of violence include the following:
    - Verbal and physical abuse, including rape and sexual assault by the police;
    - Rejection by heterosexual friends, schoolmates, and co-workers;
    - Stigmatization, shame, blame, and violence from within their own families, who might otherwise represent an invaluable source of support for people facing stigma, discrimination, and violence by the wider community, as well as support for living with HIV/AIDS; and
    - Stigmatization by healthcare providers, which can take the form of derogatory labeling, demeaning interactions, outright insults, breaches of confidentiality, and refusals of service."

A Conceptual Model of Structural Violence and Vulnerability to HIV and AIDS in MSM and Transgenders



Source: Chakrapani et al., 2007.

Facilitator Note

If time allows, you may choose to make this exercise more participatory by having participants build the structural violence conceptual model. To do so, simply draw the concentric circles and provide only the labels that follow: Vulnerability to HIV/AIDS, Stigma, Discriminatory Practices, and Structural Violence. Ask them to give examples for each circle/level.

Close by explaining that these multiple levels of stigma and violence that MSM and transgenders face lead to greater vulnerability to HIV and AIDS, which will be explained more thoroughly in the next session's presentation. Distribute the Handouts **Cycle of Violence in Intimate Partner Relationships** and **A Conceptual Model of Structural Violence**, which can be found following the case studies.

HANDOUT: Case Study: Person 1

Case Study: Person 1

It is a busy early afternoon in the local STD (sexually transmitted disease) clinic. The waiting room is full of clients. Paco is a 30-year-old man who has sexual relations with other men and sometimes sells sex in a local park, links up with clients of the neighborhood cantina, or trades sex for a night of drinks or sexual favors. He generally lasts only a few weeks with most of the partners he hooks up with, but occasionally longer.

During the past year, Paco's relations have included a strong relationship with one particular partner. Paco has felt that the relationship with this partner could turn into something more long-lasting and he likes the security and intimacy that has been developing in this relationship. They have gone on vacations together and recently took a trip to spend a week together. At the same time, Paco has had some mixed feelings about the relationship. He feels he has reached a state of more intimacy and stability in the relationship, but his partner is starting to rule Paco's life. This has included asking Paco to do sexual acts that make Paco feel like he is being used. During their recent vacation, when Paco said he did not feel comfortable, his partner slapped him around hard enough to hurt him (joking that this was how he showed his love) and later insisted that Paco fulfill his wishes. The next day his partner brought Paco a gift to say he was sorry.

Paco takes pride in generally taking care of his health and his body and regularly uses condoms with other partners and clients. However, he and his current partner have not used condoms since the first month they started seeing each other. This past month, Paco has had a burning sensation when he urinates. He suspects it is something he caught from his partner. He wants to be tested so that he can get treatment if he needs it but he is also thinking about his partner's possible reaction.

Paco is now sitting in the clinic, waiting to be tested to determine whether he has a sexually transmitted infection.

HANDOUT: Case Study: Person 2

Case Study: Person 2

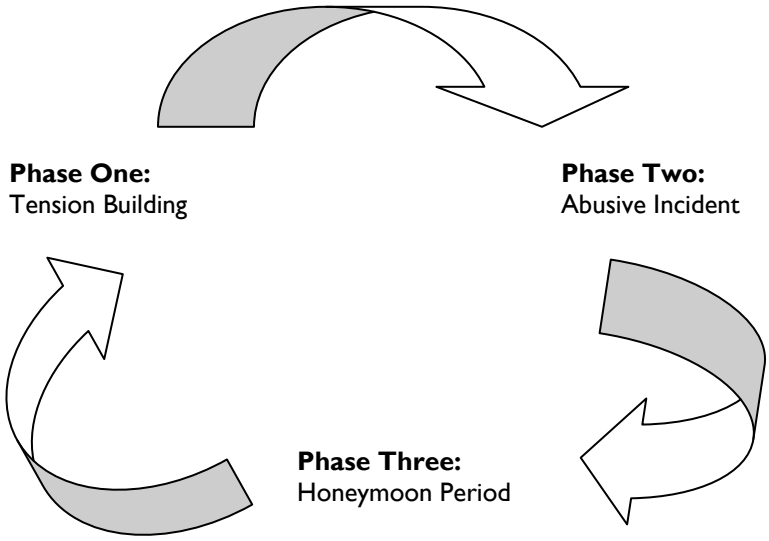
Luis was born a boy 20 years ago but sometimes dresses as a woman and has wanted to change his identity and maybe eventually, his body, to become a woman. He generally has feminine mannerisms, regardless of how he is dressed. Luis lived with his parents until a year ago. A year ago, his father saw Luis in the park dressed as a woman. When Luis came home, his dad beat Luis furiously and threw him out of the house, telling him that from that moment on Luis was no longer part of the family.

Luis packed a few things and moved in with some friends. Luis has been depressed and is very afraid about what is going to happen from now on. Until a few weeks ago, however, his situation had been more or less okay. The situation with the friend with whom Luis shares a home has worked pretty well. Luis has been able to obtain enough food and make enough money to live by selling sexual services and maintaining relations with various generous clients.

Three weeks ago, in the afternoon when Luis was heading to the park, a group of young men showed up from an outlying neighborhood with a very aggressive attitude, saying they were there to "show men how to be men, and women how to be women." They picked Luis out and separated him from the others, and after brutally beating her/him, they raped him. Since the assault, Luis has closed himself off in his room, without sleeping or eating. Luis continues to be in a lot of pain but would be feeling better if he knew for certain he hadn't caught an STD in the attack.

His roommate has convinced Luis to go to the local clinic for a general check-up. Luis is now sitting alone in the clinic waiting room.

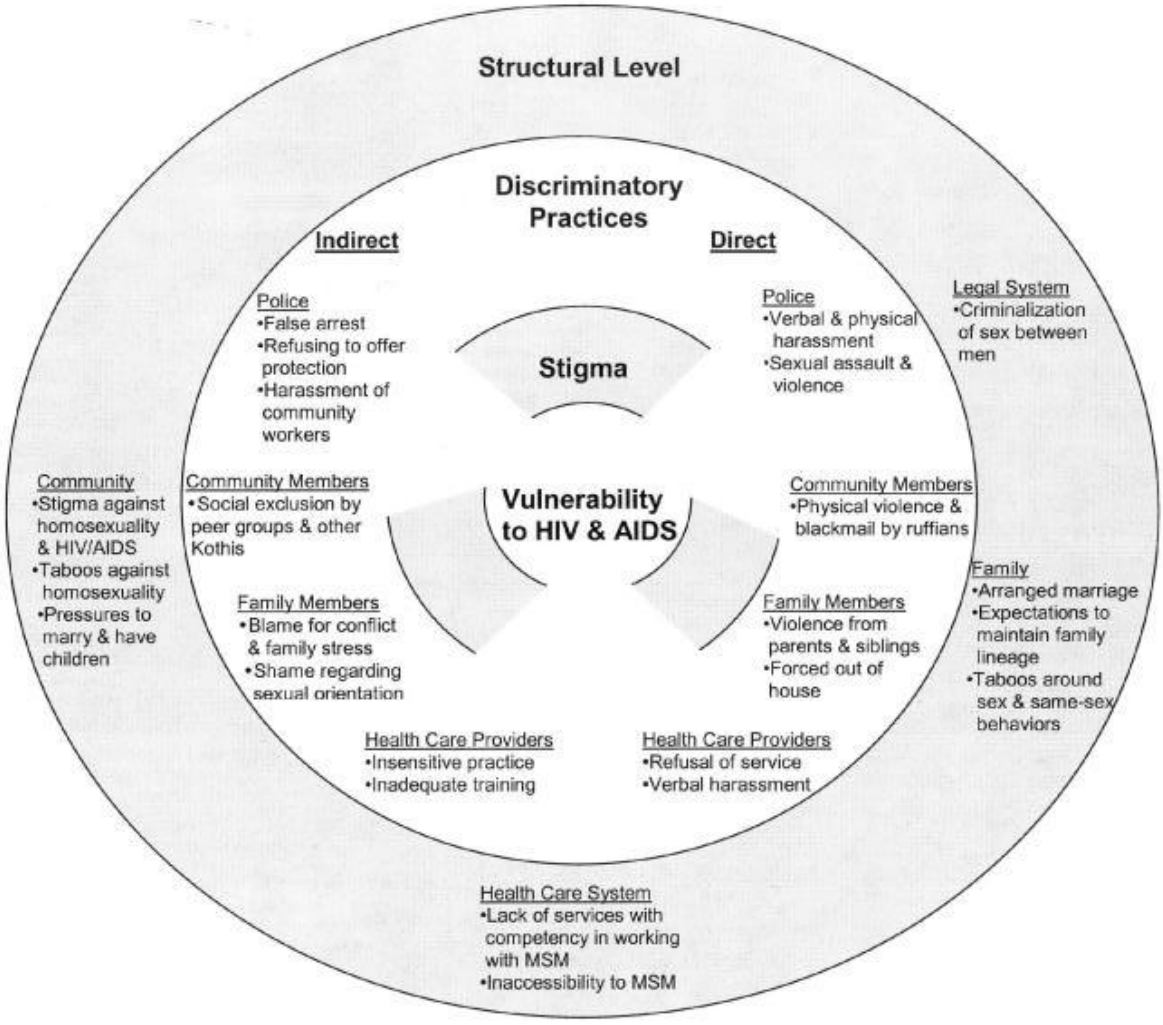
HANDOUT: Cycle of Violence in Intimate Partner Relationships



Phase One: Tension Building	Phase Two: Abusive Incident	Phase Three: Honeymoon Period
• Abuser experiences increased tension • Survivor minimizes problems • Abuser increases threats • Survivor withdraws • Abuser controls more • Tension becoming intolerable • Survivor feels that he/she must be very careful not to upset the abuser • Poor communication	• Abuser unpredictable: believes he is losing control • Survivor is helpless; feels trapped • Abuser highly abusive, incident occurs	• Abuser is loving, apologetic, and attentive • Survivor has mixed feelings • Abuser is manipulative • Survivor feels guilty and responsible • Abuser promises change • Survivor considers reconciliation • Survivor often recants/minimizes abuse

Adapted from Office of the Kansas Attorney General, Domestic Violence Unit.

HANDOUT: A Conceptual Model of Structural Violence and Vulnerability to HIV and AIDS in MSM and Transgenders



Source: Chakrapani, et al. 2007.

V. GENDER-BASED VIOLENCE, STIGMA AND DISCRIMINATION, AND HIV

Objective

- To identify the consequences of GBV and health for MARPs, focusing on HIV.

Materials

- PowerPoint presentation: **Gender-based Violence and Other Forms of Stigma and Discrimination among MARPs: Prevalence and Links to HIV/AIDS** (Available at: www.healthpolicyinitiative.com.)
- Resource Sheet: **Gender-based Violence: Direct and Indirect Pathways to Sexually Transmitted Infections**. Prepare flipchart with this diagram before the session
- Handouts: **Data on GBV in MARPs** and **What Are the Links between GBV and HIV in MARPs**

Time: 2 hours

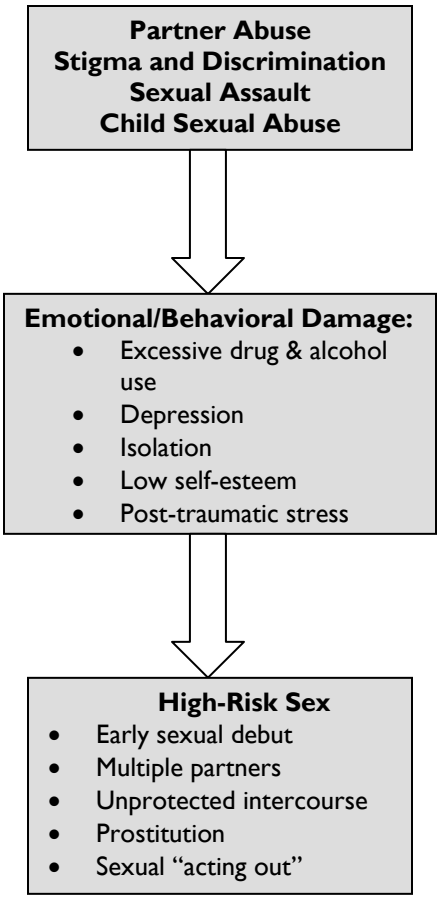
Instructions

- Present PowerPoint: **Gender-based Violence and Other Forms of Stigma and Discrimination among MARPs**.
- Display flipchart with diagram of **Gender-based Violence: Direct and Indirect Pathways to Sexually Transmitted Infections** from resource sheet found at the end of this activity. Explain the pathways from GBV to emotional/behavioral damage to high-risk sex.
- Distribute the Handouts **Data on GBV in MARPs** and **What Are the Links between GBV and HIV in MARPs**.
- Ask participants if they have any questions or if anyone recognizes the trends discussed in any clients of theirs and would like to share their experiences.

Facilitator Note

For background reading on the magnitude and dynamics of gender-based violence among MARPs and its impact on vulnerability to HIV, see Betron and Gonzalez-Figueroa, 2009.

FACILITATOR RESOURCE SHEET: Gender-based Violence: Direct and Indirect Pathways to Sexually Transmitted Infections



Adapted from: Heise et al., 1999, p. 14.

HANDOUT: Data on Gender-based Violence in Most-at-Risk Populations

USAID FROM THE AMERICAN PEOPLE | HEALTH POLICY INITIATIVE

Most-at-risk populations (MARPs) suffer from high rates of sexual coercion and gender-based violence (GBV). Being feminized is often associated with violence, and identifying oneself as female, openly gay, or taking a receptive role can significantly and independently raise the chances of sexual coercion. Violence against MARPs stems from stigma and discrimination originating from groups such as intimate partners, community and family members, and even the police.

Intimate partner violence comparable to heterosexual relations

- Of 535 male, female, and transgender sex workers in the United States, about 50 percent reported experiencing domestic violence
- Among Puerto Rican and Latino MSM in the United States, about half have experienced some form of intimate partner violence

MARPS suffer from high rates of sexual coercion

- 18.4 percent of 2,000+ MSM in Thailand reported being coerced into sex, with 67 percent of those coerced more than once
- 90 percent of 1,000 sex workers (SWs) in Cambodia have been raped in the last year
- 63 percent of 475 SWs in South Africa, Thailand, Turkey, the United States, and Zambia have experienced sexual abuse
- Of the 65 percent of 124 male and transgender sex workers that said they had been raped, 87 percent of those felt they were raped because they were effeminate (Bangladesh)

Police are common perpetrators of violence

- 48 percent of 124 transgenders in Bangladesh reported sexual assault or rape by police, 65 percent by gangsters
- Reports from around the world indicate that police extort money from SWs (female, male, and transgender)
- *"You are just whores—you can't be raped."* (Police in South Africa)

Photo Credit: Britt Herstad

I am srey sraos (transgender). I do this (sex) work for 3–4 years because my family discriminates against me…I have been abused by policemen working in the park and by male clients, such as hitting and rape without condom and without pay."
(Transgender sex worker in Cambodia)

More information can be obtained at:
USAID | Health Policy Initiative
Futures Group
One Thomas Circle, Suite #200, NW
Washington, DC 20005
www.healthpolicyinitiative.com

HANDOUT: What Are the Links between Gender-Based Violence, HIV, and Most-at-Risk Populations (MARPs)?

USAID FROM THE AMERICAN PEOPLE | HEALTH POLICY INITIATIVE

MARPs suffer from high rates of sexual coercion and GBV, which puts them at risk for unprotected sex and sexually transmitted diseases. In Kenya, 500 MSM who said they had been either verbally or physically abused reported a lower likelihood of using condoms or negotiating for safe sex. Because violence reduces the chances for safe-sex negotiation and condom use, HIV prevalence among MARPs is high. Many of those affected by GBV, sexual coercion, and the stigma and discrimination (S&D) of being openly gay or feminized also report intimidation by the police. Linking GBV, HIV, and MARPs can help us understand how to draft better strategies for their health concerns.

Decreased condom use in Cambodia:

- 90 percent of a group of 1,000 SW in Cambodia reported being raped in the last year, with half of transgenders coerced into activities without a condom

GBV and unprotected intercourse:

- In Brazil, of 1000+ MSM, those having experienced sexual violence in the past have twice the relative risk of unprotected sex
- In Kenya, MSM who had experienced verbal, physical, or other abuse were significantly more likely not to use a condom at last intercourse

Violence and its effects on health:

- In the United States, MSM experiencing intimate partner violence were less likely to get tested for HIV; those tested reported more abuse and lack of emotional support. Compounding this evidence is the high rates (2–3 times) of mood disorders and physiological trauma

Decreased health-supportive behavior:

- Broader S&D and related loneliness may push MARPs to increase risk behavior, especially when local health systems deny access to treatment
- Internalized S&D and enacted S&D by healthcare providers limits access to HIV services

Photo: Phongsak Sakhunthaksin

In this picture, workshop participants in Thailand—transgender community groups and health providers—discuss gender-based violence, its links to HIV/AIDS, and how their communities can address these issues.

THE EFFECTS OF STIGMA AND DISCRIMINATION

Some countries like the Philippines often perceive condoms as evidence of prostitution:

"I like to have plenty of condoms in my bag, but [if] I see the police, I throw my bag away."

More information can be obtained at:
USAID | Health Policy Initiative
Futures Group
One Thomas Circle, Suite #200, NW
Washington, DC 20005
www.healthpolicyinitiative.com
Contact: Myra Betron
mbetron@futuresgroup.com

VI. RESPONDING TO GBV IN MSM AND TRANSGENDERS: THE ROLE OF THE HEALTH SECTOR AND OTHER SECTORS

Objective

- To identify the role of the health sector and other sectors in GBV response.

Materials

- Flipchart sheets
- Markers
- Copies of Handout: **What Health Providers Can Do about Gender-based Violence**

Time: 2 hours

Instructions

- Ask participants to number off from 1 to 5 to form 5 teams. You may adjust numbers as needed, depending on the number of participants.
- Each team should reflect on and write their responses to one of the following questions on a flipchart sheet:
  - What have they identified in their work about GBV and the MSM/TG population?
  - To their knowledge, what has been the role of the different sectors in response to GBV in the MSM and transgender populations (health sector, legal-judicial sector, community, social sector, nongovernmental organization (NGO) sector)?
  - What can health providers do to help survivors of GBV? **Facilitator Note:** If participants are having trouble with this question, choose some examples from the following Handout **What Health Providers Can Do** to get them started.
  - What are the barriers and challenges that health providers face in trying to support GBV survivors?
  - What types of support do service providers need to provide care for GBV survivors?
- Ask participants to share with the full group their reflections on experiences from their daily activities, from their professional and personal points of view.
- Distribute and review the Handout: **What Health Providers Can Do about Gender-based Violence**.

HANDOUT: What Health Providers Can Do about Gender-based Violence

(1) Design the necessary responses for contributing to the well-being and safety of abused individuals.

(2) Treat the effects of GBV among MSM and transgenders.

(3) *Routinely screen for violence against MSM and TG, ideally when you can ensure the responses and treatment mentioned above*.

(4) *Collect data* on cases of violence against MSM and TG to better understand trends, meet client needs, and use for advocacy.

(5) *Advocate for increased support and services* from government and donors to be able to strengthen and expand upon existing services and programs.

(6) *Monitor and evaluate related services within your health setting* to improve and ensure quality of care.

(7) Offer alternative concrete and realistic options to clients.

(8) Recognize the need to make changes in the health system to offer an ideal responsive and comprehensive solution to the situation of gender-based violence.

Sources: Claramunt, 2005, p. 33; Heise et al., 1999, p. 36.

VII. BEST PRACTICES IN GBV SCREENING

Objective

- To familiarize participants with best practices in GBV screening.

Materials

- PowerPoint presentation: **Emerging Best Practices in Screening for Gender-based Violence** (Available at: www.healthpolicyinitiative.com.)
- Copies of Handout: **Strengthening Health Service Responses: Lessons Learned**
- Flipchart sheets and markers

Time: 2 hours

Instructions

- Present the PowerPoint: **Emerging Best Practices in Screening for Gender-based Violence**. Distribute copies of the accompanying handout.
- Lead a brainstorming session with participants on how they define "screening" in the context of their clinical experience.
- Ask participants which elements have proven most successful in GBV screening. Ask them to identify other best practices to screen for GBV within the clinical system and the community.
- Write on a flipchart sheet each of these identified elements, differentiating those located within the clinical setting vs. the community.
- Encourage reflection on the reasons these elements have facilitated success in GBV screening.
- Discuss the possible differences in results for MSM, transgenders, and sex workers.
- Distribute copies of the Handout **Strengthening Health Service Responses: Lessons Learned**.

Facilitator Note:

For background reading on lessons learned from screening for intimate partner violence, see Bott et al., 2004. Review Chapter 3 to prepare for this session.

HANDOUT: Strengthening Health Service Responses: Lessons Learned

Globally, health systems and providers have only recently begun to tackle the challenge of responding to physical and sexual abuse. Most violence interventions in healthcare settings—with the exception of a handful in the United States—have not been formally evaluated, and pilot interventions in resource-poor settings are just beginning. There is an urgent need for more demonstration projects, with thorough evaluation, to determine what works or does not work in different settings. Nonetheless, some tentative lessons have emerged:

(1) **Do more than train.** While training healthcare providers is important, training alone is seldom enough to change providers' behavior toward survivors of gender-based violence. Although training can improve providers' knowledge and practice in the short term, its impact generally erodes unless a variety of other measures also are implemented that support and sustain new approaches.

(2) **Adopt a systems approach.** Achieving lasting change requires transforming the health system itself, as well as changing the behavior of individual providers. When managers, administrators, and the structure of the healthcare system encourage and reward new, caring behavior toward survivors of abuse, providers will feel better able to recognize and address violence.

Adopting a systems approach usually involves changes in norms, policies, and protocols to encompass a clear response to gender-based violence; infrastructure upgrades to ensure private consultations; training all staff (including managers); ensuring that providers have adequate resources, such as referral networks and directories; and strengthening the ability of staff to provide emergency services, such as danger assessment, safety planning, emotional support, sexually transmitted infection (STI) prophylaxis, and emergency contraception. In settings where adequate referral services do not exist, health programs sometimes offer specialized services in-house, such as counseling, legal aid, and women's support groups.

(3) **Make procedural changes in client care.** Often, making simple procedural changes such as adding prompts for providers on medical charts (e.g., stickers asking about abuse or a stamp that prompts providers to screen) or including appropriate questions on intake forms and interview schedules can encourage attention to gender-based violence.

For example, in one U.S. study, identification rates almost doubled after staff were given a one-hour presentation on gender-based violence and a violence screening question was added to the emergency department client record chart. Evaluation showed that the addition of the chart prompt, rather than the training, made the difference. In another U.S. study, identification of abused women in a primary care clinic rose from none to 12 percent when a single question on abuse was added to the client health history form.

(4) **Confront underlying attitudes and beliefs.** Most training programs for healthcare workers have focused on the clinical management of survivors. This approach yields limited results, however, because providers themselves generally share the same biases, prejudices, and fears regarding abuse as the society at large. As programs have gained experience, it has become clear that providers must examine their own attitudes and beliefs about gender, power, abuse, and sexuality before they can develop new professional knowledge and skills about dealing with survivors.

(5) **Redefine success.** Health workers often feel reluctant to address cases of gender-based violence because it is a problem that cannot easily be cured, or sometimes even addressed. In response, some training projects have tried to help the provider reframe their role from "fixing" the problem and dispensing advice to providing support. Revising expectations in this way has helped

providers to overcome feelings of resentment and helplessness in addressing gender-based violence.

(6) **Provide opportunities to model new behavior.** Two major barriers to asking clients about abuse are providers' belief that violence is uncommon among their clients and their fear about how the clients will respond. Opportunities to practice new behavior can help overcome both barriers. In working with medical students, for example, Pakistani physician Fariyal Fikree often issues the following challenge: “Go out and ask your next five clinic clients a simple screening question for abuse. With this direct experience base, you will be in a better position to evaluate the utility of this practice.”

This exercise breaks down the students’ resistance, replaces assumptions with experience, and stimulates their interest in learning more about gender-based violence. Generally, students come back from the experience amazed at how many of their clients disclosed abuse and how willing they were to discuss such matters.

(7) **Be strategic about where you start.** Changing health systems is difficult. Thus, the best practice is usually to start where success is most likely. Often this strategy means choosing to undertake pilot interventions first in settings where there is substantial internal and external support for change.

Internally, it is important to gain the commitment and support of top managers early. Efforts to integrate concern for sexuality into family planning programs have shown that institutional support is absolutely essential to program success.

Externally, it is best to undertake pilot interventions where support and referral services for abuse survivors already exist. This will not be possible in all instances but, given that there are so few pilot initiatives in resource-poor settings at this point, it makes sense to begin where there are community resources already in place.

(8) **Plan for staff turnover.** In most health systems, particularly in developing countries, staff members routinely rotate in and out of clinics and other health centers. Thus, policies on violence must be institutionalized, and training will be needed for new staff members on a continuing basis.

(9) **Follow up.** Programs should provide continuing support to individuals and institutions attempting to reform their response to domestic violence. Projects that have attempted to spark change by using a “train-the-trainer model”—inviting providers to attend a centralized training and then expecting them to duplicate the training in their home setting—have generally found that such schemes do not work well without substantial continuity and support.

Adapted from Heise et al., 1999, p. 36.

VIII. PRESENTATION OF THE SCREENING TOOL

Objective

- To familiarize participants with components of the tool, its application, and its review, using group contributions.

Materials

- Copies of the **Screening Tool to Identify Violence against MSM and TG** (see Annex). (You may choose to adapt this version to better fit the context of your service setting, either prior to or during the training, which can then be done with the participants.)
- Copies of other screening and clinical history forms used in clinics, where relevant and available

Time: 1 hour

Instructions

- Begin with a presentation of the screening tool.
- Explain the objective and purpose of the tool. If you choose, explain how the Health Policy Initiative developed the tool, based on the project background in the introduction to this manual.
- Tell participants that the tool should/will be adapted to the needs of their health settings.
- Present the components of the tool.
- Explain the role of the person applying the tool, guiding them through the instructions in the tool itself. Note in particular, the need to
  - Explain the purpose of the tool to the client;
  - Continue with the questions only if clients agree that they are comfortable; and
  - Ask the questions in a confidential manner and space.
- Have participants count off from 1 to 6 to form 6 teams. Numbers can be adjusted slightly, depending on the total number of participants.
- In their teams, pass out the copies of the tool and ask participants to review them with the purpose of providing feedback on the tool and its application. Instruct them to focus on their doubts, suggestions, and any details regarding the tool's application. Participants have 20 minutes to discuss the tool.
- In a plenary session, each team should share their feedback. Then facilitate a discussion regarding participants' feedback.

IX. DEVELOPMENT OF A REFERRAL SYSTEM

Objective

- To develop a referral system of existing services that address GBV.

Materials

- PowerPoint presentation: **Steps to Develop a Referral System and Directory** (Available at: www.healthpolicyinitiative.com.)
- Handout: **Steps to Develop a Referral System and Directory**
- Handout**: Interview Guide For Developing a Referral Directory**
- Flipchart sheets and markers

Time: 1 hour

Instructions

- Begin the activity by explaining to participants the objective of a referral system, as follows: "A referral system for gender-based violence offers the client all necessary services, referring him/her to the proper area of care, for example, medical, legal, psychological, and shelter."
- Explain that, during the screening process, he/she may identify that the client needs services such as counseling, a safe place to stay, or another specialized medical service that he/she is not able to offer. As a health provider, he/she can play an important role in making clients aware of available specialized services for MSM or TG, including those that might serve the needs of those experiencing violence, stigma, and discrimination. To facilitate the referral process to outside organizations, providers need to be aware of what services exist in their communities. One way of doing this is by creating a directory of organizations that provide services to survivors of violence. This will assist providers in helping clients decide where to seek the necessary services according to the type of service offered.
- Present the PowerPoint **Steps to Develop a Functional Referral System and Directory**.
- Next, ask participants to gather in small groups according to their location of origin and draw a map of their community on a large sheet of paper, big enough to show all relevant characteristics of the community.
- Ask participants to identify on the map those locations, organizations, and groups that are significant to the community. Give them thirty minutes for this exercise.
- Have participants use different symbols to show the distinct types of locations, organizations, and groups. These could include economic, political, educational, health, recreational, cultural, human rights, legal, and religious organizations. They also could encompass shelters, markets, stores, community centers, local government offices, schools, clubs, pharmacies, health centers, sports facilities, plazas, places frequented by musicians, churches, and mosques, among others.
- Ask them to mark locations where they could give GBV-related talks and places with GBV prevention services they could include in the referral flowchart.
- Next, participants should discuss what types of services their communities offer, how accessible they are, and their quality.
- Ask participants to develop a referral flowchart showing the various types of GBV services available in the community and which organizations refer and counter-refer to each other. Allow another 15 minutes for this.

- Emphasize that, for a referral system to work, it is necessary to develop a referral directory and update it constantly, making sure that the directory information is up to date and accurate. Explain that the referral directory should, at a minimum, include: name of organization, summary of services provided, address, contact person, and phone number.

- Distribute the handouts, **Steps to Develop a Referral System and Directory** and **Interview Guide for Developing a Referral Directory.** Explain to participants that the exercises they just completed were just simulations. When they return to their communities/clinics, they should follow the steps in the handouts, using the organizations they identified in their maps as a starting point. Once they have completed the steps and interviewed various organizations, they will re-visit the flowchart to make it more complete.

HANDOUT: Steps to Develop a Referral System and Directory

Step 1. Determine the geographic area to be included in the referral network. Where do most of your clients live? How far can they travel to seek services? If the institution has clinics in several parts of the city or the country, each site may need a different directory to ensure that the services are geographically accessible.

Step 2. Identify institutions in the area that provide services relevant for survivors of violence. This list can include medical, psychological, social, and legal organizations, as well as local police contacts. You also may want to consider including institutions that address secondary issues related to violence, such as alcohol and drug abuse, and those that offer services for children who have experienced or been exposed to violence. Each institution may be able to name other local organizations to include.

Step 3. Call or (ideally) visit each institution to gather key information about its services. To ensure that you gather up-to-date information about each institution and see the services firsthand, it is best to conduct a brief, informal interview in person with a staff member from the organization providing services. After describing your own work in the area of gender-based violence, you should ask a series of key questions to identify whether and how the institution can be used for referrals.

Step 4. Organize the information into a directory. You can organize information about referral institutions in different ways (for example, by location, type of service offered, etc.). If the number of referral services available in the community is small, then the directory may be very concise. If it is large, an index of institutions by name and type of service can make the directory more user friendly. The referral directory should, at a minimum, include: name of organization, summary of services provided, address, contact person, and phone number.

Step 5. Distribute the directory among healthcare providers. Ideally, a health program should distribute a copy of the directory to each healthcare provider so that all staff members who interact with clients have access to this information. If resource constraints make it difficult to print this many copies, then every clinic should have a directory available to staff in a convenient, accessible place.

Step 6. Gather feedback from providers about how well the directory is working. Managers should take the time to discuss the directory with providers soon after it is introduced to make sure that the format is workable and that the providers have not had any difficulties with the process of making referrals. Once providers have used the directory for a period of time, they may know what referral services are accessible to their clients and which are not, for example.

Step 7. Formalize relationships with referral institutions. After creating a directory, the next step is to create more formal partnerships with other agencies. This may include setting up formal referral and counter-referral systems or collaborating on projects. In some cases, you may be able to negotiate discounted prices for their clients. Ideally, organizations involved in a referral network should be in contact with one another on a regular basis to give feedback, stay current, and provide at least minimal follow-up to selected cases and other issues related to this work.

Step 8. Update the information in the directory on a regular basis. It is essential for health programs to update the information in the directory on a regular basis (for example, every six months) to avoid giving clients misinformation. Not only can misinformation waste time, money, and energy, it can also put clients at risk in a number of ways. Remember that services can close, relocate, raise their costs, or change their procedures, especially in resource-poor settings where funding is scarce.

Source: Bott et al., 2004, p. 61.

HANDOUT: Interview Guide for Developing a Referral Directory

First, gather practical information, for example:

- What is the full name and acronym of the institution?
- What is the contact information (address, phone numbers, fax, email, etc.)?
- What is the name and title of the director of the organization?
- What is the name and title of the person providing information?
- What types of services are available at this organization?
- What are the hours of operation?
- What is the process by which clients can obtain services? For example, is an appointment required?
- Can clients get service by dropping in during open hours?
- What is the cost of services?

Then ask more specific questions about the types of services available for MSM and transgenders who experience gender-based violence, for example:

- Do you currently provide services designed specifically for MSM or TG who have experienced gender-based violence?
- If so, what types of gender-based violence do you address?
- Do you have any information about the profile of survivors of gender-based violence that you serve?
- If your organization does not specifically offer services for MSM or TG who have experienced violence, what services do you offer that might be useful to MSM or TG in that situation?
- Do you provide direct services or do you primarily refer MSM or TG to other organizations? To what other organizations do you refer clients?
- What criteria do you use for making referrals?
- Do you have any formal referral arrangements with other organizations? If so, how do they work?
- What other activities does your organization undertake to address the issue of gender-based violence (e.g., research, advocacy, educational campaigns, sensitization, training, production of materials, etc.)?
- Do you have educational or informational materials about gender-based violence that you would be willing to share with other organizations working on these issues?
- Do you know of other institutions in this area that provide services that could be helpful for MSM or TG who have experienced violence?
- Is your organization a member of any networks of organizations that work on the issue of gender-based violence?

Adapted from: Bott et al., p. 62.

X. CONSTRUCTION OF A SAFETY PLAN

Objective

- To familiarize participants with the objectives and principles of a safety plan and orient them on how to advise clients in developing a safety plan.

Materials

- PowerPoint presentation: **What Is a Safety Plan?** (Available at: www.healthpolicyinitiative.com.)
- Copies of the Handout: **Personal Safety Planning**, found at the end of this activity
- Flipchart sheets to record suggested steps or basic elements of a safety plan

Time: 1 hour

Instructions

- Start the session making reference to the responses to questions from the screening tool, in particular questions 3.1, 3.2, and 3.3, which ask about the client's risk of being attacked by their aggressor.
- Explain that in accordance with the responses to these questions, the service provider should identify the level of risk of abuse or death of the client. Offer the following examples of indicators of high risk of violence for the client:
    - Frequent abuse with significant possibility of suffering major injury (for violence in intimate partner relationships);
    - Separation (for violence in intimate partner relationships);
    - High frequency and severity of the violence;
    - Aggressor threatening to kill the client;
    - Client mentioning suicidal wishes or thoughts; and
    - Other symptoms of depression.
- Emphasize to the group that if at all possible, professionals who have the appropriate specialized skills and experience should be the first line of response for their clients who suffer from gender-based violence. Continue to explain that health service providers should create a safety plan only when the client is at risk of death and/or
    - No specialized services exist;
    - Existing services are not available; or
    - Services exist and are available, but the client does not accept the referral.
- Show the PowerPoint presentation on the objectives and principles of a safety plan. At the end, ask participants if they have any questions.
- Facilitate a brainstorming session and discussion on possible special safety strategies for each of the following groups:
    - MSM
    - Transgenders
    - Sex workers

- Write responses on flipchart sheets. Some examples you can offer as facilitator are presented in the table in the resource sheet on the following page. If you wish, the table may be prepared ahead of time.
- To close, remind participants of the following:

The survivor of violence is the expert on his/her situation, his/her problems, the level of threat of the aggressor, and the risks for him/herself and his/her children. Take into account and respect his/her opinions, ally yourself with him/her, and look for the answers together.

FACILITATOR RESOURCE SHEET: Safety Strategies for HIV Risk Populations Facing Violence

Possible Safety Strategies for Populations at High Risk of HIV		
MSM	**Transgenders**	**Sex Workers[3]**
• Identify emergency phone numbers, formal institutions, or friends you can seek help from, e.g., an organization dedicated to support for MSM or gays. • Put together an emergency bag with money/checkbooks, extra car keys, medicine, and important papers, such as identification cards and medical cards. Keep it somewhere safe and accessible, such as with a trusted friend. • Establish a self-help group and exchange phone numbers for moments of crisis.	• Identify emergency phone numbers, formal institutions, or friends you can seek help from, e.g., an organization dedicated to support for transgenders. • Put together an emergency bag with money/checkbooks, extra car keys, medicine, and important papers, such as identification cards and medical cards. Keep it somewhere safe and accessible, such as with a trusted friend. • Establish a self-help group and exchange phone numbers for moments of crisis.	• Develop a list of violent clients and share it among the network of sex workers. • Establish a self-help group and exchange phone numbers for moments of crisis. • Learn some self-defense strategies. • Always have emergency telephone numbers on hand. • If a client is difficult and threatens you, make an excuse and get out of the situation. • Never work alone. • If possible never go to the client's house. • Carry paper and pen with you to write down the license plate information of your client's car.

[3] Source: SWEAT, 2004.

HANDOUT: Optional Self-Reflection Exercise

If time allows, request that participants do the following exercise.

Development of a Safety Plan for "Carmen"[4]

Carmen has been identified as being in a potentially violent situation. Every day she is harassed by the police, and last week one policeman cornered her in the park, threatening to force sex on her. According to the information provided, answer the following questions:

- What is the primary goal of Carmen's safety plan?
    - (Response: Increase his/her safety, knowledge, and skills for protecting herself against violence.)
- What are the main tasks you should undertake before developing a plan with Carmen?
    - (Response: Identify whether there is a support group for MSM, transgenders, or sex workers and consult with them for ideas on what to do.)
- What information could prove useful in completing the risk evaluation?
    - (Refer to questions 3.1, 3.2, and 3.3 from the screening tool regarding the aggressor's proximity and threats and the client's suicide risk.)
- Develop a proposed safety plan for Carmen. Take into account available resources and materials necessary for appropriate referrals.

[4] Adapted from: Claramunt, 2005.

XI. USE OF THE SCREENING TOOL

Objective

- To review and practice the role of the health service provider with regard to the use of the screening tool with MARP populations.

Materials

- Flipchart sheets and markers
- Resource Sheet: **Guiding Principles for Treatment of Survivors of Gender-based Violence**
- Copies of the screening tool for each participant

Time: 1 hour

Instructions

- Distribute the handout of the guiding principles. Review **Guiding Principles for Treatment of Survivors of Gender-based Violence.**
- Have participants count off from 1 to 4.
- Tell those with numbers 1 and 3 that they will represent service providers. Those with number 2 will represent the role of an MSM, and the number 4s will represent the role of a transgender person. Ask numbers 1 and 2 to pair off and numbers 3 and 4 to pair off.
- Tell participants that they have 15 minutes to practice using the screening tool. Suggest they be creative in representing their characters—they should simulate the use of the screening tool with a client in a routine consultation.
- Tell participants to be attentive to the role of the service provider while using the tool. Remind them to follow the guiding principles you just reviewed.
- After completing the representations, ask participants acting as the client to share their reactions to the role of the health service provider, indicating whether his/her attitude was that of an advisor, lawyer, psychiatrist, or psychologist, or if he/she only presented a diagnostic attitude. Then ask those who acted as the service provider to share anything they found challenging, problematic, or confusing in applying the tool.
- Summarize the challenges and concerns generated regarding the use of the tool on a flipchart as participants provide comments.
- Close with a reflection focused on the importance of a health service provider's positive and comfortable attitude during the use of the tool.

HANDOUT: Guiding Principles for Treatment of Survivors of Gender-based Violence

- Recognize the different forms of gender-based violence as a violation of human rights of MSM and transgenders.
- *Acknowledge and listen* to clients' experiences with GBV in a non-judgmental and compassionate way.
- Recognize that the perpetrator is responsible for initiating abuse and also for ending it.
- *Believe and validate his/her experiences*. Tell her that he/she is not alone.
- When asking about or discussing experiences of GBV, ensure *privacy and confidentiality* by making sure discussions take place in a private space without others around (unless the client requests other people).
- *Help the client plan for his/her safety* by identifying where he/she might go if in immediate need of help or imminent risk of violence. Know the resources in the community, such as a shelter or counseling services.
- *Become educated about laws* relevant to violence and S&D against MSM and TG.
- *Educate yourselves about gender-based violence and explore your own biases and prejudices. E*ncourage *ongoing sensitization and training* on GBV for yourselves and your colleagues.
- *Refer clients* to appropriate specialized services for those experiencing GBV. Before doing so, reach out to those services to develop strong referral networks to ensure that clients are able to access them with ease.
- *Above all, respect the client's autonomy.* Respect his/her right to make decisions about his/her life. He/she is the expert on his/her life.

Adapted from: Claramunt, 2005, p. 33; Heise et al., 1999.

XII. FOLLOW-UP AND NEXT STEPS

Objective

- To review upcoming activities, tool application, and referral evaluation and monitoring.

Materials

- Flipchart sheets and markers
- Resource Sheet: **Questions Guide**

Time: 1 hour

Instructions

- Generate brainstorming on ideas for a list of upcoming activities for implementation (e.g., finalize the referral directory). Familiarize clinic personnel on development of the finalized directory before applying the tool, local technical assistance, the need to design informational and educational materials on GBV, and follow-up through referrals and counter-referrals.
- Review issues regarding tool application, clarifying frequency of use and roles within the clinic.
- Discuss upcoming activities on referral evaluation and monitoring.
- Develop a list with commitments for implementing these actions in the near future.

Optional variation: If appropriate, you may also have providers develop an action plan with specific objectives, activities, deadlines, and persons responsible.

FACILITATOR RESOURCE SHEET: Questions Guide

Development of Implementation Protocols for a Screening Tool to Identify Gender-based Violence for Populations Most at Risk of HIV/AIDS

(1) To which subgroups of transgenders and MSM will the tool be applied?

- All new clients?
- Already-registered clients who come in for medical attention or another treatment?
- Those who come in for voluntary counseling and testing?
- Mental health clients?

(2) When should the tool be applied?

- During the treatment process?
- Certain days or hours of the day?

(3) Who is going to apply the tool (among trained professionals)?

- How will the tool, which will be kept in the client's file, be explained to service providers who are not involved in its application?

(4) How will the tool be introduced?

(5) When will tool application begin?

(6) Other considerations?

XIII. CLOSING

Objective

- To review the expectations and challenges posed at the beginning of the workshop, contrasting them with the workshop objectives.

Materials

- Flipchart sheets of expectations and challenges
- Flipchart sheets of workshop objectives

Time: 30 minutes

Instructions

- Carry out a detailed review of the expectations and challenges posed by participants at the beginning of the workshop, comparing them with the workshop objectives.
- Ask participants to share their specific observations regarding the degree of fulfillment of their expectations and challenges during the workshop.
- Provide contact information and tell participants that you are available to answer remaining questions or address concerns.

ANNEX. Screening Tool to Identify Violence against Men who have Sex with Men and Transgenders

Instructions to Health Providers

Why screen?

Gender-based violence—violence "based on socially ascribed differences between males and females"—that is perpetrated against men who have sex with men (MSM) and transgenders (TG), can increase a client's vulnerability to HIV and other STIs. Evidence suggests that violence against MSM and TG and related stigma and discrimination (S&D) is associated with increased risk of acquiring HIV. Violence against MSM and TG may also affect their ability to access and adhere to care, treatment, and support, as well as their overall health status and ability to live positively.

By identifying patients who have experienced GBV, providers may be able to better identify a patient's healthcare needs and factors affecting their health; help break the silence and stigma a patient may experience related to GBV, and connect patients with other sources of support.

Whom and when to screen?

The tool is for use with MSM and transgenders—including male sex workers within both groups—in HIV service settings that specialize in services for these populations. Ideally, you will determine whether the patient belongs to one of these populations through demographic information collected in the patient intake form (for new patients) or the clinical history for returning patients.

Who is considered MSM? Any man that has sexual relations with other men. Some, but not all MSM identify as gay. MSM can include a broad range of individuals, including but not limited to sexually active gay males who identify as such, bisexuals who are sexually active with other males, men who are married to or have sex with a woman but also with men, "closeted" homosexuals having sex with other men, anonymous or faceless sexual encounters between males, and male sex workers with clients.

Who is considered transgender? Transgenders are people who were assigned a gender, usually at birth, based on their genitals, but who feel that this is a false or incomplete description of themselves. Transgender people may identify as heterosexual, homosexual, bisexual, pansexual, polysexual or asexual. Beyond sexuality, transgender identities also include many categories that may overlap, including transvestite or cross-dresser; androgynies (those who are non-gendered or between genders); people who live cross-gender; drag kings and drag queens (those who cross-dress for special occasions); and, frequently, transsexuals (those who undergo sex reassignment therapy to physically change their bodies to live and be accepted as a member of the sex opposite to that assigned at birth).

It is recommended that you screen all new and existing patients, initially, as part of introducing the new screening tool and then on a regular basis. (The times should be determined by the health service providers—the suggested time is once a year.) Both the administration and staff of your clinic should develop and agree on these protocols.

The following questions are designed to be integrated into already existing, routine interview and counseling processes within the clinic. These questions about violence ideally should follow questions you already ask about sexual history. The specific place to insert these questions into these existing processes and how often to screen should be determined in each clinic in consultation with staff.

Based on discussions in your clinic, insert these GBV-related questions inserted into one of the following:

- New patient in-take
  - [Form:_____ ; Place in format:_____]
- Mental health history
  - [Form:_____; Place in format:_____]
- Counseling for VCT
  - [Form:_____; Place in format: _____]
- For existing patients, these questions are best asked during
  - Clinical history
  - [Insert response based on consultation with clinic staff]

Step 1: Informed Consent and Sexual Identity (ASK ALL PATIENTS)

1.1 We would like to first ask information regarding your sex and sexual identity? We ensure that this information will be kept confidential and will be used only as a basis for providing you services that will best respond to your needs. So, if you don't mind, could you please indicate whether you are

☐ Male ☐Female ☐ TG (Multiple answers allowed)

1.2 Please indicate the sex of your sexual partner:

☐ Male ☐ Female ☐ TG ☐ Do not have sexual partner (Multiple answers allowed)

Note for the Healthcare Provider: To determine whether one is MSM or transgender, it is important to consider 1) sexual identity—the sex the person considers him/herself to be or has adopted; 2) sexual orientation—as defined by the sex or sexes of the person's sexual partner/s; and 3) gender expression—the preferences and behavior that communicates one's sex/gender; for example, clothing, hair styles, mannerisms, way of speaking, roles in interactions, as defined by traditional social and gender norms. Questions 1.1 and 1.2 pertain to sexual identity and sexual orientation. Based on this information, is the patient

☐ MSM ☐ TG ☐ Other, specify: _____

This tool was designed with MSM and TG patients in mind but may be used with others, provided that your clinic has instituted proper training and sensitization for staff and has implemented referral systems.

Introduction of Tool to Patients
Because of the fact that mistreatment and violence are common and can have an effect on people's health, we have begun to ask clients about them. In particular, we seek to address the needs of MSM and transgenders who may be experiencing violence. The information will be kept confidential. If you do not mind, I would like to ask you questions about any mistreatment or violence you may have experienced in the past or currently.

Understand that if you are uncomfortable or not willing to answer any questions, you are allowed to refuse to answer. Your refusal will not affect the service you are receiving. (*If the client indicates that it is okay, proceed with the following questions.)*

☐ Agree ☐ Not agree (**End the interview**)

Step 2: History of Violent Experiences

2.1 In the past year, has anyone forced or coerced you to have sexual relations against your will? This includes your partner, a client, supervisor, colleague, someone in your family, a friend, neighbor, police, or other persons.

YES ( ) NO ( ) NO RESPONSE ( )

2.2 In the past year, has anyone slapped you, punched you, hit you, or caused you any other type of physical harm? This includes your partner, a client, supervisor, colleague, someone in your family, a friend, neighbor, police, or other persons.

YES ( ) NO ( ) NO RESPONSE ( )

2.3 In the past year, has anyone insulted you, humiliated you, made you feel inadequate, or yelled at you? This includes your partner, a client, supervisor, colleague, someone in your family, a friend, neighbor, police, or other persons.

YES ( ) NO ( ) NO RESPONSE ( )

2.4 In the past year, has anyone made you feel threatened, fearful, or in danger? This includes your partner, a client, supervisor, colleague, someone in your family, a friend, neighbor, police, or other persons.

YES ( ) NO ( ) NO RESPONSE ( )

IF PATIENT RESPONDS 'NO' TO QUESTIONS 2.1 –2.4

*If the patient never experienced any of the above violence, **end the interview**, and provide the patent with a list of organizations that provide specialized services from which he/she can seek support if experiencing violence or abuse in the future.*

IF PATIENT RESPONDS 'YES' TO ANY OF THE ABOVE

If the patient responds positively to any of the above, it is important to tell them that violence is never deserved. The following is a suggested way to phrase this thought:

"Mistreatment and abuse are often more common than thought. Yet, no one deserves to be abused. I am now going to ask you a few questions so that we can evaluate possible effects on your health and outline some alternatives, if necessary."

2.5 Do you want or are you ready to tell me more detail about the incidences of violence you mentioned earlier?

- ☐ Yes, I would like to talk about the detail. (Instruction: Continue with question and allow the patient to describe all of the incidences mentioned or select only the event s/he feel was most severe.)
- ☐ No, I would not like to talk about this. But I can come back to this conversation again on _____(Date) at _____(Time)_____ (Place). (Skip to Question 3.1)
- ☐ No, I would not like to talk about this right now, but I need you to refer me to supporting service. (Skip to Question 3.1)
- ☐ I totally don't want to talk about this. (**End the interview** and provide the patient the list of referral organizations.)

Tell me about the last time you experienced violence. *Note to providers: this is an open question. You do not need to ask each of these questions. Let the patient recount their experiences—and use the following questions as follow-up probes if the* patient *does not directly state these details in their account. Afterward, fill in the chart according to the details obtained for each act of violence.*

For each act of violence the patient has experienced in the past year, please fill out columns A, B, and C.

A. Who?	**B1. When?**	**B2. Where?**	**B3. How?**	**Do you think this happened to you because you are MSM/TG? Explain.**	**C1.* What were the physical consequences?**	**C2.* What were the emotional consequences?**	**C3.* Other consequences?**
Romantic/ sexual partner( )							
Pimp ( )							
Patient/ sexual friend ( )							
Family member ( )							
Friend ( )							
Neighbor ( )							
Stranger ( )							
Police ( )							
Health Worker ( ) Specify:							
Others ( ) Specify:							

(*C1) Bruises, scratches, superficial or serious wounds, injuries from a type of weapon, disfiguration, disability, loss of consciousness, acquiring an STI or HIV.

(*C2) Depression, loss of trust, loss of self-esteem, feeling dirty, feeling guilty, fear, anxiety.

(*C3) Loss of the following: work, authority, respect (from others or self-respect), material goods, family, supportive relationships, etc.

2.6 Did you seek any support or services when you experienced this violence?
Yes ( ) No ( ) No Response ( )

2.7 *If the answer to 2.6 is 'yes,' ask:* **Can you tell me about what help or services you sought? Note**: *Please remember that this is an open question. Let the patient tell his or her experience, and afterward fill in the appropriate information below. For each type of help the patient mentions, follow up with "how much?" Also note that this information may help you decide what types of references to make in Step 3.*

Type of help	How much did the support or services help you?			
Support from a family member ( )	Much	Some	Little	None
Support from friends ( )	Much	Some	Little	None
Psychologist ( )	Much	Some	Little	None
Monk, priest, or faith leader ( )	Much	Some	Little	None
NGO offering services for violence ( )	Much	Some	Little	None
Human rights commission ( )	Much	Some	Little	None
Public hospital ( )	Much	Some	Little	None
Specific medical service ( )	Much	Some	Little	None
Red Cross ( )	Much	Some	Little	None
Other ( ) _____	Much	Some	Little	None

Step 3: Assessment of patient's safety

3.1 Are you still in contact with the person(s) who committed this violence?

Yes ( ) No ( ) No Response ( )

3.2 At this time do you feel safe, without threats, in returning to your daily life and routine?

Yes ( ) No ( ) Specify reason for feeling unsafe: _____

No Response ( )

3.3 At this time, have you thought of hurting yourself or committing suicide due to the violence that has happened to you?

Yes ( ) No ( ) No response ( )

From the information obtained, as a health provider you need to decide: do you consider that this person could be in immediate danger?

YES ( ) NO ( )

Step 4: Referrals

4.1.A. NO, the person is not in immediate danger. Make the appropriate reference:

What kind of help/support do you think you need? (Multiple answers allowed)

☐ Medical care ☐ Psychological counseling support ☐ Living place/sheltering
☐ Legal help ☐ Other (specify)_____

☐ No need for other help or support (End interview and provide the patients the list of referral organizations.)

There are groups and institutions that could offer you help. I would like to mention some of these so that you know about them and can decide if they might be able to offer help that would be useful to you.

Name of Organization	**Type of Referral**	**Referral Made?** (Mark with an X if referral made.)
List service organization	☐ General Medical care ☐ VCT ☐ Psychological support groups ☐ Shelter ☐ Social Service ☐ Drop-in center ☐ Other specify_____	
	☐ General Medical care ☐ VCT ☐ Psychological support groups ☐ Shelter ☐ Social Service ☐ Drop-in center ☐ Other specify_____	
	☐ General Medical care ☐ VCT ☐ Psychological support groups ☐ Shelter ☐ Social Service ☐ Drop-in center ☐ Other specify_____	
	☐ General Medical care ☐ VCT ☐ Psychological support groups ☐ Shelter ☐ Social Service ☐ Drop-in center ☐ Other specify_____	
	☐ General Medical care ☐ VCT ☐ Psychological support groups ☐ Shelter ☐ Social Service ☐ Drop-in center ☐ Other specify_____	

4.1.B. Did the patient accept the referral?

YES ( ) NO ( )

4.1.C. If the person is in immediate danger, and there are specialized services for MSM, transgenders, or sex workers, consult with the available service to identify the best action for ensuring the immediate safety of the person. Elaborate a safety plan when 1) no specialized services exist; 2) existing services are not available; or 3) services exist and are available, but the person does not accept a referral.

Developing a Safety Plan

One of the most important actions that a health provider can take when a client discloses that s/he is living with a violent partner or otherwise regularly in contact with his/her perpetrator, is to work with the client to assess her risk and help him/her develop a safety plan. A healthcare provider can facilitate this planning process by helping the client identify the measures she can take when needing to make quick decisions that could save her life. During this process, it is important that the provider help his/her client identify the real risk in which she finds herself. Safety planning can include a wide range of details, but at the very minimum, providers should help their clients think through the following points:

- **Identify possible escape routes (from common places where violence occurs) and a place to go (e.g., the home of a family member or friend) if s/he needs to leave her home;**
- **Know phone number(s) for organizations that provide help, including drop-in centers or rape hotlines;**
- **Notify one or more trusted friends to watch for signs of violence;**
- **Decide what s/he needs to have ready if she needs to leave her home in a hurry (e.g. clothes, money, documents, keys);**
- **Pack a bag with these items and store it somewhere in her home or with a friend or relative; and**
- **If an argument or confrontation cannot be avoided, try to deal with it in a room or location with an easy exit. Stay away from any room where weapons might be available.**

Adapted from: Skye et al., 2001, p. 9.

For the interviewer: Describe the help/support you can offer when there are no special services for MSM/TG or adequate services addressing violence issues.

Key Steps to Take Before Screening

Develop institutional values and commitment regarding care for survivors of gender-based violence

The values, mission, and overall commitment of an institution can have an enormous influence on the professional culture of frontline providers in any organization. Heise (1999) and others have argued that the most effective way for health services to respond to gender-based violence is for the whole institution to make a commitment to the issue (a systems approach) rather than simply letting the responsibility fall on the shoulders of individual providers. Ideally, senior managers should be aware of gender-based violence as a public health problem and human rights violation and should voice their support for efforts to improve the health service response to violence.

Ensure privacy and confidentiality

Privacy and confidentiality are essential for a survivor's safety in any healthcare setting, given that providers can put the survivor at risk if they share sensitive information with partners, family members, or friends without consent. Moreover, those who have experienced gender-based violence need privacy to be able to disclose those experiences to providers without fear of retaliation from a perpetrator. To protect confidentiality and privacy, health programs need adequate infrastructure and client flow, as well as clear policies outlining when and where providers are allowed to discuss sensitive information.

Provide ongoing sensitization and training for providers

Providers' attitudes, knowledge, and skills regarding gender-based violence can have a major impact on quality of care. Even without routine screening, clients may disclose experiences of physical or sexual violence, and providers who respond poorly can inflict great emotional harm. Moreover, providers who fail to consider the possibility of violence while counseling survivors about STIs and HIV prevention or other health issues may be ineffective. Ignorance about links between health and violence may lead health workers to misdiagnose certain conditions and overlook the risks that some clients face, such as internal stigma, isolation, and self-harm. Each institution must decide how much sensitization and training it can afford to provide. At a minimum, staff should be aware of the epidemiological evidence about violence, a human rights framework for understanding violence, and a basic understanding of local legislation. They should be able to respond to survivors in a compassionate way.

Set up alliances and referral networks

Before encouraging staff to discuss violence with clients, health programs have an obligation to investigate what referral services exist in the local community and to compile this information into a format that healthcare providers can use. Networks and alliances with other organizations are important for other reasons as well. For example, they allow the health sector to play a role in the broader policy debate by raising awareness of gender-based violence as a public health problem.

Understand local and national legislation

Educating providers about laws related to gender-based violence and stigma and discrimination can prepare them to inform survivors about their rights and can alleviate their concerns about getting involved in legal proceedings when a client discloses violence. Both managers and service providers need to be familiar with local and national laws about gender-based violence, stigma, discrimination, and sexuality, including what constitutes a crime, how to preserve forensic evidence, and what rights survivors have with regard to bringing charges against a perpetrator and protecting themselves from future violence. Healthcare providers also need to understand their obligations under the law, including legal reporting requirements (for example, in cases of child sexual abuse), as well as regulations governing who has access to medical records (for example, whether parents have the right to access the medical records of adolescents).

Safeguard medical records and information systems

Information systems play an important role in the response to violence in several ways. For example, health organizations have an obligation to ensure that providers know how to record sensitive information about cases of gender-based violence. Documenting information about violence in medical records may be important for completing a client's medical record and in some cases, may provide evidence for future legal proceedings and advocacy. To protect survivor's safety and well-being, medical records need to be stored securely. Information systems are also important for monitoring a health organizations' work in the area of gender-based violence. For example, healthcare organizations can gather service statistics on the number of clients identified as survivors of violence, information that can help them determine the level of demand for other services.

Adapted from: Bott et al., 2004, pp. 40–41.

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